Integrated Prevention of Mother-to-Child Transmission of HIV and Support for Infant Feeding

Community Motivators Course

LINKAGES

September 2004

COURSE ON

INTEGRATED

PREVENTION OF MOTHER-TO-CHILD TRANSMISSION OF HIV AND

SUPPORT FOR INFANT FEEDING

FOR COMMUNITY MOTIVATORS

Academy for Educational Development
LINKAGES Project

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Preface

In 2003 the prevalence rate of HIV infection in Africa ranged from about 3% in Eritrea to over 51% in some parts of Botswana. The severity of mother-to-child transmission (MTCT) of HIV in sub-Saharan Africa is a result of high rates of infection in women of reproductive age and a lack of effective prevention of mother-to-child transmission (PMTCT) strategies. Because HIV can be transmitted to infants through their mothers' breastmilk, several African ministries of health have asked the LINKAGES Project to provide technical assistance to assess infant and young child feeding practices. Pregnant women need to know their HIV status in order to make informed decisions about infant and young child feeding methods.

In 1999 the Zambian Central Board of Health recommended establishing a demonstration site for HIV and infant and young child feeding counseling in a mother and child heath (MCH) setting with full maternity services. LINKAGES joined national and international partners in the Ndola Demonstration Project to integrate HIV counseling and testing and infant feeding counseling in existing maternal and child health (MCH) services. The model eventually included policy development and advocacy, consensus and partnership building, assessment of health care facilities and communities with people living with HIV and AIDS, rapid formative research, a baseline survey, enhancement of HIV testing and counseling facilities to ensure privacy and confidentiality, training and capacity building in PMTCT and infant feeding counseling, mentoring and supervision, provision of Nevirapine prophylaxis to pregnant women and their newborns, monitoring and evaluation, and expansion to other districts in Zambia and other countries in Africa. Since 1999 LINKAGES has trained almost 2000 health providers from a dozen countries in skills to implement and monitor an integrated PMTCT and infant feeding counseling program using the LINKAGES basic PMTCT and infant and young child feeding course.

Because of the importance of community support for HIV prevention and infant and young child feeding, LINKAGES also offers training for community motivators based on the course for health providers. The curriculum was drafted by project stakeholders in late 2002, tested in community training sessions in 2002 and 2003, and revised based on the field testing. The content gives community motivators a basic understanding of HIV facts and prevention, mechanisms of MTCT, current MTCT risk reduction interventions, and infant and young child feeding in the context of PMTCT. The course also reviews nutritional recommendations for pregnant women and new mothers in areas affected by HIV.

Training methodology

The participatory training approach uses the experiential learning cycle method and prepares participants for hands-on performance of skills in their workplaces. The course employs a variety of training methods: demonstration, practice, discussion, case studies, group discussion, role play, checklists, and lecture. Videos and slides are used during the training to reinforce information and practice. Participants also act as resource persons for each other, benefit from working directly with breastfeeding mothers and pregnant women, and have opportunities to talk with people living with HIV and AIDS. At the end of the course participants are mentored and supervised. Regular updates are encouraged to keep trainees knowledgeable about new developments in infant and young child feeding in the context of PMTCT.

The community motivators' curriculum is based on the widely acknowledged theory that adults learn best by reflecting on their experience. Attempts were made to make the training sessions relevant to the needs of participants and their communities. To maximize participation, each session begins with a discussion question to invite participants to share their knowledge, experience, beliefs, feelings, and practices. The questions may be discussed using any of the many participatory methods in the table below that facilitators are familiar with.

- Brainstorming
- Questions and answers
- Demonstration
- Pictures or other visuals
- Storytelling
- Case studies
- Testimonials from satisfied users
- Role plays
- Video clips
- Games
- Merry-go-round contribution games
- Models
- Use of real people or items
- Support groups
- VIPP (Visualization in Participatory Programming)
- Fish bone exercises
- Community visits

Notes for facilitators

Participants complete pre- and post-training questionnaires and discuss their evaluations at the end of training. They are encouraged to write their names on their questionnaires so that trainers can give them feedback.

The course allows training participants to identify and practice basic counseling skills in the context of HIV, with a focus on infant and young child feeding counseling, and identify strategies to integrate interventions into existing community services. For each session, the outline includes the following components:

- Duration
- Introduction
- Learning objectives
- Training methods and content
- Materials and recommended reading

Each session contains basic facts on HIV, PMTCT, infant and young child feeding in the context of HIV, and counseling of pregnant women and family members. You are encouraged to add additional points from your experience and that of the participants during discussion.

To make the best use of the curriculum, read it through to get a sense of its structure and content. Study in advance the sessions you plan to present to get acquainted with the content and flow. Pay attention to the discussion questions and determine the discussion method to use. You may skip or modify some of the questions, depending on your style and needs.

When the class convenes, point out that each of the participants has observed or experienced bringing up children or knowing people with HIV or AIDS and has much to bring to the discussions. Feel free to share what you have observed, know, or believe. There is no right or wrong answer to the discussion questions. Encourage participants to contribute freely using their experience.

Note all contributions to brainstorming and other sessions, no matter how worthwhile you consider them, on the board, a flipchart, or VIPP cards. Ask contributors to clarify their ideas if they are not well understood. When all ideas are harvested, lead a discussion to assess them, correct misconceptions, add missing information, and categorize and arrange ideas. Add content from the curriculum that may not have come out during the discussion. Make clear that participants should use the same approach to address their clients' knowledge, attitudes, and behaviors.

Timetable: 6-day training course in prevention of mother-to-child transmission of HIV for community motivators

TIME	DAY 1	DAY 2	DAY 3	DAY 4	DAY 5	DAY 6
08:00–08:15		RECAP				
08:15–10:15	Official opening **Session 1** Introductions, expectations, and objectives	**Session 5** Community breastfeeding practices and the benefits of breastfeeding for baby, mother, family, community, nation **Session 6** How the breast works **Session 7** Composition of breastmilk	**Session 15** How to breastfeed **Session 16** Management of Breastfeeding problems or difficulties in the context of HIV	**Session 18** Infant and young child feeding options in the context of HIV	**Session 22** Establishing and working with support groups **Session 23** Women's nutrition	**Session 25** BFHI in the context of HIV **Session 26** Code of Marketing of Breast-Milk Substitutes **Session 27** Involving the community and men in prevention of mother-to-child transmission (PMTCT) of HIV
10:15–10:30	T E A B R E A K					
10:30–12:30	**Session 2** HIV and AIDS	**Session 8** Mother-to-child transmission of HIV **Session 9** Prevention of mother-to-child transmission of HIV) **Session 10**	**Session 17** Observing breastfeeding in the community or health facility	**Session 19** Young child feeding (complementary feeding)	**Session 24** Conducting a motivational activity in the community	… Continues **Session 28** Monitoring (record keeping) and the use of monitoring information in the community

		Primary prevention of HIV				Evaluation, feedback, and recommendations Official closing
12:30–14:00	**L U N C H**					
14:00–16:15	**Session 3** Behavior change communication	**Session 11** PMTCT during pregnancy **Session 12** HIV counseling and testing **Session 13** PMTCT during labor and delivery and immediate care of newborn **Session 14** PMTCT during the post-natal period		**Session 20** Communicating with mothers and community members and negotiating infant and young child feeding practices		
16:15–16:30	**T E A B R E A K**					
16:30–17:30	**Session 4** Common sexually transmitted infections that facilitate HIV infection	… Continued	Feedback from community and health facility visit	**Session 21** Using educational materials	Feedback from community visit	

Instructional plan: 6-day training course on prevention of mother-to-child transmission of HIV for community motivators

Day 1					
Session number/title	**Time**	**Learning objectives**	**Content**	**Training methods**	**Materials**
1. Introduction, Expectations, Objectives	2 hrs	• Begin to learn names of fellow participants, facilitators, and resource people • Develop a relationship with other participants and trainers • State aspects of participant and facilitator background • Discuss expectations of course and fears • Understand course objectives and purpose of the training • Understand administrative and housekeeping arrangements	• Introductions • Expectations • Course objectives	• Introduce presentation game for introductions and expectations. Cut drawings or breastfeeding pictures in half and give each participant a piece of a drawing or picture. Instruct participants to find the matching piece. Once this is accomplished, ask the pairs to give each other's names, expectations of the course, and some element of human interest (e.g., favorite food, hobbies, likes, dislikes). • Other suggestions for sharing expectations are 1) VIPP cards, 2) writing on paper, and 3) brainstorming. The three options are explained below in chart. • Write expectations on flipchart, filling in expectation "gaps" and introducing missing objectives. • Keep expectations and objectives in view during the rest of the course.	• Flipcharts, markers, and masking tape • Matching pairs of drawings or pictures for presentation game • Participants' folders • Course timetable • Flipchart with objectives
2. HIV and AIDS	2 hrs	• Define common terms used in HIV and AIDS • Discuss modes of HIV transmission • Describe factors which facilitate HIV transmission • Describe the impact of HIV and AIDS in the community	▪ Attitudes about HIV and AIDS ▪ Terms used in discussion of HIV and AIDS. Is HIV the same as AIDS? ▪ Extent of the HIV and AIDS problem in the world, the continent, and the country. How HIV and AIDS affect countries, communities, and families ▪ How people are infected with HIV, factors that contribute to the spread of HIV, and what	• Ask participants to reflect on their attitudes about HIV and AIDS, responding to statements read by the facilitator by moving to areas marked "agree" or "disagree." • Divide participants into 4 groups and give each group a set of cards with terms, questions, and definitions relating to HIV and AIDS and ask them to match the cards. • Ask participants whether HIV is the same as AIDS. • Brainstorm with participants the extent of the HIV and AIDS problem in the world, the continent, and the country. • Share UNAIDS maps of the world, continent,	• Flipcharts, markers, and masking tape • Statements and questions about HIV and AIDS that reflect attitudes • Posters marked "agree" and "disagree" • 4 sets of cards with terms and questions relating to HIV and AIDS and cards with definitions of the terms • UNAIDS maps of the

Session number/title	Time	Learning objectives	Content	Training methods	Materials
			we can we do to reduce the spread of HIV	and county. • Brainstorm answers to how HIV and AIDS affect nations, communities, and families. • Divide participants into 4 working groups. Ask each group to answer one of the following questions: How are people infected with HIV? What factors contribute to the spread of HIV? What can we do to reduce the spread of HIV? What is meant by "living positively with HIV? • Ask each group to present in plenary. • Facilitate discussion in plenary to fill in gaps. • Review key messages of session.	world, continent, and country • Questions on flipcharts for working groups
3. Behavior Change Communication	2 hrs	• Define communication • Define behavior change communication (BCC) • Identify the goal of BCC • Describe BCC steps • Describe BCC methods and processes • Identify key elements of BCC • Practice identifying behavior change stages	• Definition of communication • Exploration of why knowledge is usually not enough to change behavior • Steps of behavior change communication and interventions required at each step • Identification of behavior change steps with regard to optimal practices in communities affected by HIV	• In plenary ask the following questions and writes answers on flipchart: 1) What shall we do with the information we get from this workshop? 2) What is communication? 3) Why do people communicate? and 4) What makes it difficult for people to change behavior? • Brainstorm the definition of behavior change communication. • Divide participants into buzz groups of 3. Ask the groups to think about a time when someone told them what to do and how they felt. • Ask participants to think about a time when someone asked them what they wanted to do and how they felt in this situation. • Discuss how information is usually never enough to change behavior. • On a flipchart draw BCC steps and brainstorm with participants how people generally move through this process to change behavior. • Ask participants to close their eyes and think about a behavior (not alcohol or tobacco) they are trying to change. Ask them to identify at what step they are and why. Ask what they	• Flipcharts, markers, and masking tape • Handout 3.1: Steps of Behavior Change • Handout 3.2: Steps to Change and Interventions • Handout 3.3a: Behavior Change Case Studies • Handout 3.3b: Behavior Change Case Studies (answer key)

Session number/title	Time	Learning objectives	Content	Training methods	Materials
				think they will need to move to the next step. • Ask participants to identify the key elements of behavior change • Divide participants into 3 working groups and give each group 3 case studies. Ask each group to identify which step the mother in the case study is in. Ask each group to present 1 case study. • Facilitate discussion in plenary. • Review key messages of the session.	
4. Common Sexually Transmitted Infections (STIs) that Facilitate HIV Transmission	1 hr	• Define STIs • Identify common STIs in the community • List signs and symptoms of common STIs • State factors that contribute to the transmission of STIs • Describe the link between mother-to-child transmission of HIV and STIs • Discuss how STIs can be prevented	• Definition of sexually transmitted infection (STI) • Common STIs in the community • Grouping of STIs • Signs, symptoms, effects, complications, and prevention of STIs	• Brainstorm the meaning of STI with participants. • Write responses on flipchart and complete definition. • Ask participants what STIs are most common in their communities. • Present groups of STIs. • Divide participants into 3 working groups and ask each group to work on one of these themes: Signs and symptoms of STIs, effects and complications of STIs, and prevention of STIs. • Ask groups to present in plenary. • Facilitate discussion. • Review key messages of session.	• Flipcharts, markers, and masking tape • STI leaflets
Daily evaluation	15 min	• Evaluate the day's activities	• Sharing of what the participants: • Liked • Will use • Learned	• Ask participants to write their answers and put into a basket. • Ask participants to pick a response from the basket and read it out loud.	
Day 2					
RECAP					
5. Community Breastfeeding	1 hr	• Identify common local breastfeeding practices	• Community breastfeeding practices	• Divide participants into 4 groups. • Ask 2 of the groups to answer questions on	• Flipcharts, markers, and masking tape

Session number/title	Time	Learning objectives	Content	Training methods	Materials
Practices, and the Benefits of Breastfeeding for Infant, Mother, Family, Community, and Nation		• Discuss the benefits of breastfeeding	• Benefits of breastfeeding for baby, mother, family, community, and nation • Properties of colostrum • Optimal breastfeeding practices • Definitions of common breastfeeding terms: artificial feeding, bottle feeding, breastmilk substitute, cessation of breastfeeding, commercial infant formula, complementary foods, cup feeding, exclusive breastfeeding • Definition and elements of child survival • Benefits of breastmilk and breastfeeding for mother and baby: nutritional, health, psychological, developmental, child spacing, economic, and environmental • Risks of breastfeeding • Recommended breastfeeding practices • Risks of artificial feeding • Facts about child survival and safe motherhood	community practices regarding initiation of breastfeeding, giving them Handout 5.1 • Ask the other 2 groups to answer questions on community practices of exclusive breastfeeding, giving them Handout 5.2. • In plenary, ask 1 of the 2 groups working on the first question to present its answers and the other to add additional points. • Repeat for the second group. • Set up 4 flipcharts throughout the room with the titles: Benefits of breastfeeding for the baby, Benefits of breastfeeding for the mother, Benefits of breastfeeding for the family, and Benefits of breastfeeding for the community and nation. • Divide participants into 4 groups. Give each group 3 minutes at each flipchart and then ask them to rotate to the next flipchart. • Facilitate discussion and summary in plenary. • Divide participants into 2 groups. Give each group a set of cards. Half of the cards have properties of colostrum written on them, and the other half include the importance of each property. Ask each group to match the properties with their importance. • Ask each group to share its responses in plenary. • Divide participants into 5 groups, giving each participant 1 card (½ A4 size). • Ask each participant to write 1 optimal breastfeeding practice on his or her card, large and visible. • Ask each group to share, discuss, and list optimal breastfeeding practices. • Have each group tape its breastfeeding practices on the wall. • Facilitate discussion and summarize in	• Handout 5.1: Initiation of Breastfeeding working group questions • Handout 5.2: Breastfeeding working group questions • Handout 5.3: Benefits of Breastfeeding for the Baby • Handout 5.4: Benefits of Breastfeeding for the Mother • Handout 5.5: Benefits of Breastfeeding for the Family • Handout 5.6: Benefits of Breastfeeding for the Community and Nation • 2 sets of cards: Properties of colostrum and their importance • Handout 5.7: Optimal Breastfeeding Practices

Session number/title	Time	Learning objectives	Content	Training methods	Materials
				plenary. • Review key messages.	
6: How the Breast Works	½ hr	• Identify parts of the female breast • Describe the functions of each part • Describe how breastmilk is produced and ejected	• Parts of the breast • Prolactin and oxytocin	• Ask participants to form equal working groups to draw: - The breast as it looks on the outside - The breast as it looks from the inside • In plenary, ask each group to explain its drawings and how milk is produced. • Facilitate discussion in plenary, correcting misinformation and answering questions. • Review key messages.	• Flipcharts, markers, and masking tape • Breast model(s)
7. Composition of Breastmilk	½ hr	• State the main contents of breastmilk and their benefits to the baby • Describe the changes that take place in breastmilk composition • Compare the contents of breastmilk with the contents of animal milk	• Content of human milk • Difference between human and animal milk	• Ask participants what breastmilk contains, what the differences are between human milk and cow's milk, and whether human milk has the same substances in the same concentration all the time. • Facilitate discussion and summarize. • Present a chart comparing human milk and cow's milk.	• Flipcharts, markers, and masking tape • Handout 7: Summary of the Differences between Human and Animal Milk
8. Mother-to-Child Transmission of HIV	45 min.	• Define mother-to-child transmission (MTCT) of HIV • Describe how HIV is transmitted from mother to child • Describe factors that facilitate MTCT	• Definition MTCT of HIV • Rates of transmission during pregnancy, labor and delivery, and breastfeeding	• Brainstorm with participants the definition of mother-to-child transmission of HIV. • Reach consensus on the definition. • Ask participants when HIV can pass from an infected mother to her baby. • Ask whether all babies born to HIV-positive women are infected with HIV. • Present rates of HIV transmission during pregnancy, labor and delivery, and breastfeeding. • Display throughout the room flipcharts with 4 themes: 1) maternal conditions that facilitate (make easier) MTCT, 2) obstetrical conditions that facilitate MTCT, 3) fetal and infant	• Flipcharts, markers, and masking tape • Flipcharts with theme headings

Session number/title	Time	Learning objectives	Content	Training methods	Materials
				conditions that facilitate MTCT, and 4) other conditions that facilitate MTCT. • Ask participants to form 4 groups and rotate from flipchart to flipchart, providing additional points for each theme. • Facilitate discussion in plenary and groups. • Ask participants how a baby who has been in the womb of an HIV-positive woman for 9 months can be born without being infected with HIV. Ask why the baby is not infected at fertilization even when the father and mother are HIV positive. • Facilitate discussion. • Review key messages.	
9. Prevention of Mother-to-Child Transmission of HIV	45 min.	• Identify interventions that can reduce MTCT during pregnancy, labor and delivery, and breastfeeding	• MTCT risk reduction interventions during pregnancy, labor and delivery, and the post-natal period	• Divide participants into 3 groups. Give each group a set of cards with MTCT risk reduction interventions on them. • Ask each group to sort the interventions into 3 categories: during pregnancy, during labor and delivery, and during the post-natal period. • Facilitate discussion and summarize in plenary. • Review with participants the meaning of "living positively with HIV."	• Flipcharts, markers, and masking tape • 4 sets of cards with risk reduction interventions
10. Primary Prevention of MTCT	½ hr	• Describe primary prevention of HIV • Discuss at least 3 ways to prevent HIV infection	• Primary prevention of HIV and basic steps to avoid HIV infection • Correct way to use a condom	• Brainstorm with participants the meaning of primary prevention of HIV, basic steps that can be taken to avoid HIV infection, and whether primary prevention is enough to prevent MTCT. • Facilitate discussion and summarize. • Ask for 2 volunteers to demonstrate how a condom is used before, during and after sexual intercourse, using a model of a penis. • Facilitate discussion.	• Flipcharts, markers, and masking tape • Model of a penis

Session number/title	Time	Learning objectives	Content	Training methods	Materials
				• Demonstrate how a condom is used before, during and after sexual intercourse, using a model of a penis • Facilitate discussion. • Review key messages.	
11. PMTCT during Pregnancy	45 min.	• Identify where women go for routine health services during pregnancy • Define antenatal care • Explain the objectives of antenatal care • Discuss activities at the antenatal clinic • State the importance of each activity • Explain how antenatal care helps prevent HIV infection during pregnancy	• Antenatal clinic (where, what, why, how often) • Activities at the antenatal clinic • How antenatal care services contribute to prevention of MTCT of HIV	• Brainstorm with participants where women go for routine health services during pregnancy, the definition of antenatal care, reasons why pregnant women should go to antenatal clinics, and how often women should attend antenatal clinics. • Divide participants into 4 groups. Ask each groups to prepare a role play in which a woman who is 3 months pregnant visits an antenatal clinic for the first time. The role plays should cover all activities the mother might experience at the antenatal clinic. • Ask 1 group to demonstrate its role play in plenary and the other groups give feedback. • Facilitate discussion and help other participants fill in gaps in information. • Divide the participants into 2 groups and sub-divide each group into buzz groups of 3 people each. • Ask 1 buzz group in each larger group to prepare an answer for how antenatal services contribute to prevention of mother-to-child transmission (PMTCT) of HIV. • Ask the other buzz group in the larger group to list other precautions women need to take during pregnancy. • Facilitate discussion and summarize in plenary. • Review key messages.	• Flipcharts, markers, and masking tape • Questions for brainstorming and buzz groups written on a flipchart • Poster on pregnancy
12. HIV	45	Define HIV counseling and testing	Definition of HIV counseling and	• Brainstorm with participants the meaning of	• Flipcharts, markers,

Session number/title	Time	Learning objectives	Content	Training methods	Materials
Counselling and Testing (VCT)	min.	(VCT) Discuss the benefits of VCT Describe the process of VCT	testing (VCT) Process of HIV counseling and testing	VCT. • Brainstorm participants' fears about being tested for HIV and write the fears on a flipchart. • Ask participants whether anyone who has had HIV counseling and testing would like to share the benefits he or she experienced. • Brainstorm with participants the benefits of VCT. • Facilitate discussion of fears and benefits. • With another facilitator as client, demonstrate through role plays the process of HIV counseling and testing, including pre-test counseling, testing, post-test counseling, and supportive counseling. Do one role play for a client with an HIV-negative blood sample and one for a client with an HIV-positive blood sample. • Facilitate discussion in plenary. • Review key messages.	and masking tape
13. PMTCT of HIV during Labour, Delivery, and Immediate Care of the Newborn	45 min.	• Describe safe practices for PMTCT during labor and delivery	• Safe practices for PMTCT during labor and delivery and the immediate post-natal period	• Brainstorm with participants why labor and delivery practices are part of PMTCT. Write answers on a flipchart. • Divide participants into 4 working groups. Ask 2 of the groups to discuss what a mother can do to reduce MTCT during labor and delivery (risk reduction interventions. Ask the other 2 groups to discuss how a baby should be cared for immediately after birth to minimize HIV transmission. • In plenary, ask 1 group from the first group discussion to present and other to add points not mentioned. • Repeat for the second group discussion. • Facilitate discussion and summarize.	• Flipcharts, markers, and masking tape • Questions for working groups written on flipcharts

Session number/title	Time	Learning objectives	Content	Training methods	Materials
14. PMTCT of HIV during the Post-Natal Period	45 min.	• Describe the post-natal period • Discuss the services and support given to the mother and baby during the post-natal period	• Safe practices for PMTCT during the post-natal period	• Brainstorm with participants the meaning of the post-natal period. Write answers on a flipchart. • Divide participants into 4 working groups. Ask 2 of the groups to discuss services and support given to the mother in the post-natal period. Ask the other 2 groups to discuss services for the baby in the post-natal period. • In plenary ask 1 group from the first discussion to present and other to add points not mentioned. • Repeat for the second group discussion. • Facilitate discussion and summarize.	• Flipcharts, markers, and masking tape • Questions for working groups written on flipcharts • Handout 14: Interventions to reduce MTCT
Daily evaluation	15 min.	• Evaluate the day's activities	• Sharing of what the participants: - Liked - Will use - Learned	• Ask participants to write their answers and put them in a basket. • Ask each participant to pick a response from the basket and read it out loud.	
Day 3					
RECAP					
15. How to Breastfeed	1 hr.	• Describe the recommended ways to position and attach a baby to the breast • Demonstrate the recommended ways to hold (position) a baby and put a baby to the breast	• Proper positioning and attachment • Causes and results of poor attachment • Demonstration of different breastfeeding positions	• Demonstrate incorrect positioning and attachment using a doll. • Demonstrate proper positioning and attachment using a doll or ask a mother and baby to demonstrate. • Ask participants to explain the difference between the two ways to position and attach a baby. Add needed explanation. • Divide participants into groups of 5. If mothers and babies are present, ask one mother-baby pair to practice good positioning and attachment and receive feedback from the other participants. • If no mothers and babies are available, ask participants to practice in groups of 3 (mother,	• Flipcharts, markers, and masking tape • Handout 15.1: Checklist of Proper Positioning and Attachment • Handout 15.2: Illustration of Common Breastfeeding Positions • Handout 15.3: Illustration of Proper Attachment

Session number/title	Time	Learning objectives	Content	Training methods	Materials
				counsellor, and observer), rotating so that each participant has a chance to play each role. The observer should use a checklist of proper positioning and attachment. • Ask 2 pairs to demonstrate good positioning and attachment in plenary with a baby or doll. • Ask for feedback and facilitate discussion. • Divide participants into 4 groups. Ask 2 of the groups to discuss the causes of poor attachment and the other 2 groups to discuss the results of poor attachment. • Ask the groups to present in plenary. • Facilitate discussion and summarize. • Ask 1 or 2 participants to demonstrate the cradle, football, and side-lying positions with a doll and a breast model. • Facilitate discussion.	
16. Management of Breastfeeding Problems and Difficulties in the Context of HIV and AIDS	1 hr	• Identify breastfeeding difficulties related to the mother and baby • Discuss causes of breastfeeding difficulties related to the baby • Discuss how to prevent and manage breastfeeding difficulties related to the baby and the mother	• Common difficulties during breastfeeding • Causes, prevention measures and solutions for the most common breastfeeding difficulties and their relation to MTCT of HIV • Community and environmental factors	• Brainstorm with participants common difficulties during breastfeeding. On a flipchart group the difficulties into 2 categories: those related to the baby and those related to the mother. • Divide participants into 4 working groups. Ask each group to list ways to prevent and solve 1 of the most common breastfeeding difficulties (baby not getting enough milk, engorgement, sore and cracked nipples, and plugged ducts that can lead to mastitis). The groups should relate the difficulty to MTCT when appropriate. • Ask each group to present in plenary. Ask the rest of the participants to fill in an observation checklist of prevention measures and solutions to the difficulty. • Facilitate discussion and summarize in plenary.	• Flipcharts, markers, and masking tape • Handout 16.1: Checklist of Prevention Measures and Solutions for Insufficient Milk • Handout 16.2: Checklist of Prevention Measures and Solutions for Engorgement • Handout 16.3: Checklist of Prevention measures and Solutions for Sore and Cracked Nipples • Handout 16.4: Checklist of Prevention Measures and Solutions for Plugged Ducts that

Session number/title	Time	Learning objectives	Content	Training methods	Materials
				• Facilitate discussion in plenary of other breastfeeding problems and difficulties, using Handouts 16.5a–d. • On a flipchart makes 3 columns, headed "Breastfeeding beliefs that encourage breastfeeding," "Breastfeeding beliefs that discourage breastfeeding," and "Breastfeeding beliefs that do not hinder breastfeeding." • In plenary have participants brainstorm the breastfeeding beliefs in their communities. • In plenary ask participants to decide in which column on the flipchart to place each breastfeeding belief. • Ask participants to suggest how beliefs which have a negative effect on breastfeeding might be changed, while always respecting the beliefs. • Review key messages.	Can Lead to Mastitis • Handout 16.5a, b, c, and d: Special Situations Affecting Breastfeeding
17. Observing Breastfeeding in the Community or Health Facility	3–4 hrs	• Observe and assess a breastfeeding session • Recognize signs of good and poor positioning and attachment • Demonstrate ability to use the breastfeeding observation form • Identify a mother who may need help with breastfeeding	• Observation of a breastfeed	• Review the breastfeeding observation form. • Ask participants to form groups of 3 to role play a mother, health worker, and observer. Have the participants who role play the mothers practice attachment and positioning, with the participants who role play the health workers counseling the mothers and the participants playing the observers using the breastfeeding observation form. • Ask participants to form pairs to observe at least 2 mothers breastfeeding their babies in the community or at a health facility. • Ask 1 participant in each pair to assess a breastfeed and ask the other participant to observe and record observations on the form. The participants should then reverse roles to observe another mother breastfeeding. • After the assessments, ask the participants to	• Handout 17: Breastfeeding Observation Form

