

# PART 3: TRAINER'S GUIDE

The trainer's guide is the third of four parts contained in this module. It is NOT a training course. This guide provides guidance on how to design a training course by giving tips and examples of tools that the trainer can use and adapt to meet training needs. The trainer's guide should only be used by experienced trainers to help develop a training course that meets the needs of a specific audience. The trainer's guide is linked to the technical information found in Part 2 of the module.

Module 17 is about infant and young child feeding in emergencies (IYCF-E) and covers a range of interventions from developing policy to support for individual mothers and caregivers. The module can be used to provide orientation on key elements of IYCF-E for senior managers, and to provide guidance to fieldworkers on the main considerations in their line of work.

Module 17 forms the written content of an orientation package on IYCF-E (Module 1, v2.0, 2010). This package of resources has been developed to orientate emergency relief staff, programme managers, and technical staff involved in planning and responding to emergencies at national and international level, on IYCF-E. It comprises e-learning (available online and on CD), training resources (PowerPoints and exercises) more detailed technical notes, and key resources. It supports the practical implementation of the Operational Guidance on IYCF-E and Sphere Standards (2011).

For those requiring more technical guidance on IYCF-E, key resources are included in Part 4.

### Navigating your way around the guide

The trainer's guide is divided into six sections.

1. **Tips for trainers** provide pointers on how to prepare for and organise a training course.
2. **Learning objectives** set out examples of learning objectives for this module that can be adapted for a particular participant group.
3. **Testing knowledge** contains an example of a questionnaire that can be used to test participants' knowledge either at the start or at the end of a training course.
4. **Classroom exercises** provide examples of practical exercises that can be done in a classroom context by participants individually or in groups.
5. **Case studies** contain examples of case studies (one from Africa and one from another continent) that can be used to get participants to think by using real-life scenarios.
6. **Field-based exercises** outline ideas for field visits that may be conducted during a longer training course.

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# 1. Tips for trainers

## Step 1: Do the reading!

- Read Parts 2 of this module.
- Familiarize yourself with the technical terms from the glossary.
- Read through the following key documents (see full references and how to access them in Part 4 of this module):
  - IFE Core Group (2007). *Operational Guidance for Emergency Relief Staff and Programme Managers on Infant and Young Child Feeding in Emergencies*, Version 2.1. ENN, [www.ennonline.net/ife](http://www.ennonline.net/ife). The Operational Guidance on IFE provides concise, practical, but mainly non-technical, guidance on how to ensure appropriate infant and young child feeding in emergencies. It is endorsed in WHA Resolution 43.23 (2010). It is an essential document for any orientation on IFE.
  - IFE Core Group (2010). *Module 1 on IFE*, Version 2.0 Orientation Package. For orientation reading and reference, for all emergency relief staff, including PowerPoints and e-learning, available at <http://www.ennonline.net/ife/orientation>. Direct link to e-learning: <http://lessons.ennonline.net/>
- Materials to support training can be found at:
  - *Module 2 on IYCF-E*. This is a reference document for more technical content on IYCF-E. It provides more extensive background reading/reference for those interested in learning more. It was developed for health and nutrition staff working directly with infants and young children and their caregivers in emergencies. It includes chapters on breastfeeding support, managing breastfeeding difficulties, managing artificial feeding in emergencies and managing malnourished infants under six months of age.
  - ENN, NPP, IFE Core Group (2009). *Integration of IYCF Support into CMAM*. Facilitators notes and handouts. ENN 2009
  - *IFE Resource Library*, [www.ennonline.net/ife](http://www.ennonline.net/ife): Online library developed by the IFE Core Group that includes key resources and materials including presentations and media reports on IFE. Resources referred to in the exercises are located here.
  - *Field Exchange online search database*. Many of the case studies in Module 17 (and other modules) have been located in the Emergency Nutrition Network's *Field Exchange* publication, available online at <http://fex.ennonline.net>. This publication can be used to source experiences from more recent emergencies and to track emerging issues.

## Step 2: Know your audience!

- Find out about your participants in advance of the training:
  - How many participants will there be?
  - Are the participants 'technical staff' (health and nutrition workers) or 'generalists' in the field of IYCF-E (managers, logisticians, other)?
  - Do any of the participants already have experience of infant and young child feeding in emergencies?
  - Are any of the participants trained breastfeeding counsellors?
  - Could participants with experience be involved in the sessions by preparing a case study or contribute through describing their practical experience?

### Step 3: Design the training!

- Decide how long the training will be and what activities can be covered within the available time. In general, the following guide can be used:
  - A **60- to 120-minute** classroom-based training can provide an orientation on IYCF-E.
  - A **half-day** classroom-based training can provide an orientation on IYCF-E and include some short group exercises (3.5-4 hours).
  - **Integrate** key elements of IYCF-E into other nutrition in emergencies training sessions where possible. This will be necessary if there is not a standalone session on IYCF-E. For example, include IYCF in a session on individual assessment or complementary feeding in a session on food security.
  - A **one-day** classroom-based training can provide a more in-depth understanding of IYCF-E, more technical information, and include a number of practical exercises and/or a few case studies. However, a full technical training takes more time (3 to 5 days) and should draw on more technical materials to expand on the HTP content (see resources).
  - Where IYCF-E training is part of a broader nutrition in emergencies training, look for opportunities to integrate key elements on IYCF-E in shared practical sessions on emergency response.
- Conduct a pre-training assessment of the IYCF-E context you are dealing with to inform the key content and focus to include in training sessions. The priority IYCF issues will depend on the context (see Exercise 2 that may help in preparation regarding this).
- Identify appropriate learning objectives. This will depend on your participants, their level of understanding and experience, and the aim and length of the training.
- Decide exactly which technical points to cover based on the learning objectives that you have identified.
- Divide the training into manageable sections. One session should generally not last longer than an hour.
- Ensure the training is a good combination of activities, e.g., mix PowerPoint presentations in plenary with more active participation through classroom-based exercises; mix individual work with group work.
- Practice timing.

### Step 4: Get prepared!

- Prepare PowerPoint presentations with notes (if they are going to be used) in advance and do a trial run. Time yourself! Keep written content on PowerPoints to a minimum, use images to talk around rather than written text. Do not prepare PowerPoints as 'handouts' for a session. For existing PowerPoint presentations, consult the Module 1 orientation package at <http://www.enonline.net/ife/orientation> and the online IYCF-E Resource Library on the ENN website, [www.enonline.net/ife](http://www.enonline.net/ife). Suggested PowerPoint presentations that can be adapted from existing sources include (see full references and how to access in Part 4 of this module):

#### Existing PowerPoints for a session on IYCF-E

Author	Session
IFE Core Group, 2009	Pictorial presentation on IFE
IFE Core Group, 2009	1 hour orientation on IFE
IFE Core Group, 2009	Bonus slides on IFE
ENN. Adapted from IFE Core Group, 2009	Orientation on IYCF-E (Lebanon, 2010)
ENN. Adapted from IFE Core Group, 2009	Orientation on IYCF-E (Nairobi, 2009)
ENN. Adapted from IFE Core Group, 2009	Orientation on IYCF-E for military
IBFAN-ICDC. <i>Making sense of the Code: training course on the Code</i> (see Part 4 for full reference)	Various presentations on the Code

- Prepare exercises and case studies. These can be based on the examples given in this trainer's guide but should be adapted for the particular training context.
- Important note regarding the exercises: Exercises should be used that can be completed using Module 17 and the Operational Guidance on IYCF-E. The exception is the field exercise which draws on IYCF in CMAM training material for an adapted exercise.
- Prepare a 'kit' of materials for each participant. These should be given out at the start of the training and should include:
  - Timetable showing break times (coffee and lunch) and individual sessions
  - Parts 1 and 2 of this module
  - Pens and paper

**REMEMBER**

People remember 20% of what they are told, 40% of what they are told and read, and 80% of what they find out for themselves.

People learn differently. They learn from what they read, what they hear, what they see, what they discuss with others and what they explain to others. A good training is therefore one that offers a variety of learning methods which suit the variety of individuals in any group. Such variety will also help reinforce messages and ideas so that they are more likely to be learned.

## 2. Learning objectives

Below are examples of learning objectives for a session on IYCF-E. Trainers may wish to develop alternative learning objectives that are appropriate to their particular participant group. The number of learning objectives should be limited; up to five per day of training is appropriate. Each exercise should be related to at least one of the learning objectives.

### Examples of learning objectives

At the end of the training participants will be able to:

- Define optimal infant and young child feeding practices and their particular relevance in emergencies
- Identify risk factors and challenges to IYCF-E in a given context
- Identify key policy guidance relevant to IYCF-E
- Understand the importance of IYCF-E needs assessment
- Describe key multi-sectoral and technical interventions on IYCF-E
- Understand key aspects of coordination, communication and orientation/training in emergencies
- Understand the importance of preventing and how to manage donations of breastmilk substitutes and feeding equipment in emergencies
- Avoid Code violations and monitor/report Code violations encountered
- Identify emergency preparedness activities
- Locate sources of resources and shared experiences

## 3. Testing knowledge

This section contains one exercise, which is an example of a questionnaire that can be used to test participants' knowledge of infant feeding in emergencies either at the start and/or at the end of a training session. The questionnaire can be adapted by the trainer to include questions relevant to the specific participant group.

### Exercise 1: What are optimal infant and young child feeding practices?

#### What is the learning objective?

- To test participants' knowledge about optimal infant and young child feeding practices including some misconceptions around IYCF practices

#### When should this exercise be done?

- At the start of a training session to establish knowledge level (as pre-test)
- At the end of a training session to check how much participants have learned (as post-test)

#### How long should the exercise take?

- 20 minutes

#### What materials are needed?

- **Handout 1a:** What do you know about optimal infant and young child feeding practices and common beliefs on IYCF?: Questionnaire
- **Handout 1b:** What do you know about optimal infant and young child feeding practices and common beliefs on IYCF?: Answers

#### What does the trainer need to prepare?

- Familiarise yourself with the questionnaire questions and answers.
- Add your own questions and answers based on your knowledge of the participants and their knowledge base.

