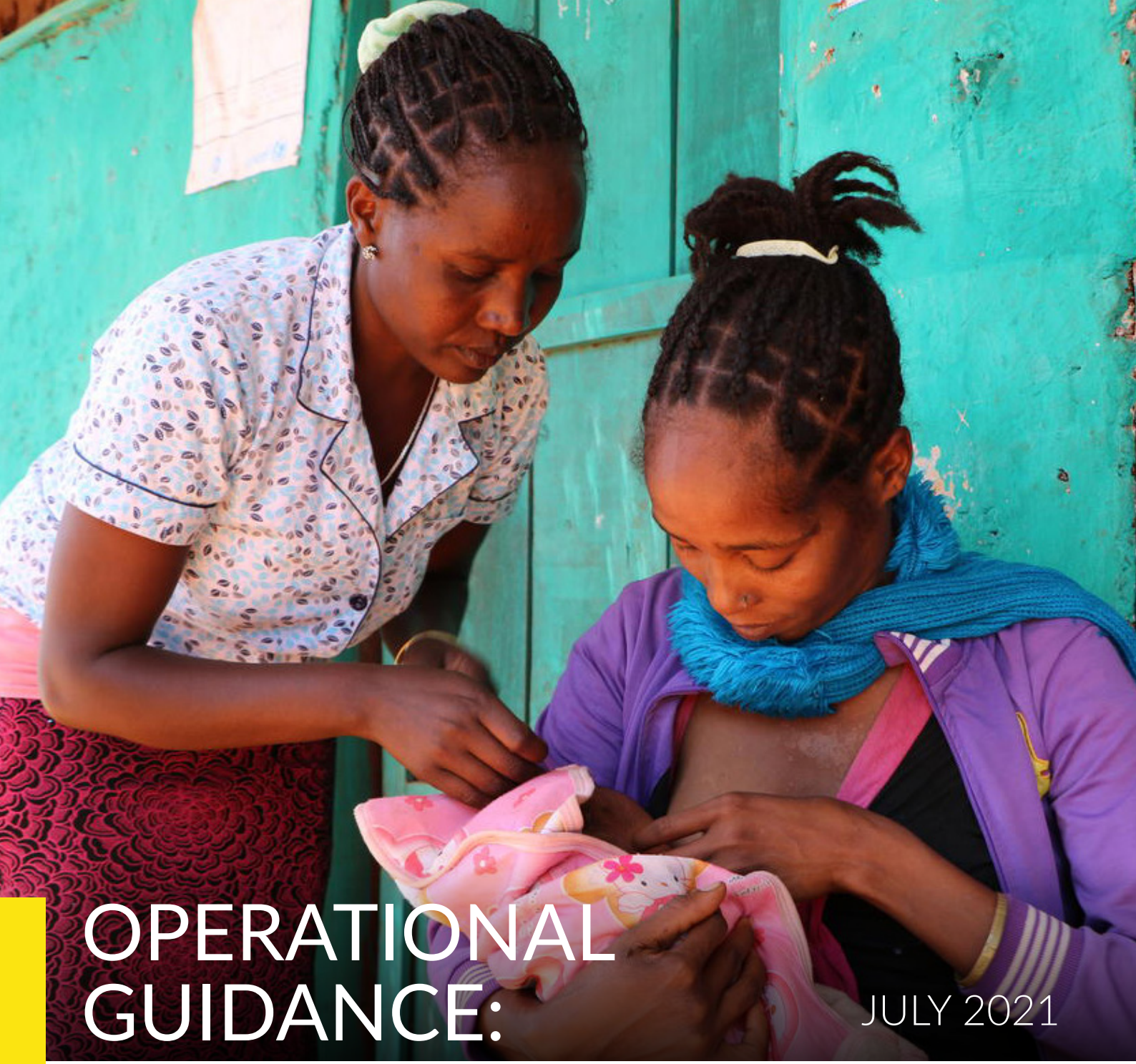

OPERATIONAL GUIDANCE:

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BREASTFEEDING COUNSELLING IN EMERGENCIES

ENN
IFE CORE GROUP
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COVER IMAGE: SAVE THE CHILDREN/EMNET DEREJE

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Acronymns

ANC	antenatal care
BMS	breastmilk substitute
BFC	breastfeeding counselling
BFHI	Baby Friendly Hospital Initiative
BFS	baby friendly space
BSFP	blanket supplementary feeding programme
CMAM	community based management of acute malnutrition
CP	child protection
ECD	Early Childhood Development
ENC	essential newborn care
ENN	Emergency Nutrition Network
FA	Full Assessment
GBV	gender based violence
HIV	Human Immunodeficiency Virus
iCCM	integrated community case management
IEC	Information Education and Communication
IG-BFC	Implementation Guidance on Counselling to Improve Breastfeeding Practices
IMCI	integrated management of childhood illness
IYCF	infant and young child feeding
IYCF-E	infant and young child feeding in emergencies (also referred to as IFE)
LBW	low birth weight
M-Health	Mobile Health
MAMI	Management of small and nutritionally at risk infants under six months and their mothers
MHPSS	Mental Health and Psychosocial Support
MISP	minimum initial service package
MIYCN	maternal, infant and young child nutrition
MNCH	maternal newborn and child health
MtMSG	mother to mother support group
MUAC	mid-upper-arm circumference
NGO	non-governmental organisation
OCHA	Office for the Coordination of Humanitarian Affairs
OG-BFC/E	Operational Guidance on Breastfeeding Counselling in Emergencies
OG-IFE	Operational Guidance on Infant and Young Child Feeding in Emergencies
PFA	psychological first aid
PMTCT	prevention of mother-to-child transmission
PNC	postnatal care
SGBV	sexual and gender based violence
SRA	Simple Rapid Assessment
TBA	traditional birth attendant
TIC	trauma informed care
UN	United Nations
UNHCR	United National Higher Commissioner for Refugees
WASH	Water, sanitation and hygiene
WFP	World Food Programme
WHO	World Health Organization

A list of terms and definitions can be found in the GLOSSARY.

1. BACKGROUND

Scope and purpose

In 2018, the World Health Organization (WHO) published *Counselling of Women to Improve Breastfeeding Practices*, a guideline with recommendations and best practice statements for breastfeeding counselling. The guidelines are complemented by the WHO and UNICEF (2021) *Implementation Guidance on Counselling to Improve Breastfeeding Practices* (IG-BFC) which explains how to execute the recommendations in practice. Due to the particular complexities of operating in emergencies, the need for specific and separate guidance was identified in a WHO-convened meeting in November 2019.

This *Operational Guidance on Breastfeeding Counselling in Emergencies (OG-BFC/E)* is a pragmatic guide which covers key considerations and potential adaptations when applying WHO's 2018 guidelines in an emergency setting. This guidance is intended to be used by policymakers and other decision makers and programmers working in emergencies (both local/national emergencies and humanitarian emergencies) including governments, United Nations (UN) agencies, national and international non-governmental organisations (NGOs), as well as donors, volunteer groups and providers of care to pregnant women and families with infants and young children.

This document recognises that how and when to introduce complementary foods in a manner that does not disrupt exclusive breastfeeding until six months of age and the subsequent continuation of breastfeeding are an important part of counselling. It acknowledges the critical importance of ensuring access to adequate amounts of appropriate, safe, complementary foods and associated support during emergencies. However, this document does not cover complementary feeding counselling specifically.

Development process

The guidance was developed using a structured approach combining 1) interviews with key informants with experience and expertise in implementing breastfeeding counselling in emergency settings, 2) case studies of breastfeeding counselling interventions in emergency settings and 3) a desk review of grey and peer reviewed literature. Successes, challenges, gaps, required resources, compromises and adaptations for implementing counselling interventions in emergency settings were identified. The development of this document was guided by an expert peer review group comprised of IFE Core Group members and drew upon the WHO's guidelines on *Counselling of Women to Improve Breastfeeding Practices and Improving Early Childhood Development*[i]. The guidance is considered an addendum to the WHO and UNICEF (2021) IG-BFC.

How to use this guidance

The guidance is divided into three main sections. The first section, BREASTFEEDING COUNSELLING, discusses what breastfeeding counselling is and the entry points for breastfeeding counselling. The second section, PROVIDING BREASTFEEDING COUNSELLING IN EMERGENCIES, covers the application of five of WHO's recommendations in emergency settings including **who to prioritise** for counselling, **when**, **how often** and **how** to provide counselling. For each recommendation, first consult the 'Challenges and Solutions' section to consider which challenges may be present in your context and to identify possible solutions. If there are no feasible solutions, move to 'Adaptations and Compromises'. The third section, COUNSELLING CAPACITY IN EMERGENCIES, provides guidance on WHO's recommendation on **who can provide counselling services** and **how to operationalise counselling services** through ensuring adequate capacity is in place. Refer to the IG-BFC for guidance which applies to both emergency and non-emergency settings as well as further considerations on advocacy and policy, service planning, coordination, leadership, monitoring and evaluation, special populations and emergency preparedness.

2. INTRODUCTION

An emergency is an event or series of events that represents a critical threat to the health, safety, security or wellbeing of a community or other large groups of people, usually over a wide area[ii]. Emergencies can be **natural disasters** (e.g., earthquake, drought, epidemic) or **human-made** (e.g., civil war, explosion, nuclear spill), **sudden** or **slow onset** and **short-term** or **protracted**. Anderson and Gerber (2018) describe an emergency as an event disruptive enough to affect the normal function of a community (e.g., town or nation) and significant enough that the affected community cannot cope with the impact using its own resources. In more developed countries, support usually comes from national or local organisations (**local/national emergency**). Where international support (humanitarian assistance) is required to meet the basic needs of a population, it is a **humanitarian emergency**[iii].

The impact of an emergency depends on the nature of the event and the preparedness and vulnerability of the population. Emergencies are commonly characterised by human suffering, loss of life and a deterioration in living conditions. Mass population movement and/or displacement may occur, increasing the risk of family separation. Public health infrastructure may be destroyed and health systems and services disrupted, partially because healthcare professionals – including those who normally provide breastfeeding counselling – may themselves be affected. Community networks and family support are often disrupted. Breastfeeding support – including counselling – may therefore be limited, discontinued or become inaccessible[1, iv]. Daily stressors and increased exposure to traumatic events, including gender based violence (GBV), often cause mental health and psychosocial wellbeing to decline, impacting caregiving capacity. Access to food, shelter, safe water, sanitation and medical care may be limited and the basic necessities required to keep infants and young children safe from harm, illness and death may not be readily available or accessible[v]. The possible impact of an emergency on breastfeeding is further discussed in 4.4 – ANTICIPATORY BREASTFEEDING COUNSELLING.

Women and children, especially pregnant girls and women, infants and young children and postpartum women, are populations that are extremely vulnerable in emergencies[vi]. Breastfeeding provides children with hydration, comfort, connection, high quality nutrition and protection against disease, shielding them from the worst of emergency conditions. This ability has been described as empowering and healing by some breastfeeding women[vii, viii]. Breastfeeding also has important consequences for maternal mental health, physical health and caregiving capacity[ix, x, xi], as well as long-term child development and educational attainment[xii]. Emergency contexts increase the importance of breastfeeding and increase the morbidity and mortality risks associated with not breastfeeding. Yet breastfeeding practices are often negatively impacted by emergencies and undermined by emergency responders[xiii, xiv] (see 4.4 – ANTICIPATORY BREASTFEEDING COUNSELLING).

Breastfeeding is a human right[xv]. Women and their children also have the right to support that enables them to breastfeed[xvi]. Breastfeeding counselling is a lifesaving intervention as it helps to mitigate the impact of an emergency and ensure that breastfeeding is started and continued. Failure to protect breastfeeding during emergencies has detrimental consequences. Providing skilled support for breastfeeding is therefore a **priority action** during emergencies as outlined in the *Sphere Humanitarian Charter and Minimum Standards in Disaster Response*[2].

[1] Brown and Shenker (2020) report that 67% of 1,219 new mothers surveyed in the UK during the COVID-19 pandemic felt they had less breastfeeding support during the UK's lockdown measures in response to COVID-19. A very strong association between perception of support and feeding practice was found ($\chi 2 = 125.75$, $P = 0.000$).

[2] For further details on why breastfeeding counselling matters in emergencies, refer to the brief which complements this guidance: IFE Core Group (2021). Brief: Breastfeeding Counselling in Emergencies.

BOX 1 Guiding principles

i. The protection, promotion and support of breastfeeding, in accordance with international guidance, standards and policies, is essential in emergency settings. Planning for provision of breastfeeding counselling should be an integral part of emergency preparedness plans for infant and young child feeding (IYCF) and integrated into formative assessments and initial and sustained responses[xvii].

ii. All interventions should be centred around the principle to "do no harm" which requires humanitarian actors to avoid exposing emergency-affected people to additional risks or suffering through their actions. *The International Code of Marketing of Breastmilk Substitutes and subsequent World Health Assembly resolutions*[3] ("The WHO International Code") protects both breastfed and non-breastfed infants; strict adherence to The WHO International Code (or its national policy equivalent, where relevant) by humanitarian actors is therefore a vital step in preventing harm. Counselling programmes should also apply a **trauma-informed approach** to care to avoid doing harm.

iii. Possible adaptations of WHO's recommendations are suggested in this document to guide those working in exceptional circumstances in acknowledgement of the complexities of delivering breastfeeding counselling interventions in emergency settings. However, an emergency alone does not justify falling short of WHO's recommendations; responders must strive to meet the recommendations to the greatest extent possible. Decision-making on appropriate adaptations and acceptable compromises should be informed by critical analysis by the infant and young child feeding in emergencies (IYCF-E) coordination authority, government, UNICEF, WHO and, where applicable, UNHCR, in consultation with service providers and affected communities, including mothers[xviii]. The consequences and risks of such decisions should be used to advocate for humanitarian access and adequate resources for counselling programmes. Appropriate monitoring and evaluation should be conducted to monitor, guide, inform and learn from response.

3. BREASTFEEDING COUNSELLING

3.1 WHAT BREASTFEEDING COUNSELLING IS (AND IS NOT)

- **Breastfeeding counselling** is a two-way interaction between a trained breastfeeding counsellor and one or more pregnant women, mothers or other caregivers of children (most typically) under two years of age. The process involves listening to concerns, discussing questions, teaching about breastfeeding and observing and assisting with the normal process of breastfeeding and breastfeeding challenges. The aim of breastfeeding counselling is to empower women to breastfeed and to strengthen responsive caregiving practices while respecting their personal situations and wishes[xix].

- Breastfeeding counselling includes support for relactation, cup feeding and increasing milk supply which are actions that are carried out with infants who may be breastfed or fully or partially artificially fed. Caregivers may transition between **artificial feeding** and breastfeeding or practice both (mixed feeding). Therefore, counselling to reduce the risks of artificial feeding and ensure it is carried out **hygienically and responsively** should not be seen as separate from breastfeeding counselling and adequate support should be provided for both breastfed and non-breastfed children as part of any emergency response[xx, xxi].

- **Infant and young child feeding (IYCF)** counselling is a commonly used term in both emergency and development settings. It describes comprehensive counselling that encompasses breastfeeding counselling and – if applicable – counselling on complementary feeding and artificial feeding. The term *counselling* used throughout this document refers to both breastfeeding counselling and IYCF counselling.

IYCF counselling includes – at minimum – counselling on:

☑ **Breastfeeding**
☑ **Complementary feeding**
☑ **Artificial feeding**

[3] View the WHO International Code here: https://www.who.int/nutrition/netcode/resolutions/en/

- Counselling is different from basic breastfeeding education or sensitisation and the sharing of key or generic messages. A key difference is the listening, learning and skills-building *interactions* that take place during counselling to support the person receiving the counselling in their decision making[xxii].

- Counselling can happen face-to-face or – particularly during an emergency – remotely. Counselling can be done one-to-one but can also take place in a group setting such as a peer support group (see 4.3 – MODE OF COUNSELLING IN EMERGENCIES). Whether a group activity can be categorised as **group counselling** depends on the facilitation style (listening and learning) and participants' interaction and engagement. Lecture or classroom-style sessions should be reported as **breastfeeding education**, not group counselling.

CASE STUDY 1 Counselling of a breastfeeding mother during an emergency response

During the European Refugee Crisis, a Lingala speaking mother from the Democratic Republic of the Congo and her four month old infant presented at the refugee shelter where CHEERing works in Athens. She was homeless and had not seen a health worker since birth. The baby appeared sick with vomiting, diarrhoea and lethargy. The mother said she was formula feeding, not breastfeeding, could not understand the formula instructions (a donation from Spain) and was looking for support. She had with her an unsanitised feeding bottle containing water. CHEERing's peer counsellor, who also speaks Lingala, discussed feeding with the mother. When she returned after briefly leaving the mother, the mother was breastfeeding. The mother said that she thought, because of her poor diet and living conditions, her milk was bad and could not nourish the baby. The counsellor assessed breastfeeding, including frequency. She reassured the mother that she could breastfeed and that her milk was the safest and healthiest option for her baby. She explained that giving the baby other milks would make her baby more vulnerable to infection and diarrhoea while breastfeeding would protect her baby. During the following week, the peer counsellor reinforced learning and offered daily support, slowly increasing breastfeeding frequency and reducing the number of artificial feeds. She also supported the mother with safer formula preparation and sanitation. Within one month, the mother was exclusively breastfeeding. At six months, she continued to breastfeed while introducing complementary foods. The child's health improved within days. Over time, weight for age improved, indicating that at intake the baby was undernourished. An informed and culturally sensitive approach relying heavily on a trained peer counsellor successfully led to exclusive breastfeeding and a healthier mother-infant dyad.

Source: CHEERing, Greece. Email discussion (2020)

3.2 KEY ENTRY POINTS FOR BREASTFEEDING COUNSELLING IN EMERGENCIES

The structures and services (entry points) through which the emergency affected population can be reached with counselling will depend to some degree on where breastfeeding counselling was delivered pre-crisis, how those services have been affected and – if applicable – which clusters (sector groups) and their respective services have been activated in response to the emergency-affected population's needs.

Wherever possible, it is preferable to integrate breastfeeding counselling into planned or existing services and structures rather than as a stand-alone/vertical intervention. Potential advantages of an **integrated approach**[4] include greater effectiveness and efficiency and the more cost-effective use of resources[xxiii, xxiv]. By combining services in one package, and in one location, both children and their caregivers can receive the services they need in a manner that eases the burden on caregivers and creates confidence. This can involve the placement of a dedicated breastfeeding counsellor within a structure or service or capacitating service providers to deliver counselling themselves (see 5 – COUNSELLING CAPACITY IN EMERGENCIES).

[4] The intentional combining of one or more sector interventions to achieve improved humanitarian outcomes. Services are jointly designed, planned and delivered by teams from all sectors involved.

The following are key steps for governments, the nutrition sector and agencies to undertake during service planning:

1. **Identify and map pre-existing breastfeeding counselling services and structures**[5]. These are typically part of the health system and may also include community-based services such as local breastfeeding support groups.

2. **Determine how pre-existing breastfeeding counselling services and structures can be re-established or scaled up**. Emergency response services should, to the greatest extent possible, build on existing systems and breastfeeding support services and support long-term recovery. (See 5 – COUNSELLING CAPACITY IN EMERGENCIES for guidance on how to examine the current level of capacity and how to strengthen capacity).

3. **Ensure that counselling is part of the minimum package of emergency health and nutrition services**. This will require engagement with both health and nutrition coordination mechanisms, if activated.
    a. As a priority, ensure adequate counselling capacity and service planning among minimum initial service package (MISP)[6] providers.
    b. Determine if infants under six months are being identified with growth faltering (underweight, wasted, stunted). Strengthen/embed skilled breastfeeding support within services that manage these infants and promote an integrated pathway of care approach to support these higher risk infants and their mothers (see **Box 2**).
    c. Identify other planned and ongoing health and nutrition services that are part of the emergency response. These may be different from routine health and nutrition services delivered pre-crisis such as acute malnutrition treatment or communicable disease outbreak services.

BOX 2 MAMI Care Pathway

The **MAMI Care Pathway** is an integrated care pathway approach to the management of small and nutritionally at risk infants under six months and their mothers. It is consistent with and supports implementation of Integrated Management of Childhood Illnesses (IMCI) guidelines. It Includes screening and assessment using existing health system contact points, strengthening existing health and nutrition services to manage the mother-infant pair in outpatient and inpatient facilities, connecting to relevant services through referral pathways, active growth surveillance of small and nutritionally at risk infants and assessment and support to maternal nutrition and health including mental wellbeing. The **MAMI Care Pathway Package** (formerly the C-MAMI Tool) comprises a framework, user guides, assessment and management tools, adaptation guide and support materials. Its development and updates are managed by ENN as MAMI Global Network Coordinator.

For more information: https://www.ennonline.net/ourwork/research/mami

Possible entry points for counselling[7] within **health and nutrition** services include **reproductive health** including essential newborn care (ENC), sexual and gender based violence (SGBV), prevention of mother-to-child transmission (PMTCT), family planning[xxv], antenatal care[xxvi] (ANC) and postnatal care (PNC); **child health** including paediatric services treating wasted infants, immunisation services, well-baby clinics, integrated community case management (iCCM)[xxvii], integrated management of childhood illness (IMCI) and growth monitoring; **mental health and psychosocial support (MHPSS)**; **communicable disease outbreak response interventions** including clinical care and case management, nutritional care and infant feeding support; **community health**; **infant and young child feeding in emergencies (IYCF-E)** and **wasting treatment** including community based management of acute malnutrition (CMAM) and MAMI services.

[5] Tool: Save the Children, UNICEF and the GNC (2020). ESAR IYCF-E Capacity Mapping and Assessment Toolkit. https://www.nutritioncluster.net/resource_IYCF-E_Capacity_Mapping_Assessment_Tool

[6] The MISP is a priority set of lifesaving activities to be implemented at the onset of every emergency (within 48 hours wherever possible). To prevent morbidity and mortality, essential services for all newborns (essential newborn care) include support for skin-to-skin contact, immediate and exclusive breastfeeding and not discarding colostrum.

[7] Note that these are **possible** entry points to consider for the delivery of counselling – it is not necessary to provide counselling within every service for every response. However, where these services are in place they should – at a minimum – be capacitated to identify counselling needs and make referrals.

4. **Integrate counselling into other humanitarian sectors and services to increase reach and coverage**. Consider which services work closely with pregnant women and girls, mothers and other caregivers of infants and young children and are sensitised to the issues they face in emergencies. While protecting and supporting breastfeeding is the responsibility of *all* emergency responders across *all* sectors, emergency services that operate at scale and/or have frequent but short contacts with the emergency-affected population (e.g., food assistance, child friendly spaces, vaccination campaigns, hygiene promotion activities, reception and registration services) are likely better placed to *identify* counselling needs and *make referrals* than to deliver counselling itself (see **Case Study 7**). **Pre-existing community/ women's groups** can also be effective entry points for counselling (see **Case Study 5**).

Possible entry points, by sector, include: PROTECTION (**MHPSS**, **SGBV services** including women and girls' safe spaces, **child protection** including case management) and EDUCATION (**ECD**, **education** for adolescent mothers).

CASE STUDY 2 Counselling as part of MAMI programming

Gambella refugee camp, open since 2014, hosts up to 330,000 South Sudanese refugees at any one time. GOAL provides MAMI services to small and nutritionally at risk infants under 6 months and their mothers in two of seven camps (Kule and Tierkidi) as part of a wider package of preventative and curative nutrition interventions. At-risk mother and infant pairs are identified by community health workers who undertake screening in the community, assessing anthropometric, clinical, feeding and maternal risk factors. Under COVID-19 adapted services, 1,500 households with infants < 6m have also been trained to measure mid-upper-arm circumference. Referral to the health facility is followed by a detailed assessment (including breastfeeding) to determine classification and subsequent enrolment based on the risk status of the mother-infant pair. High risk mother-infant pairs are referred to inpatient care and moderate risk pairs are referred to MAMI outpatient care. Both outpatient and inpatient care encompass weekly, or daily if required, tailored counselling, support and monitoring. This is delivered by MAMI-trained IYCF counsellors and nurses in dedicated IYCF spaces within health facilities. Counsellors provide one-on-one targeted support using MAMI counselling tools including a support booklet and Global Health Media videos (see Key Resources), translated into the Nuer language. Care also includes maternal mental health support. The service was conceived using 'admission' and 'discharge' criteria but it is agreed that transition to an 'enrolment' approach with de-escalated monthly follow-up is more suitable when both mother and infant are no longer at-risk. Mother-infant pairs are only discharged once the infant reaches six months of age. Between May 2019 and October 2020, 267 infant-mother pairs were being managed within the GOAL Ethiopia MAMI programme.

