





## INFANT AND YOUNG CHILD FEEDING

**Trainers' Guide** August 2016





## INFANT AND YOUNG CHILD FEEDING

Trainers' Guide







#### भारत सरकार स्वास्थ्य एवं परिवार कल्याण मंत्रालय निर्माण भवन, नई दिल्ली - 110011

Government of India Ministry of Health and Family Welfare Nirman Bhavan, New Delhi - 110011



सी.के. मिश्रा सचिव **C.K. Mishra** Secretary Tel: 011-23061863, Fax: 011-23061252 E-mail: secyhfw@gmail.com

#### **Preface**

Delivering quality healthcare in a timely manner through public health facilities is one of the main goals of the National Health Mission (NHM). For this to happen, it is of paramount importance to augment the knowledge and skills of healthcare providers to deliver quality services in essential maternal and newborn healthcare practices.

Infant and Young Child Feeding (IYCF) is a set of well-known, common and scientific recommendations for appropriate feeding of newborn and children under two years of age. The first two years of life provide a critical window of opportunity for ensuring children's optimal growth and development through adoption of correct infant and child feeding practices. It is a known fact that onset of undernutrition among Indian children occurs early, and undernutrition levels attain peak at 24 months of age. This high burden clearly shows the need for accentuating efforts towards attainment of improved rates of optimal infant and young child feeding practices in the country.

The importance of support to the mother, within the families and at health facilities, is essential towards achieving higher rates of breastfeeding. Skill building of health workers for IYCF is essential to equip them to protect breastfeeding, handle various breastfeeding challenges, counsel on issues such as 'not able to produce enough milk', correct positioning, complementary feeding, growth monitoring, etc.

It has been decided to implement a nationwide programme named 'MAA' (Mothers' Absolute Affection) across States/UTs, starting from August 2016 to give impetus to optimal IYCF practices. I am delighted that the Child Health Division, with support from Breastfeeding Promotion Network of India (BPNI) and UNICEF, has developed a 'National training module on Infant and Young Child Feeding' to be used for capacity building of healthcare providers under 'MAA' Programme. I am sure that this training module will serve as a comprehensive resource material for learning key IYCF skills and improve delivery of IYCF counselling at health facilities in the country.

C.K. Mishra







#### भारत सरकार स्वास्थ्य एवं परिवार कल्याण मंत्रालय निर्माण भवन, नई दिल्ली - 110011

Government of India Ministry of Health and Family Welfare Nirman Bhavan, New Delhi - 110011



वन्दना गुरनानी, भा.प्र.से. संयुक्त सचिव Vandana Gurnani, IAS Joint Secretary Tel: 011-23061706 E-mail: vandana.g@ias.nic.in

#### **Foreword**

With high rates of undernutrition, 38 per cent children being stunted (RSOC, 2014), and high burden of preventable causes of under-five deaths such as pneumonia and diarrhoea, promotion of optimal Infant and Young Child Feeding practices remains a priority area for intensification under National Health Mission. Malnutrition is also the underlying cause of around half of under-five deaths in the country. This high burden clearly calls for focus on efforts to promote Infant and Young Child Feeding Practices by States/UTs.

Breastfeeding is an important child survival intervention. Breastfeeding within an hour of birth can prevent 20 per cent of newborn deaths. Babies, who are exclusively breastfed in the first six months of age, are 11 times less likely to die from diarrhoea and 15 times less likely to die from pneumonia, two leading causes of death in children under-five years of age. However, in India, as per recent survey (RSOC 2014), only 44.6 per cent mothers initiate breastfeeding within one hour of birth despite of the fact that about 78.7 per cent deliver in institutions. Further, 64.9 per cent babies are exclusively breastfed in the first six months of age.

The National Health Mission provides a valuable opportunity to bring greater attention and commitment to promote IYCF interventions through the health system, both at the health facility and community outreach levels. ASHA has been the frontrunner for taking messages to the community and thus has contributed towards improving the rates of breastfeeding. Counsellors have also been deployed at all high case load facilities for counselling on Reproductive, Maternal, Newborn, Child, and Adolescent Health (RMNCH+A) issues. Various other interventions have also been designed under the nationwide 'MAA' (Mothers' Absolute Affection) Programme to give an impetus to rates of breastfeeding and child feeding in the country, being launched in August 2016.

Now that high rates of contact of pregnant and lactating mothers with healthcare facilities, and with ASHA is being achieved under the National Health Mission, skill building of frontline workers is of foremost importance. I congratulate Child Health Division for developing this National IYCF training module for healthcare providers especially ANMs and nurses, through consultations with Breastfeeding Promotion Network of India (BPNI) and UNICEF.

I am confident that by using this training module, doctors, nurses, and other service providers will be able to play a key role in taking the IYCF programme forward.

Vandana Gurnani







#### भारत सरकार स्वास्थ्य एवं परिवार कल्याण मंत्रालय निर्माण भवन, नई दिल्ली - 110011

Government of India Ministry of Health and Family Welfare Nirman Bhavan, New Delhi - 110011



Dr. Ajay Khera
M.B.B.S., D.G.O., M.D. (Public Health)
Deputy Commissioner
Child Health In-charge
Telefax: 91-11-23061281
E-mail: dcmch-mohfw@nic.in,
ajaykheramch@gmail.com

#### **Acknowledgement**

The healthcare providers both in the facility and community play a major contribution in supporting breastfeeding practices at the time of delivery and maintaining exclusive breastfeeding for six months after birth. During a yearlong 'MAA' (Mothers' Absolute Affection) Programme under National Health Mission, all the healthcare providers are to be skilled in provision of quality counselling and support to mothers for breastfeeding.

A four days training program for healthcare providers both in facility and community has been prepared with support from various stakeholders. The contribution of UNICEF, Breastfeeding Promotion Network of India (BPNI) and Child Health Division of Ministry of Health and Family welfare is acknowledged in finalizing the training program. Dr. M.M.A. Faridi, University College of Medical Sciences, Dr. Satinder Aneja, Lady Hardinge Medical College, Dr. Praveen Kumar, LHMC are the key technical resource persons for this training module. The contribution of Dr. Sila Deb, Deputy Commissioner and Dr. Ruchika Arora, Consultant Child Health is highly appreciated.

Dr. Ajay Khera

EXPERTS WHO
CONTRIBUTED
IN PREPARATION
OF THIS
TRAINERS'
GUIDE ON IYCF

Shri. C.K. Mishra, IAS	Secretary	Ministry of Health and Family Welfare
Ms. Vandana Gurnani, IAS	Joint Secretary, RCH	Ministry of Health and Family Welfare
Dr. Ajay Khera	Deputy Commissioner, Child Health In-charge	Ministry of Health and Family Welfare
Dr. Sila Deb	Deputy Commissioner, Child Health	Ministry of Health and Family Welfare
Dr. Ruchika Arora	Consultant, Child Health	Ministry of Health and Family Welfare
Dr. Gayatri Singh	Child Development Specialist	UNICEF
Ms. Rachana Sharma	Communication for Development Specialist	UNICEF

Prof. (Dr.) K.P. Kushwaha MD, FIAP Retired, Principal & Dean Professor and Head, Department of Pediatrics BRD Medical College, Gorakhpur	Prof. (Dr.) M.M.A. Faridi MD, DCH, MNAMS, FIAP Director, Professor and Head, Department of Pediatrics, University College of Medical Sciences & GTB Hospital, New Delhi
<b>Dr. J.P. Dadhich</b> MD, FNNF National Coordinator, BPNI	<b>Mr. P.K. Sudhir</b> Dy. Tech. Advisor, FNB (Rtd)
Dr. Ajay Gaur Associate Professor & HOD Department of Pediatrics, G.R. Medical College, Gwalior	<b>Dr. Ramneek Sharma</b> Chairperson Surya Foundation, Chandigarh
Dr. Anita Gupta Chief Medical Officer (SAG) Department of Community Medicine University College of Medical Sciences & GTB Hospital, New Delhi	Dr. Pardeep Khanna Sr. Professor & HOD (Community medicine) Pt.BD Sharma PGIMS Rohtak
<b>Dr. K. Kesavulu</b> Medical Superintendent Government District Hospital Hindupur, Andhra Pradesh	Dr. Rajinder Gulati Senior Medical Officer (Pediatrics), Punjab Civil Medical Services Civil Hospital, Raikot, Ludhiana (Punjab)
<b>Dr. Sangeeta Rani</b> Chief Medical Officer (SAG) Guru Gobind Singh Government Hospital Raghubir Nagar, Delhi	

### **CONTENTS**

Introduction of the Middle Level Trainers' Guide		01
Session 1	Why Optimal Infant and Young Child Feeding	
Session 2	Production and Intake of Breastmilk	15
Session 3	Assessing and Observing a Breastfeed	23
Session 4	Listening and Learning	47
Session 5	Building Confidence, Giving Support and Checking Understanding	61
Session 6	Hospital Practices and Baby Friendly Initiative	73
Session 7	Positioning Baby at the Breast	85
Session 8	Breast Conditions	95
Session 9	Refusal to Breastfeed and Crying	103
Session 10	Expressing Breastmilk	111
Session 11	Not Enough Milk	119
Session 12	Breastfeeding Low Birth Weight Babies and Twins	131
Session 13	Complementary Feeding: Foods to Fill the Nutrient Gap	139
Session 14	Feeding Techniques and Strategies	155
Session 15	Institutionalizing Skilled Infant and Young Child Feeding Counselling	169
Session 16	Nutrition for Lactating Mothers and their Health and Fertility	175
Session 17	Breastfeeding by Working Mothers	181
Session 18	Breastfeeding in Special Circumstances (Specially HIV and Infant Feeding)	187
Session 19	Clinical Practice 1 Listening and Learning, Confidence Building, Giving Support, Assessing a Breastfeed and Positioning a Baby at the Breast	193
Session 20	Clinical Practice 2 Listening and Learning, Building confidence, Giving Support Counselling for Complementary Feeding	203
Session 21	Infant Milk Substitutes (IMS) Act	207
Session 22	Growth Monitoring and Measuring	213
Session 23	Growth Monitoring by Growth Charts	219
Session 24	Measuring Growth: Taking Action	225
Session 25	Clinical Practice 3 Measuring Weight and Length, Counselling for Infant Feeding	229
Session 26	Practice 1 Preparation of Complementary Feed	233
Session 27	Practice 2 Preparation of replacement Feed	237

Session 1 Why Optimal Infant and Young Child Feeding 15 Session 2 Production and Intake of Breastmilk 23 Session 3 Assessing and Observing a Breastfeed 33 Session 6 Hospital Practices and Baby Friendly Initiative 75 Session 7 Positioning Baby at the Breast 85 Session 7 Positioning Baby at the Breast 85 Session 8 Breast Conditions 95 Session 10 Expressing Breastmilk 111 Session 11 Not Enough Milk 111 Session 12 Breastfeeding Low Birth Weight Babies Twins 131 Session 18 Breastfeeding by Working Mothers 181 Session 18 Breastfeeding by Working Mothers 181 Session 18 Breastfeeding Bepecial Circumstances (Specially HIV and Infant Feeding) 187 Complementary Feeding 199 Session 18 Complementary Feeding: Foods to Fill the Nutrient Gap 139 Session 19 Complementary Feeding: Foods to Fill the Nutrient Gap 139 Session 14 Feeding Techniques and Strategies 155 Counselling Skills Session 4 Listening and Learning 47 Session 5 Building Confidence, Giving Support and Checking Understanding 61 Clinical Practice 1 Listening and Learning, Confidence Building, Giving Support Assessing a Breastfeed and Positioning a Baby at the Breast 198 Session 20 Clinical Practice 2 Listening and Learning, Confidence, and Giving Support 203 Session 25 Clinical Practice 1 2 Listening and Learning, Confidence, and Giving Support 203 Session 26 Practice 1 Practice 1 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2	COURSE AT	A GLANCE	
Session 1 Why Optimal Infant and Young Child Feeding 15 Session 2 Production and Intake of Breastmilk 23 Session 3 Assessing and Observing a Breastfeed 33 Session 6 Hospital Practices and Baby Friendly Initiative 73 Session 7 Positioning Baby at the Breast 85 Session 8 Breast Conditions 95 Session 10 Expressing Breastmilk 111 Session 11 Not Enough Milk 111 Session 12 Breastfeeding Low Birth Weight Babies Twins 131 Session 13 Breastfeeding by Working Mothers 181 Session 14 Breastfeeding in Special Circumstances (Specially HIV and Infant Feeding) 187 Complementary Feeding 185 Session 18 Breastfeeding in Special Circumstances (Specially HIV and Infant Feeding) 187 Complementary Feeding 185 Session 14 Feeding Techniques and Strategies 165 Counselling Skills Session 14 Istening and Learning 47 Session 5 Building Confidence, Giving Support and Checking Understanding 61 Clinical Sessions 19 Clinical Practice 1 Listening and Learning, Confidence Building, Giving Support Assessing a Breastfeed and Positioning a Baby at the Breast 183 Session 25 Clinical Practice 2 Listening and Learning, Building Confidence, and Giving Support 203 Session 26 Clinical Practice 3 Practice 1 Practice 1 Clinical Practice 2 Listening and Learning, Building Confidence, and Giving Support 203 Counselling for Complementary Feeding 229 Practical Sessions 25 Practice 1 Preparation of Complementary Feeding 229 Practical Session 26 Preparation of Complementary Feeding 233 Session 27 Practice 2 Preparation of Replacement Feed 233 Session 9 Refusal to Breastfeed and Crying 103 Session 15 Institutionalizing Skilled Infant and Young Child Feeding Counselling 169 Session 17 IMS Act 207 Session 23 Growth Monitoring and Measuring 213 Session 23 Growth Monitoring by Growth Charts 219			
Session 2 Production and Intake of Breastmilk 23 Session 3 Assessing and Observing a Breastfeed 33 Session 6 Hospital Practices and Baby Friendly Initiative 73 Session 7 Positioning Baby at the Breast 85 Session 8 Breast Conditions 95 Session 10 Expressing Breastmilk 111 Session 11 Not Enough Milk 1119 Session 12 Breastfeeding Low Birth Weight Babies Twins 131 Session 13 Breastfeeding by Working Mothers 181 Session 18 Breastfeeding in Special Circumstances (Specially HIV and Infant Feeding) 187 Complementary Feeding 185 Session 19 Complementary Feeding: Foods to Fill the Nutrient Gap 139 Session 10 Expressing Techniques and Strategies 155 Counselling Skills Session 14 Feeding Techniques and Strategies 155 Counselling Skills Session 5 Building Confidence, Giving Support and Checking Understanding 61 Clinical Sessions Clinical Practice 1 Listening and Learning, Confidence Building, Giving Support Assessing a Breastfeed and Positioning a Baby at the Breast 193 Session 25 Clinical Practice 2 Listening and Learning, Building Confidence, and Giving Support Counselling for Complementary Feeding 229 Practical Sessions Session 26 Practice 1 Preparation of Complementary Feeding 229 Practical Sessions Session 27 Practice 1 Preparation of Complementary Feed 233 Miscellaneous Session 9 Refusal to Breastfeed and Crying 103 Session 15 Institutionalizing Skilled Infant and Young Child Feeding Counselling 103 Session 15 Institutionalizing Skilled Infant and Young Child Feeding Counselling 103 Session 15 Institutionalizing Skilled Infant and Young Child Feeding Counselling 103 Session 19 INS Act 207 Session 20 Growth Monitoring and Measuring 213 Session 23 Growth Monitoring by Growth Charts 219			15
Session 3 Assessing and Observing a Breastfeed 33 Session 6 Hospital Practices and Baby Friendly Initiative 73 Session 7 Positioning Baby at the Breast 85 Session 8 Breast Conditions 95 Session 10 Expressing Breastmilk 111 Session 11 Not Enough Milk 119 Session 12 Breastfeeding Low Birth Weight Babies Twins 131 Session 13 Breastfeeding in Special Circumstances (Specially HIV and Infant Feeding) 187 Complementary Feeding 18 Session 18 Breastfeeding in Special Circumstances (Specially HIV and Infant Feeding) 187 Complementary Feeding 5 Session 13 Complementary Feeding: Foods to Fill the Nutrient Gap 139 Session 14 Feeding Techniques and Strategies 155 Counselling Skills Session 4 Listening and Learning 47 Session 5 Building Confidence, Giving Support and Checking Understanding 17 Clinical Sessions Clinical Practice 1 Listening and Learning, Confidence Building, Giving Support Assessing a Breastfeed and Positioning a Baby at the Breast 2 Session 20 Clinical Practice 2 Listening and Learning, Building Confidence, and Giving Support 203 Counselling for Complementary Feeding 229 Practical Sessions Session 26 Practice 1 Preparation of Complementary Feeding 233 Measuring Weight and Length; Counselling for Infant Feeding 233 Miscellaneous Session 9 Practice 1 Preparation of Replacement Feed 233 Miscellaneous 19 Session 15 Institutionalizing Skilled Infant and Young Child Feeding Counselling Session 15 Institutionalizing Skilled Infant and Young Child Feeding Counselling 169 Session 15 Institutionalizing Skilled Infant and Young Child Feeding Counselling 169 Session 21 IMS Act 207 Session 22 Growth Monitoring and Measuring 213 Session 23 Growth Monitoring by Growth Charts 219		,	
Session 6 Hospital Practices and Baby Friendly Initiative 73 Session 7 Positioning Baby at the Breast 85 Session 8 Breast Conditions 95 Session 10 Expressing Breastmilk 111 Session 11 Not Enough Milk 119 Session 12 Breastfeeding Low Birth Weight Babies Twins 118 Session 13 Breastfeeding by Working Mothers 1181 Session 18 Breastfeeding by Working Mothers 1181 Session 18 Breastfeeding by Working Mothers 1181 Session 18 Breastfeeding in Special Circumstances (Specially HIV and Infant Feeding) 187 Complementary Feeding Session 1 Complementary Feeding: Foods to Fill the Nutrient Gap 139 Session 14 Feeding Techniques and Strategies 155 Counselling Skills Session 4 Listening and Learning 161 Cilnical Sessions 18 Building Confidence, Giving Support and Checking Understanding 161 Cilnical Session 5 Building Confidence, Giving Support and Checking Understanding 161 Cilnical Practice 1 Listening and Learning, Confidence Building, Giving Support 182 Session 19 Cilnical Practice 1 Listening and Learning, Confidence Building, Giving Support 183 Session 20 Cilnical Practice 2 Listening and Learning, Building Confidence, and Giving Support 183 Session 20 Cilnical Practice 2 Listening and Learning, Building Confidence, and Giving Support 183 Session 25 Counselling for Complementary Feeding 183 Session 26 Practice 1 Preparation of Complementary Feeding 183 Session 27 Practice 2 Preparation of Replacement Feed 183 Session 9 Refusal to Breastfeed and Crying 103 Session 15 Institutionalizing Skilled Infant and Young Child Feeding Counselling 103 Session 15 Institutionalizing Skilled Infant and Young Child Feeding Counselling 103 Session 21 IMS Act 103 Session 23 Growth Monitoring and Measuring 119 Session 23 Growth Monitoring by Growth Charts 119			
Session 7 Positioning Baby at the Breast Session 8 Breast Conditions Session 10 Expressing Breastmilk Session 11 Not Enough Milk Session 12 Breastfeeding Low Birth Weight Babies Twins Session 17 Breastfeeding by Working Mothers Session 18 Breastfeeding in Special Circumstances (Specially HIV and Infant Feeding) Session 18 Breastfeeding in Special Circumstances (Specially HIV and Infant Feeding) Session 18 Breastfeeding reeding: Foods to Fill the Nutrient Gap Session 19 Feeding Techniques and Strategies Session 14 Feeding Techniques and Strategies Session 14 Feeding Techniques and Strategies Session 15 Building Confidence, Giving Support and Checking Understanding Clinical Sessions Clinical Practice 1 Listening and Learning, Confidence Building, Giving Support Assessing a Breastfeed and Positioning a Baby at the Breast Clinical Practice 2 Listening and Learning, Building Confidence, and Giving Support Counselling for Complementary Feeding Session 25 Clinical Practice 3 Measuring Weight and Length; Counselling for Infant Feeding Practical Sessions Session 26 Practice 1 Preparation of Complementary Feed Session 27 Practice 2 Preparation of Complementary Feed Session 28 Refusal to Breastfeed and Crying Session 9 Refusal to Breastfeed and Crying Session 9 Refusal to Breastfeed and Crying Session 9 Refusal to Breastfeed and Crying Session 19 Nutrition of Lactating Mothers and their Health and Fertility 175 Session 21 IMS Act 207 Session 22 Growth Monitoring and Measuring Session 23 Growth Monitoring by Growth Charts			
Session 8 Breast Conditions 95 Session 10 Expressing Breastmilk 111 Session 11 Not Enough Milk 119 Session 12 Breastfeeding Low Birth Weight Babies Twins 131 Session 17 Breastfeeding by Working Mothers 181 Session 18 Breastfeeding in Special Circumstances (Specially HIV and Infant Feeding) 187 Complementary Feeding 19 Session 13 Complementary Feeding: Foods to Fill the Nutrient Gap 139 Session 14 Feeding Techniques and Strategies 155 Counselling Skills Session 4 Listening and Learning 47 Session 5 Building Confidence, Giving Support and Checking Understanding 61 Clinical Sessions  Clinical Practice 1 Listening and Learning, Confidence Building, Giving Support Assessing a Breastfeed and Positioning a Baby at the Breast 20 Session 20 Clinical Practice 2 Listening and Learning, Building Confidence, and Giving Support 20 Session 25 Clinical Practice 3 Measuring Weight and Length; Counselling for Infant Feeding 229 Practical Sessions  Session 26 Practice 1 Preparation of Complementary Feed 237 Ression 27 Practice 2 Preparation of Replacement Feed 237 Miscellaneous  Session 9 Refusal to Breastfeed and Crying 103 Session 15 Institutionalizing Skilled Infant and Young Child Feeding Counselling 103 Session 15 Institution of Lactating Mothers and their Health and Fertility 175 Session 21 IMS Act 207 Session 23 Growth Monitoring and Measuring 2213 Session 23 Growth Monitoring by Growth Charts 2219			
Session 10 Expressing Breastmilk 111 Session 11 Not Enough Milk 119 Session 12 Breastfeeding Low Birth Weight Babies Twins 131 Session 17 Breastfeeding by Working Mothers 181 Session 18 Breastfeeding in Special Circumstances (Specially HIV and Infant Feeding) 187 Complementary Feeding 189 Session 13 Complementary Feeding: Foods to Fill the Nutrient Gap 139 Session 14 Feeding Techniques and Strategies 155 Counselling Skills Session 15 Building Confidence, Giving Support and Checking Understanding 161 Clinical Sessions 19 Listening and Learning, Confidence Building, Giving Support 193 Session 19 Listening and Learning, Confidence Building, Giving Support 193 Assessing a Breastfeed and Positioning a Baby at the Breast 193 Session 20 Listening and Learning, Building Confidence, and Giving Support 203 Counselling for Complementary Feeding 229 Session 25 Clinical Practice 3 Measuring Weight and Length; Counselling for Infant Feeding 229 Practical Sessions Session 26 Practice 1 Preparation of Complementary Feed 233 Session 27 Practice 2 Preparation of Replacement Feed 237 Miscellaneous Session 19 Refusal to Breastfeed and Crying 103 Session 10 Nutrition of Lactating Mothers and their Health and Fertility 175 Session 21 IMS Act 207 Session 23 Growth Monitoring by Growth Charts 219			
Session 11 Not Enough Milk 131 Session 12 Breastfeeding Low Birth Weight Babies Twins 131 Session 17 Breastfeeding by Working Mothers 181 Session 18 Breastfeeding in Special Circumstances (Specially HIV and Infant Feeding) 187 Complementary Feeding Session 13 Complementary Feeding: Foods to Fill the Nutrient Gap 139 Session 14 Feeding Techniques and Strategies 155 Counselling Skills Session 4 Listening and Learning 47 Session 5 Building Confidence, Giving Support and Checking Understanding 61 Clinical Sessions Clinical Practice 1 Listening and Learning, Confidence Building, Giving Support Assessing a Breastfeed and Positioning a Baby at the Breast 193 Session 20 Clinical Practice 2 Listening and Learning, Building Confidence, and Giving Support Counselling for Complementary Feeding 229 Practical Sessions Session 25 Clinical Practice 3 Measuring Weight and Length; Counselling for Infant Feeding 229 Practical Sessions Session 27 Practice 1 Preparation of Complementary Feed 233 Session 27 Practice 2 Preparation of Replacement Feed 237 Miscellaneous Session 9 Refusal to Breastfeed and Crying 103 Session 15 Institutionalizing Skilled Infant and Young Child Feeding Counselling 169 Session 16 Nutrition of Lactating Mothers and their Health and Fertility 175 Session 22 Growth Monitoring and Measuring 213 Session 23 Growth Monitoring by Growth Charts 219	0000.0		
Session 12 Breastfeeding Low Birth Weight Babies Twins 181 Session 17 Breastfeeding by Working Mothers 181 Session 18 Breastfeeding in Special Circumstances (Specially HIV and Infant Feeding) 187 Complementary Feeding Session 13 Complementary Feeding: Foods to Fill the Nutrient Gap 139 Session 14 Feeding Techniques and Strategies 155 Counselling Skills Session 4 Listening and Learning 47 Session 5 Building Confidence, Giving Support and Checking Understanding 61 Clinical Sessions Clinical Practice 1 Listening and Learning, Confidence Building, Giving Support Assessing a Breastfeed and Positioning a Baby at the Breast 193 Session 20 Clinical Practice 2 Listening and Learning, Building Confidence, and Giving Support Counselling for Complementary Feeding 229 Session 25 Clinical Practice 3 Measuring Weight and Length; Counselling for Infant Feeding 229 Practical Sessions Session 26 Practice 1 Preparation of Complementary Feed 233 Session 27 Practice 2 Preparation of Replacement Feed 237 Miscellaneous Session 9 Refusal to Breastfeed and Crying 103 Session 15 Institutionalizing Skilled Infant and Young Child Feeding Counselling 169 Session 16 Nutrition of Lactating Mothers and their Health and Fertility 175 Session 22 Growth Monitoring and Measuring 213 Session 23 Growth Monitoring by Growth Charts 219			
Session 17 Breastfeeding by Working Mothers  Session 18 Breastfeeding in Special Circumstances (Specially HIV and Infant Feeding)  Session 13 Complementary Feeding: Foods to Fill the Nutrient Gap  Session 14 Feeding Techniques and Strategies  155  Counselling Skills  Session 4 Listening and Learning  Session 5 Building Confidence, Giving Support and Checking Understanding  Clinical Sessions  Clinical Practice 1 Listening and Learning, Confidence Building, Giving Support Assessing a Breastfeed and Positioning a Baby at the Breast  Clinical Practice 2 Listening and Learning, Building Confidence, and Giving Support Counselling for Complementary Feeding  Session 25 Clinical Practice 3 Measuring Weight and Length; Counselling for Infant Feeding  Practical Sessions  Session 26 Practice 1 Preparation of Complementary Feed  Session 27 Practice 2 Preparation of Replacement Feed  Miscellaneous  Session 9 Refusal to Breastfeed and Crying Session 15 Institutionalizing Skilled Infant and Young Child Feeding Counselling Session 16 Nutrition of Lactating Mothers and their Health and Fertility 175 Session 22 Growth Monitoring and Measuring Session 23 Growth Monitoring by Growth Charts 219			
Session 18 Breastfeeding in Special Circumstances (Specially HIV and Infant Feeding)  Complementary Feeding  Session 13 Complementary Feeding: Foods to Fill the Nutrient Gap 139  Session 14 Feeding Techniques and Strategies 155  Counselling Skills  Session 4 Listening and Learning 47  Session 5 Building Confidence, Giving Support and Checking Understanding 61  Clinical Sessions  Clinical Practice 1 Listening and Learning, Confidence Building, Giving Support Assessing a Breastfeed and Positioning a Baby at the Breast 20  Clinical Practice 2 Listening and Learning, Building Confidence, and Giving Support 20  Session 20 Clinical Practice 2 Listening and Learning, Building Confidence, and Giving Support 20  Counselling for Complementary Feeding 229  Practical Sessions  Session 25 Practice 1 Preparation of Complementary Feed 233  Session 26 Practice 2 Preparation of Complementary Feed 233  Session 27 Practice 2 Preparation of Replacement Feed 237  Miscellaneous  Session 9 Refusal to Breastfeed and Crying 103  Session 15 Institutionalizing Skilled Infant and Young Child Feeding Counselling 169  Session 21 IMS Act 207  Session 22 Growth Monitoring and Measuring 213  Session 23 Growth Monitoring by Growth Charts 219			
Complementary Feeding  Session 13 Complementary Feeding: Foods to Fill the Nutrient Gap  Session 14 Feeding Techniques and Strategies  Counselling Skills  Session 4 Listening and Learning  Session 5 Building Confidence, Giving Support and Checking Understanding  Clinical Sessions  Clinical Practice 1 Listening and Learning, Confidence Building, Giving Support Assessing a Breastfeed and Positioning a Baby at the Breast  Clinical Practice 2 Listening and Learning, Building Confidence, and Giving Support Counselling for Complementary Feeding  Session 25 Clinical Practice 3 Measuring Weight and Length; Counselling for Infant Feeding  Practical Sessions  Session 26 Practice 1 Preparation of Complementary Feed  Practice 2 Preparation of Replacement Feed  Miscellaneous  Session 9 Refusal to Breastfeed and Crying Session 16 Institutionalizing Skilled Infant and Young Child Feeding Counselling Session 21 IMS Act Session 22 Growth Monitoring and Measuring Session 23 Growth Monitoring by Growth Charts  139  139  147  158  155  158  158  159  169  179  179  170  170  170  170  170  17			
Session 13 Complementary Feeding: Foods to Fill the Nutrient Gap  Session 14 Feeding Techniques and Strategies  Counselling Skills  Session 4 Listening and Learning  Session 5 Building Confidence, Giving Support and Checking Understanding  Clinical Sessions  Clinical Practice 1 Listening and Learning, Confidence Building, Giving Support Assessing a Breastfeed and Positioning a Baby at the Breast  Clinical Practice 2 Listening and Learning, Building Confidence, and Giving Support Counselling for Complementary Feeding  Session 25 Clinical Practice 3 Measuring Weight and Length; Counselling for Infant Feeding  Practical Sessions  Session 26 Practice 1 Preparation of Complementary Feed  Session 27 Practice 2 Preparation of Replacement Feed  Miscellaneous  Session 9 Refusal to Breastfeed and Crying Session 16 Institutionalizing Skilled Infant and Young Child Feeding Counselling Session 21 IMS Act Session 22 Growth Monitoring and Measuring Session 23 Growth Monitoring by Growth Charts  139  147  158  158  158  158  159  169  179  170  170  170  170  170  170  17			187
Session 14 Feeding Techniques and Strategies  Counselling Skills  Session 4 Listening and Learning  Session 5 Building Confidence, Giving Support and Checking Understanding  Clinical Sessions  Clinical Practice 1 Listening and Learning, Confidence Building, Giving Support Assessing a Breastfeed and Positioning a Baby at the Breast  Clinical Practice 2 Session 20 Listening and Learning, Building Confidence, and Giving Support Counselling for Complementary Feeding  Session 25 Clinical Practice 3 Measuring Weight and Length; Counselling for Infant Feeding  Practical Sessions  Session 26 Practice 1 Preparation of Complementary Feed  233  Session 27 Practice 2 Preparation of Replacement Feed  Miscellaneous  Session 9 Refusal to Breastfeed and Crying Session 15 Institutionalizing Skilled Infant and Young Child Feeding Counselling  Institutionalizing Skilled Infant and Young Child Feeding Counselling  Institutionalizing Skilled Infant and Health and Fertility  Institutional Image of Counter Session 21 IMS Act  Counselling Scouth Monitoring and Measuring  Session 23 Growth Monitoring by Growth Charts  155  Counselling Skilles  47  47  47  47  47  47  47  47  47  4	•		100
Counselling Skills  Session 4 Listening and Learning 47  Session 5 Building Confidence, Giving Support and Checking Understanding 61  Clinical Sessions  Clinical Practice 1 Listening and Learning, Confidence Building, Giving Support 193 Assessing a Breastfeed and Positioning a Baby at the Breast 203  Clinical Practice 2 Listening and Learning, Building Confidence, and Giving Support 203 Counselling for Complementary Feeding 229  Practical Sessions  Session 25 Clinical Practice 3 Measuring Weight and Length; Counselling for Infant Feeding 229  Practical Sessions  Session 26 Practice 1 Preparation of Complementary Feed 233  Session 27 Practice 2 Preparation of Replacement Feed 237  Miscellaneous  Session 9 Refusal to Breastfeed and Crying 103 Session 15 Institutionalizing Skilled Infant and Young Child Feeding Counselling 169 Session 16 Nutrition of Lactating Mothers and their Health and Fertility 175 Session 21 IMS Act 207 Session 22 Growth Monitoring and Measuring 219  Session 23 Growth Monitoring by Growth Charts 219			
Session 4 Listening and Learning 47 Session 5 Building Confidence, Giving Support and Checking Understanding 61  Clinical Sessions  Clinical Practice 1 Listening and Learning, Confidence Building, Giving Support Assessing a Breastfeed and Positioning a Baby at the Breast  Clinical Practice 2 Listening and Learning, Building Confidence, and Giving Support Counselling for Complementary Feeding  Session 25 Clinical Practice 3 Measuring Weight and Length; Counselling for Infant Feeding  Practical Sessions  Session 26 Practice 1 Preparation of Complementary Feed 233  Session 27 Practice 2 Preparation of Replacement Feed 237  Miscellaneous  Session 9 Refusal to Breastfeed and Crying 103 Session 15 Institutionalizing Skilled Infant and Young Child Feeding Counselling 169 Session 16 Nutrition of Lactating Mothers and their Health and Fertility 175 Session 21 IMS Act 207 Session 22 Growth Monitoring and Measuring 213 Session 23 Growth Monitoring by Growth Charts 219			155
Session 5 Building Confidence, Giving Support and Checking Understanding  Clinical Sessions  Clinical Practice 1 Listening and Learning, Confidence Building, Giving Support Assessing a Breastfeed and Positioning a Baby at the Breast  Clinical Practice 2 Listening and Learning, Building Confidence, and Giving Support Counselling for Complementary Feeding  Session 25 Clinical Practice 3 Measuring Weight and Length; Counselling for Infant Feeding  Practical Sessions  Session 26 Practice 1 Preparation of Complementary Feed  Session 27 Practice 2 Preparation of Replacement Feed  Miscellaneous  Session 9 Refusal to Breastfeed and Crying  Session 15 Institutionalizing Skilled Infant and Young Child Feeding Counselling  Session 16 Nutrition of Lactating Mothers and their Health and Fertility  Session 21 IMS Act  Clinical Practice 2 Preparation of Replacement Feed  233  Massellaneous  Session 26 Practice 2 Preparation of Replacement Feed  Miscellaneous  Session 15 Institutionalizing Skilled Infant and Young Child Feeding Counselling  Session 16 Nutrition of Lactating Mothers and their Health and Fertility  175  Session 21 IMS Act  207  Session 22 Growth Monitoring and Measuring  213  Session 23 Growth Monitoring by Growth Charts			
Clinical Sessions  Clinical Practice 1 Listening and Learning, Confidence Building, Giving Support Assessing a Breastfeed and Positioning a Baby at the Breast  Clinical Practice 2 Listening and Learning, Building Confidence, and Giving Support Counselling for Complementary Feeding  Session 25 Clinical Practice 3 Measuring Weight and Length; Counselling for Infant Feeding  Practical Sessions  Session 26 Practice 1 Preparation of Complementary Feed 233 Session 27 Practice 2 Preparation of Replacement Feed  Miscellaneous  Session 9 Refusal to Breastfeed and Crying Session 15 Institutionalizing Skilled Infant and Young Child Feeding Counselling 169 Session 16 Nutrition of Lactating Mothers and their Health and Fertility 175 Session 21 IMS Act 207 Session 22 Growth Monitoring and Measuring 213 Session 23 Growth Monitoring by Growth Charts 207			
Session 19 Clinical Practice 1 Listening and Learning, Confidence Building, Giving Support Assessing a Breastfeed and Positioning a Baby at the Breast  Clinical Practice 2 Listening and Learning, Building Confidence, and Giving Support Counselling for Complementary Feeding  Session 25 Clinical Practice 3 Measuring Weight and Length; Counselling for Infant Feeding  Practical Sessions  Session 26 Practice 1 Preparation of Complementary Feed 233 Session 27 Practice 2 Preparation of Replacement Feed  Miscellaneous  Session 9 Refusal to Breastfeed and Crying Session 15 Institutionalizing Skilled Infant and Young Child Feeding Counselling Session 16 Nutrition of Lactating Mothers and their Health and Fertility 175 Session 21 IMS Act 207 Session 22 Growth Monitoring and Measuring 213 Session 23 Growth Monitoring by Growth Charts 208			61
Session 19 Listening and Learning, Confidence Building, Giving Support Assessing a Breastfeed and Positioning a Baby at the Breast  Clinical Practice 2 Listening and Learning, Building Confidence, and Giving Support Counselling for Complementary Feeding  Session 25 Clinical Practice 3 Measuring Weight and Length; Counselling for Infant Feeding  Practical Sessions  Session 26 Practice 1 Preparation of Complementary Feed  Session 27 Practice 2 Preparation of Replacement Feed  Miscellaneous  Session 9 Refusal to Breastfeed and Crying Session 15 Institutionalizing Skilled Infant and Young Child Feeding Counselling Session 16 Nutrition of Lactating Mothers and their Health and Fertility  Session 21 IMS Act  Clinical Practice 2 Practice 3 Measuring Weight and Length; Counselling Act  233  249  249  250  261  262  263  263  265  267  267  268  267  268  267  267  268  267  267	Clinical Sess		
Session 20 Listening and Learning, Building Confidence, and Giving Support Counselling for Complementary Feeding  Session 25 Clinical Practice 3 Measuring Weight and Length; Counselling for Infant Feeding  Practical Sessions  Session 26 Practice 1 Preparation of Complementary Feed  Session 27 Practice 2 Preparation of Replacement Feed  Miscellaneous  Session 9 Refusal to Breastfeed and Crying  Session 15 Institutionalizing Skilled Infant and Young Child Feeding Counselling  Session 16 Nutrition of Lactating Mothers and their Health and Fertility  Session 21 IMS Act  Session 22 Growth Monitoring and Measuring  Session 23 Growth Monitoring by Growth Charts  203  229	Session 19	Listening and Learning, Confidence Building, Giving Support	193
Practical Sessions  Session 26 Practice 1 Preparation of Complementary Feed 237  Session 27 Practice 2 Preparation of Replacement Feed 237  Miscellaneous  Session 9 Refusal to Breastfeed and Crying 103  Session 15 Institutionalizing Skilled Infant and Young Child Feeding Counselling 169  Session 21 IMS Act 207  Session 22 Growth Monitoring and Measuring 213  Session 23 Growth Monitoring by Growth Charts 233	Session 20	Listening and Learning, Building Confidence, and Giving Support	203
Session 26 Practice 1 Preparation of Complementary Feed 233  Session 27 Practice 2 Preparation of Replacement Feed 237  Miscellaneous  Session 9 Refusal to Breastfeed and Crying 103  Session 15 Institutionalizing Skilled Infant and Young Child Feeding Counselling 169  Session 16 Nutrition of Lactating Mothers and their Health and Fertility 175  Session 21 IMS Act 207  Session 22 Growth Monitoring and Measuring 213  Session 23 Growth Monitoring by Growth Charts 219	Session 25		229
Session 26 Preparation of Complementary Feed 233  Session 27 Practice 2 Preparation of Replacement Feed 237  Miscellaneous  Session 9 Refusal to Breastfeed and Crying 103  Session 15 Institutionalizing Skilled Infant and Young Child Feeding Counselling 169  Session 16 Nutrition of Lactating Mothers and their Health and Fertility 175  Session 21 IMS Act 207  Session 22 Growth Monitoring and Measuring 213  Session 23 Growth Monitoring by Growth Charts 219	Practical Se	ssions	
Miscellaneous  Session 9 Refusal to Breastfeed and Crying 103  Session 15 Institutionalizing Skilled Infant and Young Child Feeding Counselling 169  Session 16 Nutrition of Lactating Mothers and their Health and Fertility 175  Session 21 IMS Act 207  Session 22 Growth Monitoring and Measuring 213  Session 23 Growth Monitoring by Growth Charts 219	Session 26		233
Session 9Refusal to Breastfeed and Crying103Session 15Institutionalizing Skilled Infant and Young Child Feeding Counselling169Session 16Nutrition of Lactating Mothers and their Health and Fertility175Session 21IMS Act207Session 22Growth Monitoring and Measuring213Session 23Growth Monitoring by Growth Charts219	Session 27		237
Session 15 Institutionalizing Skilled Infant and Young Child Feeding Counselling  Session 16 Nutrition of Lactating Mothers and their Health and Fertility  175 Session 21 IMS Act  Session 22 Growth Monitoring and Measuring  Session 23 Growth Monitoring by Growth Charts  219	Miscellaneo	us	
Session 16Nutrition of Lactating Mothers and their Health and Fertility175Session 21IMS Act207Session 22Growth Monitoring and Measuring213Session 23Growth Monitoring by Growth Charts219	Session 9	Refusal to Breastfeed and Crying	103
Session 21IMS Act207Session 22Growth Monitoring and Measuring213Session 23Growth Monitoring by Growth Charts219	Session 15	Institutionalizing Skilled Infant and Young Child Feeding Counselling	169
Session 22Growth Monitoring and Measuring213Session 23Growth Monitoring by Growth Charts219	Session 16	Nutrition of Lactating Mothers and their Health and Fertility	175
Session 23 Growth Monitoring by Growth Charts 219	Session 21	IMS Act	207
	Session 22	Growth Monitoring and Measuring	213
Session 24 Measuring Growth: Taking Action 225	Session 23	Growth Monitoring by Growth Charts	219
	Session 24	Measuring Growth: Taking Action	225

# INTRODUCTION OF MIDDLE LEVEL TRAINERS' GUIDE

#### WHY THIS COURSE IS NEEDED

alnutrition has been responsible, directly or indirectly, for 60 per cent of the < 8 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. Not more than 35 per cent of infants worldwide are exclusively breastfed during the first four months of life; complementary feeding frequently begins too early or too late, and foods are often nutritionally inadequate and unsafe. Malnourished children who survive are more frequently sick and suffer the life-long consequences of impaired development. The rising incidence of overweight and obesity in children are also a matter of serious concern. Because poor feeding practices are a major threat to social and economic development, they are among the most serious obstacles to attaining and maintaining health that this age group face.

Appropriate feeding practices are of fundamental importance for the survival, growth, development, health and nutrition of infants and children everywhere. Breastfeeding is also important for the health of their mothers.

Breastfeeding exclusively upto six months, continued breastfeeding for two years or beyond along with appropriate complementary feeding, starting after completion of six months will prevent malnutrition, morbidities and mortality in under-five children significantly, and thus improve growth and development of young children which ultimately will reduce the cycle of inter-generation malnutrition. Malnutrition increases the severity of, and the risk of dying from, common childhood diseases. It also causes delayed motor development, impaired cognitive functions and lower school performance. Even mothers who initiate breastfeeding satisfactorily, give complementary foods early or stop breastfeeding within a few weeks after delivery.

Similarly complementary feeding practices are grossly inadequate. Information on how to feed young children comes from family beliefs, community practices, advertisement by food manufacturers and information from health workers. It has been often 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 appropriate food and feeding practices are often a greater determinant of malnutrition than the availability of food. Complementary feeding should be timely,

adequate, safe and proper. The information provided in this course focuses on when to introduce food in addition to breastmilk, how to enhance home-prepared food and how to educate and provide skills to counsel mothers to adopt optimal infant feeding practices.

The HIV pandemic and the risk of mother-to-child transmission of HIV through breastfeeding pose unique challenges to the promotion of breastfeeding, even among unaffected families.

Workers concerned with nutrition, and with maternal and child health, all recognize the importance of improved infant feeding practices but they lack the knowledge and skills to ensure these. Hence, there is an urgent need to train health workers, who care for mothers and young children in all countries, in the skills needed to both support and protect breastfeeding, and promote and support appropriate complementary feeding. Health workers also need such a training to provide accurate information to mothers on maternal transmission of HIV to children and various breastfeeding and feeding options to enable them to select what is acceptable and feasible.