#### Instructions

**Step 1:** Pre-training: Give each participant a copy of Handout 1a.

**Step 2:** Ask participants to complete the questions individually.

**Step 3:** Post training: repeat the exercise and compare pre-and post- answers.

Alternatively, if used as post-training test only:

**Step 1:** Give each participant a copy of Handout 1a.

**Step 2:** Go over each question, asking the group to reply orally, give quick explanation when the answer is wrong; refer back to the relevant training session.



**Handout 1a: What do you know about optimal infant and young child feeding practices?: Questionnaire**

1. According to the Lancet series on Child Survival (2003) and Maternal and Child Undernutrition (2008), which are the top three life-saving interventions for infants and young children?
  - a) Zinc supplementation
  - b) Exclusive and continued breastfeeding until 1 year of age
  - c) Complementary feeding
  - d) Vitamin A distribution
  - e) Clean delivery
  - f) Newborn temperature management
  - g) Insecticide treated materials
2. What is the recommended time to initiate breastfeeding after birth?
  - a) Within 2 hours of birth
  - b) Within 12 hours of birth
  - c) Within 1 hour of birth
  - d) Within 24 hours of birth
3. Exclusive breastfeeding means:
  - a) Breastmilk and occasional water or water-based fluids in hot weather
  - b) Breastmilk is the main food for the infant, with other liquids or solids allowed if in very small quantities (e.g. given for religious reasons)
  - c) Only breastmilk, no other liquids or solids, not even water, with the exception of vitamins, minerals supplement, medicines or ORS
4. What is important during breastfeeding (more than one answer is possible)?
  - a. The baby must be fed every 3 hours
  - b. The baby must be turned towards his/her mother and be held closely
  - c. The baby must drink around 20 minutes from each breast
  - d. After two months the baby should not be fed at night
  - e. It is best to feed the baby whenever he/she asks for it, day or night
  - f. The baby can drink from a breast as long as he/she wants
5. Complementary foods should be introduced:
  - a) from 4 months.
  - b) between 4 to 6 months.
  - c) from 6 months.

6. What proportion of energy should breastmilk contribute to the intake of a 1-2 year old?
- a) Less than 10%
  - b) 10-20%
  - c) 30-40%
  - d) Breastmilk does not significantly contribute to energy intake of breastfed children aged 1-2 years
7. Select the true statements from the following:
- a) In emergencies, micronutrient supplementation may be needed to fully meet the micronutrient needs of young children
  - b) General distribution of milk powder is a priority in populations used to having milk
  - c) Animal source foods are a valuable nutrient source during the complementary feeding period
8. Answer true or false to the following statements:
- a) A traumatised mother cannot breastfeed
  - b) Moderate malnutrition in a mother reduces breastmilk production
  - c) Acute stress does not affect production but can affect the release of breastmilk
  - d) Providing a breastfed infant with infant formula will not affect the production of the mother's breastmilk
  - e) HIV infected mothers should be discouraged from breastfeeding

## Handout 1b: What do you know about optimal infant and young child feeding practices?: Answers

1. According to the Lancet series on Child Survival (2003) and Maternal and Child Undernutrition (2008), which are the top three life-saving interventions for infants and young children?
  - b) Exclusive and continued breastfeeding until 1 year of age
  - c) Complementary feeding
  - g) Insecticide treated materials
2. What is the recommended time to initiate breastfeeding after birth?
  - c) Within 1 hour of birth: *Initiating breastfeeding within one hour of birth is essential to prevent hypoglycaemia, hypothermia and jaundice in the newborn and reduce postpartum bleeding with the mother. It is also very important for mother-child bonding, optimal milk production and is beneficial for successful breastfeeding in the long run.*
3. Exclusive breastfeeding means:
  - c) Only breastmilk, no other liquids or solids, not even water, with the exception of vitamins, minerals supplement, medicines or ORS. *This is the recommended feeding practice for infants up to 6 completed months.*
4. What is important during breastfeeding (more than one answer is possible)?
  - a) The baby must be fed every 3 hours  
**FALSE** *The recommended practice is to feed on demand, therefore there is no recommended time in between two feeds; the mother should feed when the healthy baby indicates that he/she wants to drink. In the case of weak or sick babies, the mother must initiate breastfeeding regularly herself as those babies might not indicate their need for milk. They will need to be fed more often than healthy babies as they can only take small quantities at a time.*
  - b) The baby must be turned towards his/her mother and be held closely  
**TRUE** *The baby must be turned towards its mother, in a straight line so his neck is not twisted or bent forward and held close and be fully supported to allow good attachment.*
  - c) The baby must drink around 20 minutes from each breast  
**FALSE** *Some babies drink fast, other babies drink slow, therefore there is no indicated time per feed. The mother can let the baby drink from one breast until the baby releases the breast by his/herself and then offer the other breast. Taking too little time at one breast will result in incorrect emptying of the breast which can be the cause of breast problems, insufficient weight gain in the baby and reduced milk production.*
  - d) After two months the baby should not be fed at night  
**FALSE** *It is good to feed babies at night when they ask for it, as it is an indication they need the milk at that time. In addition, feeding at night is beneficial for the mother's milk production. The baby will indicate him/herself when he/she is ready to sleep through the night.*
  - e) It is best to feed the baby whenever he/she asks for it; day or night  
**TRUE** *See answers above*
  - f) The baby can drink from a breast as long as he/she wants  
**TRUE** *See answers above*
5. Complementary foods should be introduced:
  - c) from 6 months: *Until the age of 6 months all the baby's needs are covered by the breastfeeding. From 6 months onwards the introduction of complementary food, such as meat, fish, vegetables and fruit, is necessary. Before this age, the child's intestines are not ready to eat complementary food and it only exposes the child to a higher risk of diarrhoea or other diseases.*

6. What proportion of energy should breastmilk contribute to the intake of a 1-2 year old?
- c) 30-40%: *Even for young children, breastmilk contributes significantly to the total energy requirements, and therefore remains a very important part of the diet. One should also not forget that breastmilk continues to provide protection against diseases at this age as well.*
7. Select the true statements from the following:
- a) In emergencies, micronutrient supplementation may be needed to fully meet the micronutrient needs of young children *since the food available might lack essential micronutrients*
- c) Animal source foods are a valuable nutrient source during the complementary feeding period
8. Answer true or false to the following statements:
- a) A traumatised mother cannot breastfeed **FALSE**, *a traumatised mother can breastfeed, since the trauma will not affect her production. She might experience difficulties letting down the milk, but this can be overcome by support, relaxation and motivation.*
- b) Moderate malnutrition in a mother reduces breastmilk production **FALSE**, *Malnourished mothers can breastfeed. However they should be provided with extra food and fluids to rebuild their own nutrient stores and should be encouraged to breastfeed the infant very frequently to stimulate milk production. Moderate malnutrition has little or no effect on milk production. In fact the mother will continue to produce milk, even to the detriment of her own wellbeing. Milk production is only likely to be reduced if a woman is severely malnourished; then the woman herself would need immediate feeding support while continuing breastfeeding. "Feed the mother and let her feed the baby" is the key approach.*
- c) Acute stress does not affect production but can affect the release of breastmilk **TRUE**  
*Stress does not prevent milk production but it may slow the release of milk from the breasts. This can result in babies being 'fussy' when breastfeeding. Mothers may think that there is not enough breastmilk as a result. Frequent breastfeeding will help the mother and baby to get over this and ensure the baby receives enough. Reassuring support will decrease a mother's stress and increase her confidence.*
- d) Providing a breastfed infant with infant formula will not affect the production of the mother's breastmilk **FALSE**, *every time a child drinks infant formula instead of breast milk, the milk production of the mother will reduce.*
- e) HIV infected mothers should be discouraged from breastfeeding **FALSE**, *Even though there is a chance of HIV transmission from mother to child through the breast milk, the risk is greater during pregnancy and birth. Most mothers will not transmit HIV through breastfeeding. A mother who receives ARVs and who exclusively breastfeeds in the first six months significantly reduces the risk of transmission. This risk must be balanced with the risk of disease, malnutrition and death through unsafe or inadequate use of artificial milk. If social and environmental conditions for replacement feeding are not met, breastfeeding offers a much better chance of survival for the child.*

## 4. Classroom exercises

This section provides examples of practical exercises that can be carried out in a classroom context by participants individually or in groups. Practical exercises are useful between plenary sessions, where the trainer has done most of the talking, as they provide an opportunity for participants to engage actively in the session. The choice of classroom exercises will depend upon the learning objectives and the time available. Trainers should adapt the exercises presented in this section to make them appropriate to the particular participant group. Ideally, trainers should use case examples with which they are familiar.

### Exercise 2: Country Problem Analysis

#### What is the learning objective?

- To identify the main areas of concern regarding IYCF in a given situation and region or country

#### When should this exercise be done?

- At the start of a training session

#### How long should the exercise take?

- 30-45 minutes

#### What materials are needed?

- **Handout 2a:** List of indicators around IYCF in emergencies
- Module 20 on Monitoring and Evaluation

#### What does the trainer need to prepare?

- Prepare a list of indicators around IYCF in emergencies, based on the provisions of the Operational Guidance on IFE. Consider the pre-emergency situation and any experiences in previous/current emergency, with regard to the context you are focusing on. Examples of indicators used in training in Asia and in East Africa are included below but should be adapted to the context of the training. For example, other indicators might include *low breastfeeding rate at one year in non-emergency*, to reflect a specific context.
- Participants can be asked to bring secondary data on IYCF from their work area. If this is not possible, the trainer can prepare secondary data from a specific context and put this into a case study. For example, a slide showing the most recent exclusive breastfeeding rates by country for a regional training provides useful context.
- A large chart to display the indicators

#### Instructions

**Step 1:** Give each participant Handout 2a with the list of indicators

**Step 2:** Participants are asked to rank indicators as 'a big problem', a 'medium' problem, or 'not a problem' at all. Red/yellow/green paper/markers are used to reflect this on the chart. A limited number of red (big problem) and yellow (no problem) markers are given, to encourage prioritisation.

