ACF-INTERNATIONAL

MANUAL FOR THE INTEGRATION

OF CHILD CARE PRACTICES AND MENTAL HEALTH INTO NUTRITION PROGRAMS

ACF INTERNATIONAL

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Introduction

Malnutrition, whether it is acute, chronic or linked to micronutrient deficiencies, can have permanent negative consequences on infant development. Most studies (Grantham-McGregor/Rossetti-Ferreira) carried out on acute malnutrition show a delay in mental development that lasts until adolescence and results in greater difficulties as an adult.

Improving the family's ability to adequately and sufficiently care for and fulfil children's needs contributes to increasing the efficacy of the treatment, ensuring children's healthy physical and emotional development and reducing the underlying growth delay due to malnutrition. (See MHCP technical papers, MHCP policy, etc.)

Fact sheets on childcare practices give conceptual and theoretical data on the necessity of combining prevention and treatment of severe malnutrition with mental health and child care practices. The most basic child care practices program forms an integral part of malnutrition treatment, in which attitudes, words, organization and implementation of specific programs all come into play at each step. Everyone must apply these practices in the Therapeutic Feeding Centre (TFCs) whether it is during the admission stage, playtime or mealtime, or even during outpatient treatment. The same applies to patients' wellbeing, health and recovery!

This allows nutrition program experts to implement child care practices through simple actions. In some cases, a psychologist or psychosocial workers in the program may need to address specific psychological and social aspects.

This manual is designed as a tool-kit to provide you with the key steps on how-to-do-it.

It provides you with a series of fact sheets to improve your understanding and enable you to use the basic package for child care practices at Therapeutic Feeding Centres (TFCs) or during outpatient treatment at Outpatient Therapeutic Program (OTPs) centres.

Treatment for malnutrition is increasingly integrated into healthcare facilities, making it more difficult to integrate the basic package for child care practices. However, recognizing that the integration of basic practices can make a big difference, several studies have shown its positive impact on the efficacy of the treatment (especially in reducing the number of relapses and discontinuation of treatment) and on the development of malnourished children. This research prompted WHO and ACF to consistently include this aspect in their malnutrition treatment programs. Practically speaking, treating malnutrition in health centres involves making adjustments and being creative, which you must demonstrate when integrating the basic package for child care practices. In light of this, ACF has a lot of experience to share in order to guide you. For example, recommendations on childhood illnesses include a chapter on how to promote child development. Mental Health in primary healthcare services is increasing, especially through WHO's initiative with Mental Health Gap Action Programme (mhGAP) (WHO, 2011). The information in this manual should help you to implement the basic package for child care practices through the synergy of services offered to our target populations.

The fact sheets on each topic have the same structure, as follows:

Remember: the main points on the topic covered in the fact sheet.

Understand: few basic theoretical points and concrete explanations allowing you to understand in what way mental health and child care practices are essential in the area covered by the fact sheet.

Implement: Practical information on how to implement child care practices within the topic covered.

Some fact sheets are accompanied by appendices that illustrate or supplement all these points.

You will also find links to websites that provide further information on specific topics.

1 - Depending on the country, therapeutic feeding centres and outpatient feeding centres may be referred to by different names (e.g., in Haiti they are called USN and PTA; in the Central African Republic they are called UNT and UNTA; etc.). Treatment received by children at outpatient care centres is also called home treatment.

Of course, your comments and suggestions are most welcome. They will help us to improve this manual and bring it ever closer to the realities and expectations encountered in the field!

Enjoy the reading!

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The 1st version of this manual was done in January 2006 by
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ACRONYMS & DEFINITIONS

MHCP	Mental Health Care Practices
RUTF	Ready-to-use Therapeutic Food
OTP	Outpatient Therapeutic Programme
TFC	Therapeutic Feeding centre
Feeding centres	TFC + OTP centres
MUAC	Mid-Upper Arm Circumference
SST	Supplementary Suckling Technique
Therapeutic Milk	F75 – F100
Appetite Test	The appetite test is a decisive criterion for participating in the outpatient program. The test is performed upon admission and during all follow-up sessions to ensure that the child is able to eat the ready-to-use therapeutic food (RUTF). If the child has no appetite, he must be admitted into a hospital program.
Outpatient Home Treatment	Treatment received by children at outpatient feeding centres.

I. THE DIFFERENT TYPES OF TREATMENT FOR ACUTE MALNUTRITION

REMEMBER

➔ There are many criteria for referring severely malnourished children to Therapeutic Feeding Centres or Outpatient Therapeutic Centres.

➔ The Therapeutic Feeding Centre (TFC / in-patient) admits children under 6 months, children suffering from medical complications requiring hospitalization, children who failed the appetite test and, in general, children for whom home-based treatment is not possible.

➔ Home treatment has satisfactory results and allows access to more patients over larger geographic areas, resulting in broader coverage.

➔ Feeding centres and home-based treatments must offer programs aimed at improving child care practices and mother-child relationship.

UNDERSTAND

1. THERAPEUTIC FEEDING CENTRES (TFC)

Therapeutic Feeding Centres are places that are specially adapted and equipped to care for and treat children suffering from severe acute malnutrition. Children are admitted in the company of a caregiver, usually and preferably the mother.

Children are cared for 24 hours a day and receive complete treatment to combat their malnutrition, as well as basic vaccinations and treatment for any medical complications they may have. They are also monitored continuously. However, some patients may undergo daily treatment (for example, if they live or are staying nearby).

In addition to providing children with personalized, adaptable treatment, the centres also offer various programs aimed at preventing any risk of relapse. These programs vary depending on the centre and the staff available, but in general the main objectives are to educate the caregiver and to improve good practices (feeding, hygiene and child care practices). Some programs also help in strengthening the mother-child bond, promote child development through games and child stimulation, and offer assistance and personal attention to the mother if there are specific needs (such as breast milk insufficiency, depression, rejection of the infant, apathy, etc.).

TFCs care for children who are severely malnourished and present medical complications, children who fail the appetite test (in fact, a lack of appetite does not allow for having efficient home-based treatment), children under the age of 6 months not suited for Outpatient Therapeutic Program (OTP). There are also children who do not receive adequate care practices or children whose caregiver is not in a position to properly care for the child.

The child may be referred to a Therapeutic Feeding Centre immediately upon the first consultation or as a transfer from home treatment if the latter proves to be ineffective (weight loss or delay, failure of appetite test, occurrence of medical complications, etc.).

The treatment lasts about one month but may vary depending on the child's situation and condition (whether home treatment is possible, whether there are any associated illnesses, etc.).

TFCs are either run independently or are integrated in clinics or hospitals.

2. OUTPATIENT THERAPEUTIC PROGRAMS (OTP) CENTRES

In the last few years, improvements in products, such as Ready-to-use therapeutic food (RUTF), used to treat malnutrition, along with growing community involvement, has led to the development and implementation of malnutrition treatment programs that can be performed at a child's home. This has resulted in greater geographical coverage and allows more people to benefit from such treatment programs.

Using a community-based approach in the fight against malnutrition also helps to strengthen the prevention, detection and treatment of malnutrition through various activities (group discussions, home visits, etc.).

Implementing an outpatient feeding program requires specific organization and must be adapted to a particular context, depending on the means and resources available. Home treatment programs are generally managed by the same authorities, which run therapeutic feeding centres, out of child care centres or non-medical facilities located as closely as possible to the populations being treated.

Patients admitted for home treatment come in each week to OTP in order to check whether the treatment is working well (measurements, medical consultations, appetite tests). Caregivers take part in awareness sessions (hygiene, diet, health, child care practices, etc.) to enable them to take better care of their children and improve their knowledge in order to obtain sustainable results and avoid relapses.

If a decision is made to pursue home-based treatment, the child will receive the necessary quantity of RUTF for one week.

Most patients can adequately benefit from home treatment.

The mental health aspect and child care practices should be integrated into OTPs when the treatment is first implemented, during its course and during follow-up.

This integration is achieved through specific trainings and by implementing particular programs that, depending on the context, may help improve child care practices, child wellbeing and understanding of the importance of child care in the fight against malnutrition and how to treat it.

In addition to being part of the possible underlying causes of malnutrition, some aspects related to child care practices and mental health could also explain some of the failures of the outpatient program and the referrals to inpatient treatment. Thus, it is essential to identify how best these aspects can be integrated into home treatment programs.

3. THE PROS AND CONS OF THE DIFFERENT TYPES OF TREATMENT

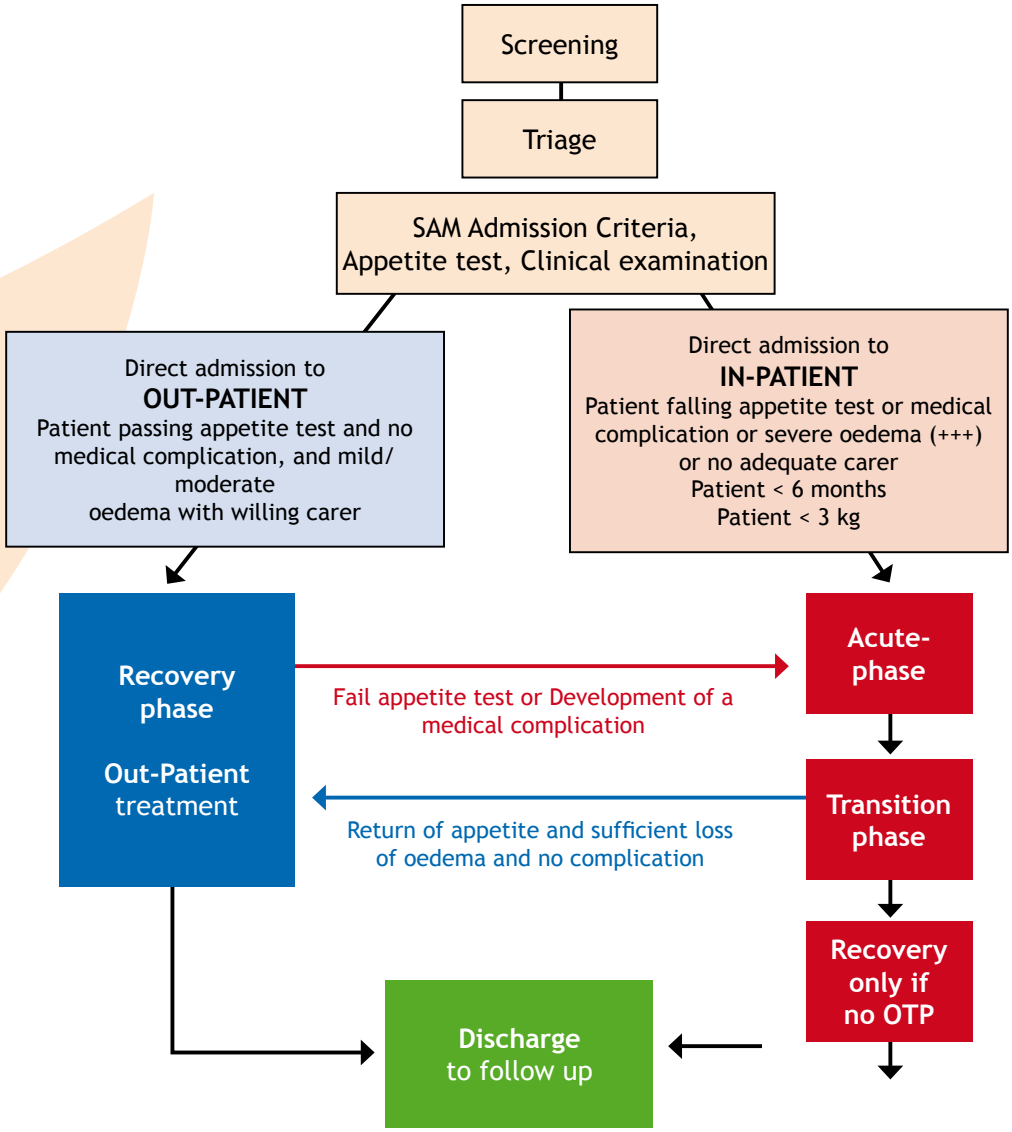
There are pros and cons associated with each type of treatment described above.
The goal is to consider patients' needs as carefully as possible in order to find the best and most appropriate solution given their health status and living conditions. In general, both types of treatment coexist in the programs implemented by ACF.

IMPLEMENT

As discussed earlier, it is of prime importance to refer children, suffering from severe malnutrition, to the type of treatment that is best adapted to their situation[2].

The following chart illustrates the different criteria that can be used for referring or redirecting patients to a TFC or to an OTP.

Table 1: Referral chart to guide beneficiaries towards the appropriate treatment.



2 - A large number of reference documents as well as videos produced by UNICEF concerning severe acute malnutrition and home treatment are available by following this link: http://motherchildnutrition.org/resources/index.html#Ethiopia

II. MAINTAINING A WELCOMING CARE ENVIRONMENT

REMEMBER

➔ The environment in which children and caregivers are admitted is of critical importance, and must be as reassuring and welcoming as possible.

➔ The areas dedicated to different activities must be well defined and, enable the easy movement of people from one area to another.

➔ Children and caregivers must feel at ease and feel that they are understood and listened to, and that their concerns are properly taken into consideration.

UNDERSTAND

Day-to-day life in feeding centres is often difficult. Some simple interventions could help to make things a lot less burdensome and more comfortable and pleasant.

This implies taking full account of the needs of both the beneficiaries and their caregivers.

Improving daily living conditions aims to:

- Recover a taste for life.
- Provide a reassuring and welcoming environment.
- Take into account the psychological wellbeing of beneficiaries (malnourished children and caregivers).
- Provide a listening space. Reduce the incidence of relapse and the giving up of treatment.
- Avoid situations where medical and nutritional care have negative or harmful consequences on the people concerned ("do no harm' principle)
- Re-build social ties.

IMPLEMENT

In order to create an atmosphere and an environment that are as pleasant as possible, the team must manage working under pressure, the difficulties faced and be motivated to share experience and engage in dialogue. The members of the team must take pleasure in their work: their contributions will then be all the more efficient!

Working with pleasure in a friendly atmosphere is of prime importance. Seeing malnourished beneficiaries, women in distress and babies dying are difficult situations to face. Encouraging time to be set aside for relaxation and play, and seeing beneficiaries smile help the team to get its energy and motivation back in order to able to continue.

The wellbeing of beneficiaries and caregivers depends a lot on the attitude of staff members who must be friendly, respectful, and warm, must take time to listen and to respond…

Simple gestures can have a big impact. Smiling or taking someone by the hand can be very comforting. The attitudes described in the section of this guide dealing with the welcome of beneficiaries will be adjusted to ensure that daily life in nutrition centers is made as pleasant as possible, which in turn will have positive effects on the treatment.

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1. LIFE IN CENTRES - CONTEXT AND ENVIRONMENT

The centres welcome both adults and children. Everyone can participate in activities.

Improving the organization of centres greatly helps the healing process, taking into account not only technical issues, but also human ones. These criteria gather all aspects relating to “life setting” or to the “living conditions” in the centres. This includes the decor and the creation of spaces to rest, meet or relax:

- Play areas outside of the phases.
- Resting area which can be used for awareness sessions.
- Kitchens for accompanying persons.
- Play corners within the phases of treatment activities.

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In addition, it would be appropriate to improve the living environment, striving to decorate it to give it a friendly and cosy appearance.

Decor is of critical importance: an austere environment is not stimulating. Aging buildings and poorly maintained facilities can give beneficiaries a poor image of themselves. They have to already endure lack of privacy, close proximity to their neighbours and a noisy surrounding. The atmosphere can be made friendly and more welcoming by utilizing appropriate colours and providing proper ventilation systems to avoid excess heat. Providing shady areas and places where people can sit are vital, especially when they are long queues.

If the manager of the centre is enthusiastic and engaged in this refurbishment project, decorating the centre can be a joint endeavour involving everyone, including beneficiaries and caregivers who can be invited to participate in activities. With some ideas and material, a facilitator can organize training sessions with a view to create decorations, and thereafter install them in the centre. These sessions offer many advantages such as a more pleasant living experience in the centre, develop people’s creativity, provide a space for relaxation, and develop expertise and know-how that could be utilized in the future.

Creativity is for everyone and could have a very strong impact on people, both in terms of development of their personality and their wellbeing. Examples of toys, which can be created, can be found in internet.

2. LIVING CONDITIONS IN OTP CENTRES

a. Offer a convenient, well-adapted and welcoming environment

The centre receiving children and their parents during the OTP visits must be organized in a way as to facilitate the shifting from one stage of treatment to another. It must be properly arranged and also as comfortable and pleasant as possible. Sometimes the OTP centre is nothing but a space under a tree. This should not stop those concerned from thinking of how best to organize the space in an appropriate way; for example, one might think of having meeting spaces in the shade; providing access to water (often people have walked long distances to get to the OTP centre), limiting waiting time, proposing activities while waiting and informing beneficiaries about the treatment process.

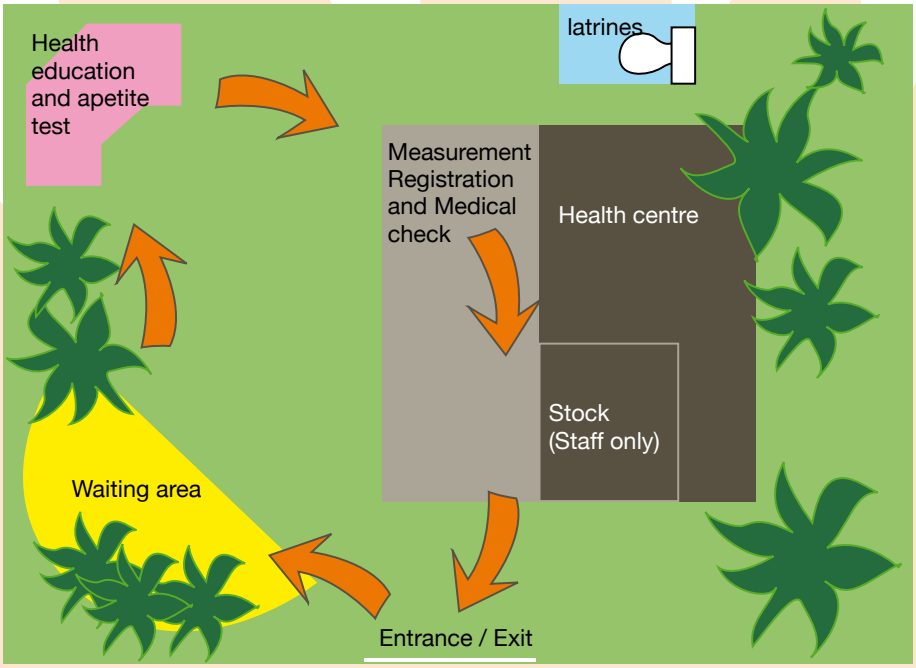

Table 2: Flow of traffic in an OTP.

Special areas for appetite testing, games and awareness-raising sessions must be specifically identified and, when possible, located away from the examination areas.

Separate zones should be made available to children and their caregivers, in order to provide calm spaces away from the hustle and bustle.

Some people spend several hours walking to get to the centre, leaving aside their other domestic priorities for an entire day. An unfriendly welcome or an austere and poorly organized environment could discourage them from coming back the following week, whereas smooth organization, a warm welcome and an appropriate management would all contribute to encouraging them to follow their treatment diligently in its entirety and given its constraints.

As for the follow up of children in the context of home treatment, their attendance at each visit is very important to the success and monitoring of the treatment.

In addition, an environment and a setting that is pleasant and well-suited to treatment will serve to motivate the surrounding populations to visit the centres, enabling coverage of a larger population, and more timely treatment for children suffering from malnutrition (word of mouth operates well in most of ACF areas of intervention).

The setting plays a role in strengthening the trust of beneficiaries, an essential component in all the levels of program implementation (detection, information exchange, treatment and follow-up).

Components of the care environment of OTP centres must reflect what seems important to us for the well-being of the child: availability of clean water, good hygiene practices and absence of any potential risks for the safety of the children. OTP centres must serve as an example; it is therefore of prime importance that OTP staff respect the same basic health and safety principles they require beneficiaries to follow at home.

The table above enables us to illustrate how an OTP centre can be organized in order to ensure smoother travel from one zone to another, as well as to identify specific zones for each activity.

b. The Waiting Period

As regards to weekly visits made by the beneficiaries receiving home treatment, the waiting period could be very long. Families may have to walk for several hours to get to the OTP centre where they must wait patiently for admission to the different treatment procedures (appetite testing, awareness-raising sessions, measurements, medical consultations and distribution of therapeutic supplies for the following week of treatment).

If the OTP is well-organized, it will reduce the waiting time significantly; however in general, waiting times are still considerable.

The waiting area should be clearly defined and should be as comfortable as possible (e.g. tarpaulin spread out on the ground, in a shady area, etc.).

It may be appropriate, where possible, to organize different waiting areas for patients in on-going treatment arriving for weekly visits and for patients coming for the first time.

The teams could take advantage of the waiting period, either by saving time and taking measures while the beneficiaries are waiting (MUAC-mid upper arm circumference measurement, notably) or by setting up specific activities.

Toys could be made available to children in order to foster mother-child interactions during the waiting period.

Guided group discussions could be organized, focusing on care practices, with a view to highlighting good practices and their importance for child development and treatment.

III. WELCOMING BENEFICIARIES

REMEMBER

➔ The welcome phase represents the beneficiaries' first contact with nutrition centres.

➔ People arriving at nutrition centres feel often helpless or anxious, and need support during the entire admission process.

➔ The entire team must be involved in welcoming beneficiaries.

➔ The welcome phase is an integral part of the treatment.

➔ Each beneficiary must be informed about the process of patient care management.

➔ A proper welcome entails that all the members of the team must have a good understanding of beneficiaries and of their situations; they must adopt appropriate attitudes and effective organization of the entire process of patient care management.

UNDERSTAND

The welcome phase includes all the steps, from arrival up to the integration or non-integration into the program. It focuses on the beneficiary and the caregiver, who most of the time is the mother.

When they arrive, they rarely know what malnutrition is, and they do not know anything about the organization of the treatment and the life in the centre. They have a lot of doubts and questions, which they are sometimes afraid to ask.

Upon arrival, caregivers and the child they are in charge of may be driven by various feelings that can sometimes be difficult to deal with. Of course, it is important to observe and talk with both children and caregivers in order to understand their background situation. Listed below are a few examples.

1. The mother[3] (AND/OR THE CAREGIVER)

- **Worry and fear:** she is faced with the seriousness of her child's health condition and wonders if he/she will survive.
- **Fatalism:** she often has difficulty to keep hope for the healing and survival of her child.
- **Confusion:** she usually does not understand the causes of her child's illness and does not always make the connection between malnutrition and its symptoms. It is possible that she may have visited traditional healers or the hospital on repeated occasions, which could explain the long period that sometimes elapses between the beginning of the illness and her arrival at the centre.
- **Anxiety:** the emergency situation in which she finds herself usually causes a hasty departure from home, leading to problems that are sometimes difficult to solve, notably when she needs to reach the centre quickly with her child: How will her absence impact the rest of the family? Who will take care of the other children? Who will manage the home? Will the husband accept her prolonged absence? Families must be well organized so that an adult can stay at the centre with the child; however this is not always easy.

3 - Even though the discussion here is focused on the mother, it is clear that all the observations on the subject of the mother, both in this chapter as well as in the rest of the guide, could be applied to any accompanying person.

- **Apprehension:** most often she does not know how daily life is organized in the centre and she may be apprehensive about community life such as day-to-day living with other people that she doesn't know (other mothers or caregivers, medical teams, etc.).
- **Doubt:** usually she is unfamiliar with the proposed treatments and may sometimes doubt whether it was a good idea to make the trip, and question why she is staying in the centre and the efficacy of therapeutic milk/RUTF.

But the mother may also have positive feelings such as a sense of relief at seeing her child taken care of, a sense of hope at seeing a possible solution to the problem and the possibility of saving her child's life. Reinforcing these feelings will contribute to the smooth process of the mother's integration and involvement in the child's treatment and in the life in the centre.

2. THE CHILD

Upon arrival, the child usually in a state of severe malnutrition, with apathy, clinging to its mother as a consequence, but also often experiencing physical pain and suffering.

Arriving at the health centre, being measured, weighed and going from hand to hand could be frightening even terrifying for the child.

The context in which the child and caregiver arrive, their sense of insecurity and the stressful situations they experience are all factors that can make the situation particularly challenging.

