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Planning and Adaptation Guide

The Community Infant and Young Child Feeding Counselling Package

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Contents

Acronyms

ANC	antenatal care
ARVs	anti-retroviral drugs
BFHI	Baby Friendly Hospital Initiative
CC	counselling card
CCM	community case management
CHS	Center for Human Services
CHW	community health worker
CMAM	community management of acute malnutrition
CSHGP	Child Survival and Health Grants Program
CWs	community workers
DHS	demographic and health survey
ENA	essential nutrition actions
ENN	Emergency Nutrition Network
FGD	focus group discussion
GMP	growth monitoring and promotion
HIV	human immunodeficiency virus
IASC	Inter-agency Standing Committee
IDIs	in-depth interviews
IFE	infant feeding in emergencies
IMCI	integrated management of childhood illness
IYCF	infant and young child feeding
KAP	knowledge, attitude and practice
KII	key informant interviews
LAM	lactation amenorrhoea method
LQAS	lot quality assurance sampling
MAMAN	minimum activities for mothers and newborns
MICS	multiple indicator cluster survey
MNC	maternal and newborn care
MUAC	mid upper arm circumference
NGOs	non-governmental organization
NPP	Nutrition Policy and Practice
PMTCT	prevention of mother-to-child transmission
SAM	severe acute malnutrition
SC	stabilisation centres
SFP	supplementary feeding program
SOW	scope of work
TB	tuberculosis
TBAs	traditional birth attendants
UN	United Nations
UNICEF	United Nations Children's Fund
URC	University Research Company
USAID	United States Agency for International Development
VCT	voluntary counselling and testing
WHO	World Health Organization

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The various elements of the *Community IYCF Counselling Package* are based on WHO/UNICEF IYCF guidance documents, training and other materials, including the WHO/UNICEF Breastfeeding, Complementary Feeding and Infant and Young Child Feeding Counselling training courses. The package also builds on materials developed by the Academy for Educational Development's LINKAGES Project; the CARE USA and URC/CHS collaboration in Dadaab Kenya; and the *Integration of IYCF Support into Community Management of Acute Malnutrition (CMAM)*, produced by the ENN/IFE Core Group and IASC Global Nutrition Cluster. The technical content of the package aims to reflect the *Guidelines on HIV and Infant Feeding 2010: Principles and Recommendations for Infant Feeding in the Context of HIV and a Summary of Evidence* related to IYCF in the context of HIV. The graphic package draws heavily from IYCF behaviour change materials and other job aids developed with the technical support of URC/CHS, financed by the United States Agency for International Development (USAID) in Tanzania, Uganda, Niger and Benin; CARE USA in Dadaab, Kenya; and the UNICEF offices in Kenya and Malawi.

The *Community IYCF Counselling Package* has been developed by the UNICEF New York, Nutrition Section team of Nune Mangasaryan, Senior Advisor, Infant and Young Child Nutrition; Christiane Rudert, Nutrition Specialist (Infant Feeding); Mandana Arabi, Nutrition Specialist (Complementary Feeding); in close collaboration with the NPP and URC/CHS team of Maryanne Stone-Jiménez, IYCF Training Expert; Mary Lung'aho, IYCF Community/Emergencies Expert; and Peggy Koniz-Booher, IYCF Behaviour Change and Job Aids Expert. The package layout and illustrations were developed by Kurt Mulholland, Senior Graphic Artist; and Victor Nolasco, Senior Graphic Illustrator. Thanks to the many country teams involved in the development and pre-testing of previous materials.

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Introduction

The *Planning and Adaptation Guide* for the *Community Infant and Young Child Feeding (IYCF) Counselling Package* outlines a summary of a series of steps and provides selected tools for use by national or local stakeholders interested in designing community-based IYCF promotion, counselling and support activities, as well as detailed tools and checklists for adapting various training and communication materials for use in their own setting. *The Community IYCF Counselling Package* focuses on the aspect of training and follow-up of community workers, while other aspects of designing and implementing a community based IYCF programme are summarized. This *Planning and Adaptation Guide* does not aim to comprehensively and in detail address all aspects needed for designing, implementing and monitoring a community-based IYCF programme.

The *Community IYCF Counselling Package* includes the *Facilitator Guide* for use in training community workers (CWs); the *Participant Materials,* consisting of "handouts" and monitoring tools; a set of 28 *IYCF Counselling Cards* and companion *Key Messages Booklet*; 3 *Take-home Brochures*; and this *Planning and Adaptation Guide*. It also includes a "Clip Art" Compendium to support the adaptation and/or development of high quality graphics. All of the materials found in the *Community IYCF Counselling Package,* described in more detail below, are available in their electronic formats to facilitate their dissemination, adaptation and use.

This *Planning and Adaptation Guide* recognizes that each country or setting potentially interested in developing and/or expanding a community IYCF programme and adopting the *Community IYCF Counselling Package* has different modalities and structures for community-based programmes, and that each country will have to identify the most appropriate entry points and approaches to implementation of community-based IYCF counselling and other activities, e.g. mother support groups. Ideally, community-based IYCF programmes and activities should build upon existing health and nutrition programmes to the extent possible, rather than creating new and separate or parallel structures**.** "Integration without dilution" should be the guiding principle for operationalizing a quality community-based IYCF programme at scale.

It also recognized that each country has socio-cultural differences, including dietary behaviours (food preparation and feeding), clothing styles, and linguistic characteristics, unique to its ethnic population(s). These differences need to be taken into consideration and reflected in all IYCF-related training and counselling materials. Such variables generally need to be systematically addressed in order to ensure that the package is appropriate, engaging, relevant, responsive and usable in the local setting.

How to Use this *Planning and Adaptation Guide*

The process for designing or strengthening community-based infant and young child feeding programmes, in any setting, is envisioned as having two parts. First of all, policies and systems need to be updated or developed and put into place to support the implementation of a range of community IYCF activities, along with the knowledge and skills development and supervision/ mentoring of community workers (CWs). Ideally, these policies and systems should link to and integrate with existing health and nutrition services. National teams or organizations interested in designing community-based programmes and activities to support community IYCF can follow the 5 basic steps outlined in the *Planning and Adaptation Guide* to design and strengthen activities for IYCF promotion, counselling and support.

Secondly, training curricula need to be designed, and tools developed to support counselling and behaviour change, supervision and mentoring, as well as monitoring and evaluation. To address these needs and guide the process, the *Community IYCF Counselling Package* was created, providing a fully integrated set of materials for use at the community level. The package is intended as a generic resource, designed to equip community workers (CWs) to promote behaviour change and support mothers, fathers and other caregivers to optimally feed their infants and young children. The package is based on a number of WHO/UNICEF IYCF-related training and guidance materials (described in detail in the *Facilitator Guide*), as well as counselling and behaviour change communication tools currently being used in a number of countries.

The proposed adaptation process involves the review of the generic package in its entirety by a national team of IYCF-related stakeholders, who then adapt and test various elements of the technical content and visual aspects of the package, as needed, depending on their specific context.

For the development of the training curricula, ten basic steps are recommended for adapting the technical content and graphics of the *Community IYCF Counselling Package*. All of these steps are based on multiple experiences in a number of countries where infant and young child feeding programmes and similar integrated packages have been developed and/or adapted, field tested and introduced on a large scale. They highlight a technically correct and doable process and identify specific elements of the generic package that will most likely need to be addressed in order to ensure the relevance of the materials.

These steps encourage a thoughtful planning process and provide a logical framework and outline of key activities. The steps provide guidance for consideration by national teams, and should be adjusted as needed to meet local needs. For adaptation of the *Community IYCF Counselling Package,* various tools, including an adaptation checklist, translation matrices and a sample focus group discussion guide for field testing the IYCF graphic materials are available to facilitate this part of the process by national stakeholders. Such tools do not guarantee success, however. The adaptation will require leadership, the dedication of resources and one or more champions who will commit the time and energy needed to guide the process from start to finish.

Part 1: Planning for Community IYCF Programmes

The community offers indispensable resources for Infant and Young Child Feeding (IYCF) promotion, counselling and support. In a number of countries, community-based programmes already offer concrete opportunities and afford useful entry points for IYCF, while in other settings, new programme frameworks - specifically tailored to the local context – will need to be designed and introduced.

Ideally, community-based IYCF programmes and activities should build upon existing health and nutrition programmes to the extent possible, rather than creating new and separate or parallel structures**.** At the same time, the programme needs to be designed and implemented in such a way that the IYCF component does not get lost or diluted among many other activities and is addressed in a thorough and quality manner, rather than superficially. In addition, while a good curriculum and quality training are important, strong programme design and systems for functioning are crucial for producing results on a sustained basis. Too many community-based programmes have trained community cadres but not paid adequate attention to the systems for ongoing implementation of the activities and ensuring supervision. Many community-based

programmes have also failed to achieve scale. A vision for scale should be the starting point in the design of the effective community based IYCF programme.

The programme also needs to be clear from the outset that IYCF counselling and the skills required to do so effectively must be distinguished from promotive packages which convey some basic information about desirable IYCF practices but tend not to build practical skills to support mothers to breastfeed and solve problems, skills in counselling and negotiating with caregivers and skills in facilitating interactive group sessions and other communication activities.

Designing community-based IYCF promotion, counselling and support programmes: 5 Steps:

The design of community-based IYCF programmes and activities should be done with the active participation of community members and other relevant stakeholders. The following five basic steps are recommended for any national team or organization interested in supporting community IYCF:

1. Conduct or update a situation assessment of existing community-based services
2. Identify, sensitize and involve community-based stakeholders
3. Strengthen existing or create new community cadres to conduct IYCF activities
4. Develop or update policies and systems to support community IYCF
5. Design the community IYCF programme (training; counselling and behaviour change; supervision and mentoring; monitoring and evaluation)

Step 1: Conduct or update a situation assessment of community-based services

Before designing a community-based IYCF programme, it is important to conduct a situation assessment at national level in order to identify opportunities, including existing community-based health and nutrition programmes and community structures as well as the current IYCF-related practices and behaviours. This information is important to ensure that the IYCF programme can effectively integrate with and build on existing programmes and that community-level counselling tools, promotional messages, training materials and communication strategies are appropriately tailored to address existing barriers to optimal IYCF practices.

The assessment should include the following activities:

1. Compile and review existing information on local infant and young child feeding practices. See *Appendix 1: Breastfeeding and Complementary Feeding Matrices*, and *Appendix 2: Calendar of Local, Feasible, Available and Affordable Foods (Home and/or Market)*
2. Identify relevant formative research results, including results from knowledge, attitudes and practices (KAP) studies
3. Determine need for, and conduct if necessary, any additional research to address gaps
4. Map existing community-based health and nutrition programmes to identify key stakeholders, coverage of programmes, scope of activities, the type and number of community workers (cadres), and the incentives and support they receive
5. Analyze the evaluations or reviews of existing community-based IYCF-related projects, if they exist, to determine which models achieve the desired results, and if scale-up is feasible. If not already reviewed/evaluated, the project(s) should be reviewed.

The assessment should be conducted in different geographic areas and among different population groups, as current community programming and existing IYCF practices and barriers may vary significantly.

Step 2: Identify, sensitise and involve stakeholders for the community-based programme

Identifying and sensitizing stakeholders for the community based IYCF programme has two stages: first, the results of the mapping of programmes and stakeholders should be analyzed to determine at **national level** who will be the main implementing partners for the programme in each administrative unit (e.g. district, province) of the country (or the target area of the country). In many countries this is likely to involve a partnership between the Government and NGOs and other civil society stakeholders. Orientation and advocacy sessions with stakeholders may be needed to gain their support and engage them in planning and implementation.

In order to achieve scale, the design and planning of the programme should encompass coverage of entire districts, rather than a few scattered communities. The achievement of full coverage may be incremental, but there should be a clear timeframe to achieve scale. A recommended approach is for one NGO to take responsibility for one or more districts or provinces. There may of course be other implementing partners in that particular district, but having one focal agency facilitates coordination and reduces fragmentation. A stakeholder meeting (or several sub-national meetings) may be convened to orient the NGO and Government partners on the programme, agree on implementation plans and the timeframe for achieving scale.

The second stage involves **local level** identification and sensitization of stakeholders. Given their knowledge and experience of networks within the community and/or their ability to influence practices and behaviours, it is important to identify, sensitize and involve community decision-makers, community-based groups and individual community members in designing community-based IYCF promotion, counselling and support programmes. The involvement and commitment of these key stakeholders can help to ensure that: IYCF programmes receive the necessary endorsements and validation; effectively mobilize the community; and are ultimately sustainable. Key community members may include community and religious leaders, local politicians, administrators, teachers, nurses, extension workers, community-based organizations, faith-based organizations, women's group leaders, health committee leaders and other community-based cadres. A specific focus on influential women and female-led groups and initiatives is important for IYCF programmes.

Involvement of influential community groups and individual is important at the initial stages of design and planning of an IYCF programme, and their ongoing participation in oversight of the implementation and supervision is also crucial. Their active participation should serve to enhance ownership and responsibility for the programme. Identifying, sensitizing and involving local stakeholders should include the following:

1. Consult with communities, local authorities and partners to identify influential community members and decision-makers
2. Identify key local stakeholders (government agencies, community-based organizations, NGOs and individuals) to include in the planning and execution of IYCF activities

3. Conduct orientation and advocacy sessions with the identified groups and individuals to gain their support and engage them in planning and implementation, as well as motivating different groups for action.

Step 3: Strengthen existing or create new community cadres to conduct IYCF activities

Existing community-based health and nutrition programmes may afford opportunities to promote and support IYCF. *Appendix 3: Potential Providers of IYCF Promotion and Support Services in the Community* lists different kinds of community-based health workers (cadres and groups), their common characteristics, and advantages and disadvantages of each in the provision of IYCF counselling, as well as other IYCF promotive and supportive activities in the community. The design of the IYCF component of a community-based health and nutrition programme should be done in consultation with communities, either to add IYCF counselling to an existing CW portfolio or to create an IYCF counsellor as a new cadre. In some countries there may be a myriad of different types of community workers in different areas of the country, and analysis of the mapping conducted in Step 1 is needed to determine which type of existing worker would be most appropriate in each area of the country for implementation of the IYCF programme.

Strengthening existing community cadres: Community-based IYCF activities should build upon existing structures as much as possible, rather than creating parallel ones. Many countries already have some form of community-based health and/or nutrition programmes and structures in place, such as community-based management of severe acute malnutrition (CMAM), community IMCI (C-IMCI) and community case management (CCM) of malaria, diarrhoea and pneumonia. These programmes have different types of community-based workers and varying types of incentives, from volunteers to paid cadres within the Government system. CHW programmes, once viewed as "a panacea for weak health systems", are now recognized as a complementary approach to facility-based health care for reaching vulnerable groups. Their success depends on the ability to motivate involvement of CWs, offer opportunities for personal growth and accomplishment, retain CWs after they have been trained, sustain their performance, and provide ongoing supervision, support, and recognition from the health system and community.[1] (See *Appendix 3: Potential Providers of IYCF Promotion and Support Services in the Community*.)

Creating a new community cadre: In some settings there may be no existing community-based health and/or nutrition programmes, and structures through which IYCF counselling can be delivered. The existing programme may not be appropriate for adding this service, or the programme may not be willing to add any additional activities. Another scenario may be that the Ministry of Health wants to create a dedicated cadre of counsellors for infant feeding. In such situations the possibilities for creating a new programme with IYCF counsellors – who may be given a locally appropriate title – should be explored. IYCF counsellors may be part of the outreach activities of the health system or associated with a nongovernmental organization. IYCF counselling may serve as an entry point to develop a more comprehensive new community-based cadre, and other elements of community-based health and nutrition care may be added to their role later on. (*See Appendix 4: Steps in creating a cadre of IYCF-related CWs.)*

[1] Bhattacharyya K, Winch P, LeBan K, Tien M. Community Health Worker Incentives and Disincentives: How They Affect Motivation, Retention, and Sustainability. Published by the BASICS Project for USAID. Arlington, Virginia, October 2001.

Step 4: Develop or update policies and systems to support community IYCF

Policies and systems need to be in place to support and facilitate the community-based programme, whether it is an integrated community-based health and nutrition programme or a stand-alone IYCF community programme. Supporting policies and systems are crucial to the effective functioning and sustainability of community-based programmes. If these are not addressed from the outset of the programme, the likelihood of success is substantially reduced.

Key policy and systems elements that need to be addressed include the following:

- The community worker needs to have official recognition by Government authorities as well as by the community; the worker's authority to provide products or medicines, to refer patients and to give advice needs to be endorsed and supported by Government policies.
- The community programme needs to be well-linked to the health system and consistent with its policies (e.g. on user fees).
- The community worker needs to have a clear profile and role.
- The supply and logistics system needs to function well.
- The community worker needs to receive appropriate incentives or remuneration on a regular basis.
- The counselling, training and communication tools provided need to be consistent with those provided to health workers.
- Regular supportive supervision needs to be conducted; simple monitoring tools need to be available and feedback provided on the data collected.

In cases where there is no official Government policy on community programmes or remuneration of community workers (these can take a long time to be formally endorsed), it is still possible to move ahead with implementation of a community based IYCF programme at scale so long as all stakeholders agree to and ensure the application of the supportive systems outlined above. To be avoided are fragmented, uncoordinated, small-scale efforts to train community workers without systems in place for sustained support for functioning of the activities and supervision of the workers.

Step 5: Design & implement the community IYCF programme

- **Training, counselling and behaviour change activities, supervision and mentoring, monitoring and evaluation.**

As noted in the introduction, *The Community IYCF Counselling Package* focuses on the aspect of training and follow-up of community workers, and other aspects of designing and implementing a community based IYCF programme are summarized.

Training: The duration and scope of the initial training packages for community cadres on health and nutrition varies greatly between countries and programmes, affording and necessitating a variety of training options. In some programmes, community workers are trained over a six-month period and cover a wide range of topics. One option, therefore, is to **integrate the *Community IYCF Counselling Package* within the overall pre-service** training package for community cadres.

In other programmes, the community workers may receive a week-long training on the key preventive health and nutrition topics, in which IYCF may be covered in a session of a few hours. The latter may imply that the community worker receives some basic information to promote good IYCF practices, but the time allotted to the IYCF component of the training may not be sufficient to build the specific counselling and problem solving skills necessary to provide practical support to mothers. This will then mean that the community worker has to refer the mother and infant to the nearest health facility if there is a feeding problem – if at all the training has provided them with the skills to assess feeding practices properly.

The IYCF counselling training can also be provided as a stand-alone package to new or existing community workers. This may be necessary if the community workers' basic training was not long enough to achieve sufficient depth on IYCF content and to build counselling, problem solving, group facilitation and communication skills. In such contexts the IYCF counselling training should be promoted as an additional capacity building tool, clearly highlighting that it builds a set of skills as opposed to just providing basic information.

The planning of the IYCF training using the training component of the *Community IYCF Counselling Package* is covered in detail in the introduction to the *Facilitator Guide*.

Counselling and Behaviour Change Activities: Multiple opportunities within the community setting can be used for sharing information, for individual counselling, and for other behaviour change activities by community cadres. Group meetings, growth monitoring or MUAC screening sessions, home visits and cooking sessions are all examples. House to house visits to pregnant women and new mothers may also be planned. Programmes and projects have been successful in achieving community-based behaviour change work through multiple channels and combine various methods, ranging from individual counselling by health facility and community-based workers, community group sessions and information sharing through traditional channels and local media. Repeated contacts and messages help to reinforce both knowledge and practice.

It may be helpful for community workers to set specific targets for activities, either as individuals or as a group: e.g. for the expected pregnant and lactating women there would be in the community who need to be followed up, or for the number of group sessions to be conducted, the number of support groups to be created, or for the number of IYCF contacts to be made each month at growth monitoring sessions, community meetings etc. These targets can be discussed and set during the training and reinforced and followed up during mentoring and supervision. Setting targets gives a concrete structure and focus to the activities and helps in monitoring performance.

Community-based IYCF support and counselling needs to be embedded in a larger context of communication activities that disseminate consistent and relevant information to mothers, other caregivers, as well as their support network, repeatedly and frequently. At the same time, the community-based programme needs to be closely linked to health system actions and impart the same messages on optimal practices and behaviours. The health system will often be involved in training and supervising the community cadres, but NGOs may also be the main facilitators. In both cases harmonization and consistency are essential. There should be a strong system of bi-directional referral: health workers should link mothers with lay counsellors or CWs and mother support groups for ongoing support and counselling on infant feeding; and the community cadres and groups should ensure that pregnant and lactating women attend consultations in health facilities.

A growing number of countries are initiating and expanding community based programmes for the management of severe and/or moderate acute malnutrition (generally referred to as CMAM). Many of these programmes, however, focus on screening and home treatment of malnourished children with little attention to counselling on feeding of the child to prevent future episodes of SAM and promote good growth. The creation of new CMAM programmes presents a good opportunity for IYCF counselling and support actions to be included from the outset. In established CMAM programmes, IYCF content may be integrated in refresher training for existing community cadres and added to training for new community workers as part of the scale up process.[2]

Similarly, more and more countries are implementing community case management (CCM) programmes for malaria, diarrhoea and pneumonia. The IYCF counselling training can be promoted as an integral module in a new CCM programme or can be provided later on to trained workers or during refresher training. Advocacy for integration should highlight the fact that optimal IYCF practices have a major impact on diarrhoea and pneumonia mortality and a community based IYCF counselling programme could significantly enhance the potential for results of the CCM programme in terms of reducing mortality from these diseases.

