

**National Breastfeeding Counselors Network:
Joint Program of the Ministry of Health of Honduras
and La Liga de La Lactancia Materna de Honduras
A Case Study
DRAFT**

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ACRONYMS

AED	Academy for Educational Development
AGI	Areas of geographic influence of MOH health centers
ARI	Acute respiratory infection
CESAMO	<i>Centro de Salud Con Medico</i> - health center with physician
CESAR	<i>Centro de Salud Rural</i> - rural health clinic
IRH	Institute for Reproductive Health
LAM	Lactational Amenorrhea Method
LLL/H	<i>La Liga de La Lactancia Materna de Honduras</i>
MADLAC	Monitoreo de apoyo directo a la lactancia en los hospitales
MCH	Maternal and Child Health
MOH	Ministry of Health in Honduras
PROALMA	<i>Proyecto de Apoyo a la Lactancia Materna</i>
UPS	<i>Unidad productora de servicio</i> - service producing unit
WHO	World Health Organization



EXECUTIVE SUMMARY

Over the last fifteen years, Honduras has attempted various types of breastfeeding promotion activities. These included changing hospital practices, training of health professionals, mass media, curriculum reform, and pilot efforts to provide peer support for breastfeeding. The Ministry of Health (MOH) and La Liga de La Lactancia Materna of Honduras (LLL/H) have recently initiated the integration of breastfeeding promotion and support into maternal and child health services. This combined strategy includes training of health institution staff (from hospitals and health centers) with linkages to a network of volunteer community-based breastfeeding counselors. This case study documents the implementation of this effort.

Chapters 1 and 2 summarize previous efforts to promote breastfeeding in Honduras and studies that have examined the relationship of breastfeeding with health and nutritional status. Chapter 3 reports on the integration of breast-feeding promotion into the MOH program. Chapter 4 discusses the process used to train health professionals and counselors, and Chapter 5 reports on the implementation through May 1996. Supervision is discussed in Chapter 6 and monitoring and evaluation of these efforts are discussed in Chapter 7. Chapter 8 gives conclusions and recommendations.



CHAPTER 1. BACKGROUND

Importance of Breastfeeding in Honduras

The Ministry of Health (MOH) in Honduras has been a leader in the promotion of breastfeeding for more than a decade. It has developed activities within the health care system (changing hospital practices and training health service providers), approved major research studies, supported health professional pre-service training curriculum revisions, promoted optimal breastfeeding practices through the mass media, and revised national policies related to breastfeeding. This report summarizes past efforts and discusses a major recent expansion of breastfeeding promotion at a community level through a system of community-based volunteer breastfeeding counselors.

Impact of Breastfeeding on Morbidity and Mortality

Breastfeeding has a major impact on reducing morbidity and mortality among Honduran infants. Half of all infant deaths occur during the first month of life and are caused primarily by asphyxia, neonatal sepsis, and acute respiratory illness (ARI).¹ Twenty-one percent (21%) of infants die from lower ARI (primarily pneumonia) annually and 17% die from diarrhea, resulting in nearly 10,000 infant deaths annually (Table 1) out of 198,000 births.

Table 1. Demographic Indicators for Honduras	
Indicator	Current
Population of Honduras (1995)	5,500,000
Population growth rate*	3.3%
Crude birth rate*	36/1000
Number of live births	198,000
Infant mortality rate**	50/1000 live births
Total number of infant deaths	9900
Number of deaths from diarrhea (17%)**	1683
Number of deaths from ARI (21%)**	2079

* MOH, 1993.

** Mid-term evaluation of Health Sector II, 1995.

The lowest rates of diarrhea and ARI are found among exclusively breastfed infants compared to breastfed infants who are fed only water or those fed other liquids or solids. The highest illness rates are found among non-breastfed infants. Table 2 gives data from carefully controlled studies in low income urban areas of Peru (morbidity) and Brazil (mortality). Because such studies are difficult and expensive to conduct, their results have been used to extrapolate the impact of improvements in breastfeeding in other countries with similar characteristics of the populations studied. Thus they can be used to estimate the benefits of improving breastfeeding in Honduras. As shown in this table, in the first six months of life infants receiving water in addition to breastmilk are twice as likely to have diarrhea and those not breastfed are five times as likely to be ill with diarrhea. Infants receiving milk in addition to breastmilk are twice as likely to be ill with pneumonia (lower ARI) and those consuming milk and solids are seven times as likely to have pneumonia. Non-breastfed infants are 23 times more likely to die from diarrhea in the first two months of life, and four times as likely to die from ARI.

¹ According to hospital data. BASICS Honduras Country Activity Plan. Draft April 17, 1995.



Breastfeeding protects against diarrhea through two mechanisms. Breastmilk contains anti-infective properties that prevent diarrhea-causing infections and breastfed infants have shorter durations of diarrhea. Exclusively breastfed infants do not face the risk of illness caused by consumption of water, other liquids and food contaminated with pathogens. The reasons for protection from ARI are less clear but may be related to factors in breastmilk that prevent the adherence of microorganisms to respiratory mucosa.²

Illness	Type of breastfeeding	Relative Risk of Morbidity*			Relative Risk of Mortality**	
		Age 0-2 mo.	Age 3-5 mo.	Age 6-11mo.	Age 0-1 mo.	Age 2-11mo.
Diarrhea	Exclusively breastfed	1	1		1	1
	Predominantly breastfed	1.9	2.0		-	-
	Breastfed + artificial milk	1.6	2.4		-	-
	Breastfed + solids ± artificial milk	2.6	3.4	1	3.3	2.2
	Not breastfed	3.4	5.5	1.6	23.3	5.3
	Lower ARI	Type of breastfeeding	Age 0-5 mo.			
	Exclusively breastfed		1		1	1
	Predominantly breastfed		1.1		-	-
	Breastfed + artificial milk		2.1		-	-
	Breastfed + solids ± artificial milk		6.9	1	2.3	1.3
	Not breastfed		5.5	4.0	4.1	3.4

*Relative risks related to prevalence of illness are given based on data from urban Peru. Brown et al, 1989.

** Relative risk of mortality based on data from Brazil, Victora et al, 1987. Adjusted for confounding variables.

Infant mortality rates have declined dramatically in Honduras from 91/1000³ in 1975 to 50/1000 in 1990. Increasing the proportion of infants that are exclusively breastfed for the first six months of life would have a major impact on reducing the number of annual deaths since few infants are protected by exclusive breastfeeding for the full six months. Most infants are not protected for more than the first month of life because exclusive breastfeeding is seldom practiced beyond this time.

Breastfeeding Practices in Honduras

Nationwide surveys conducted in Honduras in 1981, 1984, 1987, and 1991 illustrate that there have been substantial improvements in breastfeeding practices. The proportion of women who initiated breastfeeding increased from 90% in 1981 to 99% in 1991 (Table 3). This increase was most striking among urban mothers (80% to 99%). The average duration of breastfeeding also increased, especially among urban women (four months in 1981 to fifteen months in 1991).

² Brown, et al, 1989.

³ Infant mortality is reported as the number of infant deaths per 1,000 live births.



Table 3. Breastfeeding Practices from 1981 to 1991 in Honduras				
	1981	1984	1987	1991
Percent of mothers who ever breastfed*				
Urban	80%	89%	93%	99%
Rural	95%	96%	98%	99%
Total	90%	94%	96%	99%
Median Duration of breastfeeding				
Urban	4.1	8.9	12.4	14.5
Rural	16.7	18.4	19.4	19.0
Total	13.2	15.8	17.3	17.2
% of infants 0-3.9 mo. exclusively breastfed**				
Tegucigalpa/San Pedro Sula			15%	28%
Other Urban			16%	24%
Rural			37%	43%
Total			30%	37%

* Among women with children under age two years (Popkin et al, 1991, MOH, 1993).

** On day preceding the survey.

Regional Differences in Breastfeeding Rates

There are clearly regional differences in breastfeeding practices. A survey conducted in 1991 in Regions 5 and 7 illustrates higher rates of exclusive breastfeeding than those observed in a baseline survey in Region 3 in El Progreso and Puerto Cortés (Table 4) conducted in 1995.

Table 4. Proportion of Infants Aged 1-1.9 Months by Feeding Practices on the Preceding Day by Region			
Type of Feeding	Region 5* (1991)	Region 7* (1991)	Region 3, El Progreso & Puerto Cortés ^b (1995)
Exclusively breastfed	61%	38%	21%
Fed water		23%	51%
Fed other liquids		16%	23%
Fed cow's milk		19%	50%

*Hernandez et al, 1995. Academy for Educational Development (AED), p. 53-59.

^bReyes et al, 1996, Wellstart EPB, p. 83.



Exclusive Breastfeeding

Nationwide data on the proportion of infants who were exclusively breastfed in the first few months of life have been recently collected. Between 1987 and 1991-1992, nationwide surveys illustrated an increase in exclusive breastfeeding particularly in urban areas. In Tegucigalpa and San Pedro Sula, the percent of women with infants under four months of age who were exclusively breastfeeding increased from 15% to 28%. However this is still much lower than the recommendation that exclusive breastfeeding should continue until the infant reaches six months of age.

Breastfeeding Promotion Efforts

The high rates of diarrhea observed in the early 1980s among Honduran children led to many efforts to improve breastfeeding practices. Among the first were the Proyecto de Comunicación para la Salud Infantil (PROCOMSI), which included a breastfeeding communications component using radio, pamphlets and face-to-face communication to increase breastfeeding rates. From 1981-1983, 20,000 radio spots focused on breastfeeding were aired and two national medical seminars were held. From 1986 to 1996, more than 30 Honduran health professionals participated in the Wellstart International Lactation Management Education (LME) program by attending a course in San Diego (Appendix 1 lists these professionals).

Hospital-Based Interventions

The Proyecto de Apoyo a la Lactancia Materna (PROALMA) provided training to health workers in three major teaching hospitals and promoted changes in hospital practices to support breastfeeding. The MOH hospital in Tegucigalpa, and the Social Security hospitals in Tegucigalpa and San Pedro Sula were the sites for PROALMA I, (1983-1985). A breastfeeding coordinating group, a lactation clinic, and a milk bank were established in each hospital. Baseline and follow-up surveys noted improvements in health worker attitudes and practices related to breastfeeding. For example, the proportion of health workers who recommended breastfeeding at birth increased from 27% to 87%. Rates of rooming-in in all three hospitals doubled (to over 80% in two hospitals) and the proportion of mothers who touched their infants in the delivery room increased from 7% in 1982 to 50% in 1985. The proportion of women breastfeeding within the first hour after birth increased from 0% to over 50%. Community surveys conducted in the area served by the Tegucigalpa MOH hospital illustrated that the proportion of infants breastfed at six months increased from 45% to 72% and the median age at introduction of bottles increased from two weeks to 2.5 months.

PROALMA II (1986-1988) continued PROALMA I activities in these three hospitals and expanded to an additional six regional hospitals and nine area MOH hospitals (eighteen out of a total of 29 government hospitals). However only one new hospital (Hospital Leonardo Martinez in San Pedro Sula) established a breastfeeding coordinating group and a lactation clinic. Data are not available to assess the impact of PROALMA II on breastfeeding rates because of methodologic problems with the final evaluation.

Supported by UNICEF, the Baby-Friendly Hospital Initiative also provided training to health professionals and assessed the level of support for breastfeeding that individual hospitals and health centers gave to mothers. Since the inclusion of CESAMOs (Centro de Salud Con Medico) and CESARs (Centro de Salud Rural) was considered essential, in Honduras the program was referred to as the Baby-Friendly Facilities (Establecimiento Amigo de los Niños).

In 1992, a survey was conducted to assess the completion of UNICEF's *Ten Steps for Successful Breast-feeding* in the health system in Region 3 and the Metropolitan Region, which together contain half of Honduras' total



population.⁴ Within each institution a random sample of up to ten health workers and fifteen patients were interviewed. In total, 283 health personnel were interviewed and 639 mothers. The survey found that only 29% of health workers had been trained in breastfeeding. Liquids (primarily infant formula) were given to 26% of the newborns. Ten percent (10%) were given glucose water (suero).

In El Progreso, of four health facilities included, only one had completed at least three out of the ten steps, one facility had completed two steps, and the other two facilities had completed one step. In Puerto Cortés, out of three facilities, two had completed only one step and one had not completed any steps. In contrast, the MOH Hospital Dr. Mario Catarino Rivas in San Pedro Sula had completed two out of the ten and nearly completed six of the other steps, the MOH Hospital Maternal Infantil had completed three out of the ten and nearly completed five steps and the IHSS Hospital Materno Infantil in Tegucigalpa had completed six out of the ten steps.

This survey illustrated the substantial need for training health professionals working in most MOH facilities.

The cost-effectiveness of changes in hospital practices was assessed in studies conducted in two hospitals in San Pedro Sula (Catarino Rivas and IHSS) and the Hospital Escuela in Tegucigalpa in 1991-1993. In all three hospitals, rooming-in was universal and neither glucose water nor prelacteals were given to infants while in the hospital. Comparisons made between one of these hospitals (the program hospital) and a control hospital nearby illustrated that the women who delivered in the hospital had an average duration of exclusive breastfeeding of about 30 days compared to fifteen days for those delivering in the control hospital.

These studies led to the development of a questionnaire that health institutions could implement to assess their practices related to breastfeeding, specifically related to the ten steps needed to be considered Baby-Friendly. The MADLAC (Monitoreo de apoyo directo a la lactancia en los hospitales) form is administered monthly to a sample of mothers upon their leaving the hospital, either after delivery or after a child health visit (See Appendix 2). As of May 1996, no hospitals had been determined to be Baby-Friendly, but the MADLAC reports illustrate numerous improvements, and a request has been made by Hospital Catarino Rivas that they be formally assessed.

The effect of these promotion efforts have been impressive. The emphasis of PROALMA had been primarily on training hospital-based health professionals and changing hospital practices. While these changes appear to have had a major impact on the median duration of breastfeeding among urban women who were likely to give birth in hospitals, their impact on helping women to exclusively breastfeed for the recommended durations was limited. The community evaluation conducted in Tegucigalpa in the area near to the hospital found that there was a shift from early use of milk to early use of water in addition to breastmilk. Thus other interventions to promote breastfeeding have been developed to provide support outside of facilities.