Session number/title	Time	Learning objectives	Content	Training methods	Materials
				assist mothers who need advice on positioning and attachment. • Ask participants for feedback on their experience with the mothers and lead a discussion of the visit. Summarize.	
Daily evaluation	15 min	• Evaluate the day's activities	• Sharing of what the participants: - Liked - Will use - Learned	• Ask participants to write their answers and put them in a basket. • Ask each participant to pick a response from the basket and read it out loud.	
Day 4					
RECAP					
18. Infant and young child feeding options in the context of HIV	2 hrs	• Explain the challenges of HIV in relation to breastfeeding • Name and describe at least 2 major infant and young child feeding choices in the context of HIV	• Review of MTCT of HIV • Infant and young child feeding options for HIV-positive women • Expression of breastmilk	• Review with participants ways HIV can be transmitted from mother to child. • Facilitate discussion. • Brainstorm with participants thee infant and young child feeding options for an HIV-positive mother. • List 5 options on flipcharts, one option each. Distribute these flipcharts throughout the training area. • Divide participants into 5 groups. Ask each group to go to 1 flipchart, describe the option, and then rotate to the other flipcharts and do the same. • Facilitate discussion and summarize. • If a lactating mother is available and willing to demonstrate milk expression, ask her to demonstrate in front of the participants. • Otherwise, demonstrate milk expression using a model breast. • Facilitate discussion. • Ask the participants whether it is advisable for a woman who has stopped breastfeeding to start breastfeeding again and whether a	• Flipcharts, markers, and masking tape • Breast model

Session number/title	Time	Learning objectives	Content	Training methods	Materials
				mother who has stopped breastfeeding can get milk flowing in her breasts again. • Facilitate discussion.	
19. Complementary Feeding of Children 6-24 Months	2 hrs	• Define complementary feeding • List possible consequences of introducing complementary foods too early or too late • Describe dietary needs of children 6– < 9 months, 9– < 2 months, and 12 < –24 months old • Discuss suitable foods for children 6– < 24 months old • Discuss feeding concerns related to HIV and follow-up care	• Complementary feeding: what, why, and when • Grouping of local foods into categories: 0– < 6 months, 6– < 12 months and 12– < 24 months • FADVA—Helping mothers and caregivers select complementary foods • Meaning and importance of active feeding • Feeding of the sick child > 6 months old	• Brainstorm the meaning of complementary feeding and the role of complementary foods in the growth and development of a baby. • Ask participants to form 4 groups. Ask the groups to answer questions about complementary feeding practices in their communities, using Handout 19.1. Ask 1 of the groups to present its answers in plenary, with the other groups adding points not mentioned. • Ask participants what happens if a baby is given other foods too early (before 6 months) or too late (long after 6 months). • Distribute Handout 19.2, facilitate discussion, and summarize, • Give each participant 2 or more foods purchased locally at the market and distribute water and pictures or models of a breast to represent breastmilk. • On large pieces of flipchart paper on tables or on the floor, write the following categories: 0– < 6 months, 6– < 12 months, and 12– < 24 months. • Ask each participant to choose one of the local foods and place it in the appropriate category, depending on the age at which a child should begin to eat it. • Facilitate discussion and rearrangement of foods as needed. • Summarize locally available foods that can be given to children 6– < 24 months old. • Keeping in mind the previous two activities, ask participants to identify the main	• Flipcharts, markers, and masking tape • Handout 19.1: Complementary Feeding Working Group Questions • Handout 19.2: Complementary Feeding Recommended Practices Beginning at the Age of 6 months • Handout 19.3: FADVA—Helping Mothers and Caregivers Select Complementary Foods • Handout 19.4: How to Feed Actively

Session number/title	Time	Learning objectives	Content	Training methods	Materials
				complementary feeding behaviors. Write their answers on a flipchart and fill in gaps using FADVA (Frequency, Amount, Density [consistency and caloric density], Variety, and Active [responsive] feeding). See Handout 19.3. • Brainstorm the definition and importance of active feeding. • Ask participants for examples of active (responsive) feeding. • Read and discuss Handout 19.4. • Brainstorm with participants how a mother should feed a sick child >6 months old. Write the answers on a flipchart. • Facilitate discussion and summarize. • Review key messages.	
20. Communicating With Mothers And Community Members, And Negotiating Infant And Young Child Feeding Practices	2 hrs	• Describe an effective way to communicate with community members on related issues • Identify skills needed to communicate effective messages	• Listening: The most important skill in behavior change communication • Negotiation skill: ALIDRAA • Negotiation practice in an initial visit to mother with infant 0–<24 months old	• Ask participants to brainstorm the characteristics of good communication. Write the answers on a flipchart and discuss. • Ask participants to suggest the most important skill in behavior change communication. Write answers on a flipchart and discuss different aspects of listening. • Facilitate discussion. • Demonstrate a first visit of a community motivator to a woman (Aster) with a 7-month-old son (David). • Ask participants to discuss what happened in the demonstration visit. • Present the ALIDRAA steps of negotiation (**a**sks, **l**istens, **d**iscusses, **r**ecommends and negotiates, **a**grees, and makes a follow-up **a**ppointment) • Distribute and discuss Handout 20.1. • Divide participants into groups of 3 (mother,	• Flipcharts, markers, and masking tape • Handout 20.1: Observation Checklist: Negotiation Visit #1 (ALIDRAA) • Handout 20.2: Practice Case Studies 0–<12 Months

Session number/title	Time	Learning objectives	Content	Training methods	Materials
				community motivator, and observer). Give each group 1 of 5 case studies to use to practice negotiation in an initial visit. The observer should use the observation checklist. Have participants rotate so that each participant has a chance to practice the 3 different roles. • Ask participants to recall optimal breastfeeding and complementary feeding practices. • Two triads demonstrate a case study in plenary: demonstrating a negotiation visit with a mother whose child is under 6 months and a visit to a mother whose child is between 6-12 months • Facilitate discussion and summarize.	
21. Using Educational Materials	1 hr	• Describe benefits of using educational materials • Identify various materials used in educational activities • Describe how to use each type of material to the best advantage	• Types and benefits of educational materials • Use of visuals	• Divide participants into 3 groups. Ask each • group to answer one of the following questions: 1) What are educational materials? 2) What are the benefits of using educational materials? and 3) What are different types of educational materials? • Ask each group to present its answers in plenary. • Facilitate discussion, giving feedback and filling in gaps in information. • Draws on a flipchart the experience of a child touching fire, using Handout 21.1. • Explain to participants that ORPDA is used to encourage people to reflect on and personalize their experience so they can learn from it and make a decision to change their behavior. Connect ORPDA to the stages of change. • Demonstrate how to use ORPDA with a group using a counseling card (Handout 21.2). • Discuss the demonstration, using a flipchart	• Flipcharts, markers, and masking tape • Handout 21.1: How We Learn, using the ORPDA cycle • Handout 21.2: How to Use a Counselling Card with a Group • Handout 21.3: ORPDA Observation Checklist: Using a Counselling Card with a Group

Session number/title	Time	Learning objectives	Content	Training methods	Materials
				with the observation checklist (Handout 21.3). • Ask participants in groups of 5 to practice facilitating an action-oriented group discussion, taking turns as observers, facilitators, and participants. Ask observers to use the observation checklist to give feedback to the facilitators. • Facilitate discussion of participants' experience using ORPDA.	
Daily evaluation	15 min	• Evaluate the day's activities	• Sharing of what participants: - Liked - Will use - Learned	• Ask participants to write their answers and put them in a basket. • Ask each participant to pick a response from the basket and read it out loud.	
Day 5					
RECAP					
22: Establishing and working with support groups	1 hr	• Participate in an infant and young child feeding support group • Describe the characteristics of a support group • Practice conducting a support group	• Infant and young child feeding support group • Discussion of the support group experience • The role of the facilitator in an infant and young child feeding support group, characteristics of a support group, participants, and topics • Practice conducting a support group	• With 8 participants, form a "fish bowl" and conduct an infant and young feeding support group sharing their own (or wife's, mother's, sister's) experience on exclusive breastfeeding in a programme. (Only those in the "fish bowl" are permitted to talk). • After the support group, ask the group participants: - What did you like about the support group? - Did your knowledge and attitudes about breastfeeding change? - Is the support group different from an educational talk? - Do you think we found answers to the doubts expressed in the support groups? - After this meeting, do you think you would try exclusive breastfeeding? • Set up 4 flipcharts throughout the training area with the following headings: 1) Who	• Flipcharts, markers, and masking tape • Handout 22.1: Checklist for Facilitator • Handout 22.2: Characteristics of a Support Group

Session number/title	Time	Learning objectives	Content	Training methods	Materials
				participates in an infant and young child feeding support group? 2) What is the role of the facilitator of a support group? 2) What are the characteristics of a support group? and 4) Why form a support group? • Divide participants into 4 groups and give each group 4 minutes per flipchart. • Have each group present its results in plenary. • Distribute and discuss Handouts 22.1, and 22.2. • Divide participants into 3 groups of 10. Ask each group to choose a support group meeting topic from the basket. One participant from each group should be the group facilitator. • Ask the first group to demonstrate a support group in plenary using its topic. Ask the other participants to use the support group checklist. • Facilitate discussion in plenary. • Repeat this procedure for the other 2 groups.	
23. Women's Nutrition	1 hr	• Outline the importance of women's nutrition during pregnancy and lactation • Identify what women can do to improve their nutrition status • Discuss the link between women's nutrition and MTCT	• Importance of women's nutrition during pregnancy and lactation	• Ask participants to the following questions: 1) What is the importance of women's nutrition during pregnancy and lactation? 2) Can a malnourished mother breastfeed her infant? and 3) What should a mother eat and do to maintain good nutrition? • Facilitate discussion of the answers in plenary and summarize.	• Flipcharts, markers, and masking tape
24. Conducting a Motivational Activity in the community	3-4 hrs	• Practice conducting a motivational activity in the community or health centre	• Field practice in health centers or villages • Feedback on practice session	• Divide participants into groups. Ask each group to select a topic and a motivational activity (e.g., a health talk, a small group discussion, one-on-one counseling, work with a support group) to carry out in the community or health facility on that topic. The groups should plan how to carry out the activities and assemble the needed	• Making an appointment at the health centre a week ahead for immunization or weighing sessions or • Making an appointment for village

Session number/title	Time	Learning objectives	Content	Training methods	Materials
				educational aids. • Encourage the participants d to use ALIDRAA, FADVA and ORPDA as much as possible. • Distribute Handout 24: Record of Activities, and ask participants to fill in the sample record form using the motivational activity they conducted in the community. • When the participants have returned to the training site, ask each group to summarize its experience, asking the following questions: - What activity did you carry out? - Who was in the audience? - What were the objectives of the activity? - What was the general area of discussion? - What educational materials, if any, did you use? - What was the reaction of the audience? - What did you feel as you were implementing the activity? - What lessons did you learn from implementing this activity? • Ask participants to give each other feedback. • Facilitate discussion and summarize.	visits • Educational aids (posters and leaflets) and observation checklists • Handout 24: Record of Activities
Daily evaluation	15 min	• Evaluate the day's activities	• Sharing of what the participants: - Liked - Will use - Learned	• Ask participants to write their answers and put them in a basket. • Ask each participant to pick a response from the basket and read it out loud.	
Day 6					
RECAP					
25. The Baby Friendly Hospital Initiative (BFHI) in the context of HIV	40 min	• Describe the Baby-Friendly Hospital Initiative (BFHI) • Describe how communities can apply the BFHI concept to promote optimal infant	• The BFHI	• Ask participants to brainstorm the characteristics of a "baby-friendly" hospital, trying to elicit the "10 steps." • Write responses on a flipchart and fill in the gaps on the Baby-Friendly Hospital Initiative.	• Flipcharts, markers, and masking tape

Session number/title	Time	Learning objectives	Content	Training methods	Materials
		and young child feeding • Determine how to apply the BFHI concept in the context of HIV		• Ask participants what community members can do to promote BFHI. • Facilitate discussion and summarize.	
26. Code of Marketing of Breast-milk Substitutes	40 min	• Describe key elements of the national Code of Marketing of Breast-Milk Substitutes • Discuss the relevance of the Code in the context of HIV • Discuss what community members can do to protect and support breastfeeding	• Code of Marketing of Breast-Milk Substitutes	• Place on a table local commercial breastmilk substitute products (infant formulas, company infant and young child feeding posters and advertisements, feeding bottles and teats, and complementary foods for the infant below 6 months). • Asks participants to define the Code of Marketing of Breast-Milk Substitutes, why there is a need to regulate marketing of commercial breastmilk substitutes, what the Code prohibits, and what parents and community members can do to follow and enforce the Code. • Divide products between participants and ask participants whether each product complies with the Code. • Facilitate discussion and summarize.	• Flipcharts, markers, and masking tape • Commercial breastmilk substitutes (different infant formulas, company infant and young child feeding posters and advertisements, feeding bottles and teats, and complementary foods for babies < 6 months old
27. Involving the Community and Men in PMTCT	1 hr	• List types of support systems in the community • Describe strategies to establish a support system • Discuss male involvement in PMTCT	• Community support for PMTCT • Male involvement in PMTCT • Activity plan	• Brainstorm the institutions and individuals in the community that support PMTCT. • Brainstorm places where activities can be organized. • Ask participants why men should be involved in PMTCT activities and what role they can play. Facilitate discussion of the answers. • Brainstorm with participants the activities they will perform after the training. • Group community motivators by their areas and ask each group to develop an activity plan for the following 3 months. • Ask each group to make 4 columns on a piece of paper and label them 1) Groups of women the motivators will work with (e.g., pregnant	• Flipcharts, markers, and masking tape

Session number/title	Time	Learning objectives	Content	Training methods	Materials
				women, breastfeeding and wet nursing mothers, women of reproductive age, HIV-positive mothers, parents), 2) MTCT risk behaviors specific to each group, 3) Activities community motivators will perform, and 4) Where the activities will be conducted. • Ask the groups to present their activity plans in plenary and give feedback.	
28. Monitoring (Record Keeping) and the Use of Monitoring Information in the Community	½ hr	• Describe activities community motivators will undertake after the training • Identify records community motivators may need to keep for their own use and to share with others • Build consensus on a format for record keeping	• Information: Why, what, where, and who?	• Brainstorm with participants why record-keeping is necessary, what information to record, where to keep this information, and with whom to share the information. • In plenary ask 5 participants to share the results of Handout 24: Record of Activities form filled out during the motivational activity they conducted in the community. • Ask 5 participants to share in plenary. • Facilitate discussion in plenary.	• Flipcharts, markers, and masking tape • Handout 28: Sample Record Form
Evaluation, feedback, and recommendations	½ hr	• Evaluate workshop training			• Evaluation form
Official closing					

SESSION 1: INTRODUCTION, EXPECTATIONS, AND OBJECTIVES

Duration: 2 hours

1.1 Introduction

This session welcomes participants, facilitators, and other resource persons, gives a brief overview of the training and the program, and describes the course approach: active participation, teamwork, mutual respect, skill performance, and continuous feedback.

1.2 Learning objectives

- Become familiar with fellow participants, facilitators, and resource people.
- Discuss expectations of the course.
- Understand course objectives and purpose of the training.
- Understand administrative and housekeeping arrangements.

1.3 Introductions and expectations

Training methods

- Introduce presentation game for introductions and expectations. Cut drawings or breastfeeding pictures in half and give each participant one of the pieces. Instruct participants to find the matching piece. Once this is accomplished, ask the pairs to introduce each other by name, expectations of the course, and some element of human interest, e.g., favorite food, hobbies, likes, dislikes. (Other suggestions for sharing expectations are listed in the chart under 1.3.2.)
- Write expectations on a flipchart, filling in expectation "gaps" and introducing missing objectives.
- Keep expectations and objectives in view during the rest of the course.

Good introduction activities disclose background information about people and are lively, interactive, and humorous. Such activities "break the ice" and relieve tension when groups convene. Three examples of introduction activities are given below.

Option 1	Option 2	Option 3
• Divide participants into pairs. • Ask participants in pairs to exchange names, positions, and organizations and find three things they have in common. • Then ask participants to introduce each other in plenary and	• Have the group agree in plenary on the details to include in the introductions. • Ask each participant to stand up and introduce himself or herself and at the end of the introduction state the name he or she would like to be called by and an adjective or additional descriptive word to go with it. The additional word should start with the same letter as the person's name (e.g. Jim the Jackal or	• Ask each person to stand up and introduce himself or herself, including agreed details.

share the things they have in common.	Fines the Funny).	

Sharing expectations of the course

Participants come to training courses with expectations. Many have seen other participants dominate discussions, facilitators lecture without giving participants time to share their experience, or recommendations be made that are not followed. Participants should be encouraged to list both their expectations and reservations about or negative experience with past training courses. These should guide facilitators in keeping the workshop on track and meeting participants' expectations.

VIPP (Visualization in Participatory Programs) **cards**	**Paper**	**Brainstorming**
• Have participants sit in a circle or semi-circle. • Place VIPP cards of two different colors, one for expectations and another for reservations, at the centre of the circle. • Ask participants to pick one card for each idea they have and then write their ideas on the cards in big letters using a felt-tip pen. • Pin the cards on a board covered with brown paper and sort them with the participants by categories such as training needs, communication skills, or customs. • Stick the cards on the wall for reference throughout the workshop.	• Give each participant two pieces of paper. • Ask them to write their expectations on one of the pieces and their reservations on the other. • Collect the pieces of paper and have them typed.	• Ask participants in plenary to brainstorm expectations and reservations about the training and record their ideas on a flipchart.

Training objectives

Introduce the workshop objectives either by listing them on a flipchart or distributing handouts of the objectives to the participants.

- Compare the objectives with the expectations and reservations the participants listed in the previous exercise.
- Explain how the expectations that are not included in the course objectives will be met.
- Indicate whether there will be time to accommodate all expectations or whether some of the expectations are outside the scope of the workshop.

- Explain how you will try to avoid the negative experiences they may have had in other training courses.

The aim of the workshop is to equip participants with knowledge and skills to support community members on issues related to HIV and AIDS and infant and young child feeding. The workshop will:

- Introduce infant and young child feeding, HIV and AIDS, and behavior change communication
- Identify and discuss prevention of mother-to-child transmission (PMTCT) of HIV behaviors to promote in the community.
- Give participants skills to plan and implement behavior change communication and risk reduction interventions in the community.
- Strengthen referrals, links, and mutual support between health facilities and the communities they serve.
- Identify strategies for strengthening appropriate antenatal and post-natal practices, including infant and young child feeding.
- Identify strategies for integrating infant and young child feeding, HIV and AIDS counseling, and cross referrals in existing maternal and child health (MCH) and community services.

1.4 Materials

- Flipcharts, markers, and masking tape
- Matching pairs of drawings or pictures for presentation game
- Participants' folders
- Course timetable
- Flipchart with objectives

SESSION 2: HIV AND AIDS

Duration: 2 hours

2.1 Introduction

This session gives an introductory framework for understanding HIV transmission, including common misconceptions about HIV and factors that contribute to its spread.

2.2 Learning objectives

- Explore attitudes to and beliefs about HIV and AIDS.
- Define common terms related to HIV and AIDS.
- Discuss modes of HIV transmission.
- Describe the factors that facilitate HIV transmission.
- Describe the impact of HIV and AIDS in the community.

2.3 Beliefs, myths, and facts about HIV and AIDS

Training methods

- Mark two areas of the room with the labels "Agree" and "Disagree." Ask participants to reflect on their **attitudes** to **and beliefs** about toward HIV and AIDS by reading statements from the list below and asking them to move to areas of the room marked with the labels "Agree" and "Disagree."
- At the end of the exercise, ask participants to explain their choices.
- Facilitate **discussion** (because this is a discussion of beliefs, there are no "correct" answers)

What do you know about HIV and AIDS?

1. People with AIDS should have their names published in local newspapers.
2. Additional funds should be made available for AIDS research.
3. All people with HIV should be quarantined or locked up.
4. Public education about HIV and AIDS should be incorporated in the school curriculum.
5. Employers should have the right to know whether their employees are HIV positive.
6. It should be mandatory to give a person who has a blood test to detect the HIV virus the results of the test.
7. A 12-year-old diagnosed with HIV should not be allowed to attend school with other children.
8. HIV can be spread by dry social kissing.

9. HIV is a disease that affects only male homosexuals.
10. A mother with HIV can transmit the virus to her unborn child.
11. HIV is spread through sharing body fluids (semen and blood).
12. HIV is a communicable disease.
13. You can get HIV by sitting next to someone with HIV or AIDS.
14. A person with AIDS needs help and understanding.
15. Intravenous (IV) drug users are at high risk for contracting HIV.
16. A person must have symptoms of AIDS to infect others.
17. There is an extremely high risk of acquiring HIV from a blood transfusion.
18. Heterosexuals who have only a few sex partners won't get HIV.
19. Sexually active teenagers are at high risk for getting HIV.
20. AIDS has no cure.

2.4 Terms used to discuss HIV and AIDS

Training methods

- Prepare 4 sets of cards, half of the cards marked with terms related to HIV and AIDS and half with the **definitions** of the terms.
- Divide participants into 4 **groups** and give each group a set of cards. Ask them to match the cards.
- After the participants have matched the cards, ask the questions in the boxes, facilitating **discussion** of the answers in plenary.

- **AIDS: A**cquired **I**mmune **D**eficiency **S**yndrome, the weakening of the body's immunity by HIV infection so that it is attacked by different diseases
- **HIV: H**uman **Immuno d**eficiency **V**irus, the virus that causes AIDS
- **HIV prevalence:** The proportion of the population who are infected with HIV
- **Incubation period:** The time between being infected with HIV and beginning to show signs and symptoms of the infection
- **Viral load:** The amount of HIV a person has in the body
- **Window period:** The time between infection with HIV and detection of evidence of HIV in the blood through an HIV test

What does HIV do?

HIV weakens the body's immunity and leaves the body exposed to attack by diseases.

Why do we say AIDS is "acquired"?

People are not born with AIDS but get it later in life.

Why is AIDS called a "syndrome"?

AIDS itself is not a disease but shows the symptoms of many diseases that attack the body when the immune system is weakened by HIV.

How long does the window period last?

Between 3 weeks and 3 months, HIV will not yet show up in the blood of an HIV-infected person, but the person can still infect other people.

How long does it take HIV to develop in your body?

The HIV incubation period may last only a few months, but it can last many years if the infected person accepts his or her condition positively and eats well.

Is HIV the same things as AIDS?

No. HIV is the virus that weakens the immune system so that a person can be infected with different diseases. A person may live with HIV for 15 years or more without knowing it and without feeling ill. During this time the person can pass the virus to other people through sex.

2.5 HIV prevalence

Training methods

- **Brainstorm** answers to the question below on the extent of HIV and AIDS in the country, the continent, and the world.
- Show participants **UNAIDS maps** of global, continental, and national HIV prevalence.
- Facilitate **discussion** in plenary, sharing the information following the question.

How big is the AIDS problem here and in the rest of the world?

National, continental, and global HIV prevalence

- ___% of people in this country are infected with HIV.
- The HIV infection rate in sub-Saharan Africa is ____%.
- Around the world, _____ people (or ___% of the population) were infected with HIV in _____.

2.6 Impact of HIV and AIDS

Training methods

- Brainstorm answers to the question below on the impact of HIV and AIDS.
- Facilitate **discussion** in plenary.

How do HIV and AIDS affect families, communities, and countries?

- Heavy spending of family, community, and national resources to treat and care for people with HIV-related illness
- Many deaths among parents, who leave behind orphans, child-headed households, and school dropouts
- Labor shortages as a result of deaths in the workforce, including deaths of highly trained personnel
- Increased poverty as a result of the death of bread winners and expenditure on AIDS-related illnesses
- Worsening educational standards because of absenteeism and deaths among education staff and more dropouts among orphans and children forced to care for their HIV-infected parents
- Increase in street children because of poverty and food insecurity
- Increased malnutrition as a result of poverty and food insecurity
- Lack of family support as the adult population dies

2.7 HIV transmission

Training methods

- Divide participants into 4 **working groups**. Ask each group to answer one of the following questions, "How do people get infected with HIV?", "What factors contribute to the spread of HIV?", "What can we do to reduce the spread of HIV?", and "What is meant by 'living positively with HIV'?"
- Ask each group to present the **results** of its discussion in plenary.
- Facilitate **discussion** to fill in gaps, using the information below.
- Distribute **Handout 2.1** to participants.
- **Review** the key messages of the session.

How do people get infected with HIV?

People can be infected with HIV through:

- Unprotected sex with a person infected with HIV is the most common way of getting HIV.
- 30% to 40% of infants born to HIV-infected mothers are infected with HIV when they are breastfed up to 2 years.
- HIV can be transmitted through contaminated instruments such as syringes for injections, ear piercing needles, and razor blades.
- Infected blood and blood product can also transmit HIV.

The following factors contribute to the spread of HIV:

- Social values and beliefs that promote risk behaviors (the need to have many sex partners or to have sex with to make them clean and chase away ghosts; reluctance to discuss reproductive health issues openly)
- The tendency to feel that HIV will infect other people, not you
- Failure to act on knowledge about HIV and AIDS to reduce the risk of infection
- Economic hardships that lead to practices such as sex for money or gifts
- Relationships between men and women that deny women decision making and negotiation power in sexual matters
- Infection with sexually transmitted infections (STIs), which may cause cuts through which HIV can get into the blood
- Sex without using a condom
- Urbanization and migration that move people away from families and communities

- Conflict and emergency situations that create vulnerability, especially of women and children, to sexual exploitation.

What can we do to reduce the spread of HIV?

To reduce the spread of HIV:

- Go for HIV testing and counseling to know your HIV status.
- If you are HIV negative, remain negative by:
  - Abstaining from sexual intercourse.
  - Being faithful to one uninfected sex partner.
  - Using condoms correctly and consistently.
- Avoid the following practices that promote the spread of HIV:
  - Having many sex partners
  - Having sex with widows to make them "clean" and chase away ghosts
  - Having dry sex
- Go for treatment as soon as you become sick.
- Join others to discuss HIV and take action to stop its spread in the family and community.
- If you are HIV positive, live positively.

What does "living positively with HIV" mean?

- Accepting your HIV status positively
- Disclosing your HIV status to your sex partner and family members
- Encouraging your partner to go for HIV testing and counseling
- Abstaining from sexual intercourse or using a condom all the time
- Eating enough different and nutritious foods to improve your health
- Using drugs to slow the multiplication of HIV, if available
- Continuing to work as usual
- Stopping or reducing beer drinking and smoking
- Going for treatment as soon as you become sick
  - Doing light exercises to keep your body fit
  - Joining support groups
  - Finding time to rest

Key messages

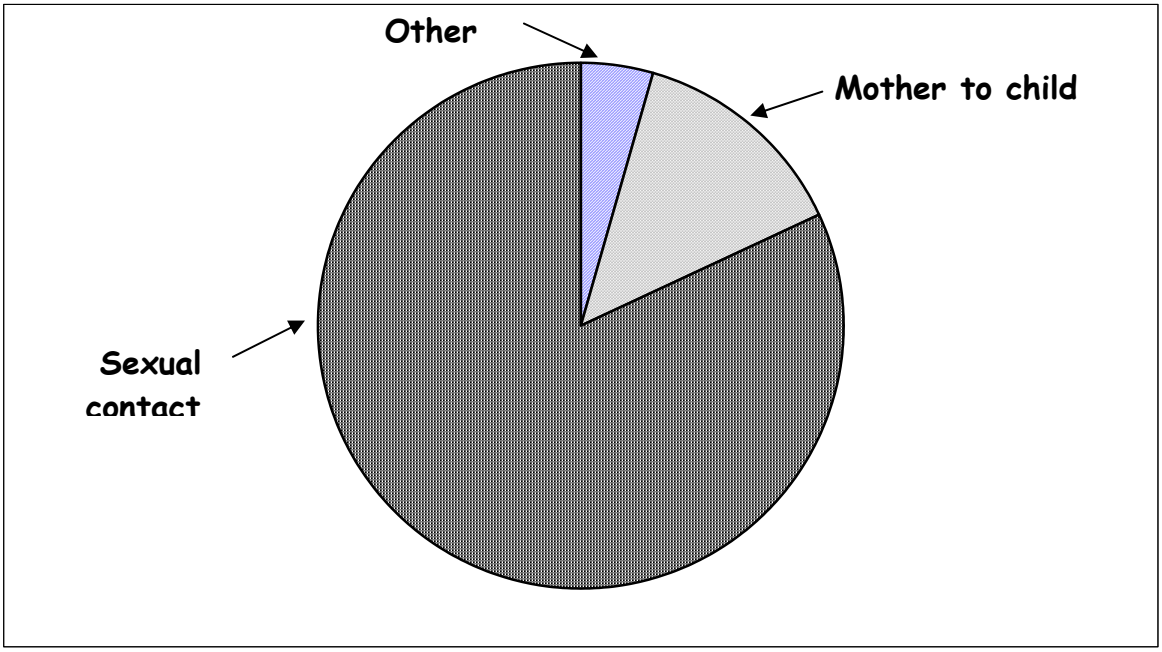
- HIV and AIDS are real.
- HIV is the virus that causes AIDS.
- You can get HIV by
  - Having unprotected sex with a person infected with HIV (the most common way)
  - Being breastfed for up to 2 years by an HIV-infected mother
  - Using contaminated instruments such as injection needles, ear piercing needles, or razor blades
  - Coming into contact with infected blood and blood products
- HIV can be prevented by
  - Abstaining from sex
  - Being faithful to one sexual partner
  - Using condoms.
- You can live with HIV in your body for 15 or more years without being infected with AIDS if you take appropriate care.
- Testing for HIV and counseling can help you take the necessary care to protect yourself and live a longer life.