Another main programmatic success factor that has emerged from multiple reviews[3] is the involvement of local NGOs, who often provided excellent facilitators as well as culture-relevant training. They are usually accountable to the community, which facilitates sustainability to a great extent.

Supervision and Mentoring: Supervision and mentoring is crucial to the success of a community-based programme, but is often the weakest link. The team responsible for the community-based programme should build a system for supervision and mentoring for each counselling channel and for each contact at which counselling is given. The persons responsible for supervision need to be clearly identified from the outset, need to include the activity in their regular workplans and tasks, and need to be provided with training tools such as a supervision checklist[4] and resources (such as transport funds) to undertake this activity. A toolkit for supervision is found in Annex 14.

Supervision and mentoring should not be seen as an optional task to be conducted only if there happens to be time or an available vehicle going in the "right" direction. It should be "institutionalized" as part of the expected tasks of the identified staff, with agreed targets for regularly scheduled supervisory visits. Supervisory visit reports should be part of the monthly information and feedback provided to the worker and facility where he or she works.

Some methods of supervision that may prove more effective than others include:

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[2] Integration of IYCF into CMAM. IASC/ENN 2009. Facilitator's Guide and handouts for participants. 1 ½ - 2 day orientation on IYCF counselling in the context of community based programmes for management of severe acute malnutrition http://www.ennonline.net/pool/files/ife/iycf-cmam-facilitators-us-final.pdf

[3] Kraisid Tontisirin and Stuart Gillespie. Linking Community-based Programs and Service Delivery for Improving Maternal and Child Nutrition. *Asian Development Review*, vol. 17, nos. 1,2, pp. 33-65. Accessed at http://www.adb.org/documents/periodicals/ADR/pdf/ADR-Vol17-Tontisin-Gillespie.pdf

[4] The Haryana manual on community IYCF contains a checklist for supervision and monitoring which may be adapted. WHO/UNICEF. Implementing Community Activities on Infant and Young Child Feeding: A manual based on the experience from Haryana, India. Field Test Draft for Kisii, Kenya. June 2008.

- Adding unscheduled visits (that is, the worker is unaware of the visit in advance) in addition to any planned visits
- Observing (using a checklist) performance of a task.
- Gathering direct feedback from caregivers (e.g. home visits made by supervisor).
- Conducting periodic group reviews at different levels.

Another approach is through questions and discussions at meetings. Workers tend to put more effort into activities that are reviewed at joint meetings or that are specifically questioned, e.g. if the IYCF programme is receiving emphasis by the national government then at local meetings workers are questioned more on their IYCF activities. If workers know that supervisors are interested in their efforts on IYCF, they may emphasize this work more. Feedback to community workers on their activities, the data they collect and their performance is essential to further building skills, solving problems and to overall programme improvements.

Monitoring and Evaluation (M&E): Regular and good quality M&E data is important to provide feedback on the implementation of the program and to adjust strategies. Programs which undertake baseline and endline surveys as well as routine monitoring and/or annual rapid assessments in program areas will be best positioned to spot problem areas and adjust programs accordingly.

A small set of clearly articulated indicators helps keep IYCF promotion and support focused on the essentials and provides trend data for assessing progress and informing program strategies. Interpretation of results is problematic when questions are not asked the same way in different surveys and baseline data are not collected.

Monitoring whether defined targets for activities were met during a defined period is helpful to assess performance of the CWs. For example (these are addressed in more detail in *Appendix 14: Package of supervisory tools*):

- % of targeted pregnant and lactating women in the community who were counselled at least once;
- % of target mothers (in supervision area) attending a mother support group meeting (per time period)
- % of target contact points (e.g. GMP or MUAC screening session, outreach visit by clinic, well child/immunization session at clinic, health post, community meeting, etc) at which IYCF counselling provided (per time period)
- % of group sessions conducted out of the target number planned;
- % of support groups created out of target number planned.

Key basic principles for the use of information for action include the requirements to: only collect data that will be used; maximize the use of data at the level they are collected; and to collect the minimum, feasible amount of data required to inform and improve decisions leading to action.

Well-designed surveys and costs studies will enable program managers to determine with greater confidence "what works" and at "what cost." This information is valuable for future program planning and implementation as well as evidence-based advocacy.

Part 2: Adapting the Community IYCF Counselling Package

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

Contents of the Community IYCF Counselling Package

The *Community IYCF Counselling Package* is comprised of the following:

The *Facilitator Guide* is intended for use in training CWs in technical knowledge related to key IYCF practices, essential counselling skills and the effective use of counselling tools and other job aids.

The *Participant Materials* includes key technical content presented during the training (consisting of "handouts" from the *Facilitator Guide*) and monitoring tools.

The 28 *IYCF Counselling Cards* present high-quality, brightly coloured illustrations that depict key infant and young child feeding concepts and practices for CWs to share with mothers, fathers and other caregivers. These job aids are designed for use during specific contact points, based on priorities identified during each individual counselling session. There are 25 *Counselling Cards* on IYCF practices and infant feeding in the context of HIV where the national policy promotes exclusive breastfeeding for 6 months with ARVs. There are also 3 *Special Circumstance Counselling Cards*: Avoid all Breastfeeding, Requirements to Avoid All Breastfeeding, and Feeding the Non-breastfed Child from 6 up to 24 Months. The 3 *Special Circumstance Counselling Cards* should be used only in those countries whose national policy is "Avoid All Breastfeeding" and for those mothers who opt-out of exclusive breastfeeding.

The *Key Messages Booklet* consists of messages related to each of the IYCF Counselling Cards, and copies of the 3 *Take-home Brochures*.

The *Take-home Brochures* are designed to complement the counselling card messages and are used as individual job aids to remind mothers, fathers and other caregivers about key breastfeeding, complementary feeding, and maternal nutrition concepts and practices. The brightly coloured illustrations found in each brochure are intended to enhance each user's understanding of the information presented in the brochures, and to promote positive behaviours. To maintain font size that is easily readable the *Take-home Brochures* should be printed following the specifications in Step 10.

Training Aids have been designed to complement the training sessions by providing visuals to help Participants grasp and retain technical knowledge and concepts.

The *Planning and Adaptation Guide* outlines a series of steps and provides a number of specific tools for use by national or local stakeholders interested in 'Planning for Community IYCF Programmes' (Part I) and in 'Adapting the *Community Infant and Young Child Feeding (IYCF) Counselling Package'* (Part II) for use in their own setting.

10 Adaptation Steps

The following 10 steps are recommended for any national team or organization interested in adapting and using the *Community IYCF Counselling Package* for their programming:

1. Build partnerships and define roles and responsibilities
2. Conduct a systematic technical review of the *Community IYCF Counselling Package (Facilitator Guide, Participant Materials, Counselling Cards, Key Message Booklet, 3 Take-home Brochures* and this *Planning and Adaptation Guide)*
3. Adapt graphics and layouts of all materials
4. Conduct final technical review of adapted package
5. Translate training content, if necessary, and *Counselling Cards, Key Messages Booklet* and *Take-home Brochures*
6. Finalize graphics and layouts for all elements of the adapted package
7. Field test graphic components of the package (illustrations, key messages and layouts) with local end-users
8. Review field test results for the graphic components of the package and make final decisions
9. Field test the integrated *Community IYCF Counselling Package* and make final adjustments based on stakeholder consensus
10. Develop plans and budgets for printing, dissemination, training, monitoring and evaluation of the package

(See *Appendix 5: Checklist for the Adaptation of the Community IYCF Counselling Package)*

Step 1: Build partnerships and define roles and responsibilities

Bringing relevant stakeholders together to review the generic *Community IYCF Counselling Package*, identify opportunities to collaborate, clarify roles and responsibilities and decide on a process and timeline is a first critical step in successfully adapting this set of materials and tools. This is especially necessary since national nutrition or IYCF teams are often made up of diverse actors with competing program priorities, work plans and funding,

Given the cross-cutting nature of infant and young child feeding, especially in HIV prevalent communities, a wide variety of government agencies, UN agencies, donors, technical assistance partners, community-based and international non-governmental organizations, faith-based organizations, advocacy groups and individuals often feel some degree of "ownership" or engagement in the field. Building partnerships and creating strategic alliances can often take an isolated community or district-level activity to scale, resulting in a significant national effort.

Who takes the leads, or who is seen as being the major IYCF champion in a given setting will often influence what other partners join and what donors step in to support the various activities involved. This first step, of building partnerships and defining roles and responsibilities, will

often determine the ultimate success and scale of the community programme. Every effort should be made, therefore, to identify all stakeholders who may play a role and think through the various options and opportunities from the very beginning. Reviewing common goals and objectives, comparing work plans and examining the feasibility of sharing roles, responsibilities and resources is a fundamental first step.

Summary of activities for Step 1:

1. Identify the government bodies (ministries, etc.), UN agencies, donors, technical assistance partners, community-based and international non-governmental organizations, faith-based organizations, advocacy groups and individuals (content experts) engaged in IYCF-related activities.
2. Establish a technical working group of major stakeholders and content experts, including those not necessarily associated with IYCF (e.g. HIV prevention, CMAM, communication, reproductive health and early childhood development programs, etc.)
3. Agree on who will lead the technical working group and define the roles and responsibilities of the various members
4. Review *Appendix 5: Checklist for the Adaptation of the Community IYCF Counselling Package*; compare organizational work plans; and examine the feasibility of sharing responsibilities and resources for the adaptation of the package.
5. Develop a corresponding work plan.
6. Determine available resources and develop an adaptation budget.

A specific timeline that will be required by country team to adapt the *Community IYCF Counselling Package* is difficult to establish, given the number of possible variables. After reviewing the package, some country teams may opt to adopt the package in its entirety, with only minor technical changes (such as adding local data and local terminology) and/or minor graphic changes (such as adding the national emblem and/or stakeholder logos to the materials). Other country teams may decide that some of the illustrations in the training package and counselling tools need to be adjusted slightly (such as hairstyles, dress colours or household items) or replaced completely. Local artists may already have the skills required to adjust the graphic elements, or may need to be trained with external technical support.

Translation may be required of some or all materials. Field testing in some countries may be limited to one or two programme sites or may be required in different languages and multiple and diverse regions of the country. From experience in adapting similar materials in other setting, a realistic estimate of the time required ranges from two-to-six months (two months for minor adjustments, up to six months for major adjustments).

The overall cost of the adaption process is directly linked to the variables described above. Decisions taken by the country team related to adjusting the technical content and graphics will determine the required budget. The following costs should be factored in when developing the adaptation budget:

- The number and size of stakeholders review and consensus building meetings/workshops (in-kind contributions of time by programme staff vs. individual payments to content experts; venue costs; transport reimbursements, etc.)
- The availability and cost of skilled local graphic artists vs. external graphic artists
- The number of sites, sample size and complexity of proposed field tests

A variety of checklists and other tools are provided in the set of appendices as guidance in developing both a work plan and budget for the adaptation of the package, including *Appendix 5: Checklist for the Adaptation of the Community IYCF Counselling Package.*

Step 2: Conduct a systematic technical review of the Community IYCF Counselling Package

Review and discuss all materials comprising the *Community IYCF Counselling Package,* including the *Facilitator Guide* (with *Appendices* and *Training Aids), Participant Materials*, *Counselling Cards, Key Messages Booklet, 3 Take-home Brochures* and the *Planning and Adaptation Guide*, to determine any critical content additions, adjustments or substitutions that should be taken into consideration during the adaptation process.

Summary of activities for Step 2:

1. Plan a review workshop or series of meetings to examine each element of the *Community IYCF Counselling Package.*
2. Collect existing IYCF counselling materials, current training curricula and M&E tools being used nationally.
3. Collect available survey data and relevant formative research findings related to the epidemiology, knowledge, practices and socio-cultural issues affecting IYCF and maternal nutrition.
4. Reproduce a sufficient number of copies of all materials (existing national tools, research data and *Community IYCF Counselling Package*) to be reviewed so that each participant has his or her own set of files.
5. Systematically review each element of the *Community IYCF Counselling Package* and determine what adjustments or adaptations are required, based on available information and relevant data, to ensure alignment with national norms, protocols and other recommendations. (See specific elements of the package that are noted below requiring special attention/review.)
6. Consider the need to adapt words and expressions to reflect local terminology, and also the need to translate the *Facilitator Guide, Participant Materials, Counselling Cards, Key Message Booklet,* and *Take-home Brochures* into local language or languages.
7. Consider the need to adapt/adjust illustrations and other graphics in relationship to the socio-cultural context and local feeding challenges.
8. Consider time available for training, varying knowledge levels of participants, and other characteristics of the proposed audience.
9. Identify technical elements that are potentially controversial. If issues are controversial, discuss until consensus is achieved.
10. Consolidate feedback from review.
11. Synthesize the comments from local content experts, other stakeholders and in-country reviewers.
12. Circulate summary recommendations for changes that need to be addressed to members of the technical working group and other stakeholders for final input and "sign-off".
13. Develop work plan and request all stakeholders to commit personnel and resources to complete the adaptation of the package.

Refer to the tools found in the Appendices for support and guidance during the systematic technical review: *Appendix 1: Breastfeeding and Complementary Feeding Matrices; Appendix 2:*

Calendar of Local, Feasible, Available and Affordable Foods (Home and/or Market); and *Appendix 6: Adaptation Tracking Matrices for IYCF Counselling Cards and Take-home Brochures.*

Specific elements requiring special attention/review:

The following is a summary of the various elements of the *Community IYCF Counselling Package* that will need to be reviewed and discussed and/or tested by the technical working group to determine their relevance to the local setting and need for adaptation or adjustment.

Review of Local data:
In the *Facilitator Guide*, Session 2, Learning Objective 3: Share in-country data on IYCF

- Substitute relevant country-specific data from a recent data source (e.g., DHS/Demographic Health Survey; UNICEF MICS/Multiple Indicator Cluster Survey) for the following data (see page 16 of the *Facilitator Guide*)
  - Breastfeeding practices
  - Complementary feeding practices
  - Maternal nutrition data
  - Malnutrition levels:
    - underweight (too thin for age)
    - stunted (too short for age)
    - wasted (too thin for height)
  - Low birth weight:

Names and Terminology:

- Consider whether or not to change the names of infants and children used in the demonstrations, case studies, activities, etc. found in the *Facilitator Gui*de, so that they reflect those commonly used in your setting.
- Decide whether or not to create l a glossary or page of definitions for the *Facilitator Guide*.
- Substitute local names for technical terms such as breastfeeding, complementary feeding, colostrum, breast anatomy, and breast engorgement, mastitis, and insufficient breast milk.

Pre/post Assessment:

- If any pre- or post-assessment question is determined to be 'less relevant' in the local context (e.g., the issue of babies needing water in a hot climate is not relevant in your setting), replace that question with another that addresses an issue of greater local importance.
- Decide if Participants will do the written or non-written assessment.

Nationally or locally-relevant issues:

- In demonstrations, case studies and other exercises or activities, reflect local issues
- The local adaptation group may also provide trainers with a list of commonly held beliefs and myths (e.g., identified during formative research) to draw upon during summary discussions (Session 3. Breastfeeding Beliefs and Session 9. Complementary Feeding Beliefs).
- Adapt or revise points of discussion for recommended breastfeeding and complementary feeding practices (Session 5. Recommended IYCF Practices: Breastfeeding and Session 7. Recommended IYCF Practices: Complementary Feeding for Children from 6 up to 24 Months) to ensure discussion of issues relevant to the local context; use local terms (e.g.,

local term of 'colostrum'). Interpersonal counselling discussion points or peer support group topics might, for example, reflect country or context-specific information obtained through formative/qualitative research (e.g., it is not acceptable for a woman to have sexual relations while breastfeeding).

- Session 13. Group Sessions, IYCF Support Groups and Home Visits. Change, as determined necessary by the local adaptation committee, the drama, mini-scenarios and visuals to reflect issues that are appropriate in your setting.

Frameworks, Recommendations and Protocols:

- Material in the *Facilitator Guide* should be adapted so that content is compatible with national or locally-relevant frameworks, recommendations and protocols.
  - Iron/folate supplements
  - Multi-micronutrient supplements
  - Vitamin A for postpartum women and under-5 children
  - Lipid-based nutrient supplements
  - Supplementary feeding programmes
  - De-worming medicines
  - National policy on infant feeding in the context of HIV
- If implementation of IYCF counselling activities is linked to distribution of any supplements, it needs to be decided if the linkage and any relevant messages should be addressed in all the materials as appropriate, e.g. the, *Facilitator Guide, Participant Materials, Counselling Cards, Key Messages* etc.
- If a different 'stages of behaviour change' model is used in the national context, it may be substituted for the figure under Session 4. How to Counsel: Part I, Learning Objective 2, Key Information.
- Review recommended breastfeeding practices (Session 5. Recommended IYCF Practices: Breastfeeding) and adapt recommendations, as necessary, to conform to national recommendations.
- Adapt complementary feeding recommendations, as necessary, to ensure alignment with national recommendation (Session 7. Recommended IYCF Practices: Complementary Feeding). If necessary, change local cup size and amounts ('amount' column) and local foods ('variety' column) for the table '*Participant Materials* 7.1: Recommended complementary feeding practices
- Session 4. How to Counsel: Part I, Objective 3 and Session 10. How to Counsel: Part II Learning Objective 4: Modify the list of contact points to reflect opportunities for IYCF counselling within the programs or frameworks commonly used in the country (e.g., Integrated Management of Childhood Illness (IMCI), Community Case Management (CCM) of diarrhoea, pneumonia and malaria, Essential Nutrition Actions (ENA), Growth Monitoring and Promotion (GMP), Minimum Activities for Mothers and Newborns (MAMAN)[5], Community Management of Acute Malnutrition (CMAM), etc). At a minimum, contact points should include sites where health system personnel interact with mothers (and their infants/young children): during pregnancy, at delivery, during the early postpartum period, during the first six months of lactation (and up to 24 months of

[5] The MAMAN framework has been developed through a collaborative process among USAID, CSTS^{+}, and the PVOs/NGOs, to identify a subset Essential Maternal and Newborn Care Interventions that would comprise the basic minimum high-impact MNC interventions that PVOs/NGOs can and should implement within the resource limitations of their health programs, primarily intended for uses by recipients of USAID Child Survival and Health Grants Program (CSHGP).

lactation); during immunizations, growth monitoring, sick child treatment, and family planning

- Session 15. Women's Nutrition
  - Learning Objective 2: Describe the actions that can break the undernutrition cycle in babies, girls, teens, and women. If desired, the local adaptation team can substitute another framework that is familiar or used locally and modify the counselling points for discussion/messages on nutrition during pregnancy and breastfeeding to reflect issues relevant in your country (e.g., the belief by women that they should restrict their dietary intake during pregnancy to restrict the size of the baby)
  - Session 15, Learning Objective 5: Modify the list of family planning options available to reflect those that are supported in the national/local context
  - *Participant Materials* 15.1: Interventions to break the malnutrition cycle. Review and adapt the interventions list to ensure compliance with the national recommendations.
- Session 16. Feeding of the Sick Child. Review recommendations for feeding of the sick child to ensure compliance with national recommendations. Ensure that terms used when talking about malnutrition and its treatment, as well as growth monitoring, reflect those used in national programmes.
- Session 18. Integrating IYCF Support into Community Services and Emergency Response. Adapt recommendations for IYCF support in the context of community services and emergency response to reflect the terms, personnel and activities (e.g., GMP, CMAM, PMTCT, TBAs, TB, Malaria, and others) in national programmes.
- Session 19. IYCF Forms: Counselling, Group Education, Mother-to-Mother Support Groups and Checklists. Adjust monitoring forms and monitoring plans related to individual counselling, group education and support group activities, as well as information on the responsibilities and role of the supervisor/mentor, to fit the details of your national/local system.
- Consider expanding the topic of IYCF in emergencies using Appendix session in the *Facilitator Guide*.

Field Visits

- Adapt any recommendations related to preparations for the field visit to your local context.
- Change, as determined if necessary by the local adaptation committee, the drama, mini-scenarios and visuals to reflect issues that are appropriate in your setting (e.g., should the individuals doing the training preparation talk with the community 'leader' or other individual(s)?

Model Dolls and Breasts: Additional Activity

- If training dolls and breasts already exist and/or other ways of making either dolls or breast models are already used in-country, substitute for the instructions provided in Session 6. How to breastfeed.

Visuals

The following is a summary of the various visual elements of the *Community IYCF Counselling Package*, particularly in the counselling cards and the take home brochures, that will need to be reviewed and discussed and/or tested by the technical working group to determine their relevance to the local setting and need for adaptation or adjustment.

