Module

7.

Involving mothers in care
Module 7

Involving mothers in care
Training course on the inpatient management of severe acute malnutrition. Module 7. Involving mothers in care

(ISBN 978-92-4-002992-7 (electronic version)
ISBN 978-92-4-002993-4 (print version)

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Web Annex
The World Health Organization (WHO) *Training course on the inpatient management of severe acute malnutrition* includes training modules, training guides, and supporting materials. The training package is based on the 2002 *WHO Training course on the management of severe malnutrition*¹, which was updated in 2009² to include the WHO Child Growth Standards, the use of mid-upper arm circumference to assess wasting, and the provision of ready-to-use therapeutic foods (RUTF) for the management of severe acute malnutrition, which enabled early transfer of children from inpatient to outpatient care. In 2013, WHO issued the *Guideline: updates on the management of severe acute malnutrition in infants and children*³, which provided updated recommendations on the following:

a. admission and discharge criteria for children aged 6–59 months with severe acute malnutrition;
b. where to manage children with severe acute malnutrition who have bilateral pitting oedema;
c. use of antibiotics in the management of children with severe acute malnutrition in outpatient care;
d. changes in the provision of vitamin A supplementation in the treatment of children with severe acute malnutrition;
e. options for therapeutic feeding approaches in the management of severe acute malnutrition in children aged 6–59 months;
f. fluid management of children with severe acute malnutrition and dehydration with and without shock;
g. management of HIV-infected children with severe acute malnutrition;
h. identifying and managing infants who are less than 6 months old with severe acute malnutrition.

The training course has been updated to incorporate these updates. Table 1 lists the key technical updates made for each module.

