

***Infant and Young Child Feeding
Counselling:
An Integrated Course***

Trainer's Guide



**World Health
Organization**

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Total time for sessions 1 – 39 = 34 hours + 35 minutes

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 15 to 23 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 flip chart - 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.

Role-Plays

- Set up role-plays carefully. Obtain 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.

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.

Practical 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 PRACTICAL DISCUSSION CHECKLIST.
- Try to get participants to identify their own strengths and weaknesses. Ask questions like - What did you do well? What difficulties did you have? What would you do differently in the future?
- Provide feedback on things which 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.

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 practical session and group work). Before participants begin to move, explain clearly what they will do.

Introduction to the Course

Why this course is needed

The WHO and UNICEF developed The Global Strategy for Infant and Young Child Feeding in 2002 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. This strategy is based on the conclusions and recommendations of expert consultations, which resulted in the global public health recommendation to protect, promote and support exclusive breastfeeding for six months, and to provide safe and appropriate complementary foods with continued breastfeeding for up to two years of age or beyond.

However, many children are not fed in the recommended way. Many mothers, who initiate breastfeeding satisfactorily, often start complementary feeds or stop breastfeeding within a few weeks of delivery. In addition, many children, even those who have grown well for the first six months of life, do not receive adequate complementary feeds. This may result in malnutrition, which is an increasing problem in many countries. More than one-third of under-five children are malnourished – whether stunted, wasted, or deficient in vitamin A, iron or other micronutrients – and malnutrition contributes to more than half of the 10.6 million deaths each year among young children in developing countries.

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 due to the confusing, and often conflicting, information available. Inadequate knowledge about how to breastfeed, the appropriate complementary foods to give, and good feeding practices are often a greater determinant of malnutrition than the availability of food.

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.

Messages about infant feeding have become confused over recent years with the HIV pandemic. In some countries, HIV infection amongst children is now one of the main causes of childhood death. In 90% of cases, children acquire the infection from their mothers, before or during delivery, or through breastfeeding. In 1997, WHO, UNICEF and UNAIDS issued a joint policy statement, indicating that HIV-positive women should be enabled to make a fully informed decision about feeding their infants, and supported to carry out the method of their choice. Guidelines developed in 1998 set out several feeding options to suggest to HIV-positive women. These guidelines also emphasized the need to protect, promote and support breastfeeding for those who are HIV-negative or untested, and to prevent any spillover of artificial feeding to infants of uninfected mothers. There is an urgent need to train those who work in areas where HIV is a problem to counsel women about infant feeding, according to these guidelines.

There are three existing courses available from WHO/UNICEF

- . Breastfeeding Counselling: A Training Course (5 days)
- . HIV and Infant Feeding Counselling: A Training Course (3 days) [with UNAIDS]
- . Complementary Feeding Counselling: A Training Course (3 days)

This 5-day *Infant and Young Child Feeding Counselling: An Integrated Course* does not set out to replace these courses. In fact, most of the material in this integrated course is taken from the three existing courses. However, it is recognized that in many situations there is simply not enough time available to allow health workers to attend all of the above courses. Given the urgency of training large numbers of health workers and counsellors, this integrated course has been developed to train those who care for mothers and young children in the basics of good infant and young child feeding.

‘Counselling’ is an extremely important component of this course, as it is in the three existing courses. 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 simple 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 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.

This course can be used to complement existing courses such as *Integrated Management of Childhood Illness (IMCI)*. This course could also be used as part of the pre-service training of health workers.

This course 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. Participants are encouraged to refer young children for further services and care as necessary. In addition this course 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. This course covers only aspects specifically related to infant feeding.

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, and to counsel and support HIV-infected mothers to choose and carry out an appropriate feeding method for the first two years of life.

Each session of this course has a set of learning objectives. You should make sure that you are clear about what these are when you are preparing to give a session.

Target Audience

This course is aimed at the following groups of people:

- . Lay counsellors
- . Community health workers
- . PMTCT counsellors (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

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

The Trainers

Ideally, course trainers on this integrated course should have completed the three existing WHO counselling courses on infant feeding, as trainers:

- . Breastfeeding Counselling: A Training Course (5 days)
- . HIV and Infant Feeding Counselling: A Training Course (3 days)
- . Complementary Feeding Counselling: A Training Course (3 days)

It is **essential** that trainers on this integrated course are trainers on the Breastfeeding Counselling Course and are competent at counselling and the technical skills required. If the trainers are not already trainers on one of the other two courses (HIV and Infant Feeding Counselling or Complementary Feeding Counselling) then time should be allocated during the training-of-trainers week to make sure that any new material is covered adequately.

The trainers should be people who have hands-on experience of caring for infants and mothers/caregivers. After completing this course it is unlikely that the participants will have learnt all the practical skills covered in the course. A follow-up session is planned after the course. It is essential that those trained as trainers will be available to mentor participants and conduct the follow-up and evaluation following the training. The trainers should, therefore, be people who live locally, and who will have time to conduct this follow-up.

The trainers should have access to the Training Guides from each of the individual courses (listed above). These Guides will provide them with additional background information which will help them to answer participants' questions and clarify issues.

Course competencies

This course is based on a set of competencies which 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), the knowledge required for each competency (column 2) and the skills required for each competency (column 3).

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 in a certain order. The competencies at the beginning of the table are those which are most commonly used, and on which later competencies depend. For example, the competency 'use listening and learning skills to counsel a mother' is used in many of the other competencies.

Competency	Knowledge	Skills
1. Use Listening and Learning skills to counsel a mother	<ul style="list-style-type: none"> List the 6 Listening and Learning skills Give an example of each skill 	<ul style="list-style-type: none"> Use the Listening and Learning skills appropriately when counselling a mother on feeding her infant or young child
2. Use Confidence and Support skills to counsel a mother	<ul style="list-style-type: none"> List the 6 Confidence and Support skills Give an example of each skill 	<ul style="list-style-type: none"> Use the Confidence and Support skills appropriately when counselling a mother on feeding her infant or young child
3. Assess a breastfeed	<ul style="list-style-type: none"> Explain the contents and arrangement of the BREASTFEED OBSERVATION JOB AID 	<ul style="list-style-type: none"> Assess a breastfeed using the BREASTFEED OBSERVATION JOB AID Recognize a mother who needs help using the BREASTFEED OBSERVATION JOB AID
4. Help a mother to position a baby at the breast	<ul style="list-style-type: none"> Explain the 4 key points of positioning Describe how a mother should support her breast for feeding Explain the main positions – sitting, lying, underarm and across 	<ul style="list-style-type: none"> Recognize good and poor positioning according to the 4 key points Help a mother to position her baby using the 4 key points, in different positions
5. Help a mother to attach her baby to the breast	<ul style="list-style-type: none"> Describe the relevant anatomy and physiology of the breast and suckling action of the baby Explain the 4 key points of attachment 	<ul style="list-style-type: none"> Recognize signs of good and poor attachment and effective suckling according to the BREASTFEED OBSERVATION JOB AID Help a mother to get her baby to attach to the breast once he is well positioned

Competency	Knowledge	Skills
6. Explain to a mother about the optimal pattern of breastfeeding	<ul style="list-style-type: none"> • Describe the physiology of breast milk production and flow • Describe unrestricted (or demand) feeding, and implications for frequency and duration of breastfeeds and using both breasts alternatively 	<ul style="list-style-type: none"> • Explain to a mother about the optimal pattern of breastfeeding and demand feeding
7. Help a mother to express her breast milk by hand	<ul style="list-style-type: none"> • 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 breast milk 	<ul style="list-style-type: none"> • 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
8. Help a mother to cup-feed her baby	<ul style="list-style-type: none"> • 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 	<ul style="list-style-type: none"> • 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
9. Plot and interpret a growth chart	<ul style="list-style-type: none"> • Explain the meaning of the standard curves • Describe where to find the age and the weight of a child on a growth chart 	<ul style="list-style-type: none"> • Plot the weights of a child on a growth chart • Interpret a child's individual growth curve
10. Take a feeding history for an infant 0-6 months	<ul style="list-style-type: none"> • Describe the contents and arrangement of the FEEDING HISTORY JOB AID, 0-6 MONTHS 	<ul style="list-style-type: none"> • Take a feeding history using the job aid and appropriate counselling skills according to the age of the child
11. Teach a mother the 10 Key Messages for complementary feeding	<ul style="list-style-type: none"> • List and explain the 6 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 2 Key Messages about quantities of food to give to an infant or young child (Key Messages 7-8) • 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) 	<ul style="list-style-type: none"> • Explain to a mother the 6 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 2 Key Messages about quantities of food to give to an infant or young child (Key Messages 7-8) • 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)

Competency	Knowledge	Skills
12. Counsel a pregnant woman about breastfeeding	<ul style="list-style-type: none"> • List the Ten Steps to Successful Breastfeeding • Describe how the International Code of Marketing of Breast-milk Substitutes helps to protect breastfeeding • Discuss why exclusive breastfeeding is important for the first six months • List the special properties of colostrum and reasons why it is important 	<ul style="list-style-type: none"> • 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 1, 2 and 6
13. Help a mother to initiate breastfeeding	<ul style="list-style-type: none"> • Discuss the importance of early contact after delivery and of the baby receiving colostrum • Describe how health care practices affect initiation of exclusive breastfeeding 	<ul style="list-style-type: none"> • Help a mother to initiate skin-to-skin contact immediately after delivery and to introduce her baby to the breast • Apply competencies 1, 2, 4 and 5
14. Support exclusive breast feeding for the first six months of life	<ul style="list-style-type: none"> • Describe why exclusive breastfeeding is important • Describe the support that a mother needs to sustain exclusive breastfeeding 	<ul style="list-style-type: none"> • Apply competencies 1 to 10 appropriately
15. Help a mother to sustain breastfeeding up to 2 years of age or beyond	<ul style="list-style-type: none"> • Describe the importance of breast milk in the 2nd year of life 	<ul style="list-style-type: none"> • Apply competencies 1, 2, 9 and 10, including explaining the value of breastfeeding up to 2 years and beyond
16. Help a mother with 'not enough milk'	<ul style="list-style-type: none"> • Describe the common reasons why a baby may have a low breast milk intake • Describe the common reasons for apparent insufficiency of milk • List the reliable signs that a baby is not getting enough milk 	<ul style="list-style-type: none"> • Apply competencies 1, 3, 9 and 10 to decide the cause • Apply competencies 2, 4, 5, 6, 7 and 8 to overcome the difficulty, including explaining the cause of the difficulty to the mother
17. Help a mother with a baby who cries frequently	<ul style="list-style-type: none"> • List the causes of frequent crying • Describe the management of a crying baby 	<ul style="list-style-type: none"> • Apply competencies 1, 3, 9 and 10 to decide the cause • Apply competencies 2, 4, 5 and 6 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
18. Help a mother whose baby is refusing to breastfeed	<ul style="list-style-type: none"> • List the causes of breast refusal • Describe the management of breast refusal 	<ul style="list-style-type: none"> • Apply competencies 1, 3, 9 and 10 to decide the cause • Apply competencies 2, 4 and 5 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 7 and 8 to maintain breast milk production and to feed the baby meanwhile

Competency	Knowledge	Skills
19. Help a mother who has flat or inverted nipples	<ul style="list-style-type: none"> • Explain the difference between flat and inverted nipples and about protractility • Explain how to manage flat and inverted nipples 	<ul style="list-style-type: none"> • Recognize flat and inverted nipples • Apply competencies 2, 4, 5, 7 and 8 to overcome the difficulty • Show a mother how to use the syringe method for the treatment of inverted nipples
20. Help a mother with engorged breasts	<ul style="list-style-type: none"> • Explain the differences between full and engorged breasts • Explain the reasons why breasts may become engorged • Explain how to manage breast engorgement 	<ul style="list-style-type: none"> • Recognize the difference between full and engorged breasts • Apply competencies 2, 4, 5, 6 and 7 to manage the difficulty
21. Help a mother with sore or cracked nipples	<ul style="list-style-type: none"> • 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 	<ul style="list-style-type: none"> • Recognize sore and cracked nipples • Recognize candida infection of the breast • Apply competencies 2, 3, 4, 5, 7 and 8 to manage these conditions
22. Help a mother with mastitis	<ul style="list-style-type: none"> • 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 the difference between treating mastitis in an HIV-negative and HIV-positive mother 	<ul style="list-style-type: none"> • Recognize mastitis and refer if necessary • Recognize a blocked milk duct • Manage blocked duct appropriately • Manage mastitis appropriately using competencies 1, 2, 3, 4, 5, 6, 7, 8 and rest, analgesics and antibiotics if indicated. Refer to the appropriate level of care • Refer mastitis in an HIV-positive mother to the appropriate level of care
23. Help a mother to breastfeed a low-birth-weight baby or sick baby	<ul style="list-style-type: none"> • Explain why breast milk is important for a low-birth-weight baby 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 	<ul style="list-style-type: none"> • Help a mother to feed her LBW baby appropriately • Apply competencies, especially 7, 8 and 9, to manage these infants appropriately • Explain to a mother the importance of breastfeeding during illness and recovery
24. Counsel an HIV-positive woman antenatally about feeding choices	<ul style="list-style-type: none"> • Explain the risk of mother-to-child transmission of HIV • Outline approaches that can prevent MTCT through safer infant feeding practices • State infant feeding recommendations for women who are HIV+ve and for women who are HIV –ve or do not know their status • List advantages and disadvantages of these feeding options 	<ul style="list-style-type: none"> • Apply competencies 1 and 2 to counsel an HIV-positive woman • Use the Flow Chart and the Counselling Cards to help an HIV-positive woman to come to her own decision about how to feed her baby

Competency	Knowledge	Skills
25. Support an HIV-positive mother in her feeding choice	<ul style="list-style-type: none"> • List the different types of replacement milks available locally and how much they cost • Explain how to prepare the milks • Describe hygienic preparation of feeds and utensils • Explain the volumes of milk to offer a baby according to weight • Explain exclusive breastfeeding and stopping early • Explain how to heat-treat and store breast milk • Describe the criteria for selection of a wet-nurse 	<ul style="list-style-type: none"> • Help a mother to prepare the type of replacement milk she has chosen • Apply competency 8 • 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 • Apply competencies 1, 2, 3, 4, 5, and 6 to support a mother to breastfeed exclusively and optimally • Show a mother how to heat-treat breast milk and apply competencies 7 and 8 • Apply competencies 1, 2, 3, 4, 5 and 6 to support the wet-nurse • Use the Counselling Cards and Flyers appropriately
26. Follow-up the infant of an HIV-positive mother 0-6 months who is receiving replacement milk	<ul style="list-style-type: none"> • 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 	<ul style="list-style-type: none"> • Show a mother how to prepare replacement feeds hygienically • Practise with a mother how to prepare replacement feeds hygienically • Apply competency 8 • 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
27. Help an HIV-positive mother to cease breastfeeding early and make a safe transition to replacement feeds	<ul style="list-style-type: none"> • 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 & how to prepare them • Explain when to arrange follow-up or when to refer 	<ul style="list-style-type: none"> • Explain to a mother how she should prepare to stop breastfeeding early • Practise with a mother how to prepare replacement feeds hygienically • Apply competencies 7 and 8 • Manage breast engorgement and mastitis in an HIV-infected woman who is stopping breastfeeding (competencies 20 and 22) • Explain to a mother ways to comfort a baby who is no longer breastfeeding

Competency	Knowledge	Skills
28. Help mothers whose babies are over six months of age to give complementary feeds	<ul style="list-style-type: none"> • List the gaps which occur after six 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 quantity, quality, consistency, frequency and method of feeding at different ages 	<ul style="list-style-type: none"> • Apply competencies 1, 2, 9 and 10 • Use the FOOD INTAKE JOB AID, 6-23 MONTHS to learn how a mother is feeding her infant or young child • Identify the gaps in the diet using the FOOD INTAKE JOB AID, 6-23 MONTHS and THE FOOD INTAKE REFERENCE TOOL, 6-23 MONTHS • Explain to a mother what foods to feed her child to fill the gaps, applying competency 11 • 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
29. Help a mother with a breastfed child over six months of age who is not growing well	<ul style="list-style-type: none"> • Explain feeding during illness and recovery • Describe how to prepare feeds hygienically 	<ul style="list-style-type: none"> • Apply competency 15 to help a mother to sustain breastfeeding up to 2 years of age or beyond • Apply competencies 1, 2, 9, 10 and 11 • Explain to a mother how to feed 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
30. Help a mother with a non-breastfed child over six months of age who is not growing well	<ul style="list-style-type: none"> • 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 quantity, quality, consistency, frequency and method of feeding • Explain feeding during illness and recovery • Describe how to prepare feeds hygienically 	<ul style="list-style-type: none"> • Apply competencies 1, 2, 9, 10 and 11 • Explain to a mother how to feed a non-breastfed child • Explain to a mother how to feed 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

The Course and the Materials

Structure of the course

The course is divided into 39 sessions, which take approximately 35 hours without meals or the opening and closing ceremonies. 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 including practicals and exercises.

Those working in areas where HIV is not a problem, and who wish to omit the information on HIV, concentrating only on Breastfeeding and Complementary Feeding Counselling, should refer to the 'Adaptation Notes for Conducting the Course Without the Sessions on HIV and Infant Feeding', on page 24 in this Guide, and to the suggested timetable in the *Director's Guide*.

Order of sessions

The sessions are in a suggested sequence (see example of Timetables in the *Director's Guide*) but the order may need to be adapted to suit local facilities – for example, if mothers and infants are not available for practical sessions at the suggested times. The course begins with breastfeeding, focussing on the first six months of life. Following these sessions are the sessions on HIV and infant feeding, covering feeding options in the first six months for mothers in areas where HIV is a problem. Finally there are the sessions on complementary feeding which discuss feeding infants and young children from 6-24 months of age.

Some 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, which prepare participants for a particular practical session, before the practical. Sessions 1-6 should be completed before Practical Session 1; sessions 8-11 before Practical Session 2; 17-23 before Practical Session 3 and Sessions 28-33 before Practical Session 4.

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, 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.

The 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 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. These are provided on a CD for projection onto a screen. Alternatively you can use overhead transparencies, and picture books containing the photographs. 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* is provided for each participant. This contains summaries of information, copies of Worksheets and Checklists for the 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.

Answer sheets

These are provided separately, 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 practical sessions and counselling exercises are provided. These are:

- . BREASTFEED OBSERVATION JOB AID
- . FEEDING HISTORY JOB AID, 0-6 MONTHS
- . FOOD INTAKE JOB AID, 6-23 MONTHS
- . LISTENING AND LEARNING SKILLS CHECKLIST
- . COUNSELLING SKILLS CHECKLIST ('listening and learning' & 'confidence and support')
- . PRACTICAL DISCUSSION CHECKLIST (for trainers only)
- . Sets of HIV and Infant Feeding Counselling Cards

Story Cards

Copies of the Counselling Stories are provided for Session 27 and 33.

Updates

Periodic updates on the topics covered on this course will be available at CAH and NHD 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 1 life-size baby doll and 1 model breast for each small working group of 3-4 participants.

If dolls and breasts are not available here are some instructions for making them very simply and out of readily available material.

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 2 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.

Resource Materials

RESOURCE MATERIALS

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

These can be downloaded from WHO web sites: www.who.int/child-adolescent-health/publications or www.who.int/nut/publications

Also available from Marketing and Distribution of Information, WHO, Avenue Appia, 1211 Geneva 27, Switzerland, Fax: 41-22-791-4857; bookorders@who.int or your local WHO Publication Stockists.

- Global Strategy for Infant and Young Child Feeding Geneva, 2003.
- Protecting, Promoting and supporting breast-feeding: the special role of maternity services. A joint WHO/UNICEF Statement, Geneva, 1989
- International Code of Marketing of Breast-milk Substitutes. Geneva, 1981.
- The International Code of Marketing of Breast-milk Substitutes: Frequently Asked Questions. WHO, Geneva, 2006.
- Evidence for the Ten Steps to Successful Breastfeeding WHO/CHD/98.9
- Annex to the Global Criteria for Baby-friendly Hospitals: Acceptable Medical Reasons for Supplementation
- Annex to Breastfeeding Counselling: A training Course on Breastfeeding and Maternal Medication: Recommendations for drugs in the WHO Model List of Essential Drugs WHO/CDR/95.11
- Relactation – a review of experience and recommendations for practice WHO/CHS/CAH/98.14
- Mastitis: causes and management WHO/FCH/CAH/00.13
- Community-Based Strategies for Breastfeeding Promotion and Support in Developing Countries WHO 2003
- Complementary Feeding – family foods for breastfed children. WHO/NHD/00.1
- Guiding Principles for Complementary Feeding of the Breastfed Child. 2003, PAHO/WHO, Division of Health Promotion and Protection/Food and Nutrition Program, Washington, DC, USA.
- Complementary Feeding of Young Children in Developing Countries: a review of current scientific knowledge. WHO/NUT/98.1
- The optimal duration of exclusive breastfeeding: a systematic review. WHO/NHD/01.08
- Breastfeeding Counselling: A training course. WHO/CDR/ 93.4; UNICEF/NUT/93.2
- HIV and Infant Feeding Counselling: a training course WHO/FCH/CAH/00.3
- Complementary Feeding Counselling: a training course WHO
- A critical link-interventions for physical growth and psychological development, a review. WHO/CHS/CAH/99.3
- HIV and Infant Feeding – guidelines for decision-makers Geneva, 2003
- HIV and Infant Feeding – a guide for health care managers and supervisors Geneva, 2003
- HIV and Infant Feeding – a review of HIV transmission through breastfeeding Geneva, 2004
- Guiding principles for feeding the non-breastfed child 6-24 months. Geneva, 2005
- Infant and young child feeding: A tool for assessing national practices, policies and programmes, Geneva 2003
- HIV and infant feeding: Framework for priority action. Geneva, 2003
- HIV and infant feeding: Counselling tools. Geneva, 2005.
- Hepatitis B and breastfeeding update. WHO 1996
- Breastfeeding and maternal tuberculosis update. WHO 1998
- Acta Paediatrica: WHO Child Growth Standards. Acta Paediatrica Supplement 2006; 450: 5-101
- De Onis M et al. The WHO Multicentre Growth Reference Study (MGRS): Rationale, planning and implementation. Food and Nutrition Bulletin 2004; 25 (Supplement 1): S3-S84

Available from WHO, Department of Food Safety (FOS) fos@who.int

- Basic principles for the preparation of safe food for infants and young children WHO/FNU/FOS/96.6 www.who.int/fsf/Documents/brochure/basic.pdf
- Adams M, & Motarjemi, Y. Basic Food Safety for Health Workers. WHO/SDE/PHE/FOS/99.1
- Five keys to safer food (poster). WHO/SDE/PHE/FOS/01.1 <http://www.who.int/foodsafety/publications/consumer/5keys/en/index.html>
- Five keys to safer food manual <http://www.who.int/foodsafety/consumer/5keysmanual/en/index.html>

Available from WHO, HIS (HIV/AIDS/STI)

- Counselling for HIV/AIDS: a key to caring WHO/GPA/TCO/HCS/95.15
- HIV in Pregnancy: a Review WHO/CHS/RHR/99.15; UNAIDS 99.35

**Available from UNAIDS Information Centre, 20 Avenue Appia, 1211 Geneva 27, Switzerland
unaids@unaids.org**

- Prevention of HIV transmission from mother to child: Strategic options. UNAIDS/99.44E
- Counselling and Voluntary HIV testing for pregnant women in high HIV prevalence countries: elements and issues. UNAIDS/99.40E

Available from WHO Regional Office for Europe, Copenhagen, Denmark

- Fleischer Michaelsen K, Weaver L, Branca F, Robertson A, Feeding and nutrition of infants and young children – guidelines for the WHO European Region. WHO Regional Publication, European Series, No 87, 2000

**Available from UNICEF, Nutrition Section, 3 United Nations Plaza, New York NY 10017, USA:
wdemos@unicef.org**

- Engle P. The Care Initiative: assessment, analysis and action to improve care for nutrition. New York: UNICEF Nutrition Section, 1997.
- Armstrong, HC. Techniques of Feeding Infants: the case for cup feeding. Research in Action, No 8, June 1998, UNICEF, NY

Available from Teaching Aids At Low Cost, PO Box 49, St Albans, Herts AL1 5TX, UK, Fax: +44-1727-846852 www.talcuk.org

- Savage-King, F & Burgess, A, Nutrition for Developing Countries, ELBS, Oxford University Press, 1995
- Savage-King, F, Helping mothers to breastfeed (Revised Edition, African Medical and Research Foundation, 1992, or an adapted version), AMREF, Kenya

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 3-4 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, 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 her 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 her to do some of the exercises in a different way.

Using Your Trainer's Guide

Before you lead any session:

Look at your Guide and read the the 'Session Outline', to find out what kind of session it will be, and what your responsibilities are. Read the 'Objectives' to find out what the participants should be able to do at the end of the session.

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 flip chart 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 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 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.

Preparing to give a presentation

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 at the end of the 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 they 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 session 4 'Assessing a Breastfeed' and session 20 'Breast conditions'.

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 a way so 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 Manuals closed while answering discussion questions so that they think about possible answers rather than read the information from their Manual.

Do not get involved in discussions which are distracting, and which 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 her 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 her, and make her feel that she is 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 pretend to be a mother. It is usually a good idea to ask a participant to help you. This can be a good learning experience for her. It increases her involvement, and helps her 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 her the words she will read the day before so that 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 the 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 transparency 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 themselves practise what you demonstrate. They will learn more if they try things out, 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 Manuals. Ask them to read the notes later on the same day.

Working in groups

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

Work in groups of 3-4 with one trainer is mainly for the practice of skills, such as the practical 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.

Facilitating 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 8, but work by themselves.

Make sure participants have found the correct page in their 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 Guide. Praise them if they have a good answer. If an answer is incorrect, do not make them feel ridiculed. Ask them if 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 easily.

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.

Practical sessions

For Practical Sessions 1, 2 and 4 each trainer takes her group of 3-4 participants to a ward or clinic to practise with mothers, caregivers and infants the skills they have learnt in the previous sessions. Use the PRACTICAL 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 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 practical session.

Checklist of training skills

At the front of the Guide 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 you how to make your session effective.

WHAT THE SIGNS USED IN THE GUIDE INDICATE

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

Further Information – these sections give extra information on topics in the text. You should not present them with the main presentation but they may help you to answer questions that arise in the course of the discussion.

Follow-up after training

It is unlikely that participants will learn all the competencies listed on pages 4-9 of this Guide during the course. They should have a sound theoretical knowledge at the end of the course, and have practised the counselling skills in many different situations. However, practical skills (e.g. helping a mother to position and attach her baby; using the FOOD INTAKE JOB AID; counselling an HIV-positive mother about different feeding options) need time to practise in many different situations before participants will become really confident.

Follow-up after this course in the participants' work-place is essential, not only to evaluate the training but also to build participants' confidence, listen to situations that they have found difficult to manage, and to assess their practical and counselling skills after the training.

The Course Director will give you details of the schedule for the follow-up visit in the Training-of-Trainers course. You will also be provided with the necessary forms and paper-work. The follow-up is designed to take one working day at the participants' work place. Ideally several participants from one facility, or area, can be assessed on the same day. The maximum number of participants to assess during one day is four.

The follow-up will be discussed with the participants in Session 39 of the course. The participants will also be asked to prepare some exercises and a log of skills ready for this follow-up.

The follow-up will start with an Introduction and Welcome to the participants. It is important to emphasize to participants that this is not an exam, but is a way for us to assess the training and to help with situations that they have found difficult to manage since the course. Participants will not be given an individual mark during the assessment.

The counselling and technical skills of participants will then be assessed in a practical situation. It will not be possible to assess all competencies for all participants. This exercise will take most of the morning, particularly if there are 2-4 participants being assessed.

The afternoon is spent in a classroom setting. You will look at the log of that the participants have kept of skills they have practised in their work setting. This can be done as a group with all the participants together. You can use this opportunity to facilitate a group discussion of skills that participants have found hard to learn and situations which they have found difficult to manage. If there are any conditions in their facility that affect the implementation of infant feeding counselling then these should be discussed. You will be asked to make a record of these.

Finally you will go through the individual written exercises that the participants have completed. This will give you further opportunities to reinforce both knowledge and application of counselling skills.

When all the trainers have completed their follow-up visits, a meeting will be held at the district level to discuss the findings and any actions needed. The purpose of this meeting is to describe the progress of infant feeding training in the district, any important or recurring problems and any actions needed.

Adaptation Notes for Conducting the Course without the Sessions on HIV and Infant Feeding

This course has been designed so that it can be conducted with or without the sessions on HIV and infant feeding.

There are some sessions which deal specifically with issues around HIV and infant feeding. These are:

- Session 17 Overview of HIV and infant feeding (45 minutes)
- Session 18 Counselling for infant feeding decisions (30 minutes)
- Session 19 Breast-milk options for HIV-infected women (45 minutes)
- Session 21 Replacement feeding in the first 6 months (45 minutes)
- Session 23 Preparation of milk feeds (45 minutes)
- Session 24 Practical Session 3: preparation of milk feeds (105 minutes)
- Session 27 Counselling on infant feeding choices for HIV-infected women (90 minutes).

In addition there are some sections of sessions which should only be included if the course will address issues around HIV and infant feeding.

- Session 20 Breast health conditions (Engorgement in an HIV-infected woman who is stopping breastfeeding, page 265 of the *Trainer's Guide*; Mastitis in an HIV-infected woman, page 270 of the *Trainer's Guide*).

If the prevalence of HIV is low in your area and you are not going to include HIV and infant feeding in the course, these are the sessions to omit. However it is recommended to include Session 17 so all participants have an overview of HIV and infant feeding.

In the counselling exercises there are some examples of HIV-infected women. These should be completed, whether or not HIV is a problem in your area, as participants should be able to use their counselling skills in any situation.

If the sessions on HIV and Infant Feeding (above) are being omitted, there is more time in the course for showing videos and spending longer on the exercises and practical sessions. Examples of suggested timetables are found in the *Director's Guide*.

Session 1

An Introduction to Infant and Young Child Feeding

Objectives

After completing this session participants will be able to:

- describe The Global Strategy for Infant and Young Child Feeding
- list the operational targets of The Global Strategy
- state the current recommendations for feeding children from 0-24 months of age

Session outline

20 minutes

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

- | | | |
|------|------------------------|------------|
| I. | Introduce the session | 3 minutes |
| II. | Present Slides 1/1-1/6 | 15 minutes |
| III. | Summarize the session | 2 minutes |

Preparation

- Refer to the Introduction for guidance on giving a presentation with slides.
- Make sure that Slides 1/1-1/6 are in the correct order. Study the slides and the text that goes with them so that you are able to present them.
- Make sure that you have one copy of The Global Strategy for Infant and Young Child Feeding for each participant.
- Read the Further Information sections so that you are familiar with the ideas that they contain.

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:

Introduction to infant and young child feeding^{1/1}

After completing this session participants will be able to:

- describe The Global Strategy for Infant and Young Child Feeding
- list the operational targets of The Global Strategy
- state the current recommendations for feeding children from 0-24 months of age

II. Present Slides 1/2 - 1/6**15 minutes**

-
- Make these points:
- We will start this course by looking at The Global Strategy for Infant and Young Child Feeding.

Ask: Has anyone heard of The Global Strategy for Infant and Young Child Feeding and what is contained in it?

Wait for a few replies and then continue.

Show **Slide 1/2 - The Global Strategy** and make the points that follow:

The Global Strategy for Infant and Young Child Feeding

1/2

- Developed by WHO and UNICEF to revitalize world attention on the impact that feeding practices have on infants and young children
- Malnutrition has been responsible, directly or indirectly, for over 50% of the 10.6 million deaths annually among children <5years
- Over two-thirds of these deaths occur in the first year of life

- The Global Strategy for Infant and Young Child Feeding was developed by WHO and 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.
- Malnutrition has been responsible, directly or indirectly, for over 50% of the 10.6 million deaths annually among children under five.
- Well over two-thirds of these deaths, which are often associated with inappropriate feeding practices, occur during the first year of life.

Show **Slide 1/3 - Policy initiatives** and make the points that follow:

1/3

Policy initiatives

- International Code of Marketing of Breast-milk Substitutes (1981)
- Innocenti Declaration (1990)
- Baby-friendly Hospital Initiative (1991)

- Global Strategy for Infant and Young Child Feeding (2002)

- The Global Strategy was launched in 2002. It was built on previous initiatives such as the International Code of Marketing of Breast-milk Substitutes in 1981, the Innocenti Declaration in 1990 and the Baby-friendly Hospital Initiative in 1991. We will be discussing some of these important initiatives later in the course.
- The Global Strategy is designed for use by governments and other concerned parties, such as health professional bodies, non-governmental organizations, commercial enterprises and international organizations.
- The Strategy lists the WHO/UNICEF recommendations for appropriate feeding of infants and young children, explains the obligations and responsibilities of governments and concerned parties, and describes the actions they could take to protect, promote and support mothers to follow recommended feeding practices.

Ask participants to turn to page 4 of their Manuals and find the box GLOBAL STRATEGY FOR INFANT AND YOUNG CHILD FEEDING: SUMMARY OF OPERATIONAL TARGETS. Ask participants to take turns to read out the targets:

GLOBAL STRATEGY FOR INFANT AND YOUNG CHILD FEEDING**SUMMARY OF OPERATIONAL TARGETS**

All governments are urged to:

A. Follow up previous targets from Innocenti Declaration:

1. Appoint a national breastfeeding coordinator with appropriate authority, and establish a multisectoral national breastfeeding committee
2. Ensure that every facility providing maternity services fully practises all the 'Ten steps to successful breastfeeding' set out in the WHO/UNICEF statement on breastfeeding and maternity services
3. Implement the International Code of Marketing of Breast-milk Substitutes and subsequent resolutions
4. Enact imaginative legislation protecting the breastfeeding rights of working women and establish means for its enforcement

B. Introduce these five NEW targets:

5. Develop, implement, monitor and evaluate a comprehensive policy on infant and young child feeding
6. Ensure that health and other relevant sectors protect, promote and support exclusive breastfeeding for six months and continued breastfeeding up to two years of age or beyond, while providing women access to the support they require
7. Promote timely, adequate, safe and appropriate complementary feeding with continued breastfeeding
8. Provide guidance on feeding infants and young children in exceptionally difficult circumstances
9. Consider what new legislation or other suitable measures may be required to implement the International Code of Marketing of Breast-milk Substitutes and subsequent resolutions

If a national strategy and/or Code exists, mention it here.

- Now let us look at some of these targets in more detail.

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

1/4

Exclusive breastfeeding

- Breastfeeding provides ideal food for the healthy growth and development of infants
- Infants should be exclusively breastfed for the first six months of life

- Breastfeeding provides ideal food for the healthy growth and development of infants, and it is all that a child needs for the first six months of life.
- As a global public health recommendation, infants should be *exclusively* breastfed for the first six 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 5 of their Manuals and find the box DEFINITION OF EXCLUSIVE BREASTFEEDING.

- Ask one participant to read out the definition.

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 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 - Complementary feeds** and make the points that follow:

1/5

Complementary feeds

- After six months all babies require complementary foods while breastfeeding continues for up to two years of age or beyond
- Complementary feeds should be:
 - timely
 - adequate
 - safe
 - properly fed

- After six months of age, all babies require other foods to complement breast milk - we call these foods complementary foods.
- When complementary feeds are introduced, breastfeeding should still continue for up to two 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 be:
 - timely** – meaning that they are introduced when the need for energy and nutrients exceeds what can be provided through exclusive and frequent breastfeeding
 - adequate** – meaning that they provide sufficient energy, protein and micronutrients to meet a growing child’s nutritional needs
 - safe** – meaning that they are hygienically stored and prepared and fed with clean hands using clean utensils and not bottles and teats
 - properly fed** – meaning that they are given in response to a child’s signals of hunger and that meal frequency and feeding methods are suitable for the child’s age.

- Show **Slide 1/6 - Feeding in exceptionally difficult circumstances** and make the points that follow:

1/6

Feeding in exceptionally difficult circumstances

- Emergency situations
- Malnourished children
- Low-birth-weight babies
- Infants of HIV-infected mothers
- Orphans

- The Global Strategy also talks about feeding in exceptionally difficult circumstances.
- It includes emergency situations, malnourished children, low-birth-weight babies, infants of HIV-infected mothers and orphans.
- In this course we will discuss feeding low-birth-weight babies and HIV and infant feeding.

III. Summarize the session

2 minutes

- Ask participants if they have any questions, and try to answer them.
- Make these points:
 - During this course we will be learning more about how to achieve the targets of The Global Strategy, and 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*, how to prepare and feed complementary foods while sustaining breastfeeding and how to help mothers who are HIV-infected.
- Explain that a summary of this session can be found on pages 3-6 of the *Participant's Manual*.

Session 2

Why Breastfeeding is Important

Objectives

After completing this session, participants will be able to:

- state the advantages of exclusive breastfeeding
- list the disadvantages of artificial feeding
- describe the main differences between breast milk and artificial milks

Session outline

30 minutes

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

- | | | |
|------|-------------------------|------------|
| I. | Introduce the session | 3 minutes |
| II. | Present Slides 2/1-2/11 | 25 minutes |
| III. | Summarize the session | 2 minutes |

Preparation

- Refer to the Introduction for guidance on giving a presentation with slides.
- Make sure that Slides 2/1-2/11 are in the correct order. Study the slides and the text that goes with them so that you are able to present them.
- Read the Further Information sections so that you are familiar with the ideas that they contain.

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 Global Strategy for Infant and Young Child Feeding recommends that infants are exclusively breastfed for the first six months of life.
 - 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.

Show **Slide 2/1 - Session 2 Objectives** and read out the objectives:

2/1

Why breastfeeding is important

After completing this session participants will be able to:

- state the advantages of exclusive breastfeeding
- list the disadvantages of artificial feeding
- describe the main differences between breast milk and artificial milk

II. Present Slides 2/2 to 2/11**25 minutes**

- Show **Slide 2/2 - The advantages of breastfeeding** and make the points that follow:

2/2

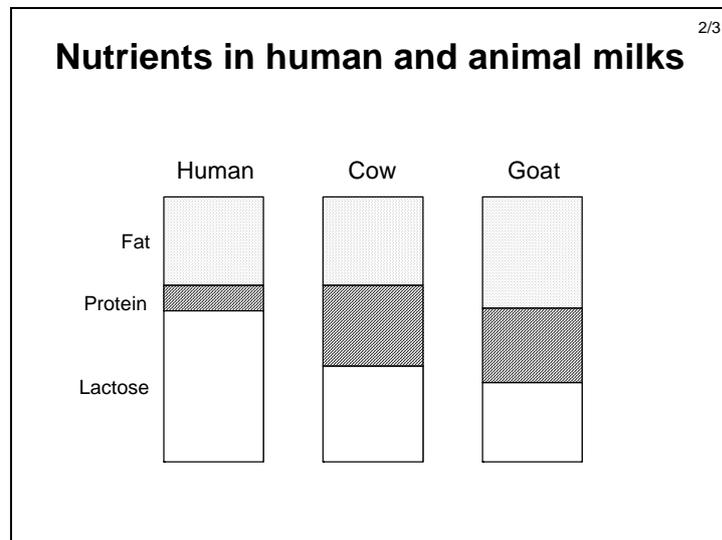
Advantages of breastfeeding

<p>Breast milk</p> <ul style="list-style-type: none"> • Perfect nutrients • Easily digested; efficiently used • Protects against infection 		<p>Breastfeeding</p> <ul style="list-style-type: none"> • Helps bonding and development • Helps delay a new pregnancy • Protects mothers' health
--	---	--

• Costs less than artificial feeding

- 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).
- 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.
- 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
 - Breastfeeding 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 2/3 - Nutrients in human and animal milks** and make the points that follow:



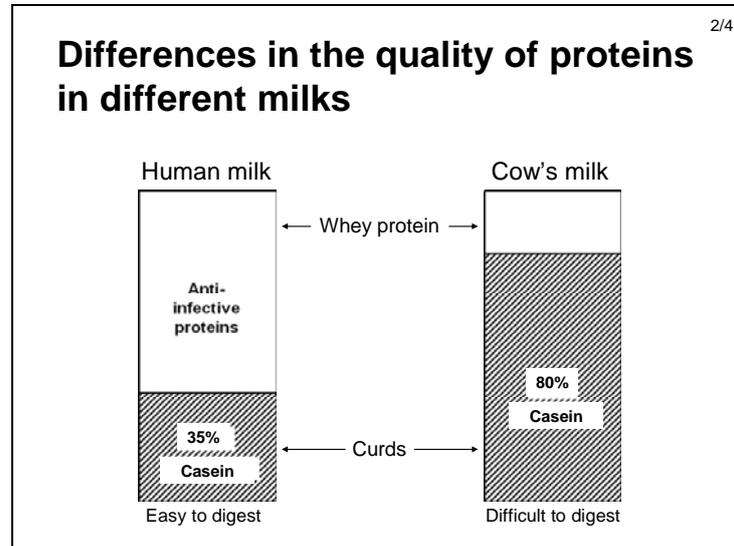
- First, we will look at the nutrients in breast milk, to see why they are perfect for a baby.
- Formula milks are made from a variety of products, including animal milks, soybean, and vegetable oils. Although they have been adjusted so that they are more like human milk, they are still far from perfect 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.

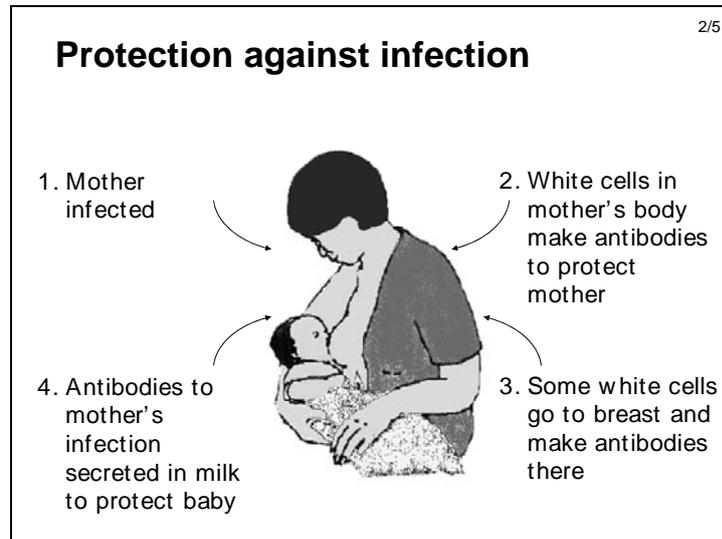
- The animal milk contains more protein than human milk.
- It is difficult for a baby's immature kidneys to excrete the extra waste from the protein in animal milks.
- Human milk also contains essential fatty acids that are needed for a baby's growing brain and eyes, and for healthy blood vessels. These fatty acids are not present in animal milks, but may have been added to formula milk.

- Show **Slide 2/4 - Quality of proteins in different milks** and make the points that follow:



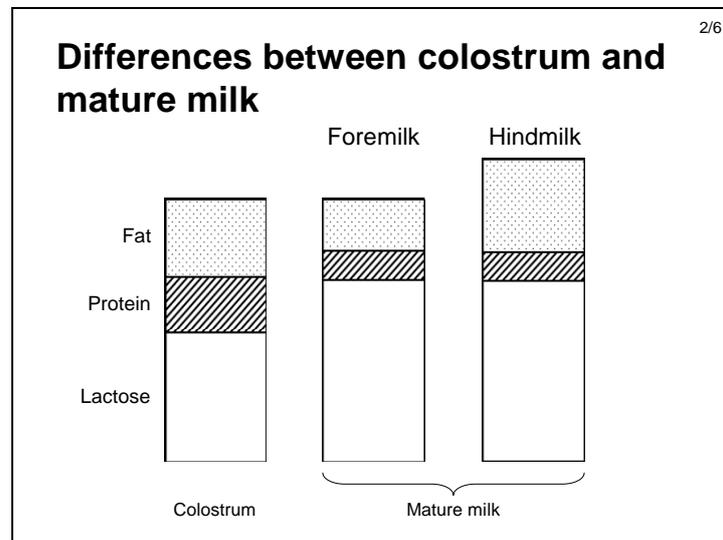
- The protein in different milks varies in quality, as well as in quantity. Whilst the quantity of protein in cow's milk can be modified to make formula, the quality of proteins cannot be changed.
- This chart shows that much of the protein in cow's milk is casein.
Ask: What happens if human babies eat 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 2/5 - 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.
- 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 his mother when she has an infection, because her breast milk protects him against the infection.

- Show **Slide 2/6 - 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.

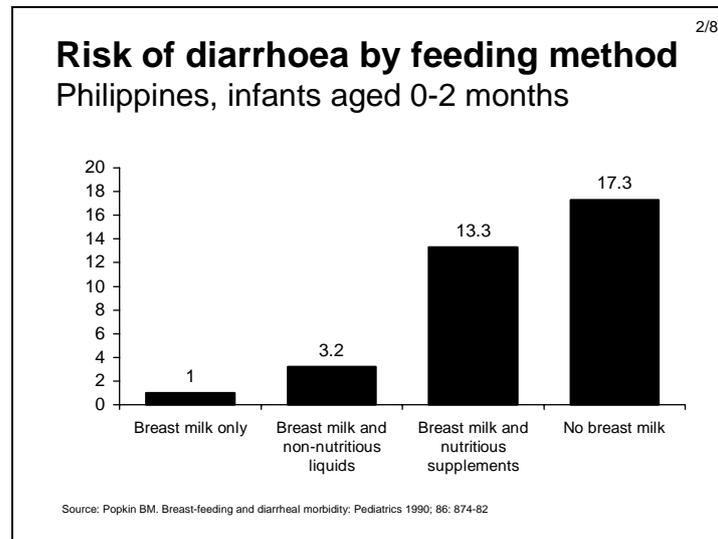
- Colostrum is the special breast milk that women produce in the first few days after delivery. It is thick, and yellowish or clear in colour. It contains more protein than later milk (*Point to the area on the graph*).
- After a few days, colostrum changes into mature milk. There is a larger amount 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 six 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', which includes all the water that he needs.

Show **Slide 2/7 - Colostrum** and make the points that follow:

Colostrum	
Property	Importance
• Antibody rich	- protects against allergy & infection
• Many white cells	- protects against infection
• Purgative	- clears meconium - helps to prevent jaundice
• Growth factors	- helps intestine to mature - prevents allergy, intolerance
• Rich in Vitamin A	- reduces severity of infection

- 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 which 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 2/8 - Risk of diarrhoea** 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 breastfeeding. The bar is small, because very few exclusively breastfed babies 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. 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 2 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.
- 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 2/9 - Psychological benefits of breastfeeding** and make the points that follow:

2/9

Psychological benefits of breastfeeding

Emotional bonding

- close, loving relationship between mother and baby
- mother more emotionally satisfied
- baby cries less
- baby may be more emotionally secure

Development

- children perform better on intelligence tests

- 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.

- Show **Slide 2/10 - Disadvantages of artificial feeding** and make the points that follow:

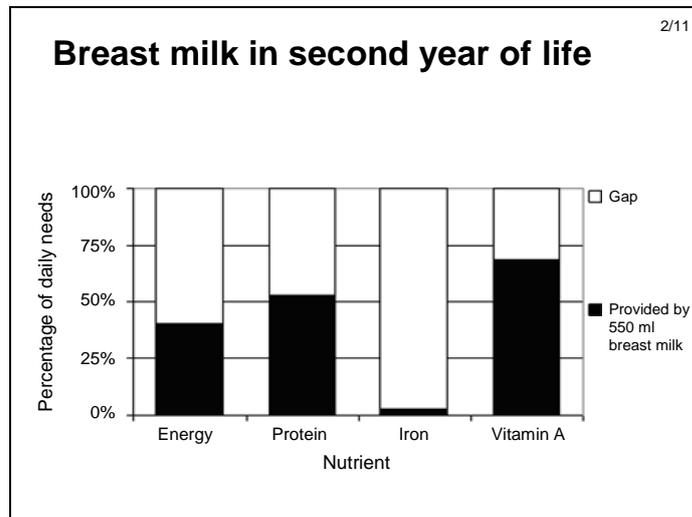
2/10

Disadvantages 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 mother

- This slide summarizes the disadvantages 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.
- He may get too little milk and become malnourished because he receives too few feeds or because they are too dilute. He is more likely to suffer from vitamin A deficiency.
- He is more likely to develop allergic conditions such as eczema and possibly asthma.
- He 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.
- He 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 and the breast.
- So artificial feeding is harmful for children and their mothers.

Show **Slide 2/11 - Breast milk in the second year** and make the points that follow:



- For the first six months of life, exclusive breastfeeding can provide all the nutrients and water that a baby needs.
- From the age of six months, breast milk is no longer sufficient by itself. In session 1 we learnt that all babies need complementary foods from six months, in addition to breast milk.
- However, breast milk continues to be an important source of energy and high quality nutrients beyond six 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.

- It can provide about one-third of the energy 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.

III. Summarize the session**2 minutes**

- Ask participants if they have any questions, and try to answer them.
- Explain that a summary of this session can be found on pages 7-14 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 contain a different balance of amino acids from breast milk, which may not be ideal for a baby. Animal milk and formula may lack the amino acid *cystine*, and formula may lack *taurine* which newborns 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 yoghurt smell). Breast milk also contains anti-viral and anti-parasitical factors.

Babies who develop intolerance to animal proteins may develop diarrhoea which becomes persistent. Babies who are fed animal milks or formula 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 it 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 mothers: Do not give a mother high dose capsules of vitamin A (over 10,000 units daily) more than 4-6 weeks after she has given birth. After 6 weeks, there is a slight possibility that she could be pregnant. If high doses of vitamin A are given in early pregnancy, they can damage the foetus.

B vitamins in different milks: For some B vitamins, the amount in human milk is the same 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.

Session 3

How Breastfeeding Works

Objectives

After completing this section participants will be able to:

- name the main parts of the breast and describe their function
- describe the hormonal control of breast milk production and ejection
- describe the difference between good and poor attachment of a baby at the breast
- describe the difference between effective and ineffective suckling

Session outline

45 minutes

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

- | | | |
|------|-------------------------|------------|
| I. | Introduce the session | 5 minutes |
| II. | Present Slides 3/1-3/11 | 35 minutes |
| III. | Summarize the session | 5 minutes |

Preparation

- Refer to the Introduction for guidance on giving a presentation with slides.
- Make sure that Slides 3/1-3/11 are in the correct order. Study the slides and the text that goes with them so that you are able to present them.
- Read the Further Information sections so that you are familiar with the ideas that they contain.

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 3/1 - Session 3 Objectives** and read out the objectives:

3/1

How breastfeeding works

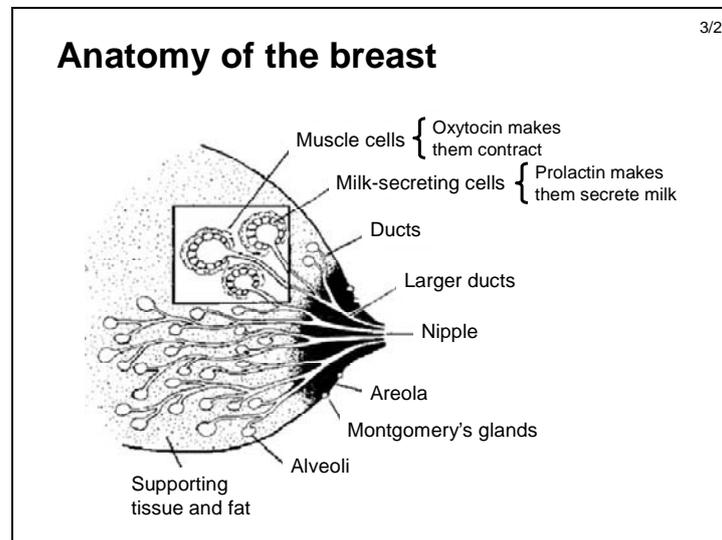
After completing this session participants will be able to:

- name the main parts of the breast and describe their function
- describe the hormonal control of breast milk production and ejection
- describe the difference between good and poor attachment of a baby at the breast
- describe the difference between effective and ineffective suckling

- Make these 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 3/2 - 3/11**35 minutes**

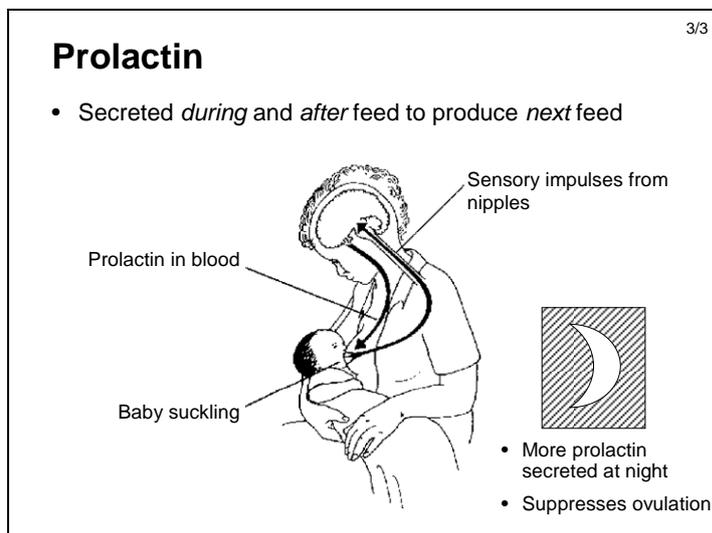
- Show **Slide 3/2 - Anatomy of the breast** and make the points that follow:



- This diagram shows the anatomy of the breast.
- First, look at the nipple, and the dark skin called the areola which surrounds it. In the areola are small glands called Montgomery's glands which secrete an oily fluid to keep the skin healthy (*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. Milk is stored in the alveoli and small ducts between feeds.
- 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 which gives the breast its shape, and which makes 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.

