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Planning Guide

The Community
Infant and Young Child Feeding
Counselling Package

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Contents

Acknowledgements

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

The *Community IYCF Counselling Package* has been developed by the UNICEF New York, Nutrition Section team of Nune Mangasaryan, Senior Advisor, Infant and Young Child Nutrition; Christiane Rudert, Nutrition Specialist (Infant Feeding); Mandana Arabi, Nutrition Specialist (Complementary Feeding); in close collaboration with the NPP and URC/CHS team of Maryanne Stone-Jiménez, IYCF Training Expert; Mary Lung'aho, IYCF Community/Emergencies Expert; and Peggy Koniz-Booher, IYCF Behaviour Change and Job Aids Expert. The package layout and illustrations were developed by Kurt Mulholland, Senior Graphic Artist; and Victor Nolasco, Senior Graphic Illustrator. Breast photo acknowledgements include: breast engorgement: Mwate Chintu; sore/cracked nipple: F. Savage-King; plugged duct/mastitis: Chloe Fisher; inverted nipple: Dr. Armida Fernandes. Thanks to the many country teams involved in the development and pre-testing of previous materials.

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Introduction

The *Planning Guide* for the *Community Infant and Young Child Feeding (IYCF) Counselling Package* outlines a summary of a series of steps and provides selected tools for use by national or local stakeholders interested in designing and implementing a community-based IYCF promotion, counselling and support programme. This *Planning Guide* does not aim to provide detailed guidance on all aspects needed for designing, implementing and monitoring a community-based IYCF programme. A comprehensive list of resources that will inform the various steps is referenced in the UNICEF *Infant and Young Child Feeding Programming Guide*, and provided in Annex 1: Resources, tools & useful websites.

The *Community IYCF Counselling Package* includes the *Facilitator Guide* for use in training community workers (CWs); the *Participant Materials*, consisting of "handouts" and monitoring tools; a set of 24 *IYCF Counselling Cards* and companion *Key Messages Booklet*; 3 *Take-home Brochures*; *Planning Guide, and Adaptation Guide*.

The *Community IYCF Counselling Package* also includes a "Clip Art" Compendium to support the adaptation and/or development of high quality graphics. All of the materials found in the *Community IYCF Counselling Package* are available in their electronic formats to facilitate their dissemination, adaptation and use.

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

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

How to Use this *Planning Guide*

The process for designing or strengthening community-based infant and young child feeding programmes, in any setting, is envisioned as having two parts. First of all, partnerships, policies and systems need to be updated or developed and put into place to support the implementation of a range of community IYCF activities. Ideally, these partnerships, policies and systems should link to and integrate with existing health and nutrition services. National teams or organizations interested in designing community-based programmes and activities to support community IYCF can follow the 8 steps outlined in the *Planning Guide* to design and strengthen activities for IYCF promotion, counselling and support.

Secondly, training curricula need to be designed, and tools developed to support implementation of counselling and behaviour change activities, supervision and mentoring, as well as monitoring and

evaluation. To address these needs and guide the process, the *Community IYCF Counselling Package* was created, providing a fully integrated set of materials for use at the community level.

The package is intended as a generic resource, designed to equip community workers (CWs) to promote behaviour change and support mothers, fathers and other caregivers to optimally feed their infants and young children. The package is based on a number of WHO/UNICEF IYCF-related training and guidance materials (described in detail in the *Facilitator Guide*), as well as counselling and behaviour change communication tools currently being used in a number of countries. The proposed adaptation process found in the *Adaptation Guide* involves the review of the generic package in its entirety by a national team of IYCF-related stakeholders, who then adapt and test various elements of the technical content and visual aspects of the package, as needed, depending on their specific context.

Planning for Community-based IYCF Programmes

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

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

The programme also needs to be clear from the outset that IYCF counselling and the skills required to do so effectively must be distinguished from promotive packages which convey some basic information about desirable IYCF practices, but tend not to build practical skills to support mothers to breastfeed and solve problems – e.g., skills in individual counselling and reaching-an-agreement with caregivers, and skills in facilitating interactive Action-oriented Groups and IYCF Support Groups.

Designing community-based IYCF promotion, counselling and support programmes: 8 Steps

The design of community-based IYCF programmes should be done through partnerships and with the active participation of community members and other relevant stakeholders. The following eight steps, with associated activities, are recommended for any national and/or district team or organization interested in designing, planning and supporting a community-based IYCF Promotion, Counselling and Support Programme:

1. Build partnerships, conduct advocacy and implement coordination mechanisms
2. Conduct a rapid review of existing community-based services and programmes in any proposed local target area

3. Confirm target programme area
4. Identify, sensitize and involve community-based stakeholders
5. Conduct a Situation Assessment
    - Collate and analyze existing data on IYCF practices
    - Conduct formative research
6. Undertake pre-implementation planning and design
    - Update data on target population size number of services providers
    - Review and update policies and systems to strengthen IYCF within community-based services
    - Develop a strategy for community-based programming
      Build upon and/or expand existing community cadres
      Create a new community cadre if required
    - Adapt the technical content and graphics of the UNICEF *Community IYCF Counselling Package*
    - Design and/or adapt Tools for supportive supervision/mentoring, and routine monitoring
    - Determine communications strategy
7. Implement the community-based IYCF program
    - Conduct training
    - Conduct IYCF Support activities
    - Implement supportive supervision/mentoring and routine monitoring
8. Integrate a limited number of carefully-selected measures or indicators of IYCF support into routine monitoring and periodic small surveys
    - During program planning
    - During early to mid-stage program implementation
    - During program expansion and ongoing management.

Step 1: Build partnerships, conduct advocacy and implement coordination mechanisms

The development of strategic partnerships among government, UN agencies, national and international NGOs, as well as across different sectors, is a critical first step toward the development and implementation of a community-based IYCF promotion and support program. Identify relevant partners at national, district and local levels to build on and integrate with already existing activities and resources, and gain commitment and ensure participation, ownership, and support among key personnel.

Key partners include those who will support or implement the intervention and follow-up actions at district and community level. Their identification may require a mapping of programmes and stakeholders to determine those likely to be main implementing partners for the programme in each administrative unit (e.g. province, district) of the country (or the target area of the country). In many countries a partnership between the district government, national and international NGOs and other civil society stakeholders will be required to 'drive a community-based IYCF intervention' at sub-national levels. Orientation and advocacy sessions with key stakeholders in relevant sectors such as agriculture, food security, water and sanitation, education, gender and women's affairs may be needed to gain their support and engage them in planning and implementation.

In order to achieve scale, the design and planning of the programme should encompass coverage of entire districts, rather than a few scattered communities. The achievement of full coverage may be incremental, but there should be a clear commitment to broad coverage from the start and recognition of the timeframe and resources necessary to achieve scale. A recommended approach is for one NGO to take responsibility for a defined geographic area (e.g., an entire district). There may be other

implementing partners in that particular district, but having one focal agency facilitates coordination and reduces fragmentation. Monitoring (and mapping) data on programme coverage should be reported regularly to government and all partners.

A stakeholder meeting (or several sub-national meetings) may be convened to orient the NGO and government partners on the broad objectives of a community-based IYCF programme and agree on subsequent actions, including their involvement in bringing community-based stakeholders into the process, conducting a situational analysis, and the development of an implementation plan and the timeframe for program implementation and achieving scale. Of paramount importance is the definition of the responsibilities for each partner as the process moves forward, determining 'who' makes the decisions around particular issues? The coordination mechanisms at district level should help to ensure that local and community-based programming builds upon, benefits from and complies with national initiatives.

Step 2: Conduct a rapid review of existing community-based services and programmes

A rapid review of existing community-based services and programmes in any proposed local target area will ensure that resource persons knowledgeable about local needs and gaps in existing services and programme coverage are 'at the table' from the start of the planning, and that any newly designed IYCF programme makes use of, integrates with and builds on existing activities and resources. Local input also helps to ensure that the broad definition of the problem takes into account local knowledge of critical issues that need to be considered in defining the target area, conducting subsequent comprehensive situation assessment activities, and designing the programme.

Step 3: Confirm target programme area

Considering the input of local partners, the findings of the rapid review of existing services and programmes, prioritization of needs, including consideration of underserved areas, and the resources and capacities available for programme implementation, agree and confirm the target programme area and population with local partners, including community leadership. This may take the form of a meeting in which the programme objectives and proposed target area are reviewed and refined. Involving all local partners at this point will help to ensure that government and local implementing partners, as well as community, are fully on board for Steps 4 and 5.

Step 4: Identify, sensitize and involve community-based stakeholders

Identifying, sensitizing and involving community-based stakeholders will ensure their understanding of the process, seek their involvement and gain their support for subsequent situational assessment, program design and implementation activities.