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<table>
<thead>
<tr>
<th>Module</th>
<th>Procedure</th>
<th>2009 version</th>
<th>New version</th>
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<tbody>
<tr>
<td><strong>Module 2: Principles of care</strong></td>
<td>Admission criteria for inpatient care for children aged 6 months or older</td>
<td>Use of visible severe wasting as a sign of severe acute malnutrition</td>
<td>Visible severe wasting is no longer recommended as a sign of severe acute malnutrition, due to its subjective nature</td>
</tr>
</tbody>
</table>
|                        |                                                                           | Admit all severely malnourished children for inpatient care                  | • Severely malnourished children with medical complications or failed appetite test should be admitted for inpatient care (or severely malnourished children who have mitigating circumstances such as disability, social issues, or difficulties with access to care)  
• Severely malnourished children without these signs or mitigating circumstances should be managed in outpatient care |
|                        |                                                                           |                                                                              | Emphasis on appetite test as an important procedure to decide whether severely malnourished children should be admitted for inpatient or outpatient care |
|                        |                                                                           | Oedema of both feet                                                          | • Children with severe acute malnutrition who have severe bilateral oedema (+++) should be admitted for inpatient care, even when they do not present with medical complications and have appetite 
• Children who have only + or ++ bilateral pitting oedema but present with medical complications or have no appetite, or are wasted, should be admitted for inpatient care 
• Children aged 6 months or older who have + or ++ bilateral pitting oedema but no medical complications and have appetite should be managed in outpatient care |
<table>
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<tr>
<th>Module</th>
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</tr>
</thead>
</table>
| Module 2: Principles of care | Criteria for transfer to outpatient care for children aged 6 months or older | Transfer to outpatient care when:  
- medical complications have been treated, and  
- the child has minimal oedema, and  
- the child is alert, and  
- the child eats 75% of the proposed daily amount of ready-to-use therapeutic food (RUTF);  
The decision should be determined by assessment of clinical condition and not anthropometric outcomes | Discharge from all care when:  
- weight-for-height/length Z-score is $\geq -2$, and  
- no oedema for at least 2 weeks, or  
- mid-upper arm circumference is $\geq 125$ mm, and  
- no oedema for at least 2 weeks  
The anthropometric indicator used to confirm severe acute malnutrition should also be used to assess whether a child has reached nutritional recovery  
Children admitted with only bilateral pitting oedema +++ should be discharged from treatment based on whichever anthropometric indicator is routinely used in programmes  
Percentage weight gain should not be used as a discharge criterion |
<table>
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<th>Module</th>
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</table>
| **Module 3: Initial management** | Doses of routine antibiotics | • Amoxicillin 25 mg/kg  
• Gentamicin 5 mg/kg  
• Ampicillin 50 mg/kg | The doses of routine antibiotics have been adjusted, for example: amoxicillin 25–40 mg/kg, gentamicin 7.5 mg/kg, to reflect the latest recommendations from the 2013 WHO *Pocket book of hospital care for children*  |
<p>| Vitamin A                   |                          |                                                                               | Children with severe acute malnutrition should receive the daily recommended nutrient intake of vitamin A (5000 IU) throughout the treatment period. If the children are receiving F-75, F-100 or RUTF that comply with WHO specifications (and therefore already contain sufficient vitamin A), or vitamin A is part of other daily supplements, the children do not require additional vitamin A. Children with severe acute malnutrition should be given a high dose of vitamin A (50 000 IU, 100 000 IU or 200 000 IU, depending on age) on admission, only if they are given therapeutic foods that are not fortified as recommended in WHO specifications and vitamin A is not part of other daily supplements. Give a high dose (50 000 IU, 100 000 IU or 200 000 IU, depending on age) of vitamin A to children with severe acute malnutrition and eye signs of vitamin A deficiency or recent measles in inpatient care on Days 1, 2, and 15 (or at discharge to outpatient care), irrespective of the type of therapeutic food they are receiving. |
|                             | High dose only indicated in corneal ulceration |                                                                               |                                                                                                                                                                                                             |
| Atropine                    | 1% 3 times a day         |                                                                              | The concentration of atropine has been adjusted to 0.1% 3 times a day following discussion with and guidance from several experts as well as the WHO Model List of Essential Medicines.                                                                                  |</p>
<table>
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<th>Module</th>
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<tbody>
<tr>
<td><strong>Module 4: Feeding</strong></td>
<td>Transition to RUTF</td>
<td>Two options for transitioning children from F-75 to RUTF are suggested:</td>
<td>a. Start feeding by giving RUTF as prescribed for the transition phase. If the child does not take the prescribed amount, then top up the feed with F-75. Increase the amount of RUTF over 2–3 days until the child takes the appropriate amount of RUTF to meet energy needs, or: b. Give the child the prescribed amount of RUTF for the transition phase. If the child does not take at least half the prescribed amount in the first 12 hours, then stop giving RUTF and give F-75 again. Retry the same approach after another 1–2 days until the child takes the appropriate amount of RUTF to meet energy needs</td>
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<tr>
<td>Transition for children with oedema</td>
<td></td>
<td>Children with bilateral pitting oedema should transition to RUTF when appetite returns and oedema is reducing</td>
<td></td>
</tr>
<tr>
<td>Rehabilitation phase for children on F-100</td>
<td></td>
<td>Children who are taking F-100 and are achieving rapid weight gain during rehabilitation should be changed to RUTF. Ensure that they are finishing up the appropriate amount of RUTF before transferring them for outpatient care</td>
<td></td>
</tr>
<tr>
<td>Admission criteria for infants aged 0–6 months</td>
<td>• Weight-for-height Z-score &lt; -3, and/or • Bilateral oedema</td>
<td>• Weight-for-length Z-score &lt; -3, or • Presence of bilateral pitting oedema, or • Recent weight loss • Prolonged failure to gain weight • Serious breastfeeding difficulties after mother’s counselling</td>
<td></td>
</tr>
<tr>
<td>Feeding for infants aged 0–6 months</td>
<td>F-75 as a supplement to breast milk</td>
<td>• Infants with severe acute malnutrition but no oedema should be given expressed breast milk. Where this is not possible, commercial (generic) infant formula or F-75 or diluted F-100 may be given, either alone or as the supplementary feed together with breast milk • Infants with severe acute malnutrition and bilateral pitting oedema should be given F-75 as a supplement to breast milk</td>
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<tr>
<td>Module</td>
<td>Procedure</td>
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<tr>
<td><strong>Module 4: Feeding</strong></td>
<td>Criteria for transfer to outpatient care for infants aged 0–6 months</td>
<td>Transfer to outpatient care when:</td>
<td>• all clinical conditions are resolved, and&lt;br&gt; • the infant has good appetite, is clinically well and alert, and&lt;br&gt; • weight gain is satisfactory, and&lt;br&gt; • the infant has been checked for immunizations, and&lt;br&gt; • the mother or caregiver is linked with community-based follow-up and support</td>
</tr>
<tr>
<td></td>
<td>Criteria for discharge from all care for infants aged 0–6 months</td>
<td>Discharge from all care when the infant:</td>
<td>• is breastfeeding effectively or feeding well with replacement feeds, and&lt;br&gt; • has adequate weight gain, and&lt;br&gt; • has a weight-for-length Z-score ≥ −2</td>
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<tr>
<td><strong>Module 5: Daily care</strong></td>
<td></td>
<td>Similar updates as those made to modules 3 and 4, where applicable</td>
<td></td>
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<tr>
<td><strong>Module 6: Monitoring and problem solving</strong></td>
<td></td>
<td>No major technical updates. Minor updates, for example where RUTF replaces F-100</td>
<td></td>
</tr>
<tr>
<td><strong>Module 7: Involving mothers in care</strong></td>
<td>Criteria for referral to outpatient care for children aged 6 months or older</td>
<td>Similar updates as in module 2</td>
<td>Similar updates as in module 2</td>
</tr>
<tr>
<td></td>
<td>Criteria for discharge from all care for children aged 6 months or older</td>
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<tr>
<td>Module</td>
<td>Procedure</td>
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<tr>
<td>Module 8: Outpatient management of severe acute malnutrition</td>
<td></td>
<td>New module</td>
<td></td>
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<tr>
<td>Supporting materials</td>
<td>Critical care pathways and answers to exercises</td>
<td></td>
<td>All critical care pathways and answers to exercises have been updated to reflect the updates in modules</td>
</tr>
<tr>
<td></td>
<td>Organization of supporting materials</td>
<td></td>
<td>The supporting materials have been incorporated within the modules and guides concerned</td>
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ACKNOWLEDGEMENTS

This updated version was coordinated by Zita Weise Prinzo, Department of Nutrition for Health and Development, together with Chantal Gegout (formerly in the Department of Nutrition for Health and Development), in collaboration with Wilson Were, Department of Maternal Child and Adolescent Health. Thanks are due to Jaden Bendabenda, Department of Nutrition for Health and Development, for finalizing this version and preparing it for publication. Special thanks are due to Diana Estevez, who helped during the finalization process.

Acknowledgements are also due to Adelheid Onyango, Hana Bekele and Férima Coulybaly-Zerbo from the WHO Regional Office for Africa, and to Marina Adrianopoli from the WHO Regional Office for the Eastern Mediterranean for their tireless support and valuable inputs, and for organizing the pilot trainings in Togo, Uganda and Zambia.

In addition, special thanks are due to Beatrice Amadi, Teaching Hospital, Lusaka, Zambia, for her contribution during the pilot testing and for reviewing the course, and to Professor Michael Golden and Dr Yvonne Grellety for reviewing and providing invaluable technical inputs to the course.