☐ Show **Slide 3/3 - 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 which is already in the breast.

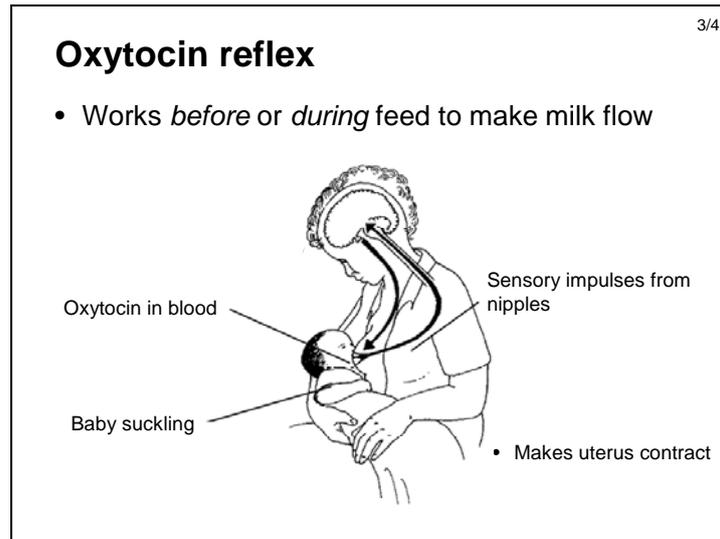
Ask: What does this suggest about how to increase a mother's milk supply?

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.

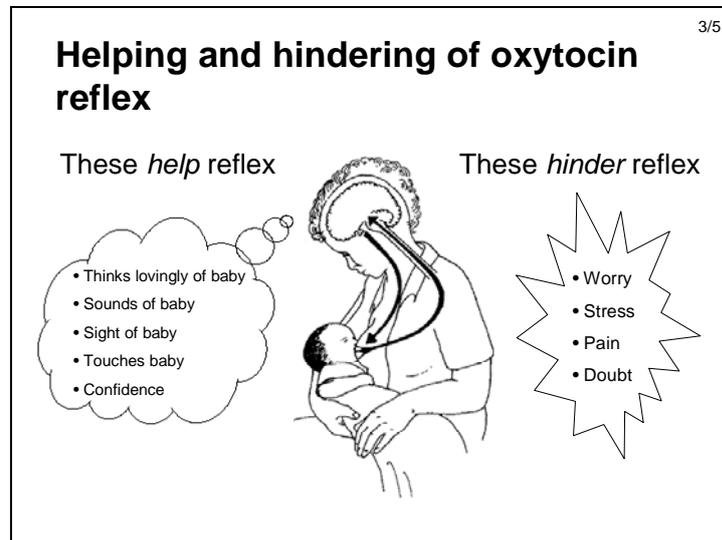
- Some special things to remember about prolactin are:
 - More prolactin is produced at night; so breastfeeding at night is especially helpful for keeping up the milk supply.
 - Hormones related to prolactin suppress ovulation so breastfeeding can help to delay a new pregnancy. Breastfeeding at night is important for this.

Show **Slide 3/4 - Oxytocin reflex** and make the points that follow:



- 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 which 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 3/5 - 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 him, and feeling confident that her milk is the best for him, can help the oxytocin reflex to work and her milk to flow. Sensations such as touching or seeing her baby, or hearing him 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 him. 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 which 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.

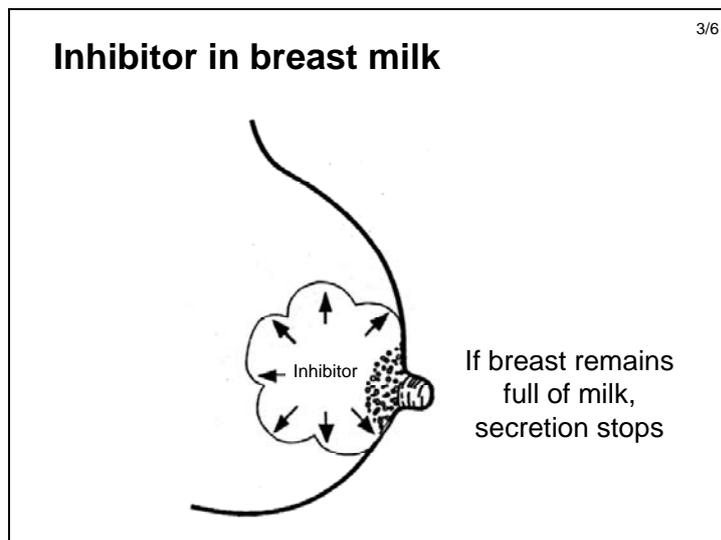
- Ask participants to turn to page 18 of their Manuals, and find the box SIGNS AND SENSATIONS OF AN ACTIVE OXYTOCIN REFLEX.
- Ask participants to take it in turns to read out the signs.

SIGNS AND SENSATIONS OF AN ACTIVE OXYTOCIN REFLEX

A mother may notice:

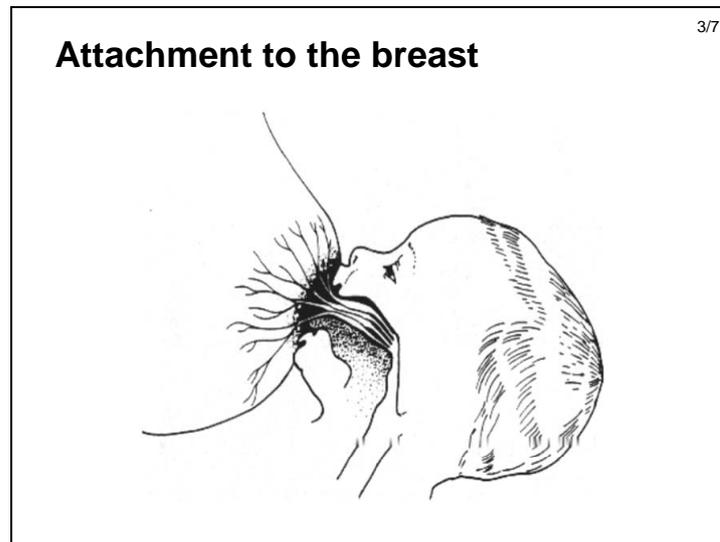
- A squeezing or tingling sensation in her breasts just before she feeds her baby, or during a feed.
- Milk flowing from her breasts when she thinks of her baby, or hears him crying.
- Milk dripping from her other breast, when her baby is suckling.
- Milk flowing from her breasts in fine streams, if 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 his mouth.

☐ Show **Slide 3/6 - Inhibitor in breast milk** and make the points that follow:



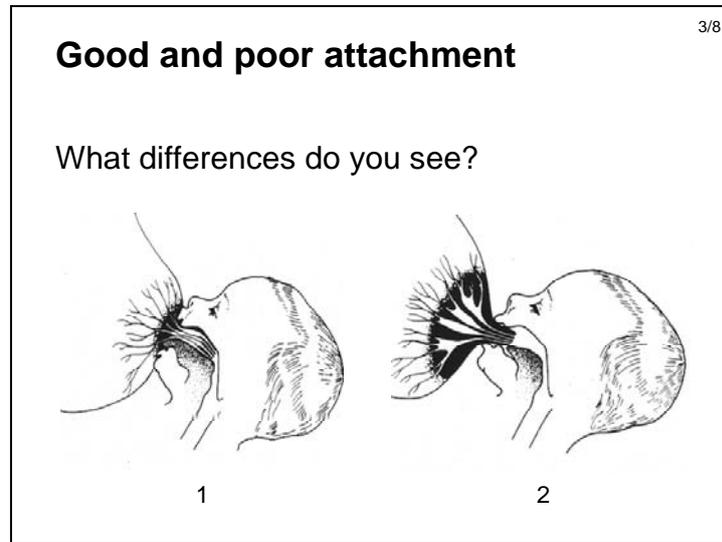
- Breast milk production is also controlled within the breast itself.
- You may wonder why sometimes one breast stops making milk, while the other breast continues to make milk - although oxytocin and prolactin go equally to both breasts. This diagram shows why.
- There is a substance in breast milk which 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. It 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 which we will discuss more later in the course when we talk about expressing breast milk.

Show **Slide 3/7 - 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:
 - He 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:
 - His tongue is forward, over his 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 his mouth in this way, we say that he is well attached to the breast. He can remove breast milk easily and we say that he is suckling effectively.
- When a baby suckles effectively, his mouth and tongue do not rub the skin of the breast and nipple.

Show **Slide 3/8 - Good and poor attachment** and make the points that follow:



- Here you see two pictures. Picture 1 is the same baby as in Slide 3/7. 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?

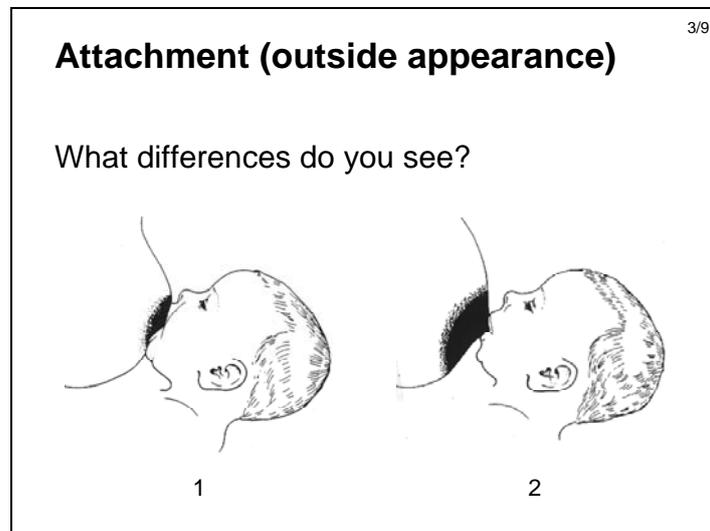
Wait for a few replies and then continue.

Make sure that the points below are clear.

If participants notice signs that are described with Slide 3/9, 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'.

- Show **Slide 3/9 - 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 his 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 which 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.
- There are other differences which you can see when you look at a real baby, which you will learn about in Session 4.

Ask: What do you think might be the results of poor attachment?

Wait for a few responses before showing the next slide.

Show **Slide 3/10 - Results of poor attachment** and make the points that follow:

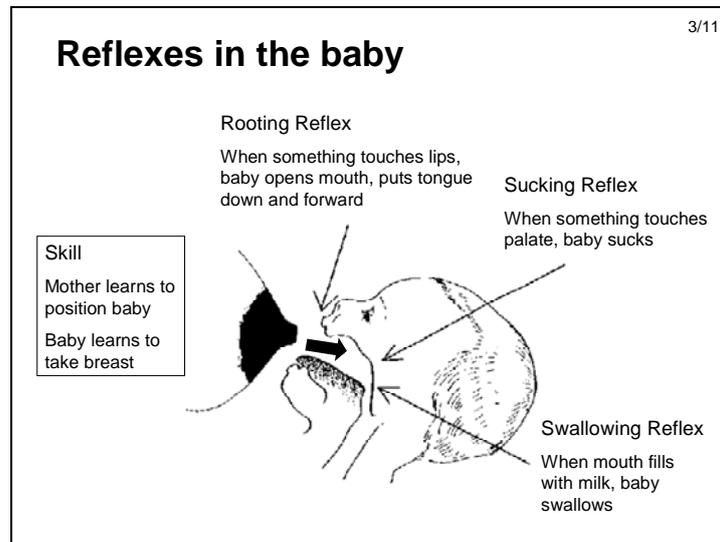
3/10

Results of poor attachment

- Painful nipples
- Damaged nipples
- Engorgement
- Baby unsatisfied and cries a lot
- Baby feeds frequently and for a long time
- Decreased milk production
- Baby fails to gain weight

- If a baby is poorly attached, and he 'nipple sucks', it is painful for his mother. Poor attachment is the most important cause of sore nipples.
- As the baby sucks hard to try to get milk he pulls the nipple in and out. This makes the nipple skin rub against his mouth. If a baby continues to suck in this way, he 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 he does not get enough breast milk, he may be unsatisfied and cry a lot. He 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, he may have difficulty suckling effectively. Even babies who start bottle feeds after a few weeks may also begin to suckle ineffectively.

☐ Show **Slide 3/11 - 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, he opens his mouth and may turn his head to find it. He puts his tongue down and forward. This is the 'rooting' reflex. It should normally be the breast that he is 'rooting' for.
- When something touches a baby's palate, he starts to suck it. This is the sucking reflex.
- When his mouth fills with milk, he swallows. 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 him 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 if they have any questions, and try to answer them.
- Explain that a summary of this session can be found on pages 15-22 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:

1. 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.
2. 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.
3. 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; 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.
4. 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 on page 61 is known as 'sucking reflex' as it refers to anything that touches the baby's palate.

Session 4

Assessing a Breastfeed

Objectives

After completing this session participants will be able to:

- explain the 4 key points of 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 BREASTFEED OBSERVATION JOB AID

Session outline

60 minutes

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

I.	Introduce the session	5 minutes
II.	Explain the BREASTFEED OBSERVATION JOB AID	20 minutes
III.	Show and discuss Slides 4/1-4/7	20 minutes
IV.	Practise using the BREASTFEED OBSERVATION JOB AID (Exercise 4.a, Slides 4/8- 4/9)	10 minutes
V.	Summarize the session	5 minutes

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.

Preparation

- Refer to the Introduction for guidance on giving a presentation with slides.
- Make sure that Slides 4/1-4/9 are in the correct order. Study the slides and the text that goes with them so that you are familiar with what each slide shows and the particular points to teach from it.
- For demonstration of the General Section of the BREASTFEED OBSERVATION JOB AID:
 - . Ask two participants to help you with the demonstration.
 - . Explain what you want them to do, and help them to practise.
 - . Make sure that they have dolls for the demonstration.
 - . If you feel that participants cannot do this on the first day of the course, ask other trainers to help instead.
- For demonstration of how to hold a breast – (General Section of BREASTFEED OBSERVATION JOB AID):
 - . 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.

I. Introduce the session**5 minutes**

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

4/1

Assessing a breastfeed

After completing this session participants will be able to:

- explain the 4 key points of attachment
- assess a breastfeed by observing 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 BREASTFEED OBSERVATION JOB AID

- Make these points:
- Assessing a breastfeed helps you to decide if 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 BREASTFEED OBSERVATION JOB AID 20 minutes

- Ask participants to turn to page 24 of their Manuals and find the BREASTFEED OBSERVATION JOB AID.
- Make these points:
 - This form will help you to remember what to look for when you assess a breastfeed.
 - The form is arranged in 5 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 4 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.

BREASTFEED OBSERVATION JOB AID

Mother's name _____ Date _____

Baby's name _____ Baby's age _____

Signs that breastfeeding is going well:

Signs of possible difficulty:

GENERAL

Mother:

- Mother looks healthy
- Mother relaxed and comfortable
- Signs of bonding between mother and baby

Mother:

- Mother looks ill or depressed
- Mother looks tense and uncomfortable
- No mother/baby eye contact

Baby:

- Baby looks healthy
- Baby calm and relaxed
- Baby reaches or roots for breast if hungry

Baby:

- Baby looks sleepy or ill
- Baby is restless or crying
- Baby does not reach or root

BREASTS

- Breasts look healthy
- No pain or discomfort
- Breast well supported with fingers away from nipple

- Breasts look red, swollen, or sore
- Breast or nipple painful
- Breast held with fingers on areola

BABY'S POSITION

- 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

- Baby's neck and head twisted to feed
- Baby not held close
- Baby supported by head and neck only
- Baby approaches breast, lower lip/chin to nipple

BABY'S ATTACHMENT

- More areola seen above baby's top lip
- Baby's mouth open wide
- Lower lip turned outwards
- Baby's chin touches breast

- More areola seen below bottom lip
- Baby's mouth not open wide
- Lips pointing forward or turned in
- Baby's chin not touching breast

SUCKLING

- Slow, deep sucks with pauses
- Cheeks round when suckling
- Baby releases breast when finished
- Mother notices signs of oxytocin reflex

- Rapid shallow sucks
- Cheeks pulled in when suckling
- Mother takes baby off the breast
- No signs of oxytocin reflex noticed

Explain the first two sections: General and Breasts

- Ask participants to keep their Manuals open at the BREASTFEED OBSERVATION JOB AID during the rest of the session.
- Ask two participants to play the roles of mothers and babies in the following demonstration.

Mother A (name) sits comfortably and relaxed, and acts being happy and pleased with her baby. She holds baby close, facing her breast, and she supports his whole body. She looks at her baby, and fondles or touches him lovingly. She supports her breast with her fingers against her chest wall below her breast, and her thumb above, away from the nipple.

Mother B (name) sits uncomfortably, and acts being sad and not interested in her baby. She holds baby loosely, and not close, with his neck twisted, and she does not support his whole body. She does not look at him or fondle him, but she shakes or prods him a few times to make him go on breastfeeding. She uses a scissor grip to hold her breast.

- 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 BREASTFEED OBSERVATION JOB AID.
- Make the following points. Ensure that the participants are clear about which point on the BREASTFEED OBSERVATION JOB AID you are referring to:
 - Look at the mother to see if 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 breast milk flow.
 - Observing how a mother interacts with her baby whilst 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 which may interfere with breastfeeding: e.g. 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:
- 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 his 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 Section: Baby's Position

- ☐ Ask one participant to read aloud the points in the third section of the BREASTFEED OBSERVATION JOB AID (Baby's Position), reading the point from the left hand column and then the corresponding point from the right hand column. Ask the participants what they observed during the previous role-play from the third section of the form. Then make these points:
- Observe how the mother holds her baby. Notice if the baby's head and body are in line.
 - Notice if she holds the baby close to the breast and facing it, making it easier for him to suckle effectively. If she holds him loosely, or turned away so that his neck is twisted, it is more difficult for him to suckle effectively.
 - If the baby is young, observe whether the mother supports his whole body or only his head and shoulders.

Explain Section: Baby's Attachment

- Ask one participant to read aloud the points in the fourth section of the BREASTFEED OBSERVATION JOB AID (Baby's Attachment), reading the 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 4 key points of attachment were covered in the last session.

Explain Section: Suckling

- Ask one participant to read aloud the points in the fifth section of the BREASTFEED OBSERVATION JOB AID (Suckling), reading the 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 he is 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 he sucks this is a sign that he is not well attached.
 - Notice whether the baby releases the breast himself after the feed, and looks sleepy and satisfied.
 - If a mother takes the baby off the breast before he has finished, for example, if he pauses between sucks, he may not get enough hindmilk.

III. Show and discuss Slides 4/2 to 4/7**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 BREASTFEED OBSERVATION JOB AID. 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 if you think the baby's attachment is good or poor.
 - . Notice if there are any signs of good or poor positioning shown.
- Ask a different participant to come forward for each of the Slides 4/2-4/7.
- 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 she sees. 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 4 key points of attachment first and then to list points from the other sections of the BREASTFEED OBSERVATION JOB AID. 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 4/2

- Signs that you can see clearly are:
 - There is more areola above the baby's top lip than below the bottom lip
 - His mouth is quite wide open
 - His lower lip is turned outwards
 - His chin is almost touching the breast.
- 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 his mother holding her breast back with her finger.

□ Show Slide 4/3

- Signs that you can see clearly are:
 - His mouth points forwards
 - The baby's chin is not touching the breast.
- This baby is poorly attached.
- In addition, his cheeks are pulled in when suckling.
- The mother is holding her breast with the 'scissor hold'.

Show Slide 4/4

- Signs that you can see clearly are:
 - There is as much areola below the baby's bottom lip as above his top lip
 - His mouth is not wide open and his lips point forwards
 - His chin is not touching her breast.
- This baby is poorly attached to the breast.
- The baby's body is not close to his mother's.
- 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 4/5

- Signs that you can see clearly are:
 - There is more areola above the baby's top lip than below the bottom lip
 - His mouth is quite wide open
 - His lower lip is turned in and not outwards
 - His chin is touching the breast.
- This baby is not well attached.
- His lower lip is turned in, so he is not well attached, even if the other signs are not bad.
- In addition, his head and body are straight and he is facing the breast.

□ Show Slide 4/6

- Signs that you can see clearly are:
 - There is as much or more areola below the baby's mouth as above it
 - His mouth is not wide open, his lips point forward
 - His chin is not touching the breast.
- This baby is poorly attached. He looks as though he is feeding from a bottle.
- In addition the baby is twisted and is not close to the breast.

Show Slide 4/7

- Signs that you can see are:
 - There is a little areola above the baby's top lip
 - His chin is touching the breast
 - As the baby is very close to the breast it makes it difficult to see many other signs
- This baby is well attached.
- Additional point: this is the same bay as in slide 4/6 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 BREASTFEED OBSERVATION JOB AID**10 minutes****Exercise 4.a Using the BREASTFEED OBSERVATION JOB AID**

- Explain what to do:
 - With Slides 4/8 to 4/9, you will use your observations to practise filling in the BREASTFEED OBSERVATION JOB AID.
 - There are two copies of the form for this exercise in the *Participant's Manual* on page 27-28. Fill in one form for each slide.
 - If you see a sign, make a ✓ in the box next to the sign. If you do not see a sign, leave the box empty.
 - Concentrate on the sections on 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 4/8 to 4/9

- Show each slide for about 4 minutes.
- In the *Trainer's Guide*, on pages 80 and 81, for each of the Slides 4/8 and 4/9, the BREASTFEED OBSERVATION JOB AID is copied. They have been marked with ✓s for the signs which 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 4/8



Show Slide 4/9



BREASTFEED OBSERVATION JOB AID – SLIDE 4/8

Mother's name _____

Date _____

Baby's name _____

Baby's age _____

Signs that breastfeeding is going well:

Signs of possible difficulty:

GENERAL

Mother:

- Mother looks healthy
- Mother relaxed and comfortable
- Signs of bonding between mother and baby

Mother:

- Mother looks ill or depressed
- Mother looks tense and uncomfortable
- No mother/baby eye contact

Baby:

- Baby looks healthy
- Baby calm and relaxed
- Baby reaches or roots for breast if hungry

Baby:

- Baby looks sleepy or ill
- Baby is restless or crying
- Baby does not reach or root

BREASTS

- Breasts look healthy
- No pain or discomfort
- Breast well supported with fingers away from nipple

- Breasts look red, swollen, or sore
- Breast or nipple painful
- Breasts held with fingers on areola

BABY'S POSITION

- 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

- Baby's neck and head twisted to feed
- Baby not held close
- Baby supported by head and neck only
- Baby approaches breast, lower lip/chin to nipple

BABY'S ATTACHMENT

- More areola seen above baby's top lip
- Baby's mouth open wide
- Lower lip turned outwards
- Baby's chin touches breast

- More areola seen below bottom lip
- Baby's mouth not open wide
- Lips pointing forward or turned in
- Baby's chin not touching breast

SUCKLING

- Slow, deep sucks with pauses
- Cheeks round when suckling
- Baby releases breast when finished
- Mother notices signs of oxytocin reflex

- Rapid shallow sucks
- Cheeks pulled in when suckling
- Mother takes baby off the breast
- No signs of oxytocin reflex noticed

BREASTFEED OBSERVATION JOB AID – SLIDE 4/9

Mother's name _____

Date _____

Baby's name _____

Baby's age _____

Signs that breastfeeding is going well:

Signs of possible difficulty:

GENERAL

Mother:

- Mother looks healthy
- Mother relaxed and comfortable
- Signs of bonding between mother and baby

Mother:

- Mother looks ill or depressed
- Mother looks tense and uncomfortable
- No mother/baby eye contact

Baby:

- Baby looks healthy
- Baby calm and relaxed
- Baby reaches or roots for breast if hungry

Baby:

- Baby looks sleepy or ill
- Baby is restless or crying
- Baby does not reach or root

BREASTS

- Breasts look healthy
- No pain or discomfort
- Breast well supported with fingers away from nipple

- Breasts look red, swollen, or sore
- Breast or nipple painful
- Breasts held with fingers on areola

BABY'S POSITION

- 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

- Baby's neck and head twisted to feed
- Baby not held close
- Baby supported by head and neck only
- Baby approaches breast, lower lip/chin to nipple

BABY'S ATTACHMENT

- More areola seen above baby's top lip
- Baby's mouth open wide
- Lower lip turned outwards
- Baby's chin touches breast

- More areola seen below bottom lip
- Baby's mouth not open wide
- Lips pointing forward or turned in
- Baby's chin not touching breast

SUCKLING

- Slow, deep sucks with pauses
- Cheeks round when suckling
- Baby releases breast when finished
- Mother notices signs of oxytocin reflex

- Rapid shallow sucks
- Cheeks pulled in when suckling
- Mother takes baby off the breast
- No signs of oxytocin reflex noticed

Session 5

Listening and Learning

Objectives

After completing this session participants will be able to:

- list the 6 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

60 minutes

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

- | | | |
|------|---|------------|
| I. | Introduce the session | 5 minutes |
| II. | Demonstrate listening and learning skills | 50 minutes |
| III. | Summarize the session | 5 minutes |

As you follow the text, remember:

- Indicates an instruction to you, the trainer
- Indicates what you say to participants.

Preparation

- Refer to the Introduction for guidance on how to give a demonstration.
- Study the notes for the session so that you are clear about what to do.
- You need two boards or flipcharts to make two summary lists.
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-5.O. (An alternative would be to use another copy of this guide).
- 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-5.G the participants read out the words of the mother. For DEMONSTRATIONS 5.H-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 she has 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.

I. Introduce the session**5 minutes**

- Show **Slide 5/1 - Session 5 Objectives** and read out the objectives:

5/1

Listening and learning

After completing this session participants will be able to:

- list the 6 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.

II. Demonstrate listening and learning skills

50 minutes

- Tell participants that in this session you will explain and demonstrate six skills for listening and learning. 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.
- 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 she 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 which 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 which 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’ on the flipchart (Flipchart 2).

2. Eye contact:

Helps: Look at her and pay attention as she speaks

Hinders: Look away at something else, or down at your notes

- 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 he or she is 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 BARRIERS’ on the flipchart.

4. Taking time:

Helps: Make her 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

Hinders: Be in a hurry. Greet her quickly, show signs of impatience, look at your watch

- Write – ‘TAKE TIME’ on the flipchart.

5. Touch:

Helps: Touch the mother appropriately

Hinders: Touch her in an inappropriate way

- Write – ‘TOUCH APPROPRIATELY’ 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
<ul style="list-style-type: none"> ▪ Keep your head level ▪ Pay attention ▪ Remove barriers ▪ Take time ▪ Touch appropriately

- 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 like '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 if she breastfed exclusively, or if 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 SHE 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: "He is well, and he is very hungry."

Health worker: "Tell me, how are you feeding him?"

Mother: "He is breastfeeding. I just have to give him one bottle feed in the evening."

Health worker: "What made you decide to do that?"

Mother: "He 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 nine-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 two 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 asks an open question, which does not help much. Then she asks two specific questions, and then follows up with an open question. Although the mother says at first that she and the baby are well, the health worker later learns that the mother needs help with breastfeeding.**

Skill 3. Use responses and gestures which show interest

- Write 'USE RESPONSES AND GESTURES WHICH 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 one-year-old child.

DEMONSTRATION 5.E USING RESPONSES AND GESTURES WHICH SHOW INTEREST

Health worker: "Good morning, (name). How is (child's name) now that he has started solids?"
Mother: "Good morning. He's fine, I think."
Health worker: "Mmm." (nods, smiles.)
Mother: "Well, I was a bit worried the other day, because he vomited."
Health worker: "Oh dear!" (raises eyebrows, looks interested.)
Mother: "I wondered if it was something in the stew that I gave him."
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 says

- Write 'REFLECT BACK WHAT THE MOTHER 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 six-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 asks factual questions, and the mother gives less and less information.**

DEMONSTRATION 5.G REFLECTING BACK

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: "(Child's name) is feeding very often?"
Mother: "Yes. This week he is so hungry. I think that my milk is drying up."
Health worker: "He seems more hungry this week?"
Mother: "Yes, and my sister is telling me that I should give him some bottle feeds as well."
Health worker: "Your sister says that he needs something more?"
Mother: "Yes. Which formula is best?"

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

Comment: **The health worker reflects back what the mother says, so the mother gives more information.**

Skill 5. Empathize - show that you understand how she feels

- Write 'EMPATHIZE – SHOW THAT YOU UNDERSTAND HOW SHE 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 which shows how she feels, it is helpful to respond in a way which 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, 5.I, 5.J and 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 ten-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

<i>Health worker:</i>	"Good morning, (name). How are you and (child's name) today?"
<i>Mother:</i>	"(Child's name) is not feeding well, I am worried he is ill."
<i>Health worker:</i>	"I understand how you feel. When my child was ill, I was so worried. I know exactly how you feel."
<i>Mother:</i>	"What was wrong with your child".
Ask:	<i>Do you think the health worker showed sympathy or empathy?</i>
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

<i>Health worker:</i>	"Good morning, (name). How are you and (child's name) today?"
<i>Mother:</i>	"He is not feeding well, I am worried he is ill"
<i>Health worker:</i>	"You are worried about him?"
<i>Mother:</i>	"Yes, some of the other children in the village are ill and I am frightened he may have the same illness."
<i>Health worker:</i>	"It must be very frightening for you."
Ask:	<i>Do you think the health worker showed sympathy or empathy?</i>
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, 5.M, 5.N and 5.O.
- Introduce the next role-play by making these points:
 - Now we will see another demonstration. Watch to see if the health worker is really listening to the mother.
 - The health worker is talking to a mother of a seven-month-old child who has recently started complementary feeds.

DEMONSTRATION 5.L ASKING FACTS

<i>Health worker:</i>	“Good morning, (name). How are you and (child’s name) today?”
<i>Mother:</i>	“He is refusing to breastfeed since he started eating porridge and other foods last week – he just pulls away from me and doesn’t want me!”
<i>Health worker:</i>	“How old is (child’s name) now?”
<i>Mother:</i>	“He is seven months old”.
<i>Health worker:</i>	“And how much porridge does he eat during a day?”
Ask:	<i>What did the health worker learn about the mother’s feelings?</i>
Comment:	The health worker asks 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.

DEMONSTRATION 5.M EMPATHY

<i>Health worker:</i>	“Good morning, (name). How are you and (child’s name) today?”
<i>Mother:</i>	“He is refusing to breastfeed since he started eating porridge and other foods last week – he just pulls away from me and doesn’t want me!”
<i>Health worker:</i>	“It’s very upsetting when your baby doesn’t want to breastfeed.”
<i>Mother:</i>	“Yes, I feel so rejected.”
Ask:	<i>What did the health worker learn about the mother’s feelings this time?</i>
Comment:	In this second version, the mother’s feelings are listened to at the beginning. Then the health worker is able to focus on what the mother sees as the problem.

Skill 6. Avoid words which sound judging

- Write ‘AVOID WORDS WHICH SOUND JUDGING’ on the list of listening and learning skills.
- Explain the skill:
 - ‘Judging words’ are words like: 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 five-month-old baby. As you watch, look for judging words.

DEMONSTRATION 5.N USING JUDGING WORDS

<i>Health worker:</i>	“Good morning. Is (name) breastfeeding normally ?”
<i>Mother:</i>	“Well - I think so.”
<i>Health worker:</i>	“Do you think that you have enough breast milk for him?”
<i>Mother:</i>	“I don't know.....I hope so, but maybe not ...” (She looks worried.)
<i>Health worker:</i>	“Has he gained weight well this month?”
<i>Mother:</i>	“I don't know.....”
<i>Health worker:</i>	“May I see his growth chart?”
Ask:	<i>What did the health worker learn about the mother's feelings?</i>
Comment:	The health worker is not learning anything useful, but is making the mother very worried.

DEMONSTRATION 5.O AVOIDING JUDGING WORDS

<i>Health worker:</i>	“Good morning. How is breastfeeding going for you and (child's name)?”
<i>Mother:</i>	“It's going very well. I haven't needed to give him anything else.”
<i>Health worker:</i>	“How is his weight? Can I see his growth chart?”
<i>Mother:</i>	“Nurse said that he gained more than half a kilo this month. I was pleased.”
<i>Health worker:</i>	“He is obviously getting all the breast milk that he needs.”
Ask:	<i>What did the health worker learn about the mother's feelings?</i>
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 if they have any questions about listening and learning 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.
- Ask participants to find the list on page 31 of their Manuals. Ask them to try to memorize it. Explain that they will use the list for Practical Session 1.

LISTENING AND LEARNING SKILLS

- Use helpful non-verbal communication
- Ask open questions
- Use responses and gestures which show interest
- Reflect back what the mother says
- Empathize - show that you understand how she feels
- Avoid words which sound judging.

Session 6

Listening and Learning Exercises

Objectives

After completing this session participants will be able to:

- demonstrate appropriate use of the 6 listening and learning skills
- provide examples of each skill

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-6.c) | 40 minutes |
| III. | Conduct the group exercise (Exercise 6.d) | 15 minutes |

Preparation

- Refer to the Introduction for guidance on how to conduct group work and facilitate written exercises.
- Study the notes for the session, so that you are clear about what to do.
- For Exercises 6.a-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 page 33 of their Manuals, and to find Exercises 6.a-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-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 which 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 6.d 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**

Do you breastfeed your baby?

'Open' Question

How are you feeding your baby?

To answer:**'Closed' Questions**

1. Does your baby sleep with you?
2. Are you often away from your baby?
3. Does Sara eat porridge?
4. Do you give fruit to your child often?

Suggested answers for 'Open' Questions

- Where does your baby sleep?*
- How much time do you spend away from your baby?*
- What kinds of foods does Sara like to eat?*
- How often does your child eat some fruit?*

Exercise 6.b Reflecting back what a mother says**How to do the exercise:**

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

Underneath 1-3 are three responses. Mark the response that 'reflects back' what the statement says. For statement 4 make up your own response which '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 six 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 him from a bottle, but he spat it out.

- a) Why did you try using a bottle?
- ✓ b) He 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 - to show that you understand how she 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 which show something about how she feels. Mark the response which 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 he 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 nine 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 concerned about how Sammy looks?
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-6.c.

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 37 of their Manuals.

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 37 of their Manuals.
- 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, which 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 Manuals.

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 if they have any questions about the exercises and try to answer them.

Session 7

Practical 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 BREASTFEED OBSERVATION JOB AID

Session outline

120 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 in a ward or clinic.

- | | | |
|-----|-------------------------------|-------------|
| I. | Prepare the participants | 20 minutes |
| II. | Conduct the clinical practice | 100 minutes |

As you follow the text, remember:

- Indicates an instruction to you, the trainer
- Indicates what you say to participants.

Preparation

- If you are leading the session:
 - Make sure that you know where the practical session will be held, and where each trainer should take her group. 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 in the following pages, so that you can prepare the participants and conduct the practical session.
 - Make sure that there are copies of the PRACTICAL DISCUSSION CHECKLIST available for each trainer.
 - Make sure that there are two copies of the BREASTFEED OBSERVATION JOB AID and one copy of the list of LISTENING AND LEARNING SKILLS CHECKLIST available for each participant and trainer.
- If you are leading the small group:
 - Study the instructions in the following pages, so that you are clear about how to conduct the clinical practice.
 - Make sure that you have a copy of the PRACTICAL DISCUSSION CHECKLIST, to help you to conduct discussions.
 - Make sure that the participants in your group each have two copies of the BREASTFEED OBSERVATION JOB AID, and one copy of the list of LISTENING AND LEARNING SKILLS CHECKLIST. Have one or two spare copies with you.
 - Find out where to take your group.

I. Prepare the participants (one trainer)**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 practical session, hold the preparatory session in the classroom before you leave. If necessary, this can take place on the evening or the morning before.

Explain the following to the participants:

- You are going to practise the 'listening and learning' skills that you learnt in Sessions 5 and 6 and assessing a breastfeed, with mothers in the ward.
- You do not give any advice or help at this stage.
- You will need to take with you two copies of the BREASTFEED OBSERVATION JOB AID, one copy of LISTENING AND LEARNING SKILLS CHECKLIST, pencil and paper to make notes.
- You will work in groups of 3-4 with one trainer.

What to do in the ward:

- Take it in turns to talk to a mother whilst the other members of the group observe.
- 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 a mother 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.
- 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 or a feeding bottle with her?
- 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 she uses a skill, to help you to remember for the discussion. Notice if she uses helpful non-verbal communication.

- Notice if the participant makes a mistake, for example, if she uses a judging word, or if she asks a lot of questions to which the mother says 'yes' and 'no'.
- When a mother breastfeeds observe the feed using the BREASTFEED OBSERVATION JOB AID 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 how to help the mother to you.
- 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 Practical 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. She needs to refer to the forms to remind her what to do, but if she wants to write, she should do so afterwards. The participants who are observing can make notes.

II. Conduct the clinical practice (all trainers)

100 minutes

These notes are for the trainers. Trainers should read these notes 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.
 - 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 BREASTFEED OBSERVATION JOB AID, LISTENING AND LEARNING SKILLS CHECKLIST, PRACTICAL DISCUSSION CHECKLIST.

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 she makes immediately. If possible wait until the discussion afterwards. Then you can both praise what she did right and talk about anything she did not do right.
- However, if she is making a lot of mistakes, or not making any progress, then you should help her. Try to help in a way that does not make her embarrassed in front of the mother and the group.
- Also, if she starts to help or advise the mother, remind her that she should not do that during this practical 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 confidence and support skills 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 PRACTICAL DISCUSSION CHECKLIST to help you to lead the discussion.
- Ask the 'General Questions', and then ask the specific questions about 'Listening and Learning' and about 'Assessing a breastfeed'.
- Ask the 'Confidence and support' questions in later practical sessions.
- Go through the LISTENING AND LEARNING SKILLS CHECKLIST, and discuss how the participant practised them. First ask the participant herself to say how well she thinks she 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 BREASTFEED OBSERVATION JOB AID, and discuss how many of the signs the group noticed. Ask them to decide if the baby was well or poorly positioned and attached.

- 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 if 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:
 - if babies room-in with their mothers
 - whether or not babies are given formula, 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
 - if the child eats any food or drinks during the session
 - whether the child was given a bottle or soother / pacifier while waiting
 - what was the interaction 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.

- At the end of the practical session ask participants if they have any questions, and try to answer them.

- Explain that a summary of this session can be found on pages 39-40 of the *Participant's Manual*.

PRACTICAL 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 her 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.

Confidence and support skills (give feedback on the use of these skills during practical sessions after Session 10)¹

- Which confidence and support skills 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 practical Session 35)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 practical 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 learned from this practical session?

¹ See list of skills on the following page

² See list of key messages on the following page

COUNSELLING SKILLS

Listening and learning skills:

- Use helpful non-verbal communication.
- Ask open questions.
- Use responses and gestures that show interest.
- Reflect back what the mother/caregiver says.
- Empathize - show that you understand how she/he feels.
- Avoid words that sound judging.

Building confidence and giving support skills:

- Accept what the caregiver thinks and feels.
- Recognize and praise what a mother/caregiver and child are doing right.
- Give practical help
- Give relevant information.
- Use simple language.
- Make one or two suggestions, not commands

KEY MESSAGES FOR COMPLEMENTARY FEEDING

1. Breastfeeding for two years of age or longer helps a child to develop and grow strong and healthy.
2. Starting other foods in addition to breast milk at 6 months helps a child to grow well.
3. Foods that are thick enough to stay in 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 to eat during illness and provide extra food after illness to help the child recover quickly.

Session 8

Positioning a Baby at the Breast

Practical Session: Positioning a Baby Using Dolls

Objectives

After completing this session participants will be able to:

- explain the 4 key points of 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 4 key points 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 | 5 minutes |
| II. | Demonstrate helping a mother to position her baby | 35 minutes |
| III. | Classroom Practical: positioning a baby using dolls (small groups) | 30 minutes |
| IV. | Summarize the session | 5 minutes |

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.

Preparation

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 Slide 8/1 is ready. Alternatively, as there is only one slide in this session, you might prefer to read aloud the objectives on slide 8/1 without projecting them onto the screen.

I. Introduce the session**5 minutes**

- Show **Slide 8/1 - Session 8 Objectives** and read out the objectives:

8/1

Positioning a baby at the breast

After completing this session participants will be able to:

- explain the 4 key points of 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 4 key points in different positions

- Ask participants to turn to page 24 of their Manuals, and find the BREASTFEED OBSERVATION JOB AID.

- Make these points:
 - We are going to learn how to position a baby at the breast.
 - We will be using the 4 key points from the section on 'positioning' on the BREASTFEED OBSERVATION JOB AID.
 - There are several steps to follow when helping a mother to position her baby at the breast.

- Now ask participants to turn to page 42 of their Manuals 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.

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 if 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 his 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.

- Now we will look at these points in more detail.
- Always assess a mother breastfeeding before you help her, using the points from the BREASTFEED OBSERVATION JOB AID.
- In Session 4 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 more than about two months old. There is no point trying to change a baby's position if he is getting breast milk effectively, and his 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 his mother cannot.

II. Demonstrate helping a mother to position her baby 35 minutes

DEMONSTRATION 8.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 118 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, the ‘mother’ should respond by saying that breastfeeding is painful.
- Assess a breastfeed**

Ask if 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 if she would like you to show her**

Say something encouraging like: “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, so that you are also comfortable and relaxed, and in a convenient position to help. 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 him 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 4 key points of 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 BREASTFEED OBSERVATION JOB AID.
- For point 1– Baby's head and body in line: A baby cannot suckle or swallow easily if his head is twisted or bent.
- For point 2 – Baby held close to mother's body: A baby cannot attach well to the breast if he is far away from it. The baby's whole body should almost face his mother's body. He should be turned away just enough to be able to look at her face. This is the best position for him to take the breast, because most nipples point down slightly. If he faces his mother completely, he may fall off the breast.
- For point 3 – Baby supported: Baby's whole body supported with the mother's arm along the baby's back. This is particularly important for newborns 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 his bottom. Holding his bottom may result in her pulling him too far out to the side, so that his head is in the crook (bend) of her arm. He then has to bend his head forward to reach the nipple, which makes it difficult for him 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 his nose opposite her nipple, so that he approaches the breast from underneath the nipple.
- Explain how she should touch her baby's lips with her nipple, so that he opens his mouth, puts out his tongue, and reaches up.
- Explain that she should wait until her baby's mouth is opening wide, before she moves him onto her breast. His mouth needs to be wide open to take a large mouthful of breast.

- It is important to use the baby's reflexes, so that he opens his mouth wide to take the breast himself. You cannot force a baby to suckle, and she should not try to open his mouth by pulling his chin down.
- Explain or show her how to quickly move her baby to her breast, when he is opening his mouth wide.
- She should 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 his nose opposite the nipple, so that the nipple aims towards the baby's palate, his tongue goes under the areola, and his chin will touch her breast.
- Hold the baby at the back of his shoulders – not the back of his 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 like "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 his mouth.
- If she is having difficulty in one position, try to help her to find a different position that is more comfortable for her.

DEMONSTRATION 8.B OTHER WAYS FOR A MOTHER WHO IS SITTING TO POSITION HER BABY

- Ask participants to turn to page 46 of their Manuals to look at other ways that mothers can position their babies.

Demonstrate these positions using a doll.

Fig. 8.2 A mother holding her baby in the underarm position

Useful for:

- twins
- blocked duct
- difficulty attaching the baby



Fig. 8.3 A mother holding her baby with the arm opposite the breast

Useful for:

- very small babies
- sick babies



DEMONSTRATION 8.C DEMONSTRATE 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 his head has to bend forward to reach the breast.
 - Breastfeeding lying down 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. 8.4 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 his mouth so that he can suckle effectively.

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 42 of their Manuals in the box HOW TO HELP A MOTHER TO POSITION HER BABY. These steps can be found on page 118 of the *Trainer's Guide*.

IV. Summarize the session 5 minutes

- Ask participants if they have any questions, and try to answer them.
- Explain that a summary of this session can be found on pages 41-46 of the *Participant's Manual*.

Session 9

Growth Charts

Objectives

After completing this session participants will be able to:

- explain the meaning of the standard curves
- plot a child's weight on a growth chart
- interpret individual growth curves

Session outline

30 minutes

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

- | | | |
|------|---|------------|
| I. | Introduce the session | 5 minutes |
| II. | Explain how to plot a growth chart | 10 minutes |
| III. | Explain how to interpret individual paths | 10 minutes |
| IV. | Summarize the session | 5 minutes |

Preparation

- Refer to the Introduction for guidance on giving a presentation with slides.
- Make sure that Slides 9/1-9/5 are in the correct order. Study the slides and the text that goes with them so that you are able to present them.
- Slide 9/2 needs to be copied onto an overhead transparency as you will demonstrate how to mark the weight 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

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 9/1 - Session 9 Objectives** and read out the objectives:

9/1

Growth charts

After completing this session participants will be able to:

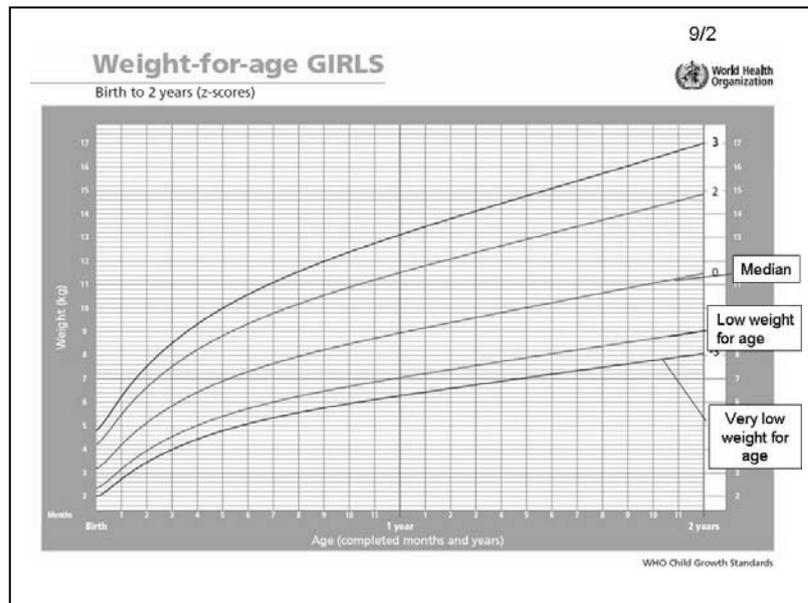
- explain the meaning of the standards curves
- plot a child's weight on a growth chart
- interpret individual growth curves

- 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 mother, 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 six months old and after complementary feeds have been introduced - can help prevent growth faltering in both weight and length as well as the tendency to overweight.

II. How to plot a growth chart

10 minutes

- Show **Slide 9/2 - 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 percent of healthy children are below it and 50 percent 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 which 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, 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?

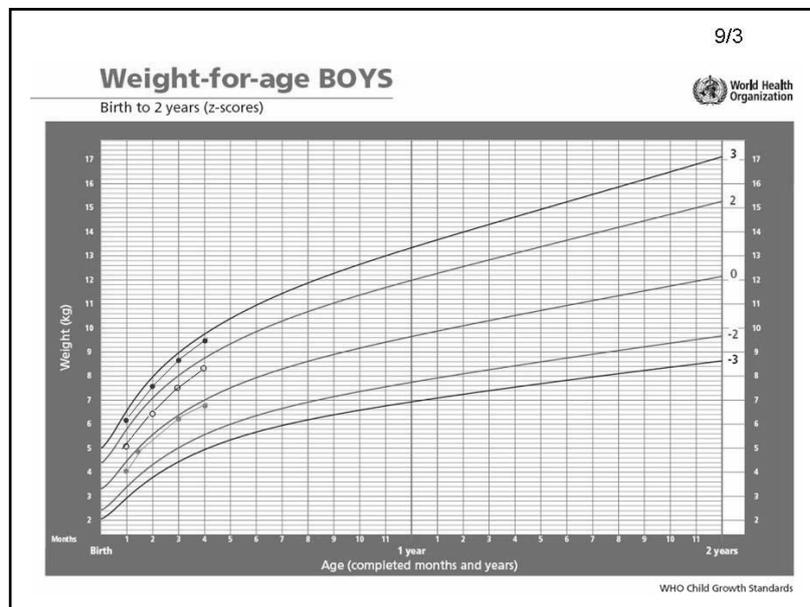
Wait for a few replies and then continue.

- 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 if 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 if she looks wasted or ill, or if she is active and healthy.
- Document Maria's weight in 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.

III. How to interpret individual growth paths

10 minutes

- Show **Slide 9/3 - Individual paths** and make the points that follow:



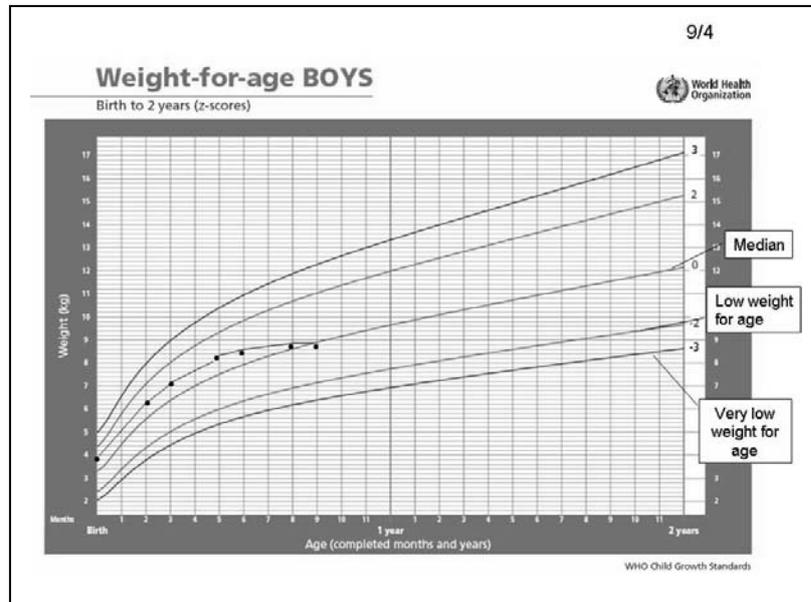
- Here we have a growth chart for boys that shows the curves of three children who were weighed regularly.

Ask: What can you tell from looking at these charts? Remember to look at the overall shape of the growth line

Wait for a few replies and then continue.

- 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 9/4 – Weight chart** and make the points that follow:



- Here we have a growth chart for Manuel who is nine months old.
Ask: What do you think of Manuel's growth?
 Wait for a few replies and then continue.
- Manuel grew well for the first few months but has not grown at all in the last three months.
Ask: What would you want to ask Manuel's mother?
 Wait for a few replies and then continue. Encourage participants to use open questions and to avoid judging words in their answers.
- Some questions you might ask are:

 - How was Manuel fed for the first six 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 six 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 six months his mother started to give him thin cereal porridge twice a day.
Ask: What is Manuel's mother doing which could be praised?
 Wait for a few replies and then continue. Although the session on Confidence and Support skills has not yet been covered it is helpful to start encouraging participants to look for things to praise.

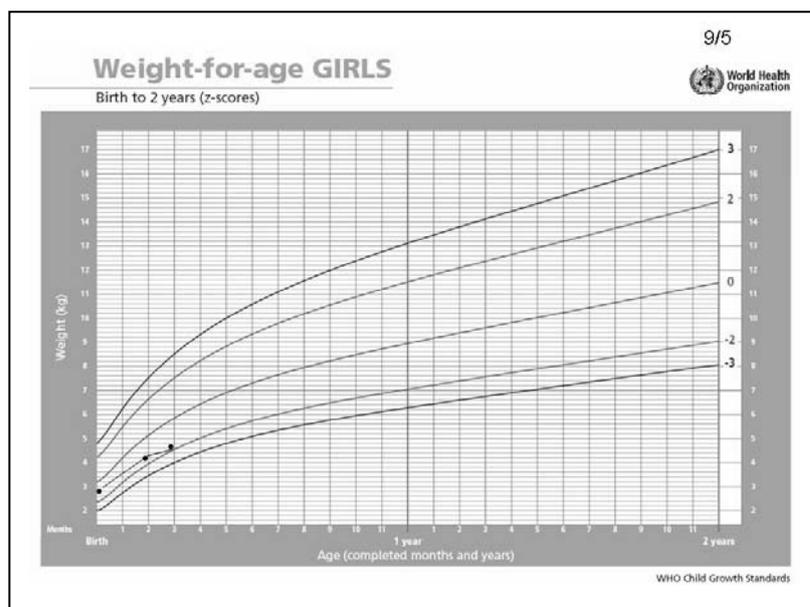
- Some ways you might praise Manuel's mother are:
 - You did well to exclusively breastfeed Manuel for the first six months of life – look how well he grew just on your breast milk.
 - It is good that you are still breastfeeding Manuel now that he is over six months of age.
 - It is good that you are continuing to feed Manuel at nights and that he is sleeping with you.

