



Facilitator Guide



*The Community
Maternal, Infant and Young Child Nutrition
Counselling Package*

October 2011



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Disclaimer

The content of this Facilitator Guide which is part of the *The National Community Maternal, Infant and Young Child Nutrition (MIYCN) Counselling Package*, is the sole responsibility of the Ministry of Health of Rwanda and does not necessarily reflect the views of USAID or the United States Government.

FOREWORD

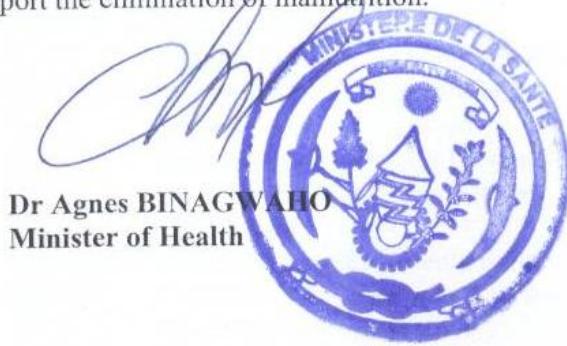
This document, and other companion tools, is the result of a collaborative effort of the Government of Rwanda and multiple stakeholders involved in nutrition in Rwanda, especially infant and young child feeding (IYCF) partners. They have worked very hard over the past year, under the leadership of the Ministry of Health, to develop a harmonised package that will address the nutritional challenges faced by families throughout the country. Appropriate maternal, infant and young child nutrition (MIYCN) is a major determinant for growth, development, health and survival. This training package promotes and supports exclusive breastfeeding for six months, followed by the introduction of safe and appropriate complementary feeding, with continued breastfeeding for up to two years of age or more.

Many children are not fed according to national recommended guidelines due to lack of knowledge, resulting in malnutrition. Currently, only 38% of infants aged 0-to-6 months are exclusively breastfed (CFSVA, 2009), and 44% of Rwanda's children are stunted, a sign of chronic malnutrition. Malnutrition beginning in early infancy contributes to about half of all deaths that occur among young children. By the time a child is two years of age, malnutrition has taken a serious toll on his or her development, and that is why this training package puts emphasis on infants and young children under the age of two.

Information on how to feed infants and young children comes from family beliefs, community practices and information from health workers. It has often been difficult for health workers to discuss with families how best to feed their young children due to confusing, and often conflicting, information available. Inadequate knowledge about how to breastfeed, the appropriate complementary foods to give and good feeding and hygiene practices, are often greater determinants of malnutrition than the availability of food.

There is urgent need to train all those involved in maternal, infant and young child nutrition counselling, in the skills needed to support breastfeeding and good complementary feeding practices. This training package focuses on the effective use of a number of communication tools, including practical, colourful counselling cards and take home brochures, which will help all involved to provide quality counselling to mothers, fathers and other caregivers.

The fight against malnutrition constitutes one of the priorities of the Rwanda Government and we urge all stakeholders to use this national package at all levels to build the necessary capacity to support the elimination of malnutrition.



Dr Agnes BINAGWAHO
Minister of Health

ACKNOWLEDGEMENT

This *Facilitator Guide* is part of *The National Community Maternal, Infant and Young Child Nutrition (MIYCN) Counselling Package*, developed under a strategic collaboration between the Ministry of Health Rwanda and its key partners in MIYCN. *The Community MIYCN Counselling Package* includes the *Facilitator Guide*, Appendices, and *Training Aids* for training community health workers; the *Participant Materials*, including training “handouts” and monitoring tools; a set of 28 *MIYCN Counselling Cards with Key Messages on the back*, 2 *Posters* and 3 *Take-home Brochures*.

The various elements of *The National Community MIYCN Counselling Package* are based heavily on the *UNICEF Community Infant and Young Child Feeding (IYCF) Counselling Package*, developed through a collaboration between UNICEF New York, Nutrition Policy Practice, and University Research Co., LLC/Center for Human Services (URC/CHS) and released in 2010. This package was adapted for the Rwanda context, harmonized with a number of materials previously developed in Rwanda; field tested, and finalized using a consensus building process with all relevant stakeholders.

The development of *The National Community MIYCN Counselling Package* was lead by the Nutrition Desk of the Ministry of Health, with support from RBC/IHDPC and all nutritional partners in the IYCF field in Rwanda, the Elizabeth Glaser Pediatric AIDS Foundation (EGPAF), PATH, EIP, RRP+, WVI, PSI, UNICEF, WHO, CRS, WFP, ICAP, FHI, IntraHealth and MCHIP.

The Ministry of Health would like to thank these institutions and partners for their critical inputs, including consultation and participation in numerous design and technical review meetings and workshops, field testing and validation of the package. Special appreciation goes to EGPAF, funded by the American people through the U.S. Agency for International Development (USAID) as part of the U.S. President's Emergency Plan for AIDS Relief (PEPFAR), for providing financial and technical resources needed to develop this package and PATH, also funded with support from USAID, for facilitating the participatory process involved in developing this package.

We would like to recognize the community health workers, mothers and health workers whose comments and contributions were extremely valuable in finalizing the materials.

Finally, we would like to extend our deepest appreciation and sincere thanks to all partners and institutions for their tireless efforts to support the Government of Rwanda to improve the lives of the Rwandan people.

ACRONYMS

ADRA	Adventist Development and Relief Agency
AIDS	Acquired Immune Deficiency Syndrome
ANC	Antenatal Care
ARI	Acute Respiratory Infection
AROM	Artificial Rupture Of Membranes
ARVs	Anti-Retroviral Drugs
CC	Counselling Cards
CHW	Community Health Worker
CMAM	Community Management of Acute Malnutrition
CRS	Catholic Relief Services
EBF	Exclusive Breastfeeding
EGPAF	Elizabeth Glaser Pediatric AIDS Foundation
EIP	Expanded Impact Project
ENA	Essential Nutrition Actions
FHI	Family Health International
GMP	Growth Monitoring and Promotion
HIV	Human Immunodeficiency Virus
IHDPC	Institute of HIV/AIDS, Diseases Prevention and Control
IMCI	Integrated management of childhood illness
ITNs	Insecticide Treated Nets
IYCF	Infant and Young Child Feeding
LAM	Lactation Amenorrhoea Method
LBW	Low Birth Weight
LQAS	Lot Quality Assurance Sampling
MAM	Moderate Acute Malnutrition
MCHIP	Maternal Child Health Integrated Program
MIYCN	Maternal, Infant and Young Child Nutrition
MTCT	Mother-To-Child Transmission of HIV
MUAC	Mid-Upper Arm Circumference
NGO	Non-Governmental Organization
OTP	Outpatient Therapeutic Programme
PEPFAR	U.S. President's Emergency Plan for AIDS Relief
PMTCT	Prevention of Mother-To-Child Transmission of HIV
PSI	Population Service International
RBC	Rwanda Biomedical Centre
RRP+	Rwanda network for people living with HIV
RUTF	Ready-to-Use Therapeutic Food
SAM	Severe Acute Malnutrition
SFP	Supplementary Feeding Programme
STI	Sexually Transmitted Infection
TB	Tuberculosis
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
WFP	World Food Programme
WHO	World Health Organization
WVI	World Vision International

TABLE OF CONTENTS

FOREWORD.....	i
ACKNOWLEDGEMENT	ii
ACRONYMS.....	iii
TABLE OF CONTENTS	iv
INTRODUCTION	1
TRAINING SCHEDULE – COMMUNITY MATERNAL, INFANT AND YOUNG CHILD NUTRITION (MIYCN) COUNSELLING PACKAGE.....	6
SESSION 1. INTRODUCTIONS, PRE-ASSESSMENT, GROUP NORMS, EXPECTATIONS AND OBJECTIVES	8
SESSION 2. WHY MIYCN MATTERS	12
SESSION 3. BREASTFEEDING BELIEFS.....	17
SESSION 4. HOW TO COUNSEL: PART I.....	20
SESSION 5. RECOMMENDED IYCF PRACTICES: BREASTFEEDING.....	26
SESSION 6. HOW TO BREASTFEED	38
SESSION 7. RECOMMENDED IYCF PRACTICES: COMPLEMENTARY FEEDING FOR CHILDREN FROM 6 UP TO 24 MONTHS	49
SESSION 8. GROWTH MONITORING AND PROMOTION.....	66
SESSION 9. COMMON BREASTFEEDING DIFFICULTIES: SYMPTOMS, PREVENTION AND ‘WHAT TO DO’	98
SESSION 10. HOW TO COUNSEL MOTHER/FATHER/CAREGIVER: PART II	105
SESSION 11. 1st FIELD VISIT AND FEEDBACK	119
SESSION 12. HOW TO CONDUCT ACTION ORIENTED GROUP SESSIONS, IYCF SUPPORT GROUPS AND HOME VISITS	122
SESSION 13. 2nd FIELD VISIT AND FEEDBACK.....	131
SESSION 14. WOMEN’S NUTRITION	135
SESSION 15: KITCHEN GARDEN AND SMALL ANIMALS PROMOTION	143
SESSION 16. FEEDING OF THE SICK CHILD	145
SESSION 17. IYCF IN THE CONTEXT OF HIV	148
SESSION 18. INTEGRATING IYCF SUPPORT INTO COMMUNITY SERVICES AND EMERGENCY RESPONSE	157
SESSION 19. IYCF FORMS: COUNSELLING, GROUP EDUCATION, IYCF SUPPORT GROUPS AND CHECKLISTS.....	165
SESSION 20. POST ASSESSMENT AND EVALUATION	167
APPENDICES	171
Appendix 1: Seven steps in planning a training/learning event	172
Appendix 2: Roles and responsibilities before, during and after training	173
Appendix 3: List of training materials	175
Appendix 4: Supervision.....	181
Appendix 5: Principles of adult learning.....	185
Appendix 6: Training methodologies: advantages, limitations, and tips for improvement	187
Appendix 7: Suggested training exercises, review energisers (group and team building), daily evaluation and faces.....	192

INTRODUCTION

Overview of the National Community Maternal, Infant and Young Child Nutrition (MIYCN) Counselling Package

The *Community MIYCN Counselling Package* is designed to equip Community Health Workers (CHWs), other community workers, or primary health care staff to support mothers, fathers and other **caregivers** to optimally feed their infants and young children. The training component of the package is intended to prepare CHWs with technical knowledge on the recommended breastfeeding and complementary feeding practices for children from 0 up to 24 months, enhance their counselling, problem solving and reaching-an-agreement (negotiation) skills, and prepare them to effectively use the related counselling tools and job aids.

Throughout this Facilitator Guide, the trainers are referred to as Facilitators and the trainees/learners as Participants.

Materials

The *National Community MIYCN Counselling Package* is comprised of the following:

1. The **Facilitator Guide** is intended for use in training CHWs in technical knowledge related to key MIYCN practices, essential counselling skills and the effective use of counselling tools and other job aids.
2. The **Participant Materials** include key technical content presented during the training (“handouts” from the Facilitator Guide) and tools for assessment of mother/father/caregiver and child counselling, growth monitoring and promotion, and supervision activities.
3. The 28 **MIYCN Counselling Cards with Key Messages (CC)** present brightly coloured illustrations that depict key maternal, infant, and young child feeding concepts and behaviours for CHWs to share with mothers, fathers and other caregivers. These job aids are designed for use during specific contact points, based on priorities identified during each individual counselling session. ***On the back of every CC, key messages are listed for community health workers.***
4. The three **Take-home Brochures** are designed to complement the counselling card messages and are used as individual job aids to remind mothers, fathers and other caregivers about key breastfeeding, complementary feeding, and maternal nutrition concepts. The brightly coloured illustrations found in each brochure are intended to enhance each user’s understanding of the information presented in the brochures, and to promote positive behaviours.
5. The two **Posters** are brightly coloured illustrations designed to reinforce the messages around the importance of antenatal care and exclusive breastfeeding, and will be displayed at strategic places frequented by large numbers of people.
6. **Training Aids** have been designed to complement the training sessions by providing visuals to help Participants grasp and retain technical knowledge and concepts.

Planning a Training

There are a series of steps to plan a training event that need careful consideration (see *Seven Steps in Planning a Training/Learning Event* in Appendix 1, and *Roles and Responsibilities Before, During and After Training* in Appendix 2).

Specific Objectives of Training

The Facilitator Guide was developed using training methodologies and technical content appropriate for use with CHWs. The content focuses on breastfeeding, complementary feeding, women's nutrition, feeding of the sick/malnourished infants and young children, Growth Monitoring and Promotion (GMP), Community Management of Acute Malnutrition (CMAM), infant feeding in the context of HIV and kitchen gardening and small animal promotion.

By the end of the training, Participants will be able to:

- Explain why MIYCN practices matter
- Demonstrate appropriate use of counselling skills (*Listening and Learning; Building Confidence and Giving Support* [practical training sessions]) and use the set of CC
- Use the *IYCF 3-Step Counselling* ('assess, analyze and act') with a mother, father, or other caregiver
- Describe recommended feeding practices through the first two years of life; demonstrate use of related possible counselling discussion points and technical materials
- Describe how to breastfeed
- Identify ways to prevent and resolve common breastfeeding difficulties
- Describe various aspects of appropriate complementary feeding from 6 up to 24 months of age
- Describe practices for feeding a sick child and a child who has acute malnutrition
- Facilitate action-oriented group sessions and mother-to-mother IYCF support groups
- Describe basic information on infant feeding in the context of HIV
- Highlight the main issues related to infant feeding in emergencies
- Be able to monitor growth and list how and when a child should be followed up
- Identify signs that require referral to a health post

Target Group

This training is geared to teach CHWs focused on child health, and/or on maternal health and other community workers on IYCF. Primary health care workers, supervisors and project staff who act as 'points of referral' for CHWs might also be trained. It is assumed that Participants will have basic literacy.

At least three Facilitators should conduct the training. Ideally, there will be one Facilitator for every 3 – 5 Participants. When the ratio exceeds this number it is impossible to oversee skills development ensuring competency. The Facilitators should be MIYCN experts with community-based experience and skills in facilitating the training of community health workers.

Training Structure

A list of materials for the training is found in Appendix 3. The Facilitator Guide is divided into 20 sessions ranging from 30 minutes to 4 hours, divided over a 5-day training. Supportive supervision, supervisory checklists, programme manager oversight of supervision and supervisory/mentoring tools are found in Appendix 4: Supervision.

Each session includes:

- A table of "Learning Objectives", related pages of the *Participant Materials, Counselling Cards with Key Messages, Take-home Brochures* and *Training Aids* for classroom work and/or fieldwork

- A list of materials
- Advance preparation
- Time allotted
- Suggested activities and methodologies based on each learning objective with instructions for the Facilitator(s)
- Key information with explanation of content

The Facilitator Guide is designed to be used by Facilitators as guidance for the preparation and execution of the training, and is not intended to be given to Participants. The *Training Aids* are for the use of the Facilitators during training only. Participants are given participant materials, a set of counselling cards with key messages on the back and copies of the 3 take-home brochures.

Technical Note: In the Facilitator Guide

- 0 up to 6 months is the same as 0 - 5 months OR 0 - 5.9 months (a period of 6 completed months)
- 6 up to 9 months is the same as 6 - 8 OR 6 - 8.9 months (a 3 month period)
- 9 up to 12 months is the same as 9 - 11 OR 9 - 11.9 months (a 3 month period)
- 12 up to 24 months is the same as 12 - 23 months OR 12 - 23.9 months (a 12 month period)

In the *Community MIYCN Counselling Package* the terms 0 up to 6 months, 6 up to 9 months, 9 up to 12 months, and 12 up to 24 months are used when discussing infant and young child age groups.

Training Methodology

The ultimate goal of community MIYCN counselling training is to change the behaviour of both the Participants and the mothers and caregivers that they counsel. Hands-on practice is the focus of the training, with emphasis on counselling skills and the effective use of the counselling cards and take-home brochures. The competency-based participatory training approach used in the facilitator guide reflects key principles of behaviour change communication (BCC), with a focus on the promotion of small doable actions, and recognition of the widely acknowledged theory that adults learn best by reflecting on their own personal experiences (see Appendix 5: *Principles of Adult Learning*).

The approach uses the experiential learning cycle method and prepares Participants for hands-on performance of skills. The course employs a variety of training methods, including the use of counselling materials, visual aids, demonstrations, group discussion, case studies, role plays, and practice (see Appendix 6: *Training Methodologies: Advantages, Limitations and Tips for Improvement*). Participants also act as resource persons for each other, and benefit from clinical and/or community practice, working directly with breastfeeding mothers, pregnant women, and mothers/fathers/caregivers who have young children (see Appendix 7: *Suggested Training Exercises, Review Energisers (group and team building), and Daily Evaluations and Fases*).

The training is based on proven participatory learning approaches, which include:

- Use of motivational techniques
- Use of the experiential learning cycle
- Problem-centred approach to training
- Mastery and performance of one set of skills and knowledge at a time
- Reconciliation of new learning with the reality of current work situation and job description
- Supervised practice of new skills followed by practice with mothers and caregivers, to provide Participants with the confidence that they can perform correctly once they leave the training
- Carefully thought out supervisory or follow up mechanisms to help counsellors maintain and improve their performance over time.

Using the Counselling Cards with Key Messages

The IYCF 3-step counselling guides take Participants through 3 important steps during an individual counselling session with a mother or caregiver and child.

To learn to conduct an IYCF assessment of the mother and child pair, Participants use an assessment tool that helps them to structure and thus remember the information they must obtain from the mother or caregiver by observing and engaging in conversation using the counselling skills they have already practiced.

Once the required information has been obtained, Participants learn to pause momentarily during the analysis process in order to reflect on what they have learned about the child and mother or caregiver. They then determine if the child's feeding is age-appropriate, and if there are other feeding difficulties.

If there are more than 2 difficulties, the counsellor prioritises the issues, selecting one or two to discuss with the mother or caregiver during the action step. The counsellor selects a small amount of relevant information to discuss with the mother to determine if together they can identify a small doable action that the mother or caregiver could try for a limited period of time.

If there is a counselling card or brochure that can help the counsellor better explain a recommended feeding practice or a skill, that card or brochure may be used during this discussion.

The counsellor should refer to the illustrations in the material to help reinforce the information that she or he is sharing. If appropriate, a Brochure may also be given to the mother or caregiver as a personal job aid to help remember the small doable action and other information that the counsellor has shared. Once a small doable action is agreed upon, the counsellor may arrange to meet with the mother at a scheduled time and location to determine if the 'new doable action' is working well, or whether they need to explore another possible action to help move the mother and child in the direction of the recommended feeding practice or practices.

Activities carried out in each session of the training are specifically designed to help the Participants understand, internalize and remember the information captured graphically in the illustrations on each counselling card. Once trained using this approach, the counsellor can select the most appropriate CC and information to discuss with a mother or caregiver. The CC may also be used during group education (action-oriented groups) and mother-to-mother support activities. During or after the telling of a story, or performance of a mini-drama, or while discussing a topic during a support group, the CC may be used to guide a discussion or to help demonstrate and discuss comprehensive information dealing with a particular topic.

Training Location and Practicum Site

Wherever the training is planned, a clinical or community-based site should be readily available to support the practicum for counselling and reaching-an-agreement; during the practicum, Participants work with mothers/fathers/caregivers to identify small doable actions that will improve infant and young child feeding practices. The practicum site needs to be coordinated with clinic and/or community leaders before the arrival of Participants and for arrangement of space to practise the skills.

Post Training Follow-Up

The desired output of *The National Community MIYCN Counselling Package* is the effective and continuing application of new skills and knowledge resulting in improved performance of both the CHW and those who receive their counselling and follow-up. Participant mastery of new knowledge can be measured immediately through the pre/post tests that are built into the training.

To assess and support the ability of Participant/CHWs to appropriately apply the knowledge and counselling skills gained in training to the post-training work in the community, the training Facilitators (who may or may not be programme supervisors) should observe and evaluate Participants at their work place as soon as feasible following the completion of the training, within at least 3 months after training. Ideally, Facilitators should provide on-the-job support or mentoring and assist with problem-solving in work situations that include:

- i) A counselling interaction with a mother/father/caregiver and child in a community or home setting,
- ii) During group education (action oriented groups), and
- iii) During support group facilitation.

Post-training follow-up will allow a Facilitator to determine the need for reinforcement of specific Participant's knowledge and skills through additional or refresher training or ongoing supportive supervision.

Ongoing follow-up through a formalized system of supervision/mentoring will allow Facilitators or Programme Managers to monitor CHW retention or erosion of knowledge and the development of skills over time; to focus ongoing supportive supervision and problem-solving to meet the needs of individual CHWs; and to determine the need and timing for on-the-job training or other refresher training. Where supervision of individual CHWs is not possible, peer discussion and mentoring among a group of CHWs might be considered.

TRAINING SCHEDULE – COMMUNITY MATERNAL, INFANT AND YOUNG CHILD NUTRITION (MIYCN) COUNSELLING PACKAGE

TIME	DAY 1	DAY 2	DAY 3	DAY 4	DAY 5
08:15– 08:30	ANNOUNCEMENTS AND DAILY RECAP				
08:30– 10:30	Session 1: 1½ hr. Introductions, pre-assessment, group norms, expectations and objectives Session 2: ½ hr. Why IYCF matters	Session 7: 2 hr. Recommended IYCF practices <ul style="list-style-type: none"> • complementary feeding for children from 6 up to 24 months • complementary feeding beliefs 	Session 10: 2 hr. How to Counsel: Part II <ul style="list-style-type: none"> • use of IYCF assessment form for mother/child pair 	Session 13: 2 hr Field Visit: <ul style="list-style-type: none"> • IYCF Assessment of mother/child pair • Action-oriented group session IYCF support group 	Session 17: 2 hr. Infant feeding in the context of HIV
10:30– 10:45	NUTRITION BREAK				
10:45– 12:45	Session 2 cont.: ½ hr. Why IYCF matters Session 3: ½ hr. Breastfeeding beliefs Session 4: 1 hr. How to Counsel: Part I <ul style="list-style-type: none"> • listening and learning skills • behaviour change steps 	Session 8: 2 hr. Growth Monitoring and Promotion	Session 11: 2 hr. Field Visit <ul style="list-style-type: none"> • IYCF Assessment of mother/child pair • Feedback from field visit 	Session 13 cont.: 2 hr Field Visit: <ul style="list-style-type: none"> • IYCF Assessment of mother/child pair • Action-oriented group session IYCF support group 	Session 18: 1 hr. Integrating IYCF support into community services and emergency response Session 19: ½ hr IYCF forms: Counselling, group education, mother-to-mother support groups and checklists Session 20: ½ hr. Post-assessment and Evaluation

TIME	DAY 1	DAY 2	DAY 3	DAY 4	DAY 5
12:45– 13:45			LUNCH		
13:45– 15:45	<p>Session 4 cont.: $\frac{1}{2}$ hr. How to Counsel: Part I <ul style="list-style-type: none"> • listening and learning skills • behaviour change steps </p> <p>Session 5: 1 hr. Recommended IYCF practices: Breastfeeding</p> <p>Session 6: $\frac{1}{2}$ hr. How to breastfeed <ul style="list-style-type: none"> • how the breast works • good attachment and positioning </p>	<p>Session 8 cont.: 2 hr. Growth Monitoring and Promotion</p>	<p>Session 11 cont.: 1 hr. Field Visit Feedback from field visit</p> <p>Session 12: 1 hr. How to conduct: Action-oriented group sessions, IYCF support groups and home visits</p>	<p>Session 14: 1 hr. Women's nutrition</p> <p>Session 15: $\frac{1}{2}$ hr Kitchen garden and small animals promotion</p> <p>Session 16: $\frac{1}{2}$ hr. Feeding of the sick child</p>	<p>Session 20 cont.: $\frac{1}{2}$ hr. Post-assessment and Evaluation</p> <p>Closing Ceremony</p>
15:45– 16:00			TEA BREAK		
16:00– 16:30	<p>Session 6 cont.: $\frac{1}{2}$ hr. How to breastfeed: <ul style="list-style-type: none"> • how the breast works • good attachment and positioning </p>	<p>Session 9: $\frac{1}{2}$ hr. Common breastfeeding difficulties <ul style="list-style-type: none"> • symptoms, prevention and what to do </p>	<p>Session 12 cont.: $\frac{1}{2}$ hr. How to conduct: action-oriented group sessions, IYCF support groups and home visits</p>	<p>Session 16 cont.: $\frac{1}{2}$ hr. Feeding of the sick child</p>	
	DAILY EVALUATION (FACES)				

SESSION 1. INTRODUCTIONS, PRE-ASSESSMENT, GROUP NORMS, EXPECTATIONS AND OBJECTIVES

Learning Objectives	Methodologies	Training Aids
1. Begin to name fellow Participants, Facilitators and resource persons.	Matching game	16 matching pair illustrations from CC
2. Discuss Participants' expectations, compare with the objectives of the training and clarify the priorities/focus of the course.	Interactive presentation	
3. Identify strengths and weaknesses of Participant's IYCF knowledge.	Non-written pre-assessment	Pre-assessment questions for Facilitators
4. Present and review set of CC and Brochures.	Buzz groups of 3 Participants	<ul style="list-style-type: none">• Set of CC• Brochures

Materials:

- Flipchart papers and stand (+ markers + masking tape or sticky putty)
- Name tags
- Participants' folders
- Course timetable

Advance Preparation:

- Flipchart: Course objectives (page 2 of Introduction)

Duration: 1½ hour

Learning Objective 1: Begin to name fellow Participants, Facilitators, and resource persons

Methodology: Matching Game

Instructions:

1. Use illustrations from CC (laminated if possible) cut in 2 pieces; each Participant is given a picture portion and is asked find his/her match; pairs of participants introduce each other, giving their partner's preferred name, what community group they belong to, work in MIYCN, one expectations for the training, and something of human interest (favourite food, hobbies and/or colour, etc.)
2. Facilitator writes expectations on flipchart.
3. Facilitator asks Participants to brainstorm "group norms"; Facilitator lists on flipchart and list remains posted throughout the training.

Learning Objective 2: Discuss Participants' expectations, compare with objectives of the training, and clarify the priorities/focus of the course

Methodology: Interactive presentation

Instructions:

1. Facilitator introduces the training objectives (includes the main objective of each session, that has been previously written on a flipchart), and compares them with the expectations of Participants.
2. Facilitator adds inspirational points:
 - You can make a difference in your community!
 - You have a role to play and with the knowledge and skills you will gain in this training you will help mothers, babies and families in your community.
 - We want you to feel empowered and energized because you do perform a vital role in your community – mothers, babies and families will be healthier.
3. Expectations and objectives remain in view during training course.

Learning Objective 3: Identify strengths and weaknesses of Participant's MIYCN knowledge

Methodology: Non-written pre-assessment

Instructions:

1. Explain that 15 questions will be asked, and that Participants will raise one hand (with open palm) if they think the answer is 'Yes', will raise one hand (with closed fist) if they think the answer is 'No', and will raise one hand (pointing 2 fingers) if they 'don't know' or are unsure of the answer.
2. Ask Participants to form a circle and sit so that their backs face the centre.
3. One Facilitator reads the statements from the pre-assessment and another Facilitator records the answers and notes which topics (if any) present confusion.

4. Advise Participants that the topics covered in the pre-assessment will be discussed in greater detail during the training.

OR

Written pre-assessment

1. Pass out copies of the pre-assessment form to the participants and ask them to complete it individually.
2. Ask participants to write their code number (previously assigned by random drawing of numbers) on the pre-assessment. Ask Participants to remember this number for the post assessment. Participants could also use a symbol of their choosing – anything that they will remember in order to match both pre- and post-assessments.
3. Correct all the tests as soon as possible the same day, identifying topics that caused disagreement or confusion and need to be addressed. Participants should be advised that these topics will be discussed in greater detail during the training.

Learning Objective 4: Present and review the complete set of Counselling Cards with Key Messages and Brochures

Methodology: Buzz groups of 3 Participants

Instructions:

1. Distribute a set of CC and Brochures to each Participant and then ask Participants to form groups of 3.
2. Explain that the CC and Brochures are going to be their tools to keep and that they are going to take a few minutes to examine their content.
3. Each group is to find a picture that shows a piece of fruit from a counselling card and take-home brochures.
4. Ask a group to hold-up the CC and Brochures, which shows the item.
5. Ask the other groups if they agree, disagree, or wish to add another the CC and Brochure
6. Repeat the process with the remaining items/characteristics.
7. Find:
 - a CHW counsellor talking with a mother
 - a sign or symbol that indicates that something should happen during ‘the day and at night’
 - a sign or symbol that indicates that the child should have ‘a meal or a snack’
 - a sign or symbol that indicates that a young child should eat 3 times a day and have 2 snacks
 - a sick baby less than 6 months
 - the card with the message that ‘hands should be washed with soap and water’
 - the card with the message that a young infant does not need water
8. Repeat the explanation that the CC and Brochures will be their tools to use.

‘Homework’ assignment:

- Read through the key messages on the back of CC 1-8, and CC 17

Pre-assessment: What do we know now?

#		Yes	No	Don't know
1.	The purpose of an IYCF support group is to share personal experiences on IYCF practices.			
2.	Poor child feeding during the first 2 years of life harms growth and brain development.			
3.	An infant aged 6 up to 9 months needs to eat at least 3 times a day in addition to breastfeeding.			
4.	A pregnant woman needs to eat 1 more meal per day than usual.			
5.	At 4 months, infants need water and other drinks in addition to breast milk.			
6.	Just telling a mother how to feed her child is an effective way of changing her infant feeding practices.			
7.	A woman who is malnourished can still produce enough good quality breast milk for her baby.			
8.	The more milk a baby removes from the breast, the more breast milk the mother makes.			
9.	The mother of a sick child should wait until her child is healthy before giving him/her solid foods.			
10.	At about six months, the first food a baby takes should have the consistency of breast milk so that the young baby can swallow it easily.			
11.	During the first six months, a baby living in a hot climate needs water in addition to breast milk.			
12.	A young child (aged 6 up to 24 months) should not be given animal foods such as eggs and meat.			
13.	A newborn baby should always be given colostrum.			
14.	An HIV-infected mother should never breastfeed.			
15.	Men should play an important role in how infants and young children are fed.			
16	Regular growth monitoring and promotion sessions with children under 2 years of age can help detect problems with infant feeding			

SESSION 2. WHY MIYCN MATTERS

Learning Objectives	Methodologies	Training Aids
1. Define the terms IYCF, exclusive breastfeeding and complementary feeding.	<ul style="list-style-type: none"> • Brainstorming • Presentation 	Illustrations: healthy, well-nourished child, mother giving complementary feeding, breastfeeding mother surrounded by family, couple taking their child to health services, and water/sanitation
2. Recognize all the conditions needed for a healthy well nourished child.	Interactive presentation	
3. Share in-country data on IYCF.	Interactive presentation (bean distribution)	Packages of 100 beans each for 5 groups

Materials:

- Flipchart papers and stand (+ markers + masking tape or sticky putty)
- Illustrations: healthy, well-nourished child, mother giving complementary feeding, breastfeeding mother surrounded by family, couple taking their child to health services, and water/sanitation
- 5 packages of 100 beans

Advance preparation:

- Flipchart: Following data (from the country, region or district):
 - Initiation of Breastfeeding (within 1 hour)
 - Exclusive breastfeeding (first 6 months)
 - Complementary feeding (early and late initiation, frequency, amount, texture, variety)
 - Malnutrition (underweight, stunting, severe acute malnutrition (AM), moderate acute malnutrition (MAM), overweight/obesity)
 - Low birth weight

Duration: 1 hour

Learning Objective 1: Define IYCF, exclusive breastfeeding and complementary feeding

Methodology: Brainstorming; presentation

Instructions:

1. On a flipchart vertically write Infant, Young Child, Feeding
2. Ask Participants:
 - What each word stands for
 - What do we mean by ‘infant’ and ‘young child’
 - Facilitator writes responses on flipchart
 - To define exclusive breastfeeding
 - To define complementary feeding
 - To define complementary foods
3. Facilitator recognizes all of the inputs, corrects errors and/or fills-in gaps
4. Facilitators create their own simple data presentation on national/regional breastfeeding and complementary feeding practices (see examples below)
5. Discussion

Key Information

IYCF = infant and young child feeding

Infant = from birth up to 1 year of age

Young child (when used with IYCF) = from birth up to 2 years of age

Definition	Requires that the infant receive	Allows the infant to receive	Does not allow the infant to receive
Exclusive breastfeeding (EBF)	Breast milk (including milk expressed or from a wet nurse)	Drops, syrups, (vitamins, minerals, medicines)	Anything else

Part 1. Definitions.

Conclusions of a consensus meeting held 6–8 November 2007 in Washington, DC, USA

Complementary feeding: the process starting when breast milk alone or infant formula alone is no longer sufficient to meet the nutritional requirements of infants, and therefore other foods and liquids are needed, along with breast milk or a breast milk substitute. The target range for complementary feeding is generally taken to be 6 up to 24 months.¹

Complementary foods: any food, whether manufactured or locally prepared, suitable as a complement to breast milk or to a breast milk substitute when either becomes insufficient to satisfy the nutritional requirements of the infant.²

¹ WHO, UNICEF. Strengthening action to improve feeding of infants and young children 6-23 months of age in nutrition and child health programmes Geneva, 6-9 October 2008. REPORT OF PROCEEDINGS

² Ibid

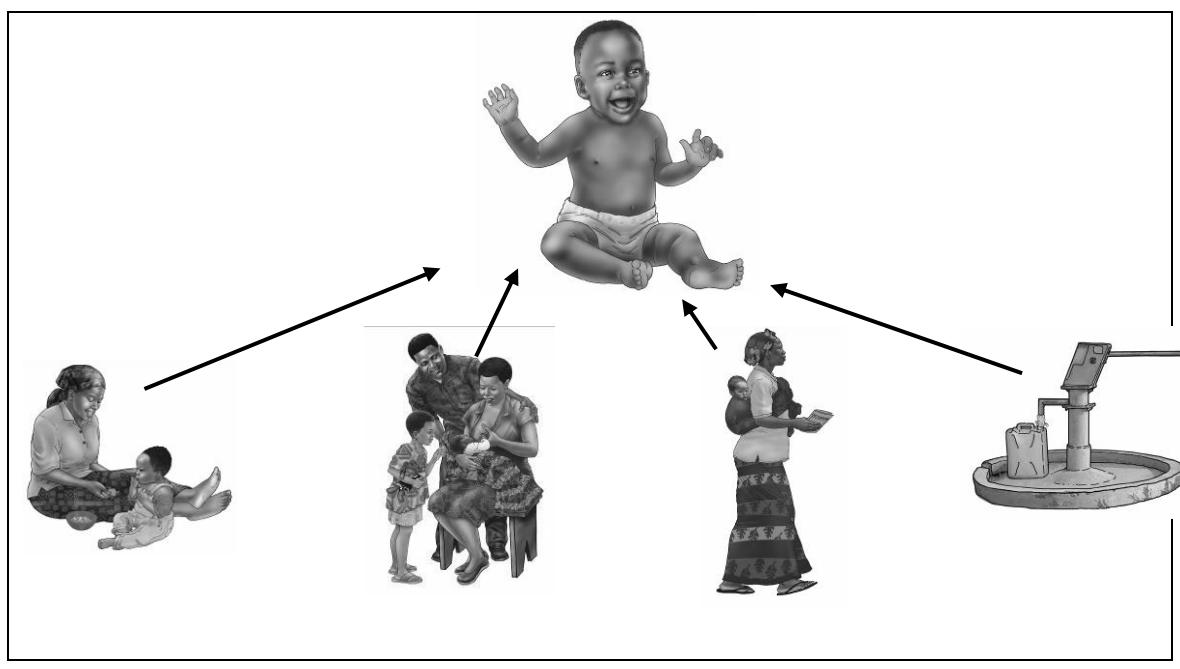
Learning Objective 2: Recognize key factors that contribute to a healthy, well-nourished child

Methodology: Interactive presentation

Instructions:

1. Tape or stick an illustration of a healthy, well-nourished child. Ask Participants to find a picture of a well-nourished child in their set of counselling cards)
2. Ask Participants to name all the things necessary to have a healthy child. As Participants mention food, water, hygiene and sanitation, care practices and health services, show that illustration and tape or stick it to flipchart
3. Draw arrows from the illustrations to the healthy, well-nourished child (see pictures below)
4. Discuss and summarize

Key Information



Food

**Care
practices**

**Health
services**

**Water, hygiene
and sanitation**

Learning Objective 3: Share in-country data on IYCF
Methodology: Interactive presentation (bean distribution)

Instructions:

1. Using beans, demonstrate the first in-country data on IYCF listed on the prepared flip-chart: initiation of breastfeeding within 1 hour
2. Ask Participants to form 5 groups. Assign each group to represent the other in-country data on IYCF using beans:
 - Exclusive breastfeeding
 - Complementary feeding
 - Breastfeeding and complementary foods
 - Undernourished children
3. From the data for each feeding practice discuss the risk for the child.

Rwanda Demographic Health Survey data – preliminary results 2010

1. Exclusive Breastfeeding

Percentages of 0-5 month-olds infants who are exclusively breastfeeding:

- < 2 months of age: 91%
- 2-3 months of age: 90%
- 4-5 months of age: 76%
- Total < 6 months of age: 85%

2. Complementary Feeding

Percentages of children under two years who are living with their mother, breastfed and are receiving complementary feeding:

- 0-1 months of age: 1%
- 2-3 months of age: 1%
- 4-5 months of age : 8%
- 6-8 months of age: 62%
- 9-11 months of age: 91%
- 12-17 months of age : 93%
- 18-23 months of age: 85%

3. Breastfeeding and Complementary Foods

	Age Group	
	0-5 Mos (%)	6-9 Mos (%)
BFD & Complementary Foods	4	70
BFD & Consuming other milk	3	6
BFD & Consuming non-milk liquids/juice	6	6
BFD & Consuming plain water only	2	2
Exclusively breastfed	85	16
Not breastfeeding	1	2

Session 2: Why MIYCN matters

4. Undernourished children

	Stunted (%)	Wasted (%)	Underweight (%)
<i>More than 2 SD below the median of WHO Child Growth Standards adopted in 2006</i>	44	3	11
<i>More than 2 SD below the median of OLD WHO Child Growth Standards before 2006</i>	37	4	15

SESSION 3. BREASTFEEDING BELIEFS

Learning Objectives	Methodologies	Training Aids
1. Distinguish between beliefs that are beneficial to breastfeeding and beliefs that should be discouraged, and discuss what can be done to address these beliefs	Brainstorming	None
2. Discuss food taboos during pregnancy and lactation.	Brainstorming	None

Materials:

- Flipchart papers and stand (+ markers + masking tape or sticky putty)

Duration: 30 minutes

Learning Objectives 1: Distinguish between beliefs that are beneficial to breastfeeding and beliefs that should be discouraged, and discuss what can be done to address these beliefs?

Methodology: Brainstorming

Instructions:

1. On a flipchart Facilitator makes 3 columns: breastfeeding beliefs that have a positive effect on breastfeeding; breastfeeding beliefs that have a negative effect on breastfeeding; and breastfeeding beliefs that neither help nor hinder breastfeeding (no problem)
2. In large group participants brainstorm the breastfeeding beliefs that influence practice in their communities
3. In large group participants decide on which column to place the breastfeeding belief
4. Participants make suggestions as to how those beliefs that have a negative effect on breastfeeding might be changed (while respecting others' belief), and who in the household and community is best able to influence changes (e.g. grandmothers, child's father, religious groups, support groups)
5. Participants suggest messages to address some of the major beliefs in their communities that negatively impact breastfeeding
6. Discuss and summarize

Key Information

Some breastfeeding beliefs and myths may have a negative effect on good breastfeeding practices (differ according to area/region). The following are true statements. Are there corresponding beliefs/myths from your area?

- Colostrum does not need to be discarded (it does not cause diarrhea nor is it 'dirty')
- A mother who is angry or frightened can breastfeed.
- A mother with a common illness should breastfeed.
- A mother who is pregnant can breastfeed.
- A breastfeeding mother can have safe sex.
- Breast milk looks thin and bluish especially at the beginning of a feed.
- A mother can still breastfeed even if she has been separated from her baby for some time.
- A breastfeeding baby under 6 months does not need additional water in a hot climate.
- A mother who breastfeeds can take most medications (check with health care provider).
- A sick infant should breastfeed more frequently.
- A mother should initiate breastfeeding within the first hour of birth (before her milk comes in or lets down).
- A malnourished mother can produce enough breast milk to feed her infant.

Note: another barrier to recommended IYCF practices is the impact of breast milk substitutes that are marketed in your communities

Learning Objective 2: Discuss food taboos during pregnancy and lactation

Methodology: Brainstorming

Instructions:

1. On a flipchart, Facilitator makes 4 columns: food taboos during pregnancy: positive and negative; food taboos during lactation: positive and negative
2. In large group, Participants brainstorm food taboos during pregnancy and during lactation that influence practices in their communities
3. In large group, Participants decide on which column to place the taboo: positive or negative
4. Participants are encouraged to support the food taboos that are positive
5. Participants make suggestions as to how those food taboos that have a negative effect might be changed (while respecting other's beliefs) and who in the household and community is best able to influence such changes (e.g. grandmothers, child's father, religious groups, support groups)
6. Participants suggest messages to address some of the major beliefs in their communities that negatively impact mothers' nutrition
7. Discuss and summarize

Key Information

*Examples of some food taboos (differ according to area/region). The following statements are true.
Are there corresponding taboos in your area?*

- Fresh fruits, vegetables and legumes can be given to the mother after delivery.
- No one special food or diet is required to provide adequate quantity or quality of breast milk.
- Breast milk production is not affected by maternal diet.
- No foods are forbidden. However, alcohol consumption is forbidden during pregnancy and lactation.
- Breastfeeding mothers have higher needs for food.
- Mothers should be encouraged to eat more food to maintain their own health.
- Mothers should be encouraged to drink plenty of potable water

Note: Encourage giving foods that mothers can eat and drink during pregnancy and breastfeeding.