Given their knowledge and experience of networks within the community and/or their ability to influence practices and behaviours, it is important to identify, sensitize and involve community decision-makers, community-based groups and individual community members in designing community-based IYCF promotion, counselling and support programmes. The involvement and commitment of these key stakeholders (in addition to local authorities and partners) can help to ensure that: IYCF programmes receive the necessary endorsements and validation; effectively mobilize the community; and are ultimately sustainable. Key community members may include community and

religious leaders, local politicians, administrators, teachers, nurses, extension workers, community-based organizations, faith-based organizations, women's group leaders, health committee leaders and other community-based cadres. A specific focus on influential women and female-led groups and initiatives is important for IYCF programmes.

Step 5: Conduct Situation Assessment

Before designing a community-based IYCF programme, it is important to conduct a situation assessment tailored to the local context, as existing IYCF practices and barriers may vary significantly across geographic areas and amongst different population groups in any country. It is also important to have updated information about the population and relevant resources available.

It is unlikely that teams will have to start from a blank sheet of paper: much of the information for a situation analysis may already exist, and similar activities may be underway at the national or other sub-national levels that can both inform the process and provide much useful information. Existing documents may merely need to be reviewed and updated, and gaps filled.

The situation assessment will help to ensure that the IYCF programme can effectively integrate with and build on existing programmes and that community-based counselling tools, promotional messages, training materials and communication strategies are appropriately tailored to address existing barriers to optimal IYCF practices.

The UNICEF *IYCF Programming Guide* provides suggestions for recommended actions and tools to support those actions (see Resources Annex 1: Resources, tools and useful websites); the results can help to inform those activities necessary at the local level to 'fill in the gaps'.

The assessment should include the following activities:

1. Compile and review existing information on infant and young child feeding practices, including national data on primary IYCF indicators and data from IYCF programmes operating in the target area. See *APPENDIX 1: Breastfeeding and Complementary Feeding Matrices*, and *APPENDIX 2: Calendar of Local, Feasible, Available and Affordable Foods (Home and/or Market)*
2. Identify relevant formative research results, including results from knowledge, attitudes and practices (KAP) studies to determine barriers and motivators to optimal practice. Assessment of social norms related to IYCF in the target area will also be important.
3. Determine need for any additional research to address information gaps and to gain better insight into the determinants of nutritional outcomes and IYCF practices. This information will help to inform the design of interventions that will promote and support social and behaviour change. Formative research must be done with the full participation of communities. (The UNICEF *IYCF Programming Guide* provides suggestions for the various methodologies that can be used. See Annex 1-3: Tools for formative research and other situation assessment tools.) Other useful tools are included in Appendices 1 and 2: Breastfeeding and Complementary Feeding Matrices and Calendar of Local, Feasible, Available and Affordable Foods.
4. Map existing community-based health and nutrition programmes to identify key stakeholders, coverage of programmes, scope of activities, the type and number of community workers (cadres), the incentives and support they receive, including supervision and mentoring, and the monitoring framework, systems and tools of the programmes in which they are involved.
5. Consider the relevant outcomes of previous national or local IYCF programmes with documented successful interventions and failures, including evaluations or reviews of community-based IYCF projects. Determine which models achieved the desired results, whether scale-up is feasible, and ensure that lessons learned are taken into consideration for the

development of new strategies and action plans. If not already reviewed/evaluated, existing community project(s) should be reviewed.

These activities need not be followed in a rigid and sequential manner; how the situation analysis can be most efficiently accomplished can be determined locally.

Step 6: Undertake pre-implementation planning and design

Update demographic and health resources data, including the mapping of existing programmes

Update information on the size of the target population and service providers. If resources are sufficient, list and map households with pregnant women and children under 24 months of age (see APPENDIX 3: Data for programme planning).

If creating an updated census of the population in the programme area is not feasible, the relative proportions of each of the target population groups below can be derived from national data. Where more specific information is not available, the following assumptions may be used to approximate the size of the target population (pregnant women and mothers/caregivers of children 0 up to 24 months):

- The proportion of the total population under 24 months is about 7%
  Approximately 25% of the population under 24 months will be 0-5 months
  About 75% of the children under 24 months will be 6-23 months
- Pregnant and lactating women are approximately 4% each, or 8% together of the total population
- Adjusting for population growth: if population size is estimated, it will be necessary to adjust the figures annually to account for population growth. In Sierra Leone, for example, CMAM programmes adjust the size of their target population for screening by assuming an annual population growth rate of 3%. Thus, a community of 5,000 members in year 1 would be estimate to have 5,150 (5000 x 1.03) members in year 2.

Describe existing health facility and community resources, existing programmes and service providers in the target area.

- Map existing community health and nutrition programmes to determine the coverage or 'reach' of the programmes and scope of their activities; note proximity of communities near and distant from health facilities.

- Obtain information on the type of community cadres (health workers and volunteers who can provide IYCF support to the community) in the target area, and the systems (including referral systems) and personnel in place to support the community cadres and their work.

  Assess what kinds of monitoring systems exist, the tools and registers the community workers use, how well these tools are used, and how well the system is functioning. If the system has a well-developed set of tools and CWs are using them appropriately, it may be more feasible to add information for community IYCF monitoring than if there is no functioning health or management information system. In such a case, it is possible to have a monitoring system that relies on annual surveys and other methods to collect information on whether activities are on track; it is not always feasible or desirable to have CWs collect information. Another possibility is to start with the simplest system possible and expand its scope as experience is gained.

  Whatever the approach used, the data obtained on the service providers and monitoring system should include information on the ratio (number) of workers who function as supervisors/mentors

to those who conduct IYCF support activities. Information on the number of service providers, including supervisors, will be necessary to determine the target number of individual who will require training. Supervisors will need to be trained both as IYCF Counsellors and as Supervisors.

- Set target numbers: State clearly what has been learned about the numbers of personnel (staff and volunteer workers) available to carry out IYCF support programme activities.

  Comparisons of the numbers of workers available with the size of the target population and the numbers required to carry out various types of IYCF support activities are needed for the design of the programme strategy (see APPENDIX 4: Counsellor to Mother/Caregiver Ratios for IYCF Support Activities). This information will inform the mix of IYCF support activities necessary for a programme to achieve full coverage of the target population, and allow those planning the programme to set and monitor targets (e.g, targets for training; for IYCF support activity levels) and determine a realistic timeline and resources needed to achieve full coverage. The data may also inform the need for a conversation about the need to expand the existing community cadres, or create a new cadre to provide IYCF support. In defining context-specific ratios of CWs to target population, it is important to consider both the vision and feasibility for scale and a realistic workload, geographic coverage etc.

Review and update policies and systems to strengthen IYCF within community-based services

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

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

- Official recognition by Government authorities as well as by the community for the community-based Community Worker (CW); the CW role needs to be endorsed and supported by government policies
- The community programme needs to be well-linked to the health system and consistent with its policies
- A CW job description that includes a percent of time for IYCF support activities, including individual counselling and facilitation of groups
- The role of the CW must include referral of patients
- The CW needs to receive appropriate incentives or recognition on a regular basis
- The counselling job aids and training and communication tools provided to the CW need to be consistent with those provided to health workers
- Regular supportive supervision and mentoring should focus on helping the CW improve his performance; simple observation and monitoring tools should be provided to the Supervisor; feedback should be provided to the CW on any data collected
- Monitoring system needs to report on spatial/geographical mapping of trained workers and functioning support groups, coverage of individual counselling, proportion of planned activities undertaken, quality benchmarks for counselling and communication/group sessions.

In cases where there is no official government policy on community-based programmes or recognition of community workers (or their formal endorsement is delayed), it is still possible to move ahead with implementation of a community-based IYCF programme at scale so long as all stakeholders agree to and ensure the application of the supportive systems outlined above. To be avoided are fragmented,

uncoordinated, small-scale efforts to train community workers without systems in place for sustained support for functioning of the activities and supportive supervision and mentoring of the workers.

Design the community IYCF programme strategy

Determine a Feasible Mix of IYCF support activities, including the following:
Frequency of contact: Research has shown that more contact between CWs and mothers/caregivers results in better feeding outcomes. IYCF CWs need specific guidance on when and how to support mothers/caregivers before, during and after delivery. If they wait for a mother experiencing a difficulty to seek assistance, they will not be effective – and will lose those mothers/caregivers who do not come forward to ask for help.

A schedule of recommended contacts between the CW and mother/caregiver that is both realistic in terms of the system's resources but also take into account the times most critical in the feeding process should be established for each programme -- e.g., counselling during the antenatal period, with more frequent contacts at critical transition points thereafter: at birth and in the first few weeks, when breastfeeding is being established; during the first 6 months, to encourage continuation of exclusive breastfeeding; during the transition to complementary feeding; periodically from 6 up to 24 months, to encourage continued breastfeeding and to monitor adherence to age-appropriate feeding recommendations; and at any time a mother has a question or experiences a feeding difficulty.