Ask: What do you think is the reason for Manuel's static weight?

Wait for a few replies and then continue.

- Manuel 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 six months of age. We will talk in more detail about complementary foods later in the course.

Show **Slide 9/5 - Weight chart** and make the points that follow:



- Here we have a growth chart for Ana who is 3 months old.

Ask: What do you think of Ana's growth?

Wait for a few replies and then continue.

- She is gaining weight too slowly.

Ask: What questions would you ask Ana's mother and what would you want to check?

Wait for a few replies and then continue. Encourage participants to use open questions and to avoid judging words in their answers.

- Some questions you might ask 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 4-5 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.

Ask: Do you think Ana should be started on complementary feeds since she is not gaining weight?

Wait for a few replies and then continue.
- Giving complementary feeds should not be necessary. If Ana is breastfed more often during the day and night (at least 8 times in each 24 hours) then she should gain weight.

IV. Summarize the session

5 minutes

- Ask participants if 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 the next session on counselling skills and in other sessions in the course.
- Explain that a summary of this session can be found on pages 47-50 of the *Participant's Manual*.

Session 10

Building Confidence and Giving Support

Objectives

After completing this session, participants will be able to:

- list the 6 confidence and support skills
- 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 | 5 minutes |
| II. | Demonstrate six skills for building confidence and giving support | 35 minutes |
| III. | Summarize the session | 5 minutes |

Preparation

- Refer to the Introduction for guidance on how to give a demonstration, and on giving a presentation with slides.
- You need one board or flipchart.
- Make sure that Slides 10/1-10/9 are in the correct order. Study the slides and the text that goes with them so that you are able to present them.
- Make copies of all the DEMONSTRATIONS 10.A-10.D. Study the instructions for DEMONSTRATIONS 10.A-10.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 10.A-10.D. Explain what you want them to do.
- Give each of the participants a copy of the demonstration that she has 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 10/1 - Session 10 Objectives** and read out the objectives:

10/1

Building confidence and giving support

After completing this session participants will be able to:

- list the 6 confidence and support skills
- 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 to her feeling that she is a failure and giving 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, 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 'CONFIDENCE AND SUPPORT SKILLS' on a board or flipchart. List the skills on the board as you demonstrate them.

Skill 1. Accept what a mother thinks and feels

- Write 'ACCEPT WHAT A MOTHER THINKS AND FEELS' on the list of confidence and support skills.
- 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 10.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 one-week-old baby.

DEMONSTRATION 10.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 like, "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 10.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 nine-month-old baby.

DEMONSTRATION 10.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, because it did not accept the mother's feelings and made her feel wrong to be upset.**

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 cry – it's not serious. (Child's name) will soon be better"

Ask: *Was this an appropriate response?*

Comment: **This is an inappropriate response. By saying things like "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?"

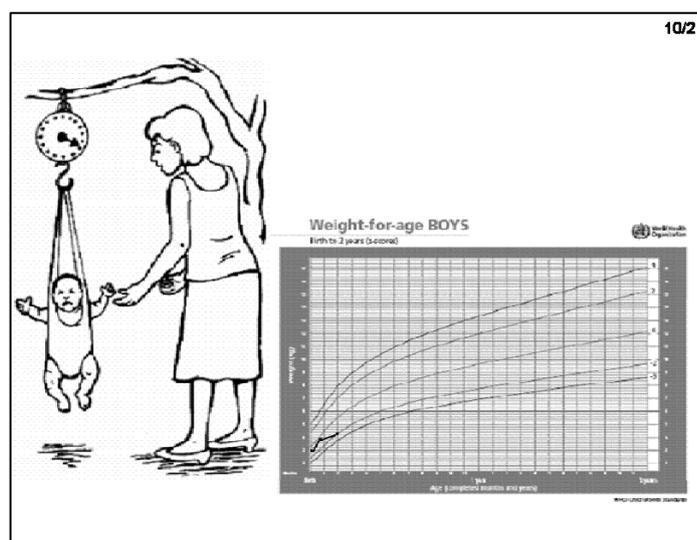
Ask: *Was this an appropriate response?*

Comment: **This is an appropriate response because it accepts how the mother feels and makes her feel that it is 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 and baby are doing right

- Write 'RECOGNIZE AND PRAISE WHAT A MOTHER AND BABY ARE DOING RIGHT' on the list of confidence and support skills.
- 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 socio-economic status or education.

- Show **Slide 10/2** and explain the situation that it illustrates:



Explain Slide 10/2:

- 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 10/3**:

-
- Read out the remarks, and ask participants to say which one helps to build the mother's confidence.

10/3

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."

- 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 confidence and support skills.
- Explain the skill:
 - Sometimes practical help is better than saying anything. 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.
- It also 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 10/4** and explain the situation that it illustrates:



Explain Slide 10/4:

- 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 him yet. My breasts are empty and it is too painful to sit up.”

Then show **Slide 10/5**:

Read out the remarks, and ask participants to say which response is the more appropriate.

10/5

Which response is more appropriate?

- “You should let your baby suckle now to help your breast milk to come in.”
- “Let me try to make you more comfortable, and then I'll bring you a drink.”

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 confidence and support skills.
- 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 10/6** and explain the situation that it illustrates:



Explain Slide 10/6:

- This baby is three 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 10/7**:

Read out the responses, and ask participants to say which one gives information in a positive way.

10/7

Which response gives positive information?

- “It is good that you asked before deciding. Diarrhoea usually stops sooner if you continue to breastfeed.”
- “Oh no, don’t stop breastfeeding. He may get worse if you do that.”

- 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 confidence and support skills.
- 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 six-month-old child.
- Ask the two participants whom you have prepared to give DEMONSTRATION 10.C to read the words of the mother and health worker. Discuss briefly what the participants have observed after each section.

DEMONSTRATION 10.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 six 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 six months old because breast milk has less than 1 milligram 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 is providing too much information. It is not relevant to the mother at this time. She is using words that are 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 10.D to read the words of the mother and health worker.

DEMONSTRATION 10.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 six 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.”

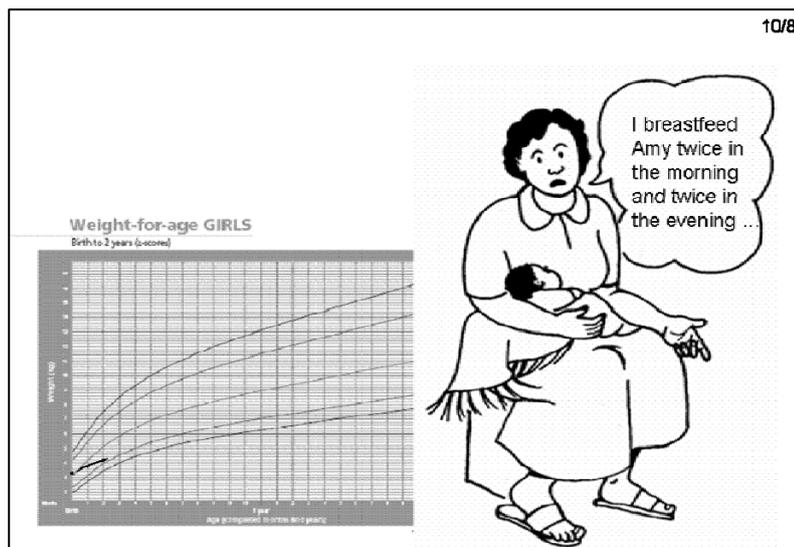
Ask: *What did you observe this time?*

Comment: **The health worker explains 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 confidence and support skills.
- 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 him 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 if she will try it or not. This leaves her feeling in control, and helps her to feel confident.

- Show **Slide 10/8** and explain the situation that it illustrates:



- Make one or two suggestions
- Explain Slide 10/8:
 - 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 **Overhead 10/9**:

- Read out the responses, and ask participants to say which is a command and which a suggestion.

10/9

Which of these responses is a command, and which is a suggestion?

- “You must feed Amy at least 10 times a day.”
- “It might help if you feed Amy more often.”

- 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 if 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 if 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.
- Ask participants to find the list on page 53 of their Manual. Ask them to try to memorize it. Explain that they will use these skills for Practical Session 2.

Session 11

Building Confidence and Giving Support Exercises – Part 1

Objectives

After completing this session participants will be able to:

- demonstrate appropriate use of the 6 confidence and support skills
- provide examples of each skill in relation to breastfeeding

Session outline

45 minutes

Participants work in groups of 8-10 with 2 trainers.

- | | | |
|-----|--|------------|
| I. | Introduce the session | 5 minutes |
| II. | Facilitate the written exercises (Exercises 11.a – 11.f) | 40 minutes |

Preparation

- Refer to the Introduction for guidance on how to conduct group work and facilitate written exercises.
- Study the notes for the session, so that you are clear about what to do.
- For Exercises 11.a – 11.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

- Make these introductory points:
- Ask participants to turn to page 55 of their Manual to find Exercises 11.a – 11.f.
- Explain what they will do:
 - You will now practise the 6 confidence and support skills that you learnt about in Session 10.
 - The examples in this session are mostly 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 which 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

40 minutes

Exercise 11.a Accepting what a mother THINKS

How to do the exercise:

Examples 1-2 are mistaken ideas which 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 six-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?”

Accepts

“It is quite safe to breastfeed a baby when he has diarrhoea.”

Disagrees

“It is often better to stop breastfeeding a baby when he has diarrhoea.”

Agrees

To answer:

1. Mother of a one-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." *Disagrees*
- "Yes, babies may need extra drinks of water in this weather." *Agrees*
- "You feel that he needs drinks of water sometimes?" *Accepts*
2. Mother of a nine-month-old baby:
 "I have not been able to breastfeed for two days, so my milk is sour."
- "Breast milk is not very nice after a few days." *Agrees*
- "You are worried that your breast milk may be sour?" *Accepts*
- "But milk never goes sour in the breast!" *Disagrees*

How to do the exercise:

Examples 3-5 are some more mistaken ideas which mothers might hold.

Make up a response that accepts what the mother says, without disagreeing or agreeing.

Example:

- Mother of a one-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 him suckle for more than ten minutes, because it would make my nipples sore." *"You are frightened that you might have sore nipples?"*
5. "I need to give him formula now that he is two months old. My breast milk is not enough for him now". *"I see....."*

Exercise 11.b Accepting what a mother FEELS**How to do the exercise:**

After the Stories A, and B below, there are three responses.

Mark with a ✓ the response which 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 which 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 A.**

Marion is in tears. She says that her breasts have become soft again, so her milk must be less, but the baby is only three 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 B.

Dora is very bothered. Her baby sometimes does not pass a stool for one or two days. When he does pass a stool, he pulls up his 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 four or five days.
- ✓ c. It really bothers you when he does not pass a stool, doesn't it?

Exercise 11.c Praising what a mother and baby are doing right**How to do the exercise:**

For Story C below, there are three responses. They are all things that you might want to say to the mother.

Mark with a ✓ the response which praises what the mother and baby are doing right, to build the mother's confidence.

For Story D make up your own response which praises the mother.

Example:

A mother is breastfeeding her three-month-old baby, and giving drinks of fruit juice. The baby has slight diarrhoea.

Mark the response which 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 six months old.

To answer:**Story C.**

The mother of a three-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 D.

A four-month-old baby is completely fed on replacement feeds from a bottle. He has diarrhoea. The growth chart shows that he weighed 3.5 kilos at birth, and that he has only gained 200 grams in the last two 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 his weight chart.

Exercise 11.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 which corresponds to the information which is most relevant for her. As an example, the correct answer for Mother 1 is already marked in brackets.

To answer:

Mothers 1-6		Information
1. Mother returning to work	a b c d (e) f	a. Foremilk normally looks watery, and hindmilk is thicker
2. Mother with a 12-month-old baby	a b c d e (f)	b. Exclusive breastfeeding is best until a baby is six 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 two-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 two years or more

Exercise 11.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:

Colostrum is all that a baby needs in the first few days.

Using simple language:

“The first yellowish milk that comes is exactly what a baby needs for the first few days.”

To answer:

Information:

1. Exclusive breastfeeding is best up to six months of age.

Using simple language:

“Breast milk alone is all a baby needs until he is about six 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 11.f Making one or two suggestions, not commands

How to do the exercise:

Examples 1-2 are some commands which you might want to give to a breastfeeding mother.

Rewrite the commands as suggestions.

The box below gives some examples of ways to make suggestions, not commands. You may find this helpful when doing the exercises below.

MAKING SUGGESTIONS, NOT COMMANDS

Commands use the imperative form of verbs (give, do, bring) and words like *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: "Keep the baby in bed with you so that he can feed at night!"

Suggestions: *"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:

1. Command: Do not give your baby any drinks of water or glucose water, before he is at least six months old!

Suggestions: *"You may find that breastfeeding is all that he needs - extra water is not usually necessary"*.

"Have you thought of giving him just breastfeeds? Babies can get all the water that they need from breast milk"

2. Command: Feed him more often, whenever he is hungry, then your milk supply will increase!

Suggestions: *"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 Session 11.
- If some participants are having difficulties with the exercises, or have not finished them, arrange to help them later.

Session 12

Practical 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 confidence and support skills when counselling a mother on feeding her infant
- demonstrate how to help a mother to position and attach her baby at the breast.

Session outline

120 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 in a ward or clinic.

- | | | |
|-----|-------------------------------|-------------|
| I. | Prepare the participants | 20 minutes |
| II. | Conduct the clinical practice | 100 minutes |

Preparation

- Study the instructions in the following pages, and ask all trainers who will lead groups to study the instructions also. You conduct Practical Session 2 in a similar way to Practical Session 1, but there are some differences. Make sure that you and the other trainers are clear about the differences.
- Make sure that there are copies of the COUNSELLING SKILLS CHECKLIST and the BREASTFEED OBSERVATION JOB AID available for each participant and trainer.
- Make sure that there are copies of the PRACTICAL DISCUSSION CHECKLIST for each trainer.

As you follow the text, remember:

- Indicates an instruction to you, the trainer
- Indicates what you say to participants.

I. Prepare the participants (one trainer)

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 practical session, hold the preparatory session in the classroom before you leave. If necessary, this can take place on the evening or the morning before.

- Explain the following to the participants:
 - You are going to practise the 'confidence and support' skills that you learnt in Sessions 10 and 11, and helping a mother to position her baby.
 - You also continue to practise 'assessing a breastfeed' and 'listening and learning'.
 - 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 like: "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 4 key points of 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 one copy of the COUNSELLING SKILLS CHECKLIST, two copies of the BREASTFEED OBSERVATION JOB AID, pencil and paper to make notes.
 - You will work in groups of 3-4 with one trainer.

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 confidence and support skills 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's counselling skills.
- Mark a ✓ on your COUNSELLING SKILLS CHECKLIST when she uses of skill, to help you remember for the discussion.
- When a mother breastfeeds observe the feed using the BREASTFEED OBSERVATION JOB AID and put ticks in the boxes.

II. Conduct the clinical practice (all trainers)**100 minutes**

These notes are for the trainers. Trainers should read these notes 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 Practical 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 she makes immediately. If possible wait until the discussion afterwards. Then you can both praise what she did right and talk about anything she did not do right.
 - However, if she is making a lot of mistakes, or not making any progress, then you should help her. Try to help in a way that does not make her 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 confidence and support skills 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 PRACTICAL DISCUSSION CHECKLIST to help you to lead the discussion. Try not to spend too long going through the practical 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 herself to say how well she thinks she 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 BREASTFEED OBSERVATION JOB AID and discuss what the participants observed when assessing a breastfeed. Discuss how the participant helped a mother to position and attach her baby.

Session 13

Taking a Feeding History

Objectives

After completing this session participants will be able to:

- take a feeding history of an infant 0-6 months
- demonstrate appropriate use of the FEEDING HISTORY JOB AID, 0-6 MONTHS.

Session outline

30 minutes

Participants are all together for a demonstration led by one trainer

I.	Introduce the session	3 minutes
II.	Explain how to take a feeding history	5 minutes
III.	Explain the FEEDING HISTORY JOB AID, 0-6 MONTHS	5 minutes
IV.	Demonstrate how to use the FEEDING HISTORY JOB AID, 0-6 MONTHS	15 minutes
V.	Summarize the session	2 minutes

Preparation

- Refer to the Introduction for general information about how to give a demonstration.
- Study the session notes so that you are clear about what to do.
- For DEMONSTRATION 13.A: USING THE FEEDING HISTORY JOB AID, 0-6 MONTHS: 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.
- Make sure Slide 13/1 is ready. As there is only one slide, you might prefer to read aloud the objectives without projecting them onto the screen.

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 13/1 - **Session 13 Objectives** and read out the objectives:

13/1

Taking a feeding history

After completing this session participants will be able to:

- take a feeding history of an infant 0-6 months
- demonstrate appropriate use of FEEDING HISTORY JOB AID, 0-6 MONTHS

- 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 0-6 months. The baby may be breastfeeding or receiving another form of milk and may, or may not, be receiving complementary feeds.
 - The FEEDING HISTORY JOB AID, 0-6 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 66 of their Manual and find the box HOW TO TAKE A FEEDING HISTORY, 0-6 MONTHS.
- Ask participants to take turns to read out the points.

HOW TO TAKE A FEEDING HISTORY, 0-6 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 FEEDING HISTORY JOB AID, 0-6 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 confidence and support skills.

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 she 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 FEEDING HISTORY JOB AID, 0-6 MONTHS 5 minutes

- Ask participants to look at the FEEDING HISTORY JOB AID, 0 TO 6 MONTHS, on page 67 of their 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.

FEEDING HISTORY JOB AID, 0-6 MONTHS
<p>Age of child Particular concerns about feeding of child</p>
<p>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)</p>
<p>Health Growth chart (birth weight, weight now) Urine frequency per day (6 times or more), if less than 6 months Stools (frequency, consistency) Illnesses</p>
<p>Pregnancy, birth, early feeds (where applicable) Antenatal care Feeding discussed at ante-natal care Delivery experience Rooming-in Prelacteal feeds Postnatal help with feeding</p>
<p>Mother's condition and family planning Age Health – including nutrition and medications Breast health Family planning</p>
<p>Previous infant feeding experience Number of previous babies How many breastfed and for how long If breastfed – exclusive or mixed fed Other feeding experiences</p>
<p>Family and social situation Work situation Economic situation Family's attitude to infant feeding practices</p>

IV. Demonstrate how to use the FEEDING HISTORY JOB AID, 0-6 MONTHS

15 minutes

- Explain that you will demonstrate how to use the FEEDING HISTORY JOB AID, 0-6 MONTHS. Ask the participants whom you have prepared to read the words of the health worker and the mother. Pass Lucy's growth chart around the participants during the demonstration.
 - Ask participants to follow the FEEDING HISTORY JOB AID, 0-6 MONTHS on page 67 of their Manual as you give the demonstration.
 - Ask them to listen for counselling skills.

DEMONSTRATION 13.A TAKING A FEEDING HISTORY, 0-6 MONTHS

<i>Health Worker:</i>	"Good morning, I am Nurse Jane. May I ask your name, and your baby's name?"
<i>Mother:</i>	"Good morning, nurse; I am Mrs Green and this is my daughter Lucy."
<i>Health Worker:</i>	"She is lovely – how old is she?"
<i>Mother:</i>	"She is 5 months now."
<i>Health Worker:</i>	"Yes – and she is taking an interest in what is going on, isn't she? Tell me, what milk have you been giving her?"
<i>Mother:</i>	"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."
<i>Health Worker:</i>	"Oh dear, it can be very worrying when a child is always hungry. You decided to start bottle feeds? What are you giving her?"
<i>Mother:</i>	"Well, I put some milk in the bottle and then mix in a spoonful or two of cereal."
<i>Health Worker:</i>	"When did she start these feeds?"
<i>Mother:</i>	"Oh, when she was about 2 months old."
<i>Health Worker:</i>	"About 2 months. How many bottles do you give her each day?"
<i>Mother:</i>	"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."
<i>Health Worker:</i>	"So she just takes the bottle little by little? What kind of milk do you use?"
<i>Mother:</i>	"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!"
<i>Health Worker:</i>	"Formula is very expensive isn't it? Tell me more about the breastfeeding. How often is she doing that now?"
<i>Mother:</i>	"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."
<i>Health Worker:</i>	"She breastfeeds at night?"
<i>Mother:</i>	"Yes she sleeps with me."
<i>Health Worker:</i>	"Oh that makes it easier, doesn't it? Did you have any other difficulties with breastfeeding, apart from worrying about not having enough?"
<i>Mother:</i>	"No, it wasn't difficult at all."
<i>Health Worker:</i>	"Do you give her anything else yet? Any other foods or drinks?"
<i>Mother:</i>	"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 kilograms when she was born, she was 5.5 kilograms when she was 2 months old, and now she is 6.0 kilograms. You can see that she gained weight fast for the first two months, but it is a bit slower since then. Can you tell me if 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 if 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 page 68-69 of their 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.” “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 FEEDING HISTORY JOB AID, 0-6 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 two 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 two months; no help with early breastfeeds; early introduction of glucose water; attitude of Lucy’s father).

V. Summarize the session

2 minutes

- Ask participants if they have any questions, and try to answer them.
- Explain that a summary of this session can be found on pages 65-70 of the *Participant’s Manual*.

Session 14

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

75 minutes

Participants are all together for a lecture presentation by one, two or three trainers.

I.	Introduce the session	5 minutes
II.	'Not enough milk'	25 minutes
III.	Crying baby	20 minutes
IV.	Refusal to breastfeed	20 minutes
V.	Summarize the session	5 minutes

Preparation

- Refer to the Introduction for guidance on how to give a presentation with slides.
- Make sure that Slides 14/1-14/5 are in the correct order. Study the slides and the text that goes with them so that you are able to present them.
- This is a long session which divides easily into 3 sections: 'not enough milk', crying baby and refusal to breastfeed. Trainers can divide the session.
- Prepare flipcharts or boards to write up lists of ideas.
- 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' section. 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**5 minutes**

- Show **Slide 14/1 - Session 14 Objectives** and read out the objectives:

14/1

Common breastfeeding difficulties

After completing this session participants will be able to identify causes of, and help mothers with, the following difficulties:

- 'not enough milk'
- a crying baby
- breast refusal

- 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 if 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.
 - We will start by looking at mothers with 'not enough milk'.

II. 'Not enough milk'**25 minutes**

- Show **Slide 14/2 - 'Not enough milk'** and make the points that follow:

14/2

'Not enough milk'

- This is one of the most common reasons for stopping breastfeeding
- Usually when a mother **thinks** she does not have enough breast milk, her baby is getting all he needs
- Sometimes a baby does **not** get enough breast milk. But this is usually because of ineffective suckling. It is rarely because his mother cannot produce enough

- 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 he needs.
- 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 he is not suckling enough, or not suckling effectively. It is rarely because his 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 if a baby is getting enough milk or not

- Develop a list of reasons that make mothers think that they do not have enough milk.

Ask: What makes mothers think that they do not have enough milk?

Write participants replies on a flipchart. Do not take too long over this.

Continue until you have a list of at least six signs, and if possible until someone has said 'poor weight gain'.

- The first step in helping mothers with insufficient milk is to confirm if 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 14/3 - Reliable signs** and read out the reliable signs from the overhead:

14/3

Reliable signs that a baby is not getting enough milk

Poor weight gain

- less than 500 grams per month

Small amount of concentrated urine

- less than 6 times per day

Make these points:

- For the first six months of life, a baby should gain at least 500g in weight each month. One kilogram is not necessary, and not usual.
- If a baby does not gain 500g in a month he is not gaining enough weight.
- Look at the baby's growth chart if available, weigh the baby now, and arrange to weigh him again in one 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 less than six times a day (often less than four times a day).
- His 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 he is getting enough milk if he is passing lots of urine.

- Show **Slide 14/4 - Possible signs** and read out the signs:

14/4

Possible signs that a baby is not getting enough breast milk

- 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 mother expresses
- 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 he has colic, although he 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 page 72 of their Manuals.

Discuss the reasons why a baby may not get enough breast milk

- 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'.

- Ask participants to turn to page 73 of their Manuals and 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
- Ask one participant to read out the reasons in the first column (Breastfeeding factors), a second participant the second column, a third participant the third column, a fourth participant the fourth column.

REASONS WHY A BABY MAY NOT GET ENOUGH BREAST MILK			
BREASTFEEDING FACTORS	MOTHER: PSYCHOLOGICAL FACTORS	MOTHER: PHYSICAL CONDITION	BABY'S CONDITION
Delayed start	Lack of confidence	Contraceptive pill, diuretics	Illness
Feeding at fixed times	Worry, stress	Pregnancy	Abnormality
Infrequent feeds	Dislike of breastfeeding	Severe malnutrition	
No night feeds	Rejection of baby	Alcohol	
Short feeds	Tiredness	Smoking	
Poor attachment		Retained piece of placenta (rare)	
Bottles, pacifiers		Poor breast development (very rare)	
Other foods			
Other fluids (water, teas)			
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 bottle feeds.

- 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'

Make these points:

- 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 he isn'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:

- Use your counselling skills to take a good feeding history.
- Assess a breastfeed to check positioning and attachment; 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 the 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 breast feed to check positioning and attachment; 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.
 - Always remember to 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.
- Discuss the following scenario as a group. Ask participants to turn to page 75 of their Manuals 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 73 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.

Mrs Singh says she does not have enough milk. Her baby is three months old and crying 'all the time'. Her baby gained 200g 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.

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 which 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 200g last month, so he 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 73 of their Manual.

- Mrs Singh is not breastfeeding him 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 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?

III. The crying baby

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 him and his 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 76 of their 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 he is growing faster than before.
 - . He demands to be fed very often.
 - . This is commonest at the ages of about two weeks, six weeks and three months, but can occur at other times.
 - . If he suckles often for a few days, the breast milk supply increases, and he 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.
 - . He may pull up his legs as if he has abdominal pain.
 - . He may appear to want to suckle, but it is very difficult to comfort him.
 - . 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 three 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 baby's 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 her that her baby is growing well and is not ill or bad or naughty.
- Demonstrate ways to carry and comfort a crying baby – holding him close, with gentle movement and pressure on his abdomen.
- Give relevant information where appropriate:

Ask: What relevant information could you give to a mother whose baby is six weeks old with colic?

Wait for a few replies and then continue.
- Explain that the baby has a real need for comfort when he is 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 he 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 three-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 she 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 (Fig.14.2a).
 - 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 (Fig.14.2b).
 - Ask a man to help with this demonstration if possible (Fig.14.2c).
 - 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.

Fig. 14.2 Some different ways to hold a colicky baby

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



- Discuss the following scenario as a group. Ask participants to turn to page 78 of their Manuals 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 76 of their Manuals 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 correct answers so they have them to refer to later.

Mrs Biyela's baby is three 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.

Ask: What can 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 which empathizes with the mother.

- "You are worried that he is crying more than before."

Ask: What can 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 can 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 feed him more often for a few days, your milk supply will increase, and he will settle down again."

IV. Refusal to Breastfeed**20 minutes**

- Make these points:
 - Finally we will look at babies who refuse to breastfeed or are unwilling to suckle.
 - 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 his mother tries to breastfeed him.
 - Sometimes a baby suckles for a minute and then comes off the breast choking or crying. He 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 14/5 - Reasons why babies refuse to breastfeed** and make the points that follow:

14/5

Reasons why babies refuse to breastfeed

- Baby ill, sedated or in pain
- Difficulty with breastfeeding technique
- Change which upsets the baby
- Apparent, not real, refusal

- Most reasons why babies refuse to breastfeed fall into one of these categories:
 - . Baby ill, in pain or sedated
 - . Difficulty with breastfeeding technique
 - . Change which upsets baby
 - . Apparent, not real, refusal.

- Ask participants to turn to page 80 of their Manual and find the box CAUSES OF BREAST REFUSAL. 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 BREAST REFUSAL

Illness, pain or sedation

Infection
Brain damage
Pain from bruise (vacuum, forceps)
Blocked nose
Sore mouth (thrush, teething)

Difficulty with breastfeeding technique

Use of bottles and pacifiers whilst breastfeeding
Not getting much milk (e.g. poor attachment)
Pressure on back of head when positioning
Mother shaking breast
Restricting length of feeds
Difficulty co-ordinating suckle

Change which upsets 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

Newborn - rooting
Age 4-8 months - distraction
Above one year - self-weaning

Discuss how to help mothers whose babies breast refuse.

- ❑ Ask participants to turn to page 81 of their 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 his mouth
 - Position him so that he can attach easily to the breast – try different positions
 - Avoid pressing the back of his head or shaking her breast.
- Feed her baby by cup
 - Give her own expressed breast milk if possible; if necessary give artificial feeds
 - Avoid using bottles, teats, pacifiers.

- Discuss the following scenario as a group. Ask participants to turn to page 82 of their 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 80 of their Manuals 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 correct answers so they have them to refer to later.

Mrs Barlow delivered a baby boy by vacuum extraction two days ago. He has a bruise on his head. When Mrs Barlow tries to feed him, he screams and refuses. She 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.

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 which empathizes with the mother.

- “You are really upset, aren’t you?”

Ask: What praise and relevant information can 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 he is crying and refusing to feed.”

Ask: What practical help can 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 him.

V. Summarize the session

5 minutes

- Ask participants if 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; confidence and support skills; 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 71-84 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 a 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 if 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 not rounded after feeds
- Breasts not full immediately after delivery
- Breasts softer than before
- Breast milk not dripping out
- Not feeling her oxytocin reflex
- Family members ask if enough milk
- Health worker said not enough milk
- Told too young or too old to breastfeed
- Told baby 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. He should regain his birth weight by the age of two 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 his birth weight at two 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, his mother's breast milk may take longer to come in, and he may take longer to start gaining weight.

Infrequent feeds:

Breastfeeding less than 8 times a day in the first 4 weeks, or less 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 he cries, 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 wake him to breastfeed every 3-4 hours.

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 his mother decides that he 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 he is too hot, because he is wrapped in too many clothes.

Poor attachment:

If a baby suckles ineffectively, he may not get enough milk.

Bottles and pacifiers:

A baby who feeds from a bottle or who sucks on a pacifier may suckle less at the breast, so the breast milk supply decreases.

Complementary feeds:

A baby who has complementary feeds (artificial milks, solids, or drinks including plain water), before 4-6 months suckles less at the breast, so the breast milk supply 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.

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 him close enough to attach well; she may breastfeed infrequently, or for a short time. She may give her baby a pacifier when he cries instead of breastfeeding him.

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 breast milk supply.

Diuretics may reduce the breast milk supply.

Pregnancy:

If a mother becomes pregnant again, she may notice a decrease in her breast milk supply.

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, which 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'.

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, his 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 he takes 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 handicap, 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. 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 complement for her baby. 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 six months of age should be RARE.

Crying

A baby who is 'crying too much' may really be crying more than other babies, or his 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 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 suckles less than before.

Pain:

Pressure on a bruise from forceps or vacuum extraction.

The baby cries and fights as his mother tries to breastfeed him.

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 his 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 his mother or a helper positioning him roughly, with poor technique. The pressure makes him want to 'fight'.
- His mother holding or shaking the breast, which interferes with attachment.
- Restriction of breastfeeds; for example, breastfeeding only at certain times.
- Early difficulty co-ordinating 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. He suddenly refuses several breastfeeds. This behaviour is sometimes called a 'nursing strike'.

Possible causes:

- Separation from his 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.
- His mother menstruating.
- A change in his mother's smell, for example, different soap, or different food.

Is it 'apparent' and not 'real' refusal?

Sometimes a baby behaves in a way which makes his mother think that he is refusing to breastfeed. However, he is not really refusing.

- When a newborn baby 'roots' for the breast, he moves his head from side to side as if he is 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 himself. This is usually gradual.

Management of breast refusal:

If a baby is refusing to breastfeed:

1. Treat or remove the cause if possible.
2. Help the mother and baby to enjoy breastfeeding again.

1. 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, he may need special care in hospital.

Help his mother to express her breast milk to feed to him by cup or by tube, until he 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.

For teething: encourage her to be patient and to keep offering him 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 which 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 him closer, so that it is easier for him to attach.

If it is *distraction*:

Suggest that she try to feed him 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 him plenty of extra attention in other ways
- continues to sleep with him because night feeds may continue.

2. 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 him.
- 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.
- He may be more willing to suckle when he is sleepy or after a cup feed, than when he is 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 him well, so that it is easy for him to attach to the breast.
- She should avoid pressing the back of his head, or shaking her breast.

Feed her baby by cup until he is 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.

Session 15

Expressing Breast Milk

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	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 general guidance on how to give a demonstration.
- Study the notes for the session so that you are clear what to do.
- Make sure that Slide 15/1 is ready. Alternatively, as there is only one slide in this session, you might prefer to read aloud the objectives on Slide 15/1 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 her 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

3 minutes

- Show **Slide 15/1 - Session 15 Objectives** and read out the objectives:

15/1

Expressing breast milk

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. 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 his 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 Session 20)
 - facilitate the transition to another method of feeding or to heat-treat breast milk (see Sessions on 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. Certainly 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 eight 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 86 of their 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. 15.1 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 (see box inset in Fig. 15.1).
 - Ask her how she feels, and if it makes her feel relaxed.
- ❑ Ask participants to work in pairs and briefly practise the technique of rubbing a mother's back.

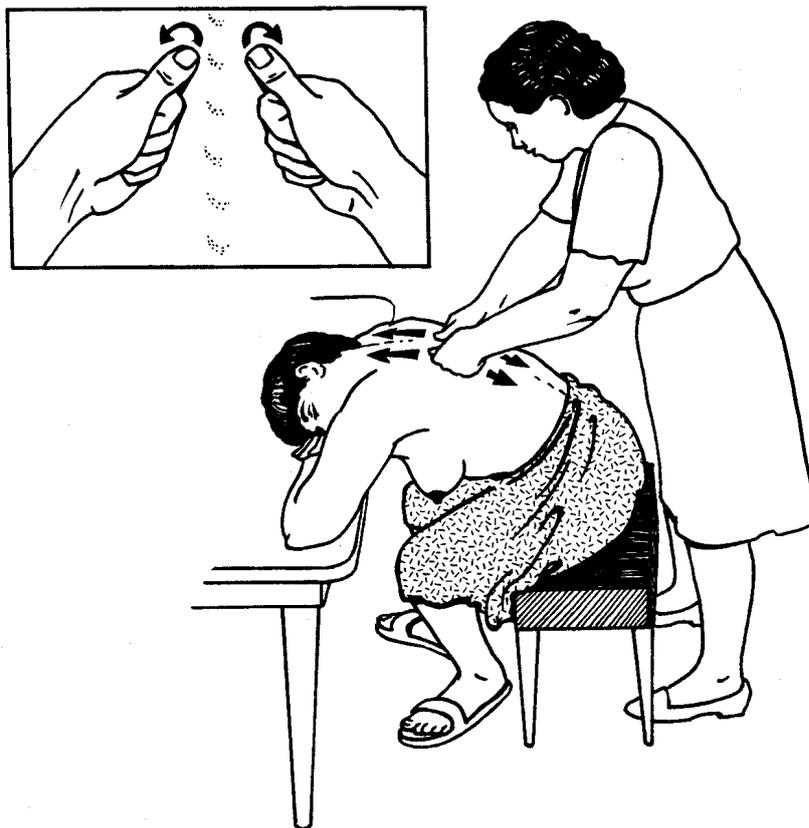


Fig. 15.1 A helper rubbing a mother's back to stimulate the oxytocin reflex

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 (EBM). (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 (EBM)

- Choose a cup, glass, jug or jar with a wide mouth.
- Wash the cup in soap and water (She can do this 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.

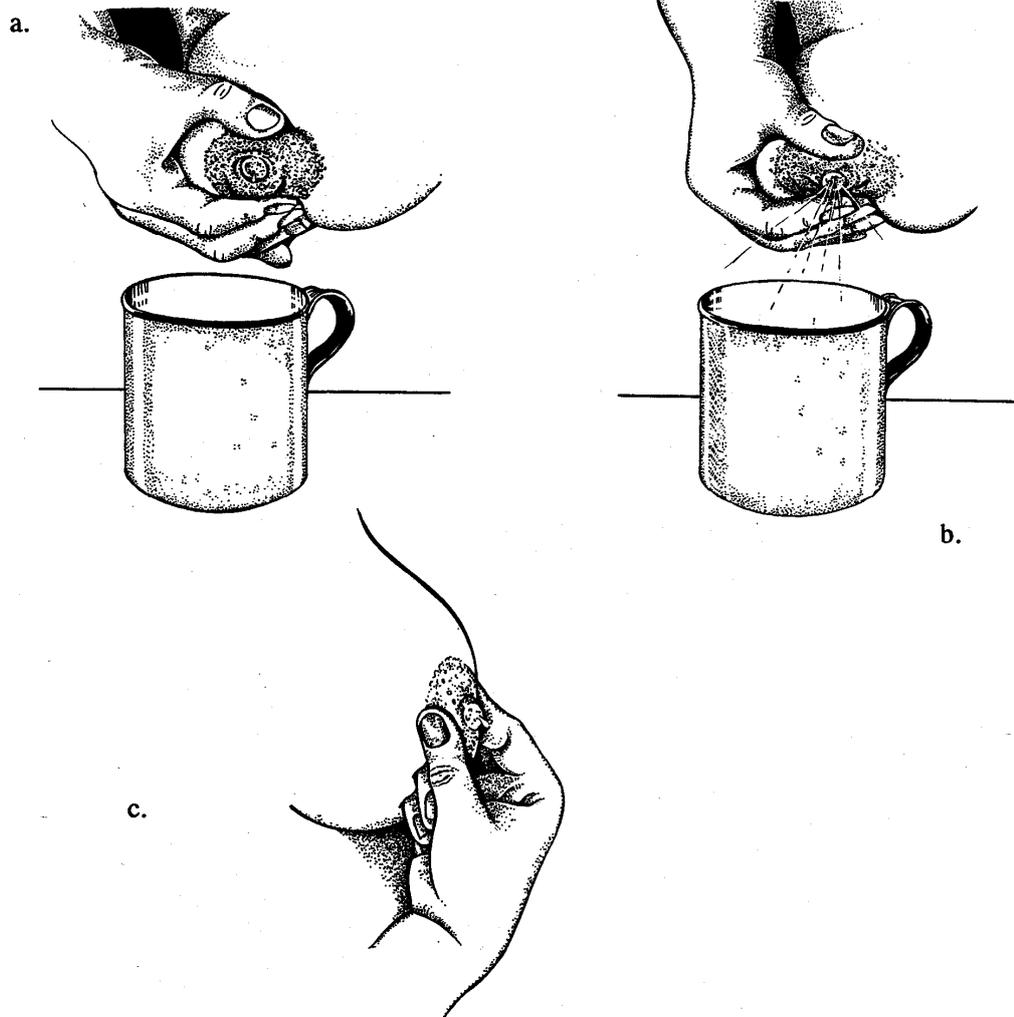
- Follow the steps in the box HOW TO EXPRESS BREAST MILK BY HAND, explaining what you do.

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:
 - Wash her hands thoroughly.
 - 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 on the breast BELOW the nipple and areola, opposite the thumb. She supports the breast with her other fingers (see Fig.15.2).
 - Press her thumb and first finger 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 finger 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.
 - 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.

Fig. 15.2 How to express breast milk.

- a. Place finger and thumb each side of the areola and press inwards towards the chest wall.
- b. Press behind the nipple and areola between your finger and thumb.
- c. Press from the sides to empty all segments.



- Tell participants that they can find the box HOW TO EXPRESS BREAST MILK BY HAND on page 88 of their Manual, and the figures on page 89.

- 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 (LBW) or sick newborn** 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 breast milk production to begin, in the same way that a baby suckling soon after delivery helps breast milk production to begin.
 - She should express as much as she can as often as her baby would breastfeed. This should be at least every three 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 three hours.
 - **To build up her milk supply, if it seems to be decreasing after a few weeks:** Express very often for a few days (every 2 hours or even every hour), and at least every three hours during the night.
 - **To leave milk for a baby while she is out at work:** 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:** 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 if 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 85-90 of the *Participant's Manual*.

Session 16

Cup-feeding

Objectives

After completing this session participants will be able to:

- list the advantages of cup-feeding
- estimate the volumes 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	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 16/1 ready. As there is only one slide, you might prefer to read aloud the objectives without projecting them onto the screen.
- For the demonstration you will need a small cup, which holds approximately 60 mls of water, a cloth and a doll.
- You will need a flipchart to demonstrate the calculation.

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 16/1 - Session 16 Objectives** and read out the objectives:

Cup-feeding

After completing this session participants will be able to:

- list the advantages of cup-feeding
- estimate the volumes of milk to give to a baby according to weight
- demonstrate how to cup-feed safely

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 which 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 himself. The person who feeds a baby by cup has to hold the baby and look at him, and give him some of the contact that he needs.
- A cup does not interfere with suckling at the breast.
- A cup enables a baby to control his own intake.

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 mls of water, to demonstrate the typical volume of milk used for one feed for a young baby.
 - Hold a doll on your lap, closely, with it sitting upright or semi-upright. Explain that a baby should not lie down too much.
 - 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 his lower lip. This is normal when a person drinks.
 - Explain that at this point, a real baby becomes quite alert, and opens his mouth and eyes. He makes movements with his mouth and face, and he starts to take the milk into his mouth with his 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 his clothes. Spilling is commoner 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 his lips.
 - Explain that when a baby has had enough, he closes his mouth and will not take any more this feed. If he has not taken the calculated amount, he may take more next time, or he may need feeds more often. Measure his 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.

- Explain to participants that the technique is described in the box HOW TO FEED A BABY BY CUP on page 92 of their Manual. There is no need to read this box out again to the participants.

HOW TO FEED A BABY BY CUP

- Wash your hands.
- Hold the baby sitting upright or semi-upright on your lap.
- 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 his mouth and eyes.
 - A low-birth-weight (LBW) baby starts to take the milk into his mouth with his 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 his lips and let him take it himself.
- When the baby has had enough, he closes his mouth and will not take any more. If he has not taken the calculated amount, he may take more next time, or you may need to feed him more often.
- Measure his intake over 24 hours - not just at each feed.



Fig. 16.1 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 (LBW) 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 93 of their Manuals to find the box AMOUNT OF MILK TO GIVE TO BABIES. Ask the participants to read this box themselves before you go through the calculation which follows.

AMOUNT OF MILK TO GIVE TO BABIES
<ul style="list-style-type: none"> ▪ Babies who weigh 2.5 kg or more 150 ml milk per kg body weight per day Divide the total into eight feeds, and give 3-hourly ▪ Babies who weigh less than 2.5 kg (Low-birth-weight) Start with 60 ml/kg body weight Increase the total volume by 20 ml per kg per day, until the baby is taking a total of 200 ml per 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 pages 94 of their Manuals. 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 two-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 per kg.
Ask: How much milk will this baby need in 24 hours?
Wait for a few replies and then continue.
 - The baby will need $150 \times 3.8 = 570$ mls in 24 hours
 - If the baby feeds every 3 hours he 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 $570 \div 8 = 71.25$ mls. This could be rounded up to 75 mls 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, which 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 which holds 150 mls, she should offer the baby approximately half a cup of milk per feed.

V. Summarize the session

3 minutes

- Ask participants if 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 91-94 of the *Participant's Manual*.

Session 17

Overview of HIV and Infant Feeding

Objectives

After completing this session participants will be able to:

- explain the risk of mother-to-child transmission of HIV
- describe factors which influence mother-to-child transmission
- outline approaches that can prevent mother-to-child transmission through safer infant feeding practices
- state infant feeding recommendations for women who are HIV-positive and for women who are HIV-negative or do not know their status

Session outline

45 minutes

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

- | | | |
|------|---|------------|
| I. | Introduce the session | 7 minutes |
| II. | Review the risk of mother-to-child transmission of HIV | 15 minutes |
| III. | Explain factors which affect mother-to-child transmission | 10 minutes |
| IV. | Outline approaches to prevent mother-to-child transmission through safer infant feeding practices | 10 minutes |
| V. | Summarize the session | 3 minutes |

As you follow the text, remember:

- Indicates an instruction to you, the trainer
- Indicates what you say to participants.

Preparation

- Refer to the Introduction for guidance on giving a presentation with slides.
- Make sure that Slides 17/1-17/15 are in the correct order. Study the slides and the text that goes with them so that you are able to present them.
- Your Course Director will tell you which slides you will use, depending on the HIV prevalence in your area. Note that there are alternative Slides 17/5 to 17/9. One has 100 mothers on it and one has 1000 mothers on it. Make sure you are clear which of these slides you are going to use.
- You will need: Feeding Options Card 1: '20 mothers and babies'.
- 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 WHO/UNICEF/UNFPA/UNAIDS documents so that you are able to refer participants to these documents as needed for further information:
 - HIV and Infant Feeding Framework for Priority Action (2003)*
 - HIV and Infant Feeding: Guidelines for decision-makers (2003)*
 - HIV and Infant Feeding: A guide for health care managers and supervisors (2003)*
 - HIV transmission through breastfeeding - A review of available evidence (2004).*
- Familiarize yourself with national policies and strategies and guidelines on infant and young child feeding, if they exist. Check if they include issues related to HIV/AIDS.

I. Introduce the session**7 minutes**

- Show **Slide 17/1 - Overview of HIV and infant feeding** and read out the objectives:

Overview of HIV and infant feeding 17/1

After completing this session participants will be able to:

- explain the risk of mother-to-child transmission of HIV
- describe factors which influence mother-to-child transmission
- outline approaches that can prevent mother-to-child transmission through safer infant feeding practices
- state infant feeding recommendations for women who are HIV-positive and for women who are HIV-negative or do not know their status

- Make these points:
- A very sad aspect of the HIV/AIDS epidemic is the number of young children who are dying from the infection. Most of these children become infected through their mothers. Her sexual partner, who is often the child's father, usually infects a woman.
 - The best way to prevent infection of children is to help their fathers and mothers to avoid becoming infected in the first place. Men's responsibility for protecting their families must be emphasized.
 - However, many women are already infected, and it is important to try to reduce the risk to their babies. One way is for them to avoid breastfeeding but, as we have seen already, not breastfeeding carries many risks.
 - You as a health worker can help an HIV-positive woman to make the difficult decision about the best way to feed her baby in her particular circumstances.
 - First let us remind ourselves what the terms HIV and AIDS stand for.

Show **Slide 17/2 - Defining HIV and AIDS** and read out the definitions:

17/2

Defining HIV and AIDS

HIV

- Human immunodeficiency virus is the virus that causes AIDS

AIDS

- Acquired immunodeficiency syndrome is the active pathological condition that follows the earlier, non-symptomatic state of being HIV-positive

Make these points:

- People infected with HIV feel well at first and usually do not know they are infected. They may remain healthy for many years as the body produces antibodies to fight HIV.
- But the antibodies are not very effective. The virus lives inside the immune cells and slowly destroys them.
- When these cells are destroyed, the body becomes less able to fight infections. The person becomes ill and after a time develops AIDS. Eventually he or she dies.
- A special blood test can be done to see if people have HIV antibodies in their blood. A positive test means that the person is infected with HIV. This is called HIV-positive or seropositive.
- Once people have the virus in their body, they can give the virus to other people.
- HIV is passed from an infected man or woman to another person through:
 - exchange of HIV-infected body fluids such as semen, vaginal fluid or blood during unprotected sexual intercourse
 - HIV-infected blood transfusions or contaminated needles.
- HIV can also pass from an infected woman to her child during pregnancy, at the time of birth or through breastfeeding. This is called mother-to-child transmission or MTCT.

Show **Slide 17/3 - Mother-to-child transmission of HIV** and read it out:

Mother-to-Child Transmission of HIV

17/3

Young children who get HIV are usually infected through their mothers

- during pregnancy across the placenta
- at the time of labour and birth through blood and secretions
- through breastfeeding

This is called mother-to-child transmission of HIV or MTCT

II. Review the risk of mother-to-child transmission of HIV

15 minutes

Make these points:

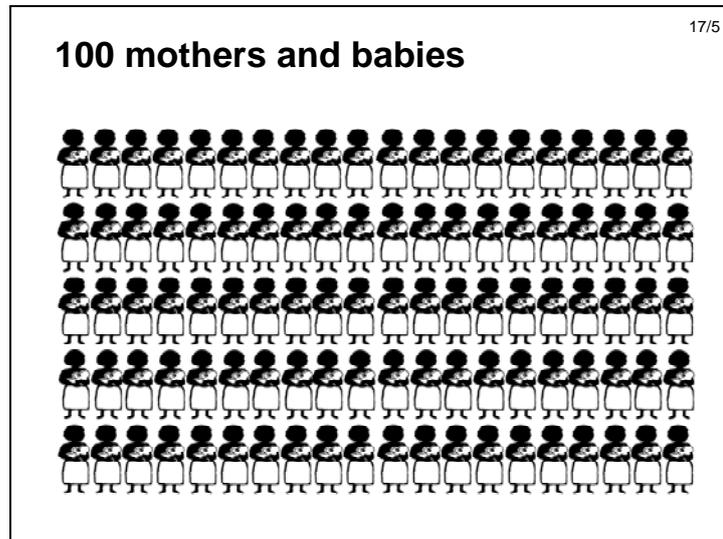
- Let us now consider how often mother-to-child transmission of HIV occurs and how many mothers and babies are likely to be affected.
- Not all babies born to HIV-infected mothers become infected with HIV.

- Show **Slide 17/4 - Estimated risk and timing of mother-to-child transmission of HIV in the absence of interventions** and read it out:

Timing of MTCT of HIV	Transmission Rate
• During pregnancy	5-10%
• During labour and delivery	10-15%
• During breastfeeding	5-20%
<hr/>	
• Overall without breastfeeding	15-25%
• Overall with breastfeeding to 6 months	20-35%
• Overall with breastfeeding to 18–24 months	30-45%

- About two-thirds of infants born to HIV-infected mothers will not be infected, even with no intervention, such as anti-retroviral prophylaxis or caesarean section.
- About 5-20% of infants born to HIV-infected mothers will get the virus through breastfeeding. The risk continues as long as the mother breastfeeds, and is more or less constant over time.
- Exclusive breastfeeding during the first few months of life carries a lower risk of HIV transmission than mixed feeding. Research has shown that the transmission risk at six months in exclusively breastfed babies is lower than in mixed fed babies.

Show **Slide 17/5 - 100 mothers and babies** and make the points that follow:



- This overhead shows 100 mothers and babies. For this example, let us assume that the prevalence of HIV infection among women is 20%

Ask: How many of these women are likely to be HIV-positive?

Wait for a few replies and then continue.

- 20% of 100 is 20. So 20 of these women are likely to be HIV-positive. The other 80 will probably be HIV-negative (*Point this out on the next slide*).

OPTIONAL: (for countries where the prevalence of HIV is low): Show a slide with 1000 mothers and babies. Use the Slide 17/5b provided.

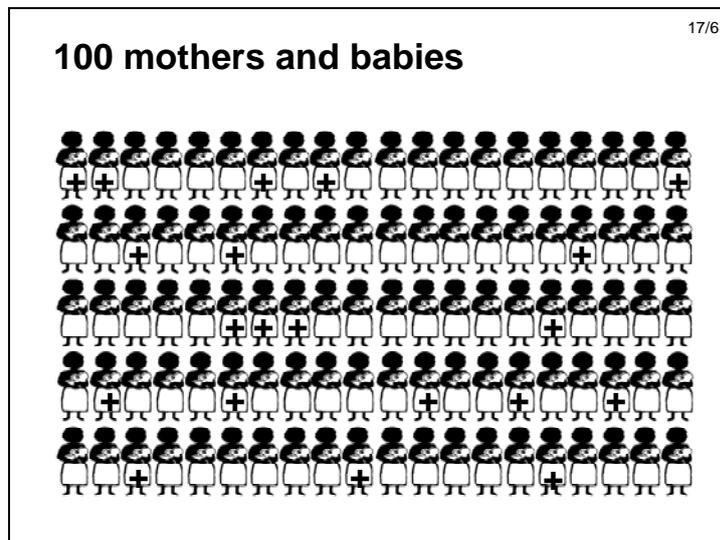
- This overhead shows 1000 mothers and babies. For this example, let us assume that the prevalence of HIV infection among women is 2%

Ask: How many of these women are likely to be HIV-positive?

Wait for a few replies and then continue.

- 2% of 1000 is 20. So 20 of these women are likely to be HIV-positive. The other 980 will probably be HIV-negative (*Point this out on the next slide. If you are using this option show the Slide 17/6b*).

