



# Facilitator Guide



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*The Community  
Infant and Young Child Feeding  
Counselling Package*

2012

## Foreword

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

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

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

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

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



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

## **Acknowledgement**

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This Nigerian *Community Infant and Young Child Feeding Counselling Package* was adapted and harmonised within the Nigerian context using a number of materials previously developed in Nigeria including policies; field tested; and finalised using a consensus building process with all relevant stakeholders.

The adaptation and harmonization process which resulted in *The Community Infant and Young Child Feeding Counselling Package* for Nigeria was coordinated by the Nutrition Division led by Mrs. B.N Eluaka and her dedicated staff of the Family Health Department

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I also want to thank everybody that has contributed in one way or the other to the success of producing this document.



Dr. B. Okoeguale

Head, Family Health Department

Federal Ministry of Health

February, 2012

## Acknowledgements

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This *Facilitator Guide* is part of *The Community Infant and Young Child Feeding (C-IYCF) Counselling Package*, developed collaboratively among the Federal Ministry of Health Nigeria and its key partners in Maternal and Infant/Young Child Nutrition. *The Community IYCF Counselling Package* includes the *Facilitator Guide* with Appendices, and *Training Aids* for training community health workers; the *Participant Materials*, including training “handouts” and monitoring tools; this set of 31C-IYCF *Counselling Cards* with *Key Messages Booklet*, and 3 *Take-home Brochures*.

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

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

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Representatives from all major stakeholders participated in the design, development, field testing, and final technical review of this *C-IYCF Counselling Package*. The important role of the following individuals is acknowledged:

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## Acronyms

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ANC	antenatal care
ARVs	antiretroviral drugs
CMAM	community management of acute malnutrition
ENA	essential nutrition actions
GMP	growth monitoring and promotion
IMCI	integrated management of childhood illness
LAM	lactation amenorrhoea method
MAM	moderate acute malnutrition
MAMAN	minimum activities for mothers and newborns
MUAC	mid-upper arm circumference
OTP	outpatient therapeutic programme
PMTCT	prevention of mother-to-child transmission
RUTF	ready-to-use therapeutic food
SAM	severe acute malnutrition
WHO	World Health Organization

# Introduction

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## Overview of the *Community Infant and Young Child Feeding Counselling Package*

The Nigerian *Community Infant and Young Child Feeding Counselling Package* is a resource designed to equip community workers, 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 community workers 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 the *Facilitator Guide*, the trainers are referred to as *facilitators* and the trainees/learners as *participants*.

## The materials

The *Community Infant and Young Child Feeding Counselling Package* is comprised of the following:

- The *Facilitator Guide* is intended for use in training community workers in technical knowledge related to key infant and young child feeding practices, essential counselling skills, and the effective use of counselling tools and other job aids.
- 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 and supervision activities.
- The 31 *Infant and Young Child Feeding Counselling Cards* (25 General Cards plus 6 Special Circumstance Cards) present brightly coloured illustrations that depict key infant and young child feeding concepts and behaviours for community workers 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.
- The *Key Messages Booklet* consists of messages related to each of the Infant and Young Child Feeding Counselling Cards.
- The *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.
- *Training Aids* have been designed to complement the training sessions by providing visuals to help participants grasp and retain technical knowledge and concepts.

All of the materials in the *Community Infant and Young Child Feeding Counselling Package* are available in their electronic formats to facilitate their adaptation for use in multiple settings.

### **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; and Roles and Responsibilities Before, During, and After Training, Appendices 1 and 2).

### **Specific objectives of training of counsellors**

The primary objective of training counsellors/community workers or primary health care staff is to equip them with the knowledge, skills, and tools to support mothers, fathers, and other caregivers to optimally feed their infants and young children. The *Facilitator Guide* was developed using training methodologies and technical content appropriate for use with community workers. The content focuses on breastfeeding, complementary feeding, the feeding of the sick/malnourished infant and young child, and infant feeding in the contexts of HIV, community management of acute malnutrition (CMAM), and emergencies. By the end of the training, participants will be able to do the following:

- Explain why infant and young child feeding practices matter.
- Demonstrate appropriate use of counselling skills (*Listening and Learning; Building Confidence and Giving Support* [practical help]) and use the set of *Infant and Young Child Feeding Counselling Cards*.
- Use the *Infant and Young Child Feeding 3-Step Counselling* ('Assess, Analyse, 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 material.
- Describe how to breastfeed.
- Identify ways to prevent and resolve common breastfeeding difficulties.
- Describe various aspects of appropriate complementary feeding during the period from 6 up to 24 months.
- Describe practices for feeding the sick child and the child who has acute malnutrition.
- Facilitate action-oriented group sessions and mother-to-mother infant and young child feeding support groups.
- Relate women's nutrition to life cycle.
- Describe basic information in infant feeding in the context of HIV.
- Highlight the main issues related to infant feeding in emergencies.
- Be able to list how and when a child should be followed up.
- Identify signs that require referral to a health post.

**Specific objectives of training of facilitators/trainers** (in addition to above content and skills):

- Develop the capacity of facilitators/trainers to plan, organise, and conduct roll-out trainings on the *Community Infant and Young Child Feeding Counselling Package*.
- Equip facilitators/trainers with the principles of adult education, effective training methodologies, and visual aids and skills to use them.
- Design action plan for roll-out trainings and follow-up of counsellors.

**Specific objectives of training master facilitators/trainers** (in addition to above content and skills):

- Orient master facilitators/trainers to the Nigerian *Community Infant and Young Child Feeding Counselling Package*.
- Develop the capacity of master facilitators/trainers to plan, organise, and conduct training of facilitators/trainers on the *Community Infant and Young Child Feeding Counselling Package*.
- Equip master facilitators/trainers with the principles of adult education, effective training methodologies, and visual aids and skills to use them.
- Design action plan: operational and roll-out for training of facilitators/trainers.

### **Target group**

Training participants may be community workers, traditional birth attendants, or other community workers. They may also be primary health care workers or project staff with more advanced infant and young child feeding training who act as ‘points of referral’ for the less experienced community workers and together form a community network of infant and young child feeding support. It is assumed that training participants will have basic literacy.

Supervisors are encouraged to attend the training, so that they are familiar with the training content and skills, and are thus better able to support and mentor the training participants on an ongoing basis. The *Participant Materials* include assessment, observation, monitoring, and supervision tools (i.e., infant and young child feeding assessment with mother, father, or caregiver and child); observation of assessment; checklist for conducting an educational talk, drama, or use of visual; checklist for conducting a support group; support group attendance form; and infant and young child feeding follow-up plan checklist to guide participants and supervisors in carrying out their work.

At least two facilitators should conduct the training. Ideally, there will be one facilitator for every three to five participants. When the ratio exceeds this number, it is impossible to oversee skills development ensuring competency. The facilitators should be infant and young child feeding experts with community-based experience and skills in facilitating the training of community workers.

### **Training materials: Structure**

A list of materials for a training of trainers is found in Appendix 3. The *Facilitator Guide* is divided into 20 sessions of one- to four-hour segments, divided over a three-day training. An alternative timetable for a five-day training course can be found in Appendix 4, as well as a three-day *Training in Infant and Young Child Feeding Support into Emergency Activities* intended for use in emergency-affected settings, with more detailed sessions on infant and young child feeding in the context of high levels of severe acute malnutrition (SAM) and in

emergencies (Appendix 5). It is strongly recommended to run all sessions of the training in one workshop rather than pursuing a modular approach. Where supervision reveals that the community workers have not understood selected topics very well, the relevant sessions can be repeated during monthly meetings or supervision visits.

Supportive supervision, supervisory checklists, programme manager oversight of supervision, and supervisory/mentoring tools are found in Appendix 6: Supervision.

Each session includes the following:

- A table detailing Learning Objectives, related pages of the *Participant Materials*, *Counselling Cards*, *Key Messages Booklet*, *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*, a *Key Messages Booklet*, and copies of the three *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 Infant and Young Child Feeding 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 infant and young child feeding counselling training is to change the behaviour of both the community workers (the learning 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 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 7: 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 8: 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 9: Suggested Training Exercises, Review Energisers [Group and Team Building], and Daily Evaluation; Appendix 10: Cut-Outs for 'Happy Faces' for Daily Evaluations ; and Appendix 11:Growth Monitoring and Nutritional Assessment).

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 and Key Messages Booklet***

The *Infant and Young Child Feeding Three-Step Counselling* guides counsellors through three important steps during an individual counselling session with a mother or caregiver and child.

To learn to conduct an infant and young child feeding Assessment of the mother and child pair, learning 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 two 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 *Take-Home 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 *Take-Home 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.

The information associated with each counselling Card is deliberately not written on the back side of the card. Avoiding or minimizing printed wording on each card eliminates the temptation to reduce the information to only key messages, which, when read, can create a barrier and negatively affect the interaction between the counsellor and the mother or caregiver. Instead, activities carried out in each session of the training are specifically designed to help the participants understand, internalise, 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 card(s) and information to discuss with a mother.

At the close of training, each participant is provided with a *Key Messages Booklet* for personal reference. The booklet summarises the most important messages on each counselling Card and contains copies of the *Take-Home Brochures*. The *Counselling Cards* 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 *Counselling Cards* and *Key Messages Booklet* 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 for the arrival of participants and for arrangement of space to practise the skills. The community/clinic needs to be contacted and visited prior to the visit to ensure effective mobilisation.

### **Post-training follow-up**

The desired output of the *Community Infant and Young Child Feeding Counselling Package* is the effective and continuing application of new skills and knowledge resulting in improved performance of both the community health worker 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/community workers 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 workplace as soon as feasible following the completion of training, within at least three months after training. Ideally, facilitators/supervisors 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/supervisor/mentor 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 formalised system of supervision/mentoring will allow supervisors/mentors or programme managers to monitor community health worker 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 community workers; and to determine the need and timing for on-the-job training or other refresher training. Where supervision/mentoring of individual community workers is not possible, peer discussion and mentoring among a group of community workers might be considered.

## Three-day Training: Community Infant and Young Child Feeding Counselling Package

	Day 1	Day 2	Day 3
8:15-8:30		Review	Review
8:30-10:30	<b>Session 1:</b> Introductions, Expectations, and Objectives (1 hr)	<b>Session 7:</b> Recommended Infant and Young Child Feeding Practices: Complementary Feeding for Children from 6 up to 24 Months (1.5 hr)	<b>Session 11:</b> First Field Visit and Feedback (4 hr)
	<b>Session 2:</b> Why Infant and Young Child Feeding Matters (1 hr)	<b>Session 8:</b> Complementary Foods 1/2 (0.5 hr)	
10:30-10:45	Tea break	Tea break	
10:45-12:45	<b>Session 3:</b> Common Situations that can Affect Young Child Feeding (1 hr)	<b>Session 8:</b> Complementary Foods 2/2 (0.5 hr)	
	<b>Session 4:</b> How to Counsel: Part I (1 hr)	<b>Session 9:</b> How to Counsel: Part II 1/2 (1.5 hr)	
12:45-13:45	Lunch	Lunch	
13:45-15:45	<b>Session 5:</b> Recommended Infant and Young Child Feeding Practices: Breastfeeding (1.5 hr)	<b>Session 9:</b> How to Counsel: Part II 2/2 (0.5 hr)	<b>Session 13:</b> Women's Nutrition (1 hr)
	<b>Session 6:</b> How to Breastfeed 1/2 (0.5 hr)	<b>Session 10:</b> Common Breastfeeding Difficulties: Symptoms, Prevention, and 'What to Do' (1.5 hr)	<b>Session 14:</b> Feeding of the Sick and Malnourished Child 1/2 (1 hr)
15:45-16:00	Tea break	Tea break	Tea break
16:00-18:00	<b>Session 6:</b> How to Breastfeed 2/2 (1 hr)	<b>Session 12:</b> Action-Oriented Groups, Infant and Young Child Feeding Support Groups, and Home Visits (2 hr)	<b>Session 14:</b> Feeding of the Sick and Malnourished Child 2/2 (1 hr)  <b>Session 20:</b> Post-Assessment and Evaluation (1 hr)

An additional half-day is required if including optional Session 17: Infant and Young Child Feeding in the Context of HIV. See alternative Five-Day Training: Community Infant and Young Child Feeding Counselling Package in Appendix 4, and Three-Day Training: Infant

and Young Child Feeding Support into Emergency Activities in  
Appendix 5.

## Session 1. Introductions, 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 <i>Counselling Cards</i>
2. Discuss participants' expectations, compare with the objectives of the training, and clarify the priorities/focus of the course. Agree on group norms.	Interactive presentation	
3. Identify strengths and weaknesses of participants' infant and young child feeding knowledge.	Non-written pre-assessment	Pre-assessment questions for facilitators
4. Present and review set of <i>Counselling Cards</i> , <i>Key Messages Booklet</i> , and <i>Take-Home Brochures</i> .	Buzz groups of three participants	<ul style="list-style-type: none"> <li>• Set of <i>Counselling Cards</i></li> <li>• <i>Key Messages Booklet</i></li> <li>• <i>Take-Home Brochures</i></li> </ul>

### Materials:

- Flipchart papers and stand (plus markers and masking tape or sticky putty).
- Name tags: encourage use of local technology rather than use of purchased materials not easily available in the community (e.g., pieces of paper and tape or pins).
- Participants' folders.
- Course timetable.

### Advance preparation:

- Flipchart: Course objectives (Page 2 of Introduction).

**Duration:** 1 hour.

**Learning objective 1:** Begin to name fellow participants, facilitators, and resource persons.

**Methodology:** Matching game.

### Instructions for activity:

1. Use illustrations from *counselling Cards* (laminated if possible) cut in two 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, their work in infant and young child feeding, one's expectations for the training, and something of human interest (favourite food, hobbies and/or colour, etc.).
2. When participants introduce themselves, ask them to hold up their 'matching-pair picture'

## Session 1. Introductions, Expectations, and Objectives

and describe it.

3. Facilitator writes expectations on flipchart.
4. Facilitator asks participants to brainstorm group norms; facilitator lists on flipchart, and list remains posted throughout the training.
5. Group decides on daily timekeeper and participant in charge of energisers.

**Learning objective 2:** Discuss participants' expectations, compare with objectives of the training, and clarify the priorities/focus of the course.

**Methodology:** Interactive presentation.

### Instructions for activity:

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 energised 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 participants' knowledge of infant and young child nutrition.

**Methodology:** Non-written pre-assessment.

### Instructions for activity:

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 two 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

**Methodology:** Written pre-assessment.

## Session 1. Introductions, Expectations, and Objectives

1. Pass out copies of the pre-assessment 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 set of *Counselling Cards*, *Key Messages Booklet*, and *Take-Home Brochures*.

**Methodology:** Buzz groups of three participants.

### Instructions for activity:

1. Distribute a set of *Counselling Cards*, *Key Messages Booklet*, and *Take-Home Brochures* to each participant and then ask participants to form groups of three.
2. Explain that the *Counselling Cards*, *Key Messages Booklet*, and *Take-Home 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*, *Key Messages Booklet*, and *Take-Home Brochure*.
4. Ask a group to hold-up the *counselling Card(s)*, the page of *Key the Messages Booklet*, and the *Take-Home Brochure(s)*, which show(s) the item.
5. Ask the other groups if they agree, disagree, or wish to add another *counselling Card*, page of *Key Messages Booklet*, or *Take-Home Brochure*.
6. Repeat the process with the remaining items/characteristics. Find the following:
  - A community worker 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 three times a day and have two snacks.
  - A sick baby less than 6 months old.
  - 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.
7. Repeat the explanation that the *Counselling Cards*, *Key Messages Booklet*, and *Take-Home Brochures* will be their tools to use.

### ‘Homework’ assignment:

- Read through the *counselling Card* messages for *Counselling Cards 1–8*, and *Counselling Card 18* in the *Key Messages Booklet*.

## Session 1. Introductions, Expectations, and Objectives

### Pre-assessment: What do we know now?

#		Yes	No	Don t know
1.	The purpose of an infant and young child feeding support group is to share personal experiences on infant and young child feeding practices.			
2.	Poor child feeding during the first two years of life harms growth and brain development.			
3.	An infant aged 6 up to 9 months needs to eat at least two times a day in addition to breastfeeding.			
4.	A pregnant woman needs to eat one more meal per day than usual.			
5.	At 4 months, infants need water and other drinks in addition to breastmilk.			
6.	Giving information alone to a mother on how to feed her child is effective in changing her infant feeding practices.			
7.	A woman who is malnourished can still produce enough good quality breastmilk for her baby.			
8.	The more milk a baby removes from the breast, the more breastmilk 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 6 months, the first food a baby takes should have the texture of breastmilk 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 breastmilk.			
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 play an important role in how infants and young children are fed.			

## Session 2. Why Infant and Young Child Feeding Matters

Learning objectives	Methodologies	Training aids
1. Define the terms ‘infant and young child feeding,’ ‘exclusive breastfeeding,’ and ‘complementary feeding.’	<ul style="list-style-type: none"> <li>Brainstorming</li> <li>Presentation</li> </ul>	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. Recognise all the conditions needed for a healthy, well-nourished child.	Interactive presentation	<i>Participant Materials 2.1: Why Infant and Young Child Feeding Matters</i>
3. Share in-country data on infant and young child feeding.	Interactive presentation (bean distribution)	Packages of 100 beans each for five groups

### Materials:

- Flipchart papers and stand (plus markers, plus 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.
- Five packages of 100 beans.

### Advance preparation:

- Flipchart: Following data (from the country, region, or district):
  - Initiation of breastfeeding (within one hour).
  - Exclusive breastfeeding (first six months).
  - Complementary feeding (early and late initiation, frequency, amount, texture, variety).
  - Malnutrition (underweight, stunting, SAM, moderate acute malnutrition [MAM], overweight/obesity).
  - Low birthweight.

**Note:** In pre-training preparation, ask participants to come with data on infant and young child feeding practices and key nutrition and health rates: initiation of breastfeeding, exclusive breastfeeding, introduction of solid, semi-solid, or soft foods (6 up to 9 months), stunting, wasting, underweight, and low birthweight.

**Duration:** 1 hour.

## Session 2. Why Infant and Young Child Feeding Matters

**Learning objective 1:** Define ‘infant,’ ‘young child,’ ‘exclusive breastfeeding,’ and ‘complementary feeding.’

**Methodology:** Brainstorming, presentation.

### Instructions for activity:

1. Ask participants:
  - What do we mean by ‘infant’ and ‘young child’?
  - What does ‘infant and young child feeding’ mean to you (facilitator writes responses on flipchart)?
  - To define ‘exclusive breastfeeding.’
  - To define ‘complementary feeding.’
  - To define ‘complementary foods.’
2. Facilitator recognises all of the inputs, corrects errors, and/or fills in gaps.
3. Discussion.

### Key information

**Infant:** From birth up to 1 year.

**Young child** (when used in the context of infant and young child feeding): From 12 months up to 2 years of age.

**Exclusive breastfeeding:** Means giving a baby only breastmilk and no other foods or drinks (liquids or solids), not even water. Drops or syrups consisting of vitamins, mineral supplements, or medicines are permitted if medically indicated.

- Requires that the infant receive: Breastmilk (including milk expressed, or from a wet nurse).
- Allows the infant to receive: Drops, syrups, (vitamins, minerals, medicines), **if medically indicated.**
- Does not allow the infant to receive: Anything else.

*Indicators for assessing infant and young child feeding practices, Part 1. Definitions. Conclusions of a consensus meeting held November 6–8, 2007 in Washington, DC, USA.*

**Complementary feeding:** The process starting when breastmilk alone is no longer sufficient to meet the nutritional requirements of infants, and therefore other foods and liquids are needed, along with breastmilk. The target range for complementary feeding is generally taken to be from 6 up to 24 months.

**Complementary foods:** Any locally prepared food suitable as a complement to breastmilk when breastmilk becomes insufficient to satisfy the nutritional requirements of the infant.

## Session 2. Why Infant and Young Child Feeding Matters

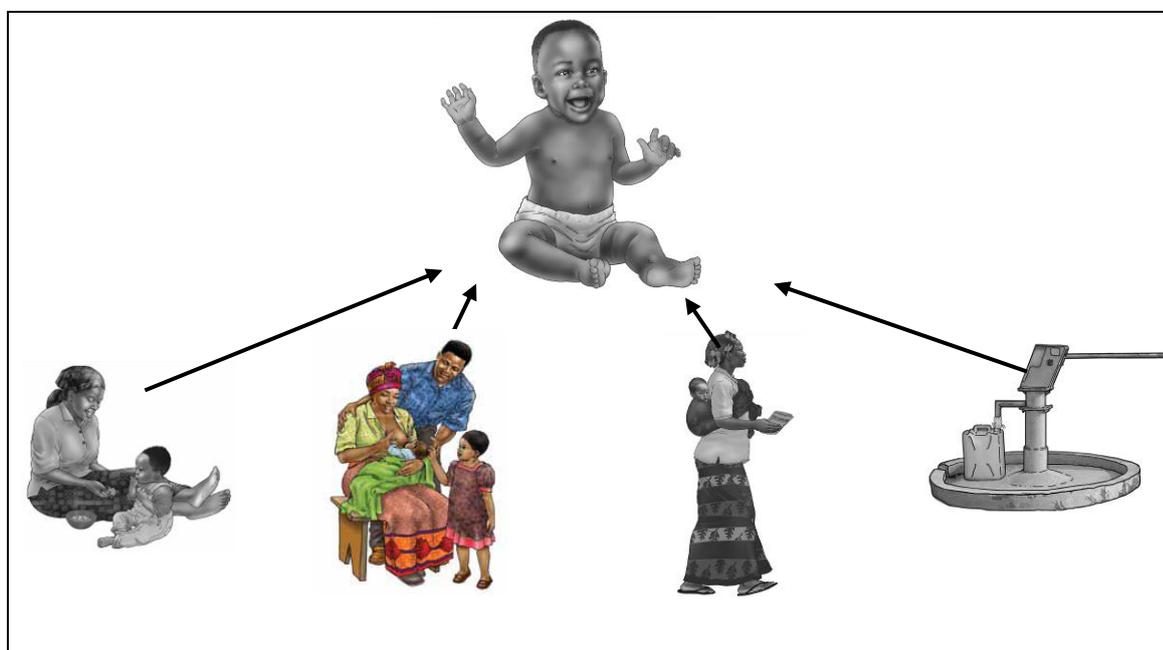
**Learning objective 2:** Recognise key factors that contribute to a healthy, well-nourished child.

**Methodology:** Interactive presentation.

### Instructions for activity:

1. Tape or stick to the flipchart the 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. Why are we focusing on the first two years of life?
  - Harm to growth and development cannot be corrected.
  - Effects of malnutrition (including stunting) are irreversible after 2 years of age.
5. Discuss and summarise.

### Key Information



**Food**

**Feeding and  
care  
practices**

**Health  
services**

**Water, hygiene,  
and sanitation**

## Session 2. Why Infant and Young Child Feeding Matters

**Learning objective 3:** Share in-country data on infant and young child feeding.

**Methodology:** Interactive presentation (bean distribution).

### Instructions for activity:

1. Ask participants to form groups, by region/district. Discuss their knowledge of the data on feeding practices in their regions/districts (out of 100 mothers/infants, how many: initiate breastfeeding within the first hour; exclusively breastfeed infants (0 up to 6 months); introduce solid, semi-solid, or soft foods (6 up to 9 months); continue breastfeeding up to 24 months).
2. Give participants a card that provides the actual data from their region/district.
3. Using beans and the prepared paper (100 blocks with dots representing 100 mothers), ask participants to demonstrate the data from their zone/district so that it can be shared with the community.
4. Ask the different regions/districts to share their data with the whole group.
5. From the data for each feeding practice, discuss the risk for the child.

### Examples of in-country data (latest Demographic Health Survey)

#### Breastfeeding practices:

- Initiation of breastfeeding (within one hour): 90 out of 100 mothers initiate breastfeeding within the first hour after birth.

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- Exclusive breastfeeding (infants under 6 months): 56 infants out of 100 are exclusively breastfed for six months.

## **Session 2. Why Infant and Young Child Feeding Matters**

### **Complementary feeding practices:**

- Early and late starting of complementary foods are common problems in Nigeria.
- Too little variety of foods is also a common problem, for example:
  - Upon introducing complementary foods, only 50 out of 100 children from age 6 up to 9 months consumed fruits and vegetables.
  - Only 10 out of 100 children from 6 up to 9 months of age consumed animal-source foods (meat, eggs).

### **Stunting:**

- 45 out of 100 children under 5 years are stunted.

### **Low birthweight:**

- 10 out of 100 infants are underweight at birth.

## Session 3. Common Situations that can Affect Infant and Young Child Feeding

Learning objectives	Methodologies	Training aids
1. Address common situations that can affect infant and young child feeding.	Game	<ul style="list-style-type: none"> <li>• Cards (fish-shaped) with a common situation that can affect infant and young child feeding written on the underside</li> <li>• <i>Participant Materials 3.1: Common Situations that can Affect Infant and Young Child Feeding</i></li> </ul>

### Materials:

- Package of cards (fish-shaped) with one common situation that can affect infant and young child feeding written on the underside: giving colostrum, low-birthweight or premature baby, kangaroo mother care, twins, refusal to breastfeed, new pregnancy, mother away from baby, crying baby, sick mother, stress, thin or malnourished mother, sick baby under 6 months, sick baby over 6 months, inverted nipple, eating during pregnancy, eating during breastfeeding.

**Duration:** 1 hour

**Learning objective 1:** Address common situations that can affect infant and young child feeding.

**Methodology:** Game.

### Instructions for activity:

1. Divide the participants into two groups, assigning to each group a package of cards.
2. On the back of each card (can be fish-shaped), write a common situation or condition related to local feeding beliefs (a paper clip can be attached to the ‘mouth’ of the fish and another paper clip to the end of a string tied to a stick).
3. Cards (fish) should be placed face-downward so participants can ‘fish’ for a belief.
4. Ask participants to fish (one card) and discuss: (i) How does this situation/belief affect infant and young child feeding in your community? (ii) How can you break the belief? (iii) What could/should be done?
5. **The common situation or belief as it relates to infant and young child feeding—how the belief can be addressed (‘what we know’).** Examples of widely shared beliefs (add and subtract from this list to adapt it to the local situation):

Giving colostrum, low birthweight or premature baby, kangaroo mother care, twins, refusal to breastfeed, new pregnancy, mother away from baby, crying baby, sick mother, stress, thin or malnourished mother, sick baby under 6 months, sick baby over 6 months, inverted nipple,

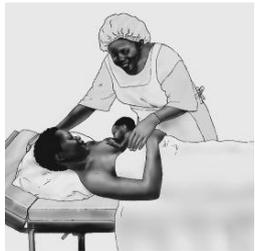
### Session 3. Common Situations that can Affect Infant and Young Child Feeding

eating during pregnancy, eating during breastfeeding.

6. Discuss and summarise in each group.

7. Review *Participant Materials 3.1: Common Situations that can Affect Infant and Young Child Feeding*.

#### Participant Materials 3.1: Common Situations that can Affect Infant and Young Child Feeding

Common situation	What to do
<p><b>Giving colostrum</b></p> 	<p><b>Local belief:</b> Colostrum should be discarded; it is ‘expired milk,’ not good, etc.</p> <p>What we know:</p> <ul style="list-style-type: none"> <li>• Colostrum contains antibodies and other protective factors for the infant. It is yellow because it is rich in vitamin A.</li> <li>• The newborn has a stomach the size of a marble. The few drops of colostrum fill the stomach perfectly. If water or other substances are given to the newborn at birth, the stomach is filled and there is no room for the colostrum.</li> </ul>
<p><b>Low-birthweight or premature baby</b></p> 	<p><b>Local belief:</b> The low-birthweight baby or premature baby is too small and weak to be able to suckle/breastfeed.</p> <p>What we know:</p> <ul style="list-style-type: none"> <li>• A premature baby should be kept in belly-to-belly contact with the mother; this will help to regulate his body temperature and breathing, and keep him in close contact with the breast.</li> <li>• A full-term, low-birthweight infant may suckle more slowly; allow him/her the time.</li> <li>• The breastmilk from the mother of a premature baby is perfectly suited to the age of her baby, and will change as the baby develops (i.e., the breastmilk for a 7-month old newborn is perfectly suited for an infant of that gestational age, with more protein and fat than the milk for a full-term newborn).</li> <li>• See Positioning Card #5, upper-right picture.</li> <li>• Mother needs support for good attachment, and help with supportive holds.</li> <li>• Feeding pattern: long, slow feeds are OK—keep baby at the breast.</li> <li>• Direct breastfeeding may not be possible for several weeks, but mothers should be encouraged to express breastmilk and feed the breastmilk to the infant using a cup.</li> <li>• If the baby sleeps for long periods of time, and is wrapped up in several layers, open and take off some of the clothes to help waken</li> </ul>

### Session 3. Common Situations that can Affect Infant and Young Child Feeding

Common situation	What to do
	<p>him for the feed.</p> <ul style="list-style-type: none"> <li>• Crying is the last sign of hunger. Earlier signs of hunger include a combination of the following signs: being alert and restless, opening mouth and turning head, putting tongue in and out, sucking on hand or fist. One sign by itself may not indicate hunger, so explain that she should respond by feeding baby when s/he shows these signs.</li> </ul>
<p><b>Kangaroo mother care</b></p> 	<p>Position (baby is naked apart from nappy and cap and is placed in belly-to-belly contact between mother's naked breasts with legs flexed and held in a cloth that supports the baby's whole body up to just under his/her ears and which is tied around the mother's chest). This position provides:</p> <ul style="list-style-type: none"> <li>• Belly-to-belly contact.</li> <li>• Warmth.</li> <li>• Stabilisation of breathing and heartbeat.</li> <li>• Closeness to the breast.</li> <li>• Mother's smell, touch, warmth, voice, and taste of the breastmilk help to stimulate the baby to establish successful breastfeeding.</li> <li>• Breastfeeding (early and exclusive breastfeeding by direct expression or expressed breastmilk given by cup).</li> <li>• Mother and baby are rarely separated.</li> </ul>
<p><b>Twins</b></p> 	<p><b>Local belief:</b> A mother of twins does not have enough breastmilk to feed both babies.</p> <p>What we know:</p> <ul style="list-style-type: none"> <li>• A mother can exclusively breastfeed both babies.</li> <li>• The more a baby suckles and removes milk from the breast, the more milk the mother produces.</li> <li>• Mothers of twins produce enough milk to feed both babies if the babies breastfeed frequently and are well-attached.</li> <li>• The twins need to start breastfeeding as soon as possible after birth. If they cannot suckle immediately, help the mother to express and cup feed. Build up the milk supply from very early to ensure that breasts make enough for two babies.</li> <li>• Explain different positions—cross-cradle, one under arm, one across, feed one-by-one, etc. Help mother to find what suits her.</li> </ul>
<p><b>Refusal to breastfeed</b></p>	<p>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 breastmilk (more salty, bitter, sour, etc.).</p> <ul style="list-style-type: none"> <li>• Check baby for signs of illness that may interfere with feeding, including signs of thrush in the mouth.</li> </ul>

### Session 3. Common Situations that can Affect Infant and Young Child Feeding

Common situation	What to do
	<ul style="list-style-type: none"> <li>• Refer baby for treatment if ill.</li> <li>• Let the baby have plenty of belly-to-belly 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.</li> <li>• Let mother/baby try different breastfeeding positions.</li> <li>• Wait for the baby to be wide awake and hungry (but not crying) before offering the breast.</li> <li>• Gently touch the baby’s bottom lip with the nipple until s/he opens his/her mouth wide.</li> <li>• Do not force the baby to breastfeed and do not try to force mouth open or pull the baby’s chin down—this makes the baby refuse more.</li> <li>• Do not hold the baby’s head.</li> <li>• Express and feed the baby by cup until baby is willing to suckle.</li> <li>• Express directly into the baby’s mouth.</li> <li>• Avoid giving the baby bottles with teats or dummies.</li> </ul>
<p><b>New pregnancy</b></p> 	<p><b>Local belief:</b> A woman must stop breastfeeding her older child as soon as she learns she is pregnant.</p> <p>What we know:</p> <ul style="list-style-type: none"> <li>• Continue to breastfeed for at least two years or more.</li> <li>• A pregnant woman can safely breastfeed her older child, but should eat very well herself to protect her own health (she will be eating for herself, the new baby, and the older child, but she should be careful not to over-eat to avoid unnecessary excess weight).</li> <li>• Because she is pregnant, her breastmilk will now contain small amounts of colostrum, which may cause the older child to experience diarrhoea for a few days (colostrum has a laxative effect). After a few days, the older child will no longer be affected by diarrhoea.</li> <li>• Sometimes the mother’s nipples feel tender if she is pregnant. However, it is perfectly safe to breastfeed two babies and will not harm either baby, as there will be enough milk for both.</li> </ul>
<p><b>Mother away from baby</b></p>	<p><b>Local belief:</b> A mother who works outside the home or is away from her baby cannot continue to exclusively breastfeed her infant.</p> <p>What we know:</p> <ul style="list-style-type: none"> <li>• If a mother must be separated from her baby, she can express her breastmilk and leave it to be fed to the infant in her absence by other caregivers (e.g., husband, grandmother, etc.).</li> </ul>

### Session 3. Common Situations that can Affect Infant and Young Child Feeding

Common situation	What to do
	<ul style="list-style-type: none"> <li>• Help mother to express her breastmilk and store it to feed the baby while she is away. The baby should be fed this milk at times when he or she would normally feed.</li> <li>• Teach caregiver how to store and safely feed expressed breastmilk from a cup. It may be stored safely at room temperature for up to eight hours.</li> <li>• Mother should allow infant to feed frequently at night and whenever she is at home.</li> <li>• Mother who is able to keep her infant with her at the work site or to go home to feed the baby should be encouraged to do so and to feed her infant frequently.</li> </ul>
<p><b>Crying baby</b></p> 	<p><b>Local belief:</b> Babies cry because they are hungry or thirsty.</p> <ul style="list-style-type: none"> <li>• Help mother to try to figure out the cause of baby's crying and listen to her feelings: <ul style="list-style-type: none"> <li>○ Discomfort: hot, cold, dirty.</li> <li>○ Tiredness: too many visitors.</li> <li>○ Illness or pain: changed pattern of crying.</li> <li>○ Hunger: not getting enough breastmilk; growth spurt.</li> <li>○ Mother's foods: can be a certain food; sometimes cow's milk.</li> <li>○ Mother's drugs.</li> <li>○ Colic.</li> </ul> </li> <li>• If the baby is less than 6 months and is thirsty, the only thing he/she needs is breastmilk</li> </ul>
<p><b>Sick mother</b></p> 	<p><b>Local belief:</b> A sick mother cannot breastfeed.</p> <p>What we know:</p> <ul style="list-style-type: none"> <li>• When the mother is suffering from common illnesses, she should continue to breastfeed her baby. (Seek medical attention for serious or long-lasting illness).</li> <li>• The mother needs to rest and drink plenty of fluids to help her recover.</li> <li>• The mother needs support from family members to enable her to breastfeed successfully.</li> </ul>
<p><b>Stress</b></p> 	<ul style="list-style-type: none"> <li>• Mother's stress does not spoil breastmilk, or result in decreased production. However, milk may not flow well temporarily.</li> <li>• If mother continues to breastfeed, milk flow will start again.</li> <li>• Keep baby in belly-to-belly contact with mother if she will permit.</li> <li>• Find reassuring companions to listen, give mother an opportunity to talk, and provide emotional support and practical help.</li> <li>• Help her to sit or lie down in a relaxed position and to breastfeed baby.</li> </ul>

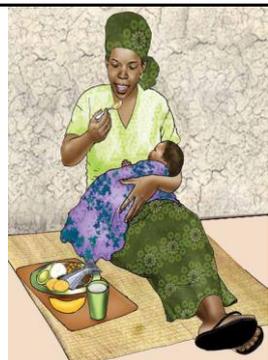
### Session 3. Common Situations that can Affect Infant and Young Child Feeding

Common situation	What to do
	<ul style="list-style-type: none"> <li>• Show her companion how to give her a massage, such as a back massage, to help her to relax and her milk to flow.</li> <li>• Give her a warm drink, such as tea or warm water, to help relax and assist the let-down reflex.</li> </ul>
<p data-bbox="188 439 384 539"><b>Thin or malnourished mother</b></p> 	<p data-bbox="480 439 1385 506"><b>Local belief:</b> A thin or malnourished mother cannot produce ‘enough breastmilk’.</p> <p data-bbox="480 528 687 562">What we know:</p> <ul style="list-style-type: none"> <li>• It is important that a mother be well-fed to protect her own health.</li> <li>• A mother who is thin and malnourished will produce a sufficient quantity of breastmilk (better quality than most other foods a child will get) if the child suckles frequently.</li> <li>• More suckling and removal of the breastmilk from the breast leads to production of more breastmilk.</li> <li>• Eating more will not lead to more production of breastmilk.</li> <li>• A mother needs to eat more food for her own health. “Feed the mother and let her breastfeed her baby”. Do not supplement the baby.</li> <li>• Mothers need to take vitamin A within six weeks after delivery, and a daily multivitamin, if available.</li> <li>• If the mother is severely malnourished, refer to health facility.</li> </ul>
<p data-bbox="188 1184 448 1252"><b>Sick baby under 6 months</b></p> 	<p data-bbox="480 1184 1385 1252"><b>Local belief:</b> Fluids should be withheld from the sick baby/baby with diarrhoea.</p> <p data-bbox="480 1274 687 1308">What we know:</p> <ul style="list-style-type: none"> <li>• A sick child often does not feel like eating, but needs even more strength to fight the illness.</li> <li>• Breastfeed more frequently during diarrhoea to help the baby fight the sickness and not lose weight.</li> <li>• Breastfeeding also provides comfort to a sick baby.</li> <li>• If the baby is too weak to suckle, express breastmilk to give to the baby (either by cup or by expressing directly into the baby’s mouth). This will help the mother keep up her milk supply and prevent engorgement.</li> </ul>

### Session 3. Common Situations that can Affect Infant and Young Child Feeding

<p><b>Sick baby over 6 months</b></p> 	<p><b>Local belief:</b> Fluids should be withheld from the sick baby/baby with diarrhoea.</p> <p>What we know:</p> <ul style="list-style-type: none"> <li>• Increase breastfeeding during diarrhoea, and continue to offer favourite foods in small quantities.</li> <li>• During recovery, offer more foods than usual (an additional meal of solid food each day) during recuperation (for the next two weeks) to replenish the energy and nutrients lost during illness.</li> <li>• Offer the young child simple foods like porridge, even if s/he does not express interest in eating.</li> <li>• Avoid spicy or fatty foods.</li> <li>• Breastfeed more frequently during two weeks after recovery.</li> <li>• Animal milks and other fluids may increase diarrhoea (the origin of the belief that milk brings about diarrhoea). However, this is not true of breastmilk. Stop giving other milks or fluids, even water (except ORS if child is severely dehydrated).</li> </ul>
<p><b>Inverted nipple</b></p> 	<p>What we know:</p> <ul style="list-style-type: none"> <li>• Antenatal treatment is not helpful (e.g., stretching the nipples).</li> <li>• Most nipples improve around the time of delivery without any treatment.</li> <li>• The baby suckles from the breast and not the nipple.</li> <li>• Let the baby have plenty of belly-to-belly contact.</li> <li>• If the baby does not attach well by himself, help his mother to position him so that he can attach better.</li> <li>• If the baby cannot suckle effectively in the first week or two, help his mother to try to express milk and feed it to her baby by cup.</li> </ul>
<p><b>Eating during pregnancy</b></p> 	<p><b>Local belief:</b> A pregnant woman should avoid certain foods that are believed to adversely affect her baby (e.g., eggs, snails, okro, grass-cutter meat, etc.).</p> <p>What we know:</p> <ul style="list-style-type: none"> <li>• Even though there are many food taboos, no foods are forbidden.</li> <li>• During pregnancy, the body needs extra food each day—eat one extra small meal or “snack” each day.</li> <li>• Drink whenever thirsty, but avoid taking tea or coffee with meals.</li> <li>• The pregnant woman should avoid alcoholic drinks, coffee, tea, cola drinks, kola nuts, and smoking.</li> </ul>
<p><b>Eating during breastfeeding</b></p>	<p><b>Local belief:</b> A pregnant woman should avoid certain foods that are believed to adversely affect her baby (e.g., eggs, snails, okro, grass-</p>

### Session 3. Common Situations that can Affect Infant and Young Child Feeding



cutter meat, etc.).