2.8 Materials

- Flipcharts, markers, and masking tape
- Labels or posters marked "Agree" and "Disagree"
- 4 sets of cards with HIV and AIDS-related terms and definitions in section 2.4.2
- UNAIDS maps of the world, region, and country
- Questions in green boxes written on flipcharts for working groups
- Brochures or leaflets on how to discuss and stop the spread of HIV and AIDS
- Handout 2.1: Most Common Modes of Transmission of HIV

Handout 2.1

Most Common Modes of Transmission of HIV



SESSION 3: BEHAVIOUR CHANGE COMMUNICATION

Duration: 2 hours

3.1 Introduction

This session emphasizes that information alone does not change behavior. Behavior change is a process. Each of us progresses through a series of steps before we change our behavior.

3.2 Learning objectives

- Define communication.
- Define behavior change communication (BCC).
- Identify the goal of behavior change communication.
- Describe BCC steps.
- Describe BCC methods and processes.
- Identify the key elements of BCC.
- Identify the stages of behavior change.

3.3 What is communication?

Training methods

- Ask the **questions** below in plenary and write the answers on a flipchart.
- Facilitate **discussion** in plenary.

Why are we here and what shall we do with the information we get from this workshop?

Possible answer: We can use the information to improve our lives, the health of mothers and children in our families, and the health of other people in our community.

What is "communication"? What do you think of when you hear the word?

Possible answers:

- Transfer of messages or meaning from one person to another
- Transfer of messages and meaning from one person to another and interaction around the messages

Why do people communicate?

Possible answers:

- To give and receive information
- To develop rapport and increase understanding
- To maintain companionship
- To satisfy the need to share information/ideas
- To get ideas
- To get basic human needs met

What makes it difficult for people to change behavior?

Communication requires a **sender** or **source**, a **message**, a **medium** or **setting** through which the message is communicated, a **receiver** or **target** audience, and an **environment** in which the communication takes place. Many factors can affect the quality of a message and its ability to bring about behavior change (table 1).

Table 1 Factors that influence communication quality and effectiveness

Sender (source)	Message	Medium/setting	Receiver	Environment
Mood	Language	Credibility of media	Mood	Availability of services
Attitudes	Vocabulary	Setting	Timing	Distance to help or service points
Beliefs	Tone	External interference	Perception about sender	Supportive policies and practices
Credibility	Presentation			
Habits	Clarity (length, presentation, number of words)	Talking space or environment	Attitudes	Community support
Biases	Context	Competing activities	Beliefs	
Level of understanding	Technical accuracy		Habits	
Body language	Benefits		Biases	

Sender (source)	Message	Medium/setting	Receiver	Environment
Age Sex Image (dress, ability to keep information confidential, integrity) Reputation	Materials and illustrations Appropriateness or acceptability		Prior experience Age Sex Poverty Fear of consequences Conflicting loyalties Personal differences Hidden agendas Group/peer pressure	

3.4 Behavior change communication (10 minutes)

What is behavior change communication?

Behavior = Action or doing
Change = Always involves motivators and barriers or obstacles
Communication = Can be interpersonal (from one person to another) or involve visuals and media

Behavior change communication = Any transfer of messages or meaning (interpersonal or through group talks, mass media, support groups, visuals, print materials, or videos) that helps foster a change in behavior in individuals, families, or communities

Is knowledge enough to change behavior?

Training methods

- Divide participants into **buzz groups** of 3. Ask groups to think about a time when someone told them what to do. Ask them to think about how they felt.
- Ask participants to think about a time when someone asked them what they wanted to do. Ask them to think about how they felt in this situation.
- In plenary facilitate **discussion** of the difference between how it feels to be told what do to and how it feels to be asked what you want to do. Ask a few participants to share their feelings.
- Facilitate discussion of whether information is enough to change behavior.

It is possible, but difficult, to change people's behavior. People need support to be able change behavior and sustain the changed behavior.

3.5 Steps of behavior change (20 minutes)

Training methods

- On a **flipchart** draw the steps (or process) of behavior change. **Brainstorm** how people generally move through these different steps to change behavior.
- Distribute and discuss **handouts**: Steps of Change Model and Steps to Change and Interventions
- Ask participants to close their eyes and think about a behavior (not alcohol or tobacco) they are trying to change. Ask them to identify at what step they are and why. Ask what they think they will need to move to the next step.
- Ask participants what they think are the key elements of behavior change
- Facilitate **discussion** in plenary.

What steps do people go through to change behavior? What support do people need at each step?

See table 2.

Table 2 Steps of behavior change

Step or Stage on the behavior change continuum	Support needed
Pre-awareness	Information
Awareness	More information, especially on benefits
Contemplation	Persuasion
Intention	Encouragement

Trial	Encouragement/Negotiation
Adoption	Benefits
Maintenance	Support
Telling others	Praise

3.6 Key elements of behavior change communication

- **Focuses on and promotes adoption of a specific behavior**
  - Go for HIV testing and counseling.
  - Start antenatal care early.
  - Use condoms.
- **Promotes maintenance of the desired behavior**
  - Does not only discuss the behavior that the target audiences should adopt, but also discusses ways to support the new behavior so it takes root and becomes routine
- **Applies adult learning methods**
  - Respects adults
  - Requests that they share their experiences
  - Invites them to discuss and choose the course of action

3.7 Identifying steps of behavior change in communities affected by HIV

Training methods

- Divide participants into 3 **working groups**. Give each group Handouts 3.3a and 3.3b. Ask each group to read a case study and decide which step the mother in the case study has reached. Ask each group to **present** one case study.
- Facilitate **discussion** in plenary.
- **Review** the key messages of the session.

Key messages

- Just giving information does not necessarily lead to behavior change.
- Approach adults with respect.
- Discuss with adults instead of telling them what to do.
- Recommend specific behaviors that target audiences should consider adopting.
- Discuss the benefits of the recommended behaviors.

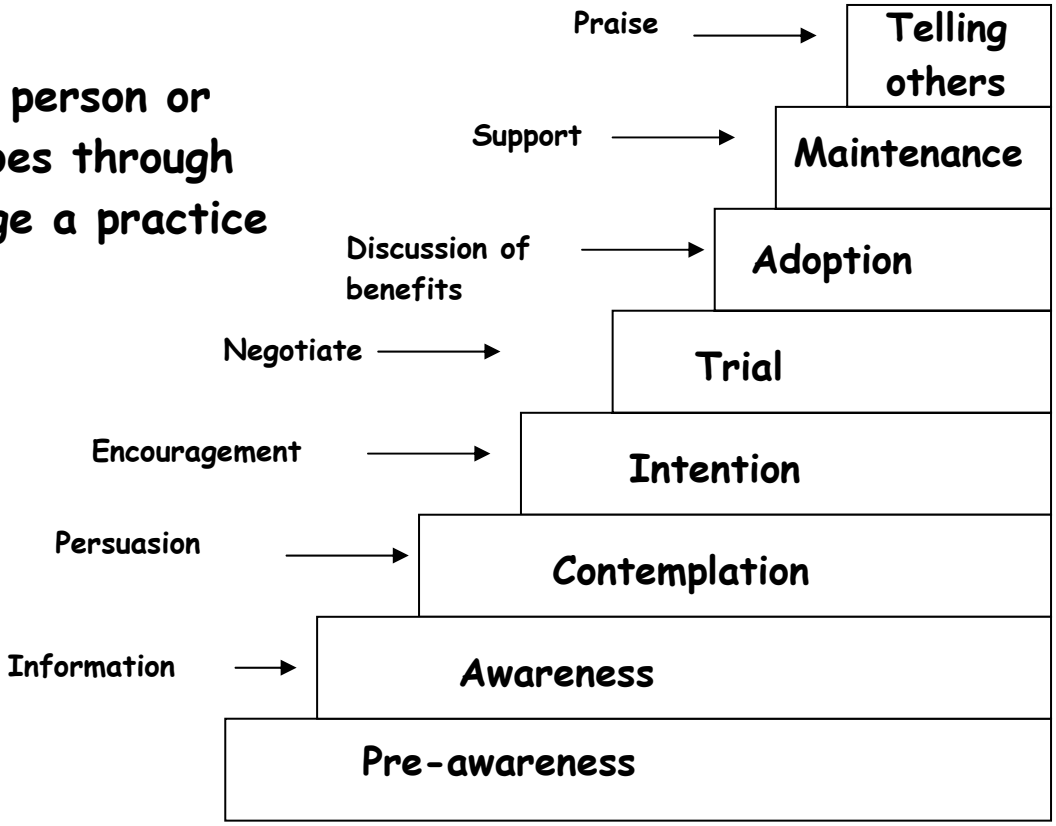
3.8 Materials

- Flipchart, markers, and masking tape
- Handout 3.1: Steps of Behavior Change
- Handout 3.2: Steps to Change and Interventions
- Handout 3.3a: Behavior Change Case Studies
- Handout 3.3b: Behavior Change Case Studies (Answer Key)

HO 3.1

Steps of Change Model

Steps a person or group goes through to change a practice



HO 3.2

Steps to Change and Interventions

Step	Appropriate interventions To convince the target audience to try a new practice, support the choice, and change community norms
Never having heard about the behavior	**Build awareness by providing information** • Drama or fairs • Community groups • Radio • Individual counseling • Infant and young child feeding support groups
Having heard about the new behavior or knowing what it is	**Encourage by discussing benefits** • Group discussion or talks • Oral and printed word • Counseling cards • Infant and young child feeding support groups
Thinking about the new behavior	**Negotiate and help overcome obstacles** • Home visits and use of visuals • Activities for family and community • Negotiation with husband and mother-in-law (or other influential family members) to support the mother
Trying the new behavior	**Praise and reinforce the benefits** • Congratulate mother and other family members • Suggest support groups for encouragement • Encourage community to provide support (e.g., through radio programs)
Continuing to practice the behavior	**Provide support at all levels** • Reinforce the benefits • Praise

HO 3.3a

Behavior Change Case Studies

1. A pregnant woman has heard about HIV counseling and testing at the local clinic. She doesn't know what to do and is worried about what her husband will say.

2. A woman has brought her 8–month-old child to the baby weighing session. The child has lost weight. The health care worker tells her to give her child different foods because the child is not growing.

3. A health worker has talked with an HIV-positive pregnant woman whose baby is due any day about her infant feeding options. The woman has decided to breastfeed her baby exclusively for 6 months.

HO 3.3b

Behavior Change Case Studies (Answer Key)

1. A pregnant woman has heard about HIV counseling and testing at the local clinic. She doesn't know what to do and is worried about what her husband will say.
   Awareness/contemplation

2. A woman has brought her 8–month-old child to the baby weighing session. The child has lost weight. The health care worker tells her to give her child different foods because the child is not growing.
   Awareness

3. A health worker has talked with an HIV-positive pregnant woman whose baby is due any day about her infant feeding options. The woman has decided to exclusively breastfeed her baby for 6 months.
   Intention

SESSION 4: COMMON SEXUALLY TRANSMITTED INFECTIONS THAT FACILITATE HIV TRANSMISSION

Duration: 1 hour

4.1 Introduction

This session examines the relationship between sexually transmitted infections (STIs) and HIV infection.

4.2 Learning objectives

- Define STIs.
- Identify the common STIs in the local community.
- List the signs and symptoms of common STIs.
- State factors that contribute to the transmission of STIs.
- Describe the link between mother-to-child transmission of HIV and STIs.
- Discuss how STIs can be prevented.

4.3 Sexually transmitted infections

Training methods

- **Brainstorm** the meaning of STI.
- Write responses on **flipchart** and complete the definition.
- Ask participants what sexually transmitted infections are common in their community.
- Make a presentation of the **groups** of STIs.

What is an STI?

STI stands for **s**exually **t**ransmitted **i**nfection. STIs are spread by having unprotected sex with an infected person.

How are STIs grouped?

STIs are grouped according to whether they cause swellings and lesions or a discharge (table 1).

Table 1 Groups of STIs

STIs which cause swelling and lesions	STIs which cause a discharge
Syphilis	Gonorrhea
Chancroid	Chlamydia
Herpes	Trichonomiasis vaginalis
Warts	Candidiasis
Lymphogranuloma venerium (Bola bola)	

4.4 Signs and symptoms, effects and complications, and prevention of STIs

Training methods

- Divide participants into 3 **working groups**.
- Ask each group to brainstorm one of the following **themes**: 1) Signs and symptoms of STIs, 2) Effects and complications of STIs, and 3) Prevention of STIs.
- Ask groups to make **presentation**s in plenary.
- Facilitate **discussion** in plenary.
- **Review** the key messages of the session.

What are the signs and symptoms of STIs?

- Discharge from the vagina or penis
- Pain when passing urine
- Lower abdominal pain
- Swelling and lesions in and around the genitals
- Swellings of the skin which covers the testicles (scrotum)
- A discharge from the eyes of a new born baby

What are the effects and complications of STIs?

- Swelling and lesions in and around the genitals
- Loss of ability to have children (infertility), especially if STIs are not treated
- Pregnancy outside the womb (ectopic pregnancy)
- Spontaneous abortions

- Increased chances of cervical cancer
- Premature rupture of membranes (early breaking of the bag of waters) during pregnancy and delivery.
- Increased chances of premature birth (the baby coming before it is full term)

These effects and complications increase the chances of HIV transmission from:

- An infected person to his/her sex partner, and
- A mother to her baby

How can STIs be prevented?

- By **a**bstaining from sex, **b**eing faithful to one uninfected sexual partner, or using **c**ondoms correctly and consistently (ABC)
- Going for treatment as soon as soon as you get an STI
- Taking the full course of treatment as advised by a health worker
- Encouraging your sex partner to go for treatment as well
- Avoiding sexual intercourse until you have been fully treated and are cured
- Discussing sexual health matters openly
- Practicing safer sex (using a condom)

Prevention and effective management of STIs contributes greatly to reducing the transmission of HIV.

Key messages

- STIs increase the chances of HIV infection.
- Go for treatment as soon as soon as you get an STI.
- Encourage your sex partner to get treated for STI as well.
- Prevent STIs by **a**bstaining from sex, **b**eing faithful to one uninfected sexual partner, or using **c**ondoms correctly and consistently (ABC).

4.5 Materials

- Flipchart, markers, and masking tape
- STI leaflets

SESSION 5: COMMUNITY BREASTFEEDING PRACTICES AND THE BENEFITS OF BREASTFEEDING FOR INFANT, MOTHER, FAMILY, COMMUNITY, AND NATION

Duration: 1 hour

5.1 Introduction

This session identifies local breastfeeding practices and discusses the benefits of breastfeeding for the baby, mother, family, community, and nation.

5.2 Learning objectives

- Identify common local breastfeeding practices.
- Discuss the benefits of breastfeeding.

5.3 Community breastfeeding practices

Training methods

- Divide participants into 4 **groups**.
- Ask 2 groups to answer questions about local initiation of breastfeeding practices (give participants **Handout 5.1**).
- Ask the other 2 groups to answer questions about local exclusive breastfeeding practices (give participants **Handout 5.2**).
- Ask 1 group to make a **presentation** in plenary on the first question and the other group to **discuss** the question, adding points not mentioned.
- Repeat for the second group.
- Facilitate **discussion** and summarize.
- Type responses and give to participants as a **handout**. Keep this record of community feeding practices and use it as background for discussing breastfeeding and infant and child feeding practices throughout the workshop.

5.4 Benefits of breastfeeding

Training methods

- Divide participants into 4 **groups**. Set up 4 **flipcharts** throughout the room with the following titles: “Benefits of breastfeeding for the infant”, “Benefits of breastfeeding for the mother”, “Benefits of breastfeeding for the family”, and “Benefits of breastfeeding for the community and nation”.
- Give each group 3 minutes at each flipchart and then ask them to rotate to the next flipchart.
- Facilitate **discussion** in plenary and summarize.
- Distribute and discuss **handouts** on the benefits of breastfeeding.

5.5 Colostrum

Training methods

- Divide participants into 2 **groups**.
- Make a set of **cards**, half of them with a property of colostrum written on each one and half with an explanation of the importance of one of the properties written on each one. Give each group a set of cards that includes equal numbers of properties and explanations and ask the groups to match the properties with the explanations of their importance (table 1).
- Ask each group to share its results in plenary.
- Facilitate **discussion** and summarize.

What are the benefits of colostrum?

Colostrum protects babies against infection and allergies, cleans the meconium (first black stool) to prevent jaundice in newborns, provides enough food until milk comes in, helps the baby's brain develop and intestines mature, and is high in vitamin A, which helps reduce the severity of some infections. The properties of colostrum are listed in table 1.

Table 1 Properties of colostrum

Property	Importance
Antibodies	Protects against infection and allergies
White cells	Protects against infection
Digestibility	Cleans meconium (first black stool) to prevent jaundice in newborns
High protein (3 times more than in mature milk)	Provides enough food despite coming in small amounts
Growth factors	Helps baby's brain and intestines grow
Vitamin A	Reduces severity of some infections (measles and diarrhea) and prevents vitamin A-related eye disease

5.6 Optimal breastfeeding practices

Training methods

- Divide participants into 5 **groups**, giving each participant 1 A4-size card.
- Ask each participant to write 1 optimal breastfeeding practice on the **card**. The writing should be large and visible.
- Ask small groups to share and discuss their results and make a **list** of optimal breastfeeding practices to tape on the wall.
- Facilitate **discussion** and summarize in plenary.
- Distribute and discuss **handouts** on optimal breastfeeding practices.
- **Review** the key messages of the session.

When should a mother begin to breastfeed her baby?

A mother should begin breastfeeding her baby as soon after birth as possible, within 1 hour of delivery.

Why is it important to start breastfeeding a baby early?

The baby should be put on the breast as soon as possible for the following reasons:

- To give the baby colostrum
- To ensure that the baby breastfeeds successfully and the baby's sucking reflex does not diminish. The sucking reflex is strongest within the first hour after birth, and breastfeeding is more successful if sucking starts as early as possible.
- To help the uterus contract, expel the placenta (if it is not already expelled), and reduce bleeding
- To help milk "come in" quickly

How long should a mother breastfeed her baby?

A mother should breastfeed exclusively for the first 6 months of her baby's life. During this time, she should not give the baby any other food, not even water. Giving the baby other foods during this time may reduce milk production and make the baby sick.

After 6 months, a mother should give her baby other foods in addition to breastfeeding the baby (see Complementary Feeding). She should continue to breastfeed the baby until the baby is 2 years old or older.

How often should a mother breastfeed her baby?

She should breastfeed whenever the baby wants, day and night. Breastfeeding at night increases milk production. The mother should breastfeed her baby 8–12 times in a day (24 hours).

What should a mother do to make enough milk for her baby?

She should breastfeed her baby more often. The more the baby suckles, the more milk is produced. She should also maintain good nutrition by:

- Eating at least 3 full meals and 1 snack a day.
- Eating different kinds of locally available foods and drinking plenty of fluids (water, juice, or milk) during each feed.

Should a woman who has stopped breastfeeding start to breastfeed her baby again?

Sometimes a mother who has stopped breastfeeding her baby needs to start breastfeeding again. Restarting breastfeeding is both possible and safe.

Can a mother who has stopped breastfeeding get milk flowing in her breasts again?

Even a mother who has not had a baby for many years can induce milk flow and breastfeed another woman's baby, for example, if the baby's biological mother has died. Health workers should be able to advise a mother on how to restart her milk supply. Before a woman puts the baby on the breast, however, both the woman and the baby should take an HIV test to be sure that both are HIV negative.

Key messages

- A mother should put the baby on the breast as soon after birth as possible, within the first hour, to:
  - Ensure that the baby feeds on colostrum
  - Maintain the baby's sucking reflex
  - Expel the placenta
  - Reduce bleeding
- Breastmilk has many benefits, for the baby, the mother, the family, the community, and the nation.
- Breastmilk is food made especially for the baby. It contains all the food and water the baby needs for the first 6 months of life. It is 87.5% water and meets all the water needs of the baby.
- Breastmilk has substances which protect the baby from disease and serves as the baby's first immunization. It helps the baby grow healthy and strong.
- Colostrum is particularly rich in nutrients and substances which protect the baby from disease.
- A baby should get only breastmilk for the first 6 months of life.
- A mother should breastfeed her baby whenever the baby wants, day and night.
- After 6 months, a mother should give her baby other foods in addition to breastmilk.
- A mother should continue to breastfeed until her baby is 2 years old or older.
- The mother should eat more than usual and have a varied diet.

5.7 Materials

- Flipcharts, markers, and masking tape
- Handout 5.1: Initiation of Breastfeeding Working Group Questions
- Handout 5.2: Breastfeeding Working Group Questions
- Handout 5.3: Benefits of Breastfeeding for the Baby
- Handout 5.4: Benefits of Breastfeeding for the Mother
- Handout 5.5: Benefits of Breastfeeding for the Family, Community, and Nation
- Handout 5.6: Optimal Breastfeeding Practices
- 2 sets of cards: Properties of colostrum and their importance

HO 5.1

Initiation of Breastfeeding Working Group

1. Who is with the woman when she gives birth?

2. Who delivers the baby?

3. What is done with the baby immediately after birth?

4. Where is the baby placed?

5. What is given to the baby to eat or drink as soon as it is born? Why?

6. When is the baby placed at the mother's breast? Why?

7. Who influences the mother to start breastfeeding?

HO 5.2

Breastfeeding Working Group

1. When and how many times a day do mothers breastfeed in your community?

2. Do babies younger than 6 months old who are breastfeeding need water or other liquids or foods? Which liquids or foods? Why?

3. What does "exclusive breastfeeding" mean?

4. Why do some mothers just breastfeed and other mothers breastfeed and give water?

5. What do mothers do when the baby cries?

6. How does a woman know that the baby has had enough and is full?

7. At what age do you stop breastfeeding babies? And why at that time?

HO 5.3

Benefits of Breastfeeding for the Baby and Young Child

Breastmilk:

- Saves babies' lives
- Is a whole food for the baby, containing balanced proportions and sufficient quantity of all the needed nutrients for the first 6 months
- Promotes adequate growth and development, thus preventing stunting
- Is always clean
- Contains antibodies that protect against diseases, especially diarrhea and respiratory infections
- Is always ready and at the right temperature
- Is easy to digest because its nutrients are well absorbed
- Protects against allergies (breastmilk antibodies protect the baby's gut, preventing harmful substances from passing into the blood)
- Contains enough water for the baby's needs (87% of water and minerals).
- Helps jaw and teeth development, and suckling develops facial muscles
- Frequent skin-to-skin contact between mother and baby lead to better psychomotor, affective, and social development of the baby
- Colostrum protects from disease and acts as a laxative, cleaning the baby's stomach

HO 5.4

Benefits of Breastfeeding for the Mother

- Breastfeeding is more than 98% effective as a contraceptive method during the first 6 months, provided that it is exclusive and amenorrhea persists.
- Putting the baby to the breast immediately after birth facilitates the expulsion of the placenta because the baby's suckling stimulates uterine contractions.
- Breastfeeding reduces the risks of bleeding after delivery.
- Breastfeeding the baby immediately after birth stimulates breastmilk production.
- Immediate and frequent suckling prevents engorgement.
- Breastfeeding reduces the mother's workload (no time is needed to boil water, gather fuel, or prepare milk).
- Breastmilk is available anytime and anywhere and is always clean, nutritious, and at the right temperature.
- Breastfeeding is economical.
- Breastfeeding stimulates the bond between mother and baby.
- Breastfeeding reduces risks of pre-menopausal breast and ovarian cancer.

HO 5.5

Benefits of Breastfeeding for the Family

- No expenses for formula, firewood, or other fuel to boil water, milk, or utensils. The money saved can be used to meet the family's other needs.
- No medical expenses because of sickness that formula could cause. Mothers and their children are healthier.
- Fewer episodes of illness for the baby and therefore fewer emotional problems associated with baby's illness
- Spaced births thanks to the contraceptive effect
- Saved time
- Reduced work because the milk is always available and ready

Benefits of Breastfeeding for the community and nation

- Hard currency savings because no need to import formula and utensils to prepare it. The currency can be used for something else.
- A healthy nation from healthy babies
- Lower national health expenditures because of fewer child illnesses
- Improved child survival from reduced child morbidity and mortality
- Environmental protection because there is no need to cut down tress to boil water, milk, and utensils. Breastmilk is a natural renewable resource.

HO 5.6

Optimal Breastfeeding Practices

1. Put the newborn to the breast immediately after birth and allow the baby to stay near the mother.
2. Breastfeed often, on demand, day and night.
3. Breastfeed exclusively during the first 6 months.
4. Continue to breastfeed even if you or your child is sick.
5. Position and attach the baby correctly at the breast.
6. Offer the second breast after the baby releases the first.
7. Eat more than usual and vary your diet.
8. When the baby reaches the age of 6 months, give the baby enriched and varied complementary food in addition to breastfeeding. Increase the quantity, frequency, and density of the complementary food.
9. Continue breastfeeding until your child is 2 years old or older.

Note: Women who breastfeed should negotiate with their husbands or partners about being faithful and using condoms in order to protect themselves against HIV infection.

SESSION 6: HOW THE BREAST WORKS

Duration: ½ hour

6.1 Introduction

This session describes the structures of the breast and the processes by which the breast produces milk.

6.2 Learning objectives

- Identify the parts of the female breast.
- Describe the functions of each part.
- Describe how breastmilk is produced and ejected.

6.3 The parts of the breast

Training methods

- Ask participants to form **working groups**. Ask each group to **draw** 1) the breast as it looks on the outside and 2) the breast as it looks from the inside.
- In plenary, ask each group to explain its drawings and how milk is produced.
- Facilitate **discussion** in plenary, correcting misinformation and answering questions.
- **Review** the key messages of the session.

What are the different parts of the breast?

<u>External</u>

Skin: A protective covering of internal tissues.

Nipple: A small protrusion at the centre of the areola. Nipples vary in shape and size. A nipple is a very sensitive part of the breast. It has openings through which milk comes out.

Areola: The darkened circular area of the breast surrounding the nipple. On the areola are pimple-like swellings called **Montgomery's glands**, which secrete an oily fluid. The fluid lubricates the areola and the nipple and protects them from bacteria during pregnancy and breastfeeding.

<u>Internal</u>

Alveoli: The milk-producing cells in which milk is manufactured. The milk flows through tubes or ducts to the nipple.

How does breastfeeding work?

Milk is produced as a result of the action of hormones (messages) and reflexes. When a baby suckles, the tongue and the mouth stimulate the nipple. The nerves in the nipple send a message to the mother's brain that the baby wants milk. The brain responds and orders the production of two hormones, **prolactin** and **oxytocin**. Prolactin works after the feed and makes the milk for the next feed. Oxytocin works while the baby is suckling and makes the milk flow for this feed.

A mother's thoughts, feelings, and sensations can affect the oxytocin reflex. If a woman is happy and confident she can breastfeed, her milk flows well. But if she doubts she can breastfeed, her worries may stop the milk from flowing.

Prolactin

- Prolactin is responsible for milk production.
- More prolactin is made at night than during the day. Breastfeeding at night keeps up the milk supply.
- Prolactin makes a mother feel relaxed, and even sleepy. So a mother rests well even if she breastfeeds at night.
- Prolactin suppresses the release of eggs from the ovary (ovulation). In this way it delays pregnancy. So night feeds are good for delaying pregnancy.

Oxytocin

- Causes contractions in the breast that squeeze out milk
- Brings good feelings, helping the mother think lovingly and become more confident about breastfeeding
- Gives the mother have a good sensation when touching, seeing, or hearing the cry of her baby
- Causes the uterus to contract and reduces bleeding

Key messages

- The more the baby breastfeeds, the more milk is produced.
- Breastfeed baby night and day.
- The hormone responsible for milk production (prolactin) is produced more at night than during the day.
- Breastfeeding at night keeps up the milk production.

6.4 Materials

- Flipcharts, markers, and masking tape
- Breast model(s)

SESSION 7: COMPOSITION OF BREASTMILK

Duration: ½ hour

7.1 Introduction

In this session participants learn the composition of breastmilk, the perfect food for babies because it contains all the necessary nutrients and is readily available in correct quantities.

7.2 Learning objectives

- State the main contents of breastmilk and their benefits for the baby.
- Describe the changes that take place in breastmilk composition.
- Compare the contents of breastmilk and the contents of animal milk.

7.3 Contents of animal milk

Training methods

- **Brainstorm** with participants the answers to the following questions: 1) What is breastmilk made of? 2) What is the difference between human milk and cow's milk? 3) Does human milk contain the same substances in the same concentration?
- Facilitate **discussion** and summarize.
- Make a **presentation** of a chart that compares human milk and cow's milk.
- **Review** the key messages of the session.

What is breastmilk made of?