□ Show **Slide 17/6 - 100 mothers and babies** and make the points that follow:



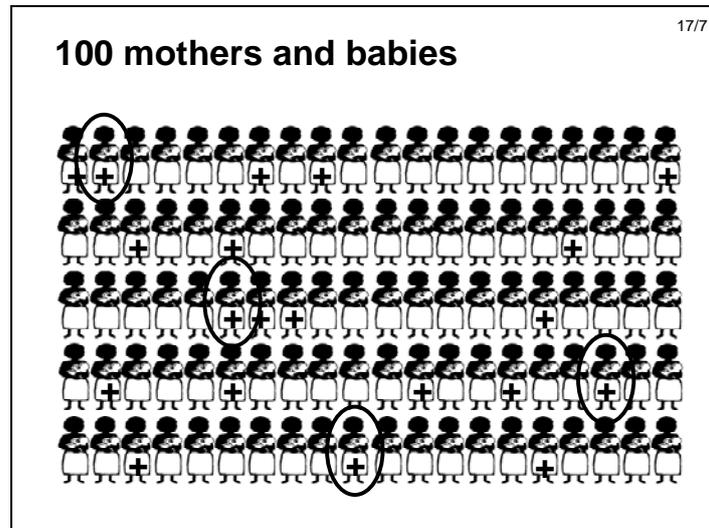
- The mother-to-child-transmission rate during pregnancy and delivery is about 15-25%. We will use 20% for this example.

Ask: So, how many of these infants were infected before or during delivery?

Wait for a few replies and then continue.

- 20% of 20 is 4. So about 4 of the infants of the HIV-positive mothers are likely to be infected during pregnancy or delivery (*Point this out on the next slide*).

☐ Show **Slide 17/7 - 100 mothers and babies** and make the points that follow:



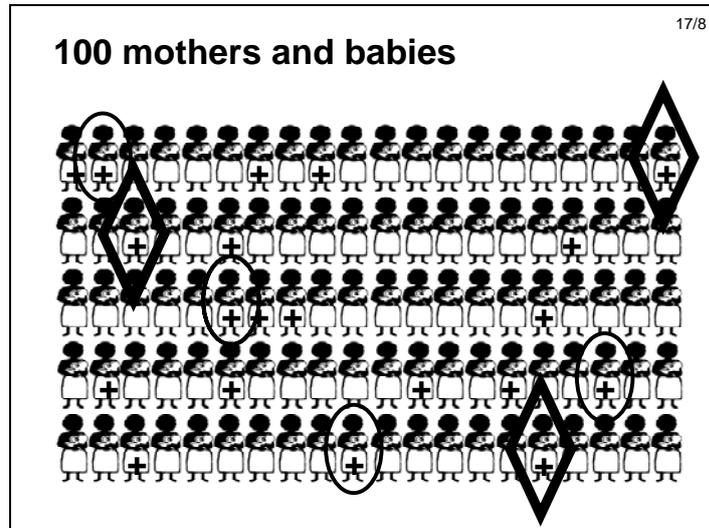
- Here we have a slide of 100 mothers. 20% of them are HIV-positive which is 20 mothers. 20% of their infants, 4 infants, are likely to be infected during pregnancy or delivery. *(If you are using the option "b" point this out that the slide has 1000 mothers, 2 % HIV-positive which is 20 mothers).*
- Now let us think about how many babies could be infected by breastfeeding.
- The transmission rate through breastfeeding is about 5-20% of the infants who are breastfed for varying lengths of time by mothers who are HIV-positive. Let us use 15% for this example.

Ask: So, assuming all these babies are breastfed for varying lengths of time, how many will be infected this way?

Wait for a few replies and then continue.

- 15% of 20 is 3. So about 3 of the infants of the HIV-positive mothers are likely to be infected by breastfeeding *(Point this out the next slide).*

Show **Slide 17/8 - 100 mothers and babies** and make the points that follow:

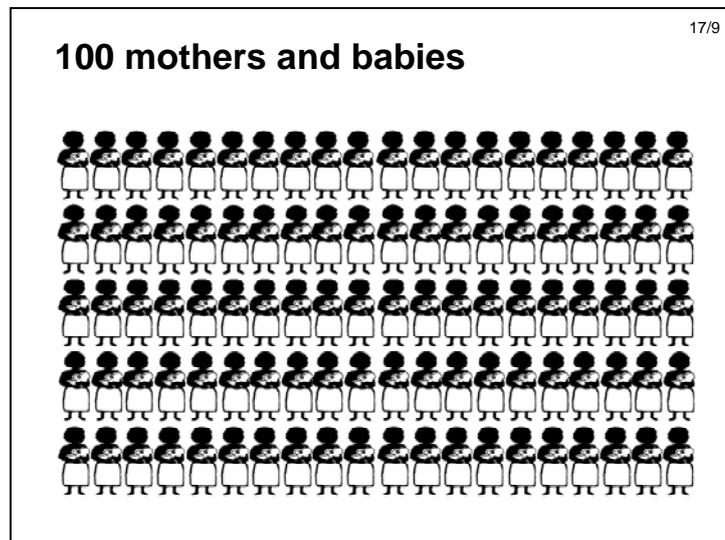


Make these points:

- In a group of 100 mothers in an area with a 20% prevalence of HIV infection among mothers, about 3 babies are likely to be infected with HIV through breastfeeding. If all HIV-positive mothers were breastfeeding exclusively, the number of infected infants would be less. *(If using alternative "b" point out that in a group of 1000 mothers in an area with a 2% prevalence of HIV infection among mothers)*
- This shows that even in areas with high HIV prevalence, most babies of HIV-infected mothers will not get the virus through breastfeeding. Of course, if the mother is not infected, she is not carrying the virus and her baby has no possibility of being infected in this way.

At this point trainers might like to use the local HIV prevalence figures for their area and calculate with the participants the number of babies who would be infected in their local situation.

Show **Slide 17/9 - 100 mothers and babies** and make the points that follow:

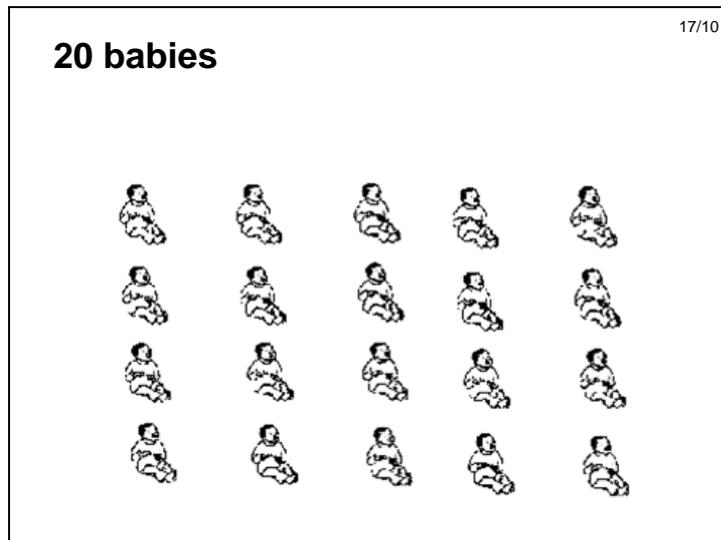


Ask: If pregnant women in a population are not tested, we cannot know which women are infected with HIV. In that case, can we predict which babies will be infected?

Wait for a few replies and then continue.

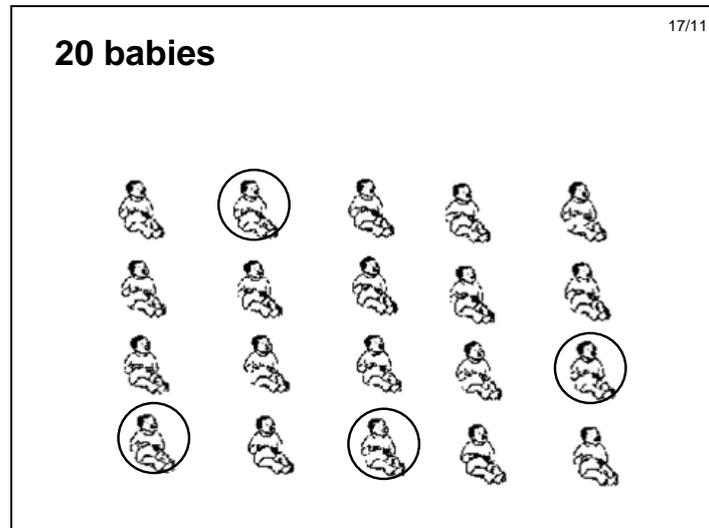
- We cannot predict which individual babies will be infected.
- If a mother does not know her HIV status, she should be encouraged to breastfeed.
- When you are explaining the risk of transmission to a mother it may be useful to use a card with 20 babies.

Show **Slide 17/10 - 20 babies** and make the points that follow:



- This slide shows only 20 babies.
- All the mothers have been tested and found to be HIV-positive. As we said earlier, the transmission rate during pregnancy and delivery (combined) to use in this example is 20%.
Ask: How many of these babies were probably infected during pregnancy or delivery?
Wait for a few replies and then continue.
- 20% of 20 is 4, so four infants (*Point this out on the next slide*).

☐ Show **Slide 17/11 - 20 babies** and make the points that follow:



- The transmission rate through breastfeeding is 5-20% depending on how long a mother breastfeeds. We will use 15% for this example.

Ask: How many will be infected through breastfeeding, if they all breastfeed for several months?

Wait for a few replies and then continue.

- 15% of 20 is 3, so 3 infants (*Point this out on the next slide*). If all HIV-positive mothers were breastfeeding exclusively, the number of infected infants would be less.

III. Explain factors which affect mother-to-child transmission 10 minutes

Make these points:

- We used the figures of 20% for transmission rates of HIV during pregnancy and delivery and 15% for the rate during breastfeeding for the purposes of the exercise. These sound very exact figures, but they are only averages from several research studies.
- Rates vary because of differences in population characteristics such as how ill the mothers are, how much virus is in their blood and how long breastfeeding lasts.
- Since several factors affect these rates, understanding them may help us to find ways to reduce transmission.

Ask: What are some factors that affect mother-to-child transmission of HIV?

Wait for a few replies and then continue.

Show **Slide 17/13 - Factors which affect mother-to-child transmission of HIV** and read it out:

17/13

Factors which affect mother-to-child transmission of HIV

- Recent infection with HIV
- Severity of disease
- Sexually transmitted infections
- Obstetric procedures
- Duration of breastfeeding
- Exclusive breastfeeding or mixed feeding
- Condition of the breasts
- Condition of the baby's mouth

Some of these factors affect transmission of HIV through breastfeeding. Sexually transmitted infections and obstetric procedures only affect transmission during pregnancy or delivery. We will discuss the ones related to breastfeeding.

- Ask participants to turn to page 100 of their Manual and find the section FACTORS WHICH AFFECT MTCT OF HIV THROUGH BREASTFEEDING.
- Ask participants to read out each point in turn.
 - **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 infant is more likely to be infected. It is especially important to prevent an HIV-negative woman from becoming infected at this time because then both the woman and her baby are at risk. All sexually active people need to know that unprotected extramarital sex exposes them to infection with HIV. They may then infect their partners, and their baby too will be at high risk, if the infection occurs during pregnancy or while breastfeeding.
 - **Severity of HIV infection**

If the mother is ill with HIV-related disease or AIDS and is not being treated with drugs for her own health, she has more virus in her body and transmission to the baby is more likely.
 - **Duration of breastfeeding**

The virus can be transmitted at any time during breastfeeding. In general, the longer the duration of breastfeeding the greater the risk of transmission.
 - **Exclusive breastfeeding or mixed feeding**

There is evidence that the risk of transmission is greater if an infant is given any other foods or drinks at the same time as breastfeeding. The risk is less if breastfeeding is exclusive. Other food or drinks may cause diarrhoea and damage the gut, which might make it easier for the virus to enter the baby's body.
 - **Condition of the breasts**

Nipple fissure (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 may also reduce transmission of HIV.
 - **Condition of the baby's mouth**

Mouth sores or thrush in the infant may make it easier for the virus to get into the baby through the damaged skin.
- Make these additional points:
 - This list of factors suggests several strategies that would be useful for all women, whether they are HIV-positive or HIV-negative. They provide ways to reduce the risk of HIV transmission, which can be adopted for everyone, and they do not depend on knowing women's HIV status.
 - Other strategies, such as the avoidance of breastfeeding, can be harmful for babies, so they should only be used if a woman knows that she is HIV-positive and has been counselled.

- ❑ Explain briefly about ARVs. Write the names of the antiretroviral drugs on the flipchart.
 - You will have heard of Antiretroviral drugs (ARVs). These are used to reduce the amount of HIV in the body. Some names that you may have heard of are AZT (*azidothymidine*) and ZDV (*zidovudine*), which are two names for the same drug, and *nevirapine*.
 - It has been shown that if a short course of ARVs are given at the end of pregnancy and at the time of delivery, the risk of transmission at that time can be reduced by about half. There are several short ARV regimens, which can be used in different ways.
 - Most countries have developed initiatives to provide one of these drug regimes to women who are HIV-positive and some are providing them for long-term treatment.
 - In some regimens, the baby is also given one or more of the ARVs for a short time.
 - We do not yet know how effective or safe ARVs are in preventing transmission through breastfeeding when given to either the baby or mother over a longer time period.

IV. Outline approaches to prevent mother-to-child transmission through breastfeeding **10 minutes**

- ❑ Make these points:
 - Reducing HIV transmission to pregnant women, mothers and their children, including transmission by breastfeeding, should be part of a comprehensive approach both to HIV prevention, care and support, and to antenatal, perinatal and postnatal care and support.
 - Policies should serve the best interests of the mother and infant as a pair, in view of the critical link between survival of the mother and that of the infant.
 - Prevention of HIV transmission during breastfeeding should be considered in a broad context that takes into account the need to promote breastfeeding of infants and young children in the general population.

Show **Slide 17/14 - Policy of supporting breastfeeding** and read it out:

17/14

Policy of supporting breastfeeding

“As a general principle, in all populations, irrespective of HIV infection rates, breastfeeding should continue to be protected, promoted and supported.”

HIV and Infant Feeding: a policy statement, developed collaboratively by UNAIDS, WHO and UNICEF, 1997.

- Women who are HIV-negative or of unknown HIV status should be encouraged and supported to breastfeed.
- We will now look at the situation where a woman has been tested and knows she is HIV-positive.

- Show **Slide 17/15 - Infant feeding recommendations for HIV-positive women** and ask one of the participants to read it out:

17/15

Infant feeding recommendations for HIV-positive women

- When replacement feeding is acceptable, feasible, affordable, sustainable and safe, avoidance of all breastfeeding by HIV-infected mothers is recommended
- Otherwise, exclusive breastfeeding is recommended during the first months of life

- Continue with these points:
- To minimize HIV transmission risk, breastfeeding should be discontinued as soon as feasible, taking into account local circumstances, the individual woman's situation and the risks of replacement feeding (including malnutrition and infections other than HIV).
 - When HIV-infected mothers choose not to breastfeed from birth or to stop breastfeeding early, they should be provided with specific guidance and support for at least the first two years of the child's life to ensure adequate replacement feeding.
 - Programmes should strive to improve conditions that will make replacement feeding safer for HIV-infected mothers and families.
 - All HIV-infected mothers should receive counselling, which includes provision of general information about the risks and benefits of various infant feeding options, and specific guidance in selecting the option most likely to be suitable for their situation.
 - Whatever a mother decides, she should be supported in her choice.
 - In the next session we will discuss counselling for infant feeding in relation to HIV.
 - *(If all the sessions in the course are included)*. During this course, we will discuss what is adequate and safe replacement feeding for the first two years of life, and how to provide infant feeding counselling to HIV-positive mothers taking into account their particular circumstances.
- If there is a national policy on Infant Feeding and HIV/AIDS available, summarize it briefly.

V. Summarize the session**3 minutes**

- Ask participants if they have any questions, and try to answer them.
- Make these points:
 - Not all infants born to HIV-infected women will be infected with HIV.
 - About 20% of babies born to HIV-positive women will become HIV-infected through breastfeeding. To reduce this risk, mothers may choose to avoid breastfeeding altogether, or to breastfeed exclusively for six months.
 - However, not breastfeeding has many disadvantages, including risks to the infant's health. Women need access to infant feeding counselling to help them to decide the best way to feed their child in their situation.
 - Mixed feeding should be avoided because it brings both the risks of HIV infection and the risk of diarrhoea and other infectious diseases.
 - Breastfeeding should continue to be protected, promoted and supported in all populations.
- Explain that a summary of this session can be found on pages 95-102 of the *Participant's Manual*.

Further information*New evidence on HIV transmission through breastfeeding:*

Exclusive breastfeeding for up to six months was associated with a three to four fold decreased risk of transmission of HIV compared to non-exclusive breastfeeding in three large cohort studies conducted in Côte d'Ivoire, South Africa and Zimbabwe.

Low maternal CD4+ count, high viral load in breast milk and plasma, maternal seroconversion during breastfeeding and breastfeeding duration were confirmed as important risk factors for postnatal HIV transmission and child mortality.

There are indications that maternal HAART for treatment-eligible women may reduce postnatal HIV transmission, based on programmatic data from Botswana, Mozambique and Uganda; follow-up trial data on the safety and efficacy of this approach, and on infant prophylaxis trials, are awaited.

New evidence on morbidity and mortality

In settings where antiretroviral prophylaxis and free infant formula were provided, the combined risk of infection and death by 18 months of age was similar in infants who were replacement fed from birth and infants breastfed for 3 to 6 months (Botswana and Côte d'Ivoire).

Early cessation of breastfeeding (before 6 months) was associated with an increased risk of infant morbidity (especially diarrhoea) and mortality in HIV-exposed children in completed (Malawi) and ongoing studies (Kenya, Uganda and Zambia).

Early breastfeeding cessation at 4 months was associated with reduced HIV transmission but also with increased child mortality from 4 to 24 months in preliminary data presented from a randomized trial in Zambia.

Breastfeeding of HIV-infected infants beyond 6 months was associated with improved survival compared to stopping breastfeeding in preliminary data presented from Botswana and Zambia.

Session 18

Counselling for Infant Feeding Decisions

Objectives

After completing this session participants will be able to:

- describe the elements to be considered for counselling on infant feeding in relation to HIV
- list the different feeding options available to HIV-positive mothers

Session outline

30 minutes

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

- | | | |
|------|--|------------|
| I. | Introduce the session | 5 minutes |
| II. | Describe counselling for infant feeding in relation to HIV | 5 minutes |
| III. | Outline counselling for infant feeding decisions | 15 minutes |
| IV. | Summarize the session | 5 minutes |

Preparation

- Refer to the Introduction for guidance on giving a presentation with slides.
- Make sure that Slides 18/1 – 18/4 are in the correct order. Study the slides 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.

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

I. Introduce the session**5 minutes**

- Show **Slide 18/1 - Session 18 Objectives** and read out the objectives:

18/1

Counselling for infant feeding decisions

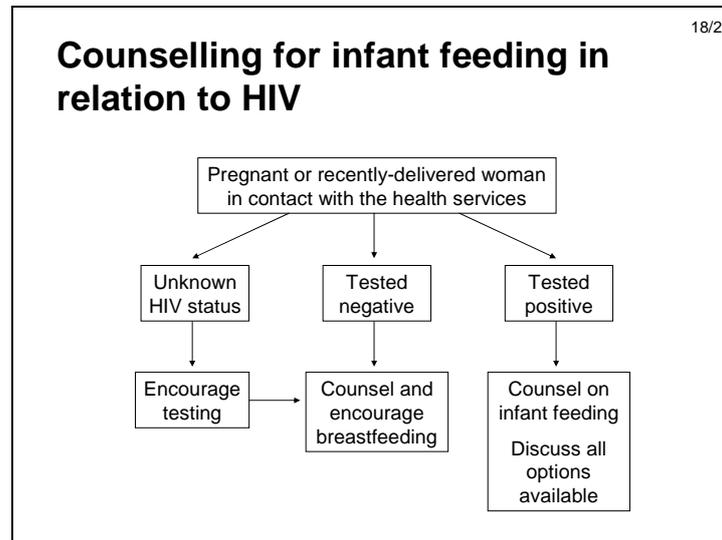
After completing this session participants will be able to:

- describe the elements to be considered for counselling on infant feeding in relation to HIV
- list the different feeding options available to HIV-positive mothers

- As infant feeding counsellors, you will not be expected to give general counselling for HIV unless you have special training to do this. If you have not been trained, you need to know where to refer women for this service.

II. Describe counselling for infant feeding in relation to HIV 5 minutes

- ☐ Show **Slide 18/2 - Counselling for infant feeding in relation to HIV** and point out the options as they come up in the text:



- ☐ Make these points:

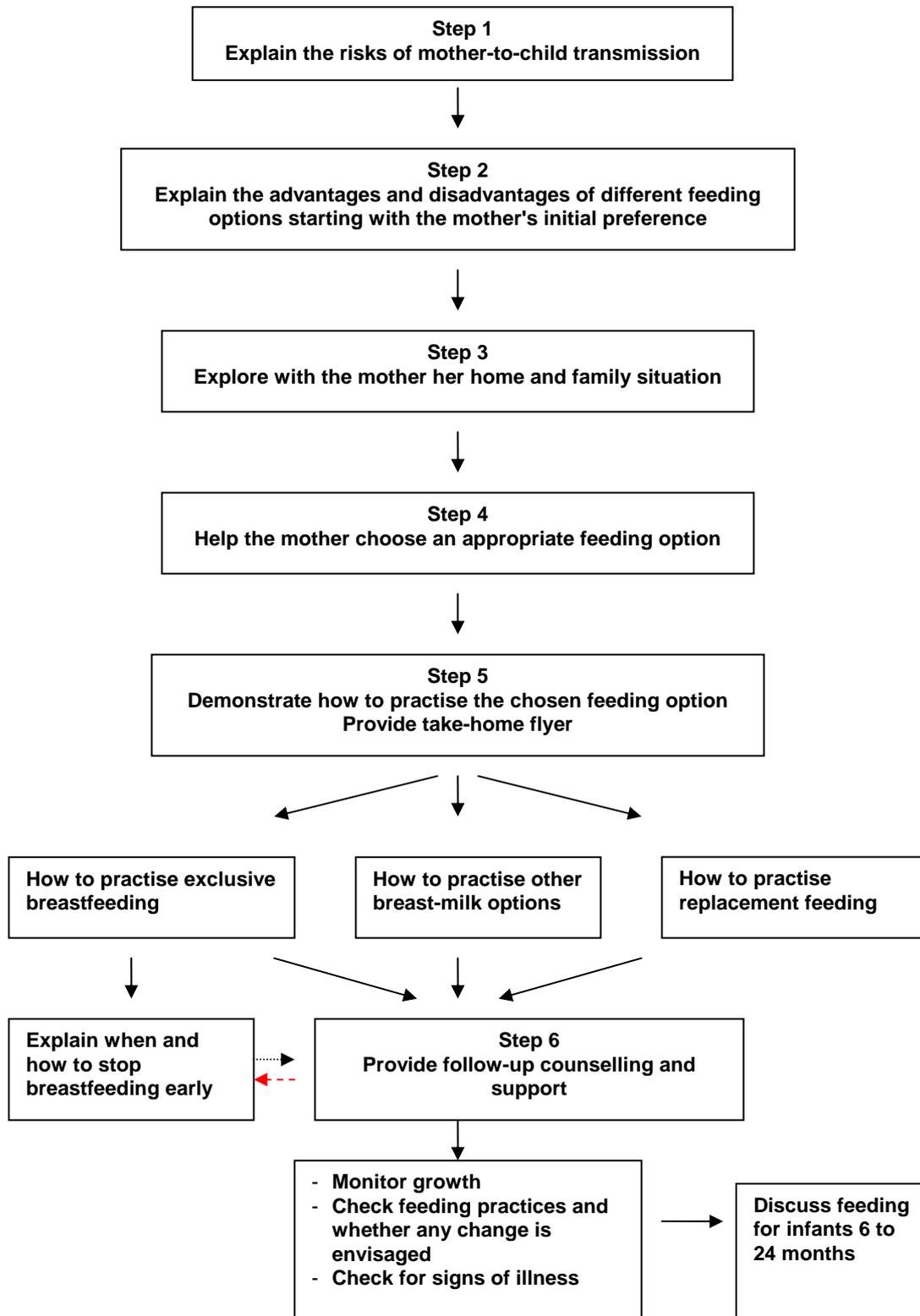
- You may be giving infant feeding counselling to women who may or may not know their HIV-status.
- HIV testing may not be available everywhere. A woman may be aware that HIV can pass to her baby, and worry about this, in particular about the possibility of transmission through breastfeeding.
- For women who have not been tested or do not know their results:
 - Talk to them of the advantages of HIV testing for them and their families.
 - Refer them to a convenient HIV testing and counselling centre if they would like a test.
 - In the absence of a test result, provide counselling about their concerns and encourage them to feed their babies as if they were HIV-negative, that is to breastfeed exclusively for six months and to continue breastfeeding with adequate complementary feeding up to two years or beyond.
 - If a woman does not know her HIV status, it is usually safer for her baby if she breastfeeds. Babies who do not breastfeed are at greater risk of illness.
 - When you counsel a woman who does not know her HIV status about infant feeding, she may need reassurance that breastfeeding is the safest option for her baby.

- . Women who give birth at home may be offered testing and counselling when they are in contact with the health service. Traditional birth attendants, community health workers or infant feeding counsellors can provide women with information and encourage them to think about testing.
- . A woman may believe that she is HIV-positive despite a negative test. She needs counselling to discuss her worries and generally should be encouraged to breastfeed.
- For women who have been tested and are HIV-negative:
 - . Talk to them of the risks of becoming infected during pregnancy or while breastfeeding.
 - . Suggest that they have a repeat test if they think they have been exposed to HIV since the last test.
 - . Suggest that they feed their babies as per the general population recommendation.
- For women who have been tested and are HIV-positive:
 - . You will need to discuss with the woman her possible infant feeding options from birth to six months.
 - . You will need to counsel her again as the child approaches six months of age, to discuss feeding options from 6 months onwards.
- We will discuss more about feeding babies older than six months in later sessions.

III. Outline counselling for infant feeding decisions 15 minutes

- Most HIV-positive women are not ready to discuss infant feeding options at their first post-test counselling session. They will need to be referred specifically for that later. The infant feeding counsellor may be a different person from the person who gives general counselling.
 - In order to help the woman without telling her what to do, you will need to follow a systematic process for providing information and support.
 - We will look at the basic steps that should be followed. In further sessions you will learn the relevant information required and how to apply your counselling skills during the process.
- Ask participants to turn to page 105 of their Manual and find the COUNSELLING FLOW CHART. Ask participants to take it in turns to read out the steps.

COUNSELLING FLOW CHART FOR HIV-POSITIVE WOMEN



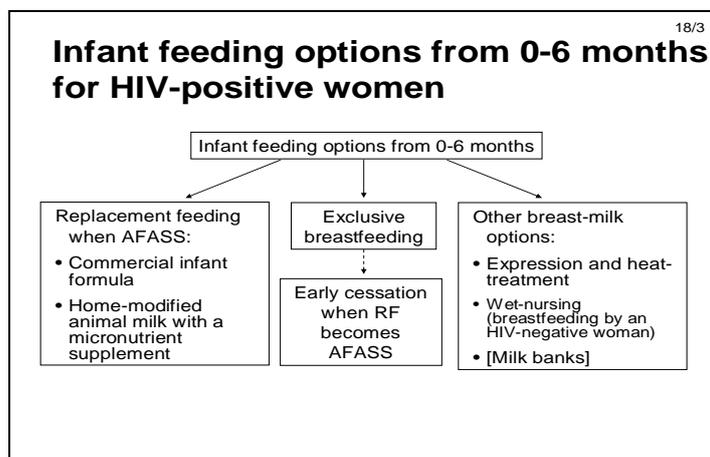
Ask: At what point could or does infant feeding counselling take place?

Wait for a few replies and then continue.

Encourage participants to think about times when women may want to talk about infant feeding.

- Infant feeding counselling for HIV-positive women may be needed:
 - before a woman is pregnant
 - during her pregnancy
 - soon after her baby is born
 - soon after receiving the results of her baby's HIV test
 - when her baby is older
 - when a woman fosters a baby whose mother is very sick or has died.
- As her baby gets older, or if her situation changes, an HIV-positive mother may need on-going infant feeding counselling. She may want to change her method of feeding and to discuss this with the infant feeding counsellor.
- Each woman's situation is different, so health workers need to be able to discuss all the various feeding options.

- Show **Slide 18/3 - Infant feeding options** and point out the options as they are discussed in the text:



- Make the following points:
- Various infant feeding options should be discussed with women who are HIV-positive. Local guidelines may indicate that not all these options should be discussed. These choices include:
 - Replacement feeding when acceptable, feasible, affordable, sustainable and safe (*Point to replacement feeding on slide*):
 - Commercial infant formula
 - Home-modified animal milk with a micronutrient supplement

- Exclusive breastfeeding for the first months followed by early (not abrupt) cessation once replacement feeding is acceptable, feasible, affordable, sustainable and safe (*Point to exclusive breastfeeding on slide*).
 - Other breast-milk options (*Point to other breast-milk options on the slide*):
 - Expression and heat-treatment of her own breast milk
 - Wet-nursing (breastfeeding from an HIV-negative woman)
 - Using breast milk from a milk bank
- Ask participants to turn to page 107 of their Manual and find the box DEFINITIONS OF ACCEPTABLE, FEASIBLE, AFFORDABLE, SUSTAINABLE AND SAFE. Ask participants to read out each definition in turn.

DEFINITIONS OF ACCEPTABLE, FEASIBLE, AFFORDABLE, SUSTAINABLE AND SAFE

Acceptable:

The mother perceives no barrier to replacement feeding. Barriers may have cultural or social reasons, or be due to fear of stigma or discrimination.

Feasible:

The mother (or family) has adequate time, knowledge, skills and other resources to prepare the replacement food and feed the infant up to 12 times in 24 hours.

Affordable:

The mother and family, with community or health-system support if necessary, can pay for the cost of purchasing/producing, preparing and using replacement feeding, including all ingredients, fuel, clean water, soap and equipment, without compromising the health and nutrition of the family.

Sustainable:

Availability of a continuous and uninterrupted supply, and dependable system of distribution for all ingredients and products needed for safe replacement feeding, for as long as the infant needs it, up to one year of age or longer.

Safe:

Replacement foods are correctly and hygienically prepared and stored and fed in nutritionally adequate quantities with clean hands and using clean utensils, preferably by cup.

- Show **Slide 18/4 - Replacement feeding** and remind participants of the definition:

18/4

Replacement feeding

is the process of feeding a child who is not breastfeeding with a diet that provides all the nutrients the child needs until the child is fully fed on family food

- Remember all children require adequate complementary foods from six months of age.
- In the following sessions, we will discuss these infant feeding options in more detail.

IV. Summarize the session

5 minutes

- Ask participants if they have any questions, and try to answer them.
- Make these points:
 - All women who are HIV-positive need infant feeding counselling to discuss infant feeding options, and to decide what is best for them in their situation.
 - Women who are HIV-negative or of unknown HIV status need counselling about their concerns and encouragement to breastfeed exclusively for six months. Thereafter, they should continue breastfeeding with adequate complementary feeding up to two years or beyond.
- Explain that a summary of this Session can be found on pages 103-108 of the *Participant's Manual*.

Session 19

Breastfeeding and Breast-milk Feeding Options for HIV-infected Mothers

Objectives

After completing this session participants will be able to:

- explain the advantages and disadvantages of breastfeeding and breast-milk feeding options for HIV-infected women
- explain the method of early cessation (stopping breastfeeding early)
- discuss wet-nursing and finding a wet-nurse
- demonstrate how to heat-treat expressed breast milk

Session outline

45 minutes

Participants are all together for a lecture presentation by one trainer

I.	Introduce the session	5 minutes
II.	Review the advantages and disadvantages of breastfeeding	10 minutes
III.	Explain about stopping breastfeeding early	10 minutes
IV.	Discuss breastfeeding by another woman who is HIV-negative	10 minutes
V.	Describe how to heat-treat expressed breast milk	5 minutes
	Summarize the session	5 minutes

Preparation

- Refer to the Introduction for general guidance on giving a lecture presentation.
- Make sure that Slide 19/1 is ready. Alternatively, as there is only one slide in this session, you might prefer to read aloud the objectives on Slide 19/1 without projecting them onto the screen.
- Review the HIV and Infant Feeding Counselling Cards, in particular the following:
 - Card 3 (Advantages and disadvantages of exclusive breastfeeding)
 - Card 4 (Advantages and disadvantages of expressing and heat-treating breast milk)
 - Card 5 (Advantages and disadvantages of wet-nursing)
 - Card 14 (How to heat-treat and store breast milk)
 - Card 15 (Wet-nursing [breastfeeding by another woman])
 - Card 17 (How to stop breastfeeding early).
- Find out where any local breast milk banks are located and their policies.

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 19/1 - Breast-milk options for HIV-infected mothers** and read out the objectives:

Breast-milk options for HIV-infected mothers

19/1

After completing this session participants will be able to:

- explain the advantages and disadvantages of breastfeeding and breast-milk options for HIV-positive women
- explain the method of early cessation
- discuss wet-nursing and finding a wet-nurse
- demonstrate how to heat-treat expressed milk

- Make these points:
 - All health workers who care for mothers and infants need to know how breastfeeding works, and how to help mothers to breastfeed. They need this competence to help both HIV-negative and HIV-positive mothers.
 - We mentioned in Session 18 several breast-milk options that HIV-positive mothers may choose. These include:
 - exclusive breastfeeding for the first few months followed by early cessation
 - expressing and heat-treating her breast milk
 - wet-nursing (breastfeeding by another woman, who is HIV-negative).
 - In this session we will discuss how to help a woman to use any of these options, and to do it as safely as possible.

- ☐ Milk banks are also mentioned as another option. However, experience with milk banks is currently limited so we will not discuss this here. If there are functioning accessible milk banks in your area, you should provide information on their policies to participants.

II. Review the advantages and disadvantages of breastfeeding for an HIV-infected mother

10 minutes

- Remember that we looked at advantages of breastfeeding in the general population in Session 2.
 - A mother who is HIV-positive needs to understand the advantages and disadvantages of breastfeeding before deciding whether this is the best option in her specific situation.
- ☐ Ask participants to turn to page 110 of their Manuals and find the box **ADVANTAGES AND DISADVANTAGES OF EXCLUSIVE BREASTFEEDING FOR AN HIV-INFECTED MOTHER**. Ask participants to take turns to read out the points.

ADVANTAGES AND DISADVANTAGES OF EXCLUSIVE BREASTFEEDING FOR AN HIV-INFECTED MOTHER

Advantages:

- Breast milk is the perfect food for babies and protects them from many diseases, especially diarrhoea and pneumonia, and the risk of dying from these diseases.
- Breast milk gives babies all of the nutrition and water they need. Breastfed babies do not need any other liquid or food.
- Breast milk is free, always available, and does not need any special preparation.
- Exclusive breastfeeding for the first six months lowers the risk of passing HIV, compared to mixed feeding.
- Many women breastfeed, so people will not ask why mothers are breastfeeding.
- Exclusive breastfeeding helps mothers recover from childbirth and protects them from getting pregnant again too soon.

Disadvantages:

- As long as the mother breastfeeds, her baby is exposed to HIV.
- People may pressurize her to give water, other liquids, or foods to the baby while she is breastfeeding. This practice, known as mixed feeding, may increase the risk of diarrhoea and other infections, and increases the risk of HIV transmission.
- The mother will need support to exclusively breastfeed until it is possible for her to use another feeding option.
- It may be difficult to do if the mother works outside the home and cannot take the baby with her.
- It may be difficult to do if the mother gets very sick.

- Point out to participants that Counselling Card 3 talks about the advantages and disadvantages of exclusive breastfeeding. Ask participants to look, briefly, at this card so that they can see it contains the same points that they have just read.
- Continue with these points:
 - If a woman does breastfeed, it is important for her to breastfeed exclusively. This gives protection for the infant against common childhood infections and also reduces the risk of HIV transmission.
 - Counselling on infant feeding may need to take into account her disease progression. Recent evidence suggests a very high rate of postnatal transmission in women with advanced disease.
 - An HIV-positive mother who chooses to breastfeed needs to use a good technique to prevent nipple fissure and mastitis, both of which may increase the risk of HIV transmission. Management of these breast conditions will be covered in the next session.

III. Explain about early cessation of breastfeeding 10 minutes

Make these points:

- We know that HIV can be transmitted at any time during breastfeeding. Early cessation reduces the risk of transmission by reducing the length of time the infant is exposed to the virus in breast milk. However, stopping breastfeeding also increases the risk of other illnesses and death.
- The most appropriate time to stop breastfeeding depends on the mother's particular situation, and may be any time between 0 - 6 months. The most appropriate time is as soon as replacement feeding becomes acceptable, feasible, affordable, sustainable and safe for her and her baby.
- The period of time during which a mother stops breastfeeding and changes to replacement milk is known as the transition period.
- Preliminary experience indicates that mothers can stop breastfeeding in a period of 2-3 days to 2-3 weeks with counselling and support.
- Some mothers may not be able to provide replacement feeding for an infant even from six months onwards. Among other factors, suitable replacement foods may not be available.
- In that case, mothers should consider other breast-milk options such as expressing and heat-treating breast milk from six months onwards.
- For some infants, the risk of malnutrition and other morbidity may still be greater if they do not receive breast milk than the risk of HIV transmission through continued breastfeeding, even after six months.
- When a mother has decided to breastfeed and stop early, she needs guidance about early cessation and replacement feeding, and support for her decision.
- It is important to help the mother to plan in advance how she will carry out early cessation and safe transition.

Ask: What suggestions would you discuss with a mother who has decided to stop breastfeeding early?

Wait for a few replies and then continue. Try to encourage participants to think of suggestions from each of the following categories: choice and preparation of replacement milk; cup-feeding; mother's health (family planning and breast health); ways to comfort the baby.

Ask participants to turn to page 112 of their Manuals and find the box HOW TO STOP BREASTFEEDING EARLY. Ask participants to take turns to read out the points.

HOW TO STOP BREASTFEEDING EARLY

- While a mother is breastfeeding, teach her baby to drink expressed, unheated, breast milk from a cup (see Cards 10 and 13).
- This milk may be heat-treated to destroy the HIV (see Card 14).
- Once the baby is drinking comfortably, replace one breastfeed with one cup-feed using expressed breast milk.
- Increase the frequency of cup-feeding every few days and reduce the frequency of breastfeeding. Ask an adult family member to help cup-feed the baby.
- Stop putting her baby to the breast completely as soon as she and her baby are accustomed to frequent cup-feeding. From this point on, it is best to heat-treat her breast milk.
- If her baby is only receiving milk, check that he is passing enough urine - at least six wet nappies in every 24-hour period. This means that he is getting enough milk.
- Gradually replace the expressed heat-treated breast milk with formula or home-modified animal milk.
- If her baby needs to suck, give a clean finger instead of the breast.
- To avoid breast engorgement (swelling) express a little milk whenever her breasts feel too full. This will help her to feel more comfortable. Use cold compresses to reduce the inflammation. Wear a firm bra to prevent breast discomfort.
- Do not begin breastfeeding again once she has stopped. If she does, she can increase the chances of passing HIV to her baby. If her breasts become engorged, express the milk by hand and discard it.
- Begin using the family planning method of her choice, if she has not already done so, as soon as she start reducing breastfeeds.

- You may have noticed that there is much information to provide. You may want to use the relevant take-home flyers to explain to the mother while showing her what to do. We will use the take-home flyers in Session 27. Card 17 talks about how to stop breastfeeding early. Remember to use your counselling skills when talking to women. Try to use suggestions rather than commands.

Ask: What has to be done to stop the production of milk?

Wait for a few replies and then continue.

- A woman's milk dries up naturally if her baby stops suckling, but this takes a week or more. She needs to express just enough milk to keep her breasts comfortable and healthy while this happens.
- If she wishes she can heat-treat the expressed milk and feed it to her baby by cup, as well as giving other milk. This may help to accustom her baby to the change.

IV. Discuss breastfeeding by another woman who is HIV-negative 10 minutes

Make these points:

- Asking another woman who is HIV-negative to breastfeed the baby may be an option. When a woman breastfeeds a baby to whom she did not give birth, it is called *wet-nursing*.

- If a woman expresses her milk for another baby, it is called *donor breast milk*.

Ask: Is breastfeeding another woman's baby accepted in your area?

Wait for a few replies and then continue.

Discuss for a minute or two the cultural acceptability of using milk from another mother.

- A woman who is breastfeeding another infant 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 an infant.

Ask: How can a baby's own mother keep her bond with a baby who is breastfed by another woman?

Wait for a few replies and then continue.

- The baby's own mother, if she is able, can provide as much of the other care of the baby as possible - cuddling, changing, washing, massaging, and later giving other foods. This contact helps to build the bond between mother and baby.

Ask: What should an HIV-positive woman consider when arranging for another woman to breastfeed her baby?

Wait for a few replies and then continue.

Ask participants to turn to page 113 of their Manuals and find the box WET-NURSING (BREASTFEEDING BY ANOTHER WOMAN). Ask participants to take turns to read out the points.

WET-NURSING (BREASTFEEDING BY ANOTHER WOMAN)

- To protect a baby from HIV, the wet-nurse must be HIV-negative. The only way for her to know for sure that she is negative is to be tested at least three months after the last time she had unprotected sex or any other possible exposure to HIV.
- The wet-nurse will need to protect herself from HIV infection the entire time that she is breastfeeding.
- This means:
 - not having sex, or
 - using a condom every time she has sex, or
 - having sex with only one partner who has tested negative for HIV and who is being faithful to her, and
 - not sharing any razors, needles or other piercing objects.
- The wet-nurse should be available to feed the baby on demand, both day and night.
- The wet-nurse 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 he can pass the virus to the wet-nurse through breastfeeding. The wet-nurse needs to know about this small risk and avoid breastfeeding while the baby has oral thrush or she has cracked nipples.

- Sometimes a woman may breastfeed a close relative's baby occasionally, or even regularly. For example, an aunt, who has a child of her own, may care for a baby while his mother is out. His mother may be delayed in returning home and the aunt breastfeeds the baby. This is not recommended in areas where HIV is prevalent.

- Ask participants to look at Counselling Cards 5 and 15 which talk about wet-nursing.

V. Describe how to heat-treat expressed breast milk 5 minutes

- Make these points
 - Expressing and heat-treating breast milk is another option to consider:
 - if a mother wishes to give her baby her own milk - either in the first few months or later on
 - if alternative milks are too expensive or difficult to obtain
 - for sick or low-birth-weight infants who are more at risk from artificial feeding and may otherwise require special types of formula.

- According to available research, heat-treatment destroys HIV in breast milk making it safe to feed to the woman's own baby.
- Heat-treatment reduces the level of some anti-infective components of breast milk. However heat-treated breast milk remains superior to breast-milk substitutes.

Ask: What does a mother need to heat-treat her breast milk?

Wait for a few replies and then continue.

- Ask participants to turn to page 114 of their Manual and find the box HOW TO HEAT-TREAT BREAST MILK. Ask Participants to take turns to read out the points.

HOW TO HEAT-TREAT AND STORE BREAST MILK

- **Before heating milk, gather the following:**
 - . clean containers with wide necks and covers, enough to store the milk
 - . a small pot to heat the milk
 - . a large container of cool water
 - . a small cup for feeding the baby
 - . fuel to heat the milk
 - . soap and clean water to wash the equipment.
- **Follow these steps:**
 - . Wash all the pots, cups and containers with soap and water.
 - . Only heat enough expressed milk for one feed.
 - . Heat the milk to boiling point in a small pot and then place the pot in a container of cool water so that it cools quickly. If that is not possible, let the milk stand until it cools.
 - . Store the boiled milk in a clean, covered container in a cool place and use it within one hour.
 - . A mother can store unheated breast milk for about 8 hours at room temperature or up to 24 hours in a refrigerator.

- Make these additional points:

- If she is in hospital where there is a pasteurizer that can control the temperature, the milk can be heated to 62.5°C for 30 minutes.
- A mother may be able to follow her infant's sleeping pattern and prepare feeds ready for when she expects the infant to wake. If necessary, to avoid leaving the milk too long, or wasting it, she may sometimes have to wake her infant for a feed.
- To avoid having to use more fuel than necessary it may be possible to heat-treat the milk while cooking the family's meals.

- Ask participants to look at Counselling Card 14 which talks about heat-treating and storing breast milk.

VI. Summarize the session

5 minutes

- Ask participants if they have any questions, and try to answer them.
- Make these points:
 - In this session, we discussed how a mother who is HIV-positive may decide that breastfeeding is her best option and that she should be supported to establish and maintain it.
 - If she breastfeeds, she should make sure that her infant is well attached to the breast, to prevent nipple fissure and mastitis, which may increase the risk of transmission of HIV.
 - She should breastfeed exclusively, giving no other foods or fluids including water. This will minimize the risk of diarrhoea and other infections. Also, the risk of HIV transmission is less with exclusive breastfeeding than with mixed feeding.
 - Other breast-milk options include exclusive breastfeeding and stopping early, wet-nursing, expression and heat-treatment of breast milk.
- Explain that a summary of this session can be found on pages 109-114 of the *Participant's Manual*.

Further Information

Cessation of breastfeeding by an HIV-positive mother:

Stopping breastfeeding quickly can lead to engorgement and mastitis and if the breasts are not relieved, to an abscess.

Breast milk production is controlled by hormones and also locally within the breast itself. There is a substance in breast milk that can reduce or inhibit milk production. If a lot of milk is left in the breast, this inhibitor stops the cells from secreting any more. This helps protect the breast from the harmful effects of being too full.

Expressing a small amount of milk helps keep the mother comfortable without increasing the production of milk. The mother should express enough milk to keep comfortable. This will be less than the baby takes, so production will decrease, and eventually stop. The management of engorgement or other breast conditions will be covered in a later session.

Breast milk banks:

Some hospitals may have breast milk banks for sick or low-birth-weight infants where the milk is pasteurized. Using donor banked milk is usually a short-term option and another way of feeding will probably need to be discussed with the mother later.

Heat-treatment of breast milk:

Breast milk should not be heat-treated unless necessary. Breast milk from an HIV-negative or untested mother does not need to be heat-treated if the milk is for her own baby. Heating reduces the immune components and enzymes in the milk.

Infants fed on heat-treated breast milk do not need extra micronutrients. Do not heat-treat milk just 'in case' the mother is HIV-positive.

Glass, stainless steel, tin or ceramic containers with a lid or cover are recommended for storing the milk. Containers made of copper or brass should be avoided for milk storage. Plastic containers can be easily scratched when cleaning, which increases the risk of contamination. Some plastics cannot be cleaned in very hot water. If used, they should be replaced frequently.

Session 20

Breast Conditions

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 lecture presentation by one trainer.

- | | | |
|------|---------------------------|------------|
| I. | Introduce the session | 3 minutes |
| II. | Present Slides 20/1-20/12 | 40 minutes |
| III. | Summarize the session | 2 minutes |

Preparation

- Refer to the Introduction for guidance on giving a presentation with slides.
- Make sure that Slides 20/1-20/12 are in the correct order. Study the slides 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' section. Make sure that you have read this as it may help you to answer participants' questions.
- For DEMONSTRATION 20.A: Syringe method for treatment of inverted nipples, prepare a 20 ml disposable syringe as shown in Fig.20.1.

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 20/1 - Breast conditions** and read out the objectives:

20/1

Breast conditions

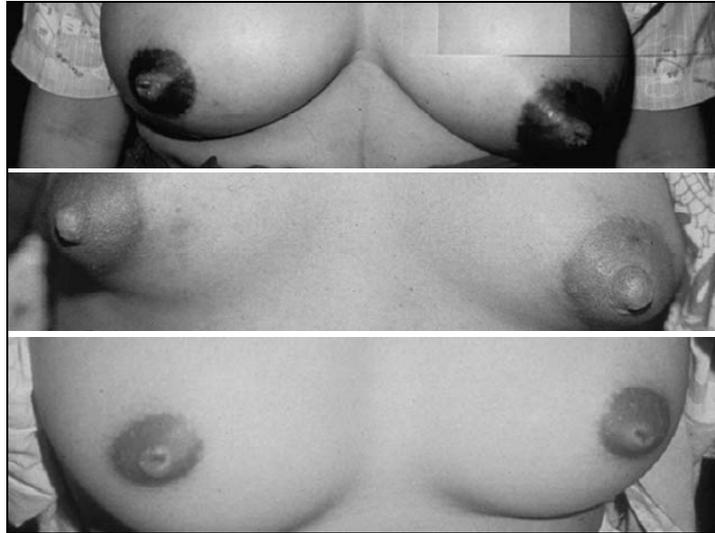
After completing this session participants will be able to recognize and manage these common breast conditions:

- flat and inverted nipples
- engorgement
- blocked duct and mastitis
- sore nipples and nipple fissure

- 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 HIV-infected. We will discuss these during the session.

II. Present Slides 20/2 to 20/12**40 minutes**

- Show **Slide 20/2 - 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 3 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 20/3 - 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 3 that a baby does not suck from the nipple. He takes the nipple and the breast tissue underlying the areola into his 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 his mouth. He 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 20/4 - 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 20/5 - Management of flat nipples** and make the points that follow:

20/5

Management of flat and inverted nipples

- Antenatal treatment is not helpful
- Build the mother's confidence
- Help the mother to position her baby
- If a baby cannot suckle effectively in the first week or two help his mother to feed with expressed milk

- Antenatal treatment is probably not helpful, for example stretching nipples. 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 (we will be discussing this further in Session 25).
- If a baby does not attach well by himself, help his mother to position him so that he 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 him to attach, for example the underarm position.
- If a baby cannot suckle effectively in the first week or two, help his 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. Expressing milk 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 117 of their Manuals 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 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, he will stretch her nipple out.

Encourage her to give plenty of skin-to-skin contact, and to let her baby explore her breasts. We will be discussing skin-to-skin contact in Session 25.

Let him try to attach to the breast on his own, whenever he is interested.

Some babies learn best by themselves.

■ Help the mother to position her baby

If a baby does not attach well by himself, help his mother to position him so that he 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 him 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 his mother to try the following:

- . 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 he is less frustrated. He may be more willing to try to suckle.

She should continue to give him skin-to-skin contact, and let him try to attach to her breast on his own.

- Demonstrate the syringe method for treating inverted nipples.

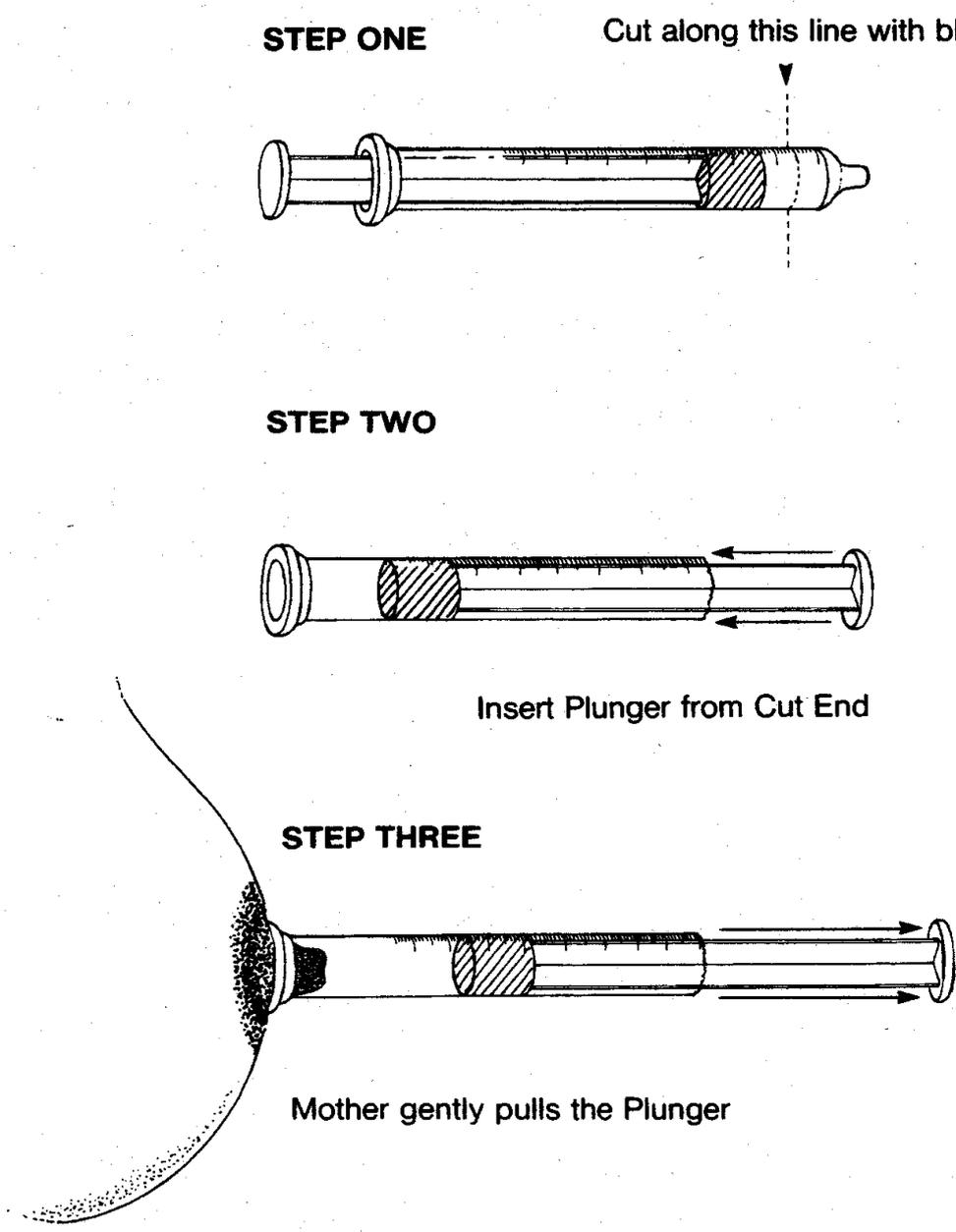
DEMONSTRATION 20.A SYRINGE METHOD FOR TREATMENT OF INVERTED NIPPLES

See Fig.20.2

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. 20.2. Preparing and using a syringe for treatment of inverted nipples.



