



Integrated Infant and Young Child Feeding Counselling

A Training Course



Participant's Manual

2012

Foreword

Optimal infant and young child feeding practices are very crucial to the growth, development, health, and survival of the children of Nigeria.

The 2008 Nigeria Demographic and Health Survey has shown that infant and young child feeding practices in Nigeria remains unsatisfactory as there is a low rate of timely breastfeeding initiation (38 percent) and even lower rates of exclusive breastfeeding for 6 months (13 percent). About half of the Nigerian infants are given complementary feeding too early. Among children under 5 years of age, 41 percent are stunted, 23 percent are underweight, while over 14 percent are wasted. It is estimated that nearly 60 percent of all childhood deaths are due to underlying malnutrition. The problem with malnutrition is further exacerbated by the HIV epidemic. Poor feeding practices largely contribute to this situation and must be addressed if the country is to achieve the Millennium Development Goals 1, 4, and 5 of reducing hunger, child mortality, and maternal mortality.

A critical step in achieving this goal is to build the capacity of health workers in Nigeria, so that they are empowered to provide caregivers with the information and support for the improvement of the nutritional status of their young children. There is therefore an urgent need to train all those involved in infant feeding counselling in the skills needed to support and protect breastfeeding, appropriate complementary feeding practices and optimal infant feeding in the context of HIV in Nigeria.

The Community Infant and Young Child Feeding Counselling Package : Facilitator Guide was adapted from the UNICEF and World Health Organization 2006 Infant and Young Child Feeding Integrated Counselling Course and updated with the 2010 national recommendations on infant feeding in the context of HIV. It is to be used as a training tool for all health workers and stakeholders working with mothers and the children in Nigeria.

I approve the use of this training manual by all healthcare personnel that are primarily responsible for the care and support of pregnant women, lactating mothers and their young children.



**Professor C.O. Onyebuchi Chukwu
Honourable Minister of Health
February, 2012**

Acknowledgement

This training course (Integrated Infant and Young Child feeding Counselling) brings together segmented training courses from “*Breastfeeding Counselling, HIV and Infant Feeding Counselling, Baby Friendly Hospital Initiative and Complementary Feeding Counselling*” all developed in Nigeria.

Thus Nigerian *Integrated Infant and Young Child Feeding Counselling---A Training Course* was developed within the Nigerian context having harmonized various numbers of materials previously developed in line with relevant Nigerian policies and guidelines. The integrated training manual has been field tested and finalized using a consensus building process with all relevant stakeholders.

The adaptation and harmonization process which resulted in *Integrated Infant and Young Child Feeding Counselling---A Training Course* for Nigeria was led by the Nutrition Division of the Federal Ministry of Health (FMOH), with technical and financial support from USAID's Infant & Young Child Nutrition (IYCN) Project, UNICEF and participation from multiple partner organizations both governmental and non-governmental.

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Dr. Bridget. Okoeguale

Head, Family Health Department
Federal Ministry of Health
February, 2012

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The various elements of *The C-IYCF Counselling Package* are based on the UNICEF Community Infant and Young Child Feeding Counselling Package, developed through a partnership among UNICEF New York, Nutrition Policy Practice, and URC/CHS and released in 2010.

This Nigerian *C-IYCF Counselling Package* was adapted for the Nigerian context, harmonized with a number of materials previously developed in Nigeria as well as relevant Nigerian policies, field tested, and finalized using a consensus building process with all relevant stakeholders. The adaptation and harmonization process which resulted in *The C-IYCF Counselling Package* for Nigeria was led by the Nutrition Division of the Federal Ministry of Health (FMOH), with technical and financial support from the United States Agency for International Development (USAID)-funded IYCN Project and UNICEF; and participation from multiple partner organizations, governmental and non-governmental. Special thanks to FCT who hosted the field test of the package in 2011.

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Table of Contents

Introduction to this guide	1
Table of Competencies	4
Session 1. Course introduction	11
Session 2. Why breastfeeding is important	18
Session 3. How breastfeeding works.....	28
Session 4. Positioning a baby at the breast.....	38
Session 5. Assessing a breastfeed.....	46
Session 6. Impact of Health Care Practices on Breastfeeding.....	56
Session 7. Listening and learning	72
Session 8. Growth charts	85
Session 9. Building confidence and giving support.....	92
Session 10. <i>Counselling Cards</i> and other tools	100
Session 11. Breast conditions	105
Session 12. Common breastfeeding difficulties	120
Session 13. The importance of complementary feeding	136
Session 14. Foods to fill the energy gap.....	143
Session 15. Clinical Practice 1: Listening and learning, assessing a breastfeed, building confidence and giving support, positioning a baby at the breast.....	150
Session 16. Foods to fill the protein, iron, and vitamin-A gaps	153
Session 17. Quantity, variety, and frequency of feeding	165
Session 18. Feeding techniques	174
Session 19. Assessing infant and young child feeding practices.....	181
Session 20. Gathering information on complementary feeding practices.....	190
Session 21. Clinical or Community Practice 2: Conducting an infant and young child feeding assessment and counselling and gathering information on complementary feeding practices	198
Session 22. Feeding during illness and low-birthweight babies.....	202
Session 23. Expressing breastmilk.....	209
Session 24. Cup feeding	214
Session 25. Overview of HIV and infant feeding	217
Session 26. Breastfeeding guidance for HIV-infected mothers (Optional).....	228
Session 27. Practice using <i>Counselling Cards</i> and role-play with scenarios for HIV counselling.....	237
Session 28. Commercial infant formula feeding	243
Session 29. Checking understanding and arranging for follow-up.....	254
Session 30. Food demonstration	257
Session 31. Maternal nutrition	264
Session 32. Follow-up after training	269

Appendix 1. Glossary of Terms	272
Appendix 2. Infant and Young Child Feeding Assessment (0 Up to 24 Months) Job Aid	279
Appendix 3. Breastfeed Observation Job Aid	280
Appendix 4. Counselling Skills Checklist.....	281
Appendix 5. Key Points for Complementary Feeding	282
Appendix 6. Food Consistency Photos	283
Appendix 7a. Food Intake (6 up to 24 Months) Job Aid.....	284
Appendix 7b. Food Intake (6 up to 24 Months) Reference Tool.....	285
Appendix 8a. Counselling Stories for Food Intake (6 up to 24 Months) Job Aid Practice....	286
Appendix 9a. Counselling Stories for Practice Using <i>Counselling Cards</i> and Role-Play with Scenarios for HIV Counselling.....	289
Appendix 10. Planning Guide for a Group Demonstration on the Preparation of Young Children’s Food	291
Appendix 11. Recipes for the Food Demonstration.....	293
Appendix 12. Growth Monitoring and Nutritional Assessment.....	294

Introduction to this guide

Why this course is needed

Optimal infant and young child feeding is fundamental for the survival, health, nutrition, growth, and development of a child. The Federal Ministry of Health, Nigeria, United Nations Children's Fund (UNICEF), and World Health Organization (WHO) have long recognized the need for the promotion of exclusive breastfeeding for the first six months of life, and sustained breastfeeding together with adequate complementary feeding until 2 years of age or beyond, to reduce infant and young child morbidity and mortality.

However, many children are not fed in the recommended way. Many mothers who initiate breastfeeding satisfactorily often start complementary foods 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 quality complementary foods. This has resulted in malnutrition, which is an increasing problem in many countries. More than one-third of children younger than 5 years 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 given by 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 is 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.

In Nigeria, infant and young child feeding practices have remained unsatisfactory, as evidenced by low rates of timely breastfeeding initiation (38%) and very low rates of exclusive breastfeeding for the first six months (13%). More than 50% of Nigerian infants are given complementary foods too early. Malnutrition is common. Among children younger than 5 years, 41% are stunted, 23% are underweight, and more than 14% are wasted (NDHS 2008). Vitamin and mineral deficiencies remain a major issue among children younger than 5 years. It is estimated that nearly 60% of all childhood deaths in the country are due to underlying malnutrition. Poor feeding practices largely contribute to this situation and must be addressed if the country is to achieve Millennium Development Goals 1, 4, and 5: reduction of hunger, child mortality, and maternal mortality.

Messages about infant feeding have become confused in recent years with the HIV pandemic. HIV infection is currently one of the main causes of ill health and death among children. The Joint United Nations Programme on HIV/AIDS (UNAIDS) estimated that by the end of 2009, 3.3 million people in Nigeria were living with HIV. Of these, 360,000 were children younger than 15 years. In 95% of cases, children acquire the infection from their mothers, before or during delivery, or after delivery through breastfeeding. This is called mother-to-child transmission (MTCT) of HIV, or vertical transmission.

Avoiding breastfeeding is one of the ways to reduce the risk of MTCT. However, not breastfeeding is also associated with increased childhood morbidity and mortality. When it was documented that MTCT occurs through breastfeeding, policymakers became reluctant to issue policies on promotion of breastfeeding, and nutrition workers remained in doubt as to whether to continue promoting breastfeeding. Accordingly, it became difficult for health workers to advise HIV-infected women how best to feed their infants. It became even more difficult for the mother and her family to decide what is best.

Health care providers who deal with mothers and children in areas where HIV is an issue need updated information and necessary skills/competencies to be able to counsel women and their families on infant and young child feeding. Therefore, there is an urgent need to train those who work in this area according to the guidelines in this training manual. These guidelines also emphasize the need to protect, promote, and support breastfeeding for those who are HIV-negative or of unknown status.

This five-day *Integrated Infant and Young Child Feeding Counselling: A Training Course* should replace the previous counselling courses available from WHO/UNICEF:

Breastfeeding Counselling: A Training Course (five days), *HIV and Infant Feeding Counselling: A Training Course* (three days) [with UNAIDS], and *Complementary Feeding Counselling: A Training Course* (three days). In fact, most of the materials in this integrated course are taken from these three courses, because in many situations, there is simply not enough time available to allow health workers to attend all of the 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 as well as the new guidelines on infant feeding within the context of HIV.

Counselling is an extremely important component of this course, as it was in the other three 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 people and try to understand how they feel, and help them decide what is best for them from various options or suggestions, and you help them to have the confidence to carry out their decisions. This course aims to give health workers basic counselling skills so that they can help mothers and caregivers more effectively.

Integrated Infant and Young Child Feeding Counselling: A Training Course has been designed to meet this need and covers six broad areas:

1. Breastfeeding.
2. Breastfeeding management.
3. HIV and infant feeding.
4. Infant and young child feeding within the context of HIV.
5. Counselling.
6. Implementation of optimal infant and young child feeding practices.

Target audience

This course is intended for maternal and child health service providers at all levels, including:

- Midwives.
- Lay counsellors.
- Community health workers.
- Dieticians, nutritionists, and health educators.
- Prevention of mother-to-child transmission of HIV (PMTCT) counsellors (first-level counsellors at the primary health care level).
- Nurses/midwives and doctors, especially supervisors, and/or those at the referral level, including lay counsellors, and community health workers.
- Clinicians at first-referral level.

This course can be used to complement existing courses such as *Integrated Management of Childhood Illness (IMCI)*. The course can also be used as part of the pre-service training of health workers. However, it does NOT prepare people to take 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 those young children for further services and care as necessary. In addition, this course does not prepare people to conduct HIV counselling and testing, which includes pre- 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 competencies

This course is based on a set of competencies that each 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 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 master 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, participants should practice as many of the skills as possible, so that they will know what to do when they return to work. The skills will be practiced further in the supervised follow-up session.

The competencies at the beginning of the table are those that are most commonly used, and on which later competencies depend. For example, ‘Use listening and learning skills to counsel a mother’ is applied to many of the other competencies.

Table of Competencies

Competency	Knowledge	Skills
1. Use listening and learning skills to counsel a mother.	<ul style="list-style-type: none"> • List the six listening and learning skills. • Give an example of each skill. 	<ul style="list-style-type: none"> • Use the listening and learning skills appropriately when counsellng 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 six confidence and support skills. • Give an example of each skill. 	<ul style="list-style-type: none"> • Use the confidence and support skills appropriately when counsellng 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. • Use the BREASTFEED OBSERVATION JOB AID to recognize a mother who needs help.
4. Help a mother to position a baby at the breast.	<ul style="list-style-type: none"> • Explain the Four Key Points of Positioning. • Describe how a mother should support her breast for feeding. • Explain the main breastfeeding positions: sitting, lying, underarm, and across. 	<ul style="list-style-type: none"> • Recognize good and poor positioning according to the Four Key Points of Positioning. • Use the Four Key Points of Positioning to help a mother to position her baby in different breastfeeding 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 Four 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.
6. Explain to a mother about the optimal pattern of breastfeeding.	<ul style="list-style-type: none"> • Describe the physiology of breastmilk production and flow. • Describe unrestricted (or demand) feeding, and the 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 breastmilk by hand.	<ul style="list-style-type: none"> • List the situations for which expressing breastmilk 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 breastmilk. • Describe how to store breastmilk. 	<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 breastmilk. • Explain to a mother the steps of expressing breastmilk by hand. • Observe a mother expressing breastmilk by hand and help her if necessary.

Competency	Knowledge	Skills
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. • Practice 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 weight of a child on a growth chart. 	<ul style="list-style-type: none"> • Plot the weight of a child on a growth chart. • Interpret a child's individual growth curve.
10. Take a feeding assessment for an infant 0-6 months.	<ul style="list-style-type: none"> • Describe the contents and arrangement of the INFANT AND YOUNG CHILD FEEDING ASSESSMENT (0 UP TO 24 MONTHS) JOB AID. 	<ul style="list-style-type: none"> • Take a feeding assessment using the job aid and appropriate counselling skills according to the age of the child.
11. Teach a mother the 11 Key Points for Complementary Feeding.	<ul style="list-style-type: none"> • List and explain the seven Key Points for Complementary Feeding about what to feed to an infant or young child to fill the nutrition gaps (Key Points for Complementary Feeding 1–7). • Explain when to use the food consistency photos, and what each photo shows. • List and explain the two Key Points for Complementary Feeding about quantities of food to give to an infant or young child (Key Points for Complementary Feeding 8–9). • List and explain the Key Point for Complementary Feeding about how to feed an infant or young child (Key Point for Complementary Feeding 10). • List and explain the Key Point for Complementary Feeding about how to feed an infant or young child during illness (Key Point for Complementary Feeding 11). 	<ul style="list-style-type: none"> • Explain to a mother the seven Key Points for Complementary Feeding about what to feed to an infant or young child to fill the nutrition gaps (Key Points for Complementary Feeding 1–7). • Use the food consistency photos appropriately during counselling. • Explain to a mother the two Key Points for Complementary Feeding about quantities of food to give to an infant or young child (Key Points for Complementary Feeding 8–9). • Explain to a mother the Key Point for Complementary Feeding about how to feed an infant or young child (Key Point for Complementary Feeding 10). • Explain to a mother the Key Point for Complementary Feeding about how to feed an infant or young child during illness (Key Point for Complementary Feeding 11).
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. 	<ul style="list-style-type: none"> • Help a mother to initiate belly-to-belly contact immediately after delivery and to introduce her

Competency	Knowledge	Skills
	<ul style="list-style-type: none"> Describe how health care practices affect initiation of exclusive breastfeeding. 	<p>baby to the breast.</p> <ul style="list-style-type: none"> Apply competencies 1, 2, 4, and 5.

Competency	Knowledge	Skills
14. Support exclusive breastfeeding 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 1–10 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 breastmilk in the second 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 low breastmilk 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 determine the cause of low breastmilk intake. 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 determine the cause of frequent crying. 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 baby with colic.
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 determine the cause of breast refusal. 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 belly-to-belly contact to help her baby accept the breast again. Apply competencies 7 and 8 to maintain breastmilk production and to feed the baby meanwhile.
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.

Competency	Knowledge	Skills
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 mother and an HIV-infected mother. 	<ul style="list-style-type: none"> • Recognize mastitis and refer if necessary. • Recognize a blocked milk duct. • Manage a blocked duct appropriately. • Manage mastitis appropriately using competencies 1, 2, 3, 4, 5, 6, 7, and 8, and rest, analgesics, and antibiotics if indicated. • Refer to the appropriate level of care. • Refer an HIV-positive mother with mastitis to the appropriate level of care.
23. Help a mother to breastfeed a low-birthweight baby or sick baby.	<ul style="list-style-type: none"> • Explain why breastmilk is important for a low-birthweight baby or sick baby. • Describe the different ways to feed breastmilk to a low-birthweight baby. • Estimate the volume of milk to offer a low-birthweight baby per feed and per 24 hours. 	<ul style="list-style-type: none"> • Help a mother to feed her low-birthweight 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. Advise an HIV-infected woman about the national recommendations on infant feeding within the context of HIV in Nigeria.	<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-infected and for women who are not HIV-infected or do not know their status. 	<ul style="list-style-type: none"> • Apply competencies 1 and 2 to advise an HIV-infected woman.
25. Support an HIV-infected mother who independently decides not to breastfeed.	<ul style="list-style-type: none"> • Explain how to prepare commercial infant formula. • Describe hygienic preparation of commercial infant formula and utensils. • Explain the volumes of milk to offer a baby according to weight. 	<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. • Practice with a mother how to prepare commercial infant formula or other replacement feeds hygienically. • Show a mother how to measure milk and other ingredients to prepare feeds. • Practice with a mother how to measure milk and other ingredients to prepare foods. • Explain to a mother the volume

Competency	Knowledge	Skills
26. Follow up the infant (0–6 months) of an HIV-infected mother who is receiving replacement milk.	<ul style="list-style-type: none"> • Describe hygienic preparation of foods. • 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"> of milk to offer her baby and the number of feeds per 24 hours. • Use the <i>Counselling Cards</i> and flyers appropriately. • Show a mother how to prepare replacement foods hygienically. • Practice with a mother how to prepare replacement foods hygienically. • Apply competency 8. • Recognize when a child needs to be referred. • Explain to a mother how to feed her baby during illness or recovery. • Use the <i>Counselling Cards</i> and flyers appropriately.
27. Help an HIV-infected mother to begin complementary feeding at 6 months and cease breastfeeding at 12 months.	<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 and 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. • Practice 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.
28. Help mothers whose babies are older than 6 months to give complementary feeds.	<ul style="list-style-type: none"> • List the nutrition gaps that occur after 6 months when a child can no longer get enough nutrients from breastmilk alone. • List the foods that can fill the gaps. • Describe how to prepare foods 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 (6 UP TO 24 MONTHS) JOB AID to learn how a mother is feeding her infant or young child. • Identify the gaps in the diet using the FOOD INTAKE (6 UP TO 24 MONTHS) JOB AID and THE FOOD INTAKE REFERENCE TOOL (6 up to 24 MONTHS). • Explain to a mother what foods to feed her child to fill the gaps, applying competency 11. • Show a mother how to prepare foods hygienically. • Demonstrate preparation of a meal for an infant or young child at different ages (8, 10, 15 months). • Practice with a mother how to prepare meals for her infant or young child. • Apply competency 15 to help a mother to sustain breastfeeding up to 2 years of age or beyond.
29. Help a mother with a	<ul style="list-style-type: none"> • Explain feeding during illness and 	<ul style="list-style-type: none"> • Apply competencies 1, 2, 9, 10,

Competency	Knowledge	Skills
breastfed child older than 6 months who is not growing well.	<ul style="list-style-type: none"> <li data-bbox="589 213 931 297">recovery. <li data-bbox="589 255 931 297">• Describe how to prepare foods hygienically. 	<ul style="list-style-type: none"> <li data-bbox="1013 213 1111 234">and 11. <li data-bbox="1013 234 1372 523">• Apply competency 15 to help a mother to sustain breastfeeding up to 2 years of age or beyond. <li data-bbox="1013 340 1323 361">• Explain to a mother how to feed during illness and recovery. <li data-bbox="1013 361 1323 382">• Demonstrate to a mother how to prepare foods hygienically. <li data-bbox="1013 382 1372 523">• Recognize when a child needs follow-up and when a child needs referral.
30. Help a mother with a non-breastfed child older than 6 months who is not growing well.	<ul style="list-style-type: none"> <li data-bbox="589 523 975 608">• Explain about the special attention to give to children who are not receiving breastmilk. <li data-bbox="589 608 975 756">• List the recommendations for feeding a non-breastfed child, including quantity, quality, consistency, frequency, and method of feeding. <li data-bbox="589 756 975 819">• Explain feeding during illness and recovery. <li data-bbox="589 819 931 878">• Describe how to prepare foods hygienically. 	<ul style="list-style-type: none"> <li data-bbox="1013 523 1372 582">• Apply competencies 1, 2, 9, 10, and 11. <li data-bbox="1013 582 1323 604">• Explain to a mother how to feed a non-breastfed child. <li data-bbox="1013 604 1323 663">• Explain to a mother how to feed during illness and recovery. <li data-bbox="1013 663 1323 722">• Demonstrate to a mother how to prepare foods hygienically. <li data-bbox="1013 722 1372 878">• Recognize when a child needs follow-up and when a child needs referral.
31. Maternal nutrition.	<ul style="list-style-type: none"> <li data-bbox="589 878 975 937">• Discuss the importance of maternal nutrition. <li data-bbox="589 937 975 996">• List the various causes of maternal malnutrition. <li data-bbox="589 996 931 1034">• Explain the best type of diet for a pregnant or lactating mother. <li data-bbox="589 1034 975 1110">• Explain what a mother needs to do to protect her health. 	<ul style="list-style-type: none"> <li data-bbox="1013 878 1356 937">• Show a mother the variety of foods to eat. <li data-bbox="1013 937 1356 1030">• Explain to a mother how best to protect her health during pregnancy and breastfeeding.

Structure of the course

The course is divided into 32 sessions, which take approximately 35 hours without meals or the opening and closing ceremonies. The sessions use a variety of teaching methods, including lectures, demonstrations, and work in small groups, including practical exercises.

Teaching materials

Teaching materials include lectures, demonstrations, clinical practice, and work in small groups for discussion, brainstorming, reading, role-play, videos, and exercises. Participants progressively develop their support and counselling skills in the classroom, and then practice them with mothers and babies in wards or clinics.

Accompanying course materials:

- **Participant's Manual:** The 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 the answers). Participants can use the manual for reference after the course, so it is not essential for them to take detailed notes, but you can add notes to it as you participate.
- **Slides:** Many sessions use slides. These are provided on a CD for projection onto a screen.

- **Forms and checklists:** Loose copies of the forms and checklists needed for the practical sessions and counselling exercises are provided. These include:
 - INFANT AND YOUNG CHILD FEEDING ASSESSMENT (0 UP TO 24 MONTHS) JOB AID (Appendix 2)
 - BREASTFEED OBSERVATION JOB AID (Appendix 3)
 - COUNSELLING SKILLS CHECKLIST (Appendix 4)
 - FOOD INTAKE (6 UP TO 24 MONTHS) JOB AID (Appendix 7a)
- **Story cards:** Copies of the counselling stories are provided for *Session 10: Counselling Cards* (Appendix 8a) and other tools and *Session 27: Practice using Counselling Cards and role-play with scenarios for HIV counselling* (Appendix 9a).
- **Visual aids:** For most of the sessions, there will be flipcharts, and a blackboard and chalk or white board and suitable markers.
- **Training aids:** For demonstration purposes, we will use props, such as a life-size baby doll and a model breast for some of the sessions.

Session 1. Course introduction

Objectives

After completing this session, participants will be able to:

- Describe the objectives of the course.
- Describe the components of the Infant and Young Child Feeding Counselling Package.
- Describe The Global Strategy for Infant and Young Child Feeding.
- State the current recommendations for feeding children from 0 up to 24 months of age.

Participants are all together for a lecture presentation by one trainer (35 minutes).

Introduction (Slides 1/1 – 1/11)	10 minutes
Description of the materials and methods for the course	5 minutes
Pre-Test	20 minutes

Introduction

Slide 1/2 and Slide 1/3: Introduction to IYCF and Course objectives include:

Introduction to IYCF	Course objectives include:
<p>After completing this session, participants will be able to:</p> <ul style="list-style-type: none">• Describe the objectives of the course.• Describe the components of the Infant and Young Child Feeding Counselling Package.• 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 up to 24 months of age.	<p>To enable health workers to develop the clinical and interpersonal skills needed to support optimal infant and young child feeding practises, and, where necessary, to help mothers to overcome difficulties.</p> 

Key point(s):

- Optimal infant and young child feeding is fundamental for the survival, health, nutrition, growth, and development of a child.
- However, many children are not fed in the recommended way.
- In Nigeria, infant and young child feeding practices have remained unsatisfactory.
 - The rate of timely breastfeeding initiation is low, at 38%.
 - The exclusive breastfeeding rate is very low, at 13%.
- It is estimated that in Nigeria, nearly 60% of all childhood deaths are due to underlying malnutrition.

Malnutrition is common. Among children younger than 5 years, 41% are stunted, 23% are underweight, and more than 14% are wasted. Micronutrient deficiencies are also a problem

among children under five.

Slide 1/4 and Slide 1/5: Why this course is needed

Why this course is needed	1/4	Why this course is needed (cont.)	1/5
<ul style="list-style-type: none">• Optimal infant and young child feeding is fundamental for the survival, health, nutrition, growth, and development of a child.• In Nigeria, infant and young child feeding practises are unsatisfactory.• Low rates of timely breastfeeding initiation (38%) and very low rates for 6 months of exclusive breastfeeding (13%).• Malnutrition is common. Among children under 5 years of age, 41% are stunted, 23% are underweight, while over 14% are wasted (NDHS 2008).		<ul style="list-style-type: none">• By the end of 2009, UNAIDS estimates that 3.3 million persons in Nigeria were living with HIV. Of these, 360,000 were children under 15 years of age.• Avoiding breastfeeding is one of the ways to reduce the risk of mother-to-child transmission of HIV.• BUT not breastfeeding is also associated with increased childhood morbidity and mortality.• It is difficult for health workers to counsel HIV-infected women on how to feed their infants, and it is even more difficult for the mother and her family to decide what is best.	

Key point(s):

- 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 is 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 in recent years with the HIV pandemic.
- HIV infection is currently one of the main causes of ill health and death among children.
- The Joint United Nations Programme on HIV/AIDS estimated that by the end of 2009, 3.3 million people in Nigeria were living with HIV. Of these, 360,000 were children younger than 15 years of age.

- It became difficult for health workers to advise HIV-infected women on how best to feed their infants, and even more difficult for the mother and her family to decide what is best.
- Health care providers who deal with mothers and children in areas where HIV is an issue need updated information and the necessary skills/competencies to be able to counsel women and their families on infant and young child feeding.

Slide 1/6: The Global Strategy for Infant and Young Child Feeding

The Global Strategy for Infant and Young Child Feeding	1/6
<ul style="list-style-type: none"> • Developed by WHO and UNICEF to revitalize world attention on the impact that feeding practises 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 <5 years. • Over two-thirds of these deaths occur in the first year of life. 	
 <i>National Integrated Infant and Young Child Feeding counselling Course</i>	

- The Global Strategy for Infant and Young Child Feeding was developed by WHO and UNICEF jointly, to revitalize world attention on 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.

Slide 1/7: Policy initiatives

Policy initiatives	1/7
<ul style="list-style-type: none"> • 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) • National Policy on IYCF (2010) 	
 <i>National Integrated Infant and Young Child Feeding counselling Course</i>	

- 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, nongovernmental organizations (NGOs), commercial enterprises, and international organizations.
- The Global 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.

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 multi-sectoral national breastfeeding committee.
2. Ensure that every facility providing maternity services fully practices 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.

Slide 1/8: How this course was developed; Slide 1/9: National recommendations

How this course was developed	National recommendations
<p>This 5-day <i>National Integrated Infant and Young Child Feeding Counselling Course</i> integrates:</p> <ul style="list-style-type: none"> • WHO/UNICEF - Breastfeeding Counselling: A Training Course (5 days) • WHO/UNICEF - HIV and Infant Feeding Counselling: A Training Course (3 days) [with UNAIDS] • WHO/UNICEF - Complementary Feeding Counselling: A Training Course (3 days) • New National Guidelines on ARVs for PMTCT and the Consensus on Infant Feeding in the Context of HIV/AIDS 	<p>1/8</p> <ul style="list-style-type: none"> • Start breastfeeding within 1/2 hour of birth. • Breastfeed exclusively from 0-6 months. • Give complementary foods to all children from 6 months. • Continue breastfeeding up to 2 years or beyond. • Counsel HIV-infected women and support them.  <p>1/9</p>

In summary, the policy promotes initiation of breastfeeding within the first hour of birth and exclusive breastfeeding for the first six months, followed by complementary feeding and continued breastfeeding for two years or beyond. HIV-infected women should be counselled to make an infant feeding choice and then supported to implement that decision.

Slide 1/10: Infant and young child feeding practices in Nigeria

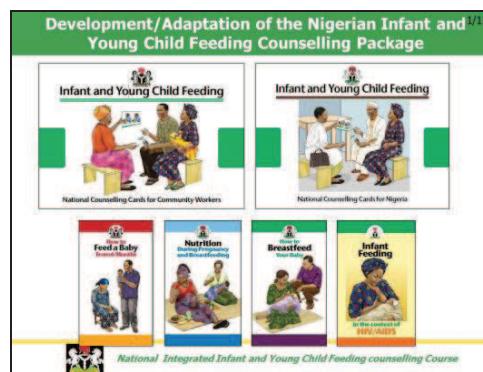
Infant and Young Child Feeding Practises in Nigeria (NDHS 2008)		1/10
Early initiation of breastfeeding (% of babies breastfed within one hour of birth)	38.4%	
Percentage of children <6 months exclusively breastfed	13%	
Use of pre-lacteal feeds	56%	
Median duration (in months) of any breastfeeding	18.1	
Percentage of infant <6 months fed using a bottle	16%	
Percentage of children ages 6–23 months in compliance with infant and young child feeding practices	30.2%	
Percentage of children 6–23months who consumed foods from at least three food groups	52%	
Percentage of children 6–35months who consumed foods rich in Vitamin A	82%	
Percentage of children 6–23months who consumed foods rich in Iron	70%	

In spite of the favourable policy environment, infant and young child feeding indicators remain unsatisfactory.

This slide summarises the findings from Nigeria with regard to infant and young child feeding practices and nutritional indicators in the country.

Slide 1/11: Development/adaptation of the Nigerian Infant and Young Child Feeding Counselling Package

Nigeria has developed and/or adapted several documents related to counselling for infant and young child feeding.



This counselling package includes:

1. Infant and Young Child Feeding National Counselling Cards for Nigeria (*Counselling Cards*).
2. *Take-Home brochures*:
 - *How to Feed a Baby from Six Months*.
 - *Nutrition During Pregnancy and Breastfeeding*.
 - *How to Breastfeed Your Baby*.
 - *Infant Feeding in the Context of HIV/AIDS*.

Description of the materials and methods for the course (5 minutes)

Key point(s):

- The course is divided into 32 sessions, which take approximately 35 hours without meals or the opening and closing ceremonies.
- The sessions use a variety of teaching methods, including lectures, demonstrations, and work in small groups, including practical exercises.
- Teaching materials include lectures, demonstrations, clinical practice, and work in small groups for discussion, brainstorming, reading, role-play, videos, and exercises.
- Participants will progressively develop their support and counselling skills in the classroom, and then practice them with mothers and babies in wards or clinics.
- **Participant's Manual:** The 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 the answers). Participants can use the manual for reference after the course, so it is not essential for them to take detailed notes, but you can add notes to it as you participate.
- **Slides:** Many sessions use slides. These are provided on a CD for projection onto a screen.

- **Forms and checklists:** Loose copies of the forms and checklists needed for the practical sessions and counselling exercises are provided. These include:
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 - **Story cards:** Copies of the counselling stories are provided for *Session 10: Counselling Cards* (Appendix 8a) and other tools and *Session 27: Practice using Counselling Cards and role-play with scenarios for HIV counselling* (Appendix 9a).
 - **Visual aids:** For most of the sessions, there will be flipcharts, and a blackboard and chalk or white board and suitable markers.
 - **Training aids:** For demonstration purposes, we will use props, such as a life-size baby doll and a model breast for some of the sessions.

Take Pre-Test

Notes:

Session 2. Why breastfeeding is important

Objectives

After completing this session, participants will be able to:

- Define ‘exclusive breastfeeding’.
- State the advantages of exclusive breastfeeding.
- List the disadvantages of commercial infant formula feeding.
- Describe the main differences between breastmilk and commercial infant formula.

Session outline

Participants are all together for a lecture presentation by one trainer (45 minutes).

Introduction (Slide 2/1)	3 minutes
Exclusive breastfeeding (Slide 2/2)	5 minutes
Presentation of Slides 2/3–2/9	35 minutes
Summary	2 minutes

Introduction

Key point(s):

- 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 breastmilk.

Slide 2/1: Objectives: Why breastfeeding is important

Objectives: Why breastfeeding is important	2/1
After completing the session, participants will be able to:	
<ul style="list-style-type: none">• Define exclusive breastfeeding.• State the advantages of exclusive breastfeeding.• List the disadvantages of commercial infant formula.• Describe the main differences between breastmilk and commercial infant formula.	
 National Integrated Infant and Young Child Feeding counselling Course	

Exclusive breastfeeding

Slide 2/2: Definition of exclusive breastfeeding

Definition of 'Exclusive breastfeeding'	2/2
<ul style="list-style-type: none">● 'Exclusive breastfeeding' means giving a baby only breastmilk, and no other liquids or solids, not even water.● Drops or syrups consisting of vitamins, mineral supplements, or medicines are permitted when medically prescribed.	
 National Integrated Infant and Young Child Feeding counselling Course	

Key point(s):

- 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.

Presentation of Slides 2/3 through 2/9

Slide 2/3: Advantages of breastfeeding

Advantages of breastfeeding	2/3		
<table border="0"><tr><td style="vertical-align: top;">Breastmilk<ul style="list-style-type: none">● Perfect nutrients.● Easily digested, efficiently used.● Protects against infection.● Costs less than commercial infant formula.</td><td style="vertical-align: top;">Breastfeeding<ul style="list-style-type: none">● Helps bonding and development.● Costs less than formula.● Helps delay a new pregnancy.● Protects mother's health.</td></tr></table>	Breastmilk <ul style="list-style-type: none">● Perfect nutrients.● Easily digested, efficiently used.● Protects against infection.● Costs less than commercial infant formula.	Breastfeeding <ul style="list-style-type: none">● Helps bonding and development.● Costs less than formula.● Helps delay a new pregnancy.● Protects mother's health.	
Breastmilk <ul style="list-style-type: none">● Perfect nutrients.● Easily digested, efficiently used.● Protects against infection.● Costs less than commercial infant formula.	Breastfeeding <ul style="list-style-type: none">● Helps bonding and development.● Costs less than formula.● Helps delay a new pregnancy.● Protects mother's health.		
 National Integrated Infant and Young Child Feeding counselling Course			

Key point(s):

- It is useful to think of the advantages of both breastmilk (listed on the left) and the process of breastfeeding (listed on the right).

The advantages of a baby having breastmilk are that:

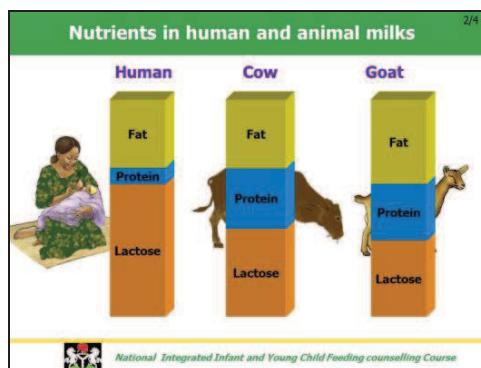
- It contains exactly the nutrients that a baby needs.
- It is easily digested and efficiently used by the baby's body.
- It protects a baby against infection.

The other advantages of breastfeeding are that:

- It costs less than commercial infant formula feeding.
- It helps a mother and baby to bond; that is to develop a close, loving relationship.
- 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.
- 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 anemia. Breastfeeding also reduces the risk of ovarian cancer and breast cancer in the mother.

Group activity: Community beliefs about breastfeeding

Slide 2/4: Nutrients in human and animal milks

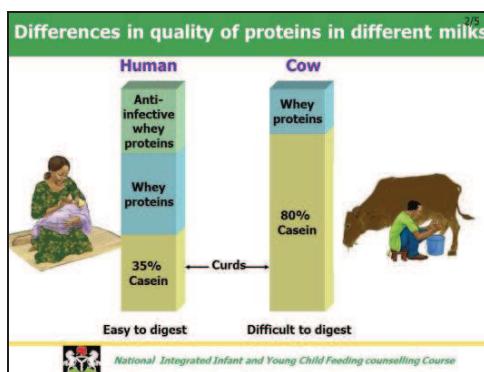


Key point(s):

- First, we will look at the nutrients in breastmilk, to see why they are perfect for a baby.
- Commercial infant formula is 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 commercial infant formula, we need to understand the differences between animal and human milks and how animal milks need to be modified to produce commercial infant formula.
- This chart compares the nutrients in breastmilk 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 that also provides energy.

- 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 commercial infant formula.

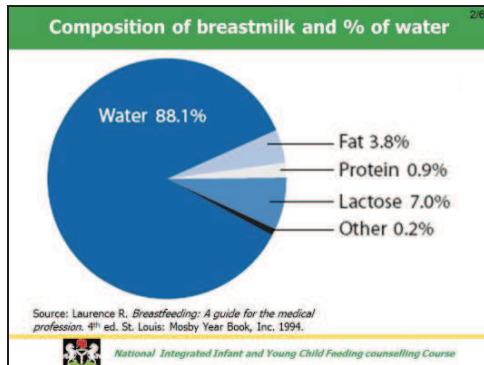
Slide 2/5: Differences in quality of proteins in different milks



Key point(s):

- The protein in different milks varies in quality, as well as in quantity. While the quantity of protein in cow's milk can be modified to make formula, the quality of proteins cannot be changed.
- This chart shows that much of the protein in cow's milk is casein.
- 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.
- Commercial infant formula-fed babies may develop intolerance to protein from animal milk. They may develop diarrhoea, abdominal pain, rashes, and other symptoms when they have foods that contain the different kinds of protein.
- Breastmilk contains white blood cells and a number of anti-infective factors, which help to protect a baby against many infections.
- Breastmilk also contains antibodies against infections that the mother has had in the past.
- When a mother develops an infection, white cells in her body become active and make antibodies against the infection to protect her.
- Some of these white cells go to her breasts and make antibodies that are secreted in her breastmilk to protect her baby.
- So a baby should not be separated from his mother when she has an infection, because her breastmilk protects him against the infection.

Slide 2/6: Composition of breastmilk and % of water

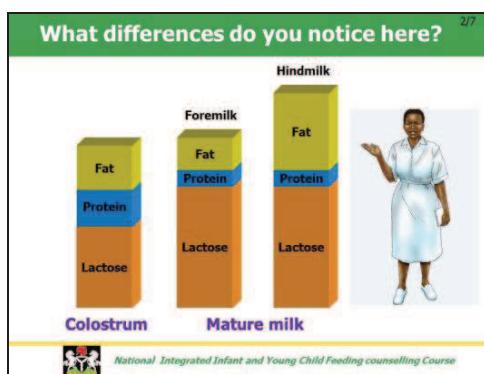


Key point(s):

- Breastmilk is 88% water.
- Every time a mother breastfeeds, she gives her baby water through her breastmilk.
- Breastmilk has everything a baby needs to quench thirst and satisfy hunger. It is the best possible food and drink that can be offered to a baby so the baby will grow to be strong and healthy.
- For the most part, the water requirements of infants 6 up to 12 months can be met through breastmilk. Additional water can be provided through fruits or fruit juices, vegetables, or small amounts of boiled water offered after a meal.
- Caution should be taken to ensure that water and other liquids do not replace breastmilk.

Group activity: Brainstorm and listing of properties of colostrum and local beliefs and practices related to colostrum

Slide 2/7: Colostrum and mature milk: What differences do you notice here?



Key point(s):

- The composition of breastmilk 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.
- Colostrum is the special breastmilk 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.

- 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 say that is 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 or water before they are 6 months old, even in a hot climate.
- Hindmilk is the whiter milk that is produced later in a feed. It contains more fat than foremilk, which is why it looks whiter [*point to the area on the graph*]. This fat provides much of the energy of a breastfeed, which is why it is important not to take the baby off a breast too quickly.
- Mothers sometimes worry that their milk is ‘too thin’. Milk is never too thin. It is important for a baby to have both foremilk and hindmilk to get a complete ‘meal’, which includes all the water that he needs.

Slide 2/8: Colostrum

Colostrum	
2/8	
Property	Importance
• Antibody rich	- Protects against infection & allergy.
• Many white cells	- Protects against infection.
• Purgative	- Clears meconium. - Helps to prevent jaundice.
• Growth factors	- Helps intestines to mature and prevents allergy, intolerance.
• Vitamin-A rich	- Reduces severity of infection, prevents eye disease.

Key point(s):

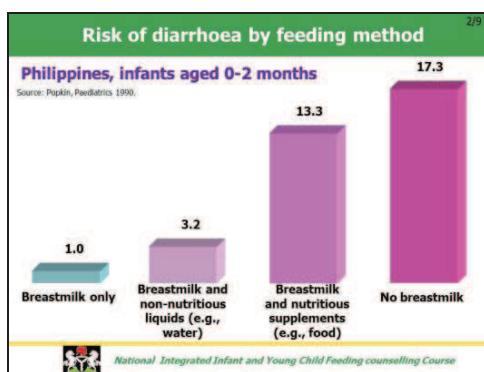
- Colostrum contains more antibodies and other anti-infective proteins than mature milk. This is part of the reason why colostrum contains more protein than mature milk.
- It contains more white blood cells than mature milk.
- Colostrum helps to prevent the bacterial infections that are a danger to newborn babies and provides the first immunization against many of the diseases that a baby meets after delivery.
- Colostrum has a mild purgative effect, which helps to clear the baby’s gut of meconium (the first dark stools). This clears bilirubin from the gut, and helps to prevent jaundice from becoming severe.
- Colostrum contains many growth factors that help a baby’s immature intestine to develop after birth. This helps to prevent the baby from developing allergies and intolerance to other foods.
- Colostrum is rich in vitamin A, which helps to reduce the severity of any infections the baby might have.

- 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. Commercial infant formula feeds given before a baby has colostrum are likely to cause allergy and infection.

Group activity: Colostrum compare local practices and medical knowledge

Group activity: Risk of diarrhoea by feeding method

Slide 2/9: Risk of diarrhoea by feeding method



Key point(s):

- Commercial infant formula-fed babies get diarrhoea more often, partly because commercial infant formula feeds lack anti-infective factors, and partly because commercial infant formula 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.

