

IMPLEMENTATION GUIDANCE ON COUNSELLING WOMEN TO IMPROVE BREASTFEEDING PRACTICES



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DEFINITIONS OF TERMS

Antenatal period: The time from conception until birth.

Anticipatory guidance: Guidance offered in anticipation of predictable challenges or situations that may impact mothers' breastfeeding goals. Anticipatory guidance includes guidance and information offered to pregnant women who do not intend to breastfeed.

Artificial feeding: Feeding an infant or child with a breastmilk substitute.

Bottle-feeding: Feeding an infant or child anything from a bottle, including expressed breastmilk, water, formula milk, etc.

Breastfeeding: The act of an infant or child suckling milk from the breast.

Breastfeeding counselling: Counselling provided by a breastfeeding counsellor (see definition) that supports pregnant women and mothers to establish the knowledge, skills and confidence needed to breastfeed and to respond to breastfeeding challenges.

Breastfeeding counsellor: Health or non-health professionals, or paraprofessionals, who have received appropriate training to provide breastfeeding counselling.

Breastmilk expression: Use of hands or a mechanical device (pump) to remove milk from the breasts.

Breastmilk substitute: Any food being either marketed or otherwise represented as a partial or total replacement for breastmilk, whether or not suitable for that purpose. These include formula milks marketed for feeding infants and young children up to the age of 3 years (including follow-up formula and growing-up milks), complementary foods and may also include modified or unmodified milk or milk substitutes.

Breast pump: A device for expressing breastmilk.

Competency: The ability 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 feeding of foods and liquids to young children in addition to breastmilk, beginning when breastmilk alone is no longer sufficient to meet children's nutritional requirements. The complementary feeding period typically occurs between 6–24 months of age and includes continued breastfeeding.

Complementary foods: Solid, semi-solid and soft foods (both locally prepared and commercially manufactured) provided to infants and young children between the ages of 6 and 24 months to complement breastmilk.

Dyad: A mother and baby pair.

Early infancy: The period between birth and 6 months of age (the first half year of life).

Early childhood: The period between a child's first and third year of life (the second two years of life).

Emergency: An event or series of events that represent a critical threat to the health, safety, security or well-being of a community or other large group of people. Emergencies can be natural disasters or human-made, sudden or slow onset, short-term or protracted. Emergencies are humanitarian crises if international support (humanitarian assistance) is required to meet the basic needs of a population.

Emergency preparedness: The knowledge and capacity developed by governments, recovery organizations, communities and individuals to anticipate, respond to and recover from the impact of potential, imminent or current hazard events, or emergency situations that call for a humanitarian response.

Exclusive breastfeeding: When an infant receives only breastmilk and no other liquids or solids, including water (with the exception of prescribed vitamins, minerals or medicines).

Feeding equipment: Bottles, teats, syringes, supplemental nursing systems, cups, spoons, spouts, straws or other feeding appliances, including breast pumps and breast pump attachment kits.

Global Breastfeeding Collective: A partnership of prominent international agencies calling on donors, policy-makers and civil society to increase investment in breastfeeding worldwide.

Group breastfeeding counselling: Breastfeeding counselling of a group of mothers during the antenatal or postpartum period under the oversight of a breastfeeding counsellor. Group counselling allows mothers to share breastfeeding experiences and support one another. This type of counselling may have an educational component, but is distinct from purely educational, lecturing or classroom-style teaching. Group breastfeeding counselling is facilitated by one or more professional or paraprofessional breastfeeding counsellor(s), who may identify individual mothers that require one-on-one breastfeeding counselling.

Infant: A person with less than 12 completed months of age (may be referred to as 0-<12 months or 0-<1 year of age).

Infant formula: A milk or milk-like product of animal or vegetable origin industrially formulated in accordance with national standards or the Codex Alimentarius Standard for Infant Formula, and intended to satisfy the nutritional requirements of infants during their first 6 months of life.

International Board-Certified Lactation Consultant: An 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 that enable them to provide breastfeeding counselling and support for complex breastfeeding issues.

Lactation consultant: Allied health professionals who have advanced training competencies in lactation management and are able to provide breastfeeding counselling and manage complex breastfeeding issues.

Late infancy: The period between 6 months and 1 year of age (the second half year of life).

Neonatal period: The first 28 days of life.

Paraprofessional breastfeeding counsellor: A type of breastfeeding counsellor trained to perform counselling without a formal professional qualification, sometimes also referred to as 'lay' breastfeeding counsellors. Paraprofessionals often work with, and as an extension of,

professional breastfeeding counselling services. They assist professionals but are not licensed or credentialed as health care, nutrition or lactation consultant professionals.

Peer breastfeeding counsellor: Paraprofessional breastfeeding counsellors who may have prior breastfeeding experience and have shared experiences with the population they serve. Peer counsellors may also be called ‘mother-to-mother’ counsellors.

Peer breastfeeding support group: A group of mothers 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. Peer support groups may also be called ‘mother support group’ or ‘mother-to-mother’ support groups.

Perinatal period: The period commencing at 22 completed weeks (154 days) of gestation and ending seven completed days after birth.

Positioning: How a mother positions herself and her baby at the breast to breastfeed.

Postnatal period: The first six weeks after birth.

Pre-lacteal feeds: Artificial feeds or drinks given to an infant before breastfeeding is established

Remote breastfeeding counselling: Using technologies to provide breastfeeding counselling, especially in contexts where face-to-face counselling capacity or access may be limited or absent.

Re-lactation: The resumption of breastmilk production (lactation) in a woman who has stopped lactating, recently or in the past, in order to provide breastmilk for her own or another infant.

Responsive (on-demand) breastfeeding: Breastfeeding a baby in response to signs of readiness to feed, as frequently and for as long as the baby wants, from one or both breasts at each feed, without specific regulations. Responsive breastfeeding may also be called ‘unrestricted’ or ‘on-demand’ feeding.

Responsive complementary feeding: An approach to feeding where caregivers encourage infants and young children to eat, providing food in response to the child’s appetite and satiety signals.

Skin-to-skin: Care in which an infant is placed prone on the mother’s abdomen or chest with no clothing separating them.

Teat: An artificial nipple by which an infant can drink milk from a bottle.

The Code: International Code of Marketing of Breast-milk Substitutes and subsequent World Health Assembly resolutions.

Young child: A person aged 12 to 24 months of age.

EXECUTIVE SUMMARY

Breastfeeding is the cornerstone of healthy infant nutrition, development and survival. The World Health Organization (WHO) and the United Nations Children's Fund (UNICEF) recommend that babies initiate breastfeeding within the first hour after birth, that breastfeeding is continued exclusively for the first six months of life, and sustained, with safe and adequate complementary foods, up to two years or beyond.

Breastfeeding counselling is recognized as an important approach to improving global breastfeeding practices. This guidance uses an established theoretical model for breastfeeding counselling programmes (1) to depict socioecological determinants that make up an enabling environment for breastfeeding. The model places breastfeeding counselling alongside complementary interventions that aim to improve breastfeeding practices.

In 2018, the WHO guideline 'Counselling of women to improve breastfeeding practices' (2) was published. The guideline outlined six key recommendations to ensure that breastfeeding counselling is provided:

- to all pregnant women and mothers with young children;
- in both the antenatal period and postnatally, and up to 24 months or longer;
- at least six times, and additionally as needed;
- through face-to-face counselling, or in addition, through telephone or other remote modes of counselling in certain contexts;
- as a continuum of care, by appropriately trained health care professionals and community-based lay and peer breastfeeding counsellors;
- as anticipatory guidance to address important challenges and contexts for breastfeeding, in addition to establishing skills, competencies and confidence among mothers.

This programme implementation guidance expands on the how to implement these six recommendations. The first step in establishing new breastfeeding counselling programmes or scaling up existing programmes, is gathering information on the target population. This includes gathering population-level data, information on special populations and potential programme stakeholders through stakeholder mapping. Gathering information on the local population aids decisions on whether to scale up existing programmes or create entirely new programmes. It helps to design programmes that are people-centred, delivered in an appropriate mode and in a suitable setting.

To ensure adequate human resources, programme planners need to design a workforce plan. This includes estimation of expected caseloads and approximate duration of breastfeeding counselling contacts. Understanding the differences in breastfeeding counsellor cadres will help to define which personnel will be the primary cadres to provide breastfeeding counselling. Develop a plan for a workforce that meets the needs of the local population. Planning and hiring of key programme staff, and adequate numbers of service delivery personnel, including breastfeeding counsellors and supervisors, is critical to meet the objectives of the guidance. Importantly, managers should determine whether existing staff structures are sufficient or if new staff, external contractors or a combination of these solutions is required.

Programmes should develop, adapt or update curricula for pre-service or in-service training programmes and coordinate with relevant vocational training stakeholders. Pre-service and in-service curricula should provide sufficient practical experiences to develop the competencies of breastfeeding counsellors. Capacity development for breastfeeding counselling programmes should begin with competency verification or training needs assessments. This aids in understanding the scope of training needed and making decisions on the appropriate mode of training. Training should take the literacy and numeracy of breastfeeding counsellors into account. Programmes should regularly verify competencies of personnel to determine the need for refresher training.

Breastfeeding counselling programmes should deliver quality, people-centred breastfeeding counselling services to all pregnant women and mothers with infants or young children. Breastfeeding counselling services should be delivered in accordance with the six key recommendations on the frequency and timing of contacts and should employ a three-step counselling process. Competent service delivery entails the use of local referral systems, and may be supported by relevant job aids.

Monitoring and evaluation are an integral part of service delivery. Programme coordinators should aim to benchmark progress using national coverage indicators, and facility-level or community-level coverage indicators. Regular, periodic monitoring and evaluation are important for adjustments to service delivery and updates to any pre-service or in-service training curricula.

Advocacy for breastfeeding counselling is needed to gain stakeholder buy-in and establish supportive policies. Vital steps for effective advocacy for breastfeeding counselling programmes include developing advocacy messages and dissemination of messages at national and subnational levels. Effective policies for breastfeeding counselling ensure that counselling is covered in broader development plans. Breastfeeding counselling should be included in national development strategies, national nutrition policies and action plans for maternal, newborn and child health.

Programmes should secure sustainable financing through the early involvement of financial stakeholders. Integration of breastfeeding counselling programmes into existing health care programmes can help with sustainability. Existing tools for estimating costs and caseloads for health care programmes may be useful for financial planning of breastfeeding counselling programmes. It is important to ensure that funding for breastfeeding counselling programmes is free from conflicts of interest. Programmes should be independent from and receive no support from companies that manufacture or market foods for infants and young children. Breastfeeding counselling programmes should abide by the International Code of Marketing of Breast-milk Substitutes and subsequent World Health Assembly resolutions (3).

Programme planners should prepare for breastfeeding counselling in emergencies by including it in national emergency preparedness and response plans. Preparing for emergencies is largely accomplished by establishing strong breastfeeding counselling programmes under normal conditions. Putting policies in place, ensuring human resources are available, developing capacity in breastfeeding counselling in emergencies, establishing monitoring and evaluation systems and allocating adequate financial resources ensure that national stakeholders are prepared when emergencies strike. Global guidance on breastfeeding counselling during emergencies is published elsewhere (4).

SCOPE AND PURPOSE

This document provides global guidance for implementing the recommendations outlined in the WHO guideline ‘Counselling of Women to Improve Breastfeeding Practices’ (2). The core purpose of this document is to ensure that all women receive high quality breastfeeding counselling through ensuring that breastfeeding counselling programmes meet mothers’ needs at the right times, with appropriately trained staff, in a sufficient number of contacts, and in a manner and mode most appropriate for their local context.

This implementation guidance describes each stage of breastfeeding counselling programme implementation, including how to plan, establish, scale and sustain programmes at national or subnational levels. It applies to programmes that are integrated into existing maternal, infant and child health or nutrition programmes, as well as those delivered as stand-alone services.

This document guides managers and programme planners on how to: gather information, establish a planning and coordination team, develop a workforce plan, implement training of new and existing staff, create systems for supervision and referral, create or identify relevant job aids, secure sustainable financing, establish supportive policies, advocate at national and subnational levels, and monitor and evaluate programme delivery. It also gives guidance on the integration of breastfeeding counselling services into emergency preparedness and response plans. However, detailed guidance on implementation of breastfeeding counselling programmes in emergencies is published elsewhere (4).

This implementation guidance is intended for a wide audience, including: policy-makers, programme coordinators and managers of national or subnational nutrition and health programmes, technical and programme staff in government or non-governmental organizations, and research institutions or other agencies involved in the evaluation of breastfeeding counselling programmes. It is also intended for administrative and health care staff, facility and community programme planners, and professional societies involved in policy-making, information-sharing, standards setting, education and training. It presumes some prior knowledge of maternal and child health and nutrition programme design, planning and implementation (5, 6).

In addition to having access to breastfeeding counselling services, women need the support of their families, health-care providers, communities and employers. However, this kind of support is beyond the scope of this guidance. This implementation guidance also does not address the management of medical issues that affect breastfeeding. It does not specify the content of counselling contacts or provide training curricula for breastfeeding counsellors. However, this information is available elsewhere (7-9).

It is crucial that this guidance be implemented within a broader context of support for mothers and infants and in accordance with related WHO and UNICEF guidance documents. This Implementation Guidance complements the following tools, guidelines and courses published previously (in alphabetical order):

- [Baby-friendly Hospital Initiative training course for maternity staff](#) (7, 10)
- [Baby-friendly Hospital Initiative for small, sick and premature infants](#) (11)
- [Breastfeeding counselling: A training course](#) (12)
- [Caring for newborns and children in the community: A training course for community health workers](#) (6, 13)

- Combined course on growth assessment and infant and young child feeding counselling (14)
- Community-based infant and young child feeding package (15)
- Community management of at-risk mothers and infants under six months of age (C-MAMI) tool (16)
- Competency verification toolkit ensuring competency of direct care providers to implement the baby-friendly hospital initiative (17)
- Counselling for maternal and newborn care: A handbook for building counselling skills (18)
- Essential newborn care course (19)
- Guideline: Counselling of women to improve breastfeeding practices (2)
- Guideline: Protecting, promoting and supporting breastfeeding in facilities providing maternity and newborn services (20)
- Guidelines on optimal feeding of low birth-weight infants in low- and middle-income countries (21)
- Infant and young child feeding in emergencies. Operational guidance for emergency relief staff and programme managers (22)
- Integrated management of childhood illness (23)
- Intrapartum care for a positive pregnancy experience (24)
- Implementation guidance: protecting, promoting and supporting breastfeeding in facilities providing maternity and newborn services – the revised Baby-friendly Hospital Initiative (25)
- Managing programmes to improve child health (5)
- Operational guidance: Breastfeeding counselling in emergencies (4)
- Standards for improving quality of maternal and newborn care in health facilities (26)
- The International Code of Marketing of Breast-milk Substitutes subsequent relevant resolutions (3)
- Updates on HIV and infant feeding guideline (27)

INTRODUCTION



Breastfeeding is a cornerstone of healthy infant nutrition, development and survival. It is critical for countries* to improve breastfeeding rates in order to achieve global targets for newborn and child health and survival, as well as economic growth and environmental sustainability (28, 29). Exclusive breastfeeding for six months provides the nutrients and energy needed for physical growth and development, and immunological protection. Beyond six months, breastfeeding continues to provide energy and nutrients that, jointly with safe and adequate complementary feeding, help prevent both undernutrition, overweight and obesity (30).

There is extensive evidence that inadequate breastfeeding increases infant mortality and morbidity(31) including numerous adverse health outcomes across the life course (32). Breastfeeding is especially important where diarrhoea, pneumonia and undernutrition are common causes of mortality among children under 5 years of age (33, 34). It also helps prevent childhood overweight and obesity (35). Globally, as many as 823,000 deaths among children under 5 years old (32) could be prevented every year by improving breastfeeding practices. Breastfeeding protects women from adverse health outcomes, including breast and ovarian cancer (36). It is estimated that 20,000 maternal deaths from breast cancer could be prevented every year by improving breastfeeding practices (36).

For these reasons, WHO and UNICEF recommend that babies be placed in skin-to-skin contact with their mother immediately after birth, that breastfeeding is initiated within the first hour

*For the purpose of this publication, the term “countries” should be understood as referring to “countries and areas

after birth, that it is continued exclusively for the first six months of life, and sustained, with safe and adequate complementary foods, up to two years or beyond (37). However, globally, a minority of infants and children meet these recommendations. Only 49 per cent of infants initiate breastfeeding within the first hour after birth, only 44 per cent of all infants under 6 months of age are exclusively breastfed, and 69 per cent of children are still breastfeeding at 2 years of age (38).

Coverage of breastfeeding counselling programmes is still lacking. In 2019, only 53 countries had infant and young child feeding (IYCF) counselling incorporated into three-quarters of their primary health-care facilities (29). Only 59 countries had community programmes that included IYCF counselling in at least three-quarters of all districts (29). Additionally, the quality of breastfeeding counselling services has not been properly examined across countries.

The global importance of breastfeeding was ratified in 1990 by the Innocenti Declaration on the protection, promotion and support of breastfeeding, which stated that all women should be enabled to breastfeed (39). In 2012, the World Health Assembly (WHA) endorsed a Comprehensive Implementation Plan on Maternal, Infant and Young Child Nutrition (40). Among its goals is increasing the prevalence of exclusive breastfeeding among infants less than 6 months of age to at least 50 per cent (41).

Globally, not breastfeeding is associated with economic losses of around US\$300 billion annually (1). Economic modelling conducted for the World Bank estimates that every dollar invested in improving breastfeeding practices yields returns of around \$35 (42). Therefore, increasing breastfeeding prevalence to 50 per cent would generate economic benefits worth US\$298 billion over the productive lives of child beneficiaries for a period of 10 years (1, 42). Data from 27 low- and middle-income countries have shown that investment in improving breastfeeding practices (including breastfeeding counselling, maternity leave benefits for six months, and breastfeeding promotion) generates benefits throughout the child's life (43).