Source: *GOAL, Ethiopia. E-mail correspondence (2020); Further reading: www.ennonline.net/fex/62/goalexperiencesofmanagement*

CASE STUDY 3 Counselling as part of Early Childhood Development programming

World Vision implements the 'Go Baby Go' model which aims to build knowledge, skills and resilience-promoting techniques to improve parenting practices at the household level. Using an integrated approach, caregivers' awareness of the interrelatedness of health, nutrition, protection and development is strengthened. In 2017, World Vision started implementing a programme with integrated breastfeeding and ECD counselling in the West Bank. Following recruitment of pregnant women at the start of the project cycle, each household is visited by community health workers a minimum of once a month to provide nutrition and ECD counselling and psychosocial support. Breastfeeding counselling is part of every household visit. Visits are increased as needed. Caregivers also participate in interactive group sessions at primary health care centres. Therefore, each household benefits from two to three activities every month. A RCT evaluating the impact of the integration of IYCF counselling with ECD's "Nurturing Care Framework" showed a 30% increase in exclusive breastfeeding amongst the intervention group.

Source: *World Vision, West Bank Palestine. Key informant interview (2020)*

4. PROVIDING BREASTFEEDING COUNSELLING DURING EMERGENCIES

Core characteristics of breastfeeding counselling in non-emergency settings, and potential adaptations and compromises during emergencies, are summarised in Table 1 below and elaborated further throughout this document.

Table 1: Key recommendations for breastfeeding counselling in emergency and non-emergency settings

Recipients	Timing	Frequency	Mode	Provider	Qualities
Key recommendations for counselling women to improve breastfeeding practices[8]					
ALL pregnant women and mothers with infants and young children	Pregnancy Directly after birth and up to 2-3 days after birth Up to 28 days after birth (neonatal period) First 3-4 months of age At 6 months of age (start of complementary feeding) After 6 months (late infancy and early childhood) Any age, as needed	At least six contacts and additional contacts as needed	In-person counselling Individual counselling is preferred Group counselling is useful as a complement to individual counselling Remote counselling may complement but not replace individual face-to-face counselling	Healthcare professionals • Physicians • Nurses • Midwives • Lactation consultants Paraprofessionals • Peer counsellors • Community-based health workers	Person-centred • Sensitive • Culturally appropriate • Trauma-informed • Participatory • Anticipatory Quality-focused • Timely • Efficient • Equitable
Adaptations of key recommendations for breastfeeding counselling in emergencies					
Prioritisation of those requiring immediate help (Priority Group 1 e.g., mothers with breastfeeding difficulties, all newborns, BMS-dependent infants, sick or premature infants) and those at increased risk of developing breastfeeding problems (Priority Group 2 e.g., adolescents, first-time mothers, pregnant women with risk-factors)	The priority is to provide timely counselling to groups requiring immediate help and high-risk groups (any age, as needed) For all other pregnant and breastfeeding women, the same timing as non-emergencies with priority given to the time around birth (before and after)	The priority is to provide counselling for groups requiring immediate help and high-risk groups as often as needed and the emergency context allows For all other pregnant and breastfeeding women, the same as non-emergencies, if possible Programmes should proceed and provide counselling as often as possible when it is not feasible to achieve six contacts	Group counselling may be appropriate to address high needs but individual counselling should also be available Remote counselling may fully or partially replace face-to-face counselling	Similar to routine providers Surge capacity and dedicated counsellors may be needed Providers require additional counselling competencies (refer to **Chapter 5 – Table 6**)	Same as above Anticipatory counselling also involves anticipating breastfeeding challenges related to the emergency context

[8] Further guidance: WHO and UNICEF (2021). IG-BFC.

4.1 RECIPIENTS OF BREASTFEEDING COUNSELLING IN EMERGENCIES

WHO Recommendation 1

Breastfeeding counselling should be provided to all pregnant women and mothers with young children.

Key Considerations

The primary populations that breastfeeding counselling interventions aim to reach during emergencies are **pregnant girls and women, mothers and other caregivers**[9] **of infants (0-11 months) and young children (12-23 months).**

It is also beneficial to include fathers/co-parents[10, 11], grandmothers[12] and mothers-in-law[xxviii] or other family members in counselling or to reach them with related activities, depending on the specific cultural context and who the decision makers and influencers are with regard to infant feeding and care seeking behaviours. Inclusion of family members in **antenatal counselling** (see 4.2 – TIMING AND FREQUENCY OF COUNSELLING IN EMERGENCIES) can help identify specific ways to assist the mother postnatally in a manner that is supportive of breastfeeding. It may be even more appropriate to include family members when the number of possible counselling contacts is limited as they can help to remember information and provide ongoing support such as in transit and evacuation settings.

CASE STUDY 4 Counselling of men

During the Rohingya response, community and religious leader consultations and community meetings conducted by Save the Children highlighted the influential role of fathers on breastfeeding practices within the Rohingya community. As a result, Save the Children recruited and trained male counsellors to counsel men/fathers on maternal, infant and young children nutrition (MIYCN), including breastfeeding, via courtyard meetings. This inclusive approach is particularly pertinent in settings with high rates of domestic violence given the known impact of such violence on breastfeeding and care practices.

Source: *Save the Children, Bangladesh. Key informant interview (2020)*

Challenges and Solutions

Various barriers to reaching pregnant women, mothers and other caregivers with counselling may be present during emergencies. Many of these challenges can be addressed through adequate preparedness, as described in the IG-BFC. Possible solutions to consider during an emergency response are presented in Table 2.

[9] Note: For the sake of brevity, where appropriate, the term *caregiver* (rather than mothers and other caregivers) will be used from this point forward while acknowledging that children who are breastfed or primarily cared for by someone who is not their biological mother/the person who gave birth to them may be more vulnerable and that programmatic distinctions should therefore be made. The term *caregiver* refers to a child's primary caregiver and encompasses mothers, adoptive/foster mothers, carers working in institutions such as orphanages, temporary carers (e.g., in Ebola treatment centre nurseries) etc. and may also include fathers and other family members acting as the child's primary caregiver.

[10] Azad et al. (2019) report that during the Rohingya Refugee Crisis, 91.97% of women who adopted infants born as a result of rape reported having to receive permission to breastfeed from their husbands or other family members.

[11] Emerson et al. (2017) identified husbands as a significant source of distress for women living in the DRC, noting that engaging fathers through responsible parenting interventions may reduce psychological distress and have a positive impact on child health.

[12] De Young et al. (2018) identified strong family influences on feeding choices in post-earthquake Nepal which suggested that interventions post disaster should include grandmothers and other members of the extended family.

Table 2: Strategies for overcoming common challenges with breastfeeding counselling in emergencies including barriers to reaching caregivers with counselling

Supply of services (Availability of skilled human resources, financial resources and organisational capacity)	
Possible barrier	**Possible solutions**
1. Lack of financial resources – Lack of adequate planning or financing by national governments, donors and agencies – Lack of prioritisation of IYCF-E by agencies applying for funding	• **Ensure that counselling is part of the minimum package of health and nutrition services for the emergency (preparedness plans, humanitarian response plans etc.)** (Refer to 3.2 – KEY ENTRY POINTS FOR BREASTFEEDING COUNSELLING) • **Ensure that the lead coordination authority on IYCF-E is meeting their responsibilities with regards to financing**[13] (e.g., inclusion in needs assessments, advocacy strategies, funding calls e.g., Country Based Pooled Funds (CBFP), Central Emergency Relief Fund (CERF)) • **Ensure breastfeeding counselling is included and adequately costed** in preparedness and response plans, strategies and funding proposals[14]. • **Explain clearly and simply what breastfeeding counselling is and its added value.** Communicate the needs of pregnant and breastfeeding women to donors, governments, etc.. Share the existing evidence base on the impact of breastfeeding counselling on breastfeeding practices and the consequences of neglecting breastfeeding during emergencies. • **Advocate to donors for flexible funding mechanisms that are able to respond to different and changing needs**[xxix].
2. Gaps in organisational capacity – Lack of/ disruption of pre-existing breastfeeding counselling (BFC) programmes – Lack of capacity to transition from non-emergency to emergency BFC programming (inadequate preparedness) – Poorly defined institutional responsibilities, lack of organisational policies – Lack of available competent partners to implement programmes[xxx] – Poor quality or inappropriate services including poor communication, lack of services that take into account MHPSS or are not trauma informed, inappropriate counselling in terms of culture/ language/lack of privacy for counselling services/ lack of inclusive services – Poor coordination	• **Sensitise decision makers and planners** on the importance of IYCF-E/BFC in emergencies. • **Strengthen organisational capacity to deliver appropriate and effective counselling services** (See 5 – COUNSELLING CAPACITY IN EMERGENCIES). • **Ensure IYCF-E /breastfeeding policies and guidance that are in line with the Operational Guidance on Infant and Young Child Feeding in Emergencies (OG-IFE) are in place and enforced.** Develop a joint statement which, in addition to addressing the prevention of breastmilk substitute (BMS) donations, addresses counselling and is signed by relevant stakeholders. Agencies should have a written policy that is communicated to all staff while funders can integrate policies into partner agreements. • **Ensure adequate IYCF-E coordination capacity**[15,16], (e.g., assess government coordination capacity and support if necessary, determine/clarify coordination roles and responsibilities, put in place adequately resourced coordination mechanisms – such as IYCF-E technical working groups – for IYCF-E specific and sensitive programming, share information about pregnant and breastfeeding women and their children in a timely manner).

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[13] Further guidance: IFE Core Group (2017). Operational Guidance on Infant and Young Child Feeding in Emergencies Section 3.

[14] Further guidance: UNICEF and WHO (2021). Implementation Guidance on Counselling to Improve Breastfeeding Practices.

[15] Further guidance: IFE Core Group (2017). Operational Guidance on Infant and Young Child Feeding in Emergencies Section 3.

[16] Further guidance: UNHCR and Save the Children (2018). IYCF Multisectoral Framework for Action.

Table 2 continued...

Possible barrier	Possible solutions
3. Human resource availability, motivation and individual capacity – Lack of trained human resources[xxxi, xxxii, xxiii] (no pre-emergency counselling capacity, counsellors impacted by emergency, shortage of women on staff[xxxiv], shortage of staff with required language skills or cultural understanding or who are accepted by the emergency-affected population, high staff turnover) – Lack of health worker time (high needs for curative services override delivery of preventative services) – Low counsellor motivation (de-prioritisation by personnel for whom counselling is one of many tasks, mothers' resistance to recommended practices[17], lack of incentives for peer counsellors)	• **Define roles and service standards** i.e., the time necessary for trained, skilled and motivated personnel to perform an activity to professional standards in the local circumstances. Where breastfeeding counselling is a defined part of a provider's role, allocate an adequate amount of time for this workload component when planning services. • **Ensure adequate numbers of counsellors**[18] by 1) recruiting trained counsellors (e.g., lactation consultants) or those who can be trained to deliver counselling (e.g., healthcare professionals, peers, traditional birth attendants (TBAs), 2) deploying surge counselling capacity from other areas/ national or emergency response teams (see 5 – COUNSELLING CAPACITY IN EMERGENCIES). • **Build the capacity of the available workforce to deliver counselling** Note this will only be effective if counselling is built into their role during service planning. Regular training is essential to address staff turnover (see 5 – COUNSELLING CAPACITY IN EMERGENCIES). • **Build communities' capacity to provide counselling** (e.g., train peer counsellors). This can increase resilience and reduce reliance on external resources and aid. • **Task shifting** e.g., hygiene promoters can teach cup feeding instead of counsellors, peer counsellors can provide basic counselling so that counsellors with more advanced competencies can focus on complex cases. • **Place dedicated breastfeeding counsellors within services** to provide in-depth counselling (see 5.1 – PROVIDERS OF BREASTFEEDING COUNSELLING). • **Raise awareness** of the importance/impact of breastfeeding in emergencies and the risks of neglecting breastfeeding in emergencies to address motivation. • **Include standard counselling indicators** in the indicator set used for monitoring provider/facility/implementing partner performance. • **Plan for adequate incentives/remuneration** (if appropriate and sustainable) and provide support and recognition for community volunteers and peer counsellors. • **Demonstrate duty of care** and support counsellors to work in a safe working environment. • **Put in place family/breastfeeding-friendly policies** to recruit and maintain a female workforce (see **Box 8** for further guidance).
Demand for and utilisation of services	
Possible barrier	**Possible solutions**
1. High case load – High needs (population influx due to mass displacement, increase in breastfeeding difficulties, increase in birth rates or overall increase in needs – such as during an epidemic)	• **Prioritise** counselling for those in need of immediate help (Priority 1) and at-risk groups (Priority 2) (see Adaptations and Compromises below). • **Prevent breastfeeding problems:** – Prioritise counselling in pregnancy and around the time of birth (see 4.2 – TIMING AND FREQUENCY OF COUNSELLING IN EMERGENCIES) – Ensure immediate skin-to-skin and early initiation of breastfeeding • **Create a breastfeeding-friendly environment**, (e.g., prevent and rapidly handle any donations of BMS, facilitate multi-sector support for pregnant and breastfeeding women[19], implement interventions which are supportive of good breastfeeding practices) to reduce the number of women with breastfeeding difficulties requiring skilled counselling. • **Ensure appropriate support for BMS dependent infants** to protect and support both breastfed and non-breastfed children. • **Ensure postnatal care and growth monitoring services** (well-baby clinics) are in place so problems can be caught early before specialised support is needed.

continued...

[17] Sami et al. (2017) found that mothers' resistance to practices such as exclusive breastfeeding and breastmilk expression lowered health workers' intention to promote these practices.

[18] Further guidance: Sphere staffing standard: 23 skilled birth attendants (doctors, nurses, midwives)/10,000 population. Note that these are **minimum** standards which are context dependent; where reproductive health consultation rates are high despite minimum standards being met, consider readjusted staffing levels.

[19] Further guidance: Save the Children and UNHCR (2017). IYCF in Refugee Situations: A Multisectoral Framework for Action.

Table 2 continued...

Possible barrier	Possible solutions
2. Low demand for services – **Gender inequality and social norms** (women's lack of decision making power to attend services, women required to stay at home etc.) – **Low awareness of services** (poor communication, lack of inclusive communication that is accessible and understood by all caregivers) – **Lack of time** (women have increased workloads and multiple competing priorities) – **Maternal motivation and prioritisation** (caregivers may not value counselling or see follow-up as important, programmes that do not offer material assistance may be of less interest to aid-dependent populations, caregiver preference for artificial feeding e.g., due to aggressive marketing by BMS manufacturers) – **Decline in health seeking behaviour** (deterioration in maternal mental health and wellbeing, lack of acceptance or trust in in available services (e.g., due to poor or inappropriate quality including culture, language, lack of privacy etc.), fear of attending face-to-face counselling during infectious disease outbreaks)[xxxv, 20]	• **Conduct a barrier analysis** to understand why uptake of services is low. • **Raise awareness and improve community acceptance of counselling services** Engage and sensitise responders, caregivers, influencers and decision makers – including community leaders – on the value of breastfeeding, the importance of counselling and available services. Use the media and other communication outlets to raise awareness. Use participatory approaches to design culturally appropriate counselling services and solicit community feedback. Deliver information via multiple communication modes (e.g., posters and audio speakers) to ensure caregivers with disabilities can access and understand information. • **Increase convenience and reduce the burden on caregivers** Deliver counselling at multiple levels (household, community and facility) and delivery platforms[xxxvi]. Ensure service hours, outreach activities and household visits are at times that are convenient for mothers (i.e., not when they are typically occupied with childcare or preparing food). Ensure trained counsellors conduct household visits, particularly for caregivers who may have difficulties travelling to breastfeeding counselling sites (e.g., caregivers living with depression or a disability, mothers who have recently given birth). Liaise with MHPSS services on identification and referral of caregivers living with mental health difficulties to counselling services or capacitate MHPSS providers to deliver counselling themselves. • **Build trust in health services** Solicit and take on board community feedback. To address fears related to communicable disease, create an environment in which the disease and its impact can be discussed and addressed openly. • **Consider provision of remote breastfeeding counselling** if caregivers fear attending in-person services such as during communicable disease outbreaks (see 4.3 – MODE OF COUNSELLING IN EMERGENCIES) • **Motivate caregivers to prioritise counselling services** Provide holistic support that takes into consideration the different components required for a mother-baby dyad's health, wellbeing, development and happiness. Co-locate or integrate breastfeeding counselling services into services with high uptake by pregnant and breastfeeding women (see 3.2 – KEY ENTRY POINTS FOR BREASTFEEDING COUNSELLING IN EMERGENCIES). Consider integrating counselling with services providing material assistance[xxxvii] (e.g., food aid), cash assistance or, where appropriate, provide incentives that enable recommended behaviours (e.g., soap, hygiene kit, menstrual hygiene products, nutritious snacks)[xxxviii, xxxix]. Provide support for BMS dependent infants as a means to bring their caregivers into contact with services including BFC. Understand what drives appeal for mothers and other caregivers e.g., through human centred design and behavioural mapping. • **Protect and support maternal mental health and psychosocial wellbeing** Collaborate with MHPSS actors to design and deliver counselling services and counsellor training in a way that promotes mental health and psychosocial wellbeing[21]. Build community counselling capacity (e.g., mother-to-mother support groups and peer counsellors) as a means of strengthening community self-help and social support networks. Within counselling services, promote and support practices that are supportive of maternal mental health such as skin-to-skin contact. • **Encourage follow-up** Collaborate on defaulter tracing efforts. Consider use of mobile health (M-Health) to issue reminders to caregivers (e.g., by phone). • **Ensure services are inclusive** e.g., accessible, appropriate and understood by a person with impairments (physical, sensory, mental, intellectual). • **Raise awareness about the WHO International Code and establish a system to monitor for and respond to Code violations.**

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[20] Brown and Shenker (2020) reported that 58.8% of new mothers surveyed in the UK during the COVID-19 pandemic (n = 1,218) reported that they were concerned, or would be, if they needed to see a healthcare professional face-to-face. Anxieties over the pandemic affected some mothers' decisions whether to contact a health professional; a significant association was found between not contacting a health professional and stopping breastfeeding.

[21] Further guidance: Inter-Agency Standing Committee (IASC) (2007). IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings. Geneva: IASC.

Table 2 continued...

Humanitarian access	
Possible barriers	**Possible solutions**
1. Lack of access to counselling services by affected population (physical barriers e.g., insecurity, restrictions on freedom of movement, destruction of civilian infrastructure, long or difficult distances to travel, climatic conditions, physical disability and social barriers e.g., stigmatised and underserved groups, restriction of women's movement, language and literacy barriers, financial barriers, lack or loss of documentation) **2. Lack of access to the affected population by humanitarian actors** (insecurity, obstructions/ interference by state and non-state actors, bureaucratic restrictions, movement restrictions, targeting of humanitarian personnel and facilities, destruction of transport infrastructure etc.) **3. Forced relocation and mass displacement/evacuation**	• **Establish/strengthen community-based counselling capacity** e.g., train mother-to-mother support groups, peer counsellors, community health workers in hard-to-reach areas, including for underserved or stigmatised populations. This can decrease reliance on external aid and help overcome e.g., language and cultural barriers to accessing support. • **Use a person-centred approach when designing and planning services** Imagine how a caregiver might engage with and access services and what challenges might arise at each step in order to pre-empt challenges and mitigate risks. • **Consider the use of translators and/or remote counselling** if counsellors who speak the same language as the affected population are not immediately available. • **Consider the provision of remote counselling services** (see 4.3 – MODE OF COUNSELLING IN EMERGENCIES) where face-to-face counselling is not possible or recommended. • **Send counsellors to mothers/families** (e.g., community outreach and household visits), prioritising women who are unable or for whom it is especially difficult to travel to counselling sites (e.g., mothers with a disability or who are severely depressed or injured). • **Establish central places where caregivers can access counselling** Establish supportive spaces[22] in e.g., transit or evacuation centres or camps. Set a maximum acceptable distance to the nearest counselling service point near/ within communities. Where applicable, sheltering families with infants and young children in a dedicated area can reduce the overall number of spaces that are needed and/or improve access to mothers and other caregivers. • **Co-locate or integrate services** to save travel time and costs. • **Facilitate safe access to counselling services** through coordinating with protection actors and engaging in dialogue with communities about basic safety concerns and safety measures including those related to GBV. • **Take older siblings into consideration**[23] Ensure caregivers can access services with older children or there are provisions for their safe care nearby (e.g., co-locate with child friendly space). • **Put in place well-managed referral pathways** (see Referrals) • **Remove financial barriers** (e.g., universal healthcare, cover transport costs) • **Meet the minimum standards for disability inclusion in humanitarian action**[24]. • **Ensure that services are adolescent-friendly** including through offering adolescent-only service hours, training providers and adapting counselling approaches to meet the needs of young counselling clients.

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Community nutrition promoter doing family IYCF counselling in Bangladesh
WORLD VISION/BANGLADESH

[22] GNC Technical Allicance (2020). Supportive Spaces for IYCF-E. https://www.ennonline.net/supportivespacesiycfetechbrief2020

[23] Hull, Kam and Gribble (2020) reported how, during the COVID-19 pandemic, a mother in Australia with a suspected breast infection was prevented from accessing a doctor by IPC policies which did not account for mothers having multiple children (only two people were allowed at a consultation).

[24] HelpAge International on behalf of the Age and Disability Consortium (2015). Minimum Standards on Age and Disability Inclusion in Humanitarian Action.

Table 2 continued...

Lack of data on pregnant and lactating women	
Possible barrier	**Possible solutions**
1. Absence or interruption of pre-existing information management systems **2. Inaccuracy/irrelevance of pre-crisis demographic data (high death toll, population influx)** **3. Data sharing sensitivities or limitations**	• **Work with local actors and authorities to gather pre-crisis data.** • **Ensure inclusion of IYCF-E/breastfeeding indicators in needs assessments** including early multi-sector needs assessments. Disaggregate data (0-5 months, 6-23 months, at a minimum)[25]. • **Conduct in-depth assessments using qualitative and quantitative approaches when possible.** • **Monitor programmes using standardised indicators[26] and disaggregated data. Share relevant information in a timely manner.** • **Identify ways to record as many pregnant women as possible.** This can include accessing antenatal records, working with TBAs and work with child protection (CP) actors to ensure birth registration of newborns within two weeks. • **In stable populations, conduct a community mapping exercise with blanket registration of all mothers and caregivers of infants and children.**
The humanitarian architecture: BF counselling/IYCF-E siloed within the nutrition sector	
Possible barrier	**Possible solutions**
1. Siloed approaches to programming (separate management, supervision or funding streams for counselling/ IYCF-E and other services, cluster approach and structure results in perception of IYCF-E as the nutrition sector/cluster's responsibility alone) **2. Low capacity for integration** (limited familiarity of the nutrition sector with approaches /interventions by other sectors resulting in missed opportunities for integration, low awareness by other sectors of IYCF-E interventions, concerns about overwhelming inexperienced frontline personnel with multi-sector responsibilities) **3. Lack of tailored tools** (limited counselling training packages and programming tools tailored to humanitarian sectors other than nutrition)	• **Advocate for relevant stakeholders across sectors to consider the needs of pregnant women, children under two and their caregivers including IYCF counselling[27].** • **Use a person-centred approach to design and operationalise an integrated emergency response or programme from the beginning whenever more than one sector is involved**[xl]. While programmes may be funded separately, their activities should contribute to shared objectives/a common goal which takes breastfeeding into consideration. Consider defining a minimum package for inter-sector collaboration and integration. • **Train programme planners and designers to recognise linkages and entry points for counselling within humanitarian services across sectors** (IYCF-E, ENC etc.). Strengthen counselling capacity within these services rather than delivering alone standing counselling interventions. • **Plan for counselling trainers and supervisors to work across sectors** rather than only within the nutrition sector.

[25] https://ir.hpc.tools/indicators

[26] Tool: Humanitarian Indicators Registry. https://ir.hpc.tools/

[27] Further guidance: Save the Children and UNHCR (2017). IYCF in Refugee Situations: A Multisectoral Framework for Action.

CASE STUDY 5 Community-based support to increase reach

In 2005, an interagency initiative known as the Dadaab IYCF Team began to implement IYCF-E activities at various levels within Dadaab refugee camp. At community level, mother-to-mother support groups (MtMSG) were established, building on pre-existing women's gatherings. Group facilitators were peers who spoke the same language as other mothers in the community and were known and trusted by the community.

Within four years, 610 peers were trained as group facilitators and 679 groups established. Each month, peer counselling was provided to thousands of pregnant women and mothers in a supportive group setting. Grandmothers, mothers-in-law and fathers were invited to participate each quarter. Between 2005 and 2009, exclusive breastfeeding rates rose from under 4.1% to 47.6%.