What we know:

- Even though there are many food taboos, no foods are forbidden.
- During breastfeeding, the body needs extra food each day. The breastfeeding woman needs to eat two extra small meals or “snacks” each day.
- No one special food or diet is required to provide adequate quantity or quality of breastmilk.
- Breastmilk production is not affected by maternal diet.
- Mothers should be encouraged to eat more food to maintain their own health.
- Some cultures claim that certain drinks help to ‘make milk;’ these drinks may have a relaxing effect on the mother but some of them can be harmful (such as potash pap [Kunu kanwa] or palm wine).
- During breastfeeding, the mother should limit alcohol consumption and avoid smoking.

## 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"> <li>Group work</li> <li>Demonstration</li> </ul>	<ul style="list-style-type: none"> <li><i>Participant Materials 4.1: Counselling Skills</i></li> <li><i>Participant Materials 9.1: Infant and Young Child Feeding Assessment of Mother/Child Pair</i></li> </ul>
2. Explain why changing behaviour is difficult.	<ul style="list-style-type: none"> <li>Interactive presentation</li> <li>Group work</li> </ul>	
3. Reflect on role of fathers in maternal and child nutrition.	Buzz groups of three	Cover of <i>Counselling Cards</i> (and others where men appear): Role of fathers in maternal and child nutrition

### Materials:

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

### Advance preparation:

- For each group of four participants, prepare a “ladder of steps;” five steps (on separate pieces of paper): not knowing, knowing, becoming motivated to try something new, adopting a new behaviour, and sustaining a new behaviour; and the role of the community health worker (on separate pieces of paper: give information, encourage, counsel/problem solve/reach an agreement, praise/discuss benefits, and support).
- Facilitators practise demonstration of infant and young child feeding assessment of mother/child pair (*listening and learning* skills).
- Flipchart: *Listening and learning* skills.
- Flipchart: Role of fathers in the nutrition of their wives/partners and infants/children.

**Duration:** 1 hour.

**Learning objective 1:** Identify *listening and learning* skills.

**Methodology:** Group work; Demonstration.

**Instructions for activity:**

**Listening**

1. Pair participants. Ask them to tell a story to each other at the same time for two minutes.
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 one 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 summarise 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 one question).
2. What did you get from this exercise? (Some types of questions bring out more information than others). Asking about 'age': gets you a specific piece of information (which is what you sometimes want).
3. Open-ended questions usually begin with *why, how, when, and where?*
4. What things can you do to bring out more information?

## Session 4. How to Counsel: Part I

- a) Reflect back what the facilitator (mother/father/caregiver) says.
- b) Listen to the facilitator's (mother/father/caregiver's) concerns
- c) Avoid using judging words.

### Demonstration:

**Note:** Two facilitators practise this demonstration in advance (with one facilitator as “mother” and the other facilitator as counsellor) using *listening and learning* skills (See *Participant Materials: 4.1*) and *Three-Step Counselling* (See Session 9).

1. Ask participants to observe how the counsellor interacts with the mother in the following role-play.
2. Model *listening and learning* skills between a mother (Tamuno) with 7-month son (Ahmed) and Counsellor following *Participant Materials 9.1: Infant and Young Child Feeding Assessment of Mother/Child Pair*. Facilitator/mother (Tamuno):
  - Breastfeeds whenever Ahmed cries.
  - Feels she does not produce enough milk.
  - Gives Ahmed some watery porridge two times a day (gruel is made from common starchy staple [e.g., corn meal]).
  - Does not give any other milks or drinks to Ahmed.
3. After the demonstration, ask participants: “How did the counsellor interact with the mother?”
4. Probe to see what *listening and learning* skills were used.

### Key information

The *listening and learning* skills listed above (on the flipchart) are from *Infant and Young Child Feeding Counselling: An Integrated Course*. World Health Organization (WHO)/UNICEF. 2006.

**Learning objective 2:** Explain why changing behaviour is difficult.

**Methodology:** Interactive presentation; Group work.

### Instructions for activity:

1. Divide participants into groups of four.
2. Give each group a “ladder of steps” and ask groups to put in ascending order the five steps: not knowing; knowing; becoming motivated to try something new; adopting a new behaviour; and sustaining a new behaviour.
3. Ask participants: What helps a person to move through the different steps?
4. Ask each group to add the role of the community health worker (give information; encourage; counsel, problem solve, reach an agreement; praise/discuss benefits, support) at the point it is appropriate in the “ladder of steps.”
5. 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

## Session 4. How to Counsel: Part I

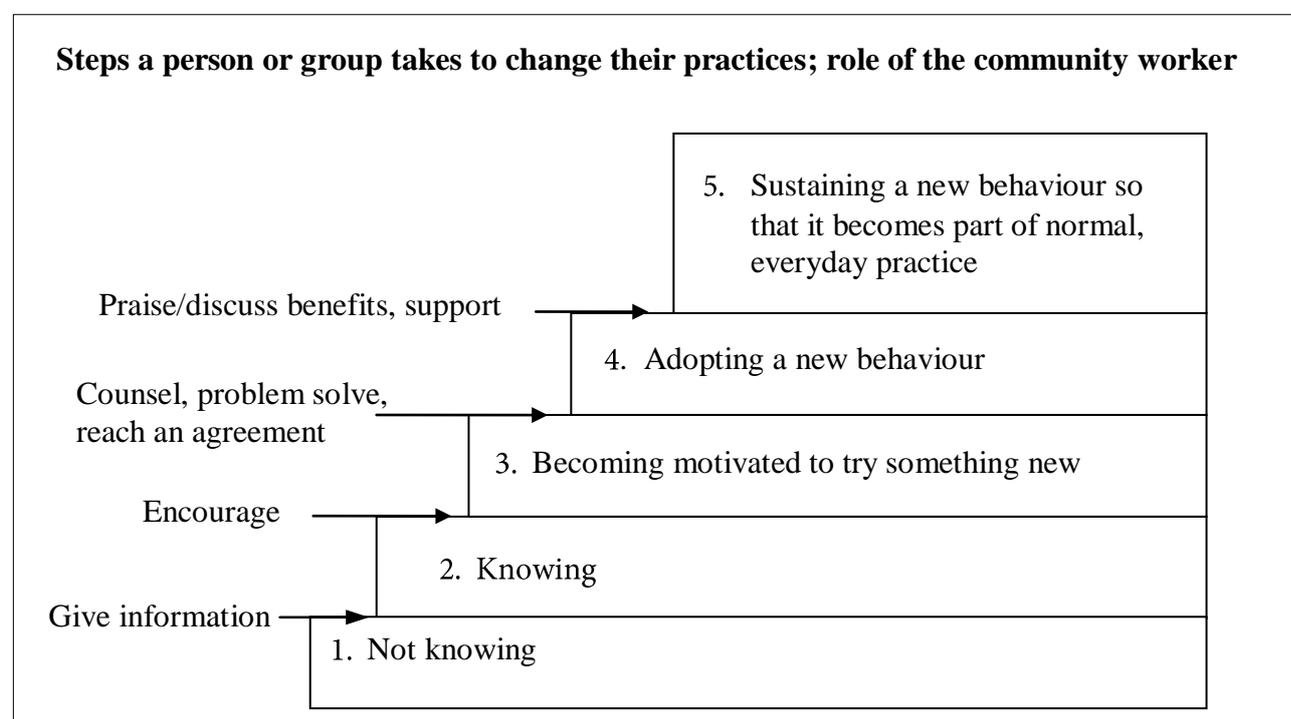
move to the next step.

6. Discussion (ask if any participants want to share their personal experience).
7. Give each group three case studies. For each case study, the group answers the question: ‘At what stage of the behaviour change process is the mother?’
8. Discuss in large group.

**NOTE:** Behaviour change should not be limited to efforts with the mother/father/caregiver, but rather encompass the entire community of influencers.

9. Include a demonstration of the above:
  - Ask a participant to represent a mother with a newborn and come and sit in an opening of the circle.
  - Ask other participants: Who needs to support this mother?
10. As participants mention different family and community members, ask a participant to come and represent that person (father, grandmothers, grandfathers, siblings, aunts, cousins, traditional birth attendant, midwife, doctor, nurse, religious leaders, elders, etc.).

### Key information



**Note:** The community health worker utilises *listening and learning* and *building confidence and giving support* skills throughout the entire process or steps of behaviour change. The *three-step infant and young child feeding counselling process*—Assess, Analyse, 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*

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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 community worker encourages her to give her child thickened porridge instead of watery porridge because the child is not growing.
3. In the past month, a community worker 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 accordingly.

### *Behaviour change case studies (Answer key)*

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

**Learning objective 3:** Reflect on the role of fathers in maternal and child nutrition.

**Methodology:** Buzz groups of three.

### **Instructions for activity:**

1. Ask buzz groups to examine the **cover of the set of Counselling Cards** and look for men who appear in other 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, 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.
- Make arrangements 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.
- Talk with his mother and his mother-in-law about feeding plan, beliefs, and customs.
- Make sure the baby exclusively breastfeeds for the first six months.

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- Provide a variety of food for a child over 6 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 6 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 immunisations.
- Provide long-lasting insecticide net for his family in malaria-endemic areas and make sure the pregnant wife/partner and small children get to sleep under the net every night.
- Encourage education of his girl children.

### Participant Materials 4.1: Counselling Skills

#### *Listening and learning skills*

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 allow 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.



Source: World Health Organization (WHO)/UNICEF. Infant and Young Child Feeding Counselling: An Integrated Course. WHO/UNICEF: 2006.

## Session 5. Recommended Infant and Young Child Feeding 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	<i>Participant Materials 5.1: 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"> <li>• <i>Participant Materials 5.2: Recommended Breastfeeding Practices and Possible Points of Discussion for Counselling</i></li> <li>• <i>Counselling Cards for recommended breastfeeding practices: 1 to 5, and 18</i></li> <li>• <i>Key Messages Booklet</i></li> <li>• <i>Take-Home Brochures: How to Breastfeed Your Baby; and Nutrition During Pregnancy and Breastfeeding</i></li> </ul>

### Materials:

- Flipchart papers and stand (plus markers, plus masking tape or sticky putty).
- Large cards (½ A4 size) or pieces of paper of the same size.

**Duration:** 1½ hours.

**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 for activity:

1. Divide participants into four groups. 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 **OR** The risks of NOT breastfeeding for the infant; The risks of NOT breastfeeding for the mother; The risks of NOT breastfeeding for the family; and The risks of NOT breastfeeding for the community/nation.
2. Each group has three 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 or the flipchart rotates to the next group. Repeat the exercise until all groups fill the four flipcharts.
3. Discuss and summarise in large group (The risks of NOT breastfeeding [see Key Information

below] for infant and mother can also be discussed).

4. Distribute from *Participant Materials 5.1: Importance of Breastfeeding for Infant/Young Child, Mother, Family, Community/Nation* (or refer to specific page in *Participant Materials*) and discuss.

### **Key information**

#### **Risks of NOT breastfeeding**

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

*For the infant:*

- Greater risk of death (a non-breastfed baby is 14 times more likely to die in the first six months than an exclusively breastfed baby).
- Formula has no antibodies to protect against illness; the mother's body makes breastmilk with antibodies that protect from the specific illnesses in the mother/child environment.
- Do not receive their "first immunisation" from the colostrum.
- Struggle to digest formula: it is not at all the perfect food for babies.
- Frequent diarrhoea, falls 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 and when families are not able to afford enough commercial infant formula.
- Under-development: retarded growth, underweight, stunting, wasting due to higher infectious diseases such as diarrhoea and pneumonia.
- Poorer bonding between mother and infant, making the baby feel 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.

*For the mother:*

- Mother may become pregnant sooner.
- Increased risk of anemia if breastfeeding is not initiated early (more bleeding after childbirth).
- Interferes with bonding.
- Increased risk of postpartum depression.
- Increased risk of developing breast conditions such as engorgement.
- Ovarian cancer and breast cancer occurrence is lower in mothers who breastfeed.

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*For the family:*

- Increased medical bills for treatment of preventable illnesses.
- Increased expenditure on infant formula.
- More time spent preparing the formula, less time for other children.

*For the community/nation:*

- Deforestation as trees are cut down for fuel.
- Increased morbidity and mortality rates.
- Foreign exchange on formula importation.
- Increased expenses in health care.

**Learning objective 2:** Identify the recommended breastfeeding practices.

**Methodology:** Group work.

### **Instructions for activity:**

*A. Identify recommended breastfeeding practices through discussion*

1. Give each group of four (participants) 11 cards or pieces of paper.
2. Facilitator gives an example of a recommended breastfeeding practice, such as initiation of breastfeeding within the first hour of birth.
3. Each group writes a recommended breastfeeding practice on each card (one per card), discusses, and groups the cards.
4. Each group tapes or sticks their cards on recommended breastfeeding practices on the wall.
5. 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.
6. Beginning with the first practice presented, ask other groups with a similar practice to tape or stick their practice on top.
7. Continue with all subsequent practices.
8. Ask other groups to tape or stick any additional practices to first 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 summarises and fills in the gaps in the 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 *Counselling Cards*:

## Session 5. Recommended Infant and Young Child Feeding Practices: Breastfeeding

- *Counselling Card 1*: Nutrition for pregnant and breastfeeding women.
  - *Counselling Card 2*: Importance of early initiation of breastfeeding.
  - *Counselling Card 3*: Breastfeeding in the first 6 months.
  - *Counselling Card 4a*: Exclusively breastfeed during the first 6 months.
  - *Counselling Card 4b*: Dangers of mixed feeding during the first 6 months.
  - *Counselling Card 5*: Breastfeeding on demand, both day and night.
  - *Counselling Card 18*: Feeding the sick baby less than 6 months of age.
  - *Take-Home Brochure*: How to Breastfeed Your Baby.
  - *Take-Home Brochure*: Nutrition During Pregnancy and Breastfeeding.
2. Ask groups to match the *Counselling Cards* and *Take-Home Brochures* with the recommended breastfeeding practices posted.
  3. Ask groups to describe the main counselling points for discussion/messages that the *Counselling Cards* and *Take-Home Brochure* represent.
  4. Ask each group to share their observations and counselling points for discussion/messages for one of the four cards and *Take-Home Brochure*.
  5. Other groups will add additional points.
- C. Participant Materials*
1. Distribute from *Participant Materials 5.2: Recommended Breastfeeding Practices and Possible Points of Discussion for Counselling* (or refer to specific page in *Participant Materials*).
  2. What additional discussion points might be added?
  3. Orient participants to the key messages from the *Key Messages Booklet*.
  4. 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.
  5. Discuss and summarise.

### Key information

- See *Participant Materials 5.2: Recommended Breastfeeding Practices and Possible points of Discussion for Counselling*.

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

**Importance of breastfeeding for the infant/young child**

Breastmilk:

- Saves infants' lives.
- Perfectly meets the needs of human infants.
- Is a complete food for the infant, and provides all babies' nutrients needs for the first six months. It also provides all the water that the baby needs.
- 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.
- Helps jaw and teeth development; suckling develops facial and jaw structure.
- Provides frequent belly-to-belly contact between mother and infant, which leads to bonding, better psychomotor, affective, and social development of the infant.
- Benefits the infant with the provision of 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 and acts as a laxative, cleaning the infant's stomach).
- Provides long-term benefits, including the reduced risk of obesity and diabetes.

**Importance of breastfeeding for the mother**

- Breastfeeding is more than 98% effective as a contraceptive method during the first six 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, breastmilk 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).
- Breastmilk is available at anytime and anywhere, is always clean, nutritious, and at the right temperature.

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- Breastfeeding is economical: formula costs a lot of money, and the non-breastfed baby or mixed-fed baby is sick much more often, which involves 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 milks could cause.
- There are no expenses involved in buying other milks, 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 are fewer illness-required trips for medical treatment.

**Note:** Families need to support mother by helping her with baby and other household chores.

### Importance of breastfeeding for the community/nation

- Healthy babies make a healthy and productive nation.
- Savings are made in health care delivery because the number of childhood illnesses is 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 breastmilk substitutes). Breastmilk 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 commercial infant formula feeding (commercial infant formula-fed babies)**

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

- Greater risk of death (a non-breastfed baby is 14 times more likely to die than an exclusively breastfed baby in the first six months).
- Formula has no antibodies to protect against illness; the mother's body makes breastmilk with antibodies that protect from the specific illnesses in the mother/child environment.
- Don't receive their "first immunization" from the colostrums.
- Struggle to digest formula: it is not at all the perfect food for babies.
- Frequent diarrhoea, falls ill more often and more seriously (mixed-fed infants less than six months who receive contaminated water, formula, and foods are at higher risk).
- Frequent respiratory infections.
- Greater risk of undernutrition, especially for younger infants and when family may not be able to afford enough formula.
- Under-development: retarded growth, underweight, stunting, wasting due to higher infectious diseases such as diarrhoea and pneumonia.
- Poorer bonding between mother and infant makes infant feel less secure.
- 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.
- Nipple confusion, leading to poor attachment and damage to the mother's nipple.

**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 diarrhoea. This is due to contaminated milk and water.
- More likely to get malnourished. Porridge is usually not enriched and has little nutritional value, formula is often over-diluted, and both displace the more nutritious breastmilk.
- Get less breastmilk because they suckle less and then the mother makes less milk.
- Suffer damage to their fragile guts from even a small amount of anything other than breastmilk.
- If mothers are HIV-infected, babies are much more likely to become infected than exclusively breastfed ones, because their guts are damaged by the other liquids and foods and thus allow the HIV virus to enter more easily.

**Participant Materials 5.2: Recommended Breastfeeding Practices and Possible Counselling Discussion Points**

Recommended breastfeeding practice	Possible counselling discussion points Note: Choose two to three most relevant to mother's situation and/or ADD other discussion points from knowledge of area
<p>Place infant belly-to-belly with mother immediately after birth</p> 	<p>Use <i>Counselling Card 2: Importance of early initiation of breastfeeding.</i></p> <ul style="list-style-type: none"> <li>• Belly-to-belly with mother keeps newborn warm and helps stimulate bonding or closeness, and brain development.</li> <li>• Belly-to-belly helps the “let down” of the colostrum/milk.</li> <li>• 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.”</li> <li>• Colostrum is the first thick, yellowish milk that protects baby from illness.</li> </ul>
<p>Initiate breastfeeding within the first half-hour of birth</p> 	<p>Use <i>Counselling Card 2: Importance of early initiation of breastfeeding.</i></p> <p>Use <i>Take-Home Brochure: How to Breastfeed Your Baby.</i></p> <ul style="list-style-type: none"> <li>• Make sure baby is well-attached.</li> <li>• This first milk is called colostrum. It is yellow and full of antibodies, which help protect your baby.</li> <li>• Colostrum provides the first immunisation against many diseases.</li> <li>• DO NOT give baby any other fluids other than breastmilk, unless medically indicated.</li> </ul>
<p>Breastfeeding in the first few days</p>	<ul style="list-style-type: none"> <li>• Breastfeeding frequently from birth helps the baby learn to attach and helps to prevent engorgement and other complications.</li> <li>• In the first few days, the baby may feed only two to three times/day. If the baby is still sleepy on Day 2, the mother may express some colostrum and give it from a cup.</li> <li>• DO NOT give baby any other fluids other than breastmilk, unless medically indicated.</li> </ul>
<p>Exclusively breastfeed (no other food or drink) from 0 up to 6 months</p>	<p>Use <i>Counselling Card 3: Breastfeeding in the first 6 months.</i></p> <p>Use <i>Counselling Card 4a: Exclusively breastfeed during the first 6 months.</i></p> <p>Use <i>Counselling Card 4b: Dangers of mixed feeding during the first</i></p>

Session 5. Recommended Infant and Young Child Feeding Practices: Breastfeeding

Recommended breastfeeding practice	Possible counselling discussion points Note: Choose two to three most relevant to mother's situation and/or ADD other discussion points from knowledge of area
	<p>6 months.</p> <p>Use <i>Take-Home Brochure: How to Breastfeed Your Baby</i>.</p> <ul style="list-style-type: none"> <li>• Breastmilk is all the infant needs for the first 6 months.</li> <li>• Do not give anything else to the infant before 6 months, not even water.</li> <li>• Breastmilk contains all the water a baby needs, even in a hot climate.</li> <li>• Giving water will fill the infant and cause less suckling; less breastmilk will be produced.</li> <li>• Water and other liquids and foods for an infant less than 6 months can cause diarrhoea.</li> </ul>
<p>Breastfeed frequently, day and night</p> 	<p>Use <i>Counselling Card 5: Breastfeed on demand, both day and night</i>. Use <i>Take-Home Brochure: How to Breastfeed Your Baby</i>.</p> <ul style="list-style-type: none"> <li>• After the first few days, most newborns want to breastfeed frequently, 8 to 12 times per day. Frequent breastfeeding helps produce lots of breastmilk.</li> <li>• Once breastfeeding is well-established, breastfeed eight or more times per day and night to continue to produce plenty of breastmilk. If the baby is well-attached, contented, and gaining weight, the number of feeds is not important.</li> <li>• More suckling (with good positioning and attachment) makes more breastmilk.</li> </ul>
<p>Breastfeed on demand</p>	<p>Use <i>Counselling Card 5: Breastfeed on demand, both day and night</i>.</p> <ul style="list-style-type: none"> <li>• Crying is a <u>late</u> sign of hunger.</li> <li>• Early signs that baby wants to breastfeed: <ul style="list-style-type: none"> <li>○ Restlessness.</li> <li>○ Opening mouth and turning head from side to side.</li> <li>○ Putting tongue in and out.</li> <li>○ Sucking on fingers or fists.</li> </ul> </li> </ul>
<p>Let infant finish one breast and come off by him/herself before switching to the other breast</p>	<p>Use <i>Counselling Card 5: Breastfeed on demand, both day and night</i>.</p> <ul style="list-style-type: none"> <li>• Switching back and forth from one breast to the other prevents the infant from getting the nutritious 'hind milk.'</li> <li>• 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.</li> </ul>

Session 5. Recommended Infant and Young Child Feeding Practices: Breastfeeding

Recommended breastfeeding practice	Possible counselling discussion points Note: Choose two to three most relevant to mother's situation and/or ADD other discussion points from knowledge of area
<p>Good positioning and attachment</p> 	<p>Use <i>Counselling Card 6: There are many breastfeeding positions</i> and <i>Counselling Card 7: Good attachment</i>.</p> <ul style="list-style-type: none"> <li>• Four 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.</li> <li>• Four signs of good attachment: <b>mouth wide open, chin touching breast, more areola showing above than below the nipple, and lower lip turned out.</b></li> </ul>
<p>Continue breastfeeding until 2 years of age or beyond</p>	<p>Use <i>Counselling Card 12: Start complementary feeding at 6 months</i>. Use <i>Counselling Card 13: Complementary feeding from 6 up to 9 months</i>. Use <i>Counselling Card 14: Complementary feeding from 9 up to 12 months</i>. Use <i>Counselling Card 15: Complementary feeding from 12 up to 24 months</i>. Use <i>Counselling Card 16: Food variety</i>.</p> <ul style="list-style-type: none"> <li>• Breastmilk contributes a significant proportion of energy and nutrients during the complementary feeding period and helps protect babies from illness.</li> </ul>
<p>Continue breastfeeding when infant or mother is ill</p>	<p>Use <i>Counselling Card 18: Feeding the sick baby less than 6 months of age</i>. Use <i>Counselling Card 19: Feeding the sick child more than 6 months</i>.</p> <ul style="list-style-type: none"> <li>• Breastfeed more frequently during child's illness.</li> <li>• The nutrients and immunological protection of breastmilk are important to the infant when mother or infant is ill.</li> <li>• Breastfeeding provides comfort to a sick infant.</li> </ul>
<p>Mother needs to eat and drink to satisfy hunger and thirst</p>	<p>Use <i>Counselling Card 1: Nutrition for pregnant and breastfeeding women</i>. Use <i>Take-Home Brochure: Nutrition During Pregnancy and Breastfeeding</i>.</p> <ul style="list-style-type: none"> <li>• No one special food or diet is required to provide adequate quantity or quality of breastmilk.</li> </ul>

**Session 5. Recommended Infant and Young Child Feeding Practices: Breastfeeding**

<b>Recommended breastfeeding practice</b>	<b>Possible counselling discussion points</b> <b>Note: Choose two to three most relevant to mother s situation and/or ADD other discussion points from knowledge of area</b>
	<ul style="list-style-type: none"> <li>• Breastmilk production is not affected by maternal diet.</li> <li>• No foods are forbidden.</li> <li>• Mothers should be encouraged to eat more food to maintain their own health.</li> </ul>
<p>Avoid feeding bottles</p> 	<p>Use <i>Counselling Card 11: Good hygiene practices.</i></p> <p>Use <i>Counselling Card 12: Start complementary feeding at 6 months.</i></p> <p>Use <i>Counselling Card 13: Complementary feeding from 6 up to 9 months.</i></p> <p>Use <i>Counselling Card 14: Complementary feeding from 9 up to 12 months.</i></p> <p>Use <i>Counselling Card 15: Complementary feeding from 12 up to 24 months.</i></p> <p>Use <i>Counselling Card 16: Food variety.</i></p> <ul style="list-style-type: none"> <li>• Foods or liquids should be given by cup to reduce nipple confusion and the possible introduction of contaminants.</li> </ul>

## 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	<i>Participant Materials 6.1: Anatomy of the Human Breast</i>
2. Demonstrate good positioning and attachment.	<ul style="list-style-type: none"> <li>• Role-play</li> <li>• Group work</li> <li>• Observation</li> <li>• Practise</li> </ul>	<ul style="list-style-type: none"> <li>• <i>Participant Materials 6.2: Good and Poor Attachment</i></li> <li>• <i>Counselling Card 6: There are many breastfeeding positions</i></li> <li>• <i>Counselling Card 7: Good attachment</i></li> <li>• <i>Take-Home Brochure: How to Breastfeed Your Baby</i></li> <li>• <i>Counselling Card 8: Breastfeeding low-birthweight (small) babies</i></li> <li>• <i>Key Messages Booklet</i></li> </ul>
3. List ways to establish and maintain breastmilk supply.	Brainstorming	
4. Describe hand expression and storage of breastmilk; and how to cup feed.	<ul style="list-style-type: none"> <li>• Brainstorming</li> <li>• Demonstration</li> <li>• Practise</li> </ul>	<ul style="list-style-type: none"> <li>• <i>Counselling Card 9: How to hand express breastmilk and cup feed</i></li> <li>• <i>Counselling Card 10: Breastfeeding and working mothers</i></li> <li>• <i>Key Messages Booklet</i></li> </ul>
<b>Additional activity:</b> Making dolls and breast models.	Working groups help each other make dolls and breast models	<i>Participant Materials 6.3: Instructions for Making Cloth Breast Models</i>

### Materials:

- Flipchart papers and stand (plus markers, plus masking tape or sticky putty).
- Dolls or rolled-up towels.
- Needles, thread, socks, cotton wool.
- 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 breastmilk expression (if possible and culturally accepted).

## Session 6. Recommended Infant and Young Child Feeding Practices: Breastfeeding

- Facilitators practice demonstration of good attachment and positioning (mother and counsellor).

### **Additional activity: Making dolls and breast model**

- 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 two socks, one sock resembling skin colour to show the outside of the breast, and another sock to show the inside of the breast.
- *Participant Materials 6.3: Instructions for Making Cloth Breast Models*

**Duration:** 1½ hours.

**Learning objective 1:** Briefly describe the anatomy of the breast and how the breast makes milk.

**Methodology:** Group work.

### **Instructions for activity:**

1. Ask participants to form working groups in which each group draws and labels:
  - 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.
3. Compare drawings with *Participant Materials 6.1: Anatomy of the Human Breast*, noting similarities and correcting misinformation.
4. Ask one group to explain how milk is produced; ask other groups to add additional points.
5. Facilitate discussion in large group, correcting misinformation and answering questions.
6. Explain that frequent removal of plenty of milk from the breast encourages milk production.
7. 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 breastmilk removed from the breast, the more breastmilk the mother makes.
8. Distribute *Participant Materials 6.1: Anatomy of the Human Breast* (or refer to specific page in *Participant Materials*).
9. Discuss and summarise.

### **Key information**

See *Participant Materials 6.1: Anatomy of the Human Breast*.

- When the baby suckles at the breast, stimulation of the nipple results in breastmilk production and the release, or “let down,” of breastmilk.
- *Suckling as well as removing plenty of milk from the breast* is essential for good milk supply.

## Session 6. Recommended Infant and Young Child Feeding Practices: Breastfeeding

- If the baby does not remove plenty of breastmilk, 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-plays*

1. Using a real mother (if possible), facilitator explains the four signs of good positioning:
    - a) The baby’s body should be straight.
    - b) The baby’s body should be facing the breast.
    - c) The baby should be close to mother (belly-to-belly).
    - d) Mother should support the baby’s whole body.
  2. If no mother is present, one facilitator (acting as a community worker) helps another facilitator (acting as a mother) role-play helping a mother position baby to breast using a doll or rolled-up towel.
  3. The community worker now explains to the mother the four signs of attachment:
    - a) The baby should be close to the breast with mouth wide open.
    - b) The chin should touch the breast.
    - c) You should see more areola above the baby’s mouth than below.
    - d) The baby’s lower lip is turned outwards.
  4. If no mother is present, one facilitator (acting as a community worker) helps another facilitator (acting as a mother) role-play helping a mother attach baby to breast using a doll or rolled-up towel.
- .....

### Instructions for Activity 2:

#### *Group work: Positioning*

1. Form groups of three and ask groups to look at *Counselling Card 6: There are many breastfeeding positions* and *Counselling Card 8: Breastfeeding low-birthweight (small) babies*.
2. Ask one group to explain the Counselling Card on different breastfeeding positions (Counselling Card 6); ask the group to explain what they observe while facilitator is demonstrating the different positions mentioned in the four points of positioning.
3. Ask another group to explain the position for feeding a low-birthweight baby (Counselling Card 8); facilitator and participants fill in the gaps.
4. Orient participants to key messages from *Key Messages Booklet*.

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**Instructions for Activity 3:**

*Observation of illustrations: Attachment*

1. Distribute *Participant Materials 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? Ask participants to explain the differences.
3. Ask participants: "What happens when attachment is poor (baby is not attached well)?"
4. Form groups of three and ask groups to look at *Counselling Card 7: Good attachment*.
5. Ask a group to explain *Counselling Card 7: Good attachment* to the entire group—what they observe, pointing out the four signs of good attachment.
6. Draw participants' attention to the signs of effective suckling.
7. Orient participants to key messages from *Key Messages Booklet*.

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**Instructions for Activity 4:**

*Practise*

1. Ask participants to divide into groups of three (mother, community worker, and observer).
2. Using dolls or rolled-up towels/material: Participants practise helping 'mother' to use good positioning (four signs) and good attachment (four 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 three. 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 mother and do it him/herself).
4. Ask groups to provide any feedback: What was new? What were the difficulties?
5. Summarise key points in large group.

**Key information**

- See *Counselling Card 6: There are many breastfeeding positions*; and *Counselling Card 7: Good attachment*.
- See *Participant Materials 6.2: Good and Poor Attachment*.

## Session 6. Recommended Infant and Young Child Feeding Practices: Breastfeeding

### 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 Counselling Card 6: There are many breastfeeding positions.*

- The mother must be comfortable.
- The four key points about baby's position are: straight, facing the breast, close to mother, and supported:
  - 1) The baby's body should be straight, not bent or twisted, but with the head slightly back.
  - 2) 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.
  - 3) The baby should be close to mother (belly-to-belly).
  - 4) 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 from *Key Messages Booklet*.

*How to help a mother attach her baby at the breast*

- Explain the four 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 **mouth wide open**, so that he or she can take in plenty of the areola and not just the nipple.
  - 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**.
  - 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 upper lip.
- 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, with the thumb above the areola and the other fingers below. The fingers need to be flat against the 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 with nose to nipple (not mouth to nipple).

## Session 6. Recommended Infant and Young Child Feeding Practices: Breastfeeding

- Notice how the mother responds.
- Look for all the signs of good attachment.
- If the attachment is not good, try again. (Do not 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.

### Activity 2: Group work

*Demonstration of different breastfeeding positions (refer participants to Counselling Card 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 a 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.
    - When 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.