Mass Media Promotion

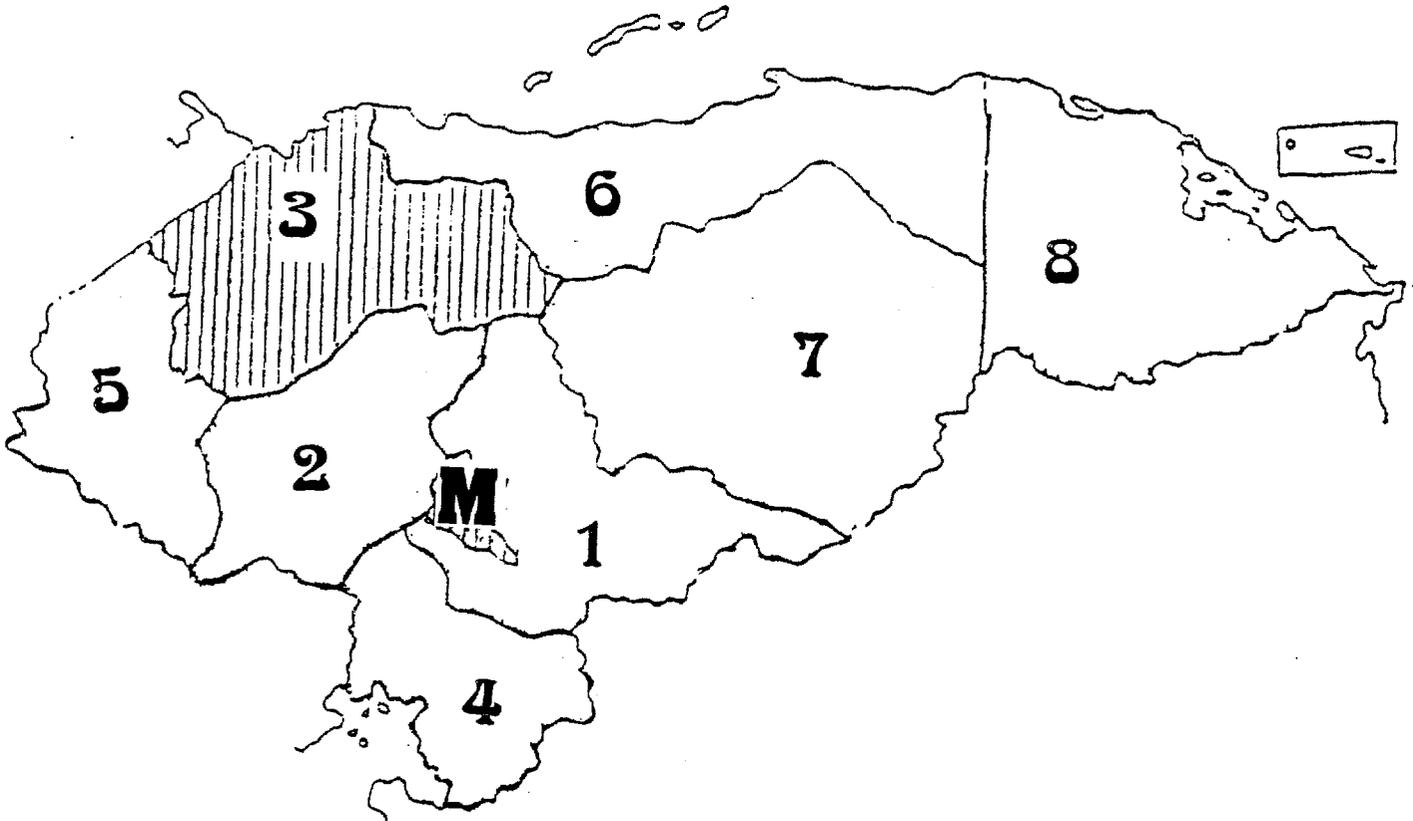
In addition to the PROCOMSI activities carried out in the early 1980s, the MOH in conjunction with the USAID funded Nutrition Communication Project (Nutricom - a USAID-funded project with the Academy for Educational Development) conducted a social marketing campaign in 1991-93 in Regions 5 and 7 (See Figure 1). The activities included health worker training which consisted of a five-hour course in breastfeeding and a 40-hour seminar in integrated child care. Print materials produced included posters and calendars for institutions, flip charts and a mini-reference guide for health workers to use in teaching mothers, and a comic book and flyer for mothers. Radio messages included thirty-second spots on national and regional radio and a one hour weekly call-in program. Radio spots reached nearly half of all target mothers, and posters were seen by two-thirds of

⁴ Rivera A, López C, Paz B, et al. Evaluación establecimiento de Salud Amigo de los Niños. MSP, IHSS, LLL/H, 1993.



mothers, but there was limited exposure to other print materials. Half of the mothers could recall the campaign's slogan "Breastmilk and nothing else in the first six months."

Figure 1. Map of Health Regions in Honduras





Rates of exclusive breastfeeding increased from 48% to 70% at one month of age and from 7% to 12% by the sixth month of age. Mothers' knowledge about the need for exclusive breastfeeding was correlated with exclusive breastfeeding rates. At six months, 21% of mothers with high knowledge levels were exclusively breastfeeding compared to only 0% for those with low knowledge. At six months of age, water use declined from 78% to 61%, and use of other liquids declined from 26% to 8%. Use of cow's milk declined from 38% to 26%.

In Region 5, 75% of health workers had been trained, while only 32% of those in Region 7 received training. However, exposure to the training did not improve the knowledge of health workers. It appears that the cascade approach used in the training (training higher level workers who were then to train other workers) was not effective.

Policy Revisions

In 1990, Honduras was one of the first countries to develop a policy statement supporting exclusive breastfeeding for the first six months of life. MOH norms were developed supporting this policy and growth charts (Tarjetas del niño) were produced which illustrate the norms (Figure 2). In addition, the MOH has recently revised the perinatal form used by health professionals with women during pregnancy and during the perinatal period (Appendix 3). This revised monitoring form was developed in conjunction with the Centro Latino Americano de Perinatalogía (CLAP). It is used to collect information on breastfeeding (whether the infant and mother were roomed together in the hospital, whether the infant was exclusively breastfed, artificially fed, or both), in addition to health and nutritional status of both the mother and infant as well as use of contraception.

Other policy changes promoted by the MOH include the development of norms including the restriction of offering glucose water to newborns, early attachment (*apego precoz*) with mothers helped to breastfeed in the first half-hour after birth, and the general policy that infants should be kept with their mothers in the same room following delivery.

ALIMENTACION DEL NIÑO DURANTE SU PRIMER AÑO DE VIDA

ALIMENTOS	EDAD EN MESES CUMPLIDOS											
	0	1	2	3	4	5	6	7	8	9	10	11
LECHE MATERNA												
VEGETALES												
FRUTAS												
MAIZ												
ARROZ												
OTROS CEREALES												
FRIJOLES												
CARNE <small>POLLO, RES, CERDO Y PESCADO</small>												
HUEVO												
DERIVADOS DE LECHE												

Marque con una "X" el mes que inicia el alimento.

El niño que amamanta no necesita tomar agua, porque la leche materna contiene suficiente agua. Al año de vida el niño debe comer de todo.

FECHAS DE ADMINISTRACION DE VITAMINA "A"

DÍA	MES	AÑO	DÍA	MES	AÑO

DEBE INICIARSE A LOS 6 MESES Y DEBE ADMINISTRARSE UNA DOSIS CADA 6 MESES



GRAFICA DE CRECIMIENTO Y DESARROLLO DEL NIÑO

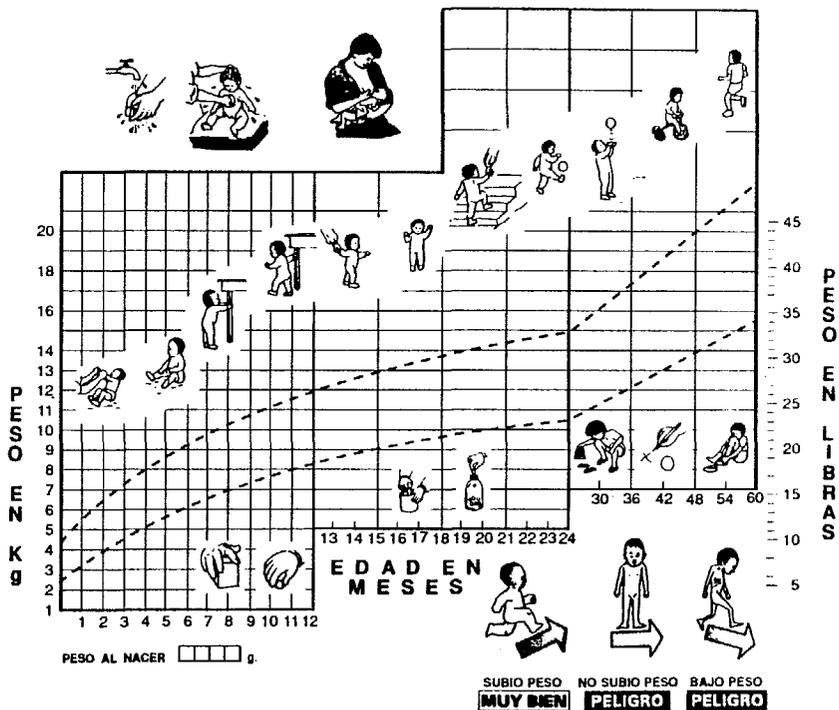


Figure 2. Growth Monitoring Card, Honduras



Community-based Pilot Interventions

Following PROALMA II several NGO efforts were developed to promote breastfeeding within the community. Through a USAID Child Survival Grant to La Leche League International, La Liga de La Lactancia Materna de Honduras (LLL/H) began providing support to breastfeeding in the peri-urban areas of San Pedro Sula in 1989. During the period of this grant (1989-1992), over 186 breastfeeding counselors and 113 promotores (from NGOs) were trained in the zones of San Pedro Sula and Choloma in Region 3 within the communities of López Arellano, La Jutosa, Quebrada Seca, Colonia Sandoval Sorto, and Las Palmas in the south-east and north-east areas of the city of San Pedro Sula.

The Asociación Hondureña de Lactancia Materna (AHLACMA) and Foster Parents Plan (Plan International) compared the impact on exclusive breastfeeding rates of community-based breastfeeding counselors to community health committees in rural areas in the Department of Francisco Morazan outside of Tegucigalpa in 1991-1992. Four volunteer counselors were selected within each community. The counselors and the committees conducted monthly group meetings with pregnant women and those with children under one year of age in twenty communities each. They were able to obtain 46% coverage during the first year of the project. The rate of exclusive breastfeeding among infants at age six months increased from 12% to 21% in the villages with breastfeeding counselors but there was no change in the village health committee communities. The median duration of exclusive breastfeeding increased from 1.2 months to three months. This program required a large amount of supervision to the breastfeeding counselors, with supervisors visiting each village at least once each month, for several hours.

La Liga de La Lactancia Materna, which formally registered as a NGO in July 1991, in conjunction with the Institute for Reproductive Health at Georgetown University and technical assistance from the Population Council, assessed the impact of breastfeeding counselors in urban *barrios* of south-east San Pedro Sula in 1990-92. The volunteer community counselors organized twelve support groups reaching over 1,000 participants in one year. They collaborated with the MOH in organizing health committees in the *barrios* and then counselors were selected from the interested committee members. Among mothers who had contact with a breastfeeding counselor, the duration of exclusive breastfeeding doubled from 4.3 weeks to 9.6 weeks. However only 12% of the target population of pregnant women and those with children under age six months had been contacted in the first year.

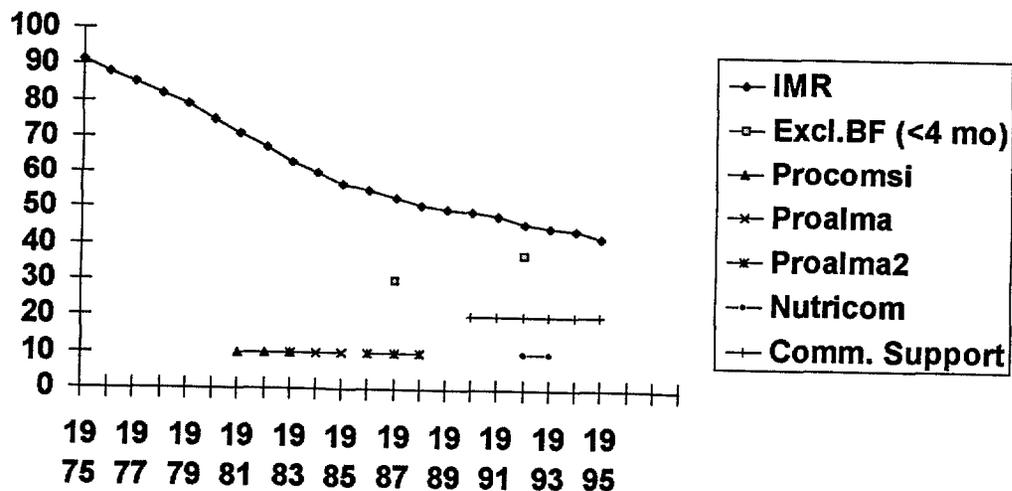
Table 5 summarizes the results of the evaluations mentioned above to illustrate the relative impacts each program has had on breastfeeding rates. As shown, the programs with the greatest impact on exclusive breastfeeding were those related to community-based support. These efforts led to the development of an expanded program of community support that would provide greater reach of the community counselors and that would integrate activities with the MOH health delivery system.

Figure 3 shows the relationship of the decline in infant mortality in relation to breastfeeding promotion activities and to changes in breastfeeding practices. While consumption of oral rehydration solution increased during this time among children under age five years with diarrhea, it is also likely that the reduction in deaths due to diarrhea, especially among children under age one year, was related to the improvements in breastfeeding practices. Further improvements in breastfeeding are as likely to result in decreases in infant mortality from acute respiratory tract infections (ARI) and diarrhea in the future.



Type of Intervention	Control (or Pre-test)	Program (or Post-test)	Year	Site	Reference
Hospital-based intervention	0.5 months	1 month	1992-1995	San Pedro Sula	Sanghvi, 1996
Mass media	2 months	2.5 months	1991-1993	Regions 5 and 7	Hernandez et al, 1995
Community-based peer support (among those contacted)	1 month	2.2 months	1990-1992	Peri-urban San Pedro Sula	Rivera et al, 1993
Community-based peer support	1.2 months	3 months	1991-1992	Dept. Francisco Morazan	Lundgren, Chavez et al, 1993

Figure 3. Infant Mortality Rates in Honduras in Relation to Breastfeeding Promotion Activities





CHAPTER 2. FACTORS ASSOCIATED WITH INFANT FEEDING PRACTICES

Socio-demographic Characteristics

As shown in Table 3, the median duration of breastfeeding is less among urban women compared to rural women, and urban women also have lower rates of exclusive breastfeeding at 0-3.9 months postpartum than their rural counterparts. Data from the 1991-1992 Family Health Survey also show that with increasing educational levels, the duration of breastfeeding declines. Women with more than seven years of education have a median duration of breastfeeding of twelve months compared to 21 months for those with no education.

Child Nutritional Status

Based on the 1991-1992 Family Health Survey, the highest prevalence of malnutrition among young children (< age five years) is seen in Regions 2 (Comayagua, Intibuca, La Paz, and Fransico Morazan) and Region 5 (Lempira, Cotepeque and Copan). Children in rural areas are nearly twice as likely as those in urban areas to be stunted (47% vs. 26%). Wasting (low weight-for-height) is not a common problem among Honduran children. Among peri-urban children, rates of stunting increase dramatically between six months and two years of age, and then level off at about 40%. However among rural children, stunting rates continue to increase to age 24-36 months and then remain at about 60%.

How is breastfeeding related to such levels of malnutrition? A ground breaking study was conducted in Honduras to examine this issue.⁵ Birth weights of Honduran children were shown to be less than those in a comparison study conducted in the US. Twenty percent weighed less than 2,500 gm and the average weight was 2,889 gm compared to 3,611 gm for the U.S. comparison group. However the exclusively breastfed Honduran infants exhibited rapid catch up in weight in the first few months of life, and the weights at three months of age were similar. At birth and through twelve months of age, more stunting was evident in the Honduran infants. However there were no differences in weight or length gain between the two groups of infants. This illustrates that breastmilk production among Honduran mothers is adequate to promote optimal growth in infants.

This study also found that the average time that an exclusively breastfed four month-old infant spends breastfeeding is about 202 minutes in 24 hours during 13.8 episodes (about thirteen minutes per episode). They breastfeed on average nine times during the day and five times at night.

An important question asked by this study was whether there were any benefits to adding complementary food at four months of age instead of six months of age. While breastmilk output was similar at four months, when complementary foods were added, breastmilk production was reduced.⁶ However the total caloric intake remained the same and growth rates did not differ from U.S. breastfed infants. This illustrates that the addition of early foods does not benefit the child's growth, but could be damaging if foods added are contaminated or if they are of lower nutrient density than breastmilk.