A monthly check-in to motivate mother/caregiver and ensure continued adherence to age-appropriate feeding recommendations is a feature of some IYCF support programmes (see paragraph below on strategies for achieving programme coverage of the target population). Opportunities to integrate IYCF support along the entire continuum of care should be sought.

Mix of IYCF support activities: A program must determine how a realistic mix of IYCF support activities (a combination of individual counselling, IYCF support groups, action-oriented groups and messaging) can help to provide support to all mothers/caregivers with children under 24 months of age. The ratio of counsellors or facilitators to mother/caregivers necessary for implementation of each activity is shown in the figure below.

It may be the individual counselling may be prioritized at only the most critical times (during the antenatal period, during the first few days after birth, and during the transition to complementary feeding. In resource-constrained settings or at the start-up of a community IYCF programme, where the number of trained CWs is being scaled-up gradually over time, support for mothers and young children may need to come from peers – e.g., in IYCF Support Groups. Whatever the design for a recommended schedule of contacts and mix of IYCF support activities in a particular setting, it needs to be clear to both CWs and mothers that a mother experiencing any feeding-related difficulty is a priority for attention from community and health facility workers.

Two different strategies for working toward scale-up to achieving full coverage of the target population are described below to help stimulate thinking about the possibilities for different program models.

> **Model 1** (currently underway in Zimbabwe: see APPENDIX 5: Zimbabwe Case Study for a summary of the Zimbabwe programme). Zimbabwe is working toward gradual scale-up to full coverage of the target population of pregnant women and children under 24 months of age, with intensive contact between 5-10 mother-child dyads who are 'registered/enrolled' and matched to a trained IYCF CW. The CW provides counselling to each of 'his' or 'her' mother-child pairs from the time of the mother's pregnancy until the child reaches two years of age. This intensive contact also provides opportunities to link the mother-child to other health services.

As more CWs are trained in IYCF (or as mothers with children over 24 months graduate out of the programme), there will be gradual scale-up until the entire target population is covered (i.e., assigned to a trained IYCF CW who will follow the mother from pregnancy until her child reaches 24 months)

- **Model 2**: Other programmes may adopt a strategy of less frequent contact initially between a mother-child pair and community workers (with mothers not necessarily an 'assigned' worker, but a worker seeing a 'manageable' number of mothers, with the intent of providing every pregnant woman and mother of child under 24 months of age in the programme area with at least 1 counselling session per year). As more CWs are trained, the intensity of counselling contacts can be gradually increased.

- Inform the CWs and community of the strategy: Whichever approach is adopted (spreading the IYCF-trained CWs among a larger number of mothers to achieve broad coverage of the target population at the start of a programme, but with less frequent contact with each mother; OR more gradual scale-up of a programme, with more frequent contact for each mother/caregiver 'adopted' by a CW), the strategy should be explicitly stated and the CWs and community made fully aware of the approach. The CWs will need to full comprehend the strategy in order to develop their individual Action Plans.

  For both models, priorities for contact points should be explicitly stated.

Action Planning at sub-national levels

The development of a micro-plan for a sub-national area (e.g., District) will mirror the steps in developing a national strategy. It will be necessary to orient the stakeholders and gain their support in the development of the local strategy and action plan. The action plan should spell out roles and responsibilities for the full set of activities associated with implementing an IYCF support system, including discussion of responsibility for incentives where appropriate. The following should be addressed:

- orientation of local stakeholders
- financial and personnel support for implementation of training at the District (or other local) level
- details of the implementation strategy, including mix of interventions (individual counselling alone, or a combination of some individual counselling and participation by mothers in IYCF Support Groups and/or Action-oriented Groups); regardless of the mix of types of activities, targets should be set for the frequency of contact between an IYCF CW and an individual mother; consideration is needed for making certain mothers/caregivers are provided with support at priority contact points (during ANC, delivery, during the first week or two, to make certain that breastfeeding gets off to a good start; during the transition to complementary feeding; and at any time a woman experiences a feeding difficulty (at a minimum, a functioning referral system is a critical part of a system of IYCF support, so that a CW or volunteer who is unable to handle a particular problem can refer a mother for more skilled assistance)
- details of the supervisory and monitoring system, including frequency of supervisory visits to individual CWs, collection and reporting of data from CWs and supervisors, scheduled periodic group meetings between supervisors and CWs, and triggers for refresher training (for instance, when more than one or a couple of CWs are experiencing difficulty with the same skill)
- strategies for collecting data on programme implementation and progress toward targets: in settings having no established supervisory system, this may require implementation of periodic

(annual, for example) small sample surveys; where programme monitoring data is collected as part of a supervisory or programme management system, periodic small sample surveys can be implemented to triangulate data on progress toward targets and to enhance understanding barriers to progress

Develop Individual CW Action Plans: Depending on the strategy to achieve coverage of the target population a programme adopts, each CW should create a personal action plan and track his/her activities against the monthly targets on a reporting form.

Model 1: For CW who will follow 5-10 mothers/caregivers intensively, pregnant women and their children should be registered (see *IYCF Community Worker Tool 4*: Register for Pregnant Women and Mothers-Children (0 up to 24 months) (see Tools in *Supportive Supervision/ Mentoring and Monitoring for Community IYCF*).

- Each CW would be expected to see every registered pregnant woman or mother/caregiver with a child under 24 months of age for whom the CW is responsible at least once every month.
- As more CWs are trained and assigned to work in the Supervision Area, a greater proportion of the target population in that Supervision Area will be covered.

Model 2: For a group of CWs who are assigned to cover women in a particular geographic (or supervision) area, determine the frequency of contact possible, as follows:

- Determine the number of pregnant women and mothers with children under 24 months of age (from census data or by calculating the numbers from data on the total population size)
- From the total number of CWs in a Supervision Area: determine what proportion of the population each CW will follow, and convert to a number. For example, in a population of 7601, there will be approximately 304 pregnant women (~4% of total population) and 547 children (~7% of total population) under 24 months

  If there are 6 CWs working in the Supervision Area, each CW would be expected to cover around 50 women and 91 children under 24 months. Seeing each pregnant woman and child only once during the year, the work load for each CW would be 4 women and 7-8 children per month. This would become the initial target number for monthly individual counselling visits (which might take place in the home or at another site) – and must be a manageable number.

  As more CWs are trained and assigned to work in the target area, each pregnant woman or mother-child pair will receive a greater number of counselling sessions.

  Register forms that enable a CW to record those mothers s/he enrolls are found in *Supportive Supervision/Mentoring and Monitoring for Community IYCF* (*IYCF Community Worker Tools 4*).

  IYCF Community Worker Tool 5: Monthly Activity Log (*Supportive Supervision/ Mentoring and Monitoring for Community IYCF*) allows all CWs to note whether each counselling session is a first-time or a repeat contact. With this reporting form, all of the counselling sessions conducted by CWs in a Supervision Area can be reported on a monthly basis, and coverage of the target mothers/caregivers calculated. This form also tracks the number of IYCF Support Groups and Action-oriented Groups a CW facilitates each month.

Adapt the technical content and graphics of the UNICEF *Community IYCF Counselling Package*

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

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

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

Determine Training Needs

- At least 1 Trainer will be required for every 4-5 Participants. Fewer Trainers than this results in Participants receiving too little direction and feedback after classroom and field practice activities, essential for effective learning.
- To be trained as a Trainer, a worker should be willing to commit to at least 2 training courses a year, as well as clinical or field practice work to maintain their counselling skills. Persons who cannot be available for this work because of other commitments should not be trained as Trainers, as this wastes precious resources.
- At national level, a decision will be needed on whether to develop national or district level training teams. The preparation of local teams could enable flexibility in conducting training and refresher trainings part time (e.g., one day a week for several week), with Participants living locally and continuing their work part time. However, what is most workable and likely to yield good results will need to be determined in each country.
- The time that will be devoted to training needs to be included in the Trainer's job description.

Plan for Supportive Supervision/Mentoring and Monitoring

On-going Routine Supportive Supervision/Mentoring: The ratio of supervisors to workers will vary depending on the characteristics and objectives of an IYCF support programme and the associated supervisory and monitoring systems. For individual supervision, up to 4 visits may be possible in one day, depending on the distance between the areas that individual CWs work. Where less frequent supervision is a necessity, a programme may adopt a strategy of a limited number of observation visits by a supervisor to an individual CW, combined with periodic discussions among a supervisor and a group of CWs to share experiences and for on-going refresher training. To the extent possible, supervision of CWs who provide IYCF support should be combined with other tasks and programs for greater efficiency and effectiveness.

Whatever the mentoring and monitoring strategy, the required frequency and type of supervisory visits for each individual CW should be explicitly stated, tracked and reported: e.g., one individual supervisory visit quarterly, or an individual supervisory visit twice a year, combined with group sessions monthly. The amount of time workers will devote to supervisory activities needs to be written into their job descriptions, and associated budget provisions made.

