

TRAINING OF TRAINERS MANUAL FOR COUNSELING ON MATERNAL, INFANT AND YOUNG CHILD NUTRITION



ETHIOPIA



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IYCN USAID's Infant
& Young Child
Nutrition Project

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About the Infant and Young Child Nutrition Project

The IYCN Project is the United States Agency for International Development's (USAID) flagship project on infant and young child nutrition (IYCN). Begun in 2006, the five-year project aims to improve nutrition for mothers, infants, and young children, and prevent the transmission of HIV to infants and children. IYCN builds on 25 years of USAID leadership in maternal, infant, and young child nutrition. Our focus is on proven interventions that are effective during pregnancy and through the first two years of life. For more information, please visit www.iycn.org.

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Acronyms

AIDS	acquired immune deficiency syndrome
ANC	antenatal care
ARI	acute respiratory infection
AROM	artificial rupture of membranes
ARVs	antiretroviral drugs
CC	counseling cards
CHS	Center for Human Services
CHW	community health worker
CMAM	community management of acute malnutrition
EBF	exclusive breastfeeding
GMP	growth monitoring and promotion
HIV	human immunodeficiency virus
INCAP	Institute of Central America and Panama
ITNs	insecticide-treated nets
IYCF	infant and young child feeding
LAM	lactational amenorrhea method
LQAS	lot quality assurance sampling
MTCT	mother-to-child transmission
NPP	Nutrition Policy and Practice
PMTCT	prevention of mother-to-child transmission
SC	stabilization center
SFP	supplementary feeding programme
STI	sexually transmitted infection
TB	tuberculosis
UNICEF	United Nations Children's Fund
URC	University Research Company
WHO	World Health Organization

Introduction

This manual is a resource designed to equip health workers to train others on how to counsel mothers, fathers, and other caregivers, using counseling cards to optimally feed their infants and young children and mothers. The counseling cards cover a range of topics including antenatal care, maternal health and nutrition, hygiene, immunizations, special health conditions, breastfeeding, and infant feeding up to two years of age.

Structure of the training

The course is divided into 21 sessions, which take approximately 35 hours without meals or the opening and closing ceremonies. The training can be conducted consecutively in a working week, or can be spread in other ways. The sessions use a variety of teaching methods, including lectures, demonstrations, and work in smaller groups including practical exercises.

Teaching materials

The teaching materials include lectures, demonstrations, clinical practice, and work in smaller groups with discussion, brain-storming, reading, role-play, video-show, and exercises. Participants progressively develop their support and counseling skills in the classroom, and then practice them with mothers and babies in wards or clinics.

This manual is accompanied by the set of 27 *MIYCN Counseling Cards*, which present brightly colored illustrations that depict key infant and young child feeding concepts and behaviors to share with mothers, fathers, and other caregivers. These job aids are designed for use during specific contact points, based on priorities identified during individual counseling sessions.

Using this manual

This manual contains what you, the trainer, need in order to lead participants through the course. The guide contains technical information, detailed instructions on how to teach each topic, the exercises that participants will do together (with answers), and the summary sheets, forms, checklists, and stories used during the course. This is your most essential tool as a trainer on the course. Write your name on it as soon as you get it, and use it at all times. Add notes to it as you work. These notes will help you in future courses.

Planning a training

There are a series of steps to plan a training event that need careful consideration (see Appendix 1). Trainer responsibilities are listed in Appendix 2, and a list of materials is in Appendix 3.

Teaching the course

This course covers a lot of information in a fairly short period of time. It is essential that the course is taught so that it is engaging, participatory, demonstrative, and affirming. The topics of infant feeding and HIV can be very emotional. Some participants may have strong feelings about these topics. It is your job as a trainer to help the group understand and accept that there may be strong feelings, and there is a need to respect them all, without judgment. In areas where HIV is prevalent, it is possible that some participants are, themselves, living with HIV/AIDS, or have close family or friends who are living with HIV. It is important to avoid comments that could sound critical of people with HIV.

Before you give one of the lecture presentations, read the notes through carefully, and study the materials that go with it. You do not have to give the lecture exactly as it is written. It is preferable not to read it out, though this is acceptable if you feel that there is no other way you can do it. However, it is important that you are thoroughly familiar with the contents of the lecture, and with the order of ideas in the presentation. This is necessary even if you are an experienced trainer, and knowledgeable about infant feeding.

Motivating participants

The success of the training will depend on how well the participants are engaged in active learning. As a trainer, there are many ways in which you can enhance the likelihood of this through active engagement with the participants.

Encouraging interaction

At the beginning of each day, ask participants to arrange their seats so that they are sitting in a half circle, without tables or other obstruction in front of them. Put a seat for yourself to sit with the participants, so that you do not stand up in front to lecture.

Some key steps one can do as a trainer include:

- **Interact:** During the first day, interact at least once with every participant, and encourage them to interact with you. This will help them to overcome any shyness they may feel, and they will be more likely to interact with you for the remainder of the course.
- **Learn their names:** Make an effort to learn participants' names early in the course, and use their names whenever it is appropriate. Use names when you ask participants to speak, or to answer questions, or when you refer to their comments, or thank them.
- **Be available:** Be readily available at all times. Remain in the room, and look approachable. Talk to participants rather than trainers during tea breaks, and be available after a session has finished. Refrain from reading magazines or talking with those outside the training.
- **Be interested:** Get to know the participants who will be in your group, and encourage them to come and talk to you at any time, to ask questions, or to discuss any difficulties, or even to tell you that they are interested and enjoying themselves.

Reinforcing participants' efforts

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

- Be careful not to use facial expressions or comments that could make participants feel ridiculed.
- Sit or bend down to be on the same level as a participant to whom you are talking, particularly when you are going over individual written exercises.
- Do not be in a hurry, whether you are asking or answering questions.
- Show interest in what participants say. For example, say: "That is an interesting question/suggestion."

- Praise or thank participants who make an effort, ask for an explanation of a confusing point, or participate in group discussion.

Be the example

You may notice that many of the counseling skills taught during the course are also important for communicating with participants. In particular, you will find it helpful to use appropriate nonverbal communication, to ask open questions, and to praise them and help them to feel confident in their work with caregivers of young children. It is important that you, as a trainer, demonstrate these counseling skills throughout the course—not only during the relevant sessions, but also in your approach to the participants, mothers, caregivers, staff in the facilities, etc. This will demonstrate to the participants that counseling skills are useful in many situations and, with practice, become a way of life.

Use of movement

- Take center stage—do not get stuck in a corner or behind a desk.
- Face the audience—do not face the board or screen when speaking.
- Make eye contact with people in all sections of the audience.
- Use natural gestures and facial expressions (but try to avoid mannerisms).
- Move around the room—approach people to get their attention and response.
- Avoid blocking the audience's view—watch for straining necks.

Use of speech

- Speak slowly and clearly, and loudly enough for everyone to hear.
- Use natural and lively speech—vary your words.
- Write difficult new words on the board, and pronounce and explain them.

Interaction

- Involve all participants. Ask questions to quiet ones, and control talkative ones.
- Move around the room—approach people to get their attention or response.
- Use participants' names.
- Allow time for participants to answer questions from the training guide, and give hints when needed.
- Repeat responses from participants when it is likely that not everyone heard.
- Respond encouragingly and positively to all answers, and correct errors gently.
- Respond adequately to questions, and offer to seek answers if you do not know.
- Handle incorrect or off-the-subject comments tactfully.

Working with smaller groups

Working in groups makes it possible for teaching to be more interactive and participatory, and it gives everybody more time to ask questions. It also allows quieter participants to have more of a chance to contribute.

The exercises are designed for groups of three to four people with a trainer. In this integrated course where there are fewer practical sessions for each skill as compared to previous trainings, it is essential that the maximum number of participants per group is *four*. If there are enough trainers to have groups of three people with each trainer, then this is even better, as it gives all participants more opportunity to practice their counseling and practical skills.

Some important things to consider when setting up the groups:

- Often it is a good idea to make one participant who knows the others in the class responsible for arranging the groups.
- Each group should have at least one person who can speak the local language. It may be appropriate to balance professional groupings and geographic areas.
- Write the names of the trainer and participants in each group on a flip chart or board, and post it where both trainers and participants can check which group they belong to.

It is important that during the week the trainers should try to spend as much time as possible with their groups to learn what the participants feel competent at and where they need more help and practice.

Be aware of language difficulties

Try to identify participants who have difficulty understanding or speaking the language in which the course is conducted. Speak slowly and clearly so that you can be more easily understood. Encourage participants in their efforts to communicate.

If necessary, speak with a participant in her own language (or ask someone else to do so for you) to clarify a difficult point. If any language problems could seriously hinder the ability of a participant to understand the material, it may be possible to arrange help for the participant, or for her to do some of the exercises in a different way.

Facilitating activities

Throughout this course, there are many opportunities to engage participants in active learning, such as role-play, demonstrations, and written exercises. These activities are designed to help participants gain hands-on experience to enhance their understanding of the material. Below are suggestions on how to improve the implementation of these activities.

Demonstrations

- Follow the instructions in the this manual.
- State clearly the objective of the demonstration before you begin.
- Demonstrate the entire, correct procedure (no short cuts).
- Describe the steps aloud while doing them.
- Project your voice so all can hear. Stand where everyone can see.
- Encourage questions from participants.
- Ask participants questions to check their understanding.

Written exercises

- Give clear instructions and a time limit before starting the exercise.
- Individuals should work by themselves and should sit a little away from each other.
- While participants work, look available, interested, and willing to help.
- Give individual help quietly, without disturbing others in the group.
- Sit down next to the participant that you are helping.
- Check answers carefully—listen as participants give reasons for their answers.
- Encourage and reinforce participants' efforts—give positive feedback.
- Help participants to understand any errors—give clear explanations.
- Remember to use your counseling skills when giving feedback.

- Try not to give answers too early—give people time to think.
- For unfinished questions, suggest they finish them in their own time and ask a trainer later to review the answers.

Group work

- Before dividing into groups, explain clearly the purpose of the activity, what participants will do, and the time limit.
- If needed, demonstrate a skill before asking participants to do it on their own.
- Select suitable cases for the session's objectives.
- Observe participants carefully as they work with real mothers or counseling stories.
- Use *Participant materials 7.2: Practical discussion checklist*.
- Try to get participants to identify their own strengths and weaknesses. Ask questions such as: What did you do well? What difficulties did you have? What would you do differently in the future?
- Keep participants busy by promptly assigning another mother or case scenario.

Role-play

- Prepare your helpers or co-facilitators for role-plays before the session, and practice if possible.
- Set up role-plays carefully. Obtain necessary props (e.g., dolls). Brief those who will play the roles, and allow them time to prepare.
- Clearly introduce the role-play by explaining its purpose, the situation, and the roles to be enacted.
- Keep the role-play brief and to the point.
- After the role-play, guide a discussion. Ask questions of both the players and observers.
- Summarize what happened and what was learned.

Space and time

Setting up the training room space

An important part of making the training environment a safe and welcoming place is to create a space that encourages interaction and participation. Some general guidelines to follow:

- Arrange the room so that all participants can see clearly what is happening. If possible, arrange seats in a U-shape with no more than two rows of seats.
- Make sure audiovisuals and teaching aids can be seen by all participants.
- If needed, place a table at the front of the room to set up visual aids and teaching materials.
- Write clearly on the board or flip chart—arrange words carefully so there is enough room.
- Have the required supplies, equipment, and teaching aids ready—check and arrange them before the session.
- Make sure audiovisual equipment is available and working.
- Allow a place for participants to handle teaching aids that you use for demonstrations.
- Cover, turn off, or remove teaching aids that are not in use any more.

Time management

- Keep to time—not too fast or too slow. Do not take too long with the early part of a session.

- Don't lose time between sessions (e.g., when going to practical session and group work). Before participants begin to move, explain clearly what they will do.

It is important not to get involved in discussions that are distracting, and that waste a lot of time. Encourage participants to make a few suggestions; discuss their suggestions, and then continue with the session. You do not have to wait until they have given all the answers listed in the text. Notes are included with many of the questions to guide you.

Specific objectives of training

The *Training of Trainers Manual* was developed using methodologies and technical content appropriate for use with health workers and support group mentors. The content focuses on breastfeeding, complementary feeding, feeding sick/malnourished infants and young children, and infant feeding in the context of HIV, as well as maternal nutrition. By the end of the training, participants will be able to:

- Explain why maternal, infant, and young child nutrition practices matter.
- Demonstrate appropriate use of counseling skills (listening and learning; building confidence and giving support [practical help]) and use the set of counseling cards.
- Use the Three-Step Counseling process (assess, analyze, and act) with a mother, father, or other caregiver.
- Describe recommended feeding practices through the first two years of life; demonstrate use of related possible counseling discussion points and technical material.
- Describe how to breastfeed most effectively.
- 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 or recovering from illness.
- Facilitate action-oriented group sessions and mother-to-mother infant and young child feeding support groups.
- Describe basic information in infant feeding in the context of HIV.
- Counsel pregnant women and mothers on appropriate nutrition during pregnancy and breastfeeding.

Target group

This training manual is for health care workers, though much of it could be adapted to train health extension workers (HEWs), mother support group mentors, or other community workers. 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 thus better able to support and mentor the participants on an ongoing basis. Appendix 4 describes some specifics of supportive supervision.

Structure of each session

At least two facilitators should conduct the training. Ideally, there will be one trainer for every three to five participants. When the ratio exceeds this number it is impossible to oversee skills development ensuring competency.

Each session in this manual includes:

- Learning objectives for the specific counseling card.

- List of materials.
- Guidelines for 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 *Training of Trainers Manual* is designed to be used by trainers as guidance for the preparation and execution of the training, and is not intended to be given to participants. Participants are given a set of counseling cards as well as handouts used during training.

Technical note on terminology

In this manual, 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.

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

Training methodology

The ultimate goal of this training manual is to help the participants improve their capacity to facilitate positive behavior change of the mothers, fathers, and caregivers that they counsel. Hands-on practice is the focus of this training, with emphasis on counseling skills and effective use of the counseling cards. The competency-based participatory training approach used in this manual reflects key principles of behavior change communication (BCC) with a focus on the promotion of small, doable actions, and recognition of the widely acknowledged theory that adults learn best by reflecting on their own personal experiences (see Appendix 5: Principles of adult learning). The approach uses the experiential learning cycle method and prepares participants for hands-on performance of skills. The course employs a variety of training methods, including the use of counseling materials, visual aids, demonstrations, group discussion, case studies, role-plays, and practice (see Appendix 6: Training methodologies). Participants also act as resource persons for each other, and benefit from clinical and/or community practice, working directly with breastfeeding mothers, pregnant women, and mothers/fathers/ caregivers who have young children (see Appendix 7: Suggested training exercises, and Appendix 8: Cut-outs for ‘happy faces’).

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

- Use of motivational techniques.
- Use of the experiential learning cycle.
- Problem-centered 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 counselors maintain and improve their performance over time.

Using the counseling cards

The Three-Step Counseling process guides counselors through three important steps during an individual counseling session with a mother or caregiver and child—assessment, analysis, and action.

To learn to conduct an infant and young child feeding assessment of the mother-and-child pair, participants use an Assessment Tool that helps them to structure and thus remember the information they must obtain from the mother or caregiver by observing and engaging in conversation using the counseling 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 counselor prioritises the issues, selecting one or two to discuss with the mother or caregiver during the action step. The counselor selects a small amount of relevant information to discuss with the mother to determine if together they can identify a small do-able action that the mother or caregiver could try for a limited period of time. If there is a counseling card that can help the counselor better explain a recommended feeding practice or a skill, that card should be used during this discussion.

The counselor should refer to the illustrations in the material to help reinforce the information that she or he is sharing.

Once a small do-able action is agreed upon, the counselor may arrange to meet with the mother at a scheduled time and location to determine if the 'new do-able 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(s).

The counseling 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 counseling cards and key messages may be used to guide a discussion or to help demonstrate and discuss comprehensive information dealing with a particular topic.

Think

- What do you think is happening in this picture?
- Is this common in our community?



Feel

- How do you feel about this practice?
- Is this something you would feel comfortable doing?
- Would others support you if you did this?



Do

- Are you willing to try this?
- When will you try?
- How will you do it?

Adapted from: LINKAGES Project. *Behavior Change Communication for Improved Infant Feeding Training of Trainers for Negotiating Sustainable Behavior Change*. Washington, DC: Academy for Educational Development; 2004.

- Think→Feel→Do is a way to remember the process for asking questions/facilitating a discussion around a counseling card that demonstrates a recommended behavior.
- These questions help to engage participants with the content and encourage them to think about how they could try this behavior.
- Encouraging participants to think about, reflect on, and plan how to do a behavior increases the likelihood that they will try it.

The questions below can encourage participants to try a practice shown on a counseling card.

1. THINK

- What do you think is happening in the picture?
- Is this a common practice in our community?
- What is the advantage of doing the action shown in the picture?
- Why is he or she doing this? (When appropriate.)

2. FEEL

- How do you feel about this practice?
- Do you agree with the actions in the picture? Why? Why not?
- Is this something you would feel comfortable doing?
- What would you do in the same situation? Why?
- What difficulties might you experience?

3. DO

Repeat the key messages:

- Are you willing to try this?
- How would you overcome any barriers to trying this?
- When will you try it?
- How will you do it?

Discuss specific actions that participants can try.

Sample schedule for five-day training

DAY 1	DAY 2	DAY 3	DAY 4	DAY 5
Welcome and introductions Session 1: (60 min) Introduction, expectations, and objectives Session 2: (60 min) Why infant and young child feeding matters	DAILY REVIEW			
	Session 7: (120+ min) Clinical practice with mothers, listening and learning, assessing a breastfeed, giving support and positioning the baby	Session 10: (120 min) Care for the woman during pregnancy and lactation	Session 15: (120 min) Clinical practice: Taking an infant and young child feeding assessment	Session 18: (180 min) Facilitating action: Field practice for working with groups of women
TEA BREAK				
Session 3: (90 min) Recommended infant and young child feeding practices and breastfeeding beliefs Session 4: (60 min) Assessing a breastfeed	Session 7: Continued Clinical practice	Session 11: (60 min) Introduction to infant feeding and care after 6 months Session 12: (60 min) Complementary feeding for children from 6 months to 24 months	Session 15: Continued Clinical practice	Session 19: (120 min) Overview of HIV and infant feeding
LUNCH				
Session 5: (60 min) Counseling a mother on how to best feed her infant Session 6: (120 min) How to counsel: Listening and learning	Session 8: (60 min) Common breastfeeding difficulties Session 9: (120 min) How to counsel mother/father/caregiver	Session 13: (60 min) Review of counseling cards on complementary feeding Session 14: (60 min) Taking an infant and young child feeding assessment	Session 16: (60 min) Feeding and care of the sick child Session 17: (120 min) Facilitating action: Conducting support groups and scheduling home visits	Session 20: (30 min) Checking understanding and follow up Session 21: (90 min) Development of action plan and post-training assessment

Session 1. Introductions, expectations, and objectives

Learning objectives
1. Begin to name fellow participants, facilitators, and resource persons
2. Discuss participants' expectations, compare with the objectives of the training, and clarify the priorities/focus of the course
3. Identify strengths and weaknesses of participants' infant and young child feeding knowledge
4. Present and review the set of counseling cards

Materials

- Flip chart papers and stand, markers, tape/sticky putty
- Name tags
- Participants' folders
- Course timetable
- Illustrations from counseling cards, laminated if possible, and cut in two pieces

Preparation

- Flip chart: Course objectives

Duration: 60 min

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

Methodology: Matching game

Instructions for activity

1. Using illustrations from counseling cards cut in two pieces, give each participant a picture and ask him/her to find the match. After matching, pairs of participants introduce each other to the group, giving their partner's preferred name, what community group they belong to, their work in infant and young child feeding, one expectation for the training, and something of human interest (favorite food, hobbies, color, etc.).
2. During the introductions, write participants' expectations on a flip chart.
3. Asks participants to brainstorm group norms. List the norms on a flip chart and keep the list posted throughout the training.

Note to facilitators: While the expectations and group norms should be generated by the group, it will be useful to include the following items on the lists:

Expectations

- Learning will include both technical information and clinical practice.
- There will be time for review and questions.
- The training will be done in a spirit of a learning environment.
- Individuals will be asked to demonstrate competency in the subject matter.
- Resource materials will be available for additional learning opportunities.

Group norms

- Individuals will be prompt and prepared for training.
- There will be mutual respect among all individuals in the training.
- Any concerns or questions can be raised during the training as appropriate.
- Individuals will come to training engaged and ready to learn the material.
- Sessions will be completed in a timely way.
- During the clinical practice, it is important to be respectful to all volunteers.

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

Methodology: Interactive presentation

Instructions for activity

1. Introduce the training objectives (includes the main objectives, which has been previously written on a flip chart), and compare them with the expectations of the participants.
2. Add inspirational points:
 - You can make a difference in your community!
 - You have a role to play—with the knowledge and skills you will gain in this training, you will help mothers, babies, and families in your community!
 - We want you to feel empowered and energized because you do perform a vital role in your community—mothers, babies, and families will be healthier because of your efforts.
3. Keep expectations and objectives in view during the training course.

Note to facilitators: This five-day TOT was developed out of several previously developed counseling courses available from WHO/UNICEF/UNAIDS focused on breastfeeding, HIV breastfeeding, HIV and infant feeding, and complementary feeding.

‘Counseling’ is an extremely important component of this course. The concept of ‘counseling’ is new to many people and can be difficult to translate. Some languages use the same word as ‘advising.’ However, counseling means more than simple advising. Often, when you advise people, you tell them what you think they should do. When you counsel, you listen to and help every person decide what is best for them from various options or suggestions, and you help them to have the confidence to carry out their decisions. You listen to them and try to understand how they feel. This course aims to give health workers basic counseling skills so that they can help mothers and caregivers more effectively.

This course has been designed to cover the following areas:

- Knowledge on breastfeeding
- Skills of breastfeeding management
- Maternal nutrition and care
- Knowledge on HIV and infant feeding
- Skills on infant and young child feeding in the context of HIV
- Counseling
- Implementation of optimal infant and young child feeding practices

Course competencies

This course is based on a set of competencies that every participant is expected to learn during the course and in subsequent practice and follow-up at their place of work. To become competent at something you need a certain amount of knowledge and to be proficient at certain skills.

The ‘knowledge’ part of the competencies will be taught during this course. Most people find that they obtain the ‘knowledge’ part of a competency more quickly than the ‘skills’ part.

The ‘skills’ part of the competencies will also be taught during this course. However, there may not be time for each participant to become proficient in every skill. This will depend on their previous experience. During the course, every participant should practice as many of the skills as possible, so that they know what to do when they return to their place of work. The skills will be practiced further in the supervised follow-up session.

Learning objective 3: Identify strengths and weaknesses of participants’ infant and young child feeding knowledge

Methodology: Non-written (or written) assessment of knowledge

Instructions for activity (non-written assessment)

1. Explain that 18 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 center.
3. One facilitator reads the statements from the 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

Instructions for activity (written pre-assessment)

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. Alternatively, participants could also use a symbol of their choosing—anything that they will remember in order to match the 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 counseling cards

Methodology: Buzz (or small discussion) groups of three participants

Instructions for activity

1. Distribute a set of counseling cards to each participant, and then ask participants to form groups of three.
2. Explain that the counseling cards 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 counseling card.
4. Ask a group to hold up the counseling card(s) that shows the item.
5. Ask the other groups if they agree, disagree, or wish to add another counseling card.
6. Repeat the process with the remaining items/characteristics. Find:
 - A counselor talking with a mother.
 - A sign or symbol that indicates that something should happen during the day and at night.
 - A sign or symbol that indicates that the child should have a meal or a snack.
 - A sign or symbol that indicates that a young child should eat 3 times a day and have 2 snacks.
 - A sick baby less than 6 months 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 to drink water.
7. Repeat the explanation that the counseling cards will be their tools to use.

Participant materials 1.1: Pre-training assessment: What do we know now?

	Statement	Yes	No	Don't know
1.	The amount and types of food a woman eats during pregnancy can affect a baby's health.			
2.	Poor child feeding during the first 2 years of life harms growth and brain development.			
3.	An infant aged 6 up to 9 months needs to eat at least 3 times a day in addition to breastfeeding.			
4.	A pregnant woman needs to eat 1 more meal per day than usual.			
5.	At 4 months, infants need water and other drinks in addition to breastmilk.			
6.	Telling a mother how to feed her child is an effective way of changing her infant feeding practices.			
7.	A woman who is malnourished can 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 about 6 months, the first food a baby takes should have the consistency 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 (the first thick, yellowish milk).			
14.	An HIV-positive mother should never breastfeed.			
15.	Men play an important role in how infants and young children are fed.			
16.	Babies should be offered the breast only when the full milk comes in.			
17.	An engorged breast cannot be easily treated at home.			
18.	A low milk supply can be increased by increasing the			

Session 1. Introductions, expectations, and objectives

	Statement	Yes	No	Don't know
	frequency of feeds.			

Session 2. Why infant and young child feeding matters

Learning objectives
1. Define the terms infant and young child feeding, exclusive breastfeeding, and complementary feeding
2. Recognize key factors that contribute to a healthy, well-nourished child

Materials

- Flip chart papers and stand, markers, tape/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

Preparation

- On flip chart paper, write the following data about infant and young child feeding in Ethiopia (include regional, or district as appropriate):

Initiation of breastfeeding within 1 hour	46%	Nutrition Baseline Survey 2010
Exclusive breastfeeding for the first 6 months	49%	Ethiopia Demographic and Health Survey (EDHS) 2005
Complementary feeding of solid or semisolid food started in the age range of 6 to 8 months	43%	Nutrition Baseline Survey 2010
Malnutrition	38% underweight 47% stunting 11% wasting	EDHS 2005
Low birthweight	23% rural areas 10% urban areas	EDHS 2005

Duration: 60 min

Learning objective 1: Define infant and young child feeding, 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? (Write responses on flip chart.)
 - What does exclusive breastfeeding mean?
 - What does complementary feeding mean?
 - What are complementary foods?

2. Recognize all of the inputs, correct errors, and fill in gaps as needed.

3. Discuss.

Key information

Infant = from birth up to 1 year

Young child (when used with ‘infant and young child feeding’) = from birth to 2 years of age

Definition	Infant must receive	Infant may also receive	Infant may not receive
Exclusive breastfeeding (EBF)	Breastmilk (including milk expressed or from a wet nurse)	Drops, syrups (vitamins, minerals, medicines)	Anything else

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

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

Make these points:

- Optimal infant and young child feeding is fundamental for the survival, health, nutrition, growth, and development of a child, but many children are not fed in the recommended way.
- Information on how to feed young children comes from family beliefs, community practices, and information from health workers. Advertising and commercial promotion by food manufacturers is sometimes the source of information for many people, both families and health workers.
- Malnutrition is one of the main health problems facing many women and children in Ethiopia. Ethiopia has the second highest rate of malnutrition in sub-Saharan Africa.
- Recent data show that 47% of children under 5 were stunted, 11% were wasted, 38% were underweight, and nearly 30% of women of reproductive age were chronically undernourished.

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

² Ibid.

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

Methodology: Interactive presentation

Instructions for activity

1. Ask participants to find a picture of a well-nourished child in their set of counseling cards. Tape or stick the illustration on the wall in the front of the room.
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, write them on small pieces of paper and tape or stick it to the flip chart.
3. Draw arrows from the words on the note cards to the picture of the healthy, well-nourished child.
4. Discuss and summarize.

Session 3. Recommended infant and young child feeding practices and breastfeeding beliefs

Learning objectives
1. Review recommended infant and young child feeding practices
2. Examine and use counseling cards related to breastfeeding
3. Distinguish between beliefs that are beneficial to breastfeeding and beliefs that should be discouraged, and discuss what can be done to address these beliefs
4. Discuss food taboos during pregnancy and lactation

Materials

- Flip chart paper and stand, markers, tape/sticky putty
- Copies of *Participant materials 3.1: Recommended breastfeeding practices and possible counseling discussion points*
- Relevant counseling cards:
 - **CC 8: Initiation of breastfeeding**
 - **CC 10: Exclusive breastfeeding**
 - **CC 9: How to put your baby on the breast**
 - **CC 13: How to make enough milk**
 - **CC 18: Hygiene**
 - **CC 14: What to do when separated from your baby**

Duration: 90 min

Learning objective 1: Review recommended infant and young child feeding practices

Methodology: Brainstorming

Instructions for activity

1. Ask: What does the term ‘exclusive breastfeeding’ mean? Wait for a few replies. Verify that the definition is understood.
2. Make the following points during the discussion:
 - Virtually all mothers can breastfeed exclusively, provided they have accurate information and support within their families and communities.
 - Mothers should have access to skilled practical help from people trained in breastfeeding counseling who can help to build their confidence, improve feeding technique, and prevent or resolve breastfeeding difficulties.
 - During this course you will start to develop these skills, or build on skills you are already using in your daily work.

3. Brainstorm on the advantages of breastfeeding. The brainstorming should bring out the main points below:
 - Breastmilk contains exactly the nutrients that a baby needs.
 - It is easily digested and efficiently used by the baby's body.
 - It protects a baby against infection.
 - It costs less than artificial feeding.
 - It helps a mother and baby to bond—that is, to develop a close, loving relationship.
4. Describe 'emotional bonding':
 - Emotional bonding means a close, loving relationship between mother and baby.
 - The mother is more emotionally satisfied.
 - The baby cries less.
 - The baby may be more emotionally secure.
5. Breastfeeding can help to delay a new pregnancy.
6. Breastfeeding protects a mother's health: It helps the uterus to return to its previous size. This helps to reduce bleeding, and may help to prevent anemia.
7. Discuss risks of NOT breastfeeding.

Risks for the infant:

 - Greater risk of death (a non-breastfed baby is 14 times more likely to die than an exclusively breastfed baby in the first 6 months).
 - Formula has no antibodies to protect against illness; the mother's body makes breastmilk with antibodies that protect from the specific illnesses in the mother/child environment.
 - Don't receive their "first immunization" from the colostrum.
 - Struggle to digest formula: it is not at all the perfect food for babies.
 - Frequent diarrhea, ill more often and more seriously (mixed-fed infants less than 6 months who receive contaminated water, formula, and foods are at higher risk).
 - Frequent respiratory infections.
 - Greater risk of undernutrition, especially for younger infants.
 - More likely to get malnourished: family may not be able to afford enough formula.
 - Under-development: retarded growth, underweight, stunting, wasting due to higher infectious diseases such as diarrhea and pneumonia.
 - Poorer bonding between mother and infant.

Risks for the mother:

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

Learning objective 2: Examine and use counseling cards related to breastfeeding

Methodology: Group work

Instructions for activity

A. Identify recommended breastfeeding practices through discussion

1. Give each group of four participants 10 cards or pieces of paper.
2. Give an example of a recommended breastfeeding practice such as initiation of breastfeeding within the first hour of birth.
3. Ask each group to write a recommended breastfeeding practice on each card (one per card), then discuss and group the cards.
4. Have each group tape their cards on recommended breastfeeding practices on the wall.
5. Select one group to tape or stick their cards on a board or flip chart 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 any additional practices to the first group's practices and discuss.
9. Remove any incorrect information.
10. Leave posted in a vertical column (in the center of the board or flip chart) the recommended breastfeeding practices.
11. Summarize and fill in the gaps to include the recommended breastfeeding practices.

B. Identify recommended breastfeeding practices through counseling cards

1. In the same groups, ask participants to look at the following counseling cards:
 - **CC 4: Nutrition during pregnancy**
 - **CC 7: Delivery**
 - **CC 8: Initiation of breastfeeding**
 - **CC 10: Exclusive breastfeeding**
 - **CC 13: How to make enough milk**
2. Ask groups to match counseling cards with the recommended breastfeeding practices posted.
3. Ask groups to describe the main counseling points for discussion/messages that the counseling cards represent.
4. Ask each group to share their observations and counseling points for discussion/messages for one of the cards.
5. Encourage other groups to share additional points.



C. Participant materials

1. Distribute *Participant materials 3.1*: Recommended breastfeeding practices and possible counseling discussion points. Review together and compare with the counseling points for discussion/messages described by the working groups. Consider what you know from research and previous experience in your area. What additional discussion points might be added?
2. Discuss and summarize.

Participant materials 3.1: Recommended breastfeeding practices and possible counseling discussion points

Recommended breastfeeding practice	Possible counseling discussion points Note: choose two or three most relevant to mother's situation and/or add other discussion points from knowledge of area
Place infant skin-to-skin with mother immediately after birth.	<ul style="list-style-type: none"> • Skin-to-skin contact with mother keeps newborn warm and helps stimulate bonding or closeness, and brain development. • Skin-to-skin helps the “let down” of the colostrum/milk. • There may be no visible milk in the first hours. For some women it even takes a day or two to experience the “let down.” It is important to continue putting the baby to the breast to stimulate milk production and let down. • Colostrum is the first thick, yellowish milk that protects baby from illness. • CC 7: Delivery
Initiate breastfeeding within the first hour of birth.	<ul style="list-style-type: none"> • Make sure baby is well attached. • This first milk [use local word] is called colostrum. It is yellow and full of antibodies that help protect your baby. • Colostrum provides the first immunization against many diseases. • CC 8: Initiation of breastfeeding
Breastfeeding in the first few days	<ul style="list-style-type: none"> • Breastfeeding frequently from birth helps the baby learn to attach and helps to prevent engorgement and other complications. • In the first few days, the baby may feed only 2 to 3 times/day. If the baby is still sleepy on day 2, the mother may express some colostrum and give it from a cup. • Give nothing else—no water, no infant formula, no other foods or liquids—to the newborn.
Exclusively breastfeed (no other food or drink) from birth to 6 months.	<ul style="list-style-type: none"> • Breastmilk is all the infant needs for the first 6 months. • Do not give anything else to the infant before 6 months, not even water. • Breastmilk contains all the water a baby needs, even in a hot climate. • Giving water will fill the infant and cause less suckling; less breastmilk will be produced. • Water and other liquids and foods for an infant less than 6 months can cause diarrhea. • CC 10: Exclusive breastfeeding

Session 3. Recommended infant and young child feeding practices and breastfeeding beliefs

Recommended breastfeeding practice	Possible counseling discussion points Note: choose two or three most relevant to mother's situation and/or add other discussion points from knowledge of area
<p>Breastfeed frequently, day and night.</p> 	<ul style="list-style-type: none"> • After the first few days, most newborns want to breastfeed frequently, 8 to 12 times/day. Frequent breastfeeding helps produce lots of breastmilk. • Once breastfeeding is well-established, breastfeed 8 or more times day and night to continue to produce plenty of (or lots of) breastmilk. If the baby is well attached, contented, and gaining weight, the number of feeds is not important. • More suckling (with good attachment) makes more breastmilk. • CC 9: How to put your baby on the breast
<p>Breastfeed on demand every time the baby asks to breastfeed.</p> 	<ul style="list-style-type: none"> • Crying is a <u>late</u> sign of hunger. • Early signs that baby wants to breastfeed: <ul style="list-style-type: none"> – Restlessness. – Opening mouth and turning head from side to side. – Putting tongue in and out. – Sucking on fingers or fists. • CC 13: How to make enough milk
<p>Let infant finish one breast and come off by him/herself before switching to the other breast.</p>	<ul style="list-style-type: none"> • Switching back and forth from one breast to the other prevents the infant from getting the nutritious 'hind milk.' • The 'fore milk' has more water content and quenches infant's thirst; the 'hind milk' has more fat content and satisfies the infant's hunger.
<p>Practice good positioning and attachment.</p>	<ul style="list-style-type: none"> • Four signs of good positioning: baby's body should be straight, baby's body faces 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. • Four signs of good attachment: mouth wide open, chin touching breast, more areola showing above than below the nipple, and lower lip turned out. • CC 9: How to put your baby on the breast
<p>Continue breastfeeding until 2 years of age or longer.</p>	<ul style="list-style-type: none"> • Breastmilk contributes a significant proportion of energy and nutrients during the complementary feeding period and helps protect babies from illness. • CC 19 to 23: Complementary feeding

Session 3. Recommended infant and young child feeding practices and breastfeeding beliefs

Recommended breastfeeding practice	Possible counseling discussion points Note: choose two or three most relevant to mother's situation and/or add other discussion points from knowledge of area
Continue breastfeeding when infant or mother is ill.	<ul style="list-style-type: none"> • Breastfeed more frequently during child illness. • The nutrients and immunological protection of breastmilk are important to the infant when mother or infant is ill. • Breastfeeding provides comfort to a sick infant. • CC 24: How to feed a sick baby from birth to 6 months
Mother needs to eat and drink to satisfy hunger and thirst.	<ul style="list-style-type: none"> • No one special food or diet is required to provide adequate quantity or quality of breastmilk. • Breastmilk production is not affected by maternal diet. • No foods are forbidden. • Mothers should be encouraged to eat more food to maintain their own health. • CC 4: Nutrition during pregnancy • CC 12: Nutrition for lactating mothers
Avoid feeding bottles.	<ul style="list-style-type: none"> • Foods or liquids should be given by cup to reduce nipple confusion and the possible introduction of contaminants. • CC 18: Hygiene • CC 14: What to do when separated from your baby • CC 21 to 23: Complementary feeding

Key information

- 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 are essential for good milk supply.
- 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.

Specific counseling cards

Counseling card 9: Initiation of breastfeeding



Mother/delivery attendant: put the baby on the breast immediately after birth, even before the placenta is expelled. Start breastfeeding within one hour.