Although adding foods at ages less than six months does not benefit the child's growth, Honduran mothers believe that it is important to accustom the infant to new foods so that she/he will eat adequately. A recent study

⁵ Cohen R, Brown KH, Canahuati J, et al. Determinants of growth from birth to twelve months among breast-fed Honduran infants in relation to age of introduction of complementary foods. *Pediatrics* 96(3);1995:504-510.

⁶The complementary foods used were given to women in pre-cooked form in jars not needing refrigeration to prevent contamination of the foods, which is a major problem associated with complementary feeding. Women were told not to store any left-overs.



in El Progreso and Puerto Cortés reported that among mothers with infants 4-5.9 months of age, over half had already given them solids, and half of these did so to accustom them to other tastes.⁷

The impact of introducing foods at ages four to six months on later complementary food consumption was assessed in another study at ages nine and twelve months of age.⁸ There were no benefits on food consumption of early introduction of solid foods. Infants consumed similar amounts of food, snacks, meals, and varieties of foods whether or not they had solids prior to six months of age.

These results strongly support the MOH recommendation of exclusive breastfeeding to six months of age. However the increasing prevalence of stunting after six months of age illustrates the importance of adequate complementary feeding after six months of age. Addressing this problem is not however only an issue of food availability. In a study of peri-urban infants nine and twelve months of age, at the mid-day meal, infants left unconsumed 40% and 25% of food offered.

Foods given to young children are often too low in calories. For example “sopa de frijoles” can fill a child’s stomach before his caloric needs are met. Cultural beliefs about appropriate foods for infant feeding are thus at times inappropriate. The problem of inadequate food consumption and poor growth may be related to low nutrient intake (for example vitamin A, iron, or zinc) associated with anorexia or poor growth, or it could be related to inactive feeding by the caretaker, or to anorexia associated with illness. Studies in other countries (Colombia, Peru) have shown that diarrhea results in decreases in growth only among infants not receiving adequate diets. Thus improving diets of young children can help reduce the normally seen growth faltering associated with diarrhea in Honduras.

The high prevalence of stunting at birth also illustrates the importance of improving maternal nutritional status, especially by reducing stunting among girls during their peak growth years. Improving nutritional status of mothers during pregnancy, especially those who are severely stunted, may help to increase birth lengths of infants.

Maternal Nutritional Status

Honduran mothers were shown to be 12 cm (4.7 inches) shorter and to weigh 7 kg (15.4 pounds) less than US mothers.⁹ However differences in maternal nutritional status were not shown to affect breastmilk output among Honduran mothers, once birth weight and milk energy density were controlled. Breastmilk output was related to birth weight, with heavier infants consuming more milk. While mothers with higher fatness levels produced milk with higher energy densities, infants of such mothers consumed less volumes of milk than those of mothers that produced lower energy density milk. Thus infants controlled their milk intake by increasing or decreasing the total volume of milk consumed.

These findings indicate that maternal malnutrition in Honduras affects the child’s nutritional status through its impact on producing lower birth weight infants but not through limitations in breastmilk production. Priority should thus be given to improving maternal nutritional status by reducing chronic malnutrition prior to pregnancy.

⁷ Reyes ME, et al. Infant health and feeding practices in El Progreso and Puerto Cortés: 1995 baseline survey to evaluate community-based breastfeeding promotion activities. Wellstart EPB, 1996.

⁸ Cohen RJ, Landa Rivera L, Canahuati J, et al. Delaying the introduction of complementary food until six months does not affect appetite or mother’s report of food acceptance of breastfed infants from 6-12 months in a low income Honduran population. *J of Nutrition* 125;1995:2787-2792.

⁹ Perez-Escamilla R, Cohen RJ, Brown KH, et al. Maternal anthropometric status and lactation performance in a low-income Honduran population: Evidence for the role of infants. *Am J of Clin Nutr* 61;1995:528-534.



Maternal Activity Patterns

In many populations, women have limited time to adequately feed their infants. Among women in peri-urban Honduras, observations of activity patterns in relation to infant feeding were observed among women not employed outside the home with infants four to six months of age. Those who were exclusively breastfeeding spent less total time feeding their infants than those who breastfed their infants and also fed them complementary foods. The total time (during a twelve-hour period) spent breastfeeding was 62 minutes for exclusively breastfeeding primiparous women at 24 weeks. However those who fed their infants complementary food spent an additional 32 minutes feeding their infants daily. The time spent preparing food was only two minutes since mothers had been given baby food in jars as the complementary foods.¹⁰ In contrast, multiparous women who were not given jars of baby food spent fourteen minutes on food preparation in addition to 21 minutes on feeding. The amount of time spent breastfeeding was not significantly different in the multiparous women either (85 minutes for exclusively breastfeeding mothers and 78 minutes for breastfeeding mothers who also gave complements).

Complementary feeding of infants at four to six months requires about an additional half hour. Since older infants will require more meals than these young infants, the total time needed to feed infants complementary foods will increase as the child ages. For example, twelve month old infants ate on average three meals and 1-1.5 snacks per day.¹¹ Breastfeeding frequency may decrease, but since most mothers introduce other milks by six months of age,¹² the time previously spent breastfeeding may be converted to time spent bottle feeding.

Milk Imports

In a recent study in El Progreso and Puerto Cortés, of infants less than six months of age who were fed cow's milk, 40% were fed powdered milk, 15% fresh cow's milk, and 45% were fed infant formula. All powdered milk and infant formulas are imported. Figure 4 illustrates the pattern of imports of formula since 1975.¹³ As illustrated, even though the number of annual births has increased since this time, the amount of milk and formula imported has decreased between 1984 and 1991-1992 when the median duration of breastfeeding increased from nine months to fifteen months for urban women. Breastfeeding has been an important reason for this decline, since much of the imported milk is not consumed by infants though nearly all of the infant formula is consumed by infants.

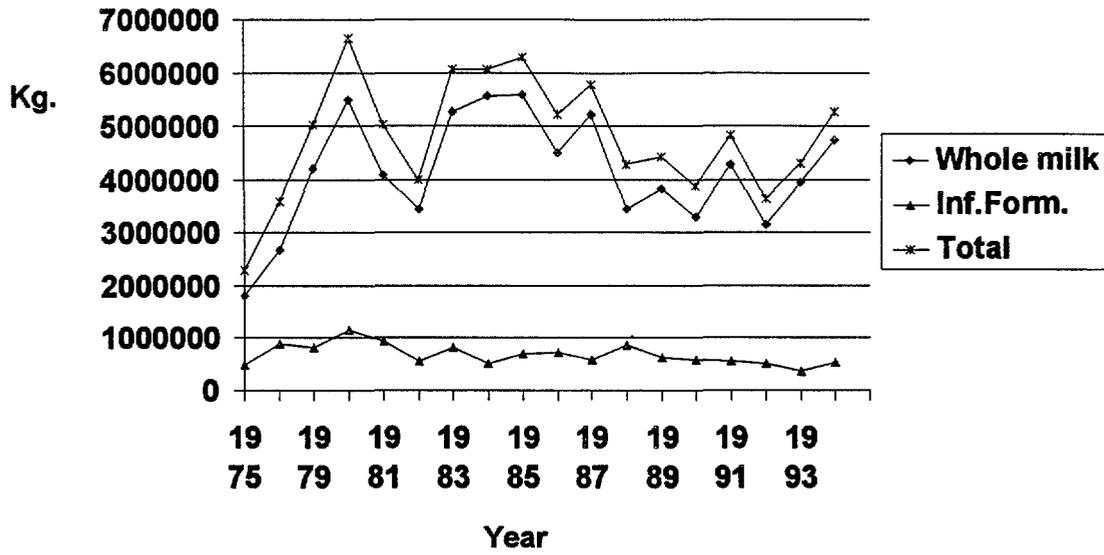
¹⁰ The original study design included only primiparous women. Those that were randomly assigned to give complementary food were given baby food in jars to assure that the foods given to infants in the study were not contaminated. This subsequent study also included multiparous women who were not randomly assigned to specific feeding patterns and thus were not given baby food in jars.

¹¹ Cohen, et al, *J of Nutrition*, 1995. Op cit.

¹² 90% of mothers fed their infants cow's milk or formula after six months of age. From Cohen et al, *Pediatrics*, 1995. Op cit.

¹³ The amounts imported reported for 1993 were misclassified due to changes in the definitions used during this year. The two surrounding years (1992 and 1994) were therefore averaged in this figure (Ministry of Commerce records, 1996).

Figure 4. Imports of whole powdered milk and infant formula to Honduras





CHAPTER 3. INTEGRATION OF BREASTFEEDING INTO MCH SERVICES

History of the Development of an Integrated Program

In 1992, agreements were made between the MOH, LLL/H, USAID, UNICEF and the World Bank to implement a component to incorporate breastfeeding into integrated MCH care. The specific objectives of the overall program were to:

- 1) Establish two national breastfeeding training centers;
- 2) Integrate breastfeeding into medical and nursing pre-service curriculum;
- 3) Create a breastfeeding commission to develop/monitor policies and legal framework;
- 4) Create a breastfeeding documentation center;
- 5) Implement a training plan for health professionals in 50% of health regions;
- 6) Support the formation of a network of counselors; and,
- 7) Monitor, evaluate, and document the process.

The integrated program was planned to take place in nineteen out of 29 health areas in four out of the nine health regions. Much of the World Bank funding was for institutional training of health professionals. Community-based training in nine health areas was to be supported through grants to the MOH by USAID in Health Sector II and ten health areas were to be supported by other agencies, including the Swedish International Development Agency (SIDA). These nineteen health areas, covering half of the 40 health areas within Honduras, are known as Access areas, because they are targeted by the MOH to be part of a primary health care program focused on community participation through municipalities. Table 6 gives the estimated number of pregnant women and infants less than six months of age for each of these regions, and the areas included in the project.

Table 6. Estimated Numbers of Pregnant Women and Infants under Age Six Months in the Target Health Regions Included in Integrated Breastfeeding Program					
Health Region	Estimated number of pregnant women in the region	Estimated number of infants under age six month	Number of areas in each region	Number currently planned	Areas included (AID)
Metropolitan	26,000	24,000	2	2	1, 2
1			4	1	1
2			5	4	1, 3, 4, 5
3	25,000	23,000	8	5**	M, 1, 2, 3, 6
4	21,000	19,000	5	0	0
5	25,000	22,000	4	0	0
6			5		
7			5		
8			2		
9					
Total	97,000	88,000	40	12	12

**The area of El Progreso was not included in the overall plan, but is included in the program to enable the evaluation to be conducted.



Because of delays and reductions in funding by USAID and the World Bank for these activities, the current proposed plan for the integrated program includes only twelve areas.

The MOH has contracted with LLL/H to develop the network of breastfeeding counselors, to provide technical assistance for the training of health professionals, to establish the documentation center, and to monitor these activities. The Wellstart Expanded Promotion of Breastfeeding Program provided technical assistance for the development of the health professional and counselor's training curricula, the revision of the strategy for training and supervision of counselors, the monitoring and evaluation of the program, and the revision of the medical and nursing pre-service training curriculum. The Nutricom project (administered through AED) and Georgetown University Institute for Reproductive Health (IRH) provided technical assistance for the development of a Counselor's Reference Manual. The Latin American and Caribbean Health and Nutrition Sustainability Project (LAC HNS) (funded by USAID) provided support to develop the MADLAC instrument which monitors hospital practices and referrals to counselors in the community.

Program Objectives, Goals, and Strategy for the Network of Counselors

The overall goal of the network of counselors is to:

Promote and support breastfeeding through a national network of counselors working in conjunction with the MOH's program of integrated maternal and child care.

The specific objectives of the program are to:

- 1) Develop an organizational structure for a national network of community-based counselors,
- 2) Promote, support, and improve breastfeeding practices at a national level, through a strategy of one-to-one counseling and use of support groups.
- 3) Strengthen the interface between the community and the health team in the integrated MCH program through an emphasis on breastfeeding.

The goals of the program are:

- 1) Increase the rate of exclusive breastfeeding among infants less than six months of age by 50% over the rate observed in the community diagnosis within two years.
- 2) Increase the proportion of children under two months of age within the area of coverage of the counselors that receive no water nor other milks to 80%.
- 3) Have at least 50% of children less than six months sleeping with their mothers in the same bed.
- 4) Have counselors refer in writing 100% of pregnant women identified within each counselor's area to prenatal care if they have not yet received care.
- 5) Have counselors refer in writing 100% of newborns within each counselor's area to integrated child care if they have not received care.
- 6) Assure that 70% of mothers with children under age six months receive information on methods of family planning and on the Lactational Amenorrhea Method (LAM).



- 7) Guarantee that at least 80% of the Level 1¹⁴ health personnel in each health region are trained prior to initiating the community intervention.
- 8) Train sufficient numbers of counselors to reach at least 60% of the UPS in each health area and 60% of the areas of geographic influence within each UPS.
- 9) Maintain 70% of counselors trained within each UPS reporting on a regular basis.
- 10) Assure that each counselor identifies at least 80% of pregnant women and breastfeeding mothers with children less than six months of age in her area of influence through community diagnosis.
- 11) Assure that each counselor covers 80% of pregnant women in her area with at least one home visit each month in the last trimester of pregnancy.
- 12) Assure that each counselor covers at least 80% of mothers of children under six months of age through at least one postpartum visit during the first several days postpartum, one visit during the following fifteen days, two additional visits within two months, and continuing with at least one contact per month through a home visit or support group.
- 13) Have at least 60% of counselors maintain at least one support group attended by pregnant women in the second and third trimester of pregnancy and breast-feeding mothers.
- 14) Complete at least four meetings per year between the UPS health team and mentors and six meetings per year between the counselors and the mentors.
- 15) Have each counselor complete at least 240 person-to-person counseling sessions annually.
- 16) Have each group of counselors within a UPS conduct at least 24 popular education sessions on maternal and child health with participative methods within their areas on maternal and child health with participatory methods.

Activities to Date

This report discusses in detail the training of health professionals and the network of breastfeeding counselors. This section summarizes the status of the other components of the integrated program.

Pre-service Curricula Revision

The MOH has coordinated with the faculty of the one medical school, the *Facultad de Medicina de la Universidad Nacional Autonomo Hondureña*, and the *Escuela de Enfermeria*. While previously through the efforts of a Wellstart Associate, a module on breastfeeding was introduced into one course in the medical curriculum, now the entire seven-year curriculum includes sections on breastfeeding, with four courses especially reoriented (Pediatrics, Obstetrics and Gynecology, Internal Medicine, and Surgery). The new school year starts in January 1997, and at that time the revised curriculum will be in place. This process has taken two and a half years to complete because of the need to build a consensus by the team of professionals from the medical and nursing schools and the MOH.

¹⁴ Level 1 health personnel include the health staff working at the CESARs and CESAMOs, including the auxiliary nurses, vaccination workers, health promoters, etc.



Breastfeeding Documentation Center

A documentation center specializing in information on breastfeeding has been established within the offices of La Liga de La Lactancia Materna in San Pedro Sula. It contains reference material on breastfeeding, training, and supervisory manuals, and copies of reports of previous breastfeeding promotion activities in Honduras. These materials are currently being entered into a database reference system (Pro-Cite).

Breastfeeding Commission

While the development of a breastfeeding commission was planned at the inception of the integrated program, the MOH has decided that because of its approach to integrated maternal and child health care, a separate breastfeeding commission is not a priority at this time. However the Vice-Minister of Population Risks serves as the technical coordinator for breastfeeding activities within the country. She is committed to carrying this process through in 1996.