Show **Slide 20/6 - 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.
- 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 119 of their Manuals 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
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 can be prevented by letting babies 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 120 of their Manuals 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 breast milk production decreases.
- If baby is able to suckle he should feed frequently. This is the best way to remove milk. Help the mother to position her baby, so that he attaches well. Then he suckles effectively, and does not damage the nipple.
- If baby is not able to suckle help his 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 AN HIV-INFECTED WOMAN 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 an HIV-infected woman who stops breastfeeding abruptly, for example, when her baby is six months old and due to start complementary feeds.
- When an HIV-positive mother 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 whilst the mother's milk supply is decreasing. If ibuprofen is not available then paracetamol may be used.

Show **Slide 20/7 - Mastitis** and make the points that follow:



Ask: What do you notice about this breast?

Wait for a few replies and then continue.

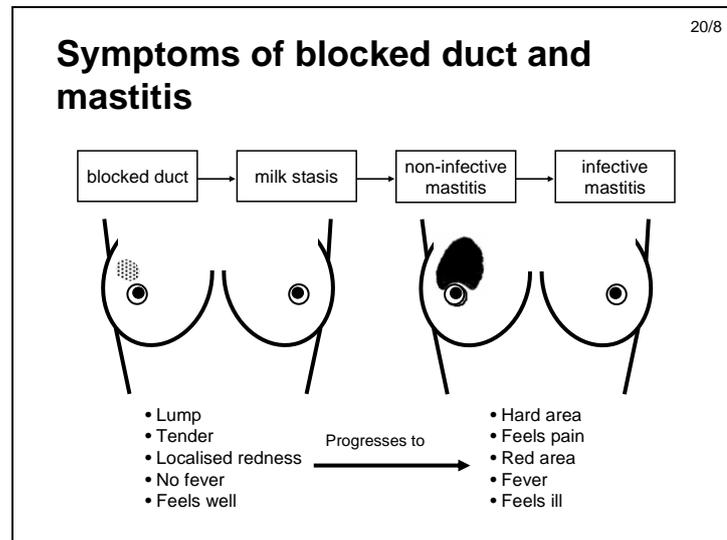
- Part of the breast looks red and swollen. There is a fissure on the tip of the nipple.

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.
- 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 20/8 - Blocked duct** 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 if 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 20/9 - Causes of blocked duct and mastitis** and make the points that follow:

20/9

Causes of blocked duct and mastitis

Poor drainage of whole breast:

- infrequent feeds
- ineffective suckling

Poor drainage of part of breast:

- ineffective suckling
- pressure from clothes
- pressure from fingers during feeds

- The main cause of a blocked duct is poor drainage of all or part of a breast
- 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 he starts 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.
- 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 20/10 - Treatment of blocked duct and mastitis** and make the points that follow:

20/10

Treatment of blocked duct and mastitis

- Most important – improve drainage of milk
- Look for cause and correct
- Suggest:
 - frequent feeds
 - gentle massage towards nipple
 - warm compresses
 - start feed on unaffected side; vary position
- Antibiotics, analgesics, rest

- 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, 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?
- Whether or not you find a cause, there are several suggestions to offer to the mother.
- Breastfeed frequently. The best way is to rest with her baby, so that she can respond to him and feed him whenever he is willing.
- Gently massage the breast while her 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 her breast between feeds.
- 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.
- Sometimes a mother is unwilling to feed her baby from the affected breast, especially if it is very painful. 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 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.

- Ask participants to turn to page 123 of their Manuals 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 commonest bacterium found in breast abscess is <i>Staphylococcus aureus</i> . 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 AN HIV-INFECTED WOMAN

- Make the following points:
 - In a woman who is HIV-infected, 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-infected gets mastitis or a fissure what should she do?
Wait for a few replies and then continue.
 - If an HIV-infected woman 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 will need to discuss other feeding options for her to give meanwhile. The mother may decide to heat-treat her expressed milk, or to give home-prepared or 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 in the HIV-uninfected woman.

- 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 20/11 - 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 4 key points of positioning and attachment. Ask participants to turn to page 24 of their Manuals and find the BREASTFEED OBSERVATION JOB AID.
- 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.
- There is more areola seen above baby's top lip.
- His mouth is closed, and his lips are pointing forwards.
- His lower lip is pointing forward.

- His chin is not touching the breast.
- 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, he pulls the nipple in and out as he sucks, and rubs the skin of the breast against his mouth. This is very painful for his 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.
- If a woman has sore nipples:
 - . 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.
 - . Suggest to the mother 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 rubs a little expressed breast milk over the nipple and areola with her finger. This promotes healing.

Show **Slide 20/12 - 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 burning or stinging which 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. He may have white patches inside his cheeks or on his tongue, or he may have a rash on his 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 HIV-infected it is particularly important to treat breast thrush and oral thrush in the infant promptly.

- Ask participants to turn to page 124 of their Manuals and find the box TREATMENT OF CANDIDA 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 OF THE BREAST

- **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.
- **Stop** using pacifiers, teats, and nipple shields.

III. Summarize the session

2 minutes

- Ask participants if they have any questions, and try to answer them.
- Explain that a summary of this session can be found on pages 115-124 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 traumatise 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.

Alternative antibiotics for treatment of infective mastitis

The following antibiotics can be used if necessary

- Cloxacillin 250-500 mg 6 hourly for 7-10 days
- Cephalexin 250-500 mg 6 hourly for 7-10 days.

Treatment of nipples 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.

Session 21

Replacement Feeding in the First Six Months

Objectives

After completing this session participants will be able to:

- describe breast-milk substitutes that can be used for replacement feeding
- list foods that are unsuitable in the first six months
- describe how milks can be modified for infant feeding

Session outline

45 minutes

Participants are all together for a demonstration by one trainer.

I.	Introduce the session	8 minutes
II.	Demonstrate locally available milks	30 minutes
III.	Describe how milks can be modified to make replacement feeds	5 minutes
IV.	Summarize the session	2 minutes

Preparation

- Refer to the Introduction for guidance on giving a demonstration.
- Make sure Slides 21/1 and 21/2 are in the correct order.
- You will need to:
 - . collect containers, tins, packets, of all milks available locally, whether or not suitable for infants, including those provided by social service organisations and supplemental nutrition programs. Find out which milks are full fat, semi-skimmed or skimmed. In addition collect a variety of miscellaneous products e.g. fruit juices, sugary drinks and tea.
 - . put all the packets, tins and cartons of milk together on a table in front of the class divided by type – fresh, tinned, powdered milks or commercial formula.
 - . make two large signs – ‘Possible for replacement feeding 0-6 months’ and ‘Unsuitable for replacement feeding 0-6 months’. Put the signs on different small tables, or at different ends of a large table. You will put the various milks beside these signs after participants have assigned them.
 - . make sure that you have read the labels carefully so that you know exactly which group to assign the different products to.
 - . find out what micronutrient supplements are available locally and which would be suitable for replacement feeding. Find out if any are provided specifically for use in prevention of MTCT programmes.

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

8 minutes

- Make these points:
 - A mother, who is HIV-positive, and who has been counselled on infant feeding options, may decide to use replacement feeding. So, we need to discuss what this mother could use to feed her baby.

- Show **Slide 21/1 - Session 21 Objectives** and read out the objectives:

21/1

Replacement feeding in the first 6 months for HIV-infected mothers

After completing this session participants will be able to:

- describe breast-milk substitutes that can be used for replacement feeding
- list foods that are unsuitable in the first six months
- describe how milks can be modified for infant feeding

Ask: In session 18 we talked about the definition of replacement feeding. Can anyone remember the definition?

Wait for a few replies and then show Slide 21/2 with the definition on it.

- Show **Slide 21/2 – Replacement feeding** and read out the definition:

21/2

Replacement feeding

is the process of feeding a child who is not breastfeeding with a diet that provides all the nutrients the child needs until the child is fully fed on family food

- Adequate replacement feeding is needed throughout the time the child is at greatest risk of malnutrition: that is until the child is at least two years old.
 - If an infant is not getting breast milk, milk in some other form is needed for at least the first six months. It is also useful if some kind of milk is part of the diet for up to two years of age or more.
 - In Session 18 we learnt that replacement feeding must be acceptable, feasible, affordable, sustainable and safe.
 - In addition to a source of milk, the child's mother will need water, soap, fuel and utensils to prepare the replacement feeds. She will also need extra time.
- Ask participants to turn to page 126 of their Manuals and find the box **ADVANTAGES AND DISADVANTAGES OF COMMERCIAL INFANT FORMULA**. Ask participants to take it in turns to read out the points.

ADVANTAGES AND DISADVANTAGES OF COMMERCIAL INFANT FORMULA

Advantages:

- Giving only formula carries no risk of transmitting HIV to the baby.
- Most of the nutrients a baby needs have already been added to the formula.
- Other responsible family members can help feed the baby. If a mother falls ill, others can feed the baby while she recovers.

Disadvantages:

- Unlike breast milk, formula does not contain antibodies that protect a baby from infections.
- A formula-fed baby is more likely to get seriously sick from diarrhoea, chest infections, and malnutrition, especially if the formula is not prepared correctly.
- A mother should stop breastfeeding completely or the risk of transmitting HIV will continue.
- A mother needs fuel and clean water (boiled vigorously for 1 to 2 seconds) to prepare the formula, and soap to wash the baby's cup.
- People may wonder why a mother is using formula instead of breastfeeding, and this could cause them to suspect she is HIV-positive.
- Formula takes time to prepare and must be made fresh for each feed (unless the mother has a refrigerator).
- Formula is expensive, and you must always have enough on hand. Your baby needs forty (40) 500g tins for the first 6 months. This will cost about ----- per month (insert local cost).
- The baby will need to drink from a cup. Babies can learn how to do this even when they are young, but it may take time to learn.
- A mother may get pregnant again too soon.

- Point out to participants that this information is on Counselling Card 2.
- Ask participants to turn to page 127 of their Manuals and find the box ADVANTAGES AND DISADVANTAGES OF HOME-MODIFIED ANIMAL MILK. Ask participants to take it in turns to read out the points.

ADVANTAGES AND DISADVANTAGES OF HOME-MODIFIED ANIMAL MILK**Advantages:**

- There is no risk of transmitting HIV through home-modified animal milk.
- Home-modified animal milk may be cheaper than commercial infant formula and is easily available if a mother has milk-producing animals.
- Other responsible family members can help feed the baby.

Disadvantages:

- Animal milk is hard for babies to digest and does not contain all the nutrients that babies need. Both fresh and processed milk need to be mixed with water and sugar in exactly the right amounts. Babies also need to have a micronutrient supplement.
- A baby is more likely to get sick from diarrhoea, chest infections, and malnutrition if he is fed home-modified animal milk, especially if it is not prepared correctly.
- A mother should stop breastfeeding completely or the risk of transmitting HIV will continue.
- Home-modified animal milk takes time to prepare and must be made fresh each time a mother feeds her baby, unless she has a refrigerator.
- A baby needs about 15 litres of milk per month for the first 6 months. A mother also needs to buy sugar and a micronutrient supplement, which will cost approximately ----- (insert local cost).
- The baby will need to drink from a cup. Babies can learn how to do this even when they are young, but it may take time to learn.
- A mother will need fuel and clean water (boiled vigorously for 1 or 2 seconds) to prepare the formula, and soap to wash the baby's cup.
- People may ask why a mother is using home-prepared formula instead of breastfeeding, and this could cause them to suspect that she is HIV-positive.
- A mother may get pregnant again too soon.

- Point out to participants that this information is on Counselling Card 6.

II. Demonstrate locally available milks

30 minutes

- Indicate the table with all the different packets, tins and cartons of milk mixed together. Make these points:
 - On this table you can see most of the different kinds of milk that are available here. We will look at each of them in turn and try to decide if:
 - it is possible to use it for replacement feeding
 - modification might be needed to make it possible
 - it is unsuitable for an infant under six months.

- Hold up each different kind of milk in turn, making the points that follow:
 - First we will start by discussing all the fresh liquid milks (low fat cow's milk; full fat cow's milk; semi-skimmed milk; sterilized milk)
 - Then the other tinned milks (evaporated milk; condensed milk)
 - Then the other powdered milks (coffee creamers; powdered milks for older children and adults)
 - Then we will discuss the commercial formulas (as many types as possible to show the variety available in your area)
 - Finally we will discuss miscellaneous products (juices, tea, sugary drinks).

Start with **Group 1: Fresh liquid milk**

- First show each kind of milk and ask a participant to place it on the table labelled 'POSSIBLE' or 'UNSUITABLE'.

- When the participants have decided on which table to put each milk in this group, discuss each kind of milk from that group in turn, making the points below. As you discuss each milk, praise the participants for those that they have put into the correct group. If they put one into the incorrect group, ask them if they want to reassign it. Encourage participants to check the 'use by' date on the products.

- Make these points:
 - **Whole cow's milk** is the commonest, or you may have buffalo or goat's milk. It may be available in cartons or bottles or people may collect it in their own containers.
 - This milk needs to be modified for an infant, but it can be in the POSSIBLE group. We will talk about how to modify it later.
 - Sometimes the fresh milk available in the market has already been diluted or some of the cream removed.
 - **Skimmed milk** has the fat (cream) removed and therefore the energy level is low. Most of the vitamins A and D are also removed because they are in the milk fat (UNSUITABLE table).

- **Semi-skimmed milk**, which contains 2% fat, is sometimes available. Milk normally contains more fat than this – about 3.5-4%. A baby may need additional energy if semi-skimmed milk is used (This milk should also be on the UNSUITABLE table).
- ☐ Make sure that all the fresh liquid milks are assigned to the correct table - POSSIBLE or UNSUITABLE.

☐ Continue with **Group 2: Tinned liquid milks**

- ☐ First show each kind of milk and ask a participant to place it on the table labelled 'POSSIBLE' or 'UNSUITABLE'.
- ☐ When the participants have decided on which table to put each milk in this group, discuss each kind of milk from that group in turn, making the points below. As you discuss each milk, praise the participants for those that they have put into the correct group. If they put one into the incorrect group, ask them if they want to reassign it. Encourage participants to check the 'use by' date on the products.
- ☐ Make these points:
 - **Evaporated milk** is sterilized, has some of the water removed, and is sealed in cans. Sometimes the fat content is altered. The processing destroys vitamin C and folate but extra vitamins may be added. Diluted with water, it has a similar composition to fresh milk (POSSIBLE table).
 - **Condensed milk** has some of the water removed but a lot of sugar has been added. This extra sugar makes bacteria grow more slowly when the tin is opened. Also, the fat level may be reduced. This balance of fat and sugar in condensed milk make it very different from evaporated milk (UNSUITABLE table).
- ☐ Make sure that all the tinned liquid milks are assigned to the correct table, POSSIBLE or UNSUITABLE.

☐ Continue with **Group 3: Powdered milk**

- ☐ First show each kind of milk and ask a participant to place it on the table labelled 'POSSIBLE' or 'UNSUITABLE'.
- ☐ When the participants have decided on which table to put each milk in this group, discuss each kind of milk from that group in turn, making the points below. As you discuss each milk, praise the participants for those that they have put into the correct group. If they put one into the incorrect group, ask them if they want to reassign it. Encourage participants to check the 'use by' date on the products.

- Make these points:
 - **Full cream powdered milk** is whole cow's milk that is dried to a powder. Much vitamin C and some B vitamins are lost, but the protein, fat, minerals and most of the vitamins A and D remain. It can be made up with water to the strength of whole fresh milk (POSSIBLE table).
 - **Dried skimmed milk** has the fat and fat soluble vitamins removed. (UNSUITABLE table)
 - Most modified powdered milks, such as '**creamers**' used for 'whitening' tea or coffee or various filled milks, may have the animal fat removed and replaced with vegetable fat. Sugar may also be added and ingredients to make it dissolve easily (UNSUITABLE table).
- Make sure that all the powdered milks are assigned to the right table, POSSIBLE or UNSUITABLE.

Continue with **Group 4: Commercial infant formula**

- First show each kind of milk and ask a participant to place it on the table labelled 'POSSIBLE' or 'UNSUITABLE'.
- When the participants have decided on which table to put each formula in this group, discuss each kind of formula from that group in turn, making the points below. As you discuss each formula, praise the participants for those that they have put into the correct group. If they put one into the incorrect group, ask them if they want to reassign it. Encourage participants to check the 'use by' date on the products.
- Make these points:
 - **Commercial infant formula** is usually made from cow's milk that has had the fat removed and is dried to a powder. Another form of fat (often vegetable fat), sugar and micronutrients are added. It needs only water added before use.
 - You may have **Generic Formula** available. The composition is the same as branded commercial formula. The only difference is in the way in which it is marketed and distributed. It is also labelled more simply.
- Make sure that all the commercial infant formulas are assigned to the correct table, POSSIBLE or UNSUITABLE.
- You now have all the milks and formula that you collected divided into 'POSSIBLE for replacement feeding 0-6 months' or 'UNSUITABLE for replacement feeding 0-6 months'.

☐ Continue with Group 5: Miscellaneous

- ☐ You will be left with a variety of miscellaneous products, e.g. juices, teas and sugary drinks. Ask participants where to put these items.
- ☐ Make these points:
 - Other foods and drinks are sometimes used to feed infants under six months of age – for example, juices, tea, sugary drinks. These fill a child's stomach and may reduce his appetite for nutritious foods. They are not suitable as an alternative to food for any young child.
- ☐ Remind participants to check their local products regularly so that they are up-to-date with the constituents and directions and aware of any new products that become available.

**III. Describe how milks can be modified to make replacement feeds
5 minutes**

- ☐ Make these points:
 - Among the 'possible' milks for infants are full cream milks, including fresh liquid milk, powdered milk, or tinned evaporated milk; and some commercial formulas.
 - In full strength full cream milk, the level of protein and some minerals is too high, and it is difficult for an infant's immature kidneys to excrete the extra waste. These milks require some modification to make the proportions more appropriate.
 - A commercial formula has been modified so that the proportions of different nutrients are appropriate for infant feeding, and micronutrients have been added. Formula needs only to be mixed with the correct amount of water.
 - It is important to remember however, that although the *proportions* of nutrients in either commercial or home-prepared formula can be altered, their *quality* cannot be made the same as breast milk. Also, the immune factors and growth factors present in breast milk are not present in animal milk or formula, and they cannot be added.

Ask: How can the high levels of protein and minerals in animal milks be reduced?

Wait for a few replies and then continue.
 - You can dilute them with water.
 - But, diluting with water makes the energy too low. You can add sugar to increase the energy.
 - If too little water is added, the infant's kidneys may be overloaded with mineral and protein waste. If too much water is added the infant will not get enough of some nutrients and may not grow well.
 - Fresh animal milk needs to be boiled to make the protein easier to digest, and less likely to irritate and damage the baby's intestinal mucosa. Processed milk (such as tinned liquid or powdered milk) has already been heat-treated.

- (Mention if used locally) Sheep or buffalo milk contains more fat than cow's or goat's milk so they need to be diluted more, and less sugar is needed.
- Ask participants to turn to page 129 of their Manuals and find the box RECIPES FOR HOME-PREPARED FORMULA. Make the following points:
- Notice that in each recipe for home-prepared formula the milk is diluted with water, and sugar is added.
 - If you are going to use these recipes you will need to have an accurate way to measure sugar, for example, special scoops.

- If you use home-prepared formula in your area, show locally-available, recommended, micronutrient formulations to the participants. Also show the relevant local measure for measuring sugar and micronutrients which should be used.

RECIPES FOR HOME-PREPARED FORMULA

Fresh cow's, goat's or camel's milk

40 ml milk + 20 ml water + 4g sugar = 60 ml prepared formula
60 ml milk + 30 ml water + 6g sugar = 90 ml prepared formula
80 ml milk + 40 ml water + 8g sugar = 120 ml prepared formula
100 ml milk + 50 ml water + 10g sugar = 150 ml prepared formula

Sheep and buffalo milk

30 ml milk + 30 ml water + 3g sugar = 60 ml prepared formula
45 ml milk + 45 ml water + 5g sugar = 90 ml prepared formula
60 ml milk + 60 ml water + 6g sugar = 120 ml prepared formula
75 ml milk + 75 ml water + 8g sugar = 150 ml prepared formula

Evaporated milk

Reconstitute with cooled, boiled water according to the label to the strength of fresh milk. Then modify as fresh milk by dilution and adding sugar. Check with specific brand. A typical recipe is:

32 ml evaporated milk + 48 ml water to make 80 ml full strength milk
plus 40 ml water + 8 g sugar = 120 ml prepared formula

Powdered full-cream milk

Reconstitute with cooled, boiled water according to the label to the strength of fresh milk. Then modify as fresh milk by dilution and adding sugar. Check with specific brand. A typical recipe is:

10 g powdered milk + 80 ml water to make 80 ml full strength milk
plus 40 ml water + 8 g sugar = 120 ml prepared formula

If mothers will use powdered full-cream milk or evaporated milk, provide a recipe specific to that brand. State the total amount of water to add both to reconstitute to the strength of milk and to dilute to make formula.

Micronutrient supplements should be given with all these kinds of home-prepared infant formula.

Micronutrients

- Make these points:
 - In addition to diluting, adding sugar and boiling animal milk, it is necessary to give the micronutrients. Breast milk contains the micronutrients that a baby needs, and if not breastfeeding these need to be provided in another way.
 - Micronutrients are the vitamins and minerals that the body needs in small amounts to keep it working well.
 - The micronutrients that may not be available easily from other milks are iron, zinc, vitamin A, vitamin C and folic acid.
 - Micronutrient supplements are added to commercial formula when it is manufactured. Infants who receive home-prepared infant formula need to be given extra micronutrients.
 - You should be aware of the locally recommended micronutrient formulations which will provide all the micronutrients needed for an infant aged 0-6 months of age. The recommended amounts of micronutrients are listed on page 130 of your Manuals (page 290 of the *Trainer's Guide*).

IV. Summarize the session

2 minutes

- Ask participants if they have any questions, and try to answer them.
- Explain that a summary of this session can be found on pages 125-130 of the *Participant's Manual*.

Further Information

Pasteurization heats the milk to a temperature below boiling. This milk keeps for a day or two in a clean, cool place, but still needs to be boiled soon before use for an infant.

Ultra-high temperature (UHT) treatment heats the milk to a very high temperature for a few seconds. This kills all the bacteria so the milk keeps for several months if it is sealed in clean containers.

Sterilization heats the milk above boiling point for several minutes. This kills the bacteria and the milk keeps for several months in a sealed clean container. Sterilization changes the taste and destroys many vitamins especially folate. Some studies show that sterilized milk may be more likely to cause necrotising enterocolitis (NEC), so it is considered UNSUITABLE.

Homogenised milk has been treated so that the cream does not rise to the top. This process does not kill bacteria and it needs to be boiled soon before use for an infant.

Different commercial formulas:

Formula from cow's milk may be processed to be high in whey proteins. This formula may be easier for the young infant to digest. Formula that is high in casein protein can be more difficult for the young infant to digest as it forms thick curds in the infant's stomach. The higher protein and mineral level make it less suitable for young infants.

Soya infant formula uses processed soya beans as the source of protein and comes in powdered form. Usually it is lactose-free and has a different sugar added instead (POSSIBLE table).

Follow-on (or follow-up) milks are marketed for older infants (over six months). They contain higher levels of protein and are less modified than infant formula. Follow-on milks are not necessary. A range of ordinary milk products can be used over six months of age and micronutrients supplements also given (UNSUITABLE table).

Low-birth-weight or preterm formula is manufactured with higher levels of protein and certain minerals and a different mixture of sugars than ordinary formula for full-term infants. Low-birth-weight formula is not recommended for healthy, full term infants. The nutritional needs of low-birth-weight infants should be individually assessed (UNSUITABLE table).

Specialized formulas are available to use in conditions such as lactose intolerance, allergic conditions and metabolic diseases like phenylketonuria. These formulas are altered in one or more nutrients and should only be used for infants with the specific conditions under medical/nutritional supervision (UNSUITABLE table).

If a type of manufactured formula is not available locally, do not spend time discussing it. Generic formula only differs in the way it is marketed and distributed. The nutrients are similar to regular commercial formula. FAO/WHO Codex Alimentarius defines food standards including formula and micronutrients.

MICRONUTRIENTS TO GIVE WITH HOME-MODIFIED ANIMAL MILK PER DAY

Minerals:

Manganese	7.5 µg
Iron	1.5 mg
Copper	100 µg
Zinc	205 µg
Iodine	5.6 µg

Vitamins:

Vitamin A	300 IU
Vitamin D	50 IU
Vitamin E	1 IU
Vitamin C	10 mg
Vitamin B1	50 µg
Vitamin B2	80 µg
Niacin	300 µg
Vitamin B6	40 µg
Folic acid	5 µg
Pantothenic acid	400 µg
Vitamin B12	0.2 µg
Vitamin K	5 µg
Biotin	2 µg

Adapted from the Codex Standard for Infant Formula, Codex Standard 72-1981. The amount for each micronutrient was calculated by subtracting the amount found in cow's milk from the amount recommended by the Codex Standard.

Session 22

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.

Session outline

30 minutes

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

- | | | |
|------|---|------------|
| I. | Introduce the session | 7 minutes |
| II. | Explain the requirements for clean and safe feeding | 20 minutes |
| III. | Summarize the session | 3 minutes |

Preparation

- Refer to the Introduction for guidance on giving a presentation with slides.
- Make sure that Slides 22/1 – 22/7 are in the correct order. Study the slides 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.

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

I. Introduce the session**7 minutes**

- Show **Slide 22/1 - Hygienic Preparation of Food** and read out the objectives:

22/1

Hygienic preparation of feeds

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 six 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.

☐ Show **Slide 22/2 - Clean hands** and make the points that follow:

22/2

Clean hands

- After using toilet
- After cleaning baby's bottom
- Before preparing or serving food
- Before feeding children or eating

An illustration showing two women in traditional attire standing at a wooden table. One woman is pouring water from a bowl into a larger bowl on the table, while the other woman is washing her hands. This illustrates the importance of hand hygiene in food preparation.

- 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 which may be contaminated, for example, raw meat and poultry products
 - after touching animals
 - 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 22/3 - Clean utensils** and make the points that follow:

22/3

Clean utensils

- Clean surface (table, mat or cloth)
- Wash utensils immediately after use
- Keep clean utensils covered
- Use clean utensils for baby

A black and white line drawing of a woman in a long dress and headscarf, standing at a sink. She is holding a bowl and washing it with her hands. On the table next to the sink, there are several plates and a cloth. The scene is set in a kitchen or food preparation area.

- 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 her mouth to check the taste or temperature, she should use a different spoon from the baby.

□ Show **Slide 22/4 – Safe water and food** and make the points that follow:

22/4

Safe water and food

- Treat water for drinking and baby's feeds
- Keep water in clean covered container
- Boil milk before use
- Give freshly prepared complementary foods



- 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 micro-organisms. 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 give 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, UHT (ultra-high temperature) or sterilization. These treatments kill the harmful micro-organisms, and they 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 mother is giving complementary foods, she should prepare them freshly each time she feeds the baby, especially if they are semi-liquid.

Show **Slide 22/5 - Safe storage** and make the points that follow:

22/5

Safe storage

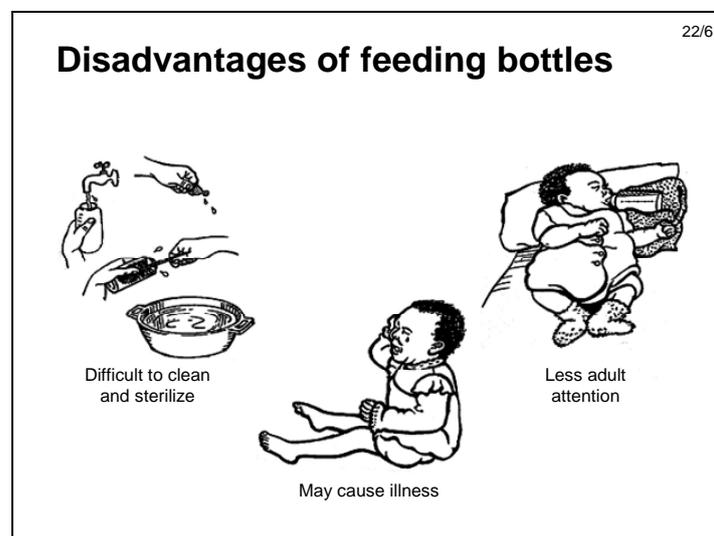
- Keep foods in tightly covered containers
- Store foods dry if possible (e.g. milk powder, sugar)
- Use milk within one day if refrigerated
- Use prepared feeds within one hour



- 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 keep 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 mother does not have a refrigerator, she 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 mother 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 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 22/6 - Disadvantages of feeding bottles** and make the points that follow:



- You will remember in Session 16 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 itself, 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 him close and making eye contact.
- Mothers need to know how to clean cups and bottles.

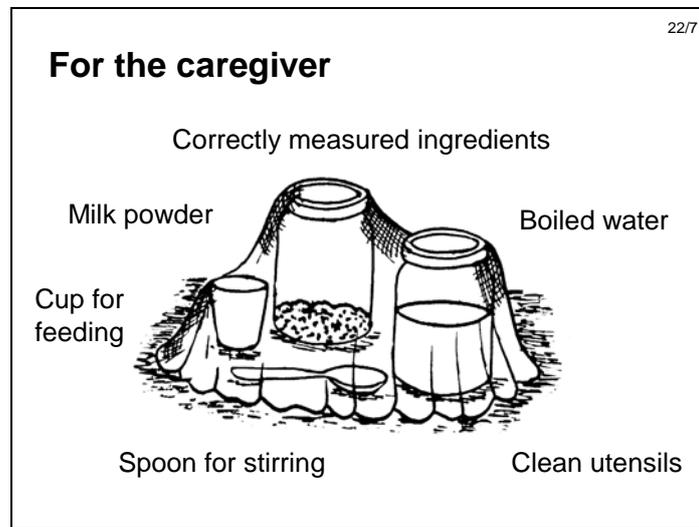
Cleaning a cup

- 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 mother 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 22/7 - 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, 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, 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 she gives the feed, and to feed it from a cup.

III. Summarize the session**3 minutes**

- Ask participants if they have any questions or if there are points that you can make clearer.
- 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 Manual on page 134 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 131-134 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 in 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 re-heating.

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 Food Safety Unit, WHO, Geneva, 2001. WHO/SDE/PHE/FOS/01.1

Session 23

Preparation of Milk Feeds - Measuring Amounts

Objectives

After completing this session participants will be able to:

- specify amounts of milk needed for an infant who is not breastfed
- make measuring utensils for liquids
- translate measures into a mother's home utensils

Session outline

45 minutes

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

- | | | |
|------|---|------------|
| I. | Introduce the session | 5 minutes |
| II. | Discuss the amount of milk to give if a baby is not breastfed | 10 minutes |
| III. | Demonstrate how to make measures for the mother | 25 minutes |
| IV. | Summarize the session | 5 minutes |

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.

Preparation

- This session needs careful preparation. You will be demonstrating to participants how to measure different volumes of fluid and how to mark a mother's container so that she can measure this volume. Make sure that you have practised this before the session so that you are clear about what to do and do not confuse the participants.
- Make sure you know which types of formula you are going to prepare in the Practical Session. Discuss this beforehand with the Course Director. This session requires some flexibility as the types of replacement milk that are appropriate for different areas will vary.
- Remind trainers to stay with their groups to make sure that they understand what to do, and that they do it correctly and completely.
- Make sure you have Slide 23/1 ready. As there is only one slide, you may prefer to read aloud the objectives without projecting them onto the screen. As this session is conducted in groups, it will also mean you do not have to provide several projectors.

You will need:

- The items needed for the measuring methods chosen before the course.
- Easily available see-through small containers - jars, glasses.
- Marker suitable for glass - ask permission before using a permanent marker on a participant's glass.
- Cloth for mopping spilt water.
- Water – about 2 litres of drinking water plus water for washing-up.
- Commercial or generic infant formula; sugar and micronutrients if using home-modified animal milk.
- Make sure that each group finishes the session with a set of marked measures for liquid or powdered milk. The group must then take the set of measures with them to use in Session 24 'Preparation of Milk Feeds – Practical.'

I. Introduce the session**5 minutes**

- Show **Slide 23/1 - Preparation of milk feeds – measuring amounts** and read out the objectives:

23/1

Preparation of milk feeds – measuring amounts

After completing this session participants will be able to:

- specify amounts of milk needed for an infant who is not breastfed
- make measuring utensils for liquids
- translate measures into a mother's home utensils

- Make these points:
 - HIV-positive mothers who choose not to give breast milk, and other caregivers, need to know how to prepare replacement feeds for their infants.
 - Replacement feeds must be prepared in the safest possible way, to reduce the risk of illness. Mothers need to practise this skill with a health worker present, either in the health facility or at home, so they can do it easily and the same way every time.
 - When a mother makes replacement feeds, it is very important that the milk and water are mixed in the correct amounts.
 - If she is preparing home-modified animal milk it is also important that sugar and micronutrients are added.
 - Wrongly prepared feeds may make a baby ill, or he may be underfed. Repeated mistakes in measuring water or milk powder may have serious long-term consequences.

II. Discuss the amount of milk or formula to give if a baby is not breastfed 10 minutes

- Make these points:
 - In Session 16 we discussed cup-feeding a baby. Remember that a baby who is cup-fed can control how much he takes, by refusing to take any more when he has had enough.
 - The amount that a baby takes at each feed varies. But the caregiver must decide how much to put in a cup to offer the baby.

Ask: How much milk is needed for a cup-feed for a young infant?

Wait for a few replies and then continue.
- Ask participants to turn to page 93 of their Manuals to remind them of how much milk to give a baby every 24 hours (this is on page 211 of the *Trainer's Guide*). Make the following point:
 - A term baby, weighing 2.5kg or more, needs an average of 150ml/kg body weight/day. This is divided into 6,7 or 8 feeds according to the baby's age. The exact amount at one feed varies.
- Ask participants to turn to page 136 of their Manual and find the table APPROXIMATE AMOUNT OF MILK NEEDED TO FEED A BABY EACH DAY. You do not need to read it out but explain to participants that they can refer to this later.

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 to 1 month	8	60 ml	480 ml
1 to 2 months	7	90 ml	630 ml
2 to 4 months	6	120 ml	720 ml
4 to 6 months	6	150 ml	900 ml

- Make these points referring to the table:
 - As you can see on the table, a newborn infant is fed small amounts frequently. The amount gradually increases as the infant grows.
 - 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, if a baby is not gaining enough weight, he may need to be fed more often, or given larger amounts at each feed, according to his expected weight at that age.
- Ask participants to turn to page 136 of their Manual and find the table APPROXIMATE AMOUNTS OF COMMERCIAL INFANT FORMULA NEEDED BY MONTH.

Make these points:

- This table shows approximately how much commercial infant formula a baby needs in the first six months. The numbers are rounded rather than exact. An individual baby may need more or less than the amount listed. You will see that this table is also found on Counselling Card 11.

APPROXIMATE AMOUNTS OF COMMERCIAL INFANT FORMULA NEEDED BY MONTH			
Month	Number of 500g tins needed per month	Number of 450g tins needed per month	Number of 400g 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 X 500g (20 kg)	44 X 450g (approx 20 kg)	51 X 400g (approx 20 kg)

Ask participants to answer the following questions from the table.

Ask: How much commercial infant formula 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.

Ask: How much commercial infant formula would you need to feed an infant for the first six 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 x 500 gm tins). (See the figures at the bottom of 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 one year of age, and if possible two years. So, the mother needs to consider how she can provide milk for all this time.

III. Demonstrate how to make measures for the mother

25 minutes

- Make these points:
 - Commercial infant formula comes with a special measure (called a scoop) in the tin of powder. This should be used only for that brand of infant formula.
 - Different brands may have different size measures. Scoops always have to be levelled. Use a clean knife or the handle of a spoon. Do not use heaped scoops.

- Show the measures from locally available commercial formula.
 - You will have to show the mother how to measure water.

Ask: If a mother does not have a measuring jug or other container marked with amounts, how can she measure the water to make up a formula feed for her baby?

Wait for a few replies and then continue.
 - A mother can bring a container from home that you can mark for her as a measure. The container should be
 - easily available
 - easy to clean and sterilize
 - see-through
 - able to be marked with paint, permanent marker, or by scratching a line on it.
 - Alternatively the container could be used as a measure simply by filling it to the top.

- Show some suitable containers.
 - Before a mother can use a container as a measure you need to mark the amount on the container, or show her how full it needs to be to measure the amount that she has to use.

Ask: How can you decide where to mark the mother's container?

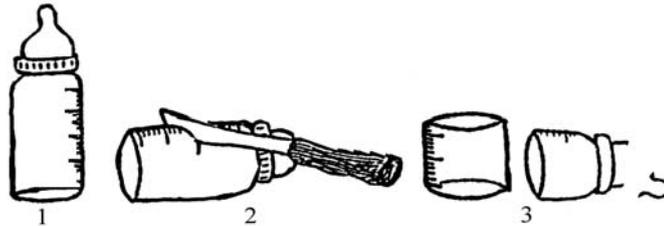
Wait for a few responses and then continue.
 - You can measure the correct amount of water or milk in your own measure, put it into the mother's measure, and make a mark at the level it reaches. If you have a measuring jug you can use that as your measure.

- ❑ **OPTIONAL:** Include this section if the only available measure is a cut-off feeding bottle. It is not necessary to include it if other measures are commonly available.

CUT-OFF FEEDING BOTTLE

- You can make a measure from a feeding bottle by cutting off the top.

Fig. 23.1 Making a Measure

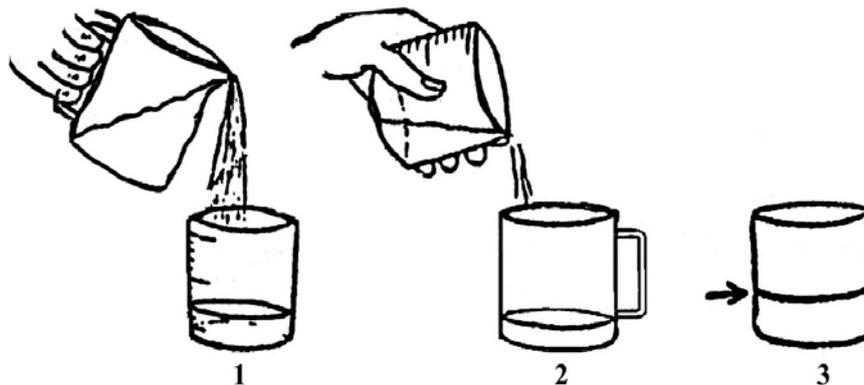


- Step 1.** Take a plastic feeding bottle which is straight up and down, and which has clear measures marked on the side.
 - Step 2.** Cut off the top, at a place well above the mark for 100 ml.
 - Step 3.** This leaves you with a straight-sided measure, which should be easy to keep clean. (No-one can be tempted to put a teat on it and use it to feed a baby. Cut up the teat and throw it away).
- The cut-off bottle is a way for a health worker to show appropriate amounts using a mother's own container. Then the mother does not have to buy her own bottle to use as a measure.

- ❑ Using the measure which you have decided is most suitable, continue with these points to demonstrate measuring the water, and marking the mother's container (Fig. 23.2). It does not matter what volumes you demonstrate to the participants – it is the principal of making a measure for a mother that is important.
 1. Decide what volume you are going to measure. This will depend on the type of milk you are preparing and the volume of the feed. For this example we will use 60 mls for a commercial infant formula feed for a baby from birth to one month.
 2. Put water into your measure, to reach the 60 ml mark.
 3. Pour the 60 ml water from your measure into the mother's container.
 4. 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.

- Explain to the mother that to make up a feed of 60 ml from commercial formula, she needs to measure this amount of water and add scoops of commercial formula.

Fig. 23.2 Mark a measure



- Now ask each group to practise making different measures. You should have discussed with the Course Director beforehand what types of milk you will be preparing during the practical session (Session 24). Make sure you have prepared appropriate measuring containers for the practical session. If you are going to prepare home-modified animal milk, then show participants the utensils you will use to measure the sugar and micronutrients.

IV. Summarize the session

5 minutes

- Ask participants if they have any questions, and try to answer them.
- All the prepared measuring items need to be brought to Session 24 'Preparation of Milk Feeds – Practical Session 3'.
 - In Session 24 'Preparation of milk feeds - practical' each person in a group will prepare a different volume of replacement milk. One feed should be 50-70ml (for a newborn baby). One feed should be 150ml. You will practise making up different types of replacement feeds which are appropriate for this area.
- Explain that a summary of this session can be found on pages 135-138 of the *Participant's Manual*.

Session 24

Practical Session 3 Preparation of Milk Feeds

Objectives

After completing this session participants will be able to:

- demonstrate how to prepare replacement milk

Session outline

105 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.

- | | | |
|------|---|------------|
| I. | Introduce the session (one trainer) | 5 minutes |
| II. | Practical preparation of milk feeds (groups of 3-4 participants with one trainer) | 90 minutes |
| III. | Discuss what was learnt in this practical session (one trainer) | 10 minutes |

As you follow the text, remember:

- Indicates an instruction to you, the trainer
- Indicates what you say to participants.

Preparation

- This session should have been discussed in detail with the Course Director beforehand. The milks you will prepare and the types of fuel you will use should be appropriate for your area and cover all local options. This session requires some flexibility as the types of replacement milk and fuels that are appropriate for different areas will vary. This session requires careful preparation by all trainers as the participants will work in small groups.
- The entire session can take place at the cooking place if it is suitable. The introduction, 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 the groups can cook.
- Each group should use a different type of fuel commonly used in your area: e.g. wood, paraffin, charcoal. If there are six groups and only three types of fuel commonly used, then two groups will prepare feeds using the same type of fuel.
- 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, that they have wicks and are filled with fuel.
- Identify a source of water near to the cooking 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. Make sure all trainers are clear about what types of milk their group is preparing.
- You will follow the appropriate HIV and Infant Feeding Take Home Flyers as you prepare the milk feeds. Make sure you have copies of the relevant flyers for your group. Use the recipes on page 314 of the *Trainer's Guide* if you are preparing home-modified animal milk.
- If you are going to prepare home-modified animal milks make sure that you know the recommended method in your area for measuring sugar, and the recommended micronutrient preparation that is available locally.

I. Introduce the session (one trainer)**5 minutes**

- ❑ Make these points:
 - Helping mothers to prepare feeds is easier if you have done it yourself using equipment similar to that which the mothers have at home.
 - Mothers have several options for replacement feeding. Knowing what is needed and how long these different options take to prepare is part of the information that you will need to give them.
 - In this session, each participant in a small group will:
 - prepare one type of replacement feed that is appropriate locally
 - prepare a specific volume of feed
 - use one kind of fuel appropriate locally
 - give a clear demonstration to others in your group of what you do, as if you are demonstrating to a 'mother', and check 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 appropriate Infant Feeding Counselling Take Home Flyers as you prepare the milk feeds. You will use the recipes on page 140 of your Manuals if you are preparing home-modified animal milks.

II. Practical preparation of milk feeds**90 minutes**

- ❑ Show each group where they will work. As soon as they are in their place, they can start to follow the instructions on the flyers. Encourage the group to take a note of how long each feed takes to prepare. If participants are preparing a fire and collecting water from a river, then the preparation time should start from this moment.
 - 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.

RECIPES FOR HOME-PREPARED FORMULA

Fresh cow's, goat's or camel's milk

40 ml milk + 20 ml water + 4g sugar = 60 ml prepared formula
60 ml milk + 30 ml water + 6g sugar = 90 ml prepared formula
80 ml milk + 40 ml water + 8g sugar = 120 ml prepared formula
100 ml milk + 50 ml water + 10g sugar = 150 ml prepared formula

Sheep and buffalo milk

30 ml milk + 30 ml water + 3g sugar = 60 ml prepared formula
45 ml milk + 45 ml water + 5g sugar = 90 ml prepared formula
60 ml milk + 60 ml water + 6g sugar = 120 ml prepared formula
75 ml milk + 75 ml water + 8g sugar = 150 ml prepared formula

Evaporated milk

Reconstitute with cooled, boiled water according to the label to the strength of fresh milk. Then modify as fresh milk by dilution and adding sugar. Check with specific brand. A typical recipe is:

32 ml evaporated milk + 48 ml water to make 80 ml full strength milk
plus 40 ml water + 8 g sugar = 120 ml prepared formula

Powdered full-cream milk

Reconstitute with cooled, boiled water according to the label to the strength of fresh milk. Then modify as fresh milk by dilution and adding sugar. Check with specific brand. A typical recipe is:

10 g powdered milk + 80 ml water to make 80 ml full strength milk
plus 40 ml water + 8 g sugar = 120 ml prepared formula

If mothers will use powdered full-cream milk or evaporated milk, provide a recipe specific to that brand. State the total amount of water to add both to reconstitute to the strength of milk and to dilute to make formula.

Micronutrient supplements should be given with all these kinds of home-prepared infant formula.

INFANT FEEDING COUNSELLING FLYER

HOW TO PREPARE COMMERCIAL FORMULA

How to prepare commercial formula

- Wash your hands before preparing the formula.
- Make..... ml for each feed. Feed the baby times every 24 hours.
- Always use the marked cup or glass to measure water and the scoop to measure the formula powder. Your baby needs scoops.
- Measure the exact amount of powder that you will need for one feed.
- Boil enough water vigorously for 1 or 2 second.
- Add the hot water to the powdered formula. The water should be added while it is still hot and not after it has cooled down.
- Only make enough formula for one feed at a time unless you have a refrigerator in good working condition. Do not keep milk in a thermos flask because it will become contaminated quickly.
- Feed the baby using a cup. Discard any unused formula, give it to an older child or drink it yourself.
- Wash the utensils.
- Come back to see me on.....

INFANT FEEDING COUNSELLING FLYER

HOW TO PREPARE EVAPORATED MILK

How to prepare evaporated milk

- Wash your hands before preparing the feed.
- Make ml for each feed. Feed the baby times each day (24 hours).
- Always use the marked cup or glass to measure the milk and water.
- Fill the cup or glass to the "milk" mark with the milk. Put the milk into the pot. Fill the cup or glass to the "water" mark with the water. Add the water to the milk in the pot.
- Measure the sugar by filling the spoon until it is level/rounded/heaped (circle one).
- Put in spoonfuls.
- Add the sugar to the liquid. Stir well.
- Bring the liquid to a boil and then let it cool.
- Keep it covered while it cools.
- Feed the baby using a cup. Discard any unused formula, give it to an older child or drink it yourself.
- Wash the utensils.
- Give your baby a micronutrient supplement every day. You can get it from.....or can buy it. It will cost
- Come back to see me on

INFANT FEEDING COUNSELLING FLYER

HOW TO PREPARE FRESH MILK

How to prepare fresh milk

- Wash your hands before preparing the formula.
- Always use the marked cup or glass to measure water and milk.
- Fill the cup or glass to the "water" mark with the water. Put the water into the pot. Fill the cup or glass to the "Milk" mark with the milk. Add the milk to the water in the pot.
- Measure the sugar by filling the spoon until it is level/rounded/heaped (circle one). Put in spoonfuls.
- Add the sugar to the liquid. Stir well.
- Bring the liquid to a boil and then let it cool. Keep it covered while it cools.
- Feed the baby using a cup.
- Discard any unused formula, give it to an older child or drink it yourself.
- Wash the utensils.
- Give your baby a micronutrient supplement every day. You can get it from or can buy it. It will cost
- Come back to see me.....

INFANT FEEDING COUNSELLING FLYER
HOW TO PREPARE POWDERED FULL-CREAM MILK

How to prepare powdered full-cream milk

- Wash your hands before preparing the formula.
- Always use the marked cup or glass to measure water and a spoon to measure the powdered milk.
- Boil enough water vigorously for 1-2 seconds and then let it cool. Keep it covered while it cools.
- Measure the powdered milk into the marked cup or glass. Measure the powder by filling the spoon as shown in the picture. Put in spoonfuls.
- Measure the sugar by filling the spoon until it is level/rounded/heaped (circle one). Put in spoonfuls.
- Add the sugar to the feed. Stir well.
- Add a small amount of the boiled water and stir. Fill the cup or glass to the mark with the water.
- Feed the baby using a cup.
- Discard any unused formula, give it an older child or drink it yourself.
- Wash the utensils.
- Give your baby a micronutrient supplement every day. You can get it from..... or can buy it. It will cost
- Come back to see me on.....

III. Discuss the practical exercise (one trainer) 15 minutes

- 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?
 - Which milk was the most difficult to prepare and why?
 - 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?

Session 25

Health Care Practices

Objectives

After completing this session participants will be able to:

- list 'THE TEN STEPS TO SUCCESSFUL BREASTFEEDING'
- describe the health care practices summarized by 'THE TEN STEPS TO SUCCESSFUL BREASTFEEDING'
- explain why the Baby-friendly Hospital Initiative is important in areas with a high HIV prevalence

Session outline

45 minutes

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

- | | | |
|------|-----------------------|------------|
| I. | Introduce the session | 5 minutes |
| II. | Explain the Ten Steps | 35 minutes |
| III. | Summarize the session | 5 minutes |

Preparation

- Refer to the Introduction for guidance on giving a presentation with slides.
- Make sure that Slides 25/1-25/24 are in the correct order. Study the slides and the text that goes with them so that you are able to present them.
- Make a poster of the 'Ten Steps' and put it on the wall of the classroom.
- If there is a 'Baby-friendly Hospital' in your area, try to obtain a copy of its Breastfeeding Policy for participants to study after the session if they wish.
- Have a copy of the Joint Statement to show to participants, if available.

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

Health care practices

After completing this session participants will be able to:

- list the Ten Steps to Successful Breastfeeding
- describe the health care practices summarized by 'The Ten Steps to Successful Breastfeeding'
- explain why the Baby-friendly Hospital Initiative (BFHI) is important in areas with high HIV prevalence

- Ask participants to turn to page 146 of their Manual and find THE TEN STEPS TO SUCCESSFUL BREASTFEEDING. Point out the poster on the wall. (There is no need to read out the 'Ten Steps' as you will be covering them in detail during this session).
- Make these introductory points:
- Health care practices can have a major effect on breastfeeding.
 - Poor practices interfere with breastfeeding, and contribute to the spread of artificial feeding.
 - Good practices support breastfeeding, and make it more likely that mothers will breastfeed successfully, and will continue for a longer time.
 - In 1989, WHO and UNICEF issued a Joint Statement called 'Protecting, Promoting and Supporting Breastfeeding: The Special Role of Maternity Services'. This describes how maternity facilities can support breastfeeding.
 - The 'Ten Steps' are a summary of the main recommendations of the Joint Statement.
 - They are the basis of the 'Baby-friendly Hospital Initiative', a world-wide effort launched in 1991 by the World Health Organisation (WHO) and UNICEF.
 - If a maternity facility wishes to be designated 'Baby-friendly', it must follow all of the 'Ten Steps'. There is clear evidence that where a combination of all the 'Ten Steps' are followed the outcome is better than if only a few steps are followed.

THE TEN STEPS TO SUCCESSFUL BREASTFEEDING

Every facility providing maternity services and care for newborn infants should:

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

- If you have a copy of the Joint Statement show it to the participants.
- Make the following points:
 - Since the launch of the Baby-friendly Hospital Initiative in 1991 the growing HIV/AIDS pandemic, especially in sub-Saharan Africa and parts of Asia, has raised concerns and questions about promoting, protecting and supporting breastfeeding where HIV is prevalent.
 - These concerns arise because breastfeeding is known to be one of the routes for infecting infants with HIV.
 - However, baby-friendly practices improve conditions for all mothers and babies, including those who are not breastfeeding.
 - It is especially important to support breastfeeding for women who are HIV-negative or of unknown status.