WHO is grateful to all those involved in the production of the first version of the training course in 2002, and would like to thank ACT International, United States of America, for having developed the manuscript of the training course. WHO acknowledges the substantial technical contribution and advice of Professor A. Ashworth-Hill from the London School of Hygiene and Tropical Medicine, who also acted as one of the first course facilitators. Special thanks are extended to Dr S. Khanum (former Director of Health Services, WHO Regional Office for South-East Asia in New Delhi), for her technical contribution, comments, and advice during the development of the first version of the training modules and for organizing the first field testing at the International Centre for Diarrhoeal Disease Research, Bangladesh.

FINANCIAL SUPPORT

WHO gratefully acknowledges the financial support from the French Muskoka Fund and the Bill and Melinda Gates Foundation for the update of the training materials.

ABBREVIATIONS

ORS  oral rehydration solution
RUTF  ready-to-use therapeutic food
SD  standard deviation
WHO  World Health Organization
INTRODUCTION

It is essential for the mother (or other caregiver) to be with her severely malnourished child in the hospital. She must be encouraged to feed, hold, comfort, and play with her child as much as possible. Some of the reasons to involve mothers in this critical moment are as follows.

• Emotional and physical stimulation are crucial for the child’s recovery and can reduce the risk of developmental and emotional problems.
• The child’s mother can provide more continuous stimulation and loving attention than busy staff.
• When mothers are involved in care at the hospital, they learn how to continue care for their children at home.
• Mothers can make a valuable contribution and reduce the workload of staff by helping with activities such as bathing and feeding children.

LEARNING OBJECTIVES

This module will describe and allow you to discuss and observe:

• ways to encourage involvement of mothers in hospital care
• ways to prepare mothers to continue good care at home, including proper feeding of the child and stimulation using play.

On the ward or in role plays, this module will allow you to practise:

• teaching a mother to bathe or feed a child
• giving complete discharge instructions.
1. ORGANIZE FACILITY ROUTINE TO ENCOURAGE MOTHERS’ INVOLVEMENT

There are many ways to encourage mothers’ involvement in hospital care. Mothers can be taught to:

• prepare food
• feed children
• bathe and change children
• play with children, supervise play sessions
• make toys.

It may be necessary to provide mothers with transportation to enable them to stay with their children. In return, the mothers can help with the above tasks on the ward. It may be helpful to organize a rotation of mothers to do these tasks under supervision. In that way each mother can make a contribution to her child’s care and still have some time off duty.

The staff must be friendly and treat mothers as partners in the care of the children. A mother should never be scolded or blamed for her child’s problems or made to feel unwelcome. Teaching, counselling and befriending the mother are essential to long-term treatment of the child.

Mothers should have a place to sit and sleep on the ward. They also need washing facilities and a toilet, and a way to obtain food for themselves. Some mothers may need medical attention themselves if they are sick or anaemic.

The staff should also make other family members feel welcome. All family members are important to the health and well-being of the child. When possible, fathers should be involved in discussions of the child’s treatment and how it should be continued at home. Fathers must be kept informed and encouraged to support mothers’ efforts in care of the children.
The group will discuss ways in which the involvement of mothers and other family members can be facilitated, as well as factors that may hinder involvement. You may discuss examples from your own facilities and from the ward that you have visited during this training course.

Prepare for the discussion by listing a few ideas below.

Ways to encourage mothers and other family members to be involved:

Factors that hinder involvement of mothers and other family members:

Tell a facilitator when you are ready for the group discussion.
2. INVOLVE MOTHERS IN COMFORTING, FEEDING AND BATHING CHILDREN

Staff should informally teach each individual mother certain skills. First, they may need to show the mother how to hold her child gently and quietly, with loving care. Immediately after any unpleasant procedure, staff should encourage the mother to hold and comfort her child.

When teaching tasks such as feeding or bathing, staff should:

1. Show the mother how to do the task, explaining each step.
2. Let the mother try the task, assisting and encouraging her as she tries.
3. Ask checking questions to make sure the mother understands what to do. For example, if you have just explained how to feed the child, ask the mother such questions as:
   - What will you feed your child?
   - How often will you feed the child?
   - How much will you give the child for a serving?
4. Observe when the mother does the task independently for the first time.
5. Give positive feedback, that is, tell the mother what she did well. Make suggestions for improvements without discouraging the mother. For example, say: “Let’s try together to do it this way.”

At all times staff must communicate clearly with mothers in a way that builds their confidence in their ability to take care of their children. For example, when a clinician examines the child, the clinician should explain what is happening and show the mother how to hold the child during the examination. Staff must treat the mothers as partners in helping the child to health.

Tell a facilitator when you have reached this point in the module.
Exercise B

This exercise will include two role plays of situations in which a nurse is teaching a mother to bathe or feed a child. Your facilitator may assign you the role of a nurse or a mother; if so, you will be given some information to help you prepare for your role. If you are an observer of the role play, you will take notes below.

Role play 1

How would you feel if you were the mother in this situation?
How did the nurse encourage or discourage the mother?

Role play 2

How would you feel if you were the mother in this situation?
How did the nurse encourage or discourage the mother?

3. TEACH GROUPS OF MOTHERS ABOUT FEEDING AND CARE

3.1 Value of group teaching and learning sessions

There are many topics that can efficiently be presented to groups of mothers and other interested family members. Group teaching sessions may be held on topics such as nutrition and feeding, hygiene, making oral rehydration solution (ORS) to treat diarrhoea, and family planning.