Funding

Funding for these efforts has been multiple. Because of different funding cycles of the institutions involved, and the varying priorities of these institutions, funding has often been erratic. Table 7 shows which organizations have provided the funding, where data were available.

Activity	Responsible Agency	Donor
Preliminary activities: Development of Counselors Reference Manual	LLL/H	USAID (through IRH and AED)
Preliminary activities: Development of curriculum for breastfeeding counselors	LLL/H, (TA from Wellstart)	USAID (through Wellstart EPB) and local USAID mission private sector support funds (Health Sector II)
Preliminary activities: Development of Supervisory and monitoring instruments	LLL,H, (TA from Wellstart)	USAID (through Wellstart EPB) and local mission funds (Health Sector II)
Preliminary activities: Development of Health Professional Training Curriculum	MOH, LLL/H	USAID (through Wellstart EPB program), USAID (Health Sector II) World Bank
Program Activities: 1) Establish two national training centers, and equip the centers and hospitals	MOH, LLL/H	World Bank USAID (training of trainers through Wellstart EPB program)
Program Activities: 2) Integrate breastfeeding into revised pre-service medical and nursing training curricula	MOH/Faculty of Medicine (TA from Wellstart, UNICEF, PAHO)	World Bank USAID (through support of Wellstart Resident Advisor)



Program Activities:		
3) Create breastfeeding commission	MOH	World Bank UNICEF USAID (TA from Wellstart Resident Advisor)
4) Create documentation center	LLL/H	World Bank UNICEF
5) Train health professionals		USAID (Health Sector II, for nine health areas in metropolitan region, Region 3, 4, 5) SIDA (for ten health areas in regions)
6) Train and supervise 1800 breastfeeding counselors	LLL/H, MOH	USAID (Health Sector II) SIDA, European Community Training Supervision World Bank SECPLAN (Region 3, Area 2)
7a) Monitor and document process	MOH, LLL/H	USAID (Health Sector II)
7b) Evaluate combined health professional training and counselor network	Wellstart/MotherCare	USAID (through Wellstart EPB and MotherCare) Development of eval. strategy Baseline survey Follow-up survey

The original Cooperative Agreement between USAID and Wellstart suggested eight purpose-level achievements that were to gauge progress and measure program success. Progress to date is shown in Table 8.

Purpose-level Goal	1993	1996
Breastfeeding Coordinator Appointed	No	Yes
Breastfeeding Committee Established	No	No
National Policy Approved (within Code of the Child)	Limited	Yes
National Program Developed	Yes	Yes
Government Funds Budgeted	Limited	Yes
Breastfeeding Promotion Integrated	No	Yes
Monitoring and Evaluation Mechanism Established	No	In development
Research Disseminated	Minimal	In development



CHAPTER 4. TRAINING OF HEALTH PROFESSIONALS AND PEER COUNSELORS

Training of Health Professionals

National Training Centers

One of the first steps in this process has been the development of two national training centers, one in San Pedro Sula (at the Hospital Dr. Mario Catarino Rivas) and the other in Tegucigalpa (Hospital Escuela). The National Training Centers began training health care workers in February 1995 (Hospital Escuela) and March 1995 (Catarino Rivas). The health workers from the Progreso and the Metropolitan Area, Area 1, and Area 5 in Region 3 were the first to be trained at the national training center in San Pedro Sula. There were twenty courses (two to four each month) held from March to November with 382 health workers trained. The staff of the center includes the coordinator (Dr. Benjamin Abdu), two assistants, one secretary, and four counselors. The training center in Tegucigalpa trained 512 health workers in 25 courses and 764 medical students from February to December 1995. It has one coordinator (Dr. Fanny Sabillon) and five counselors supported by the project. The Lactation Unit has additional staff who are funded by the hospital.

In Tegucigalpa, health workers from the Metropolitan Region and those from the IHSS hospital and Hospital Escuela were the first to receive training. Subsequently health workers from the other areas will then be trained if funds are available. Table 9 illustrates that a high proportion of the staff in two areas of San Pedro Sula have been trained by the Centers through December 1995. Over 80% of all Level 2 staff in two areas (Area 2 and Area 1), including health professionals other than physicians and nurses, such as technicians, pharmacists, and specialists have been trained. In addition, teams for 29 out of the 29 hospitals in Honduras also received training in the Baby-Friendly Hospital Initiative and the use of MADLAC to monitor hospital activities related to breastfeeding.

In addition to training, the Centers operate lactation clinics. In Tegucigalpa, where there were 19,731 births in 1995, they attended 9,000 patients at the clinic. In San Pedro Sula, where there were 7,618 births in a partial year, they had 837 consultations at the clinic. Reports from both hospitals show a low frequency of anatomical breastfeeding problems: only 1% had inverted nipples. This illustrates that the problem is less frequent than often assumed.

Region and Area	Physicians	Nurses
Metropolitan	19%	38%
Region 3		
Metropolitan	100%	100%
Area 1	100%	100%
Area 2	100%	100%

Level 2 Health Worker's Curriculum

In May 1993, a multi-disciplinary team of professionals from different institutions in Honduras started to adapt a pre-service training curriculum on breastfeeding that had been developed in Mexico (Appendix 4). The process extended over a two-year period. The revised curriculum (Appendix 5) has changed substantially from the Mexico curriculum by the Honduran staff. At the time of the curriculum development, the WHO/UNICEF

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Breastfeeding Counseling: A Trainers Course was not yet available.¹⁵ This revision process helped to make the curriculum specifically suited to local needs and to involve an inter-disciplinary team from the MOH regions and the hospital staffs. LLL/H has provided technical assistance to these efforts and has helped train the master trainers who provide training to teams of health workers from local hospitals and health centers throughout the country.

The Level 2 curriculum is taught during a 30-hour course. Participants receive per diem to cover their costs during the course. This represents a major portion of the training costs. The faculty in the training course are drawn from professionals working in the hospital and others within San Pedro Sula, who donate their time for training. They use the curriculum modules that are available at the Training Center. No materials are given out, but trainees may purchase copies of materials used.

Training of Counselors

Once the Level 2 staff have been trained, LLL/H trains the Level 1 staff from the UPS where they then train the counselors. Level 1 health workers (including auxiliary nurses, promoters and educators) are trained using the community counselors curriculum in a 40-hour course generally taught at the local health center. Upon completion of the training, they receive a diploma from the MOH and LLL/H certifying that they attended this course. These health workers are trained prior to the training of the counselors in their areas to facilitate the integration of the duties of these health workers with the training and supervision of counselors. Table 10 gives the number of Level 1 health workers who have been trained by LLL/H from January 1993 through May 1996.

Region/Area	No. of Level 1 health workers trained	No. of counselors trained	No. of counselors submitting reports	No. of UPS	No. of UPS included in program	No. of Areas of Geograp Influence
Region 3						
Area 1	44	138	107	16	6	58
Area 2	93	134	NA	16	6 (out of 11 planned)	38
Metropol.	71	158	95	10	9	70
Metropoli. (Tegucigalpa)	282 (Natl training ctr)	385		15	8	
Total	490	815				

*From 1995 LLL/H annual report, LLL/H supervisory forms (May 1996), and report for National Training Center in Tegucigalpa.

¹⁵ The WHO/UNICEF takes a total of 40 hours and the course can be conducted in one week or can be spread out. It is divided into 33 sessions. A trainer's guide, participants manual, answer sheets, forms and checklists, story cards, overhead figures, and slides, and two videos (*Helping a Mother to Breastfeed* and *Feeding the Low Birth Weight Infant*) are available from WHO/UNICEF. A set of additional reference materials are given to participants. However, this is not yet available in Spanish.



Counselor's Curriculum

In addition to training of health workers, the integrated breastfeeding component includes the training and support of a network of volunteer breastfeeding counselors. Starting in May 1993, Wellstart assisted LLL/H to develop a training curriculum to be used to train community counselors. This curriculum was field tested in May and June 1994. This pre-test provided information to help revise the Counselor's Reference Manual that had been previously prepared by LLL/H, IRH, and AED. The counselor's manual and the training curriculum now include consistent messages and drawings so that the two can be used together easily. The counselor's manual reinforces the information from the curriculum. However, due to lack of funding, the manual has not yet been reproduced or distributed to the counselors.

Selection of Counselors

The profile of a woman who is eligible for training is shown in Table 11.

Table 11. Characteristics of Counselors Used to Select Trainees	
A mother who:	
▶	has breastfeed for at least one year;
▶	has time available;
▶	is well known within the community;
▶	is interested in doing volunteer work;
▶	is 18-49 years old;
▶	can read and write (except in communities with high rates of illiteracy); and,
▶	is a permanent resident of the community.

At least two mothers from each community (defined as an area of geographic influence for each UPS) with these characteristics are then selected by the community to participate in the training program. Often some people may be selected for training who do not meet the requirements shown above (for example, a man may take the course). If they do not meet the requirements, but they finish the training, they are certified as promoters. There have been 28 promoters trained in addition to counselors.

Initial Training of Counselors

A training course is held among a minimum of ten and maximum of fifteen mothers for 40 hours, generally within five consecutive days. Appendix 6 gives the topics discussed within the twelve modules in the training course. The training is participatory, using skits, games, and various other techniques based on adult learning principals. Training is generally conducted by two LLL/H trainers but at times, a MOH staff person from the UPS and a LLL/H trainer work together, or two MOH staff who have previously trained.

Upon completion of the training course, women are certified as counselors and given a diploma and an identification card. Representatives of the MOH and LLL/H attend the graduation ceremony, thus giving public recognition that the counselors are an integral part of the volunteer health personnel.



Monthly Meetings of Counselors

Training of counselors is continued through monthly meetings held with the other counselors from the local area. Initially staff of LLL/H coordinated these sessions in conjunction with the health center staff, but often health center staff run the meetings with the counselors along, with LLL/H staff visiting them periodically.

Agendas for the monthly meetings are developed jointly by the counselors, supervisors from the UPS and LLL/H. The meetings are run in the same manner as a support group. During these monthly meetings, the following activities take place:

- 1) Review of the goals for each counselor in relation to her activities during the month;
- 2) Discussion and analysis of home visits;
- 3) Review of monitoring reports submitted for each counselor;
- 4) Programming of the activities for the coming month;
- 5) Review of clinical problems and a discussion of possible solutions; and,
- 6) Development of themes for further training and feedback.

Preferably, these monthly meetings take place at the UPS on the same day of meetings of other volunteer health workers so that counselors can be integrated into the team of volunteer health workers.



CHAPTER 5. IMPLEMENTATION OF ACTIVITIES

Meeting with Health Teams

The first step in the implementation of activities includes the regional-level MOH staff and the trainers from LLL/H meeting with previously trained health teams from the Health Areas and the UPS to discuss the process of developing the network of counselors. During this meeting, information on the estimated number of pregnant women and children under two years of age within each UPS is reviewed using vaccination lists, CEFASA (*Censo Familiar de Salud*), and lists of women enrolled in the food stamp program (*bonos maternos*) to help determine the number of counselors that will be needed in the area.

Meetings in the Community

With members from the local health team from the UPS, LLL/H staff, and staff of any NGOs working in that community, meetings are held with community members within selected communities within each health area. During this meeting, team members discuss the information in the Counselor's module on "Breastmilk is the Best Milk." The objective of the meeting is to have community leaders understand the importance of breastfeeding in the MOH's program of integrated maternal and child health. The benefits and function of the counselors are discussed with the community representatives and suggestions for women who could be trained as counselors are obtained.

Selection of Counselors

LLL/H staff then meet with the proposed counselors and explain the profile of the counselors and activities in which they will be involved. They talk to each prospective counselor and decide which ones in fact meet the profile. For example, in one community, proposed counselors had not breastfed their infants. They were thus not considered to be qualified for the position.

Mapping of the Community and Community Diagnosis

Once counselors have been trained, their first responsibility is to make a map of the community surrounding their homes. The supervisor helps the counselor to obtain a map, if one exists, from officials from the UPS, *patronato*, local government, etc. If there is not one available, the supervisor helps the counselor to make a diagram that illustrates the households within the community. This *croquis* includes 45 households that the counselor will be responsible for. The next step in the intervention process at the community level begins with the counselors learning about the situation of the communities in each UPS where they will work. To do this, they collect information through a household survey within their area which gathers information on:

1. The number of pregnant women;
2. For pregnant women, date of last menstrual period;
3. Use of prenatal care;
4. The number of infants less than age six months;
5. For infants, feeding practices;
6. Vaccination coverage; and,
7. Infant morbidity.

This information is used for planning and evaluation of activities carried out by counselors. The community diagnosis is conducted twice a year to update the list of families containing pregnant or breastfeeding mothers and to assess any changes in the population size or composition. Appendix 7 gives the form used in the community diagnosis.



Distribution and Coverage of Counselors

Each counselor is responsible for about ten pregnant women and women with children under six months of age within her community. This number was selected because interviews with previous counselors illustrated that they were able to work with this number in one year. To determine the number of households that each counselor is responsible for, several calculations were made based on the following assumptions:

- ▶ On average, each household in Honduras has five family members;
- ▶ Children under age one year represent 3% of the total population;
- ▶ Infants under six months represent 1.5% of the total population; and,
- ▶ Pregnant women represent 3% of the total population.

Thus in a population of 100 inhabitants living in twenty households, there will be three pregnant women and one to two infants. For 200 inhabitants (40 households), there would be twice that number (six pregnant women and two to four infants under ten mothers each year). An estimate of 45 households was considered necessary to have each counselor responsible for ten mothers: six pregnant women and three or four infants under age six months.

In addition to these ten "primary target women," another twelve mothers of children from the ages of seven to 24 months are considered to be within the counselor's "secondary targets."

Determination of Numbers of Counselors Needed per Health Area

First the number of UPS in each area and the population of each UPS are determined. Since the goal of the program is to select 60% of the UPS, the decision is made by the Health Area staff in conjunction with the health teams from the UPS on which UPS will be selected. This decision is in part based on the willingness of these teams to work on the program and supervise the counselors.

Once the UPSs have been selected, the number of areas of geographic influence (AGI) in each UPS are determined along with their population sizes. Most of the UPS have maps of their AGIs and know the population size because they have conducted CEFASAs previously. The UPS use this information in planning other health activities, such as vaccinations. The health teams then select 60% of the AGIs in their UPS in which to start the activities. Based on the number of families within each AGI, the number of counselors needed are estimated and recruited for training.

Table 12 illustrates how the calculations are made to determine the number of counselors needed, using the UPS of San Antonio as an example. There are sixteen UPS in Area 1 and one of the selected UPSs was San Antonio-Chamelecon. There are a total of sixteen AGIs in San Antonio and nine were selected to be included. The number of counselors needed were then calculated using the population size for each AGI, the estimate of five members per family and the ratio of one counselor for 45 families.



Table 12. Example of How the Numbers of Counselors to Be Trained per UPS Are Determined			
Region 3, Area 2, UPS=San Antonio-Chamelecon Name of AGI	Estimated population	No. of households (Population/five people per family)	No. of counselors needed (No. of households/45)
1) Los Laureles	537	107	12
2) Eben Ezer	2277	455	10
3) 10 de Sept.	1217	243	5
4) Panting	1075	215	5
5) Providencia	1665	333	7
6) San Antonio	3465	693	15
7) Suyapa	5048	1010	22
8) 15 de Sept.	1731	346	8
9) 14 de Julio	500	100	3
Total (9 out of 15 AGIs)	17,515	3503	87

Promotion Activities

The activities of the counselors are closely linked with the MOH's program on integrated child care, with an emphasis on breastfeeding. The components of this integrated approach on which counselors are trained are:

- 1) Review of the child's health card;
- 2) Monitoring of growth and development of children;
- 3) Appropriate child feeding;
- 4) ARI and diarrhea and the relationship with breastfeeding;
- 5) Prenatal care;
- 6) Maternity care;
- 7) Self-care; and,
- 8) Referrals to MOH programs.