Give your baby the first yellowish milk (colostrum). Colostrum:

- Protects the baby from illness.
- Fills the baby's small stomach and helps to pass the first dark feces.
- Helps the baby to develop well.

Waiting until your milk comes in before starting to breastfeed:

- Denies the baby the food the baby needs at birth.
- Can make breastfeeding more difficult.

Avoid giving water or other liquids to the baby. They are not necessary and are dangerous for a newborn.

Counseling card 10: Exclusive breastfeeding



For the first six months, give the baby breastmilk only and nothing else, not even water. You may also give medicine prescribed by a health worker. Breastmilk is the perfect food for a baby.

Breastmilk:

- Has all the food and water your baby needs for the first months of life.
- Has enough water to satisfy the thirst of your baby even during very hot weather.
- Has substances that protect your baby from common diseases or illnesses, such as diarrhea and respiratory infections.
- Is clean, safe, easy to digest, and readily available.

Giving other foods during this period:

- May cause your baby to suckle less and reduce milk production.
- May make it difficult for your baby to breastfeed.
- May cause the baby to become ill or not grow well.

Exclusive breastfeeding during the first six months of your baby's life protects you against another pregnancy if:

1. You have not started menstruating after delivery;
2. Your baby is less than six months old; and
3. Your baby is breastfeeding exclusively.

When you exclusively breastfeed your baby for six months and have no menses, you are practicing a family planning method called lactational amenorrhea method or LAM. LAM no longer protects against pregnancy when even one of the three conditions above does not exist. Ask your health worker for information about other family planning methods.

Counseling card 11: How to put your baby on the breast



Put your baby on the breast properly to encourage the baby to feed well and to produce enough milk. Good attachment ensures that the baby breastfeeds without pulling on the nipples and causing painful breastfeeding, sores, and cracked nipples.

To position the baby on the breast well:

- Sit in a comfortable position.
- Support the baby's whole body, not just the head or neck.
- Ensure that the baby's stomach and body are in a straight line and facing you.
- Ensure that the baby can get to the breast without turning.

Signs of good attachment:

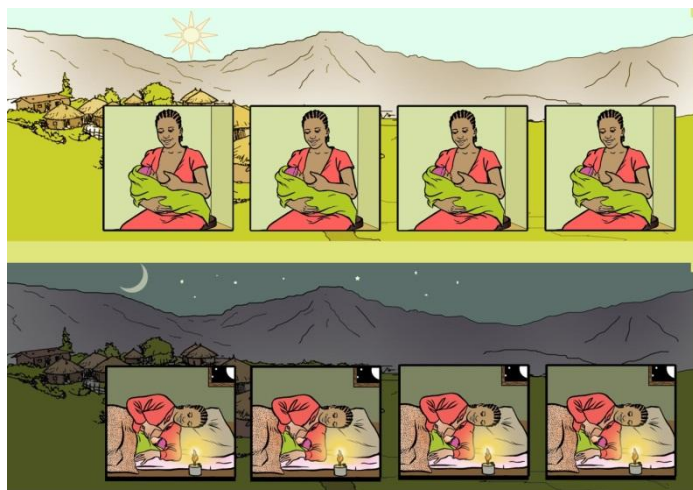
- The baby's mouth is wide open when breastfeeding.
- You can see more of the dark skin surrounding the nipple (areola) above the baby's mouth than below.
- The baby's lower lip is turned outward.
- The baby's chin is touching the mother's breast.

Signs that the baby is breastfeeding well:

- The baby takes slow, deep suckles with pauses in between.
- You can see or hear the baby swallowing after one or two suckles.
- Suckling is comfortable, with no pain to the mother.
- The baby finishes breastfeeding from one breast, releases it, and looks content and relaxed.
- The breast is soft after the feed.

Allow the baby to finish breastfeeding from one breast and then switch to the second breast.

Counseling card 12: How to make enough milk



Almost every woman can make enough milk for her baby. Even women who are not eating enough or eating well can make enough milk for their baby, and the quality of breastmilk is still the best for the baby.

- To make enough milk, breastfeed the baby whenever he or she wants, day and night. Your newborn should feed at least 8 to 12 times a day in order to grow well, and to help establish your breastmilk supply. After you feel that you have a good milk supply, continue to breastfeed 8 or more times a day.
- The amount of milk you make depends on how the baby breastfeeds. More suckling (with good attachment) makes more breastmilk.
- Let your baby stop suckling from the first breast on his or her own before offering the other breast.
- Crying is a late sign of hunger. Early signs that your baby wants to breastfeed include:
 - Restlessness.
 - Opening mouth and turning head from side to side.
 - Putting tongue in and out.
 - Suckling on fingers and fists.
- If your baby is ill or sleepy, wake him/her to offer the breast often.
- Do NOT use bottles, teats, or spouted cups. They are difficult to clean and can cause your baby to become sick.
- Get extra support from family members in caring for your baby and other children, and for doing household duties.

Note: If a mother is concerned about her baby getting enough milk, encourage the mother and build her confidence by reviewing how to attach and position the baby to her breast. Reassure her that her baby is getting enough milk when her baby is:

- Not visibly thin (or is getting fatter/putting on weight, if he or she was thin earlier).
- Responsive and active (appropriate for age).
- Gaining weight. Refer to the baby's health card (or growth velocity table if available). If you are not sure if the weight gain is adequate, refer the child to the nearest health facility.

Session 3. Recommended infant and young child feeding practices and breastfeeding beliefs

- Passing light-colored urine six times a day or more. (However, one cannot use this sign if the baby is being given water, oral rehydration salts, or other liquids as well as breastmilk.)

Learning objective 3: Distinguish between beliefs that are beneficial to breastfeeding and beliefs that should be discouraged, and discuss what can be done to address these beliefs

Methodology: Brainstorming

Instructions for activity

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

Key information

Some breastfeeding beliefs and myths may have a negative effect on good breastfeeding practices—beliefs may differ according to area/region. The following are TRUE statements. Are there related beliefs or myths from your area?

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

Note: Another barrier to recommended infant and young child feeding practices is the impact of breastmilk substitutes that are marketed in your communities.

Learning objective 4: Discuss food taboos during pregnancy and lactation

Methodology: Brainstorming

Instructions for activity

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

Key information

Food beliefs may differ according to area/region. The following statements are TRUE. Are there corresponding food beliefs in your area?

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

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

Session 4. Assessing a breastfeed

Learning objectives
1. Explain the key points of attachment and review the Breastfeed Observation Job Aid
2. Assess a breastfeed by observing a mother and baby
3. Recognize signs of good and poor attachment and positioning, and practice using the Breastfeed Observation Job Aid

Materials

- Model breast and or dolls to demonstrate (instructions for making models are provided below)
- Copies of the Breastfeed Observation Job Aid
- Slides of babies breastfeeding
- Flip chart paper and stand, markers, tape/sticky putty

Duration: 60 min

Learning objective 1: Explain the key points of attachment and review the Breastfeed Observation Job Aid

Methodology: Discussion

Instructions for activity

1. Begin discussion with the group and make these points:
 - Assessing a breastfeed helps you to decide if a mother needs help or not, and how to help her.
 - You can learn a lot about how well or badly breastfeeding is going by observing, before you ask questions.
 - There are some things you can observe when a baby is not breastfeeding. Other things you can only observe if a baby is breastfeeding.
2. List the key points of attachment, including ensuring that:
 - The breasts are in good health.
 - The baby's position is correct.
 - The baby's attachment of mouth on the breast is good.
 - The way the baby is suckling allows proper milk flow.
3. Display the Breastfeed Observation Job Aid and make the following points:
 - This form will help you to remember what to look for when you assess a breastfeed.
 - The form is arranged in five sections: general, breasts, baby's position, baby's

attachment, suckling.

- The signs on the left all show that breastfeeding is going well. The signs on the right indicate a possible difficulty.
- Beside each sign is a box to mark with a tick if you have seen the sign in the mother that you are observing.
- As you observe a breastfeed, mark a tick in the box for each sign that you observe. If you do not observe a sign you should make no mark.
- When you have completed the form, if all the ticks are on the left side of the form, breastfeeding is probably going well. If there are some ticks on the right side, then breastfeeding may not be going well. This mother may have a difficulty and she may need your help.

How to make a model doll

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

How to make a model breast

- *Use a pair of near skin-colored socks, or stockings, or an old sweater or t-shirt.*
- *Make the cloth into a round bag shape, and stuff it with other cloth or foam rubber to make it breast shaped.*
- *Stitch a 'purse string' around a circle in the middle of the breast to make a nipple.*
- *Stuff the nipple with foam or cotton.*
- *Color the areola with felt pen. You can also push the nipple in, to make an 'inverted' nipple.*
- *If you wish to show the inside structure of the breast, with the larger ducts, make the breast with two layers, for example with two socks. Sew the nipple in the outer layer, and draw the large ducts and ducts on the inside layer. You can remove the outer layer with the nipple to reveal the inside structure.*

Learning objective 2: Assess a breastfeed by observing a mother and baby

Methodology: Role-play

Instructions for activity

1. Conduct a role-play for observing breastfeeding; explain the Breastfeed Observation Job Aid during and after the role-play (see below).
2. Summarize and discuss.

Role-play instructions

Ask two participants to play the roles of mothers in the following demonstration:

- **Mother A (name)** sits comfortably and relaxed, and acts being happy and pleased with her baby. She holds baby close, facing her breast, and she supports his whole body. She looks at her baby, and fondles or touches him lovingly. She supports her breast with her fingers against her chest wall below her breast, and her thumb above, away from the nipple.
- **Mother B (name)** sits uncomfortably, and acts being sad and not interested in her baby. She holds baby loosely, and not close, with his neck twisted, and she does not support his whole body. She does not look at him or fondle him, but she shakes or prods him a few times to make him go on breastfeeding. She uses a scissor grip to hold her breast.

Key information

- When using the Breastfeed Observation Job Aid, ensure that the participants are clear about which point you are referring to.
- Look at the mother to see if she looks well. Her expression may tell you something about how she feels. For example, she may be in pain.
- Observe whether the mother looks relaxed and comfortable. If a mother holds her baby securely and feels confident, it is easier for her baby to suckle effectively, and her milk will flow more easily. If a mother is nervous and lacks confidence, she may show this by shaking or prodding the baby to make him go on feeding. This can upset her baby and interfere with suckling and breastmilk flow.
- Observing how a mother interacts with her baby while feeding is important. Remember from the last session that if a mother feels good about breastfeeding, this will help her milk to flow (help the oxytocin reflex).
- Look at the baby's general health, nutrition, and alertness. Look for conditions that may interfere with breastfeeding: e.g., a blocked nose or difficult breathing.
- Notice whether the breasts look healthy. You may notice a cracked nipple or see that the breast is inflamed. We will talk about breast conditions in more detail later in the course.
- If breastfeeding feels comfortable and pleasant for the mother, her baby is probably well attached. Ask a mother how breastfeeding feels.
- Notice how the mother is holding her breast.

Demonstrate the following points with a model breast and doll, or on your own body:

- How a mother holds her breast during feeding is important.

- Does the mother lean forward and try to push the nipple into the baby's mouth, or does she bring her baby to the breast, supporting her whole breast with her hand?
- Does she hold the breast close to the areola? This makes it more difficult for a baby to suckle. It may also block the milk ducts so that it is more difficult for the baby to get the breastmilk.
- Does the mother hold her breast back from her baby's nose with her finger? This is not necessary.
- Does the mother use the 'scissor' hold (holding the nipple and areola between her index finger above and middle finger below). This can make it more difficult for a baby to take enough breast into his mouth.
- Does the mother support her breast in the recommended way:
 - With her fingers against the chest wall.
 - With her first finger supporting the breast.
 - With her thumb above, away from the nipple.

Participant materials 4.1: Breastfeed observation job aid

THE BREASTFEED OBSERVATION JOB AID

Mother's name _____ Date _____

Baby's name _____ Baby's age _____

Signs that breastfeeding is going well:

Signs of possible difficulty:

GENERAL*Mother:*

- ☐ Mother looks healthy
- ☐ Mother relaxed and comfortable
- ☐ Signs of bonding between mother and baby

Mother:

- ☐ Mother looks ill or depressed
- ☐ Mother looks tense and uncomfortable
- ☐ No mother/baby eye contact

Baby:

- ☐ Baby calm and relaxed
- ☐ Baby reaches or roots for breast if hungry

Baby:

- ☐ Baby is restless or crying
- ☐ Baby does not reach or root

BREASTS

- ☐ Breasts look healthy
- ☐ No pain or discomfort
- ☐ Breast well supported with fingers

- ☐ Breasts look red, swollen, or sore
- ☐ Breast or nipple painful
- ☐ Breast held with fingers on areola away from nipple

BABY'S POSITION

- ☐ Baby's head and body in line
- ☐ Baby held close to mother's body
- ☐ Baby's whole body supported
- ☐ Baby approaches breast, nose to nipple

- ☐ Baby's neck and head twisted to feed
- ☐ Baby not held close
- ☐ Baby supported by head and neck only
- ☐ Baby approaches breast, lower lip/chin to nipple.

BABY'S ATTACHMENT

- ☐ More areola seen above baby's top lip
- ☐ Baby's mouth open wide
- ☐ Lower lip turned outwards
- ☐ Baby's chin touches breast

- ☐ More areola seen below bottom lip
- ☐ Baby's mouth not open wide
- ☐ Lips pointing forward or turned in
- ☐ Baby's chin not touching breast

SUCKLING

- ☐ Slow, deep sucks with pauses
- ☐ Cheeks round when suckling
- ☐ Baby releases breast when finished
- ☐ Mother notices signs of oxytocin reflex

- ☐ Rapid shallow sucks
- ☐ Cheeks pulled in when suckling
- ☐ Mother takes baby off the breast
- ☐ No signs of oxytocin reflex noticed

Ask the other participants to start observing the 'mothers and babies'. (Do not let this role-play last more than 2 minutes). As they are observing ask what they have observed from the first two sections of the BREASTFEED OBSERVATION JOB AID.

Explain: Baby's position

- Observe how the mother holds her baby. Notice if the baby's head and body are in line.
- Notice if she holds the baby close to the breast and facing it, making it easier for the baby to suckle effectively. If she holds the baby loosely, or turned away so that his/her neck is twisted, it is more difficult for the baby to suckle effectively.
- If the baby is young, observe whether the mother supports the baby's whole body or only his/her head and shoulders.

Explain: Baby's attachment

Ask one participant to read aloud the points in the fourth section of the Breastfeed Observation Job Aid (baby's attachment), first reading the point from the left column and then the corresponding point from the right column.

Explain: Suckling

Ask one participant to read aloud the points in the fifth section of the Breastfeed Observation Job Aid (suckling), first reading the point from the left column and then the corresponding point from the right column. These points will not have been observed during the role-play with the doll.

Make the following points:

- Look and listen for the baby taking slow deep sucks. This is an important sign that the baby is getting breastmilk and is suckling effectively. If a baby takes slow deep sucks then he or she is probably well attached.
- If the baby is taking quick shallow sucks all the time, this is a sign that the baby is not suckling effectively.
- If the baby is making smacking sounds as he or she sucks, this is a sign that the baby is not well attached.
- Notice whether the baby releases the breast him/herself after the feed, and looks sleepy and satisfied.
- If a mother takes the baby off the breast before the baby has finished, for example, when the baby pauses between sucks, he or she may not get enough hindmilk.

Learning objective 3: Recognize signs of good and poor attachment and positioning, and practice using the Breastfeed Observation Job Aid

Methodology: Discussion and practice

Instructions for activity

1. Show and discuss slides of babies breastfeeding.
2. Notes for the facilitator:
 - You will practice recognizing the signs of good and poor attachment that the

slides show, and you will practice using the Breastfeed Observation Job Aid. Some slides also show signs of good and poor positioning.

- You will not be able to see all of the signs in the slides. For example, you cannot see signs with movement in slides.
 - Observe the signs that are clear, and do not worry about signs that you cannot see.
 - However, when you see real mothers and babies, you should look for all the signs.
3. As you look at each slide:
 - Decide which signs of good or poor attachment you see.
 - Decide if you think the baby's attachment is good or poor.
 - Notice if there are any signs of good or poor positioning shown.
 4. Ask a different participant to come forward for each of the slides. As you show each slide:
 - Ask: What do you think of this baby's attachment (and positioning, if signs are visible)? Give the participant at the screen a few moments to study the picture, and to describe and point to the signs that she sees. Then ask other participants to describe the signs that they see.
 - Then point out any signs that they have missed. Try not to repeat signs that they have already mentioned.
 5. The text below lists the signs that each slide illustrates particularly well, and that can help the observer to make a decision. Try to encourage participants to go through the four key points of attachment first and then to list points from the other sections of the Breastfeed Observation Job Aid. This will help them to think more systematically as they assess a breastfeed.
 6. Participants may describe more signs than are given in the text. There are other signs in the slides, but most of them are not very helpful. Accept participants' observations, or gently correct them if they are incorrect.
 7. Have participants practice using the Breastfeed Observation Job Aid and assess breastfeeding on the last two slides.
 8. Summarize and discuss.

Show and discuss slides of babies breastfeeding

Slide 1

- Signs that you can see clearly are:
 - There is more areola above the baby's top lip than below the bottom lip.
 - The baby's mouth is quite wide open.
 - The baby's lower lip is turned outward.
 - The baby's chin is almost touching the breast.
- These signs show that the baby is well attached to the breast.
- In addition, the baby is close to the breast and facing it.
- The baby is breathing quite well without the mother holding her breast back with her finger.



Slide 2

- Signs that you can see clearly are:
 - There is as much areola below the baby's bottom lip as above the top lip.
 - The baby's mouth is not wide open and the lips point forward.
 - The baby's chin is not touching the breast.
- This baby is poorly attached to the breast.
- The baby's body is not close to the mother's body.
- This mother's areola is very large, so it is likely that you would see a lot of it even if her baby was well attached. However, you should see more above the baby's top lip than below the bottom lip.



Slide 3

- Signs that you can see clearly are:
 - The baby's mouth points forward.
 - The baby's chin is not touching the breast.
 - This baby is poorly attached.
- In addition, his cheeks are pulled in when suckling.
- The mother is holding her breast with the 'scissor hold' (between index and middle fingers).



Slide 4

- Signs that you can see clearly are:
 - There is more areola above the baby's top lip than below the bottom lip.
 - The baby's mouth is quite wide open.
 - The lower lip is turned in and not outward.
 - The baby's chin is touching the breast.
- His lower lip is turned in. His head and body are straight and he is facing the breast.
- Even if some of the signs are not bad, this baby is not well attached.



Slide 5

- Signs that you can see clearly are:
 - There is as much or more areola below the baby's mouth as above it.
 - The baby's mouth is not wide open; the lips point forward.
 - The baby's chin is not touching the breast.
- This baby is poorly attached.
- The baby looks as though he/she is feeding from a bottle.
- In addition the baby is twisted and is not close to the breast.



Slide 6

- Signs that you can see are:
 - There is a little areola above the baby's top lip.
 - The baby's chin is touching the breast.
- The baby is very close to the breast, making it difficult to see many other signs.
- This baby is well attached.
- Additional point: this is the same baby as in the previous slide, after the health worker has helped the mother to position the baby better. In a better position a baby can attach more easily.



Practice using the Breastfeed Observation Job Aid

With the next two slides, you will use your observations to practice filling in the Breastfeed Observation Job Aid.

- Each participant should have two copies of the form. Fill in one form for each slide.
- If you see a sign, make an **X** in the box next to the sign. If you do not see a sign, leave the box empty.
- Concentrate on the sections on baby's position and attachment. However, when you see mothers and babies in the practical sessions, you should fill in all sections of the form. Remember, you may not see all the signs with every baby.

Ask all the trainers to help. They should circulate and make sure that participants understand what to do. They should give individual feedback on participants' observations of the slides.

Show **Slides 7 and 8** for about 5 minutes each.



Further information

- If a mother says that breastfeeding is going well, but you see signs that indicate a possible difficulty, you must decide what to do.
- In the days soon after delivery, while the mother is still learning, you may want to offer to help her. Even if she is not aware of any difficulty now, you may prevent one occurring later.
- If breastfeeding seems to be well established, you probably do not want to intervene immediately. It is usually more helpful to see her again soon, and follow the baby's growth, to make sure that breastfeeding continues to go well. Intervene only if a difficulty arises.

Session 5. Counseling a mother on how to best feed her infant

Learning objectives
1. Explain the key points of positioning and describe how a mother should support her breast for feeding
2. Demonstrate the main positions: sitting, lying, underarm, and across, and help a mother position her baby at the breast
3. List ways to establish and maintain breastmilk supply
4. Describe hand-expression and storage of breastmilk and how to cup feed
5. Describe how to maintain good hygienic practices when feeding the baby

Materials

- Model breast and or dolls to demonstrate
- Copies of the Breastfeed Observation Job Aid
- Slides of babies breastfeeding
- Flip chart paper and stand, markers, tape/sticky putty

Preparations

At the beginning of the session ask participants to arrange their seats so that they are sitting in a half circle, without tables or other obstruction in front of them. Put a seat for yourself to sit with the participants, so that you do not stand up in front to lecture.

The demonstrations in this session need a lot of practice if they are to be effective. One trainer leads the session. Another trainer helps with the demonstration of helping a mother who is sitting and lying. If you do not have ready-made models, you will need to make model dolls (see the section in Session 4 describing this process).

The day before the demonstration:

- Ask a trainer to help you with the demonstration.
- Explain that you want her to role-play a mother who needs help to position her baby. Ask her to decide on names for herself and her baby. She can use her real name if she likes.
- Explain what you want to happen as follows:
 - You will demonstrate how to help a mother who is sitting.
 - She will sit holding the doll in the common way, with the doll across the front.
 - You will greet her and ask how breastfeeding is going, and she will say that it is painful and that she has sore nipples.
 - You will ask her to 'breastfeed' the doll, while you observe.
 - She will hold it in a poor position: loosely, supporting only its head, with its body away from hers, so that she has to lean forward to get her breast to its

mouth. She will pretend that breastfeeding is painful. You will then help her to sit more comfortably and to improve the doll's position.

- When the position is better, she should say “Oh! That feels better,” and look happier. She can rub the other breast, to show that now she is feeling the milk flowing (let down or ejection reflex).
- You will demonstrate how to help a mother who is lying down.
 - She will lie down, propped on her arm, with the doll far from her body, loosely held on the bed.
 - Practice giving the demonstration with the participant, so that you know how to follow the steps.
 - Decide the ‘comfortable’ position that you will help her to lie in.
 - Ask her to wear clothes such as a long skirt or trousers so that she feels comfortable lying down for this demonstration.
 - Find a cloth to cover the table, and a cloth to cover the ‘mother’s’ legs. Find some pillows if these are appropriate in this community.
- Early on the day of the demonstration, arrange chairs, a footstool, and a bed (or a table that can be used for a bed) to demonstrate breastfeeding lying down.

Duration: 60 min

Learning objective 1: Explain the key points of positioning and describe how a mother should support her breast for feeding

Methodology: Discussion and role-play

Instructions for activity

1. Ask participants to refer to the participant materials 4.1 for the Breastfeed Observation Job Aid.
2. Make these points:
 - We are going to learn how to position a baby at the breast.
 - We will be using the four key points from the section on ‘positioning’ on the Breastfeed Observation Job Aid.
 - There are several steps to follow when helping a mother to position her baby at the breast.
 - Discuss the points on “How to help a mother to position her baby.”

How to help a mother to position her baby

- Greet the mother and ask how breastfeeding is going.
- Observe and assess a breastfeed.
- Explain what might help, and ask if she would like you to show her.
- Make sure that she is comfortable and relaxed.
- Sit down yourself in a comfortable, convenient position.
- Explain how to hold her baby, and show her if necessary.

The four key points about positioning are:

1. Baby's head and body in line.
2. Baby held close to mother's body.
3. Baby's whole body supported.
4. Baby approaches breast, nose to nipple.

Show her how to support her breast:

- With her fingers against her chest wall below her breast.
- With her first finger supporting the breast.
- With her thumb above the breast.
- Her fingers should not be too near the nipple.

Explain or show her how to help the baby to attach:

- Touch her baby's lips with her nipple.
- Wait until her baby's mouth is opening wide.
- Move her baby quickly onto her breast, aiming the baby's lower lip below the nipple.
- Notice how she responds and ask her how her baby's suckling feels.
- Look for signs of good attachment. If the attachment is not good, try again.

Additional points for discussion

- Always assess a mother breastfeeding before you help her, using the points from the Breastfeed Observation Job Aid.
- In Session 4 we talked about the importance of observing a mother interacting with her baby and breastfeeding. Take time to see what she does, so that you can understand her situation clearly. Do not rush to make her do something different.
- Give a mother help only if she has difficulty. Some mothers and babies breastfeed satisfactorily in positions that would make difficulties for others.
- This is especially true with babies more than about two months old. There is no point trying to change a baby's position if he or she is getting breastmilk effectively, and the mother is comfortable.
- Let the mother do as much as possible herself. Be careful not to 'take over' from her. Explain what you want her to do. If possible, demonstrate on your own body to show her what you mean.
- Make sure that she understands what you do so that she can do it herself. Your aim is to help her to position her own baby. It does not help if you can get a baby to suckle, if the baby's mother cannot.

Learning objective 2: Demonstrate the main positions: sitting, lying, underarm, and across, and help a mother position her baby at the breast

Methodology: Demonstration and discussion

Instructions for activity

1. Demonstrate how to help a mother to position her baby (ask one of the other trainers to play the role of the mother).
2. Make these points:
 - We are going to learn how to position a baby at the breast.
 - We will be using the four key points from the section on ‘positioning’ on the Breastfeed Observation Job Aid.
 - There are several steps to follow when helping a mother to position her baby at the breast.
 - Discuss the points in the section above called “How to help a mother to position her baby.”
3. Demonstrate various positions for breastfeeding.
4. Have participants practice supporting breastfeeding in each of the positions.
5. Summarize and discuss.

Role-play instructions for helping a mother to position her baby

Greet the mother and ask how breastfeeding is going—When you have greeted the ‘mother’ and asked how breastfeeding is going, the ‘mother’ should respond by saying that breastfeeding is painful.

Assess a breastfeed—Ask if you may see how (child’s name) breastfeeds, and ask the ‘mother’ to put the baby to her breast in the usual way. She holds him loosely, away from her body, with his neck twisted (as you practiced). Observe her breastfeeding for a few minutes.

Explain what might help and ask if she would like you to show her—Say something encouraging like: “He really wants your breastmilk, doesn’t he?”

Then say: “Breastfeeding might be less painful if (child’s name) took a larger mouthful of breast when he suckles. Would you like me to show you how?” If she agrees, you can start to help her.

Make sure that she is comfortable and relaxed—Make sure the ‘mother’ is sitting in a comfortable and relaxed position (as you decided when you practiced this demonstration beforehand).

Sit down yourself, so that you are also comfortable and relaxed, and in a convenient position to help. You cannot help a mother satisfactorily if you are in an awkward or uncomfortable position yourself or if you are bending over her.

Demonstrate the following points to the participants using a doll, a high chair, a low chair, and a stool. Make sure the following points are clear:

- A low seat is usually best, and if possible one that supports the mother's back.
- If the seat is rather high, find a stool for her to put her feet onto. However, be careful not to make her knees so high that her baby is too high for her breast.
- If she is sitting on the floor, make sure that her back is supported.
- If she supports her baby on her knee, help her to hold the baby high enough so that she does not lean forward to put him onto her breast.

Explain how to hold her baby, and show her if necessary—Demonstrate how to help the mother to position her baby, making sure that the four key points of positioning are clear to the mother and to the participants.

When you have finished helping the 'mother' to position her baby, make these points to the participants, using a doll to demonstrate:

These four key points are the same as the points that you learned to observe in the Breastfeed Observation Job Aid.

For point 1: Baby's head and body in line: A baby cannot suckle or swallow easily if his or her head is twisted or bent.

For point 2: Baby held close to mother's body: A baby cannot attach well to the breast if he or she is far away from it. The baby's whole body should almost face the mother's body. The baby should be turned away just enough to be able to look at her face. This is the best position for the baby to take the breast, because most nipples point down slightly. If the baby faces the mother completely, he or she may fall off the breast.

For point 3: Baby supported: The baby's whole body is supported with the mother's arm along the baby's back. This is particularly important for newborns and young babies. For older babies, support of the upper part of the body is usually enough. A mother needs to be careful about using the hand of the same arm, which supports her baby's back, to hold his bottom. Holding his bottom may result in her pulling him too far out to the side, so that his head is in the crook (bend) of her arm. He then has to bend his head forward to reach the nipple, which makes it difficult for him to suckle.

For point 4: Baby approaches breast, nose to nipple: We will talk about this a little later when we discuss how to help a baby to attach to the breast.

Try not to touch the mother or baby if possible. But if you need to touch them to show the mother what to do, put your hand over her hand or arm, so that you hold the baby through her.

Show her how to support her breast—Demonstrate how to help the mother to support her breast. When you have finished helping the 'mother' to support her breast, make these points to the participants, demonstrating on your own body or on a model breast:

- It is important to show a mother how to support her breast with her hand to offer it to her baby.

- If she has small and high breasts, she may not need to support them.
- She should place her fingers flat on her chest wall under her breast, so that her first finger forms a support at the base of the breast.
- She can use her thumb to press the top of her breast slightly. This can improve the shape of the breast so that it is easier for her baby to attach well.
- She should not hold her breast too near to the nipple.
- Holding the breast too near the nipple makes it difficult for a baby to attach and suckle effectively. The ‘scissor’ hold can block milk flow.

Demonstrate to participants these ways of holding a breast, and explain that they make it difficult for a baby to attach:

- Holding the breast with the fingers and thumb close to the areola, pinching up the nipple or areola between your thumb and fingers, and trying to push the nipple into a baby’s mouth.
- Holding the breast in the ‘scissor’.

Explain or show her how to help the baby to attach—Demonstrate how to help the ‘mother’ to attach her baby.

When you have finished helping the ‘mother’ to attach her baby, make these points to the participants, using a doll and your own body or a model breast:

- Explain that she first holds the baby with his nose opposite her nipple, so that he approaches the breast from underneath the nipple.
- Explain how she should touch her baby’s lips with her nipple, so that he opens his mouth, puts out his tongue, and reaches up.
- Explain that she should wait until her baby’s mouth is opening wide, before she moves him onto her breast. His mouth needs to be wide open to take a large mouthful of breast.
- It is important to use the baby’s reflexes, so that he opens his mouth wide to take the breast himself. You cannot force a baby to suckle, and she should not try to open his mouth by pulling his chin down.
- Explain or show her how to quickly move her baby to her breast, when he is opening his mouth wide.
- She should bring her baby to her breast. She should not move herself or her breast to her baby.
- As she brings the baby to her breast, she should aim her baby’s lower lip below her nipple, with his nose opposite the nipple, so that the nipple aims toward the baby’s palate, his tongue goes under the areola, and his chin will touch her breast.
- Hold the baby at the back of his shoulders—not the back of his head. Be careful not to push the baby’s head forward.

Notice how she responds and ask her how her baby’s sucking feels—Ask the ‘mother’ how she feels. She should say something like “Oh, much better, thank you.” Then explain to the participants:

- Notice how the mother responds.
- Ask the mother how suckling feels.
- If suckling is comfortable for the mother, and she looks happy, her baby is probably well attached.

Look for signs of good attachment; if the attachment is not good, try again—Make these points to the participants:

- Look for all the signs of good attachment (which you cannot see with a doll). If the attachment is not good, try again.
- It often takes several tries to get a baby well attached. You may need to work with the mother again at a later time, or the next day, until breastfeeding is going well.
- Make sure that the mother understands about her baby taking enough breast into his mouth.
- If she is having difficulty in one position, try to help her to find a different position that is more comfortable for her.

Demonstrate these positions using a doll:

A mother holding her baby in the underarm position	A mother holding her baby in the cradle position	A mother holding her baby with the arm opposite the breast
Useful for: - twins - blocked duct - difficulty attaching the baby	Useful for: - most normal babies	Useful for: - very small babies - sick babies

How to help a mother who is lying down—Ask the other trainer who is helping to lie in the way that you practiced. The ‘mother’ should lie down propped on one elbow, with the doll far from her body, loosely held on the bed.

Demonstrate helping the ‘mother’ to lie down in a comfortable, relaxed position. Explain that the same steps are followed in the box “How to help a mother to position her baby,” shown earlier in this session.

During or after the demonstration make these points clear to participants:

- To be relaxed, the mother needs to lie down on her side in a position in which she can sleep. Being propped on one elbow is not relaxing for most mothers.
- If she has pillows, a pillow under her head and another under her chest may help.
- Exactly the same four key points on positioning are important for a mother who is lying down.
- She can support her baby with her lower arm. She can support her breast if necessary with her upper arm.
- If she does not support her breast, she can hold her baby with her upper arm.

Session 5. Counseling a mother on how best to feed her infant

- A common reason for difficulty attaching when lying down is that the baby is too ‘high’ (near the mother’s shoulders), and his head has to bend forward to reach the breast.
- Breastfeeding lying down is useful:
 - When a mother wants to sleep, so that she can breastfeed without getting up .
 - Soon after a Caesarian section, when lying on her back or side may help her to breastfeed her baby more comfortably.

Emphasize the following:

- There are many other positions in which a mother can breastfeed.
- In any position, the important thing is for the baby to take enough of the breast into his mouth so that he can suckle effectively.

Classroom practical: Positioning a baby using dolls

Divide the participants into small groups of three to four participants with one trainer. Each group will need one doll. The participants should take it in turns to be the ‘counselor,’ the ‘mother,’ and ‘observers.’ The ‘mother’ should pretend to be having difficulties positioning her baby. Encourage the participants to practice all the skills they have learned so far.

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

Methodology: Brainstorming

Instructions for activity

1. Ask participants to name ways to help establish and maintain breastmilk supply.
2. Fill in gaps from ‘Key information’ below.
3. Discuss and summarize.

Key information

- Place mother and baby skin-to-skin immediately after birth. Don't wash mother's breasts or baby's hands so that baby can locate the breasts by smell (as well as by sight of the areola).
- Breastfeed as soon after birth as the baby is ready. The baby may move and attach her/himself to the breast.
- Ensure good attachment (four signs)
- 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 6 months.
- Keep the baby close or skin-to-skin so that the mother can breastfeed whenever baby wants for as long as he or she wants.
- Breastfeed at night as well as during the day.
- 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 health extension or community health worker/volunteer: 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; practice

Instructions for activity

1. Ask participants to state the reasons why a mother might need to express her breastmilk; write the reasons on flip chart.
2. Demonstrate milk-expression technique using a breast model.
3. Using the breast model, participants "practice" 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. Ask groups of three to "practice" cup-feeding technique.
6. Have the same groups of three review **CC 14: What to do when separated from your baby.**
7. Ask two participants to describe what they observe. Fill in gaps from 'Key information' below.
8. Discuss and summarize.

Counseling card 14: What to do when separated from your baby



If you have to be away from your baby because of work or social responsibilities, there are some things you can do to continue to provide breastmilk for your 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 use a clean, open cup to feed your baby while you are away, and make sure they know the importance of washing the cup and other containers properly, and also of washing their hands with soap before they feed the baby.
- Remember, expressed breastmilk (stored in a cool, covered place) stays in good condition for 8 hours, even in a hot climate.
- 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 breastfeeding more during the night and on weekends.
- If possible, carry the baby with you any time 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.

Key information

A mother may need to express milk for her baby because:

- Baby is too weak or small to suckle effectively.
- Baby is taking longer than usual to learn to suckle, for example because of inverted nipples.
- To feed a low-birth-weight baby who cannot breastfeed.
- 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 work place (or anytime you have to go out of the home for more than a few hours). If this is not possible, consider having someone bring the baby to you to breastfeed when you have a break.
- Get extra support from family members in caring for your baby and other children, and for doing household chores.

Learning objective 5: Describe how to maintain good hygienic practices when feeding the baby

Methodology: Brainstorming

Instructions for activity

1. Ask participants to discuss what it means to 'prepare foods hygienically.'
2. Explore how surfaces can get contaminated and how to keep them clean.
3. Write statements on flip chart, making sure all points are included.
4. Have participants review **CC 18: Hygiene**, and have two participants read the back of the card out loud.
5. Discuss and summarize.

Counseling card: Hygiene



Prepare your child's food in a clean way—on clean surfaces and in clean pots, plates, and cups. Feed your child using a clean cup/plate and spoon or your washed hands.

Wash your hands with water and soap or ash:

- Before preparing food for the baby or the family.
- Before feeding the baby.
- After cleaning the baby.
- After using the toilet.

Wash your child's hands with water and soap or ash before the child eats. Feed your child by cup and spoon or clean hands. Avoid using bottles and teats; they are difficult to clean and easily carry germs that can cause diarrhea and other illnesses that can make your child sick. Cover your child's food and keep it in a clean place. Prepare fresh food for every feed.

Key information

Five keys to safer food are:

1. Keep clean (hands, working surfaces, utensils).
2. Separate raw foods 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.

