

Healthy play areas/Environment

Card
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Step 3: List their responses on a flip chart
Summarize the discussion using the notes below

- Provide a play space for children under two years old that has a clean mat for children to play on to prevent them from eating soil or faeces.
- Clean and sanitize the play mat once a week and whenever it is soiled with food or dirt.
- Encourage the care takers to clean and sanitize toys and other items that babies frequently stick in their mouths at least two or three times per week:
 - Each time you notice that they are soiled with food or dirt;
 - When the baby is recovering from an illness;
 - When other children have put the items in their mouth
- Keep household livestock (such as chickens or rabbits) in pens or cages to keep animal faeces away from children

Summarize session

(3 minutes)

Ask if participants have any questions, or seek clarification

Session 2

Foods to fill the energy, iron and vitamin A gaps

Objectives

At the end of this session participants should be able to

1. List the 7 food groups for children
2. List local foods that can fill the energy gap
3. Describe ways to enrich foods for complementary feeding
4. Demonstrate use of foods of a thick consistency
5. Explain the iron gaps and explain factors that influence iron absorption from foods
6. Explain the importance of animal source foods
7. Explain the importance of legumes
8. lists foods that can fill the vitamin A gap

Duration: 1hr 45minutes

Methodologies: lectures, practical's, discussions, buzzing, group work, brainstorming,

Materials: Flip charts, mark pens, pre-populated food calendar, fresh food samples, masking tapes, bowl (250mls), copies of the enriching foods, fats and oils photos, 3 clear containers (2 to hold 200 mls and 1 to hold 400 mls calibrated at 200 mls mark), calibrated jug, 450mls of cooked thick porridge, two table spoons, hot water in a thermos, copies of the stomach size illustration, serviettes, side plate, copies of the iron gaps graph, Vitamin A graph

Session plan

Duration	Topics	Methodology	Materials
2 minutes	Session introduction	Lecture	Flip charts, marker pens
15 minutes	Listing the 7 food groups for children	Brainstorming, group work, lecture, group discussions	Flip charts, mark pens, pre populated food calendar, fresh food samples, masking tapes
15 minutes	Listing local foods that can fill the energy gap	Lecture , discussions, brain storming	Flip charts, mark pens, bowl
10 minutes	Describing ways to enrich foods for complementary feeding	Lecture , discussions, brain storming	Flip charts, mark pens, copies of the enriching foods and fats and oils photos
10 minutes	Demonstrate use of foods of a thick consistency	Lecture , discussions, brainstorming, demonstration	3 see through containers (2 to hold 200 mls and 1 400 mls calibrated at 200 mls mark), calibrated jug, 450mls of cooked thick porridge, two table spoons, hot water in a thermos, copies of the stomach size illustration, serviettes, side plate

20 minutes	Explain the iron gaps and factors that influence iron absorption from foods	Lecture , brainstorming, discussions,	Flip chart, mark pens, copies of the iron gaps graph
10 minutes	Explain the importance of animal source foods	Lecture , brainstorming, discussions	Flip chart, mark pen
10 minutes	Explain the importance of legumes	Lecture , brainstorming, discussions	Flip chart, mark pen
10 minutes	List foods that can fill the vitamin A gap	Lecture , brainstorming, discussions	Flip chart, mark pen, Vitamin A graph
3 minutes	Session summary		

Introduction of the session

(2 minutes)

- In the previous session, we discussed the graph on energy needed by a growing child and how much is provided by effective breastfeeding.
- In this session, we are going to learn about foods that fill the energy, iron and vitamin A gaps

Activity 1

Listing the 7 food groups for children

(15 minutes)

Participants brain storm on 7 food groups for children

Step 1: Ask participants to brainstorm on 7 food groups for children as discussed in Unit 2 on food and nutrients

Step 2: List their responses on the flip charts

Summarize using the notes below

1. Grains, grain products and other starchy foods
2. Legumes and nuts,
3. Flesh foods
4. Eggs
5. Dairy and dairy products
6. Vitamin A rich fruits and vegetables,
7. Other fruits and vegetables

Step 3: Facilitator divides participants into 4 groups.

Step 4: Facilitator assigns the 7 food groups to the already formed groups (two food groups per each of the three groups and 1 food group for 1 group)

Example

Group 1:

1. Grains, grain products and other starchy foods
2. Eggs

Group 2:

3. Legumes and nuts, seeds
4. Dairy and dairy products

Group 3

5. Other fruits and vegetables
6. Fleshy foods
7. Vitamin A rich fruits and vegetables

Step 5: Facilitator uncovers the fresh foods

Step 6: Ask participants to arrange the foods as per the food groups assigned

Step 7: Let each group list other locally available foods from each of the food groups on the pre-populated food calendar done in unit 2

Step 8: Ask participants to take their seats

Step 9: Each group presents their food in plenary, move foods that may have been misplaced as you explain to the class the reason why that food moves to a new food group

Step 10: refer participants to their hand outs and ask them to locate the 7 food groups

Ask participants if they have any questions or seek clarification



Activity 2

Listing local foods that can fill the energy gap

(15 minutes)

Think of the child's bowl or plate (Hold up the child's bowl).

- The first food we may think of serving on the bowl is the family staple.
- Every community has at least one staple or main food. The staple may be:
 - Cereals, such as rice, wheat, maize/corn, oats or millet
 - Starchy roots such as cassava, yam, or potato, green bananas
- All foods provide some energy. However, people generally eat large amounts of these staples and they provide much of the energy needed.
- Staples also provide some protein and other nutrients, but they cannot provide all the nutrients needed on their own. The staple must be eaten with other foods for a child to get enough nutrients.
- Staples generally need preparation before eating. They may just need to be cleaned and boiled or they may be milled into flour or grated and

then cooked to make bread or porridge.

- Sometimes staple foods are specially prepared for young children, for example, wheat may be the staple and bread dipped in soup is the way it is used for young children.

It is important that you know the main staples that families eat in your area. Then you can help them to use these foods for feeding their young children.

Participants list local foods that can fill energy gap

Step 1: Ask participants to identify the common staples that are commonly used in the area

Step 2: List the common staples given to children in that area on a flip chart

- In rural areas, families often spend much of their time growing, harvesting, storing and processing the staple food.
- In urban areas, the staple is often bought, and the choice depends on cost and availability.

Step 3: Ask participants if the staple food used in this community depend on where you live or on the time of the year?

Preparing the staple may take a lot of the caregiver's time. Sometimes a family will use a more expensive staple that requires less preparation or less fuel for cooking rather than use a cheaper staple.

Activity 3

Describing ways to enrich foods for complementary feeding

(10 minutes)

Step 1: Ask participants to brainstorm on how they enrich foods for children in their community

Step 2: List their responses on a flip chart

Summarize using the notes below

- Similar to the porridge, when soups or stews are given to young children they may be thin, dilute and fill the child's stomach.
- There may be good foods in the soup pot, but little of the food ingredients are given to the child. It is mostly the watery part of the soup that is given.

Participants discuss local ways to enrich complementary foods

Step 1: Ask participants to brainstorm on how families could make the young child's food more energy rich?

Step 2: List their responses on a flip chart

Step 3: Facilitator refers participants to the handout on photo of foods that can be used to enrich staples



Summarize using the notes below

Ways to Enrich a Child's Foods

Foods can be made more energy and nutrient rich in a number of ways:

- For porridge or other staples, prepare with less water and make a thicker porridge. Do not make the food thin and runny.
- Roast cereal grains before grinding them into flour. Roasted flour does not thicken so much, so less water is needed to make thick porridge. Roasting also helps to remove substances that are hard to digest
- For a soup or stew, take out a mixture of the solid pieces in the soup or stew such as beans, vegetables, meat and the staple. Mash this to a thick puree and feed to the child instead of the liquid part of the soup.
- Add energy or nutrient rich food (Locally available foods e.g. groundnuts) to the porridge, soup or stew to enrich it. This enriching is particularly important if the soup is mostly liquid with few beans, vegetables or other foods in it
- Precook and dry legumes before mixing them with other staple flour (e.g. Beans, soya beans, chickpea)
- However do not mix more than two cereals when preparing flour for porridge

Participants discuss how they use fats and oils to enrich complementary foods

Step 1: Ask participants if they use fats and oils to enrich children foods in their community

Step 2: Refer participants to the hand out on fats and oils



Summarize using the notes below

Fats and Oils

- Stir in a paste made from nuts or seeds such as groundnut paste (peanut butter) or sesame seed paste (tahini/simsim).
- Add a spoonful of margarine, ghee or oil.

Participants discuss on use of fermented or germinated flour

Step 1: Ask participants if they use fermented or germinated flour in their community for children

Summarize using the notes below

Fermented Porridge or Germination of Grain for Flour.

Fermented porridge

- Fermented porridge can be made in two ways – the flour can be mixed with warm water and set to ferment overnight or longer before cooking, or the flour and water is cooked into porridge and then fermented. Sometimes some of a previous batch of the fermented porridge (starter) is added to speed up the process of fermentation. Porridge made from germinated grain can also be fermented.
- The advantages of using fermented porridge are:
- It is less thick than plain porridge so more grain/flour can be used for the same amount of water. This means each cupful of porridge contains more energy and nutrients than plain (unfermented) porridge.
- Children may prefer the taste of 'sour' porridge.
- The absorption of iron and some other minerals is better from the fermented porridge.
- It is more difficult for harmful bacteria to grow in fermented porridge, so it can be kept for a day or two.
- Excellent sources of good bacteria which helps improve digestion.
- Fermented foods are rich in vitamin C, K and B complex which helps protect against diseases
- Grain is also fermented to make alcohol. However, the short fermentation talked about here to make fermented porridge will not make alcohol or make the child drunk!

Germinated or sprouted flour

- Cereal or legume seeds are soaked in water and then left to sprout. The grains are then dried (sometimes toasted) and ground into flour. A family can do this at home but it is more common to buy flour already germinated.
- Mixed flours that include germinated (or malted) flour in addition to the main flour may be available in the shops.

The following ways can be used to make a thicker and more nutritious porridge:

- Use germinated flour to make porridge. This type of flour does not thicken much during cooking so less water can be used.
- Add a pinch of the germinated flour to cooked thick porridge that has cooled a little bit. The porridge should be boiled again for a few minutes after adding the germinated flour. This addition will make the porridge softer and easier for the child to eat.
- Germination also helps more iron to be absorbed.



Activity 4

Demonstrate use of foods of a thick consistency

(10 minutes)

Step 1: Ask participants if they give children foods of thick consistency in their community

Summarize the discussion using the notes below

- We have the staple in the child's bowl. Let us say this child will have (give local example, porridge, potato, rice etc) the food may be thin and runny or it may be thick and stay on the spoon.
- Often families are afraid that thick foods will be difficult to swallow, be stuck in the baby's throat, or give the baby constipation. Therefore, they add extra liquid to the foods to make it easier for the young child to eat. Sometimes extra liquid is added so that it will take less time to feed the baby.
- It is important for you to help families understand the importance of using a thick consistency in foods for young children.

The trainer demonstrates to the participants on thick porridge consistency

Step 1: Refer participants to the handout on the stomach size illustration of an 11 month old baby

Step 2: Ask participants what they see on the illustration



Step 4: This is (boy's name). He is eleven months old. At this age, (name's) stomach can hold about 200 ml at one time. This is the amount that fits into this container.

(Show the empty see-through container that holds 200 ml)

Step 5: (Name's) mother makes his porridge from maize flour. His mother is afraid (name) will not be able to swallow the porridge, so she adds extra water.

(Use one portion (200mls) of the made-up porridge (measure from the jug) put this 200mls portion into the 400 ml container and dilute this portion of porridge with the hot water provided to at least twice the volume and show to participants.) Now the porridge looks like this (thin and watery).

Step 6: Pour the porridge into a clear container 'stomach' (200mls) as you ask the question. ***Can all this thin porridge fit in his stomach?***

- No, it cannot all fit in his stomach, there is still porridge left in the bowl.
- (Name's) stomach would be full before he had finished the bowlful. So (name) would not get all the energy he needs to grow.
- (Name's) mother has talked with you, the community health volunteer, and you have suggested that she give thick porridge.
- The mother makes the porridge using the same amount of maize but does not add extra water. The porridge looks like this (thick).

Step 7: Use the other portion of the made-up porridge but do not dilute it. Show the participants how thick it is. Scoop 200mls of the porridge (remaining in the jug) into

the see-through container 'stomach' (200mls) as you ask the question, can all this thick porridge fit in (name's) stomach?

Yes. (Name) can eat a bowlful, which will help meet his energy needs.

- Look at the consistency of the porridge on the spoon. This is a good way to show families how thick the food preparation should be. The food should be thick enough to stay easily on the spoon without running off when the spoon is tilted.
- If families use a blender to prepare the baby's foods this may require extra fluid. It may be better to mash the baby's food instead so that less fluid is added.
- Porridge or food mixtures that are so thin that they can be fed from a feeding bottle, or poured from the hand or that the child can drink from a cup, do not provide enough energy or nutrients.

The consistency or thickness of foods makes a big difference to how well that food meets the young child's energy needs. Foods of a thick consistency help to fill the energy gap.

Activity 5

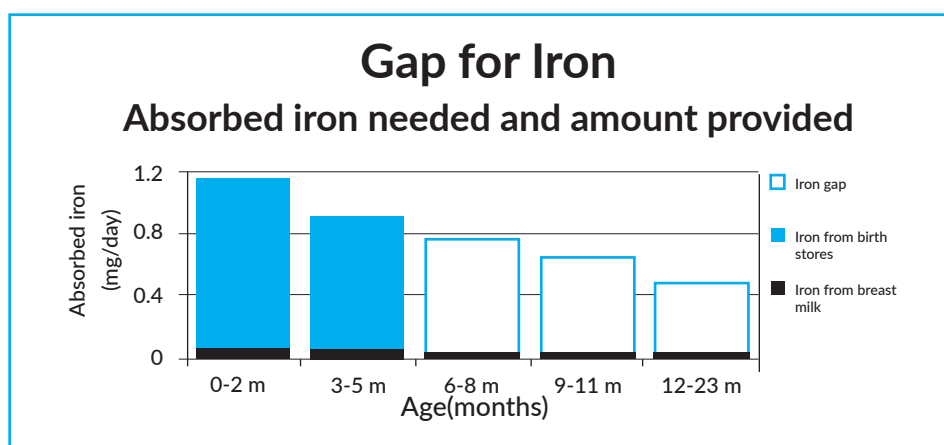
Explain the iron gaps and factors influencing Iron absorption (20 minutes)

Step 1: Ask participants what are some of the food sources of iron found in this community?

Step 2: List their responses on a flip chart
Summarize using the notes below

- A young child needs iron to make new blood, to assist in growth, development and to help the body fight infections.

Step 3: Refer participants to the handout on the iron gaps graph



Step 4: Ask participants to say what they see from the graph
Summarize the discussion using the notes below

- In this graph, the top of each column represents the amount of absorbed iron that is needed per day by the child. A full-term baby is born with good stores of iron to cover his needs for the first six months (**Point to the striped/shaded area**).
- The black area along the bottom of the columns shows us that there is some iron provided by breast milk all the time breastfeeding continues (**Point to black area**).
- The young child grows faster in the first year than in the second year. This is why the need for iron is higher when the child is younger.
- However, the iron stores are gradually used up over the first six months. So, after that time we see a gap between the child's iron needs and what they receive from breast milk.
- This gap needs to be filled by complementary foods (**Point to white area – this is the gap**).

Step 6: Ask participants what happens if the child does not have enough intake of iron to fill this gap?

Summarize using the notes below

- If the child does not have enough iron, the child will become anaemic, will likely get infections and will take longer to recover from infections. The child will also grow and develop slowly.
- Your goals, as community health workers, are:
 - To identify local foods that are rich sources of iron
 - To assist families to use food preparations methods that enhance iron absorption and content
 - To assist families to use these iron rich foods to feed their young children.

Pulses and dark-green leaves are sources of iron. However, it is not enough that a food has iron in it; the iron must also be in a form that the child can absorb and use. We will discuss this later.

Resource notes

Zinc is another nutrient that helps children to grow and stay healthy. It is usually found in the same foods as iron, so we assume that if they are eating foods rich in iron they are also receiving zinc.

Participants brainstorm on factors enhancing or inhibiting Iron absorption

Step 1: Ask participants to brainstorm on any factors that affect iron absorption. Summarize the discussion using the notes below.

The amount of iron that a child absorbs from food depends on:

1. The amount of iron in the food.
2. The type of iron (*iron from meat and fish is better absorbed than iron from plants and eggs*)
3. The types of other foods present in the same meal (*some increase iron absorption and others reduce absorption*)
4. Whether the child has anaemia (*more iron is absorbed if anaemic*).

Eating these foods below at the same meal increases the amount of iron absorbed from eggs, plant foods such as cereals, pulses, seeds, and vegetables:

- Foods rich in vitamin C such as tomato, broccoli, guava, mango, pineapple, papaya, orange, lemon and other citrus fruits.
- Small amounts of the flesh or organs/offal of animals, birds, fish and other Sea foods.

Iron absorption is decreased by:

1. Drinking teas and coffee with food
2. Taking foods high in fibre such as bran.
3. Taking foods rich in calcium together with iron rich foods.

Activity 6

Explain the importance of animal source foods

(10 minutes)

Step 1: Ask participants which are the animal source foods that they give to their children in their community?

Step 2: List these foods on the previously posted flip chart

We will now look at the importance of animal-source foods in the child's diet.

- Foods from animals, the flesh (meat) and organs such as liver and heart, as well as milk, yoghurt, cheese and eggs are rich sources of many nutrients.
- The flesh and organs of animals and birds are the best sources of iron and zinc.

- Fish (including shell fish and tinned fish) are also good for children
- Liver is not only a good source of iron but also rich in vitamin A.
- Animal-source foods should be eaten daily or as often as possible. This is especially important for children's healthy growth and development.
- Some families do not give meat to their young children because they think it is too hard for the children to eat, or they may be afraid there will be bones in fish that would make the child choke.

Step 3: Ask participants what are some of the ways of making these foods easier for the young child to eat?

Summarize the discussion using the notes below

- Some ways of making these foods easier to eat for young children are to:
 1. Cook chicken liver or other meat with rice or other staple or vegetables, and then mash them together
 2. Scrape meat with a knife to make soft small pieces
 3. Pound dried fish so bones are crushed to powder and then sieve before mixing with other foods.
- Animal-source foods may be expensive for families. However, to add even small amounts of an animal-source food to the meal adds nutrients. Organ meats such as liver or heart have more iron than other meats.
- Foods from animals such as milk and eggs are good for children because they are high in protein and other nutrients. However, milk and milk products, such as cheese and yoghurt, are not good sources of iron.
- Milk fat (cream) contains vitamin A. Therefore, foods made from whole milk are good sources of vitamin A.
- Foods made from milk (whole milk or skimmed or powdered) and any food containing bones, such as pounded dried fish, are good sources of calcium to help bones to grow strong.
- Egg yolk is another source of nutrients and rich in vitamin A.
- It can be hard for children to meet their iron needs without a variety of animal-source foods in their diet.
- Fortified or enriched foods such as fortified flours, pasta, cereals, or instant foods made for children, help to meet these nutrient needs.
- Some children may need supplements if they do not eat enough iron-containing foods or if they have particularly high needs for iron.

Activity 7

Explain the importance of legumes

(10 Minutes)

Step 1: Ask participants if communities in the area give young children legumes? If no find out why

Step 2: List their responses on a flip chart

Step 3: Ask participants what are the ways that legumes, nuts and seeds could be prepared that would be easier for the child to eat and digest?

Summarize the discussion using the notes below

- Legumes or pulses such as beans, peas, and lentils as well as nuts and seeds, are good sources of protein. Legumes are a source of iron as well.
- Some ways these foods could be prepared in a way that would be easier for the child to eat and digest are:
 - Soak beans before cooking and throw away the soaking water.
 - Remove skins by soaking raw seeds and then rubbing the skins off before cooking.
 - Boil beans then sieve to remove coarse skins.
 - Roast nuts and seeds and pound to a paste.
 - Add beans/lentils to soups or stews.
 - Mash cooked beans well.

Eating a variety of foods at the same meal can improve the way the body uses the nutrients. For example, combining a cereal with a pulse (for example: rice and beans or maize and beans)

Activity 8

List foods that can fill the vitamin A gap

(10 minutes)

Step 1: Ask participants to mention some of the vitamin A rich foods they know

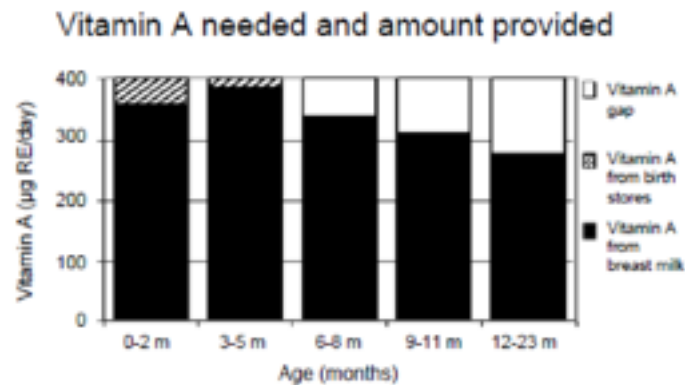
Step 2: List the foods on the previously posted flip chart

Step 3: (Show a bowl) we now have a staple in our child's bowl to fill the energy gap and foods that will help to fill the iron gap.

Another important nutrient is vitamin A, which is needed for healthy eyes and skin and to help the body fight infections.

Step 4: Refer participants to the handout on the vitamin A gap graph

Gap for vitamin A



Step 5: Ask participants to say what they see from the graph
Summarize the discussions using the notes below

- Again, on this graph the top of each column represents the amount of vitamin A that the child needs each day. Breast milk supplies a large part of the vitamin A needed provided the child continues to receive breast milk and the mother's diet is not deficient in vitamin A. As the young child grows, there is a gap for vitamin A that needs to be filled by complementary foods (Point to the white area – this is the gap to be filled).
- Good foods to fill this gap are dark-green leafy vegetables, yellow and orange-coloured vegetables and fruits.
- Other sources of vitamin A that we mentioned already were:
 - Organ foods/offal (liver) from animals
 - Milk and foods made from milk such as butter, cheese and yoghurt
 - Egg yolks
 - Foods fortified with vitamin A e.g. Margarine, cooking oil
 - Dried whole milk powder
- Vitamin A can be stored in a child's body for a few months. Encourage families to feed foods rich in vitamin A as often as possible when these foods are available, ideally every day. A variety of vegetables and fruits in the child's diet help to meet many nutrient needs.
- Remember breast milk supplies much of the vitamin A required. A child that is not breastfed needs a diet rich in vitamin A.
- In Kenya, vitamin A supplementation programmes are available. You have a role in mobilizing care givers and referring children every 6 months to health facilities for routine vitamin A supplementation.

Summarize session

(3 minutes)

Ask participants if they have any questions or seek clarification

Session 3

Quantity, Variety and Frequency of Feeding

Objectives

After completing this session, participants will be able to:

1. Describe the quantity, variety and frequency of complementary feeding
2. Describe how to feed a non-breastfeed child
3. State the quantity and frequency to offer per age group in a drill

Duration: 1hr 40 minutes

Methodologies: Lecture, group discussions, buzzing, brainstorm, group work

Materials: Counselling cards, flip charts, mark pens, masking tapes, handouts

Session plan

Duration	Topics	Methodology	Materials
2 minutes	Session introduction	Lecture	Flip charts, marker pens
60 minutes	Discuss quantity, variety, frequency and texture/ consistency	Lecture, discussion, brainstorming, group work	Counselling cards number 21-24, flip charts, marker pens
15 minutes	Discuss how to feed a non-breastfed child 6-23 months	Lecture, discussion, brainstorming, group work	Counselling cards number 26, flip charts, marker pens
20 minutes	Conducting a drill	Brainstorming	Handouts
3 minutes	Session summary		

Introduction of the session

(2 minutes)

In this session we shall discuss the quantity, variety and frequency of foods that the children need for growth from 6- 59 months

Activity 1

Discuss quantity, variety, frequency and texture/ consistency

(60 minutes)

Step 1: Ask participants to brainstorm on the 7 food groups

Step 2: Refer the participants to the flip chart posted on the wall

We are now going to learn about the frequency, amount, texture/ consistency, variety, active/responsive feeding and hygiene (FATVAH) discussed in session one of this chapter in a practical way

We are going to discuss complementary feeding based on the following categories

1. At 6 months
2. 7-8 months
3. 9-11 months
4. 12-23 months
5. 24-59 months

Participants discuss the counselling cards 21-25

Step 1: Divide participants into 5 groups: Group 1, 2, 3, 4 & 5

Step 2: Tell participants that they will discuss counselling cards number 21-24 and 25

Step 3: Ask each group to discuss and note the key information they can derive from each of the card starting from card number 25 on frequency, amount, texture/ consistency, variety, active/responsive feeding and hygiene and developmental milestone for each age categories in each of the cards.


Step 4: Ask one participant from group one to share in the plenary the notes they have made on card 21 ask the other 4 groups to add any additional information.


Step 5: Give additional information by using the summary notes on the counselling card 21 and for the rest of the cards


Step 6: Repeat the same process for cards 22, 23, 24 and 25. Example (Group 2 presents card 22, Group 3 presents card 23, Group 4 presents card 24 and group 1 presents card 25)

Complementary feeding at 6 months


Card 21








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Day

Week 1-2




Week 3-4







Evening


Week 1-2



Week 3-4







Summarise the discussion using the notes below

At 6 months

- Breast milk continues to be an important part of the diet and provides half of the child nutritional requirement up to 12 months, a quarter up to 18 months and a third up to 2 years.
- Breastfeed before giving other foods, and continue breastfeeding on demand both day and night.

THINK! Frequency, Amount, Thickness, Variety, Active feeding/ Responsive feeding, Hygiene

- **Frequency:** Feed 2 times a day, use a separate bowl to feed the baby to make sure he/she eats all the food given
- **Amount:** The child has just begun complementary foods, the care givers need to introduce small amounts of food and be patient. Start with 2 tablespoons at each feed and increase to 3 tablespoons in the 3rd to 4th week. Baby needs time to get used to new food and thus introduce one food at a time
- **Thickness:** Should be thick enough not to run off the spoon
- **Variety:** Begin with the staple foods like porridge (corn, wheat, rice, millet, sorghum), pureed banana or potato. When making porridge flour, you should not mix more than 2 cereals: introduce more variety of foods gradually as the baby grows
- **Responsive feeding:** Don't force your baby to eat.
- **Hygiene:** Good hygiene (cleanliness) is important to avoid diarrhea and other illnesses. Wash with soap and water at all critical times
- **Give the child small sips of safe drinking water**

Early detection of the delayed mile stone will help address the problem before it's too late.

At this age some infants are able to sit

Complementary feeding for 7–8 months



Card
22



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Summarise the discussion using the notes below

7- 8 months

- At this age the amount of food to offer increases and the texture changes as the child grows
- Breastfeeding continues
- Your baby can take mashed/pureed family foods by 8 months; your baby can begin eating finger foods.
- Add small amounts of oil to your baby's food
- Give your child some safe drinking water

When giving complementary foods to your baby;

THINK! Frequency, Amount, Thickness, Variety, Active feeding/ Responsive feeding and Hygiene.

- **Frequency:** Feed your baby 3 times a day
- **Amount:** Increase amount gradually to half (½) cup of 250 ml cup. Use a separate plate to make sure young child eats all the food given.
- **Thickness:** give mashed/pureed family foods, by 8 months your baby can begin eating finger foods. Thicken your baby's food as the baby grows older.