This course is a comprehensive and integrated course developed by BPNI and IBFAN Asia Pacific, which includes breastfeeding counselling, complementary feeding counselling, infant feeding, HIV counselling and growth monitoring. This course is based on WHO/UNICEF training courses – 'Breastfeeding Counselling – A Training Course', 'HIV and Infant Feeding Counselling – A Training Course' and 'Complementary Feeding Counselling – A Training Course', and several new evidences from medical literature. BPNI and IBFAN Asia Pacific have revised and rescheduled certain sessions and added new knowledge to many sessions.

#### TRAINER GUIDE

This trainer guide is for middle level trainers who have taken seven days training on breastfeeding, complementary feeding, infant feeding, HIV and growth monitoring. It is to be used by them for conducting a four day's training course for frontline workers ANMs/ASHAs regarding breastfeeding and complementary feeding issues.

#### THE COURSE FOR TRAINING OF FRONTLINE WORKERS

#### Aim

To prepare skilled frontline workers/peer counsellors for Counselling on IYCF.

#### Who can do it

• Frontline workers responsible for health, child care development or nutrition sectors. ANMs, AWWs, ASHAs, TBAs, women support groups.

#### Duration of training 4 days

• 4 days (24-26 hours), including 6 hours (2 hours x 3 days) of counselling skills practice during the training session.

#### Number of trainers needed

• 3-4 middle level trainers for 20-30 participants (trainers are those who have attended the 7 days training course for becoming middle level trainers of frontline workers).

#### Competence after receiving training

#### Able to:

- Provide IYCF counselling to pregnant and lactating women and their families;
- Solve breastfeeding problems and assistance in proper positioning while breastfeeding;

Details of criteria and guidelines on frontline workers training (See Annex Training Guideline - 3).

#### **DIFFERENT KINDS OF SESSIONS**

#### Lectures and demonstration

There are lecture presentations, demonstrations and counselling skills. Each of these should be conducted by one of the trainers, for the whole class of 25 participants together. The demonstration of Counselling skills may require two trainers in each larger group of 8-10 participants. The Course Director will assign lectures and demonstration to different trainers.

#### **Forming groups**

As soon as possible after the introductory session, the Course Director, with the help of one or two of the trainers, decides how to form the groups.

If language and gender may be a problem, each group should have at least one person who can speak the local language, and at least one woman. It may be appropriate to balance professional groupings. Sometimes it is a good idea to make a participant, who knows others in the class, responsible for arranging the groups according to these considerations. The names of the trainer and participants in each group are written on a flipchart or board and posted up where participants can check the group which they belong to.

#### **Group work**

There are small group sessions, which require one trainer for 4-5 participants. These sessions are meant for learning counselling skills through role play using different stories. There are some group work sessions, which are taken by a trainer in a larger group of 8-10 participants.

#### **Order of sessions**

The sessions are in a suggested order, but the order almost always needs to be adapted as required. The sequence of most sessions can be changed but it is necessary for some aspects of the sequence to be maintained. The main requirement is that you conduct the sessions, which prepare the participants for a particular practice before starting the practice session.

#### **MATERIAL FOR TRAINER**

#### The trainers' guide for middle level trainers

The trainers' guide is a comprehensive manual covering all 27 sessions of the course of which are to be taught to the frontline workers in a 4 days course. It is an essential tool for the trainer, and contains all the information needed, with detailed instructions on how to conduct each session. It describes the teaching methods used. It also contains practical guidelines, summary boxes, forms, lists, and checklists; and the stories to be used during the course. Towards the end, there is a short list of key textbooks, and a list of papers which are an additional source of information about points made in the presentations.

This is your most essential tool on the course as a trainer. Write your name on it as soon as you get it, and use it at all times. Add notes to it as you work. These notes will help you in future courses.

The Trainer's Guide will assist you in providing training to a batch of 24-30 frontline workers in a four day course. During the course, you will teach 18 sessions. The remaining chapters can be used during future courses.

#### Training aids for the trainer

Along with the trainer manual, all trainers are provided with a set of laminated flash cards to be used while teaching frontline workers.

#### Manual for frontline workers

This manual contains 21 sessions.

Each frontline worker is provided with a reference manual which will help her to counsel mothers and family members.

#### Counselling guide for frontline workers

A flip chart is provided to all frontline workers to be used to counsel mother and family members during their routine activities and home visits.

#### Reference materials

The Law to Protect, Promote and Support Breastfeeding and Breastfeeding and Complementary Feeding – a guide for parents are given to each participant as part of the course materials.

#### **Training aids**

For each course, it is necessary to have four life size baby dolls and four breast models so that there is one for each small working group. If dolls and breast models are not available, try to make them.

Here are instructions for one way to make them, simply and out of readily available materials.

#### HOW TO MAKE A MODEL DOLL

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

#### **HOW TO MAKE A MODEL BREAST**

Use a pair of near skin-coloured socks, or stockings, or an old sweater or T-shirt. Make the cloth into a round bag shape, and stuff it with other cloth or foam rubber to make it breast shaped. Stitch a 'purse string' around a circle in the middle of the breast to make a nipple. Stuff the nipple with foam or cotton. Colour the areola with a felt pen. You can also push the nipple in, to make an 'inverted' nipple.

If you wish to show the inside structure of the breast, with the lactiferous sinuses, makes the breast with two layers, for example with two socks. Sew the nipple in the outer layer, and draw the lactiferous sinuses and ducts on the inside layer, beneath the nipple. You can remove the outer layer with the nipple to reveal the inside structure.

#### **TEACHING THE COURSES**

#### Setting the stage for training and ensuring successful training

Any training is incomplete, without the necessary preparation for the same, in spite of the best of resources, handouts and manuals.

It is important to identify the combination of skills which will help deliver high quality service to clients.

The competence of training depends on the communication skills and needs to cope with fear, anger and embarrassment.

Interactive training methodology, allowing instructions, practice and feed back are crucial to address the sensitivity of the issues.

#### Steps

- 1. Ensure that all training materials are available.
- 2. All trainers must be present for the entire training.
- 3. Ensure that training starts on time.
- 4. Encourage trainees to ask questions.
- 5. Encourage trainees to listen carefully and respect each others contribution opinion and experiences.
- 6. Create an environment in which everybody is comfortable.
- 7. Ensure evaluation of the training.

#### Motivating and managing participants

#### • Encourage interaction

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

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

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

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

#### • Reinforce participants' efforts

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

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

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

- » try hard;
- » ask for an explanation of a confusing point;
- » do a good job on an exercise and
- » participate in group discussion;

You may notice that many of the Counselling skills taught during the course are also important for communicating with participants. In particular, you will find it helpful to use appropriate non-verbal communication, to ask open questions, and to help them feel confident in their work with mothers and babies.

#### Be aware of language difficulties

Try to identify participants who have difficulty in understanding or speaking the language in which the course is conducted. Speak slowly and clearly so that you are more easily understood. Encourage participants in their efforts to communicate. If necessary, speak with a participant in her own language (or ask someone else to do so for you) to clarify a difficult point.

#### Using your trainer's guide

#### Before you lead a session

- » Look at your guide and read the 'Objectives' and the 'Session Outline', to find out what kind of session it will be, and what are your responsibilities.
- » Read the 'Preparation' box at the beginning of the text, so that you know what you have to do in advance to prepare for the session, and what training aids (and other kind of help) you need.
- » Read through the text for the session, so that you are clear what you will have to do. The text includes detailed point by point instruction about how to conduct the session.

Remember 🖒

Keep your guide with you and use it all the time.

#### When you lead a session

You do not need to memorize what you have to do. It is extremely difficult to do so. Use the guide as your session notes, and follow it carefully.

If using the whole guide looks embarrassing, for example, because it might make some participants think that you do not know the material, decide what to do.

At the beginning of the course, explain that this is the correct method for this kind of teaching. In the same way that participants need to use their manual. Alternatively, for the sessions that you lead, copy the necessary pages of the guide, to use as your notes during the session. This will not be so bulky or conspicuous as carrying the whole guide.

Follow the guide and use it during the sessions.

#### Preparing to give a presentation

#### Lecture presentation

#### Study the material

Before you make one of the lecture presentations, read the notes carefully, and study the training kit and training aids.

You do not have to give the lecture exactly as it is written. You should not read it out, unless you feel that there is no other way of doing it. However, it is important that you are thoroughly familiar with the contents of the lecture, and with the order of ideas in the presentation. This is necessary, even if you are an experienced trainer, and knowledgeable about breastfeeding.

Go through the text, try to think of your own stories, and ways to present the information naturally in your own way.

#### • Arrange teaching aids

Make sure that you have all the material for the session, and arrange them in the correct order.

Shortly before the session, make sure that the audience will be able to see the images- on screen and are well placed. See that the chairs are arranged appropriately. You do not have to accept the arrangement from the previous session. It can be more useful to move the audience around, and present material in a new way. It may help to keep their attention.

Remember .



Giving a lecture - The Lecture should not be more than 30 minutes

#### • Talk in a natural and lively way

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

#### • Explain the laminated card carefully

Remember that these cards do not do the teaching for you.

They are aids to help you teach and to help participants to learn. Do not expect participants to learn from them without your help.

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

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

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

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

Sometimes, it is helpful when participants are asked to come to the screen to point out things to other participants.

#### • Involve the audience

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

However, it is also helpful during lectures and other sessions to ask questions, to check that participants understand, and to keep them thinking. This interactive technique helps to keep participants interested and involved, and is usually a more effective way of teaching. Ask open

questions, (which you will have learned about in session on Counselling skills) so that participants have to give an answer that is more than a "yes" or "no".

Sometimes asking the question again, in another way, can help. However, do not help them or give them the answer too quickly. It is important to wait, and to give them a genuine chance to think of the answer themselves. On the other hand, do not get involved in discussions which distract and waste a lot of time. Encourage participants to make a few suggestions; discuss their suggestions; and then continue with the session. You do not have to wait until they have given all the answers listed in the text. Notes are included with many of the questions to guide you.

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

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

Do not let several participants talk at once. If this occurs, stop the talkers, and give them an order to speak in.

Do not let the same one or two people answer all the questions. If a talkative participant tries to answer several questions, ask her to wait for a minute, and turn or walk away from her. Try to encourage quieter participants to talk. Ask someone by name who has not spoken before to answer, or walk towards someone to focus attention on her, and make her feel that she is being asked to talk.

Thank participants whose answers are short and to the point.

#### **Demonstration**

The demonstration is by the trainer and it is repeatedly practiced by the trainees. This will help them in their counselling.

We all know the golden rule that skills are best learned by repeated practice. Demonstration is one of the best ways of teaching.

#### Preparing to give a demonstration

#### Study the instruction

Before giving the demonstration, you should go through the instructions carefully, to get familiar with them. This is necessary even if you have already seen someone else give the demonstration. Even if you have given the demonstration before yourself, it is a good idea to re-read the instructions, so that you remember all the important steps.

#### • Prepare your assistant

You may need someone to help you to give the demonstration, for example, someone to pretend to be a mother. It is usually a good idea to ask a participant to help you. This can be a good learning experience for her. It increases her involvement, and helps her to learn about teaching methods. One day before the demonstration, the helper should be selected, so that she has time to prepare herself. Discuss what you want to do, and help her to practice.

#### • Practice the demonstration.

Practice giving the demonstration, by yourself, with your assistant, or with another trainer, so that you know how long it takes, what can go wrong, and if there is anything else that you need, such as

an extra table or chairs. This will make the demonstration much more convincing. It is a good idea to practice even if you have done it before.

#### Giving the demonstration

- Make sure that all the equipment is ready and at one place where you will give the demonstration. Arrange tables and chairs as you will need them.
- Make sure that you have facilities like a board to write things up, or an overhead projector if
  you need to show a transparency as part of the demonstration, without having to rearrange
  everything.
- Demonstrate slowly, step-by-step, and make sure that the audience is able to see what you do. If necessary, ask them to move close to you so that they are near enough to see and hear clearly; or you move closer to them and go to each part of the audience in turn.
- As you give the demonstration, take every opportunity to let participants handle and examine
  the equipment that you use, and practice themselves whatever you have demonstrated. They
  will learn more if they try things out themselves, than if they just see you doing them.

At the end of a lecture or demonstration, leave time for participants to ask questions, and do your best to answer them and provide feedback to the participants when they are practicing so that they are able to improve their skills.

#### **Working in groups**

Working in groups makes the teaching more interactive and participatory, and it gives everybody time to ask questions. Participants who are quiet have more chance to contribute.

Working in groups of 8-10 with two trainers, consisting mostly of discussions, reading, short demonstrations, role-play, and exercises.

The two trainers are likely to have different strengths, and can support and learn from each other. They should plan together how to conduct the session.

Working in groups of 4-5 with one trainer, is mainly for the practice of skills, such as positioning a baby at the breast, history taking and Counselling. The smaller groups give everybody a chance to practice the skills.

Remember C

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

#### **Group discussions**

It is an effective, learner-centred method. This is directed towards sharing experiences, shifting attitudes and getting comments within a group. The result of a successful decision is a better solution of a problem with action agreed and commitment to success made by group members. This is a good method for frontline workers.

#### • Conduct discussions

Some discussions consists of simple questions which you ask the group, encouraging participants to suggest answers, and to give their ideas, in a way similar to that described for asking questions in lectures. It may help to write the main question and the main points of answers on a flipchart.

- » Seating arrangements should be planned to allow interaction.
- » Do not let a few more talkative participants dominate the discussion. If necessary, ask individuals in the group by name to suggest answers in turn. Encourage quieter members to say what they think, before you allow the talkative ones to speak.

- » Leading discussion is initiated by facilitators.
- » To keep the participants discussing the questions, from time to time summarize what has been said and restate the question in another way. When participants given an incomplete answer, ask them to try to clarify and complete what they are trying to say. Add any necessary explanation and make sure that it is clear to all participants.
- » Facilitators to answer questions initially.

Give participants time to ask their own questions. Answer the questions willingly. Encourage participants to ask whenever they have a question and not to hold it for a later time. However, if they ask too many questions and it interferes with the session, you may have to ask them to wait.

#### Small group discussion

Four to six members form a group.

#### Advantages

- 1. Trainers have more opportunities to talk and are less likely to be embarrassed.
- 2. Atmosphere is more conducive for discussion and feeling.
- 3. Trainees gain self confidence through sharing information.
- 4. More ideas come from the groups.

It's important to provide clear guidelines.

- 1. On topics to be discussed.
- 2. How much time the group has.

The trainers should ask the group to select facilitators.

#### Reading

In some sessions, you ask participants to read a section of text to themselves. You then discuss the topic with them, to make sure that they understand what they have read. Later, they practice using the information in an exercise.

If it is difficult for participants to absorb information when they read it to themselves, you can, as an alternative, ask them to read it aloud. Each participant takes it in turns to read one sentence of the text. You can discuss the ideas and ask questions after each participant takes turns.

#### Role-play

Role-play is where trainer assumes a role and enacts in front of the group. It is useful for practicing skills like counselling, and for exploring how people react in specific situation. The role-play objective is an attitudinal change dealing with feeling and emotion.

#### Advantages of role-play

- » The trainees are involved in problem solving.
- » Trainees are active participants, which stimulates interest.
- » Learning process is more personal.
- » It helps trainees understanding and absorption of information.
- » The trainees have opportunities to share expertise and skills.
- » It helps developing behaviour of self and others.
- » It is a highly stimulating method of training.

Role-play allows rehearsal of activities and provides practical preparation for a genuine situation. It allows full expression and interpretation of concepts, and trainees are able to experience activities

and relate theory to practice. Frontline workers have to apply knowledge and skills learned, and roleplay sharpens such skills.

#### Steps in developing role-play

- » Brief introduction.
- » Choose the player in advance, explain carefully what you want them to do and give written instructions to help them remember what to do.
- » Actual role-play in front of audience.
- » Post role-play views of all the audience.

#### Don't

Player's performance should not be criticized.

Advice and assistance of the trainers should not be with held.

#### How to conduct meetings?

This is an important activity of frontline worker. While conducting the meeting it is important to be clear about:

#### a. Who should be called in the meeting?

Have a homogeneous group, make the atmosphere light, so that people can talk freely and there are less chances of a hostile outcome.

#### b. Preparation of meeting

A rough agenda of all the important points is prepared.

#### c. How to hold the attention of group?

At the beginning of meeting, look for supportive sets of eyes, it gives confidence.

#### d. How to control group?

This is difficult part of the meeting. During any meeting, some person will like to dominate the meeting and some are in the habit of talking of own experience. The art of diplomacy is to conduct a meeting in a democratic way without hurting anyone's ego.

#### How to use flip chart?

The trainer should explain to the frontline worker how to use the flipchart during her home visits and Mahila Mandal meetings.

Aim

The aim is to give right information to the people and form a continuous association with them so that they all can be aligned with you, for bringing about a change.

When to use this?

- » This should be used for Counselling pregnant women, mothers of infants and young children up to two years and other family members like father/mother-in-law.
- » This can be used at different ages of children like when the infant has reached the age of six months, then complementary feeding could be talked about. The mother should be reminded about what all you told last time.
- » Use it during your home visits and Mahila Mandal meetings.

Also talk about the use of the flip chart

- » Make women sit in a semicircle and you sit on a little high platform.
- » Use pen or pencil while showing the pictures.
- » Now you can show this guide by lifting it up in your hand or by keeping on the table.
- » Also remember that picture faces towards the group and written text is towards you.
- » Before using this flyer, ensure that the picture is clear to the spectators.
- » It is written on the back of the picture, how to organize the meeting, what is to be told and what is to be asked from mothers.

Three colours have been used to show the use of flip chart and its importance is as follows:

The question to be asked by you	You have to ask	When you are counselling the members of the family
		<b>Yellow</b> shows question you need to ask
Which you have to do yourself	You have to do yourself	Blue shows what you have to do
The information you have to impart to family or mothers	Information to be provided	<b>Pink</b> shows the knowledge you have to impart

#### TRAINING SKILLS CHECKLIST

Practice using these skills when you are conducting sessions, and comment on these points when you give each other feedback.

#### **Movements**

- Take centre stage: do no get stuck in a corner or behind a desk
- Face the audience: do not face the board or screen when speaking
- Make eye contact with people in all sections of the audience
- Use natural gestures and facial expression (but try to avoid mannerisms)
- Move around the room: approach people to get their attention and response
- Avoid blocking the audience's view: watch for craning necks

#### Speech

- Slow and clear, and loud enough for everyone to hear
- Natural and lively: varied
- Write difficult new words on the board, pronounce and explain them

#### Interaction

- Try to interact with all participants: use names as appropriate
- Ask the questions suggested in the text: ask different participants
- Allow time for the participant to answer: don't give the answer too quickly-drop hints
- Respond encouragingly and positively to all answers: correct errors gently
- Involve all participants: include quiet ones-control talkative ones
- Avoid discussions which are off the point or distracting: postpone them if necessary
- Try to give satisfactory answers to questions from participants

#### Visual aids

- Have the required aids and equipment ready-check and arrange them before the session.
- Make sure that everyone can see clearly: arrange the room so that they can point to what you are talking about on the projector, or on the screen cover.
- Write large and clear on the board: arrange words carefully so that there is enough room to put slides and overheads away tidely, ready for next time, at end of session.

#### Use of materials

- Prepare thoroughly: read the text and obtain any aids that you need before, prepare your helpers (e.g. for role-play) before the session-practice if possible, do not learn the session by heart. Follow the guide but talk in your own way. Follow the session plan accurately and completely, use your Trainer's Guide. Emphasize important points: do not leave important point
- Do not introduce too much extra material: but give local examples
- Try to avoid repetition unless really useful
- If you find it necessary to read from the guide, look at the audience sometimes

#### **Time management**

Keep to time: not too fast or nor too slow; don't take too long with the early part of a session don't lose time between sessions. Explain clearly what to do.



SESSION

#### Why Optimal Infant and Young Child Feeding

#### **Objectives**

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

- Understand optimal infant and young child feeding
- Know the importance of exclusive breastfeeding
- Know the dangers of artificial feeding
- Describe advantages of timely complementary feeding
- Describe current recommendations on infant and young child feeding

Session outline	(60 minutes)
Participants are all together for a lecture presentation by one trainer.	
I. Introduce the topic	(5 minutes)
II. Presentation (Teaching Aids 1.1,1.2, 1.3)	(30 minutes)
III. Summarize	(5 minutes)
IV. Discussion	(20 minutes)

#### **Preparation**

- 1. Read the introduction. How to conduct the training course?
- 2. Arrange teaching Aids 1.1 1.3.
- 3. Prepare a participant to write on the board or flip chart.
- 4. Arrange non-permanent marker pen and board/flip chart.

#### I. Introduce the topic

(5 minutes)

- Make these points:
- Before you learn how to help mothers, you need to understand what is optimal infant and young child feeding.

II. Presentation (30 minutes)

#### Optimal infant and young child feeding is

Exclusive breastfeeding from birth to six months of age, and thereafter continued breastfeeding for two years or beyond with adequate, safe and proper additional foods and liquids starting at the age of six months to meet nutritional needs of a young child.

Optimal infant and young child feeding makes a baby grow healthy and strong, prevents illness, and improves survival.

#### **Exclusive breastfeeding**

Ask to the participants what do you understand by exclusive breastfeeding

After listening the points explain

☐ Show Teaching Aid (TA) 1.1

#### TA 1.1: Exclusive breastfeeding



Exclusive breastfeeding means giving a baby only mother's milk and no other food or drink, including water. With the exception of syrup/drops of Vitamins, minerals and medicines (expressed breastmilk is also permitted).

#### Advantages of breastfeeding

#### Ask: What are the advantages of breastfeeding?

Ask one frontline worker to write on the board the main advantages of breastfeeding, as mentioned by the participants. Let them express at least one advantage to the mother and family. Thank them.

It is useful to think of the advantages of both breastmilk and breastfeeding.

The advantages of breastfeeding are more than just the advantages of feeding a baby on breastmilk.

- Trainer then explains all the advantages of breastfeeding and breastmilk.
  - a) Benefits to the baby
  - b) Benefits to the mother
  - c) Benefits to the family
  - d) Benefits to the society

Trainer then asks participants to open their manual (Session 1) and to see the advantages of breastmilk and breastfeeding. Wait for few minutes and then ask them to close.

#### 1. Benefits the baby enjoys

- Breastmilk provides numerous benefits for the baby.
  - It provides complete nutritional staple to the infant up to the age of six months, up to half of nutritional requirements between 6-12 months and up to one-third, between 12 and 24 months.
  - Breastmilk contains adequate calories and provides the right kind of proteins, fats, lactose, Vitamins, iron and other minerals, enzymes and water in the amounts necessary for the baby.
  - Breastmilk contains enough water which is sufficient for very dry and hot climates.
  - Breastmilk has many anti-infective properties and protects the child against several infections including diarrhoea and pneumonia.
  - It is easily digested.
  - It is free from contaminants.
  - Breastfed babies are less prone to have diabetes, heart disease, eczema, asthma and other allergic disorders and adult onset diseases.
- Breastfeeding provides additional benefits
  - Breastfeeding enhances the emotional bond between child and the mother and provides warmth, love and affection. It is more than food.
  - Breastfeeding enhances brain development, visual development and visual acuity leading to learning readiness.
  - Breastfed babies have been shown to have higher Intelligence quotient (I.Q), language development and mathematical abilities.

#### Ask: What benefits does a mother enjoy

Wait for 1 or 2 responses and then continue

#### 2. Benefits the mother enjoys

Breastfeeding protects a mother's health in several ways and can benefit the whole family, emotionally and economically.

- It reduces post-delivery bleeding and anemia.
- Exclusive breastfeeding has a contraceptive effect.
- Breastfeeding has protective effect against breast and ovarian cancers.
- Globally present rates of breastfeeding prevent almost 20,000 annual deaths from breast cancer and additional 20,000 can be prevented by scaling up breastfeeding to universal levels.
- Obesity is less common among breastfeeding mothers; breastfeeding helps the mother regain her normal figure.
- Breastfeeding satisfies the mother emotionally.

Trainer will further explain other benefits of breastfeeding to family and society.

#### 3. Benefits the family enjoys

- Breastfeeding is economical.
- Breastfed babies are less sick and therefore less of a financial burden to the family.
- Breastfeeding is convenient and can be done at any place and at any time.
- Breastfeeding encourages family bonding.

#### 4. Benefits the society enjoys

- Breastfeeding is eco-friendly because artificial feeding involves use of wood and other fuel
  for boiling water and milk which means more deforestation, soil erosion, pollution of water,
  air and earth, climatic changes and waste resources by using formula.
- Breastfeeding has a positive effect by providing a renewable resource and by preventing other forms of damage to the environment.
- Breastfed babies develop to be a better human resource, and therefore improve productivity and economy of a country.

#### **Early initiation**

☐ Show TA 1.2

Early initiation means starting breastfeeding within one hour of child birth.



#### **TA 1.2: Early Initiation**

☐ Trainer will then inform the importance of early initiation of breastfeeding.

Early initiation of breastfeeding is extremely important for establishing successful lactation as babies are normally very alert and responsive within one hour after delivery. They are ready to suckle and attach to the breast easily.

Early initiation also provides the benefits of colostrum (first few days milk after delivery) to the baby.

☐ Trainer will then inform the importance of colostrum.

#### Colostrum

Colostrum is the first yellow and thicker breastmilk secreted in small amounts.

Discuss the special properties of colostrum, and why it is important?

#### Colostrum is exactly what a baby needs for the first few days

- It contains more antibodies and other anti-infective factors than mature milk. This is part of the reason why colostrum contains more protein than mature milk.
- It contains more white blood cells than mature milk.
- These anti-infective proteins and white blood cells provide the natural immunization against
  the diseases that a baby meets after delivery. Colostrum helps to prevent the bacterial
  infections that are a danger to newborn babies. The antibodies probably also help to
  prevent a baby from developing allergies.
- Colostrum has a mild purgative effect, which helps to clear the baby's gut of meconium (the first rather dark stools). This clears bilirubin from the gut, and helps to prevent jaundice.
- Colostrum contains growth factors, which help a baby's immature intestine to develop after birth. This helps to prevent the baby from developing allergies and intolerance to other foods.
- Colostrum is richer than mature milk in some Vitamins especially Vitamin A. Vitamin A helps to reduce the severity of any infection the baby might have.

So it is very important for babies to have colostrum for their first few feeds. Colostrum is ready in the breasts when a baby is born. It is all that most babies need before the mature milk comes in.

#### **Prelacteal feeding**

Prelacteal feeding is any feed given before giving first mother's milk.

#### Ask: Trainer then asks about the prelacteal feeding practices.

Sugar / jaggery / honey / glucose water / ghutti / plain water



Babies should not be given any drinks or foods before they start breastfeeding. Prelacteal feeds delay milk flow and cause illness in the baby.

#### Complementary feeding

Complementary feeding means giving other foods and liquids in addition to breastmilk or non-human milk after six months of age when breastmilk alone is no longer sufficient to meet the nutritional requirements of the child.

#### Advantages of appropriate complementary feeding

Explain to frontline workers the advantages of appropriate complementary feeding

- Prevents growth faltering
- Decreases risk of nutritional deficiencies
- Lessens risk of illnesses
- Helps in proper development

#### Continue breastmilk in the second year

- ☐ Trainer explains to frontline workers why mothers should continue breastmilk in the second year.
- For the first six months of life, exclusive breastfeeding can provide all the nutrients and water that a baby needs.

After the age of six months, breastmilk is no longer sufficient by itself. After six months, all babies should receive other food, in addition to breastmilk. Complementary foods should be given by cup or cup and spoon.

However, breastmilk continues to be an important source of energy and high quality nutrients through the second year of life and beyond.

- Breastmilk provides about one-third of the protein and energy that a child needs in the second year.
- Breastmilk provides about 45% of the Vitamin A that a child needs. Breastfeeding can help to prevent Xerophthalmia (Vitamin A deficiency).
- Breastmilk provides almost all of Vitamin C requirement, provided the mother herself is not deficient.
- So, breastmilk helps to make sure that a child gets enough energy and high quality nutrients through at least the second year of life. These nutrients may not be easily available from the family diet. Continuing to breastfeed during the second year can help to prevent malnutrition, especially among children who are most at risk.
- ☐ Trainer explains the dangers of artificial feeding
- Dangers of artificial feeding
  - Artificial feeding may interfere with bonding. The mother and baby may not develop such a close, loving relationship.
  - An artificially fed baby is more likely to become ill with diarrhoea, pneumonia, ear, and other infections.
  - Child gets less balanced nutrients and is likely to suffer from nutritional disorders.
  - Child may get too little milk and may become malnourished, because s/he gets too few feeds, or because they are too dilute. S/he is more likely to suffer from Vitamin A deficiency.
  - An artificially fed baby is more likely to die from infections and malnutrition than a breastfed baby.
  - Child may become intolerant to animal milk which may cause, diarrhoea, rashes and other symptoms.
  - The risk of some chronic diseases, such as diabetes, hypertension is increased when artificially fed babies become adults.
  - A baby may get too much artificial milk and become obese.
  - The child may not develop so well mentally and may score lower on intelligence tests.
  - A mother who does not breastfeed is more likely to become fertile again and can become pregnant more quickly.
  - The mother is more likely to become anaemic after childbirth.
  - The mother is more likely to develop later on cancer of the ovary and the breast.

So, artificial feeding is harmful for children and their mothers. Breastfeeding is fundamental to child health and survival, and important for the health of women.

III. Summarize (5 minutes)

#### Recommendations (Show TA 1.3)

- Ask frontline workers to see and read these recommendations on the Teaching aid 1.3
- Before you learn how to help mothers, you need to understand what is optimal infant and young child feeding.
  - Initiate breastfeeding within 1 hour of birth.
  - Babies should not have any other food or drink except breastmilk
  - No prelacteal feeds should be given.
  - Babies should be exclusively breastfed for first six months of life.
  - At completion of six months, give appropriate complementary foods.
  - Children should continue to breastfeed up to two years of age or beyond along appropriate complementary feeding.

IV. Discussion - Answer participant's question (30 minutes)

SESSION

#### **Production and Intake of Breastmilk**

#### **Objectives**

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

- Know how milk is produced in the breast and ejection of milk
- Describe correct attachment of the baby at the breast
- Causes of poor attachment

Session outline	(60 minutes)
I. Introduce the topic	(5 minutes)
II. Presentation	(30 minutes)
» Breast models	
» Teaching Aids 2.1 - 2.6	
III. Summarize	(5 minutes)
IV. Discussion	(20 minutes)

#### **Preparation**

- 1. Read the introduction. How to conduct the training course?
- 2. Arrange Teaching Aids 2.1 2.6.
- 3. Prepare arrange breast models (average size, flat nipple).

#### I. Introduce the topic

(5 minutes)

Ask participants to keep their manuals closed during the presentation.

- ☐ Make these points:
- In this session, you will learn about the anatomy and physiology of breast. In order to help mothers, you need to understand how breastfeeding works.
- You cannot learn a specific way of counselling for every situation, or every difficulty. But if you understand how breastfeeding works, you can work out what is happening, and help each mother to decide what is best for her.

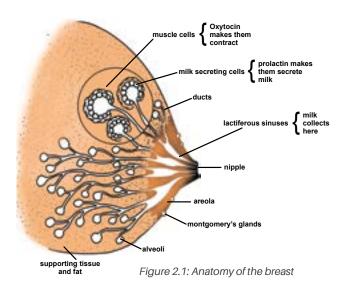
#### II. Present teaching aids 2.1 - 2.6

(30 minutes)

☐ Trainer will show the TA 2.1

#### TA 2.1: Breast Anatomy - Structure

This diagram shows the anatomy of the breast.



First, look at the nipple, and the dark skin called the areola which surrounds it. Over the areola are small glands called Montgomery's glands which 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 to contract and squeeze out the milk. A hormone called oxytocin makes the muscle cells contract to squeeze out milk.

Small tubes, or ducts, carry milk from the alveoli to the outside. Beneath the areola, the ducts become wider, and form lactiferous sinuses, where milk collects in preparation for a feed. The ducts become narrow again as they pass through the nipple.

The secretory alveoli and ducts are surrounded by supporting tissue, and fat. It is the fat and other tissues which gives the breast its shape, and which makes most of the difference between large and small breasts. Small breasts and large breasts both contain about the same amount of glandular tissue, so they can both make plenty of milk.

- ☐ Trainer will explain how milk is produced?
- ☐ Trainer will ask the trainees to see the diagram on the TA 2.2

#### TA 2.2: Prolactin reflex for milk production

This diagram explains about the hormone prolactin.



Figure 2.2: The prolactin reflex or the milk secretion response

When a baby suckles at the breast, sensory impulses go from the nipple to the mother's 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.

Prolactin level peaks in the blood about 30 minutes after feed - so it makes the breast produce milk for the NEXT feed. For this feed baby takes the milk which is already in the breast.

#### Ask: What does this suggest? How to increase a mother's milk supply?

It tells us that if her baby suckles more, her breasts will make more milk. So MORE SUCKLING MAKES MORE MILK.

Most women can produce more milk than their babies need or take. If a mother has two babies and they both suckle, her breasts make milk for two. Most mothers can produce enough milk for at least two babies.

If a baby suckles less, the breasts make less milk. If a baby stops suckling, the breasts soon stop making milk.

Some special things to remember about prolactin are:

- More prolactin is produced at night; so breastfeeding at night is especially helpful for keeping
  up the milk supply.
- Prolactin makes a mother feel relaxed, and sometimes sleepy; so she usually rests well even if she breastfeeds at night.
- Prolactin suppresses ovulation; so breastfeeding can help to delay a new pregnancy. Breastfeeding at night is important for this.
- ☐ Trainer will explain how milk is ejected?
- ☐ Trainer will ask trainees to see the diagram on the TA 2.3

#### TA 2.3: Oxytocin reflex for milk ejection

This diagram explains about the hormone oxytocin.

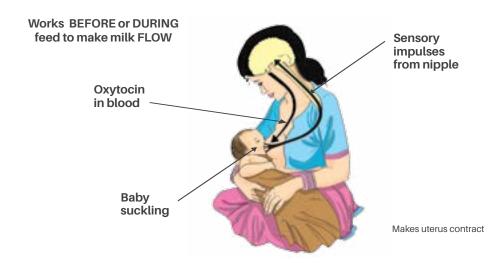


Figure 2.3: The milk flow response

When a baby suckles, sensory impulses go from the nipple to the mother's brain. In response, the posterior part of the pituitary gland, at the base of the brain, secretes the hormone oxytocin. Oxytocin goes in the blood to the breast, and makes the muscle cells around the alveoli contract. This makes the milk which has collected in the alveoli flow along the ducts to the lactiferous sinuses. Sometimes the milk flows to the outside. This is the oxytocin reflex or the milk ejection reflex.

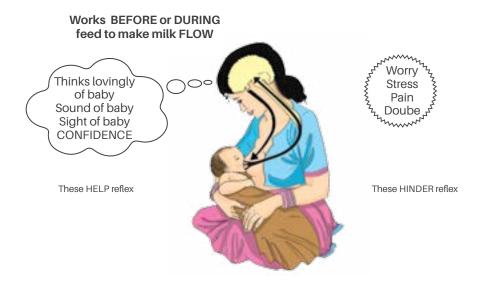
Oxytocin is produced more quickly than prolactin. It makes the milk in the breast flow for the feed. Oxytocin can start working before a baby suckles, when a mother is going to start a feed.

If the oxytocin reflex does not work well, the baby may have difficulty in getting the milk. It may seem as if the breasts have stopped producing milk. However, the breasts are producing milk, but it is not flowing out.

Another important point about oxytocin is that it makes a mother's uterus contract after delivery. This helps to reduce bleeding, but it sometimes causes uterine pain and a rush of blood during a feed for the first few days. The pains can be quite strong.

#### Show TA 2.4: Helping and hindering the oxytocin reflex

The oxytocin reflex is easily affected by mother's thoughts, feelings and sensations.



Trainers' Guide

Good feelings, for example feeling pleased with her baby, or thinking lovingly of him, and feeling confident that her milk is the best for him, can help the oxytocin reflex to work and her milk to flow. Sensations such as touching or seeing her baby, or hearing him cry, can also help the reflex.

But bad feelings, such as pain, or worry, or doubt that she has enough milk, can hinder the reflex and stop her milk from flowing. Fortunately, this effect is usually temporary.

#### Ask: Why is it important to understand the oxytocin reflex?

- Trainer explains these two key points about caring for mothers and babies:
  - » A mother needs to have her baby near her all the time, so that she can see and touch and respond to him. This helps her body to prepare for a breastfeed, and it helps her breastmilk to flow. If a mother is separated from her baby between feeds, her oxytocin reflex may not work so easily.
  - You need to remember a mother's feelings whenever you talk to her. It is important that you try to make her feel good and build her confidence, to help her breastmilk to flow well. You must not say anything which may make her worry about or doubt her breastmilk supply.
  - » Mothers are often aware of their oxytocin reflex. There are several signs of an active reflex that they or you may notice.

Ask: Can you enumerate what controls the production of milk from what you have learnt?

(Let participants suggest the answer. Give them a few minutes to think about it. Then continue.)

#### **Key points:**

- 1. The baby's suckling controls them all.
- 2. It is the baby's suckling which makes the breasts produce milk.
- 3. If the baby is unable to suckle or mother is unable to breastfeed, frequent expression of breastmilk helps in continued production of milk.
- Make these points:
- Sometimes people talk as though to make a mother produce more milk, we should give her more to eat, or 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.
- For a mother to produce enough milk, her baby must suckle often enough, and s/he must also suckle in the right way.

#### **ATTACHMENT**

- Attachment means how a baby takes the breast into his mouth and suckles.
- Trainer explains to the frontline workers to notice following points while observing a breastfeeding mother:

#### Whether,

- The child has taken much of areola and the underlying tissues into his mouth.
- The lactiferous sinuses are included in these underlying tissues

- S/he has stretched the breast tissue out to form a long 'teat'
- The nipple forms only about one-third of the 'teat'
- The baby is suckling from the breast, not the nipple.
- Trainer will then demonstrate both outside and inside appearance of attachment to frontline workers with the help of teaching aids.

#### **Show TA 2.5: Good and poor attachment (outside appearance)**

# **Good Attachment**



# Poor Attachment

Ask: What differences do you see between pictures 1 and 2?

#### In picture 1:

- The baby's chin touches the breast.
- His mouth is wide open.
- His lower lip is turned outwards.
- You can see more of the areola above his mouth and less below. This shows that s/he is reaching with his tongue under the lactiferous sinuses to press out the milk.

These are some of the signs that you can see from outside which tell you that a baby is well attached to the breast.

#### In picture 2:

- The baby's chin does not touch the breast.
- His mouth is not wide open, and it points forwards.
- His lower lip is not turned outwards.
- You can see the same amount of areola above and below his mouth, which shows that s/he is not reaching the lactiferous sinuses.

These are some of the signs that you can see from outside which show that a baby is poorly attached to the breast.

You may notice more areola outside the poorly attached baby's mouth.

Trainers' Guide

#### Show TA 2.6: Good and poor attachment (inside appearance)

# Good Attachment Picture 1



Picture 2

#### Ask: In what way is picture 2 different from picture 1?

Let participants make as many observations as they can.

Then make sure that the following three points are clear.

The most important differences to see in picture 2 are:

- Only the nipple is in the baby's mouth, not the underlying breast tissue
- The lactiferous sinuses 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 lactiferous sinuses

The baby in picture 2 is poorly attached. S/he is 'nipple sucking'

#### **Key points:**

Seeing a lot of areola is not a reliable sign of poor attachment. Some mothers have a very large areola, and you can see a lot even if the baby is well attached. It is more reliable to compare how much areola you see above and below a baby's mouth.

#### Causes of poor attachment

Trainer summarizes the common causes of poor attachment to the breast.

#### • Use of a feeding bottle

If a baby feeds from a bottle before breastfeeding is established, s/he may have difficulty suckling effectively. Some babies who start bottle feeds after a few weeks may also begin to suckle ineffectively.

The action of suckling 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 'sucking confusion' or 'nipple confusion'. So giving a baby feeds from a bottle can interfere with breastfeeding. Skilled help is needed to overcome the problem.

#### Inexperienced mother

If a mother has not had a baby before, or if she bottle fed or had difficulties breastfeeding previous babies, she may have difficulty getting her baby well attached to her breast. (However, even mothers who have previously breastfed successfully sometimes have difficulties.)

#### • Functional difficulty

Some situations can make it more difficult for a baby to attach well to the breast. For example:

- » If a baby is very small or weak;
- » If a mother's nipples and the underlying tissue are poorly protractile (difficult to stretch out to form a 'teat');
- » If her breasts are engorged and
- » If there has been a delay in starting to breastfeed.

Mothers and babies can breastfeed in all these situations, but they may need extra skilled help to succeed.

#### Lack of skilled support

A very important cause of poor attachment is lack of skilled help and support.

Some women are isolated, and lack support from the community. They may lack help from experienced women such as their own mothers; or from traditional birth attendants, who often are very skilled at helping with breastfeeding.

Women in 'bottle feeding' cultures may be unfamiliar with how a breastfeeding mother holds and feeds her baby. They may never have seen a baby breastfeeding.

Frontline workers who look after mothers and babies, for example, doctors and midwives, may not have been trained to help mothers to breastfeed.

III. Summarize (5 minutes)

- Summarize the session with these points:
- To help mothers to breastfeed, it is important to understand how breastfeeding works.

Breastmilk flow depends partly on the mother's thoughts, feelings and sensations.

- » It is important to keep mothers and babies together day and night, and to help mothers to feel good about breastfeeding.
- » Many common difficulties can be caused by poor attachment to the breast. These difficulties can be overcome by helping the mother to correct her baby's position. They can be prevented by helping a mother to position her baby in the first few days.
- » The amount of milk that the breasts produce depends on how much the baby suckles. More suckling makes more milk. Most mothers can produce more milk than their babies take, and they can produce enough for twins.

#### BREASTFEEDING WILL BE SUCCESSFUL IN MOST CASES IF:

- The mother feels good about herself
- The baby is well attached to the breast so that s/he suckles effectively
- The baby suckles as often and enough
- The environment supports breastfeeding.
- The mother is supported by health facilities family, society, employer etc.

IV. Discussion (20 minutes)



SESSION

03

#### **Assessing and Observing a Breastfeed**

#### **Objectives**

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

- Assess a breastfeed by observing mother and baby and asking questions.
- Recognizing correct positioning of the baby at the breast.
- Identify a mother who may need help.

Session outline	(60 minutes)
I. Introduce the topic	(5 minutes)
II. Role-play and demonstration	(15 minutes)
III. Show and discuss teaching aids 2.5, 3.1- 3.3	(30 minutes)
IV. Summarize	(5 minutes)
V. Discussion	(10 minutes)

#### **Preparation**

- 1. Read the introduction. How to conduct the training course?
- 2. Arrange Teaching Aids 2.5, 3.1-3.3
- 3. Prepare two participants for role-play. Ask two participants to help you with the demonstration. Explain what you want them to do, and help them practice. Make sure that they have dolls for the demonstration. If you feel that participants cannot do this on the first day of the course, ask other trainers to help instead.
- 4. Arrange breast model and feeding bottle.

#### I. Introduce the topic

(5 minutes)

Ask participants to keep their manuals closed during the presentation.

- Make these points:
- Assessing a breastfeed helps you to decide if a mother needs help or not, and how to help her.
- You can learn a lot about how well or badly breastfeeding is going by observing, before you ask questions.
- This is just as important part of clinical practice as other kinds of examination, such as looking for signs of dehydration, or counting how fast a child is breathing.
- There are certain things you can observe when a baby is not breastfeeding. Other things you can only observe if a baby is breastfeeding.

## II. Demonstrate and explain how to assess a breastfeed

(30 minutes)

☐ Trainer explains to the participants HOW TO ASSESS A BREASTFEED.

	HOW TO ASSESS A BREASTFEED
1	What do you notice about the mother?
2	How does the mother hold her baby?
3	What do you notice about the baby?
4	How does the baby respond?
5	How does the mother put her baby onto her breast?
6	How does the mother hold her breast during a feed?
7	Does the baby look well attached to the breast?
8	Is the baby suckling effectively?
9	How does the breastfeed finish?
10	Does the baby seem satisfied?
11.	What is the condition of the mother's breasts?
12	How does breastfeeding feel to the mother?

□ Explain each point in turn.

Read out the number and title of each point, or pair of points. Then give the demonstration, or explanation, or conduct the discussion as described.

Ask participants to open the manual, see "How to assess to breastfeed" and keep the list in front of them. Refer to the list as you explain the points.

#### Point 1: What do you notice about the mother?

#### Point 2: How does the mother hold her baby?

☐ Ask two participants to hold dolls to play the roles of mothers and babies.