Session 6. How to counsel: listening and learning

Learning objectives
1. Understand counseling; list and explain the basic listening and learning skills
2. Explain why changing behavior is difficult
3. Reflect on role of men in maternal and child nutrition

Materials

- Flip chart papers and stand, markers, tape/sticky putty
- Prepared flip chart with drawings of “behavior change steps”(without words)
- Copies of demonstrations

Preparation

- You need two boards or flip charts to make two summary lists. If it is difficult to get two flip charts or boards, stick flip chart sheets to the wall. Make sure that participants can see them. Make sure you are clear about the lists that will go onto each flip chart.
- Make copies of Demonstrations 6.B to 6.O. (An alternative would be to use another copy of this guide).
- Ask different participants to help you to give the demonstrations. Explain what you want them to do. One way to involve several participants is to use a different participant for each skill.
- For Demonstrations 6.B to 6.G, the participants read out the words of the mother. For Demonstrations 6.H to 6.O, the participants read out the words of the mother and the health worker.
- For Demonstrations 6.A, the participant sits and breastfeeds a doll while you demonstrate different ways of talking to her. She can respond to your greetings, but need not say anything else. Discuss and agree with her before the demonstration what you intend to do to demonstrate ‘appropriate touch’ and ‘inappropriate touch.’
- Give each of the participants a copy of the demonstrations that she has to read.
- If it is difficult for participants to help with the demonstrations for some reason, another trainer can play the part of the mother. However, try to involve participants as much as possible because it helps them to learn.
- On flip chart, draw “behavior change steps” (without words).
- Facilitators practice demonstration of infant and young child feeding assessment of mother/child pair (listening and learning skills)
- Facilitators practice demonstrations of listening and learning skills.
- Prepare flip chart: Listening and learning skills
- Prepare flip chart: Role of fathers/men in the nutrition of their wives/partners and infants/children.

Duration: 120 min

Learning objective 1: Understand counseling; list and explain the basic listening and learning skills

Methodology: Brainstorming; demonstrations

Instructions for activity

Brainstorm the definition of counseling

1. Ask all participants how they would define ‘counseling.’
2. Write the responses from the group on the flip chart.
3. Add the following points to the discussion:
 - Counseling is a way of working with people in which you try to understand how they feel and help them to decide what they think is best to do in their situation.
 - In this course we look at counseling mothers who are feeding infants and young children. They may be breastfeeding or giving complementary foods.
 - Although we talk about ‘mothers’ in this session, remember that these skills should be used when talking about infant feeding to other caregivers, such as fathers or grandmothers.
 - Counseling mothers about feeding their infants is not the only situation in which counseling is useful.
 - Counseling skills are useful when you talk to patients or clients in other situations. You may also find them helpful with your family and friends, or your colleagues at work. Practice some of the techniques with them—you may find the result surprising and helpful.
4. Stress the following points:
 - In this session we will discuss counseling of mothers who are breastfeeding. A mother may not talk easily about her feelings, especially if she is shy, and with someone whom she does not know well. You will need the skill to listen and to make her feel that you are interested in her. This will encourage her to tell you more. She will be less likely to ‘turn off’ and say nothing.
5. Demonstrate ‘listening and learning’ skills (see key points below).
 - Skill 1: Use helpful nonverbal communication.
 - Skill 2: Ask open questions.
 - Skill 3: Use responses and gestures that show interest.
 - Skill 4: Reflect back what the mother says.
 - Skill 5: Empathize: show that you understand how she feels.
 - Skill 6: Avoid words that sound judging.
6. Discuss and summarize as a group what was learned.

Key information

Demonstration of listening and learning skills

- Tell participants that in this session you will explain and demonstrate six skills for listening and learning.
- Write the heading ‘Listening and learning skills’ on a board or flip chart with room for a list of six points below it (Flip chart 1). Write the six skills underneath as you

demonstrate them.

Skill 1. Use helpful nonverbal communication

- Write ‘Use helpful nonverbal communication’ on the list of listening and learning skills (Flip chart 1).
- Write ‘Helpful nonverbal communication’ on **another** board or flip chart with room for a list of five points below it (Flip chart 2).

Explain the skill

Ask the group: What do you think we mean by ‘nonverbal communication’?

Wait for a few replies and then continue: Nonverbal communication means showing your attitude through your posture, your expression, everything except through speaking.

Demonstrate the skill

- Tell participants that you will demonstrate five different kinds of nonverbal communication.
- Ask the participant whom you have prepared to help you. She sits with a doll, pretending to be a mother. She can respond to your greeting, but she does not have to say anything else. It is important that you say the **same** words, in the **same** tone of voice, with each demonstration. It is tempting to change your tone of voice to sound kinder in the demonstration that shows ‘helpful nonverbal communication.’ However, this will confuse the participants, who may start to comment on verbal instead of nonverbal communication.
- Give the five pairs of demonstrations in Demonstration 6.A. With each pair, you approach the ‘mother’ in two ways—one way helps communication and the other way hinders communication. Demonstrate the way that helps sometimes first, and sometimes second, so that the participants who are observing cannot guess which is which just from the order of the demonstrations. Demonstrate ‘appropriate touch’ (socially acceptable) and ‘inappropriate touch’ (not socially acceptable) in the way that you agreed with the participant before the session.
- Ask other participants to:
 - Identify the form of nonverbal communication that you demonstrate. Say which form helps communication and which hinders it.

Demonstration 6.A: Nonverbal communication

With each demonstration say **exactly the same** few words, and try to say them in the same way, for example: *“Good morning, Susan. How is feeding going for you and your baby?”*

1. Posture:

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

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

- Write ‘Keep your head level’ on the flip chart (Flip chart 2).

2. Eye contact:

Helps: Look at her and pay attention as she speaks.

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

- Write ‘Pay attention’ on the flip chart.

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

3. Physical barriers:

Helps: Remove the table or the notes.

Hinders: Sit behind a table, or write notes while you talk.

- Write ‘Remove barriers’ on the flip chart.

4. Taking time:

Helps: Make her feel that you have time. Sit down and greet her without hurrying; then just stay quietly smiling at her, watching her breastfeed, and waiting for her to answer.

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

- Write ‘Take time’ on the flip chart.

5. Touch:

Helps: Touch the mother appropriately.

Hinders: Touch her in an inappropriate way.

- Write ‘Touch appropriately’ on the flip chart.

(Note: If you cannot demonstrate an inappropriate touch, simply demonstrate not touching.)

Discuss appropriate touch in this community

Ask: What kinds of touch are appropriate and inappropriate in this situation in this community? Does touch make a mother feel that you care about her? For a man, if it is not appropriate to touch the woman, is it appropriate to touch the baby?

Wait for a few replies and then continue.

You now have the following list written on Flip chart 2. Post it on the wall.

Helpful nonverbal communication

Keep your head level

Pay attention

Remove barriers

Take time

Touch appropriately

- Our nonverbal communication often demonstrates to a mother or caregiver our approval or disapproval of a situation. We should be careful to avoid allowing our own views on certain subjects, e.g., religion, to be expressed in a counseling situation where it might appear as though we are judging a mother.

Introduce Skills 2 through 6 by making the following points

- The next skills deal with what we say to mothers. In other words, ‘verbal communication.’
- Remember that the tone of our voice is important during verbal communication. We should always try to sound gentle and kind when talking to mothers.
- During counseling we are trying to find out how people feel. We need to be interested and to probe beneath the surface if we wish to learn their real worries and their concerns.

Skill 2. Ask open questions

Write ‘Ask open questions’ on the list of listening and learning skills (Flip chart 1).

Explain the skill

- To start a discussion with a mother, or to take a history from her, you need to ask some questions.
- It is important to ask questions in a way that encourages a mother to talk to you and to give you information. This saves you from asking too many questions, and enables you to learn more in the time available.
- Open questions are usually the most helpful. To answer them, a mother must give you some information.
- Open questions usually start with ‘How,’ ‘What,’ ‘When,’ ‘Where,’ ‘Why,’ or ‘Who.’ For example, “How are you feeding your baby?”
- Closed questions are usually less helpful. They tell a mother the answer that you expect, and she can answer them with a ‘yes’ or ‘no.’
- Closed questions usually start with words like ‘Are you?’ or ‘Did he?’ or ‘Has he?’ or ‘Does she?’

For example: “Did you breastfeed your last baby?”

- If a mother says ‘yes’ to this question, you still do not know if she breastfed exclusively, or if she also gave some artificial feeds.

- If you continue to ask questions to which the mother can only answer ‘yes’ or ‘no,’ you can become quite frustrated, and think that the mother is not willing to talk, or that she is not telling the truth.

Demonstrate the skill

- Ask a participant to read the words of the mother in Demonstrations 6.B and 6.C while you read the part of the health worker. After each demonstration, comment on what the health worker learned.
- Introduce the role-plays by making these points:
 - We will now see this skill being demonstrated in two role-plays. The health worker is talking to a mother who has a young baby whom she is breastfeeding.

Demonstration 6.B: Closed questions to which she can answer ‘yes’ or ‘no’

Health worker: “Good morning, (name). I am (name), the community midwife. Is (child’s name) well?”

Mother: “Yes, thank you.”

Health worker: “Are you breastfeeding him?”

Mother: “Yes.”

Health worker: “Are you having any difficulties?”

Mother: “No.”

Health worker: “Is he breastfeeding very often?”

Mother: “Yes.”

Ask: What did the health worker learn from this mother?

Comment: The health worker got ‘yes’ and ‘no’ for answers and didn’t learn much. It can be difficult to know what to say next.

Ask all participants for their ideas about how to turn the above questions into open questions.

Wait for responses and continue.

Demonstration 6.C: Open questions

Health worker: “Good morning, (name). I am (name), the community midwife. How is (child’s name)?”

Mother: “He is well, and he is very hungry.”

Health worker: “Tell me, how are you feeding him?”

Mother: “He is breastfeeding. I just have to give him one bottle feed in the evening.”

Health worker: “What made you decide to do that?”

Mother: “He wants to feed too much at that time, so I thought that my milk is not enough.”

Ask: What did the health worker learn from this mother?

Comment: The health worker asked open questions. The mother could not answer with a ‘yes’ or a ‘no,’ and she had to give some information. The health worker learned much more.

- Explain how to use questions to start and to continue a conversation:
 - A very general open question is useful to start a conversation. This gives the mother an opportunity to say what is important to her. For example, you might ask a mother of a nine-month-old baby: “How is your child feeding?”
 - Sometimes a general question like this receives an answer such as, “Oh, very well thank you.”
 - So then you need to ask questions to continue the conversation.
- For this, more specific questions are helpful. For example: “Can you tell me what your child ate for the main meal yesterday?”
- Sometimes you might need to ask a closed question. For example: “Did your child have any fruit yesterday?”
- After you have received an answer to this question, try to follow-up with another open question.

Demonstrate the skill

Ask a participant to read the part of the mother in Demonstration 6.D. You read the part of the health worker.

Introduce the role-play by making these points:

- We will now see a role-play demonstrating using questions to start and continue a conversation.
- The health worker is talking to a mother who has a young baby whom she is breastfeeding.

Demonstration 6.D: Starting and continuing a conversation

Health worker: “Good morning, (name). How are you and (child’s name) getting on?”

Mother: “Oh, we are both doing well, thank you.”

Health worker: “How old is (child’s name) now?”

Mother: “He is two days old today.”

Health worker: “What are you feeding him on?”

Mother: “He is breastfeeding, and having drinks of water.”

Health worker: “What made you decide to give the water?”

Mother: “There is no milk in my breasts, and he doesn’t want to suck.”

Ask: What did the health worker learn from this mother?

Comment: The health worker asks an open question, which does not help much. Then she asks two specific questions, and then follows up with an open question. Although the mother says at first that she and the baby are well, the health worker later learns that the mother needs help with breastfeeding.

Exercise 6.a: Asking open questions

How to do the exercise

Questions 1–4 are ‘closed’ and it is easy to answer ‘yes’ or ‘no.’

Write a new ‘open’ question, which requires the mother to tell you more.

Example	
‘Closed’ question Do you breastfeed your baby?	‘Open’ question How are you feeding your baby?
‘Closed’ question	Suggested changes to ‘Open’ questions
1. Does your baby sleep with you?	Where does your baby sleep?
2. Are you often away from your baby?	How much time do you spend away from your baby?
3. Does Aamina eat porridge?	What kinds of foods does Aamina like to eat?
4. Do you give fruit to your child often?	How often does your child eat some fruit?

Skill 3. Use responses and gestures that show interest

Write ‘Use responses and gestures that show interest’ on the list of listening and learning skills (Flip chart 1).

Explain the skill

- If you want a mother to continue talking, you must show that you are listening, and that you are interested in what she is saying.
- Important ways to show that you are listening and interested are:
 - With gestures—for example, look at her, nod and smile.
 - With simple responses—for example, you say ‘Aha,’ ‘Mmm,’ ‘Oh dear!’

Demonstrate the skill

Ask a participant to read the words of the mother in Demonstration 6.E, while you play the part of the health worker. You give simple responses, and nod, and show by your facial expression that you are interested and want to hear more.

Introduce the role-play by making these points:

- We will now see a role-play demonstrating this skill.
- The health worker is talking to a mother who has a one-year-old child.

Demonstration 6.E: Using responses and gestures that show interest

Health worker: “Good morning, (name). How is (child’s name) now that he has started solids?”
Mother: “Good morning. He’s fine, I think.”
Health worker: “Mmm.” (nods, smiles)
Mother: “Well, I was a bit worried the other day, because he vomited.”
Health worker: “Oh dear!” (raises eyebrows, looks interested)
Mother: “I wondered if it was something in the stew that I gave him.”
Health worker: “Aha!” (nods sympathetically)

Ask: How did the health worker encourage the mother to talk?

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

Discuss locally appropriate responses

In different countries, people use different responses.

Ask: What responses do people use locally?

Wait for a few replies and then continue.

Skill 4. Reflect back what the mother says

Write ‘Reflect back what the mother says’ on the list of listening and learning skills (Flip chart 1).

Explain the skill

- Health workers sometimes ask mothers a lot of factual questions. However, the answers to factual questions are often not helpful. The mother may say less and less in reply to each question.
- For example, if a mother says: “My baby was crying too much last night,” you might want to ask: “How many times did he wake up?” But the answer is not helpful.
- It is more useful to repeat back or reflect what a mother says. This is another way to show you are listening and encourages the mother or caregiver to continue talking and to say what is important to her. It is best to say it in a slightly different way, so that it does not sound as though you are copying her.
- For example, if a mother says: “I don’t know what to feed my child, she refuses everything.” You could reflect back by saying: “Your child is refusing all the food you offer her?”

Demonstrate the skill

Ask a participant to read the words of the mother in Demonstrations 6.F and 6.G while you read the part of the health worker.

Introduce the role-plays by making these points:

- We will now watch two role-plays to demonstrate this skill.
- The health worker is talking to a mother who has a six-week-old baby whom she is breastfeeding.

Demonstration 6.F: Continuing to ask for facts

Health worker: “Good morning, (name). How are you and (child’s name) today?”

Mother: “He wants to feed too much—he is taking my breast all the time!”

Health worker: “About how often would you say?”

Mother: “About every half an hour.”

Health worker: “Does he want to suck at night too?”

Mother: “Yes.”

Ask: What did the health worker learn from the mother?

Comment: The health worker asks factual questions, and the mother gives less and less information.

Demonstration 6.G: Reflecting back

Health worker: “Good morning, (name). How are you and (child’s name) today?”

Mother: “He wants to feed too much—he is taking my breast all the time!”

Health worker: “(Child’s name) is feeding very often?”

Mother: “Yes. This week he is so hungry. I think that my milk is drying up.”

Health worker: “He seems more hungry this week?”

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

Health worker: “Your sister says that he needs something more?”

Mother: “Yes. Which formula is best?”

Ask: What did the health worker learn from the mother?

Comment: The health worker reflects back what the mother says, so the mother gives more information.

Exercise 6.b: Reflecting back what a mother says

How to do the exercise

Statements 1 through 3 are some things that mothers might tell you.

Underneath the statements are three responses. Mark the response that ‘reflects back’ what the statement says. For statement 4 make up your own response that ‘reflects back’ what the mother says.

Example:

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

Possible response: She says that you have a low milk supply?

To answer:

1. Mika does not like to take thick porridge.
2. He doesn't seem to want to suckle from me.
3. I tried feeding him from a bottle, but he spat it out.

Skill 5. Empathize; show that you understand how she feels

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

Explain the skill

- Empathy is a difficult skill to learn. It is difficult for people to talk about feelings. It is easier to talk about facts.
- When a mother says something that shows how she feels, it is helpful to respond in a way that shows that you heard what she said, and that you understand her feelings from her point of view.
- For example, if a mother says: "My baby wants to feed very often and it makes me feel so tired!" you respond to what she *feels*, perhaps like this: "You are feeling very tired all the time then?"
- Empathy is different from sympathy. When you sympathize you are sorry for a person, but you look at it from **your** point of view.
- If you sympathize, you might say: "Oh, I know how you feel. My baby wanted to feed often too, and I felt exhausted." This brings the attention back to you, and does not make the mother feel that you understand her.
- You could reflect back what the mother says about the baby.
- For example: "He wants to feed very often?" But this reflects back what the mother said about the baby's behavior, and it misses what she said about how she feels. She feels tired.
- So empathy is more than reflecting back what a mother says to you.
- It is also helpful to empathize with a mother's good feelings. Empathy is not only to show that you understand her bad feelings.

Demonstrate the skill

Ask the two participants whom you have prepared to give Demonstrations 6.H, 6.I, 6.J, and 6.K. to read the words of the mother and health worker.

Introduce the role-plays by making these points:

- We will see a demonstration of this skill.
- The health worker is talking to a mother of a ten-month-old child.
- As you watch, look for empathy—is the health worker showing she understands the

mother's point of view?

Demonstration 6.H: Sympathy

Health worker: “Good morning, (name). How are you and (child’s name) today?”
Mother: “(Child’s name) is not feeding well. I am worried he is ill.”
Health worker: “I understand how you feel. When my child was ill, I was so worried. I know exactly how you feel.”
Mother: “What was wrong with your child?”

Ask: Do you think the health worker showed sympathy or empathy?
Comment: Here the focus moved from the mother to the health worker. This was sympathy, not empathy. Let us hear this again with the focus on the mother and empathizing with her feelings.

Demonstration 6.I: Empathy

Health worker: “Good morning, (name). How are you and (child’s name) today?”
Mother: “He is not feeding well. I am worried he is ill.”
Health worker: “You are worried about him?”
Mother: “Yes, some of the other children in the village are ill, and I am frightened he may have the same illness.”
Health worker: “It must be very frightening for you.”

Ask: Do you think the health worker showed sympathy or empathy?
Comment: Here the health worker used the skill of empathy twice. She said “You are worried about him” and “It must be very frightening for you.” In this second version, the mother and her feelings are the focus of the conversation.

Now let us see two more demonstrations. This time the mother is HIV-positive and pregnant and is coming to talk to the health worker about how she will feed her baby after birth. Again listen for empathy—is the health worker showing she understands the mother’s point of view?

Demonstration 6.J: Sympathy

Health worker: “Good morning, (name). You wanted to talk to me about something?”
 (smiles)
Mother: “I tested for HIV last week and am positive. I am worried about my baby.”
Health worker: “Yes, I know how you feel. My sister has HIV.”

Ask: Do you think the health worker showed sympathy or empathy?
Comment: Here the focus moved from the mother to the sister of the health worker. This was sympathy, not empathy. Let us hear this again with the focus on

the mother and empathizing with her feelings.

Demonstration 6.K: Empathy

Health worker: “Good morning, (name). You wanted to talk to me about something?”
(smiles)

Mother: “I tested for HIV last week and am positive. I am worried about my baby.”

Health Worker: “You’re really worried about what’s going to happen.”

Mother: “Yes I am. I don’t know what I should do.”

Ask: Do you think the health worker showed sympathy or empathy?

Comment: In the second version, the health worker concentrated on the mother’s concerns and worries. The health worker responded by saying “You’re really worried about what’s going to happen.” This was empathy.

Ask the two participants whom you have prepared to give Demonstrations 6.L, 6.M, 6.N, and 6.O.

Introduce the next role-play by making these points:

- Now we will see another demonstration. Watch to see if the health worker is really listening to the mother.
- The health worker is talking to a mother of a seven-month-old child who has recently started complementary feeds.

Demonstration 6.L: Asking facts

Health worker: “Good morning, (name). How are you and (child’s name) today?”

Mother: “He is refusing to breastfeed since he started eating porridge and other foods last week—he just pulls away from me and doesn’t want me!”

Health worker: “How old is (child’s name) now?”

Mother: “He is seven months old.”

Health worker: “And how much porridge does he eat during a day?”

Ask: What did the health worker learn about the mother’s feelings?

Comment: The health worker asks about facts and ignored the mother’s feelings. The information the health worker learned did not help the health worker to assist the mother with her worry that the baby won’t breastfeed since other foods were offered. The health worker did not show empathy. Let us hear this again.

Demonstration 6.M: Empathy

Health worker: “Good morning, (name). How are you and (child’s name) today?”

Mother: “He is refusing to breastfeed since he started eating porridge and other foods

last week—he just pulls away from me and doesn’t want me!”
Health worker: “It’s very upsetting when your baby doesn’t want to breastfeed.”
Mother: “Yes, I feel so rejected.”

Ask: What did the health worker learn about the mother’s feelings this time?
Comment: In this second version, the mother’s feelings are listened to at the beginning. Then the health worker is able to focus on what the mother sees as the problem.

Exercise 6.c Empathizing to show that you understand how she feels

How to do the exercise

Statements 1 through 4 are things that mothers might say.

Underneath Statements 1 through 4 are three responses that you might make.

Underline the words in the mother’s statement that show something about how she feels. Mark the response that is most empathetic.

Facilitators: write the story lines on a flip chart along with the possible answers. Have participants propose the correct answer.

Have the group discuss additional responses for these scenarios.

For statements 5 and 6, underline the feeling words, then make up your own empathizing response.

Example:

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

- a. How many times does he feed altogether?
- b. Does he wake you every night?
- X** c. You are really tired with the night feeding.

To answer:

1. Tunde has not been eating well for the past week. I am very worried about him.
Possible answer: You are anxious because Tunde is not eating?
2. My breastmilk looks so thin. I am afraid it is not good.
Possible answer: You are worried about how your breastmilk looks?
3. I feel there is no milk in my breasts, and my baby is a day old already.
Possible answer: You are upset because your breastmilk has not come in yet?
4. I am anxious that if I breastfeed I will pass HIV on to my baby.
Possible answer: I can see you are worried about breastfeeding your baby?

Skill 6. Avoid words that sound judging

Write 'Avoid words that sound judging' on the list of listening and learning skills.

Explain the skill

- 'Judging words' are words such as: right, wrong, well, badly, good, enough, properly.
- If you use judging words when you talk to a mother about feeding, especially when you ask questions, you may make her feel that she is wrong, or that there is something wrong with the baby. A breastfeeding mother may feel there is something wrong with her breastmilk.
- For example: Do not say: "Are you feeding your child **properly**?" Instead say: "How are you feeding your child?"
- Do not say: "Do you give her **enough** milk?" Instead say: "How often do you give your child milk?"

Introduce the role-play by making this point:

- We will see a demonstration of this skill. The health worker is talking to a mother of a five-month-old baby. As you watch, look for judging words.

Demonstration 6.N: Using judging words

Health worker: "Good morning. Is (name) breastfeeding **normally**?"

Mother: "Well, I think so."

Health worker: "Do you think that you have **enough** breastmilk for him?"

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

Health worker: "Has he gained weight **well** this month?"

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

Health worker: "May I see his growth chart?"

Ask: What did the health worker learn about the mother's feelings?

Comment: The health worker is not learning anything useful, but is making the mother very worried.

Demonstration 6.O: Avoiding judging words

Health worker: "Good morning. How is breastfeeding going for you and (child's name)?"

Mother: "It's going very well. I haven't needed to give him anything else."

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

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

Health worker: "He is obviously getting all the breastmilk that he needs."

- Ask:** What did the health worker learn about the mother's feelings?
- Comment:** This time the health worker learned what she needed to know without making the mother worried. The health worker used open questions to avoid using judging words.

Group exercise

Exercise 6.d Translating judging words

Ask participants to look at the list of JUDGING WORDS in their manuals.

Judging words			
Well	Normal	Enough	Problem
Good	Correct	Adequate	Fail
Bad	Proper	Inadequate	Failure
Badly	Right	Satisfied	Succeed
	Wrong	Plenty of	Success
		Sufficient	

Make these points about the list:

- The words in bold at the top of each group are words that are used most commonly.
- These are the words that we will work with in the exercises.
- Below each of the common words is a list of other words with similar meanings.
- For example, 'adequate' and 'sufficient' appear below 'enough.'
- Words with opposite meanings are in the same group. For example 'good' and 'bad.'
- All of these are judging words, and it is important to avoid them.

Ask participants to look at the box USING AND AVOIDING JUDGING WORDS.

USING AND AVOIDING JUDGING WORDS			
English	Local language	Judging question	Non-judging question
Well		Does he suckle well?	How is he suckling?
Normal		Are his stools normal?	What are his stools like?
Enough		Is he gaining enough weight?	How is your baby growing?
Problem		Do you have any problems breast-feeding?	How is breastfeeding going for you?

Ask participants if they have any questions about the exercises and try to answer them.

Ask them to suggest translations of the four common words (well, normal, enough, and problem) in the local language. Discuss their suggestions as a group.

Ask them to write the agreed translations into the box in their manuals.

For each word, read out the ‘judging question,’ and give your translation of it. Then ask participants to think of a ‘non-judging question.’ This should be a similar question that does not use the judging word. Remind them that judging questions are often closed questions, and that they can often avoid using a judging word if they use an open question.

Discuss their suggestions as a group.

Learning objective 2: Explain why changing behavior is difficult

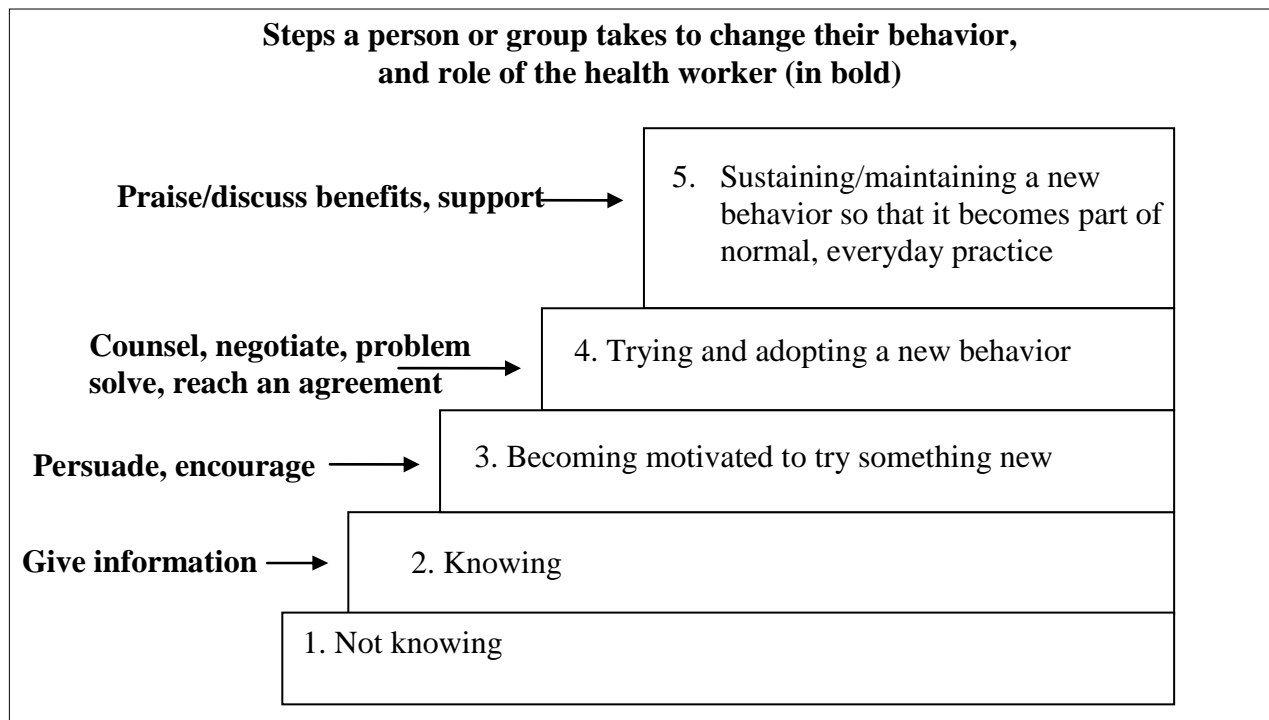
Methodology: Interactive presentation; group work

Instructions for activity

1. On a flip chart, draw behavior change steps (outlined in Figure 1 below) and brainstorm with participants how one generally moves through the different steps to behavior change (use exclusive breastfeeding as an example)
2. Ask participants: What helps a person to move through the different steps?
3. List participants’ responses on flip chart. Responses may include: information, encouragement, support, and praise. The person who provides these things is a change agent; community workers are change agents.
4. Ask participants to close their eyes and think about a behavior they are trying to change. Ask them to identify at what stage they are and why? Ask what they think they will need to move to the next step.
5. Ask if any participants want to share their personal experience, and discuss.
6. Divide participants into five working groups. Give each group the three case studies shown below. For each case study, the group answers the question: at what stage of the behavior change process is the mother?
7. Discuss in large group.

Key information

The community health worker utilizes ‘listening and learning’ and ‘building confidence and giving support’ skills throughout the entire process or steps of behavior change. The three-step counseling process (assess, analyze, and act) involves dialogue between the counselor and mother/father/caregiver to define the issues, problem-solve, and reach an agreement.

Figure 1. Behavior change steps**Behavior change case studies**

1. A pregnant woman has heard new breastfeeding information, and her husband and mother-in-law also are talking about it. She is thinking about trying exclusive breastfeeding because she thinks it will be best for her child.
2. A mother has brought her 8-month-old child to the baby weighing session. The child is being fed watery porridge that the mother thinks is appropriate for the child's age. The child has lost weight. The community worker encourages her to give her child thickened porridge instead of watery gruel because the child is not growing.
3. In the previous visit, 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 regularly.

Answer key for behavior change case studies

In the three case studies above, the participants are asked to answer the question: at what stage of the behavior change process is the mother? The answers are:

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

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

Methodology: Buzz groups of three participants

Instructions for activity

1. Ask buzz groups to examine the cover of the set of counseling 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 to help?
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 clinic (ANC).
- Remind wife/partner 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 (mother-in-law of wife) about feeding plan, beliefs, and customs.
- Support the woman so she can exclusively breastfeed for the first six months.
- Provide a variety of food for a child over six months. Feeding the child is an excellent way for fathers to interact with their child.
- Help with the active and responsive feeding of a child older than six months, several times a day (more often and in bigger portions as the child gets bigger).
- Accompany wife/partner to the health facility when infant/child is sick.
- Accompany wife/partner to the health facility for infant/child's Growth Monitoring Promotion (GMP) and immunizations.
- Provide bed nets for his family in epidemic malaria 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.

Session 7. Clinical practice 1: Listening and learning

Assessing a breastfeed, building confidence and giving support, and positioning a baby at the breast

Learning objectives
<ol style="list-style-type: none"> 1. Get practical experience using appropriate listening and learning skills when counseling a mother on feeding her infant. 2. Use the Observation Checklist for Infant and Young Child Feeding Assessment and the Practical Discussion Checklist to assess the clinical experience.

Materials

- Flip chart papers and stand, markers, tape/sticky putty
- Copies of the Breastfeed Observation Job Aid, Practical Discussion Checklist, and Observation Checklist For Infant and Young Child Feeding for each participant and trainer

Preparation

If you are leading the session:

- Make sure that you know where the practical session will be held, and where each trainer should take her group. If you did not do so in a preparatory week, visit the wards or clinic where you will go, introduce yourself to the staff members in charge, and make sure that they are prepared for the session.
- Study the instructions in the following pages, so that you can prepare the participants and conduct the practical session.
- Make sure that there are copies of the Practical Discussion Checklist available for each trainer.
- Make sure that there are two copies of the Breastfeed Observation Job Aid and one copy of the Observation Checklist For Infant and Young Child Feeding available for each participant and trainer.

If you are leading the small group:

- Study the instructions in the following pages, so that you are clear about how to conduct the clinical practice. Ask all trainers who will lead groups to study the instructions also.
- Make sure that you and the other trainers have a copy of the Practical Discussion Checklist, Counseling Skills Checklist, and Breastfeed Observation Job Aid to help you to conduct discussions.
- Make sure that the participants in your group each have two copies of the Breastfeed Observation Job Aid and one copy of the Practical Discussion Checklist and Counseling Skills Checklist. Have one or two spare copies with you.
- Find out where to take your group.

Preparation of the participants

- One trainer leads a preparatory session with all participants and the other trainers together.

- If you have to travel to another facility for the practical session, hold the preparatory session in the classroom before you leave. If necessary, this can take place on the evening or the morning before.

Duration: 120 min

Learning objective 1: Get practical experience using appropriate listening and learning skills when counseling a mother on feeding her infant

Methodology: Clinical practice

Instructions for activity

1. You are going to practice the ‘listening and learning’ as well as the ‘building confidence and giving support’ skills that you learned in previous sessions and assessing a breastfeed, with mothers in the ward.
2. You will also practice helping a mother to position her baby at the breast, or to overcome any other difficulty. Often you will find that babies are sleepy. In this case you could say to the mother something like: “I see your baby seems to be sleepy now, but can we just go through the way to hold him when he is ready to eat.” Then go through the four key points of positioning with the mother. If you do this, quite a few babies will wake up and want another feed when their nose is opposite the nipple.
3. You will need to take with you two copies of the Breastfeed Observation Job Aid, one copy each of the Observation Checklist for Infant and Young Child Feeding and the Practical Discussion Checklist, and pencil and paper to make notes.
4. You will work in groups of three to four with one trainer.

What to do in the ward:

Take it in turns to talk to a mother while the other members of the group observe. Assess a breastfeed and help her to position and attach her baby if she needs help.

If you are the counselor:

1. Introduce yourself to the mother and ask her permission to talk to her. Introduce the group and say they are interested in infant feeding. If a mother is not feeding, ask the mother to give a feed in the normal way at any time that her baby seems ready.
2. Try to find a chair or a stool to sit on.
3. Practice as many of the counseling skills as possible. Try to get the mother to tell you about herself, her situation, and her baby. You can talk about ordinary life, not only about breastfeeding. Practice as many of the six confidence and support skills as possible. In particular, try to do these things:
 - Praise two things that the mother and baby are doing right.
 - Give the mother two pieces of relevant information that are useful to her now.

If you are the observer:

1. You should stand quietly in the background. Try to be as still and quiet as possible.
2. Make general observations of the mother and baby. Notice for example: does she look

happy? Does she have formula or a feeding bottle with her?

3. Make general observations of the conversation between the mother and the participant. Notice for example: Who does most of the talking? Does the participant ask open questions? Does the mother talk freely, and seem to enjoy it?
4. Make specific observations of the participant's counseling skills. Mark an X on your Observation Checklist when she/he uses a skill, to help you remember for the discussion.
5. Notice if the participant uses helpful nonverbal communication.
6. Notice if the participant makes a mistake, for example, if she uses a judging word, or if she asks a lot of questions to which the mother says 'yes' and 'no.'
7. When a mother breastfeeds, observe the feed using the Breastfeed Observation Job Aid and put ticks in the boxes.
8. When you have finished thank the mother.

Things to avoid during clinical practice

Do not say that you are interested in breastfeeding.

The mother's behavior may change. She may not feel free to talk about formula feeding. You should say that you are interested in 'infant feeding' or in 'how babies are fed.'

Do not give a mother help or advice.

In Clinical Practice 1, if a mother seems to need help, you should inform your trainer and a member of staff from the ward or clinic.

Be careful that the forms do not become a barrier.

The participant who talks to the mother should not make notes while she is talking. She needs to refer to the forms to remind her what to do, but if she wants to write, she should do so afterwards. The participants who are observing can make notes.

Clinical practice notes for the trainers

The following notes are for the trainers. Trainers should read these notes to ensure that they know what to do. There is no need to read these notes to the participants.

At the ward or clinic

- Introduce yourself and your group to the staff member in charge.
- Ask which mothers and babies it would be appropriate to talk to, and where they are.
- Try to find a mother and baby who are breastfeeding, or a mother who thinks that her baby may want to feed soon. If this is not possible, talk to any mother.
- Try to make sure that each participant talks to at least three mothers.

- Each time the participants have finished a counseling session with a mother, take them into another room or a corner to discuss your observations.
- Take with you copies of the Breastfeed Observation Job Aid, Counseling Skills Checklist, and Practical Discussion Checklist.

Guiding the participant who is practicing

- Keep in the background, and try to let the participant work without too much interference.
- You do not need to correct every mistake that she makes immediately. If possible wait until the discussion afterwards. Then you can both praise what she did right and talk about anything she did not do right.
- However, if she is making a lot of mistakes, or not making any progress, then you should help her. Try to help in a way that does not make her feel embarrassed in front of the mother and the group.
- Additionally, if a mother and baby show something important that the participants may not have observed, you can quietly draw their attention to it.
- You need to judge as participants work what will best help them to learn.

Discussing the participant's performance

- Take the group away from the mother, and discuss what they observed.
- Use the Practical Discussion Checklist to help you to lead the discussion.
- Ask the general questions first, and then ask the specific questions about 'listening and learning' and 'assessing a breastfeed.'
- Go through the Observation Checklist, and discuss how the participant practiced these skills. First ask the participant herself to say how well she thinks she did. Then ask the other participants. Try to encourage the participants to use their counseling skills in the way they give feedback to other participants.
- Go through the Breastfeed Observation Job Aid, and discuss how many of the signs the group noticed. Ask them to decide if the baby was well or poorly positioned and attached.