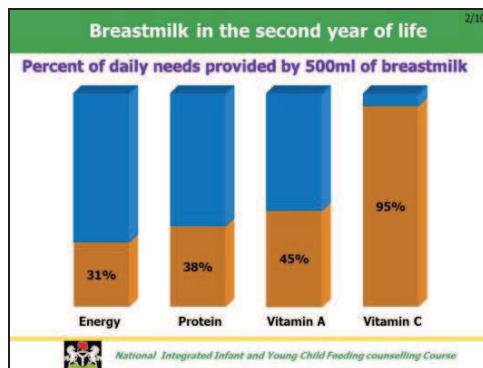
Group activity: Disadvantages of commercial infant formula feeding

Key point(s):

- Commercial infant formula feeding may interfere with bonding. The mother and baby may not develop such a close, loving relationship.
- A commercial infant formula-fed baby is more likely to become ill with diarrhoea, respiratory, and other infections. The diarrhoea may become persistent.
- The baby may get too little milk and become malnourished because he receives too few feeds or because they are too dilute.
- He is more likely to develop allergic conditions such as eczema and possibly asthma.

- He may become intolerant of animal milk, so the milk causes diarrhoea, rashes, and other symptoms.
- The risk of some chronic diseases in the child, such as diabetes, is increased.
- A mother who does not breastfeed may become pregnant sooner. She is more likely to become anemic after childbirth, and later to develop cancer of the ovary and the breast.
- Commercial infant formula feeding is harmful for children and their mothers.

Slide 2/10: Breastmilk in the second year of life



Key point(s):

- For the first six months of life, exclusive breastfeeding can provide all the nutrients and water that a baby needs.
- From the age of 6 months, breastmilk is no longer sufficient by itself. In Session 1, we learnt that all babies need complementary foods from 6 months, in addition to breastmilk.
- However, breastmilk continues to be an important source of energy and high-quality nutrients beyond 6 months of age. We will discuss this in more detail in the sessions on complementary feeding.
- This chart shows how much of a child's daily energy and nutrient needs can be supplied by breastmilk during the second year of life.
- It can provide about one-third of the energy and half of the protein a child needs.
- Breastmilk can provide about 75% of the vitamin A that a child needs, provided the mother is not deficient in vitamin A herself.

Key point(s):

- In this session, we have defined exclusive breastfeeding, and discussed the benefits of breastfeeding and the disadvantages of commercial infant formula feeding.

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. Breastmilk 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 than breastmilk, which may not be ideal for a baby. Animal milks 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 commercial infant formula.

The anti-infective proteins in human milk include lactoferrin (which binds iron, and prevents the growth of bacteria that 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 yoghury smell. Breastmilk also contains anti-viral and anti-parasitical factors.

Babies who develop intolerance to animal proteins may develop diarrhoea that 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 commercial infant formula feeds given in the first few days of life.

Vitamins:

The amounts of vitamins are different in breastmilk 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. Breastmilk contains plenty of vitamin A, if the mother has enough in her diet. Breastmilk 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 (more than 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 fetus.

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 breastmilk. These high levels are more than a baby needs. Goat's milk lacks the B vitamin folic acid, and this can cause anemia.

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

Iron:

Different milks contain similar, very small amounts of iron. However, only about 10% of the iron in cow's milk is absorbed, but about 50% of the iron from breastmilk is absorbed. Babies fed on cow's milk may not get enough iron, and they often become anemic. Some brands of formula have iron added. This added iron is not well absorbed, so a large amount has to be added to ensure that a baby gets enough iron to protect against anemia. Added iron may make it easier for some kinds of bacteria to grow, which may increase the chances of some kinds of infection (e.g., meningitis and septicaemia).

Foremilk and hindmilk:

There is no sudden change from 'fore' to 'hind' milk. The fat content increases gradually from the beginning to the end of a feed.

Protection against infection:

The main immunoglobulin in breastmilk is IgA, often called 'secretory' immunoglobulin A. It is secreted within the breast into the milk, in response to the mother's infections. This is different from other immunoglobulins (such as IgG), which are carried in the blood.

Intolerance and allergies to milk proteins:

Colostrum and breastmilk contain many hormones and growth factors. The function of all of them is not certain. However, epidermal growth factor, which is present in both, has been shown to stimulate growth and maturation

of the intestinal villi. Undigested cow's milk proteins can pass through the immature infant gut into the blood, and may cause intolerance and allergy to milk protein. Epidermal growth factor helps to prevent the absorption of large molecules by stimulating rapid development of the gut. This 'seals' the baby's intestine, so that it is more difficult for proteins to be absorbed without being digested.

Antibodies probably help to prevent allergies by coating the intestinal mucosa, and preventing the absorption of larger molecules.

Vitamin A from breastmilk in the second year of life:

There are different estimates of how much of a child's vitamin-A requirements can be provided by breastfeeding in the second year, ranging from 38% to 75%. The amount depends on the mother's vitamin-A status and the volume of breastmilk consumed. However, what we do know is that breastfeeding in the second year provides useful protection to the child against vitamin-A deficiency.

Notes:

Session 3. How breastfeeding works

Objectives

After completing this session, participants will be able to:

- Name the main parts of the breast and describe their function.
- Describe the hormonal control of breastmilk production and ejection.
- Explain the Four Key Points of Attachment.
- Describe the difference between good and poor attachment of a baby at the breast.

Session outline

Participants are all together for a lecture presentation by one trainer (70 minutes).

Introduction (Slide 3/1)	5 minutes
Presentation of Slides 3/2–3/12	60 minutes
Summary	5 minutes

Introduction

Slide 3/1: Objectives: How breastfeeding works

Objectives: How breastfeeding works 3/1

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 breastmilk production and ejection.
- Explain the Four Key Points of Attachment.
- Describe the difference between good and poor attachment of a baby at the breast.

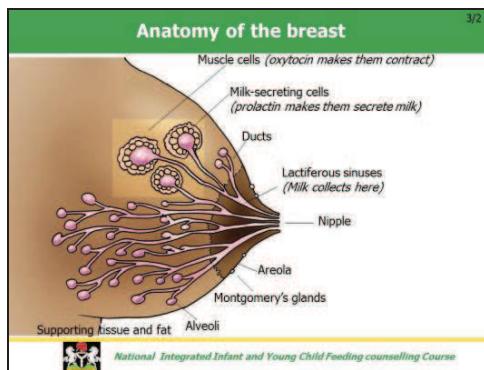
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Key point(s):

- 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.

Presentation of Slides 3/2 through 3/11

Slide 3/2: Anatomy of the breast

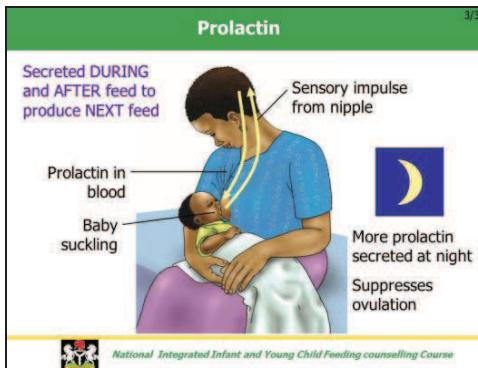


- First, look at the nipple, and the dark skin that surrounds it, called the areola. In the areola are small glands called Montgomery's glands that secrete an oily fluid to keep the skin healthy.
- Inside the breast are the alveoli, which are very small sacs made of milk-secreting cells. There are millions 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 lactiferous sinuses. Milk is stored there until it is removed.
- The larger ducts beneath the areola dilate during feeding and hold the breastmilk temporarily during the feed.
- The secretory alveoli and ducts are surrounded by supporting tissue and fat.

Some mothers think their breasts are too small to produce enough milk.

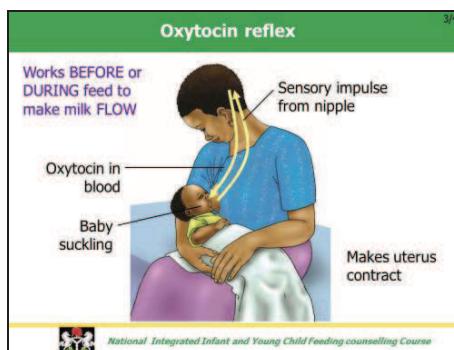
- It is the fat and other tissue that gives the breast its shape, and that makes most of the difference between large and small breasts.
- Small breasts and large breasts both contain about the same amount of gland tissue, so they can both make plenty of milk.

Slide 3/3: Prolactin



- 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 anterior part of the pituitary gland at the base of the brain secretes prolactin.
- Prolactin goes in the blood to the breast, and makes the milk-secreting cells produce milk.
- Most of the prolactin is in the blood about 30 minutes after the feed, so it makes the breast produce milk for the next feed. For this feed, the baby takes the milk that is already in the breast.
- 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.
- A special thing to remember about prolactin: 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.

Slide 3/4: Oxytocin reflex



- This diagram explains about the hormone oxytocin.
- When a baby suckles, sensory impulses go from the nipple to the brain. In response, the posterior part of the pituitary gland at the base of the brain secretes 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 gush of blood during a feed for the first few days. The pains can be quite strong.

Group activity: Brainstorm on how the oxytocin reflex affects mothers

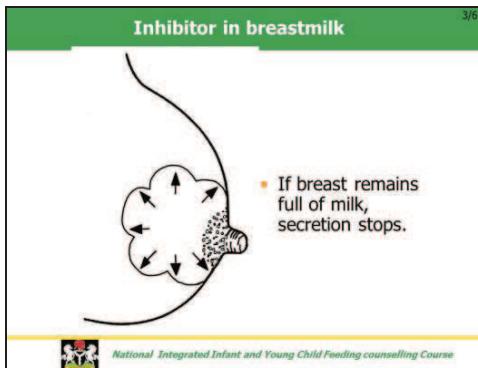
Key point(s):

- 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.
- 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.

Slide 3/5: Signs and sensations of an active oxytocin reflex

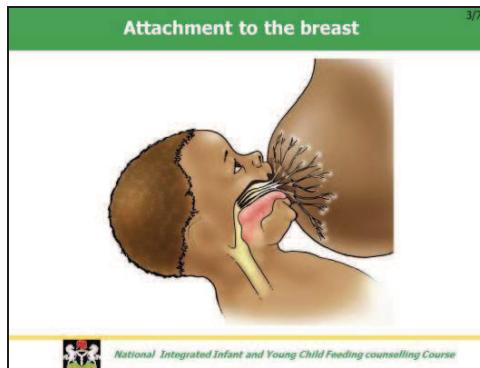
Signs and sensations of an active oxytocin reflex		3/5
A mother may notice:		
<ul style="list-style-type: none"> • A squeezing or tingling sensation in her breasts just before she feeds her baby, or during a feed. • Milk flowing from her breasts when she thinks of her baby, or hears him crying. • Milk 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 breastmilk is flowing into his/her mouth. 		
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Slide 3/6: Inhibitor in breastmilk



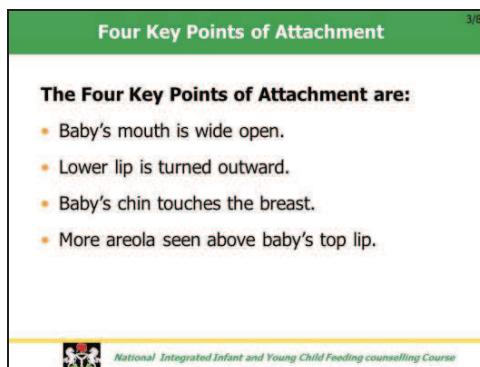
- Breastmilk production is also controlled within the breast itself.
- You may wonder why sometimes one breast stops making milk while the other breast continues to make milk, although oxytocin and prolactin go equally to both breasts. This diagram shows why.
- There is a substance in breastmilk that can reduce or inhibit milk production.
- If a lot of milk is left in a breast, the inhibitor stops the cells from secreting any more. This helps to protect the breast from the harmful effects of being too full. It is obviously necessary if a baby dies or stops breastfeeding for some other reason.
- If breastmilk 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 breastmilk must be removed by expression to enable production to continue. This is an important point, which we will discuss later in the course when we talk about expressing breastmilk.
- A baby needs to be well-attached to the breast for effective suckling.
- It is a technique to be learnt, since the baby is born knowing how to suckle.
- Health workers need to know this before they can teach mothers.

Slide 3/7: Attachment to the breast



- This diagram shows how a baby takes the breast into his mouth to suckle.
- 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 out the breast tissue 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 around the 'teat' of breast tissue. You cannot see that in this drawing, although 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 breastmilk 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.

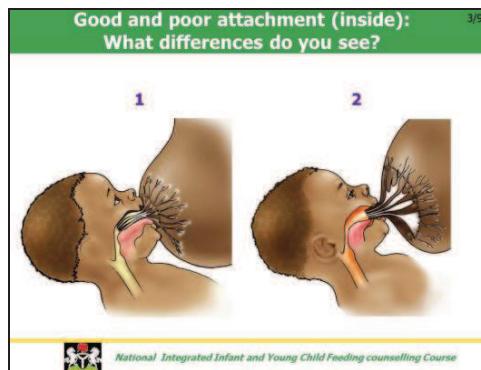
Slide 3/8: Four Key Points of Attachment



Key point(s):

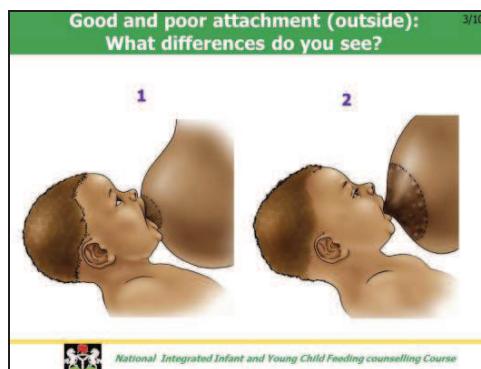
- The Four Key Points of Attachment are:
 - Baby's mouth is wide open.
 - Lower lip is turned outward.
 - Baby's chin touches the breast.
 - More areola seen above baby's top lip.

Slide 3/9: Good and poor attachment (inside): What differences do you see?



- Here, you see two illustrations. Illustration 1 is the same baby as in Slide 3/7.
- He is well-attached to the breast.
- Illustration 2 shows a baby suckling in a different way.
- The most important differences to see in illustration 2:
 - 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 illustration 2 is poorly attached. He is 'nipple sucking'.

Slide 3/10: Good and poor attachment (outside): What differences do you see?



- This illustration shows the same two babies from the outside.
- In illustration 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 illustration 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 illustration 1, his mouth is wide open. In illustration 2, his mouth is not wide open and points forward.
- In illustration 1, his lower lip is turned outward. In illustration 2, his lower lip is not turned outward.
- In illustration 1, the baby's chin touches the breast. In illustration 2, his chin does not touch the breast.
- These are some of the signs that you can see from the outside that tell you that a baby is well-attached to the breast.
- Seeing a lot of areola is not a reliable sign of poor attachment. Some mothers have a very large areola, and you can see a lot even when 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 you can see when you look at a real baby, which you will learn about in Session 4.

Slide 3/11: Results of poor attachment



Results of poor attachment:

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

Additional points:

- 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 breastmilk effectively, the breasts may become engorged.

- Because he does not get enough breastmilk, 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 breastmilk 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 from happening, all mothers need skilled help to position and attach their babies.
- Also, babies should **NOT** be given bottles feeds. If a baby feeds from a bottle before breastfeeding is established, he may have difficulty suckling effectively.

Group activity: Brainstorm on the reflexes in conjunction with Slide 3/11

- Earlier slides showed reflexes in a mother, but it is also useful to know about the reflexes in a baby.

Slide 3/12: Baby's breastfeeding reflexes



- 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 toward the breast. He is coming up to it from below the nipple. This helps him to attach well because:
 - The nipple is aiming toward 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.

Key point(s):

- In this session, we have named the main parts of the breast and described their function,

described the hormonal control of breastmilk and ejection, listed the Four Key Points of Attachment, and described the difference between good and poor attachment of a baby at the breast.

Notes:

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Session 4. Positioning a baby at the breast

Objectives

After completing this session, participants will be able to:

- Explain the Four 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 Four Key Points of Positioning in different positions.

Session outline

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 three to four with one trainer per group. (75 minutes)

Participants work in small groups of three to four each with one trainer for the practical session in a ward or clinic.

Introduction (Slide 4/1)	5 minutes
Helping a mother to position her baby (Slides 4/3–4/5)	35 minutes
Classroom Practical: positioning a baby using dolls (small groups)	30 minutes
Summary	5 minutes

Introduction

Slide 4/1: Objectives: Positioning a baby at the breast

Objectives: Positioning a baby at the breast	4/1
<p>After completing this session, participants will be able to:</p> <ul style="list-style-type: none">• Explain the Four 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 Four Key Points of Positioning in different positions.	

Key point(s):

- We are going to learn how to position a baby at the breast.
- We will be using the Four Key Points of Positioning from the section on positioning on the BREASTFEED OBSERVATION JOB AID (Appendix 3).
- There are several steps to follow when helping a mother to position her baby at the breast.

Slide 4/2: Four Key Points of Positioning

4/2

Four Key Points of Positioning

The Four Key Points of Positioning 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.

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Key point(s):

- The Four Key Points of Positioning 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.

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 of Positioning are:

1. Baby's head and body in line.
2. Baby held close to mother's body.
3. Baby's whole body supported.
4. 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.
- 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.

- Always assess a mother breastfeeding before you help her, using the Four Key Points of Positioning 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 be difficult for others.
- This is especially true with babies more than about 2 months old. There is no point trying to change a baby's position if he is getting breastmilk 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 get a baby to suckle if his mother cannot.

Helping a mother to position her baby

Demonstration 4.A: Demonstrate how to help a mother who is sitting.

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 practiced. 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 breastmilk, 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 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.

Demonstration:

- 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 on. 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 Four 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 of Positioning 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 is 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 that 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. 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 how to support her breast

Demonstrate how to help the mother to support her 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.
- 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

- 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 toward 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 suckling feels

- 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

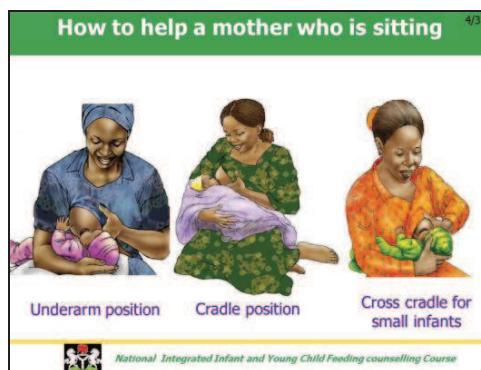
- Look for all the signs of good attachment (which you cannot see with a doll). If the attachment is not good, try again.
- It often takes several tries to get a baby well-attached. You may need to work with the mother again at a later time, or the next day, until breastfeeding is going well.

- 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 4.B: Other ways for a mother who is sitting to position her baby.

A mother holding her baby in the underarm position	A mother holding her baby in the cradle position	A mother holding her baby with the arm opposite the breast
Useful for: - Twins. - Blocked duct. - Difficulty attaching the baby.	Useful for: - Most normal babies.	Useful for: - Very small babies. - Sick babies.

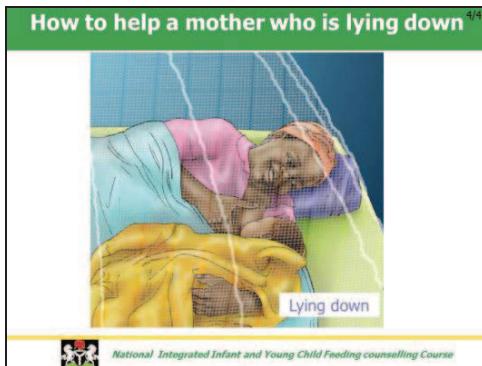
Slide 4/3: How to help a mother who is sitting



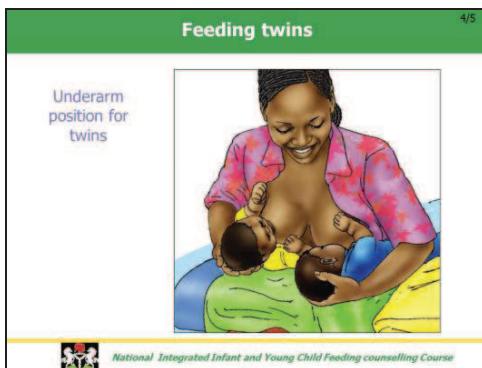
Demonstration 4.C: How to help a mother who is lying down.

- 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 of 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 Caesarean section, lying on her back or side may help her to breastfeed her baby more comfortably.

Slide 4/4: How to help a mother who is lying down



Slide 4/5: Feeding twins



- 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.
- For women who are feeding twins, there are also many ways for her to feed both of her infants at the same time. The underarm position with supports (such as pillows under the infants) can work well.

Classroom practical: Positioning a baby using dolls

Summary

- In this session, you practiced positioning a baby at the breast.

Notes:

Session 5. Assessing a breastfeed

Objectives

After completing this session, participants will be able to:

- 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.
- Describe the difference between effective and ineffective suckling.
- Explain the contents and arrangement of the BREASTFEED OBSERVATION JOB AID.

Session outline

Participants are all together for a lecture presentation by one trainer (65 minutes).

Introduction	5 minutes
The BREASTFEED OBSERVATION JOB AID	15 minutes
Presentation of Slides 5/2–5/7	20 minutes
Practice using the BREASTFEED OBSERVATION JOB AID (Exercise 5.a, Slides 5/8–5/9)	20 minutes
Summary	5 minutes

Introduction

Slide 5/1: Objectives: Assessing a breastfeed

Objectives: Assessing a breastfeed	5/1
After completing this session, participants will be able to:	
<ul style="list-style-type: none">• Explain the Four 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.	
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Key point(s):

- 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 observe only when a baby is breastfeeding.

The BREASTFEED OBSERVATION JOB AID (Appendix 3)

Key point(s):

- This form will help you to remember what to look for when you assess a breastfeed.
- The form is arranged in five sections: General, Breasts, Baby's Position, Baby's Attachment, and Suckling.
- The signs on the left 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, breastfeeding is probably going well. If there are some ticks on the right-hand side, then breastfeeding may not be going well. This mother may have a difficulty and she may need your help.
- We looked at the Four Key Points of Attachment in the last session. We will talk about positioning in a later session.

Role-play

Mother A [name] sits comfortably and relaxed, and acts happy and pleased with her baby. She holds her 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 sad and not interested in her baby. She holds her 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.

Key points to observe during the role-play

- 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 breastmilk flow.
- Observing how a mother interacts with her baby while feeding is important. Remember from the last session that if a mother feels good about breastfeeding, this will help her oxytocin reflex to work well, and this will help her milk to flow.
- Look at the baby’s general health, nutrition, and alertness. Look for conditions that may interfere with breastfeeding (for example, a blocked nose or difficult breathing).
- Notice whether the breasts look healthy. You may notice a cracked nipple or 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 the mother how breastfeeding feels.
- Notice how the mother is holding her breast.

Demonstration: How a mother holds her breasts during breastfeeding

- 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 breastmilk.
- 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 (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?

Baby's position

- 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.

Other things to observe:

Baby's attachment and suckling

Key point(s):

- Look and listen for the baby taking slow, deep sucks. This is an important sign that the baby is getting breastmilk 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.

Discussion of Slides 5/2 through 5/7

- You will now see a series of slides of babies breastfeeding.
- You will practice recognizing the signs of good and poor attachment that the slides show, and you will practice 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:** 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 photo, 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 missed. Try not to repeat the signs they mentioned.

Review photos using the BREASTFEED OBSERVATION JOB AID. This will help you to think more systematically as they assess a breastfeed.

Slide 5/2



- 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 outward.
 - 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.

Slide 5/3



- Signs that you can see clearly are:
 - His mouth points forward.
 - 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.

Slide 5/4



- 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 forward.
 - 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 likely that you would see a lot of it even if her baby was attached well. However, you should see more above the baby's top lip than below the bottom lip.

Slide 5/5



- 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 outward.
 - 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.

Slide 5/6



- 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, and 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.

Slide 5/7



- 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 baby as in slide 4/6 after the health worker helped the mother to position the baby better. In a better position, a baby can attach more easily.

Practice using the BREASTFEED OBSERVATION JOB AID

Exercise 5.a: Using the BREASTFEED OBSERVATION JOB AID

- With Slides 5/8 and 5/9, you will use your observations to practice filling in the BREASTFEED OBSERVATION JOB AID.
- There are two copies of the form for this exercise in this manual. Fill in one form for each slide.
- If you see a sign, make an X in the box next to the sign. If you do not see the 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.
- Once all participants have filled out the form, spend 10 minutes discussing their responses.

Slides 5/8 and 5/9



Summary

- In this session, we described the key signs to look for when assessing a breastfeed.

Further information

- If a mother says that breastfeeding is going well, but you see signs that indicate a possible difficulty, you must decide what to do.
- In the days soon after delivery, while the mother is still learning, you may want to offer to help her. Even if she is not aware of any difficulty now, you may prevent one occurring later.
- If breastfeeding seems to be well-established, you probably do not want to intervene immediately. It is usually more helpful to see her again soon, and follow the baby's growth, to make sure that breastfeeding continues to go well. Intervene only if a difficulty arises.

BREASTFEED OBSERVATION JOB AID

Mother's name _____ Date _____

Baby's name _____ Baby's age _____

Signs that breastfeeding is going well:

GENERAL

Mother:

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

Baby:

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

Signs of possible difficulty:

Mother:

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

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

- Baby's mouth is wide open
- Lower lip is turned outward
- Baby's chin touches the breast
- More areola seen above baby's top lip
- Baby's mouth not open wide
- Lips pointing forward or turned in
- Baby's chin not touching breast
- More areola seen below bottom lip

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

Notes:

Session 6. Impact of Health Care Practices on Breastfeeding

Objectives

After completing this session, participants will be able to:

- List the Ten Steps to Successful Breastfeeding.
- Describe the health care practices summarised 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

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

Introduction	5 minutes
Explain the Ten Steps to Successful Breastfeeding	30 minutes
Summary	5 minutes

Slide 6/1: Objectives: Impact of health care practices on breastfeeding

Objectives: Impact of health care practises on breastfeeding 6/1

After completing this session, participants will be able to:

- List The Ten Steps to Successful Breastfeeding.
- Describe the health care practises summarized by The Ten Steps to Successful Breastfeeding.
- Explain why the Baby-friendly Hospital Initiative is important in areas with a high HIV prevalence.

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Key point(s):

- Health care practices can have a major effect on breastfeeding.
- Poor practices interfere with breastfeeding, and contribute to the spread of commercial infant formula feeding.
- Good practices support breastfeeding, and make it more likely that mothers will breastfeed successfully, and will continue for a longer time.
- In 1989, the World Health Organization (WHO) and United Nations Children's Fund (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 worldwide effort launched in 1991 by the 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 is 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 breastmilk, unless medically indicated.
7. Practice 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.

- 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.

Explanation of the Ten Steps to Successful Breastfeeding

- The following slides illustrate the Ten Steps to Successful Breastfeeding.
- Keep your manuals open to the Ten Steps as you follow the slide presentation.

Slide 6/2: Ten Steps to Successful Breastfeeding

6/2

Ten Steps to Successful Breastfeeding

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 breastmilk, 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.

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Slide 6/3: Step One

6/3

Step One – Breastfeeding policy

- Have a written breastfeeding policy that is routinely communicated to all health staff.


NATIONAL POLICY
ON
INFANT AND YOUNG CHILD FEEDING
IN NIGERIA

FEDERAL MINISTRY OF HEALTH:
DEPARTMENT OF INFANT AND YOUNG CHILD
FEEDING

NOVEMBER 2010

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- 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 breastmilk substitutes.
 - A framework for assisting HIV-positive mothers to adopt and carry out optimal infant feeding practices based on national recommendations.

Slide 6/4: Step Two

6/4

Step Two – Skills training

- Train all health care staff in skills necessary to implement this policy.

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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.

Slide 6/5: Step Three

Step Three – Key information on breastfeeding 6/5

- Inform all pregnant women about the benefits and management of breastfeeding.

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Slide 6/6: Antenatal counselling

Antenatal Counselling 6/6



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Key point(s):

- 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.
- If HIV is of concern in your area, HIV-infected women should be receiving counselling and be supported to breastfeed.

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 baby a long time before they have the child—often before they become pregnant. If a mother has decided to use commercial infant formula, 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 and 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 (for example, 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.
She may be worried about the size of her breasts 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.
- Observe the breasts:
Mostly, you will be able to reassure her 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.

Slide 6/7: Step Four

Step Four – Early initiation of breastfeeding	6/7
<ul style="list-style-type: none">Help mothers initiate breastfeeding within a half-hour of birth.	
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- This step requires, in addition, that all mothers should be helped to have belly-to-belly contact with their babies for at least 1 hour shortly after delivery.
- Place the baby immediately on the mother's chest, before drying.
- Cover both baby and mother using 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 1 hour after delivery, but there is no exact fixed time.

Slide 6/8: Early contact



- This mother is holding her baby immediately after delivery. They are both naked so that they have belly-to-belly contact.
- A mother should hold her baby like this as much as possible in the first 2 hours after delivery.
- Try to delay non-urgent medical routines for at least 1 hour.
- 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.

Slide 6/9: Separation of mother and baby



- This baby was born about half an hour ago. He has been separated from his mother while the mother is resting and being bathed.
- 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 need encouragement to hold, cuddle, and have physical contact with their babies from birth onward. 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 belly-to-belly 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.

Slide 6/10: Step Five

6/10

Step Five – Teach breastfeeding skills

- Show mothers how to breastfeed and how to maintain lactation, even if they are separated from their infants.

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- This step further tasks health care staff to show non-breastfeeding mothers how to prepare and give replacement feeds safely.

Slide 6/11: Help mothers to breastfeed



- 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 breastfeeding could help a mother and baby with their first feeds.
- 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.

Slide 6/12: Mothers who are separated from their infants



6/12

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- Sometimes a baby has to be separated from his mother, because he is ill or of low birthweight 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 breastmilk for her baby.
- She may need help to believe that her breastmilk 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.

Slide 6/13: Feeding after a Caesarean section



6/13

- 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 4 hours of a Caesarean section, as soon as she has regained consciousness.
- Exactly how soon depends partly on how the mother feels after having had a Caesarean section, and partly on the type of anesthetic used. After epidural anesthesia, a baby can often breastfeed within 30 minutes to 1 hour.
- A healthy, full-term baby usually needs no food or drink before his mother can feed him, unless medically indicated. He can wait a few hours until she is ready.

Slide 6/14: Step Six

Step Six – Promote exclusive breastfeeding 6/14

- Give newborn infants no food or drink other than breastmilk, unless medically indicated.

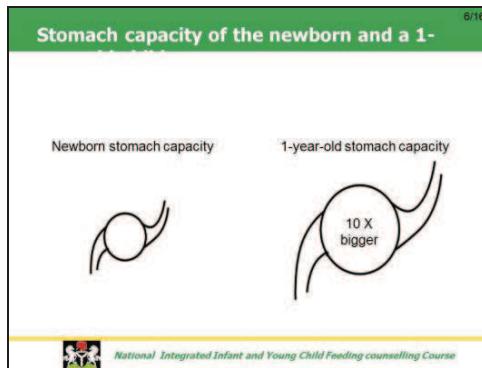
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Slide 6/15: Prelacteal feeds



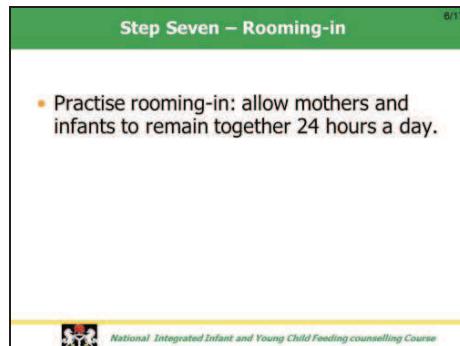
- This baby is being given a commercial infant formula feed from a bottle, before starting to breastfeed.
- Any commercial infant formula feed given before breastfeeding is established is called a prelacteal feed.
- Prelacteal feeds replace colostrum as the baby's earliest feed. The baby is more likely 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.

Slide 6/16: Stomach capacity of the newborn



- This slide shows that the volume of a newborn's stomach is approximately 10 times smaller than that of a 1-year-old child. The newborn does not need large quantities of milk in the first few days. Colostrum is sufficient.
- Step six says that no food or drink should be given to newborn infants unless medically indicated.

Slide 6/17: Step Seven



Slide 6/18: Rooming-in



- 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 the 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.

Slide 6/19: Step Eight

Step Eight – Breastfeed on demand

6/19

- Encourage breastfeeding on demand.

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Slide 6/20: Breastfeeding on demand



- Breastfeeding on demand means breastfeeding whenever the baby or mother wants, with no restriction on the length or frequency of feeds.
- Breastfeeding on demand has these advantages:
 - There is earlier passage of meconium.
 - The baby gains weight faster.
 - Breastmilk ‘comes in’ sooner, and there is a larger volume of milk intake on day three.
 - 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 (e.g., rooting) which show that he is ready for a feed.
- Let a baby suckle as long as he wants, provided he is well-attached.
- Some babies take all the breastmilk 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.

- 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. The individual needs of both breastfed and commercial infant formula-fed infants should be respected.

Slide 6/21: Step Nine

6/21

Step Nine – NO artificial teats

- Give no artificial teats or pacifiers* to breastfeeding infants.

* also called dummies and soothers

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Slide 6/22: Nipples, teats, and dummies



- 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. We will learn about cup feeding in a later session.
- 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 photo, you see a low-birthweight baby being fed from a cup. We will discuss more

about low-birthweight babies later in the course.

Slide 6/23: Step Ten

6/23

Step Ten – Foster support groups

- Foster the establishment of breastfeeding support groups and refer mothers to them on discharge from hospital or clinic.

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Slide 6/24: Support groups

6/24

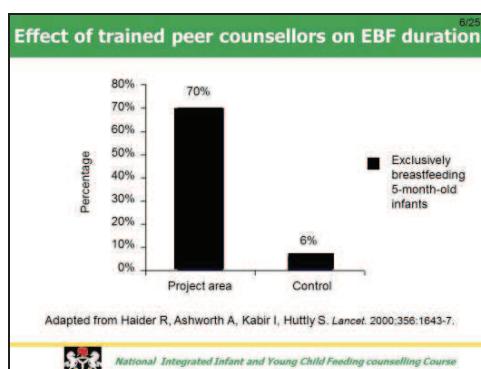
Support groups



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- 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 that 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.

Slide 6/25: Effect of trained peer counsellors on EBF duration



- This graph shows how trained peer counsellors in Bangladesh increased the proportion of infants who were still exclusively breastfeeding at 5 months of age.
- Seventy percent of mothers who had received support from a peer counsellor were still exclusively breastfeeding at 5 months, compared to 6% of those who had not had support.
- 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.

The following is a summary of what to do before a mother is discharged after delivery.

What to do before a mother leaves the maternity facility

- Find out what support she has at home.
- If possible, talk to family members about her needs.
- Arrange a postnatal check-in the first week, to include observation of a breastfeed (in addition to the six-week postnatal check).
- Make sure she knows how to contact a health worker who can help with breastfeeding if necessary.
- If there is a breastfeeding support group in her neighbourhood, refer her to that.

Summary

- In this session, we have learnt how breastfeeding works when a baby attaches to the breast and suckles.

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 these 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 toward 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 that 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 ties of affection grow gradually, but early, close contact gives babies the best possible start. Separation makes bonding more difficult, especially in high-risk families (e.g., 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 belly-to-belly 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 the hospital:

There are four common reasons why mothers and babies are separated in the 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.

Belly-to-belly contact and bacterial colonization:

Early belly-to-belly 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 1 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 commercial infant formula feeds:

Participants may want to discuss further the medical indications for giving commercial infant formula feeds. There are rare exceptions during which the infant may require other fluids or food in addition to, or in place of, breastmilk. The feeding programme of these babies should be determined by qualified health professionals on an individual basis.

The most common reasons for giving prelacteal and supplementary feeds are:

- To prevent low blood sugar, or hypoglycemia.
- To prevent dehydration, especially if a baby is jaundiced and needs phototherapy.
- Because the mother's breastmilk 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-birthweight babies may require special feeding, for example, to prevent hypoglycemia, or because they are unable to breastfeed. However, even for these babies, breastmilk is usually the best kind of feed to give. Babies who are jaundiced need more breastmilk, 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 birthweight (<1500 g) 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 one to two 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-birthweight, 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 three to seven 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.

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, all of which goes inside the baby's mouth easily; or a very large areola, so 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. 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, like doctors and midwives, may not have been trained to help mothers to breastfeed.

Sucking/Suckling:

The term "suckling" is usually used when referring to a baby feeding from the breast. The term "sucking" is used when referring to a baby feeding from a bottle. However, note that the reflex referred to on page 46 is known as the 'sucking reflex', as it refers to anything that touches the baby's palate.

Notes:

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Session 7. Listening and learning

Objectives

After completing this session, participants will be able to:

- List and explain the six basic 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

Participants are all together for a lecture presentation by one trainer (80 minutes).

Introduction	5 minutes
Demonstration: Listening and learning skills	50 minutes
Listening and learning exercises	20 minutes
Summary	5 minutes

Introduction

Slide 7/1: Objectives: Listening and learning

Objectives: Listening and learning	7/1
<p>After completing this session, participants will be able to:</p> <ul style="list-style-type: none">• List the six listening and learning skills.• Give an example of each skill.• Demonstrate the appropriate use of the skills when counselling on infant and young child feeding.	

Group activity: Brainstorm the definition of counselling

- 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 or giving complementary foods.
- Although we talk about ‘mothers’ in this session, remember that these skills should be used when talking to other caregivers about infant feeding (e.g., 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.

- Practice some of the techniques with them. You may find the result surprising and helpful.

Slide 7/2: Listening and learning skills

Listening and learning skills		7/2
<ul style="list-style-type: none"> • Use helpful non-verbal communication. • Ask open questions. • Use responses and gestures that show interest. • Reflect back what the mother says. • Empathize – show that you understand how she feels. • Avoid words which sound judging. 		
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Demonstration: Listening and learning skills

Skill 1. Use helpful nonverbal communication

Demonstration 7.A: Nonverbal 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:

Helps: Sit so that your head is level with hers.

Hinders: Stand with your head higher than the other person's.

- 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:

Helps: Remove the table or the notes.

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

- 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.)

Appropriate touch in this community

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?

Helpful nonverbal communication
Keep your head level
Pay attention
Remove barriers
Take time
Touch appropriately

- Our nonverbal 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 (for example, religion) to be expressed in a counselling situation where it might appear as though we are judging a mother.

Skills 2–6

Key point(s):

- 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

- 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 commercial infant formula 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.

Demonstration 7.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 did not learn much. It can be difficult to know what to say next.

Demonstration 7.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.

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

Demonstration 7.D: Starting and continuing a conversation

Health worker: “Good morning, [name]. How are you and [child’s name] getting on?”

Mother: “Oh, we are both doing well, thank you.”

Health worker: “How old is [child’s name] now?”

Mother: “He is 2 days old today.”

Health worker: “What are you feeding him on?”

Mother: “He is breastfeeding, and having drinks of water.”

Health worker: “What made you decide to give the water?”

Mother: “There is no milk in my breasts, and he doesn’t want to suck.”

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

Comment: The health worker 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.

Exercise 7.a: Asking open questions

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?
‘Closed’ questions	Suggested answers (‘Open’ questions)
1. Does your baby sleep with you?	1. Where does your baby sleep?
2. Are you often away from your baby?	2. How much time do you spend away from your baby?
3. Does Ngozi eat porridge?	3. What kinds of foods does Ngozi like to eat?
4. Do you give fruit to your child often?	4. How often does your child eat some fruit?

Skill 3. Use responses and gestures that show interest

- 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”, or “Oh dear!”

Demonstration 7.E: Using responses and gestures that 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.

Skill 4. Reflect back what the mother says

- 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 it 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?”
- Introduce the role-plays by making these points:
 - We will now watch two role-plays to demonstrate this skill.
 - The health worker is talking to a mother who has a 6-week-old baby whom she is breastfeeding.

Demonstration 7.F: Continuing to ask for facts

Health worker: “Good morning, [name]. How are you and [child’s name] today?”

Mother: “He wants to feed too much; he is taking my breast all the time!”

Health worker: “About how often would you say?”

Mother: “About every half an hour.”

Health worker: “Does he want to suck at night, too?”

Mother: “Yes.”

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

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

Demonstration 7.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 hungrier 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 reflected back what the mother said, so the mother gave more information.

Exercise 7.b: Reflecting back what a mother says

Example:

“My mother says that I don’t have enough milk.”

Possible response: “She says that you have a low milk supply?”

To answer:

1. “Mika does not like to take thick porridge.”
2. “He doesn’t seem to want to suckle from me.”
3. “I tried feeding him from a bottle, but he spat it out.”

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

- Empathy is a difficult skill to learn. It is difficult for people to talk about feelings. It is easier to talk about facts.
- When a mother says something that reveals how she feels, it is helpful to respond in a way that shows 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.
- 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.

Demonstration 7.H: Sympathy

Health worker: “Good morning, [name]. How are you and [child’s name] today?”

Mother: “[Child’s name] is not feeding well; I am worried he is ill.”

Health worker: “I understand how you feel. When my child was ill, I was so worried. I know exactly how you feel.”

Mother: “What was wrong with your child?”

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

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

and empathizing with her feelings.

Demonstration 7.I: Empathy

Health worker: “Good morning, [name]. How are you and [child’s name] today?”

Mother: “He is not feeding well; I am worried he is ill.”

Health worker: “You are worried about him?”

Mother: “Yes, some of the other children in the village are ill and I am frightened he may have the same illness.”

Health worker: “It must be very frightening for you.”

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

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

Demonstration 7.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 7.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 this 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.

Demonstration 7.L: Asking facts

Health worker: “Good morning, [name]. How are you and [child’s name] today?”

Mother: “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!”

Health worker: “How old is [child’s name] now?”

Mother: “He is 7 months old.”

Health worker: “And how much porridge does he eat during a day?”

Ask: What did the health worker learn about the mother’s feelings?

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

Demonstration 7.M: Empathy

Health worker: “Good morning, [name]. How are you and [child’s name] today?”

Mother: “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!”

Health worker: “It’s very upsetting when your baby doesn’t want to breastfeed.”

Mother: “Yes, I feel so rejected.”

Ask: What did the health worker learn about the mother’s feelings this time?

Comment: In this version, the mother’s feelings were listened to at the beginning. Then the health worker was able to learn what the mother saw as the problem.

Exercise 7.c: Empathizing to show that you understand how she feels

How to do the exercise

Statements 1–4 are things that mothers might say.

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

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

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?”

X c. “You are really tired with the night feeding.”

To answer:

1. “Tunde has not been eating well for the past week. I am very worried about him.”
Possible answer: “You are anxious because Tunde is not eating?”
2. “My breastmilk looks so thin. I am afraid it is not good.”
Possible answer: “You are worried about how your breastmilk looks?”
3. “I feel there is no milk in my breasts, and my baby is a day old already.”
Possible answer: “You are upset because your breastmilk has not come in yet?”
4. “I am anxious that if I breastfeed, I will pass HIV on to my baby.”
Possible answer: “I can see you are worried about breastfeeding your baby.”

Skill 6. Avoid words that sound judging

- ‘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 breastmilk.
- 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?”

Demonstration 7.N: Using judging words

Health worker: “Good morning. Is [name] breastfeeding **normally**?”

Mother: “Well, I think so.”

Health worker: “Do you think that you have **enough** breastmilk for him?”