Staff members with good communication skills should be assigned to teach these group sessions. There may be several staff members who can take turns presenting different topics. The selected staff must know the important information to cover on a topic and be able to:

• communicate clearly in a way that mothers understand;
• prepare and use suitable visual aids such as posters and real foods;
• demonstrate skills when necessary (for example, cooking procedures, handwashing, or making ORS);
• lead a discussion in which mothers can ask questions and contribute ideas.

The sessions should not be limited to lecture, but should include demonstrations and practice whenever possible. Encourage questions from the mothers so that the session is interactive.

3.2 Example outline of teaching session

The purpose of the training session is to teach parents how to prepare a nutritious food at home. The teaching session should be adapted, choosing a context-specific recipe; this means choosing locally available ingredients and culturally accepted foods.

On the following page an outline of a teaching session is presented as a model that could be used with parents of malnourished children. The food that will be prepared is called khichuri.

The outline contains information, examples and visual aids, and practice. It also includes opportunities for parents to ask questions and contribute ideas.

Although local foods in your area are likely to be different, a similar teaching outline could be used.

Teaching session

Plan in advance to obtain the necessary ingredients and to have a proper place for this activity. Consider the number of participants and the available material needed. It is also important to be aware of the time that the teaching session is expected to last.

Use common cookware as a measure – for example, a cup of rice or a moot of lentils. Keep in mind that this activity is an opportunity to teach food safety practices and share experiences with the participants.

Before the teaching session, verify that the space is clean, that the ingredients have been washed and that they are on the table. Bear in mind that some ingredients might need precooking or preprocessing.

In this example, the recipe chosen is khichuri, which is a Bengali dish.
Preparing khichuri (home-based food)

Information. Khichuri is a nutritious home-based food for children. It will help children continue to recover at home. This food should be given in addition to breast milk or breast-milk substitute.

Ingredients

<table>
<thead>
<tr>
<th>Ingredient</th>
<th>Quantity</th>
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<tbody>
<tr>
<td>Rice</td>
<td>2 moot (fistfuls)</td>
</tr>
<tr>
<td>Dal (lentils)</td>
<td>1 moot</td>
</tr>
<tr>
<td>Shak (leafy green vegetables)</td>
<td>1 moot</td>
</tr>
<tr>
<td>Mishti kumra (pumpkin)</td>
<td>1 piece</td>
</tr>
<tr>
<td>Onion (for flavour)</td>
<td>½ small onion</td>
</tr>
<tr>
<td>Vegetable oil</td>
<td>5 teaspoons</td>
</tr>
<tr>
<td>Water to be absorbed by rice</td>
<td>about 800 ml</td>
</tr>
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</table>

Note: 1 moot is about a fistful of ingredients.

This recipe is appropriate for children aged 6 to 24 months when they have recovered and are eating at home. The quantity prepared makes 589 g of cooked food (cooked soft). The recipe provides 115 kcal and 2.9 g protein per 100 g.

Preparation. Prepare a display tray with ingredients for khichuri, calling attention to the quantities of each. Begin preparing the recipe for khichuri. Have the water boiling with rice, dal, and spices as the session begins. During the teaching session you will finish the recipe.

Describe the recipe, pointing to each ingredient on the tray as you talk. If the parents can read, the recipe may be given to them in writing. If not, a picture recipe may be used. Tell parents what you have already done to begin the cooking. In the initial steps:

- wash hands before preparing food
- put rice, dal, pumpkin, onion, spices, oil, and water in pot and boil
- keep pot covered during cooking.

About 5 minutes before the rice is cooked, add cleaned, chopped shak (leafy vegetables). Spices or herbs (such as garlic and ginger) may be added for flavour. (If preparing for malnourished children who are still recovering, do not add salt, since sodium should be limited. Salt may be added when the recipe is made at home for the family.)

Practice. When it is time to add the shak, have a parent do so. Have a parent clean and chop the leaves and add them to the pot.

Remind parents to wash hands before serving food and keep food covered. Ask if they have a refrigerator to preserve the food and explain that the food cannot be stored too long or it may spoil.
Focus on giving this food to the discharged child until the child is better. Then the child can shift to other nutritious family foods.

Ask a parent to wash their hands and serve two portions of food from the pot. Show parents that this is the correct serving size for a child aged 1 year. Show and describe the portion in relation to the size of the bowl or plate. Let parents (and children, if present) taste the *khichuri*. Explain that it can be cooked longer to make it softer if the child needs softer food.

Take into account that while this food should definitely be given to the child, the rest of the family may like this food too; therefore, if resources are available, prepare enough for the whole family.

**Important information and example.** Children should be fed 5 times daily. Explain that the amount in the pot is enough for two meals for a 1-year-old child. Cook it twice daily to make four meals. Increase amounts if the whole family will eat it.

### 3.3 Discussion and review

**Discussion**

Ask the parents why they think these ingredients are good for children and all family members. In the discussion, explain that:

- oil and rice (or other staples such as potatoes) are needed to give energy;
- dal is needed to build and grow the body;
- leafy green and orange-coloured vegetables are needed to give strength and good health and also to prevent blindness.

Ask parents questions about how they can prepare *khichuri* at home. Encourage them to ask questions as well. Include the following in the discussion.

- How much do you think *khichuri* costs? The price for this recipe is about 5 Bangladeshi taka (about 6 cents in US dollars), including firewood.
- Who goes shopping for food in your family? Will they be willing to buy ingredients for *khichuri*?

**Review**

- What are the reasons to serve *khichuri*? To prevent and treat malnutrition, to prevent blindness, to ensure strong and good health.
- How often should you feed your child *khichuri*? ____ times per day.
- How much will you give at each meal? Show serving size.
- How will you prepare *khichuri*? Review the ingredients and recipe.
4. PREPARE FOR FEEDING THE CHILD AT HOME

Children who are ready for the rehabilitation phase can be transferred to outpatient care if there are appropriate support services at a local health centre, but will remain as inpatients during rehabilitation if such a facility is not available.

