

Facilitator Guide



Infant and Young Child Feeding in Emergencies Counselling Training Package for Frontline Workers

2026

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Editable versions of the training materials are available upon request to support translation and adaptation:
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Suggested citation: Save the Children. (2026). *Infant and Young Child Feeding in Emergencies Counselling Training Package*

ACKNOWLEDGEMENTS

This IYCF-E Counselling Training Package was developed with the support of a multidisciplinary team.

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We also extend our thanks to everyone who supported the development, review, and testing of this package.

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ACRONYMS

3As: Assess, Analyse, Act

ANC: Antenatal Care

BMS: Breast Milk Substitute

ECDD: Early Childhood Care and Development

ECD: Early Childhood Development

ENN: Emergency Nutrition Network

FA: Full Assessment

FSL: Food Security and Livelihoods

GBV: Gender-Based Violence

IDP: Internally Displaced Person

IPC: Infection Prevention and Control

IPV: Intimate Partner Violence

IYCF: Infant and Young Child Feeding

IYCF-E: Infant and Young Child Feeding in Emergencies

KMC: Kangaroo Mother Care

LBW: Low Birth Weight

MAM: Moderate Acute Malnutrition

MAMI: Management of At-risk Mothers and Infants

MBA: Mother–Baby Area

MHPSS: Mental Health and Psychosocial Support

MUAC: Mid-Upper Arm Circumference

PBWG: Pregnant, Breastfeeding Women and Girls

PIF: Powdered Infant Formula

PLW: Pregnant and Lactating Women

RUIF: Ready to use Infant Formula

SAM: Severe Acute Malnutrition

SRA: Simple Rapid Assessment

TIC: Trauma-Informed Care

UHT: Ultra-High Temperature

UTI: Urinary Tract Infection

UNCPRD: United Nations Convention on the Rights of Persons with Disabilities

UNICEF: United Nations Children’s Fund

WASH: Water, Sanitation, and Hygiene

WHO: World Health Organization

INTRODUCING THE TRAINING PACKAGE

1. Background

Infant and Young Child Feeding in Emergencies (IYCF-E) is a package of life-saving and critical interventions and recommended practices. In humanitarian settings, infants and young children are among the most vulnerable. Displacement, food insecurity, limited access to health services, and high levels of stress can severely disrupt feeding practices and caregiving.

Caregivers often face difficult and rapidly changing circumstances. They may be overwhelmed, distressed, and have limited support. In these situations, how support is provided is just as important as what support is provided.

Feeding decisions are often influenced by other family members and social norms, including fathers, grandmothers and community leaders. Understanding these dynamics is important for effective counselling.

Caregivers have the right to make decisions about how they feed and care for their infants. The role of the counsellor is to support informed decision-making in a respectful, non-judgmental way.

Frontline workers play a key role in protecting, promoting and supporting appropriate IYCF practices. However, emergency contexts require more than standard knowledge and counselling skills. Frontline workers must be able to:

- Adapt counselling to stressful and unstable environments
- Respond to complex situations (e.g. trauma, gender-based violence, infectious disease outbreaks)
- Communicate with empathy and clarity under pressure
- Support caregivers in making practical decisions that minimise risk in constrained conditions

Foundational IYCF counselling skills are essential. In emergencies, they are often not sufficient on their own to support caregivers facing these realities. This training package was developed to strengthen the advanced, context-specific competencies required in emergencies.

2. Purpose of the Training Package

The *Infant and Young Child Feeding in Emergencies (IYCF-E) Counselling Training Package for Frontline Workers* aims to strengthen the capacity of frontline workers to deliver effective, inclusive, and context-appropriate IYCF counselling in humanitarian contexts.

This package focuses on:

- Applying existing IYCF knowledge and counselling skills in complex emergency situations
- Strengthening practical communication and problem-solving skills
- Building confidence to manage sensitive, high-stress interactions with caregivers
- Supporting safe, respectful, and responsive care for infants and young children

This highly practical training is delivered over three days, during which participants learn by doing through realistic scenarios, role plays, reflection, and feedback. This hands-on approach enables participants to immediately practise and apply skills in ways that reflect the realities of emergency settings.

3. Audience

This training package is aimed at frontline workers who may have IYCF counselling responsibilities during emergencies. The specific learners will vary depending on context but generally fall into two categories: health professionals and paraprofessionals (lay counsellors).

The table summarizes the roles and responsibilities of these two types of counselling providers, showing where they typically work and the competencies they bring to IYCF counselling.

Healthcare professionals	Paraprofessionals
<p>Professionals within the health system, e.g., physicians, midwives, nurses, lactation consultants, nutritionists, psychologists.</p> <ul style="list-style-type: none"> • Trained and tasked to provide counselling, mostly at facility level • May also work at household and community level • May have multiple responsibilities beyond counselling • May have advanced counselling competencies, including aspects of lactation management that require clinical knowledge and skills • Good knowledge of and linkages to the health system 	<p>Lay and peer breastfeeding counsellors, e.g., mother-to-mother support-group facilitators, community health workers, traditional birth attendants, psychosocial workers.</p> <ul style="list-style-type: none"> • Trained and tasked to provide counselling, mostly at household and community level • May also work at facility level • May have advanced counselling competencies that do not require clinical knowledge and skills • Good knowledge of and linkages to the community

Adapted ENN, IFE Core Group (2021). *Operational Guidance on Breastfeeding Counselling*

Considerations for this training

- Given the 3-day duration, this package focuses on advanced skills. Participants are expected to have some pre-existing IYCF knowledge and basic counselling skills, which should be assessed prior to training.
- Where participants lack basic capacity, facilitators should first use the *UNICEF Community IYCF Counselling Package* to establish foundational skills before delivering the IYCF-E package.
- The package is flexible and adaptable:
 - For learners with limited prior experience, facilitators may spend more time on foundational skills.
 - For learners with substantial prior experience, the training can focus on advanced or emergency-specific skills.
 - For mixed-experience groups, combine participants with different levels during activities to encourage peer learning and support less experienced participants.

4. Complementarity with the UNICEF Community IYCF Counselling Package

Building on the skills that frontline workers already bring, the IYCF-E package complements the *UNICEF Community IYCF Counselling Package* by strengthening application of foundational skills and introducing advanced competencies required in emergency contexts.

It was developed to address a critical gap: the need for frontline workers to manage more complex situations and support caregivers effectively under the challenges of emergencies.

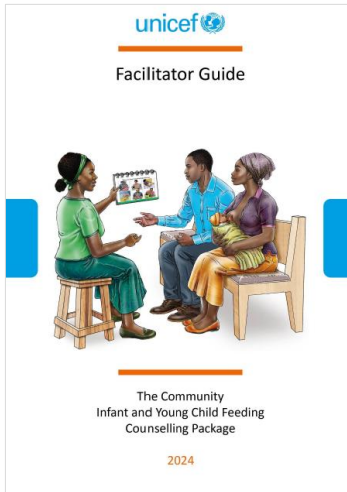
Specifically, the IYCF-E package:

- Strengthens the application of foundational skills in challenging environments
- Introduces advanced skills needed to respond to the unique demands of emergencies

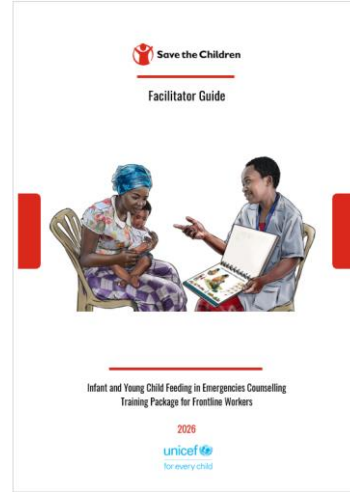
In emergency settings, caregivers face increased risks, disruptions and stress. Frontline workers must therefore be able to adapt their counselling approaches, manage more complex situations and provide technically sound, emotionally responsive support.

Key differences and complementarity

Community Infant and Young Child Feeding (C-IYCF) Counselling Package



Infant and Young Child Feeding in Emergency Counselling Training Package for Frontline Workers



AUDIENCE

Primarily for health workers at **Community** level, but also applicable in facility settings

Primarily for health workers at **Facility** level, but also applicable in community settings

DURATION

5 days

3 days

SETTINGS

Non-emergency

Emergency

SKILLS AND KNOWLEDGE

Basic skills and knowledge

- Provides the foundational competencies required to prepare for advanced emergency training

Advanced skills and knowledge

- Builds on the foundational skills to address the specific challenges of emergency contexts
- Includes refreshers on core counselling skills
- Reinforces the use of the Assess-Analyse-Act (3As) counselling process

LIST OF TOPICS

The *C-IYCF Counselling Package* provides the essential foundation for frontline workers. It introduces such key topics as:

- Why IYCF matters
- Recommended breastfeeding and complementary feeding practices
- How to counsel caregivers effectively
- Managing feeding difficulties

Building on this foundation, the *IYCF-E Counselling Training Package* focuses on more complex and context-specific situations that are typical in emergency settings. It covers:

- IYCF counselling adapted to emergency contexts
- Conducting individual assessments and triage
- Supporting caregivers experiencing stress
- Responding to gender-based violence

<ul style="list-style-type: none"> • Growth monitoring • Conducting home visits and group sessions 	<ul style="list-style-type: none"> • Adapting counselling during infectious disease outbreaks • Increasing breast milk intake, including relactation and induced lactation • Complementary feeding in emergencies • Supporting BMS-dependent infants • Refreshers on core counselling skills (Listening & Learning; Building Confidence & Giving Support) • Application of the counselling process: Assess–Analyse–Act (3As)
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Overall, this package does not replace foundational training. Instead, it enables frontline workers to deepen, adapt and expand their skills to meet the realities of emergency contexts.

How to use the two packages

To select the most appropriate training approach, it is recommended to follow two key steps:

1. Conduct an IYCF capacity assessment

Assess the existing knowledge, skills and experience of frontline workers in IYCF and counselling. This can be done through rapid assessments, supervision findings or programme experience.

2. Select the appropriate training package(s)

Based on the IYCF capacity assessment, training decisions should consider both the existing capacity of staff and the operational context.

During preparedness

Preparedness activities offer an opportunity to build or strengthen capacity before an emergency occurs:

- If staff have limited or no prior IYCF training:
 - Use the *C-IYCF Counselling Package* to build foundational knowledge and counselling skills.
 - Then, where possible, follow with the *IYCF-E Counselling Training Package* after an interval (e.g., a few months) to prepare them to confidently adapt and apply these skills if an emergency occurs.
- If staff already have basic IYCF knowledge and counselling skills:
 - Use the *IYCF-E Counselling Training Package* to strengthen advanced competencies and prepare them for emergency response.

During emergencies

In emergency contexts, training may need to be adapted to time constraints and urgent needs:

- If staff have limited or no prior IYCF training:
 - Prioritize a combined approach, using:
 - Selected essential modules from the *C-IYCF Counselling Package*, and
 - The *IYCF-E Counselling Training Package*
 This ensures that staff can quickly acquire both critical foundational knowledge and emergency-specific skills.
- If staff already have basic IYCF knowledge and counselling skills:
 - Use the *IYCF-E Counselling Training Package* directly to strengthen their ability to respond effectively in the emergency context.

5. Structure of the Training Package

The training consists of eight sessions delivered over three days, each lasting between 1 and 2.5 hours.

Together, these sessions progressively build participants' ability to apply IYCF counselling skills in emergency contexts, moving from core concepts to more complex and sensitive situations.

Session	Title	Learning objectives
Session 1	IYCF Counselling in Emergencies	<ol style="list-style-type: none"> 1. Describe the basic IYCF counselling skills and key definitions used in breastfeeding support 2. Explain how IYCF counselling is adapted in emergency contexts and why it is critical 3. Recognize cross-cutting considerations in emergencies, including trauma-informed care, responsive feeding and disability inclusion
Session 2	Individual Assessment in Emergencies	<ol style="list-style-type: none"> 1. Complete triage for IYCF counselling recipients in an emergency 2. Describe how to conduct an individual full assessment in an emergency
Session 3	Addressing Stress in Emergencies	<ol style="list-style-type: none"> 1. Describe how the timing, duration and frequency of IYCF-E counselling are adapted to support caregivers who are stressed 2. Explain how stress impacts responsive feeding; describe strategies to mitigate those impacts 3. Apply self-care strategies to manage your own stress and regulate your emotions as a counsellor
Session 4	Supporting Caregivers Affected by Gender-Based Violence	<ol style="list-style-type: none"> 1. Apply a survivor-centred approach while receiving a gender-based violence (GBV) disclosure 2. Identify safe and appropriate ways to support recommended IYCF-E practices for GBV survivors 3. Practise self-care as a counsellor working in an emergency
Session 5	Supporting Caregivers During Infectious Disease Outbreaks	<ol style="list-style-type: none"> 1. Explain how to protect recommended IYCF-E practices during an infectious disease outbreak 2. Identify key IYCF-E counselling adaptations during an infectious disease outbreak 3. Describe how to provide effective remote IYCF-E counselling
Session 6	Increasing Breast Milk Intake	<ol style="list-style-type: none"> 1. Assist a mother or caregiver to increase breast milk intake 2. Assist a mother or caregiver with relactation and induced lactation
Session 7	Complementary Feeding in Emergencies	<ol style="list-style-type: none"> 1. Support a caregiver's responsive feeding and caregiving practices 2. Assess nutritional risk and possible causes of poor growth in a child age 6–23 months 3. Counsel a caregiver on complementary feeding during extreme food insecurity

<p>Session 8</p>	<p>Assessing and Supporting Infants Receiving Breast Milk Substitutes</p>	<ol style="list-style-type: none"> 1. Assess an infant's need for commercial infant formula and identify feeding options that minimize risk 2. Counsel caregivers on recommended feeding practices when using commercial infant formula 3. Identify and act on violations of the Code as a frontline worker
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Integration of Counselling Skills

In addition to the session-specific content, the training includes targeted refreshers on foundational counselling skills, including:

- Listening and learning
- Building confidence and giving support

It also reinforces the use of the 3As counselling process (Assess–Analyse–Act).

These are integrated throughout the sessions, rather than taught as standalone modules, allowing participants to revisit and strengthen core skills while applying them in more advanced and realistic scenarios.

To keep practice focused and manageable, three counselling skills are emphasized in each session. This allows participants to concentrate on specific communication behaviours and progressively build confidence.

However, in real-life counselling, all foundational skills should be applied together to ensure high-quality, responsive support to caregivers.

Trauma-Informed Care

A trauma-informed approach is applied across all sessions. This approach recognizes that both caregivers and frontline workers may be experiencing stress, distress or exposure to difficult situations.

In practice, this means:

- Creating safe, respectful and supportive interactions
- Avoiding judgment and promoting dignity
- Recognizing signs of stress and responding appropriately
- Supporting caregiver–infant bonding and responsive feeding

Importantly, trauma-informed principles are applied not only in counselling scenarios but also throughout the training itself. Facilitators are encouraged to create a learning environment that is supportive, inclusive and responsive to participants' emotional needs.

For a full definition and principles of trauma-informed care, refer to the *Welcome and Introduction session* and the Participant Handbook. Additional guidance is available in the UNICEF resource [Trauma-Informed Approach \(UNICEF\)](#).

Regulation Practice

Because the topics addressed in this training can be emotionally intense, short stress-regulation techniques are integrated throughout the sessions to support participants' well-being, focus and learning.

These practices also model strategies that can be used by frontline workers during counselling with caregivers.

Facilitators are encouraged to include brief (2–3 minute) regulation activities at key moments:

- At the start of a session, to set a calm and focused tone
- After heavy discussions, to support emotional processing
- After breaks or lunch, to restore energy and attention
- Before role-play exercises, to help participants centre themselves
- At the end of the day, to consolidate learning

These practices replace traditional ‘energizers’ and should be adapted to be culturally appropriate and context-sensitive.

For a full set of techniques, refer to Annex 1: Emotional Regulation Practices in the Participant Handbook.

Sample Agenda

A sample agenda is provided below to illustrate how the eight sessions can be organized over three days.

The training is designed to last approximately three days (around 6.5 hours per day, excluding breaks and lunch). However, the schedule can be adapted based on the pre-existing capacity of participants and operational constraints.

For example:

- The training may be combined with selected modules from the UNICEF C-IYCF Counselling Package, e.g., by adding an additional day to strengthen foundational competencies where needed.
- The training may be delivered in a more flexible format, such as spreading sessions over several shorter days (e.g., five half-days), depending on participant availability and context.
- Timing and pacing of sessions may be adjusted to ensure adequate time for practice, reflection and discussion, particularly in groups with diverse experience levels.

	Day 1	Day 2	Day 3
15 mins	Arrival	Arrival and Recap	Arrival and Recap
3 hours	Training Introduction (1h)	Session 4: Supporting Caregivers Affected by Gender-Based Violence (2h30)	Session 6: Increasing Breast Milk Intake (2h)
	Session 1: IYCF Counselling in Emergencies (1h)		Session 7: Complementary Feeding in Emergencies (part 1 - 1h)
	Session 2: Individual Assessment in Emergencies (part 1 - 0h30)		
1 hour	Lunch break	Lunch break	Lunch break
3 hours	Session 2: Individual Assessment in Emergencies (part 2 - 1h)	Session 5: Supporting Caregivers during Infectious Disease Outbreaks (2h30)	Session 7: Complementary Feeding in Emergencies (part 2 - 1h)
	Session 3: Addressing Stress in Emergencies (2h)		Session 8: Assessing and Supporting Non- Breastfed Infants (2h)
15 mins	Wrap-up	Wrap-Up	Certificates/Photo

6. Training Approach

This training uses a practical, skills-based learning approach, where participants learn by doing, reflecting and progressively strengthening their counselling competencies.

Each session follows the same five-step structure as the full IYCF-E package:

STEP	1	Set the scene	Begin with a realistic scenario that connects the topic to an emergency setting. Use short discussions to help participants relate the situation to their work.
STEP	2	Strengthen key knowledge, concepts and skills	Present the technical content and counselling considerations linked to the session objectives. Use visuals, short inputs and examples to keep it interactive.
STEP	3	Demonstrate	Model key skills in a short role-play between two facilitators. Highlight effective communication, empathy and adaptation to an emergency context.
STEP	4	Participant role-play	Guide participants to practise in small groups of three (counsellor, caregiver, observer). Circulate to observe, support and give feedback.
STEP	5	Self-reflection	Close with individual reflection and/or group discussion. Encourage participants to identify strengths, areas to improve, and actions to apply their learning in their daily work.

Applying and Strengthening Counselling Skills

This learning approach is designed to support the progressive development and application of counselling skills in realistic emergency scenarios.

As described in the previous section, foundational counselling skills and the Assess–Analyse–Act (3As) process are integrated throughout the training. These are not taught separately but continuously reinforced through demonstrations, role plays and reflection.

Participants are encouraged to:

- Practise specific counselling skills intentionally during each session
- Reflect on what feels effective or challenging
- Gradually integrate all skills to provide responsive, high-quality support to caregivers

For a summary of the core counselling skills and the 3As process, refer to the Participant Handbook, which serves as a key resource throughout the training. These are also reinforced through posters on the Assess–Analyse–Act (3As) process and core counselling skills (Listening and Learning; Building Confidence and Giving Support), which are displayed and used throughout the sessions.

7. How to Use This Package

Materials

The training package includes two complementary resources:

- **Facilitator Guide:** Provides detailed step-by-step instructions for delivering each session, including explanations of content, scripts, facilitation tips and guidance for activities. The Facilitator Guide is a support tool for facilitators and should not be read aloud. It references the Participant Handbook throughout, so facilitators need to switch between the two files during training.
- **Participant Handbook:** Contains key messages, definitions, visuals and activity materials for learners. It is designed as the main tool for participants (similar to slides), allowing them to follow along, take notes and engage in activities.

Recommended Usage:

- Print both files in colour for clarity and engagement.
- Use the **Participant Handbook** as the primary reference with participants.
- Use the **Facilitator Guide** to know how to deliver the session: when to present content, lead discussions, conduct demonstrations, guide role plays and provide feedback.
- The Facilitator Guide always refers to content in the Participant Handbook; content is not repeated in the Facilitator Guide. Facilitators should be comfortable switching between the Facilitator Guide and Participant Handbook during sessions, as the Facilitator Guide provides guidance while the Participant Handbook provides the content that participants see.
- There are no slide presentations, but facilitators may project pages from the Participant Handbook on a wall or screen if desired.

Additional Materials:

- **Two posters** are included in the package as visual reinforcement and should be displayed in the training room:
 - Assess–Analyse–Act (3As): illustrates the three-step counselling process
 - Core Counselling Skills: covers ‘Listening & Learning’ and ‘Building Confidence & Giving Support.’
- **Five audio files for Session 5** to support demonstration of IYCF remote counselling during infectious disease outbreaks (available in English, French, Spanish, Arabic and Indonesian).
- **One video** for Session 6: Increasing Breast Milk Intake – Drip-Drop Method.

Specific handouts for participants, included in the Facilitator Guide

Material	Notes	Preparation Needed
Role-play cards	Step 4 of each session; 12 pre-formatted cards in an annex at the end of each session, ready to cut and use for role-play	Simply cut the cards. No extra printing needed.
Father support group script	For Session 6 demonstration; 3 volunteer participants act as fathers; scripts available in 3 versions (one per father) in the Session 6 annex	Cut the scripts and ensure each volunteer has a copy in advance. No extra printing needed.

Preparation

Facilitators are encouraged to:

- Review and plan:
 - Read through and annotate the Facilitator Guide.
 - Review the Participant Handbook content to become familiar with key messages, activities and visuals.
 - Practise the Demonstration script (Step 3) of each session to ensure smooth delivery.
- Adapt to the participants:
 - Adjust the complexity and examples to match the group’s pre-existing capacity, experience and profile.
 - Contextualize content to reflect the local setting and emergency context (see *Section 9 – Adaptation, Contextualization and Translation* for guidance).
- Prepare materials and the training room:
 - Ensure each participant has a Participant Handbook, highlighters and pens.
 - Display the two posters on the wall:
 - Assess–Analyse–Act (3As)
 - Core Counselling Skills
 - Check that all role-play cards and scripts are ready for Step 4 and Step 3 demonstrations.
 - Check the audio files for *Session 5 – Supporting Caregivers during Infectious Disease Outbreaks*.

- Pre- and post-knowledge tests:
 - The Pre- and Post-Test questions are included in the Facilitator Guide (*Annex 1: Pre- and Post-Training Knowledge Test*).
 - If feasible, participants can complete the Pre-Test online before the training begins so facilitators can adjust content based on results.
 - If the Pre-Test cannot be completed before training:
 - Administer it on Day 1 during the Welcome & Introduction session.
 - Review results promptly (ideally the same day) to identify areas that may require additional focus or clarification during the sessions.
 - Use the Post-Test at the end of the training to assess learning outcomes and identify topics for follow-up or refresher sessions.

<p>Required Equipment and Supplies</p> <ul style="list-style-type: none"> • Flipchart with stand and paper • Marker pens • Highlighters 	<ul style="list-style-type: none"> • Laptop to play audio files for Session 5 and video for Session 6 • Projector for displaying pages from the Participant Handbook (optional) and for showing the Session 6 video
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Facilitation

The training is designed for 12–24 participants, facilitated by 1–3 facilitators.

- We recommend one lead facilitator to manage a session. For **Step 1 (Set the Scene)**, **Step 2 (Strengthen Knowledge & Skills)** and **Step 5 (Self-Reflection)**, the lead facilitator can conduct the session independently.
- Step 3 – Demonstrations:
 - One facilitator plays the frontline worker.
 - One facilitator acts as the caregiver/counselling client.
 - A third facilitator highlights key learning points and reinforces concepts during the demonstration.
 - **If only one or two facilitators are available:** Recruit participants as volunteers to act in the demonstration. Share scripts in advance to ensure smooth delivery.
- Step 4 – Role Plays:
 - Participants are organized into small groups of three. In each group of three, participants rotate through the following roles:
 - **Counsellor** – practises the counselling skills being taught in the session
 - **Caregiver/Mother** – simulates the client situation
 - **Observer** – uses the **Counselling Skills Checklist** to note strengths and areas for improvement
 - **Rotation:** Each role-play in a session is completed once. In the next session, participants should rotate roles within their group so that everyone experiences all roles over the course of the training.
 - **Heterogeneous groups:** If participants have mixed prior experience (some trained, some new), mix them within groups. This encourages peer learning, allows more experienced participants to model good practice and ensures beginners gain confidence.
 - **Facilitator guidance during role plays:** Circulate among groups to:
 - Observe interactions
 - Provide timely, constructive feedback
 - Highlight examples of good practice or areas needing improvement
 - Each group should receive direct guidance and feedback from one facilitator to enable skill development and confidence building.
 - Encourage participants to apply the three selected Core Counselling Skills in every role play, helping them focus on specific behaviours while integrating advanced skills.

8. Creating a Safe, Supportive and Inclusive Learning Environment

Creating a safe, respectful and inclusive learning environment is essential for effective skills-based training, particularly given the sensitive and potentially distressing nature of some IYCF-E topics.

Facilitators play a key role in establishing and maintaining this environment throughout the training.

Set the tone from the start:

- Establish clear ground rules to promote respect, confidentiality and participation
- Acknowledge that some topics may be emotionally challenging

Organize the space to support learning:

- Arrange seating to encourage interaction and small group work
- Ensure materials are easily accessible to avoid disrupting the flow of sessions
- Allow space for facilitators to move easily among groups

Promote active and inclusive participation:

- Encourage participants to share experiences and perspectives
- Ask simple, open questions to build confidence
- Recognize that making mistakes is part of the learning process
- Value and build on participants' existing knowledge and experience

Apply a trauma-informed approach:

- Be attentive to signs of stress or distress among participants
- Respond with empathy and without judgment
- Allow participants to step back from activities if needed
- Model safe, respectful and supportive interactions at all times

Provide constructive and supportive feedback:

- Encourage reflection by asking "What went well?" before "What could be improved?"
- Highlight strengths as well as areas for improvement
- Maintain a positive, encouraging tone

Ensure accessibility and equal participation:

- Identify accessibility needs in advance where possible
- Make practical adjustments to support participation. For example:
 - For participants with **visual difficulties**: ensure seating close to the front, use clear and large visuals, read key information aloud
 - For participants with **hearing difficulties**: provide written instructions; ensure clear visibility of the speaker; if needed, arrange interpretation
 - For participants with **mobility challenges**: ensure the venue is accessible, allow flexible seating arrangements
- Check regularly whether participants are experiencing any difficulties, and adapt as needed

Promote inclusion and equal opportunity

- Treat all participants with respect and dignity
- Create an environment that is inclusive of diverse backgrounds and experiences

Support breastfeeding participants

- Provide a private space for breastfeeding or expressing milk if needed
- Allow breastfeeding within the training space if preferred
- Consider childcare support where feasible

9. Adaptation, Contextualization and Translation

This training package is designed to be flexible and adaptable to different emergency contexts, audiences and operational realities. Facilitators are encouraged to tailor the content to ensure it is relevant, practical and meaningful for participants.

Contextualization and Adaptation

Facilitators should adapt the training to reflect the local context and the profile of participants. This includes:

- Adapting content to the local context
 - Adapt examples, case studies and scenarios that reflect local realities
 - Replace or adapt images where possible to reflect the local population
 - Align terminology with local language and practices
- Integrating local systems and services
 - Include relevant referral pathways (e.g. health, nutrition, protection, GBV services)
 - Reflect how services are organized and accessed in the specific context
- Considering cultural norms and practices
 - Adapt approaches to communication styles, gender norms and caregiving practices
 - Ensure that activities (e.g. role-plays, movement, breathing exercises) are culturally appropriate and acceptable
- Adapting to participants' capacity
 - Adjust the level of complexity based on participants' pre-existing knowledge and experience
 - Use pre-test results, registration information or prior assessments to inform these adaptations

Contextualization should be planned, with sufficient time allocated for preparation.

Language and Translation

The training package is currently available in English. Facilitators should deliver the training in the language most appropriate for participants.

Editable versions of the training materials are available upon request to support translation and adaptation:

iycfe@savethechildren.org

10. Post-Training Support and Follow-Up

Building strong IYCF-E counselling skills takes time, practise and reflection. Participants are not expected to master all skills during the training. To ensure that knowledge and skills are reinforced and effectively applied in real-world contexts, post-training support is recommended.

Purpose:

- Strengthen participants' confidence and communication skills
- Support the application of knowledge and skills in emergency settings
- Contribute to improved caregiver–child relationships, better feeding practices, and positive outcomes for infants and young children

Recommended Follow-Up Actions:

- **Workplace mentoring:** Participating organizations should plan to observe and mentor participants at their workplace after the training. This may include on-the-job support or problem-solving guidance for real-life IYCF-E scenarios.

- **Peer learning and communities of practice:** Facilitators, organizations or participants may establish post-training Action Learning Groups or Communities of Practice. These can be supported through occasional facilitated sessions (either face-to-face or online) to reinforce learning and share experiences.
- **Knowledge retention assessment:** Three months after the training, the lead facilitator or organizer should send a survey to all participants to assess their knowledge retention and any uptake or changes in IYCF-E practices.
- **Timing:** To provide timely support and reinforcement, any follow-up visits, sessions or contacts should ideally occur within two months of the training.

By combining structured follow-up with continued practice and reflection, participants are better equipped to provide effective counselling in emergencies. Over time, this approach supports lasting improvements in both frontline worker skills and outcomes for caregivers and children.

WELCOME AND INTRODUCTION



Material and preparation:

- **Prepare for each participant and facilitator:**
 - Name tag
 - Participant Handbook
 - Training agenda
- **Ensure the two posters are visible on the wall:**
 - Assess, Analyse, Act (3As)
 - Listening and learning / Building confidence and giving support
- **Prepare 2 flipcharts:**
 - Parking Lot
 - Group Norms
- **Prepare the pre-training test:** either printed or online



1h



Facilitator Tip

If you use an online assessment, send the link the day before the training and invite participants to complete it in advance. You can also create and print a QR code so participants with a smartphone can complete the test during the session.

Welcome



15 min

1 Lead facilitator welcome participants (3 min)

Action:

- **Welcome** participants to the *Infant and Young Child Feeding in Emergencies (IYCF-E) Counselling Training*.
- **Introduce** yourself as the lead facilitator (name, affiliation, role)
- **Acknowledge** the context and importance of the training (e.g., relevance to participants' work, current or recurring emergencies, the value of their role in supporting caregivers and children).
- **Invite** each co-facilitator to briefly introduce themselves.



Facilitator Tip

- Set a warm, respectful tone from the start. Acknowledge participants' commitment to attending the training and recognize the importance of their work in emergency settings. Adapt your opening words to the local context and audience.
- Smile, make eye contact, and ensure your tone is friendly and inclusive.

Bridge: "Before we start the training, let's take a few minutes to get to know each other."

2 Participant introductions (12 min)

Action:

- **Invite** participants to write their names on their name tags before starting the introduction activity.

- **Ask** participants to line up alphabetically by first (preferred) name, as quickly as possible, without speaking.
- **Check** the order and make any quick corrections as needed.
- **Invite** each participant to briefly state:
 - Name
 - Role
 - IYCF-E counselling experience or interest
- **Ask** participants to return to their seats once introduced.

Bridge: “You bring a wide range of experience to this training. Let’s look at how we’ll work together over the next three days.”

Training overview, audience, and learning approach

 20 min

1 The participant Handbook (1 min)

Action:

- **Introduce** the Participant Handbook
- **Explain:**
 - The Handbook belongs to them and is theirs to use during the 3-day training and afterwards as a reference.
 - Space is provided for notes and reflections. These notes are for personal use and are not used to assess participation.
 - Participants must bring the Handbook to each session, as key information, exercises and visuals are used throughout the training.

! Facilitator Tip Invite participants to write their name on the front cover to prevent loss.

Bridge: “Let’s start with the goal of the training.”

2 Training goal and intended audience (2 min)

Action:

- **Invite** participants to turn to the *Training overview, audience and learning approach* section in the Participant Handbook.
- **Refer:** *Box: Goal of the training* (Participant Handbook)
- **Explain:** The training package aims to strengthen the capacity of frontline workers to deliver effective, inclusive and context-appropriate IYCF counselling in humanitarian contexts.

! Facilitator Tip Throughout the training, use the content directly from the Participant Handbook whenever it is referenced while guiding the sessions. Key content is not duplicated in this Facilitator Guide.

- **Add:** This 3-day training complements the 2024 UNICEF *Community IYCF Counselling Package* by building on its foundational counselling skills and applying them to emergency contexts, where caregivers and infants face additional risks, disruptions, and stressors.
- **Explain the intended audience:** frontline workers from diverse backgrounds, including community-based services, public health, primary care and hospital settings.
- **Clarify expected prior knowledge:**

- Participants are expected to have:
 - Basic technical knowledge of recommended nutrition practices for children 0–23 months and for pregnant and lactating women, and
 - Foundational IYCF counselling skills.
- This proficiency may come from previous training (including the 2024 UNICEF c-IYCF Counselling Package) and/or relevant field experience.
- Key concepts will be refreshed throughout the training.



Facilitator Tip

Ask participants how many have previously received IYCF or IYCF-E counselling training, and in what context. Highlight that participants' prior experience and knowledge will be actively leveraged throughout the training.

Bridge: “Now, let’s look at how the training works, including the hands-on learning approach, the session structure and how you’ll actively practice your IYCF-E counselling skills over the next three days.”

3 The learning approach (5 min)

Key points: the process

- The training consists of eight sessions over three days.
- Sessions are interactive and hands-on, emphasizing practice, reflection and peer learning.
- Each session follows the **5-Step process**, designed to support gradual skill-building and confidence.

STEP 1 Set the scene	Begin with a realistic scenario that connects the topic to an emergency setting. Use short discussions to help participants relate the situation to their work.
STEP 2 Strengthen key knowledge, concepts and skills	Present the technical content and counselling considerations linked to the session objectives. Use visuals, short inputs and examples to keep it interactive.
STEP 3 Demonstrate	Model key skills in a short role play between two facilitators. Highlight effective communication, empathy and adaptation to an emergency context.
STEP 4 Participant role-play	Guide participants to practise in small groups of three (counsellor, caregiver, observer). Circulate to observe, support and give feedback.
STEP 5 Self-reflection	Close with individual reflection and/or group discussion. Encourage participants to identify strengths, areas to improve, and actions to apply learning in their daily work.

Key points: counselling skills

- Short refreshers are integrated throughout discussions, demonstrations and role plays rather than delivered as a separate component.
- To keep practice focused and manageable, each session emphasizes **three counselling skills**. This allows intentional practice and deeper skill-building. In real-life counselling, **all foundational skills should be applied together** using the Assess–Analyse–Act (3As) process.

! Facilitator Tip

Show the two posters displayed on the wall (*Core Counselling Skills* and *The Counselling Process: Assess–Analyse–Act*). Explain that these posters provide a visual reference and that participants will return to them in Session 1 and throughout the training.

- Much of the basic knowledge and skills around IYCF and IYCF counselling are directly transferrable to the emergency context.
- Skills acquisition and confidence take time and will require more than one session.
- Participants are encouraged to:
 - Experiment with **tone, phrasing and empathy** during role plays, noticing how small changes affect the interaction.
 - Reflect on **what feels natural and what feels challenging**, and how their communication evolves with practice.
 - Identify **personal strengths** and **specific skills they want to strengthen or practise further** during the training.
- **Refer:** Section: *Practical ways to build confidence* (Participant Handbook)

Bridge: “This shared learning approach will guide all sessions over the next three days. Now, let’s take a closer look at the training agenda and how the sessions are organized.”

4 Sessions and learning objectives (7 min)

Action:

- **Refer:** Table: *Sessions and learning objectives* (Participant Handbook)
- **Walk** participants through the eight sessions.

! Facilitator Tip

Summarize major themes for the three days instead of reading each objective individually.

- **Mention** the two key resources (QR codes are provided in your Handbook):
 - *UNICEF Community IYCF Counselling Package*
 - *Operational Guidance: Breastfeeding Counselling in Emergencies*
- **Walk** participants through the agenda:
 - Highlight approximate session lengths (~1 to 2.5 hours per session)
 - Note that breaks, lunch periods and start/end times are included in the agenda

Bridge: “Now that we know what we’ll cover and when, let’s check whether it matches your expectations.”

5 Participants’ expectations (5 min)

Action:

- **Ask** participants whether the goal, objectives and topics are what they expected
- **Ask** participants to share:
 - Any topics that are missing or unclear
 - Any topics they feel that they do not have enough basic knowledge on within this training curriculum.
 - Any concerns about the schedule or the time allocated
- **Encourage** participants to note questions or concerns during sessions using sticky notes and/or their Participant Handbook.
 - Some questions may be addressed in later sessions or may require facilitators to follow up.
 - These questions will be noted on the **Parking Lot** flip chart.
 - The Parking Lot will be reviewed daily to ensure all points are addressed before the end of the training.

- **Encourage** participants to share feedback, either with an anonymous feedback box or a short daily questionnaire.



Facilitator Tip

Explain that participants' feedback improves learning and helps facilitators adjust sessions as needed.

Bridge: "Now that we've aligned on expectations, let's go over a few practical points to help create a smooth, safe and supportive learning environment for everyone."

Creating a safe and supportive learning environment



Action:

- **Explain** that agreeing on ground rules helps create a respectful, supportive learning environment and ensures everyone can contribute meaningfully.
- **Invite participants** to suggest ground rules that will help create a safe space for learning and sharing.
- **Discuss and agree** on the final set of ground rules.
- **Write the agreed rules** on a prepared flip chart titled *Group Norms* and display it on the wall for the duration of the training.
- **Add** to the suggested ground rules using the facilitator notes below, as needed.



Facilitator Tip

Some groups may be unfamiliar with this type of activity. If needed, gently prompt participants with culturally and contextually appropriate examples.