The welcome is often the moment that will determine whether or not the mother will stay and follow the treatment. It is therefore very important that the initial contact with the staff be friendly and reassuring. To guarantee the success of the treatment and to prevent or at least limit abandonment, the team must ensure that the mother has well understood the causes and consequences of the malnutrition and the components of the treatment. In fact, she must support the recovery process of her child and provide part of the care treatments needed for full recovery.

> On the one hand, the objective is to involve the mother and to encourage her to take responsibility for her child's treatment, and on the other hand, to reassure the beneficiary, notably by establishing a welcome as warm and reassuring as possible.

IMPLEMENT

In order to improve the welcome to beneficiaries and caregivers and to make it both more effective and less difficult, several factors must be taken into consideration. You will find information in this section concerning:

- Training the team.
- Adopting appropriate attitudes.
- Concrete actions to put in place.

1. TRAINING THE TEAM

The team must take into consideration not only the medical and nutritional state, but also the psychological and social state of beneficiaries and caregivers arriving at the nutrition centre. The team must consider the fact that these people often do not know what malnutrition is: they are rarely familiar with medical terms such as MUAC (measurement of the mid upper arm circumference). In general they have heard neither of the percentage nor the weight-to-height ratio, and they do not necessarily understand the meaning and purpose of these measurements.

The members of the team must first well understand what malnutrition is and what the treatment entails, in order to be able to give clear, accurate and simple information to caregivers and children.

A few possible ways to train the team on the impact of the welcome on people arriving at the centres are to put on a skit or do small role playing exercises.

By putting themselves in the place of the beneficiaries, the members of the team can develop capacity for empathy. This could enhance their awareness of these aspects of care, based on simple situations that are part of their life experience:

- The manner in which they welcome the person who visits them at home;
- How they are welcomed when they visit the hospital, for example, how they feel when met with an unfriendly welcome.

It would thus become easier for them to understand the need for and the importance of a friendly welcome.

It is therefore essential to train the teams in **verbal and non-verbal communication**. For example, very often, staff members are standing up and looking down at the mother who is sitting on the ground or on a chair, thereby maintaining a position of dominance, and making it difficult for dialogue to take place and for the mother to raise certain issues openly.

Management style is also an important dimension to consider. On the one hand, working with children or adults suffering from severe malnutrition is extremely stressful and forces us to be faced with the reality of death. On the other hand, the demands placed on the manager in terms of ensuring a level of quality in the programs sometimes causes him/her to put a lot of pressure on the team, rather than seeking joint solutions for the improvement of care management. These are stress factors which could seriously undermine the team's capacity for empathy or even result in an aggressive attitude, which is most often directed towards the patients. The manager must therefore regard the well-being and comfort of his team (for example, work organization must both enable some flexibility for patients' needs and limit their waiting time, but also reduce work pressure on staff), provide time for dialogue and exchange, with a view to discussing cases, particularly difficult ones (case summaries) and to allow staff to express their emotions (supervision).

SMALL THINGS THAT MAKE A DIFFERENCE

- Smiling at the patient.
- Introducing oneself and explaining one's role and duties.
- Using simple words that are easily understood.
- Fostering communication in the person's native language.
- Always explaining interventions with the simple and appropriate words.
- Providing information on the health status of the child and on the proposed treatment.
- Giving feedback to the caregiver on the progress of the child during each medical consultation.
- Encouraging the continuation of treatment and congratulating the mother and the child.
- Working with the mother towards trying to understand the reasons behind the child's failure to gain weight and jointly seeking solutions that the mother could implement.
- Offering a moment for the mother to ask questions and taking time to answer them.
- Making the reception area as pleasant as possible (play areas, shady spots, availability of chairs, etc.)
- Making drinking water available.

2. ADOPTING APPROPRIATE ATTITUDES

The journey of the beneficiary and the caregiver from their home, to their admission and up to receiving care in the nutrition centres, is long and may be particularly complex from their point of view.

To facilitate these stages and reassure them, the members of the team must adopt attitudes that are both simple and effective.

They must be **calm, compassionate, warm, respectful, and non-judgmental.**

The following chart illustrates what people coming to nutrition centres may be feeling and the important attitudes that the team needs to adopt accordingly.

STAGES From screening to integration	POSSIBLE FEELINGS People coming to the centre or to OTP	ATTITUDES To be adopted by the team
Departure from home: persons identified by screening staff	**Fear** that the child might die **Ignorance** of the situation **Anguish** of leaving home for a long period of time **Lack of comprehension** about the child's illness **Doubts** on the organization, that they may not know anything about and on the effectiveness of the treatment.	**Smiling,** be welcoming and friendly
Departure from home: people coming spontaneously to the centre		**Introducing oneself** and the team, explain role of each member
		Explaining: with simple words the choices, interventions, malnutrition…
Arrival at centre/OTP: meeting w/ people at the reception	**THE MOTHER** **Lack of comprehension** about the process (what are these procedures for?) **Anxiety** about the sequence of events **Doubts** concerning care at the centre or at home **Relief** at being taken into care **Worry** about the situation at home	**Involving and empowering:** get the accompanying persons involved during measuring, handling the child…
Measurements and registration encounter w/measurement staff, recorders and nurses		**Listening and reassuring:** being available for questions and doubts, provide answers or referral to a competent person
		Adapting: adjusting one's discourse and behaviour to the mother and child
Integration at centre or OTP: meeting with other beneficiaries and accompanying persons and with the other members of the team.	**THE CHILD** Malnutrition could cause certain behaviours such as **irritability, apathy, fatigue, pain;** unknown environment and hospital setting**, fear and worry.**	**Accompanying:** directing people from one treatment stage to another
		Helping to find solutions, concerning, for example, the home
		Provide Referrals if necessary to other bodies/programs
Not admitted to the centre or in OTP: do not meet the criteria	**Lack of comprehension** about procedures and non-admission. **Anger** at being rejected, feeling of abandonment. **Relief** that the child is doing well, satisfaction of being assisted, supported, listened to…	**Presenting** the functioning of the centre, other accompanying persons and children

Table 3: Adjusting attitudes

3. PRACTICALLY SPEAKING, WHAT CAN BE DONE?

The entire team must be involved and trained in order to ensure that the beneficiary and the caregiver have the best possible welcome and care, thereby improving the efficacy of the treatment and well-being.

➡ Arrival at a nutrition centre

- From admission to treatment, make sure that someone is available to accompany and guide people at each stage (job descriptions must take into account the roles and functions of each member of the team.).
- People have sometimes walked long distances, and upon arrival, caregivers are often tired, weak or even malnourished themselves. It is important to make sure that they have received a snack and/or some water.
- Play areas should be available anytime for children and their mothers.

➡ Registration and measurements:

- It is important to explain all procedures and what has been accomplished, more particularly with regard to taking measurements, which will be repeated regularly during treatment: this is a basic component for monitoring changes in the child's condition and for adjusting the treatment.
- This is also a convenient time to develop a more personal contact with the mother and her child: by talking to the child, asking its name and age, playing with it and helping the mother in undressing the child.
- Children should be handled in a tender and reassuring manner, so as to create a climate of trust between the mother, the child, and the members of the team. It is possible, for example, to weigh the child in a plastic tub attached to the scale readjusted accordingly rather than leaving the child suspended.
- Dialogue with the caregiver is of critical importance, not only to give assurance and respond to his/her questions, but also to obtain his/her cooperation in filling out personal information in the questionnaire.
- Guiding people admitted to treatment is important, as well as proposing other possible services to those that were not admitted to better meet their needs.

➡ Medical consultation

It is important to:

- Introduce medications, therapeutic food (RUTF or milk) and nutritional supplements.
- Assist the mother in giving medication to her child and show her how to do it gently; help her with milk-feeding.
- Explain the medical treatment, the possible reactions of the child and any physiological reactions.
- Inform the mother about how life is organized at the TFC or during visits at OTP centre while trying one's best to reassure the people who are worrying.

➡ Arrival at the TFC

When the treatment is to be administered at the TFC and admitted people arrive there, it is necessary to:

- Guide and accompany people at this stage and ensure their integration, allow them to visit the centre, inform them about the key facilities (location of restrooms, showers, kitchen, etc.), and information on therapeutic food (RUTF or milk), meals for caregivers, medical consultations and proposed activities (health education or game sessions, activities for mothers, group discussion, etc.). Not only do these activities form an integral part of the treatment, but they also help to

strengthen community life and everyone's wellbeing as a whole. They ultimately allow patients and caregivers to have fixed points of reference for their life in the centre.

- Introduce the other members of the team to the mother (or to the caregiver), while specifying their roles, with a view to helping her better understand to whom she could address her concerns, depending on the situation.
- Facilitate introductions between caregivers already present in the centre and the newcomers; as the case may be, organize some support for the newcomers by those already staying in the centre.
- Take into consideration particular constraints, for instance the case of a mother not able to speak the same language as the others, in which case it is necessary to find an interpreter. Likewise concerning difficulties related to ethnic differences, it could be difficult to work with people belonging to different ethnic backgrounds, and potentially from rival ethnic groups. It is extremely important to encourage them to recognize the common goals, which brought them together in the centre and to promote group cohesion.

IV. PROVIDING DAY-TO-DAY SUPPORT

REMEMBER

- ➔ Parents must be considered as partners of the program.
- ➔ The involvement of mothers in the follow-up and in daily care activities is of critical importance for building the confidence of both the child and the mother.
- ➔ The baby's bath provides a special moment of relaxation and sharing.
- ➔ At bath time, it is very important to ensure that the child is handled gently and feels comfortable and secure.

UNDERSTAND

The daily life of beneficiaries at the TFC is interspersed with periods of sanitary care and visits by nurses for various reasons: monitoring of weight, height, temperature… frequent measurements on a more or less systematic basis could turn out to be particularly restrictive.

Adopting a friendly attitude is a must in order to ease the strain of these difficult periods.

The principles highlighted in the welcoming factsheet could be adapted to the context of daily care activities: it is simply a matter of explaining, involving people, and building confidence…

In this section you will find information concerning:

- Nursing care
- Support at mealtimes
- Bathing
- Carrying the child
- Massaging the child
- Care for mothers

IMPLEMENT

Daily support to the child includes daily nursing care, hygiene (bath time of the baby), and providing information on the most comfortable positions for carrying the child whether it is awake or asleep. Of equal importance is the time set for **milk-feeding** or RUTF and **massaging the child**, which you will be provided with more details in a note having the same title.

However, support to the child can only be complete if the person in charge of providing the necessary care (most likely the mother) is not suffering from any physical or mental difficulties. Therefore, it is of prime importance to consider the mother in the planning of support to the child and to provide her with the **necessary care and support**.

1. NURSING CARE

The involvement of the mother is particularly important, on the one hand, to reassure her and, on the other hand, because she is the best person to provide a sense of security to her child.

Involving the mother implies not only having her participate in the handling of the child (undressing, carrying and holding the child), but also making sure that she understands the progress being made and the importance of the medical interventions undertaken. Therefore, nurses could fill out the OTP and In-Patient card together with the mother so that she is able to feel more involved in the treatment. For example, she will be informed first about the weight of the child on the day of admission, then about the expected weight at the end of the treatment and finally on how the curve progresses at each subsequent weighing of the child.

2. ASSISTANCE PROVIDED DURING THE MEALS

- Breast-milk is the best feeding option for babies and should be used exclusively until the age of 6 months.
- If the infant is not breastfed, it must be given therapeutic milk in a clean, open cup rather than a baby bottle, and the mother should be encouraged to start breastfeeding again if she wishes to.
- RUTF is the treatment used for malnourished children in the transitional phase, in phase two and in outpatient treatment.
- Mothers must be encouraged to have patience when feeding the child and to avoid force-feeding.
- It is important to take into account the mother-child relationship at mealtimes and to encourage the mother to communicate and interact with her child.

The meals taken in therapeutic centres include **breastfeeding**, having **therapeutic milk** and eating RUTF.

a. Breastfeeding

First of all, it is critical to promote breast milk as the exclusive food for the child, until the age of 6 months at least[4]. Given this, breastfeeding could then be encouraged, but not alone as it may not be rich enough to feed the child.

The use of breast-milk substitutes, such as powdered milk or animal milk, could put the health of infants at risk, especially when the parents cannot afford buying these substitutes in sufficient quantities due to their high cost, or because of lack of access to drinkable water to dilute the products in.

Almost every mother is able to breastfeed. Mothers who fear that they are not able to breastfeed their child need to be encouraged and to get practical support from the baby's father, their family, their friends and caregivers.

It is possible to help mothers by giving them useful advice on breastfeeding, on how to hold the baby during breastfeeding or by supplementing breastfeeding with therapeutic milk[5].

4 - You can find additional information at: http://www.factsforlifeglobal.org/04/index.html
5 - You will find interesting information in the information sheets of Dr. Newman, available at the following site: www.drjacknewman.com

© ACF-Soudan

In this photo:

- The mother has placed her hand in the place exactly where the child should place its mouth. This interferes with the feeding. The mother should have her hand under her breast to help the child but never on the areola.

- The child is in a wrong position, too far away from the breast. The mother should hold the baby closer to her breast.

- The mother by squeezing her breast can block the milk ducts carrying the milk. She can massage and press her breast, especially at the end of the feeding, but never squeeze.

To do so, the "Supplementary Suckling Technique (SST)" will be used (see photo opposite). It consists in giving the child therapeutic milk while breastfeeding. The production of breast milk is thus stimulated and the child is sufficiently fed.

If the baby refuses to be nursed, or is too weak and falls asleep while feeding, "SST" could also be practiced through the use of the fingers. The tube containing the therapeutic milk is attached to the finger and it is then put into the child's mouth.

If the child is more than 6 months old and is still breastfeeding, the mother will still be advised to breastfeed the child for approximately 10 minutes before feeding the child with the therapeutic milk or RUTF.

© ACF-Burundi

b. Therapeutic Milk and RUTF

The treatment of malnutrition is based on therapeutic milk and RUTF. It could be confusing for beneficiaries as well as for caregivers to realize that therapeutic milk and RUTF also serve as medication; to understand that it is not just a question of milk/ RUTF, but also a treatment, specially designed to heal the malnourished child and composed of nutrients necessary for its recovery.

It is often noted, especially at the beginning of the treatment, that mothers and their babies suffering from malnutrition have a disharmonious interaction during the feeding process. They do it mechanically, without even exchanging glances, words or gestures, not even the simplest ones. Feeding time is commonly accompanied by aggressive attitudes such as pushing, grumbling and forcing the child to open its mouth by holding its nose. Moreover, it may happen that malnutrition could cause paradoxical anorexia, which may not be properly understood and accepted by mothers.

This attitude could be interpreted as a lack of interest or love. However, it is important to understand that the mother is faced with a dilemma: on the one hand, her child refuses to eat and, on the other hand, she feels that if she does not force her child to have the entire milk/RUTF, it would die… She must somehow deal with both the team's instructions and the baby's refusal to be fed.

Mothers do not always understand the causes of the child's malnutrition. They may also feel guilty, given that some children refuse to be fed further to the sudden interruption of breastfeeding (when the mother gets pregnant again, for example).

Furthermore, they could become worn out by frequent daily meals they have to give to the child, at set and regular times, including during the night.

Improving support at feeding times is a way for the staff to cater to the mother's needs, that may not necessarily be verbalized: for example, mothers may feel the need to be respected, listened to, directed, guided, and possibly cared for.

In this photo:
The position of the child does not allow for exchanges between mother and child, nor does it give the mother a good view of what the child is consuming.

© ACF-Afghanistan

It is of critical importance to take feeding time into account, milk-taking/RUTF and provide support to mothers by:

- Explaining what therapeutic milk or RUTF is, as mothers lack knowledge about what they are giving to their children, they usually do not ask for it. Moreover, they will be more involved in the child's treatment if they understand what they are giving it.
- Monitoring the hygiene practices of mother and child, ensuring that they always wash their hands before meals, through simple gestures to explain how important it is. Washing the child's hands, especially when the child is eating the RUTF by him/herself.
- Fostering communication during breastfeeding: encouraging the mother to talk with her child, explaining the benefits of interacting with the child to her, particularly in terms of stimulation.
- Assisting the mother if the child refuses to eat or drink.
- Limiting "force-feeding" as much as possible: forcing the child to eat by strapping it down or by pinching its nose is ineffective from a therapeutic point of view, as in most cases the child ends up vomiting. In addition, it is a stressful experience for the child and a practice that could damage the mother-child relationship. Lastly, this attitude could have a significant adverse effect on the way the child interacts with food; an interaction which may already be negative and needs to be improved (feeding time must remain a fun time for the most part of it).

Health workers, supervisors who monitor the different treatment phases, facilitators and psycho-social workers must be present at mealtime, to offer greater support to mothers by providing them with support and guidance to improve their interactions and attitudes with regard to their children.

It is of the utmost importance that someone stays close to the mother, interacting in a more personal way during the entirety of the first milk/RUTF feeding event.

It is necessary to guide the mothers and to be particularly attentive to those in need. If a mother is not able to feed her child properly, it could be useful to isolate her from the others, give her advice on how she should hold, motivate and encourage her child to eat. If the child refuses to be fed by the mother then another person could try.

A staff member must always be by the mother's side when the "supplementary suckling technique" is being used to feed the child.

For older beneficiaries, feeding time or the taking of milk/RUTF could also be a difficult experience. Adults and adolescents are obliged to drink large quantities of milk every 2 to 3 hours or eat RUTF during the entire duration of the treatment. It is essential for the professional staff to be present in order to make the mealtime as pleasant as possible without adopting a condescending attitude. Mothers need to be treated as adults and, given that often their self-esteem is already damaged due to malnutrition, it is vital to show them respect and to propose suitable activities for them during mealtime.

© ACF-Afghanistan

Breastfeeding two infants at the same time could be very beneficial, on the one hand because the breasts will be all the more stimulated and therefore, milk production is better assured, and on the other hand, because the feeding of one infant could induce the flow of milk in both breasts, thereby ensuring that the second infant feeds.

The appetite test:

With regards to home treatment (OTP), children must pass an appetite test to determine their follow-up home treatment or their referral to a TFC. Children are tested in groups upon their arrival, a situation, which can make the testing of their appetite difficult, given that they are often tired and weak, and that their mothers deal with a lot of stress. It is therefore necessary to set aside a quiet area to clearly explain to the mother what the testing is about and to be gentle and welcoming in order to give as much support as possible to the mother and the child during testing. The mother must sit comfortably with her child on her lap; she must give the packet to the child or place a small amount of the paste on his/her finger. It is important to take one's time and not force the child. This visit allows for a clear observation of mother-child interactions, where by relational issues can be identified, subsequent follow-up can be proposed if required and/or additional support can be offered to the mother-child dyad.

3. BABY'S BATH TIME

It is important to provide the materials, space and water necessary for the parents to be able to wash their child regularly, safely and in the best conditions. The method of washing the child varies from one culture to another. It is important to understand washing techniques for infants taking into account the cultural environment in which you work. A few tips are given below for countries where bathing is practiced or for cases where you decide to buy basins/tubs for TFCs and you wish to explain to mothers how to use them.

© A.Filorizzo / ACF-Philippines

If the infant is unable to sit down or to hold up his/her head, it is recommended to soap the infant before bathing him/her. Using bare hands is preferable to using gloves or other aids (as those aids likely harbour germs). In addition, this provides the opportunity for a massage, and the direct body contact facilitates the strengthening of the mother-child bond. Moreover it will be easier to reach all of the baby's creases and folds.

In general, one starts with the neck and armpits. If the baby's arms are folded, extend them gently. Then, continue with the belly, and rotate the baby on the side by holding him/her by the shoulder in order to wash the back gently. Soap the arms, hands, legs, and feet. Finally, wash the buttocks and finish with the private parts.

Without wasting too much time so that the child does not get cold, slide one hand gently under the back of the neck and the other under the buttocks, while talking quietly to the child to reassure and encourage it and slowly immerse the child in the water starting with the lower part of the body. With the baby's buttocks laid down and keeping one hand always in place to support the back of the neck, rinse the baby using your free hand. Verify that there is no more soap in the creases. At this point it is possible to play with the water on the baby's body and have the child play with the water.

If the child starts to cry, do not force it. Rather try to be reassuring; talk, sing and if the child really does not enjoy it, take it out of the bathtub. The next bath will be better.

Take the baby out of the bathtub in the same way as it was immersed into it; that is to say, with one hand

under the neck, the other under the buttocks. Wrap the baby very quickly in a towel to prevent it from being cold. First dry the head, then wipe without scrubbing in order to limit irritating the skin, while paying special attention to creases and extremities (fingers and toes).

© ACF-Sri Lanka

Training sessions on appropriate handling procedures to adopt when bathing the baby.
ACF Sri Lanka.

Bathing lasts only two to three minutes during the first weeks. Later the child will feel more at ease and one could introduce few toys and let it splash about a little bit longer (being careful that the water remains optimally warm). The toys must be clean and well suited for water (mainly plastic).
It is important to always stay close to the baby during the bath to avoid any risk of accidents.

In some cultures washing the child is not necessarily done in a bathtub, but rather with a little water, usually quickly and possibly with a bath glove.
If it is considered culturally appropriate and if mothers have an interest in it, it could be useful to train them in bathing the child, indicating the proper techniques for the best possible health outcomes to them, while ensuring the comfort and safety of the child.
Training sessions could be organized with the help of a doll to show mothers the correct handling procedures.

Furthermore, it is preferable that staff members be present and close to the mothers during the child's first bath in order to help and guide the mothers, and ensure the safety of the child, especially if the mothers are not accustomed to this method. In cold countries, these baths require that warm water is available. One must consider the possible options available for water and heating supply for buildings, otherwise one would have to find alternative methods for bathing the babies.

TO AVOID

Sponges; real breeding grounds for germs. It is preferable to wash the baby with one's bare hands or with a large piece of cotton wool.

4. CARRYING THE CHILD

Carrying relates to the different methods used to carry the child (in the arms, body to body or with a baby carrier such as a harness or cloth, etc.) and also to the handling actions used to position the child comfortably while taking into consideration the child's different body parts and joints.

Cultural variations with regard to touching, physical and body contact are explained in the ethnopsychological literature; in the majority of countries all around the world, the small child enjoys close contact with its mother during the first months and years of its life. Due to a significantly higher frequency of carrying, physical contacts and body to body games that the child enjoys with its mother or father, or with maternal substitutes, studies show that African children have a faster psychomotor development during the course of the first two years of life than Asian and American children. In the indigenous cultures of South America as well as in Amerindian, African, Inuit, and Asian cultures, the carrying of young children is part of common care practices. The baby carrier functions as a transition womb and allows for continuity of the parent/child bonding, thus helping the emotional development of the baby, while at the same time enabling parents to get on with their daily activities. In the broad sense of the term, "to carry" means "to hold/to bear". Instead of "placing" her baby in some type of apparatus (pram, seat, playpen, etc.), the mother is able to carry the child with her, to share the warmth of her body, the rhythm of her breathing and the sound of her voice with the child.

The regular and rhythmic actions of carrying and handling create a close bond between mother and child. The mother is both a nurturing and supporting presence, the foundation of emotional security, serving to strengthen the development of the first signs of the child's personality. Within different cultures, the role of touching varies with factors such as age and also family upbringing.

Touching is the most fundamental sense; it unites the one who touches with the one who is being touched. The skin is the point of exchange between the body of the mother and the child; it is also the psychic envelope and containing function.

Some of the benefits of carrying:

- The rocking movement caused by carrying creates a cellular and visceral stimulation. It promotes proper functioning of the gastro-intestinal tract, enabling better digestion and providing relief for colic episodes.
- Children cry less because the parents are able to quickly satisfy their needs. Closeness of contact enables parents to familiarize themselves with the signs the child displays and to better understand the child.
- The baby carrier allows for greater freedom of movement. It is possible to look after an older child or to have one's hands free while the baby is being rocked and feeling reassured by the physical proximity with the mother[6].
- Pay special attention to children suffering from kwashiorkor: their skin is often extremely thin and fragile with skin lesions. Carrying should be undertaken with great precaution, or it may even not be advisable.