- **Variety:** Include at least four food groups from any of the 7 food groups per day.
 - Grains, grain products and starchy foods e.g. maize, sorghum, millet, green bananas, potatoes, rice, pasta etc
 - Legumes and nuts e.g. all types of beans, lentils, ground nuts, macadamia nuts
 - Flesh or animal source foods e.g. meat, eggs and
 - Dairy and dairy products e.g yogurt, cheese and fermented milk
 - Eggs
 - Vitamin A rich fruits and vegetables e.g. Pawpaw, mangoes, passion fruit, carrots, pumpkins, green leafy vegetables etc
 - Other fruits and vegetables e.g. Avocado, broccoli, cabbage, bananas, tomatoes
- **Active feeding/responsive feeding:** Be patient and actively encourage your baby to eat.
- **Hygiene:** Good hygiene (cleanliness) is important to avoid diarrhea and other illnesses to help them grow strong and healthy.
 - Add small amounts of oil to your baby's food.
 - Give your child some safe drinking water.
 - Enrich the baby's food by adding locally available foods e.g. avocado, peanut paste.
 - Giving a child soup of the food is not the same as giving the food itself.
 - Add small amounts of iodized salt

Card 23

Complementary feeding for 9-11 months

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Summarise the discussion using the notes below

9-11 months

- Continue breastfeeding your baby on demand both day and night.
- Milk supplies half ($\frac{1}{2}$) of baby's needs
- Breastfeeding should take place before meals
- Give your child care and affection during the earliest years as it will help your child to thrive.
- At this age, some infants are able to stand

When giving complementary foods to your baby;

THINK! Frequency, Amount, Thickness, Variety, Active feeding/ Responsive feeding and Hygiene

- **Frequency:** Feed your baby complementary foods 4 times a day (3 meals and 1 a snack). Snacks may be, ripe bananas, mangoes, boiled potatoes etc
- As the child grows increase the amount of food. Give $\frac{3}{4}$ cup of 250 ml cup per meal from family foods. Use a separate plate to serve the baby's food.
- **Thickness:** Give finely chopped family foods, finger foods, sliced foods.
- **Variety:** Include at least four food groups from any of the 7 food groups per day
 - Grains, grain products and starchy foods e.g. maize, sorghum, millet, green bananas, potatoes, rice, pasta etc
 - Legumes and nuts e.g. all types of beans, lentils, ground nuts, macadamia nuts
 - Flesh or animal source foods e.g. meat, eggs and
 - Dairy and dairy products e.g. yogurt, cheese and fermented milk
 - Eggs
 - Vitamin A rich fruits and vegetables e.g. Pawpaw, mangoes, passion fruit, carrots, pumpkins, green leafy vegetables etc
 - Other fruits and vegetables e.g. Avocado, broccoli, cabbage, bananas, tomatoes
- **Active feeding/responsive feeding:** Make meal times a relaxed and happy time for the child while encouraging and not forcing them, for example clap your hands, make funny faces, and demonstrate opening your own mouth very wide, say encouraging words
- Add small amounts of oil to your baby's food.
- Give your child some safe drinking water.
- Enrich the baby's food by adding locally available foods e.g. avocado, peanut paste.
- **Hygiene:** Good hygiene (cleanliness) is important to avoid diarrhoea and other illnesses.
- Give your child 2-3 cups (250ml/cup) of milk
- Add small amounts of iodized salt
- Provide your child with safe drinking water
- Enrich the baby's food by adding locally available foods e.g. avocado, peanut paste

Complementary feeding for 12-23 months



Card 24



Summarise the discussion using the notes below

12- 23 months

- Continue breastfeeding your baby on demand both day and night milk supplies a third (1/3) of baby's need. Breastfeeding should take place before meals
- A young child needs to learn to eat: encourage and give help with lots of patience when giving complementary foods.
- Early health care seeking for treatment/management prevents complications
- At this age, some of the young children are able to walk.

THINK! Frequency, Amount, Thickness, Variety, and Active feeding/ Responsive feeding, Hygiene


- **Frequency:** Feed your baby complementary food 5 times a day (3 meals and 2 snacks) snacks may be, ripe banana, mangoes, boiled potatoes etc
- **Amount:** Give your child 1 cup of the 250ml cup per meal. Use a separate plate to serve babies food to make sure the young child eats all the food given.
- **Thickness:** Cut food into small, soft pieces so that your child can pick, chew and swallow comfortably.
- **Variety:** Include at least four food groups from any of the 7 food groups per day.
 - Grains, grain products and starchy foods e.g. maize, sorghum,

- millet, green bananas, potatoes, rice, pasta etc
- Legumes and nuts e.g. all types of beans, lentils, ground nuts, macadamia nuts
- Flesh or animal source foods e.g. meat, eggs and
- Dairy and dairy products e.g yogurt, cheese and fermented milk
- Eggs
- Vitamin A rich fruits and vegetables e.g. Pawpaw, mangoes, passion fruit, carrots, pumpkins, green leafy vegetables etc
- Other fruits and vegetables e.g. Avocado, broccoli, cabbage, bananas, tomatoes



- **Active feeding/responsive feeding:** Make meal times a relaxed and happy time for the child and encourage the child to feed for example clap your hands, make funny faces, and demonstrate opening your own mouth very wide, use encouraging words. Do not force them to feed.
- **Hygiene:** Good hygiene (cleanliness) is important to avoid diarrhoea and other illnesses
 - Give your child 2-3 cups (250mlscup) of milk
 - Add small amounts of iodized salt
 - Provide your child with safe drinking water
 - Enrich the baby's food by adding locally available foods e.g. avocado, peanut paste

Feeding children 24-59 months


Card 25




Republic of Kenya
Ministry of Health

 Morning		+			
 Mid morning					
 Noon		+			
 Evening					
 Night		+			





Summarise the discussion using the notes below

24-59 months

- Give your child Care and affection during the earliest years as it will help your child to thrive.
- At this age some of the young children are able to talk

The child has increased energy needs and nutrient requirements. A growing child needs 2-4 meals a day plus 1-2 snacks if hungry: give a variety of foods Encourage physical activity

THINK! Frequency, Amount, Thickness, Variety, Active feeding/ responsive feeding and Hygiene

- **Frequency:** Feed your child 5 times (3 meals and 2 snacks) snacks may be, ripe banana, mango, boiled potato etc.
- **Amount:** Give your child at least 1 ½ -2 cups 250ml of food
- **Variety:** Include at least four food groups from any of the 7 food groups per day.
 - Grains, grain products and starchy foods e.g. maize, sorghum, millet, green bananas, potatoes, rice, pasta etc
 - Legumes and nuts e.g. all types of beans, lentils, ground nuts, macadamia nuts
 - Flesh or animal source foods e.g. meat, eggs and
 - Dairy and dairy products e.g yogurt, cheese and fermented milk
 - Eggs
 - Vitamin A rich fruits and vegetables e.g. Pawpaw, mangoes, passion fruit, carrots, pumpkins, green leafy vegetables etc
 - Other fruits and vegetables e.g. Avocado, broccoli, cabbage, bananas, tomatoes
- **Active feeding/responsive feeding:** Make meal times a relaxed and happy time for the child while encouraging and not forcing them, for example clap your hands, make funny faces, and demonstrate opening your own mouth very wide, say encouraging words.
- **Hygiene:** Good hygiene (cleanliness) is important to avoid diarrhea and other illnesses
 - Give your child 2-3 cups of milk of the 250-ml cup
 - Add small amounts of salt and oil
 - Provide your child with safe drinking water
 - Encourage physical health

Ask participants if they have any questions or seek clarification

Activity 2

Discuss how to feed a non-breastfed child 6- 23 months (15 minutes)

Participants discuss card number 26- the non-breastfed child

Non-breastfed children from 6-23 months

Card 26

Republic of Kenya
 Ministry of Health

6 months	7 - 8 months	9 - 11 months	12 - 23 months
Morning: Mid morning: Noon: Night:	Morning: Mid morning: Noon: Night:	Morning: Mid morning: Noon: Evening: Night:	Morning: Mid morning: Noon: Evening: Night:
Each day add:	Each day add:	Each day add:	Each day add:

Step 1: Ask participants to briefly look at the card for one minute

Step 2: Ask the participants to share in plenary what they have observed from the card

Summarise the discussion using the notes below

Non breast fed child 6-23 months

- Give your child care and affection during the earliest years as it will help your child to thrive.
- Non-breast-fed babies require extra meals and milk in order for them to continue growing stronger and healthy. Milk continues to be a very important part of the baby's diet.

THINK! Frequency, Amount, Thickness, Variety, Active feeding/ responsive feeding and Hygiene

- **Frequency:** Feed the number of times a day for age specific babies, use separate bowl to feed the baby to make sure he/she eats all the food given
- **Amount:** At 6 months start with 2 tablespoons at each feed and increase to 3 tablespoons in the 3rd to 4th week. Baby needs time to get used to new food, give 3-4 cups of milk
 - 7- 8 months feed the baby 3 times a day add one snack depending on appetite, one extra meal and 1-2 cups of milk
 - 9-11 months feed the baby 3 meals and 2 snacks provide 1-2 extra meals and 1-2 cups of milk depending on the baby's appetite

- 12-23 months feed baby with 3 meals and 2 snacks and an extra 1-2 meals and 1-2 cups of milk
- **Thickness:** should be thick enough not to run off the spoon at 6 months of age, as the child gets older modify the foods same way as the breastfed child. Begin with the staple foods like porridge (corn, wheat, rice, millet, and sorghum), pureed banana or potato. When making porridge flour only mix 2 cereals not more
- **Variety:** Variety: Include more variety as the child gets older same way as the breastfed child.

Include at least four food groups from any of the 7 food groups per day.

- Grains, grain products and starchy foods e.g. maize, sorghum, millet, green bananas, potatoes, rice, pasta etc
- Legumes and nuts e.g. all types of beans, lentils, ground nuts, macadamia nuts
- Flesh or animal source foods e.g. meat, eggs and
- Dairy and dairy products e.g yogurt, cheese and fermented milk
- Eggs
- Vitamin A rich fruits and vegetables e.g. Pawpaw, mangoes, passion fruit, carrots, pumpkins, green leafy vegetables etc
- Other fruits and vegetables e.g. Avocado, broccoli, cabbage, bananas, tomatoes

- **Active feeding/responsive feeding:**

Don't force your baby to eat, rather encourage the child to eat with lots of patience

- **Hygiene:**

Good hygiene (cleanliness) is important to avoid diarrhea and other illnesses. Wash hands with soap and water at all critical times

- Give the child small sips of safe drinking water, as the child gets older offer 2-3 cups of safe drinking water in temperate climate and 4-6 cups in hot climate

Key things to remember when feeding a non-breastfed child:

Non -breastfed children:

- Should have essential fatty acids in their diet – from animal-source foods, fish, and avocado, vegetable oil, and nut pastes.
- Should have adequate iron. If they are not receiving animal-source foods, then fortified foods or iron supplements should be considered.



Activity 3

Conducting a drill

(20 minutes)

Participants stand for a drill

- As you talk with caregivers, a frequent question you are asked may be how much and how often to give food.
- To practice these amounts, we will now do a drill. A drill is not a test. It is a way to help you learn to recall the amounts with speed and confidence.

Step 1: Ask participants to stand for a drill, reassure the participants that this is not a test but a way to help them remember the quantity and frequency of foods to give and is not meant to embarrass anyone

Step 2: Tell participants that you shall mention a child's age and they will respond by giving the amount and frequency of food for that age.

Step 3: Tell participants that all of them will have an equal opportunity to respond as you will sequentially ask the questions

Step 4: Tell participants that when a participant answers correctly he/she shall sit down. If he/she cannot answer or answers incorrectly, he/she remains standing.

Step 5: When the correct answer is given, the trainer will say a different age of child and goes to the next participant until all participants are done.

Step 6: Congratulate participants as they improve in their ability to answer correctly or more quickly. If the group is very large, this drill can be conducted in the smaller groups with the trainer for each group asking the questions.

Step 7: The drill ends when all the participants have had an opportunity to answer and when you feel they are answering with confidence. You can repeat the ages if needed to give everyone enough opportunities to practice. Thank participants for their participation.

Step 8: The participants who remained standing can be asked to sing a song or dance before they sit. This may be used as a form of energizer before the next session.

Drill: Amounts to Give

Age of child	Frequency	Amount at each meal
6 months 2 days	Two times per day	2 tablespoonful's
22 months	Three meals 2 snacks	1cup
8 months	Three meals per day	½ cup
12 months	Three meals and 2 snacks	1 cup
7 months	Three meals per day	½ cup
15 months	Three meals and 2 snacks	1 cup
9 months	Three meals and 1snack	¾ cup
13 months	Three meals and 2 snacks	1 cup
19 months	Three meals and 2 snacks	1 cup
11 months	Three meals and 1 snacks	¾ cup
21 months	Three meals and 2 snacks	1 cup
36 months	Three meals and 2 snacks	1½ to 2 cups
3 months	A trick question!	Only breastfeeding

Resource notes

Amounts to offer			
Age	Texture	Frequency	Amount of food an average child will usually eat at each meal
At 6 months	Start with thick porridge, well mashed foods Thick enough not to run off the spoon	2 times a day plus frequent breast feeds	2 table spoon each feed increase to 3 table spoons in the 3rd to 4th week
7-8 months	Mashed/pureed family foods, by 8 months your baby can begin eating finger food.	3 meals per day plus frequent breastfeeds	Increase amount gradually to half ($\frac{1}{2}$) cup (250ml cup). Use a separate bowl for the child
9-11 months	Finely chopped or mashed foods, and foods that baby can pick up	Feed your baby complementary foods 4 times a day (3 meals and 1 snack) snacks may be, ripe banana, mango boiled potato etc. Plus breastfeeds	As the child grows increase the amount of food. Give ($\frac{3}{4}$) cup (250 ml cup) daily family food. Use a separate plate to serve the babies food.
12-23 months	Cut food into small, soft pieces so that your child can pick, chew and swallow comfortably.	Feed your baby complementary foods 5 times a day (3 meals and 2 snack) snacks may be, ripe banana, mango, boiled potato etc plus breast feeds	Give your child 1 cup of 250ml cup. Use a separate plate to make sure young child eats all the food given.
24-59 months	Cut food into small, soft pieces so that your child can pick, chew and swallow comfortably.	Feed your baby 5 times (three meals and 2 snacks) ripe banana, mango, boiled potato are examples of some of the snacks a baby can be offered	Give your child 1½ -2 cups of 250ml cup. Use a separate plate to make sure young child eats all the food given.
If baby is not breastfed, give in addition: 1-2 cups of milk per day, and 1-2 extra meals per day.			

Summarize session

(3 minutes)

Ask participants if they have any questions or if there are points you can make clearer.

Session 4

Food modification, fortification and meal preparation

Participants will learn on food modification, fortification and meal preparation.

Objectives

After completing this session participant will be able to:

1. Describe modification of complementary foods for various age groups
2. Identify fortified foods for preparation of complimentary foods
3. Demonstrate the amount, variety and texture/consistency to offer for different age categories
4. Demonstrate home fortification of complementary foods using MNPs
5. Demonstrate responsive feeding technique
6. Demonstrate the use of the counseling card in a role play

Duration: 1 hour 45 minutes

Methodologies: Lecture, Demonstrations, discussion, buzzing, group work, brainstorming,

Materials: Flip charts, mark pens, masking tapes, counselling card, bowl (250 mls), fortified food samples, handout on fortification logo, MNP powder, counselling card 27, MNP policy, variety of cooked foods enough to make a child size bowl full for 5 groups, 5 plates, 5 spoons, 5 forks, 5 knives, chopping board, grater, calibrated jug, hand washing facilities, serviettes, finger foods or cooked foods,

Session plan

Duration	Topics	Methodology	Materials
2 minutes	Session introduction		
25 minutes	Modifying complementary foods for various age groups	Brainstorming, group work, lecture, group discussion	Flip charts, mark pens, masking tapes, counselling card number 28
15 minutes	Use of fortified complementary foods	Lecture, discussions, brain storming	Flip charts, mark pens, bowl, fortified foods' samples, handout on fortification logo
15 minutes	Use of Micro-Nutrient Powders(MNPs)	Lecture, discussions, brain storming	Flip charts, mark pens, MNP powder, counselling card 27, MNP policy
30 minutes	Amount, variety, texture / consistency to offer for different age group	Lecture, discussions, brainstorming, demonstration	Variety of cooked foods enough for 5 groups, 5 plates, 5 spoons, 5 forks, 5 knives, chopping board, grater, calibrated jug, hand washing facilities, serviettes, hand out-PREPARING A YOUNG CHILD'S MEAL

15 minutes	Responsive feeding technique	Lecture , brainstorming, discussions, roleplays (prepare participants before session starts), buzzing	Counselling card 29, flip charts, mark pens, finger foods or cooked foods, spoons, serviette, hand washing facilities
3 minutes	Session summary		

Introduce the session

- In previous sessions we have discussed different aspects of complementary feeding including quantity, variety, frequency, amount, texture and hygiene.
- In this session, we shall discuss how to modify complementary foods for various age groups, and make them easier for the infants to eat
- How to use Multiple micro Nutrient Powders (MNPs).
- We will also demonstrate how to measure the correct amount of food to offer to children of different ages categories between 6-23 months using locally available cooked foods

Activity 1

Modifying complementary foods for various age groups

(25minutes)

Step 1: Ask participants to turn to counselling card 28

Step 2: Ask participants to buzz in groups of 3 and say what they see on the card

Step 3 : List their responses on a flip chart

Summarize using the notes below

Counselling card 28

- It is important for the baby to try different textures as he/ she grows. This helps the baby to learn to chew, swallow and enjoy the same food the family is eating.
- Making baby food is a simple and inexpensive way to feed the baby. It allows mothers/caregivers to offer textures that are just right for baby's needs and abilities
- The texture of a child's food should be modified as they grow.
- Foods should be cooked until soft and allowed to cool before cutting them into small chunks to purée or mash
- Start with pureed texture. A baby needs pureed food only for a short time. Between 6 and 7 months, baby can progress from purees to well-mashed and soft-cooked finger foods.
- Baby food can be made from the family's daily menu as texture can be changed by mincing, mashing, shredding, finely grating, among other ways. Examples of food modification are:
 - Shredding meat into smaller pieces using a chopping board.
 - Use of clean hands to mash fish

- Use of a fork or spoon to mash eggs
- Increase and vary food textures to help baby develop. Babies adapt quickly moving from pureed and finely mashed foods to lumpy foods.

Activity 2

Use of fortified complementary foods

(15 minutes)

- At times, vitamins and minerals may be lost during processing both at industry and household level, during storage, preparation and cooking.
- We will now discuss the Kenyan guidelines on food fortification

Step 1: Ask participants if they have heard about food fortification

Summarise the discussion using the notes below

- Food fortification is the practice of intentionally increasing the content of important micronutrients, (vitamins and minerals) - in a food so as to improve the nutritional quality of the food.
- Food fortification also provides a public health benefit with minimal risk to health.
- Food fortification has many benefits some of which are;
 - Prevention or minimization of the risk of occurrence of micronutrient deficiency in a population or specific population groups.
 - Contribution to the correction of a demonstrated micronutrient deficiency in a population or specific age group
 - A potential for an improvement in nutritional status and dietary intakes that may be, or may become, suboptimal as a result of changes in dietary habits/lifestyles.
- In Kenya, there are fortified complementary foods available.

Step 2: Ask participants which products they know that are fortified?

Step 3: Facilitator shows participants samples of fortified food products

Food vehicle	Added Micronutrients
Table salt	Iodine
Maize and wheat flour	Iron, Zinc, Vitamin B1 B2 B12, Niacin, Folic acid
Fats and oils	Vitamins A, D, E

Summarise the discussion using the notes below

- The Food, Drugs and Chemical Substances Act requires all packaged wheat flour, maize meal, and edible fats and oils to be fortified with vitamins and minerals.
- Labelling of fortified products is done in accordance with the Act relating to food fortification
- You can easily identify fortified foods in the market using the MOH fortification logo

Step 4: Refer participants to the handout on fortification logo



Step 5: Pass the food samples to the participants and ask them to identify the fortification logo on the food products

Summarise the discussion using the notes below

- It is therefore important to encourage mothers and caregivers to look out for foods with the logo as they are fortified with essential vitamins and minerals good for both their health and that of their babies

Ask participants if they have any questions or seek clarification

Activity 3

Use of Micro Nutrient Powders (MNPs)

(15 minutes)

- We have discussed commercially available fortified foods.
- We will now look at how to do home fortification by adding MNPs to complementary foods

Step 1: Ask participants if they have heard about or seen MNP sachets and wait for a few responses

Step 2: Show the participants a sample of the MNP sachet
Summarise the discussion on MNPs using the notes below

- This powder is a mixture of 15 essential Vitamins and Minerals that young children need for improved nutrition.
- MNPs are added directly to soft mashed or semisolid cooked foods prepared at home to improve the nutritional quality of foods for young children.
- Most of the complementary foods do not provide enough micronutrients
- The high prevalence of micronutrient deficiencies is largely due to low dietary diversity affordability and availability)
- Poor bio availability of micronutrients due to absorption inhibitors, especially in plant source based diets can also lead to micronutrient deficiencies

Target

Children 6-23 months



Discuss benefits of MNPs using the notes below

- **Benefits of using MNPs** : Use of MNP's for home fortification has been shown to have an impact on the micronutrient status of children 6-23 months.

Micronutrient Powder helps to:

- Improve the body's immune system.
- Improve a child's appetite.
- Improves a child's ability to learn and develop.
- Makes children healthy, strong and active.
- Prevents vitamin and mineral deficiencies.

Adding micronutrient powders (MNPs) to complementary foods

Step 3: Ask participants to open counselling card 27 and buzz in threes and say what they see

Card 27

Adding Micronutrient Powders (MNPs) to complementary foods

Republic of Kenya
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1 sachet every 3rd day for 1 child							
Day	1	2	3	4	5	6	7

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Discuss use of MNPs using the notes below

Procedure for adding micronutrient powders (MNPs) to complementary foods

- Serve the baby's food in a bowl
- Pull aside a portion of the food (2-3 tablespoons)
- Add the MNP powder to that portion only and mix well.
- Feed the baby on that portion first so that they finish within half an hour.

NOTE:

- A diet of foods with inadequate micronutrients will lead to poor health and development of young children from 6 up to 24 months of age.
- The single serving sachets allow families to fortify a young child's food at an appropriate and safe level.

Dos and DONTs OF MICRONUTRIENTS POWDER

DOs	DONTs
<ul style="list-style-type: none"> • One sachet of MNP should be mixed with a portion of food for one child every third day 	<ul style="list-style-type: none"> • A child should not take more than 1 sachet of MNP per day.
<ul style="list-style-type: none"> • They should be mixed in warm semi-solid foods. 	<ul style="list-style-type: none"> • MNPs powder should not be added in hot or liquid foods as this interferes with availability of the micronutrients
<ul style="list-style-type: none"> • MNP should be added at the meal the child likes the most. 	<ul style="list-style-type: none"> • One MNP sachet should not be shared with other children.
<ul style="list-style-type: none"> • Once MNP is added into food, the food should not be kept for more than 30 minutes as this leads to altered taste and colour of food 	<ul style="list-style-type: none"> • Children who are receiving Therapeutic or supplementary Foods should not be given MNPs as those foods already contain the micronutrients.
	<ul style="list-style-type: none"> • Do not give MNPs to a child with fever and who is being treated for an active infection.

Participants discuss the possible side effects of using MNPs

Summarise using the notes below

- Side effects from MNPs are minimal, usually harmless and of short duration.
- They include:-
 - Change of colour of stool: Dark stool indicates that iron is being absorbed into your child's body
 - Change in consistency of stool: A child may have softer stools or a mild form of constipation during the first 4-5 days
- Accidental overdosing is highly unlikely. In order to reach toxicity levels as many as 20 sachets would have to be consumed.
- Use of MNPs complements vitamin A supplementation, but does not replace it. Both are needed. MNPs have also been shown to improve appetite and infant feeding practices

Activity 4

Amount, variety, texture/consistency to offer for different age groups

(30 minutes)

- From previous sessions we have learnt about the frequency, variety, texture, amount and consistency of complementary foods.
In this session we will practice how to prepare a young child's meal in groups

Step 1: Divide participants into 4 groups: (Group 1, 2, 3 and 4)

Step 2: Ask participants to sit in their groups.

Step 2 : Facilitator explains the exercise:

- (Assign each group a child's age - Group one 7 ½ months, Group two 10 months, Group three 18 months and group four 23 months)
- Ask the members in each group to think of the foods available to families in the area that could be used to make a meal for a young child
- In this exercise, try to use foods that would be eaten in an average family meal in your area. .

Step 4: Have 4 copies of the annex on PREPARING A YOUNG CHILDS MEAL for each of the groups as you shall use it to assess the foods they serve (use resource notes provided)

Step 5: Allow seven minutes for groups to decide on the meal, and modify as per the need of the age group provided considering quantity, variety and texture.

NB:

- *They are not allowed to 'test' the size of the meal during preparation.*
- *They must wait until they have finished to see if they have judged correctly.*
- *See box on quantities of food to offer a young child for a meal (used in the previous session)*

Step 6: Trainers move around groups to observe how the activity is going on while offering help as needed.

Step 7: Ask participants to come together around a table and ask each group in turn to explain their meal:

- Why they chose those foods
- Why they prepared it in the way they did (mashed finely, chopped, etc.)
- What is the consistency is - test with a spoon?
- Is the texture correct for the age?
- Any additional foods they would have included that are not available

Step 8: Facilitator gives the group the 250 ml container to measure the amount of food they prepared for their child so as to answer the following questions

- Is it the correct amount for a child of that age?
- How many meals of this size does a child of this age need each day?
- Ask the whole group: Any questions you could ask this group?
- Wrap up the discussion with your observations
- Thank the group members for the exercise

Step 10: Repeat so each group has the opportunity to explain and discuss their meal.

Annex on: PREPARING A YOUNG CHILD'S MEAL		
Group:		
Age of child	Achieved (Yes/No)	Comments
Food groups:		
Grains, grain products and other starchy foods such as sorghum, maize. Spaghetti, rice cassava, white fleshed sweet potato, bread, etc		
Legumes and nuts (beans, lentils, green grams, cow peas, pea nuts e.tc		
Flesh foods (beef, goat)		
Dairy and dairy products (fresh milk, yoghurt, cheese, etc)		
Eggs		
Vitamin A rich fruits and vegetables (e.g. pumpkin, carrots, orange flesh sweet potatoes, green leafy vegetables, yellow orange coloured fruits		
Other fruits and vegetables such as oranges, pineapples, passion fruits		
Consistency/Texture		
Amount		
Prepared in a clean and safe manner		

Resource notes

As the participants are conducting the practical, walk around and note on the specific age of child. :

1. If they washed their hand before starting the practical and tick (√) in their form on the achieved column
2. As the groups present assess on the number of food groups they have used and tick (√) in the relevant column
3. As the groups present check and tick (√) on the relevant column if they have achieved the correct:
 - a) Texture/Consistency as per the age given
 - b) Amount as per the age given
4. When the group finishes to present, measure their food (using the 250mls cup) and tick (√) on the relevant column if they have achieved the correct amount
5. Use the form assigned for each group to summarize groups presentation

Summarise using the notes below

- In the previous session we learnt about food modification and fortification.
 - We have just concluded an exercise on preparing a young child's meal.
 - We will now learn how to add MNPs to a child's food.
- We will do this by using the foods we have already served for our child

Participants gather around one table to conduct a demonstration on adding MNPs to a child's food

Step 1: Ask participants to gather around the demonstration table

Step 2: Ask one participant who has been demonstrating this at facility level to demonstrate or plan to do it yourself.

Step 3: Wash hands with soap and running water.

Step 4: Separate a small portion of the soft or mashed semi-solid cooked food within the child's bowl.

Step 5: Shake the unopened sachet to ensure that the powder is not clumped and check on the expiry date

Step 6: Tear open the sachet and pour the entire contents into the small portion of food so that the child will eat all of the micronutrients in the first few spoonfuls

Step 7: Mix the sachet contents and the small portion of food well

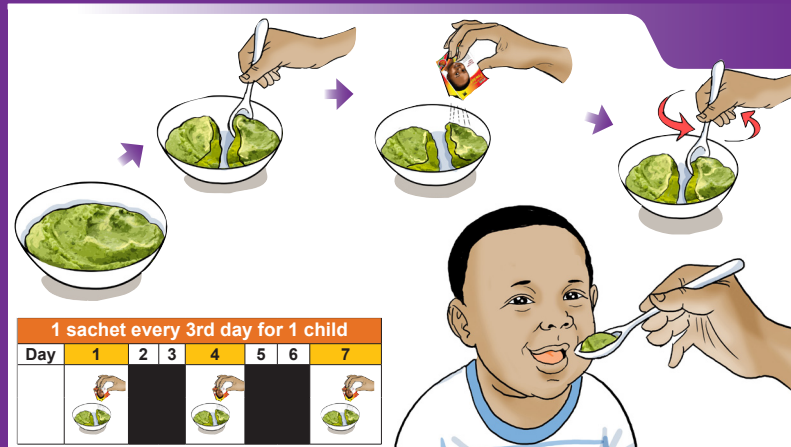
Step 8: Give the child the small portion of food mixed with MNPs to finish, and then feed the child with the rest of the food.

Step 9: Ask participants to take their seats and turn to counselling card 27 for pictorial illustration and call the participants attention to notice that the MNPs are given every third day for each child

Adding Micronutrient Powders (MNPs) to complementary foods



Card
27



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Activity 5

Responsive feeding technique

(15 minutes)

Participants observe and discuss role plays

- In previous sessions we have discussed variety, frequency, amounts texture of food to offer to children 6-59 months
- Now we will learn various feeding techniques that mothers use to feed children.
- To help understand feeding techniques we are going to do some demonstration. You will be required to observe each one of them.