**Sunita** sits comfortably and relaxed, and acts being happy and pleased with her baby. She holds it close, facing her breast, and she supports its bottom. She looks at her baby, and fondles or touches it lovingly.

**Anita** sits uncomfortably, and acts being sad and not interested in her baby. She holds it loosely, and not close, with its neck twisted, and she does not support its bottom. She does not look at it or fondle it, but she shakes or prods the baby a few times to make it go on breastfeeding. She also has a feeding bottle that is peeping out of the bag.

Ask the other participants to observe the 'mothers and babies'.

Ask the questions for Point 1 and Point 2.

Give them a few minutes to make some suggestions.

Help them think of the points listed after the questions.

Indicate which points the 'mothers' are acting.

#### Ask: Point 1: What do you notice about the mother?

- You may notice:
  - ▶ Her age, general health, nutrition, socioeconomic status:

(Clothes may be misleading if women dress up to go to a health centre.)

This may give you some clues about her life situation, and whether it is easy or difficult for her to care for and breastfeed her baby.

Her expression, which may tell you something about how she feels:

If she is happy and pleased with her baby, she is more likely to breastfeed successfully (Sunita A).

If she is miserable and not interested, she is less likely to breastfeed successfully (Anita).

Whether she looks comfortable and relaxed or uncomfortable and tense:

If she is comfortable and relaxed, it helps breastfeeding (Sunita).

If she is uncomfortable and tense, it makes breastfeeding more difficult (Anita).

- There are many other things that you may notice in different situations, for example:
  - Any other family members who are present, such as the father or grandmother, and how they relate to the mother and baby.
  - Whether the mother is carrying a feeding bottle in her bag.
  - If she has clothes which make it difficult to breastfeed.

#### Ask: Point 2: What should you notice about how a mother holds her baby?

- You may notice whether:
  - ▶ She holds him close, facing her breast, or loosely and turned away:

If she holds the baby close to the breast and facing it, it is easier for him to suckle effectively (Sunita).

If she holds him loosely, or turned away so that his neck is twisted, it is more difficult for him to suckle effectively (Anita).

#### > She holds him securely and confidently, or nervously:

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 (Sunita).

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 (Anita).

#### She shows signs of bonding to her baby:

If she looks at him, touches him, and talks to him, these are signs of bonding, which help breastfeeding (Sunita).

If she does not look at the baby, and does not touch him or talk to him, these are signs that she has not bonded well. She is more likely to have problems with breastfeeding (Anita).

#### > She supports his bottom, or only his head and shoulders:

For a young infant, it is easier to attach to the breast if his bottom is supported, and not just his head (Sunita).

For older babies support of the upper part of the body is usually enough.

Remember (

Remember that if a mother feels good about breastfeeding, and if her baby is positioned so that s/he can suckle effectively, breastfeeding is likely to be Successful

☐ Thank the participants who played the two mothers.

#### Ask: Point 3: What do you notice about the baby?

- Look at his general health, nutrition, and alertness.
- Look for signs of conditions which can interfere with breastfeeding:
  - blocked nose
  - difficult breathing
  - thrush
  - jaundice
  - dehydration
  - tongue tie
  - a cleft lip or palate

#### Ask: Point 4: How does the baby respond?

- Look for these responses:
  - If s/he is a young infant: rooting for the breast when s/he is ready for a feed.
  - S/he may turn his head from side to side, open his mouth, put his tongue down and forward, and reach for the breast.
  - If s/he is an older baby: turning and reaching for the breast with his hand. Both these responses show that a baby wants to breastfeed.
  - The baby is crying or pulling back or turning away from his mother.
     This response shows that a baby does not want to breastfeed, and that there is a problem with breastfeeding.
  - The baby being restless and slipping off the breast or refusing to feed.
     This may mean that s/he is not well attached and is not getting the breastmilk.
  - The baby being calm during a feed, and relaxed and contented after a feed.
     These are signs that s/he is getting breastmilk.

#### Ask: Point 5: How does the mother put her baby on to her breast?

- Look for these signs:
  - ☐ Demonstrate these signs with a model breast.
    - The mother trying to push her nipple into her baby's mouth.

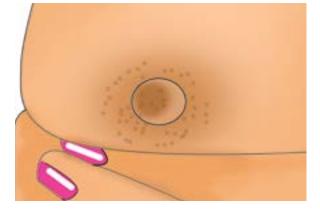
She may lean forward or pinch her nipple.

This makes it more difficult for a baby to attach to the breast.

The mother bringing her baby to her breast.

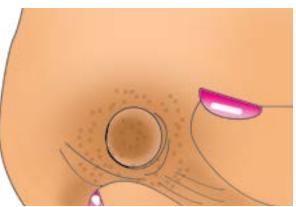
She may support her whole breast with her hand, and if necessary shape her breast with her thumb above the breast. This is helpful for a baby.

Correct holding



 Resting her fingers on her breast so that her first finger forms a support at the base of the breast

#### Incorrect holding



b. Holding her breast too near and close to nipple

Figure 3.3: How a mother holds her breast.

#### Ask: Point 6: How does the mother hold her breast during a feed?

- Demonstrate these signs with a model breast.
- Look for these signs:
  - ▶ The mother holding her breast very close to the areola.

This makes it difficult for a baby to suckle. It may block the milk ducts so that it is more difficult for the baby to get the breastmilk.

▶ The mother holding her breast back from her baby's nose with her finger.

This is not necessary.

The mother holding her breast with the 'scissor hold'.

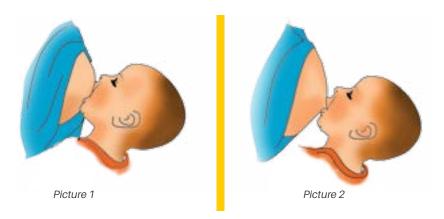
The 'scissor hold' (sometimes called the 'cigarette hold') means when she holds the nipple and areola between her index finger above and middle finger below. This can make it more difficult for a baby to take enough breast into his mouth. The pressure of her fingers may block the milk ducts.

The mother supporting her whole breast with her hand against her chest wall.

This usually helps a baby to suckle effectively, especially if his mother has large breasts.

#### Ask: Point 7: Does the baby look well attached to the breast?

#### Show TA 2.5: Good and poor attachment (Outside appearance)



#### Ask: Which signs of good attachment you may see?

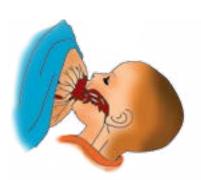
- The baby's chin touching the breast.
- His mouth wide open. His lower lip turned outwards.
- His cheeks round, or flattened against his mother's breast.
- More areola above the baby's mouth than below it.
- The breast looks rounded during a feed.

#### Ask: Which signs of poor attachment you may see?

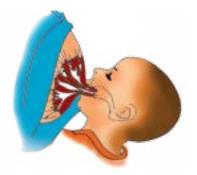
- The baby's chin is not touching the breast.
- His mouth is not wide open (especially with a large breast).
- His lips are pointing forwards or his lower lip is turned in.

Trainers' Guide

- His cheeks are tense or pulled in as s/he suckles.
- More areola below the baby's mouth than above it, or the same amount above and below.
- The breast looks stretched or pulled during a feed.







A baby poorly attached to his mother's breast

#### Ask: Point 8: Is the baby suckling effectively?

☐ Give the following demonstrations as you explain:

To demonstrate good attachment: Suck on your fist, with your mouth open wide, your tongue forward, and your lower lip curled back. Give slow deep sucks, about 1 per second.

To demonstrate poor attachment: Suck on your thumb, with your mouth almost closed, your lips pointing forwards, and letting your cheeks pull in. Give quick, small sucks.

#### Look for these signs:

The baby taking slow deep sucks.

This is an important sign that a baby is getting breastmilk. S/he is well attached to the breast, and suckling effectively.

A baby usually takes a few quick sucks to start the oxytocin reflex. Then as the milk starts flowing and his mouth fills with milk, his sucks become deeper and slower. Then s/he pauses, and starts again with a few quick sucks.

The baby taking quick shallow sucks all the time.

This is a sign that s/he is not getting the breastmilk. S/he is not well attached, and not suckling effectively.

> The baby swallowing so that you can see or hear it.

If a baby swallows, it means that s/he is getting breastmilk. Sometimes you can hear swallowing; sometimes it is easier to see swallowing.

▶ The baby making smacking sounds as s/he sucks.

This is a sign that s/he is not well attached.

▶ The baby 'gulping' as s/he swallows.

Gulps are very loud swallowing sounds, when a lot of fluid is being swallowed at once.

This is a sign that a baby is getting a lot of milk. It sometimes means that his mother has an oversupply, and her baby is getting too much milk too fast. Oversupply is sometimes the cause of breastfeeding difficulties.

#### Point 9: How does the breastfeed finish?

#### Point 10: Does the baby seem satisfied?

- Look for these signs:
  - The baby releasing the breast himself, and looking satisfied and sleepy.

This shows that s/he has had all that s/he wants from that side. S/he may or may not want the other side too.

▶ The mother taking her baby off her breast before s/he has finished.

A mother sometimes takes her baby off her breast quickly, as soon as s/he pauses, because she thinks s/he has finished; or because she wants to make sure that s/he suckles from the other side as well.

A baby who comes off the breast too quickly may not get enough hindmilk.

S/he may want to feed again soon.

Notice how long the breastfeed continues:

The exact length of time is not important. Feeds normally vary very much in length. But if breastfeeds are very long (more than about half an hour) or very short (less than about 4 minutes) it may mean that there is a problem.

However, in the first few days, or with a low-birth-weight baby, breastfeeds may be very long and this is normal.

#### Point 11: What is the condition of the mother's breasts?

#### Point 12: How does breastfeeding feel to the mother?

Notice the size and shape of the mother's breasts and nipples:

All breasts are good for breastfeeding, but a mother may be worried that her breasts are not the best size. As a result, she may lack confidence in her ability to breastfeed. Sometimes the shape of a nipple makes it more difficult for a baby to attach to a breast.

- Look and ask for signs of an active oxytocin reflex:
  - Milk dripping or spraying out of a mother's breasts.

This shows that she has an active oxytocin reflex.

If milk does not flow out, however, it does not mean that her reflex is not active.

Uterine pains during breastfeeds for the first few days.

These are called afterpains. This is another sign of an active oxytocin reflex.

- Look also for these signs:
  - Breasts which are full before and soft after a feed, showing that the baby is removing breastmilk.
  - Breasts which are very full or engorged all the time, showing that the baby is probably not removing breastmilk effectively.
  - Healthy looking skin of the nipples and breast.
  - Red skin or fissures which show that there is a problem.
  - Nipple looking squashed or with a line across the tip or down the side as the baby releases the breast. This is a sign of poor attachment.
- Ask the mother how breastfeeding feels to her:

If it is comfortable and pleasant, her baby is probably well attached.

If it is uncomfortable or painful, the baby is probably not well attached.

#### Observing a breastfeed

- ☐ Explain what will happen:
- You will now see a few photographs of baby's breastfeeding.
- You will practice recognizing the signs of good and poor positioning and attachment that the photographs show.
- 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.)

#### III. Show and discuss TA 3.1 - 3.3

(30 minutes)

- ☐ Explain what to do:
- As you look at each photograph:
  - Decide which signs of good or poor positioning and attachment you see.
  - Decide if you think the baby's position and attachment are good or poor.
- Ask a participant to come forward to the screen for each of the photographs 3.1 to 3.4.
- ☐ As you show each photograph:

#### Ask: What do you think of this baby's position and attachment?

Give the participant a few moments to study the picture, and to describe, and point to the signs that she sees.

Then ask other participants to describe the signs that they see.

Then point out any signs that they have missed.

Try not to repeat signs that they have already mentioned.

The text below lists the signs that each photograph illustrates particularly well, and which can help the observer to make a decision.

Participants may describe more signs than are given in the text. There are other signs in the photographs, but most of them are not very helpful. Accept participants' observations, or gently correct them, if they are incorrect.

#### TA 3.1 to 3.2: Recognizing signs of good positioning and attachment

#### **TA 3.1**



- Signs that you can see clearly are:
  - the baby is close to the breast, and facing it
  - his mouth is quite wide open
  - his lower lip is turned outwards
  - his chin is almost touching the breast
  - his cheeks are round
  - there is more areola above the baby's mouth than below it
- These signs show that the baby is well attached to the breast.

Additional points for teaching aid 3.1

The baby is breathing quite well without his mother holding her breast back with her finger.

#### **TA 3.2**



- The signs that you can see are:
  - the baby is close to the breast and facing it
  - his chin is almost touching the breast

- his mouth is wide open
- his lower lip is turned outwards
- you can just see his tongue, which is cupped round the breast
- his cheeks are round (s/he has a dimple, but his cheek is not pulled in)
- there is more areola above the baby's mouth than below it
- This baby is well attached.

Additional points for teaching aid 3.2

Notice that the baby's nose is well away from the breast. When a baby is attached in a good position, there is usually plenty of room to breathe.

#### **TA 3.2**



- Signs that you can see are:
  - the baby's body is not close to his mother's
  - his chin is not touching her breast
  - his mouth is not wide open and his lips point forwards
  - there is as much areola below the baby's mouth as above it
- This baby is poorly attached to the breast.

Additional points for Slide 3.3

The areola on this mother's breast is very large, so it is likely that you would see a lot of it even if her baby was well attached. However, you should see more above the baby's mouth than below it.

IV. Summarize (5 minutes)

- ☐ Conclude with these points:
- You do not see all the signs with every baby. Sometimes you see one or two signs of poor positioning, but all the other signs are good. Then you may not be sure if the baby is well or poorly attached. You may not be sure if the mother needs help or not.
- Remember that in a live baby, you will also be looking at the baby's suckling. If a baby takes slow deep sucks, then s/he is probably well attached.
- Always ask how breastfeeding feels to the mother. If she has discomfort or pain in her breasts, then her baby may not be well attached. If she is comfortable, then s/he is likely to be well attached.
- Always ask about the baby's general health and his growth and behaviour. If the baby is satisfied and growing well, s/he is probably suckling effectively.

V. Discussion (10 minutes)



SESSION

04

### **Listening and Learning**

#### **Objectives**

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

- Encourage a mother to talk without asking too many questions.
- Understand mother's feelings.

#### **Session outline**

I. Introduce the topic

II. Demonstration of skills

III. Group practice

IV. Summarize

#### (60 minutes)

(5 minutes)

(40 minutes)

(10 minutes)

(5 minutes)

#### **Preparation**

- 1. Read the introduction. How to conduct the training course?
- 2. Prepare one participant to demonstrate non-verbal communication skills and demonstration.
- 3. A-D prepare another participant to do demonstration E, F, G, H.
- 4. Prepare this participant to do demonstration J-M.
- 5. Prepare one trainer to write listening/learning skills on the black board.
- 6. Prepare cards for listening/learning skills. Use drawing sheets and write with bold pen.

Card 1: To make open questions

Q. Do you breastfeed your baby?

Card 2: Reflect back

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

Card 3: Empathize

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

#### I. Introduce the topic

(5 minutes)

Ask participants to keep their manuals closed during the presentation.

- ☐ Introduce the idea of counselling with these points:
- Counselling is a way of working with people in which you try to understand how they feel and help them to decide what to do.
- In these sessions, we will discuss mothers who are breastfeeding and how they feel.
- Breastfeeding is not the only situation in which counselling is useful. Counselling skills are useful when you talk to patients or clients in other situations. You may also find them helpful with your family and friends, or your colleagues at work. Practise some of the techniques with them you may find the result surprising and helpful.
- A breastfeeding mother may not talk about her feelings easily, especially if she is shy, and with someone whom she does not know well. You need the skill to listen, and to make her feel that you are interested in her. This will encourage her to tell you more. She will be less likely to "turn off", and say nothing.

#### II. Demonstrate listening and learning skills (30 minutes)

- Tell participants that in this session, you will explain and demonstrate six skills for listening and learning.
- → Write the heading 'LISTENING AND LEARNING SKILLS' on a board or flipchart. List the six skills underneath as you demonstrate them.

#### Skill 1. Use helpful non-verbal communication

#### Ask one trainer whom you have prepared to

Write 'Use helpful non-verbal communication' on the list of listening and learning skills.

#### Ask him/her to

- Write 'HELPFUL NON-VERBAL COMMUNICATION' on another board or flipchart with room for a list of six points below it.
- ☐ Explain the skill:

#### Ask: What do you think we mean by "non-verbal communication"?

(Let participants make one or two suggestions, and then give them the following answer.)

Non-verbal communication means showing your attitude through your posture, your expression, everything except through speaking.

□ Demonstrate the skill:

Tell participants that you will demonstrate six different kinds of non-verbal communication.

Ask the participant whom you have prepared to help you. She sits with a doll, pretending to be a mother breastfeeding. She can respond to your greeting, but she does not have to say anything else.

Give the six pairs of demonstrations in Demonstration A.

- » With each pair, you address the 'mother' in two ways.
- » One way helps communication, and the other way hinders communication.
- » Demonstrate the way which helps sometimes first, and sometimes second, so that the participants who are observing cannot guess which is which just from the order of the demonstrations.

» Demonstrate 'appropriate touch' (socially acceptable) and 'inappropriate touch' (not socially acceptable) in the way that you agreed with the participant before the session.

#### Ask other participants to:

- » Identify the form of non verbal communication after each pair of demonstrations;
- » Say which form helps communication and which hinders it.

#### **Demonstration A: Non-verbal communication**

With each demonstration say exactly the same few words, and try to say them in the same way, for example:

"Good morning, Rohini. How is breastfeeding going for you and the baby?"

#### 1. Posture

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

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

→ Write: 'KEEP SAME HEAD LEVEL' on the flipchart

#### 2. Distance

Helps: Appropriate distance from mother

Hinders: Too close or too far from mother

→ Write: 'KEEP APPROPRIATE DISTANCE' on the flipchart.

#### 3. Eye contact

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

Helps: Look at her and pay attention as she speaks

→ Write: 'PAY ATTENTION' on the flipchart

(Note: Eye contact may have different meanings in different cultures. Sometimes when a person looks away it means that he or she is ready to listen. If necessary, adapt this to your own situation.)

#### 4. 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

#### 5. Taking time

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

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

→ Write: 'TAKE TIME' on the flipchart

#### 6. Touch

Hinders: Touch her in an inappropriate way

Helps: Touch the mother appropriately

→ Write: 'TOUCH APPROPRIATELY' on the flipchart

For a man, if it is not appropriate to touch the woman, is it appropriate to touch the baby? (Let participants give some examples from their experience.)

## Ask: Do you know any other kinds of non-verbal communication which could make a mother feel that you are interested in her, and care about her, so, that she tells you more?

(Let participants give some examples. For example smiling, nodding.)

You now have the following list written on the flipchart. Post it up on the wall.

#### **HELPFUL NON-VERBAL COMMUNICATION**

Keep same head level

Keep appropriate distance

Pay attention

Remove barriers

Take time

Touch appropriately

#### Skill 2. Ask open questions

#### Ask the trainer to

→ Write 'Ask open questions' on the list of listening and learning	skills
--	--------

- □ Explain the skill:
- To start a discussion with a mother, or to take a history from her, you need to ask some questions.
- It is important to ask questions in a way which 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?" 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 s/he?" or "Has s/he?" or "Does s/he?"

For example: "Did you breastfeed your last baby?"

If a mother says "Yes" to this question, you still do not know, if she has breastfed exclusively, or if she also gave some artificial feeds.

You can become quite frustrated, and think that the mother is not willing to talk, or that she is not telling the truth.

- □ Demonstrate the skill:
- ② Ask Participant 1 to read the words of the mother in Demonstrations B and C while you read the part of the frontline worker (FW).

After each demonstration, comment on what the frontline worker learnt.

#### Demonstration B: Closed questions to which she can answer 'yes' or 'no'

FW : "Good morning, Sita. I am Radha, the community midwife. Is Rahul well?"

Mother: "Yes, thank you."

FW: "Are you breastfeeding him?"

Mother : "Yes".

FW: "Are you having any difficulties?"

Mother : "No".

FW: "Is s/he breastfeeding very often?"

Mother : "Yes".

Comment

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

#### **Demonstration C: Open questions**

FW : "Good morning, Sita. I am Radha, the community midwife. How is Rahul?"

Mother : "S/he is well, and s/he is very hungry."

FW : "Tell me, how are you feeding him?"

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

FW: "What made you decide to do that?"

Mother : "S/he wants to feed too much at that time, so I thought that my milk is not

enough".

**Comment** The frontline worker asked open questions. The mother could not answer

with a "yes" or a "no", and she had to give some information. The frontline

worker learnt much more

- Explain how to use questions to start and to continue a conversation:
- You need to ask questions to start a conversation. For this, very general open questions are often helpful. They give a mother a chance to say what is important to her. For example: "How is breastfeeding going for you?"
  - "Tell me about your baby."
- However, sometimes a mother just says "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:
  - "How old is your baby now?"
  - "How many hours after s/he was born did s/he have his first feed?"
- Sometimes you might need to ask a closed question, for example: "Are you giving him any other food or drink?" or "Are you giving the other feeds by bottle?"

#### Skill 3. Use responses and gestures which show interest

#### **Ask Trainer to**

- Write 'Use responses and gestures which show interest' on the list of listening and learning skills.
- Explain the skill:
- If you want a mother to continue talking, you must show that you are listening, and that you are interested in what she is saying.
- Important ways to show that you are listening and interested are:
  - with gestures, for example, look at her, nod and smile;
  - with simple responses, for example, you say "Aha", "Mmm", "Oh dear!".
- □ Demonstrate the skill:
- Ask Participant 2 to read the words of the mother in Demonstration D, while you play the part of the frontline worker. You give simple responses, and nod, and show by your facial expression that you are interested and want to hear more.

After the demonstration, comments and what it showed.

#### Demonstration D: Using responses and gestures which show interest

FW : "Good morning, Parveen. How is breastfeeding going for you these days?"

Mother : "Good morning. It is going quite well, I think."

FW: "Mmm." (nods, smiles.)

Mother : "Well, I was a bit worried the other day, because s/he vomited."

FW : "Oh dear!" (raises eyebrows, looks interested.)

Mother : "I wondered if it was something that I ate, so that my milk did not suit him."

FW: "Aha!" (nods sympathetically).

Comment

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

Discuss locally appropriate responses:

☐ In different countries, people use different responses, for example, "Nnn", "Eeehh". They are part of the language.

#### Ask: What responses do people use locally?

Let participants give some examples of useful responses.

#### Skill 4. Reflect back on what the mother says

#### Ask the trainer to

- → Write 'Reflect back on what the mother says' on the list of listening and learning skills.
- □ Explain the skill:
- Frontline 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 s/he wake up?". But the answer is not helpful.

It is more useful to repeat back or reflect on what a mother says. It shows that you understand, and she is more likely to say more about 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: "My baby was crying too much last night."

You could say: "Your baby kept you awake crying all night?"

□ Demonstrate the skill:

Ask Participant 2 to read the words of the mother in Demonstrations E and F while you read the part of the frontline worker.

After each demonstration, comment on what the frontline worker learnt.

#### **Demonstration E: Continuing to ask questions**

FW : "Good morning, Parveen. How are you and Hamid today?"

Mother : "S/he wants to feed too much - s/he is taking my breast all the time!"

FW: "About how often would you say?"

Mother : "About every half an hour."

: "Does s/he want to suckle at night too?"

Mother : "Yes".

Comment

The frontline worker asks factual questions, and the mother gives less and less information

#### **Demonstration F: Reflecting back**

FW : "Good morning Parveen. How are you and Hamid today?"

Mother : "S/he wants to feed too much - s/he is taking my breast all the time!"

FW: "Hamid is feeding very often?"

Mother : "Yes. This week s/he is so hungry. I think that my milk is drying up."

FW : "S/he seems more hungry just for about a week?"

Mother : "Yes, and my sister is telling me that I should give him some bottle feeds as well."

FW: "Your sister says that s/he needs something more?"

Mother: "Yes. Which formula is best?".

The frontline worker reflects back on what the mother says, so the mother

gives more information.

- ☐ Explain this other point:
- If you continue to reflect back on what a mother says every time, it can begin to sound rather rude. It is better to mix up reflecting back with other responses.

For example: "Oh really?" or "Goodness!", or an open question.

- □ Demonstrate the point:
- Ask Participant 2 to read the words of the mother in Demonstration H, while you read the part of the frontline worker.

#### **Demonstration G: Mixing reflecting back with other responses**

FW : "Good morning. How are you and Hamid today?"

Mother : "S/he wants to feed too much - s/he is taking my breast all the time."

FW: "Hamid is feeding very often?"

Mother : "Yes. This week s/he is so hungry. I think that my milk is drying up."

FW: "Oh dear!"

Mother : "Yes, it is exhausting. My sister tells me that I should give some bottle feeds and

get some rest."

FW : "Your sister wants you to give some bottle feeds?"

Mother : "Yes - she says that I am foolish to struggle on like this."

FW: "How do you feel about that?"

Mother : "Well, I don't want to give bottle feeds."

Comment The c

The conversation sounds more natural, but the frontline worker is learning more about how the mother feels.

#### Skill 5. Empathize: show that you understand how she feels

#### Ask the trainer to

→ Write 'Empathize: show that you understand how she feels' on the list of listening and learning skills.

■ Explain the skill:

When a mother says something which shows how she feels, it is helpful to respond in a way which shows that you heard what she said, and that you understand her feelings from her point of view.

For example, if a mother says:

"My baby wants to feed very often and it makes me feel so tired!"

you respond to what she feels, perhaps like this:

"You are feeling very tired all the time then?"

Empathy is different from sympathy. When you sympathize you are sorry for a person, but you look at it from YOUR point of view.

If you sympathize, you might say: "Oh, I know how you feel. My baby wanted to feed often too, and I felt exhausted." This brings the attention back to you, and does not make the mother feel that you understand her.

You might ask for more facts. For example, you might ask:

"How often does s/he feed? What else are you giving him?"

But these questions do not help a mother to feel that you understand.

You could reflect back on what the mother says about the baby.

For example: "S/he wants to feed very often?"

But this reflects back on what the mother said about the baby's behaviour, and it misses what she said about how she feels. She feels tired.

So empathy is more than reflecting back on what a mother says to you.

- It is also helpful to empathize with a mother's good feelings. Empathy is not only to show that you understand her bad feelings.
- □ Demonstrate the skill:
- Ask Participant 3 to read the words of the mother in Demonstrations J, K, L, M, and N, while you read the part of the frontline worker.

After each demonstration, comment on what the frontline worker learnt.

#### **Demonstration H: Continuing to ask for facts**

FW : "Good morning, Anju. How are you and Rachit today?"

Mother : "Rachit is refusing to breastfeed - s/he doesn't seem to like my milk now!"

FW: "How long has s/he been refusing?"

Mother : "Just this week."

FW: "How old is s/he now?"

Mother: "S/he is six weeks old."

Comment

The frontline worker asks about facts. She ignores the mother's feelings, so she learns only facts which are not very helpful.

#### **Demonstration I: Sympathizing**

FW : "Good morning, Anju. How are you and Rachit today?"

Mother : "Rachit is refusing to breastfeed - s/he doesn't seem to like my milk now!"

FW: "Oh! I know how you feel. My baby refused to breastfeed when I came back to work."

Mother : "What did you do about it then?"

**Comment** The frontline worker sympathizes, and turns the attention to her own

situation. This is not helpful - especially if the frontline worker ended up

bottle-feeding.

#### **Demonstration J: Reflecting back**

FW: "Good morning, Anju. How are you and Rachit today?"

Mother : "Rachit is refusing to breastfeed - s/he doesn't seem to like my milk now!"

FW: "S/he is refusing to breastfeed?"

Mother : "Yes s/he takes one suck and then just cries and turns away."

**Comment** When the FW reflects back, the mother continues talking, but she talks

about the baby, and not about her feelings.

#### **Demonstration K: Empathizing**

FW : "Good morning, Anju. How are you and Rachit today?"

Mother : "Rachit is refusing to breastfeed - s/he doesn't seem to like my milk now!"

FW : "You feel that s/he doesn't like you now?"

Mother : "Yes, it's as if s/he doesn't love me - it just started suddenly this week, after his

grandmother came to live with us. She so much likes to give him a bottle feed!"

FW: "You feel that she wants to be the one to feed him?"

Mother : "Yes - she wants to take him over from me!"

Comment

The FW empathizes with the mother's feelings and learns some very important things - without asking direct questions.

#### Demonstration L: Empathizing with a mother's good feelings

FW : "Good morning, Anju. How is breastfeeding going for you and Rachit?"

Mother : "S/he is suckling well and s/he seems quite contented after feeds now."

FW: "You must feel pleased that it is going so well".

Mother : "Yes, I am so happy that I don't have to give bottle feeds."

FW: "You really enjoy breastfeeding. That's wonderful."

Comment

It is important to make a mother feel that you are interested in her, even if she does not have a problem.

#### Skill 6. Avoid words which sound judgemental

#### Ask the trainer

→ Write 'Avoid words which sound judgemental' on the list of listening and learning skills.

■ Explain the skill:

- Judgemental words' are words like: right, wrong, well, badly, good, enough, properly. If you use judgemental words when you talk to a mother about breastfeeding, especially when you ask questions, you may make her feel that she is wrong, or that there is something wrong with the baby.
- For example: Do not say: "Does the baby sleep well?" Instead say: "How is the baby sleeping?"
- □ Demonstrate the skill:
- ② Ask Participant 3 to read the words of the mother in Demonstrations O and P, while you read the part of the frontline worker.

After each demonstration, comment on what the frontline worker learnt.

#### **Demonstration M: Using judgemental words**

FW : "Good morning, Anju. Is Rachit breastfeeding normally?"

Mother : "Well... I think so."

FW: "Do you think that you have enough breastmilk for him?"

Mother : "I don't know......I hope so, but maybe not ..." (She looks worried).

FW : "Has s/he gained weight well this month? May I see his growth chart?"

Mother: "I don't know......"

**Comment** The frontline worker is not learning anything useful, but she is making the

mother very worried.

#### **Demonstration N: Avoiding judgemental words**

FW : "Good morning, Anju. How is breastfeeding going for you and Rachit?"

Mother : "It's going very well. We both enjoy it!"

FW: "How is his weight? Can I see his growth chart?"

Mother : "Nurse said that s/he gained more than half a kilo this month. I was pleased."

FW : "S/he is obviously getting all the breastmilk that s/he needs."

**Comment** The frontline worker learnt what she needed to know without making the

mother worried.

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

#### **III. Group Practice**

(10 minutes)

Now show Card 1. Read the question written there. Ask participants to make open question.

**Q.** Do you breastfeed your baby? (Answer: How are you feeding your baby).

- Show Card 2. Ask participants to read the question and "Reflect Back".
  - Q. My mother says that I don't have enough milk? (Answer: (i) Your mother says so or (ii) Your mother says you do not have enough milk).
- Show Card 3: Read the question and empathize.
  - **Q.** My baby wants to feed so often at night that I feel exhausted? (Answer: You really feel tired feeding baby in the night).

IV. Summarize (5 minutes)

You now have a list of the six skills on the flipchart.

Post it on the wall.

#### LISTENING AND LEARNING SKILLS

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



SESSION

05

# **Building Confidence, Giving Support and Checking Understanding**

### **Objectives**

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

- Accept what a mother thinks or feels.
- Recognize and praise what the mother and baby are doing right.
- Give practical help.
- Give information which is of immediate relevance.
- Check understanding of the mother.
- Make suggestions instead of giving commands.

### **Session outline**

I. Introduce the topic

II. Demonstration of skills

III. Group practice

IV. Summarize

### (60 minutes)

(5 minutes)

(30 minutes)

(20 minutes)

(5 minutes)

#### **Preparation**

- 1. Read the introduction. How to conduct the training course?
- 2. Prepare one participant to demonstrate acceptance.
- 3. Prepare one trainer to write building confidence and giving support skills on the black board.
- 4. Arrange teaching aids 5.1 and 5.2.

Card 1: How to give the relevant information?

"A mother on day one of delivery with soft breasts waiting for milk to come in".

Card 2: How to give a suggestion?

"Keep the baby in bed with you so that s/he can feed at night".

# I. Introduce the topic

(5 minutes)

- ☐ Make these introductory points:
- The third and fourth counselling skills sessions are about 'building confidence and giving support'.

A breastfeeding mother easily loses confidence in herself. This may lead her to give unnecessary artificial food, and to respond to pressures from family and friends to give artificial food.

You need the skill to help her to feel confident and good about herself.

Confidence can help a mother to succeed with breastfeeding. Confidence also helps her to resist pressures from other people.

- It is important not to make a mother feel that she has done something wrong.
  She easily believes that there is something wrong with herself or with her breastmilk, or that she is not doing well. This reduces her confidence.
- It is important to avoid telling a breastfeeding mother what to do.
  Help each mother to decide for herself what is best for her and her baby. This increases her confidence.

### II. Demonstrate the skills

(30 minutes)

- ☐ Tell participants that you will now explain and demonstrate six skills for building a mother's confidence and giving her support.
- → Write 'CONFIDENCE AND SUPPORT SKILLS' on a board or flipchart. List the six skills on the board as you demonstrate them.

#### Skill 1. Accept what a mother thinks and feels

- → Write 'Accept what a mother thinks and feels' on the list of confidence and support skills.
- □ Explain the skill:
- Sometimes a mother thinks something that you do not agree with, that is, she has a mistaken idea.
- Sometimes a mother feels very upset about something that you know is not a serious problem.

# Ask: How will she feel if you disagree with her, or criticize, or tell her that it is nothing to be upset or to worry about?

(Wait for 2-3 responses, and then continue.)

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

- So it is important not to disagree with a mother.
- It is also important not to agree with a mistaken idea. You may want to suggest something quite different. That can be difficult if you have already agreed with her.
- Instead, you just accept what she thinks or feels. Accepting means responding in a neutral way, and not agreeing or disagreeing.
- ☐ Give an example of accepting what a mother THINKS:

Read out the following example. Read the mistaken idea, the appropriate and inappropriate responses, and also the statements explaining which they are.

### **Demonstration O: Accepting what a mother THINKS**

#### Read out the explanations, the idea, and the responses:

This is a mistaken idea:

"My milk is thin and weak, so I have to give bottle feeds."

This is an inappropriate response, because it is DISAGREEING:

"Oh no! milk is never thin and weak. It just looks that way!"

This is an inappropriate response because it is AGREEING:

"Yes, thin weak milk can be a problem."

This is an appropriate response, because it shows ACCEPTANCE:

"I see. You are worried about your milk."

An alternative appropriate response might be:

"Ah-ha".

- ☐ Make these additional points:
- Notice how reflecting back and simple responses are both useful ways to show acceptance, as well as being good listening and learning skills.
- You may want to give information to correct a mistaken idea. In this example, you would want to explain to the mother that breastmilk always looks thin at the beginning of a feed, but it is full of nutrients.
- You can give this information later. Give it in a tactful way which does not sound critical. However, first, you want her to feel that you accept what she thinks.

  We will come back to this point with Skill 4.
- ☐ Give an example of accepting what a mother FEELS:
- ② Ask the participant who will help you, to hold a doll, and to play the part of the mother in Demonstration R.

She reads the words which you wrote down and gave to her, and she acts being very upset, and cries.

You read out the responses, with appropriate gestures. For example, you can put your hand on her shoulder to comfort her. Ask participants to say which response accepts what the mother feels. (The accepting response is marked  $\checkmark$ ).

### **Demonstration P: Accepting what a mother FEELS**

#### The 'mother' (in tears) reads:

"It is terrible! Sonu has a cold and his nose is completely blocked and s/he can't breastfeed - s/he just cries and I don't know what to do!"

#### Read these responses (with an appropriate gesture):

#### Ask: Which response accepts what the mother feels?

Response 1: "Don't worry - your baby is doing very well"
Response 2: "You are upset about Sonu aren't you?"?

Response 3: "Don't cry - it is not serious Sonu will soon be better!"

- ☐ Explain the example, making these points:
- Responses 1 and 3 do not accept what she feels. If you say something like "Don't worry, there is nothing to worry about!" you make her feel that she is wrong to be upset. This reduces her confidence. (Yet that is just what many of us do!)
- Response 2 accepts what she feels. It makes her feel that it is alright to be upset, so it does not reduce her confidence.
- Notice how, in this example, empathizing was used to show acceptance. So this is another example of using a listening and learning skill to show acceptance.

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

- Write 'Recognize and praise what a mother and baby are doing right' on the list of confidence and support skills.
- □ Explain the skill:
- As health workers, we are trained to look for problems. Often, this means that we see only what we think people are doing wrong, and try to correct them.

# Ask: How does it make a mother feel if you tell her that she is doing something wrong, or that her baby is not doing well?

(Wait for 2-3 responses, and then continue.)

You may make her feel bad, and it reduces her confidence.

- As counselors, 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.
- It can be difficult to recognize what a mother is doing right we have to learn to recognize good practices. But any mother whose child is living must be doing some things right, whatever her socioeconomic status or education.
- It is always helpful to recognize and praise what a baby is doing right. For example, that s/he is gaining weight, or that s/he is suckling well.

# Demonstration Q: Recognizing and praising what a mother and baby are doing right

# **Explain TA 5.1: Recognising & Praising**



Here is a baby being weighed, and his mother. The baby is exclusively breastfed.

Beside the mother and baby is the baby's growth chart. His growth chart shows that s/he has gained a little weight between 1 and 2 months of age.

However, his growth line is not following the reference curves. It is rising too slowly. This shows that the baby's growth is slow.

"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

- Write 'Give practical help' on the list of confidence and support skills.
- □ Explain the skill:
- Sometimes practical help is better than saying anything. For example:
  - When a mother feels tired or dirty or uncomfortable;
  - When she is hungry or thirsty;
  - When she has had a lot of advice already;
  - When you want to show support and acceptance; and
  - When she has a clear practical problem.

#### Ask: What kind of practical help might you offer?

(Wait for 2-3 suggestions from participants, and then continue.)

Some ways to give practical help are these:

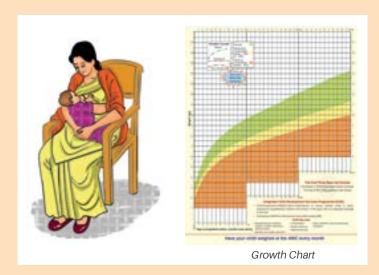
- Help to make her clean and comfortable;
- Make it easier for her to hold the baby, with pillows, or a lower or more comfortable seat;
- · Give her a warm drink, or something to eat; and
- Hold the baby yourself, while she gets comfortable, or washes, or goes to the toilet.
- Practical help also includes practical help with breastfeeding, such as positioning the baby or relieving engorgement. This is considered separately later.

#### Skill 4. Give relevant information and check understanding

- → Write 'Give little relevant information and check understanding' on the list of confidence and support skills.
- ☐ Explain the skill:
- Mothers often need information about breastfeeding. It is important to share your knowledge with them. It may also be important to correct mistaken ideas.
- However it is important to:
  - Give information which is relevant to her situation NOW. Tell her things that she can use today, not in a few weeks' time;
  - 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 advice;
  - 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; and
  - Wait until you have built the mother's confidence, by accepting what she says, and praising
    what she does well. You do not need to give new information or to correct a mistaken idea
    immediately.
- ☐ Give an example:

# **Demonstration R: Giving relevant information**

#### **Show TA 5.2: Giving Relevant Information**



Sonu is 2 months old, breastfeeding exclusively, and gaining weight. Now s/he suddenly seems hungry, and s/he wants to feed more often. His mother thinks that she does not have enough milk.

### Read these responses:

- Response 1: "Oh, Sonu is growing well. Don't worry about your breastmilk supply. It is best to breastfeed exclusively for 6 months, and then you can start complementary foods.
- Response 2: "Sonu is growing fast. Healthy babies have these hungry times when they grow fast. Sonu's growth chart shows that s/he is getting all the breastmilk that s/he needs. S/he will settle in a few days."✓

- ☐ Give this explanation:
- Response 2 explains Sonu's present behaviour, and her worries, so the information is relevant now. The information in Response 1 does not explain Sonu behaviour and is not relevant now. Telling her not to worry does not help.
- ☐ Give another example:

A baby is 3 months old. His mother has recently started giving some bottle feeds in addition to breastfeeding. The baby has developed diarrhoea. She wants to stop breastfeeding

#### Read these responses:

### Ask: Which response gives positive information?

Response 1: "It is good that you asked before deciding. Diarrhoea usually stops sooner if you continue to breastfeed." ✓

Response 2: "Oh no, don't stop breastfeeding. S/he may get worse if you do that."

- ☐ Give this explanation:
- Response 2 explains Sonu's present behaviour, and her worries, so the information is relevant now. The information in Response 1 does not explain Sonu behaviour and is not relevant now. Telling her not to worry does not help.
- ☐ Give another example:

A baby is 3 months old. His mother has recently started giving some bottle feeds in addition to breastfeeding. The baby has developed diarrhoea. She wants to stop breastfeeding

#### Read these responses:

#### Ask: Which response gives positive information?

Response 1: "It is good that you asked before deciding. Diarrhoea usually stops sooner if you

continue to breastfeed." ✓

Response 2: "Oh no, don't stop breastfeeding. S/he may get worse if you do that."

- ☐ Give this explanation:
- Response 2 is critical, and may make her feel wrong and lose confidence. Response 1 is positive, and should not make her feel wrong or lose confidence.

#### Check understanding:

Often you need to check whether the caregiver understands a practice or action s/he plan to carry out. For example, if you talked about feeding frequently, you may need to check the understanding of the term frequently.

It is not enough to ask the caregiver whether s/he understood, because s/he may not realize that s/he 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 the caregiver really understands.

Checking understanding also helps to summarize what you have talked about.

We will now see a demonstration of the need for using the skill of checking understanding. We have a caregiver and health worker coming to the end of a discussion about feeding a 12 month old baby.

### **Demonstration S: Checking questions**

**Health Worker**: Now, Mrs. Yasmin, have you understood everything that I've told you?

Caregiver : Yes, ma'am.

Health Worker: You don't have any questions?

Caregiver : No, ma'am.

Comment

This caregiver would need to be very determined to say that s/he had questions to this health worker.

Let us hear this again with the health worker using good checking questions.

Health Worker: Now, Mrs. Yasmin, we talked about many things today, so let's check

(Checking question) everything is clear.

What foods do you think you will give Anam tomorrow?

Caregiver: I will make her thick porridge.

Health Worker: Thick porridge helps her to grow.

(Checking question) Are there any other foods you could give, may be from what the family

is eating?

Caregiver : Oh yes. I could mash some of the rice and lentils we are having and I

should give her some fruit to help her to grow healthy.

**Health Worker**: Those are good foods for Anam.

(Checking question) How many times a day will you give food to Anam?

Caregiver : I will give her something to eat 5 times a day. I will give her thick

porridge in the morning and evening, and in the middle of the day I will give her food we are having. I will give her some fruit or bread in

between.

Health Worker: You've chosen well. Young children need to eat often. Would you

come back to see me in 2 weeks to see how the feeding is going?

Caregiver : Yes, okay.

**Health Worker**: What foods do you think you will give Anam tomorrow?

Caregiver: I will make her thick porridge.

Health Worker: Thick porridge helps her to grow.

Are there any other foods you.

(Checking question) Are there any other foods you

Comment

What did you observe this time? This time the health worker checked the caregiver's understanding and found that the caregiver knew what to do. S/he also asked the caregiver to come back for follow-up.

#### Skill 5. Use simple language

- → Write 'Use simple language' on the list of confidence and support skills.
- Explain the skill:
- Health workers learn about diseases and treatments using technical or scientific terms. When these terms become familiar, it is easy to forget that people who are not health workers may not understand them.
- Health workers often use these technical terms when they talk to mothers, and mothers do not understand.
- It is important to use simple, familiar terms, to explain things to mothers.
- ☐ Give an example:

Read the statements in V or T ask participants to say which is easier for mothers to understand.

### **Demonstration T: Using simple language**

#### Read these statements:

#### Ask: Which statement is easier for a mother to understand?

Statement 1: "Your baby needs to be able to reach the lactiferous sinuses to get your

breastmilk effectively."

Statement 2: "Your baby can get your breastmilk more easily if s/he takes a big mouthful of

breast."

- ☐ Give this explanation:
- Statement 2 is easier to understand. Statement 1 uses the terms 'lactiferous sinuses' and 'effectively' which many mothers would not understand.