The proper positioning of the child, whether it is asleep or awoken, is very important for its comfort and development

6 - You will find interesting information with illustrations, including methods of carrying and maintaining the baby's body, in a file written by Laurence Vaivre-Douret, under http://www.psynem.org

5. MASSAGING THE CHILD

- Massaging contributes to the baby's physical and psychological development
- The sense of touch is highly developed in babies.
- Massaging can help the mother and the father to become more sensitive, to respond better to the needs of the newborn, and to become more attached to the child.
- We must remain vigilant with regard to massages in a phase of severe acute malnutrition or in cases of kwashiorkor. Bodily discomfort and/or fragility of the skin could result in contraindications. In some situations, it is possible to place hands on and/or do some massages on the forehead and the upper part of the face.

a. The importance of touching for the child

Touching and massaging are tools of contact, connection and communication, necessary for the shaping, development and the psychosomatic stability of the child. The power of hands is quite considerable. Hands can relieve, reassure, massage, love, shape, heal and understand (and also hit, etc.).

Children severely deprived of safe physical contact in their early childhood generally present some problems adapting and communicating. Massaging influences the nervous system, blood oxygenation and circulation, energy levels, regulation of breathing, and proper skeletal development. It fosters the production of endorphins, fortifies the body's immune system and defences, and regulates sleep, appetite, digestive functions and excretion.

A newborn infant needs, above all, contact with its mother and father - contact with their hands, skin, smell, voice and breath. It is through these interactions that the child will feel loved, respected, and reassured.

Massage as a means of touching provides a unique way of communicating and having intimate contact with the baby. It encourages a close bond and strengthens the parent-child relationship. It helps with the development of body awareness and intelligence; it stimulates, strengthens and regulates the body systems: nervous, circulatory, respiratory, gastro-intestinal, muscular and immune. It helps to relieve tensions caused by crying, colic, insomnia, etc.

Massaging fosters the physical and psychological development of the baby. Here are some details:

- It relaxes the baby's body by calming the nervous system.
- It contributes to the awakening of the baby's intellect and senses.
- Massaging can result in falling asleep in a deep and peaceful sleep, and thus helps to regulate sleeping disorders. It reduces tensions at bedtime.
- It helps with digestion and improves conditions related to the elimination of waste such as diarrhoea or constipation. It can relieve colic.
- It enhances knowledge, integration and an understanding of the body system
- Massaging helps to maintain the flexibility of the baby's body as it develops and becomes stronger.
- It relaxes the joints, improves the elasticity of muscles and their capacity to relax.
- It stimulates the immune system and facilitates a well-functioning nutrition system.
- It helps to create a strong and special connection between the child and the person massaging it.
- It is a way for everyone to get involved in the care of the baby (the mother, father, grand-parents and health professionals, etc.).

Massaging must generate mutual pleasure. In cases where children are in pain (stomach ache, for example) and where the mother is afraid of hurting the child, placing the hands on the child's body could be enough

to create an emotional and reassuring contact. Little by little, recovering confidence in oneself and in the other will enable the introduction of simple massaging gestures that are a little more in depth.

In case of malnutrition, one should take care not to press on the swollen body parts and not to massage children strongly, particularly during the acute phase of the illness. As a first step, simply place your hands lightly on the child's body. Gradually, and always gently, one could massage the least painful parts of the child's body (face, hands, legs, etc.) before massaging the entire body.

It is important to ensure that the room in which the massage is performed has an adequate temperature, neither too hot neither too cold.

Before starting the massage, it is recommended to do small exercises to make the mothers feel at ease: breathing, relaxing. First gently ask the mother to remove her rings, bracelets, and necklaces that could dangle and divert the baby's attention.

After this, the mother needs to rub her hands with oil (natural oil, local cooking oil: groundnut oil, Shea butter, etc.) and ask permission from the child to perform the massage: "Do you want me to massage you today?"

Once this is done the massage can begin.

The massaging movements described and photographed below are those taught by IAIM (International Association of Infant Massage). However, massage, just like body care, is practiced in most countries. It is therefore very interesting to ask mothers whether they massage their baby and what methods they use so as to respect local practices. When massage practices have been lost you may wish to illustrate other massage techniques. Thus, you can for example use the massage movements described by IAIM.

b. Massaging different parts of the baby's body

➡ THE LEGS

- **The Indian Massage**

  Massage each leg with the inside of the hand (between the thumb and index finger, thumb at the bottom), using both hands successively, and one after the other. Place one hand in the form of a circle around the ankle, and place the other hand on the thigh at the level of the groin.
  While pressing lightly, slide the hand along the inside of the leg, from the groin to the ankle. The opposite hand replaces the first at the level of the hip, while partially enveloping the buttocks.
  Slide the hands in turn along the outside of the leg towards the ankle.
  Continue with slow and constant movements, conscious of your centre of gravity and your lower back.
  Be careful not to lift the pelvis of the baby while performing the massage.

- **Cuddles slipped in**

  Lift one leg towards you (ensuring that the baby's pelvis is totally flat) and enclose it with both your hands placed like rings (thumbs at the bottom), one next to the other so as to avoid twisting the knee.
  Encircle the leg as much as possible and slide the hands from the thigh towards the ankle, pressing gently, with the two hands performing a light rotation in opposite directions (similar to the screwing-unscrewing movement you use with a pepper shaker).
  This massage works on the entire breadth of the muscle and relaxes it.
  Massaging the foot is beneficial for the entire body as it is extremely rich in nerve endings.

- **Under the Foot**

While exerting some pressure, slide one thumb after the other on the arch of the foot, from the heel fat pad up to the toes (from the heel to the toes).

- **Each Toe**

Press and roll each toe between the thumb and the index finger.

- **Under the Toes**

With the thumb supporting the heel, press gently with the index finger placed just under the toes.

- **The Heel**

With the index finger, press, then gently massage the pad of the heel, starting from the hollow of the arch of the foot.

- **Thumb Pressure**

Massage the entire arch of the foot with both thumbs alternatively

- **Top of the Foot**

Slide one thumb after the other on the entire top of the foot from the toes towards the ankle, while exerting a bit of pressure.

- **Circles around the Ankle**

Massage in small circles around the ankle with both thumbs.

- **Swedish Massage**

One hand holds the ankle to stabilize the leg, while the other hand slides from the ankle to the beginning of the thigh. The hands are then inversed, so as to massage alternatively the inside and the outside of the leg. Be careful not to lift the baby's body while executing these movements.

- **Roll the Leg**

Roll the leg between your hands, from the thigh to the ankle. Most babies love it!

- **Relax the Buttocks**

After massaging both the legs and feet, massage the buttocks with small circular movements. Then slide the hands along the legs up to the ankles, causing legs to wobble slightly (small movements from bottom to top).

- **Integration**

Slide the hands from the buttocks down to the feet in one single movement. The movement links the legs with the torso and indicates to the baby that you will move to another part of the body.

➡ THE BELLY

The belly massage boosts the baby's digestive system and contributes to relieving bloating and constipation.

- **Hand Placement**

Firstly, establish contact by simply placing your hands on the baby's tummy, and letting the weight of your warm, relaxed hands be felt by the baby, as a way of signalling that you will start massaging it.

- **Water Mill – A**

Massage the belly by bringing your hands towards you, one after the other (as if you were digging a hole in the sand). Do not apply the cutting edge of your hand to the belly, but rather the flat palm, well moulded to the baby's belly. Repeat this action 6 times.

- **Water Mill – B**

With one hand, hold the uplifted legs of the baby by the ankles, bringing its body closer to you, while keeping the pelvis flat. Without lifting it up, repeat the previous massage with only one hand. This massage further relaxes the abdominal region.

- **Thumbs to the side**

With your thumbs flat on the baby's navel, slide them side-ways without shoving them in, making sure to keep them as flat as possible.

- **The sun and moon**

Your left hand performs a complete circle clockwise, starting to the left (at "7 o'clock"). When it reaches the lower part of the circle, your right hand draws on top of it, just under the rib cage, and makes a half-moon from your left to your right, like an upside down U. The left hand follows, as if the hands were pursuing each other.

- **I love you**

Perform this movement to accompany each of these three parts forming one syllable of "I love you". Start from the left side of the baby's belly, just underneath the ribs, tracing with your hand an uppercase "I", by sliding the extremity of your fingers towards the lower part of the belly. Repeat multiple times, pronouncing "I" or "Aïe".

Then you shall draw an upside down, horizontal uppercase "L" on his belly from your left to the right, then moving down and pronouncing "Looooove".

Then draw an upside-down, uppercase “U” starting from your left and moving up the rib cage, sliding crosswise to the right and re-descending towards the groin, in other words, from the side of the baby’s belly towards its left, while pronouncing “Yoooouuuu”.

- **The march of the fingers**

With fingers flat, “walk” from left to right on your baby’s belly, at the level of the navel. You may feel the gurgle of gas under your fingers. After the belly, you move to the chest massage.

➡ THE CHEST

Massage of the thorax helps to soothe the lungs and the heart.

- **The Open Book**

With both hands placed flat in the middle of the chest, descend towards the sides of the chest as if flattening the pages of an open book. Bring your hands together by moving up to the point of departure, your two hands thus drawing a heart. The pressure is applied from the centre of the chest, moving towards the sides and is released for the rest of the movement, which simply maintains the contact with the skin.

- **The Butterfly**

Firstly, mould your two hands around the chest. Your right hand crisscrosses the chest diagonally, reaching the right shoulder. Then, the hand returns to its point of departure without losing the contact (diagonal movement). Repeat the same diagonal movement with your left hand. Alternate the movements, using one hand, then the other, at a regular rhythm. The pressure of your hands should be stronger in moving up than in moving down.

- **Integration**

Departing from the chest, slide both hands towards the belly, then to the feet, in order to include, with one single movement, all parts of the body that you have just massaged.

➡ THE ARMS

- **Resting of Hands**

Gently establish contact with the baby’s arms by simply placing your warm hands in order to ask permission to start

- **Massage of the Armpits**

Gently massage the armpits from top to bottom. The area of the armpit is rich in lymph nodes.

- **Indian Massage**

Hold the wrist with one hand and with the other; massage the arm from the shoulder to the wrist. Repeat the movement without interruption, while alternating your two hands.
Keep the shoulder steady in order not to lift the baby while performing these movements.

- **Cuddles slipped in**

Place both hands in the form of rings around the arms and proceed with the "screw- unscrew" movement in opposite directions, with the two hands always close together in order to avoid twisting the baby's elbow. This movement mobilizes all the muscles, thus facilitating relaxation.

- **Roll the Fingers**

Open the baby's hand with your thumb and then roll each little finger between the index and the thumb.

- **Top of the Hand**

Massage by sliding your hands on top of the baby's hand.

- **Circles around the Wrist**

Massage by making small circles around the wrist.

- **Swedish Massage**

Massage one arm from the wrist to the shoulder, taking turns with each hand. Try to mould your hands around the baby's arms. Keep the baby's shoulder steady, to avoid lifting the baby with each movement.

- **Roll the arms**

Roll the baby's arm from the shoulder to the wrist several times between your two hands. Children enjoy this massage regardless of their age.

- **Touching- Relaxation**

Resort to touching- relaxation in order to help your baby relax and free its arm. Gently mould your hands around its arm and feel it weighing down and relaxing. Make use of your voice, repeating gently " relax! ", while you stroke, roll and turn the arm in your hand. When you feel that its muscles are loosening up, reward your baby by saying: «That's great, my baby, your arm is completely relaxed!"

- **Integration**

Starting with your baby's shoulders, slide your hands along its chest, along the belly, legs and up to its feet in one single movement that integrates the entire body.

➡ THE FACE

Facial massage helps the baby to relax, to better endure the period of teething and to reduce congestion in the nose.

- **The Open Book on the Forehead**

With fingers flat, smooth the forehead, moving from the middle of the forehead to the temples, as if flattening an open book. Try not to cover its eyes or nose.

- **Eyebrow Massage (Eye Relaxation)**

With the thumbs, gently press on the arch of the eyebrows, moving towards the temples.

- **Lining of the Nose and Cheeks**

Place your thumbs on either side of the base of the nose and run them down diagonally to the baby's cheeks. This movement helps to decongest the nose and relaxes the cheek muscles.

- **Smile**

With the tip of the thumbs, gently stretch the upper lip into a smile, and then repeat the action on the lower lip.

- **Jaw Relaxation**

With the tip of the fingers, draw small circles around the jaws.

- **Ears, Jaw, Chin**

Using the fingertips of both hands, simultaneously pass behind the ears and join the chin by sliding along the lower jaw. This movement helps the jaw relax and massages the lymph nodes of this region. After the face massage place your baby on the belly for a back massage.

➡ THE BACK

- **Hands Resting**

Put the baby on your thighs, loosen up and let your child know that the back massage will begin.

- **Back and Forth**

Place both hands across the upper back. Move your hands back and forth perpendicular to your baby's backbone, using one hand after the other, massaging the baby's back. Move gradually towards the buttocks, then mount up again towards the shoulders and repeat the entire movement again.

- **Sliding – A**

Keep your baby's buttocks in place with one hand and then slide the other over its back, as if to "pick up" the skin, and moving from the shoulders to the buttocks. Repeat several times.

- **Sliding – B**

Maintain your baby in place by gently holding his feet with one hand, and slide the other hand along the back and the legs up to the ankles. Repeat several times.

- **Small Circles**

With the fingertips, trace small circles on the entire surface of the back. As the baby grows, you will feel the development of its muscles under your fingers tips!

- **Combing**

Final movement: with the fingers slightly spread out, “comb” the back, moving from the shoulders to the buttocks. Gradually reduce the pressure, ending with a light touch like a feather, signalling to your baby the end of its back massage.

c. Gentle Exercises

These movements are simple exercises that gently stretch the legs and arms of the baby, massage the stomach and the pelvis, and align the spine.

- **Arms Crossed**

Cross the baby’s arms on the chest, alternating the arm on top and the arm below. Then stretch sideways gently: cross-cross-cross-open. Repeat.

- **Arms and Legs Crossed**

Take one arm by the wrist and take the opposite leg by the ankle. Gently fold the arm on the rib cage and bring the foot up towards the shoulder (bending the knee). Cross the arm on top of the leg, release, and one more time cross the arm on top of the leg. Then stretch the limbs in the opposite direction: cross-cross-cross-open. Repeat with the opposite leg and arm.

- **Legs Crossed**

Cross the baby’s legs on its tummy, one then the other, alternating one above then underneath the other. Then gently stretch them towards you: cross–cross-cross-stretch. Repeat this excellent exercise for strengthening the digestive system.

- **Knees on the Belly**

Push both knees against the belly and then stretch the legs towards you. If the baby resists, gently wiggle the legs to cause it to relax. Repeat several times.

- **The Bicycle**

Push one knee, after the other, against the belly, then stretch both legs: right knee, left knee, right knee, stretch to relax. Repeat alternating the knee you started with.

During the massage, it is important to talk to the baby and/or to sing. This will reassure the child.

You will find more detailed information on how to touch and massage a child, and more particularly a newborn baby, in Laurence Vaivre-Douret's book, *La qualité de vie du nouveau-né* (The Quality of Life of the Newborn Baby), published by Odile Jacob, October 2003, as well as in Vimala Mc Clure's book, *Le massage des enfants* (Massaging Infants) published by Tchou, May 2009

6. Care and support for mothers

Paying attention to mothers is particularly important to the fight against malnutrition in children. A mother in good physical and mental health is the greatest hope of survival for a child.

In fact, mothers who are suffering physically or psychologically are more at risk of not being able to care for their child adequately.

Given that mothers play a very important role in the wellbeing and the development of their children, it goes without saying that particular attention must be paid to their physical and mental health.

Crisis situations (wars, extreme poverty, catastrophes, etc.), in which ACF intervenes, exacerbate the relational difficulties between a mother and her child: the women that we meet have often experienced extremely difficult times that have affected their resilience. The support that they receive from their family and/or friends also varies greatly depending on the situation. This is something which must be taken into account in order to better understand the context and to better help children and their parents.

The intensity of work, maternity and under-nutrition can lead to anemia.
Fatigue is a chronic health problem which is very common among mothers. In many developing countries, women produce up to 50% of the food and take care of all the domestic tasks. Taking care of children is another responsibility that women are faced with. At the age of 30, a woman has often spent 80% of her

adult life either pregnant or feeding. In developing countries, half of all women, and 2/3 of pregnant women, suffer from anaemia. Depression or symptoms of depression, along with physical trauma, for example, can also limit a woman's appetite and lead to under-nutrition. It is therefore useful to be attentive to this when providing care for these women. At times, when a woman regains a zest for life, she also regains her appetite.

Implement:

- Understand the context and the environment in which families live. Causes of malnutrition vary depending on the child, so understanding their past is necessary to be able to provide the best support to both mother and child.
- Encourage a safe and welcoming environment for the mother. Moments of relaxation can be anticipated, especially when the children are in intensive care in the TFC. In crisis situations, fear is an emotion, which is found again and again; so ensuring a protective and safe environment (lights at night, mixed male and female staff, etc.) is essential.
- Listen: often women need to talk about the experiences they have lived through, so simply listening to them can comfort them. Having empathy with women who are suffering can help in their wellbeing.
- Identify women who are suffering physically or mentally in order to offer them help. Treat medical problems and refer people to specialist services if necessary.
- Involve the mothers in the treatment of their children to give them a responsible role in giving hope to their children and to make them want to take care of their children.

Wealth discrimination begins before birth.

Poor, malnourished women are more at risk of giving birth to children who suffer from malnutrition, and who are smaller, weaker and more likely to contract illnesses and to die at an early age.

Children who are very small at birth are 4 to 6 times more at risk of developing physical and mental handicaps and 8 to 10 times more at risk of dying in their first year.

Poverty, low levels of school attendance and barriers to accessing health care services are the main factors which lead to infant malnutrition; a complex problem that needs to be addressed from multiple and various angles such as:

- Ensuring food security in poor households. This involves ensuring the quantity of as well as the variety in the food supply.
- Educating families to understand the specific nutritional needs of children, and more specifically the importance of breastfeeding and introducing appropriate and suitable supplementary food.
- Protecting the children against disease and infection through vaccinations and immunization as well as an access to clean drinking water and good hygiene practices.
- Ensuring that children get quality care when they fall ill.
- Protecting the children against a lack of micronutrients, which could lead to death or deficiencies; particularly a lack of iodine, iron or vitamin A.
- Paying particular attention to the nutritional needs of women and girls; chronic malnutrition in pregnant women can lead to the delivery of under-weight children, and therefore can perpetuate the vicious circle of malnutrition in the following generation.

The underlying causes of malnutrition vary depending on the area being examined.

In many Asian countries, the underlying causes of malnutrition include poverty, the low status of women, lack of care during pregnancy, the high number of babies that are born under-weight, unsatisfactory care practices and problems associated with accessing care centres.

In Sub-Saharan Africa, extreme poverty, ill-adapted care practices and problems associated with accessing care structures are amongst the main causes of malnutrition.

Conflicts and natural disasters often make the situation much worse in many countries. The increase in the number of children who are malnourished in Africa also reflects the rapid population growth. In many countries, devastating effects wrought by HIV/AIDS has turned around much of the progress previously made in the fight against malnutrition.

V. THE NEEDS AND DEVELOPMENT OF THE CHILD

REMEMBER

➔ The succession of stages of development is the same from one child to another (a child can sit down before he can walk, it can babble before it can talk, etc.)

➔ However, the duration of one stage and the age are only references, as each child developing at its own rhythm.

➔ The child's environment and his family circle can help to stimulate and to encourage its development or not.

➔ Malnutrition affects the development and the behaviour of a child.

UNDERSTAND

A baby or a young child is not a passive human being but it is a genuine 'interactive' partner in the true sense of the term; it is capable of partly initiating and controlling its relationship with others, depending above all on the stage of development at which the child finds itself. The child successively goes through one development stage to another and it is not able to go onto the next stage until it has completed the previous one.

The factors discussed in this document provide elementary information about the child's development. It is important for people who wish to work with children to be familiar with these development stages. In fact, knowing these stages allows to understand the child's development and thus to adopt behaviour which is appropriate to the stage and to suggest suitable activities, thus improving the child's wellbeing.

This information should therefore be provided during the training on the nutritional programs of staff members who are in contact with the children.

Children begin to develop during pregnancy, not only physically, but also emotionally and cognitively. It is therefore important to bear in mind the impact of pregnancy on the child's future development.

Sensory organs and the brain develop progressively during intra-uterine life. Based on the present scientific knowledge, it seems that sensory stimulation influences the development of brain and organs. Multiple sensory experiences that take place in the uterus can positively affect the growth of the foetus during pregnancy. The intra-uterine environment is very rich; the baby can hear your voice, feel your caresses and can taste the amniotic liquid. Due to this great sensory potential, the mother, the father and the siblings have the opportunity to foster connections with the future baby from the beginning of the pregnancy.

The sense of touch is one of the most important things for human beings. It makes it possible to recognize the limits of the body, to locate oneself in space and to get to know one's surroundings. The sense of touch is the first sense that develops in the uterus as early as the eighth week of pregnancy. Normally, this begins with the contours of the mouth and then to the rest of the body around the fifth month of pregnancy. The baby floats in the amniotic liquid which is at a temperature of 37.5 degrees centigrade. Among other things, the liquid serves as an interface between the exterior movements of the future mother and those of the baby. The baby feels the movements of the abdominal wall and, in turn, the movements of the baby can be

felt in the abdominal wall. As the foetus grows, it gradually comes into contact with the walls of the uterus with increasing frequency. This contact gives the baby different tactile feelings.

The relationship with the mother begins even before birth. *(See the part on the importance of the mother-child relationship).*

Neurological maturing and the baby's motor skills complete progressively: head, torso then limbs towards the extremities. The child begins its development by first holding its head up, then by sitting up. Little by little the baby manages to control the extremities of its limbs until it manages to grip objects (hold with thumb-index fingers).

In order to train people in the area of child development, it is essential to first understand this information.

A child's development has many different components, which are interdependent and work together in the development of the child:

- **Motor development:**
  Psychological and neurological development of the body.
- **Language development:**
  Communication and expression skills.
- **Cognitive development:**
  Development of intellectual skills.
- **Emotional and social development:**
  Development of the personality and feelings.

Development stages involve these four different aspects simultaneously.

1. THE CHILD'S STAGES OF DEVELOPMENT

It is essential to take into account the different stages and to adapt behaviour and expectations in accordance with the needs and the abilities of the child.

The following table shows these different stages and categorizes them according to their functions. You will find in *Appendix 01* a selection of toys and activities that are the most appropriate for each stage.

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Child development from 0 to 5 years of age[7]

	MOTOR SKILLS	LANGUAGE SKILLS	COGNITIVE SKILLS	SOCIAL SKILLS AND PLAY
During pregnancy	• The baby can touch the walls of its mother's stomach. • The baby sucks its thumb. • The baby moves and co-ordinates its movements with its mother's.	• The baby can hear music and voices, especially its mother's voice.	• The baby does not have many thoughts but has reflexes.	• The baby is sensitive to its mother's emotional state.
0-3 months	• Almost no overall mobility, the baby lies down all the time. • The baby can suck. • Sleeps most of the time. • Holds its head up at around 3 months.	• Cries and noises depending on the level of unease, tension or comfort. • Smiling soon signifies pleasure or the beginning of a relationship.	• Avoids displeasure and pursues pleasure. • Learns by experience and repetition.	• The baby can see very early, first only things that are close, then things that are further away, and then can focus on human faces. • Can see clearly up to 20cm away. • The child is dependent on its surroundings for its wellbeing.
3-9 months	• Can sit up. • Can move by crawling. • Push-pull. • Digito-palmar prehension (brings objects to its mouth, moves cubes from one hand to the other)	• Uses its body to express its needs. • Laughs. • Babbles.		• Smiling is social and selective. • Pays attention to faces, comical expressions and voices. • Has exchanges with its mother, develops communication methods such as lallation and reciprocally imitating sounds. • Wants its mother to be there and wants to be in contact with her.
9-18 months	• Can stand up, first of all with some support (10 months) • Can walk independently between 10 and 16 months. • Can hold things between thumb and fingers • Moves objects around a lot: holds them, clutches them, looks at them, brings them up to its mouth, sucks them, bites them. • Can drink unaided.	• Disyllabic words. • Starts saying its first words.	• Begins to understand the permanence of objects around 10 months. • Begins to take an interest in details. • Is capable of imitation.	Relationship with the mother: • Experiences anxiety when separated from its mother. • Is conscious of the pleasure its mother gives it, ardently desires her presence. The baby knows her and can distinguish her from other people. The baby would like to play incessantly with her. • From 8-9 months the baby can express concern when faced a stranger. • Can play on its own. • Have often a favorite/transitional object (comfort object).
18-36 months	• Can go up and down a step. • Begins to run. • The movements in the child's upper limbs are more precise and better aimed. • The child can stand on one foot to reach an object. • The child can begin to draw. • The child likes pushing, pulling, fitting things together, filling things up, assembling things and separating things. • The child can catch a ball and throw it.	• The child progresses from words to its first sentences. • The child can say no between 18 months and 2 years. • The child has a vocabulary of 100 to 300 words. • The child varies its means of communication: drawing, language and imitation. • The child is capable of expressing feelings (distrust, grief, shame, anger, curiosity, joy).	• The child begins to create a mental representation of its environment (symbolism). • The child is capable of abstraction (can refer to an absent object). • The child shows opposition and develops its independence. • Opposition and imitation are ways the child identifies itself. • The child begins to discover its limits. • The child begins to show some interest in images.	• The child exercises its need for independence. • The child finds pleasure in doing new things alone. • At the same time as searching for independence, the child exercises its emotional dependence needs (resistance to going to sleep, need for rituals before going to sleep), shows distress and frustration. • The child establishes relationships (after a period of observation) with people other than those who are closest to it. The child begins to play with other children, one in particular. • Begins symbolic games. • Can pretend. • The mother is still the caregiver when the child is unhappy and she also takes care of its bodily needs.
3 to 5 years	• The child likes physical activity: running, jumping, climbing, etc. • The child is more precise in its movements and can skip.	• The child can talk and construct more complex sentences. • The child can ask questions and can respond to questions asked.	• The child develops memory, imagination (can tell stories). • The child begins to develop a personality. • The child is more conscious of its body and of different kinds of social roles.	• The child understands and respects rules. • The child likes to play with other children and have friends. • The child is capable of imitation. • The child likes stories. The child uses more and more imagination to play.