Step 1: Ask two participants whom you prepared to give demonstrations to come forward **(One participant plays the part of a child aged 18 months and the other participant the 'caregiver')**

Step 2: Ask the rest of the participants to observe the role play

Step 3: Begin with the controlled feeding role play

Controlled Feeding

- The 'young child' is sitting next to the caregiver (or on the caregiver's knees).
- The caretaker prevents the child from putting his/her hands near the bowl or the food.
- The caregiver gives food into the child's mouth.
- If the child struggles or turns away, he is brought back to the feeding position.
- Child may be slapped or forced if he does not eat.
- The caregiver decides when the child has eaten enough and takes the bowl away.

Step 4: Ask participants what style of feeding they saw?

Step 5: Uncover the flip chart written 'controlled feeding'
Summarise using the notes below

- This is an example of controlled feeding. Children may not learn to regulate their intake, which may lead to obesity and food refusal later.
- The 'child' may feel eating is very frightening and uncomfortable. He/she may feel scared.
- Now let us see another way of feeding a young child.

Step 6: Ask participants to observe another role play: *leave to themselves*

Leave to Themselves

- The 'young child' is on the floor, sitting on a mat.
- Caregiver puts a bowl of food beside the child with a spoon in it.
- Caregiver turns away and continues with other activities (nothing too distracting for those watching).
- Caregiver does not make eye contact with the child or help with feeding.
- Child pushes food around the bowl, looks to caregiver for help, eats a little, cannot manage a spoon well, he tries with his hands but drops the food, he gives up and moves away.
- Caregiver says, "Oh, it seems you are not hungry" and takes the bowl away.

Step 7: Ask participants what style of feeding they saw

Step 8: Ask: At what age do caregivers in your community expect young children to eat by themselves?

Step 9: Uncover the flip chart written 'leave to themselves'
Summarise using the notes below

- This is an example of feeding by leaving children to do it themselves. If the child has a poor appetite or is too young to manage the skills of eating, this can result in malnutrition.
- The 'child' may feel eating is very difficult. He may be hungry or sad
- A child's ability to pick up a piece of solid food, hold a spoon, or handle a cup increases with age and practice.
- Children under two years of age need assistance with feeding. However, this assistance needs to adapt as the child grows, while the care giver provides opportunities for the child to feed themselves.
- A child may eat more if he is allowed to pick up foods with his newly learned finger skills from about 9-10 months of age.
- The child may be at least 15 months old before he can eat a sufficient amount of food by self-feeding. At this age, he is still learning to use utensils and will still need assistance.

Step 9: Ask participants to observe another role-play: *Responsive feeding*



Responsive Feeding

- Caregiver washes the child's hands and her own hands and then sits level with child.
- Caregiver keeps eye contact and smiles at child. Using a small spoon and an individual bowl, small amounts of food are put to the child's lips and child opens his mouth and takes it a few times.
- Caregiver praises child and makes pleasant comments – "Aren't you a good boy/girl", "Here is lovely dinner" while feeding slowly.
- Child stops taking food by shutting mouth or turning away. Caregiver tries once – "Another spoonful of lovely dinner?" Child refuses and caregiver stops feeding.
- Caregiver offers a piece of food that child can hold - bread crust, a piece of food item from the family pot or something similar. "Would you like to feed yourself?" Child takes it, smiles and sucks/munches it.
- Caregiver encourages "You want to feed yourself, do you?"
- After a minute, the caregiver offers a bit more from the bowl. Child starts taking spoonfuls again.

Step 10: Ask participants: How did the child feel this time about feeding?

Step 11: Ask the 'child' too what they felt this time.

Summarise using the notes below

- The child may feel happy about eating. He may like the contact and the praise and enjoy feeding himself.
- In this last demonstration, the caregiver was feeding the child in response to the child's cues.
- The child's cue or signal that he is hungry may include restlessness, reaching for food, or crying.
- Cues or signals that he does not want to eat more may include turning away, spitting out food or crying.
- Caregivers need to be aware of their child's cues, interpret them accurately, and respond to them promptly, appropriately and consistently.

Step 12: Ask participants what style of feeding they saw in the last demonstration?

Step 13: Ask participants what good practices they saw in the last demonstration that we could encourage?

Step 14: List their responses on the flip chart.

Step 15: Ask participants to open counselling card number 29 and ask them to identify some of the responsive feeding behaviours demonstrated by the care giver

Responsive feeding



Card
29



unicef

Step 16: Uncover the third Responsive Feeding Practice on the flip chart. Summarise the concept using the notes below

Responsive Feeding Techniques

- Responsive feeding practice encourages care providers to talk to children during feeding with eye-to-eye contact.
- Feeding times are periods of learning and love. Children may eat better if feeding times are happy.
- Feed when the child is alert and happy. If the child is sleepy or over-hungry and upset, he may not eat well.
- Have regular meal times and focus on eating without distractions, this may also help a child to learn to eat.
- When you talk with a caregiver, ask who feeds the child.
- Children are more likely to eat well if they like the person who is feeding them.
- Give positive attention for eating not just attention when eating poorly.
- Older siblings may help with feeding but may still need adult supervision to ensure the young child is actively encouraged to eat and that the sibling does not take his food.

Participants discuss on how a child learns to eat and drink

Summarise the discussion using the notes below

- When a child is learning to eat, he often eats slowly and is messy. He may be easily distracted.
- He may make a face, spit some food out, and play with the food. This is because the child is learning to eat.
- Children need to learn to eat. Eating solid foods is a new skill and, at first takes lots of patience to teach.

- The child needs help and time to develop this new skill, to learn how to eat, to try new food tastes and textures.
- At first, the young child may push food out of his mouth. This is because they do not have the skill of moving it to the back of their mouth to swallow it.
- If you are going to counsel a mother on complementary feeding, you need to find out what her child is eating.

Summarize the role play using the notes below

- From the role play we have observed the actors apply a variety of skills including:
 - I. Use of counselling cards
 - II. Listening and learning skills
 - III. Building confidence and support skills
- It is useful for you - community health volunteers - to continue practicing using the counselling cards to help mothers overcome difficult situations during home visits, mother support groups and community meetings
- Food demonstration for complementary feeding should be encouraged at community level and can be carried out individually or in groups in the community.
- A group demonstration reaches more families and can help to reinforce optimal complimentary feeding practices.
- Using fortified foods helps to meet micronutrient requirements of children and home fortification with MNPs should be encouraged for children 6-23 months.

Summarize session

(3 minutes)

Ask participants if they have any questions or seek clarification (3 minutes)

6

UNIT 6

BREAST MILK SUBSTITUTES (REGULATION AND CONTROL) ACT, 2012

The unit is intended to orient the participants on BMS (Regulations and Control) Act, 2012 and clearly communicate their roles in the implementation of the Act.

Objectives

After completing this session, participants will be able to:

1. Describe the BMS Act, its aim and rationale
2. Name the designated products
3. State main provisions of the BMS (Regulations and Control) Act, 2012
4. Describe different types of violations
5. Explain participants' roles in the implementation of the BMS Act

Duration: 40 Minutes

Methodologies: Facilitative lecture, buzzing, brainstorming, questions and answers

Materials: Flip charts, Marker pens, masking tape, handouts on main BMS provisions and types of violations

Session plan

Duration	Topics	Methodology	Materials
2 minutes	Introduction	Interactive lecture	
5 minutes	Describe the BMS Act, its aim and rationale	Brainstorm, lecture	Stationery
5 minutes	The designated products	Brainstorming, Q&A	Stationery, handout
10 minutes	Main provisions of the BMS (Regulations and Control) Act, 2012	Buzz groups, lecture	Hand out, stationery
10 minutes	Types of violations	Q&A, brainstorming	Hand out, stationery
5 minutes	Participants roles in implementation of the BMS Act	Q&A, lecture	Hand out, stationery
3 minutes	Sessions summary	Interactive lecture	

Introduce the session

(2 minutes)

In line with global laws to protect, promote and support breastfeeding, Kenya developed a national law - The Breast Milk Substitutes (Regulation and Control) Act, 2012 for regulating the marketing of breast milk substitutes, bottles and teats.

Activity 1

The Breast Milk Substitutes (Regulation and Control) Act, 2012; aim and rationale (5 minutes)

Participants will learn the importance of the BMS Act, its aim and rationale

Step 1: Ask participants what they know about the Breast Milk Substitutes (Regulation and Control) Act, 2012

Summarize with the notes below

The BMS Act, 2012

- The BMS Act 2012 is a Kenyan law on control of use and sale of breastmilk substitute
- Kenya is one of the signatories to the Innocenti declaration signed in Italy in 1981, Kenya committed to protect, promote and support breastfeeding through regulating the marketing of breast milk substitutes, bottles and teats. As Kenya commitment to the innocent declaration a national law was enacted in 2012 to give effect to the code. That law is the Breast Milk Substitutes (Regulation and Control) Act, 2012
- The Act gives restriction on advertisement, promotion, labelling of packaging, educational and information materials (Part III).

Aim of the Act

The BMS Act is an Act of parliament whose principle objective is:

- To provide for appropriate marketing and distribution of;
 - Breast milk substitutes
 - Complementary foods marketed for children older 6 months
 - Bottles, teats, pacifiers and cups with spouts
- To promote safe and adequate nutrition for infants through the promotion of breastfeeding
- To guide on proper use of BMS where necessary and for connected purposes

Rationale of BMS Act, 2012

Nearly all mothers are able to breastfeed and will do so if they have accurate information and support.

The direct influence from breast milk substitutes' manufacturers and distributors – through marketing strategies such as; **advertisements, information packs and sales representatives and; indirect influence through public and private health systems...** may overwhelm mothers with incorrect and biased information that undermines breastfeeding

Activity 2

List of the designated products.

(5 minutes)

Participants will learn what the designated products are as per the BMS (Regulation and Control) Act, 2012

Step 1: Explain to the participants what designated products are:

Any product that undermines breastfeeding that is sold or marketed to mothers with children less than 6 months

Step 2: Ask participants to turn to handout on @DESIGNATED PRODUCTS

Step 2: Ask participants to take turns to recognize the designated products as you list them on a flip chart

Summarize using the notes below

Designated products:

The BMS Act classifies the following as designated products.

- Infant formula
- Feeding bottles
- Teats
- Follow-up formula for infants or children between the age of six months to twenty-four months;
- Products marketed or otherwise represented as being suitable for feeding infants of up to the age of six months
- Breast milk fortifiers
- Pacifiers
- Cups with spout
- Any other product the Cabinet Secretary may, by a notice in the Gazette, declare to be a designated product

Activity 3

Main provisions of the BMS (Regulations and Control) Act, 2012 (10 minutes)

The participants will understand the main provisions of the BMS (Regulations and control) Act, 2012

Step 1: Ask the participants to turn to handout on MAIN PROVISIONS of the BMS (Regulation and control) Act, 2012

Step 2: Ask participants to read out loud the points below in turns, clearly explaining each one.

10 Main provisions of the BMS (Regulations and Control) Act, 2012

1. No advertising of products under the scope of the Act to the public
2. No free samples to mothers
3. No promotion of products in health care facilities, including free or low-cost supplies.

4. No contact between BMS company representatives and families.
5. No gifts to health workers. Health workers should never pass products to mothers.
6. Information to health workers must be scientific and factual.
7. No words or pictures on the labels idealizing artificial feeding, including pictures of infants.
8. All information on artificial infant feeding must explain the benefits and superiority of breastfeeding and the costs and hazards of artificial feeding.
9. Unsuitable products, such as sweetened condensed milk, should not contain instructions on how to modify them for infant feeding.
10. Manufacturers and distributors should comply with the Breast Milk Substitutes Act which is now law.

Activity 4

Types of violations

(10 minutes)

The participants will acquaint themselves with types of BMS (Regulations and Control) Act, 2012 violations

Step 1: Ask participants to brain storm on forms of violations they may know

Step 2: List their responses down on a flip chart

Step 3: Ask participants to refer to handout on EXAMPLES OF VIOLATIONS and explain each of them

Step 4: Confirm that the CHVs are able to recognize a BMS violation in the course of their day-to-day work.

Activity 5

Roles in the implementation of the BMS Act

(5 minutes)

Participants will understand their roles in the implementation of BMS (Regulation and Control) Act, 2012

Step 1: Ask participants to brainstorm on the roles they can play in implementation of BMS (Regulations and Control) Act, 2012

Step 2: Wait for a few responses then summarize using the notes below

CHVs and level 1 health actors can support implementation of the BMS Act by;

- Sensitizing community members, entrepreneurs in their areas on the BMS Act, 2012 through existing platforms
- Proactively monitoring compliance to the Act and identifying any form of violation in the community
- Reporting any violations to the link facility, area Public health officer or CHEW
- Following up on reported violations to ensure enforcement of the Act by PHOs

Summarise the session

(3 Minutes)

Ask participants if they have any questions or seek clarification

7

UNIT 7

GROWTH MONITORING & PROMOTION AND EARLY CHILDHOOD DEVELOPMENT & STIMULATION

This unit is intended to orient participants on the importance of growth monitoring and Promotion, Early Childhood Development & Stimulation.

Session 1

Growth Monitoring and Promotion

Participants will be able to understand growth monitoring and promotion, demonstrate how assessment is done, classification and action points

Objectives

By the end of this session, participants will be able to:

1. Describe growth monitoring and promotion
2. Explain the importance of growth monitoring and promotion
3. Display the equipment's for anthropometric measurements and interpret growth charts
4. Demonstrate how to take measurements using a MUAC tape to Measure Mid Upper Arm Circumference
5. Describe the criteria for referral using MUAC
6. Describe the procedure of checking for oedema

Duration: 1 hour 30 Minutes

Methodology: Lectures, brainstorming, interactive presentations, buzz (2 to 3 participants), role play, group work, question and answer, discussions, and demonstrations.

Materials: Mother Child handbooks (All participants), Taring weighing scales, Salter scale and pants, Height/Length boards, MIYCN counselling cards – card number 38, MUAC tapes, Sisal ropes, Paper towel or soft cloth

Session Plan

Duration	Topics	Methodology	Materials
2 minutes	Introduce the session	Facilitative lecture	
10 minutes	Discuss growth monitoring and promotion	Discussion, Buzz group	Flip charts, marker pens

20 minutes	Importance of growth monitoring and promotion	Discussion lecture	Mother Child handbook, MIYCN counselling cards – no. 38
15 minutes	Display the equipment used for anthropometric measurements and interpretation of growth charts	Discussion Lecture demonstration	Taring weighing scales, Height/Length boards, Salter scale and pants, Sisal ropes. Paper towel or soft cloth, Mother Child handbook
25 minutes	Describe how to measure mid upper arm circumference using a MUAC tape	Group work Demonstration	MUAC tapes, handout, mark pens
10 minutes	Criteria for referral using MUAC	Lecture discussion	Handout, MUAC Tape
5 minutes	Checking for oedema	Lecture discussion	Handout
3 minutes	Session summary		

Activity 1

Introduction to growth monitoring and promotion

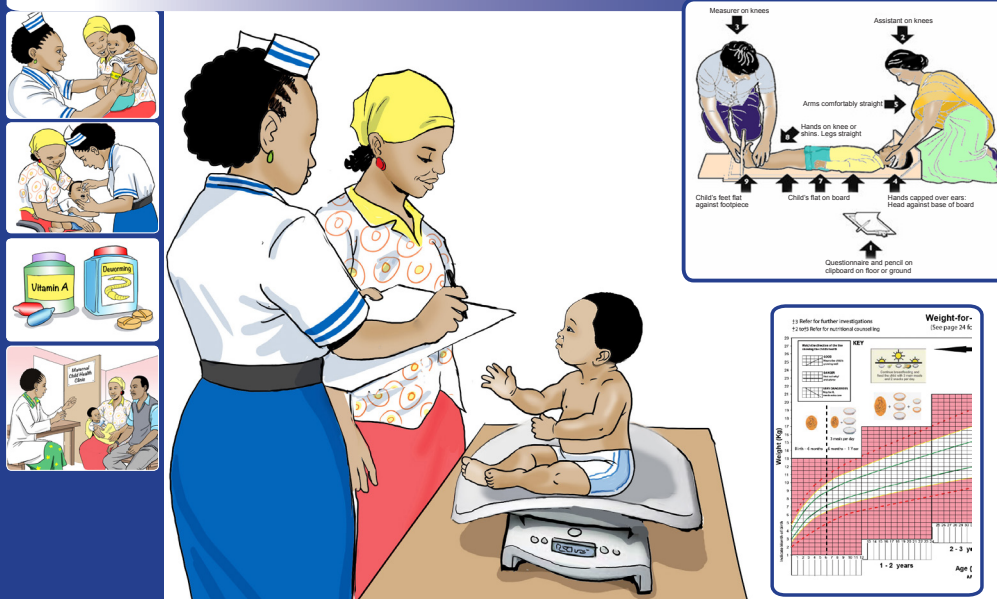
(10 minutes)

- This session is intended to orient participants on the importance of growth monitoring and promotion (GMP) and all that it entails e.g. taking weight, taking length/height and Mid Upper Arm Circumference (MUAC) in children every month.
- We will begin by learning what growth monitoring and promotion (GMP) entails.

Participants will be involved in learning how growth monitoring and promotion is done

Step 1: Ask participants to turn to card 38. Allow the participants to look at the card in twos for two minutes.

Growth monitoring and promotion



Card
38

Step 2: Ask participants to report on what they have observed from the card.

Step 3: List their responses on a flip chart

Summarize by showing the participants the mother child health handbook and using the notes below

- A healthy child who is growing well should always gain weight every month.
- Monthly growth monitoring and promotion sessions (GMP) includes:
 - Taking weight and length or height measurement for children <5years.
 - Taking MUAC for all children aged 6-59 months.
 - Health and nutrition education, including counselling on feeding children
 - Immunization for children 0-18 months
 - Vitamin A supplementation for children 6-59 months
 - Deworming for children above 1 year
 - Monitoring of developmental milestones
- This helps to monitor the child's growth and development
- It is important for measured weight and length/height to be recorded on the appropriate chart (boy or girl) in the mother child handbook

- normally done by health care worker
- MUAC reading should be recorded on the mother child handbook in the clinical notes section

Activity 2

Importance of growth monitoring and promotion

(20 Minutes)

Participants will learn the importance of Growth Monitoring and Promotion

Monitoring growth and development is an indicator or pointer to gauge health status of a child which is critical during the first five years.

Step 1: Ask participants to brainstorm on what they think is the importance of growth monitoring

Step 2: List their responses on the flip chart
Summarize using the notes below

IMPORTANCE OF GROWTH MONITORING AND PROMOTION

- The purpose is to determine whether a child is growing “normally” or has a growth problem or trend towards a growth problem that should be addressed.
- If a child has a growth trend that deviates from the normal standards, the health care provider should talk with the mother or other caregiver to determine the causes and intervene appropriately.
- In circumstances such as extreme poverty or emergencies, growth assessment aims at identifying children who need urgent intervention, such as therapeutic or supplementary feeds, to prevent death
- Children with excess weight should be referred for medical assessment and specialized management if these services are available. Non-severe problems can be managed through counselling, including age-appropriate advice on feeding and physical activity.
- Health promotion services including immunization, Vitamin A supplementation, and deworming
- Assess and educate on developmental milestones and child stimulation
- Health and nutrition education including counselling on child feeding and praising a child who is growing well

Ask if participants have any questions or seek clarification

Activity 3

Anthropometric equipment and interpreting growth charts

(20 minutes)

Participants will understand and practice the use of the different anthropometrics tools.

- We have learnt the importance of conducting growth monitoring for children.
- We will now learn the equipment used to measure the growth.
- This activity will enable us to identify the anthropometric equipment commonly used to take weight, measure length/height and then how to take MUAC measurements.
- We will also learn how to interpret growth charts

The participants will be able to see the anthropometric equipments used to take weight and height/length measurements

Step 1: Ask participants, to mention types of weighing scales used in their health facility.

Step 2: Wait for a few responses then show the ones you have provided for the session, and ask them to turn to the handout on anthropometric equipment

Step 3: Ask participants to turn to the growth charts hand out from the mother and child handbook.

Step 4: Facilitator explains to the participants the layout of the growth charts using the points below

- Growth is monitored through weighing children and taking their height/length regularly.
- The weights and heights are plotted on a growth chart in the mother and child handbook
- There are two growth charts in the mother child handbook. One for boys(blue) and one for girls(pink)
- Each growth chart has 2 sides one side is for recording Weight-for-Age while the other side is for recording height/length for age
- There are six printed lines (2 green, 2 yellow and 2 red) that run across the chart. (as shown in the growth charts in the MCH Handbook)
- These are called reference lines.

Weight -for-Age (underweight)

- When a child's growth curve falls between the lower green and the upper green lines the child is growing normally
- When the child's growth curve falls between the lower green line and the lower yellow line, the child is growing normally but at risk of under nutrition (underweight).
- When it falls between the upper green line and the upper yellow line, the child is growing normally but at risk of over nutrition (overweight).
- When the child's growth curve for Weight-for-Age falls between

the lower yellow line and the lower red line, the child is moderately underweight. This child requires further screening refer to the health facility for support

- When the path falls between the upper yellow line and the upper red line (Weight-for-Age), the child is overweight.
- When it falls below the lower red line (Weight-for-Age), the child is severely underweight and requires further screening and admission to the relevant programme
- When the child's growth curve falls above the upper red line, the child is obese.
- EBF children may have Weight-for-Age above normal. Therefore it is important to reassure such mothers and encourage them to continue breast feeding their baby on demand.
- Children above 6 months that are overweight remember to take a feeding history 6-23 months and try and establish the amounts and variety of foods that the baby is receiving. Counsel the mother according to your findings
- Young children should not be put on a weight management programme. As the baby grows older encourage physical activities that other children same age are engaging in.

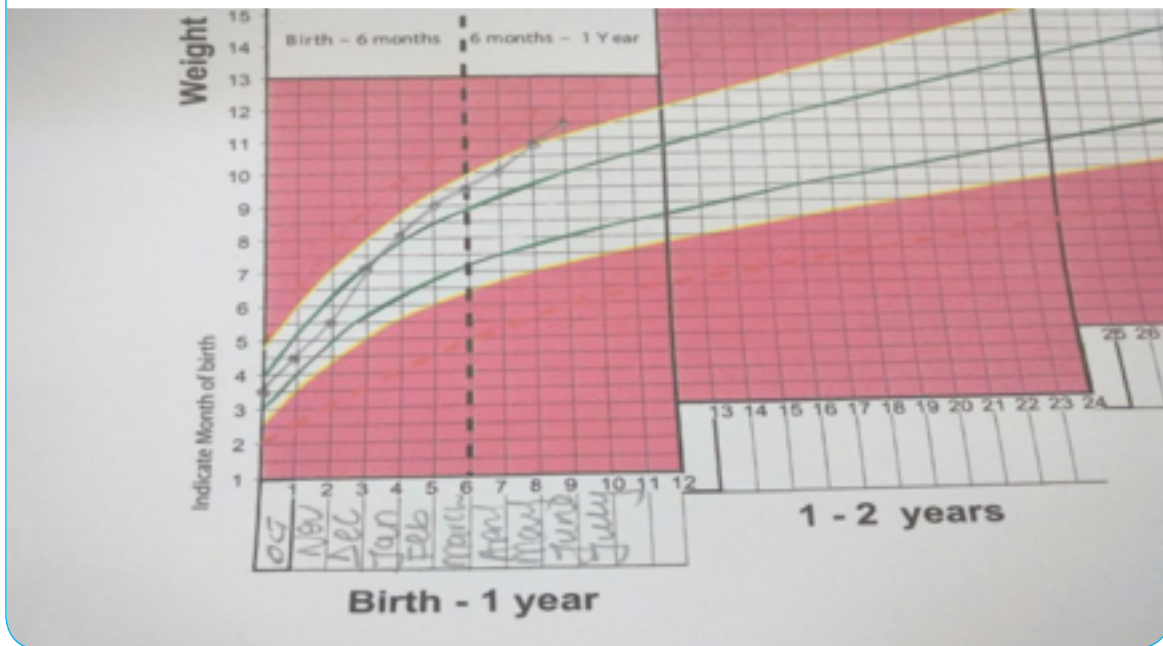
Length /Height- for- Age (stunting)

- Length /height -for-age reflect attained growth in the length or height at the child's age at a given visit.
- The indicator helps to identify children who are stunted (short) due to prolonged under nutrition or repeated illness.
- Excessive tallness may reflect uncommon endocrine disorders.

Explain to the participants how to interpret trends on plotted growth charts

Step 5: Ask participants to turn to their handouts on GROWTH CHARTS and buzz in threes and say what they see.

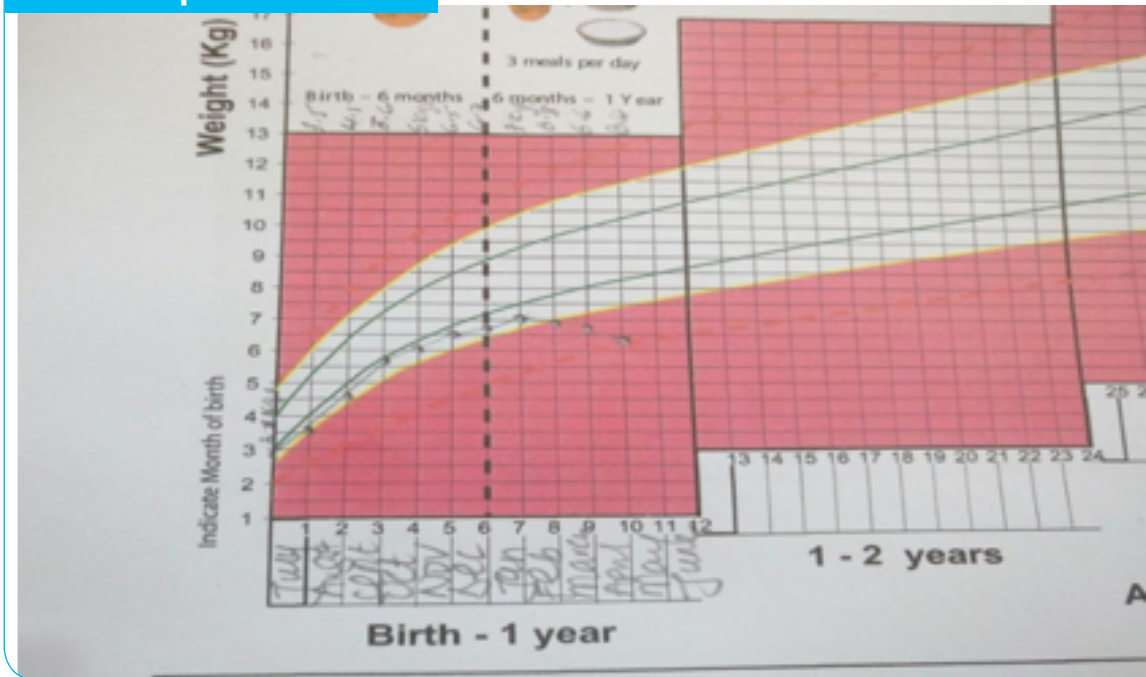
A: Sharp incline graph



Summarise the discussions using the notes below

- Any sharp incline or decline in a child's growth line requires attention.
- If a child has been ill or severely undernourished, a sharp incline is expected during the re-feeding period as the child experiences "catch-up" growth.
- Otherwise, a sharp incline is not good, as it may signal a change in feeding practices that will result in overweight.
- If a child has gained weight rapidly, look also at height. If the child grew in weight only, this is a problem.
- If the child grew in weight and height proportionately, this is probably catch-up growth from previous under-nutrition, because of improvement in feeding or cure of previous infection.
- In this situation, the weight-for-age and height-for-age charts should show inclines.