Counselors work in these areas by running support groups, providing individual one-on-one counseling, and holding popular education sessions. Counselors have a manual that contains instructions and messages that help them transmit the needed information.

Support Groups

Counselors are responsible for organizing mothers' support groups within their communities to facilitate the interchange of experiences between mothers and to provide information about child health and the MOH programs with an emphasis on breastfeeding. Using the information obtained through the community diagnosis, counselors invite pregnant women and breastfeeding mothers with children under age two (with an emphasis on those under six months), and others in the community to attend a meeting. Support groups function with a minimum of three and a maximum of fifteen mothers. Meetings generally take between 45 minutes to one hour.



The technique used to run a group meeting consists of:

- 1) Putting chairs into a circle;
- 2) Asking general questions to facilitate group discussions;
- 3) Developing a theme using participative means that attendees can reflect on and discuss;
- 4) Discussing mothers' responsibilities, experiences, and activities;
- 5) Keeping the group open so that it can receive new members; and,
- 6) Having the counselor facilitate the discussion.

One-to-One Counseling

Counseling is provided through home visits to mothers who have concerns or problems. The technique used provides information and alternatives that the mothers can use, but does not try to tell mothers what they should do. The types of concerns that are frequently raised by mothers that are addressed in the one-to-one counseling include: 1) pregnancy; 2) breastfeeding when working; 3) illness among breastfeeding mothers; 4) sore nipples; 5) inverted nipples; 6) mastitis or breast abscesses; 7) insufficient milk and children's crying; 8) sucking problems; 9) introduction of feeding; 10) sick children; and, 11) low weight children.

Popular Educational Sessions

Counselors are also responsible for running education sessions for various types of community members. These meetings can be held at schools, churches, health facilities, etc. Counselors give lectures (*charlas*) on one of the twelve themes they learned in their training course or other themes that they have learned about in their monthly follow-up training meetings.

Activities to Date

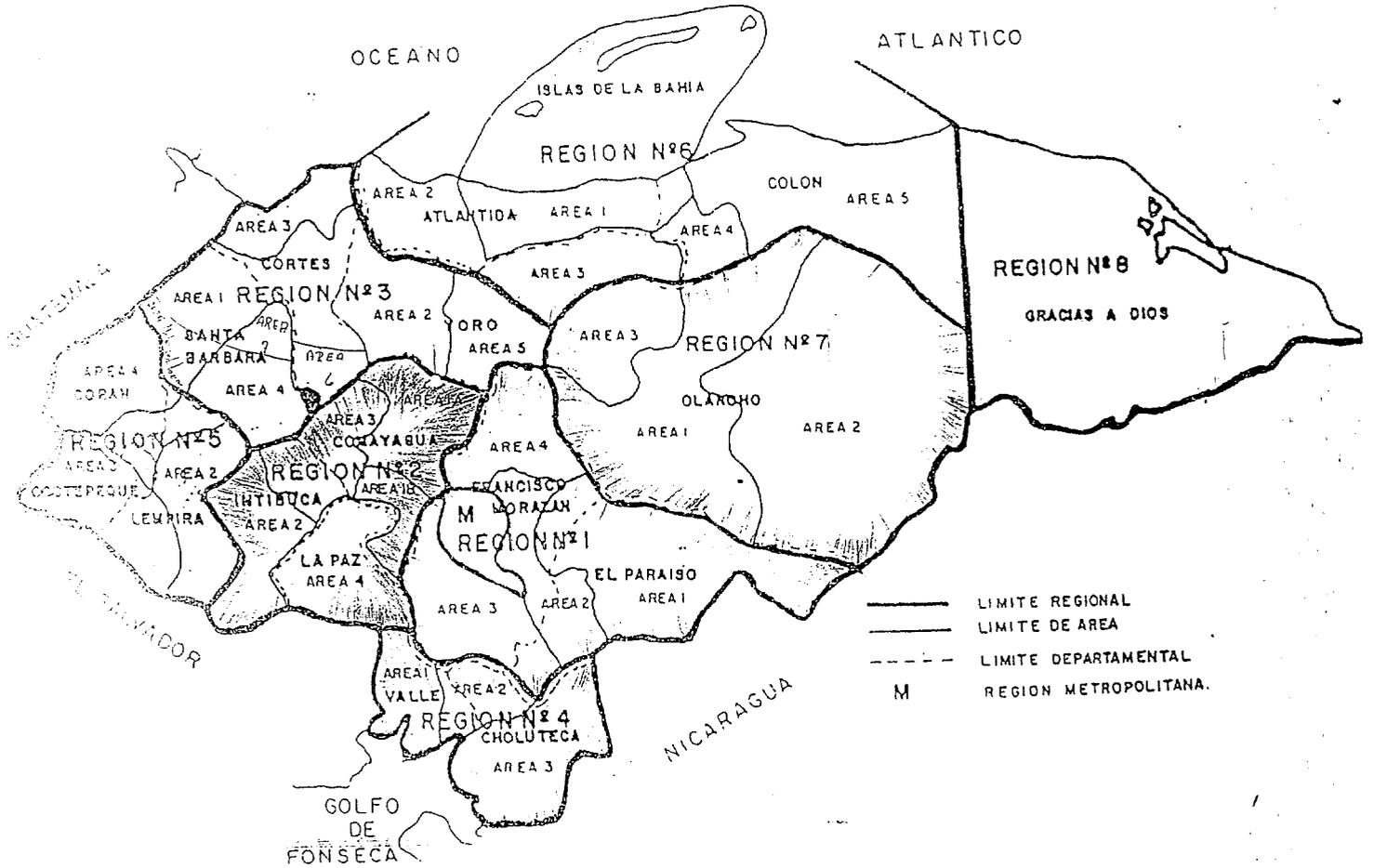
From March 1993 when the first trainings of counselors began in Region 3 through December 1995, 235 counselors were trained, 81 support groups established, and nearly 8,000 one-to-one counseling sessions held. In the Metropolitan region, 385 counselors had been trained, 160 support groups were established, and 6,020 counseling sessions held. No additional training took place in these two regions in 1996, since the focus of new training was in El Progreso. Figure 5 shows the health regions in Region 3. Table 9 gives the number of counselors trained since the inception of the program.

Of particular concern is whether sufficient counselors will be trained in El Progreso where the follow-up evaluation will be conducted. To assess the progress in relation to this area, the following calculations have been made. The total population of El Progreso is estimated at 237,000 living in nineteen UPS. The project will work in eleven of those UPS, with a total estimated population 209,000, since the city of El Progreso (with a population of 101,790) is included. Within these eleven UPS, 60% of the AGIs will be chosen, covering an estimated population of 61,074 in the city of El Progreso and 64,101 for the other ten UPS (a total of 125,175 people), if the population is equally distributed throughout the AGIs. Based on that population size, the estimated number of families is 25,080 and the estimated number of counselors needed would thus be 557.

To date (in six months), 134 counselors have been trained in six UPS, and none in the city of El Progreso. There have been only four trainers/supervisors from LLL/H available to work with local health center staff on training and supervising counselors due to limited funding. Thus during this six month period, on average each trainer was able to train 34 counselors. To finish training and implement activities by the end of the year to meet established goals, another 423 counselors will need to be trained. This would mean recruiting and training at least another eight trainers/supervisors (423 counselors / 34 trainees = twelve counselors needed in total for the next six months). Because it is more difficult to organize communities in urban areas and El Progreso has not yet been covered it appears that it may not be feasible to meet the goals until 1997. Thus the final evaluation may need to be delayed until 1998.



Figure 5. Map of Region 3 Showing the Health Areas





CHAPTER 6. SUPERVISION OF COUNSELORS

Supervisors' Role

The role of supervision is to provide systematic education, motivation, assistance, and support to the counselors. Part of this supervision is conducted at the UPS during the monthly meetings with the counselors but most is provided within the community. The activities to be supervised at the community level are:

- ▶ Community assessment;
- ▶ Coordination with the MOH;
- ▶ Community mobilization and recruitment of counselors;
- ▶ Training;
- ▶ Mapping and identifying the target group(s) at community level;
- ▶ Community-level direct supervision;
- ▶ In-service training; and,
- ▶ Monitoring.

Community Mentors

Because of problems with lack of sufficient staffing and transportation, it is often difficult for UPS or LLL/H staff to visit communities frequently enough to provide the support needed for the counselors. To find a cost-effective way to enhance supervision of counselors, this program decided to use a system of community mentors.

A community mentor is a counselor who has worked for at least six months and has received special training to help her support less experienced counselors within her area. Table 13 gives the characteristics of mentors.

Table 13. Characteristics of a Mentor	
A counselor who:	
▶	has at least six months total experience;
▶	has been active for at least the last six months;
▶	can read and write;
▶	has run a support group;
▶	has time available;
▶	maintains good relationships with other counselors, UPS staff, and the rest of the community; and,
▶	resides permanently in the community.

The mentor's role is to:

- 1) Help new counselors and others who request help to run support groups;
- 2) Hold individual and group mentoring sessions with counselors;
- 3) Compile individual reports and summarize the results on the activities of the counselors;
- 4) Write reports on the activities; and,
- 5) Monitor how counsleors are conducting local surveys and summarize the results.

The additional training for a mentor includes a 40-hour training course, including sixteen hours of theory and 24 hours of practice. In the sixteen-hour course, mentors learn about their functions, how to use the supervisor's guide (Appendix 8), how to develop their plan for supervising the other counselors, how to fill in the community

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diagnosis form and the summary forms for summarizing the counselor's monthly activities, how to facilitate a monthly follow-up training meeting with the counselors, and how to coordinate with the UPS.

The guide contains a system of questions and observations that encourages immediate interaction between advisor and supervisor and allows for positive feedback. The instrument is to be used periodically on an individual basis (every three to four months). The visit helps to establish a relationship built on confidence between the counselor and the institution and, at the same time, validates and strengthens her work.

The practicum part of the training includes observation and subsequent discussion with the supervisor of her work with counselors during an individual visit and during a support group, and then at least two mentoring sessions in which the supervisor observes the mentor during supervisory activities. Mentors are then accredited during the regional meetings of counselors.

Objectives of Individual Supervision for the Breastfeeding Counselor

1. Strengthen the communication and links between counselors, health services, and LLL/H).
2. Provide follow-up and support to counseling activities that the breastfeeding counselor uses in her community.
3. Identify training, technical support, and logistical needs that the counselor requires to do her job more efficiently.

Supervisory Manual

A manual for use by the supervisors was developed as a part of this program to aid the supervision process, shown in Appendix 9. This manual was developed in conjunction with LLL/H staff and pre-tested in Honduras among MOH staff.

Activities to Date

This systematized supervisory system was developed in 1995, but has not yet been implemented because of funding limitations and the need to focus on training. Once more trainers/supervisors have been hired, this system can be put into place, working closely with the health center staff who will be working directly with the counselors and mentors, with technical assistance from LLL/H.



CHAPTER 7. MONITORING AND EVALUATION OF COUNSELORS ACTIVITIES

Monitoring System

The information system used by the MOH and LLL/H to monitor this program is collected and reviewed by community members, counselors, and staff of the UPS and LLL/H. Three types of indicators are collected and they relate specifically to the objectives stated in Chapter 3:

- 1) Impact: On exclusive breastfeeding rates at age six months;
On coverage (of the pregnant women and mothers of children under age six months);
- 2) Quality: Assessing the impact of counselors activities on changes in practices related to introduction of water and other milks, mothers sleeping with their infants, and referrals to the UPS for family planning, prenatal care maternity care, and integrated child care services (growth monitoring, vaccination, and treatment of sick children); and,
- 3) Process: Assessing the activities of the program, including selection training, and supervision of counselors and areas covered.

The process indicators are shown in Table 14 in relation to the goals.

This system has been set up so that within each UPS and AGI, the counselors and health center staff can evaluate their own activities. Because each counselor has baseline data that includes the infant's date of birth, date of interview during the community diagnosis, and feeding practices at that time, changes in practices can be noted within the community since additional data will be collected every six months. As in the example shown in Table 12 for the UPS of San Antonio-Chamelecon, with 87 counselors, in one year there should be about 870 infants. With this size population, changes in breastfeeding practices, if they exist, should be easy to observe. However it will be important to train the local staff how to analyze the data collected through the diagnosis so that they can assess the rates of exclusive breastfeeding in their own communities.

Evaluation

The MOH and LLL/H agreed that evaluating the effectiveness of this integrated effort was important. Thus prior to the implementation of the project in all areas, a baseline survey was conducted in El Progreso and Puerto Cortés in health areas 2 and 3 of Region 3. These sites were chosen because of their similarity in socio-demographic characteristics and their relatively limited exposure to breastfeeding promotion efforts. The baseline survey illustrated that breastfeeding practices were similar in both areas.

USAID supported the cost of the baseline survey through the Wellstart International's Expanded Promotion of Breastfeeding (EPB) program and will cover the costs of the follow-up survey to assess impacts through the MotherCare project. In order for the evaluation to be carried out as planned, activities in the experimental area need to be conducted between 1995 and 1997. However, the intervention will not be supported by USAID because El Progreso is located in Area 2, which is outside the Health Sector II area of coverage. Thus other support of the activities for Area 2 was obtained from the French Secretary of Planning.



Table 14. Process Indicators Used to Assess Program		
Indicator	Goal	Measurement
Percent of UPS within the Health Area with program	60%	$\frac{\text{Number of UPS in health area with counselor}}{\text{Total number of UPS in health area}} \times 100\%$
Percent of communities (areas of influence) within UPS with a trained counselor	60%	$\frac{\text{Number of areas of influence (neighborhoods, outreach clinics, etc.) with trained community workers}}{\text{Total number of areas of influence of health unit}} \times 100\%$
Percent of UPS that held a joint meeting of UPS staff, LLL/H, and the counselors		$\frac{\text{Number of UPS holding meeting}}{\text{Total number of UPS with program}} \times 100\%$
Percent of primary health care workers who have been trained (PHC personnel include doctors, nurses, vector control, promoters, extension workers, nursing auxiliaries, educators, laboratory technicians, pharmacy employees, etc.)		$\frac{\text{Number of PHC personnel trained}}{\text{Total number at PHC level by health unit}} \times 100\%$
Percent of counselors who were expected to be trained who were trained by UPS and by area		$\frac{\text{Number of counselors trained in area}}{\text{Number of counselors needed in area}} \times 100\%$
Percent of trained counselors who remain active (who hand in monthly reports)	70%	$\frac{\text{No. of community workers turning in reports during the month}}{\text{Total number of trained community workers}} \times 100\%$
Percent of counselors with a functioning support group	60%	$\frac{\text{Number of counselors with support groups meeting during the month}}{\text{Number of counselors}} \times 100\%$
Percent of expected number of counseling sessions conducted each month (% of coverage through person to person contacts)	20 per counselor per month	$\frac{\text{Goal of each AGI}}{\text{Total number of mothers identified in community lists by pregnancy or breastfeeding status}} \times 100\%$
Percent of referrals received from counselors		$\frac{\text{Number of referrals received in the health unit}}{\text{Number of referrals made by the community workers}} \times 100\%$



CHAPTER 8. CONCLUSION

Since 1989 when LLL/H first began working in low income areas to support breastfeeding in Honduras, many changes have taken place. This project is a culmination of a series of efforts to develop a systematic means of providing support to mothers in their communities. One of the first lessons learned in this process was the importance of ensuring that health workers from selected areas weretrained prior to starting community-based activities in those areas. If counselors gave information to mothers that was later refuted by the health workers, the credibility of the counselors was lost, and their impact minimal.