Supportive Supervision/Mentoring immediately following Training: Regardless of the frequency of routine supervision visits in a particular system, all newly trained Counsellors should have an initial follow-up visit at their place of work within 2 months of their initial training. This will provide an opportunity to learn if the newly trained CW is actually using their new knowledge and skills, ask about their level of confidence and any difficulties they are experiencing, and provide feedback on their performance of IYCF support activities. Their proficiency in completing and submitting routine monitoring data also needs to be checked in the initial months following the training.

Determine communications strategy

Counselling and support group activities by CWs need to be complemented by communication for behavior and social change that reaches the wider population with messages, debate and other locally-appropriate strategies using multiple channels. Previous communications strategies that have addressed IYCF practices, if any, need to be reviewed and if necessary be updated, improved and expanded. The communication strategy needs to focus on addressing identified social norms, socio-cultural practices and barriers not conducive to optimal IYCF, and needs to emphasize reaching those who influence mothers. The UNICEF Programming Guide contains a chapter on communication with details on considerations and steps in developing and implementing an effective communication strategy for IYCF.

Step 7: Implement the community-based IYCF program

Implement the community-based IYCF programme

Conduct training

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

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

The IYCF counselling training can also be provided as a stand-alone package to new or existing community workers. This may be necessary if the basic training for CWs was not long enough to achieve sufficient depth on IYCF content and to build individual counselling, problem solving, and group facilitation and communication skills. In such contexts the IYCF counselling training should be

promoted as an additional capacity building tool, clearly highlighting that it builds a set of skills as opposed to just providing basic information.

Planning for IYCF training using the training component of the *Community IYCF Counselling Package* is covered in detail in the introduction to the *Facilitator Guide.* Additional information on the objectives for training of Master Facilitators/Trainers, Trainers and IYCF Counsellors, as well as the objectives of IYCF support for mothers and caregivers, and a comparison of the content and skills necessary for implementation of the different types of IYCF support activities are provided in APPENDIX 6: Training Structure and Training Objectives.

Implement IYCF support activities: individual counselling, Action-oriented Groups, IYCF Support Groups

Multiple opportunities can be used for sharing information, for individual counselling, Action-oriented Groups, IYCF Support Groups and for other behaviour change activities implemented by community cadres working in community settings. Group meetings, growth monitoring or MUAC screening sessions, home visits and cooking demonstration sessions are all examples. Home visits to pregnant women and new mothers should be prioritized.

Programmes and projects have been successful in achieving community-based behaviour change by working through multiple channels and combining various methods, ranging from individual counselling by health facility and community-based workers, community group sessions and information sharing through traditional channels and local media. Repeated contacts and harmonized messages help to reinforce both knowledge and practice.

Community workers and programme managers will need to set specific expectations, and where appropriate, targets for IYCF support activities: e.g. follow-up schedules for pregnant and lactating women, the number of IYCF support groups to be created within the community, the criteria for providing IYCF counselling to a mother/child attending growth monitoring, or the number of other IYCF support activities to be conducted each month at growth monitoring sessions, at community meetings, or other events. These targets can be discussed and set during the training and reinforced and followed up during supportive supervision and mentoring. Setting targets gives a concrete structure and focus to the activities and helps in monitoring performance.

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

A growing number of countries are initiating and expanding community-based programmes for the management of severe and/or moderate acute malnutrition (generally referred to as CMAM). Many of these programmes, however, focus on screening and home treatment of malnourished children with little attention to counselling that addresses feeding of the child to prevent future episodes of SAM and promote good growth. The creation of new CMAM programmes presents a good opportunity for IYCF counselling and other` support actions to be included from the outset. In established CMAM

programmes, IYCF content may be integrated into refresher training for existing community cadres and added to training for new community workers as part of the scale up process.[1]

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

Another main programmatic success factor that has emerged from multiple reviews[2] is the involvement of local NGOs, who often provide excellent facilitation as well as culturally-relevant training. They are usually accountable to the community, which facilitates sustainability to a greater extent.

Institute supportive supervision/mentoring

Supportive supervision and mentoring is crucial to the success of a community-based programme, but is often the weakest link. The team responsible for the community-based programme should build a system for supportive supervision and mentoring for each counselling channel and for each contact at which counselling is given. The persons responsible for supportive supervision need to be clearly identified from the outset, include the activity in their regular workplans and tasks, and be provided with training, tools such as a supportive supervision checklists[3], and resources (such as transport funds) to undertake this activity. A List of Tools for Community Workers and Supervisors/Mentors is included in APPENDIX 7.

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

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

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

Workers tend to put more effort into activities that are reviewed at joint meetings or that are specifically questioned, e.g. if the IYCF community-based programme is receiving emphasis by the national government, then at local meetings workers are more likely to be questioned on their IYCF

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

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

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

activities. If workers know that supervisors are interested in their efforts on IYCF, they may emphasize this work. Feedback to community workers on their activities, the data they collect and their performance is essential to further skills-building, solving problems and to overall programme improvements.

Step 8: Institute routine monitoring and periodic small surveys

Monitoring needs and activities will differ depending on the phase of a program. The programming cycle can be grouped into 3 broad phases: i) program planning, ii) early to mid-stage program implementation, and iii) program expansion and ongoing management.

During program planning, the system is being planned. Policies, guidelines and curricula are reviewed and/or developed, demographic data updated, needs or situation assessment conducted, small-scale feasibility trials may be carried out, and job aids, supervision and monitoring tools developed. During this phase, program planning tools, including checklists, calendars and timelines will help to track keep the program planning process on time.

During the implementation phase, monitoring of program activities begins. Monitoring data are used to provide feedback on the implementation of the program, tracking progress toward the achievement of targets and identifying bottlenecks or problems. Adjustments and improvements are made to the program as well as the monitoring system; this allows progressive tracking of program implementation, progress toward program objectives, and achievement of program coverage. Supportive supervision/mentoring will provide information on the quality of program delivery.

The first three steps to collecting, reporting and using routine programme monitoring data have already been described and are carried out during the programme planning phase.

1. Update information on population size and number of service providers

2. Determine target population numbers
   - Total target population (pregnant women; mothers with children 0 up to 24 months
   - Total number of service providers (CWs, Supervisors) who will need IYCF training
   - Total number of Supervisors who will need training in Supportive Supervision/Mentoring & Monitoring

3. Describe programme strategy to achieve full coverage of target population – i.e., pregnant women; mothers with children 0 up to 24 months.

During programme implementation, it will be necessary to:

4. Track progress in programme implementation (see Indicators: APPENDIX 8; *IYCF Community Worker Tools*, and *Supportive Supervision Tools* including Routine IYCF Programme Monitoring Tools in *Supportive Supervision/Mentoring and Monitoring for Community IYCF* Appendices 5 and 6)

   A small set of clearly articulated indicators will help to keep the programme focused on the essentials, as well as provide trend data for assessing progress, spotting problem areas and adjusting program strategies. Monitoring whether defined targets for activities were met during a defined period is necessary for assessing the performance of CWs.

   Examples of possible indicators are provided in APPENDIX 8: see table ‘Examples of Indicators for Routine IYCF Programme Monitoring’. Your programme may wish to create

other indicators (see additional example: UNICEF Programme Guide, p. 60, Table I: Examples of different indicator levels used in IYCF programming; p. 88, Examples of target to assess performance of CWs and mother support groups, and Table 4: Examples of indicators for IYCF communication strategy).

The selection of a few key indicators needs to be made carefully, with consideration for:

- The stage of the programme: for example, at the beginning of a programme, focus attention on getting basic activities (e.g., training, supportive supervision/mentoring, activities implementation) into place and quickly scaled up
- Focus on what's important: for example, if formative research has shown that a few beliefs or attitudes are significant barriers to behavioural change (e.g. the belief that all infants need hot water – in addition to breast milk – in a hot climate; or the belief that a breastfeeding woman cannot have sex without damaging the quality of her breast milk), then it is important to track progress in changing those beliefs to ensure that the programme strategy is effective
- 'Balance' the few indicators selected: do not put 'all eggs in one basket', focusing only on different aspects of individual counselling, for example. Ensure that measures focus on critical components of the social and behaviour change strategy – but in a balanced fashion, ensuring that a programme is paying attention to issues to help determine that:
    - programme activities are being implemented
    - workers are conducting activities with attention to quality
    - the programme is achieving coverage – both geographic coverage, and coverage of the target population
    - that programme activities are successful in having an impact on the target population's knowledge, attitudes – and ultimately behavior; periodically looking at trend data (for example, data from small sample surveys) should show progress in the right direction
- Focus only on a limited number of indicators at a time. Basic principles for the use of monitoring information for decision-making and action include the requirements to only collect data that will be used; maximize the use of data at the level they are collected; and to collect the minimum, feasible amount of data required to inform and improve decisions leading to action.
- Once the target for an indicator -- (e.g., all CWs in the programme area are trained), turn the monitoring focus to other timely activities, coming back periodically (say annually) to ensure that the ongoing need being tracked by the 'trained CWs indicator' is being met -- i.e., there is periodic training to ensure that newly hired CWs are trained within a specified period of time.
- It is important to pay attention to the 'motivational' qualities of measurement. Indicators must be carefully selected with an eye toward producing motivations that steer programme workers into activities that produce desired results.