4.1 Children transferred to outpatient care during rehabilitation

Children meeting the following criteria can be transferred to outpatient care, when a health centre accessible from the family home has the appropriate services to treat such children:

- the child eats 75% of the proposed daily amount of ready-to-use therapeutic food (RUTF);
- medical complications have been treated;
- the child has minimal oedema;
- the child is alert.

More details on outpatient care and the integration of the child into health care services are provided in Module 8, on outpatient management of severe acute malnutrition.

Food at home during rehabilitation will consist of RUTF at first and then, as a second step, RUTF is alternated with meals based on locally available foods that are nutrient rich and varied (see section below on general discharge instructions).

The mother or caregiver of the child must receive appropriate information at the health centre about feeding the child at home after discharge from care on an outpatient basis.

4.2 Children who remain as inpatients (severe acute malnutrition ward) during rehabilitation

During rehabilitation, while the child is on the ward, gradually reduce and eventually stop the feeds of RUTF or F-100, while adding or increasing the mixed diet of home foods, until the child is eating as they will eat at home. Before returning home, the child must become accustomed to eating family meals based on locally available foods.

To prepare the mother to continue appropriate feeding at home:

- Discuss with the mother (and other family members, if possible) the child’s previous diet, the foods that are available at home, and how best to use them. The “dietary history” section of Annex 1 can be used as a tool in this discussion.
- Discuss practical ways to address specific problems in the child’s past diet. Be sure to involve the mother as a partner in deciding what to feed the child, so that the decisions will be practical. Explain how to use or adapt available foods for a healthy diet in line with the guidelines in section 4.3 below.
• Summarize what to feed the child, how much to give at each meal, and how many meals and snacks to give. Write it down or give the mother a prepared card with feeding instructions. Use pictures for mothers who cannot read.
• Remind the mother to sit with the child and patiently encourage the child to eat.
• Before discharge, when the child is adjusting to home foods under hospital supervision, have the mother practise preparing recommended foods and feeding them to her child.
• Review instructions before discharge and ask the mother checking questions to be sure she understands what to do, for example:
  - What will you feed your child? Where will you get the ingredients to prepare foods at home as you have done it here?
  - How many meals and snacks will you feed your child each day?
  - How much will you feed your child at each meal or snack?
• Provide additional information and instructions if the mother needs them.

4.3 Appropriate diets for children recovering from severe acute malnutrition

Appropriate mixed diets are the same as those recommended for a healthy child. They should provide enough calories, vitamins, and minerals to support continued growth. Home foods should be consistent with the following guidelines.

• The mother should continue breastfeeding as often as the child wants.
• If the child is no longer breastfeeding, animal milk is an important source of energy, protein, minerals and vitamins.
• Solid foods should include a well cooked staple cereal. To enrich the energy content, add vegetable oil (5–10 ml for each 100 g serving) or margarine, ghee, or groundnut paste. The cereal should be soft and mashed; for infants use a thick pap.
• Give a variety of well cooked vegetables, including orange and dark green leafy vegetables. If possible, include fruit in the diet as well.
• If possible, include meat, fish, or eggs in the diet. Pulses (such as lentils or chickpeas) and beans are also good sources of protein.
• Give extra food between meals (healthy snacks).
• Give an adequate serving size (large enough that the child leaves some).

Examples of healthy snacks that are high in energy and nutrients include:

• bread, tortilla, or chapati with butter, margarine, or groundnut paste (peanut butter)
• biscuits, crackers
• bean cakes
• yoghurt, milk, cheese
• ripe banana, papaya, avocado, mango, other fruits
• cooked potatoes, boiled or fried plantain.

Tell a facilitator when you have reached this point in the module. There will be a brief video showing an educational session about preparing home food.
Exercise C

This exercise will be a group discussion of how hospitals can successfully prepare mothers to continue proper feeding at home. To prepare for the discussion, consider the questions below.

1. In your hospital, what will mothers be taught about feeding children at home?
   a. What mixtures of foods will make good meals in your area?
   b. What will be the main messages taught about feeding?
   c. Will you need more information before deciding what to teach?
   d. What information is needed and how will you get it?

2. Who will teach mothers about home foods and how will they teach?
   a. Who is most suited to teaching mothers about feeding at home?
   b. How will demonstrations or examples be given in teaching sessions?
   c. How can mothers practise making home foods in the hospital?
   d. How can transition to home foods be supervised in the hospital?
   e. How can nurses work with mothers to ensure that advice about home feeding is practical and will be followed?

A group discussion of these questions will follow the video on preparing home food.

5. TEACH MOTHERS THE IMPORTANCE OF STIMULATION AND HOW TO MAKE AND USE TOYS

Severely malnourished children have delayed mental and behavioural development. As the child recovers, he or she needs increasing emotional and physical stimulation through play. Play programmes that begin during rehabilitation and continue after discharge can greatly reduce the risk of permanent mental retardation and emotional problems.
The hospital can provide stimulation through the environment, by decorating in bright colours, hanging colourful mobiles over cots, and having toys available.

Mothers should be taught to play with their children using simple, home-made toys. It is important to play with each child individually at least 15–30 minutes per day, in addition to informal group play. Many ideas for toys and structured play are given in Annex 2 and in the video on malnutrition and mental development.