Table 4: Child development steps.

7 - For more information, please refer to Dorothy Einon's book, How Children Learn Through Play (edition Solar Famille, 1999)

2. THE NEEDS OF THE CHILD

During the development process, the child has got needs which are expressed in a simple and direct manner. The three basic needs of the child to ensure harmonious development, aside from the primary needs, are:

- A need for emotional security built on conflicting outbursts of feeling autonomous and dependent which are closely linked to the child's inner states. The primary sources of this emotional security are the parents.
- A need for differentiation, identity, a concept of self that is established gradually as the child discovers life and develops.
- A need for exploring and expanding its vision of the world, following the development of emotional security and differentiation.

More specifically, a child needs:

- To have food, clothing, rest and shelter.
- To develop its body and healthy hygiene habits.
- To feel loved.
- To be healthy (psychologically and physically).
- To be respected.
- To feel as part of a group.
- To feel the satisfaction of creating.
- To feel that its behaviour and efforts are accepted.
- To be encouraged.
- To be accompanied in its motivation to learn.
- To have permanent emotional bonds (support, comfort, environment).
- To learn how to think clearly and resolve difficulties.
- To know how to live harmoniously with others.
- To establish his first friendships.
- To develop cooperative behaviour with other children and with adults.
- To understand and appreciate values, rules, and cultural behaviours.
- To try out his first knowledge.

3. PLAYING: A NEED AS WELL AS A RIGHT

a. Importance of play in the development of a child

- Play is essential for the wellbeing and the development of the child.
- It is necessary to respect the child's moods, the times when they are active and the times when they are observers.
- Playtime is also a time for meeting and interacting.
- Play is a multiform activity: there are games for all situations and all ages.
- When playing in a Therapeutic feeding Centre, or an OTP, children need to have a specific location and appropriate space.
- Toys and games offered to children must be suitable to their ages and characteristics.

While playing children will develop their senses, will learn to coordinate their movements and will enrich their imagination.

A child's first toys are its hands. The first stage of establishing autonomy takes place around the age of 5 months. The child begins to grab whatever it discovers around it and to explore the world. The variety of games which may be offered becomes wider and the choice of toys is larger.

In order to find the right game for a child and to choose the right toys, above all, it is necessary to understand and to be aware of child's needs, abilities and tastes.
Toys given to the child vary over time according to the child's age, characteristics, state of health and preferences. Likewise, the use of mechanisms varies in accordance with the development of the child.

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It is important to offer the child a wide choice of toys and activities.

In nutrition centres, time is highly regulated and space is very organized. On the one hand, due to malnutrition, playmates are less active, less available, tired and tend to become easily tired. On the other hand, an adult is constantly present with the child. Consequently, it is absolutely essential to promote access to play opportunities and to create or re-create the desire to play among the children: by facilitating access to play activities, by making playthings available, by ensuring easy access to a play room, and by establishing an outdoor play areas.

In the framework of the OTP centres, play areas can be set up according to the context and available resources.
These play areas can allow the children to wait until their turn comes for appetite tests or medical consultations.

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On the day of the distribution and consultations, the OTP centre is often very busy, and the caregivers, along with the children, may have to wait a long time before their turn comes. The play area can be an important opportunity to gather mothers and caregivers together and offer them some mother-child game sessions. The waiting time will go more quickly and, at the same time, they will have an opportunity to strengthen the parent-child bond.
For the facilitator, this time can serve as an opportunity to observe the dynamic of the interaction between caregivers and children, in addition to carrying out the appetite test.

Toys have several functions:

- Help children learn how to have fun, learn about the world, learn vocabulary, learn mechanical actions, etc.
- Help in the development of the body.
- Foster development of the intellect and the imagination: observation, reflection, concentration, etc.
- Foster exchange and interaction between the child and the adult.
- Allow the child to discover its personal abilities and skills.

It is important to:

- Respect solitary game periods. In order to learn, the child sometimes needs to learn alone, without the intervention of adults whether to correct or to encourage it.
- Urge the child to play by making space available to them for discovery without limiting it to ready-made toys.
- Respect their rhythm: a baby or a child have also the right to daydream.
- Never forget that hyper-stimulation can also be negative.

The mother sets up all activities when the child is a toddler. As the child grows, it is able to play with toys by itself. Little by little, it becomes more sociable and it begins to play with other children.

Games and toys offered to children must be suited and adjusted to each child and be intended for children, whether they are beneficiaries or not, as well as for adults, accompanying adults, and adult beneficiaries.

b. The selection of games and the choice of toys according to age and characteristics of the child

The table shown in *Appendix 01* presents a synthesis of the development of a child as well as a non-exhaustive list of toys to select according to the child's age, as well as possible games. Do not forget that playtime does not have to involve toys but can also happen during the course of interactions through songs or storytelling, and through physical games or exercises. Moreover, any common object can be turned into a toy.

➡ Children less than 1 year old

At birth, the baby may seem to possess very little ability to do things. Appearances, however, are very misleading! Hearing, smell, touch and taste are fully developed in this little human being, and they assimilate large quantities of information about everything that surrounds them. They have perfect eyesight up to 20 centimetres. During the first three months of their lives, playing is their way of exploring and connecting with the world.

During the next three months, the child becomes more and more active. Play periods become simpler, more dynamic, and more pleasant for the family as the baby becomes more responsive.

The choice of toys for children in this age bracket will consist of toys that stimulate the senses: toys with sounds, colours, and varied textures, which the child can manipulate, shake, and bring to their mouths.

Basically, we are talking about rattles, music boxes, books made out of fabric, rag dolls.

The play-mat allows the baby's universe to change when the position of the baby's body changes even slightly. It is a place to explore sight, to touch, and to hear.

Everything is a source of interest on the play-mat:

- Attractive and diverse colours
- Varied texture according to different areas: gentle, rough, etc.
- Activities: objects, which can be grabbed, which make noise, which they can suck on and which can be observed.

The baby is typically laid on its back in the centre of the mat. Hanging or wall decorations offer visual attraction and stimulation. Also, consider sitting the baby up on some cushions, for example, in order to change its field of vision and allow it to develop other types of motor skills.

➡ Children between the ages of 1 to 2 years old

Activities are increasingly interactive. The child experiences more and more the need to play with its mother, looks for her presence and her touch.

They love all the toys involving actions like pulling, pushing, rolling, straddling, rocking, filling, emptying, manipulating, etc.

Cubes are of particular interest at this stage; these are toys that appeal to a child's intelligence and ability to manipulate. By playing, the child is going to activate the three fundamental mental operations that are:

- Observation: shapes, colours, patterns, etc.
- Understanding: how to assemble, how to classify, etc.
- Action: acting out what the child has learned, and learning through experimentation

➡ **Children over the age of 2 years old:**

The child is more and more interested in playing and being independent with respect to choices. The child begins to play with other children. It is the beginning of group play. However, the relationship with the mother remains paramount and she should stay involved in the child's activities, whether the child plays with her or with others.

Children are captivated by what they do and are able to concentrate for longer periods of time. At this age, preferred toys are symbolic toys (the child plays make-believe, role-playing, taking the place of someone else, acting out emotions, etc.), mimicking, games involving construction, stacking or building, puzzles, memory games and games involving skills.

c. Group games among children

The child begins to appreciate group games with their peers around the age of 2 years old. Even at a younger age, they may already start to play with other children, but they do not truly participate; rather they will play individually in a group setting. *Appendix 02* offers some examples of activities that can be organized with groups of children and categorized according to age groups.

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4. DEVELOPMENT AND MALNUTRITION

More than half of child mortality is associated with malnutrition, which weakens the body's resistance to disease. Malnutrition is often characterized by poor nourishment, frequent illnesses, and absence of adequate and attentive care given to a young child.

When a woman eats poorly during pregnancy or when her child is poorly nourished during the first two years of life, growth and physical and mental development can be delayed. Generally, this delay cannot be caught up later on and the child will suffer from it for the rest of its life.

Children have the right to have people around them caring for them, to be protected, and to receive food with good nutritional value and basic health care that will protect them against sickness and promote their growth and development.

Malnutrition affects their motor development, their relationship with their body, desire, and appetite. Malnourished children are weaker, more apathetic, sometimes suffer physically, and may feel no desire to play. It is important to adapt activities and games to their abilities, to offer games they find interesting and to develop their desire to use of them[8].

Malnutrition can cause the child to regress and often as a result, a child who could previously walk is not able to walk again due to the illness. Similarly, it often happens that children, who cannot walk due to their weakness, rapidly gain the ability to stand up when the treatment begins to take effect[9].

The stages of development should therefore be adjusted according to the child's state of health and level of malnutrition:

1. A child who is thriving gains weight rapidly. The child should be weighed every month between birth and the age of 2 years old. If the child has not gained weight during approximately a two-month period, this is an indication that something may be wrong.
2. Breast milk is the only food and the only drink that an infant needs during their first six months. After six months, the infant needs various other foods in addition to breast milk.
3. From 6 months and up to the age of 2 years old, the child needs to eat 5 times a day, in addition to breastfeeding.

8 - You will find more information in MHCP technical sheets.
9 - See also studies done by Suzanne Robert-Ouvray for ACF on psychomotor stimulation of the severely malnourished child.

4. Children need vitamin A to be protected against illness and to avoid sight problems. Vitamin A is contained in numerous fruits and vegetables, oil, eggs, dairy products, enriched foods, breast milk and vitamin A supplements.

5. They need foods that are rich in iron to protect their physical and mental capacity. The best sources of iron are liver, lean meat, fish, eggs, as well as food enriched with iron or iron supplements.

6. Iodized salt is vital for the prevention of learning disabilities and retardation of the development of the child.

7. The child must continue to eat regularly even when it is sick. After an illness, the child needs one supplementary meal at least each day for one week at least.

UNICEF has highlighted a certain number of important questions to raise when a child is not developing properly:

- **Is the child being fed often enough?** A child should eat 3 to 5 times a day. A child with a disability may need help and more time for feeding.

- **Is the child receiving sufficient food?** If the child asks for more food when he has finished eating, it should be given more.

- **Is the child's food too poor in « growth » or energy nutrients?** Foods that support the growth of the child include meat, fish, eggs, beans, peanuts, cereals and legumes. Adding a small amount of oil provides energy. Red palm oil and other enriched edible oils are good sources of energy.

- **Is the child refusing to eat?** If the child does not seem to like the taste of a particular food, it should be given something else. New foods should be introduced gradually.

- **Is the child ill?** When a child is ill, it should be encouraged to frequently eat small portions. After an illness, the child needs an extra meal per day during one week. Young children need one supplementary breastfeed over one week at least.

- **Is the child receiving enough foods rich in vitamin A to prevent it from becoming ill?** Breast milk is rich in vitamin A. Other foods containing vitamin A include liver, eggs, dairy products, red palm oil (only when other types of oil are not available), yellow and orange fruits and vegetables, as well as several leafy green vegetables. If these foods are not available in sufficient quantity, which is often the case in several developing countries, the child should be given a vitamin A capsule twice a year.

- **Is the child receiving breast-milk substitutes in a baby bottle?** If the child is less than 6 months old, exclusive breastfeeding is the best practice. Between the ages of 6 and 24 months, breast milk is still preferable, for it contains dietary minerals. If you are giving the child another type of milk, you should feed it with a clean and open cup rather than with a baby bottle.

- **Are different foods and water always clean?** If they are contaminated, the child will often become ill. Raw foods should be washed or cooked. Cooked foods should be consumed quickly. Water should come from a source that provides drinking water and should be kept in a clean place. Drinking water could come from a water grid system that is regularly maintained, monitored and chlorinated. Drinking water can also be obtained from an Abyssinian well, a hand-pump, or from a protected spring or well. If water is drawn from a pond, stream, spring, well or reservoir, it should preferably be boiled prior to consumption.

- **Is stool thrown into latrine pits or buried?** If not, the child may suffer from worms or be frequently ill. A child suffering from worms needs anti-worm medication.

- **Is the child often left alone or entrusted to the care of an older child?** If this is the case, the young child will need more attention on the part of adults and more stimulation, especially during meals.

It is also important to explore whether positive and effective sources of stimulation are present, as when absent or of poor quality, this could have a serious impact on the nutritional health of the child!

Severe malnutrition often leads to regression in relation to previous learning and skills acquired (for instance, a child who used to walk is no longer able to). This aspect of the child's condition should be taken into account at the time of admission into care, because severe malnutrition may directly affect its capacities. In the course of treatment, particular attention needs to be paid to stimulating a child suffering from severe malnutrition in order to contribute to the recovery of psychomotor development.

5. THE IMPORTANCE OF THE FATHER-MOTHER-CHILD RELATIONSHIP

- Parenthood is not acquired spontaneously: parenthood is not a state, but a process that is constructed from the parents' experiences, and from their relationship with their child.
- The relationship between mother and child starts before birth: there are already a large number of interactions during pregnancy.
- Interactions are exchanges that take place in both directions: from parent to child and from child to parent.
- Newborn babies have the ability to be active partners and have an impact on their family circle.

a. The Process of Parenthood

The process of parenthood is an essential component of the mother/child relationship. People are not born parents; they become parents. It is a question of constructing the process in the course of interacting with the child.

Several factors may influence this process:

- The state of the child, its appearance, health, behaviour, personality, character, etc.
- The health status of the mother as well as the relationship that she had with her parents as a child.
- The availability and emotional security of the mother and the family circle, all elements linked to the material conditions of life, to the strength of her social networks (where the father plays a special part), to any possible history of maternal psychopathology, or to recent or past events that could have a traumatic impact (death, separation, violence, etc.).
- Culture and beliefs: the representation that parents have of their child, of its capacities or needs varies from one culture to another, and can have an impact on parent-child relationships. Furthermore, culture and context also may influence the way parental roles are represented, the position of children in the family, the appropriate way of relating, or even of authority.

b. The mother is the privileged partner of the child and their communication is of critical importance for its development.

The mother-child relationship starts during pregnancy. While pregnant, the mother feels her child moving; she is able to recognize the different parts of the body and the position of the child by touching her belly; she is able to feel the impact of her actions on the attitude of her child, etc.
For its part, the child hears and physically feels the mother's heartbeat; it hears her voice and feels her emotional state.
The intrauterine relationship contributes to the future development of the child, especially at the emotional level. This is why it is important to show an interest in pregnancy, what feelings the mother has about the connection with her child or not, whether the child is desired, etc.

After birth, the child has to become aware of its body in its totality, with its limitations, enclosure, content, and motor skills. All of this can be done through tactile, behavioural, and sensory stimulation, performed by the parent or a substitute or a caregiver, without which the child finds itself alienated from "the backbone of its identity"[10].
Play sessions allow for the fostering of exchanges between mother and child, and for providing the best possible support.

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Interactions: these are characterized by the behaviour and attitude of mother and child in relation to one another.
The methods of interaction change with the age of the child. For example, babies request more visual interactions and physical contact with the mother than older children who prefer verbal interactions.
Moreover, modalities differ from one culture to another. Body interactions, for example, are more prominent in certain countries of Asia where infant massage practices are quite common.

c.Different Types of Interactions:

• **Visual interactions:** They are particularly important during the course of the first months of life. During this period, the mother and the child have a very close relationship. Visual interactions help the child to feel secure; the glances of its mother provide the child with a reference point, enabling it to find its way and to develop.

• **Verbal interactions:** the shouts and cries of the child are there to indicate that the child is not well and trigger interaction. When they are understood and interpreted in this way, they attract the proximity of an adult.

These interactions start at birth, when the mother begins talking to her child, or even during pregnancy. The child is capable of recognizing the voice of its mother and father after birth, if it heard them during pregnancy. These voices cause the child to react and reassure it.
The way in which the mother reacts in face of her child's crying could serve as a source of information

10 - Lemay M. (1979) J'ai mal à ma mère (I Feel My Mother's Pain). Fleurus, Paris.

about her representation and her competencies as a mother; her fears, as well as the type of relationship she has with her child. As the case may be, she could have a feeling of doubt about her skills, an attitude of aggressiveness or hopelessness. The way in which the mother deals with the crying of her child is an important determining factor in the development of the child.
As the child grows, it enters into the language phase, and is able to express its emotions, fears and joys verbally. Interactions between the mother and the child thus take on a new dimension, and they are still very important. The explanations provided by the mother, her answers to questions asked by her child, the tone of her voice to talk to it, are all factors that will influence the development of the child's personality.
Once again it is important to highlight the fact that these interactions vary from one context to another. Speech is widely used in some cultures, whereas others employ different modes of communication. It is of prime importance to take this into account when interpreting observations. Even if language is not the preferred mode of communication in certain cultures, it still remains an important component in the development of the child, and the mother should be encouraged to talk and communicate with her child.

• **Body and skin to skin interactions:** the focus here is on all the exchanges used by the mother in holding, supporting, maintaining the child, and how it responds to them. Skin to skin contact is very important such as caresses, tickles and kisses.
Adequate responses on the part of the mother to the demands made by her child (be it through crying, smiles, glances, etc.) enable the awakening of its psychic life, giving the child the illusion of creating the world, and a sense of its own existence. The child's basic sense of security will be fostered through primary maternal interventions, holding (physical and psychological carrying) and handling (gestures, wrapping the child) and the methods used, adapted to its capacities, to familiarize it with the world (see also Winnicott: *the baby and his mother* published by Payot, 1992).

• **Emotional interactions:** They are characterized by the reciprocal influences of the emotional life of the mother and the baby.
Emotional communication immediately exists in the newborn, and interactions between the child and the mother are instantaneous. The first days following the birth represent a sensitive period when the mother is particularly open to constructing a close connection with her child. This communication is extremely important and a strong determinant influencing the entire psychological life of the child.
The newborn is particularly dependent, and has even greater need of its mother and her protective care. Furthermore, a sick child could regress, becoming more vulnerable, and demanding even more so, these emotional interactions.
These interactions can be expressed through simple gestures and a general attitude on the part of the mother, seeking to comfort and reassuring her child.

• **Interactions and the realm of fantasy:** the fantasmatic life of parents is very much linked to their emotional life, but also, and more profoundly, to their own story and their self-image as parents. The imaginary and fantasy life of the child is built gradually, based on that of the parents.
These interactions may manifest themselves through symbolic games. Dolls for example can trigger emotions: the child role-plays the emotions it is experiencing, or wishes to experience, using symbolic characters that it creates through dolls or figurines. This type of game can serve to highlight some disorders present in the child or issues regarding its relationship with the mother. The symbolic game could assist not only in conflict resolution, but also in compensating unmet needs, in reversing roles (obedience/authority), in providing a sense of freedom and the expanding of the concept of self.

To facilitate harmonious emotional development, it is important to value:

- Emotional availability of the adult.
- Flexibility in the responses of the adult.
- Stability, continuity and coherence over time.

The context in which the mother-child interactions are anchored plays a determining role both in their relationship and in the development of the child: the anxiety experienced by the mother, displacements, loss of property and/or of loved ones, and the physical and psychological consequences of crisis situations are all factors that interfere in the relationship. The mother, if often preoccupied by vital priorities, will be less available to respond to the child's needs.

When the family loses its resources and the mother has to travel long distances to bring water, food or firewood, and when malnutrition or fatigue sets in, or again when she has lost her husband and finds herself alone to provide for the needs of the family, all those difficulties may undermine the mother's capacity to care for her child. The situational context influences the development of the child in a more or less direct way, whether motor, psychological or emotional development, its relationship with the mother, and subsequently, with others as well.

IMPLEMENT

1. ADOPT AN ATTITUDE WHICH ENCOURAGES HEALTHY CHILD DEVELOPMENT

Unicef[11] lists 5 essential factors for healthy child development:

1. The care and attention shown to a child in the first 8 years of life, and especially before the age of 3 years old, are major determinants of the child's future.
2. Babies start learning quickly from birth. They need affection, attention and stimulation, as well as good nutrition and appropriate health care in order to grow and develop.
3. Children must be encouraged to play and explore. This develops and enhances them socially, emotionally, physically and intellectually.
4. Children learn behaviour by imitating their peers.
5. All parents and caregivers should be able to recognize the signs of delayed growth and development in children.

The following chart provides information on how children develop, the behaviours and attitudes to adopt based on the stage of development and the signs of possible developmental problems. It is important to remember that these are benchmarks, which may vary from child to child, as each child develops at its own pace. Depending on culture and context, children develop differently according to the stimulation and interaction they have with their support systems and environment.

Babies that are kept swaddled until the age of 6 or 12 months, such as those in Afghanistan, for example, may display delayed development because they cannot move or respond to body stimulation during that time, although they catch it up later on.

Slow development may be "normal" or the sign of malnutrition, poor health, lack of stimulation or something more serious. In the field, it is helpful to create a network of partner institutions or service providers capable of diagnosing and treating ill children.

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11 -Additional information on child development and other interesting topics is available on the UNICEF website: http://www.factsforlifeglobal.org/

2. ADJUST BEHAVIOUR AND ATTITUDE ACCORDING TO THE AGE OF THE CHILD AND OBSERVE HIS/HER DEVELOPMENT

	The baby should be able to	Advice on important behaviour and attitudes	Signs that should not be ignored
1 month	• Turn its head towards a hand that is caressing its cheek or mouth. • Bring both hands to its mouth. • Turn its head when it hears familiar voices and sounds. • Breastfeed and touch mother's breast with its hands.	• Establish physical contact and nurse the baby within an hour of its birth. • Support the baby's head when it is being held upright. • Stroke and caress the baby often. • Always hold the baby gently. • Nurse the baby regularly. • Speak, read and sing to the baby as often as possible.	• The baby has trouble suckling or refuses to nurse. • The baby does not move its arms and legs very much. • The baby does not react, or displays little reaction, to noise or bright light. • The baby cries for long periods of time for no apparent reason. • The baby vomits or has diarrhoea.
6 months	• Lift the baby's head and torso when it is lying on its stomach. • Reach for suspended objects. • Grab and shake objects. • Roll over in both directions. • Remain sitting with support. • Explore objects with the hands and mouth. • Start to imitate sounds and facial expressions • Respond to its name and to familiar faces.	• Lay the baby on a clean, smooth, safe surface in such a way that it can freely move and grab objects. • Support the baby against something or hold it so that it can see what is going on around it. • Continue nursing it on demand night and day and start to add other food (two meals a day between 6 - 8 months, 3 to 4 meals a day between 8-12 months). • Speak, read or sing for the baby as often as possible.	• Stiffness or difficulty moving limbs. • Constant head movement (which may indicate an ear infection, which could lead to deafness if left untreated). • No reaction or limited reaction to sounds, familiar faces or mother's breast. • Refusal of breastfeed or refusal of other food.
12 months	• Sit without support. • Crawl, or stand up while holding onto something for support. • Take first steps with support. • Try to imitate words and sounds and respond to simple questions. • Enjoy playing and clapping hands. • Repeat sounds and gestures to attract attention. • Grip objects between the thumb and index finger. • Start to hold objects like spoons and glasses and try to feed itself unaided.	• Point to objects and name them; speak and play frequently with the baby. • Use mealtime to encourage interaction with all family members. • If the baby demonstrates delayed development or has a physical handicap, focus on it abilities. Provide more stimulation and interaction. • Do not leave the baby in the same position for hours at a time. • Organize its environment to minimize the occurrence of accidents. • Continue to breastfeed, ensure that the baby has eaten enough and that its diet is varied. • Help the baby try to use a spoon and a glass. • Ensure that the baby is vaccinated and receives all recommended amounts of supplements.	• The baby does not make sounds when spoken to. • The baby does not watch as objects are moved. • The baby is apathetic and does not respond when it is cared for. • The baby has no demonstrate an appetite or refuses to eat

Table 5: Adjust behaviour and attitudes in relation to the child's development.