**Step 3:** Review the different indicators as a group and discuss which are: a big problem – Red Post-It (max 8), a medium problem – Yellow Post-It (max 8), not a problem at all – Green Post-It (13)

**Handout 2a: List of indicators**

Sample indicators for problem analysis

Sample indicators from Asia (2008) and East Africa (2009)	Insert country 1	Insert country 2
<b>Infant Feeding Practices/Current Situation (outputs)</b>		
1 Low exclusive breastfeeding rate in non-emergency		
2 Significant artificial feeding/replacement feeding in non-emergency		
3 Mother to child transmission of HIV is a big concern		
4 PMTCT programmes available in non-emergency		
5 Poor nutritional status of pregnant and lactating women		
6 Complementary feeding difficult for 6-<24 month olds		
7 Acute malnutrition prevalent in U2s		
8 Orphans/non-parent carers common		
9 2006 WHO Growth Standards roll-out		
10 General perception that infant formula is as good as/better than breastfeeding		
<b>Current IYCF/IFE Programme (inputs)</b>		
11 No government IYCF-E policy/not implemented		
12 No national BMS Code/not enforced		
13 Few government trained/knowledge on IYCF-E		
14 Few NGOs trained/knowledge on IYCF-E		
15 Few lactation specialists available during emergencies		
16 Perception mothers can't breastfeed/great difficulties during emergencies		
17 Donations of BMS during emergencies		
18 No suitable complementary foods in distributions		
19 BMS included in distributions		
20 Pregnant and lactating women often not targeted		
21 Emergency coordinators do not prioritize IYCF-E		
22 NGOs act independently of national Emergency Response		
23 Early rapid assessments do not include IYCF		
24 Unclear IYCF-E indicators to use in assessments		
25 Services to encourage and support BF often absent		
26 Emergency/transit/reception areas not supportive for BF		
27 Early support to orphans in emergencies not clear		
28 No systems to minimise artificial feeding risks in an emergency.		
29 Little capacity to manage malnourished infants <6m		
30 Ready-to-Use Foods use not clear in prevention of malnutrition /complementary feeding		

**Exercise 3: What are the risk factors and challenges facing mothers and caregivers in emergencies?****What is the learning objective?**

- To be able to identify risk factors and challenges to infant feeding in different emergency settings

**When should this exercise be done?**

- Use as a quick 'brainstorming' at the start of a training session

**How long should the exercise take?**

- 10 to 20 minutes

**What materials are needed?**

- **Handout 3a:** Setting the Scene on IYCF-E (or images as PowerPoints)
- **Handout 3b:** Comments on photos of different emergencies

**What does the trainer need to prepare?**

- Be familiar with the photos and the issues that may emerge or that participants are being asked to identify, so that if they miss out something, you are able to fill them in with the answers.
- PowerPoint presentation with the photos

**Instructions**

**Step 1:** Explore perceptions around IYCF-E amongst participants. Personal and professional experiences around IYCF can have a significant influence on practice

**Step 2:** Give each participant Handout 2a or present as a PowerPoint presentation

**Step 3:** Taking each photo in turn, ask the group what the risk factors are.

**Step 4:** The trainer adds additional key information when necessary.

**Step 5:** Give each participant Handout 2b.

### Handout 3a: Setting the scene on IYCF-E

Photo 1 and 2: Queuing for food distribution





Photo 3: Unaccompanied children in DRC



Photo 4: Mother who lost her own child caring for an orphan



Photo 5: Malnourished Child



Photo 6: A mother in distress



Photo 7: An injured mother



Photo 8: People taking water from a dirty pond



Photo 9: A malnourished mother



Photo 10: Emergency workers as an IYCF risk factor



## Handout 3b: Comments on photos of different emergencies

### Photo 1 and 2: Queues

Long crowded queues in the hot sun are not suitable for babies, who may be left alone in shelters. Mothers cannot leave the queue to breastfeed the infant on demand or to prepare other feeds; they will lose their place. Crowds can be aggressive, one may have to struggle to get something. Mothers who also have to protect their children will get the least.

### Photo 3: Unaccompanied children

Children without adult caregivers may have carried infants long distances to a camp but cannot manage artificial feeding. Infants lacking adult care may have to be brought into an organized care setting.

### Photo 4: Mother who has lost all her own children caring for a sick orphan in Rwanda

The stress and sadness of a mother cannot be removed, but measures to lessen her isolation may help her to cope with her feelings and care for the orphaned infant. Seek any relatives, clan members, or women who speak her home language to be with her. If this infant is sick, partly because he/she is not getting enough breastmilk, the mother also needs encouragement and help to re-lactate if she is willing.

### Photo 5: Malnourished Child

A malnourished child needs his mother's milk even more to survive and fight against diseases. If the child is too weak to suckle the breast effectively, measures must be taken to help him by pumping the milk and feeding it to him in a different manner. If the mother does not have enough milk, a milk supplement can be given while making efforts to increase her production. Treatment with therapeutic milk should aim to complete breastfeeding, not to replace it.

### Photo 6: A mother in distress

This mother is clearly stressed in the aftermath of an emergency. If she breastfeeds she needs a quiet place where she can find the peace and quiet to nurse her child. She is carrying a baby bottle, but where is she going to prepare milk in a safe and adequate way to feed her baby?

### Photo 7: An injured mother

An injured mother is cradling her new born baby. She will need help, support and motivation to breastfeed her child with her difficulties. She must be allowed to keep her child with her and she needs health professionals to assist her so she can breastfeed the baby.

### Photo 8: People taking water from a dirty pond

This dirty pond seems to be an important water source for these people. What would happen if this water is used to prepare the powdered milk for an infant?

### Photo 9: A malnourished mother

This mother is malnourished but she is still breastfeeding, proving that she can. Instead of providing breastmilk substitutes for the baby, it is much better to treat the mother's malnutrition and let her continue to breastfeed the baby.

### Photo 10: Emergency workers as an IYCF risk factor

Here is an aid worker demonstrating artificial feeding to mothers who are breastfeeding. Preconceptions regarding IYCF practices held by workers may reflect their personal experiences and assumptions rather than the context they are working in. It also reflects a poor understanding of the risks and benefits of different practices in an emergency context.

**Exercise 4: Basic interventions and communication on IYCF-E****What is the learning objective?**

- To appreciate the basic interventions required to support a safe environment for IYCF
- To understand the power of the media in affecting humanitarian response

**When should this exercise be done?**

- *Either* at the start of a training session (to see what people know, and what they come up with themselves)
- *Or* at the end of a training session (to see what people have remembered)

**How long should the exercise take?**

- 30 to 45 minutes

**What materials are needed?**

- PowerPoint (optional)
- Handout of the article (optional)
- Media guide on IYCF-E (see Part 2 of this module, annex 12)

**What does the trainer need to prepare?**

- Familiarise yourself with the background and power of communication and its consequences so you are able to complete participants' remarks
- The original article included in the newspaper is included. Depending on the participants' proficiency in English, you may wish to summarise the article in simpler English, provide a summary on PowerPoints or simply tell the story in your own words.

**Instructions**

**Step 1:** Give participants Handout 4a or present in a PowerPoint presentation.

**Step 2:** Discuss the answers to the different questions.

**Step 3:** Give Handout 4b and discuss this outcome

**Step 3:** Discuss other ways of communication and appropriate interventions.

**Handout 3a: Article on basic interventions and communication on IYCF-E****Behind the photograph: the human face of Pakistan's deadly flood  
Mother of the child in image that went around the world tells of her family's struggle**

*Rania Abouzeid in Azakhel, Monday September 6 2010, The Guardian*



It was an image that conveyed the human cost of the Pakistani floods and the failure to deliver aid to those affected more powerfully than any statistic: four young children lying on a filthy patchwork quilt, one of them sucking on an empty yellow bottle, all of them covered by flies.

The Guardian identified the child with the bottle as two-year-old Reza Khan and tracked him down to a makeshift camp at a roadside in Azakhel, some 19 miles from Peshawar, the capital of the insurgency-plagued province of Khyber Pakhtunkhwa, bordering Afghanistan.

The camp is a hotchpotch of about two dozen tents donated by various aid organisations, but it is run by none. Its residents must fend for themselves, and rely on the charity of passers-by. There are 19 families here, all of them

Afghan refugees: people who were displaced once by conflict in their homeland have now been displaced again by the month-long deluge. Reza's family is from Butkhak, near the Afghan capital, Kabul. His father fled the area as a young boy, some 30 years ago, to escape the cycle of foreign occupation and battles plaguing his homeland.

When we found him, Reza was in a tent with his mother, Fatima, who, like most Afghans, has only one name, and six of his seven siblings, all huddled on a blue blanket extended over the muddy floor. He was still clutching the same bottle. It was still empty. Fatima tried to calm the boy, who cries in a constant, low whimper, as well as his twin brother, Mahmoud. She covered three of her other children – she has eight, all under the age of nine – with a dirty mosquito net somebody in a passing car gave her, but it has several gaping holes. Her eldest child, a nine-year-old girl called Sayma, is mute and seems dissociated from her surroundings. Her green eyes stare blankly ahead, seemingly oblivious to her brothers' wails. Flies carpet the few blankets arranged on the floor, and swarm all over the children. There is precious little in the tent, one cooking pot, a few cushions and two or three items of children's clothing. The stench of human and animal waste is overwhelming in the hot, humid air. There is no sanitation, just shallow, open ditches of raw sewage that attract flies and mosquitoes.