A. Local foods

- Staples (grains, roots and tubers) group

- Legumes and nuts (pulses and oil seeds) group
- Fruits and vegetables group (Vitamin A-rich fruits and vegetables and other fruits and vegetables; consider whether to add locally-available wild fruits)
- Animal products group (flesh foods, dairy products and eggs)
- Fats and oils
- Consider whether to add discussion of the following: high-fat and high-sugar foods; grubs, snails or insects; use of fortified foods

B. Local population characteristics, particularly
- facial features
- skin tones
- hair styles
- dress/clothing

C. Local community and environmental characteristics, particularly
- cooking pots, dishes and utensils
- housing styles
- furniture, specifically stools and beds, and mats for sitting on
- latrines
- water sources

Step 3: Adapt graphics and layouts of all materials

High quality graphics have been used in the development of the *Community IYCF Counselling Package*, involving a photo-to-illustration process and design layout used by the URC/CHS graphic team in developing culturally sensitive, colourful and engaging IYCF communication materials. Many of the images and layouts used in this package are based on earlier materials developed by URC/CHS in Tanzania, Niger, Benin, Kenya, Uganda and Malawi.

The process recommended for either developing and/or adapting illustrations and layouts uses a variety of graphic tools and state-of-the-art computer graphic programs, including PhotoShop, InDesign and Illustrator. When planning and budgeting for the adaptation of the *Community IYCF Counselling Package*, it is important to consider investing in the graphic aspects of the materials. The cultural appropriateness, acceptability by the end users and the ultimate impact of the communication components of the package is often defined by the overall quality of the illustrations and layout of the material. High quality illustrations and engaging layouts, printed in full colour are believed to affect the reaction of those involved. Investing in quality counselling and other communication materials has been shown to improve the performance of health workers and influence the behaviours of mothers and other caregivers.[6, 7]

[6] Leshabari S, P Koniz-Booher, B Burkhalter, M Hoffman, and L Jennings. 2007. Testing a PMTCT Infant-feeding Counseling Program in Tanzania. *Operations Research Results.* Published for the U.S. Agency for International Development (USAID) by QAP. Accessed on October 24, 2010 at http//www.qaproject.org/pubs/PDFs/ORRTZTestingJobAids.pdf.

[7] Leshabari SC, Koniz-Booher P, Astrom AN, de Paoli MM, Moland KM: Translating global recommendations on HIV and infant feeding to the local context: the development of culturally sensitive counselling tools in the Kilimanjaro Region, Tanzania. *Implementation Science* 2006, 1:22doi:10.1186/1748-5908-1-22.

Summary of activities for Step 3:

1. Identify high-level individuals or team of illustrators and/or graphic artists with specific computer graphic training and experience.
2. Specify the number of illustrations to be adapted and/or developed and the number of materials that will require layout adjustments.
3. Develop a contract with the illustrators and/or graphic artists that reflects that quality and quantity of work anticipated.
4. Ensure that all of the necessary equipment is available for use during the graphic adaptation process.
5. Secure copies of the original graphic files from UNICEF that will serve as the basis for adaptation and layout.
6. Develop a systematic checklist of steps involved in the graphic adaptation process.
7. Oversee the adaptation and/development of new illustrations.
8. Coordinate interface between the technical team, translation team and graphic team as needed.

A *Compendium of Clip Art* related to this package will be made available to country teams who commit to the adaptation process. A basic graphics package includes a computer, with sufficient storage space (hard drive) and memory (RAM); the Creative Suite (series number 3 or 4) computer graphics programs, which includes the two essential programs - PhotoShop and InDesign; a digital camera; lightbox; scanner; external memory portable hard drive for storing and transferring files; miscellaneous artist pens for tracing; colour printer; and paper. If the illustrator and/or graphic artist identified to support the adaptation process does not have his or her own set of equipment, the country team should consider making this equipment available to the graphic team during the adaptation process. Often, the necessary equipment can be made available through partners and/or through equipment rental agencies. The average cost of a full set of the required equipment and software may vary from approximately $3000 to $5000 US, depending on the specific desired brands and their availability in a given country.

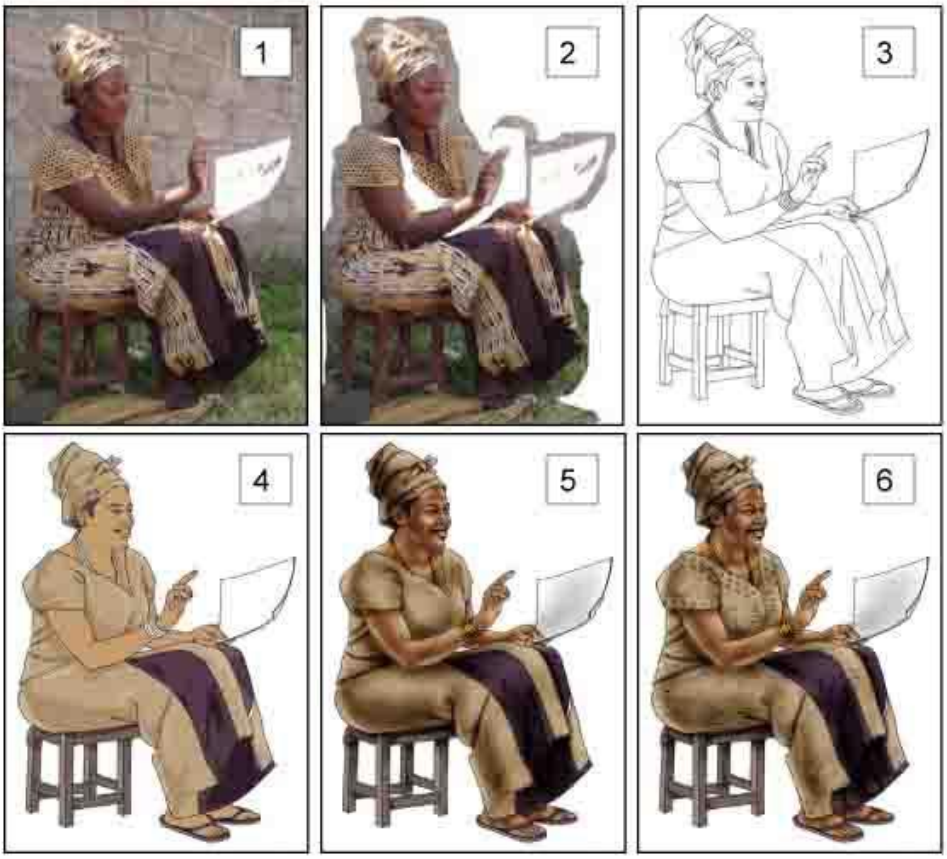
The step-by-step illustration process is described in *Appendix 7: Step-by-Step Guide for Creating/Adapting Illustrations*. This guide has been successfully used to both create new illustrations and/or adjust existing illustrations by experienced graphic artists and teams of artists with specific illustration and computer graphic skills. An initial training of local graphic artists in this process is highly recommended, however, especially if a large number of changes in illustrations and/or graphic are requested by the national team or required based on field test results. It is strongly recommended that the layout used in developing the graphic elements of the *Community IYCF Counselling Package* be followed or replicated, to the extent possible, substituting new or adjusted images and text where necessary.

The overall cost of contracting an illustrator and/or graphic art team will depend on the following variables:

- The established daily or per product rate of the illustrator/graphic artist(s) (local or external)
- The number of adapted or new illustrations and layouts that are required
- The corresponding number of days needed to complete the work, including changes requested by the technical team prior to and following field testing

A visual summary of the photo-to-illustration process used in developing the initial image of a community health worker (later modified) is presented below (Steps 1 through 6). The process begins with a digital photography session, where multiple photographs of the model/subject are taken from a variety of angles. Ideally, both close-ups and full image shots are taken to provide sufficient visual "information" for the artist to work with. A technical or content expert should participate in the photography session, if at all possible, to ensure that the scene is technically correct. (This is particularly important for infant feeding positions.) From these photographs, the most appropriate angle/image is selected (Step 1) by the illustrator and technical team. The photograph is then edited to remove any extra or unnecessary "information" (Step 2) and the photograph is printed on plain paper. The illustrator then uses a lightbox to trace the photograph (Step 3), using a soft pencil to create a line drawing. Modifications may be made or elements added to the line drawing at this time. (For example, the position of an arm, the type of shoes worn, and/or the smile or eyes can all be modified easily at this stage.) The pencil drawing is then traced using a fine-tip black pen, and the final image is cleaned using a soft eraser to remove any extraneous lines or "dirt". The final inked line drawing is then scanned and "imported" into the graphic programme (PhotoShop) for colouring and further modification. Flat colours are selected and added to the drawing to define skin tones and clothing and accessories (Step 4). Volume is then added using the various PhotoShop tools (Step 5) to create a more life-like image. Finally, patterns are selected and added to the clothing (Step 6).

Sample visual summary of the photo-to-illustration process:



Step 4: Conduct final technical review of adapted package

As the proposed adjustments to text are finalized and the new and/or adjusted illustrations are completed, the technical working group should reconvene to review the individual pieces of the package, as well as the integrated package. It is critical that consensus be reached on both the text and graphics before investing in the translation and layout of mock-ups of the materials. All key stakeholders and content experts involved in the process should be given ample time to review the package. If there are any controversial elements in the package, consensus should be reached before continuing to the next step. If government officials, donors or agency directors require a review and approval or pre-approval process, a reasonable amount of time should be allocated to ensure that this step is completed.

Step 5: Translate training content & other materials

If necessary, the training content (*Participant Materials*) and *Counselling Cards*, *Key Messages Booklet* and *Take-home Brochures* can be translated into the local language(s).

The quality of translation of text is a fundamental limiting factor to the overall quality of the final package. It is important to recognize that both writing and translating are very specific skills that not every technical team has or can easily contract. Very often, a ministry communication person is asked to organize district level translation sessions for his or her local language or dialect, and not enough attention is paid to the final quality of product. Other technical reviewers, who do not speak or write the local language are not in a position to conduct a final quality assessment. A standard approach to checking any translation is to require a "back translation", where a different translator is asked to rewrite the text in the original language. This provides a clear indication of whether or not the material has been properly interpreted. If necessary, the translation should be adjusted until the desired level of quality is achieved.

Field testing of translated materials are also a critical step in ensuring that the meaning of resulting text conforms to the intent of the original and is understood and culturally-accepted by the local population. When field testing is conducted (see below), time should be allocated for specifically testing the written text.

Another common difficulty in translation, especially of long or complex documents, is the possibility that text will be lost or inadvertently left out. To address this problem, two translation matrix tools are provided in *Appendix 8* for use in translation. The matrices provide the original language on the left side of the table with corresponding boxes for translation on the right hand side. This set up also helps to ensure that the text is relatively similar in length, which is particularly critical for the layout of key messages and the overall design of the brochures, which are limited in space. Text often corresponds with specific illustrations on a given panel or page of a brochure. The matrices are also helpful to technical working groups for cross checking all elements (sentences, bullets, headings, paragraphs) found in both the *Key Messages Booklet*, which accompanies the *IYCF Counselling Cards,* and the messages in the 3 *Take-home Brochures*.

(See *Appendix 8: Matrices for Adaptation/Translation of Key Messages & Take-home Brochures*.)

Note: The national *Key Messages Booklet* should only feature the infant feeding option in the context of HIV which is national policy in the country.

Step 6: Finalize graphics and layouts for all elements of the adapted package

Following the technical review of draft illustrations, graphics and layouts by members of the technical working group, the local graphic artist(s) will finalize all of the elements of the package and prepare sufficient quantities of the materials for pretesting, according to the established protocols. The time involved in finalizing the package should not be underestimated. Technical people who do not have experience in the development and layout of communication materials often miscalculate the time involved. It is sometimes helpful to invite the graphic artists to a technical review meeting and/or the technical team to the graphic studio so that everyone can better appreciate the different aspects and complexities of the work being conducted.

Step 7: Field test graphic components of the package with local end-users

Field testing of the graphics and illustrations is another critical and often neglected step in the process of developing or adapting both training and communication materials. A strong commitment to this step in the process and a commitment of time and funding will help to ensure that the package is culturally acceptable by the end users and "target" audiences.

Good tips on field testing:

A number of field test tools, or job aids have been assembled as appendices to the *Planning and Adaptation Guide*, to help technical teams to plan and budget appropriately. They are also intended to provide guidance in conducting high quality focus group discussions and in-depth interviews as well as providing instructions for conducting qualitative research and developing research tools. *Appendix 5: Checklist for the Adaptation of the Community IYCF Counselling Package* can be used to both orient and train a field test team, and *Appendix 9: Instructions & Sample FGD Guide for Field Testing* can be used to support the planning and execution of a field test of the graphic materials. This tool can also be adapted by the country adaptation team to focus on specific illustrations and/or cultural issues identified as being potentially difficult or controversial during the review process. *Appendix 10: Considerations for FGD and In-depth Interviews* provides guidance in conducting quality focus group discussions and in-depth interviews.

Step 8: Review field test results for graphics & make final decisions

The organization of the analysis of field test results is critical to being able to share results with members of the technical working group and other key stakeholders. A workshop or series of meetings should be planned to review the results and reach consensus related to the technical content, illustrations and layout of the package. *Appendix 11: Analyzing Field Test Results and Preparing Report* provides guidance in how to organize, interpret and present results of the field test to members of the adaptation team and other key stakeholders.

Step 9: Field test the package & make final adjustments

Based on the results of the technical review, final modifications should be made based on stakeholder consensus. Two job aids are included to help guide the technical team in the overall adaptation and approval process. See *Appendix 6: Adaptation Tracking Matrices for IYCF Counselling Cards and Take-home Brochures*. Similar job aids can be created to track the other elements of the *Community IYCF Counselling Package*.

Field test the integrated Community IYCF Counselling Package to determine whether or not the package is comprehensive, effective and culturally appropriate. See *Appendix 12: Checklist for Field Testing the Package* for guidance in designing and executing this field test.

Make final adjustments following the field test and final technical review and stakeholder consensus.

Step 10: Develop plans & budgets for printing, dissemination, training, M&E

The technical working group is generally responsible for the development and review of plans and budgets for printing, dissemination, training, monitoring and evaluation of the package. Emphasis should be placed on the identification of resources early in the process to ensure the successful scale-up of the package following its adaptation, field testing and finalization. Monitoring and evaluation are critical elements to a continuous quality improvement process. See *Appendix 13: Specifications for printing & photocopying*

List of Appendices

APPENDIX 1: Breastfeeding and Complementary Feeding Matrices

Breastfeeding Practices Matrix

Breastfeeding Practice	Current Practice	Recommended Practice	Motivators	Barriers	Feasible Practice	Counselling Discussion
Initiation of breastfeeding		Within the 1st hour of birth				
Giving colostrum (local name)		Within the 1st hour of birth				
Duration of exclusive breastfeeding		From birth until baby is 6 months old (no water, other drink, or food)				
Frequency of breastfeeding		On demand (or cue) day and night				
Duration of breastfeeding		Until baby releases both breasts				
Expressing breast milk						
Giving water		No water during first 6 months				
Breastfeeding during illness		More frequent during & after illness				
Cessation of breastfeeding		2 years of age or older				

Complementary Feeding Practices Matrix

Complementary Feeding Practice	Current Practice	Recommended Practice	Motivators	Barriers	Feasible Practice	Counselling Discussion
Continued sustained breastfeeding	6 months 9 months 12 months					
Frequency of complementary foods	6 months 9 months 12 months					
Amount of complementary foods	6 months 9 months 12 months					
Texture (thickness/consistency) of complementary foods	6 months 9 months 12 months					
Variety of complementary foods (calendar)	6 months 9 months 12 months					
Active/Responsive feeding						
Hygiene						
Use of bottles		Use cup				

APPENDIX 2: Calendar of Local, Feasible, Available and Affordable Foods

(Home and/or Market)

To be filled-in for every month (or season)

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

APPENDIX 3: Potential Providers of IYCF Services in the Community[8]

Provider[9]	Common Characteristics	Advantages	Disadvantages
Peer/lay counsellors	• Women with current or recent infant feeding experience (peer counsellors) or strong commitment to infant feeding (lay counsellors) • Similar socio-cultural characteristics as clients • May provide one to one counselling in homes, health facilities, mother support groups, informal setting • May conduct group counselling/communication sessions	• Model optimal infant feeding practices in case of peer counsellors • Ability to demonstrate improved recipes and food preparation for young children • Understand mothers' situation • Accessible • Focused attention on feeding issues	• Often high turnover rates among volunteers • Part-time work limits number of contacts
Multi-purpose community workers	• May be affiliated with health facility, community group, or NGO • May provide one to one counselling in homes, health facilities, mother support groups, informal setting • May conduct group counselling/communication sessions • May receive salary or small stipend • May have or not have personal experience of breastfeeding	• Integrated with other health services • Wider outreach • Understand mothers' situation • Accessible	• More limited IYCF support • May be distracted by other duties
Single- purpose community workers	• May be trained only for one specific intervention, e.g. CMAM, GMP or CCM. • May be affiliated with health facility, community group, or NGO • May provide one to one counselling in homes, health facilities, mother support groups, informal setting • May conduct group counselling/communication sessions • May receive salary or small stipend • May have or not have personal experience of breastfeeding	• Integrated with other health services • Wider outreach • Their involvement in IYCF is mutually beneficial to both the existing intervention and IYCF • Understand mothers' situation • Accessible	• More limited IYCF support • May be distracted by other duties • Resistance by the original programme to adding any other duties • Tendency to focus on curative aspects
Community development and extension workers	• Outreach extends beyond mothers and children • Broader set of issues • May conduct social mobilization on IYCF	• Linked with other sectors such as agriculture • Can provide information and support on production and use of appropriate and high quality local foods for young children • Re-enforcement of messages; non-health contact points	• Limited time for IYCF support • Balancing many duties

[8] Adapted from Wellstart Trilogy (1996) and Learning from Large Scale Community Based Breastfeeding Promotion (UNICEF/WHO/AED/USAID 2008)

[9] Note that many of these community-based providers are also secondary participants in the communication strategy

Provider[9]	Common Characteristics	Advantages	Disadvantages
Traditional health practitioners (traditional healers, herbalist etc)	• Provide health care using traditional methods/ products • May have knowledge of traditional and modern medicine • May conduct social mobilization on IYCF	• Serve women least likely to attend PHC facility	• May require special training curricula, materials, and trainers, may provide advice that is not according to recommendations
Local child nutrition advocates (Grandmothers, supportive men, local media, teachers, women's groups, mother-to-mother support groups, members of village health committees, community or faith based organizations (CBOs/FBOs)	• Opinion leaders within family, the community, or country • May conduct social mobilization on IYCF • May conduct group sessions on IYCF	• Broaden support network, reach secondary targets • May have special skills in community promotion and education	• Usually not ideal candidates for facilitating IYCF support groups • May be reluctant to abandon harmful traditional practices

APPENDIX 4: Steps in Creating a Cadre or Network of IYCF-Related CWs

The following steps need to be addressed in creating a cadre of IYCF-related CWs:

- **Decide on an appropriate CHW/IYCF counsellor profile** for the tasks of IYCF promotion, counselling and support, including: gender, minimum educational level, residence, etc. Individual counselling on IYCF is a key intervention that can be delivered by a trained lay counsellor, a peer, a health visitor, community volunteer, paid community health worker or extension worker or extended family member. Educational levels may vary; it is desirable for a CHW/IYCF counsellor to have at least Grade 5-8 level schooling.
- **Create a job description** for the CHW – either for IYCF tasks alone if the worker is a dedicated IYCF counsellor or for the full portfolio of tasks
- **Establish appropriate ratio** of community workers to households and proposed time commitment of the community workers. If the ratio is too low – e.g. 1 CHW for every 20 households – it will not be possible to achieve scale as the programme will be very expensive. If the ratio is too high – e.g. 1 for every 500 households – the CHW will not be able to reach all the families with young children. The ratio needs to be tailored to the local situation.
- **Establish incentives** – in-kind, cash, transport, materials, etc, and clarify who will provide these incentives and when. The dropout rate is likely to be very high and the activities very limited if no incentives or insufficient incentives are provided.
- **Undertake a participatory process of orientating existing IYCF-related CWs** on the IYCF programme and tasks followed by selection of interested and suitable candidates for training; **or**
- **Undertake a participatory process of selecting new IYCF-related CWs** if there are no existing cadres.
- **Update the knowledge and skills of health professionals** and NGO health/nutrition staff on IYCF to ensure good quality training and supervision/mentoring of community cadres.
- **Plan training** for the identified CWs, including lay IYCF counsellors, leaders of mother support groups and other available groups or cadres functioning at community level (e.g. activists, promoters, health committees and other volunteers).
- **Identify multiple contact points** most appropriate for IYCF promotion and counselling activities – e.g. home visits, early childhood care centres, community-based screening of severe acute malnutrition, growth monitoring and promotion sessions, immunization sessions, health days, and other community events.
- **Set specific targets for activities,** either as individuals or as a group: e.g. for the expected pregnant and lactating women there would be in the community who need to be followed up, or for the number of group sessions to be conducted, the number of support groups to be created, or for the number of IYCF contacts to be made each month at growth monitoring sessions, community meetings etc. These targets can be discussed and set during the training and reinforced and followed up during mentoring and supervision.
- **Design an effective system for sustained supportive supervision,** mentoring and retraining for the identified cadres and groups, and ensure that supervision is included in annual plans. Designing a list of indicators with IYCF information that is useful and feasible to collect, and integrating it within existing indicators for the community-based programme if applicable. If the community based programme is a new one or does not have a monitoring system, a system and tools need to be developed[10].
- **Ensure a strong link with the health system**, for example for referral, mentoring, supervision and data collection.
- **Create a system of mother support groups** as appropriate. The Baby Friendly Hospital Initiative (BFHI) materials provide guidance on this.