Teaching about mothers who need help

- If at any time there is a mother who needs help, or who illustrates a particular situation, take the opportunity to teach about it.
- Ask a participant who identifies a mother needing help to report it to you. Ask the staff of the ward or clinic if they would like you to help the mother. If they agree, give the mother the necessary help, together with the participant. If a participant has helped a mother to position her baby, but the mother is still having difficulties, then you should help the mother before your group leaves the mother.
- Use your confidence and support skills to correct participants and to help them to develop confidence in their own clinical and counseling skills.
- Ask the staff to be present if possible, and make sure that they understand what you suggest to the mother so that they can provide follow-up.

- Explain and demonstrate the situation to the other participants. This may take you ahead of what has been covered so far in the course, but it is important not to miss a good learning opportunity.
- If possible, suggest that participants revisit the mothers whom they talked to, to follow up with them the next day.

Encouraging participants to observe health care practices

- Encourage participants, while they are in a ward or clinic, to notice:
 - If babies room-in with their mothers.
 - Whether or not babies are given formula, or glucose water.
 - Whether or not feeding bottles are used.
 - The presence or absence of advertisements for baby milk.
 - Whether sick mothers and babies are admitted to hospital together.
 - How low-birthweight babies are fed.
 - If the child eats any food or drinks during the session.
 - Whether the child was given a bottle or soother/pacifier while waiting.
 - What the interaction was like between the mother and the child.
 - Any posters or other information on feeding in the area.
- Explain that participants should not comment on their observations, or show any disapproval, while in the health facility. They should wait until the trainer invites them to comment privately, or in the classroom.
- At the end of the practical session, gather participants in the classroom. Allow participants who came across special/unusual situations to share those experiences with the rest of the group. If they have any questions, try to answer them.

Participant materials 7.1: Observation checklist for infant and young child feeding assessment of mother/child pair

Name of counselor: _____

Name of observer: _____

Date of visit: _____

(✓ for yes and × for No)

Did the counselor

Use listening and learning skills:

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

Use building confidence and giving support skills:

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

ASSESSMENT

(✓ for yes and × for No)

Did the counselor

- ☐ Assess age accurately?
- ☐ Check mother's understanding of child growth curve? (if GMP exists in area)
- ☐ Check on recent child illness?

Breastfeeding:

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

Fluids:

- ☐ Assess 'other fluid' intake?

Foods:

- ☐ Assess 'other food' intake?

Active feeding:

- ☐ Ask about whether the child receives assistance when eating?

Hygiene:

- ☐ Check on hygiene related to feeding?

ANALYSIS

(✓ for yes and × for No)

Did the counselor?

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

Record prioritized difficulty: _____

ACTION

(✓ for yes and × for No)

Did the counselor?

- ☐ 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 behaviors
- ☐ Help the mother select one or two that she can try to address the feeding challenges?
- ☐ Use counseling 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 behavior?

Record agreed-upon behavior: _____

- ☐ 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 7.2: Practical discussion checklist

Practical skills are best developed by introducing and demonstrating the skills, observing participants as they practice the skills, and giving feedback to participants on how well they performed. Feedback should include praising participants for things done well, and giving gentle suggestions for how to overcome difficulties. Use the checklist below to help guide your feedback discussions.

Questions to ask after each participant completes her turn practicing (either in the clinic or using counseling stories)

To the participant who practiced:

- What did you do well?

- What difficulties did you have?

- What would you do differently in the future?

To the participants who observed:

- What did the participant do well?

- What difficulties did you observe?

Listening and learning skills

(give feedback on the use of these skills in all practical sessions)

- Which listening and learning skills did you use?

- Was the mother willing to talk?

- Did the mother ask any questions? How did you respond?

- Did you empathize with the mother? Give an example.

Confidence and support skills

- Which confidence and support skills were used? (check especially for praise and for two relevant suggestions)

- Which skills were most difficult to use?

- What was the mother's response to your suggestions?

Key messages for complementary feeding

(give feedback on the use of these skills)

- Which messages for complementary feeding did you use? (check especially for “only a few relevant messages”)
- What was the mother’s response to your suggestions?

General questions to ask at the end of each practical session

(in the clinic or using counseling stories)

- What special difficulties or situations helped you to learn?
- What was the most interesting thing that you learned from this practical session?

Session 8. Common breastfeeding difficulties

Learning objectives
1. Be able to identify the causes of, and help mothers with, common breastfeeding difficulties: <ul style="list-style-type: none">• ‘Not enough milk’• A crying baby• Breast refusal• Breastfeeding as a working mother

Materials

- Flip chart paper and stand, markers, tape/sticky putty
- Copies of the four scenarios for the participants

Preparation

- There are four different group topics. Consider the size of the group and how to best divide up participants.
- Make sure that there are enough copies of the four scenarios as well as the tables, diagrams, and charts.
- There is a lot of information in the ‘Further information’ section. Study it ahead of time as it may help you to answer participants’ questions.

Duration: **60 min**

Learning objective 1: Be able to identify the causes of, and help mothers with, common breastfeeding difficulties

Methodology: Group work and discussion

Instructions for activity

1. Begin with a discussion, making the following points:
 - In previous sessions, we looked at ways to find out how mothers are managing with breastfeeding. These techniques include:
 - Good counseling skills to encourage a mother to tell you her concerns.
 - Assessing a breastfeed, using your skills of observation to see if a baby is well positioned and well attached.
 - Taking a detailed feeding assessment.
 - There are many reasons why mothers stop breastfeeding or start to mix feed, even if they planned at first to breastfeed exclusively.
 - When helping mothers with difficulties, you will need to use all the skills you have learned so far. Lay counselors and community health workers have important roles in supporting mothers through these difficulties, as mothers may not visit a health facility to seek help.

2. Ask: What are some of the most common difficulties women in your communities face with breastfeeding?
3. Wait for responses, and then mention the four difficulties that will be the focus of the session: not enough milk, a crying baby, breast refusal, and working mother.
4. Explain the small group process and assign participants to groups.
5. Each group will be responsible for reviewing these difficulties, writing down some common reasons, and then choosing a leader to present their findings to the group.
6. The rest of the group will participate in the group discussion around the topic, assisted by the trainer.
7. Each group will have 30 minutes to review before the discussion.

Group 1. 'Not enough milk'

Brainstorm with the group, with the help of a trainer (have the following questions prepared in advance). Note the responses on a flip chart or paper.

- Is the problem of 'not enough milk' common in your area?
- What are some of the reasons why a mother may not have enough milk?
- How can you tell if a mother has enough milk?
- Can you think of any reasons why a baby may not get enough breastmilk?
- Discuss how to help mothers with 'not enough milk.'

Notes for the trainer

Some responses for the trainer to prompt for discussion among the group:

1. Is the problem of 'not enough milk' common in your area?

- This is one of the most common reasons for stopping breastfeeding.
- Usually when a mother **thinks** she does not have enough breastmilk, her baby is getting all he needs.

2. What are some of the reasons why a mother may not have enough milk?

- Sometimes a baby does **not** get enough breastmilk. But this is usually because of ineffective suckling.
- It is rarely because his mother cannot produce enough. Almost all mothers can produce enough breastmilk for one or even two babies.
- So it is important to think not about how much milk a mother can produce, but about how much milk a baby is getting.

3. Discuss how to decide if a baby is getting enough milk or not.

- The first step in helping mothers with insufficient milk is to confirm whether the baby is receiving enough breastmilk.
- There are only two **reliable** signs that a baby is not receiving enough breastmilk:
 - Poor weight gain (less than 500 grams per month).
 - Small amount of concentrated urine, less than six times per day.

Make these points:

- In nearly all cases, mothers are able to produce enough milk for their babies.
- For the first six months of life, a baby should gain at least 500 grams in weight each month.
- One kilogram of weight gain per month is not necessary, and not usual.
- If a baby does not gain 500 grams in a month, he is not gaining enough weight.
- Look at the baby's growth chart if available, weigh the baby now, and arrange to weigh him again in one week's time.
- An exclusively breastfed baby who is getting enough milk usually passes dilute urine at least six to eight times in 24 hours.
- A baby who is not getting enough breastmilk passes urine less than six times a day (often less than four times a day).
- His urine is also concentrated, and may be strong smelling and dark orange in color.
- If a baby is having other drinks (for example, water) as well as breastmilk, you cannot be sure he is getting enough milk if he is passing lots of urine.

Possible signs that a baby is not getting enough breastmilk

- Baby not satisfied after breastfeeds.
- Baby cries often.
- Very frequent breastfeeds.
- Very long breastfeeds.
- Baby refuses to breastfeed.
- Baby has hard, dry, or green stools.
- Baby has infrequent small stools.
- No milk comes out when mother expresses.
- Breasts did not enlarge (during pregnancy).
- Milk did not 'come in' (after delivery).

Although these signs may worry a mother, there may be other reasons for them, so they are not reliable. For example, a baby may cry often because he has colic, although he might be getting plenty of milk (we will discuss colic later in this session).

4. Discuss the reasons why a baby may not get enough breastmilk.

Wait for a few replies. Continue if possible until they have suggested at least one 'breastfeeding factor' and at least one 'psychological factor.'

5. Review with participants the table below called "Reasons why a baby may not get enough breastmilk."

Make the following points:

- The reasons are arranged in four columns: (1) Breastfeeding factors, (2) Mother: psychological factors, (3) Mother: physical condition, (4) Baby's condition.

Reasons why a baby may not get enough breastmilk			
Breastfeeding factors	Mother: psychological factors	Mother: physical condition	Baby's condition
Delayed start	Lack of confidence	Contraceptive pill	Illness
Feeding at fixed times	Worry, stress	Diuretics	Abnormality
Infrequent feeds	Dislike of breastfeeding	Pregnancy	
No night feeds	Rejection of baby	Severe malnutrition	
Short feeds	Tiredness	Alcohol	
Poor attachment		Smoking	
Bottles, pacifiers		Retained piece of placenta (rare)	
Other foods		Poor breast development (very rare)	
Other fluids (water, teas)			
These are COMMON		These are NOT COMMON	

Make these points:

- The reasons in the first two columns ('Breastfeeding factors' and 'Mother: psychological factors') are common. Look for the common reasons first.
- Psychological factors are often behind the breastfeeding difficulties—for example, lack of confidence causes a mother to give bottle feeds.
- The reasons in the second two columns ('Mother: physical condition' and 'Baby's condition') are not common. Think about these uncommon reasons only if you cannot find one of the common reasons.
- It is not common for a mother to have a physical difficulty in producing enough breastmilk.

6. Discuss how to help mothers with 'not enough milk.'

Make these points:

- We have already found out **whether** the baby is really getting enough breastmilk.
- If the baby is not getting enough breastmilk, you need to find out why, so that you can help the mother.
- If the baby is getting enough breastmilk, but the mother thinks that he is not, you need to find out why she doubts her milk supply so that you can build her confidence.

For babies who **are not** getting enough milk:

- Use your counseling skills to take a good feeding assessment.
- Assess a breastfeed to check positioning and attachment and to look for bonding or rejection.
- Use your observation skills to look for illness or physical abnormality in the mother or baby.
- The solutions you suggest to the mother will depend upon the cause of the insufficient milk.
- Always remember to arrange to see the mother again soon. If possible see the mother and baby daily until the baby is gaining weight and the mother feels more confident. It may take three to seven days for the baby to gain weight.

For babies who **are** getting enough milk but the mothers **think** they are not:

- Use your counseling skills to take a good feeding assessment.
- Try to learn what may be causing the mother to doubt her milk supply.
- Explore the mother's ideas and feelings about her milk and pressures she may be experiencing from other people regarding breastfeeding.
- Assess a breastfeed to check positioning and attachment and to look for bonding or rejection.
- Praise the mother about good points in her breastfeeding technique and her baby's development.
- Correct mistaken ideas without sounding critical.
- Always remember to arrange to see the mother again soon. These mothers are at risk of introducing other foods and fluids and need a lot of support until their confidence is built up again.

7. Discuss the following scenario as a group

- Ask participants to read the story about Mrs. Bello. Below the story are questions and spaces for participants to fill in answers.
- First read out the story.
- Then ask the participants to fill in the answers to the questions. They may refer to their manuals to remind them of the reasons why a baby may not get enough breastmilk.
- After a few minutes, go through the questions with the group and ask the participants to write in the answers so they have them to refer to later.

Mrs. Bello says she does not have enough milk. Her baby is three months old and crying 'all the time.' Her baby gained 200g last month. Mrs. Bello manages the family farm by herself, so she is very busy. She breastfeeds her baby about 2 or 3 times at night, and about twice during the day when she has the time. She does not give her baby any other food or drink.

Ask: What could you say to empathize with Mrs. Bello?

Wait for a few replies. A possible response is given below, but praise participants if they have an alternative response that empathizes with the mother.

"You are very busy. It must be difficult to find time to feed your baby."

Ask: Mrs. Bello says she does not have enough breastmilk. Do you think her baby is getting enough milk?

Wait for a few replies. The answer is:

Mrs. Bello's baby only gained 200g last month, so he is not getting enough breastmilk.

Ask: What do you think is the cause of Mrs. Bello's baby not getting enough milk?

Mrs. Bello is not breastfeeding him often enough.

Ask: Can you suggest how Mrs. Bello could give her baby more breastmilk?

Wait for a few replies, and ask:

- Could she take her baby to the farm with her so she could breastfeed him more often?
- Could someone bring her baby to her where she is working?
- Could she express her breastmilk to leave for her baby?

Group 2. The crying baby

Say to the group:

- We will now look at another common reason for a mother to stop breastfeeding: the crying baby.
- Many mothers start unnecessary foods or fluids because of their baby's crying. These additional foods and drinks often do not make a baby cry less. Sometimes a baby cries more.
- A baby who cries a lot can upset the relationship between him and his mother, and can cause tension among other members of the family.
- An important way to help a breastfeeding mother is to counsel her about her baby's crying.

Brainstorm with the group, with the help of a trainer. Have the following questions prepared in advance:

1. What are reasons for a crying baby?
2. How can you help mothers whose babies cry a lot (what are actual statements counselors can say to mothers)?
3. What questions can you ask a mother (or observe) to determine why a baby may be crying a lot?
4. What are the different ways one can soothe or comfort a crying baby?

Note the responses on a flip chart or paper.

1. Discuss the reasons why babies cry.

Ask: What reasons can you think of why babies may cry a lot?

Write the replies on a flip chart.

Reasons why babies cry	
Discomfort	(dirty, hot, cold)
Tiredness	(too many visitors)
Illness or pain	(changed pattern of crying)
Hunger	(not getting enough milk, growth spurt)
Mother's food	(any food, sometimes cow's milk)
Drugs mother takes	(caffeine, cigarettes, other drugs)
Colic	
'High needs' babies	

Make the following points:

- Some of these causes may be new to you, so we will discuss them briefly.
- Hunger due to growth spurt:
 - In this situation a baby seems very hungry for a few days, possibly because he is growing faster than before.
 - He demands to be fed very often.
 - This is commonest at the ages of about two weeks, six weeks, and three months, but can occur at other times.
 - If he suckles often for a few days, the breastmilk supply increases, and he breastfeeds less often again.
- Mother's food:
 - Sometimes a mother notices that her baby is upset when she eats a particular food.
 - This is because substances from the food pass into her breastmilk.
 - It can happen with any food, and there are no special foods to advise mothers to avoid, unless she notices a problem.
- Colic:
 - Some babies cry a lot without one of the above causes.
 - Sometimes the crying has a clear pattern.
 - For example, the baby cries continuously at certain times of day, often in the evening.
 - He may pull up his legs as if he has abdominal pain.
 - He may appear to want to suckle, but it is very difficult to comfort him.
 - Babies who cry in this way may have a very active gut, or wind, but the cause is not clear.
 - This is called 'colic.'
 - Colicky babies usually grow well, and the crying usually becomes less after the baby is 3 months old.
- 'High needs' babies:
 - Some babies cry more than others, and they need to be held and carried more.
 - In communities where mothers carry their babies with them, crying is less common than in communities where mothers like to put their babies down to leave them, or where they put them to sleep in separate cots.

2. Discuss how to help mothers whose babies cry a lot.

Make these points:

- As with 'not enough' milk, you have to try to find the cause of the crying so that you can help the mother. Use your counseling skills to take a good history.
- Help the mother to talk about how she feels and empathize with her. She may be tired, frustrated, and angry. Accept her ideas about the cause of the problem and how she feels about the baby.
- Try to learn about pressures from other people and what they think the cause of the crying is.
- Assess a breastfeed to check baby's position and attachment, and the length of a feed.
- Make sure the baby is not ill or in pain. Check the growth and refer if necessary.
- Where relevant, praise her that her baby is growing well and is not ill. Reassure her that he is not bad or naughty.

- Demonstrate ways to carry and comfort a crying baby: holding him close, with gentle movement and pressure on his abdomen.
- Give relevant information when appropriate.

Ask: What relevant information could you give to a mother whose baby is six weeks old with colic?

Wait for a few replies and then continue.

- Explain that the baby has a real need for comfort when he is crying, but that the crying will become less when the baby is three to four months old. Artificial feeds or medicines do not solve the problem.

Ask: What relevant information could you give to a mother whose baby is at the age when he might be going through a growth spurt?

Wait for a few replies and then continue.

- Encourage the mother to feed more frequently for a few days to increase her milk supply.

Ask: What practical help could you offer to a mother whose family thinks her well-grown three-month-old baby is crying too much and needs to start cereals.

Wait for a few replies and then continue.

- Offer to talk to the family. It is important to help reduce tensions so that she does not feel under pressure to give unnecessary foods in addition to breastmilk.

3. Demonstrate how to hold and carry a colicky baby

Make this introductory point:

- Babies are most often comforted with closeness, gentle movement, and gentle pressure on the abdomen. There are several ways to provide this.

Give the demonstration:

- Hold a doll along your forearm, pressing on its back with your other hand.
- Move gently backward and forward.
- Sit down and hold the doll lying face down across your lap. Gently rub the doll's back.
- Sit down and hold the doll sitting on your lap, with its back to your chest.
- Hold it around the abdomen, gently pressing on the abdomen.
- Ask a man to help with this demonstration if possible. Ask him to hold the doll upright against his chest, with the doll's head against his throat. He should hum gently, so that a baby would hear his deep voice.

Figure 8.1. Some different ways to hold a colicky baby.

a. Holding the baby along your forearm



b. Holding the baby around his abdomen, on your lap



c. Father holding the baby against his chest



4. Discuss the following scenario as a group

- Ask participants to read the story about Mrs. Ojo. Below the story are questions and spaces for participants to fill in answers.
- First read out the story.
- Then ask the participants to fill in the answers to the questions. They may refer to their manuals to remind them of the reasons why a baby may cry.
- After a few minutes, go through the questions with the group and ask the participants to write in the correct answers so they have them to refer to later.

Mrs. Ojo's baby is three months old. She says that for the last few days he has suddenly started crying to be fed very often. She thinks that her milk supply has suddenly decreased. Her baby has breastfed exclusively until now and has gained weight well.

Ask: What can you say to empathize with Mrs. Ojo?

Wait for a few replies. A possible response is given below, but praise participants if they have an alternative response that empathizes with the mother.

"You are worried that he is crying more than before."

Ask: What can you praise to build Mrs. Ojo's confidence?

Wait for a few replies. A possible response is given below but participants may offer other suitable replies.

"He has grown so well on your breastmilk."

Ask: What relevant information can you give to Mrs. Ojo?

Wait for a few replies. Encourage participants to give the information in a positive way.

“At this age, many babies have a growth spurt and become very hungry. If you feed him more often for a few days, your milk supply will increase, and he will settle down again.”

Group 3. Refusal to breastfeed

Brainstorm with the group, with the help of a trainer. Have the following questions prepared in advance:

- What are the different ways a baby refuses the breast?
- What are the different reasons why a baby refuses the breast?
- What questions would you (counselor) ask a mother who says her baby is refusing her breast?
- What types of counseling advice would you offer the mother?

Note the responses on a flip chart or paper.

Points to add to the notes:

- In some communities, refusal is a common reason for stopping breastfeeding. However, it need not lead to complete cessation of breastfeeding, and can often be overcome.
- Refusal can cause great distress to the baby’s mother. She may feel rejected and frustrated by the experience.
- There are different kinds of refusal.
- Sometimes a baby attaches to the breast, but then does not suckle or swallow, or suckles very weakly.
- Sometimes a baby cries and fights at the breast, when his mother tries to breastfeed him.
- Sometimes a baby suckles for a minute and then comes off the breast choking or crying. He may do this several times during a single feed.
- Sometimes a baby takes one breast, but refuses the other.
- You need to know why a baby is refusing to breastfeed, before you can help the mother and baby to enjoy breastfeeding again.

Reasons why babies may refuse to breastfeed

- Baby ill, sedated, or in pain.
- Difficulty with breastfeeding technique.
- Change that upsets the baby.
- Apparent, not real, refusal.

Ask participants to look briefly at the table below, called “Causes of breast refusal.” Explain any cause they do not understand but do not read out the whole list as this will take too much time.

Causes of breast refusal	
Illness, pain, or sedation	Infection Brain damage Pain from bruise (vacuum, forceps) Blocked nose

	Sore mouth (thrush, teething)
Difficulty with breastfeeding technique	Use of bottles and pacifiers while breastfeeding Not getting much milk (e.g., poor attachment) Pressure on back of head when positioning Mother shaking breast Restricting length of feeds Difficulty coordinating suckle
Change that upsets baby (especially aged 3 to 12 months)	Separation from mother (e.g., mother returns to work) New caregiver or too many caregivers Change in the family routine Mother ill Mother has breast problem (e.g., mastitis) Mother menstruating Change in smell of mother
Apparent refusal	Newborn: rooting Age 4 to 8 months: distraction Older than 1 year: self-weaning

How to help mothers whose babies refuse the breast

Ask participants to read “Helping a mother and baby to breastfeed again,” below.

Helping a mother and baby to breastfeed again

Help the mother to do these things:

- Keep her baby close (no other caregivers).
Give plenty of skin-to-skin contact at all times, not just at feeding times.
Sleep with her baby.
Ask other people to help in other ways.
- Offer her breast whenever her baby is willing to suckle.
Offer when her baby is sleepy, or after a cup-feed.
Offer when she feels her ejection reflex working.
- Help her baby to take the breast.
Express breastmilk into his mouth.
Position him so that he can attach easily to the breast; try different positions.
Avoid pressing the back of his head or shaking her breast.
- Feed her baby by cup.
Give her own expressed breastmilk if possible; if necessary, give commercial infant formula.
Avoid using bottles, teats, and pacifiers.

Discuss the following scenario as a group

- Ask participants to read the story about Mrs. Eze. Below the story are questions and spaces for participants to fill in answers.

- First read out the story.
- Then ask the participants to fill in the answers to the questions. They may refer to their manuals to remind them of the reasons why a baby may refuse to breastfeed.
- After a few minutes, go through the questions with the group and ask the participants to write in the correct answers so they have them to refer to later.

Mrs. Eze delivered a baby boy by vacuum extraction two days ago. He has a bruise on his head. When Mrs. Eze tries to feed him, he screams and refuses. She is very upset and feels that breastfeeding will be too difficult for her. You watch her trying to feed her baby, and you notice that her hand is pressing on the bruise.

Ask: What could you say to empathize with Mrs. Eze?

Wait for a few replies. A possible response is given below, but praise participants if they have an alternative response that empathizes with the mother.

“You are really upset, aren’t you?”

Ask: What praise and relevant information can you give to build Mrs. Eze’s confidence?

Wait for a few replies.

Praise: *“It is lovely that you want to breastfeed your baby.”*

Relevant information: *“At the moment, the bruise is making breastfeeding painful for your baby. That is why he is crying and refusing to feed.”*

Ask: What practical help can you give to Mrs. Eze?

Wait for a few replies. One possible answer:

Offer to help to find a way for Mrs. Eze to hold her baby that is not painful for him.

Group 4. Working mothers and infant and young child feeding

Brainstorm with the group, with the help of a trainer. Have the following questions prepared in advance. Note the responses on a flip chart or paper.

1. What is the situation for women who must work after they have their baby?
2. How can you help a working woman to breastfeed as much as possible?

Include the following points in the discussion:

- Many mothers introduce early supplements or stop breastfeeding because they have to return to work.
- This is something that many of us have had to deal with in our own lives. So it is a very important issue for all of us.
- There are ways in which health workers can support working mothers, and help them

to give their babies as much breastmilk as possible.

Ask: What type of maternity protection to do women have in your communities?

Participants' own experiences

- Ask participants if they are willing to talk about their own experiences.
- Put these questions to participants who agree:
 - How long was your maternity leave?
 - What arrangements were you able to make about childcare?
 - How did you decide to feed your children?
 - How do you feel about that now?

Ask participants to take turns reading aloud parts of the next section, “Counseling mothers who work away from home.” Discuss how practical the ideas are for the local situation.

Counseling mothers who work away from home

Mothers who breastfeed:

- If possible, take your baby with you to work. This can be difficult if there is nowhere near your work place where your baby could be cared for, or if the transport is crowded.
- If your work place is near to your home, you may be able to go home to feed the baby during breaks, or ask someone to bring him to you at work to breastfeed.
- If your work place is far from your home, you can give your baby the benefit of breastfeeding in the following ways:
 - Breastfeed exclusively and frequently for the whole maternity leave. This gives your baby the benefit of breastfeeding, and it builds up your breastmilk supply. The first two months are the most important.
 - Do not start other feeds before you really need to. Do NOT think “I shall have to go back to work in 12 weeks, so I might as well start on artificial feeds straight away.”
- It is not necessary to use a bottle at all. Even very small babies can feed from a cup. Wait until about a week before you go back to work. Leave just enough time to get the baby used to cup-feeds, and to teach the caretaker who will look after him.
- Continue to breastfeed at night, in the early morning, and at any other time that you are at home:
 - This helps to keep up your breastmilk supply.
 - It gives your baby the benefit of breastmilk, even if you decide to give him one or two artificial feeds during the day.
- Many babies ‘learn’ to suckle more at night, and get most of the milk that they need then. They sleep more and need less milk during the day.

Learn to express your breastmilk soon after your baby is born:

- This will enable you to do it more easily.
- Express your breastmilk before you go to work, and leave it for the caretakers to give to your baby.

- Leave yourself enough time to express your breastmilk in a relaxed way. You may need to wake up half an hour earlier than at other times. (If you are in a hurry, you may find that you cannot express enough milk.)
- Express as much breastmilk as you can, into a very clean cup or jar. Some mothers find that they can express 2 cups (400–500 ml) or more even after the baby has breastfed. But even 1 cup (200 ml) can give the baby three feeds a day of 60–70 ml each. Even 1/2 cup or less is enough for one feed.
- Leave about 1/2 cupful (100 ml) for each feed that the baby will need while you are out.
- If you cannot express as much as this, express what you can. Whatever you can leave is helpful.
- Cover the cup of expressed breastmilk with a clean cloth or plate.

After the groups have met and understood their specific scenario, have one or two representatives from each group present to the whole class.

Each group will have 5 to 7 minutes to present their case study. The presentation should include a description of the problem, probable causes, and best ways to manage these situations. Each group should also conduct a short role-play demonstrating how to counsel women in these situations.

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

- Notice how all the skills you have learned so far can be used to help mothers in different situations: listening and learning skills; confidence and support skills; assessing a breastfeed; helping a mother to position and attach her baby; taking a detailed feeding assessment.
- In many situations there may be no treatment, so giving the mother relevant information and suggestions is very important.

Further information

Insufficient milk

- The problem of ‘not enough milk’ may arise before breastfeeding has been established, in the first few days after delivery. Then the mother needs help to establish breastfeeding.
- The problem may arise after breastfeeding has been established, after the baby is about a month old. Then the mother needs help to maintain breastmilk production.
- Some mothers worry that they do not have milk at a certain time of day, usually in the evening.
- The causes of the problem and the needs of mothers in these different situations are sometimes different. It is important to be aware of this, but the same principles of management apply to all situations.

Stool frequency

The stool frequency of infants is very variable. A baby may not pass a stool for several days, and this is quite normal. However, when the baby does pass a stool, it is usually large and semi-liquid. Small dry stools may be a sign that a baby is not getting enough milk. It is also normal for a baby to pass eight or more semi-liquid stools in a day. If the baby has diarrhea, the stools are watery.

Disposable nappies

These absorb urine and make it difficult to decide if a baby has passed enough urine. If a mother is worried about her milk supply, it is better to use towelling nappies.

Unreliable signs of ‘not enough milk’

Participants may have suggested some of the following signs that make a mother think that she does not have enough milk. They are all unreliable and do not indicate that her baby is not getting enough:

- Baby sucks fingers.
- Baby sleeps longer after bottle feed.
- Baby’s abdomen not rounded after feeds.
- Breasts not full immediately after delivery.
- Breasts softer than before.
- Breastmilk not dripping out.
- Not feeling her oxytocin reflex.
- Family members ask if enough milk.
- Health worker said not enough milk.
- Told too young or too old to breastfeed.
- Told baby too small or too big.
- Poor previous experience of breastfeeding.
- Breastmilk looks thin.

Guidelines, not rules

The measures of weight gain and urine output as reliable signs that a baby is not getting enough breastmilk are guidelines, not rules. They can help you to diagnose and correct a clinical breastfeeding problem. However, do not apply them rigidly to all mothers, especially if there is no problem. Experience will guide you.

Weight changes in newborn babies

A newborn baby may lose a little weight in the first few days of life. He should regain his birth weight by the age of two weeks. If babies demand feed from the first day, they start gaining weight more quickly than babies who delay. A baby who weighs less than his birth weight at two weeks of age is not gaining enough weight.

The following notes may help you to explain the reasons why a baby may not get enough milk.

Breastfeeding factors:

Delayed start

If a baby does not start to breastfeed on the first day, his mother’s breastmilk may take longer to come in, and he may take longer to start gaining weight.

Infrequent feeds

Breastfeeding less than 8 times a day in the first 4 weeks, or less than 5 to 6 times a day at an older age, is a common reason why a baby does not get enough milk. Sometimes a mother does not respond to her baby when he cries, or she may miss feeds, because she is too busy or at work. Some babies are content and do not show that they are hungry often enough. In this case, a mother should not wait for her baby to 'demand,' but should wake him to breastfeed every 3 or 4 hours.

No night feeds

If a mother stops night breastfeeds before her baby is ready, her milk supply may decrease.

Short feeds

Breastfeeds may be too short or hurried, so that the baby does not get enough fat-rich hindmilk. Sometimes a mother takes her baby off her breast after only a minute or two. This may be because the baby pauses, and his mother decides that he has finished. Or she may be in a hurry, or she may believe that her baby should stop in order to suckle from the other breast. Sometimes a baby stops suckling too quickly, for example if he is too hot, because he is wrapped in too many clothes.

Poor attachment

If a baby suckles ineffectively, he may not get enough milk.

Bottles and pacifiers

A baby who feeds from a bottle or who sucks on a pacifier may suckle less at the breast, so the breastmilk supply decreases.

Complementary feeds

A baby who has complementary feeds (artificial milks, solids, or drinks including plain water), before 4 to 6 months suckles less at the breast, so the breastmilk supply decreases.

Mother—psychological factors:

Lack of confidence

Mothers who are very young, or who lack support from family and friends, often lack confidence. Mothers may lose confidence because their baby's behavior worries them. Lack of confidence may lead a mother to give unnecessary supplements.

Worry, stress

If a mother is worried or stressed or in pain, her oxytocin reflex may temporarily not work well.

Dislike of breastfeeding, rejection of the baby, and tiredness

In these situations, a mother may have difficulty in responding to her baby. She may not hold him closely enough to attach well; she may breastfeed infrequently, or for a short time. She may give her baby a pacifier when he cries instead of breastfeeding him.

Mother—physical condition

Contraceptive pill

Contraceptive pills, which contain estrogens, may reduce the secretion of breastmilk. Progestin-only pills and Depo-Provera should not reduce the breastmilk supply. Diuretics may reduce the breastmilk supply.

Pregnancy

If a mother becomes pregnant again, she may notice a decrease in her breastmilk supply.

Severe malnutrition

Severely malnourished women may produce less milk. However, a woman who is mildly or moderately undernourished continues to produce milk at the expense of her own tissues, provided her baby suckles often enough.

Alcohol and smoking

Alcohol and cigarettes can reduce the amount of breastmilk that a baby takes.

Retained piece of placenta

This is RARE. A small piece of placenta remains in the uterus, and makes hormones, which prevent milk production. The woman bleeds more than usual after delivery, her uterus does not decrease in size, and her milk does not ‘come in.’

Poor breast development

This is VERY RARE. Occasionally a woman’s breasts do not develop and increase in size during pregnancy, and she does not produce much milk. If the mother noticed an increase in the size of her breasts during pregnancy, then poor breast development is not her problem. It is not necessary to ask about this routinely. Ask only if there is a problem.

Baby’s condition:

Illness

A baby who is ill and unable to suckle strongly does not get enough breastmilk. If this continues, his mother’s milk supply will decrease.

Abnormality

A baby who has a congenital problem, such as a heart abnormality, may fail to gain weight. This is partly because he takes less breastmilk, and partly because of other effects of the condition. Babies with a deformity such as a cleft palate, or with a neurological problem or mental handicap, often have difficulty in suckling effectively, especially in the first few weeks.

Occasionally you may not be able to find the cause of a poor milk supply; or the milk supply does not improve (the baby does not gain weight) even though you have done everything you can to help the mother. Then you may need to look for one of the less common causes, and help or refer the mother accordingly.

Occasionally you may need to help a mother to find a suitable complementary feed for her baby.

Encourage her to:

- Continue breastfeeding as much as possible.
- Give only the amount of complement that her baby needs for adequate growth, and give the complement by cup.
- Give the complement only once or twice a day, so that her baby suckles often at the breast.

Remember that the need for complements before six months of age should be RARE.

Crying:

A baby who is ‘crying too much’ may really be crying more than other babies, or his family may be less tolerant of the crying or less skilled at comforting the baby. Families’ responses to crying are different in different societies. So also is the way in which parents handle children. For example, in societies where babies are carried around more, they cry less. If babies sleep with their mothers, they are less likely to cry at night. Yet babies themselves vary a lot in how much they cry. So it is impossible to say that some patterns are ‘normal’ and some are not.

Allergies:

Babies can become allergic to the protein in some foods in their mother’s diet. Cow’s milk, soy, eggs, and peanuts can all cause this problem. Babies may become allergic to cow’s milk protein after only one or two prelacteal feeds of formula.

Drugs the mother takes:

Caffeine in coffee, tea, and colas can pass into breastmilk and upset a baby. If a mother smokes cigarettes, or takes other drugs, her baby is more likely to cry than other babies. If someone else in the family smokes, that also can affect the baby.

Breast refusal:

These notes will help you to explain the reasons why babies may refuse the breast.

Is the baby ill, in pain, or sedated?

Illness: The baby may attach to the breast, but suckles less than before.

Pain: Pressure on a bruise from forceps or vacuum extraction. The baby cries and fights as his mother

tries to breastfeed him.

Blocked nose, sore mouth (Candida infection [thrush]), an older baby teething. The baby suckles a few times, and then stops and cries.

Sedation:

A baby may be sleepy because of:

- Drugs that his mother was given during labor.
- Drugs that she is taking for psychiatric treatment.

Is there a difficulty with the breastfeeding technique?

Sometimes breastfeeding has become unpleasant or frustrating for a baby. Possible causes:

- Feeding from a bottle, or sucking on a pacifier (dummy).
- Not getting much milk, because of poor attachment or engorgement.
- Pressure on the back of the baby's head, by his mother or a helper positioning him roughly, with poor technique. The pressure makes him want to 'fight.'
- His mother holding or shaking the breast, which interferes with attachment.
- Restriction of breastfeeds; for example, breastfeeding only at certain times.
- Early difficulty coordinating suckling. (Some babies take longer than others to learn to suckle effectively.)

Refusal of one breast only:

Sometimes a baby refuses one breast, but not the other. This is because the problem affects one side more than the other.

Has a change upset the baby?

Babies have strong feelings, and if they are upset they may refuse to breastfeed. They may not cry, but simply refuse to suckle. This is commonest when a baby is aged 3 to 12 months. He suddenly refuses several breastfeeds. This behavior is sometimes called a 'nursing strike.'

Possible causes:

- Separation from his mother, for example when she starts a job.
- A new caregiver, or too many caregivers.
- A change in the family routine—for example, moving house, visiting relatives.
- Illness of his mother, or a breast infection.
- His mother menstruating.
- A change in his mother's smell, for example, different soap, or different food.

Is it 'apparent' and not 'real' refusal?

Sometimes a baby behaves in a way that makes his mother think that he is refusing to breastfeed.

However, he is not really refusing.

- When a newborn baby 'roots' for the breast, he moves his head from side to side as if he is saying 'no.' However, this is normal behavior.
- Between 4 and 8 months of age, babies are easily distracted—for example, when they hear a noise. They may suddenly stop suckling. It is a sign that they are alert.

After the age of 1 year, a baby may wean himself. This is usually gradual.

Management of breast refusal:

If a baby is refusing to breastfeed:

1. Treat or remove the cause if possible.
2. Help the mother and baby to enjoy breastfeeding again.

Treat or remove the cause if possible

Illness: Treat infections with appropriate antimicrobials and other therapy. Refer if necessary. If a baby is unable to suckle, he may need special care in hospital. Help his mother to express her breastmilk to feed to him by cup or by tube, until he is able to breastfeed again.

Pain: For a bruise: help the mother to find a way to hold the baby without pressing on a painful place. For thrush: treat with nystatin. For teething: encourage her to be patient and to keep offering him her

breast. For a blocked nose: explain how she can clear it. Suggest short feeds, more often than usual for a few days.