### Activity 3: Observation of illustrations: 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 only 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.)

## Session 6. Recommended Infant and Young Child Feeding Practices: Breastfeeding

- 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—suckling action.

### *Picture #2 Poor attachment (inside baby's mouth)*

- The baby is sucking just the nipple, 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.

### *Results of poor attachment:*

- Sore and cracked nipples.
- Mastitis.
- Pain leads to poor milk release and slows milk production.

### **Activity 4: Practise**

*How to help a mother achieve good attachment (refer participants to Counselling Card 7: Good attachment and Take-Home 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.
  - Refer to Activity 1: How to help a mother attach her baby at the breast.

**Learning objective 3:** List ways to establish and maintain breastmilk supply.

**Methodology:** Buzz groups.

### **Instructions for activity:**

1. Ask participants to form buzz groups.
2. Refer participants to *Counselling Card 2: Importance of early initiation of breastfeeding; Counselling Card 3: Breastfeeding in the first 6 months; Counselling Card 4a: Exclusive breastfeeding during the first 6 months; Counselling Card 4b: Dangers of mixed feeding during the first 6 months; Counselling Card 5: Breastfeeding on demand, both day and night; Counselling Card 6: There are many breastfeeding positions; and Counselling Card 9: How to hand express breastmilk and cup feed*, and ask them to name ways to help establish and maintain breastmilk supply.
3. Refer participants to recommended breastfeeding practices which are displayed (from Session 5).
4. Facilitator fills in gaps from key information.
5. Discuss and summarise.

**Key information**

*Establish and maintain breastmilk supply:*

- Place mother and baby belly-to-belly immediately after birth—do not 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 positioning: baby’s body should be straight, and facing the breast, baby should be close to mother, and mother should support the baby’s whole body, not just the neck and shoulders, with her hand and forearm.
- Ensure good attachment: mouth wide open, chin touching breast, more areola showing above than below the nipple, and lower lip turned out.
- Breastfeed frequently: the more a baby suckles, the more breastmilk the mother makes.
- Let baby finish first breast before offering the second.
- Give only breastmilk (no other liquids, foods, or water) for the first six months.
- Keep the baby close or belly-to-belly so that the mother can breastfeed whenever baby wants for as long as he or she wants.
- Breastfeed at night.
- Express breastmilk when away from baby so that the expressed breastmilk 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 community worker: Encourage and support breastfeeding at all encounters, and build mother’s confidence.

**Learning objective 4:** Describe hand expression and storage of breastmilk; and how to cup feed.

**Methodology:** Brainstorming; Demonstration; Practise.

**Instructions for activity:**

1. Ask participants to state the reasons why a mother might need to express her breastmilk and list on flipchart.
2. Facilitator demonstrates milk-expression technique using a breast model.
3. Using the breast model, participants “practise” breastmilk expression in groups of three: participants take turns explaining to each other how to help a mother express her breastmilk, and how to store it.
4. Demonstrate cup feeding.
5. Groups of three “practise” cup-feeding technique.

## Session 6. Recommended Infant and Young Child Feeding Practices: Breastfeeding

6. Same groups of three review *Counselling Card 9: How to hand express breastmilk and cup feed* and *Counselling Card 10: Breastfeeding and working mothers*, 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 from the *Key Messages Booklet*.
9. Discuss and summarise.

### Key information

*Sometimes a mother needs to express milk for her baby:*

- Baby is too weak or small, such as low birthweight babies, to suckle effectively (see *Counselling Card 8: Breastfeeding low-birthweight (small) babies*).
- Baby is taking longer than usual to learn to suckle (e.g., because of inverted nipples).
- To feed a sick baby.
- To keep up the supply of breastmilk 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 breastmilk soon after your baby is born.
  - Breastfeed exclusively and frequently for the whole period that you are with your baby.
  - Express and store breastmilk before you leave your home so that your baby's caregiver can feed your baby while you are away.
  - Express breastmilk 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 workplace (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 for activity:**

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.

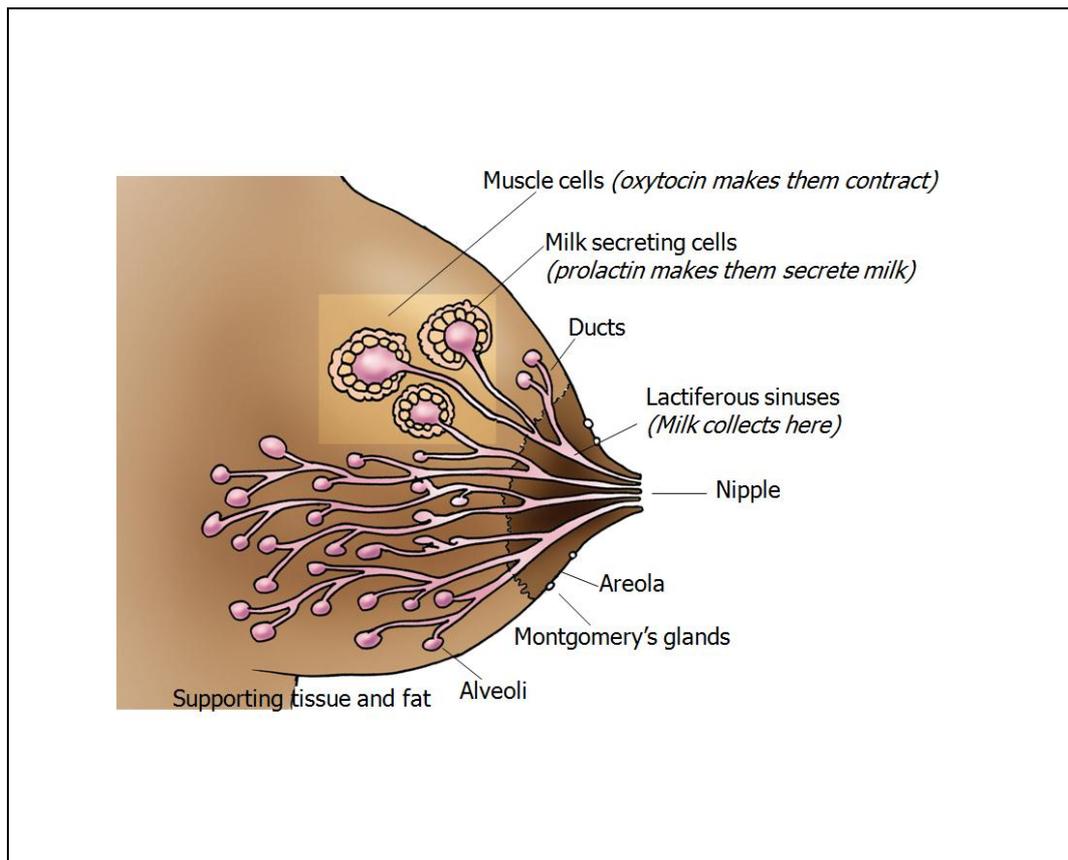


2. Participants work together to make their dolls.
3. Demonstrate how to make a breast model using simple materials (Two socks: one sock resembling skin colour to show the outside of the breast, and another sock to show the inside of the breast—*Participant Materials 6.3: Instructions for Making Cloth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

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

**Another suggestion for making dolls:** Fold a bath towel in half. Take the top middle part of the towel and form a rounded bunch of towel to make the ‘head’ of the baby (stuffed paper can help round out the ‘head’ of the baby). Secure with an elastic band around the ‘neck.’ Going down from the ‘head,’ bunch up towel to form two arms and secure with elastic bands at the point where ‘arms join the body.’ Leave some towel for the ‘body’ of the doll and bunch up towel to form two legs and secure with elastic bands at the point where ‘legs join the body.’

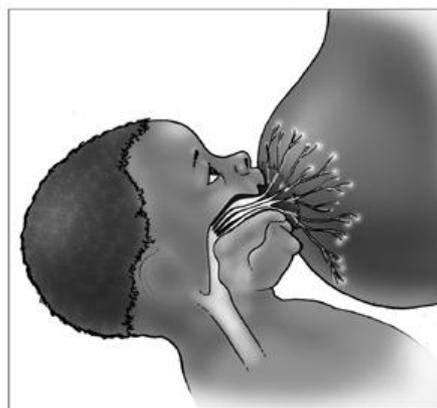
### Participant Materials 6.1: Anatomy of the Human Breast



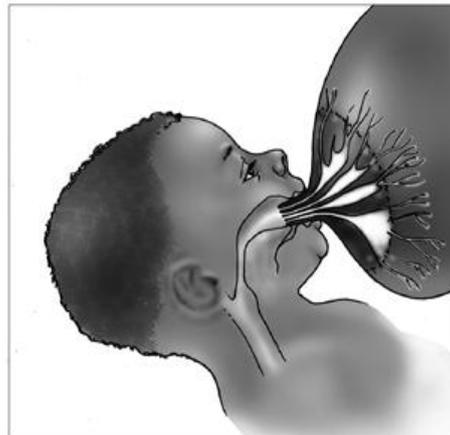
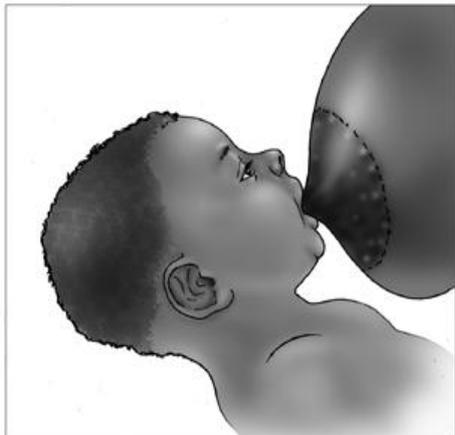
Adapted from World Health Organization (WHO)/UNICEF. Infant and Young Child Feeding Counselling: An Integrated Course. WHO/UNICEF: 2006.

### Participant Materials 6.2: Good and Poor Attachment

#### Good attachment



**Poor attachment**



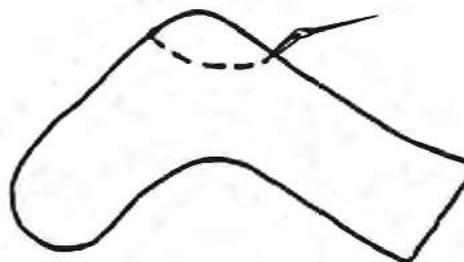
World Health Organization (WHO)/UNICEF. Infant and Young Child Feeding Counselling: An Integrated Course. WHO/UNICEF: 2006.

**Participant Materials 6.3: Instructions for Making Cloth Breast Models**

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.

**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 1½cm 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.



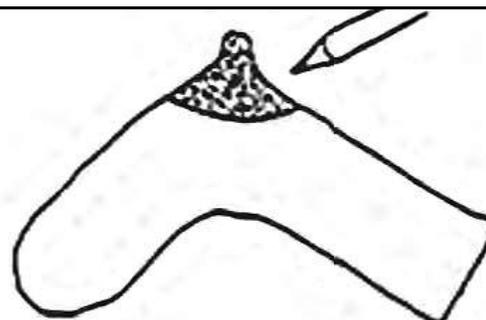
**White sock**

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.



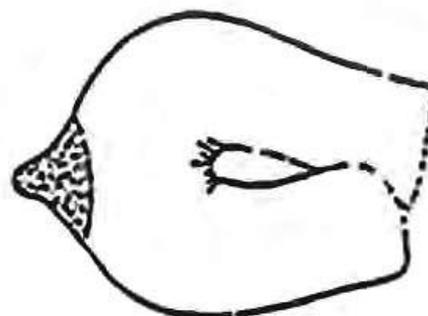
**Putting the two socks together**

Stuff the heel of the white sock with anything soft. Hold the two 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.



**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.



## Session 7. Recommended Infant and Young Child Feeding 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"> <li>• Brainstorming</li> <li>• Demonstration</li> </ul>	Three glasses with water: completely full, ½-, and ⅓-filled, respectively
2. Describe what we should consider when thinking of complementary feeding for each age group: frequency, amount, texture (thickness/consistency), variety (different foods), active/responsive feeding, and hygiene.	Brainstorming	
3. Describe recommended practices and counselling discussion points pertaining to child feeding from 6 up to 24 months.	Participatory presentation by working groups	<ul style="list-style-type: none"> <li>• <i>Participant Materials 7.1: Recommended Complementary Feeding Practices</i></li> <li>• <i>Participant Materials 7.2: Different Types of Locally Available Foods</i></li> <li>• <i>Participant Materials 7.3: Recommended Complementary Feeding Practices and Possible Counselling Discussion Points</i></li> <li>• <i>Participant Materials 7.4: Active/Responsive Feeding for Young Children</i></li> <li>• Illustrations of texture (thickness/ consistency) of porridge (cup and spoon)</li> <li>• Illustrations of food groupings (staples, legumes and seeds, vitamin A-rich fruits and vegetables, other fruits and vegetables, animal-source foods), and oils</li> </ul>

**Session 7. Recommended Infant and Young Child Feeding Practices: Complementary Feeding for Children from 6 up to 24 Months**

Learning objectives	Methodologies	Training aids
		<ul style="list-style-type: none"> <li>• <i>Counselling Card 11: Good hygiene practices</i></li> <li>• <i>Counselling Card 12: Start complementary feeding at 6 months</i></li> <li>• <i>Counselling Card 13: Complementary feeding from 6 up to 9 months</i></li> <li>• <i>Counselling Card 14: Complementary feeding from 9 up to 12 months</i></li> <li>• <i>Counselling Card 15: Complementary feeding from 12 up to 24 months</i></li> <li>• <i>Counselling Card 16: Food variety</i></li> <li>• <i>Counselling Card 19: Feeding the sick child more than 6 months</i></li> <li>• <i>Counselling Card Special Circumstance 6: Non-breastfed child from 6 up to 24 months</i></li> <li>• <i>Counselling Card 23: Kitchen gardens and fruit trees</i></li> <li>• <i>Counselling Card 24: Small animal breeding</i></li> <li>• <i>Key Messages Booklet</i></li> <li>• <i>Take-Home Brochure: How to Feed a Baby From 6 Months</i></li> </ul>

**Materials:**

- Illustrations of texture (thickness/consistency—thick and thin) of porridge (cup and spoon).
- Illustrations of food groupings (*staples, legumes and seeds, vitamin A-rich fruits and vegetables, other fruits and vegetables, animal-source foods*), and oils.

**Advance preparation:**

- Three glasses with water: completely full, ½- and ⅓-filled, respectively.

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- Flipchart with content as described in Learning objective 3, Activities 2 and 3: Pieces of paper with the chart content from *Participant Materials 7.1: Recommended Complementary Feeding Practices* to one group.
- Examples of local foods or illustrations of food groupings or photographs of local foods to place on chart from *Participant Materials 7.1: Recommended Complementary Feeding Practices*.

**Duration:** 1½ hours.

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

**Methodology:** Brainstorming; Demonstration.

### Instructions for activity:

1. Ask participants: How much energy is provided by breastmilk 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' of a child from 0 up to 6 months, 6 up to 12 months, and from 12 up to 24 months on a flipchart; leave posted throughout the training (key information below).
3. Demonstrate the same information using three glasses: completely full, half (½) and one-third (⅓) filled, respectively.

### Key information

*Energy:*

- From 0 up to 6 months, breastmilk supplies all the 'energy needs' of a child.
- From 6 up to 12 months breastmilk continues to supply about half (½) the 'energy needs' of a child; the other half of 'energy needs' must be filled with complementary foods.
- From 12 up to 24 months breastmilk continues to supply about one-third (⅓) 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 help development.

**Learning objective 2:** Describe what we should consider when thinking of complementary feeding for each age group: Frequency, amount, texture (thickness/consistency), variety (different foods), active/responsive feeding, and hygiene.

**Methodology:** Brainstorming.

### Instructions for activity:

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1. Brainstorm the definition of complementary feeding.
2. Brainstorm with participants the question: What should we consider when thinking of complementary feeding?
3. Probe until the following are mentioned: Frequency, amount, texture (thickness/consistency), variety (different foods), active or responsive feeding, and hygiene.
4. Discuss and summarise.

### Key information

- Complementary feeding means giving other foods in addition to breastmilk. (When an infant is 6 months old, breastmilk alone is no longer sufficient to meet his or her nutritional needs, and therefore, other foods and liquids should be given along with breastmilk.)
- These other foods are called complementary foods

*Things we should consider when talking about complementary feeding:*

A=Age of infant/young child

F=Frequency of feeding

A=Amount of foods

T=Texture (thickness/consistency)

V=Variety of foods

A=Active or responsive feeding

H=Hygiene

**Learning objective 3:** 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 for activity:

#### A. Participatory presentation by working groups

1. Divide the participants into two groups.
2. Prepare two flipcharts with columns: Age, Frequency, Amount, and Texture; and 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 Materials: 7.1* to one group.
4. Distribute local foods (or illustrations of food groupings, photographs of local 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 the second group placing the foods (or illustrations/photographs of local foods) and utensils (or pictures of utensils) in the

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appropriate box on flipchart.

6. Ask groups to continue until all chart content is filled.
7. Ask group one to explain its entries on the flipchart.
8. Ask group two to explain its entries using food and utensils.
9. Ask both groups: which locally available foods contain iron? And which locally available foods contain vitamin A?
10. How can kitchen gardens, fruit trees, and small animal breeding contribute to adequate complementary feeding?
11. Refer to *Participant Materials 7.1: Recommended Complementary Feeding Practices* (or refer to specific page in *Participant Materials*).
12. Together, the entire group decides what content/food/utensils need to be rearranged to coincide with *Participant Materials 7.1: Recommended Complementary Feeding Practices*.
13. Discuss and summarise.

### **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. Refer to *Participant Materials 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. Refer to *Participant Materials 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. Refer to *Participant Materials 7.4: Active/Responsive Feeding for Young Children* (or refer to specific page in *Participant Materials*) and orient participants to key information.

### **Key information**

- See *Participant Materials 7.1: Recommended Complementary Feeding Practices*.
- See *Participant Materials 7.2: Different Types of Locally Available Foods*.
- See *Participant Materials 7.3: Recommended Complementary Feeding Practices and Possible Counselling Discussion Points*.
- See *Participant Materials 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 breastmilk (although it is easily absorbed). After six months, the baby's 'iron needs' must be met by the food he or she eats.

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- 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 reduces the absorption of iron.

### Vitamin A

- Best sources of vitamin A are orange-coloured fruits and vegetables (pawpaw, mangoes, oranges, carrots, pumpkins, orange-flesh sweet potato); dark-green leaves; 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:** If country has a vitamin-A endemic deficiency, it is important to make sure that children from 6 months to 5 years receive the recommended supplement.

### C. Group work

- Divide participants into five working groups.
- Ask working groups to observe *Counselling Card 11: Good hygiene practices* and ask them what information the card contains
- Ask each group to explain the characteristics of complementary feeding in the following counselling Cards:
  - *Counselling Card 12: Start complementary feeding at 6 months.*
  - *Counselling Card 13: Complementary feeding from 6 up to 9 months.*
  - *Counselling Card 14: Complementary feeding from 9 up to 12 months.*
  - *Counselling Card 15: Complementary feeding from 12 up to 24 months.*
  - *Counselling Card 16: Food variety.*
- Each group will present one card with the characteristics of complementary feeding in the large group.
- Other groups to add any additional points; facilitator fills in gaps.
- Orient participants to key messages from *Key Messages Booklet*.
- Ask working groups to observe *Counselling Card 19: Feeding the sick child more than 6 months* and *Take-Home Brochure: How to Feed a Baby after 6 Months*, and ask them what information the card and brochure contain.
- Discuss and summarise.

### ‘Homework’ assignment:

- Read through the counselling Card messages for the following counselling Cards in the *Key Messages Booklet*:
  - *Counselling Card 12: Start complementary feeding at 6 months.*
  - *Counselling Card 13: Complementary feeding from 6 up to 9 months.*
  - *Counselling Card 14: Complementary feeding from 9 up to 12 months.*

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- *Counselling Card 15: Complementary feeding from 12 up to 24 months.*
- *Counselling Card 16: Food variety.*
- *Counselling Card 19: Feeding the sick child more than 6 months.*
- *Counselling Card Special Circumstance 6: Non-breastfed child from 6 up to 24 months.*

**Key information**

- *Counselling Card 11: Good hygiene practices.*
- *Counselling Card 12: Start complementary feeding at 6 months.*
- *Counselling Card 13: Complementary feeding from 6 up to 9 months.*
- *Counselling Card 14: Complementary feeding from 9 up to 12 months.*
- *Counselling Card 15: Complementary feeding from 12 up to 24 months.*
- *Counselling Card 16: Food variety.*
- *Counselling Card 19: Feeding the sick child more than 6 months.*
- *Counselling Card Special Circumstance 6: Non-breastfed child from 6 up to 24 months.*
- *Key Messages Booklet.*
- *Take-Home Brochure: How to Feed a Baby after 6 Months.*

**Participant Materials 7.1: Recommended Complementary Feeding Practices**

Age	Recommendations			
	Frequency (per day)	Amount of food an average child will usually eat at each meal (in addition to breastmilk)	Texture (thickness/consistency)	Variety
Start complementary foods when baby reaches <b>6 months</b> 	Two to three meals, plus frequent breastfeeds	Start with two to three tablespoons  Start with ‘tastes’ and gradually increase amount	Thick porridge/pap	Breastmilk (Breastfeed as often as the child wants)  PLUS Animal foods (local examples)  PLUS
Start complementary feeding from <b>6 up to 9 months</b>	Two to three meals plus frequent breastfeeds  One to two snacks may be offered	Two to three tablespoonfuls per feed  Increase gradually to half (½) of a 250-ml cup/bowl	Thick porridge/pap  Mashed/pureed family foods	Staples (porridge, other local examples)  PLUS Legumes

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Age	Recommendations			
				(local examples) PLUS Fruits/ Vegetables (local examples)
<p>Start complementary feeding from <b>9 up to 12 months</b></p> 	<p>Three to four meals plus breastfeeds</p> <p>One to two snacks may be offered</p>	<p>Half (½) of a 250-ml cup/bowl</p>	<p>Finely chopped family foods</p> <p>Finger foods</p> <p>Sliced foods</p>	
<p>Start complementary feeding from <b>12 up to 24 months</b></p> 	<p>Three to four meals plus breastfeeds</p> <p>One to two snacks may be offered</p>	<p>Three-quarters (¾) to one 250-ml cup/bowl</p>	<p>Sliced foods</p> <p>Family foods</p>	
<p><b>Note:</b> If child is less than 24 months and not breastfed</p>	<p>Add one to two extra meals</p> <p>One to two snacks may be offered</p>	<p>Same as above according to age group</p>	<p>Same as above according to age group</p>	<p>Same as above; in addition to one to two cups of milk per day PLUS Two to three cups of extra fluid, especially in hot climates</p>
<p>Active/ responsive</p>	<ul style="list-style-type: none"> <li>• Be patient and actively encourage your baby to eat more food.</li> <li>• If your young child refuses to eat, encourage him/her repeatedly; try holding</li> </ul>			

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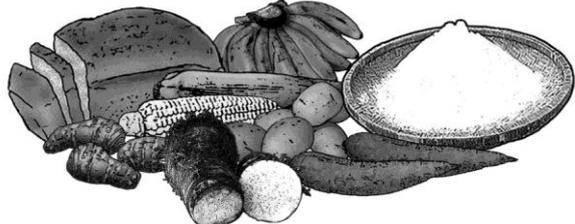
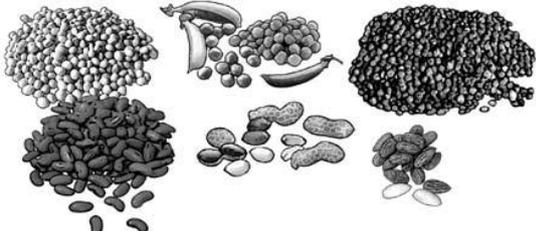
Age	Recommendations
feeding (alert and responsive to your baby's signs that she or he is ready to eat; actively encourage, but do not force your baby to eat)	<p>the child in your lap during feeding, or face him/her while he or she is sitting on someone else's lap.</p> <ul style="list-style-type: none"> <li>• Offer new foods several times; children may not like (or accept) new foods in the first few tries.</li> <li>• Feeding times are periods of learning and love. Interact and minimise distraction during feeding.</li> <li>• Do not force-feed.</li> <li>• Help your older child eat.</li> </ul>
Hygiene	<ul style="list-style-type: none"> <li>• Feed your baby using a clean cup/bowl and spoon; never use a bottle as this is difficult to clean and may cause your baby to get diarrhoea.</li> <li>• Wash your hands with soap and water before preparing food, before eating, and before feeding young children.</li> <li>• Wash your child's hands and face with soap before he or she eats.</li> </ul> <p>Some ways to discuss a sensitive issue like hygiene:</p> <ul style="list-style-type: none"> <li>• Find something to praise.</li> <li>• Use <i>Counselling Card 11</i> to introduce 'what we all should do' within our homes (environmental hygiene) or for personal hygiene. Participants should add other ideas (cut grass, etc.).</li> <li>• Use an action-oriented group/story (Session 13).</li> </ul>

Adapted from World Health Organization (WHO)/UNICEF. Infant and Young Child Feeding Counselling: An Integrated Course. WHO/UNICEF: 2006.

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.

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**Participant Materials 7.2: Different Types of Locally Available Foods**

<p><b>Staples:</b> Grains such as maize, wheat, rice, millet, sorghum, roots, and tubers such as cassava and potatoes.</p>	
<p><b>Legumes</b> such as beans, lentils, peas, groundnuts, <b>and seeds</b> such as sesame/benniseed.</p>	
<p><b>Vitamin A-rich fruits and vegetables</b> such as mango, pawpaw, passion fruit, oranges, dark-green leaves, carrots, orange-flesh sweet potato, and pumpkin; and <b>other fruits and vegetables</b> such as banana, pineapple, avocado, watermelon, tomatoes, eggplant, and cabbage.</p> <p><b>NOTE:</b> Include locally used wild fruits and other plants.</p>	
<p><b>Animal-source foods</b>, including flesh foods such as meat, chicken, fish, liver and eggs, milk, and milk products.</p> <p><b>Note: Animal foods should be started at 6 months.</b></p>	
<p>Oil and fat such as oil, seeds, margarine, 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>	

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

Recommended complementary feeding practice	Possible counselling discussion points Note: Choose two to three most relevant to mother's situation and/or ADD other discussion points from knowledge of area
<p>After baby reaches 6 months of age, add complementary foods (such as thick porridge two to three times a day) to breastfeeds.</p>	<p>Use <i>Counselling Card 11: Good hygiene practices.</i>            Use <i>Counselling Card 12: Start complementary feeding at 6 months.</i>            Use <i>Take-Home Brochure: How to Feed a Baby after 6 Months.</i></p> <ul style="list-style-type: none"> <li>• Give local examples of first types of complementary foods.</li> <li>• When possible, use milk instead of water to cook the porridge. Breastmilk can be used to moisten the porridge.</li> </ul>
<p>As baby grows older, increase feeding frequency, amount, texture, and variety.</p>	<p>Use <i>Counselling Card 11: Good hygiene practices.</i>            Use <i>Counselling Card 12: Start complementary feeding at 6 months.</i>            Use <i>Counselling Card 13: Start complementary feeding from 6 up to 9 months.</i>            Use <i>Counselling Card 14: Start complementary feeding from 9 up to 12 months.</i>            Use <i>Counselling Card 15: Start complementary feeding from 12 up to 24 months.</i>            Use <i>Counselling Card 16: Food variety.</i></p> <ul style="list-style-type: none"> <li>• Gradually increase the frequency, the amount, the texture (thickness/consistency), and the variety of foods, especially animal-source foods.</li> </ul>
<p>Complementary feeding from 6 up to 9 months; breastfeed plus give two to three meals and one to two snacks per day.</p> 	<p>Use <i>Counselling Card 11: Good hygiene practices.</i>            Use <i>Counselling Card 13: Start complementary feeding from 6 up to 9 months.</i>            Use <i>Counselling Card 16: Food variety.</i>            Use <i>Take-Home Brochure: How to Feed a Baby after 6 Months.</i></p> <ul style="list-style-type: none"> <li>• Start with two to three tablespoonfuls of cooked porridge or mashed foods (give examples of cereals and family foods).</li> <li>• At 6 months, these foods are more like ‘tastes’ than actual servings.</li> <li>• Make the porridge with milk—especially breastmilk; and pounded groundnut paste (a small amount of oil may also be added).</li> <li>• Increase gradually to half (½) cup (250-ml cup). Show amount in cup brought by mother.</li> <li>• Any food can be given to children after 6 months as long as it is mashed/chopped. Children do not need teeth to consume foods such as eggs, meat, and green, leafy vegetables.</li> </ul>

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<b>Recommended complementary feeding practice</b>	<b>Possible counselling discussion points</b> <b>Note: Choose two to three most relevant to mother's situation and/or ADD other discussion points from knowledge of area</b>
<p>Complementary feeding from 9 up to 12 months; breastfeed plus give three to four meals and one to two snacks per day.</p> 	<p>Use <i>Counselling Card 11: Good hygiene practices.</i>            Use <i>Counselling Card 14: Start complementary feeding from 9 up to 12 months.</i>            Use <i>Counselling Card 16: Food variety.</i>            Use <i>Counselling Card 23: Kitchen gardens and fruit trees.</i>            Use <i>Counselling Card 24: Small animal breeding.</i>            Use <i>Take-Home Brochure: How to Feed a Baby after 6 Months.</i></p> <ul style="list-style-type: none"> <li>• Give finely chopped, mashed foods, and finger foods.</li> <li>• Increase gradually to ½ cup (250-ml cup). Show amount in cup brought by mother.</li> <li>• Animal-source foods are very important and can be given to young children: cook well and cut into very small pieces.</li> </ul>
<p>Complementary feeding from 12 up to 24 months; give three to four meals and one to two snacks per day, with continued breastfeeding.</p> 	<p>Use <i>Counselling Card 11: Good hygiene practices.</i>            Use <i>Counselling Card 15: Start complementary feeding from 12 up to 24 months.</i>            Use <i>Counselling Card 16: Food variety.</i>            Use <i>Counselling Card 23: Kitchen gardens and fruit trees.</i>            Use <i>Counselling Card 24: Small animal breeding.</i>            Use <i>Take-Home Brochure: How to Feed a Baby after 6 Months.</i></p> <ul style="list-style-type: none"> <li>• Give family foods.</li> <li>• Give three-quarter (¾) to one cup (250-ml cup/bowl). Show amount in cup brought by mother.</li> <li>• Foods given to the child must be prepared and stored in hygienic conditions to avoid diarrhoea and illness.</li> <li>• Food stored at room temperature should be used within two hours of preparation.</li> </ul>
<p>Give baby two to three different family foods: staple, legumes, vegetables/fruits, and animal foods at each serving.</p>	<p>Use <i>Counselling Card 12: Start complementary feeding at 6 months.</i>            Use <i>Counselling Card 13: Start complementary feeding from 6 up to 9 months.</i>            Use <i>Counselling Card 14: Start complementary feeding from 9 up to 12 months.</i>            Use <i>Counselling Card 15: Start complementary feeding from 12 up to 24 months.</i>            Use <i>Counselling Card 16: Food variety.</i>            Use <i>Counselling Card 23: Kitchen gardens and fruit trees.</i>            Use <i>Counselling Card 24: Small animal breeding.</i>            Use <i>Take-Home Brochure: How to Feed a Baby after 6 Months.</i></p>

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Recommended complementary feeding practice	Possible counselling discussion points Note: Choose two to three most relevant to mother's situation and/or ADD other discussion points from knowledge of area
	<p>Try to feed different food groups at each serving to create a 4-star diet. A 4-star diet is created by including foods from the following categories:</p> <ul style="list-style-type: none"> <li>• Animal-source foods (meat, chicken, fish, liver, crayfish, snails, and periwinkles), and eggs, milk, and milk products. (1 star).</li> <li>• Staples (maize, wheat, rice, millet, and sorghum); roots and tubers (yam, cassava, and potatoes) (1 star).</li> <li>• Legumes (beans, lentils, peas, and groundnuts) and seeds (sesame) (1 star).</li> <li>• Vitamin A-rich fruits and vegetables (mango, pawpaw, passion fruit, oranges, dark-green leaves, carrots, yellow sweet potato, and pumpkin), and other fruit and vegetables (banana, pineapple, watermelon, tomatoes, avocado, eggplant, and cabbage) (1 star).</li> <li>• 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).</li> <li>• Foods may be added in a different order to create a 4-star food/diet.</li> <li>• Animal-source foods are very important. Start animal-source foods as early and as often as possible. Cook well and chop fine.</li> <li>• Additional nutritious snacks (extra food between meals) such as pieces of ripe mango, pawpaw, banana, avocado, other fruits and vegetables, boiled potato, sweet potato, and bread products can be offered once or twice per day.</li> <li>• Use iodised salt.</li> <li>• Avoid giving sugary drinks.</li> <li>• Avoid sweet biscuits.</li> </ul>
<p>Continue breastfeeding until 2 years of age or older.</p>	<p>Use <i>Counselling Card 12: Start complementary feeding at 6 months.</i>            Use <i>Counselling Card 13: Start complementary feeding from 6 up to 9 months.</i>            Use <i>Counselling Card 14: Start complementary feeding from 9 up to 12 months.</i>            Use <i>Counselling Card 15: Start complementary feeding from 12 up to 24 months.</i>            Use <i>Counselling Card 16: Food variety.</i>            Use <i>Take-Home Brochure: How to Feed a Baby after 6 Months.</i></p> <ul style="list-style-type: none"> <li>• During the first and second years, breastmilk is an important source of nutrients for your baby.</li> </ul>

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Recommended complementary feeding practice	Possible counselling discussion points Note: Choose two to three most relevant to mother's situation and/or ADD other discussion points from knowledge of area
	<ul style="list-style-type: none"> <li>• Breastfeed on demand, before meals, between meal intervals, and after meals; do not reduce the number of breastfeeds.</li> </ul>
<p>Be patient and actively encourage baby to eat all his/her food.</p> 	<p>Use <i>Counselling Card 12: Start complementary feeding at 6 months.</i>            Use <i>Counselling Card 13: Start complementary feeding from 6 up to 9 months.</i>            Use <i>Counselling Card 14: Start complementary feeding from 9 up to 12 months.</i>            Use <i>Counselling Card 15: Start complementary feeding from 12 up to 24 months.</i>            Use <i>Counselling Card 16: Food variety.</i>            Use <i>Take-Home Brochure: How to Feed a Baby after 6 Months.</i></p> <ul style="list-style-type: none"> <li>• At first, baby may need time to get used to eating foods other than breastmilk.</li> <li>• Use a separate plate to feed the child to make sure he or she eats all the food given.</li> <li>• See <i>Participant Materials 7.4: Active/Responsive Feeding for Young Children.</i></li> </ul>
<p>Wash hands with soap or ash and water before preparing food, eating, and feeding young children. Wash baby's hands and face before eating.</p> 	<p>Use <i>Counselling Card 11: Good hygiene practices.</i></p> <ul style="list-style-type: none"> <li>• 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.</li> <li>• Wash your hands with soap or ash and water after using the toilet and washing or cleaning baby's bottom.</li> </ul>
<p>Feed baby using a clean cup and spoon.</p>	<p>Use <i>Counselling Card 12: Start complementary feeding at 6 months.</i>            Use <i>Counselling Card 13: Start complementary feeding from 6 up to 9 months.</i>            Use <i>Counselling Card 14: Start complementary feeding from 9 up to 12 months.</i>            Use <i>Counselling Card 15: Start complementary feeding from 12 up to 24 months.</i></p> <ul style="list-style-type: none"> <li>• Cups are easy to keep clean.</li> </ul>

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<b>Recommended complementary feeding practice</b>	<b>Possible counselling discussion points</b> <b>Note: Choose two to three most relevant to mother s situation and/or ADD other discussion points from knowledge of area</b>
<p>Encourage the child to breastfeed more, continue eating during illness, and provide extra food after illness.</p>	<p>Use <i>Counselling Card 19: Feeding the sick child more than 6 months</i>.</p> <ul style="list-style-type: none"> <li>• Fluid and food requirements are higher during illness.</li> <li>• 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.</li> <li>• Children who have been sick need extra food and should be breastfed more frequently to regain the strength and weight lost during the illness.</li> <li>• Take advantage of the period after illness when appetite is back to make sure the child makes up for loss of appetite during sickness.</li> </ul>

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### **Note:**

- Use iodised salt in preparing family foods.
- In countries with vitamin-A endemic deficiency, provide vitamin-A supplementation to infants and young children beginning at 6 months (or as per national recommendations), every 6 months until 5 years.
- In countries with high levels of anemia and micronutrient deficiencies, multiple micronutrient powders in a small sachet may be given beginning at 6 months, according to national recommendation.
- In countries with high levels of stunting and food insecurity, special supplements may be given to children beginning at 6 months. These supplements are usually added to the usual complementary foods to enrich the diet and should not replace local foods. If such products are available through the health system or can be obtained at reasonable cost from the market, they should be recommended to caregivers as means to improve the quality of children's diets.