- Water (87.5%)
- Proteins
- Carbohydrates
- Fats
- Vitamins
- Minerals
- Substances which protect the baby against disease

Human breastmilk is more suited to the baby's needs than cow's milk.

What is the difference between human milk and cow's milk?

Human milk contains more lactose (sugar) than animal milks. Other differences are shown in table 1.

Table 1 Differences between human and animal milk

Component	Human milk	Animal milk
Water	Enough	Extra needed
Protein	Correct amount, easy to digest	Too much, difficult to digest
Fat	Enough essential fatty acids, lipase to digest	Lacks essential fatty acids, no lipase
Vitamins	Enough	Not enough A and C
Minerals (e.g., salt)	Correct amount	Too much
Iron	Small amount, well absorbed	Small amount, not well absorbed
Water	Enough	Extra needed
Anti-infective properties	Present	Absent
Growth factors	Present	Absent

Source: WHO/CDR/93.6 WHO/Wellstart

Does human milk contain the same substances in the same concentration all the time?

The **composition of breastmilk** changes from time to time, according to the needs of the baby. Breastmilk is made up of the following substances:

Colostrum: Found only in the first milk, which is present between the 1st and 5th day after delivery. Colostrum is thick and yellowish in color and rich in nutrients and substances which protect the baby from childhood disease. It therefore serves as the baby's first immunization. Colostrum is produced more readily by women who have breastfed before than by first-time mothers. It is produced only in small amounts over the 5 days.

Transitional milk: Produced from the 7th to 10th day after delivery. The milk increases in quantity and changes in appearance and composition as days go by.

Transitional milk looks thinner than cow's milk. It is 87.5% water and contains all the nutrients that a baby needs to grow and substances which protect the baby from disease.

Mature milk: Begins to flow from the breasts about the 11th day after delivery and continues throughout the breastfeeding period. Mature milk contains:

- **Fore milk**: The milk that comes at the beginning of a feed. Rich in proteins, vitamins, and mineral, it has a lot of water to meet the baby's needs, looks lighter than hind milk, and is greyish in color.
- **Hind milk**: Hind milk comes at the end of a feed and looks whiter than fore milk. It contains more fat, which helps the baby gain weight.

During each feed, the mother should breastfeed long enough to ensure that the baby benefits from both fore and hind milk.

Key messages

- Breastmilk is food made especially for the baby and is superior to any other food a baby can have, including cow's milk and formula. Breastmilk has what a baby needs to grow and develop well: nutrients, water, and substances to protect the baby from diseases.
- The composition of breastmilk changes to meet the baby's needs:
  - From birth to the 11th day after delivery, when mature milk begins to flow
  - From the beginning to the end of a breastfeed
- The baby should receive the colostrum and transitional milk.
- During each feed, the mother should breastfeed long enough to ensure that the baby benefits from both fore and hind milk.

7.4 Materials

- Flipcharts, markers, and masking tape
- Handout 7: Differences between Human and Animal Milk

HO 7

Difference between Human and Animal Milk

	Human milk	Animal milk
Water	Enough	Extra needed
Protein	Correct amount, easy to digest	Too much, difficult to digest
Fat	Enough essential fatty acids, lipase to digest	Lacks essential fatty acids, no lipase
Lactose	Less than animal milk	More than human milk
Vitamins	Enough	Not enough A and C
Minerals (e.g., salt)	Correct amount	Too much
Iron	Small amount, well absorbed	Small amount, not well absorbed
Water	Enough	Extra needed
Anti-infective properties	Present	Absent
Growth factors	Present	Absent

Source: WHO/CDR/93.6 WHO/Wellstart

SESSION 8: MOTHER-TO-CHILD TRANSMISSION OF HIV

Duration: 45 minutes

8.1 Introduction

This session includes information on the rate of HIV transmission from mother to child and factors that influence this type of HIV transmission.

8.2 Learning objectives

- Define mother-to-child transmission (MTCT) of HIV.
- Describe how HIV is transmitted from mother to child.
- Describe the factors that facilitate mother mother-to-child transmission of HIV.

8.3 Definition of mother-to-child transmission of HIV

Training methods

- **Brainstorm** in plenary the definition of MTCT of HIV.
- Reach **consensus** on the definition.
- Ask participants when HIV can pass from an infected mother to her baby.

What is mother-to-child transmission (MTCT) of HIV?

Mother-**t**o-**c**hild **t**ransmission of HIV refers to the passing of HIV from an infected mother to her baby.

When can HIV pass from an infected mother to her baby?

HIV can pass from an infected mother to her baby during pregnancy, labor and delivery, and breastfeeding.

8.4 Rates of transmission during pregnancy, labor/delivery, and breastfeeding

Training methods

- **Brainstorm** with participants the answer to the question: Are all babies born to HIV-positive women infected with HIV?
- Make a **presentation** on the rates of transmission during pregnancy, labor and delivery, and breastfeeding
- Ask participants to form 4 **groups**. Display **flipcharts** with the following themes throughout the room; 1) Maternal conditions that make it easier for a mother to pass HIV to her child, 2) Obstetrical conditions that make it easier for a baby to be infected with HIV, 3) foetal and infant conditions that make it easier for a baby to be infected with HIV, and 4) Other

conditions that make mother-to-child transmission easier. Have each group rotate from chart to chart to add points to each flipchart.

- Facilitate group **discussion** in plenary.
- Ask participants the **questions**: How can a baby be in the womb of an HIV-positive woman for 9 months without being infected with HIV? Why isn't a baby infected at fertilization even when the father and mother are HIV positive?
- Facilitate it easier for a baby to be infected with HIV.
- **Review** the key messages of the session.

Are all babies born to HIV-positive women infected with HIV?

Out of 100 HIV positive women who get pregnant:

- About 63 may not get HIV at all
- About 7 may get HIV during pregnancy
- About 15 may get HIV during labor and delivery
- About 15 may get HIV during breastfeeding if the child breastfeeds for 2 years.

What factors make HIV easier to transmit from mother to child?

Maternal conditions that facilitate MTCT

- Poor maternal nutrition
- Breastfeeding mother with cracked or bleeding nipples
- Pregnant or breastfeeding mother who has unprotected sex (sex without using condoms)
- Increased viral load because of illness or AIDS-related symptoms

Obstetrical conditions that facilitate MTCT

- Prolonged labor
- Membranes rupturing early during delivery
- Bleeding from the vagina during pregnancy
- Delivery by an untrained person
- Inappropriate delivery procedures

Fetal and infant conditions that facilitate MTCT

In the womb

- Prematurity
- Multiple pregnancy

In the baby

- Sores in the mouth
- Diarrhea
- Mixed feeding

Other conditions that facilitate MTCT

- Gender inequality makes it difficult for women to negotiate safer sex
- Anatomy of women's reproductive system makes it easier for infection to come through the birth canal
- Presence of cells in the cervix can be infected by HIV

How can a baby be in the womb of an HIV-positive woman for 9 months without being infected with HIV?

The baby in the womb is enclosed in a sac of waters with his or her own system which is different from that of the mother. The only contact the baby's system has with the mother' system is through the placenta. The placenta allows into the baby's system only what the baby needs (e.g., food and water) and usually filters out disease or other things which may harm the baby.

Why isn't a baby infected at fertilization even when the father and mother are HIV positive?

A baby is formed from the union of a woman's egg and a man's sperm. The egg and sperm do not contain HIV, even if the woman and man are HIV positive. HIV is normally in the man's semen (the fluid which transports sperm) and the woman's vaginal fluids.

Key messages

- Babies born to HIV-positive mothers can be infected with HIV.
- 30 %–40 % of children born to HIV-positive mothers are infected with HIV when they are breastfed up to 2 years.
- Infection takes place during pregnancy, labor and delivery, and breastfeeding.
- The following factors influence whether a baby is infected with HIV:
  - Viral load
  - Maternal conditions
  - Obstetrical conditions
  - Condition of the baby in the womb
  - Infant conditions

8.5 Materials

➢ Flipcharts, markers, and masking tape

- Flipcharts with 4 headings

SESSION 9: PREVENTION OF MOTHER-TO-CHILD TRANSMISSION OF HIV

Duration: 45 minutes

9.1 Introduction

This session describes the interventions that can help reduce the risk of transmission of HIV during pregnancy, labor and delivery, and the post-natal period.

9.2 Learning objective

- Identify interventions that can reduce MTCT during pregnancy, labor and delivery, and breastfeeding.

9.3 Risk reduction interventions for MTCT

Training methods

- Introduce the question, "What can we do to reduce mother-to-child transmission of HIV?" Divide participants into 3 **groups** and give each group a set of **cards** with risk reduction interventions written on them.
- Ask each group to **sort** the interventions according to 3 categories: 1) Interventions to reduce MTCT during pregnancy, 2) Interventions to reduce MTCT during labor and delivery, and 3) Interventions to reduce MTCT during the post-natal period.
- Facilitate **discussion** and summarize in plenary.
- **Review** key messages of the session.

What can we do to reduce mother-to-child transmission of HIV?

A mother, her sexual partner, and the health worker can do many things at different times to prevent transmission of HIV from the mother to the baby.

1. **During pregnancy**
   - Attend the antenatal clinic at the first sign of pregnancy to
     - Get medicine to prevent worms and anaemia
     - Get tablets to prevent malaria
     - Be screened for sexually transmitted infections (STIs)
     - Seek counseling on safer sex
     - Seek counseling on infant and young child feeding decisions
   - Sleep under an insecticide-treated mosquito net and take malaria tablets to prevent malaria
   - Seek the cooperation and involvement of sex partners
   - Eat well to improve nutritional status
   - Go for HIV testing and counseling to know your HIV status

- If the result is negative, maintain negative status
- If the result is positive, live positively

2. **During labor and delivery**
   - Deliver under the care of a trained health worker or traditional birth attendant (TBA), who will use procedures which will minimize the transmission of HIV to the baby
   - Seek the help of a trained person as soon as:
     - Labor starts
     - The bag of waters ruptures
     - There is bleeding from the birth canal
   - If HIV-positive, take antiretroviral prophylaxis (if available) according to the instructions of a health worker as soon as labor starts to protect the baby from HIV

3. **During the post-natal period**
   - Use a family planning method to space the birth of the next baby
   - Seek counseling on how best to feed the baby
   - If HIV positive, give the baby antiretroviral medicine according to the instructions of a health worker to protect the baby from HIV
   - Do not give the baby breastmilk with other liquids and foods, especially during the first 6 months (mixed feeding increases HIV infection)
   - Position and attach the baby on the breast properly to avoid cracked and bleeding nipples which can increase HIV infection
   - Prevent and quickly treat breast conditions (engorgement, plugged ducts, mastitis, abscess)
   - Care for thrush and sores in the baby's mouth
   - Seek counseling on complementary feeding at 6 months
   - Go for post-natal check ups starting at 6 weeks after delivery
   - Ensure that the baby receives all the needed immunizations at the right ages
   - Take vitamin A supplementation within 8 weeks of delivery for protection from a variety of diseases

Key messages

Interventions to reduce MTCT during pregnancy:

- Attend the antenatal clinic at the first sign of pregnancy.
- Sleep under an insecticide-treated mosquito net and take malaria tablets to prevent malaria.
- Seek the cooperation and involvement of sex partners.
- Eat well to improve nutritional status.
- Go for HIV testing and counseling to know your HIV status.

Interventions to reduce MTCT during labor and delivery:

- Deliver under the care of a trained health worker or traditional birth attendant (TBA).
- If HIV-positive, take antiretroviral prophylaxis (if available) according to the instructions of a health worker as soon as labor starts to protect the baby from HIV.

Interventions to reduce MTCT during the post-natal period:

- Seek counseling on how best to feed the baby
- If HIV positive, give the baby antiretroviral medicine according to the instructions of a health worker to protect the baby from HIV.
- Seek counseling on complementary feeding at 6 months.
- Go for post-natal check ups starting at 6 weeks after delivery.
- Ensure that the baby receives all the needed immunizations at the right ages.
- Take vitamin A supplementation within 8 weeks of delivery for protection from a variety of diseases.

9.4 Materials

- Flipcharts, markers, and masking tape
- 4 sets of cards with risk reduction interventions

SESSION 10: PRIMARY PREVENTION OF HIV

Duration: ½ hour

10.1 Introduction

This session discusses basic steps to avoid HIV infection

10.2 Learning objectives

- Describe primary prevention of HIV.
- Discuss at least three ways to prevent HIV infection.

10.3 Primary prevention of HIV and basic steps to avoid HIV infection

Training methods

- **Brainstorm** with participants the answer to the following questions: 1) What is primary prevention of HIV? 2) What basic steps can people take to avoid HIV infection? and 3) Is primary prevention of HIV enough to prevent mother-to-child transmission of HIV?
- Facilitate **discussion** and summarize in plenary.
- **Review** the key messages of the session.

What is primary prevention of HIV?

Primary prevention is the basic steps that can be taken to avoid contracting HIV.

What basic steps can people take to avoid HIV infection?

The three basic steps to prevent HIV infection are known as the "ABCs":

A: **A**bstain from sexual intercourse
B: **B**e faithful to one uninfected partner who stays faithful to you
C: Use a **c**ondom correctly and consistently

Is primary prevention of HIV enough to prevent mother-to-child transmission of HIV?

The most reliable way to prevent mother-to-child transmission of HIV is for mothers and fathers to take one or more of these steps to avoid becoming infected with HIV themselves. Pregnant women and their sex partners should also protect themselves and their babies from HIV during pregnancy, labor and delivery, and breastfeeding (see Session 6).

10.4 The correct way to use a condom

Training methods

- Ask for 2 volunteers to **demonstrate** how a condom is used before, during, and after sexual intercourse, using a model of a penis.
- Facilitate **discussion**.
- **Demonstrate** how a condom is used before, during, and after sexual intercourse, using a model of a penis and addressing any misinformation in the participants' demonstration.
- Facilitate **discussion** in plenary.

What is the correct way to use a condom?

Before use

- Store in a cool, dry place, not in the pocket or wallet
- Check hat the wrapper is not perforated (when it is not perforated, it is filled with air). If the condom is perforated, do not use it.

At the time of use

- Check the expiry date on the condom. Use only a condom which has not expired.
- When the penis is erect (hard), open the wrapper and remove the condom.
- Hold the tip of the condom between your thumbs and finger to remove air.
- With the other hand, hold the rim of the condom and roll it over the hard penis before sexual intercourse or contact with the vagina. Roll until the rim is at the base of the penis (near the pubic hair). If you have difficulty rolling the condom, you are holding it the wrong way around.
- Leave a generous space at the tip of the condom. The free space will hold semen when the man ejaculates.
- When the penis is fully covered with the condom, you can now penetrate and have sexual intercourse.

After use

- After ejaculation, remove the penis (while it is still hard) from the vagina. If the penis becomes soft while inside the vagina, the condom may slip off and spill semen in or near the vagina.
- Hold the rim of the condom as you remove it to ensure that it does not slip off the penis.
- Ensure that semen or vaginal fluids do not come into contact with the hands or body of the man or woman. If semen spills on any part of the body, wash that part with water and soap immediately.

- Wash your hands to remove vaginal secretions and semen. The fluids on your hands may carry enough HIV viruses to cause an infection.

Key messages

- Protection against HIV infection is the most reliable way to prevent mother-to-child transmission of HIV.
- Protect yourself from HIV infection by practicing the "ABCs".
  - **A:** Abstain from sexual intercourse
  - **B:** Be faithful to one uninfected partner who is faithful to you
  - **C:** Use a condom correctly and consistently.
- In addition to primary prevention of HIV, pregnant women and their sex partners should take specific steps to protect their babies from HIV during pregnancy, labor and delivery, and breastfeeding.

10.5 Materials

- Flipcharts, markers, and masking tape
- Model of a penis

SESSION 11: PREVENTION OF MOTHER-TO-CHILD TRANSMISSION OF HIV DURING PREGNANCY

Duration: 45 minutes

11.1 Introduction

This session includes information on interventions that can help reduce the risk of transmission of HIV during pregnancy.

11.2 Learning objectives

- Identify where women go for routine health services during pregnancy.
- Define antenatal care.
- Explain the objectives of antenatal care.
- Discuss the activities which take place at the antenatal clinic.
- State the importance of each activity.
- Explain how antenatal care helps prevent HIV infection during pregnancy.

11.3 Antenatal clinic (where, what, why, how often?)

Training methods

- **Brainstorm** with participants the answers to the following questions: 1) Where do women go for routine health services during pregnancy? 2) What is antenatal care? 3) Why should pregnant women go to antenatal clinics? 4) When and how often should women attend antenatal clinics?

Where do women go for routine health services during pregnancy?

Pregnant women go for routine health services at antenatal care (ANC) clinics.

What is antenatal care?

Antenatal care is the care or guidance provided to pregnant women and their families from conception to the onset of labor.

Why should pregnant women go to the antenatal clinic?

- To get the information they need to ensure good care of mother and baby
- To receive holistic physical, psychological, spiritual, and social care for the mother and baby through pregnancy

- To promote the mother's health and the baby's growth in the womb and reduce the transmission of HIV
- To give health workers time to detect and correct any problems and assess conception and delivery dates accurately

When and how often should women attend the antenatal clinic?

A woman should make her first visit to the antenatal clinic as soon as she knows she is pregnant. Each pregnant woman should make **at least 4 visits** to the clinic during 1 pregnancy:

- Within the first 16 weeks (4 months)
- At 24 weeks (6 months)
- At 32 weeks (8 months)
- During the 9th month

In addition to these visits, a woman should go to the clinic when she feels unwell or has any other need to consult a health worker.

11.4 Activities at the antenatal clinic

Training methods

- Divide participants into 4 **groups**.
- Ask each group to **role play** a woman who is 3 months pregnant visiting an antenatal clinic for the first time. The role plays should cover all the activities the mother will experience at the clinic.
- Ask 1 group to **demonstrate** its role play in plenary and the other groups to give feedback.
- Facilitate **discussion** and help participants fill in gaps in the role plays.

What happens at the antenatal clinic?

- Pregnant woman are screened and treated for abnormalities and high-risk conditions.
- Health workers do the following to detect abnormal conditions which may need to be corrected:
  - Take a history
  - Examine the woman from head to toe
  - Take a blood test to determine whether the woman has adequate or inadequate blood anemia
  - Take a blood test to determine whether the woman has syphilis
  - Give the woman an HIV test if she chooses to find out her HIV status

- If she is HIV positive and agrees to antiretroviral (ARV) prophylaxis, the woman receives medicine to protect the baby from HIV during labor and delivery.
- The woman gets advice about where to deliver her baby.
- Health workers give the woman education and counseling on:
  - Maternal nutrition
  - Infant and young child feeding
  - Partner involvement
  - Safer sex
  - Protection from anemia and malaria
  - ARVs for HIV-positive mothers
  - The need to report any of the following danger signs to the health worker:
    - Fever
    - Premature rupture of the bags of waters
    - Vaginal bleeding
    - Too much vomiting and diarrhea
    - Paleness
    - Minimal or no baby movement
    - Headache
    - Dizziness
    - Swelling of the feet
- The woman receives routine medicines for:
  - Preventing malaria
  - Preventing anemia
  - Protecting the baby from7 diseases (multivitamins)
  - Deworming
  - Protecting herself and her baby from tetanus (tetanus toxoid immunizations)
- The woman establishes a relationship with health workers in an environment of effective care and support.

11.5 Antenatal services and PMTCT

Training methods

- Divide the participants into 2 **groups**.
- Sub-divide each group into **buzz groups** of 3 people each.
- Ask one of the buzz groups to answer the **question**: How do antenatal services help prevent mother-to-child transmission of HIV?
- Ask the other 2 buzz groups to answer the question: What other precautions should women take during pregnancy?
- Facilitate **discussion** and summarize in plenary.
- **Review** the key messages of the session.

How do antenatal services help prevent mother-to-child transmission of HIV?

- Pregnant women are encouraged to go for HIV testing and counseling.
- To protect themselves and their babies from HIV, both HIV- positive and HIV-negative pregnant women are then advised to:
  - Encourage their partners to go for an HIV test,
  - Use condoms to prevent infections.
  - Deliver at a health facility under the care of a trained health worker.
  - If HIV-positive, take medicine, if available, to protect the baby from HIV during labor and delivery.
  - Discuss with health workers or counselors how to feed a baby to protect the baby from HIV.

What other precautions should women take during pregnancy?

- Eat different kinds of foods to remain healthy and help the baby grow and develop well (see Women's Nutrition, p. 128).
- Take only medicines prescribed by a health worker.
- Take medicines according to the instructions of a health worker.

Key messages

- Start attending an ANC clinic as soon as you know you are pregnant to:
  - Receive health education on important topics
  - Be screened and treated for diseases in good time
  - Be counseled on where to deliver
  - Receive help to plan for delivery
  - Receive medicine to protect the baby from HIV during labor and delivery (if you are HIV positive)

- **During pregnancy:**
  - Go for HIV testing and counseling (VCT) to know your HIV status
  - Encourage your partner to go for HIV testing and counseling
  - Whether you are HIV positive or negative, discuss with your health worker or counselor what you and your sex partner can do to protect your baby from HIV
  - Eat different kinds of foods to remain healthy and help your baby to grow and develop well
  - Take only medicines prescribed by a health worker
  - Take medicines according to the instructions of a health worker

11.6 Materials

- Flipcharts, markers, and masking tape
- Questions for brainstorming and buzz groups written on flipcharts

SESSION 12: HIV TESTING AND COUNSELLING (VCT)

Duration: 45 minutes

12.1 Introduction

This session discusses the benefits of learning your HIV status in order to receive counseling and the process of HIV counseling and testing. HIV-negative people are counseled to remain negative, and HIV-positive people are counseled to look after their health, perhaps change their lifestyles, and make an informed decision about infant feeding and future reproductive health.

12.2 Learning objectives

- Define HIV testing and counseling (VCT).
- Discuss the benefits of VCT.
- Describe the process of VCT.

12.3 HIV testing and counseling (VCT)

Training methods

- **Brainstorm** the meaning of HIV testing and counseling (VCT).
- Brainstorm with participants their fears of being tested for HIV and write the fears on a **flipchart**.
- Ask whether any participant who has had HIV counseling and testing would like to share the benefits they found in being tested.
- Brainstorm with participants the benefits of HIV testing and counseling.
- Facilitate **discussion** of worries about and benefits of HIV testing and counseling.

What is HIV testing and counseling (VCT)?

- Preparing a client for an HIV test
- Testing the client who chooses to take the test
- Giving the client the test results and discussing what they mean and what the client can do to prolong life and protect others from HIV

What are the benefits of HIV testing and counseling?

- Opens doors to:
  - **Medical support**
    - Free medical services at government clinics
    - Free medicine (Nevirapine) to protect the baby from HIV during labor, and the first few days after birth

    - Information about conditions that may occur and preparation for seeking help if needed
  - **Social support**
    - Information about appropriate groups that can help with positive living and prolonging life

- Allows discussion and agreement with your partner about:
  - Protecting each other from HIV infection
  - Protecting an unborn baby from HIV infection
  - Planning for the future of the family
- Gives peace of mind
- If you are HIV negative, Increases your determination to remain free of HIV
- If you are HIV positive, helps you live a longer life by
  - Accept your HIV status positively
  - Disclose your HIV status to your partner and family members
  - Encourage your partner to go for HIV testing and counseling
  - Abstain from sexual intercourse or use a condom all the time
  - Eat enough different foods to improve your health
  - Continue to work as usual
  - Stop or reduce drinking of alcohol and smoking
  - Go for treatment as soon as you become sick
  - Do light exercises to keep your body fit
  - Join support groups
  - Use drugs, if available, which slow down multiplication of HIV

12.4 Process of HIV counseling and testing

Training methods

- With another facilitator, demonstrate through **role plays** between a counselor and client the process of HIV counseling and testing (pre-test counseling, testing, post-test counseling, and supportive counseling (with an HIV-negative blood sample and an HIV-positive blood sample)
- Facilitate **discussion** in plenary.
- **Review** the key messages of the session.

What happens during HIV testing and counseling?

<u>STEP 1: Pre-test counseling</u>

- The counselor and client discuss and share information to help the client make an informed choice whether or not to take the HIV test.
- If the client chooses to be tested, the counselor prepares him or her to cope with the results of the test.

STEP 2: Testing

- About 2 ml of blood is collected form the client.
- The blood is taken to the laboratory for testing.
- The client waits for the results, which are ready the same day.
- The results are collected from the laboratory (or the counselor).

STEP 3: Post-test counseling

- The counselor comes with the results on a piece of paper.
- The counselor prepares the client to receive the results.
- The counselor gives or shows the client the results recorded on the result slip.
- The counselor discusses the meaning of the result with the client.
- The client discusses options for action with the client.

STEP 4: Supportive counseling

- Clients react differently to their results, depending on whether the result is positive or negative and on the personality or experience of the client.
- After the post-test counseling, the counselor may refer the client to support services the client needs.
- The counselor may agree on a follow-up visit to review the action the client has taken and options for further action.

Key messages

- Information from HIV testing and counseling (VCT) opens doors to:
  - Medical support
  - Social support
  - Protection of the pregnant client's unborn baby from HIV infection
  - Protection of the client's family and others from HIV infection
  - Planning for the future of the client's family
- HIV testing and counseling (VCT) is confidential.
- HIV testing and counseling (VCT) allows clients to understand more about HIV and AIDS, the meaning of test results, and what can be done to protect them, their babies, and their family members from HIV.
- The client can discuss what to do to live a longer life.

12.5 Materials

- Flipcharts, markers, and masking tape

SESSION 13: PREVENTING MOTHER-TO-CHILD TRANSMISSION OF HIV DURING LABOUR AND DELIVERY AND IMMEDIATE NEWBORN CARE

Duration: 45 minutes

13.1 Introduction

This session provides information on interventions that can help reduce the risk of transmission of HIV during labor and delivery and immediately after birth.

13.2 Learning objective

- Describe safe practices for PMTCT during labor and delivery.

13.3 Safe PMTCT practices during labor and delivery and immediately after birth

Training methods

- **Brainstorm** with participants the reason why labor and delivery practices are part of PMTCT.
- Write answers on **flipchart**.
- Divide participants into 4 **working groups**. Ask 2 groups to discuss what a mother can do to reduce MTCT of HIV during labor and delivery (risk reduction interventions). Ask the other 2 groups to discuss how to care for a baby immediately after birth to minimize HIV transmission.
- Ask 1 group working on the first question to **present** its answers in plenary and the other group discussing the same question to add points not mentioned.
- Repeat the procedure for the second group discussion.
- Facilitate **discussion** and summarize.
- **Review** the key messages of the session.

Why are labor and delivery practices part of PMTCT?

The highest rate of MTCT of HIV occurs during labor and delivery. During this period women in labor and birth attendants should adopt safer practices to reduce HIV infection.

What can a mother do to reduce MTCT of HIV during labor and delivery?

- Deliver under the care of a trained health worker or traditional birth attendant (TBA), who will use procedures which will minimize the transmission of HIV to the baby

- Seek the help of a trained person as soon as:
  - Labor starts
  - The bag of waters ruptures
  - There is bleeding from the birth canal
- If HIV-positive, take antiretroviral prophylaxis (if available) according to the instructions of a health worker as soon as labor starts to protect the baby from HIV
- Take vitamin A supplementation within 8 weeks of delivery for protection against a variety of infections

How should a baby be cared for immediately after birth to minimize HIV transmission?

- Wipe the baby dry immediately after birth
- Place the baby on the mother's abdomen for skin-to-skin contact with the mother.
- Initiate breastfeeding within the first hour unless you have chosen not to breastfeed
- Ask the person assisting the delivery about medicines to protect the baby's eyes from infection
- If you deliver at home, take the baby to the clinic within the first 24 hours

Key messages

- The highest rate of MTCT of HIV occurs during labor and delivery.
- Use safer delivery practices to reduce HIV infection.

13.4 Materials

- Flipcharts, markers, and masking tape
- Questions for working groups written on flipcharts

SESSION 14: PREVENTING MOTHER-TO-CHILD TRANSMISSION OF HIV DURING THE POST-NATAL PERIOD

Duration: 45 minutes

14.1 Introduction

This session describes interventions that can reduce the risk of HIV transmission during the post-natal period.

14.2 Learning objectives

- Describe the post-natal period.
- Discuss the services and support given to the mother and baby during the post-natal period.

14.3 Safe PMTCT practices during the post-natal period

Training methods and content

- **Brainstorm** with participants the meaning of the post-natal period.
- Write answers on a **flipchart**.
- Divide participants into 4 **working groups**. Ask 2 of the groups to discuss the services and support given to the mother in the post-natal period. Ask the other 2 groups to discuss the services given to the baby in the post-natal period.
- Ask 1 group from the first discussion to **present** in plenary and other group discussing the same question to add points not mentioned
- Repeat for the second group discussion.
- Facilitate **discussion** and summarize.
- **Review** key messages of the session.

What is the post-natal period?

The post-natal period is between 1 hour and 6 weeks after delivery.