#### Skill 6. Make one or two suggestions, not commands

- → Write 'Make one or two suggestions, not commands' on the list of confidence and support skills.
- □ Explain the skill:
- You may decide that it would help a mother if she does something differently for example, if she feeds the baby more often, or holds him in a different way. However, you must be careful not to tell or command her to do something. This does not help her to feel confident.
- When you counsel a mother, you suggest what she could do. Then she can decide if she will try it or not. This leaves her feeling in control, and helps her to feel confident.
- ☐ Give an example:

Then read out the two responses and ask participants to say which is a command and which is a suggestion (The suggestion is marked with a  $\checkmark$ ).

Rekha breastfeeds only 4 times a day, and she is gaining weight too slowly. Her mother thinks that she does not have enough breastmilk.

#### Read these responses:

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

Response 1: "You must feed Rekha at least 10 times a day!"

Response 2: "It might help if you fed Rekha more often." Give this explanation:

- Response 1 is a command. It tells Rekha's mother what she must do. She will feel bad and lose confidence if she cannot do it.
- The second response is a suggestion. It allows Rekha's mother to decide if she will feed Rekha more often or not.
- Another way to make a suggestion is to ask a question, for example:
  - "Have you thought of feeding her more often? Sometimes that helps."

# III. Group practice

### (10 minutes)

#### Card 1: How to give relevant information

"A mother on day one of delivery with soft breasts waiting for milk to come in" (Answer: When baby suckles on the breastmilk starts flowing; Breasts produce milk after the baby suckles; Babies suckling helps milk to 'come in'.)

#### Card 2: Show to give suggestion

"Keep the baby in bed with you so that s/he can feed at night" (Answer: Have you thought of keeping your baby in the bed so that you can breastfeed him in the night).

# IV. Summarize 'Building confidence and giving support'

(5 minutes)

You now have a list of six skills on the flipchart.

Post it on the wall.

Read the list through, to remind participants of the six skills.

#### **CONFIDENCE AND SUPPORT SKILLS**

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



SESSION

# **Hospital Practices and Baby Friendly Initiatives**

# **Objectives**

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

- Describe the 'Ten Steps to Successful Breastfeeding'.
- Give antenatal Counselling on infant feeding.
- Help mother with an early breastfeed.
- Identify and clarify myths and misconceptions about infant feeding.
- Learn to establish a mother support group in a community.

Session outline	(60 minutes)
I. Introduce the session	(5 minutes)
II. Introduce the 'Ten Steps' of the Baby Friendly Hospital Initiative (Bl	FHI) (10 minutes)
III. Discuss the importance of antenatal preparation for breastfeeding	success (20 minutes)
IV. Discuss the myths and misconceptions about infant feeding	(10 minutes)
V. Group discussion	(10 minutes)
VI. Summarize the session	(5 minutes)

# **Preparation**

- 1. Read the introduction. How to conduct the training course?
- 2. Prepare and display a chart for antenatal counselling.
- 3. Prepare a list of myths and misconceptions associated with infant feeding.

I. Introduction (5 minutes)

Hospitals play a major role in breastfeeding success. Poor practices interfere with breastfeeding, and contribute to the spread of artificial feeding. Good practices support breastfeeding, and make it more likely that mothers will breastfeed successfully, and will continue to feed for a longer time. Maternity facilities help mothers to initiate or start breastfeeding at the time of delivery, and they help them to establish breastfeeding in the postnatal period. Other parts of the healthcare services can play a very important part in helping to sustain breastfeeding up to 2 years or beyond. The Baby Friendly Hospital Initiative launched in 1991 has proven to be an effective strategy to increase breastfeeding initiation rates. Pandemic of HIV has brought a unique challenge to promotion of breastfeeding.

The global criteria for the Baby Friendly Hospital Initiative serve as the standard for measuring adherence to each of the 'Ten Steps for Successful Breastfeeding' and the International Code of Marketing of Breastmilk Substitutes (Session-41).

- In this session, we will discuss:
  - The ten steps of BFHI for successful breastfeeding.
  - The importance of how hospital care practices can help the BFHI.
  - The Myths and misconceptions about infant feeding.

# II. Introduce the 'Ten Steps' of Baby the Friendly Hospital Initiative

(10 minutes)

- Explain that in this chapter they will learn about the 'Ten Steps', and the rationale behind them
- The concept of BFHI is no longer limited to the 'Ten Steps' in maternities, but has been adapted to include many possibilities for expansion into other parts of the health system, including maternal care, child healthcare, health clinics, physicians' offices, and into other sectors and venues such as community, commercial sector, and agricultural or educational systems.
- □ Point to the poster of "THE TEN STEPS TO SUCCESSFUL BREASTFEEDING"
- ② Ask participants in turn to read out the 'Ten Steps' from the manual.

# **STEP 1.** Have a written breastfeeding policy that is routinely communicated to all healthcare staff.

The health facility should have a written breastfeeding or infant feeding policy that addresses all 10 steps and protects breastfeeding by adhering to the International Code of Marketing of Breastmilk Substitutes. The infant feeding policy should indicate that HIV-positive mothers receive counselling, including information about the risks and benefits of various infant feeding options and specific guidance in selecting the options for their situations, supporting them in their choices.

This should be available to all the staff members who take care of mothers and babies.

The BFHI policy summaries in local and simple languages should also be visibly posted in all areas of the healthcare facility which serve pregnant women, mothers and/or children.

#### STEP 2. Train all healthcare staff in skills necessary to implement the policy.

All healthcare staff members who have contact with pregnant women, mothers, and/or babies, should receive orientation on the breastfeeding/infant feeding policy.

A copy of the curricula or course session outlines for training in breastfeeding promotion and support for various types of staff should be available for review, and a training schedule for new employees should be available.

The training course should be based on minimum of 20 hours course.

# STEP 4. Inform all pregnant women about the benefits and management of breastfeeding.

If a hospital has an affiliated antenatal clinic or an in-patient antenatal ward:

- » A written description of the minimum content of the breastfeeding information and any printed materials provided to all pregnant women is available; and
- » Individual or group discussion with pregnant women may be held regularly to educate them regarding the benefits and management of breastfeeding.

### STEP 4. Help mothers initiate breastfeeding within a half-hour of birth.

Place babies in skin-to-skin contact with their mothers immediately following birth for at least an hour.

# **STEP 5.** Show mothers how to breastfeed and how to maintain lactation, even if they should be separated from their infants.

All mothers, and especially those who have previously encountered problems with breastfeeding should receive help for positioning and attachment for successful breastfeeding. Manual expression of breastmilk should be taught to all mothers. Mothers should also be helped to learn cup/katori feeding to their babies if needed.

# STEP 6. Give newborn infants no food or drink other than breastmilk, unless medically indicated.

All clinical protocols or standards related to breastfeeding and infant feeding used by the maternity services should indicate that they are in line with current BFHI standards.

No materials that recommend feeding breastmilk substitutes, scheduled feeds or other inappropriate practices are distributed to mothers.

The medical reasons for giving others foods and drinks should be known to health workers.

The hospital has an adequate facility/space and the necessary equipment for giving demonstrations of how to prepare formula and other feeding options away from breastfeeding mothers.

# STEP 7. Practice rooming-in - allow mothers and infants to remain together - 24 hours a day.

All mothers and babies are kept together or, if not, have justifiable reasons for being separated.

#### STEP 8. Encourage breastfeeding on demand.

All mothers should know the cues of babies being hungry and should feed as the baby shows signs of hunger.

The duration and frequency of breastfeeding should also be decided by the baby and the mother.

# STEP 9. Give no artificial teats or pacifiers (also called dummies or soothers) to breastfeeding infants.

The hospitals should have policy not to use artificial teats and pacifiers to breastfeeding babies.

# STEP 10. Foster the establishment of breastfeeding support groups and refer mothers to them on discharge from the hospital or clinic.

The facility fosters the establishment of and/or coordinates with mother support groups and other community services that provide breastfeeding/infant feeding support to mothers. The staffs encourages mothers and their babies to be seen soon after discharge (preferably 2-4 days after birth and again in the second week) at the facility or in the community by a skilled breastfeeding support person.

#### Note:

- The ten steps of successful breastfeeding are relevant in HIV situations as well.
- The hospital should follow the current World Health Organization and National AIDS Control Organization guidelines regarding the Counselling, testing and treatment of mothers and children suffering from HIV.

The summary of TEN STEPS TO SUCCESSFUL BREASTFEEDING is given below.

#### 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 healthcare staff.
- 2. Train all healthcare staff in skills necessary to implement this policy.
- 3. Inform all pregnant women about the benefits and management of breastfeeding.
- 4. Help mothers to initiate breastfeeding within a half-hour of birth
- 5. Show mothers how to breastfeed and how to maintain lactation even if they should be 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 for 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 hospital or clinic.

# III. Discuss the importance of antenatal preparation for breastfeeding success

(20 minutes)

Majority of pregnant women need to know what helps them to successfully breastfeed during antenatal period.

# Trainer should explain the advantages of antenatal preparation for breastfeeding and complementary feeding

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 certain things that you can discuss with a group of mothers together, in an antenatal class, or health education session.

Trainers' Guide

#### The main points to remember when you talk to a group of mothers are:

#### Explain the benefits of breastfeeding, and the dangers of artificial feeding.

Most mothers decide how they are going to feed their babies a long time before they have the child, even before they become pregnant. If a mother has decided to bottle feed, inform her of the dangers of bottle feeding. You should help mothers who are undecided, and give confidence to mothers who intend to breastfeed. You must encourage all mothers to breastfeed exclusively instead of partial breastfeeding.

#### Give information on optimal infant feeding practices.

Explain the mother that a child needs exclusive breastmilk (exclusive breastfeeding) for first 6 months and after 6 months introduction of complementary feeding is essential with continued breastfeeding for 2 years or beyond.

#### • Give simple relevant information on how to breastfeed.

It may be helpful to explain that frequent breastfeeding on demand helps in ensuring a good breastmilk supply and good positioning prevents problems.

### 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 of breastfeeding on their figures. It may help them to discuss these worries together.

When you talk to mothers individually, make sure that each mother has understood all the points that you discuss with the groups.

#### In addition, when you talk to a mother individually, remember to:

#### Ask about her previous breastfeeding experience, if she has had other babies.

If she breastfed successfully, she is likely to do so again.

If she had difficulties, or if she bottle fed, explain how she can succeed with breastfeeding this time. Reassure her that you will help her.

#### Ask whether she has any question or worries.

Encourage her to tell you if she has any worries or doubts about breastfeeding, and try to answer them.

#### Examine her breasts if she is worried about them.

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.

Almost always you will be able to reassure her that her breasts are alright, and that her baby will be able to breastfeed.

#### **Antenatal Preparation for Breastfeeding**

#### With mothers groups:

- Explain benefits of breastfeeding
- Give information on optimal infant feeding practices.
- Give simple information on how to breastfeed
- Discuss mothers' questions

#### With mother individually:

- Ask about previous experience
- Ask if any questions or worries
- Examine breasts if she is worried
- Build her confidence

#### The need for help with early breastfeeds.

The mother is having some difficulty getting her baby to breastfeed and there is no one available to help her. This is a common problem in many health facilities. Mothers are left to struggle by themselves, and this may result in problems and later failure.

Maternity ward staff often feel that they do not have enough time to help every mother.

However, a more important reason is that few frontline workers have been trained to give help, and they lack the necessary skills.

#### Helping a mother with an early breastfeed.

A skilled, experienced nurse or other person should help a mother to initiate early breastfeeding. This may be the very first feed, soon after delivery, or the next time the baby is ready to feed. It should be as early as possible, because it makes it easier to establish breastfeeding, as babies are normally very alert and responsive within one hour after delivery. They are ready to suckle and attach to the breast easily.

Early initiation also provides the benefits of colostrum (first few days milk after delivery) to the baby.

Many mothers do not need help, or they need very little. But a mother may not know if she needs help or not. It is a good idea for a counselor to spend time with each mother during an early breastfeed to make sure that everything is going well.

# Ask one of the participants, How would you suggest that a frontline worker helps this mother with an early breastfeed?

(Let participants' make some suggestions. Encourage them to think of:

- » Observing a breastfeed.
- » Helping the mother to position her baby.
- » Giving her relevant information.

#### How to help with an early breastfeed

#### Avoid hurry and noise.

Talk quietly, and be unhurried, even if you have only a few minutes.

### Ask the mother how she feels and how breastfeeding is going.

Let her tell you how she feels, before you give any information or suggestions.

#### Observe a breastfeed.

Try to see the mother when she is feeding her baby, and quietly watch what is happening. If the baby's position and attachment are good, tell her how well she and the baby are doing. You do not need to show her what to do.

### ▶ Help in positioning if necessary.

If the mother is having difficulty, or if her baby is not well attached, give her appropriate help.

#### Give her relevant information.

Make sure that she understands about demand feeding, about the signs that a baby gives that show that s/he is ready to feed, and explain how her milk will 'come in'.

### Answer the mother's questions.

She may have some questions that she wants to ask; or as you talk to her, you may learn that she is worried about something, or not sure about something. Explain simply and clearly what she needs to know.

Ask: What signs could you tell her that a baby shows when s/he is ready for a feed? (Let participants make a few suggestions, then continue).

A baby may be wakeful and restless, or makes small noises; s/he may make hand-to-mouth movements, and sucking movements; s/he may suck his fingers, and search for the breast.

#### Advantages of keeping baby with the mother:

- » Mother can respond to baby, which helps bonding.
- » Babies cry less, so less temptation to give bottle feeds.
- » Mothers are more confident about breastfeeding.
- » Breastfeeding continues longer.

#### Advantages of demand feeding:

- » Breastmilk 'comes in' sooner.
- » Baby gains weight faster.
- » Fewer difficulties such as engorgement.
- » Breastfeeding established more easily.

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

# IV. Discuss the myths and misconceptions about infant feeding

(10 minutes)

There are many misconceptions and myths about breastfeeding, prevailing in the society. Trainer should discuss and clarify these:

#### **Misconceptions**

#### 1. "You have to drink a lot of milk to produce more milk".

This is simply not true. Any type of food and fluid taken by you in adequate quantity is sufficient to produce enough milk. The production and quality of breastmilk is not dependent on the milk intake of the mother. The baby's suckling on the breast is the key factor and "More suckling makes more milk".

### 2. "Small breasts will not produce enough milk"

Being able to breastfeed successfully does not depend on the size of your breast. The size of the breast depends upon the amount of the fatty tissue layer under the skin. Breastmilk is produced by special glands in the breast that are present in all women.

#### 3. "You have to stop eating certain foods during breastfeeding"

No! You can continue eating most of your favorite foods during breastfeeding. If you are worried about a particular food, eat a small amount each time and see if it causes any problem to your baby. If it bothers your baby every time you eat it, you may consider avoiding that food.

# 4. "I was not able to breastfeed the previous baby-and I won't be able to breastfeed successfully even this time"

You can be successful in breastfeeding your baby even if you were not able to breastfeed the earlier baby. Be confident.

### **Myths**

#### Myth #1: Janam Ghuti/Gurti should be given at birth

NO! Nothing can replace the substance produced by your breasts immediately after birth of a child. Moreover use of Ghutti or Gurti and gripe water is unscientific practice and it is better not to use them. Use of Janam Ghuti/Gurti can do more harm than good by increasing the chances of infection, etc. These preparations sometimes contain medications that may induce unnatural sleep.

#### Myth #2: Milk is not enough during the first 3 or 4 days after birth

No, it is not true. During the first few days after delivery, colostrum is produced which is thick, sticky and light yellowish in colour. Although secreted in small quantities (30-90 ml), colostrum is sufficient to meet the caloric needs of a normal newborn in the first few days of life. It is rich in Vitamin A and K which are required by the newborn after birth. With lots of antibodies and other factors, colostrum works as the first line of defense against infections.

#### Myth #3: A baby should be on the breast 20 (15, 10, 5) minutes on each side

No, it is not true. Distinction needs to be made between "being on the breast" and "breastfeeding". Some babies fulfill their requirement in 5-10 minutes while other take longer. The baby should be allowed to decide the duration of the feed. However, if the duration is too long (more than half an hour) or very short (less than about 4 minutes) it means there is a problem. With low birth weight babies or during the first few days breastfeeds may be long which is normal. It is to be remembered that one breast must be emptied out fully before the second is offered, so that the baby gets both the foremilk and hind milk. The other breast should be offered first at the next feed. This will help in stimulating both breasts equally for milk production.

#### Myth #4: Breastfeeding baby needs extra water in hot weather

No, it is not true. Breastmilk contains all the water a baby needs. In fact water is the largest constituent of milk in which all other ingredients are dissolved, dispersed or suspended. It has been shown that the water requirement of infants even in hot humid climates can be adequately met by the water in breastmilk.

#### Myth #5: After a year, breastmilk loses all its nutritional value

No, it is not true. As already discussed breastmilk is a perfect, complete source of nutrition for babies under 6 months of age, and nothing else is required to be given. It is also to be noted that breastmilk continues to provide perfect nutrition although not complete for the babies above 6 months of age and as long as the mother continues to breastfeed. Supplementation of breastfeeding is required after 6 months of age. There is no need to worry that at some point of time breastmilk will become worthless. It will always contain valuable nutrients, hormones, and immunities. A mother can continue to give breastmilk to her baby for 2 yrs or more.

#### Myth #6: You can't take any medication while you're breastfeeding

No, it is not true. Only a few medications are absolutely contraindicated during breastfeeding, however, most of them can be taken safely. Most prescribed drug instructions automatically caution against being taken by pregnant or breastfeeding mothers. This warning is issued to prevent liability, and is often overly cautious. Remember to ask your doctor about non-prescription drugs.

Trainers' Guide

#### Myth #7: If the mother has an infection she should stop breastfeeding

No, it is not true. With very few exceptions, the mother's continuation to breastfeed will protect the baby. Remember by the time the mother has fever (infection) she has already given infection to the baby since she has been infectious for several days before she even knew she was sick. The baby's best protection against getting infection is for the mother to continue breastfeeding. If the baby does get sick, s/he will be less sick if the mother continues breastfeeding.

### Myth #8: If the baby has diarrhoea or vomiting, the mother should stop breastfeeding

No, it is not true. The best medicine for a baby's gut infection is breastmilk. So continue breastfeeding. Breastmilk is the only fluid which the baby requires during diarrhoea and/or vomiting, except under exceptional circumstances.

#### Myth #9: A mother should wash her nipples each time before feeding the baby

No, it is not true. Breast secretes protective oils which protects the baby against infection. Washing nipples before each feeding washes away these protective oils from the nipple. Moreover, the sterility of the water with which the nipples are washed is always questionable, which might result in spreading infection to the baby.

#### Myth #10: Breastfeeding is not possible after cesarean section birth

No, it is not true. It is entirely possible to breastfeed after a cesarean section delivery. The type of anesthesia given during cesarean section will decide how soon a mother can breastfeed. Normally, a child should be breastfed within 4 hours after cesarean section. However if spinal anesthesia is given the baby can be breastfed earlier. It is important to feed in a way that does not put pressure on the incision sight. The "football hold" position is particularly helpful.

#### Myth #11: Milk production is directly related to the size of the breast

No, it is not true. The size of breasts, either large or small, has nothing to do with the amount of milk they produce. Remember, more the baby suckles, more is the milk produced.

#### Myth #12: Many women do not produce enough milk

This is one of the commonest reasons of early introduction of supplementary milk or even terminating of breastfeeding. Mothers often worry about the amount of milk they produce specially during the early days after delivery and this problem gets aggravated when sometimes relatives/friends/frontline workers also suggest the same. But, it is not true. As already said almost all mothers can produce more than enough milk, provided the baby suckles effectively and breastfeeds as often as needed and the mother is confident. Mothers who believe that they do not have enough breastmilk need help and support of a skilled person.

### Myth #13: There is no way to know how much breastmilk the baby is getting

No, it is not true. There are two signs that show reliably that a baby is getting enough milk. One is adequate weight gain and the other is passing urine about six times a day (if the child is being exclusively breastfed). It is to be noted that if the baby is below its birth weight after two weeks or gains less than 500 grams a month during the first six months of life, then the baby is probably not getting enough milk.

#### Myth #14: Breastfeeding ties you down.

It is not true. It depends how you look at it. A baby can be nursed anywhere, anytime, and thus breastfeeding is more liberating for the mother. There is no need to

- » Drag around bottles or formula milk.
- » Worry about where to warm up the milk.
- » Worry about sterility.
- » Worry about your baby, as s/he is with you.

#### Myth #15: You can't breastfeed if you plan to go back to work or school.

Working outside home is often cited as a reason for the decline in breastfeeding rates around the world because breastfeeding and working are seen as mutually exclusive activities. But, it is not true. It is possible to continue breastfeeding the baby after returning back to work. Some mothers may be fortunate in having day care centre at work place or work may be so close to their home that they can return for nursing during breaks in their working time. In India most mothers are not able to do this as maternity leave is variable, nursing breaks are not regularized and child care crèches facilities at work place remain inadequate. However, to maximize the availability of mother's milk to the baby following advice can be followed.

- » breastfeed early in the morning.
- » breastfeed just before leaving for work
- » breastfeed frequently after returning and unrestricted breastfeeding during night.
- » expressing and appropriately storing breastmilk which can be given to the baby by the caretaker in the absence of the mother.

#### Myth #16: It is easier to bottle feed than to breastfeed

No, it is not true. Breastfeeding is certainly less time consuming than to get up, go to the kitchen, turn on the stove, sterilize a feeding bottle, prepare feed by mixing up warm water with formula milk, put the formula milk into a bottle, wait several minutes so that the right temperature is achieved, then finally return to the crying child, pick up the child and offer the bottle. It is true that you may have to feed a bit more frequently especially during night if you breastfeed because breastmilk is more easily digested than formula milk. Of course that easy digestibility translates into less time than dealing with colic, diarrhoea and other digestive ailments because of bottle feeding.

#### Myth #17: Formula milks are almost the same as breastmilk

No, it is not true. formula milks can never replicate mother's milk. In the first place, human milk contains live cells and human hormones that are impossible to obtain from the milk of another species. Every few months formula companies come up with something different to try and add something new to the formula. If you choose to breastfeed you can be confident that all the necessary nutrients, immunities, hormones and as yet undiscovered beneficial elements are present in the right amounts. Remember, your breastmilk is made as required to suit your baby whereas formulas are made to suit every baby, and thus no baby.

#### Myth #18: Night nursing causes dental problems

No, it is not true, night nursing doesn't cause dental problem rather it is other way round. In bottle feeding the artificial nipples deliver the milk into the front and middle of the mouth where it can cause decay.

#### Myth #19: Breastfeeding ruins the shape of the breasts

No, this is not true. As soon as a woman becomes pregnant some changes occur in her breasts. After delivery, breastfeeding does not effect the future shape of the breast. Heredity plays a significant role in this matter, as does excessive weight gain or loss.

## **II. Group Discussion**

(10 minutes)

Ask and Discuss

If participants wants to share any other myth related to breastfeeding.

### **Establishing breastfeeding support groups**

Trainer informs frontline workers of the need for establishment of breastfeeding support groups so that mothers can be referred to them after discharge from the hospital or clinic. Even good hospital practices can't solve all the problems.

Many mothers are discharged within a day or two after delivery, before their breastmilk has 'come in', and before breastfeeding is established, they need help.

#### Possible sources of help for breastfeeding mothers include:

Supportive family and friends.

This is often the most important source of support. Community support is often good where breastfeeding traditions are strong, and family members live near. However, some traditional ideas may be mistaken. Many women, especially in cities, have little support. Or they may have friends or relatives who encourage them to bottle feed.

This box provides information how frontline worker can help set up a breastfeeding support group.

#### **BREASTFEEDING SUPPORT GROUPS**

- A group may be started by a frontline worker; by an existing women's group (ASHAs, AWWs) and experienced mother willing to support and help breastfeeding mothers.
- Members of such support group may help women in antenatal clinics, maternity facilities and communities.
- Such mother support groups may stimulate breastfeeding mothers to meet every 3-4
  weeks, often in one of their homes, or somewhere in the community. They can have a
  topic to discuss, such as "The advantages of breastfeeding" or "Overcoming difficulties".
- They share experiences, and help each other with encouragement and with practical ideas about how to overcome difficulties. They learn more about how their bodies work.
- The group needs someone who is accurately informed about breastfeeding to train them. They need someone who can correct any mistaken ideas, and suggest solutions to difficulties. This helps the group to be positive and not to complain. This person could be a frontline worker, until someone in the group has learnt enough to play this role.
- The group needs a source of information whom they can refer to if they need help. This
  could be a frontline worker trained in breastfeeding, whom they see from time to time.
   The group also needs up-to-date materials to educate themselves about breastfeeding.
   The frontline worker can help them to get these.
- Mothers can also help each other at other times, and not only at meetings. They can visit each other when they are worried or depressed, or when they don't know what to do.
- Breastfeeding support groups can provide an important source of contact for socially isolated mothers.
- They can be a source of support which builds mother's confidence about breastfeeding and which reduces their worries.
- They can give a mother the extra help that she needs, from women like herself that health services cannot give.
- Many mothers need support regardless of their feeding method. It is essential that they
  be provided support at the level of the community.

III. Summarize (5 minutes)

SESSION

# **Positioning Baby at the Breast**

# **Objectives**

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

• Help a mother to position her baby correctly at the breast.

Session outline	(60 minutes)
Participants are all together for a demonstration led by one trainer	
I. Introduce the session	(5 minutes)
II. Demonstrate helping a mother to position her baby	(40 minutes
Participants are in groups of 4-5 with one trainer	
III. Help participants to practice positioning a baby	(15 minutes)

# **Preparation**

- 1. Read the introduction. How to conduct the training course?
- 2. Ask a participant to help you with the demonstration.

  Explain that you want her to play a mother who needs help to position her baby. Ask her to decide on a name for herself and her 'baby'. She can use her real name if she likes.
- 3. Arrange a cot or mattress with pillow, bed sheets and blanket.
- 4. You will demonstrate how to help a mother who is lying down. She will lie down, propped on her arm, with the doll far from her body, loosely held on the bed.

# I. Introduce the topic

(5 minutes)

Ask participants to find the page in their manuals, where the technique 'Positioning the baby at the breast' is described.

- ☐ Explain what the session will be about:
- In this session you will learn how to help a mother to position her baby at the breast, so that he is well attached and can suckle effectively. The techniques are described in your manuals, for you to read again later.
- There are three types of mothers whom you may need to help:
  - new mothers, who are breastfeeding for the first time;
  - mothers who have some difficulty with breastfeeding;
  - mothers who bottle fed previously but now want to breastfeed
- Make these points:
- Always observe a mother breastfeeding before you help her.
  Take time to see what she does, so that you can understand her situation clearly. Do not rush to make her do something different.
- 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 and show her what you mean.
- Make sure that she understands what you do so that she can do it herself.
  Your aim is to help her to position her own baby, it does not help, if you can get a baby to suckle, and if his mother cannot.

# II. Demonstrate and explain how to assess a breastfeed

(30 minutes)

☐ Give the four demonstrations described below.

As you follow each step:

- Demonstrate how to talk to a mother. Be gentle. Explain what you do so that she understands. Talk in a way, which builds her confidence.
- Explain to participants what you are doing.
   Sometimes you need to step out of your role of helping the mother, to make sure that participants understand what you are demonstrating.
- 1. Demonstrate how to help a mother who is sitting
- Ask one of the participants to sit on the chair or bed that you have arranged. She should hold the doll across her body in the normal way, but in a poor position as you practiced previously: loosely, supporting only his head, with his body away from hers, so that she has to lean forward to get her breast into his mouth.

Tell her that you will ask her how breastfeeding is going, and she should say that it is painful when the baby suckles.

- ☐ Follow these steps:
  - Greet the 'mother', introduce yourself, and ask her name and her baby's name.
     Ask her how she is and ask one or two open questions about how breastfeeding is going.
  - The participant says that breastfeeding is painful.
  - Assess a breastfeed.

Ask her, if you may see, "How (baby's name) breastfeeds is going on". Ask her to put her/ him to her breast in the usual way. Observe her breastfeeding for a few minutes.

• Then say:

"Breastfeeding might be less painful if (baby'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.

- □ Explain to participants:
  - 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.
  - If she is sitting in bed, pillows may help (if available in this community).
  - 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.
- Sit down yourself, so that you also are comfortable and relaxed, and in a convenient position to help.
- □ Explain to participants:

You cannot help a mother satisfactorily if you are in an awkward, uncomfortable position yourself.

Explain to the mother how to hold her baby. Show her what to do if necessary.

Make sure that you make these four key points clear:

- 1. The baby's head and body should be in a straight line.
- 2. His face should face the breast, with his nose opposite the nipple.
- 3. His mother should hold his body close to hers.
- 4. If her baby is newborn, she should support his bottom, and not just his head and shoulders.

#### ☐ Explain to participants:

For point 1: A baby cannot suckle or swallow easily if his/her head is twisted or bent.

For point 2: 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: Holding close make a better posture for breastfeeding.

For point 4: This is important for newborns. For older babies, support of the upper part of the body is usually enough.

Sometimes the best way is to use a pillow, if available.

Some mothers support the baby on their knees. Or they use the other hand.

A mother needs to be careful about using the hand of the same arm which supports her baby's shoulders, to support his bottom. The result can be that the baby's head goes too far out to the side, which makes it difficult for him to suckle.

- ☐ Show her how to support her breast with her hand during breastfeeding:
  - She should rest her fingers 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.
- □ Explain to participants:

If a mother has large and low breasts, support may help her milk to flow, because it makes it easier for the baby to take the part of the breast with the lactiferous sinuses into his mouth. If she has small and high breasts, she may not need to support them.

- ☐ Explain how she should touch her baby's lips with her nipple, so that he opens his mouth.
- 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.
- Explain to participants:
  - 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.
- Explain or show how to quickly move her baby to the 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 the baby.
  - She should aim her baby's lower lip below her nipple, so that his chin will touch her breast
- □ Explain to participants:

Try not to touch the mother or baby if possible. But if you need to touch them to show the mother what to do:

- Put your hand over her hand or arm, so that you hold the baby through her.
- 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 the mother responds.

(The participant playing the 'mother' should say, "Oh, that feels better!")

- □ Explain to participants:
  - If you improve a baby's poor suckling position, a mother sometimes spontaneously says that it feels better.
- If the mother says nothing, ask her how her baby's suckling feels.
- Explain to participants:

If suckling is comfortable for the mother, and she looks happy, her baby is probably well attached.

If suckling is uncomfortable or painful, her baby is probably not well attached.

Look for all the signs of good attachment (which you cannot see with a doll).
If the attachment is not good, try again.

Tell the mother to look into child's eyes and smile while breastfeeding. This will help in successful breastfeeding and sustainable.

Explain to participants:

It often takes several trials 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 (for example, in one of the positions described below).

- 2. Demonstrate other ways for a mother who is sitting to position (to hold her baby)
- ☐ Follow these steps:
  - Help the 'mother' to hold her baby in the underarm position, (Fig.7.1a).
     Exactly the same four key points are important.
     She may need to support the baby with pillows at her side.
- Explain to participants:

The baby's head rests in the mother's hand, but she does not push it at the breast. The underarm position is useful:

- for twins
- if she is having difficulty attaching her baby across the front
- to treat a blocked duct
- if a mother prefers it
- Show the 'mother' how to hold her baby with the arm opposite to the breast as shown in the picture (b) below.

Exactly the same four key points are important.

If she needs to support her breast, she can use the hand on the same side as the breast.

☐ Explain to participants:

The mother's forearm supports the baby's body.

Her hand supports the baby's head, at the level of his ears or lower.

She does not push at the back of the baby's head.



Figure 7.1 (a)



Figure 7.1 (b)



Figure 7.1 (c)

# A mother holding her baby in the underarm position

- Useful for:
  - » twins
  - » blocked duct
  - » difficulty attaching the baby

# A mother holding her baby with the arm opposite the breast

- Useful for:
  - » very small babies
  - » sick babies

# Mother feeding (Incorrect holding)

- » No eye to eye contact
- » Mother not supporting baby
- » Body

Mother should have eye to eye contact with the baby while breastfeeding and hold the baby close to her breast, facing it.

- 3. Demonstrate how to help a mother who is lying down
- ② Ask the participant who is helping you to demonstrate breastfeeding lying down, in the way that you had practiced.

She should lie flat on her back with the doll far from her body, loosely held on the bed.

- ☐ Follow these steps:
  - Help the mother after cesarean section to initiate the breastfeeding within an hour.
- □ Explain to participants:
  - When the mother comes out from the operation theater, staff nurse or health worker can introduce the baby to the breast from above the shoulders or from side of the mother.
  - Show how to hold the baby.
  - Exactly the same four key points are important.
  - Health worker supports the baby with her both hands under the arms of baby and gives support to the baby's chin with her forefingers and supports neck and shoulders with her thumbs and holds the chest with the rest of the hand.
  - If mother has a pillow, health worker can use that pillow for resting the baby's body.
  - Sometimes difficulty in attachment of the baby can be faced by the caregiver/ health worker
    in this position. Always remember: never push the baby's head towards the mother's chest
    for attachment in that case baby may refuse to attach to the breast. The caregiver who is
    holding the baby should first sit/stand in a comfortable position and then only help the baby
    in positioning and attachment.

Now, for second lying down position, the participant who is helping you should lie down propped on one elbow, with the doll far from her body, loosely held on the bed.

- ☐ Follow these steps:
  - Help the 'mother' to lie down in a comfortable, relaxed position.
- □ Explain to participants:

To be relaxed, she 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.

- Show her how to hold her baby.
  - Exactly the same four key points are important.

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.

Explain to participants:

A common reason for difficulty in attaching when lying down, is that the baby is too 'high', and his head has to bend forwards to reach the nipple. Breastfeeding lying down is useful.

- » when a mother wants to sleep, so that she can breastfeed without getting up;
- » soon after a Caesarian section, when lying on her back or side may help her to breastfeed her baby more comfortably.



Figure 7.2: A mother breastfeeding her baby lying down

- Make these points:
  - There are many other positions in which a mother can breastfeed. In any position, the
    important thing is for the baby to take enough of the breast into his mouth so that he can
    suckle effectively.
  - For example:
  - » A mother can breastfeed standing up.
  - » if a baby has difficulty in attaching to the breast, it sometimes helps if the mother lies on her front, propped on her elbows, with the baby underneath her.
  - » if she has an oversupply of milk, (and the baby gets too much milk too fast), lying on her back with the baby on top of her sometimes helps.

#### 4. Demonstrate some common mistakes

(10 minutes)

You can give these demonstrations quite quickly, holding a doll and a model breast yourself.

- Make this point:
  - There are some ways in which a mother holds a baby which can make it difficult for him to attach to her breast and suckle effectively.
- ☐ Give the demonstration:
  - Use a doll to show these ways of holding a baby:
  - » Too high (for example, sitting with your knees very high).
  - » Too low (for example, with the baby unsupported, so you have to lean forward).
  - » Too far to the side (for example, putting a small baby too far out in the 'crook' of the arm, instead of on the forearm.
- □ Explain to participants:

If a mother holds her baby in these ways, his mouth will not be opposite her nipple. It will be difficult for him to take the breast into his mouth.

- On your own clothed body, or on a model, show these ways of holding a breast:
- » holding the breast with 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' or 'cigarette' hold (index finger above and middle finger below the nipple)

	Explain to participants:
	Holding the breast in these ways makes it difficult for a baby to attach and suckle effectively. The 'scissor hold' can block milk flow.
	Demonstrate holding the breast back from the baby's nose with a finger.
	Explain to participants:
	This is not necessary, and can pull the nipple out of the baby's mouth. A baby can breathe quite well without the breast being held back.
	Make this point:
	There are some common mistakes that frontline workers make when they help mothers.
	Give the demonstration
$\odot$	Ask the participant to help you again. She should hold a doll in the same way as for the first demonstration. She should also hold a model breast in place as if the doll is trying to suckle.
	• Take hold of the model breast in one hand and the doll in the other and push them together.
	Explain to participants:
	This shows what some frontline workers do. They try to put the baby onto the breast, instead of helping the mother to put him on herself.
	If you do it for the mother, she does not learn how to position her baby herself, and she does not gain confidence.
	Hold the doll at the back of his head, and demonstrate trying to push him onto the breast.
	Explain to participants:
	If you put pressure on the back of a baby's head, he may react by pushing his head back. The natural reaction of a frontline worker is then to push the baby onto the breast more strongly. The baby may fight back, and this may cause him to refuse to breastfeed.
	Ask participants if they have any questions, and try to answer them.
III. I	Help participants to practice positioning a baby (15 minutes)
	Gather your group of 4-5 participants into a corner of the classroom.
	Give them a doll to work with.
	Ask them to find the box <b>HOW TO HELP A MOTHER TO POSITION HER BABY</b> in their manuals.
	Explain that this summarizes the main points of the demonstration.

□ Explain to participants:

(Other trainers do the same with the other groups.)

- You will now work in pairs to practice helping a mother to position her baby. One of you plays the mother, and one plays the frontline worker. Other participants in the group observe.
- If you are the mother:
  - » Sit and hold the doll in the common way, across your front. Hold him in a poor position.
  - » When the frontline worker asks you how breastfeeding is going, say that it is very painful, and your nipples are sore.

Trainers' Guide

- If you are the frontline worker:
  Follow all the steps in the box HOW TO HELP A MOTHER TO POSITION HER BABY.
  Try to use one or two listening and learning skills for example, try to say something to empathize with the mother.
- If you are observing:
  - Follow the steps in the box, and afterwards comment on the practice. Praise what the pair did right, remind them about steps that were left out, and correct any mistakes.
- Make sure that each participant has a turn to play the part of the frontline worker helping a mother to position her baby.

If you have enough time, let participants practice helping mothers in different positions, and with different stories.

#### HOW TO HELP A MOTHER TO POSITION HER BABY

- Greet the mother and ask how breastfeeding is going.
- Assess a breastfeed.
- Explain what might help, and ask if she would like you to show her.
- Make sure that she is comfortable and relaxed.
- Sit down yourself in a comfortable, convenient position.
- Explain how to hold her baby, and show her if necessary.

#### The four key points are:

- » with his head and body straight.
- » with his face facing her breast, and his nose opposite her nipple.
- » with his body close to her body.
- » supporting his bottom (if newborn).
- Show her how to support her breast:
  - » with her fingers against her chest wall below her breast.
  - » with her first finger supporting the breast.
  - » with her thumb above.

#### Her fingers should not be too near the nipple

- Explain or show her how to help the baby to attach:
  - » touch her baby's lips with her nipple.
  - » wait until her baby's mouth is wide open.
  - » 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.

IV. Summarize (5 minutes)

# SESSION

08

#### **Breast Conditions**

#### **Objectives**

At the end of this session, participants should be able to identify and help a mother in the following breast conditions:

- Flat, inverted, and long nipples.
- Engorgement.
- Blocked duct and mastitis.
- Sore nipples and nipple fissure.

#### Session outline (45 minutes)

I. Introduce the topic (20 minutes)

II. Demonstration of Syringe method for treatment of inverted nipples (15 minutes)

III. Summarize (10 minutes)

#### **Preparation**

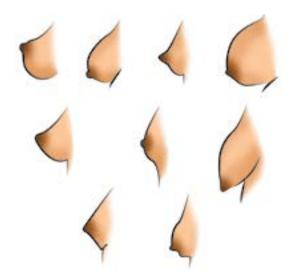
- 1. Read the introduction. How to conduct the training course?
- 2. Arrange Teaching Aids 8.1-8.5
- 3. Arrange 3 syringe pumps.
- 4. Arrange breast models.

#### I. Introduce the topic

(20 minutes)

- Make these points:
- There are several common breast conditions which sometimes cause difficulties with breastfeeding:
  - » Flat, long or big nipples.
  - » Inverted nipples.
  - » Engorgement.
  - » Blocked duct and mastitis.
  - » Sore nipples and nipple fissure.
- Identification and management of these breast conditions are important both to relieve the mother from pain and enable her to continue breastfeeding.

#### **Show TA 8.1: Different breast shapes**



TA 8.1: There are different shapes and sizes of the breast. Babies can breastfeed from almost all of them.

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. But differences in the sizes of breasts are mostly due to the amount of fat, and not the amount of gland tissue. It is important to reassure women that they can produce enough milk, whatever the size of their breasts.

The nipples and areolas are of different shapes and sizes too.

#### Ask: Does the shape of the nipple affect breastfeeding?

- Sometimes the shape makes it difficult for a baby to get well attached to the breast. The mother
  may need extra help at first to make sure that her baby can suckle effectively.
- However, babies can breastfeed quite well from breasts of any size, with almost any shape of nipple. Remember also that a baby can attach poorly whatever the shape of his mother's nipple if s/he has been given bottle feeds, or if there is no one to help his mother to improve her technique.

Trainers' Guide

#### **Show TA 8.2: Flat nipple**



- Flat nipples don't interfere with suckling as the baby doesn't suck from the nipple. Baby takes the nipple and breast tissues underlying the areola into his mouth to form a teat. The nipple forms only about one third of the teat of the breast tissue in the baby's mouth. Flat nipples 'come out' when pulled with the help of a finger and thumb as is seen in this picture. It is called protractile nipple.
- Long nipple: Baby is likely to suck only the nipple, and s/he may not take the breast with the lactiferous sinuses into his mouth. It is important to be ready to help this mother with her breastfeeding technique. Help her to get her baby to take some of her breast into his mouth and not just her nipple.
- Breast protractility is more important than the shape of the nipple.

#### **Show TA 8.3: Inverted nipple**



TA 8.3: Inverted nipple

#### Ask: What do you see? Wait and explain it is an inverted nipple

- When tested for protractility, the nipple goes into the breast tissue instead of 'coming out'.
- With skilled help probably the mother can still breastfeed successfully.
- Fortunately, inverted nipples are rare.
- There is also a scar mark below the areola it has developed due to mastitis.

#### Management of flat and inverted nipple:

- Antenatal treatment is probably not helpful.
- Help is most important soon after delivery when the baby starts feeding.
- Explain to the mother the baby needs to take a large mouthful of breast so that by stretching her breast nipple will come out.
- If the baby can't suckle effectively in first 1-2 weeks then she should express the breastmilk and give it to the baby.
- Trainer explains and demonstrates the "Syringe Pump method" for treatment of inverted nipple.

# II. Demonstration of syringe method for treatment of inverted nipples

(15 minutes)

Explain that this method is for treating flat and inverted nipples postnatally, and to help a baby to attach to the breast.

#### Ask frontline workers to open their manual and see.

- Show participants the syringe that you have prepared, and explain how you cut off the adaptor end of the barrel.
- Put the plunger into the cut end of the barrel (that is, the reverse of its usual position).
- Use a model breast, and put the smooth end of the barrel over the nipple. Pull out the plunger to create suction on the nipple.
- Explain that with a real breast, there is an airtight seal, and the nipple is drawn out into the syringe.
- Explain that the mother must use the syringe herself.

Explain that you would teach her to:

- » Put the smooth end of the syringe over her nipple, as you demonstrated.
- » Gently pull the plunger till mother feels pain and maintain steady but gentle pressure for few seconds and then release.
- » 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, 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. Do this for 30 seconds to 1 minute, several times a day.

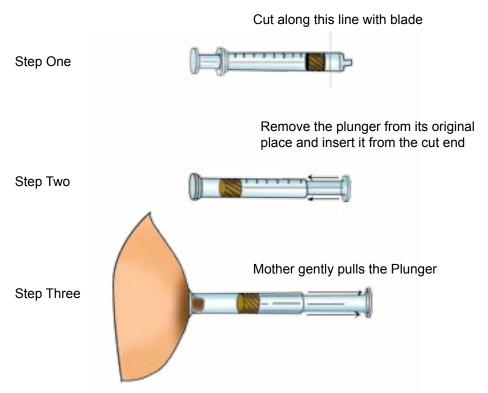


Figure 8: Preparing and using a syringe for treatment of flat and inverted nipples.

#### Now show TA 8.4: Full and engorged breasts



TA 8.4: Full and engorged breasts

**Full breast** is a condition developing a few days after delivery and as mother's milk has 'come in'. Her breasts feel hot, 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 need and they will feel less full.

**Engorgement of breast** 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 looks shiny, because it is oedematous. Her breasts feel painful, and her milk does not flow well.

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.

#### SUMMARY OF DIFFERENCES BETWEEN FULL AND ENGORGED BREASTS

# FULL BREASTS • Hot • Painful • Heavy • Oedematous • Hard • May look red • Milk flowing • No fever ENGORGED BREASTS • Painful • Oedematous • Tight, especially nipple • Shiny • Milk NOT flowing • May be fever for 24 hours

It is important to be clear about the difference between full and engorged breasts.