"They have had nothing to eat today. I have no food," Fatima says as she tries to swat the flies away from her children with a bamboo fan. "He's crying with hunger," she says, pointing to Reza. "It's been a month since he had any milk." On this day, Reza's father, Aslam, was in a nearby hospital with his seven-year-old daughter, who has a skin infection caused by the unsanitary living conditions. Reza and several of his siblings also bear red spots, and appear malnourished. Their thin hair is coming out in clumps, their mother says. "We have been here for a month, a month!" Fatima says. "We are tired of these flies and of being without food. Before the waters came my husband worked. We were poor before, but we had full stomachs."

The family of 10 used to live among the 23,000 residents of the Azakhel Afghan refugee camp, about 20 minutes' walk from their current roadside location. Aslam sold chickens for a living, travelling from door to door on a rickety bicycle, one of the family's prized possessions. He made about \$2 a day. Their mud-brick home was small, Fatima says, but it was enough for her. They lived among her husband's clan, about six families in all. "I had a kitchen, and there was a water tap close by," she says as her youngest child, one-year-old Ayad, tugs on her lilac dupatta, the scarf Pakistani women drape over their heads, arms and chest, pulling it away from her hair. She quickly readjusts the worn, holed fabric. "These clothes are all that we have now," she says, almost apologetically. The loose mud bricks of their home were no match for the raging waters of the nearby swollen Kabul River. The floodwaters gushed into the house in the morning. She and her husband snatched several of the children in their arms, while extended family members helped bundle the others out of the house. The clan of some 60 people walked toward the main road linking the town of Nowshera to Peshawar. They spent five days out in an open field, eating whatever scraps they could forage. Aslam's older brother, Taykadar, set out on foot to find help, stopping at several of the dozen or so organized relief camps nearby. "They would ask us for our Pakistani identification cards in order to register us, but we are Afghans," he says. "And we are too many, that's the problem. We don't want to be split from each other. We've already lost our homes, we don't want to lose our families." The men managed to obtain several tents from various organisations. Fatima's, for example, was donated by the Saudi government while others bear the logos of UNHCR. The Afghans say they have nothing to return to. Taykadar says they haven't received any help from a government he knows is overwhelmed by the destitution of its own people. The busy road that they have camped alongside is now their lifeline. Men, women and children rush out towards any car that appears to slow down alongside them. Hundreds of hands stretch out, hoping for food, water or clothing. "We have to run after the food, it isn't given by some organisation in the tents," Fatima says bitterly. Her children eat once a day, usually in the evenings, thanks to charity organisations that provide iftar meals during Ramadan. But Ramadan ends this week. "I just want to say to the world, isn't there any way they can get us food?" she pleads. "Look," she says, pointing to the twins in her lap. "Please, our children are dying of hunger."

1. What does this article tell you about the immediate needs of this mother to enable her to care for and to feed her children?
2. What does this article tell you about infant and young child feeding practices in this emergency?
3. What message does this piece send about what aid is needed?



## Handout 4b: Follow up article

The headlines read: **Pakistan floods: Reza Khan finally gets his milk after readers respond**, The Guardian, UK, 7 Sept 2010: A story highlighting the plight of the two-year-old and his displaced Afghan family led to worldwide donations.



Reza Khan, and his twin Mahmoud drinking their first bottle of milk since floods forced them from their refugee camp a month ago.

Fatima beamed broadly as she knelt in the mud outside her tent and filled two-year-old Reza Khan's baby bottle with milk. "Look, he's not crying anymore," she said, as he sucked down the liquid. It had been a month since the little boy had tasted milk.

The mother of eight kept an eye on her son as she lifted the lid on a blackened aluminium pot, her only one, that was bubbling over a campfire and stirred the yellow lentils inside. "Tonight my children will sleep until dawn on full stomachs,"

she said. The Guardian first met the displaced Afghan family several days ago, after a photograph of Reza and several of his siblings, covered in flies, featured in the Eyewitness slot. We tracked them down to a roadside camp in Azakhel, 19 miles from Peshawar, capital of Pakistan's insurgency-plagued Khyber Pakhtunkhwa province, bordering Afghanistan. Yesterday a story in the newspaper and on our website highlighted the family's plight: the devastating month-long deluge had driven them from their mud brick home in the nearby Azakhel Afghan refugee camp. Fatima, her husband, Aslam, and their eight children, along with their extended family, were camped in an empty field relying on the charity of passersby. The response to the Guardian story was immediate and overwhelming. Readers from the UK, North America and Europe contacted us with offers of help. Aijaz Ahmed from the Pakistani group save-humans.org had also offered immediate assistance. The organisation, which describes itself as a group of Pakistani professionals who have "joined hands to serve humanity", immediately set about buying relief supplies. Today three members of the group rented a truck, loaded it with 500,000 Pakistani rupees (£3,800) of goods, including flour, rice, oil, lentils and milk, and headed north from Islamabad on a two-hour trek to Azakhel. "The article compelled us to act," said Sufyan Kakakhel, 30, one of the three. "When I read that they were Afghans, I knew that they couldn't get rations from the government because they don't have Pakistani citizenship, and I didn't give a second thought about whether I should come here." Dozens of men, women and children, many barefoot, rushed towards the vehicles as they stopped near their encampment. "We have brought you some things and are going to distribute them in a very peaceful way," Kakakhel told the crowd. "It will be ordered." His colleague Abu Bakr Shoaib, a 30-year-old IT professional who works in Dubai but was in Pakistan for Ramadan, went tent to tent, notebook in hand, to record the number of men, women and children in each tent. Bearded men in round, flat caps thrust their small green Afghan identity cards in Shoaib's direction. "Don't worry, we're going to help everybody," he said. Some 53 Afghan families are living by the railway track and the parallel pools of stagnant water that separate this makeshift tent city from the wasteland on the other side that was once the Azakhel Afghan refugee camp, home to 23,000 people. Now, it is just a pile of muddy rubble, broken timber and straw. The two men promised to return with fumigation equipment to reduce the vast population of mosquitos and flies. They also promised to study ways to help the family rebuild their home across the railway tracks. Fatima kept her eye on the boiling pot perched on the campfire. She was smiling. Tonight, her children would have dhal for dinner.

### 4. How could the donation of milk have been avoided?

## Handout 4c: Answers

### 1. What does it tell you about the immediate needs of this mother to enable her to care for and to feed her children?

The poorest/most vulnerable/marginalised in society will be worst affected (in this story, they are displaced refugees, and falling between the gap in terms of who is responsible for them).

There are many supports needed, including enabling access to:

- Shelter
- Water and sanitation
- Mosquito net
- Food for the household (registration is difficult given their difficult status)
- Access to food for her children under 2 years
- Clothing (especially once winter sets in)
- Food for family and for her children
- Cooking facilities
- Support to minimise the risks of artificial feeding (managing bottle use)
- Restored dignity (feeling that she has regained control over her situation)
- General support from the community to her and her family members

### 2. What does this article tell you about infant and young child feeding practice?

Use of bottles and mixed feeding is common practice. It is however unclear from the article what this mother is actually feeding her younger children with, and how many times per day- all she says is that her son has not received any milk for one month. A more detailed needs assessment is needed to collect vital information.

### 3. What message does this piece send about what aid is needed?

It focuses on the need to provide milk and 'fill the baby's bottle'. It does not consider appealing for support to address the environment and support services this family needs. It is highly emotive. It may reflect it is easier to send milk than to address the more challenging reality.

### 4. How could the donation of milk have been avoided?

- Better communication towards the press on optimal infant and young child feeding practices and interventions in emergencies: the article could have included facts on the benefits of breastfeeding, the dangers of milk donations and the direction of the support in this situation
- Better communication towards humanitarian actors to avoid inappropriate milk donations and improve IYCF-E practices
- Better policy and guidelines from the Ministry of Health, known by all actors
- Information on the availability of IYCF-E interventions in the close surroundings of the family, enabling rapid transfer for appropriate help

The need for stronger and more accurate information reflects the importance of journalists and press/communication teams engaging with technical staff in press releases and articles.

**Exercise 5: Frontline assistance to infants and their mothers/caregivers****What is the learning objective?**

- To understand the nature of frontline assistance to infants and their mothers/caregivers

**When should this exercise be done?**

- This is an exercise for front line staff, likely to be involved with mothers.
- Two case studies are included, you can include one or both depending on time, or one per group.

**How long should the exercise take?**

- 30 to 45 minutes

**What materials are needed?**

- **Handout 5a:** Case studies
- **Handout 5b:** Model answers

**What does the trainer need to prepare?**

- Familiarise yourself with Part 2 Module 17 IYCF.

This exercise explores non-counselling based assistance that frontline workers can undertake when faced with acute IYCF situations. It involves exploring what basic assistance can be offered, and referral for more specialist help. It is **not** a substitute for skilled counselling or medical assistance, but it recognises that in emergency situations, many different workers will be faced with challenging situations on IYCF that they will need to respond to at the most basic level, for example during early needs assessment, at reception centres for arrivals to a camp, or while technical interventions are being established.

Module 2 IYCF-E (see Part 4 resources) is a resource to refer to, to see the nature of individual level rapid and further assessment that should be employed when such cases are referred for assessment.

**Instructions**

**Step 1:** Give each participant a copy of Handout 5a; divide the participants in groups.

**Step 2:** Ask each group to discuss the case study and to list the actions they would take

**Step 3:** Let the groups present their answers and discuss

**Step 4:** Give each participant handout 5b.

## Handout 5a: Case studies

### Case study 1:

You are a social worker, registering new arrivals in a refugee camp on the lists for distributions of shelter, food and non-food items, when the mother in the picture walks up to you.

This mother has walked a long way. She says the baby is ill and has not been suckling the breast. She says she is not producing enough breastmilk since she had to flee her village.

The baby is four months old and irritable.

The mother asks whether you can give her infant formula to feed her baby.

How can you help?



### Case study 2:

You work with a child protection team and come across this case on a village assessment, in the aftermath of a cyclone.