Mother: “I don’t know. I hope so, but maybe not....” (looks worried)

Health worker: “Has he gained weight **well** this month?”

Mother: “I don’t know.”

Health worker: “May I see his growth chart?”

Ask: What did the health worker learn about the mother’s feelings?

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

Demonstration 7.O: Avoiding judging words

Health worker: “Good morning. How is breastfeeding going for you and [child’s name]?”

Mother: “It’s going very well. I haven’t needed to give him anything else.”

Health worker: “How is his weight? Can I see his growth chart?”

Mother: “Nurse said that he gained more than half a kilo this month. I was pleased.”

Health worker: “He is obviously getting all the breastmilk that he needs.”

Ask: What did the health worker learn about the mother’s feelings?

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

Group exercise

Exercise 7.d: Translating judging words

Judging words			
Well	Normal	Enough	Problem
Good	Correct	Adequate	Fail
Bad	Proper	Inadequate	Failure
Badly	Right	Satisfied	Succeed
	Wrong	Plenty of	Success
		Sufficient	

- 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.

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 problem breastfeeding?	How is breastfeeding going for you?

Notes:

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Session 8. 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.
- Explain the difference between measuring nutritional status and monitoring growth.

Session outline

Introduction	5 minutes
How to plot a growth chart	10 minutes
How to interpret individual growth paths	15 minutes
Summary	5 minutes

Introduction

Slide 8/1: Objectives: Growth charts

Objectives: Growth charts	6/1
<p>After completing this session, participants will be able to:</p> <ul style="list-style-type: none">• Explain the meaning of the standard curves.• Plot a child's weight on a growth chart.• Interpret individual growth curves.• Explain the difference between nutritional status and monitoring growth.	
 National Integrated Infant and Young Child Feeding counselling Course	

Why it is useful to measure a child's growth.

- The adequacy of a child's growth is the simplest indicator of a child's overall health status. That is why it is important to understand growth charts when counselling on infant feeding.
- By looking at the direction of the child's growth curve, the health worker and the mother can see at a glance whether the child is gaining weight appropriately or not.
- This can make it easier for early detection of abnormal growth and development:
 - To facilitate the early treatment or correction of any conditions that may be causing abnormal growth and development.
 - To provide an opportunity for giving health education and advice for the prevention of malnutrition.

How we can tell that a child is growing well enough.

- Each country has developed its own growth references (or standards).
- There are separate ones for boys and girls.

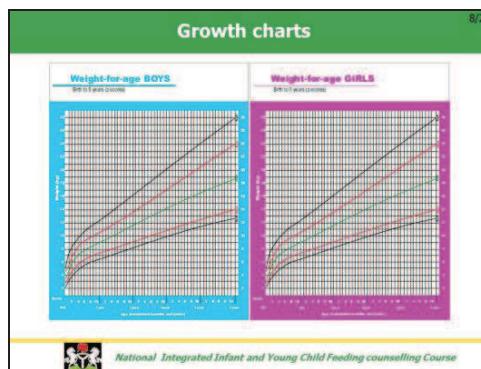
- Health workers will use a growth chart to track a child's growth and monitor how he or she is growing in relationship to other children.
- A different growth chart must be used when examining girls instead of boys, since the rates and patterns of growth between genders are very different.
- There are generally two sets of charts: (1) for birth to 2 years, and (2) from 2 to 18 years.

Why 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 may be on different lines on the growth chart for weight. This is normal.
- What is most important is to see that the curve follows a trend that indicates the child is growing and there is no growth problem.
- Good feeding practices—both before the child is 6 months old and after complementary foods have been introduced—can help prevent growth faltering in both weight and length as well as the tendency to be overweight.

How to plot a growth chart

Slide 8/2: Growth charts



- The child's age in months is along the bottom of the growth chart.
- The child's weight is up the side of the chart.
- There are four curves on this chart. The line labeled 0 is the median, which is, generally speaking, the average. It is also called the 50th percentile because the weights of 50% of healthy children are below it and 50% are above it.
- Most healthy children are near this median curve, either a little above or below it.

- The other lines, called z-score lines, indicate distance from the average. A point or trend that is far from the median, such as +3 or -3, usually indicates a growth problem.
- The growth curve of a normally growing child will usually follow a track that is roughly parallel to the median. The track may be above or below the median.
- A child whose weight-for-age is below the -2 z-score line (third 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.

Example:

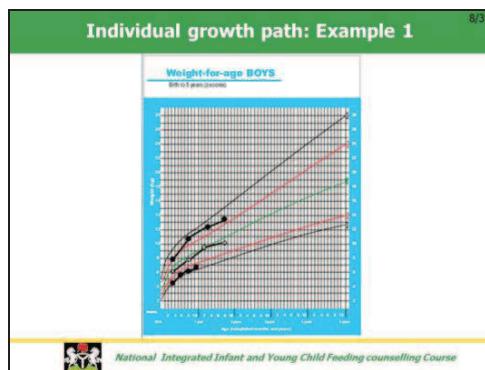
Now we will use the blank growth chart in your manuals to plot the weight of Aisha, who is 15 months (1 year and 3 months) old. When she came today to the health facility, her weight chart was not available and you do not know Aisha. Her weight today is 8 kg.

Looking at where you have plotted, what does Aisha's weight today tell you?

- 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.
- One weight on its own does not give you much information. Aisha'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 Aisha's mother to find out more about her eating and health. You will also observe Aisha to see if she looks wasted or ill, or if she is active and healthy.
- Document Aisha's weight on the growth chart. Assuming Aisha is healthy and you are not concerned about her weight or eating, encourage Aisha'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.

How to interpret individual growth paths

Slide 8/3: Individual growth path: Example 1

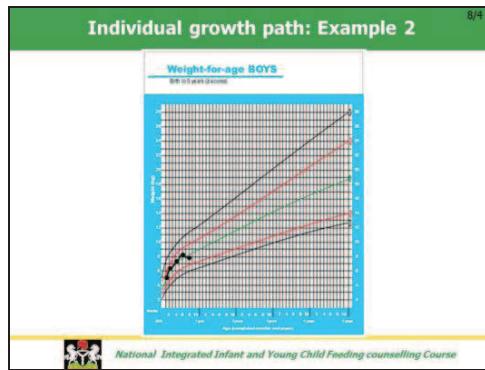


- Here we have a growth chart for boys that shows the curves of three children who were weighed regularly.

What you can tell from looking at these charts:

- 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; therefore, it is important to look at the general shape or trend.

Slide 8/4: Individual growth path: Example 2



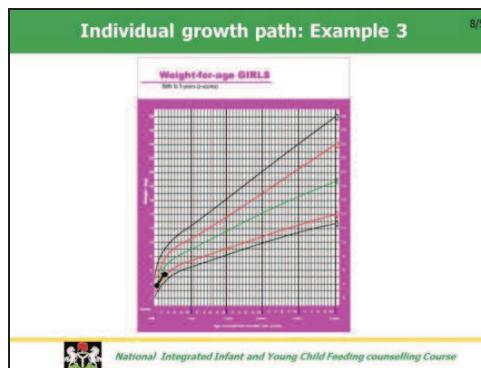
- Here we have a growth chart for Femi, who is 9 months old.
- Femi grew well for the first few months but has not grown at all in the last three months.
- Some questions you might ask are:
 - How was Femi fed for the first six months of life?
 - What milk does Femi have now?
 - What feeds does Femi receive now? How often does he eat? How much does he eat?
 - What types of food does he eat?
 - How has Femi's health been over the past few months?

- You find out that Femi 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 6 months, his mother started to give him thin cereal porridge twice a day.
- Some ways you might praise Femi's mother are:
 - You did well to exclusively breastfeed Femi for the first six months of life. Look how well he grew just on your breastmilk.
 - It is good that you are still breastfeeding Femi now that he is more than 6 months of age.
 - It is good that you are continuing to feed Femi at nights and that he is sleeping with you.

Reason for Femi's static weight:

Femi is only receiving two meals of thin porridge twice daily. He needs more frequent, nutrient-rich complementary foods each day now that he is older than 6 months. We will talk in more detail about complementary foods later in the course.

Slide 8/5: Individual growth path: Example 3



- Here we have a growth chart for Amaka, who is 3 months old.
- She is gaining weight too slowly.
- Some questions you might ask are:
 - How is Amaka?
 - How is Amaka feeding?
 - How often does Amaka feed?
 - Where does Amaka sleep?
 - If the mother says she is breastfeeding: How is breastfeeding going for you and Amaka?
- You would want to assess a breastfeed, looking at positioning, attachment, and the length of the feed.
- Her mother tells you that Amaka is well and a good baby who cries little. She only wants to feed four to five times each day, which her mother finds helpful as she is busy during the day. Amaka sleeps with her mother at night.

Cause of Amaka's slow weight gain:

- Amaka does not breastfeed often enough.

Should Amaka be started on complementary feeds since she is not gaining weight?

- Giving complementary feeds should not be necessary. If Amaka is breastfed more often during the day and night (at least eight times in each 24 hours), then she should gain weight.

Group demonstration: Mid upper arm circumference tape (MUAC)

- MUAC cannot measure growth; it is a one-time measurement.
- It is used to identify children and adults who are severely malnourished, especially during famine situations.
- Monitoring growth allows us to identify children earlier, before significant malnutrition becomes apparent.

Summary

- In this session, we have talked about the use of growth charts.
- A growth chart is 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.

Further information

For more information on MUAC, see Appendix 12, Growth Monitoring and Nutritional Assessment.

The World Health Organization Child Growth Standards and infant feeding

The growth charts used in this chapter are part of the World Health Organization (WHO) Child Growth Standards. Based on an international sample, they demonstrate that children born in different regions of the world have the potential to grow and develop to within the same range of height- and weight-for-age when given the optimum start in life.

The analysis of data from the WHO Multicentre Growth Reference Study (MGRS) documents the strong similarity in linear growth from birth to 5 years in major ethnic groups living under relatively affluent conditions, and provides the message that when health and key environmental needs are met, the world's children grow very similarly wherever they are.

In addition to being truly international, the WHO Child Growth Standards differ from existing growth charts in a number of ways: they describe how children should grow, and establish breastfeeding as the biological norm and the breastfed infant as the standard for measuring healthy growth. The shape of the WHO Child Growth Standards differs from earlier references, particularly during the first six months of life, when growth is rapid. They describe the early growth of children who are appropriately fed and protected from morbidities that could affect growth, and whose mothers did not smoke.

The WHO Child Growth Standards were derived from the WHO MGRS. A comprehensive review of the uses and interpretation of anthropometric references undertaken by WHO in the early 1990s concluded that new growth curves were needed to replace the National Center for Health Statistics (NCHS)/WHO growth reference, which had been recommended for international use since the late 1970s. The review documented deficiencies of the NCHS/WHO reference and led to a plan for developing new charts to document how children should grow

in all countries rather than merely describing how they grew at a particular time and place. To develop new standards, the MGRS was carried out to collect primary growth data and related information from 8,440 healthy breastfed children from diverse ethnic backgrounds and cultural settings (Brazil, Ghana, India, Norway, Oman, and the United States).

The sample used to create the standards complied with three infant feeding criteria: (1) exclusively or predominantly breastfed for at least four months; (2) introduced to complementary foods between four and six months; and (3) partially breastfed up to at least 12 months. Note that WHO's policy on optimal duration of exclusive breastfeeding changed in 2000 after the initiation of the MGRS in 1997. The recommendation now is that all babies should be exclusively breastfed for six months, followed by the addition of complementary feeding while continuing breastfeeding up to 2 years or beyond. The MGRS lactation support teams were successful in enhancing breastfeeding practices and achieving high rates of compliance with the study's feeding criteria. The experience confirmed the observation that community-based breastfeeding counselling is a cost-effective way to increase exclusive breastfeeding rates.

Countries should decide whether to adopt the standards, and if so, which charts to introduce for general use.

Notes

Session 9. Building confidence and giving support

Objectives

After completing this session, participants will be able to:

- List the six confidence and support skills.
- Give an example of each skill in relation to breastfeeding.
- Demonstrate the appropriate use of the skills when counselling on infant and young child feeding.

Session outline

Introduction	5 minutes
Demonstration: Building confidence and giving support	65 minutes
Summary	5 minutes

Introduction

Slide 9/1: Objectives: Building confidence and giving support

Objectives: Building confidence and giving support	9/1
<p>After completing this session, participants will be able to:</p> <ul style="list-style-type: none">• List the six 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.	

Key point(s):

- 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 breastmilk 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.

Demonstration: Building confidence and giving support

Skill 1. Accept what a mother thinks and feels

- 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.

How a mother might feel if you disagree with her, or criticize, or tell her that it is nothing to be upset or to worry about.

- You may make her feel that she is wrong. This reduces her confidence. She may not want to say any more to you.
- Therefore, 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.

Role-play

Demonstration 9.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)

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

Mother: “My milk is thin and weak, so I have to give bottle feeds.”

Health worker: “Yes, thin milk can be a problem.”

Comment: This was an inappropriate response because it was 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.”

Comment: This was an appropriate response because it showed acceptance.

Key point(s):

- 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.

Role-play

- The last role-play showed acceptance of what a mother thinks. We will now see a role-play showing acceptance of what a mother *feels*. This mother has a 9-month-old baby.

Demonstration 9.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.”

Comment: This was 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.”

Comment: This was an inappropriate response. By saying things like “don’t worry” or “don’t cry”, you can 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?”

Comment: This was an appropriate response because it accepted how the mother felt and made her feel that it was alright to be upset. Notice how in this example empathizing was used to show acceptance. So this is another example of using a listening and learning skill to show acceptance.

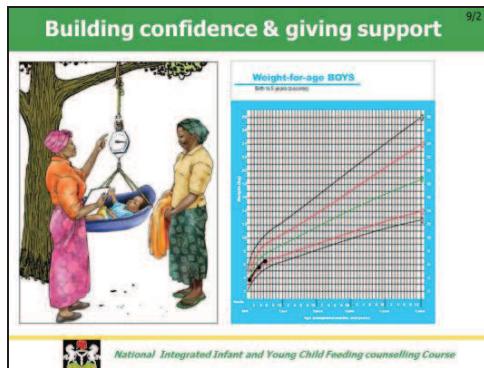
Skill 2. Recognize and praise what a mother and baby are doing right

- 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.

Below are some examples of how a mother might feel if you tell her that she is doing something wrong, or that her baby is not doing well:

- It may make her feel bad, and this can reduce her confidence.
- As counsellors, we must look for what mothers and babies are doing right.
- We must first recognize what they do right, and then we should praise or show approval of the good practices.
- Praising good practices has these benefits:
 - It builds a mother’s confidence.
 - It encourages her to continue those good practices.
 - It makes it easier for her to accept suggestions later.
- In some situations, it can be difficult to recognize what a mother is doing right. But any mother whose child is living must be doing some things right, whatever her socioeconomic status or education.

Slide 9/2: Building confidence & giving support



- Here is a baby being weighed. 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.

Ways of communicating this problem to the mother include:

- “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 breastmilk.”

Skill 3. Give practical help

- 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.
- Some ways to give practical help include:
 - 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.
 - Help with feeding, such as helping a mother with positioning and attachment, expressing breastmilk, relieving engorgement, or preparing complementary feeds.

Slide 9/3: Building confidence & giving support



- 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!"
- What you might say to this woman to help motivate her and increase her confidence: "Let me try to make you more comfortable, and then I'll bring you a drink."
- 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

- 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.

Slide 9/4: Building confidence & giving support



- This baby is 3 months old. His mother has recently started giving some formula feeds in a bottle in addition to breastfeeding. The baby has developed diarrhoea. The mother is saying to the health worker: "He has started to have loose stools. Should I stop breastfeeding?"

What you might say to this woman to help encourage her to keep breastfeeding:

- "It is good that you asked before deciding. Diarrhoea usually stops sooner if you continue to breastfeed."

Skill 5. Use simple language

- 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 the mother of a 6-month-old child.

Demonstration 9.C: Using simple language

Health worker: "Good morning, [name]. What can I do for you today?"

Mother: "Can you tell me what foods to give my baby, now that she is 6 months old?"

Health worker: "I'm glad that you asked. Well now, the situation is this: Most children need more nutrients than breastmilk alone when they are 6 months old because breastmilk has less than 1 milligram of absorbable iron and breastmilk has about 450 calories, so less than the 700 calories that are needed. The vitamin-A needs are higher than what is provided by breastmilk 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."

Comment: The health worker provided too much information; it was not relevant to the mother at this time. She also used words unlikely to be familiar to the mother.

Now we will see another mother receiving information in a different way. Again, listen for the skills listed.

Demonstration 9.D: Using simple language

Health worker: “Good morning, [name]. How can I help you?”

Mother: “Can you tell me what foods to give my baby, now that she is 6 months old?”

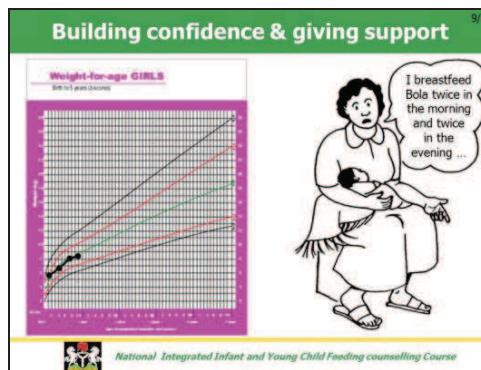
Health worker: “You are wondering about what is best for your baby. I’m glad you have come to talk about it. It is usually a good idea to start with a little porridge to get him used to the taste of different foods. Just two spoons twice a day to start with.”

Comment: The health worker explained about starting complementary foods in a simple way.

Skill 6. Make one or two suggestions, not commands

- 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 will 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.

Slide 9/5: Building confidence & giving support



- Bola breastfeeds only four times a day, and she is gaining weight too slowly. Her mother thinks that she does not have enough breastmilk.

To help encourage the mother, you could say:

- “It might help if you feed Bola more often.”
 - “Have you thought of feeding her more often? Sometimes that helps.”

Notes:

Session 10. *Counselling Cards* and other tools

Objectives

After completing this session, participants will be able to:

- Counsel women on infant feeding practices using *Counselling Cards* and *Take-Home Brochures*.
- Actively use listening and learning skills as well as building confidence and giving support skills.

Session outline

Introduction	5 minutes
Review of <i>Counselling Cards</i> and <i>Take-Home Brochures</i>	20 minutes
Role-play	10 minutes
Counselling practice (small groups)	40 minutes
Summary	5 minutes

Introduction

Slide 10/1: Objectives: *Counselling Cards* and other tools

Objectives: <i>Counselling Cards</i> and other tools	10/1
After completing this session, participants will be able to:	
<ul style="list-style-type: none">• Counsel women on infant feeding practises using <i>Counselling Cards</i> and <i>Take-Home Brochures</i>.• Actively use Listening and Learning Skills as well as Building Confidence and Giving Support Skills.	
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Review of *Counselling Cards* and *Take-Home Brochures* (20 minutes)

- This set of cards was developed for you to help counsel mothers and other caregivers about infant and young child feeding.
- Positive counselling skills are important for your success. Some basic counselling skills presented below include listening and learning; and building confidence and giving support.

Listening and learning skills:

- Use helpful nonverbal communication.
- Keep your head level with the mother/caregiver.
- Pay attention.
- Reduce physical barriers.
- Take time.
- Touch appropriately.
- Ask open questions.

- Use responses and gestures that show interest.
- Reflect back what the mother/caregiver says.
- Avoid using ‘judging’ words.

Building confidence and giving support skills:

- Accept what the caregiver thinks and feels.
- Listen carefully to the mother’s (or caregiver’s) concerns.
- Recognize and praise what a mother/caregiver and child are doing correctly.
- Give practical help.
- Give a little, relevant information at a time.
- Use simple language that the mother/caregiver will understand.
- Use appropriate *Counselling Card(s)* or *Take-Home Brochure(s)*.
- Make one or two suggestions, not commands.

Review of *Counselling Cards*:

- *Counselling Card 1* is called ‘Nutrition for pregnant and breastfeeding women’. Use this card for all women coming to you for the first time to discuss their diets, which is very important for pregnancy and lactation outcomes.
- *Counselling Card 4a* is called ‘Exclusively breastfeed during the first 6 months’. *Counselling Card 4b* is called ‘Dangers of mixed feeding during the first 6 months’. Use these cards for all HIV-negative women and for those HIV-positive women who have opted to breastfeed. It describes the practice and benefits of exclusive breastfeeding.
- *Counselling Card 5* is called ‘Breastfeeding on demand, both day and night’. All mothers should receive this information, but the card is particularly useful for counselling mothers with ‘not enough milk’.

Role-play

Demonstration of how to use these tools:

- Imagine a woman comes to you for counselling. She has a 3-month-old who is not growing well and she feels like she does not have enough milk in her breasts. She has come to see the counsellor to discuss the options for feeding her baby.

Demonstration 10.A: Counselling on infant feeding choices

Counsellor: “Hello, [woman’s name]. Thank you for coming to talk to me about feeding your baby.”

Comment: *Here the counsellor introduces the session, explaining that the purpose is to understand more about her situation and offer suggestions to help the mother feed her baby.*

The mother is in tears. She says that her breasts have become soft again, so her milk must be less, but the baby is only 3 months old.

Woman: “I don’t know what to do because I cannot make enough milk for my baby.”

Counsellor: “You are really upset about this, I know.”

Woman: “I am thinking about giving the baby some drinks of fruit juice or other foods because I cannot make enough milk for my baby.”

Counsellor: “It is very good that you have decided to come and speak to me about your baby before you give other foods. Oftentimes, this can lead to the child getting diarrhoea.”

Show Counselling Card 5: Breastfeeding on demand, both day and night to the woman.

Comment: ***The counsellor shows Counselling Card 5: Breastfeeding on demand, both day and night.***

Counsellor: “On this card, you can see that it is important to keep feeding the baby breastmilk as much as possible. The more the baby suckles at your breast, the more milk will be produced by your body.”

Woman: “But I give the baby food when he cries.”

Counsellor: “That is good. But you don’t have to wait for the baby to cry to feed him. Oftentimes, the baby only cries when he is very hungry. How many times a day do you feed the baby?”

Woman: “I think about four times in the day.”

Counsellor: “Good. Let’s try to see if you can feed the baby more frequently, say every few hours. Do you think that is possible?”

Woman: “Yes, I can try.”

Counsellor: “Let’s try feeding the baby now, and I can observe how well he is able to eat. Is that okay with you?”

Woman: “Yes, I am happy to have you help me.”

Comment: ***In this example, the counsellor has tried to make the woman feel more comfortable and at ease. She has tried to accept how the woman feels and reaffirm what she has already done.***

Counselling practice

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 *Counselling Cards* to help you counsel the mother.
- If you feel comfortable, also use the relevant *Counselling Cards* and *Take-Home Brochures* on how to practice the chosen feeding option. When you use a card, do not just read it. Use your skills to summarise 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.
- Do not 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 (Appendix 4).
- Observe which skills the counsellor uses, which skills she does not use, and which skills 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.

Counselling Story 1:

You are a first-time mother with twin boys and you are having trouble feeding them. They are 2 months old now and you would like to give them other milks instead of breastmilk.

Counselling Story 2:

A young woman comes to you with her 4-month-old baby who is completely fed on replacement milks from a bottle. He has diarrhoea. The growth chart shows that he weighed 3.5 kilos at birth, but has gained only 300 grams in the last two months.

Counselling Story 3:

The mother of a 3-month-old baby says that he is crying a lot in the evenings, and she thinks that her milk supply is decreasing. The baby gained weight well last month.

Counselling Story 4:

A young woman who is pregnant with her first child comes to you. She would like to discuss her feeding strategies and is planning to give her baby prelacteal feeds.

Group discussion: Spend 10 minutes reviewing what aspects of counselling participants found challenging and how they handled the situations.

Summary

- You now have a list of listening and learning skills and building confidence and giving support skills on the flipchart.
- These skills will be used for Clinical or Community Practice 2.

Notes:

Session 11. 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

Introduction	3 minutes
Presentation of Slides 11/1–11/13	55 minutes
Summary	2 minutes

Introduction

Slide 11/1: Objectives: Breast conditions

The slide has a green header bar with the title 'Objectives: Breast conditions'. Below the header, there is a section titled 'After completing this session, participants will be able to:' which lists the objectives. At the bottom of the slide is a small logo and the text 'National Integrated Infant and Young Child Feeding counselling Course'.

Objectives: 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.

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Key point(s):

- 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.
- 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.

Presentation of Slides 11/2 through 11/13

- **Slide 11/2: Different breast shapes**



What makes some breasts large and others small?

- Differences in the sizes of breasts are due mostly 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.
- 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.

- **Slide 11/3: Flat nipple and protractility**



- The nipple in photo 1 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 photo 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.

Slide 11/4: Inverted nipple



- The nipple is inverted.
- If this woman tests her breast for protractility, her nipple will go in instead of coming out.
- 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.

Slide 11/5: Management of flat & inverted nipples

Management of flat & inverted nipples	11/5
<ul style="list-style-type: none"> • 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/her mother to feed with expressed milk. 	

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- Antenatal treatment is probably not helpful; for example, stretching the 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 belly-to-belly contact.
- 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, on the first day, before her breastmilk '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 (e.g., 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.

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 belly-to-belly contact, and to let her baby explore her breasts. We will be discussing belly-to-belly contact in a later session.
- 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, on the first day, before her breastmilk '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.

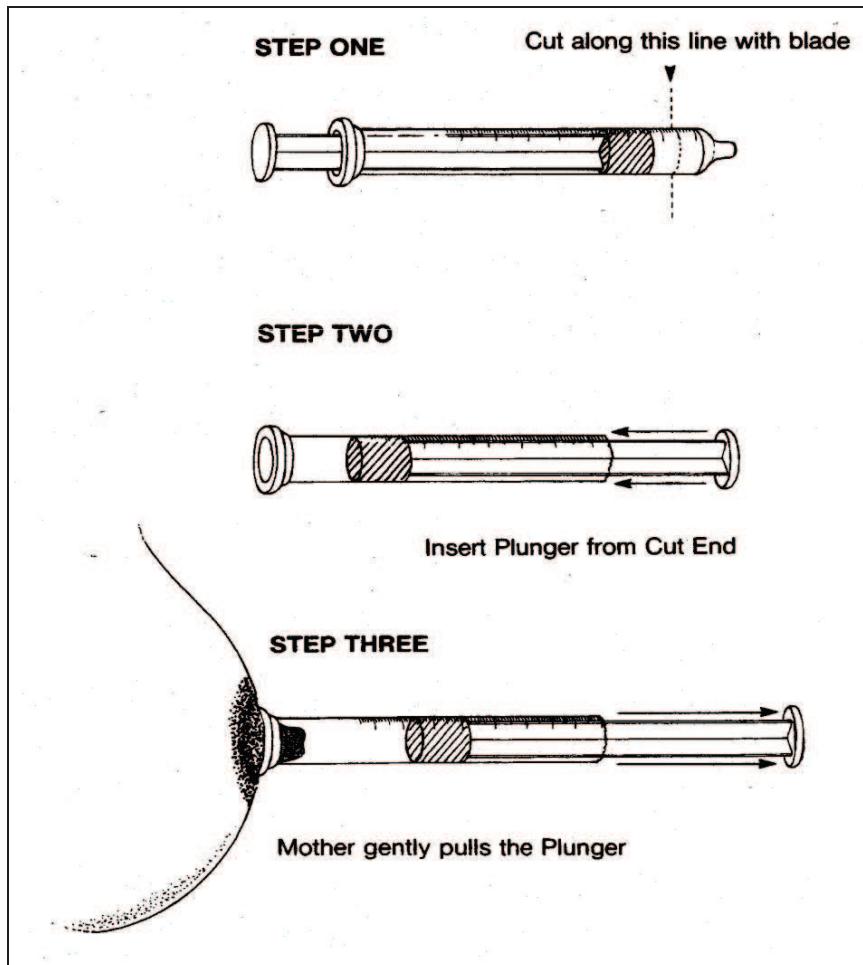
If a baby cannot suckle effectively in the first week or two, help his mother to try the following:

- 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 breastmilk.
- 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 belly-to-belly contact, and let him try to attach to her breast on his own.

Demonstration 11.A: Syringe method for treatment of inverted nipples

Figure 11.1. Preparing and using a syringe for treatment of inverted nipples.



- 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.
- With a real breast, there is an airtight seal, and the nipple is drawn out into the syringe.
- The mother must use the syringe herself.
- 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.

Slide 11/7: Full and engorged breasts



- The woman in photo 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 photo 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 photo looks shiny, because it is oedematous (swollen). Her breasts feel painful, and her milk does not flow well.

What you might notice about the nipple:

- 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 as easy to treat.

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

Reasons why breasts may become engorged:

- Delay in starting breastfeeding after birth.
- Poor attachment to the breast so breastmilk is not removed effectively.
- Infrequent removal of milk; for example, if breastfeeding is not on demand.
- Restricting the length of breastfeeds.
- 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.

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 breastmilk production decreases.

- If the 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 the 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, include the following:
 - 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

- 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 6 months old and due to start complementary feeds.
- When an HIV-positive mother is trying to stop breastfeeding, she should express only enough milk to relieve the discomfort and not to increase the milk production.
- Milk may be expressed a few times per day when the breasts are overfull to make the mother comfortable.
- You may have heard of pharmacological treatments to reduce the milk supply. These are not recommended. However, a simple analgesic—for example, ibuprofen—may be used to reduce inflammation and help the discomfort while the mother's milk supply is decreasing. If ibuprofen is not available, then paracetamol may be used.

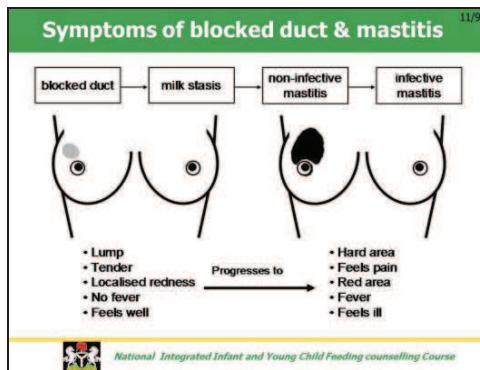
Slide 11/8: Mastitis



What you might notice about this breast:

- Part of the breast looks red and swollen. There is a fissure on the tip of the nipple.
- This condition is mastitis.
- The woman has severe pain, 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.

Slide 11/9: Symptoms of blocked duct & mastitis



- 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.

Slide 11/10: Causes of blocked duct & mastitis



- 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.

Some of the common problems associated with attachment of the baby on the breast include the following:

- 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.

Slide 11/11: Treatment of blocked duct & mastitis

Treatment of blocked duct & mastitis		11/11
<ul style="list-style-type: none">• Most important – improve drainage of milk.• Look for cause and correct.• Suggest:<ul style="list-style-type: none">– Frequent feeds.– Gentle massage toward nipple.– Warm compresses.– Start feed on unaffected side; vary position.• Antibiotics, analgesics, and/or anti-inflammatories, 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, a fissure through which bacteria may enter, and/or no improvement after 24 hours of improved drainage.

Antibiotic treatment for infective mastitis		
The most common bacterium found in a breast abscess is <i>Staphylococcus aureus</i> . Therefore, it is necessary to treat breast infections with a penicillinase-resistant antibiotic, such as flucloxacillin or erythromycin.		
Drug	Dose	Instructions
Cloxacillin	250 mg orally 6 hourly for 7–10 days	Take dose at least 30 minutes before food
Cephalexin	250–500 mg orally 6 hourly for 7–10 days	Take dose at least 30 minutes before food

Mastitis in an HIV-infected woman

- 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.

If a woman who is HIV-infected gets mastitis or a fissure, what should she do?

- 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 from 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 periods 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. If the mother is on ARVs, she can still feed her child the breastmilk. If she is not on ARVs, breastfeeding can resume when the breasts have recovered while she expresses and heat-treats her breastmilk throughout. (See Session 26 for heat-treatment of expressed breastmilk.)
- Give antibiotics for 10–14 days to avoid relapse. Give pain relief and suggest rest—the same protocol applied to 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 and reliably until the child is at least 1 year of age. She should continue to express enough milk to allow her breasts to recover and to keep them healthy, until milk production ceases.

Slide 11/12: Nipple fissure



- Photo 1 shows a mother's breast, and photo 2 shows the same mother feeding her baby on the breast.

What you might notice about her breast:

- There is a fissure, or crack, around the base of the nipple. You may be able to see that the breast is also engorged.

What you might notice about the baby's position and attachment:

- 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 the baby's top lip than below the bottom lip.
- His mouth is closed, and his lips are pointing forward.
- 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 rub a little expressed breastmilk over the nipple and areola with her finger. This promotes healing.

Slide 11/13: Candida infection



- This mother has very sore, itchy nipples.

What you see that might explain the soreness:

- 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.

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 the mother is being treated.

Stop using pacifiers, teats, and nipple shields.

Further information

Breast shape:

Breast shape and size is partly inherited. Breasts may be long in women 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 significantly help. They are unlikely to make much difference to severely inverted nipples. Nipple exercises can sometimes traumatisate 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.

Notes:

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Session 12. Common breastfeeding difficulties

Objectives

After completing this session, participants will be able to:

- Identify the causes of, and help mothers with common breastfeeding difficulties, such as:
 - ‘Not enough milk’.
 - A crying baby.
 - Breast refusal.
- Counsel working mothers on breastfeeding.

Session outline

Introduction	5 minutes
Explanation of the process and group assignments	10 minutes
Counselling practice (small groups)	30 minutes
Summary	30 minutes

Introduction

Slide 12/1: Objectives: Common breastfeeding difficulties

Objectives: Common breastfeeding difficulties 12/1

After completing this session, participants will be able to:

- Identify causes of, and help mothers with, the following breastfeeding difficulties:
 - ‘Not enough milk’.
 - A crying baby.
 - Breast refusal.
- Counsel working mothers on breastfeeding.

National Integrated Infant and Young Child Feeding counselling Course

Key point(s):

- In previous sessions, we 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 assessment.
- There are many reasons why mothers stop breastfeeding or start to mix feed, even if they had 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.

What are some of the most common difficulties women in your communities face with

breastfeeding?

In this training, we will explore some of the most common difficulties women in your communities face with breastfeeding, which include: (1) ‘not enough milk’, (2) a crying baby, (3) breast refusal, and (4) working mother.

Group assignments

Each group will be responsible for reviewing these difficulties, writing down some common reasons, and then choosing a leader to present their findings to the group.

Each group will have 30 minutes to review.

Counselling practice

Group 1. ‘Not enough milk’

Brainstorm with the group. Have the following questions prepared in advance. Note the responses on a flipchart or paper.

1. Is the problem of ‘not enough milk’ common in your area?
 2. What are some of the reasons why a mother may not have enough milk?
 3. How can you tell if a mother has enough milk?
 4. Can you think of any reasons why a baby may not get enough breastmilk?
 5. Discuss how to help mothers with ‘not enough milk’.
- ‘**Not enough milk**’ is one of the most common reasons for stopping breastfeeding.
 - Usually, when a mother *thinks* she does not have enough breastmilk, her baby is getting all he needs.

Some reasons why a mother may not have enough milk

- Sometimes a baby does *not* get enough breastmilk. But this is usually because of ineffective suckling.
- It is rarely because his mother cannot produce enough. Almost all mothers can produce enough breastmilk for one or even two babies.
- It is important to think not about how much milk a mother can produce, but about how much milk a baby is getting.

How you might decide if a baby is getting enough milk or not

- The first step in helping mothers with insufficient milk is to confirm if the baby is receiving enough breastmilk or not.
- There are only two *reliable* signs that a baby is not receiving enough breastmilk.

Reliable signs that a baby is not getting enough milk

- Poor weight gain (less than 500 g per month).

- Small amount of concentrated urine, less than six times per day.

Key point(s):

- In nearly all cases, mothers are able to produce enough milk for their babies.
- For the first six months of life, a baby should gain at least 500 g in weight each month.
- One kilogram is not necessary, and not usual.
- If a baby does not gain 500 g 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 six to eight times in 24 hours.
- A baby who is not getting enough breastmilk 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 breastmilk, you cannot be sure he is getting enough milk if he is passing lots of urine.

Possible signs that a baby is not getting enough breastmilk

- 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).

Discussion on the reasons why a baby may not get enough breastmilk

There may be a 'breastfeeding factor' and also a 'psychological factor'.

Reasons why a baby may not get enough breastmilk			
Breastfeeding factors	Mother: psychological factors	Mother: physical condition	Baby's condition
Delayed start	Lack of confidence	Contraceptive pill	Illness
Feeding at fixed times	Worry, stress	Diuretics	Abnormality

Infrequent feeds No night feeds Short feeds Poor attachment Bottles, pacifiers Other foods Other fluids (water, teas)	Dislike of breastfeeding Rejection of baby Tiredness	Pregnancy Severe malnutrition Alcohol Smoking Retained piece of placenta (rare) Poor breast development (very rare)	
These are COMMON		These are NOT COMMON	

Key point(s):

- 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.
- Therefore, it is not common for a mother to have a physical difficulty in producing enough breastmilk.
- Think about these uncommon reasons only if you cannot find one of the common reasons.

How to help mothers with 'not enough milk'

Key point(s):

- We have already found out whether the baby is really getting enough breastmilk or not.
- If the baby is not getting enough breastmilk, you need to find out *why* so that you can help the mother.
- If the baby *is* getting enough breastmilk, but the mother thinks that he is not, 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 assessment.
- Assess a breastfeed to check positioning and attachment; and to look for bonding or rejection.
- Use your observation skills to look for illness or physical abnormality in the mother or baby.
- What you suggest to the mother as solutions will depend upon the cause of the insufficient milk.
- Always remember to arrange to see the mother again soon. If possible, see the mother and baby daily until the baby is gaining weight and the mother feels more confident. It may take three to seven days for the baby to gain weight.

Babies who are getting enough milk but the mothers think they are not:

- Use your counselling skills to take a good feeding assessment.
- Try to learn what may be causing the mother to doubt her milk supply.
- Explore the mother's ideas and feelings about her milk and pressures she may be experiencing from other people regarding breastfeeding.
- Assess a breastfeed to check positioning and attachment; and to look for bonding or rejection.
- Praise the mother about good points about her breastfeeding technique and good points about her baby's development.
- Correct mistaken ideas without sounding critical.
- 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.

Group discussion

Mrs. Bello says she does not have enough milk. Her baby is 3 months old and crying ‘all the time’. Her baby gained 200 g last month. Mrs. Bello manages the family farm by herself, so she is very busy. She breastfeeds her baby about two to three 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.

What could you say to empathize with Mrs. Bello?

- One possible response “You are very busy. It must be difficult to find time to feed your baby.”

Mrs. Bello says she does not have enough breastmilk. Do you think her baby is getting enough milk?

- Mrs. Bello’s baby only gained 200 g last month, so he is not getting enough breastmilk.

Cause of Mrs. Bello’s baby not getting enough milk

- Mrs. Bello is not breastfeeding him often enough.

Suggestions on how Mrs. Bello could give her baby more breastmilk

- 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 breastmilk to leave for her baby?

Group 2. The crying baby

1. What are reasons for a crying baby?
2. How can you help mothers whose babies cry a lot (actual statements counsellors can say to mothers)?

3. What questions can you ask a mother (or observe) to determine why a baby may be crying a lot?
4. What are the different ways to soothe or comfort a crying baby?

Key point(s):

- 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.

Reasons why babies may cry a lot

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	

Key point(s):

- **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 most common at the ages of about 2 weeks, 6 weeks, and 3 months, but can occur at other times.
 - If he suckles often for a few days, the breastmilk 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 a mother 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 3 months old.
- ‘High-needs’ babies:
 - Some babies cry more than others, and they need to be held and carried more.
 - In communities where mothers carry their babies with them, crying is less common than in communities where mothers like to put their babies down to leave them, or where they put them to sleep in separate cots.

How to help mothers whose babies cry a lot:

- As with ‘not enough milk’, you have to try to find the cause of the crying so that you can help the mother. Use your counselling skills to take a good history.
- Help the mother to talk about how she feels and empathize with her. She may be tired, frustrated, and angry. Accept her ideas about the cause of the problem and how she feels about the baby.
- Try to learn about pressures from other people and what they think the cause of the crying is.
- Assess a breastfeed to check the baby’s 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.
- When relevant, praise the mother that her baby is growing well and is not ill or bad or naughty.
- Demonstrate ways to carry and comfort a crying baby: holding him close, with gentle movement and pressure on his abdomen.
- Give relevant information when appropriate.

Relevant information you could give to a mother whose baby is 6 weeks old and has colic:

- 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. Commercial infant formula feeds or medicines do not solve the problem.

Relevant information you could give to a mother whose baby is at the age when he might be going through a growth spurt:

- Encourage the mother to feed more frequently for a few days to increase her milk supply.

What practical help could you offer to a mother whose family thinks her well-grown, 3-month-old baby is crying too much and needs to start cereals?

- Offer to talk to the family. It is important to help reduce tension so that she does not feel under pressure to give unnecessary foods in addition to breastmilk.
- Babies are most often comforted with closeness, gentle movement, and gentle pressure on the abdomen. There are several ways to provide this.

Figure 12.1. Some different ways to hold a baby with colic.

- a. Holding the baby along your forearm b. Holding the baby around his abdomen, on your lap c. Father holding the baby against his chest



Group discussion

Mrs. Ojo's baby is 3 months old. She says that for the last few days, he has suddenly started crying to be fed very often. She thinks that her milk supply has suddenly decreased. Her baby has breastfed exclusively until now and has gained weight well.

One possible empathetic response to Mrs. Ojo:

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

One possible way you can praise Mrs. Ojo to build her confidence:

- “He has grown so well on your breastmilk.”

What relevant information can you give to Mrs. Ojo?

- One possible response: “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.”

Group 3. Refusal to breastfeed

1. What are the different ways a baby refuses the breast?
2. What are the different reasons why a baby refuses the breast?
3. What questions would you (counsellor) ask a mother who says her baby is refusing her breast?

4. Types of counselling advice you would offer the mother:

- In some communities, the baby's 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.

Reasons why babies refuse to breastfeed

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

Causes of breast refusal	
Illness, pain, or sedation	<ul style="list-style-type: none">• Infection• Brain damage• Pain from bruise (vacuum, forceps)• Blocked nose• Sore mouth (thrush, teething)
Difficulty with breastfeeding technique	<ul style="list-style-type: none">• Use of bottles and pacifiers while breastfeeding• Not getting much milk (for example, poor attachment)• Pressure on back of head when positioning• Mother shaking breast• Restricting length of feeds• Difficulty coordinating suckle
Change that upsets baby (especially aged 3–12 months)	<ul style="list-style-type: none">• Separation from mother (for example, mother returns to work)• New caregiver or too many caregivers• Change in the family routine• Mother ill• Mother has breast problem (for example, mastitis)• Mother menstruating• Change in smell of mother
Apparent refusal	<ul style="list-style-type: none">• Newborn: rooting• Age 4–8 months: distraction• Older than 1 year: self-weaning

Helping a mother and baby to breastfeed again

Help the mother to do these things:

- Keep her baby close (no other caregivers).
Give plenty of belly-to-belly 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.
Offer her breast when her baby is sleepy, or after a cup feed.
Offer her breast when she feels her ejection reflex working.
- Help her baby to take the breast.
Express breastmilk 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 breastmilk, if possible; if necessary, give commercial infant formula.
Avoid using bottles, teats, or pacifiers.