	The baby should be able to	Advice on important behaviour and attitudes	Signs that should not be ignored
2 years	• Walk, climb and run. • Point to objects or pictures when they are named (for example, the nose, and the eyes). • Use some short sentences (from approximately the age of 15 months). • Follow simple instructions • Scribble when given a pencil or a crayon. • Enjoy simple stories and songs. • Imitate the behaviour of others. • Start to feed itself.	• Read, sing and play with the child. • Teach the child to avoid dangerous objects. • Speak normally to the child - do not use baby talk. • Continue to nurse, and ensure that the child gets sufficient nourishment and eats a variety of foods. • Encourage the child to eat, without forcing it. • Establish simple rules and reasonable expectations. • Praise the child when it succeeds at something.	• The child does not respond when it is being cared for • It has poor balance when walking. • Inexplicable injuries and changes in behaviour (especially when others take care of it). • It does not have an appetite
3 years	• Walk, run, climb, play with a ball and jump easily • Recognize and identify images and objects by pointing to them • Speaking in sentences of 2 or 3 words • Say its name and age • Name colours • Understand numbers • Use objects in pretend play • Feed itself • Show affection	• Read and look at pictures with the child and explain the pictures. • Tell it stories and teach it songs and rhymes. • Give the child its own bowl or plate when eating. • Continue to encourage the child to eat and give it the time it needs to eat. • Help the child learn how to dress, wash hands and use the bathroom by itself.	• Loss of interest in playing • Frequent falls • Difficulty in handling small objects • Difficulty in understanding simple messages • Inability to speak using several words • Lack of interest in food
5 years	• Move in a coordinated way. • Make sentences and use many different words. • Understand opposite words (for example, fat and thin, big and small). • Play with other children. • Dress without any help. • Answer simple questions. • Count between 5 and 10 objects. • Wash its hands.	• Listen to the child. • Do a lot of activities with the child. • If the child stammers, suggest that it speak more slowly • Read to it and tell it stories. • Encourage the child to play and explore.	• Observe the roles the child takes on when playing. If the child is fearful, angry or violent, it may have emotional problems or may have been the victim of abuse. • Loss of interest in playing.

Table 5: Adjust behaviour and attitudes in relation to the child's development.

3. ENCOURAGE MOTHER-CHILD INTERACTION

Mother-child interaction contributes to the child's sense of security and allows it to engage in and explore the outside world, play with others and develop autonomy. If the child's attachment to the mother is strong through interaction, the child uses its mother as a safe base from which to respond to its environment. This interaction may be observed in mother-child sessions.

In TFCs, all staff members may promote the role of the mother:

- In daily care by demonstrating micro-interactions,
- In medical follow-ups by pointing out the child's development,
- During meals, by supporting the mother and emphasizing eye contact, etc.

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In the OTP, mothers and children only come on the day that RUTF is distributed, but the mother's role can be promoted at various times:

- When the child is being weighed or examined by a medical professional (calm, reassure the child, give it explanations or a small toy, etc.),
- During mother-child play sessions or organized activities while waiting.
- When conducting the appetite test, by taking time with the child, encouraging or praising him/her, etc.

There are also sometimes prevention programs in the same communities to which the mothers may be referred and where working on the child-parent bond may be carried out.
Observation charts may thus be developed in order to document the strengths and weaknesses of the mother-child relationship. These charts may be used in malnutrition treatment and/or prevention.
Based on the observations and interpretations that arise, it is then possible to make an action plan based on the areas that are difficult for the mother and child and to work together to reinforce strengths and mitigate weaknesses.

The following chart is an example of how to monitor and observe mother-child interactions. The points raised can be modified depending on the age of the child and the context. In all cases, it is important to interpret observations and create action plans based on the interpretations.

The best time to observe mother-child interaction is at **mother-child play sessions**, and/or **daily care** (such as when bathing or feeding the child).

More information is available in the corresponding files. List of fact sheets.

Mother-child interactions			
Date :	*Child's name:*		*Mother/caregiver's name:*
CODE	◇ = *always or constant*	● = *Occasional or absent*	✖ = *Not observed*

Child		Mother	
EMOTIONAL INTERACTIONS			
Smiles at mother		*Responds to baby smiles*	
Responds to mother's smiles		*Smiles at her baby*	
Shows affection to its mother		*Shows affection to her child*	
Seeks affection from its mother		*Seeks affection from her child*	
PHYSICAL INTERACTIONS			
Can be separated from its mother		*Takes the child in her arms*	
Seeks physical contact		*Encourages the child not to be clingy*	
Uses touch to explore		*Stimulates the child's sense of touch*	
Is active and moves		*Encourages the child to be active*	
Gives objects to its mother		*Takes objects given by the child*	
Takes objects given by its mother		*Gives objects to the child*	
Imitates his/her mother's gestures		*Encourages the child to imitate her gestures*	
VERBAL INTERACTIONS			
Uses his/her voice to communicate		*Uses her voice to communicate*	
Understands instructions and warnings		*Gives explanations*	
Laughs		*Reacts to her child's cries*	
Imitates, responds by echoing		*Encourages the child to imitate her words and sounds*	
VISUAL INTERACTIONS			
Looks for its mother and watches her		*Seeks out visual contact with the child*	
Responds to its mother's looks		*Looks at her child*	
Calls its mother's attention to objects		*Calls the child's attention to objects*	
Observes its environment		*Encourages the child to observe his/her environment*	

TOTAL

		CHILD	MOTHER	INTERACTION
EMOTIONAL INTERACTIONS	◇			
	●			
	✖			
PHYSICAL INTERACTIONS	◇			
	●			
	✖			
VERBAL INTERACTIONS	◇			
	●			
	✖			
VISUAL INTERACTIONS	◇			
	●			
	✖			
TOTAL	◇			
	●			

Notes and action plan:

Table 6: Chart for observations of mother-child interaction.

VI. EVENTS AND ACTIVITIES

REMEMBER

- ➔ The goal of organizing activities within malnutrition treatment programs is to restore interest in life, provide joy, create social bonds and enhance the treatment effects.
- ➔ Encouragement and facilitation are integral part of the treatment.
- ➔ Facilitation does not entail only activities; it is also a state of mind.

UNDERSTAND

Regardless of age group, children like adults, have certain needs that have to be balanced, as indicated in the following table[12]:

Movement: need to move, to exert themselves, to exercise their bodies, to get fresh air.	**Rest:** need to rest, to be calm.
Security: need to feel safe; to feel protected both emotionally and physically.	**Risk:** need to take risks in order to grow, and to know their limits.
Socialization: need to exist as part of a group and to contribute to its development.	**Autonomy:** need to do things on their own, to exist outside of a group.
Imitation: need to learn by imitation, need to do what others do.	**Creation:** need to differentiate, to express their personalities.
Reality: need to know about the reality that surrounds them, need to understand events and the environment.	**Imagination:** need to dream, develop their imagination, and explore their potential.
Experience: need to experience many physical and mental feelings.	**Action:** need to manipulate things and act upon them, and to transform their environment.

Table 7: The balanced needs of children.

The child's spontaneous response to its own needs starts with play and depends on the possibilities for expression that are offered to it. The more diverse they are (space, time, relationships, etc.), the more the child will find the responses that are meeting its needs.

12 - UNICEF. Early Childhood Development kit (ECD-kit)

IMPLEMENT

The following are examples of activities that may be organized in centres, OTP centres or both, for different purposes, with varying budgets as well as human and material resources.

1. OUTDOOR ACTIVITIES

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It takes very little to create a pleasant space. In most countries, you will be able to find a carpenter to build seesaws, slides, scooters, etc.
When a centre is equipped with outdoor play equipment, children have a play area, which encourages their motor and social development. Possible activities include tunnels, seesaws and other games allowing many children to play freely in fresh air, which develops physical skills as opposed to indoor activities.

Organizing games is simple and effective: team activities for older children, contests (drawings, painting, etc.).
It is also interesting to invite mothers to participate in the activities, which differ from the mother-child sessions.

2. PLAY CORNERS

In feeding programs, children should have access to a variety of toys so that each child, whatever its abilities, age and preferences, can have a toy that interests and suits him/her, and the quantity of toys must be sufficient to cover for children's changing choices.

Appendix 06 suggests some categories of toys to be provided in centres in order to satisfy the different abilities of the children and suit the child's development and preferences.

In addition, you will find in *Appendix 07* an example of a list of toys that should be available in a centre that accommodates 50 children.

Centres must have some basic materials for creating simple objects and toys, such as lead-free paint, some tools, tissue paper, needles and thread or even wool.

At OTP centres, while people are waiting, the same toys may be used in a playroom available for parents and children, and also to reassure children when they are being weighed, for example.

Most of the toys can be reproduced more or less easily[13]. Organizing workshops to create toys is one way to have toys to be used in play sessions or at home. These workshops are an opportunity for the people to learn how to make things (toys or other objects) too and develop their imagination and creativity.

Involving caregivers in the activities is important and their relationships with the children are strengthened when they have created the toys/support tools themselves. They can also reproduce the toys at home and in that way continue to use skills that they learned at the centre.

Some basic rules, in the case of creating toys, particularly with respect to safety, must be considered. Lead-free paint must be used (children put toys in their mouths and so this precaution is essential), and of course avoid nails and spikes.

If toys are intended for very young children, small pieces must be avoided that could be detached and swallowed. Wooden toys must be sufficiently smoothed and varnished to avoid splinters. Toys must be solid and must not break or be likely to cut children.

13 - You will find examples of toys that can be made locally on the cd-rom MHCP with photos

Many toys and objects may be made without much difficulty and with very basic materials. For example, books made of cloth and play-mats, musical instruments from bottles, woollen dolls, finger puppets, skittle sets in storage boxes, puzzles, dominos and egg carton memory games. *(See Appendix 04)*. You can also ask people to come up with their own ideas for things to create!

© ACF-Mali

➡ At the feeding centres

Toys can be made available for children at the nutrition centres, as well as toys for adults (cards, awale)…in stages and with free access. At the end of the day, it is important to store the toys so that they do not get damaged and so that supplies are maintained.
Mothers can be designated to be alternately in charge of the toys so as to make sure that they are available during the day and put them away at night.

During the first week of in-patient treatment, it is very difficult to organize activities:

- Children are apathetic and often sit down and rest, without moving, close to their mothers, looking lost, and are not interested in anyone or anything. They are strongly dependent on their mothers.
- They do not try to do much and they communicate very little.
- They often refuse toys, and just look at them and sometimes hold them, for example, small plastic balls. It is important to bring out every advance and every effort without forcing the children to play, but attempting to interest them as much as possible and little by little.

In this first week, even small gestures are important; a child's smile should be praised. Make small toys available to the child and reassure mothers that their children are making progress.
In the transition phase and phase 2, even if the children have improved physically, they still need psychological support, and it is crucial to give them a way to flourish and feel good about themselves. It is also necessary to prepare children and mothers for their return home. In phase 2, a play corner is essential. Children have generally regained their autonomy and are often less dependent on their mothers; they will seek a space to discover things and enjoy group games. It is therefore important that children be given some time to play and to do activities, to make toys available for them and to create outdoor play areas and offer activities for mothers as well, etc.

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➡ At the OTP centre

In the case of play areas, there are certain things to remember:

- Identify a person responsible for bringing, putting away and cleaning the toys and materials (it could be health educators, psychosocial workers or any other member of the team).
- Identify one or more people to be in charge of organizing and monitoring play sessions (it might be community volunteers, mothers or psychosocial workers).
- Define a specific area that should be located far enough in order to avoid disrupting on the its way of operating the CNA, and made secure to prevent any potential accidents.
- Wash the toys daily to avoid transmission of germs.

More information on **mother-child playing sessions** is available in the corresponding file.

3. ACTIVITIES FOR MOTHERS

The mothers you will meet at the feeding programs have often suffered a great deal, both emotionally and physically. They are often very young and do not know how to care for their children. The mothers who have malnourished children are often more depressed than those whose children are ill due to other reasons. The common characteristics of depressed people are sadness, fatigue, the feeling of being overwhelmed by problems, a lack of self-confidence or a lack of confidence in life, and withdrawing into oneself. These women often do not interact with anyone, sometimes not even with their own children.
At the TFCs, they suddenly find they have to share their lives and privacy with other women and children, whom they do not know, some of different ethnicities and who speak other languages.

Activities may be proposed for these mothers, which allow them to:
Be more active :

- Avoid getting bored
- Have a place where they can meet and exchange
- Share their experiences with others
- Regain self-confidence and have the feeling that they do something useful
- Learn activities that they can then do at home, etc.

Activities should be adapted to their needs, their knowledge and their culture. For example, they will not be offered dancing, if, in their culture, females do not dance.

It is important to provide a variety of activities and organize new ones weekly. For example, have small discussion groups and ask them what they are able to do and what they would like to learn. This allows to take into account their opinions and to suggest new ideas.

Some examples of activities:

- Make toys for children
- Share traditional stories
- Sing or dance
- Make children's clothing
- Draw or paint
- Local crafts
- Drama, etc.

These activities are not compulsory, but it is important to motivate the mothers to come and attend them freely. Exact days and hours must be established so that mothers can be informed and get organized sufficiently in advance. The activities must also take place in a quiet and spacious area where they will feel at ease.
They will often come with their children. The area must therefore be organized so that they can sit down on mats, for example.
It is necessary to choose equipment based on the number of people and type of activity. The facilitator should place an order quite in advance for sufficient quantities. He will be responsible for managing stocks, for organizing and carrying out activities, for informing mothers. He will also be in charge of facilitating sessions.

4. GROUPS DISCUSSION

Discussion groups are made up of small groups of a maximum of 7 people. They must take place in calm places where the participants feel safe and comfortable to express themselves freely.

The aim of this activity is to offer people an opportunity to express themselves, to create social connections, to increase care practices and to avoid that caregivers or adult beneficiaries feel isolated. Discussion groups are not training groups as the aim of a discussion group is different from that of an awareness-raising group,

for example. The goal of discussion groups is not to communicate information or messages, but to allow exchanges and to give people the opportunity to talk and to share. The people who participate in the discussions suggest the topics of discussion.

The person who organizes the group is called the facilitator. Generally, this is the presenter; however, other members of staff may also play this role. This person regulates the discussion group, but does not lead it.

How to organize a group discussion:

- Gather together the participants and ask them to sit in a circle.
- The facilitator welcomes everybody and opens the session.
- He/she introduces him/herself and asks each participant to do the same.
- He/she invites the participants to suggest discussion topics and to select one to begin with.
- Questions will be asked in order to ascertain what the participants know about and think of the topic chosen.
- The facilitator can go into further details on certain questions in order to go even further into the discussion.
- It is essential to allow the participants to express themselves and to encourage them to share their opinions, beliefs and attitudes with the others. However, it is also essential to respect the participants who do not wish to contribute.
- At the end of the discussion, the facilitator will summarize the most important points and then will thank each participant for his or her contribution.
- In order that the session be effective, any changes in discussion or beliefs must come from the group, not from the facilitator. The facilitator must encourage, not impose, changes in discussion.

5. AWARENESS SESSIONS

Awareness sessions can enhance the knowledge and the skills of the caregiver on good practices (food practices, hygiene, care, etc.).
The material used must be attractive, easy to understand, illustrated (depending on the context) and specifically designed for the public it targets. Facilitation is not only an activity, but also a state of mind.
Action contre la Faim emphasizes the necessity of establishing health and hygiene awareness sessions as a way of improving the living conditions of populations.

In addition to the sessions on different topics such as water and sanitation, nutrition, food safety and health, sessions specifically dedicated to care practices can be facilitated in order to emphasize the importance of stimulation and play in the development of children. It can also participate in the improvement of the treatment, or even the necessity of a strong mother-child connection in helping the child grow and feel well.
In general, two topics related to care practices could be integrated into awareness-raising sessions. These are, on the one hand, the child's needs and development and, on the other hand, the importance of playing for children.
In addition to these, other topics can be added depending on the context, for example foetal alcohol syndrome, a problem which is often found in Juba (Sudan), or even breastfeeding and its difficulties, a problem which is particularly specific to Kabul (Afghanistan).

In addition to information given in a collective way, awareness and advice can be provided to beneficiaries individually depending on the specific difficulties that they are facing[14].

14 - More information concerning health education can be found in the document « Policy paper for hygiene promotion and health education », Action Against Hunger.

VII. MOTHER/CHILD PLAY SESSION IN FEEDING PROGRAMS

REMEMBER

- Play is a way to give the child pleasure and voracity.
- Mother-child play sessions aim to:
  - Develop the mother-child relationship,
  - Stimulate the child and limit delays in development,
  - Give the mother the knowledge and skills which allow her to use the games and find her place in the activities.
- Play sessions are an integral part of the treatment. In feeding centres, these play sessions must take place daily as from the transition phase: they not only strengthen the treatment, but also make it possible to detect potential difficulties and how to deal with them. In nutrition centres, play sessions must take place as often as possible. Within the framework of integration in health centres, it is also useful to organize play sessions and to invite all children to play.
- It is essential that participation in play sessions takes place on a voluntary basis. The right not to play is as important as the right to participate.
- This fact sheet introduces structured play sessions, but as other fact sheets underlined it, the availability of toys and the play are a state of mind that goes beyond the mere management of malnutrition.

UNDERSTAND

Play is the activity that characterizes a child. It encourages the child's socialization process, and also plays a role in the development of the child's personality and in its mental development too. A child who does not play is a child that is not well.

A lack of affection can lead to malnutrition. A child is at risk of malnutrition when it has not managed to create satisfactory attachments (see: Conceptual models of child malnutrition). Situations where a child has been abandoned or neglected, whether this happens outside or within the family (a child can suffer from abandonment even within its own family), can lead to severe personality disorders[15]. Discontinuity or distortion in a child's relationship with its mother or with the mother substitute can lead to a break-up in the reassuring relationship which is necessary to the child's development and can cause an emotional lack in the child's life.
The situation may be even more complex if the child or its parents have experienced difficulties as part of a conflict or a catastrophe, which had direct consequences on the child's family circle and its psychological and emotional development.
Within this framework, mother-child play sessions can help the mother to communicate better with her child and to stimulate her child, therefore improving or restoring the relationship between them and allowing the child to find or remember its place in the dyad.

15 - Lemay M. (1979) J'ai mal à ma mère. Fleurus, Paris.

A child dealing with emotional deficiency can stand by its behaviour towards food, with regressive food intake, which is symptomatic of its state of mind.

The main consequence of malnutrition in a child is late development and specific or general damage to the child's cognitive and intellectual ability which can persist at least until adolescence.
When the child is experiencing severe malnutrition, it is often apathetic in its attitude. The mothers are worried, do not have much time for the child and are sometimes depressed, not only because of their child's malnutrition, but also because of the situation that they find themselves in. Often they are no longer in a situation to stimulate their child's development. Time is needed for the child's state of health to improve so that the mothers regain self-confidence and in turn so that the children show some interest in their family circle again.
Within this framework, play can stimulate the child, help the child getting back appetite and can limit developmental delays.

Through playing, we can stimulate the child's imagination, awaken its curiosity and develop its appetite for life as well as developing psycho-emotional exchanges between the mother and the child. It is essential to consider **the child along with its mother** or its maternal substitute as this relationship is of primordial importance to the child and has an impact on its healing process and future psychological development *(see note on the importance of the mother-child relationship).*

The representation of playing varies from one culture to another. Some cultures favour it by encouraging their children to participate in activities by providing them with toys. In other cultures, play is for children only and adults do not take part in it. The child therefore discovers play through its peers.
Playing consists in more than giving toys. Occasionally, child's play is better developed in the space rather than in handling it, especially in some African cultures where material objects do not encourage social exchanges and do not relate the child with social symbolism. Other forms of exchange are preferred in these cultures, especially the relationship to food, the body and the surrounding space. As a result, the relationship with toys can be more difficult in some countries. In this case, it is possible to use other forms of interactions and to progressively familiarize the children and their caregivers with toys and teach them how to enjoy playing with these toys.
Toys help the child to enjoy itself and to have fun. They also help the child in its development, but some activities can take place with direct interaction with the mother or the caregiver. This interaction could be visual, verbal, physical or with contact games.

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It is important to:
- Restore the connection between the mother and the child, which has often deteriorated because of the child's critical state as well as the availability and the physical state of the mother.
- Give the child the opportunity to develop his/her own capacity to play and to have a renewed taste for play and life.
- Teach the mother how to play and find her place in the game.

IMPLEMENT

Mother-child sessions must take several things into account. This is not about reuniting the children with their mothers and giving them toys. It is essential to keep in mind:

- The framework
- The organization of the session
- The progression of the session

Generally speaking, some mother-child activities can be suggested at any time in order to restore the connection between the mother and the child.
You will find in *Appendix 03* examples of activities, which can be suggested to mothers and are very easy to carry out with the child.

Sessions must therefore be planned, prepared and monitored. The Action Plans that are dealt with at the end of this document provide more details on how to adjust the sessions to match specific needs and to target optimal activities for more effective sessions.

1. FRAMEWORK OF THE MOTHER-CHILD SESSIONS

When setting up the playroom, several things must be taken into account in order to make the playroom operational and to make the sessions more effective:

- The playroom must be **a specific place which is cut off from other areas and which is properly furnished.** Depending on the centre, the place in which the sessions take place might be, for example, a room, a tent or a closed-off rakuba/hut. In OTP centres, it is often not easy to find a place where these activities may be carried out. Waiting rooms for the appetite test and the daily consultation are very noisy and over-crowded. It is important to try, as much as possible, to keep a calm and restful space available so that mothers and children can feel relaxed. Within the framework of integration with health structures, the creation of space must be considered in terms of existing space. If it is not possible to set aside an area for the play sessions, it is important to bear in mind that, despite everything, a play session can sometimes take place while mothers are waiting or around floor mats in TFCs, etc. You will sometimes need to have a lot of imagination and determination!

- The room must be **well maintained, clean, well ventilated and decorated** in such a way that it stimulates the mother and her child (colours, shapes and materials can be enhanced by dangling them, posters and other decorative objects such as drawings or objects created by the mothers or the children themselves can be used). The place must encourage playing and contribute to wellbeing.

- The place will be **comfortable**, with floor mats, lights and play mats for the babies. It must also be large enough to allow the participants to sit in a circle and not in a row, which will make exchanges easier and will also allow children to move more freely.

When mothers sit in a circle as illustrated in the left-hand diagram, they all can see each other and exchanges between mothers and their children are made easier.