Breastfeeding counselling is key to improving breastfeeding rates (2). Compared to not receiving breastfeeding counselling, receiving breastfeeding counselling may reduce the likelihood of discontinuing breastfeeding and not exclusively breastfeeding at four to six weeks and at 6 months of age (2). It also may reduce the likelihood of supplementation in the first two days after birth and probably reduces the likelihood of using teats and bottles during the first six months of life (2). When women receive breastfeeding counselling, they are more likely to breastfeed and to do so exclusively up to six months postpartum (44).

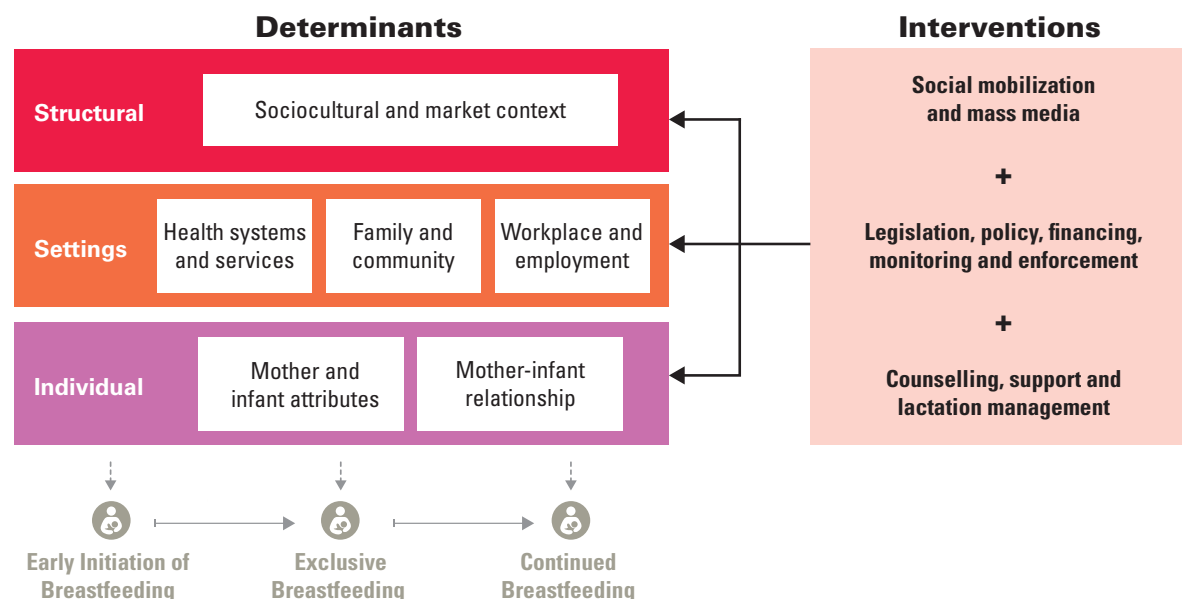
Theory of change for breastfeeding counselling programmes

Breastfeeding is often portrayed as an ideal, the achievement of which signifies true maternal devotion (45). However, devotion alone cannot sustain a breastfeeding mother whose environment or social ecology does not support breastfeeding (1). If structural, economic and cultural conditions that enable breastfeeding are allowed to deteriorate or disintegrate through inadequate or ineffective policies and programmes, breastfeeding can become extraordinarily difficult (25).

This chapter describes a theory of change model (1) to describe the components of an enabling environment for breastfeeding. It places breastfeeding counselling within a set of potential actions (interventions) that foster a social ecology (determinants) where breastfeeding can succeed (*see Figure 1*).

Figure 1: Theory of change model: An enabling environment for breastfeeding

Source: Why invest, and what it will take to improve breastfeeding practices? Rollins, et al. Lancet, 2016 (1)



Determinants

Determinants of breastfeeding behaviours are complex and occur across multiple levels (46). These levels include sociocultural and political environments, health systems, workplaces, family and community structures, or at the individual or interpersonal level. Determinants may also interact to shape breastfeeding behaviours (47-49). The role of interactions between determinants is as important as the role played by individual characteristics. In order to support or change breastfeeding behaviours, determinants that occur at each of these levels should be addressed (50).

Interventions

Providing women with breastfeeding counselling improves breastfeeding outcomes (2), but counselling alone cannot secure significant, sustainable, population-level improvements (51-53). Therefore, breastfeeding counselling programmes should be implemented together with other interventions in order to address potential barriers to breastfeeding.

One key intervention is advocacy for breastfeeding. Advocacy may encompass targeted communications or messages to key stakeholders, or social mobilization activities and mass media. These interventions are designed to increase and maintain positive attitudes towards breastfeeding through changing community, organizational and individual expectations and cultures. Expected changes at macrolevel or in the health system due to advocacy activities might include acceptance of breastfeeding in public, or improved planning to ensure non-separation of breastfeeding mothers, infants and children within health systems. At the individual level, reduction of new mothers' household responsibilities to accommodate frequent breastfeeding or fostering positive attitudes and beliefs about breastfeeding among fathers and grandparents may support breastfeeding.

At the macrolevel, interventions in legislation, policy, financing, monitoring and enforcement will address more distal determinants. For example, policies and legislation that restrict the marketing of breastmilk substitutes can help reduce exposure to these products. At the organizational level, workplace protections, such as paid leave and lactation breaks, provide critical support for working mothers and their families. At the individual level, policies can help ensure that breastfeeding is understood as an individual human right.

Finally, interventions that directly support breastfeeding, such as provision of breastfeeding counselling, can provide mothers with knowledge, skills and self-confidence (54). For example, a mother who receives anticipatory guidance about cluster feeding, is less likely to accept her own mother's interpretation of frequent breastfeeding as a sign of insufficient milk supply. Effective breastfeeding counselling can strengthen a mother's self-confidence and commitment to exclusive breastfeeding, even in the face of challenging social barriers. For example, discussing the veracity of health claims on breastmilk substitutes with a trusted breastfeeding counsellor enables mothers to resist commercial pressure to offer breastmilk substitutes (55).

Six key recommendations

The 2018 WHO guideline 'Counselling of women to improve breastfeeding practices' (2) arose from systematic literature reviews and was developed by an international group of experts. The guideline builds on previous recommendations from the 'Global Strategy for Infant and Young Child Feeding (56)' and increases the strength of the recommendation for breastfeeding counselling. It provides six evidence-informed recommendations on breastfeeding counselling (*see Box 1*).

Box 1: Six breastfeeding counselling recommendations from the 2018 WHO guideline

- 1)** Breastfeeding counselling should be provided to all pregnant women and mothers with infants and young children.
- 2)** Breastfeeding counselling should be provided in both the antenatal period and postnatally, for up to 24 months or longer.
- 3)** Breastfeeding counselling should be provided at least six times, and additionally as needed.
- 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.
- 5)** Breastfeeding counselling should be provided as a continuum of care, by appropriately trained health care professionals and community-based lay and peer breastfeeding counsellors.
- 6)** Breastfeeding counselling should anticipate and address important challenges and contexts for breastfeeding, in addition to establishing skills, competencies and confidence among mothers.

1. Breastfeeding counselling should be provided to all pregnant women and mothers with infants and young children and their families.

Breastfeeding counselling should be provided to all pregnant women and mothers with infants and young children and their families (2). Every effort should be made to ensure that counselling services are available and accessible.

2. Breastfeeding counselling should be provided during the antenatal period and postnatally, for up to 24 months or longer.

Breastfeeding counselling should be provided during the antenatal period and postnatally, for up to 24 months or longer (2). Ideal time points for the six recommended breastfeeding counselling contacts are:

- before birth (antenatal period);
- during and immediately after birth (perinatal period up to the first 2–3 days after birth);
- at 1–2 weeks after birth (within the neonatal period);
- in the first 3–4 months (early infancy);
- at 6 months (the start of complementary feeding);
- after 6 months (late infancy and early childhood);
- additional contacts as necessary.

These timepoints are recommended because they coincide with important development and physiological changes, but are not prescriptive.

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

Breastfeeding counselling should be provided at least six times, and additionally, as needed (2). A minimum of six breastfeeding counselling contacts is recommended for all mothers to provide a basic level of support, beginning in the antenatal period through to the introduction of complementary feeding and beyond. Counselling should include ongoing scheduled contacts, so that women can predict when the service will be available (57). Breastfeeding counselling that is delivered at least four times in the two years after birth is more effective than counselling delivered in the antenatal period only, or fewer than four times (44).

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

Breastfeeding counselling should be provided through face-to-face interaction (2). In-person, face-to-face counselling is a universal recommendation and the preferred mode of contact for breastfeeding counselling.

Under certain circumstances, face-to-face counselling may not be possible. In these cases, breastfeeding counselling may be provided through telephone or other remote modes (2). Efforts should be made to establish or restore in-person counselling as soon as possible. In general, individual face-to-face counselling may be complemented but not replaced by remote counselling (2). Each mode of counselling has advantages and disadvantages. Remote counselling technologies, such as counselling by telephone, may be useful in contexts where face-to-face counselling capacity or access are limited or absent.

5. Breastfeeding counselling should be provided as a continuum of care by appropriately trained health care professionals or paraprofessional breastfeeding counsellors.

Health care professionals have formal qualifications as practitioners and provide health-care services in a specific field. This includes physicians, physician assistants, nurses, pharmacists, midwives, nutritionists, dietitians and lactation consultants, among others. All health care professionals that have contact with mothers, infants and children should have basic competencies in breastfeeding counselling.

Breastfeeding counsellors are allied health professionals or paraprofessionals. They may have an educational or practical background in a health care speciality or they may be paraprofessionals. The role of the breastfeeding counsellor is different from the role of a clinician and requires a distinct and specialized set of skills, knowledge and attitudes.

Although some doctors, nurses, midwives and other allied health professionals may gain significant knowledge or expertise relevant to breastfeeding during training, they are not ordinarily equipped with the lactation management or communication skills required for breastfeeding counselling. Health professionals who provide breastfeeding counselling need further training to develop relevant competencies (knowledge, skills and attitudes). Some health care professionals might obtain continuing education qualifications in breastfeeding counselling or certify as a lactation consultant.

Paraprofessionals can become breastfeeding counsellors without formal health care qualifications. They are sometimes community health or nutrition workers or women from the local community, also known as peer counsellors. Paraprofessionals who provide breastfeeding counselling vary according to context but are often individuals with a close relationship to the communities where they work. They help to establish rapport, provide counselling in the language or dialect spoken in the community, and are familiar with local cultural and social customs.

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

In addition to establishing skills, knowledge and confidence among mothers, breastfeeding counselling should anticipate potential challenges (2). Anticipatory guidance helps to reduce potential risks, problems or complications by considering common challenges and those that are unique to the circumstances of a particular breastfeeding dyad. This includes preparing mothers for different stages of infant growth and development, which might pose specific challenges, especially for first-time mothers. Examples of anticipatory guidance include: preparing for cluster feeding during the neonatal period or during growth spurts, planning for the timely introduction to complementary foods, and planning for the return to school, work or separation from the infant.

PROGRAMME IMPLEMENTATION GUIDANCE

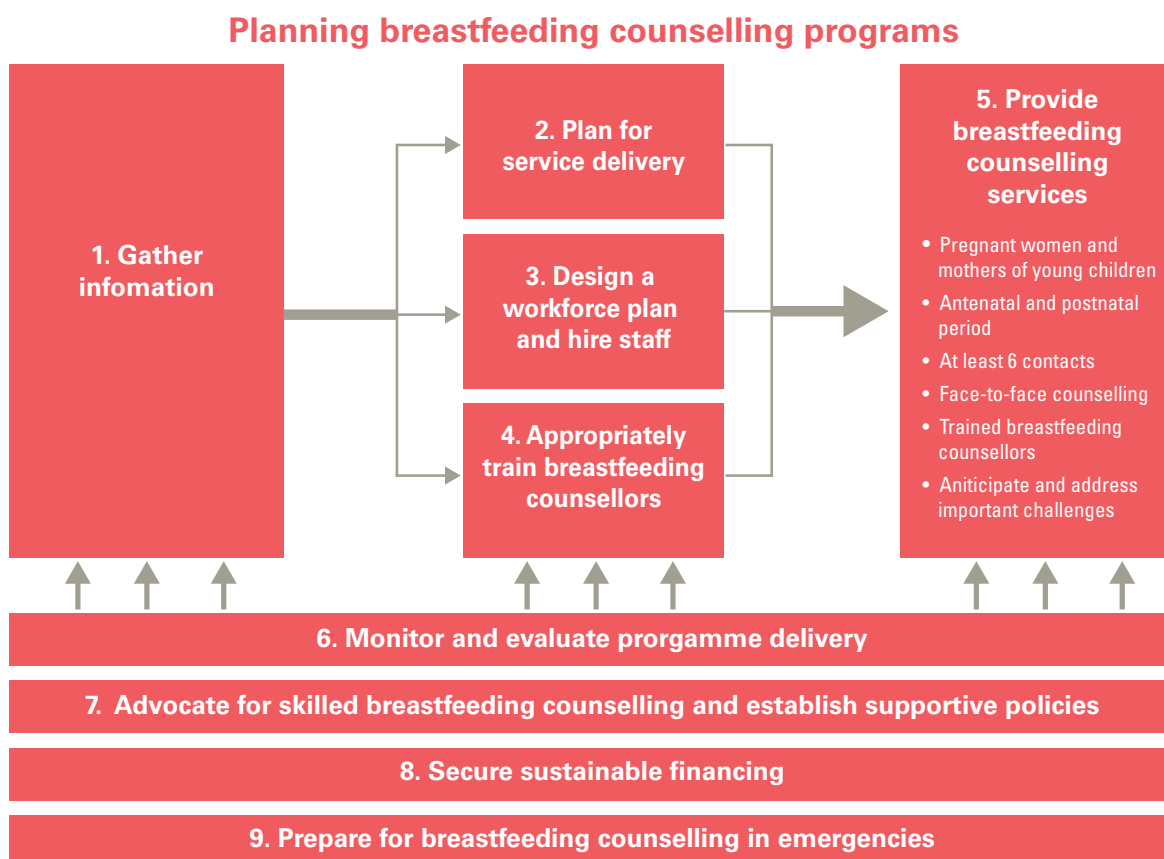
Implementing recommendations can be challenging. In some contexts, implementation means incorporating new recommendations into existing programmes or services. In others, it means designing new and separate services. New recommendations can be implemented more quickly in some contexts than in others. Often there are significant gaps between what is recommended and what is provided to communities.

Some recommendations may need to be adapted so that they are appropriate for the local context. Sometimes administrators or staff resist changing the way they work. It may also be difficult to access sufficient funding or to find staff with the necessary skills to deliver recommended services.

This implementation guidance is designed to help anticipate and address challenges in breastfeeding counselling programme implementation. It can be adapted to meet the needs of governments, programme planners or local organizations and the needs of families. It contains practical tools and resources that can be translated into feasible, sustainable breastfeeding counselling programmes in a wide range of local contexts.

Implementation is a process that moves through a series of predictable stages (5, 6). The number, order and type of activities required will vary according to the scope and local context where the breastfeeding counselling programme is implemented (*see Figure 2*).

Figure 2: Implementation framework for breastfeeding counselling programmes



1. GATHER INFORMATION



Gathering information is the first step needed to implement effective breastfeeding counselling programmes. It is necessary to gather information for new or existing programmes. Data gathered during formative assessments can be used as a baseline for monitoring and evaluation.

Information can be gathered through desk reviews, or through engaging directly with key stakeholders. First, consider what organizational resources are already available for gathering information. Consider what information needs to be gathered and how to collect that information in a standardized manner.

Gather information on the target population

Gather information from the people who the breastfeeding counselling programme aims to serve. Pregnant women, mothers and their families are the most important stakeholders to speak with. Ask questions about IYCF practices and expectations. Additional information might include places of work, nature of livelihood activities and cultural values, as these factors can influence breastfeeding initiation and duration.

It is helpful to gain an understanding of the social and cultural factors that influence IYCF practices. For example, if pre-lacteal feeding is practised in the community, gather information on its prevalence and contributing factors. In the next phase of implementation, this information can be used to inform programme strategies to counter pre-lacteal feeding practices.

If you find unexpected information during stakeholder interviews, make sure to gather further information on these factors. For instance, if reports from mothers in the community were that they never received breastfeeding counselling after birth, consider gathering information on current health-care services from staff at local maternity facilities.

Gather population-level data

Population-level needs assessments are necessary for determining the number of women and children in a country or region that should receive breastfeeding counselling services. National-level demographic data will help determine the scale of the programme and the resources needed. These data may be readily available from large national data sets, such as a census, a national Demographic and Health Survey (DHS), a Multiple Indicator Cluster Survey (MICS) or national nutrition surveys. Information may have been collected from existing breastfeeding programmes and might only need to be reviewed, compiled, updated or finalized.

Where data do not already exist, they will need to be collected. Collect key demographic information on the population size, birth rate, population growth and structure. Consider if the population is a rapidly growing urban population, a shrinking rural population or a population that migrates. These factors will impact the workforce available to serve them. Consider if the area served has sufficient numbers of key maternal and child health care personnel to serve the population. Since demographic information may vary between national, subnational and community levels, assessments may need to be collected at multiple levels.

Consider the population structure, in terms of how many pregnant women and mothers with children under 2 years of age live in the programme area. This will help estimate the resources needed for the programme to be effective. For example, determine if the programme area has a large number of adolescent and young mothers, women practising different religions, older working mothers, or all of these.

Gather information on special populations

Gather information on the needs of groups of women that cannot, or are less likely, to access routine breastfeeding counselling services due to social or physical barriers. All breastfeeding counselling programmes should plan to provide breastfeeding counselling to all women, infants and children, including at-risk infants and children and those with physical or social barriers. Gather information from women facing social or physical barriers to help design breastfeeding counselling services that meet their needs and accommodate them with extra support.