What services and support are given to the mother? in the post-natal period?

- **Check up, treatment and routine medicines**. Mothers should start attending post-natal clinics between 6 days and 6 weeks after delivery.

- **Vitamin A supplementation**. Mothers who did not take vitamin A supplementation shortly after delivery should take it no later than 6 weeks after delivery.

- **Family planning**. Family planning counseling allows women to make an informed decision about subsequent pregnancies and family planning methods.
- **Counseling**. Post-natal mothers should seek counseling on optimal infant and young child feeding and safer sex practices to protect the baby from HIV.

What services and support are given to the baby during the post-natal period?

- **ARVs**. Babies born to HIV-positive mothers receive ARVs within 72 hours (3 days) of birth to protect them from HIV infection.

- **Care for sores and thrush**. Babies with sores and thrush in the mouth should be taken to the clinic for treatment as soon as possible.

- **Immunizations**. Babies should receive all the following immunizations at the right ages::
  - BCG at birth or as soon after birth as possible
  - Polio at birth, 6 weeks, 10 weeks, and 14 weeks
  - DPT at 6 weeks, 10 weeks, and 14 weeks
  - Measles at 9 months

- **Growth monitoring and promotion**. During monthly visits, babies are weighed and their mothers counseled on what they can do to help the babies' growth and development. Growth monitoring shows whether the baby is gaining enough weight. Monitoring weight is especially important in an HIV environment because it can show:
  - Whether the baby is getting enough breastmilk or complementary foods
  - Whether the baby on replacement feeding is getting adequate nutrition
  - Whether the baby has signs of ill health

- **Insecticide-treated mosquito nets (ITNs)**. Mothers are encouraged to sleep under insecticide treated mosquito nets during pregnancy and breastfeeding to prevent malaria. Babies should also sleep under ITNs.

- **Treatment of illness**. Mothers are encouraged to go for treatment as soon as they or their children fall ill.

Key messages

- A new mother should go to the antenatal clinic between 6 days and 6 weeks after delivery for a check up, counseling, and routine medicines. (prophylaxis) to help her maintain good health.
- An HIV-positive mother should take the baby to the clinic for antiretroviral

medicine within 3 days after birth.

- Babies should be taken to the clinic for all the needed immunizations.
- Babies should be taken to monthly growth monitoring and promotion to maintain good growth and development.
- Mothers and babies should go for treatment as soon as they fall ill.
- Mothers should care for their babies according to the advice of health workers to ensue that the babies remain in good health.

14.4 Materials

- Flipcharts, markers, and masking tape
- Questions for working groups written on flipcharts
- Handout 14: Interventions to Reduce MTCT

HO 14

Interventions to Reduce MTCT

In pregnancy

- HIV testing and counseling
- Primary prevention
- Prevention, monitoring, and treatment of STIs, malaria, and opportunistic infections
- Essential ANC, including nutrition support
- ARVs
- Counseling on safer sex, partner involvement, infant feeding options, family planning, self care, and preparing for the future

In labor and delivery

- ARVs
- Keeping delivery normal
- Minimizing invasive procedures:
  - Abrupt rupture of membranes
  - Episiotomy
  - Suctioning
- Minimizing elective C-sections
- Minimizing vaginal cleansing
- Minimizing infant exposure to maternal fluids

In the post-natal period

- Early breastfeeding initiation and support for exclusive breastfeeding if breastfeeding is infant feeding choice
- Prevention and treatment of breast-feeding conditions
- Care of thrush and oral lesions
- Support for replacement feeding if this is infant feeding choice
- Vitamin A supplementation
- ARVs
- Immunizations and growth monitoring and promotion for baby
- Insecticide-treated mosquito nets
- Counseling on gender issues and sexuality
- Counseling on complementary feeding after 6 months
- Immediate treatment of illness
- Counseling on safer sex and family planning

SESSION 15: HOW TO BREASTFEED

Duration: 1 hour

15.1 Introduction

This session focuses on optimal breastfeeding techniques (positioning and attachment).

15.2 Learning objectives

- State when a newborn baby should be put on the breast.
- Discuss the importance of early initiation of breastfeeding.
- State how long and how often a baby should be breastfed.
- Describe recommended ways to position and attach a baby to the breast.
- Demonstrate the recommended ways to hold (position) a baby and put a baby to the breast.

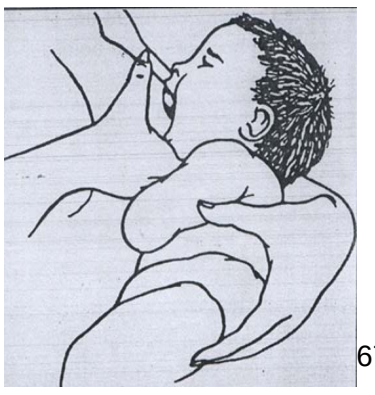
15.3 Proper positioning and attachment

Training methods

- **Demonstrate** incorrect positioning and attachment using a doll.
- Ask a mother with a baby (if available) to demonstrate correct positioning and attachment (or demonstrate using a doll).
- Ask participants to explain the difference between the two ways they have just seen to position and attach a baby.
- **Explain** any other differences between the two ways to position and attach
- a baby.
- Ask participants to form small **groups** of 5 (each with a mother and baby, if available) and then practice good positioning and attachment and give each other feedback.
- If no mothers and babies are available, use dolls and ask the participants to practice in **groups** of 3, including a "mother," a "counselor," and an "observer." Each participant should have a chance to **role play** each role. The observer should use a **checklist** of proper positioning and attachment.
- Ask 2 pairs to **demonstrate** good positioning and attachment in plenary with a baby or a doll.
- Ask for feedback and facilitate **discussion**.

What should a mother consider when positioning her baby and attaching the baby to the breast?

- **Baby's body position**
  - Baby's face is at the mother's breast level (infant should be able to look up at the mother's face, not flat to her chest or abdomen).
  - The baby's tummy should be against the mother's tummy.



- The baby's head, back, and buttocks should be in a straight line.
- The baby should be close to the mother.
- The mother should bring the baby to the breast while supporting the baby's buttocks.
- The baby's chin should be touching the breast.
- The baby's arm should be tucked under the mother's armpit.

- **Baby's head**
  - The baby's head should face the breast, not twist to one side.
  - The baby's neck should not be extended or stretched.
  - The baby's head and body should be in a straight line.

- **Mother's position**
  - The mother should sit or lie in a comfortable, relaxed position.
  - The mother's shoulders and neck should look relaxed and comfortable.
  - The mother should not lean toward the baby but instead draw the baby toward her.
  - The mother should hold her breast in a C-shape, the thumb being above the areola and the other fingers below.

15.4 Causes and results of poor attachment

Training methods

- Divide participants into 4 **groups**. Ask 2 of the groups to discuss the causes of poor attachment and the other 2 groups to discuss the results of poor attachment.
- Ask the groups to **present** their conclusions in plenary
- Facilitate **discussion** and summarize.

Why do some mothers attach their babies to the breast incorrectly?

- If the mother bottle feeds her baby, the baby may only take the nipple into its mouth (nipple feeding)
- The mother may be inexperienced.
- The baby may have a functional difficulty, for example, be too small or weak to attach correctly at the breast
- The mother may not have skilled breastfeeding support.

What happens when a mother attaches a baby on the breast incorrectly?

- Because the child is not sucking effectively, the breast is not emptied of milk, and milk production decreases.

- The nipples may be damaged and become painful. Damaged nipples in an HIV-positive mother may bleed and increase the chances of MTCT of HIV.

15.5 Recommended breastfeeding positions

Training methods

- Ask 1 or 2 two participants to **demonstrate** the cradle, football, and side-lying positions using a doll and a breast model.
- Facilitate **discussion** in plenary.
- **Review** key messages of the session.

How should a mother hold her baby to breastfeed?

- **Cradle hold position**: This position is commonly used to breastfeed new born babies. The mother holds the baby across her front, with the baby's tummy against her tummy.
- **American football hold position**: The mother holds the baby under her armpit. The baby's body rests on her s forearm with the head in her palm. This position is recommended for mothers who have had a caesarean section (to ensure that the baby does not lie on the incision), mothers with painful nipples, or mothers with twins.
- **Side lying or sleeping position**: Mothers often prefer this position at night because it allows them to breastfeed lying down. It is also a good breastfeeding position for a mother who has stitches or wants to relax. The mother and baby both lie on their sides and face each other.

Key messages

- To breastfeed a baby properly:
  - Sit in a comfortable, relaxed position.
  - Dress the baby lightly.
  - Position and attach the baby on the breast correctly. Poor attachment of the baby on the breast may cause sore nipples, poor milk flow, swollen breasts, breast infection, and abscesses.

15.6 Materials

- Flipcharts, markers, and masking tape
- Handout 15.1: Checklist of Proper Positioning and Attachment
- Handout 15.2: Illustration of Common Breastfeeding Positions and Proper Attachment

Checklist of Proper Positioning and Attachment

The baby's whole body is facing the breast (The baby should be able to look up at the mother's face, not flat to her chest or abdomen).

The baby's stomach is touching the mother's stomach.

The baby's head, back, and buttocks are in a straight line.

The baby's face is close to the breast.

The baby is brought to the breast with buttocks supported.

The baby's chin is touching the breast.

The baby's mouth is wide open.

The baby's lower lip is curled outward.

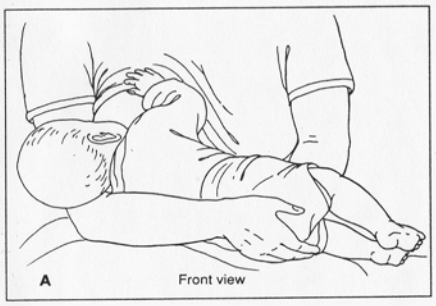
More areola is showing above the baby's upper lip and less below the lower lip (baby should take most of the dark part into his/her mouth).

The baby takes slow, deep sucks.

***Source*: Adapted from Savage King, F. 1992. *Helping Mothers to Breastfeed*. Revised edition.**

HO 15.2

Illustrations of Common Breastfeeding Positions and Proper Attachment



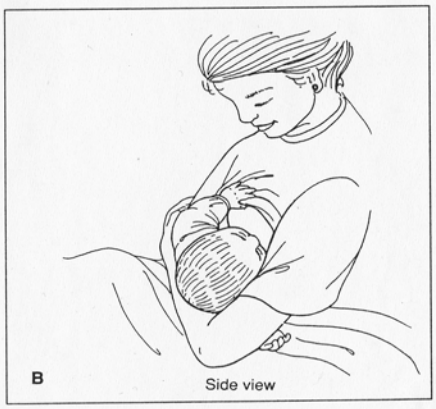


FIGURE 9–9. Madonna (cradle) position. *A. Front view. B. Side view.*

FIGURE 9–10. Football position. *A. Modified clutch position. B. Clutch hold.*

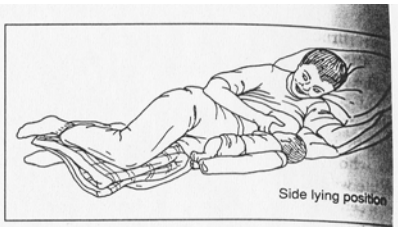


FIGURE 9–11. Side-lying position.

SECTION 16: MANAGEMENT OF BREASTFEEDING PROBLEMS IN THE CONTEXT OF HIV

Duration: 1 hour

16.1 Introduction

Managing breast difficulties is especially important for HIV-positive mothers who choose to breastfeed. Cracked nipples, mastitis, abscesses, and thrush have been associated with a higher rate of transmission of HIV to the baby.

16.2 Learning objectives

- Identify breastfeeding difficulties related to the mother and the baby.
- Discuss causes of breastfeeding difficulties related to the baby.
- Discuss how to prevent and manage breastfeeding difficulties related to the mother and the baby.

16.3 Common breastfeeding difficulties (10 minutes)

Training methods

- **Brainstorm** with participants common difficulties that can occur during breastfeeding.
- On a flipchart group the difficulties into 2 categories: 1) Difficulties related to the baby and 2) Difficulties related to the mother.

Which breastfeeding difficulties are related to the baby and which are related to the mother?

Breastfeeding difficulties related to the baby	Breastfeeding difficulties related to the mother
• **Baby not getting enough milk** • Baby refusing to breastfeed • Baby crying	• Full and painful breasts **(engorgement)** • **Cracked or sore nipples** • Lumps in the breast and milk not flowing out well **(blocked ducts)** • Hard swelling in the breast and pain accompanied by fever: **(mastitis)** • Puss in the breasts **(abscess)** • Flat or inverted nipples • Long nipples • Thrush and a prickling feeling in the breast • Milk leaking from breasts

16.4 Causes, prevention, and treatment of 4 most common breastfeeding difficulties in relation to HIV

Training methods

- Divide participants into 4 **working groups**.
- Assign 1 of the following most common breastfeeding difficulties to each group: 1) Baby not getting enough milk, 2) Engorgement, 3) Sore and cracked nipples, and 4) Plugged ducts that can lead to mastitis. Ask the groups to **list** ways to prevent and solve these difficulties, relating the difficulty to MTCT of HIV when appropriate.
- Ask each group to **present** its list of prevention measures and solutions. As each group presents, ask the rest of the participants to fill out an observation checklist for prevention and solution of each difficulty.
- Facilitate **discussion** and summarize in plenary.
- Facilitate discussion in plenary of other difficulties such as breast abscess (leaking of pus), flat or inverted nipples, long nipples, thrush, and leaking nipples (see Handout 16.5).

Problem or difficulty	Causes	Prevention	Management	Affect on MTCT of HIV
Baby not getting enough milk*	• The mother breastfeeds the baby poorly.* • The mother is unsettled and uncomfortable with breastfeeding.* • Mother is unwell.* Reliable signs that a baby is not getting enough milk: • The baby does not gain weight properly (500 grams a month for the first 6 months of life). • The baby passes a small amount of concentrated urine: (a baby who is exclusively breastfed should pass dilute urine 6–8 times in a 24-hour day. Unreliable signs that a baby is not getting enough milk: • The breast is not enlarged in pregnancy or after delivery. • Milk does not flow after delivery. • The mother thinks the baby is not satisfied after	• Correctly position the baby. • Breastfeed more frequently. • Breastfeeding exclusively day and night. • Breastfeed on demand • Breastfeed at least every 3 hours. • Encourage support from the family to do non-infant care chores. • Avoid bottles and pacifiers.	• Discuss with the mother to learn the real problem. • Reassure her that she can produce enough milk. • Encourage her to feed the baby on demand, day and night. • Help her to position and attach the baby to the breast correctly. • Advise her to wake the baby to breastfeed, even at night, if the baby sleeps a lot. • Advise her to involve her in supporting her through breastfeeding. • Explain growth spurts. • Advise her to complete a feed on one breast first before switching to the other so the baby will get the fore and hind milk.	• Undermines mother's confidence and capacity to breastfeed and discourages her from breastfeeding properly and long enough to empty the breasts. • Makes mother feel a need to give other foods in addition to breastmilk. If an HIV-positive mother gives her baby other foods in addition to breastfeeding before the baby is 6 months old, the risk of MTCT increases because the lining of the baby's immature intestines is easily damaged by other foods. HIV and other infections gain entry into the baby's blood through the damaged walls of the intestines.

Problem or difficulty	Causes	Prevention	Management	Affect on MTCT of HIV
	breastfeeding. • The baby cries often. • The baby wants to breastfeed often. • The baby breastfeeds or a long time at each feed. • The baby refuses to breastfeed. • The baby passes dry or green stools. • No milk comes out when the mother tries to express.			
Engorgement **(painful and tight breasts)** Breasts are engorged when they are full, partly with milk and partly with increased fluid in the tissue.	• Breastfeeding is initiated late. • The baby is attached poorly on the breast. • The mother infrequently breastfeeds or removes milk by expressing it. • The mother feeds the baby for a short time on each breast without completing the feeds.	• Correctly position and attach the baby. • Breastfeed immediately after birth. • Breastfeed on demand day and night, 8–12 times in 24 hours	• Put a warm compress on the breast to help the milk start flowing. • Put a cold compress on the breast after each feed to reduce the edema (swelling) and pain. • Massage the mother's neck and back to stimulate the oxytocin reflex, which will help milk flow. • Massage the breast lightly	• Undermines mother's confidence and capacity to breastfeed and discourages her from breastfeeding properly and long enough to empty the breasts. Once her confidence is undermined, the mother may start to mix feed.

Problem or difficulty	Causes	Prevention	Management	Affect on MTCT of HIV
			to get milk to flow. • Stimulate the skin of the nipple. • Encourage the mother to relax. • Apply cabbage leaves to the breast. • Ask the mother to express some milk. • Apply a warm bottle to the nipples (this can be demonstrated in the training on the arm of the trainer)	
Sore and cracked nipples	• The baby is poorly positioned and attached to the breast. • The mother uses soap on her breasts, which cracks the skin. • The mother pulls the baby off the breast while the baby is still suckling.	• Correctly position and attach the baby. • Ensure the baby correctly latches on and suckles. • Do not use soap on nipples.	• Help the mother position and attach the baby to the breast correctly. • Encourage the mother to express milk if it is painful to breastfeed. • If the mother is HIV negative and able to advise her to breastfeed, breastfeed more frequently. • Advise the mother not to	• **Enhances MTCT of HIV.** Sore and cracked nipples make HIV easier to transmit to the baby, An HIV-positive mother should heat her expressed breastmilk to boil, allow it to cool, and give to the baby. Heat kills HIV. If it is not possible to heat the milk, it should be expressed and thrown away.

Problem or difficulty	Causes	Prevention	Management	Affect on MTCT of HIV
			use soap on the breasts.	
Blocked ducts When breast ducts are blocked, milk cannot flow, and milk plugs form in the breast. Although there is no fever or any other sign of illness, this can lead to: • Lumps in the breast • Breast tenderness • Localized redness of the breast	• A tight bra or tight clothing put pressure on the breasts. • The mother breastfeeds the baby inadequately, without completing a feed on one breast before switching to the other. • The breasts are engorged. • The baby is poorly positioned and attached to the breast.	• Get support from the family to perform non-infant care chores • Ensure correct attachment • Breastfeed on demand • Avoid holding the breast in scissors hold • Avoid sleeping on stomach (mother) • Use a variety of positions to rotate pressure points on breasts	• Advise the mother to wear loose clothes which are not too tight on the breast. • Massage the lump gently towards the nipple with a warm compress to trigger milk flow. • Advise the mother to breastfeed more often and complete a feed on one breast before switching to the other. • Help the mother position and attach the baby to the breast properly. • Advise the mother to drink more liquids. • Advise the mother to rest.	• Undermines mother's confidence and capacity to breastfeed and discourages her from breastfeeding properly and long enough to empty the breasts. Once her confidence is undermined, the mother may start to mix feed. If her breasts are not emptied, milk production will decrease, and the baby will be fussy.
Mastitis This inflammation that makes the breasts swell with severe pain, fever, and localized redness	• There is poor drainage of all or part of the breast. • Infrequent breastfeeding does not empty the breasts. • The breast tissue has	• Get support from the family to perform non-infant care chores. • Ensure correct attachment. • Breastfeed on demand.	• Give the same advice as for blocked ducts. • Also advise the mother to express breastmilk from the affected breast and throw it away.	• **Enhances MTCT of HIV.** An HIV-positive mother should express milk from the unaffected breast, heat it to a boil, cool it, and give it to the baby. • If mastitis is not managed

Problem or difficulty	Causes	Prevention	Management	Affect on MTCT of HIV
is a complication of full breasts and blocked ducts.	been damaged. • Bacteria results from the poor flow of milk.	• Avoid holding the breast in a scissors hold. • Avoid sleeping on the stomach. • Use a variety of positions to rotate pressure points on the breasts.	• If both breasts are affected, or if the mother's body temperature remains high, refer her to the health centre or hospital for help. She may need antibiotics.	properly, it may lead to breast abscess. Pus will collect in the breast and the mother may feel ill, with a high temperature. Any breast infection in the HIV-positive mother facilitates MTCT of HIV
Breast abscess			• Advise the mother not to put the baby on the affected breast but instead to express and throw away the breastmilk. • Refer the mother to the health facility for treatment.	• **Enhances MTCT of HIV.** The mother should not put the baby on the affected breast, but instead express and throw away her breastmilk.
Candida This is a whitish itchy rash on the breast. Sometimes the skin may be red.			• Refer the mother and baby to the health facility for treatment of Candida and oral thrush.	• **Enhances MTCT of HIV.** In an HIV-positive mother, Candida creates openings through which HIV can be transmitted to a baby who breastfeeds on the affected breast, especially if the baby has oral thrush.
Flat and inverted nipples			• Tell the mother that breastfeeding will	• Undermines mother's confidence and capacity to

Problem or difficulty	Causes	Prevention	Management	Affect on MTCT of HIV
			improve with time. • Help the mother correctly position and attach the baby. • In the first days, help the mother express breastmilk and give it to the baby with a cup and spoon.	breastfeed and discourages her from breastfeeding the baby properly and long enough to empty the breasts • Nipples that become sore, inflamed, swollen, cracked, or infected with thrush can create passages through which HIV and other infections can be transmitted from the mother to the baby during breastfeeding.
Long and large nipples			• Encourage the mother to help the baby take as much of the breast as possible into the mouth. • Advise the mother to express her breastmilk and give it to the baby with a cup and spoon. • Encourage the mother to breastfeed the baby in a "sitting" position so that the baby does not gag on the nipple.	

Is it true that some mothers cannot produce enough milk for their babies? Why do you think so?

Almost all mothers can produce enough milk to meet her baby's needs, But some mothers may not produce enough milk under the following conditions:

- **Poor breastfeeding**
  - Delaying initiation of breastfeeding
  - Not breastfeeding often enough
  - Not breastfeeding the baby at night
  - Breastfeeding for too short a time
  - Incorrectly positioning and attaching the baby
  - Feeding the baby with a bottle or giving the baby pacifiers
  - Feeding complementary foods too early

- **Mother's discomfort with breastfeeding**
  - Lack of confidence in her ability to breastfeed
  - Dislike of breastfeeding
  - Unhappiness or rejection of the baby
  - Lack of desire to breastfeed, e.g., because she wants to retain her youthful look
  - Worry and stress
  - Tiredness

- **Illness**
  - Severe malnutrition
  - Smoking or consuming alcohol
  - Retained placenta (rare)
  - Poorly developed breasts (very rare)

Why do some babies refuse to breastfeed?

A baby may refuse to breastfeed when he or she:

- Is ill
- Is in pain
- Has a blocked nose or sores in the mouth
- Has been given medicine that makes him/her sleepy
- Is upset (nursing strike)
- Cannot handle too much milk flowing out of the breast
- Has some abnormality, such as cleft lip/palate
- Was born prematurely and is not able to breastfeed
- The baby is put on the breast long after delivery

- Is one of twins or triplets who need to be breastfed at the same time

Why do babies cry?

A baby who cries is communicating one of the following messages:

- Discomfort, for example, when the baby is wet, dirty, cold, or hot
- Irritation, for example, over being handled by many different people
- Hunger (Note: Crying is the last sign of hunger. Signs of hunger include rooting, licking movements, flexing arms, clenching fists, tensing body, and kicking legs.
- Reaction to foods or drugs (for example, coffee, tea, or cigarettes) which the mother takes and which may have gone into her breastmilk
- Pains in the abdomen
- Need for attention

What should a mother do when a baby cries?

If the baby does not seem to be crying for one of the above reasons, the mother should take the baby to the health facility to be examined and treated.

16.5 Community beliefs and myths that affect breastfeeding

Training methods

- Prepare a **flipchart** with 3 columns: 1) Breastfeeding beliefs and myths that encourage breastfeeding, 2) Beliefs and myths that discourage breastfeeding, and 3) Beliefs and myths that do not hinder breastfeeding.
- In plenary brainstorm with participants the breastfeeding beliefs in their community. Ask the participants to decide which column on the flipchart each belief belongs in.
- Ask participants to suggest how to change beliefs which have a negative effect on breastfeeding, while always respecting the beliefs.
- **Review** the key messages of the session.

What beliefs and myths in the community encourage or discourage proper breastfeeding?

Key messages

- All women can produce enough milk and breastfeed their babies effectively and successfully.
- However, problems occur during breastfeeding. Some of the problems are real. Others appear to be problems only because mothers do not have enough information to overcome them. But ALL the problems can be overcome.
- When mothers have a problem with breastfeeding, ask them to:
  - Read the pamphlets distributed by health workers to get answers to their problem
  - Discuss the problem with friends, relatives and neighbours who have had and overcome a similar problem
  - Discuss the problem with a counsellor or community health worker
  - Join a breastfeeding support group to share information and get support.

16.6 Materials

- Flipchart, markers, and masking tape
- Handout 16.1: Checklist of Prevention Measures and Solutions for Insufficient Milk
- Handout 16.2: Checklist of Prevention Measures and Solutions for Engorgement
- Handout 16.3: Checklist of Prevention Measures and Solutions for Sore and Cracked Nipples
- Handout 16.4: Checklist of Prevention Measures and Solutions for Plugged Ducts Which Can Lead to Mastitis
- Handout 16.5: Special Situations That Affect Breastfeeding

HO 16.1

Checklist for Baby Not Getting Enough Breastmilk

Prevention	Breastfeed more frequently. Exclusively breastfeed day and night. Breastfeed on demand. Correct positioning of baby. Breastfeed at least every 3 hours. Encourage support from the family to perform non-infant care chores. Avoid bottles and pacifiers.
Solutions	Withdraw any supplement, water, formulas, or tea. Feed baby on demand, day and night. Increase frequency of feeds. Wake the baby up if baby sleeps throughout the night or longer than 3 hours during the day. Make sure baby latches-on to the breast correctly. Reassure mother that she is able to produce sufficient milk. Explain growth spurts. Empty one breast first (baby takes fore and hind milk).

HO 16.2

Checklist for Engorgement

Prevention	Correct positioning and attachment Breastfeed immediately after birth Breastfeed on demand (as often and as long as baby wants) day and night: 10 – 12 times per 24 hours
Solutions	Apply cold compresses to breasts to reduce swelling; apply warm compresses to "get milk flowing." Breastfeed more frequently or longer. Improve infant positioning and attachment. Massage breasts. Apply cabbage leaves. Express some milk. Apply a warm bottle (demonstrate use of warm bottle).

HO 16.3

Checklist for Sore or Cracked Nipples

Prevention	Correctly position the baby. Correct latch-on and suckling. Do not use soap on nipples.
Solutions	Make sure baby is positioned well at the breast. Make sure the baby latches on to the breast correctly. Apply drops of breastmilk to nipples and allow to air dry. Remove the baby from the breast by breaking suction first. Expose breasts to air and sunlight. Begin to breastfeed on the side that hurts less. Do not stop breastfeeding. Do not use soap or cream on nipples. Do not wait until the breast is full to breastfeed. If full, express some milk first.

HO 16.4

Checklist for Plugged Ducts Which Can Lead to Mastitis

Prevention	Get support from the family to perform non-infant care chores. Ensure correct attachment. Breastfeed on demand. Avoid holding the breast in scissors hold. Avoid sleeping on stomach (mother). Use a variety of positions to rotate pressure points on breasts.
Solutions	Apply heat before the start of breastfeeding. Massage the breasts before breastfeeding. Increase maternal fluid intake. Rest (mother). Breastfeed more frequently. Seek medical treatment; if mastitis antibiotics may be necessary. Position baby properly.

HO 16.5

Special Situations That Affect Breastfeeding

Situation	Solutions
Sick baby	• Baby **under 6 months:** If the baby has diarrhea or fever, the mother should breastfeed exclusively and frequently to avoid dehydration or malnutrition. Breastmilk contains water, sugar, and salts in adequate quantities, which will help the baby recover quickly from diarrhea. • If the baby has severe diarrhea and shows any signs of dehydration, the mother should continue to breastfeed and provide oral rehydration solution (ORS) with a spoon or cup. • Baby **older than 6 months:** If the baby has diarrhea or fever, the mother should breastfeed frequently to avoid dehydration or malnutrition. She should also offer the baby bland food (even if the baby is not hungry). • If the baby has severe diarrhea and shows any signs of dehydration, the mother should continue to breastfeed and add ORS.
Sick mother	• A mother who is suffering from headaches, backaches, colds, diarrhea, or any other common illness SHOULD CONTINUE TO BREASTFEED. • The mother should rest and drink a lot of fluids to help her recover. • If the mother does not get better, she should consult a doctor and tell the doctor that she is breastfeeding.
Premature baby	• The mother needs support for correct latch-on. • Breastfeeding is advantageous for pre-term babies. Supportive holds may be required. • Direct breastfeeding may not be possible for several weeks, but expressed breastmilk may be stored for the baby's use. • A baby who sleeps for long periods should be unwrapped to encourage waking and held vertically to awaken. • The mother should watch the baby's sleep and wake cycle and feed during quiet-alert states.
Malnourished mother	• The mother needs to eat extra food ("Feed the mothers, nurse the baby"). • The mother needs to take micronutrients.