#### Trainer Discuss, management of engorged breast:

- Mother should be advised not to "rest" the breast".
- If the baby is able to suckle, she should be fed frequently.
- If the baby is not able to suckle, help her/his mother to express her milk.
- Before feeding or expressing milk stimulate of mother's oxytocin reflex by warm compresses or warm shower, breast light massage and help mother to relax.
- After a feed, put cold compress on her breast to reduce oedema.

#### Discuss, mastitis:

- In mastitis part of the breast looks red and swollen.
- The woman has severe pain, and fever, and she feels ill. Part of the breast is swollen and hard, with redness of the overlying skin.

Mastitis is sometimes confused with engorgement. However, engorgement affects the whole breast, and often both breasts. Mastitis affects part of the breast, and usually only one breast. However, if engorgement is not relieved, it may lead to mastitis.

- Mastitis is due to infrequent or short breastfeeds.
- Poor drainage of part or all of the breast
- Damaged breast tissues.
- Bacteria entering through nipple fissure.

#### Management of Mastitis:

- Gently massage the breast while the baby is suckling.
- Apply warm compresses to her breast between feeds.
- Breastfeed the baby in different position in different feeds.
- In case she doesn't improve refer her to healthcare provider for treatment, who will give antibiotics and analgesics to relive her pain.

#### **Show TA 8.5: Nipple fissure**



TA 8.5: Nipple fissure

- Fissure is a crack around the base of the nipple. This is due to the damage caused by baby's suckling on the nipple and damaging the skin.
- This sometimes occurs when the mother waits to put her baby to the breast until her milk had 'come in'. Consequently the breast becomes engorged and the skin becomes tight and the baby can suck only on the nipple, which damages the nipple skin.

This is one of the reasons why it is important to breastfeed soon after delivery. Starting to breastfeed early helps to prevent the milk pressure from building up in the breasts, so it helps to prevent engorgement. Also, it is easier for a baby to attach well when the breasts are still soft. There is less chance of nipple damage.

#### III. Summarize 'breast conditions'

(10 minutes)

# SESSION



# **Refusal to Breastfeed and Crying**

#### **Objectives**

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

- List reasons of refusal to breastfeed and crying.
- Help mothers of such babies.

Session outline	(45 minutes)
I. Introduce the topic	(5 minutes)
II. Discuss causes of refusal to breastfeed and excessive crying	(15 minutes)
III. How to help a family with a baby who refuses to breastfeed or cries a lot	(10 minutes)
IV. Demonstrate how to hold and carry a baby who is excessively crying because of pain in stomach or topic	(10 minutes)
V. Summarize the session	(5 minutes)

#### **Preparation**

- 1. Read the introduction. How to conduct the training course?
- 2. Arrange a black board or flip chart and non permanent marker pens.

#### I. Introduce the topic

#### (20 minutes)

This chapter is about the problem of a baby refusing to breastfeed, or being unwilling to suckle and cries a lot.

#### Ask: Have you heard of babies who refuse to breastfeed?

(Let participants relate their experience for 2-3 minutes. Thank them, and continue).

- In most communities, refusal of breastfeed is a common reason for starting artificial feeding which may lead to complete stopping of breastfeeding.
- Similarly a mother may think that she does not have enough breastmilk, if her baby is "crying too much".
- Many mothers start few feeds of animal milk or semi-solid foods if baby keeps on crying.
- An important way to help a breastfeeding mother is to counsel her about her baby's crying and refusal to feed.
- 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. S/he may do this several times during a single feed.
  - » Sometimes a baby takes one breast, but refuses the other.
- A baby who cries a lot can upset the relationship between him and his mother and can cause tension among other family members.
- Ask participants to tell the reasons for crying. Write the following on black board.

REASONS WHY BABIES CRY		
<ul> <li>Discomfort</li> <li>Tiredness</li> <li>Illness or pain</li> <li>Hunger</li> <li>Mother's food</li> <li>Drugs/substance mother consumes</li> <li>Oversupply of breastmilk</li> <li>Colic</li> </ul>	<ul> <li>'High needs' babies</li> <li>(dirty, hot, cold)</li> <li>(too many visitors)</li> <li>(earache or septicemia)</li> <li>(not getting enough milk, growth spurt)</li> <li>(any food, sometimes cow's milk)</li> <li>(caffine, nicotine and other drugs)</li> </ul>	

# II. Discuss causes of refusal to breastfeed and excessive crying

(15 minutes)

Ask participants to suggest why a baby may refuse to breastfeed
 Wait for few answers and then write on black board.

#### Causes of refusal to breastfeed

#### WHY A BABY MAY REFUSE TO BREASTFEED

#### 1. Is the baby ill, in pain, sedated due to maternal medication?

#### Illness:

→ The baby may attach to the breast, but suckles less than before.

#### Pain:

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

#### Blocked nose:

→ The baby suckles a few times, and then stops and cries.

#### Sore mouth (an older baby teething):

→ The baby suckles a few times, and then stops and cries.

#### Maternal medication:

A baby may be sleepy because of:

- Drugs that his mother was given during labour;
- → Drugs that she is taking for psychiatric treatment.

#### 2. Is there any difficulty with the breastfeeding technique?

Sometimes breastfeeding can become unpleasant or frustrating for a baby.

#### Possible causes:

- → Feeding with a bottle, or sucking on a pacifier (dummy)-Nipple Confusion.
- → Improper body position, poor attachment, engorgement of breast or flat nipple.
- → 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'.
- → Too much milk coming too fast, due to oversupply. The baby may suckle for a minute, and then comes off choking or crying, when the ejection reflex starts. This may happen several times during a feed. The mother may notice milk spraying out as s/he comes off the breast.

#### 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.

#### 3. Has a change upset the baby?

Babies have strong feelings, and if they are upset they may refuse to breastfeed. They may cry and refuse to suckle.

This is common when a baby is between the age 3-12 months. S/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, deodorant or talcum powder.
- → Babies can become allergic to the protein in some foods in their mother's diet. Cow's milk, soy, eggs, and peanuts can cause this problem.

#### 4. Is it 'apparent' and not 'real' refusal?

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

- → When a newborn baby 'roots' for the breast, s/he moves his head from side to side as if s/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 or strange cry or see strong light. 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.

#### Hunger due to growth spurt:

A baby seems very hungry for a few days, possibly because s/he is growing faster than before. S/he demands to be fed very often. This is common at the ages of about 2 weeks, 6 weeks and 3 months, but can also occur at other times. If s/he suckles often for a few days, the breastmilk supply increases, and s/he breastfeeds less often again.

#### '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 leave them, or where they put them to sleep in separate cots.

#### 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. S/he may pull up his legs as if s/he has abdominal pain. S/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.

Trainers' Guide

#### Mother's food:

Sometimes a mother notices that her baby is upset when she eats a particular food. This is because substances from the food pass into her milk. It can happen with any food, and there are no special foods to advise mothers to avoid, unless she notices a problem with some food.

- → Babies can become allergic to the protein in some foods in their mother's diet.
- → Cow's milk, soya, egg, and peanuts can all cause this problem.
- → Caffeine in coffee, tea, and colas, can pass into breastmilk and upset a baby. If someone in the family smokes, that also can affect the baby.

You will see that many reasons of refusal to feed also cause excessive crying in the baby.

# III. How to help a mother with a baby who refuses to breastfeed or cries a lot

(10 minutes)

#### 1. Treat or remove the cause if possible

#### Illness:

- → Treat infections with appropriate antimicrobials and other therapy.
- → Refer if necessary.
- → If a baby is unable to suckle, s/he may need special care in hospital.
- → Help his mother to express her breastmilk to feed him by cup or tube, until s/he is able to breastfeed again.

#### Pain:

- → For a bruise on the head of the baby help the mother to find a way to hold the baby without pressing on a painful place.
- → For thrush in baby's mouth: apply Gentian Violet (1%), locally.
- → For teething: encourage her to be patient and to keep offering him her breast.
- → For a blocked nose: explain how she can clear it by a warm cotton bud. Suggest short feeds, more often than usual for a few days.

#### **Medication:**

If the mother is on regular medication, try to find an alternative in consultation with the doctor.

#### 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 own technique.

#### Oversupply

Oversupply can result from poor attachment. If a baby suckles ineffectively, s/he may breastfeed frequently, or for a long time, and stimulate the breast so that it produces more milk than s/he needs. To reduce oversupply:

- → Help the mother to improve her baby's attachment.
- → Suggest that she lets her/him suckle from only one breast at each feed. Let her/him continue at that breast until s/he finishes by himself, so that s/he gets plenty of the fat-rich hindmilk. At the next feed, give him the other breast.

#### Sometimes a mother finds it helpful to:

- → express some milk before a feed;
- → lie on her back to breastfeed (if milk flows upwards, it is slower);
- → hold her breast with the "scissor hold" to slow the flow.

#### Changes which upset a baby:

- → discuss the need to reduce separation and changes if possible.
- → suggest that she stops using the new soap, perfume, or food.
- → 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.

This is valuable at least up to the age of 2 years.

# IV. Demonstrate how to hold and carry a baby who is excessively crying because of pain in stomach

(10 minutes)

- ☐ Make this introductory point:
- Babies are most often comforted with closeness, gentle movement, and gentle pressure on the abdomen. There are several ways to provide this.
- ☐ Give the demonstration:
- Hold a doll along your forearm, pressing on its back with your other hand. Move gently backwards and forwards (Figure 9.1 a).
- Sit down and hold the doll lying face down across your lap. Gently rub the doll's back.
- Sit down and hold the doll sitting on your lap, with its back to your chest. Hold it round the abdomen, gently pressing on the abdomen (Figure 9.1b) swinging and forward-backward with his head held by the mother's chin.

#### ② Ask a male participant (somebody) to help with this demonstration if possible.

Hold the doll upright against his chest, with the doll's head against his throat. S/he should hum gently, so that a baby would hear his deep voice. (Figure 9.1c). It is easier to compress baby's abdomen against male chest.

Ask participants if they know of other ways to comfort a crying baby that are common in their community. Ask them to demonstrate with a doll.

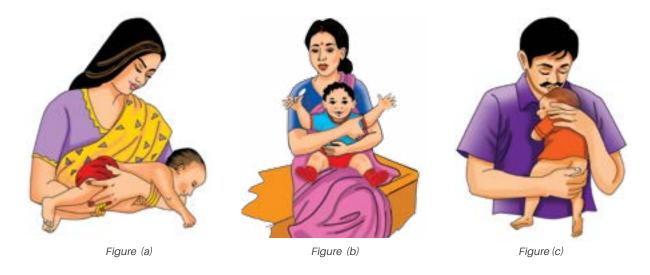


Figure 9.1: Some different ways to hold a colicky baby

#### V. Summarize the session

(5 minutes)

SESSION

## **Expressing Breastmilk**

#### **Objectives**

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

- Explain when it is useful for a mother to express breastmilk
- Help a mother to stimulate her milk flow
- Teach a mother to express breastmilk.

# Session outline I. Introduce the topic (5 minutes) II. Demonstrate how to stimulate milk flow (10 minutes) III. Demonstrate expression of breastmilk (Figure 10.1) (10 minutes)

#### **Preparation**

IV. Summarize

- 1. Read the introduction. How to conduct the training course?
- 2. Arrange breast model.
- 3. Arrange katori jar.

(5 minutes)

#### I. Introduce the topic

(5 minutes)

Ask participants to keep their manuals closed.

- ☐ Explain the purpose of the session:
- 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.
- ☐ Discuss when it is useful to express breastmilk.

#### Ask: In which situations is it useful for a mother to express her breastmilk?

Let participants suggest.

→ Write participants' ideas on a black board.

Try to develop a list with most of the ideas below.

After few minutes, if participants cannot think of any more ideas, complete the list for them.

#### Expressing milk is useful to:

- » Relieve engorgement.
- » Relieve blocked duct.
- » Feed a baby while s/he learns to suckle from an inverted nipple.
- » Feed a baby who has difficulty in coordinating suckling.
- » Feed a baby who 'refuses', while s/he learns to enjoy breastfeeding.
- » Feed a low-birth-weight baby who cannot breastfeed.
- » Feed a sick baby, who cannot suckle enough.
- » Keep up the supply of breastmilk when a mother or baby is ill.
- » Leave breastmilk for the baby when his mother goes out or to work.
- » Prevent leaking when the mother is away from her baby.
- » Help a baby to attach to a full breast.
- » Express breastmilk directly into a baby's mouth.
- » Prevent the nipple and areola from becoming dry or sore.
- So there are many situations in which expressing breastmilk is useful and it is 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 frontline workers who care for breastfeeding mothers should be able to teach mothers how to express their milk. Before one learns expression of breastmilk, it is important to know what are the other ways to stimulate hormones necessary for milk secretion (prolactin) and milk flow (oxytocin).

#### II. Stimulating the prolactin reflex

Mothers may stimulate nipple and areola to help in prolactin secretion. This is done with a gentle stroke on breast, light touch with fingers on the areola and by gently rubbing nipple between thumb and index finger. It is wise to keep on stimulating prolactin to maintain milk secretion.

Prolactin reflex may not work as well when a mother stimulates her nipple and areola as it does when a baby suckles.

Demonstrate the stimulation of breast nipple and areola on a breast model.

#### III. Demonstrate how to stimulate the oxytocin reflex

#### HOW TO STIMULATE THE OXYTOCIN REFLEX

#### A group the mother psychologically:

- Build her confidence.
- Try to reduce any sources of pain or anxiety.
- Help her to have good thoughts and feelings about the baby.

#### Help the mother practically. Help or advise her to:

- Sit quietly and privately or with a supportive friend. Some mothers can express easily in a group of other mothers who are also expressing for their babies.
- Hold her baby with skin-to-skin contact if possible. She can hold her baby on her lap
  while she expresses. If this is not possible, she can look at the baby. If this is not possible,
  sometimes even looking at a photograph of her baby helps.
- Take a warm soothing drink.
- The drink should not be coffee.
- Warm her breasts.

For example, she can apply a warm compress, or warm water, or have a warm shower.

- Stimulate her nipples.
  - She can gently pull or roll her nipples with her fingers.
- Massage or stroke her breasts lightly.
  - Some women find that it helps if they stroke the breast gently with finger tips or with a comb.
  - Some women find that it helps to gently roll their closed fist over the breast towards the nipple.
- Ask a helper to rub her back.
  - The mother sits down, leans forward, folds her arms on a table in front of her, and rests her head on her arms. Her breasts hang loose, unclothed. The helper rubs down both sides of the mother's spine. She uses her closed fist with her thumbs pointing forwards. She presses firmly making small circular movements with her thumbs. She works down both sides of the spine at the same time, from the neck to the shoulder blades, for two or three minutes.
- Demonstrate how to rub a mother's back to stimulate the oxytocin reflex.
- ② Ask the participant to help you by sitting at the table resting her head on her arms, as relaxed as possible.

She remains clothed, but explain that as a patient it is important for her breasts and her back to be naked.

Make sure that the chair is far enough away from the table for her breasts to hang free.

Explain what you will do, and ask her permission to do it.

Rub both sides of her spine with your thumbs, making small circular movements, from her neck to her shoulder blades (see box inset in Figure 10.1).

Ask her how she feels, and if it makes her feel relaxed.

- □ Participants practice rubbing a mother's back:
- ② Ask participants to work in pairs and briefly practice the technique of rubbing a mother's back.



Figure 10.1: A helper rubbing a mother's back to stimulate the oxytocin reflex

# III. Demonstrate how to express breastmilk by hand Flip Chart 10.1

(10 minutes)

- ☐ Make these points:
- Hand expression is the most useful way to express milk. It needs no appliance, so a woman can do it anywhere, at any time.
- It is easy to "hand express" when the breasts are soft. It is more difficult when the breasts are engorged and tight. So teach a mother how to express her milk in the first or second day after delivery. Do not wait until the third day, when her breasts are full.
- **Key point:** 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.

# Trainer should demonstrate to the frontline worker how to prepare a container to collect breastmilk

(Do this demonstration quickly)

Show participants some of the containers to hold the expressed breastmilk (EBM) that they have collected.

Go through the following points:

Ask participants to open manual session 10 "Expressing breastmilk" and see Expression of Breastmilk By Hand.

#### HOW TO PREPARE A CONTAINER FOR EXPRESSED BREASTMILK

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

#### Type of containers for storing EBM and feeding the baby with EBM:

- » Polypropylene plastics and glass containers are considered better for storing EBM. Food grade plastic bags may be used for long term storage of the breastmilk. Steel containers may also be used if milk is to be stored for a short period.
- » Mother may express before each feed and give desired amount of the milk soon after. She may also express as much milk as possible in each session and excess amount may be kept for next feeding.
- » Expressed milk may be kept for 6-8 hours at room temperature. It may be stored for 72 hours in the second compartment and for 2 weeks in the freezer compartment of the refrigerator. All breastmilk containers should be labeled by name of mother, date of expression and hepatitis B and HIV status.
- » Mother may use same cup for feeding in which milk is being expressed. The left out milk may be kept covered as described and given in the next feed.
- » Care should be taken that the edges of the containers used for storage or feeding the baby should not have sharp edges as it can injure the soft skin of the infant.

Table 10.1: Storage of breastmilk	
Amount	60-120 ml in a container (may reduce wastage)
Room temperature (19 °C - 26 °C)	6 hrs - 8 hrs
Refrigerator (<4 °C)	72 hrs - 8 days
Freezer compartment (-15 °C)	2 weeks
Deep freezer (-20 °C)	3-6 months (Freezer with separator door 3-6 months)
[Used in human milk banks]	6-12 months
Container	Use after is it thawed in refrigerator body overnight or under running water
	With well fitting air tight tops, washed in hot soapy water and dried in air
	Glass
	Hard sided plastic (Polypropylene soft, semi cloudy) - PP grade
	Freezer milk bags

#### 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 in a quite place 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 10.2).
- Gently press her thumb and first finger slightly inwards towards the chest wall. She should avoid pressing too far or she may block the milk ducts.
- Press her breast behind the nipple and areola between her finger and thumb. Sometimes in a
  lactating breast it is possible to feel the sinuses. They are like pods, or peanuts. If she can feel
  them, she can press on them.
- Press and release, again 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 thumbs and fingers along the skin over the nipple. 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 are tired.
- 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.

#### Figure 10.2: How to express breastmilk.

- a) Place finger and thumb on each side of the areola and press inwards towards the chest wall.
- b) Press behind the nipple and areola between your finger and thumb.
- c) Press from the sides to empty all segments.
- □ Discuss how often to express milk:

#### Ask: 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-birth-weight or sick newborn:
  - » She should start to express milk on the first day, within six hours of delivery if possible. She may only express 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.

Trainers' Guide

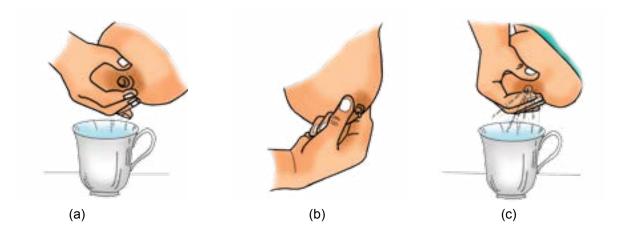


Figure 10.2: How to express breastmilk

- » She should express, as much as she can and as often as her baby would breastfeed. This should be at least after 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 1/2 -1 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.
- To keep nipple skin healthy:
  - » Express a small drop of milk to rub on nipple after a bath or shower.
- Ask participants to practice the technique.

Ask them to practice the rolling action of the fingers on a breast model or on their arms. Ask them to make sure that they avoid pinching.

Ask them to practice on their own bodies privately later.

#### IV. Summarize 'expressing breastmilk'

(5 minutes)

- Make these points:
- 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. Stimulating the oxytocin reflex is helpful for pump expression, as well as with hand expression.

SESSION

## **Not Enough Milk**

#### **Objectives**

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

- Decide if a baby is getting enough breastmilk or not.
- Decide the reason if the baby is not getting enough milk.
- Help mother whose baby is not getting enough milk.

Session outline	(60 minutes)
I. Introduce the topic	(5 minutes)
II. Discuss how to decide if a baby is getting enough milk or not	(10 minutes)
III. Discuss the reasons why a baby may not get enough breastmilk	(15 minutes)
IV. Discuss how to help a mother whose baby is not getting enough breastmilk	(15 minutes)
V. Discuss how to help a mother who thinks that she does not have enough breastmilk	(10 minutes)
VI. Summarize the session	(5 minutes)

#### **Preparation**

- 1. Read the introduction. How to conduct the training course?
- 2. Prepare chart for common causes of Not enough milk.
- 3. Arrange 1 board and a flip chart or 2 flip charts. Arrange non-permanent marker pens of different colours with broad nib.

#### I. Introduce the topic

(5 minutes)

Ask participants to keep their manuals closed.

- ☐ Make this introductory point:
- One of the commonest reasons that mothers give for starting bottle feeds or for stopping breastfeeding, is that they think that they "do not have enough milk".
- 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.
- ☐ Continue with these points:
- Usually, even when a mother thinks that she does not have enough breastmilk, her baby is in fact getting all that s/he needs. Almost all mothers can produce enough breastmilk for one or even two babies. Almost all of them can produce more than their baby needs.
- Sometimes a baby does not get enough breastmilk. But it is usually because s/he is not suckling enough, or not suckling effectively (see Session 3, 'How breastfeeding works'). It is rarely because his mother cannot produce enough.
- So it is important to think not about "how much milk a mother can produce", but about "how much milk a baby is getting".

# II. Discuss how to decide if a baby is getting enough milk or not

(10 minutes)

Develop a list of signs that make mothers think that they do not have enough milk:

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

→ Write participants' ideas in a list on a black board/flip chart.

Continue until you have a list of at least 10 signs, and if possible until someone has said "poor weight gain".

- ☐ Explain which signs are reliable:
- There are only two signs which show reliably that a baby is not getting enough milk.

These are:

- » Poor weight gain.
- » Passing small amounts of concentrated urine.
- If either sign is on the participants' list, underline it, and praise the participants for thinking of it.
- → Write the heading 'RELIABLE SIGNS' on another black board/flip chart.
- ☐ Write the two signs below the heading on left hand side (see box).

#### **RELIABLE SIGNS BABY NOT GETTING ENOUGH MILK**

- Poor weight gain
- Small amount of concentrated urine

Then complete information on right hand side

#### SIGNS THAT A BABY MAY NOT BE GETTING ENOUGH BREASTMILK

#### **RELIABLE**

- Poor weight gain
- Passing small amount of concentrated urine

(Less than 500 g a month)

(Less than birth weight after 2 weeks)

(Less than 6 times a day, yellow and strong smelling)

POSSIBLE
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 when mother tries to express
Breasts did not enlarge (during pregnancy)
Milk did not 'come in' (after delivery)

- ☐ Explain how to find out if a baby is getting enough breastmilk or not:
- Check the baby's weight gain. This is the most reliable sign.

For the first six months of life, a baby should gain a weight of at least 500 gm in each month, or 125 gm each week. (one kilogram per month is not necessary, and not usual.) If a baby gains less than 500 gm in a month, s/he is not gaining enough weight.

Look at the baby's growth chart if available, or at any other record of previous weights. If no weight record is available, weigh the baby, and arrange to weigh him again in one week's time.

If the baby is gaining enough weight, s/he is getting enough milk.

• Check the baby's urine output. This is a useful quick check.

An exclusively breastfed baby who is getting enough milk usually passes dilute urine at least 6-8 times in 24 hours.

A baby who is not getting enough breastmilk passes urine less than 6 times a day (often less than 4 times a day).

His urine is also concentrated, and may be strong smelling and dark yellow to orange, especially in a baby more than 4 weeks old.

Ask the mother how often her baby is passing urine. Ask her if the urine is dark yellow or 'strong' smelling.

- » If a baby is passing plenty of dilute urine, s/he is getting enough breastmilk.
- » If s/he is passing concentrated urine less than 6 times a day, then s/he is not getting enough breastmilk.

This can tell you quickly if an exclusively breastfed baby is getting enough milk.

However, if s/he is having any other drinks, you cannot be sure.

# III. Discuss the reasons why a baby may not get enough breastmilk

(15 minutes)

- Ask participants to suggest possible reasons why a baby may not get enough breastmilk.
- List their suggestions on a black board.

Continue if possible until they have suggested at least one 'breastfeeding factor', and at least one 'psychological factor'.

- Put the following four headings onto a black board.
- Try to list all the participants' correct reasons for a baby not getting enough breastmilk under one of the headings.

REASONS WHY A BABY MAY NOT GET ENOUGH BREASTMILK			
Breastfeeding factors	Mother: psychological factors	Baby's condition	Mother: physical condition
<ul> <li>Delayed start</li> <li>Poor support</li> <li>Poor attachment</li> <li>Feeding at fixed times</li> <li>Infrequent feeds</li> <li>No night feeds</li> <li>Short feeds</li> <li>Bottles, pacifier</li> <li>Other foods</li> <li>Other fluids (water, teas)</li> </ul>	<ul> <li>Lack of Confidence</li> <li>Worry, stress</li> <li>Dislike of breastfeeding</li> <li>Rejection of baby</li> <li>Tiredness</li> </ul>	<ul> <li>Low birth weight</li> <li>Nose block</li> <li>Illness</li> <li>Other abnormalities</li> </ul>	<ul> <li>Contraceptive pills, diuretics</li> <li>Pregnancy</li> <li>Severe malnutrition</li> <li>Alcohol</li> <li>Smoking</li> <li>Retained piece of placenta (rare)</li> <li>Poor breast development (very rare)</li> </ul>
	These are COMMON		These are NOT COMMON

- ☐ Make these points:
- The reasons in the first three columns ('Breastfeeding factors', 'Baby's conditions', 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 fourth column ('Mother: physical condition') are uncommon.
  So, 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.
- ☐ Ask participants to look at the list for 2-3 minutes.

Ask them, if they are not clear about any point.

Trainers' Guide

#### **Breastfeeding factors**

#### Delayed start:

If a baby does not start to breastfeed in the first day, his mother's breastmilk may take longer to 'come in'. This may be the reason for not getting enough milk and starting of weight gain.

#### Poor support:

If the mothers don't get immediate support in the healthcare facility for breastfeeding after delivery, she usually gets confused and many times gives some other food and fluids to the baby. First time mothers find it little difficult to hold and feed the baby. She needs proper support from a skilled worker in health facility.

#### Poor attachment:

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

#### Infrequent feeds:

Breastfeeding less than 8 times a day in the first 4 weeks, or less than 5-6 times a day at an older age, is a common reason why a baby does not get enough milk. Sometimes a mother does not respond to her baby when s/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 and 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 s/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 s/he is wrapped in too many clothes and feeling hot.

#### 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 (artificial milks, solids, or drinks including plain water), before 4-6 months suckles less at the breast, so the breastmilk supply decreases.

#### Baby's condition

#### Low birth weight:

Some low birth weight babies, especially those born before term, are not capable of suckling effectively. This leads to poor stimulation of milk secretion, less milk, removal of milk and babies may not get enough milk.

#### Blocked nose:

During suckling if the nose is blocked, babies do not suckle well and they may not get enough milk.

#### Illness:

If baby is ill, weak and unable to suckle strongly, s/he 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 s/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.

#### Mother: psychological factors

#### Lack of confidence:

Mothers who are very young, or who lack support from family and friends, often lack confidence. Mothers also 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 s/he cries instead of breastfeeding him.

#### Mother: physical condition

#### Contraceptive pill:

Contraceptive pills which contain estrogens may reduce the secretion of breastmilk. 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 which prevent milk production. The woman bleeds more than usual after delivery, her uterus does not decrease in size, and her milk does not 'come in'.

Trainers' Guide

#### 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.
- Review misconceptions about the causes of a poor milk supply:

Read quickly through the list in the box THESE DO NOT AFFECT THE BREASTMILK SUPPLY.

Do not spend much time on this. However, be ready to answer participants' questions, if they have difficulty in believing that these are not important reasons.

Some things are commonly thought to be a reason for insufficient breastmilk supply.
 However, they do not in fact affect the milk supply.

#### THESE DO NOT AFFECT THE BREASTMILK SUPPLY

- Age of mother
- Sexual intercourse
- Menstruation
- Disapproval of relatives and neighbors
- Returning to a job (if baby continues to suckle often)
- Age of baby
- Caesarian section
- Preterm delivery (if the milk is removed frequently)
- Many children
- Simple, ordinary diet
- ☐ Summarize the causes of "not enough milk":

#### **Emphasize these points:**

- The common reasons for a baby not getting enough milk are:
  - » Breastfeeding factors.
  - » Psychological factors.
- A physical difficulty in producing breastmilk is the cause occasionally.

# IV. Discuss how to help a mother whose baby is not getting enough breastmilk

(15 minutes)

- ☐ Discuss the need to find the cause of the problem:
- If a baby is not getting enough milk, you need to find out WHY.

#### Ask: How could you find out the cause of a baby not getting enough milk?

(Let participants think for a short time and make a few suggestions.

Encourage them to think of the skills that they have learnt in the course so far.

Then continue.)

To find the cause, go through the following steps:-

Listen and learn	(to learn about psychological factors, and how the mother feels)
Take a history	(to learn about breastfeeding factors, and the mother's medication)
Assess a breastfeed	(to learn about the baby's attachment and suckling and about bonding or rejection)
Examine the baby	(for illness or abnormality, and for his growth).
Examine the mother and her breasts	(to learn about her health, her nutrition, and any breast condition)

- ☐ Discuss how to help a mother:
- When you have some idea why a baby is not getting enough milk, you can decide how to help him and his mother.

#### Ask: How might you help a mother if her baby is not getting enough milk?

(Let participants think and make a few suggestions. Encourage them to think of what they have learnt in this course about how to help mothers. Then continue.)

Trainers' Guide

#### HOW TO HELP A MOTHER WHOSE BABY IS NOT GETTING ENOUGH BREASTMILK

#### Look for a cause

Steps to take: What you may learn about:

Listen and learn Psychological factors, how mother feels

Take a history Breastfeeding factors, contraceptive pill, diuretics

Assess a breastfeed Baby's position at breast, bonding or rejection

Examine the baby Illness or abnormality, growth

Examine the mother and her Her nutrition and health

breasts Any breast problem

#### • Build confidence and give support

Help the mother to give her baby more breastmilk, and to believe that she can produce enough.

Accept Her ideas about breastmilk supply

Praise (as appropriate) Her feelings about breastfeeding and her baby

Give practical help She is still breastfeeding

Give relevant Information Her breasts are good for making milk
Use simple language Improve baby's attachment to breast

Suggest Explain how baby's suckling controls milk supply

(as appropriate) Explain how baby can get more breastmilk

"Breasts will make more milk if baby takes more"

Breastfeed more often, longer, at night

Stop using bottles or pacifiers

(use cup if necessary)

Reduce or stop other feeds and drinks (if baby aged less than 6 months)

Ideas to reduce stress, anxiety

Offer to talk to family

#### Help with less common causes

Baby's condition: If ill or abnormal, treat or refer

Mother's condition: If taking estrogen pills or diuretic, help her to change

Help as appropriate with other conditions

#### • Follow-up

Examine daily, then weekly until baby starts gaining weight and mother is confident.

See daily, then weekly until baby gaining weight and mother confident.

It may take 3-7 days for the baby to gain weight (see Session 29).

#### To understand the situation:

Listen and learn	(to understand why she lacks confidence. Empathize with how she feels.)
Take a history	(to learn about the pressures that she is under going from other people to give artificial feeds.)
Assess a breastfeed	(to see if poor attachment could be the problem. If a baby is suckling very often, or for a long time, it may be because s/he is poorly attached and getting the breastmilk inefficiently. S/he may be getting enough breastmilk.)
Examine the mother	(to see the shape of her breasts, nipples, and areola. She may lack confidence if her breasts if they are small or flat, or very large or of unusual shape.)

To help a mother, use your confidence and support skills.

Use the box HOW TO HELP A MOTHER WHO THINKS THAT SHE DOES NOT HAVE ENOUGH BREASTMILK for ideas.

HOW TO HELP A MOTHER WHO THIS BREASTMILK	NKS THAT SHE DOES NOT HAVE ENOUGH
Understand her situation     Listen and learn     Take a history     Assess a breastfeed     Examine mother	To understand why she lacks confidence, empathize To learn about pressures from other people To check baby's attachment at breast Breast size may cause lack of confidence
Build confidence and give support     Accept     Praise (as appropriate)	Her ideas and feelings about her milk  Baby growing well, her milk supplies his needs  Good points about her breastfeeding technique  Good points about baby's development
Give practical help Give relevant Information	Improve attachment if necessary  Correct mistaken ideas, do not sound critical  Explain about babies' normal behaviour  Explain how breastfeeding works (what you say depends on her worries)  "Some babies do like to suckle a lot" Ideas for coping with tiredness  Offer to talk to family

Trainers' Guide

VI. Summarize (5 minutes)

Ensure that frontline workers get familiar with them.

- Signs that a baby may not be getting enough breastmilk
- Reasons why a baby may not get enough breastmilk
- These do not affect the breastmilk supply
- How to help a mother whose baby is not getting enough milk
- How to help a mother who thinks that she does not have enough breastmilk

SESSION

12

## **Breastfeeding Low Birth Weight Babies and Twins**

## **Objectives**

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

- Describe why breastmilk is the best food for low-birth-weight babies
- Help a mother to feed her baby by cup
- Help a mother to breastfeed twins

Session outline	(35 minutes)
I. Introduce the topic	(5 minutes)
II. Method of feeding low birth weight babies	(10 minutes)
III. Demonstrate how to feed a baby by cup	(10 minutes)
IV. Breastfeeding twin babies	(5 minutes)
V. Summarize	(5 minutes)

## **Preparation**

- 1. Read the introduction. How to conduct the training course?
- 2. Arrange cup, spoon, napkin and doll for demonstration.

## I. Introduce the topic

(5 minutes)

- ☐ Make this introductory point:
- The term low-birth-weight (LBW) means a birth weight less than 2,500 grams. This includes babies who are born before term, and who are small for gestational age. Babies may be small for both these reasons.
- Low-birth-weight babies are at particular risk of infection, and they need breastmilk more than normal babies. Yet, they are given artificial feeds and bottle feeds more often than normal weight babies.

## Ask: Why is it sometimes difficult for LBW babies to breastfeed exclusively?

(Let participants suggest answers. Then discuss the following.)

## Possible answers that participants might suggest include:

- » LBW babies are not able to suckle strongly at the breast.
- » They need more of some nutrients cystine and essential fatty acids and carnitine than mature breastmilk can provide.
- » It can be difficult for mothers to express enough breastmilk.
- There is some truth in all these statements, and these are the reasons why in many hospitals LBW babies are fed artificially.
- Many LBW babies can breastfeed without difficulty. Babies born at term, who are small-fordates, 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 in 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.
- If a mother is given enough skilled help and support, she can express her breastmilk, and feed it to her baby by tube or cup, until s/he can breastfeed. She can breastfeed her LBW baby fully much earlier than we used to think possible.

## II. Methods of feeding Low Birth Weight (LBW) babies (10 minutes)

Explain the different ways to feed low-birth-weight babies.

Babies who are less than about 30-32 weeks gestational age usually need to be fed by nasogastric tube. Give expressed breastmilk by tube. The mother can let her baby suck on her own finger while s/he is having the tube feeds. This probably stimulates his digestive tract, and helps weight gain.

If possible, let the mother hold her baby and give him skin-to-skin contact against her body every day. Skin-to-skin contact helps bonding, and it helps a mother to produce more breastmilk, so it helps breastfeeding.

Babies between 32-34 weeks gestational age can take feeds from a small cup, or from a spoon. You can start trying to give cup feeds once or twice a day while a baby is still having most of his feeds by nasogastric tube. If s/he takes cup feeds well, you can reduce the tube feeds. Another way to feed a baby at this stage is by expressing milk directly into the baby's mouth.

Babies more than 34 weeks gestational age are able to start suckling on the breast. Let the mother put her baby to her breast as soon as s/he is well enough. S/he may only root for the nipple and lick it

Trainers' Guide

at first, or s/he may suckle a little. Continue giving expressed breastmilk by cup or tube, to make sure that the baby gets all that s/he needs.

When a LBW baby starts to suckle effectively, s/he may pause during feeds quite often and for quite long periods. For example, s/he may take 4-5 sucks, and then pauses 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 s/he can suckle again when s/he is ready. S/he can continue for up to an hour if necessary. Offer a cup feed after the breastfeed. Or offer alternate breast and cup feeds.

Make sure that the baby suckles in a good position. Good attachment may make effective suckling possible at an earlier stage.

#### The best positions for a mother to hold her LBW baby at her breast are:

- » across her body, holding him with the arm on the opposite side to the breast;
- » the underarm position as explain earlier while discussing positioning baby at the breast.

In both of these positions, she supports her baby's body on her arm and supports and controls his head with her hand. This is important with LBW babies, but not with larger babies.

Babies from about 34-36 weeks gestational age or more (sometimes earlier) can often take all that they need directly from the breast.

For example, a baby may feed well sometimes, but tired and feed poorly at other times. If a baby suckles poorly, offer a cup feed after the breastfeed. If s/he is hungry, s/he will take milk from the cup. If s/he has had enough, s/he will not take milk from the cup. Continue to follow up babies and weigh them regularly to make sure that they are getting all the breastmilk that they need.

#### **Further information**

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 1 hour, and every 2-3 hours thereafter to prevent hypoglycaemia (low blood sugar).

#### 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.

#### Skin-to-skin contact and Kangaroo Mother Care (KMC)

Skin-to-skin contact between a mother (or father) and baby has been found to help both bonding and breastfeeding, probably because it stimulates the secretion of prolactin and oxytocin.

If a baby is too sick to move, contact can be between the mother's hand and the baby's body. If a baby is well enough, let his mother hold him next to her body. Usually the best place is between her breasts, inside her clothes. This is called kangaroo care. It has the following advantages:

- » The warmth of the mother's body keeps her baby warm. S/he does not get cold, and s/he does not use up extra energy to keep warm. There is less need for incubators.
- » The baby's heart works better, and s/he breathes more regularly.
- » The baby cries less and sleeps better.
- » It is easier to establish breastfeeding.

## III. Demonstrate how to feed a baby by cup

(10 minutes)

□ Discuss why cup feeding is safer than bottle feeding:

## Ask: Why are cups safer and better than bottles for feeding a baby?

(Let participants suggest a few answers. Then go through any of the following points that they have not mentioned.)

- » Cups are easy to clean with soap and water.
- » Cups are less likely than bottles to be carried around for a long time, giving bacteria time to breed.
- » A cup cannot be left beside a baby like a bottle, 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 s/he needs.
- » A cup does not interfere with suckling at the breast.
- » A cup enables a baby to control his own intake.
- Explain why cup feeding is usually better than feeding with a spoon and cup:
- Spoon feeding takes longer than cup feeding.
  - You need three hands to spoon feed: to hold the baby, to hold the cup of milk and to hold the spoon. Mothers often find it difficult especially at night.
- Some mothers give up spoon feeding before the baby has had enough. Some spoon fed babies do not gain weight well.
  - Mothers are more likely to continue with cup feeding.
- However, spoon feeding is safe if a mother prefers it, and if she gives the baby enough. Also, if a baby is very ill, for example with difficult breathing, it is sometimes easier to feed him with a spoon for a short time.
- ☐ Make these points about the volume of breastmilk:
- If a mother is expressing more than her LBW baby needs:
  - Let her express the second half of the milk from each breast into a different container. Let her offer the second half of the EBM first. Her baby gets more hindmilk, which helps him to get the extra energy that s/he needs. This helps a baby to grow better.
- If a mother can only express very small volumes at first:
  - Give whatever she can produce to her baby. Even very small amounts help to prevent infection. Help the mother to feel that this small amount is valuable. This helps her confidence, and will help her to produce more milk. Supplement it if, necessary with donated breastmilk.
- $\square$  Give the demonstration of cup feeding.

## Follow these steps:

- Put some water into one of the small cups.
- Hold a doll on your lap, closely, with it sitting upright or semi-upright. Explain that a baby should not lie down too much.
- Hold the small cup or glass to the doll's lips. Tip it so that the water just reaches the lips.
   Point out that the edges of the cup touch the outer part of the baby's upper lip, and the cup rests lightly on his lower lip. This is normal when a person drinks.

- Explain that at this point, a real baby becomes quite alert, and opens his mouth and eyes. S/he makes movements with his mouth and face, and s/he starts to take the milk into his mouth with his tongue.
- Some milk may spill from the baby's mouth. You may want to put a cloth/tissue paper on the baby's front to protect his clothes. Spilling is commoner with babies of more than about 36 weeks gestation, and less common with smaller babies.
- You should not pour the milk into a baby's mouth just hold the cup to his lips.
- Explain that when a baby has had enough, s/he closes his mouth and will not take any more this feed. If s/he has not taken the calculated amount, s/he may take more next time, or s/he may need feeds more often. Measure his intake over 24 hours, not just at each feed.
- Demonstrate with a doll what happens when you try to feed a baby with a spoon. You need to hold the cup and the spoon, or you need to put the cup down and take milk from it. The procedure is more awkward.
- Tell participants that the technique is described in the box (01) HOW TO FEED A BABY BY CUP.



Figure 12.1: Feeding a LBW baby by cup

#### box (01)

### **HOW TO FEED A BABY BY CUP**

- Hold the baby sitting upright or semi-upright on your lap.
- Hold the small cup of milk to the baby's lips.
- Tilt 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 LBW baby starts to take the milk into his mouth with his tongue.
- A full term or older baby sucks the milk, spilling some of it.
- DO NOT POUR the milk into the baby's mouth. Just hold the cup to his lips and let him take it himself.
- When the baby has had enough milk s/he closes his mouth and will not take any more. If s/he has not taken the calculated amount, s/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.
- Simple, ordinary diet.

## IV. Breastfeeding twin babies

(5 minutes)

## **Full term twins**

- » Most mothers have enough breastmilk to feed twins. Mothers may need support and encouragement to be able to, and believe that they can breastfeed them both.
- » Some mothers feed both twins at the same time; some feed first one twin, and then the other.

## Low birth weight/preterm twins

- » These babies require similar care feeding method as any low birth baby/preterm infant.
- » Expressed breastmilk can be fed by cup or cup and spoon.
- » Mother can produce sufficient quantity of milk for both babies.

## How to help a mother of twins

- » Reassure the mother that she can produce enough breastmilk for both babies.
- » Remind her that more suckling makes more milk. So if two babies suckle, there will be enough for them.
- » Both the babies can be fed together.

Trainers' Guide

- » One way to breastfeed twins together is to hold the babies with their bodies and legs going under the mother's arms (as shown in the figure) Encourage her to make sure that the weaker baby of the two gets enough breastmilk.
- » Talk to her husband and other family members about how they can help her with other work so that she is free to breastfeed the babies.



Figure 12.2: Two ways to hold twins for breastfeeding

IV. Summarize (5 minutes)

SESSION

13

## Complementary Feeding - Foods to Fill the Nutrient Gap

## **Objectives**

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

- Understand the optimal age for children to start complementary feeding.
- Describe the local foods and their consistency that can fill up the energy gap.
- Describe the local foods that can fill the gaps for iron and other nutrients.
- Describe the frequency and amount of complementary feed at various ages.

70 minutes)
(5 minutes)
(10 minutes)
(10 minutes)
(25 minutes)
(10 minutes)
(5 minutes)
(5 minutes)

## **Preparation**

- 1. Read the introduction. How to conduct the training course?
- 2. Arrange Teaching Aids 13.1-13.3.
- 3. Arrange bowls, cups, spoons, (two each) and two empty see-through containers that hold 200 ml and locally available complementary foods for demonstration.
- 4. Arrange towel and tissue paper.
- 5. Prepare 9 key messages on the flip chart.

## I. Introduce the topic

## (5 minutes)

Complementary food is any food or liquid given from the age of 6 months when breastmilk alone is no longer sufficient to meet the nutritional requirements of infants.

The characteristics of a good complementary food are as follows:

- » Should be rich in energy and adequate in good quality protein, Vitamins and minerals.
- » Should have soft thick consistency to enable the child to swallow easily.
- » Should have low dietary bulk.
- » Should need minimal preparation prior to feeding and easily digested by the child.
- » Should be free from anti-nutritional factors and low in indigestible fibre.
- » Should be free from artificial colours and flavors.
- » Should be locally available.
- Make these points:
- The period between six months to two year is of critical importance in child's growth and development. Mostly, feeding of children this age group does not receive adequate emphasis in child health programs. As a result, malnutrition in young children is very common.
- Malnutrition in early age may contribute to health problems in all stages of life. It is associated with deficiency of Iron, Vitamin A and other nutrients, which interferes in their development. In female children, it also affects reproductive functions.
- Undernourished children do not grow and develop optimally, whatever amount of food they consume later in the life.
- Children, who do not grow well, have increased risk of illness and take longer time to recover from illness.
- Trainer should ask participants what local foods are available and what are the cultural practices.