B: Sharp decline

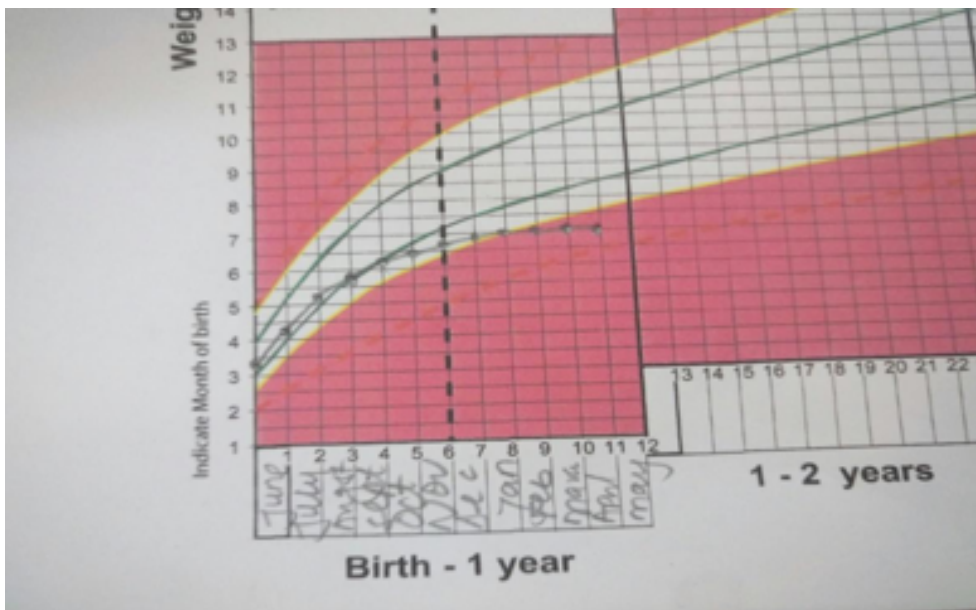


Summarise the discussions using the notes below

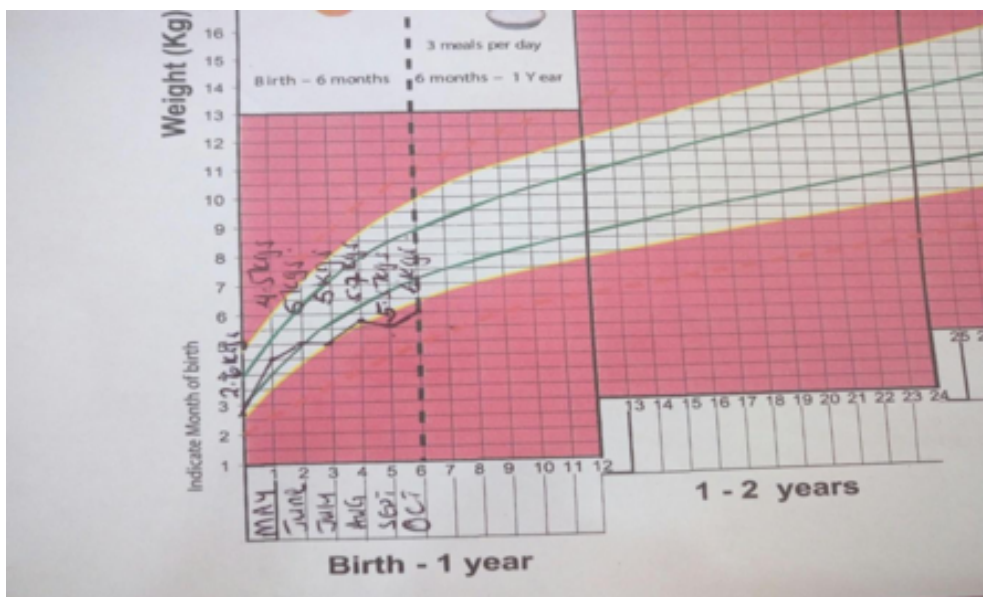
- A sharp decline in the growth line of a normal or undernourished child indicates a growth problem to be investigated and remedied.
- Even if a child is overweight, he or she should not have a sharp decline in the growth line, as losing too much weight rapidly is undesirable.
- The overweight child should instead maintain his weight while increasing in height; i.e. the child should “grow into his weight.”

C: Faltering growth line (stagnation)

C1-Flat/stagnating growth



C2: Wavering



Summarise the discussions using the notes below

- Faltering growth is an observation of slower than expected rate of growth along an infant growth curve, where the curve changes from normal weight gain.
- A flat growth line, also called stagnation, usually indicates a problem.
- If a child's weight stays the same over time as height or age increases, the child most likely has a problem. If height stays the same over time, the child is not growing.
- The exception is when an overweight or obese child is able to maintain the same weight over time, bringing the child to a healthier weight-for-height.
- If an overweight child is losing weight over time, and the weight loss is reasonable, the child should continue to grow in height. However, if the child experiences no growth in height over time, there is a problem. This problem would be evident as a flat growth line on the height-for-age chart.
- For children in age groups where the growth rate is fast, as shown by steep growth curves (e.g. during the first 6 months of life), even one month's stagnation in growth represents a possible problem.

What to be alert about when interpreting trends

- A child's growth line crosses a reference line.
- There is a sharp incline or decline in the child's growth line.
- The child's growth line remains flat (stagnant); i.e. there is no gain in weight or length/height.
- Check where the change in the growth trend began and where it is headed (catch-up or catch-down responses)
- Whether or not the above situations actually represent a problem or risk depends on where the change in the growth trend began and where it is headed.
- Thus, when a child is either failing to gain weight or is losing weight action may be taken as follows:
- Ask the mother if the child had been sick/or suffered any loss of appetite during the last month.
- Explain to the mother the meaning of the static or downward direction and position of the growth curve. Tell the mother that it is a cause for concern for both her and the health care worker.
- Ask the mother what food the child eats and how many times a day she feeds her child. Find out what other foods are available to her and together arrive at a way to improve the child's feeding.
- Explain to the mother the importance of bringing the child to the clinic regularly for weighing to know whether the child is growing well or not.
- An assessment of growth trends indicates whether a growth problem is chronic or of recent onset. Changes in growth trend are often linked with events such as illness.

Activity 4

Measuring MUAC

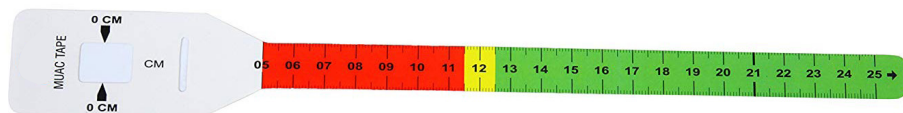
(25 minutes)

Participants will learn and practice how to take the MUAC measurement

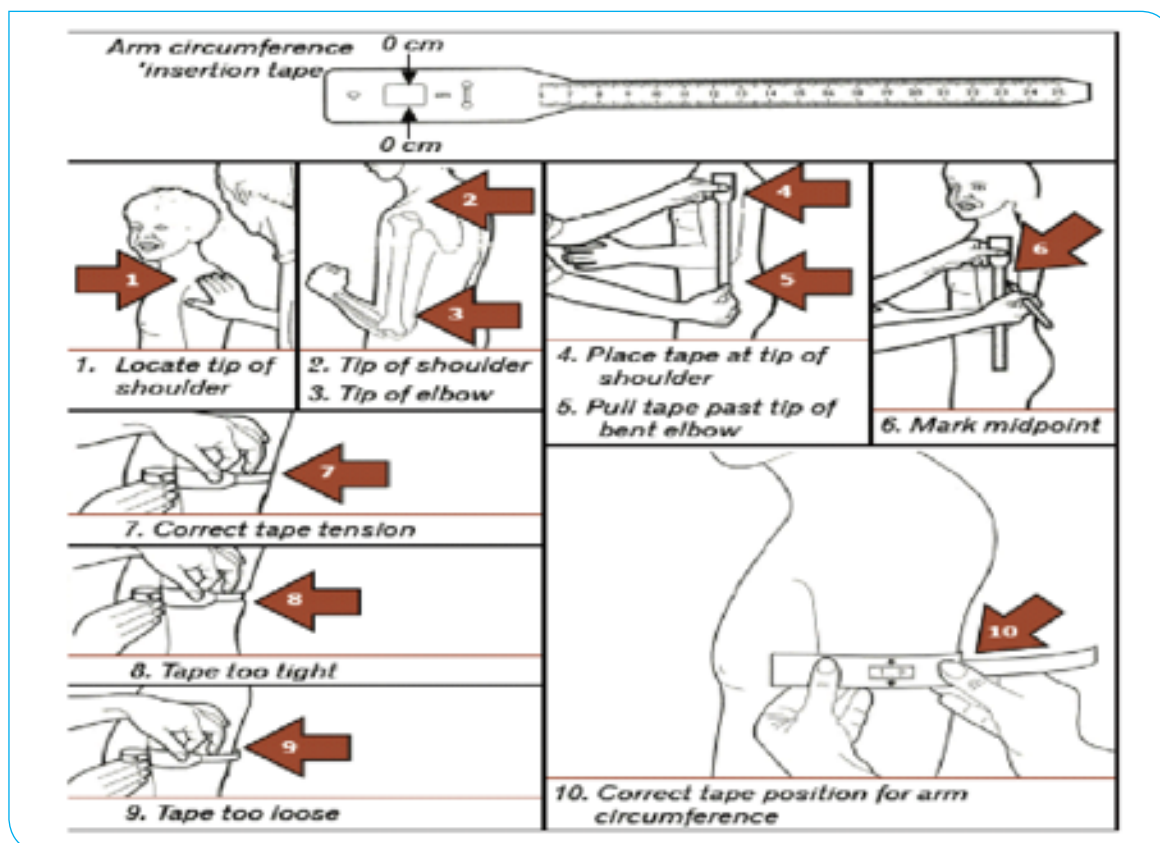
Step 1: Facilitator introduces MUAC to the participants by making the following points

- Children who are malnourished are at high risk of death and disease
- Identification, screening and referral are important so that appropriate care can be offered.
- Community Health Volunteers (CHVs) can identify children who are malnourished in the community by measuring the Mid Upper Arm Circumference (MUAC) and checking for swelling of both feet (Oedema).
- MUAC is often the screening tool used to determine malnutrition.
- MUAC (circumference of the left upper arm) is measured at the mid-point between the tip of the shoulder and the tip of the elbow, taken with the arm hanging down.
- MUAC is relatively independent of height
- It measures the muscle mass and fat stores under the skin
- It is used for bedridden patients, elderly persons, pregnant mothers, breastfeeding mothers and children.
- There are different tapes for measuring adults and children
- Pregnant women and breastfeeding mothers should also be screened using MUAC.
- A mother with a MUAC less than 21cm should be referred for appropriate care in the health facilities

Step 2: Show the participants how the MUAC tape looks like and ask them what the different colours mean.



Step 3: Distribute and demonstrate how to measure MUAC using a MUAC tape



Procedure of taking a MUAC reading

- Ask Mother to remove any clothing covering the child's left arm.
- Calculate the midpoint of the child's left upper arm:
- First locate the tip of the child's shoulder (arrows 1 and 2 in diagram below) with your finger tips
- Bend the child's elbow to make the right angle (arrow 3)
- Place the tape at zero, which is indicated by two arrows, on the tip of the shoulder (arrow 4) and pull the tape straight down past the tip of the elbow (arrow 5)
- Read the number at the tip of the elbow to the nearest centimeter.
- Divide this number by two to estimate the midpoint. As an alternative, bend the tape up to the middle length to estimate the midpoint. A piece of string can also be used for this purpose; it is more convenient and avoids damage to the tape.
- Mark the midpoint with a pen on the arm (arrow 6).
- Straighten the child's arm and wrap the tape around the arm at the midpoint. Make sure the numbers are right side up. Make sure the tape is flat around the skin (arrow 7)
- Inspect the tension of the tape on the child's arm. Make sure the tape has the proper tension (arrow 7), not too tight or too loose (arrows 8 and 9). Repeat any step as necessary
- When the tape is in the correct position on the arm with correct

tightness, read and call out the measurement to the nearest 0.1cm (arrow 10).

- MUAC reading should be recorded on the mother child handbook in the clinical notes section

Ask participants if they have any questions and answer them

Practical on MUAC Taking

- So far we have learnt how to take MUAC.
- We will now practice what we have learnt

Step 4: Divide the participant into groups of 4 or 5. Ask the participants to take turn in measuring each other's MUAC as the facilitators observe. Move around the groups with the help of the other facilitators and ensure that the participants are doing the right thing

Step 5: After everyone has participated, thank participants and ask them to share the difficulties they have encountered

Activity 5

Criteria for referral using MUAC

(10 minutes)

Participants will learn the importance of linkage and referral system to the level of care where nutrition interventions are offered for example counselling , supplementation and therapeutic feeding

- It is important for the Community Health Volunteers to be familiar with case finding and referral strategies.
- Some of the case finding strategies that can be shared to the CHV's could be screening children who are attending health centers, at vaccination sites, at homes through door to door
- Screening, at growth monitoring programs
- Children who are moderately or severely malnourished should be referred to the health facility

Classifying malnutrition using MUAC

Acute malnutrition (severity)	MUAC (cm)	Action to be taken
Healthy	>13.5	Encourage to continue with good practices
At risk	12.5 to 13.4	Assess feeding and illness, counsel on age appropriate feeding based on gaps identified, follow-up
Moderate	11.5 to 12.4	Refer to the health facility and give health and nutrition education
Severe	<11.5	Refer to the health facility and give health and nutrition education
	Kwashiorkor	

Activity 6

Checking for Oedema

(5 minutes)

Participants will learn how to check for Oedema

Step 1: Facilitator shows the participants how to check for oedema

- Apply moderate thumb pressure to just above the ankle or the tops of the feet for about three seconds(say...one hundred and one, one hundred and two, one hundred and three) on both feet at the same time
- If the pressing causes an indentation that persists for some time after the release of the pressure, then there is oedema
- Nutritional oedema is characterized by pitting on both feet



Summarize session

(3 minutes)

Ask the participants whether there be any question and answer them

Session 2

Early Childhood development and stimulation

Participants will understand the importance of Early Childhood Development and stimulation

Early Childhood Development and Stimulation

Objectives:

At the end of this session participants should be able to:

1. List key developmental milestones during early childhood
2. Discuss the importance of stimulation in early childhood
3. Give examples of age specific play and communication activities and age appropriate toys
4. Conduct a class room exercise on developmental milestones

Duration: 65 Minutes

Methodology: Lectures, brainstorming, interactive presentations, buzz (2 to 3 participants), role play, group work, question and answer, discussions, and demonstrations.

Materials: Storage container/box, assorted play toys, Flip charts, Marker pens, scissors, coloured manila papers, MIYCN counselling card number 39 and 40

Session plan

Duration	Topics	Methodology	Materials
2 minutes	Session introduction		
15 minutes	Key developmental milestones during early childhood	Discussion	MIYCN counselling cards – no. 39
10 minutes	Importance of stimulation in early childhood	Discussion	MIYCN counselling cards – no. 40
20 minutes	Sample age specific play, communication activities and toys	Group work Demonstration	MIYCN counselling cards – no. 40
15 minutes	Class room exercise on developmental milestones	Group work drill	Different coloured manila papers or sticky notes Marker pens Flip charts
3 minutes	Session summary		

Activity 1

Key developmental milestones during early childhood

(15 minutes)

Facilitator introduces the session on key developmental milestones during early childhood using the notes below

- In the past sessions we have learnt how to assess a child's growth using various anthropometric measurements and comparing the same with set standards.
- In this session we will be learning on how to assess developmental milestones as well as how to counsel caregivers on play and stimulation.
- This lesson discusses the stages, and major milestones of child development.

Step 1: Ask participants to brainstorm on the definition of the following terms:

- Child Development
- Early childhood
- Development milestones and give examples

Step 2: List their responses on a flip chart

Summarize using the note below

Child development: is the process through which human beings typically grow and mature from infancy through adulthood.

- Child development entails gaining skills in all aspects of the child's life such as cognitive development, social and emotional development, communication and speech development, motor skills and gross motor development (physical).
- The different aspects of growth and development include:
 - Cognitive development-learning to think and solve problems, to compare sizes and shapes and to recognize people and things,
 - social development –learning to communicate what is needed and use words to talk to another person
 - Emotional development- learning to calm oneself when upset, being patient when learning a new skill, be happy and make others happy
 - Communication and speech development- learning language and how to use it to communicate with others
 - Physical (motor skills and gross motor development) - learning to reach and grab an object and to stand and walk.
- All areas of development are linked together.

Early childhood is the period from birth to eight years old, and is a time of remarkable growth with brain development at its peak. It includes the period of infancy 0-2 yrs of age.

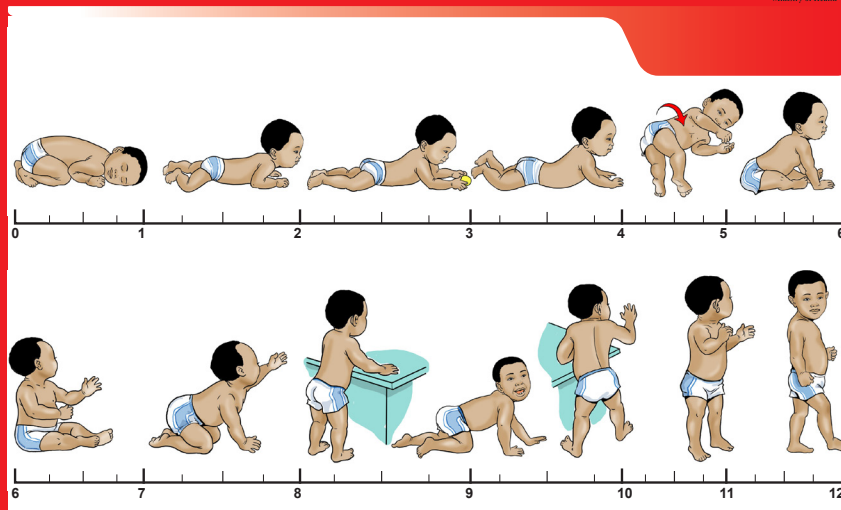
- Early childhood is a period of critical change and development as a child attains the physical and mental skills she/he will use for the rest of their life.
- During this stage it is important to offer responsive care to enhance the holistic development of a child's social, emotional, cognitive and physical needs in order to build a solid and broad foundation for lifelong learning and wellbeing.
- During this stage, children are highly influenced by the environment and the people that surround them and caregivers have the responsibility to nurture caring, capable and responsible future citizens
- Early childhood presents an incomparable window of opportunity to make a difference in a child's life. The right interventions at the right time can counter disadvantage and boost a child's development.
- Early childhood is not only the time that the brain develops most rapidly but a critical window of opportunity for establishing children's immunity and therefore the foundation of good health and optimal productivity in the future.

Lead a discussion on card number 39

Step 3: Ask participants to look at counseling card number 39 and say what milestone they see

Step 5: Facilitator to look out if they are able to associate each milestone with age of the child

Developmental milestones



Card
39

Summarize using the notes below

- Milestones refer to the age at which most children have reached a certain stage of development.
- Most children grow the same but the rate of development varies from child to child.
- Early detection of a delayed milestone will help address the problem before it's too late
- To achieve the full developmental potential in all these milestones, a child needs Responsive Care and affection during the earliest years
- During growth monitoring it is important to observe the developmental milestones for a child to ensure that they are developing well as per the age
- Ask caregivers to Seek guidance from the health care provider if they observe delays in their child's growth and development.
- Positive interactions through **play and communication** provide the **stimulation** that is key to achieving this maximum **developmental potential**

Step 7: Ask participants what additional developmental milestones are expected at certain ages?

Step 8: Wait for a few responses then proceed by showing the table on the counseling card no 39 **(with notes)**

Average Age for some development milestone	
Developmental milestone	Childs age
Social smile	4-6 weeks
Head holding/control	1-3 months
Turns toward the origin of sound	2-3 months
Extend hand to grasp a toy	2-3 months
Sitting	5-9 months
Standing	7-13 months
Walking	12-18 months
Talking	9-24months

Activity 2

Importance of stimulation in early childhood

(10 minutes)

Step 1: Ask participants to brainstorm on what cues do infants and young children use when communicating to their parents/caregivers and what does each cue mean?

Step 2: List their responses on a flip chart
Summarize using the notes below

- Early childhood stimulation is the interaction between young children and their caregivers, providing children with the opportunity to learn about their environment from the earliest age.
- Stimulation is about parents and caregivers being responsive to the emotional and physical needs of their children from birth onwards by playing and talking to them
- In practice, stimulation is about parents and other caregivers being responsive to the emotional and physical needs of their children from birth onward, playing and talking with them (even before children can respond verbally), and exposing them to words, numbers, and simple concepts while engaging in daily routines.
- Play is the main component of early childhood stimulation and central to good mother-child interactions.
- Play is an opportunity for all the significant activities that enhance good development to take place.
- Caregivers should be sensitive and be able to respond immediately and appropriately to what the child is trying to communicate e.g. hunger, pain and discomfort, interest in something or affection.
- Responding immediately and appropriately to a child's needs is known responsive care

Step 3: Ask participants to turn to card number 40 on stimulation and say what they can observe

Stimulation



Card
40

unicef

Summarize the card using the notes below

- Positive interactions through play and communication provide the stimulation that is key to achieving the child's maximum developmental potential.
- Give your child affection and show your love.
- Be aware of your child's interests and respond to them.
- Praise your child for trying to learn new skills.
- Use the Counseling skills taught in the earlier session to counsel caregivers on the importance of stimulation.
- As you counsel identify practices to support the child's development

Activity 3

Sample age specific play, communication activities, play materials and toys

(20 minutes)

The facilitator together with CHVs will organize locally made playing materials for the children

Step 1: Ask participant to open counseling card number 40

Step 2: Facilitator reads out the activities on card number 40 aloud

Card 40: Stimulation

Additional activities that can be provided as a guide for the CHV's as they provide counselling)

Newborn-1 week

- Songs and lullabies.
- Encouraging child to grasp fingers (development of motor skills).
- Playing the tongue game (i.e. stick out the tongue as baby watches).
- Smiling.
- Whistling.



1 week-6 months

- Giving toys of different textures, so that children can feel them.
- Reading books and telling stories (important, even if the parent feels the child cannot understand).
- Showing pictures/photos.
- Massage.
- Songs and sounds.



- Tickling.
- Making faces.
- Holding objects away from their reach and having them reach out to grasp.

6-9 months

- Using bathing time to play with child (e.g., splashing water)
- Picture reading.
- Clapping – sounds and movement.
- Encouraging children to roll over.
- Playing with ball.



9-12 months

- Sand and water play.
- Encouraging children to stand and walk by placing attractive objects.



12-24 months

- Scribbling.
- Coloring.
- Dancing.
- High five, blowing kisses, bye bye.



- Aiming for target objects (to develop fine-motor skills and hand-eye coordination).
- Jumping.
- Stacking objects

2 years and older

- Running, playing catch, football.
- Jumping ropes.
- Reading.
- Role playing and telling stories.
- Sorting objects.
- Playing with others.
- Role plays and asking children to tell stories.
- Giving children simple choices/decisions.



Activity 4

Class Room Exercise On Developmental Milestones

(15 Minutes)

Conduct a group activity

Step 1: Divide participants into 2-4 groups.

- On a flip chart draw a blank table on average age for some development milestones (card 39, notes)

Developmental milestone	Childs age

- Copy the content of the two charts from the tables in the training Manual on different colored stickers/cards (each group to have their colour)
- Mix them in a bowl (for each group, in a different bowl)
- Give each group a bowl with their specific colored stickers/cards
- Give participants 15 Minutes to paste the colored stickers to the appropriate place in the charts
- Award 5 marks to the group that will finish first
- Call participants back to plenary
- Go through the charts awarding marks for each group (for every correctly fixed content award 1mark.
- Do the totals for each group at the end of the exercises
- Praise the group that did well
- Encourage the others to understand the age specific developmental milestones

Summarize session

(3 minutes)

Ask participants if they have any questions or seek clarification.

8

UNIT 8

HOUSEHOLD FOOD AND NUTRITION SECURITY

This unit is intended to orient the participants on household food security, and how it can be achieved.

Objectives

After completing this session, participants will be able to:

1. Define household food and nutrition security
2. Outline the factors that affect food availability
3. Describe food production strategies that enhance food and nutrition security
4. Identify the basic community level food processing and preservation methods
5. List the factors to consider in meal planning at family level
6. List appropriate wood fuel energy saving technologies

Duration: 2hr 45 minutes

Methodologies: Buzzing, brainstorming, group work, illustrations, demonstration, discussion

Materials: Flip chart, photos of types of home gardens, food samples and plate

Session Plan

Duration	Topics	Methodology	Materials
2 minutes	Definition of household food and Nutrition security	Brainstorm, lecture	Flip chart, marker pens, masking tape
20 minutes	Outline the factors that affect food availability	Group work Discussion, lecture	Flip chart, marker pens
50 minutes	List the strategies that enhance household food and nutrition security	Brain storming, discussion, illustrations, video lecture	Photos, projector, laptop, flip chart, marker pens
30 minutes	Identify the basic community level food processing and preservation methods	Group work, discussion, illustrations, lecture	Flip chart, marker pens, photos, projector laptop
40 minutes	List the factors to consider in meal planning at family level	Illustrations, demonstration, Lecture	Photos, projector, laptop, flip chart, marker, Real objects (fireless jiko)
20 minutes	List appropriate wood fuel energy saving technologies	Brainstorm, discussion, photos, lecture	Flip chart , marker

Activity 1

Definition of household food and nutrition security

(20 Minutes)

Participants will define household foods and nutrition security.

Step 1: Ask participants to brainstorm on what they know and understand by the term household food and nutrition security

Step 2: Note down key words of the definition on a flip chart
Summarize using the definition in the notes below:

Definition of food and nutrition security

- Food security occurs when “all people at all times have physical and economic access to sufficient food to meet their dietary needs for a productive and healthy life”.
- This definition is anchored on three fundamental elements:
 1. Adequate food availability;
 2. Adequate access to food by all people (i.e., the ability of a household to acquire sufficient quality and quantity of food to meet all household members’ nutritional requirements for productive lives); and
 3. Appropriate food utilization/consumption
- The three elements have a hierarchical relationship:
 - Food must be available for households to have access,
 - A household must have access to food for individual members to have appropriate food utilization/consumption.
- All three elements must be achieved for food security to be attained

Activity 2

Outline the factors that affect food availability

(20 Minutes)

Participants discuss the factors that affect food availability in groups.

Step 1: Divides the participants into 4vgroups and asks the groups to choose a leader

Step 2: Ask the groups to discuss on factors that affect food availability and list them on a flip chart.

Step 3: Group leaders present in plenary.

Summarize the presentations with the following notes below

Factors affecting food availability

- Food availability is determined by the physical quantities of food that are produced, stored, processed, distributed, purchased and exchanged.
- It can be ensured through own production, purchase with money, barter trade or combined approach.
- Availability varies throughout the year; high market prices of food are a reflection of inadequate availability of food.
- High prices Cause people with limited resources to reduce consumption of food.
- Growing scarcities of land, water and fuel are likely to put increasing pressure on food prices.
- Enhancing food access has a key role in ensuring nutrition security.

Activity 3

Strategies that enhance household food and nutrition security (40 Minutes)

Participants brainstorm on the strategies that enhance household food and nutrition security

Step 1: Ask participants to brainstorm on the strategies that enhance household food and nutrition security

Step 2: List their responses on a flip chart

Summarize the discussion using the notes below

Strategies to enhance household food security

1. Growing diversified foods by;
 - Planting drought and pest resistant food crops like cassava, sorghum etc
 - Planting early maturing crops
 - Planting micro nutrient rich foods/bio fortified foods like the orange-fleshed sweet potatoes and local vegetables
2. Establishing an integrated kitchen garden: Which includes;
 - Small livestock like poultry to provide eggs and meat, rabbits, goats, sheep for meat
 - Assorted vegetables
 - A fruit trees
 - Staple food sources
 - Herbs, spices and medicinal plants
 - Appropriate gardening technology can be used to ensure continued supply of fresh foods throughout the year.
 - Liaise with agriculture extension officers or home economists.

Kitchen gardens

(5 Minutes)

Participants to brainstorm on the definition and advantages of a kitchen garden

Step 1: Ask participants to brainstorm on what they understand by the term kitchen garden and what are the advantages of a kitchen garden

Step 2: List their responses on a flip chart

Summarize the discussion using the notes below

Kitchen gardening

Definition of a kitchen garden

This is any convenient size of plot near a homestead where a variety of crops grown are mostly used for family consumption. Home gardening includes keeping of small animals such as rabbits, chicken, fish etc

Advantages of kitchen gardens

- A source of fresh relatively cheap and accessible foods for the family
- A good source of micronutrients e.g. green leafy vegetables, legumes and fruits which are rich in micronutrients such as vitamin A and C.
- Generates income from the sale of surplus produce. The income from the home garden can be used to purchase food items that the family cannot produce, thus adding a variety to the meals, supplementing production and other needs.
- Home gardens act as a safety net in low seasons when staple foods are depleted and before new crop is ready.
- Maintains genetic diversity

Steps in establishing a kitchen garden

Participants state the steps in establishing a vegetable garden

(10 minutes)

Step 1: Ask participant to brainstorm what they think are the steps in establishing a kitchen garden

Step 2: List their responses on a flip chart

Summarize the steps using the notes below

Steps in establishing a kitchen garden

- Site selection
 - Land preparation
 - Planting
 - Crop husbandry (weeding, pest and disease control, fertiliser and manure application, irrigation, staking & trellising, pruning, harvesting)
 - Post-harvest management (preservation, storage, processing)
- Liaise with agriculture extension officers and home economists.

Kitchen gardening technologies

Participants discuss on kitchen gardening technologies.

(10 minutes)

Step 1: Ask participants to buzz in twos on the types of kitchen gardening technologies they know.

Step 2: List their responses on a flip chart.

Step 4: Ask participants to look at counseling card number 41 and buzz in twos on the kitchen gardening technologies in the cards in reference to their responses.