Situation	Solutions
Daily separation of mother from her baby	• The mother should express or pump her breastmilk and store it for use while she is separated from the baby. The baby should be fed this milk at normal feeding times. • The mother should feed her baby frequently when she is at home. • A mother who can keep her infant with her at work should feed the baby frequently.
Twins	• A mother can exclusively breastfeed both babies. • The more the babies nurse, the more milk is produced.
Inverted nipples	• Detect this during pregnancy. • Try to pull the nipple out and rotate it, as if turning the dial on a radio. • Make a hole in the nipple area of a bra. The nipple will protrude through this opening. • If acceptable, ask someone to suckle the nipple.
Baby who refuses the breast	• Position the baby properly. • Treat engorgement (if present). • Avoid giving the baby teats, bottles, or pacifiers. • Wait for the baby to be wide awake and hungry (but not crying) before offering the breast. • Gently tease the baby's bottom lip with the nipple until the mouth opens wide. • Do not limit the length of feeds. • Do not insist more than a few minutes if baby refuses to suckle. • Avoid pressure on potentially sensitive spots, such as painful areas because of the use of forceps or a vacuum extractor or clavicle fractures. • Express breastmilk and feed it by cup.
Medication	• Most drugs pass into breastmilk. • Almost all medication appears in only small amounts in human milk, usually less than 1% of the maternal dosage. • Very few drugs are contraindicated for breastfeeding women.

Situation	Solutions
Separation of mother from her baby for an extended period	• Express breastmilk by following these steps: a. Wash your hands. b. Prepare a clean container. c. Gently massage the breasts in a circular motion. d. Position your thumb on the upper edge of the areola and the first two fingers on the underside of the breast behind the areola. e. Push straight into the chest wall. f. Avoid spreading the fingers apart. g. For large breasts, first lift and then push into the chest wall. h. Roll thumb and fingers forward as if making thumb and fingerprints. i. Repeat rhythmically: position, push, roll; position, push, roll. j. Rotate the thumb and finger positions. • Store breastmilk in a clean, covered container up to 8–10 hours at room temperature in a cool place and up to 72 hours in the refrigerator. • Feed the baby the expressed breastmilk from a cup. Bottles are unsafe to use because they are difficult to wash and can be easily contaminated.
Leaking nipples	• Apply pressure to the nipples to stop leaking. • Breastfeed the baby more frequently. • Be assured that the leaking will stop in time. • Put a pad to soak milk and change the pads frequently to avoid infection. • Express your breastmilk when away from the baby and leave the milk behind to be given to the baby.
Pregnancy	• Continue to breastfeed your baby. • ***Note*****:** Some babies who breastfeed while the mother is pregnant may have more bowel movements than usual. This does not mean they have diarrhea. This is a normal reaction of the colostrum the mother is producing and will last only a few days.

Situation	Solutions
Cleft lip/palate	• Realize how important breastmilk is for the baby. • Try to fill the space made by the cleft lip with your finger or breast. • Breastfeed in a sitting position. • Express breastmilk and give to the baby with a cup or teaspoon.

SESSION 17: OBSERVING BREASTFEEDING IN THE COMMUNITY OR HEALTH FACILITY

Duration: 3–4 hours

17.1 Introduction

Participants observe breastfeeding mothers and give appropriate help and support.

17.2 Learning objectives

- Observe and assess a breastfeeding session.
- Recognize signs of good and poor positioning and attachment.
- Demonstrate the ability to use the breastfeeding observation form.
- Identify a mother who may need help with breastfeeding.

17.3 Observation of a breastfeed

Training methods

- **Review** the breastfeeding observation form
- Ask participants to form **groups** of 3 to role play a mother, health worker, and observer. The participants who **role play** the mothers should practice attachment and positioning. The participants who role play the health workers should counsel the mothers, and the observers should practice using the breastfeeding observation form.
- Ask participants to form pairs to **observe** at least 2 mothers breastfeeding their babies in the community or at a health facility.
- Ask one participant in each pair to **assess** a breastfeed and the other participant to observe and record observations on the form. Then ask the participants in the pair to reverse roles to observe another breastfeeding mother.
- After the assessments, ask the participants to **assist** mothers who need advice on positioning and attachment.
- Ask participants for feedback on their experience with the mothers.
- Lead a **discussion** and summary of the visit.

17.4 Materials

- Handout 17: Breastfeeding Observation Form

HO 17

B-R-E-A-S-T-FEEDING OBSERVATION FORM

Mother's name _____ Date: _____
Baby's name _____ Age of baby _____

[Signs in brackets refer only to newborn, not to older babies]

Signs that breastfeeding is going well	*Signs of possible difficulty*
BODY POSITION	
☐ Mother relaxed and comfortable	☐ Shoulders tense, leans over baby
☐ Baby's body close, facing breast	☐ Baby's body away from mother's
☐ Baby's head and body straight	☐ Baby's neck twisted
☐ Baby's chin touching breast	☐ Baby's chin not touching breast
☐ (Baby's bottom supported)	☐ [Only shoulder or head supported]
RESPONSES	
☐ Baby reaching for breast if hungry	☐ No response to breast
☐ Baby rooting for breast	☐ [No rooting observed]
☐ Baby exploring breast with tongue	☐ Baby not interested in breast
☐ Baby calm and alert at breast	☐ Baby restless or crying
☐ Baby staying attached to breast	☐ Baby slipping off breast
☐ Signs of milk ejection (leaking, after-pains)	☐ No signs of milk ejection
EMOTIONAL BONDING	
☐ Secure, confident hold	☐ Nervous or limp hold
☐ Face-to-face attention from mother	☐ No mother/baby eye contact
☐ Much touching by mother	☐ Little touching or shaking or poking baby
ANATOMY	
☐ Breasts soft after feed	☐ Breasts engorged
☐ Nipples standing out, protractile	☐ Nipples flat or inverted
☐ Skin appearance healthy	☐ Skin fissured or red
☐ Round-looking breasts during feed	☐ Stretched or pulled-looking breasts
SUCKLING	
☐ Mouth wide open	☐ Mouth not wide open, points forward
☐ Lower lip turned outwards	☐ Lower lip turned in
☐ Tongue cupped around breast	☐ Baby's tongue not seen
☐ Cheeks round	☐ Cheeks tense or pulled in
☐ More areola above baby's mouth	☐ More areola below baby's mouth
☐ Slow, deep sucks, bursts with pauses	☐ Rapid sucks only
☐ Swallowing visible or audible	☐ Smacking or clicking audible
TIME SPENT SUCKLING	
☐ Baby releases breast	☐ Mother takes baby off breast
Baby suckled for __ minutes	

Adapted with permission from Armstrong, H. C. 1992. "B-R-E-A-S-T-Feeding Observation Form." *Training Guide in Lactation Management*. New York: IBFAN and UNICEF.

SESSION 18: INFANT AND YOUNG CHILD FEEDING OPTIONS IN THE CONTEXT OF HIV

Duration: 2 hours

18.1 Introduction

In this session participants learn the United Nations recommendations for infant feeding in areas affected by HIV.

18.2 Learning objectives:

- Explain the challenges of HIV in relation to breastfeeding.
- Name and describe at least two major infant and young child feeding choices in the context of HIV.

18.3 Review of mother-to-child transmission of HIV

Training methods

- **Review** the ways HIV can be transmitted from mother to child.
- **Brainstorm** with participants the infant and young child feeding options of an HIV-positive mother. At least 5 options should be mentioned.
- Write each option suggested at the top of a **flipchart**. Arrange 5 flipcharts around the training area.
- Divide the participants into 5 **groups**. Ask each group to go to one of the 5 flipcharts and describe the option written on top of the flipchart.
- Then ask the groups to rotate to another flipchart and make additional comments. Groups should rotate from flipchart to flipchart until each has had a chance to make comments on each infant feeding option.
- Facilitate **discussion** and summarize in plenary.

Can you remember at least 3 ways HIV can be transmitted from mother to child?

A baby born to an HIV positive mother can get HIV from the mother during pregnancy, labor and delivery and breastfeeding.

If 100 HIV- positive women deliver babies:

- About 63 of the babies may not get HIV.
- About 7 may be infected with HIV during pregnancy.
- About 15 may be infected with HIV during labor and delivery.
- About 15 may be infected with HIV through breastfeeding if the mothers breastfeed them for 2 years.

What is the best food for a baby?

18.4 Infant and young feeding options for the HIV-positive mother

Training methods

- **Brainstorm** with participants the infant and young child feeding options for an HIV-positive mother.
- List 5 of the suggested options on **flipcharts** (1 option per flipchart) and distribute the flipcharts throughout the training area.
- Divide the participants into 5 **groups** and ask each group to go to 1 of the flipcharts and describe the infant and young child feeding option. Then ask the groups to rotate to the other flipcharts and do the same,
- Facilitate **discussion** and summarize in plenary.

What infant and young child feeding options does an HIV-positive mother have?

An HIV-positive mother has 5 options for feeding her baby:

1. Breastfeed exclusively until AFASS criteria (acceptable, feasible, affordable, sustainable, and safe) are met **or** until the baby is 6 months old.
2. Express and heat-treat breastmilk.
3. Find a wet nurse.
4. Feed the baby commercial infant formula.
5. Feed the baby home-modified animal milk.

Option 1: Breastfeed exclusively until AFASS criteria are met or the baby reaches 6 months

- Initiate breastfeeding within 1 hour after birth.
- Breastfeed exclusively.
- Position and attach the baby on the breast properly.
- Breastfeed the baby frequently, day and night.
- Breastfeed long enough to empty the breast at each feed.
- If you will be away from the baby, express your breastmilk and leave it behind to be given to the baby by cup.
- Store expressed milk in a clean, covered container for 8– 10 hours at room temperature and up to 72 hours in a refrigerator.
- IF you have a breast condition, stop breastfeeding from the infected breast and seek prompt treatment.
- If you have cracked nipples, mastitis (inflammation of the breast), abscess, or Candida (yeast infection of the nipple and breast),

express the breastmilk and either throw it away or heat treat it before feeding it to the baby.

- Stop breastfeeding as soon as replacement feeds are acceptable, feasible, affordable, sustainable, and safe and/or the baby begins to eat other foods at the age of 6 months.

Option 2: Expressed, heat-treated breastmilk

- Express breastmilk.
- Heat expressed breastmilk to boil.
- Cool the breastmilk immediately by standing it in cold water.
- Feed the baby the expressed, heat-treated breastmilk by cup.
- Use heat-treated breastmilk within 1 hour.

Option 3: Wet nursing (breastfeeding by a woman who is not the biological mother)

- Identify a woman willing to breastfeed the baby without pay.
- Ask the woman to take an HIV test. She should breastfeed the baby only if she tests HIV negative.
- Make sure she practices all optimal breastfeeding practices and breastfeeds the baby as long as needed.
- Give the wet nurse information to enable her to practice safer sex.
- Give the wet nurse breastfeeding support: to prevent and treat cracked or bleeding nipples, mastitis, abscess, or Candida.
- There is a small chance that an HIV-positive baby can pass the virus to a wet nurse if the baby has a sore in the mouth or the wet nurse has a breast condition.

Option 4: **Replacement feeding with commercial infant formula**
Option 5: Replacement feeding with home-modified animal milk

- Give the baby foods other than breastmilk from birth (no breastfeeding) if you and your family have:
  - A reliable and affordable supply of the replacement feeds
  - Access to nutritionally adequate replacement feeds, especially for the first 6 months
  - Clean water to prepare the food
  - Clean utensils
  - An adequate supply of fuel
  - Good hygiene and good sanitation
  - Time to prepare the selected foods and give them to the baby
  - The ability to read the instructions on the commercial infant formula package
  - Access to micronutrients supplements for home-modified animal milk

- **Note**: Preparing food for the baby in unhygienic conditions can harm the baby. The cost of replacement feeds and the ability to maintain the required hygiene are the key challenges for HIV-positive mothers who choose exclusive replacement feeding.

18.5 Expressing breastmilk

Training methods

- If a lactating mother is available and willing to demonstrate milk expression, ask her to **demonstrate** in front of the participants OR
- Demonstrates milk expression using a model breast.
- Facilitate discussion.
- **Ask** participants 1) Whether it is advisable for a woman who has stopped breastfeeding to start breastfeeding again and 2) Whether a mother who has stopped breastfeeding can get milk flowing in her breasts again.
- Facilitate **discussion**.
- **Review** the key messages of the session.

How should a mother express breastmilk?

- Wash her hands.
- Prepare and wash a clean container.
- Gently massage the breasts in a circular motion.
- Position her thumb on the upper edge of the areola, with two fingers on the under side of the breast behind the areola, and keep the fingers together.
- Push straight into the chest wall.
- For big breasts, first lift and then push into the chest wall.
- Roll the thumb and fingers forward as if making thumb and finger prints.
- Repeat the motion rhythmically: position, push, roll, etc.
- Rotate the finger and thumb positions.
- Store breastmilk in a clean, covered container up to 8–12 hours in a cool place and 72 hours in the refrigerator.
- Feed the baby the expressed breastmilk from a cup. Bottles are unsafe to use because they are difficult to wash and can be easily contaminated.

Should a woman who has stopped breastfeeding start breastfeeding again?

- Sometimes mothers who have stopped breastfeeding need to start breastfeeding again. Re-starting breastfeeding is both possible and safe.

Can a mother who has stopped breastfeeding get milk flowing in her breasts again?

- Even a mother who has not had a baby for many years can induce milk flow and breastfeed another woman's baby if it needed (for example, if the biological mother has died).
- Health workers should advise mothers how to restart their milk supply.

Before a mother puts the baby on the breast, both the mother and the baby should be tested for HIV to make sure both are HIV negative. If the mother is HIV positive and replacement feeding is not AFASS, then the mother should follow options 1, 2, or 3.

Key messages

- HIV-positive mothers can choose from the following infant and young child feeding options:
  - **Option 1:** Breastmilk exclusively until AFASS (acceptable, feasible, affordable, sustainable, and safe) criteria are met **or** until the baby is 6 months old.
  - **Option 2:** Express and heat-treat breastmilk.
  - **Option 3:** Find a wet nurse.
  - **Option 4:** Replacement feed with commercial infant formula.
  - **Option 5:** Replacement feed with home-modified animal milk,
- Pregnant women need to discuss these options with their health workers or counselors during pregnancy and select the option that will work for them.

18.6 Materials

- Flipcharts, markers, and masking tape
- LINKAGES. 2004. "Infant Feeding Options in the Context of HIV." Washington DC.
- Breast model

SESSION 19: YOUNG CHILD FEEDING (COMPLEMENTARY FEEDING)

Duration: 2 hours

19.1 Introduction

In this session participants learn optimal complementary feeding practices and ways to help mothers and caregivers feed children 6–24 months old.

19.2 Learning objectives

- Define complementary feeding.
- List possible consequences of introducing complementary foods too early or too late.
- Describe the dietary needs of children 6–9 months old, 9–12 months old, and 12–24 months old.
- Discuss suitable foods for children 6–24 months old.
- Discuss feeding concerns related to HIV and follow-up care.
- Develop a calendar of seasonally available foods for counseling during negotiation sessions.

19.3 Complementary feeding (what, why, when)

Training methods

- **Brainstorm** the meaning of complementary feeding and the role of complementary foods in the growth and development of a baby.
- Form participants into 4 **groups** to answer questions on complementary feeding practices in their community. Distribute **Handout** 19.1.
- Ask 1 group to **present** its answers in plenary and the other groups to add points not mentioned.
- **Ask** participants what happens if a baby is given other foods too early (before 6 months) or too late (long after 6 months).
- Facilitate **discussion** and summarize. Distribute **Handout** 19.2.

What is complementary feeding?

- **Complementary feeding** usually means introducing a baby to foods other than breastmilk and helping the baby transition step by step transition from exclusive breastfeeding to eating family foods. During this period, the baby continues to breastfeed while being given other foods.
- In communities affected by HIV, complementary feeding means manufactured or locally prepared food given to a baby to complement breastmilk, infant formula, or animal milks when those foods are no longer sufficient to satisfy the baby's nutritional needs (beginning at 6 months of age).

How do complementary foods help a baby grow and develop?

- Breastmilk provides all the nutrition a baby needs from birth to 6 months. After 6 months the baby needs foods in addition to breastmilk or other milk-based foods.
- Other foods fill the nutrition gap left by milk and help the baby grow, develop, and resist diseases.
- At 6 months the baby begins to eat other foods while continuing to breastfeed until 2 years or older. Complementary feeding starts at 6 months and ends when the baby stops breastfeeding.
- The best time to introduce complementary foods is at 6 months.
- Breastmilk meets half a baby's nutritional needs from 6 to12 months and up to one-third of a baby's nutritional needs from 12 to 24 months.

What happens if a baby is given other foods too early (before 6 months)?

- The baby breastfeeds less, and this reduces milk production.
- The baby misses out on the substances in the milk which protect the baby from disease and may get diarrhoea and other infections.
- The mother may get pregnant sooner.
- The foods may damage the lining of the baby's intestines and allow infections, including HIV, to get into the baby's blood.

What happens if a baby is given other foods too late (long after 6 months)?

- The baby does not get extra food to fill the energy and nutrition gap left by breastmilk.
- The baby stops growing or grows slowly.
- The baby may become malnourished and less able to resist infections, including HIV infection.

What should a baby 6–24 months old eat?

A baby 6–24 months old should eat complementary foods that are:

- Rich in 1) energy, 2) protein, and 3) vitamins and micronutrients
- Easy to prepare
- Easy for the baby to eat
- Locally available and affordable
- Liked by the baby

What are the challenges of feeding babies and young children in an area affected by HIV?

- A baby may get HIV infection from the mother and need more care than a child without HIV.
- The mother or caregiver has to ensure safe replacement feeding if this is the feeding choice.
- Mothers need to go for treatment as soon as they feel ill so they will remain in good health and look after their babies well.
- Families need to space children because an early pregnancy could affect a mother's ability to look after her current baby.
- An HIV-positive mother could become ill or die, leaving her baby to relatives or older children who may not give the best care.
- Children of HIV-infected mothers may risk being undernourished if they do not breastfeed.
- Women who are HIV positive should follow the same complementary feeding guidelines as women who are HIV negative or of unknown status, modifying breastfeeding behaviors.
- Mothers should make sure their babies' diet includes milk products throughout the first year of life because they are good sources of energy and other nutrients.

19.4 Complementary foods for different age groups

Training methods

- Give each participant 2 or more **foods** purchased locally at the market.
- Distribute water and pictures or models of a breast to represent breastmilk.
- On tables or on the floor covered with flipchart paper, set out 3 **cards** marked "0– < 6 months," "6– < 12 months," and "12– < 24 months." These are the age ranges of a baby, and the " < " sign means "up to the age of".
- Ask each participant to **name** the local foods and place them under the card that is the appropriate age for the child to begin to eat the food.
- Facilitate discussion and correct **rearrangement** of foods.
- **Discuss** locally available foods that can be given to children 6– < 24 months old.

What local foods are good to give as complementary foods?

Affordable foods that can be given as complementary foods include maize porridge with groundnuts, dry fish, beans, green vegetables, fruits in season, juice squeezed out of fresh fruits, and soya.

19.5 Complementary feeding behaviors

Training methods

- Keeping in mind the previous activities, **ask** participants what they think are the main complementary feeding behaviors.
- Write answers on a **flipchart** and fill in gaps using FADUA (**F**requency, **A**mount, **D**ensity (consistency and caloric density), **U**tilization, and **A**ctive/responsive feeding (See **Handout** 19.3).

What are the main complementary feeding behaviors?

- Continue to breastfeed often.
- Increase feeding **Frequency** as the child grows older, using the WHO Guiding Principles for Complementary Feeding:
  - At the beginning of complementary feeding (6–8 months), breastfeed the baby and give complementary foods 2 – 3 times a day.
  - Between 9 and 24 months, breastfeed the baby and give other foods 3 – 4 times a day.
  - In addition, give the baby 1–2 snacks a day.
  - Introduce the baby to family foods gradually, starting with light porridge twice a day.

- Increase the **Amount** of food as the child grows older, while continuing to breastfeed.
  - Serve the baby on his or her own plate to be sure that the baby eats enough.
  - Feed the baby or actively encourage the baby to eat.

- Increase food consistency and nutrient **Density** by giving different kinds of foods, including fruits, vegetables, staple foods, animal products, or legumes.
  - Make the food (including porridge) thick enough to stay on a spoon.
  - Give the child the staple usually eaten by the family (usually food made out of maize flour or sweet potato roots).
  - At first make the food soft, later mash it, and when the baby can chew, cut it into small pieces.
  - Add protein-rich animal and plant foods, e.g., meat or fish powder, beans, groundnuts, soya beans, or eggs.
  - Add vitamin- and micronutrient-rich foods such as fruits (mangoes, oranges, bananas), leafy vegetables (tomatoes, pumpkin leaves, sweet potato leaves, leaves from pumpkins).
  - Add oils, fats, butter, or margarine to increase energy content.
  - Add vitamin A-rich foods (such as carrots and dark leafy vegetables).
  - Add citrus fruits (such as oranges) to increase iron absorption.

- Maximize the **Utilization** of food sources.
  - Practice good hygiene to keep the child healthy and free of infection.
  - Wash hands before preparing food and before feeding the child.
  - Cook and serve the baby's food on clean utensils.
  - Keep the food in a clean place and reheat it before offering it to the child.
  - Give vitamin A-rich foods with fats and give citrus with iron to increase absorption.
  - Don't give leftover food to the child the next day.

- Practice **Active** (or responsive) feeding
  - Encourage and help the child to eat from his or her own plate.
  - Play with the child.

- Encourage the child to eat a **Variety** of foods.
  - Offer a variety of foods.
  - Increase the variety of foods and colors.

Make sure the food promoted is available? Do people have it at home? Can they afford to do it daily? Twice a week? What could they do the other days?

19.6 Active feeding

Training methods

- **Brainstorm** with the participants the definition and importance of active feeding.
- Ask participants to give examples of active (responsive) feeding.
- Read and discuss **Handout** 19.4.

What is active feeding and why is it important?

Definition: Active (responsive) feeding is a method that encourages a child to eat and to finish his or her meals.

Importance of active feeding: A child who feeds himself or herself may not eat enough because he or she is easily distracted. The child may become malnourished. Therefore the child needs help. Parents, family members (older children), and child caretakers can participate in active feeding.

19.7 Feeding a sick child older than 6 months

Training methods

- **Brainstorm** with participants how to feed a sick child who is older than 6 months.
- Write answers on a **flipchart**.
- Facilitate **discussion** and summarize.
- **Review** the key messages of the session.

How should a mother feed a sick child who is older than 6 months?

- Offer and give small amounts of food more frequently (every 2 hours).
- Encourage the child to eat even if he or she is not hungry.
- Give soft, bland foods.
- Give extra liquids if the child has diarrhea or a fever. Good liquids to give include fresh fruit juice, water, rice water, soup, and oral rehydration solution.
- Give foods the child likes.

19.8 Seasonally available foods calendar

Training methods

- Distribute **Handout** 19.5.
- Ask participants to form **groups** according to their regions or villages.
- Ask each group to fill in the calendar with foods available during each month.
- Ask 2 groups to **present** their results in plenary.
- Facilitate **discussion** of the adequacy of the foods identified.
- Review the key messages of the session.

Key messages

- Breastfeed children 6–12 months old first and then give them complementary foods.
- Add other foods beginning at the age of 6 months besides breastfeeding.
- Start to give the 6-month-old child soft foods and gradually increase the food consistency.
- Increase the frequency of meals as the child grows (2–3 meals a day from 6 to 8 months, 3–4 meals a day from 9 to 24 months, with 1–2 snacks a day).
- Increase the amount of food as the child grows.
- Feed the child a wide variety of foods and enrich them with one or more of the following foods: groundnuts, dry fish, beans, green vegetables, fruits in season,

and soya.

- Encourage and help the child to eat from his or her own plate (active/responsive feeding).
- Make sure the food is prepared and kept hygienically.
- Breastfeed often during illness.
- Keep breastfeeding for at least 2 years.

19.9 Materials

- Flipcharts, markers, and masking tape
- Handout 19.1: Complementary Feeding Working Group Questions
- Handout 19.2: Complementary Feeding Recommended Practices Beginning at the Age of 6 months
- Handout 19.3: FADUA—Helping Mothers and Caregivers Select Complementary Foods
- Handout 19.4: How Do Mothers and Caregivers Feed Actively?
- Handout 19.5: Seasonal Available Foods Calendar
- LINKAGES. 2004. "Infant Feeding Options in the Context of HIV"

HO 19.1

Complementary Feeding Working Group Questions

1. When does a baby begin to eat something besides breastmilk?

2. **Frequency** - How many times a day does the baby eat? Does the baby eat from his or her own plate?

6–8 months Uses own plate?	9–24 months Uses own plate?

3. What does the baby eat? **How much** does the baby eat?

6–8 months Uses own plate?	9–24 months Uses own plate?

4. **Density** – What is the consistency of the food the baby eats?

6–8 months	9–24 months

5. **Utilization** - What does the mother or caregiver do before preparing the food and before the young child eats?

6. How long should the complementary feeding period last?

7. What challenges do people face in feeding babies and young children in an area affected by HIV?

Complementary Feeding Practices Beginning at 6 Months

- For children 6–12 months old, breastfeed first and then give complementary foods.
- Keep breastfeeding until the child is at least 2 years old.
- Add other foods beginning at the age of 6 months **(FADUA):**
  - Increase the **frequency** of meals as the child grows (2–3 times a day from 6 to 8 months, and 3–4 times a day plus 1–2 nutrition snacks).
  - Increase the **amount** of food as the child grows. Put more on the plate and feed snacks between meals.
  - Give the 6-month-old baby soft foods and gradually increase the consistency and **density** of the food. Select the best basic staple food.
  - Add to the staple food - protein-rich foods (animal or plant): groundnuts, dry fish, beans, green vegetables, fruits in season, and soya.
  - If possible, every day offer the child mangoes, papaya, leafy greens, oranges, bananas, pumpkin, carrots, and tomatoes.
  - Add oils (butter, peanut butter, or other vegetable oils) for calories.
  - Pay attention to the consistency of food. Complementary food should be mushy, not watery.
- **Utilization** of food sources:
  - Wash your hands before preparing food and before feeding the child.
  - Keep the food in a clean place and reheat it before offering it to the child.
  - Do not give leftover food to the child the next day.
- Encourage and help the child to eat from his or her own plate, playing with the child (**active**/responsive feeding). The mother or caregiver can use her fingers (after washing them) to feed the child.
- Feed the child a wide variety of foods and enrich meals with one or several of the following foods: oil, peanuts, greens, vegetables, eggs, green leafy vegetables, and fruits. Increase **variety** of food and colors.
- Make sure the child receives vitamin A supplementation.
- **AVOID** bottle feeding.

ALSO: Is the food available? Do people have it at home? Can they afford to do it daily? Twice a week? What could they do the other days?

FADUA—Helping Mothers and Caregivers Select Complementary Foods

- **F– Frequency:** Introduce food at 6 months and gradually increase the frequency.
  6–8 months: 2–3 times a day (with 1–2 snacks)
  9–24 months: 3–4 times a day (with 1–2 snacks)

- **A– Amount:** Increase the amount of food. Put more on the plate and feed snacks between meals.

- **D– Density: (**Consistency and caloric density).
  - If possible, feed the child the best basic food: porridge.
  - Add protein-rich foods (animal and plant): groundnuts, dry fish, beans, green vegetables, fruits in season, and soya.
  - If possible, offer the child every day mangoes, papaya, leafy greens, oranges, bananas, pumpkin, carrots, or tomatoes.
  - Add oils (butter, peanut butter, other vegetable oils) for calories.
  - Pay attention to the consistency of the food. It should be mushy, not watery.

- **U – Utilization:**
  - Wash your hands before preparing food and before feeding the child. Parasites decrease the amount of food available to the body. Have the baby de-wormed every 6 months, starting at the age of 2 years.
  - Keep the food in a clean place and reheat it before offering it to the child.
  - Do not give leftover food to the child the next day.

- **A – Active (or responsive) feeding:** Help and encourage the child to eat.

ALSO: Offer a variety of foods and increase variety in foods and colors

Is the food available? Do people have it at home? Can they afford to do it daily? Twice a week? What could they do the other days?

HO 19.4

Active Feeding

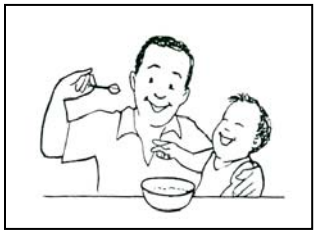
Definition: Active (responsive) feeding is a method that encourages a child to eat and to finish his or her meals.

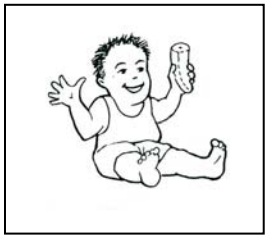
Importance of active feeding: A child who feeds himself or herself may not eat enough because he or she is easily distracted. The child may become malnourished. Therefore the child needs help.