6. **GIVE GENERAL INSTRUCTIONS FOR TRANSFER TO OUTPATIENT CARE**

In addition to feeding instructions, mothers will need to be taught:

- how to continue any needed medications (except the antibiotic treatment that will be fully given in the severe acute malnutrition ward), vitamins (if available), folic acid (for 1–2 weeks), and iron (for 1 month) at home if RUTF is not provided to the child;
- signs to bring the child back for immediate care:
  - not able to drink or breastfeed
  - stops feeding
  - develops a fever
  - has fast or difficult breathing
  - has a convulsion
  - has diarrhoea for more than a day, or blood in stool
  - has oedema (swelling in feet, legs, hands or arms);
- when and where to go for planned follow-up:
  - at 1 week, 2 weeks, 1 month, 3 months, and 6 months
  - then twice yearly visits until the child is at least 3 years old;
• when to return for next immunization (the schedule is in Annex 1 – any currently needed immunizations should be given in the hospital);
• when to go to the health centre for vitamin A (every 6 months);
• how to continue stimulating the child at home with play activities.

Before transferring the child for outpatient treatment of severe acute malnutrition, the following actions should be taken:

• A transfer slip to outpatient care should be completed, including a summary section informing health care providers at the outpatient care site about the medical interventions and treatment given to the child.
• The mother or caregiver should be informed where and on which day to go for outpatient care, at the health facility closest to her community, where she will be given sufficient RUTF to last until the next outpatient care follow-on session (usually 1 week’s worth).
• Key messages about the use of RUTF and basic hygiene are discussed again with the mother or caregiver. The mother or caregiver is also given any remaining medications, except antibiotics, and instructions on how to use them. The mother or caregiver should repeat the instructions to the health care provider to make sure they were clearly understood and will be followed correctly.
• The antibiotic treatment should be completed by the time the child leaves the severe acute malnutrition ward.
• Staff in the inpatient care facility should not retain children that are ready for outpatient care (children with good appetite who have had their medical complications treated).
• The mother or caregiver should be informed on what to do if the child’s condition deteriorates before the next outpatient care follow-on session.
• The mother should be sensitized to continue to stimulate the child at home with games and other exciting activities essential to the psychosocial development of the child.
• The mother will be given key messages regarding the use of RUTF when the child will be cared for as an outpatient for rehabilitation (see Annex 5).

**Example of discharge or transfer card**

A sample discharge card is included with your course materials (Web Annex). The card includes home feeding instructions (with blanks to be filled in) and other instructions, such as when to return for immunizations, next dose of vitamin A, or when the next follow-up will take place. The card attached here only serves as an example; countries are encouraged to make adaptations according to their national child health protocols.

A discharge card can be useful in several ways.

• It provides instructions for home care.
• It reminds the mother when and where to go for follow-up care.
• It can serve as a letter of introduction for a health care or nutritional rehabilitation facility close to the child’s home.
• It serves as a record of the child’s weight-for-height, immunizations, etc.
This exercise will be a role play about giving discharge instructions. Your facilitator may ask you to play the role of a nurse or a mother, or you may be an observer. If you are an observer, be prepared to answer the questions below based on your observations.

**Background.** This mother and child have been in the severe acute malnutrition ward for 18 days. The child, who is 2 years old, has reached a weight-for-height Z-score of $\geq -2$ SD. The mother has already been taught carefully how to continue feeding at home and how to play with her child. The mother and child are ready for discharge. It is now time for the nurse to review instructions with the mother, using a discharge card. The nurse will use the sample discharge card given in the module. Observers please note the following.

1. Did the nurse review all of the points on the discharge card?

2. Did the nurse speak clearly and simply so the mother could understand?

3. Did the nurse ask checking questions to be sure that the mother understood the instructions?

4. Did the nurse offer the mother a chance to ask questions?
7. **IF EARLY DISCHARGE IS UNAVOIDABLE, MAKE SPECIAL ARRANGEMENTS FOR FOLLOW-UP**

**Note:** If a programme on outpatient management of severe acute malnutrition is in place, early discharge means before the reduction of oedema or regaining appetite. If no programme is in place, early discharge means before reaching a weight-for-height Z-score of ≥ −2 SD.

If a child must be discharged before reaching ≥ −2 SD and there is no programme for outpatient care, it is critical to make arrangements for follow-up of the child (for example, special visits by a health worker to the child’s home, or outpatient care at a health facility or nutritional rehabilitation centre). Mothers will need special training to prepare feeds and give iron, folic acid, and multivitamins at home.

In no case should a child be discharged until the following conditions are met.

• The child is through transition to F-100 (is feeding freely on F-100) or RUTF.
• Antibiotic treatment is finished.
• The child is eating well, has appetite.
• The child is gaining weight.
• The mother has been thoroughly trained in how to feed the child at home and give the remaining basic medication and supplements.
• Arrangements have been made for support and follow-up (for example, home visits, or visits to an outpatient facility).
This exercise is an optional discussion for participants who work in hospitals where early discharge or transfer to outpatient care is common.

If your group will have this discussion, be prepared to discuss such issues as the following.

1. What are the reasons for early discharge? Are the reasons institutional (for example, limited space in the ward) or personal?
2. Is early discharge avoidable? If so, how?
3. If early discharge is not avoidable, what are the options for handling early discharge (such as home visits, follow-up by local health worker)? What are the advantages and disadvantages of these?
4. How can the mother be thoroughly prepared to feed the child at home?
5. Can RUTF be continued at home or can the home diet be adapted to meet the energy and nutritional needs of the child? (A nutritional expert may need to be consulted in order to develop adequate recipes using home foods.)
ANNEX 1. DIETARY HISTORY AND IMMUNIZATION HISTORY

Dietary history

Duration of exclusive breastfeeding (in months): 

Total duration or age at which breastfeeding stopped: 

Age at which non-milk feeds started: 

Usual diet before current illness

<table>
<thead>
<tr>
<th>Type of food or fluid given</th>
<th>Age started (months)</th>
<th>Age stopped (months)</th>
<th>Amount per feed (g or ml)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Infant formula or animal milk (specify)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cereals (specify)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other staple foods(^a) (specify)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Water, herbal teas, fruit juice or other drinks (specify)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fresh fruits</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Orange and dark green vegetables</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other vegetables and pulses</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fish, meat or eggs</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other foods (specify)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

\(^a\) Includes rice, corn, cassava, sorghum, potatoes and noodles.