At-risk infants and children who are underweight, who are affected by wasting, or who have growth failure, should be identified. Groups of infants and children who are at particular nutritional risk include unaccompanied children or children whose caregivers are disabled or ill. Infants and children with disabilities that affect feeding (e.g., cleft palate) or who require intensive medical care (small, sick, premature or with congenital abnormalities or other medical conditions) are also considered to be at-risk.

Mothers with a lower social economic class, or who are from racial, ethnic, religious or sexual minority groups may experience social barriers to breastfeeding counselling services. Mothers from minority, immigrant and refugee groups may face additional barriers in language, literacy and numeracy, and they may be survivors of traumatic experiences.

Mothers who are stigmatized or marginalized from mainstream society face greater barriers to receiving routine breastfeeding counselling services. For example, social stigmas may exist for pregnant adolescents (58), sex workers, survivors of gender-based violence, mothers who are

homeless or incarcerated. Examples of health-associated social barriers include families living with HIV (59) or disabilities. Mothers with mental illnesses or intellectual disabilities may also have difficulties accessing breastfeeding counselling services. Some populations also have restricted movement due to social norms.

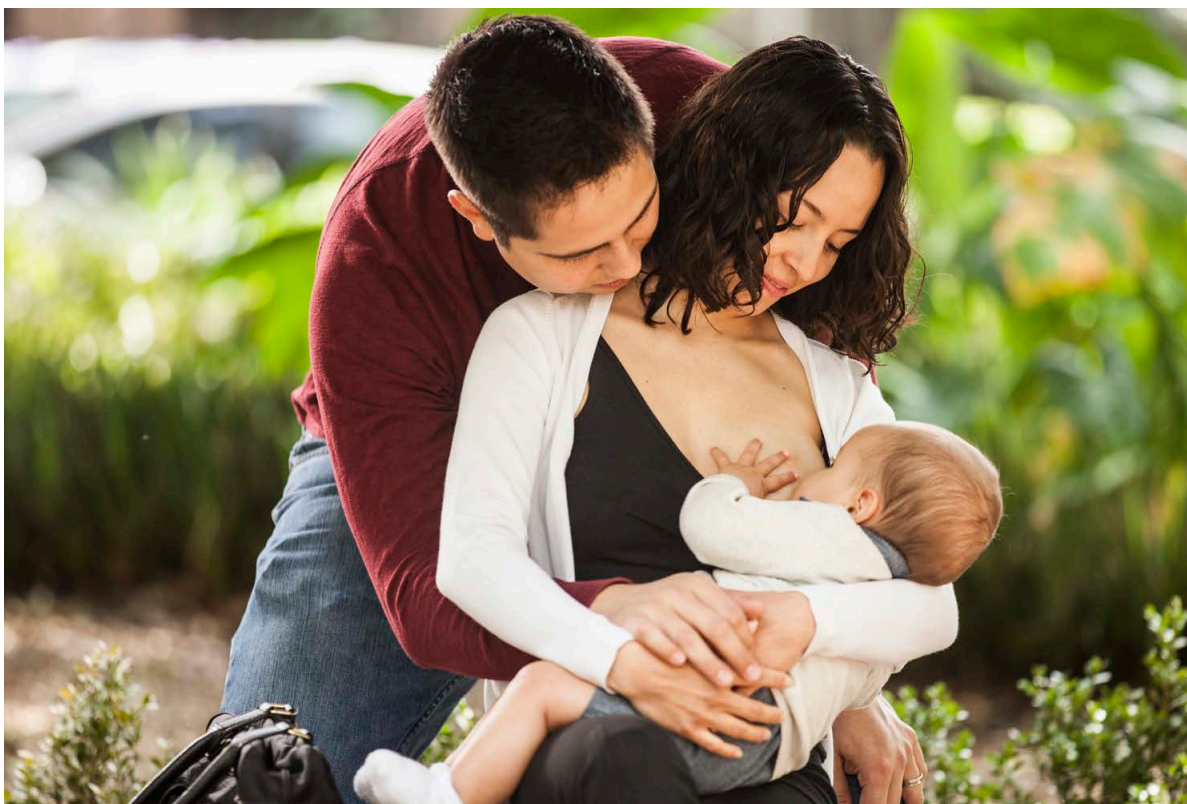
Gathering information from special populations, as well as the organizations or family members who support them, is critical. Breastfeeding counsellors may need to work closely with carers or family members who support women with disabilities and adapt their counselling approach to meet their needs.

Mothers with physical disabilities can also be referred to counsellors with specialized experience, if they are available. Mothers who are physically disabled, have visual or hearing impairment or who have communication disabilities may experience substantial barriers to services. Some mothers may not be able to receive breastfeeding counselling if they are unable to access suitable, safe transport and access to buildings. Service delivery should plan for physically disabled people, so that services can be adapted to meet individual needs and circumstances. For example, programme planners should consider infrastructure and facilities, including bathroom facilities, with ramps for wheelchairs and baby carriages. Families that live in remote communities might have trouble accessing breastfeeding counselling services. Where physical adaptation of facilities is not possible, remote counselling can be considered using telehealth technologies.

Map programme stakeholders

Decide which organizations or groups will be affected by or involved in the planned breastfeeding counselling programme. Engage with a range of community and organizational stakeholders at this early stage of information gathering. Conduct stakeholder mapping to understand the players that will be directly and indirectly involved in the programme. This will increase the likelihood of implementing an efficacious breastfeeding counselling programme that meets community needs, is welcomed by other stakeholders, and is sustainable. Some national governments maintain a National Breastfeeding Coordination Body, which includes members from all relevant sectors, usually led by the Ministry of Health. These bodies ensure protection, promotion and support of breastfeeding in the country and aim to strengthen and integrate breastfeeding counselling as a major workstream into existing health services.

2. PLAN FOR SERVICE DELIVERY



Once information has been gathered, begin planning for service delivery. Breastfeeding counselling contacts should ideally be integrated into routine services. Programme managers should envision how breastfeeding counselling contacts can be integrated into existing routine health care contacts within their local context. This might include integration into routine antenatal, postnatal or immunization visits (*see Appendix 1*) and may be in a health facility, community setting or at the family home.

When there is an intention to integrate breastfeeding counselling services into existing programmes, determine if the programme staff have already been providing breastfeeding counselling. If so, determine if staff have been formally trained to do so. If they have been providing breastfeeding counselling without formal training, a certain level of organizational change management might be needed. In some cases, existing organizational culture or politics may hinder provision of sufficient breastfeeding counselling training and service delivery. In these cases, organizational change management tasks may be needed, such as new training programmes, or changes in organizational leadership, structure and organizational culture. Examples include:

- training of all newly hired and existing staff on breastfeeding counselling and any new organizational policies;
- updating outdated or non-evidence-based organizational policies that hinder or reduce the quality of breastfeeding counselling services;
- creating incentives for existing staff to provide good quality breastfeeding counselling.

In some contexts, integration of breastfeeding counselling into existing programmes may not be feasible. In this case, consider how to make new, stand-alone breastfeeding counselling programmes sustainable. For example, plan to create strong linkages and synergies with existing health services, explore how to use local referral systems and make the most of locally available experts and resources.

Plan for all pregnant women and mothers with infants and young children

Breastfeeding counselling services are tailored to the populations they serve. People-centred breastfeeding counselling means that the counselling responds to the needs, preferences and values of individual mothers and their families (2).

Use information gathered during the initial information gathering phase to plan tailored service delivery. For example, programmes that aim to serve working mothers might consider what knowledge and tools are needed for breastmilk expression. Decide if mothers will need access to feeding equipment and supplies like cups, spoons, breast pumps or related feeding equipment. Consider if the programme will provide any supplies, and if so, take logistics, procurement and associated costs into account.

In populations where breastfeeding rates are low and mixed feeding is common, consider how the programme will deliver counselling services to partially breastfed and non-breastfed infants. Decide which services are appropriate for education on the safe use of breastmilk substitutes. Consider trainings for staff on how to appropriately counsel mothers on the use and risks of bottle-feeding, teats and pacifiers.

Anticipate and address important challenges and contexts

Breastfeeding counselling services should be adapted to meet individual needs and circumstances. Some groups of mothers and infants may need to access breastfeeding counselling services quickly. Prioritize breastfeeding counselling for at-risk infants to prevent wasting and growth failure. Breastfeeding counselling is also a core component of treatment for undernutrition in this population. Therefore, service delivery should be adapted so that groups who need urgent attention will get timely access to breastfeeding counselling services.

Working closely with existing health and social support services can build trust and allow for sensitive, targeted counselling by trusted service providers who already work with marginalized groups. For example, mothers who are homeless, living in unstable accommodation or without adequate resources and transportation may be referred to local social services. Social services may in turn provide plausible solutions, such as suitable places for breastfeeding counselling (60). Additionally, breastfeeding counselling might be added to the remit of social workers, support groups, nutrition services or other health-care services.

Providing breastfeeding counselling services to mothers who are institutionalized or incarcerated may only be possible if other support professionals, such as social workers, are equipped to deliver breastfeeding counselling. Breastfeeding counsellors who plan to work with groups that have experienced specific types of trauma, such as obstetric or gender-based violence, require additional training to provide trauma-informed care.

Consider the needs of adolescent mothers (58), including by ensuring counselling times that accommodate school and by offering adolescent-only service hours. Peer counsellors with similar social experiences are potentially better placed to facilitate relationship- and rapport-building.

Where language and literacy barriers exist, recruit breastfeeding counsellors with particular skills (e.g., spoken language skills, sign language or other communication skills). In some circumstances, local mothers can be recruited to become peer counsellors. Alternatively, breastfeeding counsellors can be trained to use language interpretation services, learn basic foreign language skills, and use supportive low-literacy materials and job aids during counselling. Offering breastfeeding counselling using language interpretation services may be an essential component of the service. Mothers with hearing, visual or communication disabilities may need interpreters, translators, guides or extra space to accommodate supportive equipment.

In settings with low health care capacity, the scale-up of breastfeeding counselling programmes may need to coincide with other endeavours to increase the capacity of the health workforce. In contexts where a large number of mothers live in remote communities, there is potential for poor coverage of primary health-care services.

A health workforce density of around 4.45 health workers per 1,000 people corresponds to the median level of health workforce density among countries that have achieved universal health coverage (61). In countries with numbers of health workers below this threshold, local mothers can be trained as peer counsellors. In this example, peer counsellors would require extensive training in advanced competencies to enable them to provide care to more women and reduce the need for referral.

In remote communities with sufficient primary health care coverage, health-care providers such as nurses, midwives and community health workers may be able to cover a broader range of services, including breastfeeding counselling. In all remote communities, plan for breastfeeding counsellors to be appropriately distributed to reach all mothers and ensure that adequate referral systems are in place.

Plan for face-to-face counselling

Consider potential settings for face-to-face service delivery. Breastfeeding counselling may take place in the family home, in a health facility or in the community. Providing breastfeeding counselling in a combination of settings is most effective (52). Consider advantages and disadvantages of service delivery in each type of setting.

If mothers do not need to travel to health facilities, it may result in better uptake of breastfeeding counselling, particularly among those with limited resources. Home-based breastfeeding counselling provides a familiar and relaxed environment for families and may provide more security and privacy. Home-based counselling may be more accessible to mothers that do not feel comfortable breastfeeding in front of others. Some mothers may not want to discuss breastfeeding in front of other members of the family, if family are critical or if the mother feels embarrassed.

Breastfeeding services might primarily take place in health facilities. Consider potential disadvantages to offering only health facility-based contacts. Evidence demonstrates that hospital environments are sometimes busy and hectic with a lack of time and privacy for breastfeeding support (2).

Consider remote counselling

Where in-person counselling services are not possible, remote counselling should be considered and appropriately planned. Remote counselling technologies might include voice messaging and calling through telephone, photo or video messaging software technologies. Where remote

breastfeeding counselling services are feasible, plan for strategies to overcome common barriers to technologies (see Appendix 2).

Consider group counselling and peer support groups

All women should have the opportunity for individual counselling to enable the development of individualized breastfeeding skills and confidence. However, group counselling of mothers during the antenatal or postpartum period may also be useful for reaching many mothers at once.

Group counselling also allows mothers to share their breastfeeding experiences and support one another. Group counselling may have an educational component but is distinct from purely educational, lecturing or classroom-style teaching. Care and skill are needed to ensure that group counselling does not take on a lecture format. Group counselling should allow for discussion, questions and answers and interaction between participants. It may be particularly effective in resource-limited settings (62).

Consider the feasibility of establishing breastfeeding peer support groups and referring mothers to them (25). Providing breastfeeding counselling to groups of mothers is often used as a means to reduce the average duration of contact per mother. In some cases, mothers can benefit from the mother-to-mother support provided in group settings and can learn from other mothers' questions and shared experiences. However, it is important that group counselling does not simply become teaching, which would not truly meet the individual needs of the participants. When planning for group breastfeeding counselling, it is critical to allow for additional follow-up and one-on-one counselling. Providing individual counselling is more time-consuming but it may also be more effective in allowing mothers the time to discuss the issues that are most relevant to them.

3. DESIGN A WORKFORCE PLAN



Design a workforce plan for programme implementation and plan for adequate human resources at the right levels. Design a workforce plan that corresponds to the size of the population being served (i.e., caseloads). Important information to consider includes the:

- number of women, infants and children being served by existing services;
- number of women, infants and children that still need to be served (service gap);
- number of breastfeeding counselling contacts currently provided;
- number of breastfeeding counselling contacts still needed (service gap).

Estimate the duration of breastfeeding counselling contacts

While studies on the duration of breastfeeding counselling contacts are limited, programme experiences have shown that the average duration varies greatly (63-66). For example, the duration of contacts can vary by country, health system and community. When estimating the duration of contacts during programme planning, it is important to strive for a balance between efficiency and quality. Breastfeeding counselling sessions that are too long may overwhelm new mothers. On the other hand, breastfeeding counselling that is rushed will not be effective.

The duration of any counselling contact varies depending on the needs of mothers and babies. Antenatal counselling contacts are generally shorter than postnatal contacts and are important

for providing anticipatory guidance before birth. Early postnatal contacts usually demand more time to establish rapport, gather relevant information on medical history and birth experience, observe breastfeeding and provide support for positioning and attachment at the breast. Subsequent contacts, when the situation is known and breastfeeding is established, usually take less time. Dyads with complex feeding issues may require longer or more frequent contacts and referrals. Longer, more frequent contacts are needed for mothers of infants under 6 months of age, compared with older infants and children.

The duration of breastfeeding counselling contacts often depends on a mother's previous breastfeeding experience. First-time mothers may require longer contacts than experienced mothers. On the other hand, mothers who have had difficult experiences may require more intensive counselling than inexperienced mothers whose babies are breastfeeding well. The complexity of feeding difficulties is a major factor contributing to the length and frequency of contacts.

Estimation of the duration of contacts needs to allow sufficient face-to-face time for counselling mothers, for travel and for future follow-up care, such as short follow-up or remote telephone contacts (67).

Understand the differences in breastfeeding counsellor cadres

A key decision to be made in scaling up breastfeeding counselling is whether to rely primarily on existing health professionals or to recruit paraprofessionals specialized in this service. The two options are not mutually exclusive, but planning for capacity building, referral systems and financing will depend on this decision.

Both health care professionals and paraprofessionals are capable of providing appropriate breastfeeding counselling. Various cadres of breastfeeding counsellors will have differing skill levels (basic versus advanced) and medical training (*see Figure 3*).

Figure 3: Various cadres that can perform breastfeeding counselling

		Medical training	
		NO	YES
Breastfeeding counselling competencies	BASIC	Peer counsellors	Health professionals
	ADVANCED	Para-professionals Lactation consultants	

Basic breastfeeding counselling competencies include the ability to provide three-step counselling (*see the 'triple-A approach' in Chapter 5*), giving mothers practical help with breastfeeding, and addressing common questions or concerns. Advanced breastfeeding competencies include assessing breastfeeding, making informed decisions and developing personalized remediation or management plans for complex breastfeeding problems. All breastfeeding counsellors should recognize problems that require referral for clinical assessment and management.

There are various terms used for different breastfeeding counselling providers. Paraprofessional breastfeeding counsellors, also called ‘lay breastfeeding counsellors,’ are allied health workers who do not have professional medical training. They often work in collaboration with and as an extension of existing health services, providing breastfeeding counselling services in the family home or in community settings.

Paraprofessionals may work at either a basic or advanced level of competency, but typically work only at a basic level of competency. Paraprofessionals with only basic training will require supervision by a more experienced breastfeeding counsellor. Community health workers are typically paraprofessionals who provide a number of health services. With appropriate training, community health workers could take on responsibilities for providing breastfeeding counselling services.

Peer breastfeeding counsellors are a specific type of paraprofessional selected because of personal prior breastfeeding experience. Peer counsellors with specific personal breastfeeding experiences are selected because they may share similar lived experiences with the women they counsel. Shared experiences may include becoming a mother in adolescence, having breastfed a premature baby, being a mother of twins or multiples, having given birth by caesarean section, or simply living in the same community or sociocultural environment. Peer counsellors have been shown to successfully inform, encourage and support breastfeeding among both employed and unemployed women (68). Choose modalities for peer breastfeeding counselling that are best suited for the local population.

An example of a programme leveraging the strengths of peer counsellors to reach low-income populations is given in the following case study from the United States (*see Box 2*).

Box 2: Case study on providing peer breastfeeding counselling services in low-income populations in the United States

The Breastfeeding Heritage and Pride (BHP) programme is an evidence-based programme that provides no-cost peer breastfeeding counselling to low-income women living in the United States (69). It is implemented by the Hispanic Health Council, a community-based organization, in partnership with health care systems serving low-income communities. The programme employs peer counsellors, who have a deep understanding of women’s lived experiences of poverty and other social determinants of health that make breastfeeding challenging (69). The BHP programme hires peer counsellors from diverse, low-income communities who have successfully breastfed, to serve in both community and health care settings.