Wait for few answers and then continue.

# II. Discuss the optimal age to start complementary feeding

(10 minutes)

Growth of most of the babies starts slowing after six months of age, if they do not get enough solid food. At this age, babies can sit upright and start taking interest in the food of other persons. They also begin to put things in thier mouth, and munch them. At this age, teeth start growing and babies have better control of the tongue movements in the mouth so they needs additional food and liquids. Babies should receive semi-solid family food from 6 months (180 days) of age along with breastfeeding for proper growth.

## Ask: What are the reasons you hear for starting complementary food by the families?

Families may decide the need of giving food by noticing certain developmental signs, such as reaching for food when others are eating or when teething starts or when baby is not growing well or when he is showing signs of hunger.

Parents may also introduce complementary food after listening to a frontline worker or under influence of advertisements of baby food products.

Trainers' Guide

Some times mother is going away from the baby to join her work and therefore wants to give other foods.

- ☐ After listening to them continue with these points:
  - » Most babies do not need complementary foods before 6 months of age. If the child appears hungry after breastfeeding or is not gaining weight adequately counsel the mother on how to breastfeed exclusively in a way that is effective.
  - » In case, the baby is not able to receive breastmilk, continue using adequate breastmilk substitutes, cow's, buffalo's and tin milk until 6 months of age rather than add complementary foods early.

## Ask: What might happen if complementary foods are started too soon (before 6 months)?

→ Write participants replies on the black board.

Refer to these points they made as you write the following points on black board:

## Adding foods too soon may

- Take the place of breastmilk
- Result in a low nutrient diet
- Increase risk of illness
- Less protective factors
- Other foods not as clean
- Difficult to digest foods
- Increase mother's risk of pregnancy
- □ Explain the above points:
- Adding complementary foods too soon may.
  - » take the place of breastmilk, making difficult to meet the child's nutritional needs.
  - » result in a diet that is low in nutrients even when, watery soups and porridges are used because these are easy for babies to eat.
  - » increase the risk of illness because the child will either get less or not at all the protective factors which are present in breastmilk.
  - » increase the risk of diarrhoea because the complementary foods may not be as clean as breastmilk.
  - » increase the risk of wheezing and other respiratory allergic conditions because the baby cannot yet digest and absorb other foods well.
  - » increase the mother's risk of another pregnancy if breastfeeding is less frequent.

# Ask: What might happen to the child if complementary foods are started too late (older than 6 months)?

→ Write participants replies on the black board.

Refer to the points they made as you make the following points on the black board:

## Adding foods too late

- Child does not receive nutrients needed
- Growth and development slows down or stops
- Risk of deficiencies and malnutrition
- Increases risk of ill health
- □ Explain the above points:
- 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
  - » the child's growth and development slows down or stops
  - » the risk of malnutrition and anemia (lack of iron) increases
  - » the malnourished child is at increased risk of ill health
- Most babies do not need complementary foods before six months of age. All babies older than six months of age should receive complementary foods.
- Trainer will then sum-up the discussion on age to start complementary feeding by stating these messages:



Message - 1

Breastfeeding for at least two years of age helps a child to grow strong and healthy.



Message - 2

Children who start complementary feeding at six months grow well.

## III. Outline foods that can fill up the energy gap

(10 minutes)

## Find out the separate bowl/plate used in the state

- It is important that you know what are the main staples that families eat in your area. Then you
  can help them to use these foods for feeding their young children or some foods may not be
  given at all to young children.
- ☐ While you show participants the child's bowl, make these points:
- Think of the child's bowl or plate. What foods can the family put in the bowl to help the child grow well?
- The first food we may think of putting in the bowl is the staple food. Every community has at least one staple or main food. The staple may be.
  - » Cereals, such as rice, wheat, maize, corn, or millet;
  - » Starchy roots such as cassava, yam, or potato; and
  - » Starchy fruits such as plantain and banana

- » All foods provide some energy. However, people generally eat larger amounts of these staples and they provide much of the energy needed.
- » Staples also provide some protein and other nutrients but they cannot provide all the nutrients. The staple must be eaten with other foods by 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 food.

# IV. Demonstrate using a thick consistency of food and ways to enrich the food

(25 minutes)

- ☐ Make these points:
- We have the staple in the child's bowl. But is the food thin and runny or is it thick and stays on the spoon?
- Often families are afraid that thick foods will be difficult to swallow, get struck in the baby's throat, or give the baby constipation. Therefore, they add extra liquid to the food to make it easier for the young child to eat. Sometimes extra liquid is added so that it will take less time to feed the baby.
- It is important for you to help families understand the importance of using a thick consistency in foods for young children.

### **Show TA 13.1: Stomach size**



- ☐ Make these points:
- This is Anil. He is 8 months old. At this age, Anil's stomach can hold about 200 ml at one time, the amount that fits into this container.
- ☐ Trainer then shows an empty see-through container that holds 200 ml.
- Anil's mother makes his porridge from maize flour and milk. His mother is afraid that Anil will not be able to swallow the porridge, so she adds extra water or milk.
- Use half of the made-up porridge and dilute this portion of porridge to at least twice the volume and show to participants.
- Now the porridge looks like this (thin and watery).

### Ask: Can all this thin porridge fit in his stomach?

Spoon or pour the porridge into the see-through container "stomach" as you ask the question. Wait for a response and then continue.

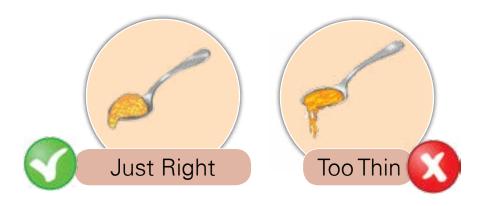
- No, it cannot fit in his stomach. Anil's stomach would be full before he had finished the bowlful. So, Anil would not get all the nutrients he needs to grow.
- Anil's mother has talked to you, the frontline worker, and you have suggested that she should give thick porridge. The mother makes the porridge using the same amount of maize and milk but does not add extra water. The porridge looks like this (thick).
- Use the other half portion of the made-up porridge but do not dilute it. Show the participants how thick it is. Spoon all the porridge into the see-through container "stomach" as you ask the question.

## Ask: Can all this thick porridge fit in Anil's stomach?

Wait for a response and then continue.

- Yes, Anil can eat a bowlful and meet many of his energy needs.
- Now, use a spoon to demonstrate the consistency of the porridge.
- Look at the consistency of the porridge on the spoon. This is a good way to show families how thick the food preparation should be. The food should be thick enough to stay easily on the spoon without running off when the spoon is tilted.
- Porridge or food mixtures that are so thin that they can be fed from a feeding bottle, or poured from the hand or that the child can drink from a cup, do not provide enough energy or nutrients.
- The consistency or thickness of feeds makes a big difference, how well that food meets the young child's energy needs. Foods of a thick consistency help to fill the energy gap.
- So when you are talking with families, tell them the importance of thickness of feeds.

#### Show TA 13.2: Thickness of feed



# Ask: If a caregiver asked you, "Why should I give my baby foods that are thick?" What would you say?

Let participants reply. Praise them for good answer and reinforce the key message.

Trainer will then sum-up the discussion on thickness and consistency of food by stating this messages:



## Message - 3

Family food with a thick, soft consistency nourish and fill the child stomach: foods that stay easily on the spoon.

\_\_\_\_\_

- ☐ Continue with these points:
- Similar to the porridge, when dal or stews are given to young children they are usually thin and dilute and fill the child's stomach. There may be good food ingredients in the soup pot, but little of these are given to the child. It is mostly the watery part of the soup that is given.

## Discuss ways to enrich foods

## Ask: How could families make the young child's food more energy rich?

Wait for a few responses and then continue. Refer to the participants' replies as you make the following points.

- Foods can be made more energy and nutrient rich in a number of ways.
- → For a dalia / porridge or other staple
  - » Use less water and make a thicker porridge as we just saw.
  - » Roast cereal grains before grinding them into flour. Roasted flour does not thicken so much, so less water is needed to make porridge.
  - » Do not make the food very thin and watery.
- → 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.
  - » Feed all the thick puree first and then if the child is still hungry feed the liquid.
- Add energy or nutrient rich food to the porridge, soup or stew to enrich it. This enriching is particularly important, if the soup is mostly liquid with few beans, vegetable or other foods in it.
- → Replace some (or all) of the cooking water with fresh or soured milk, or cream.
  - » Add a spoon of ghee, oil or butter.
  - » Mix legumes, pulses 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).
  - » Add a spoonful of margarine, ghee or oil.

### Foods to enrich staples

 Oils and fats are concentrated sources of energy. A little oil or fat, such as one teaspoonful, added to the child's bowl of food, gives extra energy in a small volume. The addition of fatty/oily foods also makes thick porridge or other staple softer and easier to eat.

## Ask: How to make energy rich foods for young children?

- → Write participants replies on the black board.
  - » Fats and oils can be mixed during or after cooking. It can be used for frying or as a spread on foods such as bread.
  - » Sugar, jaggery and honey are also energy rich, and can be added to foods in small quantities to increase the energy concentration. However, these foods do not contain any other nutrients.
  - » Caregivers need to watch that sugary foods do not replace other foods in the diet. For example, for a young child sweets, sweet biscuits and sugary drinks should not be used to replace a meal.

#### Continue with these points:

# Ask: If they are not already preparing thick food that is energy rich for the young child, what could you do to encourage families to enrich porridge or soup?

Wait for a few replies and then continue.

- » If families are worried about giving thick foods to young children, find out what the family thinks. Reassure them that the child can eat thick foods without problems. Talking with the family helps give them confidence to try new ways of feeding
- » A demonstration to prepare food, which caregivers can see, that their children can swallow thick foods, is a way of reassuring families.

#### ☐ Food from animals:

• Foods from animals are rich sources of many nutrients. Their flesh (meat) and organs/offal such as liver, heart and blood, eggs as well as milk, yoghurt, cheese are good sources of protein.

## Ask: What foods from animals are eaten in your area?

List the replies on the black board.

### Ask: Which of these foods are commonly given to children?

- Put a mark next to the foods commonly given. Refer to this list as you mention the foods below.
- The flesh and organs of animals, birds and fish (included shell fish and tinned fish), as well as foods prepared with blood, are the best sources of iron and zinc.
- Animals' foods should be eaten daily or as often as possible.

Some families do not give meat to their young children because they think it is too hard for the children to eat, it or they may be afraid that there will be bones in the fish and the child would choke. Explain to them ways of making these foods easier for the young children to eat. Mashing, mincing, pounding of meat/fish can be done before giving.

### Ask: What are some ways of making these foods easier to eat for the young child?

Wait for a few responses and then continue.

- Some ways of making these foods easier to eat for young children are to:
  - » Cook chicken liver or other meat with rice or other staple, vegetables, and then mash it together.
  - » Scrape meat with a knife to make soft small pieces.
  - » Pound dried fish so that bones are crushed to powder and then sieve before mixing with other foods. Pounded dried fish that includes the bones of the fish is also a good source of calcium.
  - » Animal foods may be expensive. However, to add very small amounts of an animal food to the meal adds nutrients. Organ meats such as liver or heart are often less expensive and have more iron than other meats.
  - » When families have animals foods available, encourage them to give some of the food to the young child.
  - » Foods from animals such as milk and eggs are good for children because they are rich in protein and other nutrients. However, milk is not a good source of iron.

## Ask: What milk products are given to children in the area?

→ List the replies on the board/flipchart.

Trainers' Guide

 Milk fat (cream) contains Vitamin A. Therefore, foods made from whole milk are good sources of Vitamin A.

- Foods made from milk (whole milk or skimmed or powdered) and any food containing bones, such as pounded dried fish, are good sources of calcium to help bones to grow strong.
- Egg yolk is another source of nutrients and rich in Vitamin A.
- It can be difficult for children to meet their iron needs without a variety of animal foods in their diet. Fortified or enriched foods such as fortified flours, paste, cereals, or instant weaning foods, help to meet these nutrient needs.

Some children may need supplements if they do not eat enough iron containing foods or if they have particularly high needs for iron.

\_\_\_\_\_

Trainer will then sum-up the discussion on foods from animals by stating this message:



Message - 5

Legumes - peas, beans, lentils and nuts are also good source of nutrients.

## Foods which fill up Iron gaps:

- Whole pulses as well as, dark-green leafy vegetables are sources of iron, dried raisins and apricots and prune juice are also good 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.
- Jaggery is also a good source of iron.

#### 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).

## Iron absorption is increased by

» Cooking in iron pots, particularly if the food is acidic.

## Iron absorption is decreased by

- » Drinking teas (including herb or bush teas) and coffee.
- » Foods high in fiber such as bran.

Iron absorption is increased by eating iron rich foods at the same meal with foods rich in Vitamin C such as tomato, broccoli, guava, mango, pineapple, papaya, orange and other citrus fruits.

Trainer will then sum-up the discussion by stating this message:



Message - 6

Vitamin C rich foods help the body in absorbing iron.

## Foods which fill up Vitamin A gap:

Now we know how 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:

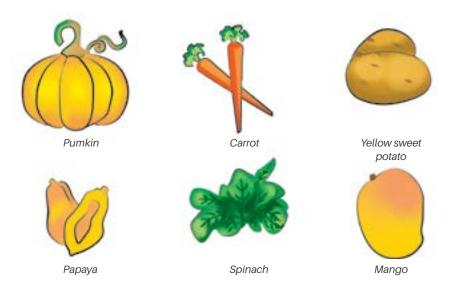
- » Healthy eyes;
- » Healthy skin; and
- » Body to fight infections.
- ☐ Check for any questions or points that need to be made clearer. Then continue.
- Good foods to fill this gap are dark green leafy vegetables, and orange and yellow coloured vegetables and fruits.

Other sources of Vitamin A that we mentioned already were:

- » Organ foods/offal from animals;
- » Milk and foods made from whole milk fat such as butter, cheese and yoghurt;
- » Eggs
- » as well as margarine, dried milk powder and other foods fortified with Vitamin A.

## Wait for a few replies and then continue.

- Vitamin A can be stored in a child's body for a few months. Encourage families to feed foods rich in Vitamin A as often as possible when these foods are available, ideally every day. A variety of vegetables and fruits, in the child's diet help to meet many nutrient needs.
- Trainer will list following items which are rich in Vitamin A:



Ask: if a caregiver said to you. "Why are dark green leafy vegetables and orange and yellow fruits so important?" What would you tell them?

Let participants reply. Praise them for good answers and reinforce the key message.

Trainer will then sum-up the discussion on Vitamin A gap by stating this message:



### Message - 7

Dark green leafy vegetables, and yellow and orange coloured fruits and vegetables help the child to have healthy eyes and fewer infections.

Ask participants if they have any questions or if there are points you can make clearer.

## Fluid needs of the young child

- Make these points:
- The baby who is exclusively breastfeeding receives all the liquid he/she needs in the breastmilk. When other foods are added to the diet, the baby may need extra fluids.
- How much extra fluid should be given depends on: what food is eaten, how thick those foods are, and how much breastmilk is taken.
- A good guide is the baby's urine output. If the baby has frequent, pale coloured urine, the baby is probably receiving enough fluid. If the urine is scant or dark, more fluid is needed.
- Extra fluid is needed if the child has a fever or diarrhoea.

# Ask: What types of drinks are given to young children between 6 and 24 months of age?

Wait for a few responses and then continue.

- Water is good for satisfying the child's thirst. A variety of pure fruit juices can also be used.
   Fruit juice needs to be diluted with water for young children. Too much fruit juice may cause diarrhoea and may reduce the child's appetite for foods.
- Drinks that contain a lot of sugar may actually make the child more thirsty as their body has to
  deal with the extra sugar. If packaged juice drinks are available in your area, find out which ones
  are pure juices and which ones have added sugar. Fizzy drink (sodas) is not suitable for young
  children.
- Tea and coffee reduce the iron that is absorbed from foods. If they are given, they should not be given at the same time as food or within 2 hours before or after foods.
- Drinks for young children must be clean and safe. Water should be boiled and kept in a covered container. Ideally, the container should have a tap or a pour spout.
- Cups, hands and diapers should not be put into the clean water. If the water is not used within 24 hours, it should be re-boiled for young children. Wash the outside of the fruit before making juice.
- Babies and young children may show they are thirsty by general signs such as irritability and crying. These general signs may be difficult for the family to interpret. Sometimes a child is thirsty during a meal, a small drink will satisfy the thirst, and they may then eat more of their meal.
- Drinks should not replace foods or breastfeeding. If a drink is given with a meal, give only small
  amounts and leave most until the end of the meal. Drinks can fill up the child's stomach leaving
  no room for foods.

# V. Discuss the frequency of feeding complementary foods

(10 minutes)

## Frequency and variety of foods

- ☐ Make these points:
  - » (Name) is already eating a full bowl of food at each meal. There is no space in his stomach for more food at mealtimes.

## Ask: What can you suggest to (name's) family to help fill the energy gap?

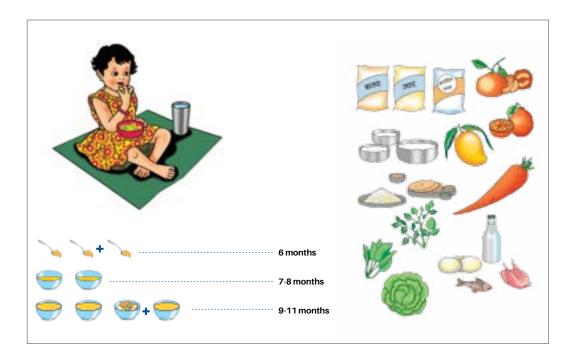
Wait for a few replies and then continue.

- (Name's) family can give him some food more often. They do not need to cook more meals.
   They can give some extra foods between meals that are easy to prepare. These extra foods are in addition to the meals they should not replace them.
- These extra foods are often called snacks. However, they should not be confused with foods such as sweets, crisps or other processed foods.
- 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 or snacks are eaten.

## Ask: What kind of snacks would be easy to feed this child?

- → Write replies on the black board. Refer to these suggestions as you make the following points.
  - » Good snacks provide both energy and nutrients. Yogurt and other milk products: bread or biscuits spread with butter, nut paste or honey; and fruit; bean cakes: cooked potatoes. are all good snacks.
  - » Poor value snacks are ones that are high in sugar but low in nutrients. Examples of these are fizzy drinks (sodas), sweet fruit drinks, sweets/candy, ice lollies, and sweet biscuits.
  - » 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 into their situation.

## Show TA 13.3: Complementary feeding-how much and how many times



- » A baby between the age of 6-8 months requires three meals a day.
- » Baby between 9-11 months needs four feeds a day.
- » Child between 12-23 months should be fed 5 times a day; three meals and two times snacks.

## Trainer will then sum-up the discussion on frequency of food by stating this message:



A growing child needs frequent meals and snacks: give a variety of foods.

# VI. Outline the quantity of complementary food to be offered

(10 minutes)

- ☐ Make these points:
- When a child starts to eat complementary food, he needs time to get accustomed to the new taste and texture of the food. A child needs to learn the skill of eating. Encourage families to start with 2-3 small spoons of the food twice a day.
- At 8 months of age, the baby's stomach could only hold about a cupful of food at a time and a
  gradual increase in the amount and variety of foods is required 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
  two snacks between meals.
- As the child develops and learns the skills of eating, s/he progresses from very soft, mashed food, to foods with some lumps that need chewing, and to family foods, Some family foods may need to be chopped for longer if the child finds them difficult to eat.

Ask participants to open their manual where the box showing the age and texture of the food offered and the amount needed.

A participant reads out the first age group and another participant reads out the next age group until all age groups are read out.

AMOUNTS OF FOODS TO OFFER					
Age	Texture	Frequency	Amount at each meal		
6 months	Soft porridge, well mashed vegetables, meat fruit	2 times per day plus frequent breastfeeds	2-3 table spoonfuls		
7-8 months	Mashed food	3 times per day plus frequent breastfeeds	Increasing gradually to 2/3 of a 250 ml <i>katori/</i> bowl		
9-11 months	Finely chopped or mashed food, and food that baby can pick up	3 meals plus 1 snack between meals plus breastfeeds	3/4 of a 250 ml <i>katori/</i> bowl		
12-24 months	Family foods, chopped or mashed if necessary	3 meals plus 2 snacks between meals plus breastfeeds	A full 250 ml <i>katori/</i> bowl or more		

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

Discuss if families give smaller amounts or larger amounts.

Ask: What are the barriers to give the recommended amounts?

Briefly discuss possible barriers.

- ☐ Continue with these points:
- As you can see in this box, as the child gets older, the amount of food offered increases. Give as much as the child will eat, with active encouragement, offer a extra helping.
- ☐ Trainer will then sum-up the discussion on quantity of complementary foods by stating this message:



Message - 9

A growing child needs increasing amounts of food.

## VII. Summarize the session

(5 minutes)

Make these points:

In this session, we talked about how much to feed a young child and how often to feed and recommendation or type of food to be taken.

Ask: If a parent asks you. "How often should I give some food to my fifteen-months old child?" What would you say?

Let participants reply.

Ask: If a parent asks you, "What amount of food should I give to my nine-month old child at each meal?" What would you say?

Let participants reply.

Praise them for good answers and reinforce the key message:

Point to the black board and read out the key messages:

## **Key messages**

(While talking to mothers or families, give these key messages)

- 1. Breastfeeding for at least two years of age helps a child to grow strong and healthy.
- 2. Children who start complementary feeding after six months grow well.
- 3. Family foods with a thick, soft consistency nourish and fill the child's stomach foods that stay easily on the spoon.
- 4. Animal foods are special food for children.
- 5. Legumes peas, beans, lentils and nuts are good source of nutrients.
- 6. Vitamin C rich foods help body to absorb iron.
- 7. Dark green leafy vegetables and orange and yellow coloured fruits and vegetables help the child to have healthy eyes and fewer infections.
- 8. A growing child needs frequent meals and snacks: give a variety of foods.
- 9. A growing child needs increasing amount of food.

## VIII. Discussion

(5 minutes)

Ask participants if they have any questions or if there are points you can make clearer.



SESSION

14

## **Feeding Techniques and Strategies**

## **Objectives**

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

- Describe feeding practices and their effect on the child's intake.
- Discuss with families specific techniques to encourage young children to eat.
- Describe feeding a young child during sickness and recovery.

Sessi	ion outline	(60 minutes)
l.	Introduce the topic	(5 minutes)
II.	Describe feeding caregiver practices	(10 minutes)
III.	Describe appropriate feeding during illness	(15 minutes)
IV.	Describe appropriate feeding during recovery	(15 minutes)
V.	Summarize	(5 minutes)
VI.	Discussion	(10 minutes)

## **Preparation**

- 1. Read the introduction. How to conduct the training course?
- 2. Prepare chart Feeding Caregiver Practices (1-4).
- 3. Arrange cup, spoon and locally available complementary foods, towel and sheets for demonstration.
- 4. Prepare two participants for demonstration.
- 5. Arrange white paper for each participant.
- 6. Arrange black board and writing pens.
- 7. Write key messages No. 10 and 11 on the flip chart.

## I. Introduce the topic

(5 minutes)

- Distribute white paper to each participant and ask them to write down the most frequent recommendations or information you give to caregivers about feeding young children?

  (After participants have written it down on the white paper, collect the papers make two columns on the black board. Do not write the headings until they have written their recommendations).
- → Write WHAT TO FEED at the top of one column and HOW TO FEED at the top of the other.
- Now read out participants recommendations, one by one. Put a tick mark (✓) in the column that relates to the recommendation. For example, the recommendation "Give fruits" or "Give animal foods" or "Feed frequently", goes in the WHAT column, the recommendation "Pay attention to the child while feeding" or "Wash your hands before feeding the child" goes in the HOW column.

## Ask: What do you see? Which type of information do you give most often?

Which column has the most tick marks  $(\checkmark)$  in it? It is probably the WHAT column.

- ☐ Make these points:
- Frontline workers like you frequently give information about feeding of young child to caregivers.
- Often frontline 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".
- Let us create a scene in our heads of a young child's first eating. What comes to mind? When a child is learning to eat, he often eats slowly and is messy. She/he may be easily distracted. He may make faces, spill 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 foods, tastes and textures. A child needs to learn to chew, move food around in the mouth and to swallow food. The child needs to learn how to get food effectively into the mouth, how to use a spoon and how to drink from a cup.
- Therefore, it is very important also to talk to caregivers and offer suggestions about how to encourage the child to learn to eat the foods offered. This can help families to have happier meal times.

# II. Describe feeding caregiver practices and their effects on intake

(25 minutes)

- Make these points:
- A child needs food, and care to grow and develop. Even when food and health resources are limited, good care giving can make best use of these limited resources.
- The behaviour and practices of a caregiver and family that provide the food, healthcare, stimulation and emotional support is necessary for the child's healthy growth and development.
- An important time to use good caring practices is at meal times while helping young children to eat

Trainers' Guide

#### Put the chart containing feeding care practices on the black board:

Uncover the FIRST Feeding Caregiver Practice on the flip chart list.

### Make these points:

The FIRST Feeding Caregiver Practice to look at is:

## Remember



#### HELP CHILDREN TO LEARN TO EAT

- Children need to learn to eat. Eating solid foods is a new skill and, at first the child will eat slowly and may make a mess. It takes lots of patience to teach children to eat.
- The child needs help and time to develop this new skill, to learn how to eat, to try new food, tastes and textures.
- At first, the young child may push food out of their mouth. This is because they do not have the skill of moving it to the back of their mouth to swallow it? Caregivers may think this pushing out of food means the child does not want to eat. Talk with them about children needing time to learn to eat, just as they need time to learn to walk and to learn other skills.

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

Wait for new responses, and then continue.

- A child's ability to pick up a piece of solid food, hold a spoon, or handle a cup increases with age and practice. Children under two years of age need assistance with feeding.
- However, this assistance needs to be limited so that the child has opportunities to feed himself. A child may eat more if he is allowed to pick up foods with his newly learned technique of using finger - from about 9-10 months of age.
- The 15 months old can eat a large amount of food by self feeding. At this age, they are learning to use utensils and will still need assistance.
- Mashed foods and foods of a thick consistency are easier and more nutritious for young children to eat than very thin foods.
- Uncover the SECOND Feeding Caregiver Practice on the flip chart list, and make these points:
- The next feeding care practices is:

## Remember



### FEED IN RESPONSE TO CHILD'S CUES OR SIGNALS

- Generally the feeding style is one of three different ways:
  - » These control feeding by the caregiver decides when and how much the child should eat. This may include force-feeding. The child may not learn to regulate their intake, which may lead to obesity later.
  - » Leaving the child to feed themselves where the caregiver believes that the child will eat if hungry. The caregiver may also believe, if the child stops feeding himself, he has had enough to eat. If the child has a low appetite or poor motor skills or is too young, this can result in under weight and malnutrition.
  - » Feed in response to the child's cues or signals using encouragement and praise.
- The easiest way to see the difference in these three feeding styles is to demonstrate them.
- Introduce the three DEMONSTRATIONS A, B, C on different feeding styles.

- Now we see demonstrations of these ways to feed a young child. After the demonstration, we will discuss what it shows.
- Ask the two participants whom you prepared to give DEMONSTRATION A. One participant plays the part of a child aged about 18 months and another participant is the 'caregiver'.

## **DEMONSTRATION 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 the food into the child's mouth.

If the child struggles or turns away, he is brought back to the feeding position.

Child may be slapped or forced if he does not eat.

The caregiver decides when the child has eaten enough and takes the bowl away.

## Ask: How do you think this child feels about eating?

- » Wait for a few replies and also ask the 'child' how he felt.
- » The 'child' may feel eating is very frightening, uncomfortable, feel scared...
- Now we see another way of feeding a young child.

#### **DEMONSTRATION B: Leave to themselves**

The 'young child' is sitting on a mat on the floor.

Caregiver puts a bowl of food besides the child with a spoon in it.

Caregiver turns away and continues with other activities.

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/she gives up and moves away.

Caregiver says, "Oh, you aren't hungry" and takes the bowl away.

#### Ask: How do you think this child feels about eating?

- » Wait for a few replies and also ask the 'child' how she felt.
- » The 'child' may feel eating is very difficult, may be hungry, sad...
- → Now we see a third way of feeding a young child.

Trainers' Guide

## **DEMONSTRATION C: Responsive feeding**

Caregiver washes the child's hands with her/his own hands and then sits facing with child 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/girl".

"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?"

### Ask: How did the child feel this time about feeding?

Wait for a few replies. Ask the 'child' too.

The child may feel happy about eating, like the contact and the praise, enjoy feeding him.

- ☐ Thank the participants for their help.
- In this last demonstration, the caregiver was feeding the child in response to the child's cues. The child's cue or signal that they are hungry may include restlessness, reaching for food, or crying. Cues or signals that they do not want to eat more may include turning away, spiting 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.

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

Wait for few responses.

- Uncover the THIRD Feeding Caregiver Practice on the flip chart list, and make these points:
- The THIRD Feeding Caregiver Practice to encourage is:

### Remember



#### HAVE A POSITIVE RELATIONSHIP BETWEEN CHILD AND CAREGIVER

- When you talk with a caregiver, ask who feeds the child. In some families, the child may be fed (or assisted to feed themselves) by someone with little positive relationship with the child.
- Children are more likely to eat well if they like the person feeding them. Older siblings may
  help with feeding but may still need adult supervision to ensure the young child is actively
  encouraged to eat and that their food is not taken by the sibling.

- □ Uncover the FOURTH Feeding Caregiver Practice on the flip chart list, and make these points:
- The fourth feeding care practice to encourage is:

Remember 💆

#### PROVIDE A SUITABLE FEEDING SITUATION

## Ask: What you understand by a suitable feeding situation?

- → Write participants' responses on the black board and then continue. Refer to the responses as you make these points:
- The overall feeding situation may also affect food intake. This includes
  - » Sit with the family or other children at mealtimes so the child sees them eating.
  - » To sit with others at the time of eating can provide an opportunity to offer extra food to the young child and an opportunity to learn new words.
  - » Give positive attention for eating throughout and not just when eating is going on poorly,
  - » Use a separate bowl for the child so that the caregiver can see the amount eaten,
  - » Use consistent routines of mealtimes, and focus on feeding,
  - » Feed when the child is alert and happy. If the child is sleepy or over-hungry and upset, he may not eat well.

### **Encourage four feeding care practices:**

- Help children learn to eat
- Feed in response to child's cues or signals
- Child and caregiver have a positive relationship
- Provide a suitable feeding situation

## **Responsive feeding**





## **Trainer explains REPONSIVE FEEDING**

- Respond positively to the child with smiles, eye contact and encouraging words.
- Feed the child slowly and patiently with good humor.
- Wait till the child stops eating and then offer more.
- Give finger foods that the child can feed himself/herself.
- Stay with the child throughout the meal and be attentive.
- Make these points:
- Young children need to be encouraged and assisted to eat this is called Active Feeding.
- The caregiver needs to concentrate on the child during the feeding.
- Showing mothers how to feed their children may be as important as explaining what to feed.

## Ask: Why do difficulties occur with feeding young children?

- Write replies on the black board and include the following that were not mentioned by participants.
- Difficulties may occur with feeding, and thus growth, if:
  - » meals are offered when a child is too tired to eat
  - » caregiver force foods into a child's mouth
  - » foods are difficult to eat
  - » a child's appetite for nutritious foods is spoiled by sugary drinks
  - » a child is not yet able to show that he is hungry
  - » a child is left to feed himself and eat alone
  - » a child has to compete with other children for the same dish of food
  - » a child is punished for not eating

## Ask: What is happening in a group of children eating together?

A young child has to compete with older children for food from the same dish.

## Ask: How it could affect the amount of food that the youngest child eats?

A young child may not get enough food, or may get only the staple, and not other nutrient rich foods.

Young children eat slowly. They should have their own dish of food, so that they get their full share and do not need to compete with others. If a child has his own dish, the caregiver can see how much the child is eating and she can make sure that the child eats enough of the nutrient rich foods.

- Extra care is needed if an older sibling feeds a young child. When you talk with a mother, ask, "Who feeds the child" and "How do they do it?" to find out if the child is actively encouraged to eat.
- Complementary feeding session is a social activity besides providing the required food. As a child starts to eat family foods, he should eat with the family or other children.

- Factors that reduce a child's appetite may include
  - » lack of variety in the food
  - » lack of nutrients needed for appetite (e.g. zinc and possibly iron)
  - » illness, sore mouth
  - » anxiety and stress in the home
- Children without much appetite (anorexic children) should be offered nutritious foods that they like and should be encouraged to eat frequently. As a child recovers from illness, he needs extra food to make up for the meals that he missed while ill. Micronutrients may help in improving the child's appetite.

### Ask: How can families encourage young children to eat?

Wait for a few replies, then continue. Ask participants to keep their manuals closed while they answer this question.

## HOW FAMILIES CAN ENCOURAGE YOUNG CHILDREN TO EAT

They can:

- » offer small amounts at times when the child is alert and happy.
- » offer more food if the child shows interest.
- » give foods of a suitable consistency, not too thick or dry.
- » give physical assistance a spoon of a suitable size, food within reach of the child, young child sitting on caregiver's lap facing his child so that the caregiver can see what the child wants and respond to it while eating.
- » offer verbal encouragement, e.g. "Open your mouth for lovely, tasty beans", smiles and other positive facial gestures.
- → If a child receives more attention for refusing food than for eating it, he may eat less.



Message - 10

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

## IV. Describe appropriate feeding during, illness

(15 minutes)

- ☐ Make these points:
- Let us look at feeding during illness.
- Sick children often need extra water and food during illness for example if they have fever or diarrhoea. A sick child may prefer breastfeeding than eating other foods. Do not withhold food from a sick child.

WORKSHEET 14.1: SUGGESTIONS FOR FEEDING DURING ILLNESS		
Illness / condition	Suggestions - possible replies	
Child's mouth or throat is sore	Give soft or smooth food.  Avoid citrus fruits, very sweet or spicy food. Drink through a straw.	
Child has stuffy nose	Clear the nose before feeding, feed slowly, give time to breathe.	
Child has fever	Give extra fluids/breastfeeds and frequent small portions of food (consult doctor).	
Child has chest infection or cough	Let child sit upright and slowly give small amounts of food and fluids (consult doctor).	
Child has diarrhoea	Continue to give normal food.  Continue breastfeeding. If child is less than six months old give exclusive breastfeeding.  Give ORS, extra fluids.  Give bananas, mashed fruits, soft rice and porridge.  Give small meals more often.  Feed child with cup and spoon. Never use a bottlea.	
Child is vomiting	Give frequent small amounts of fluids/breastfeeds and small amounts of foods as frequently as possible (consult doctor).	
Child is sleepy	Watch for times when child is alert and then feed.	

Trainer will emphasize following points while feeding the child:

## Feeding a sick child

- Encourage the child to drink and 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.

## Make the points that follow:

- When you talk with caregivers about feeding during illness, include this information as relevant to the situation:
  - » If the child is ill, he/she may need extra encouragement to drink and to eat
  - » Offer drinks and foods with lots of patience and encouragement

- » Have a person that the child likes for help with feeding.
- » Make the child comfortable before feeding.
- » Wash, rinse out his mouth, and position comfortably.
- » Offer smaller amounts of food than usual but give food more frequently during the day. Suggest that the caregiver looks for signs that the child might accept some food whenever possible, for example if he has just woken up or if the child's fever is down.
- » Give foods that the child likes to eat. Give as much variety as possible.
- » Feed the child nutrient-rich complementary food if he is able to eat them. Offer the child food of a thick consistency as well as the thinner food that the child may prefer when ill. Semisolid foods or smoother foods may help if the child has a sore throat, sore mouth or vomits with coughing.
- » Encourage the child to take extra fluids.
- » Increase the amount of breastfeeding. Breastfeeding will provide fluid, nutrients, and protective factors to combat infection besides giving comfort. Small frequent breastfeeds may be easier for the child to manage.
- Make these points:
- Sometimes a child, who is difficult to feed, may be suffering from a physical illness.

## Ask: What signs of illness should caregivers watch for and seek early treatment?

- → Write participants responses on the black board.
- Signs to watch for and seek early treatment include:
  - » Sick, not feeding and refusing drinks;
  - » Repeated vomiting;
  - » Very frequent loose watery stools that do not respond to home treatment;
  - » Marked thirst, dry lips, no tears, signs of dehydration;
  - » Blood in the stools;
  - » Fast or difficult breathing;
  - » Very sleepy, difficult to wake;
  - » Not getting better from illness by home care;
  - » Weight loss that is not corrected by attention to feeding practices.
- If it is not part of your job to treat an ill child, you need to know where to refer a child for treatment.
- Trainer explains why breastfeeding should be continued for babies who are ill:
- If a baby stops breastfeeding when he is ill:

He gets less nourishment.

He loses more weight.

He takes longer to recover.

He lacks the comfort of suckling.

His mother's breastmilk is likely to decrease.

He may refuse to start breastfeeding again when he is well.

If a baby continues to breastfeed when he is ill:

He gets the best nourishment.

He loses less weight.

He recovers more quickly (especially from diarrhoea).

He is comforted by suckling.

Breastmilk production continues.

The baby is more likely to continue breastfeeding when he is well.

Trainer explains how to help continued breastfeeding to babies who are ill:

### If a baby is in hospital:

Admit his mother too so that she can stay with him and breastfeed him.

### If a baby can suckle well:

Encourage his mother to breastfeed more often. She can increase the number of feeds up to 12 times a day or more for her child when he is sick. Sometimes a baby loses his appetite for other foods, but wants to breastfeed. This is quite common with children who have diarrhoea. Sometimes a baby likes to breastfeed more when he is ill than before, and this can increase the supply of breastmilk.

### If a baby suckles, but less than before at each feed:

Suggest that his mother gives more frequent feeds, even if they are shorter.

#### If a baby is not able to suckle, or refuses, or is not suckling enough:

Help his mother to express her milk, and give it by cup or spoon. Let the baby continue to suckle when he is willing. Even babies on intravenous fluids may be able to suckle, or to have expressed breastmilk.

#### If a baby is unable to take expressed milk from a cup:

It may be necessary to give the EBM through a nasogastric tube for a few feeds.

#### If a baby cannot take oral feeds:

Encourage his mother to express her milk to keep up the supply for her baby when he can take oral feeds again. She should express as often as her baby would feed, including at night. She may be able to store her milk, or donate it to another baby.

As soon as her baby recovers, she can start to breastfeed again. If he refuses at first, help him to start again.

Encourage his mother to breastfeed often to build up her breastmilk supply.

## IV. Describe appropriate feeding during recovery (15 minutes)

- Make these points:
- A child's appetite may be poor during illness. Even with encouragement to eat, the child may not eat well. The child's appetite usually increases after the illness so it 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.
- The child recovering from an illness needs good mixed foods to replace the nutrients such as iron and Vitamin A that they lost from their body stores.

**→** 

Trainer will emphasize following points while feeding the child during recovery:

## Feeding during recovery

- Feed extra meals
- Give extra amounts
- Use extra rich foods
- Feed with extra patience
- Give extra breastfeeds as often as child wants

# Ask: What are some ways by which families may give a child extra food during recovery?

Wait for a few replies and then continue.

### Make the points that follow

- Talk with the family about ways that these extra needs can fit in best with their household. You
  can suggest.
  - » Feed more frequently, give an extra meal or nutritious food between meals.
  - » Give an extra amount at each meal if the child's appetite is good,
  - » Use foods that are extra rich in energy and/or nutrients such as animal products, fruits and margarine or oil.
  - » Encourage the child to eat with extra patience.
  - » Continue to breastfeed and give extra breastfeeds if the child is not eating.



## Message - 11

Encourage the child to drink and eat during illness and provide extra food after illness. This helps to reduce the risk of growth faltering and malnutrition.

#### **Key messages**

(While talking to mothers or families give these key messages)

- 1. Breastfeeding for at least two years of age helps a child to grow strong and healthy.
- 2. Children who start complementary feeding after six months grow well.
- 3. Family foods with a thick, soft consistency nourish and fill the child stomach: food that stay easily on the spoon.
- 4. Animal food are special foods for children.
- 5. Legumes peas, beans, lentils and nuts are good source of nutrients.
- 6. Vitamin C rich food helps body to absorb iron.
- 7. Dark green leafy vegetables and orange/yellow coloured fruits and vegetables help the child to have healthy eyes and fewer infections.
- 8. A growing child needs frequent meals and snacks: give a variety of foods.
- 9. A growing child needs increasing amount of food.
- 10. A young child needs to learn how 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. This helps to reduce the risk of growth faltering and malnutrition.

Ask participants: if they have any questions or if there are points that you can make clearer.

V. Summarize (5 minutes)

VI. Discussion (10 minutes)

SESSION

15

# Institutionalizing Skilled Infant and Young Child Feeding Counselling

## **Objectives**

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

- Help mothers to continue to breastfeed up to 2 years or beyond.
- Support optimal feeding practices whenever they see mothers and babies.

## Session outline (35 minutes)

I. Introduce the topic (5 minutes)

II. Demonstrate how to sustain optimal infant and young child feeding (15 minutes)

III. How to set up IYCF counselling centre (10 minutes)

IV. Summarize (5 minutes)

## **Preparation**

- 1. Read the introduction: How to conduct the training course.
- 2. Arrange doll, clothes, black board and baby weighing machine for demonstration.
- 3. Prepare two participants for demonstration.

## I. Introduce the topic

(5 minutes)

- ☐ Make these points:
- In the postnatal period, healthcare practices, family support, and breastfeeding techniques are the main factors which determine whether or not breastfeeding and complementary feeding is successfully initiated and established.
- After breastfeeding is established, technique is less likely to cause problems. Social factors become more important.
- Introduction of complementary feeding after 6 months of age also does not get emphasis in child health programs. Caregiver's knowledge, attitude and behaviour in feeding young children are major determinants for infant and young child feeding status.
- Trainer writes the list on the black board and put brackets around (Breastfeeding technique), and (social factors).

Healthcare practices

Family support

(Breastfeeding technique)

Caregiver's knowledge and behaviour

Availability of food

(Social factors)

- Healthcare practices continue to have an important influence on breastfeeding throughout the first two years of life and on feeding of children throughout childhood. It is important for all health facilities to support optimal infant and young child feeding.
- Underline healthcare practices on the board.
- In some communities, many mothers stop breastfeeding after a few weeks.
- **Ask:** Why do you think that breastfeeding is sustained much longer in some communities than in others?

(Let participants make a few suggestions, then continue.)

Because of the attitude of society towards breastfeeding and towards mothers.

- Breastfeeding is likely to continue longer if:
  - » Most people think that it is natural, healthy and important
  - » People think that it is normal and good to breastfeed for two years or more
  - » It is acceptable to breastfeed in public
  - » Children who will become parents see babies breastfeeding
  - » Women who work outside the home receive support to breastfeed

**Ask:** Why children are not fed appropriately after 6 months of age? (Let participants make a few suggestions, then continue).

Many mothers do not know that the babies are capable of taking family foods at 6 months of age. They also do not have knowledge and skills to feed young children.

Complementary feeding will be optimal, if:

- » Mothers and frontline workers know the different types of food baby needs
- » The frontline workers and caregivers know that their is a gap in energy and other nutrients need after 6 months of age even if the babies are exclusively breastfed
- » The foods are given in recommended frequency and amounts

- » Feeding is responsive.
- » Babies are fed during illness and recovery.
- Changes in people's attitude may be made with school and public education, and with social mobilization.
- However, frontline workers can do a lot to support and encourage women who want to breastfeed their babies. They can help to protect remaining good practices and to encourage optimal complementary feeding. If they do not actively support breastfeeding, they may hinder it by mistake.
- Every contact that a frontline worker has with a mother may be an opportunity to encourage and sustain optimal feeding.
- ☐ Explain what frontline workers can do to help in sustaining breastfeeding:
- When a mother brings her baby to a health facility for a routine procedure, for example, weighing, or immunization, and if everything is satisfactory, the frontline worker often says nothing. She only tells a mother if something is wrong.
- Mothers are sometimes confused or even upset if a frontline worker says nothing, or sounds critical. They may not feel encouraged to come again.
- Frontline workers are often short of time, but they can use the time that they have to say something encouraging and supportive.
- Every time you see a mother, try to build her confidence.
   Praise her for what she and her baby are doing right.
   Give relevant information, and suggest something appropriate.
- → Write on the board:

Praise Inform Suggest

## II. Demonstrate how to sustain optimal infant and young child feeding (15 minutes)

- □ Demonstrate the skill:
- ② Ask a participant to play the part of mother, while you read out her story and play the part of the frontline worker.