Group discussion

Mrs. Eze delivered a baby boy by vacuum extraction two days ago. He has a bruise on his head. When Mrs. Eze 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.

What you could say to empathize with Mrs. Eze:

- One possible response: “You are really upset, aren’t you?”

What praise and relevant information you can give to build Mrs. Eze’s confidence:

- 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.”

What practical help you can give to Mrs. Eze:

- Offer to help to find a way for Mrs. Eze to hold her baby that is not painful for him.

Group 4. Working mothers and infant and young child feeding

1. What is the situation for women who must work after they have their baby?
2. How can you help a working woman to breastfeed as much as possible?
 - Many mothers introduce early supplements or stop breastfeeding because they have to return to work.
 - This is something that many of us have had to deal with in our own lives. So it is a very important issue for all of us.
 - There are ways in which health workers can support working mothers, and help them

to give their babies as much breastmilk as possible.

Type of maternity protection women have in your communities

Counselling mothers who work away from home

Mothers who breastfeed:

- If possible, take your baby with you to work. This can be difficult if there is no crèche near your workplace, or if the transport is crowded.
- If your workplace is near to your home, you may be able to go home to feed him during breaks, or ask someone to bring him to you at work to breastfeed.
- If your workplace is far from your home, you can give your baby the benefit of breastfeeding in the following ways:
 - Breastfeed exclusively and frequently for the whole maternity leave. This gives your baby the benefit of breastfeeding, and it builds up your breastmilk supply. The first two months are the most important.
 - Do not start other feeds before you really need to. Do *not* think, ‘I shall have to go back to work in 12 weeks, so I might as well start on commercial infant formula feeds straight away’.
- It is not necessary to use a bottle at all. Even very small babies can feed from a cup. Wait until about a week before you go back to work. Leave just enough time to get the baby used to cup feeds, and to teach the caregiver who will look after him.
- Continue to breastfeed at night, in the early morning, and at any other time that you are at home:
 - This helps to keep up your breastmilk supply.
 - It gives your baby the benefit of breastmilk, even if you decide to give him one or two commercial infant formula feeds during the day.
- Many babies ‘learn’ to suckle more at night, and get most of the milk that they need then. They sleep more and need less milk during the day.

Learn to express your breastmilk soon after your baby is born.

- This will enable you to do it more easily.
- Express your breastmilk before you go to work, and leave it for the caregiver to give to your baby.
- Leave yourself enough time to express your breastmilk in a relaxed way. You may need to wake up half an hour earlier than at other times. (If you are in a hurry, you may find that you cannot express enough milk.)
- Express as much breastmilk as you can, into a very clean cup or jar. Some mothers find that they can express two cups (400–500 ml) or more even after the baby has breastfed. But even one cup (200 ml) can give the baby three feeds a day of 60–70 ml each. Even 1/2 cup or less is enough for one feed.
- Leave about 1/2 cupful (100 ml) for each feed that the baby will need while you are out.
- If you cannot express as much as this, express what you can. Whatever you can leave is helpful.

- Cover the cup of expressed breastmilk with a clean cloth or plate.

Summary

- 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 assessment.
- In many situations, there may be no treatment, so giving the mother relevant information and suggestions is very important.

Further information

Common breastfeeding difficulty: 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 breastmilk 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.

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 2 weeks. If babies feed on demand from the first day, they start gaining weight more quickly than babies who delay. A baby who weighs less than his birth weight at 2 weeks of age is not gaining enough weight.

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.

Stool frequency: The stool frequency of infants is 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.

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.
- Breastmilk 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.
- Breastmilk looks thin.

Guidelines, not rules: Weight gain and urine output as signs that a baby is not getting enough breastmilk 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.

These are COMMON 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 breastmilk may take longer to come in, and he may take longer to start gaining weight.
- **Infrequent feeds:** Breastfeeding less than eight times a day in the first 4 weeks, or less than five or six 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 breastmilk supply decreases.
- **Complementary feeds:** A baby who has complementary feeds (commercial infant formula, solids, or drinks including plain water) before 4–6 months suckles less at the breast, so the breastmilk 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.

These are NOT COMMON reasons why a baby may not get enough milk.

Mother—physical condition:

- **Contraceptive pill:** Contraceptive pills, which contain estrogens, may reduce the secretion of breastmilk. Progestagen-only pills and Depo-Provera should not reduce the breastmilk supply. Diuretics may reduce the breastmilk supply.
- **Pregnancy:** If a mother becomes pregnant again, she may notice a decrease in her breastmilk 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 breastmilk that a baby takes.
- **Retained piece of placenta:** This is RARE. A small piece of placenta remains in the uterus, and makes hormones that prevent milk production. The woman bleeds more than usual after delivery; her uterus does not decrease in size; and her milk does not 'come in'.
- **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 breastmilk. 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 breastmilk, 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 complementary milk for her baby. Encourage her to:

- Continue breastfeeding as much as possible.
- Give only the amount of complementary milk that her baby needs for adequate growth; give the complementary milk by cup.
- Give the complementary milk only once or twice a day, so that her baby suckles often at the breast.

Remember that the need for complementary foods before 6 months of age is RARE.

Common breastfeeding difficulty: 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' responses 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. When babies sleep with their mothers, they are less likely to cry at night. Yet babies themselves vary a lot in how much they cry. So it is impossible to say that some patterns are 'normal' and some are not.

Allergies: Babies can become allergic to the protein in some foods in their mother's diet. Cow's milk, soy, egg, and peanuts can all cause this problem. Babies may become allergic to cow's milk protein after only one or two prelacteal feeds of formula.

Drugs the mother takes: Caffeine in coffee, tea, and colas can pass into breastmilk 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.

Common breastfeeding difficulty: 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).**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 coordinating suckling. (Some babies take longer than others to learn to suckle effectively.)

Refusal of one breast only: Sometimes a baby refuses one breast but not the other. This is because the problem affects one side more than the other.

Has a change upset the baby?

Babies have strong feelings, and when they are upset, they may refuse to breastfeed. They may not cry, but simply refuse to suckle. This is most common when a baby is aged 3–12 months. 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 caregiver, or too many caregivers.
- 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 that 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.

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 breastmilk to feed to him by cup or by tube in a hospital, 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 that upset a baby: Discuss the need to reduce separation and changes if possible. Suggest that she stop 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.

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 belly-to-belly 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.
 - 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 breastmilk and feed it to her baby from a cup (or cup and spoon). If necessary, use commercial infant formula, and feed by cup.
 - She should avoid using bottles, teats, and pacifiers (dummies) of any sort.

Notes:.

Session 13. The importance of complementary feeding

Objectives

After completing this session, participants will be able to:

- Explain the importance of continuing breastfeeding.
- Define ‘complementary feeding’.
- Explain why there is an optimal age for children to start complementary feeding.
- Explain the fluid needs of young children.
- List the Key Points for Complementary Feeding from this session.
- List their current complementary feeding activities.

Session outline

Introduction	5 minutes
Discussion on sustaining breastfeeding	5 minutes
Definition of ‘complementary feeding’	5 minutes
Discussion on the optimal age to start complementary feeding	20 minutes
Discussion on the fluid needs of the young child	5 minutes
Examination of the role of the health worker and the health facility (group work)	15 minutes
Summary	5 minutes

Introduction

- The period from 6 months of age until 2 years is of critical importance in a 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 11 Key Points for Complementary Feeding to discuss with caregivers.

Slide 13/1: Objectives: The importance of complementary feeding

Objectives: The importance of complementary feeding	13/1
<p>After completing this session, participants will be able to:</p> <ul style="list-style-type: none">• Explain the importance of continuing breastfeeding.• Define complementary feeding.• Explain why there is an optimal age for children to start complementary feeding.• Explain the fluid needs of young children.• List the Key Points for Complementary Feeding from this session.• List their current complementary feeding activities.	

Discussion on sustaining breastfeeding

Why is it important to continue breastfeeding after 6 months?

- In an earlier session, 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 his/her nutritional needs.

- As well as nutrition, breastfeeding continues to provide protection (immunity) to the child against many illnesses and provides closeness and contact that helps psychological development.
- So, remember to include this Key Point for Complementary Feeding when talking about the baby older than 6 months.

Slide 13/2: Key Point # 1

Key Point #1

13/2

- Breastfeeding for two years or longer helps a child to develop and grow strong and healthy.



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- Feeding counsellors like you can do a lot to support and encourage women 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.

Definition of 'complementary feeding'

- Complementary feeding should begin when breastmilk alone is no longer sufficient to meet the nutritional requirements of infants, and therefore other foods and liquids are needed, along with breastmilk. The target range for complementary feeding is generally from 6 up to 24 months. Let us examine what complementary feeding means.

Slide 13/3: Definition of 'complementary feeding'

Definition of 'complementary feeding'

13/3

- 'Complementary feeding' means giving other foods in addition to breastmilk after 6 months.
- These other foods are called complementary foods.



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- These additional foods and liquids are called ‘complementary foods’, as they are in addition 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 well.
- The term ‘complementary feeding’ is used to emphasize that this feeding complements breastmilk rather than replaces 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. More information on feeding techniques will be covered in a later session.

Slide 13/4: Complementary feeding

13/4

Complementary feeding	
<ul style="list-style-type: none"> After 6 months, all babies require complementary foods while breastfeeding continues for up to 2 years of age or beyond. Complementary foods should be: <ul style="list-style-type: none"> timely adequate safe properly fed 	
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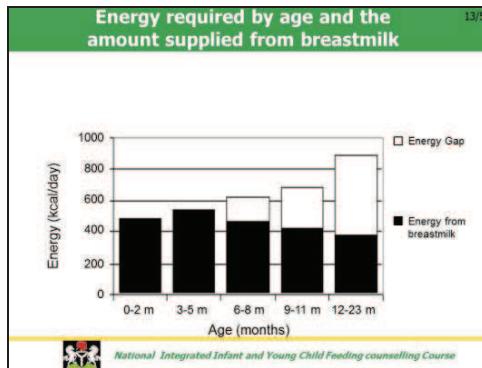
Discussion on the optimal age to start complementary feeding

- 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 breastmilk. Once you understand her reason, you can give her appropriate information.
- Complementary feeding should be started when the baby no longer gets sufficient energy and nutrients from breastmilk alone. This is usually at 6 completed months of age.

Energy needs:

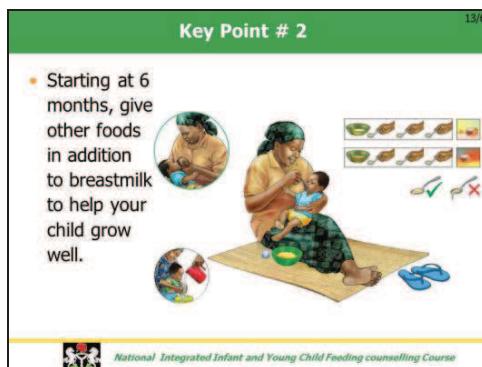
- Our bodies use food for energy to stay alive, to grow, to fight infection, to move around, and to be active. Food is like the wood for the fire; if we do not have enough good wood, the fire does not provide good heat or energy. In the same way, if young children do not have enough good food, they will not have the energy to grow and be active.

Slide 13/5: Energy required by age and the amount supplied from breastmilk



- 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 breastmilk.
- You can see that from about 6 months onward, there is a gap between the total energy needs and the energy provided by breastmilk. The gap increases as the child gets bigger.
- This graph is an ‘average’ child and the nutrients supplied by breastmilk from an ‘average’ mother. A few children may have higher needs, so the energy gap would be larger. A few children may have smaller needs, and thus a smaller gap.
- Therefore, for most babies, 6 months of age is a good time to start complementary foods. Complementary feeding from 6 completed months helps a child to grow well and be active and content.

Slide 13/6: Key Point # 2



- After six months, babies need to learn to eat thick gruel, puree, and mashed foods. These foods fill the energy gap more than liquids.
- At 6 completed months of age, it becomes easier to feed thick gruel 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.

Slide 13/7: Starting other foods too soon

Starting other foods too soon		13/7
Adding foods too soon may:		
<ul style="list-style-type: none"> • Take the place of breastmilk. • Result in a low-nutrient diet. • Increase risk of illness: <ul style="list-style-type: none"> – 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 breastmilk, making it difficult to meet the child's nutritional needs.
- Result in a diet that is low in nutrients if thin, watery soups and gruels are used.
- Increase the risk of illness because less of the protective factors in breastmilk are consumed.
- Increase the risk of diarrhoea because the complementary foods may not be as clean or as easy to digest as breastmilk.
- 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.

Slide 13/8: Starting other foods too late

Starting other foods too late		13/8
Adding foods too late may:		
<ul style="list-style-type: none"> • 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 anemia from lack of iron.

Discussion on the fluid needs of the young child (5 minutes)

- The baby who is exclusively breastfeeding receives all the liquid he needs in the breastmilk and does not require extra water.
- However, when other foods are added to the diet of a baby over 6 months, the baby may need extra fluids.
- How much extra fluid to give depends on what foods are eaten, how much breastmilk is taken, and the child's activity and temperature. Offer clean, safe (boiled or treated) water when the child seems thirsty.
- Extra fluid is needed if the child has a fever or diarrhoea. More information on feeding during illness is covered in a later session.
- For the most part, water requirements of infants 6 to 12 months can be met through breastmilk.
- Fluids that are good for young children:
 - Safe, clean water.
 - Milk.
 - Pure fruit juices (note that too much fruit juice may cause diarrhoea and may reduce the child's appetite for foods).
- Fluids that are not recommended for young children:
 - Drinks that contain a lot of sugar (this may actually make the child thirstier as his body has to deal with the extra sugar).
 - Fizzy drinks (soda drinks) and fruits with added sugar are not suitable for young children.
 - Teas and coffee reduce the iron that is absorbed from foods and are not recommended for children.
- Sometimes a child is thirsty during a meal. A small amount of water will satisfy the thirst and he may then eat more of his 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 he does not have room for foods.
- Remember that children who are not receiving breastmilk need special attention and special recommendations.
- Non-breastfed children aged 6–24 months need approximately two to three cups of clean, safe water per day in a temperate climate and four to six cups of clean, safe water per day in a hot climate.

Summary

Key point(s):

- In this session, we discussed the importance of adequate and timely complementary feeding.
- We had two Key Points for Complementary Feeding in this session.
 - Key Point 1: Breastfeeding until 2 years of age or longer helps a child to develop and grow strong and healthy.

- Key Point 2: Starting other foods in addition to breastmilk at 6 completed months helps a child to grow well.

Notes:

Session 14. 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.
- State the Key Points for Complementary Feeding from this session.

Session outline

Participants are all together for a lecture presentation by one trainer (45 minutes).

Introduction	10 minutes
Outline of foods that can fill the energy gap	10 minutes
Demonstration: Using a thick consistency of food	15 minutes
Discussion on ways to enrich foods	5 minutes
Summary	5 minutes

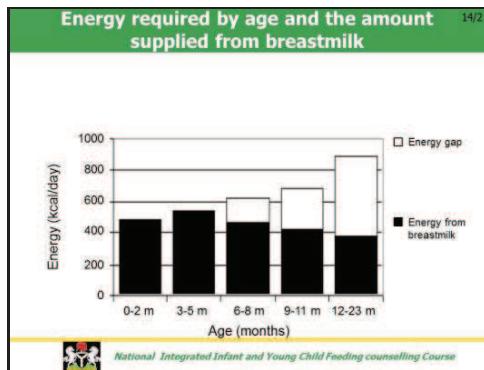
Introduction

Slide 14/1: Objectives: Foods to fill the energy gap

Objectives: Foods to fill the energy gap	14/1
<p>After completing this session, participants will be able to:</p> <ul style="list-style-type: none">• 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.• State the Key Points for Complementary Feeding from this session.	
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- We talked earlier that as a baby grows and becomes more active, an age is reached when breastmilk 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.

Slide 14/2: Energy required by age and the amount supplied from breastmilk



- As the young child gets older, breastmilk 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.

Foods that can fill the energy gap

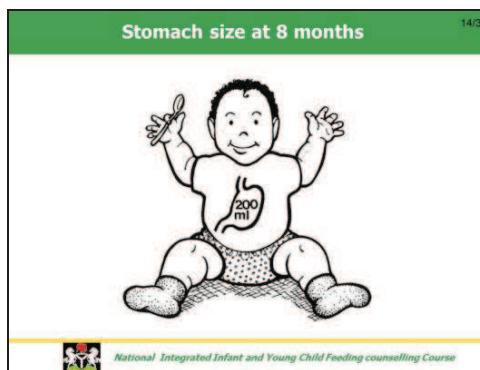
The staple may be:

- Cereals, such as rice, wheat, maize/corn, oats, or millet.
- Starchy roots such as cassava, yam, or potato.
- Starchy fruits such as plantain or green banana.
- All foods provide some energy. However, people generally eat large amounts of these staples to provide the energy they need. 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 gruel.
- 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 the main staples that families eat in your area. Then you can help them to use these foods for feeding their young children.
- 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.
- 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 using a cheaper staple.

Demonstration: Using a thick consistency of food

- We have the staple in the child's bowl. Let us say this child will have either maize or rice (or use a different local staple) in his bowl. 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, get 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.

Slide 14/3: Stomach size at 8 months



- This is Musa. He is 8 months old. At this age, Musa's stomach can hold about 200 ml at one time. This is the amount that fits into this container.
- Musa's mother makes his thick gruel from cereal flour and fermented cereals (maize, millet, sorghum, etc.). His mother is afraid Musa will not be able to swallow the porridge, so she adds extra water.

Thin gruel:

Can all this thin gruel fit in his stomach?

- No, it cannot all fit in his stomach; there is still gruel left in the bowl. Musa's stomach would be full before he had finished the bowlful. So Musa would not get all the energy he needs to grow.

Thick gruel:

- Musa's mother has talked with you, the health worker, and you have suggested that she give thick gruel. The mother makes the gruel using the same amount of cereal flour or fermented cereal (maize, guinea-corn, millet, etc.) but does not add extra water.

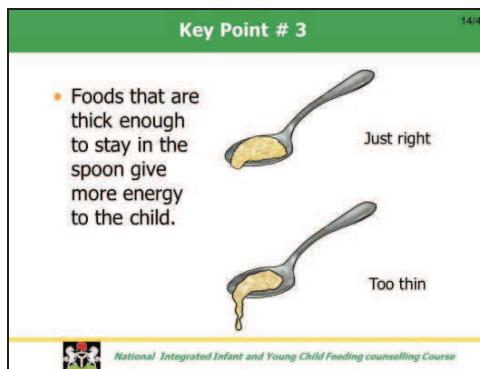
Can all this thick gruel fit in his stomach?

- Yes. Musa can eat a bowlful, which will help meet his energy needs.
- 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.
- Gruel or food mixtures that are so thin 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 in how well that food meets the young child's energy needs. Foods of a thick consistency help to fill the energy gap.

Slide 14/4: Key Point 3



Ways to enrich foods

- 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.

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 into 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, containing few beans, vegetables, or other foods.

Replace some (or all) of the cooking water with fresh or soured milk, coconut milk, or cream.

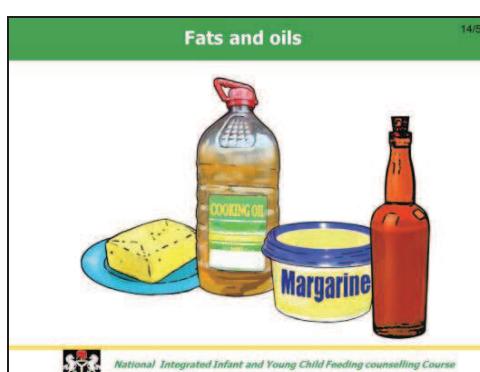
Add a spoonful of milk powder after cooking.

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.

Slide 14/5: Fats and oils



- Many foods contain fats and are very good for young children.
- Adding some fat to foods through oil or margarine can help fill the energy gap and improve taste.
- 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 foods softer and easier to eat.
- 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 and honey (not for children under 12 months) 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.

OPTIONAL: If fermented porridge or germination of grain for flour is used in your area, take turns reading out the points.

Fermented gruel or germination of grain for flour

Fermented gruel

- Fermented gruel can be made when the grain is soaked in clean water and set to ferment overnight or longer before cooking. The process involves:
 - Picking out bad grains or stones.
 - Washing grains with clean water.
 - Soaking grains in water for a day or more.
 - Washing grains again.
 - Grinding the grains.
 - Sieving.

The advantages of using fermented gruel are:

- It is thinner than plain gruel, so more grain/flour can be used with the same amount of water. This means each cupful of gruel contains more energy and nutrients than plain (unfermented) cereal.
- 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 cereal 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, they can make a thicker and more nutritious porridge the following ways:

- Use the 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.

Summary

- We had one Key Point for Complementary Feeding in this session:
 - Key Point 3: Foods that are thick enough to stay in the spoon give more energy to the child.

Notes:

Session 15. Clinical Practice 1: Listening and learning, assessing a breastfeed, building confidence and giving support, positioning a baby at the breast

Objectives

After completing this session, participants will be able to:

- Demonstrate appropriate listening and learning skills when counselling a mother.
- Assess a breastfeed using the BREASTFEED OBSERVATION JOB AID.
- Demonstrate appropriate building confidence and giving support skills when counselling a mother.
- Demonstrate how to help a mother to position and attach her baby at the breast.

Session outline

Preparation	10 minutes
Travel two ways (if site is not nearby, departure needs to be earlier)	up to 50 minutes
Clinical practice	90 minutes
Discussion of clinical practice	20 minutes

Preparation

Slide 15/1: Objectives: Clinical pPractice 1

Objectives: Clinical Practise 1	15/1
After completing this session, participants will be able to:	
<ul style="list-style-type: none">• Demonstrate appropriate Listening & Learning Skills when counselling a mother.• Assess a breastfeed using the BREASTFEED OBSERVATION JOB AID.• Demonstrate appropriate Building Confidence and Giving Support Skills when counselling a mother.• Demonstrate how to help a mother to position and attach her baby at the breast.	
 National Integrated Infant and Young Child Feeding counselling Course	

General instructions:

1. You are going to practice the listening and learning and building confidence and giving support skills that you learnt in the previous session, as well as assessing a breastfeed, with mothers in the ward.
2. You will also practice 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 Four 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.
3. You will need to take with you two copies of the BREASTFEED OBSERVATION JOB AID (Appendix 3), one copy of the COUNSELLING SKILLS CHECKLIST (Appendix

4), and pencil and paper to make notes.

4. You will work in groups of three or four with one trainer.

What to do in the ward:

Take turns talking to a mother while the other members of the group observe. Assess a breastfeed and help her to position and attach her baby if she needs help.

If you are the counsellor:

- 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.
- Practice as many of the counselling 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. Practice 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.

If you are the observer:

- You 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 counselling skills. Mark an X on your COUNSELLING SKILLS CHECKLIST when the participant uses a 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.
- Mark an X on your COUNSELLING SKILLS CHECKLIST when she uses a skill, to help you to remember for the discussion. Notice if she uses helpful nonverbal 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.
- When you have finished, thank the mother.

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 commercial infant formula feeding. You should say that you are interested in 'infant feeding' or in 'how babies feed'.

Do not give a mother help or advice.

In Clinical Practice 1, if a mother seems to need help, you should inform your trainer, and a member of the ward/clinic staff.

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 afterward. The participants who are observing can make notes.

Notes:

Session 16. Foods to fill the protein, 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 and/or fortified complementary foods.
- Explain the use of Micronutrient Powders (MNP) for home fortification
- List the Key Points for Complementary Feedings from this session.

Session outline

Introduction	2 minutes
Foods that fill the gaps: Iron	10 minutes
Discussion on iron absorption	5 minutes
Discussion on the importance of animal foods	5 minutes
Discussion on the importance of legumes	5 minutes
Foods that fill the gaps: Vitamin A	5 minutes
Discussion on the use of fortified complementary foods	10 minutes
Discussion on use of Micronutrient Powders (MNP) for home fortification	15 minutes
Summary	3 minutes

Introduction:

- It is important to feed young children a variety of foods, preferably from the different food groups.
- Eating a variety of foods provides important nutrients for children, including iron and vitamin A.

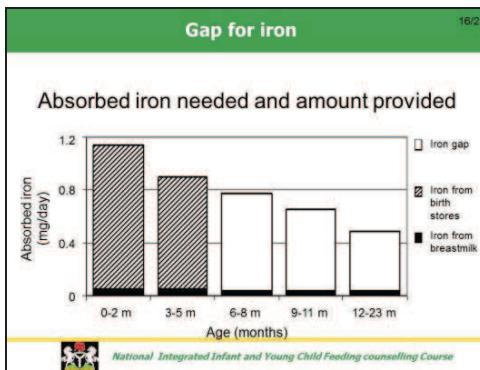
Slide 16/1: Objectives: Foods to fill the protein, iron, and vitamin A-gaps

Objectives: Foods to fill the protein, iron, and vitamin-A gaps 16/1
After completing this session, participants will be able to:
<ul style="list-style-type: none">• 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 fortified complementary foods.• Explain the use of Micronutrient Powders (MNP) for home fortification.• List the Key Points for Complementary Feeding from this session.

Foods that fill the gaps: Iron

- The young child needs iron to make new blood, to assist in growth and development, and to help the body to fight infections.

Slide 16/2: Gap for iron



- 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.
- The black area along the bottom of the columns shows us that there is some iron provided by breastmilk the whole time breastfeeding continues.
- 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 breastmilk. This gap needs to be filled by complementary foods.

What happens if the child does not have enough intake of iron to fill this gap?

- If the child does not have enough iron, the child will become anemic, and will be more likely to get infections and to recover slowly from infections. The child will also grow and develop slowly.
- Zinc is another nutrient that helps children to grow and stay healthy. It is usually found in the same foods as iron, so we assume that if 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.
 - Assist families to use these iron-rich foods to feed their young children.

Discussion on iron absorption:

- 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.

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 anemia (more iron is absorbed if anemic).

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, guava, mango, pineapple, pawpaw, orange, lemon, and other citrus fruits.
- Small amounts of the flesh or organs/offal of animals, poultry, fish, and other sea foods.

Iron absorption is decreased by:

- Drinking teas and coffee.
- Eating foods high in fibre such as cassava, cocoyam, yam, etc.
- Eating foods rich in calcium.*

*Foods rich in calcium, such as milk and cheese, inhibit iron absorption, but are needed for calcium intake.

Two more Key Points for Complementary Feeding:

- Key Point 4: Animal-source foods are especially good for children, to help them grow strong and lively.
- Key Point 5: Peas, beans, lentils, nuts, and seeds are also good for children.

Importance of animal-source foods

- Foods from animals, the flesh (meat) and organs/offal such as liver and heart, as well as milk, yoghurt, local cheese (Wara), and eggs are rich sources of many nutrients.
- The flesh and organs of animals, birds, and fish (including shellfish 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.

Ways of making these foods easier for the young child to eat

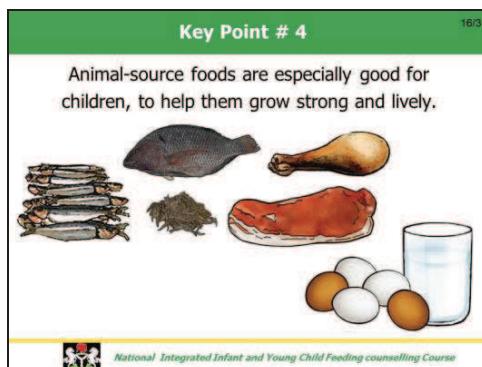
- Some ways of making these foods easier to eat for young children are to:
 - Cook chicken liver or other meat with rice or other staple or vegetables, and then mash them together and scrape meat with a knife to make soft, small pieces.
 - Pound dried fish so bones are crushed to powder, and then sieve 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.

Other foods that can provide important nutrients

- Protein: Milk, eggs, cheese, yoghurt.
- Vitamin A: Dark-green, leafy vegetables, milk fat, egg yolk.
- Zinc: Animal sources (meat, liver).
- Calcium: Dairy products, green vegetables, pounded dried fish.

When talking with families, discuss the following Key Points for Complementary Feeding:

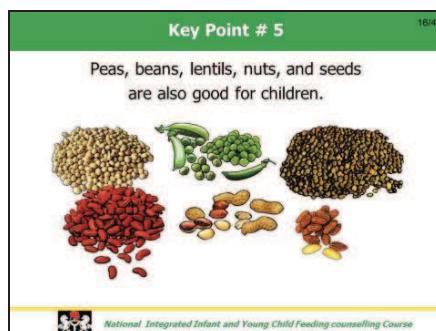
Slide 16/3: Key Point 4



Importance of legumes

Legumes or pulses such as beans and peas, as well as nuts and seeds, are good sources of protein. Legumes are a source of iron, as well.

Slide 16/4: Key Point 5



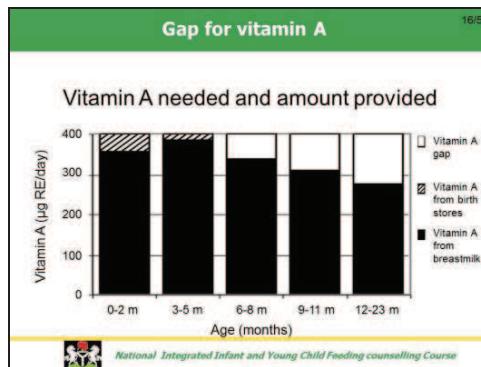
What are ways that legumes, nuts, and seeds could be prepared that would be easier for the child to eat and digest?

- 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, combine a cereal with a pulse (for example: rice and beans), or add a milk product to a cereal or grain (maize meal with milk).

Foods that fill the gaps: Vitamin A

- 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.

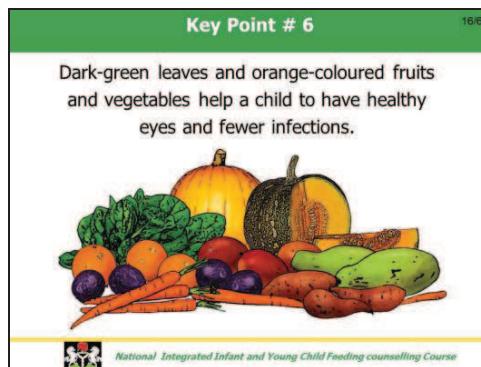
Slide 16/5: Gap for vitamin A



- Again, on this graph the top of each column represents the amount of vitamin A that the child needs each day. Breastmilk supplies a large part of the vitamin needed provided the child continues to receive breastmilk 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 orange-coloured vegetables and fruits (for example, spinach, pumpkin, carrots, and orange flesh sweet potato).
- 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, local cheese (Wara), 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 (beta-carotene).

- 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 helps to meet many nutrient needs.
- Remember that breastmilk 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 (e.g., integrated management of childhood illness).
- If a programme for vitamin-A supplementation exists in your area, mention it here.

Slide 16/6: Key Point 6



- When talking with caregivers, give this Key Point for Complementary Feeding: Dark-green leaves and orange-coloured fruits and vegetables help a child to have healthy eyes and fewer infections.

Use of fortified complementary foods

- In some areas, there are fortified complementary foods available. For example, flour or a cereal product with added iron and zinc.
- 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.

Fortified complementary foods

When discussing fortified complementary foods with caregivers, the points below should be considered.

What are the main contents or ingredients?

The food may be a staple, a 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.

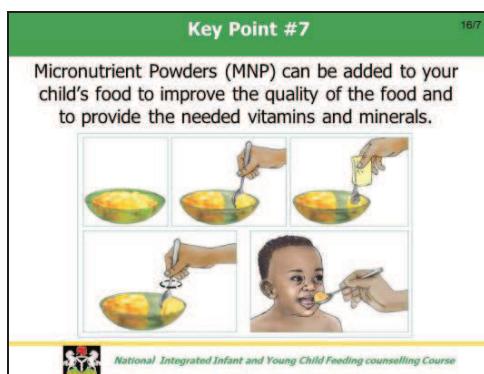
Does the label or other marketing imply that the product should be used before six months of age or as a breastmilk substitute?

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.

Discussion on the use of Micronutrient Powders (MNP) for home-fortification of food.

Note: This session should be used only if relevant.

Show Slide 16/7: Key Point 7, and make the points that follow.



Definition of MNP

MNP is a vitamin and mineral powder that can be added directly to semi-solid cooked food prepared in the home for young children 6 up to 24 months of age. The single-serving sachets allow families to fortify a young child's foods at an appropriate and safe level with needed vitamins and minerals, known as 'micronutrients'. MNP may also be used for children from 24 up to 60 months of age.

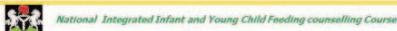
Slides 16/8a and 16/8b: Why use MNP?

Why use MNP?	16/8a	Why use MNP? (cont'd)	16/8b
<ul style="list-style-type: none">Improves the nutritional quality of food by adding micronutrients (vitamins and minerals) that are commonly insufficient in a young child's diet.Helps prevent deficiencies of key micronutrients, particularly iron, zinc, iodine, and vitamin A.Helps your child be strong, active, and healthy.MNP can help improve your child's appetite.Improves iron status and reduces anemia, increasing their ability to learn and develop.Micronutrients can help improve your child's immune system – increasing resistance to disease and infections.		<ul style="list-style-type: none">Easy to use and highly acceptable among families and young children. They do not require a change in food practises or complicated measuring and can be added to a wide range of readily available foods prepared at home.Do not conflict with breastfeeding and can help promote the timely introduction of complementary foods at 6 months of age and proper complementary feeding practises.	

Why use MNP?

- Improves the nutritional quality of food by adding micronutrients (vitamins and minerals) that are commonly insufficient in a young child's diet.
- Helps prevent deficiencies of key micronutrients, particularly iron, zinc, iodine, and vitamin A.
- Helps your child be strong, active, and healthy.
- MNP can help improve your child's appetite.
- Improves iron status and reduces anemia, increasing children's ability to learn and develop.
- Micronutrients can help improve your child's immune system by increasing resistance to disease and infections.
- Easy-to-use and highly acceptable among families and young children. MNP does not require a change in food practices or complicated measuring and can be added to a wide range of readily available foods prepared at home.
- MNP does not conflict with breastfeeding and can help promote the timely introduction of complementary foods at 6 months of age and proper complementary feeding practices.

Slides 16/9 and 16/10: MNPs from around the world; MNP formulation

MNPs from around the world		16/9
		
		

MNP formulation		16/10																																
<p>TABLE 1. RECOMMENDED NUTRIENT INTAKE (RNI) OF EACH MICRONUTRIENT PER DOSE FOR CHILDREN 6-59 MONTHS</p> <table border="1"><thead><tr><th>Micronutrients</th><th>Children (6-59 months)</th></tr></thead><tbody><tr><td>Vitamin A µg RE</td><td>400</td></tr><tr><td>Vitamin D µg</td><td>5</td></tr><tr><td>Vitamin E mg</td><td>5</td></tr><tr><td>Vitamin C mg</td><td>30</td></tr><tr><td>Thiamine (vitamin B1) mg</td><td>0.5</td></tr><tr><td>Riboflavin (vitamin B2) mg</td><td>0.5</td></tr><tr><td>Niacin (vitamin B3) mg</td><td>6</td></tr><tr><td>Vitamin B6 (pyridoxine) mg</td><td>0.5</td></tr><tr><td>Vitamin B12 (cobalamin) µg</td><td>0.9</td></tr><tr><td>Folate µg*</td><td>150.0</td></tr><tr><td>Iron mg</td><td>10.0</td></tr><tr><td>Zinc mg</td><td>4.1</td></tr><tr><td>Copper mg</td><td>0.56</td></tr><tr><td>Selenium µg</td><td>17.0</td></tr><tr><td>Iodine µg</td><td>96.0</td></tr></tbody></table>		Micronutrients	Children (6-59 months)	Vitamin A µg RE	400	Vitamin D µg	5	Vitamin E mg	5	Vitamin C mg	30	Thiamine (vitamin B1) mg	0.5	Riboflavin (vitamin B2) mg	0.5	Niacin (vitamin B3) mg	6	Vitamin B6 (pyridoxine) mg	0.5	Vitamin B12 (cobalamin) µg	0.9	Folate µg*	150.0	Iron mg	10.0	Zinc mg	4.1	Copper mg	0.56	Selenium µg	17.0	Iodine µg	96.0	
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<p>Recommended serving size (dry and reconstituted)</p> <p>Drop 1 gram sachet per child 2-3 times per week, can be taken daily... do not exceed one sachet per child per day.</p>																																		
																																		

Home fortification is recommended where complementary foods do not provide enough essential nutrients. This occurs where one or more of the following apply:

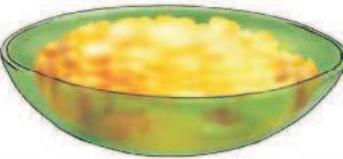
- Dietary diversity is low (due to limited availability or affordability).
- Complementary foods prepared for the small child have insufficient nutrient content and density (for example, watery porridges and foods lacking micronutrient content).
- The bioavailability of micronutrients is poor due to absorption inhibitors in the diet (fibre, phytate, tannin), which is especially the case in plant-source-based meals.

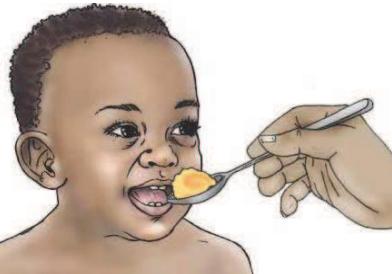
How to use MNP

- Use only one sachet per day OR use two to three sachets per week. Do not give more than one per day. If you forget, that is fine—give a sachet the following day.
- Use MNP sachet at any meal.

- Do not add MNP to any liquids or hot food.
- Food to which MNP is added should be eaten within 30 minutes (as the iron in the MNP will cause the food to darken).
- If the child does not finish the food in which the MNP has been mixed, do not reheat the food later, as the food may change in colour or taste.
- Do not share the food to which MNP is added with other household members (the amount of minerals/vitamins in a single sachet is just the right amount for one child age 6 up to 60 months).
- Store in a cool, dry, and clean place.
- Continue to give MNP during illness.

How to add Micronutrient Powders (MNP) to Complementary Foods

	<ol style="list-style-type: none"> 1. Wash hands with soap. 2. Prepare cooked any soft, semi-solid, mushy-like food, such as thick porridge or mashed potato. <ul style="list-style-type: none"> • Make sure that the food is at ready-to-eat temperature. • Do NOT add to hot food: if the food is hot, the heat will melt the lipid coating of the iron instantly and change the taste and colour of the food. • Do NOT add to any liquids (including water, tea, or watery porridge): In hot liquids, the iron will dissolve instantly and change the colour and taste of the food. In cold liquids, it lumps and does not mix (floats on top); only eventually does it dissolve and change colour.
	<ol style="list-style-type: none"> 3. Separate a small portion of food, which the child will be able to finish in a single setting, within the child's bowl, or place in a separate bowl.
	<ol style="list-style-type: none"> 4. Pour the entire contents of one sachet of MNP into the small portion of food to make sure that the child eats all the valuable micronutrients in the first few spoonfuls. <ul style="list-style-type: none"> • Shake the sachet to ensure the powder is not clumped. • Tear open the sachet. • Do NOT add to hot food: if the food is hot, your child will not be able to eat it quickly enough. If the food stands for a long time, the iron will change the colour and taste of the food, and your child might refuse to eat it. • Do NOT add to liquids (including water, tea, or

	watery porridge): the iron will dissolve instantly and change the colour and taste of the food.
	<p>5. Mix sachet contents and the small portion of food well.</p>
	<p>6. Give the child the small portion of food mixed with MNP to finish, and then feed the child the rest of the food.</p> <ul style="list-style-type: none"> • Give no more than one full sachet per day. • Use an MNP sachet at any meal. • Food to which MNP is added should be eaten within 30 minutes (as the iron in the MNP will cause the food to darken). • If the child does not finish the food in which the MNP has been mixed, do not reheat the food later, as the food may change in colour or taste. • Do not share the food to which MNP is added with other household members (the amount of minerals/vitamins in a single sachet is just the right amount for one child age 6 up to 60 months).

Possible side effects of MNP

- Any side effects are minimal and usually harmless/of short duration.
 - Colour of stool: dark stool indicates that iron is being absorbed into your child's body.
 - Consistency of stool: your child may have softer stools or a mild form of constipation during the first four to five days.
- Use of MNP complements vitamin-A supplementation, but doesn't replace it. If vitamin-A supplementation is provided when MNPs are also provided, both need to remain in place.
- Accidental overdosing is highly unlikely. In order to reach toxicity levels, as many as 20 sachets would have to be consumed.

WHO should NOT be given MNP?

- Children receiving RUTF (Ready-to-Use Therapeutic Food) for management of severe acute malnutrition.
- Suspend provision of MNP during the period of treatment for malnutrition (CSB++ and RUSF [Ready-to-Use Supplementary Food]) as children are already getting extra iron and vitamins they need.
- The guidelines presented here are not applicable to children with specific conditions such as human immunodeficiency virus (HIV) infection or tuberculosis, as the effects and safety of the intervention in these specific groups have not been evaluated.

Summary

- 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 Key Points for Complementary Feeding 1, 2, and 3.
 - Key Point 1: Breastfeeding until 2 years of age or longer helps a child to develop and grow strong and healthy.
 - Key Point 2: Starting other foods in addition to breastmilk at 6 months helps a child to grow well.
 - Key Point 3: Foods that are thick enough to stay in the spoon give more energy to the child.
- In this session, there were four new Key Points for Complementary Feeding to use with families to discuss ways to fill the gaps for iron and vitamin A.
 - Key Point 4: Animal-source foods are especially good for children, to help them grow strong and lively.
 - Key Point 5: Peas, beans, lentils, nuts, and seeds are also good for children.
 - Key Point 6: Dark-green leaves and yellow-coloured fruit and vegetables help a child to have healthy eyes and fewer infections.
 - Key Point 7: Micronutrient Powders (MNP) can be added to your child's food to improve the quality of the food and to provide the needed vitamins and minerals.

Further information

Iron:

- Absorbed iron is referred to in the text. This is the iron that passes into the body after it has been released from food during digestion. Only a small proportion of the iron present in food is absorbed. The rest is excreted in the feces.
- If a baby is born preterm or of low-birthweight, these body stores will be less, so these babies will need iron supplements, usually iron drops, from about 2 months of age.
- If fresh liquid animal milk is given to young children, it should be boiled or pasteurized (see Session 22).
- It is very difficult, if not impossible, for young children to meet the recommended intake of iron and zinc from foods unless meats are eaten regularly (ideally daily, or as frequently as possible). Organ meats are highest in iron. Mineral and vitamin supplements may be needed by children who do not have meat.
- In some parts of the world, iron pots are used for cooking. Iron absorption is increased by cooking in iron pots, particularly if the food is acidic.