[10] The Haryana manual contains a sample monitoring tool that could be adapted. WHO/UNICEF. Implementing Community Activities on Infant and Young Child Feeding: A manual based on the experience from Haryana, India. Field Test Draft for Kisii, Kenya. June 2008.

- **Create a structure for knowledge-sharing** on IYCF in the community, such as billboards, regular community meetings, religious gatherings, using outreach and child health days systematically to disseminate IYCF messages, community theatre and music groups, mobile video units, etc.
- **Ensure a vision for scale within the national health plans and budgets**, including the community IYCF actions in all districts in a phased manner.

APPENDIX 5: Checklist for the Adaptation of the *Community IYCF Counselling Package*

	Adaptation Steps and Related Activities	Proposed Dates		Responsible person, people and/or organization(s)
		Begin	End	
☑	Step 1: Build partnerships and define roles and responsibilities			
	1. Identify the government bodies (ministries, etc.), UN agencies, donors, technical assistance partners, community-based and international non-governmental organizations, faith-based organizations, advocacy groups and individuals (content experts) engaged in IYCF-related activities.			
	2. Establish a technical working group of major stakeholders and content experts, including those not necessarily associated with IYCF (e.g. HIV prevention, reproductive health and early childhood development programs, etc.)			
	3. Agree on who will lead the technical working group and define the roles and responsibilities of the various members			
	4. Review *Appendix 5: Checklist for the Adaptation of the Community IYCF Counselling Package;* compare organizational work plans; and examine the feasibility of sharing responsibilities and resources for the adaptation of the package.			
	5. Develop a corresponding work plan. (Review Appendix 3: Checklist for the Adaptation of the *Community IYCF Counselling Package.*)			
	6. Determine available resources and develop an adaptation budget.			
☑	Step 2: Conduct a systematic review of the *Community IYCF Counselling Package*			
	1. Plan a review workshop or series of meetings to examine each element of the *Community IYCF Counselling Package.*			
	2. Collect existing IYCF counselling materials, current training curricula and M&E tools being used nationally.			
	3. Collect available survey data and relevant formative research findings related to the epidemiology, knowledge, practices and socio-cultural issues affecting IYCF and maternal nutrition.			

	Adaptation Steps and Related Activities	Proposed Dates		Responsible person, people and/or organization(s)
		Begin	End	
	4. Reproduce a sufficient number of copies of all materials (existing national tools, research data and *Community IYCF Counselling Package*) to be reviewed so that each participant has his or her own set of files.			
	5. Systematically review each element of the *Community IYCF Counselling Package* and determine what adjustments or adaptations are required, based on available information and relevant data, to ensure alignment with national norms, protocols and other recommendations. (See specific elements of the package that are noted below requiring special attention/review.)			
	6. Consider the need to adapt words and expressions to reflect local terminology, and also the need to translate the *Facilitator Guide*, *Participant Materials*, *Counselling Cards*, *Key Message Booklet*, and *Take-home Brochures* into local language or languages.			
	7. Consider the need to adapt/adjust illustrations and other graphics in relationship to the socio-cultural context and local feeding challenges.			
	8. Consider time available for training, varying knowledge levels of participants, other characteristics of the proposed audience.			
	9. Identify technical elements that are potentially controversial. If issues are controversial, discuss until consensus is achieved.			
	10. Consolidate feedback from review.			
	11. Synthesize the comments from local content experts, other stakeholders and in-country reviewers.			
	12. Circulate summary recommendations for changes that need to be addressed to members of the technical working group and other stakeholders for final input and "sign-off".			
	13. Develop work plan and request all stakeholders to commit personnel and resources to complete the adaptation of the package.			
	Step 3: Adapt graphics and layouts of all materials			
	1. Identify high-level individuals of teams of illustrators and/or graphic artists with specific computer graphic training and experience.			
	2. Specify the number of illustrations to be adapted and/or developed and the number of materials that will require layout adjustments.			

	Adaptation Steps and Related Activities	Proposed Dates		Responsible person, people and/or organization(s)
		Begin	End	
	3. Develop a contract with the illustrators and/or graphic artists that reflects the quality and quantity of work anticipated.			
	4. Ensure that all of the necessary equipment is available for use during the graphic adaptation process.			
	5. Secure copies of the original graphic files from UNICEF that will serve as the basis for adaptation and layout.			
	6. Develop a systematic checklist of steps involved in the graphic adaptation process.			
	7. Oversee the adaptation and/development of new illustrations.			
	8. Coordinate interface between the technical team, translation team and graphic team as needed.			
☑	Step 4: Conduct final technical review of adapted package			
☑	Step 5: Translate training content, if necessary, and *Counselling Cards, Key Messages Booklet* and *Take-home Brochures*			
☑	Step 6: Finalize graphics and layouts for all elements of the adapted package			
☑	Step 7: Field test graphic components of the package (illustrations, key messages and layouts) with local end-users			

	Adaptation Steps and Related Activities	Proposed Dates		Responsible person, people and/or organization(s)
		Begin	End	
☑	Step 8: Review field test results for the graphic components of the package and make final decisions			
☑	Step 9: Field test the integrated *Community IYCF Counselling Package* and make final adjustments based on stakeholder consensus			
	1. Based on the results of the technical review, final modifications should be made.			
	2. Field test the integrated *Community IYCF Counselling Package* to determine whether or not the package is comprehensive, effective and culturally appropriate			
	3. Make final adjustments following the field test and final technical review and stakeholder consensus.			
☑	Step 10: Develop plans and budgets for printing, dissemination, training, monitoring and evaluation of the package			

APPENDIX 6: Adaptation Tracking Matrices for *Counselling Cards & Take-home Brochures*

Sample Adaptation Tracking Matrices for *Community IYCF Counselling Cards*

Counselling Card	Proposed Changes to Graphics & Illustrations	Proposed Changes to Key Messages/Text	Development Status	Date		Resp. Person(s)	Approvals	
				Start	End		1	2
Cover								
Acknowledgments								
Introduction								
Counselling Job Aid								
CC 1								
CC 2:								
CC 3:								
CC 4:								
CC 5:								
CC 6:								
CC 7:								
CC 8:								
CC 9:								
CC 10:								
CC 11:								
CC 12:								
CC 13:								
CC 14:								
CC 15:								
CC 16:								
CC 17:								
CC 18:								
CC 19:								
CC 20:								
CC 21:								
CC 22:								

Counselling Card	Proposed Changes to Graphics & Illustrations	Proposed Changes to Key Messages/Text	Development Status	Date		Resp. Person(s)	Approvals	
				Start	End		1	2
CC 23a:								
CC 23b:								
CC 24								
Special Circumstance 1								
Special Circumstance 2								
Special Circumstance 3								

Sample Adaptation Tracking Matrix for *Community IYCF Take-home Brochures*

Take Home Brochure	Proposed Changes to Graphics & Illustrations	Proposed Changes to Key Messages/Text	Development Status	Date		Resp. Person(s)	Approvals	
				Start	End		1	2
Exclusive Breastfeeding								
Front Cover								
Inside 1								
Inside 2								
Inside 3								
Back 1								
Back 2								
Acknowledgements								
Feeding After 6 Months								
Front Cover								
Inside 1								
Inside 2								
Inside 3								
Back 1								
Back 2								
Acknowledgements								
Maternal Nutrition								
Front Cover								
Inside 1								
Inside 2								
Inside 3								
Back 1								
Back 2								
Acknowledgements								

APPENDIX 7: Step-by-Step Guide for Creating/Adapting Illustrations

1. Develop the scenes for the illustrations that you want to create or adapt. Set up a photo shoot using models and shoot a variety of poses for each scene. You can also use existing photographs or illustrations as your reference files, scanning them if necessary.

2. Download your digital images to your computer and if necessary, combine or alter them to fit your specific needs. Then print out a large version of each selected photo or digital image for tracing.

3. Use a lightbox or similar device to trace the photo or digital image. Be careful to trace an accurate outline of your image. Include all information you will need in your tracing to make the final illustration.

4. Scan the tracing and import it into your computer. Save it as a grayscale or RGB TIF file.

5. Open the TIF file in PhotoShop and clean up the drawing, closing up areas of similar colour and erasing extraneous information.

6. Save your file under a new name. Duplicate the drawing layer and delete all white pixels from the new layer. This layer should then contain only the line drawing and should always be the top layer of your PhotoShop file. The black lines of the drawing should appear on top of your coloured layers.

7. Add areas of flat colour to your drawing. Make a new layer for each colour or article of clothing or skin. Use the drawing layer to select the different areas, but always add colour to a new layer underneath the transparent drawing layer so as not to alter the drawing layer.

8. After all colours have been added a print out of this version may be used to pretest the image for accuracy and if the drawing is successful in illustrating the idea to be conveyed.

9. Once the drawing is approved, volume can be added to the drawing. Adding volume can be done to the colour layer or on a duplicate layer to preserve your original. Use the burn and dodge tools to add shadow and highlight to each layer. Start with the shadow areas first, and use midtones at low settings to begin (15% or less).

10. After the volume has been added to all the areas, save a copy of the image as a photoshop or tif file with layers. Then flatten your image (merging all layers) and save as a TIF file. Change the mode to CMYK and review the image for colour changes, darkness, contrast, etc.

11. Once you are satisfied with the image save it and resize as necessary for the layout. Try to use images at 100% in the layout program so your files will print at proper resolution while not being too large.

12. The image is now ready to be imported into your page layout program (InDesign [version 3 or 4] is recommended).

APPENDIX 8: Matrices for Adaptation-Translation of *Key Messages* & *Take-home Brochures*

Matrix for Adaptation-Translation of *Community IYCF Counselling Cards* in *Key Messages Booklet*

Card	English	Adaptation – Translation
Cover	Infant and Young Child Feeding Counselling Cards for Community workers	
Acknowledge-ments	FILL IN	
Introduction	FILL IN	
Counselling Tips	FILL IN	
Card 1	Nutrition for pregnant and breastfeeding woman	
Text on card	No bullet	
	• During your pregnancy, eat one extra small meal or "snack" (extra food between meals) each day to provide energy and nutrition for you and your growing baby.	
	• During breastfeeding, eat two extra small meals or "snacks" (extra food between meals) each day to provide energy and nutrition for you and your growing baby.	
	• You need to eat the best foods available, including milk, fresh fruit and vegetables, meat, fish, eggs, grains, peas and beans.	
	• Drink whenever you are thirsty. • Taking tea or coffee with meals can interfere with your body's use of the foods. • Limit the amount of coffee you drink during pregnancy.	
	• During pregnancy and breastfeeding, special nutrients will help your baby grow well and be healthy. • Take iron and folic acid tablets to prevent anaemia during pregnancy and for at least 3 months after your baby's	

Card	English	Adaptation – Translation
	birth. • Take vitamin A tablets immediately after delivery or within 6 weeks so that your baby receives the vitamin A in your breast milk to help prevent illness. • Use iodised salt to help your baby's brain and body develop well.	
	• Attend antenatal care at least 4 times during pregnancy. These check-ups are important for you to learn about your health and how your baby is growing.	
	• Take de-worming tablets to help prevent anaemia. • To prevent malaria, sleep under an insecticide-treated mosquito net and take anti-malarial tablets as prescribed. • Learn your HIV status, attend all the clinic appointments and take your medicines as advised by your health provider.	
	• Adolescent mothers: you need extra care, more food and more rest than an older mother. You need to nourish your own body, which is still growing, as well as your growing baby's.	
Card 2	Pregnant woman / Delivery in facility	
	• Hold your newborn skin-to-skin immediately after birth. This will keep your baby warm and breathing well, help him or her reach the breast easily, and help you and your baby feel close.	
	• Begin breastfeeding within the first hour of birth. Early breastfeeding helps the baby learn to breastfeed while the breast is still soft, and helps reduce your bleeding.	
	• Colostrum, the thick yellowish milk, is good for your baby. • Colostrum helps protect your baby from illness and helps	

Card	English	Adaptation – Translation
	remove the first dark stool.	
	• Breastfeed frequently to help your breast milk 'come in' and to ensure plenty of breast milk.	
	• Do not give water or other liquids/fluids to your baby during the first days after birth. They are not necessary and are dangerous for your newborn.	
Card 3	During the first 6 months, your baby needs ONLY breast milk	
	• Breast milk provides all the food and water that your baby needs during the first 6 months.	
	• Do not give anything else, not even water, during your baby's first 6 months. • Even during very hot weather breast milk will satisfy your baby's thirst. • Giving your baby anything else will cause him/her to suckle less and will reduce the amount of breast milk that you produce. • Water, other liquids and foods can make the baby sick	
	• You can give medicines if they are recommended by your health care provider.	
	• **Note:** There may be a period of 24 hours in the first day or two when the baby feeds only 2 to 3 times. After the first few days, frequent breastfeeding is important for establishing a good supply.	
Card 4	Importance of exclusive breastfeeding during the first 6 months	
	• Exclusive breastfeeding means feeding your baby ONLY breast milk for the first 6 months. • Breast milk provides all the food and water that your baby needs during the first 6 months of life.	
	• Exclusive breastfeeding for the first 6 months protects	

Card	English	Adaptation – Translation
	your baby from many illnesses, such as diarrhoea and respiratory infections.	
	• When you exclusively breastfeed your baby during the first 6 months and have no menses you are protected from another pregnancy.	
	• Mixed feeding means feeding your baby both breast milk and other foods or liquids, including infant formula, animal milks or water. • Mixed feeding before 6 months can damage your baby's stomach. • Mixed feeding increases the chances that your baby will suffer from illnesses such as diarrhoea and pneumonia and from malnutrition.	
	• Giving your baby foods or any kind or liquids including infant formula animal milks, or water before 6 months can damage your baby's stomach. This reduces the protection that exclusive breastfeeding gives, and the benefits that your baby gets from your breast milk.	
	• Note for community health workers:	
	• If a mother is HIV-infected, refer to Counselling Cards 21 to 23b or the 3 Special Circumstance Cards for information on HIV and infant feeding.	
Card 5	Breastfeed on demand, both day and night (8 to 12 times) to build	
	• Breastfeed the baby on demand, day and night. • More suckling (with good attachment) makes more breast milk.	
	• Crying is a late sign of hunger. Early signs that your baby wants to breastfeed include:	
	▪ Restlessness.	

Card	English	Adaptation – Translation
	▪ Opening mouth and turning head from side-to-side.	
	▪ Putting tongue in and out.	
	▪ Sucking on fingers and fists.	
	• Let your baby finish one breast before offering the other. • Switching back and forth from one breast to the other prevents the baby from getting the nutritious 'hind milk'. The 'fore milk' has more water and satisfies the baby's thirst. The 'hind milk' has more fat and satisfies your baby's hunger.	
	• If your baby is ill or sleepy, wake him/her to offer the breast often.	
	• Do NOT use bottles, teats or spouted cups. They are difficult to clean and can cause your baby to become sick.	
	• Note for community workers:	
	• If a mother is concerned about her baby getting enough milk, encourage the mother and build her confidence by reviewing how to attach and position the baby to her breast. • Reassure her that her baby is getting enough milk when her baby is:	
	▪ Not visibly thin (or is getting fatter/putting on weight, if he or she was thin earlier).	
	▪ Responsive and active (appropriately for his or her age).	
	▪ Gaining weight - refer to the baby's health card (or growth velocity table if available). If you are not sure if the weight gain is adequate, refer the child to the nearest health facility.	
	▪ When baby passes light-coloured urine 6 times a day or more while being exclusively breastfed.	

Card	English	Adaptation – Translation
Card 6	Breastfeeding positions	
	• Good positioning helps to ensure that your baby suckles well and helps you to produce a good supply of breast milk.	
	• The four key points about your baby's position are: **straight, facing you, close, and supported.**	
	• **The baby's body should be straight**, not bent or twisted, but with the head slightly back.	
	• **The baby's body should be facing the breast** not held flat to your chest or abdomen, and he or she should be able to look up into your face.	
	• **The baby should be close to you**.	
	• **You should support the baby's whole body**, not just the neck and shoulders, with your hand and forearm.	
	• There are different ways to position your baby:	
	▪ Cradle position (most commonly used).	
	▪ Cross cradle position (good for small babies).	
	▪ Side-lying position (use to rest while breastfeeding and at night).	
	▪ Under-arm position (use after caesarean section, if your nipples are painful or if you are breastfeeding twins or a small baby).	
	• Note for community workers:	
	• If an older baby is suckling well, there is no need to change position.	
Card 7	Good attachment	
	• Good attachment helps to ensure that your baby suckles well and helps you to produce a good supply of breast milk. • Good attachment helps to prevent sore and cracked	

Card	English	Adaptation – Translation
	nipples.	
	• Breastfeeding should not be painful. • Get help to improve the attachment if you experience pain.	
	• **There are 4 signs of good attachment:**	
	1. Baby's mouth is wide open.	
	2. You can see more of the darker skin (areola) above the baby's mouth than below.	
	3. Baby's lower lip is turned outwards.	
	4. Baby's chin is touching mother's breast.	
	• **The signs of effective suckling are:**	
	a. The baby takes slow deep suckles, sometimes pausing.	
	b. You may be able to see or hear your baby swallowing after one or two suckles.	
	c. Suckling is comfortable and pain free for you.	
	d. Your baby finishes the feed, releases the breast and looks contented and relaxed.	
	e. The breast is softer after the feed.	
	• Effective suckling helps you to produce milk and satisfy your baby.	
	• After your baby releases one breast offer your baby the other breast. This will ensure that your baby stimulates your milk production in both breasts, and also gets the most nutritious and satisfying milk.	
Card 8	Feeding a low birth weight baby	
	• Breast milk is especially adapted to the nutritional needs of low birth weight infants. • The best milk for a low birth weight infant, including babies born early, is the breast milk from the baby's own mother.	

Card	English	Adaptation – Translation
	• The cross cradle and underarm positions are good positions for feeding a low birth weight baby.	
	• Breastfeed frequently to get baby used to the breast and to keep the milk flowing.	
	• Long slow feeds are fine. It is important to keep the baby at the breast.	
	• If the baby sleeps for long periods of time, you may need to unwrap the baby or take off some of his or her clothes to help waken him or her for the feed.	
	• Breastfeed the baby before s/he starts to cry. • Earlier signs of hunger include a COMBINATION of the following signs: being alert and restless, opening mouth and turning head, putting tongue in and out, sucking on hand or fist.	
	• Note for the community workers:	
	• Direct breastfeeding of a very small baby may not be possible for several weeks. Mothers should be taught and encouraged to express breast milk and feed the breast milk to the infant using a cup.	
	• Kangaroo mother care provides skin-to-skin contact, warmth and closeness to the mother's breast.	
	• Kangaroo mother care encourages early and exclusive breastfeeding, either by direct feeding or using expressed breast milk given by cup.	
	• Different caregivers can also share in the care of the baby using the same Kangaroo method position.	
Card 9	How to hand express breast milk and cup feed:	
	• Make sure your hands and utensils are clean. • Wash your hands with soap and running water.	

Card	English	Adaptation – Translation
	• Clean and boil the container you will use to express your breast milk.	
	• Get comfortable. • It is sometimes helpful to massage your breasts. A warm cloth may help stimulate the flow of milk.	
	• Put your thumb on the breast above the dark area around the nipple (areola) and the other fingers on the underside of the breast behind the areola.	
	• With your thumb and first 2 fingers push in towards chest wall and then press towards the dark area (areola).	
	• Milk may start to flow in drops, or sometimes in fine streams. Collect the milk in the clean container.	
	• Avoid rubbing the skin, which can cause bruising or squeezing the nipple, which stops the flow of milk.	
	• Rotate the thumb and finger positions and press/compress and release all around the areola.	
	• Express one breast for at least 3 to 5 minutes until the flow slows, then express other breast, then repeat both sides again (20 to 30 minutes total).	
	• Store breast milk in a clean, covered container. Milk can be stored 6 to 8 hours in a cool place and up to 72 hours in the back of the refrigerator.	
	• Give baby expressed breast milk from a cup. Bring cup to the baby's lower lip and allow baby to take small amounts of milk, lapping the milk with his/her tongue. Do not pour the milk into baby's mouth.	
	• Pour just enough breast milk from the clean covered container into the feeding cup.	
	• Bottles are unsafe to use because they are difficult to wash and can be easily contaminated.	