Suggested ground rules – Facilitator notes

- Manage time well: for facilitators and participants
- Maintain confidentiality: whatever happens during the training stays in the room
- Actively listen to each other: use the training as an opportunity to practise this vital skill
- Respect everyone's opinions and remain non-judgmental
- Discuss ideas, not people
- Focus on applying new skills, not just memorizing information
- Question assumptions and beliefs respectfully during discussions
- Stay curious and open to different perspectives
- Be inclusive and support others to participate
- Limit the use of laptops and mobile phones
- Avoid side conversations
- Share any safety concerns with a facilitator immediately
- Share feedback throughout the training



Facilitator Tip

To support time management, ask for one volunteer each day to help remind the group to return on time from breaks and lunch.

Bridge: "Before we begin the training sessions, we'd like to take a few minutes to understand everyone's starting point. This will help us tailor discussions and emphasize areas that are most useful for you."

Pre-training knowledge test

 20 min

Action:

- Introduce the pre-training knowledge test on IYCF-E counselling (16 technical questions).
- Explain the purpose of the pre- and post-training knowledge tests:
 - They help identify areas that may need adjustment or additional emphasis.
 - They help facilitators assess how well the training meets its objectives.
- Clarify confidentiality and use of results:
 - Pre- and post-test scores are matched using a code to ensure anonymity.
 - Results are not used for individual assessment or performance evaluation.
 - Individual responses are not used for any other purpose.
- Reassure participants: *“This is a way to assess how well we are facilitating the training, not how skilled you are.”*
- Encourage participants to:
 - Answer honestly based on their current knowledge, and
 - Not worry about knowing all the answers. All topics will be covered during the training, and participants are not expected to answer every question correctly.

! Facilitator Tip

Review the assessment results as soon as possible, ideally the same day, to identify areas of disagreement or confusion that may need to be addressed during the training.

Bridge: *“Thank you for completing the pre-training knowledge test. This gives us a helpful snapshot of where we are starting as a group. Now, let’s begin Session 1.”*

SESSION 1: IYCF COUNSELLING IN EMERGENCIES



LEARNING OBJECTIVES

1. Describe the basic IYCF counselling skills and key definitions used in breastfeeding support
2. Explain how IYCF counselling is adapted in emergency contexts and why it is critical
3. Recognize cross-cutting considerations in emergencies, including trauma-informed care, early childhood care and development, and disability inclusion



Material and preparation:

- The two posters on the wall:
 - Assess, Analyse, Act (3As)
 - Listening and learning / Building confidence and giving support



1h

Action:

- **Explain** that this session:
 - Introduces key concepts that will be used throughout the training,
 - Helps build a shared understanding of IYCF counselling and the adaptations emergency contexts require, and
 - Invites participants to reflect on their own experiences of emergencies and how these affect caregivers – especially pregnant women, mothers, infants and young children.
- **Say:** *“This session sets the foundation for the rest of the training. It is shorter and more conceptual than the other sessions. There are no role-plays in this session. Instead, we’ll focus on building a common understanding through short presentations and discussion. The skills we discuss today will be practised in much more detail in later sessions.”*
- **Read learning objectives:**
 - Describe the basic IYCF counselling skills and key definitions used in breastfeeding support
 - Explain how IYCF counselling is adapted in emergency contexts and why it is critical
 - Recognize cross-cutting considerations in emergencies, including trauma-informed care, early childhood care and development, and disability inclusion



Facilitator Tip

- *Lead this session in an interactive way. Encourage participants to share experiences from their own experiences in emergency contexts and reflect together on common challenges.*
- *Use this session as a “warm-up” for the group. As this is the first technical session, focus on building trust, participation, and a safe learning environment.*

Bridge: *“Let’s start by looking at the basic IYCF counselling skills and key definitions used in breastfeeding support.”*




LEARNING OBJECTIVE 1:

Describe the basic IYCF counselling skills and key definitions used in breastfeeding support

Time: 12 min

1 Counselling definition (4 min)

Action:

- **Invite** participants to share their own definition of counselling.
- **Ask** them not to look at the Participant Handbook for this activity.
- **Use prompts** if needed:
 - “What does counselling cover or include?”
 - “What are the different modes of counselling you have used?”
- **Ask** : “How is counselling different from health education or awareness sessions you may have facilitated?”
- **After discussion, refer to** Section: Counselling definition (Participant Handbook).
- **Highlight** the use of counselling cards (if applicable) and ask, “Are you using counselling cards? Are they the counselling cards in the c-IYCF training package?”





Facilitator Tip

Depending on the group and time, you may skip some questions or prompts. Keep this section to 5 minutes.

Bridge: “Counselling is more than just sharing information or giving advice. It requires a set of practical skills to listen, understand and support caregivers effectively. Let’s now look at the core counselling skills that form the foundation of all your interactions.”

2 Core counselling skills (4 min)

Action:

- **Point** to the **counselling skills poster** displayed in the room and the corresponding page in the Participant Handbook.
- **Explain** that these are **foundational skills** that apply across all sessions.
- **Remind** participants: for practice purposes, we focus on **3 skills per session**. This allows you to concentrate and improve rather than trying to apply all skills at once.
- **Emphasize:** while we focus on 3 skills during practice, in real-life counselling, **all skills are interconnected and should be applied together**.
- **Ask** participants in pairs:
 -  “Which counselling skills do you already feel confident using?”
 -  “Which skills do you find most challenging?”
- **Invite** 1–2 participants to share in plenary.





Facilitator Tip

Observe who appears more confident and who is less familiar with the skills. This informal assessment can help you later when forming mixed-experience groups for role-plays.

Bridge: “Now that we’ve reviewed the core counselling skills, let’s see how these skills are applied in a structured approach. The Assess–Analyse–Act (3As) process helps guide your counselling interactions and ensures that your support is clear, focused and effective.”

3 The counselling process: Assess–Analyse–Act (4 min)

Action:

- **Refer** participants to the **3As poster** on the wall and the corresponding page in the Participant Handbook.
- **Briefly explain** that this process **organizes counselling skills into practical steps**.
- **Ask:**
 -  “How many of you have used the Assess–Analyse–Act process before?” (show of hands)
 -  “Would anyone like to explain one of the steps in their own words?”
- **Invite** 1–2 volunteers to respond.
- **Clarify:**
 - The 3As process is flexible, not linear or rigid
 - Counsellors may move back and forth between steps
- **Refer** to *Job Aid 1.1: Three-Step IYCF Counselling – Assess, Analyse and Act* (Participant Handbook).

! Facilitator Tip

When participants answer a question or share their understanding, **acknowledge their contribution first**, even if it's incomplete or slightly inaccurate. Instead of immediately correcting them:

- **Build on their response** by adding details, clarifying points or connecting it to the key concept.
- **Encourage peer learning** by asking others whether they have similar experiences or can expand on what was shared.

Bridge: “Now that we’ve refreshed what counselling is, the skills we use, and the 3As process, we’ll look at how counselling needs to be adapted in emergency settings, where conditions, timing and support systems are often disrupted.”





LEARNING OBJECTIVE 2:


Explain how IYCF counselling is adapted in emergency contexts and why it is critical

Time: 23 min

1 Counselling in emergencies (5 min)

Action:

- **Introduce:** Emergencies are events that pose a critical threat to the health, safety or wellbeing of a community. They can be natural or human-made, sudden or slow-onset, short-term or prolonged.
- **Ask participants:**
 -  “What are some of the ways you have observed emergencies have impacted infant and child feeding practices?”
 -  “What changes did you notice in health services or community routines during the emergency in your context?”
- **Explain:**
 - Emergencies disrupt families, health systems and community networks. They increasing stress, trauma, and risks for caregivers and children.

- Women and children face increased risks, especially pregnant girls and women, infants and young children (<2 years), and women who have recently given birth.
- Breastfeeding provides lifesaving nutrition, hydration, comfort and protection from disease, while supporting maternal health and caregiving capacity. Protecting breastfeeding in emergencies as part of the right to health and adequate nutrition is a fundamental human right is a core component of humanitarian response.
- **Link to counselling and ask participants:**  “How do you think counselling in emergencies might differ from routine counselling?”
- **Highlight:**
 - Skilled counselling becomes even more important in emergencies because caregivers are under increased stress, services are disrupted, and feeding practices are more vulnerable to being undermined.
 - Counselling is not just information-sharing. It is a supportive, two-way process requiring empathy, non-judgment and active listening.
- **Emphasize** that counselling in emergencies **builds on the basic skills** but requires heightened sensitivity to stress, trauma and disrupted routines.
- **Encourage** participants to see counselling as a **critical, life-saving component of the response**, not just advice-giving.

Bridge: “Understanding how emergencies affect caregivers and services helps us anticipate challenges. Let’s now look at how these disruptions impact breastfeeding and explore practical adaptations through a case study.”

2 Scenario discussion (8 min)

Action:

- **Introduce:** “In emergencies, normal services and support systems are often disrupted, and family routines are affected. One of the first practices to be impacted is early initiation of breastfeeding after birth. By understanding these challenges, we can better anticipate problems and adapt how we provide counselling.”
- **Ask:** Volunteer reads *Scenario: Maternity care hospital* (Participant Handbook).
- **Discuss:**

 **What are some barriers to early initiation of breastfeeding in this scenario?**

Facilitator Tip

Encourage participants to focus on system-wide disruptions, including health service capacity, caregiver stress, social support and accessibility of counselling.



- **Write:** Capture ideas on flipchart.
- **Add:** Use key points if missing:
 - Overcrowded and overstretched maternity services
 - Lack of time or support from health workers
 - Too few IYCF counsellors or late involvement
 - High rates of caesarean and forceps deliveries
 - No skin-to-skin contact or rooming-in
 - Mothers arriving exhausted, traumatized or sick
 - Premature or low-birthweight babies needing special care
 - Mothers delivering alone, without support
 - Separation of mothers and babies after birth
 - Grief, fear and emotional distress
 - Lack of privacy or safe spaces in camps or hospitals

- No clear breastfeeding protocols in emergencies
- Disrupted access to prenatal care and follow-up

Bridge: “We’ve seen how emergencies disrupt breastfeeding and maternity support, let’s look at practical recommendations for adapting counselling services to meet these challenges.”

3 Service delivery adaptations during emergencies (10 min)

Action:

- **Refer:** Table: Overview of service delivery adaptations during emergencies (Participant Handbook).
- **Explain:** This table summarizes the key service delivery recommendations for IYCF counselling and how they may need to be adapted in an emergency context. Each column represents an aspect of counselling:
 - **Recipients:** who should receive IYCF counselling
 - **Timing:** at what stage should IYCF counselling be provided (pregnancy, birth, etc.)
 - **Frequency:** how often should IYCF counselling be provided (min 6 times)
 - **Mode:** how is the counselling provided (face to face vs remote, individual vs group)
 - **Provider:** who is providing the counselling (providers operating outside usual role)
 - **Quality:** what is the nature of the counselling (unchanged)
- **Add:** “In this session, we’re not going into the details of each column. Those will be covered in later sessions. Here, the goal is to get familiar with the overall framework and see how emergencies require us to adapt.”
- **Give** participants a few minutes to read the table quietly.
- **Ask:**
 -  “Looking at this table, which adaptation stands out to you as most challenging?”
 -  “Based on your experience, how have emergencies affected how counselling is delivered in your work?”
- **Encourage** a few participants to share their thoughts.
- **Point out that prioritization is often needed** in emergencies: some groups need immediate attention (e.g., newborns, sick infants, mothers with breastfeeding difficulties) while others may follow routine schedules when possible. This will be discussed in detail in the next session.
- **Add:** “Even when services are disrupted, counsellors can rely on a variety of systems of support (WhatsApp groups, peer support, helplines) to help mothers and caregivers maintain breastfeeding practices.”

! Facilitator Tip

Encourage participants to keep the table in mind for later sessions, when each column will be discussed in depth.

Bridge: “Now that we have seen how counselling services are adapted in emergencies, let’s take a step back and look at some factors that affect both how we counsel and how caregivers respond. These include trauma-informed care, early childhood care and development, and disability inclusion.”



LEARNING OBJECTIVE 3:


Recognize cross-cutting considerations in emergencies, including trauma-informed care, early childhood care and development, and disability inclusion

Time: 25 min

1 Trauma-Informed Care (10 min)


Defining trauma

Action:

- **Ask:**  "How many of you have heard of trauma-informed care?"
- **Say:** "Before explaining trauma-informed care, let's define trauma."
- **Explain:** Trauma is a response to a **deeply threatening** experience that causes **overwhelming physical, emotional, or psychological distress or harm**, beyond a person's ability to cope. Trauma can result from single events (e.g., accident, assault, disaster), prolonged events (e.g., conflict, kidnapping), or patterns (e.g., intimate partner violence).
- **Refer:** Table: What can trauma look and feel like? (Participant Handbook)
- **Say:** "These reactions help us understand why the way we interact with caregivers matters."

What trauma-informed care is and why it matters in emergencies

Action:

- **Explain** trauma-informed care:
 - Trauma-informed care is an approach to support caregivers in ways that are sensitive to trauma's ongoing impact on a person's wellbeing, relationships, and caregiving.
 - The goal is to avoid re-traumatization and create safe, respectful, supportive interactions.
- **Ask:**  "Why do you think trauma-informed care is especially important in emergency contexts?"
- **Highlight** that emergency-affected populations often experience high levels of trauma and that trauma-informed care helps prevent harm, improves access to services and supports recovery.
- **Say:** "So what does this mean for us, practically, as IYCF-E counsellors?"

Your role in providing trauma-informed care

Action:

- **Refer:** Figure: Multi-tiered approach to trauma-informed care (Participant Handbook)
- **Explain:**
 - **Universal trauma-informed care:** To be provided by all counsellors to all caregivers. Assume anyone may be affected by trauma.
 - **Trauma-specific care:** Provided by mental health and psychosocial support (MHPSS) counsellors or case managers for identified trauma survivors.
 - **Trauma-specialist care:** Provided by mental health professionals for those requiring specialized support.
- **Emphasize:** Not all caregivers will disclose trauma, so trauma-informed care should be applied universally.
- **Say:** "To apply trauma-informed care consistently, counsellors rely on a set of shared principles."

Guiding principles of trauma-informed care in practice

Action:

- **Refer:** Box: Five guiding principles for trauma-informed care (Participant Handbook)

- **Present the Five Guiding Principles:** Safety, Trustworthiness, Choice, Collaboration, Empowerment.
- **Give** a brief example for each:
 - **Safety:** asking before touching; not blaming the mother for her problems.
 - **Trustworthiness:** sending referrals as promised; not sharing information without consent.
 - **Choice:** asking the mother which of several options she would like to try, emphasizing her right to decide.
 - **Collaboration:** involving the mother in identifying the problem and agreeing on next steps.
 - **Empowerment:** recognizing strengths and reinforcing the caregiver’s confidence in her ability to care for her infant.
- **Say:** “Many more examples will be highlighted across all sessions.”

! Facilitator Tip


- Reinforce that trauma-informed care is a universal approach: applied to all clients, regardless of known trauma history.
- Emphasize that trauma-informed care protects both caregivers and counsellors from inadvertently causing harm.

BRIDGE: “Trauma-informed care is one key lens for counselling in emergencies. We will now turn to two other cross-cutting considerations – early childhood care and development and disability inclusion – which also shape how we provide effective support.”

2 Early Childhood Care and Development (8 min)


Introduction to Early Childhood Care and Development (ECCD)

Action:

- **Ask:**  “When you look at an infant or young child, what signs do you see that tell you they are developing well?”
- **Say:** “What you’ve just described fits into a broader concept called ‘early childhood care and development,’ or ECCD. Let’s take a look at the formal definition in your Participant Handbook.”
- **Refer:** Box: Early childhood care and development definition (Participant Handbook)
- **Explain:** Early childhood care and development, or ECCD, refers to how children grow and develop physically, cognitively, socially and emotionally from the prenatal period up to school entry. It also includes the care and interactions they receive to thrive.
- **Explain** that in this training, ECCD focuses on **mothers and caregivers of children from pregnancy through 23 months**, but the principles extend beyond this age.

The child development domains

Action:

- **Refer:** Figure: The four domains of development (Participant Handbook)
- **Describe** briefly each domain:
 - **Physical:** How children’s bodies grow in weight and height, and move, including both big (gross motor) and small (fine motor) movements
 - **Language:** How children communicate, both what a child understands and what they are able to say/express
 - **Cognitive:** How children think, understand and make sense of their environments
 - **Social/emotional:** How children connect with others, and how they express and understand emotions.
- **Ask:** “Let’s look at some examples of children’s behaviours.
 -  Can you identify which developmental domain(s) each behaviour represents?”

- List behaviours to discuss:
 - **Jump** → Physical
 - **Draw a stick figure** → Cognitive, Physical
 - **Babble or talk** → Language
 - **Embrace** → Social/Emotional, Physical
 - **Stacking cups** → Physical, Cognitive, Social/Emotional (trial and error, persistence)
 - **Playing with a doll** → Physical, Cognitive, Social/Emotional
 - **Pointing to an object** → Physical, Cognitive, Language

! Facilitator Tip

- *If time allows, make the exercise more interactive by distributing coloured sticky notes or cards (as shown in the figure “The four domains of development” in the Participant Handbook):*
 - *Yellow = Physical development*
 - *Green = Language development*
 - *Blue = Cognitive development*
 - *Pink = Social/emotional development*
- *Read out a child behaviour and ask participants to raise the colour they think best represents the domain being developed.*
- *Use this to reinforce that many behaviours relate to more than one domain; there may be more than one correct answer.*

- **Emphasize** that in our interactions with caregivers, we have ongoing opportunities to support child development by helping them understand how their child is growing and learning and what influences that development. Counselling is not only about feeding or nutrition; it also supports caregivers to think about how everyday interactions can stimulate their child’s speech, thinking, movement and relationships with others.

! Facilitator Tip

- *Encourage participants to reflect on their own counselling sessions. How do they already support caregivers in understanding child development?*
- *Emphasize that even small conversations about child behaviour, play or responsiveness can make a meaningful difference.*

Responsive caregiving and responsive feeding

Action:

- **Introduce** responsive caregiving: This is the ability of a caregiver to notice a child’s signals, understand what they mean, and respond appropriately.
 - Key steps: **Notice** → **Understand** → **Respond**
- **Say:** “Responsive feeding is a type of responsive caregiving. It involves feeding infants and young children in response to their cues, encouraging independence and ensuring that nutrition supports healthy growth.”
- **Refer:** *Definition: Responsive caregiving and responsive feeding* (Participant Handbook)
- **Emphasize:** Responsive feeding is not a stand-alone topic in this training. It is embedded across multiple sessions and practised throughout counselling activities, especially during role plays and case discussions.

ECCD and IYCF

Action:

- **Refer:** *Table: Which category does each goal fall under?* (Participant Handbook).
- **Ask** participants to decide which statements reflect ECCD goals, IYCF goals, or both.
- **Pause:** Allow participants time to complete the table.

- **Ask:** Go through the statements **one by one**, asking participants to share their answers (by show of hands or calling out).
- **Reveal:** “*Trick question! All of these statements reflect both ECCD and IYCF goals.*”
- **Explain briefly:** This shows how closely nutrition and child development are linked: supporting feeding practices also supports learning, relationships and overall development.

Why ECCD matters in emergencies


- Say: “Responsiveness is particularly important in emergencies. It is one area caregivers can control even under adversity, and it provides stress-buffering positive interactions for children and caregivers.”
- Highlight that **nutrition and ECCD interventions should be integrated** whenever possible, coordinating with dedicated ECCD services in the community.
- Counsellors are not expected to assess all areas of development in detail. Focus on simple observations and supporting responsive caregiving during everyday interactions.

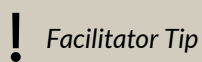
Bridge: “*Another cross-cutting issue that shapes how we counsel in emergencies is disability inclusion. At this stage, we’re focusing on awareness: recognizing both the risks of exclusion and the important role played by counsellors in ensuring that care is inclusive.*”

3 Disability inclusion (7 min)

What do we mean by disability?

Action:

- **Ask:**  “When you hear the word ‘disability’, what comes to mind?”
- **Listen briefly** and acknowledge responses.
- **Say:** “*Disability is not always visible. In emergencies, it is often overlooked. This section is about recognizing disability as a cross-cutting issue in IYCF-E counselling – not becoming specialists, but becoming more inclusive.*”
- **Refer:** Box: Disability definition (Participant Handbook).
- **Explain:** According to the UN Convention on the Rights of Persons with Disabilities, disability results from the interaction between a person’s impairment and barriers in their environment. It’s not only about the impairment but also about what prevents participation.
- **Highlight:** Barriers may be
 - **Physical** (inaccessible services),
 - **Attitudinal** (assumptions, stigma), or
 - **Communication-related** (information not adapted).
- **Refer:** Figure: Relationship among impairments, barriers, and disability (Participant Handbook).
- **Explain briefly:** Disability is not caused by an impairment alone. Disability emerges when impairments interact with barriers—such as inaccessible services, stigma or communication challenges.



Facilitator Tip

Encourage participants to reflect on barriers they may unintentionally create in counselling settings.

Why disability inclusion matters in IYCF counselling during emergencies

Action:

- **Say:** “*Disability inclusion is essential in IYCF-E because emergencies both increase the risk of disability and amplify existing barriers.*”
- **Explain briefly:**
 - Conflict, displacement, injury, illness, malnutrition, disrupted services, and stress can lead to new or worsening disabilities among infants and caregivers.

- At the same time, inaccessible services, stigma, and communication barriers may prevent families from accessing infant feeding support.
- Inclusive counselling helps ensure that all infants receive appropriate feeding care and that no caregiver is excluded from lifesaving assistance. This may include adapting feeding support for infants or children who have difficulties with sucking, swallowing, or coordination.
- **Conclude:** *“This is why disability inclusion is integrated into this training package. We are not becoming specialists but strengthening our ability to recognize barriers and respond inclusively.”*

Models of disability

Action:

- **Say:** *“Over time, different models have been used to explain disability. How we understand disability shapes how we respond as counsellors.”*
- **Refer:** *Figure: Models of disability (Participant Handbook).*
- **Add** for each model:
 - **Charity model (outdated):** This model can feel kind, but it often removes dignity and reinforces dependency and pity.
 - **Medical model (outdated):** This model places the problem in the person, not in the environment.
 - **Human rights-based model (current approach):** This is the model that guides our work. Our role is not to fix people but to reduce barriers and ensure inclusion in services.
- **Say:** *“In IYCF-E counselling, this means adapting how we communicate, making space for caregivers’ choices, and ensuring children with disabilities and their caregivers can access and benefit from services on an equal basis to those without disabilities.”*
- **Highlight:**
 - Inclusion does not require specialist expertise.
 - It starts with awareness, respectful language and flexibility.

! Facilitator Tip

During the training, if participants share examples rooted in charity or medical models, acknowledge gently and reframe towards inclusion and rights.

Person-centred language

Action:

- **Refer:** *Section: Person-centred language (Participant Handbook).*
- **Explain:**
 - Person-centred language puts the person first, not the impairment.
 - Using person-centred language reflects the human rights-based approach. It reminds us not to define people by a diagnosis or make assumptions about their abilities.
 - How we think about and talk to or about people with disabilities can impact whether a person with a disability decides to access or return to IYCF-E or other services. Language matters.

Twin Track: What does disability inclusion mean for counsellors?

Action:

- **Explain:** Disability inclusion means two things:
 - **Mainstreaming:** making sure IYCF-E counselling is accessible and inclusive for *all* caregivers and children
 - **Disability-specific support:** recognizing when additional adaptations or referrals may be needed
- **Clarify:**
 - Most of the counsellors’ role involves **mainstreaming:**

- Adapting communication for caregivers with hearing, speech, learning or psychosocial difficulties;
- Allowing extra time for counselling sessions when needed; and
- Adapting counselling approaches to match caregiver and infant needs, abilities, preferences and situations.
- Adapting feeding support where needed (e.g., positioning, pacing, or additional support for infants with feeding difficulties)
- Disability-specific services may require **referral or coordination** with specialized providers and other services.
- **Say:** *“In emergencies, children and caregivers with disabilities face higher risks of exclusion, malnutrition and stress. Counsellors play a key role in noticing these risks and ensuring families are not unintentionally left out.”*



Facilitator Tip

Remind participants that simple adaptations can make a big difference in emergencies.

Session wrap-up

Action:

- **Summarize** key points from the session:
 - **Counselling fundamentals:** Skills; 3As process; the importance of supportive, two-way interactions
 - **IYCF in emergencies:** Understanding disruptions; adapting service delivery; prioritizing high-risk groups
 - **Cross-cutting considerations:** trauma-informed care; ECCD; disability inclusion
- **Reinforce:**
 - Participants don't need to master everything in this session. This was an **overview and awareness session**.
 - Practical application and deeper skill-building will happen in later sessions with role-plays and scenario-based exercises.

Bridge: *“In the next session, we will look at Individual Assessment in Emergencies, where you'll start applying these concepts directly with caregivers. You'll practise assessing feeding and caregiving practices, and you will learn how to adapt counselling based on what you observe.”*

SESSION 2: INDIVIDUAL ASSESSMENT IN EMERGENCIES



LEARNING OBJECTIVES

1. Complete triage for IYCF counselling recipients in an emergency
2. Describe how to conduct an individual full assessment in an emergency



COUNSELLING SKILLS FOCUS*

- Ask open questions
- Reflect back on what the mother or caregiver says
- Accept what a mother or caregiver thinks and feels

**Reminder: The full 3A process and counselling skills set remain essential. The focus on these particular three skills is for practice and learning purpose.*



Material and preparation:

- Prepare a set of 3 blank-coloured cards per participant to vote: RED, ORANGE, GREEN – to be used in [Step 2](#)
- Role-play cards – Aunt Ayen (Step 4): Cut cards for approximately one-third of participants from Annex 2.1 (at the end of this session).



1h30

STEP 1: Set the Scene

10 min

1 IYCF counselling recipient (1 min)

Key Points:


- In non-emergency settings, IYCF counselling reaches **all pregnant women and mothers/caregivers with infants and young children**, in line with WHO 2021 recommendations (See Session 1 – *Table: Service delivery adaptations and compromises during emergencies*, Participant Handbook, column Recipients, first row).
- In emergencies, we often cannot reach everyone immediately.

Bridge: “Let’s think about how this might look in an emergency situation.”

2 Scenario discussion (5 min)

Action:

- Ask: Volunteer reads *Scenario: Health centre responding to flood displacement* (Participant Handbook).
- Discuss:

 **In this situation, who might need IYCF counselling, and how might this differ from a non-emergency setting?**

- **Write:** Capture ideas on flipchart.
- **Add:** Use key points if missing.
 - **Who might require counselling:**
 - **Higher population of pregnant and breastfeeding women and girls (PBWG) and children:** Emergencies often displace large numbers of PBWG, increasing the demand for counselling.
 - **Broader audience for counselling:** Fathers, grandparents and community members might become caregivers and require IYCF guidance.
 - **Non-traditional caregivers:** Older siblings or relatives might become caregivers as well, necessitating counselling on proper infant nutrition.
 - **Community-based humanitarian response:** Local leaders and health workers might become primary recipients of IYCF-E training to reach a broader population.
 - **What they might need:**
 - **Increased focus on vulnerable populations:** Particular attention is needed for PBWG, malnourished children, and families under stress or trauma.
 - **Displaced families:** Refugees or displaced people might lack access to normal feeding resources, requiring adapted guidance on breastfeeding and safe feeding practices.
 - **Increased need for mental health support:** Caregivers facing stress and trauma might need emotional support alongside practical feeding advice.
 - **Cultural and religious diversity:** Counsellors need to respect diverse cultural practices while promoting evidence-based feeding practices in mixed populations.

Bridge: “So, emergencies can completely change who receives IYCF counselling and what support they need. Let’s see what that means in practice.”

3 **Impact of an emergency on recipients of IYCF counselling demand and caseloads (2 min)**

Action:

- **Refer:** *Diagram: When needs exceed capacity* (Participant Handbook).
- **Explain:**
 - In emergencies, **needs, caseloads and risks increase sharply** while resources remain limited.
 - 100% coverage is not possible. The focus therefore **shifts from universal to priority-based coverage**.
 - Understanding who needs counselling most is the first step.
 - Counsellors must adapt both **who they assess** and **how they assess**.

Bridge: “In this session, we’ll learn how to put this into practice, including how to adapt counselling and prioritize support when needs exceed available services.”

4 **Learning objectives (2 min)**

Action:

- **Say:** “To guide our session, let’s review the learning objectives together.”
- **Read learning objectives:**
 - Complete triage for IYCF counselling recipients in an emergency.
 - Describe how to conduct an individual full assessment in an emergency.
- **Highlight counselling skills focus:**
 - In this session, for learning and practice purposes, we are focusing on the three key skills:
 - Ask open questions

- Reflect back on what the mother or caregiver says
- Accept what a mother or caregiver thinks and feels

Bridge: “Now that we understand how emergencies change counselling needs and priorities, let’s move into Step 2 to explore how to identify and assess who needs IYCF support first.”

STEP 2: Strengthen key knowledge, concepts and skills

 40 min



LEARNING OBJECTIVE 1:

Complete triage for IYCF counselling recipients in an emergency

Time: 20 min

1 What triage means and why it matters (1 min)

Key points:

- The WHO recommendation of 100% coverage for PBWGs and caregivers of children 0–23m in non-emergency contexts is not possible in an emergency.
- **Triage**, used in all emergency responses, means prioritizing cases at greatest risk to save the most lives with the available capacity.
- Triage aims to identify those in **immediate need** and those **at high risk** of developing feeding or nutrition problems:
 - Ensure those in urgent danger receive prompt support (e.g., newborns, severely stressed mothers)
 - Identifies and supports high-risk pairs early to prevent complications later



Facilitator Tip Keep it high-level. Do not read word-for-word; just summarize the main points.

Bridge: “Now, let’s look at how triage actually works.”

2 How triage works (2 min)

Action:

- **Explain:**
 - **How triage is organized in practice (where it happens and who conducts it) will vary by context.**
 - **Triage usually takes place at the first point of contact** with caregivers and infants (for example, at the entrance of a facility, during registration, or at the start of a community activity), so urgent cases can be identified early.
 - **Triage can be conducted by different staff depending on the context**, including IYCF counsellors, health or nutrition staff, or other trained frontline workers using a simple tool.
 - Effective triage is **rapid, simple and accurate**.
 - Triage criteria must be **clear and consistent** so that any frontline worker can apply them.
 - Triage groups caregivers and infants into **three priority levels** based on urgency of need.
- **Show:** *Diagram: Triage overview* (Participant Handbook)

Key points

- **Priority 1 (RED):** Urgent or life-threatening situations → need immediate IYCF-E counselling.
- **Priority 2 (ORANGE):** At-risk pairs → need IYCF-E counselling soon to prevent deterioration.

- **Priority 3 (GREEN):** Stable pairs → can be provided with less intensive forms of IYCF-E support (e.g., nutrition education, supportive spaces)
- All individuals in **Priority 1 (RED)** and **Priority 2 (ORANGE)** must receive IYCF counselling. **Priority 1** cases take **precedence** for immediate attention. They are supported first when capacity is limited.



Facilitator Tip



Emphasize simplicity: triage is about identifying urgency early and prioritizing support when resources are limited, not about solving all problems at once or designing the full service model.

Bridge: “Let’s see how these categories are applied in practice through the Priority Triage Tool.”

3

Priority Triage tool (7 min)

Action:

- **Refer:** Tool: Priority Triage (Participant Handbook)
- **Explain** the tool can be used by untrained, non-IYCF staff
- **Describe** the three priority categories and colour coding.
- **Ask:**  “Did you notice that some risk factors appear in both Priority 1 and Priority 2? Which ones do you see?”
- **Answers:** Disability, malnutrition, GBV
- **Ask:**  “Why does the priority change depending on whether the woman is pregnant or breastfeeding?”
- **Answers:**
 - Because **the level of risk to the mother and infant and the urgency of support are different.**
 - **Breastfeeding women:** Feeding is happening **right now**. Any problem (stress, illness, malnutrition, disability, GBV) can **immediately affect the baby’s feeding and survival**, so the situation may be **more urgent**.
 - **Pregnant women:** The mother will have additional requirements for her own health. Furthermore, the baby has **not yet been born**, so there is often **more time to support and prevent problems**, unless there are serious risks or complications.
 - **The same risk factor can mean different urgency** depending on whether feeding is already taking place or will happen later.
 - The level of priority depends on how the condition affects feeding, health, or caregiving. The presence of disability alone does not determine urgency.



Facilitator Tip

Encourage participants to refer to the tool while answering questions.



Coloured cards activity: Who needs help first?

Instructions:

- **Distribute:** Three coloured cards to each participant — **red, orange, green** — representing Priority 1, 2 and 3.
- **Say:** “I’ll read short case descriptions. Consider which priority group they belong to and hold up the matching colour card. You can use the Priority Triage tool.”
- **Read:** Each case aloud, giving participants a few seconds to choose their card.
- **Reveal:** The correct answer after each case.
- **Wrap-up:** “Emergencies often amplify the needs and risks facing caregivers and children. Triage helps us quickly decide who needs IYCF-E counselling first and who can potentially wait or receive lighter support.”

! Facilitator Tip Keep it short. Acknowledge quick answers and move on.

Cases and answers


1. Infant who is one week old
→ **Priority 1 (RED)**
2. Adolescent mother with a four-month-old infant
→ **Priority 2 (ORANGE)**
3. Pregnant woman who is malnourished
→ **Priority 2 (ORANGE)**
4. Pregnant woman in good health, with no feeding or medical concerns identified
→ **Priority 3 (GREEN)**
5. Mother with 4-month-old twins
→ **Priority 1 (RED)**
- Breastfeeding mother with a disability that impacts feeding
→ **Priority 1 (RED)**
- Pregnant woman with a disability that impacts feeding
→ **Priority 2 (ORANGE)**
- Breastfeeding mother who has disclosed that she is a survivor of GBV
→ **Priority 1 (RED)**
6. Healthy breastfeeding mother with 6-month-old baby growing well
→ **Priority 3 (GREEN)**
7. Pregnant, first-time mother
→ **Priority 2 (ORANGE)**

Bridge: “Sometimes a person’s priority isn’t obvious: a pregnancy that’s not visible, a hidden feeding difficulty, a child’s age. To identify these cases accurately, we need a simple tool that guides our questions and observations. Let’s look at the Simple Rapid Assessment next.”

4 Simple Rapid Assessment (6 min)

Action:

- **Refer:** Tool: Simple Rapid Assessment (Participant Handbook)
- **Introduce the Simple Rapid Assessment (SRA):** A quick tool that helps identify key information about both the mother/caregiver and the child to determine their triage priority.
- **Explain how to use the SRA:**
 - **Same colour coding** as the Priority Triage Tool: **Red (Priority 1), Orange (Priority 2), Green (Priority 3)**. Each response on the form is colour-shaded to help you see risk levels briefly.
 - If there is any red response → the pair is Priority 1: urgent.
 - If there are no red but one or more orange responses → the pair is Priority 2: at risk.
 - If all responses are green → the pair is stable and can receive routine IYCF support.
 - The form serves as a **memory aid**. It does **not have to be printed or kept on record**. Once learned, it can be used verbally or mentally.
- **Emphasize:**

- During triage, **both the mother/caregiver and child** must be present and observed.
- Always **unwrap infants** to see their whole body and check for any visible danger signs (e.g., wasting, rash, lethargy).
- **Clarify the use of the SRA and the Priority Triage Tool:**
 - The SRA does not fully capture all criteria in the Priority Triage Tool. Some important risk factors, such as complementary feeding practices, MUAC or prematurity, are not included.
 - **Use both tools together:** The SRA guides rapid screening, while the Priority Triage Tool confirms priorities and guides triage decisions.
- **Introduce the Referral Form:**
 - **Refer:** *Job Aid 2.1: IYCF-E Referral Form* (Participant Handbook)
 - **Say:** *“When the SRA identifies a mother–baby pair as Priority 1 or Priority 2, **complete the Referral Form** to document and refer them for a full assessment.”*
- **Wrap up:**
 - **Ask:**  “Has anyone used the SRA or a similar tool before? Did you find it helpful in practice?”


! Facilitator Tip

*If participants indicate that they have used the SRA or a similar tool, ask them how they used it practically. Encourage new users to keep a **laminated copy** as a quick reference while learning and establishing this new practice.*

Bridge: *“The SRA helps us identify key risk factors that might not be obvious at first glance. But even with these tools, some risks – like stress, disability or GBV – may remain hidden. Let’s look at what this means in practice.”*

5 Hidden risks (2 min)

Action:

- **Explain:**
 - Even with good tools, **not all risks are immediately visible** during triage.
 - Parents and caregivers usually want help, but some may avoid sharing if they sense **stigma, disapproval or lack of compassion** from staff.
 - Triage should always be conducted in a **respectful, non-judgmental way** to make caregivers feel safe and supported. Despite this, some situations may still not be shared.
- **Ask:**  “What kinds of situations might a caregiver choose not to share during triage?”
- **Sample answers:**
 - A caregiver may hesitate to show a child with visible impairment (e.g., spina bifida, club foot).
 - A pregnancy outside cultural norms (e.g., adolescent pregnancy, unmarried pregnancy or pregnancy resulting from GBV) may not be disclosed openly.
 - Caregivers may hide emotional distress, trauma or mental health challenges.
- **Explain GBV considerations:**
 - It is **not** the role of IYCF workers to ask whether someone is a survivor of GBV. However, counsellors should create a safe, respectful environment where caregivers feel able to share concerns if they choose.
 - This priority only applies if a caregiver **voluntarily** discloses GBV-related information.
 - A full session on GBV later in the training will expand on how to respond safely and appropriately.
- **Wrap up:** *“Even with tools like the SRA, some information may remain unknown during triage. Remember, triage is not about collecting every detail. It’s about creating a safe first contact that allows important information to emerge. Assessment should always lead to action. Even in brief interactions, aim to identify one or two practical next steps to support the caregiver.”*

Bridge: “Let’s now summarize the key points and reflect on what we’ve learned.”

6 Key takeaways and questions (2 min)

Action:

- **Refer:** *Key learning points – Objective 1* (Participant Handbook).