SESSION 4. HOW TO COUNSEL: PART I

Learning Objectives	Methodologies	Training Aids
1. Identify <i>Listening and Learning</i> skills.	<ul style="list-style-type: none"> • Group work • Demonstration 	<ul style="list-style-type: none"> • Participant Material 11.1: <i>IYCF Assessment of Mother/Child Pair</i> • Participant Materials 4.1: <i>Counselling Skills</i>
2. Explain why changing behaviour is difficult.	<ul style="list-style-type: none"> • Interactive Presentation • Group work 	
3. Reflect on role of men in maternal and child nutrition.	Buzz groups of 3	<ul style="list-style-type: none"> • All CC where men appear: <i>Role of men in maternal and child nutrition</i>

Materials:

- Flipchart papers and stand (+ markers + masking tape or sticky putty)
- Behaviour change communication case studies

Advance Preparation:

- On flipchart draw behaviour change steps (without words)
- Facilitators practise demonstration of *IYCF Assessment of Mother/Child Pair (Listening and Learning skills)*
- Facilitators practise demonstrations of *Listening and Learning skills*
- Flipchart: *Listening and Learning skills*
- Flipchart: *Role of fathers/men in the nutrition of their wives/partners and infants/children*

Duration: 1½ hours

Learning Objective 1: Identify listening and learning skills

Methodology: Group work; demonstration

Instructions:

Listening:

1. Pair participants. Ask them to tell a story to each other at the same time for 2 min.
2. Then come back to large group:
 - How did you feel talking at the same time with another person?
 - Did you catch anything of the story?
3. In the same pairs repeat the exercise, but this time listen to one another with lots of concentration (do not take notes, but listen carefully).
4. Then, tell each other's stories (each of pair speaks for 1 minute).
5. In large group Facilitator asks:
 - How much of your story did your partner get right?
 - How did it make you feel inside to tell a story and see someone listening to you?
6. What things did you do to make sure that your partner was listening to you?
7. Probe until the following listening and learning skills have been mentioned and list on flipchart:
 - a) Non-verbal communication
 - Keep head at same level
 - Pay attention (eye contact)
 - Remove barriers (tables and notes)
 - Take time
 - Appropriate touch
 - b) Use responses and gestures that show interest
8. Explain that listening and learning skills are the first set of skills to be learned and practised.
9. Ask Participants to observe the cover of the set of counselling cards and mention what listening and learning skills they observe in the illustration.
10. Discuss and summarize the different listening and learning skills

Asking questions:

1. Everyone gets to ask me (Facilitator) one question. Facilitator will answer truthfully. Facilitator stops Participants at just 1 question.
2. What did you get from this exercise? (Some types of questions bring out more information than others)
3. What things can you do to bring out more information?
 - a) Reflect back what the Facilitator (mother/father/caregiver) says
 - b) Listen to the mother/father/caregiver's concerns
 - c) Avoid using judging words

Demonstration:

Note: Two Facilitators should practise this demonstration in advance (one Facilitator as "mother", and one as "counsellor") using these listening and learning skills (see Participant Materials: 4.1; and *3-Step Counselling: session 11*)

1. Ask Participants to observe how the counsellor interacts with the mother in the following role-play:
 - Model listening and learning skills between a mother (Mukamana) with 7-month son (Murenzi) and counsellor following Participant Material 10.1: *IYCF Assessment of*

Session 4. How to Counsel: Part I

Mother/Child Pair

- Facilitator/Mother (Mukamana): breastfeeds whenever Murenzi cries; feels she does not produce enough milk; gives Murenzi some watery gruel 2 times a day (gruel is made from common starchy staple e.g. corn meal); does not give any other milks or drinks to Murenzi
- After the demonstration, ask Participants: “How did the counsellor interact with the mother?”
- Probe to see what listening and learning skills were used

Learning Objective 2: Explain why changing behaviour is difficult

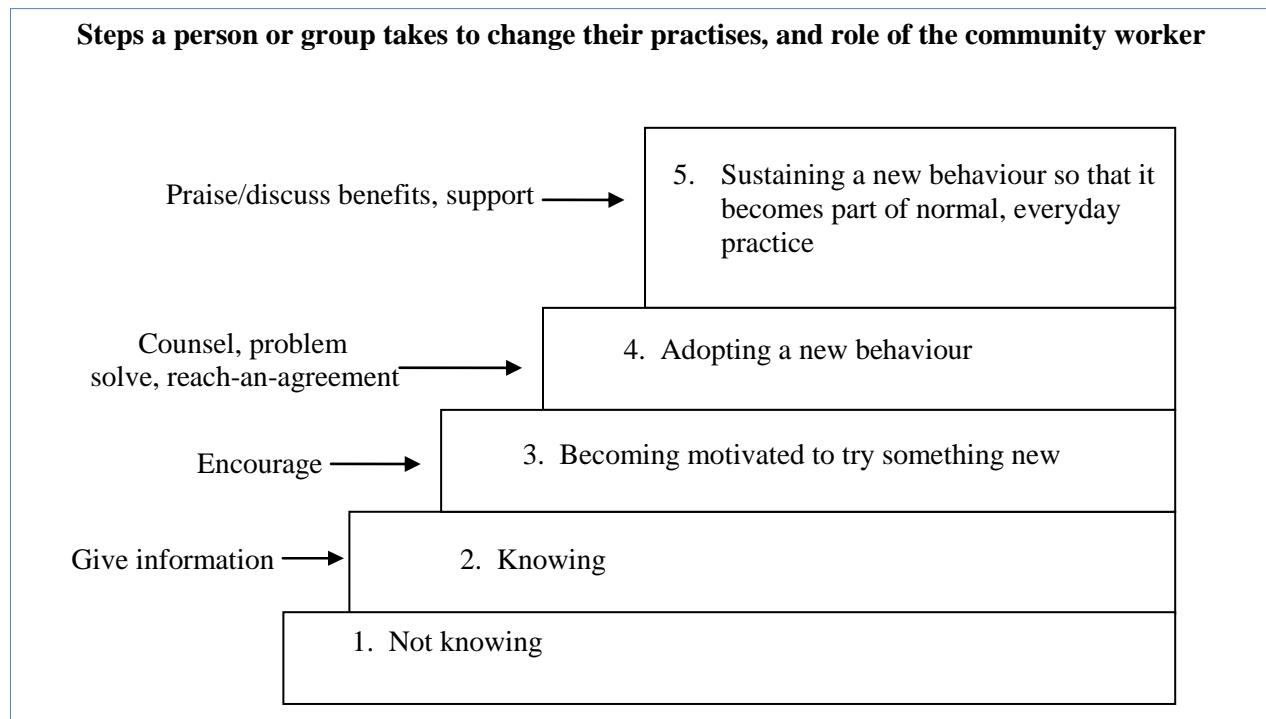
Methodology: Interactive presentation and group work

Instructions:

1. On a flip-chart draw behaviour change steps (outlined below) and brainstorm with participants how one generally moves through the different steps to behaviour change (use exclusive breastfeeding as an example).
2. Ask Participants: What helps a person to move through the different steps?
3. List Participants' responses on flipchart: information, encouragement, support and praise – the person who provides these things is a change agent; CHWs are change agent
4. Ask participants to close their eyes and think about a behaviour they are trying to change. Ask them to identify at what stage they are and why? Ask what they think they will need to move to the next step.
5. Discussion (ask if any Participants want to share their personal experience)
6. Divide Participants into 5 working groups – give each group 3 case studies. For each case study, group answers the question “at what stage of the behaviour change process is the mother”?
7. Discuss in large group.

Session 4. How to Counsel: Part I

Key Information



Note: The CHW utilizes listening and learning and building confidence and giving support skills throughout the entire process or steps of behaviour change. The *3-Step IYCF counselling process: Assess, Analyze and Act* involves dialogue between the counsellor and mother/father/caregiver to define the issues, problem-solve and reach-an-agreement.

Behaviour Change Case Studies

1. A pregnant woman has heard new breastfeeding information, and her husband and mother-in-law also are talking about it. She is thinking about trying exclusive breastfeeding because she thinks it will be best for her child.
2. A mother has brought her 8-month-old child to the baby weighing session. The child is being fed watery porridge that the mother thinks is appropriate for the child's age. The child has lost weight. The CHW encourages her to give her child thickened porridge instead of watery gruel because the child is not growing.
3. The past month a CHW talked with a mother about gradually starting to feed her 7-month-old baby three times a day instead of just once a day. The mother started to give a meal and a snack and then added a third feed. Now the baby wants to eat three times a day, so the mother feeds him regularly.

Behaviour Change Case Studies (Answer Key)

1. Becoming motivated to try something new
2. Becoming aware (has now heard about it)
3. Adopting a new behaviour

Learning Objective 3: Reflect on the role of men in maternal and child nutrition

Methodology: Buzz groups of 3

Instructions:

1. Ask buzz groups to examine the cover of the set of CC and look for men who appear on the cards. Ask them to describe the role(s) that fathers/men play in the nutrition of their wives/partners and babies/children; what could they do?
2. In large group, groups share their observations
3. Discuss and fill-in the gaps

Key Information

Fathers/men can actively participate in improving the nutrition of their wives/partners and babies/children in the following ways:

- Accompany wife/partner to antenatal clinics (ANC), reminding her to take her iron/folate tablets
- Provide extra food for their wives/partners during pregnancy and lactation
- Help with non-infant household chores to reduce wife/partner's workload
- Make sure wife/partner has a trained birth attendant
- Prepare for safe transportation (if needed) to facility for birth
- Encourage wife/partner to put the baby to the breast immediately after the birth
- Encourage wife/partner to give the first thick yellowish milk to the baby
- Talking with his mother (mother-in-law of wife) about feeding plan, beliefs and customs
- Make sure the baby exclusively breastfeeds for the first 6 months
- Provide a variety of food for child over six months. Feeding the child is an excellent way for fathers to interact with their child.
- Help with the active and responsive feeding of child older than six months, several times a day (more often and in bigger portions as the child gets bigger)
- Accompany wife/partner to the health facility when infant/child is sick
- Accompany wife/partner to the health facility for infant/child's growth monitoring and promotion (GMP) and immunizations
- Provide bed nets for his family and make sure the pregnant wife/partner and small children get to sleep under the net every night
- Encourage education of his girl children and be a role model of good male behaviour for his boy children

Participant Material 4.1: Counselling Skills

Listening and Learning skills³

1. Use helpful non-verbal communication
 - Keep your head level with mother/father/caregiver
 - Pay attention (eye contact)
 - Remove barriers (tables and notes)
 - Take time
 - Appropriate touch
2. Ask questions that allows mother/father/caregiver to give detailed information
3. Use responses and gestures that show interest
4. Listen to mother's/father's/caregiver's concerns
5. Reflect back what the mother/father/caregiver says
6. Avoid using judging words



³ WHO/UNICEF. Infant and Young Child Feeding Counselling: An Integrated Course. 2006

SESSION 5. RECOMMENDED IYCF PRACTICES: BREASTFEEDING

Learning Objectives	Methodologies	Training Aids
1. Describe the importance of breastfeeding for the infant, the mother, the family, and the community/nation.	Group work and rotation of flipcharts	Participant Material 5.1: <i>Importance of breastfeeding for infant/young child, mother, family, community/nation</i>
2. Identify the recommended breastfeeding practices.	Group work	<ul style="list-style-type: none"> • Participant Material 5.2: <i>Recommended breastfeeding practices and possible points of discussion for counselling</i> • Participant Materials 5.3: <i>Recommended schedule for visits from birth up to 6 months</i> • CC for recommended breastfeeding practices: 1 to 5; 20 • Brochures: <i>How to Breastfeed Your Baby and Nutrition During Pregnancy and Breastfeeding</i>
3. Reflect on when and where counselling on recommended breastfeeding practices occur.	Brainstorming	

Materials:

- Flipchart papers and stand (+ markers + masking tape or sticky putty)
- Large cards ($\frac{1}{2}$ A4 size) or pieces of paper of the same size

Duration: 1 hour

Learning Objective 1: Describe the importance of breastfeeding for the infant, the mother, the family, and the community/nation

Methodology: Group work and rotation of flipcharts

Instructions:

1. Divide Participants into 4 groups.
2. Four flipcharts are set-up throughout the room with the following titles: *Importance of breastfeeding for the infant, Importance of breastfeeding for the mother, Importance of breastfeeding for the family, and Importance of breastfeeding for the community/nation*
3. Each group has 3 minutes at each flipchart to write as many points as they can think of (without repeating those already listed), then the groups rotate to the next flipchart and repeat the exercise
4. Discuss and summarize in large group (The risks of not breastfeeding for infant and mother can also be discussed.)
5. Distribute from Participant Material 5.1: *Importance of breastfeeding for infant/young child, mother, family, community/nation* (refer to specific page in Participant Materials) and discuss

Key Information

Risks of not breastfeeding

For the infant:

- Greater risk of death (a non-breastfed baby is 14 times more likely to die than an exclusively breastfed baby in the first 6 months)
- Formula has no antibodies to protect against illness; the mother's body makes breast milk with antibodies that protect from the specific illnesses in the mother/child environment
- Cannot receive their "first immunization" from the colostrum
- Struggle to digest formula: it is not the ideal food for babies
- Frequent diarrhea, ill more often and more seriously (mixed-fed infants less than 6 months who receive contaminated water, formula and foods are at higher risk.)
- Frequent respiratory infections
- Greater risk of undernutrition, especially for younger infants
- More likely to get malnourished: family may not be able to afford enough formula
- Under-development: retarded growth, under-weight, stunting, wasting due to higher infectious diseases such as diarrhea and pneumonia
- Poorer bonding between mother and infant less secure
- Lower scores on intelligence tests and lower ability to learn at school
- More likely to be overweight
- Greater risk of heart disease, diabetes, cancer, asthma, dental decay etc. later in life

Note: the younger the infant is, the greater these risks.

For the mother:

- Mother may become pregnant sooner
- Increased risk of anaemia if breastfeeding is not initiated early (more bleeding after childbirth)
- Interferes with bonding
- Increased risk of post-partum depression
- Ovarian cancer and breast cancer occurrence are lower in mothers who breastfeed

Learning Objective 2: Identify the recommended breastfeeding practices

Methodology: Group work

Instructions:

A. Identify recommended breastfeeding practices through discussion

1. Form groups of 4 participants each
2. Give each group 10 cards or pieces of paper
3. Facilitator gives an example of a recommended breastfeeding practice such as initiation of breastfeeding within the first hour of birth
4. Each group writes a recommended breastfeeding practice on each card (one per card), discusses and groups the cards
5. Each group tapes or sticks their cards on recommended breastfeeding practices on the wall
6. Select one group to tape or stick their cards on a board/flipchart in front of the whole group in a vertical column and to read their practices one by one.
7. Beginning with the first practice presented, ask other groups with a similar practice to tape or stick their practice on top
8. Ask other groups to tape or stick any additional practices to 1st group's practices and discuss
9. Remove any incorrect information
10. Leave posted in a vertical column (in the centre of the board/flipchart) the recommended breastfeeding practices
11. Facilitator summarizes and fills-in the gaps in large group to include the recommended breastfeeding practices

B. Identify recommended breastfeeding practices through counselling cards

1. In the same groups ask Participants to observe the following CC:
 - CC 1: *Nutrition for pregnant and breastfeeding woman*
 - CC 2: *Immediate breastfeeding after birth*
 - CC 3: *During the first 6 months, give ONLY breast milk*
 - CC 4: *Exclusive breastfeeding during the first six months*
 - CC 5: *Breastfeed on demand, both day and night*
 - CC 20: *Feeding your sick baby less than 6 months of age*
 - Brochure: *How to Breastfeed Your Baby*
 - Brochure: *Nutrition During Pregnancy and Breastfeeding*
2. Ask groups to match the counselling cards and brochures with the recommended breastfeeding practices posted
3. Ask groups to describe the main counselling points for discussion/messages that the counselling cards and brochure represent
4. Ask each group to share their observations and counselling points for discussion/messages for one of the 4 cards and brochures
5. Other groups will add additional points

C. Participant Materials

1. Distribute form Participant Material 5.2: *Recommended breastfeeding practices and possible points of discussion for counselling* (or refer to specific page in Participant Materials); review together and compare with the counselling points for discussion/messages described by the working groups.

Session 5. Recommended IYCF Practices: Breastfeeding

- Consider what you know from research and previous experience in your area. What additional discussion points might be added?
2. Orient Participants to the key messages on the back of each counselling card
 3. Point out to Participants that these are the discussion points and key messages that they will use when counselling a mother and/or family on recommended breastfeeding practices
 4. Discuss and summarize

Key Information

- See Participant Materials 5.2: *Recommended breastfeeding practices and possible points of discussion for counselling*

Learning Objective 3: Reflect on when counselling on recommended breastfeeding practices can occur

Methodology: Brainstorming

Instructions:

1. Ask Participants to think about when community workers can counsel mothers on recommended breastfeeding practices
2. List on flipchart and compare with key information below
3. Include recommended schedule for visits between mother and the CHW from pregnancy up to 12 months
4. Distribute Participant Materials 5.3: *Recommended Schedule for Visits through Pregnancy up to 6 Months of Infant's Age*
5. Review counselling points for discussion during the scheduled visits
6. Discuss and summarize in large group

Key Information

Counselling Contact Points (within the health facility or community outreach):

- Antenatal Clinic and at every contact with a pregnant woman
- At delivery or as soon as possible thereafter
- Again within the first week of birth (days 2 or 3 and days 6 or 7)
- At two other postnatal points (for example, at weeks 4 and 6), or family planning sessions and at other times if mother has a difficulty
- Monthly during the first six months of breastfeeding; at 9, 12 and 18 months
- Growth Monitoring and Promotion (GMP)
- At immunization sessions
- At every contact with mothers or caregivers of sick children
- At contact points for vulnerable children, e.g. HIV-exposed or infected children
- Community follow-up
 - Action-oriented group session
 - IYCF support groups

Session 5. Recommended IYCF Practices: Breastfeeding

- At in-patient facilities for management of children with severe acute malnutrition, such as stabilisation centres (SC), nutrition rehabilitation units, therapeutic feeding centres, malnutrition wards
- At CMAM sites or screening sessions
- At supplementary feeding programme (SFP) sites
- Link mother/father/caregiver to counsellor

Participant Material 5.1: Importance of Breastfeeding for Infant/Young Child, Mother, Family, Community/Nation

Importance of breastfeeding for the infant/young child

Breast milk:

- Saves infants' lives.
- Meets the needs of human infants
- Is a whole food for the infant, and covers all babies' needs for the first 6 months.
- Promotes adequate growth and development, thus helping to prevent stunting.
- Is always clean.
- Contains antibodies that protect against diseases, especially against diarrhoea and respiratory infections.
- Is always ready and at the right temperature.
- Is easy to digest- nutrients are well absorbed.
- Contains enough water for the baby's needs.
- Helps jaw and teeth development; suckling develops facial and jaw structure.
- Leads to bonding, better psychomotor, affective and social development of the infant.
- Reduced risk of obesity and diabetes (long-term effects)

Note: The infant greatly benefits from the colostrum, which protects him/her from diseases (Colostrum is the yellow or golden [first] milk the baby receives in his or her first few days of life. It has high concentrations of nutrients and protects against illness. Colostrum is small in quantity. The colostrum acts as a laxative, cleaning the infant's stomach).

Importance of breastfeeding for the mother

- Breastfeeding is more than 98% effective as a contraceptive method during the first 6 months if the mother is exclusively breastfeeding, day and night and if her menses/period has not returned.
- Putting the baby to the breast immediately after birth facilitates the expulsion of placenta because the baby's suckling stimulates uterine contractions.
- Breastfeeding reduces the risk of bleeding after delivery.
- When the baby is immediately breastfed after birth, breast milk production is stimulated.
- Immediate and frequent suckling prevents engorgement.
- Breastfeeding reduces the mother's workload (no time is involved in going to buy the formula, boiling water, gathering fuel, or preparing formula).
- Breast milk is available at anytime and anywhere, is always clean, nutritious and at the right temperature.
- Breastfeeding is economical: formula costs a lot of money, and the non-breastfed baby or mixed-fed baby is sick much more often, which brings costs for health care.
- Breastfeeding stimulates a close bond between mother and baby.
- Breastfeeding reduces risks of breast and ovarian cancer.



Importance of breastfeeding for the family

- Mothers and their children are healthier.
- No medical expenses due to sickness that other milk could cause.
- There are no expenses involved in buying other milk, firewood or other fuel to boil water, milk or utensils.
- Births are spaced if the mother is exclusively breastfeeding in the first six months, day and night, and if her menses/period has not returned.
- Time is saved because there is less time involved in purchasing and preparing other milks, collecting water and firewood, and there is less illness-required trips for medical treatment.

Note: Families need to help mother by helping with household chores.

Importance of breastfeeding for the community/nation

- Healthy babies make a healthy nation.
- Savings are made in health care delivery because the number of childhood illnesses are reduced, leading to decreased expenses.
- Improves child survival because breastfeeding reduces child morbidity and mortality.
- Protects the environment (trees are not used for firewood to boil water, milk and utensils, and there is no waste from tins and cartons of breast milk substitutes). Breast milk is a natural renewable resource.
- Not importing milks and utensils necessary for the preparation of these milks saves money that could be used for something else.

Risks of artificial feeding (artificially-fed babies)

- Greater risk of death (a non-breastfed baby is 14 times more likely to die than an exclusively breastfed baby in the first 6 months)
- Formula has no antibodies to protect against illness; the mother's body makes breast milk with antibodies that protect from the specific illnesses in the mother/child environment
- Inability to receive their “first immunization” from the colostrum
- Struggle to digest formula: it is not ideal for all babies
- Frequent diarrhea, ill more often and more seriously (mixed-fed infants less than 6 months who receive contaminated water, formula and foods are at higher risk.)
- Frequent respiratory infections
- Greater risk of under-nutrition, especially for younger infants
- More likely to get malnourished: family may not be able to afford enough formula
- Under-development: retarded growth, under-weight, stunting, wasting due to higher infectious diseases such as diarrhoea and pneumonia
- Less bonding between mother and infant, and less secure infant
- Lower scores on intelligence tests and more difficulty learning at school
- More likely to be overweight
- Greater risk of heart disease, diabetes, cancer, asthma, and dental decay later in life

Note: the younger the infant is, the greater these risks.

Risks of mixed feeding

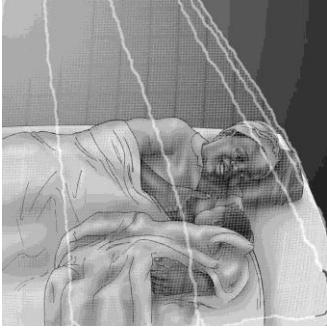
Mixed-fed babies in the first six months:

- Have a higher risk of death
- Are ill more often and more seriously, especially with diarrhea: due to contaminated milk and water
- Are more likely to be malnourished: gruel has little nutritional value, formula is often diluted, and both displace the more nutritious breast milk
- Get less breast milk because they suckle less
- Suffer damage to their fragile guts from even a small amount of anything other than breast milk
- Are much more likely to be infected with HIV than exclusively breastfed babies, because their guts are weakened by the other liquids and foods and thus allow the HIV virus to enter more easily

Participant Material 5.2: Recommended Breastfeeding Practices and Possible Counselling Discussion Points

Recommended breastfeeding practice	Possible counselling discussion points Note: choose 2 to 3 most relevant to mother's situation and/or ADD other discussion points from knowledge of area
Place infant skin-to-skin with mother immediately after birth	<ul style="list-style-type: none"> • Skin-to-skin with mother keeps newborn warm and helps stimulate bonding or closeness, and brain development. • Skin-to-skin helps the "let down" of the colostrum/milk • There may be no visible milk in the first hours. For some women it even takes a day or two to experience the "let down". It is important to continue putting the baby to the breast to stimulate milk production and let down. • Colostrum is the first thick, yellowish milk that protects baby from illness. • CC 2: <i>Immediate breastfeeding after birth</i>
Initiate breastfeeding within the first hour of birth  Note: Breastfeeding in the first few days	<ul style="list-style-type: none"> • Make sure baby is well attached • This first milk 'local word' is called colostrum. It is yellow and full of antibodies which help protect your baby. • Colostrum provides the first immunization against many diseases. • CC 2: <i>Immediate breastfeeding after birth</i> • Brochure: <i>How to Breastfeed Your Baby</i> <ul style="list-style-type: none"> • Breastfeeding frequently from birth helps the baby learn to attach and helps to prevent engorgement and other complications. • In the first few days, the baby may feed only 2 to 3 times per day. If the baby is still sleepy on day 2, the mother may express some colostrum and give it from a cup. • Give nothing else -- no water, no infant formula, no other foods or liquids -- to the newborn.
Exclusively breastfeed (no other food or drink) from 0 up to 6 months 	<ul style="list-style-type: none"> • Breast milk is all the infant needs for the first 6 months. • Do not give anything else to the infant before 6 months, not even water. • Breast milk contains all the water a baby needs, even in a hot climate. • Giving water will fill the infant and cause less suckling; less breast milk will be produced. • Water and other liquids and foods for an infant less than 6 months can cause diarrhoea. • CC 3: <i>During the first 6 months, give ONLY breast milk</i> CC 4: <i>Exclusive breastfeeding during the first six months</i> • Brochure: <i>How to Breastfeed Your Baby</i>
Breastfeed frequently, day and night	<ul style="list-style-type: none"> • After the first few days, most newborns want to breastfeed frequently, 8 to 12 times per day. Frequent breastfeeding helps produce lots of

Session 5. Recommended IYCF Practices: Breastfeeding

Recommended breastfeeding practice	Possible counselling discussion points Note: choose 2 to 3 most relevant to mother's situation and/or ADD other discussion points from knowledge of area
	breast milk. <ul style="list-style-type: none"> Once breastfeeding is well-established, breastfeed 8 or more times day and night to continue to produce plenty of breast milk. If the baby is well attached, contented and gaining weight, the number of feeds is not important. More suckling (with good attachment) makes more breast milk. CC 5: <i>Breastfeed on demand, both day and night</i> Brochure: <i>How to Breastfeed Your Baby</i>
Breastfeed on demand every time the baby asks to breastfeed	<ul style="list-style-type: none"> Crying is a <u>late</u> sign of hunger. Early signs that baby wants to breastfeed: <ul style="list-style-type: none"> Restlessness Opening mouth and turning head from side to side Putting tongue in and out Sucking on fingers or fists CC 5: <i>Breastfeed on demand, both day and night</i>
Let infant finish one breast and come off by him/ herself before switching to the other breast	<ul style="list-style-type: none"> Switching back and forth from one breast to the other prevents the infant from getting the nutritious 'hind milk' The 'fore milk' has more water content and quenches infant's thirst; the 'hind milk' has more fat content and satisfies the infant's hunger CC 5: <i>Breastfeed on demand, both day and night</i>
Good positioning and attachment	<ul style="list-style-type: none"> 4 signs of good positioning: baby's body should be <u>straight</u>, and <u>facing</u> the breast, baby should be <u>close</u> to mother, and mother should <u>support</u> the baby's whole body, not just the neck and shoulders with her hand and forearm. 4 signs of good attachment: mouth wide open, chin touching breast, more areola showing above than below the nipple, and lower lip turned out. CC 6: <i>There are many breastfeeding positions</i> CC 7: <i>Good attachment is important</i>
Continue breastfeeding for 2 years of age or longer	<ul style="list-style-type: none"> Breast milk contributes a significant proportion of energy and nutrients during the complementary feeding period and helps protect babies from illness. CC 13 to 17: complementary feeding CC
Continue breastfeeding when infant or mother is ill	<ul style="list-style-type: none"> Breastfeed more frequently during child illness. The nutrients and immunological protection of breast milk are important to the infant when mother or infant is ill. Breastfeeding provides comfort to a sick infant. CC 18: <i>When your baby is sick, seek advice</i>

Session 5. Recommended IYCF Practices: Breastfeeding

Recommended breastfeeding practice	Possible counselling discussion points Note: choose 2 to 3 most relevant to mother's situation and/or ADD other discussion points from knowledge of area
Mother needs to eat and drink to satisfy hunger and thirst	<ul style="list-style-type: none"> • No one special food or diet is required to provide adequate quantity or quality of breast milk. • Breast milk production is not affected by maternal diet. • No foods are forbidden. • Mothers should be encouraged to eat more food to maintain their own health. • CC 1: <i>Nutrition for pregnant and breastfeeding woman</i> • Brochure: <i>Nutrition During Pregnancy and Breastfeeding</i>
Avoid feeding bottles	<ul style="list-style-type: none"> • Foods or liquids should be given by cup to reduce nipple confusion and the possible introduction of contaminants. • CC 11: <i>Good hygiene practices prevent disease</i> • CC 12: <i>Safe water and good compound hygiene</i> • CC 13 to 17: complementary feeding CC

Participant Material 5.3: Recommended Schedule for Visits through Pregnancy up to 6 Months of Infant's Age

	When	Discuss
Prenatal	All prenatal visits 	<ul style="list-style-type: none"> • Good attachment and positioning • Early initiation of breastfeeding (give colostrum) • Breastfeeding in the first few days • Exclusive breastfeeding from birth up to 6 months (avoid other liquids and food, including water) • Breastfeeding on demand– up to 12 times day and night • Mother needs to eat extra meals and drink a lot of fluids to be healthy • Attendance at mother-to-mother support group • How to access CHW if necessary
Delivery	Labor and delivery	<ul style="list-style-type: none"> • Place baby skin-to-skin with mother • Good attachment and positioning • Early initiation of breastfeeding (give colostrum, avoid water and other liquids) • Breastfeeding in the first few days
Postnatal	Within the first week after birth (2 or 3 days and 6 or 7 days)	<ul style="list-style-type: none"> • Good attachment and positioning • Breastfeeding in the first few days • Exclusive breastfeeding from birth up to 6 months • Breastfeeding on demand– up to 12 times day and night • Ensure mother knows how to express her breast milk • Preventing breastfeeding difficulties (engorgement, sore and cracked nipples)
	1 month • Immunization Sessions • Growth Monitoring Promotion (GMP)	<ul style="list-style-type: none"> • Good attachment and positioning • Exclusive breastfeeding from birth up to 6 months • Breastfeeding on demand– up to 12 times day and night • Breastfeeding difficulties (plugged ducts which can lead to mastitis, and not enough breast milk)
	6 weeks • Family planning sessions • GMP • Sick Child clinic • Community follow-up	<ul style="list-style-type: none"> • Increase breast milk supply • Maintain breast milk supply • Continue to breastfeed when infant or mother is ill • Family planning • Prompt medical attention
	From 5 up to 6 months • GMP • Sick child Clinic • Community follow-up	<ul style="list-style-type: none"> • CHW should not try to change positioning if older infant is not having difficulties • Prepare mother for changes she will need to make when infant reaches 6 months (AT 6 months) • At 6 months, begin to offer foods 2 to 3 times a day - gradually introduce different types of foods (staple, legumes, vegetables, fruits and animal products) and continue breastfeeding

SESSION 6. HOW TO BREASTFEED

Learning Objectives	Methodologies	Training Aids
1. Briefly describe the anatomy of the breast and how the breast makes milk.	Group work	Participant Material 6.1: <i>Anatomy of the human breast</i>
2. Demonstrate good positioning and attachment.	<ul style="list-style-type: none"> • Role play • Group work • Observation • Practise 	<ul style="list-style-type: none"> • Participant Material 6.2: <i>Good and Poor Attachment</i> • CC 6: <i>There are many breastfeeding positions</i> • CC 7: <i>Good attachment is important</i> • Brochure: <i>How to Breastfeed Your Baby</i> • CC 8: <i>Care and feeding of a low birth weight baby</i> • Note: Key Messages on the back of each counselling card
3. List ways to establish and maintain breast milk supply.	Brainstorming	
4. Describe hand expression and storage of breast milk; and how to cup feed.	<ul style="list-style-type: none"> • Brainstorming • Demonstration • Practise 	<ul style="list-style-type: none"> • CC 9: <i>How to hand express and cup feed</i> • CC10: <i>Give breast milk even away from home</i> • Note: Key Messages on the back of each counselling card
Additional Activity for training of trainers only: Making dolls and breast models	Working groups help each other make dolls and breast models	Participant Material 6.3: <i>Instructions for Making Cloth Breast Models</i>

Materials:

- Flipchart papers and stand (+ markers + masking tape or sticky putty)
- Dolls or rolled up towels
- Cups available for working groups of Participants to practice cup feeding
- Training Aids: *Good and Poor Attachment*; *Anatomy of the Breast* (internal)

Advance Preparation:

- Invite several women with young infants to demonstrate attachment and positioning and breast milk expression (if possible and culturally accepted)
- Facilitators practice demonstration of good attachment and positioning (mother and counsellor)

Additional Activities: Making dolls and model breasts

- For dolls: paper rolled into a ball for the head covered in same fabric used for the body, small bottle filled with water for trunk of doll, rubber bands to help define neck, arms and legs, typical baby clothes if available, and a cloth or blanket to cover the doll.
- For breast model: Use 2 socks, 1 sock resembling skin colour to show the outside of the breast, and another sock to show the inside of the breast
- Participant Material 6.3: *Instructions for Making Cloth Breast Models*

Duration: 1 hour (1½ hour for TOT training)

Learning Objective 1: Briefly describe the anatomy of the breast and how the breast makes milk

Methodology: Group work

Instructions:

1. Ask Participants to form working groups in which each group draws:
 - The breast as it looks on the outside
 - The breast as it looks from the inside
2. In large group, ask each group to explain their drawings and how milk is produced
3. Compare drawings with Participant Material 6.1: *Anatomy of the Human Breast*, noting similarities and correcting misinformation
4. Facilitate discussion in large group, correcting misinformation and answering questions
5. Explain that frequent removal of plenty of milk from the breast encourages milk production
6. Ask Participants the question: “If the mother eats more, will she produce more milk?” Probe until Participants respond: milk production depends on frequent removal of plenty of milk from the breast - the more breast milk removed from the breast, the more breast milk the mother makes.
7. Distribute from Participant Material 6.1: *Anatomy of the Human Breast* (or refer to specific page in Participant Materials)
8. Discuss and summarize

Key Information

- When the baby suckles at the breast, stimulation of the nipple results in breast milk production and the release or let down of breast milk.
- Suckling as well as removing plenty of milk from the breast are essential for good milk supply.
- If the baby does not remove plenty of breast milk, less milk will be produced in that breast because the presence of the milk inhibits milk production.
- The release of milk (sometimes called the ejection reflex) can be affected by a mother’s emotions – fear, worry, pain, embarrassment

Note: The ‘fore milk’ has more water and satisfies the baby’s thirst. The ‘hind milk’ has more fat and satisfies the baby’s hunger.

Learning Objective 2: Demonstrate good positioning and attachment

Methodology: Role play, Group work, Observation, Practise

Instructions for Activity 1:

Role Play

1. Using a real mother (if possible), Facilitator explains the 4 signs of good positioning and demonstrates how to hold baby (pointing out that mother should not press baby's head into her breast, and baby should not be held too far out to the side) - various positions can be demonstrated later
2. If no mother with a baby is present use a doll to demonstrate. One Facilitator helps another Facilitator role play helping a mother position and attach baby to breast using a doll or rolled-up towel

Instructions for Activity 2:

Group work

1. Form groups of 3 and ask groups to look at CC 6: *There are many breastfeeding positions* and CC 8: *Care and feeding of a low birth weight baby*
2. Ask 1 group to explain the counselling card on Different breastfeeding positions (CC 6) - what they observe, Facilitator demonstrating the different positions mentioning the 4 points of positioning
3. Ask another group to explain the position for feeding a low birth weight baby - what they observe, and to describe Kangaroo Mother Care (CC 8); Facilitator and Participants fill-in the gaps
4. Orient Participants to key messages on the back of the CC

Instructions for Activity 3:

Observation (of attachment)

1. Distribute from Participant Material 6.2: *Good and Poor Attachment* (or refer to specific page in Participant Materials)
2. Ask Participants: What is happening inside the baby's mouth in *Good Attachment and Poor Attachment?* and explain the differences
3. Ask Participants; "What happens when attachment is poor (baby is not attached well)?"
4. Form groups of 3 and ask groups to look at CC 7: *Good attachment is important*
5. Ask a group to explain the counselling card on good attachment (CC 7) to the entire group - what they observe, pointing out the 4 signs of good attachment
6. Orient Participants to key messages behind each counselling card

Instructions for Activity 4:

Practise

1. Ask Participants to divide into groups of 3 (mother, CHW and observer).
2. Using dolls or rolled-up towels/material: Participants practise helping 'mother' to use good positioning (4 signs) and good attachment (4 signs). Each Participant practises each role. (Participants can practise positioning a baby and helping a mother to do so, but they cannot practise attachment until they are with a real mother and baby. They can go through all the steps with each other and with a doll so that they know what to do with a real mother.)
3. Facilitators observe and provide feedback to groups of 3. Remind the Participants that the counsellor should talk to the mother, using "supportive and encouraging words and tone of voice" to explain the steps necessary to position or reposition or attach or reattach the baby (and not take the baby from the

Session 6. How to breastfeed

- mother and do it him/herself)
4. Ask groups to provide any feedback: What was new? What was difficult?
 5. Summarize key points in large group

Key Information

- See CC 6: *There are many breastfeeding positions* and CC 7: *Good attachment is important*
- See Participant Materials 6.2: *Good and poor attachment*

Activity 1: Role-Play

How to help a mother position or hold her baby at the breast (especially important for newborns; if older baby is properly attached positioning is not a priority) – refer Participants to CC 6: *There are many breastfeeding positions*

- The mother must be comfortable
- The four key points about baby's position are: **straight, facing mother, close, and supported**:
 - The baby's body should be straight, not bent or twisted, but with the head slightly back
 - The baby's body should be facing the breast and he or she should be able to look up into mother's face, not held flat to her chest or abdomen
 - The baby should be close to mother
 - Mother should support the baby's whole body, not just the neck and shoulders, with her hand and forearm.
- The infant is brought to the breast (not the breast to the infant)
- Orient Participants to the key messages on the back of each counselling card

Activity 2: Group work

Demonstration of different breastfeeding positions (refer Participants to CC 6: *There are many breastfeeding positions*)

1. Cradle position (most common position)
2. Cross cradle—useful for newborns and small or weak babies, or any baby with difficulty attaching
3. Side-Lying
 - This position is more comfortable for the mother after delivery and it helps her to rest while breastfeeding.
 - The mother and infant are both lying on their sides and facing each other.
4. Under-arm
 - This position is best used:
 - after a Caesarean section,
 - when the nipples are painful
 - for small babies
 - breastfeeding twins
 - The mother is comfortably seated with the infant under her arm. The infant's body passes by the mother's side and his/her head is at breast level.
 - The mother supports the infant's head and body with her hand and forearm.
5. Cross position for twins

Session 6. How to breastfeed

Kangaroo mother care:

- The naked baby (except for the nappy and cap) is placed in direct skin-to-skin contact between the mother's naked breasts. The baby's legs should be flexed and the baby should be held in place using a cloth that supports the baby's whole body up to just under his/her ears. The cloth should be tied around the mother's chest.
- This position provides skin-to-skin contact, warmth and closeness to the mother's breast. It helps to stabilize the baby's breathing and heart beat. Mother's smell, touch, warmth, voice, and taste of the breast milk help to stimulate the baby to establish successful breastfeeding.
- Kangaroo mother care encourages early and exclusive breastfeeding, either by direct feeding or using expressed breast milk given by cup, and more breastfeeding because mother and baby are rarely separated.
- Different caregivers can also share in the care of the baby using the same Kangaroo method position.
- Orient Participants to the key messages on the back of each counselling card

Activity 3: Observation (of attachment)

Picture #1 Good Attachment (inside baby's mouth)

- Baby has taken much of the areola and the underlying tissues into the mouth
- Baby has stretched the breast tissue out to form a long "teat"
- The nipple forms only about one third of the teat
- The baby is suckling from the breast, not the nipple
- The position of the baby's tongue: forward, over the lower gums and beneath the areola. The tongue is in fact cupped around the "teat" of breast tissue. (You cannot see that in this drawing, though you may see it when you observe a baby)
- A wave goes along the baby's tongue from the front to the back. The wave presses the 'teat' of breast tissue against the baby's hard palate. This presses milk out of the milk ducts into the baby's mouth to be swallowed

Picture #2 Poor Attachment (inside baby's mouth)

- Only the nipple is in the baby's mouth, not the underlying breast tissue
- The milk ducts are outside the baby's mouth, where the tongue cannot reach them
- The baby's tongue is back inside the mouth and not pressing on the milk ducts
- **Note:** Results of poor attachment:
 - Sore and cracked nipples
 - Pain leads to poor milk release and slows milk production

Activity 4: Practise

How to help a mother achieve good attachment (refer Participants to CC 7: *Good Attachment is important* and Brochure: *How to Breastfeed Your Baby*)

- Greet mother, introduce yourself
- If the baby is poorly attached, ask mother if she would like some help to improve baby's attachment
 - Make sure mother is sitting in a comfortable, relaxed position
 - Be comfortable and relaxed yourself
- Explain the 4 signs of good attachment:
 1. The baby should be close to the breast, (tucked right in to mother so that baby's nose is lifted clear of breast) with a wide open mouth, so that he or she can take in plenty of the areola and not just the nipple.

Session 6. How to breastfeed

2. The chin should touch the breast (this helps to ensure that the baby's tongue is under the areola so that he or she can press out the milk from below).
 3. You should see more areola above the baby's mouth than below; and
 4. You may be able to see that the baby's lower lip is turned outwards (but it may be difficult to see if the chin is close to the breast – do not move the breast away to see as this will pull the breast from the baby).
- To begin attaching the baby, the mother's nipple should be aimed at the baby's nose
 - When the baby opens his or her mouth wide, bring the baby onto breast from below (rather than approaching the breast straight-on)
 - Show mother how to hold her breast with her fingers in a C shape, the thumb being above the areola and the other fingers below. The fingers need to be flat against chest wall to avoid getting in the baby's way. Make sure that the fingers are not too close to the areola so the baby can get a full mouthful of breast. Fingers should not be in "scissor hold" because this method tends to put pressure on the milk ducts and can take the nipple out of the infant's mouth.
 - Explain how she should touch her baby's lips with her nipple, so that the baby opens his/her mouth
 - Explain that she should wait until her baby's mouth opens wide
 - Explain how to quickly move the baby to her breast (aiming her baby's lower lip well below her nipple, so that the nipple goes to the top of the baby's mouth and his/her chin will touch her breast) - baby should approach breast nose to nipple
 - Notice how the mother responds
 - Look for all the signs of good attachment
 - If the attachment is not good, try again (don't pull the baby off as this will damage the breast and hurt)
 - Good attachment is not painful; good attachment results in an effective suckling pattern (slow deep sucks with pauses)
 - Look for signs of effective suckling: slow deep sucks with pauses; you can see or hear the baby swallowing. Cheeks are rounded and not dimpled or indrawn. These signs show that the baby is getting enough milk.

Learning Objective 3: List ways to establish and maintain breast milk supply

Methodology: Brainstorming

Instructions:

1. Ask Participants to name ways to help establish and maintain breast milk supply
2. Facilitator fills-in gaps from key information
3. Discuss and summarize

Key Information

- Place mother and baby skin-to-skin immediately after birth - don't wash mother's breasts or baby's hands – so that baby can locate the breasts by smell (as well as sight of the areola).
- Breastfeed as soon after birth as the baby is ready. The baby may move and attach her/himself to the breast.
- Ensure good attachment (4 signs)
- Breastfeed frequently: the more a baby suckles, the more breast milk the mother makes.