II. Explain the Ten Steps to Successful Breastfeeding 35 minutes

- Make the following points:
 - The following slides illustrate the 'TEN STEPS TO SUCCESSFUL BREASTFEEDING'.
 - Keep your Manuals open on page 146 at the 'Ten Steps' as you follow the slide presentation.

- Show Slide 25/2 - Step one** and make the points that follow:

25/2

Step one

Have a written breastfeeding policy that is routinely communicated to all health staff

- Having a breastfeeding policy helps establish consistent care for mothers and babies.
- It also provides a standard that can be evaluated.
- The policy should cover:
 - the Ten Steps to Successful Breastfeeding
 - an institutional ban on acceptance of free or low cost supplies of breast-milk substitutes
 - a framework for assisting HIV-positive mothers to make informed infant feeding decisions that meet their individual circumstances and then support for this decision.

Show Slide 25/3 - Step two and make the points that follow:

25/3

Step two

Train all health care staff in skills necessary to implement this policy

- Make the following points:
- It is important that all staff are trained to implement the breastfeeding policy.
 - In hospitals where training is inadequate, health care practices do not improve.

Show Slide 25/4 - Step three and make the points that follow:

25/4

Step three

Inform all pregnant women about the benefits and management of breastfeeding

Show Slide 25/5 - Antenatal counselling and make the points that follow:



- It is important to talk to all women about breastfeeding when they come to an antenatal clinic. Show that you support breastfeeding, and that you want to help them.
 - It is especially important to talk to young mothers who are having their first baby. They are the ones who are most likely to need help.
 - There are some things that you can discuss with a group of mothers together, in an antenatal class. There are other things that it is usually better to discuss with mothers individually.
- Ask participants to turn to page 147 of their Manuals and find the box ANTENATAL PREPARATION FOR BREASTFEEDING. Ask participants to take turns to read out the points.

ANTENATAL PREPARATION FOR BREASTFEEDING

With mothers in groups:

- Explain the benefits of breastfeeding especially exclusive breastfeeding.

Most mothers decide how they are going to feed their babies a long time before they have the child - often before they become pregnant. If a mother has decided to use formula milk, she may not change her mind. But you may help mothers who are undecided, and give confidence to others who intend to breastfeed. You may encourage a mother to breastfeed exclusively instead of partially.

- Talk about early initiation of breastfeeding; what happens after delivery; explain about the first breastfeeds, and the practices in the hospital, so that they know what to expect.
- Give simple relevant information on how to breastfeed e.g. demand feeding and positioning a baby.
- Discuss mothers' questions.

Let the mothers decide what they would like to know more about, for example some of them may worry about the effect that breastfeeding may have on their figures. It may help them to discuss these worries together.

With each mother individually:

- Ask about previous breastfeeding experience.

If she breastfed successfully, she is likely to do so again. If she had difficulties, or if she formula fed, explain how she could succeed with breastfeeding this time. Reassure her that you will help her.

- Ask if she has any questions or worries.
- Examine her breasts only if she is worried about them.

She may be worried about the size of her breast or the shape of her nipples. It is not essential to examine breasts as a routine if she is not worried about them.

- Build her confidence, and explain that you will help her.

Mostly you will be able to reassure that her breasts are all right, and that her baby will be able to breastfeed. Explain that you or another counsellor will help her.

Note: Antenatal education should not include group education on formula preparation.

Show **Slide 25/6 - Step four** and make the following points:

25/6

Step four

Help mothers initiate breastfeeding within a half-hour of birth

Show **Slide 25/7 - Early contact** and make the following points:



- This mother is holding her baby immediately after delivery. They are both naked, so that they have skin-to-skin contact.
- A mother should hold her baby like this as much as possible in the first two hours after delivery.

Ask: What can you do to prevent a baby from getting cold?

Wait for a few replies and then continue.

- Dry the baby, and cover both him and his mother with the same blanket.
- The mother should let the baby suckle when he shows that he is ready. Babies are normally very alert and responsive in the first 1-2 hours after delivery. They are ready to suckle, and easily attach well to the breast.
- Most babies want to feed between half to one hour after delivery, but there is no exact fixed time.
- Try to delay non-urgent medical routines for at least one hour.

Ask: What medical routines occur in your hospital or clinic which could interrupt early contact between the mother and her baby?

Wait for a few replies. Encourage participants to think of ways in which these non-urgent medical routines could be postponed.

- If the first feed is delayed for longer than about an hour, breastfeeding is less likely to be successful. A mother is more likely to stop breastfeeding early.

Show **Slide 25/8 - Separation of mother and baby** and make the following points:



- This baby was born about half an hour ago. He has been separated from his mother while she is resting and being bathed.

Ask: What is he doing with his mouth?

Wait for a few replies and then continue.

- He is opening his mouth and rooting for the breast. This shows that he is now ready to breastfeed but he is separated from his mother so she is not there to respond to him.
- Separating a mother and her baby in this way, and delaying starting to breastfeed, should be avoided. These practices interfere with bonding, and make it less likely that breastfeeding will be successful.
- Remember mothers who have chosen not to breastfeed, for example mothers who are HIV-positive, and have decided to replacement feed, need encouragement to hold, cuddle and have physical contact with their babies from birth onwards. This helps a mother to feel close and affectionate toward her baby. There is no reason that the baby of an HIV-positive mother should not have skin-to-skin contact after birth, even if the mother is not going to breastfeed.
- Mothers who are HIV-positive and who have decided to breastfeed, should be assisted to put the baby to the breast soon after delivery in the usual way.

Show **Slide 25/9 - Step five** and make the following points:

25/9

Step five

Show mothers how to breastfeed and how to maintain lactation, even if they should be separated from their infants

Show **Slide 25/10 - Help mothers to breastfeed** and make the points that follow:



- This photo shows a baby having an early breastfeed. It is the first day of life. A midwife who has been trained in breastfeeding counselling has come to help the mother. Anyone competent at helping a mother to initiate breastfeeds could help a mother and baby with their first feeds.

Ask: How would you suggest that this midwife helps the mother?

Wait for a few replies.

Encourage participants to think of the following: observing a breastfeed, helping the mother to position the baby and giving her praise and relevant information.

- Keep a baby with his mother, and let him breastfeed when he shows that he is ready. Help his mother to recognize rooting and other signs that he is ready to breastfeed.
- It is a good idea for someone skilled in breastfeeding counselling to spend time with each mother during an early breastfeed to make sure that everything is going well.
- This should be a routine in maternity wards before a mother is discharged. It need not take a long time.

- Show **Slide 25/11 - Mothers who are separated from their infants** and make the points that follow:



- Sometimes a baby has to be separated from his mother, because he is ill, or of low-birth-weight, and he needs special care.
- While they are separated, a mother needs a lot of help and support.
- She needs help to express her milk as you see a mother doing here. This is necessary both to establish and maintain lactation, and to provide breast milk for her baby.
- She may need help to believe that her breast milk is important, and that giving it will really help her baby. She needs help to get her baby to suckle from her breast as soon as he is able.

- Show **Slide 25/12 - Feeding after a caesarean section** and make the points that follow:



- A common reason for babies to be separated from their mothers in some hospitals is after a caesarean section.
- It is usually possible for a mother to breastfeed within about four hours of a caesarean section - as soon as she has regained consciousness.
- Exactly how soon depends partly on how ill the mother is, and partly on the type of anaesthetic used. After epidural anaesthesia, a baby can often breastfeed within 30 minutes-1 hour.

Ask: Does a baby need a feed while he waits for his mother to breastfeed him?

Wait for a few replies and then continue.

- A healthy, term baby usually needs no food or drink before his mother can feed him. He can wait a few hours until she is ready.

Show **Slide 25/13 - Step six** and make the points that follow:

25/13

Step six

Give newborn infants no food or drink other than breast milk, unless medically indicated

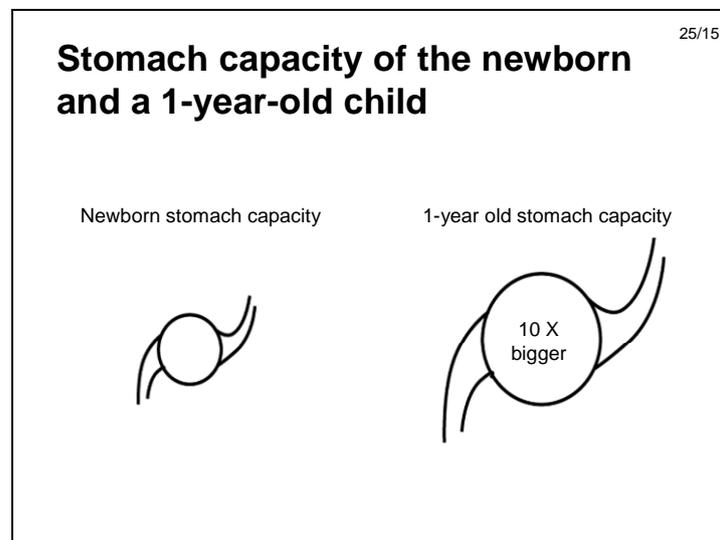
Show **Slide 25/14 - Prelacteal feeds** and make the points that follow:



- This baby is being given an artificial feed from a bottle, before starting to breastfeed.
- Any artificial feed given before breastfeeding is established is called a prelacteal feed.
- Prelacteal feeds replace colostrum as the baby's earliest feed. The baby is more likely to develop infections such as diarrhoea.

- If milk other than human milk is given to the baby he is more likely to develop intolerance to the proteins in the feed.
- A baby's hunger may be satisfied by prelacteal feeds so that he wants to breastfeed less.
- If a baby has even a few prelacteal feeds, his mother is more likely to have difficulties such as engorgement. Breastfeeding is more likely to stop early than when a baby is exclusively breastfed from birth.
- Many people think that colostrum is not enough to feed a baby until the mature milk 'comes in'. However, the volume of an infant's stomach is perfectly matched to the amount of colostrum produced by the mother.

Show **Slide 25/15 - The perfect match** and make the points that follow:



- This photo shows that the volume of a newborn's stomach is approximately 10 times smaller than that of a one-year-old child. The newborn does not need large quantities of milk in the first few days. Colostrum is sufficient.
- Make the following points:
- Step six says that no food or drink should be given to newborn infants unless medically indicated.
 - If a mother has been counselled, tested and found to be HIV-positive and has decided not to breastfeed, this is an acceptable medical reason for giving her newborn infant other milks in place of breast milk.
 - Even if many mothers are giving replacement feeds, this does not prevent a hospital from being designated as baby-friendly, if those mothers have all been counselled and offered testing, and have made a genuine choice.

- Show **Slide 25/16 - Step seven** and make the points that follow:

25/16

Step seven

Practise rooming-in: allow mothers and infants to remain together 24 hours a day

- Show **Slide 25/17 - Rooming-in** and make the points that follow:



Ask: What are the advantages of rooming-in or bedding-in?

Wait for a few replies and then continue.

- Rooming-in has these advantages:
 - it enables a mother to respond to her baby and feed him whenever he is hungry. This helps both bonding and breastfeeding
 - babies cry less so there is less temptation to give bottle feeds
 - mothers become confident about breastfeeding
 - breastfeeding continues longer after the mother leaves hospital

- All healthy babies benefit from being near their mother, rooming-in or bedding-in.
- Mothers who are HIV-positive do not need to be separated from their babies. General mother-to-child contact does not transmit HIV.

Show **Slide 25/18 - Step eight** and make the points that follow:

25/18

Step eight

Encourage breastfeeding on demand

Show **Slide 25/19 - Breastfeeding on demand** and make the points that follow:



Ask: What does breastfeeding on demand mean?

Wait for a few replies and then continue.

- Breastfeeding on demand means breastfeeding whenever the baby or mother wants, with no restriction on the length or frequency of feeds.

Ask: What are the advantages of breastfeeding on demand?

Wait for a few replies and then continue.

- Breastfeeding on demand has these advantages:
 - . There is earlier passage of meconium.
 - . The baby gains weight faster.
 - . Breast milk 'comes in' sooner and there is a larger volume of milk intake on day 3.
 - . There are fewer difficulties such as engorgement.
 - . There is less incidence of jaundice.
- A mother does not have to wait until her baby is upset and crying to offer him her breast. She should learn to respond to the signs that her baby gives, for example rooting, which show that he is ready for a feed.

Ask: What would you suggest to a mother about how long she should let her baby suckle?

Wait for a few replies and then continue.

- Let a baby suckle as long as he wants, provided he is well attached.
- Some babies take all the breast milk they want in a few minutes; other babies take half an hour to get the same amount of milk, especially in the first week or two. They are all behaving normally.

Ask: Would you suggest that a mother lets her baby suckle from one breast, or from both breasts at each feed?

Wait for a few replies and then continue.

- Let her baby finish feeding on the first breast, to get the fat-rich hindmilk. Then offer the second breast, which he may or may not want.
- It is not necessary to feed from both breasts at each feed. If a baby does not want the second breast, his mother can offer that side first next time, so that both breasts get the same amount of stimulation.
- This step is still important for babies who are receiving replacement milk. Their individual needs should be respected and responded to for both breastfed and artificially fed infants.

Show **Slide 25/20 - Step nine** and make the points that follow:

25/20

Step nine

Give no artificial teats or pacifiers* to breastfeeding infants

* also called dummies and soothers

Show **Slide 25/21 - Nipples, teats and dummies** and make the points that follow:



- Teats, bottles and pacifiers can carry infection and are not needed, even for the non-breastfeeding infant.
- Cup-feeding is recommended, as a cup is easier to clean and also ensures that the baby is held and looked at while feeding. It takes no longer than bottle feeding. You will remember that we learnt about cup feeding in Session 16.
- If a hungry baby is given a pacifier instead of a feed, he may not grow well.

- Babies can be encouraged to suck on the mother's clean finger or other body areas other than the nipple, if not breastfeeding.
- In this picture you see a low-birth-weight baby being fed from a cup. We will discuss more about low-birth-weight babies later in the course.

Show **Slide 25/22 - Step ten** and make the points that follow:

25/22

Step ten

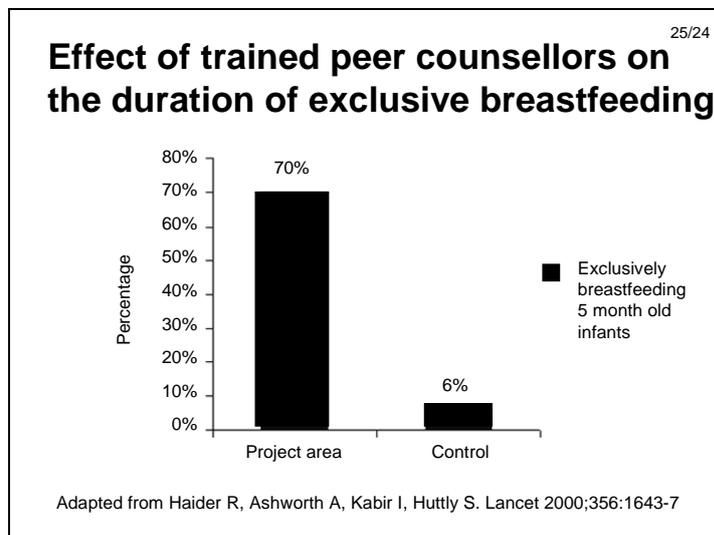
Foster the establishment of breastfeeding support groups and refer mothers to them on discharge from hospital or clinic

Show **Slide 25/23 - Support group** and make the points that follow:



- The key to best breastfeeding practices is continued day-to-day support for the breastfeeding mother within her home and community
- Those who support breastfeeding mothers in the community do not have to be medically trained personnel.
- There is a lot of research which shows the effect of trained peer or lay counsellors on the duration of exclusive breastfeeding. These counsellors visit the mothers in their homes after discharge from the clinic or hospital, and support them to continue breastfeeding.

- Show **Slide 25/24 - Effect of trained peer counsellors** and make the following points:



- This graph shows how trained peer counsellors in Bangladesh increased the proportion of infants who were still exclusively breastfeeding at five months of age.
- 70% of those mothers who had received support from a peer counsellor were still exclusively breastfeeding at five months compared to 6% of those who had not had support (*Point this out on the graph*).
- Many mothers need support regardless of their feeding method. Mothers with HIV who are not breastfeeding in a community where most mothers breastfeed may need extra support from a group especially concerned with HIV.

III. Summarize the session

5 minutes

- Ask participants if they have any questions, and try to answer them.
- Explain that a summary of this session can be found on pages 145-152 of the *Participant's Manual*.

Further Information

Examination of women's breasts:

It is not essential to examine women's breasts routinely, because it is not often useful, and it can make a woman worry about them when she was quite confident before. However, it may be the policy in your health service to do so. If so, it gives you an opportunity to talk to the mother about breastfeeding. Almost always you will be able to reassure her that her breasts are good for breastfeeding.

Preparation of breasts for feeding:

Preparing breasts physically for breastfeeding is not necessary. Traditional ways of preparing the breasts, that are culturally important, may give a mother confidence. If you feel that they help mothers psychologically, there is no need to discourage them. If a mother has flat or inverted nipples, doing stretching exercises, or wearing nipple shells during pregnancy, does not help. Most nipples improve towards the end of pregnancy, and in the first week after delivery. A nipple that looked difficult in pregnancy, may not be a problem after the baby is born. The most important time to help a mother is soon after delivery. If a mother is worried about inverted nipples, explain that they will improve, and that you can help her to breastfeed. Explain about how a baby suckles from the breast behind the nipple, not from the nipple itself. If a mother has a problem with her breasts that you are not sure about, such as previous breast surgery, or burns, try to get help from someone more experienced. Meanwhile, it may help to encourage her that babies often can breastfeed from a breast which has had surgery, or that a baby can get enough milk from just one breast if necessary.

Bonding:

Participants may need to discuss bonding at some length. Allow time to discuss this if necessary. Mothers may not be aware of bonding happening immediately. Strong affectionate ties grow gradually. But early close contact gives them the best possible start. Separation makes bonding more difficult, especially in high risk families, for example, young mothers with poor support. However, the effects of early separation can be overcome, and bonding can also take place later, particularly during the first nine months of a baby's life. If initiation of breastfeeding is delayed, for example, if a mother or her baby is ill, or for cultural reasons, breastfeeding can still be successfully established. It is helpful if the mother and baby have prolonged skin-to-skin contact as soon as possible, and if the mother is well supported. However, separation and delay put bonding and breastfeeding at risk, and should be avoided.

Reasons why mothers and babies are separated in hospital:

There are four common reasons why mothers and babies are separated in hospital. The intentions behind them are often good, but the reasons themselves are unsound.

1. *To allow the mother to rest.*

Immediately after delivery, both mother and baby are usually alert and need close contact. After this period, they can rest quite well together.

2. *To prevent infection.*

There is no evidence that putting babies in nurseries reduces infection. On the contrary, it may increase cross-infection between babies, which can be carried by health care staff.

3. *A lack of space in the wards for cots.*

Administrators can often overcome the problem of space if they realise how important rooming-in is. In many hospitals, babies stay in the same bed with their mothers, so there is no need for extra space.

4. *To observe the baby.*

Health care staff can observe babies with their mothers just as well as in a nursery. Mothers observe their babies very closely, and they often notice something wrong before busy health care staff. There is no justification for separating mother and baby while waiting for a doctor to examine a baby.

Skin-to-skin contact and bacterial colonization:

Early skin-to-skin contact also enables harmless bacteria from the mother to be the first to colonize her baby. These harmless bacteria help to protect a baby against more harmful bacteria, such as those from the hospital and hospital staff.

Prophylaxis of eye infection:

It may be health service policy to put either silver nitrate drops or tetracycline ointment into the eyes of all newborns to prevent gonococcal and chlamydial infection, which can lead to blindness. To be effective, the treatment must be given within one hour of delivery. To minimize any interference with breastfeeding, allow the baby to suckle if possible before putting in drops or ointment. Tetracycline ointment may be preferable, because it is less irritating than silver nitrate drops.

Medical indications for giving artificial feeds:

Participants may want to discuss further the medical indications for giving artificial feeds.

There are rare exceptions during which the infant may require other fluids or food in addition to, or in place of, breast milk. The feeding programme of these babies should be determined by qualified health professionals on an individual basis.

The commonest reasons for giving prelacteal and supplementary feeds are:

- To prevent low blood sugar, or hypoglycaemia
- To prevent dehydration, especially if a baby is jaundiced, and needs phototherapy
- Because the mother's breast milk has not 'come in'.

Full-term, normal weight babies are born with a store of fluids and glycogen. Breastfeeding, which provides first colostrum and then mature milk, is all that they need. Sick or low-birth-weight babies may require special feeding, for example to prevent hypoglycaemia, or because they are unable to breastfeed. However even for these babies, breast milk is usually the best kind of feed to give. Babies who are jaundiced need more breast milk, which helps to clear jaundice. Other fluids, such as glucose water, do not help to clear jaundice, and are only needed if the baby is dehydrated. Acceptable medical reasons for supplementation or replacement feeding include: severe illness in the mother if breastfeeding is difficult to achieve; maternal medications such as anti-metabolites, radioactive iodine and some anti-thyroid drugs; absence of the mother; very low birth weight (<1500g) or born before 32 weeks gestational age (feeds are usually withheld for the first 24 hours); inborn errors of metabolism such as galactosaemia, PKU and maple syrup urine disease; sick infants in intensive care; severe dehydration and malnutrition.

Patterns of breastfeeding in the first few days:

Babies differ very much in how often they want to feed. These patterns are all normal. For the first 1-2 days, a baby may not want many feeds. Some babies sleep for 8-12 hours after a good feed. Provided a baby is warm and well and not low-birth-weight, and he has had at least one good breastfeed, it is not necessary to wake him at any fixed time for another feed. For the next 3-7 days, a baby may want to feed very often - as the milk supply becomes established. After that babies usually feed less often, but their habits continue to vary a lot. Any baby may want to feed more on some days and nights than on others.

Session 26

International Code of Marketing of Breast-milk Substitutes

Objectives

After completing this session participants will be able to:

- explain how manufacturers promote formula milks
- summarize the main points of the International Code of Marketing of Breast-milk Substitutes
- describe how the International Code of Marketing of Breast-milk Substitutes helps to protect breastfeeding
- explain the difficulties with donations of formula milk

Session outline

30 minutes

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

I.	Introduce the session	3 minutes
II.	Discuss how manufacturers promote formula	5 minutes
III.	Describe the International Code of Marketing of Breast-milk Substitutes	10 minutes
IV.	Discuss the difficulties with donations of formula	10 minutes
V.	Summarize the session	2 minutes

Preparation

- Refer to the Introduction for guidance on giving a lecture presentation and a demonstration.
- Make sure that Slides 26/1-26/3 are in the correct order. Study the slides and the text that goes with them so that you are able to present them.
- Ask two participants to read the words of the charity worker and Mrs P in DEMONSTRATION 26.A
- If possible gather some examples of promotional material from formula manufacturers.
- You will need a flipchart and marker.

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:
 - All manufacturers promote their products, to try to persuade people to buy more of them. Formula manufacturers also promote their products, to persuade mothers to buy more formula.
 - This promotion undermines women's confidence in their breast milk, and makes them think that it is not the best for their babies. This harms breastfeeding.
 - Breastfeeding needs to be protected from the effects of formula promotion. One essential way to protect breastfeeding is to regulate the promotion of formula, both internationally and nationally.
 - Individual health facilities and health workers can also protect breastfeeding, if they resist letting companies use them to promote formula. This is an important responsibility.

- Show **Slide 26/1 - Session 26 Objectives** and read out the objectives:

International Code of Marketing of Breast-milk Substitutes 26/1

After completing this session participants will be able to:

- explain how manufacturers promote formula milks
- summarize the main points of the International Code of Marketing of Breast-milk Substitutes
- describe how the International Code of Marketing of Breast-milk Substitutes helps to protect breastfeeding
- explain the difficulties with donations of formula milk

II. Discuss how manufacturers promote formula**5 minutes**

- Develop lists of ways in which manufacturers promote formula to the public and to health workers. You only have 5 minutes to complete this section so try and move through this quickly.

Ask: In what ways do manufacturers promote formula to the public?

Write on the board the title 'PROMOTION TO THE PUBLIC' and make a list of participants' ideas.

- The list should include most of the following:

- Manufacturers stock shops and markets with formula and feeding bottles, so that mothers can always see them when they go shopping.
- They give free samples of formula to mothers. Sometimes this is part of another gift. We know that even mothers who intend to breastfeed, are more likely to give up if they receive a free sample.
- They give coupons to mothers for a discount on formula.
- They advertise on radio, television, videos for hire, billboards, buses, and magazines.

Ask: In what ways do manufacturers use health workers and health facilities to promote formula?

Write on the board the title 'PROMOTION THROUGH HEALTH SERVICES' and make a list of participants' ideas.

- The list should include most of the following:

- They give posters and calendars to health facilities to display on the walls. These are very attractive and make the place look better.
- They give attractive information materials to health facilities to distribute to families. Often there are no other materials to give to families, and some of the information is useful.
- They give useful bits of equipment, such as pens or growth charts, with the company logo on it. Sometimes they give larger items such as television sets, or incubators to doctors or health facilities.
- They give free samples and free supplies of formula to maternity units.
- They give free gifts to health workers.
- They advertise in medical journals and other literature.
- They pay for meetings or conferences, workshops or trips, or they give free lunches for medical, nutrition, or midwifery schools.
- They fund and sponsor health services in many other ways, and give grants.

- If you have any examples of promotional material or free gifts from the manufacturers show these to the participants at the end of the session or during the next break.

III. Describe the International Code of Marketing of Breast-milk Substitutes 10 minutes

- Show **Slide 26/2 - The International Code** and make the points that follow:

26/2

The International Code

- 1981 World Health Assembly adopted The Code, which aims to regulate promotion and sale of formula
- The Code is a code of **marketing**
- The Code covers all breast-milk substitutes – including infant formula, other milks or foods, including water and teas and cereal foods which are marketed for infants under 6 months, and teats and bottles

- In 1981, the World Health Assembly (WHA) adopted The International Code of Marketing of Breast-milk Substitutes, which aims to regulate promotion and sale of formula. This Code is a minimum requirement to protect breastfeeding.
 - The Code is a code of marketing. It does not ban infant formula or bottles, or punish people who bottle feed. The Code allows baby foods to be sold everywhere, and it allows every country to make its own specific rules.
 - The code covers all breast-milk substitutes – including infant formula, any other milks or foods, including water and teas and cereal foods which are sometimes marketed as suitable for infants under six months of age, and also feeding bottles and teats.
- Ask participants to turn to page 154 of their Manuals and find the box SUMMARY OF THE MAIN POINTS OF THE INTERNATIONAL CODE. Ask participants to take turns to read out the points. With each point, ask participants to say if they have ever observed the Code being broken in this way.

SUMMARY OF THE MAIN POINTS OF THE INTERNATIONAL CODE

1. No advertising of breast-milk substitutes and other products to the public.
2. No free samples to mothers.
3. No promotion in the health service.
4. No company personnel to advise mothers.
5. No gifts or personal samples to health workers.
6. No pictures of infants, or other pictures idealizing artificial feeding, on the labels of the products.
7. Information to health workers should be scientific and factual.
8. Information on artificial feeding, including that on labels, should explain the benefits of breastfeeding and the costs and dangers associated with artificial feeding.
9. Unsuitable products, such as sweetened condensed milk, should not be promoted for babies.

Continue with the following points:

- Some people are confused and think that The Code no longer applies where there are women living with HIV who may choose to feed their infants artificially.
- However, The Code is still relevant, and it fully covers the needs of mothers with HIV.
- If formula is made easily available, there is a risk that women who are HIV-negative or who have not been tested, will want to use it. They may lose confidence in breastfeeding, and decide to feed their babies artificially. This spread is called 'spillover'.
- So implementing The Code, is in fact, even more important, both to protect HIV-positive mothers and to help prevent spillover.
- Supplies of breast-milk substitutes (where needed) should be distributed in a manner that is accessible and sustainable. They should be distributed in a way that avoids spillover to women who are breastfeeding.

IV. Discuss the difficulties with donations of formula 10 minutes

- Make these points:
 - You may have heard that some manufacturers and distributors have offered to donate formula for women who are HIV-positive. Let us look at what the Code says.

- Show **Slide 26/3 - Donated supplies** and read it out:

26/3

Donated supplies

“ Where donated supplies of infant formula ... are distributed ... the institution or organization should take steps to ensure the supplies can be continued as long as the infants concerned need them ”

- Under The Code and its subsequent resolutions these donations cannot be given through the health care system – that is, through maternity or paediatric wards, MCH or family planning clinics, private doctors’ offices and child care institutions.
 - The health system if it wishes can provide free or subsidized formula to HIV-positive mothers, but the health service has to **buy** the formula to give to mothers, in the same way that it does for most drugs and food for patients and other supplies.
 - In addition the health service should ensure that the mother will have a supply of formula for as long as her infant needs it – that is at least 6 months – and milk in some form after that.
 - If hospitals and health centres have to buy formula, as they usually buy drugs and food, it is more likely that they will ensure that it is given out in a carefully controlled way, and not wasted or misused. Formula is more likely to be given only to mothers who are HIV-positive, who have been counselled and who have chosen to use formula.
- Ask the two participants whom you prepared to give DEMONSTRATION 26.A to read the words of the charity worker and Mrs P.

- Introduce the role-play by making these points:
- Mrs P has been counselled about HIV and about infant feeding, and has decided to use formula. The counsellor has referred her to a charity organization to obtain free supplies of formula. She is talking to the charity worker who is **not** a counsellor.

DEMONSTRATION 26.A DONATIONS OF INFANT FORMULA

Charity Worker: “Good morning Mrs P, how can I help you?”

Mrs P: (Nervous and embarrassed – looks around to see if anyone is observing her. Gives Charity Worker a letter)
 “Good morning, madam. The counsellor at the health centre gave me this letter to give you – she said that I can get some formula here to feed my baby, as I can’t afford to buy any.”

Charity Worker: “Oh yes, I understand. Of course we can help you. I will give you these four tins of FatBoy 1, which the FatCat milk company donated to us. This should be enough for one month. You learnt how to make it up in hospital, didn’t you? Next time you go for the baby to be weighed, she will give you another note, and you can come back for more formula.”

Mrs P: “Thank you. I was so worried about how I would afford the tins. We have so little money. Now I know that I will have enough to feed my baby.” (*Mrs P leaves*)

Trainer: **Mrs P returns to the charity worker one month later.**

Mrs P: “Good morning – my baby is growing well on the formula that you gave me one month ago, but it is nearly finished, so I need some more.”

Charity Worker: “Oh dear, I am so sorry. I am afraid that we are out of stock at the moment, and we just don’t have anything that we can give you. No more supplies have arrived – and all the last delivery has been given out. I don’t know what to suggest – I am really sorry, but there is nothing I can do. Can you come back next week? Perhaps some will have arrived.”

Mrs P: (crying) “What can I do now? My breast milk has dried up, and I have no money to buy milk. How can I feed my baby?”

Session 27

Counselling Cards and Tools Counselling Scenarios

Objectives

After completing this session, participants will be able to:

- counsel HIV-positive women on infant feeding options, using the cards, flow chart and take-home flyers.

Session outline

120 minutes

Participants are all together for a demonstration by one trainer; followed by group work with all trainers.

- | | | |
|------|---|------------|
| I. | Introduce the session | 5 minutes |
| II. | Review the Flow Chart, Cards 1-6 and take-home Flyers | 20 minutes |
| III. | Review Card 7 (Assessing the mother's situation) | 10 minutes |
| IV. | Facilitate the counselling practice (small groups) | 85 minutes |

Preparation

- Refer to the Introduction for guidance on how to give a demonstration.
- You will need:
 - For each group, 1 copy of Counselling Stories 1-4 on pages 360-361.
 - For each participant, 1 copy of the Flipchart which includes the Flow Chart and all the Counselling Cards and 1 set of take-home Flyers. NOTE: these tools should be distributed at the beginning of the Course and participants should be asked to read them before this session.
- For DEMONSTRATION 27.A: Ask two trainers to do this demonstration. This requires a lot of practice as they will demonstrate the use of the Counseling Cards to the participants. They should have practised this several times before this session.
- Prepare two flipcharts with the lists of Counselling Skills, one with a list of LISTENING AND LEARNING SKILLS, the other with a list of BUILDING CONFIDENCE AND GIVING SUPPORT SKILLS.
- Make sure Slide 27/1 is ready. As there is only one slide, you might prefer to read aloud the objectives without projecting them onto the screen.

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 27/1 - Counselling cards and tools** and read out the objectives:

27/1

Counselling cards and tools

After completing this session participants will be able to:

- counsel women with HIV on infant feeding options, using the cards, flow chart and take-home flyers

- Make these points while showing each of the tools:
 - The first set of tools we will look at is a Flipchart that includes a flow chart illustrating the counselling process and counselling cards to be used during one-to-one sessions with pregnant women and/or mothers.
 - The second tool is a set of take-home Flyers for mothers on how to practise safely the chosen feeding options.
 - The third tool is a Reference Guide to provide additional technical information for you, the counsellors.
 - The Flow Chart included in the flipchart helps you to work through options with a woman in a logical way. It is important that a woman is not overwhelmed with many choices and given little time to express her own feelings.

II. Review the Flow Chart and Cards 1 to 6**20 minutes**

- Ask participants to look at the cards which were handed out earlier in the course. Explain how to use the Flow Chart and Cards 1 to 6 in turn. Hold the card up and ask the participants to find, and study, their own card as you explain it.
 - The first page is a **Flow Chart** of the recommended steps to follow for HIV and infant feeding counselling. On the left-hand side there are some simple instructions for how to use the flow chart, depending on the type of session (first session, follow-up) and whether the woman is pregnant or her baby is already born. Each of the cards we will now look at has a step number which fits in with the steps on the flowchart.
 - **Card 1** is called 'The risk of mother-to-child transmission'. Use this card to help you to explain to a woman the chances of her child being infected. Remember from Session 17, if all the mothers of the babies shown are HIV-positive, three of the babies are likely to get HIV through breastfeeding.
 - **Cards 2-6** illustrate the feeding options discussed in earlier sessions. Each card shows the advantages and disadvantages of one option.
 - **Card 2** is called 'Advantages and disadvantages of commercial infant formula'.
 - **Card 3** is called 'Advantages and disadvantages of exclusive breastfeeding'. Exclusive breastfeeding for the first few months is one option for a woman to consider when replacement feeding is not acceptable, feasible, affordable, sustainable or safe.
 - **Card 4** shows 'Advantages and disadvantages of expressing and heat-treating breast milk.'
 - **Card 5** shows 'Advantages and disadvantages of wet-nursing'. Another woman who must be HIV-negative breastfeeds the baby, while the mother carries out all other kinds of feeding and care.
 - **Card 6** shows 'Advantages and disadvantages of home-modified animal milk'.
 - It is important to remember that a woman may choose one method to start with and then later change to another, depending on whether the conditions for replacement feeding are present.
 - Note that each card has several sections which are: 'use with', 'ask', 'main information', 'ask to probe and check understanding'.

III. Review Card 7 (Assessing the mother's situation) 10 minutes

- The table shown in **Card 7** should be used with mothers who are pregnant or have infants under six months old. It helps the counsellor to explore the woman's living conditions in order to help her choose the most suitable feeding method for her situation.
- The first step is to ask the woman about all of the things in the first column. For example: *Where do you get your drinking water?*
- Keep a mental note of the woman's responses to each question. You will use this information to help her choose a feeding option.
- This table is not designed as a scoring tool or to make the mother's choice for her. The mother should choose the method herself after learning the advantages and disadvantages of each method.
- When you use the cards it is important to use your counselling skills and not to tell a woman what to do. Do not simply read out the points on the card. It is important to use open questions, to listen and learn from the woman and to support her in the choice she makes.
- It may take a woman more than one counselling session to make up her mind about the feeding option she will choose. It is important for you to give the woman as much time as she needs and not to force her to make a decision when she is not ready.

IV. Practise counselling skills 85 minutes

- Two other trainers now demonstrate how to use the counselling tools. One of the trainers plays the part of an infant feeding counsellor and the other the part of a pregnant woman. The trainer leading Session 27 will make the comments (written in bold) during the role-play.
- Introduce the role-play to the participants by making these points:
 - We will now see a demonstration of how to use these tools. Imagine that a pregnant woman has recently tested positive for HIV. She has come to see the counsellor to discuss her options for feeding her baby.
 - First we will see the opening of the counselling session, before the counsellor reaches Step 1.

DEMONSTRATION 27.A COUNSELLING ON INFANT FEEDING CHOICES

Counsellor: “Hello (woman’s name). Thank you for coming to talk to me about ways you could feed your baby. We want to help you to make a choice which is best for you, in your situation, and which gives the best chance for your baby to remain healthy.”

Comment: Here the counsellor introduces the session, explaining that the purpose is to help the mother to make an appropriate feeding choice. The counsellor also emphasizes the idea that we want a healthy baby. In many cases we have to balance the risks of HIV transmission with the risk of a baby getting very sick from diarrhoea or pneumonia.

Now we will see the counsellor moving to Step 1: “explain the risks of mother-to-child transmission.”

Counsellor: “What have you heard about the ways in which HIV can be transmitted from a mother to her baby?”

Woman: “Well, I know that the baby can be infected during birth, and if I choose to breastfeed.”

Counsellor: “It is true that babies may get HIV in these ways. Let me show you a picture which may help you to understand.”

Show Card #1 to the woman

Comment: The counsellor shows Card #1.

Counsellor: “What do you see in this picture?”

Woman: “I see some babies, and some of them have different coloured shirts on.”

Counsellor: “This card shows 20 babies born to HIV-positive women. As you mentioned HIV can be passed to the baby at three stages: during the time you are pregnant, during delivery and during breastfeeding. The babies with white shirts are the babies that will NOT be infected at all. The babies with black shirts were already infected with HIV through pregnancy and delivery. The babies with grey shirts are the ones who may be infected with HIV through breastfeeding.”

Woman: “So don’t all babies get HIV through breastfeeding?”

Counsellor: “No – as you see most of them will not be infected. Some things can increase the risk of passing HIV through breastfeeding. For example, there is a higher chance if you have been recently infected with HIV or if you breastfeed for a long time. There are ways of reducing the risk of transmission by practising a feeding option that is appropriate for your situation. What other questions do you have about what I have just told you?”

Woman: “I think I understand. I am relieved to hear that not all babies are infected through breastfeeding”

Comment: How did the counsellor introduce the risk of mother-to-child transmission?

Wait for a few replies, and then explain:

She used an open question to assess the mother’s understanding of the risk. She said: “What have you heard about the ways in which HIV can be transmitted from a mother to her baby?”

This is a useful way to introduce the concept of risk.

Now the counsellor moves to Step 2 of the Flow Chart. She will explain the advantages and disadvantages of different feeding options starting with the mother’s initial preference.

Counsellor: “There are various ways you could feed your baby. Is there any particular way you have thought of?”

Woman: “Well, now that I know not all babies are infected through breastfeeding, can we talk about that first, as I breastfed my other children?”

Counsellor: “Yes, what do you see in this picture?”

Show Card #3 to the woman

Comment: **At this point the counsellor shows Card #3 to the woman to help explain the next points.**

Woman: “I see a mother breastfeeding her baby, and someone trying to give her baby a bottle. The mother seems to be refusing.”

Counsellor: “Yes, this is about exclusive breastfeeding. What do you think exclusive breastfeeding means?”

Woman: “Well, I’m not sure, but I saw something about it on a poster once.”

Counsellor: “Yes, there are a lot of posters about exclusive breastfeeding these days. Exclusive breastfeeding means giving only breast milk and no other drinks or foods, not even water. Exclusive breastfeeding for the first few months may lower the risk of passing HIV, compared to mixed feeding. Breastfeeding is a perfect food because it protects against many illnesses. Also, it prevents a new pregnancy. On the other hand, as long as you breastfeed, there is some chance that your baby might get HIV.”

Comment **At this stage the counsellor would go through the other advantages and disadvantages of exclusive breastfeeding with the mother using Card #3.**

Counsellor: “How do you feel about breastfeeding now?”

Woman: “Oh, well, I could think about it. I’d still be worried about the baby getting HIV, though. Could you tell me about formula feeding?”

Comment: **The counsellor will discuss the questions and messages on Card #2, using counselling skills. Let us imagine that she has done this.**

Note that the counsellor has discussed the two main options: exclusive breastfeeding and infant formula.

Counsellor: “How do you feel about infant formula?”

Woman: “I’m not sure. My husband really wants me to breastfeed but I think I would like to try formula. If I start formula could I change back later?”

Counsellor: “That is really difficult to do.”

Comment:	<p>The counsellor would discuss the two main : infant formula and exclusive breastfeeding.</p> <p>If neither of these options is feasible, then the counsellor will discuss other options that are suitable and appropriate for the local area with the woman.</p> <p>It is important to be led by the mother's preferences, and not to overwhelm her with information in a series of lists. Leave time for a woman to ask questions and check she understands what is being discussed.</p> <p>Imagine the different feeding options have been discussed with the woman. Now the counsellor moves to Step 3: Explore with the woman her home and family situation.</p>
<i>Counsellor:</i>	"We have just discussed different feeding methods. After hearing all of this information, which method are you most interested in trying?"
<i>Woman:</i>	"I would like to use formula, since they give it for free here at the clinic."
Comment:	Note that this is not the final decision by the woman. She may change her mind at a later stage.
<i>Counsellor:</i>	"Let's think together about the things you will need in order for you to decide if formula is the best choice for you."
<i>Woman:</i>	"Yes, OK."
Comment:	The counsellor shows the woman Card #7.
<i>Counsellor:</i>	"Where do you get your drinking water from?"
<i>Woman:</i>	"We have a tap in our kitchen with clean water."
<i>Counsellor:</i>	"That's good – you need clean water to make formula. Can you prepare each feed with boiled water and clean utensils?"
<i>Woman:</i>	"That seems like too much work. Do I need to boil the water each time if we have clean water from the tap?"
<i>Counsellor:</i>	"Yes, it's recommended."
<i>Woman:</i>	"OK, well then....I guess I could manage. I could ask my niece to help me."
<i>Counsellor:</i>	"That's a good idea. What about preparing formula at night? Would you be able to do this two or three times each night?"
<i>Woman:</i>	"Can't I just prepare it before I go to bed and then just keep the bottle near the bed and use it all night?"
<i>Counsellor:</i>	"I understand why this might seem easier, but it's best to prepare the formula fresh for each feed. This will prevent your baby from getting sick....Perhaps we could talk about the cost of formula now?"
<i>Woman:</i>	"Oh, but I thought it was free?"
<i>Counsellor:</i>	"Even though you are getting the formula for free, you may run out before you can get more, or the clinic might temporarily run out. Formula costs about ----- per tin (INSERT LOCAL COST). If you had to buy 3 or 4 tins, could you afford do to this?"
<i>Woman:</i>	"Yes, my husband has steady work. We could find the money if we need to."
<i>Counsellor:</i>	"That's good. The cost is not too much of a problem if your husband is working. Does your husband know that you are HIV-positive?"
<i>Woman:</i>	"Yes, he does. He's HIV-positive too."

<i>Counsellor:</i>	"It must be difficult for you, but it can be helpful that you both know. What about the rest of your family?"
<i>Woman:</i>	"We haven't told anybody else. We are afraid of what they might say."
<i>Counsellor:</i>	"Oh, that must be a worry, In this case, how will your family feel if you don't breastfeed?"
<i>Woman:</i>	"My mother-in-law might get upset, since she breastfed all her children. She really thinks it's the best thing to do."
<i>Counsellor:</i>	"What reason do you think that you could give her for why you don't want to breastfeed?"
<i>Woman:</i>	"Maybe I could tell her that I am taking some medicine which will affect the breast milk. That happened to our neighbour last year."
<i>Counsellor:</i>	"Do you think that your mother-in-law would accept this explanation? Or would she insist that you breastfeed?"
<i>Woman:</i>	"I think that she would accept it. That neighbour is a friend of hers, and her baby is doing OK."
Comment:	At this stage the counsellor would ask the woman if she would like to go through any other feeding options and whether she has any questions. The counsellor then moves to Step 4: "Help the woman choose an appropriate feeding option."
<i>Counsellor:</i>	"We have talked about many things today. After all we have discussed, what are your thoughts about how you might like to feed your new baby?"
<i>Woman:</i>	"I am so confused. There seem to be good things and bad things about each feeding option for me. What would you suggest that I do?"
<i>Counsellor:</i>	"Well, let's think through the different ways, looking at your situation. You have breastfed your other children and your mother-in-law wants you to breastfeed."
<i>Woman:</i>	"Yes, she does."
<i>Counsellor:</i>	"Also, your husband knows that you are HIV-positive, so perhaps he could support you to exclusively breastfeed ... On the other hand, you do have all the things needed for you to be able to prepare formula feeds safely. You have clean water, fuel, and money to buy the formula."
<i>Woman:</i>	"That's right"
<i>Counsellor:</i>	"As your husband knows your status, he could help to support and to formula feed and perhaps talk to his mother."
<i>Woman:</i>	"Mmm. I would like to think more about this and discuss it with my husband. But I think I would like to give formula feed to this baby. I could explain to my husband about what you have said. I think he'll understand."
Comment:	The counsellor did not tell the woman what to do. She summarized the reasons why the different feeding options would be suitable for her. The woman then made an initial choice, but will go home to discuss this with her husband. The counsellor would then go on to Step 5 – "Explain how to practise the chosen feeding options and provide a take-home flyer."

- Ask the participants if they have any questions about the role-play or the use of the counselling tools.

- Now split into groups of 3-4 participants with one trainer. Give each group a copy of Counselling Stories 1-4 (pages 360-361 of the *Trainer's Guide*). Each group should have a set of 4 stories, so that each participant can have a different one to practise with. Explain what the participants will do:
 - You will now use role-plays to practise counselling women on feeding choices.
 - You will work in groups of 3-4, taking turns to be a 'mother' or a 'counsellor' or observer. When you are the 'mother', use the story on your card. The 'counsellor' counsels you about your situation. The other participants in the group observe.

- The trainer for each small group should explain to the participants what they should do, making the following points:
 - **When you are the 'counsellor':** Greet the 'mother' and introduce yourself. Ask for her name and use it. Ask one or two open questions to start the conversation and to find out why she is consulting you. Use each of the counselling skills to encourage her to talk to you. Use the Cards to help you counsel the mother. Especially, use the Table to help her make her feeding choice based on her circumstances. If you feel comfortable, also use the relevant Cards and take-home Flyers on how to practise the chosen feeding option. When you use a card do not just read it. Use your skills to summarize the information without being prescriptive.

 - **When you are the 'mother':** Give yourself a name and tell it to your 'counsellor'. Answer the counsellor's questions from your story. Don't give all the information at once. If your counsellor uses good listening and learning skills, and makes you feel that she is interested, you can tell her more.

 - **When you are observing:** Use your COUNSELLING SKILLS CHECKLIST. Observe which skills the counsellor uses, which she does not use, and which she uses incorrectly. Mark your observations on your list in pencil. After the role-play, praise what the counsellor does right, and suggest what she could do better.

- Trainers each sit with a group of 3-4 participants. Make sure that the participants understand the exercise and do it as intended – and that the 'mother' doesn't give all the information at once. At the beginning of the exercise, give participants a few minutes to read their stories. After each role-play, you lead the discussion. Then thank participants and praise them for their efforts. Make sure that all participants have a chance to practise. Try to encourage the 'counsellor' to guide the mother to a choice in Step 4, without telling her what to do. This is difficult to do and participants will need a lot of practice.

Counselling Story 1:

- You are 28 weeks pregnant with your first baby. You are a teacher, married to a lawyer. You live in your own house which has running water and electricity.
 - You were tested and found to be HIV-positive. You have not told your husband yet as you are worried about what he might think if you avoid breastfeeding. You are confused what to do, as you think you could manage to formula-feed.
 - You will take three months maternity leave when the baby is born and then go back to work. You will employ a nanny to look after the baby.
-

Counselling Story 2:

- You are 35 weeks pregnant with your second baby. You have been tested and found to be HIV-positive. You have not told anyone else at home that you are HIV-positive. You live with your partner, your sister and your mother.
- You breastfed your first baby – giving him breast milk and glucose water for the first two months of life. Then, at the suggestion of your mother, you introduced solids when he was three months of age as he started to cry a lot.
- You have to walk half a kilometre to collect water from a well. You have a paraffin stove, but sometimes use wood for fuel if you run out of money.
- Your mother receives a small pension. Your sister works part-time as a domestic worker. Neither you nor your partner are working.
- You are not sure how to feed this baby, but are frightened to disclose your status to your family.

Counselling Story 3:

- You are 39 weeks pregnant with your third baby. You found out you were HIV-positive when you were 28 weeks pregnant.
 - You work as a clerk in an office. You will be off work after you deliver for six weeks, and then you will return to your job. When you are working you are away from the house for 10 hours each day, and your mother-in-law will look after the baby.
 - You breastfed your other two children, giving them breast milk only for the first four weeks and then giving them breast milk and formula milk when you went back to work. You introduced solids at three months, whilst continuing to breastfeed at night until they were about one year of age.
 - You are married and live with your in-laws. Everyone in the family will expect you to breastfeed this baby. Only your husband knows your status. You are worried about anyone else suspecting that you are HIV-positive.
 - Your husband works as a mechanic. You have piped water to your kitchen and electricity to your home.
-

Counselling Story 4:

- You are 34 weeks pregnant. You have not been tested for HIV. This is your first visit to the antenatal clinic. Your husband has been very sick for a few months. You think that he may have AIDS and you are worried that you may be infected too. You have received information about preventing HIV infection and were encouraged to breastfeed.
- You have come to the infant feeding counsellor because you want to know how to get formula for your baby as you think that it will be safer than breastfeeding.
- Statements that you might use:
 - “My baby is due soon and I want to find out about getting infant formula for him.”
 - “I am really worried because my husband is ill – he has been sick for a long time now. I don’t know what the illness is, but it might be HIV so I think that I had better give my baby formula.”
 - “I think it would be better if I didn’t breastfeed at all - then the baby would be protected.”

Notes on stories for trainers to refer to during feedback.**Counselling story 1:**

This woman knows she is HIV-positive.

She has several of the conditions necessary to support replacement feeding. She has access to clean water and electricity; she has regular employment so could afford to buy formula milk; and will employ a nanny to look after her baby.

The main issue here is that she has not disclosed to her husband. She is worried about him finding out her status and worried that he might suspect she is HIV-positive if she avoids breastfeeding.

Counselling story 2:

This woman knows she is HIV-positive.

She does not have access to clean water or a regular supply of fuel (if she runs out of money she used wood). She does not have regular employment and relies on the small income from her mother's pension and her sister's part-time work as a domestic.

She has not disclosed her status to anyone and is frightened of them finding out.

She breastfed her last baby – but not exclusively. She gave glucose water during the first few weeks and introduced solids early.

This woman does not have the conditions necessary for safe replacement feeding. However, if she chooses to breastfeed she needs help and support to do this exclusively, as she has not had experience of this with her last baby.

Counselling story 3:

This woman knows she is HIV-positive and has disclosed only to her husband.

She has breastfed previously, although not exclusively.

She has electricity to her home, clean water in her kitchen and help from her mother-in-law. Both she and her husband work so they could afford to buy formula milk.

The main issue here is that the family expect her to breastfeed, and she is worried about disclosing her status by avoiding breastfeeding.

One option for this woman would be to exclusively breastfeed for the first 6 weeks, then to change to formula feeds when she returns to work.

Counselling story 4:

This woman does not know her HIV status.

She is worried that her husband might have AIDS because he is sick, but her husband has not been tested. So they are both of unknown HIV status.

Because she is worried that she might have HIV she thinks she should give formula feeds. So she has come to see the infant feeding counsellor.

The main issue here is that the woman does not know her status. She and her husband should be encouraged to test. However, if she does not wish to be tested she should be encouraged to exclusively breastfeed for the first six months and continue breastfeeding thereafter, as for an HIV-negative woman.

Session 28

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 complementary feeding activities.

Session outline

45 minutes

Participants are all together for a lecture presentation by one trainer, followed by group work with all trainers.

I.	Introduce the session	1 minutes
II.	Discuss sustaining breastfeeding	5 minutes
III.	Define complementary feeding	2 minutes
IV.	Discuss the optimal age to start complementary feeding	20 minutes
V.	Examine the role of the health worker and the health facility (group work)	15 minutes
VI.	Summarize the session	2 minutes

Preparation

- Refer to the Introduction for guidance on giving a presentation with slides.
- Make sure that Slides 28/1-28/8 are in the correct order. Study the slides and the text that goes with them so that you are able to present them.
- You need a flip chart and markers.
- Write up the two Key Messages from this session:
 - Key Message 1: Breastfeeding for two years of age or longer helps a child to develop and grow strong and healthy.*
 - Key Message 2: Starting other foods in addition to breast milk at six 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 flip chart 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 scrap paper for participants to write their recommendations on. These will be used again in Session 34.

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 six months of age until two years is of critical importance in the child's growth and development. You, as health workers, 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 feeds.