Summarize the discussion by showing the participant's the kitchen gardening technologies below and explain them

KITCHEN GARDENING TECHNOLOGIES



Tyre garden



Hanging garden



Hanging garden



Multi storey garden



Micro-garden



Ordinary kitchen Garden

TECHNOLOGIES (contd)



Staircase garden



Green house technology



Raised moist bed



Container gardens



Drip irrigation

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KITCHEN GARDENING TECHNOLOGIES



Small scale Drip irrigation



Poultry/fish and Fruit tree farming

Keeping small livestock.

(15 Minutes)

Participants discuss on importance of keeping small livestock

Step 1: Ask participants to be in their already formed groups and select someone to present their work

Step 2: Ask participants to discuss the importance of keeping small livestock, reasons for keeping small livestock, identify small livestock that can be kept and identify livestock husbandry measure to undertake for healthy livestock rearing

Step 3: Groups present in plenary.

Summarize the discussion using the notes below

Importance of keeping small livestock

- Crop farming alone cannot meet the family needs
- Hence the need to keep small livestock (pigs, goats, sheep, rabbits & poultry).
- Rearing small livestock is particularly important livelihood. It Supplies the much-needed nutrition (milk, eggs, meat, blood, etc.) and income (sell of excess).
- Integrating animals into cropping systems is important in nutrients recycling (composting, feeds)
- By-products (dung, biomass from field or processing wastes) are cheap & available fuel, fodder, manure

Participants discuss the reasons for keeping small livestock

Reasons to keep small livestock

- Women who are responsible for household nutrition have control over small livestock
- Livestock yield products such as milk, meat, blood and eggs for home consumption or sale.
- They recycle by-products such as straw, kitchen and farm waste into manure.
- Serve as an investment or a bank. (Sold when cash is required)
- They can produce dung which is of great importance for soil fertility of the kitchen garden, biogas production and for other fuel products

Participants identify small livestock that can be kept. Refer the participants to the hand out on gallery of small livestock rearing and small live stock and counseling card number 42

Gallery of small livestock rearing



Indigenous poultry and layers



Dairy keeping



Goat keeping

SMALL LIVESTOCK CONT.



Pig

Rabbits

Rabbit skin



Broiler
chicken



Milk goat

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Participants identify livestock measures to undertake for healthy livestock rearing (10 minutes)

Livestock husbandry measures to consider for keeping small livestock

Setting of the animal project

- Know the type of livestock you want to keep
- Fodder and feed should be in adequate quality and quantity; for non-ruminants: diversity in fodder is usually required.
- Have access to sufficient clean drinking water.
- Have appropriate sheds /housing of sufficient size and with adequate light and fresh air.
- Have sufficient freedom to move around and perform their natural behavior.
- Healthy conditions and veterinary follow up, for vaccination and treatment regime is needed (for vaccines consult a veterinary officer).
- Sufficient contact with other animals, but no stress due to overcrowding.
- For herd animals: an appropriate age and sex distribution within the herd

Activity 4

Food processing and preservation

(30 Minutes)

Participants brainstorm on what they understand by the term food processing and preservation

Step 1: Ask participants to brainstorm on what they understand by the term food processing and preservation

Step 2: List their responses on a flip chart

Summarize the definition using the notes below

Food processing

- Food processing means doing something to a food in order to: preserve it, remove harmful substances, make it easier to handle, store, cook or digest and add nutrients.

Food preservation

- It is the process of treating and handling food in a way that it maintains its edibility and nutritional value. The main aim is to slow down or stop spoilage to prevent food-borne illnesses through contamination.

Benefits of food processing and preservation

Participants brainstorm on the benefits of food processing and preservation

(10 minutes)

Step 1: Ask participants to brainstorm on the benefits of food processing and preservation

Step 2: List their responses on a flip chart

Summarize the benefits of food processing using the notes below

Benefits of food processing

- Provides convenience foods requiring little time for preparation.
- Minimizes post-harvest losses and thus strengthen food security
- Removes toxins and makes foods safe to eat by de-activating spoilage and pathogenic micro-organisms.
- Enables transportation of delicate perishable foods across long distances and increases seasonal availability of many foods.
- Improves preservation, easy marketing and distribution of perishable foods
- Increases food consistency
- Preserves nutrients

Benefit of food preservation

- Contributes to household food security and better nutrition, reduces seasonal shortages, preserves nutrients and post-harvest losses as well as increases income through food processing.

Food preservation Methods

Participants to discuss the food preservation method that are common in their area or those they know

(10 minutes)

Step 1: Ask participants to be in their already formed groups and select someone to present their work



Step 2: Ask participants to discuss the food preservation methods that are common in their area/those that they know and record them on the flip chart.

Step 3: Groups present in plenary

Step 4: Ask participants to look at the photos on their hand outs on drying technologies

Summarize the discussion using the photos below

DRYING TECHNOLOGIES



Solar drying compartment. Drying peeled raw bananas



Drying tray – drying vegetables



Dried kales



Dried kales

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DRIED MEAT



Meat preservation: Drying process, dried meat and meat fried until dry (nyirinyiri)







Dried green locust delicacy



Dried edible white ants

270

DRIED FOOD PRODUCTS



Dried cassava chips aired to dry and packaged, Cassava flour)

Example of industrial processed foods: Fortified Maize flours



Vegetable Drying

Step in drying

- Wash the freshly harvested green leafy vegetable
- Shred the vegetables (do not shred very thinly)
- Blanch (dip in boiling salted water) for about 5 seconds
- Remove and run under cold water
- Spread thinly on a tray/solar drier and dry for about 1 hour or until completely dry
- Store in airtight containers

Food preservation methods	Examples
<p>Drying reduces water in the food thus preventing or delaying bacterial growth.</p>	<ul style="list-style-type: none"> • Dried :fish, meat (cut into thin strips and dried in the sun). • Dried vegetables (e.g.kales, mushrooms, fruits (e.g. mangoes). • Cereals (e.g. maize, sorghum, millet, cassava).
<p>Salting and curing Salting draws moisture from the food.</p> <p>Sugar is used to preserve fruits. The fruits can be preserved either in syrup or cooked in sugar to the point of hardening then stored in jars.</p>	<ul style="list-style-type: none"> • Meat, fish, insects. • Apples, pears, citrus fruit, plums for jam.
<p>Fat/oil treatment (Potting) is a traditional way of preserving meat and other cooked foods by setting it in a pot and sealing it with a layer of fat or just covering with a lid/ banana leaves</p>	<ul style="list-style-type: none"> • Meat
<p>Burying in the ground: Many root vegetables are very resistant to spoilage and require no other preservation than storage in cool dark conditions e.g. burying.</p>	<ul style="list-style-type: none"> • Sweet potatoes, cassava, arrow roots, yams, potatoes.
<p>Fermentation: A process where micro-organisms (good bacteria) in food changes sugars in the food to acid or alcohol and keep longer.</p>	<ul style="list-style-type: none"> • Sour milk, sour porridge.
<p>Freezing: Can be used to preserve food by storing in refrigerators where power is available.</p>	<ul style="list-style-type: none"> • Milk, githeri, legumes.
<p>Removal of harmful substances (Anti nutrients) This can be done by soaking, fermenting and drying of bitter and toxic cassava which removes harmful substances from the roots. Pounding and boiling for at least 20 minutes removes harmful substances from the leaves.</p>	

Utilization of preserved foods

Participants will brainstorm on how to utilize preserved foods that they know
(10 minutes)

Step 1: Ask participants to brainstorm on how to utilize preserved foods that they know

Step 2: List their responses on a flip chart

Summarize the discussion using notes below

How to Use Dried Foods

- Dried vegetables and fruits can be used alone, in combination with other foods, or to add flavour.
- Rehydrating is done by soaking or cooking (or a combination of both) the dried food in water until the desired volume is restored. Vegetables such as spinach, kale, cabbage or tomatoes are refreshed by covering with hot water and simmering to desired tenderness. Root (Arrowroots), stem (carrot) and seed vegetables (green pepper, French beans, cucumber) are soaked 1/2 to 1-1/2 hours in enough cold water to keep them immersed. After soaking, they are simmered until tender, and excess water is allowed to evaporate. If dried vegetables are added to boiling water, refreshing takes less time.
- Dried fruits are soaked in hot water and then cooked, if appropriate, in the soaking water. If extra water is needed for preparation, it can be added after the soaking period.
- Dried vegetables are best used as ingredients for soups, sauces and stews. Dried vegetables that have been refreshed take less time to cook than fresh vegetables. Dried fruits can be eaten as is or refreshed and cooked until tender. Spices or flavorings such as cinnamon, ginger and nutmeg can be used to enhance flavor. Dried fruits can be used in desserts, breads, pies or puddings.
- Do not add sugar until fruit is tender, because sugar will toughen the product.
- Dried foods should be refreshed only when ready to use.
- Do not store rehydrated foods. Drying temperatures are not high enough to destroy all microbes, so use quickly after rehydration
- For vegetables, use boiling water; for fruits, use water at room temperature.

Activity 5

Meal Planning and Management

(40 minutes)

Participants will discuss the definition of meal planning, list the factors that affect meal planning, list the benefits of meal planning, develop local menus and recipes using locally available foods and learn the proper cooking methods for nutrient retention.

Definition of meal planning

Participants will understand the term meal planning

(5 minutes)

Step 1: Ask participants to brainstorm on what they understand by the term meal planning

Step 2: List their responses on a flip chart

Summarize the definition using the notes below

Meal planning

Meal planning entails all decisions and activities undertaken in order to make meals or food affordable and yet still attain its intended purpose in the human body. Decision-making in the purchase of wholesome food is the responsibility of the head of the household

Factors affecting meal choices

Participants will learn about factors affecting meal choices.

(5 minutes)

Step 1: Ask participants to be in their already formed groups and select someone to present their work

Step 2: Ask participants to discuss the factors that affect meal choices and list them on a flip chart

Step 3: Groups present in plenary

Summarize the discussion using notes below

Factors affecting meal choices include:

- Available foods in farm, kitchen garden, stores, market, local shops
- The cost of the food and available income
- The family size
- The specific needs for each of the family members (e.g. baby, pregnant, breastfeeding mother, sick, teenager, elderly)
- Access and cost of fuel e.g. charcoal, firewood, kerosene, gas, biogas, electricity, solar etc.
- The tastes and preferences of the family
- Religious beliefs, and cultural practices

Benefits of meal planning

Participants will learn about the benefits of meal planning.

(10 minutes)

Step 1: Ask participants to brainstorm on what they think are benefits of meal planning

Step 2: List their responses on flip chart

Summarize using the notes below

Benefits of Meal Planning

- **Save Time:** When you make a meal plan, you can select easy recipes that don't require a lot of preparation work. After selecting your recipes, make a grocery list. You can buy what you need for the entire week without return trips to the store for forgotten items.
- **Save Money:** There are three main ways that meal planning saves money. You can choose recipes that take advantage of sales at the local grocery store. When you build your grocery list around a meal plan, you buy only what you need and avoid impulse shopping. Eating at home is more economical than dining out.
- **Manage your dietary intake:** When you eat at home, you have more control over the ingredients in your meals. Restaurant dishes contain ingredients you don't know or need. You will use recipes with ingredients you trust and serving sizes you understand.
- **Improve Family Relationships:** Studies show that the more often families eat together the more they bond and the more likely the children are to do well in school, eat their vegetables, helps prevent snacking that leads to obesity
- **Meal planning can stimulate growing own foods** which give fresh source of foods,
- A personalized weekly meal plan **contributes to household food security** by promoting food preservation and making correct food choices

Develop local menus and recipes using locally available foods

Participants will learn how to develop a menu and recipe using locally available foods

(10 minutes)

Steps 1: Ask participants to be in their already formed groups and select someone to present their work

Step 2: Ask groups to formulate a nutritious meal plan for one day using the food calendar developed e.g. breakfast, lunch, snack and supper.



Step 3: Groups present in plenary

Step 4: Guide the participants on how to populate the weekly sample menu based on locally available foods and using the food calendar developed by participants

Summarize the discussion using the resource notes below and make reference to the demonstrated meal plan by the participants.

Template of a sample weekly menu.

Day	Breakfast	Lunch	Snack	Supper
Sunday				
Monday				
Tuesday				
Wednesday				
Thursday				
Friday				
Saturday				

Consider the following when planning meals for your family

- Color, texture, flavor, temperature, meal presentation, preparation method, and dietary diversity

How it works.

- Choose what you like to eat
- Select your dietary preferences taking into consideration diversified diets
- Note which day you would like to go shopping (for the people who purchase their foods)
- Choose your plan (3 months, 6 months, 12 months)
- Draw your weekly menu, shop bulk & Save money and time. Alternatively, for those who grow foods for own consumption, preserve the foods when in excess and save.

Proper cooking methods for nutrient retention

Participants will learn proper cooking methods for nutrient retention (10 minutes)

Step 1: Ask participants to brainstorm on proper cooking methods for nutrient retention

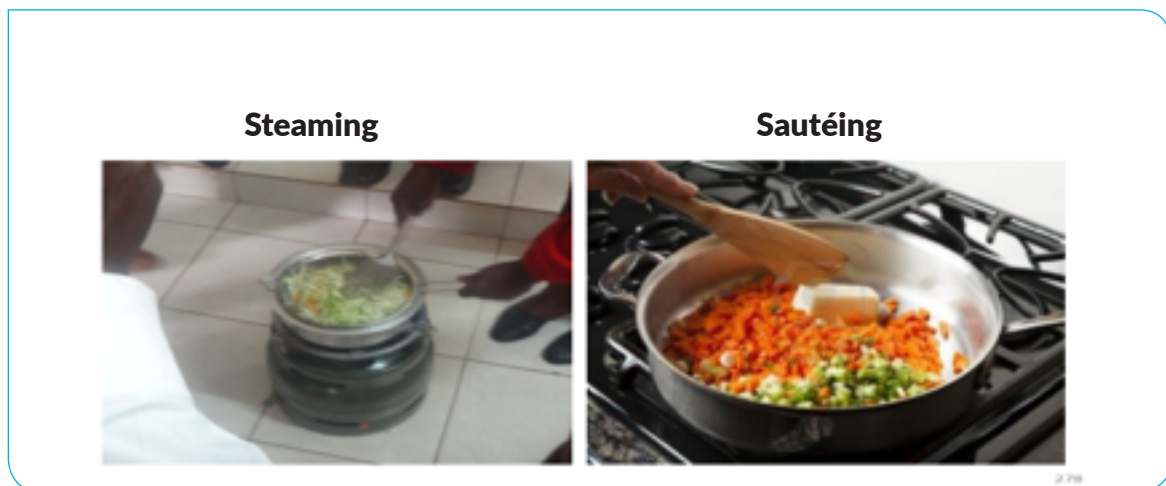
Step 2: List their responses on a flip chart

Summarize the discussion using the notes and photos. Refer the participants to their hand outs

Cooking methods for nutrient retention

- Preparing food for eating generally requires selection, measurement and combination of ingredients in an ordered procedure so as to achieve desired results.
- Food preparation includes but is not limited to cooking.
- Food is cooked for a number of reasons:
- Cooking changes and enhances the flavour of many foods
- It increases palatability
- It improves digestibility of foods
- It improves the texture and aroma of foods
- Preserves nutrients

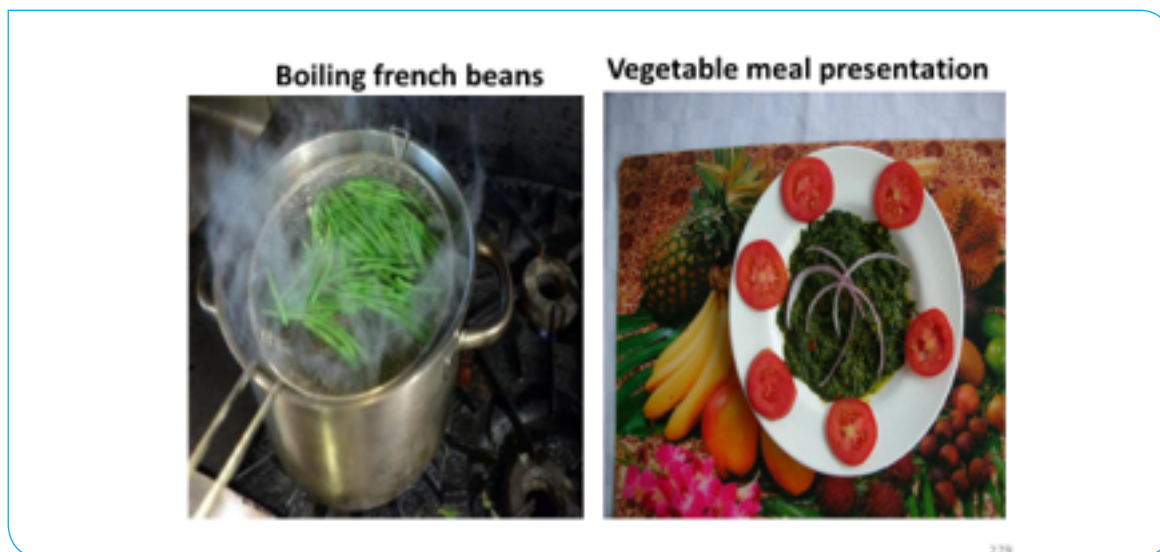
Cookery -steaming and sautéing



Steaming

- Steaming is the best methods for cooking food to retain nutrients
- Steaming is a quick method of cookery.
- Steaming retains the colour, flavour and nutritional value of food.
- It is a fat-free method of cookery and therefore healthier.
- This can be achieved on a normal pan/sufuria or by placing a colander over a pot of boiling water.
- A major benefit of steaming is that it retains the colour, flavour and nutritional value of food. Steaming (unlike boiling) will not greatly enhance the flavour of a dish.

Cookery- boiling and vegetable meal presentation



- Boiling Root vegetables are placed into cold water and then brought to the boil. The vegetables cook more evenly.
- Rice and flour for ugali are placed into water that is already boiling. This sets the starch and stops the food sticking together or lumping.
- Blanching- Green and leafy vegetables are placed in boiling water. This reduces the loss of colour and nutrition.

Activity 6

Appropriate Wood Fuel Saving Technologies

(15 minutes)

Participants will outline the importance of saving fuel energy to household food and nutrition security and identify different types of household wood fuel energy saving technologies

(15 minutes)

Step 1: Ask participants to be in groups formed earlier and select someone to present their work

Step 2: Ask participants to discuss the importance of saving fuel energy for household food and nutrition security

Step 3: Groups present in plenary

Summarize the discussion using with notes and photos below

Importance of wood fuel energy saving to household food and nutrition security

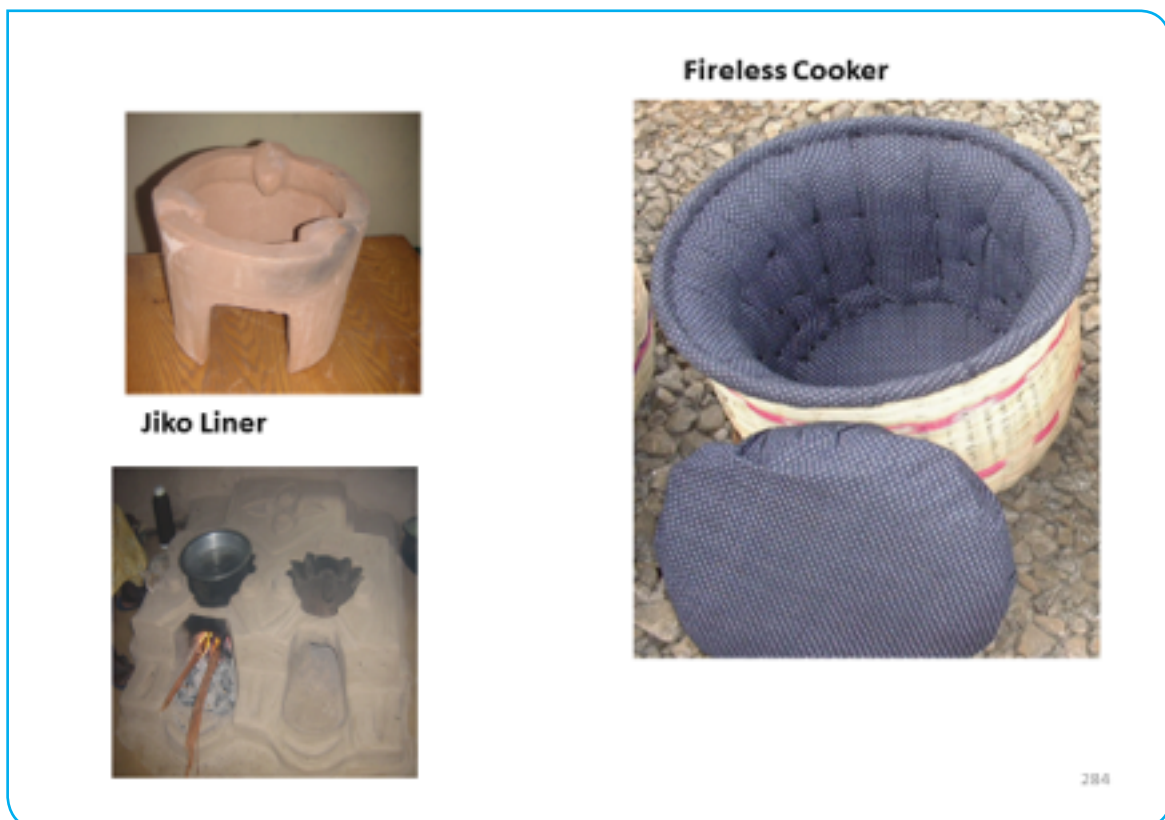
- Fuel energy saving technologies reduce demand on wood fuel and save money for the household
- It also leads to improved in-door air condition and time is saved in cooking.
- This has important implicate for empowering women by greatly reducing their work load, freeing them to engage in other income generating activities
- Children are safe from accidental burning so common in kitchens using traditional three stones fires, which have no protective cover.
- It is easy to make and its durable

Different types of household wood fuel energy saving technologies

Step 1: Ask participants to brainstorm and identify different types of household wood fuel energy saving technologies

Step 2: Record their responses on a flip chart

Summarize the discussion using the following photos and resources notes below. Refer participants to the hand out for the photos



Maendeleo Liner stove

- The maendeleo liner stove is built around a special pottery liner.
- This liner automatically gives the proper size and pot rests which assures top efficiency.
- A tongue supports the wood so air can flow below the wood into the fire, and also so that long pieces of wood will not fall out.
- By being protected from wind and excess air, the fire burns hot and clean. You can have two or more inserts in your kitchen.

Fireless Cooker

- A fireless cooker is an insulated basket container or box that is designed to complete cooking that has been partially started on conventional cooking methods e.g. open fires, charcoal , firewood , paraffin , gas and electrical cookers.

Main uses:

- It completes cooking which has been partially cooked
- It is a food warmer as it can keep food hot for more than 8 hours e.g. chapatti, rice etc.
- Can be used to maintain the temperature of cold drinks
- Yoghurt can be processed in the basket for the purpose of maintaining it cool temperature

Appropriate Wood Fuel saving technologies

Charcoal Briquettes



How to use charcoal briquettes



- Charcoal briquettes is a technology where waste like charcoal dust, waste papers etc. are used to make charcoal briquettes that are used like charcoal for fuel
- Shortage of fuel for cooking is one of the many problems faced by people in the homes.
- Gathering fuel is generally women's work but is fraught with dangers; it's becoming scarce by the day due to deforestation, population growth coupled with climate change.
- In certain areas, firewood is completely depleted, leading women to travel further and further which is time consuming. Firewood which is over relied on in most households is potentially deadly due to smoke fumes.
- Practical Action for tackling these issues is the use of more fuel-efficient woodstoves, which are both affordable and easy to use
- Cutting the amount of firewood that needs to be used allows more trees the opportunity to grow. Subsequently, burning smaller amounts of wood fuel means less smoke in the kitchen hence better health

Summarize session

(5 minutes)

Ask participants if they have any questions or seek clarification

9

UNIT 9:

ESTABLISHING BABY FRIENDLY COMMUNITIES

In this unit, participants will learn how to expand the tenth step (10th) of BFHI through a community-based initiative known as Baby Friendly Community initiative (BFCI)

Session 1

Introduction to Baby Friendly Community Initiative

In this session, participants will learn about the baby friendly community initiative

Objectives

After completing the session, participants will be able to:

1. Define Baby friendly community initiative (BFCI)
2. List and explain the 8 steps of BFCI

Duration: 60 Minutes

Methodologies: Buzzing, brainstorming, discussion, group work, facilitative lecture, gallery walk

Materials: Flip chart, marker pen, masking tape, 8 point plan, MIYCN policy statement

Session Plan

Duration	Topics	Methodology	Materials
2 minutes	Introduction to BFCI	Lecture	Flip chart, marker pen, masking tape
5 minutes	Definition of BFCI	Buzzing, Facilitative lecture	Flip chart, marker pen, masking tape
50 minutes	8 steps to BFCI	Buzzing, group discussions, gallery walk	8 steps to BFCI
3 minutes	Session summary	Lecture	Flip charts, marker pens

Activity 1

Definition of Baby friendly community initiative

(5 minutes)

Participants will brainstorm on the definition of baby friendly community initiative

Step 1: Ask the participants to brainstorm on the definition of the Baby Friendly Community Initiative as defined in unit 1.

Step 2: Wait for a few responses

Summarize the discussion using the notes below

- Baby friendly community initiative (BFCl) is a community-based initiative to promote, protect and support, breast feeding, optimal complementary feeding and maternal nutrition
- It also includes environmental sanitation and hygiene, early childhood stimulation, referral and linkages, HIV services and other nutrition sensitive programmes
- Works through:
 - Formation community mother support groups (CMMSG) and mother to mother support groups (MtMSG) with close links to health centres and local authorities.
 - Home visitation
 - Community campaigns for Maternal Infant and Young Child Nutrition (MIYCN)
- The community Units (CUs) are used as the main entry for BFCl implementation

Resource notes

- The BFCl was developed to expand the 10th step to successful breastfeeding
- The tenth step states “ coordinate discharge so that parents and their infants have timely access to ongoing support and care” hence mother to mother support groups have been used as the main strategy for establishment of BFCl
- The focus of BFCl is support for mothers at community level (Tier 1 and 2)
- It covers intervention to improve maternal, infant and child feeding focussing mainly on the first 1000 days.

Activity 2

Discussing activities to conduct for each BFCl step

(50 minutes)

Participants will brainstorm on ways they can contribute towards the 8 steps to BFCl

Step 1: Display 8 pre prepared flip charts each with one step of BFCl in different corners of the room and explain each of the steps.

Step 2: Divide the participants to 8 groups randomly by asking them to count 1-8

Step 3: Ask each group to identify ways in which the community can contribute to achieving the step and to record their responses on the flip chart

Resource notes

8 steps of BFCI

1. Have a written MIYCN policy summary statement that is routinely communicated to all health providers, community health volunteers, and the community members.
2. Train all healthcare providers and community health volunteers, to equip them with the knowledge and skills necessary to implement the MIYCN policy
3. Promote optimal maternal nutrition amongst women and their families
4. Inform all pregnant women and lactating women and their families about the benefits of breastfeeding and risks of artificial feeding
5. Support mothers to initiate breastfeeding within one hour of birth, establish and maintain exclusive breastfeeding for first six months. Address any breastfeeding problems.
6. Encourage sustained breastfeeding beyond six months to two years or more, alongside the timely introduction of appropriate, adequate and safe complementary foods while providing holistic care (physical, psychological, spiritual and social) and stimulation of the child.
7. Provide a welcoming and supportive environment for breastfeeding families
8. Promote collaboration between healthcare staff, CMSG, MtMSG and the local community

Step 4: Do a gallery walk from one group to the other, as the assigned rapporteur from each group presents their points.

Step 5: Summarize each step during the gallery walk using the table below.