Session 6. How to breastfeed

- Let baby finish first breast before offering the second
- Give only breast milk (no other liquids, foods or water) for the first 6 months
- Keep the baby close or skin-to-skin so that the mother can breastfeed whenever baby wants for as long as he or she wants
- Breastfeed at night
- Express breast milk when away from baby so that the expressed breast milk may be fed to baby and so the mother's breasts do not become too full.
- Mothers who are breastfeeding should have plenty to drink and an extra, nutritious snack a day.
- **Note for CHW:** Encourage and support breastfeeding at all encounters, and build mother's confidence.

Learning Objective 4: Describe hand expression and storage of breast milk; and how to cup feed

Methodology: Brainstorming; demonstration; practise

Instructions:

1. Ask Participants to state the reasons why a mother might need to express her breast milk and list on flipchart
2. Facilitator demonstrates milk expression technique using a breast model
3. Using the breast model, Participants “practise” breast milk expression in triads: Participants take turns explaining to each other how to help a mother express her breast milk, and how to store it
4. Demonstrate cup feeding
5. Groups of 3 “practise” cup feeding technique
6. Same groups of 3 review CC 9: *How to hand express and cup feed* and CC 10: *Give breast milk even away from home*, and discuss what is happening in each illustration
7. Ask two Participants to describe what they observe and Facilitator fills-in gaps from Key Information
8. Orient Participants to key messages on the back of each counselling card
9. Discuss and summarize

Key Information

Sometimes a mother needs to express milk for her baby:

- baby is too weak or small to suckle effectively
- baby is taking longer than usual to learn to suckle, for example because of inverted nipples
- to feed a low birth weight baby who cannot breastfeed (see CC 8)
- to feed a sick baby
- to keep up the supply of breast milk when mother or baby is ill
- to relieve engorgement or blocked duct
- Mother has to be away from her baby for some hours
- Points to consider when mother is separated from her baby:
 - Learn to express your breast milk soon after your baby is born.
 - Breastfeed exclusively and frequently for the whole period that you are with your baby.

Session 6. How to breastfeed

- Express and store breast milk before you leave your home so that your baby's caregiver can feed your baby while you are away.
- Express breast milk while you are away from your baby, even if you cannot store it. This will keep the milk flowing and prevent breast swelling.
- Teach your baby's caregiver how to store expressed milk and use a clean open cup to feed your baby while you are away.
- Take extra time for the feeds before separation from baby and when you return home Increase the number of feeds while you are with the baby. This means increasing night and weekend feedings.
- If possible, carry the baby with you to your work place (or anytime you have to go out of the home for more than a few hours). If this is not possible, consider having someone bring the baby to you to breastfeed when you have a break.
- Get extra support from family members in caring for your baby and other children, and for doing household chores.

Additional Activity: Making dolls and breast models

Methodology: Working groups help each other make dolls and breast models

Instructions:

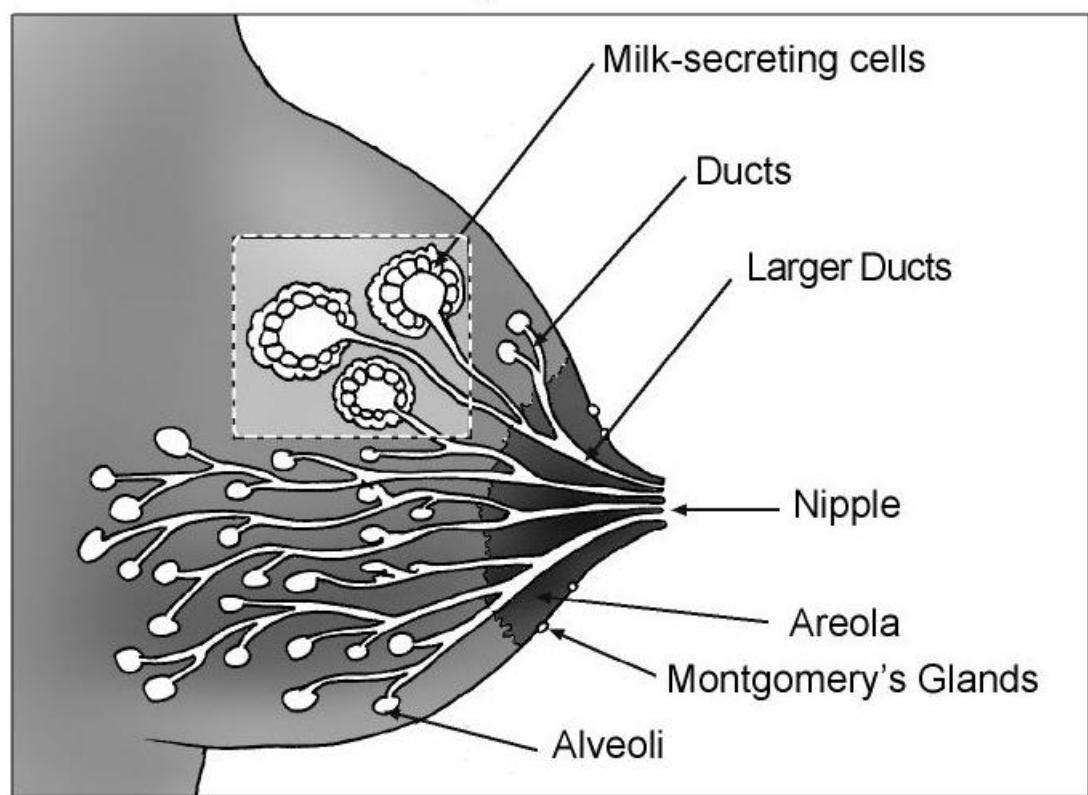
1. Demonstrate how to make a doll using simple materials (paper rolled into a ball for the head covered in same fabric used for the body, small bottle filled with water for trunk of doll or using a towel without a bottle, rubber bands to help define neck, arms and legs, typical baby clothes if available, and a cloth or blanket to cover the doll). See photo.



2. Participants work together to make their dolls.
3. Demonstrate how to make a breast model using simple materials (2 socks: 1 sock resembling skin colour to show the outside of the breast, and another sock to show the inside of the breast – Participant Material 6.3: *Instructions for Making Cloth Breast Models*

Note: Each training team should create at least one doll for use in conducting future trainings.

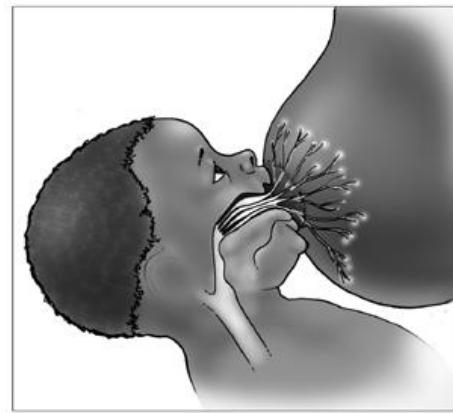
Participant Material 6.1: Anatomy of the Human Breast⁴



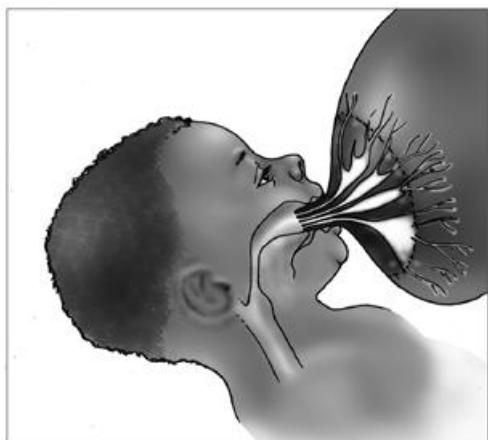
⁴ WHO/UNICEF. Infant and Young Child Feeding Counselling: An Integrated Course. 2006

Participant Material 6.2: Good and Poor Attachment

Good attachment⁵

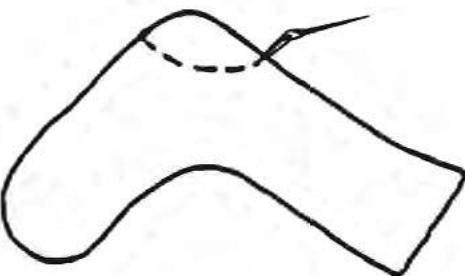
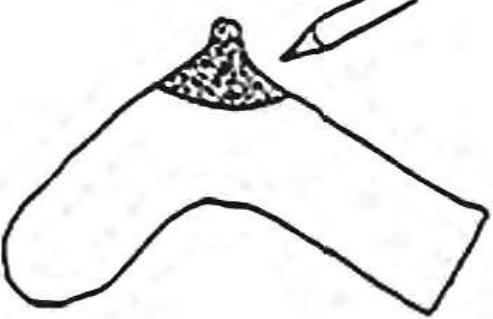
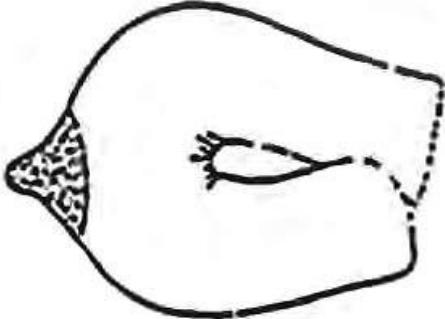


Poor attachment



⁵ WHO/UNICEF. Infant and Young child Feeding Counselling: An Integrated Course. 2006.

Participant Material 6.3: Instructions for Making Cloth Breast Models

<p>Use two socks: one sock in a brown or other colour resembling skin to show the outside of the breast, and the other sock white to show the inside of the breast.</p>	
<p>Skin-colour sock Around the heel of the sock, sew a circular running stitch (purse string suture) with a diameter of 4cm. Draw it together to 1 ½ cm diameter and stuff it with paper or other substance to make a “nipple.” Sew a few stitches at the base of the nipple to keep the paper in place. Use a felt-tip pen to draw an areola around the nipple.</p>	
<p>White sock On the heel area of the sock, use a felt-tip pen to draw a simple structure of the breast: alveoli, ducts, and nipple pores.</p>	
<p>Putting the two socks together Stuff the heel of the white sock with anything soft. Hold the 2 ends of the sock together at the back and form the heel to the size and shape of a breast. Various shapes of breasts can be shown. Pull the skin-coloured sock over the formed breast so that the nipple is over the pores.</p>	
<p>Making two breasts If two breasts are made, they can be worn over clothing to demonstrate attachment and positioning. Hold them in place with something tied around the chest. The correct position of the fingers for hand expression can also be demonstrated.</p>	

SESSION 7. RECOMMENDED IYCF PRACTICES: COMPLEMENTARY FEEDING FOR CHILDREN FROM 6 UP TO 24 MONTHS

Learning Objectives	Methodologies	Training Aids
1. Describe the importance of continuation of breastfeeding after 6 months.	<ul style="list-style-type: none"> • Brainstorming • Demonstration 	3 glasses with water: completely full, $\frac{1}{2}$ and $\frac{1}{3}$ filled respectively
2. Name beliefs about complementary feeding that should be discouraged, and what can be done to address them	<ul style="list-style-type: none"> • Interactive presentation 	None
3. Explain how to complement breast milk with family foods	<ul style="list-style-type: none"> • Interactive presentation • Demonstration 	<ul style="list-style-type: none"> • Participant Material 7.1: <i>Recommended complementary feeding practices</i> • Participant Material 7.2: <i>Different types of locally, available foods</i> • CC 11: <i>Good hygiene practices prevent disease</i> • CC 12: <i>Safe water and good compound hygiene</i> • CC for complementary foods for each age group: CC 13 to 17 • Brochure: <i>How to Feed your Baby After 6 Months</i> • CC 18: <i>When your baby is sick, seek advice</i> • Note: Key Messages on the back of the counselling cards
4. Give practical help to a mother/father/caregiver in preparing complementary foods for a baby over 6 months, discussing examples of local recipes	<ul style="list-style-type: none"> • Group work • Demonstration 	<ul style="list-style-type: none"> • Participant Material 7.2: <i>Different types of locally, available foods</i> • Participant Material 7.3: <i>Recommended complementary feeding practices and possible counselling discussion points</i> • Different foods: staples, legumes and seeds, vitamin A rich fruits and vegetables, other fruits and vegetables, animal-source foods, and oils • Local recipes
5. Describe recommended practices and counselling discussion points pertaining to child feeding from 6 up to 24 months.	<ul style="list-style-type: none"> • Participatory presentation by working groups 	<ul style="list-style-type: none"> • Participant Material 7.1: <i>Recommended complementary feeding practices</i> • Participant Material 7.2: <i>Different types of locally, available foods</i>

Session 7. Recommended IYCF practices: complementary feeding for children from 6 up to 24 months

Learning Objectives	Methodologies	Training Aids
		<ul style="list-style-type: none"> • Participant Material 7.3: <i>Recommended complementary feeding practices and possible counselling discussion points</i> • Participant Material 7.4: <i>Active/Responsive Feeding for Young Children</i> • Illustrations of texture (thickness/consistency) of porridge (cup and spoon) • Illustrations of locally available foods • Illustrations of food groupings (staples, legumes and seeds, vitamin rich fruits and vegetables, other fruits and vegetables, animal-source foods and oils) • CC 11: <i>Good hygiene practices prevent disease</i> • CC 12: <i>Safe water and good compound hygiene</i> • CC for complementary foods for each age group: CC 13 to 17 • CC 18: <i>When your baby is sick, seek advice</i> • CC 3: <i>Non-breastfed child from 6 up to 24 months</i> • Brochure: <i>How to Feed your Baby After 6 Months</i>
6. Discuss complementary feeding difficulties and poor practices.	<ul style="list-style-type: none"> • Group work 	None

Materials:

- Illustrations of texture (thickness/consistency – thick and thin) of porridge (cup and spoon)
- Flipchart: 7 columns titled Age, Frequency, Amount, Texture, Variety, Active/responsive feeding and Hygiene; and 3 Rows: 6 up to 9 months, 9 up to 12 months, and 12 up to 24 months
- Illustrations of locally available foods and food groupings (staples, legumes and seeds, vitamin A rich fruits and vegetables, other fruits and vegetables, animal-source foods and oils)

Advance Preparation:

- 3 glasses with water: completely full, $\frac{1}{2}$ and $\frac{1}{3}$ filled respectively
- Flipchart and flipchart content as described in learning objective 3, #2 and #3.
- Examples of local foods (or illustrations of food groupings or illustrations of local foods) to place on chart from Participant Material 7.1: *Recommended complementary feeding practices*

Duration: 2 hours

Learning Objective 1: Describe the importance of continuation of breastfeeding after 6 months.

Methodology: Brainstorming; demonstration

Instructions:

1. Ask Participants: How much energy is provided by breast milk for an infant/young child:
 - From 0 up to 6 months
 - From 6 up to 12 months
 - From 12 up to 24 months
2. Write ‘energy needs and type of feeding’ of a child from 0 up to 6 months, 6 up to 12 months and from 12 up to 24 months on a flipchart using a table with 3 columns, (age, energy needs from breast milk, type of feeding); leave posted throughout the training (key information below*)
3. Demonstrate the same information using 3 glasses: completely full, half ($\frac{1}{2}$) and one third ($\frac{1}{3}$) filled respectively

Key Information

- From 0 up to 6 months breast milk supplies all the ‘energy needs’ of a child
- From 6 up to 12 months breast milk continues to supply about half ($\frac{1}{2}$) the ‘energy needs’ of a child; the other half of ‘energy needs’ must be filled with complementary foods
- From 12 up to 24 months breast milk continues to supply about one third ($\frac{1}{3}$) the energy needs of a child; the missing ‘energy needs’ must be filled with complementary foods
- Besides nutrition, breastfeeding continues to provide protection to the child against many illnesses, and provides closeness, comfort, and contact that helps development.

Learning Objective 2: Name beliefs about complementary feeding that should be discouraged; and what can be done to address them

Methodology: Interactive Presentation

Instructions:

1. Tape or stick a flipchart with columns: Age, Frequency, Amount, Texture, Variety, Active/responsive feeding and Hygiene; and Rows: 6 up to 9 months, 9 up to 12 months, and 12 up to 24 months
2. Keeping in mind both age and characteristics of complementary feeding: frequency, amount, thickness (consistency), variety, active/responsive feeding, and hygiene, ask participants to name a complementary feeding belief in their communities that has a negative effect on feeding practices
3. Participants make suggestions as to how those beliefs that have a negative effect on feeding might be changed (while always respecting the belief), and who in the household and community is best able to influence changes (e.g. grandmothers, child’s father, religious groups, support groups)
4. Participants suggest key messages to address some of the major beliefs in their communities which negatively impact complementary feeding
5. Discuss and summarize

Learning Objective 3: Explain how to complement breast milk with family foods
Methodology: Interactive presentation; demonstration

Instructions:

A. Family Foods

1. Using examples of real foods (if available) or illustrations of the foods or food groupings that are available locally (in the market and/or at home), ask Participants to choose those food that they consider to be “staple foods”, and put them in one grouping or pile.
2. Ask Participants to identify the locally available food that they consider to be a “legume”, and put them in one grouping or pile.
3. Ask Participants to identify the fruits and/or vegetables that are locally available, and put them in one grouping or pile. From this grouping, make a special grouping or pile of those fruits that they think are rich in vitamin A (including papaya, mangoes, passion fruit, oranges). Make another grouping of pile of those vegetable that they think are rich in vitamin A (including dark-green leaves, carrots, pumpkins, yellow sweet potato and make a separate grouping or pile).
4. Ask Participants to identify the animal-source foods that are locally available (including meat, chicken, fish, liver; and eggs and milk, and milk products such as cheese or yogurt) and put them in one grouping or pile.
5. Distribute Participant Material 7.2: *Different types of locally available foods*
6. Review, discuss and Facilitator corrects or fills-in gaps.
7. Divide Participants into 5 groups and ask each group to study the CC 13 to 17 on complementary feeding, and Brochure: *How to Feed your Baby after 6 Months*
8. Ask each group to comment on one card
9. Other groups add additional points
10. Discuss Key Messages on the backs of CC
11. Discuss and summarize

Key Information

Continue to breastfeed (for at least 2 years) and give a variety of foods, called a diversified diet of complementary foods to your young child. A diversified diet is created by including foods from the following categories:

- Animal-source foods: meat, chicken, fish, liver; and eggs and milk, and milk products
- Staples: grains, roots, tubers
- Legumes: beans, lentils, peas; and seeds
- Fruits /Vegetables: especially vitamin A-rich fruits - papaya, mango, passion fruit, oranges; and vitamin A-rich vegetables - dark-green leaves, carrots, pumpkins, yellow sweet potato
- *Animal source foods are very important* and can be given to babies and young children. They must be cooked well and chopped into very small pieces that the baby will not choke on.
- *Give 1 to 2 snacks each day.* Between meals give extra foods that are easy to prepare, are clean, safe, locally available, and can be eaten as finger foods. Snacks can be pieces of ripe mango, papaya, banana, avocado, other fruits and vegetables, fresh and fried bread products, boiled potato, yellow/orange sweet potato
- Use iodised salt

Note: 'Biscuits', tea and coffee are not an appropriate complementary food, and therefore are not recommended for young children.

- Avoid giving sugary drinks and industrial juices, use homemade juices
- Explain how mothers can add one single new food item to a child's diet each week

Session 7. Recommended IYCF practices: complementary feeding for children from 6 up to 24 months

- Complementary foods for young children need to be prepared differently from adult foods. This helps children gradually transition from breastfeeding alone to eating grown-up foods by the time they are 2 years of age.
- See Participant Material 7.1: *Recommended complementary feeding practices*
- See Participant Material 7.2: *Different types of locally, available foods*
- See CC 13 through 17 on complementary feeding
- See key messages on the back of the CC
- See Brochure: *How to Feed your Baby After 6 Months*

Learning Objective 4: Give practical help to a mother/father/caregiver in preparing complementary foods for a baby over 6 months

Methodology: Group work and Demonstration

Instructions:

1. Demonstrate cooking a thick porridge
2. Divide Participants into 4 groups
3. Give each group locally, available, feasible, affordable and seasonal foods (staples, legumes and seeds, vitamin A rich fruits and vegetables, other fruits and vegetables, animal-source foods), and oils
4. Ask Participants to refer to Participant Material 7.1: *Recommended complementary feeding practices and possible counselling discussion points* and Participant Material 7.2: *Different types of locally, available foods*
5. Ask each group to prepare appropriate complementary foods for one of the following age-groups:
 - At 6 months
 - From 6 up to 9 months
 - From 9 up to 12 months
 - From 12 up to 24 months
6. Ask each group to show and explain the prepared food to the entire group, discussing age-appropriate characteristics of complementary feeding: frequency, amount, thickness (consistency), variety, active/responsive feeding, and hygiene
7. Ask Participants to brainstorm the 5 keys to safer food.
8. Discuss and summarize

Key Information

- See Participant Material 7.1: *Recommended complementary feeding practices*
- See Participant Material 7.2: *Different types of locally, available foods*
- See CC 13–17 on complementary feeding
- See CC Special Circumstance 3: *Non-breastfed child from 6 up to 24 months*
- See key messages on the back of the counselling cards
- See Brochure: *How to Feed your Baby After 6 Months*

At 6 months

- Babies have small stomachs and can only eat small amounts at each meal so it important to feed them frequently throughout the day (review table 7.1)
- Start with the staple cereal to make porridge (e.g. corn, wheat, rice, millet, potatoes, sorghum)

Session 7. Recommended IYCF practices: complementary feeding for children from 6 up to 24 months

- Animal source foods are very important and can be given to babies and young children. Cook well and chop fine.
- The consistency of the porridge should be thick enough to be fed by hand
- When possible use milk instead of water to cook the porridge.
- Use iodised salt to cook the porridge
- Continue breastfeeding to 24 months or older
- Foods intended to be given to the child should always be stored and prepared in hygienic conditions to avoid contamination, which can cause diarrhea and other illnesses

From 6 up to 9 months

- An 8-month old stomach holds about 200 ml or less than a cup
- Add colourful (variety) foods to enrich the staple including beans, peanuts, peas, lentils or seeds; orange/red fruits and vegetables (such ripe mango, papaya, and carrots, pumpkin); dark-green leaves (such as kale, chard), avocado. Soak beans and legumes before cooking to make them more suitable for feeding children
- Add animal-source foods: meat, chicken, fish, liver; and eggs and milk, and milk products (whenever available)
- Mash and soften the added foods so your baby/child can easily chew and swallow.
- By 8 months the baby should be able to begin eating finger foods. It is important to give finger foods to children to eat by themselves only after they are able to sit upright.
- Use iodised salt
- Continue breastfeeding
- Additional nutritious snacks (such as fruit or bread or bread with nut paste) can be offered once or twice per day, as desired
- Foods intended to be given to the child should always be stored and prepared in hygienic conditions to avoid contamination, which can cause diarrhea and other illnesses

From 9 up to 12 months

- Add colourful (variety) foods to enrich the staple including beans, peanuts, peas, lentils or seeds; orange/red fruits and vegetables (such ripe mango, papaya, and carrots, pumpkin); dark-green leaves (such as kale, chard), avocado.
- Add animal-source foods: meat, chicken, fish, liver; and eggs and milk, and milk products (whenever available)
- Give at least 1to 2 snacks each day such as ripe mango and papaya, avocado, banana, other fruits and vegetables, fresh and fried bread products, boiled potato, sweet potato
- Use iodised salt
- Continue breastfeeding
- Foods intended to be given to the child should always be stored and prepared in hygienic conditions to avoid contamination, which can cause diarrhea and other illnesses

From 12 up to 24 months

- Add colourful (variety) foods to enrich the staple including beans, peanuts, peas, lentils or seeds; orange/red fruits and vegetables (such ripe mango, papaya, and carrots, pumpkin); dark-green leaves (such as kale, chard), avocado.
- Add animal-source foods: meat, chicken, fish, liver; and eggs and milk, and milk products every day at least in one meal (or at least 3 times /week)
- Give at least 1 to 2 snacks each day such as ripe mango and papaya, avocado, banana, other fruits and vegetables, fresh and fried bread products, boiled potato, sweet potato
- Use iodised salt

Session 7. Recommended IYCF practices: complementary feeding for children from 6 up to 24 months

- Continue breastfeeding to 24 months or beyond
- Foods intended to be given to the child should always be stored and prepared in hygienic conditions to avoid contamination, which can cause diarrhea and other illnesses

Note: Wash hands with soap and water before preparation of food and feeding child

Note: refer to Participant Material 7.1: *Recommended complementary feeding practices* to address the need for milk products and extra fluids for a non-breastfed child.

- Exclusive breast milk substitute from 0 up to 6 months
- After 6 months of age, add the following:
 - 1 to 2 extra meals and offer 1 to 2 snacks (especially 'animal flesh' foods) i.e. 4 meals/day of family foods
 - 1 to 2 cups of milk per day
 - About 2 cups/day of extra fluids (in addition to the 1 to 3 cups/day of water that is estimated to come from milk and other foods in a temperate climate, and 3 to 4 cups/day in a hot climate)

5 keys to safer food:

1. Keep clean (hands, working surfaces, utensils)
2. Separate raw from cooked foods including utensils and containers
3. Use fresh foods and cook thoroughly (especially meat, poultry, eggs and fish)
4. Keep food at safe temperature
5. Use clean and safe water

Learning Objective 5: Describe recommended practices and possible points of discussion for counselling pertaining to child feeding from 6 up to 24 months

Methodology: Participatory presentation by working groups

Instructions:

A. Participatory Presentation by Working Groups

1. Divide the Participants into 2 groups
2. Prepare 2 flipcharts with columns: Age, Frequency, Amount, and Texture, and with rows: 6 up to 9 months, 9 up to 12 months, and 12 up to 24 months
3. Distribute pieces of paper with the chart content from Participant Material: 7.1 to one group
4. Distribute illustrations of food groupings, or illustrations of locally available foods and local utensils (or pictures of local utensils) to the second group
5. Ask both groups to fill in their flipchart content: one group taping or sticking their pieces of paper in the appropriate box on flipchart; and second group placing the illustrations of locally available foods or food groups, and utensils (or pictures of utensils) in the appropriate box on flipchart
6. Ask groups to continue until all chart content is filled
7. Ask group one to explain their entries on the flipchart
8. Ask group two to explain their entries using food and utensils
9. Ask both groups: which locally available foods contain iron? and which locally available foods contain vitamin A?
10. Distribute from Participant 7.1: *Recommended complementary feeding practices* (or refer to specific page in Participant Materials)

11. Together the entire group decides what content/food/utensils need to be rearranged to coincide with Participant Materials 7.1: *Recommended complementary feeding practices*
12. Discuss and summarize

B. Other Materials

1. Distribute Training Aid 1: *Illustrations of texture (thickness/consistency) of porridge (cup and spoon)* to describe texture of complementary foods
2. Distribute from Participant Material 7.2: *Different types of locally, available foods* (or refer to specific page in *Participant Materials*) and orient Participants to variety and discuss the importance of iron and vitamin A
3. Distribute from Participant Material 7.3: *Recommended complementary feeding practices and possible counselling discussion points* (or refer to specific page in *Participant Materials*) and orient Participants, drawing attention to additional counselling discussion points; ask Participants if there are other discussion points they want to add
4. Distribute from Participant Material 7.4: *Active/Responsive Feeding for Young Children* (or refer to specific page in *Participant Materials*)

Key Information

- See Participant Material 7.1: *Recommended complementary feeding practices*
- See Participant Material 7.2: *Different types of locally, available foods*
- See Participant Material 7.3: *Recommended complementary feeding practices and possible counselling discussion points*
- See Participant Material 7.4: *Active/responsive feeding for young children*
- Illustrations of texture (thickness/consistency) of porridge (cup and spoon)

Iron

- The iron stores present at birth are gradually used up over the first six months
- There is little iron from breast milk (although it is easily absorbed). After 6 months the baby's 'iron needs' must be met by the food he or she eats.
- Best sources of iron are animal foods, such as liver, lean meats and fish. Some vegetarian foods such as legumes have iron as well. Other good sources are iron-fortified foods and iron supplements.
- Plant sources such as beans, peas, lentils and spinach are a source of iron as well.
- Eating foods rich in vitamin C together with/or soon after a meal, increases absorption of iron.
- Drinking tea and coffee with a meal reduce the absorption of iron.

Vitamin A

- Best sources of vitamin A are yellow-coloured fruits and vegetables (papaya, mangoes, passion fruit, oranges, carrots, pumpkins, yellow sweet potato); dark-green leaves, and organ foods/offal (liver) from animals; eggs, milk and foods made from milk such as butter, cheese and yoghurt; dried milk powder and other foods fortified with vitamin A.

Note: After 6 months of age, children should receive vitamin A supplements twice a year. Consult your health care provider.

Session 7. Recommended IYCF practices: complementary feeding for children from 6 up to 24 months

C. Group work

1. Divide Participants into 5 working groups
2. Ask working groups to observe CC 11: *Good hygiene practices prevent disease*, CC 12: *Safe water and good compound hygiene* and ask them what information the cards contain
3. Ask each group to explain the characteristics of complementary feeding in the following *Counselling Cards*:
 - CC 13: *Start complementary feeding at 6 months*
 - CC 14: *Complementary feeding from 6 up to 9 months*
 - CC 15: *Complementary feeding from 9 up to 12 months*
 - CC 16: *Complementary feeding from 12 up to 24 months*
 - CC 17: *Feed your baby a variety of foods*
4. Each group will present one card with the characteristics of complementary feeding in large group
5. Other groups to add any additional points; Facilitator fills-in gaps
6. Orient Participants to Key Messages on the back of the counselling cards
7. Ask working groups to observe CC 18: *When your baby is sick, seek advice* and Brochure: *How to Feed your Baby After 6 Months* and ask them what information the card and brochure contain
8. Discuss and summarize

'Homework' assignment:

- Read through the messages on the back of CC 12 to 17, CC 18, and CC Special Circumstance 3: *Non-breastfed child from 6 up to 24 months*

Key Information

- CC 11: *Good hygiene practices prevent disease*
- CC 12: *Safe water and good compound hygiene*
- CC 13 to17: *Complementary feeding counselling cards*
- CC 18: *When your baby is sick, seek advice*
- CC Special Circumstance 3: *Non-breastfed child from 6 up to 24 months*
- Brochure: *How to feed your baby after 6 months*

Learning Objective 6: Discuss complementary feeding difficulties and poor practices

Methodology: Buzz groups (3 Participants)

Instructions:

1. In buzz groups ask Participants to 1) list complementary feeding difficulties and poor practices they have seen in their communities, and 2) consequences of inappropriate complementary feeding
2. Ask several groups to share their lists of complementary feeding difficulties and the consequences of inappropriate complementary foods (Facilitator writes on flipchart)
3. Ask additional groups to add any new difficulties not already mentioned
4. Discuss and summarize

Key Information

Complementary Feeding Difficulties and Consequences for Young Children and Mothers

	Young children	Mothers
Difficulties	<ul style="list-style-type: none"> • Lack of appetite • Premature introduction of complementary foods OR delay in introduction of complementary foods • Delay in introduction of complementary foods • Low feeding frequency • Inadequate amounts served and consumed by young child • Inappropriate thickness • Low nutrient density • Low micronutrient density 	<ul style="list-style-type: none"> • “Not enough” time for preparation of foods • No appropriate storage facilities or space • Lack of resources to buy a variety of food • Not responsive to young child feeding signs • Lack of encouragement to young child • Food taboos • Lacks support for continued breastfeeding
Consequences	<ul style="list-style-type: none"> • Increase risk of illness • Reduced intake of breast milk • Nutrient deficiencies • Growth restriction • Infection and death • Period of recovery not recognized 	<ul style="list-style-type: none"> • Breastfeeding reduced • Earlier pregnancy • More resources needed for sick child

Note: The period between 0 up to 24 months is a window of opportunity. If children become poorly nourished at this age, it will be very hard to catch up later in life.

Participant Material 7.1: Recommended Complementary Feeding Practices⁶

Age	Recommendations			
	Frequency (per day)	Amount of food an average child will usually eat at each meal (in addition to breast milk)	Texture (thickness/consistency)	Variety
Start complementary foods when baby reaches 6 months 	2 to 3 meals plus frequent breastfeeds	Start with 2 to 3 tablespoons Start with ‘tastes’ and gradually increase amount	Thick porridge/pap	Breastfeeding (Breastfeed as often as the child wants) + Animal foods (local examples)
From 6 up to 9 months 	2 to 3 meals plus frequent breastfeeds 1 to 2 snacks may be offered	2 to 3 tablespoonfuls per feed Increase gradually to half (½) 250 ml cup/bowl	Thick porridge/pap mashed/ pureed family foods	Staples (porridge, other local examples) + Legumes (local examples)
From 9 up to 12 months 	3 to 4 meals plus breastfeeds 1 to 2 snacks may be offered	Half (½) 250 ml cup/bowl	Finely chopped family foods/finger foods; Sliced foods	+ Fruits/ Vegetables (local examples)
From 12 up to 24 months 	3 to 4 meals plus breastfeeds 1 to 2 snacks may be offered	Three-quarters (¾) to 1 250 ml cup/bowl	Sliced foods/ family foods	

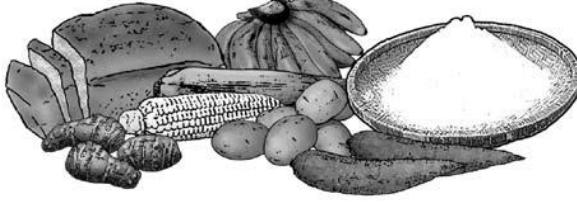
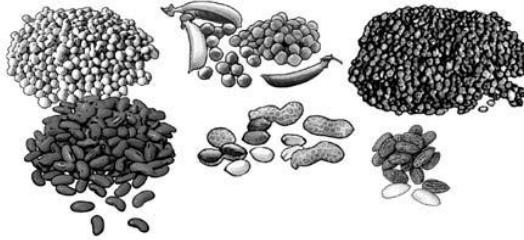
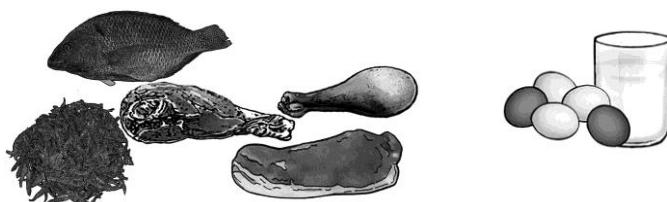
⁶ Adapted from WHO Infant and Young Child Feeding Counselling: An Integrated Course (2006)

Session 7. Recommended IYCF practices: complementary feeding for children from 6 up to 24 months

Age	Recommendations			
Note: If child is less than 24 months and is not breastfed	Add 1 to 2 extra meals 1 to 2 snacks may be offered	Same as above according to age group	Same as above according to age group	Same as above, in addition 1 to 2 cups of milk per day + 2 to 3 cups of extra fluid especially in hot climates
Active/responsive feeding (alert and responsive to your baby's signs that she or he is ready-to-eat; actively encourage, but don't force your baby to eat)	<ul style="list-style-type: none"> • Be patient and actively encourage your baby to eat more food • If your young child refuses to eat, encourage him/her repeatedly; try holding the child in your lap during feeding, or face him/her while he or she is sitting on someone else's lap. • Offer new foods several times, children may not like (or accept) new foods in the first few tries. • Feeding times are periods of learning and love. • Interact and minimize distraction during feeding. • Do not force feed. • Help your older child eat. 			
Hygiene	<ul style="list-style-type: none"> • Feed your baby using a clean cup and spoon; never use a bottle as this is difficult to clean and may cause your baby to get diarrhoea. • Wash your hands with soap and water before preparing food, before eating, and before feeding young children. • Wash your child's hands with soap before he or she eats. 			

*Adapt the chart to use a suitable local cup/bowl to show the amount. The amounts assume an energy density of 0.8 to 1 Kcal/g; use iodised salt in preparing family foods

Participant Material 7.2: Different Types of Locally, Available Foods

<p>Staples include grains such as maize, wheat, rice, millet and sorghum, and roots and tubers, such as cassava and potatoes.</p>	
<p>Legumes, such as beans, lentils, peas, groundnuts and seeds such as sesame.</p>	
<p>Fruits and vegetables, rich in Vitamin A, such as mango, papaya, passion fruit, oranges, dark-green leaves, carrots, yellow sweet potato and pumpkin.</p> <p>Other fruits and vegetables, such as banana, pineapple, avocado, watermelon, tomatoes, eggplant and cabbage.</p> <p>Note: include locally-used wild fruits and other plants.</p>	 
<p>Animal-source foods including flesh foods such as meat, chicken, fish, liver and eggs and milk and milk products</p> <p>Note: animal foods should be started at 6 months.</p>	
<p>Oil and fat, such as oil seeds, margarine, ghee and butter added to vegetables and other foods will improve the absorption of some vitamins and provide extra energy. Infants only need a very small amount (no more than half a teaspoon per day).</p>	

Participant Material 7.3: Recommended Complementary Feeding Practices and Possible Counselling Discussion Points

Recommended complementary feeding practice	Possible counselling discussion points Note: choose 2 to 3 most relevant to mother's situation and/or ADD other discussion points from knowledge of area
After baby reaches six months of age add complementary foods (such as thick porridge 2 to 3 times a day) to breastfeeds	<ul style="list-style-type: none"> • Give Local Examples of first types of complementary foods • When possible, use milk instead of water to cook the porridge. Breast milk can be used to moisten the porridge. • CC 11: <i>Good hygiene practices prevent disease</i> • CC 12: <i>Safe water and good compound hygiene</i> • CC 13: <i>Start Complementary Feeding at 6 Months</i> • Brochure: <i>How to Feed your Baby After 6 Months</i>
As baby grows older increase feeding frequency, amount, texture and variety	<ul style="list-style-type: none"> • Gradually increase the frequency, the amount, the texture (thickness/consistency), and the variety of foods , especially animal-source • CC 11: <i>Good hygiene practices prevent disease</i> • CC 12: <i>Safe water and good compound hygiene</i> • CC 13 to 17: <i>Complementary Feeding</i>
Complementary Feeding from 6 up to 9 months breastfeed plus give 2 to 3 meals and 1 to 2 snacks per day 	<ul style="list-style-type: none"> • Start with 2 to 3 tablespoonfuls of cooked porridge or mashed foods (give examples of cereals and family foods) • At 6 months these foods are more like 'tastes' than actual servings • Make the porridge with milk – especially breast milk; pounded groundnut paste (a small amount of oil may also be added) • Increase gradually to half (½) cup (250 ml cup). Show amount in cup brought by mother • Any food can be given to children after 6 months as long as it is mashed or chopped into very fine or small pieces. Children do not need teeth to consume foods such as eggs, meat, and green leafy vegetables • CC 11: <i>Good hygiene practices prevent disease</i> • CC 12: <i>Safe water and good compound hygiene</i> • CC 14: <i>Complementary feeding from 6 up to 9 months</i> • CC 17: <i>Feed your baby a variety of foods</i> • Brochure: <i>How to Feed your Baby After 6 Months</i>
Complementary Feeding from 9 up to 12 months breastfeed plus give 3 to 4 meals and 1 to 2 snacks per day 	<ul style="list-style-type: none"> • Give finely chopped, mashed foods, and finger foods • Increase gradually to ½ cup (250 ml cup). Show amount in cup brought by mother • Animal source foods are very important and can be given to young children: cook well and cut into very small pieces • CC 11: <i>Good hygiene practices prevent disease</i> • CC 12: <i>Safe water and good compound hygiene</i> • CC 15: <i>Complementary feeding from 9 up to 12 months</i> • CC 17: <i>Feed your baby a variety of foods</i> • Brochure: <i>How to Feed your Baby After 6 Months</i>

Session 7. Recommended IYCF practices: complementary feeding for children from 6 up to 24 months

Recommended complementary feeding practice	Possible counselling discussion points Note: choose 2 to 3 most relevant to mother's situation and/or ADD other discussion points from knowledge of area
Complementary Feeding from 12 up to 24 months give 3 to 4 meals and 1 to 2 snacks per day, with continued breastfeeding 	<ul style="list-style-type: none"> • Give family foods • Give three-quarter ($\frac{3}{4}$) to one cup (250 ml cup/bowl). Show amount in cup brought by mother • Foods given to the child must be prepared and stored in hygienic conditions to avoid diarrhoea and illness • Food stored at room temperature should be used within 2 hours of preparation • CC 11: <i>Good hygiene practices prevent disease</i> • CC 12: <i>Safe water and good compound hygiene</i> • CC 16: <i>Complementary feeding from 12 up to 24months</i> • CC 17: <i>Feed your baby a variety of foods</i> • Brochure: <i>How to Feed your Baby After 6 Months</i>
Give baby 2 to 3 different family foods: staple, legumes, vegetables/fruits, and animal foods at each serving	<p>Try to feed different food groups at each serving. For example:</p> <ul style="list-style-type: none"> • Animal-source foods: flesh foods such as chicken, fish, liver, and eggs and milk and milk products • Staples: grains such as maize, wheat, rice millet and sorghum and roots and tubers such as sweet potatoes, potatoes • Legumes such as beans, lentils, peas, groundnuts and seeds such as sesame • Vitamin A-rich fruits and vegetables such as mango, papaya, passion fruit, oranges, dark-green leaves, carrots, yellow sweet potato and pumpkin, and other fruits and vegetables such as banana, pineapple, watermelon, tomatoes, avocado, eggplant and cabbage • Add a small amount of fat or oil to give extra energy (additional oil will not be required if fried foods are given, or if baby seems healthy/ fat) • CC 13–17: Complementary Feeding • Brochure: <i>How to Feed your Baby After 6 Months</i> • Note: foods may be added in a different order to create a 4 star food/diet. Adding animal-source foods is extremely important.
Continue breastfeeding for two years of age or longer	<ul style="list-style-type: none"> • During the first and second years, breast milk is an important source of nutrients for your baby • Breastfeed between meals and after meals; don't reduce the number of breast feeds • CC 13-17 on complementary feeding • Brochure: <i>How to Feed your Baby After 6 Months</i>
Be patient and actively encourage baby to eat all his/her food	<ul style="list-style-type: none"> • At first baby may need time to get used to eating foods other than breast milk • Use a separate plate to feed the child to make sure he or she eats all the food given

Session 7. Recommended IYCF practices: complementary feeding for children from 6 up to 24 months

Recommended complementary feeding practice	Possible counselling discussion points Note: choose 2 to 3 most relevant to mother's situation and/or ADD other discussion points from knowledge of area
	<ul style="list-style-type: none"> • See Participant Materials 7.4: <i>Active/ Responsive Feeding for Young Children</i> • CC 13-17 on complementary feeding • Brochure: <i>How to Feed your Baby After 6 Months</i>
Wash hands with soap and water before preparing food, eating, and feeding young children. Wash baby's hands before eating. 	<ul style="list-style-type: none"> • Foods intended to be given to the child should always be stored and prepared in hygienic conditions to avoid contamination, which can cause diarrhoea and other illnesses • Wash your hands with soap and water after using the toilet and washing or cleaning baby's bottom. • CC 11: <i>Good hygiene practices prevent disease</i> • CC 12: <i>Safe water and good compound hygiene</i>
Feed baby using a clean cup and spoon	<ul style="list-style-type: none"> • Cups are easy to keep clean • CC 13–17 on complementary feeding
Encourage the child to breastfeed more and continue eating during illness and provide extra food after illness	<ul style="list-style-type: none"> • Fluid and food requirements are higher during illness. • It is easier for a sick child to eat small frequent meals. Feed the child foods he or she likes in small quantities throughout the day. • Children who have been sick need extra food and should be breastfed more frequently to regain the strength and weight lost during the illness. • Take advantage of the period after illness when appetite is back to make sure the child makes up for loss of appetite during sickness. • CC 18: <i>When your baby is sick, seek advice</i>

Note:

- Use iodised salt in preparing family foods
- Provide vitamin A supplementation to infant and young child beginning at 6 months , every six months until 5 years
- Micronutrient powders in a small sachet may be given beginning at 6 months to prevent anaemia or micronutrient deficiencies.
- Refer all malnourished children to the health centre for appropriate care and supplementation

Participant Material 7.4: Active/Responsive Feeding for Young Children

Definition: Active/responsive feeding is being alert and responsive to your baby's signs that she or he is ready-to-eat; actively encourage, but don't force your baby to eat.