Card	English	Adaptation – Translation
Card 10	When you are separated from your baby	
	• Learn to express your breast milk soon after your baby is born. (CC 9)	
	• Breastfeed exclusively and frequently for the whole period that you are with your baby.	
	• Express and store breast milk before you leave your home so that your baby's caregiver can feed your baby while you are away.	
	• Express breast milk while you are away from your baby. This will keep the milk flowing and prevent breast swelling.	
	• Teach your baby's caregiver how to use a clean open cup to feed your baby while you are away.	
	• Expressed breast milk (stored in a cool, covered place) stays in good condition for 8 hours, even in a hot climate.	
	• Take extra time for the feeds before separation from baby and when you return home.	
	• Increase the number of feeds while you are with the baby. This means increasing night and weekend feedings.	
	• If possible, carry the baby with you to your work place or consider having someone bring the baby to you to breastfeed when you have a break.	
	• Get extra support from family members in caring for your baby and other children, and for doing household chores.	
	• Note for a working mother with formal employment:	
	• Get your employer's consent for: ▪ breastfeeding breaks at your work place and flexible working hours ▪ safe storage of expressed breast milk at your work place	

Card	English	Adaptation – Translation
Card 11	Good hygiene practices prevent disease	
	• Good hygiene (cleanliness) is important to avoid diarrhoea and other illnesses. (CC 11)	
	• Wash your hands with soap and water before preparing foods and feeding baby.	
	• Wash your hands and your baby's hands before eating.	
	• Wash your hands with soap and water after using the toilet and washing or cleaning baby's bottom.	
	• Feed your baby using clean hands, clean utensils and clean cups.	
	• Use a clean spoon or cup to give foods or liquids to your baby. • Do not use bottles, teats or spouted cups since they are difficult to clean and can cause your baby to become sick.	
	• Store the foods given to your baby in a safe clean place.	
Card 12	Start Complementary Feeding when Baby Reaches 6 months	
	• Starting at about 6 months, your baby needs other foods in addition to breast milk.	
	• Continue breastfeeding your baby on demand both day and night. • Breast milk continues to be the most important part of your baby's diet.	
	• Always give your baby breast milk first before giving other foods.	
	• When giving complementary foods to your baby, think: Frequency, Amount, Thickness, Variety, Active/ responsive feeding, and Hygiene.	
	• **Frequency**: Feed your baby 2 times a day.	
	• **Amount**: Give 2 to 3 tablespoonfuls ('tastes') at each feed.	

Card	English	Adaptation – Translation
	• **Thickness**: should be thick enough to be fed by hand.	
	• **Variety**: Begin with the staple foods like porridge (corn, wheat, rice, millet, potatoes, sorghum), mashed banana or mashed potato.	
	• **Active/responsive feeding**: • Baby may need time to get used to eating foods other than breast milk. • Be patient and actively encourage your baby to eat. • Don't force your baby to eat. • Use a separate plate to feed the baby to make sure he or she eats all the food given.	
	• **Hygiene**: Good hygiene (cleanliness) is important to avoid diarrhoea and other illnesses. (CC 11).	
	• Use a clean spoon or cup to give foods or liquids to your baby.	
	• Store the foods given to your baby in a safe hygienic place.	
	• Wash your hands with soap and water before preparing foods and feeding baby.	
	• Wash your hands and your baby's hands before eating.	
	• Wash your hands with soap and water after using the toilet and washing or cleaning baby's bottom.	
	• Note about the size of cups: All cups shown and referred to in the Counselling Cards are mugs which have a volume of 250 ml. If other types or sizes of cups are used to feed a baby, they should be tested to see what volume they hold and the recommended quantities of food or liquid should be adjusted to the local cup or mug.	
	• After 6 months or whenever you begin complementary foods you can no longer use LAM.	

Card	English	Adaptation – Translation
	• You will need to use another family planning method even though your menses has not yet returned. • There are many methods of family planning that will not interfere with breastfeeding.	
Card 13	Complementary feeding from 6 up to 9 months	
	• Continue breastfeeding your baby on demand both day and night. This will maintain his or her health and strength, as breast milk continues to be the most important part of your baby's diet. • Breast milk supplies half (1/2) baby's energy needs from 6 up to 12 months.	
	• Always give your baby breast milk first before giving other foods.	
	• When giving complementary foods to your baby, think: Frequency, Amount, Thickness, Variety, Active/ responsive feeding, and Hygiene.	
	• **Frequency**: Feed your baby complementary foods 3 times a day.	
	• **Amount**: Increase amount gradually to half (½) cup (250 ml cup: show amount in cup brought by mother). • Use a separate plate to make sure young child eats all the food given.	
	• **Thickness**: Give mashed/pureed family foods. By 8 months your baby can begin eating finger foods.	
	• **Variety**: Try to feed a variety of foods at each meal. For example: Animal-source foods (flesh meats, eggs and dairy products) **1 star***; Staples (grains, roots and tubers) **2 stars****; Legumes and seeds **3 stars***** ; Vitamin A rich fruits and vegetables and other fruits and vegetables **4 stars****** (CC 16).	

Card	English	Adaptation – Translation
	• **NOTE: foods may be added in a different order to create a 4 star food/diet.**	
	• Animal source foods are very important and can be given to young children: cook well and chop fine. • Infants can eat well-cooked and finely-chopped eggs, meat and fish even if they don't have teeth. • Additional nutritious snacks (extra food between meals) such as fruit or bread or bread with nut paste can be offered once or twice per day.	
	• If you prepare food for the baby that has oil or fat in it, use no more than half a teaspoon per day.	
	• Use iodized salt.	
	• Each week you can add one new food to your child's diet.	
	• Avoid giving sugary drinks.	
	• Avoid sweet biscuits.	
	• **Active/responsive feeding**: • Be patient and actively encourage your baby to eat. • Don't force your baby to eat. • Use a separate plate to feed the baby to make sure he or she eats all the food given.	
	• **Hygiene**: Good hygiene (cleanliness) is important to avoid diarrhoea and other illnesses. (CC 11).	
	• Use a clean spoon or cup to give foods or liquids to your baby.	
	• Store the foods given to your baby in a safe hygienic place.	
	• Wash your hands with soap and water before preparing foods and feeding baby.	
	• Wash your hands and your baby's hands before eating.	
	• Wash your hands with soap and water after using the toilet	

Card	English	Adaptation – Translation
	and washing or cleaning baby's bottom.	
	• Note about the size of cups: All cups shown and referred to in the Counselling Cards are mugs which have a volume of 250 ml. If other types or sizes of cups are used to feed a baby, they should be tested to see what volume they hold and the recommended quantities of food or liquid should be adjusted to the local cup or mug.	
	• After 6 months or whenever you begin complementary foods you can no longer use LAM. • You will need to use another family planning method even though your menses has not yet returned. • There are many methods of family planning that will not interfere with breastfeeding.	
Card 14	Complementary feeding from 9 up to 12 months	
	• Continue breastfeeding your baby on demand both day and night. This will maintain baby's health and strength as breast milk continues to be the most important part of your baby's diet. • Breast milk supplies half (1/2) baby's energy needs from 6 up to 12 months.	
	• Always give your baby breast milk first before giving other foods.	
	• When giving complementary foods to your baby, think: Frequency, Amount, Thickness, Variety, Active/ responsive feeding, and Hygiene.	
	• **Frequency**: Feed your baby complementary foods 4 times a day.	
	• **Amount**: Increase amount to half (½) cup (250 ml cup: show amount in cup brought by mother). • Use a separate plate to make sure young child eats all the	

Card	English	Adaptation – Translation
	food given.	
	• **Thickness**: Give finely chopped family foods, finger foods, sliced foods.	
	• **Variety**: Try to feed a variety of foods at each meal. For example: Animal-source foods (flesh meats, eggs and dairy products) **1 star***; Staples (grains, roots and tubers) **2 stars****; Legumes and seeds **3 stars***** ; Vitamin A rich fruits and vegetables and other fruits and vegetables **4 stars****** (CC 16). • **NOTE: foods may be added in a different order to create a 4 star food/diet.**	
	• Animal source foods are very important and can be given to young children: cook well and chop fine. • Additional nutritious snacks (extra food between meals) such as fruit or bread or bread with nut paste can be offered once or twice per day.	
	• Use iodized salt.	
	• Avoid giving sugary drinks.	
	• Avoid sweet biscuits.	
	• **Active/responsive feeding**: • Be patient and actively encourage your baby to eat. • Don't force your baby to eat. • Use a separate plate to feed the baby to make sure he or she eats all the food given.	
	• **Hygiene**: Good hygiene (cleanliness) is important to avoid diarrhoea and other illnesses. (CC 11).	
	• Use a clean spoon or cup to give foods or liquids to your baby.	
	• Store the foods given to your baby in a safe hygienic place.	

Card	English	Adaptation – Translation
	• Wash your hands with soap and water before preparing foods and feeding baby.	
	• Wash your hands and your young child's hands before eating.	
	• Wash your hands with soap and water after using the toilet and washing or cleaning baby's bottom.	
	• Note about the size of cups: All cups shown and referred to in the Counselling Cards are mugs which have a volume of 250 ml. If other types or sizes of cups are used to feed a baby, they should be tested to see what volume they hold and the recommended quantities of food or liquid should be adjusted to the local cup or mug.	
	• You will need to use another family planning method even IF your menses has not yet returned. • There are many methods of family planning that will not interfere with breastfeeding.	
Card 15	Complementary feeding from 12 up to 24 months	
	• Continue breastfeeding your baby on demand both day and night. This will maintain baby's health and strength as breast milk continues to be the most important part of your baby's diet.	
	• Breast milk continues to make up about one third (1/3) of the energy needs of the young child from 12 up to 24 months.	
	• To help your baby continue to grow strong and breastfeed, you should use a family planning method to prevent another pregnancy.	
	• When giving complementary foods to your baby, think: Frequency, Amount, Thickness, Variety, Active/ responsive feeding, and Hygiene.	

Card	English	Adaptation – Translation
	• **Frequency**: Feed your young child complementary foods 5 times a day.	
	• **Amount**: Increase amount to three-quarters (¾) to 1 cup (250 ml cup: show amount in cup brought by mother). • Use a separate plate to make sure young child eats all the food given.	
	• **Thickness**: Give family foods cut into small pieces, finger foods, sliced foods.	
	• **Variety**: Try to feed a variety of foods at each meal. For example: Animal-source foods (flesh meats, eggs and dairy products) **1 star***; Staples (grains, roots and tubers) **2 stars****; Legumes and seeds **3 stars***** ; Vitamin A rich fruits and vegetables and other fruits and vegetables **4 stars****** (CC 16). • **NOTE: foods may be added in a different order to create a 4 star food/diet.**	
	• Animal source foods are very important and can be given to young children: cook well and chop fine. • Additional nutritious snacks (extra foods between meals) such as pieces of ripe mango, papaya, banana, avocado, other fruits and vegetables, boiled potato, sweet potato and fresh and fried bread products can be offered once or twice per day.	
	• Use iodized salt.	
	• Avoid giving sugary drinks.	
	• Avoid sweet biscuits.	
	• **Active/responsive feeding**: • Be patient and actively encourage your baby to eat. • Don't force your baby to eat. • Use a separate plate to feed the baby to make sure he or	

Card	English	Adaptation – Translation
	she eats all the food given.	
	• **Hygiene**: Good hygiene (cleanliness) is important to avoid diarrhoea and other illnesses. (CC 11).	
	• Use a clean spoon or cup to give foods or liquids to your baby.	
	• Store the foods given to your baby in a safe hygienic place.	
	• Wash your hands with soap and water before preparing foods and feeding baby.	
	• Wash your hands and your young child's hands before eating.	
	• Wash your hands with soap and water after using the toilet and washing or cleaning baby's bottom.	
	• Note about the size of cups: All cups shown and referred to in the Counselling Cards are mugs which have a volume of 250 ml. If other types or sizes of cups are used to feed a baby, they should be tested to see what volume they hold and the recommended quantities of food or liquid should be adjusted to the local cup or mug.	
Card 16	Food Variety	
	• Continue to breastfeed (for at least 2 years) and try to feed a variety of foods at each meal to your young child. For example:	
	• Animal-source foods (meat, chicken, fish, liver), and eggs and dairy products **1 star***	
	• Staples (maize, wheat, rice, millet and sorghum); roots and tubers (cassava, potatoes) **2 stars****	
	• Legumes (beans, lentils, peas, groundnuts) and seeds (sesame) **3 stars*****	
	• Vitamin A-rich fruits and vegetables (mango, papaya,	

Card	English	Adaptation – Translation
	passion fruit, oranges, dark-green leaves, carrots, yellow sweet potato and pumpkin), and other fruit and vegetables (banana, pineapple, watermelon, tomatoes, avocado, eggplant and cabbage) **4 stars****** • **NOTE: foods may be added in a different order to create a 4 star food/diet.**	
	• Introduce animal source foods early to babies and young children and give them as often as possible. • Cook them well and chop them finely.	
	• Additional nutritious snacks (extra food between meals) such as pieces of ripe mango, papaya, banana, avocado, other fruits and vegetables, boiled potato, sweet potato and fresh and fried bread products can be offered once or twice per day.	
	• Use iodized salt.	
Card 17	Feeding the sick baby less than 6 months of age	
	• Breastfeed more frequently during illness, including diarrhoea to help the baby fight sickness, reduce weight loss and recover more quickly. • Breastfeeding also provides comfort to your sick baby. If your baby refuses to breastfeed, encourage your baby until s/he takes the breast again.	
	• Give baby only breast milk and medicines recommended by your doctor/health care provider.	
	• If your baby is too weak to suckle, express breast milk to give the baby. This will help you to keep up your milk supply and prevent breast difficulties.	
	• After each illness, increase the frequency of breastfeeding to help your baby regain health and weight.	
	• When you are sick, you can continue to breastfeed your	

Card	English	Adaptation – Translation
	baby. • You may need extra food and support during this time.	
Card 18	Feeding the sick child more than 6 months of age	
	• Breastfeed more frequently during illness, including diarrhoea, to help your baby fight sickness, prevent weight loss and recover more quickly.	
	• Your baby needs more food and liquids while he or she is sick. • If your child's appetite is decreased, encourage him or her to eat small frequent meals. • Offer the baby simple foods like porridge and avoid spicy or fatty foods. Even if the child has diarrhoea, it is better for him or her to keep eating.	
	• After your baby has recovered, actively encourage him/her to eat one additional meal of solid food each day during the following two weeks. • This will help your child regain the weight s/he has lost and make up for missed growth.	
	• When you are sick, continue to breastfeed your baby. • You may need extra food and support during this time. • When you are sick, you will also need plenty of liquids.	
Card 19	Regular growth monitoring and promotion	
	• Attend regular growth monitoring and promotion sessions (GMP) to make sure your baby is growing well.	
	• Take your baby to growth monitoring and promotion monthly during the first year.	
	• A healthy child who is growing well always gains a certain amount of weight every month. If your child is not gaining weight or is losing weight, there is a problem.	
	• Attending growth monitoring and promotion sessions can	

Card	English	Adaptation – Translation
	help identify nutrition problems your child may have, such as severe thinness or swelling. • Nutrition problems may need urgent treatment with special (therapeutic) foods.	
	• Measuring the upper arm of a child over 6 months (MUAC) also identifies severe thinness.	
	• During growth monitoring and promotion sessions, you can ask questions about your child's growth, health and nutrition.	
	• It is important to address poor growth and other signs of poor nutrition quickly, as soon as they are identified. If the problem is severe, you should immediately take your child to the nearest health facility.	
	• When you go to the health facility for growth monitoring, ask about family planning too.	
	• You should also ask about your baby's immunization schedule. Immunizations protect babies against several diseases.	
Card 20	Optimal family planning promotes improved health and survival for both mother and child	
	• Healthy timing and spacing of pregnancy means waiting at least 2 to 3 years before becoming pregnant again.	
	• Spacing your children allows: ▪ More time to breastfeed and care for each child.	
	▪ More time for your body to recover between pregnancies.	
	▪ More money because you have fewer children, and thus fewer expenses for school fees, clothing, food etc.	
	• Feeding your baby only breast milk for the first 6 months	

Card	English	Adaptation – Translation
	helps to space births in a way that is healthy for both you and your baby. • By exclusively breastfeeding your baby for the first 6 months you can prevent pregnancy ONLY if:	
	▪ You feed the baby only breast milk.	
	▪ Your menstrual period has not returned.	
	▪ Your baby is less than 6 months old.	
	• This family planning method is called the Lactational Amenorrhea Method, or LAM. • L = lactational • A = no menses • M = method of family planning • If any of these three conditions change, you are no longer protected from becoming pregnant again.	
	• It is important to seek advice from the nearest clinic about what modern family planning methods are available, as well as when and how to use them.	
Card 21	If a woman is HIV-infected.....	
	What is the risk of HIV passing to her baby when NO preventive actions are taken?	
	• A woman infected with HIV can pass HIV to her baby during pregnancy, labour, delivery or through breastfeeding.	
	• Not all babies born to women with HIV become infected with HIV, however.	
	• If NO preventive actions are taken to prevent or reduce HIV transmission, out of every 100 HIV-infected women who become pregnant, deliver, and breastfeed for up to two years, about 35 of them will pass HIV to their babies:	
	• 25 babies may become infected with HIV during	

Card	English	Adaptation – Translation
	pregnancy, labour and delivery.	
	• 10 babies may become infected with HIV through breastfeeding, if the mothers breastfeed their babies for up to 2 years.	
	• **The other 65 women will NOT pass HIV to their babies.**	
	• All women with HIV should prevent HIV re-infection by practicing safer sex. This means using condoms during pregnancy and during breastfeeding.	
	• All breastfeeding mothers infected with HIV should seek help from their community health worker or treatment at their nearest health facility if they have any infections or breast problems.	
	Notes for community worker: • Use this card if the mother asks about the risk of breastfeeding.	
Card 22	If a woman is HIV-infected.....	
	What is the risk of passing HIV to her baby if both take ARVs and practise exclusive breastfeeding during the first 6 months?	
	• A woman infected with HIV should be given special medicines (called antiretroviral drugs or ARVs) to decrease the risk of passing HIV to her infant during pregnancy, birth, or breastfeeding.	
	• A baby born to a woman who is HIV-infected should also receive special medicines (ARVs) to decrease the risk of getting HIV during the breastfeeding period.	
	• Throughout the entire period of breastfeeding, antiretroviral drugs are strongly recommended for either the HIV-infected mother or her HIV-exposed infant.	
	• If an HIV-infected mother and her baby practise exclusive	

Card	English	Adaptation – Translation
	breastfeeding during the first six months and either the mother or her infant take ARVs throughout the breastfeeding period, the risk of infection decreases tremendously.	
	• If these preventive actions are taken, out of every 100 HIV-infected women who become pregnant, deliver, and breastfeed for at least one year, less than 5 of them will pass HIV to their babies:	
	• About 2 babies may become infected with HIV during pregnancy, labour and delivery.	
	• About 3 babies may become infected with HIV through breastfeeding.	
	• **More than 95 of these women will NOT pass HIV to their babies.**	
	Note for community worker: • Use this card if the mother asks about risks of breastfeeding	
Card 23a	Exclusively Breastfeed and Take ARVs	
	• Infant feeding recommendations are given to the mother at health facility	
	• Exclusive breastfeeding (giving ONLY breast milk) for the first 6 months together with special medicines (ARVs) for either mother or baby greatly reduces the chance of HIV passing from an HIV-infected mother to her baby.	
	• When an HIV-infected mother exclusively breastfeeds, her baby receives all the benefits of breastfeeding including protection from diarrhoea and other illnesses.	
	• Use counselling cards on exclusive breastfeeding and building your milk supply (Counselling Cards 3 to 7).	
	• Support the mother to feed her baby:	

Card	English	Adaptation – Translation
	▪ Follow recommended breastfeeding practices. ▪ Very important to avoid mixed feeding. ▪ Identify breast conditions of the HIV-infected mother and refer for treatment.	
	• HIV-exposed babies should be tested for HIV when they are about 6 weeks old.	
	• **All babies who test positive at 6 weeks** should breastfeed exclusively until 6 months, even in the absence of ARV interventions, and then continue to breastfeed for up to two years or longer. Complementary foods should be introduced at 6 months, as recommended.	
	• All breastfeeding babies who test negative at 6 weeks should continue to exclusively breastfeed until 6 months, even in the absence of ARV interventions, and continue to breastfeed until 12 months. Complementary foods should be introduced at 6 months, as recommended. After 12 months, breastfeeding should only stop once a nutritionally adequate and safe diet without breast milk can be provided.	
	• **Notes for community worker:**	
	• When mother is on life-long treatment and breastfeeds, her baby should receive daily NVP from birth to 6 weeks.	
	• With one type of ARVs (depends on national policy) mother takes these medicines up to 1 week after breastfeeding stops and her baby receives daily NVP from birth to 6 weeks.	
	• With another type of ARVs (depends on national policy) mother takes these medicines for 1 week after birth and her baby receives daily NVP from birth until 1 week after	