Sedation: If the mother is on regular medication, try to find an alternative.

Breastfeeding technique: Discuss the reason for the difficulty with the mother. When her baby is willing to breastfeed again, you can help her more with her technique.

Changes that upset a baby: Discuss the need to reduce separation and changes if possible. Suggest that she stops using the new soap, perfume, or food.

Apparent refusal:

If it is rooting: Explain that this is normal. She can hold her baby at her breast to explore her nipple. Help her to hold him closer, so that it is easier for him to attach.

If it is distraction: Suggest that she try to feed him somewhere more quiet for a while. The problem usually passes.

If it is self-weaning: Suggest that she:

- Makes sure that the child eats enough family food.
- Gives him plenty of extra attention in other ways.
- Continues to sleep with him because night feeds may continue.

Help the mother and baby to enjoy breastfeeding again:

This is difficult and can be hard work. You cannot force a baby to breastfeed. The mother needs help to feel happy with her baby and to enjoy breastfeeding. They have to learn to enjoy close contact again. She needs you to build her confidence, and to give her support.

Help the mother to do these things:

Keep her baby close to her all the time:

- She should care for her baby herself as much of the time as possible.
- Ask grandmothers and other helpers to help in other ways, such as doing the housework, and caring for older children.
- She should hold her baby often, and give plenty of skin-to-skin contact at times other than feeding times.
- She should sleep with her baby.
- If the mother is employed, she should take leave from her employment—sick leave if necessary.
- It may help if you discuss the situation with the baby's father, grandparents, and other helpful people.

Offer her breast whenever her baby is willing to suckle:

- She should not hurry to breastfeed again, but offer the breast if her baby does show an interest.
- He may be more willing to suckle when he is sleepy or after a cup-feed, than when he is very hungry. She can offer her breast in different positions.
- If she feels her milk let down (ejection reflex) working, she can offer her breast then.

Help her baby to breastfeed in these ways:

- Express a little milk into her baby's mouth.
- Position him well, so that it is easy for him to attach to the breast.
- She should avoid pressing the back of his head, or shaking her breast.

Feed her baby by cup until he is breastfeeding again:

- She can express her breastmilk and feed it to her baby from a cup (or cup and spoon). If necessary, use artificial feeds, and feed them by cup.
- She should avoid using bottles, teats, and pacifiers (dummies) of any sort.

Session 9. How to counsel mother/father/caregiver

Learning objectives
1. Describe Three-Step Counseling process (assess, analyze, and act)
2. Demonstrate ‘building confidence and giving support’ skills
3. Practice Three-Step Counseling process
4. Explain where Three-Step Counseling can be conducted

Materials

- Three case studies
- Flip chart papers and stand, markers, tape/sticky putty
- Photocopies of *Participant materials 7.1*: Observation checklist for infant and young child feeding assessment of mother/child pair (three copies per participant)
- Laminated copy of *Participant materials 7.1*: Observation checklist for infant and young child feeding assessment of mother/child pair (one per participant)

Preparation

- Practice demonstrating infant and young child feeding assessment of mother/child pair (using Three-Step Counseling process).
- On a separate paper, list the section ‘Read to mothers’ from the three case studies.

Duration: 120 min

Learning objective 1: Describe Three-Step Counseling process (assess, analyze, and act)

Methodology: Demonstration; interactive presentation

Instructions for activity

Note: Two facilitators need to prepare this demonstration in advance (to act as mother and counselor, respectively).

Review with participants the points covered to demonstrate listening and learning skills between a mother (Tamina) with 7-month son Ahmed and a counselor (for Step 1: Assess). In this scenario, Tamina:

- Breastfeeds whenever Ahmed cries.
- Feels she does not produce enough milk.
- Two times a day, gives Ahmed some watery porridge made from corn meal.
- Does not give any other milks or drinks to Ahmed.

The facilitator acting as counselor uses *Participant materials 7.1*: Observation checklist for

infant and young child feeding assessment of mother/child pair to demonstrate the Three-Step Counseling process.

1. **Step 1: Assess**

- Greet mother and introduce him/herself.
- Allow mother to introduce herself and the baby.
- Use ‘listening and learning’ and ‘building confidence and giving support’ skills.
- Complete *Participant materials 7.1*: Observation checklist for infant and young child feeding assessment of mother/child pair.
- Listen to Tamina’s concerns, and observe Ahmed and Tamina.
- Accept what Tamina is doing without disagreeing or agreeing, and praise Tamina for one good behavior.

2. **Step 2: Analyze**

Facilitator acting as counselor notes that:

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

3. **Step 3: Act**

- Praise Tamina for breastfeeding.
- Ask Tamina about breastfeeding frequency and whether she is breastfeeding whenever Ahmed wants and for as long as he wants, both day and night. Does Ahmed come off the breast himself? Is Ahmed fed on demand? (age-appropriate recommended breastfeeding practices)
- Suggest that Tamina breastfeed Ahmed when he shows interest in feeding (before he starts to cry).
- Share with Tamina and discuss **CC 13: How to make enough milk**. Talk with Tamina about the characteristics of complementary feeding.
- Present options/small do-able actions (time-bound) to overcome the difficulty of inadequate complementary feeding: F = frequency of breastfeeding, T = texture (thickness/consistency), and V = variety.
- Help Tamina select an action that she can try (e.g., breastfeed more frequently day and night, thicken porridge, add family foods during this week).
- Share with Tamina and discuss **CC 21: How to feed a child 6 to 8 months old**.
- Ask Tamina to repeat verbally the agreed-upon action.
- Tell Tamina that a counselor will follow up with her at her next weekly visit.
- Suggest where Tamina can find support (attend educational talk, infant and young child feeding support group, supplementary feeding programme, community volunteer).
- Refer as necessary.
- Thank Tamina for her time.

4. Discuss the demonstration with participants and answer questions.

5. Review and complete together/or talk through *Participant materials 7.1*: Observation checklist for infant and young child feeding assessment of mother/child pair.

6. Discuss and summarize.

Key information

- The Three-Step Counseling process involves:
 - Assess age-appropriate feeding and condition of mother/father/caregiver and child: ask, listen, and observe.
 - Analyze feeding difficulty: identify difficulty, and if there is more than one, prioritize.
 - Act—discuss, suggest small amount of relevant information, agree on feasible, do-able option that mother/father/caregiver can try.
- The purpose of the process is to provide information and support on infant and young child feeding to the mother/father/caregiver.

Step 1: Assess

- Greet the mother/father/caregiver and ask questions that encourage her/him to talk, using ‘listening and learning’ and ‘building confidence and giving support’ skills.
- Complete *Participant materials 7.1*: Observation checklist for infant and young child feeding assessment of mother/child pair, by asking the following questions:
 - a) What is your name, and your child’s name?
 - b) Observe the general condition of mother/father/caregiver.
 - c) What is the age of your child?
 - d) Has your child been recently sick? If presently sick, refer mother to health facility.
 - e) 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?
 - f) In areas where there are no child growth cards, ask mother/father/caregiver how he or she thinks the child is growing?
 - g) 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/days 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*

- h) Does your child use a cup? (If mother says “no,” then ask “What does your child use to drink from?”)
- i) Who assists child to eat?
- j) Are there other challenges mother faces in feeding the child?

Step 2: Analyze

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

Step 3: Act

- Depending on the age of the baby and your analysis (above), select a small amount of 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 the mother.
- For any difficulty, discuss with the mother/father/caregiver how to overcome the difficulty.
- Present options/small do-able actions (time-bound) and help the mother select one that she can try to overcome the difficulty.
- Share and discuss with the mother/father/caregiver any appropriate counseling cards.
- Ask the mother to repeat the agreed-upon new behavior to check her understanding.
- Let the mother know that you will follow up with her at the next weekly visit.
- Suggest where the mother can find additional support—e.g., attend educational talk or support group for infant and young child feeding, confirm that the mother knows (or knows how to reach) 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 the mother for her time.

Learning objective 2: Understand the ‘building confidence and giving support’ skills

Methodology: Brainstorming

Instructions for activity

1. Brainstorm with whole group by asking participants: What helps to give a mother, father, or caregiver confidence and support?
2. Probe until the skills in 'Key information' below have been mentioned, and list them on a flip chart.
3. Refer participants to *Participant materials* 9.1: Building confidence and giving support skills.
4. Discuss and summarize.

Key information

Participant materials 9.1: Building confidence and giving support skills

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

Learning objective 3: Practice Three-Step Counseling process

Methodology: Practice

Instructions for activity

1. Divide participants into groups of three, to take the roles of mother, counselor, and observer.
2. Distribute *Participant materials* 7.1: Observation checklist for infant and young child feeding assessment of mother/child pair to counselors.
3. Distribute *Participant materials* 7.2: Practical discussion checklist.
4. Ensure that each group of three has a full set of counseling cards.
5. Practice Case Study 1: Ask the 'mothers' of the working groups to gather together.
6. Read a case study to the mothers ONLY, and ask them 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 mothers to answer other questions that the counselors may ask

- outside the case study.
7. The counselor of each working group (of three) asks the mother about her situation, and practices the ‘assess, analyze, and act’ steps with ‘listening and learning’ and ‘building confidence and giving support’ skills.
 8. In each working group, the observer’s task is to record the skills the counselor used and to provide feedback after the case study.
 9. Then participants in working groups switch roles and the above steps are repeated using Case Studies 2 and 3.
 10. Ask one working group demonstrates a case study in front of the whole group.
 11. Discuss and summarize.

Key information

- See *Participant materials 7.2*: Practical discussion checklist.

Case studies to practice Three-Step Counseling

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

Case study 1

Read to ‘mothers’: You are Fatuma. Your son, Shukri, is 18 months old. You are breastfeeding once or twice a day. You are giving Shukri milk and millet cereal two times a day.

Step 1: Assess

- Greet Fatuma and ask questions that encourage her to talk, using ‘listening and learning’ and ‘building confidence and giving support’ skills.
- Complete *Participant materials 7.1*: Observation checklist for infant and young child feeding assessment of mother/child pair.
- Observe Fatuma and Shukri’s general condition.
- Listen to Fatuma’s concerns, and observe Shukri and Fatuma interacting.
- Accept what Fatuma is doing without disagreeing or agreeing.

Step 2: Analyze

- Fatuma is breastfeeding Shukri.
- Fatuma is giving another milk to Shukri.
- Fatuma is not following age-appropriate feeding recommendations (e.g., frequency and variety).

Step 3: Act

- Praise Fatuma about continuing breastfeeding.
- Talk with Fatuma about the characteristics of complementary feeding: frequency, amount, thickness (consistency), variety, active/responsive feeding, and hygiene.
- Present options/small do-able actions (time-bound) to overcome the difficulty of inadequate complementary foods. For example, suggest an increase in feeding frequency to four times a day; ask about the amount of cereal Shukri receives and the possibility of

increasing the amount; ask about the texture (thickness/consistency) of the cereal; suggest adding other locally available family foods and help Fatuma select one or two that she believes will be possible for her to try.

- Select the portion of the information on the age-appropriate counseling cards that are most relevant to Shukri's situation and discuss that information with Fatima:
 - **CC 18: Hygiene**
 - **CC 20: Give a variety of foods**
 - **CC 23: How to feed a child 12 to 23 months old**
- Ask Fatuma to say again the agreed-upon behavior.
- Tell Fatuma that you will follow up with her at her next weekly visit.
- Suggest where Fatuma can find support (attend educational talk, infant and young child feeding support group, supplementary food programme, community worker).
- Refer as necessary.
- Thank Fatuma for her time.
- Discuss the demonstration with participants.
- Answer questions.

Case study 2:

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

Step 1: Assess

- Greet Justina and ask questions that encourage her to talk, using 'listening and learning' and 'building confidence and giving support' skills.
- Complete *Participant materials 7.1*: Observation checklist for infant and young child feeding assessment of mother/child pair.
- Observe Justina and Marielena's general condition.
- Listen to Justina's concerns, and observe Marielena and Justina interacting.
- Accept what Justina is doing without disagreeing or agreeing.

Step 2: Analyze

- Justina is breastfeeding Marielena.
- Justina is also giving water to Marielena.
- Justina has not started complementary foods yet.

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 Marielena.
- Discuss the risks of contaminated water.
- 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 do-able actions (time-bound) and help Justina select one or two that she can try. For example, begin with a small amount of staple food (porridge, other local examples); add legumes, vegetable/fruit, and animal foods; increase feeding frequency of foods to three times a day; talk about appropriate texture (thickness/consistency) of staple; assist Marielena during feeding times; and discuss hygienic preparation of foods.
- Select the portion of the information on the age-appropriate counseling cards that are most relevant to Marielena's situation and discuss it with Justina:
 - **CC 18: Hygiene**
 - **CC 20: Give a variety of foods**
 - **CC 21: How to feed a child 6 to 8 months old**
- Ask Justina to say again the agreed-upon behavior.
- 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, supplementary food programme, 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 Anik, who is 3 weeks old. You feel a lump in your breast; it is tender and red.

Step 1: Assess

- Greet Rahima and ask questions that encourage her to talk, using 'listening and learning' and 'building confidence and giving' support skills.
- Complete *Participant materials 7.1*: Observation checklist for 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 interacting.
- Accept what Rahima is doing without disagreeing or agreeing.

Step 2: Analyze

- Rahima wants to breastfeed Anik.
- Rahima has a lump in her breast that is tender and red (plugged duct).

Step 3: Act

- Praise Rahima for wanting to breastfeed Anik.
- Help Rahima get in a comfortable position to breastfeed Anik (using pillows, rolled-up towels).
- Use pillows or rolled-up towels to help Rahima get comfortable.
- Help Rahima improve attachment of Anik to the breast.
- Give ideas to relieve plugged ducts:

- Do not stop breastfeeding (if milk is not removed, the risk of abscess increases; let the baby feed as often as possible).
- Apply warmth (warm water, warm cloth).
- Hold baby in different positions, so that the baby's tongue/chin is close to the site of the plugged duct/mastitis (the reddish area). The tongue/chin will massage the breast and release the milk from that part of the breast.
- Apply gentle pressure to breast with the hand, rolling fingers towards nipple; then express milk or let baby feed every two to three hours day and night.
- Explain to Rahima the importance of exclusive breastfeeding, allowing Anik to release the breast by himself, and frequent breastfeeding (day and night and as often as possible).
- Select the portion of the information on the age-appropriate counseling cards that are most relevant to Anik's situation and discuss it with Rahima:
 - **CC 9: How to put your baby on the breast**
 - **CC 13: How to make enough milk**
- Ask Rahima if there are others in the home who can help with household chores.
- Help Rahima select the practices she can try—for example, good attachment and positioning, exclusive breastfeeding, and frequent breastfeeding (day and night and as often as possible).
- Ask Rahima to say again the agreed-upon behavior.
- Tell Rahima that you will have someone come to follow up with her in two days.
- Suggest where Rahima can find support (attend an infant and young child feeding support group, and refer to community worker).
- Thank Rahima for her time.
- Discuss the demonstration with participants.
- Answer questions.

Learning objective 4: Mention where 3-Step Counseling can be conducted

Methodology: Buzz groups

Instructions for activity

1. Ask participants to form groups of three with their neighbors.
2. Ask participants: Where can Three-Step Counseling be conducted?
3. Ask groups to list the contact points.
4. Ask one group to share. Ask others to contribute additional information.
5. Probe until the contact points in 'Key information' below are mentioned.
6. Discuss and summarize.

Key information

Three-Step Counseling can be conducted in health clinics as well as by community-based outreach. Locations and timing include:

- At antenatal clinic and at every contact with a pregnant woman.
- At delivery or as soon as possible thereafter.

- Again within the first week of birth (days 2 or 3 and days 6 or 7).
- At two other postnatal points (for example, at weeks 4 and 6).
- At family planning sessions and at other times if mother has a difficulty.
- During the first 6 months of lactation (and up to 24 months of lactation).
- At Growth Monitoring Promotion (GMP) and immunization sessions.
- At every contact with mothers or caregivers of sick children.
- At contact points for vulnerable children, e.g., HIV-exposed or infected children.
- During community follow-up.
- In action-oriented group session.
- At infant and young child feeding support groups.
- At in-patient facilities for management of children with severe acute malnutrition, such as stabilization centers (SC), nutrition rehabilitation units, therapeutic feeding centers, and malnutrition wards.
- At community-based management of acute malnutrition (CMAM) sites or screening sessions.
- At supplementary feeding programme (SFP) sites.
- Link mother/father/caregiver to counselor.

Session 10. Care for the woman during pregnancy and lactation

Learning objectives
1. Review best practices for antenatal care and explore beliefs and practices that may interfere with regular ANC attendance and adopting healthy behaviors
2. Describe the undernutrition cycle: undernourished baby, girl-child, teenager, and pregnant woman
3. Describe the actions that can break the undernutrition cycle in babies, girls, teens, and women
4. Describe best practices for labor and delivery and postnatal care
5. Name the recommended time for spacing children and the criteria for the lactational amenorrhea method (LAM)

Materials

- Flip chart papers and stand, markers, tape/sticky putty
- Illustrations of well-nourished baby, girl-child, teenager, adult woman, and pregnant woman.
- Relevant counseling cards for the woman during pregnancy and lactation:
 - **CC 1. Antenatal care (ANC)**
 - **CC 2. Care during pregnancy**
 - **CC 4. Nutrition during pregnancy**
 - **CC 5. Avoiding malaria during pregnancy**
 - **CC 7. Delivery**
 - **CC 11. Postnatal care**
 - **CC 12. Nutrition for lactating mothers**

Duration: 120 min

Learning objectives 1: Review best practices for antenatal care and explore beliefs and practices that may interfere with regular ANC attendance and adopting healthy behaviors

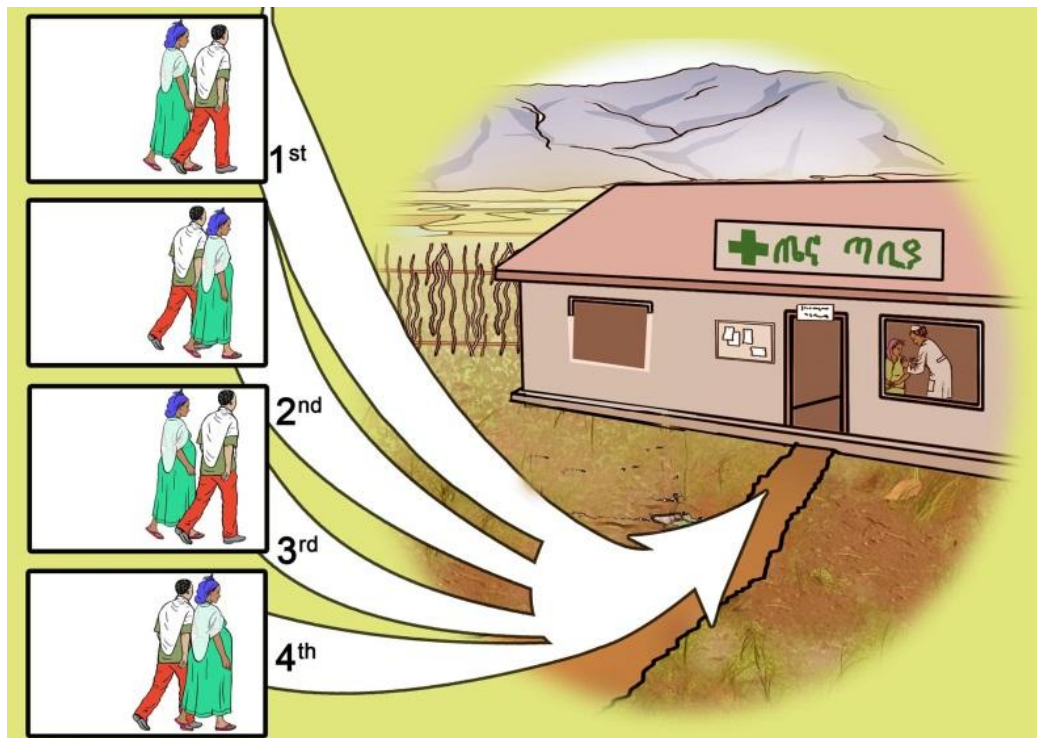
Methodology: Brainstorming

Instructions for activity

1. Have each participant review the first counseling card.
2. Ask several participants to read aloud the key messages on the backs of CC 1, CC2, and CC 5.

3. On a flip chart, make three columns: 1) positive, 2) negative, and 3) neutral. 1) health-seeking beliefs/behaviors that have a positive effect on obtaining ANC and adopting healthy practices; 2) health-seeking beliefs/behaviors that have a negative effect on obtaining ANC and adopting healthy practices; and 3) health-seeking beliefs/behaviors that neither help nor hinder adopting healthy practices.
4. In large group, have participants brainstorm the health-seeking beliefs/behaviors that influence the practices in their communities
5. In large group, ask participants to decide on which column to place the beliefs/behaviors.
6. Ask participants for suggestions as to how the negatively impacting beliefs/behaviors might be changed (while always respecting the belief), and who in the household and community is best able to influence changes (e.g., grandmothers, child's father, religious groups, support groups).
7. Ask participants to suggest messages to address some of the major beliefs/behaviors in their communities that negatively impact health-seeking.
8. Discuss and summarize.

Counseling card 1: Antenatal care (ANC)



Counseling card 2: Care during pregnancy



Look after yourself during pregnancy to remain healthy and to help the baby grow and develop well.

- Eat adequate amounts of nutritious food.
- Prepare for the birth of your baby.
 - Decide the health facility where you will deliver.
 - Save some of the money you will need.
 - Prepare the clothes and bedding the baby will need.
- Go to the health facility for help immediately if you experience any of the following:
 - Vaginal bleeding
 - Fever
 - Severe lower abdominal pain
 - Headache
 - Blurred vision
 - Swollen face and arms
- Rest more and avoid hard labor during pregnancy to have a health and normal-size baby.

Counseling card 3: Avoiding malaria during pregnancy



Sleep under an insecticide-treated mosquito net to protect yourself against mosquito bites that bring malaria. Malaria causes anemia, which harms the health of the mother and baby

Learning objective 2: Describe the undernutrition cycle: undernourished baby, girl-child, teenager, and pregnant woman

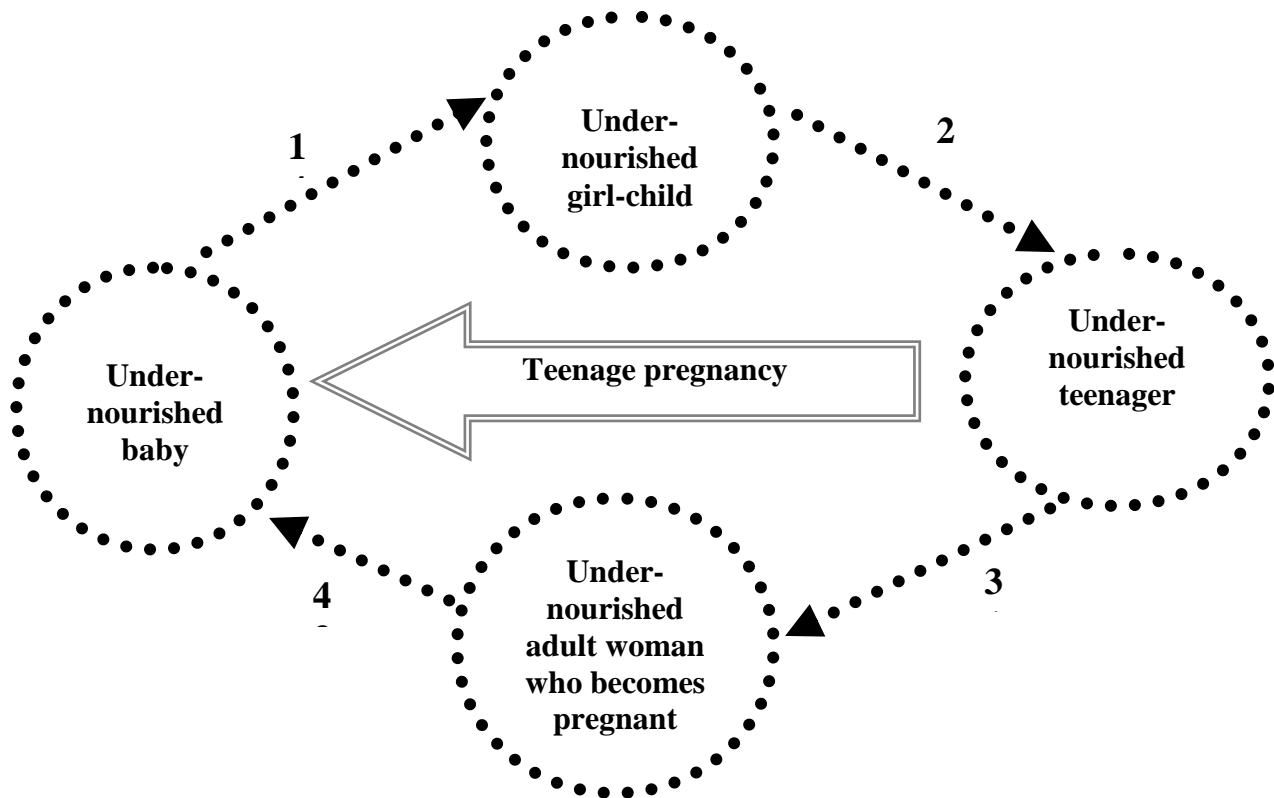
Methodology: Brainstorming; interactive presentation

Instructions for activity

1. Draw four circles on a flip chart with arrows connecting the circles (see diagram below).
2. Label the circles: undernourished baby, girl-child, teenager, and pregnant woman.
3. Explain that this diagram represents the undernutrition cycle.
4. Ask participants: What are the consequences of undernutrition for women?
5. Write answers on flip chart.
6. Discuss and summarize.

Key information

Possible outcomes of undernutrition



Consequences of undernutrition for women

- More infections due to weakened immune system.
- Weakness and tiredness leading to lower productivity.
- Difficult labor due to small bone structure.
- Increased risk of complications in the mother, leading to death during labor and delivery.
- Increased risk of death if mother bleeds during or after delivery.
- Increased risk of giving birth to an underweight child who, if female, will be at greater risk of a more difficult labor 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 labor if her pelvis is small.

Learning objective 3: Describe actions that can break the undernutrition cycle in babies, girls, teens, and women

Methodology: Group work

Instructions for activity

1. Divide participants into four groups. Ask each group to focus on one point in the undernutrition cycle (one arrow) and think of recommendations that can break the cycle at that point.
2. Ask each group to present their work in large group.
3. As each group presents, place an illustration on the corresponding circle of the undernutrition cycle: well-nourished baby, well-nourished girl child, well-nourished teenager, and 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* 10.1: Actions to break the undernutrition cycle, and discuss.
7. Ask working groups to read **CC 4: Nutrition during pregnancy** and **CC 12: Nutrition for lactating mothers** and to comment on the counseling discussion points of the card.
8. Discuss and summarize.

Counseling card 4: Nutrition during pregnancy



Pregnant women: Eat a variety of foods during pregnancy to remain healthy and strong and to help the baby grow and develop well. Eating a variety of foods makes you strong enough to deliver without problems. Eat a variety of the following foods as available:

- Cereals (injera, bread, kolo, nifro, kita, rice)
- Roots and tubers (potatoes, beetroots, onions, kocho)
- Animal, fish, and poultry products (meat, fish, chicken, milk, eggs, liver)
- Legumes (beans, peas, chickpeas, lentils)
- Oils and fats (butter, cooking oil, sesame, nuts, groundnuts, linseed)
- Fresh fruits (ripe papaya, bananas, mango, oranges)
- Vegetables (carrots, pumpkins, kale, cabbages, tomatoes)

Eat one extra meal each day. Eating more helps the baby to develop well and strengthens you for delivery. Eating an extra meal will not cause your baby to grow too big.

- Use iodized salt to help your baby's brain and body develop well.
- Drink at least 10 glasses of water a day unless you are told not to do so by a health worker.
- Avoid alcohol and smoking during pregnancy. Alcohol and cigarette smoking can harm the health of the fetus in the womb.
- Avoid drinking tea and coffee during meals. Tea and coffee changes the way your body uses the food you eat. It is better to drink tea and coffee at least one or more hours before or after a meal.

Husband: Make sure your wife gets one extra meal each day. Support your wife so she can rest more during pregnancy. Rest and avoiding hard labor helps to have a healthy, normal-size baby.

Counseling card 8: Nutrition for lactating mothers



Key information

- Actions to improve child survival must start long before a woman becomes pregnant.
- Actions should start by improving the woman's health status, and solving her economic and social problems.

See *Participant materials* 10.1: Actions to break the undernutrition cycle

Participant materials 10.1: Actions to break the undernutrition cycle

Actions for the child

Prevent growth failure by:

- Encouraging early initiation of breastfeeding.
- Exclusive breastfeeding from 0 up to 6 months.
- Encouraging timely introduction of complementary foods at 6 months with continuation of breastfeeding up to 2 years or beyond.
- Feeding different food groups at each serving. For example:
 - Animal-source foods such as chicken, fish, liver, eggs, and milk products **1 star***
(**Note: animal foods should be started at 6 months**)
 - Staples: grains such as maize, rice, millet, and sorghum; roots and tubers such as cassava and potatoes **2 stars****
 - Legumes such as beans, lentils, peas, and groundnuts; seeds such as sesame **3 stars*****
 - Vitamin A-rich fruits and vegetables such as mango, papaya, passion fruit, oranges, dark-green leaves, carrots, yellow sweet potato, and pumpkin; other fruits and vegetables such as banana, pineapple, watermelon, tomatoes, avocado, eggplant, and cabbage **4 stars******

NOTE: foods may be added in a different order to create a 4 star food/diet.

- Adding oil and fat such as oil seeds, margarine, ghee, and butter to vegetables and other foods to improve the absorption of some vitamins and provide extra energy. Infants only need a very small amount (no more than half a teaspoon per day).
- Using iodated salt.
- Feeding a sick child frequently (for 2 weeks after recovery).

‘Non-feeding’ actions to break the undernutrition cycle include:

- Practicing good hygiene.
- Attending GMP and immunization sessions.
- Using insecticide-treated bed nets.
- Deworming.
- Preventing and treating infections.
- Supplementing with Vitamin A.

Actions for the teenage girl

Promote appropriate growth by:

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

Actions for adult women

Improve women's nutrition and health by:

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

Encourage family planning by:

- Visiting a family planning center 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.)

Decrease energy expenditure by:

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

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 bed nets for use by their families and making sure the pregnant wives/partners and children get to sleep under the net every night.
- Support equal access to education for girls and boys.

Actions for the developing child/fetus: prevent low birthweight

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 she knows she is pregnant and continue for at least 3 months **after** delivery of the child.
- Giving vitamin A to the mother within 6 weeks after birth.
- Preventing and seeking early treatment of infections:
 - Completing anti-tetanus immunizations for pregnant women (five injections in total)
 - Using insecticide-treated bed nets
 - De-worming and giving anti-malarial drugs to pregnant women between the 4th and 6th month of pregnancy.
 - Prevention and education on sexually transmitted infection (STI) and HIV/AIDS transmission.
- Encouraging good hygiene practices.

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.

Encourage men's participation so that they:

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

Note on HIV and nutrition

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

Learning objective 4: Review best practices for delivery and postnatal care and explore beliefs and practices that may interfere with adopting healthy behaviors

Methodology: Brainstorming

Instructions for activity

1. Have each participant review CC 7 and CC 11.
2. Ask several participants to read aloud the key messages on the backs of CC 7 and CC 11.
3. On a flip chart, make three columns: health-seeking beliefs/behaviors that have a positive effect on obtaining proper delivery care and adopting healthy practices; health-seeking beliefs/behaviors that have a negative effect on obtaining proper delivery care and adopting healthy practices; and health-seeking beliefs/behaviors that neither help nor hinder obtaining proper delivery care and adopting healthy practices (no problem)
4. In large group, have participants brainstorm the health-seeking beliefs/behaviors that influence practice in their communities.
5. In large group, ask participants to decide on which column to place the beliefs/behaviors.
6. Ask participants for suggestions as to how the negatively impacting beliefs/behaviors might be changed (while always respecting the belief), and who in the household and community is best able to influence changes (e.g., grandmothers, child's father, religious groups, support groups).
7. Ask participants to suggest messages to address some of the major beliefs/behaviors in their communities that negatively impact health-seeking.
8. Discuss and summarize.

Counseling card 7: Delivery



Deliver at the health facility under care of a trained health worker. A trained health worker:

- Knows when complications are coming and can act quickly to save your life and the life of your baby.
- Can help you to keep your baby warm and to begin breastfeeding immediately following birth.

Hold your baby skin-to-skin immediately after delivery. Skin-to-skin contact with your baby:

- Helps the baby to stay warm and breathe well.
- Establishes a strong bond between you and your baby, and helps your baby feel secure.
- Encourages your baby to start breastfeeding immediately.

Beginning breastfeeding immediately after delivery has many benefits. It:

- Helps the baby to learn how to breastfeed.
- Reduces maternal bleeding.
- Helps the placenta to come out quickly.
- Helps to increase the production of breastmilk.
- Provides the baby with colostrum, which provides protection from illness.

Key information

It is critical that women and families know the benefit of having a trained health worker at delivery. There may be beliefs or concerns about costs, feasibility, or value of having a trained health worker at delivery that should be discussed.

Learning objective 5: Name the recommended time for spacing children and the criteria for the lactational amenorrhea method (LAM)

Methodology: Interactive presentation; group work

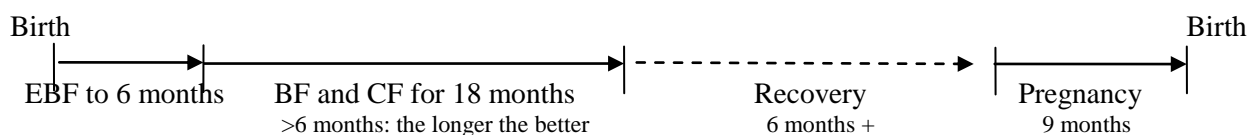
Instructions for activity

1. Ask participants, “What is the recommended time for spacing children?” After hearing comments, explain that the recommended time between babies is at least 3 years, and draw the timeline shown in ‘Key information,’ below.
2. Ask participants to discuss whether and how women in the communities relate breastfeeding and child spacing.
3. Ask participants to brainstorm the definition of LAM and LAM criteria.
4. Describe LAM and the LAM criteria and what to do when the criteria are not met (to continue to prevent pregnancy).
5. Divide participants into three groups, and ask the groups to look at **CC 7: Postnatal care** and comment on the counseling discussion points of the card.
6. Discuss and fill in gaps.

Key information

Spacing children

The recommended time for spacing children is **at least** 39 months (more than 3 years), as shown in the timeline below.



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

Note: Data from The Nutritional Institute of Central America and Panama (INCAP) suggest 6 months of exclusive breastfeeding, followed by at least 18 additional months 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 **CC 11: Postnatal care**.

Lactational amenorrhea method (LAM)

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

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

- Amenorrhea (no menses).
- Exclusive breastfeeding is practiced.
- 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 counseling at their nearest health facility. Communicate with fathers on the importance of child spacing/family planning, and that pregnancy before the age of 18 increases the health risks for the mother and her baby.

Counseling card 11: Postnatal care



Go to the health facility for a follow-up check on the 6th day and the 6th week after delivery. During these visits, the health worker will examine you and your baby and advise you on what you can do to maintain your health and that of the baby. The services provided during these visits include the following:

- Weighing the baby and counseling you on how your baby is growing and how to care for and feed the baby.
- Immunizing the baby.
- Giving you vitamin A (taking vitamin A within 45 days after delivery will protect you and your baby from diseases).
- Family planning counseling and services. It is important to think about family planning options in order to have time for you and your baby to be healthy and grow strong. Healthy timing and spacing of pregnancy means waiting at least 3 years before becoming pregnant again. It is also best to wait until at least 6 months after stopping breastfeeding before becoming pregnant. Healthy timing and spacing of pregnancy allows you and your baby enough time to grow strong and healthy before becoming pregnant again too soon.

Session 11. Introduction to infant feeding and care after 6 months

Learning objectives
1. Understand the importance of monitoring the child's growth
2. Review the Ethiopian immunization schedule for children under 2 years of age
3. Understand the importance of specific nutrients, especially vitamins A and D
4. List appropriate complementary foods and provide a variety of foods
5. Name beliefs about complementary feeding that should be discouraged, and address these beliefs

Materials

- Flip chart papers and stand, markers, tape/sticky putty
- Ethiopian growth charts
- Relevant counseling cards:
 - **CC: Monitoring your child's growth**
 - **CC: Immunization**
 - **CC: The importance of vitamins A and D**
 - **CC: Appropriate complementary foods**
 - **CC: Give a variety of foods**

Preparation

- Have samples (or photos) of a variety of appropriate complementary foods on display.

