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# HIV and INFANT FEEDING COUNSELLING

## From Research to Practice

**WHO, Geneva, 15-16 November 2004**

**Meeting Report**

CHILD AND ADOLESCENT HEALTH AND DEVELOPMENT

CAH

**Department of Child and Adolescent Health and Development**

**WORLD HEALTH ORGANIZATION**

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# 1 Executive Summary

Given the complexities involved in providing infant feeding counselling to HIV-positive women, WHO has supported research on counselling practices, and WHO and partners have developed tools to improve the effectiveness of infant feeding counselling, including tools for training counsellors. In order to increase access to adequate support for infant feeding, health care providers should have the competencies necessary to provide it. For this reason, WHO is currently developing a course (*Integrated Infant Feeding Counselling: A training course*) on breastfeeding counselling, HIV and infant feeding counselling and complementary feeding counselling, with a five-day duration.

WHO convened an informal meeting in Geneva on 15 and 16 November 2004 to share the latest findings from research related to HIV and infant feeding counselling and from implementation experience, and to discuss the implications for the integrated infant feeding counselling course. The expected output was a set of specific recommendations for the content and methods of the HIV and infant feeding component of the course.

The purpose of this report is to share and provide a brief explanation of the recommendations formulated during the informal meeting "HIV and Infant Feeding Counselling: From Research to Practice".

Experience in research settings suggests that adequate training of health workers and lay counsellors in infant feeding counselling skills, followed by monitoring and supervision, leads to effective support to mothers in areas of high HIV prevalence. Such efforts have resulted in reduced mixed feeding and increased exclusive breastfeeding.

The group discussed the implications of the above findings for ongoing and future efforts to increase the effectiveness of infant feeding counselling. Discussions focused on training tools and processes, health systems constraints and family and community practices.

An important challenge related to programming support for infant and young child feeding is the urgency to address the needs of all mothers (HIV-negative, HIV-positive, and those of unknown status) in order to be more effective. Different levels of health workers need different competencies (for clinical management, training, supervision, and programme management) at different contact points.

The group recognized the need to mobilize resources and secure political commitment for skills building on infant feeding. Given the many different training courses available or soon to be available, there is also a need to ensure a common understanding about the objectives of each course, the competencies addressed and the target audience.

Finally, the group agreed that the *Integrated Infant Feeding Counselling: A training course* is needed for various cadres of health workers and provided specific recommendations for improving the content and methods of the draft course materials.

# 2 Introduction

According to current UN recommendations, infants should be exclusively breastfed for the first six months of life. Thereafter, infants should receive adequate and safe complementary foods while breastfeeding continues up to 24 months or beyond. However, specific recommendations apply to infants born to HIV-infected mothers[1]. They should receive counselling on the risks and benefits of various infant feeding options, specific guidance in selecting the most suitable option for their situation, and support to carry out their choice.

Given the complexities involved in providing infant feeding counselling to HIV-positive women, WHO has supported research into counselling practices, and WHO and partners have developed tools to train counsellors. WHO is currently developing an integrated course on breastfeeding counselling, HIV and infant feeding counselling and complementary feeding counselling, with a shortened length of five days.

WHO convened an informal meeting in Geneva on 15 and 16 November 2004 to share the latest findings from research related to HIV and infant feeding counselling and information from implementation experience, and to discuss their implications for the integrated infant feeding counselling course. The expected output was a set of specific recommendations for the content and methods of the HIV and infant feeding component of the integrated course.

The purpose of this report is to share and provide a brief explanation of the recommendations formulated during the informal meeting "HIV and infant feeding counselling: From research to Practice".

The report starts by presenting the key research findings, programmatic experience and on-going efforts in the development of materials for skills building. Next, it presents a summary of the implications for on-going and future efforts to increase the effectiveness of infant feeding counselling. It also presents the specific recommendations and next steps related to further development of the HIV component of the integrated infant feeding counselling course. The annexes include the agenda of the meeting (Annex 1), the list of participants (Annex 2), and a summary of individual presentations (Annex 3).

Some participants stayed on 17 November to work with the Secretariat to discuss, in detail, some issues relevant for the integrated course. Annex 4 is the Note for the Record of that meeting.

[1] UN guidance states that "when replacement feeding is acceptable, feasible, affordable, sustainable and safe, avoidance of all breastfeeding by HIV-infected mothers is recommended. Otherwise, exclusive breastfeeding is recommended during the first months of life."

# 3 Summary of key information presented

## *3.1 Research findings*

Below are the main research findings; a summary of individual presentations is available in Annex 3.

The experience of UNICEF in programmes for the prevention of mother-to-child transmission (PMTCT) has been that the infant feeding component is still weak and not all staff are trained in infant feeding counselling.

In Brazil and South Africa it was found that the quality of counselling in PMTCT programmes, despite training, remains poor even when health workers had good communication skills.

Experience from Tanzania suggests that the use of job aids could improve knowledge of health workers and mothers.

In HIV-positive mothers better infant feeding practices were associated with intensive training and supervision - as found in the Vertical Transmission Study in South Africa -and with a large number of contacts for counselling, including home contacts.

In mothers with unknown HIV status - as was the case in the ZVITAMBO study - the number of exposures to counselling was associated with improved practices.

In the Vertical Transmission Study of South Africa, the WHO/UNICEF infant feeding counselling courses were suitable for both health professionals and lay counsellors. Community support through community health workers or volunteers may be considered as a valid channel for increasing access of HIV-positive mothers to infant feeding counselling.

Adequate training of health workers and lay counsellors, followed by monitoring and supervision, leads to effective counselling and support to mothers. Such efforts have resulted in reduced mixed feeding and increased exclusive breastfeeding. Conversely, when training of health workers is not adequate, they cannot deliver the intended interventions.

There are many different approaches to training infant feeding counsellors, and it is common to find that the duration of such training, particularly in MTCT prevention activities, is insufficient (two hours) to develop meaningful skills. In the context of routine programmes, health workers are often expected to counsel mothers about infant feeding with little or no training.

However, training is not the only limiting factor for effective infant feeding counselling. Health worker performance depends also on the health system. Often policies are unclear or non-existent, health systems are weak, staff turnover and attrition is high, supervision is limited or poor, time for performing the expected tasks is insufficient, and job satisfaction is low.

Stigma is still a significant problem for HIV-positive women who choose replacement feeding as well as those who choose exclusive breastfeeding. It influences the effectiveness of support for improved feeding practices in health facilities and in the community.

## *3.2 Implementation experience on skills development for IYCF counselling*

This section presents the key information on competencies, tools and materials under development and implementation of current training. A summary of individual presentations is available in Annex 3.

### 3.2.1 Competencies needed at different contacts and by different providers

In order to have a clear training strategy on IYCF, it is important to identify the minimum competencies required, the contact points and the different levels of workers who should perform them. Health workers need specific competencies for supporting breastfeeding, replacement feeding and complementary feeding. There is a need to increase the emphasis on training and supervisory skills and involve lower levels of health workers as much as possible. Trainers and supervisors should perform specific tasks such as on-the-job training and follow-up after training. However, human resources are limited, health facilities cannot release health workers for every course, and it is extremely difficult to set up a system for follow-up after training. WHO and partners should explore alternatives such as daily sessions of on-the-job training in health facilities. Planning, competency-based training, follow-up after training and on-going assessment of competencies should be part of the training strategy. Ideally, health workers should learn these competencies during pre-service training.

### 3.2.2 Review of training materials available and implementation of experience

The experience to date with breastfeeding counselling and HIV and infant feeding counselling courses in Africa is extensive compared to other regions. However