Card	English	Adaptation – Translation
	breastfeeding stops.	
	• Explain the benefits of ARVs, both for the mother's health if she needs them and for preventing transmission of HIV to her baby.	
	• Support HIV-infected women to go to a clinic that provides ARVs, or refer for ARVs.	
	• Reinforce the ARV message at all contact points with HIV-infected women and at infant feeding support contact points.	
	• Refer to health facility if HIV-infected mother changes feeding option or her ARVs are going to run out soon.	
Footnote	**Reminder**: This *Counselling Card* is for countries where national policy for HIV-exposed infants is exclusive breastfeeding + ARVs.	
Card 23b	Exclusively Breastfeed even when there are no ARVs	
	• Exclusively breastfeeding (giving ONLY breast milk) for the first 6 months.	
	• Exclusive breastfeeding (giving ONLY breast milk) for the first 6 months greatly reduces the chance of HIV passing from an HIV-infected mother to her baby.	
	• When an HIV-infected mother exclusively breastfeeds, her baby receives all the benefits of breastfeeding including protection from diarrhoea and other illnesses.	
	• Mixed feeding (feeding baby both breast milk and any other foods or liquids, including infant formula, animal milks, or water) before 6 months greatly increases the chances of an HIV-infected mother passing HIV to her baby.	
	• Mixed can cause damage to the baby's stomach. This	

Card	English	Adaptation – Translation
	makes it easier for HIV and other diseases to pass into the baby.	
	• Mixed feeding also increases the chance of the baby dying from other illnesses such as diarrhoea and pneumonia because he or she is not fully protected through breast milk and the water and other milks or food can be contaminated.	
	• If an HIV-infected mother develops breast problems, she should seek advice and treatment immediately. She may be encouraged to express and heat treat her breast milk so that it can be fed to her baby while she is recovering.	
	• Use counselling cards on exclusive breastfeeding and building your milk supply (Counselling Cards 3 to 7).	
	• HIV-exposed babies should be tested for HIV when they are about 6 weeks old.	
	• **Note for community worker**: An HIV- infected mother should exclusively breastfeed during the first 6 months even if there is not always access to ARVs.	
Card 24	When to bring your child to the health facility	
	• Take your child immediately to a trained health worker or clinic if any of the following symptoms are present:	
	• Refusal to feed and being very weak.	
	• Vomiting (cannot keep anything down)	
	• Diarrhoea (more than 3 loose stools a day for two days or more and/or blood in the stool, sunken eyes)	
	• Convulsions (rapid and repeated contractions of the body, shaking)	
	• The lower part of the chest sucks in when the child breathes in, or it looks as though the stomach is moving up and down (respiratory infection)	

Card	English	Adaptation – Translation
	• Fever (possible risk of malaria)	
	• Malnutrition (loss of weight or swelling of the body)	
Special Circumstance Card 1	Avoid All Breastfeeding	
	• Infant feeding recommendations are given to the mother at health facility.	
	• Exclusive replacement feeding (giving ONLY infant formula) for the first 6 months eliminates the chance of passing HIV through breastfeeding.	
	• Replacement feeding is also accompanied with provision of ARVs for the mother (at least 1 week after birth) and the infant (for six weeks after birth).	
	• Maintaining the mother's central role in feeding her baby is important for bonding and may also help to reduce the risks in preparation of replacement feeds.	
	• Mixed feeding (feeding baby both breast milk and any other foods or liquids, including infant formula, animal milks, or water) before 6 months greatly increases the chances of an HIV-infected mother passing HIV to her baby.	
	• Mixed feeding is always dangerous for babies less 6 months. A baby less than 6 months has immature intestines. Other food or drinks than breast milk can cause damage to the baby's stomach. This makes it easier for HIV and other diseases to pass into the baby.	
	• Support the mother to feed her child: ▪ No mixed feeding ▪ No dilution of formula ▪ Help mother read instructions on formula tin	

Card	English	Adaptation – Translation
	▪ Feed the baby with a cup ▪ See Special Circumstances Card 2	
	• Refer to health facility if her baby gets sick with diarrhoea or other illnesses or she has difficulty obtaining sufficient formula.	
Footnote	**Reminder:** This *Counselling Card* is only for countries where national policy for HIV-exposed infants is exclusive replacement feeding OR for mothers who decided at the health facility to opt out of breastfeeding + ARVs.	
Special Circumstance Card 2	Conditions needed to avoid all breastfeeding	
	• Infant feeding recommendations are given to the mother at health facility.	
	• Wash hands with soap and water before preparing formula and feeding baby.	
	• Make sure to get enough supplies for the baby's normal growth and development until he or she reaches at least 6 months. (A baby needs about 40 tins of 500g in formula for the first 6 months.)	
	• Always read and follow the instructions that are printed on the tin very carefully. Ask for more explanation if you do not understand.	
	• Use clean water to mix with the infant formula. If they can, prepare the water that is needed for the whole day. Bring the water to a rolling boil for at least 2 minutes and then pour into a flask or clean covered container specially reserved for boiled water.	
	• Keep or carry boiled water and infant formula powder	

Card	English	Adaptation – Translation
	separately to mix for the next feeds, if the mother is working away from home or for night feeds.	
	• Wash the utensils with clean water and soap, and then boil them to kill the remaining germs.	
	• Use only a clean spoon or cup to feed the baby. Even a newborn baby learns quickly how to drink from a cup. Do not use bottles, teats or spouted cups.	
	• Store the formula tin in a safe clean place.	
	• Only prepare enough infant formula for one feed at a time, and use the formula within one hour of preparation.	
	• DO NOT reintroduce breastfeeding: avoid any mixed feeding.	
Footnote	**Reminder:** This *Counselling Card* is only for countries where national policy for HIV-exposed infants is exclusive replacement feeding OR for mothers who decided at the health facility to opt out of breastfeeding + ARVs.	
Special Circumstance Card 3	Non-breastfed Child from 6 up to 24 months	
	• **Note for community worker**: only use this card for non-breastfed children who are between 6 up to 24 months.	
	• A minimum of 2 cups of milk each day is recommended for all children under 2 years of age who are no longer breastfeeding.	
	• This milk can be either commercial infant formula, prepared according to directions, or animal milk, which should always be boiled for children who are less than 12 months old. It can be given to the baby as a hot or cold	

Card	English	Adaptation – Translation
	beverage, or can be added to porridge or other foods.	
	• All children need complementary foods from six months of age.	
	• The non-breastfed child from 6 up to 9 months needs the same amount of food and snacks as the breastfed child of the same age plus 1 extra meal plus 2 cups of milk each day (1 cup = 250 ml).	
	• The non-breastfed child from 9 up to 12 months needs the same amount of food and snacks as the breastfed child of the same age plus 2 extra meals plus 2 cups of milk each day.	
	• The non-breastfed child from 12 up to 24 months needs the same amount of food & snacks as the breastfed child of the same age plus 2 extra meals plus 2 cups of milk each day.	
	• After 6 months, also give 2 to 3 cups of water each day, in especially hot climates.	

Matrix for Adaptation-Translation of *Take-home Brochures*

Brochure	English	Adaptation - Translation
Brochure #1: Nutrition During Pregnancy and Breastfeeding		
Cover	**Nutrition During Pregnancy and Breastfeeding**	
Inside 1	**Practice Good Nutrition**	
	What do you need to know?	
	During your pregnancy, eat 3 healthy meals each day plus one extra small meal or "snack" (food taken in between main meals).	
	During breastfeeding, eat 3 healthy meals each day plus two extra small meals or "snacks".	
	Eating different types of locally available foods each day.	
	No special food is required to produce breast milk.	
	Adolescent mothers need more food, extra care and more rest.	
Inside 2	**Plan a 4-star diet**	
	Staples: grains such as maize, rice, millet and sorghum and roots and tubers such as cassava and potatoes **1 star***	
	Legumes such as beans, lentils, peas, groundnuts **and seeds** such as sesame **2 stars****	
	Vitamin A-rich fruits and vegetables such as mango, papaya, passion fruit, oranges, dark-green leaves, carrots, yellow sweet potato, and pumpkin and **other fruits and vegetables** such as banana, pineapple, avocado, watermelon, tomatoes, eggplant and cabbage **3 stars*****	
	Animal-source foods including flesh foods such as meat, chicken, fish, liver and eggs and dairy products **4 stars********	
	Oil and fat such as oil seeds, margarine, ghee and butter improve the absorption of some vitamins and provide extra energy.	

Brochure	English	Adaptation - Translation
Inside 3	**Protect Your Health**	
	Pregnant and Breastfeeding women need to:	
	Attend antenatal care at least 4 times during pregnancy starting as early as possible.	
	Drink whenever you are thirsty.	
	Avoid taking tea or coffee with meals and limit the amount of coffee you drink during pregnancy. .	
	What supplements do you need	
	You need iron and folic acid tablets during pregnancy and for at least 3 months after your baby's birth.	
	Take iron tablets with meals to increase absorption.	
	Always use iodised salt to prevent learning disabilities, delayed development, and poor physical growth in the baby; and goitre in the mother.	
	Take vitamin A supplements immediately after delivery or within 6 weeks so that your baby receives the vitamin A in your breast milk.	
Back 1	**Safe preparation of food**	
	Good hygiene (cleanliness) is important to avoid diarrhoea and other illnesses.	
	Use clean utensils and store foods in a clean place.	
	Cook meat, fish and eggs until they are well done.	
	Wash vegetables, cook immediately for a short time and eat immediately to preserve nutrients.	
	Wash raw fruits and vegetables before eating.	
	Wash your hands with soap and water before preparing foods and after using the toilet and washing baby's bottom.	
	Other important tips	
	Rest more during the last 3 months of pregnancy and the first	

Brochure	English	Adaptation - Translation
	months after delivery.	
	To prevent malaria, sleep under an insecticide-treated mosquito net.	
	Take anti-malarial tablets as prescribed.	
	Take de-worming tablets to treat worms and help prevent anaemia.	
	Do not use alcohol, narcotics or tobacco products.	
Back 2	**HIV and Nutrition**	
	Know your HIV status	
	To know your HIV status you must take a test.	
	If you are HIV-infected, consult your health care provider for care and treatment and how best to feed your baby.	
	If you are HIV-infected, you need extra food to give you extra energy.	
	Protect yourself and your baby from HIV and other sexually transmitted infections during pregnancy and while you are breastfeeding by practicing safe sex.	
	Use condoms consistently and correctly. Consult a family planning counsellor.	

Brochure	English	Adaptation-Translation
Brochure #2: How to Breastfeed your Baby		
Cover	**How to Breastfeed your Baby**	
Inside 1	**Breastfeeding**	
	What do I need to know?	
	Breast milk provides all the food and water that your baby needs during the first 6 months of life.	
	Make sure you feed your baby the thick yellowish milk known	

Brochure	English	Adaptation-Translation
	as colostrums.	
	Colostrum protects your baby from many diseases.	
	Exclusive breastfeeding means giving breast milk only, and nothing else (no other milks, foods or liquids, not even sips of water), except for medicines prescribed by a doctor or nurse.	
	Feeding your baby both breast milk and other foods or liquids, including infant formula, animal milks, or water (called 'mixed feeding') before 6 months reduces the amount of milk that you produce and can make your baby sick.	
Inside 2	**Help baby attach to your breast**	
	Put the baby to your breast within the first hour of birth.	
	Good attachment helps to ensure that your baby suckles well.	
	Good attachment helps you to produce a good supply of breast milk.	
	Good attachment helps to prevent sore and cracked nipples.	
	To make sure your baby is attached well:	
	• Touch the baby's lips with your nipple • Wait until your baby mouth opens wide • Quickly bring onto your breast from below, aiming your nipple up towards the roof of the baby's mouth • Baby should take a big mouthful of breast	
	The 4 signs of good attachment are: 1. Baby's mouth is wide open 2. You can see more of the darker skin (areola) above the baby's mouth than below 3. Baby's lower lip is turned outwards 4. Baby's chin is touching your breast	
	Your baby should take slow deep sucks while breastfeeding, sometimes pausing.	
Inside 3	**How often should I breastfeed?**	
	Breastfeed your baby on demand, both day and night, at least 8	

Brochure	English	Adaptation-Translation
	to 12 times each day.	
	Frequent feeding will help your body to produce breast milk.	
	Continue to feed until your baby finishes the breast and comes off on his own. Offer the other breast and let your baby decide if he or she wants more or not.	
	You will know if your baby is taking enough breast milk if he or she passes light-coloured urine at least 6 times a day and is gaining weight.	
Back 1	**How to prevent common breastfeeding difficulties**	
	Position and attach your baby correctly on the breast. Breastfeeding should not hurt.	
	If you develop cracked nipples, put some breast milk on them. Do not use any types of creams or ointments except when prescribed by a health care provider.	
	Feed frequently to prevent your breasts from becoming swollen.	
	If the baby misses a feed you should express some milk to keep your breasts soft.	
	Keep expressed breast milk in a cool place, but not for longer than 6 to 8 hours.	
	If one or both of your breasts become painful or hot to the touch, see a health care provider.	
	Check for sores and thrush in your baby's mouth. If you find any, see a health care provider.	
	Mixed feeding (combining breast milk with anything else) is not healthy for your baby before 6 months of age. Mixed feeding reduces the amount of milk that you produce and can make your baby sick.	
	If you have trouble practicing exclusive breastfeeding, discuss your situation with a trained counsellor.	
Back 2	**Things to remember**	
	Exclusive breastfeeding during the first six months protects you	

Brochure	English	Adaptation-Translation
	from getting pregnant as long as your periods have not returned. Consult a family planning counsellor as soon as possible after birth.	
	When your baby is 6 months old, continue breastfeeding and begin giving other foods.	
	Watch for signs of diarrhoea, fever, difficulty breathing, or refusal to feed because these need prompt attention.	
	If a woman is HIV-infected, she should not feed her baby from a nipple that is cracked or bleeding. Instead, feed from the other breast and express and discard the milk from the breast that is affected.	
	Getting infected or re-infected with HIV while breastfeeding increases the risk of mother to child transmission. Practice safe sex by using condoms consistently and correctly.	
	To protect your baby, know your HIV status.	

Brochure	English	Adaptation - Translation
Brochure #3: How to feed your baby after 6 months		
Cover	**How to feed your baby after 6 months**	
Inside 1	**After 6 Months**	
	What do you need to know?	
	For the first 6 months, exclusively breastfeed your baby (no other milks, foods or liquids, not even sips of water).	
	When your baby reaches 6 months, continue breastfeeding on demand both day and night.	
	Breast milk continues to be an important part of the diet until the baby is at least 2 years.	
	When feeding a baby between 6 and 12 months old always give breast milk first before giving other foods.	
	After 6 months of age, in countries with endemic	

Brochure	English	Adaptation - Translation
	vitamin A deficiency, children should receive vitamin A supplements twice a year. Consult your health care provider.	
Inside 2	**When your baby first starts to eat**	
	Give your baby 1 or 2 tablespoons of soft food three times each day. Gradually increase the frequency, amount, thickness (consistency), and variety of food.	
Labels	Too thin Good thickness	
	Enrich the baby's porridge and mashed foods with breast milk, mashed groundnuts, fruits and vegetables, and start animal source foods as early and as often as possible.	
	Your baby needs a variety of foods:	
	Infants only need a very small amount of oil (no more than one half (½) a teaspoon per day).	
Inside 3	**Safe preparation and storage**	
	Wash your hands with running water and soap before preparing food, and before feeding your baby. Baby's hands should be washed also. Wash your hands after changing nappies or going to the toilet.	
	Wash all bowls, cups and utensils with clean water and soap. Keep covered before using.	
	Prepare food in a clean area and keep it covered. A baby should have his or her own cup and bowl.	
	Serve food immediately after preparation.	
	Thoroughly reheat any food that has been kept for more than an hour.	
	Babies gradually learn to feed themselves. An adult or an older child should encourage the baby to eat enough food and ensure that the food remains clean.	

Brochure	English	Adaptation - Translation
Back 1	**Feed more as the baby grows**	
	Begin to feed at 6 months	
	Type of food:	
	Soft porridge, well mashed food	
	How often:	
	2 to 3 times each day	
	How much:	
	Feed 2 to 3 tablespoons at each meal.	
	From 6 up to 9 months	
	Type of food:	
	Mashed food	
	How often:	
	2 to 3 times each day and 1 to 2 snacks	
	How much:	
	Feed 2 to 3 tablespoons up to one-half (½) cup at each meal.	
	From 9 up to 12 months	
	Type of food:	
	Finely chopped or mashed food and foods that baby can pick up with his or her fingers	
	How often:	
	3 to 4 times each day and 1 to 2 snacks	
	How much:	
	Feed at least one half (½) cup at each meal	
	From 12 up to 24 months	
	Type of food:	
	Family foods, chopped or mashed if necessary	
	How often:	
	3 to 4 times each day and 1 to 2 snacks	
	How much:	

Brochure	English	Adaptation - Translation
	Feed three-quarters (¾) up to 1 full cup at each meal.	
	*A snack is extra food between meals	
	**A cup is 250 ml	
Back 2	**Things to remember**	
	Between the age of 6 months and 2 years a child needs to continue breastfeeding.	
	If you are not breastfeeding, feed your baby 2 cups (500 ml total) of milk every day.	
	Avoid giving a baby tea, coffee, soda and other sugary or coloured drinks. Limit amount of fresh juices.	
	Always feed the baby using a clean open cup. Do not use bottles, teats or cup with a mouth piece.	
	Continue to take your child to the clinic for regular check-ups and immunizations.	
	During illness give the baby small frequent meals and more fluids, including breast milk or other liquids. Encourage the baby to eat a variety of (his or her) favourite soft foods. After illness feed more food and more often than usual for at least 2 weeks.	

APPENDIX 9: Instructions & Sample FGD Guide for Field Testing

Summary of Instructions for Conducting the Focus Group Discussion (FDG) on the graphic materials

A. Begin the FGD Session

1. Introduce yourself and the note-taker.
2. Explain the purpose of tape recorder (if used), and ask permission before turning on the tape recorder (tape recorder only for support - checking notes).
3. Explain general purpose of the discussion.
4. Establish ground rules, such as:
   - Set a time frame
   - Ensure confidentiality
   - Stress that participants' input is very valuable
   - Ensure respect for the opinions of others
   - Note that questions will be answered after the session
5. Begin to develop rapport with participants:
   - Greet everyone
   - Make eye contact with everyone
   - Have participants introduce themselves using their name or alias
   - Initiate general conversation to create a relaxed environment

B. **Initiate warm-up discussion**

1. Use the FGD guide to initiate the warm-up discussion.
2. Begin by asking neutral questions, and then proceed to general questions.
3. Allow participants to talk uninterrupted.
4. Be supportive of the participants' interpretations and comments, even if the information presented is incorrect.
5. Try to establish trends and explore those in more depth.

C. **Probe more on the topic of discussion**

1. Use open-ended questions to probe more deeply into key issues mentioned by participants.
2. Allow for debate among group participants.
3. If participants ask questions, encourage the group to answer them.
4. Ensure that all participants have an opportunity to talk; encourage quieter participants to talk by calling on them directly.
5. Be supportive of respondents' comments. **Do not correct misinformation or wrong perceptions.**
6. If information is not forthcoming, consider using creative approaches, such as:
   - Describing a scene and getting participants' reactions
   - Asking participants to imagine something (like the ideal health worker) and then describe it to you
   - Role playing
   - Sharing what other people have said about a topic and getting the group's reaction
7. Note responses and non-verbal cues

D. **Wrap up the session**

1. Review and summarize main points arising in the discussion.
2. Clarify conclusions and relative importance of responses with participants.
3. Identify differences of perspectives, contrasting opinions, and areas of agreement.
4. Allow a round of final comments and insights.
5. Thank participants for their time and participation and explain how valuable their comments have been.
6. Invite participants to refreshments, if available.

E. **Take advantage of post-session discussions.**

1. Answer participants' questions and clarify any misinformation provided by participants.
2. Leave the tape recorder running as participants disburse to capture any additional comments.

F. Immediately after each FGD session

1. Meet with the note-taker to review notes to review their notes.
2. If necessary, add information that may have been missed.

Sample Recruitment and Registrations Sheets for FGD

FGD Recruitment Sheet: Primary Audience

Community IYCN Counselling Materials (Counselling Cards and Brochures)

Name of Recruiter: _____

Phone number or contact number for recruiter: _____

Place of Recruitment (Circle Rural [R] or Urban [U]): _____

Circle the audience that you are recruiting for:

Mothers 15-25 Mothers 26-40 Other Caregivers

Note the proposed date of this Focus Group: _____Circle the proposed time.

8:30 am – 10:30 am 11:00 am – 1:00pm 2:00 pm – 4:00 pm.

Note where the Focus Group will be held (house, school, clinic, meeting hall, etc.)

_____

Steps to take in recruiting a potential participant for the Focus Group Discussion:

1) Start by identifying yourself.
2) Explain what you are recruiting for (see explanation below), when the group will be held, what will be required of them, and approximately how long it will take.
3) Tell them what they will be given (_____) for their time.
4) Put their name on the Recruitment List, and note their age, gender, and ask whether or not they have children. If so, note how many and what ages.
5) Make sure that they are willing and able to spend up to 2 hours of time on the day of the focus group.
6) Tell them the date, location and what time their group will be held, either 8:30 am to 10:30 am, 11:00 am to 1:00pm, or 2:00 pm to 4:00 pm.
7) Ask for and note their phone number or contact number in case of change.
8) Give them your phone number or contact number in case of change.