Duration: 60 min

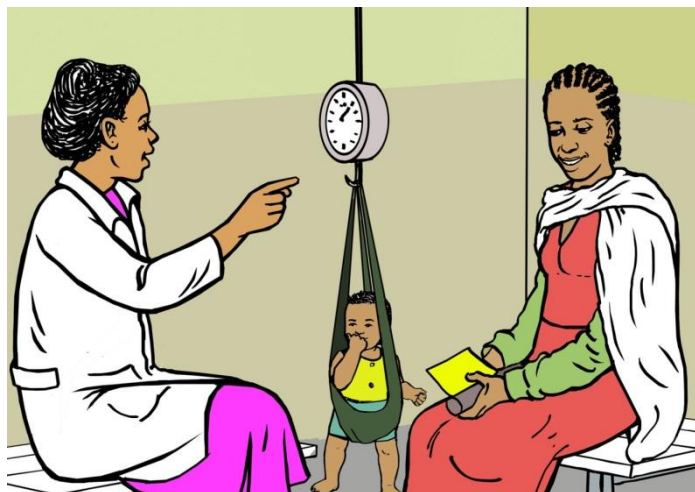
Learning objective 1: Understand the importance of monitoring the child's growth

Methodology: Group discussion

Instructions for activity

1. Ask participants to review **CC: Monitoring your child's growth**.
2. Ask participants, "Why is it useful to measure a child's growth?"
3. Review the information, correcting misinformation and answering questions from 'Key information,' below.
4. Examine a growth chart and describe a normal growth trajectory.
5. Discuss and summarize.

Counseling card: Monitoring your child's growth



During the first two years, take your child to be weighed regularly, to know how the child is growing and gaining weight. During weighing, the health worker will:

- Discuss with you how your baby is growing.
- Tell you if your baby has any health problems.
- Counsel you on what you can do to ensure the continued growth and development of your baby.

Key information

- The adequacy of a child's growth is the simplest indicator of a child's overall health status. That is why it is important to understand growth charts when counseling on infant feeding.
- By looking at the direction of the child's growth curve, the health worker and the mother can see at a glance whether the child is gaining weight appropriately or not.
- Each country has developed their own growth references (or standards).
- Health workers will use a growth chart to track a child's growth and monitor how he or she is growing in relationship to other children.
- A different growth chart must be used when examining girls instead of boys, since the rates and patterns of growth between sexes are very different.
- If growth charts are not interpreted accurately, incorrect information can be given to a mother, leading to worry and loss of confidence.
- Growth charts can reflect past and present conditions including food intake and health status.
- As well as weight, another measurement you may use is length or height.
- A child who is undernourished for a long time will show slow growth in length or height. This is referred to as stunting or very short height for age.
- A shorter child generally weighs less than a taller child of the same age and so they may be on different lines on the growth chart for weight. This is normal.

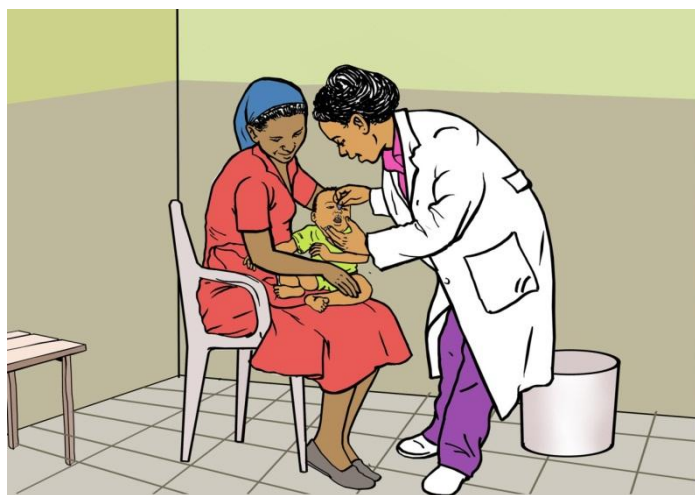
- What is most important is to see that the curve follows a trend that indicates the child is growing and there is no growth problem.
- Good feeding practices—both before the child is six months old and after complementary feeds have been introduced—can help prevent growth faltering in both weight and length.

Learning objective 2: Review the Ethiopian immunization schedule for children under 2 years of age

Instructions for activity

1. Ask participants to get into groups of three and review **CC: Immunization**, and the Ethiopian immunization schedule.
2. Have the groups discuss why immunizations are important, as well as local beliefs and behaviors around getting immunizations.
3. On paper, have the groups create a timeline of immunizations based on the Ethiopian guidelines.
4. Come together as a group and discuss some of the main points from the group work.

Card. Immunization



Take your child for immunization to protect your child from diseases. Ensure that the child finishes all of the immunizations for 1 year of age.

1 st visit: at birth or during the first contact within two weeks	TB (BCG) and polio immunizations
2 nd visit: 6 th week	Penta-1 vaccine dose and the first polio-1 immunization
3 rd visit: 10 th week	Penta-2 and the second polio immunization
4 th visit: 14 th week	Penta-3 and the third polio immunization
5 th visit: 9 th month	Measles immunization, along with vitamin A supplementation

Key information

- Timely immunization is critical to prevent major illness and possibly death of young children.
- Local beliefs, challenges to health-seeking, and lack of knowledge may make it difficult for the child to get immunized according to the guidelines.
- Specific memory tools can be created to help the mother (or guardian) maintain the immunization schedule.

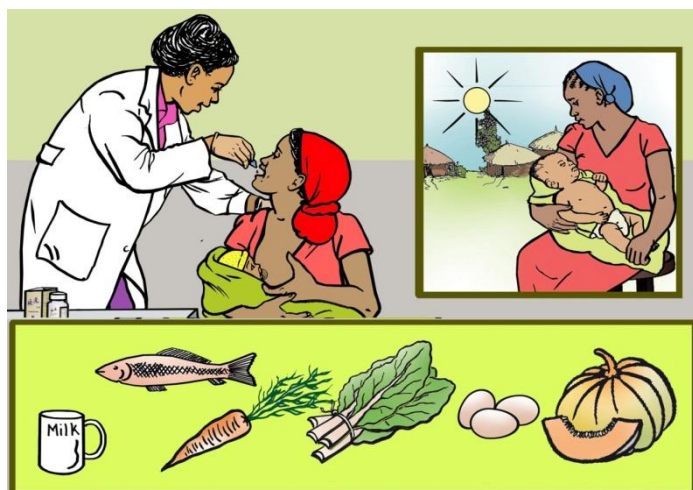
Learning objective 3: Understand the importance of specific nutrients, especially vitamins A and D

Methodology: Group discussion and group work

Instructions for activity

1. Discuss and summarize the need for specific nutrients in the diet.
2. Ask participants to review **CC 17: The importance of vitamin A and D**. Have participants read the back of the card.
3. Break into small groups and brainstorm on which local foods would be rich in vitamin A and what are the barriers to giving them to the child.
4. In large group, discuss ‘What are some ways of making these foods easier for the young child to eat?’
5. On a flip chart, list the vitamin A–rich foods and potential challenges and possible solutions to increase consumption.
6. Review suggestions related to obtaining vitamin D. Discuss possible local barriers to taking the baby outside in the sun.
7. Discuss and summarize.

Counseling card: The importance of vitamins A and D



Take vitamin A within 45 days after delivery—this will increase vitamin A in your breastmilk and protect your baby from diseases.

Vitamin A also:

- Strengthens your immune system and protects you from diseases.
- Protects the child's eyesight and strengthens the immune system.
- Helps your baby grow and develop well.

Expose your child to sunlight for 20 to 30 minutes daily (in the morning or evening). The sun's rays help the body to develop vitamin D, which strengthens bones and will help your child to grow well.

Make sure that your child gets vitamin A capsules starting at the age of six months. You can obtain vitamin A capsules at the health facility, and give them to your child until five years of age.

After your baby is six months old, give foods rich in vitamin A, including ripe yellow and orange fruits such as mango and papaya, vegetables such as carrots and kale, liver, and eggs.

Key information

It is important to feed young children a variety of foods, preferably from the different food groups. Eating a variety of foods provides important nutrients for children, including iron and vitamin A.

Vitamin A

- Good food sources of vitamin A are dark-green leaves and yellow-colored vegetables and fruits (e.g., spinach, pumpkin, carrots, and yellow sweet potato).
- Other sources of vitamin A:
 - Organ foods/offal (liver) from animals.
 - Milk and foods made from milk such as butter, local cheese (wura), and yogurt.
 - Egg yolks.
 - Margarine, dried milk powder, and other foods that have been fortified with vitamin A.
- Unbleached red palm oil is also rich in vitamin A (beta-carotene).
- Vitamin A can be stored in a child's body for a few months. Encourage families to feed foods rich in vitamin A as often as possible when these foods are available, ideally every day. A variety of vegetables and fruits in the child's diet help to meet many nutrient needs.
- Remember that breastmilk supplies much of the vitamin A required. A child that is not breastfed needs a diet rich in vitamin A.
- In many countries, vitamin A supplementation programs are available—for example, integrated management of childhood illness. If a program for vitamin A supplementation exists in your area, mention it here.

Vitamin D

- Very few foods have vitamin D.
- Exposing the baby to sunlight on a daily basis is the easiest way to get vitamin D.
- Without enough vitamin D, the baby can get bone diseases, such as rickets.

Learning objective 4: List appropriate complementary foods and provide a variety of foods

Methodology: Group discussion and group work

Instructions for activity

1. Have participants review CC 19 and CC 20. Ask two participants read aloud the back of the cards.
2. Remind the participants that this activity is just a summary—more detailed information on feeding during specific ages will be covered in subsequent sessions.
3. Break participants into groups of three.
4. While discussing both CC 19 and CC 20, have the participants develop several types of daily complementary meals and snacks for infants and children under two years of age.

5. Discuss these in the larger group.

Counseling card: Appropriate complementary foods



At six months, start giving your child other foods as you continue breastfeeding, to help your child grow healthy and strong.

- Start with food that is as thick as or thicker than honey and increase the thickness as the child grows older. Porridge should be thick enough to stay on the spoon without running off. Thin gruel does not give a child enough nutrients.
- Give a variety of nutritious foods. Give two or three kinds of foods during each feeding. Add oil to the food to increase the energy content.
- Give adequate amounts to make the child full. Serve the child on a separate plate to insure that he/she eats enough. This will also help you to know how much the child has eaten.

Babies/young children need to eat more food more often as they continue to grow. Feeding frequency increases as the age of the child increases.

- Between 6 and 8 months, a child needs two or three meals a day with one or two snacks.
- Between 9 and 23 months, a child needs three or four meals a day with one or two snacks.

Be patient and encourage your child to eat.

- Feed the child or sit with the child and encourage the child to eat by talking and singing songs.

Remember that when you introduce complementary foods to your baby at 6 months, you are no longer practicing LAM. You will need to use another family planning method even if your menses has not yet returned. By avoiding another pregnancy too soon, you can help your baby to grow strong.

Counseling card: Give a variety of foods



Try to feed a variety of foods at each meal.

Give two or three kinds of food during each feeding, prepared from:

- Cereals (injera, bread, kolo, nitro, kita, rice)
- Roots and tubers (potatoes, beetroots, onions, kocho)
- Animal, fish, and poultry products (meat, fish, chicken, milk, eggs, liver)
- Legumes (beans, peas, chickpeas, lentils)
- Oils and fats (butter, oil, sesame, ground nuts, linseed)
- Fresh fruits (ripe papaya, bananas, mango, oranges)
- Vegetables (carrots, pumpkins, kale, cabbage, tomatoes)

Animal-source foods are important and can be given to young children. Cook them well and chop them fine.

Use iodized salt.

Learning objective 5: Name beliefs about complementary feeding that should be discouraged, and address these beliefs

Methodology: Interactive presentation

Instructions for activity

1. On a flip chart, write the following column headings: Age, Frequency, Amount, Texture, Variety, Active/responsive feeding, and Hygiene. Write the following row headings: 6 up to 9 months, 9 up to 12 months, and 12 up to 24 months.
2. Keeping in mind both age of child and characteristics of complementary feeding (frequency, amount, thickness/consistency, variety, active/responsive feeding, and hygiene), ask participants to name complementary feeding beliefs in their communities that have a negative effect on feeding practices.
3. Ask participants to make suggestions as to how the negatively impacting beliefs might be

changed (while always respecting the belief), and who in the household and community is best able to influence changes (e.g., grandmothers, child's father, religious groups, support groups).

4. Ask participants to suggest key messages to address some of the major beliefs in their communities that negatively impact complementary feeding.
5. Discuss and summarize.

Session 12. Complementary feeding for children 6 to 24 months old

Learning objectives
1. Describe the importance of continued breastfeeding after 6 months
2. Describe the characteristics of complementary feeding: frequency, amount, texture, variety, active or responsive feeding, and hygiene
3. Describe recommended practices and possible points of discussion for counseling pertaining to child feeding from 6 up to 24 months
4. Discuss complementary feeding difficulties and poor practices

Materials

- Illustrations of porridge consistency, both thick and thin (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)
- Relevant counseling cards:
 - **CC: How to feed a child 6 to 8 months old**
 - **CC: How to feed a child 9 to 11 months old**
 - **CC: How to feed a child 12 to 23 months old**

Preparation

- Fill three glasses with water: completely full, $\frac{1}{2}$ full, and $\frac{1}{3}$ full, respectively
- Prepare flip chart with content as described in Learning Objective 3 (steps 2 and 3).
- Prepare examples of local foods (or illustrations of food groupings or illustrations of local foods) to place on chart from *Participant materials* 12.1: Recommended complementary feeding practices.

Duration: 90 min

Learning objective 1: Describe the importance of continued 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. On a flip chart, write the energy needs of a child from 0 up to 6 months, 6 up to 12 months, and 12 up to 24 months (as shown in 'Key information,' below); leave posted throughout the training.
3. Demonstrate the same information using three glasses: completely full, half ($\frac{1}{2}$) full, and one-third ($\frac{1}{3}$) full, respectively.
4. Review **CC: How to feed a child 6 to 8 months old** and read aloud the back of the card.
5. Discuss and summarize.

Key information

Energy needs

- 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 ($\frac{1}{2}$) of 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 ($\frac{1}{3}$) of 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.
 - Provide closeness, comfort, and contact that helps the child's development.

Learning objective 2: Describe the characteristics of complementary feeding: frequency, amount, texture, variety, active or responsive feeding, and hygiene

Methodology: Brainstorming

Instructions for activity

1. Brainstorm with participants the definition of complementary feeding.
2. Brainstorm with participants on the question: 'What are the characteristics of complementary feeding?'
3. Probe until the following characteristics are mentioned: frequency, amount, texture (thickness/consistency), variety (different foods), active or responsive feeding, and hygiene.
4. Discuss and summarize.

Key information

- Complementary feeding means giving other foods in addition to breastmilk.
- When an infant is 6 months old, breastmilk or formula 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

Characteristics of complementary feeding

F = Frequency of foods

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 counseling 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 flip charts with the following column headings: Age, Frequency, Amount, and Texture; and row headings: 6 up to 9 months, 9 up to 12 months, and 12 up to 24 months.
3. Distribute to one group pieces of paper with the chart content from *Participant materials*: 7.1.
4. Distribute to the other group local foods (or illustrations of food groupings, or illustrations of local foods) and local utensils (or pictures of local utensils).
5. Ask both groups to fill in their flip chart content—one group taping or sticking their pieces of paper in the appropriate boxes on their flip chart, and the second group placing the foods (or illustrations/photographs of local foods) and utensils (or pictures of utensils) in the appropriate boxes on their flip chart
6. Ask groups to continue until all chart content is filled.
7. Ask both groups to explain the entries on their flip chart.
8. Ask both groups: Which locally available foods contain iron? Which locally available foods contain vitamin A?
9. Distribute *Participant materials* 12.1: Recommended complementary feeding practices. Have the entire group decide what content/food/utensils need to be rearranged to match *Participant materials* 12.1.
10. Discuss and summarize.

B. Other materials

1. Distribute Training Aid 1: Illustrations of texture (thickness/consistency) of porridge (cup and spoon) to describe texture of complementary foods.
2. Distribute *Participant materials* 12.2: Different types of locally available. Orient participants to variety of foods, and discuss the importance of iron and vitamin A.
3. Distribute *Participant materials* 12.3: Recommended complementary feeding practices and possible counseling discussion points. Orient participants to the practices and discussion points; ask participants if there are other discussion points they want to add.
4. Distribute *Participant materials* 12.4: Active/responsive feeding for young and orient participants to key information.

Key information

- See *Participant materials* 12.1: Recommended complementary feeding practices.
- See *Participant materials* 12.2: Different types of locally available foods.
- See *Participant materials* 12.3: Recommended complementary feeding practices and possible counseling discussion points.
- See *Participant materials* 12.4: 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 6 months.
- There is little iron in breastmilk (although it is easily absorbed). After 6 months, the baby's iron needs must be met by the food he or she eats.
- The best sources of iron are animal foods, such as liver, lean meats, and fish. Some vegetarian foods such as legumes have iron as well. Other good sources are iron-fortified foods and iron supplements.
- Plant sources such as beans, peas, lentils, and spinach are a source of iron as well.
- Eating foods rich in vitamin C together with or soon after a meal increases absorption of iron.
- Drinking tea and coffee with a meal reduce the absorption of iron.

Vitamin A

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

Note: It is important to make sure that children from 6 months to 5 years receive the recommended supplement.

C. Group work

1. Divide participants into five working groups.
2. Ask working groups to look at **CC: Hygiene**. Ask them what information the card contains.
3. Ask each group to explain the characteristics of complementary feeding in the following counseling cards:
 - **CC: How to feed a child 6 to 8 months old**
 - **CC: How to feed a child 9 to 11 months old**
 - **CC: How to feed a child 12 to 23 months old**
 - **CC: Give a variety of foods**
4. Each group will present to the larger group one card about the characteristics of complementary feeding.
5. Ask other groups to share any additional points. Fill in any gaps.
6. Ask working groups to look at **CC: How to feed a sick child 6 to 23 months old**, and ask them what information the card contains.
7. Discuss and summarize.

Learning objective 4: Discuss complementary feeding difficulties and poor practices

Methodology: Buzz groups of three participants each

Instructions for activity

1. Divide into buzz groups, and ask participants to list 1) complementary feeding difficulties and poor practices they have seen in their communities and 2) consequences of inappropriate complementary feeding.
2. Ask several groups to share their lists of complementary feeding difficulties and the consequences of inappropriate complementary foods. Write the lists on a flip chart.
3. Ask additional groups to add any new difficulties not already mentioned.
4. Discuss and summarize.

Key information

Complementary feeding difficulties and consequences for young children and mothers

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

Note: The period from 0 up to 24 months is a key window of opportunity for children's development. If children are poorly nourished at this age, it will be very hard to catch up later in life.

Participant materials 12.1: 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 6 months	2 to 3 meals plus frequent breastfeeds	Start with 2 to 3 tablespoons Start with ‘tastes’ and gradually increase amount	Thick porridge/pap	Breastfeeding (Breastfeed as often as the child wants) + Animal foods (local examples) + Staples (porridge, other local examples) + Legumes (local examples) + Fruits/ vegetables (local examples)
From 6 up to 9 months	2 to 3 meals plus frequent breastfeeds 1 to 2 snacks may be offered	2 to 3 tablespoonfuls per feed Increase gradually to half (½) 250 ml cup/bowl*	Thick porridge/pap Mashed or pureed family foods	
From 9 up to 12 months	3 to 4 meals plus breastfeeds 1 to 2 snacks may be offered	Half (½) 250 ml cup/bowl	Finely chopped family foods Finger foods Sliced foods	
From 12 up to 24 months	3 to 4 meals plus breastfeeds 1 to 2 snacks may be offered	Three-quarters (¾) to one 250 ml cup/bowl	Sliced foods Family foods	

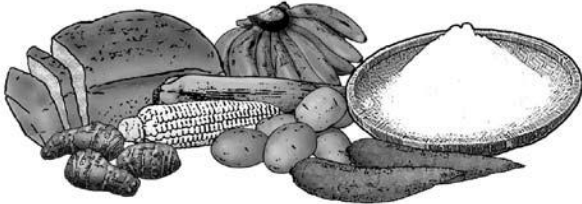
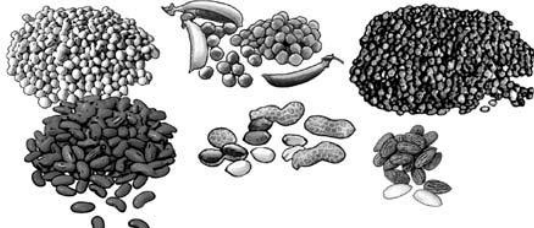

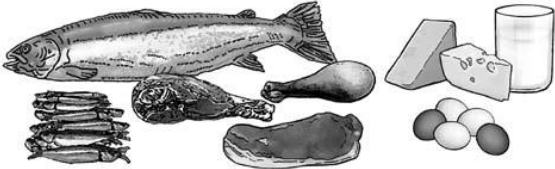

Session 12. Recommended practices: Complementary feeding for children 6 to 24 months old

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

Adapted from *WHO Infant and Young Child Feeding Counselling: An Integrated Course* (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 iodized salt in preparing family foods.

Participant materials 12.2: Different types of locally available foods


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

Participant materials 12.3: Recommended complementary feeding practices and possible counseling discussion points

Recommended complementary feeding practice	Possible counseling discussion points Note: choose two or three points most relevant to mother's situation and/or ADD other discussion points from knowledge of area
After baby reaches 6 months of age, add complementary foods (such as thick porridge 2 to 3 times a day) to breastfeeds.	<ul style="list-style-type: none"> • Give local examples of first types of complementary foods. • When possible, use milk instead of water to cook the porridge. Breastmilk can be used to moisten the porridge. • CC: Hygiene • CC: How to feed a child 6 to 8 months old
As baby grows older, increase feeding frequency, amount, texture, and variety.	<ul style="list-style-type: none"> • Gradually increase the frequency, amount, texture (thickness/consistency), and variety of foods, especially animal-source foods. • CC: Hygiene • CC: How to feed a child 6 to 8 months old • CC: How to feed a child 9 to 11 months old • CC: How to feed a child 12 to 23 months old
Complementary feeding from 6 up to 9 months: breastfeed plus give 2 to 3 meals and 1 to 2 snacks per day.	<ul style="list-style-type: none"> • Start with 2 to 3 tablespoonfuls of cooked porridge or mashed foods (give examples of cereals and family foods). • At 6 months, these foods are more like 'tastes' than actual servings. • Make the porridge with milk, especially breastmilk; can add pounded groundnut paste (a small amount of oil may also be added). • Increase gradually to half (½) cup (250 ml cup). Show amount in cup brought by mother. • Any food can be given to children after 6 months as long as the food is mashed or finely chopped. Children do not need teeth to consume foods such as eggs, meat, and green leafy vegetables. • CC: Hygiene • CC: How to feed a child 6 to 8 months old • CC: Give a variety of foods
Complementary feeding from 9 up to 12 months: breastfeed plus give 3 to 4 meals and 1 to 2 snacks per day.	<ul style="list-style-type: none"> • Give finely chopped foods, mashed foods, and finger foods. • Increase gradually to ½ cup (250 ml cup). Show amount in cup brought by mother. • Animal-source foods are very important and can be given to young children: cook well and cut into very small pieces. • CC: Hygiene • CC: How to feed a child 9 to 11 months old • CC: Give a variety of foods

Session 12. Recommended practices: Complementary feeding for children 6 to 24 months old

Recommended complementary feeding practice	Possible counseling discussion points Note: choose two or three points most relevant to mother's situation and/or ADD other discussion points from knowledge of area
Complementary feeding from 12 up to 24 months: give 3 to 4 meals and 1 to 2 snacks per day, with continued breastfeeding.	<ul style="list-style-type: none"> • Give family foods. • Give three-quarters ($\frac{3}{4}$) to one cup (250 ml cup/bowl). Show amount in cup brought by mother. • Foods given to the child must be prepared and stored in hygienic conditions to avoid diarrhea and illness. • Food stored at room temperature should be used within 2 hours of preparation. • CC: Hygiene • CC: How to feed a child 12 to 23 months old • CC: Give a variety of foods
Give baby 2 to 3 different family foods at each serving: staple, legumes, vegetables/fruits, and animal foods.	<p>Try to feed different food groups at each serving. For example:</p> <ul style="list-style-type: none"> • Animal-source foods such as chicken, fish, liver, eggs, milk, and milk products 1 star* • Staples: grains such as maize, wheat, rice, millet, and sorghum; roots and tubers such as sweet potatoes, potatoes, and cassava 2 stars** • Legumes such as beans, lentils, peas, and groundnuts; seeds such as sesame 3 stars*** • Vitamin A-rich fruits and vegetables such as mango, papaya, passion fruit, dark-green leaves, carrots, yellow sweet potato and pumpkin; other fruits and vegetables such as banana, pineapple, watermelon, tomatoes, avocado, eggplant and cabbage 4 stars**** • Add a small amount of fat or oil to give extra energy (additional oil will not be required if fried foods are given, or if baby seems healthy/fat) • CC 21 to 23 (complementary feeding counseling cards)
Continue breastfeeding until two years of age or older.	<ul style="list-style-type: none"> • During the first and second years, breastmilk is an important source of nutrients for your baby. • Breastfeed between meals and after meals; don't reduce the number of breast feeds. • CC 21 to 23 (complementary feeding counseling cards)
Be patient and actively encourage baby to eat all his/her food.	<ul style="list-style-type: none"> • At first, the baby may need time to get used to eating foods other than breastmilk. • Use a separate plate to feed the child to make sure he or she eats all the food given. • See <i>Participant Materials</i> 12.4: Active/responsive feeding for young children. • CC 21 to 23 (complementary feeding counseling cards)

Recommended complementary feeding practice	Possible counseling discussion points Note: choose two or three points most relevant to mother's situation and/or ADD other discussion points from knowledge of area
<p>Wash hands with soap and water before preparing food, eating, and feeding young children. Wash baby's hands before eating.</p> 	<ul style="list-style-type: none"> • Foods intended to be given to the child should always be stored and prepared in hygienic conditions to avoid contamination, which can cause diarrhea and other illnesses. • Wash your hands with soap and water after using the toilet and after washing or cleaning baby's bottom. • CC: Hygiene
<p>Feed baby using a clean cup and spoon.</p>	<ul style="list-style-type: none"> • Cups are easy to keep clean. • CC 21 to 23 (complementary feeding counseling cards)
<p>Encourage the child to breastfeed more and continue eating during illness; provide extra food after illness.</p>	<ul style="list-style-type: none"> • Fluid and food requirements are higher during illness. • It is easier for a sick child to eat small frequent meals. Feed the child foods he or she likes in small quantities throughout the day. • Children who have been sick need extra food and should be breastfed more frequently to regain the strength and weight lost during the illness. • Take advantage of the period after illness when appetite is back to make sure the child makes up for loss of appetite during sickness. • CC 25: How to feed a sick child 6 to 23 months old

Note:

- Use iodized salt in preparing family foods.
- Provide vitamin A supplementation to infants and young children beginning at 6 months (or as per national recommendations), every six months until 5 years.
- In areas 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 normal 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.

Participant materials 12.4: Active/responsive feeding for young children

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

Importance of active feeding

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

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



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

Session 13. Review counseling cards on complementary foods for children 6 to 24 months old

Learning objectives

1. Give practical help to a mother/father/caregiver in preparing complementary foods for a baby over 6 months

Materials

- Locally available, affordable, and seasonal foods (local foods as used in Session 12)
- *Participant materials 13.1*: Using a counseling card with a group
- Local recipes

Duration: 30 min

Learning objective 1: Give practical help to a mother/father/caregiver in preparing complementary foods for a baby over 6 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 12.1*: Recommended complementary feeding practices and possible counseling discussion points and *Participant materials 12.2*: Different types of locally available foods.
4. Have each group review counseling cards CC 21, CC 22, and CC 23. Use *Participant materials 13.1*: Using a counseling card with a group.
5. Ask each group to prepare appropriate complementary foods for one of the following age groups:
 - At 6 months
 - From 6 up to 9 months
 - From 9 up to 12 months
 - From 12 up to 24 months
6. Ask each group to show and explain the prepared food to the entire group, discussing age-appropriate characteristics of complementary feeding: frequency, amount, thickness (consistency), variety, active/responsive feeding, and hygiene.
7. Discuss and summarize.

Participant materials 13.1. Using a counseling card with a group

Use the questions below to help participants consider trying a practice shown on a counseling card.



Adapted from: LINKAGES Project. Behavior Change Communication for Improved Infant Feeding: Training of Trainers for Negotiating Sustainable Behavior Change. Washington, DC: Academy for Educational Development; 2004.

1. THINK

- What do you think is happening in the picture?
- Is this a common practice in our community?
- What is the advantage of doing the action shown in the picture?
- Why is he or she doing this? (When appropriate.)

2. FEEL

- How do you feel about this practice?
- Do you agree with the actions in the picture? Why? Why not?
- Is this something you would feel comfortable doing?
- What would you do in the same situation? Why?
- What difficulties might you experience?

3. DO

Repeat the key messages:

- Are you willing to try this?
- How would you overcome any barriers to trying this?
- When will you try it?
- How will you do it?

Discuss specific actions that participants can try.

Counseling card 21: How to feed a child 6 to 8 months old



At 6 months, start giving your child complementary foods as you continue breastfeeding. Continue to breastfeed on demand at least 8 times day and night. Frequent feeding makes your child healthy and strong.

- Breastfeed the child first, and then give other foods.
- Start with porridge as thick as honey or thicker.
- Increase thickness to semi-solid mashed foods as child grows older.

Small children have small stomachs and can only eat small amounts at each meal, so feed your child many times in a day:

- Between 6 and 8 months of age, feed the child 2 or 3 times a day; serve one buna cup of food at each meal.
- Give the child 1 or 2 snacks between meals.

The meals should include a variety of foods, such as cereal porridge, bread, kita, enset (bula), fruits, vegetables, meat, milk, potatoes, sweet potatoes, beans, eggs, and fish. Give 2 or 3 different kinds of foods at each feed.

- From 6 months, babies can eat a variety of foods as long as they are soft or pureed.
- Wash your hands and use a clean cup and spoon to feed your child.
- Store the child's food in a clean place.
- For a baby older than 6 months, a few sips of boiled or treated water from a clean, open cup can be offered after the child is full on breastmilk. Too much water can fill the baby up so he breastfeeds and eats less. Babies need the nutrition and calories in breastmilk to grow; water does not have these.

Key information

At 6 months

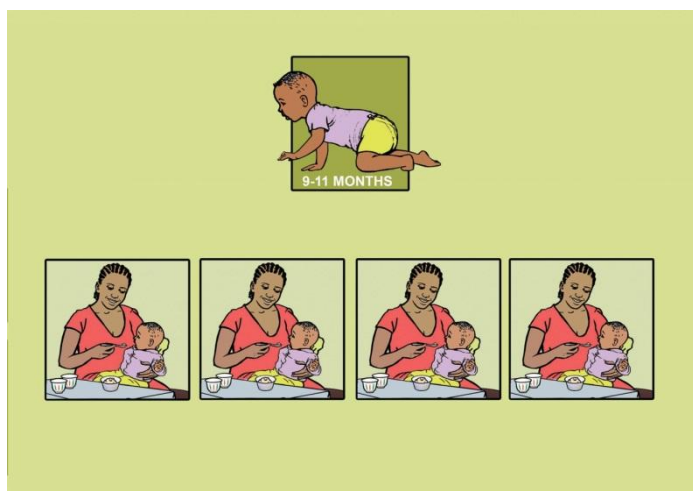
- Babies have small stomachs and can only eat small amounts at each meal, so it is important to feed them frequently throughout the day.

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

From 6 up to 9 months

- An 8-month-old's stomach holds about 200 ml (less than a cup).
- Add colorful (variety) foods to enrich the staple, including beans, peanuts, peas, lentils, or seeds; orange/red fruits and vegetables (such ripe mango, papaya, carrots, and pumpkin); dark-green leaves (such as kale, 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, 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 iodized salt.
- Continue breastfeeding.
- Offer additional nutritious snacks (such as fruit or bread or bread with nut paste) once or twice per day, as desired.
- Foods intended to be given to the child should always be stored and prepared in hygienic conditions to avoid contamination, which can cause diarrhea and other illnesses.

Counseling card 22: How to feed a child 9 to 11 months old



At 6 months, start giving your child complementary foods as you continue breastfeeding. Continue to breastfeed on demand at least 8 times day and night. Frequent feeding makes your child healthy and strong.

Between 9 and 11 months, feed the child 3 to 4 times a day. Serve one buna cup of food at each meal. Give the child 1 or 2 snacks between meals.

The meals should include a variety of foods, such as cereal porridge, bread, kita, enset (bula), fruits, vegetables, meat, milk, potatoes, sweet potatoes, beans, eggs, and fish. Give 2 or 3 different kinds of foods at each feed.

- By 1 year of age, the baby is old enough to feed himself soft foods as well as foods and fruits cut in small pieces.
- Wash your hands and use a clean cup and spoon to feed your child.
- Store the child's food in a clean place.
- Give the child a few sips of boiled or treated water from a clean, open cup after the child is full on breastmilk or food. Too much water can fill the baby up so that he breastfeeds and eats less.

Babies need the nutrition and calories in breastmilk to grow; water does not have these.

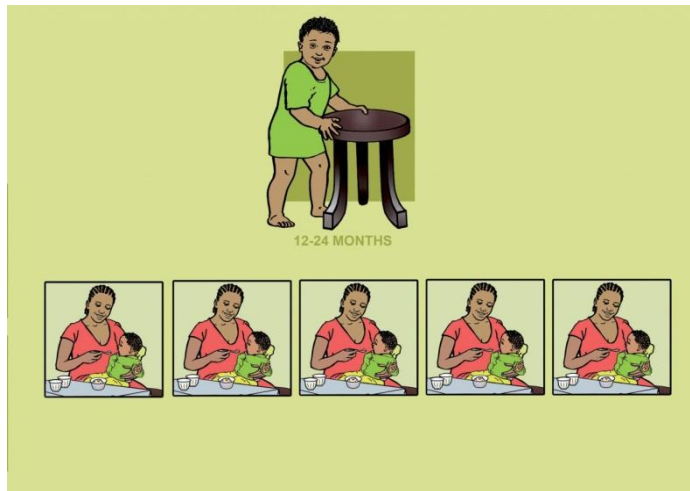
Key messages

From 9 up to 11 months

- Add colorful (variety) foods to enrich the staple, including beans, peanuts, peas, lentils, or seeds; orange/red fruits and vegetables (such ripe mango, papaya, carrots, and pumpkin); dark-green leaves (such as kale, chard); and avocado.
- Add animal-source foods: meat, chicken, fish, liver, eggs, milk, and milk products (whenever available).
- Give at least 1 to 2 snacks each day such as ripe mango and papaya, avocado, banana, other fruits and vegetables, bread, boiled potato, and sweet potato.
- Use iodized salt.
- Continue breastfeeding.

- Foods intended to be given to the child should always be stored and prepared in hygienic conditions to avoid contamination, which can cause diarrhea and other illnesses.

Counseling card 23: How to feed a child 12 to 23 months old



By 1 year of age, a child is old enough to eat food eaten by everyone in the family.

The child needs 3 to 4 meals a day, plus 1 or 2 snacks. Serve 1 to 1.5 cups of family food per meal in a separate bowl.

- Cut the food in small pieces that the child can chew and swallow without difficulty.
- Continue to breastfeed until the child is 2 years or older.
- Use iodized salt to prepare food for both the family and child.
- If the child wants, give small amounts of boiled or treated water after eating. Use a clean, open cup.
- Avoid giving your child sugary foods. Sugary foods spoil the teeth.
- Wash your child's hands with soap and water.

Key messages

From 12 up to 24 months

- Add colorful (variety) foods to enrich the staple, including beans, peanuts, peas, lentils, or seeds; orange/red fruits and vegetables (such as ripe mango, papaya, carrots, and pumpkin); dark-green leaves (such as kale, 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 3 times each week).
- Give at least 1 to 2 snacks each day such as ripe mango and papaya, avocado, banana, other fruits and vegetables, bread, boiled potato, and sweet potato.
- Use iodized salt.
- Continue breastfeeding to 24 months or beyond.
- Foods intended to be given to the child should always be stored and prepared in hygienic conditions to avoid contamination, which can cause diarrhea and other illnesses.

Session 13. Review counseling cards on complementary foods

Note: Wash hands with soap and water before preparing food and feeding child.

Session 14. Taking an infant and young child feeding assessment

Learning objectives
1. Assess infant and young child feeding practices to help diagnose any feeding difficulties
2. Demonstrate ability to use <i>Participant materials 7.1</i> : Observation checklist for infant and young child feeding assessment of mother/child pair to observe the use of the Infant and Young Child Feeding Assessment Form (<i>Participant materials 14.1</i>).

Materials

- *Participant materials 7.1*: Observation checklist for infant and young child feeding assessment of mother/child pair
- For the demonstration: Using the Infant Feeding Assessment Form.
- Refer to the introduction for general information about how to give a demonstration.

Preparation

- Write the session objectives on a flip chart.
- Study the session notes so that you are clear about what to do.
- Arrange with the other trainer in your group how to do the demonstration. Decide who will be Mrs. Ikeh and who will be Nurse Hauwa. Fill in a local growth chart for Tosin, and have it ready for the demonstration.
- Make sure that copies of Assessment forms 1-5 are available (on cards or paper). They should not have the comments with them. Each group of four or five participants needs one set of copies.
- Fill in a local growth chart for the baby in each of the assessment forms.
- Have loose copies of the Infant and Young Child Feeding Assessment Form (*Participant materials 14.1*) available for participants.
- Read the comments at the end of each assessment, to help you with the discussion of each pair practice.
- Decide how you will conduct the exercise. In some situations, participants may have difficulty in reading the assessment quickly. An alternative way to conduct the exercise is for a trainer to play the part of the mother, while one of the participants takes her assessment.