! Facilitator Tip Point participants to the Key learning points in their Handbook. If needed, quickly summarize from the Handbook to reinforce.

- Ask whether participants have any questions before moving on.

! Facilitator Tip If you have an extra minute or want more discussion, ask: “Which part of triage do you think will be hardest to apply in your context?”

Bridge: “We’ve just looked at identifying who needs IYCF-E support first. The next step is understanding how to gather more detailed information and how to conduct an individual full assessment in an emergency.”



LEARNING OBJECTIVE 2:

Describe how to conduct an individual full assessment in an emergency

Time: 20 min

1 From triage to care (3 min)

Action:

- **Show:** *Diagram: From triage to care* (Participant Handbook)
- **Explain:**
 - Triage identifies who needs support urgently (Priority 1), soon (Priority 2) or with basic support (Priority 3).
 - For Priority 1 and Priority 2, the next step is a **Full Assessment** using the IYCF-E Full Assessment Form.
 - The assessment leads to a **Care Plan** and/or **Referral** depending on needs.
 - Priority 3 caregiver and child do not need a full assessment but still receive supportive services.

! Facilitator Tip Keep the overview brief and use the diagram to orient participants visually. Avoid going into detail.

Bridge: “Now that we know where triage fits in the wider pathway, let’s explore the Full Assessment Form, which guides us step-by-step in understanding a caregiver’s situation.”

2 IYCF-E Full Assessment Form (10 min)

Action:

- **Refer:** *Tool: IYCF-E Full Assessment form* (Participant Handbook)
- **Introduce:**
 - Once the triage identifies a pair as Priority 1 or 2, a **full assessment** is needed.
 - This assessment collects the key details needed to understand a caregiver’s situation and guide recommended counselling, referrals and follow-up.

- Using a structured form helps ensure important information is not missed and supports clear communication between service providers.
- At the end, you should be able to create a **care plan** and determine any necessary **referrals**.
- **Walk through the Full Assessment form** using the facilitator notes below.

Facilitator Tip

*The Full Assessment form is detailed and should **not** be read aloud line by line. Give only a brief overview of each section and focus on the flow and purpose of the assessment. Participants will have a chance to practice using the form in Step 4 (Role Play).*

IYCF-E Full Assessment Form – Facilitator notes

MUAC measurement: The updated 2023 WHO guideline on the prevention and management of wasting and nutrition oedema in infants and children under 5 years includes a recommendation to use mid-upper arm circumference (MUAC) (< 110 mm) for identifying wasting in infants aged 6 weeks to under 6 months, based on emerging evidence. This may be a new or unfamiliar practice in some contexts.

It is important to note that Management of At-risk Mothers and Infants (MAMI) programs may use different criteria and cut-offs, and implementation varies by country. Frontline workers should always follow local and national guidance on MUAC use and admission criteria for infants under 6 months.

For the purposes of this training and role-play, clinical signs remain the primary method used for this age group, with MUAC included here for awareness and discussion.

<https://www.childwasting.org/guidance>

SECTION 1: COLLECT BASIC INFORMATION

Many fields will already be collected during the SRA, but it may not have been fully captured or written down (in the case where the SRA is memorized).

SECTION 2: CHECK FOR DANGER SIGNS

This section helps identify any **immediate, life-threatening concerns** in the infant or caregiver. Some signs may already have been noticed during triage, but the full assessment may be the first chance to observe them closely.

If any **danger sign** is present, **stop the assessment and refer immediately to Health Services**. It is not appropriate to continue a nutrition assessment when urgent medical care is needed.

SECTION 3: ASK ABOUT FEEDING PRACTICES

This section helps you build a clear picture of how the baby is being fed. Understanding the caregiver’s main concern, recent illness, and any changes in feeding is essential to fully understand feeding practices and the additional risks they may pose during emergencies. Mothers and caregivers may not understand the implications of an emergency on their feeding practices. Inappropriate foods or practices that increase the risk of illness and infection need to be identified.

This section should be completed carefully, without assumptions about what the caregiver means.

If information about the infant’s diet is incomplete, the accuracy of the overall assessment will be affected.

SECTION 4: CHECK HYDRATION AND STOOL OUTPUT

This section provides a quick indicator of possible illness that might have been missed (e.g., bladder infection, dehydration, diarrhoea) as well as an indirect measure of intake. While output of urine and stool is a less reliable sign of intake after the early weeks of life, most mothers and caregivers can provide a fairly reliable estimate.

SECTION 5: ASK ABOUT BREASTFEEDING/BREASTMILK FEEDING

This section gathers key information about how breastfeeding or breast milk feeding is going. The focus is on frequency, effectiveness and maternal comfort – all factors that strongly influence whether breastfeeding can be sustained and remain exclusive.

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

This section does not require a line-by-line reading and check off. The items listed serve as reminders to ensure a comprehensive assessment. These reminders are particularly useful in a chaotic setting, where it may be difficult to remain focused through the whole feeding.

Wherever possible, assess breastfeeding with the baby undressed and observe both breasts and nipples without a bra or other garment over the torso. While you are assessing the feeding, you are also sharing relevant observations with the mother and providing suggestions as indicated.

Always request the mother’s permission before observing a breastfeed, touching her or the baby, or providing any hands-on support. Explain what you would like to do and why; remind her that she can say no at any time. Requesting permission is a trauma-informed practice and helps build trust, particularly in emergency settings where privacy, dignity and bodily autonomy may already be compromised.

SECTION 7: ASSESS MATERNAL/CAREGIVER WELLBEING

This section focuses on the caregiver’s wellbeing. The aim is to ensure that mothers and caregivers receive appropriate support, as well as to identify priorities for the care plan and any necessary referrals. It captures the current situation (last two weeks), including emotional state, coping, and available family or social support that may influence the care plan.

Asking about a caregiver’s mental health can be sensitive. Probing this topic later in the assessment, once rapport and trust are established, increases the likelihood of obtaining accurate information. Visual aids, drawings, or pictures can help caregivers express their mood and feelings.

SECTION 8: (IF 6–23 MONTHS) ASSESS COMPLEMENTARY FEEDING PRACTICES

This section applies only to children 6–23 months. Complementary feeding is critical in emergencies, where food insecurity and disrupted routines may affect diet quality. Even when breastfeeding difficulties exist, care plans should consider the child’s complementary diet to ensure adequate nutrient intake.

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

Additional risk factors that are likely to impact the care plan are summarized in section 9.

SECTION 10: NOTE DOWN ANY OBSERVATIONS MADE DURING THE ASSESSMENT

Observations help confirm the information gathered and highlight anything that may need further probing. They can also flag possible health concerns. A request for infant formula should *always* prompt additional counselling, **even when the assessment shows that breast milk substitutes are not needed**, so that the counsellor can understand the reason for the request and provide appropriate support.

SECTION 11: COUNSELLING ACTIONS/DECIDE ON CARE PLAN

This section can serve as your notes for the initial visit and referral to follow-up for further counselling. The completion of the full assessment should end with a care plan, which includes:

- Agreed actions that the mother or caregiver has selected from options discussed
- Expected outcomes
- Timeframe for follow-up

The **Care Plan** may be a separate document. See an example in the *Job Aid 2.2: Care action plan for mother/caregiver and baby receiving skilled support and/or breast milk substitutes* (Participant Handbook), with attached follow-up notes and a BMS feeding checklist and plan as applicable.

! Facilitator Tip

To keep the walkthrough engaging, avoid lecturing through every section. Instead, involve participants with quick prompts, such as: “What are we trying to understand in this section?” “How could this information influence a care plan?”

Key point: Disability focus:

- Where a disability that may impact feeding is suspected or confirmed but immediate referral to specialized services is not possible, the supporting tool below provides guidance for frontline workers to assess needs and offer practical, appropriate feeding support until specialized care becomes available.



GNC Disability Inclusion Working Group (July 2024) [Connecting Inclusive Feeding & Disability Resources to Nutrition Practices in Humanitarian Settings](#)

Bridge: “After completing the Full Assessment and developing an initial care plan, the final step is to determine whether any additional services are needed to support the mother–child pair.”

3 Referrals (2 min)



Action:

- **Explain:**
 - Referrals are used when a need is identified that **cannot be fully addressed by the IYCF-E counsellor**.
 - The referral form used will depend on the local context and available services (see *Job Aid 2.1: IYCF-E Referral Form*).
 - To make effective referrals, counsellors need **up-to-date, written information** on:
 - Admission criteria
 - Location of the service
 - Opening days and hours
 - Any associated costs
- **Highlight the purpose:**
 - Quality referrals improve the efficiency of the system and ensure families receive the right support at the right time.
 - Many issues outside IYCF still affect a caregiver’s ability to feed and care for their child, for example:
 - Missing family members
 - Food insecurity
 - Violence in the home (only if voluntarily disclosed)
 - Recognizing these issues and referring caregivers to appropriate services supports overall wellbeing and leads to better IYCF outcomes.

Bridge: “We’ve gone through the assessment content and how to act on what you find, including referrals. Now, let’s talk about what it looks like to use this tool in real life.”

4 Using the IYCF-E Full Assessment Form in practice (3 min)

Action:

- **Invite** participants to reflect on how the tool will work in their context.
- **Ask:**  “How do you think this tool could help you in your work?”
- **Sample answers:** consistency, confidence, fewer missed details, clearer referrals.
- **Ask:**  “What challenges do you anticipate when using it?”
- **Sample answers:** long form, lack of time, crowded spaces, caregiver stress, multiple priorities.

Key points: How to use the tool effectively


- The form supports the conversation. It is **not** meant to replace natural counselling.
- Ask questions in a natural, conversational way:
 - Avoid reading the form line-by-line.
 - **Start with broad, open questions. Then use the form to check what might be missing.**
 - When first learning the tool, counsellors may rely on the form more heavily. This is normal. With practice, they will use it more fluidly.
- Use mostly open-ended questions, supported by checklists, with clarifying questions when needed. (Refer to *Table: Types of questions* in the Participant Handbook.)

Bridge: “At this point, you can see that the Full Assessment is less about completing every box and more about understanding the caregiver’s situation well enough to identify the most urgent need, make a clear care plan, and connect them to the right support. Let’s now review the key takeaways from this objective.”

5 Key takeaways and questions (2 min)


Action:

- **Refer:** Key learning points – Objective 2 (Participant Handbook).

 **Facilitator Tip**

Point participants to the Key learning points in their Handbook. If needed, quickly summarize from the Handbook to reinforce.

- **Ask** whether participants have any questions before moving on.

 **Facilitator Tip**

If you have an extra minute or want more discussion, ask: “What part of the process do you feel most confident about?”

Bridge: “We are now moving into a demonstration where you will see how to apply what we learned in Step 2.”

STEP 3: Demonstrate

 15 min

1 Introduction (3 min)

Action:

- **Introduce:** *“In this demonstration, we will continue from the context we discussed in Step 1 – a health centre receiving families displaced by mudslides and flooding – and apply the tools and skills from Step 2, with a focus on the following three counselling skills:*
 - Ask open questions
 - Reflect back on what the mother or caregiver says
 - Accept what a mother or caregiver thinks and feels
- **Refer:** *Case study: Aunt Ayen and Deng (Participant Handbook).*
- **Summarize** the case:
 - **Setting:** Health Centre serving an IDP camp
 - **Mother/Caregiver:** Ayen
 - **Child:** Deng, 2 months old
 - **Reason for contact:** New arrival for screening / first contact with services
 - **Counsellor:** IYCF-E counsellor responsible for triaging PLW and children 0–23 months, using the Simple Rapid Assessment (SRA) as the first step in the triage process.



Facilitator Tip

Remind participants to focus on how the counsellor uses the SRA and applies the counselling skills. This demonstration is about learning, not evaluating performance.

2 Script (5 min)

Action:

- **Act out** the script below in teams of three.



Facilitator Tip

- **This demonstration format will be used throughout the course.** Because this is the first one, the script is intentionally simple so that both facilitators and participants can become familiar with the flow.
- **Use the script as a guide.** You may adapt the language to make it feel natural, but be sure to model the key counselling skills (open-ended questions, reflection, acceptance) and keep the core technical content accurate.
- **Act, don't read.** Demonstrations are most effective when they feel realistic. Play the roles in a natural, human way, rather than reading line-by-line.



Counsellor

Hello, my name is [Counsellor]. Welcome. I am an IYCF-E counsellor at the health centre and am here to help you. Would you like to sit down? What's your name, and who is this with you?



Aunt Ayen

My name is Ayen. This is my sister's child, Deng. He is just 2 months old. His mother was killed in the floods a week ago, and his father had to stay back to look after our cattle.



Counsellor I am so sorry for your loss. Losing your sister and caring for such a young baby during a difficult time sounds like a lot to cope with at once. How are you managing?



Aunt Ayen Thank you. It's been very hard. I have been feeding Deng porridge because that's all we have. I urgently need infant formula for him.



Counsellor It sounds like you're going through a really difficult time, and you're doing your best to take care of Deng with what you have, even though you're feeling a lot of stress. It must be very difficult not having what you need for him right now. You need help finding appropriate food for him so that you can feed him in the best way possible. Is that right?



Aunt Ayen Yes!



Counsellor You're doing a great job in your circumstance. I can see how much you care for and love Deng. I would like to gather a bit more information so that I can get you and Deng the right kind of help, including your questions about infant formula. Oh, my goodness – what a sweet little face! Let's first take a moment to look at Deng and see how he is doing. Are you able to unwrap him from the blankets for a quick look?



Aunt Ayen Yes, you can have a look.



Counsellor Thank you, Ayen. I see that Deng is quite thin. Deng seems to need immediate attention. You did a great job bringing him here. While porridge can be filling, Deng is still young for this type of food. I will refer you both to our IYCF services for a full assessment, where you can explain your situation further in a calm and quiet place. This will help us understand his nutritional needs better and determine the best course of action.





Aunt Ayen Yes, I just want him to be ok.







Counsellor We're here to do everything we can to help you with that. Let's get you to the IYCF team now for that full assessment. They will guide you through the next steps. Please follow me.

3 Debrief (7 min)

Action:

- **Identify the priority level:**
 - **Ask:**  "Using your coloured cards, what priority level would you assign to Ayen and Deng?"
 - **Answer:** Red – Priority 1
 - **Ask:**  "What information in your SRA form and in the Priority Triage tool led you to choose Priority 1?"
 - **Answer:**
 - Priority Triage Tool: maternal orphan (caregiver is an aunt)
 - SRA: Infant <6 months, not breastfed, feeding porridge only, infant appears thin, acute stress
 - **Explain:**

- These are most Priority 1 red flags. Even if the SRA form wasn't completely filled, you gathered enough information to recognize an urgent need for a full assessment and immediate IYCF-E counselling.
 - Some additional details, like the feeding history before the mother died, may come later in the full assessment, but the SRA alone was enough to correctly classify them as Priority 1.
- **Reflect on using the tools:**
 - **Ask:**  "Did you feel you had enough information to make a triage decision?" "Did you manage to fill the whole form, or only part of it?"
 - **Remind:** The purpose of the SRA is **not** to collect every detail. It's to capture just enough to assign a priority. You noticed the urgent issues quickly, which is exactly the skill we're practicing.
- **Debrief on the counselling skills:**
 - **Accepting feelings and expressing empathy**
 - **Ask:**  "What did the counsellor say that helped build trust at the beginning?" "How did the counsellor acknowledge Ayen's situation?"
 - **Explain:** The counsellor paused to recognize Ayen's loss and stress before asking any technical questions. This builds rapport and safety.
 - **Script example:** "I am so sorry for your loss... sounds like a lot to cope with."
 - **Asking open-ended questions**
 - **Ask:**  "Which question opened the door for Ayen to express what was most urgent for her?"
 - **Explain:** The counsellor used an open question, "How are you managing?", that let Ayen choose what to talk about. As a result, Ayen shared her main concern (feeding porridge and needing formula). If the counsellor had asked a closed or leading question, like "What is this baby eating?", Ayen might have felt judged and shared less.
 - **Reflecting back and accepting without judgment**
 - **Ask:**  "Where did you hear the counsellor reflect back what Ayen said?" "How did she avoid judging the porridge feeding?"
 - **Explain:** The counsellor repeated Ayen's meaning in her own words, checked understanding, and accepted the request for help. She did not correct or criticize Ayen's actions. Reflection helps the caregiver feel understood and keeps the conversation open.
 - **Script example:** "You're doing your best with what you have... You need help finding appropriate food for him. Is that right?"
- **Wrap-up:** "Thank you for your thoughtful observations. You've highlighted the most important points from this triage scenario."

Bridge: "In this demonstration, you saw how using the tools, combined with the three counselling skills, leads to a clear and timely triage decision. In the next step, you'll have a chance to practise these skills yourselves."

STEP 4: Role-Play

 25 min

1 Introduction (5 min)

Action:

- **Explain:** Participants will now practise conducting a **Full Assessment** for Deng and Aunt Ayen, based on the triage result from Step 3.
- **Organize:** Ask participants to form groups of three: **Counsellor, Aunt Ayen, Observer**. Participants stay in the same groups in the next sessions but rotate roles.
- **Clarify:** In this practice, the counsellor uses:
 - The **SRA result** from the demonstration in Step 3
 - The **blank Full Assessment form** (Step 2) to complete during the role-play
Counsellors are **not** expected to create a care plan at this stage.
- **Distribute:** Hand out the role cards to each 'Aunt Ayen' (*prepared in advance – see 'Aunt Ayen' role card from the Annex 2.1*).
- **Explain:** The observer uses the Counselling Skills Checklist to note strengths and areas for improvement.
- **Remind:** Counsellors should practise using the three key skills demonstrated in Step 3:
 - Ask open questions
 - Reflect back on what the mother or caregiver says
 - Accept what a mother or caregiver thinks and feels
- **Allow:** Give groups 2–3 minutes to get ready before beginning their role-plays. Participants can take a minute to review the Counselling Skills Checklist to refresh their memory of the key recommendations discussed during the session.
- **Time:** The role-play lasts around 10 minutes.

! Facilitator Tip

- Encourage counsellors to **follow the caregiver's flow rather than the order of the form**. The Full Assessment can be completed afterwards if needed.
- Remind counsellors to **practise the counselling skills**, not just ask questions mechanically.
- Participants playing **Aunt Ayen should respond naturally** using only the role card, choosing what to share first in response to open questions. **They should not read the card aloud.**


4 Role-play practice (10 min)



Action:

- **Encourage:** Ask groups to start quickly and use their full time.
- **Support:** Move quietly between groups, observe, and answer questions if needed.
- **Manage time:** Give a **5-minute** and **2-minute** warning so participants can pace themselves.
- **End:** Stop the activity on time, even if some groups have not finished the full role-play.

4 Debrief (10 min)

Action:

- **Gather:** Bring everyone back together and thank participants for their role-plays and effort.
- Ask 'Aunt Ayen' participants  :
 - "How did it feel to be in Ayen's place?"
 - "Did anything in the counsellor's approach make it easier or harder to talk?"

- **Ask observers**  :
 - “What strengths did you notice in the counsellor’s approach?”
 - “What areas could be improved?”
- **Ask counsellors**  :
 - “How did it feel to conduct the full assessment?”
 - “What was most challenging? What worked well?”
- **Refer:** Role-play debrief: Aunt Ayen and Deng (Participant Handbook).
- **Add:** Highlight key points if they do not come up. Use the debrief box from the Participant Handbook to emphasize practices that should have been used during the full assessment, e.g., using SRA info to avoid repeating questions, using open questions, reflecting and accepting feelings.

Bridge: “In real situations, caregivers may arrive stressed, tired or unsure, just like Ayen. A natural, respectful assessment helps us understand their needs and build trust. In Step 5, you will reflect individually on what you learned in this session and how you will apply these assessment skills in your counselling practice.”

STEP 5: Self-reflection

 5 min

Action:

- **Invite:** Ask participants to take a quiet moment to reflect and note their answers in the Participant Handbook.
- **Guide:** Read the three questions (also in the participant Handbook) out loud and give participants 2–3 minutes of silence to think/write.
- **Share (optional):** If time allows, invite 1–2 volunteers to share a key takeaway.
- **Close:** Thank participants for their reflections. Emphasize that applying these insights in real-life counselling is where change happens.



Facilitator Tip

Keep the activity short and personal. This is not a group discussion but an opportunity for each participant to consolidate their own learning.

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ANNEX 2.1: Role-play card – Ayen Cut the cards below and give one to each participant acting Ayen.



<p style="text-align: center;">Card: Aunt Ayen</p> <p>Tell the counsellor, if you are asked:</p> <ul style="list-style-type: none"> • Deng was exclusively breastfed before your sister passed away. • You have never been pregnant or breastfed before. • You evacuated with two neighbour women who are your only support. • You give Deng a pacifier occasionally when he cries. • Deng’s urine and stool are normal, with no recent changes in frequency or appearance. • You are feeling tired, stressed and worried about caring for Deng. You sometimes feel overwhelmed and unsure if you are doing the right thing. <p>During the conversation, you can show good interaction with Deng. Hold him, smile at him, make eye contact.</p>	<p style="text-align: center;">Card: Aunt Ayen</p> <p>Tell the counsellor, if you are asked:</p> <ul style="list-style-type: none"> • Deng was exclusively breastfed before your sister passed away. • You have never been pregnant or breastfed before. • You evacuated with two neighbour women who are your only support. • You give Deng a pacifier occasionally when he cries. • Deng’s urine and stool are normal, with no recent changes in frequency or appearance. • You are feeling tired, stressed and worried about caring for Deng. You sometimes feel overwhelmed and unsure if you are doing the right thing. <p>During the conversation, you can show good interaction with Deng. Hold him, smile at him, make eye contact.</p>
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Card: Aunt Ayen

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- You are feeling tired, stressed and worried about caring for Deng. You sometimes feel overwhelmed and unsure if you are doing the right thing.

During the conversation, you can show good interaction with Deng. Hold him, smile at him, make eye contact.

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During the conversation, you can show good interaction with Deng. Hold him, smile at him, make eye contact.

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SESSION 3: ADDRESSING STRESS IN EMERGENCIES



LEARNING OBJECTIVES

1. Describe how the timing, duration and frequency of IYCF-E counselling is adapted to support caregivers who are stressed
2. Explain how stress impacts responsive feeding, and describe strategies to mitigate those impacts
3. Apply self-care strategies to manage your own stress and regulate your emotions as a counsellor



COUNSELLING SKILLS FOCUS*

- Show that you understand how mother or caregiver feels (showing empathy)
- Recognize and praise what the mother or caregiver and baby are doing right
- Use simple language

**Reminder: The full 3A process and counselling skills set remain essential. The focus on these particular three skills is for practice and learning purposes.*



Material and preparation:

Role-play cards – Hana (Step 4): Cut cards for approximately one-third of participants from Annex 3.1 (at the end of this session).



2h

STEP 1: Set the Scene



15 min

1 Why this topic (1 min)

Key Points:

- Stress affects how caregivers **think, make decisions and interact** with their children.
- Stress can **reduce a person's ability to learn, reason and make decisions**.
- IYCF-E counsellors need strategies to **adapt counselling** in stressful contexts.

Bridge: "Stress is everywhere in emergencies. Let's look at common causes."

2 Stress factors in emergencies (3 min)

Action:

- **Show:** *Figure: Sources of stress in emergencies* (Participant Handbook).
- **Explain each category briefly:** Emergencies create multiple, overlapping stressors that affect caregivers in different ways.
 - **Environmental factors** can create insecurity and constant alertness.
 - **Social factors** like isolation or loss of loved ones make stress harder to cope with.

- **Health system disruptions** trigger fear and worry about children’s wellbeing .
- **Financial strain** pushes families into ‘survival mode,’ making care and feeding more difficult.
- **Individual vulnerabilities**, such as disability or increased GBV risk, can magnify the impact of all other stressors.


! Facilitator Tip Keep it high-level. Just summarize; do not read word-for-word.

Bridge: “These stressors shape the experience of every family. Remember, the emergency context creates stress, and that stress can influence how caregivers feed their infants and young children. Let’s see what this looks like in real life.”

3 Scenario discussion (7 min)

Action:

- **Ask:** Volunteer reads *Scenario: Stress Impacts Feeding* (Participant Handbook).
- **Discuss:**

 **How might the stress caregivers experience in these conditions impact IYCF-E practices?**

- **Write:** Capture ideas on flipchart.
- **Add:** Use key points if missing:
 - **Stress can reduce a caregiver’s confidence in breastfeeding**
 - When mothers feel anxious or believe stress reduces milk supply, they may shorten feeds or feed less often.
 - Emotional distress can make it harder to focus on a child’s cues and feed responsively.
 - **Stress may increase reliance on bottles or BMS**
 - Crying babies in crowded spaces can cause anxiety and pressure, leading caregivers to introduce BMS for quick relief.
 - Caregivers under stress may see formula as a ‘safe’ or ‘easier’ option, despite having less access to safe drinking water and cleaning supplies.
 - **Stress combined with disrupted routines leads to feeding challenges**
 - Emotional and physical fatigue from long queues and crowded shelter conditions can result in missed feeding opportunities.
 - High stress can make mothers feel they have ‘no time’ or ‘too many things to manage.’
 - **Stress combined with lack of privacy creates barriers**
 - Mothers who feel self-conscious or judged in shared spaces may avoid breastfeeding or shorten feeds.
 - **Stress can make decision-making harder**
 - When anxious and tired, caregivers may follow incorrect advice or adopt unsafe practices (e.g., improper BMS prep).

Bridge: “Now let’s think about families who face even more challenges.”

4 Disability focus (3 min)

Action:

- **Ask:**

 **What additional stress might caregivers with disabilities experience?**

- **Summarize:**
 - **Overcrowding and mobility barriers:** Crowded spaces make movement difficult and exhausting for caregivers with physical and/or sensory disabilities.
 - **Privacy challenges:** Lack of private spaces for breastfeeding can be especially stressful and undermine a person’s dignity, particularly for women facing cultural stigma.
 - **Greater physical strain:** Completing daily tasks or moving through the camp may require extra energy. Caregivers of children with disabilities may also have to carry or assist their child more frequently.
 - **Feeding and food access difficulties:** For infants who relied on BMS before the emergency, shortages and unsafe supplies and drinking water add more anxiety. Children with disabilities may require specific foods or have sensory sensitivities, making emergency rations or crowded feeding centres stressful.

Bridge: *“These challenges are on top of the stress everyone else faces. Being aware helps us provide inclusive support.”*

5 Learning objectives (1 min)

Action:

- **Say:** *“To guide our session today, let’s review the learning objectives together.”*
- **Read learning objectives:**
 - Describe how the timing, duration and frequency of IYCF-E counselling is adapted to support caregivers who are stressed
 - Explain how stress impacts responsive feeding and describe strategies to mitigate those impacts
 - Apply self-care strategies to manage your own stress and regulate your emotions as a counsellor
- **Highlight counselling skills focus:**
 - In this session, for learning and practice purposes, we are focusing on the three key skills:
 - Show that you understand how the mother/caregiver feels (empathy)
 - Recognize and praise what a mother or caregiver and baby are doing right
 - Use simple language

Bridge: *“Now that we’ve explored how stress affects caregivers, and how it shapes feeding practices, let’s build on this understanding.”*

STEP 2: Strengthen key knowledge, concepts and skills

 55 min



LEARNING OBJECTIVE 1:

Describe how the timing, duration and frequency of IYCF-E counselling is adapted to support caregivers who are stressed

Time: 15 min

1 Introduction (1 min)

Action:

- **Explain:** *“In emergencies, usual counselling schedules often break down. Services are disrupted, families may wait long hours, and caregivers are under stress. Three things about counselling need to be adapted:*
 - When you provide it (timing)

- How long you spend (duration)
- How often you meet (frequency)
- **Show:** *Table: Adapting counselling in emergencies – Timing, duration, frequency* (Participant Handbook).


Bridge: “With this first objective, we will explore how to adapt these three aspects so that counselling still supports caregivers, even through very short sessions or in stressful situations like overcrowding, loss or uncertainty.”


2 When: Timing challenges and adaptations (3 min)

Key Points: Why timing matters

- Disrupted services mean counselling may happen **too late** (e.g., no prenatal counselling) or **too early** (e.g., complementary feeding advice during newborn care).
- When this happens, caregivers can feel **overwhelmed** and lose **confidence in themselves** (“I don’t know how to do this”) or in the **system** (“Why didn’t my midwife tell me this before?”).
- These feelings often lead to **self-blame, anger or shame**, which can cause hopelessness and inaction.


Action:

- **Ask:**  “Why might it be harmful to give advice that a caregiver can’t act on yet?”
- **Sample answers:** ‘It increases stress,’ ‘it might confuse them,’ ‘they might feel like failures or give up on all advice.’
- **Wrap-up:** “Exactly, advice that can’t be used now often leads to frustration or hopelessness. So, always prioritize what they can act on today.”

 **Facilitator Tip** Keep the discussion very brief (1–2 quick answers). Do not turn it into a full discussion.

Key Points: Adaptations

- **Acknowledge feelings:** Validate frustration or shame caused by missed information or services.
 - Example: “It’s understandable to feel this way. The situation has been difficult for everyone.”
- **Address self-blame:** Shift the focus to what caregivers can do now:
 - Example: “The past was beyond your control, but here’s what you can do today for your baby.”
- **Prioritize the present:** Focus on **immediate needs** rather than future or past gaps.
- **Avoid overload:** Do not give advice that the caregiver cannot act on right now.
- **Highlight strengths:** Reinforce what the caregiver is already doing well to build confidence.


 **Facilitator Tip** Keep it high-level. Do not read word for word; just summarize.

3 How long: Counselling duration challenges and adaptations (3 min)

Key Points: Why duration matters

- Caregivers under stress may be facing additional feeding challenges and need **more time to express concerns** but may have a **reduced attention span** for new information.
- Counsellors face **time pressure** and **high caseloads**, making balance difficult.
- Sessions that are too short **miss context**. Those that are too long **overwhelm caregivers**.

Action:

- **Ask:**  “If you only had 3 minutes with a caregiver, what would you do first?”
- **Sample answers:** ‘Listen to their main concern,’ ‘Give one key message,’ ‘Show one thing, like positioning.’
- **Wrap-up:** “Yes, keep it simple, set one goal, and leave them feeling confident they can do it.”

Key Points: Adaptations


- **Start with emotional connection:** Even in a short interaction, begin with a supportive tone and welcoming body language.
- **Set one clear goal:** Agree on the main issue to address and a simple step to take.
- **Break information into smaller steps:** Give one point at a time and repeat key messages at the end to help with memory under stress.
- **Plan next steps:** End with a realistic plan, even if it's just, "We'll talk again at the distribution tomorrow."
- **Positive closure:** Always leave caregivers feeling supported and hopeful.

4 How often: frequency challenges and adaptations (3 min)

Key Points: Why frequency matters

- Six recommended contacts may not be feasible in emergencies.
- High stress reduces the ability to **remember and apply information**, so **repetition of information during each session is critical**.

Action:

- **Ask:**  "What are some places or moments where you could give quick advice in an emergency?"
- **Sample answers:** 'At distributions,' 'While waiting in line,' 'During health visits,' 'Home visits if possible.'
- **Wrap-up:** "Every interaction counts. One message, many times, many places."

Key Points: Adaptations

- **Seize opportunities:** Provide counselling wherever possible: at food distribution points, in health post queues, etc.
- **Short and focused:** Give **1–2 key messages per contact** instead of trying to cover everything.
- **Repeat and reinforce:** Use multiple brief interactions to build understanding over time.

5 Why stress matters for timing, frequency and duration (2 min)

Key Points:

- **Stress impacts thinking:** It reduces memory, decision-making and problem-solving capacity.
- **Keep it simple and repeat:** Short, focused messages that are repeated across contacts are more effective than one long session.
- **Use multiple messaging formats:** Combine verbal, written and visual communication to support recall under stress.
- **When time is extremely limited** (e.g., in a transit point):
 - Give simple, visual handouts with key points.
 - Focus on one or two immediate actions.
- **For caregivers with disabilities:**
 - Provide adapted formats (large print, pictorial cards, braille) and allow extra time if possible.
 - Involve a trusted support person who knows their needs.

6 Key takeaways and questions (3 min)

Action:

- **Refer:** *Key learning points – Objective 1* (Participant Handbook).



Facilitator Tip

Point participants to the Key learning points in their Handbook. If needed, quickly summarize from the Handbook to reinforce.

- Ask whether participants have any questions before moving on.



Facilitator Tip

If you have an extra minute or want more discussion, ask:
 “Which of these adaptations do you think will be most challenging in your setting?”

Bridge: “We’ve just looked at adapting when, how long, and how often we provide counselling. Another key challenge is how caregiver stress affects feeding itself. In the next session, we’ll look at how stress impacts responsive feeding and strategies to support both caregivers and infants.”



LEARNING OBJECTIVE 2:

Explain how stress impacts responsive feeding and describe strategies to mitigate those impacts

Time: 30 min

1 Activity: Common beliefs and practices: TRUE or FALSE (8 min)

Action:

- **Introduce:** “Very often, long-standing beliefs and practices around infant and young child feeding are passed down through generations. These beliefs may sometimes differ from current recommended guidelines. It’s important to approach these cultural practices with respect and understanding, while providing evidence-based information that supports the health and wellbeing of both mothers and children.”

Key Points: Why does this matter?

- Beliefs often **shape caregiver confidence and behaviour**, especially in stressful/emergency settings.
- These beliefs can **increase anxiety** and lead to changes in feeding behaviour (e.g., stopping breastfeeding, introducing foods too early).
- Our role: **affirm the caregiver’s feelings**, acknowledge the context and gently provide accurate information.



TRUE or FALSE activity: Common beliefs and practices

Instructions:

- **Refer:** Activity: Common beliefs and practices (Participant Handbook).
- **Read:** Each statement aloud to the group.
- **Say:** “Stand if you think it is TRUE. Sit if you think it is FALSE.”
- **Explain:** Share the correct answer using the facilitator notes below.

TRUE or FALSE activity: Common beliefs and practices – Facilitator notes

Milk production can continue even in very stressful situations.

TRUE

- **Fact:** Stress does **not** stop milk production. Milk remains nutritious even when the mother is worried or upset.
- **Additional details:**
 - Stress may affect let-down (temporarily) but not overall milk supply.
 - Skilled support can help mothers manage stress and maintain feeding.
 - Reassuring mothers that their milk is sufficient is important.

Maternal adrenaline inhibits the let-down reflex, slowing milk flow at the beginning of a feed.

TRUE

- **Fact:** Stress hormones (adrenaline) may make milk flow a little slower at the start of a feed, but it does **not** reduce the amount of milk.
- **Additional details:**
 - Adrenaline can interfere with oxytocin (which triggers milk release), temporarily slowing milk ejection (“stressed breastfeeding cycle”).
 - Mothers may misinterpret slower flow as low milk supply and try unnecessary interventions (BMS, early weaning).
 - A counsellor can reassure the mother that slower milk flow or fussiness is normal and guide effective feeding techniques, even when she feels stressed.

During emergencies, infant behaviour, such as crying or acting unsettled, does not necessarily mean the baby is not getting enough milk.

TRUE

- **Fact:** Crying or fussing is often a normal response to stress, change or discomfort – not just hunger. These behaviours are **not reliable** signs of inadequate milk intake.
- **Additional details:**
 - Infants also respond to environmental stressors (noise, separation, emergency conditions).
 - Frequent crying does **not** reliably indicate insufficient milk intake.

Breastfeeding while stressed or sad can harm the infant, physically or emotionally.

FALSE


- **Fact:** Breast milk remains nutritious even if the mother feels stressed, sad, or has experienced trauma. Breastfeeding can calm both mother and baby.
- **Additional details:**
 - Breastfeeding itself supports emotional regulation for both mother and child.
 - Reassure mothers that feeding while stressed is **safe and beneficial**.
 - Avoid language that might reinforce guilt or fear.

Fathers and other family members have little influence on feeding practices.

FALSE

- **Fact:** Fathers and family members commonly influence a mother’s beliefs and practices around feeding. While they are exposed to many of the same beliefs as mothers, they may have fewer opportunities to correct their understanding.
- **Additional details:**
 - Fathers and other family members may hold the same beliefs, affecting maternal confidence.
 - Mothers may feel pressured to stop breastfeeding or introduce BMS.
 - Counsellors can engage family members to provide support and correct misconceptions.

Debrief:


- **Ask:**  “How might these beliefs affect a mother’s confidence and feeding behaviour?”
- **Sample answers:**
 - **Increase stress and anxiety:** Mothers may feel guilty, incompetent, or worried that their milk is insufficient.
 - **Change feeding behaviour:** Mothers or caregivers might shorten or skip feeds, supplement unnecessarily with formula, introduce complementary foods too early, or misinterpret normal infant cues.
 - **Affect mother-child bonding:** Less responsive feeding and reduced skin-to-skin time.

- **Influence from family:** Conflicting advice can worsen stress through increased pressure and confusion.

Transition:

- **Emphasize that these beliefs can indirectly affect milk supply through affecting feeding-related behaviours.** This can be addressed with respectful counselling.
- Understanding this helps the counsellor approach a mother **with empathy and practical guidance.**

Action:

- **Ask:**  "How can we, as counsellors, approach a mother or caregiver who holds these beliefs?"
- **Refer:** Job Aid 3.1: Addressing common beliefs and practices in emergencies (Participant Handbook) for examples and sample sentences.

Key Points:

- Acknowledge and respect the caregiver's feelings.
- Provide accurate information gently.

! Facilitator Tip


Keep time on this activity, as it is easy to veer into a lengthy discussion about common beliefs. Use a flip chart as a "parking lot" to capture questions or comments that are outside the scope of this session. If time allows, you can return to them later.



Bridge: "We've just seen how stress, beliefs and practices can influence what mothers believe about breastfeeding. Now let's look at another important part of feeding and care: responsive feeding. This is key to both nutrition and emotional wellbeing."