Another issue that became clear was that to have sufficient coverage of a program of community-based support, it was essential to work beyond the reach of an NGO assisting the health services. It was essential to have a completely integrated effort that had the health system fully involved in the development of the activities, with a clear view of it being a MOH high priority program.

Another concern to assure coverage was that rather than working on an *ad hoc* basis with their communities, there was a need to target women with infants less than six months of age and pregnant women. To locate these women, a system of mapping the community and interviewing women was designed. Counselors can now provide support within a defined population and thus coverage of the target population can be assessed. This helps to ensure that those women and children at highest risk are reached.

Lessons Learned

- 1) Training counselors at a community level in breastfeeding is an excellent way to extend breastfeeding promotion to improve exclusive breastfeeding rates, which must be addressed outside of hospitals. Volunteer counselors have been trained within a short time to provide support to mothers.
- 2) These counselors are now part of the health system and they help extend services to a community level. They are trained to refer infants to health services for vaccination, growth monitoring and integrated child care, and treatment of illnesses (especially for diarrhea and ARI). Because counselors knowing who is pregnant within their communities and referring pregnant women for pre-natal care, and postpartum women for family planning services to the health center, staff are better able to provide care when needed. By providing a formal referral system from the community to the health center, it helps mothers to have more confidence in the health system. Since the health center also has the lists of infants and pregnant women and the maps that counselors prepared, they are able to locate cases within the community and this increases their ability to work at a community level efficiently.
- 3) By focusing on breastfeeding, counselors are able to help mothers to improve the health of their infants through an intervention that the mothers themselves control. The impact on their self-confidence is substantial, and when counselors talk about breastfeeding, their enthusiasm is evident. By starting with this type of intervention, they develop relationships with the health center staff that are more equitable, since it is not a drug- or knowledge-based invention that only health workers have. Thus the counselors gain confidence in their ability to interact with health workers on other issues (such as with regard to referrals). This new type of relationship between health workers and counselors can lead to increased and earlier use of health services since the counselors feel more confident in requesting help from center staff for problems that they encounter.
- 4) The support group method provides a focus for organizing women around other issues of importance to them. It also gives women an opportunity to discuss issues that they may never have discussed with other women, providing a means to expand their understanding of their own and their neighbors' experiences.
- 5) The development of support by the MOH for this effort takes time. While LLL/H had been working with the MOH at the local community level with health center staff, at the hospital level with delivery staff, and at a regional and national level on policy reform, this project integrated these efforts. However because of the



different expectations faced by a government compared to an NGO, in terms of services, staffing, and funders, each effort can be faced with roadblocks that take time to resolve.

6) Honduras has provided in-service training on breastfeeding to health workers for years, beginning in the mid-1980s with PROALMA. Such training is expensive and has limited impact, as new health professionals come into the national health service. Pre-service curriculum revisions are essential to have long lasting changes. This project has shown that such revisions are possible, but that they take time and substantial effort to coordinate efforts between the MOH and the medical school professionals, which is still in process. The experience gained through this effort should be used to promote additional revisions in pre-service curricula in reproductive health and integrated child care. Health professionals are more open to new ideas on health practices earlier in their training but it is more difficult to revise practices once they have been the norm for practitioners.

7) The use of health center staff to supervise counselors has the benefit of keeping a focus on breastfeeding by these staff as well and institutionalizing the practices, since they meet with counselors monthly. Since LLL/H, along with the health center staff, provides ongoing supervision to the counselors, they provide a means of ongoing support and training in breastfeeding for the health center staff.

8) The MADLAC system also serves a similar purpose of keeping a focus on breastfeeding with health facilities if the data are reviewed and discussed with health facility staff.

9) Supervision is the last priority of many health programs although it needs to be one of the first. In order for this effort to be successful, a supervisory system that is clearly defined and feasible will need to be put into operation. However this system will need to be closely linked to the other responsibilities of health center staff and it will need to be supportive and non-disciplinary. Incentives that will help promote retention of volunteer workers will need to be considered in the development of this system. It will be equally important to consider incentives to help overburdened health center staff to feel benefits to themselves so that they will be able to provide the appropriate type of supportive supervision needed.



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Appendix 1. List of Wellstart Associates from Honduras

NAME	TITLE	INSTITUTION	COURSE DATES
Argentina de Chavez	Director	PROALMA	01/21/85 - 01/25/85
Benjamin Abdu Matute	Obstetrician/Gynecologist	Ministry of Health	12/03/86 - 12/13/86
Feiberta V. Benitez de Velasquez	Lactation Program Supervisor	PROALMA	12/03/86 - 12/13/86
Reina Regina Cortez	Associate Director	PROALMA	12/03/86 - 12/13/86
Kelin Maria Gonzalez de Jiron	Lactation Counselor	PROALMA	12/03/86 - 12/13/86
Parcia E. Meza de Velasquez	Lactation Counselor	PROALMA	12/03/86 - 12/13/86
Mirna Lili Ruiz de Gomez	Lactation Program Coordinator	PROALMA	12/03/86 - 12/13/86
Berta Marina Salmeron de Davila	Lactation Program Coordinator	Social Security Institute	12/03/86 - 12/13/86
Regina M. Sierra de Figueroa	Lactation Program Coordinator	PROALMA	12/03/86 - 12/13/86
Maria Tomasa Cardenas de Ramos	Maternal and Child Health Technician	Ministry of Health	01/28/87 - 02/07/87
Olga Leticia Castillo	Maternal and Child Health Technician	Ministry of Health	01/28/87 - 02/07/87
Melbi Castro Soto de Zuniga	Nursing Supervisor	Ministry of Health	01/28/87 - 02/07/87
Maria del Carmen Miranda Quesada	Population Advisor	USAID	01/28/87 - 02/07/87
Regina Duron de Amaya	Asst. Chief, Div. Maternal & Child Health	Ministry of Health	01/28/87 - 02/07/87
Maria O. Fernandez Sevilla de Martinez	Nursing Supervisor	Ministry of Health	01/28/87 - 02/07/87
Aida Concepción Figueroa Ayala	Maternal and Child Health Technician	Ministry of Health	01/28/87 - 02/07/87
Digna Emerita Guerrero de Reyes	Maternal and Child Health Technician	Ministry of Health	01/28/87 - 02/07/87
Jose Cipriano Ochoa Vasquez	Chief, Div. Maternal and Child Health	Ministry of Health	01/28/87 - 02/07/87
Olga Marina Portillo	Nurse	Ministry of Health	01/28/87 - 02/07/87
Bessy A. Rapalo Galeano de Cruz	Maternal and Child Health Technician	Ministry of Health	01/28/87 - 02/07/87
Concepción Sandoval de Caceres	Maternal and Child Health Technician	Ministry of Health	01/28/87 - 02/07/87
Juana Carolina Buchanan Stanley	Professor	Universidad Nacional Autónoma de Hond.	05/18/92 - 06/12/92
Dolores Ferman de Barahona	Nursing Faculty	Centro Adiestramiento Recursos Humanos	05/18/92 - 06/12/92
Arturo Bendana Pinel	Director	Hospital Escuela	05/18/92 - 06/12/92
Elliethe Giron Gonzalez	Chief of Postpartum Ward	Hospital Escuela	05/18/92 - 06/12/92



Appendix 2. MADLAC Questionnaire

PROYECTO MADLAC
 MONITOREO DE SALUD PUBLICA/INSTITUTO HONDUREÑO DE SEGURIDAD
 SOCIAL
 REPUBLICA DE HONDURAS

ENTREVISTA A LA MADRE EN EL ALTA DEL HOSPITAL

DESPUES DE SALUDAR A LA MADRE PREGUNTELE SI LE PUEDE HACER UNA ENTREVISTA QUE DURA UN MAXIMO DE 5 MINUTOS

- M1. Número de encuesta () () ()
- M2.a. Fecha ___ / ___ / ___ M2.b. Día de la semana _____ ()
- M3. Hospital
- M3.a Nombre _____ () () ()
- M3.b Tipo: MSP () IHSS ()
- M4. Nombre encuestadora _____ () ()
- M5. Número expediente () () () () () () () () ()
- M6. Hora de la Entrevista () () : () () (usar sistema de 24 h)
- M7. Cómo se llama usted? _____
- M8. Cuántos años tiene? () ()
- M9. Dónde vive Ud? _____ urbana () rural ()
- M10. Su bebé es varón () o niña ()?
- M11. A qué hora nació el bebé () () : () () (sistema de 24 h)
no sabe () no contesta ()
- M12. El parto fue vaginal () o por cesárea ()?
- M13. Su bebe nació prematuro () o a tiempo ()?
- M14. Le piensa dar pecho a su bebé? Si () No ()

- M15. Cuánto tiempo le piensa dar puro pecho (es decir sin agua, tés, ni jugos) a su bebé? () () días () () semanas () () meses
- M16. Cuándo piensa despechar a su bebé? () () meses.
- M17. Le va a dar chupon a su bebe? Si () No ()
- M18. Puso (o le pusieron) a su bebé a mamar en el cuarto donde nació?
Si () No () No sabe () No contesta ()
- M19. Alguien en este hospital le ha ayudado a colocar a su bebé para dar de mamar?
Si () No () No sabe () No contesta ()
- M20. Cuánto tiempo despues del nacimiento dio el pecho por primera vez?
<1h (), 1-2h (), 2-4 (). >4h ()

(Las preguntas M20 a M24 se refieren a lo sucedido en el hospital a partir del nacimiento)

- M21. Alguien en este hospital le ha enseñado como ordeñarse?
Si () No () No sabe () No contesta ()
- M22. Desde que nació su bebé, alguien en este hospital le ha hablado sobre la lactancia materna?
Si () No () No sabe () No contesta ()
- M23. Alguien en este hospital le ha dicho por lo menos cuantos pañales debe mojar su bebé al día?
(Si si) Cuántos le dijeron? _____ () ()
No () No sabe () No contesta ()
- M24. Le dijeron en este hospital cuál es la mejor manera de aumentar su producción de leche? (Si si) Qué le dijeron?: _____
Correcto () Incorrecto/otro () (La respuesta sé considera correcta únicamente si la madre reporta aumentar su frecuencia de amamantamiento)
No () No sabe () No contesta ()
- M25. Después de que nació su bebé, alguien le dijo en el hospital:Cuál es la edad para comenzar a dar aguas o tés a su bebé?
Si () No () No sabe () No contesta ()
- M26. En el hospital le han dicho donde acudir después de salir del hospital si está teniendo problemas para dar el pecho?
Si () No () No sabe () No contesta ()



**Appendix 3. Perinatal Card
Honduras**

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Appendix 4. Health Professionals Training Curriculum

MEXICO: BREASTFEEDING: A TRAINING CURRICULUM FOR HEALTH PROFESSIONALS

- Module 1 Breastfeeding Situation
 - 1. Decline of breastfeeding: an international problem
 - 2. Ways to promote, protect, and support breastfeeding
 - 3. Epidemiology, 4. Advantages of breastfeeding
- Module 2 Foundation of Breastfeeding
 - 5. Anatomy and physiology of the mother
 - 6. Sucking mechanisms
 - 7. Composition of human breastmilk, 8. Immunology
- Module 3 Successful Breastfeeding
 - 9. Prenatal care
 - 10. Care during delivery and the immediate postpartum period
 - 11. Postpartum care
- Module 4 Care of the Lactating Mother
 - 12. Maternal nutrition during lactation
 - 13. Problems of the mother that affect successful breastfeeding
 - 14. Breastfeeding and medications
 - 15. Breastfeeding and fertility
 - 16. Working mothers and breastfeeding
 - 17. Manual extraction, storage, preservation, and feeding of breastmilk
 - 18. Relactation
- Module 5 Care of the Nursing Child
 - 19. Infant nutrition and complementary feeding
 - 20. Growth monitoring of the newborn and nursing child
 - 21. Sucking problems and refusal to breastfeed
 - 22. Feeding the newborn in special situations
 - 23. Infections in the child and breastfeeding
 - 24. Jaundice and breastfeeding
- Module 6 Support for Breastfeeding
 - 25. Listening and learning from other mothers
 - 26. Group support for mothers
 - 27. Acceptance and support; obtaining the mother's confidence
 - 28. Observation of feeding at the mother's breast
 - 29. Psychological aspects in feeding at the mother's breast



Appendix 5. Health Professionals Training Curriculum (Honduras)

**A TRAINING CURRICULUM FOR HEALTH PROFESSIONALS
HONDURAS, 1995**

- MODULE 1: Epidemiological Aspects of Breastfeeding
- MODULE 2: Support Groups
- MODULE 3: Anatomy of the Breast and the Physiology of Breastfeeding
- MODULE 4: The Composition of Breastmilk
- MODULE 5: Preparing for Breastfeeding: Pregnancy
- MODULE 6: Management of Breastfeeding after Vaginal and Cesarean Delivery and during the Puerperium

- MODULE 7: Managing Breastfeeding in Special Circumstances of the Mother
- MODULE 8: Medications during Pregnancy and Lactation
- MODULE 9: Breastfeeding and Fertility
- MODULE 10: Working and Breastfeeding
- MODULE 11: Maternal Nutrition during Pregnancy and Lactation
- MODULE 12: Feeding of the Infant
- MODULE 13: Integrated Child Health Care
- MODULE 14: Managing Breastfeeding in Special Circumstances of the Infant
- MODULE 15: Jaundice and Breastfeeding
- MODULE 16: Relactation and Induced Lactation
- MODULE 17: The Advantages of Breastfeeding



Appendix 6. Counselor's Training Curriculum

COMMUNITY-BASED BREASTFEEDING SUPPORT: A TRAINING CURRICULUM

MODULE	TITLE OF MODULE	ESTIMATED TRAINING TIME HOURS
	Welcome and Introduction	1:00
1	Organizing support groups for breastfeeding women	3:00
2	Breastmilk is the best milk	1:30
3	Components of breastmilk and protective factors	2:30
4	How milk is produced	1:00
5	Counseling the mother	3:00
6	Women's health	1:30
7	Spacing pregnancies while breastfeeding	2:30
8	Breastfeeding techniques	2:30
9	Raising healthy, well-nourished babies	3:00
10	Special situations and difficulties of the mother and child	4:00
11	Beliefs and doubts affecting breastfeeding	3:00
12	Assessing your community	3:00
	Graduation	



Appendix 7. Community Diagnosis Form
ENCUESTA DEL DIAGNOSTICO COMUNITARIO
MINISTERIO DE SALUD PUBLICA, I.H.S.S./LLL/H

INICIE LA ENTREVISTA SALUDANDO A LA FAMILIA
EXPLIQUELE QUE EL PROPOSITO DE LA ENCUESTA ES TENER INFORMACION SOBRE LA SALUD
DE LA MADRE Y EL NIÑO Y LA EMBARAZADA.

DIGALE QUE LA INFORMACION NOS PERMITIRA TRABAJAR MAS COORDINADAMENTE CON EL
CENTRO DE SALUD Y EL SEGURO SOCIAL.

ESTA ENCUESTA DEBERA HACERSE A CADA EMBARAZADA O MADRE CON NIÑO MENOR DE SEIS
(6) MESES.

INSTRUCTIVO PARA EL LLENADO DEL FORMATO DEL DIAGNOSTICO COMUNITARIO

Quisiera hacerle unas preguntas sobre usted o su bebé menor de seis meses.