Source: UNHCR and CARE, Kenya – Key informant interviews and email correspondence with former staff (2020)
Lung'aho and Stone-Jimenez (2009). Mother to Mother Support Groups in the Dadaab Refugee Camp. https://www.waba.org.my/pdf/mstfnl_V7N2_MtMSG_Dadaab.pdf

Training Package: https://windowofopp.files.wordpress.com/2010/12/mtmsg-instructional-training-package1.pdf

CASE STUDY 6 Mobile health teams to increase reach

Mobile health teams (MHTs) were rolled out in Afghanistan (complex protracted crisis) by UNICEF with a local partner to reach pregnant women and children under five years of age with reproductive, maternal and newborn child health and wasting treatment services in remote hard to reach communities (populations living far from fixed health facilities). Teams consisted of a midwife, vaccinator, nurse or doctor and nutrition counsellor. The nutrition counsellor delivered nutrition services including MIYCN counselling. MHTs visited designated service delivery points on a monthly basis for a period of 10 months to increase reach and sensitise the community on health and nutrition services. As a result, coverage increased by 10% and the project was able to reach 89% of its ANC target. MHTs were found to be successful in improving coverage, reach and access to services. However, sustainability was a challenge due to the high cost. Outreach services delivered by mobile teams can improve counselling coverage in contexts where communities live far from fixed facilities.

Source: Qarizada et al., Afghanistan (2018) Scale up of I-MAM services in Afghanistan. Field Exchange 57.

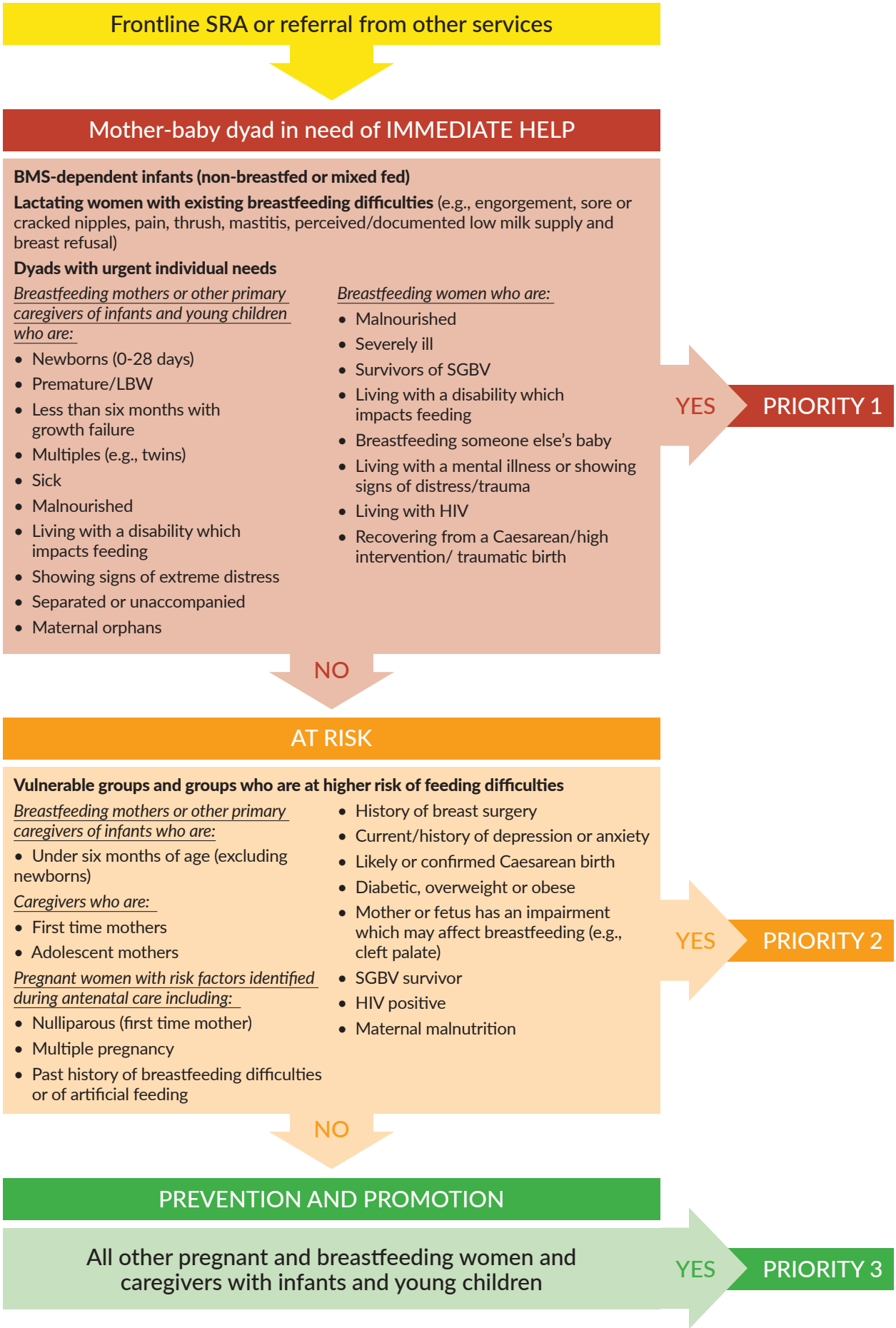
BOX 3 Key messages on identifying and reaching mothers and caregivers for breastfeeding counselling

1. Cover as many different levels (household, community, facility) and sectoral entry points as possible to reach women
2. Ensure or establish mechanisms to have all pregnant women on record and to track them
3. Bring services to the women, rather than expecting them to come to you
4. Make it as easy and appealing as possible for women to access breastfeeding counselling services (**Table 2**)

Adaptations and Compromises

When unable to provide counselling to all, consider **prioritising specific groups** for counselling (**Figure 1**). Through rapid screening and triage, those requiring immediate support or who are at high risk of developing breastfeeding problems can be identified and referred for further assessment and counselling, as discussed below. Mothers not experiencing difficulties can be provided with less intensive forms of breastfeeding support (e.g., education, enabling environment) that can help to prevent breastfeeding problems and reduce the need for counselling in the future.

Figure 1: Prioritisation for counselling, by category



Prioritisation Process

1. **Screen all primary caregivers of children under two using a Simple Rapid Assessment.** To the greatest extent possible, all (100%) of pregnant women and caregivers of children under two should be screened as soon as possible after the onset of a crisis. This can be done using a standardised triage[28] tool such as a **Simple Rapid Assessment** (**Annex A: SRA**). The purpose of the tool is to rapidly assess children under two and their caregivers to decide who should be referred for a full assessment and counselling or to other forms of breastfeeding support. All frontline workers who frequently interact with children under two and their caregivers should be trained on how to use the SRA so that it can be used whenever the opportunity arises such as when processing new arrivals at a reception centre, as part of a household survey (active screening[xli]), as part of child protection case management processes, upon presentation at a health care facility and during food assistance registration (**Case Study 7**).

2. **Progress to full assessment and counselling if indicated by the SRA.** During the first counselling contact, the counsellor will conduct a more thorough individual-level assessment of the caregiver-baby dyad known as a Full Assessment (**Annex B: FA**). This should include an assessment (listen and learn) of baby's behaviour, mother's behaviour, positioning, attachment, effective feeding, health of the baby, breast health and mother's perception of how breastfeeding is going[xlii, 29]. A breastfeeding woman's nutritional health (HIV status, infectious diseases e.g., Ebola, COVID-19) and psychological wellbeing are also important considerations in emergency settings. Counsellors should therefore be trained on voluntary disclosure and relevant referral mechanisms. The counsellor will then determine[30] (analyse and act) what type of support is needed e.g., rapid resolution of a simple issue (e.g., positioning), continued skilled breastfeeding counselling (e.g., relactation support) and/or referral to other forms of support (e.g., malnutrition treatment, MHPSS, health services). Where more than one counselling cadre is responsible for carrying out a full assessment (e.g., peer counsellors at community level and lactation consultants at facility level), different tools, or different versions of the same tool, may be necessary[xliii].

3. **Monitor those referred to other forms of breastfeeding support.** Problems may develop after the SRA is conducted or initially be missed. Therefore, train educators, supportive space facilitators, group counsellors and other breastfeeding support service providers to remain vigilant and identify caregivers who may be in need of individual counselling.

Note that the SRA is a simple screening tool designed so that laypersons can easily identify the majority of dyads to be prioritised for counselling. Not *all* groups requiring urgent help and high risk groups can be identified with the SRA. For example, it may not be possible or appropriate for a layperson to identify low birth weight (LBW) infants or infants with growth failure, breastfeeding survivors of SGBV or breastfeeding women who are HIV positive. It may also not be possible to rapidly reach all breastfeeding women with an SRA (e.g., when a refugee population is dispersed within a host community).

Therefore, alongside screening using the SRA, it is important to **put in place different routes through which caregivers can access counselling** including self-presentation (see **Table 3**). Ideally, counselling is directly integrated into services used by vulnerable groups who may be missed bycouns` the SRA. Priority services include **maternity, those that support small and nutritionally at risk infants including malnutrition treatment programmes, MHPSS, HIV** (especially PMTCT) and **adolescent services** (**Figure 2**) If it is not possible for these service providers to directly provide counselling, at a minimum ensure that these service providers are trained to identify and refer caregivers who may require counselling.

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[28] The primary goal of triage is to do the greatest good for the greatest number of people. In an overwhelming emergency, triage also assists in guiding decisions about allocation of scarce resources (Jorgensen et al. 2010).

[29] For a review of available breastfeeding assessment tools, refer to the MAMI Project: Chapter 7.

[30] **Job aids such as decision flow charts can assist counsellors to decide next steps.** Tool: UNHCR Infant and Young Child Feeding Standard Operating Procedures for Handling of Breastmilk Substitutes (BMS) in Refugee Situations for children 0-23 months (page 11): https://www.unhcr.org/55c474859.pdf

[31] Infant feeding counselling is a required component of a minimum HIV response when initiating antiretroviral therapy for pregnant and lactating women and their infants in an emergency (WHO and UNICEF, 2018).

Counsellors and counselling programme managers should also be aware of key services for priority groups and make proactive attempts to establish contact with pregnant and breastfeeding women accessing these services (**Case Study 10**).

CASE STUDY 7 Screening for counselling needs using an SRA

In the Democratic Republic of the Congo, malnutrition remains a public health problem with chronic malnutrition rates at 42% and wasting at 6.5% (MICS 2018). IYCF practices are low with only 8% of children 6-23 months of age having a minimum acceptable diet and 53.5% of children under six months of age who are exclusively breastfed (MICS 2018). The World Food Programme (WFP)'s emergency assistance programmes (such as cash-based transfers, in-kind food) targeting vulnerable families have great potential to act as platforms for supporting and promoting IYCF practices, especially in emergency contexts. Since 2019, WFP DRC has piloted a nutrition- sensitive approach within its emergency cash-based transfer interventions. At distribution sites and community level, activities have included conducting simple and rapid individual level assessments of IYCF practices, providing guidance and support for IYCF problems with referral to appropriate IYCF services as appropriate, mass sensitisation on IYCF and malnutrition through dissemination of context-specific messages and screening for malnutrition with cases of concern referred to the healthcare facility. Additional community level activities have included establishing or revitalising IYCF support groups and conducting cooking demonstrations.

***Source:** UWFP, DRC (2020) email correspondance*

Referral Systems

The diverse and multiple needs of emergency-affected populations reinforce the need for collaboration and coordination between services and sectors (referrals *to* and *from* counselling services). It is important for a counsellor to try to identify issues (e.g., missing family members, food insecurity, violence in the home) which may be indirectly impacting a caregiver's ability to responsively care for and feed their child and to provide practical assistance with accessing relevant services. Referrals also occur *within* counselling services such as upward referral of complex problems to more experienced and skilled counsellors. To ensure continuity of care, referral systems should be developed as described in the IG-BFC. Key considerations for referral of caregivers or infants and young children in emergencies are outlined in Table 3.

CHEERing team screening and referring refugees in Greece.
FOODKIND

Table 3: Key considerations for referral systems in emergency settings

Referrals within counselling services	Referrals from counselling services	Referrals to counselling services
Shortage/lack of counsellors with advanced counselling competencies. Specialist counselling capacity may not be immediately available. To improve access, maximise the use of technology for remote counselling[32] (see 4.3 – MODE OF COUNSELLING IN EMERGENCIES), taking into account time zones and the need for remote specialists to be equipped with context-specific competencies (see 5 – COUNSELLING CAPACITY IN EMERGENCIES). By empowering health workers and paraprofessionals to provide basic counselling, more time is created for available counsellors with more advanced competencies (e.g., lactation consultants) to focus their attention on caregivers with more complex counselling needs. **Clarity in scope of work.** The roles and responsibilities of different cadres need to be clearly delineated (see 5.1 – PROVIDERS OF BREASTFEEDING COUNSELLLING). Particularly in settings where services are overloaded and specialist capacity is unavailable, there is a risk that counsellors may step outside their scope of practice; it is essential that counsellors are trained to recognise and acknowledge their limitations and to know when to refer. **Clinical lactation management.** The presence of health professionals who are equipped with advanced counselling competencies (see 5.2 COUNSELLING COMPETENCIES) to appropriately support breastfeeding problems requiring clinical skills is important.	**Counsellor awareness of available services.** To conduct effective referrals, providers should have the following up-to-date, written information: admission criteria, location, opening hours and days for new admissions, costs. **Health services.** Ensure provision of breastfeeding friendly clinical services (e.g., prescription of breastfeeding-compatible medication, including contraceptives). **Multi-sector sensitisation.** Conflicting information and advice can undermine confidence and cause frustration. At a minimum, ensure all services that breastfeeding women may be referred to are oriented on IYCF-E and equipped with a minimum set of standardised competencies.	**Referral routes.** Referrals to counselling services may take place through i) proactive screening using an SRA tool, ii) detection of risk factors for breastfeeding difficulties during ANC, iii) referral by sensitised service providers (e.g., health workers providing HIV services), iv) self-presentation by caregivers[33] (see 4.1 – RECIPIENTS OF BREASTFEEDING COUNSELLING IN EMERGENCIES for further details).

4.2 TIMING AND FREQUENCY OF COUNSELLING IN EMERGENCIES

WHO Recommendation 2

Breastfeeding counselling should be provided in both the antenatal period and postnatally, and up to 24 months or longer.

WHO Recommendation 3

Breastfeeding counselling should be provided at least six times, and additionally as needed.

[32] Further guidance: Save the Children with support from IFE Core Group Members (2021) Conducting and supporting IYCF-E e-Counselling: Considerations for Planning and Implementation.

[33] Hargest-Slade and Gribble (2015) describe how awareness about available counselling services was raised through media messages following the 2011 Christchurch earthquake.

The minimum six counselling contacts are not spread out equally over the suggested timeframe but planned for key moments and milestones[34] within the first thousand days. Suggested counselling content during timed and targeted contacts includes information that is relevant to the life stage and anticipatory guidance for the next stage, to prepare caregivers and prevent future problems. These recommendations refer to services designed to reach all pregnant and breastfeeding women including those who are not experiencing breastfeeding difficulties. In addition, the WHO guidelines recommend that additional contacts take place "as necessary" (for instance, when concerns or challenges related to breastfeeding arise) or when opportunities for breastfeeding counselling occur. See IG-BFC for further guidance.

Challenges and Solutions

- An important barrier to achieving scheduled contacts as planned is **lack of humanitarian access** (difficulties in reaching emergency affected populations with counselling services or inability of affected population to access counselling services e.g., due to insecurity). Community-based peer counselling may help to enable basic counselling to continue at recommended times when access is restricted and for transient populations (see 5 – COUNSELLING CAPACITY IN EMERGENCIES).

- Other barriers are similar to those for attempting to reach everyone with counselling (See **Table 2**). These include **resource constraints, high caseloads and provider lack of time, lack of information on caregivers and counsellor and caregiver motivation and prioritisation**. Community outreach (**Case Study 6**) and household visits (**Case Study 8**) can be effective at reaching caregivers in a timely and frequent manner but are resource-intensive. "Client-led" counselling can also help to ensure that breastfeeding concerns are addressed on time. Refer to Table 2 for a breakdown of possible challenges and further solutions for consideration.

CASE STUDY 8 Increasing contact frequency through household visits

Between 2012 and 2017, Save the Children's counsellors worked with health services to identify women attending ANC or PNC at health facilities and requested their address in Zaatari refugee camp. Rather than waiting for mothers to return to the health facility, counsellors then visited women requiring counselling at home. This resulted in higher uptake of counselling services compared to facility-based ANC and PNC services.

Source: *Save the Children, Jordan. Key informant interview with former staff (2020)*

- **An emergency may be shorter** than the timeframe covered in the guidelines, though the average humanitarian crisis now lasts nine years[xliv]. During protracted or chronic crises lasting more than two years, breastfeeding counselling programmes are often hampered by short-term funding and humanitarian planning cycles. Best practice is for emergency and non-emergency programmers to work together from preparedness to recovery and transition to ensure continuity of care for the breastfeeding dyad. Multi-year response and organisational strategies, and preparedness plans that embed breastfeeding counselling, can help to ensure that counselling remains available as recommended.

Adaptations and Compromises

During emergencies, the priority is to provide counselling **when it is most needed** (timing) **as often as needed** (frequency).

Responders should not be discouraged from planning and delivering breastfeeding counselling services even if it may not be feasible to achieve the recommended minimum of six counselling contacts and should provide counselling as often as possible instead. While not ideal, a single counselling contact can

[34] 1. Before birth; 2. During and immediately after birth (first 3 days); 3. 1-2 weeks after birth; 4. 3-4 months (early infancy); 5. Around 6 months (at the start of complementary feeding); 6. After 6 months (late infancy/early childhood) (WHO, 2018).

make a difference[xlv], particularly during difficult or stressful times when positive feedback and emotional support is especially valuable in supporting women's confidence and self-efficacy in breastfeeding. The counselling approach will need to be adapted to focus on the most urgent issues and biggest risks (see **Case Study 9**). During mass displacement, counselling contact frequency can be increased through informing caregivers about available services along their onward journey and communicating with these services about incoming high-risk cases. Counsellors can also request caregiver's contact details, if available, so that follow-up can be done remotely. Impact can be maximised by combining counselling with other forms of multi-sector breastfeeding protection, promotion and support.

Particularly when population movement is low, such as in an established refugee settlement, providing counselling at least six times in both the antenatal period and postnatally, up to 24 months or longer, is likely to be feasible and **no adaptation** of the recommendations is necessary. Timely, scheduled counselling contacts are encouraged as they contribute to a sense of normalcy and predictability that is supportive of psychosocial wellbeing. To facilitate continuity of care, it is also important to ensure the same counsellor sees the caregiver at each contact whenever possible[35].

However, when timed and targeted counselling is not feasible, the priority is to ensure groups requiring immediate help and high-risk groups are counselled on time. For these dyads, counselling contacts should take place as detailed in Table 4 below.

Table 4: Timing and frequency of counselling by priority group

Group	Timing	Frequency
Immediate help (Priority 1)	Counselling needs to **urgently** occur to address the current problem.	As often as needed.
At risk (Priority 2)	Counselling should take place **as soon as possible** after counselling needs are identified to prevent potential problems from developing.	As often as needed.
All pregnant and breastfeeding women (Priority 3)	As per the IG-BFC, counselling can take place during planned contacts (e.g., during a scheduled antenatal visit or group counselling[36] session). Counselling may also be spontaneous or ad hoc (e.g., when a caregiver is admitted to hospital). Regardless of whether counselling takes place at suggested time-points or not, content relevant to the dyad's life stage is covered[37]. Counselling around the time of birth is prioritised[38].	At least six times, to the extent the emergency timeframe and context allows.

- It is common for breastfeeding problems (e.g., difficulties latching, damaged nipples, engorgement, worries about milk supply) to occur in the **immediate and early postnatal period** which, if not overcome with adequate support, can lead to early infant supplementation or premature weaning[xlvi, 39]. Therefore, antenatal anticipatory counselling is important for all pregnant women. Support in the **postnatal period** is *especially* important in emergencies where increased rates of distressing birth experiences, adverse birth outcomes and/or postnatal separation (see **Table 5**) may increase difficulties with establishing

[36] Note: In settings where activities can be scheduled (e.g., established camps) but human resources are limited, organising group counselling by cohort (e.g., pregnancy/0-5 months/6-23 months) can facilitate the delivery of relevant and timely counselling content and appropriate activities (e.g., play and stimulation) for large numbers of caregivers (see 4.3 – MODE OF COUNSELLING IN EMERGENCIES).

[37] Further guidance: Refer to IG-BFC. Job aids can also be used to guide the counsellor in selecting relevant content.

[38] Further guidance: IFE Core Group (2021). Infographic on Early Initiation of Breastfeeding in Emergencies.

[39] Brown and Shenker (2020) reported that of 1,219 surveyed new mothers living in the UK who had given birth just before or during the start of the COVID-19 pandemic, mean infant age at the introduction of infant formula was 2.79 weeks and 3.15 weeks for breastfeeding cessation. Of those participants who had stopped breastfeeding, only 13.5% described themselves as ready to do so. The most common reason for cessation was insufficient professional support.

breastfeeding. As outlined in Chapter 4, Section 4.1 on recipients of counselling, newborns and high risk pregnant women are groups who are prioritised for comprehensive counselling in emergencies. This can be achieved by ensuring adequate counselling capacity within services in frequent contact with pregnant women and new mothers such as maternity/perinatal services (see 5 – COUNSELLING CAPACITY IN EMERGENCIES).

- Which additional moments and milestones should be prioritised for counselling will depend on the context and prevalent feeding practices as determined during needs assessment and through monitoring. Scheduling may be further adapted to align with other available services (e.g., ANC or immunisation schedules).

- When counselling a caregiver with existing challenges or concerns, counselling is provided as **frequently as needed**[40]. The priority is to provide care based on actual individual needs rather than aiming to meet a set number of counselling contacts with each caregiver.

- **Follow-up** is important, both to address problems and encourage success[xlvii]. Stress can reduce a caregiver's ability to absorb and retain information. Multiple difficulties are often present and time is needed to build a trusting relationship under difficult circumstances. Therefore, counselling contacts may take place frequently at short intervals to maximise impact. Standard practice in emergencies involves regular (weekly or monthly) contact with some form of breastfeeding support which may include counselling. This practice acknowledges the value of investing in counsellor-caregiver relationships beyond their impact on breastfeeding practices alone and is particularly appropriate when the breadth of support provided during contacts is wider and more holistic than breastfeeding counselling alone (e.g. MAMI or ECD programming).

CASE STUDY 9 Counselling during mass displacement

In spring 2015, Save the Children launched a frontline IYCF-E response as overwhelming numbers of refugees and migrants (up to 8,000 people per day) arrived at the Croatia/Serbian border. Mothers were in distress and facing significant barriers to feeding their children safely and adequately. They were observed giving cows' milk to infants under six months of age, not measuring water and formula quantities when preparing a feed and re-using unclean feeding bottles. The government's approach aimed to minimise transit times, hindering humanitarian assistance. Caregivers were often exhausted and highly stressed by the constant movement, compromising their ability to process information. During the short stay in the transit camp, caregivers had multiple needs to address in a very limited time. Stress levels were often exacerbated by a lack of information on departure times and processes.

As a result, caregivers tended to be rushed and focused on leaving. Efforts were made to create a calming and comfortable environment in the counselling space by staff trained in psychological first aid. Counsellors reassured caregivers and facilitated access to other services. Save the Children also developed kits to rapidly provide essentials. A lack of cross-border and regional coordination of actors implementing IYCF-E – and a subsequent lack of consistency and standardisation of services – compromised what could have been achieved in terms of minimising risk and supporting safer practices. Caregivers were often tired and confused by the many different actors providing varying messages, materials and products. Save the Children's approach to counselling was therefore to accept feeding behaviours and to focus on risk management and minimisation (e.g., bottle sanitation when cup feeding was refused).

Source: *Modigell, Fernandes and Gayford (2016) Save the Children's Rapid IYCF-E Response in Croatia. Field Exchange 52.*

[40] For example, counselling protocols may indicate that a caregiver undergoing the process of relactation should at first be followed-up on a daily basis, reducing as confidence grows (Burrell et al., 2020). In their description of GOAL's C-MAMI programme in Ethiopia, Murphy et al. (2017) note that acutely malnourished infants may be required to present daily if more intensive support is required to help rehabilitate the child and support the mother, or may be followed up on a weekly basis prior to blanket supplementary feeding programme (BSFP) distributions. Counselling contacts for wet nurses (Burrell et al., 2020; Azad et al., 2019), and BMS-dependent may occur on a weekly basis. Using their best judgement, a counsellor may determine that it is necessary to follow-up more frequently.

CASE STUDY 10 Counselling around the time of birth

Early initiation of breastfeeding and skin-to-skin contact play a vital role in reducing newborn and maternal mortality and improving both breastfeeding outcomes and maternal caregiving capacity. In Lebanon, International Orthodox Christian Charities (IOCC) has been implementing breastfeeding protection, promotion and support as part of their health and nutrition programme for Lebanese nationals and (predominantly Syrian) refugees since 2012. Through close collaboration with primary health care centres, lactation specialists aim to reach pregnant women two to three times antenatally. Counselling is tailored if a Caesarean birth has been planned. IOCC has collaborated with the Ministry of Public Health (MOPH) on the implementation of the Baby Friendly Hospital Initiative (BFHI) in selected hospitals. IOCC's lactation specialists, whose professional background is midwifery, visit hospitals on a daily basis to provide breastfeeding support to women as soon as possible after birth. If permitted by the hospital, they attend the birth. If not, they attend as soon as possible afterward, on the maternity ward or upon discharge, to assess and support breastfeeding. Postnatal breastfeeding difficulties are usually addressed within two to three contacts, but may require more.