Whatever the indicators chosen, a programme will need to provide a definition of each indicator, and suggestions for data sources. Examples of how to define indicators are also included in APPENDIX 8.

5. Reporting

Supervisors (or programme managers/others, as required by the system) will:

- obtain data from activity reports or logs from front-line community workers
- compile the data
- submit periodic reports (monthly/quarterly/other) to a District (or other) office.

At the District level, data across supervision areas will be compiled and submitted to a provincial (or other) office. Compiled data should also be returned the Supervisors for informing programme management at the local level

6. Share visual displays of programme progress

   Visuals displays of data may be more easily understood and motivating to community workers. At the local level (Supervision Area), visual displays of data can be posted in prominent sites for discussion with CWs and community members. Examples of the types of visual display that can help to engage the interest of the viewer are included in *Supportive Supervision/ Mentoring and Monitoring for Community IYCF,* Appendix 9 and described below.

   Example 1: The Monitoring Graph visually displays the progress made by all CWs in a Supervision Area (or District) in reaching target mothers/caregivers with IYCF counselling activities. Note that the numbers of target pregnant women and mothers with children under 24 months of age can be disaggregated, if desired.

   Such a monitoring graph/chart might also be used to track progress in reaching the target numbers of:

   - CWs who have received IYCF training
   - Mothers/caregivers who have received IYCF counselling at least once; this would be particularly useful in areas where the programme strategy Model 2 is being implemented
   - CWs who have received a supportive supervision/mentoring visit

   At different levels (individual CW, Supervision Area or District), the numbers of activities implemented might also be graphed against the number of activities planned. See Bar Graph where the number of planned and actual counselling sessions provided to pregnant women and mothers/caregivers with children under 24 months of age is plotted.

   To engage the interest of CWs and community, select only a small number of the most critical pieces of information to display.

   At District Level, the disaggregated monitoring data (from all of the Supervision Areas, for example) may be aggregated and compiled into summary reports and displays.

   Example 2: Monitoring Chart for tracking % of target mothers/caregivers counselled

   Example 3: The Map is an example that a Supervisor might use to demonstrate where each CW within the supervision area (or each CW associated with a health centre) works. By creating such a map on flipchart paper, it is possible to show visually the location and size of the total population (or target population – i.e., the pregnant women and mothers with children under 24 months of age), where trained (and not-yet-trained) IYCF CWs are located, and where IYCF Support Groups have been formed.

7. Triangulate routine monitoring data with Lot Quality Assurance Sampling (LQAS) surveys.

   Small sample surveys using methodologies such as LQAS can be used to triangulate information from routine monitoring, and to measure broad changes in programme processes and outcomes. For example, the results of routine monitoring data that provide information on 'proportion of target mothers/caregivers individually counselled at least once' can be compared with LQAS survey results on the 'percentage of caregivers reporting a contact with a counselling provider'.

Other examples of changes that can be tracked include:

- From exit interviews with mothers/caregivers: have caregivers heard communications messages, received counselling from a community or health worker, caregiver satisfaction with counselling, advice received, small, do-able action negotiated
- Changes in priority knowledge and attitudes identified as a key barrier to changing feeding practices
- Trends toward change in key IYCF practices using standard indicators (e.g., exclusive breastfeeding; minimum acceptable diet). Questionnaires to measure these IYCF practices and services have been developed for use at household level by UNICEF; there are also questionnaires for CWs and health facilities.

8. Use the data: Hold periodic meetings to review programme progress and use data to make decisions to improve programme implementation, coverage, quality and results

   Involve all stakeholders in review of data and problem-solving. Review data with workers as part of the supervisory process.

Programme Evaluation: During program expansion and ongoing management, the program is scaled up. Emphasize rapid scale-up, to ensure sufficient time to realize programme results.

As monitoring indicates that progress toward adequate program implementation targets, achievement of program objectives and adequate program coverage (for a minimum period of time: 6 mos, 1 year, 2 years) are realized – and not before -- planning for impact evaluation is realistic.

List of APPENDICES

APPENDIX 1: Breastfeeding and Complementary Feeding Matrices

Breastfeeding Practices Matrix

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

Complementary Feeding Practices Matrix

Complementary Feeding Practice	Current Practice	Recommended Practice	Motivators	Barriers	Feasible Practice	Counselling Discussion Points
Continued sustained breastfeeding	6 up to 9 months 9 up to 12 months 12 up to 24 months					
Frequency of complementary foods	6 up to 9 months 9 up to 12 months 12 up to 24 months					
Amount of complementary foods	6 up to 9 months 9 up to 12 months 12 up to 24 months					
Texture (thickness/consistency) of complementary foods	6 up to 9 months 9 up to 12 months 12 up to 24 months					
Variety of complementary foods (calendar)	6 up to 9 months 9 up to 12 months 12 up to 24 months					
Responsive feeding						
Hygiene						
Use of bottles		Use cup				

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

(At Home and/or at Market)

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

January	February	March
Home	Home	Home
Market	Market	Market

April	May	June
Home	Home	Home
Market	Market	Market

July	August	September
Home	Home	Home
Market	Market	Market

October	November	December
Home	Home	Home
Market	Market	Market

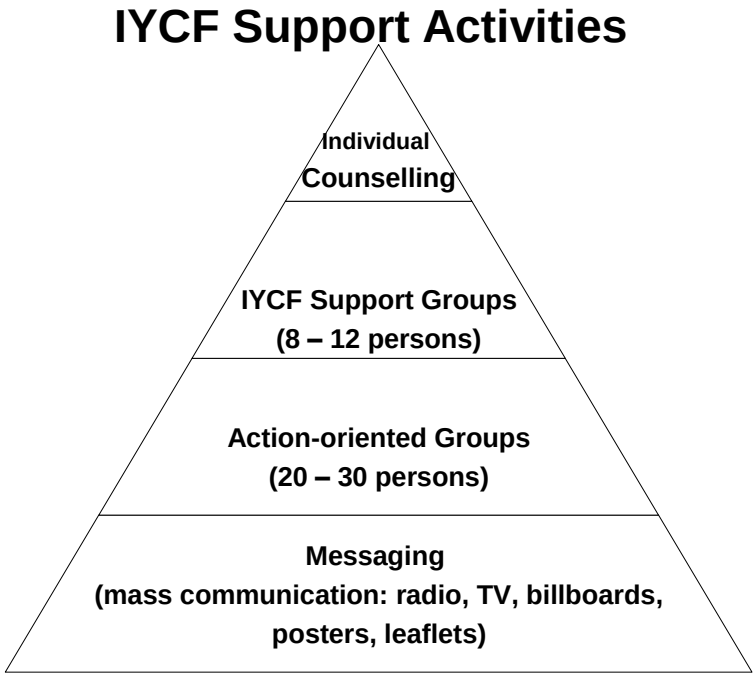
APPENDIX 3: Data for Programme Planning

Supervision Area:_____

Date: _____

District	Supervision Area	Village	Total Population	Number of Children under 24 months		Number of Pregnant Women	Number of Health Centres (or other	Number of Health Posts (or other)	Number of facility workers	Number of community workers	Number of IYCF Support Group (facilitators)	Other Volunteers
				0-5 months (same as 0 up to 6 months)	6-23 months (same as 6 up to 24 months)							
Koinadugu	Supervision Area 1	Village 1										
		Village 2										
		Village 3										
		Village 4										
	Supervision Area 2	Village 5										
		Village 6										
		Village 7										
		Village 8										
		Village 9										
		Village 10										
		Village 11										
		Village 12										
	Etc.											