1. ¿Cuál es su nombre completo?
2. Escriba la fecha en que está haciendo la entrevista.
3. ¿Qué edad tiene usted?
4. ¿Trabaja usted fuera de su casa?
5. ¿Está usted embarazada actualmente?
Si contesta NO, pase a la pregunta #9.
Si contesta SI, continúe con la pregunta #6.
6. ¿Cuándo fue la última vez que le vino la regla?
7. ¿En que fecha espera que nazca su niño-niña?
8. ¿Ha ido a control de embarazo? ¿Quién la atendió?
9. ¿Qué edad tiene su niño-niña actualmente?
Si no tiene niño-niña de 6 meses, dé las gracias y finalice la entrevista.
Si tiene niño-niña menor de seis meses, continúe con la pregunta 10.
10. ¿Fue a una consulta para usted, después del parto? ¿Quién la atendió?
11. ¿Actualmente está usted planificando?
Si contesta SI, pregunte. ¿ Con que método? Escriba el método.
12. ¿Ha recibido información sobre lactancia materna? ¿Quién le dió esa información?
13. ¿Después del parto, le han dado a usted a beber o tomar una perlitita de vitamina A?
14. ¿Ha recibido información sobre planificación familiar? ¿Quién le dió esa información?

TERMINA LA ENTREVISTA PARA LA EMBARAZADA.

SI LA MADRE TIENE UN NIÑO O NIÑA MENOR DE SEIS MESES, CONTINUE CON LA ENTREVISTA.

15. ¿En que fecha nació su niño-niña?
16. ¿Qué edad tiene su niño o niña actualmente?
17. ¿Qué le nació? ¿ Niño-Niña?
18. Ayer, incluyendo el día y la noche le ha dado:
Agua
Otras leches (leche de lata, vaca, de bolsa, de cabra).
Otros líquidos (refrescos naturales o de botella, café, té).
Atole-Purés
Fruta
Verduras
Arroz
Frijol
Otro alimento sólido (carnes, espaguetes).
Pecho
19. Desde que nació su niña-niño. ¿ Lo ha llevado a vacunar?



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- Pida a la madre que le muestre la tarjeta de vacunación del niño-niña.
20. ¿Con quién duerme su bebé durante la noche?
Si la madre dice que duerme con ella, pregunte. ¿ En la misma cama?. Si contesta SI, significa que es alojamiento conjunto.
21. Si la madre dice que ya introdujo otros alimentos, preguntele?
¿Porqué ? Leche rala, trabajo, enfermedad de la madre, enfermedad del niño o niña, dolor de pezones, fracaso anterior, no planeó dar lactancia materna.
22. Desde que nació su niña-niño. ¿ Lo ha llevado al centro de salud?
23. Para finalizar. ¿ Me podría dar la dirección de su casa?
Al finalizar la entrevista, dele las gracias a la persona entrevistada por el tiempo e información brindada.
Dígale a la madre o embarazada que usted como consejera la va a estar visitando periódicamente para apoyarla y brindarle información sobre el amamantamiento de su bebé.
Dele la dirección de su casa como consejera y póngase a las órdenes de la madre.



This is the English version of questions that are asked, with additional detail given that is included when counselors are trained. The Spanish version is much shorter because of the training and decision by the counselors that they did not need such an extensive questionnaire.

**MINISTRY OF PUBLIC HEALTH
LIGA DE LA LACTANCIA MATERNA DE HONDURAS
COMMUNITY DIAGNOSTIC SURVEY**

I. GENERAL INFORMATION: This part should be completed by you before beginning.

Community: _____

Health Center: _____

Municipality: _____ Date: _____ Counselor/Promoter Name: _____

(FOR COUNSELOR ONLY) REMEMBER:

- 1) Initiate the survey by greeting the family.
- 2) Explain to them that the information will allow us to work in a more coordinated fashion with the health and social security centers.
- 3) One survey should be conducted for each family. In a house where there are two families, two surveys should be done. All of the people who live in the house and are related to one another (father, mother, children, brothers, aunts and uncles, or in-laws) constitute a family.
- 4) when you ask the questions, remember that you should read them exactly as they are written.

II. FAMILY MAKE-UP

How many families live in this house? _____

(REMEMBER. YOU HAVE TO CONDUCT A SEPARATE SURVEY FOR EACH FAMILY.)



I would like to ask you some questions about your family and the people who live with you.

Could you give me the name and age of all of the people in your family who live in this house, including the youngest children?		
NAME	AGE	SEX
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		
11.		
12.		
13.		

- How many women from 12 to 49 who live in this house work outside the home?
- Has someone spoken previously to you or your family about breastfeeding?
YES _____ NO _____
- If the previous answer is yes, ask who?
- Has someone spoken previously to you or your family about family planning Yes _____ No _____
- If the answer is yes, ask who?
- Is any family member of this household pregnant? IF YES, WRITE THE NAME.

THE FOLLOWING TWO QUESTIONS SHOULD BE ASKED ONLY IF THERE ARE PREGNANT WOMEN IN THE HOUSE AT THIS TIME.

- Did you receive any prenatal care? YES _____ NO _____
- Where is you go to obtain prenatal care? _____
- How many mothers from your family in this house are breastfeeding their children? _____
- Now tell me the name of the mothers who have children under six months of age.

(FOR COUNSELOR ONLY) THE QUESTIONS ON THE FOLLOWING PAGES SHOULD BE ASKED ONLY IF THE MOTHERS HAVE CHILDREN UNDER SIX MONTHS OF AGE.



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IF THERE IS MORE THAN ONE MOTHER WITH CHILDREN UNDER SIX MONTHS OF AGE IN THE HOUSE, PLEASE ASK EACH MOTHER THE QUESTIONS ON THE FOLLOWING TWO PAGES SEPARATELY.

11. Ask each mother with a child under six months of age the following questions: (IN THE CASE OF TWINS, APPLY ONE SURVEY FOR EACH CHILD)

- a. Mother's name: _____
- b. Child's name: _____
- c. Child's age: _____

12. How old was the child when you began to give him:

Water _____

Other milks _____



13. With whom does your baby sleep during the night?

(DO NOT READ THE ANSWERS. IF THE MOTHER SAYS THAT HE SLEEPS WITH HER, ASK IF IN THE SAME BED.)

- a. Alone _____
- b. With mother _____
- c. with brothers _____
- d. with another person _____
- e. combination of the above _____

14.

Yesterday, including day and evening, did you feed your child?:		
	YES	NO
Other milk		
Water alone		
Water with sugar		
Tea		
Atol		
Coffee		
Soup		
Other liquids		
Fruit		
Tortilla/bread		
Rice/beans		
Vegetables		
Breastmilk		
Other meals		



15. If the mother says that she is not breastfeeding or already introduced other foods, ask why?

16. In the last two weeks the baby has had:

Diarrhea Yes ___ No ___

Cough or cold Yes ___ No ___

17. Since birth, have you brought him to be vaccinated?

(ASK THE MOTHER IF YOU CAN SEE THE CARD)

YES ___ NO ___

18. Since birth, have you brought the baby to the Health Center for a check-up?

YES ___ NO ___

19. Have you had a check-up since your 40 day post-partum check-up?

YES ___ NO ___

20. IF THE MOTHER SAYS YES, ask: who gave you the check-up before the 40 day check-up?

a. Midwife _____

b. Doctors _____

c. Nurse _____

21. After the birth, did they give you a red pill to swallow?

YES ___ NO ___



Appendix 8. Supervision Form COVERAGE

FOR EVERY 45 FAMILIES IT IS EXPECTED THAT THAT THERE WILL BE AT LEAST BETWEEN 6/7 PREGNANCIES, 4 CHILDREN UNDER 6 MONTHS
12 CHILDREN FROM 6 TO 24 MONTHS

REVIEW THE LIST WITH THE COUNSELOR AND MAKE CERTAIN THAT ALL THE BREASTFEEDING MOTHERS WITH CHILDREN YOUNGER THAN SIX MONTHS AND PREGNANT HAVE BEEN IDENTIFIED AND INCORPORATED INTO THE LIST.

OBSERVATIONS	RESULTS			
	1.	2.	3.	4.
<p>REVIEW LIST Verify that all of the pregnant women have answered "YES" in the pregnancy column. Make certain that birth dates for all of the children have been recorded. In the box labeled "Risk", verify that all are filled out with a "YES" when the mother is at risk or "NO" when the opposite is true. In the box labeled "children's age in months" verify:</p> <ul style="list-style-type: none"> - that the correct number of boxes has been completed to reflect accurately the child's age i.e. if a child was born on February 4 and the supervision is being carried out on May 13, the baby is three months and the boxes that should be completed are the first three (0, 1, 2 months). - In relation to the child's age, all boxes dealing with information about breastfeeding practices should contain a "YES" or "NO." Answers will depend on whether or not breastfeeding was initiated. In the previous example the first three boxes (0, 1, 2 months) should all be filled out. <p>Discuss with the counselor cases on the list that you consider to be problematic, risks, or bad breastfeeding practices and write your observations in the following spaces.</p>				

OBSERVATIONS FROM THE FIRST SUPERVISION: _____

OBSERVATIONS FROM THE SECOND SUPERVISION: _____

OBSERVATIONS FROM THE THIRD SUPERVISION: _____

OBSERVATIONS FROM THE FOURTH SUPERVISION: _____

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KNOWLEDGE

INSTRUCTIONS FOR THE SUPERVISOR:

- EXPLAIN TO THE COUNSELOR THAT YOU WANT TO SHARE WITH HER SOME BASIC CONCEPTS TO RESOLVE THE DAY TO DAY PROBLEMS WITH WHICH THE MOTHER PRESENTS US, AND THEREFORE YOU WILL ASK HER SOME QUESTIONS TO INITIATE THE DISCUSSION.
 - SIT IN FRONT OF THE COUNSELOR DEMONSTRATING BY YOUR ATTITUDE THAT YOU FEEL CONFIDENT ENOUGH TO INITIATE THE DIALOGUE.
 - FORMULATE THE QUESTIONS AND OBSERVE DISCRETELY IF THE ANSWER THAT THE COUNSELOR GIVES COINCIDES WITH THE DESCRIPTION IN THE FOLLOWING PARAGRAPH. IF THIS IS THE CASE, PLACE A "YES" IN THE CORRESPONDING COLUMN AND MAKE COMMENTS THAT RECOGNIZE HER KNOWLEDGE.
- ???-IF SHE DOES NOT ANSWER OR IF THE ANSWER IS INADEQUATE OR INCOMPLETE, PLACE A "NO" IN THE BOX. CAREFULLY DISCUSS THE CORRECT ANSWER WITH HER USING THE ANSWER LOCATED BESIDE THE INSTRUMENT.
- ** REMEMBER THAT THE ANSWERS SHOULD BE DISCUSSED AND NOT READ.**

QUESTION	RESPONSE	RESULT			
		1	2	3	4
<p>How does having children so close together affect the mother's health?</p> <p>How does it affect the child's health?</p>	<p>Increases the risk of a rupture or removal of the uterus. Increases the risk of bone weakness. Increases the risk of uterine and breast cancer.</p> <p>Breastfeeding can be interrupted abruptly and prematurely. The child resents that he is not receiving the attention he received earlier. Children are sick more frequently and development slows. The weaned child is more susceptible to malnutrition.</p>				
<p>In what special situations is the mother's health at risk if she is pregnant with respect to:</p> <ul style="list-style-type: none"> - Age - Number of children - Problems in other pregnancies - Time that should pass between each pregnancy - Illnesses 	<ul style="list-style-type: none"> - Becoming pregnant before 18 and after 25 years of age. - Closely-spaced pregnancies. - Previous abortions or cesareans. - When she has a baby who is less than one year old. - If she suffers from low blood sugar, high blood pressure, blood circulation, anemia, epilepsy. 				
<p>What information do you give to the mother in relation to monitoring the growth and development of the child?</p>	<p>Help the mother to interpret the growth curves and their importance, the vaccination status, the child's health, type and form of nutrition, and micronutrients (iron, vitamin A) are evaluated.</p>				
<p>What is exclusive breastfeeding? What are the benefits?</p>	<p>Give only the breast without water, tea, juices, or other foods. This allows the practice of breastfeeding to become well established, which increases milk production and diminishes the risk of infection or other illnesses. The baby experiences good growth and development, and the mother is protected from a new pregnancy.</p>				



QUESTION	RESPONSE	RESULT			
		1.	2.	3.	4.
<p>How does the child benefit from being put to his mother's breast immediately after he is born?</p> <p>How does the mother benefit?</p>	<p>He learns how to breastfeed without suction problems more quickly. He receives colostrum. He satisfies the need to suction, which is rather strong in the first half hour after birth.</p> <p>It helps the affectionate bond between mother and child to form earlier. It helps the mother to expel the placenta at the moment of birth. It diminishes the risk of hemorrhage following the birth. It helps the uterus to recover its normal size. The breasts do not become congested when milk flows. She will not develop a fever with the release of milk.</p> <p>REMEMBER TO EXPLAIN TO THE COUNSELOR THAT THE MOTHER SHOULD BE VISITED IN HER HOUSE DAILY DURING THE FIRST SEVEN DAYS SO THAT SHE CAN BE ADVISED ABOUT BREASTFEEDING, SINCE THIS HELPS THE MOTHER A GREAT DEAL TO EXCLUSIVELY BREASTFEED SUCCESSFULLY.</p>				
<p>Why does the baby have to grasp the breast and the majority of the aureola to breastfeed well?</p>	<p>Lactating glands are found beneath the aureola, which is where the milk is collected. For this reason the baby has to take the nipple into his mouth and part of the aureola to express the milk.</p>				
<p>What should be explained to the mother if she thinks that her milk is too thin?</p>	<p>First, you must ask the mother why she believes that.</p> <p>The milk changes during the feeding. At the beginning it is thin because it contains more water to quench the baby's thirst. After a while it becomes thicker because it contains other nutrients like vitamins, calcium, iron, phosphorus, and a little fat. At the end it is very thick because its content is almost entirely fat, which is what makes the baby gain more weight.</p> <p>Breastmilk contains special substances that make it more digestible than any other milk and, as a result, the baby can be breastfed more frequently.</p> <p>REMEMBER THAT IT IS IMPORTANT TO EXPLAIN TO THE MOTHER SIGNS OF GOOD CHILD GROWTH.</p> <ul style="list-style-type: none"> - AN INCREASE IN WEIGHT. - SEVEN OR EIGHT WET DIAPERS, INCLUDING DAY AND NIGHT. - AN ACTIVE CHILD. - THE CHILD SUCKS STRONGLY SWALLOWING SUCCESSIVELY. - THE CHILD'S SKIN IS SMOOTH AND GLOSSY. 				