Source: IOCC, Lebanon. Key informant interview, 2020.

Duration

The time required for an individual counselling session varies depending on the type of contact, the breastfeeding dyad's needs, state and availability, the setting, the counsellor's skill and experience, translation requirements and the breadth of support provided. **Counselling contacts may be longer or more frequent** in emergencies compared to non-emergency settings as multiple needs[41] and issues often need to be addressed. Under intense stress, instructions and guidance are less likely to be heard or fully understood[xlviii] and may need to be repeated during the contact. Traumatised caregivers' ability to communicate effectively may be jeopardised. Patience is required to establish trust and rapport with caregivers whose trust may have been eroded, who have undergone – and want to disclose – distressing experiences or who find themselves in an unfamiliar setting.

For service planning purposes in emergencies, ideally allow for sufficient time to establish rapport and conduct a Full Assessment (**Annex B**) during the first contact. Shorter contacts without Full Assessment may be necessary in certain settings (e.g., during mass displacement – see **Case Study 9**).

BOX 4 Key messages on timing and frequency of breastfeeding counselling

1. Screen all mothers or caregivers of infants and young children using SRA within a set short period of time
2. The priority is to ensure groups requiring immediate help and high-risk groups are counselled on time
3. Frequency and duration of counselling contacts will vary per case
4. Follow-up is important and is likely to take place frequently with short intervals during emergencies

4.3 MODE OF COUNSELLING IN EMERGENCIES

WHO Recommendation 4

Breastfeeding counselling should be provided through face-to-face counselling. Breastfeeding counselling may, *in addition*, be provided through telephone or other remote modes of counselling.

[41] Note: Including needs beyond breastfeeding support; caregivers may not be receptive to breastfeeding counselling until a counsellor links them to other services to ensure their basic survival needs are met.

Face-to-face counselling may occur at **household**, **community**[42] **or facility level** and in a **one-to-one** (individual) **or group counselling format** (see **Case Study 11**). Group counselling is particularly appropriate for addressing common concerns and sub-optimal practices in resource limited settings with high needs, such as humanitarian contexts. It can have important benefits for maternal wellbeing by creating an opportunity for experience sharing and mutual support. One-on-one counselling should remain accessible to address individual needs.

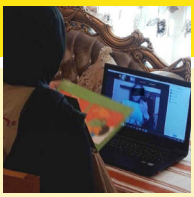
CASE STUDY 11 Mixed group counselling

Following Typhoon Ondoy in 2009, Arugaan's Breastfeeding Experts Supports Team (BESTeam) visited affected communities with their mobile unit. All community members, including fathers (who were typically the decision makers) as well as adolescents and community leaders, were welcomed as observers. All mothers, regardless of how their children were fed, were included in group counselling. Women of non-breastfed children who were inspired to relactate by information shared by the BESTeam and positive experiences shared by breastfeeding mothers were provided with immediate relactation counselling and support using the drip-drop relactation method[43]. Once the mother was relaxed following a lactation massage, the baby was offered the mother's breast. Witnessing these activities reportedly strengthened fathers' and community leaders' acceptance and support for breastfeeding.

Source: Arugaan, Philippines. Key informant interview, 2020

Telephone counselling and other technologies (**Box 5**) are identified in the guidelines as "very useful options as adjuncts" which "may empower end-users, as well as health workers and lay or peer counsellors." Information shared face-to-face can be reinforced through sharing of information, education and communication (IEC) materials such as video links[xlix,44] to caregiver's mobile phones.

BOX 5 Examples of technology options for remote counselling



IOCC

Using voice only
- Telephone
- Voice messages

Using voice and pictures
- WhatsApp/Facebook Messenger/Instagram/Telegram

Using voice and video
- Skype/Zoom/WhatsApp/FaceTime/ Facebook Messenger/Signal/Telegram

Challenges and Solutions Related to Delivering Face-To-Face Counselling in Emergencies

- **During displacement and when living in crowded conditions** (e.g., camps or evacuation shelters), space may be lacking for women to be counselled comfortably and privately which can negatively impact the counselling process. For mass sheltering scenarios, preparedness and response plans should ensure resources are allocated for the establishment of supportive spaces (e.g., mother baby areas or baby friendly spaces (BFS)) where women can safely and privately breastfeed[l,li]. Such supportive spaces can also be used to provide face-to-face breastfeeding counselling[45].

- **Where access is limited or sporadic** (e.g., insecure or hard to reach areas), follow-up may be conducted by community based counsellors (e.g., peer counsellors) or remotely using technology.

Other factors that may impede reaching caregivers with face-to-face counselling and potential solutions to enable the continuation of counselling are detailed in Table 2.

[42] Note: For example, during mobile outreach services or within a supportive space for IYCF-E placed within the community.

[43] Further guidance: https://www.llli.org/drip-drop-feeding/

[44] Tools: https://globalhealthmedia.org/videos/breastfeeding/

[45] Further guidance: GNC Technical Alliance (2020) Technical Brief: Supportive Spaces for IYCF-E.

A nutrition facilitator shows a colourful flipchart depicting breastfeeding positions to mothers at a Mother and Baby Area in the Rohingya refugee camps in Cox's Bazar, Bangladesh
SAVE THE CHILDREN/DAPHNEE COOK

Adaptations and Compromises

Full and unimpeded humanitarian access is a fundamental prerequisite to effective humanitarian action[lii]. However, attacks on humanitarian personnel and active hostilities have increasingly contributed to limited access to conflict affected populations in recent years[liii]. WHO's guidelines state that face-to-face counselling may be complemented *but not replaced* by telephone counselling and/or other technologies.

During emergencies where:
i) There is no humanitarian access and there are no immediate solutions[46]
ii) Suitable[47] counsellors cannot be immediately operational in the affected location
iii) Physical distancing public health measures are in place (e.g., during an infectious disease outbreak, see **Case Study 12**),
remote counselling may fully or partially[48] replace face-to-face counselling, if feasible[49]. Remaining in contact with caregivers who may otherwise feel isolated or abandoned can positively impact wellbeing and consequently also feeding and caregiving practices. Remote counselling may facilitate the rapid recruitment and training of counsellors in areas not affected by the emergency and facilitate support by experienced counsellors with advanced skills for dyads with complex counselling needs. As it appears to be better appreciated by caregivers and more effective[50, liv, 51] efforts should be made to establish or resume face-to-face counselling as soon as possible.

For an overview of key considerations and strategies to overcome **possible challenges related to using remote technologies** for counselling, refer to **Annex C**.

[46] Note: For example, remote training of peer counsellors to establish counselling capacity within communities is a solution that may take some time to establish and implement to an adequate standard if capacity was not established in preparedness.

[47] Note: Meaning those with the required characteristics and competencies, including language skills (see Chapter 5).

[48] Note: Meaning that basic counselling continues to be provided face-to-face but counselling requiring advanced competencies is provided remotely.

[49] Further guidance: Save the Children with the Collaboration of IFE Core Group (2021). Conducting and supporting IYCF-E e-Counselling: Considerations for Planning and Implementation.

[50] Research that is specifically related to virtual care in lactation is limited (Dhillon and Dhillon, 2020).

[51] Brown and Shenker (2020) reported that 72.6% of surveyed mothers who gave birth in the UK during the COVID-19 pandemic attributed stopping breastfeeding to a lack of face-to-face support caused by COVID-19 restrictions.

CASE STUDY 12 Remote breastfeeding support

At the start of lockdown measures implemented in the Philippines during the COVID-19 pandemic, a mother noticed a need for breastfeeding support in her community. In response to a post on a local Facebook group (a shopkeeper had lost her income and could no longer buy infant formula for her infant) she shared information about relactation; within two hours, she had received 35 queries. A remote team of five peer counsellors and two trained pediatricians were assembled. Rapid assessment and triage was done through Facebook messenger using a set of simple questions to determine who in the team would be best suited to support each woman. The majority of women wanted help increasing their milk supply and some wanted to relactate. Those reaching out were generally in the lowest wealth quintile and did not own breast pumps: hand expression and breast massage were taught remotely. The counsellors called every day to two days, depending on needs. In between calls, the counsellors would answer questions via Facebook messenger. This intensive support and 24/7 availability usually lasted around two weeks. The peer counsellors noticed that women were often panicked or agitated when they reached out so they would start by providing reassurance, making practical suggestions to improve maternal wellbeing (e.g., establishing how mothers could improve their diet with limited financial resources) and discussing how to calm and soothe the baby. Many of the mothers had not been the baby's primary caregiver prior to the pandemic; the counsellors realised that although it was difficult to describe the technicalities of breastfeeding over the phone, breastfeeding often came naturally once bonding and closeness was established. They therefore adapted their approach to focusing on bonding and building mothers' confidence. Cost, connectivity and lack of camera phones were barriers; the counsellors covered the cost of phone calls, used descriptive language (building on training on how to support people who are visually impaired) and asked specific questions (e.g., "where are your hands?"). A low resolution graphic was developed to overcome the cost of downloading videos.

***Source:** Philippines. Key informant interview, 2020*

4.4 ANTICIPATORY BREASTFEEDING COUNSELLING IN EMERGENCIES

WHO Recommendation 5

Breastfeeding counselling should anticipate and address important challenges and contexts for breastfeeding, in addition to establishing skills, competencies and confidence among mothers.

Adaptations and Compromises

In non-emergency settings, anticipatory guidance focuses on educating families about the normal anatomy and physiology of lactation and prepares them for normal and expected infant development and behaviours[lv, lvi]. Suggestions are provided in the IG-BFC on anticipatory guidance to provide at specific life stages such as preparing to introduce complementary foods. During emergencies, anticipatory guidance *also* involves (and may prioritise) anticipating and addressing challenges related to infant and young child feeding specific to the current emergency context.

By understanding a specific emergency context or imminent threat and anticipating how it may undermine or complicate breastfeeding (**Table 5**), counsellors can help to reduce potential risks and problems[52]. For example:

- During any emergency, it can be assumed that concerns about milk supply will be common[lvii]. Breastfeeding women should therefore be provided with anticipatory guidance concerning how stressful and difficult circumstances impact infant behaviour, that stress does not impact milk production[lviii]; the

[52] Note: Particularly in geographic regions with predictable, seasonal natural disasters, an important preparedness action is to ensure that counsellors are equipped with the skills and knowledge required to provide anticipatory guidance. The competencies required to appropriately support emergency-specific challenges are listed in 5 – COUNSELLING CAPACITY IN EMERGENCIES.

importance of effective (good positioning and attachment) and frequent milk removal to maintain supply and reliable signs that the infant is receiving enough breastmilk.

- If a counsellor is aware that **uncontrolled distributions of BMS** are taking place, she can counsel on the dangers of introducing BMS in the current setting and focus on building confidence to exclusively breastfeed.

- To help **prepare for evacuation** (e.g., during natural disasters such as wildfires), counsellors can provide anticipatory guidance on the basic supplies caregivers of BMS-dependent infants should bring with them[53].

BOX 6 Programmatic considerations for anticipating barriers to breastfeeding during emergencies

It is also important for decision makers and programme planners across all sectors to understand what factors facilitate breastfeeding and why breastfeeding problems may increase in a particular emergency context so that they can address the underlying causes to the greatest extent possible (Hirani et al., 2019). For example, in a camp setting, a programme planner can anticipate the problems that uncontrolled BMS distributions can cause and work with camp management to prevent BMS distributions in the camp to complement a breastfeeding counsellor's efforts. Numerous underlying causes can be addressed via multi-sector collaboration to create an environment that protects and supports breastfeeding, as outlined in Save the Children and UNHCR (2018) IYCF-E Multisectoral Framework for Action.

Breastfeeding counselling during emergencies
ARUGAAN/PHILIPPINES

[53] Further guidance: Gribble and Chad (2019). Evacuating with a baby? Here's what to put in your emergency kit. Online article – The Conversation.

Table 5: Possible challenges faced by caregivers during emergencies and their potential implications for breastfeeding

Individual level (mother, caregiver, infant, young child)		
Possible challenge related to the emergency	**Example**	**Possible implications for breastfeeding and breastfeeding support**
1. Poor child health and nutritional status	Increased rates or diarrhoeal disease in infants following uncontrolled BMS distributions, increased rates of malnutrition in children, poor health and nutrition status at birth e.g., low birth weight or premature[lix], poor pre-emergency IYCF practices	• Infants and young children who are severely ill or malnourished may be too weak to suckle effectively at the breast. • Beliefs about need to supplement infants (e.g., with formula) during illness may be prevalent. • Premature and/or LBW infants often require skilled breastfeeding support to overcome challenges such as fatigue and increased sleepiness, reduced feeding volume, long feedings, disorganised feedings, physical challenges, oral motor challenges (weak suck) and growth and nutrition concerns.
2. Poor maternal physical health and nutritional status[lx]	High exposure to aggravating factors including food insecurity, disease and poor sanitation, increased rates of morbidity and mortality, including increased rates of HIV infection among girls and women[lxi]	• Decline in maternal wellbeing reduces a mother's ability to responsively feed and care for children. Mother may breastfeed less often or for shorter durations. This leads to milk stasis, increased risk of engorgement, blocked ducts and mastitis and, eventually, a gradual decline in milk production. • Breastfeeding women whose nutrition has been compromised are likely to have concerns about the quality and quantity of breastmilk[lxii, lxiii, lxiv] despite milk production and quality being largely unaffected by diet unless malnutrition is severe. • Maternal malnutrition in pregnancy increases the rate of pregnancy complications and adverse birth outcomes (e.g., pre-term birth) and subsequent difficulties in establishing breastfeeding (see 1). • Mothers who are incapacitated by severe illness or malnutrition may require physical support to breastfeed/express milk. • During illness or disease outbreaks, caregivers may have concerns about the transmission of a communicable disease to their child[lxv] (e.g., Ebola, cholera, etc.). • During infectious disease outbreaks, mothers may wish to continue or restart breastfeeding to protect their infants[lxvi, lxvii] • Increased rates of maternal mortality result in increased numbers of non-breastfed infants. • Possible need for increased PMTCT interventions[lxviii]. Mothers living with HIV will require counselling on infant feeding recommendations within the emergency context. In the absence of antiretroviral (ARV) drugs, mothers living with HIV may need additional counselling to maintain confidence in the importance of breastfeeding for child survival and support on making it safer. • Fear of HIV transmission among families and health workers may result in inappropriate responses including avoiding breastfeeding (of biological/non-biological children) in the absence of testing and demand for, or offers of, BMS[lxix].

continued...

Table 5 continued...

Possible challenge related to the emergency	Example	Possible implications for breastfeeding and breastfeeding support
3. Low breastfeeding knowledge and spread of myths and misconceptions about breastfeeding[54, lxx, lxxi, lxxii, lxxiii]	Poor understanding of IYCF-E recommendations among response providers including health workers supporting MNCH[lxxiv], provision of conflicting advice and/or inappropriate promotion and prescription of BMS, harmful and disempowering media messages[lxxv], spread of myths and misconceptions	• Women's confidence in their ability to breastfeed their child safely and adequately is shaken, impacting breastfeeding self-efficacy and maternal wellbeing. • Poor understanding of the needs of breastfeeding women and their children during emergencies leads to calls for donations of BMS e.g., by the media (see 14). • Inappropriate information/advice is given to mothers leading to inappropriate feeding practices.
Possible challenge related to the emergency	**Example**	**Possible implications for breastfeeding and breastfeeding support**
4. Increased numbers of caregivers and infants with disabilities which cause feeding difficulties	Temporary disabilities e.g., injuries which prevent a mother from holding/breastfeeding her child[lxxvi]; environmental or nutritional factors may result in increased rates of congenital abnormalities in newborns e.g., cleft palates[lxxvii, lxxviii]	• Increased levels of non-breastfed infants if specialist breastfeeding support is not available. • Children with disabilities impacting feeding may require skilled breastfeeding support to overcome difficulties which may include inefficient feeding, increased risk of aspiration, oral motor challenges, sensory sensitivities and growth and nutrition concerns[lxxix].
5. Maternal mental health and psychosocial wellbeing negatively impacted[lxxx, lxxxi, lxxxii]	Increased levels of exposure to trauma, rise in GBV, loss of loved ones, high levels of caregiver concern about their/their child's immediate physical needs e.g., food, water, shelter, medical care, lack of access to growth monitoring/ infant weighing services for reassurance, breakdown of social networks/family structures and social isolation, breakdown or lack of access to postpartum support services and social networks[55]	• Caregiver's ability to responsively feed and care for their child is reduced. Mother may breastfeed less often or for shorter durations. • Maternal adrenaline inhibits the let-down reflex, slowing milk flow and mistakenly resulting in concerns around breastmilk supply[lxxxiii, lxxxiv, lxxxv]. • Maternal distress may result in increased infant fussiness, more frequent feeds, night waking and intolerance of maternal separation, commonly interpreted by mothers as signifying milk supply problems[lxxxvi]. • Beliefs about impact of breastfeeding while stressed or upset on infant wellbeing and breastmilk quality may be prevalent[lxxxvii, lxxxviii, 56, lxxxix] • Depression may interfere with mother-baby bond and result in early cessation of breastfeeding[xc]. Depressed mothers are less likely to seek care, including help with breastfeeding. • Increased levels of concern may cause mothers to keep babies closer than usual, resulting in more frequent breastfeeding and (in the case of newborns) earlier onset of lactogenesis II[xci]/ . • Trauma, fear and anxiety make it harder to learn how to breastfeed and care for a baby (mothers are in survival mode)[xcii].

continued...

[54] Brown and Shenker (2020); 4.3% of surveyed mothers in the UK were told by a health professional that breastfeeding might not be safe during COVID-19 which was associated with stopping breastfeeding.

[55] Brown and Shenker (2020) found that a high proportion of new mothers who had stopped breastfeeding perceived that a lack of social and emotional support had negatively impacted their breastfeeding experience. Many participants talked about missing meeting other breastfeeding mothers and socialising in baby groups or out with friends. Many talked about the isolation they felt which was impacting their wellbeing and mental health.

[56] Pantanella (2018) notes that while research demonstrates that dietary insufficiency rarely affects the amount or quality of breastmilk that a woman produces, this maternal perception represents a powerful barrier to enabling a lifesaving intervention.

Table 5 continued...

Household and social level		
Possible challenge related to the emergency	**Example**	**Possible implications for breastfeeding and breastfeeding support**
6. Changes in routine and family structures, increased burden on mothers	Disruption of daily routine, long queues for services (e.g., food distribution), constant or frequent movement during displacement, increased demands on women e.g., assuming additional role of head of household[xciii, xciv] and/or caring for the elderly and injured[xcv] and/or caring for older children at home[57, xcvi], changes in family structures and family living arrangements	• Mothers whose routine has been disrupted/ whose workload has increased may feed less often or for shorter durations. • Maternal exhaustion reduces mother's ability to recognise and respond to infant needs. • Mothers may experience pressure to wean from family members[58] and providers who perceive breastfeeding as a burden.
Possible challenge related to the emergency	**Example**	**Possible implications for breastfeeding and breastfeeding support**
7. Lack of privacy and overcrowding[xcvii, xcviii, xcix, c, ci, cii]	Changes in family living arrangements and conditions, lack of privacy while on the move during displacement/ evacuation, overcrowding in camps and shelters, long queues for services	• Mothers who do not feel comfortable breastfeeding in the presence of others (e.g., in queues, shared shelters) may feed less often or for shorter durations • Mothers may feel pressured to introduce a bottle or BMS at night when sleeping in close proximity to others (e.g., in crowded shelters) due to the false perception that this will reduce baby crying at night. • Lack of privacy can increase mothers' stress levels and feelings of dignity, impacting milk let-down reflex and maternal wellbeing (see 5).

continued...

[57] Brown and Shenker (2020) reported that many new mothers surveyed in the UK during the COVID-19 pandemic experienced stress related to establishing breastfeeding while having to care for older children who would usually not be at home.

[58] De Young et al. (2018) note pressure to wean from family members was a stressor frequently listed by breastfeeding women evacuating during the Fort McMurray wildfire in Canada.

Table 5 continued...

Institutional (service provision) level		
Possible challenge related to the emergency	**Example**	**Possible implications for breastfeeding and breastfeeding support**
8. Increased levels of mother-child separation[59, 60, ciii]	e.g., lack of evidence and/or poor understanding of infant feeding and care recommendations during outbreaks of new infectious diseases results in unnecessary separation, recommended separation and temporary cessation of breastfeeding e.g., in certain cases during Ebola outbreaks[civ]; accidental separation during displacement or at the onset of a natural disaster, forced separation in detention centres.	• Increased needs for support with regular breastmilk expression, storage and transportation (if feasible). Women may find the process emotionally and physically challenging, particularly if separated due to illness. • Separation disrupts breastfeeding[cv] resulting in an increase in the number of non-exclusively and non-breastfed infants. • Absence of skin-to-skin contact, proximity and breastfeeding influences early maternal-infant interaction and caregiving capacity and therefore infant mental health and development[cvi]. • Separation limits breastfeeding's protection against infectious disease[cvii]. • Mothers may experience negative emotions (e.g., loss of identify, feelings of failure, regret, shame, disappointment, grief and feeling let down) when the breastfeeding relationship ends prematurely[cviii]. Separation magnifies the maternal health consequences of insufficient breastfeeding[cix].
9. Increased rates of difficult/traumatic birth and postnatal experiences and practices that are not supportive of successful breastfeeding[cx, cxi]	Increased rates of pregnancy complications and adverse birth outcomes e.g., LBW or premature, increased rates of distressing or traumatic birth experiences e.g., birthing in an unfamiliar setting, birthing without family/partner support, increases in obstetric violence[cxii], lack of access to skilled birth support and emergency obstetric care, increased rates of Caesarean births[cxiii, cxiv]	• Decline in maternal wellbeing reduces a mother's ability to responsively breastfeed and care for child(ren) • A traumatic birth may cause breastfeeding to be difficult, including through delaying lactogenesis II, negatively impacting cognition and mood and interfering with bonding and attachment. Breastfeeding may also trigger flashbacks of traumatic birth or sexual violence[cxv]. • Caesarean births, birth complications and unsupportive practices may delay initiation of breastfeeding and skin-to-skin contact and lower newborn breastfeeding frequency, resulting in increased difficulties in establishing breastfeeding. • Increased rates of maternal mortality result in higher numbers of non-breastfed infants.

continued...

[59] Brown and Shenker (2020) reported that of 103 mothers surveyed in the UK who had a baby in the neonatal intensive care unit (NICU) during the COVID-19 pandemic, 19.4% (n = 20) were told they could not visit their baby in the NICU due to Infection Prevention Control (IPC) measures. Not being able to visit their baby in NICU was associated with no longer breastfeeding ($\chi 2 = 44.645$, $P = 0.000$). At the time of survey completion, 80.0% who were told they could not visit their baby were no longer breastfeeding compared with 9.6% of those who could.

[60] Gribble et al., (2020) found that during the COVID-19 pandemic, although many countries followed WHO guidance to keep mothers and their newborns together, others implemented IPC policies that imposed postpartum separation and discouraged or prohibited breastfeeding.

Table 5 continued...

Environmental level		
Possible challenge related to the emergency	**Example**	**Possible implications for breastfeeding and breastfeeding support**
10. Insecure access to supplies for BMS-dependent infants[cxvi]	Security constraints make travel to markets/shops dangerous to purchase BMS, supply chains interrupted/ damaged, besiegement, shortages due to panic buying following emergency measures declarations[cxvii]; reduced purchasing power[cxviii]	• Mothers may wish to restart breastfeeding to transition from mixed to exclusive breastfeeding to reduce infant formula use[cxix].
11. Increased gender based constraints, control and violence[cxx, cxxi]	n/a	• Abandonment of children born as a result of unwanted pregnancies or rape[cxxii] can result in increased number of non-breastfed infants. • Survivors of sexual violence may find breastfeeding distressing (e.g., experience flashbacks) or difficult. • Intimate partner violence is associated with breastfeeding difficulties[cxxiii]. • Increased rates of early/child marriage increase the risk of birth complications and adverse birth outcomes and subsequent breastfeeding difficulties in young mothers.
12. Inadequate Water, sanitation and hygiene (WASH)	n/a	• Women may minimise fluid intake due to lack of accessible drinking water or lack of acceptable toilet facilities (e.g., at border crossings[cxxiv] and on evacuation transport) resulting in severe dehydration and a temporary drop in breastmilk volume. • Difficulties adequately cleaning BMS preparation and feeding equipment[cxxv] and breast pumps[cxxvi] and hygienically preparing powdered infant formula. • Higher risk of malnutrition and diarrhoea in infants.
13. Increased levels of environmental toxins[cxxvii] **(e.g., in flood water) or radioactive contamination**[61]	n/a	• Mothers may have concerns about the safety of breastfeeding[62, cxxviii] • Mothers may have concerns about the safety of available foods.
14. Donations and uncontrolled distributions of BMS[cxxix, cxxx, cxxxi, cxxxii, cxxxiii, cxxxiv, cxxxv, cxxxvi, cxxxvii, cxxxviii]	n/a	• Blanket distribution of infant formula conveys negative message about breastfeeding, undermining maternal confidence in ability to breastfeed[cxxxix]. • Women who would normally breastfeed may introduce BMS and/or discontinue breastfeeding. • Increased rates of diarrhoeal disease among infants consuming donated BMS[cxl] impacts child health and maternal wellbeing (stress).