**Session 7. Recommended Infant and Young Child Feeding Practices: Complementary Feeding for Children from 6 up to 24 Months**

**Participant Materials 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 do not 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/his fingers (after washing) to feed the 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—i.e., 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 to drink before or during meals.
- Congratulate the child when he or she eats.



Parents, family members (older children), and child caregivers can participate in active/responsive feeding.

## Session 8. Complementary Foods

Learning objectives	Methodologies	Training aids
1. Explain how to complement breastmilk with family foods.	<ul style="list-style-type: none"> <li>Interactive presentation</li> <li>Demonstration</li> </ul>	<ul style="list-style-type: none"> <li><i>Counselling Card 16: Food variety</i> (pictures from <i>Counselling Card 16</i> should be cut out separately from <i>Training Aids</i> package)</li> <li><i>Key Messages Booklet</i></li> </ul>
2. 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"> <li>Group work</li> <li>Demonstration</li> </ul>	<ul style="list-style-type: none"> <li><i>Participant Materials 7.2: Different Types of Locally Available Foods</i></li> <li><i>Participant Materials 7.3: Recommended Complementary Feeding Practices and Possible Counselling Discussion Points</i></li> <li>Different foods: staples, legumes and seeds, vitamin A-rich fruits and vegetables, other fruits and vegetables, animal-source foods; and oils</li> <li>Local recipes</li> </ul>
3. Recognise and name the fortified foods and/or supplements which are available in the community.	<ul style="list-style-type: none"> <li>Interactive presentation</li> <li>Demonstration</li> </ul>	Examples of locally fortified foods, and micronutrient supplements
4. Describe the importance of micronutrient powders (MNP).	<ul style="list-style-type: none"> <li>Interactive presentation</li> <li>Demonstration</li> </ul>	<i>Counselling Card 17: How to add micronutrient powder (MNP) to foods</i> <i>Key Messages Booklet</i>

### Materials:

- Locally available, affordable, and seasonal foods in pictures or (local foods as used in Session 7).
- Four stars on four different pieces of paper.
- Local recipes.

### Advance preparation:

- Examples of locally fortified foods and micronutrient supplements.

**Duration:** 1 hour.

**Learning objective 1:** Explain how to complement breastmilk with family foods.

**Methodology:** Demonstration; small groups.

**Instructions for activity:**

**A. Family foods**

1. Separate the four food groupings on *Counselling Card 16: Food variety* and arrange on table or floor so all can see.
2. Place illustrations of local available foods (or use real foods) on a mat or table. Ask participant ‘mother/caregiver’ to select those she has in her home.
3. Instruct ‘mother/caregiver’ to sort the different local available foods from her home into the four food groupings (by placing the food cards onto the correct food-grouping picture).
4. Ask ‘mother/caregiver’ to choose foods from among the different groups that she would combine to make a meal for her child older than 6 months. Place them into a bowl or on a plate to ‘build a meal’ or ‘build a bowl’ of nutritious food.
5. With each food selected from a different food grouping, give the ‘mother/caregiver’ a star (drawn on a piece of paper). The ‘mother/caregiver’ tries to build a 4-star meal/bowl.

**NOTE** and mention: The order in which the foods/food groupings are added is not important; the aim is to include foods from all four food groupings in the bowl/on the plate. Refer to boxes in *Key Messages Booklet for Counselling Cards 13–16* for message on the order of food groupings.

6. Ask participants for their feedback.
7. Discuss and summarise.

**Key information**

Continue to breastfeed for at least two years or more and give a 4-star diet of complementary foods to your young child. A 4-star diet is created by including foods from the following categories:

- Animal-source foods (meat, chicken, fish, liver, crayfish, snails, and periwinkles), and eggs, milk, and milk products. (1 star).
- Staples (maize, wheat, rice, millet, and sorghum); roots and tubers (yam, cassava, and potatoes) (1 star).
- Legumes (beans, lentils, peas, and groundnuts) and seeds (sesame) (1 star).
- Vitamin A-rich fruits and vegetables (mango, pawpaw, passion fruit, oranges, dark-green leaves, carrots, yellow sweet potato, and pumpkin), and other fruits and vegetables (banana, pineapple, watermelon, tomatoes, avocado, eggplant, and cabbage) (1 star).
- 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).
- Foods may be added in a different order to create a 4-star food/diet.
- Animal-source foods are very important. Start animal-source foods as early and as often as possible. Cook well and chop fine.

## Session 8. Complementary Foods

- Additional nutritious snacks (extra food between meals) such as pieces of ripe mango, pawpaw, banana, avocado, other fruits and vegetables, boiled potato, sweet potato, and bread products can be offered once or twice per day.
- Use iodised salt.
- Avoid giving sugary drinks.
- Avoid sweet biscuits.
- Explain how mothers can add one single new food item to a child's diet each week.
- 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 Materials 7.1: Recommended Complementary Feeding Practices*.
- See *Participant Materials 7.2: Different Types of Locally Available Foods*.
- See *Counselling Card 13: Start complementary feeding from 6 up to 9 months*.
- See *Counselling Card 14: Start complementary feeding from 9 up to 12 months*.
- See *Counselling Card 15: Start complementary feeding from 12 up to 24 months*.
- See *Counselling Card 16: Food variety*.
- See *Key Messages Booklet*.
- See *Take-Home Brochure: How to Feed a Baby after 6 Months*.

**Learning objective 2:** Give practical help to a mother/father/caregiver in preparing complementary foods for a baby over six months.

**Methodology:** Group work and demonstration.

### Instructions for activity:

1. Divide participants into four groups.
2. Give each group locally available, affordable, and seasonal foods (*staples, legumes and seeds, vitamin A-rich fruits and vegetables, other fruits and vegetables, animal-source foods*) and oils.
3. Ask participants to refer to *Participant Materials 7.1: Recommended Complementary Feeding Practices and Possible Counselling Discussion Points* and *Participant Materials 7.2: Different Types of Locally Available Foods*.
4. Ask each group to use the available 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.
5. 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.

## Session 8. Complementary Foods

6. Ask participants to brainstorm the five keys to safer food.
7. Discuss and summarise.

### Key information

#### *At 6 months:*

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

#### *From 6 up to 9 months:*

- An 8-month old stomach holds about 200ml, or less than a cup.
- Add colourful (variety) foods to enrich the staples, including beans, groundnuts, peas, lentils or seeds; orange/red fruits and vegetables (such as ripe mango, pawpaw, carrots, pumpkin, orange-flesh sweet potato); dark-green leaves (such as kale, fluted pumpkin leave/ugu, spinach, chard); and 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, 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 to 24 months or older.
- 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 diarrhoea and other illnesses.

#### *From 9 up to 12 months:*

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- Add colourful (variety) foods to enrich the staples, including beans, groundnuts, peas, lentils or seeds; orange/red fruits and vegetables (such as ripe mango, pawpaw, carrots, pumpkin, orange-flesh sweet potato); dark-green leaves (such as kale, fluted pumpkin leave/ugu, spinach, chard); and avocado.
- Add animal-source foods: meat, chicken, fish, liver, eggs, milk, and milk products (whenever available).
- Give at least one to two snacks each day, such as ripe mango, pawpaw and avocado, banana, other fruits and vegetables, bread products, boiled potato, sweet potato.
- Use iodised salt.
- 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 diarrhoea and other illnesses.

*From 12 up to 24 months:*

- Add colourful (variety) foods to enrich the staples, including beans, peanuts, peas, lentils or seeds; orange/red fruits and vegetables (such as ripe mango, pawpaw, carrots, pumpkin, orange flesh sweet potato); dark-green leaves (such as kale, fluted pumpkin leave/ugu, spinach, chard); and avocado.
- Add animal-source foods: meat, chicken, fish, liver; eggs, milk, and milk products every day at least in one meal (or, at least three times/week).
- Give at least one to two snacks each day such as ripe mango and pawpaw, avocado, banana, other fruits and vegetables, bread products, boiled potato, sweet potato.
- Use iodised salt.
- 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 diarrhoea and other illnesses.

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

**Note:** Refer to *Participant Materials 7.1: Recommended Complementary Feeding Practices* to address the need for milk products and extra fluids for a non-breastfed child.

### **Five 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.

See *Counselling Card Special Circumstance 6: Non-breastfed child from 6 up to 24 months.*

## Session 8. Complementary Foods

**Learning Objective 3:** Recognise and name the fortified foods and/or supplements that are available in the community.

**Methodology:** Interactive presentation; demonstration.

### Instructions for activity:

1. Ask participants what kind of fortified foods and/or supplements are available in their communities (facilitators identify and purchase ahead of time in order to demonstrate to participants).
2. List on flipchart the fortified foods/supplements that are available:
  - Fortified blended foods.
  - ‘Point-of-use’ fortificants that are added to foods to improve nutrient quality.
  - Micronutrient powders (MNP).
  - Micronutrient products with added protein/energy/essential fatty acids.
3. Discuss the use of the above list of supplements as a ‘short-term’ strategy, not a replacement of family foods (recognizing that the provision of these products may not be sustainable). The long-term goal should be to provide a nutrient-sufficient diet from local foods.

**Learning Objective 4:** Describe the importance of micronutrient powders (MNP)

**Methodology:** Interactive presentation; demonstration.

### Instructions for activity:

1. Brainstorm the definition of micronutrient powders (MNP).
2. Set up four flipcharts throughout training room with the following headings:
  - a. Why use MNP?
  - b. How to use MNP.
  - c. How to add MNP to complementary foods.
  - d. Possible side effects of MNP.
  - e. Who should NOT be given MNP.
3. Assign participants to one of the four flipcharts and ask them to respond to the flipchart title (5 minutes).
4. Ask each group to summarise their results.
5. Discuss and fill in gaps.

### Definition of micronutrient powders (MNP)

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

### Why use MNP?

- Improves the nutritional quality of food by adding micronutrients (vitamins and minerals) that are commonly insufficient in a young child’s diet.
- Helps prevent deficiencies of key micronutrients, particularly iron, zinc, iodine, and vitamin A.
- Helps your child be strong, active, and healthy.

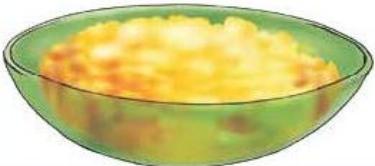
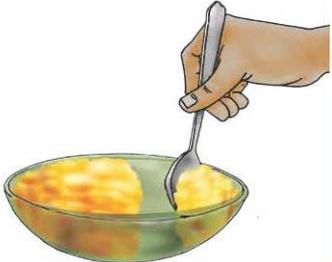
## Session 8. Complementary Foods

- MNP can help improve your child's appetite.
- Improves iron status and reduces anemia, increasing their ability to learn and develop.
- Micronutrients can help improve your child's immune system, increasing resistance to disease and infections.
- Easy-to-use and highly acceptable among families and young children. They do not require a change in food practices or complicated measuring and can be added to a wide range of readily available foods prepared at home.
- Do not conflict with breastfeeding and can help promote the timely introduction of complementary foods at 6 months of age and proper complementary feeding practices.

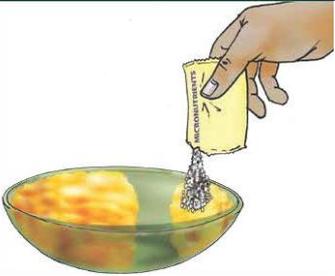
### How to Use MNP

- Use only one sachet per day OR use two to three sachets per week. Do not give more than one per day. If you forget, that is fine; give a sachet the following day.
- Use MNP sachet at any meal.
- Do not add MNP to any liquids or hot food.
- Food to which MNP is added should be eaten within 30 minutes (as the iron in the MNP will cause the food to darken).
- If the child does not finish the food in which the MNP has been mixed, do not reheat the food later as the food may change in colour or taste.
- Do not share the food to which MNP is added with other household members (the amount of minerals/vitamins in a single sachet is just the right amount for one child age 6 up to 60 months).
- Store in a cool, dry, and clean place.
- Continue to give MNP during illness.

### Participant Materials 7.5: How to add micronutrient powders (MNP) to Complementary Foods

	<ol style="list-style-type: none"><li>1. Wash hands with soap.</li><li>2. Prepare any soft, semi-solid, mushy-like food, such as thick porridge or mashed potato.<ul style="list-style-type: none"><li>• Make sure that the food is at ready-to-eat temperature.</li><li>• Do NOT add to hot food: if the food is hot, the heat will melt the lipid coating of the iron instantly and change the taste and colour of the food.</li><li>• Do NOT add to any liquids (including water, tea, and watery porridge): in hot liquids, the iron will dissolve instantly and change the colour and taste of the food. In cold liquids, it lumps and does not mix (floats on top); only eventually does it dissolve and change colour.</li></ul></li></ol>
	<ol style="list-style-type: none"><li>3. Separate a small portion of food, which the child will be able to finish in a single setting, within the child's bowl, or place in a separate bowl.</li></ol>

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	<p>4. Pour the entire contents of the one sachet of MNP into the small portion of food to make sure that the child eats all the valuable micronutrients in the first few spoonfuls.</p> <ul style="list-style-type: none"><li>• Shake the sachet to ensure the powder is not clumped.</li><li>• Tear open the sachet.</li><li>• Do NOT add to hot food: if the food is hot, your child will not be able to eat it quickly enough. If the food stands for a long time, the iron will change the colour and taste of the food, and your child might refuse to eat it.</li><li>• Do NOT add to liquids (including water, tea, and watery porridge): the iron will dissolve instantly and change the colour and taste of the food.</li></ul>
	<p>5. Mix sachet contents and the small portion of food well.</p>
	<p>6. Give the child the small portion of food mixed with MNP to finish, and then feed the child the rest of the food.</p> <ul style="list-style-type: none"><li>• Give no more than one full sachet per day.</li><li>• Use MNP sachet at any meal.</li><li>• Food to which MNP is added should be eaten within 30 minutes (as the iron in the MNP will cause the food to darken).</li><li>• If the child does not finish the food in which the MNP has been mixed, do not reheat the food later as the food may change in colour or taste.</li><li>• Do not share the food to which MNP is added with other household members (the amount of minerals/vitamins in a single sachet is just the right amount for one child age 6 up to 60 months).</li></ul>

## **Session 8. Complementary Foods**

### **Possible Side Effects of MNP**

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

### **Who should NOT be given MNP?**

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

## Session 9. How to Counsel: Part II

Learning objectives	Methodologies	Training aids
1. Describe <i>infant and young child feeding three-step counselling</i> (Assess, Analyse, and Act).	<ul style="list-style-type: none"> <li>• Demonstration</li> <li>• Interactive presentation</li> </ul>	<i>Participant Materials 9.1: Infant and Young Child Feeding Assessment of Mother/Child Pair</i>
2. Name <i>building confidence and giving support</i> skills.	Brainstorming	<i>Participant Materials 9.3: Building Confidence and Giving Support Skills</i>
3. Practise infant and young child feeding counselling with mother/father/caregiver.	Practise	<ul style="list-style-type: none"> <li>• <i>Participant Materials 9.1: Infant and Young Child Feeding Assessment of Mother/Child Pair</i></li> <li>• <i>Participant Materials 9.2: Observation Checklist for Infant and Young Child Feeding Assessment of Mother/Child Pair</i></li> <li>• <i>Set of Counselling Cards.</i></li> <li>• <i>Key Messages Booklet</i></li> <li>• <i>Take-Home Brochure: How to Breastfeed Your Baby</i></li> <li>• <i>Take-Home Brochure: How to Feed a Baby after 6 Months</i></li> </ul>

### Materials:

- Three case studies.
- Flipchart papers and stand (plus markers, plus masking tape or sticky putty).
- Photocopies of *Participant Materials 9.1: Infant and Young Child Feeding Assessment of Mother/Child Pair* (Three per participant).
- Laminated copy of *Participant Materials 9.1: Infant and Young Child Feeding Assessment of Mother/Child Pair* (One per participant).

### Advance preparation:

- Facilitators practise demonstration of *Infant and Young Child Feeding Assessment of Mother/Child Pair* (*infant and young child feeding three-step counselling*).
- On a separate paper, list the section ‘read to mothers’ from the three case studies.

**Duration:** 2 hours.

**Learning Objective 1:** Describe *infant and young child feeding three-step counselling* (Assess, Analyse, and Act).

**Methodology:** Demonstration; interactive presentation.

**Instructions for activity:**

**Note:** Two facilitators (facilitator/mother and facilitator/counsellor) need to prepare this demonstration in advance.

Review with participants the points covered to demonstrate listening and learning skills between a mother (Amina) with 7-month son Ahmed, and counsellor. In this scenario, Amina:

- Breastfeeds whenever Ahmed cries.
- Feels she does not produce enough milk.
- Gives Ahmed some watery porridge two times a day (porridge is made from corn meal).
- Does not give any other milks or drinks to Ahmed.

1. Step 1 – Assess: Facilitator/counsellor:

- Greets mother and introduces him/herself.
- Allows mother to introduce herself and the baby.
- Uses *listening and learning* skills, and *building confidence and giving support* skills.
- Completes *Participant Materials 9.1: Infant and Young Child Feeding Assessment of Mother/Child Pair*.
- Listens to Amina’s concerns, and observes Ahmed and Amina.
- Accepts what Amina is doing without disagreeing or agreeing.
- Praises Amina for one good behaviour.

2. Step 2 – Analyse: Facilitator/counsellor to speak out loud to group, noting that:

- Amina is waiting until Ahmed cries before breastfeeding him—a ‘late sign’ of hunger.
- Amina is worried she does not have enough breastmilk.
- Amina is not feeding Ahmed age-appropriate complementary foods.

3. Step 3 – Act: Facilitator/counsellor:

- Praises Amina for breastfeeding.
- Asks Amina about breastfeeding frequency and if she is breastfeeding whenever Ahmed wants and for as long as he wants, both day and night. Does Ahmed come off breast himself? Is Ahmed fed on demand? (Age-appropriate recommended breastfeeding practices).
- Suggests that Amina breastfeed Ahmed when he shows interest in feeding (before he starts to cry).
- Shares with Amina and discusses *Counselling Card 5: Breastfeed on demand, both day and night* and *Take-Home Brochure: How to Breastfeed Your Baby*.
- Talks with Amina about the characteristics of complementary feeding.
- Presents options/small, doable actions (time-bound) to overcome the difficulty of inadequate complementary feeding: F=Frequency of breastfeeding, T=Texture (thickness/consistency), and V=Variety.
- Helps Amina select one that she can try (e.g., breastfeed more frequently day and night, thicken porridge, or add family foods during this week).
- Shares with Amina and discusses *Counselling Card 13: Start complementary feeding from 6 up to 9 months* and *Take-Home Brochure: How to Feed a Baby after 6 Months*.

## Session 9. How to Counsel: Part II

- Asks Amina to repeat verbally the agreed-upon behaviour.
  - Tells Amina that a counsellor will follow up with her at her next weekly visit.
  - Suggests where Amina can find support (attend educational talk, infant and young child feeding support group in community, supplementary feeding programme, and referral to community volunteer).
  - Refers as necessary.
  - Thanks Amina for her time.
4. Discuss the demonstration with participants and answer questions.
  5. Review and complete together/or talk through *Participant Materials 9.1: Infant and Young Child Feeding Assessment of Mother/Child Pair*.
  6. Discuss and summarise.

### Key information

- The *infant and young child feeding three-step counselling* process involves the following:
  - *Assess* age-appropriate feeding and condition of mother/father/caregiver and child: ask, listen, and observe.
  - *Analyse* feeding difficulty: Identify difficulty, and if there is more than one, prioritise.
  - *Act*: Discuss, suggest small amount of relevant information, and agree on feasible, doable option that mother/father/caregiver can try.
- **Purpose:** Provide infant and young child feeding information and support to the mother/father/caregiver.
- See *Participant Materials 9.1: Infant and Young Child Feeding Assessment of Mother/Child Pair*.
- Explain the *infant and young child feeding three-step counselling*: Assess, Analyse, Act.

**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 9.1: Infant and Young Child Feeding Assessment of Mother/Child Pair* by asking the following questions:
  - What is your name, and your child's name?
  - Observe the general condition of mother/father/caregiver.
  - What is the age of your child?
  - Has your child been recently sick? If presently sick, refer mother to health facility.
  - In areas where child growth cards exist, ask mother/father/caregiver if you can check child's growth card. Is growth curve increasing? Is it decreasing? Is it levelling off? Does the mother know how her child is growing?
  - Ask the mother how the child is doing, whether the child is gaining weight (do not just rely on the plots on the growth card).
  - In areas where there are no child growth cards, ask mother/father/caregiver how he or she thinks the child is growing.
  - Ask about the child's usual intake:
    - Ask about *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.
    - Ask about *complementary foods*:
      - Is your child getting anything else to eat (*what type/kinds*)?
      - How many times per 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*)?
    - Ask about *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?
    - Ask about *other liquids*:
      - Is your child drinking other liquids (*what kinds*)?
      - How many times/day does your child drink "other liquids" (*frequency*)?
      - How much (*amount*)?
  - Does your child use a cup? If mother says "no," then ask "What does your child use to drink from?"
  - Who assists the child to eat?
  - Are there other challenges the mother faces in feeding the child?

**Step 2: Analyse**

- Is feeding age-appropriate? Identify feeding difficulty (if any).
- If there is more than one difficulty, prioritise 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 INFORMATION RELEVANT 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, infant and young child feeding 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 for activity:**

1. Brainstorm with whole group the *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 Materials 9.3: Building Confidence and Giving Support Skills*.
4. Discuss and summarise.

## Session 9. How to Counsel: Part II

### 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. Recognise 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(s)*.
7. Make one or two suggestions, not commands.

**Learning objective 3:** Practise *infant and young child feeding three-step counselling*.

**Methodology:** Practise.

#### Instructions for activity:

1. Participants are divided into groups of three: mother, counsellor, and observer.
2. Distribute *Participant Materials 9.1: Infant and Young Child Feeding Assessment of Mother/Child Pair* (or refer to specific page in *Participant Materials*) to counsellors.
3. Distribute *Participant Materials 9.2: Observation Checklist for Infant and Young Child Feeding Assessment of Mother/Child Pair* (or refer to specific page in *Participant Materials*) to observers and review with participants.
4. Distribute a set of *Counselling Cards*, *Key Messages Booklet* and three *Take-Home Brochures* to each group of three.
5. Practise Case Study 1: Ask the ‘mothers’ of the working groups to gather together.
6. Read a case study to the ‘mothers’ ONLY, 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.
7. EMPHASISE to participants the need to stick to the (minimal) information in the case studies and not embellish.
8. The counsellor of each working group (of three) asks the ‘mother’ about her situation, and practises the ‘Assess, Analyse, 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 summarise.

## Session 9. How to Counsel: Part II

### Key information

- See *Participant Materials: 9.2: Observation Checklist for Infant and Young Child Feeding Assessment of Mother/Child Pair*.
- Case studies.

### Case studies to practise *infant and young child feeding three-step counselling*

**Note:** The information (under Assess, Analyse, 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 Fatima. Your son, Shakiru, is 18 months old. You are breastfeeding once or twice a day. You are giving Shakiru milk and millet cereal two times a day. You notice that during the last weeks, Shakiru has been weak and inactive.

#### *Step 1: Assess*

- Greet Fatima and ask questions that encourage her to talk, using listening and learning, building confidence, and giving support skills.
- Complete *Participant Materials 9.1: Infant and Young Child Feeding Assessment of Mother/Child Pair*.
- Observe Fatima’s and Shakiru’s general condition.
- Listen to Fatima’s concerns, and observe Shakiru and Fatima.
- Accept what Fatima is doing without disagreeing or agreeing.

#### *Step 2: Analyse*

- Fatima is breastfeeding Shakiru.
- Fatima is giving another milk to Shakiru.
- Shakiru has been weak and inactive.
- Fatima is not following age-appropriate feeding recommendations (e.g., frequency and variety).

#### *Step 3: Act*

- Praise Fatima about continuing breastfeeding.
- Talk with Fatima about the characteristics of complementary feeding: frequency, amount, thickness (consistency), variety, active/responsive feeding, and hygiene.
- Suggest that Shakiru may be weak and inactive because of lack of food/inadequate food.
- Present options/small, doable actions (time-bound) to overcome the difficulty of inadequate complementary foods (e.g., increase feeding frequency of foods to four times a day); ask about the amount of cereal Shakiru 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 Fatima 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*

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*Card* that is most relevant to Shakiru's situation, and discuss that information with Fatima:

- *Counselling Card 11: Good hygiene practices.*
  - *Counselling Card 15: Start complementary feeding from 12 up to 24 months.*
  - *Counselling Card 16: Food variety.*
  - *Take-Home Brochure: How to Feed a Baby after 6 Months.*
- Ask Fatima to repeat the agreed-upon behaviour.
  - Tell Fatima that you will follow up with her at her next weekly visit.
  - Suggest where Fatima can find support (attend educational talk, infant and young child feeding support group in community, supplementary food programme, and refer to community worker).
  - Refer as necessary.
  - Thank Fatima for her time.
  - Discuss the demonstration with participants.
  - Answer questions.

### Case study 2:

**Read to 'mothers':** You are Justina. Your daughter, Ada, is 8 months old. You are breastfeeding Ada because you know breastmilk is the best food for her. You also give Ada water because it is so hot. You do not think Ada is old enough to eat other foods. Ada has been gaining weight well, but she had diarrhoea last week.

#### *Step 1: Assess*

- Greet Justina and ask questions that encourage her to talk, using *listening and learning, building confidence, and giving support skills*.
- Complete *Participant Materials 9.1: Infant and Young Child Feeding Assessment of Mother/Child Pair*.
- Observe Justina and Ada's general condition.
- Listen to Justina's concerns, and observe Ada and Justina.
- Accept what Justina is doing without disagreeing or agreeing.

#### *Step 2: Analyse*

- Justina is breastfeeding Ada.
- Justina is also giving water to Ada.
- Ada had diarrhoea last week.
- Justina has not started complementary foods.

#### *Step 3: Act*

- Praise Justina for breastfeeding.
- Talk with Justina about the importance of breastfeeding.
- Talk about breastmilk being the best source of liquids for Ada.
- Discuss the risks of contaminated water.
- Suggest that Ada may have had diarrhoea last week because of contaminated water.

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- Talk with Justina about beginning complementary foods and why it is necessary for Justina at this age.
- Talk with Justina about the characteristics of complementary feeding: frequency, amount, thickness (consistency), variety, active/responsive feeding, and hygiene.
- Present options/small, doable actions (time-bound) and help Justina select one or two that she can try (e.g., begin with a small amount of staple food [porridge, other local examples]; add legumes, vegetables/fruit and animal foods; increase feeding frequency of foods to three times a day; talk about appropriate texture [thickness/consistency] of staple; assist Ada 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 Ada's situation—and discuss it with Justina:
  - *Counselling Card 11: Good hygiene practises.*
  - *Counselling Card 13: Complementary feeding from 6 up to 9 months.*
  - *Counselling Card 16: Food variety.*
  - *Take-Home Brochure: How to Feed a Baby after 6 Months.*
- Ask Justina to repeat the agreed-upon behaviour.
- Tell Justina that you will follow up with her at her next weekly visit.
- Suggest where Justina can find support (attend educational talk, infant and young child feeding support group in community, supplementary food programme, and refer to community worker).
- Refer as necessary.
- Thank Justina for her time.
- Discuss the demonstration with participants.
- Answer questions.

### Case study 3:

**Read to 'mothers':** You are Rahima. You are breastfeeding your 1-year old, Anik. You have two other children. You give Anik food that the family is eating, three times a day. Anik is very healthy and has not been sick.

#### *Step 1: Assess*

- Greet Rahima and ask questions that encourage her to talk, using *listening and learning, building confidence and giving support* skills.
- Complete *Participant Materials 9.1: Infant and Young Child Feeding Assessment of Mother/Child Pair.*
- Observe Rahima and Anik's general condition.
- Listen to Rahima's concerns, and observe Anik and Rahima.
- Accept what Rahima is doing without disagreeing or agreeing.

#### *Step 2: Analyse*

- Rahima is breastfeeding Anik.
- Rahima is feeding Anik family food three times a day.
- Rahima has two other children.

### *Step 3: Act*

- Praise Rahima for breastfeeding.
- Talk with Rahima about the importance of breastfeeding for at least two years.
- Praise Rahima for giving Anik family foods three times a day.
- Talk with Rahima about what to consider when giving complementary foods: frequency, amount, thickness, variety, active/responsive feeding, and hygiene.
- Present options/small, doable actions (time-bound) and help Rahima select one or two that she can try (e.g., increase frequency of foods to four times a day; ask about the amount of food Anik receives, texture [thickness/consistency], and add other local available family foods).
- Counsellor will select the portion of the information on the age-appropriate *Counselling Card* that is most relevant to Anik's situation; and discuss it with Rahima:
  - *Counselling Card 11: Good hygiene practices.*
  - *Counselling Card 15: Complementary feeding from 12 up to 24 months.*
  - *Counselling Card 16: Food variety.*
  - *Take-Home Brochure: How to Feed a Baby after 6 Months.*
- Suggest it may be helpful for Anik to have his own plate.
- Asks Rahima to repeat the agreed-upon behaviour.
- Tell Rahima that you will have someone come to follow up with her in two days.
- Suggest where Rahima can find support (attend an action-oriented group or an infant and young child feeding support group in the community, and refer to community worker).
- Thank Rahima for her time.
- Discuss the demonstration with participants.
- Answer questions.

**Participant Materials 9.1: Infant and Young Child Feeding Assessment of Mother/Child Pair**

	Name of mother/ caregiver		Name of child		Age of child (completed months)	Number of older children
<b>Observation of mother/caregiver</b>						
<b>Child illness</b>	Child ill		Child not ill		Child recovering	
<b>Growth curve increasing</b>	Yes		No		Levelling off/Static	
<b>Tell me about breastfeeding</b>	Yes	No	When did breast-feeding stop?	Frequency: Times/day	Difficulties: How is breastfeeding going?	
<b>Complementary foods</b>	Is your child getting anything else to eat?	What else is he/she eating?		Frequency: Times/day	Amount: How much? (Ref. 250ml)	Texture: How thick?
	Staple (porridge, other local examples)					
	Legumes (beans, other local examples)					
	Vegetables/Fruits (local examples)					
	Animal: Meat/fish/offal/bird/eggs					
<b>Liquids</b>	Is your child getting anything else to drink?	What else is he/she drinking?		Frequency: Times/day	Amount: How much? (Ref. 250ml)	Bottle use? Yes/No
	Other milks					
	Other liquids					
<b>Other challenges?</b>						
<b>Mother/caregiver assists child</b>	Who assists the child when eating?					
<b>Hygiene</b>	Feeds baby using a clean cup and spoon		Washes hands with clean, safe, water and soap/ash 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 Materials 9.2: Observation Checklist for Infant and Young Child Feeding 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?
- Recognise 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 mother's understanding of child growth curve (if GMP exists in area)?
- Check on recent child illness?

#### *Breastfeeding:*

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- 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?
- Prioritise difficulties? (if there is more than one)

Record prioritised 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 *Counselling Cards* and *Take-Home 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 Materials 9.3: 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. Recognise 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(s)*.
7. Make one or two suggestions, not commands.



## Session 10. 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 prevention measures of “not enough” breastmilk.	Group work	<ul style="list-style-type: none"> <li>• <i>Participant Materials 10.1: Common Breastfeeding Difficulties</i></li> <li>• <i>Participant Materials 10.2: “Not Enough” Breastmilk</i></li> <li>• Take-Home Brochure: How to Breastfeed Your Baby</li> </ul>
3. Help mothers to overcome these common breastfeeding difficulties, and “not enough” breastmilk.		
4. Describe relactation.	Interactive presentation	

### Materials:

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

### Advance preparation:

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

**Duration:** 1½ hours.

**Learning objective 1:** Recognise common breastfeeding difficulties that can occur during breastfeeding.

**Methodology:** Brainstorming.

### Instructions for activity:

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 it on the wall so that all can see (participants may also mention inverted nipple, low-birthweight baby, crying baby, and refusal to breastfeed—these difficulties were addressed in Session 3: Common Situations that can Affect Breastfeeding).
3. Probe until all images are displayed (breast engorgement, sore/cracked nipple, plugged duct,

and mastitis).

4. Participants usually mention “not enough” breastmilk 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” breastmilk.

### **Key information**

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

**Learning objective 2:** Describe the symptoms and prevention of common breastfeeding difficulties: engorgement, sore and cracked nipples, and plugged ducts that can lead to mastitis; and describe prevention of “not enough” breastmilk.

**Learning objective 3:** Help mothers to overcome these common breastfeeding difficulties and “not enough” breastmilk.

**Methodology:** Group work.

### **Instructions for activity:**

1. Divide participants into four 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” breastmilk.
2. Ask each group to discuss symptoms, prevention, and “what to do” for the assigned common breastfeeding difficulty.
3. Each group presents their findings to the whole group.
4. Ask other groups to contribute any additional points.
5. Distribute from *Participant Materials 10.1: Common Breastfeeding Difficulties* (or refer to specific page in *Participant Materials*) and *Participant Materials 10.2: “Not Enough” Breastmilk* (or refer to specific page in *Participant Materials*).
6. Ask participants to use *Participant Materials 10.1* and *10.2* as a checklist for groups’ responses.
7. Do a quick review on ‘how to tell if a baby is suckling effectively’ (Session 6).
8. Facilitator fills in gaps.
9. Address other common difficulties that were mentioned.
10. Distribute, and orient participants to *Take-Home Brochure: How to Breastfeed Your Baby*.
11. Discuss and summarise.

### **Key information**

- See *Participant Materials 10.1: Common Breastfeeding Difficulties*.
- See *Participant Materials 10.2: “Not Enough” Breastmilk*.

## Session 10. Common Breastfeeding Difficulties: Symptoms, Prevention, and 'What to Do'

- “Not enough” breastmilk is one of the most common reasons that mothers introduce breastmilk substitutes or foods, and give up breastfeeding. However, true breastmilk insufficiency is not as common as mothers believe.

**Learning objective 4:** Describe relactation.

**Methodology:** Interactive presentation.

### Instructions for activity:

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 summarise.

### 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 breastmilk 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 are required. Refer to health facility (management could also be done in the home by a community health worker with special training).

*What is the length of time for relactation?*

- It varies, depending on the mother's strong motivation, and if her baby is willing to suckle frequently.
- If a baby is still breastfeeding sometimes, the breastmilk supply is likely to increase in a few days.
- If a baby has stopped breastfeeding, it may take one to two weeks or more before much breastmilk comes.