Importance of active feeding: When feeding him/herself, a child may not eat enough. He or she is easily distracted. Therefore the young child needs help. When a child does not eat enough, he or she will become malnourished.



- Let the child eat from his/her own plate (caregiver then knows how much the child is eating)
- Sit down with the child, be patient and actively encourage him/her to eat.
- Offer food the child can take and hold; the young child often wants to feed him/herself. Encourage him/her to, but make sure most of the food goes into his/her mouth.
- Mother/father/caregiver can use her fingers (after washing) to feed child.
- Feed the child as soon as he or she starts to show early signs of hunger.
- If your young child refuses to eat, encourage him/her repeatedly; try holding the child in your lap during feeding.
- Engage the child in "play" trying to make the eating session a happy and learning experience...not just an eating experience.
- The child should eat in his/her usual setting.
- As much as possible, the child should eat with the family in order to create an atmosphere promoting his/her psycho-affective development.
- Help older child eat.
- Do not insist if the child does not want to eat. Do not force feed.
- If the child refuses to eat, wait or put it off until later.
- Do not give child too much drink before or during meals.
- Congratulate the child when he or she eats.

Note: Parents, family members (older children), child caretakers can participate in active/responsive feeding.



SESSION 8. GROWTH MONITORING AND PROMOTION

Learning Objectives	Methodologies	Training Aids
1. Describe why to take anthropometric measurements of a child	<ul style="list-style-type: none"> • Brainstorming • Demonstration • Discussion 	<ul style="list-style-type: none"> • Participant Material 10.1: <i>IYCF Assessment of Mother/Child pair</i> • CC 23
2. Describe how to take anthropometric measurements of a child	<ul style="list-style-type: none"> • Demonstration • Discussion • Practical exercises 	<ul style="list-style-type: none"> • Salter scale • Measuring board • MUAC tape • Participant Material 8.1: <i>10 steps for weighing children up to 25 kg</i> • Participant Material 8.2: <i>Using a measuring board to take the length of children up to 24 months</i> • Participant Material 8.3: <i>Using a MUAC tape for Nutritional Assessment</i> • Participant Material 8.4: <i>Steps to accurately use a MUAC tape</i> • CC 23
3. List and demonstrate how to fill in the tools for anthropometric measurements follow up	<ul style="list-style-type: none"> • Demonstration • Lecture • Questions and Responses • Practical exercises 	<ul style="list-style-type: none"> • Individual growth charts (weight-for-age and height-for-age) for boys and girls • Participant Material 8.5: <i>Community children register</i> • Participant Material 8.6: <i>Pregnant or lactating women register</i>
4. Demonstrate how to interpret the anthropometric measurements (weight and height curves and MUAC)	<ul style="list-style-type: none"> • Presentation • Reading • Questions and answers • Practical exercises 	<ul style="list-style-type: none"> • Participant Material 8.1: <i>10 steps for weighing children up to 25 kg</i> • Children growth curves (weight for age and height for age) • MUAC tape (the three colour zones) • Filled in Community growth chart
5. Practise	<ul style="list-style-type: none"> • Taking weight, height and MUAC • Observation • Feedback 	<ul style="list-style-type: none"> • Participant Material 8.1: <i>10 steps for weighing children up to 25 kg</i> • Participant Material 8.2: <i>Using a measuring board to take the length of children up to 24 months</i>

Session 8. Growth monitoring and promotion

		<ul style="list-style-type: none"> • Participant Material 8.3: <i>Using a MUAC tape for Nutritional Assessment</i> • Participant Material 8.4: <i>Steps to accurately use a MUAC tape</i> • Children growth charts • Community children register • Community pregnant or lactating women register
6. Describe MIYCN in the context of CMAM	<ul style="list-style-type: none"> • Brainstorming • Interactive presentation • Group work 	<ul style="list-style-type: none"> • Participant Material 18.1: <i>IYCF follow up plan checklist</i> • Illustrations of texture (thickness/ consistency) of porridge (cup and spoon) and CC 13-16 (spoons containing porridge) • CC 11: <i>Good hygiene practices prevent disease</i> • CC 12: <i>Safe water and good compound hygiene</i> • CC for complementary foods for each age group: CC 13 to 17 • Note: Key Messages on the back of the CC • Brochure: <i>How to Breastfeed your Baby</i> • Brochure: <i>How to feed your baby after 6 months</i> • Participant Material 7.1: <i>Recommended complementary feeding practices</i> • Participant Material 7.2: <i>Different types of local, available foods</i> • Participant Materials 7.3: <i>Recommended complementary feeding practices and possible counselling discussion points</i> • Participant Material 7.4: <i>Active/Responsive feeding for young children</i> • Participant Material 8.6: <i>Pregnant or Lactating Women Register</i> • Participant Material 8.7: <i>How to Assess for Bilateral Pitting Oedema</i> • Participant Material 8.8:

Session 8. Growth monitoring and promotion

		<p><i>Referral form for CHW</i></p> <ul style="list-style-type: none"> • Participant Material 8.9: <i>SFP education card</i> • Participant Material 8.10: <i>OTP monitoring card</i> • Participant Material 8.11: <i>OTP education card</i> • Participant Material 8.12: <i>RUTF instructions to be given to caretaker</i> • Participant Material 8.13: <i>OTP questions to ask caregiver</i> • Participant Material 8.14: <i>Rules for patients and caregivers in SFP</i> • Participant Material 8.15: <i>Behaviour Change Communication</i> • Participant Material 8.16: <i>Supplementary food rations</i> • Participant Material 8.17: <i>SFP ration card</i> • CC 20: <i>Feeding your sick baby less than 6 months of age</i> • CC 21: <i>Feeding your sick baby more than 6 months of age</i> • Note: Key Messages on back of counselling cards
7. Explain the system of documentation and reporting in MIYCN and the use of the reporting forms	<ul style="list-style-type: none"> • Demonstration • Discussion • Practical exercises • Presentation 	<ul style="list-style-type: none"> • Participant Material 8.5: <i>Community Children register</i> • Participant Materials 8.6: <i>Pregnant and Lactating women register</i> • Monthly reporting forms (Community and Health Centre)

Materials:

1. Flipchart papers and stand (+ markers + masking tape or sticky putty)
2. Weighing Salter scales with shorts
3. Measuring boards
4. MUAC tapes
5. Different tools: Child health card (boys and girls), community register (for children and for pregnant or lactating women), CC, community and health centre reporting forms
Community growth charts indicating nutritional status of children (z-scores of children in green, yellow and red zones)

Duration: 4 hours

Learning Objective 1: Describe why to take anthropometric measurements of a child

Methodology: Brainstorming, demonstration, discussion

Instructions:

1. Ask participants why is it important to take anthropometric measurements of a child
2. Write participants answers on the flip chart
3. Ask participants to describe all the materials used during growth monitoring and promotion. Write the responses on the flipchart, complete summarize and conclude
4. Make a summary explaining why to correctly take anthropometric measurements

Key Information

Growth Monitoring & Promotion

Healthy and well-nourished young children grow steadily. However, parents/caregivers cannot always tell just by looking at the child, whether the child is growing at a *normal* rate or not. One way to find out if the child is growing well is to weigh the child regularly and identify if the child is gaining weight or not. If children are not growing well, parents/caregivers and communities can take action to help the children grow better.

Training people in the communities to monitor the growth of the children will have significant impact on children's health. The regular weighing and plotting of a child's weight on the growth chart to decide if the child is gaining enough weight or not is called growth monitoring. Using the information gained from growth monitoring to take action to make sure that children grow well (counseling mothers and care takers) is called growth promotion.

Growth Monitoring (GM) is the process of regularly weighing and plotting a child's weight on the growth chart to assess growth adequacy and identify early faltering.

Growth Monitoring and Promotion (GMP) is a preventive and promotional activity comprised of GM linked with promotion (usually counseling) that increases awareness about child growth and the importance of nutrition; improves caring practices; and increases demand for other health services as needed. GMP often serves as the core activity in an integrated child health and nutrition program. As an intervention, it is designed to improve family-level decisions and individual child health and nutritional outcomes.

Why a child is weighed?

1. The nutritional status of a child should be determined by various methods: the weight measurement, the Mid Upper Arm Circumference (MUAC) measurement, and the height measurement. The commonly used indexes to determine the nutritional status are: weight for age, height for age, and weight for height. For growth and promotion surveillance, the index used is weight for age.
2. The weighing enables a community health worker and parents to know if the child is growing or faltering. Regular growth monitoring (weighing) allows monitoring and protection of the nutritional and health status of the child. A sick or poorly fed and malnourished child does not gain an adequate amount of weight or actually loses weight. This is called growth faltering.
3. Measuring a child's growth regularly is a means to know about his or her nutritional and health status. The child's growth should be measured in different ways. Taking the child's weight is the simplest and most common measure for young children. Adequate weight gain is an indicator that a child is growing well

Session 8. Growth monitoring and promotion

Why a child's length is measured?

Children who suffer from chronic undernourishment (in terms of protein-energy consumption), or chronic malnutrition, are short for their age, or simply defined as stunted. Stunting reflects failure to receive adequate nourishment over a long period of time and may also be caused by chronic or recurrent illnesses. The height of a child is compared to his/her age. Height-for-age is an indicator of nutritional status, and is used to identify stunted children. Children whose height-for-age is below -2 standard deviations from the median are classified as moderately stunted. Those whose height-for-age is below -3SD from the median, are classified as severely stunted.

Why is a child's MUAC taken?

Taking a child's *mid-upper arm circumference* (MUAC) measurement is both easy to teach and do. It can be applied to rapid triage settings especially where quick assessment of children is needed. MUAC measurement uses a tri-colored band (green, yellow and red) measuring tape that is positioned around the mid upper arm. Position and placement of tape are critical so that proper correlation can be made with the protein composition and lean tissue mass. MUAC measurement can be used as a screening criteria for referral to a health centre or admission to an outpatient therapeutic feeding center.

Learning Objective 2: Describe how to take anthropometric measurements of a child

Methodology: Demonstration, Discussion, Practical exercises

Instructions:

1. Show the participants the weighing scale (Salter scales), measuring boards and MUAC tapes.
2. Ask 2 participants in turns to demonstrate how to weigh a child, measure the height of a child, and how to measure the mid arm circumference of a child using a MUAC tape.
3. Ask participants to note down their observations in their block notes.
4. Ask participants to comment.
5. Make a summary explaining how to correctly take anthropometric measurements.
6. Re-demonstrate.

Key Information

How to correctly take a child's weight using a Salter scale

Follow these steps:

1. Hang the scale from a firm support with the dial at eye level so that it can be accurately read. Be sure that the scale hangs freely and does not touch the support or walls.
2. Every time before each session, check the scale with an object of a known weight to determine if the scale is recording correctly.
3. Attach the empty weighing pant to the hook of the scale and adjust the scale to zero. Every scale should have a screw or wheel that may be turned to adjust the scale. This is generally at the back. Be sure all the children will hang freely so that their hands and feet do not touch walls or the floor.
4. Have the mother remove child's clothes and shoes so that the child is weighed in underclothes only if you have not already done that.
5. Take the weighing pants from the scale and have the mother put the weighing pant on the child. Put your arms through the leg holes of the pants. The strap of the pants should be in front of the child.

Session 8. Growth monitoring and promotion

6. Have mother hang the straps of the pants, with the child in it, to the hook of the scale. One should not carry the child by the strap of the weighing pant only.
7. Gently lower the child and allow the child to hang freely, without touching anything. Have the mother face the child to help calm the child.
8. Wait until the child is still and the needle is steady, and then read the weight to the nearest 100gm. If the needle continues to swing slightly, estimate the mid-point of the swing and use that number as the weight. Find this point in the respective picture in the chart and mark it.
9. Have the mother remove the child from the scale with the same care you used to hang him or her there. Have the mother hold the child with one arm and take the weighing pants' strap off the lower hook with the other arm.
10. Tell the mother the current weight of the child.
11. Record the child's weight on the growth chart.

How to correctly measure a child's length (recumbent length) using a measuring board

Note: This is mainly for children who are below 24 months of age and those who cannot stand up straight without assistance. Measuring board should have a stationary headboard and moveable footboard that are perpendicular to the backboard.

1. Explain the procedure to the child's mother caretaker. For this measurement, two people are required to make the measurement.
2. Remove the child's shoes and any hair ornament or top knot (if any) on the child's head.
3. Position the child in the supine position (lying on his or her back).
4. Make sure that the zero end of the board is at the edge of the headboard and allow the child's length to be read from the footboard.
5. Tell the mother or caretaker to hold the child's head against the backboard with the crown of the head securely against the headboard and with Frankfort plane perpendicular to the backboard.
6. Tell the mother or caretaker to also keep the long axis of the child's body aligned with the centre line of the backboard, the child's shoulders and buttocks securely touching the backboard, and the shoulders and hips at right angles to the long axis of the body.
7. Keep the child's legs straight and against the backboard, slides the footboard against the bottom of the feet (without shoes or socks) with the toes pointing upward, and read the measurement.
8. The footboard should be pressed firmly enough to compress the soft tissues of the soles but without diminishing the vertebral column length. Length should be recorded to the nearest 0.1 cm.

How to correctly use a MUAC measuring tape with infants from 6 months of age and children up to 5 years of age

Follow these steps:

1. Keep your work at eye level. Sit down when possible. Very young children can be held by their mother. Ask the mother to remove clothing that may cover the child's left arm.
2. Calculate the midpoint of the child's left upper arm by first locating the tip of the child's shoulder with your finger tips. Bend the child's elbow to make a right angle. Place the tape at zero, which is indicated by two arrows, on the tip of the shoulder, and pull the tape straight down past the tip of the elbow. Read the number at the tip of the elbow to the nearest centimeter. Divide this number by two to estimate the midpoint. As an alternative to dividing the number by two, bend the tape up to the middle length to estimate the midpoint. A piece of string can also be used for this purpose. Either you or an assistant should then mark the midpoint with a pen on the arm.
3. Straighten the child's arm and wrap the tape around the arm at the midpoint. Make sure the numbers are right side up. Make sure the tape is flat around the skin.
4. Inspect the tension of the tape on the child's arm. Make sure the tape has the proper tension and is not too tight or too loose.
5. Repeat any steps as necessary.
6. When the tape is in the correct position on the arm, with the correct tension, read and call out the measurement to the nearest 0.1cm, and the colour zone observed (green, yellow or red).
7. Immediately record the measurement and the associated color.
8. Remove the tape from the child's arm.

Participant Material 8:1: 10 Steps for Weighing Children up to 25 kg

10 Steps for Weighing Children Up to 25 Kgs

1. Hook the scale to a tree, a tripod or a sturdy horizontal beam so that the scale hangs at eye level.
2. Suspend the weighing pants from the lower hook of the scale and readjust the scale to zero.
3. Undress the child and place in the weighing pants.
4. Make sure one of the child's arms passes in between the straps, to prevent him or her from falling.
5. Hook the pants to the scale.
6. Ensure that the child hangs freely without holding onto anything.
7. When the child is settled and the weight reading is stable record the weight to the nearest 0.1kg.
8. Read and announce the value from the scale. The mother or an assistant should repeat the value for verification. Record the weight immediately.
9. Plot the weight on the child's growth chart.
10. Discuss with the mother the actual change in weight and the expected change in weight, and most importantly the growth curve's trend.



Initial or Previous Month Weight	Minimum Expected Weight Gain Per Month
<5 Kg	0.5 Kg
5.7 Kg	0.4 Kg
7.9 Kg	0.3 Kg
9-12 kg	0.2 Kg
>12 Kg	0.1 Kg



(Adapted from a URC/Nutife job aid funded by USAID/Uganda.)

Participant Material 8.2: Using a Measuring Board to Take the Length of Children up to 24 months

Using a Measuring Board to Take the Length of Children up to 24 Months



- Place the head in Frankfort plane, with crown of head touching headboard.
- The shoulders and buttocks should touch the backboard.
- Place long axis of the body in line with the center line of the backboard.
- Place the heels flat against the footboard and read the length.

(Adapted from a URC/Nulife job aid funded by USAID/Uganda.)

Participant Material 8.3: Using a MUAC Tape for Nutritional Assessment

Using a MUAC Tape for Nutritional Assessment

Use with infants from 6 months of age, and children up to 5 years of age.



MUAC stands for "mid upper arm circumference" tape.

A MUAC measurement can be used for nutritional assessment of infants from 6 months and children up to 5 years of age.

MUAC is simple to use and requires no reference to age or height.

MUAC cut-off points or colour zones are used to classify acute malnutrition.

RED The red colour of the MUAC tape indicates severe acute malnutrition (SAM).

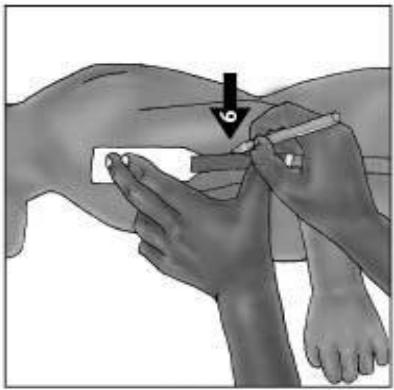
YELLOW The yellow colour indicates moderate acute malnutrition (MAM).

GREEN The green colour indicates mild or no malnutrition.

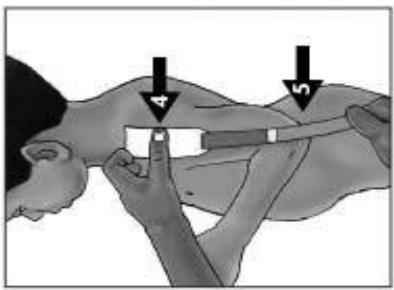
(Adapted from a URC/Nutlife job aid funded by USAID/Uganda.)

Participant Material 8.4: Steps to Accurately Use a MUAC Tape

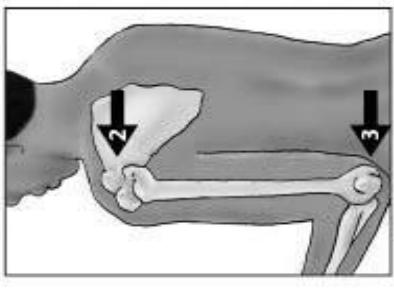
Steps to Accurately Use a MUAC Tape



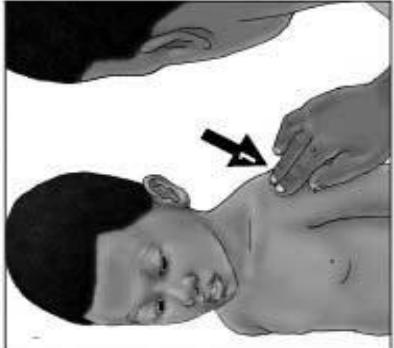
6. Determine mid-point by either:
- folding the tape in half from "0" to the measured length of upper arm, OR
- calculating



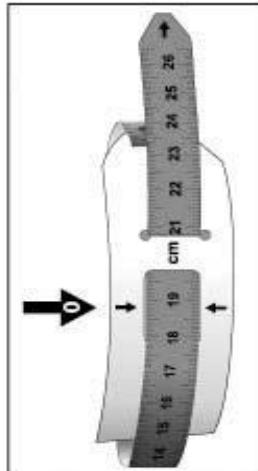
4. Place tape at 0 cm at tip of shoulder.
5. Pull tape past tip of bent elbow and read length of upper arm.



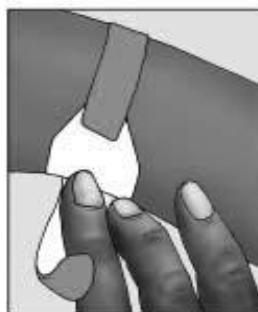
2. Locate tip of shoulder.
3. Locate tip of elbow.



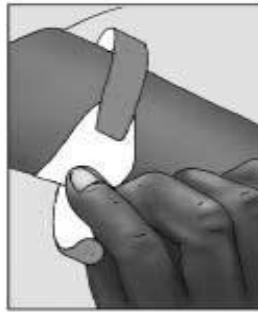
1. Bend left arm at an angle of 90 degrees.



7. Mark mid-point using finger or pen



10. Read the cm measurement in the window at arrow
11. Record measurement and the colour zone observed



- Tape too tight
Tape too loose
8. Straighten arm and place MUAC tape around the mid-point.
9. Place MUAC tape through "window" of tape, and correct the tape tension.



(Adapted from a URC/Nutlife job aid funded by USAID/Uganda.)

Learning Objective 3: List and demonstrate how to fill in the tools for anthropometric measurements follow-up

Methodology: Demonstration; lecture ; questions and responses; practical exercises

Instructions:

1. Provide each participant with two child growth charts. If there is not enough child growth charts, divide participants into 2 or more groups. Ask a volunteer to explain what he or she sees on first page of the card. Ask a second volunteer to look at the back and share with others what he or she sees. Provide extra explanations.
2. Ask participants to plot the child's weight from birth to 24 months of age (in turn if in groups) on the growth chart (Exercises A and B).
3. Distribute each participant/each group with a page of the community register to fill in (Exercise C) using data from exercises A and B. Assume that the two children were born in January. Write or tick (✓) in appropriate place.
4. Facilitator moves around to supervise the participants work and allows them to ask questions while doing the exercises.
5. Exercises can be done as individual work or group work.
6. During the exercises, the facilitator moves around to see the progress and to help as needed. The facilitator then collects all the plotted charts and gives feedback.
7. Ask participants to comment on the child growth curves. Provide more explanations as needed.
8. Allow the participants to ask questions before concluding the exercise.

A. Normal growth (ascending curve)

Age (Months)	0	1	2	3	4	5	6	7	8	9	10	11	12
Weight (Kg)	4	5	5.5	6.5	7.4	8	8.4	8.7	9.4	10	10.2	10.8	11

Age (Months)	13	14	15	16	17	18	19	20	21	22	23	24
Weight (Kg)	11.2	11.4	11.7	12.1	12.3	12.5	13	13.3	13.8	14	14.1	14.4

B. Malnutrition and/or illness

Age (Months)	0	1	2	3	4	5	6	7	8	9	10	11	12
Weight (Kg)	4	5	5.5	6.5	7.4	8	7	5.8	6	5.5	5.5	6	6

Age (Months)	13	14	15	16	17	18	19	20	21	22	23	24
Weight	7	7.2	7.3	7	6.8	7	7	7.5	8	8.4	9	9.4

C. Information to be collected in community registers

Session 8. Growth monitoring and promotion

Participant Material 8.5: Community Children Register

District:	Child ID Number:									
Health Center:	Child's names:									
Sector:	Sex (Male/Female):									
Cell:	Father's name:									
Village:	Mother's name:									
	Lives in HC's Catchment area (Yes/No):									
Year	Month of visit	Age (Months)	Weight (recorded to the nearest 0.1kg).	Growth chart			MUAC			Bilateral Oedema (Yes/No)
				Green	Yellow	Red	Weight curve ascending since the last visit (Yes/No)	Green	Yellow	
Exclusive breastfeeding for the first 6 months? (Yes/No)	Started the complementary feeding? (Yes/No)	If yes, at which age?	Child breastfed? (Yes/No)	Received Vitamin A? (Yes/No)	Received de-worming tablet? (Yes/No)	Receiving vaccines timely? (Yes/No)	Receiving RUTF? (Yes/No)			
Receiving CSB (Yes/No)	Received a home visit (Yes/No)	Separated meal preparation for the child (Yes/No)	Mother & Child pair received nutrition counseling (Yes/No)	Was referred at a Health Facility (Yes/No)	Re-joined the program in the Community (Yes/No)	No longer in the program (Yes/No)	Explanations			

Session 8. Growth monitoring and promotion

Participant Material 8.6: Pregnant or Lactating Women Register

District:	Woman's names: Pregnant/Lactating (Delete what is unnecessary)																														
Health Center:	Age:																														
Sector:	Matrimonial status (Married, widow, divorced/separated, single):																														
Cell:	Husband's name:																														
Village:	Lives in HC's Catchment area (Yes/No):																														
MUAC																															
Year	Month of visit	< 21 cm (Yes/No)	>21 cm (Yes/No)	Oedema (Yes/No)	Lactating mother with a child under 6 weeks (Yes/No)	Received Vitamin A? (Yes/No)	Received de-worming tablet? (Yes/No)	Receiving vaccines timely? (Yes/No)	Receiving RUTF? (Yes/No)	Receiving CSB? (Yes/No)																					
<table border="1"> <tr> <td>Received a home visit (Yes/No)</td> <td>Respectful of the ANC visits (Yes/No)</td> <td>Received Nutrition counseling (Yes/No)</td> <td>Was referred at a Health Facility (Yes/No)</td> <td>Re-joined the program in the Community (Yes/No)</td> <td>No longer in the program (Yes/No)</td> <td>Explanations</td> </tr> <tr> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> </table>											Received a home visit (Yes/No)	Respectful of the ANC visits (Yes/No)	Received Nutrition counseling (Yes/No)	Was referred at a Health Facility (Yes/No)	Re-joined the program in the Community (Yes/No)	No longer in the program (Yes/No)	Explanations														
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Key Information

How to fill the individual growth chart?

On the growth chart, there is a square ruled table with:

- Horizontal lines, showing the weights in kilograms;
- Vertical lines showing age in months; and
- Three oblique lines are found in the interior of the table that divides 3 color zones: green (indicating normal or good nutritional status); yellow (indicating moderate malnutrition); red (indicating severe malnutrition);
- Small rectangles with numbers of ages are found on the bottom of the table.
- On the child's first visit, fill the first rectangle with the month the child was born. Then, fill other rectangles according to the age of the child at each monthly visit.
- To record the weight, locate the left vertical line, starting at the current rectangle month and the horizontal weight line corresponding to the current weight. Mark a point (.) or a cross (X) where the two lines meet.
- In the same way, record the child's weight every month. The weight is recorded to nearest 0.1kg. If the weight doesn't fall on entire number for example 7.0, mark at estimated distance of the rectangle (assume you get 7.3, you mark at third distance).
- After two weighing sessions, you will have 2 points in the square ruled table. Using a ruler and a pen, link the two points with a straight line. This straight line, or multiple lines connecting additional points on the growth chart, is called the *growth curve*. The child's *growth curve* will be completed at each weighing session by linking the last plotted point to the new one, and so on.

How to fill the community register?

On the *Children Community Register*, you will find the following:

- Above the table, identification information that includes the sex of the child. The sex determines the type of growth chart to use because there are different growth charts for girls and boys.
- The table has been divided into multiple small tables in order to make it fit in a portrait format page. Otherwise, it is a solidified table with all indicators on a same line. Specific guidance is provided below to fill in the register:
 - In the 1st column, write down the current year.
 - Write down the month of the visit.
 - Under the title "Weight", record the child's weight to the nearest 0.1kg.
 - Tick (✓) inside the rectangle corresponding to the color (nutritional status)where the child's weight falls (consult the individual weight curve).
 - Fill in other columns as indicated.
 - Provide explanations where necessary.

Note: The pregnant and lactating women register is filled in the same way.

Learning Objective 4: Demonstrate how to interpret the anthropometric measurements (weight curve and MUAC)

Methodology: Individual child growth chart samples, presentation, questions and answers and practical exercises

Instructions:

- Show examples of different individual growth curves (including those built on Exercises A and B) and explain the different types of growth curves: ascending line, flat line, or down line.

Session 8. Growth monitoring and promotion

- Ask participants to comment on the trend of the child's curves. Provide more explanations.
- Show on the community growth chart the green, yellow and red zones. Give explanations.
- Explain the formulas to calculate percentages.
- Divide participants into 2 working groups.
- Provide each group with a community growth chart that has been filled in.
- Ask each group to calculate percentages of children in green, yellow and red zones.
- Ask a participant to make corrections on a flip chart as needed.
- Allow participants to ask questions.
- Give feedback for each exercise.

Key Information

How the growth curve is interpreted

- The trend of the growth curve is the most important thing. The increase of weight for age is more important than the weight itself at a given moment.
- The individual growth chart has 3 zones: green, yellow and red. The growth curve within these 3 zones can be an ascending line, a flat line or a down line.
- An adequately ascending curve shows that the child has gained weight, and is presumed to be well nourished. This indicates that his or her nutritional status is improving or continues to be good.
- An ascending curve that is starting to “flatten” may indicate that the child has been ill or inadequate food intake for his or her age.
- A flat line indicates that the child is faltering, due to illness and/or inadequate food intake for his or her age (the growth curve should always be ascending.)
- A down line curve indicates that the child has lost weight in comparison with the last month or months. This indicates serious growth faltering, and that his or her nutritional status is deteriorating. He or she may be suffering from an illness, which requires urgent attention and care. After 3 months without gaining weight, the child needs to be referred to a health center for assessment.
- Flat or down line growth curves indicate that the child is faltering. He or she is at risk and requires specific nutritional care. The nutrition behaviors and food security situation in the home should be assessed, and the mother and/or caregiver should be counseled on infant or young child feeding and care.
- A good curve must be always ascending

Note: It is rare to see a child's weight above the upper curve. If the weight is plotted above the curve, the mother or caregiver of the child often does not have his or her precise age. Rural parents sometimes do not recall the actual birth date, and therefore round the age of the child, either higher or lower than it really is. An effort should be made to determine the actual birth date with as much precision as possible.

Determine whether the child gaining adequate weight or not and counsel the mother

Compare the weight of the child for this month with the previous month and identify whether the child has gained adequate weight or not. To gain adequate weight means an increase of the minimum expected weight from the previous month's weight. If a child has gained less than the minimum expected weight or has not gained any weight or has lost weight (meaning this month's weight is less than previous), then the child is considered to be “faltering”. Participant's material 8.1 shows the expected weight gain per month.

Session 8. Growth monitoring and promotion

Based on the result of this weight comparison from the last and the current measurement, the CHW will start negotiation with the child caretaker using the pictorial counseling cards. The objective of this counselling is to negotiate with the mother or caretaker to reach an agreement on what she can do to maintain or improve the growth of her child by improving care and feeding practices of the young child at home. The agreement also helps to promote and maintain helpful family behavior, as well.

Learning Objective 5: Practise weighing and taking MUAC

Methodology: Taking weight and MUAC, observation, feedback

Instructions:

Note: Facilitators need to make an appointment in advance with mothers, fathers and/or caretakers of children under 2 years through a community leader or a health worker and tell the mothers, fathers and/or caretakers to bring the children's growth charts with them.

1. Prepare a room or another cool place to receive the mothers, fathers and/or caretakers and children
2. Tell the Participants to take turns or to work in couples (Measurements taker/Recorder), depending on the number of children available
3. Ask a Participant to introduce the activity to the mothers, fathers and/or caretakers
4. Practice taking the weights of each child
5. Practice taking the MUAC of each child
6. After taking the weight of all children, gather all the individual growth charts to plot on the Community growth curve.

Weighing steps:

1. Hook the scale to a tree, a tripod or a sturdy horizontal beam, so that the scale hangs at eye level.
2. Suspend the weighing pants from the lower hook of the scale and readjust the scale to zero.
3. Undress the child and place him or her in the weighing pants.
4. Make sure one of the child's arms passes in between the straps, to prevent him or her from falling.
5. Hook the pants to the scale.
6. Ensure that the child hangs freely without holding onto anything.
7. When the child is settled and the weight reading is stable record the weight to the nearest 0.1kg.
8. Read and announce the value from the scale. The mother or an assistant should repeat the value for verification. Record the weight immediately.
9. Plot the weight on the child's growth chart.
10. Discuss with the mother/father/caretaker the actual change in weight and the expected change in weight and most importantly the growth curve's trend

Steps to take a child's (or adult's) MUAC

1. Bend left arm at an angle of 90 degrees.
2. Locate tip of shoulder and tip of elbow
3. Place tape at 0 cm at tip of shoulder.
4. Pull tape past tip of bent elbow and read length of upper arm.

Session 8. Growth monitoring and promotion

5. Determine mid-point by either:
 - folding the tape in half from “0” to the measured length, OR
 - calculating
6. Mark mid-point using finger or pen.
7. Straighten arm and place MUAC tape around the mid-point.
8. Place MUAC tape through “window” of tape, and correct the tape tension. Not too loose/not too tight.
9. Read the cm measurement in the window at arrow.
10. Record measurement and the color zone observed.

Key information

- One way to find out if the child is growing well is to weigh the child regularly and identify if the child is gaining weight or not. Mothers, fathers and/or caretakers should be aware of the importance of taking regular monthly anthropometric measurements.
- A good weight curve is always ascending
- A MUAC measurement can be used for nutritional assessment of infants from 6 months and children up to 5 years of age
- MUAC cut-off points or color zones are used to classify acute malnutrition: The red color indicates severe acute malnutrition (SAM); the yellow color indicates moderate acute malnutrition (MAM) and the green color indicates mild or no malnutrition
- See participant materials 8.1: *10 steps for weighing children up to 25 kg*, 8.2: *Using a measuring board to take the length of children up to 24 months*, 8.3 *Using a MUAC tape for Nutritional Assessment*, and 8.4 *Steps to accurately use a MUAC tape?*
- Providing information to the mother, father and/or caregiver on the child’s growth and nutrition status, and providing MIYCN information and support is an important role of the community health worker.

Learning Objective 6 : Describe IYCF in the context of CMAM

Methodology: brainstorming, interactive presentation, group work

Instructions for Activity 1: CMAM

1. Present an overview of the ***management of severe acute malnutrition without complication***, sometimes referred to as community management of acute malnutrition (CMAM)
2. Ask participants to form working groups of 5 participants
3. Ask each group to write down on a flipchart what a CHW should do at every supplementary feeding program (SFP) and outpatient therapeutic program (OTP) session
4. Discuss and summarize

Instructions for Activity 2: SFP

1. Present an overview of the SFP
2. Explain the conditions of admission into SFP and how the treatment of malnourished children is conducted
3. Explain the follow-up of a child after discharge from outpatient care
4. Discuss and summarise

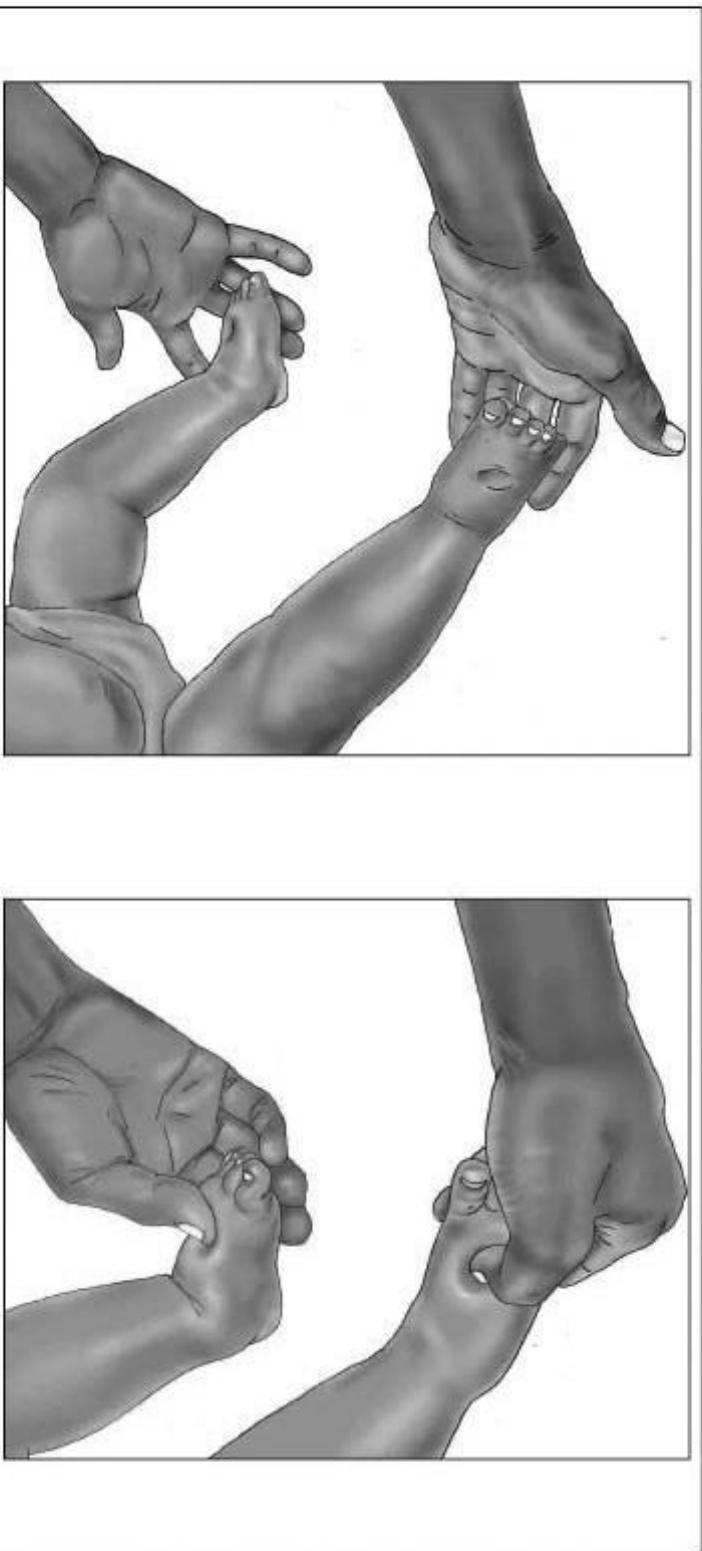
Instructions for Activity 3: Bilateral pitting oedema

1. Present an overview of assessing bilateral pitting oedema
2. Present an overview of why oedema is of nutritional significance only if it is bilateral and starts from the feet.
3. Demonstrate how to apply firm pressure with your thumbs to both feet for three full seconds then remove your thumbs.
4. Explain how to make an assessment of the grade for seriousness of the oedema.
 - Grade 1 (+): Is when a depression persists on both feet. This indicates that the patient has bilateral pitting oedema.
 - Grade 2 (+): Is when the feet are oedematous, and when you repeat the process by pressing the thumb into the leg, a depression persists.
 - Grade 3 (+): Is when the leg is oedematous, and when you repeat the process by pressing the thumb into the forehead, a depression persists.
5. Discuss how if an infant or young child is found to have bilateral pitting oedema, you should refer immediately to the health clinic for an evaluation and treatment.

Participant Material 8.7: How to Assess for Bilateral Pitting Oedema

How to Assess for Bilateral Pitting Oedema

1. Oedema is of nutritional significance only if it is bilateral and starts from the feet.
2. Apply firm pressure with your thumbs to both feet for three full seconds then remove your thumbs.
3. Make an assessment of the grade (or seriousness) of the oedema.
 - Grade 1 (+): is when a depression persists on both feet. This indicates that the patient has bilateral pitting oedema.
 - Grade 2 (++): is when the feet are oedematous, and when you repeat the process by pressing the thumb into the leg, a depression persists.
 - Grade 3 (+++): is when the leg is oedematous, and when you repeat the process by pressing the thumb into the forehead, a depression persists.
4. If an infant or young child is found to have bilateral pitting oedema, you should refer immediately to the health clinic for an evaluation and treatment.



(Adapted from a URC/Nutlife job aid funded by USAID/Uganda.)

Session 8. Growth monitoring and promotion

Key information

Management of severe acute malnutrition without complications

Admission to OTP

A child diagnosed with severe acute malnutrition without complications should be referred to the outpatient therapeutic program (OTP). Once a child is referred in this program support, the CHW is required to:

- Explain to the mother/caretaker that a child should be enrolled in the program to avoid that he/she develops complications;
- Explain the importance of the weekly medical checks at the health center by saying that a severely malnourished child is at risk of developing medical complications and die;
- Show the mother/caretaker the venue for nutrition education sessions counseling, and the room for the weekly food distribution rations.
- Explain to the mother/caretaker the importance of regular presence and proper use of Ready-to-Use Therapeutic Food (RUTF), as indicated in the national protocol for the management of malnutrition.
- Recommend to the mother/caretaker to visit the health centre immediately if the child refuses to eat or becomes ill;
- Verify the referral form provided by the health centre.
- Verify if the mother/caretaker of the child received a SFP education card

Participant Material 8.8: Referral Form for CHW

Date: _____ Age of Child: _____
Name: _____
Cell /Village: _____
MUAC: Red: _____ Yellow: _____ Green: _____
Oedema: Yes: _____ No: _____
Referred to Health Centre: _____
Referred by: _____
CHW's Contact: _____

.....

Date: _____ Health Centre: _____
Name of Child: _____
Name of Parent(s)/Caretaker(s): _____
Cell / Village: _____
Admitted to: Hospitalization: _____ PTA: _____ PAS: _____
Examined By: _____
Instructions: _____
CHW's: _____

Participant Material 8.9: Supplementary Feeding Program (SFP) Education Card

Patient Name		Name of accompanying parent			
Mutuelle N°		Identification Number (ID)			
Date	Topic of Educational Class	Place Class Was Held	Name of Instructor	Signature of Instructor (or HC stamp)	
	Birth preparedness before delivery				
	Exclusive breastfeeding				
	Complementary feeding				
	Meal planning				
	Basic hygiene				
	Prevention and treatment of diarrhea, malaria, and respiratory illness				
	Family planning				
	Importance of the role of the father in prevention of malnutrition				
	Nutritional Security				
	Other topics as appropriate				

** Sessions do not have to be attended in any particular order.

** Even if caregivers have previously attended these sessions in another programme, for reinforcement they should repeat the sessions in the SFP.