[61] Ishii et al., (2016) found that out of 16,001 women who had given birth around the time of the Great Japan Earthquake and subsequent Fukushima nuclear power plant incident, 20.3% of women who formula fed their babies did so because of concern regarding radioactive contamination of breastmilk. The use of formula was associated with residence in the evacuation zone and interruption of antenatal care. The authors noted the importance of breastfeeding support following the nuclear accident.

[62] Brown and Shenker (2020) reported that 22% of surveyed mothers who gave birth in the UK during the COVID-19 pandemic stated that worries about the safety of breastfeeding had affected their decision to stop breastfeeding.

CASE STUDY 13 Experiences of breastfeeding during a public health emergency

During the COVID-19 pandemic, lockdown and social distancing measures were imposed in the United Kingdom to limit the spread of the virus. An online survey of 1,219 breastfeeding mothers of infants revealed two very different experiences: 41.8% of mothers felt that breastfeeding was protected due to lockdown but 27.0% had a negative experience. Reported positive impacts of the lockdown included more time to focus on breastfeeding, fewer visitors, more privacy, increased responsive feeding, greater partner support and a delay of return to work outside the home. 18.9% of respondents stopped breastfeeding (mean age for cessation was 3.15 weeks) yet only 13.5% of this group described themselves as ready to do so. A high proportion of the group who had stopped breastfeeding felt that the lack of access to social and emotional support during lockdown (e.g., no visitors, baby groups cancelled) had negatively impacted their breastfeeding experience. Other negative impacts included a lack of face-to-face breastfeeding support, stress of trying to juggle caring for older children without family support, intense focus on breastfeeding (feeling overwhelmed), no experience of breastfeeding in public (feeling worried about future breastfeeding in public) and work pressures. These work pressures were particularly felt by health professionals who reported that very busy schedules and cumbersome personal protective equipment (PPE) resulted in engorgement or lowered milk supply. The researchers concluded that their findings were vital in understanding how to support those women who may be grieving their loss of breastfeeding and are affected by their negative experiences.

Source: *Brown and Shenker (2020) Experiences of breastfeeding during COVID-19: Lessons for future practical and emotional support.*

BOX 7 Programmatic considerations: integrated MHPSS and counselling

Pregnant women, mothers and infants are at increased risk of MHPSS difficulties during emergencies[cxli]. A woman's experience of breastfeeding and the breastfeeding support she receives can positively or negatively impact her mental health and her mental health can impact her ability to responsively feed and care for her child. Given how closely mental health and breastfeeding are connected, consider integrating MHPSS and counselling services[cxlii]. Embedding MHPSS activities within wider systems tends to increase access, carry less stigma[cxliii] and may amplify sectoral outcomes.

Tending to a caregiver's emotional health is an important component of counselling. Breastfeeding counselling programmes should be designed and implemented in a way that takes the psychosocial wellbeing of caregivers into consideration. Counselling should be conducted in comfortable and welcoming spaces which aid relaxation. It is important for counsellors to concentrate on being calm and kind, helping caregivers feel safe, giving realistic reassurance and not compelling caregivers to talk but actively listening when they do[cxliv]. Tools that assess both the caregiver-baby dyad's feeding practices and psychosocial wellbeing will give a more complete picture of their needs (**Annex C**). Where capacity exists, MHPSS support can be provided directly by counsellors. For example, simple relaxation interventions for breastfeeding mothers can positively impact infant behaviour and growth[cxlv]. An alternative is for MHPSS and counselling services to be co-located and well-coordinated so that caregivers can easily access both services. Group counselling activities can be co-facilitated by IYCF-E and MHPSS personnel. Even when referral mechanisms are in place between counselling and MHPSS services, it is helpful for breastfeeding counsellors to be trained on the provision of **trauma informed care** and **psychological first aid** (see 5 – COUNSELLING CAPACITY IN EMERGENCIES). Local culture brokers should be consulted to understand and navigate the cultural understanding of mental health issues in the emergency-affected area.

Mothers share their experiences during Typhoon Haiyan in a Women and Young Children Space
WORLD VISION/MONALINDA KADIZ

CASE STUDY 14 A psychosocial approach to breastfeeding counselling

Since 2017, ACF has implemented Baby Friendly Spaces (BFS) in refugee camps in Ethiopia. Attendees benefit from tailored psychosocial interventions in order to improve maternal and child health and wellbeing. In the BFS, psychologists and psychosocial workers ensure the safety of the space. This allows breastfeeding practices and the provision of psychosocial support to be optimised within a holistic mother and child friendly environment. In this context, the BFS programme is also considered as a nutrition-sensitive intervention aimed at preventing child undernutrition and supporting the recovery of malnourished children under two. Upon admission, intake interviews are conducted with mothers to obtain details about issues related to breastfeeding, pregnancy and wellbeing as well as other significant health-related information. Elements of the MAMI approach are integrated. Based on the interview, mothers and babies are invited to participate in recommended activities such as relaxation focus group discussions on child development, baby bathing and massaging and breastfeeding counselling. Beyond breastfeeding practices, a psychosocial approach to breastfeeding involves critical observation of mothers' daily routine practices such as child stimulation, hygiene, emotional attachment and bonding. All mothers receive regular one-to-one follow-up meetings that explore their psychosocial wellbeing and how it may be affecting their ability to provide care to their babies or themselves. Trained staff provide emotional support and build mothers' confidence in their abilities. In 2018, a study[cxlvi] conducted in collaboration with Johns Hopkins University showed that within a two-month period, improvements were observed in all domains of breastfeeding and statistically significant reductions were observed in signs of breastfeeding difficulty in terms of body positioning, response, emotional bonding, anatomy and suckling. Maternal mental health also improved.

Source: Action Against Hunger, Ethiopia. Email correspondence, 2020

5. COUNSELLING CAPACITY IN EMERGENCIES

This section focuses on how to identify and develop the capacity of human resources who can deliver counselling during an emergency. In order to ensure adequate capacity for counselling, it is necessary to understand 1) who can deliver counselling (service providers) and 2) what knowledge and skills (competencies) are required to counsel effectively during an emergency. Another important step is to conduct a **capacity assessment and mapping** to understand who is available to respond to the emergency and what competencies they have compared to what is needed. The final step is to implement a counselling **capacity building plan** to address any gaps identified during the capacity assessment. These steps are described within this chapter.

While capacity building activities such as training can effectively contribute to the timely restoration and strengthening of services during emergencies[cxlvii] (**Case Study 16**), **capacity development** efforts must go beyond training alone to support and empower counsellors in their roles[cxlviii]. Examples include putting in place breastfeeding policies, incorporating breastfeeding indicators into health information systems, ensuring the availability of counselling and referral protocols, ensuring counsellors have access to adequate technical support and improving the supply of key products, including BMS when necessary. Further guidance on capacity development can be found in the IG-BFC.

5.1 PROVIDERS OF BREASTFEEDING COUNSELLING

WHO Recommendation 6

Breastfeeding counselling should be provided as a continuum of care by appropriately trained healthcare professionals and community-based lay and peer breastfeeding counsellors.

Counsellors, supervisors and trainers will be needed to deliver counselling during an emergency. Both health professionals (e.g., midwives) and paraprofessionals (e.g., peers) can be breastfeeding counsellors (**Figure 2**). Who should deliver breastfeeding counselling as part of an emergency response will vary considerably depending on which providers and services offered counselling before the emergency and how they have been impacted. There may be 1) existing cadres who were already providing counselling before the emergency, 2) existing cadres who can add counselling to their tasks and 3) new cadres that can be established.

Figure 2: Possible providers of counselling: roles and responsibilities

Healthcare professionals	Paraprofessionals	Other breastfeeding supporters
Professionals within the health system such as physicians, midwives, perinatal nurses, lactation consultants, nutritionists, psychologists etc. • Trained and tasked to provide counselling, *mostly* at facility level • *May* also work at household and community level • *May* have multiple other responsibilities in addition to counselling • *May* have advanced counselling competencies including aspects of lactation management that require clinical knowledge and skills • Good knowledge of, and linkages to, the health system	**Lay and peer breastfeeding counsellors such as** mother-to-mother support group facilitators, community health workers, traditional birth attendants, psychosocial workers, etc. • Trained and tasked to provide counselling, *mostly* at household and community level • *May* also work at facility level • *May* have advanced counselling competencies that do not require clinical knowledge and skills • Good knowledge of, and linkages to, the community	**Frontline workers such as** IYCF educators, volunteers, mobilisers, hygiene promoters, child protection case workers, first responders, etc. • Trained and tasked with delivering general breastfeeding promotion and support including identification and referral (SRA)
Identification & counselling	Identification & counselling	Identification, education & general support

In circumstances where the local system cannot cope, consult available preparedness plans and consider deploying counsellors through emergency surge mechanisms (e.g., counsellor rosters, civil society groups), temporarily relocating national staff from unaffected areas and/or recruiting new personnel. Desired characteristics of counsellors are outlined in Box 8 below.

A health worker supports a mother to breastfeed her malnourished child
WORLD VISION/CHRISTOPHER LETE

BOX 8 Desired characteristics of counsellors

Preferred characteristics of individuals who provide counselling are outlined in the IG-BFC including a preference for female providers with similar characteristics to those counselling is intended for; who speak the same language and are familiar with local cultural and social customs. Personal breastfeeding experience can be helpful. Additional key considerations in emergency settings include:

- **Motivation.** Willingness and commitment to respond to the crisis are critical requirements[cxlix].
- **Acceptance.** It may be challenging to identify counsellors who are accepted by both the local authorities and the affected population. For example, in some contexts TBAs are well accepted by communities but not by national health systems. A possible solution that may enhance community acceptance of counselling services is to engage with communities and local authorities to task shift TBAs to work alongside (accompany) counsellors.
- **Conflict and context sensitivity.** Consider the safety and security of counsellors in their expected role. Where surge capacity is provided through mobilising counsellors from other locations, pay close attention to nuances in culture, custom and language. Particularly in the context of conflict, be sensitive to the drivers of the conflict when deploying counsellors (do no harm) and be aware of potential community mistrust of staff with certain profiles.
- **Gender.** Staffing a programme that relies on a majority of female staff can be challenging in contexts where husbands may prevent their wives from working or it may not be seen as socially acceptable for women to work, travel or visit homes unaccompanied. Potential solutions include engaging community and religious leaders, planning for counsellors to work in pairs and channelling recruitment through local partners who are trusted and accepted by the community. Counselling services should anticipate and accept that a proportion of female counsellors will require maternity leave and that some may not return to work after marriage or childbirth and plan accordingly. Particularly when working in emergency conditions, it may be challenging for counsellors themselves to breastfeed as recommended. Family and breastfeeding friendly policies – such as paid maternity leave, access to childcare, breastfeeding breaks and dedicated breastfeeding/breastmilk expression spaces – promote gender equality and support women's participation in the workforce[cl].
- **Expatriate counsellors.** Dependence on expatriate providers raises concerns about long-term sustainability, cost effectiveness and cultural appropriateness of services. If they are temporarily necessary as a last resort (e.g., during international mass displacement), ensure they are culturally competent (see 5.2 – COUNSELLING COMPETENCIES) and that part of their role is to strengthen local capacity.
- **Language.** When available counsellors do not speak the same language (or dialect) as the emergency-affected population (as may be the case in IDP or refugee contexts), translators or a remote counselling modality may be used as an interim solution. Both may hamper communication and the establishment of the counsellor-caregiver relationship. When recruiting translators, pay close attention to the demographics (e.g., gender, age, ethnicity) of translators. It is important that translators are trained on concepts such as "exclusive breastfeeding" which may not be easily translated and understood in other languages. Counselling capacity should be established within the affected community as soon as possible.

Establishing capacity in a way that ensures IYCF practices are protected, promoted and supported at household, community and facility level will have the greatest impact (see **Figure 3** for an example of a 3-tier system).

Key considerations for counsellors (service providers) at facility level

Health workers play a critical role in minimising disruption to and supporting breastfeeding[63,64,cli, clii], a low-cost, high-impact child survival intervention that is especially relevant during emergencies. Breastfeeding counselling is an important component of treatment and recovery in certain clinical settings (for example, when treating infantile diarrhoea or malnutrition, particularly in infants under six months[cliii]). However, good counselling takes time and skill. During emergencies, health workers may:

[63] Castillo et al., (2016) report on experiences from the Philippines following Typhoon Haiyan which demonstrated that in emergency settings, training of health workers can lead to improved IYCF practices; three months following training on an Essential Intrapartum and Newborn Care (EINC) package breastfeeding initiation rates had improved from 50% to 86%.

[64] Brown and Shenker (2020) reported that significant associations were found between being told that breastfeeding may not be safe and feeding practices; surveyed new mothers living in the UK during the COVID-19 pandemic who had stopped breastfeeding were more likely to have been told by a healthcare professional that breastfeeding was not safe (X2 = 18.84, P = 0.000)

- Lack the time to meet all counselling needs
- Deprioritise breastfeeding support due to increased need for curative services
- Lack necessary counselling competencies or knowledge of lactation

Possible ways to overcome these barriers are suggested in Table 2. If health professionals have not been adequately trained in preparedness (as recommended in the IG-BFC), given the time required for adequate training, it may not be possible or advisable to remove health workers from their posts for training in the acute phase of an emergency. Instead, health workers should be rapidly and regularly *oriented* on key infant and young child feeding recommendations and general breastfeeding promotion and support and instructed on how to identify and refer dyads requiring counselling (e.g., using the SRA). This helps to ensure pregnant and breastfeeding women receive accurate and consistent information and prevents breastfeeding from being undermined[cliv]. It is important for some health workers to be equipped with counselling competencies that require clinical skills as soon as possible to enable appropriate clinical management of lactation (e.g., prescription of antibiotics to treat mastitis, if necessary).

The immediate availability of counselling services at facility level can be ensured through **placing a dedicated IYCF/breastfeeding counsellor** within services[65]. Placing counsellors within health teams brings clinical and counselling services together and can help to avoid the creation of parallel systems that may diminish community trust in health services or weaken the health system. If counselling services are delivered through sectors other than health, it is important to ensure clear linkages to health services.

The protection, promotion and support of breastfeeding in facilities providing maternity/perinatal services need to be maintained and, where necessary, strengthened during emergencies[clv]. Maternity service providers are in contact with priority populations for counselling at critical times; their actions can significantly influence the breastfeeding journey of a mother and her infant[66]. Even when dedicated counsellors are needed within maternity services, **maternity care providers** (e.g., midwives, maternity nurses) must be enabled (through service planning and capacity building) to provide basic counselling and to support early initiation of exclusive breastfeeding[67, 68, 69, 70]. In line with global guidance, the Ten Steps to Successful Breastfeeding of the WHO/UNICEF BFHI should be integrated into maternity/perinatal services during emergencies[71, 72]. Health facilities that are BFHI-accredited should ensure BFHI standards are maintained to the greatest extent possible, even when the emergency context does not allow for external assessment, accreditation and monitoring.

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[65] Hargest Slade and Gribble (2011) describe how, following the 2011 Christchurch earthquake, the first author worked as a breastfeeding adviser in the maternity unit of a hospital located in the area most of the emergency-affected population evacuated to. After the earthquake, she worked within the health system to provide support to breastfeeding women who had evacuated. The presence of individuals within the health system who had the skills to provide appropriate breastfeeding support and were supported to do so was identified as a key factor that made it possible to provide effective support to breastfeeding evacuees. This is an example of how health systems can respond effectively in emergencies to support breastfeeding mothers.

[66] Note: Maternity care providers are usually also well suited to support breastfeeding in emergencies (used to working with mothers and infants, familiar with their needs, motivated to support them) and have typically already received some pre-service breastfeeding education.

[67] Further guidance: IFE Core Group (2021). Infographic: Early Initiation of Breastfeeding in Emergencies – Guidance for Maternity Service Providers.

[68] Note: Similar considerations can be applied to traditional birth attendants who can play an important role in contexts with high rates of community births.

[69] Further guidance: https://www.healthynewbornnetwork.org/resource/newborn-health-humanitarian-settings-field-guide/

[70] https://resourcecentre.savethechildren.net/node/11145/pdf/iafm_on_reproductive_health_in_hs_2018.pdf

[71] Further guidance: IFE Core Group (2017). Infant and Young Child Feeding in Emergencies. Operational Guidance for Emergency Relief Staff and Programme Managers

[72] A cluster-randomised controlled trial by Yotebieng et al. (2015) in Kinshasa, DR Congo, found that a basic two-day (16h) training of health workers on BFHI Steps 1-9 significantly increased exclusive breastfeeding (36% compared to 12% in the control group) and decreased diarrhoea rates at age six months. The study found this low-intensity, low-technology short-cut (without accreditation) intervention was suitable for rapid scale-up in maternity settings and can be considered as a means to rapidly reduce under five child mortality.

Key considerations for counsellors (service providers) at community level

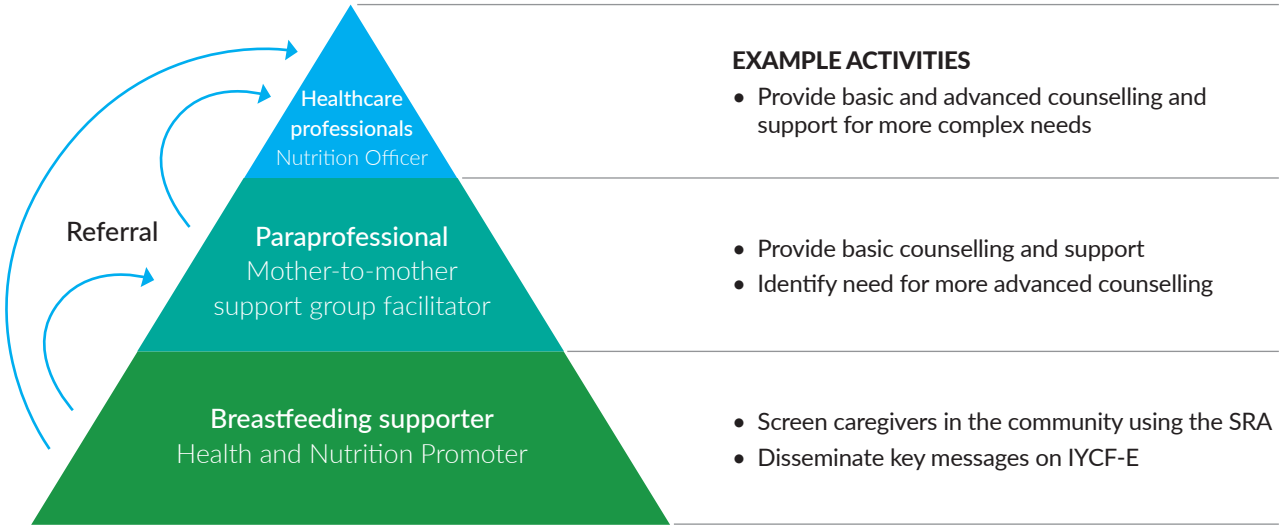
Counsellors at the community level are commonly known as **peer counsellors** or **paraprofessionals**. Emergency response primarily occurs at the local level with community members who are serving as first responders[clvi]. If present, counsellors from breastfeeding community support organisations are an important resource who can be rapidly mobilised. In many emergency contexts[73], members of the affected community can also be trained to become breastfeeding counsellors. Motivated, experienced mothers can provide peer counselling to a set number of households in their community and/or facilitate mother-to-mother support groups.

Strengthening counselling capacity at community level via peer counsellors is important[clvii] given that:

- Peer counsellors often have similar experiences to those of other emergency-affected women which can facilitate relationship and rapport building and can be an important source of social support at times when social networks and structures are disrupted.
- When privacy is lacking, peers can help to build confidence to breastfeed in the presence of others.
- It has been found that training and deployment of peer counsellors can prevent unnecessary use of BMS in emergencies (see **Case Study 16**)[clviii].
- Establishing counselling capacity within emergency affected communities can potentially improve access and coverage[clix], alleviate pressure from overwhelmed health systems, help overcome language barriers (particularly in refugee contexts), allow for increased trust and improved understanding of culturally-sensitive topics[clx], permit simultaneous focus on local capacity strengthening and creating more sustainable services[clxi] and empower communities to help themselves.

It is essential that linkages with the health system are maintained (see **Figure 2**), that lay counsellors are recognised and appreciated, have access to technical support and the equipment and resources needed to counsel safely and effectively and that they know when and how to refer complex cases (see REFERRAL SYSTEMS).

Figure 3: Example of a 3-tier system for provision of counselling and support at multiple levels[74]



[73] Note: A significant investment in time, training and supportive supervision is required to establish quality peer counselling interventions. This is unlikely to be feasible during the acute phase of a rapid onset emergency or in contexts with high population movement.

[74] Note: This is an example for provision of counselling and support that starts with SRA at the community level with mothers referred to different levels based on difficulties and counselling needed. Other scenarios also exist that may include SRA at different levels.

5.2 COUNSELLING COMPETENCIES

To ensure continuity of care, all counsellors, across and within any sectors and agencies who are engaged in infant and young child feeding as part of the emergency response, should be equipped with a **consensus-driven set of core counselling competencies** (knowledge and skills). Such a set can be agreed upon within coordination mechanisms such as the nutrition cluster. Informed by needs assessment, this set should focus on the **essential counselling skills and knowledge needed to address the most urgent needs of the emergency-affected population**.

Competencies are considered **basic** or **advanced**. Competencies that require specific skills or medical knowledge are considered advanced competencies. Basic competencies are required to achieve advanced competencies. The basic and advanced competencies that can be considered for inclusion in the set of core counselling competencies are listed in Table 6 below.

The following should be considered when **defining the set of core counselling competencies required for an emergency response**:

1. In resource-limited settings, the focus should be on equipping counsellors with the competencies required for **simple, effective, low-cost, low-technology interventions** such as listening and reassurance, skin-to-skin contact, hand expression and cup feeding[clxii]. So that the greatest number of caregiver-baby dyads can be helped, competencies should aim to address the most common sub-optimal practices that carry the greatest risk[75], the most widespread IYCF problems and caregiver concerns[76] and prevalent myths and misconceptions that may be relevant during counselling[77, clxiii].

2. Regardless of setting, most counselling needs can be met with the **basic counselling competencies** required for both emergency and non-emergency settings. These competencies should *always* be included in the set of core competencies for *all* counsellors and put in place as a first step.

3. Some counsellors may also be trained and evaluated on **advanced counselling competencies**. Relactation is an important advanced competency in emergencies[clxiv]. Depending on their role, counsellors may require further competencies (e.g., supportive supervision or mother-to-mother support group facilitation) not specified in this guidance.

4. In emergency settings, counsellors are likely to need **additional competencies** in order to provide appropriate support and fully meet the needs of the emergency affected population. These additional basic and advanced competencies are listed in the right hand column of Table 6 below.

    a. Some competencies, such as *help a mother to breastfeed when stressed*, are applicable to *all* emergency settings and should therefore *always* be included in the set of core counselling competencies. Rapid training may be needed to equip existing counsellors with these competencies if this was not done in preparedness.

    b. Some competencies, such as *help a mother to breastfeed during infectious disease outbreaks*, are applicable to *some* emergency settings and should therefore *sometimes* be included in the set of core counselling competencies, depending on the specific cultural and/or emergency context. Whether they will be needed can be decided during scenario-planning in preparedness or during needs assessment. These are listed in *italics*.

[75] Note: For example, non-exclusive breastfeeding is particularly risky in emergency settings where sanitation and hygiene are poor.

[76] Note: Across emergencies, the research conducted for this document found that the most common concern caregivers have is "not enough milk".

[77] Note: There will always be diversity within communities and cultural contexts and it is therefore essential to practice active listening to adapt counselling to an individual's needs and beliefs.

A breastfeeding counsellor supports a mother to relactate using the drip drop method with donor human milk
ARUGAAN/PHILIPPINES

Considering the diverse and multiple needs of breastfeeding women during emergencies, it may not always be possible to have immediate support available for all breastfeeding problems. Start by ensuring basic counselling competencies are in place. Additional counselling competencies can gradually be added according to a phased capacity building plan as counsellors' knowledge, skills and confidence improve and the response progresses.