The BHP programme provides training for peer counsellors, provides them with supportive supervision, and ensures their integration into the clinical team. An International Board-Certified Lactation Consultant gives guidance to peer counsellors and provides advanced clinical breastfeeding counselling skills when needed, according to a protocol delineating scopes of work. Programme leaders, health care managers, the IBCLC and peer counsellors meet periodically to coordinate and continuously improve the quality of the continuum of breastfeeding care.

Lessons learned include the importance of:

- assigning each mother to one peer counsellor and offering breastfeeding counselling services during pregnancy and after birth, in a variety of settings, to foster continuity of care;
- integrating peer counsellors into clinical teams, which fosters an environment where mothers are understood and barriers to breastfeeding are factored into breastfeeding counselling.

Health professionals

Health professionals, including doctors, nurses and midwives may also serve as breastfeeding counsellors. However, health professionals usually require further training to develop the advanced competencies (skills, expertise and attitudes) required of a breastfeeding counsellor. In most settings, breastfeeding counselling skills are not adequately covered in medical, nursing or midwifery training. Furthermore, health care training often fails to cover aspects relevant to caring for breastfeeding mothers and their infants.

In some settings, specialists in breastfeeding care have developed as a separate cadre of health workers. Often called lactation consultants, or lactation specialists, they may or may not carry other health professional credentials. This cadre can assist with more advanced breastfeeding issues and may be able to supervise paraprofessional breastfeeding counsellors. However, lactation consultants are generally too few in number to serve all pregnant and lactating mothers and thus cannot be the only cadre used for all breastfeeding counselling.

Health care professionals may have had some training on breastfeeding and should have had training on health counselling, generally. It should not be assumed, however, that health care professionals are inherently skilled in breastfeeding counselling, as the amount of specific training received is typically inadequate.

Good quality breastfeeding counselling cannot be rushed. However, health care professionals, particularly physicians, often have an overabundance of responsibilities that compete with the time needed for breastfeeding counselling. The amount of time allotted to spend with an individual mother is typically already limited, such that breastfeeding counselling can usually only comprise a small part of the scope of their work. Some programmes have found that an average counselling contact takes about 30 minutes (64). Adding this amount of time to the existing tasks of health care workers would require a significant increase in the amount of time spent with each patient. It may also diminish the possible caseload per health care worker. Therefore, if breastfeeding counselling services are provided by existing health care professionals, it is critical to work with broader health system strengthening approaches to improve coverage (70-72).

Health care professionals typically earn higher salaries than paraprofessionals, suggesting that reduced reliance on health care professionals might be cost-effective. On the other hand, there is often greater attrition of paraprofessional staff, creating the need for better mechanisms of motivation and retention, such as credible certification and recognition, supportive supervision, non-financial incentives, useful tools, as well as increased recruitment and training (73).

Decide on the primary cadres to provide breastfeeding counselling

There are advantages and disadvantages to establishing breastfeeding counselling programmes using existing health professional cadres versus recruiting new paraprofessionals to specialize in breastfeeding (see Table 1).

Table 1: Advantages and disadvantages of using health professionals or paraprofessionals for breastfeeding counselling

Health care professionals	Paraprofessionals
Advantages: <ul style="list-style-type: none">• Already well-integrated into the local health care system• Referral mechanisms may already be well-established in some settings• Typically, a more stable workforce• May already have some existing skills in health counselling and/or breastfeeding counselling	Advantages: <ul style="list-style-type: none">• Can more easily be recruited to meet expanded service demands• Salaries are usually lower compared to health care professionals (nevertheless, a liveable wage is recommended)• More easily available to make home visits
Disadvantages: <ul style="list-style-type: none">• Already overstretched and have minimal time to add quality counselling into busy appointment schedules• Often need specific training in breastfeeding counselling• Usually, higher salary compared to paraprofessionals• Women need to travel to a health facility for counselling	Disadvantages: <ul style="list-style-type: none">• Requires new or strengthened systems to ensure continuity with the health care system• Requires clear referral systems to be created unless they work directly under the supervision of the health system• May have more rapid turnover, creating increased demands for recruitment and training of new staff• Likely require more training to develop necessary competencies

In many contexts, relying on existing health care professionals, particularly midwives and nurses, to integrate breastfeeding counselling into the care provided for pregnant and lactating women is the most obvious solution. These cadres are already in contact with women at the most important time points during antenatal care, delivery, well-baby care and postpartum follow-ups. Integrating breastfeeding counselling with these services could help ensure that the full spectrum of infant and young childcare is handled cohesively. When referral is needed, standard systems may already be in place in a well-functioning health system. However, there may not be enough midwives and nurses to carry out all breastfeeding counselling contacts in health facilities, at home or in the community, in addition to the tasks they are already performing. Hence, in most cases, either more health care professionals will be needed or paraprofessional breastfeeding counsellors will need to be recruited to work in collaboration to extend their reach and capacity.

To attain adequate coverage with quality breastfeeding counselling services, it may be advantageous to rely on a combination of both health care professionals and paraprofessionals. For example, health care professionals may be better positioned to provide breastfeeding counselling in the immediate postpartum period while mothers are still in the maternity facility, whereas paraprofessionals might provide optimal services in the days and weeks after mothers go home when more questions about breastfeeding arise and counselling sessions need to be longer.

Plan for service delivery

After estimating the number of women, infants and children being served and mapping potential service gaps, it may be apparent that breastfeeding counselling services should be scaled up. Discuss with key stakeholders what the scale-up of existing breastfeeding counselling service would encompass. Decide whether to hire experienced breastfeeding counsellors, newly trained breastfeeding counsellors, or both. This will depend partly on who is available and how many breastfeeding counsellors are needed. It is always useful to rely on experienced breastfeeding counsellors, but competencies will need to be verified and refreshed according to current evidence-based practices and policies.

When planning to scale up programmes, existing cadres of medical professionals may be willing to provide breastfeeding counselling. However, consider if staff are able to provide services in addition to existing responsibilities. Reflect on whether increasing the frequency of breastfeeding counselling contacts would cause neglect of other important routine health care tasks or compromise the quality of breastfeeding counselling. If the quality of care would be negatively affected by programme scale-up, plan to hire additional staff. Ensure that breastfeeding counsellors have manageable workloads.

It is important to identify human resources already available and the extent to which workloads could be expanded to cover additional breastfeeding counselling contacts or improve the quality of services already being provided. Decide how much, if any, of the programme can be delivered by existing personnel, considering services already provided. Consider the:

- number of health professionals and paraprofessionals providing services;
- workloads of existing staff;
- additional time needed for breastfeeding counselling contacts;
- attitudes and willingness of staff to accommodate or support additional programme activities alongside existing responsibilities.

Plan for an adequate number of supervisors

Plan for an adequate number of supervisors to direct, oversee and provide support to breastfeeding counsellors. Supervisors provide supportive supervision, monitor the performance of breastfeeding counsellors and assess adherence to organizational protocols. Their responsibilities include supervisory visits for newly trained breastfeeding counsellors within a few weeks of initial training and at intervals thereafter. Supervisors assess breastfeeding counsellors' competence and confidence, guide and instruct them in the management of difficult cases, directly observe their counselling skills and progress, and determine the need for refresher trainings.

Recruit programme staff

Recruit a core planning and coordination team comprised of one or more programme managers and support staff. National programme managers provide a national vision and leadership. Appoint an experienced manager to lead, build political support and mobilize financial resources for breastfeeding counselling services. Strong subnational leaders are also essential for successful programme implementation and provide oversight of programme activities at regional and local levels. Appoint subnational managers to develop plans that are locally contextualized and coordinated.

Hire programme support staff to organize and coordinate day-to-day programme activities. Their responsibilities include recruitment of personnel, communication, scheduling of daily programme activities, contracting, documentation, procurement and potentially reporting, or activities for continuous process improvement. In addition, breastfeeding counselling programmes need either in-house or contracted trainers and assessors, administrators, and information technology support staff.

Some programmes may decide to contract or outsource all or part of breastfeeding counselling programme coordination or implementation to third-party organizations. Contractors should be chosen after performing vetting, which gauges their capacity to implement effective programmes. In general, implementing organizations should be assessed for capacity in the following domains:

- Policy and programming environment
- Human resources administration, management and supportive supervision
- Coordination
- Information management
- Service delivery
- Commitment to equity
- Financial tracking

Recruitment of service delivery staff should bridge coverage gaps identified during the information gathering stage. Create position descriptions including competencies, roles and responsibilities which:

- outline required or preferred experience in breastfeeding counselling programming or support;
- include required or preferred management and supportive supervision experience needed for supervisor positions.; and stipulate the level of competence for supervisors to maintain high service standards;
- outline additional tasks and functions that staff should perform, such as maintenance of records, referrals and continuing education.

4. APPROPRIATELY TRAIN BREASTFEEDING COUNSELLORS



Capacity development is the process of acquiring, strengthening or retaining competencies. It includes identifying and building upon existing skills and knowledge, using strategies that are appropriate for the local context. Ensure that breastfeeding counsellors and trainers have the appropriate skills, knowledge and resources to do their jobs competently.

Develop, adapt or update curricula for training programmes

Based on the information gathered in formative assessments, decide if new training programmes and curricula will be established. Take into account that internationally developed curricula almost invariably need adaptation to local contexts (65). Think about how existing training curricula can be regularly updated and maintained.

Engage with relevant local stakeholders to develop, adapt or update training curricula. Stakeholders might include vocational schools, colleges, universities, health-care facilities, non-for-profit organizations, community health centres, training centres and institutions, licensing and credentialing boards, ministries of health, health-care facilities or others.

Pre-service training programmes refer to programmes that take place before employment, such as courses and training at vocational colleges or undergraduate programmes. Health care curricula that emphasize breastfeeding can improve breastfeeding knowledge, attitudes and confidence of students (66). Develop breastfeeding counselling content for existing medical,

nursing, midwifery, pharmacy, nursing, dietetics and nutrition, or other health professional curricula (67-69).

Health care credentialing and licensing programmes serve as a quality control mechanism for pre-service training programmes. Professional licensure and board examinations serve as a quality control mechanism for pre-service training programmes before entry into the workforce in health care institutions. Therefore, breastfeeding counselling programmes should coordinate with relevant organizations to:

- develop, improve and update curricula for pre-service training programmes;
- integrate curricula into health care credentialing and licensing programmes.

In-service training programmes refer to programmes that take place during employment (e.g., residency or fellowship training programmes). Before developing curricula for in-service training programmes, determine the extent to which existing staff have the needed knowledge and skills. Generally, it can be assumed that:

- all newly recruited breastfeeding counsellors will require training;
- training of paraprofessional breastfeeding counsellors without prior experience will need to start from the fundamentals with a comprehensive course;
- experienced health professionals with complementary skillsets in health counselling will not necessarily be equipped with breastfeeding counselling competencies, unless they have received formal training;
- staff who have prior experience delivering breastfeeding counselling without adequate training may need as much, if not or more training, than new staff, in order to modify established attitudes and practices.

To determine the scope of your in-service training programme, consider the:

- number of health professionals who have received training;
- type of staff and respective training needed;
- the types of training and numbers of trainers available or needed;
- the number of supervisors with capacity for mentoring.

In-service training programmes should aim to:

- improve existing curricula, based on current knowledge and scientific evidence;
- establish evidence-informed standards for trainings;
- ensure curricula is regularly updated;
- verify competencies at all levels.

Consider literacy and numeracy of counsellors

Breastfeeding counsellors may have limited levels of literacy or numeracy. Community health workers with low literacy and numeracy may be an underrecognized resource for breastfeeding counselling programmes. While low literacy and numeracy does not prevent development of basic competencies, it may require training sessions with more practical one-to-one discussions with role-play, experience with mothers and babies, less reading, more visual materials, and more ongoing practical and clinical training linked to supervision. For example, community health workers with low literacy in South Sudan demonstrated the ability to follow a simplified treatment protocol for uncomplicated severe wasting with high accuracy, using adapted tools (74).

It is important to adapt training tools in contexts with low literacy and numeracy, which may include the use of simplified job aids. Adaptation of job aids to accommodate low literacy levels can positively impact the quality of service and the duration of contacts. The Community Infant and Young Child Feeding Counselling Package (75) is an example of a simple tool for breastfeeding counselling that includes images to assist counsellors with low numeracy. One counselling card includes images to elucidate the concept of frequent breastfeeding on-demand. It depicts a series of 12 images of the same mother and baby pair, breastfeeding during the morning, evening and night (75).

Increased supervision by professional health workers in the initial delivery of breastfeeding counselling sessions can provide quality assurance and enhance outcomes. It has been demonstrated that close supervision of community health workers improves accuracy of messages (76). Frequent supportive supervision visits while counselling is ongoing also allow for timely observation, correction and guidance.

In some contexts, it may be appropriate to adapt the pace of training to match the learning needs of individuals. This allows learners to acquire knowledge at their own pace and at their own levels of literacy and numeracy skills. For example, training may take place during one-day or two half-days a week. Some approaches might include blended-learning sessions or self-study materials.

Ensure opportunities for practical training

In both pre-service and in-service training programmes, hands-on clinical training is necessary during training courses, health care practicums, fellowships or residencies. Aim to establish evidence-informed pre-service training and clinical experiences in breastfeeding counselling (70). Theoretical knowledge, while helpful, does not equip health workers with the skills necessary to provide effective breastfeeding counselling. Breastfeeding counsellors must also develop counselling communication skills, practical and clinical skills, and supportive attitudes. Plan for supervised contact hours with mothers and infants, in order for trainees to learn applied skills.

Developing skills and modifying attitudes is a time of intensive activity that requires learners to engage in repeated cycles of structured observation and practice, feedback, reflection and further practice. Activities that support practical skills-building include demonstrations, role-play in small groups, and observation of breastfeeding counselling interactions. Training should utilize active and participatory teaching and learning methods such as debate, observation counselling materials, visual aids, demonstrations, group discussions, case studies, and most importantly, supervised clinical practice.

In order to engage in these activities, learners must be willing to try new practices, knowing that they must fail repeatedly in order to succeed. Therefore, it is crucial that training facilitators have the skills and attitudes required to establish and maintain psychologically safe learning environments (77).

Ensure supportive supervision

Practising breastfeeding counselling under close supervision is essential for acquiring necessary skills to work independently. However, a common pitfall of training courses is insufficient time for clinical practice sessions. On-the-job, supervised breastfeeding counselling after training may help to compensate for insufficient clinical practice during training. Supervisors ideally are locally based, and may also be trainers. They can supervise breastfeeding counsellors without excessive travel and reinforce knowledge and skills through ongoing supportive supervision.

Supervisors should assess, observe, evaluate and encourage breastfeeding counsellors to apply their new knowledge and skills, during and as soon as feasible following training.

Monitor the retention of knowledge and skills development over time through a formalized system of supervision. Ongoing supportive supervision helps determine the need for refresher training. Where supervision of individual counsellors is not possible, peer mentoring among a group of counsellors may be considered.

Decide on the mode of training

The mode of breastfeeding counsellor training may vary depending on the local context. Face-to-face training is preferable. However, training of personnel can also be remote, or a mixture of both, using various technologies (e.g., online training using e-learning modules, hands-on workshops and clinical practice sessions). At the same time, consider that practical learning activities with opportunities to give and receive feedback, or reflect and practice, are challenging to deliver remotely. One option is to begin with theoretical training delivered remotely, followed by shorter face-to-face practical sessions.

Consider cascade training

Cascade training, also known as training-of-trainers, can be a useful approach to developing the competencies of trainers. Cascade training uses a top-down approach to transfer knowledge, skills and training expertise (78, 79) mainly through deploying informal learning activities (see Figure 4).

Figure 4: Cascade training structure for breastfeeding counselling programme



Cascade training has a strong multiplier effect and rapidly increases the final number of recipients (80, 81). Expert trainers conduct the first phase of the training cycle. When cascade training participants are qualified, they become the second cohort of trainers (82). This procedure is repeated in successive phases, and breastfeeding counselling knowledge is cascaded down. One advantage of cascade training is increasing the availability of trainers in different localities, so that successive trainings can take place closer to where trainees live, with less need for travel.

Cascade training for breastfeeding counselling is often an in-person or face-to-face approach. Other methods use blended approaches that combine in-person and e-learning training. Choose the right combination of training, depending on the local curriculum, trainer profiles and other relevant factors.

Consider the advantages and disadvantages of cascade training

Cascade training can be useful when the number of training recipients is high and there is a need for rapid dissemination. It cuts down on the upfront costs of training, and reduces travel costs for breastfeeding counsellor trainers. The time required of external consultants is also limited, since local programme teams typically manage the dissemination of the training programmes. Most training is managed internally, making it easier to accommodate schedules and minimize service disruption. Cascade training may help to increase programme ownership and sustainability when the trainer is an internal team leader. Local trainers may support a greater sense of ownership, interest, enthusiasm and may positively influence participation.

The quality of the entire cascade training programme will indeed depend on the quality of the original training and curricula. Apart from breastfeeding counselling expertise, the quality of cascade training is also highly dependent on the availability of qualified experts, master and local trainers. When there is a high turnover of trainers (a common challenge faced by large-scale breastfeeding programmes), interruptions can compromise the overall quality of trainings. In addition, it becomes difficult to track and follow-up with trainees. Trainer availability also affects the continuity of trainings (e.g., refresher trainings) and the sustainability of cascade training programmes over time.

Cascade training helps to rapidly scale up breastfeeding counselling programmes. Training rollout starts with a competent, in-house subject matter expert to rollout the training. Once the master trainees become trainers, knowledge can be rapidly transferred to the next level, reaching a large number of breastfeeding counsellor trainees. However, cascade training is a modality that can result in poor-quality training if content is lost or diluted at each successive stage of the training cascade. Indeed, a common problem is lack of thorough monitoring of the intermediate stages of training. Only reporting the outputs of the total number of breastfeeding counsellors trained during the last phase is not sufficient. Continuous process monitoring of breastfeeding counselling cascade training programmes is essential to ensure success.