The CHW should organize weekly education sessions for the mothers/caretakers by covering important topics related to IYCF nutrition promotion. This will also be done at every SFP and OTP session. *It is the most important factor in treating and preventing malnutrition.*

- Identify and give support to very sick children before health education sessions.
- Counsel the individual caregivers on important topics such as:
 - Birth preparedness for delivery
 - CC 3-10 on exclusive breastfeeding
 - CC 13-17 on complementary feeding
 - Participant Material 7.1 on meal planning
 - Marasmus versus kwashiorkor (laminated training aids)
 - CC 11-12 on household hygiene and sanitation
 - Prevention and recognition of signs and symptoms of diarrhea, malaria, and respiratory illness

Session 8. Growth monitoring and promotion

- When and where to access health services
- Mutuelle membership
- CC 24 on family planning
- Importance of the role of the father in prevention of malnutrition
- Nutritional Security

OTP Nutritional Treatment

Therapeutic food (RUTF) will be given only to severely acute malnourished. Before giving RUTF, CHW should verify that caregiver and patient is attending medical checkups at the health centre by checking the patient's *OTP Monitoring Card* (Participants Material 8.10). Caregivers or patients must attend at least 1 educational session every 2 weeks in order to receive food ration. the *OTP Education Card* (Participants Material 8.11) must, therefore, also be checked as the caregiver may have attended a session at the health centre.

Participant Material 8.10: Outpatient Therapeutic Program (OTP) Monitoring Card

Patient Name					Name of accompanying parent					
Mutuelle N°					Identification Number (ID)					
Week	ADM.	2	3	4	6	8	10	12		
Date										
Anthropometric										
Weight (kg)										
Loss of weight *(Y/N)				*					*	
Height (cm)										
W/H (%) or BMI										
MUAC (cm)										
Oedema (+ ++ +++)										
<p>* Children with weight loss for 3 consecutive weeks or no weight gain by the 3rd month refer for inpatient treatment.</p>										
History										
Diarrhea (# days)										
Vomiting (# days)										
Fever (# days)										
Cough (# days)										
Physical Examination										
Temperature (°C)										
Respiratory rate(# / min)										
Dehydrated (Y/N)										
Anaemia (Y/N)										
Skin infection (Y/N)										
RUTF Test (Good/Ok/Refuse)										
Intervention needs (Y/N)** (write below)										
Other medications										
RUTF (# sachets)										
Consultant Name										
RESULTS ***										
<p>*** A= absent Ab= abandons (3 consecutive absences) T= transfer to inpatient HV=home visit X= deceased D= discharge and transfer to Supplementary Feeding Programme R= transfer refused NC= non-cured</p>										
** Action taken (to date)										

Participant Material 8.11: Outpatient Therapeutic Program (OTP) Education Card

Patient Name		Name of accompanying parent		
Mutuelle N°		Identification Number (ID)		
Date	Topic of Educational Class	Place Class Was Held	Name of Instructor	Signature of Instructor (or HC stamp)
	Birth preparedness before delivery			
	Exclusive breastfeeding			
	Complementary feeding			
	Meal planning			
	Basic hygiene			
	Prevention and treatment of diarrhea, malaria, and respiratory illness			
	Family planning			
	Importance of the role of the father in prevention of malnutrition			
	Nutritional Security			
	Other topics as appropriate			

** Sessions do not have to be attended in any particular order.

** Sessions are required while patient is on RUTF.

Session 8. Growth monitoring and promotion

Nutritional treatment is given through RUTF. It contains all of the energy and nutrients to meet the nutritional needs of the child and does not require any cooking or preparation. RUTF provides approximately 545 Kcal per 100g and the ration given to a child is based on the need for an intake of 175 - 200 kcal/kg/day. The amount of RUTF to be consumed per day is based on the weight of the child.

Using the RUTF ration table below determine the amount of RUTF required for a severely acutely malnourished child, given his or her current weight, taking into account the number of weeks before the next distribution.

Weight of Child (kg)	Packets per Day	Packets per week
3.5-3.9	1.5	11
4.0-5.4	2	14
5.5.-6.9	2.5	18
7.0-8.4	3	21
8.5-9.4	3.5	25
9.5-10.4	4	28
10.5-11.9	4.5	32
≥ 12	5	35

Source: Valid International. Community-based Therapeutic Care. 2006.

Give the required RUTF ration to the caregiver and advise on proper use (Participants materials 8.12 and 8.13). Caregivers should be advised not to mix RUTF with liquids, as this may foster bacteria.

Participant Material 8.12: RUTF Instructions to be Given to Caretaker

- 1) RUTF is both a food and a medicine. It is for children who are acutely ill. It should not be shared with anyone.
- 2) Sick children sometimes don't like to eat. You should give the child small portions of RUTF and encourage her or him to eat (up to 8 times per day)
- 3) The sick child should be given ____ number of packets of RUTF per day.
- 4) RUTF is the only food the child needs to recover during the course of treatment. Do not mix RUTF with liquid before serving.
- 5) For younger children, you should continue to breastfeed before giving RUTF. RUTF should always be fed after breastfeeding but before other food.
- 6) Offer the child milk or clean water while he or she is taking RUTF.
- 7) Wash your own hands and your child's hands and face with clean water and soap if possible before feeding RUTF. Keep all food clean and covered from flies.
- 8) Sick children get cold easily. Cover the child and keep him or her warm.
- 9) If the child gets diarrhea, don't stop feeding. If the infant or young child is still breastfeeding, increase breastfeeding, if possible. After feeding RUTF increase the amount of clean (boiled) water you give to the child. Additional food may also be given after RUTF if the child is still hungry.

Tell the caretaker to repeat these instructions to test that he or she understood.

Participant Material 8.13: Outpatient Therapeutic Program (OTP) Questions to ask Caregiver

These questions should be used to ensure the caregiver understands how to provide RUTF to the child.

1. How many packets should the child eat a day?
2. Should you mix RUTF need to be mixed with a liquid before feeding?
3. For younger children, should you breastfeed before or after feeding RUTF?
4. What can you do to ensure that your does not get sick?
5. How can you keep your child warm?
6. When should you come into the clinic next?

Supplementary Feeding Program (SFP) for Children with Moderate Acute Malnutrition without Medical Complications

Admission to SFP

Children may be admitted directly into SFP after being diagnosed with moderate to acute malnutrition without complications or transferred to the SFP after treatment in the OTP or Inpatient Malnutrition Unit (IMU). Once the child has been referred for management in the SFP, CHWs should do the following:

- Explain to the caregiver why the child should be in the program
- Explain to the caregiver the importance of returning to the health centre bi-weekly for medical check-ups
- Instruct the caregiver to return to a specified location within the community for weekly educational sessions and food distribution if applicable- caregiver may also go to the health centre for educational sessions.
- Explain the rules to be followed (regular attendance, proper use of supplementary food, if applicable, etc.), Participants Material 8.14: *Rules for patients and caregivers in SFP*
- Advise the caregiver to seek medical care immediately if the child refuses to eat or becomes ill
- Check *Referral Slip* (Participants Materials 8.8) given by the health centre.
- Check that the caregiver was given a *SFP Educational Card* (Participants Materials 8.9) by the health centre

Participant Material 8.14: Rules for Patients and Caregivers in Supplementary Feeding Program (SFP)

1. In order to receive monthly rations, the caregiver or patient should be attending at least 3 of the 4 bi-weekly sessions every two months either in the community or the health centre.
2. Ration should be given only to the malnourished child and is not to be shared with others.
3. The child should be brought to the nearest health facility immediately if any of the following symptoms develop.
 - Diarrhea
 - Vomiting
 - Cough
 - Anorexia, poor appetite
 - Fever
 - Not alert, very weak, apathetic, unconscious, or convulsions
 - Skin lesions
 - Difficult or fast breathing
4. Even if caregiver or patient has previously attended the health education sessions in another programme, for reinforcement they should repeat the sessions in the SFP.
5. Caregiver should be sure that the *Ration Card*, *Monitoring Card*, and *Educational Card* have been filled out by the appropriate health care worker before leaving the Health Centre on each visit.
6. Caregiver should not be discharged from the programme until all educational sessions have been attended

SFP Nutritional Treatment

Food supplementation will be given only to moderately malnourished children. All food ration distribution will be given by the CHW on a weekly basis. Caregivers or patients must attend at least 1 educational session every 2 weeks in order to receive the food ration. *SFP Education Card* must be checked for this as caregivers have attended a session at the health centre. *SFP Monitoring Card* should also be checked to assure that the caregiver is getting medical checkups bi-weekly at the health centre. Food distribution should occur after the Behaviour Change Communication session (Participants Material 8.15). Food is distributed by weight using a balance or calibrated container and should be transported home by caregivers in their own containers. Only if necessary, provide container.

Participant Material 8.15: Behaviour Change Communication

CHWs should have weekly sessions to educate caregivers on a variety of important topics. This will also be done at every SFP and OTP session and within the IMU. It is the most important factor in treating and preventing malnutrition.

- Identify and attend to very sick children before health education sessions.
- Counsel the individual caregivers on important topics such as:
 - Birth preparedness for delivery
 - Exclusive breastfeeding
 - Complementary feeding
 - Meal planning
 - Marasmus versus kwashiorkor
 - Household hygiene and sanitation
 - Prevention and recognition of signs and symptoms of diarrhea, malaria, and respiratory illness
 - When and where to access health services
 - Mutuelle membership
 - Family planning
 - Importance of the role of the father in prevention of malnutrition
 - Nutritional Security

The ration for one child per day should provide a maximum of 1000 to 1200 kcal/person/day and 10-12% of energy from protein. The following foods may be used:

- Corn soy blended cereal: (Participants materials 8.17: SFP ration card)
 - Provides 350-400 kcal per 100 g of dry product
 - Supplementary feeding should be added to blended cereals which are not pre-fortified
 - Blended cereals are often mixed with sugar prior to distribution to increase energy density. The caregiver can be taught to add oil when cooking.
- Local foods and family diets
 - Where possible, supplementary rations should be based on locally available foods such as beans, rice, and vegetables purchased or grown locally.
 - Where animal source foods are in limited supply, a fortified food or a micronutrient supplement should be added.
- High-energy and protein (HEP) biscuits
 - Long term dependence on these products should be avoided.
 - These products should not be given priority over locally available products.
- Ready-to-use-supplementary food (RUSF) (Participants Materials 8.16: *SFP Ration Card*)
 - This is similar to the product used in severe acute malnutrition that has been adapted for moderate malnutrition.
 - These products should not be given priority over locally available products.
- Whole or dry skimmed milk powder
 - Should not be distributed alone as a dry ration because when mixed with water becomes an ideal growth medium for bacteria and causes diarrhoea.
 - Can be added to a blended food pre-mix for distribution.

Participant Material 8.16: Supplementary Food Rations

PREMIX (Corn Soy Blend + Oil + Sugar)

1. Corn soy blend (CSB) dry rations for management of moderate malnutrition

Product	Quantity per day (in gr)	Quantity for a week (in gr)	Quantity for 2 weeks (in gr)
CSB (in gr)	200	1400	2800
Oil (in gr)	25	175	350
TOTAL	225	1575	3150
Total kcal	1021		
% protein	14.1%		
% lipid	32.6%		

Preparation of the PREMIX with CSB (1 sac of CSB = 25kg)

CSB (in kg)	Oil (in kg)	Total	Number of children/week	Number of children/2 weeks
25	3.125	28.1	18	9
50	4.625	54.6	35	17
75	6.125	81.1	52	26
100	7.625	107.6	68	34
125	9.125	134.1	85	43
150	10.625	160.6	102	51
175	12.125	187.1	119	59
200	13.625	213.6	136	68

2. UNIMIX dry rations for management of moderate acute malnutrition

Product	Quantity per day (in gr)	Quantity for a week (in gr)	Quantity for 2 weeks (in gr)
Unimix (in gr)	270	1890	3780
Oil (in gr)	20	140	280
TOTAL	290	2030	4060
Total kcal	1192		
% protein	15.6%		
% lipid	29.1%		

Preparation of the PREMIX with UNIMIX (1 sac of Unimix = 25kg)

CSB (in kg)	Oil (in kg)	Total	Number of children/week	Number of children/2 weeks
25	1.8	26.8	13	7
50	3.6	53.6	27	13
75	5.4	80.4	40	20
100	7.2	107.2	54	27
125	9.0	134.0	67	34
150	10.8	160.8	80	40
175	12.6	187.6	94	47
200	14.4	214.4	107	54

Sprinkles

- Daily micronutrient supplement
- Added to child's meals

Session 8. Growth monitoring and promotion

SFP Home Visits Follow-up

Children should receive a home visit if:

- Child is continuing to have weight loss or no weight gain despite involvement in the program.
- The child has been absent or defaulted from the program

The CHWs should visit the patients at their homes between the SFP sessions if the child requires special attention to check the child's health and the caregiver's compliance with the SFP protocol.

All absences from SFP medical check-ups should be followed up by CHWs. It is important to gain an understanding of the reason for absence and to encourage return. The absentee should not be reprimanded as this can discourage return. Instead, information on reasons for absence should be used to see if there are ways that the organization of the program could be modified to facilitate caregivers being able to attend each distribution.

The CHWs should record all follow-up visits on the patient's *SFP Ration Card* (Participants Material 8.17) and report the results.

Participant Material 8.17: SFP Ration Card

Mutuelle N° Centre de Santé Mother's Name Name			Ident. N° Village		
			Sex of Child	M/F	
		Age		Birth weight	
Distribution/Week					
Date					
Weight (kg)					
MUAC					
Ration (type and quantity)					

Follow-up of child after discharge from outpatient care

- Growth monitoring promotion (GMP) or well baby sessions
- Immunization sessions
- At every contact with mothers or caregivers of sick children
- Community follow-up
 - Action-oriented group session
 - IYCF support groups
 - MUAC screening sessions
- Supplementary Feeding Programme (SFP)

Messages must be reinforced by practice

Session 8. Growth monitoring and promotion

- Practise good hygiene (see CC 11-12)
- Continue optimal feeding of infants and young children from 6 up to 24 months (See CC 2 to 10, and CC 13 to 17; Brochures: *How to breastfeed your baby* and *How to feed a baby after 6 months*; and Participant Materials 5.2, 7.1, 7.2, and 7.3)
- Practise frequent and active feeding (Participant Material 7.4)
- Identify local foods to give to young children (Participant Material 7.2)

Other activities

- Identify undernutrition (when to bring children to outpatient care)
- Manage diarrhea and fever
- Recognise danger signs (see CC 19)
- Assess what challenges may be hindering the child's recovery
- Support the family to help the child recover through counselling, education and close monitoring of the child's progress
- Make sure the child is enrolled in and attending any support programmes that are available, such as supplementary feeding or a social protection programme

Learning Objective 7: Explain the system of documentation and reporting in MIYCN and the use of the reporting forms

Methodology: Demonstration; discussion; practical exercises; presentation

Instructions:

1. Explain the system of reporting in MIYCN
2. Divide participants into small groups of 2 or 3 people
3. Provide each group with:
 - A page of the register for pregnant or lactating women
 - A page of the register for children
 - Monthly report form for CHWs or health centers (depending on who is being trained)
4. Ask participants in each group to look at the registers and the form one by one to understand all the indicators
5. Ask each group to fill in the register for women and the register for children with imaginary but logic information (example: the age of the child, his/her weight must be logically corresponding to the color zone he/she is placed on the growth chart)
6. Divide participants into 3 groups
7. Provide each group with 4 filled in pages of the register for pregnant or lactating women and 4 filled in pages of the register for children all gathered from the small groups
8. Ask the 3 groups to fill in the monthly report form for CHWs (or health centers) using the information on pages they were given
9. Facilitators turn around to help and to respond to any asked question
10. Invite in turn the big groups to present their monthly reports
11. Discuss and summarize

Key Information

- A register is used to record individual information
- The report form serves to record and report collective information
- Working without reporting may be interpreted as not working
- One cannot report adequately if he/she has not been regularly recording appropriate information about the work done
- Accurate information is required in reporting: recorded information must reflect the reality.
- The reporting system in MIYCN is pyramidal from the village to the national level
- Accurate information provided helps the health and administrative responsible to take appropriate decisions to address problems
- Regular and timely reporting is required to enable responsible to do a good follow-up and conduct appropriate punctual actions.

SESSION 9. COMMON BREASTFEEDING DIFFICULTIES: SYMPTOMS, PREVENTION AND ‘WHAT TO DO’

Learning Objectives	Methodologies	Training Aids
1. Identify common breastfeeding difficulties.	Brainstorming	Photos of breast engorgement, sore/cracked nipple, plugged duct and mastitis
2. Describe the symptoms and prevention of common breastfeeding difficulties, and “not enough” breast milk	Group work	<ul style="list-style-type: none"> • Participant Material 9.1: <i>Common breastfeeding difficulties</i> • Participant Material 9.2: “<i>Not enough</i>” <i>breast milk</i> • Brochure: <i>How to Breastfeed Your Baby</i>
3. Help mothers to overcome these common breastfeeding difficulties, and “not enough” breast milk		
4. Describe re-lactation	Interactive presentation	

Materials:

- Photos of breast engorgement, sore/cracked nipple, plugged duct and mastitis
- Flipchart papers and stand (+ markers + masking tape or sticky putty)
- Breast models

Advance Preparation:

- Flipcharts: 4 flipcharts with one of the following headings: 1) breast engorgement, 2) sore/cracked nipple, 3) plugged duct and mastitis, and 4) “not enough” breast milk

Duration: ½ hour

Learning Objective 1: Recognise common breastfeeding difficulties that can occur during breastfeeding

Methodology: Brainstorming

Instructions:

1. Brainstorm common breastfeeding difficulties that Participants have identified in their communities.
2. As Participants mention each breastfeeding difficulty, put an image of the mentioned difficulty on the floor or stick on the wall so that all can see (Participants may also mention inverted nipples, low birth weight baby and refusal to breastfeed)
3. Probe until all images are displayed (breast engorgement, sore/cracked nipple, plugged duct and mastitis).
4. Participants usually mention “not enough” breast milk as a common breastfeeding difficulty.
5. Explain that worldwide, women complain of: 1) breast engorgement; 2) sore/cracked nipple; 3) plugged duct/mastitis; and 4) “not enough” breast milk

Key Information

See photos of breast engorgement, sore/cracked nipple, plugged duct and mastitis

Baby who refuses the breast

Usually refusal to breastfeed is the result of bad experiences, such as pressure on the head. Refusal may also result when mastitis changes the taste of the breast milk (more salty).

- Check baby for signs of illness that may interfere with feeding, including looking for signs of thrush in the mouth.
- Refer baby for treatment if ill.
- Let the baby have plenty of skin-to-skin contact; let baby have a good experience just cuddling mother before trying to make baby suckle; baby may not want to go near breast at first – cuddle in any position and gradually over a period of days bring nearer to the breast.
- Let baby try lots of different positions.
- Wait for the baby to be wide awake and hungry (but not crying) before offering the breast.
- Gently touch the baby’s bottom lip with the nipple until she or he opens mouth wide.
- Do not force baby to breastfeed and do not try to force mouth open or pull the baby’s chin down – this makes the baby refuse more.
- Do not hold baby’s head.
- Express and feed baby by cup until baby is willing to suckle.
- Express directly into baby’s mouth.
- Avoid giving the baby bottles with teats or dummies.

Learning Objective 2: Describe the symptoms and prevention of common breastfeeding difficulties and “not enough” breast milk;

Learning Objective 3: Help mothers to overcome these common breastfeeding difficulties and “not enough” breast milk

Methodology: Group work

Instructions:

1. Divide Participants into 4 working groups and assign a common breastfeeding difficulty, with corresponding photo, to each group: breast engorgement, sore and cracked nipples, plugged ducts that can lead to mastitis, or “not enough” breast milk.
2. Ask each group to discuss symptoms, prevention and “what to do” for the assigned common breastfeeding difficulty or “not enough” breast milk.
3. Each group presents their findings to the whole group.
4. Ask other groups to contribute any additional points.
5. Facilitator fills-in gaps.
6. Address other common difficulties that were mentioned.
7. Distribute from Participant Material 9.1: *Common breastfeeding difficulties* (or refer to specific page in Participant Materials)
8. Distribute from Participant Material 9.2: *“Not enough” breast milk* (or refer to specific page in Participant Materials)
9. Distribute, and orient Participants on Brochure: *How to Breastfeed Your Baby*
10. Discuss and summarize.

Key Information

- See Participant Material 9.1: *Common breastfeeding difficulties*
- See Participant Materials 9.2: *“Not enough” breast milk*
- “Not enough” breast milk is one of the most common reasons that mothers introduce breast milk substitutes or foods, and give up breastfeeding. However, true breast milk insufficiency is not as common as mothers believe.

Learning Objective 4: Describe relactation

Methodology: Interactive presentation

Instructions:

1. Ask Participants the following questions:
 - a) Who can relactate?
 - b) What is needed to successfully relactate?
 - c) What is the length of time for relactation?
2. Discuss and summarize

Key Information

Relactation: re-establishing breastfeeding after a mother has stopped, whether in the recent or distant past.

Who can relactate?

- Women who have breastfed in the past, or whose breast milk production has diminished, can be helped to breastfeed again.

What is needed for successful relactation?

- Woman’s motivation
- Infant’s frequent suckling
- Skilled staff with adequate time to spend helping mothers
- A designated area where progress can be followed
- Whenever possible women who have experience in relactation giving help to others
- Support for continued breastfeeding
- Sometimes a breastfeeding supplementer or a fine tube and syringe is required. Refer to health facility (management could also be done in the home by a CHW with special training).

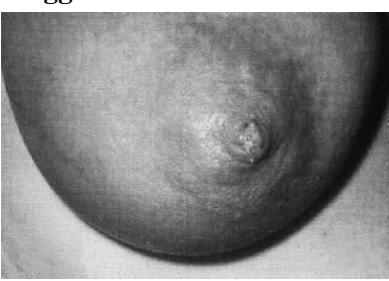
What is the length of time for relactation?

- Varies, depending on mother’s strong motivation, and if her baby is willing to suckle frequently.
- If a baby is still breastfeeding sometimes, the breast milk supply is likely to increase in a few days.
- If a baby has stopped breastfeeding, it may take 1 to 2 weeks or more before much breast milk comes.
- It is easier for a mother to relactate if a baby is very young (less than 2 months) than if he or she is older (more than 6 months). However, it is possible at any age.
- It is easier if a baby stopped breastfeeding recently, than if he stopped a long time ago.
- A woman who has not breastfed for years can produce milk again, even if she is postmenopausal. For example - a grandmother can breastfeed a grandchild.

Participant Material 9.1: Common Breastfeeding Difficulties

Breastfeeding difficulty	Prevention	What to do
Breast engorgement  Photo by Mwate Chintu Symptoms: <ul style="list-style-type: none"> • Occurs on both breasts • Swelling • Tenderness • Warmth • Slight redness • Pain • Skin shiny, tight and nipple flattened and difficult to attach • Can often occur on 3rd to 5th day after birth (when milk production increases dramatically and suckling not established) 	<input type="checkbox"/> Start breastfeeding within an hour of birth <input type="checkbox"/> Good attachment <input type="checkbox"/> Breastfeed frequently on demand (as often and as long as baby wants) day and night: 8 to 12 times per 24 hours <input type="checkbox"/> Don't stop breastfeeding abruptly	<input type="checkbox"/> Improve attachment <input type="checkbox"/> Breastfeed more frequently <input type="checkbox"/> Gently stroke breasts to help stimulate milk flow <input type="checkbox"/> Press around areola to reduce swelling, to help baby to attach <input type="checkbox"/> Offer both breasts <input type="checkbox"/> Express milk to relieve pressure until baby can suckle <input type="checkbox"/> Apply warm compresses to help the milk flow before expressing <input type="checkbox"/> Apply cold compresses to breasts to reduce swelling after expression
Sore or Cracked Nipples  Photo by F. Savage King Symptoms: <ul style="list-style-type: none"> • Breast/nipple pain • Cracks across top of nipple or around base • Occasional bleeding • May become infected 	<input type="checkbox"/> Good attachment <input type="checkbox"/> Do not use feeding bottles (sucking method is different than breastfeeding so can cause ‘nipple confusion’) <input type="checkbox"/> Do not use soap or creams on nipples	<input type="checkbox"/> Do not stop breastfeeding <input type="checkbox"/> Improve attachment making certain baby comes onto the breast from underneath and is held close <input type="checkbox"/> Begin to breastfeed on the side that hurts less <input type="checkbox"/> Change breastfeeding positions <input type="checkbox"/> Let baby come off breast by him/herself <input type="checkbox"/> Apply drops of breast milk to nipples when the baby gets off the breast <input type="checkbox"/> Do not use soap or cream on nipples <input type="checkbox"/> Do not wait until the breast is full to breastfeed <input type="checkbox"/> Do not use bottles

Session 9. Common breastfeeding difficulties: symptoms, prevention and ‘what to do’

Breastfeeding difficulty	Prevention	What to do
<p>Plugged Ducts and Mastitis</p>  <p>Photo by F. Savage King</p> <p>Symptoms:</p> <ul style="list-style-type: none"> • Lump, tender, localized redness, feels well, no fever <p>Symptoms:</p> <ul style="list-style-type: none"> • Hard swelling • Severe pain • Redness in one area • Generally not feeling well • Fever • Sometimes a baby refuses to feed as milk tastes more salty 	<ul style="list-style-type: none"> <input type="checkbox"/> Get support from the family to perform non-infant care chores <input type="checkbox"/> Ensure good attachment <input type="checkbox"/> Breastfeed on demand, and let infant finish/come off breast by him/herself <input type="checkbox"/> Avoid holding the breast in scissors hold <input type="checkbox"/> Avoid tight clothing 	<ul style="list-style-type: none"> <input type="checkbox"/> Do not stop breastfeeding (if milk is not removed risk of abscess increases; let baby feed as often as he or she will) <input type="checkbox"/> Apply warmth (water, hot towel) <input type="checkbox"/> Hold baby in different positions, so that the baby’s tongue/chin is close to the site of the plugged duct/mastitis (the reddish area). The tongue/chin will massage the breast and release the milk from that part of the breast. <input type="checkbox"/> Ensure good attachment <input type="checkbox"/> For plugged ducts: apply gentle pressure to breast with flat of hand, rolling fingers towards nipple; then express milk or let baby feed every 2-3 hours day and night <input type="checkbox"/> Rest (mother) <input type="checkbox"/> Drink more liquids (mother) <input type="checkbox"/> If no improvement in 24 hours refer <input type="checkbox"/> If mastitis: express if too painful to suckle <input type="checkbox"/> Seek for further treatment at the health facility

Participant Material 9.2: “Not Enough” Breast Milk

“Not enough” breast milk	Prevention	What to do
<p>Perceived by mother</p> <ul style="list-style-type: none"> • You “think” you do not have enough milk • (Baby restless or unsatisfied) <p>First decide if the baby is getting enough breast milk or not (weight, urine and stool output)</p>	<ul style="list-style-type: none"> <input type="checkbox"/> Put baby skin-to-skin with mother <input type="checkbox"/> Start breast feeding within an hour of birth <input type="checkbox"/> Stay with baby <input type="checkbox"/> Ensure good attachment <input type="checkbox"/> Encourage frequent demand feeding <input type="checkbox"/> Let baby empty the first breast first <input type="checkbox"/> Breastfeed exclusively day and night <input type="checkbox"/> Avoid bottles <input type="checkbox"/> Encourage use of suitable family planning methods 	<ul style="list-style-type: none"> <input type="checkbox"/> Listen to mother’s concerns and why she thinks she does not have enough milk <input type="checkbox"/> Decide if there is a clear cause of the difficulty (poor breastfeeding pattern, mother’s mental condition, baby or mother ill) <input type="checkbox"/> Check baby’s weight and urine and stool output (if poor weight gain refer) <input type="checkbox"/> Build mother’s confidence – reassure her that she can produce enough milk <input type="checkbox"/> Explain what the difficulty may be - growth spurts (2 to 3 weeks, 6 weeks, 3months) or cluster feeds <input type="checkbox"/> Explain the importance of removing plenty of breast milk from the breast <input type="checkbox"/> Check and improve attachment <input type="checkbox"/> Suggest stopping any supplements for baby – no water, formulas, tea, or liquids <input type="checkbox"/> Avoid separation from baby and care of baby by others (express breast milk when away from baby) <input type="checkbox"/> Suggest improvements to feeding pattern. Feed baby frequently on demand, day and night. <input type="checkbox"/> Let the baby come off the breast by him/herself <input type="checkbox"/> Ensure mother gets enough to eat and drink that helps her to ‘make milk’ <input type="checkbox"/> The breasts make as much milk as the baby takes – if he or she takes more, the breasts make more (the breast is like a ‘factory’ – the more demand for milk, the more supply) <input type="checkbox"/> Ensure that the mother and baby are skin-to-skin as much as possible.
<ul style="list-style-type: none"> • Baby is not gaining weight: trend line on growth chart for infant less than 6 months is flat or slopes downward • For infants after day 4 up to 6 weeks: at least 6 wets and 3 to 4 stools/ day 	<input type="checkbox"/> Same as above	<ul style="list-style-type: none"> <input type="checkbox"/> Same as above <input type="checkbox"/> If no improvement in weight gain after 1 week, refer mother and baby to nearest health facility

SESSION 10. HOW TO COUNSEL MOTHER/FATHER/CAREGIVER: PART II

Learning Objectives	Methodologies	Training Aids
1. Describe <i>IYCF 3-Step Counselling</i> (assess, analyse and act)	<ul style="list-style-type: none"> • Demonstration • Interactive Presentation 	Participant Material 10.1: <i>IYCF Assessment of Mother/Child Pair</i>
2. Name <i>Building Confidence and Giving Support skills</i>	Brainstorming	Participant Material 10.3: <i>Building Confidence and Giving Support skills</i>
3. Practise <i>IYCF 3-Step Counselling</i> with mother/father/caregiver.	Practise	<ul style="list-style-type: none"> • Participant Material 10.1: <i>IYCF Assessment of Mother/Child Pair</i> • Participant Material 10.2: <i>Observation Checklist for IYCF Assessment of Mother/Child Pair</i> • CC with Key Messages • Brochure: <i>How to Breastfeed Your Baby</i> • Brochure: <i>How to Feed your Baby After 6 Months</i>
4. Mention where IYCF 3-Step Counselling can be conducted	Buzz groups	

Materials:

- 3 Case Studies
- Flipchart papers and stand (+ markers + masking tape or sticky putty)
- Photocopies of Participant Materials 10.1: *IYCF Assessment of Mother/Child Pair* (3 per Participant)
- Laminated copy of Participant Materials 10.1: *IYCF Assessment of Mother/Child Pair* (1 per Participant)

Advance Preparation:

- Facilitators practise demonstration of *IYCF Assessment of Mother/Child Pair (IYCF 3-Step Counselling)*
- On a separate paper, list the section ‘Read to Mothers’ from the 3 Case Studies.

Duration: 2 hours

Learning Objective 1: Describe IYCF 3-Step Counselling (assess, analyse and act)
Methodology: Demonstration; interactive presentation

Instructions:

Note: Two Facilitators need to prepare this demonstration in advance (one Facilitator acts as a Mother and the other as a Counsellor)

1. Review with Participants the points covered to demonstrate listening and learning skills between a mother (Mukamana) with 7-month son Murenzi and Counsellor (assess)

Facilitator/Mukamana:

- breastfeeds whenever Murenzi cries
- feels she does not produce enough milk
- gives Murenzi some watery porridge 2 times a day (porridge is made from corn meal)
- does not give any other milks or drinks to Murenzi

2. Facilitator to speak out loud to group during Step 2 - Analyze

3. Facilitator Counsellor completes Participant Material 10.1: *IYCF Assessment of Mother/Child Pair* by following *IYCF 3-Step Counselling*:

4. **Step 1: Assess**

- Greet mother and introduces yourself
- Allow mother to introduce herself and the baby.
- Use *listening and learning* skills, and *building confidence and giving support* skills
- Complete Participant Material 10.1: *IYCF Assessment of Mother/Child Pair*
- Listen to Mukamana's concerns, and observe Murenzi and Mukamana
- Accept what Mukamana is doing without disagreeing or agreeing and praise Mukamana for one good behaviour

5. **Step 2: Analyze**

Facilitator/Counsellor notes that:

- Mukamana is waiting until Murenzi cries before breastfeeding him – a 'late sign' of hunger
- Mukamana is worried she does not have enough breast milk
- Mukamana is not feeding Murenzi age-appropriate complementary foods

6. **Step 3: Act**

- Praise Mukamana for breastfeeding
- Ask Mukamana about breastfeeding frequency and if she is breastfeeding whenever Murenzi wants and for as long as he wants, both day and night. Does Murenzi come off breast himself? Is Murenzi fed on demand? (discuss age-appropriate recommended breastfeeding practices)
- Suggest that Mukamana breastfeed Murenzi when he shows interest in feeding (before he starts to cry)
- Share with Mukamana and discuss CC 5: *Breastfeed on demand, both day and night* and

Brochure: *How to Breastfeed Your Baby*

- Talk with Mukamana about the characteristics of complementary feeding
 - Present options/small do-able actions (time-bound) to overcome the difficulty of inadequate complementary feeding: F = Frequency of feeding, T = Texture (thickness/consistency) and V = Variety
 - Help Mukamana select one that she can try (e.g. breastfeed more frequently day and night, thicker porridge, add family foods during this week)
 - Share with Mukamana and discuss CC 14: *Complementary feeding from 6 up to 9 months* and Brochure: *How to Feed your Baby After 6 Months*
 - Ask Mukamana to repeat verbally the agreed upon behaviour
 - Tell Mukamana that a Counsellor will follow-up with her at her next weekly visit
 - Suggest where Mukamana can find support (attend educational talk, IYCF support groups in community, supplementary feeding programme, and refer to a Community Volunteer).
 - Refer as necessary
 - Thank Mukamana for her time
7. Discuss the demonstration with Participants and answer questions
 8. Review and complete together/or talk through Participant Material 10.1: *IYCF Assessment of Mother/Child Pair*
 9. Discuss and summarize

Key Information

- The *IYCF 3-Step Counselling* process involves:
 - Assess age appropriate feeding and condition of mother/father/caregiver and child: ask, listen and observe
 - Analyze feeding difficulty: identify difficulty and if there is more than one - prioritize, and
 - Act: discuss and suggest small amount of relevant information, agree on feasible doable option that mother/father/caregiver can try
- Purpose: provide IYCF information and support to the mother/father/caregiver
- See Participant Materials 10.1: *IYCF Assessment of Mother/Child Pair*
- Explain the *IYCF 3-Step Counselling*: Assess, Analyze, Act

Session 10. How to counsel mother/father/caregiver: Part II

Step 1: Assess

- Greet the mother/father/caregiver and ask questions that encourage her/him to talk, using *listening and learning, building confidence and giving support* skills.
- Complete Participant Materials 10.1: *IYCF Assessment of Mother/Child Pair* by asking the following questions:
 - a) What is your name and your child's name?
 - b) What is the age of your child?
 - c) Has your child been recently sick? If presently sick, refer mother to health facility.
 - d) Ask mother/father/caregiver if you can check child's growth card. Is growth curve increasing? Is it decreasing? Is it levelling off?
 - e) If the child doesn't have a growth chart, make one for him/her
 - f) Ask mother/father/caregiver how he or she thinks the child is growing?
 - g) Ask about the child's usual intake of:

Breastfeeding:

- About how many times/day do you usually breastfeed your baby? *frequency*
- How is breastfeeding going for you? *possible difficulties*
Observe mother and baby's general condition
Observe baby's position and attachment

Complementary foods:

- Is your child getting anything else to eat? *what type/kinds*
- How many times/day are you feeding your child? *frequency*
- How much are you feeding your child? *Amount*
- How thick are the foods you give your child? *texture (thickness/consistency: mashed, sliced, chunks)*

Other milks:

- Is your child drinking other milks?
- How many times/day does your child drink milk? *frequency*
- How much milk? *amount*
- If breastfeeding, why do you think baby needs additional milk?

Other liquids:

- Is your child drinking other liquids? *What kinds?*
 - How many times/day does your child drink “other liquids”? *frequency*
 - How much? *Amount*
- h) Does your child use a cup? (If mother says “no”, then ask “What does your child use to drink from?”)
- i) Who assists child to eat?
- j) Are there other challenges mother faces in feeding the child?

Session 10. How to counsel mother/father/caregiver: Part II

Step 2: Analyze

- Is feeding age-appropriate? Identify feeding difficulty (if any)
- If there is more than one difficulty, prioritize difficulties
- Answer the mother's questions (if any)

Step 3: Act

- Depending on the age of the baby and your analysis (above), select a small amount of relevant information to the mother's situation (if there are no difficulties, praise the mother for carrying out the recommended breastfeeding and complementary feeding practices).
- Praise mother.
- For any difficulty, discuss with mother/father/caregiver how to overcome the difficulty.
- Present options/small doable actions (time-bound) and help mother select one that she can try to overcome the difficulty.
- Share with mother/father/caregiver appropriate *Counselling Cards* and discuss
- Ask mother to repeat the agreed upon new behaviour to check her understanding.
- Let mother know that you will follow-up with her at the next weekly visit.
- Suggest where mother can find additional support (e.g. attend educational talk, IYCF support groups in community, confirm that the mother knows (or knows how to access) the community worker), supplementary feeding programme (if available) in cases where food availability is a constraint in feeding children, or a social protection programme for vulnerable children (if available).
- Refer as necessary.
- Thank mother for her time.

Learning Objective 2: Name *Building Confidence and Giving Support* skills

Methodology: Brainstorming

Instructions:

1. Brainstorm with whole group on *Building Confidence and Giving Support* skills by asking Participants: What helps to give a mother/father/caregiver confidence and support?
2. Probe until the skills in 'Key Information' below have been mentioned and list on flipchart.
3. Refer Participants to Participant Material 10.3: *Building Confidence and Giving Support* skills
4. Discuss and summarize.

Key Information

Building Confidence and Giving Support skills

1. Accept what a mother/father/caregiver thinks and feels (to establish confidence, let the mother/father/caregiver talk through her/his concerns before correcting information)
2. Recognize and praise what a mother/father/caregiver and baby are doing correctly
3. Give practical help
4. Give a little, relevant information
5. Use simple language

Session 10. How to counsel mother/father/caregiver: Part II

6. Use appropriate counselling card or cards
7. Make one or two suggestions, not commands

Learning Objective 3: Practise IYCF 3-Step Counselling

Methodology: Practise

Instructions:

1. Participants are divided into groups of three: Mother, Counsellor, and Observer.
2. Distribute Participant Material 10.1: *IYCF Assessment of Mother/Child Pair* (or refer to specific page in Participant Material) to Counsellors.
3. Distribute Participant Material 10.2: *Observation Checklist for IYCF Assessment of Mother/Child Pair* (or refer to specific page in *Participant Material*) to Observers and review with Participants.
4. Distribute a set of CC and 3 Brochures to each group of 3.
5. Facilitators to move around and provide support to each group
6. Practise Case Study 1: Ask the ‘Mothers’ of the working groups to gather together.
7. Read a case study to the ‘Mothers’, and ask the ‘Mothers’ to return to their working groups.
Note: The ‘Mothers’ need to be sure that they give all the information included in their ‘Case study’. Prepare the mother to answer other questions that the Counsellor may ask outside the case study.
8. The Counsellor of each working group (of three) asks the ‘Mother’ about her situation, and practises the ‘assess, analyze and act’ steps with *listening and learning* skills and *building confidence and giving support* skills.
9. In each working group, the Observer’s task is to record the skills the Counsellor used and to provide feedback after the Case Study.
10. The Participants in working groups switch roles and the above steps are repeated using Case Studies 2 and 3.
11. One working group demonstrates a case study in front of the whole group.
12. Discuss and summarize.

Key Information

- See Participant Material: 10.2: *Observation Checklist for IYCF Assessment of Mother/Child Pair*
- Case Studies

Case Studies to practise IYCF 3-Step Counselling

Note: The information (under Assess, Analyze, Act) in the following case studies should NOT be read to the Participants before they carry out the counselling practise.

Case Study 1:

Read to ‘Mothers’: You are Mukandoli. Your son, Sakindi, is 18 months old. You are breastfeeding once or twice a day. You are giving Sakindi milk and millet cereal 2 times a day.

Step 1: Assess

- Greet Mukandoli and ask questions that encourage her to talk, using *listening and learning*, *building confidence and giving support* skills.
- Complete Participant Material 10.1: *IYCF Assessment of Mother/Child Pair*
- *Observe* Mukandoli and Sakindi’s general condition

Session 10. How to counsel mother/father/caregiver: Part II

- Listen to Mukandoli's concerns, and observe Sakindi and Mukandoli
- Accept what Mukandoli is doing without disagreeing or agreeing

Step 2: Analyze

- Mukandoli is breastfeeding Sakindi
- Mukandoli is giving another milk to Sakindi
- Mukandoli is not following age-appropriate feeding recommendations (e.g. Frequency and Variety)

Step 3: Act

- Praise Mukandoli about continuing breastfeeding
- Talk with Mukandoli about the characteristics of complementary feeding: frequency, amount, thickness (consistency), variety, active/responsive feeding, and hygiene
- Present options/small do-able actions (time-bound) to overcome the difficulty of inadequate complementary foods(e.g. increase feeding frequency of foods to 4 times a day); ask about the amount of cereal Sakindi receives and the possibility of increasing the amount; ask about the texture (thickness/consistency) of the cereal, and add other locally available family foods and help Mukandoli select one or two that she can try or that she believes will be possible for her and she is willing to try
- Counsellor will select the portion of the information on the age-appropriate counselling card that is most relevant to Sakindi's situation- and discuss that information with Mukandoli:
 - CC 11: *Good hygiene practices prevent disease*
 - CC 12: *Safe water and good compound hygiene*
 - CC 16: *Complementary feeding from 12 up to 24 months*
 - CC 17: *Feed your baby a variety of foods*
 - Brochure: *How to Feed your Baby After 6 Months*
- Ask Mukandoli to repeat the agreed upon behaviour
- Tell Mukandoli that you will follow-up with her at her next weekly visit
- Suggest where Mukandoli can find support (attend educational talk, IYCF support group in community, supplementary food programme, and refer to a Community Worker).
- Refer as necessary
- Thank Mukandoli for her time
- Discuss the demonstration with Participants
- Answer questions

Case Study 2:

Read to 'Mothers': You are Kankindi. Your daughter, Umutoni, is 8 months old. You are breastfeeding Umutoni because you know breast milk is the best food for her. You also give Umutoni water because it is so hot. You do not think Umutoni is old enough to eat other foods.