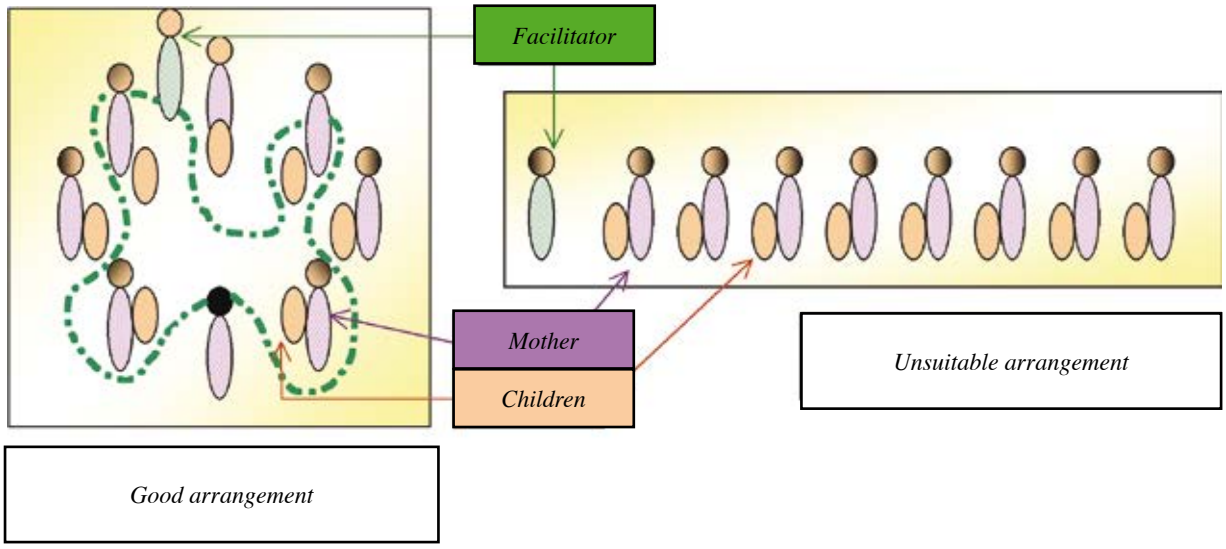

Table 8: arrangement of mothers and children in mother-child play sessions

- **Safety is of utmost importance:** be careful of sharp toys, toys which can break easily, are heavy or which are made of small bits which could be swallowed, etc. Make sure there is no one coming in unannounced, no noise, which could scare the child (especially when they have experienced stressful situations, etc).

- **Hygiene:** the toys must be well maintained, cleaned and put away in a clean place. Children put in their mouth whatever they are holding, which makes it easy for them to ingest germs. Malnutrition makes them weaker and more susceptible to infection and illness. You will probably come across the fear the teams have of handing out the toys, in case they disappear. It is therefore important to reassure them and to think of ways of making the adults present as responsible for giving back the toys at the end of the evening or before they leave to go home.

A bit of imagination and some local materials can be a good starting point for setting up a fun playroom.

2. ORGANIZING THE SESSIONS

Play sessions must take place when no other activities (consumption of milk, medical visits, health education) are being run in the therapeutic feeding centre. Discussion with the rest of the team will establish a specific time for the sessions.

At OPT centres, sessions may be organized while those attending are waiting for an appetite test and consultation, or may be offered once consultations are over and ready-to-use therapeutic food distributed, provided that mothers are not in a hurry to return to their activities. Much thought should be given in advance to organizing the space for carrying out the activities so that those relating to child care practices may be incorporated as an integral part of the treatment.

Given how weak children are at the start of treatment, play sessions are generally organized at TFCs from phase 2 onwards. It remains important, however, to stimulate the weakest children, including those receiving phase 1 of treatment. Activities tailored to suit their abilities can therefore be introduced by offering very short

sessions with minimum moving around. In addition, some children in the transition phase of treatment may be capable of taking part in play sessions. In all cases, the toys available during each treatment phase facilitate the individual stimulation of every child. In OTP centres, the children generally have fewer complications and are stronger: they can therefore participate in play sessions.

To facilitate the organization and the smooth running of the session and the choice of activities and toys, it is important to divide children into groups according to age and ability. The number of children involved must not be too big (around 5 to 7 accompanied children per session), in order to enable the follow-up to be as individually focused as possible. Similarly, the length of sessions must be tailored to the characteristics of the child and sessions must be long enough for the children to enjoy themselves without becoming tired. The length of sessions may vary depending on children's age, concentration span and levels of interest. In general, 20 minutes is sufficient for the youngest and weakest, but sessions may be extended depending on the situation and the children involved. Activities are organized once a day from the second phase of treatment.

A good quantity as well as variety of toys must be made available.

It is advisable to inform those accompanying the children in advance and to explain to them what the activity involves and where the session will be taking place.

- It is important to motivate mothers to come along in order to ensure their cooperation.
- The presence of a facilitator is essential to make sure that the session runs smoothly, to offer mothers support and guidance and to adjust activities to meet specific needs.
- The play leader must ensure that each child's desires, abilities and pace are taken into account.
- Participation must take place on a voluntary basis; it must not be forced: choosing not to play is as much a right as choosing to play.

As a first step, it may be important and useful to allow parents to explore and discover the toys and the world of play. Organizing an initial session with parents and those accompanying the children without the latter being present can be a way of familiarizing them with the games and of helping them understand notions of play and pleasure they will then share to an even greater extent with the children.

3. FORMAT OF THE SESSION

Before each session, it is important to introduce the people in the group to create an atmosphere of trust and wellbeing.

REMINDER

- Maximum of 5 accompanied children
- Around 20 minutes per session
- Toys of sufficient variety and quantity.

The session is divided into several stages.

1. Allow time for the introduction and installation, with explanations of how activities will take place.
2. Activities aimed at restoring or strengthening the mother-child relationship take most of the time.
3. The end of the session should be marked by a cool-down activity (song, storytelling, etc.).

4. Time is then devoted to conclude the session. These final minutes allow mothers to say what they thought of the session, their doubts, concerns, satisfaction and expectations and speak about any changes they felt or observed in their child's development and their relationship with it. This also provides an opportunity for the play leader to give some feedback about the session and to give a date for the next one. Any particular wishes of the mothers and children should be taken into account when planning the next session (the play leader may for example invite them to select the activities for the next session).

Settle in children and caregivers	Play activities and role of play leader	End of session	Final exchange
• Place mothers and children in a circle. • Set out toys close to the children. • Explain the format of the session.	• Choose activities in accordance with ready-made action plans. • Adjust activities in relation to children's ages and abilities. • Ensure toys are suitable and safe. • Circulate from one pair to another. • Spend enough time with each pair to ensure that the mother understands properly. • Promote interaction and stimulation • Observe and note weaknesses and strengths in each mother/child relationship in order to draw up a subsequent plan of action.	• Introduce quiet and common activities to close the session (storytelling, singing, etc.)	• Spend time with the mothers to give them feedback on the session and to allow them to talk about the session.

Table 9: Format of a play session.

The schema below shows these elements

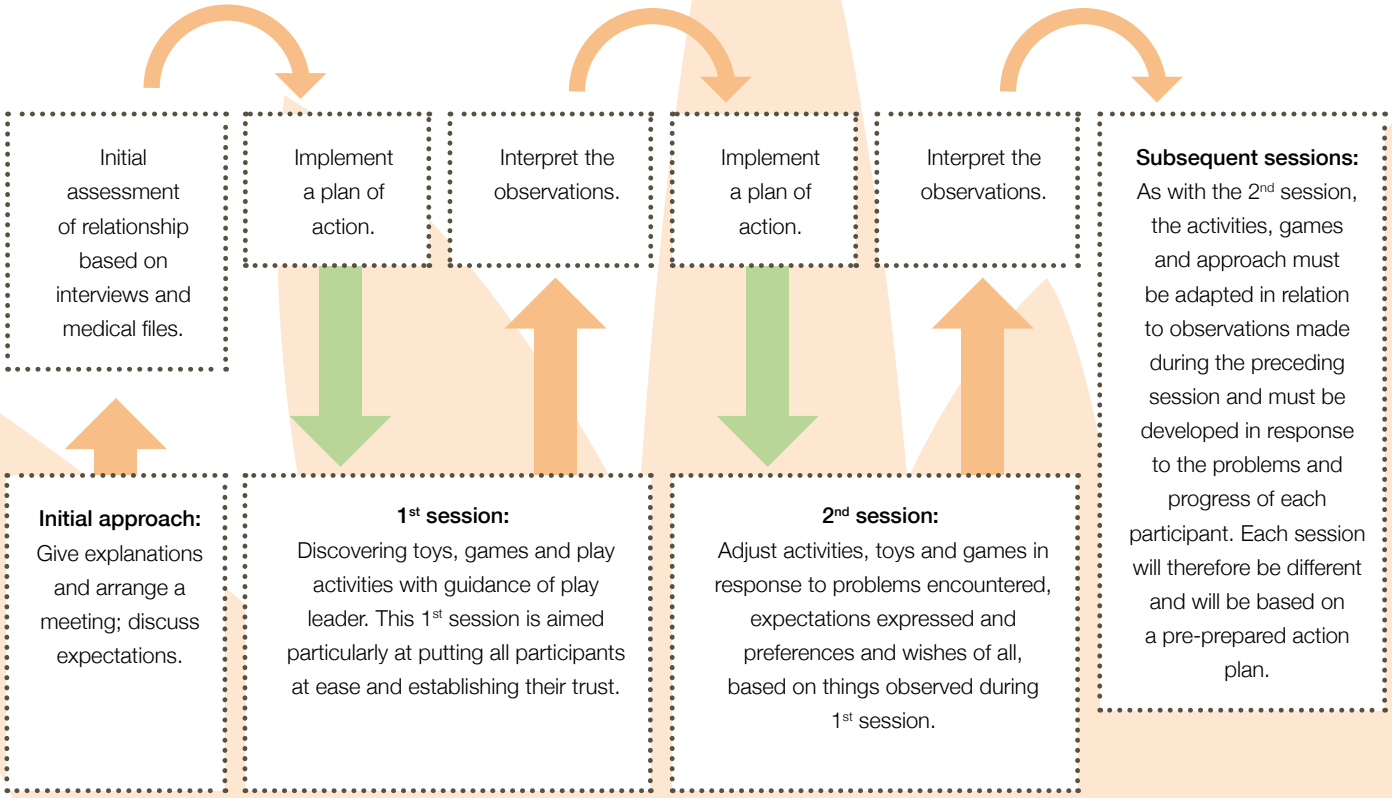

Table 10: Organizing play sessions in accordance with evaluations and action plans.

REMINDER

- Each session must be different.
- Do not judge or take the place of the mother.
- Explain to the mother her role as guide, facilitator and secure point of reference for her child.
- By observing interactions and evaluating sessions an action plan can be drawn up for subsequent sessions.

4. EVALUATING PLAY SESSIONS AND PLAN OF ACTION

The sessions must be adjusted to each other. Each session should take into account the problems and positive developments of the previous session in order to put in place an action plan.

The action plan is a way of planning the sessions and involves selecting the activities which are the most appropriate and toys which are best suited to achieve the desired objectives. To evaluate the sessions, the facilitator may use an observation grid. This is a tool to help him/her identify which elements to observe during the session. The facilitator must direct its observations towards the child, the mother and the interactions between the two in turn.

Each grid must be adjusted as required in order to match expectations as closely and appropriately as possible. The grid should be a working tool to facilitate the organization, the running and the evaluation of play sessions. In this way these special activities may be more effective and enjoyable for all those taking part as well as be in line with the objectives.

It is important to remember that each observation must be about the mother-child dyad. The facilitator will therefore use one grid per pair.

This observation grid may be presented in different ways and linked to the grid for observing mother-child interaction *(See fact sheets on the importance of the mother-child relationship)*.

Using observations made during play sessions, the facilitator is responsible for filling out an observation chart with the date, name of each beneficiary, types of activity offered and observations. This chart is used to produce an appraisal of the session and to monitor the development of each mother-child pairing. This aspect of the play sessions may be difficult to implement in the context of OTP or to integrate into health centre. It is advisable, therefore, to be flexible and to train teams to identify children or mothers in difficulty and to invite them to a subsequent session.

The observation record or chart contains the following information:

Date	Name of children	Age and group	Types of activity	Observations	Evaluation
06/05	Rachida (+mother)	7 months Group A	• Foam balls • Finger puppets	Mother forces child to play with the puppets but Rachida plays with the ball.	-
	Hamid (+aunt)	9 months Group A		Aunt ignores child and seeks company of other adults.	- -
	Jasmine (+father)	8 months Group A		Allows Jasmine to discover the toys, lots of visual interaction and encouragement.	+ +
	Amadou (+mother)	1 year Group A		Amadou takes little interest in the toys; he is very clingy and seeks his mother's breast.	-

With these observation examples, during subsequent sessions the play leader may:

- *Discuss with Rachida's mother the importance of leaving the child free to choose for herself. It may take a while to show the mother the attitude to adopt to give the child more independence.*
- *Try to encourage Hamid's aunt to become more involved and to offer him a wider choice of toys and activities.*
- *Emphasize the value of the right attitude of Jasmine's father, congratulate him and emphasize the impact of this positive attitude on the child.*
- *Encourage Amadou's mother to stimulate her child through quiet activities, to give her child more time to become familiar with the toys so that he gradually takes an interest in them.*

Table 11: Record of observations of a mother/child play session.

The observations noted in this record provide the basis for an appraisal of the session just completed and for preparing subsequent ones. Any weaknesses revealed must form the basis for drawing up an action plan.

These parameters take into account different elements which, on the one hand, comprise a self-appraisal designed to target problems associated with how the sessions are organized and led and, on the other hand, identifies what needs to be worked on in order to progress the mother-child relationship in a positive way and to promote the development of the child.

Observation grid for a mother/child pairing during a play session			
	Child	**Mother**	**Interactions**
Choice of toy	• Chooses for itself • Accepts toys offered by the mother • Refuses toys offered by the mother • Type of toy(s) chosen • Tries to get toys others have chosen or takes toys available	• Imposes a toy of her choice on the child • Places toys around child and lets it choose • Takes no interest in toys and does not offer any to	• Is the child searching for his/her mother – by looking? By moving? • How does she react to her child seeking attention? • Does she touch her child? Does she take her child in her arms? • Does she talk to her child? • Does she encourage and stimulate her child? How? • How does the child attract the attention of his/her mother and how does the mother react?
Behaviour during session	• Calm or excited • Seems to be having fun or is crying • Passive or active • Refuses to play • Moves hyperactively from one toy to the next • Has it understood the activity? • Does the child respect the rules of the game? • Does it play an active part? • Does the child have fun with other children? • Does it stay close to an adult or adults? • Is it shy? Does it seek out contact with others? Is the child rather solitary? • Does it frequently seek his/her mother's attention? • Does it look for its mother? • Seek the attention of other adults? • What interaction is there with other children? Does it try to take their toys? Allow its toys to be taken?	• Is she a leader? Active participant? • Is she enjoying herself? • Does she ask questions? What about? • Does she converse with other mothers? What about? • How does the mother react to interventions by the play leader or other mothers? • Does she take part in the activity? How? • Does she motivate her child? • Does she try to protect her child from other children? • Does she try to encourage her child to play with the other children?	
End of the session	• Does he/she readily accept the end of the session? Does he/she show a desire to stay? • Does he/she give up his/her toy(s) easily? If not, how are the toys obtained?	• Does she leave at the end of the session? • Does she take part in tidying up? • Does she discuss the session just finished or next sessions with the play leader?	
Interpreting the observations and appraisal	• Are there changes with regard to previous sessions? If so, what are they and why have they come about? • What elements have actually developed? • What are the negative aspects of the session? What are the highlights? • What general observations can be made?		
Action plan for Follow-up of session	• What aspects need to be worked on in particular? What are the objectives for the following sessions? What will be the most suitable activities? What will be the most appropriate toys? What points will need particular attention?		

Table 12: Observation grid for a mother/child play session.

VIII. CARE PRACTICES IN OTP CENTRES

REMEMBER

- ➔ Taking into account care practices is an integral part of treatment in the OTP centre.
- ➔ The waiting area is a place where activities can be organized (games, group discussion…).
- ➔ The appetite test is a defining moment for observing the mother-child relationship and for proposing advice and support.
- ➔ During each visit to the site the counsellors must support the family, improve communication with the caregiver and the child, facilitate relations between them and stimulate the child.
- ➔ The OTP counsellors and home visitors should be able to detect difficulties arising from the treatment as well as from the mother-child relationship.

UNDERSTAND

For many years, the medical and nutritional protocol of caring for children who are severely malnourished has recommended follow-up treatment at home for children without medical complications and having passed the appetite test[16].

The treatment of malnutrition in the therapeutic centres presents some constraints sometimes difficult to manage in the family such as the long distance between the home and the TFC, the absence of an adult at home during 3 or 4 weeks (problematic for the other children, maintenance of the home, family savings, lack of manpower during an agricultural season, sharing of daily life with other people that are generally strangers, constraints tied to the medical environment and so on).

However, treatment in the centres equally presents some advantages such as allowing the mother to be attentive to her child, which is more difficult at home, granting the mother no obligation to go work …

Furthermore, at home, the mother does not have the necessary support needed to take care of her child, or she may not have time for the child. She does not have a contact person to answer her questions as to the treatment and status of the child, and she has little to no possibilities for receiving emotional and psychosocial support from a trained counsellor, or to discuss with other mothers on their difficulties, pain …

Continuing in-patient or outpatient treatment is always the family's choice as long as the children are eligible for the treatment. In the two treatment methods, the care practices must be integrated into the treatment and follow-up.

Some mother-child pairs can be monitored in the centre in the absence of medical complications or lack of appetite. That can arise when:

- The mother makes the request
- The mother-child relationship seems problematic: the mother rejects the child, the mother complains about the child …
- The mother seems sad, unhappy and/or depressed
- The mother does not seem capable of taking care of her child: alcoholism, mental delay, etc.
- The mother lives too far away to be able to come to the centre every week

16 -You will find information concerning the establishment and follow-up of the outpatient in the medical and nutritional protocol.

Each week, the caregiver accompanies the child to the site for a medical check-up, anthropometric (body measurements) and an appetite test. This visit is also an opportunity to involve the child in some stimulating activities and provide support for the mother.
Increasingly, ACF treatment programs for malnutrition are integrated into the health centres/hospitals supervised by the Ministry of Health in the country of intervention. Consequently, there are community volunteers who will be conducting screening and awareness sessions in the home.
These people choose voluntarily (or are designated by the community) to be involved in the treatment of malnutrition. Their role and involvement can vary from one country to another. But in general, they are responsible for referring children with symptoms of malnutrition, making visits to the families whose child has not come to the weekly visit to the centre, and giving simple advice when the child is ill, refuses to eat, etc.
They can also make recommendations for preventing malnutrition.

IMPLEMENT

One of the key objectives is the effective and voluntary participation of the parents and actual involvement in the child's recovery.

1. TAKING INTO ACCOUNT PSYCHOSOCIAL WELLBEING AND IMPROVEMENT OF CARE PRACTICES IN OTP

Even though the organization of home treatment makes the implementation of activities more difficult, psychosocial wellbeing and improvement of care practices must not be absent from the OTP.

One of the essential elements for ensuring efficiency within the operational framework of the OTP is a good communication with the beneficiaries and their caregivers, and a good transmission of key messages to allow them to effectively follow the treatment at home.

In fact, one of the challenges is the insufficient time allocated to provide the caregivers with all the relevant information for continuing the treatment at home.

Moreover, they need to acquire more knowledge than the people staying in the centre, given that they will not have the permanent support of care teams at their disposal. The crucial information that they must assimilate relates to the management of meals, hygiene, detecting symptoms of a relapse or another illness, listening to their child and identifying the child's needs.

Weekly visits to the centre should allow staff members to be assured that the mother is capable of taking care of her child correctly, that their relationship is good, and that the mother will be sufficiently attentive.

Through the visits the staff can gauge the quality of the mother's care practices and her capacity to care for her child, from both the medical as well as emotional point of view.

The insufficiency of satisfactory care practices or the incapacity of the mother to manage the treatment of her child at home, are factors pushing children towards nutrition centres as opposed to home treatment. It is thus essential to observe and evaluate these factors (See the orientation plan of beneficiaries toward the adapted method of treatment). However, this direction is not straight forward as it is dependent on the availability of services. For example, there is often a shortage of beds in the health centres, which restricts the number of children that can be admitted in cases where the mothers have trouble taking care of them. Other strategies will be covered for providing increased support to the mothers such as developing activities directly in the community catering for mothers in difficulty (in a group or through individual home visits), strengthening activities in the OTP centres for certain mothers, and creating a place to come for several days for children under treatment who are not gaining weight so as to better observe the situation and identify the problems, as it is the case in Myanmar.

Many strategies can be organized and put into place to integrate mental health into the OTP and to improve

care practices. It could entail specific activities in additional strategies related to the environment and to the quality of life previously covered. Monitoring the number of children the OTP is very important, however, it is not always possible to offer them some specific activities individually. Therefore, it would be useful to develop and establish a system to rapidly detect problematic cases and/or cases requiring closer monitoring. For example, the criteria selected could be based on effectiveness of the therapeutic treatment (for example, children who do not gain weight, even lose weight) and the treatment of more serious psychosocial problems (mothers who show little interest in their child, violence in the relationship, etc.)

The specific activities can include the following:

- Have a discussion with the mother and with the child together determine the health status of the child, the events of the week, and the plans for the week ahead.
- Implement discussion groups with different mothers whose children follow the treatment at home. They can express their doubts and fears more freely than during individual interviews due to the dynamic of the exchanges.
- Organize game sessions. These sessions correspond to those explained in the guide note on mother-child game sessions. The observations and the work done around these sessions will serve as a basis for the follow-up at home and the subsequent visits to the centre, and also will serve to raise specific tasks that the mother can work on during the week with her child.
- Make an individual assessment with the mother before she leaves, to ensure that she is still confident and all the questions that she put forward were adequately responded to.

The mother should leave the centre with the feeling of being capable of participating in her child's recovery with clear understanding of what she can do to make the treatment more effective.

2. THE APPETITE TEST

- The main goal of the appetite test is to ensure that the child's appetite is adequate to allow treatment at home or, if it is not, to direct the child toward a TFC.
- The test period is a special moment for observing the mother-child relationship and for providing key messages on the importance of good care and hygiene practices.
- Simple advice can be given to the mothers during the appetite test, such as looking at their children and speaking to them.
- An area separated from the group should be designated to allow children who may feel uncomfortable when eating with the group to go with just their mother in order to be more successful with the test, avoiding disturbing the other children with its cries.
- Simple games can be suggested to relieve stress generated by the test, but it is preferable to use them with the children who have been previously isolated in order to avoid disturbing those who are eating.

a. Why conduct an appetite test?

The result obtained from the appetite test represents one of the most important criteria for deciding how to direct the beneficiary toward home treatment or treatment in TFC. In fact, a child having a weak appetite will not take the necessary dosages of RUTF, making the treatment ineffective and putting the child at risk. Moreover, the lack of appetite can be related to a serious infection or to a metabolic problem such as dysfunction of the liver. In these cases the child faces the imminent danger of death.

b. How to perform the appetite test?

- The appetite test must be conducted in a calm and separate area.
- It is essential to explain the objective and reason for this test to the mother, as well as how it is conducted.
- The mother (or person accompanying the child) as well as the child must wash their hands before beginning the test.
- The caregiver must be seated comfortably with the child on his/her lap.
- The caregiver gives the packet of RUTF to the child either directly or by putting a bit of the product on his/her finger and giving it to the child.
- The caregiver must offer the RUTF in a gentle and kind manner in order to encourage the child, to gently insist, in taking all the time of the duration of the test, if need be. The test can be very quick, but can also last up to one hour.
- The child must not be forced to take the RUTF.
- The child must be given the opportunity to drink a lot of water while consuming the RUTF.

c. The results of the appetite test

The appetite test is successful when the child has eaten the optimal quantity of RUTF according to its weight and within the time allotted.

If the child does not pass the test, it will be immediately transferred to the TFC.

If the child follows the treatment at home and passes the appetite test, but does not gain weight, or even it loses some, it is important to talk with the mother or caregiver in order to understand the reasons for this failure (the child does not eat at home, food is shared, etc.).
The probable causes can be economic ones (reselling or division of rations) or linked to care practices (the mother is not capable of giving the needed attention and care to ensure that the treatment is progressing smoothly).
Under these circumstances, the child must be transferred to the TFC and more effort will be made towards communicating with the mother to help her better understand the stakes of the treatment and appropriate care practices for the survival of her child.

d. Important considerations

The appetite test should always be carried out carefully. Beneficiaries failing the test should be encouraged to go to the TFC until appetite gets back and the relevant criteria are met, which allows the treatment to be continued at home.

The patient must have the minimum food quantity required to maintain its weight. It is vital that a child should not be sent home if there is a risk that its health continues to deteriorate as a result of not eating enough therapeutic food.

It may happen that a child does not eat during the appetite test because it is afraid or intimidated by the OTP protocols or the medical staff, or because there are too many people around and too much noise. If such factors seem to be unsettling the child, it may be appropriate to suggest that the test be carried out in a separate and quiet area. Small toys can be given to the child depending on the circumstances.

The appetite test should be carried out during each visit made by the child (usually on a weekly basis). An unsuccessful test at any time should be taken as evidence to support transfer to the TFC where the child can be treated and the causes of its loss of appetite can be analysed.