Explanation to give to potential participants for the Focus Group Discussion:

"We would like to invite you to participate in a small group discussion to be held on _____ (date) at _____(hour). Your participation in the discussion will help us improve some educational materials that are being prepared related to children's health. We will be asking questions about 1) the acceptability of the images and layout, 2) your understanding of the content, both images and text, 3) whether or not the messages and recommendations are clear?), and 4) your ideas about ways to improve the images, text and layout of the material.

RECRUITMENT LIST

#	Name	Age	M/F	No. and ages of Children	R/U
1					
2					
3					
4					
5					
6					
7					
8					
9					
10					
11					
12					

Additional names can be taken as replacement participants if someone(s) does not show up for the Focus Group. The group should be limited to no more than 12 people because it makes the group unmanageable if there are too many participants.

Conducting the Focus Group Discussion

Explaining the purpose of the Focus Group Discussion: Several educational material are being prepared for community workers to use to in counselling mothers and other caregivers related to health. We need your help in finalizing these materials. We will be asking questions about 1) the acceptability of the images and layouts, 2) your understanding of the content, both images and text, 3) whether or not the messages and recommendations are clear, and 4) requesting ideas about ways to improve the images, text and layout of the material.

Date of Focus Group: _____

Place of Focus Group: _____

Name of Facilitator: _____

Name of Observer(s): _____

#	Name	Age	M/F	No. and ages of Children	R/U
1					
2					
3					
4					
5					
6					
7					
8					
9					
10					
11					
12					

NOTE TO FACILITATOR:

- Introduce yourself and others who accompanied you.
- Your full names
- Your work place
- Purpose of your visit/ this meeting
- What do you want them to do/ their role
- Their permission to continue
- If using tape recorder, explain that it is to help with notes and get their permission
- If there is a need for taking their photographs ask for their permission

Introduce yourself and your team: Hello, my name is _____. I am working with the Ministry of Health to develop some educational materials related to health. (Introduce others.) We are interested in getting all of your views on a draft of one of the new materials in order to improve the images, text and layout before we finalize them and have them printed and distributed. We will be asking a series of questions about the materials, which should not take more than about one and one half hours.

Reassure the participants that there are no right or wrong answers and they should feel free to ask questions or stop you in between. Explain that the material you are going to give them is just a draft and was prepared so that it can be used to educate the community after incorporating their inputs and come up with the final version. Therefore, their comments/ suggestions are very important in improving this brochure.

Ask if anyone have any questions? Do we have your permission to continue? Do we have your permission to take photographs? Do we have permission to use an audio-tape recorder during the discussion. (Explain that it is just to help with the note taking.)

(NOTE TO FACILITATOR: Give each participant a copy of one of the brochures to review, or one of the counselling cards, after they sign in. Ask them to look it over, read it over and be prepared to answer some question about it. (Make sure that each participant as 10 to 15 minutes to review the brochure before starting the group discussion.) Start by asking some general "warm up" questions, then proceed to asking question about the illustration and text on each panel of the brochure.

WARM-UP QUESTIONS:

- How many brothers and sisters do you have?
- In this community, how many children do most families have nowadays?
- Why do you think most families in this community have ____ number of children?

GUIDING QUESTIONS:

COVER OF BROCHURE XX:

1. What message do you get from these people?
2. What do you think they are doing?
3. What do you like about this picture?
4. Is there anything you would like to change in relation to this image (Probe if necessary: colours, images of the people, relationship between the people?)

5. What about the words or heading, does it suite your requirements?

Page 1 (Open up the brochure completely):

- Could you please tell me, in your own words, what do you think this material is all about?

(NOTE TO FACILITATOR: Take the participants through each component of the brochure starting with the cover illustration, the text about types of methods, and each method image/symbol. Then, link the picture and the text/content. Ask different people to volunteer to read the text out loud. Have them take turns in reading. If someone seems uncomfortable, do not force them to read.)

1. What is the woman in the big picture doing?
2. What do you think the message is here?
3. What do you like about that image?
4. Is there anything you would like to change about the image?

First picture and the text

1. Who is the person in the first small picture? What is she doing? What do you think the message is?
2. What about the text? (Ask for volunteer to read it.) Does it relate to the picture?
3. Is there anything you are not comfortable with/you would like to be changed so that it can suite you and your community?

Second picture and the text

1. What do you see in the picture? What message do you get?
2. What about the text? (Ask for volunteer to read it.) Does it relate to the picture?
3. Is there anything you are not comfortable with/you would like to be changed so that it can suite you and your community?

Third picture and the text

1. What do you see in the picture? What does the boy and the girl doing? What message do you get?
2. What about the text? (Ask for volunteer to read it.) Does it relate to picture?
3. Is there anything you are not comfortable with/you would like to be changed so that it can suite you or your community?

Fourth picture the text contents

1. What do you see in the picture? What message do you get?
2. What about the text? (Ask for volunteer to read it.) Does it relate to the picture?
3. Is there anything you are not comfortable with/you would like to be changed so that it can suite you and your community?

Fifth picture and the text

1. What do you see in the picture? What message do you get?
2. What about the text? (Ask for volunteer to read it.) Does it relate to the picture?
3. Is there anything you are not comfortable with/you would like to be changed so that it can suite you and your community?

Note: Continue with questions along the same line, depending on which material(s) you are field testing and with which audience(s)

WRAP-UP QUESTIONS

1. After going through all the parts of the brochure, what do you think about the heading (or title), does it suite the content of the material?
2. Is there anything you would change about the heading?
3. Who do you think would be the person to share this information with or do you think we should give this material to and why?
4. When and where do you think this material can be given out (time and/or place)?
5. How do you feel after reading this brochure?
6. Would you like to have a copy after producing the final brochure?
7. Would you like to share the material with anybody else, and if so, who?
8. Do you have any general comment before we close our discussion?

(**NOTE TO FACILITATOR**: This is the time when you can answer any questions from the participants about the content of the material. After everyone finishes talking, ask the note taker or observer if they have any questions.)

APPENDIX 10: Considerations for FGD and In-depth Interviews[11]

Things to consider in developing focus group discussions (FGDs)

Focus group research originated with commercial marketing. Focus groups are in-depth discussions, usually one to two hours in length, in which eight to twelve representatives of the target audience, under the guidance of a facilitator, discuss topics of particular importance - in this instance to the development of materials. The results of focus group sessions are expressed in qualitative terms.

Materials developers usually choose focus group discussions (FGDs) as their audience research method. Because a number of people are interviewed at once, FGDs are usually cost-effective. Also, FGDs are interactive: participants hear the thoughts of others, triggering their own memories or ideas and thereby enriching the discussion.

FGDs are easily tailored to the research needs of the project staff. For instance, FGD data can be used to:

- Develop appropriate messages for informational or motivational materials or media
- Identify myths, misconceptions, or beliefs about a product or practice
- Evaluate existing materials or drafts of materials
- Design survey questionnaires

FGDs are particularly useful for developing concepts for the communication process, stimulating the creative thinking of communication professionals as they develop messages. FGDs can help project staff test out these ideas and discover which approach is likely to be more effective.

Conducting several FGDs with groups having similar characteristics will help to confirm findings and ensure that the materials produced address all common informational needs. To collect enough relevant information on a topic, two FGDs per participant characteristic are usually required and strongly encouraged if resources are available. Sample participant characteristics include sex, age, education, and use (or lack of use) of a health service or intervention.

The following are some guidelines for improving the reliability of FGD results:

1. Selecting FGD Participants

FGD participants should represent the materials' intended audience. Follow these tips for selecting FGD participants:

- Each focus group should contain people sharing similar characteristics such as age, sex, and socioeconomic status. Participants tend to be more relaxed among others with the same or similar backgrounds.

[11] Modified for use in the URC/QAP BCC/Materials Development Programs in Tanzania from Developing Materials on HIV/AIDS/STIs for Low-Literate Audiences, by PATH and FHI, supported by a USAID Cooperative Agreement (HRN-A-00-97-0017-00) with Family Health International (FHI) through a task order to the Program for Appropriate Technology (PATH).

- Participants should not know each other or be told the exact subject of discussion in advance of the FGD to help ensure that the responses will be spontaneous and uninhibited.
- The recruitment method will depend on the situation: clinics or markets may be good places to find candidates. House-to-house recruiting can be an effective, but more time consuming technique.
- Use a participant screening questionnaire (or set of recruitment criteria) to make sure that selected participants represent the intended audience.

2. FGD Facilitator

The facilitator is the person who leads the individual interviews or FGDs. The facilitator's most important characteristic is the ability to establish good rapport with the participants rapidly.

The facilitator does not have to be an expert in the subject matter being discussed, but should understand the topic and which subjects of special research interest should be explored in depth. A good facilitator remains neutral, probing responses without reacting to, or influencing, the respondents, and emphasizing that there are no right or wrong answers. The facilitator introduces topics, makes sure participants stay on topic, and encourages participation in the conversation. An effective facilitator is personable and flexible, and has a good sense of humour. (See below: Tips for the FGD Facilitator.)

What Kind of Person Makes a Good Facilitator? Personality type seems to be a better indicator of success than a university degree. People who like being around other people and who are good conversationalists can, with practice, become good facilitators. Those who are used to telling people to do things-such as doctors, teachers, and nurses, sometimes find it difficult to curb this tendency and become skilled listeners. This too can be altered with good training and practice.

3. FGD Note-Taker

Although FGDs are sometimes tape recorded as a backup, a note-taker should always assist the facilitator, objectively and carefully recording both individual opinions and group consensus verbalized throughout the FGD. The note-taker also records nonverbal responses, such as head nodding that could indicate group attitudes or sensitivities. Select a note-taker who can write quickly, uses abbreviations and symbols, and knows the language of the respondents. Useful skills for a note-taker include a good memory and the ability to listen carefully, concentrating on all that is said and how other participants react to what is said. (See below: Tips for the FGD Note-Taker.)

4. Tips for the FGD Facilitator

The following are a list of “tips” that a good FGD facilitator should take into considerations when organizing and conducting a group:

1) Open the discussion with a general statement (e.g., "We're all mothers who care for small children and we've probably experienced such and such") and wait for participants to comment. Starting with a question can make the group expect a question-and-answer session and discourage discussion.

2) Practice a form of "sophisticated naiveté" (e.g., "Oh, I didn't know that-can you tell me more about it?").
3) Make incomplete statements and wait for responses (e.g., "Well, maybe breastfeeding isn't so..").
4) Use silence to your advantage. Do not let it be intimidating; a pause in the conversation may compel participants to talk.
5) Use "closed-ended" questions to solicit a brief and exact reply (e.g., "How many ways can HIV/AIDS be transmitted from a mother to her baby?").
6) Use "open-ended" questions to solicit longer, thoughtful responses (e.g., "What have you heard about what foods are good for pregnant women to eat?").
7) Use "probing" questions to obtain further information (e.g., "Why should a breastfeeding mother who is HIV-infected always use condoms with her sex partner?").
8) Avoid "leading" questions that prompt respondents to answer in a particular way (e.g., "Have you heard that replacement feeding is dangerous for your baby's health?"), unless they are part of the "probing" strategy.
9) Remember to include those sitting next to you in the discussion. You will tend to relate most actively to those seated across from you because you have direct eye contact. See the group as a clock face; be sure to get a report from every "hour" (but don't require that they respond in order).
10) If you are using a recorder, keep the tape going even as the session breaks up. People tend to say things to you that they may not want to say in front of others.
11) Sometimes it is a good idea to pretend the discussion will end soon by saying, "Oh, our time is running out." This may encourage participants to speak up.
12) At the end of a session, help the group reach some final conclusions together. Ask summary questions like, "So, can we say that some of you feel that clinic guidelines on partner notification are clear, but some of you feel they need further clarification?" Reaching some conclusions like this ends the discussion with clear statements that can be summarized easily.
13) After the FGD, think about both the good moments and the not-so-good moments to learn from the process and enhance your skills. Ask the person taking notes to suggest how he or she might have handled the group. Facilitators' skills improve as they discuss and think about their experiences.
14) 14. Debrief with the note-taker immediately following each FGD.

5. **Tips for the FGD Note-Taker**

The following are a list of "tips" that a good FGD Note-Taker should take into considerations when participating in a group:

1) Work with the facilitator as a team and communicate before, during, and after the FGD. Before the FGD, carefully review the FGD guidelines with the facilitator. Agree on nonverbal cues to use discreetly during the session to indicate which comments are important to note or require elaboration. After the FGD, collaborate to clarify notes and compare impressions.
2) Diagram the group and assign each participant a number or initials to identify the source of the comment.
3) Do not let a tape recorder substitute for good note-taking. Although sessions might also be tape recorded, problems during recording are common (e.g., too much noise, dead batteries, forgetting to turn over the tape); etc. Therefore, always take good

notes. Tapes should be used as a back-up ONLY and are often valuable for double checking notes, comments or questions raised.

4) Only take notes on and/or record relevant information. Summarize what is said and note/record useful and interesting quotations when possible. You may use abbreviations, including quotation marks under words to show repetition of comments.
5) Observe nonverbal group feedback (e.g., facial expressions, tone of voice, laughter, posture), that may suggest attitudes or unspoken messages to be noted in FGD reports. Such signs must be interpreted in context, and thus can only be evaluated by those present during the interview or FGD.
6) Stop and ask for clarification if you miss something that seems important or relevant, but do not become a second facilitator.

Note taking and Use of Tapes: Have the note taker keep notes throughout the focus group discussion. If a tape recorder is used, keep track of each tape that is inserted in the order of use. Mark on the notes when a new tape is used and the number of that tape so that you can more easily identify which tapes contains questions that are under review. At the end of the focus group, the note taker should be given an opportunity to clarify the notes or ask one or two questions to specific participants, if needed, to enrich the findings.

Observations: If there is a person specifically assigned to "observe", that person should keep notes on the general group dynamic to add to the discussion and findings. At the end of the focus group, the observer should be given an opportunity to ask a couple of question to specific participants if they think it would help to clarify or enrich the findings.

Using and Transcribing Tapes: If project staff intend to record the interview in addition to having a note-taker, be aware that tapes are primarily used to fill in gaps in the handwritten notes. Transcribing tapes is very labour-intensive, requiring between four and ten hours to transcribe each hour of recorded conversation. Because of the expense, transcription is rarely done. The notes taken by the note-taker-augmented by listening to the tapes to fill in gaps-are the primary means of documenting the raw research data, and should therefore be thorough. Meaningful analysis depends on the quality of the notes.

6. Selecting/Preparing a FGD Site

The FGDs should be conducted in a quiet place that is convenient for the participants. For a comfortable group discussion, the space should be large enough to comfortably accommodate the facilitator, the note-taker, and 8 to 12 participants. The setting should promote comfort and ease among group members. Participants should be seated in a circle so that the facilitator and note-taker can clearly see and hear everyone and so that there is no image of a "head of the table" leader.

7. FGD Discussion Guide

To cover all topics of interest, project staff must develop a series of topics and questions organized in a document called a discussion guide, prior to holding the in-depth interviews and/or FGDs. (See below: FGD Discussion Phases.) Although discussion guides will differ depending on the group and their experiences, most FGD guidelines include:

- An introduction of the facilitator, participants, and FGD format
- General topics to open up the discussion

- Specific topics to reveal participants' attitudes and perception
- Probing questions to reveal more in-depth information or to clarify earlier statements or responses

8. **Conducting a FGD Session**

A. **Focus Group Discussion Phases**

Phase I: Facilitator's Opening Statement

Introduces the facilitator and note-taker (and any other member of the team)

- Explains the general purpose of the discussion. States that information received will remain confidential.
- Asks for consent from participants to continue. If a tape recorder is to be used, asks for permission to tape. If a camera is to be used, asks for permission to take photographs. Explains how the information (and photographs) will be used.
- Establishes ground rules for the discussion. These can include time frame; rest room breaks; availability of food; importance of talking one at a time and respecting divergent opinions; stressing that a response is not needed for each question from every participant and that the questions can be answered after the discussion; and reminding participants that their ideas are valuable and that they are the experts.
- Begins to develop rapport with and among group members.

Phase II: Warm-up

- Invites members to introduce themselves, gives everyone an opportunity to speak (which lessens performance anxiety), and stimulates participants to begin thinking concretely about the issues at hand.
- Starts with neutral, topical questions to stimulate discussion, leads into general questions, and finally moves to questions about the primary topic.

Phase III: Main Body of Group Discussion

- Using open-ended questions (questions that cannot be answered with "yes" or "no"), the facilitator probes, follows up on answers to get additional information, clarifies points, and obtains increasingly deep responses to key questions.
- Connects emergent data from separate questions into an integrated analysis.
- Ensures that all participants who want to comment can do so.

Phase IV: Wrap-up and Closure

- Allows the moderator to review, clarify, and summarize main points arising in the discussion.
- Checks out hunches, ideas, conclusions, and relative importance of responses with the group members, allowing ample time for further debate. Identifies differences of perspective, contrasting opinions, and areas of agreement. Summarizes and tests with the group the relative importance of certain categories of responses.
- Allows a round of final comments and insights.
- Thanks the participants for their contributions.

B. General Content of Most FGDs

Identifying Patterns

As the facilitator moderates, it is critical for her or him to look for similarities or patterns within and between key issues. Ideally, these patterns should be identified during the FGD and confirmed with the participants through follow-up or "probing" questions to make sure that any pattern is an accurate interpretation of what the participants are saying (or even what they are consistently leaving out). The facilitator should also ask questions to identify the underlying causes for these patterns If the facilitator does not spot the pattern until after the focus group session, e.g., by listening to the tapes and reviewing the notes, he or she should add questions to the discussion guide to confirm and explore the pattern in future focus groups.

Here is an example of a possible pattern, with examples of follow-up probing questions that can confirm patterns suggested by the group discussion: "During our discussion one of you said that the community health worker explained that not all babies who are born to women with HIV get HIV, even if they are breastfed for a long time, if they exclusively breastfeeding during the first 6 months. Two other participants scowled. Later another woman said that her sister's baby got HIV while breastfeeding. Then others chimed in to say that she heard that HIV is always passed through breast milk but that poor women have no option but to breastfeed. Later, someone else remarked that we all know that HIV can be passed to the baby in more way than the health workers at the clinic will admit." And, someone mentioned that coughs-accompanied by bloody sputum- pass HIV infection to another person.

Follow up with probing questions to confirm a pattern:

- Am I understanding you correctly that you feel that health workers and others may not be telling you all they know about ways that HIV is transmitted to babies?
- Do any of you think you know a baby who got HIV just because the mother breastfed him/her? How do you know this is so?
- What messages would help you believe that, while breastfeeding can pass HIV from an HIV-infected mother to her baby, exclusive breastfeeding for the first 6 months of life helps to protect the baby from infection?

It is critical for the facilitator to ask the follow-up probing questions on important issues because the answers they bring to light form the key pieces of information necessary to create useful messages.

In this particular example, by recognizing a pattern and probing, the researchers learned that it was important to re-emphasize the fact that coughs-even when accompanied by bloody sputum-do not pass HIV infection to another person. However, since severe coughs can be a symptom of tuberculosis, if a purpose of the project is to provide information that will help persons caring for HIV-positive family members or friends, then it will also be important to provide information on ways to prevent TB, control its spread, and/or cure those who are infected.

Encouraging Everyone to Speak

The facilitator should give each participant an opportunity to speak during the focus group. It is useful at the beginning of a focus group to place a check mark next to each participant's name when he or she speaks. This will help the facilitator keep track of who may be

dominating the conversation and who may not be expressing opinions at all or often enough. The facilitator can then encourage the more quiet participants through nonverbal signals (such as looking at them or turning toward them when asking a question) or gently encouraging them to speak by using their name: "Do you have anything else you would like to add to the discussion, Maria?"

Dealing with Questions from Participants

Sometimes participants ask the facilitator questions or give incorrect information during the FGD. The facilitator naturally wants to help by answering questions or correcting errors. However, this should not be done during the FGD. Instead, the facilitator needs to throw the questions or incorrect statement back to the group: "What do you think about Maria's question (or comment)?" If a facilitator begins answering questions during the FGD, participants may stop giving their own ideas and the FGD will become a teaching session instead of a research activity. If participants persist in asking questions, the facilitator should assure the group that time will be provided at the end of the session to discuss these issues. As a general rule, the facilitator should try to speak only 10 percent of the time and listen to the participants 90 percent of the time.

Asking for Participants' Final Comments

About 15 to 20 minutes before the end of the allotted time, the facilitator should let the participants know that they are coming to the end of the discussion; he or she now needs their help to identify and refine key themes that emerged from the discussion. The facilitator should identify differences of perspective, contrasting opinions, and areas of agreement. It is not necessary for the group to reach consensus on items, but should rather review some of the major findings and confirm that the facilitator has understood them correctly. Allow plenty of time for this final round of comments and insights because participants frequently choose this last opportunity to speak up about important issues.

Using Creative Approaches

In some circumstances it is appropriate to consider creative approaches to focus groups in order to meet research needs. For instance, teenagers may get bored during traditional FGDs or feel too shy to participate fully. Elders in some societies are shown respect by not being interrupted, which makes them a challenging group for the facilitator to manage. In some cultures, people are not accustomed to expressing their opinions. Under such circumstances, it is appropriate to find an approach that will give insight into the participants' personal attitudes and experiences without threatening their comfort or privacy. Here are some ideas.