Step 1: Assess

- Greet Kankindi and ask questions that encourage her to talk, using *listening and learning, building confidence and giving support* skills.
- Complete Participant Material 10.1: *IYCF Assessment of Mother/Child Pair*
- Observe Kankindi and Umutoni's general condition
- Listen to Kankindi's concerns, and observe Umutoni and Kankindi
- Accept what Kankindi is doing without disagreeing or agreeing

Session 10. How to counsel mother/father/caregiver: Part II

Step 2: Analyze

- Kankindi is breastfeeding Umutoni
- Kankindi is also giving water to Umutoni
- Kankindi has not started complementary foods

Step 3: Act

- Praise Kankindi for breastfeeding
- Talk with Kankindi about the importance of breastfeeding
- Talk about breast milk being the best source of liquids for Umutoni
- Discuss the risks of contaminated water
- Talk with Kankindi about beginning complementary foods and why it is necessary for Kankindi at this age
- Talk with Kankindi about the characteristics of complementary feeding: frequency, amount, thickness (consistency), variety, active/responsive feeding, and hygiene
- Present options/small do-able actions (time-bound) and help Kankindi select one or two that she can try, e.g. begin with a small amount of staple food (porridge, other local examples); add legumes, vegetable/fruit and animal foods; increase feeding frequency of foods to 3 times a day; talk about appropriate texture (thickness/consistency) of staple; assist Umutoni during feeding times; and discuss hygienic preparation of foods
- Counsellor will select the portion of the information on the age-appropriate counselling card that is most relevant to Umutoni's situation -- and discuss it with Kankindi:
 - CC 11: *Good hygiene practices prevent disease*
 - CC 12: *Safe water and good compound hygiene*
 - CC 14: *Complementary feeding from 6 up to 9 months*
 - CC 17: *Feed your baby a variety of foods*
 - Brochure: *How to Feed your Baby After 6 Months*
- Ask Kankindi to repeat the agreed upon behaviour
- Tell Kankindi that you will follow-up with her at her next weekly visit
- Suggest where Kankindi can find support (attend educational talk, IYCF Support Group in community, Supplementary Food Programme, and refer to Community Worker).
- Refer as necessary
- Thank Kankindi for her time
- Discuss the demonstration with Participants
- Answer questions

Case Study 3:

Read to ‘Mothers’: You are Kamaliza. You are breastfeeding Gasore who is 3 weeks old you feel a lump in your breast; it is tender and red.

Step 1: Assess

- Greet Kamaliza and ask questions that encourage her to talk, using *listening and learning, building confidence and giving support* skills.
- Complete Participant Material 10.1: *IYCF Assessment of Mother/Child Pair*
- Observe Kamaliza and Gasore’s general condition
- Listen to Kamaliza’s concerns, and observe Gasore and Kamaliza
- Accept what Kamaliza is doing without disagreeing or agreeing

Session 10. How to counsel mother/father/caregiver: Part II

Step 2: Analyze

- Kamaliza wants to breastfeed Gasore
- Kamaliza has a lump in her breast that is tender and red (plugged duct)

Step 3: Act

- Praise Kamaliza for wanting to breastfeed Gasore
- Help Kamaliza get in a comfortable position to breastfeed Gasore (using pillows, rolled up towels)
- Use pillows or rolled up towels to help Kamaliza get comfortable
- Help Kamaliza improve attachment of Gasore to the breast
- Give ideas to relieve plugged ducts:
 - Do not stop breastfeeding (if milk is not removed risk of abscess increases; let baby feed as often as possible)
 - Apply warmth (warm water or warm cloth)
 - Hold baby in different positions, so that the baby's tongue/chin is close to the site of the plugged duct/mastitis (the reddish area). The tongue/chin will massage the breast and release the milk from that part of the breast.
- Apply gentle pressure to breast with the hand, rolling fingers towards nipple; then express milk or let baby feed every 2 to 3 hours day and night
- Explain to Kamaliza the importance of exclusive breastfeeding; frequency of breastfeeding; allowing Gasore to release the breast by himself; breastfeeding day and night and as often as possible
- Counsellor will select the portion of the information on the age-appropriate counselling card that is most relevant to Gasore's situation - and discuss it with Kamaliza:
 - CC 7: *Good Attachment is important*
 - CC 6: *There are many breastfeeding positions*
 - CC 5: *Breastfeed on demand, both day and night*
 - Brochure: *How to Breastfeed Your Baby*
- Ask Kamaliza if there are others in the home who can help with household chores
- Help Kamaliza select the practices she can try, e.g. good attachment and positioning, exclusive breastfeeding and frequent breastfeeding day and night as often as possible
- Ask Kamaliza to repeat the agreed upon behaviour
- Tell Kamaliza that you will have someone come to follow-up with her in two days
- Suggest where Kamaliza can find support (attend an IYCF support group in community, and refer to community worker)
- Thank Kamaliza for her time
- Discuss the demonstration with Participants
- Answer questions

Learning Objective 4: Mention where *IYCF 3-Step Counselling* can be conducted
Methodology: Buzz Groups

Instructions:

1. Ask Participants to form groups of 3 with their neighbours
2. Ask Participants the question: Where can *IYCF 3-Step Counselling* be conducted?
3. Ask groups to list the contact points
4. Ask 1 group to share and others to add only additional information
5. Probe until the contact points in ‘Key Information’ are mentioned
6. Discussion and summarize

Key Information

Contact points where *IYCF 3-Step Counselling* can be conducted:

At health clinic or community-based outreach:

- ANC and at every contact with a pregnant woman
- At delivery or as soon as possible thereafter
- Again within the first week of birth (days 2 or 3 and days 6 or 7)
- At two other postnatal points (for example, at weeks 4 and 6), or family planning sessions and at other times if mother has a difficulty
- During the first six months of lactation (and up to 24 months of lactation)
- GMP and immunization sessions
- At every contact with mothers or caregivers of sick children
- At contact points for vulnerable children (e.g. HIV-exposed or -infected children)
- Community follow-up
 - Action-oriented group session
 - IYCF support groups
- At in-patient facilities for management of children with severe acute malnutrition, such as stabilisation centres, nutrition rehabilitation units, therapeutic feeding centres, malnutrition wards
- At CMAM sites or screening sessions
- At community-based nutrition program sites
- At SFP sites
- Link mother/father/caregiver to Counsellor

Participant Material 10.1: IYCF Assessment of Mother/Child Pair

	Name of Mother / Caregiver	Name of Child		Age of child (completed months)	
Observation of mother/caregiver					
Child Illness	Child ill		Child not ill		Child recovering
Growth Curve	Yes		No		Increasing/Levelling off/Static
Tell me about Breastfeeding	Yes	No	When did BF stop?	Frequency: times/day	Difficulties: How is BF going?
Complementary Foods	Is your child getting anything else to eat?	What		Frequency: times/day	Amount: how much (Ref. 250 ml) Texture: how thick
	Staple (porridge, other local examples)				
	Legumes (beans, other local examples)				
	Vegetables/Fruit s (local examples)				
	Animal: meat/fish/ offal/chicken/ eggs				
Liquids	Is your child getting anything else to drink?	What		Frequency: times/day	Amount: how much (Ref. 250 ml) Bottle use? Yes/No
	Other milks				
	Other liquids				
Other challenges?					
Mother/caregiver assists child	Who assists the child when eating?				
Hygiene	Feeds baby using a clean cup and spoon	Washes hands with clean, safe water and soap before preparing food, before eating, and before feeding young children		Washes child's hands with clean, safe water and soap before he or she eats	

Participant Material 10.2: Observation Checklist for IYCF Assessment of Mother/Child Pair

Name of Counsellor: _____

Name of Observer: _____

Date of visit: _____

(✓ for yes and × for No)

Did the Counsellor

Use Listening and Learning skills:

- Keep head level with mother/parent/caregiver?
- Pay attention? (eye contact)
- Remove barriers? (tables and notes)
- Take time?
- Use appropriate touch?
- Ask open questions?
- Use responses and gestures that show interest?
- Reflect back what the mother said?
- Avoid using judging words?
- Allow mother/parent/caregiver time to talk?

Use Building Confidence and Giving Support skills:

- Accept what a mother thinks and feels?
- Listen to the mother/caregiver's concerns?
- Recognize and praise what a mother and baby are doing correctly?
- Give practical help?
- Give a little, relevant information?
- Use simple language?
- Make one or two suggestions, not commands?

ASSESSMENT

(✓ for yes and × for No)

Did the counsellor

- Assess age accurately?
- Check if mother understands the child growth curve?
- Check on recent child illness?

Breastfeeding:

- Assess the current breastfeeding status?
- Check for breastfeeding difficulties?
- Observe a breastfeed?

Fluids:

- Assess ‘other fluid’ intake?

Foods:

- Assess ‘other food’ intake?

Active Feeding:

- Ask about whether the child receives assistance when eating?

Hygiene:

- Check on hygiene related to feeding?

ANALYSIS

(*✓ for yes and × for No*)

Did the counsellor?

- Identify any feeding difficulty?
- Prioritize difficulties? (if there is more than one)

Record prioritized difficulty: _____

ACTION

(*✓ for yes and × for No*)

Did the counsellor?

- Praise the mother/caregiver for doing recommended practices?
- Address breastfeeding difficulties e.g. poor attachment or poor breastfeeding pattern with practical help.
- Discuss age-appropriate feeding recommendations and possible discussion points?
- Present one or two options? (time-bound) that are appropriate to the child’s age and feeding behaviours
- Help the mother select one or two that she can try to address the feeding challenges?
- Use appropriate CC and Brochures that are most relevant to the child’s situation - and discuss that information with mother/caregiver?
- Ask the mother to repeat the agreed-upon new behaviour?

Record agreed-upon behaviour: _____

- Ask the mother if she has questions/concerns?
- Refer as necessary?
- Suggest where the mother can find additional support?
- Agree upon a date/time for a follow-up session?
- Thank the mother for her time?

Participant Material 10.3: Building Confidence and Giving Support Skills

1. Accept what a mother/father/caregiver thinks and feels (to establish confidence, let the mother/father/caregiver talk through her/his concerns before correcting information)
2. Recognize and praise what a mother/father/caregiver and baby are doing correctly
3. Give practical help
4. Give a little, relevant information
5. Use simple language
6. Use appropriate counselling card or cards
7. Make one or two suggestions, not commands



SESSION 11. 1st FIELD VISIT AND FEEDBACK

Learning Objectives	Methodologies	Training Aids
1. Practise <i>IYCF 3-Step Counselling</i> by conducting an IYCF Assessment of Mother/Child Pair with mother/father/caregiver and a child 0 up to 24 months.	Practise	<ul style="list-style-type: none"> • CC • Brochures • Participant Material 10.1: <i>IYCF Assessment of Mother/Child Pair</i> • Participant Material 10.2 <i>Observation Checklist for IYCF Assessment of Mother/Child Pair</i>
2. Identify key gaps that need more practise/observation time at site.		
3. Reflect on strengths and weaknesses of counselling field practise.	Feedback exchange	

Materials:

- Set of CC
- Photocopies of *Participant Material 10.1: IYCF Assessment of Mother/Child Pair* (3 per Participant)
- Laminated Participant Material10.1: *IYCF Assessment of Mother/Child Pair* (1 per Participant)

Advance preparation:

- Discuss with the health facility a week ahead how and when to do the field practise during immunization or weighing sessions, or
- Discuss with the community “leader” a week ahead for village visits
- Prepare groups, give instructions the day before
- Flipchart: Enlarged copy of summary sheet for Counselling (several flipcharts size)

Duration: 3 hours

Learning Objective 1: Practise counselling with mothers/caregivers of a child 0 up to 24 months

Learning Objective 2: Identify key issues that need more practise/ observation time at site

Methodology: Practise

Instructions:

1. In large group, review *IYCF 3-Step Counselling*
2. Divide Participants in pairs: one will counsel, problem solve, reach-an-agreement with the mother/father/caregiver of a child (0 up to 6 months) and (6 up to 24 months) months while the other follows the discussion with the observation checklist in order to give feedback later
3. Ask the counsellor to use the Participant Material 10.1: *IYCF Assessment of Mother/Child Pair*
4. Ask the counsellor to share age-appropriate CC and Brochures featuring mother/father/caregiver
5. Ask the observer to fill out Participant Material 10.2: *Observation Checklist for IYCF Assessment of Mother/Child Pair*
6. Ask Participants to change roles until each Participant practises at least 2 counselling sessions
7. Identify key gaps that need more time for practise and observation at the site

Key Information

- The *IYCF 3-Step Counselling* process involves:
 - **Assess** age appropriate feeding and condition of mother/father/caregiver & child: ask, listen and observe
 - **Analyze** feeding difficulty: identify difficulty and if there is more than one - prioritize, answer mother/father/caregiver's questions, and
 - **Act** – discuss, suggest small amount of relevant information, give practical help to the breastfeeding mother, agree on feasible doable option that mother/father/caregiver can try

Note: Refer to Key Information of Session 10.

- See Participant Material 10.1: *IYCF Assessment of Mother/Child Pair*
- See Participant Material 10.2: *Observation Checklist for IYCF Assessment of Mother/Child Pair*

Learning Objective 3: Reflect on strengths and weaknesses of counselling field practise

Methodology: Feedback exchange

Instructions:

1. In large group, ask each pair of Participants to summarize their counselling experience by filling-in the summary sheet for visits (attached to the wall or on the floor)
2. Use the following chart as a sample to record each pair of Participant's field visit experience. Draw

Session 11. 1st field visit and feedback

- this table on flipchart paper and display it throughout the rest of the training. Add additional columns for other counselling sessions
3. Table shows: Participants' names; child's name and age;
 - Assess: illness; breastfeeding (frequency and difficulties); complementary feeding: frequency, amount, texture (thickness), variety, active feeding, hygiene
 - Analyze: difficulty identified, priorities determined;
 - Act: suggested options/proposals to mother/alternatives; agreed upon actions/small-doable actions – time bound/negotiated agreement
 4. Participants receive and give feedback
 5. Facilitators and Participants identify key gaps that need more practise/observation time at site
 6. Discuss and summarize

SESSION 12. HOW TO CONDUCT ACTION ORIENTED GROUP SESSIONS, IYCF SUPPORT GROUPS AND HOME VISITS

Learning Objectives	Methodologies	Training Aids
1. Facilitate an action-oriented group session using the steps: Observe, Think, Try, and Act.	<ul style="list-style-type: none"> • Experiential (sharing experiences) • Discussion 	<ul style="list-style-type: none"> • Set of CC • Participant Material 12.1: <i>How to conduct an action-oriented group session: story, drama, or visual – Observe, Think, Try, Act</i>
2. Facilitate an IYCF support group of mothers/fathers/ caregivers to help them support each other in their IYCF practices.	<ul style="list-style-type: none"> • Experiential (sharing experiences) • Discussion • Practise 	<ul style="list-style-type: none"> • Participant Material 12.2: <i>Characteristics of an IYCF Support Group</i> • Participant Material 12.3: <i>Observation Checklist for IYCF Support Groups</i> • Participant Materials 12.4: <i>IYCF support group attendance</i>
3. Identify the steps in conducting a home visit.	Brainstorming	<ul style="list-style-type: none"> • CC • Brochures

Materials:

Some suggested topics for IYCF support groups:

1. Importance of breastfeeding for mother, baby, family (1 to 3 different topics)
2. Techniques of breastfeeding:
 - positioning and attachment
3. Prevention, symptoms, and solutions of common breastfeeding conditions/difficulties:
 - breast engorgement, cracked/sore nipples, blocked ducts that can lead to mastitis, and “not enough” milk
4. Common situations or beliefs that can affect breastfeeding:
 - sick baby or mother, malnourished mother, twins, mother away from baby, low birth weight baby, pregnancy, etc.
5. Introduction of complementary foods after 6 months
6. Working mothers:
 - some possible solutions to help make breastfeeding possible

Advance Preparation:

- Prepare and practise ‘Story’
- Prepare and practise ‘Mini-drama’
- Prepare and practise ‘Visual’
- Prepare stories and make hard copies

Duration: 1½ hours

Learning Objective 1: Facilitate an action-oriented group session using the steps: Observe, Think, Try, Act

Methodology: Experiential (sharing experiences)

Instructions for Activity 1:

1. Facilitator models an action-oriented group session with Participants acting as community members by telling a story, conducting a drama, or using a CC on some aspect of IYCF- applying the steps: Observe, Think, Try and Act
2. See examples of a story and mini drama scenarios (below)
 - Tell a story: do not read the story, but practise before hand and tell it in an interesting tone
 - Conduct a mini drama: role play the mini drama assigning Facilitators and/or Participants to the different roles
 - Use a CC with a working group
3. At the end of the story, mini drama or visual ask the Participants/community members:
 - a) What would you do in the same situation? Why?
 - b) What difficulties might you experience?
 - c) How would you be able to overcome them?
 - d) What practical help would you give?
4. Discuss and summarize

Key Information

- See Participant Material 12.1: *How to conduct an action-oriented group session: story, drama, or visual– Observe, Think, Try and Act*
- Traditionally group talks are organized to communicate ideas or convey information to a group. Usually a leader directs the group talk, and group participants ask and answer questions. An ‘action-oriented’ group talk is slightly different. Facilitators encourage group participants to personalize the information and to try something new or different (an action) from what they normally do by following the sequence of activities below:
- Apply the steps:
 - Observe
 - Think
 - Try
 - Act
- Health talks are effective for giving information but do not necessarily lead to changes in behaviour. Using the steps: Observe, Think, Try and Act during health talks can motivate group participants to change their behaviour.
- Explain to Participants that applying the steps: Observe, Think, Try and Act is used to encourage group participants to reflect on and personalize their experiences so they can learn from them and make a decision to change their behaviour.

Story (example)

Once upon a time, in a village not far from here, a young woman, Umutesi, had her first baby, a son named Kalisa. She heard the community worker talk about giving only breast milk to babies until they were 6 months old. She wanted to do what the community health worker was saying, but both her mother and mother-in-law told her that the baby would need more than her breast milk to grow

strong and healthy in those first months. Of course she wanted Kalisa to be a healthy boy and so she breastfed Kalisa and gave him porridge and water from the time he was 1 month old. He has been sick. Now Kalisa is 2 months old and the community worker who did a home visit the other day told Umutesi to take Kalisa to the health facility.

Mini-Drama Scenarios

Drama number 1

Mother: Your baby is 7 months old and you are giving him porridge once a day. You are afraid your husband may not agree to buy any more food.

Husband: You do not think that your wife needs money to buy anything extra for your child.

Community Worker: You are doing a home visit. You help the mother and father identify foods they can give the baby and increase to three times the number of feeds each day (use CC).

Drama number 2

Mother: Your baby is 10 months old and you are breastfeeding. You go to work and leave the child with the grandmother, who feeds him.

Grandmother: You watch your 10-month old grandchild every day when your daughter is at work.
You feed him porridge twice a day.

Community Worker: You try to get the mother and grandmother together and make recommendations to them both to increase 1) number of times the baby receives food, 2) the amount of food that the child is eating, and 3) the thickness of foods, and to add other locally available foods (use CC).

Objective 1, Activity 2: Discussion on the group session experience

Methodology: Discussion

Instructions for Activity 2:

1. After the story, mini drama, or use of CC, the following questions are asked of the Participants:
 - What did you like about the action-oriented group session?
 - How was this group session different from an educational talk?
2. Distribute and discuss Participant Materials 12.1: *How to conduct an action-oriented group session: story, drama, or visual applying the steps – Observe, Think, Try and Act* (or refer to specific page in *Participant Materials*)

Learning Objective 2: Facilitate an IYCF support group of mothers/fathers/caregivers to help them support each other in their IYCF practices.

Methodology: Experiential (sharing experiences)

Instructions:

Activity 1: Experience a support group

Methodology: Experiential (sharing experiences)

1. Select 5 participants
2. Facilitator and 5 participants sit in a circle as a “support group”
3. Ask other participants to form a circle around the “support group”.
4. Ask members of the “support group” to share their own (or wife’s, mother’s, sister’s) experience of breastfeeding.

Note: only those in the ‘support group’ are permitted to talk.

5. Facilitator models how to fill-out Participant Material 12.4: *IYCF support group attendance*
6. Ask other Participants who observe the support group to fill out Participant Material 12.3: *Observation Checklist for Support Groups*

Activity 2: Discuss the support group experience

Methodology: Discussion

1. Ask the following questions to the support group Participants after sharing their experiences:
 - What did you like in the support group?
 - How is the support group different from an educational talk?
 - Were your questions answered?
2. Ask Participants who observed the support group to share their observations, ideas and fill-out observation form: Participant Material 12.3: *Observation Checklist for IYCF Support Groups*
3. Ask Participants what contributions a support group can make to an IYCF program?
4. Distribute Participant Material 12.2: *Characteristics of an IYCF Support Group* (or refer to specific page in Participant Materials)

Activity 3: Practise conducting a support group

Methodology: Practise

1. Divide the participants into 3 or 4 groups, each group with 7 or 8 participants
2. Each group chooses a topic from page 125 out of basket for the support group meeting
3. One Participant from each group will be Facilitator of the support group
4. After the support group, ask the group to fill-out Participant Material 13.3: *Observation Checklist for IYCF Support Groups*
5. Share observations and discuss in large group

Key Information

- See Participant Materials 12.2: *Characteristics of an IYCF Support Group*
- See Participant Materials 12.3: *Observation Checklist for IYCF Support Groups*
- See Participant Materials 12.4: *IYCF support group attendance*

Definition: A support group on infant and young child feeding is a group of mothers/fathers/caregivers who promote breastfeeding and complementary feeding behaviours, share their own experiences and provide mutual support. Periodic support groups are facilitated by experienced mothers who have infant and young child feeding knowledge and have mastered some group dynamic techniques. Group Participants share their experiences, information and provide mutual support.

Learning Objective 3: Identify steps in conducting a home visit

Methodology: Brainstorming

Instructions:

1. Ask Participants to identify the steps in conducting a home visit
2. Write answers on flipchart
3. Probe until the following steps are mentioned:
 - Greeting and introduction
 - Establish comfortable setting with caregiver
 - *Building confidence and giving support* skills (list)
 - *Listening and learning* counselling skills (list)
 - *IYCF 3-Step Counselling* (describe)
 - During the Assess Step (ask, listen and observe), observe the home situation: Is there food? Are there feeding bottles?
 - Can use age appropriate CC and Brochures
4. Discuss and summarize

**Participant Material 12.1: How to Conduct a Group Session: Story, Drama, or Visual
Applying the Steps Observe, Think, Try and Act**

INTRODUCE YOURSELF

OBSERVE

- Tell a story; conduct a drama to introduce a topic or hold a visual so everyone can see it.
- Ask the group participants:
 - What would you do in the same situation? Why?
 - What difficulties might you experience?
 - How would you be able to overcome them?

THINK

- Ask the group participants:
 - Whom do you agree with? Why?
 - Whom do you disagree with? Why?
 - What is the advantage of adopting the practice described in the story/drama or visual?
- Discuss the messages of today's topic.

TRY

- Ask the group participants:
 - If you were the mother (or another character), would you be willing to try the new practice?
 - Would people in this community try this practice in the same situation? Why?

ACT

- Repeat the key messages.
- Ask the group participants:
 - What would you do in the same situation? Why?
 - What difficulties might you experience?
 - How would you be able to overcome them?

Set a time for the next meeting and encourage group participants to come ready to talk about what happened when they tried out the new practice or encouraged someone to try it and how they managed to overcome any obstacles.

Participant Material 12.2: Characteristics of an IYCF Support Group



A safe environment of respect, attention, trust, sincerity, and empathy.

1. The group allows participants to:
 - Share infant feeding information and personal experience
 - Mutually support each other through their own experience
 - Strengthen or modify certain attitudes and practices
 - Learn from each other
2. The group enables participants to reflect on their experiences, doubts, difficulties, popular beliefs, myths, information, and infant feeding practices. In this safe environment participants have the knowledge and confidence to decide to strengthen or modify their infant feeding practices.
3. IYCF support groups are not lectures or classes. All participants play an active role.
4. Support groups focus on the importance of one-to-one communication. In this way all the participants can express their ideas, knowledge, and doubts, share experience, and receive and give support.
5. The sitting arrangement allows all participants to have eye-to-eye contact.
6. The group size varies from 3 to 15.
7. The group is facilitated by an experienced Facilitator/Mother who listens and guides the discussion.
8. The group is open, allowing all interested pregnant women, breastfeeding mothers, women with older children, fathers, caregivers, and other interested women to attend.
9. The Facilitator and the participants decide the length of the meeting and frequency of the meetings (number per month).

Participant Material 12.3: Observation Checklist for IYCF Support Groups

Community:	Place:	
Date:	Time:	Theme:
Name of IYCF Group Facilitator(s):		Name of Supervisor:
<hr/> <hr/>		<hr/> <hr/>
Did	✓	Comments
1. The Facilitator(s) introduce themselves to the group?		
2. The Facilitator(s) clearly explain the day's theme?		
3. The Facilitator(s) ask questions that generate participation?		
4. The Facilitator(s) motivate the quiet women/men to participate?		
5. The Facilitator(s) apply skills for <i>Listening and Learning, Building Confidence and Giving Support</i>		
6. The Facilitator(s) adequately manage content?		
7. Mothers/fathers/caregivers share their own experiences?		
8. The Participants sit in a circle?		
9. The Facilitator(s) invite women/men to attend the next IYCF support group (place, date and theme)?		
10. The Facilitator(s) thank the women/men for attending the IYCF support group?		
11. The Facilitator(s) ask women to talk to a pregnant woman/man or breastfeeding mother before the next meeting, share what they have learned, and report back?		
12. Support Group monitoring form checked and corrected, as necessary?		
Number of women/men attending the IYCF support group:		
Supervisor/Mentor: indicate questions and resolved difficulties:		
Supervisor/Mentor: provide feedback to Facilitator(s):		

Participant Material 12.4: IYCF Support Group Attendance

Date _____ Village (UmuDugudu) _____ Cell _____
Sector _____ District _____

Facilitator(s) Name(s) _____



Teenage girls



Pregnant women



Breastfeeding women



Old women



Infants / Young children



Teenage boys



Couples



Fathers

SESSION 13. 2nd FIELD VISIT AND FEEDBACK

Learning Objectives	Methodologies	Training Aids
1. Practise <i>IYCF 3-Step Counselling</i> by conducting an IYCF Assessment of Mother/Child Pair with mother/father/caregiver and a child from 0 up to 24 months.	Practise	<ul style="list-style-type: none"> • Set of CC • Brochures • Participant Material 10.1: <i>IYCF Assessment of Mother/Child Pair</i> • Participant Material 10.2: <i>Observation Checklist for IYCF Assessment of Mother/Child Pair</i>
2. Practise facilitating an action oriented group session or support group.		<ul style="list-style-type: none"> • Participant Material 13.1: <i>Observation Checklist on How to Conduct a Group Session: Story, Drama, or Visual</i> • Participant Material 12.3: <i>Observation Checklist for IYCF Support Groups</i> • Participant Material 12.4: <i>IYCF support group attendance</i>
3. Reflect on strengths and weaknesses of counselling field practise.	Feedback exchange	

Materials:

- Set of CC

Advance preparation:

- Make an appointment at the health facility a week ahead to do the field practise during immunization or weighing sessions, or
- Make an appointment with the community “leader” a week ahead for village visits
- Prepare groups, give instructions the day before
- Flipchart: Enlarged copy of summary sheet for Counselling (several flipcharts size)

Duration: 4 hours

Learning Objective 1: Practise IYCF 3-Step Counselling with mothers/caregivers of a child from birth up to 24 months

Methodology: Practise

Instructions:

1. In large group, review *IYCF 3-Step Counselling*
2. Divide Participants into pairs: one will counsel with the mother/father/caregiver of a child from 0 to 6 months of age and a child from 6 to 24 months of age while the other follows the dialogue with the observation checklist in order to give feedback later
3. Ask the counsellor to use Participant Material 10.1: *IYCF Assessment of Mother/ Child Pair*
4. Ask the counsellor to share age-appropriate CC and Brochures with mother/father/caregiver
5. Ask observer to fill out Participant Material 10.2: *Observation Checklist for IYCF Assessment of Mother/Child Pair* and provides feedback
6. Ask Participants to change roles until each Participant practises at least 2 counselling sessions

Learning Objective 2: Practise facilitating an action-oriented group session or a support group

Methodology: Practise

Instructions:

1. Pair the participants
2. Ask each pair to practise facilitating an action-oriented group session using a story, mini-drama or visual (some pairs may have to work together depending on the number of community participants)
3. Ask each pair to practice facilitating a support group (some pairs may have to work together depending on the number of community participants)
4. Ask Participants to fill-in Participant Material 13.1: *Observation Checklist on How to Conduct a Group Session: Story, Drama, or Visual after the action oriented group session*
5. Ask Participants to fill-in Participant Material 12.3: *Observation Checklist for IYCF Support Groups* after the support group
6. Ask Participants to fill-in the Participant Material 12.4.: *IYCF support group attendance*, is filled out after the support group

Learning Objective 3: Reflect on strengths and weaknesses of counselling field practise

Methodology: Feedback Exchange

Instructions:

Individual Counselling

1. At training site, in large group, ask each pair of Participants to summarize their counselling experience by filling-in the summary sheet for visits (attached to the wall or on the floor)
2. Use the following chart as a sample to record each pair of Participant's field visit experience. Draw this table on flipchart paper and display it throughout the rest of the training. Add additional columns for other counselling sessions
3. Table shows: Participants' names; child's name and age; illness; breastfeeding: frequency and difficulties; complementary feeding: frequency , amount, texture (thickness), variety, active feeding, hygiene; difficulty identified, options suggested, and small doable action mother/father/caregiver agreed to try
4. Participants receive and give feedback
5. Facilitators and Participants identify key gaps that need more practice/observation time at site
6. Discuss and summarize

Support Groups and Action-oriented Groups

1. Ask Facilitators of support groups and action-oriented groups:
 - What did you like about facilitating the support group/ facilitating the action-oriented group?
 - What were the challenges?
 - Fill-in the sentence: I feel confident to facilitate a support group/action oriented group because _____.
2. Ask Observers of support groups and action oriented groups to comment on the facilitation of the groups, the Observer Checklist, Attendance, and discuss the challenges?
3. Discuss and summarize

**Participant Material 13.1: Observation Checklist on How to Conduct a Group Session:
Story, Drama, or Visual, Applying the Steps: Observe, Think, Try, and Act**

Did the Counsellor?

(✓ for yes and × for No)

- Introduce him/herself?

Use Observe-ask the group participants:

- What happened in the story/drama or visual?
- What are the characters in the story/drama or visual doing?
- How did the character feel about what he or she was doing? Why did he or she do that?

Use Think- ask the group participants:

- Whom do you agree with? Why?
- Whom do you disagree with? Why?
- What is the advantage of adopting the practice described in the story/drama or visual?
- Discuss the key messages of today's topic?

Use Try—ask the group participants:

- If you were the mother (or another character), would you be willing to try the new practice?
- Would people in this community try this practice in the same situation? Why?

Use Act— ask the group participants

- What would you do in the same situation? Why?
- What difficulties might you experience?
- How would you be able to overcome them?
- To repeat the key messages?

SESSION 14. WOMEN'S NUTRITION

Learning Objectives	Methodologies	Training Aids
1. Describe the undernutrition cycle: undernourished baby, girl-child, teenager, and pregnant woman.	<ul style="list-style-type: none"> • Brainstorming • Interactive presentation 	
2. Describe the actions that can break the undernutrition cycle in babies, girls, teens, and women.	Group work	<ul style="list-style-type: none"> • Participant Material 14.1: <i>Actions to break the undernutrition cycle</i> • Illustrations of well nourished baby, girl-child, adolescent, and adult and pregnant woman • CC 1: <i>Nutrition for pregnant and breastfeeding woman</i> • Note: Key Messages on back of counselling cards • Brochure: <i>Nutrition During Pregnancy and Breastfeeding</i>
3. Name the recommended time for spacing children and the criteria for the Lactation Amenorrhoea Method (LAM)	<ul style="list-style-type: none"> • Interactive presentation • Group work 	CC 24: <i>Family planning improves health and survival</i> <ul style="list-style-type: none"> • Note: Key Messages on back of counselling cards

Materials:

- Flipchart papers and stand (+ markers + masking tape or sticky putty)
- Illustrations of well nourished baby, girl-child, teenager, adult woman, and pregnant woman

Duration: 1 hour

Learning Objective 1: Describe the undernutrition cycle: baby, girl-child, teenager, and pregnant woman

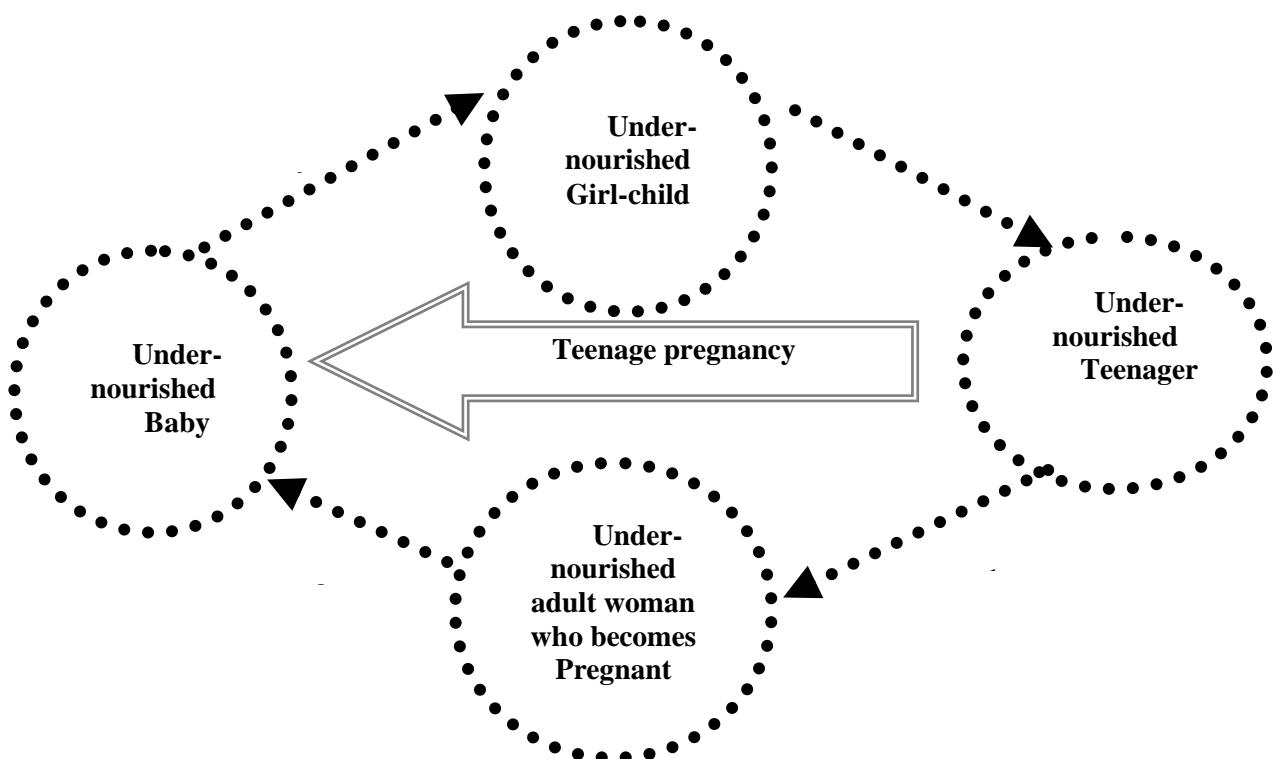
Methodology: Brainstorming; Interactive Presentation

Instructions:

1. Facilitator draws 4 circles on a flipchart with arrows connecting the circles (see diagram below)
2. Facilitator writes undernourished baby, girl-child, teenager, and pregnant woman – one for each circle
3. Facilitator explains that this diagram represents the undernutrition cycle
4. Ask Participants: What are the consequences of undernutrition for women?
5. Write answers on flipchart and discuss
6. Discuss and summarize

Key Information

Possible outcomes of undernutrition



Consequences of undernutrition for women

- Increased infection due to weakened immune system
- Weakness and tiredness leading to lower productivity
- Difficult labour due to small bone structure
- Increased risk of complications in the mother leading to death during labour and delivery
- Increased risk of death if mother bleeds during or after delivery
- Increased risk of giving birth to an underweight child who, if female, will be at greater risk of a more difficult labour during her own pregnancy unless the undernutrition cycle is broken

Note: Some girls have their first pregnancy during the teen years when they are still growing themselves:

- Teenage mother and the growing baby compete for nutrients
- When the teenage mother does not complete her growth cycle, she is at risk for a more difficult labour if her pelvis is small.

Learning Objective 2: Describe actions that can break the undernutrition cycle in babies, girls, teens and women

Methodology: Group work

Instructions:

1. Divide Participants into 4 groups and ask each group to focus on one point in the undernutrition cycle (one arrow) and think of recommendations that can break the cycle at that point
2. Each group will present their work in large group
3. As each group presents, place an illustration on the corresponding circle of the undernutrition cycle: 1) a well nourished baby, 2) a well nourished girl child, 3) well nourished teenager, and 4) well nourished adult woman and pregnant woman
4. Ask Participants the following question: Can a malnourished mother breastfeed her infant?
5. Facilitate a discussion and summary of the answers in large group
6. Distribute Participant Material 14.1: *Actions to can break the undernutrition cycle* (or refer to specific page in Participant Materials) and discuss
7. Ask working groups to observe CC 1: *Nutrition for pregnant and breastfeeding woman* and Brochure: *Nutrition During Pregnancy and Breastfeeding* and to comment
8. Orient Participants to the key messages on the back of the CC
9. Discuss and summarize

Key Information

- Actions to improve child survival must start long before woman becomes pregnant.
- Actions should start by improving the woman's health status, and solving her economic and social problems.
- See Participant Material 14.1: *Actions to break the undernutrition cycle*
- *Some factors affecting teenage and women's nutrition*
 - Nutrient intake: beliefs and culture, cravings
 - Child spacing
 - Heavy workload
 - Physical exercise
 - Body image
 - Alcohol, tobacco, caffeine

Session 14. Women's Nutrition

- Teenage mothers: need extra care, more food and more rest than an older mother. She needs to nourish her own body, which is still growing, as well as her growing baby.
- Good nutrition for a woman is key for child survival and growth

Learning Objective 3: Name the recommended time for spacing children and the criteria for the Lactation Amenorrhoea Method (LAM)

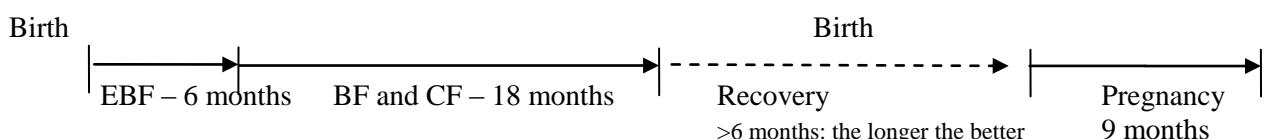
Methodology: Interactive presentation; Group work

Instructions:

1. Ask Participants what is the recommended time for spacing children? After hearing comments, explain that the recommended time between baby's is at least 3 years by drawing the time-line shown in Key Information
2. Ask Participants to discuss how women in the communities relate breastfeeding and child spacing
3. Ask Participants to brainstorm the definition of LAM and LAM criteria
4. Describe LAM and the LAM criteria and what to do when the criteria are not met, emphasize need for another FP method
5. Divide Participants into 3 groups
6. Ask the 3 groups to observe CC 24: *Family planning promotes improved health and survival*
7. Orient Participants to the Key Messages on the back of the CC
8. Discuss and fill-in gaps

Key Information

There should be an inter-birth spacing of at least 39 months (more than 3 years)



Note: Data from The Nutritional Institute of Central America and Panama (INCAP) suggest six months exclusive breastfeeding, followed by at least 18 months additional breastfeeding with complementary foods, and at least six months of neither breastfeeding nor pregnancy for best child outcomes. This would be inter-birth spacing of 39 months. (Merchant, Martorell, and Hass, 1990)

LAM

Breastfeeding is essential to child survival. It has many benefits for the child as well as for the mother, including birth spacing.

L = Lactation
A = Amenorrhoea
M = method

LAM is more than 98% effective if the 3 following criteria are met:

1. Amenorrhoea (no menses)
2. Exclusive breastfeeding is practised

Session 14. Women's Nutrition

3. The infant is less than 6 months of age

Note: when a woman no longer meets one of the 3 criteria at any point during the first six months, she immediately needs to begin another family planning method to prevent pregnancy.

Note for the community workers on family planning methods:

- Encourage mother and partner to seek family planning counselling at their nearest health facility.
- Communicate with fathers on the importance of child spacing/family planning
- Pregnancy before the age of 18 increases the health risks for the mother and her baby.

Participant Material 14.1: Actions to Break the Undernutrition Cycle

1. For the Child

Prevent growth failure by:

- Encouraging early initiation of breastfeeding
- Exclusive breastfeeding 0 up to 6 months
- Encouraging timely introduction of complementary foods at 6 months with continuation of breastfeeding up to 2 years or beyond
- Feeding different food groups at each serving. For example:
 - Animal-source foods: flesh foods such as chicken, fish, liver, and eggs and milk, and milk products (**Note:** animal foods should be started at 6 months)
 - Staples: grains such as maize, rice millet and sorghum and roots and tubers such as cassava, potatoes
 - Legumes such as beans, lentils, peas, groundnuts and seeds such as sesame
 - Vitamin A-rich fruits and vegetables such as mango, papaya, passion fruit, oranges, dark-green leaves, carrots, yellow sweet potato and pumpkin, and other fruits and vegetables such as banana, pineapple, watermelon, tomatoes, avocado, eggplant and cabbage
- Oil and fat such as oil seeds, margarine, ghee and butter added to vegetables and other foods will improve the absorption of some vitamins and provide extra energy. Infants only need a very small amount (no more than half a teaspoon per day).
- Using iodated salt
- Feeding sick child frequently for 2 weeks after recovery



Other 'non-feeding' actions:

- Appropriate hygiene
- Attending GMP and Immunization sessions
- Use of insecticide treated nets (ITNs)
- De-worming
- Prevention and treatment of infections
- Vitamin A supplementation.

2. For the Teenage Girl

Promote appropriate growth by:

- Increasing the food intake
- Encouraging different types of locally available foods as described above
- Delaying first pregnancy until her own growth is completed (usually 20 to 24 years)
- Preventing and seeking early treatment of infections
- Encouraging parents to give girls and boys equal access to education
 - undernutrition decreases when girls/women receive more education.
- Encouraging families to delay marriage for young girls
- Avoiding processed/fast foods
- Avoiding intake of coffee/tea with meals
- Encouraging good hygiene practices.
- Encouraging use of Insecticide treated nets (ITNs)



3. For Adult Women

A. Improve women's nutrition and health by:

- Encouraging different types of locally available foods
- Preventing and seeking early treatment of infections
- Encouraging good hygiene practices.