Diet since current illness began (describe any changes)


Diet during past 24 hours (record all intake)

<table>
<thead>
<tr>
<th>Time of Day</th>
<th>Intake</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Immunization history

<table>
<thead>
<tr>
<th>Immunization</th>
<th>First</th>
<th>Second</th>
<th>Third</th>
<th>Booster</th>
</tr>
</thead>
<tbody>
<tr>
<td>BCG</td>
<td>At birth or &gt; 6 months</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Polio</td>
<td>At birth</td>
<td>2 months</td>
<td>3 months</td>
<td>12 months</td>
</tr>
<tr>
<td>DTP</td>
<td>3 months</td>
<td>4 months</td>
<td>5 months</td>
<td>12 months</td>
</tr>
<tr>
<td>Measles</td>
<td>6 or 9 months</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
</tbody>
</table>

BCG: bacille Calmette-Guérin vaccine; DTP: diphtheria-tetanus-pertussis vaccine.

* Circle immunizations already given.
Severely malnourished children have delayed mental and behavioural development, which, if not treated, can become the most serious long-term result of malnutrition. Emotional and physical stimulation through play programmes that start during rehabilitation and continue after discharge can substantially reduce the risk of permanent mental retardation and emotional impairment.

**Rehabilitation**

Care must be taken to avoid sensory deprivation. The child’s face must not be covered; children must be able to see and hear what is happening around them. They should never be wrapped or tied to prevent them moving around in the cot.

It is essential that the mother (or caregiver) be with her child in hospital and at the nutrition rehabilitation centre, and that she be encouraged to feed, hold, comfort and play with her child as much as possible. The number of other adults who interact with the child should be as few as possible. Each adult should talk, smile and show affection towards the child. Medical procedures, such as venepuncture, should be done by the most skilled person available, preferably out of earshot and sight of the other children. Immediately after any unpleasant procedure the child should be held and comforted.

**The environment**

The austerity of a traditional hospital has no place in the treatment of malnourished children. Rooms should be brightly coloured, with decorations that interest children. Colourful mobiles should be hung over every cot, if possible. The staff should wear normal clothing rather than uniforms. Brightly coloured aprons may be used to protect their clothing. A radio can provide background music. The atmosphere in the ward should be relaxed, cheerful and welcoming.

Toys should always be available in the child’s cot and room, as well as in the play area; they should be changed frequently. Toys should be safe, washable and appropriate for the child’s age and level of development. Inexpensive toys made from cardboard boxes, plastic bottles, tin cans and similar materials are best, because mothers can copy them. Examples of suitable toys are described in Annex 3.

**Play activities**

Malnourished children need interaction with other children during rehabilitation. After the initial phase of treatment, the child should spend prolonged periods with other children on large play mats, and with the mother or a play guide. The child can also be fed in the play area. These activities do not increase the risk of cross-infection appreciably and the benefit for the child is substantial. One person,
usually a nurse or volunteer, should be responsible for developing a curriculum of play activities and for leading the play sessions. Activities should be selected to develop both motor and language skills, and new activities and materials should be introduced regularly. One aim should be to play with each child, individually, for 15–30 minutes each day, in addition to informal group play. A sample curriculum of play activities, arranged by level of development, is provided in Annex 4. Mothers can be trained to supervise play sessions.

Learning through play should be fun for children. A child’s efforts to perform a task should always be praised and never criticized. When a child is taught a skill, the nurse or volunteer should demonstrate the skill first, then help the child do it, and finally let the child do it alone. This sequence should be repeated until the child has mastered the skill.

Physical activities

Physical activities promote the development of essential motor skills and may also enhance growth during rehabilitation. For those children who are unable to move, passive limb movements and splashing in a warm bath are helpful. For other children, play should include such activities as rolling on a mattress, running after and tossing a ball, climbing stairs, and walking. The duration and intensity of physical activities should increase as the child’s nutritional status and general condition improve. If there is sufficient space, an outdoor playground could be developed.
ANNEX 3. TOYS FOR SEVERELY MALNOURISHED CHILDREN

Ring on a string (from 6 months)
Thread cotton reels and other small objects (e.g. cut from the neck of plastic bottles) on to a string. Tie the string in a ring, leaving a long piece of string hanging.

Bottle (from 12 months)
Cut long strips of plastic from coloured plastic bottles. Place them in a small transparent plastic bottle and glue the top on firmly.

Drum (from 12 months)
Any tin with a tightly fitting lid.

Mirror (from 18 months)
A tin lid with no sharp edges.

Posting bottle (from 12 months)
A large transparent plastic bottle with a small neck and small long objects that fit through the neck (not small enough to be swallowed).

Blocks (from 9 months)
Small blocks of wood. Smooth the surfaces with sandpaper and paint in bright colours, if possible.

Push-along toy (from 12 months)
Make a hole in the centre of the base and lid of a cylindrical-shaped tin. Thread a piece of wire (about 60 cm long) through each hole and tie the ends inside the tin. Put some metal bottle tops inside the tin and close the lid.

Stacking bottle tops (from 12 months)
Cut at least three identical round plastic bottles in half and stack them.

Pull-along toy (from 12 months)
As above, except that string is used instead of wire.