- Present the group members with a photo or verbal description of a scene (e.g., an image of a healthy young pregnant woman who has tested HIV-positive, or of a VCT clinic) for their reaction.
- Ask participants to imagine a healthy baby and then to describe him or her to you.
- Set up role playing among the participants (e.g., a husband and wife discussing white patches they noticed in the baby’s mouth and listen to discover not only their knowledge, but also their feelings about the topic and the vocabulary they use.
- Share what other people have said about an issue (e.g., a woman who is HIV-positive should still breastfeed her infant) and see how the group reacts.

Such methodological elements can:

- Generate a truly focused discussion

- Create a more relaxed, tranquil, and informal atmosphere that will foster interaction among participants and between participants and facilitator
- Generate interest and motivation to actively involve participants in the process
- Produce creative answers that better reflect the language, interests, expectations, knowledge, and feelings of the participants
- Bring out distinct points of view and avoid domination of the group by a few individuals

In-depth Interviews (IDIs)

In-depth Interviews (IDIs) collect information in a manner similar to FGDs, with the main difference that IDIs take place in a private, confidential setting between one interviewer and one participant. Such an interview allows researchers to gain a great deal of insight into a person's thoughts, feelings, and behaviours. However, while a survey questionnaire may take only a few minutes to complete, IDIs often take one to two hours because they allow the respondent to talk at length about topics of interest."

There are specific circumstances for which IDIs are particularly appropriate:

- ***When Subject Matter is Complex and Respondents are Knowledgeable***. For example, research on the attitudes and practices of doctors, nurses, and health workers regarding severely ill HIV-infected pregnant or postpartum women.
- ***When Subject Matter Is Highly Sensitive.*** For example, a study about attitudes toward breastfeeding among HIV-infected women who have had a child die from an illness that was possibly caused by HIV transmission during breastfeeding.
- ***When Respondents are Geographically Dispersed.*** For example, a study among logistics managers throughout a country examining how costly ARV drugs are.
- ***Where There Is Substantial Peer Pressure.*** For example, research to determine attitudes about integrating family planning services into PMTCT clinics, where providers have sharply divided opinions.

Key Informant Interviews (KII)

Key informants are respondents who have special knowledge, status, or access to observations unavailable to a researcher, and who are willing to share their knowledge and skills. They are good at communicating with their peers, and their peers readily share information with them. Because key informants tend to be especially observant, reflective, and articulate, they are usually consulted more than once or regularly by the research team. Key informants' abilities to describe events and actions may or may not include analytical interpretation; they may simply describe things without offering their thoughts on meaning or significance.

Key informants may be stakeholders. For example, bartenders, sex workers, clients, or sex site managers might be good key informants regarding condom use in brothels.

Sometimes participants may overlap as key informants and as FGD or IDI subjects, but there are important differences. One is that key informants may be consulted several times on an ongoing basis, while FGD and IDI participants are usually interviewed only once. Continual consultation of key informants may show the researcher new research directions or new areas to explore. Key informants can also review materials that subsequently will be presented in FGDs and IDIs. They may also introduce researchers to community or target population

members, acting as cultural intermediaries. They may help improve the quality and reliability of information by strengthening links between observation and information on one hand, and meaning and understanding on the other.

Interviews with key informants can be highly structured, using a pre-coded questionnaire, or fairly unstructured and open-ended. They might be based on a one-page list of well-thought out topics, or on a set of questions without pre-coded answers.

APPENDIX 11: Analyzing Field Test Results and Preparing Report

A. Organize the notes from all the FGD sessions.

B. Review the individual FGD forms and data to determine/describe the following:

General adherence to the field test protocol

1. Description of the recruitment process and characteristics of the field test participants
2. Any issues related to the implementation of the field test that might affect the findings

C. Summarize the major findings for the major questions asked during the FDGs.

1. Emerging patterns and trends can be stated in the following way:
   - Most of the participants said _____
   - Some of the participants said _____
   - A few of the participants said _____

   (Note: Do not quantify FGD data by counting or creating percentages for the number of similar responses.)
2. General understanding of specific illustrations, text and/or layouts
3. General preference for specific illustrations, text and/or layouts
4. Include some participant quotes to support your findings

D. Write a report that summarizes all of the findings, including a general description of the field test and major findings related to each individual material. Key elements of the report should include:

1. General description of the field test:
   - Number of FGD and/or in-depth interviews conducted for each category of participant or audience
   - Location of each FGD or in-depth interview (city, clinic, home, etc.)
   - Length of time for each FGD or in-depth interview

2. Major findings including:
   - Key points from the data
   - Patterns (trends) in the data

3. Specific suggestions from participants for improving or clarifying illustrations or text of each individual materials

4. Specific suggestions/consensus from the field test team(s) related to improving or clarifying the materials based on what they learned in conducting the field test with different groups.

APPENDIX 12: Checklist for Field Testing the *Package*

OBJECTIVE: Organize and conduct a Field Test to assess the appropriateness and effectiveness of the curriculum content, methodology and communication materials for training community workers.

A. FIELD TEST PREPARATION: The checklist below outlines some essential tasks and responsibilities for the organizing authority (for example, MoH in collaboration with the UNICEF Country Office). Key stakeholders in the organisations for which they are conducting the field testing should establish who is responsible for each task.

1. **Participant and Facilitator Selection; Skills, Needs and Resources (Who):** Refer also to Appendices 1 and 2 in the Facilitator Guide: Seven Steps in Planning a Training/Learning Event, and Roles and Responsibilities Before, During and After Training.
   - Identify criteria for selecting Participants
   - Include Supervisors as Participants
   - Know audience (profile and number of Participants). Number of Participants will depend upon budget; number of Facilitators (ideal Facilitator/Participant ratio of 1:10); available accommodation
   - Inform Participants of the purpose of the training and clarify their roles and responsibilities after training (clear job expectations)
   - Identify Facilitators/ (minimum: 2)
     - Develop SOW and contract Facilitators
     - Complete logistical arrangements; allow time for preparation, travel, on-site training preparation and discussions, training, debrief and write-up

2. **Setting Objectives and Expectations of the Field Test (Why):**
   - Identify and collaborate with appropriate organisations and partners
   - Facilitators and organisations identify together the desired **goals and objectives**
   - Secure funding

3. **Logistics (When and Where):**
   - Determine Field Test dates
   - Secure a training venue
     - Training room large enough to accommodate all Facilitators/Participants/helpers/observers
     - Transportation if needed from accommodation to training site
     - Break-out rooms or space
     - Tables or space for group work
     - Adequate lighting and ventilation; free from noise/other disturbance
     - Space where supplies can be stored or locked up, as necessary
     - Lunch or refreshments
   - Identify days, times of training
   - Reproduce training materials, ensuring sufficient numbers for Facilitators, Participants and observers

- **Arrange a practicum site:**
  - Confirm hours during which access to mother/caregivers and infants is possible
  - Number of mother:infant pairs available on an average day in the practicum site
  - Plan the site visits and field practicals with the staff and supervisors at selected sites
  - Organise transport for site visits and field practical and provide sufficient time for transport to and from field sites
  - Plan for any language barriers (between Facilitator and Participants or between Participants and local community members)
  - Pair speakers and non-speakers
  - Arrange for translators
  - To ensure an adequate number of mother/caregiver-child pairs for counselling practice, it may be necessary to schedule field site visits at multiple locations to accommodate the full number of Participants
  - Programme time for debriefing and discussion of site visits
  - Obtain permission and arrange practicum visits to fit with facility schedule, ensuring access to a maximum number of mother/caregivers with children of the desired ages

- **Issue announcement/invitation**: The announcement should include:
  - Name of authority responsible for organizing the course
  - Aims of the training
  - Intended Participants (and number of Participants expected from each group invited)
  - How to register Participants; date by which registration must be received
  - Outline of training course content and skills
  - Dates of training activities; venue
  - Accommodation, travel and financial arrangements (e.g., if per diem, meals, accommodation is covered)
  - Date by which confirmation notice will be send to selected Participants

- Plan the timetable
- Obtain and reproduce the training package materials
- Develop list for items for demonstration and other resources (cups, spoons, materials to make dolls, breasts, etc.)
- Training course completion certificate (Note: we now give these only after successful completion of post-training requirements)

4. Document Process

- Designate one member of the training or field test team to document the training process, recording observations, difficulties, lessons learned, and recommendations for changes to training package. The real-time and post-training assessment should be structured to capture observations, comments and recommendations from Facilitators, Participants, and observers.

B. FIELD TEST ASSESSMENT

1. Curriculum Content (What): Evaluation of Individual Sessions by Facilitators/; Participants
   - Topic addresses IYCF competencies required of CWs: 4-point Likert (v useful, useful; somewhat useful, not useful)
   - Content: unnecessary, too much detail, missing content
   - Instructions: key information, materials, time requirement

2. Use of Communications Materials/Graphics/Tools (What)
   - Assessment of value in Participant learning
   - Assessment of value in talking with mother/caregivers
   - Suggestions for modifications/changes

3. Participant Materials (What): Participant feedback
   - Request for additional materials: what

4. Training Methodology (How)
   - Interactive (vs. didactic); applies adult learning principles
   - Role-plays
   - Demonstrations and Return-Demonstrations
   - Training Aids
   - Observations
   - Working groups

5. Practicum (How)
   - For each Participant: number of mother/child pairs counselled (3-step approach) by age-group of child
   - For each Participant: number of supervised practicum counselling
   - Participant feedback
   - Facilitator observations

C. EVALUATING RESULTS AND EFFECTIVENESS (What For): What Participants will be able to do after completing the training

The strategy outlined below evaluates Participant results on 4 levels, 3 of which are proposed for use during the Field Test.

Reaction: What did Participants think and feel about the training.
Tools:
- Daily feedback forms: include Participant rating of sessions from 1 to 5 for activities and methodologies; if Participant does not assign the session a '5', ask Participant to describe what could be done to get a '5'
- Final evaluation questionnaire
- Verbal feedback

Learning: The resulting increase in Participant knowledge

Tools:

- Pre- and post-test results (multiple choice or short answer) comparison to identify content areas that are difficult for Participants to grasp and to help develop approaches to facilitate learning of challenging content
- Evaluation games or exercises during implementation of training
- Facilitator/Observer assessment during training: e.g., practical case study (by small group or individual) to test whether theory (knowledge and skills) can be effectively translated into practice

Behaviour: Is the Participant able to translate the acquired knowledge and the enhanced skills into effective practical use?

- Participant appraisal at conclusion of training: confidence in his/her ability and intent to use new knowledge and apply new skills on the job; observation and evaluation by Facilitators of Participant ability to appropriate apply the knowledge and counselling skills being practiced in the training practicum
- Expert observer: interview Participants before and after training and compare results to evaluate the impact of training on Participant knowledge and skills; observe Participant performing a task or conducting an activity (in training session; in practicum)

NOTE: the activities below, while critical to a full assessment training results, are beyond the scope of the immediate Field Test activities

Assessing the Impact of counselling on the Mother/Caregiver: e.g. mother/caregiver satisfaction with the interaction with the CHW; mother/caregiver comprehension of counselling discussion; mother/caregiver intent to comply with counselling recommendations

In addition to on-going mentoring and supervision, systematic appraisal of Participant on-the-job performance should be carried out at about 3 months after the training. However, this assessment is also beyond the scope of the immediate Field Test activities.

More conclusive evaluation results could be obtained by comparing the performance of a control group with that of Participants who have received the training

Results: The effect of improved counselling on the feeding behaviour in the population. This is also beyond the scope of the Field Test, and is dependent upon multiple other factors including programme coverage, etc.

Appendix 13: Specifications for printing & photocopying

Note: Full colour is every page that has colour. Black and white pages are the acknowledgment page and any page that is added, like a foreword.

Take Home Brochures
Paper 115 Matt Text, trim size 40.1cm x 23cm
CMYK 4/4 as in full colour
3 Fold (U-Fold)
Two sided
(THERE ARE A TOTAL OF 3 BROCHURES)

Community Counselling Cards*
Paper: 300 Matt Card, trim size 29.7cm x 21.cm (A4 Size)
Pages: 56 (Note: The number of pages is always 2 times the number of cards, i.e. if there are 28 cards, there will be 52 pages.)
Cards: 28
Full Colour Pages 4/4: XX
Black Pages 4/0: XX
Binding: Either a metal or plastic spiral binding technique can be used, or a single metal ring can be placed through holes punched in the upper left corner of each card).

Key Messages Booklet
XX pages plus cover
Book size: 29.7cm x 21.6 cm (A4 Size)
Cover: 300 Matt Card with soft lamination, Full colour
Inside: 130 Matt, Full colour
Binding: A saddle stitch binding is recommended.

Training Aids
XX pages plus cover
Book size: 29.7cm x 21.6 cm (A4 Size)
Cover: 300 Matt Card with soft lamination, Full colour
Inside: 300 Matt, Full colour
Binding: Binding is not necessary or required. Training aids will be cut after printing.
Lamination: If lamination of individual training aids is possible, 130 Matt paper can be used instead of 300 Matt.

Facilitator Guide
XX pages plus cover
Book size: 29.7cm x 21.6 cm (A4 Size)
Cover: 300 Matt Card with soft lamination, Full colour
Inside: 130 Matt, black ink on white paper
Binding: Discuss options and prices with printer.

Participant Materials

XX pages plus cover
Book size: 29.7cm x 21.6 cm (A4 Size)
Cover: 300 Matt Card with soft lamination, Full colour
Inside: 130 Matt, black ink on white paper
Binding: Discuss options and prices with printer.

Planning and Adaptation Guide

(Note: given the limited number that would be needed by a country planning/review team, this document could be printed from a computer and/or photocopied for team members.)
XX pages plus cover
Book size: 29.7cm x 21.6 cm (A4 Size)
Cover: 300 Matt Card with soft lamination, Full colour
Inside: 130 Matt, Full colour
Binding: Discuss options and prices with printer.

*Photocopies: If black and white photocopies of the counselling cards or other materials containing illustrations or graphics (covers, training aids, facilitator guide or participant materials) are needed for field testing or for temporary use during training or by community workers, it is best to identify a photocopy machine that has a "grayscale" or "photograph" setting. Care should be taken to experiment with the setting options, especially the contract setting, in order to identify the best setting for obtaining clear "grey scale" black and white images. If this step is not taken, the photocopies often have too much contrast and will not be easy to understand or appreciate.

APPENDIX 14: Package of supervisory tools

SUPERVISION

Objectives of 'Supportive Supervision'

1. Guide, support and motivate staff & community workers to perform their designated tasks

2. Facilitate improved worker performance (enhanced staff & community worker skills and knowledge). Possible avenues:
   - Scheduled supervisory visits to individual workers
   - Non-scheduled supervisory visits to individual workers
   - On-the-job refresher training
   - Problem-solving group supervision sessions

3. Monitor and report on the following in your supervision area (as appropriate):
   - Implementation of:
     - Training of trainers
     - Training of IYCF counsellors
     - Training of mother support group facilitators
     - Individual counselling sessions
     - Action-oriented group sessions
     - Mother support group sessions
     - Other activities

   - Coverage of the target population in your supervision area:
     - Percent of target mothers reached by individual counselling, mother support group sessions, action-oriented group sessions, other (using LQAS methodology, for example; determine reporting period)

   - Result of program activities in your supervision area:
     - Comprehension of key information by target audience, retention of key information by target audience (using LQAS methodology, for example; determine reporting period)

SUPERVISION CHECKLIST

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

Training Needs (by Supervision Area)

___ Target number of IYCF Counsellors required in supervision area (establish target with Programme Manager)
___ Number of Counsellors active during the reporting period
___ #/% of active IYCF Counsellors trained

___ Target number of Mother Support Group Facilitators required in supervision area
___ Number of Facilitators active during the reporting period
___ #/% active Mother Support Group Facilitators trained

Program Implementation: Supervision Activities

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

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

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

- ❑ Set schedule for supervisory visit with Facilitator
- ❑ Observe entire Support Group session
- ❑ Complete Observation Checklist (*Participant Materials* 13.3: Observation Checklist for Support Groups)
- ❑ Share results of observation checklist and discuss with Facilitator
- ❑ Document your feedback to Facilitator
- ❑ Document comments by Facilitator
- ❑ Identify Needs to support Facilitator
- ❑ Actions Required by Date Person responsible
- ❑ Scheduled date of next supervision visit: _____
- ❑ Signature of Facilitator acknowledging receipt of supervision _____
- ❑ Supervisor's signature: _____
- ❑ Report submitted to Programme Manager (date): _____

Supervisor Monitoring

Caseload:

- ❑ Collect monitoring data from IYCF Counsellors (per time period; each country/ programme will design its own data collection form to reflect country/programme priorities).
- ❑ Collect completed Support Group Attendance Monitoring Form (*Participant Materials* 13.4: Support Group Attendance Monitoring Form) from Facilitators (per time period)

Program Coverage:

- ❑ Percent target mothers (in supervision area) receiving individual IYCF counselling (per time period)
- ❑ Percent target mothers (in supervision area) attending a mother support group meeting (per time period)
- ❑ Percent target contact points (e.g. GMP or MUAC screening session, outreach visit by clinic, well child/immunization session at clinic, health post, community meeting, etc) at which IYCF counselling provided (per time period)

PROGRAMME MANAGER OVERSIGHT OF SUPERVISION

The following indicators are examples of the kinds of programmatic data on the community IYCF activities which a programme manager can collect. These can be adapted to the local programme structure and needs.

Programme coverage and functioning

- ❑ Coverage of counsellors: % of total target number of areas (to be specified locally: e.g. sub-district administrative unit, health centre catchment area, etc) which have at least xx active IYCF counsellors operating

- ❑ Dropout rate: # IYCF counsellors who have dropped out of the programme & need to be replaced

- ❑ Coverage of mother support groups: % of total target number of areas (to be specified locally: e.g. sub-district administrative unit, health centre catchment area, etc) which have at least xx mother support groups for IYCF operating

Training

- ❑ Training of Trainers: % of total target number of Trainers who have been trained

- ❑ Training of Counsellors: % of total target number of Counsellors who have been trained (by Supervision Area)

- ❑ Training of Facilitators: % of total target number of Facilitators who have been trained (by Supervision Area)

Program Supervision

<u>Program Supervision of IYCF Counsellors</u>:

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

<u>Program Supervision of Mother Support Group Facilitators</u>:

- ❑ Percent of Mother Support Group Facilitators who receive at least one supervisory visit per agreed time period

Reporting

<u>Reporting Form Submission</u>

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

Participant Materials 10.1: IYCF Assessment of Mother/Child Pair

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

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

Name of Counsellor: _____

Name of Observer: _____

Date of visit: _____

(√ for yes and × for No)

Did the Counsellor

Use Listening and Learning skills:

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

Use Building Confidence and Giving Support skills:

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

ASSESSMENT

(√ for yes and × for No)

Did the counsellor

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

Breastfeeding:

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

Fluids:

- ❑ Assess 'other fluid' intake?

Foods:

- ❑ Assess 'other food' intake?

Active Feeding:

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

Hygiene:

- ❑ Check on hygiene related to feeding?

ANALYSIS

(√ for yes and × for No)

Did the counsellor?

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

  Record prioritized difficulty: _____

ACTION

(√ for yes and × for No)

Did the counsellor?

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

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

Participant Materials 13.3: Observation Checklist for IYCF Support Groups

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

Participant Materials 13.4: Support Group Attendance Monitoring Form

Date _____ District_____

Facilitator(s) Name(s) _____

Participant Materials 14.1: Observation Checklist for How to Conduct a Group Session: Story, Drama, or Visual, applying the steps Observe, Think, Try, and Act

Did the Counsellor?

(√ for yes and × for No)

- ❑ Introduce him/herself?

Use Observe - ask the group participants:

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

Use Think - ask the group participants:

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

Use Try – ask the group participants:

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

Use Act – ask the group participants

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

Participant Materials 18.1: IYCF Follow-up Plan Checklist

1. Mobilisation and sensitisation

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

2. Admission

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

3. Weekly or bi-weekly follow-up

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

4. Discharge (MOH)

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

5. Follow-up at home/community

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

Contact Points to Integrate IYCF into CMAM (other than OTP) - at health facility or community outreach

- ❑ Growth Monitoring Promotion (GMP)
- ❑ Antenatal Care (ANC) at health facility
- ❑ Stabilisation Centres (SC)
- ❑ Supplementary Feeding Programme (SFP)
- ❑ Community follow-up (CW)
  - Action-oriented group session
  - IYCF support groups

Contact points for implementing the Essential Nutrition Actions (ENA) - at health facility or community outreach

- ❑ At every contact with a pregnant woman
- ❑ At delivery
- ❑ During postpartum and/or family planning sessions
- ❑ At immunization sessions
- ❑ During Growth Monitoring Promotion
- ❑ At every contact with mothers or caregivers of sick children

Other contact points

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

And

- ❑ Set appointment for the next follow-up visit