BCFI STEP	COMMUNITY ACTIONS	JUSTIFICATION
<p>Step 1: Have a written MIYCN policy summary statement that is routinely communicated to all health providers, community health volunteers, and the community members.</p>	<ul style="list-style-type: none"> Clearly display the policy in strategic areas where mothers and children frequent Development of community code of care for mothers and babies 	<ul style="list-style-type: none"> For guidance and standardization
<p>Step 2: Train all HCW and CHV to equip them with knowledge and skills necessary to implement the MIYCN policy</p>	<ul style="list-style-type: none"> Identification of CHVs to be trained on BFCI Maintenance of a community Training database, schedule of reports Keep record of minutes of all CHVs/CHA meetings 	<ul style="list-style-type: none"> Monitoring knowledge and skills development and community actions
<p>Step 3: Promote optimal maternal nutrition amongst women and their families</p>	<ul style="list-style-type: none"> Promotion of dietary diversity using locally available foods Promotion of IFAS uptake through out pregnancy Encourage families to provide extra meals for women during pregnancy and breastfeeding. Enhance dietary diversity among women and their families through kitchen gardening and domestic animal rearing 	<ul style="list-style-type: none"> Prevent Premature labour, Low birth weight and other birth related complications due to undernutrition and anaemia
<p>Step 4: Inform all pregnant women and lactating women and their families about the benefits of breastfeeding and risks of artificial feeding</p>	<ul style="list-style-type: none"> Develop a community code promoting exclusive breastfeeding and discouraging artificial feeds and use of teats and bottles. Advocate for change of harmful cultural behaviors, myths and misconceptions 	<ul style="list-style-type: none"> Dealing with barriers to optimal infant feeding



<p>Step 5: Support mothers to initiate breastfeeding within one hour of birth, establish and maintain exclusive breastfeeding for the first six months.</p>	<ul style="list-style-type: none"> • Promote Birth practices that enhance breastfeeding; skin to skin contact, early initiation and consumption of colostrum by encouraging hospital deliveries • Promote appropriate breast feeding techniques; attachment, positioning, breast support, demand feeding, expression of breastmilk • Encourage families to support breastfeeding mothers with household chores • Encourage male involvement • Teach mothers how to recognize signs that the babies are hungry and ready to breastfeed 	<ul style="list-style-type: none"> • Prevention of breast conditions and breastfeeding difficulties • Provision of essential nutrients for the infant • Build mothers confidence • Support for working breastfeeding mothers
<p>Step 6: Encourage sustained breastfeeding beyond six months to two years or more, alongside the timely introduction of appropriate, adequate and safe complementary foods.</p>	<ul style="list-style-type: none"> • Educate families on benefits of continued breastfeeding for up to 2 years or longer. • Promotion of Timely introduction of adequate, appropriate and safe complementary foods at 6 month's using the FATVAH principle • Conduct community food cooking demonstrations • Encourage early childhood stimulation and teach mothers how to make home made toys 	<ul style="list-style-type: none"> • Breast milk continues to be an important part of the diet.

<p>Step 7: Provide a welcoming and supportive environment for breastfeeding families</p>	<ul style="list-style-type: none"> • Designate breastfeeding corners in public utility areas • Advocate for a workplace support policy for breastfeeding mothers • Promote breastfeeding support for mothers by family, CHVs and other community members • Encourage community members to participate in the baby friendly meetings 	<ul style="list-style-type: none"> • Build mothers' confidence to breastfeed their babies in all areas in the community • Community ownership in the care of the mother and baby
<p>Step 8: Promote collaboration between CHVs, CMSG, MtMSG and the local community</p>	<ul style="list-style-type: none"> • Ensure a work plan for community activities is in place. • Promptly refer mothers to existing MtMSG • Ensure community reports of group activities are available at the resource centre • Strengthen the referral mechanisms to the facility and back to the community 	<ul style="list-style-type: none"> • Strengthen community linkage and referral

Summarize session

(3 minutes)

Ask participants if they have any questions or seek clarification

Session 2

Process of Establishing BFCI

In this session participants will discuss how to make communities baby friendly and shall start by discussing the process to follow when establishing baby friendly communities. It is very important to follow these processes for successful implementation and sustainability of BFCI.

Objective

By the end of the session participants will be able to

1. List and explain the process to follow in establishing BFCI

Duration: 30 minutes

Methodologies: Buzzing, brainstorming, discussion, facilitative lecture

Materials: Flip chart, marker pens, masking tape,



Session Plan

Duration	Topics	Methodology	Materials
2 minutes	Introduce session		Flip chart, mark pens
25 minutes	List and explain the process to follow in establishing BFCI	Discussion, facilitative lecture	Flip charts, marker pens ,masking tape
3 minutes	Session summary	Lecture	Flip charts, masking tape, marker pens

Activity 1

Process of establishing BFCI

(25 minutes)

Participants will discuss the process of establishing Baby friendly community initiative

Step 1: List the nine BFCI process on a flip chart

Resource notes

1. Orientation of the national policy and decision makers
2. Training of TOTs on BFCI: National/County
3. Orientation of County and Sub-county health management teams together with key stakeholders: National / County
4. Training CHEWs/CHAs and Health Care Workers
5. Orientation of Community Health Committee, Primary Health Care Facility Committee, and other community leaders on BFCI
6. Establishment of Community Mother Support Groups
7. Training of CHVs and community mother support group (CMSG) on BFCI
8. Mapping of households
9. Establishment of Mother-to-Mother Support Groups (MtMSG)

Step 2: Explain to the participants in brief that the first 5 processes are mainly executed by other stakeholders other than the CHVs

Summarize the first 5 processes using the notes below

1. Orientation of the national policy and decision makers: Done at national level and includes directors and managers of health and other line departments
2. Training of TOTs on BFCI: TOTs are selected and trained from the national and county level
3. Orientation of County and Sub-county health management teams together with key stakeholders: Includes the governor and the team, directors of health and other line departments, County heads of departments within health and line departments
4. Training CHEWs and Health Care Workers: The trained TOTs will conduct a 6 days training for the health workers and CHEWs. The CHEW/CHA will participate in the establishment of the CMSG. This is a deliverable from the training
5. Orientation of Community Health Committee, Primary Health Care

Facility Committee, and other community leaders on BFCI: The CHC, PHCF and other community leaders are taken through a one day orientation on BFCI

Step 3: Discuss process 6 Establishment, criteria and composition of community mother support groups in details using the notes below

- CMSG is a group of community members that oversees plans and executes community baby friendly meetings and mobilizes all the community members to participate in BFCI activities.
- **Members includes:**
 - CHEW/CHAs
 - nutritionist
 - representatives from CHCs and CHVs
 - local administrators (chiefs or assistant chief)
 - lead mother/model mother
- **May also include**
- Religious leaders, opinion leaders, birth companions and other representatives in the community e.g. young mothers (<18 years), person with disability
- The health worker at the Primary Health Care Facility (PHCF), CHC and CHVs, together with the CHEW and nutritionist will support the identification of the appropriate members in the community.
- A lead mother is a mother who belongs to one of the MtMSG (in case they exist) and has been a models in exclusive breastfeeding practices in addition to other MIYCN practices such as she has successfully achieved continued breastfeeding for two years and practiced optimal complementary feeding. The lead mothers should be from the local community and act as a link between the CMSGs and the MtMSG.
- Note: The lead mother being referred to here is the overall lead mother in places where we have more than one mother support group or the lead mother in areas where only one support group exist
- The guidelines for establishment of community health unit clearly lays down the criteria and eligibility of members of the community health committee and the same criteria applies to community mother support groups which include the following
- **Criteria for CMSGs**
 - Membership should be at least 1/3 women.
 - Term of membership should be fixed at 3 years unless otherwise stated
 - Must be elected/selected from the chiefs' barazas
 - It is recommended that CMSGs have 9-11 members.
- **Eligibility criteria**
 - Must demonstrate leadership qualities
 - Ability to read and write (based on the literacy levels of the implementation area)
 - Demonstrate commitment to community service
 - Role model in positive health practice

- Sometimes there is uniqueness in each community and its best to evaluate what applies best in each scenario.

Step 4: Discuss process 7 Training of CHVs and community mother support group (CMSG) members on BFCI

Summarize using the notes below

- The CHVs will be trained on a module focusing on the 8 steps to BFCI
- CHV's are also taken through the following key contents,
 - How to establish MtMSGs, Bi-monthly CMSG meetings
 - Orientation on the use counseling cards
 - How to counsel mothers.
 - Conducting targeted home visits
 - Bi-monthly "Baby-Friendly meeting"
 - Reporting: Collecting data using the individual child feeding and growth monitoring form, MOH 513,514,100 and the monthly reporting tool for pregnant and new mothers

Step 5: Discuss process 8 mapping of households

Summarize using the notes below

- **Selection and training of Community Health Volunteers for mapping**
 - CHVs will be selected through the existing Ministry of Health structures in the Community Units.
 - Where there are no community Units, volunteers (who can read and write, are permanent residents of the community, have been vetted and accepted by the community) will be selected with the participation of the community leaders.
 - Where we have existing community units- this process should have already been done
- **Mapping of households**
 - After selection, the CHVs will then undergo an orientation to enable them map the required households.
 - Mapping of households is an important exercise that identifies the number and place where the primary target audience can be found and will be done every six months.
 - MOH 513 will be used for the mapping exercise

Step 6: Discuss process of establishment of mother to mother support groups
Summarize using the notes below

- Mother-to-Mother Support Groups are groups of women, of any age, who come together to learn about and discuss issues in pregnancy, infant and young child nutrition (breastfeeding and complementary feeding) and other health related issues.
- They also support one another on issues of maternal nutrition (during pre-pregnancy, pregnancy and lactation) and all aspects of complementary feeding.
- Mother to mother support groups give peer support to each other in relation to adjustment to motherhood and emerging issues in motherhood.
- Pool of mentors for mothers in the community.

Formation

- Recruited by the CHVs and the lead mothers during home visitations, antenatal care (ANC), MCH, and any other community gatherings and groups.
- Membership of between 9 and 15 participants.
- If the groups become larger than 15 members, they should be split into smaller manageable groups.

Selection

- A mother to be included as members of the MtMSG should be a pregnant woman or
- Has a child from 0 -15 months and willing to join and participate in the group

Functionality

For a M2MSG to be functional it should have:

- Regular meetings with clear documentation
- Active participation of all members
- Monthly reporting by CHVs, with assistance of the lead mother
- Schedule of the planned activities

Transition from the mother to mother support groups

- A mother who has gone through the complete module (approximately 6 months)
- Mother has a child above 23 months

Step 7: discuss the eligibility criteria of a lead mother
Summarize using the notes below

Eligibility to be a Lead Mother of a Mother-to-Mother Support Group

- Belong to an existing community group
- Able to read and write (based on the literacy levels of the implementation area).
- Is interested and has experience in matters relating to infant and young child feeding
- Have good relations with members of the community.
- Be able to express themselves clearly and confidently.
- Be role models who are well respected in the community.
- Be either breastfeeding mothers or mothers with children under 2 years.
- Stay within 5 Km radius of a health facility (where applicable).
- Live near the community group meeting site.

Summarize session

(3 minutes)

Ask participants if they have any questions or seek clarification

Session 3

BFCI interventions

In this session participants will learn and discuss the activities to conduct in the baby friendly communities once they are established.

Objectives

By the end of the session, participants will be able to:

1. List the BFCI key interventions
2. Describe how the interventions will be implemented

Duration: 45 Minutes

Methodologies: Buzzing, discussion, facilitative lecture

Materials: Flip chart, marker pens, masking tape, , CHV counseling schedule

Session plan

Duration	Topics	Methodology	Materials
2 minutes	Introduction to BFCI interventions	Facilitative lecture	Flip chart, marker pen, masking, BFCI implementation guidelines
40 minutes	List and describe the BFCI key Intervention	Buzzing, discussion, facilitative lecture	Flip chart , marker pen, masking tape, monthly reporting tool for pregnant and new mothers, MOH 514, Form 1, MOH 100 CHV counseling schedule
3 minutes	Session summary	Lecture	Flip charts, marker pens

Activity 1

List and describe how each intervention will be implemented (40 Minutes)

Participants will be taught in details on how each intervention will be implemented

Step 1: post a flip chart on the wall and write on it the first BFCI intervention

Step 2: discuss the intervention (training on BFCI)
use the resource notes below

1. Training on BFCI

- The training content for BFCI at all levels is based on the 8 steps to BFCI (refer to Session 1) using the BFCI approved modules for both health care workers and CHVs
- The MIYCN Counselling Cards should be used as a key job aid for training.
- Refresher trainings should be conducted during monthly CHV meetings by the CHEW/CHAs/Nutritionist and also for all the new CHVs who join later to replace those who have left
- Trainings for new recruits or replacement CHVs and lead mothers should be conducted on the entire BFCI package.
- Linkages with agriculture will also be fostered, such as discussing how to cook locally available foods through cooking demonstrations/ local recipes, availability and utilization of seasonal fruits and vegetables, as well as kitchen gardens, and raising small animals.

Step 3: write on the flip chart targeted home visits and discuss using the notes below

2. Targeted home visits

- There are two main ways that CHVs can share information about MIYCN, care and stimulation with mothers in the community:
 - Through targeted visits with individual mothers where the information shared is tailored for that individual mother.
 - Formal or informal group sessions with multiple mothers (two to three mothers, or more) at once.
- Targeted home visits can take place at:
 - Home (the volunteer/lead mother goes to visit the woman at her home)
 - In the volunteer's home (if the mother comes to the volunteer/lead mother for advice)
 - Any other convenient place where the women normally meet in the community.
 - Also can be done when the mother misses a support group visit or when there is a barrier within the household to practising the optimal MIYCN practises.

Step 4 Distribute the monthly reporting tool for pregnant and new mothers

Step 5: Explain to the participants using the notes below on how to conduct visits for pregnant and new mothers using the monthly reporting tools for pregnant and new mothers

- A pregnant mother should be visited and counselled on optimal maternal nutrition on monthly basis throughout the pregnancy.
- In the last month of pregnancy, it is recommended that pregnant mothers be visited more frequently and be accompanied by a birth companion or CHV to the facility for delivery.
- The birth companion, together with the health facility staff, should ensure that breastfeeding is initiated within one hour of birth and no pre-lacteal feeds are given.
- Soon after birth, frequent visits by the CHV and/or lead mother are recommended to provide support for proper attachment, positioning, and optimal breastfeeding and to address any problems with breastfeeding (i.e. perceptions of insufficient milk, early introduction of foods and liquids), as well as care and stimulation.
- Thereafter, a mother should be visited at least once a month for up to one year. Beyond one year, the mother is visited at least every two months up to 24 months for continued support for optimal MIYCN practices, including feeding during illness, child spacing, growth monitoring, and immunisation/supplementation, care and stimulation

Step 6: Distribute the counselling topics to be covered by CHVs hand out, to the participants

Step 7: Refer participants to the monthly reporting tool for pregnant and new mothers and call their attention to the box “topics taught in group session”

Step 8: Ask participants to refer to the counselling topics to be covered by CHVs and call their attention to step 3

Step 9: Explain how to report on topics taught to mothers during group sessions using codes i.e first digit represents the step while subsequent digits represent the topics taught. (3.1,3,7). Encourage the CHVs to avoid too many topics in one session

Step 10: Distribute MOH 514 and call the participants attention to column E. Explain that number of pregnant women reported in the monthly reporting tool for pregnant and new mothers should tally with column E in MOH 514

Step 11: Ask the participants to locate column G and H in the MOH 514, explain to them that the total of the two columns should tally with the number of new born babies this month except when there is a multiple delivery or a child mortality

Step 12: Distribute form 1 (Individual child form) to each of the participants, call their attention to question number 7 (low birth weight babies). Explain to the participants that the number of low birth weights reported in the monthly reporting tool for pregnant and new mothers should tally with those reported in Form 1. Explain to the participants that the form 1 will be discussed in details in a later session

Step 13: Distribute MOH 100 to each of the participants, link it with the MOH 514

and give a few examples of from the service log that the MOH 100 may be useful. E.g columns P,Q,R,S,W,X,L,M,N and O. Encourage the participants to strengthen the referral system by making use of the already existing tools

Step 14: write on the flip chart Bi- monthly “baby-friendly meeting” and explain using the notes below

3. Bi-monthly “Baby-Friendly meeting”

- A baby friendly meeting is a meeting organized by the CMSG within the community whose agenda is MIYCN, care and stimulation.
- During these meetings, health and nutrition promotion including cooking demonstrations, hygiene and sanitation, stimulation amongst other topics should be discussed
- After every two months, the CMSG members work together with the CHEW/CHAs/Nutritionist to mobilize pregnant women and mothers of children less than two years of age as the primary targets for the bi monthly baby friendly meetings.
- Women of reproductive age, fathers, grandmothers, and other caregivers of the children are secondary targets.
- CMSG members together with the CHVs will support and guide mothers on the cooking demonstration on how to make recipes for nutritious complementary foods that meets the frequency, amount, texture, variety, active feeding and hygiene (FATVAH) criteria and healthy diets for pregnant and breastfeeding women.
- In addition, to community baby friendly meetings, community dialogues and community action days will be conducted monthly and quarterly, respectively. CHVs will use this opportunity to promote baby friendly community activities.

Step 15: write on the flip chart Bi- monthly CMSG meetings and explain using the notes below

4. Bi-monthly CMSG meetings

- The first CMSG meeting is always held before the first baby friendly meeting as this is the team that plans on the activities to be undertaken during the baby friendly meeting
- There after the CMSG meeting is held after the community baby friendly meeting to deliberate on
 - The achievements,
 - Challenges,
 - Plan for other activities in the community as well as the next baby friendly meeting.
- The CHEW/CHAs with the support of the chairman who may be the chief or any other member of the CMSG will call and organize for the meeting

Step 16: write on the flip chart MtMSG and explain using the notes below



5. MtMSG meetings

- MtMSGs will be established within each community and be linked to a Primary Health Care Facility.
- There may be more than one MtMSG in one community.
- Each group will have a lead mother who will work with the CHV in facilitating group activities. The lead mother will be responsible for engaging group members in discussions about MIYCN, care and stimulation and providing basic health education, in an interactive, participatory manner.
- This will be an opportunity to address problems mothers have with MIYCN, including breastfeeding and early introduction of foods and liquids that impede exclusive breastfeeding, and discuss solutions as a group.

Step 17: write on the flip chart monthly CHVs meetings and explain using the notes below

6. Monthly CHVs meetings

- The CHVs will hold monthly meetings with the CHEWs/CHAs and Nutritionist for routine reporting and experience sharing in BFCI implementation in their communities.
- During these meetings, they will identify areas of challenge during home visits and possible solutions to these challenges.
- The CHEW/CHAs and Nutritionist will guide and provide any MIYCN updates to the CHVs.

Step 18: write on the flip chart education sessions for mothers and explain using the notes below

7. Education sessions for mothers

- The education sessions will be conducted at MCH Clinics by the CHVs, health facility staff or the CHEW/CHA. The CHEW/CHA/Health Facility in charge will document the topics covered and the attendance.
- Other avenues for health and nutrition promotion will be during baby friendly community meetings and other gatherings within the community, such as market places, chiefs' barazas, and other social gatherings.
- Sharing MIYCN information informally is a strategic vehicle for educating mothers, but should not replace formal routine contacts for counseling mothers, such as targeted home visits and monthly MtMSG meetings.
- **NOTE:** Bringing mothers together during ANC or child welfare clinics and teaching them does not qualify to be a mother to mother support group

Step 19: write on the flip chart mentorship and support supervision and explain using the notes below

8. Mentorship and supervision

- The SCHMT will supervise and mentor the Primary Health Care Facility (PCF) staff at least once per month for the initial six months of establishment to support and strengthen the BFCI, and quarterly thereafter.
- Action points to be acted upon will be developed based on the findings and verified in subsequent visits.
- The SCHMT will supervise the CHEW/CHA using supervision checklists provided as part of the implementation guidelines (see Annex).
- The CHEW/CHA and nutritionist will continuously supervise and mentor the CHVs for quality improvement in the implementation of BFCI activities.
- The CHVs are followed up on monthly basis, and the CHEW/CHA and nutritionist may also accompany the CHVs during the targeted home visits to observe their activities and ensure they are counseling the mothers appropriately.
- CHVs will mentor lead mothers

Step 20: write on the flip chart establishment of mother an baby friendly resource center and explain using the notes below

9. Establishment of Mother and Baby Friendly Resource Centre

- The site for the resource center will be identified by the MtMSGs members in consultation with the CSGM and the facility staff.
- It may be located within the health facility or anywhere within the community.
- Simple furniture for sitting and writing will be sourced locally.
- IEC materials on MIYCN, child care and stimulation will be placed in the identified venue.
- CMSG, CHVs, MtMSG and health care workers who have been trained in BFCI will then manage the Centre, giving information and offering practical support to any person who comes to the center.
- Attainment of a 'baby friendly community' status is dependent upon implementation of different interventions
- All key stakeholders should be part of the process

Summarize session

(3 minutes)

Ask participants if they have any questions or seek clarification

Session 4

Role of different stakeholders in BFCI

In this session participants will understand the roles of different stakeholders in BFCI

Successful implementation of BFCI will be dependent on the collaborative efforts and synergies of all the stakeholders and actors through the establishment of effective partnerships.

Key actors at different levels should play their roles to effectively plan, coordinate, implement, monitor, and evaluate BFCI activities.

In return, the community will be able to attain the “baby friendly” status.

Objectives:

At the end of the session, participants should be able to

1. List and explain the roles of different stake holders in BFCI implementation

Duration: 30 Minutes

Methodologies: Brainstorm, discussion, facilitative lecture

Materials: Flip chart, marker pens, masking tape

Session plan

Duration	Topics	Methodology	Materials
2 minutes	Session introduction	Lecture	
25 minutes	List and explain the roles of different stakeholders in BFCI implementations	Brainstorm, discussion, facilitative lecture	Flip chart, marker pen
3 minutes	Session summary	Lecture	

Activity 1

Roles of different stakeholders in BFCI implementation

(25 Minutes)

Participants will brainstorm on the roles of different stakeholders

Step 1: Ask participants to brainstorm on the roles of CHVs

Step 2: List their responses on the flip chart

Summarize using the notes below

Roles of community health volunteers (CHVs)

- Facilitate formation of MtMSGs
- Conduct targeted home visits
- Conduct education and counseling on MIYCN, care and stimulation including addressing any problems mothers face
- Conduct community mobilization for uptake of BFCI
- Mobilize the identified influencers on MIYCN
- Participating in baby friendly community meetings
- Mapping the primary audience within their area of operation

- Reporting to the CHEW on the activities they have been involved in and keeping records
- Participate in resource mobilization for community baby friendly meetings
- Referral of cases to the nearest health facility
- Promoting care seeking and uptake of optimal MIYCN practices
- Participate in CHV meeting

Step 3: Distribute to the participants hand out on roles and responsibilities for CHVs

Step 4: Discuss the roles of CMSG using the notes below

Roles of the CMSG

- A CMSG oversees plans and executes community baby friendly meetings.

The activities include:

- Mobilizes all the community members to participate in BFCl activities.
- Supporting the CHEW and Nutritionist in monitoring and documentation of monthly BFCl activities at the community level
- Monitoring, and documenting the maternal, infant, and child nutrition activities in the community on a monthly basis.
- Conducting annual planning/review meetings with the CHEW and nutritionist
- Advocate for allocations of funds to BFCl activities in the community

Step 5: Discuss role of the chief/ assistant chief

Roles of Chief/ assistant chief

- Participate in planning for BFCl activities together with other CMSG members
- Mobilize the community members for community meetings on cooking demonstration.
- Participates in the CMSG meetings in the PHCF every two months
- Calls the meetings for the CMSG
- Mobilization of community members to provide for materials and food e.g. green vegetables, rice, to be used during cooking demonstrations
- Allocates responsibilities in the baby friendly community meetings and cooking demonstrations.

Step 6: Discuss the roles of the lead mother using the notes below

Roles of the lead mother

The lead mother should:

- Mentor other group members.
- Convene monthly MtMSG meetings
- Together with the CHV, deliver key messages for MIYCN, care and

stimulation and discuss with mothers how to address any problems.

- Be a link between the MtMSG and the CMSG
- Models the health and nutrition behaviors in MtMSG and community
- Support the CHV in collecting BFCI data
- Identification and referral of mothers to the CHVs, and other mother support groups

Step 7: Tell participants that the summary of the roles are found in the hand out

Summarize session

(3 minutes)

Ask participants if they have any questions or seek clarification

10

UNIT 10

MONITORING AND EVALUATION

In this unit participants will learn the importance of documentation, and the tools to use at community level.

Objectives:

After completing this session participant will be able to:

1. Defining Monitoring & Evaluation
2. Describe monitoring in BFCI
3. Describe the Key BFCI outcome indicators
4. Describe BFCI documentation and reporting tools
5. Describe BFCI Assessment and accreditation

Duration: 2 hour 30 minutes

Methodologies: Discussions, brainstorming, group work, demonstration, observations and facilitative lecture

Materials: Flip charts, mark pens, masking tapes, reporting tools form1, Counseling topics to be covered and visit schedule for community health workers, monthly visits, monthly reporting tools, case studies.

Session plan

Duration	Topics	Methodology	Materials
5 minutes	Introduce the session	Facilitative lecture	
10 minutes	Defining Monitoring & Evaluation	Facilitative Lecture , discussions	Flip charts, marker pens
30 minutes	Describe monitoring in BFCI	Buzzing	Flip charts, marker pens
20 minutes	Describe the Key BFCI outcome indicators		
60 minutes	BFCI documentation and reporting tools	Observations, brain storming discussions	Guidance notes
20 minutes	BFCI Assessment and Accreditation	Buzzing , discussions	
5 minutes	Summarize the session	Discussions, practicals, observations	

Activity 1

Defining monitoring and evaluation

(10 Minutes)

Participants will discuss the importance of data collection

Step 1: Ask the participants to discuss what is the importance of collecting data?

Step 2: List their responses on a flip chart

Summarize the discussions using the notes below

- Documentation is key. Monitoring of BFCI activities will be conducted routinely at all levels and is essential to the success of BFCI.
- Community health volunteers have an important role in ensuring that all documentation tools are properly filled and reported in a timely manner to the next level.

Definition of M & E

- **Monitoring:** This is a process of assessing day to day activities in a program or project. It is done regularly (Eg. monthly) to provide reports for decision making. This is done by CHVs, Health care providers or other staff
- **Evaluation:** Is a periodic assessment (e.g mid or end of a project) to assess progress of a program.
- This is done by the program staff/ partners, or other staff. It gives direction on if the program should continue or not, or if there are things that need to be changed for the program to run well

Activity 2

Monitoring in BFCI

(30 minutes)

Participants will buzz in pairs on the importance of supervision

Step 1: Ask participants to buzz in twos on the importance of supervision

Step 2: List the responses on a flip chart

Summarize the discussions with the notes below.

- Improves the performance
- Continuous mentorship and training
- Ensures effectiveness of implementation
- Builds the relationship of team players

Step 3: Ask participants who supervises their activities

Summarize the discussions with the notes below

- It is the role of the CHA/CHEW to supervise and mentor the CHVs in their day to day activities
- It's the role of the Sub County Health Management Team to support communities to ensure that they move towards making their communities Baby Friendly through mentorship and supervision of the CHAs and CHEWs
- Monitoring on the process of BFCl implementation will be at various levels by various people.
- We are now going to look at monitoring at the community level, and the tools that will be used.
- For communities to move towards being Baby Friendly, monitoring has to be done

Participants will discuss monitoring by their immediate supervisor (Community Health Assistant (CHA/Community Health Extension Worker CHEW)

The CHEW/ CHA will:

- Monitor the CHVs to ensure that all BFCl activities are conducted and reported by the CHV in a timely manner coordinate the formation and activities of the CMSG.
- Monitor to ensure Form 1 is filled and reported monthly.
- Keep reports for the CHV activities to ensure they are active and functional. i.e. files for MtMSG activities, Bi monthly CMSG, Form 1 data etc ,

Step 4: Distribute the supervision check list for CHEWs/CHA.

Step 5: Briefly discuss the tool and explain to the CHVs that the tool among others shall be used by the CHEW/CHA during support supervision

Step 6: Ask participants what their roles are in BFCl

Step 7: List their responses on a flip chart

Summarize the discussions with the notes below

Monitoring by CHV

The CHV will collect information on five indicators (listed below) on a monthly basis. This will be done through home visits and filling of Form 1.

- Infants who are initiated to breastfeeding within one hour after delivery (below one year)
- Exclusively breastfed in the first six months of life (zero to at six months of age)
- Pre-lacteal feeds within the first three days of life
- Children aged six to eight months who receive complementary foods (semisolid or solid) in addition to breast milk
- Children aged six month to below one year who ate any animal-source, iron-rich foods in the last 24 hours



Activity 3

BFCI outcome indicators

(20minutes)

Participants will discuss the BFCI outcome indicators

When conducting BFCI activities, certain outcomes are expected. There are five outcome indicators that we will now discuss.

Step 1: Remind participants of the bean activity they conducted during unit 1 on why BFCI matters?

Step 2: Tell participants that for communities to have better practices, they would have to improve on the percentages of the indicators'

Step 3: Use beans previously counted to demonstrate a reducing percentage (Proportion of children who receive any pre-lacteal feeds within the first three days of life).

Use a hypothetical figure or local data if available(e.g 30% of infants in area X are given pre-lacteal feeds, separate 30 beans from the 100 beans and tell participants that counselling in addition to other interventions can help reduce the 30% to 20% .Minus 10 beans from the 30 and add them to the 70)

Step 4: Use a similar bean activity to demonstrate the exclusive breastfeeding proportion

Step 5: Explain to the participants that they shall work to increase some percentages and also to reduce some percentages

Summarize the discussion using the notes below

BFCI Outcome Indicators

- Proportion of infants who are initiated to breastfeeding within one hour after delivery (early initiation of breastfeeding) zero to below twelve months of age
- Proportion of infants who are exclusively breastfed in the first six months of life (zero to at six months of age)
- Proportion of children who receive any pre-lacteal feeds within the first three days of life
- Proportion of children aged 6-8 months who receive complementary foods (semi solid or solid) in addition to breast milk
- Proportion of children aged six months to below one year who ate any animal source, iron rich foods in the last 24 hours

Step 6: Give each participant a copy of guidance notes for BFCI indicators (see Annex), give the participants time to read individually and ask them for feedback on how they understand the indicators.