QUESTION	RESPONSE	RESULT			
		1.	2.	3.	4.
What should be explained to a mother who thinks she does not have sufficient milk?	<p>First you should investigate why the mother says that.</p> <p>When the baby breastfeeds strongly and continuously the tongue and the mouth stimulate the nipple, and the nerves transmit an order to the brain stating that it wants milk, the brain orders the breast to make milk, forming a continuous circle of 'I want milk. Make milk.' As a result, the more the child breastfeeds, the more milk the mother produces.</p>				
What are the alternatives that can be suggested to a mother who works outside the home so that she continues breastfeeding when she returns to work?	<p>Fifteen days before returning to work you should begin to extract milk, practicing the technique from the extraction manual.</p> <p>Negotiate with your boss to combine part of the prenatal/postnatal time and vacation.</p> <p>Bring the baby to work with the help of a babysitter.</p> <p>Breastfeed more at night and extract your milk? during the day.</p> <p>If the distance from the house to work is minimal, then bring the baby to work to breastfeed during breastfeeding hours.</p> <p>If the economic situation allows, obtain a license until the baby is six months old.</p> <p>Negotiate an hour to breastfeed to facilitate feeding the child.</p> <p>REMEMBER THAT THE MOTHER AS WELL AS THE PERSON WHO IS GOING TO CARE FOR THE CHILD SHOULD BE TRAINED ADEQUATELY IN MILKING TECHNIQUES, HOW TO PRESERVE EXTRACTED MILK, AND HOW TO GIVE IT TO THE BABY.</p>				

OBSERVATIONS FROM THE FIRST SUPERVISION: _____

OBSERVATIONS FROM THE SECOND SUPERVISION: _____

OBSERVATIONS FROM THE THIRD SUPERVISION: _____

OBSERVATIONS FROM THE FOURTH SUPERVISION: _____



ONE-ON-ONE COUNSELING

INSTRUCTIONS FOR THE SUPERVISOR:

- SELECT ONE MOTHER FROM THE LIST OF PREGNANT WOMEN WHO ARE BREASTFEEDING CHILDREN UNDER SIX MONTHS OF AGE AND OFFER THE COUNSELOR THE OPPORTUNITY TO ACCOMPANY YOU TO HER HOUSE TO HELP YOU DURING THE COUNSELING SESSION.
- EXPLAIN TO THE COUNSELOR THAT AFTER ARRIVING AT THE MOTHER'S HOUSE SHE WILL CONDUCT A COUNSELING SESSION AND YOU WILL BE BESIDE HER TO HELP HER WHEN NECESSARY.
- DISCRETELY OBSERVE WHETHER OR NOT THE COUNSELOR FOLLOWS THE STEPS DESCRIBED BELOW TO ENSURE THAT THE COUNSELING SESSION IS SUCCESSFUL.
- YOU SHOULD INTERVENE EACH TIME YOU PUT A "NO" IN THE BOXES MAKING CERTAIN THAT NEITHER THE MOTHER NOR THE CHILD FEELS INADEQUATE AS A RESULT OF THE INTERVENTIONS.
- REMEMBER THAT YOUR INTERVENTIONS SHOULD BE DIRECTED TOWARD ENSURING THAT THE COUNSELING SESSION IS SUCCESSFUL AND, AT THE SAME TIME, THAT THE COUNSELOR IS TRAINED.
- ONCE YOU HAVE ENDED THE COUNSELING SESSION YOU SHOULD MEET WITH THE COUNSELOR TO REVIEW THE RESULTS OF THE COUNSELING, TO RECOMMEND WHAT SHE SHOULD DO IN THE FUTURE, AND TO OFFER HER WHATEVER SUPPORT MAY BE NECESSARY.

ELEMENTS TO OBSERVE DURING THE COUNSELING SESSION	OBSERVATIONS	RESULT			
		1.	2.	3.	4.
<p>1. ESTABLISH AN ATMOSPHERE OF CONFIDENCE.</p> <p>1.1 Was she interested in the general situation of the family?</p> <p>1.2 Did she call the mother and child by their names?</p> <p>1.3 Did she give the mother the opportunity to speak about her worries?</p> <p>1.4 Does she share and respect the mother's feelings?</p> <p>1.5 Did she ask open questions?</p>	<p>- Observe whether or not she greeted her. It is important to be interested in the family situation since that is the best form of initiating dialogue with the mother.</p> <p>- Addressing the mother and child by name is a sign of interest on the part of the counselor.</p> <p>- Observe whether or not the counselor asks why the mother is worried and if she asks the mother additional questions so that the mother will speak about the situation in greater detail.</p> <p>- Observe that the counselor DOES NOT CRITICIZE OR CHASTISE WHEN THE MOTHER DOES THINGS INCORRECTLY AND THAT SHE CONGRATULATES HER FOR WHAT SHE DOES CORRECTLY.</p> <p>- A question is open when it generates discussion about the situation. The mother's answers should not be YES, NO, or MAYBE. Make certain that the answer is not implicit in the question.</p>				



<p>2. OFFER INFORMATION AND NOT ADVICE.</p> <p>2.1 The form in which the information is offered.</p> <p>2.2 Does the information offered respond to the worries of the mother?</p>	<ul style="list-style-type: none"> - Observe whether or not she is not giving orders or saying to the mother "you should ..., you have to... or you never..." - If the information that the counselor offers responds to the worries and problems expressed by the mother. - If the information offered is sufficient. 				
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ELEMENTS TO OBSERVE DURING THE COUNSELING SESSION	OBSERVATIONS	RESULT			
		1.	2.	3.	4.
<p>3. SHARE EXPERIENCES AND DISCUSS THE ALTERNATIVES.</p> <p>3.1 Are all of the alternatives that address the mother's worries being discussed?</p> <p>3.2 Are the majority of the alternatives discussed proposed by the mother?</p> <p>3.3 Who is making the final decision about what the mother is going to do?</p>	<ul style="list-style-type: none"> - Observe whether or not, in relation to the mother's experience, all possible alternatives are being discussed to respond to her worries or problems. - A good counseling session should result in the majority of the alternatives being proposed by the mother as a product of the information received and discussed. - The mother should make the decision about what she can do based on the information that she is receiving. The decision should NEVER be made by the counselor. 				
<p>4. PROGRAMMING FOLLOW-UP</p> <p>4.1 Verify before saying goodbye that the counselor has programmed a follow-up visit and that the interval of time for the next visit is appropriate given the mother's situation.</p>	<p>-ALL OF THE COUNSELING SESSIONS SHOULD HAVE FOLLOW-UP AND IT SHOULD BE MADE CLEAR TO THE MOTHER THAT THE COUNSELOR IS AVAILABLE FOR ANY EVENTUALITY THAT ARISES BETWEEN THAT MOMENT AND THE DATE AGREED UPON FOR THE NEXT VISIT.</p>				

OBSERVATIONS FROM THE FIRST SUPERVISION: _____

OBSERVATIONS FROM THE SECOND SUPERVISION: _____

OBSERVATIONS FROM THE THIRD SUPERVISION: _____

OBSERVATIONS FROM THE FOURTH SUPERVISION: _____



SUPPORT GROUP

INSTRUCTIONS FOR THE SUPERVISOR:

- YOU SHOULD FORM PART OF GROUP E AND CONTINUE TO TAKE NOTES DISCRETELY.
- YOU SHOULD LEAVE FACILITATION TO THE COUNSELOR AND OBSERVE HER ROLE IN RELATION TO THE INSTRUMENT'S ORDER.
- FOR EACH NEGATIVE ANSWER (NO), THE SUPERVISOR WILL NEED TO INTERVENE BEING CAREFUL NOT TO ASSUME THE COUNSELOR'S ROLE OF FACILITATOR.
- AFTER THE MEETING, THE SUPERVISOR SHOULD REMAIN WITH THE COUNSELOR AND/OR CO-FACILITATOR TO DISCUSS THE RESULTS OF THE SUPERVISION AND TO OFFER THE SUPPORT NECESSARY TO CORRECT ANY ERRORS.

ELEMENTS TO OBSERVE DURING THE MEETING	OBSERVATIONS	RESULT			
		1.	2.	3.	4.
<p>1. LOCATION OF GROUP MEMBERS.</p> <p>1.1 Will group members be placed so that they are all looking at one another?</p> <p>1.2 Is the counselor included as a member of the group?</p>	<p>- To create a favorable atmosphere for group participation all of the members should be able to see one another. This allows for equality among the members and facilitates everyone's participation.</p> <p>- To exercise effectively her role as facilitator, the counselor should be just one more group member.</p>				
<p>2. GROUP FACILITATION</p> <p>EVALUATING THE ADVISOR:</p> <p>2.1 Does she welcome group members? Does she encourage introductions between regular participants and new group members?</p> <p>2.2 Remind the group of the agreements?</p> <p>2.3 Introduction of the theme lasts for at least three minutes. Is this introduction adequate?</p> <p>Does she use questions to generate discussions?</p> <p>2.5 Does the counselor allow group members to answer one another's questions?</p>	<p>- A cordial welcome and an introduction to the participants help to break the ice and improve relations among them.</p> <p>- Group agreements help the group to function with certainty and confidence and favor help counselor to facilitate.</p> <p>- A short, substantial summary of the selected theme for that day assures that there will be sufficient time during the meeting for the entire group to participate in relation to the theme and to present their particular concerns.</p> <p>- Remember that the questions that the counselor should ask should be open and motivating so that the participants can share their experiences (THE COUNSELOR SHOULD ALWAYS REMEMBER THAT HER MOST IMPORTANT ROLE IS TO FACILITATE DISCUSSION).</p> <p>-For the reasons stated in parentheses above, the counselor should derive questions from group members so that other participants can respond to them (ALTHOUGH SHE KNOWS THE ANSWER REMEMBER THAT THE BEST MEETING IS THAT IN WHICH THE COUNSELOR SPEAKS LESS AND OTHER MEMBERS PARTICIPATE MORE).</p>				



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ELEMENTS TO USE DURING THE MEETING	RESPONSE	RESULT			
		1.	2.	3.	4.
<p>2.6 The counselor has the floor only when necessary</p> <p>2.7 By supporting one another, participants help to address a mother's concerns.</p> <p>2.8 Was the next meeting planned with the group?</p> <p>2.9 Did the counselor say goodbye?</p>	<ul style="list-style-type: none"> - The counselor has the floor when there is confusion about a concept, when the conversation has been halted or digressed, when it is time to draw conclusions or resume discussion of the theme. - It is important for group members to have confidence in the group and to feel after participating in the group that their concerns and problems are resolved and that they too played a role in resolving the concerns and problems of the rest of the group. - Date and place of the next meeting are decided with group members, as well as the theme that will be addressed. - The counselor says goodbye to group members, expresses her gratitude for their attendance at the meeting, and provides an opportunity for group members to express their feelings. 				
<p>AT THE END OF THE MEETING DISCUSS THE FOLLOWING WITH THE COUNSELOR:</p> <p>3. GROUP SUSTAINABILITY</p> <p>3.1 During the past six months have they met at least once a month?</p>	<ul style="list-style-type: none"> - If the group got started less than 6 months ago, find out if it has met at least once a month since then. - If there has not been a meeting every month, find out why and discuss with the counselor ways to avoid not having meetings. 				
<p>4. GROUP ATTENDANCE</p> <p>4.1 The number of attendants is greater than three or less than fifteen?</p> <p>4.2 Are there pregnant women, mothers who are breastfeeding, and other participants?</p> <p>4.3 Are there new group members?</p> <p>4.4 Does the counselor complete the forms?</p>	<ul style="list-style-type: none"> - If it does not meet this condition, after finishing the meeting, discuss with the counselor the reason why the group should not be less than three or more than fifteen people. It is better to have one on one counseling if the group is less than three people. If the group is more than fifteen people, it is difficult to facilitate and provide everyone with the opportunity to participate. The best decision in this case is to divide people into two groups. - In support groups it is NECESSARY that pregnant women, mothers who are breastfeeding, and all community people participate who have a relationship with the mother and child to enrich the interchange of experiences and to promote broader optimal breastfeeding practices. - If the answer is "no" and the number of participants is less than fifteen, it is necessary to discuss with the counselor the need to invite other participants. She should discuss this later with group members. - It is important for the counselors to fill out the forms at the end of the meeting. 				



OBSERVATIONS FROM THE FIRST SUPERVISION: _____

OBSERVATIONS FROM THE SECOND SUPERVISION: _____

OBSERVATIONS FROM THE THIRD SUPERVISION: _____

OBSERVATIONS FROM THE FOURTH SUPERVISION: _____



Appendix 9. Guide for Trainers and Supervisors

**COMMUNITY-BASED BREASTFEEDING SUPPORT:
AN IMPLEMENTATION GUIDE FOR TRAINERS AND SUPERVISORS**

Chapter 1	Introduction
Chapter 2	Recruitment and Selection of Breastfeeding Counselors and Promoters
Chapter 3	Training Breastfeeding Counselors and Promoters
Chapter 4	Effective Communication
Chapter 5	Emotions, Pregnancy, and Mothering
Chapter 6	Individual Contacts
Chapter 7	Meeting with Mothers in Groups
Chapter 8	Community Education
Chapter 9	Follow-up and Supervision for Breastfeeding Counselors and Promoters



Appendix 10. Measurement of Indicators on Monthly Activities

Counselor's activity report and monthly work plan

INSTRUCTIONS

This instrument is for the community worker to use and to register the following activities:

- 1) The number of daily person to person counseling contacts by status: pregnant, mothers of babies under 6 months and others.
- 2) The agreed upon dates for support group meetings.
- 3) The number of pregnant women, mothers with babies under six months, and others attending the support group meeting.
- 4) Any additional activities programmed for the month (talk at a school, church, social club, etc.)
- 5) Any referrals made to health programs (PAI, GM, CDD, ARI, FP, etc.)
- 6) The kinds and numbers of breastfeeding problems encountered.
- 7) The numbers and kinds of educational sessions and the number of participants. .

HOW TO FILL IT OUT

Daily counseling contacts should be placed in the boxes for New and Follow-up. Only women being seen for the first time ever are new or women who were pregnant and are now mothers, on the first contact. Programmed activities are written with the name of the activity in the blank spaces that correspond to the date of the activity.

The supervisory personnel will collect these forms in the monthly meetings.

WELLSTART INTERNATIONAL

Wellstart International is a private, nonprofit organization dedicated to the promotion of healthy families through the global promotion of breastfeeding. With a tradition of building on existing resources, Wellstart works cooperatively with individuals, institutions, and governments to expand and support the expertise necessary for establishing and sustaining optimal infant feeding practices worldwide.

Wellstart has been involved in numerous global breastfeeding initiatives including the Innocenti Declaration, the World Summit for Children, and the Baby-Friendly Hospital Initiative. Programs are carried out both internationally and within the United States.

International Programs

Wellstart's *Lactation Management Education (LME) Program*, funded through USAID/Office of Nutrition, provides comprehensive education, with ongoing material and field support services, to multidisciplinary teams of leading health professionals. With Wellstart's assistance, an extensive network of Associates from more than 40 countries is in turn providing training and support within their own institutions and regions, as well as developing appropriate in-country model teaching, service, and resource centers.

Wellstart's *Expanded Promotion of Breastfeeding (EPB) Program*, funded through USAID/Office of Health, broadens the scope of global breastfeeding promotion by working to overcome barriers to breastfeeding at all levels (policy, institutional, community, and individual). Efforts include assistance with national assessments, policy development, social marketing including the development and testing of communication strategies and materials, and community outreach including primary care training and support group development. Additionally, program-supported research expands biomedical, social, and programmatic knowledge about breastfeeding.

National Programs

Nineteen multidisciplinary teams from across the U.S. have participated in Wellstart's lactation management education programs designed specifically for the needs of domestic participants. In collaboration with universities across the country, Wellstart has developed and field-tested a comprehensive guide for the integration of lactation management education into schools of medicine, nursing and nutrition. With funding through the MCH Bureau of the U.S. Department of Health and Human Services, the NIH, and other agencies, Wellstart also provides workshops, conferences and consultation on programmatic, policy and clinical issues for health care professionals from a variety of settings, e.g. Public Health, WIC, Native American. At the San Diego facility, activities also include clinical and educational services for local families.

Wellstart International is a designated World Health Organization Collaborating Center on Breastfeeding Promotion and Protection, with Particular Emphasis on Lactation Management Education.

For information on corporate matters, the LME or National Programs, contact:

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