2 Responsive feeding (2 min)

Action:

- **Ask:** Volunteer reads *Definition: Responsive care* (Participant Handbook).
- **Explain:** "Responsive feeding means watching for your baby's signs of hunger and fullness and responding with warmth and care. It's about feeding when the baby needs it, not on a strict schedule; and offering not just food but comfort, such as soothing or holding the baby."
- **Ask:**  "When caregivers respond warmly and promptly to their child's needs, what positive effects do you see for the child?"
- **Sample answers:** 'Feeling safe,' 'mother-baby bonding,' 'improved sleep patterns,' 'better attainment of developmental milestones,' 'reduced stress and improved ability to self-soothe, leading to improved emotional regulation in the future.'
- **Refer:** Key points (Participant Handbook).

Bridge: "When caregivers respond warmly and promptly, babies feel safe and calm. This reduces stress for both the baby and the mother. But in an emergency, stress can make it harder for caregivers to respond in this way. We'll now look at how stress affects responsive feeding and what that means for our counselling work."

3 How stress impacts responsive feeding (5 min)

Stress and missed cues in responsive feeding

Action:

- **Introduce:** *“When a caregiver is stressed, their attention is divided. They may be worried about safety, food, shelter or their other children. This can make it harder for them to notice their child’s early hunger cues or to stay calm during feeding. The child may also feel stressed, which can lead to more crying or fussiness. This combination can reduce responsiveness during feeding.”*



Mini-Exercise: The mental load

Instructions:

- **Read:** *“Think about being at work with an urgent deadline. You’re trying to finish quickly, but tasks keep piling up, and your phone keeps ringing.”*
- **Pause:** Give 10 seconds for participants to imagine the situation.
- **Ask:** *“While focused on this, if someone raised their hand nearby, would you notice immediately? Probably not. When your mind is busy, small signals are easy to miss.”*
- **Explain:** *“This kind of thing is what happens for a mother under stress in an emergency setting. Her mental load is heavy, so early cues from her baby may be missed. Feedings happen later, when the baby is already upset. This makes the experience stressful for both.”*
- **Show:** *Diagram: How missed cues affect breastfeeding over time (Participant Handbook).*
- **Explain:** ***Why does milk supply decrease?** Breast milk production works on a supply-and-demand system: the less milk is removed from the breast, the less is made. Stress does not directly reduce milk, but missed cues and disrupted feeding behaviour can gradually impact supply over time.*



Additional ways stress impacts feeding behaviours:

- **Refer:** *Section: Additional ways stress impacts feeding behaviours (Participant Handbook).*
- Stress affects behaviours of both caregivers and their children.
- These are normal reactions in emergencies. All these behaviours can reduce effective milk removal and responsive breastfeeding. They also affect the timely introduction of complementary foods, which can gradually impact nutrition.
- What matters is supporting behaviours that protect positive feeding opportunities.

Key Points:

- Stress does not directly reduce milk supply but affects responsive feeding behaviours and the introduction of timely, appropriate complementary feeding.
- Supporting caregiver behaviours can maintain milk supply, ensure appropriate complementary feeding practices are in place, and protect infant and young child nutrition.

Bridge: *“Stress can change how mothers and caregivers behave. These behaviours, which can affect feeding, can be supported and improved. Let’s now explore how to do this.”*

4 Strategies to mitigate impact (12 min)



Small group discussion: Strategies to mitigate the impact of stress

Instructions:

- **Introduce the activity:** *“We’ve seen how stress can make responsive feeding harder. But there are things we can do to support mothers and caregivers. In groups, you’ll brainstorm practical strategies that you can apply during counselling sessions.”*
- **Divide participants into three groups:**
 - Group 1 → Support caregiver emotional state
 - Group 2 → Strengthen responsive feeding
 - Group 3 → Engage family and community
- **Refer:** *Activity: Strategies to support mothers under stress* (Participant Handbook).
- **Explain the task:** *“You have 5 minutes to discuss and write down as many ideas as possible. Then we’ll share highlights.”*
- **Monitor and support:** Walk around, encourage quieter participants, and prompt with examples if needed.

Debrief:

- **Ask** each group for 2–3 key strategies.
- **Summarize and reinforce key points.** If any important strategies were not mentioned, refer to the facilitator notes below to ensure they are covered.
- **Explain:** Participants are encouraged to use the counselling cards during sessions to support caregivers. For example:
 - **Card 28 – Teach your child to eat with patience and love:** supports responsive feeding.
 - **Card 33 – Take care of yourself to manage stress and fatigue:** encourages caregiver wellbeing.
- **Refer:** *Job Aid 3.2: Practical strategies to support mothers under stress* and *Job Aid 3.3: Counselling cards* (Participant Handbook).

Wrap-up message

- *“Stress can make feeding harder, but with the right support – emotional care, practical tips for feeding responsiveness, and family support – mothers can continue to breastfeed successfully.”*



Small group discussion: Strategies to mitigate the impact of stress – Facilitator notes

Group 1 – Support a caregiver’s emotional state: *“What practical things can you do to help a mother or caregiver feel calmer, more supported, and less alone in this situation?”*

Possible answers:

- Sit in a calm, safe space with the mother.
- Listen without judgment and validate her feelings.
- Normalize stress response: *“It’s normal to feel this way. Your milk is still good.”*
- Encourage skin-to-skin for calming both mother and baby.
- Encourage calming techniques before feeding: deep breathing, grounding exercises, supportive positioning.

- Reassure her that stress does not stop milk production.
- Encourage care-seeking when needed: *“If these feelings do not go away, you can visit the health facility. Depression and anxiety are common after birth and can be treated.”*
- Connect her with mother-to-mother or peer-support groups.

Group 2 – Strengthen responsive feeding: *“What tips can you give a mother to help her respond to her young child’s feeding cues, even when life is stressful?”*

Possible answers:

- Explain early hunger cues (e.g., rooting, hand-to-mouth movements) vs late cues (crying).
- Show her how to watch and listen for cues while holding her baby close.
- Minimize distractions: Find a quiet corner or use a privacy screen if possible.
- Encourage skin-to-skin to promote bonding and relaxation.
- Support comfortable positioning to reduce stress for both mother and baby.
- Reassure her that feeding frequently, even for comfort, is normal during stressful times.
- Offer tips to keep the baby close (baby-wearing, safe room-sharing) to make cue recognition easier.

Group 3 – Engage family and community: *“What can you do to involve family or community members so they support the mother and do not recommend harmful practices or pressure her with myths?”*

Possible answers:

- Invite family to counselling sessions if possible.
- Address common myths in a respectful way.
- Encourage family members to reduce pressure and give emotional support.
- Suggest practical help: share household chores, prepare food and/or care for older children.
- Promote positive messages within the family: *“Breastfeeding is still best, even when stressed.”*
- Involve fathers in creating calm feeding spaces and supporting skin-to-skin.
- Encourage the mother: When feeling exhausted or overwhelmed, reach out for help from partner, family or friends.
- Suggest sharing experiences with a trusted confident, both successes and challenges.
- Where possible, link to community mother-to-mother or peer-support groups.

5 Key takeaways and questions (3 min)

Action:

- **Refer:** Key learning points – Objective 2 (Participant Handbook).
- **Ask** whether participants have any questions before moving on.



Facilitator Tip

If you have an extra minute or want more discussion, ask:

“Which of these strategies to support mothers under stress do you think will be most challenging to implement in your setting?”

Bridge: *“We’ve explored how stress affects mothers and infants and how responsive feeding can be supported even in challenging situations. Now, think about this: as frontline workers, your own stress and mental load can influence the effectiveness of the support you offer to mothers and young children. Just as stress can change a mother’s responsiveness, your stress can affect your listening, patience and counselling. In the next session, we’ll focus on strategies for self-care and stress regulation so you can remain calm, present and effective while supporting others.”*



LEARNING OBJECTIVE 3:

Apply self-care strategies to manage your own stress and regulate your emotions as a counsellor

Time: 10 min

1 The concept of stress regulation (2 min)

Action:


- **Introduce:** *“In this session, we will explore how stress affects us and learn practical strategies to regulate our own stress, so we can stay calm, focused and effective when supporting caregivers.”*
- **Explain:**
 - “Regulation means managing your stress response so you can return to a calm, balanced state. This is called being regulated.
 - We all have a **nervous system** that helps us respond to stress. When we are calm and balanced, we can think clearly, make decisions and connect well with others.
 - When stress becomes too much, our ability to think clearly becomes compromised. We often take on different behavioural reactions:
 - **Fight or Flight response:** Feeling impatient, restless or frustrated.
 - **Freeze response:** Feeling stuck, unsure or disconnected.
 - These reactions are normal. But if we stay dysregulated too long, it affects our **health**, our **relationships** and our **counselling work**.”

Key Points: Link to counselling

- **Refer:** First column of the *Table: Effects of regulation and dysregulation on counselling* (Participant Handbook).
- Being regulated matters for effective counselling and wellbeing.
- As IYCF-E counsellors, being regulated allows you to:
 - **Build** trust and rapport with caregivers.
 - **Listen** actively and **make** good decisions.
 - **Support** mothers in feeling calm. Because calm is contagious!

2 Effect of dysregulation on counselling (2 min)

Action:

- **Ask:**  *“When you are stressed or anxious, how does it impact the way you engage with the families that you are supporting?”*
- **Collect:** 2–3 short answers.

Key Points: Link to counselling

- **Refer:** Second column of the *Table: Effects of regulation and dysregulation on counselling* (Participant Handbook).
- During IYCF counselling, dysregulation might look like:
 - Impatience when a mother doesn’t follow your advice.
 - Avoiding a difficult conversation.
 - Feeling stuck when a mother has many problems.
- Learning to regulate is essential for providing effective IYCF-E counselling.

3 Self-regulation vs co-regulation (1 min)

Action:

- **Say:**
 - “When we are calm, caregivers feel it. Our **emotional state influences theirs**. This is called **co-regulation**.”
 - “But here’s the key: **you can’t calm others if you are not calm yourself**. That’s why we focus on **self-regulation** first.”
- **Refer:** *Table: Self-regulation vs co-regulation* (Participant Handbook).

Key Points:

- **Self-regulation** = calming and grounding yourself to stay focused and resilient.
- **Co-regulation** = using your calm presence to help others (caregivers/babies) feel calm.
- Co-regulation **can be taught** to mothers and caregivers to use with their children.
- We focus on **self-regulation** first, then build towards **co-regulation**.

4 Regulation techniques (2 min)

Action:

- **Explain:** “Some techniques help calm us when we feel tense (**soothing**). Others give us energy when we feel tired (**activating**). We’ll practise one example now, but there are many more in your Handbook in Annex 1.”
 - **Soothing** → Slow breathing, grounding, self-hold
 - **Activating** → Stomping feet, shaking, gentle movement
- **Refer:** *Two types of regulation practices and Different styles of practices* (Participant Handbook)



Practice: Breathing (short version)

Instructions:

- **Introduce:** “Let’s try one technique together.”
- **Guide:**
 - “Place one hand on your chest.
 - Inhale for 1, 2, 3, 4...
 - Hold for 1, 2...
 - Exhale slowly for 1, 2, 3, 4, 5, 6.
 - Let’s repeat this three times together.”
- **Ask:** “How do you feel now compared to before?”
- **Refer:** *Annex 1: Emotional regulation practices* (Participant Handbook).


! Facilitator Tip

If time allowed, this practice could be extended. This is just one example. There are many others that participants can try during the training and afterwards.



5 Integration regulation techniques in daily work (2 min)

Action:

- **Ask:**  "When could you use this in your day as a counsellor?"
- **Collect:** 2–3 short answers.
- **Summarize:**
 4. **Before a counselling session:** Take a few breaths, notice your state, set aside distractions.
 5. **During a session:** Model calmness, speak slowly, listen fully. Your calm presence helps regulate the caregiver, which in turn helps their baby (co-regulation).
 6. **After a difficult session:** Reset before moving to the next caregiver.
- **Conclude:** "These techniques take just a minute or two, but they make a big difference for you, for the caregiver, and for the infant or young child."

6 Key takeaways and questions (1 min)

Action:

- **Refer:** Key learning points – Objective 3 (Participant Handbook).
- **Ask** whether participants have any questions before moving on.
- **Wrap up:** "We will continue to practise these techniques throughout the training – before breaks, after intense sessions and during role-plays."



Facilitator Tip

If you have an extra minute or want more discussion, ask, "Which self-regulation or co-regulation practice(s) do you think will be easiest to use in your daily counselling work?"

Bridge: "We are now moving into a demonstration where you will see how to apply what we learned in Step 2."

STEP 3: Demonstrate

 15 min

1 Introduction (2 min)


Action:

- **Introduce:** "In this demonstration, we will continue from the context we discussed in Step 1 and apply the knowledge and skills from Step 2, with a focus on the following three counselling skills:
 - Show that you understand how the mother/caregiver feels (empathy)
 - Recognize and praise what a mother or caregiver and baby are doing right
 - Use simple language
- **Refer:** Case study: Hana and Mariam (Participant Handbook).
- **Summarize** the case:
 - Setting: Mother–Baby Tent in the transit camp
 - Counsellor has been referred to the mother, Hana
 - Baby Mariam is 4 months old and has been exclusively breastfed until now
 - She is considering introducing breast milk substitute (BMS)

2 Script (10 min)

Action:

- **Act out** the script below as a team of three people.

 **Facilitator Tip**

- **Act, don't read:** You are encouraged to perform the counsellor or mother naturally rather than reading the script word-for-word. Use the dialogue as a guide.
- **Use prompts sparingly:** You may not have time to ask all prompts during the demo. Pauses should be realistic but brief.
- **Set the tone:** Model calm, patient and supportive behaviour throughout. This helps participants see how emotional safety is created.



Counsellor Hello Hana, my name is [Counsellor]. Welcome. Please come sit down, and I can bring you a cup of tea if you'd like. Let's take a moment to breathe. It's busy out there.



Hana Oh yes, thank you.



Counsellor You're welcome! [pause]



Facilitator

Prompt:

- What did you notice the counsellor did at the very beginning?
- How do you think Hana might feel after this kind of welcome?

Explanation:

The counsellor creates emotional safety by greeting Hana warmly, offering comfort (tea, the bathroom, etc.) and pausing calmly. These small gestures help reduce stress and show care before discussing feeding.



Counsellor I understand from my colleague that you're thinking about using formula for Mariam. Can you tell me more about what's happening?



Hana Breastfeeding has been fine until now, but it's been so hard. When we were walking, our whole group had to stop every time I fed her, so I tried to delay feeding her until she was really crying or my breasts were very full and painful. Here, I've been stressed. I spend my day in queues for every little thing. There are people everywhere, and I can't find a quiet place to sit – even at night. I didn't plan to use formula, but I feel like my milk isn't enough. Mariam acts like she is starving.



Counsellor What a difficult few weeks you've had! I hear you saying you're exhausted, with so many things to do and so little time to rest. These feelings are normal. This is a very stressful situation.



Hana Yes, I feel like I'm never calm, and Mariam cries so much.



Counsellor That must feel overwhelming. Sometimes babies cry more when things around them are noisy or stressful. Crying doesn't always mean they're hungry.



Hana Really? I thought it was because I don't have enough milk.



Counsellor This is a very common concern for mothers in this situation. But your milk is still good. Stress does not stop your body from making milk, even with everything you are going through. Mariam is healthy. Look how she is watching you and listening to your voice right now.



Facilitator **Prompt:**

- What words or tone did the counsellor use to show empathy?
- How did the counsellor respond when Hana worried her milk wasn't enough?

Explanation:
The counsellor validates Hana's stress by naming her feelings and linking them to the difficult situation. This shows Hana that she is heard and understood. Then, the counsellor debunks the myth that stress stops milk production, while praising Hana's mothering and highlighting Mariam's healthy behaviour. This combination reassures Hana and builds her confidence.



Hana But I want things to go back to how they were before. She used to feed every few hours and only once in the night. Now she wants to feed all the time, and I don't understand it.



Counsellor This is hard. The changes you're describing are very common when life changes as quickly as it has for you and your family. At home, you may have had more time and space to feed Mariam whenever she wanted. Here in the camp, with so many demands and so little privacy, it makes sense that feeding has felt more difficult.

Your milk is still nutritious and enough for Mariam. What makes the difference is how quickly you're able to feed her when she's hungry. If feeds are delayed, she may cry more, take less milk, and seem unsettled. But if you notice her signs of hunger early and put her to the breast right away, feeds go more smoothly, and your body keeps making the milk she needs.



Hana I usually wait until she cries. Isn't that the sign she's hungry?



Counsellor Crying is usually the last sign of hunger. By then, she's already very hungry and harder to calm. Before that, babies give smaller signals. For example, Mariam might root around looking for your breast, move her hands to her mouth, or fuss a little. Watching for these early signs helps you feed her before she gets upset, so feeds are calmer and more effective.



Hana Oh, I didn't know that. So, if I catch it before she cries, she'll feed better?



Counsellor Exactly. The sooner you respond, the calmer Mariam will be and the easier the feed. The more you watch her eyes, mouth, and movements, the easier it gets to understand what she needs. Try to keep her close so you can notice those little signals as they are happening. And remember, it's important to put her to the breast often, even if it feels like many times in a day.



Facilitator **Prompt:**

- What advice did the counsellor give about when to feed Mariam?
- What signs of hunger were mentioned before crying?

Explanation:
The counsellor explains that crying is a late hunger sign and shows how to look for earlier signs that make feeding easier and calmer. She keeps her language simple; avoids jargon; and gives

clear, practical examples. By encouraging Hana to keep Mariam close and feed her often, the counsellor supports her confidence and helps protect her milk supply.



Hana

Well, that makes sense! But what am I supposed to do? There's nowhere to feed her that is private or comfortable. And the tent is open to everyone. So, I don't feel comfortable feeding her, especially at night.



Counsellor

I understand that your privacy and safety is important. I have noticed that some families have made screens out of sheets that can be used to create a private space. Would that be possible to do?



Hana

It might. I can try. At least it would be worth trying to see if she cries less.



Counsellor

That sounds like a good step. So, for now, you'll try to make a little private space with a sheet and keep Mariam close so you can notice her signals early. I'll check in with you tomorrow to see how it goes and what else might help. You're doing a great job caring for Mariam in such a difficult situation.



Facilitator

Prompt:

- How did the counsellor respond when Hana raised concerns about privacy?
- What steps did they agree on together?


Explanation:

The counsellor showed empathy for Hana's concern about privacy and offered a practical suggestion, then waited for Hana's feedback. Mothers who are stressed may take longer to get into problem-solving mode. The counsellor also summarizes the plan, praises Hana, and sets a follow-up for the next day. This leaves Hana supported and gives her clear next steps.

3

Debrief (3 min)

Action:

- **Ask:**  "What did you notice that the counsellor did that helped Hana feel supported?"

Bridge: "Thank you for observing the demonstration. Now it's your turn to put these skills into practice through a role-play."

STEP 4: Role-Play

 30 min

1 Regulation technique (5 min)



Practice: 5-4-3-2-1 method

Instructions:

- **Introduce:** *“Before we begin, let’s try another regulation technique. Counsellors can use this kind of practice before or between sessions to reset. It’s called the 5-4-3-2-1 method.”*
- **Guide:** Ask participants to notice: 5 things you can see, 4 things you can feel, 3 things you can hear, 2 things you can smell, and 1 thing you can taste (or imagine tasting).
- **Refer:** Activity: 5-4-3-2-1 method (Participant Handbook).



2 Introduction (5 min)

Action:

- **Explain:** The role-play is a continuation of Hana’s story from Step 3. She returns the next day.
- **Organize:** Ask participants to form groups of three: **Counsellor, Hana, Observer.**
- **Distribute:** Hand out the role cards from Annex 3.1 to each ‘Hana.’
- **Option:** Invite counsellors to choose a regulation technique from Annex 1, if they would like to use one in the role-play.
- **Explain:** The observer uses the Counselling Skills Checklist to note strengths and areas for improvement.
- **Remind:** Counsellors should practise using the three key skills demonstrated in Step 3:
 - Demonstrate empathy by showing that you understand how the mother/caregiver feels
 - Recognize and praise what a mother or caregiver and young child are doing right
 - Use simple language
- **Allow:** Give groups 2–3 minutes to get ready before beginning their role-plays. Participants can review the Counselling Skills Checklist to refresh their memory of the key recommendations discussed during the session.
- **Time:** The role-play lasts about 10 minutes.




3 Role-play practice (10 min)


Action:

- **Encourage:** Ask groups to start quickly and use their full time.
- **Support:** Move quietly between groups, observe, and answer questions if needed.
- **Manage time:** Give a **5-minute** and **2-minute** warning so participants can pace themselves.
- **End:** Stop the activity on time, even if some groups have not finished the full role-play.

4 Debrief (10 min)

Action:

- **Gather:** Bring everyone back together and thank participants for their role-plays and effort.
- **Ask the observers**  :
 - “What strengths did you notice in the counsellor’s approach?”
 - “What areas could be improved?”
- **Ask the counsellors**  :
 - “How did it feel to be in the counsellor role?”
 - “What was most challenging? What worked well?”
- **Ask those who played ‘Hana’**  :
 - “How did it feel to be in Hana’s place?”
 - “What kind of responses were most supportive?”
- **Refer:** Role-play debrief: Hana (Participant Handbook).
- **Add:** Highlight key points if they do not come up. Use the debrief box from the Participant Handbook to add practical advice that should have been applied during the counselling session (acknowledging progress, empathy, addressing the stress/milk myth, family support, co-regulation, clear next steps).

 **Facilitator Tip**

Manage time: Keep the discussion practical and focused. Aim to complete the debrief within 10 minutes. Participants can continue reading the box ‘Role-play debrief: Hana’ afterwards in the Participant Handbook for further reflection.


Bridge: “These skills take time and practice. Each conversation is an opportunity to improve. In Step 5, we’ll reflect individually on your own counselling experiences and think about how to apply these lessons in your daily work.”

STEP 5: Self-reflection

 5 min

Action:

- **Invite:** Ask participants to take a quiet moment to reflect and note their answers in the Participant Handbook.
- **Guide:** Read the three questions aloud and give participants 2–3 minutes of silence to think/write.
- **Share (optional):** If time allows, invite 1–2 volunteers to share a key takeaway.
- **Close:** Thank participants for their reflections and emphasize that applying these insights in real-life counselling is where change happens.

 **Facilitator Tip**

Keep the activity short and personal. This is not a group discussion but an opportunity for each participant to consolidate their own learning.

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ANNEX 3.1: Role-play card – Hana Cut the cards below and provide one to each participant acting Hana.



<p style="text-align: center;">Card: Hana</p> <p>Progress from yesterday:</p> <ul style="list-style-type: none"> • The privacy sheet worked well; your husband helped set it up, giving more privacy for feeds. • You’ve been watching Mariam more and putting her to the breast more often. <p>BUT you are still thinking about using formula:</p> <ul style="list-style-type: none"> • Your husband heard other men say Mariam keeps them up at night; he suggests formula. • Milk takes a long time to flow at the start of feeds, and Mariam is fussy and seems frustrated during this period. • You feel this fussiness is caused by stress. Each time you feed, you feel stressed at the start of the feed because you worry Mariam will be fussy or not get enough milk. It feels like a cycle. 	<p style="text-align: center;">Card: Hana</p> <p>Progress from yesterday:</p> <ul style="list-style-type: none"> • The privacy sheet worked well; your husband helped set it up, giving more privacy for feeds. • You’ve been watching Mariam more and putting her to the breast more often. <p>BUT you are still thinking about using formula:</p> <ul style="list-style-type: none"> • Your husband heard other men say Mariam keeps them up at night; he suggests formula. • Milk takes a long time to flow at the start of feeds, and Mariam is fussy and seems frustrated during this period. • You feel this fussiness is caused by stress. Each time you feed, you feel stressed at the start of the feed because you worry Mariam will be fussy or not get enough milk. It feels like a cycle.
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SESSION 4: SUPPORTING CAREGIVERS AFFECTED BY GENDER-BASED VIOLENCE



LEARNING OBJECTIVES

1. Apply a survivor-centred approach while receiving a gender-based violence (GBV) disclosure
2. Identify safe and appropriate ways to support recommended IYCF-E practices for GBV survivors
3. Practise self-care as a counsellor working in an emergency



COUNSELLING SKILLS FOCUS*

- Use helpful non-verbal communication
- Accept what a mother or caregiver thinks and feels
- Avoid using words that sound judgmental

**Reminder: The full 3A process and counselling skill set remain essential. The focus on these particular three skills is for practice and learning purposes.*



Material and preparation:

- **GBV Pocket Guide:** Download and read the guide at <https://gbvguidelines.org/en/pocketguide/>.
- **Video – Survivor-Centred Approach (UNHCR, 4:38):** If you are not familiar with the survivor-centred approach, watch this short video as preparation. It illustrates key principles of a survivor-centred response. <https://www.youtube.com/watch?v=Fk3pQyeobZE&t=51s>
- **Activity – Decode Your Attitudes (Step 2, Objective 1):** Prepare sticky notes and a flipchart, as described in Step 2.
- **Role-play cards – Tamara (Step 4):** Cut cards for approximately one-third of participants from Annex 4.1 (at the end of this session).



2h30

STEP 1: Set the Scene



15 min

1 Acknowledge the sensitive subject matter (1 min)

Action:

- **Introduce with care:**
 - Discussing GBV can be distressing and may bring up unwanted memories or strong feelings.
 - Participants will not be asked to share personal experiences.
 - Anyone can step out at any time. Facilitators are available during the break for debriefing if needed.

Bridge: “Let’s start by making sure we are clear on what we mean when we say gender-based violence.”

2 GBV definition (2 min)

Action:

- **Ask:** Volunteer reads *Definitions: Gender-Based Violence and Intimate Partner Violence* (Participant Handbook).
- **Explain:**
 - “GBV means any harmful action done to someone because of their gender. GBV happens because some people have more power or control over others and because society expects certain behaviours based on gender. These power imbalances and harmful gender norms make violence more likely and may limit the ability of survivors to protect themselves. Understanding this helps us see that GBV is never the survivor’s fault; it’s about the context and social structures.”
 - “Intimate Partner Violence, or IPV, is one specific form of GBV that occurs within intimate relationships, where one partner uses abusive behaviours to maintain control over the other.”
 - “You’ll also notice we use the term ‘survivor’ rather than ‘victim.’ This language emphasizes dignity, resilience, and the person’s right to make decisions about their own care and safety.”
- **Show:** Figure: *Types of GBV in Emergencies* (Participant Handbook).
- **Add:** “These types of GBV can overlap, and a survivor may experience more than one at a time.”

Bridge: “These forms of violence directly and indirectly affect how caregivers feed their infants and young children. Let’s look at why this topic matters for IYCF counsellors working in emergencies.”

3 Why this topic (2 min)

Key Points:

- **Emergencies increase the risk of GBV:** Displacement, crowding, loss of income, increased stress and weakened protection systems create conditions where violence can be more likely.
- **GBV is almost always under-reported:** Survivors are prevented from coming forwards by stigma, fear of negative consequences, lack of confidential services and social norms that normalize violence. In emergencies, disrupted services and limited privacy make reporting even less likely.
- **GBV affects infant and young child feeding practices:** Trauma, safety concerns, and controlling partners can directly influence how caregivers feed and care for their children.
- **IYCF-E counsellors may be the first point of contact for survivors:**
 - Counselling often happens in private, women-only spaces and includes sharing sensitive and personal experiences, such as birth, breastfeeding and caregiving.
 - This setting makes it more likely that women may disclose violence. Sometimes, breastfeeding itself can even trigger distressing memories, leading to disclosure.
 - It is essential for counsellors to know that:
 - GBV is happening in the community, whether it is disclosed or not.
 - Disclosures must be received with empathy and without judgment.
 - The counsellor’s role is **not to investigate or “fix” GBV** but to listen with care and, if the woman chooses, connect her with referral services.
 - Gender norms and power dynamics can influence who makes decisions about infant feeding, access to food, and access to services. Counsellors should be aware of these dynamics when supporting caregivers.



Facilitator Tip

Keep this section high-level. The aim is to explain why GBV matters for IYCF-E counsellors, not how to respond.


Bridge: “Now let’s look at a real-life scenario to see how a caregiver may experience these issues in an emergency setting.”

4 Scenario discussion (8 min)

Action:

- **Ask:** Volunteer reads *Scenario: Leyla's first hours after birth* (Participant Handbook).
- **Discuss:**


 **“Have you ever heard or seen situations like this in your work?”**

 **Facilitator Tip**

Encourage participants to share experiences from their own work or observations, but remind them they are not being asked to disclose personal experiences of violence.

- **Discuss:**

 **“If you were the counsellor in this situation, what would you find most challenging?”**

 **Facilitator Tip**

When discussing challenges, prompt reflection on what skills, knowledge or strategies they think would help in these situations.

- **Write:** Capture ideas on a flipchart to refer to later when you introduce the learning objectives

Bridge: *“Thank you for sharing your experiences and reflections. From this scenario, we can see how GBV and the surrounding emergency context may affect a caregiver’s abilities to feed and care for their infants. This discussion leads us directly to the learning objectives for today’s session.”*

5 Learning objectives (2 min)

Action:

- **Read learning objectives:**
 - Apply a survivor-centred approach while receiving a GBV disclosure
 - Identify safe and appropriate ways to support recommended IYCF-E practices for GBV survivors
 - Practice self-care as counsellors in emergencies
- **Highlight counselling skills focus:**
 - In this session, for learning and practice purposes, we are focusing on the three key skills:
 - Use helpful non-verbal communication
 - Accept what a mother or caregiver thinks and feels
 - Avoid using words that sound judgmental

Bridge: *“Now, let’s move to Step 2, where we will strengthen key knowledge, concepts and practical skills for each of these learning objectives.”*

STEP 2: Strengthen key knowledge, concepts and skills

 75 min


LEARNING OBJECTIVE 1:

Apply a survivor-centred approach while receiving a GBV disclosure

Time: 40 min

The content for this objective is adapted from the *GBV Pocket Guide: How to Support Survivors of Gender-Based Violence*. This is the global standard tool for frontline workers who are not GBV specialists. Strongly encourage participants to explore it further. The link and QR code to download the Pocket Guide App for offline use are available in the *Resources* section of the Participant Handbook.

1

Clarify the role of IYCF-E Counsellors in GBV disclosures (2 min)

Action:

- **Explain:** “The role of an IYCF-E Counsellor in GBV disclosures is not to initiate or investigate incidents but to be prepared in case someone chooses to share an experience. Disclosures are common because IYCF-E counselling often happens in private settings.”
- **Ask:** Volunteer reads *Your role in GBV disclosures* (Participant Handbook).

Key Points:

- Do not seek out or try to identify survivors of GBV. This can cause harm.
- Stay within your role: You are not expected to provide GBV case management or to investigate or solve the situation.
- Be a supportive resource if someone chooses to approach you.




Facilitator Tip Keep this section short and high-level. The goal is to set the boundaries and reassure participants.

Bridge: “Now that we’re clear about the counsellor’s role and boundaries, let’s look at the key principles that guide how we should respond when a disclosure happens.”

2

Guiding principles: Survivor-centred approach and Do No Harm (7 min)

Action

- **Ask:**  “What kinds of harm could be caused if we respond poorly to a GBV disclosure?”
- **Encourage** participants to reflect on Leyla’s story from Step 1.
- **Sample prompts to guide discussion:**
 - What if the counsellor said, ‘Don’t worry, you’ll be fine’? How do you think Leyla might react?
 - Her trust in the counsellor could be lost. She may choose not to seek support from that counsellor again, including for IYCF-E.
 - What if the counsellor shared Leyla’s disclosure with others?
 - She could be at greater risk of more violence at home.
 - What if the counsellor pressured her to share more than she was ready to?
 - This could retraumatize her. She might feel overwhelmed and unsafe.
 - What if the counsellor judged her feeding difficulties?
 - She might feel blamed and withdraw further.

- **Wrap up:** “This is why we follow guiding principles in every interaction: to ensure we do no further harm and create safety, trust and dignity for the mother.”
- **Refer:** Figure: Key guiding principles to ensure we do no harm to survivors of GBV (Participant Handbook)

Key Points: Guiding principles – Survivor-centred approach and Do No Harm

- **Safety:**
 - In every response, the survivor’s safety and security must be the first priority.
 - Safety includes both physical protection and psychological and emotional security.
 - Survivors who disclose GBV may face further violence from the perpetrator, their allies, or even family or community members because of ‘honour’ issues.
 - The safety of the survivor’s family members and of those providing support also matters.
- **Confidentiality:**
 - Confidentiality means keeping any information shared by the survivor private, unless they give explicit permission for it to be shared.
 - Even details such as names, locations or family information should never be shared without the survivor’s informed consent.
 - Maintaining confidentiality promotes safety, trust and empowerment. Breaching confidentiality can put the survivor at risk of further harm. It can also put the person they disclosed to at risk.
- **Dignity and self-determination:**
 - Survivors have the right to make their own choices about disclosure and which types of support or services to access (health, psychosocial, protection, legal).
 - The counsellor’s role is to respect those choices and provide clear, accurate information.
 - Survivors are the primary actors in their recovery. Helpers should never take control or decide for them.
 - Failing to respect a survivor’s dignity, wishes or rights can increase harm by reinforcing shame, self-blame or helplessness.
- **Non-discrimination:**
 - Treat every survivor equally and fairly, regardless of age, gender, disability, marital status, sexual orientation and gender identity, ethnicity, religion, or social status.
 - Avoid assumptions about ‘who’ is a survivor or ‘what’ they should do.
 - Support survivors regardless of who committed the violence or the circumstances in which it occurred.
- It is important for the person seeking support to feel accepted and heard. If a caregiver discloses GBV and the counsellor responds insensitively or fails to provide appropriate support, the survivor may lose trust and never return – even for IYCF-E or other essential services. **A poor response can therefore close the door to both protection and nutrition support.**



Facilitator Tip

Keep the discussion practical. Emphasize that counsellors don’t need to be experts in GBV response; they need to know and apply these guiding principles in every counselling interaction.

- **Say:** “But not all caregivers who experience violence or trauma will disclose it. This is why our approach cannot depend only on disclosure.”

Trauma-Informed Care

Action

- **Explain:** “Remember, many caregivers may never disclose experiences of GBV, yet its effects can still be profound and can contribute to severe trauma – especially in the already deeply distressing contexts of displacement and crisis. Apply trauma-informed care to all counselling as a **universal precaution**, not just for known GBV cases. Think of this like wearing gloves in health care. Gloves are worn not because every patient has an infection, but because you assume there could be a risk and want to ensure everyone’s safety and dignity.”

Key practices:

- **Assume** anyone may have experienced trauma, even if it's not visible.
- **Create** an environment of safety, respect, and calm.
- **Understand** that trauma may affect communication, memory or decision-making.

Facilitator Tip

The definition of trauma-informed care (TIC) is provided in the Introduction section of the Participant Handbook. Invite participants to refer to it if they need a reminder of what TIC means and why it applies to all counselling interactions.

- **Refer:** Table: How Trauma-Informed Care and Survivor-Centred Approach work together (Participant Handbook)
- **Explain:** “A survivor-centred approach and trauma-informed care go hand in hand. Trauma-informed care guides how that support is delivered; by fostering safety, trust and empowerment in every interaction. The survivor-centred approach ensures that your support upholds safety, dignity, choice and confidentiality, placing the survivor’s rights and agency at the core. Together, these two practices ensure that all caregivers are supported in ways that promote healing and prevent harm – not only for survivors of GBV but also for anyone experiencing trauma or distress.”
- **Clarify:** “While the survivor-centred approach was developed for GBV response, its principles – safety, dignity, choice and confidentiality – can also guide how we support any caregiver who has experienced trauma or distress. However, the term ‘survivor’ should only be used when a person has disclosed GBV or self-identifies as such.”

Additional resources:

- **Refer:** Section: Resources (Participant Handbook) at the end of the GBV session
- **Invite** participants to watch the 5-minute UNHCR video on the survivor-centred approach (when they have time).

Bridge: “Even when we understand the guiding principles, our own beliefs and assumptions can still influence how we respond to survivors. It is important to reflect on these values and biases to truly apply a survivor-centred approach.”

3 Check your own biases and assumptions (12 min)



Activity: Decode your attitudes

Instructions:

- **Introduce:** “We all carry personal attitudes and beliefs about GBV, shaped by our families, communities and cultures. Some of these can unintentionally cause harm to survivors if left unexamined. This exercise will help us reflect privately and challenge our own assumptions.”
- **Refer:** Activity: Decode Your Attitudes (Participant Handbook).
- **Explain:** “In your Handbook, you will find six statements. For each one, mark your response using a simple code:
 - **A = Agree**
 - **D = Disagree**
 - **K = Don’t Know/Not Sure**
 At the end, you will have a personal code like A-D-K-K-D-A. Write your code on a sticky note, then hand it in. **It is anonymous.** No one will know which one is yours.”
- **Allow 5 minutes** for participants to read and record their code individually. Encourage honesty: “This is not about right or wrong. It’s about noticing your own reactions.”

- **Collect** all sticky notes and write each code clearly on the flipchart in a table with six columns labelled 1–6 (representing the statements). Align the codes so it is easy to see patterns (e.g., where most ‘A’s appear).
- **Highlight** the results: Identify the 2–3 statements with the highest number of A = Agree.

1	2	3	4	5	6
D	D	A	A	K	A
D	D	A	D	A	D
A	D	A	K	A	D
K	D	A	A	D	A

Debrief:

- **Invite discussion** for each selected statement.

Facilitator Tip If time is short, discuss only one statement.

- **Say:** “You can see on the flipchart that many of us agreed with this statement. Let’s explore what these responses might tell us about the beliefs or ideas that exist in our communities, without focusing on who said what.”

• **Ask:**

- “What might influence people to agree with this statement?”
- “How could this belief affect how survivors are treated or supported?”

- **Wrap-up:** “Many of us may start with these beliefs. The important step is being willing to reflect, grow and put the survivor’s best interests at the centre. For more examples of attitudes and beliefs that can either harm or support survivors, take time to review the Job Aid 4.1: Survivor-Centred Attitudes in your handbook.”

- **Refer:** Job Aid 4.1: Survivor-Centred Attitudes (Participant Handbook).