B. Encourage family planning by:

- Visiting a family planning centre to discuss which family planning methods are available and most appropriate for their individual situation (using a family planning method is important in order to be able to adequately space the births of her children)

C. Decrease energy expenditure by:

- Delaying the first pregnancy to 20 years of age or more
- Encouraging couples to use appropriate family planning methods

D. Encourage men's participation so that they:

- Understand the importance of delaying the first pregnancy until their wives/partners are at least 20 years of age
- Provide ITN for use by their families and making sure the pregnant wives/partners and children get to sleep under the net every night
- Encourage girls and boys equal access to education

4. For the Developing Child/Foetus: prevent low birth weight

A. Improve women's nutrition and health during pregnancy by:

- Increasing the food intake of women during pregnancy: eat one extra meal or "snack" (food between meals) each day; during breastfeeding eat 2 extra meals or "snacks" each day.
- Encouraging consumption of different types of locally available foods. All foods are safe to eat during pregnancy and while breastfeeding.
- Giving iron/folate supplementation (or other recommended supplements for pregnant women) to the mother as soon as mother knows she is pregnant and continue for at least 3 months after delivery of the child.
- Giving vitamin A to the mother within 6 weeks after birth.
- Preventing and seeking early treatment of infections:
 - Completing anti-tetanus immunizations for pregnant women, (5 injections in total)
 - Using of ITN
 - De-worming and giving anti-malarial drugs to pregnant women between 4 and 6 months of pregnancy.
 - Prevention and education on STI and HIV/AIDS transmission
- Encouraging good hygiene practices.

B. Decrease energy expenditure by:

- Delaying the first pregnancy to 20 years of age or more
- Encouraging families to help with women's workload, especially during late pregnancy
- Resting more, especially during late pregnancy

C. Encourage men's participation so that they:

- Accompany their wives/partners to antenatal care and reminding them to take their iron/folate tablets
- Provide extra food for their wives/partners during pregnancy and lactation
- Help with household chores to reduce wives/partners' workload
- Encourage their wives/partners deliver at health facility
- Make arrangements for safe transportation to facility (if needed) for birth
- Encourage their wives/partners to put the babies to the breast immediately after birth
- Encourage their wives/partners to give the first thick yellowish milk to babies immediately after birth
- Provide ITNs for their families and make sure that their pregnant wives/partners and small children get to sleep under the net every night

Note: If woman is HIV-infected, she needs extra food to give her more energy. HIV puts an additional strain on her body and may reduce her appetite. Eating a variety of foods is important.

SESSION 15: KITCHEN GARDEN AND SMALL ANIMALS PROMOTION

Learning Objectives	Methodologies	Training Aids
1. Describe the importance of a kitchen garden and rearing small animals at a household level	<ul style="list-style-type: none"> • Brainstorming • Interactive presentation 	<ul style="list-style-type: none"> • CC 25 and 26
2. Enumerate the types of kitchen gardens	<ul style="list-style-type: none"> • Brainstorming • Interactive presentation 	

Materials:

- Flipchart papers and stand (+ markers + masking tape or sticky putty)
- Illustrations of kitchen gardens and different types of small animals.

Duration: 30 minutes

Learning objective 1: Describe the importance of the Kitchen gardens and rearing small animals at a household level

Methodology: brainstorming, interactive presentation

Instructions:

1. Facilitator brainstorms and write on flipchart the importance of kitchen gardens
2. Facilitator brainstorms and write on a flipchart the importance of small animals at household level
3. Discuss simple ways to establish a kitchen garden
4. Discuss and summarize

Key Information

Kitchen garden

- Create a kitchen garden where you can grow different vegetables for your family throughout the year, like amaranths, carrots, and dark-green leaves such as spinach. All of these foods are important sources of body protecting nutrients, including minerals and vitamins that you and your young children need.
- If space allows, it is best to have at least three different kitchen gardens that you plant at different times of the year, taking advantage of the different growing seasons. This will allow you to harvest fresh vegetables regularly, throughout the year, for your family to enjoy.
- Gardens can be created with simple tools and materials, and minimal work. They will need to be weeded, watered and cared for regularly, however.
- Fruit trees, such as banana, mango, papaya and citrus are also a wonderful investment for the future. They are rich in Vitamin A and C.

Small animals

- Breeding small, inexpensive animals such as hens, rabbits and guinea pigs can provide you and your young children with important body building protein and other important nutrients.
- Goats and sheep are also excellent animals to breed, although they require more space.

Session 15. Kitchen Garden and Small Animals Promotion

- Keeping pigs can boost the household income because they produce many piglets that can be sold and get money.
- If possible, breeding cows that produce milk will provide your children with body building protein and many other important nutrients.
- The extra meat, eggs and milk that you get from your animals can also be sold to buy other kinds of food that your family needs.
- Breeding of these animals boosts household income and purchasing power, where food will always be available to feed the family

Learning objective 2: Enumerate the types of kitchen gardens

Methodology: brainstorming, interactive presentation

Instructions:

1. Facilitator writes on flipchart the types of kitchen gardens
2. Discuss different ways to establish a kitchen garden
3. Discuss and summarize

Types of kitchen gardens:

1. The common kitchen garden

- Prepare a circle garden with 1.5 m in length; surround it with blocks or 4 woods.
- Mix the soils with fertilizers (e.g., 1 basket of soils and another basket of fertilizers).
- In the middle, form a circle of 30 cm long and 30 cm deep.
- Surround that inner circle with sticks of 1.2 m. interlock those sticks with reeds, bamboo or other small sticks. Where holes remains, cover them with dry grass or banana leaves (ibirere) so that the soils don't gain access inside.
- The outer area of the garden is surrounded and constructed using either stones, bricks, blocks, banana stems or big trunks of trees.
- Put the prepared soils in between the circle inner circle and outer circle up to 20 cm. from above. The soil heap appears like a rounded house traditional house.
- You can add decomposing materials in the garden. This type of kitchen garden can be used throughout the year without adding more fertilizers. After 1 year, this garden should be re-worked on and prepared for new planting. Add 4 baskets of fertilizers and mix it with soils.

2. Sack garden

- Prepare the mixed soils with organic fertilizers. One basket of fertilizers, plus one basket of soils.
- Put the mixed soils in the sack until it reaches 20 cm.
- Inside the sack surrounds it with the tin iron (idebe)
- Fill the stones inside the tin (idebe)
- Compact the tin with soils and fertilizers. Continue the process until a small space is left covered with stones to enable water irrigation
- Plant the seeds surrounding the sack- it's better to use the nursery instead of planting using the seeds
- Surround the sack with four supporting woods planted deep into the soils.
- Plant the nursery in the sides of the sack, and then compact
- Every morning and every evening, irrigate the sack with home water. But avoid the water mixed with soap.
- When the yield is completed, and the sacks are still fine, hit the sides of the sacks and if they are still in good conditions, plant news seeds.

SESSION 16. FEEDING OF THE SICK CHILD

Learning Objectives	Methodologies	Training Aids
1. Describe the relationship between illness, recovery and feeding.	<ul style="list-style-type: none"> • Brainstorming • Interactive Presentation 	
2. Name the practices for feeding the sick child.	Group work	<ul style="list-style-type: none"> • CC 11: <i>Good hygiene practices prevent disease</i> • CC 12: <i>Safe water and good compound hygiene</i> • CC 20: <i>Feeding your sick baby less than 6 months of age</i> • CC 21: <i>Feeding your sick baby more than 6 months of age</i> • Note: key messages on back of CC
3. Identify signs requiring the mother/father/caregiver to seek care	<ul style="list-style-type: none"> • Brainstorming • Small Group Work 	<ul style="list-style-type: none"> • CC 19: <i>When to bring your child to the health facility</i> • Note: key messages on back of CC

Materials

- Flipchart papers and stand (+ markers + masking tape or sticky putty)

Duration: 1 hour

Learning Objective 1: Describe the relationship between illness, recovery and feeding

Methodology: Brainstorming; Interactive Presentation

Instructions:

1. Ask Participants: what is the relationship between feeding and illness?
2. Compare answers with ‘Relationship between feeding and illness’ described below in the *Key Information*
3. Ask Participants what the “sick child” feeding practices are in their community
4. Discuss and summarize

Key Information

Relationship between feeding and illness

- A sick child (diarrhea, ARI, measles, fever) usually does not feel like eating but needs even more strength to fight sickness.
- Strength comes from the food he or she eats.
- The child is more likely to suffer long-term sickness and malnutrition that may result in a physical or mental disability.
- If the child does not eat or breastfeed during sickness, he or she will take more time to recover and may die.
- It is very important to encourage the sick child to continue to breastfeed or drink fluids and eat during sickness, and to eat even more during recovery in order to quickly regain strength.
- Take advantage of the period after illness when appetite is back to make sure the child makes up for loss of appetite during sickness.

Learning Objective 2: Name the practices for feeding the sick child

Methodology: Group work

Instructions:

1. Set-up 4 flipcharts around the room
2. Divide participants into 4 groups
3. Each group will spend 3 minutes at each flipchart answering the following:
 - a) How to feed a child less than 6 months old during illness
 - b) How to feed a child less than 6 months old after illness
 - c) How to feed a child older than 6 months during illness
 - d) How to feed a child older than 6 months after illness
4. Groups do not repeat the same information, but only add new information.
5. After 3 minutes ask the groups to rotate to another flipchart
6. Each group presents the feeding practices on the flipchart to the large group
7. Ask groups to observe and study CC 20: *Feeding your sick baby less than 6 months of age*, CC 21: *Feeding your sick baby more than 6 months of age*, CC 11: *Good hygiene practices prevent disease and to review* and CC 12: *Safe water and good compound hygiene*
8. Orient Participants to the Key Messages on the back of the counselling cards
9. Discuss and summarize

Key Information

- See counselling discussion points and key messages on CC 20: *Feeding your sick baby less than 6 months of age*
- See counselling discussion points and key messages on CC 21: *Feeding your sick baby more than 6 months of age*
- See counselling discussion points and key messages on CC 11: *Good hygiene practices prevent disease*
- See counselling discussion points and key messages on CC 12: *Safe water and good compound hygiene*

Learning Objective 3: Identify signs requiring the mother/father/caregiver to seek care

Methodology: Brainstorming; Small Group Work

Instructions:

1. Ask participants to brainstorm signs that require referral to health facility by mother/father/caregiver.
2. Divide Participants into small groups.
3. Ask each group to study CC 19: *When to bring your child to the health facility* and to identify the signs that require referral to the health facility by mother/father/caregiver.
4. Ask one small group to share with the large group the signs requiring referral to a health facility by mother/father/caregiver. Ask other groups to add additional points.
5. Discuss Key Messages on CC
6. Discuss and summarise

Key Information

- See CC 19: *When to bring your child to the health facility* and Key Messages

SESSION 17. IYCF IN THE CONTEXT OF HIV

Learning Objectives	Methodologies	Training Aids
1. Explain when the HIV virus can be transmitted from mother to child and explain the risk of transmission with and without interventions.	<ul style="list-style-type: none"> • Brainstorming • Group work 	<ul style="list-style-type: none"> • CC 27: <i>Risks for babies born to HIV positive mothers.</i> • Note: key messages on back of CC
2. Describe infant feeding in the context of HIV	<ul style="list-style-type: none"> • Brainstorming • Buzz groups • Group work 	<u>When mother opts in of exclusive breastfeeding and ARVs:</u> <ul style="list-style-type: none"> • CC 28: <i>Exclusively Breastfeed and Take ARVs</i> • Benefits and risks of different feeding methods for HIV-exposed infants less than 6 months of age <u>When mother opts out of breastfeeding:</u> <ul style="list-style-type: none"> • CC Special Circumstance 1: <i>Conditions needed if you choose not breastfeed</i> (to be used for health care workers training) • CC Special Circumstance 2: <i>If using infant formula, avoid all breastfeeding</i> (to be used for health care workers training)
3. Describe feeding a child from 6 to 24 months of age when a HIV-positive mother breastfeeds or does NOT breastfeed	<ul style="list-style-type: none"> • Group work 	CC Special Circumstance 3: <i>Non-breastfed child from 6 up to 24 months</i> (to be used for health care workers training)
4. Identify breast conditions of the HIV-positive breastfeeding woman and refer for treatment.	<ul style="list-style-type: none"> • Brainstorming 	
5. Describe the role of the CHW who has training in IYCF	<ul style="list-style-type: none"> • Group work 	Flipchart with role of CHWs
6. Discuss the importance of HIV testing and counselling for the mother and the infant (at 6 weeks and after breastfeeding has stopped)	<ul style="list-style-type: none"> • Brainstorming 	

Materials:

- Flipchart papers and stand (+ markers + masking tape or sticky putty)
- Training Aid: Benefits and risks of different feeding methods for HIV-exposed infants less than 6 months of age
- Flipchart: role of the community health worker trained in IYCF

Duration: 2 hours

Learning Objective 1: Explain when the HIV virus can be transmitted from mother to child and explain the risk of transmission with and without intervention

Methodology: Brainstorming; group work

Instructions:

1. Brainstorm with Participants about how the HIV virus can be transmitted from mother-to-child. After listening to Participants' responses indicate infant outcomes on the bar charts: When NO preventive actions are taken, 60 are not infected, 25 become infected during pregnancy, labour and delivery, and 15 become infected during breastfeeding. If both mother and baby take ARVs and practice exclusive breastfeeding during the first 6 months, 95 babies are not infected with HIV, 2 become infected with HIV during pregnancy, labor and birth and 3 can become infected during breastfeeding. Exclusive and safer breastfeeding reduces the risk.
2. Form working groups of 5 Participants
3. Distribute CC 27: *Risks for babies born to HIV-positive mothers*. What is the risk of HIV passing to her baby when NO preventive actions are taken? When mother is exclusively breastfeeding for 6 months and continuing to breastfeed for 2 years, ask groups to observe and examine the number of children (out of 100) who will not be infected with HIV, and those who will be infected during pregnancy, labour and delivery, and breastfeeding with and without interventions.
4. Ask one group to explain CC 27
5. Discuss Key Messages on CC
6. Discuss and summarize

Key Information

- CC 27: *Risks for babies born to HIV-positive mothers...*
 - A baby born to a HIV-infected mother can get HIV from the mother during pregnancy, labour and delivery, and breastfeeding.
- *In the absence of any interventions*⁷ to prevent or reduce HIV transmission, research has shown that if 100 HIV-infected women get pregnant, deliver, and breastfeed for two years⁸:
- About 25 may be infected with HIV during pregnancy, labour and delivery
 - About 15 may be infected with HIV through breastfeeding, if the mothers breastfeed their babies for 2 years
 - About 60 of the babies will not get HIV
 - The aim is to have infants who do not have HIV but still survive (HIV-free survival). Therefore the risks of getting HIV through breastfeeding have to be compared to the risks of increased morbidity and mortality associated with not breastfeeding.

⁷Interventions to reduce MTCT

During pregnancy: HIV counselling and testing; primary prevention; prevent, monitor, and treat STIs, malaria, opportunistic infections; provide essential ANC, including nutrition support; ARVs; counselling on safe sex; partner involvement; infant feeding options; family planning; self care; preparing for the future.

During labor and delivery: ARVs; keep delivery normal; minimize invasive procedures – artificial rupture of membranes (AROM), episiotomy, suctioning; minimize vaginal cleansing; minimize infant exposure to maternal fluids

During post-partum and beyond: Early BF initiation and support for EBF if breastfeeding is infant feeding choice; prevent, treat breastfeeding conditions; care for thrush and oral lesions; support replacement feeding if that is infant feeding choice; ARVs for mother and infant for duration of breastfeeding period; immunizations, and growth monitoring and promotion for baby; insecticide-treated mosquito nets; address gender issues and sexuality; counsel on complementary feeding at 6 months; treat illness immediately; counsel on safe sex; and offer family planning counselling

⁸De Cock KM et al. Prevention of mother-to-child HIV transmission in resource-poor countries: translating research into policy and practice. Journal of the American Medical Association, 2000, 283(9): 1175–1182

What is the risk of passing HIV to her baby if both take ARVs and practise exclusive breastfeeding during the first 6 months?

- Risk of transmission decreases with special treatment or ARVs
- A pregnant women living with HIV should be given special medicines to decrease the risk of passing HIV to her infant during pregnancy, birth, or breastfeeding
- Her baby may also receive special medicine to decrease the risk of getting HIV during the breastfeeding period
- To reduce HIV transmission through breastfeeding, exclusive breastfeeding in the first six months is combined with provision of ARVs for the mother and the baby. This is the best way for a mother to breastfeed her infant safely.
- If a 100 HIV-infected women and their babies take ARVs and practise exclusive breastfeeding during the first 6 months:
 - About 2 babies are infected during pregnancy and delivery
 - About 3 babies are infected during breastfeeding
 - About 95 babies will not get HIV

Note: When mother takes ARVs from at least 14 weeks of pregnancy, the risk of transmission during pregnancy and labour is virtually non-existent. Some studies have also shown that the transmission during breastfeeding with ARVs is as low as 1 out of 100 babies.

Learning Objective 2: Describe infant feeding in the context of HIV

Methodology: Brainstorming; Buzz Groups; Group work

Instructions for Activity 1:

Ask Participants to define: exclusive breastfeeding, replacement feeding and mixed feeding

Instructions for Activity 2:

1. Form buzz groups: As the national policy is exclusive breastfeeding for 6 months, ask buzz groups to observe CC 28: *Exclusively Breastfeed and Take ARVs* and discuss
2. Ask Participants:
 - What should an HIV-infected mother do if she does not have access to ARVs?
3. If mother opts out of exclusive breastfeeding: ask buzz groups to observe CC Special Circumstance 1: *Conditions needed if you choose not to breastfeed* and discuss
 - Point out that CC Special Circumstance 2: *If using infant formula, avoid all breastfeeding* is used with the HIV-infected mother at the health facility, and the community worker supports the mother to implement the recommendations
4. Discuss Key Messages on CC
5. Discuss and summarize

Key Information

Activity 1

Definitions

- **Exclusive breastfeeding:** only breast milk during the first 6 months, no other food or drink (including water) is given to the infant.
- **Replacement feeding** is the process of feeding a child who is not breastfeeding with a diet that provides all the nutrients the child needs until the child is fully fed on family food. *During the first six months of life, replacement feeding should be with a suitable breast milk substitute, usually with infant formula, given exclusively (not mixed with breast milk or other foods). After six months the suitable breast milk substitute should be complemented with other foods.*
- **Mixed feeding** is giving breast milk plus other foods or drinks, including ready to use therapeutic foods before the age of 6 months of age. *Giving solids or liquids to a breastfeeding child less than 6 months increases HIV transmission risk. The mother should be advised to EITHER exclusively breastfeed OR exclusively replacement feed her child up to 6 months of age. (Mixed feeding is dangerous for ALL infants less than 6 months, irrespective of knowing HIV status of mother. In an HIV prevalent area, there is even more reason to support exclusive breastfeeding.)*
- **Note:** A baby less than 6 months has immature intestines. Food or drinks other than breast milk can cause damage to the baby's stomach. This makes it easier for HIV and other diseases to pass to the baby.

Activity 2:

HIV-negative mother or mother of unknown status:

Exclusively breastfeed for up to 6 months, add complementary foods at 6 months and continue breastfeeding for 2 years and beyond

HIV-infected mother whose infant is HIV uninfected or of unknown HIV status:

Mother has two main options for feeding her baby (depending on national policy).

1. Exclusively breastfeed together with ARVs for mother AND infant

- Exclusive breastfeeding in the first six months helps to significantly reduce the baby's risk of illness, malnutrition and death, and carries a relatively low average risk of transmission in the first six months as compared to mixed feeding.
- Same recommended breastfeeding practices that apply for HIV-negative mother and mother of unknown status (See Participant Material 5.2: *Recommended breastfeeding practices and possible counselling discussion points*)
- Breastfeeding should continue until 18 months and ARVs for life

Cessation of breastfeeding at 18 months

WHO recommends against early, abrupt or rapid cessation of breastfeeding. Mothers known to be HIV-positive who decide to stop breastfeeding at any time should stop gradually within one month. The recommended time for HIV-positive mothers to stop breastfeeding in Rwanda is 18 months.

HIV-infected mother whose infant is HIV-infected:

Exclusively breastfeed for up to 6 months, add complementary foods at 6 months and continue breastfeeding for 2 years and beyond

2. If mother opts out of exclusive breastfeeding:

Avoid all breastfeeding; feed using industrially produced infant formula

Note: The replacement feeding option is also accompanied with provision of ARVs for the mother and the infant (the latter for six weeks after delivery)

The mother gives the baby industrially produced infant formula from birth (no breastfeeding). Maintaining the mother's central role in feeding her baby is important for bonding and may also help to reduce the risks in preparation of replacement feeds.

Activity 3

Balance of Risks for Infant Feeding Options in the Context of HIV

	Exclusive Breastfeeding	Exclusive Replacement Feeding	Mixed Feeding
Risk of HIV	Yes; but lower than with mixed feeding	No	Yes
Risk of Morbidity/Mortality	Much lower risk, but doesn't eliminate the risk entirely	Yes	Yes

- Mixed feeding is the worst option, as it increases the risk of HIV transmission as well as exposing the infant to the risks of illness from contaminated formula made with dirty water and given in dirty bottles, and contaminated foods and other liquids.
- **Note:** After 6 months the baby who is not breastfed needs an additional 1 to 2 cups of milk per day

Learning Objective 3: Describe feeding a child from 6 up to 24 months when an HIV-infected mother breastfeeds or does NOT breastfeed

Methodology: Group work

Instructions:

1. Divide Participants into 2 groups
2. Ask each group to respond to 2 questions on a flipchart:
 - a) When an HIV-infected mother breastfeeds, how should she feed her child from 6 up to 24 months?
 - b) When an HIV-infected mother is NOT breastfeeding, how should she feed her child from 6 up to 24 months of age?
3. Invite one group to respond to the first question and the other groups to add additional comments
4. Invite another group to respond to the second question and the other groups to add additional comments
5. Observe CC Special Circumstance 3: *Non-breastfed child from 6 up to 24 months*
6. Discuss and summarize

Key Information

When HIV-infected mother is breastfeeding, how should she feed her child from 6 up to 24 months of age?

- Once an infant reaches 6 months of age, the mother should continue to breastfeed for up to 18 months (and taking ARVs for life), but should start the transitional period around 17 months; reducing frequency of breastfeeding and replacing breast with a cup
- Same recommended complementary feeding practices that apply for HIV-negative mothers and mothers of unknown status (See Participant Material 7.3: *Recommended complementary feeding practices and possible counselling discussion points*)

When HIV-infected mother is NOT breastfeeding, how should she feed her child from 6 up to 24 months of age?

- At about 6 months an infant is better able to tolerate undiluted animal milk and a variety of semi-solid foods.
- Add 1 to 2 extra meals and, depending on the child's appetite, offer 1 to 2 snacks
- Add 1 to 2 cups of milk per day
- Add about 2 cups/day of extra fluids (in addition to the 1 to 3 cups/day of water that is estimated to come from milk and other foods in a temperate climate, and 3 to 4 cups/day in a hot climate)
- For infants 6 to 12 months old, milk provides many essential nutrients and satisfies most liquid requirements. However, in some places, neither animal milk nor infant formula is available.
- Mother or caregiver needs to feed infant animal foods (meat, poultry, fish, eggs, or milk products), additional meals and/or specially formulated, fortified foods where suitable breast milk substitutes are not available.
- Mother should not chew food prior to giving to child, especially when her gums are bleeding.
- Calcium-rich foods such as papaya, orange juice, guava, green leafy vegetables, and pumpkin should be consumed daily.
- Infants not fed milk should be offered plain, clean, boiled water several times a day to satisfy thirst.
- Where neither breast milk substitutes nor animal milk or animal foods are available, nutrient requirements cannot be met unless specially formulated, fortified foods or nutrient supplements are added to the diet.

Learning Objective 4: Identify breast conditions of the HIV-infected mother and refer for treatment

Methodology: Brainstorming

Instructions:

- Ask Participants to brainstorm on the questions: What breast conditions of breastfeeding woman need special attention? And what should the breastfeeding woman do when these breast conditions present themselves?
- Discuss and summarize

Key Information

- An HIV-positive mother with cracked nipples, mastitis (inflammation of the breast), abscess, or thrush/Candida (yeast infection of the nipple and breast) has increased risk of transmitting HIV to her baby and so should:
 - stop breastfeeding from the infected breast and seek prompt treatment
 - continue breastfeeding on demand from uninfected breast
 - express breast milk from the infected breast(s) and either discard it or heat-treat it before feeding to baby

Note: Cracked nipples and mastitis are discussed more fully in Session 9: *Common breastfeeding difficulties – symptoms, prevention and what to do*

- Mothers known to be HIV-positive may consider expressing and heat-treating breast milk as an interim feeding strategy⁹:
- In special circumstances such as when the infant is born with low birth weight or is otherwise ill in the neonatal period and unable to breastfeed; **or**
- When the mother is unwell and temporarily unable to breastfeed or has a temporary breast health problem such as mastitis; **or**
- To assist mothers to stop breastfeeding.

How to heat-treat breast milk

- Express breast milk into a glass cup/jar
- Add water to a pot to make a water bath up to the 2nd knuckle of the index finger, over the level of the breast milk in the glass cup/jar (Note that the glass cup/jar must be taller than the water level in the pot)
- Bring water to the boiling point. The water will boil at 100° C, while the temperature of the breast milk in the glass cup/jar reaches about 60° C and will be safe and ready to use.
- Remove the breast milk from the water and cool the breast milk to the room temperature (not in fridge).
- Give the baby the breast milk by cup.
- Once breast milk is heat-treated, it should be used within 8 hours.

Note: Flash-heat¹⁰ is a recently developed, simple method that a mother can implement over an outdoor fire or in her kitchen to heat-treat her breast milk. However, field studies are urgently needed to determine the feasibility of in-home flash-heating of breast milk.

Learning Objective 5: Identify the role of the CHW who has training in IYCF

Methodology: Group work

Instructions:

1. Divide Participants into 5 groups
2. Ask the groups to identify the role of the community worker on a flipchart
3. Ask one group to present their work

⁹WHO.HIV and infant feeding: Revised Principles and Recommendations - Rapid Advice, November 2009

¹⁰Israel-Ballard K et al. Flash heat inactivation of HIV-1 in human milk. A potential method to reduce postnatal transmission in developing countries. J Acquir Immun Defic Syndr 45 (3): 318-323, 2007

4. Ask the other groups to contribute additional points
5. Compare the responses with list already prepared
6. Discuss and summarize

Role of the Community Health Worker (What do CHW trained in IYCF need to know and do?)

- Recognize the following process:
 1. HIV testing and counselling takes place at health facility where PMTCT services are available
 2. Infant feeding option is decided upon at health facility
- Explain the benefits of ARVs, both for the mother's health and for preventing transmission of HIV to her baby
- Support HIV-infected women to go to a health facility that provides ARVs or refer for ARVs
- Reinforce the ARV message at all contact points with HIV-infected women and at infant feeding support contact points
- Support the mother in her infant feeding decision
- If exclusively breastfeeding:
 - Recommended breastfeeding practices (See Participant Material 5.2: *Recommended breastfeeding practices and possible counselling discussion points*)
 - Identify breast conditions of the HIV-positive mother and refer for treatment
- If exclusively replacement feeding:
 - No mixed feeding
 - No dilution of formula
 - Help mother read instructions on formula tin
 - Make sure mother is preparing formula correctly, feeding with a cup and not a bottle, washing hands and cleaning utensils properly
- Refer to health facility if HIV-positive mother changes feeding option or no longer meets the requirements for her chosen feeding option

Learning Objective 6: Discuss the importance of HIV testing and counselling for the mother and for the infant (at 6 weeks and after breastfeeding stopped)

Methodology: Brainstorming

Instructions:

A. Importance of testing and counselling for the mother:

1. Ask Participants to brainstorm the importance of HIV testing and counselling for the mother
2. Probe until the following reasons are presented:
 - HIV counselling and testing forms the first step to prevention, care, treatment (including anti-retroviral treatment) and support
 - Encourages more people to be tested and to reduce the stigma surrounding HIV testing.
 - Increases the number of people who know they are infected.
 - Helps prevent further HIV transmission.
 - For those not infected with HIV - promotes behaviour change towards "safe sex" and hence its importance for HIV prevention.
 - Allows for management of infections like pneumonia and tuberculosis
 - Allows for ARVs during pregnancy, labour and breastfeeding

B. Importance of early testing for the infant (at 6 weeks)

1. Ask Participants to brainstorm responses to the question: Why is HIV counselling and testing important for the infant?
2. Probe until the following reasons are presented:
 - Allows for early diagnosis of an HIV-infected child
 - HIV-infected child can then be treated early with anti-retroviral drugs (ARVs), which improves chances of survival
 - HIV-infected child should be breastfed to 2 years or beyond and can be breastfed with confidence, as this helps protect the child from malnutrition and illness like diarrhoea
 - If the child is negative, the mother continues to implement the feeding option she has chosen to give the best chance of HIV-free survival and reduced death and sickness: breastfeeding and ARVs, no breastfeeding

C. Importance of testing of the infant after breastfeeding stopped

1. Ask Participants to brainstorm responses to the question: Why is HIV testing after breastfeeding stopped important for the infant?
2. Probe until the following reasons are presented:
 - There is a small risk of HIV transmission as long as the infant is breastfed
 - Once breastfeeding has stopped and the infant tests negative for HIV, there is no need for follow up of the infant anymore
 - If the infant tests positive for HIV, (s)he should be initiated on ART
3. Discuss and summarize.

SESSION 18. INTEGRATING IYCF SUPPORT INTO COMMUNITY SERVICES AND EMERGENCY RESPONSE

Learning Objectives	Methodologies	Training Aids
1. Identify how IYCF can be integrated into community services	• Group work	Participant Materials 18.1: <i>IYCF follow-up plan checklist</i>
2. Describe how the Community Health Worker can conduct follow-up of a child.	• Buzz groups	
3. Identify priority issues for IYCF during an emergency	• Group work • Rotation of flipcharts	

Materials:

- Flipchart papers and stand (markers + masking tape or sticky putty)

Advanced Preparation:

- 4 Flipcharts: each one with one of the following headings
 1. Risks to infants and young children in emergencies
 2. Information to address beliefs (held community and media) about IYCF in emergencies
 3. Recommended IYCF practices for emergency-affected populations
 4. Role of CHWs in protecting, promoting and supporting recommended IYCF practices in emergencies

Duration: 1 hour

Learning Objective 1: Identify how IYCF support can be integrated into community services

Methodology: Group work

Instructions:

1. Ask participants to group themselves into the community services in which they are involved in their communities: GMP, CMAM, PMTCT cIMCI, cMNH, TB, Malaria, Community Based Environmental Health/WASH , health promotion and others.
2. Form working groups of participants who work in each community service.
3. Ask each group to list recommendations that should be included to integrate IYCF support into the community service in which they work
4. Ask participants who form the CMAM group to look at *Participant Materials 18.1: IYCF follow-up plan checklist* from CMAM (or refer to specific page in *Participant Materials*) and ask for feedback
5. Ask each group to report back, and other groups to add additional information.

Session 18. Integrating IYCF support into community services and emergency response

6. Distribute Participant Material 18.1: *IYCF follow-up plan checklist* (or refer to specific page in Participant Materials) to all Participants
7. Discuss and summarize.

Key Information

Integration of IYCF into community services:

- Use *Listening and Learning* skills, and *Build Confidence and Giving Support* skills
- Conduct *3-Step Counselling* on recommended IYCF practices
- Conduct action-oriented groups (use of stories, role-plays and visuals)
- Conduct support groups
- Use CC and Brochures
- **Note:** key messages on back of CC
- Identify children whose growth is static or faltering (GMP)Identify children who are undernourished: (CMAM)
 - During Community Outreach: case-finding and group education
 - At supplementary feeding sites
 - During follow-up visits at out-patient care
- Identify pregnant women, discuss pregnant woman's nutrition, encourage use of iron/folate, prepare for breastfeeding (Birth Attendants)
- Review and strengthen IYCF component in materials (including Integrated Treatment Guidelines (TB and Malaria))
- Train community leaders, including local and church leaders, in recommended IYCF practices
- Discuss role of Lactating Amenorrhea Method (LAM) in family planning
- Conduct home visits and follow-up
- Use existing reporting systems and community registers

Materials:

- CC on recommended breastfeeding practices
- CC 11: *Good hygiene (cleanliness) practices prevent disease*
- CC 13 to 17: Counselling Cards for complementary feeding for each age group
- **Note:** Key Messages on back of CC
- Brochures
- Participant Material 7.1: *Recommended complementary feeding practices*
- Participant Material 7.2: *Different types of locally, available foods*
- Participant Material 7.3: *Recommended complementary feeding practices and possible points of discussion for counselling*
- Participant Material 7.4: *Active/Responsive Feeding for Young Children*
- See Participant Material 18.1: *IYCF follow-up plan checklist*

Note: in a context of high rates of severe acute malnutrition, a more detailed session on IYCF and CMAM can be given. See Appendix 4.

Learning Objective 2: Describe how the Community Health Worker (CHW) can conduct follow-up of a child

Methodology: Buzz groups

Instructions:

1. Ask Participants to form buzz groups of 3
2. Ask buzz groups to list the ways in which the CHW can conduct follow-up of a child
3. Ask buzz groups to share the tasks of the CHW
4. Discuss and summarize.

Key Information

Follow-up of child at:

- Immunization sessions
- Every contact with mothers/fathers/caregivers of a sick child
- Community follow-up
 - Growth Monitoring and Promotion (GMP): Weight/Age
 - Action-oriented group session
 - IYCF support groups
 - MUAC screening sessions
- Supplementary Feeding Programme (SFP)

Messages must be reinforced by practice

- Practise good hygiene
- Continue optimal feeding of infants and young children from 6 up to 24 months
- Practise frequent and active feeding
- Identify locally available foods to give to a young child
- Cooking demonstrations

Learning Objective 3: Identify priority issues for IYCF during an emergency

Methodology: Group work; rotation of flipcharts

Instructions :

1. Divide participants into 5 groups. Four flipcharts are set-up throughout the room with the following headings:
 - Risks to infants and young children in emergencies (e.g. earthquake, floods, civil war, volcanic eruption, cholera outbreak, draught)
 - Information to address myths and misconceptions (held by women, community, media) about IYCF in emergencies
 - Recommended IYCF practices for emergency-affected populations
 - Role of CHWs in protecting, promoting and supporting recommended IYCF practices in emergencies

- Simple measures to meet the needs of mothers, infants and young children in an emergency
2. Each group has 3 minutes a teach flip chart to write as many points as they can think of (without repeating those already listed). Groups then rotate to the next flipchart and add any additional points.
 3. In large group, ask each group to read out the points listed on the flipchart next to them.
 4. Discuss and summarize in large group. Facilitator helps to fill in gaps.

Key Information

1. Risks to infants and young children in emergencies?

- Separation from mothers (orphan hood)
- Lack of shelter
- Insecurity and lack of privacy
- Contaminated environment (dirty water, poor sanitation)
- Lack of sufficient, familiar, and nutritious food
- Poor availability of fuel and cooking equipment
- Lack of health care
- Being artificially fed

Note: The youngest babies are at the greatest risk of becoming sick, malnourished and even dying.

2. Information to address beliefs about IYCF in emergencies

Beliefs	What to do
Breast milk dries up when mothers are stressed. Stress makes milk go bad (or otherwise affects breast milk quality).	<ul style="list-style-type: none"> • A hand or shoulder massage can help the mother feel less stressed and will help her breast milk flow more easily when she breastfeeds. • A safe, quiet and private space with supportive counsellors and peers can also help. • Stressful or traumatic situations can interfere with when or how often a mother feeds her baby. If a mother breastfeeds less frequently, she will produce less breast milk. • Babies and young children may be disturbed by stressful situations and become difficult to settle down for feeding. But both mothers and babies will be reassured by more breastfeeding. • More frequent breastfeeds will help the mother make more milk if she is concerned she doesn't have enough. Keeping the baby close, day and night, will reassure the baby and help the mother breastfeed more and thus make more milk.
The right kind of food or water is necessary to produce good breast milk.	<ul style="list-style-type: none"> • No special foods are needed to produce good quality breast milk. • Many nutrients in breast milk are not affected by maternal nutritional status (including iron and vitamin D). • Even malnourished mothers can breastfeed. Only the most severely malnourished will face some problems to breastfeed well. • The additional rations distributed to breastfeeding women will be used for the mother's own nutrition while she continues to breastfeed, protecting her baby from diarrhoea. Some nutrients

Session 18. Integrating IYCF support into community services and emergency response

Beliefs	What to do
	will be deficient in the breast milk if mother is deficient (most importantly, B vitamins, Vitamin A and iodine), therefore maternal supplementation will be beneficial to children as well.
If a mother has been feeding her baby with infant formula, she may think she cannot return to breastfeeding.	She can return to breastfeeding. [See response above].
The most urgent and important need in an emergency is to give formula to babies	The most important action is to protect and support breastfeeding. Formula is not needed except in a small number of cases where the baby has no possibility to be breastfed, like orphaned and unaccompanied children. Formula is very risky for babies in an emergency. The dirty water, bottles and other utensils cause diarrhoea and malnutrition and the baby might die. The supplies might run out. Breast milk doesn't run out, is safe and is the best food for the baby.
Orphaned and unaccompanied babies must be fed on infant formula	Wet nurses need to be found for babies who are separated from their mothers. Artificial feeding is extremely difficult and dangerous in emergencies, so infant formula should be used only as a last resort, accompanied by intensive support.

3. Recommended IYCF practices for emergency-affected populations

See Sessions 5 and 7 on *Recommended IYCF Practices: Breastfeeding and Complementary Feeding*.

Stress the following:

- Exclusively breastfed babies are largely protected from diarrhea
- Feeding babies under 6 months any food or liquid other than breast milk will greatly increase their likelihood of dying from diarrhea or another infection
- The supply of any milk product should be tightly controlled so as to protect infants
- Characteristics of complementary feeding: frequency, amount, texture (thickness), variety, active/responsive feeding, and hygiene

4. Role of CHWs in protecting, promoting and supporting appropriate infant and young child feeding in emergencies

- Assess breastfeeding and complementary feeding practices
- Provide counselling on breastfeeding and complementary feeding in “counselling corners”, “baby tents”, temporary health clinics or outreach/house to house activities
- Conduct MUAC screening to find severely malnourished children
- Refer severe malnutrition cases to the health centre
- Sensitize community members and community leaders on the life-saving benefits and importance of breastfeeding and the risks of artificial feeding
- Monitor formula donations and distributions in the community and alert health workers and NGO staff
- Help to identify those children who are orphaned or unaccompanied and who need help with artificial feeding
- Teach and help caregivers to feed non-breastfed infants safely with formula

5. Simple measures to meet the needs of mothers, infants and young children in an emergency

- Ensure that mothers have priority access to food, water, shelter, security, medical care
- Register households with children less than 2 years. Registration may require outreach to homes, camps for displaced people or other sites to find emergency-affected populations.
- Register (within 2 weeks of delivery) mothers of all newborn infants. This helps to ensure they receive the additional household food rations for lactating mothers and children of complementary feeding age.
- Skilled breastfeeding counselling
 - Provide secure and supportive places (designated shelters, baby corners or mother-baby tents, child-friendly spaces) for mother/father/caregivers of infants and young children; this offers privacy for breastfeeding mothers (important for a displaced population or those in transit) and enables access to basic IYCF and peer-to-peer support.
 - Include infant and young child feeding in early, rapid assessment; involve experts in analysis to help identify priority areas for support and any need for further assessment
 - Stop donations of breast milk substitutes and prevent the donations being distributed to the general population
 - Involve local/national breastfeeding experts

Participant Material 18.1: IYCF Follow-up Plan Checklist

1. Mobilisation and sensitisation

- Assess community IYCF practices: breastfeeding and complementary feeding
- Analyze of data to reach feasible behaviour and counselling discussion points (or messages)
- Identify locally, available and seasonal foods
- Ensure that community know who are CWs
- Assess cultural beliefs that influence IYCF practises

2. Admission

- Encourage mothers to continue breastfeeding
- Discuss any breastfeeding difficulty

3. Weekly or bi-weekly follow-up

- Encourage mothers to continue breastfeeding
- Encourage HIV positive mothers to continue breastfeeding until 18 months
- Discuss any breastfeeding difficulty
- Assess age-appropriate feeding: child's age and weight, child's (usual) fluid and food intake, and breastfeeding difficulties the mother perceives
- Initiate *IYCF 3-StepCounselling* on recommended breastfeeding practices when appetite returns and/or at 4 weeks before discharge
- Conduct action-oriented group session (story, drama, use of visuals)
- Facilitate IYCF support groups

4. Discharge (MOH)

- Encourage mothers to continue breastfeeding
- Encourage HIV positive mothers to continue breastfeeding until 18 months
- Support, encourage and reinforce recommended breastfeeding practices
- Work with the mother/caregiver to address any ongoing child feeding problems she anticipates
- Support, encourage and reinforce recommended complementary feeding practices using locally available foods
- Encourage monthly growth monitoring and promotion visits
- Improve health seeking behaviours
- Encourage mothers to take part in IYCF support groups
- Link mother to CHW

5. Follow-up at home/community

- Conduct ongoing and periodic IYCF monitoring at home/community/other health facilities e.g. growth monitoring and promotion
- Home visits

- MUAC screening sessions
 - Weight / Age
- 6. Contact Points to Integrate IYCF into CMAM (other than OTP) - at health facility or community outreach**
- Growth Monitoring and Promotion (GMP)
 - Antenatal Care (ANC) at health facility
 - Supplementary Feeding Programme (SFP)
 - Community follow-up (CHW)
 - Action-oriented group session
 - IYCF support groups
- 7. Contact points for implementing the Essential Nutrition Actions (ENA) - at health facility or community outreach**
- At every contact with a pregnant woman
 - At delivery
 - During postpartum and/or family planning sessions
 - At immunization sessions
 - During Growth Monitoring and Promotion
 - At every contact with mothers or caregivers of sick children
- 8. Other contact points**
- Special consultations for vulnerable children if available, including HIV-exposed and infected children
 - Link to social protection programme if available
- 9. And**
- Set appointment for the next follow-up visit

SESSION 19. IYCF FORMS: COUNSELLING, GROUP EDUCATION, IYCF SUPPORT GROUPS AND CHECKLISTS

Learning Objectives	Methodologies	Training Aids
1. Review monitoring forms and their use.	Group work	<ul style="list-style-type: none"> • Participant Material 10.1: <i>IYCF Assessment of Mother/Child Pair</i> • Participant Material 10.2: <i>Observation Checklist for IYCF Assessment of Mother/Child Pair</i> • Participant Material 12.3: <i>Observation Checklist for Support Groups</i> • Participant Material 12.4: <i>IYCF Support Group Attendance</i> • Participant Material 13.1: <i>Observation Checklist on How to Conduct a Group Session: Story, Drama, or Visuals</i> • Participant Material 18.1: <i>IYCF Follow-up Plan Checklist</i>

Materials:

- Flipchart papers and stand (+ markers + masking tape or sticky putty)
- Monitoring forms

Duration: ½ hour

Learning Objective 1: Review monitoring forms and their use

Methodology: Group work

Instructions:

1. Ask Participants “what forms do you remember using in this training?” Probe until they mention:
 - Participant Material 10.1: *IYCF Assessment of Mother/Child Pair*
 - Participant Material 10.2: *Observation Checklist for IYCF Assessment of Mother/Child Pair*
 - Participant Material 12.3: *Observation Checklist for IYCF Support Groups*
 - Participant Material 12.4 : *IYCF Support Group Attendance*
 - Participant Material 13.1 : *Observation Checklist on How to Conduct a Group Session: Story, Drama, or Visuals*
 - Participant Material 18.1: *IYCF Follow-up Plan Checklist*
2. Ask Participants “How were these forms useful during the training? Why?”
3. Discuss and summarize

Key Information

From using the data we collect during monitoring, we could learn:

- How much did we do? How many mothers did the counsellor see? How many IYCF support groups were conducted?
- How well did we do it? Did the counsellor listen to the mother? Did the counsellor praise what the mother was doing right? Did the counsellor identify difficulties and prioritize them for discussion with the mother?
- Was it effective? Was anyone better off? Did the counsellor ‘reach an agreement’ with the mother (i.e. something that the mother was going to try to do)? Did the mother return for a 2nd visit? Did she report or did you observe a change in her behaviour (change in skills/knowledge, attitude/opinion, behaviour, circumstance)?