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

- Let the child eat from his or her own plate.
- Sit down with the child and encourage him or her if needed.
- Offer food the child can hold. A young child often wants to feed himself or herself. Encourage this but make sure most of the food goes into the child's mouth.

- Feed the child as soon as he or she starts to get hungry.
- The child should eat in his or her usual setting.
- As much as possible, let the child eat with the family to promote psycho-affective development.
- If the child does not want to eat, do not insist. Wait or put it off until later.





- Play with the child while he or she eats.
- Make sure the child is not thirsty (but do not give too much drink before or during meals).
- Congratulate the child when he or she eats.

Calendar: Inexpensive and Available Foods (at the Market and at Home)

January	February	March
Home	Home	Home
Market	Market	Market

April	May	June
Home	Home	Home
Market	Market	Market

July	August	September
Home	Home	Home
Market	Market	Market

October	November	December
Home	Home	Home
Market	Market	Market

SESSION 20: COMMUNICATING WITH COMMUNITY MEMBERS AND NEGOTIATING INFANT AND YOUNG CHILD FEEDING PRACTICES

Duration: 2 hours

20.1 Introduction

Listening is the most important communication skill in behavior change communication. Negotiation relies heavily on listening skills.

20.2 Learning objectives

- Describe an effective way to communicate effectively with community members about PMTCT-related issues.
- Identify skills needed to communicate effective PMTCT messages.
- Explain the steps of negotiation with mothers, caregivers, or community members.
- Practice negotiation skills.

20.3 Community and communication

Training methods

- Ask participants what "community" means and who makes up a community.
- Ask participants to **brainstorm** the characteristics of good communication in communities.
- Write answers on a flipchart and discuss.
- Ask participants to **identify** the most important skill in behavior change communication.
- Write answers on **flipchart**.
- **Discuss** the different ways people can listen.
- Facilitate **discussion** in plenary.

What is a community? Who makes up a community?

- A **community** is a group of people who share a history and values.
- A community is made up of
  - Men
  - Women
  - Young people
  - Children
  - Leaders
  - Organizations

Why should we communicate PMTCT messages to the community?

- To increase relevant information
- To promote positive attitudes
- To promote adoption and maintenance of desired behaviors

What are the characteristics of good communication by community motivators?

- Two-way communication
- Partnership between the community motivator and the community member.
- Conversation in an atmosphere of caring and respect
- Use of existing community networks
- Effectively verbal communication
- Effective non-verbal communication
- Ample opportunities for asking and discussing

What do you think is the most important skill in behavior change communication?

Listening is the most important skill in behavior change communication. A good listener practices the following skills:

- **Attending**
  - Keeping a posture of involvement
  - Making eye contact
  - Using appropriate body movement

- **Following**
  - Observing
  - Encouraging the other person to put non-verbal cues into words
  - Avoiding interruption
  - Keeping an attentive silence

- **Reflecting**
  - Paraphrasing
  - Encouraging the other person to put feelings into words
  - Encouraging the other person to explain or clarify what he or she means
  - Summarizing and checking comprehension

20.4 Negotiating using ALIDRAA

Training methods

- **Demonstrate** an initial visit of a community motivator to the house of a woman named Aster, who has a 7-month-old son named David.
- Facilitate **discussion** of the demonstration visit.
- **Present** the steps of negotiation: **A**sk, **L**isten, **I**dentify the problem, **D**iscuss options, **R**ecommend and negotiate, **A**gree, and make a follow-up **A**ppointment (ALIDRAA)
- Distribute and discuss **Handout** 20.1.

What skill can be help mothers, caregivers, or other community members change their behavior?

Negotiation

ALIDRAA is a method of negotiation that is proven to be effective in negotiating behavior change in the community. The method involves these steps:

- **A**sk.
- **L**isten.
- **I**dentify the problem.
- **D**iscuss options. Help the mother relate the content to his or her own situation by asking questions such as "What do you think about this?" "Does any of this apply to you? How?" "How would it benefit you?" Praise the mother for the good practices she is carrying out.
- **R**ecommend and negotiate possibilities.
- **A**gree on feasible action. The mother may agree to try a practice, or the two of you may agree on a referral to somewhere else for further help.
- Agree on an **A**ppointment to assess progress and discuss emerging issues and obstacles.

20.5 Practice negotiating with a mother of a baby 0–24 months old in an initial visit

Training methods

- Divide participants into **groups** of 3 (mother, community motivator, and observer). Give each group **Handout** 20.2. Ask the members to choose one of the case studies to **practice** negotiation with a mother in an initial visit. The observer should use the observation checklist. The participants should rotate roles.
- Ask the participants to **recall** the optimal breastfeeding and complementary feeding practices and **review** these if necessary.
- Ask 2 of the groups of 3 to **demonstrate** their case studies in plenary. These demonstration negotiations should include a mother with a baby under 6

months old and a mother whose baby is between 6 and 12 months old.
- Facilitate **discussion** and summarize in plenary.
- **Review** the key messages of the session.

Key messages

- Listening may be the most important skill in behavior change communication.
- Characteristics of good communication by community motivators
  - Two-way communication
  - Partnership between the community motivator and the community member
  - An atmosphere of caring and respect
  - Use of existing community networks
  - Effective verbal and non-verbal communication
  - Plenty of opportunity for asking and discussing

NEGOTIATION SKILLS: ALIDRAA

- **A**sk.
- **L**isten.
- **I**dentify problem(s).
- **D**iscuss options, helping mothers relate the content to their own situations by asking questions such as "What do you think about this?", "Does any of this apply to you? How?", "How would it benefit you?" Praise people for their good practices.
- **R**ecommend and negotiate possibilities.
- **A**gree on feasible action. A mother may agree to try a practice, or the two of you may agree to refer her to somewhere else for further help.
- Agree on an **A**ppointment to assess progress and discuss emerging issues and obstacles.

20.6 Materials

- Flipcharts, markers, and masking tape
- Handout 20.1: Observation Checklist: Negotiation Visit #1 (ALIDRAA)
- Handout 20.2: Practice Case Studies Babies 0–12 Months Old

HO 20.1

Observation Checklist: Negotiation Visit #1 (ALIDRAA)

- ❑ Greets the mother and establishes confidence.
- ❑ Asks the mother about current practices (breastfeeding/ FADUA) and listens to what she says. Identifies key problems, if any, and selects the most important one to work on.
- ❑ Listens to the mother.
- ❑ Identifies feeding problems and causes of the problem.
- ❑ Discusses different feasible options with the mother.
- ❑ Recommends and negotiates doable actions, presenting options and helping the mother choose one she can try.
- ❑ Gets the mother to Agree to try one of the options.
- ❑ Makes an Appointment for the follow-up visit.

Practice Case Studies 0–12 months

Case study #1: 0–6 months
You visit a new mother, Christina, who has a newborn son. Christina is breastfeeding, and her mother-in-law insists that she give water to her grandson.

Case study #2: 0–6 months
You visit Lydia, who has a $2\frac{1}{2}$-month-old daughter. Lydia is breastfeeding and has decided to give her daughter some gruel to accustom her to eating food.

Case study #3: 6–12 months
You visit Maureen, whose baby is $6\frac{1}{2}$ months old. Maureen tells you that her baby is too young for foods because his stomach is too small, so she will just continue to breastfeed him until he is older. Maureen's husband and mother-in-law agree with her.

Case study #4: 6–12 months
You visit Miriam, who has a 9-month-old daughter. The baby is eating some gruel once a day. You talk to Miriam about the need to add other foods to the porridge and to give fruit every day.

Case study #5: 6–12 months
You visit Josephina', whose baby is 12 months old. Josefina gives her baby bites of adult food at meal time only.

SESSION 21: USING EDUCATIONAL MATERIALS

Duration: 1 hour

21.1 Introduction

In this session participants learn the benefits, types, and use of educational materials in trying to change behavior.

21.2 Learning objectives

- Describe the benefits of using educational materials.
- Identify various educational materials.
- Describe how to use each type of material to the best advantage.

21.3. Benefits and types of educational materials

Training methods

- Divide participants into 4 **groups**.
- Ask each group to think of answers to the following questions: 1) What are educational materials? 2) What are the benefits of using educational materials? and 3) What are different types of educational materials?
- Ask the groups to **present** their results in plenary.
- Facilitate **discussion**, ask for feedback, and fill in gaps in information.

What are educational materials?

Educational materials are materials used to illustrate messages and improve communication.

What are the benefits of educational materials?

- Research shows that people retain:
  - 20 % of what they hear
  - 40 % of what they hear and see
  - 80 % of what they discover for themselves

- Speech (lecturing) is the least effective form of communication because it involves the fewest number of systems people use to transfer and receive messages.

- Education materials increase comprehension, retention, and the chances of taking positive action because they involve more of these primary message systems.

- **Benefits of educational materials**
  - Make learning more interesting and effective

- Remind the communicator of the important points to cover
- Simplify training because they can be given out as handouts and reference materials
- Remind the audience of the messages once they are back at home
- Help spread the messages among people who did not attend the educational session
- Make audiences happy because they have something to carry home
- Give messages importance and credibility

What kinds of educational materials are there?

1. **Materials which attract attention and trigger discussion** (posters)
   - Place these at vantage points where they can be seen by many people.
   - You can usually leave these materials unattended (not stand next to them to explain the messages on them).
   - **Improve the use of these materials by:**
     - Drawing attention to them when teaching and highlighting the messages on them.
     - Referring to them at every opportunity (e.g., during group discussions) to draw people's attention to them and encourage discussion of the messages
     - Training community members to understand the messages on the materials so that they can provide correct information during discussions and when they are asked questions about them.

2. **Materials which provide detailed information** (booklets or pamphlets)
   - **Improve the use of these materials by:**
     - Reading through them beforehand
     - In discussions with target groups, pointing to the information and pictures and holding them out for people to see.
     - Referring to relevant sections as you answer questions and drawing the audience's attention to those sections
     - Giving the materials out only after you have used them for discussion
     - Reminding the audience that the materials contain answers to many of their questions
     - Suggesting that the audience refer to the materials at home if they forget the information discussed

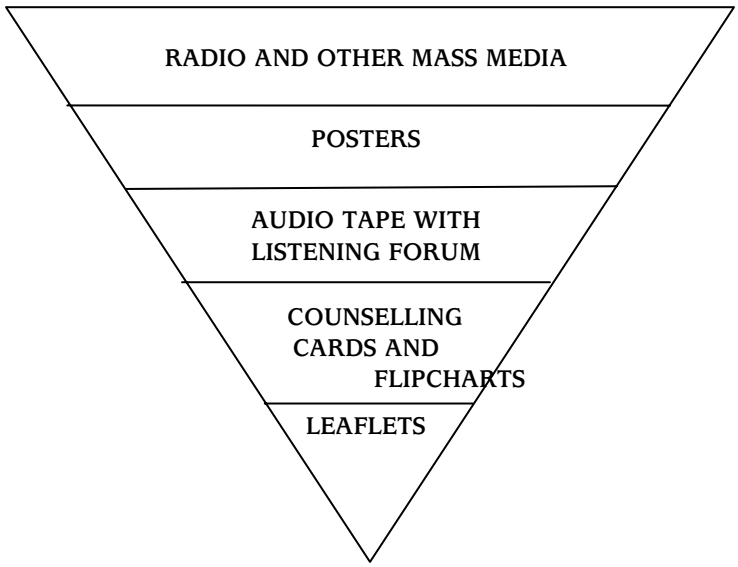
- Letting the audience know whether additional copies can be found
- Encouraging people who cannot read to look at the pictures or have a family member or friend read the materials to them
- Encouraging the audience to share and discuss the materials with other people

3. Special teaching aids (flipcharts, counseling cards)

- These materials may be used with groups or one-on-one.
- Sections may be selected, or the entire material may be covered.
- Improve the use of these materials by:
  - Reading and studying the materials in advance
  - Selecting the sections you wish to use
  - Planning how to use the selected materials (short, interesting educational sessions are better than long, boring ones).

Educational materials can be grouped according to their distance from the target audience (illustration 1).

Illustration 1: Classification of educational materials by distance from target audience



21.4 Use of visuals

Teaching methods

- Draw on a **flipchart** the experience cycle of a child who touches fire (Handout 21.1).
- **Explain** that a method called ORPDA is used to encourage people to reflect on and personalize their experience so they can learn from it and decide to change their behavior. Connect ORPDA to the stages of behavior change.
- **Demonstrate** how to use ORPDA with a group, using a counseling card. Distribute Handout 21.2.

- Facilitate **discussion** of the demonstration, using a flipchart with the observation checklist in Handout 21.3.
- Form participants into **groups** of 5 to **practice** facilitating an action-oriented group discussion. Ask them to take turns being observers, facilitators, and participants. Ask observers to use the observation checklist to provide feedback to the facilitators.
- Facilitate **discussion** of participants' experience using ORPDA.

Use the ORPDA facilitation method to improve the use of visuals. ORPDA stands for **O**bserve, **R**eflect, **P**ersonalize, **D**ecide and **A**ct.

OBSERVE

- Show target audience a visual.
- Ask them to share what they see.
- Discuss the message in the visual.
- Encourage participants to share what they think about the message (their views, feelings, experience applying the message, the appropriateness and feasibility of the message).

REFLECT

- Encourage the group to reflect of the experience of their fellow participants. Has anyone else been through a similar experience?
- Encourage others to tell their stories.
- Select one or two related experiences to discuss. Save other experiences in a notebook for discussion another day.
- Ask the group what they feel about these experiences.
- Ask what people learn from these experiences?

PERSONALIZE

- Encourage people in the group to relate the messages and ideas discussed to their own situations.
- Ask people for views on how these ideas or messages have helped them in the past or could help them in the future.

DECIDE

- Encourage people in the group to indicate what they plan or are willing to try as a result of the discussion.

ACT

- Encourage participants to try what they have chosen and set a date to come back and share their experience.
- During this session, ask them to share factors which made it easy to implement the chosen option.
- Ask them to share factors which made it difficult to implement the chosen option.
- Ask them to share how they resolved the difficulties.
- Ask them where they found additional help and support.

Follow up: Group facilitators may carry out visits to support participants in their homes

Next meeting: Set a date for the next meeting. The next meeting should start with a review of experiences based on what members said hey would try out.

Key messages

- Educational materials are materials used to illustrate messages and improve communication.
- People retain 20% of what they hear, 40% of what they hear and see, and 80% of what they discover for themselves.
- ORPDA (**O**bserve, **R**eflect, **P**ersonalize, **D**ecide, and **A**ct) can improve experiential learning and the use of visual materials.

21.5 Materials

- Flipchart, markers, and masking tape
- Handout 21.1: "How We Learn," using the ORPDA cycle
- Handout 21.2: "How to Use a Counseling Card with a Group"
- Handout 21.3: "ORPDA Observation Checklist: Using a Counseling Card with a Group"

HO 21.1

How We Learn: ORPDA

OBSERVE

The child touches the flame.

REFLECT

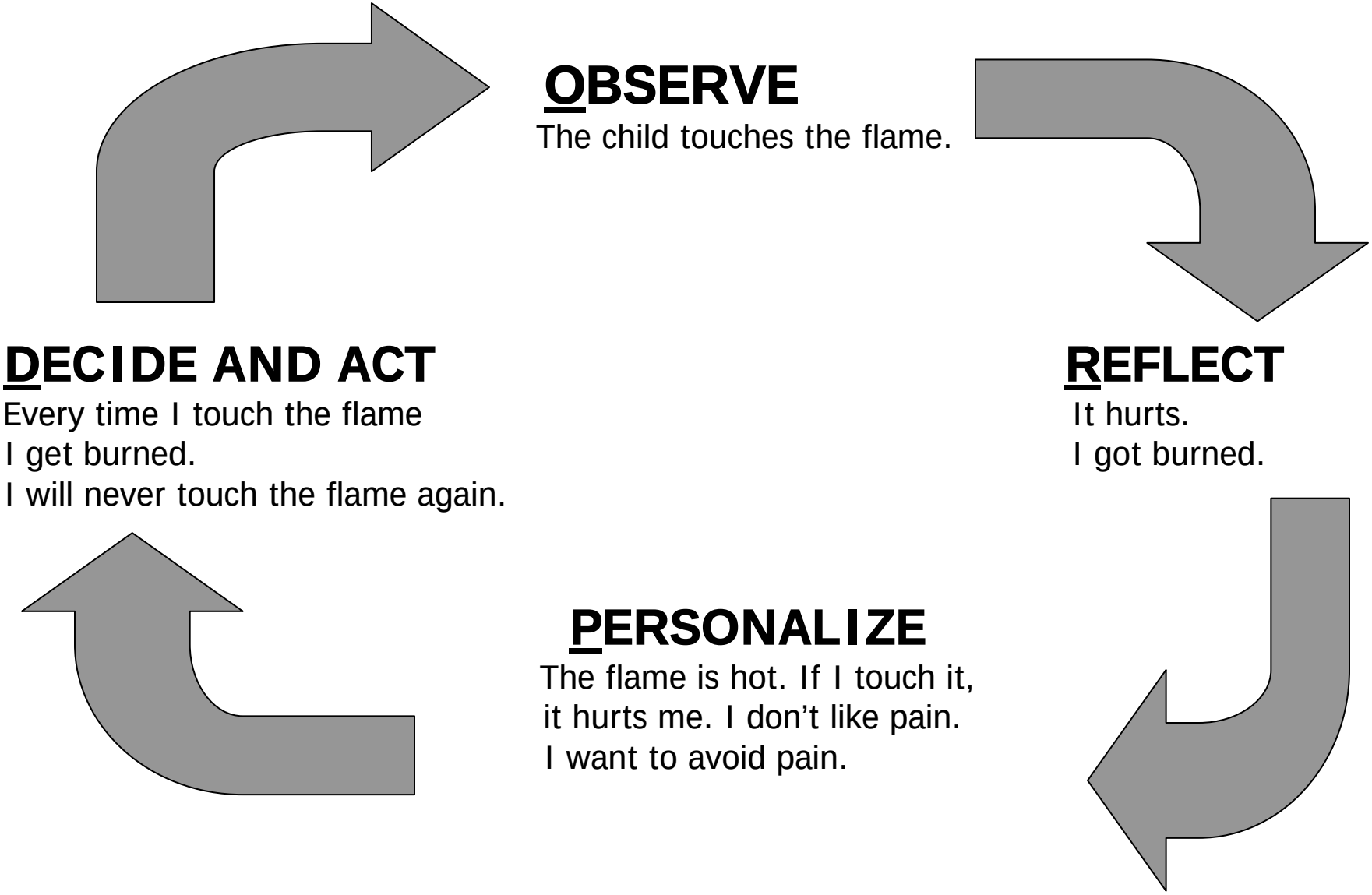
It hurts.
I got burned.

PERSONALIZE

The flame is hot. If I touch it,
it hurts me. I don't like pain.
I want to avoid pain.

DECIDE AND ACT

Every time I touch the flame
I get burned.
I will never touch the flame again.



How to Use a Counseling Card with a Group

Introduce yourself.

1. **OBSERVE**
   - Hold the counseling card so everyone can see it.
   - Ask the group: **WHOM do you see in the picture? WHERE are they?**
   - For each character in the picture, ask: **WHAT is he or she doing? HOW does he or she feel about what he or she is doing? Why is he or she doing that?**

2. **REFLECT**
   - **Ask what the group thinks of what each person is doing in the picture.** Ask with whom they agree. Why?
   - Ask with whom they disagree. Why?
   - Ask: **What is the advantage of adopting the practice shown on the counseling card?**
   - Discuss the key messages of today's topic.

3. **PERSONALIZE**
   - Ask: **What do the women** (or others) **in this community do in the same situation? Why?** What would YOU do in the same situation? Why?
   - Ask: What difficulties have you experienced? Were you able to overcome them? How?

4. **DECIDE and ACT**
   - Repeat the key messages.
   - Ask the group: **Would you be willing to try or recommend the practice shown on the counseling card?**
   - Ask the group: **How could you overcome obstacles to trying the new practice?**
   - Set a time for the next meeting and encourage participants to come ready to talk about what happened when they tried the new practice and how they overcame obstacles.

HO 21.3

ORPDA Observation Checklist for Using a Counseling Card with a Group

- ❑ Introduces self (name and organization) and puts people at ease
- ❑ Shows respect and interest
- ❑ Listens and looks attentively
- ❑ Shows counseling card to everyone
- ❑ Asks who is in the picture and what they are doing. Then explains the picture, giving the main message
- ❑ Asks whether the audience agrees with the practice shown on the card and why or why not
- ❑ Explains appropriate messages:
  - ……
  - ……
  - ……
- ❑ Asks how participants would handle the situation on the card
- ❑ Asks what keeps people from doing the recommended practice and how they might overcome these obstacles
- ❑ Repeats the message
- ❑ Asks whether participants would be willing to try this practice
- ❑ Sets a time for the next meeting and encourages participants to try the new practice and talk about how it went next time
- ❑ One or more things the facilitator did well:

_____

- ❑ One important thing the facilitator should work on to improve the next time:

_____

SESSION 22: ESTABLISHING AND WORKING WITH SUPPORT GROUPS

Duration: 1 hour

22.1 Introduction

Support groups are a strategy for behavior change. They allow people in a common situation to share information and experience and support one another. In this session participants experience the dynamics of a support group.

22.2 Learning objectives

- Participate in an infant and young child feeding support group.
- Describe the characteristics of a support group.
- Practice conducting a support group.

22.3 Experience an infant and young child feeding support group

Training methods

- With 8 participants, form a "**fish bowl**."
- Conduct an infant and young feeding **support group** in which the participants share their own (or their wives', mothers', sisters', etc.) experience with exclusive breastfeeding in a PMTCT program. Allow only participants in the "fish bowl" to talk.
- After the support group, **ask** the following questions of the support group participants:
  - What did you like in the support group?
  - Did your knowledge and attitudes about breastfeeding change?
  - Is the support group different from an educational talk?
  - Do you think we found answers to the doubts expressed in the support group?
- After this meeting, do you think you would try exclusive breastfeeding?

22.4Support groups

Training methods

- Set up 4 **flipcharts** throughout the room with the following headings: 1) Participants in an infant and young child feeding support group in a PMTCT program, 2) Role of the support group facilitator, 3) Characteristics of a support group, and 4) Reasons to form a support group.
- Divide participants into 4 **groups**. Give each group 4 minutes at each flipchart to try to answer the questions.
- Ask each group to **present** its results in plenary.
- Distribute and discuss **Handouts** 22.1and 22.2.

What is a support group?

A **support group** is a self-help group made up of people affected by the same conditions who come together to share experience, learn from one another, and strengthen and support each other. Support groups meet from time to time and they may engage in mutually beneficial activities such as educational activities or income generating ventures.

An **infant and young child feeding support group** is a group of mothers or caregivers that promote optimal infant feeding and complementary feeding behaviors and support one another. Such a group meets periodically and is usually facilitated by experienced mothers with breastfeeding and young child feeding knowledge who have mastered some group dynamics techniques. There are also mother/father support groups.

Who participates in an infant and young child support group in a PMTCT program?

- Breastfeeding mothers
- Mothers who have breastfed in the past
- Pregnant women
- Community workers
- Care takers and parents
- Formally trained health workers
- People who have had an HIV test and obtained their results

Who can facilitate a support group?

- Trained mothers
- Formally trained health workers
- Community workers

What do you need to be able to facilitate an infant and young child feeding support group?

- Experience in breastfeeding
- Residence in the community and acceptance by the community and health personnel

- Desire and willingness to learn from and share experience with pregnant women and mothers
- Good listening and communication skills
- Effective problem posing and questioning skills
- Care, consideration, and respect for other people
- Time to spare
- The support of your partner and family

22.5 Practice conducting a support group

Training methods

- Divide participants into 3 **groups** of 10 each.
- Ask each group to choose a topic for a support group meeting out of a basket.
- Ask 1participant from each group to act as the group facilitator.
- Ask the first group to demonstrate a support group around its topic in plenary. The other participants should fill out the support group checklist.
- Facilitate discussion in plenary.
- Repeat the procedure for the second and third groups.

22.6 Forming support groups

Training methods

- Ask participants the following **questions**:
  - Why would people form a support group?
  - How large should a support group be?
  - How can health promoters [community motivators?] and health workers help support groups?
- Facilitate **discussion** of the answers in plenary.
- **Review** the key messages of the session.

Why would people form a support group?

A person with a problem or a condition other people do not share, understand, or look kindly on may feel misunderstood, isolated, rejected, lonely, and burdened. He or she needs to talk to other people who have been through the same experience in order to:

- Feel that others are struggling with the same problem
- Feel accepted and understood
- Receive empathy and social and emotional support
- Get information to deal with day-to-day challenges
- Share experience, problems, and stories

- Learn about the difficulties other people go through and how they overcome them
- Feel strengthened by the success of others in similar circumstances

How large should a support group be?

A support group can have as few as 3 members and as many as 12. It should be small enough for each participant to be noticed and play an active role.

How can community motivators and health workers help support groups in a PMTCT program?

- **They can guide communities to form appropriate support groups.**
  - Discuss the need for support groups with local PMTCT program managers.
  - Discuss the need for support groups with community motivators during training or community meetings.
  - Discuss the kinds of support groups that may be appropriate in the community.
  - Identify existing support groups and analyze their strengths, weaknesses, and needs.
  - Discuss support group needs (Do they need to be formed? Strengthened?)
  - Agree on follow-up steps and a date to review progress.
  - Share progress reports and keep in contact with community motivators who facilitate the groups.
  - Visit the groups periodically and participate in their activities.

- **They can help the groups organize themselves effectively.**
  - Develop guidelines for support groups.
  - Appoint leaders.
  - Help leaders get training in group facilitation; interpersonal communication; negotiation skills and counseling; the use of information, education, and communication (IEC) materials to change behavior; and the use of observation checklists.

- **They can suggest beneficial activities.**
  - Meet from time to time in a place participants can reach easily.
  - With the assistance of a facilitator:
    - Share experiences, stories of difficulties and successes
    - Express ideas.
    - Share feelings.
    - Explore options.
    - Discuss and test new behaviors.
    - Discuss ways to resolve participants' difficulties.

- Share information on where to find help and other resources.
- Be there for one another.
- Learn from one another.
- Advocate for participants' needs with their partners and authorities.
- Disseminate information about themselves to other people so that other people may understand and support them.
- Recruit and receive new participants into their groups.
- Visit each other to share and support one another in their homes.
- Meet in people's homes, at health centers, in religious facilities, in schools, or under trees (short meetings of 60–90 minutes are better than long ones).

- **They can empower group leaders and facilitators with the following skills to lead their groups effectively:**
  - How to facilitate group discussion using participatory methods
  - How to encourage participants to share not only what they have been through, but also their ideas, feelings and solutions to the problems they encounter
  - How to facilitate discussion using ORPDA for educational materials

- **They can facilitate productive interactions.**
  - Lead discussions by asking questions, listening carefully, and motivating participants to share their experiences. He or she does not dictate or give instructions
  - Facilitate support group meetings at agreed intervals (every 2 weeks or every month)
  - Motivate eligible people from the community to join the support group.
  - Provide awareness and information
  - Promote favorable attitudes
  - Encourage participants to choose positive practices to try out
  - Give participants skills to implement the chosen decision (e.g., how to position and attach the baby on he breast properly)
  - Encourage participants to implement positive behaviors
  - Follow up and provide support that can ensure trial and continuation of the desired behaviors (e.g., by visiting participants in their homes to support them and making available information on where to go for support)
  - Keep a record of what is done and reports on it as agreed
  - Help participants share their experiences, analyze them and learn from one another
  - Help participants make their own decisions

Key message

- **A support group** is a group of people who share information and experience and give mutual support on something they have in common.

22.7 Materials

- Flipchart, markers, and masking tape
- Handout 22.1: Support Group Checklist for Facilitator
- Handout 22.2: Characteristics of a Support Group

HO 22.1

Support Group Checklist for Facilitator

- ❑ Sits in a circle at the same level as the rest of the group
- ❑ Introduces self 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
- ❑ Encourages everyone to talk, even the quieter participants
- ❑ Encourages participants to share experiences and ideas
- ❑ Repeats key messages
- ❑ Asks participants to summarize what they learned

Characteristics of a Support Group

1. Provides a safe environment of respect, and trust

2. Allows participants to:
   - Share information and personal experiences
   - Support each other through their own experiences
   - Strengthen or modify certain attitudes and practices
   - Learn from each other

3. Allows participants to reflect on their experiences, doubts, difficulties, popular beliefs, myths, information, and adequate practices. In this safe environment the participant has the knowledge and confidence needed to decide to either strengthen or modify his/her practices.