Facilitator Tip

- **Acknowledge the belief without judging the person:** “This is a common belief in many communities, but here’s why it can be harmful.”
- **Use myth-busting language:** “It may feel true to some, but research and survivor experiences show otherwise...”
- **Apply survivor-centred framing:** “How might a survivor feel if they heard this belief?”
- **Invite gentle peer challenge:** “Can anyone think of an example that shows why this belief could be harmful?”
- **Introduce supportive/accurate beliefs:** If most participants agree with a negative belief, present the supportive belief from Job Aid 4.1: Survivor-Centred Attitudes (Participant Handbook).
- **Manage tension:** If discussion becomes tense, remind participants: “The goal is reflection, not debate. Survivors benefit when we all examine our assumptions.”
- **Encourage respectful dialogue:** Emphasize reflection rather than judgment: “This is not about judging each other but about exploring how our attitudes may impact survivors.”



Bridge: “Now that we have reflected on your own beliefs and assumptions, we will focus on practical steps to take when a caregiver approaches you. There are three steps: LOOK, LISTEN and LINK. We will go through each one with examples and practice scenarios.”

4 Look (5 min)

Action:

- **Introduce:** “When someone discloses GBV, the first step is to LOOK.”
- **What it means:** Observing the GBV survivor and their situation to identify urgent needs and ensure safety.
- **Focus on** immediate safety and basic, urgent needs.
- **Refer:** Section LOOK (Participant Handbook) and the GBV Pocket Guide.

Key Points:

- **Do not ignore anyone seeking support.** Acknowledge and thank them for their presence and willingness to share.
- **Check urgent needs:** Identify urgent medical needs, access to water, food, restroom, clothing or other essentials.
- **Ensure safety:** Provide a private, culturally sensitive and gender-appropriate space. Consider the presence of others who may pose risk, and adapt accordingly.
- **Observe emotional and environmental cues:** Look for signs of distress, fear, shame, withdrawal or anger.
- **Include the child:** If the caregiver has an infant or young child with them, include the child’s safety and comfort as part of your observation. Pay attention to environmental cues that may reflect safety or wellbeing, such as visible injuries, hygiene concerns or the overall condition of clothing or belongings.
- **Consider context:** Recognize how cultural norms, gender roles, religion, ethnicity, age (including adolescence), disability, and other social factors may shape a survivor’s comfort, needs and sense of safety.

! Facilitator Tip

The facilitator notes below provide additional context and guidance to help you understand the content and respond confidently to questions. You do not need to read them aloud to participants. Review them as needed, along with the GBV Pocket Guide, to familiarize yourself with key points and considerations for assessing needs and ensuring safety.

Look: Facilitator additional notes

- **Address urgent needs:** The survivor’s immediate needs always come first. These can range from a need for water or clothing to needing medical care or help finding a loved one. For GBV survivors, clothing may also help restore comfort and dignity. Always ask what the survivor needs rather than assuming.
- **Ensure safety:** Rather than assuming, always ask survivors how they feel about their personal safety. Whenever possible, create conditions for them to feel safe: for instance, offer privacy and care by female staff members to any women and girls who are uncomfortable interacting with men.
- **If the caregiver has an infant or young child with them:** Ask gently whether the caregiver feels comfortable continuing the conversation with the child present or, alternately, whether someone they trust (e.g., family member, friend, staff member) could help care for or play with the child during the interaction. For older children, be aware that the caregiver may not wish to discuss sensitive topics in their presence.
- **For postpartum women:** Distress may be visible in their interactions with their baby. Notice whether the mother avoids eye contact, appears detached or anxious when the baby cries, or seems overwhelmed. Observe without judgment, as they may reflect emotional distress or the challenges of caregiving after trauma.

Bridge: “Having addressed any urgent needs and safety matters, the next step is to LISTEN.”

5 Listen (7 min)

Action:

- **Introduce:** *“The second step after LOOK is LISTEN.”*
- **What it means:** Actively listen to the survivor’s words, emotions and concerns. Pay attention to what they share about their experience, feelings and needs.
- **Focus:** Listen without judging the survivor; validate their feelings.
- **Refer:** Section LISTEN (Participant Handbook) and the GBV Pocket Guide.

Key Points:

- **Listen without judgment**
 - Allow survivors to share as much or as little as they feel comfortable with.
 - Never ask detailed questions about the incident itself.
 - Listen more than you speak. Don’t ask ‘why’ or for specific details of the incident.
- **Validate and normalize feelings**
 - Survivors’ emotions are normal reactions to abnormal events, no matter how they are presenting. Everyone will respond differently.
 - Your role is to provide the space for survivors to feel and express whatever they need, even if their reactions are unexpected or make you feel uncomfortable.
 - Avoid minimizing or discouraging emotions by saying e.g., *“It’s not so bad”* or *“Don’t cry.”*
 - Instead, **validate** and **normalize** feelings:
 - *“You have every right to be upset.”*
 - *“It’s okay to cry. I will sit with you until you’re ready.”*
 - Use supportive phrases to promote healing (refer to *Definition: Healing Statements* Participant Handbook).
 - In order to build trust, survivors need to be believed and not blamed.

! Facilitator Tip

Review the notes below and the GBV Pocket Guide as needed to familiarize yourself with key points and considerations for listening effectively. You do not need to read these notes verbatim to participants; they are to support your understanding and confidence in facilitating this step.

Listen: Facilitator additional notes

- **Listen without judgment:** When a GBV survivor shares their experience, it is essential to listen actively and without judgment. GBV can be a very traumatic experience for people. In an emergency, this can be in addition to wider traumatic experiences. People respond to trauma in many different ways: some may be quiet, withdrawn or hesitant to speak; others may be angry, blame themselves, cry or express distress in ways that feel uncomfortable to you. All of these reactions are normal and valid. Your role is to create a safe space for whatever emotions or responses the survivor presents, without interrupting or pressing for details about the incident. Do not ask ‘why’ questions or request specific information. Instead, focus on being present and attentive to what the survivor chooses to share.
- **Validate and normalize:** Validating and normalizing emotions is a critical part of listening. Survivors’ feelings are normal reactions to abnormal events. The best thing we can do is acknowledge and validate these emotions rather than trying to stop or minimize them. For example, if a survivor begins to cry, you might say: *“You have every right to be upset. It’s okay for you to cry. I will stay with you until you’re ready to talk.”* Our instinct may be to comfort survivors by saying things like *“Don’t cry,” “Don’t be afraid,”* or *“Everything will be fine.”* But these statements can diminish the survivor’s experience. Instead, allow them to feel what they need to feel, even if it makes us uncomfortable to have to sit with someone who is crying, angry, or

depressed. Being a true helper means creating space for their emotions. It is also important to believe the survivor and never assign blame for the violence they experienced. Creating this environment of trust and respect allows the survivor to feel heard, maintains their dignity and reinforces their autonomy. This approach not only supports emotional safety but also lays the foundation for future discussions, including guidance around safe infant and young child feeding practices.

Bridge: *“Together, LOOK and LISTEN help provide a safe, respectful response to disclosure. First, we ensure safety and dignity; then, we create space for the survivor’s voice and choices. The next step, LINK, focuses on offering information, resources and support while respecting the survivor’s autonomy.”*

6 Link (5 min)

Action:

- **Introduce:** *“The third step is to LINK.”*
- **What it means:** Providing information to connect the survivor with appropriate services in a way that respects their dignity, safety, and choice.
- **Focus:** Ensure the survivor knows what services exist and how to access them, while supporting their autonomy to decide the next steps.
- **Refer:** Section LINK (Participant Handbook) and the GBV Pocket Guide

Key Points:

- **Ensure the survivor knows what services exist and how to access them**
 - Provide the survivor with accurate, up-to-date information on available health, psychosocial, child protection, legal and other relevant services.
 - Use *Job Aid 4.2: Service mapping sheet* (Participant Handbook) to record and regularly update key referral contacts and services in your area.
 - Work with your team leader, GBV focal point, and partners to keep this information current and accessible.
 - Maintain confidentiality when sharing information or making referrals.
 - Be honest about what is and isn’t available. If services are limited, express empathy and acknowledge the difficulty, then work with the survivor to find options that feel best for them.
- **Support the survivor’s autonomy to decide the next steps**
 - Provide information, not advice.
 - Advice = telling someone what you think they should do (not useful).
 - Information = facts that allow survivors to decide (empowering).
 - Never pressure or force a survivor to accept help; respect their right to choose.
 - Reinforce the survivor’s control and decision-making: *“You can decide what feels right for you.”*
 - End each conversation with care and reassurance, even if the survivor chooses not to take further action at this time.

! Facilitator Tip Refer to the Facilitator notes below and the GBV Pocket Guide for further guidance.

Link: Facilitator additional notes

- **Ensure the survivor knows what services exist and how to access them**
 - Preparation is key. Before offering support, make sure you are familiar with the local referral pathways, including health, psychosocial, legal and child-protection actors. Know who to contact

- in emergencies and who is the GBV focal point or provider of last resort. This list should be hung in the nutrition point and easily seen by staff and those seeking care.
- If you are unsure of available services or contacts, do not guess. Reassure the survivor that you will confirm information and follow up through your supervisor or GBV focal point.
 - When services are limited or unavailable, be honest. People will value transparency and empathy more than false promises. Even when no service is immediately accessible, maintaining dignity and offering a compassionate ear are powerful forms of support.
 - Always respect confidentiality when sharing service details or seeking guidance, and never share identifying information without the survivor’s explicit consent.
 - **Support the survivor’s autonomy to decide the next steps**
 - A survivor-centred approach means empowering survivors to make their own decisions. Your role is not to solve the problem or give advice but to provide clear, accurate information, so the survivor can decide what feels safe and right for them.
 - Giving advice, such as “You should report this” or “You need to see a doctor,” removes control from the survivor. In contrast, giving information – for example, “There is a clinic nearby that offers free care if you decide you’d like to go” – supports autonomy and respects choice.
 - Respecting autonomy also means being patient. Survivors may not act immediately, and that’s okay. What matters is that they feel heard, respected and informed enough to make choices on their own timeline. By simply being a trusted source of support and information, you are doing enough. It is valuable and impactful.

Bridge: “LOOK, LISTEN and LINK form the foundation of a survivor-centred first-line response. By ensuring safety, offering space to be heard, and connecting survivors to services with respect for their choices, we support healing and empowerment from the very first moments after disclosure.”

7 Key takeaways and questions (2 min)

Action:

- **Refer:** Key learning points – Objective 1 (Participant Handbook).

! Facilitator Tip

Point participants to the Key learning points in their handbook. If needed, quickly summarize from the handbook to reinforce.

- **Ask** whether participants have any questions before moving on.

! Facilitator Tip

If you have an extra minute or want more discussion, ask:
“Which part of LOOK, LISTEN or LINK do you anticipate being most challenging to implement in your field context?”

Bridge: “We’ve explored how to receive a GBV disclosure using a survivor-centred approach, ensuring safety, dignity and respect at every step. Next, we will move to Objective 2, where we will identify safe and appropriate ways to support recommended IYCF-E practices for GBV survivors.”



LEARNING OBJECTIVE 2:

Identify safe and appropriate ways to support recommended IYCF-E practices for GBV survivors

Time: 35 min

1 Feeding challenges faced by GBV survivors (15 min)

Action:

- **Introduce:** “Now we will look at some common consequences of GBV and discuss how these might affect infant and young child feeding practices. This will help you think about the specific challenges mothers and caregivers may face and how to support them.”



Pair activity: Feeding challenges faced by GBV survivors

Instructions:

- **Refer:** Activity: Feeding challenges faced by GBV survivors (Participant Handbook).
- **Say:** “Work in pairs to fill in the empty column with the feeding challenges you think might result from each GBV consequence. Each pair will focus on two consequences only.”
- **Assign:** Two GBV consequences to each pair: Pair 1 works on #1–2, Pair 2 on #3–4, etc.
- **Timing:** 4 min



Facilitator Tip

Encourage participants to draw on their own experiences, the scenario discussed in Step 1, and the key points from the session. There are no ‘wrong answers.’ The goal is to think critically and explore the connections between GBV consequences and potential feeding challenges.

Debrief:

- Invite a few pairs to share one or two examples for any of the categories.
- Validate their responses and encourage discussion about differences in context or feeding challenges.
- Highlight any key points participants may have missed, using the filled table in the *Facilitator Notes* below.

Pair activity: Facilitator notes

	GBV consequences	Feeding challenges
1	<p>Psychological distress: Trauma, anxiety, depression, extreme stress.</p>	<p>Emotional distress can make it harder to sustain breastfeeding, introduce complementary feeding at recommended times, and respond to feeding cues. Survivors may feel disconnected from their own bodies or overwhelmed by caregiving.</p> <p>Some mothers may find typical infant behaviours difficult to tolerate, e.g.:</p> <ul style="list-style-type: none"> • Grabbing or pinching the breast or nipple • Throwing food or rejecting meals • Touching the mother while she is resting or unaware • Wanting constant contact or waking frequently through the night • Crying or fussing <p>Complementary feeding challenges:</p>

		<ul style="list-style-type: none"> • Difficulty preparing meals consistently due to fatigue, anxiety or low motivation. • Skipping or delaying meals because of emotional overwhelm or depression. • Limited patience to encourage a child to try new foods, leading to more restrictive or less diverse diets. • Avoiding feeding interactions when feeling triggered or stressed, resulting in missed meals. • Difficulty managing feeding routines in crowded or unsafe environments. <p>Responsive feeding challenges:</p> <ul style="list-style-type: none"> • Reduced sensitivity to child hunger and satiety cues, leading to feeding on a schedule rather than in response to the child. • Difficulty recognizing or responding calmly to a child's cues for food or comfort. • Frustration or irritability during mealtimes, potentially causing negative feeding interactions. • Avoidance of face-to-face interaction or physical closeness during feeding due to emotional distress. • Less engagement in playful, encouraging or nurturing feeding behaviours.
<p>2</p>	<p>Physical injuries: Pain, restricted movement or other physical injury from violence.</p>	<p>Injuries can cause pain, limit mobility, or prevent safe positioning during feeding. Breastfeeding may become physically difficult or unsafe without support. This may lead to increased reliance on bottles or unsafe substitutes.</p> <p>Breastfeeding / positioning challenges:</p> <ul style="list-style-type: none"> • Pain or limited mobility can make safe breastfeeding positions difficult, especially for older infants who require more upright or supported positions. • Caregiver may need extra support or adaptive positioning aids to maintain comfort and safety during feeding. <p>Complementary feeding challenges:</p> <ul style="list-style-type: none"> • Difficulty preparing or offering finger foods or meals if the caregiver has limited mobility or pain. • Reduced ability to supervise self-feeding safely, increasing risk of choking or mess-related stress. • Limited energy or stamina to maintain regular feeding routines or offer repeated meals/snacks. <p>Responsive feeding challenges:</p> <ul style="list-style-type: none"> • Harder to respond promptly to hunger or satiety cues if moving or bending is painful. • Because of physical limitations, may struggle to comfort or redirect a child during feeding or play. • Reduced capacity to engage in interactive, nurturing feeding behaviours, especially during messy or challenging meals.

<p>3</p>	<p>Fear and safety concerns:</p> <p>Constant stress from danger or threats to the survivor’s safety.</p>	<p>Stressful or unsafe environments can disrupt feeding routines. Mothers may avoid public or shared spaces for breastfeeding. Feeding choices may be influenced by efforts to avoid conflict with the abuser. Perpetrators may deliberately interfere with infant feeding because they resent time spent with the baby, feel jealous of the bond, or are using the child to exert control or coercion. Caregivers may prioritize their partner’s or other household members’ needs to prevent escalation of violence.</p>
<p>4</p>	<p>Negative body image:</p> <p>Discomfort or disconnection from one’s own body.</p>	<p>GBV can lead to shame, discomfort or detachment from physical closeness. Survivors may find the intimacy of breastfeeding challenging, may avoid skin-to-skin contact, or may stop breastfeeding earlier than planned. They may also feel reluctant to accept help with feeding support.</p>
<p>5</p>	<p>Lack of support / isolation and control:</p> <p>Emotional or psychological abuse may isolate survivors or restrict their access to family, friends, and essential services, increasing vulnerability and stress.</p>	<p>The absence of family, community or health-service support makes feeding more difficult. A controlling partner may block access to care or to safe spaces. Isolation reduces emotional encouragement and practical help.</p> <ul style="list-style-type: none"> • Without emotional or practical support, caregivers may struggle to maintain consistent feeding routines for infants and children up to age 2. • A controlling partner may prevent access to health facilities, breastfeeding spaces, or complementary feeding support. • In reducing the encouragement and hands-on help that the caregiver needs, isolation makes tasks like meal preparation, responsive feeding, and maintaining breastfeeding more difficult. • Caregivers may feel overwhelmed, stressed or unsafe, which can affect their responsiveness and interaction with the child.
<p>6</p>	<p>Cultural and social stigma:</p> <p>Shame, judgment, or community-level stigma linked to GBV or feeding choices.</p>	<p>Survivors may experience rejection, blame or discrimination. Stigma can intensify feelings of shame and reduce willingness to seek help or access feeding support.</p> <ul style="list-style-type: none"> • Caregivers may feel embarrassed or fearful of judgment, reducing their willingness to seek support from family, community or health services. This may lead them to hide feeding challenges, skip health or nutrition appointments, or avoid using safe spaces for support. • Stigma can increase stress and anxiety, which may interfere with breastfeeding, complementary feeding or responsive feeding. For children up to age 2, this can indirectly affect feeding frequency, diet diversity and caregiver responsiveness, as caregivers may feel isolated or unsupported.



Action:


- **Refer:** *Evidence Box: GBV and recommended IYCF-E practices* (Participant Handbook)
- **Explain:** Research shows that survivors of GBV are less likely to exclusively breastfeed or introduce complementary feeding at recommended times due to trauma, stress and lack of support.
- **Refer:** *Focus: Babies born as a result of sexual assault* (Participant Handbook)

- **Say:** “Mothers with babies born as a result of sexual assault and rape face unique challenges. The mother may experience intense trauma and complex emotions, which can affect bonding. Social stigma and isolation may further reduce available support. In these cases, responsive caregiving and supportive IYCF-E counselling are especially important.”
- **Note:** Fathers or male partners may also be survivors of violence or distress. Recognizing their needs and challenges can help create a more supportive environment for both mother and child.
- **Wrap up:** “By recognizing the different feeding challenges faced by GBV survivors, we can better tailor our counselling to be sensitive, practical and survivor centred. Our role is to identify challenges, not to judge or assume what a particular survivor of GBV will experience.”

Bridge: “We’ve seen how GBV can affect infant feeding in many ways, but it can also impact the counselling process itself. Let’s look at the challenges this creates.”

2 IYCF-E counselling challenges for GBV survivors (5 min)

Action:


- **Say:** “Survivors might not attend, engage with or accept support as expected; trauma symptoms may make counselling harder.”
- **Ask:**  “What challenges might this mother face in engaging with counselling?”
- **Encourage:** participants to refer back to the scenario from Step 1 when answering (if helpful).
- **Sample answers:**
 - Survivors may not attend or accept IYCF-E services.
 - Survivors may be unable to verbalize concerns, withhold information or struggle to focus.
 - Survivors may reject advice for reasons that are protective, but might seem irrational.
 - Survivors might not feel or be able to name symptoms or sensations in their body.

Bridge: “Behaviours that might seem unusual or hard to understand from the outside often serve as ways for a survivor to protect themselves or cope with their situation. As IYCF-E counsellors, your role is to meet them where they are; respect their pace; and focus on providing practical, supportive guidance, without pressuring them to disclose or take actions they aren’t ready for.”

3 Adapting IYCF-E counselling to support survivors of GBV (10 min)

Action

- **Say:** “Whether or not a survivor discloses GBV, the trauma and stress they’re experiencing can affect how they interact, feed and care for their baby. As IYCF-E counsellors, we can adapt our approach to create safety, trust and realistic solutions that support both mother or primary caregiver and child.”
- **Refer:** Return to Leyla’s story from Step 1:
 - She has just given birth and is struggling to initiate breastfeeding.
 - She avoids contact and finds it difficult to accept support.
 - Later, she begins to share that she is experiencing violence at home.
- **Discuss:**

 “How could you support Leyla?”

- **Write:** Capture ideas on flipchart.
- **Add:** Use key points if missing.
 - **Apply universal trauma-informed care**

- Always assume that trauma may be present, whether disclosed or not.
- Use a calm tone and gentle body language. Avoid sudden movements or personal questions.
- Respect boundaries. Never pressure for details or disclosure.
- **Create a sense of safety and control**
 - Work with the caregiver to find practical ways to create privacy in the available space. This might include adjusting seating, using a cloth or partition, or identifying quieter times or areas. Always ask what feels most comfortable for her, so she retains a sense of control and dignity.
 - Explain each step of counselling so the mother or caregiver knows what to expect.
 - Allow the survivor to choose where and how they sit, and who is present.
- **Respect the body and boundaries**
 - Some survivors may feel uncomfortable with physical touch, even from their child.
 - Ask before demonstrating positioning or touching the baby.
 - If direct breastfeeding feels difficult, discuss expressing milk, partial breastfeeding, or wet nursing as an option.
- **Adapt counselling messages to the survivor's capacity**
 - Believe what they say they can manage, even if it's not the 'ideal.'
 - Offer flexible, realistic options (e.g., *"Feed your child wherever you feel safe, whether that's at home, in a private corner of a shelter, or in another safe space."*).
 - Focus on what she **can** do safely and confidently. Do not focus on what she cannot do.
- **Strengthen attachment and responsive caregiving**
 - Encourage gentle, positive contact that feels comfortable: holding, talking, eye contact.
 - Reinforce that small, loving actions build the bond, even when breastfeeding is limited.
 - Provide reassurance that recovery and connection take time.
- **Provide ongoing practical support**
 - Coordinate with protection or MHPSS actors when appropriate, always with consent.
 - Connect mothers with peer- or women's-support groups or fathers with father-support groups.
 - Keep follow-ups short and consistent to build trust gradually.
- **Wrap-up:** *"Supporting survivors of GBV through IYCF-E counselling is not always easy. It requires patience, sensitivity, and flexibility. Remember the Do No Harm principle: prioritize the survivor's safety, respect their boundaries, and avoid pushing for actions they are not ready for. Even small, consistent acts of support can make difference for both mother, primary caregiver, and child."*

4 GBV as an acceptable indication for BMS use (3 min)

Action

- **Refer** Section: *GBV as an acceptable indication for BMS use* (Participant Handbook)
- **Explain:** *"According to WHO and OG-IFE guidance, GBV that results in a mother being unable or unwilling to breastfeed is a legitimate reason to offer BMS."*
- **Encourage** participants to remember:
 - **Confidentiality is essential.** Conversations about feeding options for GBV survivors must happen privately and never be shared outside the care team.
 - **Informed choice comes first.** The mother's emotional readiness, safety and wishes guide all decisions. No one should be pressured to breastfeed or to use BMS.
 - **BMS provision must always be coordinated** through IYCF-E protocols, with sustained follow-up to prevent risk of contamination, malnutrition or stigma.
 - **Alternative options such as wet nursing** can be considered when culturally acceptable and safe, with the mother's consent.
 - This approach aligns with **TIC** and the **survivor-centred approach** of supporting autonomy, safety and dignity above all else.

! Facilitator Tip

When discussing this topic with participants, emphasize that the goal is not to promote BMS use. It is to ensure that survivors' choices are respected and that any feeding decision is safe, informed and supported.

Bridge: "Now let's summarize the key learning points for this learning objective before moving on to the third one."

5 Key takeaways and questions (2 min)

Action:

- **Refer:** Key learning points – Objective 2 (Participant Handbook).
- **Ask** whether participants have any questions before moving on.

! Facilitator Tip

If you have an extra minute or want more discussion, ask: "What small changes could you make in your counselling space or approach to make it more trauma-informed?"

Bridge: We've looked at how GBV can affect infant feeding practices and explored practical ways to adapt counselling, regardless of a mother or caregiver discloses violence. It's important to recognize that working with survivors can also affect us as counsellors, emotionally and professionally. In the next part of this session, we'll discuss how to care for ourselves as counsellors, so we can continue providing effective support.



LEARNING OBJECTIVE 3:

Identify simple self-care strategies to maintain wellbeing as an IYCF-E counsellor

Time: 10 min

1 Secondary trauma and vicarious trauma (2 min)

Action:

- **Explain:** "Counselling people experiencing distress, especially survivors of GBV, can be emotionally demanding. Hearing others' painful stories can expose us to their trauma. This is called secondary or vicarious trauma."

Key points:

- Vicarious trauma happens when counsellors absorb the emotions and pain of the people they support.
- Over time, this can lead to **compassion fatigue** or **burnout**, which can negatively impact the quality of support and counselling that a counsellor provides to clients.
- Experiencing secondary or vicarious trauma is not a sign of weakness. It is a normal human response to repeated exposure to others' distress. The brain and body react as protective mechanisms, signalling stress and the need for rest and self-care.

! Facilitator Tip

Emphasize that caring for oneself is a professional responsibility, not a luxury.

2 How IYCF-E counsellors can protect themselves (6 min)

Action:


- **Explain:** "We can't always prevent stress, but we can protect ourselves from its deeper impacts by staying aware and maintaining boundaries."

Key points:

- **Self-awareness:** Check how you feel regularly, especially after a difficult counselling session.
- **Boundaries:** Keep a clear line between your professional and personal life.
- **Grounding and relaxation:** Use short breathing or grounding techniques from the stress session. Refer: *Annex 1: Emotional regulation practices* (Participant Handbook).
- **Small actions:** Include small, daily self-care actions: rest, hydration, movement, connecting with trusted people.
- **Self-care toolbox:** Keep a set of practical tools or actions to recharge and stay grounded.
- **Routine debrief:** Regularly debrief with peers or a supervisor in a safe, structured way to process work-related stress and emotions. When debriefing, **never share any names or identifying details about survivors** (such as age, location or personal circumstances).
- **Seek support if needed:** Reach out to a supervisor, team lead, mental health focal point or peer-support spaces when necessary.

Focus: Self-care toolbox

Action:

- **Explain:** “Each of us needs a few practical tools to keep us grounded and well.”
- **Ask:**  “What is one thing that helps you recharge after a difficult day?”
- **Record** 3–4 examples on a flipchart as part of a ‘self-care toolbox’.
- **Examples:**
 - Taking a few deep breaths after each counselling session
 - Having a short walk or stretch before meeting the next person
 - Debriefing with a trusted colleague or team lead
 - Keeping a short journal of what went well during the day
 - Scheduling rest or quiet time before going home
 - Spending time with friends and family
- **Refer:** *Job Aid 4.3: My self-care toolbox* (Participant Handbook)

! Facilitator Tip

Encourage participants to choose realistic actions they can do regularly, and not big goals that are hard to maintain.

Focus: Get help or support if needed

Action:

- **Introduce:** “Sometimes self-care isn’t enough, and that’s okay.”
- **Explain:**
 - Talk to a trusted peer, supervisor, team leader, or mental health focal point.
 - Use peer-support or staff-care spaces, if available.
 - Remember: asking for help is a professional strength.
- **Refer:** *Box: Peer debriefing for self-care* (Participant Handbook).

! Facilitator Tip

Mention that organizations should have systems for staff support, and participants can ask their team leader about available options. If debriefing isn’t currently offered where you work, participants may consider suggesting it to your supervisor. Supporting staff wellbeing is part of an organization’s Do No Harm commitment, not only to avoid harm to families but to prevent harm to staff, as well.

Bridge: “Let’s now wrap up with the key points and address any questions before moving on.”

6 Key takeaways and questions (2 min)

Action:

- **Refer:** *Key learning points – Objective 3 (Participant Handbook).*
- **Ask** whether participants have any questions before moving on.



Facilitator Tip

If you have an extra minute or want more discussion, ask: “What signs tell you that you need extra support or rest?”

Bridge: “Listening to people’s most painful experiences and providing comfort in moments of crisis takes courage and empathy, but it also requires self-care. Looking after yourself is not selfish; it’s part of being an effective, compassionate helper. We are now moving into a demonstration where you will see how to apply what we learned in Step 2.”

STEP 3: Demonstrate

 15 min

1 Introduction (2 min)

Action:

- **Introduce:** “In this demonstration, we will continue discussing the scenario from Step 1 and apply the knowledge and skills from Step 2, focusing on the practical use of LOOK, LISTEN and LINK when supporting a mother who may be experiencing violence or distress.”
- **Add:** “You will also notice the counsellor applying three of the general counselling skills to help create emotional safety and trust:
 - Use helpful non-verbal communication,
 - Accept what a mother or caregiver thinks and feels, and
 - Avoid using words that sound judgmental.”
- **Refer:** *Case study: Leyla and Solomon (Participant Handbook)*
- **Summarize** the case:
 - **Setting:** A mobile health tent in a temporary settlement following severe drought and displacement. The tent is run by a health and nutrition team linked to a nearby referral facility. A community health volunteer alerted the team that Leyla, who recently gave birth in her family tent, may need follow-up support. The counsellor meets Leyla privately in the tent to ensure a safe and quiet space for conversation.
 - **Mother:** Leyla, who gave birth six hours ago
 - **Baby:** Solomon, a newborn
 - **Situation:** Leyla refuses skin-to-skin contact and breastfeeding

2 Script (10 min)

Action:

- **Act out** the script below as a team of 3.



Facilitator Tip

- **Counsellor:** *Avoid dramatization. Keep emotions authentic but measured. The goal is to model a respectful, survivor-centred interaction, not to create distress for the audience.*

- **Mother (Leyla):** Show emotional cues gently. A quiet tone, lowered gaze or brief pause can express distress effectively without needing tears or strong reactions.



Counsellor

Hello Leyla, my name is [Counsellor]. Congratulations on your baby! I can imagine that it's been a long night. How are you feeling right now?



Leyla

I'm... tired. I don't really want to talk.



Counsellor

That's completely okay. You've just given birth, it's a lot to go through. You can rest; I'll just sit nearby for a bit, unless you'd prefer to be alone.



Leyla

It's fine... you can stay.



Counsellor

Thank you. If you need anything, some water, an extra pillow, or a blanket, please tell me.



Leyla

Maybe... some water.



Counsellor

Of course. Here you go. Take your time.
(Counsellor waits quietly while Leyla drinks.)



Counsellor

I see your baby is wrapped nearby. Everyone has their own reasons for how they keep their baby close. Would you like to talk about what feels most comfortable for you?



Leyla

I... I just can't. It's too much.



Counsellor

That's okay. It sounds like things have been really hard.



Leyla

It's just been such a hard time. During the pregnancy, I was often alone. There was never enough food. I worried every day about what would happen when the baby came.



Counsellor

It sounds like you went through your pregnancy with a lot of worry and without much support.



Leyla

Yes... and at home, things were tense. I tried to stay calm for the baby, but... it wasn't easy.



Counsellor

It sounds like things may have felt tense or frightening at home. Thank you for sharing that with me. You only need to share what feels safe for you. This is a private space, and I'm here to listen and support you in the way that feels most helpful to you right now. You're not alone.



Leyla

Hesitant, softly:
Sometimes... he would shout and raise his fist. I was so scared of what he might do.



Counsellor

I'm so sorry you went through that. No one should have to live in fear, especially while pregnant.

	Facilitator	<ul style="list-style-type: none"> • Prompt: What helped Leyla feel safe enough to share this information? <p>Explanation: The counsellor begins by creating emotional safety and trust through gentle tone, respectful distance, and offering choices. The counsellor avoids assumptions and gives Leyla control over the interaction. These are key trauma-informed practices that help a survivor feel safe enough to confide and speak openly to the counsellor.</p>
	Counsellor	Leyla, thank you for trusting me with that. You've been through so much. Before we talk more, I just want to check that you feel safe to stay here with your baby right now.
	Leyla	Yes... here it's quiet.
	Counsellor	OK. Great. If at any time you start to feel unsafe, please tell me or any of the staff nearby. We'll make sure you and your baby feel protected.
	Facilitator	<p>Prompt:</p> <ul style="list-style-type: none"> • What did the counsellor check before continuing the conversation? <p>Explanation: The counsellor applied LOOK by ensuring Leyla felt safe and calm before proceeding. The counsellor did not probe about the perpetrator or incident, but reassured Leyla that safety was a priority.</p>
	Counsellor	You've been carrying so much alone. It takes courage to share this with me. I understand things have been difficult at home. Would you like to tell me a bit more about that? Only what you feel comfortable sharing.
	Leyla	<p><i>Speaks softly</i></p> <p>It's my husband... since we lost everything in the drought, he's been angry all the time. When he comes to the tent, I never know what mood he'll be in. Now I worry he'll come here and start again. I never know what will make him angry.</p>
	Counsellor	I'm so sorry this happened to you, Leyla. You do not deserve to be treated this way.
	Leyla	<p><i>Quietly, with trembling voice</i></p> <p>I feel so tired... like I have nothing left.</p>
	Counsellor	You have every right to feel that way. It's okay to cry, if you need to.
	Counsellor	Leyla, thank you for trusting me with this. There are people here who can help you stay safe and talk through what's been happening, if and when you're ready. Would you like me to give you some information about how they might be able to help?
	Leyla	<p><i>Shakes head</i></p> <p>Not now... I don't want anyone to know.</p>
	Counsellor	<p>That is completely okay. What actions to take or not take is your choice. You don't need to talk to anyone unless you want to.</p> <p>If you ever change your mind, I can help you connect with someone confidentially. For now, we can focus on what helps you and your baby feel calmer together.</p>

	Facilitator	<p>Prompt:</p> <ul style="list-style-type: none"> • How did the counsellor demonstrate LISTEN? How did the counsellor use healing statements to validate Leyla’s feelings without asking for details of the violence? • How did she move into LINK while still respecting Leyla’s pace and choices? <p>Explanation: The counsellor listened without judgment and used healing statements, like: “I’m sorry this happened,” “You do not deserve this,” “It’s okay to cry,” validating Leyla’s feelings. When introducing LINK, the counsellor offered support options gently and respected Leyla’s decision not to be referred yet, reinforcing survivor autonomy and trust.</p>
	Counsellor	<p>You’ve been through so much, and you’re still here caring for your baby. That shows incredible strength. How are you feeling now when you think about caring for your baby?</p>
	Leyla	<p>I don’t know if I can. When he cries, I feel frozen. I know I should hold him, but sometimes I just... can’t move.</p>
	Counsellor	<p>That reaction makes sense. Your body is trying to protect you from memories of danger. It doesn’t mean you’re doing a bad job, it means you’ve been hurt. You deserve support and rest.</p>
	Leyla	<p>(quietly) I just want to feel close to him, but I don’t know how.</p>
	Counsellor	<p>Would you like me to show you one small thing that might help you and the baby feel calmer together?</p>
	Leyla	<p>Maybe... yes.</p>
	Counsellor	<p>We could try placing him gently on your chest. You can keep him wrapped if that feels safer. Would you like to try? I could show you how, or you can do it yourself if you’d like?</p>
	Leyla	<p>Maybe I can try... just for a moment.</p>
	Counsellor	<p>I will pick him up now and bring him to you, OK? You can hold him against your heartbeat for a few minutes. <i>Counsellor demonstrates gentle positioning.</i></p>
	Leyla	<p>He’s so warm... He’s calming down.</p>
	Counsellor	<p>Yes, he knows your heartbeat. You’re already giving him comfort, just by holding him.</p>
	Leyla	<p>It feels... nice.</p>
	Counsellor	<p>You’re doing wonderfully, Leyla. Thank you so much for talking to me about all of this. You have been through so much. When I come back in a few hours, we can see if you’d like to try to breastfeed again or simply keep resting together.</p>
	Leyla	<p>Thank you for helping me.</p>

**Facilitator****Prompt:**

- What did you notice about how the counsellor supported Leyla to reconnect with her baby?
- What key counselling skills helped the counsellor end the session with calm and dignity?

Explanation:


The counsellor offered gentle, choice-based support, encouraging Leyla to decide what felt right for her and her baby. The counsellor reinforced Leyla's capacity as a mother and created a positive emotional link with the baby.

The counsellor accepted Leyla's feelings without judgment, even when Leyla expressed difficulty with bonding, through using key counselling skills:

- Accepting what a mother or caregiver thinks and feels.
- Avoiding words or tones that sound judgmental.

The counsellor helped Leyla take one small, achievable action that restored connection and confidence. The closing emphasized follow-up and continuity of care, showing that Leyla is not alone and that small steps towards bonding and breastfeeding are meaningful progress.

3 Debrief (3 min)**Action:**

- **Ask:**  "After watching this demonstration, would you feel comfortable supporting a mother or caregiver who is a survivor of GBV like Leyla?" "If not fully comfortable yet, what would help you feel more prepared?"
- **Collect:** 2-3 short answers.

Bridge: "Thank you for observing the demonstration. Remember, our goal is not to 'fix' the survivor's situation but to create emotional safety, respond with empathy, and link her to appropriate support. Now, you'll have a chance to practice these skills yourselves through a short role-play."

STEP 4: Role-Play **30 min****1 Introduction (5 min)****Action:**

- **Explain:** The role-play is a first visit with Tamara, a mother struggling to bond with her 1-month-old baby, Chikondi.
- **Organize:** Ask participants to form groups of 3: **Counsellor, Tamara, Observer**. Participants stay in the same groups as previous sessions but rotate roles: i.e., the previous observer is now a counsellor or Tamara.
- **Distribute:** Hand out the role cards to each 'Tamara' (*prepare the role-play card 'Tamara' from Annex 4.1*).
- **Explain:** The observer uses the Counselling Skills Checklist to note strengths and areas for improvement.
- **Remind:** Counsellors should practise using the three key skills demonstrated in Step 3:

- Use helpful non-verbal communication
- Accept what a mother or caregiver thinks and feels
- Avoid using words that sound judgmental
- **Allow:** Give groups 2–3 minutes to get ready before beginning their role-plays. Participants can take a minute to review the Counselling Skills Checklist to refresh their memory of the key recommendations discussed during the session.
- **Time:** The role-play lasts around 10 minutes.