Ask her to stand near you, while you weigh the baby, fill in his growth chart and give it to her.

#### **Demonstration A: Saying too little**

#### Read out the story:

Karishma has brought her baby Anand for weighing at 6 months. He is exclusively breastfed, and perfectly well. He has gained 800 g in the last month, and now weighs 7.5 kg.

#### Play the frontline worker:

- FW: (Pretend to weigh Karishma's baby and mark his growth chart. Do not say anything while you do this. When you have finished, hand over Karishma the growth chart and say what follows.)
- FW: "All right Karishma, thank you. Make sure that you keep Anand 's growth chart carefully and come back next month."

**Ask:** Is what the frontline worker said to Karishma helpful?

Will Karishma think that it is worth coming back, especially if Anand is well?

(Let participants give their opinions briefly.)

What the frontline worker said did not help Karishma or encourage her to come back.

Explain that you will now see Karishma again, and this time you will say three things to her. After weighing Anand and filling in his growth chart, you will praise Karishma, you will give her some relevant information, and you will suggest something.

#### **Demonstration B: Sustaining breastfeeding**

FW: (As you pretend to weigh the baby.) "How are you feeding Anand?"

Karishma: "Just breastfeeding, whenever he wants to."

FW: "Oh, that's good."

(As you fill in his growth chart.)

"Look at Anand's growth line now! What do you think of that?"

Karishma: "It is going up, isn't it? Does that mean that he is gaining weight?"

FW: "Yes, Anand gained quite a lot of weight last month - and that is just because of your

breastmilk" (praise).

"You know, breastfeeding helps to keep a child healthy up to the age of 2 years or

more" (information).

"Now your baby is 6 months old, he may need few spoons of porridge also"

(information)

"Have you thought about starting such a food yet, as well as continuing to

breastfeed?" (suggestion).

Ask: Is it helpful to say these things to Karishma?

Did weighing Anand and talking to Karishma take much longer than weighing and saying nothing?

(Let participants give their opinions. Then give yours.)

Saying these things to Karishma is helpful and supports breastfeeding and complementary feeding. It does not take much longer than weighing and saying nothing.

## III. How to setup IYCF counselling centre

(10 minutes)

IYCF counselling and support centers run by trained counselors are meant for promotion, protection and support of breastfeeding; to prevent problems and difficulties during breastfeeding and to solve them, if they do arise; and to help mothers for timely introduction of sufficient amount of family foods in appropriate consistency and given in responsive manner.

The center will also assist HIV +ve mother in choosing the most appropriate feeding option for her infant.

## **Management of feeding difficulties**

 Breast conditions - flat nipples, inverted nipples, sore nipples, cracked nipples, engorgement of breast, mastitis, etc.

Trainers' Guide

- Not enough milk.
- Other conditions Mothers with illness, mother on medication.
- Excessive crying and refusal to breastfeed.
- Complementary feeding what to feed and how to feed.
- Counselling on infant feeding options for HIV positive mothers.
- Working mothers.
- Other feeding problems in children.

### **Physical infrastructure**

- A separate medium sized ordinary room with privacy for one-to-one counselling.
- Two to three chairs (one chair for the service provider, one for the mother and the third chair or bench for the companion of the mother).
- One bed or couch.
- Weighing machine, measuring tape and infantometer.
- Baby doll and breast models for demonstration.
- 20 ml disposable syringe.
- A cup or small bowl with rounded margin, easy to clean, with a lid and a teaspoon.
- Two medium size (250 ml), Katori with lids, spoons.
- Posters for demonstration of position, attachment and expression of milk, how milk is produced, how baby suckles.
- Counselling guide.
- Growth Chart Register.

IV. Summarize (5 minutes)

SESSION

16

# **Nutrition of Lactating Mothers and their Health and Fertility**

### **Objectives**

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

- Advise food to mother who is breastfeeding.
- Help a mother who is ill to continue breastfeeding.
- Inform mothers about how her breastfeeding can help family planning.

### **Session outline**

(20 minutes)

I. Introduce the topic

(10 minutes)

II. Discussion

(10 minutes)

### **Preparation**

- 1. Read the introduction. How to conduct the training course?
- 2. Arrange Teaching Aids 16.1 and 16.2.

## I. Introduce the topic

(10 minutes)

- ☐ Explain what the session will be about:
- When you help a mother to breastfeed, it is important to remember her own health, and to care for her as well as her baby.
- You need to think about the mother's nutrition, because this affects her health, energy and well-being.
- You need to know how to help a mother to breastfeed if she becomes sick. You may be concerned about whether her illness or the drugs that she is taking can affect her baby.
- Breastfeeding and family planning help each other. You need to be able to give mothers the information that they need about breastfeeding and family planning.
- ☐ Remind participants of the factors such as pregnancy, sickness or malnutrition of the mother as important reasons for stopping breastfeeding or for starting complementary feeds early in their situation.

## Mothers' nutritional needs during pregnancy and lactation for breastfeeding

Pregnancy and lactation is a time when a woman needs to pay more attention to her diet. Pregnant mother has not only to nourish herself but also the growing foetus in her womb. In this period, growing foetus is entirely dependent on the mother. On an average a pregnant mother gains 10-12 kg weight which includes weight of the foetus also. This is possible only when pregnant mother provides all the nutrients to the fetus which she gets from her diet. Similiarly lactating mother breastfeeds her baby for his growth and well-being. For this, it is necessary that she should take adequate amount of a nutritious diet and liquids which help her to keep healthy.

During her pregnancy and lactation period, she requires an additional 600 calories and 15 gm protein daily for which she has to eat a variety of foods in order to prevent her own body tissues from burning up. In pregnancy if mothers do not take sufficient diet then it affects baby's growth. Their babies are either low birth weight or at the risk of getting malnourished.

#### Important facts related to food and nutrition during pregnancy and lactation:

#### **Show TA 16.1**



Trainers' Guide

- 1. Period of pregnancy and lactation this is a time when a pregnant woman requires more food than a normal woman because she has not only to nourish herself but also the growing fetus in her womb, and after delivery for her growing infant.
- 2. She should take extra amount of cereals, pulses and vegetables. She should eat more than her normal diet. If she is not able to eat more than normal at lunch, dinner or snack time then she should eat more frequently. She should eat 5-6 times in a day.
- 3. She should take mixed diet, which means she should use mainly cereals for her energy requirements, mix two different cereals or mix cereal with pulses and add vegetables in it. This single recipe will fulfill all nutritional requirements, e.g. "paushtik khichari", in which rice gives calorie, pulses gives protein and fiber and added green leafy vegetables like spinach and other seasonal vegetables which provide minerals and vitamins. Add 1 tsp. of pure ghee or oil to it, which will give extra energy, and taste to it.
- 4. Every day she should eat green leafy vegetables which are very good source of iron. It will protect her as well as baby from anemia. Pregnant woman should take iron and folic acid tablets regularly in her last trimester of pregnancy.
- 5. Meat, fish, eggs, are very good foods. Vegetarians can include legumes, beans, pulses in place of these foods.
- 6. Seasonal fruits should also be included in her diet. Daily 1-2 fruits servings will provide mineral and vitamins and add variety of foods to provide additional energy.
- 7. She should use iodized salt in her diet as pregnant women require sufficient iodine for brain development of the fetus in her womb.
- 8. Heavy work should be avoided throughout pregnancy.

## Trainer will explain with example of extra food providing (600 calories needed) each day by a breastfeeding woman (TA 16.2):

She needs to eat food which provides about 600 extra calories from a variety of foods.

Table: TA 16.2: Balanced Diet for Adult Women

Food Groups	Diet for Adult Women	Diet During Pregnancy	Diet During Lactation
Cereals	270 gms/day	270 gms/day	270 gms +
			30 gms/day
Pulses	60 gms/day	60 gms/day	60 gms +
			60 gms/day
Vegetables	300 gms/day	300 gms +	300 gms +
		50 gms/day (green leafy	50 gms/day (green leafy
		vegetables)	vegetables)
Fruits	100 gms/day	100 gms +	100 gms +
		100 gms/day	100 gms/day
Milk	300 gms/day	300 gms +	300 gms +
		200 gms/day	200 gms/day
Sugar and	20 gms/day	20 gms/day	20 gms/day
Jaggery			
Fats and Oils	20 gms/day	20 gms +	20 gms +
		10 gms/day	10 gms/day

Based on balanced diet for adult women (sedentary). Dietary Guidelines for Indians ICMR (2010)

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.

If you give any food or vitamin supplements during breastfeeding, give them to the mother, and not to the baby and it should be given through out 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-birth-weight.

#### Breastfeeding when a mother is ill:

- Discuss the question for a few minutes before you show the flipchart.
   Is it necessary for a mother to stop breastfeeding when she is ill?
   (Let a few participants give their opinions, or mention experiences. Then continue).
- It often happens that a mother stops breastfeeding when she is ill, for a variety of reasons. She may fear that her baby will catch the illness; someone may have advised her to stop. She may be admitted to hospital, and separated from her baby.

However, it is rarely necessary for a sick mother to stop breastfeeding.

With most common infections, breastfeeding does not increase the chance of the baby becoming ill. Antibodies in breastmilk may be the best protection for the baby. It is no longer considered necessary to separate mothers with TB or leprosy from their infants. If necessary, treat both mother and baby together.

### How the problem may arise

#### 1. A mother believes that she cannot breastfeed if she is ill

When you treat a woman for illness, always ask her: "How old is your youngest child?" "Does he breastfeed at all?"

- Reassure her that she can continue to breastfeed the baby even during her illness.
- If she has an infectious illness, it is much more likely to be transmitted to the baby by droplets,
  or by hands, than by breastfeeding. The baby has already been exposed while she was
  developing the illness. Her breastmilk does contains antibodies, which are the best protection
  for the baby.
- If she is very unwilling to breastfeed, ask her to express her milk. Her breasts will continue to produce milk and she can breastfeed again when she is well.

#### Help ill mothers to continue breastfeeding

#### 2. A mother says that her milk dried up when she was ill

Milk dries up because the baby stops suckling, not because of illness. However, if a women has a fever and loses a lot of fluid from sweating, her milk supply may decrease.

To prevent the milk drying up encourage her to:

- Continue breastfeeding if possible
- Drink plenty of fluids
- Express her milk
- Let the baby breastfeed again as soon as possible

Trainers' Guide

#### 3. The problem affects the breast

If a woman has mastitis or a breast abscess, she may decide to stop feeding the baby – from that breast or from both breasts. It is not necessary to stop breastfeeding.

Help her to continue breastfeeding.

The main difficulty arises when a mother is so sick that it is difficult for her to care for her baby.

- ☐ Helping a sick mother to breastfeed:
- Prepare a list on black board summarizing the points what you can do to help a sick mother to continue to breastfeed.
  - 1. When you treat a sick woman, remember to ask if she has a breastfeeding baby. Reassure her that she can continue to breastfeed, and that you will help her.
- 2. If a mother is admitted to hospital, admit her baby with her, so that she can continue to breastfeed.
- 3. If she has a fever, encourage her to drink plenty of water and milk, so that her breastmilk does not decrease because of dehydration.
- 4. If she is unwilling to breastfeed, or feels too unwell, suggest that she should express her breastmilk to keep up the supply. Help her to express her milk as often as her baby would feed, or about every 3 hours. Feed the baby his mother's EBM, or artificial milk if necessary. Feed him from a cup, so that he is willing to breastfeed again when she is well.
- 5. If she is so ill that she is unable to care for her baby at all (for example if she is unconscious) it may be possible to express her milk for him. Feed the baby by cup, until his mother is well enough to start breastfeeding again.
- 6. If she is mentally ill, try to keep the baby with her, and look after them together. Let the mother breastfeed if she can. If possible find a helper who can stay with her to make sure that she does not neglect or injure her baby.
- 7. When the mother is well again, help her to start breastfeeding her baby.

#### Breastfeeding to delay a new pregnancy

Breastfeeding can delay the return of ovulation and menstruation, so it can be a useful way to help space pregnancies.

Exclusive breastfeeding can protect against a new pregnancy only if the mother is not menstruating, that is, while she still has amenorrhea after delivery. If she is menstruating, her fertility is back to normal, and breastfeeding does not protect her.

Breastfeeding can give good protection for the first 6 months after delivery, if the mother breastfeeds exclusively. If she gives complementary feeds, protection is less. Protection is probably best if she breastfeeds frequently, both during the day and at night.

After the age of 6 months, breastfeeding gives less protection. At this age, all babies should have complementary food. However, if a baby continues to breastfeed frequently, in addition to complementary food, his mother is partly protected against a new pregnancy. This partial protection can be useful, if she is unable to use another family planning method for social or other reasons.

II. Discussion (10 minutes)

SESSION

1 7

## **Breastfeeding by Working Mothers**

## **Objectives**

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

- Counsel a working woman about continuing to breastfeed.
- Show women how to give their babies as much breastmilk as possible when they are away from home.
- Show cup feeding to caregiver.

Session outline	(30 minutes)
I. Introduce the topic	(2 minutes)
II. Discuss participants' own experience	(5 minutes)
III. Discuss how to help breastfeeding when mother works away from home	(10 minutes)
IV. Conduct the role play "helping a mother who works away from home"	(8 minutes)
V. Summarize	(5 minutes)

### **Preparation**

- 1. Read the introduction. How to conduct the training course?
- 2. Ask participants to do the role play of Sonia and her counselor.

## I. Introduce the topic

(2 minutes)

- ☐ Explain what the session is about:
- 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 frontline workers can support working mothers, and help them to give their babies as much breastmilk as possible.

We will discuss what frontline workers can do, under existing conditions.

- ☐ Trainer should ask what the local practices are.
- Ask participants for reasons for stopping breastfeeding or giving complementary foods early.

  Remind participants if they identified employment outside the home as an important reason for stopping breastfeeding.

## II. Discuss participants' own experiences

(5 minutes)

## ② Ask participants if they are willing to talk about their own experiences.

Put these questions to participants who agree:

How long was your maternity leave?

What arrangements were you able to make about child care?

How did you decide to feed your children?

How do you feel about that now?

Is there anything that could have made your experience more satisfactory?

Encourage the group to use their counselling skills as they talk, so that participants who share their experiences feel supported and not criticized.

Summarize the information that you have collected about local maternity leave, child care facilities, and the conditions of employment for women.

Discuss with the group how this relates to their own experiences.

It is possible to extend maternity leave by adding other type of leaves due to women.

# III. Discuss how to help breastfeeding when mother works away from home

(10 minutes)

## ② Ask participants to read ADVICE TO MOTHERS WHO WORK AWAY FROM HOME.

Let them take 10 minutes to read it to themselves, and then discuss the points.

If you and the participants prefer, read the section aloud together and discuss it. Let participants take turns and read aloud the first three paragraphs, and the first line after the bullet (I) of the other paragraphs. You read and explain the notes, which follow each of the first lines.

Discuss how practical the ideas are for the local situation.

#### ADVICE TO MOTHERS WHO WORK AWAY FROM HOME

If possible, take your baby with you at work, if crèche is near your work place.

If your work place is near to your home, you may be able to go home during breastfeeding breaks to feed him, or ask someone to bring him to you at work place to breastfeed.

If your work place 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 bottle feed straight away."
  - It is not necessary to use a bottle at all. Even very small babies can take 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 artificial 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 with the caregiver to give it 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 2 cups (400-500 ml) or more even after the baby has breastfed. But even 1 cup (200 ml) can give the baby 3 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.
  - » Leave the milk in the coolest place that you can find, in a refrigerator if you have one, or in a safe, dark corner of the house.
  - » Do not boil or reheat your breastmilk for your own baby. Heat destroys many of the antiinfective factors.
- Exclusive breastmilk stays in good condition longer than cow's milk, because of the antiinfective factors in it. Germs do not start growing in EBM for at least 8 hours, even in a hot climate, and outside the refrigerator and 24 hrs in the refrigerator.

- Breastfeed your baby after you have expressed.
- Suckling is more efficient than expressing, so he will get breastmilk that you cannot express, including some hindmilk.
- If you decide to use cow's milk for some or all of the feeds:
  - » To make 1 cup (200 ml) of feed, boil 1 cup (200 ml) of cow's milk. Add 1 level spoonful of sugar (15 g).
  - » Leave 1/2 to 1 cup (100-200 ml) of mixture for each feed.
  - » Leave the mixture in a clean covered container.
- If you decide to use formula feed:
  - » Measure the powder as given in the instructions for a feed into one clean cup or glass.
  - » Measure the water accordingly to make up the feed into another clean glass.
  - » Cover them both with a clean cloth, or put them in a covered pan.
  - » Teach the baby's caregiver to mix the milk powder and water when she is going to feed the baby. She must mix and use the formula immediately, because it spoils quickly after it is mixed.

**Note:** There are many different ways to leave milk for a baby. These are satisfactory methods. You may find that a different method is better for you in your situation.

- Teach the caregiver properly and carefully:
  - » Teach her to feed your baby with a cup, and not to use a bottle. Cups are cleaner, and they do not satisfy the baby's need to suckle. So, when you come home, your baby will want to suckle at the breast, and this will stimulate your breastmilk supply.
  - » Teach her to give all of one feed at one time. She must not keep it to give later; and she must not give a small amount every now and then.
  - » Teach her not to give the baby a pacifier but to calm him with other attention.
- While you are at work express your breastmilk 2-3 times (about 3-hourly):
  - » If you do not express, your breastmilk supply is more likely to decrease.
  - » Expressing also keeps you comfortable, and reduces leaking.
  - » If you work where you can use a refrigerator, keep your expressed breastmilk there. Carry a clean jar with a lid to store your breastmilk, and take it home for the baby. If you can keep it refrigerated at home, it will be safe to use the next day.
  - » If you cannot keep your EBM, throw it away. Your baby has not lost anything -your breasts will make more milk.

# IV. Conduct the role-play "Helping a mother who works away from home"

(8 minutes)

② Ask two participants to role-play Sonia and her counselor, as they discuss how to express breastmilk, and how to feed it to the baby when Sonia is at work.

If you or the participants wish, adapt the story to illustrate the local situation better.

Ask the role-players to emphasize these points:

» The practical difficulties faced by Sonia, with so much to do, getting back to work, and looking after her family.

Trainers' Guide

- » How the counselor helps Sonia to think what she will do that is really possible for her.
- » The value of breastfeeding at night, and of cup feeding instead of bottle feeding when Sonia is away from the baby.
- » How the counselor supports Sonia, using confidence building techniques. She should help Sonia to feel good about whatever she can manage.

## Role-play: Helping a mother who works away from home

Sonia had her third baby 4 weeks ago.

Sonia works in a shop. She will have to return to work when her baby will be 2 months old. She stopped breastfeeding her other children at 6 weeks, and bottle fed them, because of returning to work. They were often ill, and she missed the closeness of breastfeeding.

Sonia would prefer to breastfeed this baby, and a friend said that some women do, but Sonia does not know how. She is worried about leaking and smelling at work - it would be embarrassing, and might upset her employers and customers. She is worried about trying to breastfeed, work, and care for her other children and their father. She will be away from home for about 10 hours altogether, five days a week. Her younger sister will be caring for the baby, and is quite reliable. There is no refrigerator. Sonia has bought two new feeding bottles.

V. Summarize (5 minutes)

- ☐ Ask the group to discuss these questions:
  - 1. What did the story of Sonia suggest about how frontline workers can help a mother to breastfeed who works away from home?
  - 2. What could you do in your situation to help mothers who work away from home to breastfeed as much as possible?

SESSION

18

# Breastfeeding and Special Circumstances Specially HIV and Infant Feeding

## **Objectives**

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

• Help and guide mothers for breastfeeding in special situations.

### **Session outline**

- I. Introduce the topic
- II. Discuss breastfeeding in special situations
- III. Infant feeding options for HIV positive mothers
- IV. Summarize

### (30 minutes)

(2 minutes)

(10 minutes)

(15 minutes)

(3 minutes)

### **Preparation**

1. Read the introduction. How to conduct the training course?

## I. Introduce the topic

(2 minutes)

### Helping mother to breastfeed when she is seriously ill:

A common reason for a mother to stop breastfeeding is that she has become ill, for a short time or a long time. Some mothers stop for very minor illnesses such as cold.

However, it is seldom necessary to stop breastfeeding and it is much more dangerous to start a baby on artificial feeds than to let him feed from his sick mother.

In all special circumstances, trainer should ask all frontline workers to ensure that mother has taken consultation from medical healthcare provider.

## II. Discuss breastfeeding in various illness of the mother

(10 minutes)

## Trainer explains the optimally feeding practices that should be followed in special circumstances:

#### 1. The mother is mentally ill

Some mothers may become mentally ill for a short time after childbirth (puerperal psychosis, or puerperal depression). They usually recover and look after their children normally after some months. The illness is not passed on to the baby.

- Keep the baby with the mother if possible.
- Let her breastfeed the baby.
- Find a helper (usually a relative) who can be with her all the time to make sure that she does not neglect or injure the baby.

#### 2. Caesarian Section

Caesarian section should not prevent a woman from breastfeeding her baby, and it should not affect her milk supply. However, she may need extra help in the beginning for breastfeeding.

As soon as she recovers consciousness after the operation, she can hold the baby and give him the first breastfeed. Now a days caesarian section is done under spinal anesthesia, mother remains conscious and breastfeeding can be started soon after the mother comes out of the OT. A normal baby needs no food or drink before his mother can feed him. He can just wait until she is ready.

The baby can then stay in a cot besides the mother's bed and she can feed him whenever he is hungry. Mothers may need help to put the baby to the breast for the first few days. They need help to find a comfortable position in which to feed the baby, to turn over, and to move the baby from one side to the other. At first, it is often easiest to feed the baby lying down. Later, holding the baby in one of the "twins" positions may help.

Whatever position the mother uses, make sure that the baby faces her, and suckles in a good position.

#### 3. Specific Illnesses

The lactating mother may get affected by a variety of diseases.

#### Cancer

Most of the anti-cancer drugs are secreted in breastmilk and can affect the baby adversely

#### Diabetes mellitus

Breastfeeding offers advantages for the diabetic mother. The hormones released during breastfeeding and the extra energy used during milk production may decrease the amount of insulin the mother needs. The diabetic mother can breastfeed her babies.

Trainers' Guide

#### **Thyroid**

Low thyroid level in mother can decrease milk production. Thyroid supplement during breastfeeding brings the mother's thyroid up to a normal level, improving her milk supply therefore baby should be breastfeed.

#### **Tuberculosis**

Mother must be treated and baby must receive Isoniazide for 3 months if mother's sputum is positive for TB bacteria but breastfeeding should be continued.

## **Hepatitis B**

Though hepatitis B virus is transmitted via human milk, yet mothers who are positive for hepatitis can breastfeed. Their infants should be given hepatitis B vaccine and hepatitis B immune globulin at birth and hepatitis B vaccine again at 6, 10, and 14 weeks of age to stay protected.

#### 4. Infant feeding in emergency:

In emergencies (national disasters like crop failures, earthquakes, floods, armed conflicts, wars, displacement), infant feeding is an important issue because nutrition is closely linked to an infant's health and survival, in the short and long-term. During emergencies, inappropriate and harmful feeding practices are often initiated and supported through donations of infant formula and infant foods from the general public in response to emergency appeals. Such interventions are often borne out of a genuine though misguided wish to help. Artificial feeding in emergency situations is difficult due to no clean water, no sterile environment making impossible to ensure cleaning and sterilization of feeding utensils leading to increased risk of malnutrition, disease and infant death.

In emergency and relief situations, breastfeeding is the optimal and safest feeding method: it saves babies' lives. Breastfeeding not only give comfort and antibodies to protect babies from infection, it also helps mothers to relax under difficult circumstances and gives them a sense of control, empowerment and satisfaction. During an emergency, to ensure proper breastfeeding practices following actions should be taken:

- Support to mother by providing safe place and counselling to reduce her stress.
- Counselling for lactation maintenance and relactation support.
- Providing pregnant and lactating mother appropriate rations and water.

Trainer should tell all frontline workers that donations of breastmilk substitutes, infant formula, bottles, teats should be refused and not provided to the mother because these will lead to more illness.

Trainer will counsel the frontline workers against following myths during emergency

- 1. Stress causes milk to dry up.
- 2. Malnourished mother can't breastfeed.
- 3. Once breastfeeding has stopped it can't be resumed.
- 4. Babies with diarrhoea need water or tea.

Where mother has died or is unable to breastfeed, wet nursing should be advised and only where wet nursing is unacceptable, inappropriate and unavailable, give support to ensure safe artificial feeding.

## III. Infant Feeding options for HIV positive mothers (15 minutes)

- Make these points:
- A very sad aspect of the HIV/AIDS epidemic is that large number of young children are dying from the infection. Most of these children become infected through their parents. A woman is usually infected by her sexual partner, who is often the child's father.

- The best way to prevent infection in children is to help their parents to avoid becoming infected in the first place. This can be done by imparting education to men and women. Men's responsibility for protecting their families must be emphasized.
- However, many women are already infected, and it is important to reduce the risk of transmission to their babies.
- First let us remind ourselves about what the terms HIV and AIDS stand for.

#### Defining HIV and AIDS and read out the definitions.

#### Defining HIV and AIDS

HIV - Human Immunodeficiency Virus is a virus that destroys part of the body's immune system

AIDS - Acquired Immuno-Deficiency Syndrome is the final stage of the disease caused by HIV

- Explain to participants.
- The parent-to-child transmission rate at birth is about 20-25%.
- The risk of transmission of HIV to the unborn child through placenta is about 7%.
- About 15% infants are infected at the time of delivery when baby comes out of the birth canal which contains lot of maternal blood and vaginal secretions. These secretions have significant amount of HIV.
- 10-20% children are Infected during breastfeeding.
- Generally 63% babies born to HIV+ve mothers never get infection from them without any intervention and breastfeeding for 2 years.
  - Now explain how PTCT can be prevented.

### The Parent to Child Transmission (PTCT) of HIV can be prevented by:

#### 1. Primary prevention for transmission of HIV during pregnancy;

- I. First, parents protects themselves from getting HIV infection (primary prevention)
- II. Avoiding pregnancy.
- III. Medical termination of pregnancy, if mother decides after counselling.
- IV. Observing safe sex practices.
- V. Providing anti-retroviral drugs (ARV/ART) as per recommendations.

#### 2. During Delivery:

- Avoiding or doing careful and fewer vaginal examination.
- Avoiding artificial rupture of membrane, episiotomy, forceps and vacuum application.
- Doing caesarian section before labour begins.
- Avoiding oral and nasal suction during resuscitation of the baby as it causes injury to the oral mucosa and makes the baby breathe and inhale contaminated blood and fluids.
- Providing antiretroviral therapy (ART/ARV) at the time of birth and after birth to mother and infant as per recommendations.

Therefore, it is necessary that delivery should take place in a hospital where anti-retroviral drug will be given to mother and the baby.

#### 3. During breastfeeding:

- Providing anti-retroviral drugs (ARV/ART) as per recommendations.
- Exclusive breastfeeding (mixed feeding increases risk of transmission).
- Avoiding and treating mastitis/cracked nipples.

- Prevention and prompt treatment of oral lesions of the infant.
- Practicing safe sex. If HIV infection is acquired during pregnancy and lactation, risk of transmission is more.

**Ask:** Can we predict which babies will be infected? Wait and then say-No, we cannot predict which individual babies will be infected.

The infants feeding options to be discussed with women who are HIV-positive are:

- » Providing anti-retroviral drugs (ARV/ART) and exclusive breastfeeding for 6 months and continued breastfeeding till 12 months if infant is HIV negative and for 24 months if infant is HIV positive.
- » Expression and heat-treatment of her own breastmilk.
- » Breastfeeding from an HIV-negative woman or using donor breastmilk.
- » Replacement feeding either with home-prepared milk or with commercial formula.
- The risk of HIV transmission is greatest with mixed feedings. It is to be ensured that baby either gets exclusive breastfeeding or exclusive animal milk feeding.
- Adequate complementary foods from 6 months of age will be needed in all cases.
  - Mothers should give replacement feed only when specific conditions are met.

#### Six criteria to assess for replacement feeding

## Six criteria to assess for replacement feeding

- 1. Safe water and sanitation are assured at the house hold level and in the community, and
- 2. Mother, or care giver can reliably afford to provide sufficient replacement feed (milk), to support normal growth and development of the infant, and
- 3. The mother or caregiver can prepare it frequently enough in a clean manner so that it is safe and carries a low risk of diarrhoea and malnutrition, and
- 4. The mother or caregiver can, in the first six months exclusively give replacement feeding, and
- 5. The family is supportive of this practice, and
- 6. The mother or caregiver can access healthcare that offers comprehensive child health services.
- Mothers may consider expressing and heat treating breastmilk as interim feeding strategy in
  case of low birth weight babies, sick newborn, babies unable to breastfed, mother is sick and
  has breast conditions like sore nipple and mastitis or is going to stop breastfeeding or when
  ART are not available temporarily.
- If infant and young children are known to be HIV-infected, mothers are strongly encouraged to exclusive breastfeeding for the first 6 months of life and continue breastfeeding as per the recommendations for the general population, that is up to two years or beyond.
- Breastfeeding by an HIV-negative woman or using donor breastmilk. WHO (2009), however, does not mention these feeding options.
- Giving breastfeeding along with any other (animal + formula) milk is called mixed feeding. The risk of HIV transmission is greatest with mixed feeding. It is to be ensured that baby either gets exclusively breastfeeding or exclusive animal milk feeding.
- Adequate complementary foods after 6 months of age will be needed in all cases.
- Clarify any doubt of the participants.

#### IV. Summarize

(3 minutes)

SESSION

## **Clinical Practice 1**

## Listening and learning, Confidence Building and Giving Support Assessing a Breastfeed and Positioning a Baby at the Breast

#### **Objectives**

At the end of the clinical practice, participants are able to practice:

- 'listening and learning', 'Confidence building and giving support' to mothers in a ward or clinic.
- 'Assessing a breastfeed' and 'Positioning a baby at the breast'.

Session outline (120 minutes)

Participants are together as a class led by one trainer to prepare for the session and to discuss it afterwards.

Participants work in small groups of 4-5 each with one trainer for clinical practice in a ward or clinic.

I. Prepare the participants (20 minutes)

II. Conduct the clinical practice (80 minutes)

III. Discuss the clinical practice (20 minutes)

#### **Preparation**

Refer to page XV in the Introduction, for general guidance on conducting clinical practices.

If you are leading the session: Make sure that you know where the clinical practice will be held, and where for each student, each trainer should take her group. If you did not do so in a preparatory week, visit the wards or clinic where you will go, introduce yourself to the staff members in charge, and make sure that they are prepared for the session (see Director's Guide).

Study the instructions in the following pages, so that you can prepare the participants and conduct the clinical practice make sure that there are copies of the CLINICAL PRACTICE DISCUSSION CHECKLIST available for each trainer.

Make sure that there are two copies of the CLINICAL PRACTICE FORM and a list of LISTENING AND LEARNING and CONFIDENCE BUILDING SKILLS available for each participant and trainer.

If you are leading the group: Study the instructions in the following pages, so that you are clear about how to conduct the clinical practice.

Make sure that you have a copy of the CLINICAL PRACTICE DISCUSSION CHECKLIST, to help you to conduct discussions.

Find out where to take your group, and where to meet for the discussion afterwards.

## I. Prepare the participants

## (20 minutes)

One trainer leads a preparatory session with all participants and the other trainers together. If you have to travel to another facility for the clinical practice, hold the preparatory session in the classroom before you leave. If necessary, this can take place on the evening or the morning before.

- ☐ Explain the objective of the exercise:
- You practice 'assessing a breastfeed' and 'listening and learning', using the skills that you learnt in Sessions 3, 4, 5 and 6.
- ☐ Explain what each participant should take with her:
- Take with you:
  - » two copies of the Counselling Practice Form;
  - » one copy of LISTENING AND LEARNING AND CONFIDENCE BUILDING SKILLS;
  - » pencil and paper to make notes.

You do not need to take books or manuals or anything else. These other things can interfere with the clinical practice.

- ☐ Give each participant the forms that she needs.
- Make sure that trainers have these to take:
  - » spare copies of the Clinical Practice Form;
  - » spare copies of LISTENING AND LEARNING SKILLS and CONFIDENCE BUIDLING;
  - » a copy of the CLINICAL PRACTICE CHECKLIST.
- ☐ Explain how the participants will work:
- You work in your groups of 4-5 each with a trainer. To start with, the whole group works together. The trainer demonstrates what to do, and then you practice. You take turns to talk to a mother, while the other members of the group observe. When everyone knows what to do, you can work in pairs, while the trainer circulates.
- Explain what the participant, who talks to the mother, will do:
- Introduce yourself to the mother, and ask permission to talk to her. Introduce the group, and explain that they are interested in infant feeding. Ask permission to watch her baby feed. (Avoid saying 'breastfeeding': see the box **MISTAKES TO AVOID** in this Guide or Participants' Manual.)
  - Try to find a chair or stool to sit on. If necessary, and if permissible, sit on the bed.
  - If the baby is feeding, ask the mother to continue as she is doing. If the baby is not feeding, ask the mother to give a feed in the normal way at any time that her baby seems ready. Ask the mother's permission for the group to watch the feed.

Before or after the breastfeed, ask the mother some open questions about how she is, how her baby is, and how feeding is going, to start the conversation. Encourage the mother to talk about herself and her baby. Practice as many the listening and learning skills, as possible.

- ☐ Explain what the other participants will do:
- Stand quietly in the background. (There are unlikely to be enough stools or chairs for the whole group.) Try to be as still and quiet as possible. Do not comment, or talk among yourselves.
  - Make general observations of the mother and baby. Notice for example: Does she look happy? Does she have formula or a feeding bottle with her?
  - Make general observations of the conversation between the mother and the participant. Notice for example: Who does most of the talking? Does the participant ask open questions? Does the mother talk freely, and seem to enjoy it?

Make specific observations of the participant's listening and learning skills.

Mark a  $\checkmark$  on your list of **LISTENING AND LEARNING AND CONFIDENCE BUILDING SKILLS** when she uses a skill, to help you to remember the discussion. Notice if, she uses helpful nonverbal communication.

Notice if the participant makes a mistake, for example, if she uses a judgemental word, or if she asks a lot of questions to which the mother says 'yes' and 'no'.

- Explain what participants do when they observe a breastfeed:
- ☐ Stay quietly watching the mother and baby as the feed continues.

While you observe, fill in a Clinical Practice Form.

Write the name of the mother and baby; mark a  $\checkmark$  beside each sign that you observe; add the time that the feed takes.

Under 'Notes:' at the bottom of the form, write anything else that you observe which seems important for breastfeeding.

- ☐ Explain what to do when they have finished observing:
- Thank the mother for her time and cooperation, and say something to praise and support her.
- Go with the group into another room or corner to discuss your observations.
- ☐ Warn participants about **MISTAKES TO AVOID**:

#### Box

#### 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 bottle 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 staff from the ward or clinic.

• Be careful that the forms do not become a barrier.

The participant who talks to the mother should not make notes while she is talking. She needs to refer to the forms to remind her what to do, but if she wants to write, she should do so afterwards. The participants who are observing can make notes.

## II. Conduct the clinical practice

(80 minutes)

- ☐ Take your group to the ward or clinic:
  - » Introduce yourself and your group to the staff member in charge
  - » Ask which mothers and babies it would be appropriate to talk to, and where they are
  - » Try to find a mother and baby who are breastfeeding, or a mother who thinks that her baby may want to feed soon. If this is not possible, talk to any mother and baby
- □ Demonstrate to the group what to do:
  - » Explain that you will first demonstrate what participants should do
  - » Ask participants to stand quietly in the background, and to refer to their list of LISTENING AND LEARNING AND CONFIDENCE BUILDING SKILLS, and the Clinical Practice Form
  - » Introduce yourself and the group to the mother

- » Ask her permission to talk to her and to watch the baby feed.
- » Sit on a chair or stool, or the bed if permissible.
- » Ask her a few open questions.
- » Use as many listening and learning skills as possible to encourage the mother to tell you about herself and the baby. Follow the list of skills.
- » Observe the baby breastfeeding, using the Clinical Practice form.
- » Thank the mother, and say something to praise and support her.

If you cannot speak the mother's language, ask a participant who can speak it to interpret for the demonstration.

☐ Discuss the demonstration:

Take the group away from the mother, and discuss what they observed.

#### Ask them:

- » What did they observe generally about the mother and baby?
- » What signs from the Clinical Practice Form did they observe?
- » Which listening and learning skills did you demonstrate?

If the mother and baby showed any signs of good or poor positioning and attachment, which participants did not see, point them out.

☐ Arrange for a participant to talk to a mother:

Find another mother, and ask a participant to talk to her. She should practice listening and learning skills, while the rest of the group observes. If the baby breastfeeds, they should all observe the feed.

☐ Guide the participant who is practicing:

Keep in the background, and try to let the participant work without too much interference. You do not need to correct every mistake that she makes immediately. If possible wait until the discussion afterwards. Then you can both praise what she did right and talk about anything she did not do right.

However, if she is making a lot of mistakes, or not making any progress, then you should help her. Try to help in a way which does not make her embarrassed in front of the mother and the group.

Also, if she starts to help or advise the mother, remind her that she should not do that during this practice session.

Additionally, if the mother and baby show something important that the participants may not have observed, you can quietly draw their attention to it.

You need to judge as participants work what will best help them to learn. Use your confidence and support skills to correct participants and to help them develop confidence in their own clinical and counselling skills.

☐ Discuss the participant's performance:

Take the group away from the mother, and discuss what they observed.

Use the **CLINICAL PRACTICE DISCUSSION CHECKLIST** to help you to lead the discussion. Ask the general questions, and then ask the specific questions about 'listening and learning' and about 'assessing a breastfeed'.

Go through the **LISTENING AND LEARNING AND CONFIDENCE BUILDING SKILLS** checklist, and discuss how the participant practiced them. First ask the participant herself to say how well she thinks she did. Then ask the other participants.

Go through the Clinical Practice Form, and discuss how many of the signs the group noticed. Ask them to decide if the baby was well or poorly positioned and attached.

Arrange for the other participants in turn to talk to mothers:

Find another mother, and ask another participant to talk to her. Discuss the group's observations, and the participant's performance.

Work with the group together until you are sure that they know what to do. Make sure that you are present the first time when a participant talks to a mother.

Try to make sure that each participant talks to at least one mother.

□ Let participants work in pairs:

When you have observed participants talking to at least one mother, and you are confident that they know what to do, let them work in pairs to talk to other mothers without you. Circulate between the pairs to see how they are doing. When a pair has finished, move away from the mother, and discuss their observations with them.

☐ Teach about mothers who need help:

If at any time there is a mother who needs help, or who illustrates a particular situation, take the opportunity to teach about it.

Ask a participant who identifies a mother needing help to report it to you. Ask the staff of the ward or clinic if they would like you to help the mother. If they agree, give the mother the necessary help, together with the participant.

Ask the staff to be present if possible, and make sure that they understand what you suggest to the mother so that they can provide follow-up.

Explain and demonstrate the situation to the other participants. This may take you ahead of what has been covered in the course, but it is important not to miss a good learning opportunity.

If possible, suggest that participants revisit the mothers whom they talked to, to follow them up the next day.

☐ Encourage participants to observe healthcare practices:

Encourage participants, while they are in a ward or clinic, to notice:

- » if babies room-in with their mothers
- » whether or not babies are given formula, or glucose water
- » whether or not feeding bottles are used
- » any other item being fed to babies
- » the presence or absence of advertisements for baby milk
- » whether sick mothers and babies are admitted to hospital together
- » how low-birth-weight babies are fed

Encourage participants also to talk to staff in the health facility, to learn:

- » their attitude to breastfeeding
- » their knowledge and information about breastfeeding
- » how they care for breastfeeding mothers
- » if they have babies of their own, and how they feed them

Explain that participants should not comment on their observations, or show any disapproval, while in the health facility. They should wait until the trainer invites them to comment privately, or in the classroom.

## III. Discuss the clinical practice

(20 minutes)

The whole class comes back together to discuss the clinical practice exercise, led by the trainer who led the preparatory session.

Ask one participant from each group to report briefly on what they learnt:

Ask them to comment:

- » on any special situations of mothers and babies from which they learnt;
- » on their experiences using the Clinical Practice Form and the list LISTENING AND LEARNING AND CONFIDENCE BUILDING SKILLS.

Do not allow participants to report on details of every individual mother. They should report only on points of special interest.

Use the CLINICAL PRACTICE DISCUSSION CHECKLIST to help you to guide the discussion.

However, do not go through the whole checklist, because this was done in the small groups.

☐ Ask participants to fill in their **CLINICAL PRACTICE PROGRESS FORM**:

Explain that the form of their manuals.

On the form they should record each mother and baby that they talked to during the Clinical Practice 1. They record each mother twice. In Section 1 of the form, they record the skills that they practiced with the mother; in Section 2 they record the mother's situation.

## **Counselling CHECKLISTS**

LISTENING AND LEARNING SKILLS			
	Use helpful non-verbal communication.		
	Ask open questions.		
	Use responses and gestures which show interest.		
	Reflect backon what the mother says.		
	Empathize-show that you understand how she feels.		
	Avoid words which sound judging.		
CON	IFIDENCE AND SUPPORT SKILLS		
	Accept what a mother thinks and feels.		
	Recognize and praise what a mother and baby are doing right.		
	Give a practice help.		
	Give a little relevant information and check understanding.		
	Use simple language.		
	Make one or two suggestions, not commands.		
Coun	selling PRACICE FORM		

ASSESSING A BREASTFEED		
	Body position.	
	Responses of mother and baby.	
	Emotional bonding.	
	Anatomy of breast.	
	Suckling.	
	Time spent suckling.	

OBS	SERVING A BREASTFEED
	Mouth wide open.
	Chin touching the breast.
	Lower lip turned out.
	More areola above the mouth.
Add	itional points
	Cheek rounded.
	Slow deep sucks may be appreciated.
CLI	NICAL PRACTICE DISCUSSION CHECKLIST
Gen	eral questions
	How did your clinical practice go?
	What did you do well? What difficulties did you have?
	Was the mother willing to talk? Did she seem to enjoy talking to you?
	Did the mother ask any questions? How did you respond?
	What was the most interesting thing that you learnt from her?
	Did she have a special difficulty or situation which helped you to learn?
Liste	ening and learning
	How many of the listening and learning skills were you able to use?
	What mistakes did you make? Did you ask a lot of questions?
	Did using the skills encourage the mother to talk?
Asse	essing a breastfeed
	What did you learn by general observation?
	What did you learn using the BREASTFEED Observation Form?
Con	fidence and support
	How many of the confidence and support skills were you able to use? (especially praise 2 things, and give 2 pieces of relevant information)
	What mistakes did you make? Did you give the mother a lot of advice?
	Did using these skills help you to help the mother?
Hist	ory-taking
	What did you learn by taking a breastfeeding history?
	Did you remember to ask something from each section of the form?
	Did using the form help you to understand the mother's situation?

## **BREASTFEEDING OBSERVATION FORM**

Mother's name:			Date:		
Baby's name:					
	in brackets refer only to newborn, not to				
Signs that breastfeeding is going well		Signs	Signs of possible difficulty		
BOD	Y POSITION				
	Mother relaxed and comfortable		Shoulders tense, leans over baby		
	Baby's head and body in straight line		Baby's head and body in not straight line		
	Baby's face facing breast		Baby's face not facing breast		
	Baby's nose opposite the nipple		Baby's nose away from nipple		
	Baby's body close to mother's		Baby's body not close to mother's		
	Baby's back supported		Only shoulder or head supported		
	Baby reaches breast from below		Baby reaches breast from above		
	Breast well supported (optional)		Breast supported in scissor hold or nipple being pushed in babies mouth		
RESF	PONSES				
	Baby reaches for breast if hungry		No response to breast		
	Baby roots for breast		No rooting observed		
	Baby explores breast with tongue		Baby not interested in breast		
	Baby calm and alert at breast		Baby restless or crying		
	Baby stays attached to breast		Baby slips off breast		
	Signs of milk ejection,		No signs of milk ejection		
	[leaking, after-pains]				
ЕМО	TIONAL BONDING				
	Secure, confident hold		Nervous or limp hold		
	Face-to-face attention from mother		No mother/baby eye contact		
	Much touching by mother		Little touching or		
			Shaking or poking baby		
ANA	ТОМҮ				
	Breasts soft after feed		Breasts engorged		
	Nipples average size		Nipples large/flat/inverted		
	Nipples stand out, protractile		Nipples not protractile		
	Skin appears healthy		Fissures or redness of skin		
	No lump in breast		Lump in breast		
	Breast looks round during feed		Breast looks stretched or pulled		

Signs that breastfeeding is going well		Signs of possible difficulty	
SUCK	LING		
	Mouth wide open		Mouth not wide open, points forward
	Chin touching the breast and nose close to breast		Chin and nose away from the breast
	Lower lip turned outwards		Lower lip turned in
	Tongue cupped around breast		Baby's tongue not seen
	Cheeks round		Cheeks tense or pulled in
	More areola above baby's mouth		More areola below baby's mouth
	Slow deep sucks, bursts with pauses		Rapid sucks only
	Can see or hear swallowing		Can hear smacking or clicking
TIMES	SPENT SUCKLING		
	Baby releases breast Baby suckled for minutes		Mother takes baby off breast

### Notes:

© Adapted with permission from "Breastfeeding Observation Form" by H C Armstrong, Training Guide in Lactation Management, New York, IBFAN and UNICEF 1992.