## **Session 10. Common Breastfeeding Difficulties: Symptoms, Prevention, and 'What to Do'**

- 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 Materials 10.1: Common Breastfeeding Difficulties

Breastfeeding difficulty	Prevention	What to do
<p><b>Breast engorgement</b></p>  <p>Photo by Mwate Chintu</p> <p><b>Symptoms:</b></p> <ul style="list-style-type: none"> <li>• Occurs on both breasts.</li> <li>• Swelling.</li> <li>• Tenderness.</li> <li>• Warmth.</li> <li>• Slight redness.</li> <li>• Pain.</li> <li>• Skin shiny, tight, and nipple flattened and difficult to attach.</li> <li>• Can often occur on third to fifth day after birth (when milk production increases dramatically and suckling is not established).</li> </ul>	<ul style="list-style-type: none"> <li><input type="checkbox"/> Put baby belly-to-belly with mother.</li> <li><input type="checkbox"/> Start breastfeeding within an hour of birth.</li> <li><input type="checkbox"/> Good attachment.</li> <li><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.</li> </ul> <p>Note: On the first day or two, a baby may only feed two to three times.</p>	<ul style="list-style-type: none"> <li><input type="checkbox"/> Improve attachment.</li> <li><input type="checkbox"/> Breastfeed more frequently.</li> <li><input type="checkbox"/> Gently stroke breasts to help stimulate milk flow.</li> <li><input type="checkbox"/> Press around areola to reduce swelling, to help baby to attach.</li> <li><input type="checkbox"/> Offer both breasts.</li> <li><input type="checkbox"/> Express milk to relieve pressure until baby can suckle.</li> <li><input type="checkbox"/> Apply warm compresses to help the milk flow before expressing.</li> <li><input type="checkbox"/> Apply cold compresses to breasts to reduce swelling after expression.</li> </ul>
<p><b>Sore or cracked nipples</b></p>  <p>Photo by F. Savage King</p> <p><b>Symptoms:</b></p> <ul style="list-style-type: none"> <li>• Breast/nipple pain.</li> <li>• Cracks across top of nipple or around base.</li> <li>• Occasional bleeding.</li> </ul>	<ul style="list-style-type: none"> <li><input type="checkbox"/> Good attachment.</li> <li><input type="checkbox"/> Do not use feeding bottles (sucking method is different than breastfeeding, so can cause 'nipple confusion').</li> <li><input type="checkbox"/> Do not use soap or creams on nipples.</li> </ul>	<ul style="list-style-type: none"> <li><input type="checkbox"/> Do not stop breastfeeding.</li> <li><input type="checkbox"/> Improve attachment, making certain baby comes onto the breast from underneath and is held close.</li> <li><input type="checkbox"/> Begin to breastfeed on the side that hurts less.</li> <li><input type="checkbox"/> Change breastfeeding positions.</li> <li><input type="checkbox"/> Let baby come off breast by him/herself.</li> <li><input type="checkbox"/> Apply drops of breastmilk to nipples.</li> <li><input type="checkbox"/> Do not use soap or cream on nipples.</li> <li><input type="checkbox"/> Do not wait until the breast is full to</li> </ul>

Breastfeeding difficulty	Prevention	What to do
<ul style="list-style-type: none"> <li>• May become infected.</li> </ul>		<p>breastfeed.</p> <ul style="list-style-type: none"> <li>❑ Do not use bottles.</li> </ul>
<p><b>Plugged ducts and mastitis</b></p>  <p>Photo by F. Savage King</p> <p><b>Symptoms of plugged ducts:</b></p> <ul style="list-style-type: none"> <li>• Lump, tender, localised redness, feels well, no fever.</li> </ul> <p><b>Symptoms of mastitis:</b></p> <ul style="list-style-type: none"> <li>• Hard swelling.</li> <li>• Severe pain.</li> <li>• Redness in one area.</li> <li>• Generally not feeling well.</li> <li>• Fever.</li> <li>• Sometimes a baby refuses to feed, as milk tastes more salty.</li> </ul>	<ul style="list-style-type: none"> <li>❑ Get support from the family to perform non-infant care chores.</li> <li>❑ Ensure good attachment.</li> <li>❑ Breastfeed on demand, and let infant finish/come off breast by him/herself.</li> <li>❑ Avoid holding the breast in scissors hold.</li> <li>❑ Avoid tight clothing.</li> </ul>	<ul style="list-style-type: none"> <li>❑ Do not stop breastfeeding (if milk is not removed, risk of abscess increases; let baby feed as often as he or she will).</li> <li>❑ Apply warmth (water, hot towel).</li> <li>❑ 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.</li> <li>❑ Ensure good attachment.</li> <li>❑ For plugged ducts: apply gentle pressure to breast with flat of hand, rolling fingers towards nipple; then express milk or let baby feed every two to three hours, day and night.</li> <li>❑ Rest (mother).</li> <li>❑ Drink more liquids (mother).</li> <li>❑ If no improvement in 24 hours, refer.</li> <li>❑ If mastitis: express if too painful to suckle.</li> </ul>

**Participant Materials 10.2: “Not Enough” Breastmilk**

“Not enough breastmilk	Prevention	What to do
<p><b>Perceived by mother</b></p> <ul style="list-style-type: none"> <li>You “think” you do not have enough milk.</li> <li>Baby restless or unsatisfied.</li> </ul> <p>First, decide if the baby is getting enough breastmilk or not (weight, urine, and stool output).</p>	<ul style="list-style-type: none"> <li>Put baby belly-to-belly with mother.</li> <li>Start breastfeeding within an hour of birth.</li> <li>Stay with baby.</li> <li>Ensure good attachment.</li> <li>Encourage frequent demand feeding.</li> <li>Let baby release first breast first.</li> <li>Breastfeed exclusively, day and night.</li> <li>Avoid bottles.</li> <li>Encourage use of suitable family planning methods.</li> </ul>	<ul style="list-style-type: none"> <li>Listen to mother’s concerns and why she thinks she does not have enough milk.</li> <li>Decide if there is a clear cause of the difficulty (poor breastfeeding pattern, mother’s mental condition, baby or mother ill).</li> <li>Check baby’s weight and urine and stool output (if poor weight-gain, refer).</li> <li>Build mother’s confidence—reassure her that she can produce enough milk.</li> <li>Explain what the difficulty may be—growth spurts (2 to 3 weeks, 6 weeks, and 3 months) or cluster feeds.</li> <li>Explain the importance of removing plenty of breastmilk from the breast.</li> <li>Check and improve attachment.</li> <li>Suggest stopping any supplements for baby—no water, formulas, tea, or liquids.</li> <li>Avoid separation from baby and care of baby by others (express breastmilk when away from baby).</li> <li>Suggest improvements to feeding pattern.</li> <li>Feed baby frequently on demand, day and night.</li> <li>Let the baby come off the breast by him/herself.</li> <li>Ensure mother gets enough to eat and drink.</li> <li>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 greater the demand for milk, the greater the supply).</li> <li>Take local drink or food that helps mother to ‘make milk.’</li> <li>Ensure that the mother and baby are belly-to-belly as much as possible.</li> </ul>
<p><b>Real “not enough”</b></p>	<ul style="list-style-type: none"> <li>Same as above.</li> </ul>	<ul style="list-style-type: none"> <li>Same as above.</li> </ul>

**Session 10. Common Breastfeeding Difficulties: Symptoms, Prevention, and 'What to Do'**

<p><b>breastmilk</b></p> <ul style="list-style-type: none"><li>• Baby is not gaining weight: trend line on growth chart for infant less than 6 months is flat or slopes downward.</li><li>• For infants after day 4 up to 6 weeks: at least six wets and three to four stools/day.</li></ul>		<ul style="list-style-type: none"><li>❑ If there is no improvement in weight gain after one week, refer mother and baby to nearest health post.</li></ul>
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## Session 11. First Field Visit and Feedback

Learning objectives	Methodologies	Training aids
1. Practise <i>infant and young child feeding three-step counselling</i> by conducting an infant and young child feeding assessment of mother/child pair with mother/father/caregiver and a child 0 up to 24 months.	Practise	<ul style="list-style-type: none"> <li>• Set of <i>Counselling Cards</i></li> <li>• <i>Key Messages Booklet</i></li> <li>• Set of three <i>Take-Home Brochures</i></li> <li>• <i>Participant Materials 9.1: Infant and Young Child Feeding Assessment of Mother/Child Pair</i></li> <li>• <i>Participant Materials 9.2: Observation Checklist for Infant and Young Child Feeding Assessment of Mother/Child Pair</i></li> </ul>
2. Identify key gaps that need more practise/observation time at site.		
3. Reflect on strengths and weaknesses of counselling field practise.	Feedback exchange	<ul style="list-style-type: none"> <li>• <i>Participant Materials 11.1: Sample Summary Sheet for Counselling During Field Visits</i></li> </ul>

### Materials:

- Set of *Counselling Cards*.
- Photocopies of *Participant Materials 9.1: Infant and Young Child Feeding Assessment of Mother/Child Pair* (three per participant).
- Laminated *Participant Materials 9.1: Infant and Young Child Feeding Assessment of Mother/Child Pair* (one per participant).

### 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. Ensure that people are mobilised properly.
- 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 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 for activity:**

1. In large group, review *infant and young child feeding three-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), while the other follows the discussion with the observation checklist in order to give feedback later.
3. Ask the counsellor to use the *Participant Materials 9.1: Infant and Young Child Feeding Assessment of Mother/Child Pair*.
4. Ask the counsellor to share age-appropriate *Counselling Cards* and *Take-Home Brochures* with mother/father/caregiver.
5. Ask the observer to fill out *Participant Materials 9.2: Observation Checklist for Infant and Young Child Feeding Assessment of Mother/Child Pair*.
6. Ask participants to change roles until each participant practises at least two counselling sessions.
7. Identify key gaps that need more time for practise and observation at the site.

**Key information**

- The *infant and young child feeding three-step counselling* process involves the following:
  - **Assess** age-appropriate feeding and condition of mother/father/caregiver and child: Ask, listen, and observe.
  - **Analyse** feeding difficulty: Identify difficulty, and if there is more than one, prioritise, answer mother/father/caregiver's questions.
  - **Act:** Discuss, suggest small amount of relevant information, give practical help to the breastfeeding mother, and agree on feasible, doable option that mother/father/caregiver can try.

**Note:** Refer to **Key information** Session 9.

- See *Participant Materials 9.1: Infant and Young Child Feeding Assessment of Mother/Child Pair*.
- See *Participant Materials 9.2: Observation Checklist for Infant and Young Child Feeding Assessment of Mother/Child Pair*.

**Learning objective 3:** Reflect on strengths and weaknesses of counselling field practise.

**Methodology:** Feedback exchange.

**Instructions for activity:**

1. At training site, in large group, ask each pair of participants to summarise their counselling experience by filling in *Participant Materials 11.1: Sample Summary Sheet for Counselling During Field Visits*.
2. 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; number of older children.
  - ASSESS: Illness; breastfeeding (frequency and difficulties); complementary feeding: frequency, amount, texture (thickness), variety, active feeding, and hygiene.
  - ANALYSE: 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 summarise.

Session 11. First Field Visit and Feedback

Participant Materials 11.1: Sample Summary Sheet for Counselling During Field Visits

ASSESS												ANALYSE	ACT		
Participants' names	Name/Age of child	Illness	Number of older children	Breast-feeding		Difficulties identified for breastfeeding	Complementary Feeding					Difficulties identified for complementary feeding	Difficulties identified/ Priorities determined	Suggested options/ Proposals to mother/ Alternatives	Agreed-upon actions/ Small, doable actions; Time-bound/ Negotiated agreement
				Y/N	Freq.		Freq.	Amt.	Texture	Variety	Active feeding				

## Session 12. Action-Oriented Groups, Infant and Young Child Feeding Support Groups, and Home Visits

Learning objectives	Methodologies	Training aids
1. Facilitate an action-oriented group using the steps: Observe, Think, Try, and Act.	<ul style="list-style-type: none"> <li>• Experiential (sharing experiences)</li> <li>• Discussion</li> </ul>	<ul style="list-style-type: none"> <li>• Set of <i>Counselling Cards</i></li> <li>• <i>Participant Materials 12.1: How to Conduct an Action-Oriented Group Session—Story, Drama, or Visual—Applying the Steps Observe, Think, Try, Act</i></li> </ul>
2. Facilitate an infant and young child feeding support group of mothers/fathers/caregivers to help them support each other in their infant and young child feeding practices.	<ul style="list-style-type: none"> <li>• Experiential (sharing experiences)</li> <li>• Discussion</li> <li>• Practise</li> </ul>	<ul style="list-style-type: none"> <li>• <i>Participant Materials 12.2: Characteristics of an Infant and Young Child Feeding Support Group</i></li> <li>• <i>Participant Materials 12.3: Observation Checklist for Infant and Young Child Feeding Support Groups</i></li> <li>• <i>Participant Materials 12.4: Infant and Young Child Feeding Support Group Attendance</i></li> </ul>
3. Identify the steps in conducting a home visit.	Brainstorming	<ul style="list-style-type: none"> <li>• <i>Counselling Cards</i></li> <li>• <i>Take-Home Brochures</i></li> </ul>

### Materials:

*Some suggested topics for infant and young child feeding support groups:*

1. Importance of breastfeeding for mother, baby, family (one to three 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-birthweight 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.’

## Session 12. Action-oriented Groups, Infant and Young Child Feeding Support Groups, and Home Visits

- Prepare and practise ‘mini-drama.’
- Prepare and practise ‘visual.’

**Duration:** 2 hours.

**Learning objective 1:** Facilitate an action-oriented group using the steps: Observe, Think, Try, Act.

**Methodology:** Experiential (sharing experiences).

### Instructions for Activity 1:

1. Facilitator models an action-oriented group with participants acting as community members by telling a story, conducting a drama, or using a visual (*Counselling Card*) on some aspect of infant and young child feeding—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 beforehand 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 *Counselling Card* 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 summarise.

### Key information

- See *Participant Materials 12.1: How to Conduct an Action-Oriented Group Session—Story, Drama, or Visual—Applying the Steps Observe, Think, Try, Act.*
- Traditionally, group talks are organised 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 is slightly different. Facilitators encourage group participants **to personalise 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.

## Session 12. Action-oriented Groups, Infant and Young Child Feeding Support Groups, and Home Visits

- Explain to participants that applying the steps Observe, Think, Try, and Act is used to encourage group participants to reflect on and personalise 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 Miriam had her first baby, a son, whom she named Thomas. She heard the community worker talk about giving only breastmilk to babies until they were 6 months old. She wanted to do what the community worker was saying, but both her mother and mother-in-law told her that the baby would need more than her breastmilk to grow strong and healthy in those first months. Of course, she wanted Thomas to be a healthy boy and so she breastfed Thomas and gave him porridge and water from the time he was 1 month old. He has been sick. Now Thomas is 2 months old and the community worker who did a home visit the other day told Miriam to take Thomas 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.

#### *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.

**Objective 1, Activity 2:** Discussion on the action-oriented group experience.

**Methodology:** Discussion.

**Instructions for Activity 2:**

1. After the story, mini-drama, or visual (use of poster or enlarged *Counselling Card*), the following questions are asked of the participants:
  - What did you like about the action-oriented group?
  - How was the action-oriented group 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, Act* (or refer to specific page in *Participant Materials*).

**Learning objective 2:** Facilitate an infant and young child feeding support group of mothers/fathers/ caregivers to help them support each other in their infant and young child feeding practices.

**Methodology:** Experiential (sharing experiences).

**Instructions for activities:**

**Activity 1:** Experience a support group.

**Methodology:** Experiential (sharing experiences).

1. Select five participants.
2. Facilitator and five 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 Materials 12.4: Infant and Young Child Feeding Support Group Attendance*.
6. Ask other participants who observe the support group to fill out *Participant Materials 12.3: Observation Checklist for Infant and Young Child Feeding 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 and ideas and fill out an observation form: *Participant Materials 12.3: Observation Checklist for Infant and Young Child Feeding Support Groups*.

## Session 12. Action-oriented Groups, Infant and Young Child Feeding Support Groups, and Home Visits

3. Ask participants what contributions a support group can make to an infant and young child feeding program?
  4. Distribute *Participant Materials 12.2: Characteristics of an Infant and Young Child Feeding Support Group* (or refer to specific page in *Participant Materials*).
- .....

**Activity 3:** Practise conducting a support group.

*Methodology:* Practise.

1. Divide participants in groups of seven.
2. Each group chooses a topic out of the 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 Materials 12.3: Observation Checklist for Infant and Young Child Feeding Support Groups*.
5. Share observations and discuss in large group.

### Key information

- See *Participant Materials 12.2: Characteristics of an Infant and Young Child Feeding Support Group*.
- See *Participant Materials 12.3: Observation Checklist for Infant and Young Child Feeding Support Groups*.
- See *Participant Materials 12.4: Infant and Young Child Feeding Support Group Attendance*.

**Definition:** An infant and young child feeding support group on infant and young child feeding is a group of mothers/fathers/caregivers who promote recommended 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**.

**Note:** If support group numbers grow to exceed 12, consider splitting the group into two (with a trained counsellor conducting each support group).

**Learning objective 3:** Identify steps in conducting a home visit.

*Methodology:* Brainstorming.

### Instructions for activity:

1. Ask participants to identify the steps in conducting a home visit.
2. Write answers on flipchart.

## Session 12. Action-oriented Groups, Infant and Young Child Feeding Support Groups, and Home Visits

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).
  - *Infant and young child feeding three-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 *Counselling Cards* and *Take-Home Brochures*.
4. Discuss and summarise.

**Participant Materials 12.1: How to Conduct an Action-Oriented 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 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?

**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 Materials 12.2: Characteristics of an Infant and Young Child Feeding 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 experience, 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. Infant and young child feeding 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 12.
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).

**Session 12. Action-oriented Groups, Infant and Young Child Feeding Support Groups, and Home Visits**

**Participant Materials 12.3: Observation Checklist for Infant and Young Child Feeding Support Groups**

<b>Community:</b>		<b>Place:</b>	
<b>Date:</b>		<b>Time:</b>	
		<b>Theme:</b>	
<b>Name of Infant and Young Child Feeding Group Facilitator(s):</b>		<b>Name of Supervisor:</b>	
-----		-----	
-----		-----	
<b>Did:</b>	<input checked="" type="checkbox"/>	<b>Comments</b>	
1. The facilitator(s) introduce themselves to the group?	<input type="checkbox"/>		
2. The facilitator(s) clearly explain the day's theme?	<input type="checkbox"/>		
3. The facilitator(s) ask questions that generate participation?	<input type="checkbox"/>		
4. The facilitator(s) motivate the quiet women/men to participate?	<input type="checkbox"/>		
5. The facilitator(s) apply skills for <i>listening and learning, building confidence and giving support</i> ?	<input type="checkbox"/>		
6. The facilitator(s) adequately manage content?	<input type="checkbox"/>		
7. Mothers/fathers/caregivers share their own experiences?	<input type="checkbox"/>		
8. The participants sit in a circle?	<input type="checkbox"/>		
9. The facilitator(s) invite women/men to attend the next infant and young child feeding support group (place, date, and theme)?	<input type="checkbox"/>		
10. The facilitator(s) thank the women/men for attending the infant and young child feeding support group?	<input type="checkbox"/>		
11. The facilitator(s) ask women to talk to a man, pregnant woman, or breastfeeding mother before the next meeting, share what they have learned, and report back?	<input type="checkbox"/>		
12. Support group attendance form checked?	<input type="checkbox"/>		
Number of women/men attending the infant and young child feeding support group:			
<b>Supervisor/Mentor</b> —Indicate questions and resolved difficulties:			
<b>Supervisor/Mentor</b> —Provide feedback to facilitator(s):			

**Session 12. Action-oriented Groups, Infant and Young Child Feeding Support Groups, and Home Visits**

**Participant Materials 12.4: Infant and Young Child Feeding Support Group Attendance**

Date: \_\_\_\_\_ District: \_\_\_\_\_

Facilitator(s) name(s): \_\_\_\_\_



## Session 13. 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"> <li>Brainstorming</li> <li>Interactive presentation</li> </ul>	
2. Describe the actions that can break the undernutrition cycle in order to have a well-nourished child, teen, woman, and baby.	Group work	<ul style="list-style-type: none"> <li><i>Participant Materials 13.1: Actions to Break the Undernutrition Cycle</i></li> <li>Illustrations of well-nourished child, adolescent, adult, pregnant woman, and baby</li> <li><i>Counselling Card 1: Nutrition for pregnant and breastfeeding women</i></li> <li><i>Counselling Card 23: Kitchen gardens and fruit trees</i></li> <li><i>Counselling Card 24: Small animal breeding</i></li> <li><i>Key Messages Booklet</i></li> <li><i>Take-Home Brochure: Nutrition During Pregnancy and Breastfeeding</i></li> </ul>
3. Name the recommended time for spacing children and the criteria for the Lactation Amenorrhoea Method (LAM).	<ul style="list-style-type: none"> <li>Interactive presentation</li> <li>Group work</li> </ul>	<ul style="list-style-type: none"> <li><i>Counselling Card 1: Nutrition for pregnant and breastfeeding women</i></li> <li><i>Counselling Card 21: Birth spacing improves health and survival</i></li> <li><i>Key Messages Booklet</i></li> </ul>

### Materials:

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

**Duration:** 1½ hours.

**Learning objective 1:** Describe the undernutrition cycle: child, teenager, adult, pregnant woman, and baby.

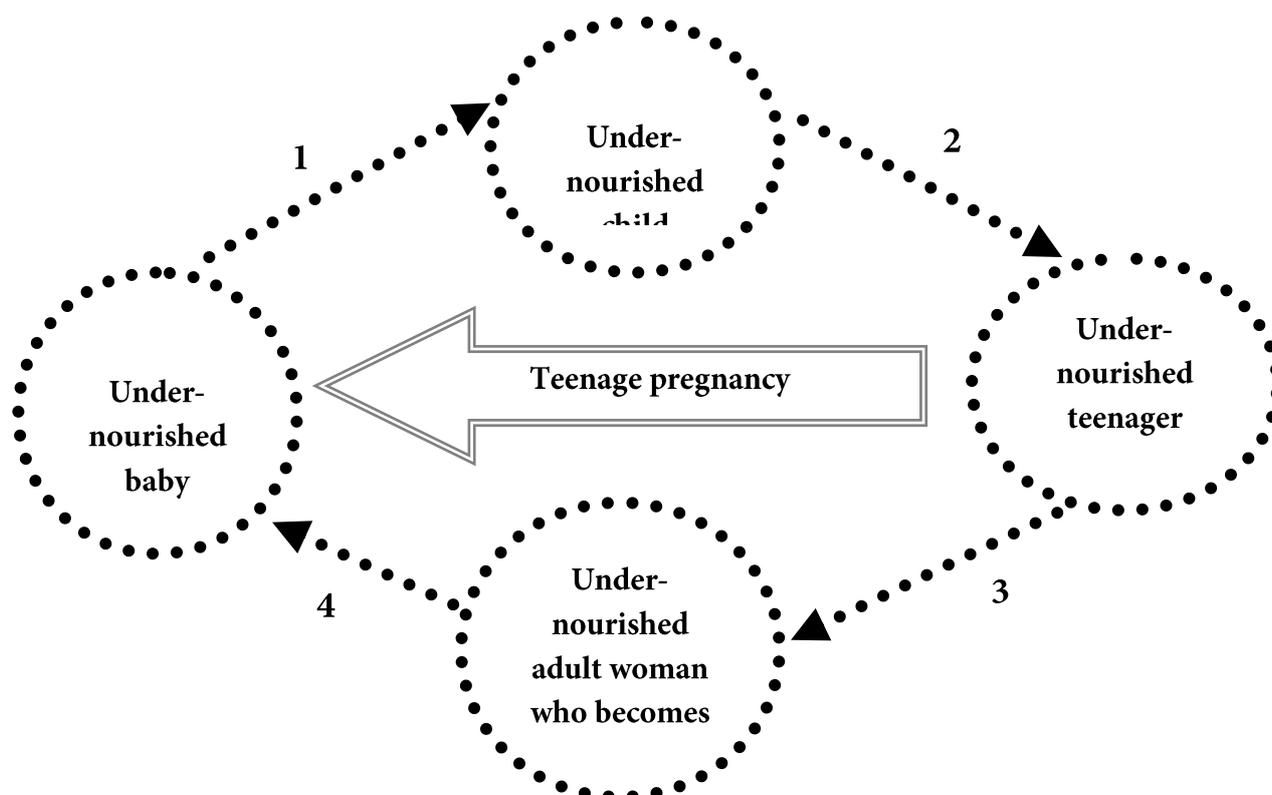
**Methodology:** Brainstorming; interactive presentation.

**Instructions for activity:**

1. Facilitator draws four circles on a flipchart with arrows connecting the circles (see diagram below).
2. Facilitator writes undernourished child, teenager, pregnant woman, and baby—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 summarise.

**Key information**

*Possible outcomes of undernutrition*



*Consequences of undernutrition for women:*

- Increased infection due to weakened immune system.

## Session 13. Women's Nutrition

- 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 excessively 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 a child, teen, woman, and baby.

**Methodology:** Group work.

### Instructions for activity:

1. Divide participants into four 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 (from undernourished to well-nourished).
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 child; 3) a well-nourished teenager; and 4) a 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 Materials 13.1: Actions to Break the Undernutrition Cycle* (or refer to specific page in *Participant Materials*) and discuss.
7. Ask working groups to observe *Counselling Card 1: Nutrition for pregnant and breastfeeding women* and *Take-Home Brochure: Nutrition During Pregnancy and Breastfeeding* and to comment on the counselling discussion points of the card.
8. Orient participants to the key messages from *Key Messages Booklet*.
9. Discuss and summarise.

## Session 13. Women's Nutrition

### 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 Materials 13.1: 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.

**Teenage mother:** Needs 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 LAM.

**Methodology:** Interactive presentation; group work.

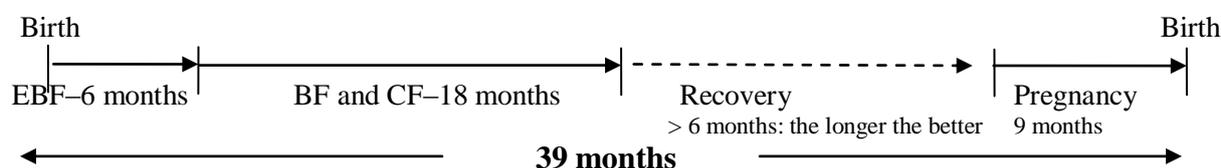
### Instructions for activity:

1. Ask participants what is the recommended time for spacing children. After hearing comments, use a timeline showing the breakdown of recommended practices leading to optimal child spacing; let participants fill in the number of months.
2. Explain that the recommended time between babies is two to three years.
3. Ask participants to discuss how women in the communities relate breastfeeding and child spacing.
4. Ask participants to brainstorm the definition of LAM and LAM criteria.
5. Describe LAM and the LAM criteria and what to do when the criteria are not met (to continue to prevent pregnancy).
6. Divide participants into three groups.
7. Ask the three groups to review *Counselling Card 21: Birth spacing improves health and survival* and comment on the counselling discussion points.
8. Orient participants to the key messages from *Key Messages Booklet*.

9. Review information on adolescent pregnancy from *Counselling Card 1: Nutrition for pregnant and breastfeeding women*.
10. Discuss and fill in gaps.

### Key information

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



BF=breastfeeding; CF=complementary feeding; EBF=exclusive breastfeeding

**Note:** Data from The Nutritional Institute of Central America and Panama suggest 6 months exclusive breastfeeding, followed by at least 18 months of additional breastfeeding with complementary foods, and at least 6 months of neither breastfeeding nor pregnancy for best child outcomes. This would be inter-birth spacing of 39 months (Merchant, Martorell, and Hass, 1990).

See *Counselling Card 21: Birth spacing improves health and survival* and *Key Messages Booklet*.

### LAM

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

- L = Lactational
- A = Amenorrhoea (no menses)
- M = Method of family planning

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

1. Amenorrhoea (no menses)—no bleeding after eight weeks of birth.
2. Exclusive breastfeeding is practiced—no more than four hours between breastfeeds and no more than one six-hour period (in 24 hours) between breastfeeds.
3. The infant is less than 6 months of age.

**Note:** When a woman no longer meets one of the three 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 Materials 13.1: Actions to Break the Undernutrition Cycle

**1. For the child:** How do we break the cycle so that an undernourished baby can become a well-nourished child?

*Prevent growth failure by:*

- Encouraging early initiation of breastfeeding.
- Encouraging exclusive breastfeeding from 0 to 6 months.
- Encouraging timely introduction of complementary foods at 6 months with continuation of breastfeeding for at least 2 years or more.
- Feeding different food groups at each serving to create a 4-star diet. A 4-star diet is created by including foods from the following categories:
  - Animal-source foods (meat, chicken, fish, liver, crayfish, snails, and periwinkles), and eggs, milk, and milk products. (1 star).
  - Staples (maize, wheat, rice, millet, and sorghum); roots and tubers (yam, cassava, and potatoes) (1 star).
  - Legumes (beans, lentils, peas, and groundnuts) and seeds (sesame) (1 star).
  - Vitamin A-rich fruits and vegetables (mango, pawpaw, passion fruit, oranges, dark green leaves, carrots, yellow sweet potato, and pumpkin), and other fruit and vegetables (banana, pineapple, watermelon, tomatoes, avocado, eggplant, and cabbage) (1 star).
- Foods may be added in a different order to create a 4-star food/diet.
- Animal-source foods are very important. Start animal-source foods as early and as often as possible. Cook well and chop fine.
- Oil and fat such as oil, seeds, margarine, 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 iodised salt.
- Feeding the sick child more frequently for two weeks after recovery.

*Other 'non-feeding' actions:*

- Appropriate hygiene.
- Attending GMP and immunisation sessions.
- Use of long-lasting, insecticide-treated bed nets.
- Deworming.
- Prevention and treatment of infections.
- Vitamin-A supplementation.

**2. For the teenage girl:** How do we break the cycle so that an undernourished child can become a well-nourished teen?



*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; in some settings, it may be more politically acceptable to use the wording 'delay pregnancy' than 'delay marriage.'
- Avoiding processed/fast foods.
- Avoiding intake of coffee/tea with meals.
- Encouraging good hygiene practices.
- Encouraging use of long-lasting, insecticide-treated bed nets.



**3. For adult and pregnant women:** How do we break the cycle so that an undernourished teen can become a well-nourished adult and pregnant woman?

*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 situations (*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 insecticide-treated nets for use by their families and making sure the pregnant wives/partners and children sleep under the net every night.
- Encourage girls and boys equal access to education.

**4. For the developing child/foetus—prevent low birthweight:** How do we break the cycle so that an undernourished pregnant adult woman can give birth to a well-nourished baby?

*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 two 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 three months **after** delivery of the child.
- Giving vitamin A to the mother within six weeks after birth.
- Preventing and seeking early treatment of infections:
  - Completing anti-tetanus immunizations for pregnant women (five injections in total).
  - Using of long-lasting, insecticide-treated bed nets.
  - Deworming and giving antimalarial drugs to pregnant women between the fourth and sixth 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 (ANC) and remind 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.



**Community Infant and Young Child Feeding Counselling Package: Facilitator**

- Encourage their wives/partners to put the babies to the breast immediately after birth.
- Encourage their wives/partners to give colostrum, the first thick, yellowish milk, to babies immediately after birth.

## **Session 13. Women's Nutrition**

## Session 14. Feeding of the Sick and Malnourished Child

Learning objectives	Methodologies	Training aids
1. Describe the relationship between illness, recovery, and feeding.	<ul style="list-style-type: none"> <li>Brainstorming</li> <li>Interactive presentation</li> </ul>	
2. Name the practices for feeding the sick child.	<ul style="list-style-type: none"> <li>Group work with rotation of flipcharts</li> </ul>	<ul style="list-style-type: none"> <li><i>Counselling Card 11: Good hygiene practices</i></li> <li><i>Counselling Card 18: Feeding the sick baby less than 6 months of age</i></li> <li><i>Counselling Card 19: Feeding the sick child more than 6 months</i></li> <li><i>Key Messages Booklet</i></li> </ul>
3. Recognise the signs of SAM.	<ul style="list-style-type: none"> <li>Brainstorming</li> </ul>	<ul style="list-style-type: none"> <li>Two pictures/illustrations of malnourished children: a very thin child, and a swollen child</li> <li><i>Counselling Card 20: Monitor the growth of your baby regularly</i></li> <li><i>Key Messages Booklet</i></li> </ul>
4. Describe home management of the sick child, and ‘When to bring your child to the health facility.’	<ul style="list-style-type: none"> <li>Brainstorming</li> </ul>	<ul style="list-style-type: none"> <li><i>Counselling Card 22: When to take your child to the health facility</i></li> <li><i>Key Messages Booklet</i></li> </ul>

### Materials:

- Flipchart papers (plus markers and masking tape).
- Two pictures/illustrations of undernourished children: a very thin child, and a swollen child.

**Duration:** 2 hours.

**Learning objective 1:** Describe the relationship between illness, recovery, and feeding.

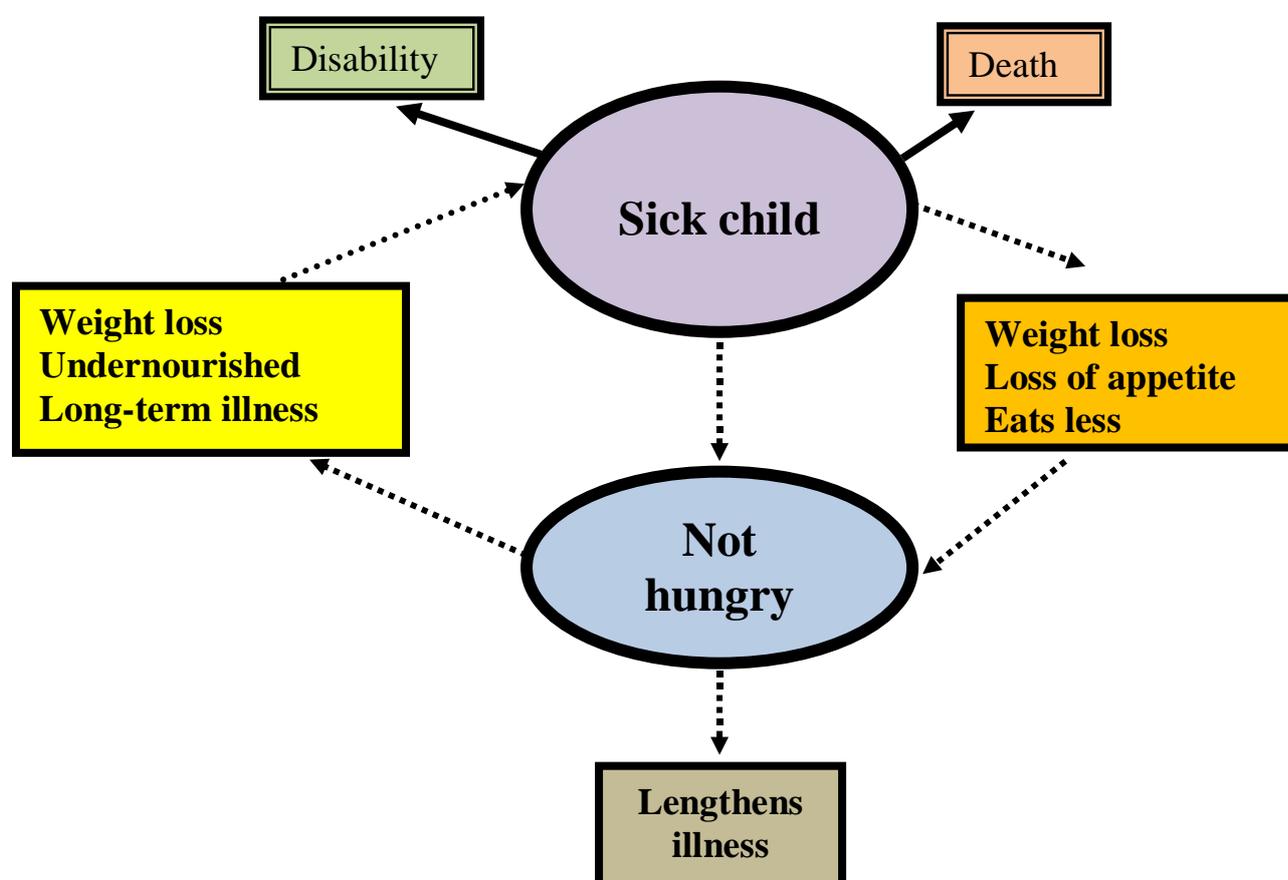
**Methodology:** Brainstorming; interactive presentation.

**Instructions for activity:**

1. Ask participants: ‘What is the relationship between feeding and illness?’
2. Compare answers with ‘Relationship between illness and feeding’ described below.
3. Ask participants what the sick child feeding practices are in their community.
4. Discuss and summarise.

**Key information**

**Relationship between illness and feeding**



*Relationship between feeding and illness:*

- A sick child (diarrhoea, acute respiratory infection, measles, fever) usually does not feel like eating.
- But he or she needs even more strength to fight sickness.
- Strength comes from the food he or she eats.