4 Role-play practice (10 min)

Action:

- **Encourage:** Ask groups to start quickly and use their full time.
- **Support:** Move quietly between groups, observe and answer questions if needed.
- **Manage time:** Give a **5-minute** and **2-minute** warning, so participants can pace themselves.
- **End:** Stop the activity on time, even if some groups have not finished the full role-play.

4 Debrief (15 min)

Action:

- **Gather:** Bring everyone back together and thank participants for their role-plays and effort.
- **Ask the ‘Tamara’s’**  :
 - “How did it feel to be in Tamara’s place?”
 - “Did you choose to disclose the GBV? If yes, what helped you decide to share? If not, what made it difficult?”
- **Ask the observers**  :
 - “What strengths did you notice in the counsellor’s approach?”
 - “What areas could be improved?”
- **Ask the counsellors**  :
 - “How did it feel to be in the counsellor role?”
 - “What was most challenging? What worked well?”
- **Refer:** Role-play debrief: Tamara (Participant Handbook).
- **Add:** Highlight key points if they do not come up. Use the debrief box from the Participant Handbook to add practical advice that should have been applied during the counselling session (e.g., build trust through acceptance and non-judgment, apply TIC, sensitively use LOOK / LISTEN / LINK after disclosure, support feeding without judgment or pressure, summarize next steps).

Facilitator Tip

If time allows, invite participants to practise a regulation technique from Annex 1: Emotional regulation practices as a way to care for themselves after a challenging counselling session, like the role play with Tamara.

Bridge: “GBV disclosure may not happen often, but you need to be prepared to respond safely and respectfully whenever it does. In Step 5, we’ll reflect individually on what you’ve learned and how you can apply it in your counselling practice, including both supporting survivors and taking care of yourself.”

STEP 5: Self-reflection

 5 min

Action:

- **Invite:** Ask participants to take a quiet moment to reflect and note their answers in the Participant Handbook.
- **Guide:** Read the four questions (also in the Participant Handbook) out loud and give participants 2–3 minutes of silence to think/write.
- **Share (optional):** If time allows, invite 1–2 volunteers to share a key takeaway.
- **Close:** Thank participants for their reflections and emphasize that applying these insights in real-life counselling is where change happens.



Facilitator Tip

Keep the activity short and personal. This is not a group discussion but an opportunity for each participant to consolidate their own learning.

ANNEX 4.1: Role-play card – Tamara Cut the cards below and provide one to each participant acting Tamara.



Card: Tamara

You tell the counsellor:

- You feel tense and uncomfortable each time the baby is at your breast.
- You worry that you don't have enough milk and think formula might be better.
- You feel very tired and unsure of whether you can care for Chikondi well.
- You are doing your best, but sometimes you just want to be left alone.

If the counsellor asks about Chikondi's father, say:

- There is no father. You prefer not to talk about it.

If you feel safe and trust the counsellor, you may say:

- You became pregnant after a sexual assault by a stranger. You have never talked about it before.

Card: Tamara

You tell the counsellor:

- You feel tense and uncomfortable each time the baby is at your breast.
- You worry that you don't have enough milk and think formula might be better.
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SESSION 5: SUPPORTING CAREGIVERS DURING INFECTIOUS DISEASE OUTBREAKS



LEARNING OBJECTIVES

1. Explain how to protect recommended IYCF practices during an infectious disease outbreak
2. Identify key IYCF-E counselling adaptations during an infectious disease outbreak
3. Describe how to provide effective remote IYCF-E counselling



COUNSELLING SKILLS FOCUS*

- Reflect back what the mother/caregiver says
- Give some relevant information
- Use simple language

**Reminder: The full 3A process and counselling skill set remain essential. The focus on these particular three skills is for practice and learning purposes.*



Material and preparation:

- **Audio recordings (Step 3)**, available in 5 languages (English, French, Spanish, Arabic and Indonesian):
 - Assess_1_EN.mp3 (or FR / SP / AR / ID)
 - Assess_2_EN.mp3 (or FR / SP / AR / ID)
 - Analyse_1_EN.mp3 (or FR / SP / AR / ID)
 - Analyse_2_EN.mp3 (or FR / SP / AR / ID)
 - Act_EN.mp3 (or FR / SP / AR / ID)

Test and review the audio files in advance to familiarize yourself with the Step 3 demonstration.

- **Role-play cards – Miriam (Step 4)**: Cut cards from Annex 5.1 (at the end of this session) for approximately one-third of participants.



2h30

Session content:

- This session is adapted from two e-learning courses published by the READY Consortium:
 - [Infant and Young Child Feeding in Emergencies during Infectious Disease Outbreaks](#)
 - [IYCF Remote Counselling: How to support caregivers during infectious disease outbreaks and other settings](#)
- Participants are strongly encouraged to explore these courses further. Links and QR codes to access them are provided in the Resources section (Participant Handbook).
- This session differs slightly from previous ones:
 - Step 3 is longer because it uses five pre-recorded audio files performed by professional actors, following the script in the Demonstration section. These recordings are available in English, French, Spanish, Arabic and Indonesian.
 - The audio content is taken directly from the e-learning course *IYCF Remote Counselling: How to support caregivers during infectious disease outbreaks and other settings*.

STEP 1: Set the Scene

 10 min

1 Why this topic? (1 min)

Key Points:

- Infectious disease outbreaks are a unique type of emergency.
- They can be the main crisis or occur within an existing humanitarian emergency.
- Outbreaks spread quickly in crowded settings with limited hygiene and safe water. They create fear, confusion and rapid changes in routines – especially in emergencies
- These conditions can disrupt how families care for and feed their infants and young children.

Bridge: “Let’s look at a real-life scenario to see how an infectious disease outbreak can affect IYCF practices.”

2 Scenario discussion (7 min)

Action:

- **Ask:** Volunteer reads *Scenario: Outbreak in the transit centre* (Participant Handbook).
- **Discuss:**

 **“How could this outbreak negatively impact IYCF practices?”**

Facilitator Tip

Encourage participants to share examples from their work or observations during past outbreaks. Remind them to keep the discussion focused on professional experiences and community situations – NOT personal medical details or confidential cases.

- **Write:** Capture ideas on a flipchart.
- **Add:** Use the facilitator notes below and mention any points that are not included by participants.
- **Refer:** When BMS donations are discussed, point participants to the section *Opportunistic marketing of breast milk substitutes* (Participant Handbook).

Facilitator Tip

Do not read the facilitator notes aloud or repeat points already mentioned by participants. Use the notes only to fill gaps if key issues are missing, and to summarize or clarify the discussion. Use participants’ own words as much as possible.

Ways that outbreaks disrupt IYCF practices: Facilitator notes

Infectious disease outbreaks can disrupt recommended IYCF practices in many ways:

Conflicting or inappropriate advice

- Rumours spread quickly during outbreaks, especially in humanitarian settings.
- Caregivers may receive mixed messages (from community, family, medical providers) about breastfeeding safety, disease transmission or the need for separation.
- Confusion can lead to harmful decisions regarding feeding practices, such as separation, stopping breastfeeding, avoiding skin-to-skin contact or switching to unnecessary formula feeding.

Disrupted health and nutrition services

- Health facilities may be overwhelmed or re-purposed for outbreak response.
- Counselling services, mother-to-mother groups, and safe spaces may stop or shift to remote delivery.

- Frontline workers may lack personal protective equipment (PPE) or clear guidance on how to safely provide IYCF support.
- As a result, caregivers lose access to essential counselling and to early and routine support.

Uncontrolled donations and distribution of breast milk substitutes (BMS)

- Fear of transmission often leads to surges in unsolicited formula donations.
- Bottles and teats may be distributed without assessment or mitigation, increasing infection risks.
- Misuse of formula undermines breastfeeding and exposes infants to contaminated water or unsafe preparation.
- Well-intentioned donations of infant formula from the public or other organizations may increase during outbreaks, even when such donations can put infants at risk.
- Opportunistic marketing by the commercial infant formula industry may increase during outbreaks, misleading families with claims that formula is safer, better or 'immunity-boosting.' Refer to the section *Opportunistic marketing of breast milk substitutes* (Participant Handbook).

Supply chain disruptions

- Outbreaks can interrupt supplies of food, micronutrient supplementation, medications, and targeted use of BMS for infants already dependent on it.
- In humanitarian settings, fluctuating population movements makes supply-chain management difficult.
- Caregivers may be forced into harmful coping strategies, such as diluting infant formula, relying on unsafe substitutes like tea or juices, or decreasing feeding frequency.

Reduced access to clean water, sanitation, and hygiene supplies

- Limited potable water access and lack of fuel for boiling water makes hygienic formula preparation difficult or impossible.
- Lack of handwashing facilities increases contamination risks during complementary feeding.
- Infants on formula are especially vulnerable to diarrheal disease and dehydration owing to lack of hygienic conditions and disrupted services.

Increased stress, fear, and grief

- Caregivers may face stigma, isolation or fear of infecting their child.
- In outbreaks with high illness or mortality rates, caregivers may experience grief and anticipatory fear.
- Repeated exposure to illness or death within families or communities can affect mental wellbeing and caregiving capacity.
- High levels of stress and distress can affect feeding routines, milk expression, and responsive feeding.

Bridge: *"We can see that outbreaks can have serious consequences, not only for infant feeding practices but also for maternal wellbeing and child survival. As frontline workers, you play a crucial role in protecting recommended IYCF practices during outbreaks. Let's look at what we're going to learn in this session."*

5 Learning objectives (2 min)

Action:

- **Read learning objectives:**
 - Explain how to protect recommended IYCF practices during an infectious disease outbreak
 - Identify key IYCF-E counselling adaptations during an infectious disease outbreak
 - Describe how to provide effective remote IYCF-E counselling
- **Highlight counselling skills focus:**
 - In this session, for learning and practice purposes, we are focusing on the three key skills:

- Reflect back what the mother/caregiver says
- Give some relevant information
- Use simple language

Bridge: “Now that we understand how outbreaks can disrupt infant feeding, let’s strengthen the technical knowledge and counselling skills needed to protect IYCF practices safely and effectively.”

STEP 2: Strengthen key knowledge, concepts and skills

 70 min



LEARNING OBJECTIVE 1:

Explain how to protect recommended IYCF practices during an infectious disease outbreak

Time: 25 min

1 Introduction (3 min)

Action:

- **Introduce:** “Once an outbreak starts, there are several considerations and actions that you can take to protect, promote and support recommended IYCF practices. These actions should continue throughout the response.”

Key Points

- Follow national disease-specific IYCF-E guidance, which should align with WHO recommendations and be updated as evidence evolves.
- In almost all outbreaks, breastfeeding should continue, even when the mother is infected or symptomatic.
- Breastfeeding offers vital protection to infants and young children during infectious disease outbreaks – both prior to maternal infection and, in most infectious disease outbreaks, during maternal infection – because it supports infant immunity.
- Mother–infant separation should be avoided *unless* medically indicated and recommended in your national, disease-specific IYCF-E guidance. It can cause serious harm and is rarely medically justified. Evidence shows that the risks of separating mothers and infants far outweigh the risks of transmission through breastfeeding.
- Separation has serious consequences, including distress for mother and child, impaired bonding and risk of breastfeeding failure. Caregivers may request or agree to separation out of fear, even if not required.
- **Refer:** *Visual: Risks of separation compared to direct infection* (Participant Handbook)

Detailed evidence: Facilitator notes

- A 2021 study estimated that policies separating mothers and infants and stopping breastfeeding would have caused 188,000–275,000 infant deaths, compared with 1,800–2,800 deaths expected from COVID-19 directly.
- For every 1 infant death potentially prevented by separation, 1,000 infant deaths would result from not breastfeeding.

Rollins, N. et al., *A public health approach for deciding policy on infant feeding and mother–infant contact in the context of COVID-19*, Lancet Global Health, 2021.



Facilitator Tip

Emphasize the magnitude of the risk to help participants understand why separation is almost never justified.

Bridge: “Now that we understand why protecting breastfeeding and keeping mothers and infants together is so important, let’s explore practical actions and strategies that you can take to protect recommended IYCF practices during an infectious disease outbreak.”

2 Protecting recommended IYCF practices (17 min)

Action:

- **Introduce:** “Let’s look at some real-life scenarios of mothers facing illness during infectious disease outbreaks. This activity will help you think about the challenges mothers may encounter and the actions frontline workers can take to protect recommended IYCF practices.”



Group activity: Case studies – Anfisa, Nadia

Instructions:

- **Refer:** Activity: Case Studies – Anfisa, Nadia (Participant Handbook).
- **Divide participants into 2 groups:** assign each group one case (Anfisa, Nadia).
- **Say:** “Each group will read your case study and discuss the two questions:
 4. What went wrong in this scenario?
 5. What steps should be taken to protect mothers like in this scenario?”
- **Timing:** 7 minutes

Debrief:

- Ask each group to briefly summarize their discussion.
- Highlight common themes across cases:
 - Avoid unnecessary separation
 - Support breastfeeding or safe alternatives
 - Combat misinformation with clear guidance
- Highlight any key points participants may have missed, using the filled table in the *Facilitator Notes* below.

Group activity: Facilitator notes

Group 1 – Anfisa

- What went wrong:
 - Mother separated from the infant unnecessarily
 - Conflicting or unclear advice from health workers
 - Lack of breastfeeding support during hospitalization
 - Misinformation and fear circulating in the community
- Steps to protect mothers:
 - **Support rooming-in and continued breastfeeding whenever safe:** Ensure mothers and infants stay together during hospitalization whenever medically possible. This supports bonding and protects infant nutrition.
 - **Implement SOPs for unwell mothers in health facilities:** Facilities should have clear protocols in place – established, ideally, before an outbreak – to support mothers and infants to remain together during illness or outbreak response.
 - **Provide counselling and relactation support:** Offer specialized breastfeeding support if the mother has concerns of a reduced milk supply or has stopped breastfeeding. Follow up at the community

level after discharge to ensure ongoing support. It is important that your facility includes relactation support in discharge protocols.

- **Promote recommended breastfeeding (or IYCF) practices:** Share recommended IYCF practices during outbreaks, according to your national, disease-specific IYCF-E guidance, to promote optimal IYCF behaviours and counteract rumours and misinformation.
- **Support maintenance of the mother's milk supply during separation:** Provide counselling for regular breast milk expression and safe storage
- **Ensure hygienic alternatives if temporary separation occurs:** If separation is unavoidable, provide donor human milk, a wet nurse, or an age-appropriate and safe BMS option until the mother can safely resume breastfeeding.

Group 2 – Nadia

- What went wrong:
 - Mother was severely ill and unable to breastfeed or express milk.
 - No support was provided to maintain lactation or plan age-appropriate feeding during separation.
 - Lack of guidance increased the risk of reduced milk supply due to prolonged interruption.
 - The child lost continued nutritional, immune and emotional benefits of breastfeeding during a period of stress and illness.
- Steps to protect mothers:
 - **Support milk expression when feasible:** Encourage gentle milk expression during illness when medically possible to help maintain milk production and comfort. At this age (15 months), maintaining supply is the primary goal, not preventing engorgement.
 - **Support continued feeding with appropriate foods:** Ensure the child continues receiving safe, diverse complementary foods and fluids during maternal illness or separation.
 - **Avoid unnecessary use of breast milk substitutes:** For children over 12 months, breast milk substitutes are not required unless there is a specific medical requirement (which is very rare).
 - **Support return to breastfeeding after recovery:** Provide reassurance that breastfeeding can resume gradually, even after interruption. Encourage frequent contact, responsive feeding, and patience as milk supply rebuilds.



Action:

- **Say:** “Now that we’ve explored real-life scenarios, let’s look at a structured approach to protecting recommended IYCF practices during outbreaks.”
- **Refer:** Table: Protecting recommended IYCF practices during an infectious disease outbreak (Participant Handbook)
- **Explain:** It is organized around three possible situations:
 - **National outbreak guidance recommends continuing breastfeeding**
 - This is the **most common scenario** in infectious disease outbreaks.
 - Breastfeeding remains the safest option and should be actively protected and supported.
 - The focus is on:
 - Preventing unnecessary separation
 - Supporting mothers to continue breastfeeding safely
 - Reinforcing appropriate IPC measures
 - **National outbreak guidance recommends using temporary alternatives**

- This situation is **rare** and should only occur when national, disease-specific guidance explicitly recommends it.
- Breastfeeding interruption should be **temporary**, not permanent.
- Protecting the mother’s milk supply and planning for return to breastfeeding or relactation are essential.
- Such decisions follow national guidance. They are **not made by individual staff**.
- **Guidance is not yet available (novel outbreak)**
 - This is often the most challenging scenario.
 - Misinformation and harmful practices – including unnecessary separation – can spread quickly.
 - The safest default approach is to **maintain recommended standards of care** unless evidence shows otherwise.
 - In the absence of specific guidance, priority should be given to:
 - Continuing breastfeeding
 - Avoiding separation of mother and child
 - Not introducing changes to feeding practices without official guidance
 - Questions or uncertainty should be escalated to supervisors or technical leads.
 - Updated evidence or protocols should be followed as soon as these are formally communicated by managers or health authorities.

! Facilitator Tip

Reinforce that the table is meant to be a quick reference tool, not something to memorize. Remind participants that there are two sessions in this training which go deeper on related topics: one on Increasing Breast Milk Intake (Session 6), another on BMS-Dependent Infants (Session 8).

- **Refer:** Section: *If mother–child separation is necessary* (Participant Handbook)
- **Emphasize:** Separation is an **exceptional measure** and should only occur when explicitly recommended in national, disease-specific IYCF-E guidance. Frontline workers should never make this decision independently.
- **Explain:** Non-breastfed infants are particularly vulnerable during outbreaks owing to the loss of immune protection from breast milk and increased exposure to infection risks related to feeding practices.
- **Refer:** Section: *Infection prevention while continuing breastfeeding* (Participant Handbook).
- **Emphasize:** When breastfeeding continues during an outbreak, appropriate IPC measures are essential and must follow national disease-specific guidance.

Wrap up: “So far, we have focused on protecting breastfeeding and ensuring safe alternatives when needed. Complementary feeding is the next critical component of IYCF practices.”

3 Complementary feeding (3 min)

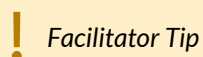
Action:

- **Explain:**
 - Complementary feeding is a critical IYCF practice for children 6 months and older and must be protected during infectious disease outbreaks, alongside continued breastfeeding.
 - Outbreaks often disrupt food availability, caregiving routines and hygiene practices, which can increase the risk of illness and malnutrition in young children.
- **Emphasize** three key points:
 1. **Hygiene is essential**
 - Support recommended food and feeding-related hygiene practices, based on the illness of concern.
 - Encourage caregivers to avoid high-risk feeding equipment that is difficult to clean, such as bottles or sippy cups with lids and spouts.
 2. **Diet quality matters**

- A balanced and diverse diet supports child growth and immune function.
- Malnutrition and specific nutrient deficiencies (such as in iron or zinc) can worsen the severity and duration of many infectious diseases.
- If food is limited, prioritize the safest and most nutrient-dense options available. Where possible, link families to available food or nutrition support.

3. Respect and work with family beliefs

- Acknowledge and understand practices: Stay respectful, ask open questions about why a belief or practice is used, and link guidance to the child’s wellbeing.
- Support safer adaptations and escalate when needed. Suggest small, safe changes to reduce infection or feeding risks; raise serious concerns to supervisors or technical leads.



Facilitator Tip

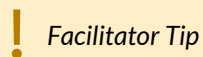
Explain that complementary feeding will be covered in more detail in an upcoming session, but it is highlighted here because it is often deprioritized during outbreaks, despite its importance.

Bridge: “Now let’s summarize the key learning points for this learning objective before moving on to the second one.”

4 Key takeaways and questions (2 min)

Action:

- **Refer:** Key learning points – Objective 1 (Participant Handbook).
- **Ask** whether participants have any questions before moving on.



Facilitator Tip

If you have an extra minute or want more discussion, ask: “Which of the practices we discussed today do you think will be most challenging to implement in your context?”

Bridge: “Now that we’ve explored how to protect recommended IYCF practices during an infectious disease outbreak, we’ll move to Objective 2, where you will learn how to adapt your counselling to support caregivers effectively in these challenging situations.”



LEARNING OBJECTIVE 2:

Identify key IYCF-E counselling adaptations during an infectious disease outbreak

Time: 20 min

1 Adapting IYCF-E service delivery (5 min)

Action:

- **Introduce:** “Suspending IYCF services often leads to increased use of breast milk substitutes, spread of misinformation, and missed opportunities to support breastfeeding and safe feeding. During infectious disease outbreaks, services should continue, but they need to be adapted to reduce infection risk while maintaining quality support.”
- **Remind participants:** Table: Adapting counselling in emergencies – Timing, duration, frequency (Participant Handbook, Session 1)
- **Show:** Table: Key adaptations to IYCF-E counselling service delivery during an infectious disease outbreak (Participant Handbook)
- **Optional engagement:** Ask participants to take turns reading a row and share brief reflections or examples from their own context.
- **Emphasize (briefly):**
 - Priority is given to the most vulnerable infants, children and caregivers.

- The mode, timing and frequency of counselling may change, but **standards of care remain the same**.
- Group programs can continue outdoors, in the community, or through hybrid/remote models.
- Maintain essential services by adjusting location, staffing or hours.
- Refer to good-quality community alternatives if facility-based services are disrupted.
- Increase availability of self-help resources online and in the community.



Facilitator Tip

Keep this section short. Remind participants that the table was introduced in Session 1. Highlight key adaptations during outbreaks, but avoid adding too much detail.

Bridge: “We’ve looked at how IYCF services adapt at the system level. Now we will focus on what might change during the counselling interaction itself.”

2 Communication adaptations during counselling in infectious disease outbreaks (5 min)

Action:

- **Introduce:** “Even when services continue, the counselling interaction itself often changes during an infectious disease outbreak. Fear, misinformation, stress, illness and infection-control measures can all affect how counselling happens. Let’s look at the key adaptations counsellors need to make, starting with communication.”

Key points: Challenges

- **Personal protective equipment (PPE)**
 - Depending on the disease, PPE may be needed to prevent transmission. Masks, face shields or full protective suits can limit facial expressions, visibility and physical proximity.
 - In some outbreaks, such as Ebola, PPE use might reduce the usual visual and emotional cues that support trust. This can be frightening for children and caregivers.
- **Physical distance**
 - For some infectious diseases, physical distancing from suspected or confirmed cases is required. This can affect usual ways of building rapport, which often rely on eye contact, body language, and proximity to feel safe and understood.
- **High stress and emotions**
 - Outbreaks place high emotional demands on both caregivers and responders.
 - Counsellors may be stressed, fatigued, or worried about their own families and safety.
 - Caregivers may be scared, angry, grieving or overwhelmed. This can reduce their ability to express their needs or absorb information.
 - Acknowledge that these reactions are normal and affect communication.



Facilitator Tip

Refer participants to the strategies discussed in Session 3: Addressing Stress in Emergencies, which highlights practical ways to manage stress during counselling and to maintain empathy, even under pressure.

Action:


- **Explain:** “Body language is the conscious and unconscious way we communicate through posture, facial expressions, gestures, tone of voice and eye contact. People often rely on these cues even more when they are stressed or afraid.”
- **Refer:** Exercise: Can you tell which person is smiling? (Participant Handbook)
- **Say:** “Let’s look at these images. Who do you think is smiling?”
- **Ask** participants to call out the letter of the person they think is smiling.
- **Correct answer:** Image D
- **Debrief:**
 - Even with a mask, many people can still identify emotion.
 - Small cues matter, like eyes, posture, and head position.

- Tone of voice, hand gestures, calm pacing, and pauses to acknowledge emotions also communicate empathy and safety.
- **Emphasize:** Counsellors may need to adapt their non-verbal communication by:
 - Slightly exaggerating positive movements,
 - Speaking clearly and slowly,
 - Checking understanding more frequently, and
 - Pausing to acknowledge emotions before giving technical advice

Bridge: “Now that we’ve explored how to adapt our communication during counselling, let’s move to another critical challenge: addressing fears, rumours and misinformation that often emerge during infectious disease outbreaks.”

3 Addressing fears and misinformation (5 min)

Action:

- **Explain:**
 - Outbreaks often amplify fears, rumours and misinformation. Low trust in authorities can drive people to informal or incorrect sources.
 - Misinformation is expected and not a personal failure of caregivers.
- **Share:** Practical tips:
 - Ask caregivers what they’ve heard and listen carefully.
 - Respond with curiosity and empathy, avoid judgment.
 - Provide correct information calmly and clearly, acknowledging evolving evidence.
 - Use concrete examples when possible (e.g., benefits of breastfeeding, vaccination).
- **Ask:**  “Have you ever encountered rumours or misinformation during an outbreak? How did you address them?”
- **Debrief:** Highlight strategies that worked, reinforce empathy and active listening.

! Facilitator Tip

Keep this section concise. If time allows, encourage one or two brief examples from participants. The goal is to show empathy and correct misinformation without spending too much time on anecdotes.

Bridge: “Now, we’ll move to some special considerations that may arise during outbreaks: supporting mothers and infants when separation occurs, handling milk safely and providing care for bereaved mothers.”

4 Special considerations (3 min)

Key point: Maintaining lactation during mother–child separation

- Separation is rare and disease-specific. Counsellors do not decide when separation occurs.
- Once separation is required, the counsellor’s role is to protect the mother’s health, breast milk supply and future breastfeeding options.
- Sudden weaning increases pain/mastitis and creates emotional distress for both mother and child.
- Assisted expression is acceptable when clinically appropriate, with strict IPC protocols.

Supporting a bereaved mother

- Presence, empathy and respectful listening matter more than technical advice.
- Avoid rushing decisions about lactation suppression. Instead, support a gradual decrease in milk supply or, if the mother wishes, discuss options such as wet nursing (breastfeeding another infant), where culturally acceptable and safely supported. Some mothers may find wet nursing to be comforting or supportive in coping with loss.
- Reassure mothers that support remains available, no matter their decision.
- Know and provide referral pathways for mental health and psychosocial care.



Facilitator Tip

Remind participants they are not expected to “fix” grief. Their role is to provide support, safely and humanely.

Bridge: “We’ve looked at how IYCF counselling needs to adapt during infectious disease outbreaks, including how services are delivered, how we communicate, how we address fears and misinformation, and how we support families facing exceptional situations. Let’s take a moment to highlight the key takeaways from this objective and address any questions before moving on.”

5 Key takeaways and questions (2 min)

Action:

- **Refer:** Key learning points – Objective 2 (Participant Handbook).
- **Ask** if participants have any questions before moving on.



Facilitator Tip

If you have an extra minute or want more discussion, ask: “Which counselling adaptation we discussed today do you think would make the biggest difference for caregivers during an outbreak?”

Bridge: “We will now move to Objective 3, where we’ll look specifically at how to provide effective remote IYCF-E counselling.”




LEARNING OBJECTIVE 3:


Identify key IYCF-E counselling adaptations during an infectious disease outbreak

Time: 25 min

1 Introduction (4 min)

Action:

- **Introduce:** “Remote counselling should complement in-person counselling whenever possible. However, in some contexts – infectious disease outbreaks, insecurity, access constraints, etc. – replacing in-person counselling with remote counselling may be the best or only option.”
- **Refer:** Section: What is remote counselling? (Participant Handbook)
- **Explain:** Why remote counselling is needed:
 - Physical distancing during outbreaks (e.g. COVID-19, Ebola)
 - Insecurity, disasters or damaged infrastructure
 - Population displacement and language needs
 - Limited availability of skilled counsellors locally
 - Need for specialized or referral-level counselling
 - When face-to-face counselling is not recommended or simply not feasible
- **Explain** the benefits: Reduced travel, lower infection risk, improved continuity of care, reduced costs
- **Ask:**  “What do you think are the main challenges of counselling remotely compared to in person?”
- **Sample answers:**
 - Limited visual or physical assessment
 - Less information gained from observing the home environment
 - Building trust without usual body language
 - Privacy and confidentiality concerns

- Technology and connectivity disruptions
- **Ask:**  “Looking at the Key Counselling Skills poster, which skills might be more challenging or need adaptation in a remote session?”
- **Capture** 2 to 3 answers.
- **Emphasize:** quality counselling skills are still possible in remote sessions. They will require **more intentionality, creative solutions and verbal reinforcement**, and they may require practise in advance if the method of counselling is unfamiliar. You will see these adaptations demonstrated in Step 3 and practised in Step 4.

Facilitator Tip


If time allows, invite brief sharing: “Is remote counselling something you already use in your context? Would anyone like to briefly share their experience?” Keep responses short (1–2 examples).

- **Wrap-up:** “Understanding the challenges and adaptations of remote counselling helps you prepare for effective sessions.”

Bridge: “Throughout this objective, we’ll follow the same 3A approach you already know. You don’t need to memorize all of this. The goal is to recognize what changes when counselling remotely. But before we can assess, analyse or act remotely, we first need to be well prepared. Let’s start with how to prepare for a remote counselling session.”

2 Prepare for a remote counselling session (4 min)

Action:

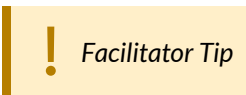
- **Say:** “Effective remote counselling starts before the session begins. Preparation helps reduce disruptions, protect privacy and allow you to focus on the caregiver rather than the technology.”
- **Refer:** Section: Prepare for a remote counselling session (Participant Handbook)
- **Explain:**
 - **Action 1 – Choosing the right technology**
 - The first step is choosing technology that works for both the counsellor and the client.
 - The ‘best’ technology is not the most advanced kind. It is the kind that is reliable, accessible, and comfortable for both the caregiver and counsellor.
 - When choosing a technology, consider what is commonly used in the community, which groups may face access or literacy barriers, and how the emergency may affect connectivity or the ability to buy data or minutes.
 - **Tip:** Encourage practising with a colleague before first use.
 - **Action 2 – Managing technology challenges**
 - Even with good preparation, technical issues are common. What matters is how we plan for them by anticipating problems, having backups, and staying calm and flexible.
 - **Action 3 – Setting up your counselling space and gathering supplies**
- **Ask:**  “What do you think are the most important elements of a good remote counselling space?”

Facilitator Tip

Ask participants to answer from their own experience, without looking at the Participant Handbook. This helps surface practical realities before confirming the full list.

- **Sample answers:**
 - **Headset:** keeps hands free, maintains privacy, supports demonstrations
 - **Pen and paper:** take notes to analyse and act on the feeding situation
 - **Information resources:** keep counselling cards/checklists ready; digital versions for sharing
 - **Demonstration tools:** baby mannequin, breast model, food models or demonstration videos for video calls

- **Quiet and good reception:** ensure privacy and minimize interruptions
 - **Emphasize:** “Your counselling space should help you stay focused, minimize distractions, and support effective assessment and counselling even when you are not physically present with the caregiver.”
- **Action 4 – Ensuring client privacy and confidentiality**
 - As an IYCF counsellor, you are trusted with very personal and intimate issues. Respecting privacy and confidentiality are essential, even when working remotely.
 - **Practical guidance:**
 - Make sure you can conduct your sessions alone in a room with no distractions.
 - Tell those you live or work with not to disturb you during your sessions.
 - Do not use the speaker function on your device. Instead, use a headset device to help protect your client’s privacy.
 - Counselling sessions should not be recorded.
 - Use end-to-end encrypted communication services and ensure that your counselling services abide by local data protection policies, laws and regulations.
 - Even though you are not physically present, confidentiality and privacy standards remain the same as in-person counselling. These steps protect both the caregiver and you.
- **Wrap up:** “Good preparation reduces technical stress, protects confidentiality and allows you to focus fully on the caregiver and child.”



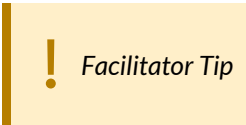
If time allows, invite brief sharing: “What preparation challenges do you anticipate in your context?” Encourage one or two short examples only.

Bridge: “Once we are prepared – with the right technology, space, and safeguards – we can move into the first step of the counselling process: assessing the feeding situation remotely.”

3 Assess the feeding situation (5 min)

Action:

- **Say:** “In remote counselling, assessment is often the most challenging step. You may not be able to see the mother, the child, or the feeding behaviours. Therefore, it’s even more important how you start the session and how you listen.”
- **Explain:** Assessing remotely is not about rushing through questions. It’s about creating safety, building trust and gathering enough information to understand the feeding situation.
- **Refer:** Section: *Assess the feeding situation* (Participant Handbook)
- **Explain** the four actions using the facilitator notes below.



Make sure you don’t spend too much time on the 3As. The best way to learn is to practise remote counselling. We’ll move quickly through the 3A approach so we have time for the demonstration and role-play in Steps 3 and 4.

Assess the feeding situation: Facilitator notes

Action 1: Starting the session well

A strong start helps establish trust, clarity and comfort, especially when you are not physically present.

- Introduce yourself slowly and clearly (connections may lag).
- Confirm:
 - Am I speaking with the client?
 - Is this still a good time?
 - Can the caregiver hear you clearly?
 - Are they in a place where they feel comfortable talking?

- Explain:
 - How long the session will last
 - What will happen if the call drops
- Reassure confidentiality very early in the session, as caregivers may worry more during remote calls.
- Agree on a simple signal or phrase to pause or change the topic if privacy is suddenly compromised.

Why this matters remotely:

- Caregivers may feel uncertain or rushed on the phone.
- Clear expectations reduce anxiety and distractions.
- A calm start improves the quality of information you receive.

Action 2: Creating a safe and supportive space (WITHOUT physical presence)

In remote counselling, your voice often replaces your body language.

- Tone, pace and silence carry more meaning.
- Caregivers may hesitate to interrupt or ask questions. Check in with the client to ask if they are understanding or if they have any questions.
- Use verbal empathy more frequently:
 - “That sounds really difficult.”
 - “You’re doing your best in a hard situation.”
- Pause often and invite the caregiver to speak.
- Listen for:
 - Changes in voice
 - Long pauses
 - Signs of distress you would normally see on someone’s face

Key message: Remote assessment requires *intentional emotional check-ins*, not just questions.

Action 3: Assessing feeding challenges remotely

Because you may not see the feeding, you need to rely more on how you ask and how you listen.

- Ask more open-ended and descriptive questions:
 - “Can you walk me through the last time you fed your baby?”
 - “What does your baby do when feeding starts?”
- Break complex questions into smaller parts.
- Ask caregivers to *describe* what you would normally observe.
- Summarize frequently:
 - “Let me check that I understood correctly...”

Important difference from face-to-face:

- You may need *more time* to assess.
- You must confirm understanding more often.
- Assumptions are riskier when visual cues are missing.

Action 4: Adapting assessment to the modality

Assessment looks different depending on whether you’re using voice-only or voice-and-video.

- **Voice-only**
 - Ask more clarifying questions
 - Use simple language

- Encourage descriptive explanations
 - Use images if possible: images can be used *before, during or after* the call, if the caregiver has access to a phone or computer that can receive messages or emails.
 - **Voice-and-video**
 - Observe posture, positioning and interaction
 - Ask permission before observing feeding
 - Use demonstrations or visual aids if helpful
- The goal is not perfection. The goal is to gather *enough* information to support the caregiver safely.**

- **Remind** participants that they already have these skills from in-person counselling. Remote counselling requires *adapting*, not starting from zero.

Bridge: “Now that you have gathered information about the caregiver and their infant, it’s time to analyse the information: identify feeding challenges, understand their possible causes and decide which issues to focus on.”

4 Analyse the feeding challenges (5 min)

Action:

- **Say:** “Analysis builds on assessment: What does this information suggest?”
- **Explain:**
 - **Assess** = gather information
 - **Analyse** = interpret that information to understand **why** the problem is happening
 - Your goal is not to solve everything immediately but to understand the situation clearly, so you can act effectively in the next step.
- **Refer:** Section: *Analyse the feeding challenges* (Participant Handbook)
- **Explain** the 3 actions using the facilitator notes below.

Analyse the feeding challenges: Facilitator notes

Action 1: Identify the feeding challenge(s)

Analysis begins once enough information has been gathered to move from “what is happening” to “what might be going wrong.”

- At this stage, the counsellor moves from listening to interpreting.
- Remote counselling often reveals multiple, interconnected concerns (e.g., pain, milk-supply worries, fatigue).
- Identifying challenges does not mean solving them yet.
- The goal is to clearly recognize what might be going wrong.

Acknowledging the caregiver’s concern is part of the analysis process.

Action 2: Explore possible causes using what you can see, hear, and ask

In remote counselling, analysis requires intentional questioning and careful interpretation to compensate for limited visual information.

- Analysing feeding challenges means understanding the **causes**, not just the symptoms.
- In remote counselling, this often requires:
 - Asking more targeted questions than in face-to-face sessions
 - Using a process of elimination
 - Guiding the caregiver to describe what they are seeing or experiencing
- Use everyday language the caregiver understands.

- Descriptive prompts help counsellors “see” feeding remotely (e.g., mouth position, pain timing, feeding behaviour).

What can I see? (video sessions)

- Appearance of caregiver and infant (tired, distressed, comfortable)
- Ability to demonstrate feeding or positioning
- Environmental clues that may affect feeding

What can I hear? (all remote sessions)

- Emotional cues (tearful, anxious, confident)
- Signs of stress or distraction
- Background noises that provide context

What can I ask?

- Ask clarifying questions when information is incomplete.
- Move from open questions to more specific ones when needed.
- Check understanding before drawing conclusions.

Careful listening is especially critical in voice-only counselling.

Action 3: Prioritize issues to address

Prioritization is essential in remote counselling, where time, attention and connection may be limited.

- Remote sessions may be shorter or interrupted.
- Addressing too many issues can overwhelm the caregiver.
- Work with the caregiver to decide what to focus on.
- Prioritize:
 - Issues causing the most distress
 - Issues affecting feeding immediately
 - Issues that can be safely addressed now

Other concerns can be acknowledged and scheduled for follow-up.

- **Remind** participants that analysis is a skill they already use in face-to-face counselling. Remote counselling requires greater intentionality in questioning, listening and interpretation – *not* a different way of thinking.