APPENDIX 4: Counsellor to Mother/Caregiver Ratios for IYCF Support Activities



Individual Counseling
- Effective but highly skills-based and resource-intensive
- Involves individual assessments of mothers'/caregivers' feeding practices
- Based on the WHO-recommended counseling guidelines of listening and learning, building confidence, and giving support; and UNICEF 3-Step Counselling of Assess, Analyze and Act
- The intent is to move mothers/caregivers in small, doable steps toward an ideal practice
- 1 to 1

Support Groups
- An IYCF support group is a group of pregnant women, mothers, fathers, caregivers, etc. who share IYCF experiences and information, and provide mutual support
- Facilitated by experienced mothers who have IYCF knowledge and have mastered some group dynamic techniques
- Labour and time intensive
- 8 to 12 persons

Action-oriented Groups
- IYCF practices are incorporated into group activities in a way to personalize information and encourage participants to try an action that is new or different
- Facilitators are trained on Observe, Think, Try, Act (OTTA) skills to use stories, mini-dramas, or visuals
- Requires additional training, time and resources
- 20 to 30 persons

Messaging
- Limited and relevant information on IYCF promotion that can reach large audiences: caregivers, influential community members, and communities at large
- Development based on formative research

Build upon and/or expand existing community cadres:

In some countries there may be a myriad of different types of community workers in different areas of the country, and the mapping and analysis of existing community-based health and nutrition programmes undertaken in Step 6: Undertake pre-implementation planning and design, is needed to determine which type of existing worker would be most appropriate in each area of the country for implementation of the IYCF programme. APPENDIX 9: Potential Providers of IYCF Promotion and Support Services in the Community, lists different kinds of community-based health workers (cadres and groups), their common characteristics, and advantages and disadvantages of each in the provision of IYCF counselling and other IYCF promotive and supportive activities (Action-oriented Groups and IYCF Support Groups) in the community.

Existing community-based health and nutrition programmes may afford opportunities to promote and support IYCF. Community-based IYCF activities should build upon existing structures as much as possible, rather than create parallel ones. Many countries already have some form of community-based health and/or nutrition programmes and structures in place, such as community-based management of severe acute malnutrition (CMAM), community IMCI (C-IMCI), Essential Nutrition Actions (ENA), and community case management (CCM) of malaria, diarrhoea and pneumonia. These programmes have different types of community-based workers and varying types of incentives, from volunteers to paid cadres within the Government system. Community Worker (CW) programmes, once viewed as "a panacea for weak health systems", are now recognized as a complementary approach to facility-based health care for reaching vulnerable groups. Their success depends on the ability to motivate involvement of CWs, offer opportunities for personal growth and accomplishment, retain CWs after they have been trained, sustain their performance, and provide ongoing supervision, support, and recognition from the health system and community.[4]

Create a new community cadre: In some settings there may be neither existing community-based health and/or nutrition programmes nor structures through which IYCF counselling and other support activities can be delivered. The existing programme may not be appropriate for adding these services, or the programme may not be willing to add any additional activities. Another scenario may be that the Ministry of Health wants to create a dedicated cadre of counsellors for infant feeding. In such situations the possibilities for creating a new programme with IYCF counsellors – who may be given a locally appropriate title – should be explored. IYCF counsellors may be part of the outreach activities of the health system or associated with a non-governmental organization. IYCF counselling may serve as an entry point to develop a more comprehensive new community-based cadre, and other elements of community-based health and nutrition care may be added to their role later on. (See APPENDIX 10: Steps in creating a cadre of IYCF-related CWs).

The design of the IYCF component of a community-based health and nutrition programme, whether it involve the addition of IYCF support activities to an existing Community Worker portfolio or the creation of a new cadres of worker to support IYCF counselling, should be done in consultation with communities.

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

APPENDIX 5: Zimbabwe Case Study

From Field Exchange Issue 43, July 2012, pp. 95-97.

IYCF Counselling in Zimbabwe

As part of its Community IYCF (cIYCF) Initiative, the UNICEF programme in Zimbabwe is implementing rapid scale-up of IYCF counselling using the following approach:

Training: Zimbabwe has developed a pool of national Facilitators/Trainers (nutritionists, nurse midwives and tutors) who are trained in the UNICEF *Community IYCF Counselling Package*. Several national Trainings of Facilitators/Trainers were required to prepare this pool of trainers.

The Facilitators/Trainers were themselves trained with a low ratio of Trainees (future Facilitators/Trainers) to Trainers, necessary for facilitating skills-based training. They then train VHWs as IYCF Counsellors in the same ratio: 1 Facilitator/Trainer to 4-5 Trainees.

The Master Facilitators/Trainers form a national team available to conduct Training of Counsellors (ToC) throughout the country. A ToC prepares Village Health Workers (VHWs) to function as Community IYCF Counsellors (CCs). Zimbabwe's aim is to quickly scale-up training for IYCF Counselling, with training conducted at District Level. The trainings are conducted at a health centre, in a site close to the communities where the newly-trained Community IYCF Counsellors (CCs) can practice their new skills with community mothers.

In preparation for training at District Level, 6 teams of national Facilitator/Trainers travel from their respective locations within the country to spend one day on orientation and preparation of the training materials, a 2nd day is necessary for travel to the training site. The Facilitator/Trainers are divided into 6 teams, with each training team having 4 Facilitator/Trainers and 2 persons organizers/managers. Each of the 6 training teams prepares a group of 25 VHWs as Community IYCF Counsellors. This ensures standardized training throughout the District, achievement of coverage, and a critical mass of trained IYCF Community Counsellors (150 IYCF CCs, or 70-100% of VHWs in a district) in one week's time.

Implementation of IYCF Support activities: Immediately following the training, each newly trained IYCF CC is required to identify, register and become 'attached to' between 5-10 pregnant women or mothers of young children from their communities. The newly trained CCs will continue to perfect their assessment and counselling skills, following these women and their children for up to 2 years, providing timely support and counselling, and generating movement toward changing IYCF practices. Thus, in each District, the week of training results in 150 newly trained IYCF CCs who are following 1500 pregnant women and mothers with young children. Between August and December, training was conducted in 12 Districts, with close to 200 VHWs trained to support an initial 20,000 women. Each of the VHW/IYCF CCs also initiates and facilitates at least one mother Support Group in the community, allowing women to share experiences and support each other toward optimal IYCF practices.

This system of ongoing identification, assessment and counselling of mothers also serves as an opportunity to promote the use of (and compliance with) other health and nutrition services; it serves as a backbone to build on additional interventions (maternal, newborn, EPI, HIV, etc.) to address the nutritional needs of mothers and young children. Frequent visits to households in their catchment areas provide opportunities for ongoing nutritional screening, ensuring that a child with acute malnutrition will be quickly identified and referred to the health facility for management, and to address critical issues arising in households.

Supporting Quality: To ensure adequate support for the newly trained CCS, in every District where training is done, VHW Trainers and one nurse from every health institution are also trained. They are then equipped with a checklist for supportive supervision. The CCs refer mothers with complication and cases they cannot handle to the local health centre; the health centre staff likewise refer mothers who need community support to the CCs.

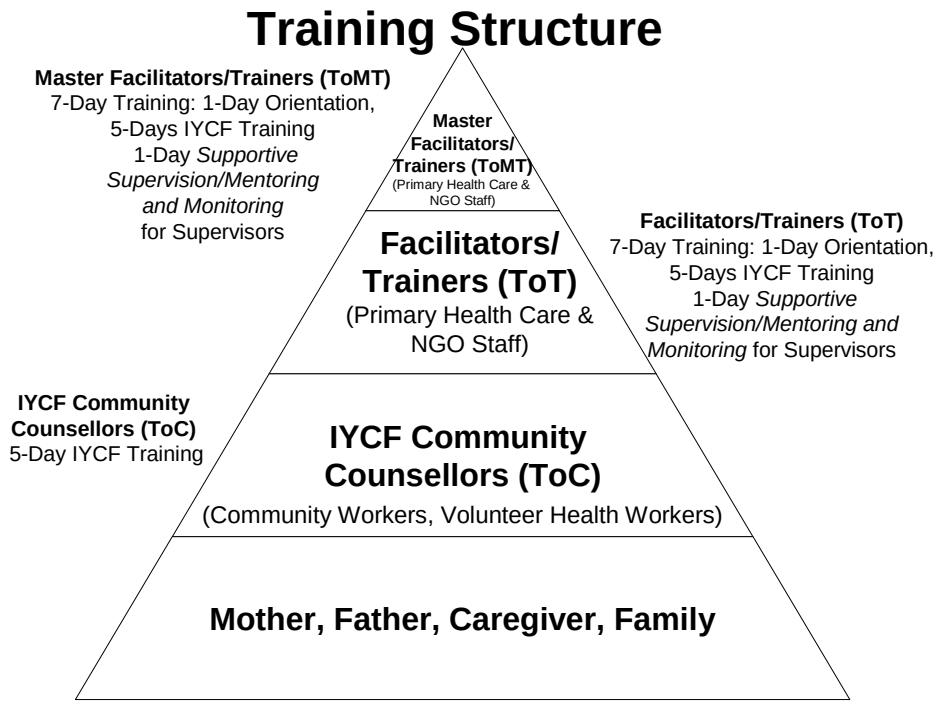
Accountability: At the completion of training, each CC prepares a simple register/notebook to document and track the pregnant women and mothers-children under 2 years that s/he is following. It lists the mothers and children, documents IYCF practices and challenges, and tracks other key interventions and compliance with recommendations. VHWs and health centre staff have monthly meetings where VHS submit their monthly reports on their programme activities and discuss any difficult issues they have encountered.