Design cascade training

The duration and scope of cascade training packages for breastfeeding counselling vary between countries and programmes. Most trainings are packaged as the IYCF counselling curriculum (8). Sometimes breastfeeding counselling training is provided within a comprehensive package of maternal and child health and nutrition curriculum training. In this way, breastfeeding counselling may be covered in only a few sessions. While this may be sufficient time to cover basic information to promote good breastfeeding practices, the time for practising breastfeeding counselling is likely insufficient to build the problem-solving skills necessary.

Breastfeeding counselling training can be provided as a stand-alone package, which may be necessary to achieve sufficient understanding of specific content and build individual counselling, problem-solving, group facilitation and communication skills (9). The following case study illustrates how cascade training was used in Kathmandu Valley, Nepal, to improve breastfeeding counselling through education on the practice of recommending pre-lacteal feeds (*see Box 3*).

Box 3: Case study on cascade training for improved breastfeeding counselling in hospitals in Nepal

In Nepal, a population-based study showed that 27 per cent of newborns receive pre-lacteal feeds. Helen Keller International partnered with the Ministry of Health and Population to conduct a study in 2013 in Kathmandu Valley hospitals. An assessment within Kathmandu hospitals revealed that:

- health care staff lacked knowledge and skills to help initiate breastfeeding;
- staff perceived low milk production in the first few days after birth, believed colostrum was insufficient and commonly recommended infant formula.

To improve breastfeeding counselling provision by health care workers, a three-day training curriculum was developed. The curriculum was based on:

- the WHO and UNICEF Infant and Young Child Feeding training package;
- assessments to identify specific gaps in knowledge and skills;
- input from local experts to adapt the package to the Nepalese context.

Cascade training was performed in 10 Kathmandu Valley hospitals, covering over 90 per cent of facility-based births in the Valley. In total, 47 master trainers, including senior health workers from participating hospitals, were trained. Master trainers rolled out 24 batches of training to 575 nurses. The training package focused on local challenges, including:

- the mother-newborn dyad in an early postpartum hospital setting;
- staff misperceptions on colostrum, hunger cues and signs of milk transfer;
- enabling early initiation of breastfeeding after caesarean birth.

The cascade training used participatory training methods, such as oral and visual demonstrations, case studies and role plays. A hospital-based practice session was included to enhance nurses' confidence in their ability to perform the targeted skills while practising in a real-life work setting. A pre- and post-test were administered at the beginning and end of each batch of training. Follow-up visits were conducted three months after the training with interviews at each participating hospital.

Lessons learned were as follows:

- Acceptability of training was achieved by tailoring curriculum to address the practical knowledge and skill gaps in the local context.
- Country-specific evidence helped convince health facility leaders, who were initially hesitant towards the need for additional training.
- Ownership was achieved by involving health facilities from the planning stage.
- Engagement of local leaders ensured that time and resources were allocated for training.
- Smooth execution of large-scale training with full participation is possible through frequent communication and follow-up with health facilities.
- Sustainability is achieved through preparing master trainers from the facilities to plan and facilitate future trainings in their hospitals.

Choose experienced expert trainers

Choose expert trainers that are experienced breastfeeding counsellors, health care workers, employees with a background in community health or nutrition, or breastfeeding support-group-leaders. In large health-care facilities, trainers may be recruited directly from the facility. Even experienced staff need to be trained on how to be effective trainers. Trainers need to learn how to administer sessions and courses, understand and develop competence in teaching methodologies and apply newly acquired skills under supervision. Trainers should demonstrate necessary skills and knowledge before independently conducting trainings. They should attend refresher trainings to maintain and further develop clinical and teaching competencies.

Careful selection of the expert trainers is crucial for cascade training. The number of expert trainers for the first training of master trainers should be at least two (12). Ensure a good ratio of trainers to trainees, which should be one trainer for four to five trainees (8).

Programmes should select trainers who are interested and available to conduct training in the future (8). Ideally, trainers must have some previous training experience in breastfeeding counselling and facilitation skills. Consider the gender of the trainer for the local context.

Monitor participant learning and satisfaction during cascade training

Quality assurance and formative evaluation in all phases are essential to verify competencies. To ensure quality as the cascade training unfolds, a team should be established for continuous monitoring.

For cascade training, it is important to verify that the final recipients of training are as well trained as those at the first level. Participant mastery of new knowledge can be measured immediately through the pre- and post-tests, which are built into the training sessions. Some indices that could be used to evaluate the training are:

- proportion of participants who complete cascade training;
- proportion of participants who succeed in accreditation procedures;
- participant satisfaction levels;
- participant-reported readiness for independent counselling.

Verify competencies

The assessment of competencies can be used to identify gaps in skills or knowledge and can be used to pinpoint training needs, or to plan effective capacity development strategies. Global tools are available for the verification of breastfeeding counselling competencies of health care staff, which can be adapted for local contexts (17).

Competency verification usually includes written or oral questioning, discussion of case-based scenarios, and direct observation of skills and attitudes. Skills and attitudes can only be accurately assessed using direct observation. Simulated breastfeeding counselling contacts with simulated patients (role plays) or actual women and mothers (provided they are informed of the purpose of the encounter and volunteer or consent to participate) may be used for this purpose. Examiners must themselves have verifiable breastfeeding counselling competencies, qualifications and experience delivering breastfeeding counselling. Ideally, examiners should be selected based on experience providing breastfeeding counselling in situations similar to those that will be encountered by breastfeeding counsellors in programme.

The WHO/UNICEF Baby-friendly Hospital Initiative Competency Verification Toolkit (17) offers flexible guidance and tools that may be adapted for verifying breastfeeding counselling knowledge, skills and attitudes. The Competency Verification Form is a useful template for developing a record of competency assessments. Most of the performance indicators map directly to breastfeeding counselling competencies described in the breastfeeding counselling curriculum (15).

5. PROVIDE BREASTFEEDING COUNSELLING SERVICES



Breastfeeding counselling is different from education, promotion or sharing of generic messages. Key aspects of breastfeeding counselling include listening with respect, supporting women in their own decision-making, providing anticipatory guidance and helping with challenges during critical time points. Breastfeeding counselling involves discussing questions and concerns with the mother, supporting her to build skills and self-confidence, and observing and assisting the dyad to breastfeed.

Breastfeeding counselling should be both people-centred and quality-focused. People-centred counselling means putting women and mothers at the centre of the service provided, supporting them in their decision-making, and responding to their needs and preferences in a compassionate and holistic manner. It requires offering information and support needed to make decisions and to participate in care. Quality-focused counselling is counselling that is effective in achieving the desired outcome in a timely, efficient and equitable manner.

Breastfeeding counselling should provide anticipatory guidance on potential challenges to reduce potential risks, problems or complications that may arise. Consider common challenges as well as challenges that are unique to the circumstances of a particular breastfeeding dyad. Anticipate potential breastfeeding challenges during the first hours and days after birth and how to solve them, such as those related to cluster feeding, timely introduction to complementary foods, planning to return to school and work or separation from the infant.

Provide at least six breastfeeding counselling contacts

Provide at least six breastfeeding counselling contacts. Consider key time points and tasks for counselling contacts (see Table 2). Counselling contacts should occur during both the antenatal and postnatal periods.

Table 2: Key time points for breastfeeding counselling contacts

Contact one: Before birth (antenatal period)
<ul style="list-style-type: none"> • Ask about plans for feeding, previous breastfeeding experience and concerns • Give information about the benefits of breastfeeding and risks of artificial feeding • Give anticipatory guidance for birth (vaginal and caesarean), such as uninterrupted skin-to-skin contact, self-attachment to the breast and the importance of colostrum • Explain patterns of infant feeding (cluster feeding) • Demonstrate positioning and attachment and encourage practice with a doll • Demonstrate hand expression of breastmilk in the case of breastfeeding difficulties • Reinforce the importance of exclusive breastfeeding • Engage other health professionals as appropriate
Contact two: During and immediately after birth (perinatal period up to the first two to three days after birth)
<ul style="list-style-type: none"> • Explain importance of avoiding separation of mother and infant, regardless of mode of childbirth • Explain importance of uninterrupted skin-to-skin contact for one hour immediately after birth • Observe infant self-attach to the breast, assisting where needed • Help to achieve good positioning and attachment and show alternative positions • Explain infant feeding cues and behaviours, onset of lactation, responsive breastfeeding and signs of adequate transfer of milk • Reinforce the importance of exclusive breastfeeding • Counsel mothers on the use and risks of feeding bottles, teats and pacifiers • Counsel on the importance of breastfeeding as part of continuous kangaroo care for low birthweight, small-for-age or preterm infants
Contact three: At one to two weeks after birth (within the neonatal period)
<ul style="list-style-type: none"> • Observe a breastfeed and ask how breastfeeding is going • Reassure on what is going well, talk through any difficulties and offer help • Explain good positioning and attachment and alternative positions • Help with position and attachment as needed • Reinforce the importance of exclusive breastfeeding • Teach the skill of expressing milk, as needed • Counsel on maternal or infant medical indications for supplementation following assessment and management, as needed
Contact four: In the first three to four months (early infancy)
<ul style="list-style-type: none"> • Reassure the mother on what is going well and ask if there are any difficulties • Reinforce the importance of exclusive breastfeeding until 6 months of age. Discuss timely, adequate, safe and appropriate complementary feeding, and responsive complementary feeding, as anticipatory guidance • Discuss any concerns about milk supply. Counsel on maternal or infant medical indications for supplementation following assessment and management, as needed • Provide information and explain infant feeding behaviour

Contact five: At 6 months of age <i>(at the start of complementary feeding)</i>
<ul style="list-style-type: none"> • Ask how the mother is getting on, reassure her and help with any difficulties • Discuss any challenges with feeding and growth spurts • Discuss the benefits of continued breastfeeding up to 2 years of age • Discuss timely, adequate, safe and appropriate complementary feeding, and emphasize responsive complementary feeding
Contact six: After 6 months of age <i>(late infancy and early childhood)</i>
<ul style="list-style-type: none"> • Discuss the benefits of continued breastfeeding up to 2 years of age and beyond • Discuss the importance of timely, adequate, safe and appropriate complementary feeding, and emphasize responsive complementary feeding
Additional contacts as necessary
<ul style="list-style-type: none"> • Provide counselling when concerns or challenges arise, including feeding during illness • Counsel when opportunities for breastfeeding counselling occur (e.g., postnatal check-ups, immunization contacts) • Anticipate challenges for returning to work and practice breastmilk expression, as needed

Provide basic or advanced breastfeeding counselling services

Breastfeeding counselling services can be considered basic or advanced services (*see Table 3*). Services that require specific skills or medical knowledge are considered advanced.

Table 3: Breastfeeding counselling service delivery

Basic breastfeeding counselling services
Listen and learn by (83):
<ul style="list-style-type: none"> • using helpful non-verbal communication • asking open questions • using responses and gestures that show interest • reflecting back what the mother says • empathizing and communicating that you understand how the other person feels • avoiding words that sound judgemental.
Build confidence and give support by (83):
<ul style="list-style-type: none"> • accepting what a mother thinks and feels • recognizing and praising what a mother and child are doing right • giving practical help • giving relevant information • using simple language • making one or two suggestions, not commands.
Assess and document:
<ul style="list-style-type: none"> • feeding histories of healthy and sick infants or young children • the mother's history, present difficulties and possible future challenges • breastfeeding of healthy and sick infants and young children • the mother feeding and interacting with her baby • the infant's general condition, and measure and assess growth • the general condition of the mother, and check and palpate breasts as needed.

Assist mothers to:

- initiate breastfeeding within an hour of vaginal or caesarean birth
- position themselves and their infant for breastfeeding
- attach their infant to their breast
- understand and practice responsive (unrestricted) breastfeeding
- hand-express breastmilk
- cup- or spoon-feed infants
- manage flat or inverted nipples
- manage sore or cracked nipples
- manage engorgement and recognize signs of mastitis
- recognize the signs of adequate milk transfer
- manage perceived insufficient milk supply
- manage low or excess milk supply
- soothe infants who cry frequently or have sleeping difficulties.

Prepare:

- pregnant women for breastfeeding
- mothers to breastfeed exclusively for six months
- mothers who are returning to work or periods away from their infant to maintain breastfeeding
- mothers with information on timely, adequate, appropriate and safe complementary feeding
- mothers who wish to wean their infants or young children from breastfeeding with information on how to do so.

Refer:

- mothers and infants to breastfeeding counsellors with advanced competencies or health care professionals with specialized skills, as needed.

Advanced breastfeeding counselling services**Assist mothers to:**

- manage mastitis
- manage candida
- manage tongue tie (ankyloglossia)
- breastfeed a low birthweight, preterm or sick infant
- successfully breastfeed despite deeply inverted or very large nipples
- breastfeed infants through difficult personal circumstances or postpartum depression
- breastfeed infants who are refusing to breastfeed (nursing strike)
- induce or re-establish lactation (re-lactation).

Prepare:

- pregnant women at high-risk for low milk supply, including overweight or obese women
- pregnant women who are HIV-positive with information on how to safely breastfeed
- high-risk pregnant women to breastfeed a small, sick or preterm infant.

Refer:

- mothers and infants to counsellors with basic breastfeeding competencies for follow-up or to health care professionals with specialized skills, as needed.

Apply a three-step counselling process

The three-step counselling process is also referred to as the triple-A approach. It involves a dialogue on breastfeeding between breastfeeding counsellors and women or their family

members. It identifies feeding difficulties, provides practical support and helps mothers overcome difficulties. It involves the following three steps:

- **Assess:** Listen to a mother's breastfeeding concerns and respond appropriately. This step enables counsellors to assess age-appropriate feeding, as well as the mother and child's situation. It involves asking questions about age, feeding history and encompasses listening to the mother's concerns, observing a feed, and the general condition of the mother and child. This stage also includes breastfeeding plans.
- **Analyse:** Analyse the situation or potential feeding difficulty presented by the mother or her family members. Prioritize the most important issues, if there is more than one issue. Decide if there is a problem that needs referral.
- **Act:** Discuss or suggest a small amount of relevant information. Answer questions, explain the cause of any difficulty and how this could be improved. At the same time, agree on a feasible option that the parent or caregiver can try to address the problem at hand. This stage also enables referral to health professionals for breastfeeding issues that require advanced competencies. Prepare pregnant mothers for breastfeeding and provide anticipatory guidance.

The three steps require basic counselling skills, utilizing listening and learning skills to effectively build a mother's confidence and give practical support throughout the counselling process. The three-step counselling process table gives specific actions that breastfeeding counsellors can take at each step (*see Appendix 3*).

Use referral systems

Use referral systems for the care of at-risk infants to facilitate continuity of care (16). Referral systems ensure continuity of counselling between facility and community settings. They also ensure that health facilities and human resources are used optimally and cost-effectively.

A key concept of referral systems is the division of responsibilities. Tasks of highly-trained specialists might include handling breastfeeding counselling in situations that require specialized knowledge. Paediatricians and obstetrician-gynaecologists should refer infants and mothers requiring treatment for mastitis, candida or breast abscess for follow-up with breastfeeding counsellors in their community. Conversely, breastfeeding counsellors in community settings should work in close collaboration with local health facilities to refer mothers requiring specialized help to appropriate health care professionals. All health care professionals and paraprofessionals should be aware of referral systems for breastfeeding counselling and know how to use them.

Use relevant job aids

Job aids are useful tools to assist breastfeeding counselling. Many different types of job aids exist (see Table 4). Job aids should be appropriate for local contexts and culture, and should therefore be carefully planned and regularly updated.

Table 4: Types of job aids

In-person breastfeeding counselling
<p>Job aids for one-on-one breastfeeding counselling may include:</p> <ul style="list-style-type: none">• counselling cards with visual elements, guides for messages, and questions at specific times;• flipcharts with visual elements on the front, and guides on the back;• pocket guides for counsellors, and visual cards for mothers for use during contacts;• mobile apps with prompts, including integrated visual elements for age-appropriate questions and guidance on the course of action based on answers. <p>Job aids for group breastfeeding counselling may include:</p> <ul style="list-style-type: none">• pictorial job aids with illustrations or photographs printed on large posters;• counselling cards (in resource-constrained settings, methodology may be adapted so that the whole group can see illustrations);• videos or media material disseminated in health facility waiting areas. <p>Job aids for either one-on-one or group breastfeeding counselling may include:</p> <ul style="list-style-type: none">• physical models, dolls, knitted nappies, breast models and breastfeeding simulators.
Remote breastfeeding counselling
<p>Job aids for remote breastfeeding counselling may include:</p> <ul style="list-style-type: none">• counselling checklists;• integrated assessment tools with open-ended questions, prompts and decision-trees;• videos or media for mobile phones to complement counselling, during or after contacts;• pre-recorded audio counselling messages for mobile phones;• automated, question-answer mobile apps with referrals for advanced counselling, as needed.