Bridge: *“Once the feeding challenges are clearly identified and prioritized, the next step is to act – by agreeing on practical, realistic actions that respond to the caregiver’s needs and fit the remote setting.”*

5 Act to address the feeding challenges (5 min)

Action:

- **Say:** *“Now that we’ve assessed the situation and prioritized key feeding challenges, it’s time to take action. This means working with the caregiver to discuss practical solutions and agree on behaviour changes that can improve the situation.”*
- **Explain:** Discuss the prioritized challenges further with the caregiver and jointly agree on realistic, achievable actions.
- **Refer:** *Section: Act to address the feeding challenges* (Participant Handbook)
- **Explain:** This step includes three actions, outlined below.

Act to address the feeding challenges: Facilitator notes

Action 1: Discuss key feeding challenges and agree together on solutions

Use simple, clear language and avoid technical terms. Confirm the caregiver understands your suggestions.

- Check understanding frequently: This is especially important in voice-only sessions where visual cues are missing.
- Use tools and resources to support counselling. Sending images, videos or links can help caregivers to visualize correct techniques and reinforce what they've learned.
- **Tips:**
 - If using a video call, demonstrate techniques with a mannequin, breast model or food props.
 - Ensure caregivers know how to access and use the resources you send.

Acknowledging the caregiver's concerns and emotions builds trust and creates the conditions for effective action.

Action 2: Finish the session positively

Ending a session well builds confidence and increases the likelihood that caregivers will practise the agreed actions at home.

- Recap the key behaviour changes or actions discussed.
- Encourage the caregiver to try the techniques and observe progress.
- Acknowledge the caregiver's positive efforts and provide reassurance to build confidence.

Schedule follow-up sessions: Consistent follow-up helps caregivers address ongoing challenges.

- Ask for consent before scheduling additional sessions.
- Agree on frequency, day, and a time that fits both the caregiver's schedule and access to technology.
- Adapt session duration based on the complexity of the challenges.

Make referrals as needed. Always follow your organization's referral pathways and explain clearly to the caregiver what the referral involves – and why it is being made.

Action 3: Support after the session

Even after the session, caregivers can continue receiving guidance.

- Send follow-up educational materials (e.g. handouts, images, short videos, links) via text or email to reinforce agreed actions.
- Share clear contact information so caregivers know how to reach you if questions or concerns arise.
- Inform caregivers about available hotlines, call centres or community-based support mechanisms, if applicable.

Acknowledging caregivers' concerns and checking in after the session reinforces trust and supports continued behaviour change.

- **Remind** participants that acting on feeding challenges is a skill they already use in face-to-face counselling. In remote counselling, the same skills apply, but greater intentionality is required in communication, follow-up and support.

Bridge: *"We've just reviewed how to act on feeding challenges remotely. Before we move on to practising these skills in Steps 3 and 4, let's take a moment to summarize the key takeaways from this objective."*

6 Key takeaways and questions (2 min)

Action:

- **Refer:** *Key learning points – Objective 3* (Participant Handbook).
- **Ask** whether participants have any questions before moving on.



Facilitator Tip

If you have an extra minute or want more discussion, ask: “Which adaptations for remote counselling do you think would be most important in your own context?”

Bridge: “Now that we’ve covered the principles of effective remote IYCF-E counselling, we will move to Step 3. Here, you will observe a demonstration by the facilitators to see how these principles are applied in a real remote counselling session.”

STEP 3: Demonstrate

 35 min

1 Introduction (2 min)

Action:

- **Introduce:** “In this demonstration, we will be exploring a scenario with Sofia and Sara. The session will follow the structure of **Assess, Analyse and Act**, the three key steps of remote IYCF-E counselling. Pay attention to how the counsellor interacts with Sofia to build trust and support behaviour change, even though this is a voice-only session.”
- **Add:** “You will also notice the counsellor applying three of the general counselling skills to help create emotional safety and trust, even in a voice-only session:
 - Reflect back what the mother/caregiver says,
 - Give some relevant information, and
 - Use simple language.”
- **Refer:** *Case study: Sofia and Sara* (Participant Handbook).
- **Summarize** the case:
 - **Setting:** Remote counselling via cell phone due to COVID-19 restrictions
 - **Mother:** Sofia, in her 20s
 - **Baby:** Sara, 3 weeks old
 - **Reason for contact:** Sofia is struggling with breastfeeding. First-time counselling session remotely.

Note: For this demonstration, we have **five pre-recorded audio files**, performed by professional actors, following the script you will see below. These recordings are available in English, French, Spanish, Arabic and Indonesian. They correspond to the different stages of the counselling session: two files for Assess, two files for Analyse, and one file for Act.

2 Script (28 min)

Action:

- Use the sound files or live acting



Facilitator Tip

- Check the audio before the training session starts to make sure all files play correctly and the volume is appropriate for the room.













- If audio is not possible, two facilitators will act the roles of the counsellor and Sofia. One facilitator should lead the prompts and discussion.
- If acting without audio, the two role-players should sit back-to-back so they cannot see each other, simulating a voice-only counselling environment.




- **Explain:** “For the first step of the demo – ASSESS – we will show a version of the session where the counsellor does not demonstrate best practices. This is to help you understand what **not** to do and to put you in Sofia’s shoes. You will then see a corrected version.”

ASSESS Version 1

- **Say:** “Look out for any ways you think the counsellor could improve how she starts this remote counselling session.”
- **Play audio file:** *Assess_1_EN.mp3* (or FR / SP / AR / ID) – (00:55)

Sound of a phone ringing and then being picked up.

	Sofia	<i>[Sounding nervous, uncertain]</i> Hello?
	Counsellor	<i>[Sounds rushed, with a cold tone of voice, a bit mechanical]</i> Hi – it’s Fatima, your infant and young child feeding counsellor. Sorry I’m late for our session.
	Sofia	<i>Sounds of a child crying in the background</i> <i>[Tired]</i> This isn’t a great time. I’m very busy right now.
	Counsellor	<i>[Unsympathetic, not picking up on SOFIA’s tone]</i> That’s fine – this will only take five minutes.
	Sofia	<i>[Sighs]</i>
	Counsellor	<i>[Ignores SOFIA’s unhappiness. Speaking quite coldly and quickly, as though reading from a script, no feeling]</i> This call is to check if you are following the IYCF recommendations properly and exclusively breastfeeding the baby.
	Sofia	<i>[Sounds a bit confused]</i> Right...
	Counsellor	<i>[Doesn’t notice SOFIA is unsure of what’s going on, ploughs ahead with her checklist of questions regardless]</i> How old is your baby?
	Sofia	Three weeks.
	Counsellor	And how are you feeding the baby?
	Sofia	I’m breastfeeding her.
	Counsellor	OK.



		<i>[Reads next question as though straight from a textbook]</i> Are you having any difficulties?
	Sofia	<i>[Sounds tearful]</i> Yes, it's very hard. I don't know if this is working.
	Counsellor	<i>[Continues as though going through a checklist rather than sympathizing with SOFIA's distress]</i> Right. Can you give me further details?
	Facilitator	<p>Prompt:</p> <ul style="list-style-type: none"> • What did you notice about the counsellor's tone and approach in this version? • How do you think Sofia felt during this call? • What could the counsellor have done differently to make Sofia feel more at ease and listened to? <p>Explanation:</p> <ul style="list-style-type: none"> • The counsellor sounded rushed, cold, and mechanical → Sofia likely felt anxious, unheard and judged. • No greeting, no confirmation of consent, no empathy shown and no attempt to make Sofia comfortable. • Counselling felt like a checklist rather than a supportive conversation. <p>Here's what we think the counsellor could have done differently:</p> <ul style="list-style-type: none"> • Introduce herself properly at the start of the call • Request Sofia's consent to continue the call • Make sure Sofia was comfortable and ready to talk • Pay attention to the tone of Sofia's voice and what she was saying • Be sympathetic to Sofia's feelings and concerns, and demonstrate empathy • Ask for the baby's name and age • Speak warmly and with a smile (even though Sofia can't see her) • Use simple, non-technical language • Give praise straightaway for things Sofia is doing well to boost her confidence


















ASSESS Version 2

Rewind and reset

- **Say:** "Now, let's rewind and reset this session. We'll play the Assess stage again, but this time the counsellor is going to do all she can to start the session off well. As we go through, pay attention to how she builds trust, creates a safe space and starts to gather information."
- **Play audio file:** Assess_2_EN.mp3 (or FR / SP / AR / ID) – (02:03)

Sound of a phone ringing and then being picked up.

	Sofia	<i>[Sounding nervous, uncertain]</i> Hello?
	Counsellor	<i>[Warm, friendly voice, sounds like she's smiling]</i> Hi, this is Fatima from MotherAid. I'm calling to see how you and your baby are doing and how their feeding is going. Is this a good time for you? Our session will last approximately 30 minutes.

	Sofia	<i>Sounds of a child crying in the background</i> [Sounds unsure, but calmed slightly by FATIMA's warm tone] I... I am quite busy, but I can talk, yes.
	Counsellor	Would you like to continue the call now, or would you prefer I call you another time?
	Sofia	No, we can continue.
	Counsellor	[Warm, understanding tone] Thank you. I appreciate it. Are you somewhere quiet and comfortable? Is there anyone who could look after your children while we talk?
	Sofia	Yes, my husband is going to look after them while I'm on the call.
	Counsellor	[Voice shows she's clearly smiling] That's great! I'd just like to confirm that this call will be completely confidential. Are you happy for us to get started?
	Sofia	Yes, thanks, I'm OK to begin.
	Counsellor	Excellent. So, I'd like to ask you a few questions about how your baby is doing. Could you tell me your baby's name and how old they are?
	Sofia	[Sounding tired, but also quite proud] Yes. She's called Sara, and she is three weeks old.
	Counsellor	And how are things going? It sounds like you're very busy.
	Sofia	[Sighs slightly] Yes, I'm very tired.
	Counsellor	[Warm voice] I understand. It's hard work having a newborn, especially when there are other children about.
	Sofia	[Gives a slightly weary laugh] Yes.
	Counsellor	And could you tell me about how you're feeding Sara?
	Sofia	I'm breastfeeding her.
	Counsellor	[Bright tone of voice] That's great; you should be very proud. Breastfeeding gives your baby the healthiest start in life, so you're doing a great job there. How is breastfeeding going for you and Sara?
	Sofia	[Sounds a little tearful] It's very hard. I don't know if this is working.



Counsellor

[Sympathetic voice]

I'm sorry to hear it's been challenging. Let's talk some more about this...



Facilitator

Prompt:

- What changed between the bad and good versions?
- How does Sofia likely feel now compared to before?
- What techniques helped build trust remotely?

Explanation:

- Warm greeting, smiles through voice, empathy, and checking consent make Sofia feel safe.
- Asking about the environment and comfort demonstrates care.
- Non-judgmental, clear language fosters openness.

Reflection:

- One of the challenges that a remote counsellor faces is how to help the client feel comfortable, safe and open to behaviour changes.
- The counsellor had a positive and empathetic attitude. Sofia felt much safer, more relaxed and more trusting.
- Having a positive mindset is what you can bring to every interaction. Smile – even when your client can't see you – and use a warm, positive tone of voice. Leave any judgment, negative comments or stress out of the counselling session.

ANALYSE

- **Say:** "The counsellor and Sofia are continuing their counselling session, and the counsellor is about to discover an issue that Sofia is having with her breastfeeding."
- **Play audio file:** *Analyse_1_EN.mp3 (or FR / SP / AR / ID) – (00:33)*

Starting to analyse



Counsellor

[Sympathetic voice]

I'm sorry to hear it's been challenging. Let's talk some more about this. What's concerning you?



Sofia

[Sounding quite tearful]

My breasts really hurt. This never happened with my other children. I don't know what I'm doing wrong this time.



Counsellor

[Warm, understanding]

Every baby is different. You're doing a wonderful job by breastfeeding. We just need to work out how to help you. Where are you feeling the pain?



Sofia

It's my nipples. They are so sore.



Counsellor

I'm really sorry to hear that, Sofia...



Facilitator

Prompt:

- The counsellor now knows that Sofia is suffering from nipple pain, but she doesn't yet know why. Since this is a voice-only call, what next steps could the counsellor take to analyse the feeding situation?

Explanation:

- Ask some more specific questions to narrow down the issue and eliminate some possibilities
 - Use creative and descriptive language to try and 'see' what's going on
- Before moving onto other concerns, it is important that the counsellor assesses this issue in depth.

Investigating further

- **Say:** "The counsellor decides to ask some more questions about Sofia's breast pain. She then thinks through what the information suggests to her."
- **Play audio file:** *Analyse_2_EN.mp3* (or FR / SP / AR / ID) - (01:44)



Counsellor

I'm really sorry to hear that, Sofia. Are you experiencing any bleeding or cracking around your nipples?



Sofia

Yes! Both my nipples are bleeding and the skin is cracked. I think that's what hurts so much.



Counsellor

The bleeding and cracking must be really painful. Do you have pain anywhere else in your breasts?



Sofia

No.



Counsellor

[A thought happening inside her own head]

Hmm, doesn't sound like blocked ducts, then. I bet this is an issue with positioning and attachment.

[Out loud again to SOFIA]

Do you experience pain when Sara latches and/or when she's feeding?



Sofia

Yes, it's quite painful.



Counsellor

[Inside her own head]

OK, it does seem to be an issue with latch and positioning, then. How am I going to ask about that over the phone?

[Out loud again to SOFIA]

OK, I'd now like to understand how Sara is attaching to your breast. When Sara is approaching your nipple, what does her mouth look like? Is it open really wide, like she's yawning? Or are her lips curled in and her mouth quite small?



Sofia

Um... I think mostly her mouth is small and curled in, like you described.



Counsellor

OK, and the darkened area around your nipple – the areola – how much of it can you see while Sara is feeding?



Sofia

Lots of it. Is that a problem?



Counsellor

[In her own head]

So, yes, it's an attachment issue.

[Out loud to SOFIA]

Don't worry – this is quite a common challenge, but it's one that we can address. It sounds like Sara isn't attaching to your breast well. Let's discuss this some more...



Facilitator

Prompt:

- What did the counsellor do well while analysing Sofia's feeding challenge?

Explanation:

- She showed empathy by acknowledging Sofia's feelings
 - She investigated different options and proceeded by elimination
 - She used precise but non-technical language in her questions
- In voice-only sessions, descriptive questions and clear language are essential.*

Sofia's other concern

- **Say:** "Later in the session, Sofia shares that she's worried she doesn't have enough milk and is thinking of giving Sara infant formula."
- **Note:** We don't have a full dialog for this part and the next one to keep the demonstration concise.



Facilitator

Prompt:

- Based on what you know of Sofia's situation, what steps would you take to best analyse this situation?

Explanation:

- Ask Sofia why she feels she doesn't have enough milk
- Ask Sofia about Sara's weight history and about how many times she is feeding and how many wet diapers she has each day.
- Assure Sofia that her body is capable of making enough breast milk to meet Sara's needs

It's important for Sofia to understand that Sara should be exclusively breastfed because she is only three weeks old and this is the healthiest way to feed her. Encourage Sofia to keep breastfeeding, and assure her that the more she breastfeeds Sara, the more milk her body will make.

Prioritizing challenges

- **Say:** "Sofia and the counsellor identified two key feeding challenges to address during the session:
 - Sara's latch, which is causing nipple pain
 - Sofia's concern about whether she is producing enough breast milk
 Later in the discussion, Sofia also asked about how to express her breast milk when she returns to work in two months."



Facilitator

Prompt:

- At this point in the session, Sofia has raised several concerns. **What should the counsellor and Sofia prioritize addressing during this session? Why?**

Explanation:

- **Prioritize key feeding challenges:**
 - Your analysis will often reveal **multiple feeding challenges**. However, it is rarely helpful – especially in a remote session – to address everything at once.
 - As a counsellor, you should usually **prioritize 2–3 key issues** to discuss during the **Act** stage, to avoid overwhelming the mother or caregiver.
- **Sofia's situation:**

- *In Sofia's case, the latch issue and her concern about milk supply are **immediate and interconnected**. These are not issues that need to be postponed. A counsellor can address more than one feeding challenge within a single session.*
- *However, Sofia's question about expressing breast milk for returning to work in two months is **less urgent**. Given her current pain and worries, it makes sense to agree to discuss milk expression in a **future session**.*
- **Shared decision-making:**
 - *When prioritizing challenges, it's important to do this **together with the client**.*
 - *Always take the mother's concerns seriously. If something is worrying her, it deserves attention.*
 - *Prioritization is not about ignoring issues but about **sequencing support in a way that feels manageable and respectful**.*

ACT

- **Say:** "The counsellor now begins to guide Sofia on how to address the feeding challenges identified earlier, focusing on latch, positioning and boosting Sofia's confidence with breastfeeding."
- **Play audio file:** Act_EN.mp3 (or FR / SP / AR / ID) – (02:27)



Counsellor

You're doing a great job with breastfeeding, but let's work on making it less painful for you and helping Sara latch on better. Does that sound OK?



Sofia

Yes, thank you.



Counsellor

Great. Let's talk about breastfeeding positions and attachment. I'm going to send you some images to your phone.



Sofia

Yes, I've just received them.



Counsellor

Perfect. I'd like you to take a look at the first photo. This shows an example of what we call the "cradle position". Can you see how the mother in the image has put a pillow beneath the baby?



Sofia

Yes, I can see.



Counsellor

Doing that would help you properly position Sara to set her up for a strong latch. In this position, you're able to move Sara so that your bodies are fully touching and there's no space between the two of you. This is also important for a strong latch.



Sofia

OK.



Counsellor








Does that make sense to you?



Sofia

Yes, it does. When I breastfeed, there's normally space in between us. So it's useful to know that I need to keep Sara's body close to mine.

[Conversation continues]

	Counsellor	...and in the last photo, you see how the baby's mouth is really wide open?
	Sofia	<i>[Sounding sure]</i> Mm-hmm.
	Counsellor	That's what you want. If Sara looks like that and you lead her into your breast chin-first, she should latch on well.
	Sofia	OK.
	Counsellor	Does all that make sense? Do you have any questions or anything you'd like me to explain again?
	Sofia	<i>[Sounding confident]</i> No, I think I understand. I just need to try it out.
	Counsellor	I'm really glad to hear you sound so positive about it. Remember, you've got these images to refer back to whenever you like, and I will be following up with you soon during our next session. As we discussed earlier, Sara is getting enough breast milk, so this is just about making you more comfortable. It may take some practice to improve positioning, but you and Sara can learn together. Remember, if you are experiencing pain after she has latched, gently unlatch her using the technique we discussed and try again. With a good position, your nipple pain will get better really soon.


**Facilitator****Prompt:**

- How did the counsellor empower Sofia to take action?
- How did she reinforce confidence and provide clear steps?

Explanation:

- The counsellor used **clear, simple, non-technical language**, which is especially important in remote counselling and outbreak contexts where stress and misinformation are common.
- She used **visual aids sent to the phone** to compensate for the lack of in-person demonstration.
- She broke actions into **small, practical steps**, making behaviour change feel manageable.
- She **gave choices**, not commands, allowing Sofia to remain in control of decisions about feeding.
- The counsellor consistently **acknowledged Sofia's efforts and strengths**, reinforcing confidence and motivation to try new practices.

3 Debrief (5 min)**Action:**

- **Ask:**  "After watching this demonstration, would you feel comfortable providing remote IYCF-E counselling during an infectious disease outbreak?" "If not fully comfortable yet, what would help you feel more prepared?"
- **Collect:** 2-3 short answers.

Bridge: “Thank you for observing the demonstration. Remember, during infectious disease outbreaks our role is to listen carefully, give clear and simple information, and support caregivers to make safe feeding decisions in difficult circumstances. Now, you’ll have the opportunity to practice these skills yourselves through a short role play.”

STEP 4: Role-Play

 30 min

1 Introduction (5 min)

Action:

- **Say:** “In this role-play, you will practice applying the Assess – Analyse – Act approach during a remote, voice-only IYCF counselling session, using the skills discussed throughout the session.”
- **Explain:** The role-play is a first remote counselling session with Miriam, a mother of a newborn, Sam, who was born slightly early and is following the feeding advice received at the health facility. This session takes place in an Influenza A context.
- **Organize:** Ask participants to form groups of 3: **Counsellor, Miriam, Observer**. Participants stay in the same groups as previous sessions but rotate roles so that the previous observer is now a counsellor or Miriam.
- **Explain:** The counsellor and Miriam should sit back-to-back so they don’t see each other. You may use your phones (without calling) or simply speak aloud to simulate a phone conversation.
- **Distribute:** Hand out the role cards to each “Miriam” (*prepared in advance the role-play card – Miriam from the Annex 5.1*).
- **Explain:** The observer uses the Counselling Skills Checklist to note strengths and areas for improvement.
- **Remind:** Counsellors should practice using the three key skills demonstrated in Step 3:
 - Reflect back what the mother/caregiver says.
 - Give some relevant information.
 - Use simple language.
- **Allow:** Give groups 2–3 minutes to get ready before beginning their role-plays. Participants can take a minute to review the Counselling Skills Checklist to refresh their memory of the key recommendations discussed during the session.
- **Time:** The role play lasts around 10 minutes.

4 Role-play practice (10 min)




Action:


- **Encourage:** Ask groups to start quickly and use their full time.
- **Support:** Move quietly between groups, observe, and answer questions if needed.
- **Manage time:** Give a **5-minute** and **2-minute** warning so participants can pace themselves.
- **End:** Stop the activity on time, even if some groups have not finished the full role-play.

4 Debrief (15 min)

Action:

- **Gather:** Bring everyone back together and thank participants for their role plays and effort.

- Ask to “Miriam’s”  :
 - “How did it feel to be in Miriam’s place?”
 - “What was most challenging about expressing your concerns or asking for guidance?”
- Ask to observers  :
 - “What strengths did you notice in the counsellor’s approach?”
 - “What areas could be improved?”
 - “Did the counsellor use clear descriptive language and check for understanding?”
- Ask to counsellors  :
 - “How did it feel to be in the counsellor role?”
 - “What was most challenging about guiding a mother remotely? What worked well?”
- **Refer:** Role-play debrief: Miriam (Participant Handbook).
- **Add:** Highlight key points if they do not come up. Use the debrief box from the participant Handbook to add practical advice that should have been applied during the counselling session (build trust through empathy, acceptance, and non-judgment; guide step-by-step and check understanding; encourage the mother while addressing feeding challenges; prioritize 2–3 key issues; summarize next steps and follow-up).

 **Facilitator Tip**

Check with participants if they thought about using a regulation technique from Annex 1 to help Miriam manage her stress or worries. If time allows, invite participants to practice one now.


Bridge: “This role-play demonstrates how effective IYCF-E counselling can take place even without visual contact. By combining empathy, clear communication, thoughtful prioritization, and step-by-step guidance, counsellors can support mothers to overcome feeding challenges remotely. In Step 5, we’ll reflect individually on what you’ve learned in this session and how you can apply it in your counselling practice.”

STEP 5: Self-reflection

 5 min

Action:

- **Invite:** Ask participants to take a quiet moment to reflect and note their answers in the Participant Handbook.
- **Guide:** Read the three questions (also in the participant Handbook) out loud and give participants 2–3 minutes of silence to think/write.
- **Share (optional):** If time allows, invite 1–2 volunteers to share a key takeaway.
- **Close:** Thank participants for their reflections and emphasize that applying these insights in real-life counselling is where change happens.

 **Facilitator Tip**

Keep the activity short and personal. This is not a group discussion but an opportunity for each participant to consolidate their own learning.

ANNEX 5.1: Role-play card – Miriam Cut the cards below and provide one to each participant acting Miriam.

<p style="text-align: center;">Card: Miriam</p> <p>You tell the counsellor:</p> <ul style="list-style-type: none"> You are trying to hand-express your milk and feed Sam with a cup, as advised at the health facility, but you feel unsure about your technique. Expressing your milk is painful, and you worry you are not producing enough. You are concerned you may have Influenza A and are afraid of passing it to Sam through your breast milk. <p>If you feel safe and trust the counsellor, you may say:</p> <ul style="list-style-type: none"> You feel anxious, tired, and uncertain, but you are trying your best. 	<p style="text-align: center;">Card: Miriam</p> <p>You tell the counsellor:</p> <ul style="list-style-type: none"> You are trying to hand-express your milk and feed Sam with a cup, as advised at the health facility, but you feel unsure about your technique. Expressing your milk is painful, and you worry you are not producing enough. You are concerned you may have Influenza A and are afraid of passing it to Sam through your breast milk. <p>If you feel safe and trust the counsellor, you may say:</p> <ul style="list-style-type: none"> You feel anxious, tired, and uncertain, but you are trying your best.
<p style="text-align: center;">Card: Miriam</p> <p>You tell the counsellor:</p> <ul style="list-style-type: none"> You are trying to hand-express your milk and feed Sam with a cup, as advised at the health facility, but you feel unsure about your technique. Expressing your milk is painful, and you worry you are not producing enough. You are concerned you may have Influenza A and are afraid of passing it to Sam through your breast milk. <p>If you feel safe and trust the counsellor, you may say:</p> <ul style="list-style-type: none"> You feel anxious, tired, and uncertain, but you are trying your best. 	<p style="text-align: center;">Card: Miriam</p> <p>You tell the counsellor:</p> <ul style="list-style-type: none"> You are trying to hand-express your milk and feed Sam with a cup, as advised at the health facility, but you feel unsure about your technique. Expressing your milk is painful, and you worry you are not producing enough. You are concerned you may have Influenza A and are afraid of passing it to Sam through your breast milk. <p>If you feel safe and trust the counsellor, you may say:</p> <ul style="list-style-type: none"> You feel anxious, tired, and uncertain, but you are trying your best.
<p style="text-align: center;">Card: Miriam</p> <p>You tell the counsellor:</p> <ul style="list-style-type: none"> You are trying to hand-express your milk and feed Sam with a cup, as advised at the health facility, but you feel unsure about your technique. Expressing your milk is painful, and you worry you are not producing enough. You are concerned you may have Influenza A and are afraid of passing it to Sam through your breast milk. <p>If you feel safe and trust the counsellor, you may say:</p> <ul style="list-style-type: none"> You feel anxious, tired, and uncertain, but you are trying your best. 	<p style="text-align: center;">Card: Miriam</p> <p>You tell the counsellor:</p> <ul style="list-style-type: none"> You are trying to hand-express your milk and feed Sam with a cup, as advised at the health facility, but you feel unsure about your technique. Expressing your milk is painful, and you worry you are not producing enough. You are concerned you may have Influenza A and are afraid of passing it to Sam through your breast milk. <p>If you feel safe and trust the counsellor, you may say:</p> <ul style="list-style-type: none"> You feel anxious, tired, and uncertain, but you are trying your best.



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Card: Miriam

You tell the counsellor:

- You are trying to hand-express your milk and feed Sam with a cup, as advised at the health facility, but you feel unsure about your technique.
- Expressing your milk is painful, and you worry you are not producing enough.
- You are concerned you may have Influenza A and are afraid of passing it to Sam through your breast milk.

If you feel safe and trust the counsellor, you may say:

- You feel anxious, tired, and uncertain, but you are trying your best.

Card: Miriam

You tell the counsellor:

- You are trying to hand-express your milk and feed Sam with a cup, as advised at the health facility, but you feel unsure about your technique.
- Expressing your milk is painful, and you worry you are not producing enough.
- You are concerned you may have Influenza A and are afraid of passing it to Sam through your breast milk.

If you feel safe and trust the counsellor, you may say:

- You feel anxious, tired, and uncertain, but you are trying your best.

Card: Miriam

You tell the counsellor:

- You are trying to hand-express your milk and feed Sam with a cup, as advised at the health facility, but you feel unsure about your technique.
- Expressing your milk is painful, and you worry you are not producing enough.
- You are concerned you may have Influenza A and are afraid of passing it to Sam through your breast milk.

If you feel safe and trust the counsellor, you may say:

- You feel anxious, tired, and uncertain, but you are trying your best.

Card: Miriam

You tell the counsellor:

- You are trying to hand-express your milk and feed Sam with a cup, as advised at the health facility, but you feel unsure about your technique.
- Expressing your milk is painful, and you worry you are not producing enough.
- You are concerned you may have Influenza A and are afraid of passing it to Sam through your breast milk.

If you feel safe and trust the counsellor, you may say:

- You feel anxious, tired, and uncertain, but you are trying your best.

Card: Miriam

You tell the counsellor:

- You are trying to hand-express your milk and feed Sam with a cup, as advised at the health facility, but you feel unsure about your technique.
- Expressing your milk is painful, and you worry you are not producing enough.
- You are concerned you may have Influenza A and are afraid of passing it to Sam through your breast milk.

If you feel safe and trust the counsellor, you may say:

- You feel anxious, tired, and uncertain, but you are trying your best.

Card: Miriam

You tell the counsellor:

- You are trying to hand-express your milk and feed Sam with a cup, as advised at the health facility, but you feel unsure about your technique.
- Expressing your milk is painful, and you worry you are not producing enough.
- You are concerned you may have Influenza A and are afraid of passing it to Sam through your breast milk.

If you feel safe and trust the counsellor, you may say:

- You feel anxious, tired, and uncertain, but you are trying your best.

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SESSION 6: INCREASING BREASTMILK INTAKE



LEARNING OBJECTIVES

1. Assist a mother or caregiver to increase breast milk intake
2. Assist a mother or caregiver with relactation and induced lactation



COUNSELLING SKILLS FOCUS*

- Recognize and praise what a mother or caregiver and baby are doing right
- Give some relevant information
- Give practical help

**Reminder: The full 3As process and counselling skill set remain essential. The focus on these particular three skills is for practice and learning purposes.*



Material and preparation:

- **Video Drip-Drop Method (Step 2):** Session 6_Video_Drip-Drop-Method.mp4. **Test and review the video** in advance to familiarize yourself with the method.
- **Infographic Drip-Drop Feeding (Step 2):** The visual included in *Job Aid 6.2: Drip-Drop Feeding* is also available in multiple languages : [DRIP-DROP FEEDING - La Leche League International](#).
- **Infographic Cup Feeding (Step 2):** The visual included in *Job Aid 6.3: Cup Feeding* is also available in multiple languages: [Cup Feeding - La Leche League International](#).
- **Role-play cards – Rima and Rima’s Mother (Step 4):** Cut cards for approximately one-third of participants from Annex 6.1 and Annex 6.2 (at the end of this session).
- **Spoons and cups for practice (Step 4):** Provide 6–8 spoons and cups on a table so participants can demonstrate supplementation methods. Optional, but recommended to enhance hands-on practice.
 - **Spoons:** Use small, shallow spoons with smooth, rounded edges and a narrow bowl.
 - **Cups:** Use small, open cups with a smooth rim and a stable base.



2h

STEP 1: Set the Scene

 15 min

1

Why this topic? (1 min)

Key Points:

- Concern about “not having enough milk” is one of the most common challenges reported by caregivers in emergency settings.
- This concern may lead caregivers to introduce breast milk substitutes (BMS) or adopt other high-risk feeding practices.
- In crisis contexts, how this concern is addressed can have serious consequences for infant health and survival.

- The aim is to support the caregiver based on her goals and situation. Counselling should remain respectful of her choices and focus on what is feasible for her.

Bridge: “Let’s consider what this can look like in real life.”


2 Scenario discussion (9 min)

Action:

- **Ask:** Volunteer reads *Scenario: Aisha and Zainab in the transit camp* (Participant Handbook).
- **Discuss:**


 **“What might make Aisha think she does not have enough milk?”**

- **Write:** Capture ideas on a flipchart.
- **Add:** Use key points if missing:
 - No access to traditional teas believed to support milk production
 - Aisha’s exhaustion and reduced food/water intake
 - Stress is affecting her milk letdown
 - Belief that frequent crying means hunger
 - Zainab cries more and is harder to settle, making Aisha believe she needs solids or infant formula.
 - Baby sleeping more or behaving differently
- **Explain:**
 - These are very common concerns in emergencies. Mothers often worry that they don’t have enough milk, even in non-emergencies.
 - Sometimes this reflects perceived low milk supply, when milk production is adequate but the mother feels unsure or lacks confidence in her milk. In other cases, it may reflect true low milk supply, which is less common. This can develop if feeding becomes less frequent or milk is not removed effectively, often because of concerns about low milk supply.
 - In crisis settings, normal infant behaviours (crying, frequent feeding, changes in sleep) often increase. → These behaviours are frequently misinterpreted as signs of insufficient milk.
 - At the same time, stress, exhaustion, maternal undernutrition, displacement and disrupted routines increase. → These reduce caregivers’ confidence in breastfeeding.
 - **As a result, mothers in emergencies are more likely to doubt their milk supply is sufficient, regardless of whether their supply truly is low.**

 **Facilitator Tip**

Remind participants about what was learned in **Session 3: Addressing Stress in Emergencies**. Stress, exhaustion and disrupted routines can reduce caregiver confidence and affect how they perceive infant feeding.

- **Discuss:**

 **“At the same time, what aspects of the emergency situation could affect milk production?”**


- **Add:** Use key points if missing.
 - Challenging environments, such as heat, overcrowding and noise, that make feeding more difficult or stressful for mother and baby.
 - Interrupted feeding routines during travel or camp life, including delayed, missed or shortened feeds.
 - Opportunities for regular feedings may be reduced, so milk removal may be less frequent or effective.

- Older infants may become more easily distracted by unfamiliar or noisy surroundings. Shorter or interrupted feeds may reduce effective milk removal.
- Infant illness or dehydration, which may be more common in emergencies and can reduce feeding effectiveness or intake.
- Infants with developmental delays may feed less efficiently; and, in emergencies, disrupted routines or stress can make feeding even harder.
- **Explain:**
 - In these situations, perceived low milk supply can sometimes lead to reduced milk production if feeding becomes less frequent or milk is not removed effectively.
 - In emergencies, disrupted routines, illness, environmental challenges, or less frequent and effective feeding can reduce milk removal from the breast. Because breast milk production works on a supply-and-demand basis, this may lead to reduced milk production over time.
- **Wrap up:**
 - In emergencies, both situations are possible.
 - Some mothers experience **perceived low milk supply**.
 - Others may experience **low milk supply** due to disrupted routines, illness or reduced milk removal.
 - But in both cases, those concerns should be addressed.

Bridge: “Next, let’s consider what could happen if these concerns aren’t addressed.”

3 Consequences in emergencies (2 min)

Action:

- **Ask:**  “What is the risk if milk supply concerns are not properly addressed?”
- **Explain:**
 - Caregivers may introduce BMS unnecessarily.
 - In emergencies, BMS introduction increases the risk of:
 - Infection and diarrhoeal disease due to lack of clean water
 - Reduced breast milk production
 - Malnutrition
 - Financial strain and dependency

Bridge: “This shows why addressing concerns around milk supply is so important in emergencies.”

4 Learning objectives (3 min)

Action:

- **Say:** “To support mothers like Aisha effectively, our role goes beyond reassurance. We need careful assessment and practical problem-solving. We also need the skills to help mothers to both increase their milk production and develop feeding plans based on recommended practices that reduce risks for the infant.
- **Explain:**
 - Many mothers can successfully increase milk production, even after partial or complete interruption.
 - In some situations, relactation or induced lactation may be appropriate.
 - Caregivers need skilled support and a realistic feeding plan.
- **Read learning objectives:**
 - Assist a mother or caregiver to increase breast milk intake.
 - Assist a mother or caregiver with relactation and induced lactation.
- **Highlight counselling skills focus:**
 - In this session, for learning and practice purposes, we are focusing on the three key skills:

- Recognize and praise what a mother or caregiver and baby are doing right.
- Give some relevant information.
- Give practical help.

Bridge: "With these objectives in mind, let's move into Step 2, where we will build the knowledge and practical skills to help mothers increase milk intake and support recommended feeding practices in emergencies."

STEP 2: Strengthen key knowledge, concepts, and skills

 60 min




LEARNING OBJECTIVE 1:

Assist a mother or caregiver to increase breast milk intake

Time: 25 min

1 Assess (12 min)

Action:

- **Ask:**  "When a mother says, 'I don't have enough milk,' what are some ways we can assess how much breast milk the baby is getting?"
- **Probe further:**
 - What signs would you look for?
 - What questions would you ask?
 - What would you observe?
- **Capture** responses on a flipchart.



Facilitator Tip

Do not ask participants to open the Participant Handbook yet. Encourage them to rely on what they remember from the Full Assessment form introduced in Session 2. After the short discussion, invite participants to open their handbook to compare.

- **Refer:** Section: Assess (Participant Handbook)
- **Invite** participants to compare their answers with the key points in their handbook.
- **Clarify and complete** any missing points using the facilitator notes below.

Assess: Facilitator additional notes

Feeding pattern and observation:

To understand whether the baby is effectively removing milk from the breast and whether feeding is frequent enough to meet the baby's needs.

- Deep suckling followed by visible or audible swallowing indicates milk transfer.
- If swallowing is not observed, milk transfer may be limited.
- Baby feeds for very long periods without signs of effective milk transfer.
- Refusal to breastfeed may indicate illness, stress, poor attachment, or difficulty with milk flow.
- Night feeds are important for maintaining milk production.
- Poor attachment reduces milk transfer and decreases breast stimulation, which can reduce milk production over time.

Observation (if applicable) of the infant-mother interaction and feeding gives invaluable insight. A feeding observation often reveals more than reported symptoms.

- Always ask permission before observing.

- Observe respectfully and privately where possible.

See the full assessment from *Section 5: Ask about breastfeeding/breast milk feeding* and *Section 6: Request permission to observe the mother breastfeeding*.

Urine and stool output:

Output of urine and feces in the early days and weeks is a useful indirect indicator of milk intake.

- Passing black stools (meconium) on day 4 and onwards may indicate delayed milk transfer.
- After the first few days of life, most infants urinate at least six times per day. Many exclusively breastfed infants also pass several soft stools each day in the early weeks, though stool frequency can vary.
- Hard, dry, green or infrequent small stools may suggest insufficient intake.