SESSION 20. POST ASSESSMENT AND EVALUATION

Learning Objectives	Methodologies	Training Aids
1. Identify strengths and weaknesses of Participant's IYCF knowledge post training.	Non-written post assessment <u>or</u> written post assessment	
2. Conduct evaluation of training.	Non-written evaluation – buzz groups OR written evaluation	

Materials:

- Post-assessment questions for Facilitators (or for Participants in the case of a written post-assessment)
- Evaluation questions or forms

Duration: 1 hour

Learning Objective 1: Identify strengths and weaknesses of Participant's IYCF knowledge post-training

Methodology: Non-written post-assessment

Instructions:

- Explain that 12 questions will be asked, and that Participants will raise one hand (with open palm) if they think the answer is 'Yes', will raise one hand (with closed fist) if they think the answer is 'No', and will raise one hand (pointing 2 fingers) if they 'Don't know' or are unsure of the answer.
- Ask Participants to form a circle and sit so that their backs are facing the centre.
- One Facilitator reads the statements from the post-assessment and another Facilitator records the answers and notes which topics (if any) present confusion.
- Share results of pre and post-assessment with Participants and review the answers of post assessment questions.

Or: written post-assessment:

- Pass out copies of the post-assessment to the participants and ask them to complete it individually.
- Ask participants to write their code number (previously assigned by random drawing of numbers) on the pre-assessment or a symbol of their choosing – to match both pre and post assessments).
- Correct all the tests, identifying topics that still cause confusion and need to be addressed.
- Share results of pre- and post-assessment with Participants and review the answers of post-assessment questions

Learning Objective 2: Conduct evaluation of training

Methodology: Non-written evaluation – buzz groups

Instructions:

1. Ask Participants to form buzz groups.
2. Explain that their suggestions will be used to improve future trainings.
3. Ask the groups to discuss the following:
 - What did you like the most and the least about the methodologies used in the training?
 - What did you like about the materials?
 - What did you like about the field practise?
 - Which sessions did you find most useful?
 - What are your suggestions to improve the training?
 - Do you have any other comments?
4. Ask different buzz groups to respond to the questions.
5. Discuss and summarize

Or: written evaluation:

1. Distribute end-of-training evaluations to Participants and ask them to write their comments.
2. Have Participants fill the form without writing their name on it.
3. Tick the corresponding box: good, average, unsatisfactory.
4. Explain that their suggestions will be used to improve future trainings.

Post-assessment: What have we learned?

#		Yes	No	Don't know
1.	The purpose of an IYCF support group is to share personal experiences on IYCF practices.			
2.	Poor infant feeding during the first 2 years of life harms growth and brain development.			
3.	A child aged 6 up to 9 months needs to eat at least 3 times a day in addition to breastfeeding.			
4.	A pregnant woman needs to eat 1 more meal per day than usual.			
5.	At 4 months, infants need water and other drinks in addition to breast milk.			
6.	Just telling a mother how to feed her child is an effective way of changing her infant feeding practices.			
7.	A woman who is malnourished can still produce enough good quality breast milk for her baby.			
8.	The more milk a baby removes from the breast, the more breast milk the mother makes.			
9.	The mother of a sick child should wait until her child is healthy before giving him/her solid foods.			
10.	At about six months, the first food a baby takes should have the consistency of breast milk so that the young baby can swallow it easily.			
11.	During the first six months, a baby living in a hot climate needs water in addition to breast milk.			
12.	A young child (aged 6 up to 24 months) should not be given animal foods such as eggs and meat.			
13.	A newborn baby should always be given colostrum.			
14.	An HIV-infected mother should never breastfeed.			
15.	Men should play an important role in how infants and young children are fed.			
16.	Regular growth monitoring and promotion sessions with children under 2 years of age can help detect problems with infant feeding			

End-of-Training Evaluation

Place a √ in the box that reflects your feelings about the following:

	Good	Average	Unsatisfactory
Training expectations			
Methods used			
Materials used			
Field Practise			

1. Which sessions did you find most useful?

2. What are your suggestions to improve the training?

Other comments:

APPENDICES

Appendix 1: Seven steps in planning a training/learning event

Who: The learners (think about their skills, needs and resources) and the Facilitator(s)/trainer(s)

Why: Overall purpose of the training and why it is needed

When: The time frame should include a precise estimate of the number of learning hours and breaks, starting and finishing times each day and practicum sessions

Where: The location with details of available resources, equipment, how the venue will be arranged and practicum sites

What: The skills, knowledge and attitudes that learners are expected to learn—the content of the learning event (keep in mind the length of the training when deciding on the amount of content)

What for: The achievement-based objectives—what participants will be able to do after completing the training

How: The learning tasks or activities that will enable participants to accomplish the “what for”.

Note:

- In order to facilitate the hands-on practical nature of the field site visits, ideally, no more than five-seven Participants should accompany each Facilitator in any one field practical session.
- Provide sufficient time for transport to and from field sites.
- Programme time for debriefing and discussion of site visits.
- Be aware of the schedules of the sites you are visiting.

Appendix 2. Roles and responsibilities before, during and after training

Appendix 2: Roles and responsibilities before, during and after training

Personnel	Before training	During training	After training
Management ¹¹	<ul style="list-style-type: none"> • Identify the results wanted • Assess needs and priorities (know the problem) • Develop strategy to achieve the results including refresher trainings and follow-up • Collaborate with other organizations and partners • Establish and institutionalize an on-going system of supportive supervision or mentoring • Commit resources • Take care of administration and logistics 	<ul style="list-style-type: none"> • Support the activity • Keep in touch • Receive feedback • Continuously monitor and improve quality • Motivate • Management presence demonstrates involvement (invest own time, effort) 	<ul style="list-style-type: none"> • Mentor learner • Reinforce behaviours • Plan practice activities • Expect improvement • Encourage networking among learners • Be realistic • Utilize resources • Provide supportive on-going supervision and mentoring • Motivate • Continuously monitor and improve quality
Facilitator	<ul style="list-style-type: none"> • Know audience (profile and number of learners) • Design course content (limit content to ONLY what is ESSENTIAL to perform) • Design course content to apply to work of learners • Develop pre- and post-assessments, guides, and checklists • Select practice activities, blend learning approaches and materials • Prepare training agenda 	<ul style="list-style-type: none"> • Know profile of learners • Specify the jobs and tasks to be learned • Foster trust and respect • Use many examples • Use adult learning • Create practice sessions identical to work situations • Monitor daily progress • Use problem-centred training • Work in a team with other facilitators • Adapt to needs 	<ul style="list-style-type: none"> • Provide follow up refresher or problem-solving sessions

¹¹Management includes stakeholders, ministries, organizations, and supervisors/mentors

Appendix 2. Roles and responsibilities before, during and after training

Learner	<ul style="list-style-type: none"> • Know purpose of training and roles and responsibilities after training (clear job expectations) • Expect that training will help performance • Have community volunteers “self-select” • Bring relevant materials to share 	<ul style="list-style-type: none"> • Create an action plan • Provide examples to help make the training relevant to your situation (or bring examples to the training to help develop real solutions and include findings from formative research conducted in your area to identify relevant examples) 	<ul style="list-style-type: none"> • Know what to expect and how to maintain improved skills • Be realistic • Practise to convert new skills into habits • Accountable for using skills
Management and facilitator	<ul style="list-style-type: none"> • Establish selection criteria • Establish evaluation criteria • Establish criteria for adequate workspace, supplies, equipment, job aids • Specify the jobs and tasks to be learned 	<ul style="list-style-type: none"> • Provide feedback 	<ul style="list-style-type: none"> • Provide feedback • Monitor performance
Management and learner	<ul style="list-style-type: none"> • Conduct situational analysis of training needs 	<ul style="list-style-type: none"> • Provide feedback 	<ul style="list-style-type: none"> • Provide feedback • Monitor performance
Management and facilitator and learner	<ul style="list-style-type: none"> • Conduct needs assessment • Establish goals • Establish objectives • Identify days, times, location (WHEN, WHERE) • Establish and commit to system of on-going supervision or mentoring 	<ul style="list-style-type: none"> • Provide feedback 	<ul style="list-style-type: none"> • Provide feedback • Monitor performance • Commit to system of on-going supervision or mentoring
Facilitator and learner	<ul style="list-style-type: none"> • Needs assessment feedback 	<ul style="list-style-type: none"> • Provide feedback 	<ul style="list-style-type: none"> • Provide feedback • Evaluate

Appendix 3: List of training materials

Training Room Set-up:

- Facilitators and Participants seated in circle (without tables)
- Tables (6-8) scattered around edge of room for group work and facilitation preparation
- Ideally: wall space for hanging flipchart material

Materials:

- ***Facilitator's Guide:*** 1 per Facilitator
- ***Training Aids:*** 2 per training
- ***Participant Materials:*** 1 per counsellor/Participant
- Set of ***Counselling Cards with Key Messages:*** 1 per Facilitator and 1 per Participant
- ***Take-home Brochures:*** 1 each per Facilitator and Participant
- Name card materials: [e.g., hard paper, punch, safety pins]
- Skills Assessment Self-Rating forms
- VIPP cards, various sizes (or stiff coloured paper)
- Flipchart paper, flipchart stands: 4
- Markers: black, blue, green; a few red
- Masking tape or sticky putty, glue stick, stapler, staples, scissors
- Large envelopes for individual session preparation materials
- Behaviour Change Case Studies
- Dolls (life-sized); or bath towels and rubber bands: 1 for every two Participants
- 3 clear glasses (identical size)
- Local bowls and utensils/spoons
- Different types of locally available foods
- Local cups (examples, including one 250 ml)
- Counselling Case Studies (print hard copies of case studies)
- Small sets HIV activity cards
- Certificate (requirements)
- Child growth card
- Community register
- MUAC tapes
- Salter scale
- Pins for name tags

Practicum Sessions:

- Transport arrangements
- Additional copies of tools:
 - Participant Materials 10.1: *IYCF Assessment of Mother/Child Pair*
 - Participant Materials 10.2: *Observation Checklist for IYCF Assessment of Mother/Child pair*
 - Participant Materials 12.2: *Observation Checklist for IYCF Support Groups*
 - Participant Materials 12.4: *IYCF Support Group Attendance*
 - Participant Materials 13.1: *Observation Checklist on How to Conduct a Group Session: Story Drama, or Visual, applying the steps Observe, Think, Try, and Act*

Counselling Seating:

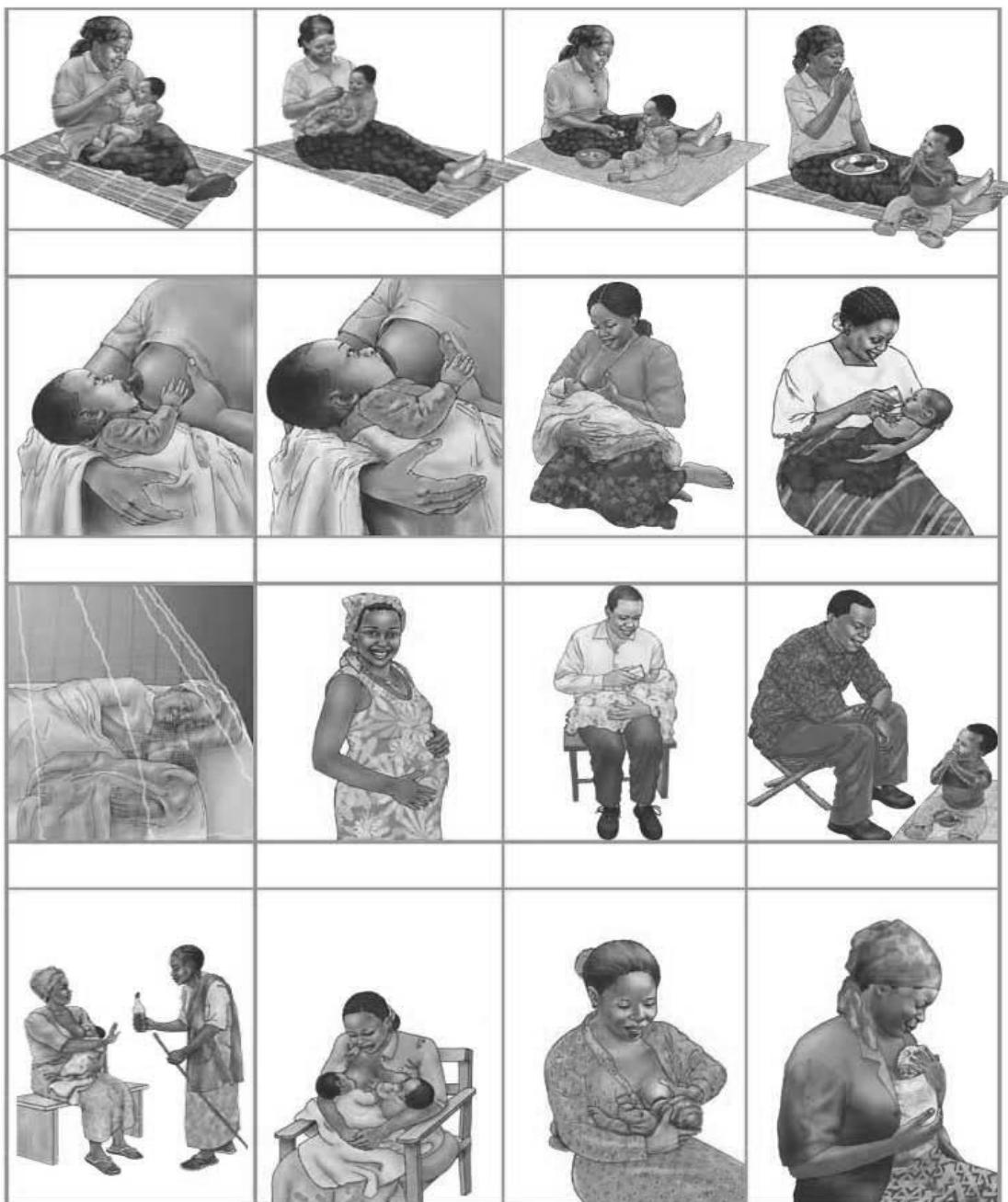
- Mats, chairs or both

Appendix 3. List of training materials

Training aids by session¹²

Session 1

16 infant feeding-related pictures for use during presentation to Participants and Facilitators (matching game)

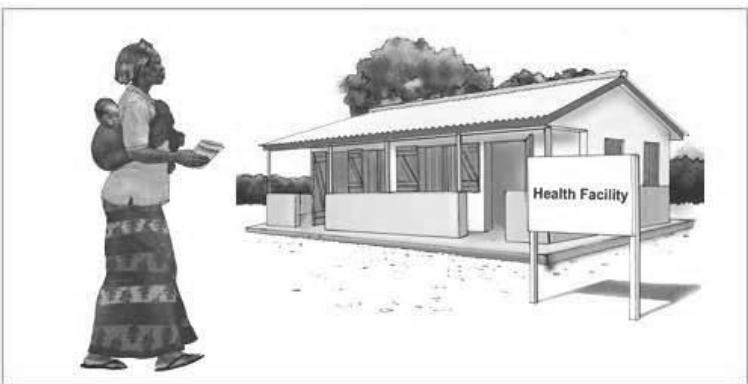


¹² Individual food images can be used in several sessions

Appendix 3. List of training materials

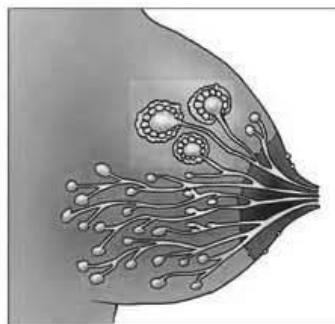
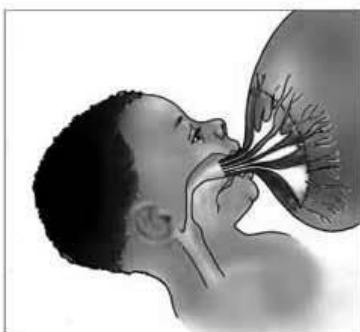
Session 2

Illustrations of well nourished baby/young child, mother giving complementary feeding, breastfeeding mother surrounded by family, mother taking her child to the health facility and water/sanitation.



Session 6

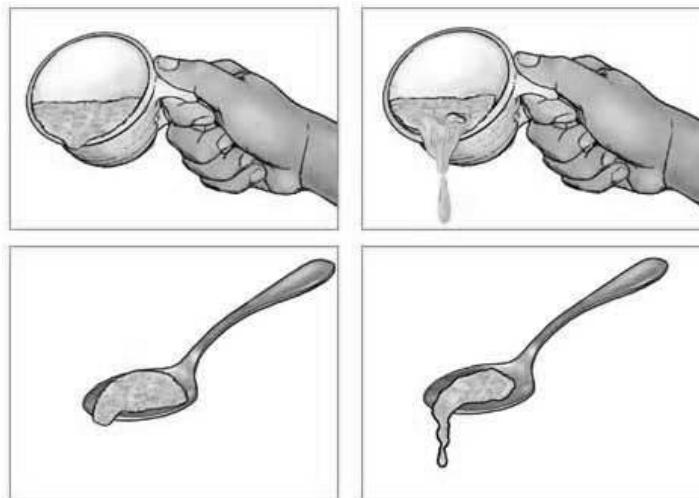
Good and poor attachment; anatomy of the breast (internal)



Appendix 3. List of training materials

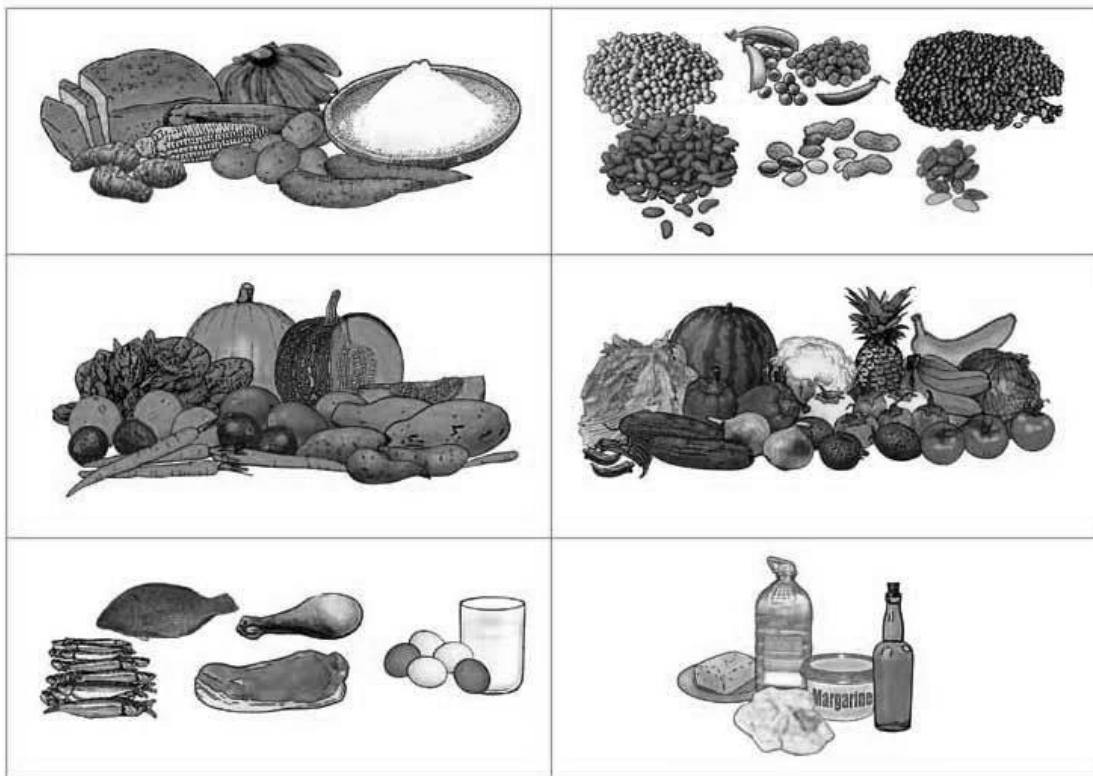
Session 7

Illustrations of texture (thickness/consistency – good and poor) of porridge (cup and spoon)



Session 7

Illustrations of food groupings (*staples, legumes and seeds, vitamin A rich fruits and vegetables, other fruits and vegetables, animal-source foods*), and oils



Appendix 3. List of training materials

Session 9

Photos of breast engorgement, sore/cracked nipple, plugged duct and mastitis



Photo by Mwate Chintu



Photo by F. Savage King



Photo by F. Savage King

Session 14

Illustrations of well nourished baby, teenager, adult woman, and pregnant woman



Appendix 4: Supervision

Objectives of 'Supportive Supervision'

1. Guide, support and motivate staff & community workers to perform their designated tasks
2. Facilitate improved worker performance (enhanced staff & community worker skills and knowledge). Possible avenues:
 - Scheduled supervisory visits to individual workers
 - Non-scheduled supervisory visits to individual workers
 - On-the-job refresher training
 - Problem-solving group supervision sessions
3. Monitor and report on the following in your supervision area (as appropriate):
 - Implementation of:
 - Training of trainers
 - Training of IYCF counsellors
 - Training of mother support group facilitators
 - Individual counselling sessions
 - Action-oriented group sessions
 - Mother support group sessions
 - Other activities
 - Coverage of the target population in your supervision area:
 - Percent of target mothers reached by individual counselling, mother support group sessions, action-oriented group sessions, other (using LQAS methodology, for example; determine reporting period)
 - Result of program activities in your supervision area:
 - Comprehension of key information by target audience, retention of key information by target audience (using Lot Quality Assurance Sampling (LQAS) methodology, for example; determine reporting period)

Supervision Checklist

The following checklist assumes that activities and targets for supervisory activities have been defined and that a monitoring system is in place. Adapt this list as is appropriate for your program.

Training Needs (by Supervision Area)

- ___ Target number of IYCF counsellors required in supervision area (establish target with Programme Manager)
- ___ Number of counsellors active during the reporting period
- ___ #/% of active IYCF counsellors trained
- ___ Target number of mother support group facilitators required in supervision area
- ___ Number of Facilitators active during the reporting period
- ___ #/% active mother support group facilitators trained

Program Implementation: Supervision Activities

A. CHECKLIST of activities to be conducted during supervisory visit with an IYCF Counsellor

- Set schedule for supervisory visit with counsellor
- Observe entire IYCF counselling session
- Complete Observation Checklist (Participant Materials 10.2: *Observation Checklist for IYCF Assessment of Mother/Child Pair*)
- Share results of observation checklist and discuss with counsellor
- Document your feedback to counsellor
- Document comments by counsellor
- Identify needs to support counsellor
- Actions required (by date and person responsible): _____; _____
- Scheduled date of next supervision visit: _____
- Signature of IYCF counsellor acknowledging receipt of supervision: _____
- Supervisor's signature: _____
- Report submitted to Programme Manager (date): _____, _____

Appendix 4. Supervision

CHECKLIST of activities to be conducted during supervision visit with a Mother Support Group Facilitator

- Set schedule for supervisory visit with Facilitator
- Observe entire support group session
- Complete Observation Checklist (Participant Material 12.3: *Observation Checklist for IYCF Support Groups*)
- Share results of observation checklist and discuss with Facilitator
- Document your feedback to Facilitator
- Document comments by Facilitator
- Identify needs to support Facilitator
- Actions required (by date and person responsible): _____; _____
- Scheduled date of next supervision visit: _____
- Signature of Facilitator acknowledging receipt of supervision: _____
- Supervisor's signature: _____
- Report submitted to Programme Manager (date): _____, _____

Supervisor Monitoring

Caseload:

- Collect IYCF Counselling Sessions Monitoring Form from IYCF Counsellor (per time period)
- Collect completed Support Group Attendance Monitoring Form (*Participant Materials 12.4: Support Group Attendance Monitoring Form*) from Facilitators (per time period)

Program Coverage:

- Percent target mothers (in supervision area) receiving individual IYCF counselling (per time period)
- Percent target mothers (in supervision area) attending a mother support group meeting (per time period)

Appendix 4. Supervision

Programme Manager Oversight of Supervision

Training

- Training of Trainers: % of total target number of trainers who have been trained
- Training of Counsellors: % of total target number of counsellors who have been trained (by supervision area)
- Training of Facilitators: % of total target number of Facilitators who have been trained (by supervision area)

Program Supervision

Program Supervision of IYCF Counsellors:

- Percent of IYCF counsellors who receive at least one supervisory visit per agreed time period (set time period: quarter, for example).

Program Supervision of Mother Support Group Facilitators:

- Percent of mother support group facilitators who receive at least one supervisory visit per agreed time period

Reporting

Reporting Form Submission

- Percent of supervisors who complete and submit reporting forms (define time period: within X days of close of reporting period)

Appendix 5: Principles of adult learning¹³

1. **Dialogue:** Adult learning is best achieved through dialogue. Adults have enough life experience to dialogue with facilitator/trainer about any subject and will learn new attitudes or skills best in relation to that life experience. Dialogue needs to be encouraged and used in formal training, informal talks, one-on-one counselling sessions or any situation where adults learn.
 2. **Safety in environment and process:** Make people feel comfortable making mistakes. Adults are more receptive to learning when they are both **physically and psychologically comfortable**.
 - Physical surroundings (temperature, ventilation, overcrowding, and light) can affect learning.
 - Learning is best when there are no distractions.
 3. **Respect:** Appreciate learners' contributions and life experience. Adults learn best when their experience is acknowledged and new information builds on their past knowledge and experience.
 4. **Affirmation:** Learners need to receive praise for even small attempts.
 - People need to be sure they are correctly recalling or using information they have learned.
 5. **Sequence and reinforcement:** Start with the easiest ideas or skills and build on them. Introduce the most important ones first. Reinforce key ideas and skills repeatedly. People learn faster when information or skills are presented in a structured way.
 6. **Practice:** Practise first in a safe place and then in a real setting.
 7. **Ideas, feelings, actions:** Learning takes place through thinking, feeling and doing and is most effective when it occurs across all three.
 8. **20/40/80 rule:** Learners remember more when visuals are used to support the verbal presentation and best when they practise the new skill. We remember 20 percent of what we hear, 40 percent of what we hear and see, and 80 percent of what we hear, see and do.
 9. **Relevance to previous experience:** People learn faster when new information or skills are related to what they already know or can do.
- Immediate relevance:** Learners should see how to use and apply what they have learned in their job or life immediately
- Future relevance:** People generally learn faster when they realise that what they are learning will be useful in the future.
10. **Teamwork:** Help people learn from each other and solve problems together. This makes learning easier to apply to real life.

¹³Adapted from J. Vella.1994. *Learning to Listen, Learning to Teach*.

Appendix 5. Principles of adult learning

11. **Engagement:** Involve learners' emotions and intellect. Adults prefer to be **active participants** in learning rather than passive recipients of knowledge. People learn faster when they actively process information, solve problems, or practise skills.
12. **Accountability:** Ensure that learners understand and know how to put into practice what they have learned.
13. **Motivation:** Wanting to learn
 - People learn faster and more thoroughly when they want to learn. The trainer's challenge is to create conditions in which people want to learn.
 - Learning is natural, as basic a function of human beings as eating or sleeping.
 - Some people are more eager to learn than others, just as some are hungrier than others. Even in one individual, there are different levels of motivation.
 - All the principles outlined will help the learner become motivated.
14. **Clarity**
 - Messages should be clear.
 - Words and sentence structures should be familiar. Technical words should be explained and their understanding checked.
 - Messages should be VISUAL.
15. **Feedback:** Feedback informs the learner in what areas s/he is strong or weak.

Appendix 6: Training methodologies: advantages, limitations, and tips for improvement

Training method	Advantages	Limitations	Tips for improvement
Small group discussion in a group of no more than 7 participants who discuss and summarise a given subject or theme. The group selects a chairperson, a recorder, and/or someone to report to plenary.	<ul style="list-style-type: none"> Can be done anytime and anywhere Allows two-way communication Lets group members learn each other's views and sometimes makes consensus easier Allows group members to take on different roles (e.g., leader, recorder) to practice facilitation techniques Involves active participation Lets participants ask and learn about unclear aspects Often lets people who feel inhibited share Can produce a strong sense of sharing or camaraderie Challenges participants to think, learn, and solve problems 	<ul style="list-style-type: none"> Strong personalities can dominate the group. Some group members can divert the group from its goals. Some participants may try to pursue their own agendas. Conflicts can arise and be left unresolved. Ideas can be limited by participants' experience and prejudices. 	<ul style="list-style-type: none"> Outline the purpose of the discussion and write questions and tasks clearly to provide focus and structure. Establish ground rules (e.g., courtesy, speaking in turn, ensuring everyone agrees with conclusions) at the beginning. Allow enough time for all groups to finish the task and give feedback. Announce remaining time at regular intervals. Ensure that participants share or rotate roles. Be aware of possible conflicts and anticipate their effect on the group's contribution in plenary. Reach conclusions but avoid repeating points already presented in plenary.
Buzz group (2–3 participants) can allow participants to discuss their immediate reactions to information presented, give definitions, and share examples and experiences	<ul style="list-style-type: none"> Gives everyone a chance and time to participate Makes it easier to share opinions, experiences, and information Often creates a relaxed atmosphere that allows trust to develop and helps participants express opinions freely Can raise energy level by getting participants to talk after listening to information Does not waste time moving participants 	<ul style="list-style-type: none"> Discussion is limited. Opinions and ideas are limited by participants' experience. Participants may be intimidated by more educated participants or find it difficult to challenge views. 	<ul style="list-style-type: none"> Clearly state the topic or question to be discussed along with the objectives. Encourage exchange of information and beliefs among different levels of participants.
Brainstorming: A spontaneous process through which group members' ideas	<ul style="list-style-type: none"> Allows many ideas to be expressed quickly Encourages open-mindedness (every idea should be acceptable, and judgement 	<ul style="list-style-type: none"> The ideas suggested may be limited by participants' experiences and prejudices. People may feel 	<ul style="list-style-type: none"> State clearly the brainstorming rule that there is no wrong or bad idea. Ensure a threat-free,

Appendix 6. Training methodologies: advantages, limitations, and tips for improvement

Training method	Advantages	Limitations	Tips for improvement
and opinions on a subject are voiced and written for selection, discussion, and agreement. All opinions and ideas are valid.	<ul style="list-style-type: none"> • should be suspended) • Gives everyone an opportunity to contribute • Helps stimulate creativity and imagination • Can help make connections not previously seen • Is a good basis for further reflection • Helps build individual and group confidence by finding solutions within the group 	<ul style="list-style-type: none"> • embarrassed or if they have nothing to contribute. • Some group members may dominate, and others may withdraw. 	<ul style="list-style-type: none"> • non-judgemental atmosphere so that everyone feels he or she can contribute. • Ask for a volunteer to record brainstorming ideas. • Record ideas in the speaker's own words. • State that the whole group has ownership of brainstorming ideas. • Give participants who haven't spoken a chance to contribute.
Plenary or whole group discussion: The entire group comes together to share ideas	<ul style="list-style-type: none"> • Allows people to contribute to the whole group • Enables participants to respond and react to contributions • Allows facilitators to assess group needs • Enables people to see what other group members think about an issue • Allows individuals or groups to summarise contents 	<ul style="list-style-type: none"> • Can be time consuming • Doesn't give each participant a chance to contribute • Some individuals may dominate the discussion. • Consensus can be difficult if decisions are required. • Some group members may lose interest and become bored. • Contribution from a limited number of participants can give a false picture of the majority's understanding of an issue. 	<ul style="list-style-type: none"> • Appoint someone to record the main points of the discussion. • Appoint a timekeeper. • Pose a few questions for group discussion. • Use buzz groups to explore a topic in depth. • Ask for contributions from participants who haven't shared their views.
Role play: Imitation of a specific life situation that involves giving participants details of the "person" they are asked to play	<ul style="list-style-type: none"> • Helps start a discussion • Is lively and participatory, breaking down barriers and encouraging interaction • Can help participants improve skills, attitudes, and perceptions in real situations • Is informal and flexible and requires few resources • Is creative • Can be used with all kinds of groups, regardless of their education levels 	<ul style="list-style-type: none"> • Possibility of misinterpretation • Reliance on goodwill and trust among group members • Tendency to oversimplify or complicate situations 	<ul style="list-style-type: none"> • Structure the role-play well, keeping it brief and clear in focus. • Give clear and concise instructions to participants. • Carefully facilitate to deal with emotions that arise in the follow-up discussion. • Make participation voluntary.
Drama: Unlike role-play in that the actors are briefed in advance on what to say and do	<ul style="list-style-type: none"> • Commands attention and interest • Clearly shows actions and relationships and makes them easy to understand • Is suitable for people who 	<ul style="list-style-type: none"> • Audience cannot stop the drama in the middle to question what is going on • Can be drawn out and time consuming 	<ul style="list-style-type: none"> • Encourage actors to include the audience in the drama. • Follow the drama by discussion and analysis to make it an effective

Appendix 6. Training methodologies: advantages, limitations, and tips for improvement

Training method	Advantages	Limitations	Tips for improvement
and can rehearse. As a result, the outcome is more predictable. Drama is often used to illustrate a point.	<ul style="list-style-type: none"> cannot read or write Involves the audience by letting them empathise with actors' feelings and emotions Does not require many resources Can bring people together almost anywhere 	<ul style="list-style-type: none"> Tends to simplify or complicate situations 	<ul style="list-style-type: none"> learning tool. Keep it short, clear, and simple.
Case study: Pairs or small groups are given orally or in writing a specific situation, event, or incident and asked to analyse and solve it.	<ul style="list-style-type: none"> Allows rapid evaluation of trainees' knowledge and skills Provides immediate feedback Increases analytical and thinking skills Is the best realistic alternative to field practice 	<ul style="list-style-type: none"> Sometimes not all trainees participate. 	<ul style="list-style-type: none"> Make the situation, event or incident real and focused on the topic. Initiate with simple case studies and gradually add more complex situations. Speak or write simply.
Demonstration with return demonstration: A resource person performs a specific operation or job, showing others how to do it. The participants then practise the same task.	<ul style="list-style-type: none"> Provides step-by-step process to participants Allows immediate practice and feedback Checklist can be developed to observe participants' progress in acquiring the skill 		<ul style="list-style-type: none"> Explain different steps of the procedure. Resource person demonstrates an inappropriate skill, then an appropriate skill, and discusses the differences. Participants practise the appropriate skill and provide feedback to each other. Practise.
Game: A person or group performs an activity characterised by structured competition that allows people to practise specific skills or recall knowledge.	<ul style="list-style-type: none"> Entertains Competition stimulates interest and alertness Is a good energizer Helps recall of information and skills 	<ul style="list-style-type: none"> Some participants feel that playing games doesn't have a solid scientific or knowledge base. Facilitators should participate in the game. 	<ul style="list-style-type: none"> Be prepared for "on the spot" questions because there is no script. Give clear directions and adhere to allotted time.
Field visit: Participants and facilitators visit a health facility or community setting to observe a task or procedure and practice.	<ul style="list-style-type: none"> Puts training participants in real-life work situations Allows participants to reflect on real-life work situations without work pressures Best format to use knowledge and practice skills 	<ul style="list-style-type: none"> Time consuming Needs more resources 	<ul style="list-style-type: none"> Before the visit, coordinate with site, give clear directions before arrival, divide participants into small groups accompanied by the facilitator Provide reliable transportation Meet with those responsible on arrival

Appendix 6. Training methodologies: advantages, limitations, and tips for improvement

Training method	Advantages	Limitations	Tips for improvement
VIPP (Visualization in participatory programming): Coloured cards varying in shape and size allow participants to quickly classify problems to find solutions.	<ul style="list-style-type: none"> Allows visualisation of problems, ideas and concerns in a simple way Allows everyone to participate Gives participants who tend to dominate a discussion equal time with quieter participants 	<ul style="list-style-type: none"> Used more by members of the same organization to evaluate progress and revise objectives and strategies Time consuming Needs more resources 	<ul style="list-style-type: none"> Provide opportunity to share experiences and give and receive feedback Apply modified version of VIPP if problems arise in training that can be dealt with quickly.
Action plan preparation: Allows participants to synthesise knowledge, skills, attitudes, and beliefs into a doable plan; bridges classroom activities with practical application at work site	<ul style="list-style-type: none"> Team building for participants from the same site, district, or region Two-way commitment between trainers and institutions Basis for follow up, action and supervision 	<ul style="list-style-type: none"> Time consuming Requires work on action plan after hours to support action plan development 	
Talk or presentation: Involves imparting information through the spoken word, sometimes supplemented with audio or visual aids	<ul style="list-style-type: none"> Is time-efficient for addressing a subject and imparting a large amount of information quickly Facilitates structuring the presentation of ideas and information Allows the facilitator to control the classroom by directing timing of questions Is ideal for factual topics (e.g., steps on conducting HIV testing) Stimulates ideas for informed group discussion 	<ul style="list-style-type: none"> Lack of active participation Facilitation and curriculum centred, essentially one-way learning No way to use experience of group members Can be limited by facilitators' perception or experience Can sometimes cause frustration, discontent, and alienation within the group, especially when participants cannot express their own experience 	<p>Build interest</p> <ul style="list-style-type: none"> Use a lead-off story or interesting visual that captures audience's attention. Present an initial case problem around which the lecture will be structured. Ask participants test questions even if they have little prior knowledge to motivate them to listen to the lecture for the answer. <p>Maximise understanding and retention</p> <ul style="list-style-type: none"> Reduce the major points in the lecture to headlines that act as verbal subheadings or memory aids and

Appendix 6. Training methodologies: advantages, limitations, and tips for improvement

Training method	Advantages	Limitations	Tips for improvement
			<ul style="list-style-type: none"> • arrange in logical order. • Give examples and analogies, using real-life illustrations of the ideas in the lecture and, if possible, comparing the material and the participants' knowledge and experience. • Use visual backup (flipcharts, transparencies, brief handouts, and demonstrations) to enable participants to see as well as hear what you are saying. • Set a time limit. <p><u>Involve participants during the lecture</u></p> <ul style="list-style-type: none"> • Interrupt the lecture periodically to challenge participants to give examples of the concepts presented or answer spot quiz questions. <p><u>Illustrate activities</u> throughout the presentation to focus on the points you are making.</p> <p><u>Reinforce the lecture</u></p> <ul style="list-style-type: none"> • Allow time for feedback, comments, and questions • Apply the problem by posing a problem or question for participants to solve based on the information in the lecture. • Ask participants to review the contents of the lecture together or give them a self-scoring test. • Avoid distracting gestures or mannerisms such as playing with the chalk, ruler, or watch or adjusting clothing.

Appendix 7: Suggested training exercises, review energisers (group and team building), daily evaluation and faces

Training exercises

Forming small groups

1. Depending on the number of Participants (for example, 20), and the number of groups to be formed (for example, 5) ask Participants to count off numbers from 1 to 4. Begin to count in a clockwise direction. On another occasion begin to count counter-clockwise.
2. Depending on the number of Participants (for example, 16), and the number of groups to be formed (for example, 4), collect 16 bottle caps of 4 different colours: 4 red, 4 green, 4 orange, and 4 black. Ask Participants to select a bottle cap. Once selected, ask Participants to form groups according to the colour selected.
3. Sinking ship: ask Participants to walk around as if they were on a ship. Announce that the ship is sinking and life boats are being lowered. The life boats will only hold a certain number of Participants. Call out the number of persons the life boats will hold and ask Participants to group themselves in the number called-out. Repeat several times and finish with the number of Participants you wish each group to contain (for example, to divide 15 Participants into groups of 3, the last "life boat" called will be the number 5).

The following are descriptions of several **review energizers** that Facilitators can select from at the end of each session to reinforce knowledge and skills acquired.

1. Participants and Facilitators form a circle. One Facilitator has a ball that he or she throws to one Participant. The Facilitator asks a question of the Participant who catches the ball. The Participant responds. When the Participant has answered correctly to the satisfaction of the group, that Participant throws the ball to another Participant asking him/her a question in turn. The Participant who throws the ball asks the question. The Participant who catches the ball answers the question.
2. Form 2 rows facing each other. Each row represents a team. A Participant from one team/row asks a question to the Participant opposite her/him in the facing team/row. That Participant can seek the help of her/his team in responding to the question. When the question is answered correctly, the responding team earns a point and then asks a question of the other team. If the question is not answered correctly, the team that asked the question responds and earns the point. Questions and answers are proposed back and forth from team to team.
3. Form 2 teams. Each person receives a CC or a visual image. These visual aids are answers to questions that will be asked by a Facilitator. When a question is asked, the Participant who believes s/he has the correct answer will show her counselling card or visual image. If correct, s/he scores a point for her/his team. The team with the most correct answers wins the game.

Appendix 7. Suggested training exercises, review energizers (group and team building), daily evaluation and faces

4. From a basket, a Participant selects a CC or visual image and is asked to share the practices/messages; feedback is given by other Participants. The process is repeated for other Participants.
5. Form 2 circles. On a mat in the middle of the circle a set of CC is placed “face down”. A Participant is asked to choose a counselling card and tell the other Participants in what situations an IYCF counsellor can share the practices/messages the counselling card represents. One Facilitator is present in each circle to assist in responding.

Daily Evaluations

The following examples are descriptions of several evaluations that Facilitators can select at the end of each day (or session) to assess the knowledge and skills acquired and/or to obtain feedback from Participants.

1. Form buzz groups of 3 and ask Participants to answer one, two, or all of the following questions in a group*:
 - 1) What did you learn today that will be useful in your work?
 - 2) What was something that you liked?
 - 3) Give a suggestion for improving today’s sessions.

* Ask a Participant from each buzz group to respond to the whole group
2. ‘Faces’ measuring Participants’ moods. Images of the following faces (smiling, neutral, frowning) are placed on a bench or the floor and Participants (at the end of each day [or session]) are asked to place a stone or bottle cap on the “face” that best represents their level of satisfaction (satisfied, mildly satisfied and unsatisfied).

Appendix 7. Suggested training exercises, review energizers (group and team building), daily evaluation and faces

Cut-outs of ‘Faces’