Nesting toys (from 9 months)
Cut off the bottom of two bottles of identical shape, but different size. The smaller bottle should be placed inside the larger bottle.

Puzzle (from 18 months)
Draw a figure (e.g. a doll) in a crayon on a square- or rectangular-shaped piece of cardboard. Cut the figure in half or quarters.

Doll (from 12 months)
Cut out two doll shapes from a piece of cloth and sew the edges together, leaving a small opening. Turn the doll inside-out and stuff with scraps of materials. Stitch up the opening and sew or draw a face on the doll.

Book (from 18 months)
Cut out three rectangular-shaped pieces of the same size from a cardboard box. Glue or draw a picture on both sides of each piece. Make two holes down one side of each piece and thread string through to make a book.
Each play session should include language and motor activities, and activities with toys. Teach the games or skills listed below when the child is ready for them. Encourage the child to use appropriate words to describe what he or she is doing.

Language activities (from 12 months)

At every play session, teach the child local songs, and games using the fingers and toes. Encourage the child to laugh, vocalize and describe what he or she is doing. Teach the child to use words such as “bang” when beating the drum, “bye” when waving goodbye, and “thank you” when given something.

Motor activities (from 6 months)

Always encourage the child to perform the next appropriate motor activity. For example, bounce the child up and down and hold the child under the arms so the child’s feet support his or her weight. Help the child to sit up by propping him or her up with cushions or any other appropriate materials. Roll toys out of reach to encourage the child to crawl after them. Hold the child’s hands and help him or her to walk. As soon as the child has started to walk unaided, give the child a push-along toy and later a pull-along toy (see Annex 3).

Activities with toys

Ring on a string (from 6 months)

1. Swing a ring on a string within reach of the child and encourage him or her to reach for it.
2. Suspend the ring over the crib and encourage the child to knock it and make it swing.
3. Let the child examine the ring. Then place the ring a short distance from the child, leaving the string within reach of the child. Teach the child to get the ring by pulling on the string.
4. Sit the child on your lap. Then, holding the string, lower the ring towards the floor.
5. Teach the child to get the ring by pulling on the string. Also, teach the child to dangle the ring.

Rattle and drum (from 12 months)

1. Let the child examine the rattle. Teach the child to use the word “shake” when shaking the rattle.
2. Encourage the child to beat the drum with the rattle. Teach the child to use the word “bang” when beating the drum.
3. Roll the drum out of the child’s reach and encourage him or her to crawl after it.

*In-and-out toy with blocks (from 9 months)*

1. Let the child examine the container and blocks. Put the blocks into the container and shake it. Then teach the child to take them out, one at a time. Teach the child the meaning of the words “out” and “give”.
2. Teach the child to take out the blocks by turning the container upside-down.
3. Teach the child to hold a block in each hand and to bang the blocks together.
4. Teach the child to put the blocks in the container and to take them out again. Teach the child to use the words “in” and “out”.
5. Cover the blocks with the container and let the child find them. Then hide them under two or three covers or pieces of cloth and repeat the game. Teach the child to use the word “under”.
6. Turn the container upside-down and teach the child to put blocks on top of it.
7. Teach the child to stack the blocks, first two, then gradually more. Teach the child to use the words “up” when stacking the blocks and “down” when knocking them down.
8. Line up the blocks horizontally, first two, then more. Teach the child to push them along, making train or car noises. For children aged 18 months or more, teach the meaning of the words “stop”, “go”, “fast”, “slow” and “next to”. Then teach the child to sort the blocks by colours, first two colours, then more. Teach the meaning of the words “high” and “low”. Make up games.

*Posting bottle (from 12 months)*

Put some objects into a bottle. Shake it. Teach the child to turn the bottle upside-down and empty out the objects. Then teach the child to put the objects into the bottle and to take them out again. Try the same game again with different objects.

*Stacking bottle tops (from 12 months)*

Let the child play with two bottle tops. Then teach the child to stack them. Later increase the number of bottle tops. Teach children aged over 18 months to sort the bottle tops by colour and to use the words “high” and “low” when describing the stacks.

*Doll (from 12 months)*

Encourage the child to hold the doll. Teach the child to identify his or her own body parts and those of the doll when you name them. Teach children aged over 2 years to name their own body parts. Put the doll in a box for a bed and teach the child the words “bed” and “sleep”.

*Books (from 18 months)*

Sit the child on your lap. Teach the child to turn the pages of the book and to point to the pictures. Then teach the child to point to the pictures that you name. Talk about the pictures. Show the child pictures of simple familiar objects and of people and animals. Teach children aged over 2 years to name the pictures and to talk about them.
ANNEX 5. KEY MESSAGES ABOUT THE USE OF READY-TO-USE THERAPEUTIC FOOD (RUTF)

The following are important notes to give to a mother before transfer for rehabilitation through outpatient care.

• RUTF is both a food and medicine for malnourished children only. It should not be shared.
• Give small regular meals of RUTF and encourage the child to eat often (if possible eight meals a day).
• During the first week of treatment at home, give mainly RUTF to the child. Over the following weeks, the child will need to receive, alternately with RUTF, locally available foods, nutrient rich and varied. The health centre will instruct the mother how to feed the child with food available locally.
• For young children, continue to breastfeed regularly.
• Always offer the child plenty of clean water to drink or breast milk when the child takes RUTF.
• Wash the child’s hands and face with soap before eating, if possible.
• Keep food clean and covered, including sachets of RUTF, which should be kept closed and covered.
• Always keep the baby covered and warm.
• When a child has diarrhoea, continue to feed the child. Offer frequent meals in small quantities if the child’s appetite is reduced.
• Return to the health facility whenever the child’s condition deteriorates or if the child is not eating sufficiently.