## Session 14. Feeding of the Sick and Malnourished Child

- If the child does not eat or breastfeed during sickness, he or she will take more time to recover.
- The child is more likely to suffer long-term sickness and malnutrition that may result in a physical or intellectual disability. The child takes more time to recover, or the child's condition may worsen; he or she might even die.
- Therefore, 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 recuperation in order to quickly regain strength.

**Learning objective 2:** Name the practices for feeding the sick child.

**Methodology:** Group work.

### Instructions for activity:

1. Set-up four flipcharts throughout the room and divide participants into four groups; each group will spend three 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.
2. Groups do not repeat the same information, but only add new information.
3. After three minutes, the groups rotate to another flipchart.
4. Each team presents to large group.
5. Ask groups to observe and study *Counselling Card 18: Feeding the sick baby less than 6 months of age*, *Counselling Card 19: Feeding the sick child more than 6 months*, and to review *Counselling Card 11: Good hygiene practices*.
6. Orient participants to key messages from *Key Messages Booklet*.
7. Discuss and summarise.

### Key information

- See counselling discussion points/messages on *Counselling Card 18: Feeding the sick baby less than 6 months of age*.
- See counselling discussion points/messages on *Counselling Card 19: Feeding the sick child more than 6 months*.
- See counselling discussion points/messages on *Counselling Card 11: Good hygiene practices*.

**Learning objective 3:** Recognise the signs of SAM.

**Methodology:** Brainstorming.

**Instructions for activity:**

1. Ask participants: What happens to the child with acute malnutrition?
2. On the wall, tape two pictures of malnourished children: a very thin child, and a swollen child.
3. Ask participants to describe the conditions in the pictures.
4. Ask participants: what should the community worker do?
5. Refer to *Counselling Card 20: Monitor the growth of your baby regularly* and review counselling points for discussion/messages.
6. Orient participants to key messages from *Key Messages Booklet*.
7. Show mid-upper arm circumference (MUAC) tapes used in a local CMAM programme (where there is a CMAM programme).
8. Discuss and fill in gaps.

**Key information**

- Children can become acutely malnourished if they have too little food in combination with a lot of disease. This can happen both during “abnormal” situations of severe food shortages and emergencies, and also in “normal” situations (e.g., as a result of poor feeding and care practices, poverty, frequent illness, and lack of health care).
- Some young children will develop SAM. They may become very thin or have swollen body parts.
- Children are often assessed for acute malnutrition by looking for signs of severe thinness by measuring their MUAC with a special coloured tape called a ‘MUAC tape’ and by looking for oedema or swelling in both legs or feet (or other sites).
- Children with either extreme thinness or swelling (or a combination of both) require immediate care.

*Very thin children*

Very thin children often show other specific, clinical manifestations including:

- Severe weight loss.
- Ribs stick out.
- Arms and legs look very thin (wasted, flabby muscles).
- Buttocks look wrinkled (‘baggy pants’).
- May have sunken eyes.
- Mild skin and hair changes.

## Session 14. Feeding of the Sick and Malnourished Child

- May have increased appetite (eats greedily).
- Mood change (irritable).

### *Children with swelling:*

- Swelling (oedema, pitting type) can appear on both of the lower limbs, but it can also be located on the child's hands, face, eyelids, or belly; or it can spread to the whole body. Oedema means the body collects too much fluid.
- Loss of appetite.
- Lack of interest in surroundings, no energy.
- Mood change (irritable).
- Hair changes, such as straightening of hair and presence of different colour bands of the hair, indicating periods of good and poor nourishment (flag sign). Straightening of hair at the bottom and curling on the top, giving an impression of a forest (forest sign) and brittle, thinning, and easily pluckable hair.
- In severe cases, there may be changes to the skin (skin flakes and peels off, sores, and infections).
- Children with swelling are at great risk of death.

### *What should the community worker do?*

When a child with severe thinness or swelling is identified in the community, refer the mother to the nearest health facility, to a CMAM site, or to a therapeutic feeding centre.

**Learning objective 4:** Describe home management of the sick child, and signs that require mother/caregiver/family to seek care.

**Methodology:** Brainstorming.

### **Instructions for activity:**

1. On four different flipcharts, write one of the following topics: 1) prevention of diarrhoea; 2) management of child with diarrhoea; 3) signs of severe dehydration; and 4) general danger signs of illness.
2. In large group, ask participants to brainstorm the answers; facilitator writes responses in the appropriate column.
3. Ask the four groups to observe and study *Counselling Card 22: When to take your child to the health facility*.
4. Ask two groups to share their observations and others to add additional points.
5. Review together key messages from *Key Messages Booklet*.
6. Discuss and summarise.

### Key information

**Note:** Review recommendations for feeding of the sick child and for home management to ensure compliance with national recommendations. Ensure that terms used when talking about malnutrition and its treatment, as well as growth monitoring, reflect those used in national programmes.

#### 1. Prevention of diarrhoea

- Exclusive breastfeeding for the first 6 months.
- Hand-washing before preparing food.
- Hand-washing before feeding infants and young children.
- Hand-washing after using the toilet.
- Appropriate disposal of wastes.
- Personal and environmental hygiene.
- Adequate and safe water supply.
- Vaccinations.
- Vitamin-A supplementation.
- Avoid bottle feeding.

#### 2. Management of child with diarrhoea

- Continue exclusive breastfeeding if less than 6 months.
- Increase liquids and foods if older than 6 months, and increase frequency of breastfeeding.
- Increase frequency of feedings.
- Never use bottle feeding.
- Refer to health facility.

#### 3. Signs of severe dehydration

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

## HOME MANAGEMENT OF DIARRHOEA

### The Evidence Base for Zinc

Zinc, when given in conjunction with oral rehydration salts (ORS) for at least 10 days during and after diarrhoea, reduces the duration and severity of diarrhoeal episodes and can have a protective effect against diarrhoea morbidity in the subsequent two-month period after treatment.

Zinc supplementation results in a 25% reduction in duration of acute diarrhoea and a 40% reduction in treatment failure or death in persistent diarrhoea.

### Basic Information on Diarrhoea Management using Zinc with LO ORS

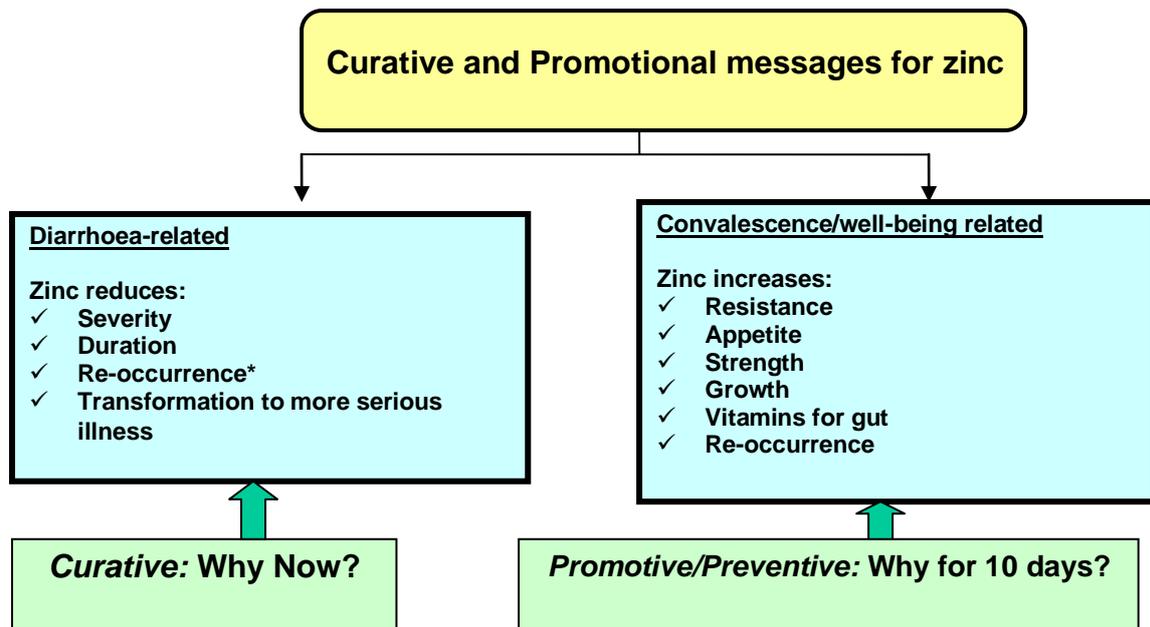
- ✓ Zinc, together with low-osmolarity oral rehydration salts (LO-ORS), is the appropriate treatment for uncomplicated diarrhoea.
- ✓ Treatment of diarrhoea using Zinc with LO-ORS aims at preventing or treating dehydration (use of LO-ORS) and to prevent nutritional deficiency (use of Zinc).
- ✓ Dispersible Zinc tablets and LO-ORS are available from either public- or private-sector clinics.
- ✓ Diarrhoea treatments using anti-diarrhoeals and antibiotics may be harmful to children and are not the most effective treatment.
- ✓ Correctly treat the child by providing both Zinc and ORS for the recommended periods of time.

### Dosages

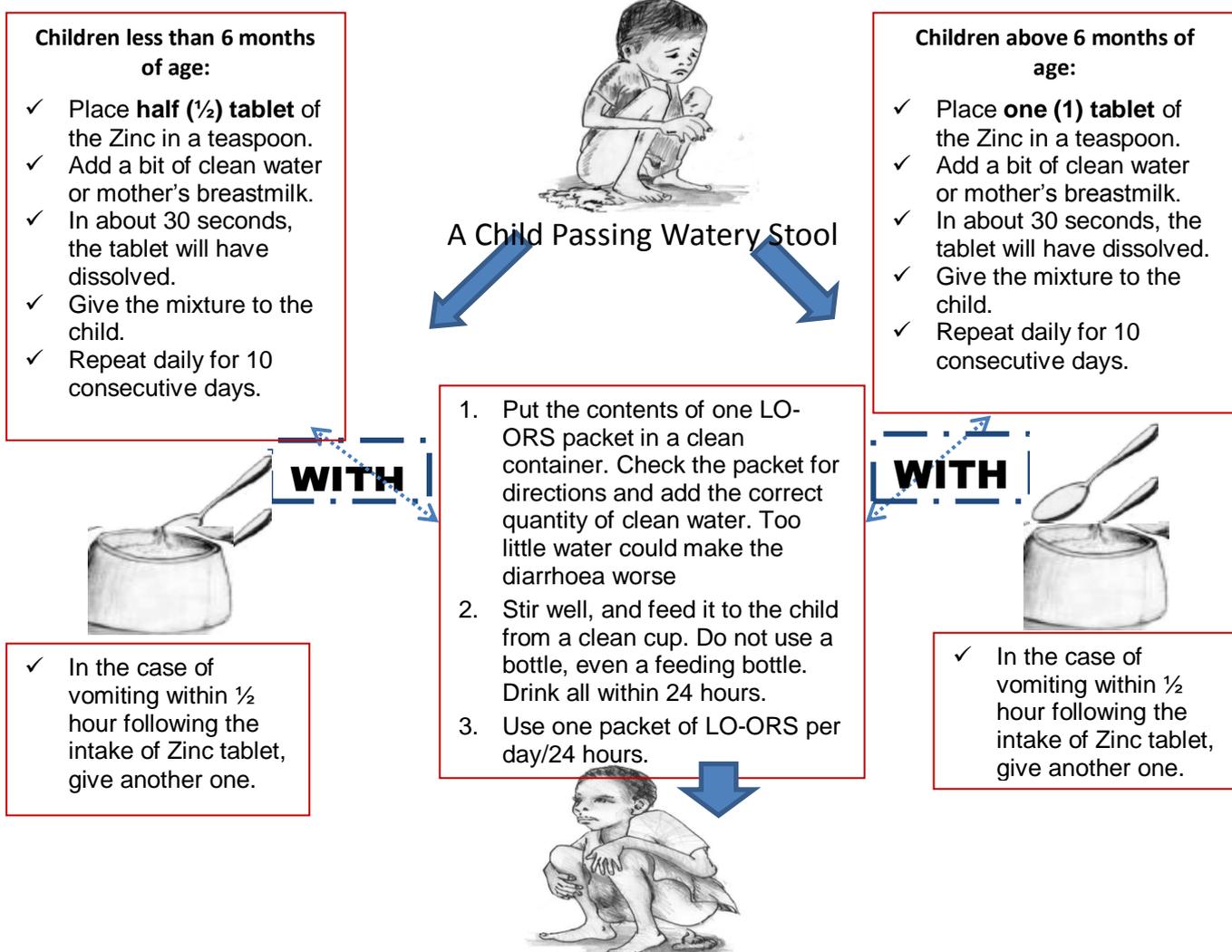
- *Children under 6 months with diarrhoea:* Five tablets of Zinc Sulfate (each divided into two equal halves) and three sachets of LO-ORS.
- *Children 6–59 months with diarrhoea:* Ten 20-mg tablets of Zinc Sulfate and three sachets of low-osmolarity ORS.

### Caution

1. Zinc + LO-ORS should be administered to children with no dehydration and some dehydration. Children with severe dehydration should be referred to a hospital immediately.
2. Diarrhoea is preventable through exclusive breastfeeding, improved hygiene and sanitation, and access to clean water.
3. Zinc serves both curative and preventive purposes, as shown below.



**HOW TO PREPARE AND USE ZINC WITH**



## Session 15. When to Bring the Sick Child to the Health Facility

Learning objectives	Methodologies	Training aids
1. Identify signs requiring the mother/father/caregiver to seek care.	<ul style="list-style-type: none"> <li>Brainstorming</li> <li>Small group work</li> </ul>	<ul style="list-style-type: none"> <li><i>Counselling Card 22: When to take your child to the health facility</i></li> <li>Use illustrations of cases when to bring the child to the health facility</li> <li><i>Key Messages Booklet</i></li> </ul>

### Materials:

- Flipchart papers and stand (plus markers, plus masking tape or sticky putty).
- Illustrations: refusal to feed, vomiting, diarrhoea, convulsions, respiratory infection, fever, malnutrition.

**Duration:** ½ hour.

**Learning objective 1:** Identify signs requiring the mother/father/caregiver to seek care.

**Methodology:** Brainstorming; small group work.

### Instructions for activity:

1. Ask participants to brainstorm signs that require referral to health facility by mother/father/caregiver.
2. As participants mention the signs that require referral, place the illustrations on the wall or floor so all can see.
3. Divide participants into small groups.
4. Ask each group to study *Counselling Card 22: When to take your child to the health facility* and to identify the signs that require referral to the health facility by mother/father/caregiver.
5. 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.
6. Probe until the key and supporting messages (found in *Key Messages Booklet*) are mentioned.
7. Discuss and summarise.

### Key information

- See *Counselling Card 22: When to take your child to the health facility* and *Key Messages Booklet*.

## Session 16. Second Field Visit and Feedback

Learning objectives	Methodologies	Training aids
1. Practise facilitating an action-oriented group or support group.	Practise	<ul style="list-style-type: none"> <li>• <i>Participant Materials 16.1: Observation Checklist on How to Conduct an Action-Oriented Group—Story, Drama, or Visual—Applying the Steps Observe, Think, Try, and Act</i></li> <li>• <i>Participant Materials 12.3: Observation Checklist for Infant and Young Child Feeding Support Groups</i></li> <li>• <i>Participant Materials 12.4: Infant and Young Child Feeding Support Group Attendance</i></li> </ul>
2. Practise <i>infant and young child feeding three-step counselling</i> by conducting an infant and young child feeding assessment of mother/child pair with mother/father/caregiver and a child from 0 up to 24 months.		<ul style="list-style-type: none"> <li>• <i>Set of Counselling Cards</i></li> <li>• <i>Key Messages Booklet</i></li> <li>• <i>Set of Take-Home Brochures</i></li> <li>• <i>Participant Materials 9.1: Infant and Young Child Feeding Assessment of Mother/Child Pair</i></li> <li>• <i>Participant Materials 9.2: Observation Checklist for Infant and Young Child Feeding Assessment of Mother/Child Pair</i></li> </ul>
3. Reflect on strengths and weaknesses of counselling field practise.	Feedback exchange	

### Materials:

- *Set of Counselling Cards.*

### 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 facilitating an action-oriented group or a support group.

**Methodology:** Practise.

**Instructions for activity:**

1. Pair the participants.
2. Ask each pair to practise facilitating an action-oriented group 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) using the topic “Let’s talk about how we feed our children.”
4. Ask participants to fill in *Participant Materials 16.1: Observation Checklist on How to Conduct an Action-Oriented Group—Story, Drama, or Visual—Applying the Steps Observe, Think, Try, and Act* after the action-oriented group session.
5. Ask participants to fill in *Participant Materials 12.3: Observation Checklist for Infant and Young Child Feeding Support Groups* after the support group.
6. Ask participants to fill in the *Participant Materials 12.4: Infant and Young Child Feeding Support Group Attendance* after the support group.

**Learning objective 2:** Practise *infant and young child feeding three-step counselling* with mothers/caregivers of a child from birth up to 24 months.

**Methodology:** Practise.

**Instructions for activity:**

1. In large group, review *infant and young child feeding three-step counselling*.
2. Divide participants into pairs: one will counsel with the mother/father/caregiver of a child from 0 up to 6 months and a child from 6 up to 24 months; while the other follows the dialogue with the observation checklist in order to give feedback later.
3. Ask the counsellor to use *Participant Materials 9.1: Infant and Young Child Feeding Assessment of Mother/Child Pair*.
4. Ask the counsellor to share age-appropriate *Counselling Cards* and *Take-Home Brochures* with mother/father/caregiver.
5. Ask observer to fill out *Participant Materials 9.2: Observation Checklist for Infant and Young Child Feeding Assessment of Mother/Child Pair* and provide feedback.
6. Ask participants to change roles until each participant practises at least two counselling sessions.

**Learning objective 3:** Reflect on strengths and weaknesses of counselling field practise.

**Methodology:** Feedback exchange.

**Instructions for activity:**

*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 Observation Checklist, Attendance, and discuss the challenges.
3. Discuss and summarise.

*Individual counselling*

1. At training site, in large group, ask each pair of participants to summarise their counselling experience by filling in the summary sheet for visits, attached to the wall or on the floor, and used after First Field Visit: Session 11.
2. Participants receive and give feedback.
3. Facilitators and participants identify key gaps that need more practise/observation time at site.
4. Discuss and summarise.

**Participant Materials 16.1: Observation Checklist on How to Conduct an Action-Oriented Group—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 17. Infant and Young Child Feeding in the Context of HIV – OPTIONAL.

Learning objectives	Methodologies	Training aids
<p>1. Explain when the HIV virus can be transmitted from mother to child and explain the risk of transmission with and without interventions.</p>	<ul style="list-style-type: none"> <li>• Brainstorming</li> <li>• Group work</li> </ul>	<ul style="list-style-type: none"> <li>• <i>Counselling Card Special Circumstance 1: If a woman is HIV-infected... what is the risk of HIV passing to her baby when NO preventive actions are taken?</i></li> <li>• <i>Counselling Card Special Circumstance 2: If a woman is HIV-infected... what is the risk of HIV passing to her baby if both take ARVs and practise exclusive breastfeeding during the first 6 months?</i></li> <li>• <i>Key Messages Booklet</i></li> </ul>
<p>2. Describe infant feeding in the context of HIV (according to Nigerian policy).</p>	<ul style="list-style-type: none"> <li>• Brainstorming</li> <li>• Buzz groups</li> <li>• Group work</li> </ul>	<p><i>As Nigerian policy is exclusive breastfeeding and ARVs:</i></p> <ul style="list-style-type: none"> <li>• <i>Counselling Card Special Circumstance 3: Exclusively breastfeed and take ARVs</i></li> <li>• Benefits and risks of different feeding methods for HIV-exposed infants less than 6 months of age</li> </ul> <p><i>When mother opts out of exclusive breastfeeding</i></p> <ul style="list-style-type: none"> <li>• <i>Counselling Card Special Circumstance 4: For a woman who decides not to follow the national recommendation to breastfeed</i></li> <li>• <i>Counselling Card Special Circumstance 5: Conditions needed to use commercial infant formula</i></li> <li>• <i>Key Messages Booklet</i></li> </ul>
<p>3. Describe feeding a child from</p>	<p>Group work</p>	<p><i>Counselling Card Special</i></p>

## Session 17. Infant and Young Child Feeding in the Context of HIV

Learning objectives	Methodologies	Training aids
6 up to 24 months when an HIV-infected mother breastfeeds or does NOT breastfeed.		<i>Circumstance 6: Non-breastfed child from 6 up to 24 months</i>
4. Identify breast conditions of the HIV-infected breastfeeding woman and refer for treatment.	Brainstorming	
5. Describe the role of the community worker who has training in infant and young child feeding, but not in PMTCT.	Group work	Flipchart with role of community workers
6. Discuss the importance of HIV testing and counselling for the mother and the infant (at 6 weeks).		

### Materials:

- Flipchart papers and stand (plus markers, plus masking tape or sticky putty).
- Training aid: Five sets of illustrations on the benefits and risks of different feeding methods for HIV-exposed infants less than 6 months of age.
- Flipchart: Role of the community worker trained in infant and young child feeding but not trained in PMTCT.

**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 interventions.

**Methodology:** Brainstorming; group work.

### Instructions for activity:

1. On a flipchart, draw a bar chart to indicate infant outcomes at two years when 100 HIV-infected mothers receive NO antiretroviral drugs (ARVs) and breastfeed for two years.
2. Brainstorm with participants when the HIV virus can be transmitted from mother to child.
3. After listening to participants' responses, indicate infant outcomes on the bar chart: 65 are not infected; 25 become infected during pregnancy, labour, and delivery; and 10 become infected during breastfeeding.
4. Form working groups of five participants.
5. Distribute *Counselling Card Special Circumstance 1: If a woman is HIV-infected... what is the risk of HIV passing to her baby when NO preventive actions are taken?* and 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 when NO preventive actions are taken, mother is exclusively breastfeeding for six months, and continuing to breastfeed for two years.

6. Ask one group to explain *Counselling Card Special Circumstance 1: If a woman is HIV-infected... what is the risk of HIV passing to her baby when NO preventive actions are taken?*
7. Distribute *Counselling Card Special Circumstance 2: If a woman is HIV-infected... what is the risk of HIV passing to her baby if both take ARVs and practice exclusive breastfeeding during the first 6 months?* and 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 breastfeeding.
8. Ask one group to explain *Counselling Card Special Circumstance 2: If a woman is HIV-infected... what is the risk of HIV passing to her baby if both take ARVs and practice exclusive breastfeeding during the first 6 months?*
9. Construct another bar chart indicating infant outcomes at six months of 100 HIV-infected mothers who practice exclusive breastfeeding for six months and both mother and infant take ARVs.
10. Make sure the bar charts are labelled and compare them.
11. Orient participants to the key messages from *Key Messages Booklet*.
12. Discuss and summarise.

### Key information

#### *Counselling Card Special Circumstance 1: If a woman is HIV-infected... what is the risk of HIV passing to her baby when NO preventive actions are taken?*

- A baby born to an HIV-infected mother can get HIV from the mother during pregnancy, labour, and delivery, and breastfeeding.
- **In the absence of any interventions<sup>1</sup>** to prevent or reduce HIV transmission, research has shown that if 100 HIV-infected women get pregnant, deliver, and breastfeed for two years:<sup>2</sup>
  - About 25 may be infected with HIV during pregnancy, labour, and delivery.
  - About 10 may be infected with HIV through breastfeeding, if the mothers breastfeed their babies for two years.

<sup>1</sup> Interventions to reduce mother-to-child transmission of HIV:

**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 labour and delivery:** ARVs; keep delivery normal; minimize invasive procedures—artificial rupture of membranes, episiotomy, suctioning; minimise elective Caesarean Section; minimise vaginal cleansing; minimize infant exposure to maternal fluids.

**During postpartum and beyond:** Early breastfeeding initiation and support for exclusive breastfeeding 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; immunisations, 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.

<sup>2</sup> DeCock 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.

## Session 17. Infant and Young Child Feeding in the Context of HIV

- **About 65 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.

***Counselling Card Special Circumstance 2: If a woman is HIV-infected... what is the risk of HIV passing to her baby if both take ARVs and practice exclusive breastfeeding during the first 6 months?***

*Risk of transmission decreases with special treatment or preventive medicines (ARVs):*

- A pregnant woman 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 a 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 OR the baby. **This is the best way for a mother to breastfeed her infant safely.**
- If 100 HIV-infected women and their babies take ARVs and practise exclusive breastfeeding during the first six months:
  - About two babies are infected during pregnancy and delivery.
  - About three babies are infected during breastfeeding.
  - **About 95 babies will not get HIV.**

**Note:** When mother takes ARVs from 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 (**dependent on Nigerian policy**).

***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 six months, ask buzz groups to observe *Counselling Card Special Circumstance 3: 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 *Counselling Card Special Circumstance 4: For a woman who decides not to follow the national recommendation to breastfeed* and discuss.

- Point out that *Counselling Card Special Circumstance 5: Conditions needed to use commercial infant formula* is used with the HIV-infected mother at the health facility, and the community worker supports the mother to implement the recommendations.
4. Orient participants to the *Key Messages Booklet*.
  5. Discuss and summarise.
- .....

**Instructions for Activity 3:**

1. Form five groups and give to each group the training aid: Benefits and risks of different feeding methods for HIV-exposed infants less than 6 months of age (in the absence of ARVs).
  - Three cards, each one with an **illustration** depicting rate of transmission of HIV with mode of infant feeding: only breastmilk, only replacement milk, and mixed feeding.
  - Three cards with **titles**: only breastmilk, only replacement milk, and mixed feeding.
  - Legend cards.
2. Ask working groups to match the illustration cards with the correct title.
3. Ask one group to show and explain their matches; ask other groups if they agree or disagree and to make additional points.
4. Ask participants: “Why is mixed feeding especially dangerous?”
5. Discussion and facilitator fills in gaps.

**Key information**

**Activity 1:**

*Definitions:*

- **Exclusive breastfeeding:** Only breastmilk, 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 breastmilk substitute, usually with infant formula, given exclusively (not mixed with breastmilk or other foods). After six months, the suitable breastmilk substitute should be complemented with other foods.*
- **Mixed feeding** is giving breastmilk, plus other foods or drinks (including RUTF) before 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 the 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 breastmilk can cause damage to the baby’s stomach. This makes it easier for HIV and other diseases to pass to the baby.

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**Activity 2** (from World Health Organization [WHO] 2010 Guidelines):

*HIV-uninfected 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 Nigerian policy).

### **1. Exclusively breastfeed together with ARVs for mother OR 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.
- The same recommended breastfeeding practices apply for HIV-negative mother and mother of unknown status (See *Participant Materials 5.2: Recommended breastfeeding practices* and possible counselling discussion points).
- Breastfeeding and ARVs should continue until 12 months.

### **2. Exclusively breastfeed even when no ARVs are available:**

- The 2010 WHO Guidelines on HIV and Infant Feeding, Principles and Recommendations for Infant Feeding in the Context of HIV and a summary of evidence state: *When a national authority has decided to promote and support breastfeeding and ARVs, but ARVs are not yet available, mothers should be counselled to exclusively breastfeed in the first six months of life and continue breastfeeding thereafter unless environmental and social circumstances are safe for, and supportive of replacement feeding.*
- *In circumstances where ARVs are unlikely to be available, such as acute emergencies, breastfeeding of HIV-exposed infants is also recommended to increase survival.*

### **Cessation of breastfeeding at 12 months**

WHO does not recommend early, abrupt, or rapid cessation of breastfeeding. Mothers known to be HIV-infected who decide to stop breastfeeding at any time should stop gradually over a period of one month. Mothers or infants who have been receiving ARV prophylaxis should continue prophylaxis for one week after breastfeeding is fully stopped.

*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.

*If mother opts out of exclusive breastfeeding:*

Avoid all breastfeeding; feed using commercial 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 commercial 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**

	<b>Exclusive breastfeeding</b>	<b>Exclusive replacement feeding</b>	<b>Mixed feeding</b>
<b>Risk of HIV</b>	Yes	No	Yes
<b>Risk of morbidity/mortality</b>	Much lower risk, but does not eliminate the risk entirely	Yes	Yes

- Mixed feeding is the worst option, as it increases the risk of HIV transmission as well as exposes 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 one to two 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 for activity:**

1. Divide participants into two groups.
2. Ask each group to respond to two 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?
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 *Counselling Card Special Circumstance 6: Non-breastfed child from 6 to 24 months*.
6. Discuss and summarise.

**Key information**

*When an 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 (along with ARVs for mother and child) up to 12 months, but then should stop breastfeeding when a nutritionally adequate diet without breastmilk can be provided.

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- The same recommended complementary feeding practices apply for HIV-negative mother and mother of unknown status (See *Participant Materials 7.3: Recommended Complementary Feeding Practices and Possible Counselling Discussion Points*).

*When an 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 one to two **extra** meals and, depending on the child's appetite, offer one to two snacks.
- Add one to two cups of milk per day.
- Add about two cups/day of extra fluids (in addition to the one to three cups/day of water that is estimated to come from milk and other foods in a temperate climate and three to four cups/day in a hot climate).
- For infants 6 up 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 breastmilk substitutes are not available.
- Calcium-rich foods such as pawpaw, 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 breastmilk 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 for activity:**

1. Ask participants to brainstorm the questions: What breast conditions of the breastfeeding woman need special attention? And what should the breastfeeding woman do when these breast conditions present themselves?
2. Discuss and summarise.

### **Key information**

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- An HIV-infected mother with cracked nipples, mastitis (inflammation of the breast), abscess, or thrush/*Candida* (yeast infection of the nipple and breast) has increased risk of transmitting HIV to her baby and so should:
  - Stop breastfeeding from the infected breast and seek prompt treatment.
  - Continue breastfeeding on demand from uninfected breast.
  - Express breastmilk from the infected breast and discard it or heat-treat it before feeding to baby, in case of double mastitis.
  - Thrush: no breastfeeding from either breast; heat-treat expressed breastmilk; treat both mother and infant.

**Note:** Cracked nipples and mastitis are discussed more fully in Session 10: Common Breastfeeding Difficulties.

- Mothers known to be HIV-infected may consider expressing and heat-treating breastmilk as *an interim feeding strategy*.<sup>3</sup>
- In special circumstances, such as when the infant is born with low birthweight or is otherwise ill in the neonatal period and unable to breastfeed; OR
- When the mother is unwell and temporarily unable to breastfeed or has a temporary breast health problem, such as mastitis; OR
- To assist mothers to stop breastfeeding.

*How to heat-treat breastmilk:*

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

**Note:** Flash-heat<sup>4</sup> is a recently developed, simple method that a mother can implement over an outdoor fire or in her kitchen to heat-treat her breastmilk. However, field studies are urgently needed to determine the feasibility of in-home flash-heating of breastmilk.

**Learning objective 5:** Identify the role of the community worker who has training in infant and young child feeding, but not in PMTCT.

<sup>3</sup> WHO. HIV and infant feeding: Revised Principles and Recommendations - Rapid Advice, November 2009.

<sup>4</sup> Israel-Ballard K, et al. Flash heat inactivation of HIV-1 in human milk. A potential method to reduce postnatal transmission in developing countries. *Journal of Acquired Immunodeficiency Deficiency Syndrome*. 2007; 45(3):318–323.

**Methodology:** Brainstorming.

**Instructions for activity:**

1. Ask the groups to identify the role of the community worker.
2. Write contributions on a flipchart.
3. Compare the responses with list previously prepared.
4. Discuss and summarise.

**Role of the community worker** (What community workers trained in infant and young child feeding but not trained in PMTCT need to know and do):

- Recognise the following process:
  1. HIV testing and counselling takes place at health facility where PMTCT services are available.
  2. Decision on infant feeding option is taken at health facility.
- Explain the benefits of ARVs, both for the mother's health if she needs them 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.
- Reinforce the message of exclusively breastfeeding as in the Nigerian policy:
  - See *Participant Materials 5.2: Recommended Breastfeeding Practices and Possible Counselling Discussion Points*.
  - Identify breast conditions of the HIV-infected mother and refer for treatment.
- If a mother opts out of exclusive breastfeeding, ensure the following:
  - No mixed feeding.
  - No dilution of formula.
  - Help mother read instructions on formula tin.
  - Mother prepares formula correctly, feeding with a cup and not a bottle, washing hands, and cleaning utensils properly.

Refer to health facility or relevant CBOs (where available) if HIV-infected mother changes feeding option or no longer meets the requirements for her chosen feeding.

**Learning objective 6:** Discuss the importance of HIV testing and counselling for the mother and for early infant diagnosis at 6 weeks.

**Methodology:** Brainstorming.

**Instructions for activities:**

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 ARV treatment), and support.
  - Encourages more people to be tested and to reduce the stigma surrounding HIV testing.
  - Increases the number of people who know their status.
  - 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 (preventive drugs) during pregnancy and breastfeeding.
  - Allows for ARV therapy (treatment drugs) for the mother’s own health if she needs it.

*B. Importance of early infant diagnosis at 6 weeks (dried-blood spot):*

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 testing in an HIV-exposed child.
  - HIV-infected child can then be treated early with 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 HIV-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, breastfeeding, no breastfeeding.
3. Discuss and summarise.

## Session 18. Integrating Infant and Young Child Feeding Support into Community Services (Using CMAM as an Example) OPTIONAL

Learning objectives	Methodologies	Training aids
<p>1. Identify how infant and young child feeding can be integrated into community services (using CMAM as an example).</p>	<ul style="list-style-type: none"> <li>• Group work</li> </ul>	<ul style="list-style-type: none"> <li>• <i>Participant Materials 18.1: Checklist—Integration of Infant and Young Child Feeding Support into CMAM Programming</i></li> <li>• <i>Counselling Card 2: Monitor the growth of your baby regularly</i></li> </ul>
<p>2. Reflect on when and where counselling on recommended infant and young child feeding practices occur.</p>	<ul style="list-style-type: none"> <li>• Brainstorming</li> </ul>	<ul style="list-style-type: none"> <li>• <i>Participant Materials 18.2: Recommended Schedule for Visits from Pregnancy up to 6 Months</i></li> </ul>
<p>3. Identify what infant and young child feeding information should go into a discharge plan from OTP of CMAM.</p>	<ul style="list-style-type: none"> <li>• Interactive presentation</li> <li>• Group work</li> </ul>	<ul style="list-style-type: none"> <li>• <i>Participant Materials 18.1: Checklist—Integration of Infant and Young Child Feeding Support into CMAM Programming</i></li> </ul>
<p>4. Explain transition to family foods as child’s appetite increases during recovery and when RUTF treatment course ends.</p>	<ul style="list-style-type: none"> <li>• Group work</li> </ul>	<ul style="list-style-type: none"> <li>• Illustrations of texture (thickness/ consistency) of porridge (cup and spoon)</li> <li>• <i>Counselling Card 11: Good hygiene practices</i></li> <li>• <i>Counselling Card 12: Start complementary feeding at 6 months</i></li> <li>• <i>Counselling Card 13: Start complementary feeding from 6 up to 9 months</i></li> <li>• <i>Counselling Card 14: Start complementary feeding from 9 up to 12 months</i></li> <li>• <i>Counselling Card 15: Start complementary feeding from 12 up to 24 months</i></li> <li>• <i>Counselling Card 16: Food variety.</i></li> </ul>

**Session 18. Integrating Infant and Young Child Feeding Support into CMAM Community Services**

		<ul style="list-style-type: none"> <li>• <i>Counselling Card 23: Kitchen gardens and fruit trees</i></li> <li>• <i>Counselling Card 24: Small animal breeding</i></li> <li>• <i>Key Messages Booklet</i></li> <li>• <i>Take-Home Brochure: How to Feed Baby After 6 Months</i></li> <li>• <i>Participant Materials 7.1: Recommended Complementary Feeding Practices</i></li> <li>• <i>Participant Materials 7.2: Different Types of Locally Available Foods</i></li> <li>• <i>Participant Materials 7.3: Recommended Complementary Feeding Practices and Possible Counselling Discussion Points</i></li> <li>• <i>Participant Materials 7.4: Active/Responsive Feeding for Young Children</i></li> <li>• <i>Counselling Card 18: Feeding the sick baby less than 6 months of age</i></li> <li>• <i>Counselling Card 19: Feeding the sick child more than 6 months</i></li> </ul>
<p>5. Describe how the community worker conducts follow-up of a child after discharge from outpatient care.</p>	<ul style="list-style-type: none"> <li>• Buzz groups</li> </ul>	

**Materials:**

- Flipchart papers and stand (plus markers, plus masking tape or sticky putty).