Job aids should adhere to human-centred design principles. They can be created using a three-part process (84):

- 1. Conduct a desk review to learn what is already available in the context or what existing tools can be adapted.**
- 2. Conduct an assessment to identify key behaviour determinants and use results to design the job aids, including prototyping and testing with the population.**
- 3. Implement the job aid and ensure adequate monitoring and evaluation of its use, redesigning where necessary.**

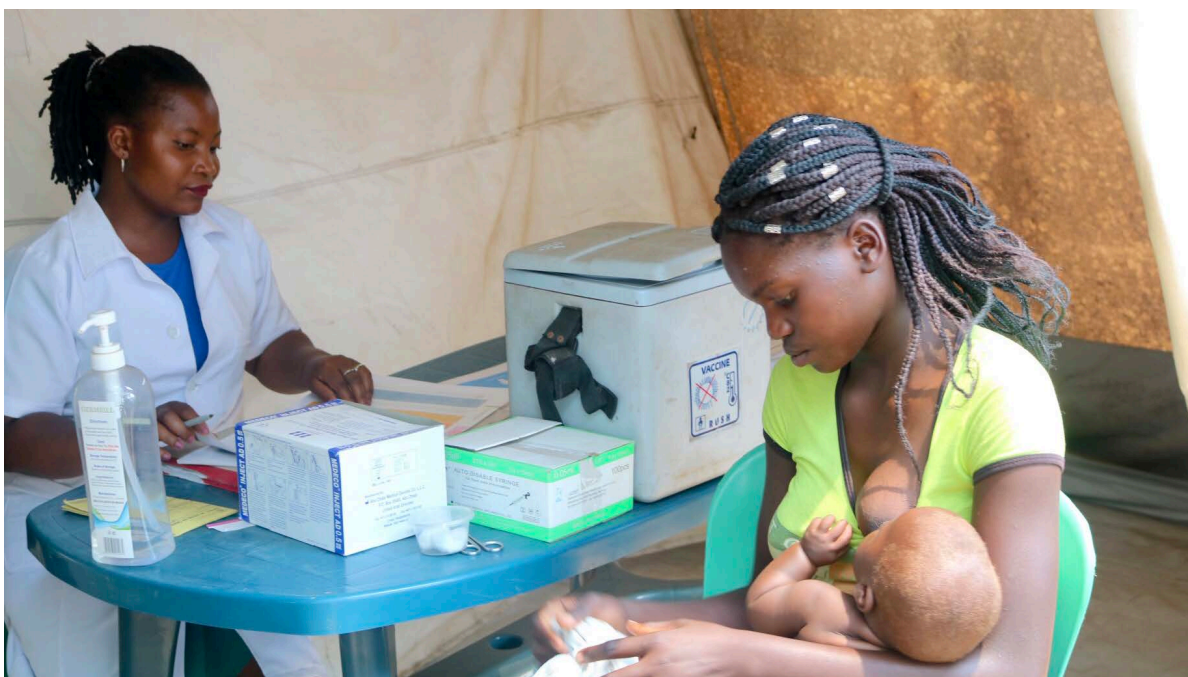
When designing, selecting and rolling out job aids, some operational considerations should be taken into account.

- Keep job aids simple and evidence-based.
- Ensure job aids are developed based on initial assessment of behaviour determinants, tested before rollout and evaluated at regular intervals for improvement or scale-up.
- Focus content on the main issues identified.
- Consider job aids for downloading on devices and sharing on battery-operated projectors.

Creating or adapting job aids also requires formative research. When designing new job aids for breastfeeding counselling programmes, programme planners should take both the breastfeeding counsellors and the population being counselled into consideration.

- Job aids should be culturally and contextually appropriate.
- Eye colour, clothing and language should match the local population.
- Mothers should be able to identify themselves in the material.
- Translations should be verified and back-translated by a member of the community.
- Job aids should be tailored to the level of education and literacy of the counsellor.

Knowing how and when to use job aids is an important skill. Breastfeeding counsellors should be trained on the effective and appropriate use of job aids. Using job aids has been shown to improve counsellors' assessment of breastfeeding techniques and can increase confidence to identify and resolve breastfeeding problems (85). Training programmes should therefore demonstrate correct and appropriate use of job aids to support breastfeeding counselling, but not replace the counselling itself. Integrating job aids into supportive supervision is also critical to building providers' skillsets and competencies to provide quality supervision. In low-literacy settings, pictorial job aids can serve to remind breastfeeding counsellors of key knowledge and skills. Adaptations may be needed when counselling hard-to-reach populations.

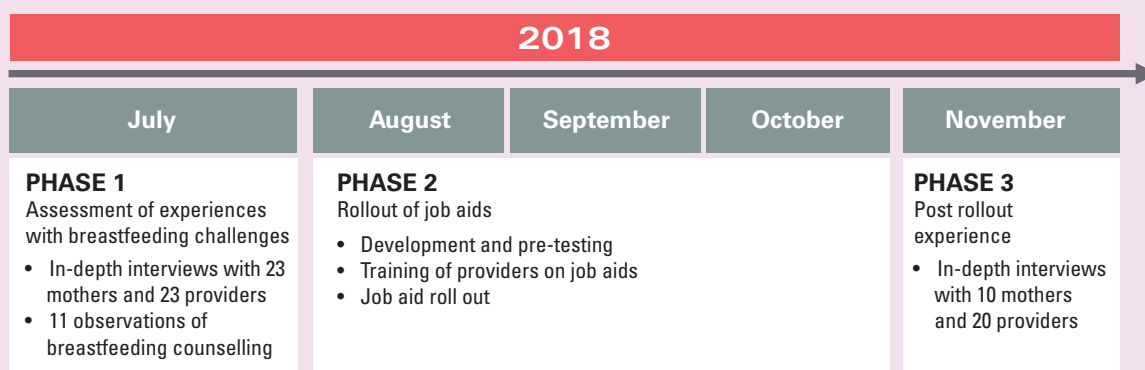


The case study from Mozambique illustrates how job aids were adapted to address local challenges to breastfeeding (see Box 4).

Box 4: Case Study on the adaptation of breastfeeding counselling job aids in Mozambique

From 2017 to 2018, the United States Agency for International Development-funded Maternal and Child Survival Programme in collaboration with the Mozambique Ministry of Health conducted formative and implementation science studies to identify challenges to exclusive breastfeeding practices in Nampula, Mozambique. The assessments aimed to understand the quality of breastfeeding counselling and type of breastfeeding problems, and to assess the usefulness of job aids (85).

A three-step implementation science study for development and pre-testing of job aids (76)



Formative evaluations revealed that mothers were advised by health professionals to delay breastfeeding after birth. Therefore, global job aids were contextualized to focus on these main issues identified during formative assessments and were validated through consultations with members of the nutrition technical working group of the Nampula Provincial Health Directorate and with programme nutritionists. Since the tools developed were to be used by some paraprofessionals with low literacy and education, they were adapted into step-by-step, clearly illustrated flowcharts.

Health facility- and community-based providers attended a half-day training using job aids. Following the training, suggestions for improvement were taken up. A three-month rollout and monthly supportive supervision visits were conducted.

Lessons learned were that:

- job aids can be tailored to specific contact points;
- quality trainings are key to build skilled lactation support at the country level;
- regular post-training supervision during implementation is fundamental to the reinforcement of counselling skills and use of the job aids.

6. MONITOR AND EVALUATE PROGRAMME DELIVERY



Build strong monitoring and evaluation systems rooted in a well-articulated theory about what is expected to change as a result of planned programme activities. Perform monitoring of programme intervention activities (e.g., development of curricula, training of breastfeeding counsellors, policy changes) as well as intended outcomes (e.g., improvements in breastfeeding counselling coverage) (86).

Collect baseline data before changes occur and evaluate progress in the implementation of planned activities. Process evaluations measure the activities designed to produce desired outcomes and determine if a service has been implemented as intended. Plan process evaluations ahead of time and conduct evaluations as soon as service begins, as well as periodically during implementation. Process evaluations can determine how well the service is working and the extent to which the service is being implemented as designed. These evaluations can identify unforeseen challenges or barriers and help refine the service before broader implementation.

Monitor implementation of training programmes

Process indicators measure activities designed to produce desired outcomes. For in-service training programmes, measure pre-service and in-service training programme quality and select indicators based on programme objectives. For example, monitor the establishment of standards or curricula for programmes (*see Figure 5*).

Figure 5: Indicators for monitoring breastfeeding counselling training programmes

Pre-service training programmes	In-service training programmes	Standards and guidelines
<p>Minimum, required competency standards for breastfeeding counselling are established for health-care professionals and paraprofessionals</p> <p>Breastfeeding counselling curricula are integrated into medical, nursing and other allied health pre-service training programmes</p>	<p>Regular competency verification or recertification of breastfeeding counselling competencies is uniformly required of health-care professionals and paraprofessionals</p> <p>Breastfeeding counselling curricula are integrated into related in-service training programmes</p> <p>Verification and in-service training programmes are implemented</p>	<p>Evidence-informed national standards and guidelines for breastfeeding counselling are established</p> <p>Standards and guidelines are integrated into health or community facilities providing maternity, infant and child care</p>

Note: Indicators are adapted from the World Breastfeeding Trends Initiative

Monitor training at health facility-level

Individual health facilities should collect data on staff training. Monitoring data at the facility level might include:

- numbers and cadres completing initial breastfeeding counselling training;
- numbers and cadres completing refresher training;
- number of supervisory contacts and any issues arising;
- assessment of the performance of individual breastfeeding counsellors;
- adherence to organizational protocols.

It may also be possible to integrate monitoring into existing systems for breastfeeding counselling training; for example, during quality assurance assessments, or facility licensing and accreditation processes conducted by ministries of health or related partners. Training data could be collected together with data on the:

- number of Baby-friendly Hospital Initiative certifications or recertifications (87, 88);
- number of staff with verified Baby-friendly Hospital Initiative competencies (17).

Monitor national-level coverage

Monitor breastfeeding counselling coverage at the national level. While no stand-alone monitoring guideline exists for breastfeeding counselling, indicators related to breastfeeding counselling are included in different monitoring frameworks.

In support of the WHA global breastfeeding target, the WHA Global Nutrition Monitoring Framework consists of an indicator to monitor breastfeeding counselling coverage across all Member States (89). Similarly, the implementation guidance on the Baby-friendly Hospital Initiative proposes some indicators related to breastfeeding counselling and support (87). In addition, UNICEF generates yearly data on IYCF counselling through the Nutridash platform (90). The information is mainly aggregated from national information systems, programme partner

reports, and other reports with nutrition programmes and interventions. Nutridash reports on the number of caregivers of children aged 0–23 months who received IYCF counselling (90).

Choose national-level coverage indicators

Integrate and use national breastfeeding counselling coverage indicators. Breastfeeding counselling indicators can be integrated into national household surveys such as the DHS, MICS, health and nutrition surveys and other national surveys.

The DHS collects and disseminates nationally representative data on health and population in low- and middle-income countries. The MICS programme, developed by UNICEF, is an international multipurpose household survey programme to support countries in collecting internationally comparable, statistically rigorous data on a wide range of indicators on the situation of children and women. The Phase-7 DHS and MICS surveys collect data on breastfeeding counselling as part of postnatal care.

Breastfeeding counselling coverage indicators measure breastfeeding counselling coverage against established benchmarks. For example, the following indicators on breastfeeding counselling are included in DHS and MICS surveys:

- Percentage of women aged 15–49 years with a live birth in the last two years who, within two days of the most recent live birth, received breastfeeding counselling.
- Percentage of women aged 15–49 years with a live birth in the last two years who, within two days of the most recent live birth, had breastfeeding observed.

The recently published Phase-8 DHS questionnaires include questions and indicators to assess counselling coverage during pregnancy and the postnatally (*see Table 5*) (91, 92).

Table 5: Phase-8 Demographic Health Survey breastfeeding counselling questions

Question	Response
Question 418. As part of your antenatal care during this pregnancy, did a health care provider do any of the following at least once: Talk with you about breastfeeding?	Yes No Don't Know
Question 473. During the first two days after (NAME) 's birth, did any health care provider do the following: • Observe (NAME) breastfeeding? • Talk with you about breastfeeding?	Yes No Don't Know
Question 641. In the last six months, did any health care provider or community health worker talk with you about how or what to feed (NAME)?	Yes No Don't Know

WHO's Global Nutrition Policy Review (93) reported that many countries implement programmes to support breastfeeding. However, there are no standard indicators collected and reported across all health information systems for breastfeeding counselling. Several countries report on breastfeeding counselling through their health management or administrative information systems. The review of administrative reporting forms from countries revealed the following:

- Data on breastfeeding counselling are typically collected at the health facility level.
- There is no standardized way that countries collect and report data on IYCF counselling. While some countries measure contact by asking if any counselling was provided, others collect data on the content of IYCF counselling.
- At the individual level, information about counselling services is collected in maternal

antenatal, delivery and postnatal registers, and child registers. Individual-level data are aggregated at the health facility level to report the number of mothers counselled on IYCF.

Monitor coverage in health facilities and communities

A minimum set of breastfeeding counselling coverage indicators should be routinely collected at health facilities and community levels by staff. Individual health facilities need to regularly report to subnational and national bodies, alongside other key health care data. Monitoring data should include:

- number or proportion of pregnant women, mothers, infants and children receiving breastfeeding counselling by individual health facility- or community-based staff;
- whether defined targets for breastfeeding counselling coverage were met.

Qualitative assessment of breastfeeding counselling at the facility level should cover the critical elements of the service, namely (94):

- timing
- place
- frequency
- mode
- content of individual contact.

A valuable way to collect facility or community-level data is through adapting existing documentation tools to include breastfeeding counselling indicators. Examples of documentation tools that could be adapted include prenatal and postpartum maternal medical records or records belonging to the infant, such as infant weight cards, paediatric medical records and immunization records.

Choose indicators for health- and community-level coverage

A minimum set of indicators should be used for the antenatal and postnatal periods, infancy and beyond. Separate indicators for these timepoints are needed to align with the WHO guideline (2). Indicators should also align with those provided in the recent Guidance for Community Health Worker Strategic Information and Service Monitoring (95).

The following indicators for monitoring breastfeeding counselling are proposed (*see Table 6*). These indicators may need to be further adapted for the local context. For instance, an indicator is proposed on how to monitor the provision of the recommended minimum of six breastfeeding counselling contacts in countries with individual tracking.

Table 6: Indicators of breastfeeding counselling coverage for health facilities and community care*

Proposed column for register	Indicator	Numerator	Denominator
Antenatal period			
Mother counselled on early initiation of breastfeeding and/or exclusive breastfeeding	Proportion of antenatal care contacts during which pregnant women received breastfeeding counselling	Number of antenatal care contacts in the reporting period during which pregnant women received any breastfeeding counselling	Total number of antenatal care contacts in the reporting period
Postnatal period and early infancy			
Mother counselled on exclusive breastfeeding or support provided for mothers unable to breastfeed	Proportion of consultations for mothers of infants under 6 months of age that provide counselling on breastfeeding	Number of consultations for mother of an infant aged 0–5 months that provide any counselling on breastfeeding in the reporting period	Total number of consultations for an infant aged 0–5 months, such as during postnatal care, immunization and other services at the health facility/in the community in the reporting period
Beyond infancy			
Mother counselled on the importance of continued breastfeeding up to 2 years of age and/or when and how to feed the child complementary foods	Proportion of consultations for infants aged 6–23 months and their mothers that provide counselling on breastfeeding	Number of consultations for infants aged 6–23 months and their mothers that provide any counselling on breastfeeding in the reporting period	Total number of consultations for infants aged 6–23 months and their mother, such as immunization and nutrition services, at the health facility/in the community in the reporting period
All the indicators presented above Optional indicator for countries with individual tracking	Percentage of women with a child aged 24–35 months who were counselled at least six times	Number of women with a child aged 24–35 months who were counselled fewer than six times at the community and/or health facility	Total number of women with a child aged 24–35 months who accessed services at the community and/or health facility

Monitor mothers' experiences and satisfaction

Regular, periodic monitoring of mothers' receiving breastfeeding counselling is needed. Assess mothers' perceptions about the quality of breastfeeding counselling and seek family perspectives. Take into account that maternal reporting may have some limitations. For example, mothers may feel inclined to report receiving breastfeeding counselling even if they did not (due to social desirability bias).

Options for assessing mothers' experiences and satisfaction include:

- integration of breastfeeding counselling receipt indicators in national household surveys (e.g., DHS, MICS, national health, and nutrition surveys);
- exit/satisfaction interviews (by phone, in person or online) that can be conducted nationally on a random sample of breastfeeding counselling services;

* These are new indicators for breastfeeding counselling coverage. Therefore, programmatic experience with these indicators has not yet been collected or reported.

- integration of breastfeeding counselling receipt indicators into other national surveys that look at access and utilization of essential services, such as national household expenditure surveys or social services assessments.

Assessing maternal experiences and perceptions of breastfeeding counselling may also help to:

- compensate for potential provider reporting bias;
- verify health service data;
- identify areas where breastfeeding counselling services do not function well;
- identify training gaps and plan refresher trainings for breastfeeding counsellors.

Evaluate programme delivery outcomes

Programme evaluations should measure the effects of breastfeeding counselling services or changes in a target population (i.e., improvement of breastfeeding rates or breastfeeding behaviours). Evaluate programmes to measure performance and inform timely corrective action. Evaluations are conducted periodically after services start, when new services are established, when changes are made to services, or if the population characteristics change. Assess the degree of change that breastfeeding counselling services achieve. Evaluate the efficiency and humanity of services, as well as equity in service delivery. Programmes should be evaluated thoroughly, with actions taken as indicated. Report evaluation results to inform future implementation of breastfeeding counselling programmes.

7. ADVOCATE FOR BREASTFEEDING COUNSELLING AND ESTABLISH SUPPORTIVE POLICIES



Advocating for breastfeeding counselling increases awareness and acceptance of breastfeeding counselling programmes among important stakeholders and is important for ensuring programme sustainability. Advocacy refers to actions that are directed at changing policies. These actions aim to draw attention to breastfeeding counselling as a solution for improving breastfeeding practices.

Advocacy builds support from policy-makers and directs decision-makers towards financing, support and implementation of breastfeeding counselling programmes. The overarching goals of advocacy initiatives are for local governments to: 1) fully implement existing breastfeeding counselling policies; and 2) adopt new policies that ensure the provision of breastfeeding counselling. This chapter describes the actions needed to advocate for breastfeeding counselling.

Develop a strategy for advocacy

The first step in developing an advocacy strategy is to conduct formative assessments. Learn about the target audiences and the opportunities and barriers that exist in reaching them. This will help inform a framework of action, which includes a comprehensive assessment of the epidemiological, operational and sociopolitical domains that inform agenda setting (96, 97).

Second, develop a strategy for advocacy based on data collected during the formative assessment. Decide if advocacy will be conducted alone or coordinated together with other organizations. For example, gauge the interest of national health care professional associations to advocate for breastfeeding counselling.