Ma Gan is a new mother who survived cyclone Nargis. She is traumatised, and has withdrawn from family activities.

Ma Gan is not breastfeeding and her baby girl of 2 months old is growing weaker. There is precious little food. The family have not accessed any health services. A grandmother has taken charge of the infant and is trying to keep her alive by feeding her drops of water from a polluted canal.

How can you help her?

### Case Study 3

Sophie, the aid worker in the picture, is a nurse from a western country where bottle feeding is the norm. Upon arrival in a tsunami-hit country she finds that women have problems breastfeeding. She is genuinely concerned about the health of those women's children and organises a shipment of infant formula to arrive quickly so as to distribute them to the concerned women so that the children can be well fed. Aware of the poor hygienic conditions in which the population lives she takes care of providing bottled water to dilute the formula with and teaches good hygiene practices to prepare the formula.

What do you think motivated Sophie's actions?

If you came across this situation, what would you do?



## Handout 5b: Model answers

### Case study 1:

Congratulate the mother on taking such good care of her child, coming this distance to seek help and caring for her baby all along the way.

*Note: It is important to act quickly for medical assessment and referral. If the baby had been floppy, this should be considered a medical emergency and the baby in need of urgent medical attention. Assure the mother that you will refer her to the appropriate help. Keep the baby and mother under surveillance. While urgent referral/ transfer is being arranged, give the mother some water and something to eat. Once the infant is stabilised, follow up with the points below.*

In this case, assure the mother that you will refer her to the appropriate help. Tell her that the best thing for her child and for her is to continue to give the breast to the child, as frequently as possible, so that she will keep producing some milk if the child continues to suckle the breast. Encourage her as much as possible, telling her that her milk is the best protection for her baby in this difficult situation.

Arrange for the mother and child to get basic support and professional help:

- Give the mother water, something to eat and a place where she can rest while arrangements are made for transfer.
- Both mother and child need a medical check-up and treatment as quickly as possible; refer to a health post
- Both mother and child should be screened for malnutrition and treated accordingly as quickly as possible; refer to a screening site for feeding programmes
- The mother needs skilled breastfeeding counselling. If she is not admitted in a health facility or feeding programme where breastfeeding counselling is available, she should be referred to a baby friendly tent or other programme where she can receive counselling.
- The mother should be helped to access shelter, water, food distribution and non-food distributions. Explain to her how she can access all the help she is entitled to, and if there are priority lists that she can be added to.
- Explore her family situation and whether she needs access to any family tracing services.
- This mother needs extra rations of food for lactating women. Help her to register on any targeted food distribution programmes and explain to her how she can access this food.

### Case study 2:

The priority for the health of the infant is to quickly establish exclusive breastfeeding. It is not too late to establish breastfeeding. The priority for the mother is to support her to do this and help her psychological state. The priority for the household is to enable access to shelter, warmth and food. The well-being of the mother is central to the well-being of her infant. The grandmother is well placed to care and support her daughter to feed and care for her new baby.

Use of infant formula in this situation is highly risky, especially since the baby is young and already unwell. If artificial feeding is needed temporarily while breastfeeding is established, this needs to be based on skilled assessment and conducted under close supervision.

Both the mother and infant need referral to a health clinic for assessment. The grandmother or other mothers in the community who have positive breastfeeding experiences may be able to offer support and assistance to her.

In the immediate term:

- Advise the family and mother how important the mother is to the nourishment and wellbeing of her baby.
- Encourage skin to skin contact between the mother and infant and frequent breastfeeding.
- Refer the mother to any psychosocial services support available, and for medical assessment.
- Register/ensure the family know how to access food, shelter
- Refer for more specialised assistance for breastfeeding support, if/as available.
- Be alert for donations of infant formula in general – such activities are often reported by the media, as they make a 'good' human interest story. Inform your superiors of the case and details on return from your field trip, and share this case with the nutrition coordination agency.

In preparation for an assessment, it is useful to prepare in advance by orientating yourself on the key cross-sectoral services and contacts available. This will help inform cases and ensure you know how and to whom to refer cases.

### Case Study 3

Sophie is a concerned nurse, but her interventions are coloured by her background as a health professional in a country where artificial feeding is the norm. She has not made an objective assessment of the context she is working in and the different risks and benefits of feeding options in this situation. She does not seem to be aware of the IYCF context that she is working in where breastfeeding is the norm.

When you come across a situation like this, it is important to establish a professional relationship in which the concerned person/organisation can see you as a professional aid worker who is there to help. IYCF-E can be highly emotive. Congratulate her on her efforts to help the emergency relief. Confirm that she is right to worry about the children's health status and that these women need help. Introduce her to the objective assessment of risks of different feeding options that are needed in this instance. Explain about the importance and the possibilities of sustaining/improving breastfeeding and the many risks of artificial feeding. Explain how her actions are a Code violation. Provide her with key information on IYCF-E resources, support and invite her to attend coordination meetings, IYCF-E training sessions or schedule more time to inform her about potential, more appropriate action.

Alert the IYCF-E coordinating agency of this case.

**Exercise 6: HIV and IYCF in emergencies****What is the learning objective?**

- Understand the concept of HIV-free child survival
- Understand the balance of risks regarding IYCF recommendations
- Understand IYCF in HIV recommendations (WHO, 2010)

**When should this exercise be done?**

- During orientation training and/or technical training of health/nutrition staff

**How long should the exercise take?**

- 30 to 45 minutes

**What materials are needed?**

- Flipchart and pens
- **Handout Exercise 6a:** List of multiple choice questions on HIV and IYCF-E
- **Handout Exercise 6b:** List of answers on multiple choice questions on HIV and IYCF-E

**What does the trainer need to prepare?**

- Familiarise yourself with Part 2 of this module
- WHO (2010) Guidance on HIV and infant feeding (See Part 4 Resources)
- WHO (2011) FAQs on HIV and infant feeding (forthcoming Sept 2011)

**Instructions****A. Balance of Risks for Infant Feeding Options in the Context of HIV to maximise HIV-free child survival**

**Step 1:** Draw or distribute the table in Handout 6a.

**Step 2:** Ask participants to define HIV-free child survival and the three feeding options given in the table.

**Step 3:** Ask participants to brainstorm on the risks of HIV transmission and morbidity and mortality associated with different feeding options.

**Step 4:** Complete the table using yes/no.

**Step 5:** Discuss the results.

**B. IYCF in HIV recommendations (WHO, 2010)**

**Step 1:** Give each participant a copy of the questions Handout 6a.

**Step 2:** Present each question and discuss with the group, correct answers when necessary.

**Step 3:** Give each participant a copy of Handout 6b

**Note:** When asking true/false questions in a group, you can have the group sit in a circle with everyone's back to the centre of the group. Each can raise a hand for 'true', without being aware of the responses of the majority of the group. This can be a less threatening environment in which to share.

### Handout 6a: Questions on HIV and IYCF-E

#### A. Balance of Risks for Infant Feeding Options in the Context of HIV to maximise HIV-free child survival

Balance of risks

HIV-free child survival:	Exclusive Breastfeeding	Exclusive Replacement Feeding	Mixed Feeding
Risk of HIV			
Risk of Morbidity/Mortality			

#### B. IYCF and HIV recommendations (based on WHO, 2010)

Circle whether each statement is true or false:

	True/False
1 If a mother's HIV status is unknown in an HIV-prevalent population, she should replacement feed until she knows her HIV status	
2 An HIV-infected mother should breastfeed for 6 months only, then switch to replacement feeding	
3 HIV-infected infants have a better chance of survival if breastfed	
4 If there are no ARVs available, an HIV-infected mother should not breastfeed	
5 Rapid cessation of breastfeeding is not recommended when switching from breastfeeding to replacement feeding, to reduce the risk of HIV transmission.	
6 An HIV-infected mother should stop breastfeeding at 12 months in all circumstances	



## Handout 6b: Answers on HIV and IYCF-E

### HIV-free child survival

#### A. Balance of Risks for Infant Feeding Options in the Context of HIV

	Exclusive Breastfeeding	Exclusive Replacement Feeding	Mixed Feeding
<b>Risk of HIV</b>	Yes	No	Yes
<b>Risk of Morbidity/Mortality</b>	Much lower risk, but doesn't eliminate the risk entirely	Yes	Yes

Note: mixed feeding is the worst option, as it increases the risk of HIV transmission as well as exposing the infant to the risks of illness from contaminated formula made with dirty water and given in dirty bottles, and contaminated foods and other liquids.

#### C. IYCF and HIV recommendations

- 1. If a mother's HIV status is unknown in an HIV-prevalent population, she should replacement feed until she knows her HIV status FALSE**

*This statement is false. If a mother's HIV status is unknown, then she should be encouraged to breastfeed her infant in keeping with the IYCF feeding recommendations for all children. This gives the best chance of child survival.*

- 2. HIV-infected infants have a better chance of survival if breastfed TRUE**

*This statement is true. Non-breastfed HIV-infected infants have been shown to be more at risk of malnutrition, morbidity and death. So breastfeeding an HIV-infected infant gives the best chance of survival.*

- 3. If there are no ARVs available, an HIV-infected mother should not breastfeed FALSE**

*This statement is false. For HIV-infected mothers, even when ARVs are not available, mothers should be counselled to exclusively breastfeed in the first six months of life and continue breastfeeding thereafter, unless environmental and social circumstances are safe for, and supportive of replacement feeding. Every effort should be made to make ARVs available.*

- 4. Rapid cessation of breastfeeding is not recommended when switching from breastfeeding to replacement feeding. TRUE**

*This statement is true. Rapid cessation of breastfeeding increases the risk of breast conditions that leads to increased HIV transmission risk. So a gradual cessation of breastfeeding over up to 1 month is recommended.*

- 5. An HIV-infected mother should stop breastfeeding at 12 months in all circumstances. FALSE**

*This statement is false. Breastfeeding and ARVs should continue until 12 months. Breastfeeding should cease at 12 months only if a nutritionally adequate diet without breastmilk can be provided. Otherwise, breastfeeding should continue until such time that such a diet can be provided.*

**Exercise 7: Individual risk assessment for artificial feeding****What is the learning objective?**

- Understand how to investigate key conditions for risk assessment for artificial feeding

**When should this exercise be done?**

- During orientation training and/or technical training of health/nutrition staff

**How long should the exercise take?**

- 15 minutes

**What materials are needed?**

- This module 17
- **Handout Exercise 7a:** Risk assessment exercise
- **Handout Exercise 7b:** Model answers

**What does the trainer need to prepare?**

- The Operational Guidance on IFE
- Read Part 2 of this module, particularly sections describing the conditions necessary for artificial feeding.