**Duration:** 2 hours.

**Learning objective 1:** Identify how infant and young child feeding support can be integrated into community services (using CMAM as an example).

**Methodology:** Group work.

**Instructions for activity:**

1. Ask participants: ‘What knowledge and skills learned this week could be integrated in different services and at various contact points to provide infant and young child feeding support?’
2. We will use CMAM as an example.
3. Form working groups of participants and ask each group to list activities/interventions that could be included to integrate infant and young child feeding support into CMAM community services.
4. After groups share, ask participants to look at *Participant Materials 18.1: Checklist—Integration of Infant and Young Child Feeding Support into CMAM Programming* (or refer to specific page in *Participant Materials*) and review together.
5. Review together *Counselling Card 20: Monitor the growth of your baby regularly* and *Key Messages Booklet on Counselling Card 20*.
6. Orient participants to:
  - *Session 14: Feeding of the Sick and Malnourished Child*.
  - *Session 19: Infant and Young Child Feeding in Emergencies*.
7. Discuss and summarise.

**Key information**

*Skills, activities/interventions, and materials used in integrating infant and young child feeding support into community services:*

- Use *listening and learning* skills, and *build confidence and giving support* skills.
- Conduct *three-step counselling* on recommended infant and young child feeding practices.
- Conduct *action-oriented groups* (use of stories, role-plays, and visuals).
- Conduct *support groups*.
- Use *Counselling Cards* and *Take-Home Brochures*.
- Conduct *home visits*.
- Use *messaging*.

**Materials:**

- *Counselling Card 3: Breastfeeding in the first 6 months.*
- *Counselling Card 4a: Exclusively breastfeed during the first 6 months.*
- *Counselling Card 4b: Dangers of mixed feeding during the first 6 months.*
- *Counselling Card 5: Breastfeed on demand, both day and night.*
- *Counselling Card 11: Good hygiene practices.*
- *Counselling Card 12: Start complementary feeding at 6 months.*
- *Counselling Card 13: Start complementary feeding from 6 up to 9 months.*
- *Counselling Card 14: Start complementary feeding from 9 up to 12 months.*

## Session 18. Integrating Infant and Young Child Feeding Support into CMAM Community Services

- *Counselling Card 15: Start complementary feeding from 12 up to 24 months.*
- *Counselling Card 16: Food variety.*
- *Counselling Card 20: Monitor the growth of your baby regularly.*
- *Key Messages Booklet.*
- *Take-Home Brochures.*
- *Participant Materials 7.1: Recommended Complementary Feeding Practices.*
- *Participant Materials 7.2: Different Types of Locally Available Foods.*
- *Participant Materials 7.3: Recommended Complementary Feeding Practices and Possible Points of Discussion for Counselling.*
- *Participant Materials 7.4: Active/Responsive Feeding for Young Children.*
- *See Participant Materials 18.1: Checklist—Integration of Infant and Young Child Feeding Support into CMAM Programming.*

**Learning objective 2:** Reflect on when counselling and follow-up on recommended infant and young child feeding practices can occur.

**Methodology:** Buzz groups.

### Instructions for activity:

1. Ask participants to form buzz groups of three.
2. Ask buzz groups to list when counselling and follow-up on recommended infant and young child feeding practices can occur.
3. Ask buzz groups to share their reflection with the entire group.
4. Discuss and summarise.

### Key information

- See *Participant Materials 18.2: Recommended Schedule for Visits from Birth up to 6 Months.*

### **Other opportunities for infant and young child feeding counselling:**

Within the programs or frameworks commonly used in the country—e.g., integrated management of childhood illness (IMCI), essential nutrition actions (ENA), minimum activities for mothers and newborns (MAMAN).

### **Messages must be reinforced by practise:**

- 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.

**Learning objective 3:** Identify what infant and young child feeding information should go into a discharge plan from outpatient therapeutic programme (OTP) of CMAM.

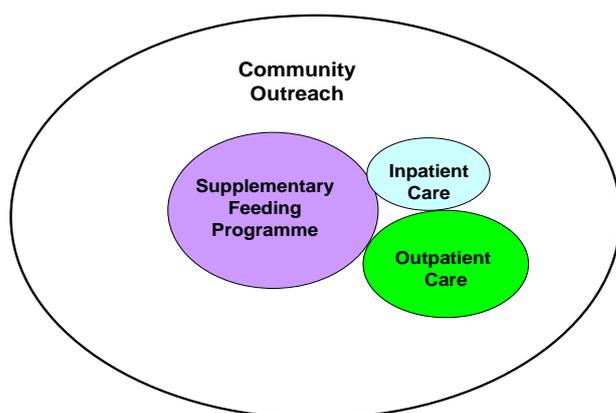
**Methodology:** Interactive presentation; group work.

**Instructions for activity:**

1. Present an overview of CMAM.
2. Form small working groups of five participants.
3. Ask each group to list recommendations that should be included in the discharge plan to discuss with mother/caregiver and to identify the best contact points/opportunities in the CMAM programme to provide infant and young child feeding counselling.
4. Ask one group to report back, and other groups to add additional information.
5. Distribute the Discharge Plan from *Participant Materials 18.1: Checklist—Integration of Infant and Young Child Feeding Support into CMAM Programming* (or refer to specific page in *Participant Materials*).
6. Discuss and summarise.

**Key information**

**Linking IYCF support with CMAM**



- Discharge Plan from *Participant Materials 18.1: Checklist—Integration of Infant and Young Child Feeding Support into CMAM Programming*.

**Note:** Adapt recommendations for discharge of a child from the CMAM programme to reflect the terms, personnel, and activities (e.g., CMAM, RUTF, community health worker, GMP, or other terms) in national programmes.

*Contact points/opportunities in the CMAM programme to provide infant and young child feeding counselling:*

During community outreach, screening and group education:

- At supplementary feeding sites.

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- During follow-up visits at outpatient care.
- At discharge from outpatient care.
- During in-patient care.

**Learning objective 4:** Explain transition to family foods as child's appetite increases during recovery and when RUTF treatment course ends.

**Methodology:** Group work.

### Instructions for activity:

1. Divide participants into three working groups and assign a child of a different age to each group: 8 months, 11 months, and 20 months (each child was enrolled in a CMAM programme and is nearly ready for discharge).
2. Ask each group to describe what they would discuss with the mother/caregiver about helping the child transition to family foods in such a way that the child is prevented from getting SAM again.
3. Each working group has a set of *Counselling Cards*, *Key Messages Booklet*, *Take-Home Brochures* and *Participant Materials* on recommended infant and young child feeding practices.
4. Ask each group to present their case.
5. Give feedback, discuss, and summarise.

### Key information

- *Counselling Card 11: Good hygiene practices.*
- *Counselling Card 12: Start complementary feeding at 6 months.*
- *Counselling Card 13: Start complementary feeding from 6 up to 9 months.*
- *Counselling Card 14: Start complementary feeding from 9 up to 12 months.*
- *Counselling Card 15: Start complementary feeding from 12 up to 24 months.*
- *Counselling Card 16: Food variety.*
- *Counselling Card 23: Kitchen gardens and fruit trees.*
- *Counselling Card 24: Small animal breeding.*
- *Key Messages Booklet.*
- *Take-Home Brochures.*
- *Participant Materials 7.1: Recommended Complementary Feeding Practices.*
- *Participant Materials 7.2: Different Types of Locally Available Foods.*
- *Participant Materials 7.3: Recommended Complementary Feeding Practices and Possible Counselling Discussion Points.*
- *Participant Materials 7.4: Active/Responsive Feeding for Young Children.*

### Note:

- Continue to breastfeed.

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- Gradually feed your baby a 4-star diet. A 4-star diet is created by including foods from the following categories:
  - Animal-source foods (meat, chicken, fish, liver, crayfish, snails, and periwinkles), and eggs, milk, and milk products. (1 star).
  - Staples (maize, wheat, rice, millet, and sorghum); roots and tubers (yam, cassava, and potatoes) (1 star).
  - Legumes (beans, lentils, peas, and groundnuts) and seeds (sesame) (1 star).
  - Vitamin A-rich fruits and vegetables (mango, pawpaw, passion fruit, oranges, dark-green leaves, carrots, yellow sweet potato, and pumpkin), and other fruit and vegetables (banana, pineapple, watermelon, tomatoes, avocado, eggplant, and cabbage) (1 star).
- Additional nutritious snacks (extra food between meals) such as pieces of ripe mango, pawpaw, banana, avocado, other fruits and vegetables, boiled potato, sweet potato, and bread products can be offered once or twice per day.
- Be patient and actively encourage your baby to eat.
- Use a clean spoon or cup to give foods or liquids to child.
- Foods given to your child must be stored in hygienic conditions to avoid diarrhoea and illness.

Wash hands with soap and water before preparation of food and feeding child, and after using the toilet and washing baby's bottom.

**Learning objective 5:** Describe how the community workers should conduct follow-up of a child after discharge from outpatient care.

**Methodology:** Buzz groups.

### Instructions for activity:

1. Ask participants to form buzz groups of three and list the ways in which the community worker can conduct follow-up of a child after discharge from CMAM.
2. Ask buzz groups to share the tasks of the community worker.
3. Discuss and summarise.

### Key information

*Follow-up of child after discharge from outpatient care:*

- GMP or well-baby sessions.
- Immunisation sessions.
- At every contact with mothers or caregivers of sick children.
- Community follow-up:
  - Action-oriented group session.
  - Infant and young child feeding support groups.
  - MUAC screening sessions.
- Supplementary feeding programme.

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Messages must be reinforced by practise:

- Practise good hygiene.
- Continue optimal feeding of infants and young children from 6 up to 24 months.
- Practise frequent and active feeding.
- Identify local foods to give to young children.

Other activities:

- Identify undernutrition (when to bring children to outpatient care).
- Manage diarrhoea and fever.
- Recognise danger signs.
- 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.

### Participant Materials 18.1: Checklist—Integration of Infant and Young Child Feeding Support into CMAM Programming

#### 1. Mobilisation and sensitisation:

- Assess community infant and young child feeding practices: breastfeeding and complementary feeding.
- Analyse data to reach feasible behaviour and counselling discussion points (or messages).
- Identify locally available and seasonal foods
- Ensure that the community know who the community workers are.
- Assess cultural beliefs that influence infant and young child feeding practices.

#### 2. Admission:

- Encourage mothers to continue breastfeeding.
- Discuss any breastfeeding difficulty.

#### 3. Weekly or bi-weekly follow-up:

- Encourage mothers to continue breastfeeding.
- 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 *infant and young child feeding three-step counselling* on recommended

breastfeeding practices when appetite returns and/or at four weeks before discharge.

- Conduct action-oriented group (story, drama, use of visuals).
- Facilitate infant and young child feeding support groups.

**4. Discharge:**

- Encourage mothers to continue breastfeeding.
- 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 visits.
- Improve health-seeking behaviours.
- Encourage mothers to take part in infant and young child feeding support groups.
- Link mother to community worker.

**5. Follow-up at home/community:**

- Conduct ongoing and periodic infant and young child feeding monitoring at home/community/other health facilities (e.g., growth monitoring).
- Home visits.
- Mid-upper arm circumference (MUAC) screening sessions.

**Contact points to integrate infant and young child feeding into CMAM and other health and nutrition interventions at health facility or via community outreach:**

- GMP.
- ANC at health facility.
- Stabilisation centres.
- Supplementary feeding programme.
- Community follow-up (community worker):
  - Action-oriented group session.
  - Infant and young child feeding support groups.

**Contact points for implementing the essential nutrition actions—at health facility or via community outreach:**

- At every contact with a pregnant woman.

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- At delivery.
- During postpartum and/or family planning sessions.
- At immunisation sessions.
- During GMP.
- At every contact with mothers or caregivers of sick children.

**Other contact points:**

- Special consultations for vulnerable children if available, including HIV-exposed and -infected children.
- Link to social protection programme, if available.

**And:**

- Set appointment for the next follow-up visit.

**Participant Materials 18.2: Recommended Schedule for Visits from Pregnancy up to 6 Months**

When	Discuss
<p>Prenatal visits</p> 	<ul style="list-style-type: none"> <li>• Early initiation of breastfeeding (give colostrum).</li> <li>• Good attachment and positioning.</li> <li>• Breastfeeding in the first few days.</li> <li>• Exclusive breastfeeding from birth up to 6 months (avoid other liquids and food, even water).</li> <li>• Breastfeeding on demand, up to 12 times per day and night.</li> <li>• Mother needs to eat one extra meal and drink a lot of fluids to be healthy.</li> <li>• Attendance at mother-to-mother support group.</li> <li>• How to access community worker if necessary.</li> <li>• Use of long-lasting insecticide nets.</li> </ul>
<p>Delivery</p> 	<ul style="list-style-type: none"> <li>• Place baby belly-to-belly with mother.</li> <li>• Good attachment and positioning.</li> <li>• Early initiation of breastfeeding (give colostrum; avoid water and other liquids).</li> <li>• Breastfeeding in the first few days.</li> </ul>
<b>Postnatal visits</b>	
<p>Within the first week after birth (two or three days and six or seven days)</p>	<ul style="list-style-type: none"> <li>• Good attachment and positioning.</li> <li>• Breastfeeding in the first few days.</li> <li>• Exclusive breastfeeding from birth up to 6 months.</li> <li>• Breastfeeding on demand, up to 12 times per day and night.</li> <li>• Ensure mother knows how to express her breastmilk.</li> <li>• Preventing breastfeeding difficulties (engorgement, sore and cracked nipples).</li> </ul>
<p>1 month</p>	<ul style="list-style-type: none"> <li>• Good attachment and positioning.</li> </ul>

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<ul style="list-style-type: none"> <li>• Immunisation sessions</li> <li>• GMP</li> </ul>	<ul style="list-style-type: none"> <li>• Exclusive breastfeeding from birth up to 6 months.</li> <li>• Breastfeeding on demand, up to 12 times per day and night.</li> </ul>
<p><i>6 weeks</i></p> <ul style="list-style-type: none"> <li>• Family planning sessions</li> <li>• GMP</li> <li>• Sick child clinic</li> <li>• Community follow-up</li> </ul>	<ul style="list-style-type: none"> <li>• Breastfeeding difficulties (plugged ducts, which can lead to mastitis; and not enough breastmilk).</li> <li>• Increase breastmilk supply.</li> <li>• Maintain breastmilk supply.</li> <li>• Continue to breastfeed when infant or mother is ill.</li> <li>• Family planning.</li> <li>• Prompt medical attention.</li> </ul>
<p><i>From 5–6 months</i></p> <ul style="list-style-type: none"> <li>• GMP</li> <li>• Sick child clinic</li> <li>• Community follow-up</li> </ul>	<ul style="list-style-type: none"> <li>• Community worker should not try to change positioning if older infant is not having difficulties.</li> <li>• Prepare mother for changes she will need to make when infant reaches 6 months (AT 6 months).</li> <li>• At 6 months, begin to offer foods two to three times a day; gradually introduce different types of foods (staple, legumes, vegetables, fruits, and animal products) and continue breastfeeding.</li> </ul>

## Session 19. Infant and Young Child Feeding in Emergencies (OPTIONAL to be discussed in emergency-prone areas)

Learning objectives	Methodologies	Training aids
1. Describe the risks and challenges to feeding infants and young children in emergencies.	<ul style="list-style-type: none"> <li>Brainstorming in working groups</li> </ul>	<i>Participant Materials 19.1: Infant and Young Child Feeding in Emergencies: Priority Information for Community Workers</i>
2. Identify key measures necessary to support infant and young child feeding in emergencies. <ul style="list-style-type: none"> <li>Recommended infant and young child feeding practices in emergencies.</li> <li>Simple measures to meet the needs of mothers, infants, and young children.</li> </ul>	<ul style="list-style-type: none"> <li>Group work</li> <li>Rotation of flipcharts</li> </ul>	
3. Role of community workers in protecting, promoting, and supporting appropriate infant and young child feeding practices.	<ul style="list-style-type: none"> <li>Buzz groups</li> </ul>	

### Materials:

- Flipchart papers and stand (plus markers and masking tape).

### Advance preparation:

- Adapt case study to reflect emergency conditions that might occur in the area(s) from which training participants come.
- Flipchart with following instructions/questions:
  - ADD TO the global breastfeeding and complementary feeding recommendations any emergency-specific feeding recommendations.
  - What simple measures can meet the needs of mothers, infants, and young children in an emergency?
  - What could you do to deal with beliefs that may interfere with infant and young child feeding?

**Duration:** 1½ hours.

**Learning objective 1:** Describe the risks and challenges to feeding infants and young children in emergencies.

**Methodology:** Brainstorming in working groups.

**Instructions for activity:**

1. Facilitator reads the case study to large group.
2. Divide participants into four groups. Ask groups to brainstorm and list the risks to infants and young children in emergencies as they move from table to table (with flipchart paper that has at the top a picture(s) showing different aspects of emergencies to help stimulate additional ideas about risks in different environments). Include beliefs that may interfere with feeding practices during emergencies.
3. Each group has three minutes at each flipchart to write as many points as they can think of (without repeating those already listed); the groups then rotate to the next flipchart and continue with the exercise.
4. In large group, ask each working group to read out the points listed on the flipchart next to them.
5. Discuss and summarise in large group. Facilitator helps to fill in gaps.

**Key information**

**Sample case study:**

One-year-old Mahmoud is living with his family in a makeshift camp along a roadside in a contested area along the Pakistan-Afghanistan border. The 17 families have been displaced for over one month when severe flooding ravaged their home area. They fled together, spending five days walking toward the nearest large town, living in open fields and eating whatever they could forage.

Mahmoud and his seven siblings, all under the age of nine, now huddle beneath a blanket extended over a mud flood. Mahmoud holds an empty feeding bottle. Flies swarm all over the children. The stench of human and animal waste is overwhelming in the hot, humid air. There is no sanitation, just shallow, open ditches of raw sewage that attract flies and mosquitoes.

There is little else in the tent: only one cooking pot, a few cushions, and two pieces of children's clothing. There is no food today—and no milk for Mahmoud, who is crying with hunger. 'It has been a month since he had any milk,' says his mother, who is holding her infant twins. On a good day, when Mahmoud's father can compete with the others for handouts from passers-by, the children eat once a day, usually in the evenings.

The children appear malnourished. Their skin has red spots, and their thin hair is coming out in clumps. Their mother is pleading to the world: 'Our children are dying of hunger. Isn't there any way we can be helped with food?'

**Risks to infants and young children in emergencies:**

**NOTE:** The youngest babies are at the greatest risk of becoming sick or malnourished, or even dying.

- Separation from mother and family.
- Lack of shelter.
- Insecurity and lack of privacy.
- Contaminated environment, dirty water, and poor sanitation.
- Lack of sufficient, familiar, and nutritious food.
- Poor availability of fuel and cooking equipment.
- Lack of health care.
- Being fed commercial infant formula.
- Little experience in infant and young child feeding support among emergency-assisting community.
- Beliefs held by either the emergency-affected community or the emergency-assisting community (about the impact of emergency-related factors—e.g., food quality and quantity; stress; rape) that may interfere with the feeding of infants and young children. See #3 under Key Information: Learning objective 2.

**Learning objective 2:** Identify key measures necessary to support infant and young child feeding in emergencies.

**Methodology:** Group work; rotation of flipcharts.

**Instructions for activity:**

1. Participants remain in the same four groups. Facilitators draw attention to flipcharts or cards previously posted that list the global breastfeeding and complementary feeding recommendations.
  - Provide a flipchart paper to each group to answer the following instructions/questions:
  - ADD TO the global breast- and complementary feeding recommendations any emergency-specific feeding recommendations?
  - What simple measures can meet the needs of mothers, infants, and young children in an emergency?
  - What could you do to deal with beliefs that may interfere with infant and young child feeding?
2. One group presents their results; other groups add additional points,
3. Orient participants to *Participant Materials 19.1: Infant and Young Child Feeding in Emergencies—Priority Information for Community Workers*.
4. Discuss and summarise in large group. Facilitator helps to fill in the gaps (framing the discussion around ‘what can be done to support mothers/caregivers to care for their children in emergency situations’).

## Key information

### Risks to infants and young children in emergencies

**NOTE:** The youngest babies are at the greatest risk of becoming sick or malnourished, or even dying.

- Separation from mother and family; orphaned.
- Lack of shelter.
- Insecurity and lack of privacy.
- Contaminated environment, dirty water, and poor sanitation.
- Lack of sufficient, familiar, and nutritious food.
- Poor availability of fuel, cooking equipment.
- Lack of health care.
- Being fed commercial infant formula.
- Little experience in infant and young child feeding support among emergency-assisting community.
- Beliefs held by either the emergency-affected community or the emergency-assisting community (about the impact of emergency-related factors—e.g., food quality and quantity; stress; rape) that may interfere with the feeding of infants and young children.

See *Participant Materials 19: Infant and Young Child Feeding in Emergencies—Priority Information for Community Workers*.

**Learning objective 3:** Role of community workers in protecting, promoting, and supporting recommended infant and young child feeding practices in emergencies.

**Methodology:** Buzz groups.

### Instructions for activity:

1. Ask participants to form groups of three.
2. Ask participants the question: What can community workers do to protect, promote, and support recommended infant and young child feeding practices in emergencies?
3. Ask groups to list possible roles of community workers in emergencies.
4. Ask one group to share and others to add only additional information.
5. Probe until the points in ‘Key information’ are mentioned.
6. Discussion and summarise.

**Key information**

**Role of community workers:**

**Objective:** to improve the delivery of preventive and curative health care in emergencies.

- Give access to individuals unfamiliar with health care system in emergency context (e.g., help mobilise communities).
- Help identify malnourished children; monitor health and nutritional status.
- Help with client-provider communication.
- Provide cultural linkages and social support; overcome distrust; act as role model and advocate; as necessary, change personal behaviour to reflect role.
- Encourage adherence to health recommendations and medical care.

**Activities:**

- Assess breastfeeding and complementary feeding practices (as part of *infant and young child feeding three-step counselling*).
- Provide counselling on breastfeeding and complementary feeding in “counselling corners,” “baby tents,” temporary health clinics, or outreach/house-to-house activities; also form and strengthen support groups and conduct action-oriented group sessions.
- Conduct MUAC screening to find severely malnourished children.
- Sensitise community members and community leaders on the life-saving benefits and importance of breastfeeding and the risks of commercial infant formula feeding.
- Monitor formula donations and distributions in the community and alert health workers and nongovernmental staff.
- Help to identify those children who are orphaned or unaccompanied and who need help with commercial infant formula feeding.
- Teach and help caregivers to feed non-breastfed infants safely with formula.

## Participant Materials 19.1: Infant Feeding in Emergencies—Priority Information for Community Workers

### 1. Recommended infant and young child feeding practices in emergencies (ADDITIONS to global recommendations in bold)

#### *Breastfeeding practices:*

- The most effective way of protecting babies from illness, malnutrition, and death is to breastfeed them.
- Breastmilk gives the baby the best and safest food and enough water, and helps to fight illness.
- All newborns should be put to the breast within one hour of birth. This will safeguard the health of both the mother and the infant.
- Babies under 6 months should not be given anything except breastmilk. Giving a baby under 6 months water, breastmilk substitutes (whether infant formula, milk or milk powders, and teas), or solid food under emergency circumstances is dangerous. It can cause diarrhoea and can be fatal.
- Exclusive **breastfeeding guarantees food and fluid security** for infants less than 6 months and provides active immune protection.
- Children over 6 months should continue to breastfeed until at least 2 years.
- Continued breastfeeding to 2 years and beyond contributes to the food and fluid security of the young child; it is especially important in contexts where water, sanitation, and hygiene conditions are poor, and where **breastmilk is likely to be the most nutritious and accessible food available for the young child** in emergency situations.

#### *Complementary feeding practices:*

- Appropriate complementary foods should be introduced at 6 months and breastfeeding continued to 2 years and beyond.
  - **The general food ration should contain commodities that are suitable as complementary foods for young children** (e.g., ready-to-use complementary foods and supplementary foods appropriate for children from 6 up to 24 months of age).
  - When possible, add inexpensive, locally available foods (especially animal-source foods).
  - **A micronutrient-fortified blended food** (e.g., corn soya blend, wheat soya blend) **should be included in the general ration for older infants/young children when a population is dependent on food aid.**
  - **Additional nutrient-rich, ready-to-use foods may be provided in supplementary feeding programmes or in ‘blanket’ feeding programmes to targeted age-groups**, especially those aged from 6 up to 24 months.
  - **Multi-micronutrient powders can be added to the local foods or general food rations** given to children aged 6 months to 5 years and to pregnant and lactating women.
  - The food should be prepared and given to the baby or young child hygienically.

- **Ready-to-use therapeutic food (RUTF) is a type of medicine food** that is used in the treatment of SAM but is **not an infant complementary food**.
2. **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, and medical care.
  - Register households with children less than 2 years of age.
  - Registration may require outreach to homes, camps for displaced people, or other sites to find emergency-affected populations.
  - Register (within two 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.
  - Divide mothers/caregivers of infants less than 1 year into groups needing different types of help: basic aid/basic support and more skilled help. Using assessment skills, identify infants who require immediate referral for urgent, life-saving support, and those who will receive assessment for infant and young child feeding status.
  - Basic aid: provide general information and support to:
    - Ensure that suckling is effective.
    - Build mother's confidence and help milk flow.
    - Provide information on how to increase milk production.
    - Encourage age-appropriate feeding.
    - Highlight the risks of commercial infant formula feeding, including mixed feeding.
  - Skilled help for low-birthweight infants; babies visibly thin or underweight; babies who refuse the breast; for malnourished mothers who need help with breastfeeding; for mothers who are traumatised or rejecting their infants; and for caregivers of babies without mothers or separated from their mothers. Groups of mothers/caregivers with similar problems may be formed, for example:
    - Mothers who need help to increase their breastmilk production.
    - Mothers no longer breastfeeding who want to relactate.
    - Wet nurses to provide feeding for infants with no other source of breastmilk; in many emergency contexts, the benefits to child survival of wet-nursing may outweigh the risks of HIV transmission, and this option should be considered where local assessment shows that wet-nursing is acceptable and government approves.
    - Caregivers who require support to safely commercial infant formula feed (in a separate site).
  - Provide secure and supportive places (designated shelters, baby corners, or mother-baby tents, child-friendly spaces) for mother/caregivers of infants and young children. This offers privacy for breastfeeding mothers (important for a displaced population or that in transit) and enables access to basic infant and young child feeding and peer-to-peer support.

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- Integrate breastfeeding support, including individual counselling and help with difficulties, in key services (e.g., antenatal and reproductive health activities, early childhood development and psychosocial services, selective feeding programmes).
- Protect and support the nutritional, physical, and mental health of pregnant and lactating women.
- 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 breastmilk substitutes and prevent the donations from being distributed to the general population ('spillover' phenomenon).
- Involve local/national breastfeeding advocates.

### 3. Information to address beliefs that interfere with infant and young child feeding in emergencies

Belief	Explanation
<p>Milk quantity or quality is affected by disasters that cause great stress (earthquake, flood, tsunami, drought, conflict, displacement).</p> <p>Stress will make a mother's milk dry up.</p> <p>Stress will make the milk go bad.</p>	<ul style="list-style-type: none"> <li>• It is not true that stress makes milk dry up or go bad. A hand or shoulder massage can help the mother feel less stressed and will help her breastmilk flow more easily when she breastfeeds. A safe, quiet, and private space with supportive counsellors and peers can also help.</li> <li>• 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 breastmilk.</li> <li>• 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.</li> <li>• More frequent breastfeeds will help the mother make more milk if she is concerned she does not have enough. Keeping the baby close, day and night, will reassure the baby and help the mother breastfeed more and thus make more milk.</li> </ul>
<p>Mothers must have enough or the right kind of food or water to produce good breastmilk.</p>	<ul style="list-style-type: none"> <li>• No special foods are needed to produce good-quality breastmilk.</li> <li>• Many nutrients in breastmilk are not affected by maternal nutritional status (including iron and vitamin D).</li> <li>• Even malnourished mothers can breastfeed. Only the most severely malnourished will face some problems to breastfeed well.</li> <li>• 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 will be deficient in breastmilk (most importantly, B vitamins,</li> </ul>

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Belief	Explanation
	<p>vitamin A, and iodine); therefore, maternal supplementation will benefit the nursing child as well.</p>
<p>A woman who has been raped cannot breastfeed.</p>	<p>The experience of violence does not spoil breastmilk or the ability to breastfeed. However, all traumatised women need special attention and support. There may be traditional practices that restore a woman’s readiness to breastfeed after sexual trauma.</p>
<p>If a mother has been breastfeeding her baby and giving infant formula or other milks, she cannot return to exclusive breastfeeding.</p> <p>If a mother has stopped breastfeeding, she cannot start again.</p>	<ul style="list-style-type: none"> <li>• The mother can return to exclusive breastfeeding. She can increase her milk supply by reducing the amount of formula given to her baby and by breastfeeding more frequently.</li> <li>• The mother can return to breastfeeding. Letting the baby suckle at the breast will start the milk flowing again. It may take a few days to a couple of weeks for there to be enough breastmilk, depending on how long it has been since she stopped.</li> </ul>
<p>The most urgent and important need in an emergency is to give formula to babies.</p>	<p>This is not true. 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. Breastmilk does not run out, is safe, and is the best food for the baby.</p>

## Session 20. Post-Assessment and Evaluation

Learning objectives	Methodologies	Training aids
1. Identify strengths and weaknesses of participant's infant and young child feeding knowledge post-training.	Non-written post-assessment OR 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 participants' infant and young child feeding knowledge post-training.

**Methodology:** Non-written post-assessment.

### Instructions for activity:

1. Explain that 12 questions will be asked, and that participants will raise one hand (with open palm) if they think the answer is 'Yes;' participants will raise one hand (with closed fist) if they think the answer is 'No' and will raise one hand (pointing two 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 are facing the centre.
3. One facilitator reads the statements from the post-assessment, and another facilitator records the answers and notes which topics (if any) present confusion.
4. 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 for activity:

1. Ask participants to form buzz groups.

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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. Explain that their suggestions will be used to improve future trainings.
6. Discuss and summarise.

**Post-Assessment: What Have We Learned?**

#		Yes	No	Don t know
1.	The purpose of an infant and young child feeding support group is to share personal experiences on infant and young child feeding 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 two times a day in addition to breastfeeding.			
4.	A pregnant woman needs to eat one more meal per day than usual.			
5.	At 4 months, infants need water and other drinks in addition to breastmilk.			
6.	Giving information alone to a mother on how to feed her child is effective in changing her infant feeding practices.			
7.	A woman who is malnourished can still produce enough good-quality breastmilk for her baby.			
8.	The more milk a baby removes from the breast, the more breastmilk 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 6 months, the first food a baby takes should have the texture of breastmilk so that the young baby can swallow it easily.			
11.	During the first 6 months, a baby living in a hot climate needs water in addition to breastmilk.			
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 play an important role in how infants and young children are fed.			

**Post-Assessment: What Have We Learned? (Answers to questions from Previous page)**

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

### End-of-Training Evaluation

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

	Very Good	Good	Unsatisfactory
Training objectives			
Methods used			
Materials used			
Field practice			

1. Which sessions did you find most useful?

2. What are your suggestions to improve the training?

Other comments:

## Appendix 1: Seven Steps in Planning a Training/Learning Event

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**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 timeframe 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.”

### Notes:

- In order to facilitate the hands-on practical nature of the field site visits, ideally, no more than five to seven participants should accompany each facilitator in any one field practical session.
- Communities should be briefed ahead of time through the community leaders or development associations.
- Ensure that communities are enlightened on the significance of the visit and subsequent work within the communities.
- 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

Personnel	Before training	During training	After training
<b>Management<sup>5</sup></b>	<ul style="list-style-type: none"> <li>• Identify the <b>results</b> wanted.</li> <li>• Assess needs and priorities (know the problem).</li> <li>• Develop strategy to achieve the results, including refresher trainings and follow-up.</li> <li>• Collaborate with other organisations and partners.</li> <li>• Establish and institutionalise an ongoing system of supportive supervision or mentoring.</li> <li>• Commit resources.</li> <li>• Take care of administration and logistics.</li> </ul>	<ul style="list-style-type: none"> <li>• Support the activity.</li> <li>• Keep in touch.</li> <li>• Receive feedback.</li> <li>• Continuously monitor and improve quality.</li> <li>• Motivate.</li> <li>• Management presence demonstrates involvement (invest own time, effort).</li> </ul>	<ul style="list-style-type: none"> <li>• Mentor learner.</li> <li>• Reinforce behaviours.</li> <li>• Plan practice activities.</li> <li>• Expect improvement.</li> <li>• Encourage networking among learners.</li> <li>• Be realistic.</li> <li>• Utilise resources.</li> <li>• Provide supportive ongoing supervision and mentoring.</li> <li>• Motivate.</li> <li>• Continuously monitor and improve quality.</li> </ul>

<sup>5</sup> Management includes stakeholders, ministries, organisations, and supervisors/mentors.

**Appendix 2: Roles and Responsibilities Before, During, and After Training**

<b>Personnel</b>	<b>Before training</b>	<b>During training</b>	<b>After training</b>
<b>Facilitator</b>	<ul style="list-style-type: none"> <li>• Know audience (profile and number of learners).</li> <li>• Design course content (limit content to ONLY what is ESSENTIAL to perform).</li> <li>• Design course content to apply to work of learners.</li> <li>• Develop pre- and post-assessments, guides, and checklists.</li> <li>• Select practice activities, blend learning approaches and materials.</li> <li>• Prepare training agenda.</li> </ul>	<ul style="list-style-type: none"> <li>• Know profile of learners.</li> <li>• Specify the jobs and tasks to be learned.</li> <li>• Foster trust and respect.</li> <li>• Use many examples.</li> <li>• Use adult learning.</li> <li>• Create practice sessions identical to work situations.</li> <li>• Monitor daily progress.</li> <li>• Use problem-centred training.</li> <li>• Work in a team with other facilitators.</li> <li>• Adapt to needs.</li> </ul>	<ul style="list-style-type: none"> <li>• Provide follow-up refresher or problem-solving sessions.</li> </ul>
<b>Learner</b>	<ul style="list-style-type: none"> <li>• Know purpose of training and roles and responsibilities after training (clear job expectations).</li> <li>• Expect that training will help performance.</li> <li>• Have community volunteers “self-select.”</li> <li>• Bring relevant materials to share.</li> </ul>	<ul style="list-style-type: none"> <li>• Create an action plan.</li> <li>• 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).</li> </ul>	<ul style="list-style-type: none"> <li>• Know what to expect and how to maintain improved skills.</li> <li>• Be realistic.</li> <li>• Practise to convert new skills into habits.</li> <li>• Be accountable for using skills.</li> </ul>
<b>Management and facilitator</b>	<ul style="list-style-type: none"> <li>• Establish selection criteria.</li> <li>• Establish evaluation criteria.</li> <li>• Establish criteria for adequate workspace, supplies, equipment, job aids.</li> <li>• Specify the jobs and tasks to be learned.</li> </ul>	<ul style="list-style-type: none"> <li>• Provide feedback.</li> </ul>	<ul style="list-style-type: none"> <li>• Provide feedback.</li> <li>• Monitor performance.</li> </ul>
<b>Management and learner</b>	<ul style="list-style-type: none"> <li>• Conduct situational analysis of training needs.</li> </ul>	<ul style="list-style-type: none"> <li>• Provide feedback.</li> </ul>	<ul style="list-style-type: none"> <li>• Provide feedback.</li> <li>• Monitor performance.</li> </ul>

**Appendix 2: Roles and Responsibilities Before, During, and After Training**

<b>Personnel</b>	<b>Before training</b>	<b>During training</b>	<b>After training</b>
<b>Management, facilitator, and learner</b>	<ul style="list-style-type: none"> <li>• Conduct needs assessment.</li> <li>• Establish goals.</li> <li>• Establish objectives.</li> <li>• Identify days, times, location (WHEN, WHERE).</li> <li>• Establish and commit to system of ongoing supervision or mentoring.</li> </ul>	<ul style="list-style-type: none"> <li>• Provide feedback.</li> </ul>	<ul style="list-style-type: none"> <li>• Provide feedback.</li> <li>• Monitor performance.</li> <li>• Commit to system of ongoing supervision or mentoring.</li> </ul>
<b>Facilitator and learner</b>	<ul style="list-style-type: none"> <li>• Needs assessment feedback.</li> </ul>	<ul style="list-style-type: none"> <li>• Provide feedback.</li> </ul>	<ul style="list-style-type: none"> <li>• Provide feedback.</li> <li>• Evaluate.</li> </ul>

## Appendix 3: List of Materials for Training of Trainers

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### Training room set-up:

- Facilitators and participants seated in circle (without tables).
- Tables (six to eight) scattered around edge of room for group work and facilitation preparation.
- Ideally: wall space for hanging flipchart material.