Step 7: List their responses on a flip chart

Step 8: Explain to the participants that the guidance notes are useful during the home visits and work as a guide to CHVs on how to ask questions to mothers during home visits

Guidance notes to key BFCI indicators

Indicator	Questions to ask the mother	YES (1)	NO (1)	DON'T KNOW (8)
Early Initiation of Breastfeeding (for children 0-11.9 months)	Was the child initiated to the breast?			
	within 1 hour after delivery			
	later than 1 hour after delivery			
Pre-lacteal feeding (for children 0-11.9 months)	In addition to breastmilk, what was the child given to drink/eat in the first three days of life?			
	1. Water/other liquids			
	2. Milk (not breastmilk)/infant formula			
	3. Other: _____			
Exclusive breastfeeding (for children below six months)	4. Nothing			
	Is (NAME) still breastfeeding?			
	Was (NAME) breastfed yesterday during the day and at night?			
	Did (NAME) take ANY liquids or semi-solid/solid foods yesterday day and night?			
	Liquids: MILK (other than breast milk), plain water, sugar/glucose water, gripe water, sugar/salt solution, fruit juice, infant formula, tea/infusions, coffee, honey etc.			
	Semi-solid/solid foods: cereals, vegetables, fruits, meats,			
	Pulses/legumes, etc.			
	(Exclusive breastfeeding means Yes to the first question above, and No to the second and third questions above)			
Proportion of children 6-8.9 months of age who had complementary feeding in addition to breastmilk.	Was the child given solid or semi-solid foods in the last 24hours?			
Animal source in complementary Feeding (for children 6-11.9 months of age)	Was the baby given meat, poultry, fish or eggs in the last 24hours?			



Activity 4

BFCI documentation and reporting tools

(60 minutes)

Participants discuss on the BFCI reporting tools

- We will now discuss the set of tools that will be used for reporting the BFCI indicators from the community level to the primary facility.
- BFCI reporting process involves 5 forms
- We will discuss only form 1
- Form 2 is to be completed by the CHEW/CHA, using Form 1 data every month
- The CHEW/PCF staff must compile the data monthly and present the forms for onward data transmission with the following reporting deadlines:
 - From facility to sub-county by 5th of the subsequent month,
 - From the sub-county to the county by 10th of the subsequent month,
 - From county to national by 15th of the subsequent month.
- It is therefore important for the CHVs to report on time for timely onward transmission

Step 1: Distribute copies of form 1 to the participants

Step 2: Discuss the contents of form 1

Form 1

- This is the Individual Child Feeding and Growth Monitoring form.
- The record is filled at the village level by the CHV who may be supported by the lead mother
- One form per child is used for a period of 0-11.9 months
- The CHV at the end of every month presents the updated form 1 to the CHEW/CHA for the monthly reports
- The form 1 is kept by the CHV
- When the child is one year the form 1 is surrendered to the CHEW/CHA for filling at the link health facility
- The record is initiated as soon as possible after the birth of the child and is updated on a monthly basis, thereafter.

Step 3: Assist participants to locate the number 1-9 in form 1. Tell the participants that during the first visit (as soon as possible after delivery), the CHV should complete questions 1 through 9:

Step 4: Assist participants locate all the 5 indicators from the form 1

Indicator 1: Early initiation (question 8)

Indicator 2: Pre lacteal feeding (question 9)

NB: Demarcated by thick bold lines

Indicator 3: Exclusive breastfeeding (0 to 0.9 – 5 to 5.9 locate age from row number 11)

Indicator 4: Complementary feeding (6 to 6.9 – 8 to 8.9 locate age from row number 11)

Indicator 5: Animal source foods (6 to 6.9 – 11 to 11.9 locate age from row number 11)

Step 5: Explain number 11 on the form (Infant's age at the moment of the visit (in months))

0 to 0.9 caters for all children below one complete month, when a child has completed a month fill the data on the column 1 to 1.9 as this child is 1 month and a few days old towards month 2 such that when the child will have completed 2 months their data shall be filled in column 2 to 2.9 and the same applies in subsequent months

Step 6: Ask participants to refer to hand out on the counseling topics to be covered and visit schedule for community health workers issued to them in unit 8 session 3.

Step 7: Explain to the participants that they shall be selecting topics to teach the mothers from the counselling topics tool and code the topic on number 19 of form 1.

Step 8 : Ask participants to look at form 1 and locate number 19 (feeding recommendations given to the mother)

Step 9: Topic selection will be guided by the mother's needs (first digit represent the step, second or other subsequent digits represent the topics chosen separated in commas

(e.g Step 5: : Support mothers to initiate breastfeeding within the first one hour of birth, establish and maintain exclusive breastfeeding for first six months

(1st topic (4): Breastfeeding on demand-why

(2nd topic (6): Good attachment-4 key points of good attachment

(3rd topic (7) Good positioning-4 key points of good positioning

The code to appear on number 19 will be: 5.4,6,7

Step 10: Divide the participants into 5 groups and give each group a set of 3 form 1

Step 11: Give participants case studies for filling form 1 to each group

Step 12: Ask participants to practice filling form 1 using the case studies. Each case study to be filled in a separate form 1

Step 13: Move around the class and ensure the participants are doing the right thing, assist those that may have difficulties

Step 14: Distribute copies of the Community Health Volunteers (BFCI implementation) summary of activities and schedule for meetings

Step 15: Explain to the participants that the tool will act as a reminder of all the activities they are required to conduct to make BFCI a success

Activity 5

BFCI assessment and accreditation

(20minutes)

- All communities implementing BFCI will be working towards becoming baby friendly. As a first step communities will need to appraise its current practices with regard to the 8 steps to BFCI.
- A community self-appraisal tool, has been developed for use by communities to evaluate how their current practices measure up to the 8 steps to BFCI
- The CHEW and nutritionist, with support from the CMSG members, will conduct a self-assessment for BFCI using the Community self-assessment tool for BFCI.
- The assessment calls for random samples of HCWs, CHVs, mothers and household members to test knowledge and practices on BFCI
- Simple random or systematic random sampling is used to select the sample size.

Participants will discuss accreditation

- For a community to get certified as baby friendly, series of assessments are conducted at different levels. If the threshold is met the community is acknowledged in an official ceremony and certified as baby friendly
- The CHMT will use a set of tools to assess communities in readiness for certification. If the County team scores the community at 80 % and above the county requests for external assessment to the national MIYCN Steering Committee for accreditation consideration.
- When the external assessors from the national MIYCN committee assesses the community they score as follows

A score of 0 - 49% is poor

The CHVs and the HCWs should put in more effort to ensure the mothers are taught and behaviour change takes place

A score of 50-79% is satisfactory

Highlight the achievements the community has made that far. A certificate of commitment is issued at an official ceremony to acknowledge the efforts put in towards the community becoming baby friendly

A score of 80%-100% is good

- The communities/facilities are BFCI compliant and can now be certified as Baby Friendly.
- After every three years, they will apply for re-certification.
- A permanent sign will be displayed in a strategic location in the community, such as the entrance road, the center of the community, PCF, market place or at the chiefs/assistant chief's office, declaring that "(Name of Community) is a Baby-Friendly Community".

Summarize session

(5 minutes)

Ask participants if they have any questions or seek clarification

ANNEX 1

TRAINING CHECKLIST

1.1: EQUIPMENT AND STATIONERY

ITEMS NEEDED	NUMBER NEEDED
Laptop	1 If power is available
LCD	1
Speakers	1
Trainers' manual	All trainers
MIYCN Counseling cards	All participants
Flip charts	3 rolls
Felt pens	Chisel shaped , 1 dozen, all colors
Sticky notes or manila cards	Different colors
Policies MIYCN IFAS MNP VAS BMS Act, 2012	4-6 copies each
Mother and child handbook	1 per 2participants
1000 days booklet	All facilitators

1.2: DEMONSTRATION ITEMS

ITEM	NUMBER NEEDED
Baby dolls	2 soft and big size
Manual Breast pump (optional)	1
Bowls (250mls)	4
Cup with spout	1
Calibrated jugs	2
Ordinary jugs	2 (sourced from venue)
Breast model (may be made with cotton, thread and a pair of socks)	1
20 cc syringe	2
Surgical blade	1
Pencils	One per participant
Rubbers	One per participant
Sharpeners	One per participant
MNP powder (sachets)	2

Anthropometric equipment MUAC tapes (child, Adult) Weighing scale Height/ length board	MUAC tapes- each participant or 4 for demo 2 sets 2 sets
400mls thick porridge	Divided into two portions 200mls each
Variety of cooked food for children 6-23 months	For 4 working groups
Logistics for clinical field experience	Transport to and from the nearby health facility
	Name tags for all participants and trainers

1.3: FOOD ITEMS

ITEM (10 food groups)	QUANTITY NEEDED (Any 3 items from each food groups)
Grain, grain products and other starchy foods	Whole grains: rice, maize, millet, sorghum, Starchy roots: white fleshed sweet potato, unripe bananas, arrowroots, cassava, yam among others Products : wheat flour, maize flour, spaghetti, Weetabix, cornflakes, porridge flours among others
Legumes /Pulses	Dried beans any variety, dried peas, cow peas, green grams, lentils among others
Nuts and seeds	Macadamia, peanuts/ ground nuts , cashew nuts, baobab seeds, Simsim, pumpkin seeds, chia seeds, poppy seeds
Flesh foods	Red meat variety, white meat varieties, insects, canned meats,
Eggs	Any type available and consumed by community
Dairy and dairy products	Fresh milk, processed milk, fermented milk (lala), yoghurt, cheese
Green leafy vegetables	Any green vegetables available and consumed in the region
Other vitamin A rich fruits and vegetables	Fruits: mangoes, pawpaw, purple skin passion fruit, peaches, loquats, yellow or orange fleshed sweet potatoes Vegetables: carrots, pumpkin
Other fruits	Ripe bananas, guavas white and red fleshed, tree tomatoes, water melon red color, oranges, pineapples, apples among others
Other vegetables	Tomatoes, dhania, hoho, onions, cabbage, cucumber, green peas, green beans, green maize among others available in the market

1.4: ITEMS TO PRINT/PHOTOCOPY

TITLE	NO. OF COPIES
c-BFCI Training timetable	1 per participant
Pre/post test	10 copies
MIYCN policy	4-6 copies
MNP policy	4-6 copies
VAS policy	4-6 copies
Demonstration 4: A-I Listening and learning skills	2 sets
Demonstration 5: A-D Confidence and support	2 sets
Counseling skills checklist	All participants
Breastfeeding observation job aid	All participants
Taking a feeding history 0-6 months	All participants
Amounts of food to offer to a child	All participants
Taking a feeding history 6-23 months	All participants
Assess your practices	All participants
8 steps to successful BFCI	All participants
SCHMT mentorship and supervision check list	1 copy to be shared by two participant
Supervision checklist for CHEW	1 copy to be shared by two participant
Guidance notes for CHVs	1 copy per participant
CHV counseling topics and visit schedule	1 copy per participant
Scheduled visits for pregnant mothers	All participants
Form 1 stories	5 copies
Form 1	All participants
Monthly reporting on number of education contacts	All participants
Action plan template	12 copies

ANNEX 2

TIME TABLE

Time	Activity	Facilitator
DAY 1		
8:00–8:30	Arrival and Registration	
8:30–9:15	Introduction, expectation and why we are here and opening remarks and administrative issues	
9:15–10:00	Pre test	
10:00–10:30	Tea break	
10:30–11:15	UNIT 1: Orientation to the MIYCN counselling cards Session 1	
11:15–12:40	Why BFCI matters Session 2	
12:40–01:00	UNIT 2 Food nutrients and nutrition	
01:00–02:00	Lunch break	
2:00–4:40	Food, nutrients and nutrition continued	
4:40–5:00	Days evaluation and closure	
5:00–5:30	Tea break, leave at own leisure	
DAY 2		
8:30–8:45	Recap for day 1	
8:45–10:25	UNIT 3 Maternal nutrition	
10:25–10:55	Tea break	
10:55–11:55	UNIT 4 Session 1: Importance of breastfeeding	
11:55–1:20	Session 2: How breastfeeding works	
1:20–2:20	Lunch break	
2:20–3:50	Session 3: Breastfeeding techniques	
3:50–4:50	Session 4: Listening and learning skills	
4:50–5:00	Days evaluation and closure	
	Tea break, leave at own leisure	
DAY 3		
8:30–8:45	Recap day 2	
8:45–9:35	Session 5: Building confidence and support skills	
9:35–10:00	Session 6: Common breastfeeding difficulties	
10:00–10:30	Tea break	
10.30–11.35	Session 6 cont.....	

11:35-12:40	Session 7: Expressing breast milk and cup feeding	
12:40-1:00	Session 8: Breast conditions	
01.00 - 02.00	Lunch break	
2:00-2:35	Session 8 cont.....	
2:35-4:05	UNIT 5 Session 1: Importance of complementary feeding	
4:05-4:30	Days evaluation and closure	
4:30-5:00	Tea break leave at own leisure	
DAY 4		
8:30-8:45	Recap	
8:45-10:30	Session 2: Food to fill the energy ,Iron and Vitamin A gaps	
10:30-11:00	Tea break	
11:00-12:40	Session 3: Quantity and variety	
12:40-1:00	Session 4: Food modification and fortification	
1:00-2:00	Tea break	
2:00-3:20	Session 4 cont.....	
3:30-4:00	UNIT 6 The Breast Milk Substitutes (Regulation and Control) Act, 2012	
4:00-5:00	UNIT 7 Session 1: growth monitoring and promotion	
5:00-5:45	Days evaluation and closure	
5:45-6:30	Tea break leave at own leisure	
DAY 5		
8:30-8:45	Recap	
8:45-9:40	Session 2: Early childhood stimulation	
9:40-10:00	UNIT 7: Household food security	
10:00- 10:30	Tea break	
10:30-11:40	Unit 7 cont.....	
11:40-12:40	UNIT 8 Session 1: 8 steps to BFCI	
12:40-1:10	Session 2: Process of establishing BFCI	
1:10-2:00	Lunch break	
2:00-2:45	Session 3: BFCI interventions	
2:45-3:15	Session 4: Roles of different stakeholders	
3:15-6:00	UNIT 9: Monitoring and evaluation	
6:00-6:30	Way forward and closure	
6:30- 7:00	Tea break departure	



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ANNEX 3

PRE-POST TEST

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3.1: PRE-POST TEST QUESTIONNAIRE

S. No.		Yes	No	DK
1.	The purpose of a mother to mother support group is to share personal experiences on Maternal, infant and young child Nutrition (MIYCN) practices.			
2.	Poor child feeding during the first 2 years of life harms growth and brain development.			
3.	An infant aged 6 months one week needs to eat at least 2 times a day in addition to breastfeeding.			
4.	A pregnant woman needs to eat 1 more meal per day than usual.			
5.	At 4 months, infants need water and other drinks in addition to breast milk.			
6.	Correct information alone on how to feed her child changes mother's practice.			
7.	A woman who is malnourished can still produce enough good quality breast milk for her baby.			
8.	The more milk a baby removes from the breast, the more breast milk the mother makes.			
9.	The mother of a sick child older than 6 months should wait until her child is healthy before giving him/her solid foods.			
10.	When complementary feeding starts at six months, the first food a baby takes should have the texture or thickness/consistency of breast milk so that the young baby can swallow it easily.			
11.	During the first six months, a baby living in a hot climate needs water in addition to breast milk.			
12.	A young child (aged 6 up to 12 months) should not be given animal foods such as fish and meat.			
13.	A new-born baby should always be given colostrum.			
14.	A mother living with HIV should never breastfeed.			
15.	Men play an important role in how infants and young children are fed.			

3.2: PRE-POST TEST MARKING SCHEME

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



ANNEX 4

FOOD CALENDAR TEMPLATE

(Year food calendar for feasible, affordable and locally available foods)

Month	Food group	Food items available at home	Food items available at the market
January	Grains and grain products and other starchy foods		
	Pulses/legumes		
	Nuts and seeds		
	Dairy and dairy products		
	Eggs		
	Flesh foods (poultry, beef, fish etc)		
	Dark green leafy vegetables		
	Other vitamin A rich fruits and vegetables		
	Other vegetables		
	Other fruits		
February	Grains and grain products and other starchy foods		
	Pulses/legumes		
	Nuts and seeds		
	Dairy and dairy products		
	Eggs		
	Flesh foods (poultry, beef, fish)		
	Dark green leafy vegetables		
	Other vitamin A rich fruits and vegetables		
	Other vegetables		
	Other fruits		
March	Grains and grain products and other starchy foods		
	Pulses/legumes		
	Nuts and seeds		
	Dairy and dairy products		
	Eggs		
	Flesh foods (poultry, beef, fish)		

	Dark green leafy vegetables		
	Other vitamin A rich fruits and vegetables		
	Other vegetables		
	Other fruits		
April	Grains and grain products and other starchy foods		
	Pulses/legumes		
	Nuts and seeds		
	Dairy and dairy products		
	Eggs		
	Flesh foods (poultry, beef, fish etc)		
	Dark green leafy vegetables		
	Other vitamin A rich fruits and vegetables		
	Other vegetables		
	Other fruits		
May	Grains and grain products and other starchy foods		
	Pulses/legumes		
	Nuts and seeds		
	Dairy and dairy products		
	Eggs		
	Flesh foods (poultry, beef, fish etc)		
	Dark green leafy vegetables		
	Other vitamin A rich fruits and vegetables		
	Other vegetables		
	Other fruits		
June	Grains and grain products and other starchy foods		
	Pulses/legumes		
	Nuts and seeds		
	Dairy and dairy products		
	Eggs		
	Flesh foods (poultry, beef, fish etc)		
	Dark green leafy vegetables		
	Other vitamin A rich fruits and vegetables		
	Other vegetables		
	Other fruits		



July	Grains and grain products and other starchy foods		
	Pulses/legumes		
	Nuts and seeds		
	Dairy and dairy products		
	Eggs		
	Flesh foods (poultry, beef, fish etc)		
	Dark green leafy vegetables		
	Other vitamin A rich fruits and vegetables		
	Other vegetables		
	Other fruits		
August	Grains and grain products and other starchy foods		
	Pulses/legumes		
	Nuts and seeds		
	Dairy and dairy products		
	Eggs		
	Flesh foods (poultry, beef, fish etc)		
	Dark green leafy vegetables		
	Other vitamin A rich fruits and vegetables		
	Other vegetables		
	Other fruits		
September	Grains and grain products and other starchy foods		
	Pulses/legumes		
	Nuts and seeds		
	Dairy and dairy products		
	Eggs		
	Flesh foods (poultry, beef, fish etc)		
	Dark green leafy vegetables		
	Other vitamin A rich fruits and vegetables		
	Other vegetables		
	Other fruits		
October	Grains and grain products and other starchy foods		
	Pulses/legumes		
	Nuts and seeds		
	Dairy and dairy products		

	Eggs		
	Flesh foods (poultry, beef, fish etc)		
	Dark green leafy vegetables		
	Other vitamin A rich fruits and vegetables		
	Other vegetables		
	Other fruits		
November	Grains and grain products and other starchy foods		
	Pulses/legumes		
	Nuts and seeds		
	Dairy and dairy products		
	Eggs		
	Flesh foods (poultry, beef, fish etc)		
	Dark green leafy vegetables		
	Other vitamin A rich fruits and vegetables		
	Other vegetables		
	Other fruits		
December	Grains, grain products and other starchy foods		
	Pulses/legumes		
	Nuts and seeds		
	Dairy and dairy products		
	Eggs		
	Flesh foods (poultry, beef, fish etc)		
	Dark green leafy vegetables		
	Other vitamin A rich fruits and vegetables		
	Other vegetables		
	Other fruits		



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ANNEX 5

COUNSELLING SKILLS -DEMONSTRATIONS

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5.1: LISTENING AND LEARNING SKILLS (KINDLY UPDATE WHEN THE MANUAL IS FINALLY UPDATED)

Demonstration 4.1.A Non-Verbal Communication

With each demonstration say exactly the same few words, and try to say them in the same way, for example:

“Good morning, Susan. How is feeding going for you and your baby?”

1. Posture:

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

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

- Write – ‘Keep Your Head Level’ on the flip chart (Flip chart2).

2. Eye contact:

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

Helps: Look at her and pay attention as she speaks

- Write – ‘Pay Attention’ on the flip chart.

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

3. Barriers:

Hinders: Sit and hold the MIYCN counselling card, in way blocking the mother from seeing your face.

Helps: Hold the counselling card in way that is not blocking the mothers face

- Write – ‘Remove Barriers’ on the flip chart.

4. Taking time:

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

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

- Write – ‘Take Time’ on the flip chart.

5. Touch:

Hinders: Touch her in an inappropriate way

Helps: Touch the mother appropriately (if applicable)

- Write – ‘Touch appropriately’ on the flip chart.

(Note: Discuss appropriate touch in this community and have the list written on Flip chart 2 and post it up on the wall. If you cannot demonstrate an inappropriate touch, simply demonstrate not

touching. In infant feeding, it may be helpful to touch the baby and not the mother.)

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

Demonstration 4.1 B Closed Questions to Which she can Answer 'Yes' or 'No'

Community

health volunteer: "Good morning, (name). I am (name), the community midwife. Is (child's name) well?"

Mother: "Yes, thank you."

Community

health volunteer: "Are you breastfeeding him?"

Mother: "Yes."

Community

health volunteer: "Are you having any difficulties?"

Mother: "No."

Community

health volunteer: "Is he breastfeeding very often?"

Mother: "Yes."

Ask: What did the Community health volunteer learn from this mother?

Comment: **The Community health volunteer got 'yes' and 'no' for answers and didn't learn much. It can be difficult to know what to say next.**

Demonstration 4.1.C Open Ended Questions

Community

health volunteer: "Good morning, (name). I am (name), the community midwife. How is (child's name)?"

Mother: "He is well, and he is very hungry."

Community

health volunteer: "Tell me, how are you feeding him?"

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

Community health volunteer: “What made you decide to do that?”

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

Ask: What did the Community health volunteer learn from this mother?

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

Demonstration 4.1.D Starting and Continuing a Conversation

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

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

Community health volunteer: “How old is (child’s name) now?”

Mother: “He is two days old today.”

Community health volunteer: “What are you feeding him on?”

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

Community health volunteer: “What made you decide to give the water?”

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

Ask: What did the Community health volunteer learn from this mother?

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

Demonstration 4.1.E Using Responses and Gestures Which Show Interest

The Community health volunteer is talking to a mother who has a one-year-old child

- Community health volunteer:* “Good morning, (name). How is (child’s name) now that he has started solids?”
- Mother:* “Good morning. He’s fine, I think.”
- Community health volunteer:* ““Mmm.” (Nods, smiles.)
- Mother:* “Well, I was a bit worried the other day, because he vomited.”
- Community health volunteer:* “Oh dear!” (Raises eyebrows, looks interested.)
- Mother:* “I wondered if it was something in the stew that I gave him.”
- Community health volunteer:* “Aha!” (Nods sympathetically).
- Ask:* How did the Community health volunteer encourage the mother to talk?

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

Demonstration 4.1.F Reflecting Back

- Community health volunteer:* “Good morning, (name). How are you and (child’s name) today?”
- Mother:* “He wants to feed too much - he is taking my breast all the time!”
- Community health volunteer:* “(Child’s name) is feeding very often?”
- Mother:* “Yes. This week he is so hungry. I think that my milk is drying up.”
- Community health volunteer:* “He seems more hungry this week?”
- Mother:* “Yes, and my sister is telling me to breastfeed him more often”
- Community health volunteer:* “Your sister says that he needs to breastfeed more?”

Mother: “Yes. How often should i breastfeed?”

Ask: What did the Community health volunteer learn from the mother?

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

Demonstration 4.1 G Empathy

Community health volunteer: “Good morning, (name). How are you and (child’s name) today?”

Mother: “He is not feeding well, I am worried he is ill”

Community health volunteer: “You are worried about him?”

Mother: “Yes, some of the other children in the village are ill and I am frightened he may have the same illness.”

Community health volunteer: “It must be very frightening for you.”

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

Comment: **Here the Community health volunteer used the skill of empathy twice. She said “You are worried about him” and “It must be very frightening for you.” In this second version the mother and her feelings are the focus of the conversation.**

Demonstration 4.1 H Empathy.

CHV talking to a pregnant mother who is HIV positive

Community health volunteer: “Good morning, (name). You wanted to talk to me about something? “Smiles.

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

Community health volunteer: “You’re really worried about what’s going to happen.”

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

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

Comment: In the second version the Community health volunteer concentrated on the mother's concerns and worries. The Community health volunteer responded by saying "You're really worried about what's going to happen." This was empathy.

Identifying Judging Words

Demonstration 4.1 I Using Judging Words

The Community health volunteer is talking to a mother of a five-month-old baby. As you watch, look for judging words

Community health volunteer: "Good morning. Is (name) breastfeeding normally?"

Mother: "Well - I think so."

Community health volunteer: "Do you think that you have enough breast milk for him?"

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

Community health volunteer: "Has he gained weight well this month?"

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

Community health volunteer: "May I see his growth chart?"

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

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

Avoiding Judging Words

Demonstration 4.1 J Avoiding Judging Words

Community health volunteer: "Good morning. How is breastfeeding going for you and (child's name)?"

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

Community health volunteer: "How is his weight? Can I see his growth chart?"

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

Community health volunteer: “He is obviously getting all the breast milk that he needs.”

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

Comment: **This time the Community health volunteer learnt what she needed to know without making the mother worried. The Community health volunteer used open questions to avoid using judging words.**

5.2: BUILDING CONFIDENCE AND SUPPORT SKILLS

Demonstration 5.1 A Accepting What a Mother Thinks

Mother: “My milk is thin and weak, and so I have to give bottle feeds.”

Community health volunteer: “Oh no! Milk is never thin and weak. It just looks that way.”
(nods, smiles.)

Ask: Did the Community Health Volunteer agree, disagree or accept?

Comment: **This is an inappropriate response, because it is disagreeing.**

Mother: “My milk is thin and weak, so I have to give bottle feeds.”

Community health volunteer: “Yes – thin milk can be a problem.”

Ask: Did the Community Health Volunteer agree, disagree or accept?

Comment: **This is an inappropriate response because it is agreeing.**

Mother: “My milk is thin and weak, so I have to give bottle feeds.”

Community health volunteer: “I see. You are worried about your milk.”

Ask: Did the Community Health Volunteer agree, disagree or accept?

Comment: **This is an appropriate response because it shows acceptance.**

Demonstration 5.1 B Accepting What a Mother Feels

This mother has a nine-month-old baby

Mother (in tears): “It is terrible, (child’s name) has a cold and his nose is completely blocked and he can’t breastfeed. He just cries and I don’t know what to do.”

Community health volunteer: “Don’t worry, your baby is doing very well.”

Ask: Was this an appropriate response?

Comment: **This is an inappropriate response, because it did not accept the mother’s feelings and made her feel wrong to be upset.**

Mother (in tears): “It is terrible, (child’s name) has a cold and his nose is completely blocked and he can’t breastfeed. He just cries and I don’t know what to do.”

Community health volunteer: “Don’t cry – it’s not serious. (Child’s name) will soon be better”

Ask: Was this an appropriate response?

Comment: **This is an inappropriate response. By saying things like “don’t worry” or “don’t cry” you make a mother feel it is wrong to be upset and this reduces her confidence.**

Mother (in tears): “It is terrible, (child’s name) has a cold and his nose is completely blocked and he can’t breastfeed. He just cries and I don’t know what to do.”

Community health volunteer: “You are upset about (child’s name) aren’t you?”

Ask: Was this an appropriate response?

Comment: **This is an appropriate response because it accepts how the mother feels and makes her feel that it is alright to be upset. Notice how, in this example, empathizing was used to show acceptance. So this is another example of using a listening and learning skill to show acceptance.**

Demonstration 5.1 C Using Simple Language

Community

health volunteer: “Good morning (name). What can I do for you today?”(name)?”

Mother: “Can you tell me what foods to give my baby, now that she is six months old.”

Community

health volunteer: “I’m glad that you asked. Well now, the situation is this. Most children need more nutrients than breast milk alone when they the need for other micronutrients like vitamin A is higher than what is provided by breast milk.

“However, if you add foods that aren’t prepared in a clean way it can increase the risk of diarrhoea and if you give too many poor quality foods the child won’t get enough calories to grow well.”

Ask: What did you observe?

Comment: The health worker is providing too much information. It is not relevant to the mother at this time. She is using words that are unlikely to be familiar to the mother.

Demonstration 5.1 D Using Simple Language

Community

health volunteer: “Good morning (name). How can I help you? “

Mother: “Can you tell me what foods to give my baby, now that she is six months old?”