**Instructions**

**Step 1:** Let each participant fill out the exercise on handout 7a

**Step 2:** Correct together with the group

**Step 3:** Give each participant a copy of Handout 7b

### Handout 7a: Exercise on individual risk assessment for artificial feeding

A mother with a 1 month old infant presents to your temporary clinic. She is requesting infant formula for her baby. This is her third baby. She started breastfeeding both her older children at birth, but introduced infant formula at around 2 months of age. She is currently breastfeeding but wishes to establish formula feeding like she did with her older children. She received a donation of one pack of infant formula in a general distribution and began giving this to her baby, but she has just one more day's supply. Over the last few days the baby has had diarrhoea and is now not breastfeeding well.

Since the conflict started, she has moved in with her sister-in-law and her four children. Water supply to the house has been just cut off and they are accessing household supplies via distributions.

You are exploring what conditions are in place to support artificial feeding safely. You have recorded the information below. Are all the conditions for artificial feeding met in your opinion?

Current situation	Are conditions for artificial feeding met?		
	Yes	No	Maybe
Mother familiar with artificial feeding (fed older baby), many family members familiar with it (acceptable).			
Mother can understand and read instructions in the local language. Current available supplies are imported and in foreign language (labels being made). She has no refrigeration, storage facility and rationed fuel supply (feasible).			
Normal market sources have greatly reduced. As a result prices have increased. Alternative supplies are being procured by your agency but awaiting custom clearance (affordable).			
Disruption in supply chain means market supplies are uncertain. Funding for a six month programme is being sought by your agency but not secured yet (sustainable).			
Water supply disrupted and risk of contamination. No facilities for storage of prepared formula. One stove for all family meals with little fuel. Preparation of night feeds in particularly difficult (safe).			

- What would you advise the mother regarding artificial feeding as a feeding option?
- What support does the mother need?

**Note:** An alternative/additional case you could consider is where a caregiver presented with an artificially fed infant for whom there was no option of breastfeeding, eg a 2 month orphaned infant with no wet nurse available. This exercise could be used to explore what interventions would be needed to meet all the conditions necessary for artificial feeding the infant.

## Handout 7b: Answers on individual risk assessment for artificial feeding

Are all the conditions for artificial feeding met in your opinion? No they are not

Current situation	Is it met?		
	Yes	No	Maybe
Mother familiar with artificial feeding (fed older baby), many family members familiar with it (acceptable).	x		
Mother can understand and read instructions in the local language. Current available supplies are imported and in foreign language (labels being made). She has no refrigeration, storage facility and rationed fuel supply (feasible).		x	
Normal market sources have greatly reduced. As a result prices have increased. Alternative supplies are being procured by your agency but awaiting custom clearance (affordable).			x
Disruption in supply chain means market supplies are uncertain. Funding for a six month programme is being sought by your agency but not secured yet (sustainable).		x	
Water supply disrupted and risk of contamination. No facilities for storage of prepared formula. One stove for all family meals with little fuel. Preparation of night feeds in particularly difficult (safe).		x	

Note: Even if the conditions had all been met, it is less risky for the child to continue breastfeeding.

### What would you advise the mother regarding artificial feeding as a feeding option?

Artificial feeding is a risky option in this environment. Her baby is more likely to get sick and become malnourished. Supplies are expensive and are uncertain.

Returning to exclusive breastfeeding is the safest and most secure way to feed her infant.

### What supports does the mother need?

The mother may need some skilled breastfeeding support to help establish exclusive breastfeeding. She needs advice on how to manage her baby with diarrhoea and follow up at your clinic.

Refer this woman for breastfeeding counselling so as to increase her milk supply and motivate her to continue breastfeeding.

You can explore whether any of her peers, e.g. sisters, friends, mother, breastfed exclusively and could give support.

**Exercise 8: Community level risk assessment regarding artificial feeding and milk and milk product use****What is the learning objective?**

- Recognise the risks associated with different interventions around the use of breastmilk substitutes and milk and milk products

**When should this exercise be done?**

- During orientation training and/or technical training of health/nutrition staff

**How long should the exercise take?**

- 15 to 30 minutes

**What materials are needed?**

- The operational guidance on IYCF-E (full text).
- **Handout Exercise 8a:** Community level risk assessment regarding artificial feeding and milk and milk product use
- **Handout Exercise 8b:** Interventions with artificial milk: Model answers

**What does the trainer need to prepare?**

- Operational Guidance on IYCF-E

**Instructions**

**Step 1:** Hand out copies of the operational guidance.

**Step 2:** Give each participant a copy of Handout 8a.

**Step 3:** Present each case and discuss with the group, correct answers when necessary.

**Step 4:** Give each participant a copy of Handout 8b

## Handout 8a: Community level risk assessment regarding artificial feeding and milk and milk product use

Please read the following examples of interventions with artificial milk and say whether this is a suitable intervention or not, stating why.

Are any of the proposed interventions a potential Code violation?

1. After an earthquake devastated a big city, many people are homeless and have lost all their belongings. They live in makeshift camps. Many mothers had been feeding their babies both breastmilk and artificial milk before the earthquake. They are requesting milk for their babies, as they are used to mixed feeding. Since the earthquake, there are reports that mothers are having difficulty breastfeeding, particularly those with infants under six months of age. Your team is preparing to distribute kits to the victims including tarpaulin, soap, cooking set, blankets etc. A colleague proposes to include two boxes of infant formula, together with a baby bottle in each kit to answer to the needs of those mothers. Do you agree with this proposition?
2. You are in charge of a health clinic in an emergency setting. Your expatriate head of mission says that a food manufacturer from his homeland wishes to donate 5 MT of infant formula. He proposes to accept this, so you can provide it to those infants who have lost their mothers. The staff can make a thorough assessment of whether breastfeeding is indeed not possible, and each child can be followed individually to assess its health throughout the whole period where infant formula is provided. Will you agree with this proposition?
3. You are part of a team that assesses the needs of the population in an emergency, so that you can recommend what actions need to be taken. A person from the Child Protection team informs you that the disaster has caused a lot of deaths and that many children are orphaned or separated from their parents. Among them, there are even small infants and young children, for whom they have not been able to find family to care for. She says they urgently need infant formula for the young infants. What will you recommend?
4. The food distribution team of your organisation plans to include milk cartons in a general food distribution. You tell them about the dangers of milk distribution, that it can negatively affect breastfeeding and consequently cause diseases and even death. The food distribution team says this is not an issue here, because the milk is intended for children older than 2 years old only, not for children of breastfeeding age. It clearly says on the carton in English it should not be used as a breast milk substitute. In addition, the milk cartons are ready-to-use, so no dilution with water is needed. The cartons are presented as 1 litre cartons. Do you agree?

**Handout 8b: Interventions with artificial milk: model answers**

1. This is not a good idea. The Operational Guidance on IYCF-E recommends that there is no untargeted distribution of breastmilk substitutes such as infant formula. Untargeted distribution of infant formula with no guarantee of supply for as long as the infant needs it is a Code violation (WHA 47.5). Giving a mother infant formula in this way will decrease her breastmilk production further, as the more the baby suckles, the more breastmilk is produced. After those two boxes you provided, she will have no access to additional milk. The hygiene, access to safe water and sanitation in the camps is likely to be poor. This means that the use of powdered infant formula poses a large threat to the health of the children, putting them at risk of diseases such as diarrhoea, pneumonia, malnutrition and even death. Baby bottles are difficult to clean and pose an additional risk of infection. Rather than infant formula supplies, these mothers need skilled breastfeeding support. Where the infant is less than six months of age, support to establish exclusive breastfeeding is the best option.
2. The Operational Guidance on IYCF-E recommends that donations of infant formula (and any other BMS, bottles and teats) are not accepted in emergencies. Donations are typically in the wrong language and are supplied disproportionate to need. It is unlikely that you will need 5 MT of infant formula for the individual cases that present to your clinic. Any supplies should be purchased, labelled in the local language and meet Codex Alimentarius requirements. Note that distribution of donated supplies through a health facility is a Code violation. The quantities of infant formula that need to be purchased should be based on the assessment of needs, taking into consideration that the children enrolled in the programme receive the formula for as long as needed. This is not a good intervention.
3. This is a situation where there is indeed a need for infant formula and all the associated supports and care, since those infants do not have the possibility to breastfeed. As reflected in the Operational Guidance on IYCF-E, there are considerable supports necessary to minimise the risks of artificial feeding. You will need to urgently notify the designated coordinating agency on IYCF-E, UNICEF and WHO. The designated agency for managing artificial feeding will need to work with Child Protection to register and manage these cases.
4. The Operational Guidance on IYCF-E recommends that there is no general distribution of milk and milk products. There is a strong risk that this milk will be used as a breast milk substitute. Mothers may not be able to read the instructions on the carton, especially if it is not in the local language. Once open, liquid milk is a rich medium for bacterial growth. It is likely that cartons will not be immediately consumed and without refrigeration, will quickly become contaminated. If such a distribution is already happening, it is better to recommend the milk is used in family cooking (e.g. to fortify porridge) with strong messaging regarding infant feeding.