Ask: Write down the most frequent recommendations or information that you give to caregivers about feeding children aged 6-24 months.

After participants have written on any piece of scrap paper, collect these and give them to the trainer who is conducting session 34. We will come back to these recommendations in Session 34.

- Show **Slide 28/1 - Session 28 Objectives** and read out the objectives:

28/1

Importance of complementary feeding

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 complementary feeding activities

II. Discuss sustaining breastfeeding**5 minutes**

Ask: Why is it important to continue breastfeeding after six months?

Wait for a few responses and then continue.

- Make these points:
 - In Session 2 we discussed the importance of continued breastfeeding. From 6-12 months, breastfeeding continues to provide half or more of the child's nutritional needs, and from 12-24 months, at least one-third 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 the baby over six months old.

- Show **Slide 28/2 - Key Message 1: Breastfeeding** and ask a participant to read out the Key Message:

28/2

Key Message 1

Breastfeeding for two years or longer helps a child
to develop and grow strong and healthy

- 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 from 6-24 months. We will be looking at these recommendations in the following 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 28/3 - Definition of complementary feeding** and read out the definition:

28/3

Definition of complementary feeding

- Complementary feeding means giving other foods in addition to breast milk
- These other foods are called complementary foods

- These additional foods and liquids are called complementary foods, as they are additional or complementary to breastfeeding, 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

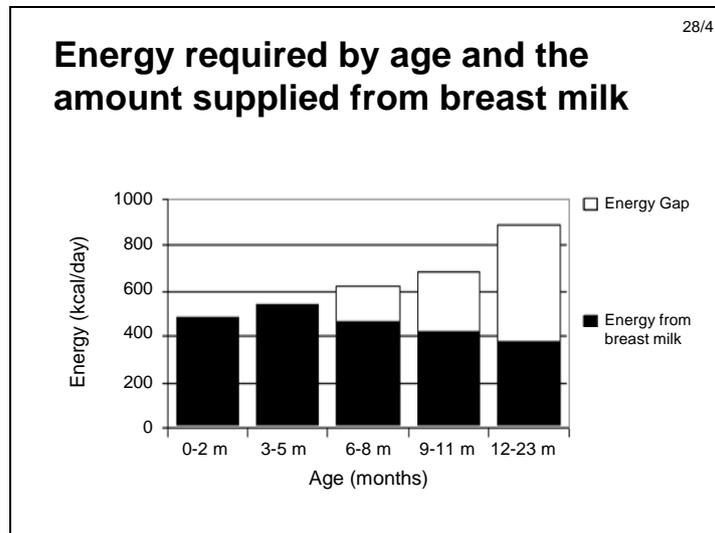
20 minutes

- 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 the baby is showing what they believe to be signs of hunger. Signs such as the baby putting his 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.
 - Complementary foods may be started because a baby under six 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 six completed months of age.¹

- Explain energy needs.
 - Our body uses food for energy to keep alive, to grow, to fight infection, 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.

¹ Six completed months – 180 days, not the start of the sixth month.

- Show **Slide 28/4 - Energy required by age and the amount supplied from breast milk** and make the points that follow:



- On this graph, each column represents the total energy needed at that 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 six 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 is 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, six months of age is a good time to start complementary foods. Complementary feeding from six completed months helps a child to grow well and be active and content.

- Show **Slide 28/5 - Key Message 2: When to start complementary feeding** and ask a participant to read out the Key Message:

28/5

Key Message 2

Starting other foods in addition to breast milk at 6 completed months helps a child to grow well

A black and white line drawing of a woman sitting on the floor, feeding a baby. The woman is wearing a headscarf and a short-sleeved shirt. She is holding a small bowl and a spoon, feeding the baby who is sitting in front of her. The baby is looking up at the woman. The woman's hands are positioned to feed the baby.

- After six months, babies need to learn to eat thick porridge, puree and mashed foods. These foods fill the energy gap more than liquids.
- At six completed months of age it becomes easier to feed thick porridge 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.

Ask: What might happen if complementary foods are started too soon (before six months)?

Write participants' replies on the flip chart. Refer to the points they made as you make the following points.

Show **Slide 28/6 - Adding foods too soon** and make the points that follow:

28/6

Starting other foods too soon

Adding foods too soon may:

- take the place of breast milk
- result in a low nutrient diet
- increase risk of illness
 - less protective factors
 - other foods not as clean
 - difficult to digest foods
- increase mother's risk of pregnancy

- 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
 - . increase the risk of illness because less 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: What might happen to the child if complementary foods are started too late (older than six months)?

Write participants' replies on the flip chart. Refer to the points they made as you make the following points.

- Show **Slide 28/7 - Adding foods too late** and make the points that follow:

28/7

Starting other foods too late

Adding foods too late may

- result in child not receiving required nutrients
- slow child's growth and development
- risk causing deficiencies and malnutrition

- Starting complementary foods too late is also a risk because the child:
 - does not receive the extra food required to meet his/her growing needs
 - grows and develops more slowly
 - might not receive the nutrients to avoid malnutrition and deficiencies such as anaemia from lack of iron.

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 ten months old and has come to the health facility regularly for immunizations and health checks.

- Show **Slide 28/8 - Maria and mother** and introduce **EXERCISE 28.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 169 of your Manual (Page 376 of *Trainer's Guide*). Think about the health facility where you work. When a young child comes 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 overall health. Health is not only growth and development but also the ability to fight off illness, and 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 healthy children.

EXERCISE 28.A ASSESS YOUR PRACTICES				
Does this practice occur?	With all children	With some children	Does not occur	Comments
Weigh child				
Measure child's length				
Look at child's growth chart				
Discuss how the child is feeding				
Note on 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 nutrition-related activities occurring in your health facility

Least frequent nutrition-related activities occurring in your health facility

VI. Summarize the session**5 minutes**

- Ask participants if they have any questions or if there are points you can make clearer.
- 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 two years of age or longer helps a child to develop and grow strong and healthy.
 - Key Message 2: Starting other foods in addition to breast milk at six 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 165-170 of the *Participant's Manual*. The Key Messages are found at the back of the *Participant's Manual*.

Session 29

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 foods
- list the Key Message from this session.

Session outline

30 minutes

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

I.	Introduce the session	2 minutes
II.	Outline foods that can fill the energy gap	10 minutes
III.	Demonstrate using a thick consistency of food	10 minutes
IV.	Discuss ways to enrich foods	5 minutes
V.	Summarize the session	3 minutes

Preparation

- Refer to the Introduction for guidance on giving a presentation with slides.
- Make sure that Slides 29/1-29/5 are in the correct order. Study the slides and the text that goes with them so that you are able to present them.
- You need a flip chart and markers.
- Write up the Key Message from this session:
Key Message 3: Foods that are thick enough to stay in 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 if germinated flours or fermented porridge is 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 box on page 380. Practise the demonstration beforehand.
- Check if an IMCI food box for the variety of available foods has been developed for the country.

CONSISTENCY DEMONSTRATION EQUIPMENT

- 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 in the spoon when the spoon is tilted.
- Divide the cooked porridge into 2 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 porridge.
- A large eating spoon.
- Cleaning materials to tidy-up afterwards, including hand washing facilities.
- This session can be conducted with a second trainer 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 diluted) as the stomach size. The second portion should all fit in with none left over and the stomach full.

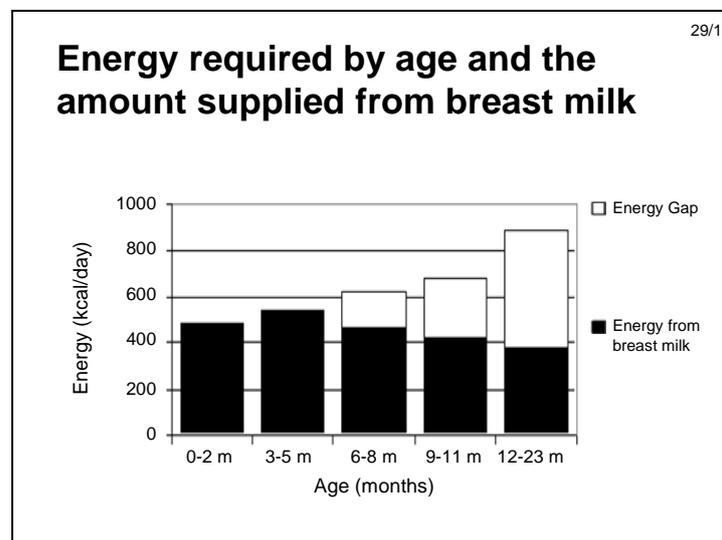
As you follow the text, remember:

- Indicates an instruction to you, the trainer
 - Indicates what you say to participants.

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 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 this graph of the energy needed by the growing child and how much is provided by effective breastfeeding.

 Show **Slide 29/1 - Energy gap** again and ask the question:

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.
- 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.

Show Slide 29/2 - Foods to fill the energy gap and read out the objectives:

29/2

Foods to fill the energy gap

After completing this session participants will be able to:

- list the local foods that can help fill this energy gap
- explain the reasons for using foods of a thick consistency
- describe ways to enrich foods
- list the Key Message from this session

II. Outline foods that can fill the energy gap

10 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. The staple 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 and breadfruit.

Ask: What are the main staples eaten in your community?

Wait for a few replies and then continue.

Write participants' replies on the flip chart.

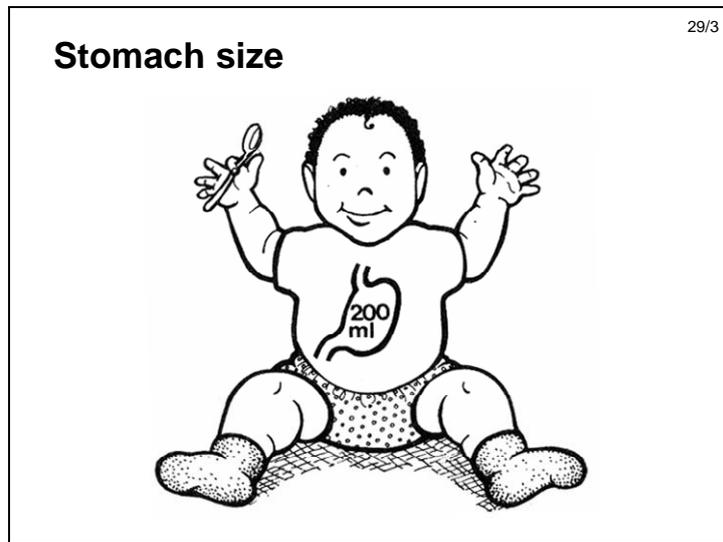
- All foods provide some energy. However, people generally eat large amounts of these staples and they provide much of the energy needed. Staples also provide some protein and other nutrients, but they cannot provide all the nutrients needed on their own. The staple must be eaten with other foods for 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 are the main staples 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 flip chart.
Ask: Which of these staples are given to young children?
Wait for a few replies and then continue.
Mark which staples are given to 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.
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 29/3 - Stomach size** and make the points that follow:



- This is (boy's name). He is eight 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.

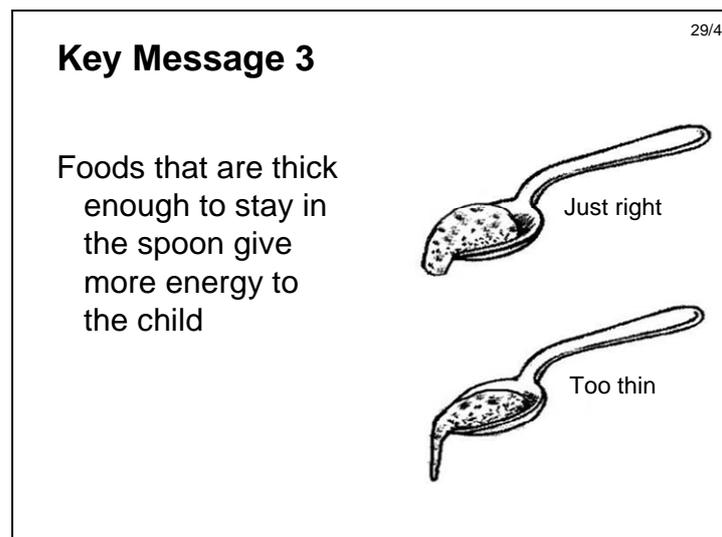
Ask: Can all this thick porridge fit in (name's) stomach?

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 need extra fluid to work. 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 29/4 - Key Message 3: Thick foods** and ask a participant to read out the Key Message:



IV. Discuss ways to enrich foods**5 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 little 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?

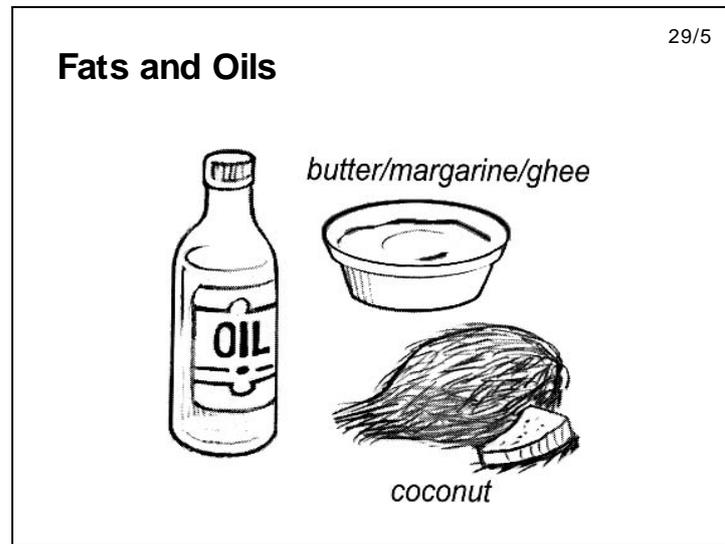
Wait for a few replies and then continue.
- Ask participants to turn to page 172 of their Manuals find the box WAYS TO ENRICH A CHILD'S FOOD. Ask participants to take it in turns to read out the points.

WAYS TO ENRICH A CHILD'S FOODS

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 as we just saw. 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 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 29/5 - Fats and oils** and make the points that follow:



- Ask participants to turn to page 173 of their Manuals and find the box FATS AND OILS. Ask participants to take it in turns to read out the points.

FATS AND OILS

- Oils and fats are concentrated sources of energy. A little oil or fat, such as one-half teaspoon, added to the child's bowl of food, gives 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 less 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 (see Session 2).
- For children over six months old, 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 30).

- ☐ **OPTIONAL:** If fermented porridge or germination of grain for flour is used in your area ask participants to turn to page 174 of their Manuals 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 is 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 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 if they have any questions or if there are points you can make clearer.
- Make these points:
 - In this session, we talked about the Key Message to help fill the energy gap.
 - We had one Key Message:
 - Key Message 3: Foods that are thick enough to stay in the spoon give more energy to the child.
- Display the flipchart pages 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 171-174 of the *Participant's Manual*.

Session 30

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

60 minutes

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

I.	Introduce the session	2 minutes
II.	Outline foods that can fill these gaps – Iron	5 minutes
III.	Discuss the importance of animal-source foods	5 minutes
IV.	Discuss the importance of legumes	5 minutes
V.	Discuss iron absorption	5 minutes
VI.	Outline foods than can fill these gaps – Vitamin A	5 minutes
VII.	Discuss the use of fortified complementary foods	10 minutes
VIII.	Discuss the fluid needs of the young child	5 minutes
IX.	Conduct EXERCISE 30.A: WHAT IS IN THE BOWL?	15 minutes
X.	Summarize the session	3 minutes

Preparation

- Refer to the Introduction for guidance on giving a presentation with slides.
- Make sure that Slides 30/1-30/6 are in the correct order. Study the slides and the text that goes with them so that you are able to present them.
- You need a flip chart and markers.
- Write up the 3 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.*
- 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.

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 30/1 - Session 30 Objectives** and read out the objectives:

Foods to fill the iron and vitamin A gaps

30/1

After completing this session participants will be able to:

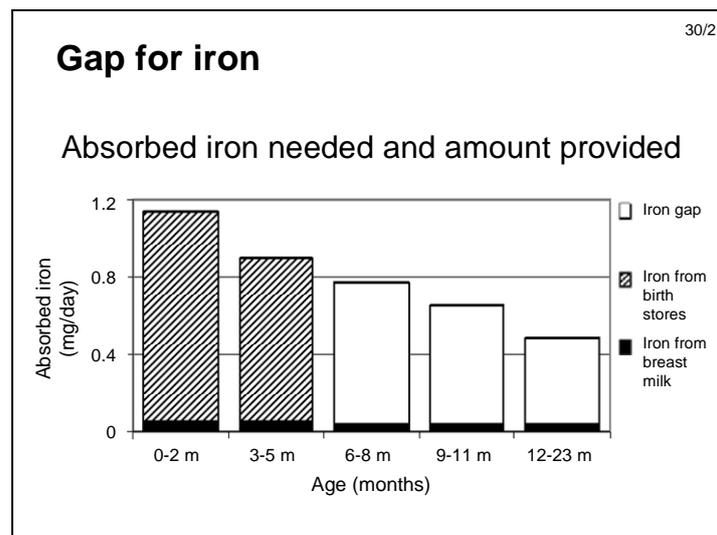
- list the local foods that can fill the nutrient gaps for iron and vitamin A
- explain the importance of animal-source foods
- explain the importance of legumes
- explain the use of processed complementary foods
- explain the fluid needs of the young child
- list the Key Messages from this session

II. Outline foods that can fill these gaps - Iron**5 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 30/2 - Gap for iron** and make these points:



- 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 his needs for the first six months (*Point to the striped/shaded 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 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 six 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 gap*).

Ask: What happens if the child does not have enough intake of iron to fill this gap?

Wait for a few replies and then continue.

- If the child does not have enough iron, the child will become anaemic, 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 they are eating foods 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 flip chart.
 - The flesh and organs of animals, birds and fish (including shell fish and tinned fish), are the best sources of iron and zinc.
 - Liver is not only a good source of iron but also of 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 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

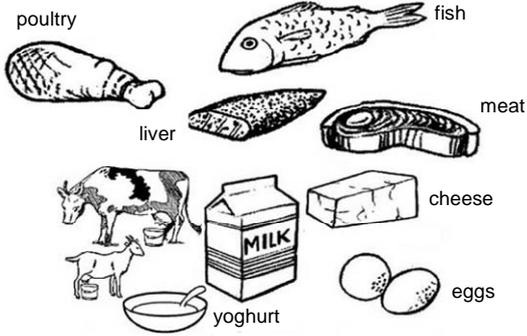
- Read the following section for all areas, whether meat is eaten or not. Make the following points:
 - Foods from animals such as milk and eggs are good for children because they are high in protein and other nutrients. However, milk and milk products, such as cheese and yoghurt, are not good sources of iron.
 - Milk fat (cream) contains vitamin A. Therefore, foods made from whole milk are good sources of vitamin A.
 - Foods made from milk (whole milk or skimmed or powdered) 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 30/3 (A or B) - Key Message 4: Animal-source foods** and ask a participant to read out the Key Message:

30/3

Key Message 4

Animal-source foods are especially good for children, to help them grow strong and lively



The illustration shows a variety of animal-source foods. At the top left is a poultry drumstick. Next to it is a piece of liver. To the right is a whole fish. Below the fish is a piece of meat. In the center is a carton of milk labeled 'MILK'. To the right of the milk is a block of cheese. Below the milk is a bowl of yoghurt. To the right of the yoghurt are two eggs. On the left side, there is a cow and a calf.

IV. Discuss the importance of legumes

5 minutes

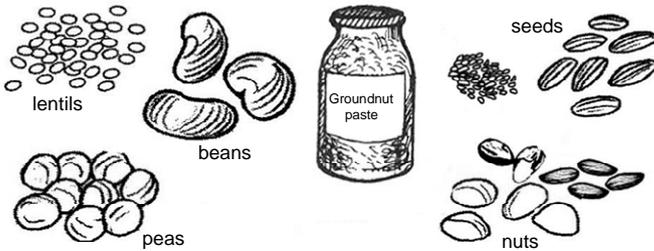
- Legumes or pulses such as beans, peas, and lentils as well as nuts and seeds, are good sources of protein. Legumes are a source of iron as well.

- Show **Slide 30/4 - Key Message 5: Legumes** and read out the Key Message:

30/4

Key Message 5

Peas, beans, lentils, nuts and seeds are also good for children



The illustration shows various legumes and nuts. On the left, there is a pile of lentils. Below them is a pile of peas. In the center, there are several beans. To the right of the beans is a jar of groundnut paste labeled 'Groundnut paste'. Further right, there is a pile of seeds. Below the seeds is a pile of nuts.

Ask: What types of legumes are used in the area?

Wait for a few replies and then continue.

List the replies on the flip chart.

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 way 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).

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 178 of their Manuals 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 anaemic).

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 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 high in fibre such as bran
- foods rich in calcium ¹

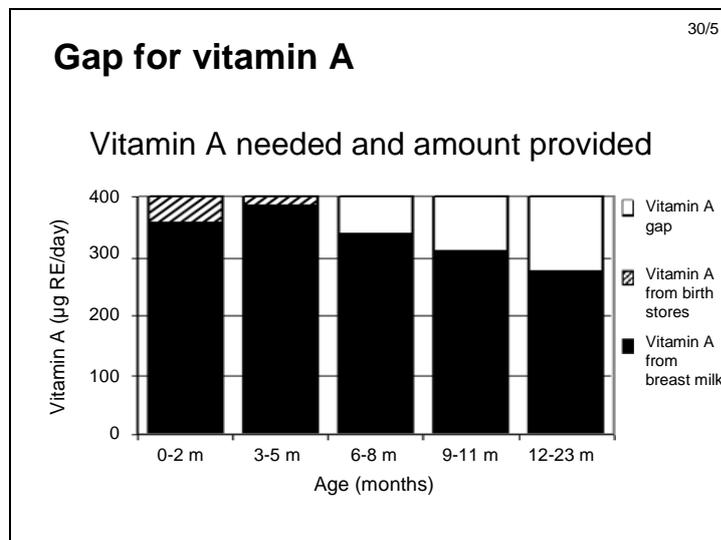
- Display the flip chart page with the Key Messages from this section and read them out. Keep these Messages displayed throughout the course.
 - We have two more Key Messages:
 - Key Message 4: Animal-source foods are especially good for children, to help them grow strong and lively.
 - Key Message 5: 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 these gaps – Vitamin A 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.

¹ Foods rich in calcium such as milk and cheese inhibit iron absorption, but are needed for calcium intake

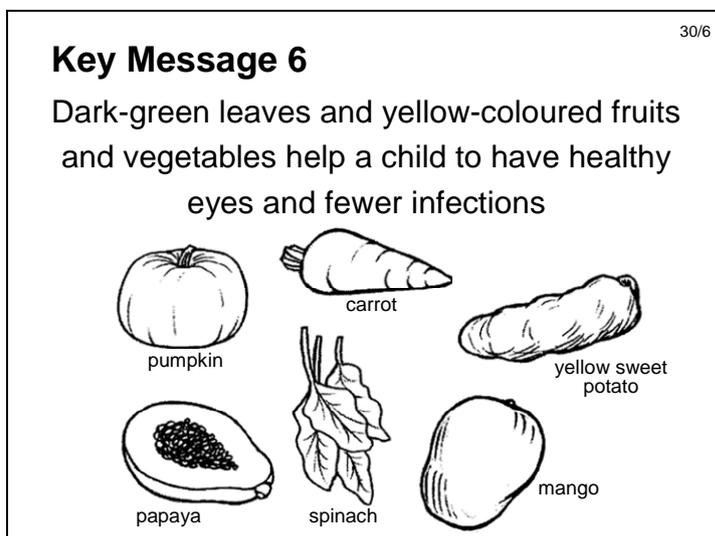
Show **Slide 30/5 - Vitamin A gap** and make the points that follow:



- 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 mentioned already were:
 - 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 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 help 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 IMCI (Integrated Management of Childhood Illness).
- If a programme for vitamin A supplementation exists in your area mention it here.

- Show **Slide 30/6 - Key Message 6: Vitamin A foods** and make the following points:

- When talking with caregivers, give this Key Message: Dark-green leaves and yellow-coloured fruits and vegetables help a child to have healthy eyes and fewer infections.



- Display the flip chart 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 cereal product 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, 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 180 of their Manuals and find the box FORTIFIED COMPLEMENTARY FOODS. Ask participants to take turns to read out the points.

FORTIFIED COMPLEMENTARY FOODS

When discussing fortified 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 six 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 and subsequent resolutions and should be reported to the company concerned and the appropriate government authority.

VIII. Discuss the fluid needs of the young child

5 minutes

- ☐ Make these points:
 - The baby who is exclusively breastfeeding receives all the liquid he needs in the breast milk and does not require extra water. Likewise, a baby who is under six months of age and only receiving replacement milks 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 between six and 24 months old?

Wait for a few responses and then continue.

- Ask participants to turn to page 181 of their Manuals 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 his 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 two 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 6-24 months of age 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.

IX. Conduct EXERCISE 30.A: WHAT IS IN THE BOWL?

15 minutes

- Ask the participants to sit in their groups. Ask them to turn to page 182 of their Manuals to EXERCISE 30.A – WHAT IS IN THE BOWL?
Explain the exercise:
 - Now we will put these recommendations or Key Messages into foods. 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 eat 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 if others might be used instead. Allow seven minutes to decide on the meal and why they choose each food. Remind participants that they can find a list of the Key Messages at the back of their 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.
- Thank participants at the end for their meal suggestions. Display the exercise sheets so the groups can see them.

EXERCISE 30.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 Key Messages you could give for the foods that you have chosen?

X. Summarize the session**3 minutes**

- Ask participants if they have any questions or if there are points that you can make clearer.
- 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 two years of age or longer helps a child to develop and grow strong and healthy.
 - . Key Message 2: Starting other foods in addition to breast milk at six months helps a child to grow well.
 - . Key Message 3: Foods that are thick enough to stay in 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 flip chart page with the 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 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.
- 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 175-182 of the *Participant's Manual*.

Session 31

Quantity, Variety and Frequency 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

45 minutes

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

I.	Introduce the session	2 minutes
II.	Discuss the importance of using a variety of foods	10 minutes
III.	Discuss the frequency of feeding complementary foods	10 minutes
IV.	Outline the quantity of complementary food to be offered	10 minutes
V.	Conduct EXERCISE 31.A: AMOUNTS TO GIVE	10 minutes
VI.	Summarize the session	3 minutes

Preparation

- Refer to the Introduction for guidance on giving a presentation with slides.
- Make sure that Slides 31/1-31/9 are in the correct order. Study the slides 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 common local cup, bowl or other containers.
- You need a flip chart and markers, and a means of fixing the flip chart page to the wall.
- Write the Key Messages for this session on a flip chart page. Keep covered until later in the session:

Key Message 7: A growing child needs 2-4 meals plus 1-2 snacks if hungry: give a variety of foods.

Key Message 8: A growing child needs increasing amounts of food.

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 have discussed what types of food help to fill the gaps in children over six 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 it¹.

- Show **Slide 31/1 - Session 31 Objectives** and read out the objectives:

Quantity, variety and frequency of feeding 31/1

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 foods to offer
- list the recommendations for feeding a non-breastfed child
- list the Key Messages from this session

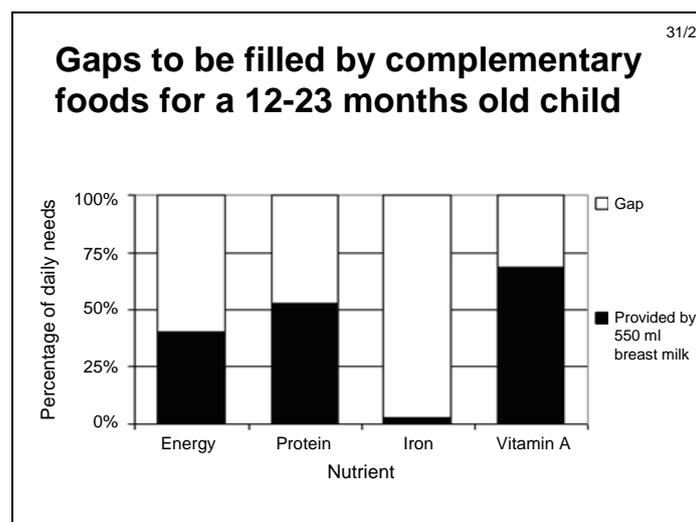
¹ They may also ask about how to feed a child who does not want to eat. How to feed will be discussed in a later session

II. Discuss the importance of using a variety of foods 10 minutes

☐ Make these points:

- Most adults and older children eat a mixture or variety of foods at mealtime. 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 31/2 - Gaps to be filled by complementary foods 12-23 month old child** and make the points that follow:

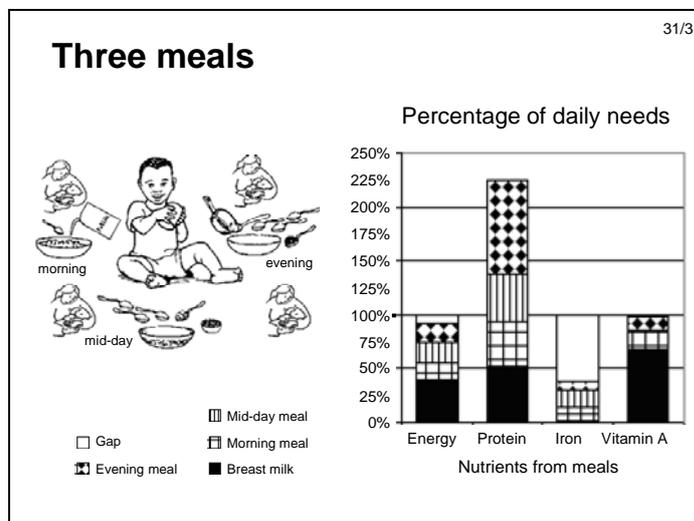


- In session 2 of this course we talked about the importance of breastfeeding and the nutrients breast milk can supply in the second year of life.
- On this graph the top line represents how much energy, protein, iron and vitamin A are needed by an 'average' child aged 12-23 months. The dark section 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.

☐ Show **Slide 31/3 - Percentage of needs** 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 breastfeeding² as well as eating complementary foods. The breast milk gives energy, protein, some iron and vitamin A (*Show where breast milk is on 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 graph*).
 - Midday:** A full bowl of food - Three big spoonfuls of rice, one spoon 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 graph*).
 - Evening:** A full bowl of food - 3 big spoons of rice, one spoon of fish, one spoon of green leaves (*Show where this meal is on graph*).

² Approximately 550 ml of breast milk per day

- (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: What do you see from the graph? Are these foods filling the gaps?

Wait for a few replies and then continue.

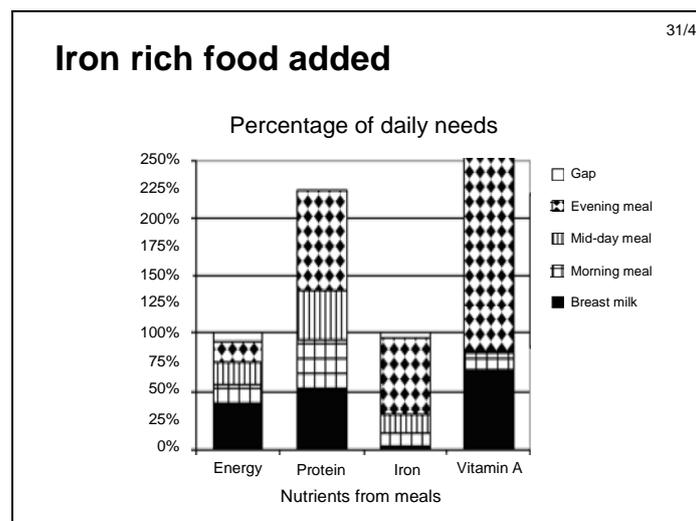
- The protein and vitamin A gaps are more than filled. However these meals do not fill this child's needs for iron or energy.

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 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.

Show **Slide 31/4 - 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 should be used to help fill the iron gap³.
- If an iron rich food is not available, you as the health worker may need to recommend using a micronutrient supplement to ensure he gets sufficient iron.
- Another nutrient that 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.

³ Remind participant of iron fortified foods if discussed in the previous session

- 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

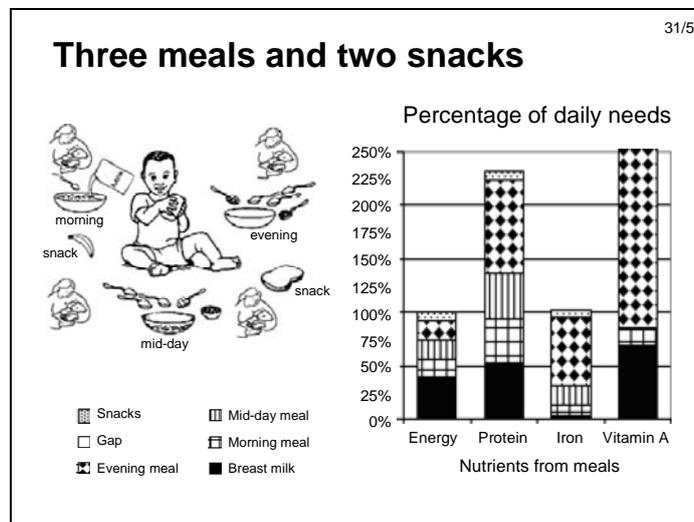
10 minutes

- ☐ 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 foods⁴, which may include the term snack foods in their name.
 - These extra foods may be easy to give, however the child still needs to be helped and supervised while eating to ensure the extra foods are eaten.
Ask: What kind of healthy snacks would be easy to feed this child?
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; cooked potatoes⁵, 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.

⁴ Give examples of local processed foods that might be called snack foods

⁵ Cooked moist foods (such as potatoes) should not be kept more than one hour if there is no refrigeration

- Show **Slide 31/5 - Percentage of needs with snacks**⁶ and make the points that follow:



- (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:

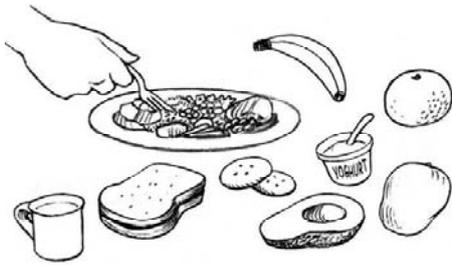
⁶ Liver instead of fish in evening meal

- Show **Slide 31/6 - Key Message 7: Frequency of feeding** and read out the Key Message:

31/6

Key Message 7

A growing child needs 2-4 meals a day plus 1-2 snacks if hungry: give a variety of foods



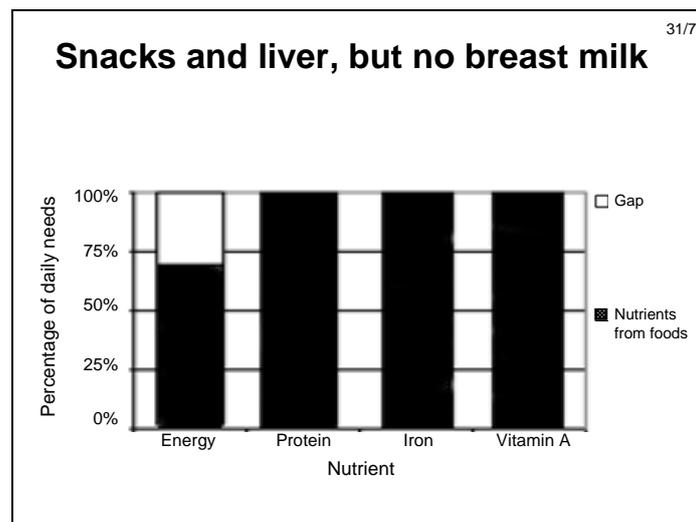
The illustration shows a hand using a spoon to feed a child from a plate. Surrounding the plate are various food items: a banana, an orange, a cup of milk, a sandwich, crackers, and a bowl of yogurt.

- 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 he gets sufficient food.

☐ Show **Slide 31/7 - 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 milk⁷) 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 his nutrient needs.
- A child who does not have breast milk needs special attention to ensure he receives sufficient food.
- Children over six months of age who are not receiving breast milk need 1-2 cups of milk (where one cup is equal to 250mls) 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 six months of age who are not receiving breast milk?

Wait for a few replies and then continue by displaying the next slide.

⁷ Infant formula if affordable, acceptable and available

- Show **Slide 31/8 - Recommendations for the non-breastfed child 6-24 months** and make the points that follow:

31/8

Recommendations for feeding the non-breastfed child from six months

The non-breastfed child should receive:

- extra water each day (2-3 cups in temperate climate and 4-6 cups in hot climate)
- essential fatty acids (animal-source foods, fish, avocado, vegetable oil, nut pastes)
- adequate iron (animal-source foods, fortified foods or supplements)
- milk (1-2 cups per day)
- extra meals (1-2 meals per day)

- 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, he needs 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, he progresses 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.

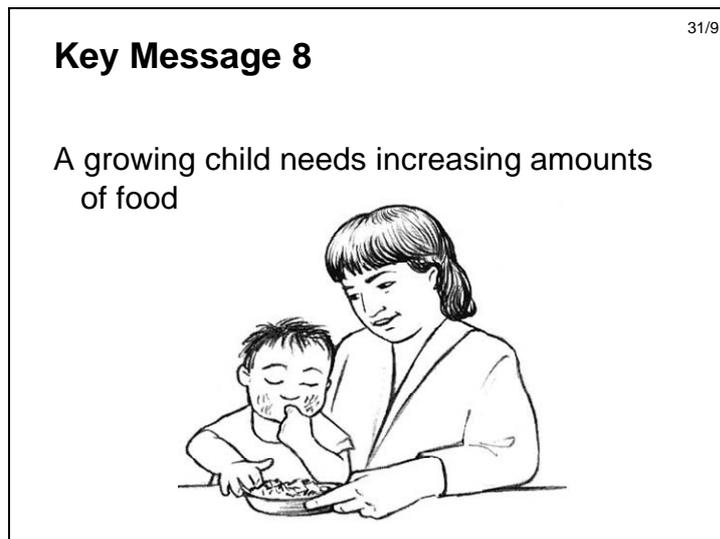
- Ask participants to turn to page 185 of their Manual and find the box AMOUNTS OF FOOD TO OFFER showing the age, texture of the food offered and the amount of food an average child will usually eat at each meal.
- Ask a participant to read out the first age group. Then ask another participant to read out the next age group until all the age groups are read out.

AMOUNTS OF FOODS TO OFFER			
Age	Texture	Frequency	Amount of food an average child will usually eat at each meal⁸
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	³ / ₄ to one 250 ml cup/bowl
If baby is not breastfed, give in addition: 1-2 cups of milk per day, and 1-2 extra meals per day.			

⁸ Adapt the chart to use a suitable local cup/bowl to show the amount. The amounts assume an energy density of 0.8 to 1 Kcal/g

- 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 encouragement⁹.
 - When you are talking with families, give this key message

- Show **Slide 31/9 - Key Message 8: Amount of food** and read out the key message:



IV. Conduct EXERCISE 31.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 two minutes to look again at the box on page 185 of your Manuals.

⁹ Active encouragement of feeding is discussed in session 34

- 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 31.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)	$\frac{3}{4}$ to 1 cup
8 months	Two to three times per day (may offer 1-2 snacks)	up to $\frac{1}{2}$ cup
12 months	Three to four meals (may offer 1-2 snacks)	$\frac{3}{4}$ to 1 cup
7 months	Two to three times per day (may offer 1-2 snacks)	up to $\frac{1}{2}$ cup
15 months	Three to four meals (may offer 1-2 snacks)	$\frac{3}{4}$ to 1 cup
9 months	Three to four meals (may offer 1-2 snacks)	$\frac{1}{2}$ cup
13 months	Three to four meals (may offer 1-2 snacks)	$\frac{3}{4}$ to 1 cup
19 months	Three to four meals (may offer 1-2 snacks)	$\frac{3}{4}$ to 1 cup
11 months	Three to four meals (may offer 1-2 snacks)	$\frac{1}{2}$ cup
21 months	Three to four meals (may offer 1-2 snacks)	$\frac{3}{4}$ 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.

V. Summarize the session

3 minutes

- Ask participants if they have any questions or if there are points that you can make clearer.
- 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.

Session 32

Building Confidence and Giving Support Exercises – Part 2

Objectives

After completing this session participants will be able to:

- demonstrate appropriate use of the confidence and support skills
- provide examples of each skill in relation to feeding of children 6-24 months.

Session outline

45 minutes

Participants work in groups of 8-10 with 2 trainers.

- | | | |
|-----|---|------------|
| I. | Introduce the session | 3 minutes |
| II. | Facilitate the written exercises (Exercises 32.a -32.f) | 42 minutes |

Preparation

- Refer to the Introduction for general guidance on how to conduct group work and facilitate written exercises.
- Make sure that Answer Sheets for Exercises 32.a-32.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 page 187 of their Manuals to find Exercises 32.a-32.f.
- Explain what they will do:
 - In Session 11 we practised the six Confidence and Support Skills with examples of breastfeeding mothers. We will now use these skills with mothers whose children are over six months of age and receiving complementary feeds.
 - Exercises 32.a-32.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 which 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 32.a Accepting what a mother THINKS

How to do the exercise:

Examples 1-2 are mistaken ideas which 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:	“You are worried about giving him milk?”	<i>Accepts</i>
“I am worried that my child will become a fat adult so I will stop giving him milk”.	“It is important that children have some milk in their diet until they are at least two years of age”.	<i>Disagrees</i>
	“Yes, fat babies tend to turn into fat adults.”	<i>Agrees</i>

To answer

1. Mother of a seven-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.”

Disagrees

“I see...”

Accepts

“Yes, sometimes babies do get full up on breast milk?”

Agrees

2. Mother of a 12-month-old child:

“My baby has diarrhoea so I must stop giving him any solids.”

“Yes, often foods can make the diarrhoea worse.”

Agrees

“You are worried about giving foods at the moment?”

Accepts

“But solids help a baby to grow and gain weight again – you must not stop them now.”

Disagrees

How to do the exercise:

Examples 3-4 are some more mistaken ideas which mothers might hold.

Make up a response that accepts what the mother says, without disagreeing or agreeing.

To answer:**Possible responses to accept what the mother thinks are:**

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 if your child is getting enough to eat?”

4. “I am worried about giving my one year old child family foods in case he chokes.”

“Mmm. You are concerned that he might choke.”

Exercise 32.b Accepting what a mother FEELS**How to do the exercise:**

After the Stories A, and B below, there are three responses.

Mark with a ✓ the response which shows acceptance of how the mother feels.

Example:

Edith's baby boy has not gained much weight over the past two months. As Edith tells you about it, she bursts into tears.

Mark with a ✓ the response which 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 A.**

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 B.

Susan is crying. Since starting complementary feeds her baby has developed a rash on his 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 32.c Praising what a mother and baby are doing right

How to do the exercise:

For Stories C and D below, make up a response which praises something the mother and baby are doing right.

Example:

A mother is giving her nine-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.

Suggestions (In your answer, you only need to give ONE answer)

“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 C.

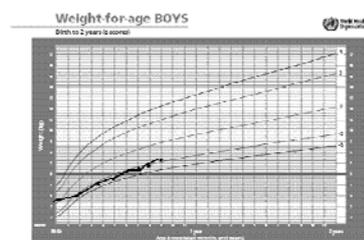
A 15-month-old child is breastfeeding and having thin porridge and sometimes tea and bread. He has not gained weight for six months, and is thin and miserable.

“It is good that you are continuing to breastfeed him at this age.”

Story D.

A nine-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 32.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 which corresponds to the information which is most relevant for her.

To answer:

Mothers 1-4

1. Mother with a seven-month-old baby a (b) c d
2. Mother with a 15-month-old baby
who is getting two meals per day a b (c) d
3. Mother with a 12-month-old baby
who thinks that the baby is too old to
breastfeed any longer a b c (d)
4. Mother of a non-breastfed child who
is 11 months old (a) b c d

Information

- a. Children need extra water at this age –
about 4-5 cups in a hot climate
- b. Children who start complementary
feeding at six completed months of age
grow well
- c. Growing children of this age need three to
four meals per day, plus one to two
snacks if hungry, in addition to milk.
- d. Breastfeeding to at least two years of age
help a child to grow strong and healthy

Exercise 32.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:**

Dark-green leaves and yellow-coloured fruit and vegetables are rich in vitamin A.

Using simple language:

“Dark-green leaves and yellow-coloured vegetables help the child to have healthy eyes and fewer infections.”

To answer:**Information:**

1. Breastfeeding beyond six months of age is good as breast milk contains absorbable iron, calories and zinc.

Using simple language:

“Breastfeeding to at least two 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 32.f Making one or two suggestions, not commands

How to do the exercise:

Below are some commands which you might want to give to a mother.
Rewrite the commands as suggestions.

Example:

Command:

“You must start complementary foods when your baby is six completed months old.”

Suggestions:

“Children who start complementary foods at six completed months grow well and are active and content.”

“Could you start some foods in addition to milk now that your baby is six completed months old?”

To answer:

Command:

Suggestions:

(In your answer, you only need to give ONE answer):

1. “You must use thick foods.”

“Family foods with a thick consistency nourish and fill the child.”

“Would you be able to use thicker foods?”

2. “Your child should be eating a full bowl of food by one 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 Session 32.
- If some participants are having difficulties with the exercises, or have not finished them, arrange to help them later.

Session 33

Gathering Information on Complementary Feeding Practices

Practice scenarios

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 FOOD INTAKE JOB AID, 6-23 MONTHS

Session outline

90 minutes

Participants are all together for a lecture presentation by one trainer, followed by small group work with all trainers.

I.	Introduce the session	2 minutes
II.	Demonstrate gathering information on feeding practices	30 minutes
III.	Practise gathering information using the FOOD INTAKE JOB AID, 6-23 MONTHS	55 minutes
IV.	Summarize the session	3 minutes

Preparation

- Refer to the Introduction for guidance on giving a presentation with slides.
- Make sure 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.
- You need a flip chart and marker.
- You need a typical bowl that a young child would use – one set for each group.
- Have ready copies of the FOOD INTAKE JOB AID, 6-23 MONTHS for the practice – one copy for each participant.
- Have ready pictures of different consistencies of foods – 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 participants or a trainer and a participant, to assist with DEMONSTRATION 33.A. Show them the text and forms. Ask them to read through it and to practise. The consistency pictures, a FOOD INTAKE JOB AID, 6-23 MONTHS, a bowl will be needed plus the growth chart.

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 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 13 you looked at the FEEDING HISTORY JOB AID, 0-6 MONTHS. You learnt how to take a feeding history.
 - Now we are going to look at assessing the intake of complementary feeds in detail.
- Ask participants to turn to page 67 of their Manuals to remind them of the FEEDING HISTORY JOB AID, 0-6 MONTHS.

- Show **Slide 33/1 - Session 33 Objectives** and read out the objectives:

33/1

Gathering information on complementary feeding practices

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 FOOD INTAKE JOB AID, 6-23 MONTHS

II. Demonstrate gathering information on feeding practices

30 minutes

- Make these points:
 - In Session 4 we 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 197 of their Manual and find the FOOD INTAKE JOB AID , 6-23 MONTHS (page 442 in *Trainer's Guide*). Make these points:
 - A useful way to find out what a child eats is to ask the mother 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 FOOD INTAKE JOB AID, 6-23 MONTHS helps you to do this.
 - The mother is asked to recall everything the child consumed the previous day. This includes all foods, snacks, drinks, breastfeeds and any vitamin or mineral supplements.
 - As you can see, the first column has questions about feeding practices. As you listen to the mother 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 all closed questions. When you use this tool with a mother or caregiver to gather information you should use your counselling skills, including open questions. We will see how this is used in a demonstration later.

- Distribute the consistency pictures to the participants (if not on the back of the FOOD INTAKE REFERENCE TOOL, 6-23 MONTHS). Point out how the pictures are different.
 - If you ask a mother about the consistency of the food – if 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 mother and ask which drawing is most like the food she 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 FOOD INTAKE JOB AID, 6-23 MONTHS, you then choose two or three Key Messages to give. It is important to listen to the mother first so that you gather all the information on complementary feeding before you decide which Key Messages to give to her. There is a column on the FOOD INTAKE JOB AID, 6-23 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 mother?
Wait for a few replies and then continue.
- It is important to choose just 2-3 Key Messages at a visit so the mother is not overwhelmed.
- Discuss the Key Messages you think are most important at this time and that the mother thinks that she can do.
- Ask participants to turn to page 198 and the FOOD INTAKE REFERENCE TOOL, 6-23 MONTHS. This can be found on page 443 of the *Trainers Guide*. Ask one participant to read the first feeding practice question, 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 34. We will discuss feeding the child who is ill in Session 37.
 - The other Key Messages have already been introduced.
 - On page 196 in your Manual, there are instructions on how to use the FOOD INTAKE JOB AID, 6-23 MONTHS.
- Ask participants to take turns to read out the instructions.

INSTRUCTIONS TO COMPLETE FOOD INTAKE JOB AID, 6-23 MONTHS

1. Greet the mother. 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 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 mother mentions a preparation, such as a porridge or stew, ask her 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 mother to help her remember all the food/drinks/breastfeeds that the child had.
9. Continue to remind the mother you are interested in what the child ate and drank yesterday (mothers 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 FOOD INTAKE JOB AID, 6-23 MONTHS the practices that are present. If appropriate, show the mother the pictures of thin and thick consistency (for porridge and mixed foods). Ask her which drawing is most like the food she gave the child. Was it thick, stayed in the spoon and held a shape on the plate, or thin, flowed off the spoon and did not hold its shape on the plate?
12. Praise practices you wish to encourage. Offer 2-3 Key Messages as needed and discuss how the mother 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 FOOD INTAKE JOB AID, 6-23 MONTHS when the child is eating again.

- Now we will see this FOOD INTAKE JOB AID, 6-23 MONTHS in use. During the demonstration, you can follow the completed in FOOD INTAKE JOB AID, 6-23 MONTHS on page 200 of your Manual. Later, you will use a FOOD INTAKE JOB AID, 6-23 MONTHS with mothers in the practical session.
 - In this demonstration listen for open questions and other listening and learning skills that we discussed in Session 5.
- Ask the two participants whom you prepared to assist. One person is the mother and one is the Health Worker who fills in the FOOD INTAKE JOB AID, 6-23 MONTHS.
- Room setting: Seats 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. Health Worker has a FOOD INTAKE JOB AID, 6-23 MONTHS, FOOD INTAKE REFERENCE TOOL, 6-23 MONTHS, consistency pictures and a typical bowl. Mother has a growth chart for the child.
- Find out the mother 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.

DEMONSTRATION 33.A LEARNING WHAT A CHILD EATS

<i>Health worker: (show growth chart)</i>	"Thank you for coming today. (Mother 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?"
<i>Mother:</i>	"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."
<i>Health worker:</i>	"I can see you are anxious about his weight."
<i>Mother:</i>	"Yes. I was wondering if I was feeding him the right sorts of food."
<i>Health worker:</i>	"Perhaps we could go through everything that (child's name) ate or drank yesterday?"
<i>Mother:</i>	"Yes, I can tell you about that."
<i>Health Worker:</i>	"What was the first thing you gave (child's name) after he woke up yesterday?"
<i>Mother:</i>	"First thing, he breastfed. Then about one hour later the baby had a small amount of bread with butter, and several pieces of papaya."
<i>Health Worker:</i>	"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?"
<i>Mother:</i>	"At mid morning, the baby had some porridge with milk and sugar."
<i>Health Worker: (show 2 consistency pictures)</i>	"Which of these drawings is most like the porridge you gave to (child's name)?"

<i>Mother:</i>	“Like that thick one.” (Points to the thick consistency)
<i>Health Worker:</i>	“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?”
<i>Mother:</i>	“Let’s see, in the middle of the day, he had soup with vegetables and beans.”
<i>Health Worker:</i>	“How did the baby eat the vegetables and beans?”
<i>Mother:</i>	“I mashed them all together and added the liquid of the soup so he could eat it.”
<i>Health Worker:</i> (show 2 consistency pictures)	“Which picture is most like this food that you fed (child’s name) yesterday in the middle of the day?”
<i>Mother:</i>	“This one – the more runny one.” (Points to the thin consistency)
<i>Health Worker:</i>	“Was there anything else that (child’s name) had at mid-day yesterday?”
<i>Mother:</i>	“Oh yes, he had a small glass of fresh orange juice.”
<i>Health Worker:</i>	“That is a healthy drink to give to (child’s name). After this meal at mid-day, what was the next thing he ate?”
<i>Mother:</i>	“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.”
<i>Health Worker:</i> (show 2 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?”
<i>Mother:</i>	“This thicker one. I mashed up the foods together and it looked like that.”
<i>Health Worker:</i>	“Did (child’s name) eat or drink anything more for the evening meal yesterday?”
<i>Mother:</i>	“No, nothing else.”
<i>Health Worker:</i>	“After that or during the night, what other foods or drinks did (child’s name) have?”
<i>Mother:</i>	“(Child’s name) breastfeeds during the night but he had no more foods.”
<i>Health Worker:</i> (show typical bowl)	“Using this bowl, can you show me about how much food (child’s name) ate at his main meal yesterday?”
<i>Mother:</i>	(Points to bowl) “About half of that bowl.”
<i>Health Worker:</i>	“Thank you. Who helps (child’s name) to eat, or does he eat by himself?”
<i>Mother:</i>	“Oh, yes. (Child’s name) needs help. Usually I help him, but sometimes if my mother or sister is there, they will help also.”
<i>Health Worker:</i>	“Is (child’s name) taking any vitamins or minerals?”
<i>Mother:</i>	“No, not now.”
<i>Health Worker:</i>	“Thank you for telling me so much about what (child’s name) eats.”