Training Register

Name of Trainer(s)	Date of Training	Location of Training	Name of VHWs trained	VHW contact details	Name of Pregnant Woman or Mother-Child pair registered by VHW*

*The first 5-10 names listed in each VHWs personal register will be the first mothers/children ‘’adopted’ following the VHWs training. As eac child reaches two years of age, the VHW may become attached to a new mother/child pair.

APPENDIX 6: Training Structure and Training Objectives



Training Objectives

Specific Objectives of Training of Counsellors (TOC)
The primary objective of training community workers (CWs) or primary health care staff as Counsellors is to equip them with the knowledge, skills and tools to support mothers, fathers and other caregivers to optimally feed their infants and young children. The *Facilitator Guide* was developed using training methodologies and technical content appropriate for use with CWs. The content focuses on breastfeeding, complementary feeding, feeding the sick/malnourished infant and young child, and infant feeding in the contexts of HIV, CMAM and emergencies. By the end of the training, Participants will be able to:

- Explain why IYCF practices matter
- Demonstrate appropriate use of counselling skills (*Listening and Learning*; *Building Confidence and Giving Support* [practical help]) and use the set of *IYCF Counselling Cards*
- Use the *IYCF 3-Step Counselling* ('assess, analyze and act') with a mother, father or other caregiver
- Describe recommended feeding practices through the first two years of life
- Describe how to breastfeed
- Identify ways to prevent and resolve common breastfeeding difficulties
- Describe practices for feeding the sick child and the child who has acute malnutrition
- Facilitate Action-oriented Groups and IYCF Support Groups
- Relate women's nutrition to life cycle
- Describe basic information on infant feeding in the context of HIV
- Identify signs that require referral to a health post
- Highlight key issues related to infant feeding in emergencies and apply the knowledge and skills to support IYCF in an emergency context

Specific Objectives of Training of Master Facilitators/Trainers (ToMT) and Training of Facilitators/Trainers (ToT) in addition to above content and skills:

- Orient Master Facilitators/Trainers and other Facilitators/Trainers to the UNICEF *Community IYCF Counselling* Package
- Develop Master and other Facilitators/Trainers capacity to plan, organize and conduct roll-out trainings on the *Community IYCF Counselling* package
- Equip Master and other Facilitators/Trainers with the principles of adult education, effective training methodologies, visual aids and skills to use them, and
- Design Action Plan for roll-out trainings (ToT and ToC) and follow-up of Facilitators/Trainers and Counsellors

APPENDIX 7: List of Tools for Community Workers and Supervisors/ Mentors

The following Tools are found in: *Supportive Supervision/Mentoring and Monitoring for Community IYCF*

COMMUNITY WORKER TOOLS

- *IYCF Community Worker Tool 1*: IYCF Assessment
- *IYCF Community Worker Tool 2*: How to Facilitate an Action-oriented Group
- *IYCF Community Worker Tool 3*: How to Facilitate an IYCF Support Group
- *IYCF Community Worker Tool 4*: Register Form for Pregnant Women and Mothers-Children (0 up to 24 months)
- *IYCF Community Worker Tool 5*: Community Worker's Monthly Activity Log: IYCF Support to Pregnant Women or Mothers-Children (0 up to 24 months)

SUPERVISION TOOLS:

- *Supportive Supervision Tool 1*: Observation Checklist for IYCF Counselling
- *Supportive Supervision Tool 2*: Observation Checklist for Action-oriented Groups Facilitation
- *Supportive Supervision Tool 3*: Observation Checklist for IYCF Support Groups
- *Supportive Supervision Tool 4*: Supervisor Record for Tracking Individual Community Worker Progress
- *Supportive Supervision Tool 5*: Supervisor's Monthly Activity Log

REPORTING FORMS: Supervisor Reports

- *Supportive Supervision Tool 6:* Spatial/Geographic Coverage: Communities with CW trained in IYCF
- *Supportive Supervision Tool 7*: Training Register
- *Supportive Supervision Tool 8*: Training Report
- *Supportive Supervision Tool 9*: Monthly /(Quarterly/ Period) Summary of IYCF Routine Programme Monitoring Data

EXAMPLES OF HOW TO VISUALLY DISPLAY ROUTINE PROGRAMME MONITORING DATA (Visual Display of Quantitative Data)

- Example 1: BAR Graph showing Planned vs Completed Activities
- Example 2: Monitoring Chart for Tracking % of Target Mothers/Caregivers Counselled
- Example 3: Map showing Supervision Areas, with village size and presence/absence of trained Community Workers

APPENDIX 8: Indicators

Examples of Indicators for Routine IYCF Programme Monitoring

Note: all indicators should be time-bound (reflecting activity 'during reporting period')

How much did we do? Are we doing the activities we planned to do? What proportion of planned activities is being conducted?	**How well did we do it?** Are we meeting geographic/spatial coverage targets? Are we meeting coverage targets to reach the population we planned to reach? Are the activities being carried out with increased quality	
Activities	**Coverage***	**Quality Benchmarks**
<u>Training</u> 1. % of target CWs trained in IYCF Counselling (or IYCF support activities) <u>Individual Counselling Sessions</u> 2. # of newly registered target mothers/caregivers counselled (disaggregate by: pregnant women, mothers of children 0 up to 24 months) 3. # of previously registered target mothers/caregivers counselled (disaggregate by: pregnant women, mothers of children 0 up to 24 months)	<u>Geographic/Spatial Coverage</u> 8.% of programme communities with at least 1 trained (and active) IYCF Counsellor <u>Coverage: Target population reached with Individual Counselling</u> 9. % of target mothers/caregivers individually counselled at least once** 10. % of CWs who counsel at least XX% of the target number of mothers/ caregivers at least once (e.g., during reporting period; and cumulative total percentage)	<u>Quality: Individual Counselling</u> 12. % of IYCF Counsellors who used/demonstrated 4 (of 6) skills for 3-Step Counselling (Assess, Analyze and Act) 13. % of mothers/ caregivers (on exit interview, for example) who recall message (or have knowledge of ideal practices, or key attitudes changed, for example)
<u>IYCF Support Groups</u> 4. % of planned IYCF Support Group sessions implemented 5. % of IYCF Support Groups active (implementing at least 1 IYCF Support Group session during reporting period)	<u>Coverage: Target population participation in IYCF Support Groups</u> 11. % of target mothers/caregivers who attended at least one IYCF Support Group meeting	<u>Quality: IYCF Support Groups</u> 14. % IYCF Counsellors who used/ demonstrated 4 (of 6) skills in Support Group facilitation 15. % of IYCF Counsellors who managed at least 4 discussion points in breastfeeding, complementary feeding and women's nutrition content
<u>Action-oriented Groups</u> 6. % of planned Action-oriented Groups implemented		<u>Quality: Action-oriented Groups</u> 16. % of IYCF Counsellors who used/demonstrated 4 (of 5) skills for OTTA steps (Observe, Think, Try and Act)
<u>Supervision Activity</u> 7. % of CWs who received at least 1 supervision/mentoring visit		

* Depending on the characteristics of the IYCF support system, it may or may not be possible to calculate some of these indicators from data collected during routine monitoring. For example, where CWs report monthly by documenting their activities against the list of target women-children for whom they are responsible, it will be possible to determine what % of target women received counselling through routine monitoring. Where mothers-children are not assigned to a particular CW, a small survey (e.g., LQAS) could be used to collect coverage data on the % of women who have received individual counselling or participated in an IYCF support group. Data could also be obtained from exit interviews with mothers/caregivers to determine the % of targeted mothers/caregivers who can recall messages or have knowledge of ideal practices (post-counselling).

** This indicator can be disaggregated to report on i) % of pregnant women counselled, and ii) % of mothers/caregivers of children 0 up to 24 months counselled (during reporting period).

Two examples of the information that needs to be provided to fully define an indicator are provided on the next pages. Complete definitions that are appropriate for the local context must be developed for all indicators that are tracked as part of routine programme monitoring. .

Example Indicator #5:

INDICATOR TITLE: IYCF Support Groups Active

DEFINITION: Percentage of IYCF Support Groups holding at least 1 meeting (during specified period)

RATIONALE: IYCF Support Groups are an IYCF support activity that complements individual counselling. An IYCF Support Group is comprised of pregnant women and mothers/caregiver, with other participants (fathers, teenaged girls, etc.) included in some groups.

IYCF Support groups are often facilitated by experienced mothers who have IYCF knowledge and have mastered group dynamic techniques. In some systems, Community Workers trained in support group facilitation may facilitate the group. Participants share IYCF experiences and information, and provide mutual support. Generally, sessions last 40 minutes to an hour, and 8 to 12 mothers/caregivers participate. A programme may encourage IYCF Support Groups to meet once a month (or other frequency).