Community

health volunteer: “You are wondering about what is best for your baby. I’m glad you have come to talk about it. It is usually a good idea to start with a little porridge to get him used to the taste of different foods. Just two spoons twice a day to start with.”

Ask: What did you observe this time?

Comment: The Community Health Volunteer explains about starting complementary foods in a simple way.

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ANNEX 6

PREPARING A YOUNG CHILD'S MEAL

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Annex on: PREPARING A YOUNG CHILD'S MEAL		
Group:		
Age of child	Achieved (Yes/No)	Comments
Food groups:		
Grains, grain products and other starchy foods such as sorghum, maize. Spaghetti, rice cassava, white fleshed sweet potato, bread, etc		
Legumes and nuts (beans, lentils, green grams, cow peas, pea nuts e.tc		
Flesh foods (beef, goat)		
Dairy and dairy products (fresh milk, yoghurt, cheese, etc)		
Eggs		
Vitamin A rich fruits and vegetables (e.g. pumpkin, carrots, orange flesh sweet potatoes, green leafy vegetables, yellow orange coloured fruits		
Other fruits and vegetables such as oranges, pineapples, passion fruits		
Consistency/Texture		
Amount		
Prepared in a clean and safe manner		

ANNEX 7

MOH 100 - COMMUNITY REFERRAL FORM

SECTION A: Patient /Client Data	
Date:	Time of referral:
Name of the patient:	
Sex: Male <input type="checkbox"/> Female <input type="checkbox"/>	Age:
Name of Community Health Unit:	
Name of Link Health Facility:	
Reason(s) for Referral	
Main problem(s):	
Treatment given:	
Comments:	
CHV Referring the Patient:	
Name:	Mobile No:
Village/Estate:	Sub Location:
Location:	
Name of the community unit:	
Receiving Officer:	
Date:	Time:
Name of the officer:	
Profession:	
Name of the Health facility:	
Action taken:	
SECTION B : Referral back to the Community	
Name of the officer:	Mobile No:
Name of CHV:	Mobile No:
Name of the community unit:	
Call made by referring officer:	Yes: <input type="checkbox"/> No: <input type="checkbox"/>
Kindly do the following to the patient:1.	

Official Rubber Stamp & Signature _____

HOUSEHOLD LEVEL INDICATORS					
Date of Data Collection	Village Name	Household Number	Household has a functional latrine in use (✓/X)	Household with hand washing facilities (✓/X)	Household using treated water (✓/X)
AG*	AH*	AI*	AJ	AK	AL

AG*, AH*, AI* contain data similar to A, B and C respectively.

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ANNEX 9

COUNSELING/EDUCATION TOPICS PER BFCI STEP

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Step	Topics to be covered
Step 3: Promote optimal maternal nutrition among women and their families	<ol style="list-style-type: none">1. Importance of good maternal nutrition2. Consequences of malnutrition (underweight and overweight/obesity) during pregnancy3. Promotion of appropriate maternal nutrition through consumption of diversified diet and extra meals4. Consumption of iron rich foods and how to increase iron intake in foods5. Maternal nutrition assessment (including weight monitoring for pregnant women) and counseling within the healthcare system.6. Importance of gaining adequate weight during pregnancy7. Effects of anemia in pregnancy8. Anemia control in pregnancy through<ol style="list-style-type: none">a. dietary diversification andb. strengthening uptake and utilization of ironc. Malaria controld. Deworming9. Benefits of IFAS during pregnancy10. IFAS policy11. Importance of attending Ante Natal Clinic (ANC) in the first trimester (1st three months)12. Importance of early HIV testing during ANC visit13. Importance of tetanus vaccine during pregnancy14. Importance of male accompaniment to the ANC clinic15. Family support to pregnant women16. Family support to HIV positive women

Step 4: Inform all pregnant women and their families about the benefits of breastfeeding and risks of artificial feeding

1. Advantages of breast milk
2. Advantages of breast feeding to the mother and the baby
3. Nutrients in human milk
4. differences in quality of protein and fats in human milk as compared to other milks
5. Duration and importance of exclusive breast feeding for 6 months
6. Importance of early initiation
7. Feeding the baby on colostrum in the first days of birth
8. Benefits of colostrum
9. Risks of not breastfeeding
10. Disadvantages of mixed feeding
11. Dangers of using bottles, teats and pacifiers
12. How breast feeding works (removal and manufacturer of milk for the next feed to address problem of not enough milk), attachment and positioning (importance of feeding on demand)
13. Focus on changing negative attitudes and perceptions which set up barriers to exclusive breastfeeding and continued breastfeeding
14. Lactation amenorrhea (LAM)-exclusive breast feeding as a family planning method)- does it work- 3 criteria that must be met for LAM to be effective as a family planning method
15. Advantages of family planning
16. Prevention of mother to child transmission during –pregnancy, labour and delivery, and during breastfeeding
17. Basic facts about HIV-exclusive breast feeding and use of ARVS for HIV positive mothers
18. Importance of male accompaniment to ANC
19. Birth plan during pregnancy
20. Importance of having a companion during labour and delivery
21. Counselling family members to support a mother during birth and delivery
22. Importance of Hygiene during pregnancy and delivery

Step 5: Support mothers to initiate breastfeeding within the first one hour of birth, establish and maintain exclusive breastfeeding for first six months

1. Why early initiation of breast feeding
2. How to do early initiation within the first one hour of birth (Skin to skin contact)
3. Importance of early initiation
4. Breastfeeding on demand-why
5. Signs of recognizing hunger cues from the baby
6. Good attachment-4 key points of good attachment
7. Good positioning-4 key points of good positioning
8. Effective suckling-4 key points of effective suckling
9. Results of poor positioning and attachment
10. Expressing breast milk-in which situation
11. Stimulation of oxytocin
12. How to express breast milk
13. How often to express
14. Storing breast milk-how long
15. How to warm breast milk
16. Common breast feeding difficulties and how to address them-
 - a. Not enough milk
 - b. Baby crying a lot
 - a. Breast refusal
17. Common breast conditions and how to prevent
18. Importance of attendance to child welfare clinic for immunization and growth monitoring every month
19. Importance of adequate diet for a breastfeeding mother
20. Referral to health facility in case of a problem

Step 6: Encourage sustained breastfeeding beyond six months to two years or more alongside timely introduction of appropriate, adequate and safe complementary foods

1. Benefits of continued breastfeeding upto 2 years
2. Age of introduction of complementary feeds
3. Complementary feeding criteria
 - Frequency
 - Amount
 - Texture (Thickness)
 - Timely introduction
 - Variety
 - Active feeding
 - Hygiene
4. Dangers of starting other foods too soon
5. Dangers of starting other foods too late
6. Iron gaps after 6 months and feeding on iron rich foods
7. Vitamin A gaps and feeding on vitamin A rich food
8. What is the frequency of feeding as per age?
9. What is the quantity/amount of food as per age?
10. Variety of food to be offered

	11. Active and responsive feeding
Step 7: Provide a welcoming and conducive environment for breastfeeding families	<ol style="list-style-type: none"> 1. Establishment of designated breastfeeding rooms/ corner for breastfeeding mothers <ol style="list-style-type: none"> a. running water, sink b. Bench for changing babies c. IEC materials d. Friendly colors 2. advocating for baby friendly workplace 3. advocating for Family involvement (mother in-law, husbands, relatives) 4. Companion accompaniment to the facility
Step 8: Provide a welcoming and conducive environment for breastfeeding families	<ol style="list-style-type: none"> 1. Establishment of mother support groups 2. Deciding on activities of the support groups 3. collaboration with the staff

ANNEX 10

MONTHLY REPORTING TOOL FOR PREGNANT AND NEW MOTHERS

MONTH_____		MONTH_____		MONTH_____	
Record the number of:					
<input type="checkbox"/>	Early pregnancy visits (0-6m)	<input type="checkbox"/>	Early pregnancy visits (0-6m)	<input type="checkbox"/>	Early pregnancy visits (0-6m)
<input type="checkbox"/>	Late pregnancy visits (7-9m)	<input type="checkbox"/>	Late pregnancy visits (7-9m)	<input type="checkbox"/>	Late pregnancy visits (7-9m)
<input type="checkbox"/>	New mother visits (0-6m)	<input type="checkbox"/>	New mother visits (0-6m)	<input type="checkbox"/>	New mother visits (0-6m)
<input type="checkbox"/>	Group sessions	<input type="checkbox"/>	Group sessions	<input type="checkbox"/>	Group sessions
<input type="checkbox"/>	Number of pregnant women this month	<input type="checkbox"/>	Number of pregnant women this month	<input type="checkbox"/>	Number of pregnant women this month
<input type="checkbox"/>	Number of babies born this month	<input type="checkbox"/>	Number of babies born this month	<input type="checkbox"/>	Number of babies born this month
<input type="checkbox"/>	Any low birth weight babies <2.5kg	<input type="checkbox"/>	Any low birth weight babies <2.5kg	<input type="checkbox"/>	Any low birth weight babies <2.5kg



ANNEX 11

FORM 1 - INDIVIDUAL INFANT AND YOUNG CHILD FEEDING AND GROWTH MONITORING RECORD

- 1. Village name: _____
- 2. Household number: _____
- 3. CHVs Name: _____

Form 1 - Individual-Child Feeding Practices

<p>MOTHER</p> <p>2. Mother's name:</p> <p>3. Mother's Age..... 4. Parity:.....</p>	<p>INFANT</p> <p>5. Baby's date of birth (day/month/year)</p> <p>6. Baby's weight at birth (kg and g).....</p> <p>7. Low Birth Weight (if < 2,500 g, tick the box)</p>	<p>PRE-LACTEAL FEEDING</p> <p>9. In addition to breastmilk, what was the child given to drink/eat in the first three days of life?</p> <p>9.1. Water/other liquids ; 9.2. Milk (not breastmilk)/infant formula <input type="checkbox"/> ;</p> <p>9.3. Others specify <input type="checkbox"/> 9.4. None <input type="checkbox"/></p>																																																																									
<p>EARLY INITIATION</p> <p>8. The child put to the breast/breastfed?</p> <p>8.1. Within 1 hour after delivery <input type="checkbox"/> ;</p> <p>8.2. Later than 1 hour after delivery <input type="checkbox"/></p>	<table border="1" style="width: 100%; border-collapse: collapse; text-align: center;"> <tr> <td style="width: 5%;">10. Date of the visit (day month/year)</td> <td style="width: 5%;">1 to 1.9</td> <td style="width: 5%;">2 to 2.9</td> <td style="width: 5%;">3 to 3.9</td> <td style="width: 5%;">4 to 4.9</td> <td style="width: 5%;">5 to 5.9</td> <td style="width: 5%;">6 to 6.9</td> <td style="width: 5%;">7 to 7.9</td> <td style="width: 5%;">8 to 8.9</td> <td style="width: 5%;">9 to 9.9</td> <td style="width: 5%;">10 to 10.9</td> <td style="width: 5%;">11 to 11.9</td> </tr> <tr> <td style="width: 5%;">11. Infant's age at the moment of the visit (in months)</td> <td style="width: 5%;">0 to 0.9</td> <td style="width: 5%;">1 to 1.9</td> <td style="width: 5%;">2 to 2.9</td> <td style="width: 5%;">3 to 3.9</td> <td style="width: 5%;">4 to 4.9</td> <td style="width: 5%;">5 to 5.9</td> <td style="width: 5%;">6 to 6.9</td> <td style="width: 5%;">7 to 7.9</td> <td style="width: 5%;">8 to 8.9</td> <td style="width: 5%;">9 to 9.9</td> <td style="width: 5%;">10 to 10.9</td> </tr> <tr> <td style="width: 5%;">12. Baby's weight during the visit (in kg and g)</td> <td colspan="11"></td> </tr> <tr> <td style="width: 5%;">13. Did you breastfed the child in the last 24 hours?</td> <td colspan="11"></td> </tr> <tr> <td style="width: 5%;">14. In the last 24 hours did you give the child water or other fluids?</td> <td colspan="11"></td> </tr> <tr> <td style="width: 5%;">15. Is the child given powder milk, condensed milk, infant formula?</td> <td colspan="11"></td> </tr> </table>			10. Date of the visit (day month/year)	1 to 1.9	2 to 2.9	3 to 3.9	4 to 4.9	5 to 5.9	6 to 6.9	7 to 7.9	8 to 8.9	9 to 9.9	10 to 10.9	11 to 11.9	11. Infant's age at the moment of the visit (in months)	0 to 0.9	1 to 1.9	2 to 2.9	3 to 3.9	4 to 4.9	5 to 5.9	6 to 6.9	7 to 7.9	8 to 8.9	9 to 9.9	10 to 10.9	12. Baby's weight during the visit (in kg and g)												13. Did you breastfed the child in the last 24 hours?												14. In the last 24 hours did you give the child water or other fluids?												15. Is the child given powder milk, condensed milk, infant formula?											
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15. Is the child given powder milk, condensed milk, infant formula?																																																																											

Guidelines for Completing Form 1- Infant and Young Child Feeding and Growth Monitoring Record:

1. The record is to be filled at the village level by the CHV who may be supported by the lead mother
2. One record per child is used.
3. The record is kept with the CHV assigned to the current family/child.
4. The record is initiated as soon as possible after the birth of the child and is updated on monthly basis, thereafter.
5. At the first visit (as soon as possible after delivery), the CHV should complete questions 1 through 9:
 - Question 1: write down the name of the village, household number and the name of the CHV.
 - Questions 2 and 3: ask and write down the name of the mother and her age in years.
 - Question 4: ask and write down child's number in the family. Is he/she the 1st, the 2nd, the 3rd, etc. child in the family?
 - Questions 5 & 6: write down the name and the date of birth by indicating the day, the month, and the year of birth
 - Question 7: write down the weight of the baby at birth. It is very important to weigh the child after the birth and write down his/her weight for future monitoring of the baby growth and for giving specific advice for low-birth-weight newborns [see below under follow-up actions]. Write down the weight of the baby in grams [example: 3,500 g]. If the child weigh less than 2,500 g, tick the box for Low Birth Weight Baby;
 - For question 8, tick "☑" in the box 8.1 if the mother put the baby to the breast within 1 hour after delivery. If the mother put the baby to the breasts later than 1 hour after delivery tick-in the box 8.2.
 - For question 9, tick-in the box 9.1 if the mother gave the child water or other liquids; tick-in the box 9.2 if the mother gave milk (not breastmilk) or infant formula; and tick-in the box 9.3 if the child was given other liquids in the first 3 days after birth
6. At the first and subsequent visits, the CHV fills in the following questions:
 - For question 10, write down the date, the month and the year of your visit to the family/child
 - For question 11, ask the mother how old is the child and write down her answer.
 - For question 12, ask the mother to provide the mother child booklet and record the weight of the child indicated for that month. Write down the infant's weight in grams [example: 3,500 g].
 - For question 13, 14, 16, 17, 18 it is very important to refer to the last 24 hours.
 - For question 16 is very important to stress the consistency of the food. The liquid part of soup or broths is not considered a solid or semi-solid food. Soup with mashed vegetables is considered a semi-solid food. Examples of complementary foods include mashed potatoes; rice with vegetables, meat, fish, eggs; fruit; other family food.
 - In question 19 mention the key recommendations provided to the mother. [Examples: (a) Continue exclusive breastfeeding. Do not give water or other liquids; (b) Increase the frequency of breastfeeding sessions to at least 8 during the day and the night; etc.]
 - Please ask mother to sign the record. This will be used for monitoring purposes.

Follow-up actions:

- i. At the first visit (immediately after the birth) provide support for immediate and exclusive breastfeeding;
- ii. If the newborn is less than 2,500g, pay particular attention to the following recommendations: (a) keeping the baby warm (kangaroo method or skin-to skin care), (b) paying extra-attention to hygiene and frequent hand-washing, and (c) assisting with early & exclusive breastfeeding [provision of cup feeding if necessary]. Because babies with less than 2,500g are at higher risk of becoming ill and dying, it is important to inform the mother and other family members on the importance of seeking immediate medical care if any of the following danger signs arise in the baby:
 - a. stops feeding or is not feeding well;
 - b. is difficult to awake;
 - c. becomes restless, irritable, or unconscious;
 - d. has fever;
 - e. is cold;
 - f. has difficulty breathing;
 - g. has diarrhoea;
 - h. shows any other worrying sign;
 - i. Inform health workers on all the cases of birth of low-birth weight babies.
- iii. At the subsequent visits, identify key breastfeeding and/or complementary problems and counsel the mother and other family members. Write down main recommendations in the record (ex. continue exclusive BF; do not give water or other liquids before 6 months of age; initiate giving meat or fish or eggs at 6 months of age, address any problems with breastfeeding (mastitis, insufficient breastmilk).

- iv. Assess if the baby is growing well and make recommendations.
- v. If the case is more serious and the child needs specific services or specialized nutrition advice refer the caretaker/child to the closest facility for support/advice.

At every visit, sign the record and ask the mother to sign it as well.



ANNEX 12

S/CHMT SUPERVISION CHECKLIST

NAME OF PERSONS SUPERVISING:			
DATE OF VISIT (DD/MM/YY):			
NAME OF COMMUNITY UNIT ATTACHED TO THE FACILITY:			
NAME OF HEALTH FACILITY:			
CRITERIA 1: FUNCTIONAL COMMUNITY MOTHER SUPPORT GROUP (CMSG)			
	Is there a CMSG?	Yes ()	No () and reason
	If yes, what is its composition? Core members (CHEW, Nutritionist, Chief/assistant chief, CHVS and CHCs representative, lead mothers)	Yes ()	No () and reason
	Does the CMSG meet bi-monthly? If yes, check minutes/reports for CMSG	Yes ()	No () and reason
	Is there a plan for bi-monthly (after every two months) baby friendly meetings with clear roles of key players available?	Yes ()	No () and reason
	Is there evidence of clear documentation of CMSG activities?	Yes ()	No () and reason
CRITERIA 2: FUNCTIONAL MOTHER-TO-MOTHER SUPPORT GROUP (M2MSG)			
	Are there Mother to Mother Support Groups (M2MSG)? If Yes, how many M2MSGs? [_____] How many members in the M2MSG? [_____] If more than one M2MSG, provide membership for each	Yes ()	No () and reason
	Does the M2MSG meet monthly? If yes, check minutes/reports (Observe and check records)	Yes ()	No () and reason
	Is there a functional referral system from the facility to M2MSG? (Check record whether there is a referral book from facility to community either through maternity or MNCWC)	Yes ()	No () and reason
CRITERIA 3: TARGETED HOME VISITS			
	Have the CHVs conducted targeted home visits? (Check records)	Yes ()	No () and reason

	Is there clear documentation of number of women reached? (Check records)	Yes ()	No () and reason
	Are there reports compiled by the CHEW/CHV from the individual child feeding and growth monitoring form?	Yes ()	No () and reason
CRITERIA 4: BI-MONTHLY BABY FRIENDLY COMMUNITY MEETINGS			
	Is there clear documentation of bi monthly baby friendly meetings?	Yes ()	No () and reason
	Did the activities conducted in the previous meeting include cooking demonstrations on appropriate adequate, safe complementary foods?	Yes ()	No () and reason
	Was there inclusion of other health promotion activities during the baby friendly community meetings? If yes, list the activities	Yes ()	No () and reason
	Did other community members, in addition to pregnant and lactating mothers, attend the baby friendly meetings? (Check report)	Yes ()	No () and reason
CRITERIA 5: MONTHLY MEETING FOR COMMUNITY HEALTH VOLUNTEERS (CHVs)			
	Are monthly CHVs meetings conducted? (check evidence of documentation)	Yes ()	No () and reason
	Was BFCI agenda included during the CHVs meetings? (check evidence of documentation)	Yes ()	No () and reason
	Were follow-up actions for BFCI carried out? (check evidence of documentation)	Yes ()	No () and reason
CRITERIA 6: REGULAR TRAININGS FOR CHVS ON BFCI			
	Have all CHVs been trained on BFCI? (confirm whether there are new additional after drop outs)	Yes ()	No () and reason
	Once a year, the complete training is offered to replacement volunteers (new volunteers that replace drop-out volunteers).	Yes ()	No () and reason
CRITERIA 7: SUPPORT FOR HIV POSITIVE MOTHERS			
	Does the facility offer PMTCT HIV services?	Yes ()	No () and reason
	Facility fully independent in offering PMTCT services (Check records)	Yes ()	No () and reason
CRITERIA 8: BABY FRIENDLY COMMUNITY RESOURCE CENTRE			
	Is there a BFCI resource centre in the facility or community? (Observe)	Yes ()	No () and reason

	Are there adequate IEC materials in the resource centre? (Observe)	Yes ()	No () and reason
	Is there evidence of use for the resource centre? (Check attendees to the centre)	Yes ()	No () and reason
CRITERIA 9: MONITORING AND SUPERVISION			
	Does the CHEW monitor activities of the CHVs?	Yes ()	No () and reason
	Are there compiled reports by the CHEW from individual child feeding and growth monitoring form?	Yes ()	No () and reason
CRITERIA 10: FACILITY OBSERVATION			
	Does the facility have a written MIYCN policy summary statement present and displayed in all relevant areas of the health facility (MCH, maternity, paediatric wards, notice boards, Critical Care Centre)	Yes ()	No () and reason
	Labour and delivery area Yes No Area does not exist		
	Antenatal clinic Yes No Area does not exist		
	Postpartum ward/room Yes No Area does not exist		
	Well baby clinics/Rooms Yes No Area does not exist		
	ANC inpatient ward Yes No Area does not exist		
	Consultation rooms Yes No Area does not exist		
	Special baby units Yes No Area does not exist		
	PMTCT clinic Yes No Area does not exist		
	Waiting Bay Yes No Area does not exist		
	Paediatric ward Yes No Area does not exist		
	Is the MIYCN policy statement displayed, illustrated in a pictorial and/or any other possible way of simplifying, contextualized and understood by the local population?	Yes ()	No () and reason
	Are pregnant women attending the MNCWC given IFAS supplementation at the health facility?	Yes ()	No () and reason
	Does the PCF conduct health talks to educate mothers on the benefits of breast feeding? (If schedule and topic covered not present circle No)	Yes ()	No () and reason
	Does the PCF have hand washing facilities in points accessible by mothers/caregivers? (Check for leaky pit in close to toilets and other hand washing facilities)	Yes ()	No () and reason

ANNEX 13

CHEW SUPERVISION CHECKLIST

NAME OF CHEW -			
DATE OF VISIT (DD/MM/YY) -			
NAME OF VILLAGE -			
NAME OF COMMUNITY UNIT ATTACHED TO THE FACILITY -			
NAME OF HEALTH FACILITY -			
MONTHLY INFORMATION ON BFCI			
	Has the CHV submitted the monthly information for BFCI activities	Yes ()	No () and reason
	Are all records up to date?		
	Is the data in the individual child monitoring form complete for each child?		
The CHEW will accompany the CHV to the baby friendly gathering or mother support groups gathering, she/he may accompany the CHV to visit pregnant women, mothers and children in the community. During this time the CHEW may assess a few mothers through asking them questions			
FEEDBACK FROM MOTHER SUPPORT GROUPS			
	Is there any feedback from the mother support group about what is working well for BFCI or what is not working well?	Yes ()	No () and reason
Write the feedback in this row			
Questions for pregnant women			
	Have you been to the health centre for ANC?	Yes ()	No () and reason
	How many meals should you eat in one day when you are pregnant?	_____ (number of meals) (should be 4)	
	Are you taking iron tablets now? Any problems? (If problems, counsel the mother)	Yes / No (should be Yes) If No, why not?	
	What are the benefits of taking IFAS during pregnancy?		
	If a mother tested HIV positive for how is she supposed to feed the infant		
Questions for mothers with infants less than 6 months			
	How soon after giving birth were you able to put the baby to the breast?	_____ minutes/hours (should be within 1 hour)	
	What did you feed the baby in the first three days? What else?	(should be breastmilk only)	
	What do you feed the baby now?	(should be breastmilk only)	
	At what age (of the baby, in months) do you plan to start giving foods other than breastmilk to the baby?	_____ (number of months) (should be 6 months)	

ANNEX 14

SUMMARY OF BFCI ACTIVITIES

Activity	Summary of requirements
House hold mapping	<ul style="list-style-type: none"> • Frequency – every 6 months as per CHS guidelines • As soon as CHVs are trained, they need to have a database of all pregnant women, breastfeeding mothers with children 0-23 months in their respective area of coverage • This database may be available if mapping of households through CHS has been done in the last 2 months
Targeted home visits	<ul style="list-style-type: none"> • CHVs will visit individual mothers (both pregnant and lactating) in their households. • The CHVs will identify and visit the pregnant women as follows; <ul style="list-style-type: none"> - Once every month up-to 34 weeks - Weekly until delivery and first one month - Once a month until 6 months - Thereafter according to need • The CHVs will visit breastfeeding mothers as follows; <ul style="list-style-type: none"> - When the volunteer learns that a woman is pregnant - When a pregnant woman is close to her date of delivery (around the 8th month) - As soon as possible after the baby is born (at delivery or within 2 days (48 hrs) after delivery) - When the infant is about 5 1/2 months old to begin discussion on complementary feeding - When a child is sick • CHVs will always encourage pregnant and breastfeeding mothers to join and regularly attend mother-to-mother support groups
Mother-to-Mother Support Group meetings (CHVs and/or lead mothers meeting with caretakers, grandmothers, fathers, community leaders	<ul style="list-style-type: none"> • Frequency – Monthly (or more frequently if group decides) • Health facilities and CHVs will refer mothers to existing MtMSGs • Where they do not exist, CHVs will foster the establishment of such according to guidelines provided

	<p>CHVS will facilitate identification of a lead mother for each MtMSG who will ensure meetings are done and learning is taking place. The lead mother should be one who has leadership skills. The CHEW/CHV will continually build the capacity of the lead mothers for enhanced support. It is desirable that lead mothers receive training on BFCI</p> <ul style="list-style-type: none"> • A MtMSG meeting will last about 1-2 hours. • Activities during a meeting may include; <ul style="list-style-type: none"> - Experience sharing - Learning sequential BFCI topics (see annex 9) - Addressing mothers' concerns (knowledge, skill, experience, etc) • CHVs/Lead mothers will maintain documentation on attendance, topics discussed and any issues emanating from the meetings for action • CHVs will provide a report on MtMSGs
Monitoring and supervision of the CHV by the CHEW	<ul style="list-style-type: none"> • Using the CHEW/CHA supervision checklist (Annex 13), the CHEW will conduct regular supervision visits • The CHEW will supervise and follow up household visits and mother-to-mother support group meetings where they will observe the activities to ensure they meet stipulated guidance • A report will be required for each visit to mother support group and later consolidated in the monthly report
Monitoring and supervision by CHMT and national team	<p>Frequency</p> <ul style="list-style-type: none"> - Once every month for first 3 months, - then quarterly thereafter. <p>The teams will use the S/CHMT supervision checklist (Annex 12)</p>
CHV review meetings	<ul style="list-style-type: none"> • Frequency – Every Month • Activities include but are not limited to; <ul style="list-style-type: none"> - Feedback from CHVs to the SCHMT & CHEW (sharing experiences between villages within the CU) - Monthly reporting (Submission of FORM 1 forms to CHEW/Nutritionist) - Action planning according to need

Regular training and mentorship for CHV	<ul style="list-style-type: none"> • Frequency - Every month • This may be incorporated into all monthly meetings at the health facility but may be done at any other convenient time • Topics will be discussed based on identified knowledge/skills gaps among the CHVs • SCHMT and the CHEW will support the facilitation
Community Baby Friendly gatherings (organized by Community Mother Support Group (CMSG) members at the community level)	<ul style="list-style-type: none"> • Frequency - Once every 2 months • The CHVS with the support of the area chief should work together to gather mothers of children less than 2 years old for the monthly “Baby Friendly Gathering”. These are the primary target groups for “Baby-Friendly Gatherings”. • CHVs should also invite fathers, grandmothers, and older siblings to “Baby-Friendly Gatherings”. These people are important secondary targets for learning about improved child feeding. They have an important role in supporting the mother in caring for the child. • The gatherings will focus on promoting good breastfeeding and complementary feeding practices • The gatherings should take 1-3 hours in the morning or afternoon • Below are the suggested activities that may take place during the meeting; <ol style="list-style-type: none"> 1. Education and discussion sessions (by lead mother or CHV) with mothers about how to provide good nutrition and care for themselves and their young children 2. Cooking demonstrations and sharing healthy foods for children 6-23 months of age (enriched porridge, vitamin-rich fruits, for example) 3. Weighing of children (this is optional, if the MtMSG decides to include this component). • The CHEW/Nutritionist/Facility I/C will write an activity report • Other community health platforms like worship centres and chief’s barazas may be used to promote infant feeding practices
Annual BFCI meetings	<p>This meeting may be held after conducting BFCI self-assessment to review the coverage</p>

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