### Materials:

- *Facilitator's Guide*: one per facilitator.
- *Training Aids*: two per training.
- *Participant Materials*: one per counsellor/participant.
- Set of *Counselling Cards*: one per facilitator and one per participant.
- *Key Messages Booklet*: one per facilitator and one per participant.
- *Take-Home Brochures*: one per facilitator and four per 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: four.
- 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: one for every two participants.
- Needles, thread, cotton wool and socks: one for every participant to make model breast.
- Three clear glasses (identical size).
- Local bowls and utensils/spoons.
- Different types of locally available foods.
- Local cups (examples, including one 250ml).
- Counselling case studies.
- Small sets of HIV activity cards.
- Certificate (requirements).

### Practicum sessions:

- Transport arrangements.
- Additional copies of tools:
  - *Participant Materials 9.1: Infant and Young Child Feeding Assessment of Mother/Child Pair.*
  - *Participant Materials 9.2: Observation Checklist for Infant and Young Child Feeding Assessment of Mother/Child Pair.*

### **Appendix 3: List of Materials for Training of Trainers**

- *Participant Materials 12.3: Observation Checklist for Infant and Young Child Feeding Support Groups.*
- *Participant Materials 12.4: Infant and Young Child Feeding Support Group Attendance.*
- *Participant Materials 15.1: Observation Checklist on How to Conduct an Action-Oriented Group—Story, Drama, or Visual—Applying the Steps Observe, Think, Try, and Act.*

#### **Counselling seating:**

- Mats, chairs, or both.

## Appendix 4: Five-Day Training Schedule: Community Infant and Young Child Feeding Counselling Package

TIME	DAY 1	DAY 2	DAY 3	DAY 4	DAY 5
08:15–08:30	<b>Session 1:</b> 1 hour Introductions, Expectations, and Objectives  <b>Session 2:</b> 1 hour Why Infant and Young Child Feeding Matters	<b>DAILY REVIEW</b>			
08:30–10:30		<b>Session 6 cont'd:</b> 1 hour  <b>Session 7:</b> 1 hour Recommended Infant and Young Child Feeding Practices: Complementary Feeding for Children from 6 up to 24 Months	<b>Preparation for field visit</b>  <b>Session 11:</b> 2½ hours Field visit <ul style="list-style-type: none"> <li>• Infant and young child feeding assessment form for mother/child pair</li> </ul>	<b>Session 13:</b> 2½ hours <b>Second field visit</b> <ul style="list-style-type: none"> <li>• Infant and young child feeding assessment of mother/child pair</li> <li>• Action-oriented group session</li> <li>• Infant and young child feeding support group</li> </ul>	<b>Session 16:</b> 2 hours Infant Feeding in the Context of HIV
10:30–10:45	<b>T E A B R E A K</b>				
10:45–12:45	<b>Session 3:</b> 1 hour Common Situations that can Affect Infant and Young Child Feeding  <b>Session 4:</b> 1 hour How to Counsel: Part I <ul style="list-style-type: none"> <li>• <i>Listening and Learning skills</i></li> <li>• Behaviour change steps</li> </ul>	<b>Session 7 cont'd:</b> ½ hour  <b>Session 8:</b> 1 hour Complementary Foods  <b>Session 9:</b> ½ hour How to Counsel: Part II <ul style="list-style-type: none"> <li>• <i>Infant and young child feeding three-step counselling</i></li> <li>• <i>Building confidence and giving support skills</i></li> <li>• Use of infant and young child feeding assessment form for mother/child pair</li> </ul>	<b>Session 11:</b> 1½ hours Field visit and feedback from field visit	<b>Session 13:</b> 1½ hours Field visit and feedback from field visit	<b>Session 17:</b> 1 hour Integrating Infant and Young Child Feeding Support into CMAM Community Services  <b>Session 18:</b> 1 hour <ul style="list-style-type: none"> <li>• Post-assessment</li> <li>• Evaluation</li> </ul>
12:45–13:45	<b>L U N C H</b>				
13:45–15:45	<b>Session 5:</b> 1½ hours Recommended Infant and	<b>Session 9 cont'd:</b> 1½ hours	<b>Session 12:</b> 2 hours <ul style="list-style-type: none"> <li>• How to conduct:</li> </ul>	<b>Session 14:</b> 1½ hours Women's Nutrition	<ul style="list-style-type: none"> <li>• Action Plan</li> <li>• Operational</li> </ul>

**Appendix 5: Three-day Training: Infant and Young Child Feeding Support into Emergency Activities**

TIME	DAY 1	DAY 2	DAY 3	DAY 4	DAY 5
	Young Child Feeding Practices: Breastfeeding  <b>Session 6:</b> ½ hour How to Breastfeed <ul style="list-style-type: none"> <li>• How the breast works</li> <li>• Good attachment and positioning</li> </ul>	<b>Session 10:</b> ½ hour Common Breastfeeding Difficulties	<ul style="list-style-type: none"> <li>- Action-oriented groups</li> <li>- Infant and young child feeding support groups</li> <li>- Home visits</li> <li>• Use of community-monitoring tools:                             <ul style="list-style-type: none"> <li>- Action-oriented group</li> <li>- Infant and young child feeding support group</li> </ul> </li> </ul>	<b>Session 15:</b> ½ hour When to Bring the Sick Child to the Health Facility	framework <ul style="list-style-type: none"> <li>• Presentations by participants</li> </ul>
15:45–16:00	<b>T E A B R E A K</b>				
16:00–16:30	<b>Session 6 cont'd:</b> ½ hour	<b>Session 10 cont'd:</b> 1 hour	<b>Preparation for field visit</b>		

## Appendix 5: Three-Day Training: Infant and Young Child Feeding Support into Emergency Activities

TIME	DAY 1	DAY 2	DAY 3
08:15–08:30	<b>Session 1</b> Introductions, Expectations, and Objectives	<b>DAILY REVIEW</b>	
08:30–10:30	<b>Session 5</b> Recommended Infant and Young Child Feeding Practices: Breastfeeding	<b>Session 9</b> Part II: How to Counsel, Problem Solve, Reach an Agreement - <i>Infant and young child feeding three-step counselling</i> - <i>Building confidence and giving support skills</i> • Use of infant and young child feeding assessment form for mother/child pair	<b>Session 13</b> Field visit • Infant and young child feeding assessment of mother/child pair
10:30–10:45	<b>T E A B R E A K</b>		
10:45–12:45	<b>Session 6</b> How to Breastfeed: Good Positioning and Attachment  <b>Session 7</b> Recommended Infant and Young Child Feeding Practices: Complementary Feeding for Children from 6 up to 24 Months	<b>Session 5C</b> Infant and Young Child Feeding Support in the Context of CMAM	<b>Session 13</b> Feedback from field visit
12:45–13:45	<b>L U N C H</b>		
13:45–15:45	<b>Session 5A:</b> Infant Feeding in Emergencies  <b>Session 5B</b> Feeding of the Sick and Malnourished Child	<b>Session 10</b> Common Breastfeeding Difficulties  <b>Session 15</b> Infant Feeding in the Context of HIV	<b>Planning</b> Organisation and follow-up of infant and young child feeding activities
15:45–16:00	<b>T E A B R E A K</b>		
16:00–16:30	<b>Session 5B cont'd</b>	<b>Preparation for field visit</b>	<b>Session 18:</b> Post-assessment and Evaluation

## Appendix 6: Supervision

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### Objectives of supportive supervision

1. Guide, support, and motivate staff and community workers to perform their designated tasks.
2. Facilitate improved worker performance (enhanced staff and 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 infant and young child feeding 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:
    - Percentage of target mothers reached by individual counselling, mother support group sessions, action-oriented group sessions, other (using lot quality assurance sampling methodology, for example; determine reporting period).
  - Result of programme activities in your supervision area:
    - Comprehension of key information by target audience, retention of key information by target audience (using lot quality assurance sampling 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 infant and young child feeding counsellors required in supervision area (establish target with programme manager).
- \_\_\_ Number of counsellors active during the reporting period.
- \_\_\_ Number/percentage of active infant and young child feeding counsellors trained.
  
- \_\_\_ Target number of mother support group facilitators required in supervision area.
- \_\_\_ Number of facilitators active during the reporting period.
- \_\_\_ Number/percentage of active mother support group facilitators trained.



### **Supervisor monitoring**

#### *Caseload:*

- Collect infant and young child feeding counselling sessions monitoring form (Participant Materials 12.3: Observation Checklist for Infant and Young Child Feeding Support Groups) from infant and young child feeding counsellor (per time period).
- Collect completed support group attendance monitoring form (Participant Materials 12.4: Infant and Young Child Feeding Support Group Attendance) from facilitators (per time period).

#### *Programme coverage:*

- Percentage of target mothers (in supervision area) receiving individual infant and young child feeding counselling (per time period).
- Percentage of target mothers (in supervision area) attending a mother support group meeting (per time period).

### **Programme manager oversight of supervision**

#### **Training**

- Training of trainers: percentage of total target number of trainers who have been trained.
- Training of counsellors: percent of total target number of counsellors who have been trained (by supervision area).
- Training of facilitators: percent of total target number of facilitators who have been trained (by supervision area).

#### **Programme supervision**

##### *Programme supervision of infant and young child feeding counsellors:*

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

##### *Programme 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 7. Principles of Adult Learning<sup>6</sup>

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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% of what we hear; 40% of what we hear and see; and 80% 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.

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<sup>6</sup> Adapted from Vella J. *Learning to Listen, Learning to Teach: The Power of Dialogue in Educating Adults*. Jossey-Bass, Inc., Publishers; New York, NY: 1994.

## Appendix 7. 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 8. Training Methodologies: Advantages, Limitations, and Tips for Improvement

Training method	Advantages	Limitations	Tips for improvement
<p><b>Small group discussion</b> in a group of no more than seven participants who discuss and summarise a given subject or theme. The group selects a chairperson, a recorder, and/or someone to report to plenary.</p>	<ul style="list-style-type: none"> <li>• Can be done anytime and anywhere.</li> <li>• Allows two-way communication.</li> <li>• Lets group members learn each other's views and sometimes makes consensus easier.</li> <li>• Allows group members to take on different roles (e.g., leader, recorder) to practice facilitation techniques.</li> <li>• Involves active participation.</li> <li>• Lets participants ask and learn about unclear aspects.</li> <li>• Often lets people who feel inhibited share.</li> <li>• Can produce a strong sense of sharing or camaraderie.</li> <li>• Challenges participants to think, learn, and solve problems.</li> </ul>	<ul style="list-style-type: none"> <li>• Strong personalities can dominate the group.</li> <li>• Some group members can divert the group from its goals.</li> <li>• Some participants may try to pursue their own agendas.</li> <li>• Conflicts can arise and be left unresolved.</li> <li>• Ideas can be limited by participants' experience and prejudices.</li> </ul>	<ul style="list-style-type: none"> <li>• Outline the purpose of the discussion and write questions and tasks clearly to provide focus and structure.</li> <li>• Establish ground rules (e.g., courtesy, speaking in turn, ensuring everyone agrees with conclusions) at the beginning.</li> <li>• Allow enough time for all groups to finish the task and give feedback.</li> <li>• Announce remaining time at regular intervals.</li> <li>• Ensure that participants share or rotate roles.</li> <li>• Be aware of possible conflicts and anticipate their effect on the group's contribution in plenary.</li> <li>• Reach conclusions, but avoid repeating points already presented in plenary.</li> </ul>
<p><b>Buzz groups (two to three participants)</b> can allow participants to discuss their immediate</p>	<ul style="list-style-type: none"> <li>• Gives everyone a chance and time to participate.</li> <li>• Makes it easier to share opinions, experiences, and information.</li> <li>• Often creates a relaxed</li> </ul>	<ul style="list-style-type: none"> <li>• Discussion is limited.</li> <li>• Opinions and ideas are limited by participants' experience.</li> <li>• Participants may be</li> </ul>	<ul style="list-style-type: none"> <li>• Clearly state the topic or question to be discussed along with the objectives.</li> <li>• Encourage exchange of information and beliefs among</li> </ul>

## Appendix 8. Training Methodologies: Advantages, Limitations, and Tips for Improvement

Training method	Advantages	Limitations	Tips for improvement
<p>reactions to information presented, give definitions, and share examples and experiences.</p>	<p>atmosphere that allows trust to develop and helps participants express opinions freely.</p> <ul style="list-style-type: none"> <li>• Can raise energy level by getting participants to talk after listening to information.</li> <li>• Does not waste time moving participants.</li> </ul>	<p>intimidated by more educated participants or find it difficult to challenge views.</p>	<p>different levels of participants.</p>
<p><b>Brainstorming:</b> A spontaneous process through which group members' ideas and opinions on a subject are voiced and written for selection, discussion, and agreement. All opinions and ideas are valid.</p>	<ul style="list-style-type: none"> <li>• Allows many ideas to be expressed quickly.</li> <li>• Encourages open-mindedness (every idea should be acceptable, and judgement should be suspended).</li> <li>• Gives everyone an opportunity to contribute.</li> <li>• Helps stimulate creativity and imagination.</li> <li>• Can help make connections not previously seen.</li> <li>• Is a good basis for further reflection.</li> <li>• Helps build individual and group confidence by finding solutions within the group.</li> </ul>	<ul style="list-style-type: none"> <li>• The ideas suggested may be limited by participants' experiences and prejudices.</li> <li>• People may feel embarrassed or if they have nothing to contribute.</li> <li>• Some group members may dominate, and others may withdraw.</li> </ul>	<ul style="list-style-type: none"> <li>• State clearly the brainstorming rule that there is no wrong or bad idea.</li> <li>• Ensure a threat-free, non-judgemental atmosphere so that everyone feels he or she can contribute.</li> <li>• Ask for a volunteer to record brainstorming ideas.</li> <li>• Record ideas in the speaker's own words.</li> <li>• State that the whole group has ownership of brainstorming ideas.</li> <li>• Give participants who have not spoken a chance to contribute.</li> </ul>
<p><b>Plenary or whole group discussion:</b> The entire group comes together to share ideas.</p>	<ul style="list-style-type: none"> <li>• Allows people to contribute to the whole group.</li> <li>• Enables participants to respond and react to contributions.</li> <li>• Allows facilitators to assess group needs.</li> <li>• Enables people to see what other group members think</li> </ul>	<ul style="list-style-type: none"> <li>• Can be time-consuming.</li> <li>• Doesn't give each participant a chance to contribute.</li> <li>• Some individuals may dominate the discussion.</li> <li>• Consensus can be difficult if decisions</li> </ul>	<ul style="list-style-type: none"> <li>• Appoint someone to record the main points of the discussion.</li> <li>• Appoint a timekeeper.</li> <li>• Pose a few questions for group discussion.</li> <li>• Use buzz groups to explore a topic in depth.</li> <li>• Ask for contributions</li> </ul>

## Appendix 8. Training Methodologies: Advantages, Limitations, and Tips for Improvement

Training method	Advantages	Limitations	Tips for improvement
	<p>about an issue.</p> <ul style="list-style-type: none"> <li>Allows individuals or groups to summarise contents.</li> </ul>	<p>are required.</p> <ul style="list-style-type: none"> <li>Some group members may lose interest and become bored.</li> <li>Contribution from a limited number of participants can give a false picture of the majority's understanding of an issue.</li> </ul>	<p>from participants who have not shared their views.</p>
<p><b>Role-play:</b> Imitation of a specific life situation that involves giving participants details of the “person” they are asked to play.</p>	<ul style="list-style-type: none"> <li>Helps start a discussion.</li> <li>Is lively and participatory, breaking down barriers and encouraging interaction.</li> <li>Can help participants improve skills, attitudes, and perceptions in real situations.</li> <li>Is informal and flexible and requires few resources.</li> <li>Is creative.</li> <li>Can be used with all kinds of groups, regardless of their education levels.</li> </ul>	<ul style="list-style-type: none"> <li>Possibility of misinterpretation.</li> <li>Reliance on goodwill and trust among group members.</li> <li>Tendency to oversimplify or complicate situations.</li> </ul>	<ul style="list-style-type: none"> <li>Structure the role-play well, keeping it brief and clear in focus.</li> <li>Give clear and concise instructions to participants.</li> <li>Carefully facilitate to deal with emotions that arise in the follow-up discussion.</li> <li>Make participation voluntary.</li> </ul>
<p><b>Drama:</b> Unlike role-play in that the actors are briefed in advance on what to say and do and can rehearse. As a result, the outcome is more predictable. Drama is often used to illustrate a point.</p>	<ul style="list-style-type: none"> <li>Commands attention and interest.</li> <li>Clearly shows actions and relationships and makes them easy to understand.</li> <li>Is suitable for people who cannot read or write.</li> <li>Involves the audience by letting them empathise with actors' feelings and emotions.</li> <li>Does not require many resources.</li> <li>Can bring people together almost anywhere.</li> </ul>	<ul style="list-style-type: none"> <li>Audience cannot stop the drama in the middle to question what is going on.</li> <li>Can be drawn out and time-consuming.</li> <li>Tends to simplify or complicate situations.</li> </ul>	<ul style="list-style-type: none"> <li>Encourage actors to include the audience in the drama.</li> <li>Follow the drama by discussion and analysis to make it an effective learning tool.</li> <li>Keep it short, clear, and simple.</li> </ul>

## Appendix 8. Training Methodologies: Advantages, Limitations, and Tips for Improvement

<p><b>Case study:</b> Pairs or small groups are given orally or in writing a specific situation, event, or incident and asked to analyse and solve it.</p>	<ul style="list-style-type: none"> <li>• Allows rapid evaluation of trainees' knowledge and skills.</li> <li>• Provides immediate feedback.</li> <li>• Increases analytical and thinking skills.</li> <li>• Is the best realistic alternative to field practice.</li> </ul>	<ul style="list-style-type: none"> <li>• Sometimes not all trainees participate.</li> </ul>	<ul style="list-style-type: none"> <li>• Make the situation, event, or incident real and focused on the topic.</li> <li>• Initiate with simple case studies and gradually add more complex situations.</li> <li>• Speak or write simply.</li> </ul>
<p><b>Demonstration with return demonstration:</b> A resource person performs a specific operation or job, showing others how to do it. The participants then practice the same task.</p>	<ul style="list-style-type: none"> <li>• Provides step-by-step process to participants.</li> <li>• Allows immediate practice and feedback.</li> <li>• Checklist can be developed to observe participants' progress in acquiring the skill.</li> </ul>		<ul style="list-style-type: none"> <li>• Explain different steps of the procedure.</li> <li>• Resource person demonstrates an inappropriate skill, then an appropriate skill, and discusses the differences.</li> <li>• Participants practise the appropriate skill and provide feedback to each other.</li> <li>• Practise.</li> </ul>
<p><b>Game:</b> A person or group performs an activity characterised by structured competition that allows people to practice specific skills or recall knowledge.</p>	<ul style="list-style-type: none"> <li>• Entertains.</li> <li>• Competition stimulates interest and alertness.</li> <li>• Is a good energiser.</li> <li>• Helps recall of information and skills.</li> </ul>	<ul style="list-style-type: none"> <li>• Some participants feel that playing games does not have a solid scientific or knowledge base.</li> <li>• Facilitators should participate in the game.</li> </ul>	<ul style="list-style-type: none"> <li>• Be prepared for “on the spot” questions because there is no script.</li> <li>• Give clear directions and adhere to allotted time.</li> </ul>
<p><b>Field visit:</b> Participants and facilitators visit a health facility or community setting to observe a task or procedure and practice.</p>	<ul style="list-style-type: none"> <li>• Puts training participants in real-life work situations.</li> <li>• Allows participants to reflect on real-life work situations without work pressures.</li> <li>• Best format to use knowledge and practice skills.</li> </ul>	<ul style="list-style-type: none"> <li>• Time-consuming.</li> <li>• Needs more resources.</li> </ul>	<ul style="list-style-type: none"> <li>• Before the visit, coordinate with site, give clear directions before arrival, and divide participants into small groups accompanied by the facilitator.</li> <li>• Provide reliable transportation.</li> </ul>

## Appendix 8. Training Methodologies: Advantages, Limitations, and Tips for Improvement

			<ul style="list-style-type: none"> <li>• Meet with those responsible on arrival.</li> <li>• Provide opportunity to share experiences and give and receive feedback.</li> </ul>
<p><b>Visualisation in participatory programming:</b> Coloured cards varying in shape and size allow participants to quickly classify problems to find solutions.</p>	<ul style="list-style-type: none"> <li>• Allows visualisation of problems, ideas, and concerns in a simple way.</li> <li>• Allows everyone to participate.</li> <li>• Gives participants who tend to dominate a discussion equal time with quieter participants.</li> </ul>	<ul style="list-style-type: none"> <li>• Used more by members of the same organisation to evaluate progress and revise objectives and strategies.</li> <li>• Time-consuming.</li> <li>• Needs more resources.</li> </ul>	<ul style="list-style-type: none"> <li>• Apply modified version of visualisation in participatory programming if problems arise in training that can be dealt with quickly.</li> </ul>
<p><b>Action plan preparation:</b> Allows participants to synthesise knowledge, skills, attitudes, and beliefs into a doable plan; bridges classroom activities with practical application at work site.</p>	<ul style="list-style-type: none"> <li>• Team building for participants from the same site, district, or region.</li> <li>• Two-way commitment between trainers and institutions.</li> <li>• Basis for follow up, action, and supervision.</li> </ul>	<ul style="list-style-type: none"> <li>• Time-consuming.</li> <li>• Requires work on action plan after hours to support action plan development.</li> </ul>	
<p><b>Talk or presentation:</b> Involves imparting information through the spoken word, sometimes supplemented with audio or visual aids.</p>	<ul style="list-style-type: none"> <li>• Is time-efficient for addressing a subject and imparting a large amount of information quickly.</li> <li>• Facilitates structuring the presentation of ideas and information.</li> <li>• Allows the facilitator to control the classroom by directing timing of questions.</li> <li>• Is ideal for factual topics (e.g., steps on conducting HIV testing).</li> <li>• Stimulates ideas for</li> </ul>	<ul style="list-style-type: none"> <li>• Lack of active participation.</li> <li>• Facilitation- and curriculum-centred, essentially one-way learning.</li> <li>• No way to use experience of group members.</li> <li>• Can be limited by facilitators' perception or experience.</li> <li>• Can sometimes cause frustration, discontent, and alienation within</li> </ul>	<p><b>Build interest</b></p> <ul style="list-style-type: none"> <li>• Use a <b>lead-off story or interesting visual</b> that captures audience's attention.</li> <li>• Present an <b>initial case problem</b> around which the lecture will be structured.</li> <li>• Ask participants <b>test questions</b> even if they have little prior knowledge to motivate them to listen to the lecture for the answer.</li> </ul> <p><b>Maximise understanding</b></p>

**Appendix 8. Training Methodologies: Advantages, Limitations, and Tips for Improvement**

	<p>informed group discussion.</p>	<p>the group, especially when participants cannot express their own experience.</p>	<p><b>and retention</b></p> <ul style="list-style-type: none"> <li>• Reduce the major points in the lecture to <b>headlines</b> that act as verbal subheadings or memory aids and arrange in logical order.</li> <li>• Give <b>examples and analogies</b>, using real-life illustrations of the ideas in the lecture and, if possible, comparing the material and the participants' knowledge and experience.</li> <li>• Use <b>visual backup</b> (flipcharts, transparencies, brief handouts, and demonstrations) to enable participants to see as well as hear what you are saying.</li> <li>• Set a <b>time limit</b>.</li> </ul> <p><b>Involve participants during the lecture</b></p> <ul style="list-style-type: none"> <li>• Interrupt the lecture periodically to challenge participants to give examples of the concepts presented or answer <b>spot quiz</b> questions.</li> <li>• <b>Illustrate activities</b> throughout the presentation to focus on the points you are making.</li> </ul> <p><b>Reinforce the lecture</b></p> <ul style="list-style-type: none"> <li>• <b>Allow time for feedback</b>, comments, and questions.</li> <li>• <b>Apply the problem</b> by posing a problem or question for participants to solve</li> </ul>
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## Appendix 8. Training Methodologies: Advantages, Limitations, and Tips for Improvement

			<p>based on the information in the lecture.</p> <ul style="list-style-type: none"><li>• Ask participants to review the contents of the lecture together or give them a self-scoring test.</li><li>• <b>Avoid distracting gestures or mannerisms</b> such as playing with the chalk, ruler, or watch; or adjusting clothing.</li></ul>
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## Appendix 9. Suggested Training Exercises, Review Energisers (Group and Team Building), and Daily Evaluation

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### 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 hold only a certain number of participants. Call out the number of persons the lifeboats 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 energisers** 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 two 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 two teams. Each person receives a *counselling Card* 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.
4. From a basket, a participant selects a *Counselling Card* 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 two circles. On a mat in the middle of the circle, a set of *Counselling Cards* is placed “face down.” A participant is asked to choose a *Counselling Card* and tell the other participants in what situations an infant and young child feeding counsellor can

## **Appendix 9. Suggested Training Exercises, Review Energisers (Group and Team Building), and Daily Evaluation**

share the practices/messages the *Counselling Card* represents. One facilitator is present in each circle to assist in responding.

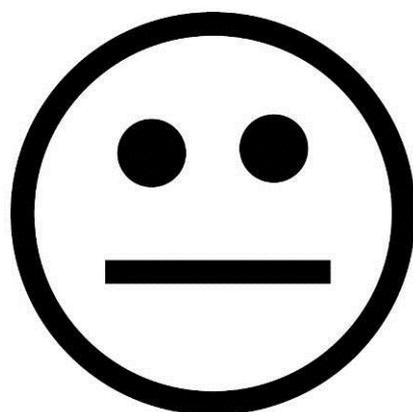
### **Daily evaluations**

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 three 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. 'Happy 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). (See Appendix 10: Cut-Outs of 'Happy Faces')

## Appendix 10. Cut-Outs of 'Happy Faces'



## Appendix 11. Growth Monitoring and Nutritional Assessment

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

The regular weighing and plotting of a child's weight on the growth chart to decide if the child is gaining enough weight or not is called growth monitoring. Using the information gained from growth monitoring to take action to make sure that children grow well (counselling mothers and caregivers) is called growth promotion.

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

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

### Why is a Child Weighed?

The nutritional status of a child should be determined by two methods: the weight measurement and the height measurement. The commonly used indexes to determine the nutritional status are: weight-for-age, height-for-age, and weight-for-height. For growth and promotion surveillance, the index used is weight-for-age.

The weighing enables health workers and parents to know if the child is growing or faltering. Regular GM (weighing) allows monitoring and protection of the nutritional and health status of the child. A sick or poorly fed and malnourished child does not gain an adequate amount of weight or actually loses weight. This is called growth faltering.

Measuring a child's growth regularly is a means to know about his or her nutritional and health status. The child's growth should be measured in different ways. Taking the child's weight is the simplest and most common measure for young children. Adequate weight gain is an indicator that a child is growing well.

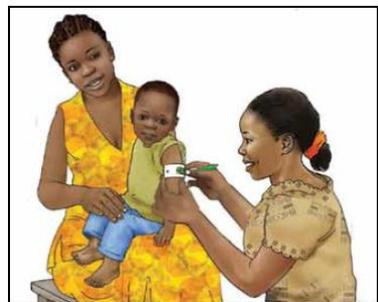
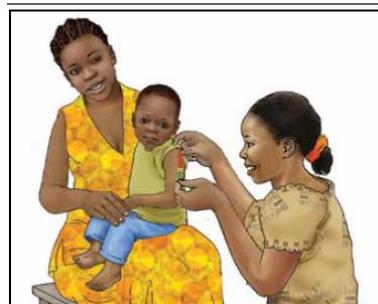
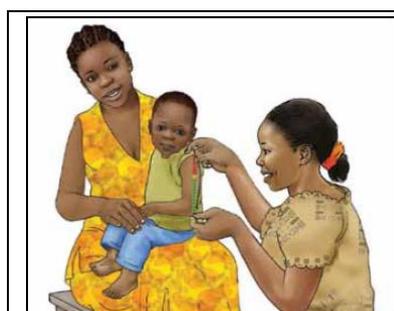
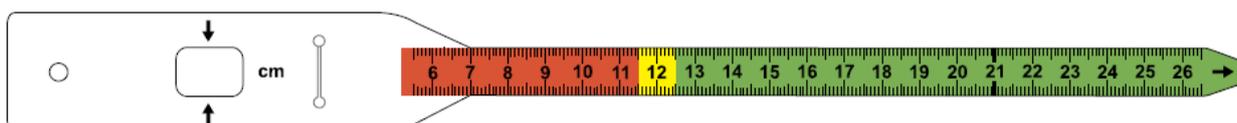
### Why is a Child's Length Measured?

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

### Why is a Child's MUAC Taken?

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

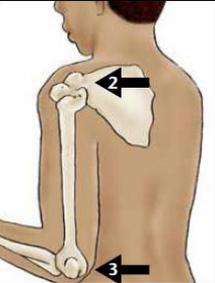
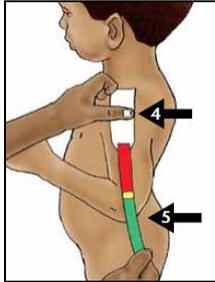
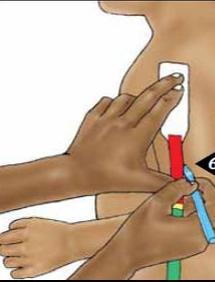
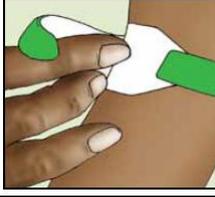
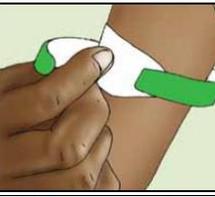
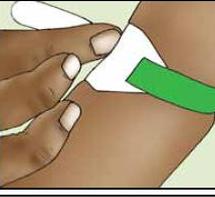
### Using a MUAC Tape for Nutritional Assessment



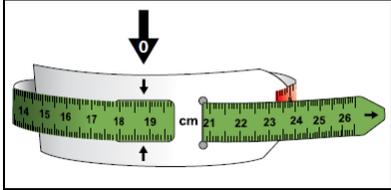
- MUAC stands for “mid-upper arm circumference” tape.
- A MUAC measurement can be used for nutritional assessment of infants from 6 months and children up to 5 years of age.
- MUAC is simple to use and requires no reference to age or height.
- MUAC cut-off points or colour zones are used to classify acute malnutrition.
  - The red colour of the MUAC tape indicates severe acute malnutrition (SAM).
  - The yellow colour indicates moderate acute malnutrition (MAM).
  - The green colour indicates mild or no malnutrition.

### Steps to Accurately Use a MUAC Tape

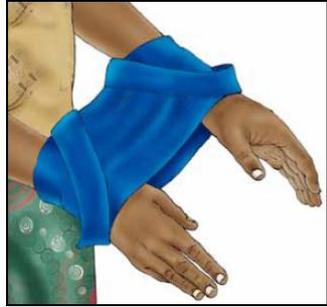
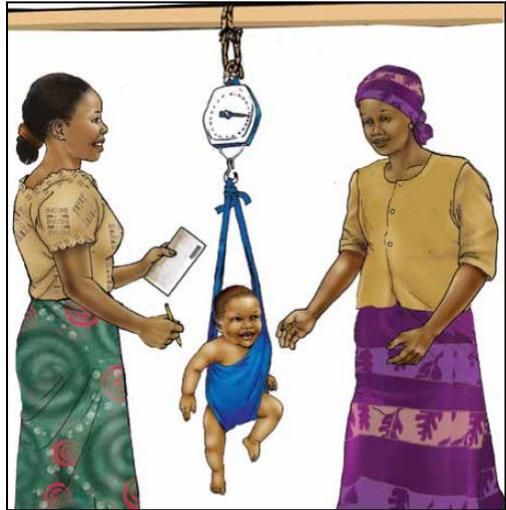
## Appendix 11. Growth Monitoring and Nutritional Assessment

	<ol style="list-style-type: none"> <li>1. Bend left arm at an angle of 90 degrees.</li> </ol>
	<ol style="list-style-type: none"> <li>2. Locate tip of shoulder.</li> <li>3. Locate tip of elbow.</li> </ol>
	<ol style="list-style-type: none"> <li>4. Place tape at 0 cm at tip of shoulder.</li> <li>5. Pull tape past tip of bent elbow and read length of upper arm.</li> </ol>
	<ol style="list-style-type: none"> <li>6. Determine mid-point by either: <ul style="list-style-type: none"> <li>• Folding the tape in half from “0” to the measured length of upper arm, OR</li> <li>• Calculating.</li> </ul> </li> <li>7. Mark mid-point using finger or pen.</li> </ol>
	<ol style="list-style-type: none"> <li>8. Straighten arm and place MUAC tape around the mid-point.</li> <li>9. Place MUAC tape through “window” of tape, and correct the tape tension.</li> </ol>
	<p>Tape too loose.</p>
	<p>Tape too tight.</p>

## Appendix 11. Growth Monitoring and Nutritional Assessment

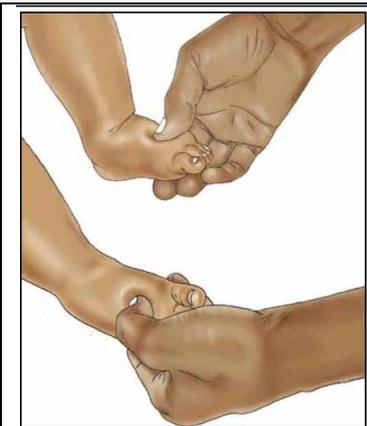
	<p>10. Read the cm measurement in the window at arrow. 11. Record measurement and the colour zone observed.</p>
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### 10 Steps for Weighing Children Up to 25 kg

	<ol style="list-style-type: none"> <li>1. Hook the scale to a tree, a tripod, or a sturdy horizontal beam so that the scale hangs at eye level.</li> <li>2. Suspend the weighing pants from the lower hook of the scale and readjust the scale to zero.</li> <li>3. Undress the child and place in the weighing pants.</li> <li>4. Make sure one of the child's arms passes in between the straps, to prevent him or her from falling.</li> <li>5. Hook the pants to the scale.</li> <li>6. Ensure that the child hangs freely without holding onto anything.</li> <li>7. When the child is settled and the weight reading is stable, record the weight to the nearest 0.1 kg.</li> <li>8. Read and announce the value from the scale. The mother or an assistant should repeat the value for verification. Record the weight immediately.</li> <li>9. Plot the weight on the child's growth chart.</li> <li>10. Discuss with the mother the actual change in weight and the expected change in weight, and, most importantly, the growth curve's trend.</li> </ol>
	
	

Initial or Previous Month's Weight	Minimum Expected Weight Gain Per Month
<5 kg	0.5 kg
5–7 kg	0.4 kg
7–9 kg	0.3 kg
9–12 kg	0.2 kg
>12 kg	0.1 kg

### How to Assess for Bilateral Pitting Oedema

	<ol style="list-style-type: none"><li>1. Oedema is of nutritional significance only if it is bilateral and starts from the feet.</li><li>2. Apply firm pressure with your thumbs to both feet for three full seconds; then remove your thumbs.</li><li>3. Make an assessment of the grade (or seriousness) of the oedema.<ul style="list-style-type: none"><li>• Grade 1 (+): is when a depression persists on both feet. This indicates that the patient has bilateral pitting oedema.</li><li>• Grade 2 (++) : is when the feet are oedematous, and when you repeat the process by pressing the thumb into the leg, a depression persists.</li><li>• Grade 3 (+++) : is when the leg is oedematous, and when you repeat the process by pressing the thumb into the forehead, a depression persists.</li></ul></li><li>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.</li></ol>