**Exercise 9: Rapid Assessments on IYCF-E****What is the learning objective?**

- To be able to identify priority questions for IYCF-E Assessment
- To be able to make a picture of the IYCF situation from multi-sectoral assessment information

**When should this exercise be done?**

- During orientation training and/or technical training of health/nutrition staff

**How long should the exercise take?**

- 15 minutes

**What materials are needed?**

- The operational guidance on IFE (full text).
- **Handout Exercise 9a:** Exercise on rapid assessment
- **Handout Exercise 9b:** Model answers

**What does the trainer need to prepare?**

- Familiarise yourself with Part 2 of this module

**Instructions**

**Step 1:** Give Handout 9a to all participants

**Step 2:** Let participants discuss the different questions in groups

**Step 3:** Present answers and discuss

**Step 4:** Give Handout 9b to complete answers from presentations by groups



## Handout 9a: Exercise on rapid assessment

An area you work in has just been hit by extensive flooding due to torrential rain. Many people have been displaced from their homes. Many are now housed in temporary accommodation, such as football stadiums and schools and tents on high ground. A multi-sectoral (nutrition, health, water and sanitation, food security, population data) initial rapid assessment is being planned in the next 24 hours. This will involve key informant interviews and focus group discussions in some of the affected areas that are accessible.

Pre-emergency, most mothers initiated breastfeeding, but mixed feeding was common.

You can include only 3 questions on infant and young child feeding. This assessment will help identify if infant and young child feeding risks are significant and whether further, more comprehensive assessment is needed.

1. Suggest three questions you could include in the assessment.
2. What other infant and young child information can be used to build a picture of infant and young child feeding in the population?
3. What findings from your analysis would indicate the need for further assessment?

## Handout 9b: Model Answers

### 1. Suggest three questions you could include in the assessment.

- i. Have infant formula or other milk products and/or baby bottles/teats been distributed since the emergency started?
- ii. What is the estimated proportion of infants 0-<6 months and 6-<12 months who currently are not breastfed?
- iii. Has the community/health staff/parents/caregivers identified any problems in feeding children <2 years since the crisis started?

Note: It is important not to add lots of questions on IYCF in this context but to ask just the key questions, otherwise they will be left out, badly questioned, risk information and data overload, and hamper timely analysis.

### 2. What other infant and young child information can be used to build a picture of infant and young child feeding in the population?

- Pre-crisis rates of initiation of breastfeeding/Exclusive breastfeeding rates 0-<6 month pre-emergency
- Proportion of infants not breastfed pre-emergency
- Common complementary feeding practices
- Continued breastfeeding at 1 year of age/2 years of age
- Household food security indicators
- Water and sanitation indicators
- Check methods, use of standard indicators and age assessment

### 3. What findings from your analysis would indicate the need for further assessment?

- Distribution of infant formula and dried milk powder to the population
- Mothers report conflict has led to breastfeeding difficulties
- Low exclusive breastfeeding rates (e.g. <25% exclusive breastfeeding 0-<6m)
- More than 90% of mothers initiate breastfeeding
- Bottle feeding and mixed feeding is common

## 5. Case studies

A case study from Haiti is presented in this section. Case studies are useful for getting participants to think through real-life scenarios. They also provide an opportunity for participants to work in a group and develop their analytical and decision-making skills. Trainers should develop their own case studies which are contextually appropriate to the particular participant group. Ideally, trainers should use scenarios with which they are familiar.

### Exercise 10: Support for infant and young child feeding in the Haiti 2010 earthquake

#### What are the learning objectives?

- To know the key measures required to support IYCF-E
- To be aware of interventions to support safe IYCF-E in populations
- To be aware of the key steps required to set up a safe artificial feeding programme and suitable breastmilk substitutes that can be used
- To have a basic knowledge of the Operational Guidance on IYCF-E and the Code and to be aware of Code violations that can occur during emergencies
- To enable participants to imagine what could be done in a specific situation (and compare to what was actually done)

#### When should this exercise be done?

- During an orientation session (if time allows) or during a training of technical staff

#### How long should the exercise take?

- 30 to 60 minutes (depending on whether carried out in plenary, or done as group work)

#### What materials are needed?

- **Handout 10a:** Case study I: Aftermath of the Haiti 2010 earthquake
- **Handout 10b:** Case study I: Aftermath of the Haiti 2010 earthquake: Model answers
- Example of key messages for emergencies (see Annex 6 of Part 2)

#### What does the trainer need to prepare?

- Familiarise yourself with the case study and the possible answers

#### Instructions

**Step 1:** Give each participant a copy of Handout 10a.

**Step 2:** Ask participants to identify measures of support to IYCF-E.

**Step 3:** Give each participant a copy of Handout 10b.

## Handout 10a: Case study I: Aftermath of the Haiti 2010 earthquake

*Read the case study and address the following question:*

*What actions should be taken and interventions should be put in place to protect, promote and support optimal IYCF practices?*

On January 12th 2010, a severe earthquake hit Port-Au-Prince, the capital of Haiti, and surrounding towns and reduced it to rubble. More than 200,000 people were killed, around 300,000 people were wounded and approximately 1 million people made homeless. People lived in makeshift camps all over the parks and squares of the town, or in the streets in front of the remains of their houses.

There were hundreds of these 'camps' in and outside Port-Au-Prince, registration was difficult and time consuming, therefore there was no clear view of the affected population, the aid already provided to them and the gaps in the relief effort.

Assessments revealed a high need for intervention. The population was highly shocked, living in constant fear due to the continuous aftershocks. Living conditions were difficult with large amounts of people living together in small spaces, in makeshift tents with limited access to water and a near non-existent access to toilets or latrines.

Breastfeeding was the norm in Haiti in 2005-2006, when it was found that 98% of children until 5 months old were breastfed, however only 41% of those children received exclusive breastfeeding. Breastfeeding rates in the cities were lower than in the countryside. The Haitian people held many myths and misconceptions with regards to breastfeeding: children were not taken along when leaving the house out of fear of bad spirits possessing them; there was the very strong belief that a mother passes her shock to the baby through the breastmilk etc. Haiti, and especially Port-Au-Prince, has a high number of HIV/AIDS programmes. Many infants of HIV-infected mothers within these programmes were being replacement-fed (artificial feeding) to prevent mother-to-child transmission.

The government of the country was also severely hit, many of their offices had collapsed or were damaged, so consequently they lost employees and materials. National staff and staff of many established agencies in Haiti lost their lives or family members, devastating the immediate national response capacity even further.

A massive international intervention was mounted, providing shelter, water and sanitation, food aid, psychological care and much more. The relief was brought by UN agencies, international non-governmental organisations (NGOs), local NGOs, churches and other religious organisations, universities and many other different aid groups large or small.

Distributions of milk products were observed in different forms: infant formula given to mothers; full milk powder as part of general distribution kits to households, etc.

## Handout 10b: Case study I: Aftermath of the Haiti 2010 earthquake: Model answers

### *What interventions should be put in place to protect, promote and support optimal infant feeding practices?*

It can be useful to broadly classify responses from discussions under the following categories, to help identify any gaps in actions and to allow participants to consider the different types of action needed:

- Policy guidance, coordination and communication
- Basic interventions
- Technical interventions
- Handling milk and milk products, including donations

Below describes what was actually implemented in this scenario. Participants may come up with other valid possible responses.

#### **Policy guidance, coordination and communication**

- The Nutrition Cluster was activated at country level and within it, an Infant & Young Child Feeding Working Group. An IYCF-E expert was brought in to lead the group. All aid agencies working within the field of nutrition, IYCF or related areas were urged to attend the regular meetings.
- A joint statement, *Call for Appropriate Feeding of Babies and Infants in Haiti*, was drafted, based on the model from IFE Core Group (see Annex 5), signed by the Haitian Ministry of Health, UNICEF, the World Health Organisation (WHO) and the Pan American World Health Organisation (PAHO). It was translated into French and distributed widely. In response to concerns regarding HIV prevalence and infant feeding, a *Technical Note on HIV and Infant Feeding* was issued by WHO, UNICEF and the Haitian Ministry of Health.
- Key IYCF messages were translated into Creole (Kreyol), the local language, and distributed widely through NGOs. Means of communication included advertising cars, theatre plays in the camps and health education sessions. Messages were disseminated through local and international media. Different radio interviews on the subject were held in local language on the local radio.
- There was an intense effort to map the IYCF activities of different aid organisations by location, in order to have an overview of *who* was doing *what* and *where* (3 Ws). This would help in set up of referral systems, but also identify gap areas in programming.
- Nutrition Cluster partners were urged to report Code violations through a monitoring form. Organisations responsible for violations or pending violations (e.g. donation pending) were approached, given the *Call for Appropriate Feeding* and urged to change their plans.

#### **Handling milk and milk products and donations**

- The Nutrition Cluster worked together with the Logistics Cluster, who issued the following statement: çThe Logistics Cluster will not accept milk powder or infant formula into its warehouses or deliver it as cargo with its assets (trucks, boats, planes and helicopters) if it is not part of Nutrition Cluster approved programmes. This is in line with international policy as agreed among WHO, UNICEF, UNHCR and major NGOs.é In addition, steps were taken to reach a similar agreement with the Haitian customs.
- Milk powder that was retrieved from (potential) Code violators, was mixed with corn soy blend (CSB) for fortified porridge.
- Media watch (monitoring of press coverage) at international level was used to identify inappropriate actions, especially donations being called for and sent to Haiti. These were relayed via the global nutrition cluster to those working at country level. To support country efforts, approaches were made by government donors and by technical agencies to military and professional groups where inappropriate interventions were identified, such as calls for international supplies of donor breastmilk.