Table 6: Breastfeeding counselling competencies for emergencies

Basic breastfeeding counselling competencies	Considerations for emergencies
Use listening and learning skills (1)	
• Ask open ended questions • Use responses and gestures that show interest • Reflect back what the mother says • Empathise – show that you understand how the other person feels • Avoid words that sound judgemental • Use helpful non-verbal communication • Adapt communication style and content to the caregiver e.g., particular barriers, challenges, needs, preferences and values.	Same as in non-emergencies
Use skills to build confidence and give support (1)	
• Acknowledge what a mother thinks and feels • Recognise and praise what a mother and child are doing right • Give practical help • Give relevant information • Use simple language • Make one or two suggestions, not commands	Same as in non-emergencies
Assess and document	
• Feeding histories of healthy and sick infant(s) or young child(ren) • Learn the mother's history, present difficulties and possible future challenges • Breastfeeding of healthy and sick infant(s) and young child(ren) • Observe the mother feeding and interacting with her baby • Observe the infant(s) general condition, measure and assess growth using growth chart(s) • Observe general condition of the mother, check and palpate breast(s) as needed	• Conduct an SRA and FA for a breastfed infant (**Annexes A** and **B**) • Conduct an FA for an artificially fed infant and calculate an infant's caloric and volume requirements to prescribe/ provide BMS to a BMS dependant infant

continued...

Table 6 continued...

Assist mothers to:	
• Initiate breastfeeding within an hour of vaginal or Caesarean birth • Position themselves and their infant(s) for breastfeeding • Attach their infant(s) to the breast • Understand how breastfeeding works • Respond to feeding cues (understand and practice responsive feeding) • Hand-express breastmilk • Cup or spoon-feed their infant(s) • Manage flat or inverted nipples • Manage sore or cracked nipple(s) • Manage engorgement of their breast(s), recognise mastitis • Recognise the signs of adequate milk transfer, swallowing and infant satisfaction • Manage perceived insufficient milk supply • Manage low or excess milk supply • Breastfeed and soothe infant(s) who cry frequently or have sleeping difficulties	• Overcome concerns about breastmilk quality and safety[78] • *Breastfeed in crowded public spaces/in the presence of others*[79] • *Breastfeed at night*[80] • Understand the heightened risks of using feeding bottles, pacifiers or BMS in the current context and the risks of not breastfeeding[81] • Breastfeed when stressed[82] • Breastfeed when busy[83] • Feed a non-breastfed child • *Breastfeed someone else's infant (wet nurse)* • *Breastfeed during infectious disease outbreaks and take appropriate infection prevention control measures*[84] • *Reject donations of BMS, feeding bottles and teats*
Prepare:	
• Pregnant women for breastfeeding • Mother(s) to breastfeed exclusively for six months • Mother(s) who are returning to work or having periods away from their infant to maintain breastfeeding • Mother(s) for timely, appropriate, adequate and safe complementary feeding • Mother(s) who wish to wean their infants or young children from breastfeeding	• *Caregivers to feed and care for infants and young children during an expected crisis/ natural disaster*
Refer:	
• Recognise when to refer mothers and infant(s) to breastfeeding counsellors with advanced competencies or healthcare professionals with specialised skills, as needed	• Identify needs beyond counselling and make appropriate referrals[85]

continued...

[78] Note: In humanitarian settings, it is very common for breastfeeding women to be concerned about the quality of their breastmilk, particularly when their diet has changed due to the emergency. They may also be concerned about the safety of their breastmilk – for example, if they have been exposed to chemicals in floodwater.

[79] Note: Although the preference is to build confidence to breastfeed in public, there may not be sufficient time or contact opportunities to achieve this (e.g., during mass displacement). Where appropriate, shawls may be provided e.g., as part of dignity kits.

[80] Note: For example, counselling on safe sleep arrangements and breastfeeding positions can be helpful in overcrowded conditions where mothers may feel pressure to supplement a crying baby at night.

[81] Note: Particularly in settings where artificial feeding was common prior to the onset of the crisis, interest in breastfeeding may be low. Counsellors need strong interpersonal and communication skills to bring attention to breastfeeding as well as analytical skills to understand a caregiver's needs and current situation. In accordance with global guidance (OG-FE), BMS should only be provided to infants who meet set eligibility criteria. However, maternal choice is an issue counsellors may find difficult to navigate. This is particularly common for peer counsellors (who are "close" to the mother) or counsellors who normally work in non-emergency, high resource settings. Training on the ethics of maternal choice, drawing comparisons between the pre-crisis and the current context with its increased risks and mechanisms for referral to experienced counsellors may be helpful

[82] Note: Listen, build confidence about milk supply and information on reassuring signs that baby is getting enough breastmilk, discuss stress management techniques, counsel on skin-to-skin and responsive breastfeeding, counsel on positive aspects of breastfeeding (e.g., calming hormones and bonding).

[83] Note: For example, show a mother how to use a (provided) baby sling, counsel on responsive breastfeeding and how to breastfeed while queuing or walking, explore possible ways to decrease workload (including during family discussions/home visits).

[84] Note: For example, hand and breast hygiene, use of a face mask (e.g., respiratory illness outbreak), handling expressed breastmilk (e.g., of a mother recovering from Ebola Virus Disease).

[85] Note: For example, malnutrition treatment services, food assistance, SGBV services, MHPSS support can be considered as the action principles of *look*, *listen and link* which are part of psychological first aid.

Table 6 continued...

Advanced breastfeeding counselling competencies	Considerations for emergencies
Assist mothers to:	
• Manage mastitis • Manage candida • Manage tongue tie (ankyloglossia) • Breastfeed a LBW, pre-term or sick infant(s) • Successfully breastfeed despite deeply inverted or very large nipple(s) • Breastfeed infant(s) or child(ren) with disabilities • Breastfeed infant(s) through difficult personal circumstances or postpartum depression • Breastfeed infant(s) who are refusing to breastfeed (nursing strike) • Induce or re-establish lactation (relactation) • Manage feeding an infant who needs fluids other than breastmilk	• Breastfeed a malnourished infant • *Rapidly stop breastfeeding*[86] • Suppress lactation following infant loss or stillbirth • Maintain lactation while separated from their infant • Reduce or stop supplementation and use of bottles, nipple shields and teats • Hygienically prepare and responsively feed a breastmilk substitute[87] • *Cost and maximise available food to support maternal diet*[88] • Practice Lactation Amenorrhea Method (LAM) for family planning • *Feed their infant while living with HIV*[89]
Prepare:	
• Pregnant women at high-risk for low milk supply • Pregnant women who are HIV positive to breastfeed • Pregnant women at high-risk to breastfeed a small, sick or preterm infant(s)	Same as in non-emergencies
Refer:	
• Recognise when to refer mothers and infant(s) to counsellors with basic breastfeeding competencies for follow-up with healthcare professionals with specialised skills, as needed	Same as in non-emergencies

Additional competencies required for emergencies

- **Psychological first aid.** Because mental health services are often lacking or overwhelmed during emergencies, psychological first aid is an important skillset that all counsellors should possess to support caregivers in the aftermath of crisis events and to prevent trauma from taking root in the first place.

- **Trauma informed care.** To avoid doing harm, provide effective care and improve access to services, it is important that breastfeeding counselling programmes serving populations with high levels of exposure to trauma apply a **trauma informed approach** (see definitions). This includes equipping counsellors with trauma informed care competencies. The first tier of trauma-informed care (TIC) is universally offered to all counselling clients on the assumption that anyone may be a survivor of trauma (universal care) and is a basic competency required for all counsellors. The second tier of TIC is trauma-specific care for clients identified as survivors of trauma and is considered an *advanced* competency. Finally, some caregivers will require specialised support from trained mental healthcare providers. Where trauma-specific and trauma-specialist care is available, it is important that counsellors are trained on when to refer (see **Figure 4**).

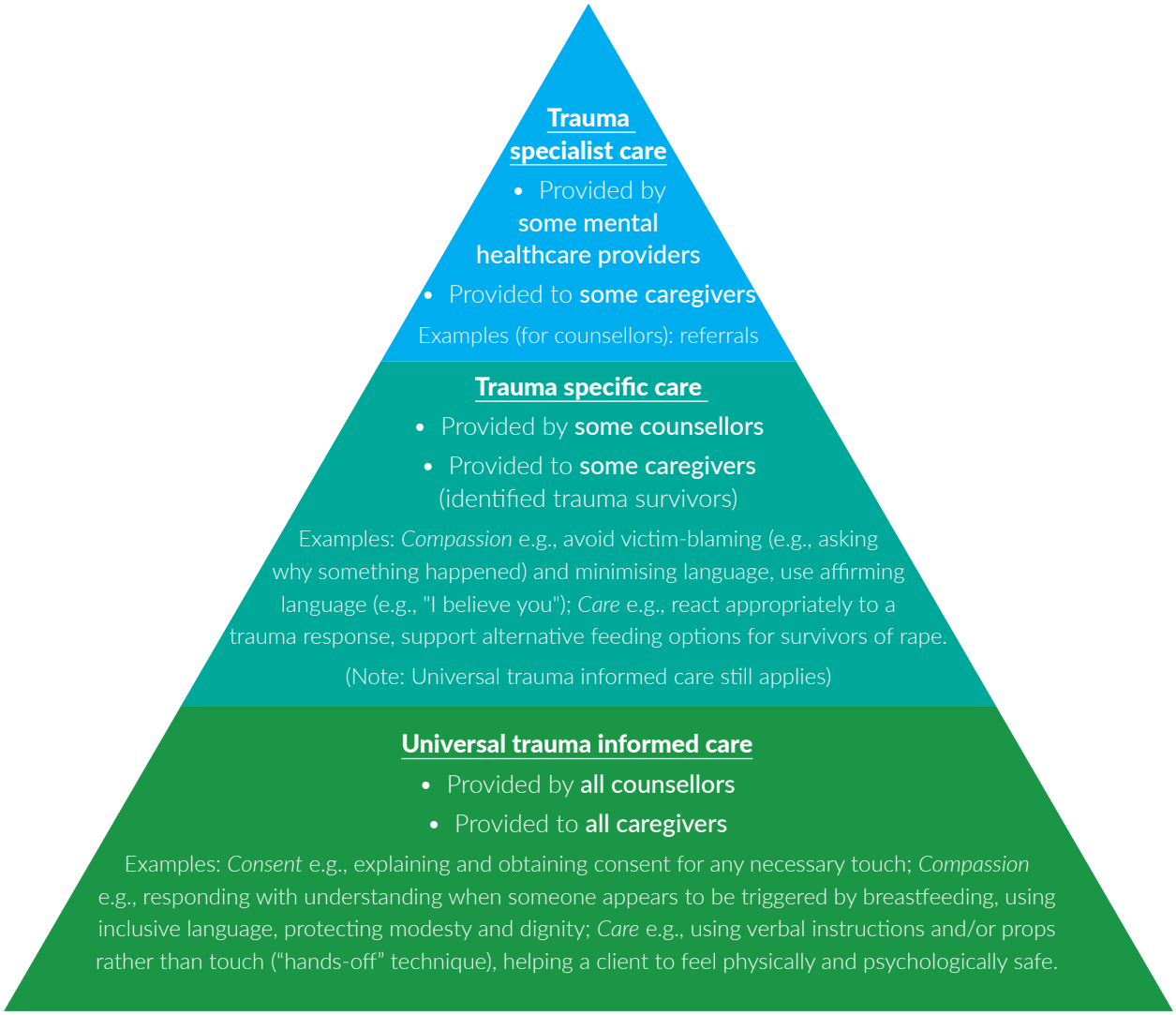
[86] Note: This competency is rarely required. It is particularly relevant during outbreaks of infectious diseases for which breastfeeding cessation is recommendation if infected e.g., Ebola Virus Disease. Support should include counselling on breast care, safely discarding breastmilk (if recommended), providing emotional support and facilitating replacement feeding for the infant. Note that breastfeeding cessation should be done gradually rather than rapidly whenever possible.

[87] Note: Including provision of information on preparation, feeding and storage.

[88] Hashmi et al. (2019) describe how counselling in Mae La refugee camp in Thailand was tailored for mothers by providing cheaper food options for infants and specific examples of low cost meals to meet minimum acceptable diet requirements based on household expenditure data collected during monthly home-based counselling sessions.

[89] Further guidance: WHO (2018). Operational Guidance: HIV and Infant Feeding in Emergencies.

Figure 4: Example of multi-tiered approach to trauma-informed care



- **Cultural competency.** Counsellors must be culturally competent as an important component of trauma informed care. Key to the design of culturally sensitive interventions is an understanding of caregivers' perceptions and other factors driving feeding practices[clxv]. Examples of culturally informed knowledge about infant feeding include the traditional use of natural galactagogues[90], traditional newborn care practices and postpartum traditions, communal caretaking practices[91], maternal perceptions of factors that can impact breastmilk supply[92] and quality[93], myths and misconceptions that have arisen during the emergency, attitudes towards modesty, maternal beliefs about BMS and to what extent breastfeeding

[90] De Young et al. (2018) identified jwano as a spice traditionally used to boost lactation in Nepalese families. Evidence is limited on the impact of natural galactagogues ("milk boosters") on infant weight gain and milk production in mothers of healthy, term infants (Foong et al, 2020). However, facilitating access to locally known galactagogues (with no known adverse effects) may benefit women's confidence and emotional wellbeing. Counsellors' priority should be to identify and correct the causes for low milk production.

[91] De Young et al. (2018) noted that caretakers in the post-earthquake settlements in Nepal expressed that infant care was a communal activity and the responsibilities of infant and childcare were shared. This kinship of breastfeeding was reflected in the ways in which women supported one another in the villages and tent camps.

[92] Emerson et al. (2017) found that mothers in the DRC often perceived that stress caused milk insufficiency and frequently made associations between poor maternal nutritional status and difficulties breastfeeding (pain while breastfeeding or perceived milk insufficiency).

[93] Dorneman and Kelly (2013) found that mothers in post-earthquake Haiti believed the quality of their breastmilk would deteriorate if their diet was poor or the mother was afflicted by a psychosocial condition known as "bad blood". To protect children in these situations, early supplementation was introduced.

is a part of maternal or religious identity. **Where counsellors are not from the emergency-affected population**, additional knowledge and skills will be required to enable them to understand caregivers' cultural, ethnic, religious, linguistic and socioeconomic needs so that they can operate effectively and ethically in a multicultural environment.

- **Counsellors who normally work in non-emergency settings** are likely to be aware of, but may have little practical experience of, practices such as relactation and wet nursing[94] or issues such as malnutrition in infants. Lactation professionals deployed from high-resource settings may be accustomed to working with tools such as feeding bottles, breast pumps and nipple shields and must be supported to adjust their practice to the context. Even when working in high-income settings, it is imperative that counsellors are aware of the increased risks of using such tools during emergencies and supported to adapt their practice to simplified, safer approaches (e.g., using the drip-drop relactation method rather than a supplementary feeding device, using hand expression as a safer alternative to breast pumps, cup feeding as a safer alternative to bottle feeding).

- **Early Childhood Development.** Counsellors should have basic knowledge of ECD including the skills and capacities that children acquire in the first years of life and the critical role of responsive caregiving, including responsive feeding. The responsive interactions that naturally occur during breastfeeding and that can be extended through playful communications lay the foundation for the child's future health, behaviour and intellectual abilities.

CASE STUDY 15 Supporting IYCF in the context of Ebola Virus Disease

In August 2018, an Ebola Virus Disease (EVD) outbreak was declared in the Democratic Republic of the Congo (DRC). By the time the outbreak ended in June 2020, 3,470 confirmed and probable cases had been reported. Women and infants were disproportionately affected. In line with global and national guidance, breastfeeding women were recommended to stop breastfeeding if they, or their child, developed EVD-like symptoms. Ebola is an exception to global breastfeeding recommendations because available evidence indicates that the risks of EVD infection outweigh the risks of not breastfeeding. Mother-baby dyads admitted to a facility for testing were jointly counselled by a nutritionist and a psychosocial worker on the recommendation to temporarily be separated and stop breastfeeding. No cases of refusal were reported, attributed to the counselling process and integration of psychosocial support. Infants received BMS as part of a comprehensive package of support. Gaps in national guidance for this stage of care included how to support a mother to rapidly stop breastfeeding, hand expression as a technique to prevent engorgement and inflammation, instructions on how to handle and discard expressed breastmilk of mothers with EVD according to Infection Prevention Protocols. Upon discharge, caregivers were counselled on hygienic artificial feeding and cup feeding. Mothers who had survived Ebola were also counselled on the possibility of re-starting breastfeeding once two consecutive laboratory tests confirmed that the virus was no longer detectable in her breastmilk. At community level, trained psychosocial workers (supervised by nutritionists) followed-up and supported women to increase or re-start breastmilk production once it was deemed safe to do so. Relactation was found to be a challenging process. Mothers expressed worries around restarting breastfeeding after EVD infection and the availability of nutritionists to support the intensive relactation process was limited. A key lesson learned from this experience was that, if not yet in place, it is vital to focus on building breastfeeding counselling competencies from the start of an EVD response.

Source: *Global Nutrition Cluster (GNC) Technical Alliance (2020). Supporting Non-Breastfed Children as part of an Ebola Response. Experiences from the Democratic Republic of the Congo.*

[94] Palmquist and Gribble (2018) identify lack of education and support for relactation and wet nursing as one of the most common barriers to an effective IYCF-E response.

BOX 9 Important topics to cover during training

- **How to provide breastfeeding counselling services in practice during emergencies.** Where, when, how often and how to counsel (i.e., the content of this guidance). Counsellors should also be trained on when and how to correctly use job aids and other tools.
- **The lifesaving importance of breastfeeding in emergencies as well as the risks associated with use of BMS**[95]. This is key to solidifying provider motivation.
- **How breastfeeding practices may be undermined or damaged by the emergency** (see **Table 5**) to enable the provision of anticipatory counselling.
- **How breastfeeding works.** Counsellors should have an excellent understanding of how breastfeeding works and its robustness so that they can confidently counsel mothers who are malnourished or stressed. It can be particularly challenging to counsel a caregiver whose diet is compromised due to **food insecurity**; counsellors should be aware of what foods are available and at what cost to enable sensitive and practical counselling on maternal diet. Adequate time and attention should be given to ensuring that counsellors understand the relationship between breastfeeding and infant and maternal mental health and caregiving capacity, that **stress** does not directly impact breastmilk production and how to effectively convey this knowledge to a caregiver.
- Complementing the above with knowledge of the **potential mental health consequences of emergencies**[clxvi] has the potential to ensure compassionate counselling of stressed or traumatised caregivers.
- **How behaviour change works.** Changing behaviour can be particularly challenging in emergencies, given the various stressors present and the potentially short duration of an emergency. Understanding how to effectively bring about behaviour change and that it is a stepwise process[clxvii] that takes time and repeated contacts can prevent counsellor demotivation and frustration.
- **The basics of the humanitarian system.** To make effective referrals and successfully advocate for the needs of caregivers and their children, counsellors should be equipped with a basic understanding of humanitarian coordination mechanisms, the package of humanitarian services being delivered and referral pathways.
- **How the OG-IFE and the WHO International Code applies to emergency settings in general and a counsellor's role specifically and how to report Code violations.**

5.3 CAPACITY ASSESSMENT AND MAPPING

Capacity assessment and mapping is an important activity to identify learning and human resource planning needs. It should ideally be conducted in preparedness and rapidly updated at the start of an emergency. If this has not been done, a rapid capacity assessment and mapping should be conducted as soon as possible after the onset of the emergency.

1. **Identify *how many* counsellors are needed and *where* they are needed (needs assessment).** In addition to existing services, new services and structures requiring counselling services may be set up in response to new or heightened needs (e.g., malnutrition treatment or psychosocial support services, cholera treatment centres – see 3.2 – KEY ENTRY POINTS FOR BREASTFEEDING COUNSELLING IN EMERGENCIES). Counsellors may also be requested to provide services in temporary locations where the affected population is sheltering such as camps or evacuation centres.

2. **Identify *who* is available to deliver counselling and where they are.** At the start of the response, rapidly verify how many existing counsellors in the area are able to work/function. Many countries have a pre-existing supply of breastfeeding counsellors who should be viewed as an important resource in an emergency[clxviii]. However, they may have been affected by the emergency themselves. Counselling supervisors and trainers can also be identified through reviewing and updating any existing local database of counselling trainers as well as national expertise and breastfeeding support networks.

[95] Tool: IFE Core Group (2021). Brief: Breastfeeding Counselling in Emergencies.

3. **Understand what level of knowledge, skill and confidence to provide counselling during emergencies exists**[96]. At the start of the emergency, rapidly review capacity assessments conducted in preparedness or – if these are not available – rapidly consider the overall level of pre-emergency support for breastfeeding and whether health professionals and other responders interacting with infants, young children and their caregivers have adequate breastfeeding knowledge and skills (e.g., through examining pre-service and in-service training materials and reports) and experience of counselling in emergency contexts. Consider the education and literacy levels and professional background[97] of those available to provide counselling.

At later stages of the emergency response, more in-depth individual level capacity assessments[98] can be carried out to assess which competencies counsellors already have and which need to be developed. These may be different for different cadres. Multiple choice quizzes[99] and observation of counselling contacts using performance checklists can be used to assess pre-training knowledge and skills respectively.

Note individual capacity assessments should be part of a broader capacity mapping exercise[100, 101] that also examines programming and coordination capacity, amongst others[clxix].

5.4 CAPACITY BUILDING PLANNING

Depending on the number of trained and available counsellors and their level of emergency preparedness, as determined during the capacity assessment and mapping exercise, there may be a need to **rapidly but carefully plan and implement orientation and training**[102] for those tasked with counselling as part of the response (see **Box 8** for additional training guidance).

- **Within 72 hours/as soon as possible:** provide a generic, pre-positioned orientation for early response teams. Rapid orientation on new or heightened breastfeeding challenges can support existing counsellors to deliver appropriate services to the affected population.

- **Week 2–4/once the capacity assessment and mapping exercise is complete:** Develop and roll out a tailored **capacity building plan** with measurable learning objectives which plans for comprehensive training for new counsellors/further orientation and training for existing counsellors. The plan should include government and partner plans for training, practical skills building, training follow-up, refresher training, ongoing learning, supportive supervision (see 5.5 – JOB AIDS) and monitoring the impact of the training. Update pre-positioned training materials based on the results of the **capacity assessment** and the agreed upon **core set of counselling competencies**. Where available, ensure that lessons captured during previous emergency responses are also integrated into training packages.

- **Ongoing:** Continue system strengthening and building local capacity to ensure sustainability of services after the emergency[clxx]. In addition to regular supportive supervision, provision of reference materials (e.g., educational videos) and opportunities for ongoing learning can reinforce learning for providers working under pressure. It is recommended to organise refresher training every six months to refresh existing skills and knowledge and to share new evidence, tools, and experiences.

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[96] Tool: Tech RRT and Save the Children (2020). IYCF-E Individual Capacity Assessment Tool for Health and Nutrition Service Providers. https://www.nutritioncluster.net/IYCF-E_Ind_Cap_Assessment

[97] Note: For example, skilled midwives who are refugees and do not have permission to work as midwives in their host country can be trained to become counsellors. Note that having a professional background or formal education is not required to be an effective counsellor.

[98] Tool: Save the Children and Tech RRT (2020). IYCF-E Individual Capacity Assessment Tool for Health and Nutrition Service Providers https://www.nutritioncluster.net/IYCF-E_Ind_Cap_Assessment

[99] Note: How they are administered can be adapted to the cadre e.g., a verbal multiple choice quiz can be conducted if peer counsellor's literacy levels are low (in a circle, facing outwards).

[100] Tool: Save the Children and Tech RRT (2020). IYCF-E Capacity Assessment / Mapping Report Template.

[101] Tool: Global Nutrition Cluster (2020). IYCF-E Checklist.

[102] Tool: Save the Children and Tech RRT (2020). IYCF-E Standard Operating Procedures for Emergency Response Teams.