Vitamin A:

If a mother is deficient in vitamin A during pregnancy, the baby will have lower stores at birth and there will be less vitamin A in the breastmilk. Supplements may be used for pregnant and newly delivered mothers in areas where vitamin-A deficiency is common.

Fluids:

Large quantities of artificial sweeteners, such as saccharine or aspartame, are not good for young children. When tea is referred to in the text, this includes black tea, green tea, and herbal or bush teas.

Notes:

Session 17. 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.
- Describe the recommendations for feeding a non-breastfed child.
- List the Key Points for Complementary Feeding from this session.

Session outline

Introduction	2 minutes
Discussion on the importance of using a variety of foods	10 minutes
Discussion on the frequency of feeding complementary foods	10 minutes
Outline of the quantity of complementary food to be offered	10 minutes
Exercise 17.a: Amounts to give	10 minutes
Summary	3 minutes

Introduction

- We have discussed what types of food help to fill the gaps in children older than 6 months. However, just offering suggestions for the types of food is not enough information for the caregivers.
- Caregivers need to know what amount of food to give and how often to give it. They may also ask about how to feed a child who does not want to eat. How to feed will be discussed in a later session.

Slide 17/1: Objectives: Quantity, variety, and frequency of feeding

Objectives: Quantity, variety, and frequency of feeding 17/1
<p>After completing this session, participants will be able to:</p> <ul style="list-style-type: none">• Explain the importance of using a variety of foods.• Describe the frequency of feeding complementary foods.• Outline the quantity of complementary food to be offered.• Describe the recommendations for feeding a non-breastfed child.• List the Key Points for Complementary Feeding from this session.

The importance of using a variety of foods

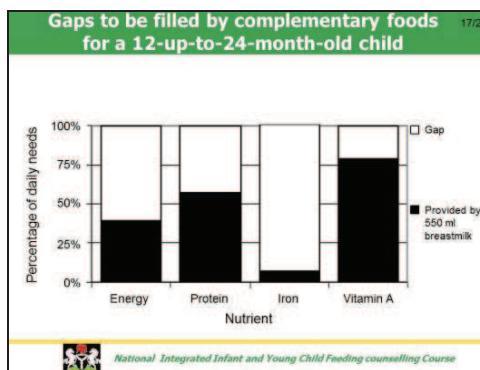
Key point(s):

- Most adults and older children eat a mixture or variety of foods at meal time. 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.

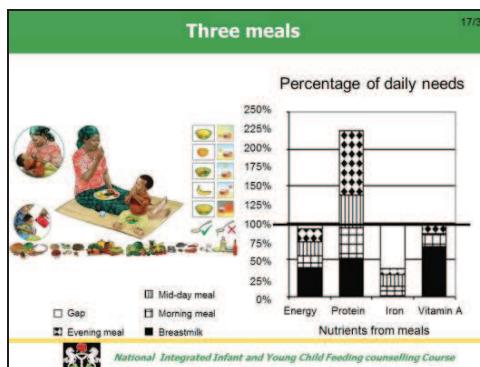
- When you build on the usual food preparations in a household, it is easier for families to feed their young children a diet with good complementary foods.
- Earlier, we looked at the difference between young children's needs and the amount of energy, vitamin A, and iron supplied by breastmilk. If we put the day's needs on one graph, it will look like this.

Slide 17/2: Gaps to be filled by complementary foods for a 12- up to 24-month-old child



- In Session 2, we talked about the importance of breastfeeding and the nutrients breastmilk 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 12–24 months. The dark section in each column indicates how much breastmilk supplies at this age if the child is breastfeeding frequently.
- Notice that:
 - Breastmilk 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.

Slide 17/3: Three meals



- This is Mba, who is 15 months old. The daily needs for a child this age are shown by the line at 100%.

- Mba continues breastfeeding (approximately 550 ml of breastmilk per day) as well as eating complementary foods. The breastmilk gives energy, protein, some iron, and vitamin A.
- This is what he has to eat in a day in addition to breastfeeding:
 - Morning:** A bowl of thick gruel, with milk and a small, level teaspoon/cube of sugar.
 - 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.
 - Evening:** A full bowl of food: Three big spoons of rice, one spoon of fish, one spoon of cooked mashed green vegetables.
- Mba's family gives 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.

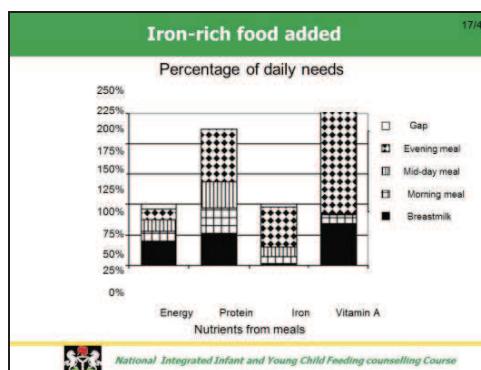
What do you see in the graph? Are these foods filling the gaps?

- The protein and vitamin-A gaps are more than filled. However, these meals do not fill this child's needs for iron or energy.

How could this child get more iron?

- If meat is eaten in the area, Mba 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, Mba's family could give him a spoonful of liver instead of the fish. This would fill the iron gap, as shown in the following graph.

Slide 17/4: Iron-rich food added



- If foods fortified with iron are available, these should be used to help fill the iron gap. (Remind participants of iron-fortified foods if discussed in the previous session.)
- 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 from family foods is zinc. The best sources of zinc in the diet are meat and fish, the same foods as iron-rich foods.
- Foods fortified with zinc can be used when it is not possible for a young child to eat enough meat, fish, or liver.
- However, in the graph, the energy gap is still not filled. Next, we will look at ways of

filling this gap.

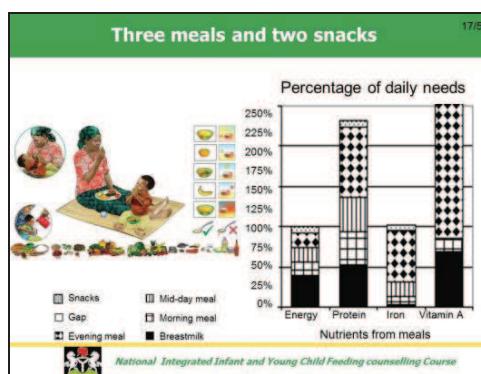
Frequency of feeding complementary foods

- Mba is already eating a full bowl of food at each meal. There is no space in his stomach for more food at meal times.
- Mba's family can give him some food more often. They do not need to cook more meals. They can give some extra foods between meals that are easy to prepare.
- These extra foods are in addition to the meals; they should not replace them.
- These extra foods are often called snacks. However, they should not be confused with foods such as sweets, crisps, or other processed foods, which may include the term "snack food" in their name. Give examples of local processed foods that might be called snack foods.
- 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.

What kind of healthy snacks would be easy to feed this child?

- Good snacks provide both energy and nutrients. Yoghurt and other milk products; bread or biscuits spread with butter, margarine, nut paste, or honey; fruit; bean cakes; and cooked potatoes are all good snacks. Note: Cooked, moist foods (such as potatoes) should not be kept more than 1 hour if there is no refrigeration.
- Poor-value snacks are ones that are high in sugar but low in nutrients. Examples of these are fizzy drinks (soda drinks), 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.

Slide 17/5: Three meals and two snacks



- [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 orange-coloured fruit or vegetable and an animal-source food in addition to the staple food.

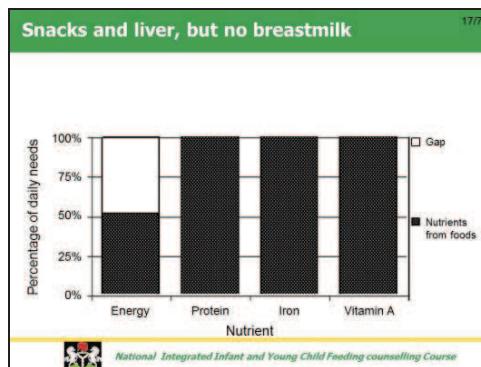
- When you are talking with caregivers, give these Key Points for Complementary Feeding.

Slide 17/6: Key Point 8



- 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.
- It is important to emphasize a variety of foods or different foods in each of the food groups. Make sure there is an understanding of how to ensure variety in the diet.
- Now we will look at feeding the non-breastfed child. We have mentioned in previous sessions that a child who does not receive breastmilk needs special attention to ensure he gets sufficient food.

Slide 17/7: Snacks and liver, but no breastmilk



- If the child is not taking any breastmilk 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 commercial infant formula), plus other dairy products (for example, eggs and other animal-source foods; infant formula if affordable, acceptable, and available).
- 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 receive breastmilk needs special attention to ensure he receives sufficient food.
- Children older than 6 months of age who are not receiving breastmilk need one to two cups of milk (where one cup is equal to 250 ml) and an extra one to two 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.

What other recommendations have we discussed in previous sessions for children older than 6 months who are not receiving breastmilk?

Slide 17/8: Recommendations for feeding the non-breastfed child 6–24 months

Recommendations for feeding the non-breastfed child 6–24 months	
The non-breastfed child should receive:	
• Extra water each day (two to three cups in temperate climate and four to six cups in hot climate).	17/8
• Essential fatty acids (animal-source foods, fish, avocado, vegetable oil, nut pastes).	
• Adequate iron (animal-source foods, fortified foods, or supplements).	
• Milk (one to two cups per day).	
• Extra meals (one to two meals per day).	
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- 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: two to three cups in a temperate climate and four to six cups 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 one to two cups of milk per day and an additional one to two meals.

Quantity of complementary food to be offered

Key point(s):

- 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 two to three spoonfuls of the food twice a day.
- Gradually increase the amount and 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 well-chopped if the child finds them difficult to eat.

What amounts of food do the families in your area give to their young children?

Amounts of foods to offer			
Age	Texture	Frequency	Amount of food an average child will usually eat at each meal
6–8 months	Start with thick porridge, well-mashed foods. Continue with mashed family foods.	Two to three meals per day plus frequent breastfeeds. Depending on the child's appetite, one to two snacks may be offered.	Start with two to three tablespoons per feed, increasing gradually to $\frac{1}{2}$ of a 250-ml cup.
9–11 months	Finely chopped or mashed foods, and foods that baby can pick up.	Three to four meals plus breastfeeds. Depending on the child's appetite, one to two snacks may be offered.	$\frac{1}{2}$ of a 250-ml cup/bowl.
12–23 months	Family foods, chopped or mashed if necessary.	Three to four meals plus breastfeeds. Depending on the child's appetite, one to two snacks may be offered.	$\frac{3}{4}$ 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.

*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.

- As you can see in this chart, as the child gets older, the amount of food offered increases. Give as much as the child will eat with active encouragement. Feeding techniques are discussed in a later session.
- When you are talking with families, give this Key Point for Complementary Feeding.

Slide 17/9: Key Point 9



Exercise 17.a: Amounts to give

Key point(s):

- As you talk with caregivers, a frequent question you are asked may be how much and how often to give food. To practice these amounts, we will now do an exercise. This is not a test. It is a way to help you learn to recall the amounts with speed and confidence.
- The facilitator will say an age of a child. The first person the facilitator calls 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, the facilitator says a different age of a child and we continue.

Exercise 17.a: Amounts to give		
Age of child	Frequency	Amount at each meal
6 months, 2 days	Two times per day	Two to three tablespoons
22 months	Three to four meals (may offer one to two snacks)	$\frac{3}{4}$ to one cup
8 months	Two to three times per day (may offer one to two snacks)	up to $\frac{1}{2}$ cup
12 months	Three to four meals (may offer one to two snacks)	$\frac{3}{4}$ to one cup
7 months	Two to three times per day (may offer one to two snacks)	up to $\frac{1}{2}$ cup
15 months	Three to four meals (may offer one to two snacks)	$\frac{3}{4}$ to one cup
9 months	Three to four meals (may offer one to two snacks)	$\frac{1}{2}$ cup
13 months	Three to four meals (may offer one to two snacks)	$\frac{3}{4}$ to one cup
19 months	Three to four meals (may offer one to two snacks)	$\frac{3}{4}$ to one cup
11 months	Three to four meals (may offer 1-2 snacks)	$\frac{1}{2}$ cup
21 months	Three to four meals (may offer one to two snacks)	$\frac{3}{4}$ to one cup
3 months	A trick question!	Only breastfeeding

Summary

- In this session, we talked about how much and how often to feed a young child .
- We also talked about the recommendations for feeding a child who is not receiving breastmilk.
- Key Point 8: Feed your child three to five times per day in addition to breastfeeding. Give a variety of different foods.
- Key Point 9: A growing child needs increasing amounts of food; add more feeds as your child grows.

Notes:

Session 18. 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 Point for Complementary Feeding from this session.

Session outline

Introduction	7 minutes
Feeding care practices and their effect on intake	25 minutes
Summary	3 minutes

Introduction

- 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.
- Often, health workers talk about what foods to give to 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 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 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.

Slide 18/1: Objectives: Feeding techniques

Objectives: Feeding techniques	18/1
<p>After completing this session, participants will be able to:</p> <ul style="list-style-type: none">• Describe feeding practises and their effect on the child's intake.• Explain to families specific techniques to encourage young children to eat.• List the Key Points for Complementary Feeding from this session.	
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Feeding care practices and their effect on intake

Key point(s):

- A child needs food, health, and care to grow and develop. Even when food and health care are limited, good caregiving can help to 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 meal times, when helping young children to eat.

Responsive feeding practice:

- 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 he does not have the skill of moving it to the back of his 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.

At what age do caregivers in your community expect young children to be able to eat by themselves?

- 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 younger than 2 years 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 learnt 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 when 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.

Demonstration 18.A: Controlled feeding

- The ‘young child’ is sitting next to the caregiver (or on the caregiver’s knees). The caregiver prevents the child from putting his 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.

What style of feeding did we see here?

- This is an example of controlled feeding. Children may not learn to regulate their intake, which may lead to obesity and food refusal later.

How do you think this child feels about eating?

- The ‘child’ may feel eating is very frightening and uncomfortable. He may feel scared.
- Now we will see another way of feeding a young child.

Demonstration 18.B: Leave to themselves

- The ‘young child’ is 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.

What style of feeding did we see here?

- 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.

How do you think this child feels about eating?

- The ‘child’ may feel eating is very difficult. He may be hungry or sad.
- Now we will see a third way of feeding a young child.

Demonstration 18.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.

How did the child feel this time about eating?

- The ‘child’ may feel happy about eating. He may like the contact and the praise and enjoy feeding himself.

What style of feeding did we see in the last demonstration?

- 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.

Another Responsive Feeding Practice

- Now we have another Responsive Feeding Practice: Feed slowly and patiently; encourage, but do not force.

What good practices did we see in the last demonstration that we could encourage?

- 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 manuals.

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.

- The third Responsive Feeding Practice to encourage is: Talk to children during feeding, with eye-to-eye contact.
- Feeding times are periods of learning and love. Children may eat better if feeding times are happy.
- Feed when the child is alert and happy. If the child is sleepy or over-hungry and upset, he may not eat well.
- Regular meal times 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.

Slide 18/2: Feeding situation #1 and Slide 18/3: Feeding situation #2



What can we see in these feeding situations that could encourage the young child to eat?

- The overall feeding environment may also affect food intake. This includes:
 - Sitting with the family or other children at meal times, so the child sees them eating.
 - Sitting with others eating to provide an opportunity to offer extra food to the young child.
 - Using a separate bowl for the child, so the caregiver can see the amount eaten.
 - Talking with the child.
 - Encouraging the whole 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.

Slide 18/4: Key Point 10

Key Point #10

18/4

- A young child needs to learn to eat: encourage and give help ... with lots of patience.



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Summary

- In this session, we discussed the importance of feeding and care practices to assist in feeding a young child.

Notes:

Session 19. Assessing infant and young child feeding practices

Objectives

At the end of this session, participants should be able to:

- Assess infant and young child feeding practices to help them diagnose any feeding difficulties.
- Demonstrate the ability to use the INFANT AND YOUNG CHILD FEEDING ASSESSMENT (0 UP TO 24 MONTHS) JOB AID.

Session outline

Introduction	5 minutes
Taking an infant and young child feeding (IYCF) assessment	35 minutes
Exercises using the INFANT AND YOUNG CHILD FEEDING ASSESSMENT (0 UP TO 24 MONTHS) JOB AID	35 minutes
Summary	5 minutes

Introduction

Slide 19/1: Objectives: Assessing infant and young child feeding practices

Objectives: Assessing infant and young child feeding practises
After completing this session, participants will be able to:
<ul style="list-style-type: none">Assess infant and young child feeding practises to help them diagnose any feeding difficulties.Demonstrate ability to use the INFANT AND YOUNG CHILD FEEDING ASSESSMENT (0 UP TO 24 MONTHS) JOB AID.
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Why it is necessary to do an assessment?

- If a mother asks for your help, you need to understand her situation.
- You cannot learn everything that you need to know by observing and listening and learning. You need to ask some questions.
- Doing an assessment means asking relevant questions in a systematic way.

There are things you can learn only by *asking* the mother, such as:

- When the baby was born.
- What happened at the time of delivery.
- What else she feeds her baby.

How to take an infant and young child feeding assessment

Specific skills to use:

Use the mother's name and the baby's name (if appropriate).

Greet the woman in a kind and friendly way. Introduce yourself, and ask her name and the baby's name. Remember and use them, or address her in whatever way is culturally appropriate.

Ask her to tell you about herself and her baby in her own way.

- Let her tell you first what she feels is important. You can learn the other things that you need to know later.
- Use your listening and learning skills to encourage her to tell you more.

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.

- You will need to ask questions, including some closed questions, but try not to ask too many.
- The INFANT AND YOUNG CHILD FEEDING ASSESSMENT (0 UP TO 24 MONTHS) JOB AID 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.

Take time to learn about more difficult, sensitive things.

- Some things are more difficult to ask about, but they can tell you about a woman's feelings, and whether she really wants to breastfeed.
- What have people told her about breastfeeding?
- Does she have to follow any special 'rules'?
- What does the baby's father say? Her mother? Her mother-in-law?
- Did she want this pregnancy at this time?
- 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.

Be aware of the following behaviours:

Be careful not to sound critical.

- Ask questions politely. For example:
 - Do not ask: "Why are you bottle feeding?"
It is better to say: "What made you decide to give [name] some bottle feeds?"
 - Use your confidence and support skills.
 - Accept what the mother says, and praise what she is doing well.

Try not to repeat questions.

- Try not to ask questions about facts that either the mother or the growth chart has told you already.
- If you do 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?"

Introduction to the INFANT AND YOUNG CHILD FEEDING ASSESSMENT (0 UP TO 24 MONTHS) JOB AID

Key point(s):

- You will use a special form, the INFANT AND YOUNG CHILD FEEDING ASSESSMENT (0 UP TO 24 MONTHS) JOB AID (Appendix 2), to help you remember what questions to ask.
- When you first learn to use the form, you need to ask all the questions. As you become more experienced, you learn which questions are relevant for which mothers. Then you do not need to ask all the questions every time.
- It also helps you practice the counselling skills you have learnt.

Explanation of INFANT AND YOUNG CHILD FEEDING ASSESSMENT (0 UP TO 24 MONTHS) JOB AID:

- This is a guide to help you to organize your thoughts so that you do not get lost when you talk with a mother. It lists the main points that you may need to ask about a mother and baby. You may need to follow up some questions with more detailed questions. It will also help you practice with mothers the counselling skills you have learnt.
- The points are grouped into six sections to help you to remember what you need to ask about.
 - The first two sections are about the baby and how he is feeding now.
 - The third section is about the mother's pregnancy and delivery.
 - The fourth section is about the mother and her health and family planning.
 - The fifth section is about her previous experience of feeding infants.
 - The sixth section is about the family and their social situation.
- Often, questions about points in the first two sections give you the answer to a problem. Sometimes you need to find out more about the mother, her pregnancy and delivery, her previous baby(ies), or the family's situation, before you can understand her difficulties.
- Start with the first two sections. They are the most important. Then continue through the other sections until you are clear about the problem. When you are clear, you need not continue to ask about all the other points.
- However, it is a good idea to ask each mother about something from each section. Think quickly through all the six sections, and ask yourself what might be important for this family.
- If at any time a mother wants to tell you about something that is important to her, let her tell you that first. Ask about the other things afterward.
- Study the form and try to memorize the six sections. When you know the sections, you will find it easier to remember the different points in each.
- When you first use it, go through the whole form. This will help you to learn how to take a breastfeeding history. As you gain experience, you will find it easier to choose which questions to ask.

Demonstration 19.A: Using the INFANT AND YOUNG CHILD FEEDING ASSESSMENT (0 UP TO 24 MONTHS) JOB AID

Mrs. Ikeh's complaint: "Tosin is really feeding too much."

1. Tosin is 3 months old and breastfeeds about 10–12 times a day, sometimes every 1–2 hours, sometimes after 5–6 hours. She breastfeeds about twice in the night. You (Mrs. Ikeh) do not give any complementary milk feeds, but you sometimes give drinks of water from a spoon.
2. Tosin is gaining weight well, and she is very healthy. She passes urine six to eight times a day. Her growth chart shows that she is gaining weight.
3. Tosin was born in the hospital, and started breastfeeding soon after delivery. She roomed-in with you, and did not have any prelacteal feeds. The midwife helped you and you had no difficulties.
4. You are aged 25 years, and healthy. You are not using any family planning method. You think that breastfeeding is very healthy, and you want to continue.
5. Tosin is your first baby.
6. You stay at home, and do not go out to work. Tosin's father works as a clerk. Tosin's father thinks that it is time the baby stopped having night feeds.

Discussion

What do you think is the cause of Mrs. Ikeh's difficulty? (*Mr. Ikeh wants her to stop breastfeeding.*)

Is Mrs. Ikeh's idea of the problem correct? (*No—anyway, not what she says.*)

What misunderstanding may have given her this idea? (*The baby sometimes wants to feed again quite soon. But this is normal.*)

Questions to consider:

- Did the Nurse ask questions from all six sections of the INFANT AND YOUNG CHILD FEEDING ASSESSMENT (0 UP TO 24 MONTHS) JOB AID?
- Did she leave out any important questions?
- Did asking questions from each section of the form help her to understand the problem?
- Point out that continuing to Section 6 helped Nurse Hauwa to remember to ask about the father's attitude. It is clear that it is the father's attitude toward Tosin's breastfeeding that is making Mrs. Ikeh worry about how often Tosin breastfeeds.

Slide 19/2: Summary: How to conduct an infant and young child feeding assessment

Summary: How to conduct an infant and young child feeding assessment	19/2
<ul style="list-style-type: none">• 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.• Look at the child's growth chart.• Ask the questions that will tell you the most important facts.• Be careful not to sound critical.• Try not to repeat questions.• Take time to learn about more difficult, sensitive things.	
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Exercises using the INFANT AND YOUNG CHILD FEEDING ASSESSMENT (0 UP TO 24 MONTHS) JOB AID

- Use role-play to practice taking a feeding assessment.
- Follow the INFANT AND YOUNG CHILD FEEDING ASSESSMENT (0 UP TO 24 MONTHS) JOB AID (Appendix 2).
- Work in pairs, taking turns being a ‘mother’ or a ‘counsellor’. When you are a ‘mother’, play the part of the mother in the assessment on your card. Your partner takes your assessment.
- You are the only one in the group who has a copy of your assessment. Conceal it from the others. Look only at your own assessment.
- Give yourself and your baby a name, either your own real name or another, if you prefer.
- Other participants in the group observe the pair practice, until it is their turn.

The pair practice

If you are the ‘counsellor’:

- Greet the ‘mother’ and ask her how she is. Use her name and her baby’s name.
- Ask one or two open questions about breastfeeding to start the conversation.
- Ask the ‘mother’ questions from all six sections of the assessment form, and look at the baby’s growth chart to learn about the situation.
- You can make brief notes on the form, but try not to let it become a barrier.
- Use your listening and learning skills.
- Do not give information or suggestions, or give any advice.

If you are the ‘mother’:

- Read out the reason for the visit in response to the ‘counsellor’s’ open questions.
- Answer the ‘counsellor’s’ questions from the information in your assessment.
- If the information to answer a question is not in your assessment, make up information to

fit with the assessment.

- If your ‘counsellor’ uses good listening and learning skills, give her the information more easily.

If you are observing:

- Follow the pair practice using your INFANT AND YOUNG CHILD FEEDING ASSESSMENT (0 UP TO 24 MONTHS) JOB AID, and observe if the ‘counsellor’ takes the assessment correctly.
- Notice if she asks relevant questions, if she misses important questions, and if she asks questions from all sections of the form.
- Try to decide if the ‘counsellor’ has understood the ‘mother’s’ situation correctly.
- During discussion, be prepared to praise what the players do right, and to suggest what they could do better.

Exercise 19a: Taking an infant feeding assessment

Assessment 1

Reason for visit: “I have brought Niyi for immunization. Everything is fine.”

Assessment:

1. I give him formula, about three bottles a day, with two spoonfuls of milk powder in each bottle. He had difficulty in suckling when he was born, so I gave him bottle feeds while I tried to breastfeed. He has refused to breastfeed for two weeks.
2. He is 6 weeks old and weighs 2.5 kilos. He was born in the hospital and weighed 2.0 kilos. He has two to three soft stools a day.
3. No one discussed breastfeeding in the antenatal clinic. In the hospital, he was in the nursery for 6 hours. The midwives did not help me to breastfeed. I was discharged after 24 hours. I started trying to breastfeed after two days. This is my first visit to a health centre.
4. I am 19 years old, and healthy. I had plenty of milk, and I wanted to breastfeed. But my nipples are flat, so I could not.
5. This is my first baby.
6. I am a housewife, and my husband bought the tins of formula. I have not thought about family planning. My mother lives a long way away.

Comments:

The baby refused to breastfeed because he was given bottle feeds. The mother did not have early contact, or help to breastfeed in the first day. She needed help for flat nipples, this is her first baby, and her baby was small. She did not complain about her difficulties, and you only learnt about this serious situation by taking an assessment.

Assessment 2

Reason for visit: “Niyi has diarrhoea.”

Assessment:

1. I breastfeed him often, and he sleeps with me at night. I give him thin cereals in a bottle, two to three times a day. I started this when he was 6 weeks old.
2. He was born in the hospital, and weighed 3.0 kilos. He weighed 4.5 kilos at 2 months, and weighs 4.8 kilos now, at the age of 4 months.
3. When he was 6 weeks old, he cried to be fed often; that is why I started cereal feeds. But now he has less appetite, and is passing watery stools.
4. He started to breastfeed soon after delivery. The midwife helped me, and I had no difficulties.
5. I am aged 30, and well. I rely on breastfeeding for family planning until my periods start again.
6. I have two previous children. I breastfed both without any difficulty.
7. I work on a small farm with my husband and his parents. My mother-in-law helps me very much. She advised me to start cereals, because of the crying.

Comments:

The baby was hungry because of a growth spurt. The mother gave diluted cereal feeds, but they were not necessary. This has caused diarrhoea. You learnt the reason for the diarrhoea by the end of Section 1. However, in Section 6, you learnt that it is her mother-in-law who advises her.

Assessment 3

Reason for visit: "I have sore nipples."

Assessment:

1. I breastfeed my baby many times a day, for about 20–30 minutes each time.
2. She weighed 4.0 kilos when she was born. Now she is 3 weeks old and weighs 4.5 kilos. She is well.
3. She was born by Caesarean section, and was kept in the nursery and bottle fed for two days. Since then, I have been trying to breastfeed, but my baby had difficulty in learning to suckle. The midwives suggested bottles, but I did not want to bottle feed. I persisted with breastfeeding until now.
4. Nobody asked me about breastfeeding at the antenatal clinic.
5. I am 26, and healthy. I am disappointed because I really want to breastfeed, but my nipples hurt so much that I will have to give up.
6. They bleed sometimes.
7. I had one baby before. I breastfed him, but I never had enough milk and he was never satisfied. I gave up after a few weeks.
8. I am divorced, but my mother stays with me and helps me with the children.

Comments:

She did not receive the necessary help from the hospital staff to enable her to breastfeed. Her

baby is suckling in a poor position, which is causing sore nipples. She is growing, so she must be getting plenty of milk, but she is suckling inefficiently, and needs to suckle often and for a long time. You learnt her main problem early in the assessment. But it is important to know that she had problems breastfeeding her previous baby.

Assessment 4

Reason for visit: "I have a painful swelling in my breast, and I feel feverish."

Assessment:

1. I breastfeed my baby whenever I am at home, about once in the morning, twice in the evening, and once or twice at night. She suckles for about 5 minutes each time. I am too busy to breastfeed her for long. While I am working, my helper gives her bottle feeds of formula. This started when I went back to work about one month ago. Before that, I just breastfed.
2. My baby is healthy. She weighed 3.5 kilos at birth. Now she is 4 months old and weighs 5.9 kilos. I don't know how often she passes urine. I am not at home.
3. She was born at home, and I breastfed her straight away.
4. The community midwife helped me.
5. I am 27 years old, and healthy. I had a painful swelling in the other breast soon after I went back to work. It was the weekend, I continued breastfeeding, and it got better by itself. This time it is worse.
6. I have one older child. I breastfed him for four months, until my milk dried up. I started work when he was 2 months old, and bottle fed him when I was out.
7. I was very disappointed when I had to stop breastfeeding.
8. I work in a factory, and I am away from home for about 10 hours every day. I am exhausted when I get home. I have a helper who cares for the children. My parents live a long way away.

Comments:

She has mastitis, probably because her baby is feeding only for a short time, and not often enough, so he is not emptying the breasts properly. It is important not to stop when you make the diagnosis of mastitis, but to continue to Section 6, so that you learn how busy and tired this mother is. This is important for management.

Summary

Remember that there is no need to ask every mother all of the questions at each visit. This is just a guide to remind the counsellor of the questions that are important to ask.

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.

Notes:

Session 20. Gathering information on complementary feeding practices

Objectives

After completing this session, participants will be able to gather information on complementary feeding practices by:

- Demonstrating appropriate use of counselling skills.
- Observing a mother and child using the FOOD INTAKE (6 UP TO 24 MONTHS) JOB AID and FOOD INTAKE (6 UP TO 24 MONTHS) REFERENCE TOOL.

Session outline

Introduction	2 minutes
Demonstration: Gathering information on feeding practices	30 minutes
Exercise 20.a: Gathering information using the FOOD INTAKE (6 UP TO 24 MONTHS) JOB AID and FOOD INTAKE (6 UP TO 24 MONTHS) REFERENCE TOOL	60 minutes
Summary	3 minutes

Introduction

- 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 an earlier session, you looked at the INFANT AND YOUNG CHILD FEEDING ASSESSMENT (0 UP TO 24 MONTHS) JOB AID. You learnt how to take a feeding history.
- Now we are going to look at assessing the intake of complementary feeds in detail.

Slide 20/1: Objectives: Gathering information on complementary feeding practices

Objectives: Gathering information on complementary feeding practices	201
<p>After completing this session, participants will be able to:</p> <ul style="list-style-type: none">• Gather information on complementary feeding practises by:<ul style="list-style-type: none">- Demonstrating appropriate use of counselling skills.- Observing a mother and child using the FOOD INTAKE (6 UP TO 24 MONTHS) JOB AID and FOOD INTAKE (6 UP TO 24 MONTHS) REFERENCE TOOL.	
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Demonstration: Gathering information on feeding practices

- In an earlier session, 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.

- In an earlier session, we looked at the INFANT AND YOUNG CHILD FEEDING ASSESSMENT (0 UP TO 24 MONTHS) JOB AID and learnt how to take a feeding history.
- 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 Points to help improve practices.
- The FOOD INTAKE (6 UP TO 24 MONTHS) JOB AID (Appendix 7a) and FOOD INTAKE (6 UP TO 24 MONTHS) REFERENCE TOOL (Appendix 7b) help you to do this.
- The mother is asked to recall everything the child consumed the previous day. This includes all foods, snacks, drinks, and 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 if the practice occurred the previous day.
- You will see that most of the questions in the first column are closed questions.
- When you use this tool with a mother or caregiver to gather information, you should use your counselling skills, including open questions. We will see how this is used in a later demonstration.

Use the Food Consistency Photos (Appendix 6) to show differences in thickness:

- 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 photos to show a thick and a thin consistency.
- Show the food consistency photos 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 (6 UP TO 24 MONTHS) JOB AID, you then choose two or three Key Points 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 Points to give to her. There is a column on the FOOD INTAKE (6 UP TO 24 MONTHS) JOB AID to indicate which items you discussed in more detail and gave Key Points about.
- Put your initials at the Key Points you gave.

Why is it important to choose just two or three Key Points to give the mother?

- It is important to choose just two or three Key Points at a visit so the mother is not overwhelmed.
- Discuss the Key Points you think are most important at this time and that the mother thinks that she can do.

Additional points:

- We will discuss feeding the child who is ill in a later session.

- The other Key Points have already been introduced.

Instructions to complete the FOOD INTAKE (6 UP TO 24 MONTHS) JOB AID

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’s name], let us talk about what [child’s name] ate yesterday.”
5. Continue with:
“As we go through yesterday, tell me all [child’s name] ate or drank, meals, other foods, water, or breastfeeds.”
“What was the first thing you gave [child’s name] after he woke up yesterday?”
“Did [child’s name] eat or drink anything else at that time, or breastfeed?”
6. If the mother mentions a preparation, such as a gruel or stew, ask her for the ingredients in the gruel or stew.
7. Then continue with:
“What was the next food or drink or breastfeed [child’s name] had yesterday?”
“What else did [child’s name] eat/drink 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 (6 UP TO 24 MONTHS) JOB AID the practices that are present. If appropriate, show the mother the photos of thin and thick consistency (for gruel and mixed foods). Ask her which photo is most like the food she gave the child. Was it thick, did it stay in the spoon and hold a shape on the plate, or was it thin and flowed off the spoon and did not hold its shape on the plate?
12. Praise practices you wish to encourage. Offer two or three Key Points as needed and discuss how the mother might use this information using the FOOD INTAKE (6 UP TO 24 MONTHS) REFERENCE TOOL.
13. If the child was ill on that day and not eating, give Key Point for Complementary Feeding 11:
Encourage the child to drink and eat during illness and provide extra food after illness to help the child recover quickly.
14. See the child another day and use the FOOD INTAKE (6 UP TO 24 MONTHS) JOB AID when the child is eating again.

Demonstration 20.A: Learning what a child eats

[Child's 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 [child's 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 [child's name] is eating.

Health worker: *[Shows growth chart.]* "Thank you for coming today. [Mother's name], your child's weight line is going upward, 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?"

Mother: "I am pleased that he has put on some weight, as [child's name] has been ill recently and I was worried that he might have lost weight."

Health worker: "I can see you are anxious about his weight."

Mother: "Yes. I was wondering if I was feeding him the right sorts of food."

Health worker: "Perhaps we could go through everything that [child's name] ate or drank yesterday."

Mother: "Yes, I can tell you about that."

Health worker: "What was the first thing you gave [child's name] after he woke up yesterday?"

Mother: "First thing, he breastfed. Then about 1 hour later, he had a small amount of bread with butter, and several pieces of pawpaw."

Health worker: "Breastfeeding, then bread, butter, and some pieces of pawpaw. That is a good start to the day. What was the next food, drink, or breastfeed that he had yesterday?"

Mother: "At mid-morning, he had some gruel with milk and sugar."

Health worker: *[Shows two consistency photos.]* "Which of these drawings is most like the gruel you gave to [child's name]?"

Mother: "Like that thick one." *[Points to the thick consistency.]*

Health worker: "A thick gruel helps [child's name] to grow well. After the gruel mid-morning, what was the next food, drink, or breastfeed [child's name] had?"

Mother: "Let's see, in the middle of the day, he had soup with vegetables and beans."

Health worker: "How did the baby eat the vegetables and beans?"

Mother: "I mashed them all together and added the liquid of the soup so he could eat it."

Health worker: *[Shows two consistency photos.]* "Which photo is most like this food that you fed [child's name] yesterday in the middle of the day?"

Mother: "This one, the more runny one." *[Points to the thin consistency.]*

Health worker: "Was there anything else that [child's name] had at mid-day yesterday?"

- Mother:* “Oh yes, he had a small glass of fresh orange juice.”
- Health worker:* “That is a healthy drink to give to [child’s name]. After this meal at mid-day, what was the next thing he ate?”
- Mother:* “Let’s see, he didn’t eat anything more until we all ate our evening meal. He breastfed a few times in the afternoon. In the evening, he ate some rice, a spoonful of mashed greens, and some mashed fish.”
- Health worker:* *[Shows two consistency photos.]* “Breastfeeding will help [child’s name] to grow and to stay healthy. It is good that you are still breastfeeding. Which of these photos looks most like the food the baby ate in the evening?”
- Mother:* “This thicker one. I mashed up the foods together and it looked like that.”
- Health worker:* “Did [child’s name] eat or drink anything more for the evening meal yesterday?”
- Mother:* “No, nothing else.”
- Health worker:* “After that or during the night, what other foods or drinks did [child’s name] have?”
- Mother:* “[Child’s name] breastfeeds during the night, but he had no more foods.”
- Health worker:* *[Shows typical bowl.]* “Using this bowl, can you show me about how much food [child’s name] ate at his main meal yesterday?”
- Mother:* *[Points to bowl.]* “About half of that bowl.”
- Health worker:* “Thank you. Who helps [child’s name] to eat, or does he eat by himself?”
- Mother:* “Oh, yes. [Child’s name] needs help. Usually I help him, but sometimes if my mother or sister is there, they will help also.”
- Health worker:* “Is [child’s name] taking any vitamins or minerals?”
- Mother:* “No, not now.”
- Health worker:* “Thank you for telling me so much about what [child’s name] eats.”

Questions:

Q(uestion): Is the growth curve heading upward?

R(esponse): Yes; however, it is only going upward very slowly.

Q: Does the child receive breastmilk?

R: Yes, frequently. A practice to praise.

Q: How many meals are of a thick consistency?

R: Two: the gruel 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.

Q: Did the child eat an animal-source food yesterday?

R: Yes, fish in the evening.

Q: Did the child eat a dairy product?

R: Yes, there was milk on the gruel.

Q: Did the child eat pulses or nuts yesterday?

R: Yes, beans at mid-day. And the child had juice with the meal, which helps iron absorption.

Q: Did the child eat a dark-green or orange-coloured fruit or vegetable yesterday?

R: Yes, some pawpaw in the morning, some green vegetables in the evening, maybe some green or orange vegetables 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 an orange fruit so as to meet 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.

Q: Number of meals and snacks?

R: Three meals and one snack.

Q: Are three meals and one snack adequate for this child aged 11 months?

R: Yes, they are adequate.

Q: Was the quantity of food eaten at the main meal adequate for the child's age?

R: Yes, the child is 11 months old and received about half of a bowl.

Q: Does the mother assist with eating?

R: Yes.

Q: Any vitamins or mineral supplements?

R: Not at this time.

Q: Was the child healthy and eating?

R: Yes.

This summary helps you to pick out the practices to praise and specific Key Points 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 two or three Key Points to discuss.

Q: What practices of this mother could you praise and support to continue?

Some possible 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.

What are the main points on which to give relevant information? What Key Point could you give to this mother?

- After you had praised the practices, you would then discuss:
 - The amount of food in each meal; suggest increasing it 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 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 with the mother the practices that could be improved, giving the relevant Key Points.
- The health worker puts her initials at the Key Points she discussed.
- You will have an opportunity to practice how to gather information on feeding practices with actual mothers later in the course; for now, we will practice with each other.

Exercise 20.a: Gathering information using the FOOD INTAKE (6 UP TO 24 MONTHS) JOB AID

- 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 (6 UP TO 24 MONTHS) JOB AID 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 Points to give to the mother.
 - When you are observing:
 - Follow the pair as they practice with the FOOD INTAKE (6 UP TO 24 MONTHS) JOB AID 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.

Discussion of the role-play:

- Ask the ‘mother’ how she felt. Did she say all she wanted to, or did she feel restricted?
 - 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 for which to praise the ‘mother’.
 - If necessary, try again, at least for a short time.

Summary

- In this session, we looked at various ways to gather information on complementary feeding practices. This included observation, listening, using growth charts, and asking questions.
 - We discussed the FOOD INTAKE (6 UP TO 24 MONTHS) JOB AID and FOOD INTAKE (6 UP TO 24 MONTHS) REFERENCE TOOL to be used in Clinical/Community Practice 2.

Notes:

Session 21. Clinical or Community Practice 2: Conducting an infant and young child feeding assessment and counselling and gathering information on complementary feeding practices

Objectives

At the end of this session, participants should be able to:

- Practice taking an infant feeding assessment with mothers and babies in a ward or clinic/community.
- Demonstrate how to gather information about complementary feeding using counselling skills and the FOOD INTAKE (6 UP TO 24 MONTHS) JOB AID.
- Provide information about complementary feeding and continuing breastfeeding to the mother of a child 6 up to 24 months.

Session outline

Introduction	10 minutes
Travel two ways (if site is not nearby, departure needs to be earlier)	up to 50 minutes
Conducting clinical/community practice	120 minutes
Discussion of the clinical/community practice and findings as a whole group	20 minutes

Introduction

Slide 21/1: Objectives: Clinical Practice 2

Objectives: Clinical practise 2	
After completing this session, participants will be able to:	21/1
<ul style="list-style-type: none">• Practise taking an infant feeding assessment with mothers and babies in various situations in a ward or clinic/community.• Demonstrate how to gather information about complementary feeding using counselling skills and the FOOD INTAKE (6 UP TO 24 MONTHS) JOB AID.• Provide information about complementary feeding and continuing breastfeeding to the mother of a child 6 up to 24 months.	
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Objectives of the clinical practice:

- During this session, you will practice taking an infant feeding assessment. You will continue to practice assessing a breastfeed, listening and learning, and building confidence and giving support.
- If there is an opportunity, you will practice helping a mother to position her baby at the breast, or to overcome any other difficulty.

What you should take with you:

- Two copies of the INFANT AND YOUNG CHILD FEEDING ASSESSMENT (0 UP TO 24 MONTHS) JOB AID (Appendix 2).
- Two copies of the BREASTFEED OBSERVATION JOB AID (Appendix 3).

- One copy of the COUNSELLING SKILLS CHECKLIST (Appendix 4).
- Food consistency photos (Appendix 6).
- Two copies of the FOOD INTAKE (6 UP TO 24 MONTHS) JOB AID (Appendix 7a).
- The FOOD INTAKE (6 UP TO 24 MONTHS) REFERENCE TOOL (Appendix 7b).
- Common bowl used to feed a young child for each pair of participants.
- Pencil and paper to make notes.

Use the INFANT AND YOUNG CHILD FEEDING ASSESSMENT (0 UP TO 24 MONTHS) JOB AID for taking an assessment.

- You will work in pairs in a ward or clinic. Each trainer will circulate between the pairs in her group to observe, comment, and help where necessary.
- Take a full infant feeding assessment from the mother, using the INFANT AND YOUNG CHILD FEEDING ASSESSMENT (0 UP TO 24 MONTHS) JOB AID.
- Try to ask the most relevant questions, and ask something from each section of the form.
- Use your listening and learning skills, and try not to ask too many questions. Practice your confidence and support skills, and avoid giving a lot of advice.
- If a mother has a breastfeeding difficulty, try to decide the reason, and how to help the mother. However, before you give the mother any help, or suggest what she should do, talk to the trainer.