During the second visit to the OTP centres and for all subsequent visits the taking of the treatment should be increasingly rapid and efficient; a sign that the child is well on the way to recovery.

The children undergo the appetite test each week. If a child is able to consume the amount of RUTF it needs, the child can continue its treatment at the OTP centre; if not, the child will be admitted to the TFC.

During the appetite test and especially during the first test on the day of admission, children can be exhausted, stressed, surprised by the RUTF (new texture, new taste, etc.); caregivers may also be stressed or anxious (because the facilitators are watching them, worried that the child will not eat, doubts about the efficacy of the treatment, etc.). The role of the facilitator or the health educator will then consist in reassuring the mother and the child and gaining their trust so that this test can be carried out as calmly as possible.

The appetite test is a key phase in the monitoring of each beneficiary. It is important that it is carried out in a peaceful and decorated environment with toys available. A facilitator should be there with the mothers and the beneficiaries and help each mother to stimulate her child, if necessary. A meal is a good opportunity to observe the mother-child relationship and the difficulties which may arise from it.

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When one or several positive signs are present, the facilitator can:

- Praise the mother and the child,
- Encourage them to continue

When one or several negative signs are present, the facilitator can:

- Help the mother to stimulate her child: talk to it, offer a toy, tell a story, sing a song, etc.
- Show the mother how to give her child time to feed it, without forcing it
- Ask the mother questions about her family situation (other children, living/working conditions, presence of the child's father, etc.), about the child's history (how the child became malnourished, how breastfeeding/ weaning went, what mealtimes at home are like, etc.), about her circle of friends, any external support she receives, etc.

This discussion aims to gain an understanding of the mother's situation and that of the child, in order to help the mother to find solutions to what caused malnutrition or preventing the smooth progress of the treatment of malnutrition.

- Suggest that the mother takes part in discussions, either in a group or one-to-one, following the appetite test (if this is done at the centre).
- Refer the mother to a person or an association in the area that is able to provide emotional support: an imam, a priest, a traditional healer, a friend, the family, etc.

Behaviour of mother/caregiver	
Positive signs	Negative signs
• Distracts the child with an object or a toy • Distracts the child without objects or toys (e.g. touches the table, speaks, touches the child, sings a song…) • Stimulates the child, praises the child for eating well, compliments it • Makes positive comments about food (e.g. it tastes good…) • Play with the food to make child want to eat (e.g. the plane is landing on the runway, open the hangar door…) • Gives child independence if it wants to feed itself • Changes child's position (from the chair to her lap) • Uses other examples (e.g. other children, dolls) to encourage the child to eat	• Orders child (e.g. Eat it!) • Threatens, shouts, makes negative comments, scolds… • Leaves the child to eat alone, ignores child • Stops the child exploring food, does not allow the child to feed itself if it wishes to do so • Put pressure on the child so that it finishes quickly • Forces the child to swallow
Feelings of mother/caregiver	
Positive signs	Negative signs
• Is involved, motivated, shows affection… • Is happy, smiling, good-humored • Is patient, responds to child's signals	• Is cross, aggressive, irritable… • Is sad, depressed, anxious • Is impatient • Rejects the child, is violent with it • Seems indifferent
Behaviour of the child	
Positive signs	Negative signs
• Eats with pleasure • Explores or plays with food • Responds to mother's stimulation by smiling, babbling, looks, words… • Watches what is going on around it, seeks mother's look	• Refuses to eat • Spits food out, vomits • Does not respond to caregiver's stimulus: turns away, closes mouth, cries, and becomes upset…
Feelings of the child	
Positive signs	Negative signs
• Seems glad, happy: smiles, laughs	• Is sad: does not smile and cries… • Is listless: shows no reaction • Is cross: cries, struggles, kicks… • Is afraid: huddles up, cries, looks around fearfully

Table 13: Grid to be Used for the Observation of Mother-Child Relations.

3. MONITORING THE BENEFICIARY

a. On-site beneficiary visits

Once a week, children should come to the OTP centre with a caregiver.
Visits to the OTP centre have a number of aims:

- Identify children suffering from severe malnutrition. Indeed it is advisable for mothers with children identified as being at-risk to come to the health centre on the day of the OTP. This advice can be passed on by home visitors or by other mothers who know about OTP centres.
- Assess the development of children receiving treatment: measurements and the appetite test will ensure that treatment at home is efficient, and if this is unsuccessful, refer the child to the TFC.

- Assess the ability of caregivers to look after children for home treatment, and give them appropriate advice with a view to improving care practices.
- Increase the knowledge of caregivers on various issues which can be linked to the physical and mental wellbeing of children by means of awareness sessions.

b. Home visits

Home visits are organized differently according to the person responsible for this and varies according to situations.

The main aims of these visits are to:

- Identify the children at risk of malnutrition and give information about the dates and locations for OTP visits for an in-depth examination and possible care.
- Check that home treatment is progressing well and give additional information on care and hygiene practices.
- Identify the children who are not receiving sufficient care, so they can be referred to the OTP centre for care, for the child as well as the caregiver who will be given appropriate advice and support.

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- Carry out regular visits identifying possible reasons behind the child missing weekly visits.

Home visits can be the responsibility of team members who are specifically designated and trained for this, but most often, and increasingly because of the wish to involve communities more, **community volunteers** will be responsible for these visits.

Examples of activities listed below are for information only and can be adapted according to the resources of each program and the skills of the team.

During their visits, facilitators can:

- Check that **care and meals are progressing well.** Make sure that hygiene rules are being respected, attend mealtimes in order to help the mother in case she has difficulty changing her way of doing things, for example.
- Organize **play sessions** with the mother and child from the methods suggested during earlier observations. The action plan should establish the kind of activities and toys to provide. These mother-child play sessions have the same objectives as the mother-child play sessions organized in centres. They should make it possible to develop the mother-child bond and help the mother to relate to and communicate with her child.
- Take into consideration the presence of **other children** especially during play sessions: if other children who are present might disrupt the mother-child interaction, which is the purpose of this activity, the visitor can offer them toys which they can play with during the session, or suggest a parallel activity for them.
- Make sure, during **individual interviews** that the person feels at ease, that there are no neighbours or friends present who might restrict the mother's replies and that someone is looking after the children, if necessary.
- Offer the child **a toy** that he could keep until the next home visit, when it could be exchanged for another one. Providing a toy is a simple and effective way of promoting the mother-child relationship by encouraging the mother to play with her child, not only during the play sessions, but also spontaneously on a daily basis.

- Special attention will be focused on cases of **stabilized weight or weight loss** and an investigation will be carried out into the possible causes of treatment failure.

4. REFUSAL OF HOME TREATMENT OR RETURN TO THE CENTRE AFTER FAILURE OF HOME TREATMENT

When a child does not meet or no longer meets the conditions required for home treatment, it is transferred to the TFC.

The length of stay in the TFC depends on whether it is possible to incorporate or reinstate the home treatment program.

The period during which the child and its caregiver are in the TFC can be used for further observation of the child and the mother-child dyad, and thus lead to a better understanding of the possible reasons for the failure of home treatment in terms of mental health and care practices.

If home treatment is impossible (due to medical complications for example) or if the condition of the child requires returning to the centre, it is imperative that the family understands the reasons for this decision, and realizes that staff are seeking the most appropriate and best suited solution for the recovery of the child. The health workers must explain this decision, emphasizing that this does not mean that the mother is incapable or lacks involvement. Individual interviews with her should make it possible to explain this to her to make sure that she understands and to involve her in identifying the best solution given her situation and depending on her child's state of health.

IX. THE ANNOUNCEMENT OF BAD NEWS

REMEMBER

- ➔ Announcing a death is a procedure that requires taking into consideration the person's individuality and socio-cultural affiliations.
- ➔ It is a difficult moment for the teams to manage. The national staff must not manage these difficult moments alone.
- ➔ Simple, but appropriate gestures can make the situation less difficult.
- ➔ Specific surroundings, calm and serene, are preferable for announcing bad news to the family.

UNDERSTAND

The child in phase 1 can be in a critical state. In a state of advanced malnutrition, the physical weakness in which it finds itself makes the child more fragile and sometimes he may suffer from another illness that makes its state even worse (typhoid fever, measles, malaria, etc.). Everyone is worrying about its future, particularly the person who accompanies the child who often is the mother. It may have to know a quarantine period (being isolated) or even worse, it may die. The following advice is also to be applied when the child returns to phase 1 after having gone through the transition phase and phase 2.

The announcement of this type of news is not easy to manage by the staff and difficult to hear for the mother or the caregiver. If this announcement is badly handled, it can cause a break in the "centre personnel/caregiver and beneficiary" relationship. There is no specific solution or universal speech adapted to all situations and each individual. The context, personal experience, the relationship with death, and resilience[17] are different from one person to another.

Nursing staff should adjust their gestures and speech in taking into consideration these factors, but also the history they have had with this mother and her child.

IMPLEMENT

While the child is in a particularly critical state, it is sometimes possible to prepare the caregiver for the risk of potential death. Some simple sentences can have the double purpose of assuring the caregiver that everything is being done for their child and to prepare them for a possible failure:
"We are going to do everything possible, but we are very concerned about the condition of… -it is important to call the child by its name!-, etc."
"The team is doing everything possible that can be done, but the situation is getting worse".
When the probable or possible death of the child is announced, it may be that the caregiver prefers to take the child back home so they spend their final days with the family. The caregiver will have to manage the situation, whether to accept this departure or try to negotiate and make them stay, especially if there remains a hope of a cure.
In announcing the seriousness of the illness, or worse, the death of the child, some considerations must be taken into account, which can be all the more so difficult that the caregiver is frequently affected emotionally

17 - Ability to successfully face a situation of intense stress because of its being harmful or of the risk that it represents, as well as re-gaining self-control, adapting and succeeding in living and developing in a positive way despite such unfavorable circumstances.

as well and has to make the announcement. Below are some points that can help to that respect:

- Find an empty and private room in which to meet with the person.
- Sit across him/her, face-to-face.
- Anticipate the situation and have a box of tissues and a glass of water within reach.
- Try to determine what the person knows about their situation or that of the child, how he/she perceives the symptoms, etc. That can help to lessen the shock of the announcement.
- Take all the necessary time to make the announcement, explain it to him/her, and answer questions calmly. The person must be allowed time to assimilate the information.
- Choose words carefully: some can be shocking.
- Look at him/her and do not try to do anything else, even if that would hide the awkwardness. The person could interpret this gesture very badly.
- Speak in a soft, composed and neutral voice.
- If the announcement must be made during a medical consultation, wait until the person or his/her child is dressed again and ready to listen.
- Try to prepare a strategy about the answers you may give the person (psychological help, reference to another location, etc.). Also, ACF can take care of the return of the caregiver to their home.
- Ensure before leaving the person, that he/she can stay alone, or that someone will be with him/her to support and comfort him/her (family, another mother, etc.). In any case, be responsive to the person's state (if he/she prefers to stay alone or, conversely, is afraid of it).
- If the situation permits and if the person desires it ensure that he/she can go to a calm or peaceful place afterward.

No matter the place where it occurs (admission, phases, etc.) a death is to be observed with calm and dignity. Furthermore, it is important to keep out people not concerned or involved who could potentially make the situation even more delicate and difficult.

When the death occurs and the caregiver has been informed, it can be suggested that they pray in the presence of the body. However, this step must once again take into consideration the culture and the individual: in certain cultures it is not accepted that the mother sees the dead body of her child, or, the mother may not want to or feels incapable of it, which is neither serious nor bad.

As much as possible, contact the other members of the family. They may wish to be present when the child is in a critical condition in order to share these last moments together. Furthermore, they are a support for the caregiver and can be of some help in this situation (the caregiver will not have to take on and deal with these difficult moments alone).

Helping the caregiver face the announcement to the family, informing the other relatives beforehand and involving them into the decisions to be made in a quite close future can be useful.

Taking into consideration other caregivers and beneficiaries who are witnessing the situation is essential. Their worries and fears can be heightened. Furthermore, the death of a beneficiary can call into question confidence in the treatment, such as spreading rumours, for example, that the milk is poisoned or that a bad spirit resides there. It may be important to have a space dedicated to talks and discussions to explain what has happened and to reassure the other mothers.

When the announcement is made and the sequence of event has been decided, the mother is in some cases accompanied during her departure. Being surrounded by cured children who can return home can cause additional suffering and feelings of injustice to the mother who has recently lost a child. Ensure that the mother is ready to accept this situation or suggest to her another alternative than the room where patients check out.

The psychosocial officer can be called in to accompany the grieving parent and offer them a space to listen and talk in order to express their feelings while waiting for them to leave the centre.

X. HUMAN RESOURCES

REMEMBER

- ➔ The improvement of care practices and taking into consideration psychosocial wellbeing in the treatment of malnutrition is everyone's business, but it is important to clearly identify the responsibilities of each person.
- ➔ Training, which shows the importance of care practices in the treatment of malnutrition, must be proposed to everyone intervening with the beneficiaries. The integration of the treatment of malnutrition in the health centres makes the implementation of care practice activities very complex. Creativity and exchanges with human resource managers are thus key dimensions to address. Certain aspects such as mental health care (e.g. maternal depression) or early child development which today are part of care recommendations in primary health care setting are assets.

UNDERSTAND

1. SKILLS REQUIRED

The personnel involved in the fight against malnutrition must be prepared specifically to work with people monitored in centres or in OTP centres. Their speech and gestures must avoid raising a feeling of guilt or depreciation in the person they address.

- **Knowledge:** they must master information concerning malnutrition and its treatment, more general medical basics, as well as information concerning paediatric care practices and child development.
- **Ability to listen:** the responsibility of parents is important and they may have fears, apprehension or questions. It is important that the counsellors take the time to listen to the parents, that they hear what the parents have to say in order to respond to them with relevant and satisfactory information. One must be able to spot the signs even if they are not clearly expressed. A person does not always speak openly about its difficulties for fear of being judged, accused of being incompetent or negligent.
- **Ability to observe:** they must be capable of quickly observing the parents and the beneficiary, to identify potential problems, weaknesses and to act accordingly.

They must make the mother understand her role as partner and that the counsellor is not there to evaluate or judge her, but rather to work with her in the interest of the child.

2. PEOPLE INVOLVED IN THE IMPROVEMENT OF PSYCHOSOCIAL WELL-BEING AND CARE PRACTICES IN NUTRITION PROGRAMS

This chapter is based on some examples of nutrition programs which are described below. First of all, it is important to focus primarily on the activities to be implemented, then to designate the people in charge depending on the program design and thus train them in the required skills. In fact, ACF has nutritional programs set up in which ACF can freely train the team according to the needs. However, more and more frequently, implementation is done in partnership with health centres or local non-governmental organizations

(NGOs). In this framework, it will be necessary to define each time how the activities will be distributed and the people who will be in charge. However, be aware that "integrated management of childhood illness (IMCI)" recommended by WHO includes a chapter on care that facilitates child development. *(See: http://www.who.int/child_adolescent_health/documents/imci/en/index.html).*

In the overall strategy on primary health care, you will thus find arguments in support of the value of training in child development in primary health care centres both for malnourished children and other children. In another area, the mhGAP program seeks to integrate mental health care within primary health care. Maternal depression, among others, is covered and the need to provide treatment for it. It is therefore useful to know these different mechanisms which connect the different services offered to the population in primary health care centres and encourage training of the health personnel in important themes of care practices within the framework of treating malnutrition and more generally to facilitate better development, growth and survival of the child.

a. Nutrition Program Team

All staff members working under a nutrition program can have an impact on care practices and the wellbeing of beneficiaries and the people who accompany them.

As described in the fact sheets on how to welcome people, the way of presenting oneself and taking those who arrive into consideration, giving advice on care practices, establishing communication with mothers and children, explaining the treatment, the manipulation and process, are factors that will help the mother to gain or regain confidence in both herself and health care professionals; it will also help the child to feel more at ease and reassured.

Whether it is a nurse, a measurer, or the person in charge of distributing food rations, whether one is in an OTP centre or TFC, in a centre managed by ACF or by the Ministry of Health, the integration of care practices is based on changing attitudes prior to the implementation of specific activities.

It is therefore fundamental that the entire team is aware of the aspects relating to the wellbeing of patients, care practices, how to welcome people, communicate with them, and how important the relationship between caregiver and patient is.

b. Professional staff managing activities directly linked to care practices

The people in charge of psychosocial wellbeing and of the improvement of care practices vary from one country to another and even from one base to another, depending on the context of intervention, the financial and human resources, the qualification systems available in the country, local culture and many other factors.

This implies that different competencies and the activities set up may vary in quantity as well as in quality.

In each case, it is a crucial to identify the person who will be in charge of implementing the activity, the person who will be responsible for facilitation and the person in charge of supplies. Depending on the circumstances and the resources available, it may be the same person or several different people.

The responsibilities of each person must be clearly established and defined, and an appropriate training must be provided.

The main idea is to ensure the availability of people specifically trained in care practices and to give them the tools and resources necessary for implementing activities that are the most adapted to the needs and culture of beneficiaries.

➡ Psychosocial Workers

The professionals directly in charge of these activities would ideally be psychosocial workers who have a specific educational background in psychology and are particularly sensitive to mother-child relationships.

In crisis situations or during particularly stressful events, a specific training can be an advantage in providing

better care of people who are suffering.
These psychosocial workers will be brought in to implement and supervise activities such as play sessions, individual interviews and group discussions.
They will also be able to work on nutritional programs in order to set up a basic package of care practice or to work in mental health and care practices programmes for a more comprehensive intervention.

➡ The facilitator

He/she will organize and lead play sessions. He/she will be equally responsible for maintenance (the cleanliness of the room and toys, decor, etc.).

The facilitator will need to offer toys and activities suitable to the age of the children in the group. He/she is there to encourage the interplay between the mother and the child and to provide support to those who are struggling.

During the session, he/she will need to be able to balance its time between moments spent with children and their caregivers on an individual basis and the others, placing him/herself at the centre of the group to observe and guide the session.

During sessions, he/she will need to be capable of encouraging play and allocating time for play, and counselling the mother on activities and toys as well as her attitude towards her child.

The facilitator's work must be adjusted and adapted to each group (taking into consideration the age and characteristics of the children) and to each mother-child pair. The facilitator's attitude must, above all, inspire confidence in all the participants by explaining and informing but also listening and responding to everybody's expectations. The facilitator must emphasize play activities and provide a moment of relaxation and enjoyment. He/she will facilitate play by proposing interesting activities for children and caregivers without always involving toys. It is important to encourage the participation in games and not to force.

The facilitator demonstrates a lot of patience:

- **With adults:** depending on their life experiences, their isolation may be very important and require days, months or even years of work, without immediate visible results, which does not mean that it is futile. The facilitator should not become discouraged, but must persevere in his/her approach, as his/her audience needs to feel treated as individuals in their own right, in the sense that someone is paying attention to them even if they are not able to respond.
- **With children and their accompanying persons:** depending on the maturity of children: the mother may have to throw the ball 100 times to her child before the child throws it back to her one day.

The facilitator is responsible for setting up activities and monitoring the relationship between mother and child.

The facilitator at the TFC

He/she plays an essential role in the dynamic of the centre and it is crucial to give particular importance to its recruitment and job description. The facilitator is an integral part of the team; its actions have a direct impact on the treatment of malnutrition. However he/she does not have to be solely responsible for leading the centre. Consider the gender of the facilitator: in some circumstances, a woman will be better suited to working with women.
The facilitator's days should be organized as follows:

- Spending time with the most depressed and isolated beneficiaries on an individual basis, with mother-child pairs in difficulty;
- Leading small groups of adults or mothers and children in planned activities at specific times and for fixed durations;
- Leading programs for everyone: songs, stories, dance, etc.

The facilitator's personality is important: he/she must enjoy contact and feel at ease with adults and children as well as with babies, and be cheerful and creative and show empathy. Its role is neither to judge nor to lecture people.
He/she may act as a liaison between the beneficiaries and the care teams as its frequent interaction with the beneficiaries may establish a relationship of trust. As a result, they may entrust him/her with their difficulties or troubles more easily, which enables the facilitator to determine if the beneficiaries need to be referred to medical personnel or not. In the same way, the teams reporting to the facilitator may signal to him/her that certain patients are depressed and need more individual support. He/she also serves as a liaison between beneficiaries in initiating activities. Its role is to encourage interactions, initiate exchanges, motivate people and establish a climate of sharing and fun (play and spontaneous activities in which he/she does not necessarily intervene).

As from phase 1, the facilitator should speak to the child, smile and attempt to make contact. He/she may not get any response for several days, possibly several weeks: however, the facilitator will often discover that the child remembers all the moments of contact they have had previously, and trust can be quickly established.
Sessions with mothers and babies require a somewhat individual approach as they attempt to develop the mother-child bond; this is why it is important that interactions between the two happen as regularly as possible. It does not mean giving lectures to the mother, but encouraging her to interact with her child. Playing, talking, laughing with the child can be more effective ways to demonstrate and give advice to the mother. (If the mother sees the child smiling and interacting with the group, she will want to do the same). It is essential to emphasize interactions between the mother and the child (looks, smiles, gestures, etc.).

The facilitator in the OTP centre

In the OTP setting, activity sessions must be integrated into the care processes and follow-up of beneficiaries. Therefore, depending on the context, determine the most appropriate time for setting up activities as well as designate people in charge of them and that will be the most able to lead these activities (in terms of availability and skills).

➡Health promoters

Some countries or some bases may lack psychosocial workers.
In this case, health promoters may lead some activities provided that they get appropriate training.
Already being in charge of appetite tests, they may also be asked to manage other activities such as play sessions or group discussions.

➡ Home visitors

Their recruitment is very specific. Certain precautions must be taken care of, for example avoid sending women alone in some difficult circumstances or avoid recruiting men when the culture forbids women from being alone with them.
Home visitors must be respectful because they go at someone else's home in their private space. They are not there to evaluate or judge, but to help.
Being autonomous during their visits, they must be able to deal with potential difficulties they may encounter in homes. They must try to manage situations and may be asked to make important decisions such as the return of an ill child to the centre.

c. Community volunteers

In some countries, particularly when ACF works in conjunction with the Ministry of Health, the ministry personnel and/or community volunteers are in charge of monitoring beneficiaries when they are treated at home and not by home visitors employed by ACF.

Community volunteers are less trained and have less time available. As a consequence, they may bring a different type of support than that offered by the ACF teams.

Community volunteers must be trained on the symptoms and treatment of malnutrition. They must be able to identify the symptoms during home treatment indicating that a child needs to be referred to a centre (refusal to eat, vomiting, diarrhoea, etc.). They must also be able to communicate simple information about care practices. This may include information about breastfeeding, hygiene, child development, etc. depending on the needs identified in the intervention zones. But the principal role of community volunteers is to inform the community about malnutrition and to identify and refer cases of child malnutrition with the goal of expanding the coverage of nutritional programs.

In general, community volunteers are present at OTP sites. It is pertinent and important to involve them in the follow-up and treatment of beneficiaries (see the section concerning home visits). These volunteers, particularly those in charge of home visits, may also be involved in leading some activities, such as play sessions. In this case, a short training to make them aware of the importance of play for children and the necessity of the mother-child bond must be offered to them.

ACF leaders and community volunteers must have specific skills, global expertise, be flexible and be able to respond to various requests.

In some countries, as in Ethiopia for example, the government is setting up programs to extend health services (Health Service Extension Program - HSEP).
It consists of an innovative approach aimed at mitigating the lack of medical staff and the difficulties encountered by populations in obtaining health services in remote locations.
The government is training « Health extension workers » (HEW), who will be in charge of providing basic health care and promoting health and hygiene in the most remote villages.
These HEW are generally included in the framework of OTP centres, which they may manage themselves[18].

IMPLEMENTATION

1. TEAM TRAINING AND SUPERVISION

As previously explained, it is important that everyone involved in the nutrition programs is aware of the importance of administering care and of psychosocial wellbeing.

The aim of this training is to develop certain key competencies, such as communication and observational skills, thereby ensuring the best possible integration of the various elements capable of improving how care is administered as well as the psychosocial wellbeing of the beneficiaries (and, where necessary, their accompanying persons).

18 - You will find more information about HEWs in the "management of severe acute malnutrition at health post level", document in the following link: http://motherchildnutrition.org/resources/pdf/mcn-otp-quick-ref-manual-for-hew.pdf

Therefore, it is a matter of strengthening the whole team's knowledge and skill-set in relation to the basic needs of children, the importance of mother-child interaction and the need for play (See guide notes, especially The importance of the mother/child relationship and the needs of children and their development)

This training can also be adapted for government bodies in order to strengthen their understanding of just how important it is to recognize the psychosocial wellbeing and the administering of care within the treatment of malnutrition, thereby leading to the integration of these elements into national protocols.