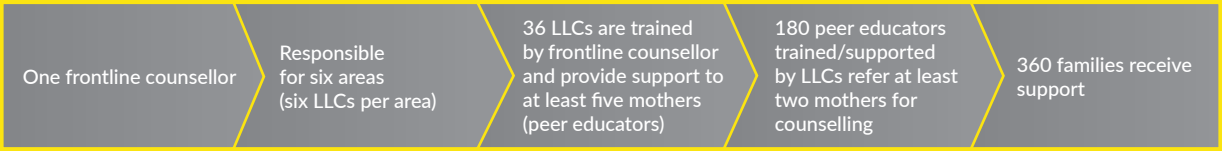
BOX 10 Key considerations for training in emergencies

- **Use methodologies that support adult learning including practical-skills building.** True active listening and supportive two-way discussions may be a new experience for trainees, particularly in settings with a didactic healthcare culture of "telling women what to do". Given the increased difficulties in effectively communicating in times of high stress or when noisy transmission and distraction are present, adequate attention and time should be dedicated to strengthening "listening and learning" and "building confidence and giving support" skills, including through role-play simulation of potentially challenging situations (e.g., counselling a mother who is malnourished, distressed or disinterested in breastfeeding). Trainees should also practice using job aids and reporting tools. On-the-job practice during which trainees apply each core competency a set number of times under supervision may help to compensate for insufficient practice during training. See the IG-BFC for further guidance.
- **Identify the right trainers with the right expertise.** While national trainers (e.g., from the Ministry of Health or national expertise and breastfeeding support networks) should ideally deliver training, their availability may be affected by the emergency. If preparedness has been inadequate, they may also lack emergency-specific counselling competencies themselves. Therefore, deployment of external trainers for training, mentoring and supportive supervision may be warranted. In settings where it is not considered culturally appropriate for men to train female staff, to counsel women or to observe counselling, women should be selected to become master trainers.
- **Address existing beliefs and assumptions:** Those recruited as counsellors may have beliefs, assumptions or feelings about infant feeding that are not supportive of successful breastfeeding. It can sometimes be difficult for individuals who have practiced inadvisable behaviours (e.g., prelacteal feeding) to counsel others against doing the same. Sufficient time must be allocated to process provider beliefs and reflect on past feeding practices in light of new knowledge to ensure that counsellors do not reinforce culturally based myths and misconceptions about infant feeding and care.
- **Consider a modular approach:** During emergencies, competing capacity building activities and local emergency recovery efforts often involve the same set of (limited) local human resources (Castillo et al; Garg et al 2016) . It may be more efficient and effective to spread out training with opportunities to apply skills in practice in between modules and to focus efforts on on-the-job training and mentoring. Standardised counselling modules can be added to planned training curricula on maternal newborn and child health (MNCH) in emergencies. Advanced or more specialised counselling competencies can be added gradually.

CASE STUDY 16 Cascade training

At the start of the 2006 Yogyakarta Earthquake Response in Indonesia, there were few trained breastfeeding counsellors able to provide skilled breastfeeding counselling. The number was not enough to address the counselling needs of thousands of mothers and to counteract inappropriate distributions of donated BMS that were occurring. To address gaps in infant and young child feeding response and ensure the highest possible coverage, quality and sustainability, a 'cascade' system of training and breastfeeding counselling was activated. The 40-hour WHO/UNICEF training course was delivered to community workers/volunteers and village midwives. Training was delivered for 3–4 hours twice a week over a period of six weeks. Facilitators met regularly to evaluate the training process. Twelve frontline counsellors/trainers were placed in the community, each covering six areas. Each frontline counsellor recruited six local lactation counsellors (LLCs) from each of the areas and was responsible for training 36 LLCs over a six week period. Each LLC was required to provide direct support to five mothers before graduating. Mothers provided with support were recruited as peer educators and required to refer at least two other mothers to LLCs for counselling. The cascade approach led to a 'trickle' effect with each frontline trainer indirectly reaching up to 360 families (total programme reach: around 4,260 families). A monitoring exercise showed that more mothers initiated breastfeeding in the first hour after birth and that 63% of 54 mothers interviewed were exclusively breastfeeding regardless of access to free BMS, attributed to counselling and support received from LLCs. Considerations for cascade training included the varied level of education of LLCs, the cost of the training (approximately USD225 per LLC due to the need to bring trainers from the central level) and the relatively longer time needed to administer the training taking into consideration the extension of the trainings over a six week period.

Source: Assefa, F., Sukotjo, S., Winoto, A., & Hipgrave, D. (2008). Increased diarrhoea following infant formula distribution in 2006 earthquake response in Indonesia: evidence and actions. Field Exchange 34, 29.



Supportive supervision

Regular[103] supportive supervision, as described in the IG-BFC, is particularly important during emergency responses as new counsellors may quickly be given significant responsibility following rapid training. Supervisors play a vital role in supporting and monitoring the quality of counselling service provision and evaluating the effectiveness of in-service training and other capacity building activities. Supervisors may be the trainers of the counsellors as well as lactation consultants or other experienced breastfeeding counsellors. Where services are integrated with other disciplines, ensure interdisciplinary collaboration and supervision (e.g., PSS supervisors can supervise counsellors and jointly review client records with counselling supervisors). New local trainers and supervisors should themselves be adequately supported, including through training on how to conduct supportive supervision[104], the provision of tools (e.g., supervision checklists[105] and learning materials) and access to technical support as needed (See **Case Study 17**).

CASE STUDY 17 Supportive supervision

During the Rohingya Crisis, Save the Children (SC) set up a nutrition programme providing basic and skilled IYCF support in 12 Mother-Baby-Areas (MBAs) and other nutrition facilities (IYCF corners) within refugee camps in Cox's Bazaar, Bangladesh. A main challenge voiced within the nutrition cluster was the lack of skilled staff available to provide IYCF counselling and serve a population of almost one million. SC conducted a two-day IYCF-E training based on the national IYCF training package for over 140 newly recruited health and nutrition staff. In addition, a supportive supervision system was put in place to ensure ongoing support for the newly trained counsellors as follows:

1. **On-site support:** At each nutrition facility, a nutrition supervisor was available onsite to provide daily routine support for the different nutrition services, including IYCF counselling.
2. **Rotational supervision and support:** A core group of five trained senior IYCF specialists were further trained on supportive supervision and tasked to provide onsite support to IYCF counsellors on a rotational basis. Each member of the core group was assigned to a number of MBAs/IYCF corners to visit to:
    1. Observe and provide feedback and guidance on individual and group counselling sessions conducted by the IYCF counsellor
    2. Review data recording tools and forms
    3. Meet with the IYCF counsellors to discuss challenges and recommendations.

The continuous and systematic supervision helped to improve the consistency and quality of counselling services provided and to ensure effective monitoring and tracking of counselling services.

Source: Save the Children, Bangladesh. Key informant interviews, 2020.

Where access is limited or specialist support is required for complex cases, remote supervision and mentoring can be considered to ensure counsellors are adequately supported. Technology can be particularly useful for monitoring in insecure and inaccessible areas of operation (See **Case Study 18**) However, real-time support can be challenging due to connectivity issues and time zone differences. It is also important for remote mentors to be familiar with the cultural and emergency context and response. Ongoing learning and support for counsellors can be facilitated through supervised peer to peer support, such as online group chats (e.g. WhatsApp groups[clxxi]) and regular reviews of difficult cases with team members.

[103] Note: More frequent supervisory contacts are likely to be needed where training of new counsellors has been shortened due to the emergency. Criteria used for selecting priority areas for supportive supervision visits can include poor breastfeeding practices, low counselling coverage rates, poor reports from previous supervision visits, low post-training test results, areas with recent reports of disease outbreaks, uncontrolled BMS distributions or other threats to breastfeeding.

[104] Tool: UNICEF (2013). Supportive Supervision/Mentoring and Monitoring for Community IYCF. https://sites.unicef.org/nutrition/files/Supervision_mentoring_monitoring_module_Oct_2013(1).pdf

[105] Tools: Save the Children's IYCF-E Toolkit – Section H (examples of supervision and observation checklists).

CASE STUDY 18 Remote monitoring and supportive supervision

From 2017 to 2018, Save the Children (SC) piloted an integrated, remotely managed IYCF-E and PSS programme in Southern Syria. The programme was implemented by a local partner. SC staff did not have access to the project sites to directly supervise and support activities and therefore needed to rely heavily on data. For security reasons, it was not possible to video or record one-to-one counselling sessions. To mitigate the impact of the lack of on-the-ground presence on counselling quality, SC invested significantly in MEAL capacity (training, mentoring and coaching of dedicated MEAL staff, electronic tablets) and developed an innovative MEAL system using KOBO. As SC's implementing partner was new to IYCF-E, SC opted to closely follow activities through day-to-day monitoring and supervision. The partner's relatively inexperienced IYCF supervisors were provided with an IYCF-E counselling supervision checklist and were remotely supported by experienced technical staff. The quality of one-to-one IYCF-E counselling sessions was indirectly supervised by SC's programme manager (PM) through spot-checking Full Assessment forms (scanned and uploaded via KOBO each day) to verify whether issues had been picked up on, correctly noted and appropriately handled by the counsellors. Counsellors also extracted key information (date, child's age, feeding practices, support provided) into a behaviour change tracking tool to allow tracking of changes in feeding practices over time (programme impact). At the end of each day, counsellors summarised their activities in an electronic form sent to SC. Once a week, SC's PM discussed the received data with their partner staff and provided feedback. While the day-to-day monitoring system was found to be a time-, training and staff-intensive investment that took time to set up, it did facilitate communication between SC and partner staff. It also allowed for increased control, transparency and a continuous model of improvement whereby SC had oversight of daily IYCF-E activities at each centre and could provide regular feedback. For example, the PM received valuable information on the type and number of activities carried out by each counsellor, the operating hours of each centre and the working hours of each counsellor. The PM could ask questions (e.g., why a certain counsellor was doing less follow-ups than their colleagues or why attendance was higher in some centres than others) and provide support in response.

Source: *Save the Children (2018). Review: IYCF-E and PSS Programme in South Syria.*

5.5 JOB AIDS

Job aids supplement counselling by reinforcing the discussion and grasping of concepts by the caregiver (e.g., educational tools), as well as guiding and documenting the counselling process for the counsellor (e.g., checklists and forms). They are particularly important during the early phase of an emergency when counsellors may not have much experience to build confidence and improve quality support. It is essential that job aids used during an emergency response are adapted to the emergency context (e.g., culture, available food, public health recommendations), the counsellors who will use them and the population they are intended for (**Case Study 19**). For example, different job aids may be needed when counselling caregivers from refugee and host communities. In low-literacy settings, pictorial job aids can serve to remind breastfeeding counsellors of key knowledge and skills (**Case Study 20**). Refer to the IG-BFC for an overview of job aids.

Although visual tools are important, where possible, **practice with the mother** in order for her to see, listen to and feel her own body. The counsellor can also use her own body or ask the help of other mothers to act as 'model mother' (e.g., to demonstrate hand expression).

Job aids that counsellors may use in emergencies to support and document the counselling process can include Full Assessment forms (**Annex B**), breastfeeding observation checklists[106] and postpartum visit checklists[107] among others. Counsellors can also maintain client case files to which information is added during each counselling visit to track progress, monitor behaviour change and ensure continuity of care.

[106] Tool: https://resourcecentre.savethechildren.net/sites/default/files/documents/4.11._template_of_breastfeed_observation_form.docx

[107] Tool: https://www.unicef.org.uk/babyfriendly/baby-friendly-resources/implementing-standards-resources/breastfeeding-assessment-tools/

CASE STUDY 19 Adapting counselling cards

In response to the COVID-19 pandemic, UNICEF and USAID Advancing Nutrition, with the support of the Infant IFE Core Group represented by Save the Children and Safely Fed Canada, have developed a counselling package, Infant and Young Child Feeding Recommendations when COVID-19 is Suspected or Confirmed. The set is based on the original set of counselling cards which have been adapted to reflect the global recommendations from WHO and UNICEF (March 2020) on IYCF in the context of COVID-19. The cards were developed in a way that they can be adapted and updated to reflect new or emerging evidence as well as different emergency contexts.

CASE STUDY 20 Home-based counselling for low-literacy refugee mothers

Hashmi et al. (2019) report on a small-scale study which piloted educational materials for home-based counselling of refugee mothers along the Thai-Myanmar border. Educational materials (a "health-baby flipbook") were designed to feature a basic script for health workers and photos of locally available, appropriate foods for largely illiterate mothers. Important elements of the script were adapted and updated based on findings from focus group discussions that provided common rationale among refugee mothers for inappropriate behaviours.

Source: Hashmi et al. (2019). The Healthy Baby Flipbook: piloting home-based counselling for refugee mothers to improve infant feeding and Water, sanitation and hygiene (WASH) practices.

5.6 WHAT TO DO WHEN THERE IS NO BREASTFEEDING COUNSELLING CAPACITY

Breastfeeding counselling should be considered as a lifesaving activity in the first phase of an emergency[108, 109]. However, where counselling capacity has not been adequately established in preparedness or where counsellors are not immediately available, the following steps can be taken to protect and support breastfeeding[110] while action is taken to establish counselling capacity:

1. **Prevent harm:** Sensitise humanitarian actors on the Code and emergency-specific infant feeding recommendations. To prevent breastfeeding from being undermined, health workers in contact with pregnant women and mothers – including those working in the informal health sector – are usually a priority group to sensitise. Take proactive steps to prevent separation of children from mothers/caregivers. Prevent donations and uncontrolled distributions of BMS and feeding bottles[111] including through engaging different sectors in preventing, monitoring and reporting on Code violations. To protect caregiver wellbeing and prevent re-traumatisation, orient responders working with the caregivers of infants and young children on universal trauma-informed care.
2. **Advocate and plan for basic multi-sector breastfeeding support and protection**[112]. Enable priority access for pregnant and breastfeeding women to essential services, facilitate non-separation of children from their caregivers (e.g., provide baby carriers), register households with pregnant women, children under two years of age and at risk groups and provide supportive spaces to breastfeed[113]. For further guidance on how all sectors can contribute to the establishment of a breastfeeding-friendly environment see UNHCR and Save the Children (2018) A Multisectoral Framework for Action
3. **Communicate effectively about IYCF-E.** The right message at the right time from the right person can save lives. To be effective it is important to be first, be right, be credible, express empathy, promote action and show respect[114]. Among others, audiences include emergency-affected communities and their leaders, emergency responders and public health officials[115] and the media[116].

[108] High quality counselling *does* save lives; however, it can be difficult to achieve in situations where caregivers are highly stressed, exhausted or distracted. The feasibility, acceptability and potential impact of counselling needs to be carefully considered during high-stress, mass displacement situations and a minimum package of essential breastfeeding support activities defined.

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6. KEY RESOURCES

GUIDELINES

WHO and UNICEF (2017) Protecting, promoting and supporting breastfeeding in facilities providing maternity and newborn services. *English.*

WHO (2018) Guideline: Counselling of Women to Improve Breastfeeding Practices. *English.*

WHO (2020) Guideline: Improving Early Childhood Development. *English.*

GUIDANCE

Academy of Breastfeeding Medicine. Protocols. *English, Spanish and more. Guidelines for the care of breastfeeding mothers and infants, covering various breastfeeding problems and clinical situations.*

WHO and UNICEF UK. The International Code of Marketing of Breastmilk Substitutes. *English. Includes guidance for health professionals on working within the WHO International Code.*

WHO (2011) Psychological First Aid: Guide for Field Workers. *English, Arabic, French, Spanish and more.*

WHO and UNICEF (2018) Implementation guidance: protecting, promoting, and supporting breastfeeding in facilities providing maternity and newborn services: the revised Baby-friendly Hospital Initiative 2018

WHO and UNICEF (2018) Operational Guidance: HIV and Infant Feeding in Emergencies. *English, French, Spanish, Arabic and Russian.*

COUNSELLING CAPACITY

Capacity Assessment and Mapping

Tech RRT and Save the Children (2020) IYCF-E Individual Capacity Assessment Tool

Tech RRT and Save the Children (2020) IYCF-E Capacity Assessment / Mapping – Report Template

Online Learning

Caroline Global Breastfeeding Institute Breastfeeding University. *English. Short modules for staff working in healthcare settings and childcare settings.*

UNICEF Agora: Nutrition in Emergencies Learning Channel – IYCF-E Short Course

Training Packages

UNICEF Community Based IYCF Counselling Package. *English and French. Includes planning guide, adaptation guide, facilitator guide, training aids , participant materials and further resources. Also includes a module on supportive supervision, mentoring and monitoring.*

WHO and UNICEF (2006) IYCF Counselling: An Integrated Course. *English, Spanish and Russian. Training course for health professionals and lay counsellors. Includes trainer's guide, participant's guide, director's guide, training follow-up guidelines.*

WHO and UNICEF (2020) BFHI Training Course for Maternity Staff. *English. Includes trainer's guide, participant's guide, director's guide and customisation guide.*

WHO and UNICEF BFHI Competency Verification Toolkit. *English. Comprehensive toolkit to assess staff competency in the knowledge, skills and attitudes needed to implement the Ten Steps.*

Job/Training Aids

CDC (2019) Storage and Preparation of Breastmilk. *English and Spanish. Poster.*

Global Health Media Breastfeeding Videos. *English, French, Spanish, Arabic and more. Videos for counsellors and mothers describing how to support mothers with breastfeeding, how to breastfeed and how to overcome common challenges.*

IBFAN, Safely Fed Canada, Breastfeeding Advocacy Australia and La Leche League International Cup Feeding. *English, French, Spanish and More. Posters describing a simple three-step process for cup feeding.*

IBFAN, Safely Fed Canada, Breastfeeding Advocacy Australia and La Leche League International Drip Drop Feeding. *English, Spanish and more. Posters and videos describing a simple three-step process on using the drip-drop method to encourage infants to feed at the breast.*

La Leche League Tear Sheet Toolkit. *English. Tips and tools for breastfeeding mothers and their families.*

UNICEF Community Based IYCF Counselling Package. *English, French, plus examples of country-level adaptations. Counselling cards for community workers.*

UNICEF IYCF Image Bank. *Images of recommended IYCF practices, which can be used for job aids and other tools.*

REFERENCE WEBSITES FOR COUNSELLORS AND PARENTS

Breastfeeding Support
Kellymom
UNICEF UK – The Baby Friendly Initiative
Australian Breastfeeding Association

FURTHER RESOURCES ON IYCF-E

GNC Technical Alliance Nutrition for Infants and Young Children. *English and more. Technical assistance and resources.*

IFE Core Group IFE Core Group Resources and Outputs. Guidance and tools for IYCF-E programming.

IFE Core Group (2017) Operational Guidance on Infant Feeding in Emergencies (v3.0). *Key global guidance on IYCF-E programming. English, Arabic, French, Spanish and more.*

IFE Core Group EN-NET IYCF-E Forum. *English and French. Free and open online platform to provide field practitioners with prompt technical advice for operational challenges.*

Save the Children IYCF-E Toolkit. *English, with some documents in Arabic and French. Collection of information and practical resources to guide the rapid startup of an IYCF-E response.*

Glossary

Best practice statement: Inclusive language does not deliberately or inadvertently exclude people. Instead, it acknowledges diversity, conveys respect to all people, is sensitive to differences and promotes equal opportunities. The phrase "mothers and other caregivers" has been used in this document in acknowledgement that not all people who birth a child identify as a mother and, particularly in emergencies which are often characterised by high morbidity and mortality rates and increased mother-child separation, not all primary caregivers of infants and young children are mothers. What terminology is appropriate to use is culture and caregiver dependent. In line with the basic principles of counselling, counsellors should actively listen and reflect whatever language the person they are counselling is using, including how they want to be referred to. When unsure, it is better to ask than to make assumptions.

Antenatal: The time from conception until birth.

Artificial feeding: The feeding of infants with a breastmilk substitute.

Breastmilk substitute (BMS): Any food (solid or liquid) being marketed, otherwise represented or used as a partial or total replacement for breastmilk, whether or not suitable for that purpose. In terms of milk products, recent WHO guidance has clarified that a BMS includes any milks that are specifically marketed for feeding infants and young children up to the age of three years. See the Code definition for more details (OG-IFE, 2017).

Breastfeeding: The provision of breastmilk, either directly from the breast or indirectly through expression. Note that the feeding of expressed breastmilk can also be referred to as "breastmilk feeding" to more accurately describe *how* an infant is fed, in addition to *what* they are fed.

Breastfeeding counsellor: Health professional or paraprofessional who has appropriate training to provide breastfeeding counselling.

Client-led counselling: Caregiver initiates counselling when needed/wanted.

Competency: The capability to use a set of related knowledge and skills to successfully perform identified jobs, roles or responsibilities. Breastfeeding counselling competencies can be either basic or advanced competencies.

Complementary feeding: The use of age-appropriate, adequate and safe solid or semi-solid food in addition to breastmilk or a breastmilk substitute in children aged 6-23 months (OG-IFE, 2017).

Continued breastfeeding: The provision of breastmilk beyond the first six months of life (OG-IFE, 2017).

Early initiation of breastfeeding: Provision of mother's breastmilk to infants within one hour of birth.

Exclusive breastfeeding: An infant receives only breastmilk without any other liquids or solids, not even water, except for oral rehydration solution or drops or syrups of vitamins, minerals or medicines (WHO, 2016).

Frontline workers: Emergency/humanitarian responders who interact directly with the emergency-affected population. Examples include community health workers, midwives, child protection caseworkers, hygiene promoters and distribution staff.

Full Assessment (FA): A systematic way for trained counsellors to gain an in-depth understanding of the feeding practices of a child under two years of age in order to assess and analyse what type of support is needed. The FA commonly follows on from the Simple Rapid Assessment (SRA).

Group counselling: Counselling of a group of pregnant women, mothers or other caregivers during the antenatal or postpartum period which allows them to share their breastfeeding experiences and support

one other. Group counselling may have an educational component but is distinct from purely educational, lecturing or classroom-style teaching. Group counselling is facilitated by a counsellor who may identify individual mothers who require one-on-one breastfeeding counselling.

Individual level assessment: A process to evaluate a caregiver-baby pair, establish infant feeding practice and needs and decide what type of support may be necessary. There are two levels of assessment: Simple Rapid Assessment and Full Assessment (OG-IFE, 2017).

Infant: A child aged 0-11 completed months (may be referred to as 0-<12 m or 0-<1 year). An older infant refers to a child from the age of six months up to 11 completed months of age (late infancy) (OG-IFE, 2017).

Lactation consultant (International Board Certified Lactation Consultation – IBCLC): Allied health professional who has received a minimum of 90 hours of lactation specific education as well as clinical experience. Lactation consultants have advanced competencies which enable them to provide breastfeeding counselling and support for complex breastfeeding issues.

Lay counsellor: A type of paraprofessional (see definition). In the context of breastfeeding, an individual who is not a certified healthcare professional who has been trained to provide breastfeeding counselling.

Low birth weight (LBW): Newborns with a weight of less than 2,500 grams, irrespective of gestational age (OG-IFE, 2017).

Nurturing care: Characterised by a caregiving environment that is sensitive to children's health and nutritional needs, responsive, emotionally supportive and developmentally stimulating and appropriate with opportunities for play and exploration and protection from adversities (WHO, 2020).

Paraprofessional: A type of breastfeeding counsellor trained to perform counselling without a formal professional/graduate-level qualification. Paraprofessionals often work with and as an extension of professional breastfeeding counselling services. They assist professionals but are not licensed or credentialed as healthcare, nutrition or lactation consultant professionals. Paraprofessionals with extended training and advanced competencies can support more complex breastfeeding problems. Examples include peer counsellors and lay counsellors.

Peer counsellor: A type of paraprofessional. Breastfeeding peer counsellors are women or caregivers from the community to be served who usually have prior breastfeeding experience and are trained to provide knowledge, experience, emotional and practical help to breastfeeding mothers. Peer counsellors may also be known as "mother-to-mother counsellors".

Peer support group: A group of mothers (or other caregivers) who meet regularly to share their breastfeeding experiences and knowledge to support each other in feeding and caring for their infants. A peer support group may be moderated by a professional or paraprofessional who may provide breastfeeding counselling to individual mothers. A peer support group may also be called a "mother support group" or "mother-to-mother support group". Peer support groups involving fathers are known as "father support groups" or "father-to-father support groups".

Postnatal period: The time immediately after birth until six weeks (42 days) thereafter. The postnatal period consists of immediate (first 24 hours), early (day 2-7) and late (day 8-42) periods.

Prevention of mother-to-child transmission (PMTCT): Programmes and interventions designed to reduce the risk of mother-to-child (vertical) transmission of HIV (OG-IFE, 2017).

Preparedness: The capacities and knowledge developed by governments, professional response organisations, communities and individuals to anticipate and respond effectively to the impact of likely, imminent or current hazard events or conditions (OG-IFE, 2017).

Psychological first aid (PFA): First-line emotional and practical support for someone experiencing acute distress following a recent (large scale or individual) crisis event. PFA key action principles are to *look*, *listen* and *link* as part of a humane and supportive response.

Relactation: The resumption of breastmilk production (lactation) in a woman who has stopped lactating, recently or in the past, in order to breastfeed her own or another infant, even without a further pregnancy. *Induced lactation* is the stimulation of breastmilk production in a woman who has not previously lactated (OG-IFE, 2017).

Responsive feeding: Part of responsive caregiving and an approach to feeding which involves recognising a child's cues (e.g., hunger, fullness, need for comfort) and responding appropriately. Feeding responsively recognises that feeds are not just for nutrition but also for love, comfort and reassurance between baby and caregiver. Responsive *breastfeeding* also involves responding to a mother's own need to breastfeed her baby (e.g., to relieve engorgement, for connection).

Simple Rapid Assessment (SRA): A simple screening tool that does not require training in breastfeeding used to rapidly prioritise mothers or other caregivers for full assessment and further counselling (Module 2 IFE).

Supplementary feeding device: A lactation aid that allows for supplementary feeding (with expressed breastmilk, donor breastmilk or infant formula) at the breast (OG-IFE, 2017).