Conduct clinical/community practice

At the ward or clinic/community:

- You will conduct the session in the same way as Clinical Practice 1, except that you work in pairs from the beginning.
- You will go to different parts of the health facility (wards or clinic) or community to meet breastfeeding mothers and babies in as many situations as possible. Depending on the numbers of mothers available, and the distance between different areas, a group may visit more than one area during the session.
- You may help a mother who needs help with breastfeeding, but first discuss with your workshop facilitator what you plan to do, to make sure that it is appropriate.
- Make sure the mother cannot hear what you are saying while you discuss what to do.
- Discuss the difficulty and its management with the staff in charge of the ward or clinic. It is important that you and the staff say the same things to the mother, so that you do not confuse her. The staff will be responsible for following up with the mother and baby.
- When you talk with the mother of a child 6 up to 24 months, fill in the FOOD INTAKE (6 UP TO 24 MONTHS) JOB AID at the same time.
 - Your partner will observe and fill in the counselling checklist.
 - If you meet a child who is ill or has a major feeding difficulty in the community, encourage the mother to bring the child to the local health centre.
 - Do not offer suggestions for treatment of an ill child.

When you are the counsellor and 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 that you are interested in learning about feeding young children in general.
- You may wish to say you are participating in a training course.
- Try to find a chair or stool to sit on, so you are at the same level as the mother.
- Practice as many of the counselling skills as possible as you gather information from the mother using the FOOD INTAKE (6 UP TO 24 MONTHS) JOB AID.
- 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 (6 UP TO 24 MONTHS) JOB AID 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 you can. Ask your trainer for assistance if necessary.

When you are the observer:

- Mark a tick on the COUNSELLING SKILLS CHECKLIST for every skill that you observe your partner practicing.
- 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 partner 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.

Take note of 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.

Group discussion:

- 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?

Notes:

Session 22. Feeding during illness and low-birthweight babies

Objectives

After completing this session, participants will able to:

- Explain why children need to continue to eat during illness.
- Describe appropriate feeding during illness and recovery.
- Describe the feeding of low-birthweight babies.
- Estimate the volume of milk to offer to a low-birthweight baby.
- State the Key Point for Complementary Feeding from this session.
- Explain how to manage the malnourished child and children in difficult circumstances.

Session outline

Introduction	3 minutes
Why children need to continue to eat during illness	5 minutes
Description of appropriate feeding during illness and recovery	10 minutes
Description of the Four Steps for Home Treatment of Diarrhoea	5 minutes
Demonstration of LO-ORS/Zinc preparation and feeding	5 minutes
Discussion on feeding of low-birthweight babies	10 minutes
Summary	2 minutes

Introduction

- 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 is at higher risk of more illness. Children recover more quickly from illness and lose less weight when 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.

Slide 22/1: Objectives: Feeding during illness and low-birthweight babies

Objectives: Feeding during illness and low-birthweight babies 22/1

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-birthweight babies.
- Estimate the volume of milk to offer to a low-birthweight baby.
- State the Key Points for Complementary Feeding from this session.
- Explain how to manage the malnourished child and children in difficult circumstances.

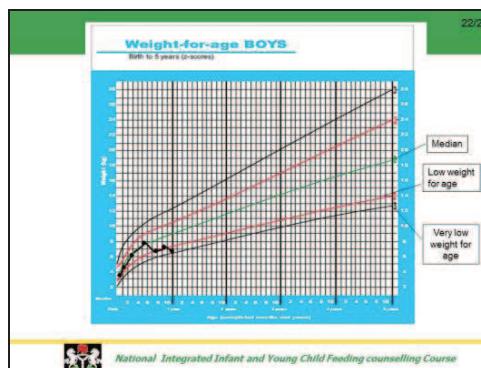
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Why might a young child feed less during illness?

- 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.

What are some typical feeding responses to different types of illnesses experienced in the community? Are there different feeding strategies for different illnesses or symptoms, such as respiratory disease, diarrhoea, or fever?

Slide 22/2: Weight chart of ill child

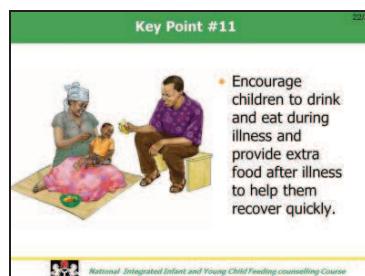


- This is the growth chart of John, who is 12 months old.

What do you think of the growth chart?

- 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 toward being malnourished.
- During infections, a 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.

Slide 22/3: Key Point 11



- 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.

Appropriate feeding during illness and recovery

Slide 22/4: Feeding the child who is ill

Feeding the child who is ill	22/4
<ul style="list-style-type: none"> 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. 	

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Slide 22/5: Feeding during recovery.

Feeding during recovery	22/5
<ul style="list-style-type: none"> Give extra breastfeeds. Feed an extra meal. Give an extra amount. Use extra-rich foods. Feed with extra patience and love. 	

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Key point(s):

- 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.

Description of the Four Steps for Home Treatment of Diarrhoea

Circumstances under which children can be treated at home for diarrhoea:

- Children exhibiting few or no signs of dehydration.
- Children who do not present bloody stool.
- Children who pass the pinch test—when skin is pinched, it returns to normal shape within a couple of seconds.
- Children who do not present sunken eyes.

Signs of severe dehydration:

- Sunken eyes, dryness of eyes.
- Skin pinch goes back very slowly.
- Lethargic or unconscious.
- Failure to suckle, drink, or feed.

Zinc + LO-ORS (Low Osmolarity Oral Rehydration Salts) can be administered at home to children aged 6 months through 5 years who are suffering from diarrhoea with few to moderate signs of dehydration. Children under 6 months should continue exclusive breastfeeding or be referred to a health clinic.

The Four Steps for Home Treatment of Diarrhoea to be used for counselling caregivers:

1. Give extra breastmilk or fluids while the child is sick.
2. Give Zinc Supplements + Oral Rehydration Salts (LO-ORS).
 - The child should be given one tablet (20 mg) of zinc sulfate for 10 days.
 - The child must continue taking the zinc for all 10 days, even after diarrhoea ends.
 - The child should be given one packet of special Oral Rehydration Salts (LO-ORS) each day for three days.
3. Continue feeding:
 - Encourage the child to eat as much as he/she wants during illness.
 - Give the child normal complementary foods and avoid sugar and candy, which can worsen diarrhoea.
4. Visit clinic or health worker if the child:
 - Passes many watery stools.
 - Becomes very thirsty.
 - Has sunken eyes.
 - Passes bloody stool.
 - Does not improve after three days.
 - Has a fever.
 - Does not eat or drink normally.
 - If you pinch the skin and it does not return to normal in a few seconds.

Demonstration of LO-ORS/Zinc preparation and feeding

- Zinc tablets can be chewed or dissolved in a small amount of clean water or expressed breastmilk in a small spoon.
- LO-ORS is easily mixed in a small, clean container using the following steps:
 1. Put the contents of one LO-ORS packet in a clean container.
 2. Check the packet for directions and add the correct quantity of clean water. (It is very important not to mix with too much or too little clean water.)
 3. Stir well, and feed it to the child from a clean cup. Do not use a bottle—even a feeding bottle. Drink all within 24 hours.

Discussion on feeding of low-birthweight babies

- The term ‘low-birthweight’ means a birthweight of less than 2.5 kg (up to and including 2.49 kg), 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-birthweight.
- In Nigeria, 8% of all babies are low-birthweight.
- Low-birthweight babies are at particular risk of infection, and they need breastmilk more than larger babies. However, they are given commercial infant formula feeds more often than larger babies.
- Many low-birthweight 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 breastmilk by tube or cup, and helped to establish full breastfeeding later. Breastfeeding is easier for these babies than bottle feeding.
- Mothers of low-birthweight babies need skilled help to express their milk and to cup feed.
- It is important to start expressing breastmilk on the first day, within 6 hours of delivery, if possible. This helps to start the flow of breastmilk, in the same way that suckling soon after delivery helps breastmilk to ‘come in’.
- If a mother can express just a few millilitres of colostrum, it is valuable for her baby.

Age at which low-birthweight babies can suckle from the breast

Slide 22/6: Feeding low-birthweight babies

Feeding low-birthweight babies	
• <u>32 weeks gestation</u>	– Able to start suckling from the breast.
• <u>30-32 weeks gestation</u>	– Can take feeds from a small cup or spoon.
• <u>Below 30 weeks gestation</u>	– Usually need to receive feeds by tube in hospital.
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- Depending on the weight at birth, 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 younger than 30 weeks usually need to receive their feeds by a tube in the 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 breastmilk by cup to make sure the baby gets all that he needs.

- When a low-birthweight baby starts to suckle effectively, he may pause during feeds quite often and for quite long periods. For example, he may take four or five 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 low-birthweight baby at the breast are:
 - Across her body, holding him with the arm on the opposite side to the breast.
 - The underarm position.
- Low-birthweight babies need to be followed-up regularly to make sure that they are getting all the breastmilk that they need.
- Low-birthweight babies of mothers who are HIV-positive and who have chosen formula 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.

Amount of milk for low birthweight babies who cannot breastfeed
<p>What milk to give?</p> <p>Choice 1: Expressed breastmilk (if possible, from the baby's mother).</p> <p>Choice 2: Commercial infant formula made up according to instructions.</p> <p>Babies who weigh less than 2.5 kg (low-birthweight babies):</p> <p>Start with 60 ml/kg body weight.</p> <p>Increase the total volume by 20 ml/kg per day, until the baby is taking a total of 200 ml/kg per day.</p> <p>Divide the total into 8–12 feeds, to feed every 2–3 hours.</p> <p>Continue until the baby weighs 1,800 g or more, and is fully breastfeeding.</p> <p>Check the baby's 24-hour intake.</p> <p>The size of individual feeds may vary.</p>

Summary

- In this session, we discussed the importance of adequate feeding during illness and recovery.
- We also discussed the feeding of low-birthweight babies.
- Key Point 11: Encourage the child to drink and eat during illness and provide extra food after illness to help the child recover quickly.

Further information

Whenever possible, low-birthweight 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 hypoglycemia (low blood sugar).
 - Until the mother has produced colostrum, give feeds of donated breastmilk if available. If breastmilk is not available, give glucose water or formula. Glucose water is not necessary for well, term babies who are not at risk of hypoglycemia.

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 g. Many can breastfeed fully when they weigh about 1,600–1,800 g or less.

Belly-to-belly contact and kangaroo care:

- Belly-to-belly 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.

Notes:

Session 23. Expressing breastmilk

Objectives

After completing this session, participants will be able to:

- List the situations when expressing breastmilk 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 breastmilk.
- Explain to a mother the steps of expressing breastmilk by hand.
- Describe how to store breastmilk.

Session outline

Introduction	5 minutes
Demonstration: How to stimulate the oxytocin reflex	15 minutes
Demonstration: How to express breastmilk by hand	20 minutes
Summary	5 minutes

Introduction

Slides 23/1: Objectives: Expressing breastmilk

Objectives: Expressing breastmilk	23/1
<p>After completing this session, participants will be able to:</p> <ul style="list-style-type: none">• List the situations when expressing breastmilk 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 breastmilk.• Explain to a mother the steps of expressing breastmilk by hand.• Describe how to store breastmilk.	

Key point(s):

- In this session, you will learn how to express breastmilk effectively. Expressing breastmilk 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 breastmilk 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.

Expressing breastmilk is useful to:

- Leave for a baby when his mother goes out or goes to work.
- Feed a low-birthweight baby who cannot breastfeed.
- Feed a sick baby who cannot suckle enough.
- Empty milk from a breast that is sore, if it hurts when the baby latches on.

- Empty milk from a sore or infected breast of an HIV-positive woman.
- Prevent leaking when a mother is away from her baby.
- Help a baby to attach to a full breast.
- Help with breast health conditions.
- Facilitate the transition to another method of feeding or to heat-treat.
- As you can see, there are many situations in which expressing breastmilk 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.
- Breastmilk can be stored for about 8 hours at room temperature or up to 24 hours in a refrigerator.

Demonstration: How to stimulate the oxytocin reflex

Why it is helpful to stimulate a mother's oxytocin reflex before she expresses milk:

- 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.

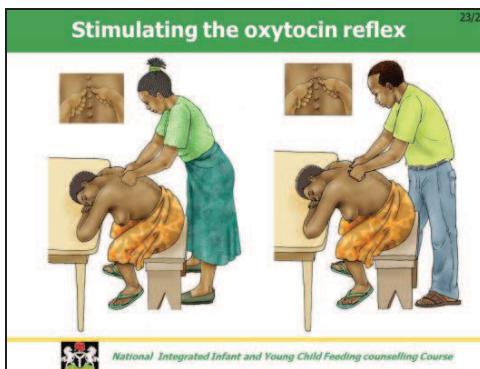
How to stimulate the oxytocin reflex

- **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 belly-to-belly 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 a comb.
Some women find that it helps to gently roll their closed fist over the breast toward the nipple.
- **Ask a helper to rub her back.**

How to rub a mother's back:

- Participant should sit at the table resting her head on her arms, as relaxed as possible.
- She remains clothed, but 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.
- Ask her how she feels, and if it makes her feel relaxed.

Slide 23/2: Stimulating the oxytocin reflex



Demonstration: How to express breastmilk by hand

- 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 breastmilk. 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.

How to prepare a container for expressed breastmilk

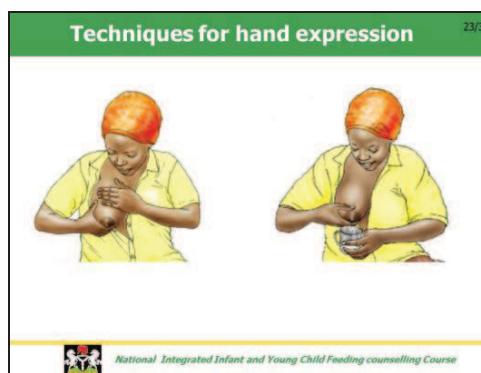
- Choose a cup, glass, jug, or jar with a wide mouth.
- Wash the container in soap and water (she can do this the day before).
- Pour boiling water into the container and leave it for a few minutes. Boiling water will kill most of the germs.
- When ready to express milk, pour the water out of the container.

How to express breastmilk 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 Figure 15.2).
- Press her thumb and first finger slightly inward toward 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 the 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 breastmilk 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.

Slides 23/3: Techniques for hand expression



1. Place finger and thumb on each side of the areola and press inward toward the chest wall.
2. Press behind the nipple and areola between your finger and thumb.
3. Press from the sides to empty all segments.

How often should a mother express her breastmilk?

- 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-birthweight or sick newborn**, she should start to express milk on the first day, as soon as possible after delivery. She may express only a few drops of colostrum at first, but it helps breastmilk production to begin, in the same way that a baby suckling soon after delivery helps breastmilk production to begin.
- She should express as much as she can as often as her baby would breastfeed. This should be at least every 3 hours, including during the night. If she expresses only a few times, or if there are long intervals between expressions, she may not be able to produce enough milk.
- **To keep up her milk supply to feed a sick baby:** She should express at least every 3 hours.
- **To build up her milk supply, if it seems to be decreasing after a few weeks:** Express very often for a few days (every 2 hours or even every hour), and at least every 3 hours during the night.
- **To leave milk for a baby while she is out at work:** 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.

Summary

- Hand expression is the most useful way to express breastmilk. 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.

Notes:

Session 24. 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

Introduction	2 minutes
Discussion on the advantages of cup feeding	5 minutes
Demonstration: How to feed a baby by cup	10 minutes
Discussion on volumes of milk to give to a baby	10 minutes
Summary	3 minutes

Introduction

Slide 24/1: Objectives: Cup feeding

Objectives: Cup feeding	24/1
<p>After completing this session, participants will be able to:</p> <ul style="list-style-type: none">• List the advantages of cup feeding.• Estimate the volume of milk to give to a baby according to weight.• Demonstrate how to cup feed safely.	
 National Integrated Infant and Young Child Feeding counselling Course	

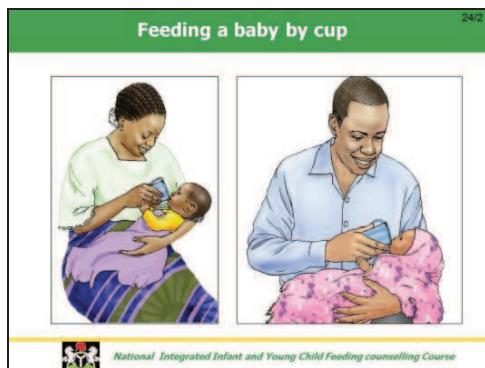
Discussion on the advantages of cup feeding

Why are cups safer and better than bottles for feeding a baby?

Key point(s):

- 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.

Slide 24/2: Feeding a baby by cup



Demonstration: How to feed a baby by cup

- Put some water into one of the small cups. Use approximately 60 ml of water, to demonstrate the typical volume of milk used for one feed for a young baby.
- Hold a doll on your lap, closely, with it sitting upright or semi-upright. 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.
- 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 more common with babies of more than about 36 weeks gestation, and less common with smaller babies.
- You should not pour the milk into a baby's mouth; just hold the cup to his lips.
- When a baby has had enough, he closes his mouth and will not take any more of 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.
- 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.

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-birthweight 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.

Discussion on volumes of milk to give to a baby

The amount of milk to give to babies can be calculated.

- Let us calculate the volume of milk, per feed, for a 2-week-old baby.
- Let us imagine that the baby weighs 3.8 kg.
- The volume of milk the baby needs in 24 hours is 150 ml per kg.

Amount of milk this baby will need in 24 hours

- The baby will need $150 \times 3.8 = 570$ ml in 24 hours.
- If the baby feeds every 3 hours, he will take 8 feeds in 24 hours.

Amount of milk the baby should be offered at each feed

- The baby should be offered $570 \div 8 = 71.25$ ml. This could be rounded up to 75 ml, as this will be easier for the mother to measure, and some milk might spill during the cup feed.
- Many mothers do not have equipment for measuring volumes. You could explain to the mother how much milk the cup holds, 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 that holds 150 ml, she should offer the baby approximately half a cup of milk per feed.

Summary

- 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 practice 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.

Notes:

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Session 25. Overview of HIV and infant feeding

Objectives

After completing this session, participants will be able to:

- Explain mother-to-child transmission of HIV.
- Describe factors that influence mother-to-child transmission.
- Understand new evidence on the significant impact of antiretroviral drugs (ARVs) on preventing mother-to-child transmission of HIV (PMTCT) through breastfeeding.
- Describe the concept of “HIV-free survival” in HIV-exposed children.
- Explain the national guidelines on infant feeding within the context of HIV.
- Explain the national PMTCT guidelines.

Session outline

Introduction	5 minutes
Review of the risk of mother-to-child transmission of HIV	15 minutes
Explanation of the factors that affect mother-to-child transmission of HIV	10 minutes
Description of the concept of “HIV-free survival” in HIV-exposed children	10 minutes
Explanation of the national guidelines on infant feeding within the context of HIV	20 minutes
Summary	10 minutes

Introduction

Slide 25/1: Objectives: Overview of HIV and infant feeding

Objectives: Overview of HIV and infant feeding 25/1

After completing this session, participants will be able to:

- Explain mother-to-child transmission of HIV.
- Describe factors that influence mother-to-child transmission.
- Understand new evidence on the significant impact of antiretroviral drugs (ARVs) on preventing mother-to-child transmission of HIV through breastfeeding.
- Describe the concept of “HIV-free survival” in HIV-exposed children.
- Explain the national guidelines of infant feeding in the context of HIV.
- Explain the national prevention of mother-to-child transmission of HIV (PMTCT) guideline.

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Key point(s):

- The epidemic of HIV and AIDS has become a major problem in many countries. A very sad aspect of the epidemic is the number of young children who are infected. This is one cause of the increasing number of child deaths.
- It is important to remember that the best way to prevent infection of children is to help their fathers and mothers to avoid becoming infected in the first place, and to avoid infecting each other. Men’s responsibility for protecting their families must be emphasized.

Slide 25/2: Defining ‘HIV’ and ‘AIDS’

Defining HIV and AIDS	25/2
<ul style="list-style-type: none"> ● 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. 	
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How does a person infected with HIV feel just after infection? What happens over time?

- 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.

How can one tell if they have HIV?

- A special blood test can be done to determine if there are HIV antibodies in the blood. A positive test means that the person is infected with HIV. This is called ‘HIV-positive’ or ‘seropositive’.

How does an HIV-infected person pass on the virus to others?

- 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 of HIV’, or ‘MTCT’.

Review of the risk of mother-to-child transmission of HIV (MTCT)

Key point(s):

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

Slide 25/3: Estimated risk and timing of MTCT

Estimated risk & timing of MTCT	
Estimated risk and timing of mother-to-child transmission of HIV in the absence of interventions	
Timing of MTCT of HIV	Transmission Rate
— During pregnancy	5-10%
— During labour and delivery	15%
— During breastfeeding	5-15%
Source: National PMTCT Guidelines	
 National Integrated Infant and Young Child Feeding counselling Course	

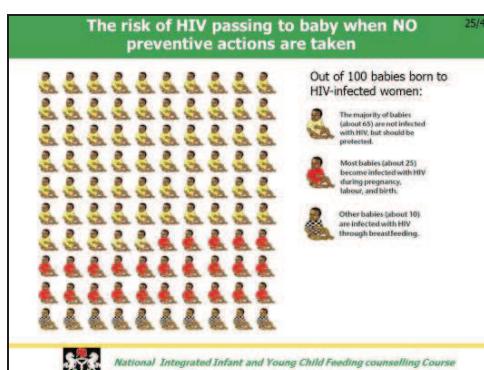
Rate of mother-to-child transmission of HIV

- Sixty to seventy-five percent of infants born to HIV-infected mothers will not be infected, even with no intervention, such as ARV prophylaxis or Caesarean section.
- You can see from the slide above that there is variation in the number of infants who become infected. There are many factors that impact the risk of a child becoming infected at each time point. We will discuss those factors that affect risk of transmission during breastfeeding in the coming hours. Just like there are interventions to reduce risk during pregnancy, labour, and delivery (such as ARVs), there are also interventions that can reduce the risk during breastfeeding.
- The transmission rate through breastfeeding is about 5–15% of the infants who are breastfed for several months by mothers who are HIV-positive. Let us use 15% for this example. Assuming all the infants are breastfeeding, about three of the infants of the HIV-positive mothers are likely to be infected by breastfeeding.

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?

- We cannot predict which individual babies will be infected.
- If a mother does not know her HIV status, she should be encouraged to breastfeed. She should also be assisted to protect herself against infection with HIV.

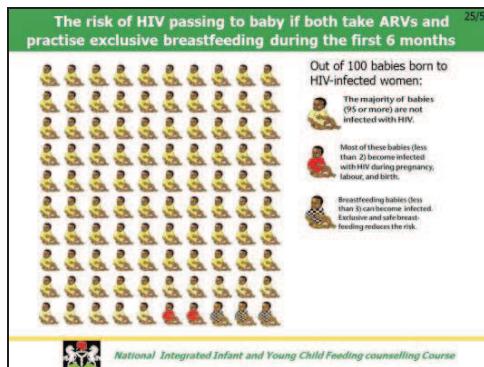
Slide 25/4: The risk of HIV passing to baby when NO preventive actions are taken



Key point(s):

- This slide shows 100 babies.
- All the mothers have been tested and found to be HIV-positive.
- If NO preventive actions are taken to prevent or reduce HIV transmission, out of every 100 HIV-infected women who become pregnant, deliver, and breastfeed for up to two years, about 35 of them will pass HIV to their babies:
 - Twenty-five babies may become infected with HIV during pregnancy, labour, and delivery.
 - Ten babies may become infected with HIV through breastfeeding, if the mothers breastfeed their babies for up to two years.
- The other 65 women will NOT pass HIV to their babies.

Slide 25/5: The risk of HIV passing to baby if both take ARVs and practice exclusive breastfeeding during the first 6 months



Key point(s):

- A woman infected with HIV should be given special medicines (ARVs) to decrease the risk of passing HIV to her infant during pregnancy, birth, or breastfeeding.
- A baby born to a woman who is HIV-infected should also receive ARVs to decrease the risk of getting HIV during the breastfeeding period.
- Throughout the entire period of breastfeeding, ARVs are strongly recommended for either the HIV-infected mother or her HIV-exposed infant.
- If an HIV-infected mother and her baby practice exclusive breastfeeding during the first six months and either the mother or baby take ARVs throughout the breastfeeding period, the risk of infection greatly decreases.
- If these preventive actions are taken, out of every 100 HIV-infected women who become pregnant, deliver, and breastfeed for at least one year, less than five of them will pass HIV to their babies:
 - Two babies may become infected with HIV during pregnancy, labour, and delivery.
 - Three babies may become infected with HIV through breastfeeding.

Key point(s):

- Among women who know they are HIV-positive, not all of their infants are likely to be infected through breastfeeding.
- There are risks of HIV transmission if a mother who is HIV-infected decides to breastfeed her infant. However, there are also risks if a mother decides not to breastfeed.
- For the majority of babies in Nigeria, the risk of illness and death from gastroenteritis, respiratory, and other infections may be greater than the risk of HIV infection through breastfeeding. That is why the Federal Ministry of Health (FMOH) recommends that all women, regardless of their HIV status, breastfeed their infants.

Explanation of the factors that affect mother-to-child transmission of HIV

Slides 25/6: Factors which affect MTCT of HIV

Factors which affect MTCT of HIV	25/6
<ul style="list-style-type: none"> • Recent infection with HIV. • Severity of disease. • Sexually transmitted infections. • Other conditions (e.g., malaria). • Trauma during pregnancy. • Obstetric procedures. • Duration of breastfeeding. • Mixed feeding. • Condition of the breasts. • Condition of the baby's mouth. 	

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- **Maternal viral load:** The most important risk factor for MTCT is the amount of virus in the mother's blood. The higher the amount of virus in the mother's blood, the higher the risk of MTCT. When the viral load is undetectable (very low), transmission is very rare.
- **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 men 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. However, recent evidence has shown that ARV use can make breastfeeding safe for up to a year.
- **Exclusive breastfeeding or mixed feeding:** There is strong evidence that the risk of transmission is greater if an infant is given any other foods or drinks at the same time as breastfeeding during the first six months of life. That is called mixed feeding. The risk is less if breastfeeding is exclusive. Other foods or drinks may cause diarrhoea and damage the gut, which might make it easier for the virus to enter the baby's body.

- **Sores or infection of the breast:** 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. An HIV-positive woman should express and discard milk from an affected breast until she heals.
- **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.
- **Use of ARVs:** It is now established that use of triple ARVs (highly active antiretroviral therapy) during pregnancy and breastfeeding for HIV-positive mothers and ARV prophylaxis for their breastfed infants further reduces HIV transmission in up to 99% of these infants.

What can be done to reduce the risk of MTCT during breastfeeding?

- Abstain from sex or have protected sex during the period of breastfeeding.
- Take ARVs immediately and do CD4 test as soon as possible.
- Mothers should breastfeed their babies on demand, start breastfeeding immediately after birth, and should not give any foods, water, or medicines other than those recommended by a health provider until the baby is 6 months old.
- Make sure that other caregivers do not give their babies anything besides the mother's expressed breastmilk until the baby is 6 months old.
- Avoid breast sores or infections by ensuring frequent feeding (day and night) and proper positioning and attachment of the baby.
- Treat breast health problems immediately and do not feed from an infected breast or a breast that has cracked nipples or other sores.
- Treat opportunistic infections immediately.
- Treat infant mouth sores immediately.

Key point(s):

- Women who are HIV-negative or of unknown HIV status should be encouraged and supported to breastfeed. Exclusive breastfeeding during the first six months of life is beneficial to all infants, regardless of the mother's HIV status.
- We will now look at a situation in which a woman has been tested and knows she is HIV-positive.

Slide 25/7: Infant feeding recommendations for HIV-infected women

Infant feeding recommendations for HIV-infected women	
25/	
	<ul style="list-style-type: none"> • HIV-infected mothers should exclusively breastfeed their infants for the first 6 months of life, introduce complementary foods at 6 months, and continue breastfeeding until 12 months.

Key point(s):

- All HIV-positive pregnant women and mothers should be informed that not breastfeeding has many disadvantages, including risks to the infant's health (malnutrition, diarrhoea, and respiratory infections, particularly pneumonia) and death. Counselling for these women should include general information about the benefits of breastfeeding and the risk of using commercial infant formula or other milks or foods.
- HIV-infected mothers who independently decide not to breastfeed despite being fully informed about the national recommendations should be able to do so without discrimination or prejudice. Health care workers should, however, provide appropriate support, such as counselling on how to prepare and give commercial infant formula safely to their infants.
- Mixed feeding in the first six months of life should be avoided because it carries the risks of HIV-infection and the risks of diarrhoea and other infectious diseases.
- Summarise briefly the national policy on infant and young child feeding within the context of HIV/AIDS.

Description of the concept of 'HIV-free survival' in HIV-exposed children

Slide 25/8: HIV-free survival

HIV-free survival	25/8
<ul style="list-style-type: none">To have children of mothers known to be HIV-infected survive while remaining HIV-uninfected is the top priority.	

 National Integrated Infant and Young Child Feeding counselling Course

Key point(s):

- Balancing HIV prevention with protection from other causes of child mortality is a key principle that will ensure that infants and children of HIV-infected mothers survive while remaining HIV-uninfected.
- The success of PMTCT (prevention of mother-to-child transmission of HIV) activities, including cost-effectiveness, could be measured in terms of HIV-free survival and not just transmissions averted. In other words, a PMTCT programme is most successful when the number of infants who either get HIV or die from other causes is as low as possible.
- The overall aim of the 2010 national recommendations on infant feeding within the context of HIV is to improve HIV-free survival of infants.
- There is now strong evidence of the role of exclusive breastfeeding in preventing HIV and improving child survival. Recent research findings in sub-Saharan Africa have revealed that as the numbers of exclusively breastfed infants increased, HIV infections and deaths declined.

- The efficacy and safety of ARVs to prevent HIV transmission through breastfeeding has been well-established through recent clinical trials. Effective ARVs were shown to block postnatal transmission by up to **99%**.
- The risks associated with not breastfeeding are significant. There is early excess mortality in formula-fed infants as compared to breastfed infants from infections other than HIV. Therefore, even if ARVs are not available during breastfeeding, it is still beneficial to counsel HIV-positive women to breastfeed exclusively.
- A dual-pronged approach of breastfeeding and provision of ARV prophylaxis for infants of HIV-infected mothers is the strategy adopted in the national guidelines on infant feeding within the context of HIV.
- Health workers need to offer simplified messages that emphasize that all infants can now gain the protection and benefits of breastfeeding, and if mothers have HIV-infection, ARV interventions (antiretroviral therapy or prophylaxis) that significantly reduce the risk of transmission are available as protection to allow breastfeeding for up to 12 months.

Explanation of the national guidelines on infant feeding within the context of HIV

Slides 25/9 and 25/10: The national recommendations on infant and young child feeding within the context of HIV

The national recommendations on infant and young child feeding in the context of HIV	25/9	The national recommendations on infant and young child feeding in the context of HIV (continued)	25/10
<ul style="list-style-type: none"> The goal of all prevention of mother-to-child transmission (PMTCT) interventions in Nigeria is HIV-free survival, which focuses on both prevention of HIV transmission and child survival. All mothers, including HIV-infected mothers, should exclusively breastfeed their infants for the first 6 months of life and introduce complementary foods at 6 months of age. HIV-infected mothers should continue breastfeeding until 12 months, while mothers who are HIV-negative should continue breastfeeding for up to 2 years and beyond. Improved complementary feeding of all infants, especially those born to HIV-infected mothers, should be promoted, and, where possible, supported. 		<ul style="list-style-type: none"> The Federal Ministry of Health (FMOH) will continue to provide antiretroviral (ARV) drug interventions to reduce the risk of HIV transmission through breastfeeding, and strongly recommends that all mothers, including those known to be HIV-infected, breastfeed their infants. HIV-infected mothers should be assessed to determine if they need lifelong antiretroviral therapy (ART), according to national recommendations, and if so, should start as early as possible after presentation for antenatal care (ANC) or HIV diagnosis. If HIV-infected mothers do not require ART for their own health, ARVs should be started to reduce the risk of HIV transmission, and provided until one week after the end of all breastfeeding. 	

The goal of all PMTCT interventions in Nigeria is HIV-free survival, which focuses on both prevention of HIV transmission and child survival.

- All mothers, including HIV-infected mothers, should exclusively breastfeed their infants for the first six months of life, and introduce complementary foods at 6 months of age. However, HIV-infected mothers should continue breastfeeding until 12 months, while mothers who are HIV-negative should continue breastfeeding for up to two years and beyond.
- Improved complementary feeding of all infants, especially those born to HIV-infected mothers, should be promoted, and, where possible, supported.
- The FMOH will continue to provide ARV drug interventions to reduce the risk of HIV transmission through breastfeeding, and strongly recommends that all mothers, including those known to be HIV-infected, breastfeed their infants (see National PMTCT Guidelines below).
- HIV-infected mothers should be assessed to determine if they need lifelong antiretroviral therapy (ART), according to World Health Organization (WHO) and national

recommendations, and, if so, should start as early as possible after presentation for antenatal care or HIV diagnosis.

- If HIV-infected mothers do not require ART for their own health, ARVs should be started to reduce the risk of HIV transmission, and provided until one week after the end of all breastfeeding.
- WHO recommendations on the use of ARV drugs for treating pregnant women and preventing HIV-infection in infants should inform the choice of the drugs (see Nigeria Rapid Advice for the use of ARVs for PMTCT).

NATIONAL PMTCT GUIDELINES

The Nigerian guideline is a set of specific ways of using ARVs in different clinical settings to prevent MTCT of HIV. The details are summarised below:

A) HIV-infected woman in need of ART for her own health

Mother: Start antiretroviral therapy irrespective of the gestational age and continue throughout pregnancy, labour, delivery, and thereafter.

Baby: Daily nevirapine for six weeks only. Exclusive breastfeeding for the first six months of life. Introduce complementary foods thereafter and continue breastfeeding for the first 12 months of life.

B) HIV-infected woman who does not need ART for her own health

First option: Centres with capacity for highly active antiretroviral therapy (HAART).

Mother: Start HAART prophylaxis from 14 weeks' gestation or as soon as possible after presentation to ANC /HIV diagnosis and continue until one week after cessation of breastfeeding.

Baby: Daily nevirapine for the first six weeks of life only.

Second option: Centres without capacity for HAART.

Mother: Start daily AZT from 14 weeks' gestation or as soon as possible after presentation to ANC /HIV diagnosis, single-dose nevirapine at onset of labour, AZT + lamivudine during labour, delivery, and for seven days after delivery.

Baby: Daily nevirapine from birth until one week after cessation of breastfeeding. Breastfeed exclusively for the first six months, introducing complementary foods thereafter and continue breastfeeding up to 12 months of age.

C) HIV-positive pregnant woman detected for the first time in labour

Mother: Evaluated for HAART eligibility and started on treatment accordingly.

Baby: Daily nevirapine until one week after cessation of breastfeeding.

D) HIV-positive mother who is TB co-infected

Mother: Start anti-TB first.

Evaluate and start ARV from 14 weeks' gestation or as soon as possible after commencement of anti-TB.

Baby: Isoniazid (INH) prophylaxis for the first six months of life. Daily nevirapine for the first six weeks of life.

Basis for these recommendations

- ARVs can safely prevent 99% of HIV transmission through breastfeeding.
- Exclusive breastfeeding results in significant survival and economic benefits.
- Commercial infant formula feeding is associated with increased infant mortality from malnutrition, diarrhoea, and pneumonia.
- In Nigeria, a large number of women practice mixed feeding (giving both commercial infant formula and breastmilk), which has been proven to significantly increase the risk of HIV transmission to the baby.

In Nigeria, it is no longer necessary to counsel HIV-infected mothers on alternative infant feeding options.

- The FMOH strongly recommends that HIV-infected mothers exclusively breastfeed their infants for the first six months of life and thereafter introduce complementary foods with continued breastfeeding up to 12 months.
- Before this recommendation, health workers used to provide information on all the feeding options available, and allowed HIV-infected mothers to make decisions based on individual circumstances.
- ARVs will be provided during the period of breastfeeding, according to the national guidelines.
- The Nigerian guidelines are a set of specific ways of using ARVs in different clinical settings for PMTCT. The details are summarised in the box above.

If an HIV-infected mother decides not to breastfeed her baby, health workers should provide support, such as advising the mother on how to make nutritionally adequate and safe food for her baby. Otherwise, they should refer the mother to where she can receive such support.

Summary

- Not all infants born to HIV-infected women will be infected with HIV.
- Up to 15% of babies born to HIV-infected women can become HIV-infected through breastfeeding, but this risk can be dramatically reduced through optimal breastfeeding practices.
- To reduce this risk, HIV-infected mothers should exclusively breastfeed their infants for the first six months of life, with ARVs, introduce complementary foods at 6 months, and continue breastfeeding up to 12 months, with cessation of ARVs one week after cessation of all breastfeeding.
- It may be possible that an HIV-infected mother chooses to continue breastfeeding beyond 12 months. While there is no specific policy, it is expected that the woman should continue to receive ARVs during the period she is breastfeeding her child.
- For Nigeria, it is no longer necessary to counsel HIV-infected mothers on alternative infant feeding options.

- If an HIV-infected mother decides not to breastfeed her baby, health workers should provide support, such as advising the mother on how to make nutritionally adequate and safe food for her baby, or refer the mother to where she can receive such support.
- Improved complementary feeding of all infants, and especially those born to HIV-infected mothers, needs to be promoted.
- Mixed feeding should be avoided because it increases the risks of HIV infection, diarrhoea, and other infectious diseases.
- Breastfeeding should continue to be protected, promoted, and supported in all populations.

Notes:

Session 26. Breastfeeding guidance for HIV-infected mothers (Optional)

Objectives

After completing this session, participants should be able to:

- Describe national recommendations on infant feeding within the context of HIV.
- Explain the advantages of breastfeeding and disadvantages of not breastfeeding an HIV-exposed infant.
- Explain how to stop breastfeeding at 12 months.
- Treat or refer HIV-infected mother with breast conditions.

Session outline

Introduction	5 minutes
Review of the national recommendations on infant feeding	10 minutes
Explanation of how to counsel mothers on breastfeeding in the context of HIV	10 minutes
Review of the advantages of breastfeeding and the challenges of breastfeeding an HIV-exposed infant	10 minutes
Stopping breastfeeding at 12 months	15 minutes
Summary	5 minutes

Introduction

Good and adequate nutrition in the early stages of life helps build the foundation for a healthy and productive life as an adult. Children who get adequate energy and nutrients during the first two years of life are more likely to experience better health. Health workers need to provide nutritional guidance according to national recommendations to ensure safe and optimal infant feeding practices, reduce the risk of HIV transmission from mothers to their children, and promote HIV-free survival.

Slide 26/1: Objectives: Breastfeeding guidance for HIV-infected mothers

Objectives: Breastfeeding guidance for HIV-infected mothers	
After completing this session, participants will be able to:	26/1
<ul style="list-style-type: none">• Describe national recommendations on infant feeding within the context of HIV.• Explain the advantages of breastfeeding and disadvantages of not breastfeeding an HIV-exposed infant.• Explain how to stop breastfeeding at 12 months.• Treat or refer an HIV-infected mother with breast conditions.	
 National Integrated Infant and Young Child Feeding counselling Course	

National recommendations on infant feeding

- HIV-free survival of HIV-exposed infants, and not just prevention of HIV infection in infants, should be the goal of all prevention of mother-to-child transmission of HIV (PMTCT) interventions in Nigeria.
- The Federal Ministry of Health (FMOH) should provide antiretroviral (ARV) interventions to reduce the risk of HIV transmission through breastfeeding and strongly recommend all mothers, including those known to be HIV-infected, to breastfeed their infants.
- HIV-infected mothers should exclusively breastfeed their infants for the first six months of life, introduce complementary feeds at 6 months, and continue breastfeeding until 12 months; cessation of breastfeeding should occur at 12 months.
- HIV-infected mothers should be assessed to determine if they need lifelong ARV therapy, and if so, start as early as possible.
- If HIV-infected mothers do not require ARV therapy for their own health, then ARVs to reduce the risk of HIV transmission should be started and provided until one week after the end of all breastfeeding.
- The World Health Organization (WHO) recommendations on the *Use of antiretroviral drugs for treating pregnant women and preventing HIV-infection in infants* should inform the choice of ARVs (see Nigeria *Rapid Advice* and/or the national recommendations for the use of ARVs for PMTCT contained in the brochure: *Infant Feeding in the Context of HIV/AIDS*).
- Health workers should not counsel HIV-infected mothers to assess their individual circumstances and which infant feeding practice would be most appropriate, but should advise mothers of what infant feeding practice is strongly recommended by the FMOH and the services that are available, including ARVs.

What is the evidence base in support of the national recommendations?

- Exclusive breastfeeding in the first six months of life is associated with reduced mortality during the first year of life in HIV-exposed infants compared to mixed feeding and replacement feeding in both research and programme settings.
- The efficacy and safety of ARVs to prevent HIV transmission through breastfeeding have been well-established through recent trials. ARVs have been demonstrated to have a significant role in reducing mother-to-child transmission of HIV (MTCT) during breastfeeding.
- The risks associated with not breastfeeding:
 - Increased child mortality. Studies have shown that providing infant formula as a way to reduce MTCT increases rates of mortality among children. Research also shows a two- to six-fold increase in the risk of child mortality among women not breastfeeding.
 - No benefit for HIV-free survival. Studies show that although breastfeeding avoidance reduces HIV transmission, HIV-free survival does not improve due to increased mortality.
- The optimal duration of exclusive breastfeeding by HIV-infected mothers is six months. Early breastfeeding cessation has been shown to increase the risk of child death with no benefit for HIV-free survival.

- Strong evidence that:
 - ARV interventions for infants or mothers significantly reduce HIV transmission through breastfeeding.
 - Transmission is reduced while ARV interventions are given. Protection continues for as long as ARVs are taken.
 - There is no evidence of significant drug-related adverse events.
- No increased adverse events with prolonged ARV intervention.
- Nevirapine adverse events occur within the first few weeks and do not accumulate with longer exposure.