4. Is not a LECTURE or CLASS. All participants play an active role.

5. Focuses on the importance of interpersonal communication. In this way each participant can express his/her ideas, knowledge, and doubts, share experiences and receive and give support to the other women who make up the group

6. Has a seating arrangement that allows all participants to have eye-to-eye contact

7. Varies in size from 3 to 12 participants

8. Is usually facilitated by an experienced facilitator who listens and guides the discussion

9. Is open, allowing the admission of all interested participants

10. Is as long and held as often as the facilitator and the participants decide

SESSION 23: WOMEN'S NUTRITION

Duration: 1 hour

23.1 Introduction

Malnutrition is responsible for a wide range of negative short-term and long-term problems for women. Women's nutritional status affects child morbidity and mortality through the impact of birth weight. In this session participants learn the importance of maternal nutrition during pregnancy and lactation and identify what women can do to improve their nutrition.

23.2 Learning objectives

- Outline the importance of maternal nutrition during pregnancy and lactation.
- Identify what women can do to improve their nutrition status.
- Discuss the link between maternal nutrition and MTCT of HIV.

23.3 The importance of maternal nutrition during pregnancy and lactation

Training methods

- Ask participants the **questions**: 1) Why is maternal nutrition important in pregnancy and lactation? 2) How can a pregnant woman know whether she is eating enough? 3) Can a malnourished mother breastfeed her infant? and 4) What should a mother eat and do to maintain good nutrition?
- Facilitate a **discussion** and summary of the answers in plenary.
- **Review** the key messages of the session.

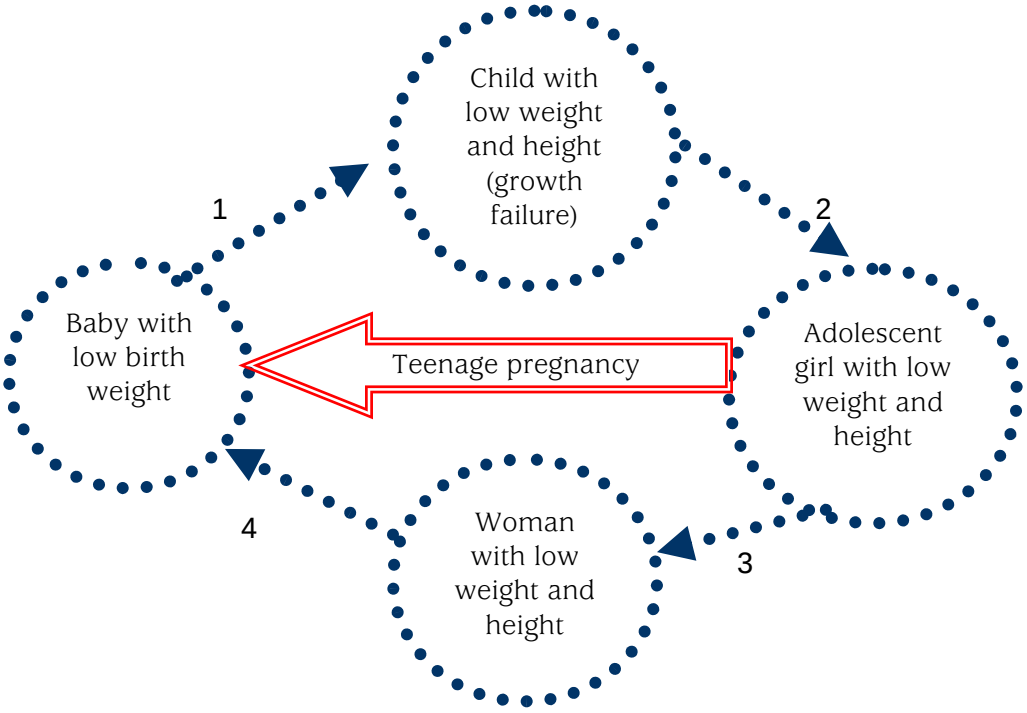
Why is women's malnutrition important during pregnancy and lactation?

- A mother needs to eat well to stay healthy. Women's nutritional status is even more important during pregnancy and lactation. A pregnant or lactating woman eats for two people, herself and her fetus or baby. If she does not eat enough good food, some nutrients are taken from her body reserves for fetus or baby, and she can end up malnourished.
- Malnourished mothers run a higher risk of transmitting HIV to her baby.
- When a woman is malnourished, the next generation may also suffer from malnutrition and poor health.
  - Babies tend to be born pre-term and are underweight at birth.
  - Children continue to be underweight and are stunted.
  - Some adolescent girls have their first pregnancy while they are underweight and stunted.
  - Women are undernourished, have close spaced pregnancies, and have heavy workloads during pregnancy and breastfeeding periods

which require considerable amounts of calories. All this can contribute to maternal nutritional depletion.

The cycle of malnutrition is shown in illustration 2 below.

Illustration 2: The cycle of malnutrition



How can a pregnant woman know if she is eating enough?

A woman should gain about 1kilogramme per month in the second and third trimesters of pregnancy. Women should attend antenatal clinics regularly so their weight can be monitored.

Can a malnourished mother breastfeed her infant?

Malnutrition does not change the composition of breastmilk significantly but can affect the total amount of milk produced. In extreme cases of famine, milk quality may decrease and supply may eventually stop.

What should a mother eat and do to maintain good nutrition?

- Eat at least 1 extra serving a day of staple foods during pregnancy and 1 extra meal a day during lactation.

- Gain at least 1kilogramme per month in the second and third trimesters of pregnancy and attend antenatal clinics regularly for weight monitoring.
- Rest more during pregnancy and lactation.
- Increase daily consumption of fruits and vegetables, animal products, and fortified foods, especially during pregnancy and lactation.
- Consume daily supplements of iron and folic acid during pregnancy and the first 3 months after delivery.
- Take a high-dose (red) vitamin A capsule immediately after delivery or within 8 weeks after delivery if breastfeeding and within 6 weeks after delivery if not breastfeeding.
- Reduce malaria infection during pregnancy.
  - Take weekly anti-malaria prophylaxis, starting at the first antenatal visit.
  - Seek treatment for fever during pregnancy.
  - Sleep under an insecticide-treated bed net.

- Reduce hookworm infestation during pregnancy
  - Wear shoes.
  - Dispose of feces carefully.
  - Seek anti-worm treatment in the second trimester of pregnancy.
- Space births at least 3 years apart.
  - If HIV negative, initiate breastfeeding within 1 hour after delivery.
  - Breastfeed exclusively for 6 months and continue to breastfeed for 2 years or more.
  - Practice family planning to space births at least 3 years apart.
  - Use contraceptives which do not interfere with breastfeeding.
  - Use condoms during pregnancy and lactation.

Key messages

- It is important for a mother to eat well to stay healthy.
- Maternal malnutrition facilitates MTCT.
- Pregnant and lactating women should eat well to maintain good nutrition.
- Mothers should eat at least 1extra serving of staple foods a day during pregnancy and an extra meal a day during lactation.
- Mothers should protect themselves against malaria and hookworm.
- Mothers should space births at least 3 years apart.

23.4 Materials

➢ Flipchart, markers, and masking tape

SESSION 24: CONDUCTING A COMMUNITY MOTIVATIONAL ACTIVITY

Duration: 3–4 hours

24.1 Introduction

In this session participants practice organizing and conducting a motivational activity in the community.

24.2 Learning objective

- Practice conducting a motivational activity in the community or health facility.

24.3 Field practice in the community or health facility

Note: Make an appointment at the health centre a week ahead for immunization or weighing sessions and/or make an appointment with appropriate people for village visits.

Training methods

- Divide participants into **groups**. Ask each group to choose a topic to promote in the community of health facility and an activity to promote it (e.g., a health talk, a small group discussion, one-on-one counseling, work with a support group). Ask the groups to plan how they will carry out the activities and assemble the educational aids they will need.
- Urge participants to use ALIDRAA, FADUA and ORPDA as much as possible.
- Distribute **Handout** 24: Record of Activities, and ask participants to fill in the sample record form using the motivational activity they conducted in the community.
- Allow the participants enough time to conduct their **activities** in the community or health centre.
- On their return, ask each group to **summarize** its experience:
  - What activity did you carry out?
  - Who was in the audience?
  - What were the objectives of the activity?
  - What was the general content or area of discussion?
  - What educational materials, if any, did you use?
  - What was the reaction of the audience?
  - How did you feel as you were implementing the activity?
  - What lessons have you learned implementing this activity?
- Ask participants to give each other **feedback**.
- Facilitate **discussion** and summarize.

Lessons learned from past motivational activities in the community

1. Mothers hear conflicting messages. Messages need to be corrected.
2. There is a great deal of misinformation, myth, and misconception about HIV and AIDS in the community.

3. People have many unanswered questions and are asking them but do not always get answers readily.
4. Health workers do not always have the knowledge or time to deal with community members' questions and concerns.
5. There is perceived and real lack of appropriate complementary foods in homes.
6. Health promoters usually use verbal communication, which often fails to help mothers visualize or accept information (for example, that if you boil breastmilk it does not turn into blood). There is a need for more interaction and visual and experiential approaches (for example, demonstrating boiling breastmilk so mothers can see what happens to it) to help community members visualize and personalize information and act on messages.

24.4 Materials

- Posters
- Leaflets
- Observation checklists
- Handout 24: Record of Activities

HO 24

Record of Activities

Date	Place or address	Purpose	Number in audience	Audience description	Activity

SESSION 25: THE BABY-FRIENDLY HOSPITAL INITIATIVE IN THE CONTEXT OF HIV

Duration: 40 minutes

25.1 Introduction

This session explains the continued importance of the Baby-Friendly Hospital Initiative in HIV-affected communities.

25.2 Learning objectives

- Describe the Baby-Friendly Hospital Initiative (BFHI).
- Describe how a community can apply BFHI concepts to promote optimal infant and young child feeding.
- Determine how to apply the BFHI concept in the context of HIV.

25.3 The Baby-Friendly Hospital Initiative

Training methods

- Ask participants what the Baby-Friendly Hospital Initiative (BFHI) is and what communities know about BFHI.
- Write responses on a **flipchart** and fill in gaps in information.
- Ask the participants what community members can do to promote BFHI.
- Facilitate **discussion** and summarize.

What is the Baby-Friendly Hospital Initiative?

- The Baby-Friendly Hospital Initiative (BFHI) promotes, protects, and supports successful breastfeeding in maternity hospitals and health facilities that have services for mothers and babies.
- BFHI increases awareness of the critical role of the health services in protecting, promoting, and supporting breastfeeding.
- BFHI describes what to do to give mothers appropriate information and support for successful breastfeeding.
- Baby-friendly facilities also help HIV-positive mothers who decide not to breastfeed to make another infant and young child feeding choice and support them in their decision.

What should community members know about BFHI?

- Certified baby-friendly hospitals provide HIV counseling and testing, including information on infant and young child feeding options.
- BFHI encourages mothers to be and sleep with their babies immediately after delivery regardless of HIV status or feeding choice.

- Baby-friendly facilities give pregnant women information on the benefits and management of breastfeeding.
- They also provide information on prevention of HIV, including infant and young child feeding counseling in the context of HIV.
- Baby-friendly facilities help mothers initiate breastfeeding within 1 hour of delivery and facilitate bonding by helping mother hold their babies skin-to- skin immediately after delivery. This pleases the mother and promotes successful initiation of breastfeeding.
- Baby-friendly facilities help mothers who decide to breastfeed to establish breastfeeding, including the use of good breastfeeding techniques to prevent nipple damage and other breast conditions which can facilitate HIV transmission.
- Baby-friendly facilities do not give mothers any feeding schedule. They encourage mothers to breastfeed on demand.
- Baby-friendly facilities support mothers to use cups to feed babies because teats and pacifiers interfere with breastfeeding, carry infection, and are not needed even for babies that are not breastfeeding.
- Baby-friendly facilities encourage formation of support groups which can support mothers after they are discharged from the hospital.

What can community members do to promote BFHI?

- Inform all parents about the superiority of breastmilk.
- Tell pregnant mothers to demand services and support promoted by BFHI.
- Promote the formation of infant and young child feeding support groups where mothers can be referred.

Key messages

- **The Baby-Friendly Hospital Initiative** promotes, protects, and supports successful breastfeeding in maternity hospitals and health facilities which provide service to mothers and babies. BFHI also helps HIV-positive mothers who decide not to breastfeed to make another infant and young child feeding choice and supports them in their decision.

25.4 Materials

➢ Flipchart, markers, and masking tape

SESSION 26: CODE OF MARKETING OF BREAST-MILK SUBSTITUTES

Duration: 40 minutes

26.1 Introduction

This session examines the marketing of commercial baby foods in the context of HIV.

26.2 Learning objectives

- Describe key elements of the national Code of Marketing of Breast-Milk Substitutes.
- Discuss the relevance of the Code in the context of HIV.
- Discuss what community members can do to protect and support breastfeeding.

26.3 The Code of Marketing of Breast-Milk Substitutes

Training methods

- **Display** on a table local commercial infant formulas, company infant and young child feeding posters and advertisements, feeding bottles and teats, and complementary foods promoted for babies under 6 months old.
- Using the commercial products as visuals, ask participants the following **questions**: 1) What is the Code of Marketing of Breast-Milk Substitutes? 2) Why are rules needed to regulate marketing of these products? 3) What does the Code prohibit? and 4) What can parents and community members do to follow and enforce the Code?
- Divide display products among participants. Ask if each product complies with the Code.
- Facilitate **discussion** and summarize.

What is the Code of Marketing of Breast-Milk Substitutes?

The **Code of Marketing of Breast-Milk Substitutes** is a set of rules which specify how to market the following products:

- Breastmilk substitutes, including infant formula and follow-up milks
- Complementary foods such as juices, waters, teas, and cereals that are marketed as suitable for babies under 6 months old
- Feeding bottles and teats

Why do we need rules to regulate marketing of these products?

- To ensure that products include complete and accurate information so customers can make informed decisions about buying them
- To promote, protect, and support breastfeeding
- To protect artificially fed infants by ensuring that product labels carry the necessary instructions, warnings. and instructions for safe preparation and use
- To ensure that customers choose products on the basis of independent medical advice instead of commercial pressure

What does the Code prohibit?

- Companies from advertising infant foods to the public
- Companies from giving free gifts to mothers or health workers
- Employees of manufacturing companies advising mothers
- Manufacturers or health workers giving free samples or supplies to pregnant women or mothers
- Manufacturers using words or pictures that promote artificial feeding on labels
- Companies or hospitals promoting products (for example, condensed milk) which are unsuitable for babies
- Companies or hospitals promoting complementary foods for babies below 6 months old
- Product labels that do not include information on the benefits or superiority of breastfeeding over artificial feeding and the dangers of bottle feeding

What can parents and community members do to follow and enforce the Code?

- Seek the advice of a health worker before putting the baby on commercial formula.
- Report to the Ministry of Health any health worker or company that is involved in practices which go against the provisions of the Code.

Key messages

- Breastmilk remains the best food for a baby, and a baby less than 6 months old should be given other foods only if it is absolutely necessary.

- Seek the advice of a health worker before putting a baby on commercial formula.
- Report to the Ministry of Health any health worker or company that is involved in practices which go against the provisions of the Code.

26.4 Materials

- Flipchart, markers, and masking tape
- Commercial breastmilk substitutes and products (different infant formulas, company infant and young child feeding posters and advertisements, feeding bottles and teats, and complementary foods promoted for babies under 6 months old)

SESSION 27: INVOLVING THE COMMUNITY AND MEN IN PMTCT

Duration: 1 hour

27.1 Introduction

Community support is critical to sustain an integrated PMTCT program. This session examines the types of support needed for infant and child feeding and PMTCT.

27.2 Learning objectives

- List support systems in the community.
- Describe strategies to establish a support system.
- Discuss male involvement in PMTCT.

27.3 Local community support for PMTCT

Training methods

- Draw 3 columns on a **flipchart** and label them "Institutions", "Individuals", and "Locations where PMTCT activities can be organized".
- **Brainstorm** with participants the institutions and individuals in the local community that support PMTCT.
- Brainstorm the places where PMTCT activities can be organized.

What institutions and individuals in this community support PMTCT?

Table 1 shows possible answers. Support activities and approaches will vary according to the venue, audience, and environment.

Table 1 Community support for PMTCT

Institutions	Individuals	Locations where PMTCT activities can be organized
Neighborhood committees	Community leaders	Health facilities, especially ANC, MCH, and family planning
Breastfeeding support groups	Mothers and other women	Places where women's groups meet (including kitchen parties)
Support groups	Experienced community members	Health facilities, community

Institutions	Individuals	Locations where PMTCT activities can be organized
Orphans and vulnerable children's committees	Fathers and other men	Homes
Home-based care groups	Men's group leaders	Village, section, or ward meetings
Area-based organizations	Men in recreation areas	Health centre meetings
Youth organizations	Youth and youth leaders	Youth-friendly corners
Faith-based organizations	Women's group leaders	Places of worship
Nongovernmental organizations (NGOs)	Traditional healers	Organizations' facilities
Community-based organizations (CBOs)	Traditional birth attendants (TBAs)	Markets
Political parties	Growth monitors and promoters	Political party meetings
Cooperatives	Pastors	Workplaces
Schools	Teachers	Schools (special meetings for adults)
Bars, taverns, and clubs	Traditional leaders	Bars, taverns, clubs, other entertainment places, men's fellowships, men's sections in churches
	Home-based care volunteers	Border posts
		Funerals

27.4 Male involvement in PMTCT

Training methods

- **Brainstorm** with participants reasons men should be involved in PMTCT activities.
- Facilitate **discussion** of the answers.
- **Brainstorm** what men can do as spouses, fathers, and heads of families to promote PMTCT behaviors.
- Facilitate **discussion** of the answers.

Why should men be involved in PMTCT activities?

- Men have a lot of power in the community and influence what happens both in the community and in their families.
- As the heads of families, men should provide leadership in matters of health.

What can men do as spouses, fathers, and heads of families to promote PMTCT behaviors?

- Learn facts about reproductive health, including STIs and HIV and AIDS.
- Lead by example, serving as a role model for PMTCT behaviors.
- Promote discussion of reproductive health and PMTCT behaviors at home.
- Encourage women to attend ANC at the first sign of pregnancy and book appointments.
- Promote abstinence, having one sexual partner, and using a condom.
- Be tested and counseled for HIV together with their spouses.
- Share test results with partners, discussing what to do next in view of the results, and providing leadership and cooperation to ensure that the agreed steps are taken.
- Cooperate and take the lead in using condoms.
- Learn about pregnancy and lactation and educate other men on these subjects so they can support their wives and partners.
- Support partners and spouses in eating well during pregnancy and lactation and making a variety of adequate nutritious foods available.

- Provide partners and spouses with enough money to purchase a variety of adequate and available nutritious foods.
- Helping partners and spouses with work at home so they can devote more time to breastfeeding.
- Discuss appropriate feeding options with partners, spouses, and health professionals and support agreed choices.
- Promote discussion of the role of men in PMTCT and infant and young child feeding in formal and informal gatherings such as PTA meetings and club events.
- Join father/mother support groups.
- Form new men's support groups as appropriate.

27.5 Activity plans

Training methods

- **Brainstorm** with participants the activities they can conduct after the training to promote health-seeking and HIV prevention behaviors.
- Group community motivators from the same areas and ask them to develop activity plans for the next 3 months. Ask each group to write 4 columns on a piece of paper: 1) *Groups of women* they will work with (pregnant women, breastfeeding and wet nursing mothers, women of reproductive age, HIV-positive mothers, parents), 2) *MTCT risk behaviors* specific to each group, 3) *Activities* the community motivators will perform, and 4) *Locations* where the activities will be conducted (see Sample action plan).
- Ask the groups to **present** their activity plans in plenary.
- Give the groups **feedback** on their plans.
- **Review** the key messages of the session.

What can community motivators do to promote health-seeking and HIV prevention behaviors?

- Increase the number of women who attend ANC.
- Increase the number of people who go for HIV testing and counseling, share results with their partners, and cooperate with their partners to take needed actions according to the test results.
- Increase the number of young unmarried people who abstain from sexual intercourse or delay it until they are married.
- Increase the number of couples and young people who stay faithful to one sexual partner.
- Increase the number of people who use condoms during casual sex or while pregnant or breastfeeding.

- Increase the number of HIV-negative women and women of unknown HIV status who breastfeed their babies exclusively for the first 6 months of life.
- Increase the number of HIV-positive couples who go for counseling at health facilities on how to feed their babies during the first months of life.
- Increase the numbers of people and groups that provide support to HIV-positive people, breastfeeding support to nursing mothers, and support consistent abstinence, fidelity and condom use.

Planning of motivation activities starts with the community motivator and ends with planning at the health centre level through the following stages:

- The community motivator prepares an **individual activity plan**.
- The plan is shared during zonal meetings.
- Community motivators' plans are consolidated during these meetings.
- During neighborhood health committee (NHC) meetings, zonal leaders consolidate these plans into an **NHC plan**.
- Representatives of the various neighborhood committees meet heath centre representatives and consolidate the plans into one **health centre plan**.

Key messages

- Community motivators need to know about local people and institutions that support PMTCT and the places where PMTCT activities can be organized.
- Men can and should play an important role in PMTCT.
- Community motivators should develop activity plans for PMTCT support.

27.6 Materials

- Flipchart, markers, and masking tape
- Sample Activity Plan

Sample activity plan

Target audience	MTCT risk behaviors	Motivators	Activities	Place
Pregnant women	• Not going for VCT • Not going for ANC • Having sex without a condom • Having multiple partners	• Community health workers, nurses, doctors • Counselors • Community members (e.g., fathers, mothers) • Father–mother support groups	• Education sessions • Experience sharing • Focus group discussions • Baby-Friendly Hospital Initiative • Follow up, drama	• Clinics • AIDS service organisations • Growth monitoring promotion (GMP) points • Churches • Special meetings
Breastfeeding and wet nursing mothers	• Not going for VCT • Initiating breastfeeding late • Using poor breastfeeding practices • Having unsafe sex	• Community health workers • Father–mother support groups • Clinic nurses • Caregivers • Growth monitoring promoters	• Discussion • Drama • Group discussion • Home visits • Experience sharing • Formation of clubs	• GMP points • Clinics • Churches • Hospitals • Schools
Women of reproductive age (13–25 years old)	• Being pregnant for the first time • Booking ANC late • Not going for VCT	• Community health workers • Father–mother support groups • Parents • Doctors and nurses	• Group discussion • Health education • Drama performances • Follow up and home visits	• Communities • Clinics • Churches • GMP points
Women of reproductive age (26–35 years old)	• Booking ANC late • Giving birth at home • Not going for VCT	• Community health workers • Father–mother support groups	• Group discussion • Health education • Drama performance • Follow up and home visits	• Communities • Clinics • Churches • GMP points
Women of reproductive age (36–49 years old)	• Booking ANC late • Giving birth at home • Not going for VCT	• Community health workers • Father–mother support groups	• Group discussion • Health education • Drama performance • Follow up and home visits	• Communities • Clinics • Churches • GMP points
HIV-positive mothers/parents	• Not going for VCT • Not attending ANC • Using mixed feeding • Not practicing family planning • Not getting immediate treatment • Not using condoms	• Community health workers • Health providers • Church leaders • Peer educators • Nutrition promoters • Father–mother support groups • Church leaders	• Group discussion • Health education • Drama performances • Follow up and home visits Educational video shows • Songs and dances • Radio programs • Free condom distribution	• Community • Clinic • Churches • Counseling centers • Clinics • Weighing points

SESSION 28: MONITORING (RECORD KEEPING) AND THE USE OF MONITOTRING INFORMATION IN THE COMMUNITY

Duration: 30 minutes

28.1 Introduction

Community monitoring involves collecting, analyzing, and **using** accurate and reliable information to improve program implementation.

28.2 Learning objectives

- Describe PMTCT activities community motivators will be involved in after training.
- Identify records community motivators should keep for their own use and to share with others.
- Build consensus on the format to use for record keeping.

28.3 Information: why, what, where, and who?

Training methods

- **Brainstorm** with participants the answers to the following questions: 1) Why should we keep records of community activities? 2) What information should be recorded? 3) Where should this information be kept? and 4) With whom should the information be shared?
- In plenary ask 5 participants to **share** the results of **Handout** 24: Record of Activities form that they filled out during the motivational activity they conducted in the community.
- Give and ask for **feedback**.
- **Review** the key messages of the session.

Why should we keep records?

- For personal reference
- To share the information with health workers
- To improve program planning
- To improve program performance
- To improve program management
- To determine the outcomes of activities

What information should be recorded?

- Date
- Address

- Purpose of the visit
- Description of the activity
- Number in the audience
- Audience description (e.g., age, gender, role, status)
- Issues and questions asked during the activity
- Action taken by the motivator

Where should we keep this information?

In a hard-cover book provided by LINKAGES through the Central Board of Health

With whom should we share this information?

The information should first be used by the motivator to improve his or her activities. Then it should be shared:

- During zonal meetings (chaired by zonal supervisors)
- During neighborhood health committee meetings (also attended by staff of health facilities)
- During residential development committee meetings
- With visitors who come to the project

Key messages

- Activities should be monitored and records should be kept for:
  - Personal reference
  - Sharing information with health workers
  - Improving program planning
  - Improving program performance
  - Improving program management
  - Determining outcomes of activities

28.4 Materials

- Flipchart, markers, and masking tape
- Handout 28: Sample Record-Keeping Form

Sample Record-Keeping Form

HO 28

Date	Place or address	Purpose	Number in audience	Audience description	Activity

GLOSSARY

Active (or responsive) feeding: Encouraging a child to eat by talking to, praising, and helping the child put food on the spoon

AFASS: Acceptable, feasible, affordable, sustainable, and safe

Artificial feeding: Feeding a baby a breastmilk substitute

Bottle feeding: Feeding a baby a liquid (e.g., expressed breastmilk, water, or formula) from a bottle

Breastmilk substitute: Any food marketed or otherwise represented as a partial or total replacement for breastmilk, whether or not it is suitable for that purpose

Cessation of breastfeeding: Stopping breastfeeding

Commercial infant formula: A breastmilk substitute manufactured industrially in accordance with applicable Codex Alimentarius standards to satisfy the nutritional requirements of infants up to 6 months old

Complementary feeding: Giving a baby other liquids and foods along with breastmilk or other form of a milk diet beginning at around 6 months of age

Complementary food: Any manufactured or locally prepared food suitable as a complement to breastmilk or infant formula when the latter are no longer sufficient to satisfy a baby's nutritional requirements (previously referred to as weaning food or breastmilk supplement)

Cup feeding: Feeding a baby from an open cup

Demand feeding: Breastfeeding a baby when and as long as the baby wants to nurse

Exclusive breastfeeding: Giving a baby no food or drink except breastmilk, not even water or breastmilk substitute (with the exception of drops or syrups containing vitamins, mineral supplements, or medicine)

Exclusive replacement feeding: Giving a baby a breastmilk substitute (commercial infant formula or home-prepared formula) only, with no breastmilk

Human immunodeficiency virus (HIV): In this document refers to HIV-1, as cases of mother-to- child transmission of HIV-2 are rare

HIV counseling and testing: Testing for HIV, usually antibody, that is voluntary, confidential, based on fully informed consent, and accompanied by pre- and post-test counseling; also referred to as voluntary counseling and testing (VCT)

HIV-negative: Tested for HIV with a negative result

HIV-positive or HIV-infected: Tested for HIV with a positive result (also referred to as "living with HIV")

Home prepared formula: Infant formula prepared at home from fresh or processed animal milks, suitably diluted with water and with sugar added

Infant: A child from birth to 12 months of age

Micronutrients: Nutrients required by the body in small quantities (e.g., vitamin A, iron, iodine)

Mother-to-child transmission (MTCT): Transmission of HIV to an infant from an HIV-positive woman during pregnancy, labor and delivery, or breastfeeding (also referred to as vertical transmission)

Nutrients: Substances that come from food and are needed by the body (i.e., carbohydrates, proteins, fats, minerals, and vitamins)

Nutritional needs: Amounts of nutrients needed by the body for normal functioning, growth, and health

Of unknown HIV status: Refers to a person who has not been tested for HIV or who has been tested but does not know the result

Partial breastfeeding: Giving a baby some breastfeeds and some artificial feeds (milk, cereal, or other food)

Porridge: Cereal flour, grated cassava or other roots, or grated fruit cooked with water until it is smooth and soft

Replacement feeding: Feeding a child who is not receiving any breastmilk with a diet that provides all the nutrients the child needs. For the first 6 months this diet should be a suitable breastmilk substitute, either commercial or home-prepared formula with micronutrient supplements. After 6 months the diet should be a suitable breastmilk substitute complemented with appropriately prepared and nutrient-rich family foods 3 times a day. If suitable breastmilk substitutes are not available, the baby should receive appropriately prepared and further enriched family foods 5 times a day.

Seroconversion: The development of antibodies to a particular antigen as a result of infection or immunization. When people develop antibodies to HIV, they "seroconvert" from antibody negative to antibody positive.

Staples: The main foods people eat, usually grains or cereals, starchy roots and fruits

VCT: Voluntary counseling and testing (also referred to as HIV counseling and testing)

Viral load: Amount of HIV virus in the blood of an HIV-infected person

Wet nursing: Breastfeeding of a baby by a woman other than the mother who is breastfeeding her own child.