Supportive space: An overarching term that describes the different kinds of safe spaces where pregnant women and girls, mothers and other infants and young children can access support with feeding and caring for their children and themselves during emergencies. Included in this term are Baby Friendly Spaces, Mother Baby Areas, Baby Tents and IYCF Corners, among others (GNC Technical Alliance, 2020).

Supportive supervision: A process of helping counsellors to improve their work performance continuously in a collaborative and positive way that promotes mentorship, joint problem-solving and two-way communication.

The International Code of Marketing of Breast-milk Substitutes and subsequent resolutions (The Code): The Code intends to ensure BMS will be used as safely as possible when they are necessary based on impartial, accurate information. The Code does not restrict the availability of BMS, feeding bottles or teats or prohibit the use of BMS during emergencies. In the context of the Code, BMS means any food being marketed or otherwise represented as a partial or total replacement for breastmilk, whether suitable for that purpose or not. The Code applies to the marketing and related practices, quality, availability and information on use, including but not limited to breastmilk substitutes (including infant formula, follow-on/follow-up milk, growing-up milk, other milk products, including bottle-fed complementary foods) specifically marketed for feeding children up to three years of age, foods and beverages (baby teas, waters and juices) when marketed for use as a partial or total replacement of breastmilk during the first six months of life, feeding bottles and teats. Note that the promotion of foods for infant and young children over six months is covered by 69th WHA Provisional Agenda Item 21.1 A69/7 Add.1. stating that "products that function as breast-milk substitutes should not be promoted" (OG-IFE 2017).

Trauma informed care (TIC): A framework that guides counsellors' support of caregivers that is sensitive to a trauma's ongoing impact (e.g., on a person's perception of self, relationship to others and caregiving/breastfeeding experience) and seeks to avoid activating post-traumatic responses or causing trauma. Principles of trauma-informed care include 1) the recognition that not all caregivers will disclose trauma and so TIC should be applied universally, 2) respect for bodily autonomy, 3) facilitating a sense of control, 4) compassionate listening, 5) clear communication, 6) unbiased and culturally competent support.

Wet nursing: Breastfeeding of a child by someone other than the child's mother. (NB: This term should be used with caution given its negative connotations in certain historical/cultural settings such as the USA). When the child's mother also continues to breastfeed the child, this practice can also be referred to as *co-nursing*. When a lactating woman provides expressed breastmilk for feed a child that is not her own, this practice can also be referred to as expressed *breastmilk sharing ('milk sharing')*.

Young child: A person from the age of 12 months up to the age of 23 completed months (may also be referred to as 12-<24m or 1-<2 years) (OG-IFE, 2017).

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Annex A
SIMPLE RAPID ASSESSMENT[1]

Instructions:

a) Use this assessment form for all mothers/caregivers with children 0-23 months (under 2)
b) Once this assessment has been completed, decide whether the caregiver/mother needs counselling/full assessment and/or other services.
   - If yes, complete the referral form
   - If no, refer for IYCF support services (e.g., education, peer support group)

SIMPLE RAPID ASSESSMENT			
Staff name/ID		**Date of assesment**	
Child's name		**Gender**	
Child's age			
Caregiver's name		**Caregiver relationship**	
Facility ID		**Location**	

ASK			
Age of baby	❑ **0-5.9 months** ❑ **Newborn (<28 days)**	❑ **6-12 months**	❑ **12-24 months**
Is the baby breastfed?	❑ **Yes** ❑ **No**	❑ **Yes** ❑ **No**	❑ **Yes** ❑ **No**
(If yes) Are there any difficulties breastfeeding?	❑ **Yes** ❑ **No**	❑ **Yes** ❑ **No**	❑ **Yes** ❑ **No**
Is the baby drinking infant formula/milk powder?	❑ **Yes** ❑ **No**	❑ **Yes** ❑ **No**	❑ **Yes** ❑ **No**
Is the baby getting anything else to drink?	❑ **Yes** ❑ **No**	n/a	n/a
Is the baby getting anything else to eat?	❑ **Yes** ❑ **No**	❑ **Yes** ❑ **No**	❑ **Yes** ❑ **No**

OBSERVE			
Multiples (twins/triplets etc.)?	❑ **Yes** ❑ **No**	❑ **Yes** ❑ **No**	❑ **Yes** ❑ **No**
Caregiver requested infant formula?	❑ **Yes** ❑ **No**	❑ **Yes** ❑ **No**	❑ **Yes** ❑ **No**
Baby looks very thin/lethargic/ill?	❑ **Yes** ❑ **No**	❑ **Yes** ❑ **No**	❑ **Yes** ❑ **No**
Baby has sunken eyes/sagging skin?	❑ **Yes** ❑ **No**	❑ **Yes** ❑ **No**	❑ **Yes** ❑ **No**
Caregiver/child has an impairment?	❑ **Yes** ❑ **No**	❑ **Yes** ❑ **No**	❑ **Yes** ❑ **No**
Caregiver looks very thin/ill?	❑ **Yes** ❑ **No**	❑ **Yes** ❑ **No**	❑ **Yes** ❑ **No**
Caregiver appears to be very anxious, stressed, sad or distressed?	❑ **Yes** ❑ **No**	❑ **Yes** ❑ **No**	❑ **Yes** ❑ **No**

Key:

Priority 1 – refer for full assessment **Priority 2** – refer for full assessment
❑ No need for IYCF counselling – provide praise and encouragement

[1] Adapted from Save the Children's IYCF-E Toolkit

Annex B
IYCF FULL ASSESSMENT FORM: 0-23 MONTHS[1]

This is a sample feeding assessment tool that has been adapted from Save the Children's IYCF-E Toolkit and should be contextualised before use. Always check for nationally and sub-nationally approved assessment guides and guidelines first.

1. COLLECT BASIC INFORMATION

Counsellor's ID		**Location**		**Date of assesment**	/ /
Caregiver's name		**Relationship to child**	Mother/Father/Grandmother/Sibling/Other: _____		
Child's name		**Sex**	Male/Female	**Child's ID No.**	
Child's D.O.B.	/ /	**Child's age**	_____ months	**Caregiver's age**	_____ years
Caregiver's name		**Relationship to child**			
Facility ID		**Facility name**		**District**	
Source of referral	❑ Self-referral ❑ SRA – from _____ service ❑ No SRA – direct from _____ service				

2. CHECK FOR DANGER SIGNS[2]

Lethargic/unconscious?	❑ **Yes**	❑ **No**
Vomits everything?	❑ **Yes**	❑ **No**
Unable to drink/breastfeed?	❑ **Yes**	❑ **No**
Difficulty breathing? (respiration rate, chest indrawing)	❑ **Yes**	❑ **No**
Low or high temperature? (< 35.5 or ≥ 38°C)	❑ **Yes**	❑ **No**
Bilateral pitting oedemata? (+/++/+++)	❑ **Yes**	❑ **No**
Caregiver appears out of touch with reality or infant appears to be at risk from caregiver's behaviour?	❑ **Yes**	❑ **No**
ACTION: IF ANY MARKED AS YES → URGENT REFERRAL TO HEALTH SERVICES BEFORE CONTINUING IYCF ASSESSMENT		

3. ASK ABOUT FEEDING PRACTICES

Please tell me about your experiences of feeding your baby. What concerns or questions would you like to discuss today?	
What and how is the baby fed? *(Select all that apply)*	❑ Breastfeeding – at mother's breast ❑ Expressed breastmilk – mother's own ❑ Expressed breastmilk – informally shared ❑ Donor human milk ❑ Breastfed by a woman who is not the child's mother ❑ Some artificial feeding (BMS) ❑ Fully artificially fed (BMS) ❑ Fully artificially fed (BMS)
	❑ Bottle ❑ Spoon ❑ Cup

Does the baby eat or drink anything other than breastmilk?[3]	❑ **Yes**	❑ **No**

[1] Adapted from Save the Children's IYCF-E Toolkit: Rapid Start Up for Emergency Nutrition Personnel and the WHO B-R-E-A-S-T-FEED Observation Form.

[2] Adapted from IMCI Danger Signs. Please refer to national IMCI guidelines.

[3] Note: Counsellor should be trained to probe (e.g., "how about water – do you give baby any water?").

(If yes) What else do you give the baby?	❑ Infant formula ❑ Other milks ❑ Water ❑ Tea/coffee ❑ Sugary drinks/soda ❑ Juice: _____ ml/cups ❑ Medicine ❑ Food ❑ Other[4]: _____		
No. of previous children:		**No. of previous breastfed children:**	
ACTION: IF ARTIFICIALLY FED → COMPLETE FULL ASSESSMENT – ARTIFICIAL FEEDING FORM			
***(If yes)* What else do you give the baby?**			
Do you use a pacifier for the baby?		❑ **Yes**	❑ **No**
Is the baby currently sick?		❑ **Yes**	❑ **No**
***(If sick)* Since your baby has been sick, have there been any changes in the way you have been feeding?**			
Breastfeeding	❑ More/no change	❑ Less often	❑ Stopped
***(If 6-23 months)* Complementary feeding**	❑ More/no change	❑ Less often	❑ Stopped
Extras	❑ Extra nutrious food	❑ Infant formula	

4. CHECK DIAPER OUTPUT

How many wet diapers does baby have in 24 hours?	_____ times		
Does the baby's urine have a strong smell or colour?	❑ **Yes**	❑ **No**	
How many soiled diapers does baby have in 24 hours?	_____ times[5]		
Have there been any recent changes from usual?	❑ Less frequent stooling	❑ Diarrhoea	❑ No changes
ACTION: IF DIAPER OUTPUT IS LOW/CONCERNING → EXPLORE POSSIBLE LOW MILK SUPPLY **ACTION: IF CHILD HAS DIARRHOEA → REFER TO HEALTH SERVICES**			

5. ASK ABOUT BREASTFEEDING/BREASTMILK FEEDING

How often do you breastfeed/feed your baby breastmilk?	_____ times total	_____ times in the night
How do you decide when to feed your baby?	❑ Responsive	❑ Scheduled
***(If breastfeeding)* Do you experience any pain or discomfort while breastfeeding?**	❑ **Yes** ❑ Extreme ❑ Moderate ❑ Mild	❑ **No**

6. REQUEST PERMISSION TO OBSERVE THE MOTHER BREASTFEEDING (IF APPLICABLE)

Assess breast health:	*Colour:* ❑ Normal ❑ Redness *Condition:* ❑ Normal ❑ Shiny ❑ Hard ❑ Warm ❑ Engorged ❑ Damaged nipple ❑ Suspected blocked duct ❑ Suspected mastitis ❑ Suspected thrush ❑ Suspected breast abscess

ACTION: IF THRUSH, BREAST ABSCESS OR MASTITIS → REFER TO HEALTH SERVICES FOR TREATMENT

Signs breastfeeding is going well	Signs of possible difficulty
BODY POSITION	**BODY POSITION**
❑ Mother relaxed and comfortable	❑ Shoulders tense/leaning over baby
❑ Mother's back and arms are well supported	❑ Baby's body far away from mother's body
❑ Baby's body close, facing breast	❑ Starts feed with baby's mouth opposite nipple
❑ Starts feed with baby's nose opposite nipple	❑ Baby's head cannot move back freely
❑ Baby's head free	❑ Baby's neck twisted/not in line with shoulder and hip
❑ Baby's head and body straight (in line)	❑ Baby's chin not touching breast
❑ Baby's chin touching breast	

[4] Note: Contextualise with most commonly given liquids.

[5] Note: Counsellors need to be provided with job aids or reference materials and trained on what is considered acceptable in terms of stooling depending on the infant age and what they are fed.

Signs breastfeeding is going well	Signs of possible difficulty
RESPONSES ❑ Baby reaches for breast if hungry ❑ [Baby roots for breast] ❑ Baby explores breast with tongue ❑ Baby calm and alert ❑ Baby stays attached to breast ❑ [Signs of milk ejection] – leaking, afterpains	**RESPONSES** ❑ No response to breast ❑ [No rooting observed] ❑ Baby not interested in breast ❑ Baby restless or crying ❑ Baby slips off breast ❑ [No signs of milk ejection] ❑ Mother shows signs of pain/discomfort ❑ Baby coughs/gags/chokes
EMOTIONAL STATE AND BONDING ❑ Secure, confident hold ❑ Eye contact ❑ Mirroring of facial expressions between parent and child ❑ Much touching by mother ❑ Responsive to baby's needs	**EMOTIONAL STATE AND BONDING** ❑ Nervous/limp hold ❑ No eye contact ❑ Shaking or poking baby/breast ❑ Little touching ❑ Struggles to soothe baby when crying
SUCKLING/ATTACHMENT ❑ Mouth wide open ❑ Lower lip turned outwards ❑ Tongue cupped around breast ❑ Cheeks round ❑ More areola above baby's mouth ❑ Slow deep sucks, bursts with pauses ❑ Can see or hear swallowing	**SUCKLING/ATTACHMENT** ❑ Mouth not wide open/points forward ❑ Lower lip turned in ❑ Baby's tongue not seen ❑ Cheeks tense or pulled in ❑ More areola below baby's mouth ❑ Rapid sucks only ❑ Can hear smacking or clicking
END OF FEED ❑ Baby releases breast ❑ Nipple looks normal/round/erect ❑ Baby suckled for 5+ minutes ❑ Mother keeps breast available/offers other breast ❑ Baby's hands are relaxed/open ❑ Baby looks relaxed/satisfied/sleepy ❑ Breasts feel softer	**END OF FEED** ❑ Mother takes baby off breast ❑ Nipple looks creased/squashed/flattened ❑ Baby suckled for <5 minutes ❑ Mother does not keep breast available offer other ❑ Baby's hands are clenched/near face ❑ Baby fusses/cries/appears unsatisfied
Time spent breastfeeding _____ minutes	

7. ASSESS MATERNAL/CAREGIVER WELLBEING[6]

Over the last two weeks, have you experienced any of the following feelings?			***(If yes)* Frequency in the last 2 weeks?**		
Feeling anxious or worrying uncontrollably	❑ **Yes**	❑ **No**	❑ Sometimes	❑ Often	❑ Almost every day
Difficulties coping with daily chores	❑ **Yes**	❑ **No**	❑ Sometimes	❑ Often	❑ Almost every day
Little interest or pleasure in doing things that you used to enjoy	❑ **Yes**	❑ **No**	❑ Sometimes	❑ Often	❑ Almost every day
Feeling down, depressed or hopeless	❑ **Yes**	❑ **No**	❑ Sometimes	❑ Often	❑ Almost every day

On a scale of 1 (very unsupported) to 5 (very supported), how supported to you feel by family and friends in caring for your baby?	**1**	**2**	**3**	**4**	**5**
Who do you mostly rely on for support, if anyone?					
How does your family feel about you breastfeeding?					

ACTION: IF ANSWERED YES – OFTEN / ALMOST EVERYDAY OR SCORE 1 – 3 → CONDUCT MHPSS ASSESSMENT

[6] Instead of questions, caregivers may also be shown drawings and asked which most accurately reflects their mood.

Do you have any concerns about the baby's growth and development or level of alertness, compared to other babies of a similar age?	❑ **Yes**	❑ **No**
ACTION: IF ANSWERED YES → REFER TO HEALTH AND ECD SERVICES		
How is your current health?		

8. *(IF 6-23 MONTHS)* ASSESS COMPLEMENTARY FEEDING PRACTICES

Who helps/assists the child with eating?			
How many times did (name) eat solid, semi-solid or soft foods yesterday during the day or at night?	_____ times		
Yesterday, during the day and night what did you give your child to eat?	**WHAT?**	**HOW MUCH?** (cups/handfuls)	**TEXTURE?** (thick/thin/ chopped/whole)
Grains, roots, tubers			
Legumes and nuts			
Dairy products (e.g., milk, yoghurt, cheese)			
Flesh foods (meat, fish, poultry, liver/organ meats)			
Eggs			
Vitamin A rich fruits and vegetables			
Other fruits and vegetables			
Check: ≥ 4 food groups?		❑ **Yes**	❑ **No**
Did you give your child micronutrient powder (MNP)?		❑ **Yes**	❑ **No**
What do you use to feed your child liquids?	❑ Open cup ❑ Cup with spout ❑ Bottle		
At what important times in the day do you wash your hands with water and soap?	❑ Before preparing food ❑ Before eating ❑ Before feeding child		
Do you wash the child's hands with clean water and soap before they eat?		❑ **Yes**	❑ **No**
Have you noticed the child experiencing any difficulties when eating?		❑ **Yes**	❑ **No**
❑ Coughing/choking ❑ "Wet"/"gurgly" voice breathing ❑ Discomfort ❑ Watery eyes ❑ Changes in colour/breathing			
ACTION: IF SIGNS OF POSSIBLE ASPIRATION ARE PRESENT → REFER FOR PAEDIATRIC ASSESSMENT			

9. NOTE DOWN ANY KNOWN RISK FACTORS (e.g., noted when referred)

Child	❑ Premature ❑ Low birth weight ❑ Under 6m with growth failure ❑ Sick ❑ Multiple ❑ Malnourished ❑ Disability impacting feeding ❑ Signs of extreme distress ❑ Maternal orphan ❑ Separated/unaccompanied
Mother/caregiver	❑ Malnourished ❑ Severely ill ❑ Recovering from Caesarean birth/difficult birth ❑ Disability impacting feeding Voluntary disclosure only: ❑ MHPSS difficulties ❑ SGBV survivor ❑ HIV positive ❑ First time mother ❑ Adolescent mother
ACTION: IF RISK FACTOR(S) ARE PRESENT → ENROL FOR COUNSELLING + REFER TO REQUIRED SERVICES	

10. NOTE DOWN ANY OBSERVATIONS MADE DURING THE ASSESSMENT			
Quality of mother's/caregiver's-child interaction (holding, touching, visual contact, verbal exchange, mirroring, playing)	❑ Poor	❑ Moderate	❑ Good
Child's reaction to the mother's/caregiver's stimulation	❑ Poor	❑ Moderate	❑ Good
Mother's/caregiver's reaction to the child's calls for attention and need for comfort	❑ Poor	❑ Moderate	❑ Good
Mother's/caregiver's awareness of child's movements	❑ Poor	❑ Moderate	❑ Good
Mother's/caregiver's response to child needing correction	❑ Poor	❑ Moderate	❑ Good
Child moves both arms and legs equally		❑ Yes	❑ No
Normal tone and posture		❑ Yes	❑ No
Mother/caregiver requested infant formula		❑ Yes	❑ No

11. COUNSELLING ACTIONS/DECIDE ON CARE PLAN			
Possible problems:			
Counselling actions taken:	❑ Positioning and attachment: _____ ❑ Stress management: _____ ❑ Information given on: _____ ❑ Supplies provided: _____ ❑ Referrals made: health/nutrition/MHPSS/ECD/FSL/WASH/other: _____ _____ ❑ Other: _____		
Further counselling needed?		❑ Yes	❑ No
ACTION: IF NO → REFER FOR OTHER IYCF SERVICES	❑ Education ❑ Peer group support ❑ Other _____		
Reason for further counselling ***(refer to triage tool)***			

Support to be provided

BASIC SUPPORT AND COUNSELLING

- ❑ Positioning and attachment
- ❑ Maternal confidence
- ❑ Milk expression
- ❑ Cup/spoon feeding
- ❑ Flat or inverted nipples
- ❑ Sore or damaged nipples
- ❑ Engorgement
- ❑ Increase/decrease milk production
- ❑ Restorative care/emotional support
- ❑ Wet nursing
- ❑ Breastfeeding in public/crowded spaces
- ❑ Breastfeeding at night
- ❑ Infection Prevention Control
- ❑ Rejecting donations of BMS/feeding bottles/teats
- ❑ Preparing for crisis/evacuation
- ❑ Encourage age appropriate feeding
- ❑ Complementary feeding
- ❑ Maternal diet
- ❑ Other: _____

ADVANCED SUPPORT AND COUNSELLING

- ❑ Manage mastitis/thrush
- ❑ Manage tongue tie
- ❑ Breastfeed LBW or preterm infant/KMC
- ❑ Breastfeeding during maternal/child severe illness
- ❑ Feeding with a disability impacting feeding
- ❑ Feeding while experiencing mental health difficulties
- ❑ Relactation
- ❑ Suppress lactation (stillbirth/infant loss)
- ❑ Maintaining lactation during separation
- ❑ Breast refusal
- ❑ Other: _____

Follow up date:	
Time spent today:	

Annex C
STRATEGIES FOR OVERCOMING BARRIERS TO REMOTE BREASTFEEDING COUNSELLING[1]

Possible challenges	Possible solutions
Inability to see each other (telephone counselling) • Counsellor cannot gather information on caregiver's receptiveness, understanding or wellbeing through non-verbal cues (e.g., facial expression, body language) • Harder to build rapport (facial expressions, eye contact) • Counsellor cannot reinforce with non-verbal communication (e.g., gestures) • Counsellor cannot see signs of malnutrition or conditions of the infant, latch, anatomy or positioning • Counsellor cannot see signs of infection or other physiological conditions of the breast • Caregiver may feel that she is not being heard	• Focus on strengthening counsellors' verbal communication skills e.g., active listening, reflective techniques, descriptive language, tone of voice, use of affirmative sounds • Train counsellors to assess growth and how breastfeeding is going without visuals • Allow for more time for caregivers to build trust and disclose personal or sensitive issues • Consider making the connection via an outreach worker who is in the community to introduce the counsellor and encourage trust between the counsellor and the caregiver • Discuss the option and viability of using a technology that allows visuals such as pictures • Use a comprehensive, structured approach to gather information otherwise gathered visually. Follow up with clarifying questions to reach required levels of detail
No physical presence • Counsellor cannot gather information from home environment (e.g., hygiene) • Harder to build a trusted and warm relationship (e.g., no touch or physical greeting possible) • Cannot physically help caregiver (e.g., positioning or conduct a physical assessment) • Cannot weigh the infant	• Focus on strengthening counsellors' rapport building skills (e.g., active listening, verbal engagement, match communication styles and language, appropriate tone and texture of voice, breathing) to build a relationship • Train counsellors on a no-touch/hands off approach[2] (e.g., demonstrate positioning using a doll or giving verbal cues) • Allow more time for caregivers to build trust and disclose personal or sensitive issues • Train counsellors on how to assess newborn intake remotely[3]
Technology availability and access • Poor quality or coverage of phone or internet connection • Caregiver may not have access to telephone or technology due to cost (cost of device, cost of communication or data streaming) or may share with others	• Use a community/community health worker phone • Cover caregiver's mobile data/internet costs or provide toll-free phone numbers • Share low resolution images • Agree on a day and time when the caregiver will be able to use the phone/device • Provide contact details for the caregiver to initiate counselling (client-led counselling) • Let the caregiver know you will re-connect/call back if the connection is disrupted
Cultural acceptance • Use of technologies not culturally accepted • Caregiver may not own phones/technology	• Engage community leaders in discussions around best modality for remote counselling

[1] Adapted from: WHO and UNICEF (2021). Implementation Guidance on Counselling to Improve Breastfeeding Practices.

[2] Note: this is a best practice that is also encouraged during face-to-face counselling.

[3] Tool: https://abaprofessional.asn.au/assessing-newborn-intake-in-the-context-of-covid-19/

Possible challenges	Possible solutions
Lack of confidentiality/privacy • Caregiver cannot speak freely/lack of privacy at home • Fears about overhearing personal/sensitive information/spying/hacking	• Start counselling sessions by verifying that the caregiver is comfortable to be counselled. If not, agree on a date and time during which they expect to have privacy and feel comfortable • Use a text rather than voice or video service when appropriate • Use closed (yes/no) questions to verify a caregiver's safety and wellbeing (e.g., if violence against women and girls is suspected) • Ensure confidentiality in online groups, e.g., not sharing information without consent • Use end-to-end encrypted communication services • Ensure remote counselling services abide by data protection policies, laws and regulations
Distractions and responsibilities at home • Caregiver may need to attend to household or childcare duties during counselling operating hours • Caregiver may be distracted by children and other family members in the home	• Use text rather than voice or video so that the caregiver can reply when it is convenient for her • Use flexible call schedules so calls can be returned at convenient times • Thoroughly check caregiver's understanding • Follow-up frequently and reinforce information through following up with IEC materials
Caregiver's ability to use technology • Caregiver may have little/no experience with using technology • Caregiver may have low literacy level	• Use voice/visuals instead of text • Engage community health workers in the setting up of remote counselling sessions

For further guidance on remote counselling, refer to: Save the Children, IFE Core Group, ENN, USAID, ACF USA, PATH, SafelyFed Canada (2021). Practical Guidelines for conducting and Supporting Infant and Young Child Feeding – e-Counselling via telephone with considerations for planning and implementation. www.iycfehub.org/document/practical-guidelines-for-conducting-and-supporting-infant-and-young-child-feeding-e-counselling-via-telephone-with-considerations-for-planning-and-implementation

Notes

A community health worker counsels a breastfeeding woman using a pictorial job aid during a home visit
ACTION AGAINST HUNGER/KHAULA JAMIL

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