How to counsel mothers on breastfeeding within the context of HIV

Slide 26/2: Counselling on feeding of HIV-exposed infants

Counselling on feeding of HIV-exposed infants		26/2
Counselling for mothers of HIV-exposed infants should include: <ul style="list-style-type: none"> ▪ Support for breastfeeding. ▪ Support for safe breastfeeding cessation when appropriate. ▪ Support for infant and young child feeding counselling around the time of infant HIV testing. ▪ Support for timely and appropriate introduction and continuation of complementary feeding. ▪ Adherence to ARVs for both mother and baby. ARV prophylaxis for either mother or baby (as per national PMTCT guidelines) should continue until one week after all exposure to breastmilk has ended. ▪ Safer sex for avoidance of re-infection. ▪ Family planning and reproductive health. 		
 <i>National Integrated Infant and Young Child Feeding counselling Course</i>		

Counselling for mothers of HIV-exposed infants should include:

- Support for breastfeeding.
- Support for safe breastfeeding cessation at 12 months.
- Support for infant and young child feeding counselling around the time of infant HIV testing.
- Support for timely and appropriate introduction and continuation of complementary feeding.
- Adherence to ARVs for both mother and baby. ARV prophylaxis for either mother or baby (as per national PMTCT guidelines) should continue until one week after all exposure to breastmilk has ended.
- Safer sex for avoidance of re-infection.
- Family planning and reproductive health.

Review of the advantages of breastfeeding and the challenges of breastfeeding an HIV-exposed infant

- Remember that we looked at advantages of breastfeeding in the general population earlier in the training.
- A mother who is HIV-positive needs to understand some challenges associated with breastfeeding so that she can reduce the risk of transmitting the virus to her baby.

Advantages and challenges of exclusive breastfeeding for an HIV-infected mother

Advantages:

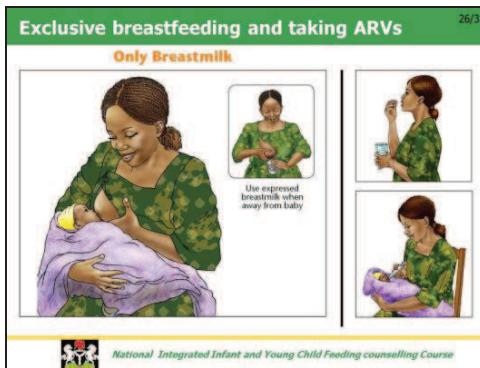
- Breastmilk is the perfect food for babies and protects them from many illnesses; above all, diarrhoea, malnutrition, and pneumonia.
- Breastmilk gives babies all the nutrients and water they need. Babies fed at the breast do not need other foods or liquids, not even water.
- Breastmilk is free, always available, and needs no special preparation.
- Exclusive breastfeeding for the first six months lowers the risk of HIV transmission compared with mixed feeding.
- Many women breastfeed, so people will not ask why this mother breastfeeds.
- Exclusive breastfeeding assists mothers in recovering from childbirth and protects against a new pregnancy.

Challenges:

- As long as the mother breastfeeds, her baby is exposed to HIV.
- People may pressure 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 gets very sick.

- If a woman does breastfeed, it is important for her to breastfeed exclusively for the first six months. 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 was covered in an earlier session.

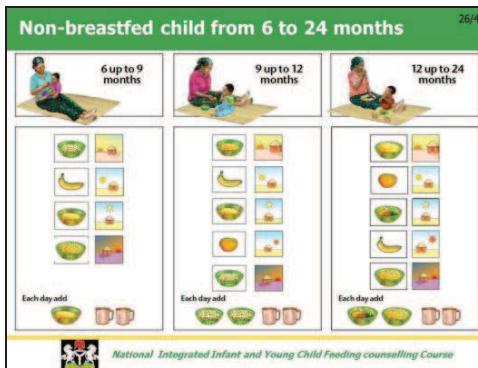
Slide 26/3: Exclusive Breastfeeding and Taking ARVs



Key point(s):

- Exclusive breastfeeding (giving ONLY breastmilk) for the first six months, together with special medicines (ARVs) for either mother or baby, greatly reduces the chance of HIV passing from an HIV-infected mother to her baby.
- When an HIV-infected mother exclusively breastfeeds, her baby receives all the benefits of breastfeeding, including protection from diarrhoea and other illnesses.
- Mixed feeding (feeding baby both breastmilk and any other foods or liquids, including infant formula, animal milks, or water) before 6 months of age greatly increases the chances of an HIV-infected mother passing HIV to her baby.
- Mixed feeding can cause damage to the baby's stomach. This makes it easier for HIV and other diseases to pass into the baby.
- Mixed feeding also increases the chance of the baby dying from other illnesses, such as diarrhoea and pneumonia, because he or she is not fully protected through breastmilk, and the water and other milks or food can be contaminated.
- If an HIV-infected mother develops breast problems, she should seek advice and treatment immediately. She may be encouraged to express and heat-treat her breastmilk so that it can be fed to her baby while she is recovering.
- HIV-exposed babies should be tested when they are about 6 weeks old.
- All babies who test positive at 6 weeks should breastfeed exclusively until 6 months, even in the absence of ARV interventions, and then continue to breastfeed for up to 2 years or longer. Complementary foods should be introduced at 6 months, as recommended.
- All breastfeeding babies who test negative at 6 weeks should continue to exclusively breastfeed until 6 months and continue to breastfeed until 12 months. Complementary foods should be introduced at 6 months, as recommended.
- After 12 months, breastfeeding should stop. However, abrupt stopping of breastfeeding should be avoided. It should be gradually stopped over the course of one month.

Slide 26/4: Non-breastfed child from 6 to 24 months



Key point(s):

- A minimum of two cups of milk each day is recommended for all children under 2 years of age who are no longer breastfeeding.
- This milk can be either commercial infant formula, that is prepared according to directions, or animal milk, which should always be boiled for children who are less than 12 months old. It can be given to the baby as a hot or cold beverage, or can be added to porridge or other foods.
- Fresh animal milk should always be boiled for children who are less than 12 months old.
- All children need complementary foods from 6 months of age.
- The non-breastfed child from 6 up to 9 months needs the same amount of food and snacks as the breastfed child of the same age, plus one extra meal plus two cups of milk each day (one cup = 250 ml).
- The non-breastfed child from 9 up to 12 months needs the same amount of food and snacks as the breastfed child of the same age, plus two extra meals plus two cups of milk each day.
- The non-breastfed child from 12 up to 24 months needs the same amount of food and snacks as the breastfed child of the same age, plus two extra meals plus two cups of milk each day.
- After 6 months, also give two to three cups of water each day, especially in hot climates.

When it is important to give infant feeding education to HIV-positive women:

- 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.
- In special circumstances, such as when a woman fosters a baby whose mother is very sick or has died.

Each woman's situation is different, so health workers need to be able to discuss and provide support as needed.

Adequate complementary foods from 6 months of age will be needed. This is discussed in earlier sessions.

Stopping breastfeeding at 12 months

Key point(s):

- We know that HIV can be transmitted at any time during breastfeeding. Stopping at 12 months reduces the risk of transmission by reducing the length of time the infant is exposed to the virus in breastmilk.
- The period of time during which a mother stops breastfeeding and changes to the family diet is known as weaning.
- The most appropriate time to stop breastfeeding in Nigeria is 12 months, since the child can grow well without breastmilk after this time. Many infants self-wean by 12 months.
- Preliminary experience indicates that mothers can stop breastfeeding in a period of three days to three weeks with counselling and support. It is important not to abruptly wean the child.

How to wean an infant from breastmilk:

- The mother should begin to wean her child at around 12 months.

Instructions for the mother:

- Gradual weaning is best for both you and your baby. Gradual weaning will sidestep feelings of rejection for your baby and will prevent you from going through the unnecessary pain of engorgement or blocked milk ducts, which can lead to breast infections.
- Start by dropping one feeding and allow a two- to three-day adjustment period for your baby and your milk supply. Substitute the dropped feed with affection, drinks, or snacks.
- After a few days, when you and your baby have adjusted to your substitutions for the missed breastfeeding session, drop another feeding. Continue this plan for several weeks until you and your baby feel comfortable with your level of weaning.
- During the weaning process, it is important to give your baby extra attention. It may be especially difficult for your baby to get used to not nursing at bedtime/naptimes.
- A baby being weaned too quickly may become more demanding of your attention, more insistent on feeding, or show physical upset such as allergic reactions, stomach upsets, or constipation.
- To avoid breast engorgement (swelling), express a little milk whenever your breasts feel too full. This will help you 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 the baby has stopped. If you do, it can increase the chances of passing HIV to your baby. If your breasts become engorged, express some milk by hand and discard it.

How to help an HIV-positive woman with cracked nipples or other breast conditions.

- An HIV-infected mother with cracked nipples, mastitis (inflammation of the breast), abscess, or thrush/*Candida* (yeast infection of the nipple and breast) has increased risk of transmitting HIV to her baby and so should:
 - Stop breastfeeding from the infected breast and seek prompt treatment.
 - Continue breastfeeding on demand from the uninfected breast.
 - Express breastmilk from the infected breast and discard it or heat-treat it before feeding to baby, in case of double mastitis.
 - Thrush: no breastfeeding from either breast; heat-treat expressed breastmilk; treat both mother and infant.

Note: Cracked nipples and mastitis are discussed more fully in an earlier session.

- Mothers known to be HIV-infected may consider expressing and heat-treating breastmilk as *an interim feeding strategy*:¹
 - In special circumstances, such as when the infant is born with low-birthweight or is otherwise ill in the neonatal period and unable to breastfeed; OR
 - When the mother is unwell and temporarily unable to breastfeed or has a temporary breast health problem, such as mastitis; OR
 - To assist mothers to stop breastfeeding.

How to heat-treat breastmilk:

- Express breastmilk into a glass cup/jar.
- Add water to a pot to make a water bath up to the second knuckle of the index finger, over the level of the breastmilk in the glass cup/jar (Note that the glass cup/jar must be taller than the water level in the pot).
- Bring water to the boiling point. The water will boil at 100° C, while the temperature of the breastmilk in the glass cup/jar reaches about 60° C and will be safe and ready to use.
- Remove the breastmilk from the water and cool the breastmilk to the room temperature (not in fridge).
- Give the baby the breastmilk by cup.
- Once breastmilk is heat-treated, it should be used within 8 hours.

Note: Flash-heat² is a recently developed, simple method that a mother can implement over an outdoor fire or in her kitchen to heat-treat her breastmilk.

¹ WHO. HIV and infant feeding: Revised Principles and Recommendations - Rapid Advice, November 2009.

² Israel-Ballard K, et al. Flash heat inactivation of HIV-1 in human milk. A potential method to reduce postnatal transmission in developing countries. *Journal of Acquired Immunodeficiency Syndrome*. 2007; 45(3):318–323.

Summary

- In this session, we discussed the national recommendations on infant feeding within the context of HIV. HIV-infected mothers should be encouraged to breastfeed exclusively and continue breastfeeding for 12 months.
 - Counselling should include support for breastfeeding, adherence to ARVs for both mother and child, and safer sex for avoidance of re-infection and prevention with positives.
 - 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.

Further information

Cessation of breastfeeding by an HIV-infected mother:

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

Breastmilk production is controlled by hormones and also locally within the breast itself. There is a substance in breastmilk 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.

References for further reading:

Federal Ministry of Health (Nigeria). Infant and young child feeding in the context of HIV [informational flyer]. 2010.

World Health Organization (WHO). *Rapid Advice: Infant Feeding in the Context of HIV*. Geneva, CH: WHO; 2010.

Notes: .

Session 27. Practice using *Counselling Cards* and role-play with scenarios for HIV counselling

Objectives

After completing this session, participants will be able to:

- Counsel HIV-infected women, using *Counselling Cards*, *Key Messages Booklet*, and *Take-Home Brochures*, to overcome their challenges and better deal with their concerns related to infant feeding.

Session outline

Introduction	5 minutes
Review of the <i>Counselling Cards</i> and <i>Take-Home Brochures</i>	20 minutes
Counselling practice (small groups)	45 minutes

Introduction

Slide 27/1: Objectives: Practice using *Counselling Cards* and role-play scenarios for HIV counselling

Objectives: Practise using *Counselling Cards* 27/1 and role-play scenarios for HIV counselling

After completing this session, participants will be able to:

- Counsel HIV-infected women, using *Counselling Cards*, *Key Messages Booklet*, and *Take-Home Brochures*, to overcome their challenges and better deal with their concerns related to infant feeding.

 National Integrated Infant and Young Child Feeding counselling Course

- The first set of tools we will look at is the *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 Brochures* for mothers on how to implement optimal feeding practices.
- The third tool is the *Key Messages Booklet* to provide additional technical information for you, the counsellor.

Review of a sample of the *Counselling Cards* and *Take-Home Brochures*

Here are some examples to use.

- ***Counselling Card 4a*** is called ‘Exclusively breastfeed during the first 6 months’, and ***Counselling Card 4b*** is called ‘Dangers of mixed feeding during the first 6 months’. Use these cards to help you to explain to a woman to give only breastmilk during the first 6 months of life.
- ***Counselling Card 5*** is called ‘Breastfeeding on demand, both day and night’ to encourage women to continue feeding on demand throughout the day and night.

- **Counselling Special Circumstances Card 1** is called ‘If a woman is HIV-infected... what is the risk of HIV passing to her baby when NO preventive actions are taken?’
- **Counselling Special Circumstances Card 2** is called ‘If a woman is HIV-infected... what is the risk of HIV passing to her baby if both take ARVs and practice exclusive breastfeeding during the first 6 months?’
- **Counselling Special Circumstances Card 3** is for women who are HIV-infected and is called ‘Exclusively breastfeed and take ARVs’.
- **Counselling Special Circumstances Card 4** is called ‘For a woman who decides not to follow the national recommendation to breastfeed’.
- **Counselling Special Circumstance Card 5** is called ‘Conditions needed to use commercial infant formula’.
- **Take-Home Brochure** entitled ‘Infant feeding in the context of HIV/AIDS’ explains the Nigerian recommendations for HIV-infected mothers.

Counselling practice

- 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 and assumes she cannot breastfeed, and she is worried about her family’s reaction.
- First, we will see the opening of the counselling session, before the counsellor reaches Step 1.

Demonstration 27.A: Counselling on infant feeding practices

Counsellor: “Hello [woman’s name]. Thank you for coming to talk to me about ways you could feed your baby. We can advise you on how to give your baby the best chance to remain healthy.”

Comment: Here, the counsellor introduces the session, explaining that the purpose is to help the mother understand the national recommendations for feeding infants of HIV-infected women. 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.

Counsellor: “Can you tell me what concerns you may have for your baby, since you now know your HIV status?”

Woman: “Well, I know that the baby can be infected through breastmilk and if I breastfeed. I am worried about what my family will think if I don’t breastfeed.”

Counsellor: “It is true that babies may get HIV through breastmilk. But let me explain how you can make the best choice to breastfeed and reduce the chances of your child becoming sick. Let me show you a picture which may help you to understand.”

Comment: The counsellor shows *Counselling Special Circumstances Card 3: Exclusively breastfeed and take ARVs*.

Counsellor: “What do you see in this picture?”

Woman: “I see a woman breastfeeding her baby and also taking some medicines. Another

picture shows the mother taking milk from her breast to feed her baby.”

Counsellor: “That is correct. These are all ways to keep your baby healthy.”

Woman: “Don’t all infants who get breastmilk also get HIV?”

Counsellor: “No, it depends on many factors; let me show you.”

Comment: *The counsellor shows Counselling Special Circumstances Card 1: If a woman is HIV-infected... what is the risk of HIV passing to her baby when NO preventive actions are taken?*

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.”

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?”

Comment: *At this point, the counsellor shows Counselling Card 3: Breastfeeding in the first 6 months 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 breastmilk and no other drinks of foods, not even water. Exclusive breastfeeding for the first six months may lower the risk of passing HIV. 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 challenges of exclusive breastfeeding with the mother using Counselling Special Circumstances Card 3: Exclusively breastfeed and take ARVs.*

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. I heard it is best for HIV-positive women to formula feed; could you tell me more about formula feeding?”

Comment: The counsellor will discuss the questions and messages on *Counselling Card 2: Importance of early initiation of breastfeeding*, using counselling skills. Let us imagine that she has done this. Note that the counsellor has discussed exclusive breastfeeding as the national recommendation and the mother wants to know about formula feeding.

Counsellor: “How do you feel about infant formula?”

Woman: “I thought I had to formula feed; I don’t want my child to have HIV. But I am worried about what others may say to me if I don’t breastfeed.”

Counsellor: “You don’t have to formula feed if you have HIV, but let me tell you more about it. The main thing is that you should not breastfeed and also try formula feeding. The Federal Ministry of Health has recommended that all mothers breastfeed, even mothers with HIV.”

Comment: The counsellor would explain to the woman the rationale behind the national recommendation on infant feeding in the context of HIV.

It is important to be led by the mother’s concerns, and not to overwhelm her with information in a series of lists. Leave time for a woman to ask questions and check that she understands what is being discussed.

Imagine that the woman has been told the rationale for opting for exclusive breastfeeding. Now the counsellor moves to Step 3: Explore with the woman her home and family situation.

Counsellor: “We have just discussed the national recommendation on exclusive breastfeeding for HIV-positive mothers. After hearing all of this information, what have you decided to do?”

Woman: “I still don’t know; what if I choose to give formula?”

Counsellor: “Let’s think together about the things you will need in order for you to decide if formula is the best for your child.”

Woman: “Yes, okay.”

Comment: The counsellor shows the woman *Counselling Special Circumstance Card 5: Conditions needed to use commercial infant formula*.

Counsellor: “Where do you get your drinking water from?”

Woman: “We have a tap in our kitchen with clean water.”

Counsellor: “That’s good. You need clean water to make formula. Can you prepare each feed with boiled water and clean utensils?”

Woman: “That seems like too much work. Do I need to boil the water each time if we have clean water from the tap?”

Counsellor: “Yes, it’s recommended.”

Woman: “Okay, well then....I guess I could manage. I could ask my niece to help me.”

Counsellor: “That’s a good idea. What about preparing formula at night? Would you be able to do this two or three times each night?”

Woman: “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?”

Counsellor: “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?”

Woman: “Oh, but I thought it was free?”

Counsellor: “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 1,800 Naira per tin. If you had to buy three or four tins, could you afford to do this?”

Woman: “Yes, my husband has steady work. But I don’t know if we could have enough to use formula.”

Counsellor: “That is important to consider. The cost can be too much of a problem even if your husband is working. Does your husband know that you are HIV-positive?”

Woman: “Yes, he does. He’s HIV-positive, too.”

Counsellor: “It must be difficult for you, but it can be helpful that you both know. What about the rest of your family?”

Woman: “We haven’t told anybody else. We are afraid of what they might say.”

Counsellor: “Oh, that must be a worry. In this case, how will your family feel if you don’t breastfeed?”

Woman: “My mother-in-law might get upset, since she breastfed all her children. She really thinks it’s the best thing to do.”

Counsellor: “What reason do you think that you could give her for why you don’t want to breastfeed?”

Woman: “Maybe I could tell her that I am taking some medicine which will affect the breastmilk. That happened to our neighbour last year.”

Counsellor: “Do you think that your mother-in-law would accept this explanation? Or would she insist that you breastfeed?”

Woman: “I think that she would accept it. That neighbour is a friend of hers, and her baby is doing okay.”

Comment: At this stage, the counsellor would ask the woman if she has any questions. The counsellor then moves to Step 4: Help the woman choose if she wants to follow the national recommendation or not.

Counsellor: “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?”

Woman: “I am so confused. What would you suggest that I do?”

Counsellor: “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.”

Woman: “Yes, she does.”

Counsellor: “Also, your husband knows that you are HIV-positive, so perhaps he could support you to exclusively breastfeed. As you can see, if you will be giving formula, you must prepare the formula carefully. You must have clean water, fuel, and money to buy the formula until the baby is old enough to eat regular

foods.”

Woman: “That’s right.”

Counsellor: “You will also need to make sure you can exclusively breastfeed. As your husband knows your status, he could help to support you to exclusively breastfeed and get ARVs and take them regularly.”

Woman: “Mmm. I would like to think more about this and discuss it with my husband. But I like the fact that my baby will get the good things from my breastmilk and it will also not raise alarm to my family members.”

Comment: **The counsellor did provide the information for the woman on the various risks and benefits and advised her along the national infant feeding recommendations. 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 practice her choice and provide a *Take-Home Brochure*.**

You will now use role-plays to practice counselling women on feeding choices.

- **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 *Counselling Cards* to help you counsel the mother. Use the relevant *Counselling Cards* and *Take-Home Brochures* on how to feed the baby. When you use a *Counselling Card*, do not just read the key messages. Encourage the mother to explain or interpret what she thinks is happening in the illustration. Use your skills to reinforce the visual messages or correct the mother if necessary. Identify the most relevant information for that mother at that moment in time. Summarise this 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 skills she does not use, and which skills 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.

Notes:

Session 28. Commercial infant formula feeding

Objectives

After completing this session, participants will be able to:

- Describe commercial infant formula (in special circumstances) as a substitute for breastmilk in the first six months.
- Explain ways of assisting with clean and safe feeding of young children.
- Demonstrate hygienic preparation of commercial infant formula.
- Understand the International Code of Marketing of Breast-milk Substitutes.
- Understand the NAFDAC Regulations 2005, Marketing of Breast-milk Substitutes.

Session outline

Introduction	5 minutes
Challenges in the use of commercial infant formula	10 minutes
Demonstration: Hygienic preparation of commercial infant formula	15 minutes
Understanding the International Code of Marketing of Breast-milk Substitutes	15 minutes
Summary	5 minutes

Introduction

Slide 28/1: Objectives: Commercial infant formula feeding

Objectives: Commercial infant formula feeding	28/1
After completing this session, participants will be able to: <ul style="list-style-type: none">• Describe commercial infant formula (in special circumstances) as a substitute for breastmilk in the first six months.• Explain ways of assisting clean and safe feeding of young children.• Demonstrate hygienic preparation of commercial infant formula.• Understand the International Code of Marketing of Breast-milk Substitutes.• Understand the National Agency for Food and Drug Administration and Control (NAFDAC) Regulations 2005.	

- The federal government policy on infant and young child feeding is exclusive breastfeeding for the first six months of life for children born to HIV-positive mothers, and introducing complementary feeding from 6 months while continuing breastfeeding until 12 months, with ARVs.
- 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.
- Some mothers may choose to use commercial infant formula and need to be supported.

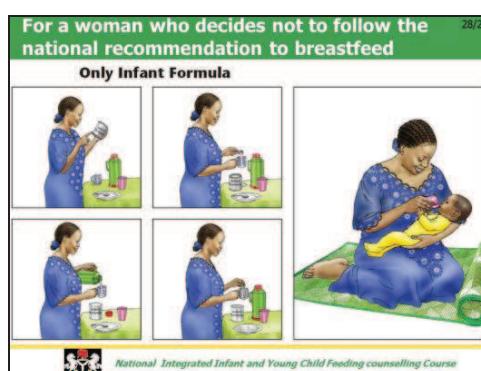
Challenges in the use of commercial infant formula

- A commercial infant formula-fed baby is more likely to get seriously sick from diarrhoea, chest infections, and malnutrition, especially if the formula is not prepared correctly.
- Commercial infant formula-fed babies are much more likely to die.
- 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 minutes) to prepare the commercial infant formula, and soap to wash the baby's cup.
- People may wonder why a mother is using commercial infant formula instead of breastfeeding, and this could cause them to suspect she is HIV-positive.
- 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 does not benefit from the natural contraception provided by exclusive breastfeeding for the first six months of life, before her menses returns. She therefore needs other forms of contraception to avoid getting pregnant again too soon.

Challenges of infant formula

- **Hygienic preparation:** Hygienic preparation is a challenge in many settings, even when safe water is available.
- **Adequate and sustained supply:** Interrupted supply of formula puts infants at risk of malnutrition and infections.
- **Costs:** Very few HIV-infected women in sub-Saharan Africa, including Nigeria, can afford the high costs of formula. Similarly, the costs are very high for PMTCT programmes.
- **Lack of antibodies and other immune factors:** Although commercial infant formula provides critical nutrients, it does not have breastmilk's maternal antibodies to support the development of the infant's maturing immune system. Breastmilk contains these immunologic factors regardless of a mother's HIV status.
- **Time:** Hygienic preparation is a challenge in many settings, even when safe water is available.

Slide 28/2: For a woman who decides not to follow the national recommendation to breastfeed



- HIV-positive mothers who choose not to give breastmilk, and other caregivers, need to know how to prepare commercial infant formula for their infants. This must be prepared in the safest possible way, to reduce the risk of illness.

Key point(s):

- Exclusive replacement feeding (giving ONLY commercial infant formula) for the first six months eliminates the chance of passing HIV through breastfeeding.
- Replacement feeding is also accompanied with provision of ARVs for the mother (at least one week after birth) and the infant (for six weeks after birth).
- Maintaining the mother's central role in feeding her baby is important for bonding and may also help to reduce the risks in preparation of replacement feeds.
- Mixed feeding (feeding baby both breastmilk and any other foods or liquids, including infant formula, animal milks, or water) before 6 months of age greatly increases the chances of an HIV-infected mother passing HIV to her baby.
- Mixed feeding is always dangerous for babies less than 6 months. A baby less than 6 months has immature intestines. Other food or drinks than breastmilk can cause damage to the baby's stomach. This makes it easier for HIV and other diseases to pass to the baby.
- Support the mother to feed her child:
 - No mixed feeding.
 - No dilution of formula.
 - Help mother read instructions on formula tin.
 - Feed the baby with a cup.
- Discard additional commercial infant formula left over after one meal.
- Baby should be given clean water in addition to commercial infant formula.
- It is very important to take note of the expiry date of the formula to ensure that the infant does not consume expired food.

Slide 28/3: Conditions needed to use commercial infant formula



A baby who is not breastfed is at increased risk of illness for two reasons:

1. Replacement feeds may be contaminated with organisms that can cause infection.

2. The baby lacks the protection provided by the breastmilk.

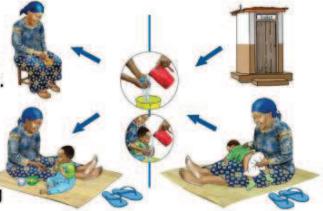
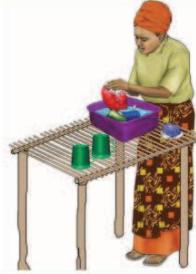
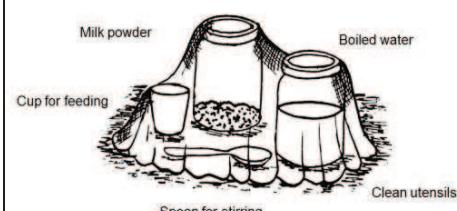
Clean and safe storage and preparation of formula can help to reduce risk.

Key point(s):

- Wash hands with soap and water before preparing formula and feeding baby.
- Make sure to get enough supplies for the baby's normal growth and development until he or she reaches at least 6 months.
 - A baby needs about 44 tins of 450 g in formula for the first six months.
 - A baby needs about 50 tins of 400 g in formula for the first six months.
- Always read and follow the instructions that are printed on the tin very carefully. Ask for more explanation if you do not understand.
- Use clean water to mix with the infant formula. If caregivers are able, prepare the water that is needed for the whole day. Bring the water to a rolling boil for at least 2 minutes and then pour into a flask or clean, covered container especially reserved for boiled water.
- Keep or carry boiled water and infant formula powder separately to mix for the next feeds, if the mother is working away from home or for night feeds.
- Wash the utensils with clean water and soap, and then boil them to kill the remaining germs.
- Use only a clean spoon or cup to feed the baby. Even a newborn baby learns quickly how to drink from a cup. Do not use bottles, teats, or spouted cups.
- Store the formula tin in a safe, clean place.
- Only prepare enough infant formula for one feed at a time, and use the formula within 1 hour of preparation.
- DO NOT reintroduce breastfeeding: avoid any mixed feeding.

Demonstration: Hygienic preparation of commercial infant formula

Slides 28/4 through 28/8: Clean hands, Clean utensils, Safe water, Safe storage, and For the caregiver

<p>Clean hands</p> <ul style="list-style-type: none"> After using toilet. After cleaning baby's bottom. Before preparing or serving food. Before feeding children or eating. 	<p>28/4</p> <p>Clean utensils</p> <ul style="list-style-type: none"> Clean surface (table, mat, or cloth). Wash utensils immediately after use. Keep clean utensils covered. Use clean utensils for baby. 
<p>Safe water</p> <ul style="list-style-type: none"> Boil water to prepare the infant formula. Keep water in clean, covered container. 	<p>28/6</p> <p>Safe storage</p> <ul style="list-style-type: none"> Keep foods in tightly covered container. Store infant formula tin in a safe, clean place. Use prepared commercial formula within one hour. 
<p>28/7</p> <p>For the caregiver</p> <p>Correctly measured ingredients</p> 	

How to make measures for the mother:

- When a mother prepares commercial infant formula, it is very important that the milk and water are mixed in the correct amounts. Wrongly prepared formula may make a baby ill, or he may be underfed.
- A term baby, weighing 2.5 kg or more, needs an average of 150 ml/kg body weight/day. This is divided into 6, 7, or 8 feeds according to the baby's age.
- Only make enough commercial infant formula for one feed at a time unless you have a refrigerator and a power source in good working condition.** However, the exact amount at one feed varies; the amount gradually increases as the infant grows. Feed the baby using a cup and discard any unused commercial infant formula.
- 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.
- 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 commercial infant formula.

- Different brands may have different size measures. Scoops always have to be levelled. Use a clean spatula that comes with the commercial infant formula. Do not use heaped scoops.

Understanding the International Code of Marketing of Breast-milk Substitutes

Slide 28/9: The International Code

The International Code	28/9
<p>International Code of Marketing of Breast-milk Substitutes:</p> <ul style="list-style-type: none"> • 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 breastmilk substitutes - including infant formula and other milks or foods, including water, teas, and cereal foods which are marketed for infants under 6 months, and teats and bottles. 	
 <i>National Integrated Infant and Young Child Feeding counselling Course</i>	

The International Code of Marketing of Breast-milk Substitutes

- In 1981, the World Health Assembly adopted The International Code of Marketing Breast-milk Substitutes, which aims to regulate the promotion and sale of commercial infant formula. This Code is a minimum requirement to protect breastfeeding.
- The overall purpose of the Code is to contribute to safe and adequate nutrition for infants by the protection and promotion of breastfeeding. However, it was voted for adoption the same year in Nigeria as the Code of Ethics and Professional Standards for Marketing of BMS (Annex 4). Decree 1990 No. 41 (now an act) (Annex 5).
- In 1999, Nigeria amended the earlier decree promulgating “Marketing (BMS) (Amended) Decree 1999 (Decree No. 22). (Now an Act) (Annex5)”. The Code covers all breastmilk substitutes, including infant formula, any other milks or foods, including water, teas, and cereal foods, which are sometimes marketed as suitable for infants younger than 6 months of age.

Slide 28/10: Summary of the main provisions of the NAFDAC Regulation 2005

Summary of the main provisions of the NAFDAC regulation 2005		28/10
1. No advertising of breastmilk 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 commercial infant formula on the labels of the products. 7. Information to health workers should be scientific and factual. 8. Information on commercial infant formula, including that on labels, should explain the benefits of breastfeeding and the costs and dangers associated with commercial infant formula and should be translated in three (3) Nigerian languages (Igbo, Hausa, and Yoruba). 9. Unsuitable products, such as sweetened condensed milk, should not be promoted for babies.		



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Summary

- Some people are confused and think that the Code no longer applies where there are women living with HIV and who may choose to feed their infants with commercial infant formula.
- 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 with commercial infant formula. This spread is called ‘spillover’.
- Implementing the Code is, in fact, even more important, both to protect HIV-positive mothers and to help prevent spillover.

Slide 28/11: Importance of the regulation of marketing of breastmilk substitutes

Importance of the regulation of marketing of breastmilk substitutes		28/11
<ul style="list-style-type: none">• Manufacturers promote their products.• Mothers' confidence is undermined by:<ul style="list-style-type: none">- Marketing practises.- Availability of infant formula/BMS.- Health workers and health facilities who allow manufacturers and distributors to freely distribute and market these products.• Health worker/health facility responsibility: protect mothers and babies from these negative influences.		



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- Breastfeeding needs to be protected from the effects of commercial infant formula promotion. One essential way to protect breastfeeding is to regulate the promotion of commercial infant formula, both internationally and nationally.
- Individual health facilities and health workers can also protect breastfeeding if they resist letting companies use them to promote commercial infant formula. This is an important responsibility.

- All manufacturers promote their products to try to persuade people to buy more of them. Commercial infant formula manufacturers also promote their products to persuade mothers to buy more commercial infant formula.
- This promotion undermines women's confidence in their breastmilk, and makes them think that it is not the best for their babies. This hampers breastfeeding.
- Breastfeeding needs to be protected from the effect of commercial infant formula promotion. One essential way to protect breastfeeding is to regulate the promotion of commercial infant formula, both internationally and nationally.
- If commercial infant formula is available in maternity hospitals, or easily available to mothers in shops or health centres from soon after delivery, this also can reduce a mother's confidence and interfere with breastfeeding.
- Individual health facilities and health workers can also protect breastfeeding if they resist letting companies use them to promote commercial infant formula. This is an important responsibility.

How manufacturers promote commercial infant formula

Develop lists of ways in which manufacturers promote commercial infant formula to the public and to health workers. You have only 5 minutes to complete this exercise, so try and move through this quickly.

In what ways do manufacturers promote commercial infant formula to the public?

- Manufacturers stock shops and markets with commercial infant formula and feeding bottles, so that mothers can always see them when they go shopping.
- They give free samples of commercial infant 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 commercial infant formula.
- They advertise on radio, television, videos for hire, billboards, buses, and magazines.

In what ways do manufacturers use health workers and health facilities to promote commercial infant formula?

- 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 informational 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 commercial infant 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.

Further information

REGULATION 2005 ON MARKETING OF BREASTMILK SUBSTITUTES AND OTHER REGULATED PRODUCTS

ARTICLES OF THE CODE

In exercise of the powers conferred on the Government Council of the National Agency for Food and Drug Administration and Control Act 1993 (as amended) and of all the powers enabling it in that behalf, the Government Council of the National Agency for Food and Drug Administration and Control with the approval of the Honourable Minister of Health hereby makes the regulation of marketing of Infant and Young Children Food and other Designated Products (Registration, Sales, Etc.) Regulations 2005 (Ref NAFDAC ACT 2003 [AS AMENDED]).

From Article 4.2

“Informational and educational materials...should include clear information on all the following points:

- (a) The benefits and superiority of breastfeeding.
- (b) Maternal nutrition, and the preparation for and maintenance of breastfeeding.
- (c) The negative effect on breastfeeding of introducing partial bottle feeding.
- (d) The difficulty of reversing the decision not to breastfeed.
- (e) Where needed, the proper use of infant formula and the social as well as financial implications of its use.”

From Article 5

5.1 “There should be no advertising or other form of promotion to the general public of products within the scope of this Code.”

5.2 “Manufacturers and distributors should not provide, directly or indirectly, to pregnant women, mothers or members of their families, samples of products within the scope of this Code.”

5.4 “Manufacturers and distributors should not distribute to pregnant women or mothers of infants and young children any gifts of articles or utensils which may promote the use of breast-milk substitutes or bottle-feeding.”

From Article 6

6.2: “No facility of a health care system should be used for the purpose of promoting infant formula or other products within the scope of this Code.”

6.3: “Facilities of health care systems should not be used for the display of products within the scope of this Code, for placards or posters concerning such products....”

6.5: “Feeding with infant formula, whether manufactured or home prepared, should be demonstrated only by health workers, or other community workers if necessary; and only to the mothers or family members who need to use it; and the information given should include a clear explanation of the hazards of improper use.”

From Article 9

9.1 “Labels should be designed to provide the necessary information about the appropriate use of the product and so as not to discourage breastfeeding.”

9.2 “Manufacturers and distributors of infant formula should ensure that each container has a clear, conspicuous, and easily readable and understandable message printed on it, or on a label which cannot easily become separated from it, in an appropriate language, which includes all the following points:

- (a) The words ‘Important Notice’ or their equivalent.
- (b) A statement of the superiority of breastfeeding.
- (c) A statement that the product should be used only on the advice of a health worker as to the need for its use and the proper method of use.
- (d) Instructions on appropriate preparation and warning about health hazards of inappropriate preparation.
- (e) Information on commercial infant formula feeding, including that on the label should explain the benefit, cost and dangers associated with commercial infant formula feeding and should be translated in three (3) major Nigerian languages (Igbo, Hausa and Yoruba). ”

Difficulties with donations of formula

You may have heard that some manufacturers and distributors have offered to donate formula for women who are HIV-positive. Look at what the Code says:

From Article 6.7

“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.”

If donations are made by manufacturers, they must be given to mothers through some other system, for example, as part of social welfare, and there are three conditions that must apply:

- They are only given for infants who have to be fed on breastmilk substitutes, including HIV-positive mothers who have chosen this option.
- The supply is continued for as long as the infants concerned need it; as we have said, for formula, this should be a minimum of six months, and the need for milk of some sort continues through infancy.
- The supply is not used as a sales inducement.
- Free supplies should not be given to hospitals and health centres because:
 - Experience shows that when free supplies are given, they become too easily available. Many mothers who do not need them want to use them. These mothers often lose confidence in their ability to breastfeed, and may unnecessarily give up breastfeeding.
 - Donations make health facilities dependent on them. If the donations cease—which often happens—there may be no alternative source of milk available, and no provision in the health service budget to buy them.
 - Donations are a very successful form of promotion that encourages families to buy the same product. The Code does not allow any form of promotion.

NOTES ON THE CODE

Article 4.2

This section ensures that:

- Appropriate information about breastfeeding is included in all materials, so that the value of breastfeeding is not undermined.
- Accurate information can be given about other options, for mothers who are considering not breastfeeding for reasons such as HIV. This would include the information that you learnt to give in this course.
- Such information should include the cost of commercial infant formula feeding.

Article 5

- Some people think that advertisements and free samples would be helpful for mothers with HIV. This is not true. It is difficult enough for a woman to make up her mind what to do without advertisements trying to influence her choice, and to persuade her to buy a breastmilk substitute that she cannot afford.
- Women need one-to-one individual counselling to make their choice, including discussing costs and other difficulties of commercial infant formula feeding.
- Advertisements and gifts should not influence the information that she receives from her infant feeding counsellor, or her choice of a particular brand of formula. She needs objective and non-commercial information.
- A free sample of formula or other product will not help her, if she cannot afford to buy more when it has finished. If she uses it, her breastmilk will dry up, and she could be left with nothing to feed her baby on.
- If she mixes breast and formula feeding, she may increase the risk of HIV transmission.

Article 6

- This protects mothers who are HIV-negative or untested from promotion of formula and other products that they do not need.
- Any formula used by HIV-positive mothers should be kept out of sight, and not displayed on the ward where it could influence mothers who do not need it.
- HIV-positive women should be taught how to use formula privately, and not by a demonstration in front of other mothers. This both protects their own confidentiality and dignity, and avoids influencing other mothers.
- HIV-negative and untested women should not watch demonstrations of how to prepare formula. Doing so could undermine their confidence in their ability to breastfeed, and make them disbelieve the messages that promote breastfeeding as the best option for them.
- HIV-positive women should be warned about the dangers of preparing breastmilk substitutes incorrectly, so that they are not tempted to economize by over-dilution, or by not cleaning the utensils often enough.

The Code thus allows for mothers who need to use formula to have help; however:

- (1) They must be identified as needing to use formula (for example, by a positive HIV test and following counselling on the feeding options).
 - (2) They can only receive help from an appropriately trained and independent person, not from someone employed by the manufacturers.
 - (3) The dangers of using the formula incorrectly must be clearly explained to them.

Article 9

- For breastfeeding mothers, this labelling protects them from thinking that after all, formula is just as good as breastfeeding.
 - For HIV-positive mothers, when they have chosen to use the formula, and have been instructed in its proper use, in consultation with a health worker, it ensures that adequate instructions in an understandable form are always there as a reminder.
 - One way to avoid the formula being used as a sales inducement is for it to be provided in *generically labelled* containers. This means a simple label without a brand name or attractive package design. Most labels and packages are designed to attract attention, and to identify a particular brand and advertise it. You may see generically packaged formula being provided for mothers in some places.

Notes:

Session 29. Checking understanding and arranging for 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 for referral or follow-up of a child.

Session outline

Introduction	5 minutes
Demonstration: Two skills for checking understanding and arranging for follow-up	15 minutes
Summary	5 minutes

Introduction

Slide 29/1: Objectives: Checking understanding and arranging follow-up

Objectives: Checking understanding and arranging follow-up 29/1
After completing this session, participants will be able to:
<ul style="list-style-type: none">• Demonstrate how to ensure that a mother understands information provided by using checking questions.• Arrange referral or follow-up of a child.
 National Integrated Infant and Young Child Feeding counselling Course

- In this session, you will learn two more skills to help support mothers: Checking understanding and arranging for follow-up.

Demonstration: Two skills for checking understanding and arranging for follow-up

- We have already practiced 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 that 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 her understanding of the term ‘frequently’.
- It is not enough to ask a mother if she understands, because she may not realise 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 summarise 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.

Demonstration 29.A: Checking understanding

Health worker: “Now, [mother’s 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: 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, [mother’s name], we talked about many things today, so let’s check to make sure everything is clear. What foods do you think you will give [child’s name] tomorrow?”

Mother: “I will make his gruel thick.”

Health worker: “Thick gruel 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 [child’s name]?”

Mother: “I will give him something to eat five times a day. I will give him thick gruel in the morning and evening, and in the middle of the day, I will give him the food we are having. I will give him some fruit or bread in between.”

Health worker: “You have chosen well. Children who are 1 year old need to eat often. Would you come back to see me in two weeks to see how the feeding is going?”

Mother: “Yes, okay.”

Comment: 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.

Key point(s):

- 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; and checking the child's weight, health, general development, and care.
 - The follow-up visits also give an opportunity to praise and reinforce practices, thus building the mother's confidence, to offer relevant information and to discuss suggestions as needed.
 - It is especially important for children with special difficulties—for example, children whose mothers are living with HIV—to receive regular follow-up from health workers.
 - These children are at special risk. In addition, it is important to check how the mother is coping with her own health and difficulties.

Notes:

Session 30. 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

Introduction	2 minutes
How to help a mother learn to prepare a suitable meal	20 minutes
Role-play of a demonstration for mothers	20 minutes
Preparing a plate of food	10 minutes
Discussion on the meals prepared	10 minutes
Summary	3 minutes

Introduction

Slide 30/1: Objectives: Food demonstration

Objectives: Food demonstration	30/1
<p>After completing this session, participants will be able to:</p> <ul style="list-style-type: none">• Prepare a plate of food suitable for a young child.• Explain why they have chosen these foods.• Conduct a food demonstration with a mother.	

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How to help a mother learn to prepare a suitable meal

- 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.
- You can use your skills to:
 - Ask open questions to find out if the mother understands.
 - Avoid words that sound judging or critical.
 - Praise the mother.
 - Explain things in a simple and suitable way to help her understand.

- Now we will see a demonstration of helping a mother to learn in a supportive way. Listen for supportive ways of giving information.

Role-play of a demonstration for mothers

- [Mother's name] 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's] feeding and praised good practices. The health worker gave some information on two Key Points 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 on 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 30.A: Supportive teaching

Health worker: “Good morning, [mother's name]. How are you and [child's name] today?”

Mother: “We are well, thank you.”