Duration: 60 min

Learning objective 1: Assess infant and young child feeding practices to help diagnose any feeding difficulties

Methodology: Group work and demonstration

Instructions for activity

1. Explain why it is necessary to do an assessment.

Make these points:

- If a mother asks for your help, you need to understand her situation.
 - You cannot learn everything that you need to know by observing and listening and learning. You need to ask some questions.
 - Doing an assessment means asking relevant questions in a systematic way.
2. Ask: What things can you only learn if you ASK the mother? (Let participants make 5 or 6 suggestions. Then continue.) Examples include:
 - When the baby was born.
 - What happened at the time of delivery.
 - What else she feeds her baby.
 3. Ask participants to find in their manuals the box called 'How to do an infant and young child feeding assessment.'
 4. Ask them to take turns reading the information aloud; discuss each point to make sure that it is clear.

How to do an infant and young child feeding assessment

Specific skills to use:

Use the mother's name and the baby's name (if appropriate).

Greet the woman in a kind and friendly way. Introduce yourself, and ask her name and the baby's name. Remember and use them, or address her in whatever way is culturally appropriate.

Ask her to tell you about herself and her baby in her own way.

- Let her tell you first what she feels is important. You can learn the other things that you need to know later.
- Use your listening and learning skills to encourage her to tell you more.

Look at the child's growth chart.

It may tell you some important facts and save you asking some questions.

Ask the questions that will tell you the most important facts.

- You will need to ask questions, including some closed questions, but try not to ask too many.
- The Infant and Young Child Feeding Assessment Form is a guide to the facts that you may need to learn about. Decide what you need to know from each of the six sections.

Take time to learn about more difficult, sensitive things.

- Some things are more difficult to ask about, but they can tell you about a woman's feelings, and whether she really wants to breastfeed.
- What have people told her about breastfeeding?
- Does she have to follow any special 'rules'?
- What does the baby's father say? Her mother? Her mother-in-law?
- Did she want this pregnancy at this time?
- Is she happy about having the baby now? About the baby's sex?

Some mothers tell you these things spontaneously. Others tell you when you empathize, and show that you understand how they feel. Others take longer. If a mother does not talk easily, wait, and ask again later, or on another day, perhaps somewhere more private.

Be aware of the following behaviors:

Be careful not to sound critical.

- Ask questions politely. For example:
 - Do not ask: "Why are you bottle feeding?"
It is better to say: "What made you decide to give (name) some bottle feeds?"
 - Use your 'building confidence and giving support' skills.
 - Accept what the mother says, and praise what she is doing well.

Try not to repeat questions.

- Try not to ask questions about facts that either the mother or the growth chart has told you already.
- If you do need to repeat a question, first say: "Can I make sure that I have understood clearly?" and then, for example, say: "You said that (name) had both diarrhea and pneumonia last month?"

Introducing the Infant and Young Child Feeding Assessment Form

1. Make these points:
 - You will use a special form, the Infant and Young Child Feeding Assessment Form, to help you remember what questions to ask.
 - When you first learn to use the form, you need to ask all the questions. As you become more experienced, you learn which questions are relevant for which mothers. Then you do not need to ask all the questions every time.
 - It also helps you practice the counseling skills you have learned.
2. Ask participants to look at the Infant and Young Child Feeding Assessment Form in their manuals.
3. Explain the form, as follows:
 - This is a guide, to help you to organize your thoughts, so that you do not get lost when you talk with a mother. It lists the main points that you may need to ask about a mother and baby. You may need to follow up some questions with more detailed questions. It also helps you practice with a mother the counseling skills you have learned.
 - The form is divided into six sections to help you to remember what you need to ask about.
 - The first two sections are about the baby and how he/she is feeding now.
 - The third section is about the mother's pregnancy and delivery.
 - The fourth section is about the mother and her health and family planning.
 - The fifth section is about her previous experience of feeding infants.
 - The sixth section is about the family and their social situation.
 - Often, questions about items in the first two sections will help you to understand a problem. Sometimes you need to find out more about the mother, her pregnancy and delivery, her previous babies, or the family's situation, before you can understand her difficulties.
 - **Key point:** Start with the first two sections. They are the most important. Then continue through the other sections until you are clear about the problem. When you are clear, you need not continue to ask about all the other items.
 - However, it is a good idea to ask each mother about something from each section. Think quickly through all six sections, and ask yourself what might be important for this family.
 - If at any time a mother wants to tell you about something that is important to her, let her tell you that first. Ask about the other things afterward.
4. Ask participants to make themselves familiar with the form:
 - Study the form and try to memorize the titles of the six sections. When you know the sections, you will find it easier to remember the different items in each.
 - When you first use it, go through the whole form. This will help you to learn how to take an infant feeding assessment. As you gain experience, you will find it easier to choose which questions to ask.

Demonstrating how to use the Infant and Young Child Feeding Assessment Form

1. Explain that you will demonstrate how to use the Infant and Young Child Feeding Assessment Form.
2. Follow the story of Mrs. Ikeh and her baby Lucy in the story below. One trainer plays the part of Mrs. Ikeh, and the other trainer is Nurse Hauwa.
3. Nurse Hauwa greets the mother, asks her name, and asks how she is doing. Mrs. Ikeh tells Nurse Hauwa her 'complaint,' and then Nurse Hauwa assesses her 'history.' She asks to see the baby's growth chart. Try to demonstrate some 'listening and learning' and 'confidence building' skills.
4. Go through the Infant and Young Child Feeding Assessment Form, asking questions from Sections 1 to 6. Mrs. Ikeh responds following the story, which is arranged in the same six sections. If Mrs. Ikeh adds information, it must fit with the story.

Participant materials 14.1: Infant and young child feeding assessment form

Mother's name _____ Baby's name _____ Date of birth _____

Reason for consultation _____

1. Baby's feeding now If baby is breastfeeding	How often..., Length of breastfeeds..., Longest time between feeds..., (time mother away from baby), Feeds from one or both breasts...	Day feeds	Night feeds
If baby is on replacement feeds	Type of feed..., How fed (cup, bottle, spoon)..., Amount per feed..., How many feeds..., How feeds are prepared (ingredients, dilution, hygiene)		
If baby is on complementary feeds	Type of feed..., How fed (cup, bottle, spoon)..., Amount per feed..., How many feeds..., How feeds are prepared (ingredients, dilution, hygiene)		
2. Baby's health and behavior (Ask about all these items)	Full term or premature..., Singleton or twin..., Birth weight..., Weight now..., Growth/development..., Current urine output (</>6 times per day)..., Stools (soft, yellow/brown; hard or green; frequency)..., Feeding behavior (appetite, vomiting)..., Sleeping behavior..., Illness/Abnormalities...		
3. Antenatal, natal, postnatal periods	Antenatal care (attended or not)..., Delivery (normal, abnormal)..., Bedding in..., Prolactal feeds..., Antenatal/Natal/Postnatal feeding support received..., Time first fed..., How fed (breastfed/replacement fed)...		
4. Mother's health	Age..., Literacy..., Health status (including HIV status)... Use of family planning methods and type used... Breast conditions..., Current medication... Use of alcohol, smoking, coffee, drugs...		
5. Previous infant feeding experience	No. of previous babies..., How many breastfed?... Any use of spouted cup/bottles... Experience in feeding and reasons...		
6. Family and social situation	Work situation..., Economic situation..., Male partner attitude toward and involvement in feeding..., Other family members' attitudes toward feeding..., Family support with child care...		

Demonstration 14.A: Using the Infant and Young Child Feeding Assessment Form

Mrs. Ikeh's complaint: "Tosin is really feeding too much"

1. Tosin is 3 months old and breastfeeds about 10 to 12 times a day—sometimes every 1 or 2 hours, sometimes after 5 or 6 hours. She breastfeeds about twice in the night. You (Mrs. Ikeh) do not give any complementary milk feeds, but you sometimes give drinks of water from a spoon.
2. Tosin is gaining weight well, and she is very healthy. She passes urine 6 to 8 times a day. Her growth chart shows that she is gaining weight.
3. Tosin was born in hospital, and started breastfeeding soon after delivery. She roomed-in with you and did not have any prelacteal feeds. The midwife helped you and you had no difficulties.
4. You are 25 years old and healthy. You are not using any family planning method. You think that breastfeeding is very healthy, and you want to continue.
5. Tosin is your first baby.
6. You stay at home, and do not go out to work. Tosin's father works as a clerk. Tosin's father thinks that it is time the baby stopped having night feeds.

Discuss the demonstration

Ask: What do you think is the cause of Mrs. Ikeh's difficulty? (*Mr. Ikeh wants her to stop breastfeeding.*)

Is Mrs. Ikeh's idea of the problem correct? (*No—anyway, not what she says.*)

What misunderstanding may have given her this idea? (*The baby sometimes wants to feed again quite soon. But this is normal.*)

Now ask the group to think about the technique of taking an infant and young child feeding assessment. Ask these questions:

- Did Nurse Hauwa ask questions from all six sections of the Infant and Young Child Feeding Assessment Form?
- Did she leave out any important questions?
- Did asking questions from each section of the form help her to understand the problem?
- Point out that continuing to Section 6 helped Nurse Hauwa to remember to ask about the father's attitude. It is clear that it is the father's attitude to Tosin's breastfeeding which is making Mrs. Ikeh worry about how often Tosin breastfeeds.

Learning objective 2: Demonstrate ability to use *Participant materials 7.1* Observation checklist for infant and young child feeding assessment of mother/child pair to observe the use of the Infant and Young Child Feeding Assessment Form

Methodology: Group work and demonstration

Instructions for activity (assessment practice exercise)

1. Give each participant a copy of *Participant materials 14.1: Infant and Young Child Feeding*

Assessment Form and *Participant materials 7.1*: Observation checklist for infant and young child feeding assessment of mother/child pair. Explain that this is exactly the same form as they studied earlier in this session.

2. Give each participant a copy of one of the assessments and a growth chart filled in for the baby in the assessment.
3. Use role-play to practice taking a feeding assessment and following the Infant and Young Child Feeding Assessment Form.
4. Work in groups of three, and take turns being a 'mother' or 'counselor' or observer. When you are a 'mother,' play the part of the mother in the assessment on your card.
5. You are the only one in the group who has a copy of your assessment. Conceal it from the others. Look only at your own assessment.
6. Each assessment has six sections, which are the same as the six sections in the Infant and Young Child Feeding Assessment Form. There is some information in each section, so it is important to ask questions relating to each section of the form.
7. Ask participants to read their histories through, and to study the growth chart. Allow 3 minutes.
8. They can ask you questions about anything that they do not understand.

Explain how to do the pair practice

If you are the 'counselor':

- Greet the 'mother' and ask her how she is. Use her name and her baby's name.
- Ask one or two open questions about breastfeeding to start the conversation.
- Ask the 'mother' questions from all six sections of the Infant and Young Child Feeding Assessment Form, and look at the baby's growth chart to learn about the situation.
- You can make brief notes on the form, but try not to let it become a barrier.
- Use your listening and learning skills.
- Do not give information or suggestions, or give any advice.

If you are the 'mother':

- In response to the 'counselor's' open questions, read aloud the reason for the visit.
- Answer the 'counselor's' questions from the information in your assessment.
- If the information to answer a question is not in your assessment, make up information to fit with the assessment.
- If your 'counselor' uses good listening and learning skills, give her the information more easily.

If you are observing:

- Follow the pair practice with your Infant and Young Child Feeding Assessment Form, and observe whether the 'counselor' takes the assessment correctly.
- Notice if she asks relevant questions, if she misses important questions, and if she asks questions from all sections of the form.
- Try to decide if the 'counselor' has understood the mother's situation correctly.
- During discussion, be prepared to praise what the players do right, and to suggest what they could do better.

Exercise 14.A: Taking an infant and young child feeding assessment

Assessment 1.

Reason for visit: “I have brought Niyi for immunization. Everything is fine.”

Assessment:

1. I give him formula, about 3 bottles a day, with 2 spoonfuls of milk powder in each bottle. He had difficulty in suckling when he was born, so I gave him bottle feeds while I tried to breastfeed. He has refused to breastfeed for 2 weeks.
2. He is 6 weeks old and weighs 2.5 kilos. He was born in hospital and weighed 2.0 kilos. He has 2 or 3 soft stools a day.
3. No one discussed breastfeeding in the antenatal clinic. In hospital, he was in the nursery for 6 hours. The midwives did not help me to breastfeed. I was discharged after 24 hours. I started trying to breastfeed after 2 days. This is my first visit to a health center.
4. I am 19 years old and healthy. I had plenty of milk, and I wanted to breastfeed. But my nipples are flat, so I could not.
5. This is my first baby.
6. I am a housewife, and my husband bought the tins of formula. I have not thought about family planning. My mother lives a long way away.

Comments:

The baby refused to breastfeed because he was given bottle feeds. The mother did not have early contact, or help to breastfeed in the first day. She needed help for flat nipples, this is her first baby, and her baby was small. She did not complain about her difficulties, and you only learn about this serious situation by taking an assessment.

Assessment 2.

Reason for visit: “Niyi has diarrhea.”

Assessment:

1. I breastfeed him often, and he sleeps with me at night. I give him thin cereals in a bottle, 2 or 3 times a day. I started this when he was 6 weeks old.
2. He was born in hospital, and weighed 3.0 kilos. He weighed 4.5 kilos at 2 months, and weighs 4.8 kilos now, at the age of 4 months. When he was 6 weeks old, he cried to be fed often; that is why I started cereal feeds. But now he has less appetite, and is passing watery stools.
3. He started to breastfeed soon after delivery. The midwife helped me and I had no difficulties.
4. I am aged 30, and well. I rely on breastfeeding for family planning until my periods start again.
5. I had two previous children. I breastfed both without any difficulty.
6. I work on a small farm with my husband and his parents. My mother-in-law helps me very much. She advised me to start cereals, because of the crying.

Comments:

On assessment Section 2, her baby was hungry with a growth spurt. She gave dilute cereal feeds but they were not necessary. This has caused diarrhea. You know the reason for the diarrhea by the end of Section 2. However, in Section 6, you learn that it is her mother-in-law

who advises her.

Assessment 3.

Reason for visit: “I have sore nipples.”

Assessment:

1. I breastfeed my baby many times a day, for about 20 to 30 minutes each time.
2. She weighed 4.0 kilos when she was born. Now she is 3 weeks old and weighs 4.5 kilos. She is well.
3. She was born by Caesarian section, and was kept in the nursery and bottle fed for 2 days. Since then I have been trying to breastfeed, but my baby had difficulty in learning to suckle. The midwives suggested bottles, but I did not want to bottle feed. I persisted with breastfeeding until now. Nobody asked me about breastfeeding at the antenatal clinic.
4. I am 26, and healthy. I am disappointed because I really want to breastfeed, but my nipples hurt so much that I will have to give up. They bleed sometimes.
5. I had one baby before. I breastfed him, but I never had enough milk and he was never satisfied. I gave up after a few weeks.
6. I am divorced, but my mother stays with me and helps me with the children.

Comments:

She did not receive the necessary help from the hospital staff to enable her to breastfeed. Her baby is suckling in a poor position, which is causing sore nipples. She is growing, so she must be getting plenty of milk, but she is suckling inefficiently, and needs to suckle often and for a long time. You know her main problem early in the assessment. But it is important to know that she had problems breastfeeding her previous baby.

Assessment 4.

Reason for visit: “I have a painful swelling in my breast, and I feel feverish.”

Assessment:

1. I breastfeed my baby whenever I am at home, about once in the morning, twice in the evening, and once or twice at night. She suckles for about 5 minutes each time. I am too busy to breastfeed her for long. While I am working, my helper gives her bottle feeds of formula. This started when I went back to work about 1 month ago. Before that I just breastfed.
2. My baby is healthy. She weighed 3.5 kilos at birth. Now she is 4 months old and weighs 5.9 kilos. I don't know how often she passes urine. I am not at home.
3. She was born at home, and I breastfed her straight away. The community midwife helped me.
4. I am 27 years old, and healthy. I had a painful swelling in the other breast soon after I went back to work. It was at the weekend, I continued breastfeeding, and it got better by itself. This time it is worse.
5. I have one older child. I breastfed him for 4 months, until my milk dried up. I started work when he was 2 months old, and bottle fed him when I was out. I was very disappointed when I had to stop breastfeeding.
6. I work in a factory, and I am away from home for about 10 hours every day. I am exhausted when I get home. I have a helper who cares for the children. My parents live a long way away.

Comments:

She has mastitis, probably because her baby is only feeding for a short time, and not often enough, so he is not emptying the breasts properly. It is important not to stop when you make the diagnosis of mastitis, but to continue to Section 6, so that you learn how busy and tired this mother is. That is important for the management.

Session 15. Clinical practice 2: Taking an infant and young child feeding assessment

Learning objectives
1. Practice taking infant and young child feeding assessments with mothers and babies in a ward or clinic.

Preparation

- Make sure that you know where the clinical practice will be held. Visit the various wards or clinics that you will go to if you have not done so before.
- Arrange for different groups to see mothers in different situations; for example, some can go to maternity wards, to see mothers after normal or Caesarian deliveries, or to pediatric wards, or special care units; some can go to outpatient clinics or health centers to see mothers with sick or well children, or women receiving antenatal care or family planning services.
- Make available a copy of: the list of ‘building confidence and giving support’ skills for each participant and trainer, spare copies of the Breastfeed Observation Job Aid, the list of ‘listening and learning’ skills, and a copy of the Practice Discussion Checklist for the trainers.

Duration: 120 min

Learning objective 1: Practice taking infant and young child feeding assessments with mothers and babies in a ward or clinic.

Methodology: Clinical practice

Instructions for activity

1. Explain the objectives of the clinical practice:
 - During this session, you practice taking an infant and young child feeding assessment. You continue to practice ‘assessing a breastfeed,’ ‘listening and learning,’ and ‘building confidence and giving support’ skills.
 - If there is an opportunity, you will practice helping a mother to position her baby at the breast, or to overcome any other difficulty.
2. Explain what participants should take with them:
 - One copy of the Infant and Young Child Feeding Assessment Form.
 - Breastfeed Observation Job Aid.
 - One copy of the Counseling Skills Checklist.
 - Pencil and paper to make notes.
3. Use the Infant and Young Child Feeding Assessment Form for taking an assessment.
4. Use the Counseling Skills Checklist instead of the other three forms (the lists of ‘listening and learning’ and ‘building confidence and giving support’ skills and the Breastfeed Observation Job Aid).

5. Explain that participants will work in pairs in a ward or clinic. Each trainer circulates between the pairs in her group, to observe, comment and help where necessary.
6. Explain what participants should do when they talk to a mother:
 - Take a full infant and young child feeding assessment from the mother, using the Infant and Young Child Feeding Assessment Form.
 - Try to ask the most relevant questions, and ask something from each section of the form.
 - Use your ‘listening and learning’ skills, and try not to ask too many questions. Practice your ‘building confidence and giving support’ skills, and avoid giving a lot of advice.
 - If a mother has a breastfeeding difficulty, try to decide the reason, and how to help the mother. However, before you give the mother any help, or suggest what she should do, talk to the trainer.
7. Clinical practice at the ward or clinic:
 - Different groups will go to different parts of the health facility to meet breastfeeding mothers and babies in as many situations as possible. Depending on the number of mothers available, and the distance between different areas, a group may visit more than one area during the session.
8. Help pairs to find mothers in different situations to talk to. Look for any situation in which you may find a mother with a breast condition that would help participants to learn.
9. Discuss how to help mothers.
10. If a mother needs help with breastfeeding, let participants help her. However, first discuss with them what they plan to do, to make sure that it is appropriate.
11. If necessary, take participants where the mother cannot hear what you are saying while you discuss what to do. Then return to the mother to give the help.
12. Discuss the breastfeeding difficulty and its management with the staff in charge of the ward or clinic. It is important that you and the staff say the same things to the mother, so that you do not confuse her. The staff will be responsible for following up the mother and baby.
13. Discuss the participants’ performance:
 - When a pair have finished, take them away from the mother, and discuss what they did, and what they learned.
 - Ask them to tell you about the mother, what she is doing well, whether she has any difficulties, and what they would suggest to help her.
 - Go through the PRACTICE DISCUSSION CHECKLIST to help you to conduct the discussion.
14. Discuss what they learned from the mother, and whether her situation is common or unusual. Discuss what else it might be possible to do in other, similar situations.

Counseling skills checklist

Listening and learning

Helpful nonverbal communication
Ask open questions
Respond showing interest
Reflect back
Empathize
Avoid judging words

Building confidence and giving support

Accept what the mother says
Praise what is right
Give practical help
Give relevant information
Use simple language
Make one or two suggestions

Assessing a breastfeed

Body position
Responses of mother and baby
Emotional bonding
Anatomy of the breast
Suckling
Time spent suckling

Taking a history

Baby's feeding now
Baby's health and behavior
Pregnancy, birth, early feeds
Mother's condition and family planning
Previous infant feeding
Family and social situation

Session 16. Feeding and care of the sick child

Learning objectives
1. Describe the relationship between illness, recovery, and feeding
2. Name the practices for feeding the sick child
3. Identify signs requiring the mother/father/caregiver to seek care.

Materials

- Flip chart papers and stand, markers, tape/sticky putty

Duration: 60 min

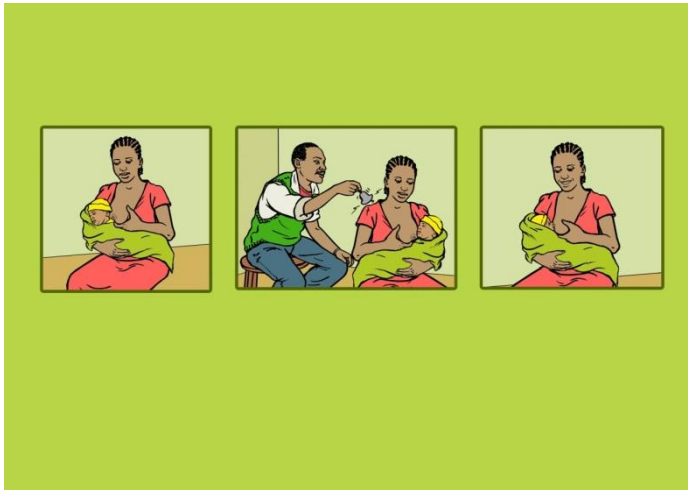
Learning objective 1: Describe the relationship between illness, recovery, and feeding

Methodology: Brainstorming; interactive presentation

Instructions for activity

1. Ask the participants: “What is the relationship between feeding and illness?”
2. Discuss the most common types of illness that affect feeding.
3. Review **CC 24: How to feed a sick baby from birth to 6 months**, and have participants read the information on the back of the card.
4. Review **CC 25: How to feed a sick child 6 to 23 months old**, and have participants read the information on the back of the card.
5. Compare answers with ‘Relationship between feeding and illness’ described below in the ‘Key information’ section.
6. Ask participants what the ‘sick child’ feeding practices are in their community.
7. Discuss and summarize.

Counseling card 15: How to feed a sick baby from birth to 6 months



Breastfeed your baby more frequently when the baby is sick. It is important to feed your baby more often to help fight the illness, reduce weight loss, and recover quickly.

- Encourage the baby to breastfeed often.
- Continue to breastfeed your baby even if the baby is sick or has diarrhea.
- Express milk and give it to the baby if the baby is too weak to suck. Expressing also helps the milk supply to continue, and helps you to avoid breast problems.
- Take your baby to the nearest health facility for treatment when he/she is sick, if he/she has sores in the mouth, or if the illness gets worse.
- Seek immediate help at the health facility if you have swollen breasts or cracked nipples.
- Give the baby only medicines recommended by a health worker. Breastfeed your baby even more frequently after the baby recovers from illness. This will help the baby to regain his/her health, weight, and growth.

When you are sick, you can continue to breastfeed your baby. You may need extra support and food during this time.

Counseling card 24: How to feed a sick child 6 to 23 months old



Breastfeed your child more frequently when the child is sick. Give more food and liquids than usual. Your child needs more food and liquids when sick to make his/her body strong and able to fight the illness.

- Encourage your child to eat small amounts many times a day.
- Give his/her favorite foods to encourage him/her to eat.
- Prepare the food in a way that will encourage the child to eat.
- Give foods that are easy to eat, such as thick porridge.
- Avoid giving food with spices.
- Continue to breastfeed and give food even when the child has diarrhea and is vomiting.
- If the child has diarrhea, give oral rehydration salts (ORS). Make ORS according to the instructions on the packet.
- Take the baby to the nearest health facility for treatment if he/she is seriously sick, if he/she has sores in the mouth, or if the sickness gets worse.

When your child gets better, encourage the child to eat an extra meal of solid food each day. This will help the child to gain the lost weight and grow well again.

When you are sick, you can continue to breastfeed your baby. You may need extra food and support during this time.

Key information

- Some of the children you see for feeding counseling may be ill or recovering from an illness.
- Children who are ill may lose weight because they have little appetite or their families may believe that ill children cannot tolerate much food.
- If a child is ill frequently, he or she may become malnourished and therefore at higher risk of more illness. Children recover more quickly from illness and lose less weight if they are helped to feed when they are ill.
- Children who are fed well when healthy are less likely to falter in growth from an

illness and more likely to recover faster. They are better protected.

- Breastfed children are protected from many illnesses. Special care needs to be given to those who are not breastfed and who do not have this protection.

Relationship between feeding and illness

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

When to take the child to a health facility

- If the child is getting progressively sicker over time.
- If the child is becoming non-responsive.
- If the child has sores in their mouth and cannot eat.

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

Methodology: Group work

Instructions for activity

1. Set up four flip charts around the room, each with one of the following headings:
 - How to feed a child less than 6 months old during illness
 - How to feed a child less than 6 months old after illness
 - How to feed a child older than 6 months during illness
 - How to feed a child older than 6 months after illness
2. Divide participants into four groups.
3. Each group will spend 3 minutes at each flip chart writing answers to the question.
4. After 3 minutes, ask the groups to rotate to another flip chart. Groups do not repeat the same information, but only add new information.
5. Each group presents the feeding practices on one flip chart to the large group.
6. Ask groups to observe and study **CC: How to feed a sick baby from birth to 6 months** and **CC: How to feed a sick child 6 to 23 months old**, and to review **CC: Hygiene**.
7. Discuss and summarize.

Key information

See counseling discussion points/messages on:

- **CC: How to feed a sick baby from birth to 6 months**
- **CC: How to feed a sick child 6 to 23 months old**
- **CC: Hygiene**

Session 17. Facilitating action: Conducting support groups and scheduling home visits

Learning objectives
1. Learn how to run a mother-to-mother support group; list the characteristics and responsibilities of a mother-to-mother support group facilitator
2. Learn to identify points in a child's life cycle when key feeding changes are likely and contact should be made with the mother, and how to schedule home visits

Materials

- Flip chart papers and stand, markers, tape/sticky putty
- Participant material 17.1: Characteristics of a mother-to-mother support group
- Participant material 17.2: Checklist for mother-to-mother support group facilitator
- Participant material 17.3: Characteristics of a support group facilitator
- Participant material 17.4: Responsibilities of the facilitator to the community
- Participant material 17.5: Possible support groups themes
- Participant material 17.6: Scheduling home visits and messages
- Flip chart with timeline (from pregnancy to birth to 2 years)

Duration: 60 min

Learning objective 1: Learn how to run a mother-to-mother support group; list the characteristics and responsibilities of a mother-to-mother support group facilitator

Methodology: Group work

Instructions for activity

1. Explain the goals and purpose of a mother-to-mother support group, making the following points:
 - Mother-to-mother support groups provide a safe environment of respect, attention, trust, sincerity, and empathy.
 - In mother-to-mother support groups women can:
 - Share infant feeding information and personal experience.
 - Mutually support each other through their own experiences.
 - Strengthen or modify certain attitudes and practices.
 - Learn from each other.
 - Women can reflect on their experiences, doubts, difficulties, popular beliefs, myths, information, and infant feeding practices.
 - In this safe environment, the mother finds the knowledge and confidence to decide to strengthen or modify her infant feeding practices.
 - Infant feeding mother-to-mother support groups are not lectures or classes; all participants play active roles.
 - Support groups focus on the importance of mother-to-mother communication. In this way all the participants can express their ideas, knowledge, and doubts; share experiences; receive support; and support the other women in the group.
 - The sitting arrangement with everyone at the same level allows all participants to have eye-to-eye contact.
2. Review each of the handouts and discuss.
3. Facilitate a 15-minute mother-to-mother support group with participants.
4. Then ask participants to refer to the checklist and generate a list of characteristics of a mother-to-mother support group and a mother-to-mother support group facilitator, based on their experience.
5. Compare participants' list with information in the handouts.
6. Ask participants how they felt participating in the support group. Ask the facilitator of the group how she felt.
7. Ask the group specific questions about the way the leader handled certain situations.
8. Ask how to use mother-to-mother support groups to change behavior.

Learning objective 2: Learn to identify points in a child's life cycle when key feeding changes are likely and contact should be made with the mother, and how to schedule home visits

Methodology: Group work

Instructions for activity

1. Show timeline on flip chart (pregnancy to birth to 2 years). Ask participants to identify the important points in a baby's life to discuss with the mother. Ask about the time before birth. Is it important? Why? Ask what to emphasize and discuss at each point.
2. Complete the timeline on the flip chart.

Session 17: Facilitating Action: Conducting Support Groups and Scheduling Home Visits

3. Discuss related messages.
4. Pass out handouts and compare with the discussion.
5. Ask participants what they plan to discuss with the women when they make their follow-up visits in the community.

Handout 17.1: Characteristics of a mother-to-mother support group

This is a safe environment of respect, attention, trust, sincerity, and empathy.

The group allows women 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.

The group enables women to reflect on their experience, doubts, difficulties, popular beliefs, myths, information, and infant feeding practices.

In this safe environment, mothers have the knowledge and confidence to decide to strengthen or modify their infant feeding practices.

Infant feeding mother-to-mother support groups are not LECTURES or CLASSES. All participants play an active role.

Support groups focus on the importance of mother-to-mother communication. In this way all the women can express their ideas, knowledge, and doubts; share experiences; and receive and give support.

The circular seating arrangement allows all participants to have eye-to-eye contact.

The group size varies from 3 to 15.

The group is facilitated by an experienced mother who listens and guides the discussion.

The group is open, allowing all interested pregnant women, breastfeeding mothers, women with older toddlers, and other interested women to attend.

The facilitator and the participants decide the length of the meeting and frequency of the meetings (number per month).

Handout 17.2: Checklist for mother-to-mother support group facilitator

- ☐ Sits in a circle at the same level as the rest of the group
- ☐ Introduces herself and ask the group participants to introduce themselves
- ☐ Introduces the purpose and theme of the meeting
- ☐ Explains that the support group meeting will last 1–1½ hours
- ☐ Uses open-ended questions to encourage participation
- ☐ Gets everyone to talk, even the quieter participants
- ☐ Gets mothers to share experiences and ideas
- ☐ Uses communication skills such as active listening and answering questions (maintains eye contact, repeats key messages, corrects incorrect information)
- ☐ Repeats key messages
- ☐ Asks participants to summarize what they learned

Handout 17.3. Characteristics of a support group facilitator

For a mother-to-mother support group, or any support group, the facilitator:

- Greets and welcomes all who attend.
- Creates a comfortable atmosphere in which participants feel free to share their experience.
- Introduces self and invites each participant to introduce themselves.
- Explains the objective of the meeting and gives a brief introduction of the topic.
- Actively listens to the participants and gives each one her full attention.
- Maintains eye contact and exhibits other appropriate body language.
- Asks questions to generate a discussion.
- Raises other questions to stimulate discussion when necessary.
- Directs questions to other participants of the group.
- Limits interruptions and outside distractions.
- Talks only when there are questions that the group cannot answer and offers an explanation or correct information to clarify.
- Briefly summarizes the theme of the day.

Handout 17.4: Responsibilities of the mother-to-mother support group facilitator to her community

The facilitator should:

- Facilitate the mother-to-mother support group in her community at least once a month.
- Conduct each meeting in an animated yet simple way.
- Motivate the participation of as many women as possible.
- Collect designated information that has been formally agreed on.


Handout 17.5: Possible themes for mother-to-mother support groups on infant and young child feeding

Possible themes include:

- Advantages of breastfeeding for mother, baby, family, and community.
- Techniques of breastfeeding: positioning and attachment.
- Symptoms, causes, solutions, and prevention of common breastfeeding difficulties: engorgement, low milk supply, cracked or sore nipples, blocked ducts, mastitis.
- Special situations: sick baby or mother, premature baby, malnourished mother, twins, pregnancy, separation from baby.
- Beliefs and myths about breastfeeding.
- Breastfeeding and the introduction of complementary foods at 6 months.

Handout 17.6: Scheduling home visits and messages

Recommended visits from pregnancy up to 6 months

When	Discuss
Prenatal visits	<p>Good attachment and positioning</p> <p>Early initiation of breastfeeding (give colostrum)</p> <p>Breastfeeding in the first few days</p> <p>Exclusive breastfeeding from birth up to 6 months (avoid other liquids and food, even water)</p> <p>Breastfeeding on demand (up to 12 times day and night)</p> <p>Mother needs to eat extra meals and drink a lot of fluids to be healthy</p> <p>Attendance at mother-to-mother support group</p> <p>How to access community health worker if necessary</p>
<p>Delivery</p> 	<p>Place baby skin-to-skin with mother</p> <p>Good attachment and positioning</p> <p>Early initiation of breastfeeding (give colostrum, avoid water and other liquids)</p> <p>Breastfeeding in the first few days</p>
Postnatal visits	
<p>Within the first week after birth (2 or 3 days and 6 or 7 days)</p>	<p>Good attachment and positioning</p> <p>Breastfeeding in the first few days</p> <p>Exclusive breastfeeding from birth up to 6 months</p> <p>Breastfeeding on demand (up to 12 times day and night)</p> <p>Ensure mother knows how to express her breastmilk</p> <p>Preventing breastfeeding difficulties (engorgement, sore and cracked nipples)</p>
<p>1 month</p> <p>Immunization sessions</p> <p>Growth Monitoring Promotion (GMP)</p>	<p>Good attachment and positioning</p> <p>Exclusive breastfeeding from birth up to 6 months</p> <p>Breastfeeding on demand (up to 12 times day and night)</p> <p>Breastfeeding difficulties (plugged ducts, which can lead to mastitis; not enough breastmilk)</p> <p>Increase breastmilk supply</p> <p>Maintain breastmilk supply</p> <p>Continue to breastfeed when infant or mother is ill</p> <p>Family planning</p> <p>Prompt medical attention</p>
<p>6 weeks</p> <p>Family planning sessions</p> <p>GMP</p> <p>Sick child clinic</p> <p>Community follow-up</p>	

Session 17: Facilitating Action: Conducting Support Groups and Scheduling Home Visits

From 5 up to 6 months GMP Sick child clinic Community follow-up	Community health worker should not try to change positioning if older infant is not having difficulties breastfeeding Prepare mother for changes she will need to make when infant reaches 6 months (no changes until 6 months) At 6 months, begin to offer complementary foods 2 to 3 times a day; gradually introduce different types of foods (staple, legumes, vegetables, fruits, and animal products) and continue breastfeeding
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Session 18. Facilitating action: Field practice for working with groups of women

Learning objectives
1. Facilitate a mother-to-mother group talk; observe group talks and provide feedback using an observation checklist

Materials

- Flip chart papers and stand, markers, tape/sticky putty
- Observation checklist

Duration: 120 min

Learning objective 1: Facilitate a mother-to-mother group talk; observe group talks and provide feedback

Methodology: Field practice

Instructions for activity

1. Introduce the idea of the group talk, emphasizing the following points:
 - Traditionally, group talks are organized to communicate ideas or convey information to a group.
 - Usually a leader directs the group talk, and others participate by asking and answering questions.
 - Use counseling cards with the group and get feedback on card contents.
 - An 'action-oriented' group talk is slightly different. Facilitators encourage participants to personalize the information and to try something new or different from what they normally do (an action).
 - At the next scheduled meeting, participants should be prepared to discuss their experiences.
2. Ask participants in pairs to facilitate a group talk for any of the following groups:
 - Men's groups
 - Women's groups
 - Mothers of children 0 to 6 months old
 - Mothers of children 6 to 12 months old
 - Grandmothers' groups
3. Ask participants who do not facilitate the talks to observe the talks using the observation checklist.
4. Ask observers for each group to share their experience facilitating a group talk.
5. On flip chart paper, list common experiences and feelings and suggestions for improvement.

Handout 18.1. Observation checklist for field practice

- | | |
|--------------|---|
| Introduction | <input type="checkbox"/> Introduces self (name and organization) and puts people at ease |
| | <input type="checkbox"/> Shows respect and interest |
| | <input type="checkbox"/> Listens and looks attentively |
| | <input type="checkbox"/> Shows a counseling card to everyone |
| THINK | <input type="checkbox"/> Asks who is in the picture and what they are doing |
| | <input type="checkbox"/> Asks why they are doing it |
| | <input type="checkbox"/> Asks what the benefits are |
| | <input type="checkbox"/> Explains the picture and shares the main message |
| FEEL | <input type="checkbox"/> Asks if participants agree with the practice shown on the card and why or why not |
| | <input type="checkbox"/> Asks if participants would feel comfortable doing this practice |
| DO | <input type="checkbox"/> Repeats the message |
| | <input type="checkbox"/> Asks participants if they would be willing to try this practice |
| | <input type="checkbox"/> Discusses specific actions that participants can try |
| | <input type="checkbox"/> Sets a time for the next meeting and encourages participants to try the new practice and be prepared to talk about how it went |

Name one or more things the facilitator did well:

Recommendations for the facilitator to improve upon for next time (name one important thing):

Adapted from LINKAGES Project. *Behavior Change Communication for Improved Infant Feeding Training of Trainers for Negotiating Sustainable Behavior Change*. Washington, DC: Academy for Educational Development;2004.