**Frontline assistance**

- Over 100 Baby Friendly Tents or *Points de Conseil en Nutrition pour bébés* were set up in or nearby displaced camps. The aim of the 'baby tents' was to protect and support optimal IYCF practices by providing a place where mothers or caregivers with children under 2 years old, as well as pregnant women, could come for privacy, advice, and IYCF counselling. Psycho-social support, growth monitoring and other activities were also provided. For this intervention, a special manual was designed together with the Ministry of Health, based on IFE Module 2 and an Action Contre la Faim Manual for Baby Friendly Tents. Operational agencies were invited to participate in a training of trainers on breastfeeding support (see below).

**Skilled breastfeeding support**

- A training of trainers on the basics of breastfeeding and counselling was set up in the local language, targeting NGOs and government health workers. Over 100 key personnel were trained. The training was based on WHO Breastfeeding Course and IFE Module 2.
- A module on the integration of IYCF into community based management of acute malnutrition (CMAM) was added to the CMAM training of trainers of regional Nutritional Focal Points of the Ministry of Health. The IYCF in CMAM training material was translated into French.

**Complementary feeding**

- Children aged 6 months to 5 years, as well as pregnant and lactating women, were targeted with a blanket supplementary feeding programme, providing them with high energy biscuits, fortified porridge or other supplementary food.

**Management of artificial feeding**

- Ready-to-Use Infant Formula (RUIF) was purchased through the Nutrition Cluster and provided to those NGOs who followed the training of trainers on breastfeeding and counselling AND who signed an agreement to deliver the RUIF in accordance with the set guidelines for the use of RUIF in this context (in accordance with the Code and Operational Guidance on IYCF-E).
- RUIF was to be given in a separate space from breastfeeding infants and young children, so as not to send mixed messages to breastfeeding women. It was supplied to infants under one year of age who fulfilled strict criteria:
  - Mother is dead or absent and no wet nurse can be identified
  - Infant was exclusively artificially fed prior to the emergency
  - Infants of HIV-infected mothers who were artificially fed as part of the prevention of mother to child transmission (PMTCT) programme prior to the emergency (children born to HIV-infected mothers after the emergency were encouraged to breastfeed)
  - Children enrolled in relactation programme until relactation is complete
  - Children of mothers who were raped and who did not wish to breastfeed

Organisations providing the RUIF to these infants were responsible for educating the family of the infant on hygiene, health and psycho-social matters related to IYCF, as well as for monitoring the child's health and nutrition status. They also committed to provide the RUIF until the infant reached 6 months of age at least, but preferably until they reached 1 year of age. Initial supplies of RUIF were in English and so were relabelled locally. Subsequent supplies were non-branded and labelled in local language.

## 6. Field based exercises

The section outlines ideas for exercises that can be carried out as part of a field visit. Field visits require a lot of preparation. An organisation that is actively involved in programming or nutrition surveillance has to be identified to host the visit. This could be a government agency, an international NGO or a United Nations agency. The agency needs to identify an area that can be easily and safely visited by participants. Permission has to be sought from all the relevant authorities and care taken not to disrupt or take time away from programming activities. Despite these caveats, field-based learning is probably the best way of providing information that participants will remember.

### Exercise 11: Assessing prevailing IYCF practices

#### What is the learning objective?

- To enable participants to practice assessing IYCF practices through focus group discussions.

#### When should this exercise be done?

- During training of technical health/nutrition staff. It should be done only after key orientation on IYCF-E has taken place
- This exercise is based on an adapted exercise in the Integration of IYCF in CMAM training material (see Part 4 resources). It can be used to reinforce optimal IYCF practices with trainees and enable them to explore the barriers to achieving them in a community. Good knowledge of prevailing IYCF practices is an important consideration in devising any IYCF intervention.

Notes: Ideally, this training session should be supervised by an IYCF counsellor with experience in assessment and focus group discussions.

If the community has experienced an emergency situation, the discussion can consider the impact that this had on IYCF practices.

If time allows and depending on the ability of the group, actions to take, such as key messages, counselling points and broader interventions, can be developed in the classroom discussions to address the sub-optimal IYCF practices identified. It is important that trainees understand that to effect change in practices, many types of support may be necessary.

#### How long should the exercise take?

A whole morning in the community at least (including transportation to and from the community), followed by a feedback and discussion session with the group in the classroom. Explanations to the group prior to going out to the community can be provided the day before the field trip, in order to give people time to do their reading and prepare, as well as to maximise time dedicated to the field-based exercise.

#### Advance preparations

- Collect as much secondary data on IYCF in the area as possible and share it with participants.
- Arrangements to visit community sites to conduct focus group discussions
- Choose the target group of the focus group discussions and invite those people according to local customs: pregnant women, mothers, grandmothers, fathers, community health workers, traditional healers, etc.
- Arrangements for transport

#### What materials are needed?

- Handout 11a: Community Focus Group Discussion Matrix<sup>1</sup>
- Handout 11b: Team Checklist for Community Outreach practicum<sup>2</sup>
- Module 19 Working with Communities:
- Handout 7a (Trainers Notes on how to conduct a FGD)
- Handout 7b (How to conduct a FGD)

<sup>1</sup> Adapted from ENN, NPP, IFE Core Group, IASC (2009) Integration of IYCF Support into CMAM. ENN 2009

<sup>2</sup> Idem

**Exercise 11: Assessing prevailing IYCF practices** (continued)**What does the trainer need to prepare?**

- This exercise has been adapted from Integration of IYCF Support into CMAM. 2009. ENN, NPP, IFE Core Group (2009) (see Part 4). Consultation with this resource would be valuable in preparation for managing this exercise.
- Ideally the trainer needs to be experienced in breastfeeding and infant and young child feeding assessment, standard indicator definitions and counselling, as well as focus group discussion methodology (length of the discussion, number of people per focus group, how to lead the questions...)
- Facilitators in each group needs to be experienced with the methodology used for focus group discussions, as well as the definitions of the standard IYCF indicators.
- Familiarise yourself with the materials to be used for the training.

**Instructions**

**Step 1:** Ensure participants are familiar with focus groups discussions.

Decide on the information you want to obtain and how you will obtain it. Ensure all terminology (e.g. exclusive breastfeeding) is clear to all participants.

**Step 2:** Divide participants into groups, each group will conduct a focus group discussion with a different target group (see above, as arranged), under the guidance of an experienced facilitator (see above). Explain how to proceed in the field with emphasis on polite introduction, explaining that they are in training on infant and young child feeding, explaining the purpose of the visit and what is expected from the interviewees. The aim is not to judge but to remain open and friendly, while listening and observing at the same time. One person can ask the questions, another person can note down the answers. Time available of the interviewees must be taken into consideration and they must be thanked afterwards (see handout 11b).

**Step 3:** Once the focus groups start, participants ask interviewees on each topic: what they would like that practice to be ideally and how it is done now. Ask them what motivates them to conduct recommended practices, or what holds them back (barriers). If time allows, discuss how an emergency has or could affect this community's IYCF practices. See 'Issues to be investigated during an IYCF Community Assessment' and the discussion matrix (Handout 11a).

**Step 4:** Back in the classroom, each group presents its matrix and adds their recommendation to improve practices as feasible in the community, which is then discussed with all participants together. Discuss how an emergency has or could affect this community's IYCF practices. As time allows, identify key actions to address sub-optimal practices, such as key messages (e.g. that could be disseminated to the different groups in the community), counselling discussion points (for one to one counselling with mothers), and broader interventions (e.g. food security, water and sanitation, maternal workload).

**Issues to be investigated during an IYCF Community Assessment**

1. **Ideal practice:** How the community would like to practice
2. **Current Practice:** What is actually practiced by the individual or community.
3. **Recommended Practice:** practices recommended by health authorities because they support normal health, growth and development.
4. **Motivators:** What helps the individual or community perform the recommended practice.
5. **Barriers:** What prevents the individual or community from performing the recommended practice.
6. **Feasible practice:** the most realistic do-able behaviour that an individual or community agrees to and is expected to adopt. Gradual acceptance and practice of feasible behaviour could eventually lead to the adoption of recommended practice.
7. **Impact of an emergency:** *discuss how IYCF practices were impacted in an emergency-affected community (as time allows and in a community with a recent history of an emergency)*
8. **Identify actions:** Discuss and develop messages, key counselling discussion points, and broader actions around the recommended practice.



**Handout 11a: Community Focus Group Discussions Matrix**

Breastfeeding and complementary feeding practice	Ideal practice community	Current practice (reality)	Recommended practice	Motivators	Barriers	Feasible practice (recommendation)	Discussion
Initiation of breastfeeding			Within one hour after birth				
Duration of exclusive breastfeeding			From birth until baby is 6 months old				
Frequency of breastfeeding			On demand, day and night				
Giving other fluids			No other fluids are needed until 6 months of age, only medicine or vitamins				
Breastfeeding during illness			Breastfeed more frequently				
Start complementary feeding			From 6 months onwards				
Frequency of feeding complementary food per day			<ul style="list-style-type: none"> <li>6-8m: 2-3 times/day (food)</li> <li>9-11m: 4 times/day (food and snacks)</li> <li>12-23m: 5 times/day (food and snacks)</li> </ul>				
Type of complementary food			Vegetables, fruit, meat, fish, staples for older children in a balanced variety				
Stop breastfeeding			At 2 years or later				
Reasons for stopping breastfeeding			Very few medical conditions or medical treatments, if HIV-infected mother only if all conditions are in place				

**Handout 11b: Team Checklist for Community Outreach Focus Groups**

<b>Community Focus Groups</b>
Courteous treatment of community members
Explain objectives to focus groups: the information will be used to help mothers and fathers better feed their children
Clarity of instruction
Efficient use of village time and maximum use of opportunities
Ability to employ a variety of tactics to prompt discussion
Good written record of the discussion
Thanking for participation and restating objectives
<b>Post Focus Group Discussions</b>
Content gaps are recognised by teams
Team is able to distil useful insights from material of focus group discussions
Team can identify changes and improvements needed to matrices and undertake these
Team can draw practical and operational conclusions and insights from focus groups
Team can determine priority actions - messages, counselling discussion points, broader intervention