Advocacy is important for mobilizing funding for breastfeeding counselling programmes. Securing sustainable financing requires stewardship through the responsible national ministries. One approach is to use investment cases as a strategy for equipping policy-makers with the evidence needed to prioritize investments and allocate sufficient funding. Local ministries can mobilize funding by:

- estimating current economic losses from not reaching national breastfeeding goals, using tools like [the Cost of Not Breastfeeding Tool](#) (98);
- conducting cost-benefit or economic analyses on existing breastfeeding programmes;
- developing proposals for programmes that integrate breastfeeding as a minimum package of care for mothers and infants;
- investigating potential programme costs for new breastfeeding counselling programmes and measuring the efficacy of existing breastfeeding counselling programmes, including financial tracking or expenditure reviews, to inform for scale-up.

Develop advocacy messages

Finally, develop locally appealing, easily-understood, consistent and evidence-informed messages. Successful global advocacy materials and messages (99) can be adapted to national and subnational levels to raise awareness on the potential gains from breastfeeding counselling.

However, for advocacy messages to be effective, an understanding of relevant communication channels and the local political context is needed. When developing messages, organizations should familiarize themselves about suitable cadres, existing capacity, quantity of breastfeeding counsellors required, financial resources already available, and how proposed programmes would function within the local context.

Use advocacy messages that state which changes are required, for example:

“Breastfeeding counselling must be integrated in the services provided by a wide variety of perinatal and postpartum care providers, from peer supporters to lactation consultants to midwives and physicians (99).”

Be sure to create advocacy messages that state the desired goal (e.g., improving breastfeeding rates or practices). For instance:

“Skilled breastfeeding counselling is one of the most effective strategies for improving breastfeeding: it provides information, answers common questions and helps overcome challenges (99).”

Advocate at national and subnational levels

Once formative assessments are conducted, a strategy is in place, and advocacy messages are developed, initiate dialogue for policy support. Remember that advocacy messages need to reach influential individuals and organizations in order to influence the discussion on breastfeeding counselling.

Seek regular occasions to advocate for breastfeeding counselling and leverage windows of opportunity to influence key policy discussions. Opportunities include using the momentum of established annual events that centre on maternal and child health. One example is World Breastfeeding Week, which is celebrated yearly during the first week of August to commemorate the signing of the Innocenti Declaration in August 1990. National organizations and stakeholders might advocate for breastfeeding counselling through celebrating World Breastfeeding Week and engaging in outreach activities like public walks, competitions, and online or digital media engagement.

Advocate at national levels by cultivating champions. For instance, soft power figures, such as first ladies, have an important role in shaping the political agenda and budget allocation. Build the capacities of advocacy champions.

Be sure to use multi- sectoral approaches and collaborate with other sectors (water, sanitation and hygiene; health; food security; social protection, etc). Use multiple platforms to amplify advocacy messages. A comprehensive, multisectoral and sustained approach to advocating simultaneously at national and subnational levels for breastfeeding counselling will be more likely to initiate change that is effective and sustainable. Advocate at subnational levels, including state, district and community levels. This is important for influencing real change and strengthening support for breastfeeding counselling, locally.

Establish supportive policies

To ensure adequate provision of breastfeeding counselling, policies are needed to ensure that breastfeeding counsellors are skilled. High-level policies to achieve the Sustainable Development Goals, respect child rights, or address key national challenges such as reducing infant mortality or preventing childhood obesity, should include discussion of breastfeeding as a contributing factor.

At national levels, policies should be relevant to all contexts where women receive other health-care services. For example, where health care is provided through the Ministry of Health, policies on the content and quality of services must cover breastfeeding counselling. In contexts where health insurance pays for health services, policies are needed to ensure that all health plans include coverage for breastfeeding counselling. Where private clinics are a key delivery platform, policies are needed to ensure that counselling is included as a key part of antenatal and postnatal care services. It is often important to ensure that breastfeeding counselling is covered in broader development plans, such as the national development strategy, a national nutrition policy, and action plans for maternal, newborn and child health. Such inclusion will facilitate the integration of service delivery and resource allocation in national budgets. A case study from the Philippines demonstrates how national policies can ensure allocation of financing for breastfeeding counselling services (*see Box 5*).

Box 5: Case study on policies for financing breastfeeding counselling in the Philippines

Half of under-five deaths in the Philippines are newborn deaths. The first health insurance benefit package for newborns was implemented in 2006, which consisted of newborn interventions given at birth (e.g., thermal care, ophthalmia neonatorum prophylaxis, vitamin K, umbilical cord care, vaccine administration, etc.).

In 2009, a national policy for newborn care, known as Administrative Order 2009-0025, was issued in the Philippines. The policy requires facilities to provide breastfeeding counselling during antenatal and perinatal visits and focuses on the provision of four core steps (called *Unang Yakap*, or The First Embrace), which are:

- immediate and thorough drying of the newborn;
- early skin-to-skin contact between the mother and newborn;
- properly-timed umbilical cord clamping and cutting;
- non-separation of the newborn and mother for early breastfeeding initiation.

The policy applies to government and private health facilities providing maternity and newborn care services. In 2010, both the Department of Health and the Philippine Health Insurance Corporation agreed to link this policy with a newborn care health financing benefit package. To date, the package offers many benefits to families, including:

- a reduction of out-of-pocket expenditures in private birthing facilities;
- a reduction of patient contributions to zero for those eligible;
- a benefit package for preterm and small babies.

The policy also allowed for hospitals to be reimbursed for salaries of lactation nurses who provide breastfeeding counselling. To date, the newborn care package continues to be implemented in the Philippines.

Depending on the scope of national breastfeeding policies already in place, amendments or adaptations may be required to strengthen existing language. Policies should encompass the scope of breastfeeding counselling necessary to improve breastfeeding rates. Such policies need to address who can provide breastfeeding counselling, what type of training is needed, where counselling is to be done, who receives it, and when it should be done. All national policies should ensure that breastfeeding counselling is well-integrated into existing health care systems and services in order to ensure its sustainability.

Breastfeeding counselling should be written into the standards of care established by health care professional bodies. Standards for nursing, midwifery, family medicine, obstetrics, paediatrics, neonatology, and dietetics should delineate responsibilities in ensuring that pregnant and postpartum mothers receive recommended counselling. Policies on the educational content of pre-service training need to guarantee that at least the basic breastfeeding counselling skills outlined in section 4 on Capacity Development are included. Some international professional organizations have published recommendations in this regard (100).

It is also important to ensure that other supportive policies that protect breastfeeding are developed. National policies on the implementation of the Baby-friendly Hospital Initiative can help to ensure that breastfeeding counselling is provided in the early postpartum period and that problems with breastfeeding are circumvented through appropriate care at birth (25). The full implementation of the International Code of Marketing of Breast-milk Substitutes (3) and related WHA resolutions is necessary to protect women from predatory promotion of breastmilk

substitutes, which can undermine their confidence in breastfeeding. Legislation on paid maternity leave and workplace accommodations is central to removing some of the key barriers many mothers face in trying to continue breastfeeding (101, 102).

8. SECURE SUSTAINABLE FINANCING



Breastfeeding counselling is a necessary service for the improvement of breastfeeding rates, which comes with expected costs. Reaching the global target of increasing exclusive breastfeeding rates to 50 per cent has been estimated by economic experts to require an additional average annual investment of US\$570 million over 10 years (103). On the other hand, improved breastfeeding practices are associated with an increase of US\$300 billion of income annually, or nearly 0.5 per cent of the world's gross national income (1).

Liaise with all financial stakeholders

Governments should directly finance breastfeeding counselling programmes. However, in many countries health care financing is not provided by governments alone, but rather supported by private sector health insurance companies. Some countries rely heavily on donor funding for health care. Supplementary funding might come from donors, social health insurance companies or programmes, health maintenance organizations, universities, local or international non-governmental organizations or philanthropical organizations. Therefore, financing of breastfeeding counselling services should be considered with the interests of donors, taxpayers and the national government in mind (104). Ultimately, national governments set standards for the quality of health care. Therefore, they have leverage to integrate breastfeeding counselling into related national health care packages or include it as a benefit within health insurance schemes.

Identify programme costs

Financial planning of breastfeeding counselling services includes consideration of potential programme costs. Some examples are as follows.

- **Coordination:**
 - » programme management
 - » updating strategies or guidance
 - » advocacy
 - » assembling steering committees, and
 - » meeting costs
- **Training:**
 - » curriculum development or adaptation
 - » training delivery
 - » competency assessments
- **Staff salaries:**
 - » breastfeeding counsellors
 - » trainers
 - » supervisors
 - » administrative support staff
- **Supervision:**
 - » logistics
 - » continued professional development activities
- **Service delivery:**
 - » communications or social mobilization activities
 - » procurement
 - » travel
 - » infrastructure with privacy and accessibility
- **Research:**
 - » programme monitoring and evaluation
 - » empirical data collection and analysis

Choose payment methods

Health financing of breastfeeding counselling services also includes consideration of the types of payment methods. A payment method is defined by the features that determine when, how and under what conditions an amount is transferred from a purchaser to a provider. The main purchasers include ministries of health, local authorities or a national health insurance programme, while providers include health facilities, health and community centres.

There are a number of different payment methods used by purchasers to pay for health services. Each provider payment method has advantages and disadvantages, and each creates its own financial incentives (105, 106). Retrospective payment methods can be effective in reimbursement of preferred service providers. Prospective payment methods tend to be fixed amounts used to cover the cost of services (e.g., salaries).

The pay-for-performance method is growing rapidly in low- and middle-income countries and is often used in services such as consultations. It links compensation to measures of work quality or goals. Pay-for-performance indicators for breastfeeding counselling might include (107):

- the total number of patients seen per provider;
- the length of a counselling contact;
- measures of service quality, such as patient satisfaction.

Pay-for-performance can also be mixed with line-item budgets. For example, providers receive a fixed payment amount for a specified time period to cover expenses, such as personnel and utilities. Since a line-item payment method is inflexible and expenditures must follow line items, pay-for-performance can encourage longer counselling contacts or additional breastfeeding counselling contacts. This is achieved by incentivizing payment bonuses (salary or budget increases) on the number of breastfeeding counselling contacts given, or the amount of time spent. While line-item budgets control the financing of staff time and capacity, they may also attract new funding sources to existing programmes where there is potential to increase breastfeeding.



Choose tools for estimating programme costs

There are a variety of tools available for estimating the implementation costs of various health care programmes, which can be adapted to calculate the costs of breastfeeding counselling programmes (42, 108, 109) (see Table 7).

Table 7: Tools for estimating costs of national breastfeeding counselling programmes

Tools for estimating costs of national breastfeeding counselling programmes			
Name	Responsible organizations	Audience	Description
World Breastfeeding Costing Initiative (WBCi) (108)	International Baby Food Action Network Asia, Breastfeeding Promotion Network of India	Programme planners, nutrition officers, public health practitioners, finance and programme personnel, health budget specialists, agency directors and programme managers	Tool that helps users estimate the cost to implement a minimum set of interventions proposed by the Global Strategy for Infant and Young Child Feeding (56). Annual IYCF financial plans, multi-year estimates and budget proposals, can be generated using local estimates, inputs and information. A WBCi User manual is available for download.
An Investment Framework for Nutrition (42)	World Bank Group, the Results for Development Institute, and 1,000 Days.	Policy-makers	Tool for estimating the costs, impacts, and financing scenarios for stunting, anaemia, breastfeeding and wasting to achieve the WHA global nutrition targets.
The United Nations OneHealth Costing Tool (109)	United Nations Inter-Agency Working Group on Costing (including the Joint United Nations Programme on HIV/AIDS, United Nations Development Programme, United Nations Population Fund, UNICEF, the World Bank and WHO)	Health sector planners, programme planners, non-governmental organizations, international development agencies, donors, academics, United Nations agencies	Provides technical oversight to its development, facilitates capacity building and provides technical support to policy-makers to inform national planning and resource needs estimates. The OneHealth Tools is designed to inform national strategic health planning in low- and middle-income countries. A Frequently Asked Questions sheet is available for download.
The Lives Saved (LiST) Costing Tool (110)	Institute for International Programs at Johns Hopkins Bloomberg School of Public Health and funded by the Bill & Melinda Gates Foundation	Non-governmental organizations, government partners, researchers, project planners and graduate students	Estimates the impact of scaling up maternal, newborn, and child health and nutrition interventions in low- and middle-income countries.

Perhaps the most appropriate for breastfeeding counselling programmes is the World Breastfeeding Costing Initiative (WBCi) tool. The WBCi tool has been developed following the principles and structure of the World Breastfeeding Trends Initiative. The aim of the tool is to initiate constructive and productive advocacy with governments and donors. Annual financial plans and multi-year estimates can be generated, while using local estimates, inputs and information. Through cost analysis, the tool can identify the financial and human resources required to implement breastfeeding counselling, identifying potential gaps or opportunities for payment methods.

Countries may also wish to calculate the economic costs associated with not reaching breastfeeding targets. In 2019, Alive & Thrive developed [the Cost of Not Breastfeeding Tool](#) (98) which aims to help policy-makers and advocates quantify the human and economic costs of not breastfeeding, including lost life, productivity, and increased costs to health systems at country, regional and global levels.

Consider tools for estimating costs based on caseloads

An example tool for estimating costs based on caseloads is the [Breastfeeding Cancelling Caseload Calculator](#), which is being used in the Hispanic Health Council Breastfeeding, Heritage and Pride evidence-based, peer counselling programme (69). The tool, adapted from Damio, et al (67), enables the estimation of the number of mothers and infants expected to be seen by a single breastfeeding counsellor over a given time period. It allows for planning the duration of contacts for the individual health and social needs of the population of focus, taking job descriptions and organizational characteristics (e.g., paid time off, number of contacts) into account.

Ensure funding is free from conflicts of interest

It is critical to ensure that all funding bodies for breastfeeding counselling programmes are free from conflicts of interest, meaning they are independent from and receive no direct or indirect support from companies that manufacture or market foods for infants and young children, and *must* abide by International Code of Marketing of Breast-milk Substitutes and subsequent WHA resolutions (3). Companies that manufacture breastmilk substitutes, foods or beverages for infants and young children should not participate in financing breastfeeding counselling and related educational or training activities for health care workers.

9. PREPARE FOR BREASTFEEDING COUNSELLING IN EMERGENCIES



Infants and young children are the most vulnerable in emergencies, and breastfeeding provides critical protection to help them survive and thrive (22, 111). In emergencies, infants who are not breastfed have the greatest risk of malnutrition, morbidity and mortality (111, 112). Breastfeeding offers comfort, connection and protection from infectious diseases (113). Breastfed infants benefit from a safe and secure food supply. In emergencies, breastfeeding may be disrupted or stopped because of lack of support, illness, physical or psychological trauma, and separation (111). Infants and young children can become distressed through witnessing their parents' distress. Emergencies may disrupt children's daily routines, making it difficult to feed and calm them. Mothers may face direct challenges to breastfeeding, such as a lack of privacy or a safe and clean place to feed and care for children.

In addition, health systems may be directly affected by the emergency, in part, because health workers themselves may be affected. Facilities may become unable to function and emergencies can result in high caseloads, which can overwhelm systems and services. Pre-existing services such as breastfeeding counselling may be limited, discontinued or inaccessible.

Donations of breastmilk substitutes in emergencies compound already difficult situations (114), resulting in reduced breastfeeding, increased formula feeding and increased rates of preventable illness, malnutrition and infant deaths (115, 116).

There is a dearth of evidence on the effectiveness of interventions to improve breastfeeding in emergency settings (117). Yet experience demonstrates that breastfeeding counselling offers an opportunity to reach mothers with vital information and support to successfully initiate or continue breastfeeding. It is therefore crucial that governments protect, promote and support breastfeeding by ensuring that breastfeeding counselling is integrated into national and subnational emergency preparedness and response plans.

Emergency preparedness is defined as the capacities and knowledge to anticipate and respond effectively to likely, imminent or current hazard events or conditions (22). Breastfeeding counselling should be an integral part of emergency preparedness and response plans. A key component of emergency preparedness is strengthening the local government structures and health systems that are already in place. Ensuring that breastfeeding counselling is adequately delivered in non-emergency settings is a form of emergency preparedness (118).

Lessons learned from the delivery of breastfeeding counselling services in emergencies can help inform preparedness activities. See the case study on a postnatal home visiting programme in Gaza (*see Box 6*).

Box 6: Case study on lessons learned from a postnatal home visiting programme in Gaza

The UNICEF-supported Postnatal Home Visiting Programme in Gaza was launched in 2011 (119). It serves women and infants during a complex and protracted humanitarian crisis, with the Ministry of Health as the implementing partner, and was funded by the Government of Iceland.

A comprehensive situational analysis identified high levels of neonatal mortality and low rates of exclusive breastfeeding in Gaza. Strengthening postnatal care through home visits was identified as an effective entry point for reaching mothers and newborns and supporting optimal breastfeeding practices. The programme provided breastfeeding counselling services as an integral part of postnatal care, and by 2016, had reached around 7,500 women. Capacity development trainings were held for midwives and nurses on postnatal care and home-based, community health care. An annual two to three-day training covered basic postnatal care for mothers and newborns. An additional 22,257 high risk mothers received services from 2017–2020.

Lessons learned were as follows:

- Identifying and filling gaps along the continuum of care provides more comprehensive services. For example, a situational analysis identified low coverage and quality of postnatal care as a barrier to breastfeeding. Based on this information, a solution was designed to improve implementation of an existing policy to deliver postnatal care services through home visits.
- Investing in and harmonizing existing health management information systems is important. The lack of a centralized health information system made it difficult to coordinate care. Improving information systems can support improved communication and coordination, helping to tailor care appropriately and ensure families are not left behind.
- Developing community capacity to strengthen postnatal care is an important entry point. A comprehensive approach was taken to train nurses and midwives to deliver essential postnatal nutrition and health services to mothers and babies, supported by supervision, mentoring and coaching. On a practical level, home visitors were equipped with postnatal home visit kits, transportation and telecommunication to support their work.

- Integrating within other activities may increase the chances of securing funds for breastfeeding counselling in emergencies. New elements were introduced to the programme to promote early child development, stimulation and the early detection of children with developmental delays and disabilities.