Session 19. Overview of HIV and infant feeding

Learning objectives
1. Explain when HIV can be transmitted from mother to child, and explain the risk of transmission with and without interventions
2. Discuss the importance of HIV testing and counseling for the mother (during pregnancy or at 6 weeks) and the infant (at 6 weeks)
3. Describe infant feeding in the context of HIV
4. Describe feeding a child from 6 up to 24 months when an HIV-positive mother breastfeeds or DOES NOT breastfeed
5. Identify breast conditions of the HIV-positive breastfeeding woman and refer for treatment

Materials

- Flip chart papers and stand, markers, tape/sticky putty
- Training Aid: Benefits and risks of different feeding methods for HIV-exposed infants less than 6 months of age
- Flip chart on role of the community worker trained in infant and young child feeding but not trained in prevention of mother-to-child transmission of HIV
- Relevant counseling cards:
 - **CC: HIV testing and counseling**
 - **CC: Mother-to-child transmission of HIV**
 - **CC: Protecting your baby from HIV**
 - **CC: Breastfeeding for HIV-positive mothers**

Duration: 120 min

Learning objective 1: Explain when HIV 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 flip chart, draw a bar chart to indicate infant outcomes at 2 years when 100 HIV-positive mothers receive NO antiretrovirals (ARVs) and breastfeed for 2 years.
2. Brainstorm with participants when HIV 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, labor and delivery; and 10 become infected during breastfeeding.

Key information

If a woman is HIV-positive, what is the risk of HIV passing to her baby when NO preventive actions are taken?

- A baby born to a HIV-positive mother can get HIV from the mother during pregnancy, labor and delivery, and breastfeeding.
- In the absence of any interventions³ to prevent or reduce HIV transmission, research has shown that if 100 HIV-positive women get pregnant, deliver, and breastfeed for 2 years⁴:
 - About 25 may be infected with HIV during pregnancy, labor, and delivery.
 - About 10 may be infected with HIV through breastfeeding, if the mothers breastfeed their babies for 2 years.
 - **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.

If a woman is HIV-positive, what is the risk of passing HIV to her baby if both take antiretrovirals (ARVs) and practice exclusive breastfeeding during the first 6 months?

- The risk of transmission decreases with special treatment or prevention medicines (ARVs).
- A pregnant women living with HIV should be given special medicines to decrease the risk of passing HIV to her infant during pregnancy, birth, or breastfeeding.
- Her baby may also receive 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 6 months is combined with provision of antiretroviral medicines for the mother OR the baby. **This is the best way for a mother to breastfeed her infant safely.**
- If 100 HIV-positive women and their babies take ARVs and practice exclusive breastfeeding during the first 6 months:
 - About 2 babies are infected during pregnancy and delivery.
 - About 3 babies are infected during breastfeeding.
 - **About 95 babies will not get HIV.**

³ Interventions to reduce mother-to-child transmission of HIV:

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

During labor and delivery: ARVs; keep delivery normal; minimize invasive procedures such as artificial rupture of membranes (AROM), episiotomy, suctioning; minimize elective Caesarian-sections; minimize vaginal cleansing; minimize infant exposure to maternal fluids.

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

⁴DeCock 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.

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

Learning objective 2: Discuss the importance of HIV testing and counseling for the mother (during pregnancy or at 6 weeks) and the infant (at 6 weeks)

Methodology: Brainstorming

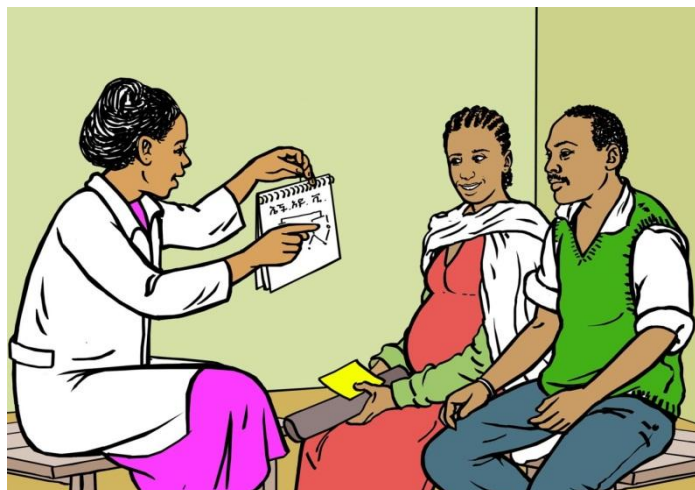
Instructions for activities

A. Importance of testing and counseling for the mother:

1. Ask participants to brainstorm the importance of HIV testing and counseling for the mother.
2. Ask participants to review and read **CC: HIV testing and counseling**.
3. Probe until the following reasons are presented:
 - HIV testing and counseling is the first step to prevention, care, treatment (including anti-retroviral treatment) and support.
 - It encourages more people to be tested and to reduce the stigma surrounding HIV testing.
 - It increases the number of people who know they are infected.
 - It helps prevent further HIV transmission.
 - For those not infected with HIV, testing and counseling promotes behavior change toward “safe sex” (hence its importance for HIV prevention).
 - It allows for management of infections such as pneumonia and tuberculosis.
 - It allows for ARVs (prevention drugs) during pregnancy and breastfeeding.
 - It allows for ART (treatment drugs) for the mother’s own health if needed.

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

1. Ask participants to brainstorm responses to the question: Why is HIV testing and counseling important for the infant?
2. Probe until the following reasons are presented:
 - It allows for early diagnosis of an HIV-positive child.
 - The HIV-positive child can then be treated early with ARVs, which improves chances of survival.
 - The HIV-positive 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 such as diarrhea.
 - If the child is negative, the mother continues to practice the feeding option she has chosen to give the best chance of HIV-free survival and reduced death and sickness: breastfeeding and ARVs, breastfeeding, or no breastfeeding.
3. Discuss and summarize. Emphasize that negative test results should not change how women are feeding their babies; if women are exclusively breastfeeding, they should continue until the baby is 6 months old.

Counseling card 5: HIV testing and counseling

Get tested for HIV at the health facility to know your status. Encourage your partner to be tested as well. The only way to know your status is to be tested. During the visit, the health worker will tell you about HIV and AIDS.

If both of you test negative, the health worker will explain what you and your partner can do to remain HIV-negative. If you test positive, the health worker will:

- Give you the information you need to protect your partner from HIV. (This also applies if your partner tests positive and you test negative.)
- Discuss what you can do to remain healthy and live a long life.
- Advise you on what you can do to protect your baby from becoming infected with HIV during pregnancy, labor and delivery, and breastfeeding.
- Give you antiretroviral medications so you can remain strong and to help prevent the transmission of HIV to your baby.
- Provide information on how you can get other kinds of support you may need.

Learning objective 3: Describe infant feeding in the context of HIV

Methodology: Brainstorming; buzz groups; group work

Instructions for activity 1

Ask participants to define: exclusive breastfeeding, replacement feeding, and mixed feeding. (Answers are given in 'Key information' below.)

.....

Instructions for activity 2

1. Ask participants: How should an HIV-positive mother feed her baby if she does not have access to ARVs? What about a woman who does not know her HIV status?
 2. Ask buzz groups to look at **CC 6**, **CC 26**, and **CC 27**.
 3. Discuss and summarize.
-

Instructions for activity 3

1. Form five groups and give to each group 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. Discuss and fills in gaps.

Key information

Good and adequate nutrition in the early stages of life help build the foundation for a healthy and productive life as an adult. Children who get adequate energy and nutrients during the first two years of life are more likely to experience better health. Health workers need to provide nutritional guidance according to national recommendations to ensure safe and optimal infant feeding practices, **reduce the risk of HIV transmission** from mothers to their children, and **promote HIV-free survival**.

- Exclusive breastfeeding in the first six months of life is associated with reduced mortality during the first year of life in HIV-exposed infants compared to mixed feeding and replacement feeding in both research and program settings.
- Efficacy and safety of ARVs to prevent HIV transmission through breastfeeding. ARVs have been demonstrated to have a role in reducing mother-to-child transmission of HIV (MTCT) during breastfeeding.
- The risks associated with **not** breastfeeding include:
 - Increased child mortality. Studies have shown that providing infant formula as a way to reduce MTCT increases rates of mortality among children. Research also shows a two- to six-fold increase in the risk of child mortality among children who are not breastfed.
 - No benefit for HIV-free survival. Studies show that, although breastfeeding avoidance reduces HIV transmission, HIV-free survival does not improve due to increased mortality.
- The optimal duration of exclusive breastfeeding by HIV-infected mothers is six months. Early breastfeeding cessation has been shown to increase the risk of child death with no benefit for HIV-free survival.
- There is strong evidence that:
 - ARV interventions to infants or mothers significantly reduce HIV transmission through breastfeeding.
 - Transmission is reduced while ARV interventions are given. Protection continues for as long as ARVs are taken.
 - No evidence of significant drug-related adverse events.
- No increased adverse events with prolonged ARV intervention.

- Nevirapine adverse events occur within the first few weeks and do not accumulate with longer exposure.

Counseling for mothers of HIV-exposed infants should include:

- Support for breastfeeding.
- Support for safe breastfeeding cessation at 12 months.
- Support for infant and young child feeding counseling around the time of infant HIV testing.
- Support for timely and appropriate introduction and continuation of complementary feeding.
- Adherence to ARVs for both mother and baby. ARV prophylaxis for either mother or baby (as per national prevention of mother-to-child transmission [PMTCT] guidelines) should continue until one week after all exposure to breastmilk has ended.

Review of the advantages and challenges of breastfeeding an HIV-exposed infant

- Remember that we looked at advantages of breastfeeding in the general population earlier in the training.
- A mother who is HIV-positive needs to understand some challenges associated with breastfeeding so that she can reduce the risk of transmitting the virus to her baby. Brainstorm on advantages and challenges, and then ask participants to turn to their manuals and find the box, ‘Advantages and challenges of exclusive breastfeeding for an HIV-infected mother.’

Additional advantages

- Exclusive breastfeeding for the first six months lowers the risk of passing HIV, compared to mixed feeding.
- Many women breastfeed, so people will not ask why mothers are breastfeeding.
- Exclusive breastfeeding helps mothers recover from childbirth and protects them from getting pregnant again too soon. This is particularly important for the HIV-infected woman.

Challenges

- As long as the mother breastfeeds, her baby is exposed to HIV.
- People may pressure her to give water, other liquids, or foods to the baby while she is breastfeeding. This practice, known as mixed feeding, may increase the risk of diarrhea and other infections, and increases the risk of HIV transmission.
- The mother will need support to exclusively breastfeed until it is possible for her to use another feeding option.
- It may be difficult to exclusively breastfeed if the mother gets very sick.

Continue with these points

- If a woman does breastfeed, it is important for her to breastfeed exclusively for the first six months. This gives protection to the infant against common childhood infections and also reduces the risk of HIV transmission.
- Counseling on infant feeding may need to take into account the progression of the mother's disease.
- Recent evidence suggests a very high rate of postnatal transmission in women with advanced disease.
- An HIV-positive mother who chooses to breastfeed needs to use a good technique to prevent nipple fissure and mastitis, both of which may increase the risk of HIV transmission. Management of these breast conditions will be covered in the next session.

Ask: When is it important to provide infant feeding education for HIV-positive women?

Wait for replies and make sure the following points are mentioned:

- Before a woman is pregnant.
- During her pregnancy.
- Soon after her baby is born.
- Soon after receiving the results of her baby's HIV test.
- When her baby is older.
- In special circumstances, such as when a woman fosters a baby whose mother is very sick or has died.

Each woman's situation is different, so health workers need to be able to discuss and provide support as needed.

Adequate complementary foods from 6 months of age will be needed.

Stopping breastfeeding at 12 to 18 months

Make the following points:

- We know that HIV can be transmitted at any time during breastfeeding. Stopping at 12 to 18 months reduces the risk of transmission by reducing the length of time the infant is exposed to the virus in breastmilk.
- The period of time during which a mother stops breastfeeding and changes to the family diet is known as 'weaning.'
- The most appropriate time to stop breastfeeding in Ethiopia is 12 to 18 months, since the child can grow well without breastmilk after this time. Many infants self-wean by 12 to 18 months.
- Preliminary experience indicates that mothers can stop breastfeeding in a period of 3 days to 3 weeks with counseling and support. It is important not to abruptly wean the child.

Ask: When and how are infants weaned in your local area? Ask the group members to describe the different ways infants are weaned and what factors contribute to the weaning process.

Wait for replies, and then continue the discussion with the following points below.

How to wean an infant from breastmilk

- The mother should begin to wean the child at around 12 months.
- Gradual weaning is best for both the mother and her baby. Gradual weaning will help avoid feelings of rejection for the baby and will prevent the mother from going through the unnecessary pain of engorgement or blocked milk ducts, which can lead to breast infections.
- Mothers can start by dropping one feeding, and allow a 2- to 3-day adjustment period for your baby and your milk supply. Replace the dropped feed with affection, drinks, or snacks.
- After a few days, when the mother and baby have adjusted to the substitutions for the missed breastfeeding session, drop another feeding. Continue this plan for several weeks until the mother and her baby feel comfortable with the level of weaning.
- During the weaning process, it is important for the mother to provide extra attention for her baby. It may be especially difficult for your baby to get used to not nursing at bedtime/naptimes.
- A baby being weaned too quickly may become more demanding of your attention or more insistent on feeding, or may show physical symptoms such as allergic reactions, stomach upsets, or constipation.
- To avoid breast engorgement (swelling), mothers can express a little milk whenever her breasts feel too full. This will help her to feel more comfortable. Use cold compresses to reduce the inflammation. Wear a firm bra to prevent breast discomfort.
- Do not begin breastfeeding again once the baby has stopped. If you do, it can increase the chances of passing HIV to the baby. If her breasts become engorged, express some milk by hand and discard it.

Further information on cessation of breastfeeding by an HIV-infected mother

Stopping breastfeeding abruptly can lead to engorgement and mastitis and, if the breasts are not relieved, to an abscess.

Breastmilk production is controlled by hormones and also locally controlled within the breast itself. There is a substance in breastmilk that can reduce or inhibit milk production. If a lot of milk is left in the breast, this inhibiting substance stops the cells from secreting any more. This helps protect the breast from the harmful effects of being too full.

Expressing a small amount of milk helps keep the mother comfortable without increasing the production of milk. The mother should express enough milk to keep comfortable. This will be less than the baby takes, so production will decrease, and eventually stop. The management of engorgement or other breast conditions will be covered in a later session.

References for further reading:

World Health Organization (WHO). *Rapid Advice: Infant Feeding in the Context of HIV*. Geneva, CH: WHO; 2010.

Counseling card 25: Mother-to-child transmission of HIV



Take measures to protect your baby from HIV infection if you are HIV-infected.

If an HIV-positive mother is breastfeeding, it is important for her to breastfeed exclusively for the first 6 months. Giving other liquids or foods puts your baby at greater risk of becoming infected with HIV while you're breastfeeding.

- Most babies born to women who are infected do not get infected with HIV.
- There is much that an HIV-positive woman can do to protect her baby from becoming infected, and when women take these actions, the risk of passing HIV is much lower.
- Exclusive breastfeeding up to 6 months of age, and continuing breastfeeding with complementary feeding after 6 months, will protect your child from HIV infection.
- HIV can be passed from a mother to her baby during pregnancy, childbirth, and breastfeeding. However, HIV-positive mothers who take measures to protect their babies from HIV infection have a very good chance of having an HIV-free baby.
- If you are HIV-positive it is still important to use a condom during sex. Being infected with HIV again increases the viral load in your body. When the viral load is high, it increases the chance of infecting your baby with HIV.

Key information

Definitions for Activity 1

- **Exclusive breastfeeding:** giving only breastmilk, no other food or drink (including water), to the infant.
- **Replacement feeding:** 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 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:** giving breastmilk plus other foods or drinks, including ready-to-use therapeutic foods) before the age of 6 months. *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, no matter 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.

Answers to questions in Activity 2

HIV-negative mother or mother of unknown status:

The recommended practice is to exclusively breastfeed for up to 6 months, add complementary foods at 6 months, and continue breastfeeding for 2 years and beyond.

HIV-positive mother whose infant is HIV-negative or of unknown HIV status:

In Ethiopia a mother is advised to:

1. Exclusively breastfeed together with ARVs for mother OR infant.

- Exclusive breastfeeding in the first 6 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 6 months, as compared to mixed feeding.
- Follow the same recommended breastfeeding practices as the HIV-negative mother and mother of unknown status.
- Breastfeeding and ARVs should continue until at least 12 months. Stop breastfeeding at 12 to 18 months once a nutritionally adequate and safe diet without breastmilk can be provided.

2. Exclusively breastfeed even when no ARVs are available.

- The WHO Guidelines on HIV and Infant Feeding 2010 state: *When a national authority has decided to promote and support breastfeeding and ARVs, but ARVs are not yet available, mothers should be counseled 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 to 18 months

WHO recommends against early, abrupt, or rapid cessation of breastfeeding. Mothers known to be HIV-positive who decide to stop breastfeeding at any time should stop gradually within one month. Mothers or infants who have been receiving ARV prophylaxis should continue prophylaxis for one week after breastfeeding is fully stopped.

HIV-positive mother whose infant is HIV-positive:

The recommended practice is to exclusively breastfeed for up to 6 months, add complementary foods at 6 months, and continue breastfeeding for 2 years and beyond.

Answers to Activity 3 card exercise

Balance of risks for infant feeding options in the context of HIV:

	Exclusive breastfeeding	Exclusive replacement feeding	Mixed feeding
Risk of HIV	Yes	No	Yes
Risk of death and illness	Much lower risk, but doesn't eliminate the risk entirely	Yes	Yes

Mixed feeding is the worst option, as it increases the risk of HIV transmission as well as exposing the infant to the risks of illness from contaminated formula made with dirty water and given in dirty bottles, and contaminated foods and other liquids.

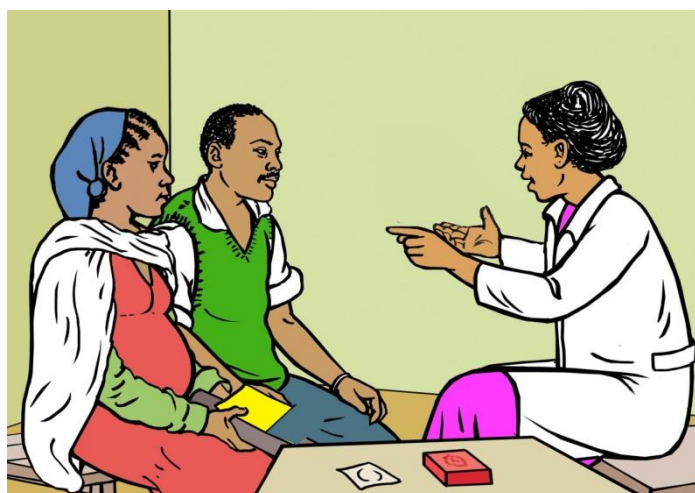
Learning objective 4: Describe feeding a child from 6 up to 24 months when an HIV-positive mother breastfeeds or DOES NOT breastfeed

Methodology: Group work

Instructions for activity

1. Divide participants into two groups.
2. Ask each group to respond to the following questions, written on a flip chart:
 - a) When an HIV-positive mother breastfeeds, how should she feed her child from 6 up to 24 months?
 - b) When an HIV-positive mother is NOT breastfeeding, how should she feed her child from 6 up to 24 months of age?
3. Invite one group to respond to the first question and the other group to add additional comments.
4. Invite the other group to respond to the second question, and the first group to add additional comments.
5. Discuss and summarize.

Counseling card 26: Protecting your baby from HIV



If you are HIV-positive and pregnant, discuss with your partner before your baby is born and agree on the way you will feed your baby. Seek the help of a health worker to make the decision.

If an HIV-positive mother is breastfeeding, it is important for her to breastfeed exclusively for the first 6 months. Giving other liquids or foods puts the baby at greater risk of becoming infected with HIV while breastfeeding.

Exclusive breastfeeding:

- Exclusive breastfeeding (giving **ONLY** breastmilk) for the first 6 months greatly reduces the chance of an HIV-positive mother passing HIV to her baby as compared with mixed feeding (feeding baby both breastmilk and any other milks or food, including water). In addition, an exclusively breastfed baby also receives protection from diarrhea and other illnesses.
- Mixed feeding (feeding the baby both breastmilk and any other foods or liquids, including infant formula, animal milks, or water) before 6 months is the most dangerous way to feed a baby. Mixed feeding greatly increases the chance of an HIV-positive mother passing HIV to her baby, and also increases the chance the baby dying from other illnesses, such as diarrhea and pneumonia, because he or she is not fully protected through breastmilk.
- Mixed feeding is always dangerous for babies younger than 6 months. A baby less than 6 months has an immature digestive system. Foods or drinks other than breastmilk can cause damage to the baby stomach. This makes it easier for HIV and other diseases to pass into the baby.

If you are HIV-positive, it is still important to use a condom during sex. Being infected with HIV again increases the viral load in your body. When the viral load is high, it increases the chance of infecting your baby with HIV.

Counseling card 27: Breastfeeding for HIV-positive mothers



If you are HIV-positive and your baby is HIV-negative or of unknown status, give your baby breastmilk **ONLY** for the first 6 months. Do not give anything—else not even water.

- Exclusive breastfeeding (giving **ONLY** breastmilk) for the first 6 months greatly reduces the chance of HIV passing from an HIV-positive mother to her baby, especially when both the mother and baby receive special medicines or antiretrovirals (ARVs).
- When an HIV-positive mother exclusively breastfeeds, her baby receives all the benefits of breastfeeding, including protection from diarrhea and other illness.

If you are an HIV-positive breastfeeding mother, it is important to:

- Seek immediate help from the health facility if you develop breast problems such as a breast abscess or sore or cracked nipples.
- Take ARVs to improve your health and prevent HIV transmission to your baby.
- Visit the health facility for continuous assessment of you and your baby.
- Introduce appropriate complementary feeding at 6 months and continue breastfeeding until your baby is 12 to 18 months old.
- Stop breastfeeding at 12 to 18 months once a nutritionally adequate and safe diet without breastmilk can be provided.

HIV-positive mothers whose children are also HIV-positive are advised to breastfeed exclusively in the same way as HIV-negative women:

1. Breastfeed exclusively for the first 6 months.
2. Introduce suitable complementary foods at 6 months of age.
3. Ensure that both the mother and child are on ARV drugs.

Key information

When an HIV-positive 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.
- Follow the same recommended complementary feeding practices that apply for an HIV-negative mother and mother of unknown status (See *Participant Materials* 12.3:

Recommended complementary feeding practices and possible counseling discussion points).

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

- At about 6 months an infant is better able to tolerate undiluted animal milk and a variety of semi-solid foods.
- Add 1 to 2 **extra** meals and, depending on the child's appetite, offer 1 to 2 snacks per day.
- Add 1 to 2 cups of milk per day.
- Add about 2 cups per day of extra fluids (in addition to the 1 to 3 cups per day of water that is estimated to come from milk and other foods in a temperate climate or 3 to 4 cups per 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.
- Where suitable breastmilk substitutes are not available, the mother or caregiver needs to feed the infant animal-source foods (meat, poultry, fish, eggs, or milk products), additional meals, and/or specially formulated, fortified foods.
- Calcium-rich foods such as papaya, orange juice, guava, green leafy vegetables, and pumpkin should be consumed daily.
- Infants not fed milk should be offered plain, clean, boiled water several times a day to satisfy thirst.
- Where neither breastmilk substitutes nor animal milk or animal-source foods are available, nutrient requirements cannot be met unless specially formulated, fortified foods or nutrient supplements are added to the diet.

Learning objective 5: Identify breast conditions of the HIV-positive mother and refer for treatment

Methodology: Brainstorming

Instructions for activity

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

Key information

An HIV-positive mother with cracked nipples, mastitis (inflammation of the breast), abscess, or thrush/Candida (yeast infection of the nipple and breast) has an increased risk of transmitting HIV to her baby and should:

- Stop breastfeeding from the infected breast and seek prompt treatment.
- Continue breastfeeding on demand from the uninfected breast.

- Express breastmilk from the infected breast(s) and either discard it or heat-treat it before feeding to baby.
Note: Cracked nipples and mastitis are discussed more fully in Session 8: Common breastfeeding difficulties.
- Identify breast conditions of the HIV-positive mother and refer her for treatment.

If the HIV-positive mother is exclusively replacement feeding, emphasize:

- No mixed feeding.
- No dilution of formula.
- Help mother read instructions on formula tin.
- Make sure mother is preparing formula correctly, feeding with a cup and not a bottle, washing hands, and cleaning utensils properly.

Refer the HIV-positive mother to a health facility if she changes her feeding option or no longer meets the requirements for her chosen feeding option.

Session 20. Checking understanding and following up

Learning objectives
<ol style="list-style-type: none"> 1. Demonstrate how to ensure that a mother understands information provided by using checking questions 2. Arrange for follow-up or referral of a child

Materials

Flip chart papers and stand, markers, tape/sticky putty

Preparation

- Prepare two flip charts: one with the ‘listening and learning’ skills and one with the ‘building confidence and giving support’ skills. Have a blank flip chart ready to list the two new skills we will be discussing in this session.
- Study the instructions for Demonstration 20.A, so that you are clear about the ideas they illustrate, and you know what to do. Ask two participants to be prepared to read the parts of the mother and the health worker in the demonstration.

Duration: 30 min

Learning objective 1: Demonstrate how to ensure that a mother understands information provided by using checking questions

Methodology: Demonstration

Instructions for activity

1. Put on the wall two lists: one of the ‘listening and learning’ skills and another of the ‘building confidence and giving support’ skills. Then put up a blank flip chart and write ‘checking understanding.’
2. Make these points:
 - We have already practiced the counseling skills of ‘listening and learning’ and ‘building confidence and giving support.’ However, you also need to discuss the suggestions you make with a mother so she can decide on a course of action. Your suggestion does not automatically become what a mother will do.
 - Often you need to check that a mother understands a practice or action she plans to carry out. For example, if you have talked about ‘feeding frequently,’ you may need to check her understanding of the term ‘frequently.’
 - Ask the mother if she feels confident that she can do this?
 - Does the mother feel this action is helpful and important?
 - It is not enough to ask a mother if she understands, because she may not realize that she understood incorrectly.
3. Ask open questions to find out if further explanation is needed. Avoid asking closed questions, because they suggest the answer and can be answered with a simple “yes” or “no.”

They do not tell you if a mother really understands. ‘Checking understanding’ also helps to summarize what you have talked about.

4. Say: We will now see a demonstration of the need for using the skill of checking understanding. The demonstration involves a mother and health worker coming to the end of a discussion about feeding a 12-month-old baby.
5. Ask the two participants whom you have prepared to give Demonstration 20.A.
6. After each part of the demonstration, briefly discuss what the participants have observed.

Demonstration 20.A: Checking understanding

Health worker: “Now, (name), have you understood everything that I’ve told you?”

Mother: “Yes, ma’am.”

Health worker: “You don’t have any questions?”

Mother: “No, ma’am.”

Comment: What did you observe?

This mother would need to be very determined to say that she had questions for this health worker. Let us hear this again with the health worker using good checking questions.

Health worker: “Now, (name), we talked about many things today, so let’s check everything is clear. What foods do you think you will give (name) tomorrow?”

Mother: “I will make his gruel thick.”

Health worker: “Thick gruel helps him to grow. Are there any other foods you could give, maybe from what the family is eating?”

Mother: “Oh yes. I could mash some of the rice and lentils we are having and I could give him some fruit to help his body to use the iron in the food.”

Health worker: “Those are good foods to give your child to help him to grow. How many times a day will you give food to (name)?”

Mother: “I will give him something to eat five times a day. I will give him thick gruel in the morning and evening, and in the middle of the day, I will give him the food we are having. I will give him some fruit or bread in between.”

Health worker: “You have chosen well. Children who are one year old need to eat often. Would you come back to see me in two weeks to see how the feeding is going?”

Mother: “Yes, okay.”

Comment: What did you observe this time?

- This time the health worker checked the mother’s understanding and found that the mother knew what to do. She also asked the mother to come back for follow-up.
- If you get an unclear response, ask another checking question. Praise the mother for correct understanding or clarify any information as necessary.
- Arrange follow-up or referral.

Learning objective 2: Arrange for follow-up or referral of a child

Methodology: Discussion

1. Write ‘Arrange follow-up or referral’ on the flip chart below ‘Checking understanding.’
2. Make these points:
 - All children should receive visits to check their general health and feeding. If a child has a difficulty that you are unable to help with, you may need to refer him for more specialized care.
 - Follow-up is especially important if there has been any difficulty with feeding. Ask the mother to visit the health facility in five days for follow-up.
 - This follow-up includes checking what foods are used and how they are given; checking how breastfeeding is going; and checking the child’s weight, health, general development, and care.
 - The follow-up visits also give an opportunity to praise and reinforce practices, thus building the mother’s confidence, to offer relevant information, and to discuss suggestions as needed.
 - It is especially important for children with special difficulties—for example, children whose mothers are living with HIV—to receive regular follow-up from health workers. These children are at special risk. In addition, it is important to check how the mother is coping with her own health and difficulties.

Session 21. Training development plan and post-training assessment

Learning objectives
1. Develop a training plan
2. Conduct a post-training knowledge assessment

Materials

- Flip chart papers and stand, markers, tape/sticky putty
- *Participant materials 20.1*. Training plan template
- *Participant materials 1.1* Post-training assessment

Duration: 30 min

<p>Learning objective 1: Develop a training plan</p> <p>Methodology: Group discussion</p>
<p>Instructions for activity</p> <ol style="list-style-type: none"> 1. Ask a community official to assist in this activity if possible. 2. Review the training plan template and each of the categories. Answer questions. 3. Form groups by region to begin the design of the training, follow-up, and support plans for building capacity in the region in the area of infant and young child feeding. 4. Provide participants with information on support and resources that will be available to them.

Participant materials 20.1: Training plan template

Region:

District:

Profile of trainees	Trainers	People responsible	Resources needed	Collaborators	Time frame	Expected outcomes	Follow-up

Learning objective 2: Conduct a post-training knowledge assessment

Methodology: Non-written (or written as possible) assessment

Instructions for activity (non-written assessment)

1. Explain that 18 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 center.
3. One facilitator reads the statements from the assessment, and another facilitator records the answers and notes which topics (if any) present confusion.

OR

Instructions for activity (written assessment)

1. Pass out copies of the 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 assessment. (Use the same number or symbol as was used for the pre-assessment.)
3. Correct all the tests as soon as possible the same day. Clarify any points of confusion.

Participant materials 21.1: Post-training assessment: What do we know now?

	Statement	Yes	No	Don't know
1.	The amount and types of food a woman eats during pregnancy can affect a baby's health.			
2.	Poor child feeding during the first 2 years of life harms growth and brain development.			
3.	An infant aged 6 up to 9 months needs to eat at least 3 times a day in addition to breastfeeding.			
4.	A pregnant woman needs to eat 1 more meal per day than usual.			
5.	At 4 months, infants need water and other drinks in addition to breastmilk.			
6.	Telling a mother how to feed her child is an effective way of changing her infant feeding practices.			
7.	A woman who is malnourished can 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 about 6 months, the first food a baby takes should have the consistency 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 colostrums (the first thick, yellowish milk).			
14.	An HIV-positive mother should never breastfeed.			
15.	Men play an important role in how infants and young children are fed.			
16.	Babies should be offered the breast only when the full milk comes in.			
17.	An engorged breast cannot be easily treated at home.			
18.	A low milk supply can be increased by increasing the frequency of feeds.			

APPENDICES

Appendix 1. Seven steps in planning a training event

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

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

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

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

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

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

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

Note:

- In order to facilitate the hands-on, practical nature of the field site visits, ideally, no more than five to seven participants should accompany each facilitator in any one practical session in the field.
- Provide sufficient time for transport to and from field sites.
- Allow 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
Management⁵	<ul style="list-style-type: none"> Identify the results wanted Assess needs and priorities (know the problem) Develop strategy to achieve the results including refresher trainings and follow-up Collaborate with other organizations and partners Establish and institutionalize an ongoing system of supportive supervision or mentoring Commit resources Take care of administration and logistics 	<ul style="list-style-type: none"> Support the activity Keep in touch Receive feedback Continuously monitor and improve quality Motivate Management presence demonstrates involvement (invest own time, effort) 	<ul style="list-style-type: none"> Mentor learner Reinforce behaviors Plan practice activities Expect improvement Encourage networking among learners Be realistic Utilize resources Provide supportive ongoing supervision and mentoring Motivate Continuously monitor and improve quality

⁵ Management includes stakeholders, ministries, organizations, and supervisors/mentors

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

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

Appendix 3. List of materials for training of trainers

Training room set-up

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

Materials

- *Facilitator's Guide*: 1 per facilitator
- *Training Aids*: 2 per training
- *Participant Materials*: 1 per counselor/participant
- Set of *Counseling Cards*: 1 per facilitator and 1 per participant
- Name card materials (e.g., hard paper, punch, safety pins)
- Skills Assessment Self-Rating forms
- Paper cards, various sizes (or stiff colored paper)
- Flip chart paper, flip chart stands: 4
- Markers: black, blue, green; a few red
- Tape or sticky putty, scissors
- Behavior change case studies
- Dolls (life-sized); or bath towels and rubber bands: 1 for every two participants
- Clear glasses (3 of identical size)
- Local bowls and utensils/spoons
- Different types of locally available foods
- Local cups (as examples, including one 250 ml)
- Counseling case studies
- Certificate (requirements)

Practicum sessions

- Transport arrangements
- Additional copies of tools such checklists and job aids

Counseling seating

- Mats, chairs, or both

In-country partners/stakeholders

- *Planning & Adaptation Guide*: 1 per partner and stakeholder

Appendix 4. Supportive supervision

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 include:
 - 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 counselors
 - Training of mother-to-mother support group facilitators
 - Individual counseling sessions
 - Action-oriented group sessions
 - Mother-to-mother support group sessions
 - Other activities
 - Coverage of the target population in your supervision area:
 - Percent of target mothers reached by individual counseling, mother-to-mother support group sessions, action-oriented group sessions, other (using LQAS methodology, for example; determine reporting period)
 - Result of program activities in your supervision area:
 - Comprehension of key information by target audience, retention of key information by target audience (using LQAS methodology, for example; determine reporting period)

Appendix 5. Principles of adult learning⁶

1. **Dialogue:** Adult learning is best achieved through dialogue. Adults have enough life experience to dialogue with a facilitator or 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 counseling 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:** Practice 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 visual aids are used to support the verbal presentation, and they learn best when they practice the new skill. We remember 20 percent of what we hear, 40 percent of what we hear and see, and 80 percent of what we hear, see and do.
9. **Relevance to previous experience:** People learn faster when new information or skills are related to what they already know or can do.

Immediate relevance: Learners should see how to use and apply what they have learned in their job or life immediately.

Future relevance: People generally learn faster when they realise that what they are learning will be useful in the future.

⁶ Adapted from Vella J. *Learning to Listen, Learning to Teach*. San Francisco, CA: Jossey-Bass; 1994.

10. **Teamwork:** Help people learn from each other and solve problems together. This makes learning easier to apply to real life.
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 practice skills.
12. **Accountability:** Ensure that learners understand and know how to put into practice what they have learned.
13. **Motivation:** Wanting to learn:
 - People learn faster and more thoroughly when they want to learn. The trainer's challenge is to create conditions in which people want to learn.
 - Learning is natural, as basic a function of human beings as eating or sleeping.
 - Some people are more eager to learn than others, just as some are hungrier than others. Even in one individual, there are different levels of motivation.
 - All the principles outlined will help the learner become motivated.
14. **Clarity:**
 - Messages should be clear.
 - Words and sentence structures should be familiar. Technical words should be explained and their understanding checked.
 - Messages should be VISUAL.
15. **Feedback:** Feedback informs the learner in what areas s/he is strong or weak.

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

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

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

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

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

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

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

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 colors. Ask participants to select a bottle cap. Once selected, ask participants to form groups according to the color selected.
3. Sinking ship: ask participants to walk around as if they were on a ship. Announce that the ship is sinking and life boats are being lowered. The life boats will only hold a certain number of participants. Call out the number of persons the life boats will hold and ask participants to group themselves in the number called-out. Repeat several times and finish with the number of participants you wish each group to contain (for example, to divide 15 participants into groups of 3, the last 'life boat' called will be the number 5).

Review energizers

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

1. Participants and facilitators form a circle. One facilitator has a ball that he or she throws to one participant. The facilitator asks a question of the participant who catches the ball. The participant responds. When the participant has answered correctly to the satisfaction of the group, that participant throws the ball to another participant, asking him/her a question in turn. The participant who throws the ball asks the question. The participant who catches the ball answers the question.
2. Form 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 counseling 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 counseling 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 counseling 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 counseling cards is placed face down. A participant is asked to choose a counseling card and tell the other participants in what situations a counselor can share the practices/messages the card represents. One facilitator is present in each circle to assist in responding.

Daily evaluations

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

1. Form buzz groups of 3 participants and ask them to answer one, two, or all of the following questions (ask one participant from each buzz group to respond to the whole group):
 - What did you learn today that will be useful in your work?
 - What was something that you liked?
 - Give a suggestion for improving today's sessions.
2. 'Happy faces' can be used to measure 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 8: Cut-outs of 'happy faces.'

Appendix 8. Cut-outs of 'happy faces'