- As you can see from the example form on page 200 in your Manual (page 445 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.

☐ 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: Child receives breast milk?

Wait for a few replies and then continue.

- Yes, frequently. A practice to praise.

Ask: How many meals of a thick consistency?

Wait for a few replies and then continue.

- 2, 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: Ate a dairy product?

Wait for a few replies and then continue.

- Yes, there was milk on the porridge.

Ask: Ate pulses or nuts yesterday?

Wait for a few replies and then continue.

- Yes, beans at mid-day. And the child had juice with the meal, which helps iron absorption.

Ask: Ate a dark-green or yellow-coloured fruit or vegetable yesterday?

Wait for a few replies and then continue.

- Yes, some paw-paw in the morning, some green vegetables in the evening, maybe some green or yellow vegetables in the pot at mid-day. 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: Number of meals and snacks*
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: Mother assists with eating?*
Wait for a few replies and then continue.
 - Yes.
 - Ask: 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.
 - 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 health worker needs 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.

 - 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 had a full bowl
 - . to make the food a thick consistency at each meal (remember the bean and vegetable meal was thin).
 - 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 which 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, now we will practise with each other.
- Ask if there is any point the participants would like made clearer or any questions.

IV. Practise gathering information on feeding practices (small groups)

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 Food Intake Stories 1-6 (page 446-448). Each group of participants should have a set of four stories plus growth charts, 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 FOOD INTAKE JOB AID, 6-23 MONTHS.
Make sure each group has a set of the consistency pictures and a child's bowl.

- Ask participants to read through their own story to themselves. Allow two 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 she is interested, you can tell her 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 FOOD INTAKE JOB AID, 6-23 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.

- When you are observing:
 - . Follow the pair practise with the FOOD INTAKE JOB AID, 6-23 MONTHS and observe if the 'health worker' gathers useful information.
 - . Notice which counselling skills the health worker uses and which she does not use.
 - . After the role-play, be prepared to praise what the health worker does right, and suggest what she could do better.

- ☐ Trainers each sit with one group of 3-4 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 with the group through the points to praise the 'mother' for. Make sure that the relevant Key Messages were focussed 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.

V. Summarize the session**3 minutes**

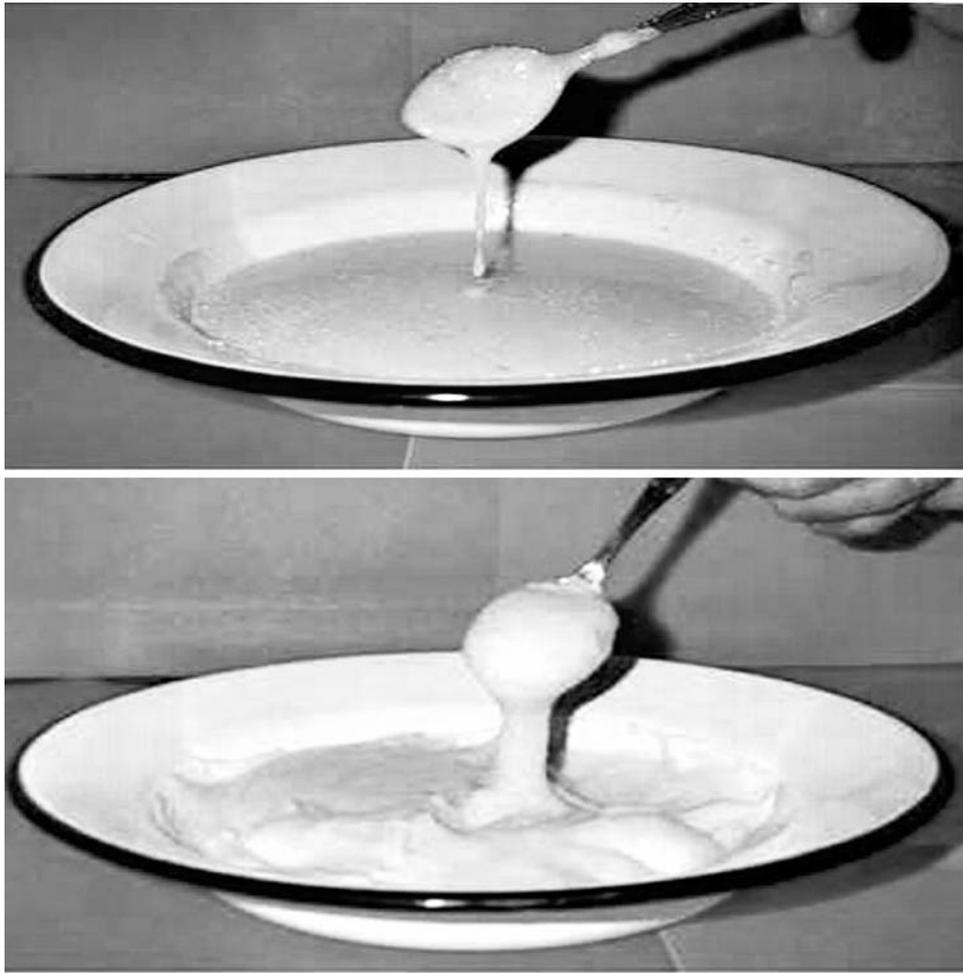
- Ask participants if they have any questions or if there are points you can make clearer.
- Make these points:
 - In this session, we looked at various ways of gathering information on complementary feeding practices. This included observation, listening, using growth charts and asking questions.
 - We also discussed the FOOD INTAKE JOB AID, 6-23 MONTHS which will be used in Practical Session 4

Enter ✓ in the Yes column if the practice is in place.

Enter your initials if a message is given (see FOOD INTAKE REFERENCE TOOL, 6-23 MONTHS for the message).

FOOD INTAKE JOB AID, 6-23 MONTHS		
Child's name		
Date of birth		Age of child at visit
Feeding practice	Yes / number where relevant	Key Message given
Growth curve rising?		
Child received breast milk?		
How many meals of a thick consistency did the child eat yesterday? (use consistency photos 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 his/her age?		
Quantity of food eaten at main meal yesterday appropriate for child's age?		
Mother assisted the child at meals times?		
Child took any vitamin or mineral supplements?		
Child ill or recovering from an illness?		

FOOD INTAKE REFERENCE TOOL, 6-23 MONTHS		
Feeding Practice	Ideal Feeding Practice	Key Messages to help counsel mothers
Growth curve rising?		<i>Look at the shape of the growth curve of the child: is the child growing?</i>
Child received breast milk?	Yes	Breastfeeding for 2 years of age 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 consistency photos as needed)	3 meals	Foods that are thick enough to stay in 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 his/her age?	Child 6 – 8 months: 2 – 3 meals plus 1 – 2 snacks if hungry Child 9 – 23 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 – 23 months: approx. ¾ – 1 cup at each meal	A growing child needs increasing amounts of food
Mother assisted the child at meals times?	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	<i>Explain how to use vitamin and mineral supplements if they are needed</i>
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 FOOD INTAKE REFERENCE TOOL, 6-23 MONTHS for the message)

FOOD INTAKE JOB AID, 6-23 MONTHS		
Child's name:		
Date of birth:		Age of child at visit: 11 months
Feeding practice	Yes / number where relevant	Key Message given
Growth curve rising?	<i>slowly</i>	
Child received breast milk?	✓	
How many meals of a thick consistency did the child eat yesterday? (use consistency photos 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 his/her age?	✓	
Quantity of food eaten at main meal yesterday appropriate for child's age?	✓	
Mother assisted the child at meals times?	✓	
Child took any vitamin or mineral supplements?	-	
Child ill or recovering from an illness?	-	

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 spoon of sugar
 - Mid-morning: Small piece of bread with nothing on it, breastfeed
 - Mid-day: 3 large spoons of rice, two spoon of mashed beans ($\frac{3}{4}$ of a bowl), pieces of mango ($\frac{1}{4}$ of a bowl), drink of water
 - Mid-afternoon: Breastfeed, one small biscuit/cookie
 - Evening: Two large spoons of rice, one large spoon of mashed fish, two large spoon of green vegetables ($\frac{3}{4}$ 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, spoon of sugar
 - Mid-morning: Half a mashed banana, small drink of fruit drink
 - Mid-day: Thin soup, one spoon of rice, and one spoon of mashed beans (half full bowl), drink of water
 - Mid-afternoon: Sweet biscuit, half cup of cow's milk
 - Evening: Two spoons of rice, one spoon of mashed meat and vegetable from family meal (half a bowl), drink of water
 - Bedtime: Piece of bread with no spread, half 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
- Mid-day: Three spoons of rice, three spoons of mashed beans and vegetables from the family meal (one full bowl), $\frac{1}{2}$ 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 spoons of mashed banana, breastfeed
 - Mid-day: Four spoons of thin soup, one spoon of mashed meat/vegetables/potato from the soup ($\frac{3}{4}$ of a bowl), breastfeed
 - Mid-afternoon: Breastfeed, two spoons mashed mango
 - Evening: Two spoons of mashed meat/vegetable/potato from family meal (less than $\frac{1}{2}$ a bowl), breastfeed
 - Bedtime: Breastfeed, sweet biscuit mashed in cow's milk ($\frac{1}{4}$ of cup).
 - During the night: Breastfeed
-

Story 5:

Child is six and a half months old and healthy. Growing well. Easy to feed. Has recently started complementary feeds.

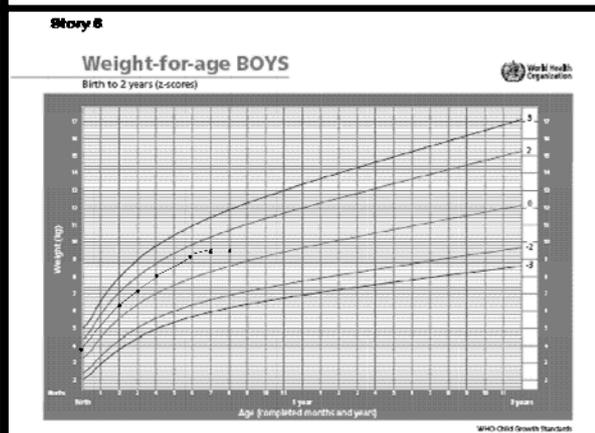
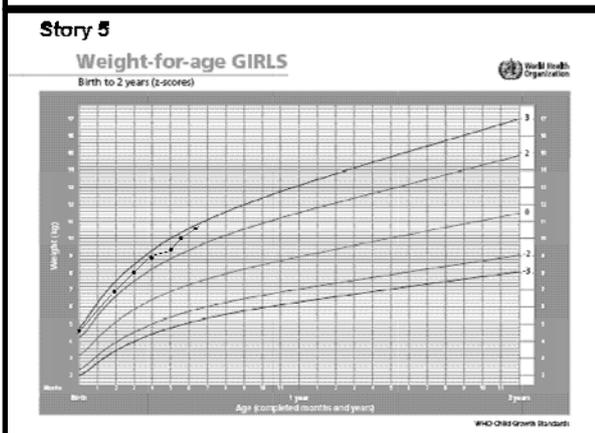
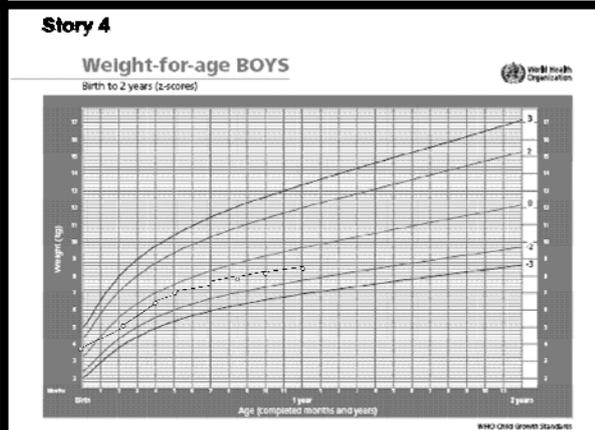
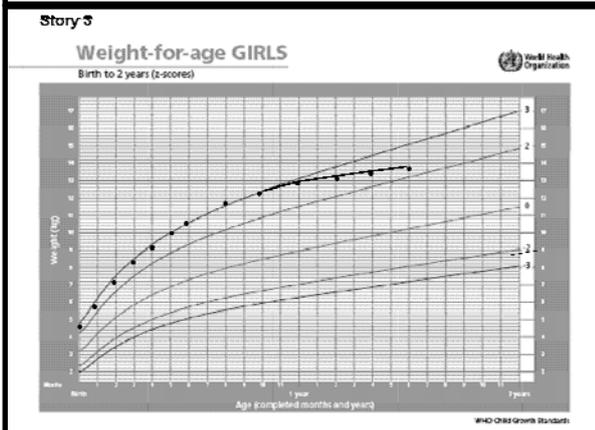
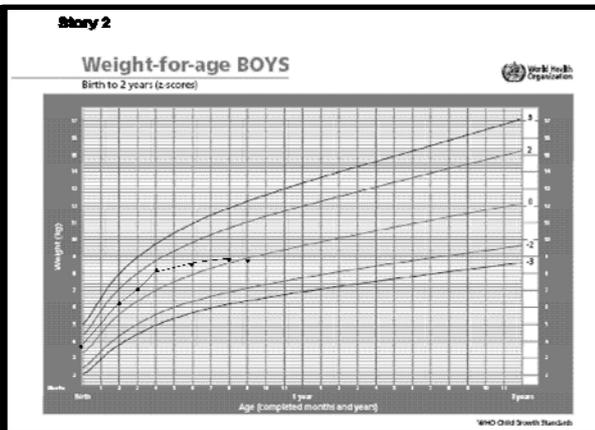
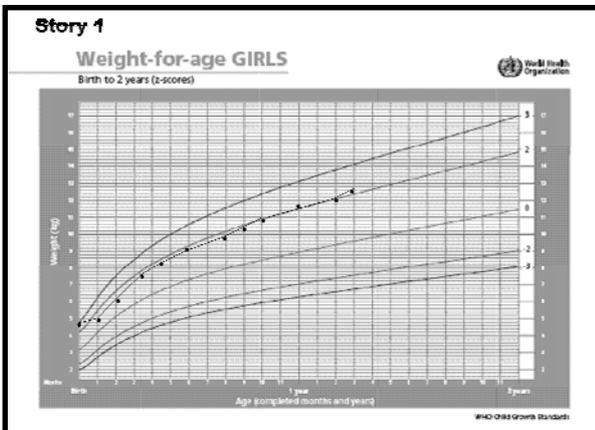
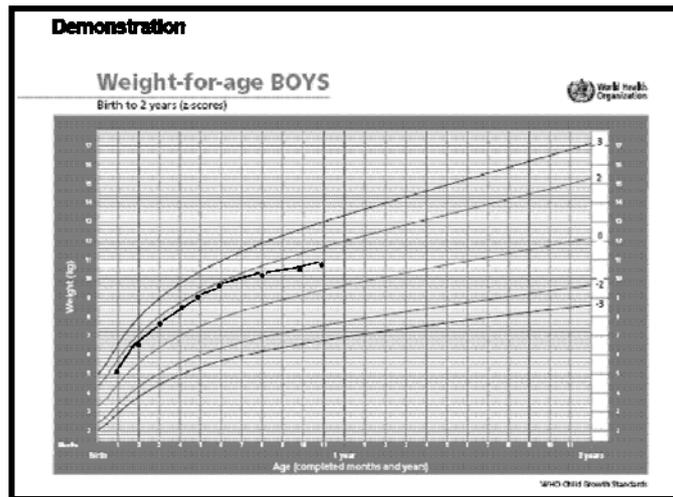
- Early morning: Breastfeeds
 - Mid-morning : 3 spoons of thin porridge with milk, breastfeeds
 - Mid-day: breastfeeds
 - Mid-afternoon : breastfeeds
 - Evening : 3 spoons of mashed family meal – potato, fish, carrots. Thick consistency
 - Bedtime: Breastfeed
 - During night : Breastfeeds
-

Story 6:

Child is 8 months old. Not ill. Does not show much interest in eating.

- Early morning : Breastfeed, 2 spoons thin porridge with milk and sugar (less than $\frac{1}{2}$ a bowl)
- Mid-morning : Breastfeed
- Mid-day: One spoon rice, one spoon mashed beans, small piece of egg, one spoon mashed greens, from the family meal ($\frac{1}{2}$ 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 SESSION



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 mid-day
 - Ate greens with evening meal and mango at mid-day
 - Had 3 meals and 2 snacks
 - Amount of food for a 15-month-old child is $\frac{3}{4}$ to one cup (250ml) 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 old
 - 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-score. 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 – one and a half cups = 375 ml (this child is not breastfeeding so should receive 1-2 cups of milk per day)
 - Ate beans at mid-day
 - Although ate vegetables it is not clear from story whether these were green or yellow
 - Had 3 meals and 3 snacks
 - Received half a bowl of food for meals (at 9 months should be receiving $\frac{1}{2}$ a bowl)
-
- Suggest making morning porridge and mid-day 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 half cup of milk per day. Suggest putting some margarine or peanut butter on the bread at bed-time.

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 mid-day meals)
- No animal-source foods
- Ate beans at mid-day
- Although ate vegetables with mid-day 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 mid-day meals, but the evening meal was less than one bowl – at 18 months should be receiving $\frac{3}{4}$ to one 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 mid-day meal of a thin consistency
- Meat given at the mid-day 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 half 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 $\frac{3}{4}$ to one full bowl

- Suggest making the food thicker
- Suggest giving a larger quantity of food at meals – $\frac{3}{4}$ to one full bowl
- Suggest increasing the energy of the morning porridge with oil, peanut butter or margarine

Story 5:

Female child age 6 ½ 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.

- Mid-day meal of thick consistency, but early morning porridge of a thin consistency
- Small piece of egg given at the mid-day meal
- Ate mashed greens at mid-day
- 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

Session 34

Feeding Techniques

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

Session outline

30 minutes

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

I.	Introduce the session	7 minutes
II.	Describe feeding care practices and their effect on intake	25 minutes
III.	Summarize the session	3 minutes

Preparation

- Refer to the Introduction for guidance on giving a presentation with slides.
- Make sure that Overheads 34/1-34/3 are in the correct order. Study the slides and the text that goes with them so that you are able to present them.
- Have ready the feeding recommendations which participants wrote down in Session 28.
- Ask two participants to assist with the DEMONSTRATIONS 34.A, 34.B, 34.C.
- For 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 page of flip chart paper. 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.

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 an earlier session.

- Make two columns on the flip chart. 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 which participants wrote on paper in Session 28, 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.
Which column has the most tick marks ✓ in it?
It is probably the WHAT column.

 - 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, he often eats slowly and is messy. He may be easily distracted.
 - He 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 to 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 meal times.

- Show **Slide 34/1 – Session 34 Objectives** and read out the objectives:

34/1

Feeding techniques

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 25 minutes

- Make these points:
- A child needs food, health and care to grow and develop. Even when food and health care are limited, good care-giving 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 flip chart 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.
 - 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 his 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 two years of age need assistance with feeding.
 - However, this assistance needs to adapt so that the child has opportunities to feed himself, as he is able.
 - A child may eat more if he is allowed to pick up foods with his newly learned finger skills from about 9-10 months of age.
 - The child may be at least 15 months old before he can eat a sufficient amount of food by self-feeding. At this age, he is 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 when the child stops eating that he has 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 34.A, 34.B, 34.C.
- Now we see demonstrations of three ways to feed a young child. After each demonstration, we will discuss what it shows.
- Ask the two participants whom you prepared to give DEMONSTRATIONS 34.A, 34.B and 34.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.

DEMONSTRATION 34.A CONTROLLED FEEDING

The 'young child' is sitting next to the caregiver (or on the caregiver's knees). The caretaker prevents the child from putting his/her hands near the bowl or the food.

The caregiver spoons food into the child's mouth.

If the child struggles or turns away, he is brought back to the feeding position.

Child may be slapped or forced if he does 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 he felt.

- The 'child' may feel eating is very frightening and uncomfortable. He may feel scared.
- Now we see another way of feeding a young child.

DEMONSTRATION 34.B LEAVE TO THEMSELVES

The 'young child' on the floor sitting on a mat.

Caregiver puts a bowl of food beside the child with a spoon in it.

Caregiver turns away and continues with other activities (nothing too distracting for those watching).

Caregiver does not make eye contact with the child or help very much with feeding.

Child pushes food around the bowl, looks to caregiver for help, eats a little, cannot manage a spoon well, he tries with his hands but drops the food, he gives up and moves away.

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 he felt.

- The 'child' may feel eating is very difficult. He may be hungry or sad
- Now we see a third way of feeding a young child.

DEMONSTRATION 34.C RESPONSIVE FEEDING

Caregiver washes the child's hands and her own hands and then sits level with child. Caregiver keeps eye contact and smiles at child. Using a small spoon and an individual bowl, small amounts of food are put to the child's lips and child opens his mouth and takes it a few times.

Caregiver praises child and makes pleasant comments – “Aren't you a good boy”, “Here is lovely dinner” while feeding slowly.

Child stops taking food by shutting mouth or turning away. Caregiver tries once – “Another spoonful of lovely dinner?” Child refuses and caregiver stops feeding.

Caregiver offers a piece of food that child can hold - bread crust, biscuit or something similar. “Would you like to feed yourself?” Child takes it, smiles and sucks/munches it.

Caregiver encourages “You want to feed yourself, do you?”

After a minute, the caregiver offers a bit more from the bowl. 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 flip chart 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 flip chart 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.

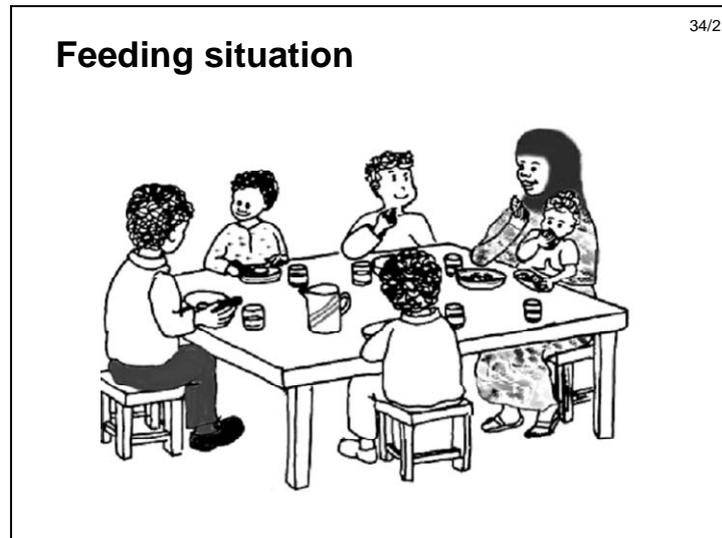
- Offer a few suggestions for other practices they could try.
 - Some practices you can suggest are listed in your Manual.
- Ask participants to turn to page 204 of their Manual and find the box **RESPONSIVE FEEDING TECHNIQUES**. Ask participants to take it in turns to read out the points.

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 him/herself
- 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 flip chart list, and make these points:
- The third Responsive Feeding Practices 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, he may not eat well.
 - Regular mealtimes and the 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 his food.

Show **Slide 34/2 - 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 flip chart and then continue. Refer to the responses as you make these points:

- The overall feeding environment may also affect food intake. This includes:
 - to sit with the family or other children at mealtimes so the child sees them eating
 - to sit with others eating to provide an opportunity to offer extra food to the young child
 - to use a separate bowl for the child so the caregiver can see the amount eaten
 - to talk with the child
 - to encourage 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 34/3 - Key Message 9: Responsive feeding** and read out the message:

34/3

Key Message 9

A young child needs to learn to eat:
encourage and give help
... with lots of patience



VI. Summarize the session

3 minutes

- Ask participants if they have any questions or if there are points that you can make clearer.
- 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 out the Key Message on the flipchart.
- Explain that a summary of this session can be found on pages 203-204 of the *Participant's Manual*.

Session 35

Practical Session 4

Gathering Information on Complementary Feeding Practices

Objectives

After completing this session participants will be able to:

- demonstrate how to gather information about complementary feeding using counselling skills and the FOOD INTAKE JOB AID, 6-23 MONTHS
- provide information about complementary feeding and continuing breastfeeding to a mother of a 6-24 month old child

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 practice in a ward or clinic.

I.	Prepare the participants for the Practical Session	5 minutes
II.	Conduct the Practical Session	100 minutes
III.	Discuss the findings as a whole group	15 minutes

Preparation

- Ensure you know exactly where the practice will be held and what times you are expected there.
- Make sure Slide 35/1 is 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.
- Make sure that two copies of the FOOD INTAKE JOB AID, 6-23 MONTHS and two copies of the COUNSELLING SKILLS CHECKLIST are available for each participant.
- Make sure that each trainer has a copy of the PRACTICAL DISCUSSION CHECKLIST to help conduct discussions.
- Make sure the one set of the food consistency pictures is available for each participant.
- Each group needs a typical bowl that a young child would use.

As you follow the text, remember:

- Indicates an instruction to you, the trainer
- Indicates what you say to participants.

I. Prepare the participants for the practical (one trainer) 5 minutes

- Show **Overhead 35/1 – Practical Session** and read out the objectives:

35/1

Practical session

After completing this session participants will be able to:

- demonstrate how to gather information about complementary feeding using counselling skills and the FOOD INTAKE JOB AID, 6-23 MONTHS
- provide information about complementary feeding and continuing breastfeeding to a mother of a 6-23 months old child

- 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:
 - . The FOOD INTAKE REFERENCE TOOL, 6-23 MONTHS.
 - . Pencil
 - . Two copies of the COUNSELLING SKILLS CHECKLIST
 - . Two copies of the FOOD INTAKE JOB AID, 6-23 MONTHS and the picture of the thick and thin consistency
 - . Common bowl used to feed a young child - between each pair of participants.
- Distribute two blank copies to each person of the COUNSELLING SKILLS CHECKLIST, the FOOD INTAKE JOB AID, 6-23 MONTHS and consistency pictures.
- Explain how the 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, filling in the FOOD INTAKE JOB AID, 6-23 MONTHS at the same time.
 - Talk with mothers of children 6-23 months.
 - The others in the group observe and fill in the counselling 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.

- 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.
 - . 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 FOOD INTAKE JOB AID, 6-23 MONTHS.
 - . 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 FOOD INTAKE JOB AID, 6-23 MONTHS as you listen and learn from the mother.
 - . Use the information you have gathered and then:
 - Try to praise two 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 as you can. Ask your trainer for assistance if necessary.
 - The participants that are observing can mark a ✓ 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.
- Encourage participants to notice feeding practices such as:
- . if children eat any food or have any 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 PRACTICAL DISCUSSION CHECKLIST to guide you as you give feedback to the participants.
- Discuss arrangements for travel (if needed) and any other details of the Practical Session and whether the discussions will be done at the site or back at the classroom.

II. Conduct the practice (all trainers) 100 minutes

These notes are for the trainers. Trainers should read these notes 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 mothers of children over six months of age.
- If you cannot find any more children over six months of age, you can take a feeding history from mothers with children under six months of age using the FEEDING HISTORY JOB AID, 0-6 MONTHS from Session 13.
- About 10 minutes before the end of the time, remind the groups to start finishing up.

III. Discuss the findings as a whole group (one trainer) 15 minutes

- Return to the whole class group. Discuss what the participants learnt from listening to the mothers and from the completed FOOD INTAKE JOB AID, 6-23 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 FOOD INTAKE JOB AIDS, 6-23 MONTHS which 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 if they have any questions or if there are points you can make clearer.

Session 36

Checking Understanding and Arranging Follow-up

Objectives

After completing this session participants will be able to:

- demonstrate how to ensure that a mother 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 demonstration led by one trainer.

- | | | |
|------|---|------------|
| I. | Introduce the session | 2 minutes |
| II. | Demonstrate two skills for checking understanding and arranging follow-up | 10 minutes |
| III. | Summarize the session | 3 minutes |

Preparation

- Refer to the Introduction for guidance on how to give a demonstration.
- Prepare two flipcharts: one with the LISTENING AND LEARNING SKILLS and one with the CONFIDENCE AND SUPPORT SKILLS. Have a blank flipchart ready to list the 2 new skills we will be discussing in this session.
- Make sure Slide 36/1 is ready. As there is only one slide, you might prefer to read aloud the objectives on Slide 36/1 without projecting them onto the screen.
- Study the instructions for DEMONSTRATION 36.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 36/1 - Session 36 Objectives** and read out the objectives:

36/1

Checking understanding and arranging follow-up

After completing this session participants will be able to:

- demonstrate how to ensure that a mother understands information provided by using checking questions
- arrange referral or follow-up of a child

- Make these introductory points:
- In this session you will learn two further skills to help support mothers: Checking understanding and arranging follow-up.

II. Demonstrate the Skills**10 minutes****Checking understanding**

- Put up on the wall 2 lists: one of the LISTENING AND LEARNING SKILLS and another of the BUILDING CONFIDENCE AND GIVING SUPPORT SKILLS. Then put up a blank flip chart 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 mother so she can decide on a course of action. Your suggestion does not automatically become what a mother will do.
 - Often you need to check a mother understands a practice or action she plans 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 mother if she understands, because she may not realize that she understood incorrectly.
 - Ask open questions to find out if 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 if a mother 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 36.A. The trainer briefly discusses what the participants have observed after each section.

DEMONSTRATION 36.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 one year old need to eat often. Would you come back to see me in two 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.

Arrange 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 him for more specialized care.
 - Follow-up is especially important if there has been any difficulty with feeding. Ask the mother to visit the health facility in five days for follow-up.
 - This follow-up includes checking what foods are used and how they are given, checking how breastfeeding is going, 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 check how the mother is coping with her own health and difficulties.

III. Summarize the session**3 minutes**

- Ask participants if they have any questions, and try to answer them.
- Explain that a summary of this session can be found on page 207 of the *Participant's Manual*.

Session 37

Feeding During Illness and 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

30 minutes

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

I.	Introduce the session	3 minutes
II.	Explain why children need to continue to eat during illness	5 minutes
III.	Describe appropriate feeding during illness and recovery	10 minutes
IV.	Discuss feeding of low birth-weight babies	10 minutes
V.	Summarize the session	2 minutes

Preparation

- Refer to the Introduction for guidance on giving a presentation with slides.
- Make sure that Slides 37/1-37/6 are in the correct order. Study the slides 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 flip chart page. Keep covered until later in the session.
 - *Key Message 10: Encourage the child to drink and to eat during illness and provide extra food after illness to help the child recover quickly.*
- You need
 - the flip chart list of Responsive Feeding Practices from Session 34.
 - a flip chart of all the Key Messages from earlier sessions.
 - to find out what % of babies are low-birth-weight in your area.

As you follow the text, remember:

- Indicates an instruction to you, the trainer

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, he or she 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 faster. 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 37/1 - Session 37 Objectives** and read out the objectives:

Feeding during illness and low-birth-weight babies 37/1

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

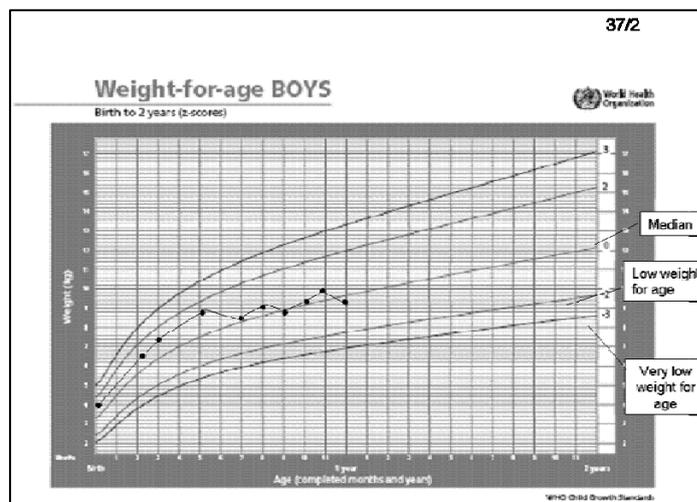
5 minutes

Ask: *Why might a young child feed less during illness?*

Write participants' replies on the flip chart. Refer to their responses as you make these points:

- A child may eat less during illness because:
 - the child does not feel hungry, is weak and lethargic
 - the child is vomiting or the child's 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 37/2 - 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 five 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 is used as fuel. This is why they lose weight, look thin and stop growing.

Show **Slide 37/3 - Key Message 10: Feeding during and after illness** and read it out:

37/3

Key Message 10

Encourage children to drink and eat during illness and provide extra food after illness to help them recover quickly



- The goal in feeding a child during and after illness is to help him to return to the growth he had before he was ill.

III. Describe appropriate feeding during illness and recovery

10 minutes

- Show **Slide 37/4 - Feeding the child who is ill** and ask a participant to read out the points:

37/4

Feeding the child who is ill

- Encourage the child to drink and to eat – with lots of patience
- Feed small amounts frequently
- Give foods that the child likes
- Give a variety of nutrient-rich foods
- Continue to breastfeed – often ill children breastfeed more frequently

- Show **Slide 37/5 - Feeding during recovery** and ask a participant to read out the points:

37/5

Feeding during recovery

- Give **extra** breastfeeds
- Feed an **extra** meal
- Give an **extra** amount
- Use **extra** rich foods
- Feed with **extra** patience and love

- 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

10 minutes

Ask: What does the term low-birth-weight mean?

Wait for a few replies and then continue.

- The term *low-birth-weight* (LBW) means a birth weight of less than 2,500 grams (up to and including 2,499g), regardless of gestational age. This includes babies who are born *premature* (that is, who are born before 37 weeks of gestational age), and babies who are *small for gestational age*. Babies may be small for both these reasons.
- 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.
- Low-birth-weight babies 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 LBW babies to breastfeed exclusively?

Wait for a few replies and then continue. (Participants may give answers such as: LBW 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 LBW 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 LBW 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. Encourage participants to think back to Session 15 on Expressing breast milk.

- It is important to start expressing on the first day, within six hours of delivery if possible. This helps to start breast milk to flow, 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 37/6 - Feeding low-birth-weight babies** and make the points that follow:

37/6

Feeding low-birth-weight babies

- 32 weeks gestation
 - able to start suckling from the breast
- 30-32 weeks gestation
 - can take feeds from a small cup or spoon
- Below 30 weeks gestation
 - usually need to receive feeds by tube in hospital

- Babies of about 32 weeks gestational age or more are able to start suckling on the breast.
- Babies between about 30-32 weeks gestational age can take feeds from a small cup, or from a spoon.
- 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 he is well enough. He may only root for the nipple and lick it at first, or he may suckle a little. Continue giving expressed breast milk by cup to make sure the baby gets all that he needs.
- When a LBW baby starts to suckle effectively, he may pause during feeds quite often and for quite long periods. For example, he may take 4-5 sucks and then pause for up to 4 or 5 minutes.
- It is important not to take him off the breast too quickly. Leave him on the breast so that he can suckle again when he is ready.

- He 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.
 - The best positions for a mother to hold her LBW baby at the breast are:
 - . across her body, holding him with the arm on the opposite side to the breast
 - . the underarm position.
- Ask participants to turn to page 46 of their Manuals 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 HIV-positive and who have chosen replacement feeding are at higher risk of complications and should also be followed 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 212 of their Manuals and find the box AMOUNT OF MILK FOR LOW-BIRTH-WEIGHT BABIES WHO CANNOT BREASTFEED. Ask participants to look at this in their own time.

AMOUNT OF MILK FOR LOW-BIRTH-WEIGHT BABIES WHO CANNOT BREASTFEED

What milk to give

Choice 1: Expressed breast milk (EBM) (if possible from the baby's mother)

Choice 2: Formula made up according to the instructions

Babies who weigh less than 2.5 kg (Low-birth-weight)

Start with 60 ml/kg body weight

Increase the total volume by 20 ml per kg per day, until the baby is taking a total of 200 ml per 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 if they have any questions or if there are points you can make clearer.
- 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 flip chart page and read out the Key Message:
 - Key Message 10: Encourage the child to drink and to eat during illness and provide extra food after illness to help the child recover quickly.
- Point to the flip chart with the 10 Key Messages listed. Explain to participants that they can find this list at the back of their Manuals.
- Explain that a summary of this session can be found on pages 209-212 of the *Participant's Manual*.

Further Information: Low-birth-weight babies

Whenever possible, LBW 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 produced 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.

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 breastmilk that they need. By about 36 weeks, most babies can coordinate suckling and breathing, and they can take all that they need by breastfeeding.

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 1,300-1,500 grams. Many can breastfeed fully when they weigh about 1,600-1,800 grams or less.

Skin-to-skin contact and kangaroo 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 his mother hold him next to her body. Usually the best place is between her breasts, inside her clothes. This is called *kangaroo care*. It has the following advantages:

- The warmth of the mother's body keeps her baby warm. He does not get cold, and he does not use up extra energy to keep warm. There is less need for incubators.
- The baby's heart works better, and he breathes more regularly.
- The baby cries less and sleeps better.
- It is easier to establish breastfeeding.

Session 38

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 mother

Session outline

45 minutes

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

I.	Introduce the session	2 minutes
II.	Role-play of a demonstration for mothers	20 minutes
III.	Prepare a plate of food	10 minutes
IV.	Discuss the meals prepared	10 minutes
V.	Summarize the session	3 minutes

Preparation

- Refer to the Introduction for guidance on how to give a demonstration.
- Make sure that Slide 38/1 is ready. As there is only one slide, you might prefer to read aloud the objectives without projecting them onto the screen.
- EXERCISE 38.A PREPARE A YOUNG CHILD'S MEAL - one copy for each group.
- Display all the Counselling Skills and 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 31, marked at $\frac{1}{2}$ and $\frac{3}{4}$ 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 38.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 38.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 38/1 - Food demonstration** and read out the objectives:

38/1

Food demonstration

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 mother

II. How to help a mother learn to prepare a suitable meal**20 minutes**

- Make these points:

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 if the mother understands
 - avoid words which sound judging or critical
 - praise the mother
 - explain things in a simple and suitable way to help her understand.

- Now 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 38.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 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 six 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) 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 38.A SUPPORTIVE TEACHING

<i>Health Worker:</i>	“Good morning (mother name). How are you and (child's name) today?”
<i>Mother:</i>	“We are well, thank you.”
<i>Health Worker:</i>	“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?”
<i>Mother:</i>	“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.”
<i>Health Worker:</i>	“Those sound good snacks. Now, we want to talk about how much food to give for his main meal.”
<i>Mother:</i>	“Yes, I'm not sure how much to give.”
<i>Health Worker:</i>	“It can be hard. What sort of bowl or cup do you feed him from?”
<i>Mother:</i>	“We usually use this bowl.” (Shows a bowl – about 250 ml size) ¹
<i>Health Worker:</i>	“How full do you fill the bowl for his meal?”
<i>Mother:</i>	“Oh, about a third.”
<i>Health Worker:</i>	“(Child's name) is growing very fast at this age so he needs increasing amounts of food.”

¹ If a different size cup or bowl is used, adjust the text according. 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.

<i>Mother:</i>	“What foods should I use?”
<i>Health Worker:</i>	“You have some of the food here from the family today. Let us see.” (Uncovers food) ”First we need to wash our hands.”
<i>Mother:</i>	“Yes, I have some water here.”(Washes hands with soap and dries them on clean cloth.)
<i>Health Worker:</i>	“Now, what could you start with for the meal?”
<i>Mother:</i>	“I guess we would start with some rice.” (Puts in 2 large spoonfuls)
<i>Health Worker:</i>	“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?”
<i>Mother:</i>	“I kept a few pieces of fish from our meal.” (Puts in 1 large spoonful)
<i>Health Worker:</i>	“Fish is a good food for (child’s name). A little animal-source food each day helps him to grow well.”
<i>Mother:</i>	“Does he need some vegetables too?”
<i>Health Worker:</i>	“Yes, dark-green or yellow vegetables help (child’s name) to have healthy eyes and fewer infections. What vegetables could you add?”
<i>Mother:</i>	“Some spinach?” (Puts in some)
<i>Health Worker:</i>	“Spinach would be very nutritious. Some would fill half the bowl.”
<i>Mother:</i>	“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.”
<i>Health Worker:</i>	“Yes, you are able to do it. Now, what about his morning meal?”
<i>Mother:</i>	“I can give some porridge, with milk and a little sugar.”
<i>Health Worker:</i>	“That’s right. How much will you put in the bowl?”
<i>Mother:</i>	“Until it is at least ½ full.”
<i>Health Worker:</i>	“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?”
<i>Mother:</i>	“Well, he would have some banana or some bread like I said before.”
<i>Health Worker:</i>	“Those are healthy foods to give between meals. (Child’s name) needs at least ½ full bowl of food three to four times a day as well.”
<i>Mother:</i>	“Oh, I don’t know what else to give him.”
<i>Health Worker:</i>	“Your family has a meal in the middle of the day. What do you eat in the evening?”
<i>Mother:</i>	“Usually there is a pot of soup with some beans and vegetables in it. Could I give him that?”
<i>Health Worker:</i>	“Thick foods help him to grow better than thin foods like 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?”
<i>Mother:</i>	Yes, I could do that easily enough.
<i>Health Worker:</i>	“So, how much will you put in (child’s name) bowl for each meal?”

<i>Mother:</i>	“I will fill it ½ full.”
<i>Health Worker:</i>	“Very good. And how often each day will you give him some food?”
<i>Mother:</i>	“I will give ½ bowlful of food three to four times a day. If he is hungry I will give some extra food between meals.”
<i>Health Worker:</i>	“Exactly. You know how to feed (child’s name) well. Will you bring (child’s name) back to the health centre in two weeks so we can look at his weight?”
<i>Mother:</i>	“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.
 - . ‘Building confidence and giving support’ skills: praise, she 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/his child?

Wait for a few replies.

- This mother probably will be able to prepare foods well.

Continue the discussion with the following points:

- 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 prepares 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 34.

III. Prepare a plate of food

10 minutes

- Each group will now prepare a bowl or plate of food suitable for the age of child they are assigned: 6½ month old, 8 month old, 10 month old, 15 month 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 if 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**10 minutes**

- Gather all the groups together with their finished plates of food. Distribute EXERCISE 38.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 is the consistency (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 of 6½ months², 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 if they have judged correctly.
 - . See box QUANTITIES OF FOOD TO OFFER A YOUNG CHILD FOR A MEAL (page 491 of *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? Any suggestions you could give this group?

- Repeat so each group has the opportunity to explain and discuss their meal.

² The baby of 6½ months would have 2-3 spoonfuls.

AMOUNTS OF FOODS TO OFFER			
Age	Texture	Frequency	Amount of food an average child will usually eat at each meal³
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	³ / ₄ to one 250 ml cup/bowl
If baby is not breastfed, give in addition: 1-2 cups of milk per day, and 1-2 extra meals per day.			

- Turn to page 216 in your Manuals. 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 494 of the *Trainer's Guide*).

³ Adapt the chart to use a suitable local cup/bowl to show the amount. The amounts assume an energy density of 0.8 to 1 Kcal/g.

EXERCISE 38.A PREPARING A YOUNG CHILD'S MEAL		
Group:		
Task	Achieved	Comments
Mixture of foods:		
Staple		
Animal-source food		
Bean / pulse <i>plus</i> 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 if they have any questions or if there are points that you can make clearer.

- 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 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

Select 1-3 Key Messages to say to mothers (see Key Messages, inside back cover)
Follow each message with a checking question (a question that you cannot answer with a simple 'yes' or 'no')

For example:

1. Foods that are thick enough to stay in 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. 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 two days?
(*Answer:* meats, fish, egg, milk, cheese – these are special foods for the child).
3. 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 2 or 3 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 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 if they would have difficulty in obtaining any of the ingredients (suggest alternatives). Ask the mothers if 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 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^{4,5} fill in the food and the amount needed

Recipe 1

Family food for a 10-month-old child's main course
(about 1/2 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 cut them into small pieces or slightly mash them together (depending on the child's age).
Add the oil or margarine and mix well.

⁴ The amounts indicated are recommended if the energy content of the meals is 0.8-1.0 Kcal/g. These amounts should be adjusted if the foods are diluted

⁵ If there is need to increase the amounts of food for each meal, instruct the participants to make the change in their recipes

Session 39

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

Session outline

45 minutes

Participants are all together for a lecture presentation by one trainer

I.	Introduce the session	5 minutes
II.	Discuss the competencies expected of participants	20 minutes
III.	Discuss the follow-up session	5 minutes
IV.	Discuss the preparation for the follow-up session	10 minutes
V.	Summarize the session	5 minutes

Preparation

- 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 that Slide 39/1 is ready. As there is only one slide, you might prefer to read aloud the objectives on Slide 39/1 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 221 of their Manuals 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.

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 39/1 - Session 39 Objectives** and read out the objectives:

39/1

Follow-up after training

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 they should complete for the follow-up session

- 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 skills 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 competencies**20 minutes**

- Ask participants to turn to page 221 of their Manuals and find the TABLE OF COMPETENCIES they are expected to learn. (These competencies are in your *Trainer's Guide* on page 4 in the Introduction). They should have looked at this the previous evening.
- 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 already have 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 FOOD INTAKE JOB AID, 6-23 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 five minutes to look at the table. (The previous evening they 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 five 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 flip chart 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 *Participants Manual*.

III. Discuss the follow-up session**5 minutes**

- Make these points:
 - The follow-up session will take place between 1-3 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 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 Manual. You may be taken to the post-natal 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 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 231 of your 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 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 227 of your Manuals you will find a log of skills to be completed. This log has three columns. There is one column for the date, one column for skills, 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 which you are expected to learn are on pages 221-226 of your Manual.
 - So, for example. On the 1st July 2005 you practise the skill of assessing a breastfeed using the BREASTFEED OBSERVATION JOB AID. 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 so that you can discuss these with your trainer when she comes for follow-up.
- Finally on page 229 of your Manuals there is a place where you can note down any 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 etc. 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:
 - To complete the exercises on page 231 of your manuals
 - To complete the log of skills you practise over the next few months
 - To 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. Summarize the session

5 minutes

- Ask participants if 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 two years of age, including special situations, such as mothers who are HIV-positive.
 - 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 which suits both you and the facility.
- Explain that a summary of this session can be found on pages 219-243 of the *Participant's Manual*.

PRACTICAL 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 his/her 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.

Confidence and support skills (give feedback on the use of these skills during practical sessions after Session 10)¹

- Which confidence and support skills 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 practical Session 35)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 practical 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 learned from this practical session?

¹ See list of skills on the following page

² See list of key messages on the following page

COUNSELLING SKILLS

Listening and learning skills:

- Use helpful non-verbal communication.
- Ask open questions.
- Use responses and gestures that show interest.
- Reflect back what the mother/caregiver says.
- Empathize - show that you understand how she/he feels.
- Avoid words that sound judging.

Building confidence and giving support skills:

- Accept what the caregiver thinks and feels.
- Recognize and praise what a mother/caregiver and child are doing right.
- Give practical help
- Give relevant information.
- Use simple language.
- Make one or two suggestions, not commands

KEY MESSAGES FOR COMPLEMENTARY FEEDING

1. Breastfeeding for two years of age or longer helps a child to develop and grow strong and healthy.
2. Starting other foods in addition to breast milk at 6 months helps a child to grow well.
3. Foods that are thick enough to stay in 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 to eat during illness and provide extra food after illness to help the child recover quickly.

Glossary of Terms

Absorbed iron: 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.

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, due to oxytocin released.

AIDS: Acquired immune deficiency syndrome, which means that the HIV-positive person 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: Preparing a mother for the delivery of her baby.

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

Anti-infective factors: Factors which prevent or which 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 his 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 WHO/UNICEF statement on Protecting, promoting and supporting breastfeeding: the special role of maternity services (1989).

Baby-led feeding: See demand feeding.

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

Bilirubin: Yellow breakdown products of haemoglobin which cause jaundice.

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

Bonding: Mother and baby developing a close loving relationship.

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

Breast pumps: Devices for expressing milk.

Breast refusal: A baby not wanting to suckle from his 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 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.

Calories: Kilocalories or Calories measure the energy available in food.

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

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 which 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 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 he shows that he is ready, both day and night. This is also called 'unrestricted' or 'baby-led' feeding.

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

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

Dummy: 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 which removes the milk efficiently from the breast.

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

Engorgement: 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 which are essential for a baby's growing eyes and brain, which are not present in cow's milk or most brands of formula.

Exclusive breastfeeding: An infant receives only breast milk and no other liquids or solids, not even water, with the exception of drops or syrups consisting of vitamins, mineral supplements or medicines.

Expressed breast milk (EBM): 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.

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 which sticks out less than average.

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

Formula: 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: These are foods that have certain nutrients added to improve their nutritional quality.

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

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 the 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 or buffalo milk and is widely used in India. In the Middle East it is called *samna*.

Growth factors: Substances in breast milk which promote growth and development of the intestine, and which 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, *uji* in Africa.

Gulp: Loud swallowing sounds, due 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 (acquired immune deficiency syndrome).

HIV-infected: Refers to a person infected with HIV, but who may not know that he/she is infected.

HIV-negative: Refers to people who have taken a test with a negative result and who know their result.

HIV-positive: Refers to persons who have taken an HIV test, whose results have been confirmed and who know and/or their parents know that they tested positive.

HIV-status unknown: Refers to people who have not taken an HIV test or who do 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 HIV-positive client it should include life planning, and, if the client is pregnant or has recently given birth, it should include infant-feeding considerations.

Home-modified animal milk: A breast-milk substitute prepared at home from fresh or processed animal milk, suitably diluted with water and with the addition of sugar and micronutrients.

Hormones: Chemical messengers in the body.

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

Infant feeding counselling: Counselling on breastfeeding, on complementary feeding, and, for HIV-positive women, on HIV and infant feeding.

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

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

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

Infective mastitis: Mastitis due to bacterial infection.

Inhibit: To reduce or stop something.

Inspection: Examining by looking.

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

Inverted nipple: A nipple which goes in instead of sticking out, or which 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 eyes and skin.

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

Lactation: The process of producing breast milk.

Lactation Amenorrhoea Method (LAM): Using the period of amenorrhoea after childbirth as a family planning method.

Lactose: The special sugar present in all milks.

Lipase: Enzyme to digest fat.

Low-birth-weight (LBW): Weighing less than 2.5 kg at birth.

Mastitis: Inflammation of the breast (see also infective and non-infective mastitis).

Matooke: Green banana.

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

Micronutrients: Essential nutrients required by the body in small quantities (like vitamins and some 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.

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

Micronutrient supplements: Preparations of vitamins and minerals.

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 which secrete an oily liquid.

Natural (passive) immunity: Is the protection a baby inherits from his/her 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 his mouth, so that he 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-to-child transmission: Transmission of HIV to a child from an HIV-infected woman during pregnancy, delivery or breastfeeding.

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

Oedema: Swelling due to fluid in the tissue.

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

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

Oxytocin: The hormone which 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 your hand.

Partially breastfed: Breastfed and given some artificial feeds.

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

Pathogen: Any organism that causes disease.

Persistent diarrhoea: Diarrhoea which starts like an acute attack, but which 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 which is difficult to stretch out to form a 'teat'.

Porridge: Is 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.

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 which makes the breasts produce milk.

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

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

Psychological: Mental and emotional.

Pulses: Peas, lentils, beans and groundnuts.

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

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

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-establishing 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 the child needs until the child is fully fed on family foods. During the first six months this should be with a suitable breast-milk substitute. After six 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 his mother.
- Rooting:** A baby searching for the breast with his mouth.
- Rooting reflex:** A baby opening his 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.
- Secrete:** Produce a fluid in the body.
- Self-weaning:** A baby more than one year old deciding by himself to stop breastfeeding.
- Sensory impulses:** Messages in nerves which 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 or of misinformation or of the ready availability of breast-milk substitutes.
- Sucking:** Using negative pressure to take something into the mouth.
- Sucking reflex:** The baby automatically sucks something that touches his palate.
- Suckling:** The action by which a baby removes milk from the breast.
- Supplements:** Drinks or artificial feeds given in addition to breast milk
- Support:** Help.
- Sustaining:** Continuing to breastfeed up to 2 years or beyond; helping breastfeeding mothers to continue to breastfeed.

Swallowing reflex: The baby automatically swallows when his mouth fills with fluid.

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

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 breads 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. Traditionally eaten in Central America. Wheat flour can also be used.

Toxin: A poisonous substance.

Unrestricted feeding: See demand feeding.

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

Whey: Liquid part of milk which 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).