Take action for emergency preparedness

Key actions to ensure readiness to respond to the needs of infants and young children in the event of a crisis are as follows:

Action 1: Put relevant policies in place

Governments and humanitarian aid agencies should have policies in place that ensure protection, promotion and support of breastfeeding, including provision of breastfeeding counselling (22). Policies that prohibit donations of breastmilk substitutes and control procurement and distribution in emergencies are part of emergency preparedness (118). Breastfeeding counselling in emergencies should be reflected in pre-crisis policies, strategies and advocacy efforts.

Action 2: Ensure human resources are available

Prepare and equip staff to ensure an adequate emergency response, including breastfeeding counselling (120). Human resources will depend on pre-existing counselling providers and services and how they have been affected by the emergency. Conduct capacity assessments and mapping to identify human resources to deliver breastfeeding counselling, training or supportive supervision. Emergency preparedness plans should describe roles and responsibilities through pre-defined terms of reference. Plans should include a database of breastfeeding counsellors and trainers to be mobilized at the onset of an emergency as well as surge capacity mechanisms which include breastfeeding counsellors.

Action 3: Develop capacity

Capacity building is an integral part of emergency preparedness. Especially in disaster-prone areas, counsellors, health and other frontline workers should be oriented and trained on IYCF in emergencies (IYCF-E) and breastfeeding counselling in emergencies. During training, integrate key competencies for breastfeeding counselling in emergencies to prepare mothers for imminent threats (anticipatory guidance) and provide appropriate counselling during a crisis (22). Pre-service breastfeeding counselling curricula and regular in-service refresher trainings for health-care providers should integrate content on IYCF-E. Breastfeeding counsellors should also be included in emergency preparedness activities, such as simulation exercises.

Strengthen breastfeeding counselling capacity at the community level to increase resilience to emergencies and decrease reliance on external support. First responders such as midwives and paraprofessional breastfeeding counsellors should be prioritized for orientation on IYCF-E to facilitate the provision of appropriate and effective breastfeeding counselling support.

Orient and strengthen capacity for breastfeeding counselling in emergencies. Make materials available for immediate adaptation and use in case of emergencies. Training content should be developed based on lessons learned from previous relevant emergency responses (22).

Action 4: Establish monitoring and evaluation systems

Ensure tracking and monitoring of breastfeeding counselling services, including breastfeeding counselling indicators. Good record-keeping and tracking of services under normal conditions

increases the chances of continuity in reporting during emergencies. Governments and organizations can refer to existing tools (121) to evaluate their progress on preparedness for an IYCF-E response.

Monitor IYCF practices (breastfeeding, complementary feeding, and artificial feeding) and regularly update the country profile with disaggregated data. This facilitates early decision-making and appropriate design of counselling programmes for emergencies.

Include needs assessment plans in national emergency preparedness plans. Take into account that multisectoral data should be disaggregated in a way that is useful to breastfeeding counselling programmes (at minimum data should be disaggregated by ages 0–5 months and 6–23 months). Include key questions on breastfeeding in pre-developed, multisectoral early needs assessment tools. Regularly orient members of needs assessment teams on IYCF-E.

During non-emergencies, ensure a pre-established system for preventing, monitoring and reporting on violations of the International Code of Marketing of Breast-milk Substitutes and subsequent WHA resolutions. This facilitates rapid action at the early onset of the emergency. Emergency response plans should include details on the prevention, monitoring and management of donations and uncontrolled distribution of breastmilk substitutes, other milk products and feeding equipment.

Action 5: Allocate adequate financial resources

Financing secured for the delivery of breastfeeding counselling in non-emergencies should be partially allocated to ensuring emergency preparedness and response. An estimate of planned activities should be costed and included in the emergency preparedness plan with secured financing. Allocate local emergency funds and activate them when needed. Identify processes for rapid mobilization of funds and strategies for reserving funds. To increase the chances of securing funds, breastfeeding counselling can be integrated within other activities in the response plan such as health or early childhood development.

Action 6: Integrate breastfeeding counselling into emergency response plans

Emergency preparedness and response plans are plans that are set ahead of a crisis. These plans serve as the basis for an emergency response. Integrate requirements for breastfeeding counselling into national preparedness and response plans. Include a description of the allocation of funding for services that need to be offered during emergency response. Prepare all elements of an emergency preparedness and response plan (*see Appendix 4*).

Action 7: Put health, nutrition and social service coordination mechanisms in place

Establish mechanisms for coordination to ensure breastfeeding counselling is continued during emergencies. Clear terms of reference should be established for the coordination authority beforehand.

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APPENDICES

APPENDIX 1

Integration of breastfeeding counselling contacts into routine antenatal, postnatal, postpartum and immunization visits

Type of visit	Time period	
1) Before birth (antenatal period)	Antenatal care	WHO recommends antenatal care models with a minimum of eight contacts during pregnancy (122). Breastfeeding counselling could potentially coincide with one or more routine antenatal care visits.
	Immunizations	WHO recommends that pregnant women have the highest priority for seasonal influenza vaccination (123). Breastfeeding counselling could potentially coincide with seasonal influenza vaccination visits for pregnant women.
2) During and immediately after birth (perinatal period up to the first two to three days after birth)	Postnatal care	After birth in a health facility, WHO recommends that mothers and newborns receive postnatal care for at least 24 hours (124). For home births, the first postnatal contact should be as early as possible, within 24 hours (124). Breastfeeding counselling is recommended as an integral part of postnatal care (124) and should be integrated into all routine postnatal visits for newborns or mothers within 24 hours of birth.
	Immunizations	WHO recommends hepatitis B vaccination for all infants worldwide, including low birth weight and premature infants (123). The first dose of the hepatitis B vaccine should be administered as soon as possible after birth, ideally within 24 hours (123). Breastfeeding counselling could potentially coincide with routine hepatitis B vaccination directly after birth.
	Newborn care	WHO recommends that all newborns be given 1 mg of vitamin K intramuscularly after birth (i.e., after the first hour, during which the infant should be in skin-to-skin contact with the mother and breastfeeding should be initiated) (125). Breastfeeding counselling could potentially coincide with routine vitamin K prophylaxis 1-hour after birth.
3) At 1–2 weeks after birth (within the neonatal period)	Postnatal care	WHO recommends at least three additional postnatal contacts for infants on (124): <ul style="list-style-type: none"> • day three (48–72 hours) after birth • between 7–14 days after birth and • at six weeks after birth Breastfeeding counselling could potentially coincide with these early postnatal care contacts. Contacts at 14 days of life are necessary for ensuring breastfed infants are growing well, sucking well, and getting enough milk, as evidenced by regaining their birthweight (126, 127).
	Postpartum care	Many obstetrical care services offer mothers check-up appointments around six weeks postpartum. These services could integrate breastfeeding counselling services into the care provided.

4) In the first 3–4 months (early infancy)	Immunizations	WHO recommends that the initial hepatitis B vaccine at birth be followed by 2–3 additional doses at later time points to complete the primary series, with intervals between doses of at least 4 weeks (123). In addition, a primary series of 3 doses of diphtheria, tetanus and pertussis (DTP)-containing vaccine are recommended, with the first dose administered as early as 6 weeks of age (123). Subsequent doses of DTP-containing vaccines should be given with an interval of at least 4 weeks (123). Breastfeeding counselling could potentially coincide with routine hepatitis B and DTP-containing immunization visits.
5) At 6 months of age (at the start of complementary feeding)	Immunizations	The third dose of the primary series of the DTP-containing vaccine series should be completed by 6 months of age (123). Breastfeeding counselling contacts at 6 months of age could potentially coincide with routine immunization visits for infants receiving the final dose of the DTP vaccine.
6) After 6 months (late infancy and early childhood)	Immunizations	WHO recommends reaching all children with the measles vaccine (123). In countries with ongoing transmission with high risk of measles mortality, the first dose should be given at age 9 months of age, and the second dose between 15-18 months of age (123). Breastfeeding counselling potentially coincide with routine measles immunization visits for older infants and young children.

APPENDIX 2

Strategies to overcome barriers to remote breastfeeding counselling

Possible challenges	Possible solutions
Inability to see each other (telephone counselling): <ul style="list-style-type: none"> Breastfeeding counsellor cannot gather information on mother's receptiveness, understanding or well-being through non-verbal cues (<i>e.g., facial expression, body language</i>) Harder to build rapport (<i>facial expressions, eye contact</i>) Counsellor cannot reinforce with non-verbal communication (<i>e.g., gestures</i>) Breastfeeding counsellor cannot see signs of malnutrition or conditions of the infant, anatomy, positioning or attachment at the breast Counsellor cannot see signs of infection or other physiological conditions of the breast 	<ul style="list-style-type: none"> Focus on strengthening breastfeeding counsellors' verbal communication skills (<i>e.g., active listening, reflective techniques, descriptive language</i>) Train breastfeeding counsellors to assess growth and how well breastfeeding is going without visuals Allow for more time for mothers 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 breastfeeding counsellor and establish rapport 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: <ul style="list-style-type: none"> Breastfeeding counsellor cannot gather information from home environment Harder to build a trusted and warm relationship (<i>e.g., no touch or physical greeting possible</i>) Cannot conduct a physical assessment or physically help mother with positioning and attachment 	<ul style="list-style-type: none"> Focus on strengthening counsellors' rapport-building skills (<i>e.g., active listening, verbal engagement, match communication styles and language, appropriate tone and texture of voice, breathing</i>) to build a relationship Train counsellors on a no-touch/hands off approach (<i>e.g., demonstrate positioning using a doll or giving verbal cues</i>) Allow for more time for mothers to build trust and disclose personal or sensitive issues
Connectivity problems (cost and access) <ul style="list-style-type: none"> Poor-quality internet connection, phone or internet does not reach the community Mothers may not have access to telephone or technology due to cost (<i>costs for device, data, live or video streaming</i>) 	<ul style="list-style-type: none"> Using a community phone or phone of community health worker Cover mothers' mobile data or internet costs or provide toll-free phone numbers Share low resolution images
Cultural acceptance <ul style="list-style-type: none"> Use of technologies not culturally accepted Mothers not owners of phone/technology 	<ul style="list-style-type: none"> Engage community leaders in discussions around best modality for remote counselling

<p>Lack of confidentiality</p> <ul style="list-style-type: none"> • Mothers cannot speak freely • Lack of privacy at home, fears about overhearing personal information 	<ul style="list-style-type: none"> • Use a text rather than voice or video service when appropriate • Use closed (yes/no) questions to verify a mother's safety and well-being (e.g., if violence against women and girls is suspected) • Ensure confidentiality in online groups, (e.g., not sharing information without consent)
<p>Distractions at home</p>	<ul style="list-style-type: none"> • Use flexible call schedules so calls can be returned at convenient times • Thoroughly check mothers' understanding • Follow-up frequently and reinforce information with information, education and communication materials

APPENDIX 3

How to counsel: A three-step counselling process

1. Assess the situation

- Greet the woman, mother and family in a friendly way.
- Use good communication skills through encouraging the mother to talk about her situation; listening and learning her history; and discussing present difficulties and potential future challenges.
- Observe the mother feeding and interacting with her infant(s).
- Look at the mother and the infant's general condition and growth chart, if the baby has been or can be weighed.
- Document maternal and infant history, any feeding difficulties, and any relevant observations.

2. Analyse the situation

- Decide if the care needed is within scope of practice.
- Determine if the mother needs a referral to another provider.
- Decide what preparation a pregnant woman may need to feed her baby.
- Analyse whether an infant is feeding appropriately and suckling effectively.
- Decide what help a woman may need for present feeding difficulties.
- Decide if anticipatory guidance is needed.

3. Act

- Use counselling skills to build confidence.
- Praise what a mother and her infant are doing well.
- Communicate relevant information, using simple language.
- Give practical help as needed, including with positioning and attachment at the breast.
- Teach relevant skills, such as expressing milk and cup-feeding.
- Suggest what a woman might do differently.
- Give anticipatory guidance as needed.
- Make a plan with the mother on steps to take moving forward.
- Document the care plan and make a plan for follow-up care as necessary.
- Determine a date and time for the next counselling contact, as necessary.
- Refer to breastfeeding counsellors with advanced competencies, as needed.
- Refer to breastfeeding counsellors in the community for follow-up, as needed.

APPENDIX 4

Key elements of an emergency response plan that takes breastfeeding counselling into account

Element	Description:
Situation analysis	<ul style="list-style-type: none"> • Analysis of the situation related to breastfeeding in the country, including contextual data on feeding practices and important stakeholders. • Provides a list of information sources including government, non-governmental organizations and United Nations country programmes (household surveys, existing databases etc.).
Needs assessment	<ul style="list-style-type: none"> • Provides instructions and references to tools for rapid implementation of needs assessment and guidance on estimating caseloads.
Coordination	<ul style="list-style-type: none"> • Details a structure for coordination mechanisms that clarifies key responsibilities, referrals and multisectoral coordination.
Human resources	<ul style="list-style-type: none"> • Identifies potential providers of breastfeeding counselling and may include a roster of counsellors to be mobilized, terms of references for breastfeeding counsellors and trainers, roles and responsibilities, and training plans.
Communication	<ul style="list-style-type: none"> • Provides details on communication channels to reach the emergency-affected population, including how to access breastfeeding counselling services. • Communication messages can be prepared ahead of time for rapid dissemination at the start of the response (120). • Describes technologies which can be harnessed in the event that face-to-face counselling is no longer possible or recommended.
Guidance and resources	<ul style="list-style-type: none"> • Includes clear guidance on protection, promotion, and support of breastfeeding, including guidelines for implementation and monitoring of breastfeeding counselling. This includes details on indicators to report on. • Contains details on systems and services (entry points) through which breastfeeding counselling should be provided, including relevant national actors. • Identifies locations where women can safely breastfeed, receive counselling and resources required to operationalize supportive spaces (120). • Identifies and makes provisions for vulnerable groups. • Provides reference to suitable breastfeeding counselling job aids and guidance on rapid adaptation to reflect the humanitarian emergency context, as needed. • Lists supplies and equipment to be pre-positioned.
Management of donations	<ul style="list-style-type: none"> • Details a plan for prevention, monitoring and management of donations and uncontrolled distributions of breastmilk substitutes.

APPENDIX 5

Breastfeeding counsellor caseload estimator

Breastfeeding counsellor caseload estimator			
1. Employer job standards			
number of weeks per year	52	weeks	
number of days per week	5	days	
total workdays per year (weeks per year times the number of days per week)	260	days	
total paid days off (subtract the average number of vacation days, holidays, personal days and sick days)	36	days	
work days per year	224	days	
hours worked per day	7	hours	
total work hours per year (work days per year multiplied by the number of hours per work day)	1568	hours	
2. Counselor job requirements			
a. Administrative time			
weekly meetings (case review, staff meetings, supervision, etc.)	4	hours	
weeks per year	52	weeks	
weekly meeting time per year (rounded)	182	hours	
other annual paid administrative time (training, conferences, annual meetings)	21	hours	
total administrative time per year	203	hours	
remaining work hours (administrative hours subtracted from total work hours per year)	1365	hours	
b. Participation in community meetings or advocacy activities			
total number of meetings or activities per year	6	meetings	
hours per meeting or activity, including travel if applicable	2	hours	
total meeting or activity hours per year (meetings or activities per year times the hours per meeting)	12	hours	
remaining work hours (meeting or activity hours subtracted from remaining work hours)	1353	hours	
c. Outreach to recruit women direct recruitment and follow-up on referrals			
recruitment: number of outreach activities per woman	2	number	
minutes spent on each direct recruitment activity	5	minutes	
minutes spent on direct recruitment outreach per woman (number of activities multiplied by the minutes per activity)	10	minutes	
hours spent on direct recruitment of each woman (minutes per woman divided by 60 minutes)	0	hours	
number of woman reached (both enrolled and refused)	120	number	
total direct recruitment time (hours spent per woman multiplied by the number of women)	20	hours	
referral follow-up: number of outreach activities per referral	2	number	

minutes spent per referral follow-up outreach activity	5	minutes
minutes spent on referral follow-up or outreach per woman (number of activities times the minutes per activity)	10	minutes
hours spent on referral follow-up outreach per woman (minutes per woman divided by 60 minutes)	0	hours
number of referred women (both enrolled and refused)	20	number
total time spent for follow-up on referrals (hours per women multiplied by the number of women)	3	hours
total direct recruitment time and referral follow-up outreach time	23	total hours
Total time available for service provision (total recruitment and referral time subtracted from remaining work hours)	1330	remaining hours
d. Home visits to each program woman		
pre-visit case or data review and post-visit documentation time	0	hours
travel time for roundtrip	0	hours
time in home	1	hours
service follow-up, post-home visit	0	hours
number of outreach activities between visits (scheduling, etc.)	2	number
minutes per outreach activity	5	minutes
total minutes on outreach between visits (number of activities multiplied by the minutes per activity)	10	minutes
total hours spent on outreach between visits: scheduling, etc. (minutes per activity divided by 60 min.)	0	hours
total time per home visit (pre-visit review and documentation, travel, time in home, follow-up and outreach)	2	hours
average number home visits per woman	5	number
hours required for home visits per woman (total hours per visit multiplied by the average number of visits per woman)	9	hours
e. Face-to-face contact without travel and phone calls to each woman		
pre-contact case or data review and post-visit documentation time	0	hours
contact duration	0	hours
service follow-up post-contact	0	hours
number of outreach activities between contacts (scheduling, etc.)	2	Number
minutes per outreach activity	5	Minutes
total minutes on outreach between contacts (number of activities multiplied by minutes per activity)	10	Minutes
total hours spent on outreach between activities: scheduling, etc. (minutes divided by 60)	0	Hours
total time required per contact (data review and documentation, contact duration, follow-up and outreach)	1	hours
average number of contacts for each woman	11	number
time required for phone calls for each woman (total time per woman multiplied by the average number of visits per woman)	9	hours

Total time per woman (home visits, other face-to-face contacts and phone calls)		18	hours
f. Annual caseload			
	Volume of women served per year (Total time available for service provision divided by total time per woman)	76	women served per year

These are example figures.