SESSION

#### Clinical Practice 2

# Listening and Learning Building Confidence and Giving Support Complementary Feeding

#### **Objectives**

At the end of the clinical practice participants are able to practice:

- 'Building confidence and giving support' and counsel mothers for complementary feeding in a ward or clinic.
- Participants continue to practice the skills from Clinical Practice 1.

Session outline (120 minutes)

Participants meet together as a class led by one trainer to prepare for the session, and to discuss it afterwards.

Participants work in small groups of 4-5 each with one trainer, or in pairs for clinical practice in a ward or clinic.

I. Prepare the participants (20 minutes)

II. Conduct the clinical practice (80 minutes)

III. Discuss the clinical practice (20 minutes)

#### **Preparation**

Refer to page XV in the Introduction, for general guidance on conducting clinical practices.

Study the instructions in the following pages, and ask all trainers who will lead groups to study the instructions also. You conduct Clinical Practice 2 in a way similar to Clinical Practice 1, but there are some differences. Make sure that you and the other trainers are clear about the differences.

Make available a copy of the list of **LISTENING AND LEARNING and CONFIDENCE AND SUPPORT SKILLS** for each participant and trainer.

Make available two copies of the Clinical Practice Form.

Make sure that all trainers have a copy of the CLINICAL PRACTICE DISCUSSION CHECKLIST.

#### I. Prepare the participants

(20 minutes)

- ☐ Explain the objectives of the clinical practice:
- During this session, you practice listening and learning and building confidence and giving support.

You also continue to practice 'assessing a breastfeed'.

If there is an opportunity, you will practice helping a mother to position her baby at the breast, or to overcome any other difficulty.

- ☐ Explain what participants should take with them:
- Take with you:
  - » One copy of LISTENING AND LEARNING SKILLS and CONFIDENCE AND SUPPORT SKILLS.
  - » One copy of key messages for complementary feeding.
  - » Two copies of the Clinical Practice Form.
  - » Pencil and paper to make notes.
  - » A bowl, spoon and consistency food photo.
- ☐ Give each participant the forms and lists that she needs.
- ☐ Explain how participants will work:
- You work in groups of 4-5 each with a trainer, in the same way as in Clinical Practice 1.

When you feel ready, you can start working in pairs, while the trainer circulates.

If you meet a mother who needs help positioning her baby at the breast, or with any other difficulty, inform the trainer, so that she can demonstrate how to help the mother.

- Explain what participants should do when they talk to a mother:
- 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.
- » Be careful about not giving a lot of advice.
- In addition, continue to practice 'assessing a breastfeed' and 'listening and learning'.

The participant who is observing, can mark a ✓ in the box on the **LISTENING AND LEARNING** and **CONFIDENCE AND SUPPORT SKILLS** checklist for every skill that she observes her partner practicing.

☐ Discuss any difficulties from Clinical Practice 1:

Discuss especially things that participants found difficult or forgot to do in Clinical Practice 1.

#### II. Conduct the clinical practice

(80 minutes)

☐ Take your group to the ward or clinic:

Conduct the session in the same way as Clinical Practice 1, except that participants may now work in pairs, if you feel that they are ready to do so.

Find a mother with the baby 6-23 months old. Participants ask about feeding of the baby.

S/he then asks frequency, amount, type, and consistency of the food given to the baby.

Show to participant how to ask the mother about amount of food by showing bowl to her.

Food consistency is found out by showing photo to mother.

Participants counsel the mothers about complementary feeding and tell them key messages.

Use the CLINICAL PRACTICE DISCUSSION CHECKLIST to guide you in your discussions.

Help participants to find another mother and baby to talk to.

#### III. Discuss the clinical practice

(20 minutes)

The whole class comes back together to discuss the clinical practice, led by the trainer who led the preparatory session.

Ask one participant from each group to report briefly on what they learnt:

Participants may not have finished seeing mothers and babies at the end of the 80 minutes allowed for Clinical Practice II. Conduct the clinical practice. If you feel that finishing the clinical practice is more valuable, let them continue and finish, and if necessary omit the class discussion. You must decide what is the most useful way to spend this time.

Ask participants to fill in their **CLINICAL PRACTICE FORM**.

On the form, they should record each mother and baby that they talked to in Clinical Practice II.

SESSION

### **Protecting Breastmilk from Commercial Influence**

The Infant Milk Substitutes, Feeding Bottles and Infant Foods (Regulation of Production, Supply and Distribution) Act 1992 and Amendment in 2003 (IMS Act)

#### **Objectives**

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

- List provisions of IMS Act
- Identify violation of the Act
- Enlist dos and don'ts for healthcare systems under IMS Act

Session outline	(30 minutes)
I. Introduce the topic	(2 minutes)
II. Describe objectives of the IMS Act	(5 minutes)
III. What is violation of the Act	(10 minutes)
IV. Provisions for the healthcare system	(10 minutes)
V. Summarize	(3 minutes)

#### **Preparation**

Read the introduction. How to conduct the training course?

#### I. Introduce the topic

(2 minutes)

During the last many decades, extensive promotions by the infant food manufacturing companies, through the advertisements, free samples, gifts to mothers and health workers has led to convincing them that bottle feeding is as good as breastfeeding. This undermines breastfeeding in many ways and has contributed to the decline of breastfeeding rates. This is assuming dangerous proportions, subjecting millions of infants to great risk of infection, malnutrition and death. In the absence of strong interventions to protect, promote and support breastfeeding, this decline could assume a more dangerous pattern.

In view of the vulnerability of young infants to the aforesaid risks, it became necessary to regulate the marketing of such products. Recognizing this fact, the World Health Assembly adopted the International Code of Marketing of Breastmilk Substitutes in 1981. (5) The aim of the Code is to contribute to the provision of safe and adequate nutrition for infants, by the protection and promotion of breastfeeding, and by ensuring the proper use of breastmilk substitutes, when these are necessary, on the basis of adequate information and through appropriate marketing and distribution. Keeping the objectives of the International Code in view, the Indian Parliament enacted national legislation to this effect titled Infant Milk Substitutes, Feeding Bottles and Infant Foods (Regulation of Production, Supply and Distribution) Act 1992 (IMS Act) which came into force on August I, 1993. The Act was further amended in the year 2003.

The IMS Act prohibits the promotion of infant foods, infant milk substitutes and feeding bottles in any form and reflects Government of India's commitment to protect, promote and support breastfeeding in the country.

#### II. Discuss the Cable Television Network (Regulation) Act, 1995

■ Make these points:

The purpose of this Act is to prohibit transmission or retransmission of any advertisement to promote directly or indirectly production, sale or consumption of Infant milk substitutes, feeding bottles and infant foods through cable service. It extends to the whole of India. This Act supports implementation of the IMS Act to all cable service providers of India.

#### III. Describe objectives of the IMS Act

(5 minutes)

- To protect, promote and support breastfeeding.
- To prohibit any kind of promotion of infant milk substitutes, infant foods and feeding bottles.
- To ensure proper education of pregnant and lactating mothers about breastfeeding by providing accurate information.

The IMS Act does not stop infant formulas and other infant foods under the scope of the Act being available, being sold and used whenever necessary.

#### **Further information**

"Infant milk substitute" means any food being marketed or otherwise represented as a partial or total replacement for mother's milk, for infants up to the age of two years. Read definitions under the act in the original copy of the Act given in the appendix?

#### IV. What is violation of the Act

(10 minutes)

Promote any food by whatever name for children up to two years.
Promote use of infant foods before the age of six months.
Advertise by any meanstelevision, newspapers, magazines, journals, through SMS, emails, radio, pamphlets, etc.
Distribute the product or samples to any person.
Contact pregnant or lactating mothers using any person.
Give any kind of inducements like free gifts, tied sales, to any one.
Distribute information and educational material to mothers, families, etc. (They can give educational material to health professionals like doctors, nurses, etc provided it has information prescribed in Clause 7 of the IMS Act, 2003. The education material should have only factual information and should not promote the products of the company).
Give tins, cartons, accompanying leaflets of these products having picture of mothers or babies, cartoons or any other such images.
Display placards, posters in a hospitals, nursing homes, chemist shops, etc for promoting these products.
Make payments to doctors, nurses for promoting these products.
Demonstrate to mothers or their family members how to feed these products. However, a doctor can demonstrate this to the mother.
Give gifts to doctors, nurses for promoting these products.
Give benefits to doctors, nurses or associations like Indian Academy of Pediatrics, Indian Medical Association, etc, for example, funds for organizing seminars, meetings, conferences, contests, fee of educational courses, sponsoring for projects, research work or tours.
Fix commission of employees on the basis of volume of sales of these products.

#### V. Provisions for healthcare system

(10 minutes)

Certain provisions of IMS Act pertaining to the healthcare systems.

- IMS Act prohibits providing free samples of infant milk substitute, infant foods and feeding bottles and gifts to pregnant women, mothers of infants and members of the families.
- IMS Act prohibits donation of free or subsided supplies of infant milk substitute, infant foods and feeding bottles to healthcare institutions, however, it allows donations to the orphanages.
- IMS Act prohibits display of posters at healthcare facilities / hospitals /health centers.
- IMS Act prohibits any contact of employers manufacturing and distributing company with pregnant women, even for providing educational material to them.
- IMS Act prohibits direct or indirect financial inducement or gift to health workers or to any members of her/his family by the producer, supplier or distributor of the infant milk substitute, infant foods and feeding bottles. The Act also prohibits offering or giving any contribution or pecuniary benefit to a health worker or any association thereof including funding of seminars, meetings, conferences, educational courses, contests, fellowship, research work or sponsorships, etc. by the manufacturers, supplier or distributors of the products mentioned above.

#### Scope of the IMS Act

The IMS Act controls marketing and promotion of products like:

1. Infant milk substitutes which means any food for consumption by infants up to the age of six months which totally or partially replaces mother's milk. Some examples of such products are given in the table below.

Name of company	Brands
Abbott Nutrition	Isomil
Amul	Amul Spray
Dalmia Dairy	Milk Care
FDC Ltd.	Prosoyal, Simyl- MCT
Nestle	Lactogen-1, Lactogen-2, Nestogen-1, Nestogen-2, NAN-1, NAN-2
Raptakos Brett	Lactodex-1, Lactodex-2, Zerolac, Lactodex HMF
Wockhardt/Danone	Farex1, Farex2, Dexolac, Nubsobee

- 2. Feeding bottles of any brand like Bonny Baby, Hello Baby, Wipro or any other brand.
- 3. Infant foods which means any food for consumption of children after the age of six months and up to the age of two years. Some examples of such foods are given in the table below.

Name of company	Brands
Dalmia	Weano Care
Nestle	Nestum, Cerelac
Nutricia	Infacare
Reptakos Brett	Veelac
Wockhardt/Danone	First Food, Dexrice, Easum, Farex

VI. Summarize (3 minutes)

The IMS Act has a clear intent; the saving of millions of children's lives and improving their nutritional status by preventing the baby food industry from enticing mothers and the health system to give infants breastmilk substitutes. Enactment of the Act has been seen as an example of an innovative and progressive legislation and India was heralded as a global leader in the area of legislation on infant and young child health. Still, the formula industry is finding innovative ways to bypass this legislation and working against the spirit of the Act. There are examples where the industry has floated some front organizations and collaborating with the healthcare associations in conducting seminars, conferences etc. There is need to address such activities very decisively.



SESSION

### **Growth Monitoring and Measuring**

#### **Objectives**

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

- Define growth and describe advantages of growth monitoring.
- Take weight and length/height from newborn infant to under-5 children.

Session outline (50		(50 minutes)
l.	Introduce the topic	(5 minutes)
II.	Definition of growth	(5 minutes)
III.	Growth monitoring	(5 minutes)
IV.	Taking weight	(10 minutes)
V.	Measuring length	(10 minutes)
VI.	Measuring height	(10 minutes
VII.	Summarize	(5 minutes)

#### **Preparation**

- 1. Read the introduction. How to conduct training course?
- 2. Arrange weighing scales (basket type).
- 3. Arrange height meter, measuring tape, infantometer.
- 4. Arrange a cardboard sheet 12"X12". Or use participant's manual.
- 5. Prepare a participant to act as mother who will be counseled for getting her baby weighed.
- 6. Prepare a participant for height measurement.
- 7. Arrange a doll for measuring weight.

#### I. Introduce the topic

(5 minutes)

- Make these points:
  - Growth is a characteristic feature of childhood. It is affected by nutrition and in disease state.
  - If diet is poor in quantity and quality of nutrients, then weight, length/height and head circumference of the child does not increase as expected.
  - If dietary intake is in excess then child tends to be over-weight and obese. It is also a form of
    malnutrition and may lead to several metabolic illnesses, like diabetes and cardiovascular
    diseases in later life.
  - Frequent assessment of weight and length/height during infancy and childhood may detect growth faltering at an early stage. Hence, adequate steps may be taken promptly for the management of suboptimal growth and prevention of serious repercussions.

#### II. Definition of growth

(10 minutes)

Growth is defined as increase in the physical size and shape of the body. It is measurable. Generally weight is measured in kilograms after neonatal period; weight of newborn baby may be described in grams. Length, and head and chest circumferences are depicted in centimetres.

- ☐ Make these points:
  - Weight, length/height, and head circumference are some important indicators of growth. These
    are also called age dependent parameters of physical growth.
  - The growth takes place in an orderly and linear fashion. The velocity of growth is highest in infancy and early childhood.
  - The brain grows very rapidly in infancy and almost 90% of its adult weight and size are achieved by 2 years of age. Head circumference is the surrogate marker of brain growth.
  - Adequate energy and micronutrients are essential for optimal growth of the child.
  - Therefore optimal feeding of an infant and young child is extremely important for achieving proper physical growth and development.

**Ask:** If a baby does not get optimal feeding in infancy and early childhood what will happen? Wait for few answers and then continue.

- Weight and length/height of the baby will not increase as expected. Baby will suffer from undernutrition and will fall sick more often.
- When complementary feeding is not started on time, inadequate feeding is done, or baby does
  not take adequate feeds then initially weight is affected; baby looks lean and thin with loose
  folds of skin in the groin and over buttocks.
- If improper and suboptimal feeding is continued for a long period then height is also affected and child becomes stunted.
- Thus weight loss indicates inadequate feeding in the recent past whereas stunting occurs after prolonged deprivation of nutrients.

#### **Growth monitoring**

- Growth monitoring consists of routine anthropometric (weight, height, head circumference, etc.) measurement to observe pattern of growth so as to institute preventive action when deviations are detected.
- Growth monitoring is an important tool to
  - » Detect early faltering in the growth by plotting and tracking the weight on Growth standards
  - » Asses how a child is growing.

Trainers' Guide

- » Know whether undernutrition is acute i.e. recent in origin or chronic or long standing, and
- » Know what the severity of malnutrition is.
- Growth assessment prompts a health worker to ask from mother about feeding and health of the child.
- Through discussion and counselling, Growth monitoring increases the participation and capabilities of families to understand and improve child care and feeding practices. It helps families to understand the linkage between child growth and dietary intake, healthcare, safe drinking water and environmental sanitation.

#### Measuring growth: weight and length/height

- In order to assess growth of a child it is important to measure growth parameters accurately.
- An exclusively breastfed baby gains, a minimum of 500 gm weight in a month till first 6 months of age. At one year a girl should weigh 9 kg and a boy should be 9.6 kg.
- Below 2 years of age, the head to toe distance is taken in lying down posture and described as length. Beyond two years of age the same distance is measured in standing position and is called height.

Further reading: If both length and height are taken in a child then length tends to be more because in standing posture spinal discs and sole tissue get compressed, decreasing the height in comparison to length.

- Many parents feel apprehensive and their children get frightened when weight and length/ height are measured.
- Therefore, mother should be greeted first and then made comfortable by offering a seat; praise her and give information about importance of growth monitoring before taking measurements.
- Suggest to parents to bring the child for regular growth measurements and keep the growth charts safely.

#### **Taking measurement**

- The trainer will show different types of weighing machines and length/height measuring stadiometers and will demonstrate how to take weight and length/height.
- First the trainer will demonstrate to the participants how to talk to the mother (ask one participant who has already been prepared), greet her and obtain her permission to take weight and length/ height of the child.

#### **Taking weight**

- Infants and young children up to two years of age are weighed in a basket type of weighing machine with a minimum weighing of 50 gm.
- Weight of older children is measured either by electronic weighing scale or ordinary weighing machine which can weigh 10 to 100 gm.
- Before weighing, zero error should be corrected.
- The reading should be read by standing in front of the dial of the weighing scale.
  - » Now show how to set zero error and put machine on an even platform. Asks mother to take off child's cloths and shoes (show it on the doll) except panty/under wear. Trainer then lays the baby on the weighing pan if, baby is less than 2 years of age; older children can stand on the machine.
  - » He then stands in front of the weighing machine and reads the weight and records it for plotting on the growth chart.

#### **Taking length**

- The length is taken from head to toe on infantometer up to two years of age. If infantometer is not available then length may be taken by a non-stretchable measuring tape.
- While taking height, put off shoes, ask child to stand upright on the platform of the stadiometer
  and look forward. If stadiometer is not available then child may stand by the side of the wall
  with both heels, shoulders and head touching the wall, and eyes looking forward. Height is
  then measured by a non-stretchable tape.
  - » Trainer will show how to take length on an infantometer. S/he will place the baby on the infantometer with head against fixed end and both feet firmly against the sliding scale and note the reading.
  - » Trainer will also show taking length by tape. S/he will lay baby in supine position on the table covered with rubber sheet, blanket or thick clothing. S/he will hold head and will request mother to hold feet. Health worker then puts a register or cardboard by the side of the head, marks a line by pen on the inner side of the cardboard. A similar line is made towards feet horizontal to sole. Baby is then removed and distance between two lines is measured. It is the length. Care is taken to avoid making creases on the blanket or clothing.
  - » Trainer will ask a participant to stand on the stadiometer after taking off shoes and looking forward. S/he will lower the horizontal rod and place it firmly on the head, and will note the reading.
  - » Trainer will also show taking height by asking the participant to stand by the side of the wall as described above and put a book or cardboard on the head. S/he will then mark a line from the undersurface of the cardboard. S/he will ask the participant to be away and then measure the distance from the floor to the marked line. It will represent height.

#### Summarize

- Growth monitoring helps in early detection of faltering in the weight, length and weight-for height of a child.
- Measuring weight and height are simple tools to assess how a child is growing and how is she/ he being fed.
- On every visit to health facility a child should be weighed and height/length recorded.
- This gives an opportunity to praise mother and empathize with her for taking good care of the baby.



SESSION

23

### **Growth Monitoring by Growth Charts**

#### **Objectives**

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

- Plot weight and length/height for age, and weight for length/height on the WHO growth charts.
- Identify abnormal growth on the basis of weight and length/height measurements.
- Assess nutritional status on the basis of MCP card.

Sess	ion outline	(60 minutes)
l.	Introduction	(5 minutes)
II.	Describe WHO growth standard charts	(10 minutes)
III.	Demonstrate plotting of weight and length/height on WHO growth standard charts	(5 minutes)
IV.	Exercise: Plotting measurements on WHO growth standard charts	(15 minutes)
V.	MCP charts	(10 minutes)
VI.	Exercise: Plotting measurements on MCP charts	(10 minutes)
VII.	Summarize	(5 minutes)

#### **Preparation**

- 1. Read the introduction. How to conduct training course?
- 2. Draw WHO weight-for-age and height-for-age and weight for length/height growth chart on separate flipcharts.
- 3. Arrange a set of WHO growth charts-weight-for-age, length/height-for-age, weight-for-length/height for each participant. Write age, and weight, length and weight-for-length/height on each chart. Ensure that every trainee gets anthropometric values corresponding to normal growth, and falling between -2/-3 and +2/+3 lines of different ages as well as for both sexes.
- 4. Arrange MCP charts.

I. Introduction (5 minutes)

- ☐ Make these points:
  - Growth monitoring helps in early detection of faltering in growth of a child.
  - As WHO growth standard charts are universal, these can be used in any country. Separate growth charts should be used for boys and girls.
  - Mother and Child Protection Card (MCP) based on WHO growth standard charts is used in India, developed and released by Government of India.

#### II. Describe WHO growth charts

(10 minutes)

- ☐ Make these points:
  - Measuring weight, length/height, head circumference and body mass index (BMI) of the child and keeping record of them at regular intervals are important for assessing growth.
  - WHO growth charts have been developed for breastfed infants to record weight, length/height, head circumference, BMI and weight for length/height separately for girls and boys.
  - The WHO growth charts are applicable to all children in the world from any region, race, religion or community.
- Now display WHO growth charts for weight, length/height and weight-for-length/height which have been prepared on the flip charts. Explain them to trainees and show them with the help of ruler/finger.
- ☐ Make these points on the growth chart:
- Age of the child is depicted on the horizontal line. The weight or length/height is marked on the vertical line.
- Each growth chart has a middle line marked "0" that represents normal growth.
- Two lines are below "0" line marked "-2" and "-3" showing increasing degree of growth faltering. Value for any growth parameter falling below the line marked ""3" indicates severe malnutrition.
- Similarly two lines are above "0" line marked "+2", and "+3" showing that child is gaining more weight and is overweight or obese.
- It is expected that a healthy and adequately fed child will gain weight and length/height which will fall between "0" and "-2" or "0" and "+2" lines. In other words, weight and height values falling between "-2" and "+2" lines are regarded normal.

## III. Demonstrate plotting of weight and length/height on WHO growth charts

(5 Minutes)

- Tell participants that you will plot weight of a 2 years old girl child who weighs 9.7 kg on the WHO weight-for age chart.
- Display WHO weight-for-age growth chart for girls on the board. Demonstrate how to locate age on the weight-for-age growth chart by counting age from left to right on the horizontal line.
- Demonstrate how to ascertain weight by counting 9 from below upwards on the vertical line. Now follow horizontal line from this point (9 kg) from left to right till it meets vertical line representing age at 2 years.
- Put a cross/large dot on the intersection where horizontal and vertical lines meet.

Trainers' Guide

- Ask the participants where is the weight of the child falling? Wait for few moments and then explain that weight is falling between "0" and "+2" lines and it is normal for age.
- Every time child is weighed on follow up, his/her weight is recorded on the chart in the similar manner. Then two points are joined by drawing a line. This line represents weight growth pattern of the child.
- Now display WHO height-for-age growth chart on the board and explain that length/height is also recorded in the similar manner.

## IV. Exercise: Plotting measurements on WHO growth charts

(15 minutes)

- 1. Distribute one set of WHO growth charts (weight and height for age and weight for height with age and growth values written on the charts).
- 2. Ask trainees to record weight, height and weight-for-height values on the respective growth charts with the pencil.
- 3. Ask other trainers to help participants in the exercise. Ask them to encourage participants to think whether weight, length/height and weight for length/height are normal or there is growth faltering. Again encourage trainees to think whether undernutrition is acute or chronic.

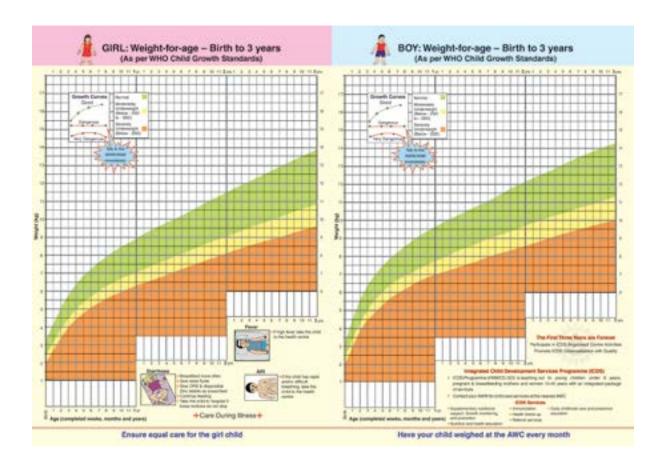
#### V. Mother and Child Protection Card (MCP)

(10 minutes)

- In the ICDS scheme and National Rural Mission (NRM), growth monitoring of children is an important activity. Children under 3 are weighted once in a month and children 3-6 years of age are weighted quarterly. To harmonize growth monitoring in government health and nutrition programmes with WHO growth standards, and to track the nutritional status, immunization schedule and developmental milestones for both child, the pregnant and lactating mothers Mother Child Protection Card (MCP Card) was developed and released on 5 September 2008 by Government of India.
- MCP card helps in:
  - » Correct assessment of child undernutrition.
  - » Gender specific link to improved care of the girl child.
  - » Greater attention to pregnant mother's health and early infancy timely interventions.
  - » Promote early and exclusive breastfeeding for the first six months of life and optimal infant and young child feeding.
  - » Respond to improve care, feeding, health referrals.

#### Interpretations of growth curves:-

- An upward growth curve, showing adequate weight gain for age of the child indicates the child is growing and healthy.
- A flat growth curve indicates child has not gained weight and requires attention.
- A downward growth curve indicates loss of weight and requires immediate attention.



#### Filling weight-for-age MCP chart

(10 minutes)

- Distribute one weight-for-age chart to each participants and ask them to fill it.
- Ask other trainers to help trainees.
- Ask participants what is the nutritional status of the child according to their growth charts.

VI. Summarize (5 minutes)

- 1. Growth monitoring helps in early detection of faltering in the weight, length and weight-for height of a child.
- 2. As WHO growth charts are universal hence these can be used in any part of the country. Separate growth charts should be used for boys and girls.
- 3. If length/height of a child is normal for age but his/her weight is below "-2" line then it shows that malnutrition is acute or recent in origin.
- 4. If length/height of a child is below "-2" line for age but his/her weight is between "0" and "-2" lines then child is designated as stunted; it shows that malnutrition is chronic.
- 5. If weight for length/height at any age is below "-3" line, then it is described as severe acute malnutrition (SAM) which is a very serious form of undernutrition.
- MCP Card- An upward growth curve, showing adequate weight gain for age of the child
  indicates the child is growing and healthy. A flat growth curve indicates child has not gained
  weight and requires attention. A downward growth curve indicates loss of weight and requires
  immediate attention.



SESSION

24

### **Measuring Growth: Taking Action**

#### **Objectives**

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

- Counsel mother to improve growth faltering.
- Make referral to specialized center.

#### **Session outline**

(60 minutes)

I. Introduction

(10 minutes)

II. Role-play

(40 minutes)

III. Summarize session

(10 minutes)

#### **Preparation**

- 1. Read how to conduct role-play.
- 2. Arrange filled WHO growth charts-- weight for age, length/height for age and weight for length/height for different ages and sex.

I. Introduction (10 minutes)

- ☐ Make these points
  - Growth monitoring is an important tool to detect growth faltering at a very early stage.
  - If growth line is following the path between +2 and -2 lines on the growth chart and showing an
    upward trajectory then it shows that child is receiving optimal nutrition and is free from illness.
    Health worker should praise mother and counsel her to reinforce optimal infant and young
    child feeding practices.
  - When a health worker finds that child's growth line is deviating from beyond +2 or below -2
    lines, or there is growth faltering, s/he should take history of breastfeeding; when breastfeeding
    was initiated, whether it was exclusive breastfeeding, and difficulty being experienced by the
    mother.
  - Then enquire about introduction of solid foods. When, what and how complementary feeding is being done?
- Ask: What other information will assist health worker to understand the situation and help her/him to counsel mother?

  (Wait for few answers, thank the participants) and then continue—
  - Look whether child's weight for age and weight for length/height and weight for length/height fall beyond a line representing "-3". If it is, then it indicates severe malnutrition and carries high risk of death and disability. The child requires immediate medical attention.
  - Enquire how much time mother spends away from the child and who generally feeds the baby. Whether she breastfed elder sibling if there was one?
  - Observe and assess breastfeeding and take history of breast conditions.
  - Enquire about difficulties in feeding solid foods by using 'listening and learning skills', ask about consistency and variety of foods being given to the child and if feeding is responsive.
  - Then build mother's confidence by using 'confidence building' and 'checking understanding' skills to improve IYCF.
  - Follow child weekly to record weight. It is the weight which increases first after feeding improves.
  - Assess feeding on follow up. If growth pattern is not satisfactory ask about difficulties and constraints in practicing optimal infant feeding. Enquire about consistency of food and its quantity. Counsel for breastfeeding for two years or beyond.
  - If weight does not improve after 2-3 weeks after counselling or shows downward trend, then refer the child to a health facility for further management.

II. Role-play (40 minutes)

- Prepare for role-play. Tell participants that they will practice how to counsel mother after growth monitoring. Participants will sit in groups of 4-6 with a trainer.
- Give filled up growth charts of any sex or age, one for each trainee, to the trainers. The trainer will sit with his/her group and distribute one growth chart to each trainee and ask them to read it carefully.
- One participant will act as mother and another, as health worker. Other trainees will observe.
   The health worker will greet mother, praise her for keeping growth chart and request her to show it.

Trainers' Guide

- Health worker will observe growth line and will counsel accordingly.
- Every participant will take turn to be mother or health worker. The trainer will give comments and help participants to practice counselling after growth monitoring.

III. Summarize (10 minutes)

- ☐ Make the following points:
  - Growth monitoring gives an opportunity of frequent assessment of the weight and length/height of the child.
  - There are two situations. Either child is growing normally, when there is an upward trajectory and growth line is falling between +2 and -2 lines on the growth chart, or there is growth faltering, when growth line is deviating from beyond +2 or below -2 lines on the growth charts.
  - If child is maintaining normal growth then mother should be praised and counseled to continue optimal feeding practices.
  - However, if there is growth faltering, then feeding history should be elicited and mother should be counseled to adopt optimal infant and young child feeding.
  - Child should be followed up regularly. If there is no improvement in the weight gain after 2-3
    weeks or if child is severely malnourished then s/he be referred to health facility for further
    management.

SESSION

25

#### **Clinical Practice-3**

#### Measuring weight and length

#### Counselling for infant feeding

#### **Objectives**

At the end of clinical practice participants will be able to:

- Take weight and length of children 0-5 years of age.
- Determine nutritional states by filling WHO growth chart.
- Counsel mother for infant feeding.

Session outline (120 minutes)

Participants are together as a class led by one trainer to prepare for the session and to discuss it afterwards.

Participants work in small groups of 4-5 each with one trainer for clinical practice in a ward or clinic.

I. Prepare the participants (20 minutes)

II. Conduct the clinical practice (80 minutes)

III. Discuss the clinical practice (20 minutes)

#### **Preparation**

- 1. Refer to "introduction" to conduct clinical practice session.
- 2. Make sure that you know where the clinical practice will be held. Visit the wards or clinic if you have not done so before.
- 3. Study the instructions in the following pages, and ask other trainers to study them also. Make sure that you are clear about how this session differs from previous clinical practices.
- 4. Give one set (boy and girl) of weight for age, length for age and weight for length growth charts (<2 years of age) to each participant.
- 5. Give a measuring tape to each group.
- 6. Make two weighing scale available (weighing scales should weight minimum 50 gm)
- 7. Bowl, food consistency photo and list of key messages.

Make sure that you and other trainers each have a copy of the **CLINICAL PRACTICE DISCUSSION CHECKLIST**.

#### As you follow the text, remember the signs:

- ☐ An instruction to you, the trainer:
- What you, the trainer, say to the participants
- That you ask participants for their help.
- That you should write on a board or flipchart.
- General instructions, e.g., how to do a task or series of major points.

Do not present the Further information sections.

Use them to help you to answer questions.

#### I. Prepare the participants

(10 minutes)

☐ Explain the objectives of the exercise:

You practice all the clinical and counselling skills that you have learnt.

You will work in groups.

- ☐ Explain what participants should take with them:
- Take with you:
  - » one copy of the COUNSELLING SKILLS CHECKLIST
  - » pencil and paper to make notes.
  - » Growth charts one set (boy and girl) for weight for age, length for age and weight for length
  - » Bowl, food consistency photo, one measuring tape for each group.
  - » List of key messages to each participant. You have to focus today on Dietary Recall Forms. Have a copy of Dietary Recall Form.
  - » Have a copy of key messages for complementary feeding.
  - » Have a copy of WORKSHEET CLINICAL PRACTICE 5.

You do not need to take anything else.

#### II. Conduct the clinical practice

(90 minutes)

- ☐ Take your group to the ward or clinic:
  - Allot a mother and baby pair (6-23 months) to the group.
  - Keep minimum cloths on the baby and take shoes off the baby.
  - Adjust "zero" of the weighing machine and take weight. Read and record weight.
  - Next take length in lying down posture.

If a mother has a difficulty, participants can help her. Discuss with them what they do, to make sure that they give appropriate help.

If possible ask a responsible member of staff of the facility to be with when you help a mother.

- Ask participant to fill up growth chart.
  - Once they have completed the growth charts take them away from the mother, and discuss what they did, and what they learnt.

Trainers' Guide

- » Ask them to tell you about the nutritional status of the baby and how to help mother for practicing optimal feeding for her child.
- » Go through the CLINICAL PRACTICE DISCUSSION CHECKLIST to help you to conduct the discussion.
- » Discuss what they learnt from the mother, and if her situation is common or unusual. Discuss what else it might be possible to do in other similar situations.

#### WORKSHEET 25.1: Summary of Small Group's Diet Recalls

Recommendation	Practice exists	Practice does NOT exists
Continue breastfeeding		
Ate animal food yesterday (meat/fish/offal/bird/egg)		
Eat animal product daily (meat/fish/offal/bird/egg)		
Ate vitamin A rich vegetable or fruit yesterday		
Eat a vitamin A rich vegetable or fruit daily		
Quantity of food eaten adequate for age - yes		
Eat at least 2 foods with a thick consistency		
Number of meals and snacks adequate for age		

#### III. Discuss the clinical practice

(20 minutes)

The whole class comes back together to discuss the clinical practice, led by the same trainer who led the preparatory session.

- Ask one participant from each group to report briefly on what they learnt:
- ② Ask them to report on the most interesting situations that they observed among the mothers and babies whom they saw, and what they learnt from them.

If participants have not finished seeing mothers and babies at the end of the 90 minutes allowed for it, they can continue and finish, and if necessary omit the class discussion.

You must decide what the most useful way to spend this time is.

SESSION

#### Practice - 1

#### **Preparation of Complementary Feed**

#### **Objectives**

• Participants will practice making complementary feed-one meal for their child.

#### **Session outline**

- I. Introduce the topic
- II. Preparation of feed
- III. Discussion

#### (60 minutes)

(5 minutes)

(40 minutes)

(15 minutes)

#### **Preparation**

Make available foods like:

- 1. Cereals (over cooked rice, bread, etc.), cooked pulses (legumes, beans),cooked vegetable (green, yellow), boiled leafy vegetable, potato(boiled), milk, curd, butter/ghee/oil, boiled egg, fruits (banana, orange, etc.), sugar, lemon.
- Plate, bowl (250-300 ml) spoon for each group.
   Service plate and service spoons, towels.
   Keep them on a table kept at the corner of the training room.

#### I. Introduce the topic

(5 minutes)

Participants will work in small group of 4-5 each with one trainer

One trainer will prepare participants

- How to conduct clinical session.
- Discuss the clinical session with the groups.

#### □ Explain objectives-

Give each group children in different age groups, eg. 7, 10 and 15 months, etc., child and ask them to prepare feed (one meal) for that child.

Also tell them to write 3 key messages on a paper about the food.

#### II. Preparation of feed

(40 minutes)

#### **Explain how participants will work:**

You will work in a group of 4-5 each with 1 trainer. Two of the participants from each group will go to the table where cooked food is kept and bring the ingredients in the plate for making one meal for their child.

#### WORKSHEET 26.1: Amount of Food in 1 meal of a young child?

Ask participants to choose foods that have been provided for the demonstration and mention the amount of different foods for one meal for a young child aged 7, 10, 12 and 15 months.

Amount of food for 1 meal	Age			
(cooked/ripe)-table spoon/tea spoon	7 Months	10 months	12 months	15 months
Rice				
Bread				
Raggi				
Maize				
Potato				
Bengal gram				
Beans				
Legumes				
Thick pulse				
Vegetables				
Fruits				
Banana				
Orange				
Liver				
Egg				
Fish				
Cured				
Yoghurt				
Oil				
Butter				
Ghee				
Sugar				

What key message could you give for each of the foods you have chosen?	

- Whether hygiene was maintained (hand washing, etc.)
- What all ingredients were taken?
- How much quantity was taken?
- What is the consistency made? Trainer will demonstrate how to evaluate consistency. Take some prepared feed on a spoon and demonstrate that it stays there.

Put two spoonful of prepared feed on a plate. Tilt plate at 30° and show whether:

- 1. Feed travels and takes tongue shape—good consistency.
- 2. Feed travels fast or runs. Thin consistency.
- 3. Feed stays at plate and does not move. Consistency is hard and very thick.

#### III. Discuss participant's performance

(15minutes)

Discuss with each group about following points:

- Hygiene maintained while preparing food--safe hands, safe utensils, safe surface, etc.
- Quantity of food prepared -according to age of the child.
- Quality of food prepared (what all in gradients added).
- Consistency of food prepared.
- What message written on the paper.

Thank the participants and summarize.

SESSION

Trainers' Guide

#### Practice - 2

#### **Preparation of Replacement feed**

#### **Objectives**

• Participants will be able to make one replacement feed - one feed for the newborn.

#### **Session outline**

(60 minutes)

I. Introduce the topic

(5 minutes)

II. Preparation of feed

(40 minutes)

III. Discussion

(15 minutes)

#### **Preparation**

Read the introduction

Participants are divided in 4 groups led by one trainer.

Make available these ingredients and equipments - on a table kept at the corner of the training room.

- Formula milk (tin), animal milk.
- Sugar.
- Measuring jar/glass (preferably see through).
- Spoon to stir and level the milk powder measuring scoop.
- Sauce-pan (with lid) to boil water.
- Piece of cloth for mopping and holding the hot pan.
- Drinking water.
- Katori with cover to feed the child.
- Arrange burner, stove, hot plate, and chulha for boiling the water.

Arrange four mattresses for four groups for sitting and working.

Give one sheet to each group for writing. One or two participants may be asked to perform each of the following tasks.

- How much time was taken in boiling the water?
- How the amount of powder was measured?
- How much time it took to prepare one feed?
- How cleanliness was observed: hand washing, covering water container, and covering prepared milk feed?

#### I. Introduce the topic

(5 minutes)

One trainer will prepare all participants in the class.

#### Make these points:

- Mothers who choose not to give breastmilk need to know how to prepare replacement feeds for their Infants.
- It must be prepared in the clean and safest possible way
- It is important to measure these feeds accurately as small differences which might not matter for one or two feeds may have a serious effect if they are repeated for every feed.
- Mothers need to practice this skill in the presence of health worker.

#### **Explain:**

- How to conduct clinical session each trainer will take his/her group and ask them to sit on the
  mattress. One measuring jar, spoon, katori with cover, and cloth piece and sauce-pan will be
  given to each group. One group will be given task to prepare milk feed for 2 months (90 ml) old
  baby; another group may prepare meal for 4 months (135 ml) old baby and so on.
- Each group will be asked to write on a paper regarding time taken to boil water + in measuring and preparing one feed.
- Different groups would be tasked to boil water on gas, stove, hot plate and chulha respectively.
- Each trainer will help group to prepare one accurate and safe feed for the infant.
- Discuss the clinical session with all the groups in the class after the practical session is over.

#### II. Preparation of feed

(40 minutes)

#### **Explain how participants will work:**

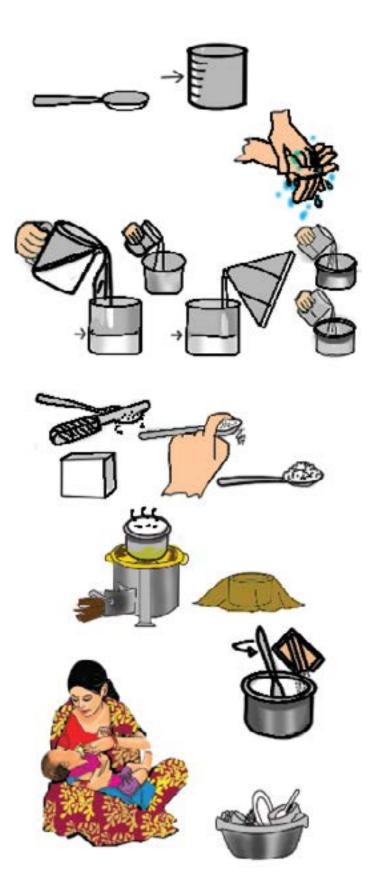
- Each group will go to the different (4) corners where gas burner, stove, hot plate and chulha is kept.
- Two of the participants from each group will boil the water on different heating gadgets.
- Another two participants from each group will note the time taken to boil the water.
- Now the group will go to table where commercial milk formula tin is kept and bring the
  ingredients (milk powder) in the glass for making given amount of milk feed for the child Then
  they will mix it with required amount of water.
- Again time required is noted.

All group members will take part in preparing the milk feed. Trainer as well as one participant from each group will observe the following things-

- Whether hygiene was maintained (hand washing, etc.).
- How quantity of milk powder and water was measured to prepare given amount of feed?
- What was the total time taken to prepare one feed?
- How temperature of the feed (prepared) was tested to say that feed is ready for the child to consume?

### TA 22.1: Simple instruction for preparing milk (These instructions are helpful teaching even illiterate mothers)

Fresh Milk Feeds for (name) \_\_\_\_\_ (born) \_\_\_\_ from (date) \_\_\_\_ Make \_\_\_\_ ml for each feed. Feed the baby \_\_\_\_\_ times each day (24 hours)



Always use the marked cup or glass and spoon to measure the feeds.

Wash your hands before preparing a feed.

Fill the cup or glass to the mark with water. Pour the water into the pot.

Fill the cup or glass to the mark with milk. Add to the water in the pot.

Use 2 measures of milk and 1 measure of water.

Measure the sugar. Use the spoon filled the way it is marked in the picture. Put in \_\_\_\_\_ spoonfuls.

Bring the milk and water to the boil and let it cool. Keep it covered while it cools.

Add the micronutrients to the feed. Stir well.

Feed the baby using a cup. Wash the utensils.

Come back to the healthcentre on

-----

### TA 27.2: Simple instructions for preparing milk Commercial infant formula

Feeds for (name) \_\_\_\_\_ (born) \_\_\_\_ from (date) \_\_\_\_ Make \_\_\_ ml for each feed. Feed the baby \_\_\_\_ times each day (24 hours)



Always use the marked cup or glass and spoon to measure water and the scoop to measure the formula powder.

Wash your hands before preparing a feed.

Bring the water to the boil and then let it cool. Keep it covered while it cools.

Measure the formula powder into the marked cup or glass.
Make the scoops level.
Put in \_\_\_\_scoops.

Add a small amount of the cooled boiled water and stir. Fill the cup or glass to the mark with the water. Stir well.

Feed the baby using a cup.

Wash the utensils.

Come back to the health centre on \_\_\_\_\_

#### III. Discuss participant's performance

(15minutes)

Discuss with each group about following points-

- Whether hygiene was maintained while preparing food--clean hands, clean utensils, clean surface, etc.
- How quantity of milk powder was measured?
- Time required in preparing one feed by different group (time in boiling of water + measuring and preparing feed +time in cooling the milk).
- ☐ Ask participants about cost of formula feeding.

Wait for few answers and then enumerate direct and indirect costs.

Buying formula, fuel, detergent for cleaning, bottle and nipple are direct cost of artificial feeding. Indirect cost involves discarding of excess amount of prepared milk, fetching milk from the market, time and money spent on healthcare as artificially fed children are more prone to develop diarrhoea and pneumonia.

Thank the participants and summarize.

## **NOTES**

### NOTES

## **NOTES**