Health worker: “A few days ago, we talked about feeding [child's name], and you decided you would offer [child's name] some food more often. How is that going?”

Mother: “It is good. One time, he had about half a banana. Another time, he had a piece of bread with some butter on it.”

Health worker: “Those sound like good snacks. Now, we want to talk about how much food to give for his main meal.”

Mother: “Yes, I'm not sure how much to give.”

Health worker: “It can be hard. What sort of bowl or cup do you feed him from?” *[Adjust the text according to cup size. If a smaller cup is used, it will need to be a full cup. If a larger cup is used, it may need to be less full.]*

Mother: “We usually use this bowl.” *[Shows a bowl about 250-ml size.]*

Health worker: “How full do you fill the bowl for his meal?”

Mother: “Oh, about a third.”

Health worker: “[Child's name] is growing very fast at this age, so he needs increasing amounts of food.”

Mother: “What foods should I use?”

Health worker: “You have some of the food here from the family today. Let us see.” *[Uncovers food.]* “First, we need to wash our hands.”

Mother: “Yes, I have some water here.” *[Washes hands with soap and dries them on clean cloth.]*

Health worker: “Now, what could you start with for the meal?”

- Mother:* “I guess we would start with some rice.” [*Puts in two large spoonfuls.*]
- Health worker:* “Yes, the rice would almost fill half of the bowl. Animal-source foods are good for children. Are there some animal-source-foods you could add to the bowl?”
- Mother:* “I kept a few pieces of fish from our meal.” [*Puts in one large spoonful.*]
- Health worker:* “Fish is a good food for [child’s name]. A little animal-source food each day helps him to grow well.”
- Mother:* “Does he need some vegetables, too?”
- Health worker:* “Yes, dark-green or orange-coloured vegetables help [child’s name] to have healthy eyes and fewer infections. What vegetables could you add?”
- Mother:* “Some spinach?” [*Puts in some.*]
- Health worker:* “Spinach would be very nutritious. Some would fill half the bowl.”
- Mother:* “Oh, that isn’t hard to do. I could do that each day. Two spoons of rice, a spoon of an animal-source food, and some dark-green or orange-coloured vegetable so the bowl is half-full.”
- Health worker:* “Yes, you are able to do it. Now, what about his morning meal?”
- Mother:* “I can give some gruel, with milk and a little sugar.”
- Health worker:* “That’s right. How much will you put in the bowl?”
- Mother:* “Until it is at least half-full.”
- Health worker:* “Yes. So, we’ve talked about his morning meal, and the main meal with the family. [Child’s name] needs three to four meals each day. What else could you give?”
- Mother:* “Well, he could have some banana or some bread, like I said before.”
- Health worker:* “Those are healthy foods to give between meals. [Child’s name] needs at least half a bowl of food three to four times a day, as well.”
- Mother:* “Oh, I don’t know what else to give him.”
- Health worker:* “Your family has a meal in the middle of the day. What do you eat in the evening?”
- Mother:* “Usually, there is a pot of soup with some beans and vegetables in it. Could I give him that?”
- Health worker:* “Thick foods help him to grow better than thin foods 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?”
- Mother:* “Yes, I could do that easily enough.”
- Health worker:* “So, how much will you put in [child’s name’s] bowl for each meal?”
- Mother:* “I will fill it half-full.”
- Health worker:* “Very good. And how often each day will you give him some food?”
- Mother:* “I will give him one-half bowl of food three to four times a day. If he is hungry, I will give some extra food between meals.”

Health worker: “Exactly. You know how to feed [child’s name] well. Will you bring [child’s name] back to the health centre in two weeks so we can look at his weight?”

Mother: “Yes, I will. With all this food, I know he will grow very well.”

What did you observe about how the health worker taught this mother?

- The health worker let the mother prepare the food.
- The health worker explained points carefully.
- The health worker used the Key Points, 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 she 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.

How will this mother manage with preparing food for her child?

- This mother probably will be able to prepare foods well.
- Remember to use the counselling skills when you teach a mother. This supportive teaching can help to build her confidence as well as making it easier for her to learn.
- Whenever possible, let the mother prepare the food herself, with the support of the health worker, until she is confident and competent. Watching a health worker prepare foods is not enough, particularly if there is a problem with the child’s weight gain or feeding.
- The health worker in our demonstration could also stay and observe *how* the mother feeds the child.

What practices would the health worker look for when the child was being fed?

- 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 27.

Preparing a plate of food

- 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 afterward 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 Points 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 Points that are relevant to the child for whom you are preparing the meal.

Discussion on the meals prepared

EXERCISE 30.a: Preparing a young child's meal.

Points for discussion:

- Why you chose those foods.
- Why you prepared it in the way you did (mashed finely, chopped, etc.).
- How thick is the consistency (for a young child)? Test with a spoon.
- Any additional foods you would include that are not available.
- The one or two Key Points for Complementary Feeding they would use in a demonstration for mothers.
- Why you gave that amount.

Amounts of foods to offer			
Age	Texture	Frequency	Amount of food an average child will usually eat at each meal*
6–8 months	Start with thick gruel, well-mashed foods. Continue with mashed family foods.	Two to three meals per day plus frequent breastfeeds. Depending on the child's appetite, one to two snacks may be offered.	Start with two to three tablespoons per feed, increasing gradually to $\frac{1}{2}$ of a 250-ml cup.
9–11 months	Finely chopped or mashed foods, and foods that baby can pick up.	Three to four meals plus breastfeeds. Depending on the child's appetite, one to two snacks may be offered.	$\frac{1}{2}$ of a 250-ml cup/bowl.
12–23 months	Family foods, chopped or mashed if necessary.	Three to four meals plus breastfeeds. Depending on the child's appetite, one to two snacks may be offered.	$\frac{3}{4}$ to one 250-ml cup/bowl.

If baby is not breastfed, give in addition: One to two cups of milk per day, and one to two extra meals per day.

*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 30.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 Points for Complementary Feeding:

1.

2.

Summary

- 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 practice 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 Points for Complementary Feeding.

Notes:

Session 31. Maternal nutrition

Objectives

At the end of this topic, participants should be able to:

- Counsel couples (during pregnancy, lactation, and illness) on maternal health, nutrition, and family planning.
- Counsel couples and other caregivers on how to protect the mother's health during pregnancy and lactation.

Session outline

Introduction	5 minutes
Understanding causes of malnutrition	15 minutes
General guidance on good nutrition	20 minutes
Protecting a woman's health	20 minutes
Summary	5 minutes

Introduction

Slide 31/1: Objectives: Maternal nutrition

Objectives: Maternal nutrition	31/1
<p>After completing this session, participants should be able to:</p> <ul style="list-style-type: none">• Counsel couples (during pregnancy, lactation, and illness) on maternal health, nutrition, and family planning.• Counsel couples and other caregivers on how to protect the mother's health during pregnancy and lactation.	

 National Integrated Infant and Young Child Feeding counselling Course

- Good nutrition is important for the health of women as well as for the survival and development of their children. A woman's nutritional status prior to and during pregnancy influences the baby's and her own health.
- Pregnant and lactating mothers need to focus on getting a complete diet to support their extra energy needs. Women should also protect their health to reduce the chance of becoming ill during this time.
- To preserve their health and nutritional status, there is need to counsel mothers on appropriate diets, family planning methods, and medications.

Understanding causes of malnutrition

How women become malnourished:

- They have been malnourished in childhood.
- They do not eat enough food to cover energy needs.
- They have a heavy physical workload.

- They do not eat enough of different types of foods.
- They are not getting extra food when pregnant and/or lactating.
- They have babies when they are young (teenage pregnancy/delivery).

Strategies to prevent malnutrition in women:

- Reducing workload of women, especially during pregnancy and lactation.
- Teaching school children about the nutritional needs of the girl-child and pregnant and lactating mothers.
- Educating/sensitizing the community about the nutrition of women in all the stages of their lifecycle.

Effects of maternal malnutrition	
ON MOTHER'S HEALTH	ON BABY'S HEALTH
Anemia	Anemia
Faster progression to AIDS	Nutritional deficiencies
Lethargy	Foetal abnormalities
Low immunity (increased risk of infections)	High risk of infections
Low weight gain	Low birthweight
Premature labour	Intrauterine foetal death
Death	Still birth

- In order to have good health during pregnancy and lactation, all mothers should try to have appropriate diets.
- “Appropriate diets” refers to a variety of foods in adequate amounts to meet the daily nutritional requirements.
- A meal should have at least one food from each of the following food groups; energy-giving, body-building, protective food, and water.
- Typically, meals that contain foods that are several different colours are healthier because they contain a variety of nutrients.

General guidance on good nutrition

Slide 31/2: Guidance for good nutrition

Guidance for good nutrition		31/2
	<ul style="list-style-type: none"> • Pregnancy: eat three meals PLUS one snack. • Breastfeeding: eat three meals PLUS two snacks. • Eat different types of food. • Plan a 4-star diet. 	
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Nutritional needs of a breastfeeding mother

- Women of reproductive age need to eat enough food before and during pregnancy to keep strong, and to build good stores of energy and nutrients. During pregnancy, women should eat an extra meal per day as well as reduce their physical workload during the final months of pregnancy in order to gain enough weight.
- A breastfeeding mother also needs extra food to keep her feeling strong and healthy, and to prevent her own body tissues from being used up. Even though she can still make enough breastmilk without eating more, she needs enough food to help her to feel well and stay strong enough to care for her family.
- In general, she needs to eat food that provides about 500 calories extra. She needs to eat an extra small meal or snack in addition to her usual food each day. It is important to understand, however, that women who are underweight may require more calories, whereas women who are overweight may require fewer additional calories.
- No special food is required to produce breastmilk.
- Adolescent mothers need more food, extra care, and more rest.

The 4-star diet

Slide 31/3: Planning a 4-star diet

This slide illustrates the 'Planning a 4-star diet' with five categories of foods, each assigned a star rating:

- Staples:** Grains such as maize, wheat, rice, millet and sorghum, and root tubers such as cassava and potatoes. **1 star ***
- Legumes:** Legumes such as beans, lentils, peas, groundnuts, and seeds such as sesame. **2 stars ****
- Vitamin A-rich fruits and vegetables:** Foods such as papaya, passion fruit, oranges, dark-green leaves, carrots, yellow sweet potato and mangoes, and other fruits and vegetables such as bananas, pineapple, avocado, watermelon, tomatoes, eggplant and cabbage. **3 stars *****
- Animal-source foods:** Foods such as meat, chicken, fish, liver and eggs, and dairy products. **4 stars ******
- Oil and fat:** Oil and fat such as oil seeds, margarine, ghee and butter improve the absorption of some vitamins and provide extra energy. **5 stars *******

National Integrated Infant and Young Child Feeding counselling Course

Slide 31/4: Examples of extra food needed

Examples of extra food needed		
Example of extra food needed each day by a breastfeeding woman		
60 g Rice	1 fistful	240 Calories
Vegetables	2 fistful	
1 Banana		90 Calories
5 ml Oil	1 teaspoonful	50 Calories
30 g Beans	1/2 fistful	120 Calories

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- This slide gives an example from one country of the extra food that a breastfeeding mother is advised to eat, in addition to her usual food.
- She needs to eat food that provides about 500 calories extra. If this is from a variety of foods, then the extra protein, vitamins, and minerals will automatically be provided.
- Women who can afford to eat freely increase their food intake in response to their appetite. They do not usually need advice to eat more, though they may need advice to eat a variety of foods.
- Women who are poor may need help if they are to eat any extra food at this time. Probably the most useful recommendation for a mother is to eat an extra helping of her usual food each day. Different or special foods are unlikely to be available.
- If you give any food or vitamin supplements during breastfeeding, give them to the mother, and not to the baby. Give them to the mother through the whole breastfeeding period, not just for the first few months.
- It is equally important for a woman to eat enough before and during pregnancy. This will help her to keep strong, and to build good stores of energy and nutrients, which her body can use to make breastmilk. Also, if she is well-nourished, her baby is less likely to be low-birthweight.

Group activity

- List common and affordable foods in their communities that fall under the various food groups discussed.
- As a group, discuss and report the list of foods that can be suggested to mothers to enhance their caloric intake.
- Discuss, on average, what foods can add enough calories for breastfeeding women. Show the slide for an example.

Protecting a woman's health

Slides 31/5 and 31/6: Protecting a woman's health

Protecting a woman's health	31/5	Protecting a woman's health (cont.)	31/6
<ul style="list-style-type: none"> • Attend the ANC at least four times during pregnancy. • Drink whenever thirsty. • Avoid taking coffee or tea. • Take supplements: <ul style="list-style-type: none"> - Iron and folate (with meals). - Iodised salt. - Vitamin-A supplements. 		<ul style="list-style-type: none"> • Prepare all foods in a hygienic way. • Rest more during the last three months of pregnancy. • Use a long-lasting insecticide net when sleeping. • Take deworming tablets. • Do not drink alcohol or take drugs. • Know your HIV status. • Practise appropriate family planning. 	

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- It is important that women attend the antenatal clinic AT LEAST four times during their pregnancy, starting as early as possible.
- In addition to eating more, women should also remember to drink enough water. Women should drink whenever they are thirsty.

- Women should refrain from consuming coffee or tea as much as possible during pregnancy and lactation.
- Pregnant and lactating women should take supplements to improve their health. This includes:
 - Iron and folic acid tablets during pregnancy and for at least three months after the baby is born. Iron and folic acid tablets should be taken with meals to increase absorption and prevent stomach upset.
 - Iodized salt should always be used to prevent learning disabilities, delayed development, poor physical growth in the baby, and goiter in the mother.
 - Vitamin-A supplements should be taken immediately after birth or within six weeks after delivery to ensure that the baby receives the vitamin A in the breastmilk.
- Safe (hygienic) preparation of food:
 - Good hygiene (cleanliness) is important to avoid diarrhoea and other illnesses.
 - Use clean utensils and store foods in a clean place.
 - Cook meat, fish, and eggs until they are well-done.
 - Wash vegetables, cook immediately for a short time, and eat immediately to preserve nutrients.
 - Wash raw fruits and vegetables.
- It is critical to get enough rest during pregnancy. Reduce the amount of hard labour or heavy lifting. Rest more during the last three months of pregnancy.
- To prevent malaria and other mosquito-borne diseases, sleep under an insecticide-treated bednet.
- Take antimalarial tablets as prescribed.
- Take deworming tablets to treat worms and prevent anemia.
- Do not use alcohol, narcotics, or tobacco products.
- It is important to know your HIV status and to consult your health care provider on your care and treatment and how to best feed your baby.
- If you are HIV-infected, you need extra food to give you extra energy.
- Consult a family planning counsellor so that you may protect yourself and your baby from HIV and other sexually transmitted infections and also prevent another pregnancy when your baby is very young.

Notes:

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Session 32. 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

Introduction	5 minutes
Discussion on the competencies expected of participants	10 minutes
Discussion on the follow-up session	5 minutes
Discussion on preparation for the follow-up session	10 minutes
Summary	5 minutes

Introduction

Slide 32/1: Objectives: Follow-up after training

Objectives: Follow-up after training	32/1
<p>After completing this session, participants will be able to:</p> <ul style="list-style-type: none">• 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.	
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Key point(s):

- In this session, we will discuss the follow-up you will receive after this training course.
- This follow-up is not an exam or a test. It is designed to help you to continue to practice the skills expected of participants, and to help you with any difficulties you may have come across in infant feeding after you return to your facilities.
- The trainer who comes to conduct this follow-up session might be one of the trainers who has facilitated during 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.

Expected competencies of participants

Review the Table of Competencies found in the Introduction to this guide.

- 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 in which 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-birthweight baby or the skill to gather information on complementary feeding using the FOOD INTAKE (6 UP TO 24 MONTHS) JOB AID.
- After you go back to your facility, you will have the opportunity to practice many of these skills. The more you practice, the more skilled you will become.

Follow-up session

- The follow-up session will take place between one and three 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 conducted individually.
- The competencies that you will be assessed on in the morning are all in the table you have in your manuals. There are many ways that you will be able to learn about how well you have mastered this material. This may happen during your direct clinical practice at the postnatal ward, when you are asked to help a mother with a newborn baby to position and attach her baby. 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. Understanding what you have learnt and how you can continue to increase your knowledge is important as you continue to promote best practices in maternal, infant, and young child nutrition.

Preparation for the follow-up session

- There are some things you need to prepare for the follow-up session.
- First, there is a list of exercises that starts in the manual. These are exercises on breastfeeding difficulties so that you can practice applying the knowledge and counselling skills that you have learnt. Complete the answers in your manuals 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.
- So, for example, on November 17, 2012 you practice 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 try 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, in your participant’s manual, 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 members.
- 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 practice.

Summary

Make sure that everyone is clear about what is expected of them and that they understand the Table of Competencies (found in the Introduction of the Participant’s Manual). This concept will be new to many participants.

Key point(s):

- You have now completed this course in infant feeding.
- We have covered aspects of infant feeding from birth to 2 years of age, including special situations, such as mothers who are HIV-positive.
- It is important that you now continue revising the knowledge and practising the skills you have learnt, after 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.

Appendix 1. 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 feces.

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.

AIDS: Acquired immune deficiency syndrome, which means that the HIV-positive person has progressed to active disease.

Allergy: Abnormal response to a food triggered by the body's immune system. Allergic reactions to food can sometimes cause serious illness and death.

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

Anemia: The condition of having less than the normal number of red blood cells or less than the normal quantity of hemoglobin in the blood.

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

Antibodies: Proteins in the blood and in breastmilk that fight infection.

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

Appropriate touch: Touching somebody in a socially acceptable way.

Areola: Dark skin surrounding the nipple.

Asthma: Chronic respiratory disease characterised by recurrent attacks of breathlessness and wheezing.

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: An approach to transforming maternity practices as recommended in the joint World Health Organization/United Nations Children's Fund statement on *Protecting, promoting and supporting breastfeeding: the special role of maternity services* (1989).

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

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

Bilirubin: Yellow breakdown products of hemoglobin that 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, including expressed breastmilk, water, formula, etc.

Breast pump: Device 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.

Calories: Kilocalories or calories measure the energy available in food.

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

Casein: Protein in milk that forms curds.

Cessation of breastfeeding: Completely stopping breastfeeding, including suckling.

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

Closed questions: Questions that can be answered with "Yes" or "No".

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

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

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

Commercial infant formula: A breastmilk 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.

Commercial infant formula feeding: Feeding an infant on a breastmilk substitute.

Commercial infant formula feeds: Any kind of milk or other liquid given instead of breastfeeding.

Commercial infant formula fed: Receiving commercial infant formula feeds only, and no breastmilk.

Complementary feeding: The child receives semi-solid or solid foods in addition to breastmilk or a breastmilk substitute.

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

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

Contaminated: Containing harmful bacteria or other harmful substances.

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 that deliver 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 that removes the milk efficiently from the breast.

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

Engorgement: Swollen with breastmilk, blood, and tissue fluid. Engorged breasts are often painful and oedematous, and the milk does not flow well.

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

Exclusive breastfeeding: An infant receives only breastmilk and no other liquids or solids, not even water, with the exception of drops or syrups consisting of vitamins, mineral supplements, or medicines.

Express: To squeeze or press out.

Expressed breastmilk: Milk that has been removed from the breasts manually.

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 that sticks out less than average.

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

Formula: Commercial infant formula 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 that are full of milk, and hot, heavy, and hard, but from which the milk flows.

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 gruel, it makes the gruel 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. It is called *Man Shanu* in Hausa Language.

Growth factors: Substances in breastmilk that 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. Other names in Nigeria include *Pap*, *Akamu*, *Ogi*.

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

'High-needs' baby: A baby who seems to need to be carried and comforted more than other babies.

Hindmilk: The fat-rich breastmilk 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 breastmilk 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, that fight infection.

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

Infective mastitis: Mastitis due to bacterial infection.

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

Inhibit: To reduce or stop something.

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

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

Jaundice: Yellow colour of eyes and skin.

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

Lactation: The process of producing breastmilk.

Lactose: The special sugar present in all milks.

Low-birthweight: Weighing less than 2.5 kg at birth.

Mastitis: Inflammation of the breast (see also infective and non-infective mastitis).

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

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

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

Micronutrient supplements: Preparations of vitamins and minerals.

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

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

Mistaken idea: An idea that is incorrect.

Mixed feeding: Feeding both breastmilk and other foods or liquids.

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

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.

Nonverbal communication: Showing your attitude through your posture and expression.

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

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

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

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

Oedema: Swelling due to fluid in the tissue.

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

Open questions: Questions that can only be answered by giving information, and not with just a “Yes” or a “No”.

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

Pacifier: Artificial nipple made of plastic for a baby to suck; a dummy/soother.

Palpation: Examining by feeling with your hand.

Partially breastfed: Breastfed and given some commercial infant formula feeds.

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

Pathogen: Any organism that causes disease.

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

14 days.

Pneumonia: Infection of the lungs.

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

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

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

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

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: Commercial infant formula feeds given before breastfeeding is established.

Premature, preterm: Born before 37 weeks’ gestation.

Prolactin: The hormone that makes the breasts produce milk.

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

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

Psychological: Mental and emotional.

Pulses: 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.

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 breastmilk 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 breastmilk substitute. After six months, it should be with a suitable breastmilk 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 1 year old deciding by himself to stop breastfeeding.

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

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

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 breastmilk 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 commercial infant formula feeds given in addition to breastmilk.

Support: Help.

Sustaining: Continuing to breastfeed for up to two 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.

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.

Unrestricted feeding: See 'Demand feeding'.

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

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

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

Appendix 2. Infant and Young Child Feeding Assessment (0 Up to 24 Months) Job Aid

Mother's name _____ Baby's name _____ Date of birth _____

Reason for consultation _____

1. Baby's feeding now If baby is breastfeeding	How often...., Length of breastfeeds...., Longest time between feeds (time mother away from baby),...., Feeds from one or both breasts....	Day feeds	Night feeds
If baby is on replacement feeds	Type of feed...., How fed (cup, bottle, spoon)...., Amount per feed...., How many feeds...., How feeds are prepared (ingredients, dilution, hygiene).....		
If baby is on complementary feeds	Type of feed...., How fed (cup, bottle, spoon)...., Amount per feed...., How many feeds...., How feeds are prepared (ingredients, dilution, hygiene).....		
2. Baby's health and behaviour (Ask all these points)	Full-term or premature...., Singleton or twin.... Birthweight...., Weight now...., Growth/development.... Current urine output (</>6 times/day).... Stools (soft, yellow/brown; hard or green; frequency).... Feeding behaviour (appetite, vomiting).... Sleeping behaviour.... Illness/Abnormalities....		
3. Antenatal, natal, postnatal periods	Antenatal care (attended or not).... Delivery (normal, abnormal).... Bedding-in...., Prelacteal feeds.... Antenatal/Natal/Postnatal feeding support received.... Time first fed...., How fed (breastfed/replacement fed)....		
4. Mother's health	Age...., Literacy...., Health status (including HIV status).... Use of family planning methods and type used.... Breast conditions...., Current medication.... Use of alcohol, smoking, coffee, drugs....		
5. Previous infant feeding experience	No. of previous babies...., How many breastfed?.... Any use of spouted cup/bottles.... Experience in feeding and reasons...		
6. Family and social situation	Work situation...., Economic situation.... Male partner attitude toward and involvement in feeding.... Other family members' attitudes toward feeding.... Family support with childcare....		

Appendix 3. 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 looks 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 is calm and relaxed
- Baby reaches or roots for breast when 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

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

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

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

Appendix 4. Counselling Skills Checklist

Listening and learning skills:

- Use helpful nonverbal communication.
- Keep your head level with the mother/caregiver.
- Pay attention.
- Reduce physical barriers.
- Take time.
- Touch appropriately.
- Ask open questions.
- Use responses and gestures that show interest.
- Reflect back what the mother/caregiver says.
- Avoid using ‘judging’ words.

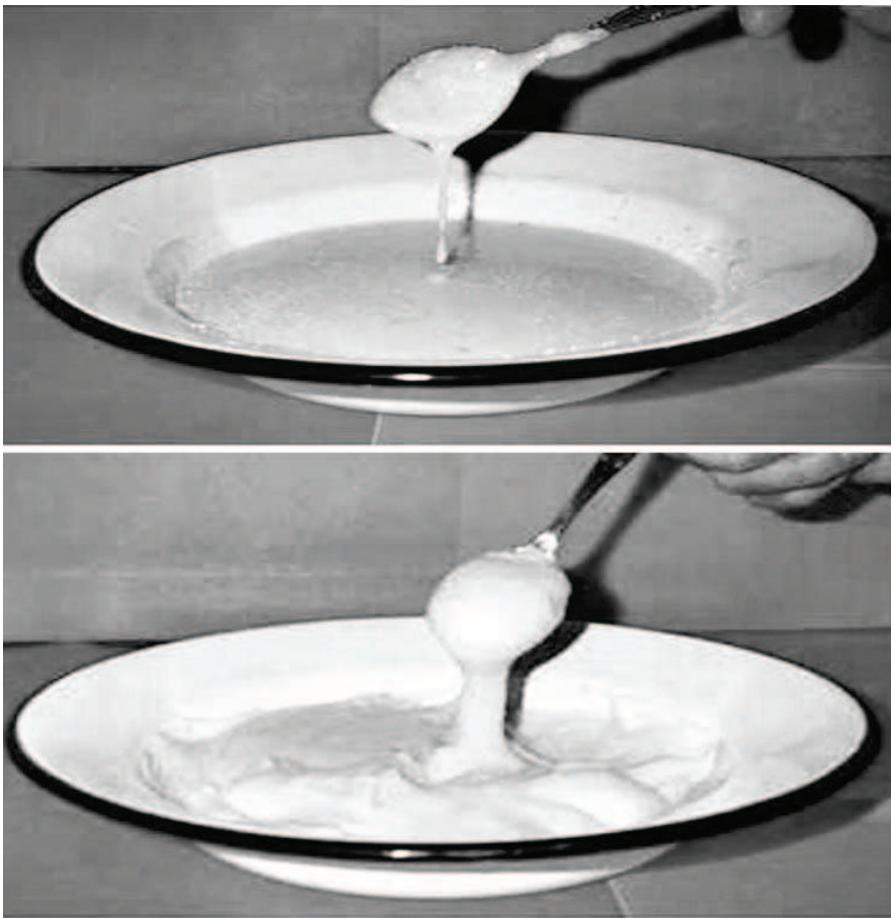
Building confidence and giving support skills:

- Accept what the caregiver thinks and feels.
- Listen carefully to the mother’s (or caregiver’s) concerns.
- Recognize and praise what a mother/caregiver and child are doing correctly.
- Give practical help.
- Give a little, relevant information at a time.
- Use simple language that the mother/caregiver will understand.
- Use appropriate *Counselling Card(s)* or *Take-Home Brochure(s)*.
- Make one or two suggestions, not commands.

Appendix 5. Key Points for Complementary Feeding

1. Breastfeeding until 2 years of age or longer helps a child to develop and grow strong and healthy.
2. Starting other foods in addition to breastmilk at 6 months of age 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. Micronutrient Powders (MNP) can be added to your child's food to improve the quality of the food and to provide the needed vitamins and minerals.
8. Feed your child three to five times per day in addition to breastfeeding. Give a variety of different foods.
9. A growing child needs increasing amounts of food; add more foods as your child grows.
10. A young child needs to learn to eat: encourage and give help...with lots of patience.
11. Encourage the child to drink and eat during illness and provide extra food after illness to help the child recover quickly.

Appendix 6. Food Consistency Photos



Appendix 7a. Food Intake (6 up to 24 Months) Job Aid

Fill in appropriately if the practice is in place. Enter the message given using the FOOD INTAKE (6 UP TO 24 MONTHS) REFERENCE TOOL (Appendix 7b).

Child's name:		Date of birth:	Age of child at visit:
Feeding practice	Yes / Number where relevant	Summarise the Key Points given	
Growth curve rising?			
Child received breastmilk?			
How many meals/snacks did the child eat yesterday?			
Of these, how many meals/snacks of a thick consistency did the child eat yesterday? (Use consistency photos as needed.)			
Child ate an animal-source food yesterday (meat/fish/offal/poultry)?			
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 meal times?			
Child took any vitamin or mineral supplements?			

Appendix 7b. Food Intake (6 up to 24 Months) Reference Tool

Feeding practice	Ideal feeding practice	Key Points to help counsel mothers
Growth curve rising?		<i>Look at the shape of the growth curve of the child: is the child growing adequately?</i>
Child received breastmilk?	Yes.	Breastfeeding until 2 years of age or longer helps a child to develop and grow strong and healthy.
How many meals/snacks did the child eat yesterday?	Three meals.	Several meals/snacks in addition to breastmilk help the child grow adequately.
Of these, how many meals/snacks of a thick consistency did the child eat yesterday? (Use consistency photos as needed.)	Two 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/poultry)?	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.	Dairy 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: Two or three meals plus one or two snacks if hungry. Child 9–23 months: Three or four meals plus one or two snacks if hungry.	A growing child needs two to four meals a day, plus one or two 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. $\frac{1}{2}$ cup at each meal. Child 9–11 months: approx. $\frac{1}{2}$ cup at each meal. Child 12–23 months: approx. $\frac{3}{4}$ –1 cup at each meal.	A growing child needs increasing amounts of food.
Mother assisted the child at meal 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.	Explain how to use vitamin and mineral supplements if they are needed.
Child ill or recovering from an illness?	Continue to eat and drink during illness and recovery.	Encourage the child to drink and eat during illness and provide extra food after illness to help him/her recover quickly.

Appendix 8a. Counselling Stories for Food Intake (6 up to 24 Months) Job Aid Practice

Story 1:

Child is 15 months old. Healthy, growing well, and eating normally. Breastfeeds frequently.

- Early morning: Breastfeed, half-bowl of thick porridge, milk, and level teaspoon of sugar.
 - Mid-morning: Small piece of bread with nothing on it, breastfeed.
 - Mid-day: Three tablespoons of rice, two tablespoons of mashed beans ($\frac{3}{4}$ bowl), pieces of mango ($\frac{1}{4}$ bowl), drink of water.
 - Mid-afternoon: Breastfeed, one small biscuit.
 - Evening: Two tablespoons of rice, one tablespoon of mashed fish, two tablespoons of green vegetables ($\frac{3}{4}$ 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 juice.
 - Mid-day: Thin soup, one spoon of rice, and one spoon of mashed beans (half-bowl), drink of water.
 - Mid-afternoon: Biscuit, half-cup of cow's milk.
 - Evening: Two spoons of rice, one spoon of mashed meat and vegetable from family meal (half-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 gruel 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), half-cup of diluted fruit juice.
- Mid-afternoon: Large piece of bread with jam, breastfeed.
- Evening: Whole mashed banana, one biscuit, cup of fruit juice.

- Bedtime: Breastfeed.
 - During the night: Breastfeed.
-

Story 4:

Child is 12 months old. Growing very slowly.

- Early morning: Breastfeed, half-bowl of thin porridge.
 - Mid-morning: Two teaspoons of mashed banana, breastfeed.
 - Mid-day: Four spoons of thin soup, one spoon of mashed meat/vegetables/potato from the soup ($\frac{3}{4}$ bowl), breastfeed.
 - Mid-afternoon: Breastfeed, two spoons mashed mango.
 - Evening: Two spoons of mashed meat/vegetable/potato from family meal (less than half-bowl), breastfeed.
 - Bedtime: Breastfeed, biscuit mashed in cow's milk ($\frac{1}{4}$ cup).
 - During the night: Breastfeed.
-

Story 5:

Child is 6½months old and healthy. Growing well. Easy to feed. Has recently started complementary foods.

- Early morning: Breastfeed.
 - Mid-morning: Three spoons of thin porridge with milk, breastfeeds.
 - Mid-day: Breastfeed.
 - Mid-afternoon: Breastfeed.
 - Evening: Three spoons of mashed family meal: potato, fish, carrots. Thick consistency.
 - Bedtime: Breastfeed.
 - During night: Breastfeed.
-

Story 6:

Child is 8 months old. Not ill. Does not show much interest in eating.

- Early morning: Breastfeed, two spoons of thin porridge with milk and sugar (less than half-bowl).
- Mid-morning: Breastfeed.
- Mid-day: One spoon of rice, one spoon of mashed beans, small piece of egg, one spoon of mashed green vegetables from the family meal (half-bowl), drink of water.
- Mid-afternoon: One biscuit, breastfeed.
- Evening: One piece of bread with some butter, breastfeed.

- Bedtime: Breastfeed.
- During the night: Breastfeed.

Appendix 9a. Counselling Stories for Practice Using *Counselling Cards* and Role-Play with Scenarios for HIV Counselling

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 that 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 about 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 breastfeeding your second baby. He is 2 months old. You were tested during your pregnancy 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 are experiencing pain in your breast and sometimes your nipples feel cracked.
 - You also don't think you are able to provide enough milk for your baby.
 - Your mother receives a small pension. Your sister works part-time as a domestic worker.
 - Neither you nor your partner is 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 breastfeeding your third baby who is 1 month old. You found out you were HIV-positive when you were 28 weeks pregnant.
 - You work as a clerk in an office. But you have three months of maternity leave 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 breastmilk only for the first four weeks and then giving them breastmilk and commercial infant formula when you went back to work. You introduced solid food at three months, while continuing to breastfeed at night until they were about 1 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.”

Appendix 10. Planning Guide for a Group Demonstration on 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 Points

Select one to three Key Points for Complementary Feeding (Appendix 5) to say to mothers. 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 two or three pairs of mothers 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; mash a potato; add the correct quantity of fish or egg, etc.; add the correct quantity of milk or water.
- Point out the consistency of the preparation as the mothers are making it, and demonstrate with a spoon when they are finished.
- Reinforce the use of local, inexpensive, and nutritious ingredients, especially using foods from the family pot.
- Ask the mothers 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.
- Invite the mothers who prepared the food to taste it in front of the rest of the participants 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 Points 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 (for example, tomorrow).
- You may repeat the Key Points and checking questions again.

Conclude the demonstration

- Thank the mothers for coming and participating.
- Ask the mothers to share their new knowledge of preparing this food with a neighbour who has small children.
- Invite mothers to visit the health facility for nutrition counselling and growth checks.

Appendix 11. Recipes for the Food Demonstration

Fill in the foods and the amounts needed.

Recipe 1

Family food for a 10-month-old child's main course
(about $\frac{1}{2}$ 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: One 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. Add only 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: One teaspoon (small spoon)

- Wash hands and use clean surface, plates, and utensils.
- Cut the cooked foods into small pieces or slightly mash them together (depending on the child's age).
- Add the oil or margarine and mix well.

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.

If there is need to increase the amounts of food for each meal, instruct the participants to make the change in their recipes.

Appendix 12. Growth Monitoring and Nutritional Assessment

Healthy and well-nourished young children grow steadily. However, parents/caregivers cannot always tell just by looking at the child, whether the child is growing at a normal rate or not. One way to find out if the child is growing well is to weigh the child regularly and identify if the child is gaining weight or not. If children are not growing well, parents/caregivers and communities can take action to help the children grow better.

The regular weighing and plotting of a child's weight on the growth chart to decide if the child is gaining enough weight or not is called growth monitoring. Using the information gained from growth monitoring to take action to make sure that children grow well (when counselling mothers and caretakers) is called growth promotion.

Growth Monitoring (GM) is the process of regularly weighing and plotting a child's weight on the growth chart to assess growth adequacy and identify early faltering.

Growth Monitoring and Promotion (GMP) is a preventive and promotional activity comprised of GM linked with promotion (usually counselling) that increases awareness about child growth and the importance of nutrition; improves caring practices; and increases demand for other health services as needed. GMP often serves as the core activity in an integrated child health and nutrition program. As an intervention, it is designed to improve family-level decisions and individual child health and nutritional outcomes.

Why is a child weighed?

The nutritional status of a child should be determined by two methods: the weight measurement, and the height measurement. The commonly used indexes to determine the nutritional status are: weight-for-age, height-for-age, and weight-for-height. For growth and promotion surveillance, the index used is weight-for-age.

The weighing enables health workers and parents to know if the child is growing or faltering. Regular growth monitoring (weighing) allows monitoring and protection of the nutritional and health status of the child. A sick or poorly fed and malnourished child does not gain an adequate amount of weight or actually loses weight. This is called growth faltering.

Measuring a child's growth regularly is a means to know about his or her nutritional and health status. The child's growth should be measured in different ways. Taking the child's weight is the simplest and most common measure for young children. Adequate weight gain is an indicator that a child is growing well

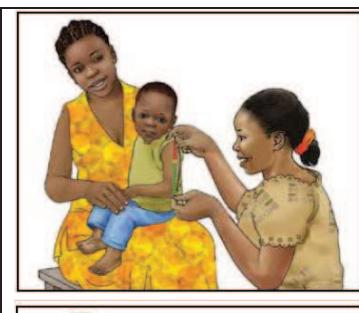
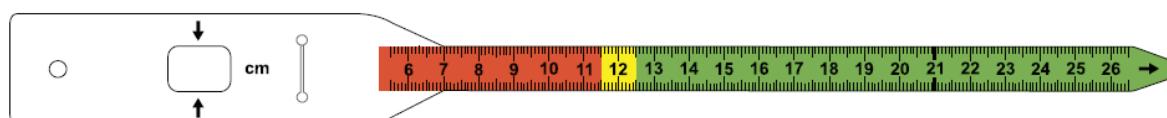
Why is a child's length measured?

Children who suffer from chronic undernourishment (in terms of protein-energy consumption), or chronic malnutrition, and are short for their age, are simply defined as stunted. Stunting reflects failure to receive adequate nourishment over a long period of time and may also be caused by chronic or recurrent illnesses. The height of a child is compared to his/her age. Height-for-age is an indicator of nutritional status, and is used to identify stunted children. Children whose height-for-age is below -2 standard deviations from the median are classified as moderately stunted. Those whose height-for-age is below -3SD from the median are classified as severely stunted.

Why is a child's MUAC taken?

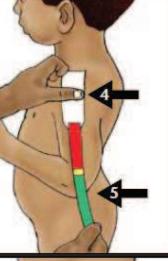
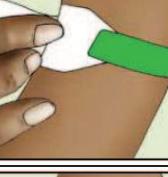
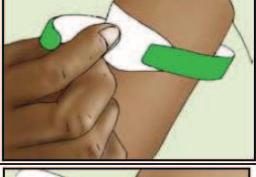
Taking a child's mid-upper arm circumference (MUAC) measurement can be applied to rapid triage settings, especially where quick assessment of children is needed. MUAC measurement uses a tri-coloured band (green, yellow, and red) measuring tape that is positioned around the mid-upper arm. Position and placement of the tape are critical so that proper correlation can be made with the protein composition and lean tissue mass. MUAC measurement can be used as a screening criteria for referral to a health centre or admission to an outpatient therapeutic feeding centre.

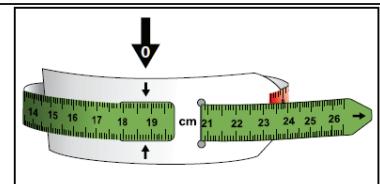
Using a MUAC Tape for Nutritional Assessment



- MUAC stands for 'mid-upper arm circumference' tape.
- A MUAC measurement can be used for nutritional assessment of infants from 6 months and children up to 5 years of age.
- MUAC is simple to use and requires no reference to age or height.
- MUAC cut-off points or colour zones are used to classify acute malnutrition.
 - The red colour of the MUAC tape indicates severe acute malnutrition (SAM).
 - The yellow colour indicates moderate acute malnutrition (MAM).
 - The green colour indicates mild or no malnutrition.

Steps to Accurately Use a MUAC Tape

	1. Bend left arm at an angle of 90 degrees.
	2. Locate tip of shoulder. 3. Locate tip of elbow.
	4. Place tape at 0 cm at tip of shoulder. 5. Pull tape past tip of bent elbow and read length of upper arm.
	6. Determine mid-point by either: <ul style="list-style-type: none">• Folding the tape in half from "0" to the measured length of upper arm, OR• Calculating. 7. Mark mid-point using finger or pen.
	8. Straighten arm and place MUAC tape around the mid-point. 9. Place MUAC tape through 'window' of tape, and correct the tape tension.
	Tape too loose.
	Tape too tight.



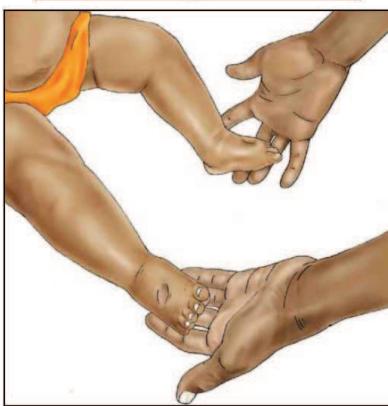
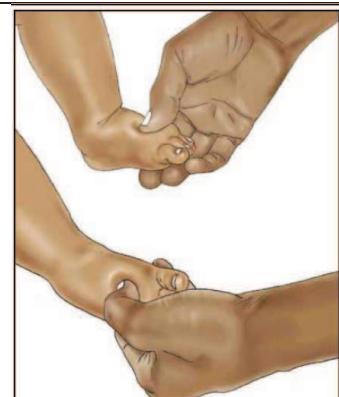
10. Read the cm measurement in the window at arrow.
11. Record measurement and the colour zone observed.

10 Steps for Weighing Children up to 25 Kgs

 	<ol style="list-style-type: none"> 1. Hook the scale to a tree, a tripod, or a sturdy horizontal beam so that the scale hangs at eye level. 2. Suspend the weighing pants from the lower hook of the scale and readjust the scale to zero. 3. Undress the child and place in the weighing pants. 4. Make sure one of the child's arms passes in between the straps, to prevent him or her from falling. 5. Hook the pants to the scale. 6. Ensure that the child hangs freely without holding onto anything. 7. When the child is settled and the weight reading is stable, record the weight to the nearest 0.1kg. 8. Read and announce the value from the scale. The mother or an assistant should repeat the value for verification. Record the weight immediately. 9. Plot the weight on the child's growth chart. 10. Discuss with the mother the actual change in weight and the expected change in weight, and, most importantly, the growth curve's trend.
	

Initial or Previous Month's Weight	Minimum Expected Weight Gain Per Month
<5 Kg	0.5 Kg
5–7 Kg	0.4 Kg
7–9 Kg	0.3 Kg
9–12 Kg	0.2 Kg
>12 Kg	0.1 Kg

How to Assess for Bilateral Pitting Oedema



1. Oedema is of nutritional significance only if it is bilateral and starts from the feet.
2. Apply firm pressure with your thumbs to both feet for three full seconds; then remove your thumbs.
3. Make an assessment of the grade (or seriousness) of the oedema.
 - Grade 1 (+): is when a depression persists on both feet. This indicates that the patient has bilateral pitting oedema.
 - Grade 2 (++): is when the feet are oedematous, and when you repeat the process by pressing the thumb into the leg, a depression persists.
 - Grade 3 (+++): is when the leg is oedematous, and when you repeat the process by pressing the thumb into the forehead, a depression persists.
4. If an infant or young child is found to have bilateral pitting oedema, you should refer immediately to the health clinic for an evaluation and treatment.