2. TRAINING RESPONSIBLE STAFF FOR ADMINISTERING CARE PRACTICES ACTIVITIES

Those responsible for activities relating to administering care practices must have relevant training in children and their development, in organizing and facilitating play sessions and activities, in bottle feeding and breastfeeding and in caring for children and their mothers. Play is an integral part of treatment, and not only within the formal framework of mother-child play sessions. All members of the team can be called upon to suggest activities to children or to respond to their requests.

Leading play sessions requires specific training. The group leader and the psychosocial worker are generally responsible for these sessions, but the team set up varies from country to country and even from centre to centre.

One of the first things to put in place within the framework of this training is how the team itself initiates play and the act of playing. Initially, it can be highly beneficial to encourage the team to play and to get familiar with the different types of toys. In doing so, everyone will not only be able to appreciate the importance of play, but also share and convey the joy of play, because it is something they themselves have felt.

The key elements that are to be passed on within the training on play sessions are as follows:

- Mother-child interaction (see note on the importance of the mother-child relationship);
- Children and their development (see corresponding note);
- What toys and activities to suggest;
- The development of play session;
- The role of the facilitator.

The self-training module on administering care can be used to train personnel either individually or by approaching certain aspects within a group setting. There are also videos that are accessible regardless of the module.

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APPENDIX 01

Recognizing development stages in the selection of toys nd activities

	MOTOR SKILLS	LANGUAGE	COGNITIVE ABILITY	SOCIABILITY AND PLAY	TYPES OF TOY	APPROPRIATE ACTIVITIES
0-3 months	• Overall mobility almost nil, remains lying down. • Able to suckle. • Focused sight up to 20cm. • Sleeps majority of time. • Can hold its head around the age of 3 months.	• Cries or modulated noises depending on state of uneasiness, tension or wellbeing. • Smiling will quickly indicate pleasure and formation of relationships.	• No real intent, only reflexes. • Turns away from displeasure and seeks out pleasure. • Learns from experience and repetition.	• From early stages will start to look at faces, first briefly and then for longer periods. • The child is dependent on those around for their wellbeing.	- Music boxes - Mobiles - Play mats - Rattles - Ragdolls or fabric animals	- Motor-sensory mat-based activities - Fine motor skills - Affective activities - Making faces - Massage
3-9 months	• Able to sit up. • Movement by crawling. • Push-pull. • Digito-palmar gripping ability (Brings objects to the mouth, manipulates cubes from one hand to the other)	• Uses the body to express needs • Laughing • Babbling		• Smiling is selective and has a social function. • Aware of faces, expressions and the voice. • Exchanges with mother, developing modes of communication with mother such as pre-language and imitation of sounds. • Wishes for presence of and contact with mother.	- Play mat - Swings and arches - Activity boards - Balls and balloons - Toys that stack or fit together (cubes, Lego…) - Stuffed animals - Fabric or cardboard books - Toy telephones, tea sets, doctor sets… - Dolls and baby dolls - Toys for pushing or pulling - Small cars - Large markers or paints - Simple puzzles	- Games requiring manipulation (fine motor skills): constructing towers, building Lego structures… - Gross motor skills: pulling a cart, pushing a pram… - Pretend play - Imagination-based activities (reading stories, dolls…) - Symbolic play (dolls
9-18 months	• Standing up, initially with support (10 months). • Walking independently between 10 and 16 months. • Thumb and index finger grip. • Lengthy handling of objects within reach: grasping, holding close, looking at, bring to the mouth, sucking and chewing them. • Able to drink unaided.	• Appearance of first words. • Disyllabic words.	• Beginning to understand the permanent nature of objects around 10 months. • Beginning to become interested in details. • Able to imitate.	Mother-child relationship: • Anxious when separated from mother. • Baby aware of the pleasure mother brings; recognizes her and can distinguish her from others; would like to continue playing endlessly just with mother. • From 8-9 months baby can express anxiety caused by unfamiliar people. • Can play alone for short spells.		

	MOTOR SKILLS	LANGUAGE	COGNITIVE ABILITY	SOCIABILITY AND PLAY	TYPES OF TOY	APPROPRIATE ACTIVITIES
18-36 months	• Able to walk up and down a single step. • Begins to run • Upper limb gestures are precise and oriented. • Able to stand on one leg in order to grasp an object. • Able to attempt drawing. • Likes pushing, pulling, piecing together, filling, assembling and separating. • Becomes interested in images. • Begins to play with symbolism. • Able to imitate. • Often has a favorite or transitional object (security blanket). • Baby can catch a ball and throw it back.	• Moves on from single words to phrases. • Able to say no between 18 months and 2 years. • Has a vocabulary of 100 to 300 words. • Uses a variety of communication: drawing, language, imitation. • Able to express feelings (suspicion, sadness, shame, anger)	• Begins to create a mental picture of its surroundings (symbolism). • Capable of abstraction (referring to an object not currently present) • Demonstrates opposition and develops autonomy. • Opposition and imitation act as methods of identification. • Begins to test its limits.	• Exercises the need for autonomy. • Takes pleasure in trying out new things alone. • At the same time as exercising autonomy baby exercises need for emotional dependency (dislike of going to sleep, need to implement bedtime rituals), shows distress and frustration. • (Subsequent to a period of observation) baby establishes relationships with people other than its family. Starts playing with other children, especially one. • When upset or in physical need mother remains the primary comforter.	- Shape puzzles - Dolls and baby dolls - Cars and trains - Building blocks - Marker pens and paints - Puzzles - Tea sets, doctor sets, telephones… - Books - Balloons - Small figures - Feathers	- Games requiring manipulation - Symbolic activities (dolls, figurines…) - Make believe - Games of skill Beginning of collective play Motor skill activities Creativity-based activities
3-5 years	• Likes physical activities: running, jumping, climbing... • Movements are more precise and can jump over a rope.	• Able to speak in fully formed phrases. • Able to ask questions and respond to questions asked.	• Develops memory and imagination (able to tell stories). • Begins to develop own personality. • Becomes more aware of own body, gender and social roles.	• Understands and respects rules. • Likes to play with other children and have friends. • Able to imitate. • Likes stories and uses imagination more and more during play.	- Rules-based games, board games - Dolls. Figures - Cars - Doctor sets, tea sets - Blackboards - Circuits - Books - Costumes - Dominos and memory games	- Memory-based games - Group games - Games of skill - Symbolic activities - Outdoor games - Imitation - Activities requiring creativity and imagination

APPENDIX 02

Example of games for groups of children

Games for very small children are mostly those implemented by the mother. When older, children are able to play by themselves and over time they become more socialized and begin to play with other children.
The games suggested below are examples of activities that can be carried out with small groups of children, depending on their age.

→ GAMES FOR 2-3 YEAR OLDS

Jumping Frogs

Draw a large circle on the ground (or get the children to do this), which represents the frog pond. Next, draw a circle around each child where they are standing, either with chalk or by marking one out on the ground with a stick. Each child must stay inside the circle.
Choose a leader. Then gather the children together around the pond; ready to jump when the signal is given. On the signal "Into the pond" all the children must jump, with their feet together, into the circle. The last one in the circle is out of the game.
On the signal "Onto the shore" all the children must jump, with their feet together, out of the circle, which represents the pond and into their own circle. The last ones back are out of the game.

Red Light Green Light

Divide the children into two teams:
- The car team.
- The pedestrian team.

Choose a way of distinguishing between the cars and the pedestrians (for example, the cars wear a hat). Choose a leader. The leader will have a disc with one red side and one green side; it will serve as traffic lights (this can be made out of cardboard and paint or marker pens). Choose how long each session should last.
At the start, the cars and pedestrians circulate freely. Then the leader holds up the red light the cars must immediately crouch down. The pedestrians run after and catch the cars that have not crouched down. The captured cars then become pedestrians.
When the time is up, the team that has the greatest number of children in it is the winner.

Shadow Play

Hang a sheet across a doorway, place a lamp a few meters behind it and play between the light source and the sheet.
A child can use this to create a Chinese shadow theatre show. This game can be nicely livened up with a few accessories, for example a doll could become an imaginary character.

→ GAMES FOR 3-4 YEAR OLDS

Laughing circle

Place the children in a circle, and choose a leader and also the direction of play (to the left or to the right). The leader does something (funny) to its immediate neighbour, tickles them on the stomach, for example. The rules of the game are that no one must laugh or smile. Anyone who breaks those rules is out.
Then it is the neighbour's turn to repeat the action on their neighbour and so on. When the action gets back to the leader they choose another one. If they are out it is up to their neighbour to choose another instruction. The children can take turns in choosing the instruction. The winner is the most serious player!

Orchestra Conductor

Choose one member of the group who will sit to one side where they cannot hear the group. During this time appoint a conductor.
The conductor leads the group. They decide which part of the body the group will use to make noise, for example, by tapping on the knees or tapping on the feet... and everyone must copy them.
When they come back into the group, the child who was sitting to one side has to try and guess who the orchestra conductor is. The number of guesses the child is able to make can be decided beforehand (depending on the number of players).

Mind Your Tail

The children attach something to their backs that represents a tail (a scarf, a piece of fabric, a sock, etc.) At the starting signal everyone must try and grab as many tails from the other players as possible, all the while taking care not to lose their own. When a player has lost his/her tail he/she is no longer allowed to chase. The player with the greatest number of tails is the winner.

➔ GAMES FOR 4-5 YEAR OLDS

Stopping Trains

Choose one child from the group to be the engine. In the game the children should line up in single file behind the engine and copy the way in which they move forward. The leader moves forward in whatever silly way they choose and can change movements at any time (hopping, like a duck, jumping, etc.).
Be careful! If the engine stops and quickly turns around, everyone must stay frozen whatever position they are in.

Head in the Clouds

When the sky is blue and a little cloudy get the children to lie down. Ask the children to look at the clouds and, one by one, say what the clouds make them think of: an elephant, a dog chasing a monster, etc. Get the children tell a story for each one of their discoveries.

Guided Walking

This game is played with three players (at least).
The children hold onto each other arm in arm, but the player in the centre is turned the other way around. The two players on either side guide the player in the middle. The pace starts off slow but then speeds up, and then the players turn. This can even be played with several players, by alternating one player facing the right way and then the next facing backwards. Play can also be reversed, where the player in the middle guides the two on either side.

➔ GAMES FOR 5-6 YEAR OLDS

Silly Racing

Mark out a starting line and a finishing line.
Get the children to sit down along the starting line with their legs stretched out in front of them.
At the starting signal they must start running only using their bottoms to move themselves forward.
The winner is the first one over the finishing line.

1-2-3 Kangaroos

This is a variation of the game “Grandmother’s footsteps”
Choose a leader.
Instead of running towards the leader who has his/her back facing to the players, they must hop like kangaroos.

The leader says “1-2-3 kangaroo” and then turns round quickly.
The player who is not entirely still takes the place of the leader.

The Detective Hand

Choose a leader. He/she will turn around facing a wall or a tree and hold a hand behind their backs.
One at a time the children can amuse themselves by coming up and tapping or tickling the hand.
The player has to guess who it is. If the player guesses correctly that person takes his/her place.

Musical statues

The children are standing up. While the music plays they must move in all directions.
When the music stops they must stand completely still.
Anyone who is spotted moving is out.
The music continues again and the process is repeated until there is only one child left, who wins the game.

APPENDIX 03

Examples of mother-child activities

The following table presents some activities that can be carried out between the mother (or maternal substitute) and the child. These activities serve as a reference point and should be adjusted according to opportunities, resources, demands, situations, capacities, etc. The important thing to keep in mind is that the games between mother and child can be very simple, easy to implement and can be repeated even after having visited a TFC.

THREE CUPS	Provide 3 non-transparent cups and one small object. Place the object under one of the cups in front of the child. Shuffle the cups around. The child must pay attention and find the object under the correct cup.
MYSTERIOUS SOUND	Position yourself behind the child. Make some noise with an object, for example a shaken-up water bottle. The child asks questions to find out what the object is. Answer with yes or no.
HIDDEN OBJECT	Take an object and hide it under a towel. Ask the child to identify the hidden object, first by observing the form that the towel has taken, and if not, then by feeling the towel.
PAPER, BASKET	Take a sheet of old newspaper and make a ball. Place a wastebasket in the middle of the room. The game consists of shooting the ball of paper into the basket. Move the basket further away or closer according to the desired level of difficulty. It is possible also to place the wastebasket on a chair or table.
GAME OF SHADOWS	Hang a sheet in a door frame, place a lamp a few feet away and play between this light source and the cloth. A Chinese shadow puppet show has thus been created. Some accessories can nicely liven up this game, for example a doll could become an imaginary character…
FIND THE OBJECT	Take an object in the room and show it to the child. Have the child leave the room and place this object in a spot, which is neither too hard nor too easy to find. Bring the child back into the room and ask him/her to find the object.
GUESS THE DRAWING	Make a drawing on a large sheet of paper without the child seeing it. Hide some parts of the drawing with other sheets and ask the child to figure out what it is about. With each wrong answer take away a sheet to provide extra clues.
CONSTRUCTION OF A TOWER	With the child, make a large pile of toys and various objects (which do not break). Separate it into two piles, taking one pile and giving one to the child. Each one places one object on top of the other from his/her pile in turns, thus building the original tower. Try to make it as tall as possible and the first one who makes the tower fall loses.
THE REFLECTION	Get on your knees in front of the child to be at his height. Explain to the child that he/she must behave as if he/she were a reflection in a mirror. The child must reproduce the gestures and take the same attitudes as you. He/she must also try to be as accurate and fast as possible.
SOAP BUBBLES	Dissolve a little dishwashing liquid in water in a bowl. Make bubbles and teach the child to catch them, crush them on the ground, and blow them. With the aid of a straw, make the child blow into the bowl. He/she will create magical clusters of bubbles!
OPEN, FILL, CLOSE	Help the child find the necessary parts for this new game. Look for boxes or containers which can be opened, closed, and filled up without endangering the child, if possible vary the systems for opening and closing: Shoeboxes, boxes with compartments, lids of containers (on condition they cannot be swallowed by the child), small boxes, large boxes, boxes or cabinets with drawers or lids, plastic trays. Choose a group of small objects (small, but big enough to avoid being swallowed) that the child can put into the boxes. Begin to fill a box and then let the child discover it him/herself.
WHAT ARE YOU THINKING ABOUT?	Think about something. The child must find the object you are thinking about by asking questions, with yes or no answers. When the child finds it, reverse the roles.
SPEAK, SPEAK …	With a signal, the child must speak about a subject without stopping until the next signal. The time of speaking can be progressively made longer and a subject fixed in advance.
SERIES OF WORDS	Propose to the child a series of words while taking care to repeat one. The child must find the word, which was repeated. Choose the number of words in the series according to the desired difficulty.

WITH THE FEET	Ask the child to act out daily routines but using its feet instead of its hands. Ask it, for example, to hold a pencil, to grab a small object…
DISAPPEARING CARDS	Take 3 to 6 playing cards, or cards with images. Present them to the child. Withdraw one and hold them up again to the child. He/she must find which card is missing.
WHERE DOES IT COME FROM?	Say the names of objects to the child. With each word, it must find the origin of it. For example, "Rain: rain comes from clouds." Make it more complicated like "Jam comes from fruit and sugar. Furniture comes from wood, which comes from trees."
THE MISSING WORD	Say a sentence in which there is a word missing to the child. For example, "It's necessary to brush our _____ with a toothbrush and toothpaste." The child must find the missing word. Reverse the roles.
THE GOOD DRAWING	Without the child looking, choose an illustration in a book. Then, give it clues so he/she can find the image chosen. For example, say "I see a river with children bathing in it". Then give the book to the child. By shuffling the pages, it must find the chosen image. You can reverse the roles.
LIGHT DRAWING	Stick a white sheet of paper on a wall. Place a source of light towards this medium. Reproduce on the paper the shadow made by an object.
FINGERS	Show the child a number of fingers while clearly announcing the number in a strong voice. Then, hide the hand(s) behind your back and ask the child to show the same number of fingers. Verify with the child that it has the correct number by comparing your fingers with its fingers.
INTERRUPTED SONG	Sing a song that the child knows well while stopping from time to time. The child must then sing during the blanks.
THE MYSTERIOUS OBJECT	Blindfold the child or ask him/her to close his/her eyes. Place an ordinary object in his/her hands and ask him/her to recognize it by touch. The game can be made more complicated by choosing less familiar objects.
CATCH THE CORK	Give the child a cup. Attach a cork (or other small object) to the end of a string. Play at cat and mouse. The child must place the cup on the cork while you make it move in pulling the string on a support. Reverse the roles.
THE NEVER-ENDING SONG	With a chosen melody, propose a phrase to the child in a similar way: in the house there is a room. The child must then continue the story in making his/her own proposal, for example, in the room there is a cupboard. Then each one in turn continues the song until one of the two runs short of ideas.
LIKE ...	Propose an adjective to the child who must continue by adding a word. For example, sugary like … a candy, or blue like … the sky.
THE INTRUDER	Tell the child a series of words being related to each other and slip an intruder into this list (monkey, dog, cat, house). The child must find the intruder (odd one out).
THE BLIND GUARD	Place an object in front of the child, he/she must guard it, but without touching or holding it. Blindfold the child's eyes and try to slip away with the object. The child must listen carefully to try and stop you. Reverse the roles until he/she catches you or you succeed in slipping the object away.
STORY WITH TWO VOICES	Propose a sentence to the child, the starting point of a story. The child must find a second sentence to continue the story and thus follow in turn. The roles can be reversed and the child can give the first sentence. The story's theme can be fixed before beginning the game.
THE SCHMILBLICK	A popular and funny game. Think of an object and speak about it to the child while replacing it with a schmilblick (imaginary object). For example, "At the market, I put the schmilblick in my basket." The child must then ask questions to find the schmilblick.
THE FORBIDDEN SOUND	Choose a sound, which will be the forbidden sound. Each one in his/her turn proposes a word, which must not contain the forbidden sound. Each error gives a point to the adversary. The game is played up to three points. You can vary the game by forbidding a vowel or a consonant (more difficult).
SKY, SEA, EARTH	Say "Sky", "Sea" or "Earth" and the child must respond each time with the name of an animal that flies, that swims, or that walks. When he/she makes a mistake or repeats a word, the roles are reversed.
WORDS IN RELATIONSHIP	Announce a list of some words (3 or 4) having a common point. The child must find the relationship between the words. Reverse the roles when he/she has found it.
THE LIE	Say 3 sentences to the child, one of them being false. For example "birds have teeth", "bicycles have wheels" and "dogs have four paws". Then, the child, in asking questions, must find which of the sentences is false. When he/she has found it, the roles can be reversed.
STORY IN A PHOTO	With the child, choose a photo. From this photo, the two of you invent a story. To begin, it is possible to give a name to the (invented) character, talk about its environment…. Little by little, the story will be constructed.
SURPRISE BOX	Put various objects into a closed box with holes so that hands can be inserted into it. The child must touch the objects without taking them out of the box and identify what they are. A variation on this game can be to place pairs of objects and ask the child to find them by touching the identical objects.

APPENDIX 04

Games and toys for therapeutic centres

The list of toys presented here is mainly intended for children from 0-5 years.

It is important to:

- Provide toys listed in the different age categories in order to offer children a variety of tools to develop various skills, targeting different age groups and ensuring that the child will have toys at its disposal to arouse both its interest and pleasure.
- Choose attractive toys (vibrant colours, comfortable materials…)
- Ensure that the toys are safe especially in the case of toys for infants and babies (risk of swallowing small pieces, broken toys may have sharp edges and cut, heavy toys…).

EARLY-LEARNING SENSORY TOYS

These toys are mainly intended for children from birth up to one year old. It is necessary to stimulate their senses with toys with sounds, colours, and varied textures so that the child can handle, shake and bring the toy to its mouth. Be careful of toys that are too noisy, too bright: they can cause fatigue in young babies.

- Play mats: vary the materials, sounds and colours.
- Rattles and rings: objects to grab and chew: make sure that the materials are non-toxic and that no small parts can be ripped off or break loose that the child could swallow.
- Small balls made of rubber or cloth: object to catch and to throw. Some have little bells on them, which can make the toy more attractive.
- Cubes in rubber or cloth: objects to grab and later stack up. It is advisable to choose soft materials.
- Small vehicles: objects to grab and roll on the ground (be careful that wheels cannot be taken out).

MUSICAL EARLY LEARNING

According to the instrument, music learning can be adapted for children of different ages. Any object that makes noise will please a baby without doubt, but it can be sometimes disturbing for the others. Important for the development of the child, they must be strong if chosen:

- Shakers
- Trumpets
- Tambourines
- Cymbals

COORDINATION AND CONCENTRATION

For children older than a year:

- **Cubes in wood.** It is not until the talking age that the child begins to be truly interested in cubes. Cubes are toys that appeal to its intelligence. Through the game it will put into action 3 fundamental mental operations which are:
    - Observation: shapes, colour, patterns …
    - Understanding: what can be done or not with cubes, how they can be assembled, sorted …
    - Action: implementing what the child has understood and learned through experimentation.
- **Pieces of wood to stack:** different shapes, colours, to be able to build towers. Be careful of heavy pieces that could hurt someone if they fell.
- **Pieces of wood to link together**, such as Lego or Clippo. They allow the development of coordination and precision.
- **Pieces to string:** these are large pearls of different shapes and colours, with a hole in their centre that the child will have fun stringing (the string must be thick enough).
- **Games of skill:** ninepins, for example, in rubber for the younger children, in wood for the older ones.

- **Puzzles:** depending on age, puzzles where pieces have to be fitted in, by placing a piece taken out and put back into the space with the same shape, then pieces to assemble by placing them strategically back on the image on which the shape is represented, then pieces to assemble without any guiding image. After the age of 2 years the child's intellectual and motor development allows it to be interested in puzzles, to perceive the pieces not as isolated and independent elements, but as parts of a whole that the child visualizes on an image placed to the side, then in its mind. The puzzle is a game of complete development that helps the child to implement its skills (in terms of abstraction, logic, observation, construction, spatial recognition, concentration).

SYMBOLISM

Symbolic game: a game in which the activity or the toy becomes something else.

Around 18 months the child plays with a doll, and can make the doll cry, walk, and sleep, as if the child were caring for a real baby. The toy represents something other than what it actually is; it has significant value representing an imaginary world.

Around 2 years old the child has the capacity to transform the function of an object into something else. It can for example utilize a small stick as if it were a pencil.

After 2 years the child carries out symbolic combinations, it speaks to the doll while feeding it, giving it a bath in imaginary water as if the doll were too hot.

- Dolls
- Puppets (interactive game)
- Figurines (social and familial representation)
- A person to assemble (representing the body)
- Imitating games: Play sets which enable the child to become someone else (tea sets, doctor kits, costumes or masks…)
- Mirror (allows for the discovery of oneself and the construction of body image)

PSYCHOMOTOR SKILL DEVELOPMENT

This concerns objects that bring the child to use his/her body and develop his/her motor skills.

- Tunnels
- Cushions (upon which the children can roll for example or tumble without getting hurt)
- Balloons
- Objects to push or pull (wheelbarrows, carts, prams…)

IMAGINATION

Picture books: the first books can be proposed as early as 6 months so long as they cannot be torn. Certain picture books are in cloth with different textures allowing the simultaneous development of imagination, observation and the sense of touch.

GAMES FOR THE BATH

The bath is a special time. It is possible to propose little plastic floating objects which the children can play with during the bath.

A catalogue with photos is available at the centre if you wish to order some toys from Paris, if you are not able to find them in the field. There are toy kits as well for the opening of TFCs and for home treatment programs.

APPENDIX 05

Examples of toys to have in centre for 50 children (toys made and/or bought)

Musical instruments : 10 (Various choice)

Dolls : 10

Glove puppet: 5
Finger puppet: 10

Cartoon and wooden puzzle: 5 various

Cubes (wood or mousse): 2 box
Wood pieces to pile: 4 box

Plastic or mousse ballons : 15-20
Foot ballons : 5
Motricity toys: 1 each

Dinette set: 3
Doctor set: 2
Big mirror: 1

Images books: 10
Paper and pencils: 10 box

Skittles, toys to push, toys in wood etc…:
4 different per place

Discovery carpets: 3
Rattles: 15
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