Some programmes aim to increase IYCF Support Group coverage so that every mother/caregiver in the programme target group becomes a Support Group member.

Numerator: number (#) of IYCF Support Groups that met at least once (during specified period)

Denominator: total number (#) of IYCF Support Groups in programme area

Percent (%) of IYCF Support Group active (during specified period) = number (#) of IYCF Support Groups that met at least once (during specified period)/total number (#) of IYCF Support Groups in programme area x 100

MEASUREMENT: The data on this indicator is collected from attendance forms that record date of meeting and numbers of participants

DATA SOURCE: Monthly IYCF Support Group attendance forms, collected by CWs from IYCF Support Group facilitators (facilitator-mothers or CW facilitator), or from CW monthly activity logs, depending on the local system; data are compiled and aggregated by Supervisors

Example Indicator #8:

INDICATOR TITLE: Spatial/Geographical Coverage of IYCF-trained Community Workers

DEFINITION: Percentage of programme communities with at least 1 trained and active Community Worker trained as an IYCF Counsellor

RATIONALE: Measuring the percentage of communities in the programme area served by trained community workers is an important step in tracking a programme's progress in reaching its target population. This indicator estimates the spatial/geographical coverage of a programme by assessing the proportion of communities with at least 1 Community Worker trained as an IYCF Counsellor who was active in the assigned communities during the reporting period.

Numerator: number (#) of programme communities served by at least 1 Community Worker trained in IYCF counselled

Denominator: total number (#) of communities in the programme area

Percent (%) of programme communities with at least 1 trained and active CW trained as an IYCF Counsellor = number (#) of programme communities served by at least 1 CW trained in IYCF counselling/ total number (#) of communities in programme area x 100

MEASUREMENT: Calculating spatial/geographic coverage using programme data requires the following:

- The list of CWs who have completed IYCF training
- Community Worker's monthly activity logs
- A complete list of communities in the programme area

NOTE: If a CW is assigned to more than one community, then a system for tracking the community in which the CW has provided services needs to be devised.

DATA SOURCES: Monthly supervisor's report on Community Worker activities and community in which the activity occurred, matched with a list of all communities in the programme area.

Supervision Area: _____

Community	Community Workers: List by name	CW trained in IYCF Y/N	CW active during current month
Community 1			
Community 2			

APPENDIX 9: Potential Providers of IYCF Services in the Community[5]

Provider[6]	Common Characteristics	Advantages	Disadvantages
Peer/lay counsellors	• Women with current or recent infant feeding experience (peer counsellors) or strong commitment to infant feeding (lay counsellors) • Similar socio-cultural characteristics as clients • May provide one to one counselling in homes, health facilities, mother support groups, informal setting • May conduct Action-oriented Groups	• Model optimal infant feeding practices • Ability to demonstrate improved recipes and food preparation for young children • Understand mothers' situation • Accessible • Focused attention on feeding issues	• Often high turnover rates among volunteers • Part-time work limits number of contacts
Multi-purpose community workers	• May be affiliated with health facility, community group, or NGO • May provide one to one counselling in homes, health facilities, mother support groups, informal setting • May conduct Action-oriented Groups • May receive salary or small stipend • May have or not have personal experience of breastfeeding	• Integrated with other health services • Wider outreach • Understand mothers' situation • Accessible	• More limited IYCF support • May be distracted by other duties
Single- purpose community workers	• May be trained only for one specific intervention, e.g. CMAM, GMP or CCM • May be affiliated with health facility, community group, or NGO • May provide one to one counselling in homes, health facilities, mother support groups, informal setting • May conduct Action-oriented Groups • May receive salary or small stipend • May have or not have personal experience of breastfeeding	• Integrated with other health services • Wider outreach • Their involvement in IYCF is mutually beneficial to both the existing intervention and IYCF • Understand mothers' situation • Accessible	• More limited IYCF support • May be distracted by other duties • Resistance by the original programme to adding any other duties • Tendency to focus on curative aspects
Community development and extension workers	• Outreach extends beyond mothers and children • Broader set of issues • May conduct social mobilization on IYCF	• Linked with other sectors such as agriculture • Can provide information and support on production and use of appropriate and high quality local foods for young children • Re-enforcement of messages; non-health contact points	• Limited time for IYCF support • Balancing many duties
Traditional health practitioners (traditional healers, herbalist etc)	• Provide health care using traditional methods/products • May have knowledge of traditional and modern medicine • May conduct social mobilization on IYCF	• Serve women least likely to attend PHC facility	• May require special training curricula, materials, and trainers • May provide advice that is not according to recommendations

[5] Adapted from Wellstart Trilogy (1996) and Learning from Large Scale Community Based Breastfeeding Promotion (UNICEF/WHO/AED/USAID 2008)
[6] Note that many of these community-based providers are also secondary participants in the communication strategy

Provider[6]	Common Characteristics	Advantages	Disadvantages
Local child nutrition advocates (Grandmothers, supportive men, local media, teachers, women's groups, mother-to-mother support groups, members of village health committees, community or faith based organizations (CBOs/FBOs)	• Opinion leaders within family, the community, or country • May conduct social mobilization on IYCF • May conduct group sessions on IYCF	• Broaden support network, reach secondary targets • May have special skills in community promotion and education	• Usually not ideal candidates for facilitating IYCF support groups • May be reluctant to abandon harmful traditional practices

APPENDIX 10: Steps in Creating a Cadre or Network of IYCF-Related CWs

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

- **Decide on an appropriate CW/IYCF counsellor profile** for the tasks of IYCF promotion, counselling and support, including: gender, minimum educational level, residence, etc. Individual counselling on IYCF is a key intervention that can be delivered by a trained lay counsellor, a peer, a health visitor, community volunteer, paid community health worker or extension worker or extended family member. Educational levels may vary; it is desirable for a CW/IYCF counsellor to have at least Grade 5-8 level schooling.
- **Create a job description** for the CW – either for IYCF tasks alone if the worker is a dedicated IYCF counsellor or for the full portfolio of tasks
- **Establish appropriate ratio** of community workers to households and proposed time commitment of the community workers. If the ratio is too low – e.g. 1 CW for every 20 households – it will not be possible to achieve scale as the programme will be very expensive. If the ratio is too high – e.g. 1 for every 500 households – the CW will not be able to reach all the families with young children. The ratio needs to be tailored to the local situation.
- **Establish incentives** – in-kind, cash, transport, materials, etc, and clarify who will provide these incentives and when. The dropout rate is likely to be very high and the activities very limited if no incentives or insufficient incentives are provided.
- **Undertake a participatory process of orientating existing IYCF-related CWs** on the IYCF programme and tasks followed by selection of interested and suitable candidates for training; **or**
- **Undertake a participatory process of selecting new IYCF-related CWs** if there are no existing cadres.
- **Update the knowledge and skills of health professionals** and NGO health/nutrition staff on IYCF to ensure good quality training, harmonization of practices, and supportive supervision/ mentoring of community cadres.
- **Plan training** for the identified CWs, including lay IYCF counsellors, leaders of mother support groups and other available groups or cadres functioning at community level (e.g. activists, promoters, health committees and other volunteers).
- **Identify multiple contact points** most appropriate for IYCF promotion and counselling activities – e.g. home visits, early childhood care centres, community-based screening of severe acute malnutrition, growth monitoring and promotion sessions, immunization sessions, health days, and other community events.
- **Set specific targets for activities,** either as individuals or as a group: e.g. follow-up for the expected pregnant and lactating women, the number of Action-oriented Groups to be conducted, the number of support groups to be created, or the number of IYCF contacts to be made each month at growth monitoring sessions, community meetings etc. These targets can be discussed and set during the training and reinforced and followed up during supportive supervision and mentoring.
- **Design an effective system for sustained supportive supervision,** mentoring and retraining for the identified cadres and groups, and ensure that supportive supervision and mentoring is included in annual plans. Designing a list of indicators with IYCF information that is useful and feasible to collect, and integrating it within existing indicators for the community-based programme if applicable. If the community-based programme is a new one or does not have a monitoring system, a system and tools need to be developed[7].
- **Ensure a strong link with the health system** for referral, supportive supervision, mentoring, and data collection.
- **Create a system of IYCF Support Groups** as appropriate. The Baby Friendly Hospital Initiative (BFHI) materials provide guidance on this.
- **Create a structure for knowledge-sharing** on IYCF in the community, such as billboards, regular community meetings, religious gatherings, using outreach and child health days systematically to disseminate IYCF messages, community theatre and music groups, mobile video units, etc.
- **Ensure a vision for scale within the national health plans and budgets**, including the community-based IYCF actions in all districts in a phased manner.

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