However:

- After the first few weeks, stool frequency becomes highly variable and is no longer a reliable indicator of intake.
- Urine output remains more useful than stool frequency but must be interpreted cautiously.
- Diapers are not used in all cultures.
- In emergency settings, counting diapers may be unreliable owing to:
 - Limited diaper supply
 - Cloth or improvised materials
 - Reduced frequency of changes

See the full assessment form *Section 4: Check hydration and stool output*.

Weight:

Weight gain is one of the most reliable indicators of growth in infants and young children. WHO Growth Charts are global growth standards used to monitor how children grow and should be interpreted according to age and sex. However, growth charts are not available or used in all settings. Therefore, feeding observation, the baby's overall condition and caregiver concerns are also important when assessing growth.

In emergency settings:

- Accurate scales may be limited in availability and difficult to power, calibrate and maintain.
- Hanging scales (such as Salter scales) are commonly used in many settings and can be useful for monitoring weight trends over time. However, small day-to-day changes in weight can be difficult to measure accurately, especially in young infants, and should not be used alone to interpret short-term changes in growth.
- Clothing, diapers and infant movement can affect the reading. Furthermore, in some settings, caregivers may prefer not to remove clothing if it is cold or if diapers are limited. For this reason, trends over time are usually more useful than a single measurement.
- Adult scales are too imprecise at low infant weights and should not be used for clinical decision-making.
- A single weight measurement cannot show whether a baby is growing well. Growth is assessed by looking at weight changes over time.

Reported changes in behaviour:

Changes reported by mothers and caregivers are critical in determining whether a difficulty exists and should be taken seriously.

- Caregivers are often very accurate in noticing when something has changed for their baby. While they may not always know the reason, their observations are important for understanding feeding concerns.

- Changes in behaviour should be interpreted in context, including stress, illness, recent events, developmental changes (growth spurts, cluster feeding), environmental disruption or changes in daily routines.
- Changes in mother–baby interaction, such as temporary separation or reduced time together, may also affect feeding patterns. Babies may feed more frequently when reunited with their caregiver.
- Behaviour changes may reflect feeding difficulties, illness or psychosocial stress.
- Changes in bonding or interaction between the caregiver and baby may also affect feeding effectiveness.


What is not a reliable indicator of intake or milk supply

- Behaviour, developmental milestones and temperament alone do **not** reliably indicate whether a baby is getting enough milk.
- A happy baby is not necessarily well-fed. A grumpy baby is not necessarily hungry.
- Breast pump output and breast fullness are frequently misinterpreted:
 - Pumps do not empty the breast as effectively as a well-latched infant.
 - Breast expression may appear sufficient but does not guarantee milk transfer to the baby.
 - Breast fullness varies naturally and stabilizes as lactation establishes.



Facilitator Tip

Keep this discussion brief. Only add explanations or points if participants seem unsure or miss key aspects. Most of this content should already be familiar from basic IYCF training.

- **Ask:**  “What if the mother or caregiver is pregnant? Is breastfeeding still possible?”
- **Discuss** briefly:
 - Breastfeeding during pregnancy is generally **safe and common**.
 - **Milk supply may decrease** during pregnancy because of hormonal changes, and some mothers may feel **nipple tenderness or discomfort**.
 - Milk often changes to **colostrum**, which may cause some older children to breastfeed less while others continue as usual.
 - If the mother wishes to continue breastfeeding and feels comfortable doing so, **she should be supported**.

Bridge: “Now that we’ve reviewed how to assess intake and what signals to trust or interpret with caution, the next step is to analyse the information we’ve collected.”

2 Analyse (3 min)

Key Points

- After ASSESS, summarize what the data tell you.
- Consider possible contributing factors of low intake:
 - **Access:** Are there enough opportunities for the baby to breastfeed? Are early hunger cues noticed and responded to? Is the baby offered the breast often enough, including at night?
 - **Transfer:** Are latch, positioning or other conditions affecting milk transfer from the breast (for example disability, prematurity or oral differences)?
 - **Baby needs:** Are there medical conditions or illness increasing the baby’s needs? Alternately, are normal developmental changes (growth spurts, cluster feeding, etc.) affecting feeding patterns?
 - **Milk ejection (let-down):** Is milk release being delayed or inhibited? Is this due to stress?
 - **Milk production:** Are maternal factors like illness, medications or pregnancy affecting production?

- Whether intake concerns are related to caregiver concern or to reduced milk intake, the counselling approach is similar: focus on improving feeding effectiveness and supporting the mother or caregiver.

Bridge: “Now that we understand the nature of the reduced intake and its causes, we can discuss practical actions to help the mother increase milk intake.”

3 Act (8 min)

Action:

- **Say:** “Based on the reasons identified in Assess and Analyse, we now Act.”
- **Explain** the four key points below:

4. Optimize access (frequency)

- **Say:** “First, ensure the baby has frequent access to the breast to increase milk supply.”
- **Refer:** Poster: Increasing Milk Supply is as Easy as 1-2-3 (Participant Handbook)

! Facilitator Tip

Participants should already be familiar with the content of the poster. Do **not** read it aloud or go through it line by line. Invite participants to review it later if needed.

- **Ask:** “Looking at the poster. What are the three key actions that increase milk supply?”
- **Confirm:**
 - Skin-to-skin contact
 - Frequent breastfeeding
 - Breast compression
- **Add:**
 - Build the mother’s confidence: reassure her that low milk supply is not common and praise her for what she is doing right.
 - Explain what the difficulty may be: growth spurts (around 3 weeks, 6 weeks, 3 months) or cluster feeds (feeds bunched closely together during certain times of the day or night).
 - Help the mother prioritize feeding and reduce competing demands.
 - Ensure the mother eats and drinks adequately (general wellbeing).
 - Encourage the mother to consume local drinks or foods that help her to ‘make milk’.
- **Conclude:** “Access is a necessary condition for everything else. If the baby does not have enough access to the breast, supply cannot increase.”

2. Improve transfer (attachment and effectiveness)

- **Say:** “If the baby is at the breast often but milk is not being removed effectively, increasing frequency alone will not solve the problem.”
- **Refer:** Job Aid 6.1: Counselling cards (Participant Handbook)
- **Ask:** “Have you used these counselling cards during breastfeeding support sessions?”
- **Add:** During your counselling session:
 - Support correct positioning and attachment
 - Observe and listen for swallowing
 - Help the caregiver create a calm moment for feeding so the baby can feed effectively.
- **Conclude:** “Effective milk removal is what signals the body to produce more milk.”

3. Support let-down (stress)

- **Ask:** “Do you remember what we discussed in Session 3: Addressing stress in emergencies about the let-down reflex?”

- **Explain:** “Stress can temporarily delay the milk ejection reflex, also called let-down, which may slow the flow of milk. This does not usually reduce milk production, but it may make the baby seem frustrated or unsettled at the breast.”
- **Add:** During counselling, support the mother to feel calmer and more confident at the time of feeding.
 - Encourage simple calming strategies (refer participants to *Annex 1: Emotional regulation practices* [Participant Handbook]).
 - Promote skin-to-skin contact to stimulate oxytocin and milk flow.
 - Encourage a calm and supportive feeding environment.
 - Reassure the mother that stress may delay milk flow but does not usually stop milk production.
- **Conclude:** “With reassurance and continued breastfeeding, milk supply can be maintained, even in stressful situations.”

4. Consider baby’s needs (medical barriers)

- **Say:** “When the positioning and attachment are effective and drinking is observed at the breast, consider whether there is a medical or physical condition affecting the feeding.”
- **Highlight the key points:**
 - Prematurity
 - Illness or medical conditions increasing energy requirements
 - Increased caloric needs (e.g., cardiac or metabolic conditions)
 - Check weight gain: if no improvement after 7 days → refer mother and baby to the nearest health facility
- **Conclude:** “Medical or physical conditions can limit intake even when positioning, attachment and milk transfer appear effective. Referral and ongoing support are essential to ensure the baby’s growth and wellbeing.”

Bridge: “Let’s now summarize the key points and reflect on what we’ve learned.”

4 Key takeaways and questions (2 min)

Action:

- **Refer:** Key learning points – Objective 1 (Participant Handbook).

! Facilitator Tip Point participants to the Key learning points in their handbook. If needed, quickly summarize from the handbook to reinforce.

- **Ask** whether participants have any questions before moving on.

! Facilitator Tip If you have an extra minute or want more discussion, ask: “Which part of supporting a mother to increase breast milk intake do you think will be most challenging in your context?”

Bridge: “We have learned how to support a mother or caregiver to increase her baby’s breast milk intake. Now, let’s look at how to assist mothers with relactation or induced lactation, helping them rebuild or establish milk supply when needed.”



LEARNING OBJECTIVE 2:

Assist a mother or caregiver with relactation and induced lactation

Time: 35 min

1 Understanding relactation and induced lactation (10 min)

Action:

- **Say:** “Even when breastfeeding has stopped or decreased, it can be possible to rebuild milk production through relactation. Let’s look at how this can be supported.”



Activity: What do you think?

Instructions:

- **Refer:** Activity: *What do you think?* (Participant Handbook).
- **Ask** participants to answer the three questions in their handbook.
- **Timing:** 3 minutes
- **Ask** few participants to share their answers.



Facilitator Tip

Do not give the answers yet. Let participants discuss and compare answers. Many may be surprised by the last question.

Debrief:


- **Say:** “Let’s look at the questions one by one.”
 - **Question 1:** Refer to the definition of *Relactation* (Participant Handbook).
 - **Question 2:** Refer to the definition of *Induced lactation* (Participant Handbook).
 - **Question 3:** It is possible for a woman to relactate or induce lactation – even after menopause, and even if she has never been pregnant. However, this requires comprehensive support, which is a very important component.
- **Wrap-up:** “Breastfeeding plays a critical role in infant survival, especially in emergencies. Milk production is more flexible than many people realize. With appropriate support, mothers can rebuild their milk supply or even start producing milk after a period of not breastfeeding.”



Facilitator Tip

If participants question the menopause answer: Pituitary glands are necessary in the production of breast milk (by producing prolactin). Menopause does not restrict the pituitary glands’ ability to function. Therefore, even after menopause, it is still possible to produce enough breast milk to nourish a baby.



- **Ask:**  “What may be some reasons for relactation or induced lactation being needed?”
- **Write:** Capture participants’ ideas on a flipchart.



Facilitator Tip


Ask participants not to look at their handbook at this stage.

- **Refer:** Section: *Reasons for relactation or induced lactation* (Participant Handbook).

- **Add** (only if missing):
 - **Breastfeeding was interrupted or prevented**
 - Separation after birth
 - Illness (mother or infant)
 - Unresolved breastfeeding challenges
 - Childbirth complications
 - **Formula intolerance or allergy**
 - Suspected or diagnosed intolerance or allergy (e.g., cow’s milk protein allergy)
 - *Note: True intolerance or allergy is not very common, but caregivers may be concerned about how their infant is tolerating formula. These concerns should be explored and taken seriously.*
 - **Mother regrets early weaning or formula use**
 - Wishes to return to exclusive breastfeeding
 - **Wet nursing**
 - A caregiver (e.g., aunt, grandmother) may relactate or – if she has never breastfed – induce lactation.
 - **Adoption or foster care**
 - Desire to breastfeed
 - Support bonding
 - Infant health concerns
 - **Emergency context:** A mother may not have been breastfeeding before an emergency; but, when an emergency occurs, she may decide that she wants or needs to breastfeed because of:
 - Increased risks associated with BMS use
 - Lack of access to BMS or feeding supplies
 - Desire to protect infant during infectious disease outbreak
- **Close with the testimony:** ‘The grandmother’s story’
- **Say:** “To illustrate how relactation is possible in real life, let’s look at a short testimony from a grandmother who successfully relactated in an emergency context.”
- **Ask:** Volunteer reads *Testimony: The grandmother’s story* (Participant Handbook)

! Facilitator Tip

If we don’t have time, participants can read the full testimony later. Emphasize that this is a real example of a grandmother successfully relactating after decades without breastfeeding.

- **Ask:**  “What factors made this story successful?”
- **Sample answers:** trained provider support, determination and motivation of the grandmother, technical guidance, emotional encouragement

! Facilitator Tip

If technical questions about relactation arise, note that these will be covered in the next part of the session.

Bridge: “From our discussion, we can see that motivation, technical guidance and emotional support were key to this grandmother’s success. Let’s now look in more detail at how relactation works and how you can support a mother or caregiver to stimulate or resume milk production.”

2 Supporting relactation and induced lactation in practice (15 min)

Action:

- **Say:** “Let’s look at the main methods and practical steps to support a caregiver to rebuild or establish milk supply.”

! Facilitator Tip

If time allows, ask participants whether:

- They have ever supported a caregiver through relactation or induced lactation as a counsellor.
- They know of anyone in their community (family, friend, neighbour) who successfully relactated.

- **Explain:**

- Relactation does not work through one action alone.
- It requires three actions happening together and consistently:
 - Frequent stimulation to build milk production
 - Ensuring the baby receives enough milk while supply increases
 - Providing practical and emotional support to the caregiver

- **Refer:** *Visual: The three Actions of successful relactation* (Participant Handbook)

- **Emphasize:** These three actions are interconnected. If one is missing or weak, progress is slower.

- **Guide:** Walk through each Action **using the Participant Handbook content** as your reference.

- **Use** the Video Drip-Drop Method (25 sec) to show the method in practice.

Key points on the Three Actions:

- **Action 1:** The first action is frequent stimulation of the breast to build milk production.
 - Milk production is stimulation-driven; visible milk is not required at first.
 - Baby's suckling is the most effective way to stimulate milk production.
 - Hand expression can also help stimulate the breasts and support milk production.
 - Night stimulation helps because prolactin levels are higher.
 - Early encouragement and reassurance are important when no milk is visible.
- **Action 2:** The second action is making sure the baby receives enough milk while the caregiver's milk supply is increasing.
 - Ensures the baby receives adequate nutrition while milk supply builds.
 - Supplementation supports relactation but does not replace it.
 - At-the-breast methods (drip-drop, supplementary suckling) are preferred:
 - Baby learns to breastfeed by breastfeeding.
 - Mother's milk production is stimulated while supplementing.
 - Reduces risk of breast rejection.
- **Action 3:** The third action is providing practical and emotional support to help the caregiver continue.
 - Skilled support and early problem-solving increase success.
 - Family involvement is essential: help with feeds, protect breastfeeding time and provide encouragement.
 - Emotional reassurance helps maintain motivation, confidence and persistence.

Action:

- **Say:** "Let's look at what caregivers can expect during relactation or induced lactation."
- **Explain briefly:** Milk production is gradual, and not all caregivers will reach a full milk supply. Some supplementation may still be needed. Every increase in breast milk matters, and progress will look different for each caregiver.
- **Refer:** Section: *What to Expect* (Participant Handbook)

Focus: Galactagogues

- **Say:** "In many cultures, certain foods or herbs are believed to boost milk production. These are called galactagogues."
- **Refer:** Definition: *Galactagogue* (Participant Handbook)
- **Ask:** "Are there any local foods or herbs that caregivers in your community believe help with milk supply?"
- **Capture** answers briefly without debating their effectiveness.
- **Explain:**

- Core principle: Milk production works on a supply-and-demand basis. Frequent and effective milk removal is the main driver of milk production. **Galactagogues alone cannot replace this.**
- Evidence for the impact of traditional galactagogues (foods, herbs) is limited or unclear.
- Some practices surrounding galactagogues may support caregiver confidence, relaxation, and a positive breastfeeding experience, which can help caregivers continue frequent feeding. This can indirectly help milk production.
- Encourage caregivers to continue helpful traditional practices if culturally meaningful, but clarify that they are not essential.
- Galactagogues may not be available, affordable or consistent in emergency settings, so feeding support should not rely on them.
- If using herbs or supplements, caution that “natural” does not always mean safe. Some herbs or products may have side effects or interact with medications, so caution is needed. Dosage and safety matter. Professional guidance may be sought when available.

Bridge: “Relactation and induced lactation take time and ongoing support. To help caregivers increase milk supply, build confidence and ensure the baby receives enough nutrition, it is important to develop a clear feeding plan together. Let’s look at how to do that now.”

3 Developing a feeding plan (8 min)

Action:

- **Say:** “Let’s look at a real case example from Jordan.”
- **Refer:** *Timeline: From birth to exclusive breastfeeding* (Participant Handbook).
- **Ask** participants to review the timeline silently for 1–2 minutes.
- **Guide the discussion:**
 - “What actions made the biggest difference in rebuilding milk supply?”
 - “How long did it take before visible milk appeared?”
 - “What does this case tell us about the importance of follow-up and persistence?”
- **Emphasize:**
 - Relactation takes time, often weeks to months.
 - Multiple strategies were used together (stimulation, supplementation adjustments, skin-to-skin, counselling).
 - Regular follow-up visits were critical.
 - Gradual reduction of infant formula was possible only after milk production increased.

Facilitator Tip

- Do not retell the entire story. Allow participants to extract the lessons from the visual timeline.
- Keep discussion focused on practical learning points that will inform feeding-plan development.

- **Say:** “We will now look at how to develop a feeding plan using the Care Action Plan, which we introduced in Session 2: *Individual Assessment in Emergencies*.”
- **Refer:** *Job Aid 2.2: Care Action Plan for Mother/Caregiver and Child Receiving Skilled Support and/or Breast Milk Substitutes* (Participant Handbook).
- **Explain briefly:** “This tool helps document the assessment, feeding recommendations, and follow-up for each mother–baby pair. It is adaptable for infants under 6 months and should always be complemented with clinical judgment.”
- **Point out** the key sections:
 - Child and caregiver information
 - Main findings of assessment
 - Recommendations for feeding (continuing support, relactation, BMS support, wet nursing, etc.)

- Follow-up and monitoring plan
- Emphasize that the Care Action Plan is a **living document**. It is updated at each contact.
- Encourage participants to think practically: How would they adapt recommendations based on the baby's intake as well as the caregiver's situation and milk-supply progress?

Bridge: "Now that we've seen how a real case was assessed and how a feeding plan can be developed and updated over time, let's pause to summarize the key learning points before moving to step 3."

4 Key takeaways and questions (2 min)

Action:

- **Refer:** Key learning points – Objective 2 (Participant Handbook).



Facilitator Tip

Point participants to the Key learning points in their handbook. If needed, quickly summarize from the handbook to reinforce.

- **Ask** whether participants have any questions before moving on.



Facilitator Tip

If you have an extra minute or want more discussion, ask:
"How confident are you to assist a mother/caregiver with relactation or induced lactation?"

Bridge: "Now, let's do a demonstration using the first counselling session of Rima. This will show how we apply what we've learned to a real case."

STEP 3: Demonstrate

 20 min

1 Introduction (3 min)


Action:

- **Introduce:** "In this demonstration, we will meet Rima and her baby Adam for the first counselling session to support relactation in an emergency setting, using a practical, supportive approach and a focus on the following three counselling skills:
 - Recognize and praise what a mother or caregiver and baby are doing right
 - Give some relevant information
 - Give practical help
- **Refer:** Case study: Rima and Adam (Participant Handbook)
- **Summarize** the case:
 - **Setting:** Primary health facility serving displaced families
 - **Mother/Caregiver:** Rima, 20 years old
 - **Child:** Adam, 2 months old
 - **Reason for contact:** Rima wants to relactate and breastfeed exclusively after postpartum hospitalization; Adam has been fed with commercial infant formula by bottle in her absence.
 - **Counsellor:** IYCF-E counsellor providing support to begin relactation

2 Script (7 min)

Action:

- **Act out** the script below as a team of three.

 **Facilitator Tip**

- *This demonstration includes more detailed explanations from the counsellor than in previous sessions because relactation involves technical guidance. It could be tempting to read it word for word, but try to act naturally and conversationally.*
- *While you talk, pretend you are filling in the care plan. There are prompts in the script where you can note information, just as you would in a real session. Participants have a partially filled care plan in their handbook that will be used in the debrief discussion.*
- *Unlike previous sessions, there are no prompts in the script. Reflection and discussion will happen in the debrief afterward, giving participants the chance to analyse the demonstration without interrupting the flow.*
- *Caregivers are often already doing many things to support their infants, even in difficult circumstances. Counselling should start by recognizing these strengths and building from them.*



Counsellor

Hello Rima, my name is [Counsellor]. Welcome. Please sit down. I understand you were in the hospital for many weeks. That must have been very difficult. How have things been with Adam since you came home?



Rima

It has been very hard to be away from Adam for so long. I feel so sad that I couldn't breastfeed him for the first two months. In the first few days after birth, it went well, but then I got very sick... I was in the hospital for almost 40 days. My mother looked after him and fed him with infant formula. But I feel like I missed so much.



Counsellor

I hear you, Rima. Being separated from your baby for so long is very painful. It's completely understandable to feel this way. It sounds like you were very sick and had to fully focus on your own health to get better. And it is good that you have a strong support network that came together to help you and Adam during this difficult time. Now that you're better, we can talk about the ways that can make it possible to breastfeed again. This is called relactation. If you're willing, I can guide you through it.



Rima

Really? I didn't think I could. Yes... I would like to try. I want to breastfeed him again.



Counsellor

That's wonderful. Yes, your body can respond to Adam's suckling and begin making milk again. It may take some weeks, but with patience and support, many mothers succeed. I can support you throughout the process. How has he been feeding today?



Rima

He's been taking formula about seven times a day. Sometimes 90 ml, sometimes 120 ml. I also give him a little anise tea, maybe 30 ml, to help him digest.



Counsellor

Pretend to note this on the care plan with a pen.

I see. And how do you usually give the formula? By cup, bottle or something else?



Rima

With a bottle.



Counsellor

Thank you for explaining. For today, we won't change everything at once. We'll go step by step.

To help your body make milk again, two things are very important. Adam needs to be close to you, and your breasts need regular stimulation through feeding or expressing to help build milk production.

The best way to stimulate the breast is by putting Adam to the breast and letting him try to suckle, even if there is not much milk yet. His suckling sends a message to your body to start producing milk again.

If he does not suckle much at first, you can also stimulate the breast yourself with your hands. Have you heard about hand expression before?



Rima

I've heard of it, but I'm not sure I know how to do it properly.



Counsellor

That's very common. Many mothers feel unsure at first. At our next visit, I can show you step by step how to do it comfortably and safely. Even a small amount of stimulation, whether from Adam suckling or from expressing milk with your hands, helps your body understand that milk is needed.

And keeping Adam skin-to-skin, directly against your chest, also makes a big difference. When he feels your warmth and hears your heartbeat, it helps him feel calm and secure. At the same time, it supports your milk production.



Rima

I did that in the maternity ward at the beginning. I would be happy to do it again.



Counsellor

That's wonderful. You already know how to do it. Because you were separated for some time, skin-to-skin will also help rebuild that closeness between you. It supports bonding and helps your body respond more quickly.

You are already showing how much you care about Adam. Coming here and wanting to breastfeed again is a very strong step.



Rima

Thank you... that's very encouraging. Do you think I should stop the formula now?



Counsellor

Not yet. We'll start slowly so Adam can adjust to the changes, and we don't disturb him too much.

For now, the first change will be to stop giving the anise tea. We will keep the formula as it is while your milk supply begins to build. At the same time, start keeping Adam skin-to-skin every day, as much as you can. Try offering the breast several times during the day, even if it's only for a few minutes and even if he doesn't latch for long. There's no pressure. Even short attempts help your body start the process.



Rima











Okay. I can do that. How often should I try to put him at the breast?



Counsellor


Start with a few times a day. Doing this before feeding him infant formula can help him to suckle more and fill his belly with the nutrients and protection from breast milk. Choose moments when he is calm, showing early cues of being hungry and not when he is crying and upset. We'll increase the frequency gradually as things improve.





At the beginning, it can feel challenging, especially if he is not used to the breast. That's normal. We'll take small, manageable steps and adjust as we go.



		Because the first weeks are important, I would like us to see each other quite often, maybe once or even twice a week, so I can support you and adapt the plan if needed. Would that be okay for you?
	Rima	Yes, that would help. Thank you, I feel a little more confident.
	Counsellor	I'm glad to hear that. Do you have someone who can help you at home? Your mother or another family member?
	Rima	Yes, my mother can help.
	Counsellor	That's excellent. Would it be possible for her to come with you next time? It can help if she understands how to support you during this process.
	Rima	Yes, she can come.
	Counsellor	Good. So let's summarize our plan for this week. <i>Pretend to write all of this in the care plan with a pen.</i> Here's what we will focus on: <ul style="list-style-type: none"> • Stop giving the anise tea. • Keep Adam skin-to-skin as much as possible, including at night if you can. • Offer the breast several times a day without pressure. Even a few minutes at a time is a good start. • Continue formula for now while your milk supply builds. Does that all make sense? Do you feel comfortable with this plan?
	Rima	Yes, I understand. I can do that.
	Counsellor	Great. When we meet again in about two days, we'll see how the breast stimulation is going and practice hand expression together. We'll also talk about other ways of giving milk that can help Adam return to the breast more easily. Relactation takes time, often several weeks. But many mothers succeed with support and patience. I will be here to guide you through each step. You're already doing something very important for Adam by being here and taking action.
	Rima	Thank you. I feel like maybe I can do this after all.
	Counsellor	You absolutely can. Let's see each other in two days. I'll be with you through each step of this process.

3 Debrief (10 min)

Action:

- **Discuss the application of the three Actions of relactation support:**
 - **Ask:**  "How did the counsellor apply Action 1 in this session, and what will be done in future visits?"
 - **Remind:** Action 1: Frequent breast stimulation/skin-to-skin contact

- **Explanation:**
 - **In this session:** The counsellor encouraged Rima to put Adam to the breast several times a day (even briefly) and explained the benefits of skin-to-skin contact. The focus was on taking small, achievable steps without overwhelming her.
 - **Next session/future steps:** The counsellor plans to monitor progress, increase frequency gradually and review hand-expression techniques if needed.
- **Ask:**  "How did the counsellor apply Action 2 in this session, and what will be done in future visits?"
- **Remind:** Action 2 = Temporary supplementation
- **Explanation:**
 - **In this session:** The counsellor advised stopping anise feeds, offering the breast as much as possible and delaying other supplementation changes until Rima and Adam are adjusted. This step-by-step approach prevents distress for the baby and avoids overwhelming the mother.
 - **Next session/future steps:** The counsellor will introduce safer supplementation methods that reduce risk (e.g., cup feeding, drip-drop) and gradually replace formula with breast milk as milk supply increases.
- **Ask:**  "How did the counsellor apply Action 3 in this session, and what will be done in future visits?"
- **Remind:** Action 3 = Emotional/practical support for the mother
- **Explanation:**
 - **In this session:** The counsellor validated Rima's feelings of sadness and separation, praised her willingness to relactate, emphasized that progress takes time and patience, and reassured her that support would continue through frequent follow-ups. The counsellor also discussed involving her mother in the next visit for practical support.
 - **Next session/future steps:** The counsellor will guide Rima on practical techniques (hand expression, positioning, safe supplementation), monitor progress and continue encouragement.
- **Discuss step-by-step support and pacing:**
 - **Ask:**  "How would you decide what the mother can handle in one session?" "How would you pace technical information and support her step by step over several visits?"
 - **Explanation:**
 - This part illustrates the Analyse step in the 3As counselling process. The counsellor assesses Rima's emotional state, motivation and practical situation before deciding how much to introduce in one visit.
 - Relactation requires patience and sustained motivation. The counsellor provided small, achievable actions and planned frequent follow-ups rather than trying to solve everything at once.
 - Technical information was introduced gradually, with reassurance and clear next steps.
 - Stepwise progress avoids overwhelming the mother and increases confidence and adherence over time.
- **Debrief on the counselling skills:**
 - **Recognize and praise what the mother and baby are doing right**
 - **Ask:**  "How did the counsellor acknowledge what she has already done for Adam?"
 - **Explain:** Counsellor praised Rima for wanting to breastfeed and practising skin-to-skin before.
 - **Give some relevant information**

- **Ask:**  “What relevant information did the counsellor give Rima?”
- **Explain:** Counsellor explained how breast stimulation and skin-to-skin help milk production, bonding and gradual reintroduction of breastfeeding.
- **Give practical help**
 - **Ask:**  “What practical steps did the counsellor suggest for Rima to start relactation?”
 - **Explain:** Counsellor demonstrated stepwise actions: put Adam to the breast, small sessions, stop anise feeds and continue formula for now. They planned for hands-on guidance in the next visit.
- **Wrap-up:** “Thank you for your thoughtful observations. You’ve highlighted how the three Actions and the selected counselling skills were applied in a practical relactation session. You also identified how pacing and step-by-step support are essential to avoid overwhelming the mother and to build motivation over time.”

Bridge: “Now, in the next step, you will practise leading the second counselling session with Rima, continuing her relactation support step by step.”

STEP 4: Role-Play

 20 min

1 Introduction (2 min)

Action:

- **Explain:** Participants will now practise leading the **second counselling session with Rima**, building on what was agreed in Session 1 (begin skin-to-skin, start putting Adam to the breast, stop anise tea, continue formula feeding). Rima is accompanied by her mother.
- **Organize:** Ask participants to form groups of three: **Counsellor, Rima, Observer (also acting as Rima’s mother)**. Participants stay in the same groups as previous sessions but rotate roles. The observer alternates between acting as the supportive mother and silently observing.
- **Distribute:** Hand out the role cards to each participant:
 - “Rima” – prepared in advance (Annex 6.1)
 - “Rima’s Mother” – prepared in advance (Annex 6.2)
- **Use the care plan:** Counsellors should refer to and update the care plan created in step 3 during the demonstration, just like in a real session.
- **Prepare materials:** Ensure each group has a small cup and a spoon on the table for the counsellor to demonstrate drip-drop method and cup feeding during the role-play.

Facilitator Tip

While you distribute the cups and spoons, explain:

- **Spoons:** Use small, shallow spoons with smooth, rounded edges and a narrow bowl. The spoon should be small enough to comfortably fit an infant’s mouth and allow milk to be offered slowly, in small amounts. Avoid deep or large spoons that can deliver too much milk at once. The spoon should be easy to hold and made of a smooth material that can be cleaned easily.
- **Cups:** Use small, open cups with a smooth rim and a stable base. The rim should be thin enough to allow the infant to sip or lap milk while the caregiver gently tilts the cup. Avoid cups with spouts, lids or valves. Transparent or lightly-coloured cups are helpful so caregivers can see the milk level and control the flow during feeding.

- **Explain:** The observer uses the Counselling Skills Checklist to note strengths and areas for improvement.
- **Remind:** Counsellors should practise using the three key skills demonstrated in Step 3:

- Recognize and praise what a mother or caregiver and baby are doing right
- Give relevant information
- Give practical help
- **Allow:** Give groups 2–3 minutes to get ready before beginning their role-plays. Participants can take a minute to review the Counselling Skills Checklist to refresh their memory of the key recommendations discussed during the session.
- **Time:** The role-play lasts around 10 minutes.

Facilitator Tip

- *If you feel more comfortable, consider forming groups of four, so Rima and her mother each have a dedicated ‘actor’ and the observer focuses solely on observing.*
- *If available, provide a small cup and spoon to each group, so the counsellor can demonstrate drip-drop feeding. This is optional but recommended to make the role-play more realistic.*
- *Participants can involve the mother in the demonstration of the supplementation methods, letting her practise the method under the counsellor’s guidance.*
- *Remind counsellors to pretend to update the care plan during the role-play.*





4 Role-play practice (10 min)

Action:

- **Encourage:** Ask groups to start quickly and use their full time.
- **Support:** Move quietly among groups, observe and answer questions if needed.
- **Manage time:** Give a **5-minute** and **2-minute** warning so participants can pace themselves.
- **End:** Stop the activity on time, even if some groups have not finished the full role-play.

4 Debrief (8 min)

Action:

- **Gather:** Bring everyone back together and thank participants for their role-plays and effort.
- **Ask the ‘Rimas’**  :
 - “How did it feel to be in Rima’s place?”
 - “Did the counsellor’s approach make it easier or harder to feel supported?”
- **Ask the ‘mothers’**  :
 - “How did it feel to support Rima?”
 - “Were there moments when the counsellor involved you in a way where it felt useful?”
- **Ask the ‘observers’**  :
 - “What strengths did you notice in the counsellor’s approach?”
 - “What areas could be improved?”
- **Ask the ‘counsellors’**  :
 - “How did it feel to conduct the second counselling session with Rima and her mother?”
 - “What was most challenging? What worked well?”
- **Refer:** Role-play debrief: Rima, her mother and Adam (Participant Handbook).
- **Add:** Highlight key points if they do not come up. Use the debrief box from the Participant Handbook to emphasize practices that should have been used during the session (following the three Actions, involving the mother, updating the care plan...).

Bridge: "In real situations, mothers may feel discouraged if their baby refuses the breast or if they doubt their ability to relactate. Involving a supportive family member and using step-by-step guidance helps build confidence and promotes adherence to the plan. In Step 5, you will reflect individually on what you learned in this session and how you can apply these counselling strategies in your daily practice."

STEP 5: Self-reflection

 5 min

Action:

- **Invite:** Ask participants to take a quiet moment to reflect and note their answers in the Participant Handbook.
- **Guide:** Read the three questions (also in the Participant Handbook) out loud and give participants 2–3 minutes of silence to think/write.
- **Share (optional):** If time allows, invite 1–2 volunteers to share a key takeaway.
- **Close:** Thank participants for their reflections and emphasize that applying these insights in real-life counselling is where change happens.



Facilitator Tip

Keep the activity short and personal. This is not a group discussion but an opportunity for each participant to consolidate their own learning.

ANNEX 6.1: Role-play card – Rima Cut the cards below and provide one to each participant acting Rima.



Card: Rima

You tell the counsellor, if you are asked:

- You stopped giving anise.
- You have been doing a lot of skin-to-skin, and you feel that is going well.
- You tried putting Adam to the breast, but he refused, making you feel a bit discouraged.
- You have practised hand expression; your mother helped show you, so you are confident doing it.
- You don't understand why you should switch to a cup, which seems more complicated.
- You're feeling slightly pessimistic, worried about being able to relactate.

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- You stopped giving anise.
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ANNEX 6.2: Role-play card – Rima’s Mother

Cut the cards below and provide one to each participant acting Rima’s Mother.

Card: Rima’s Mother

- You are very supportive and confident in Rima’s ability to relactate.
- You showed Rima hand expression and can demonstrate it again if asked.
- You can assist with drip-drop feeding (only if the counsellor demonstrates it during the visit).
- You can help reduce household workload and support skin-to-skin as well as provide general breastfeeding encouragement.
- You are reassuring, calm and encouraging.

Card: Rima’s Mother

- You are very supportive and confident in Rima’s ability to relactate.
- You showed Rima hand expression and can demonstrate it again if asked.
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SESSION 7: COMPLEMENTARY FEEDING IN EMERGENCIES



LEARNING OBJECTIVES

1. Support a caregiver's responsive feeding and caregiving practices
2. Assess nutritional risk and possible causes of poor growth in a child from 6 to 23 months
3. Counsel a caregiver on complementary feeding during extreme food insecurity



COUNSELLING SKILLS FOCUS*

- Ask open questions
- Avoid using words that sound judging
- Make one or two suggestions, not commands

**Reminder: The full 3A process and counselling skill set remain essential. The focus on these particular three skills is for practice and learning purposes.*



Material and preparation:

- **Script – Fathers (Step 3):** Cut the scripts for **Father 1, Father 2 and Father 3**. Each participant should receive one script (to role-play either Father 1, Father 2 or Father 3) to guide their responses during the group counselling demonstration. Scripts are found in Annex 7.1, 7.2, and 7.3.
- **Role-play cards – Angela (Step 4):** Cut cards for approximately one-third of participants from Annex 7.4.



2h

STEP 1: Set the Scene



10 min

1

Why this topic? (2 min)

Key Points:

- Children 6–23 months are among the most nutritionally vulnerable in any crisis. This is the period when growth faltering and stunting most often begin. While breastfeeding is life-saving, appropriate complementary feeding is also critical for survival, growth and development, yet it is often overlooked in emergencies.
- In many responses, we focus on food distribution and therapeutic care. But everyday feeding practices like what, how, how often and in what environment children eat are deeply affected by crisis conditions.
- In emergencies:
 - Food access and affordability may be limited.
 - Water, fuel and food storage may be unavailable/or unsafe.
 - Caregivers are under extreme stress.
 - A child's emotional wellbeing is also important. Stress, fear or disruption can reduce appetite and affect how a child engages with feeding.

- Complementary feeding may be deprioritized.

Bridge: “These factors shape how children are fed, not just what foods are available. Let’s look at what this can look like in real life.”

2 Scenario discussion (5 min)

Action:

- **Ask:** Volunteer reads *Scenario: Angela’s family* (Participant Handbook).
- **Discuss:**



“What might explain Adeline’s slower recovery compared to her younger brother?”

- **Write:** Capture ideas on a flipchart.
- **Add:** Use key points if missing:
 - Feeding frequency
 - Food quantity
 - Child’s illness recovery
 - Child’s impacted mental health
 - Breastfeeding status
 - Caregiver time and stress
 - Food safety
- **Explain:**
 - What we see here is shaped by more than just food. It reflects how the child is fed, the caregiver’s situation, illness, stress, the conditions the family is living in, and the support and services available to them.
 - Child’s emotional wellbeing and sense of safety, which can affect appetite, feeding behaviour and recovery
 - Complementary feeding in emergencies is often one of the most difficult parts of IYCF to support because families may have limited access to food, fuel, and safe preparation and storage supplies/spaces. They may also be managing high levels of stress. In many settings, available options may be constrained by the wider response, including the safety, accessibility, or acceptability of shared cooking or food distribution systems.
 - Emergency conditions do not change recommended feeding practices. What changes is how we prioritize and adapt those recommendations to what is possible for the caregiver. This becomes even more important in emergencies, where constraints are greater and options may be limited.
 - In crisis settings, counsellors focus first on:
 - Protecting and supporting continued breastfeeding
 - Ensuring the child can safely eat enough appropriate foods
 - Working with foods and resources families already have
 - Supporting caregivers and children under stress
 - Our role is not to create perfect diets, but to support safe and realistic feeding in the family’s situation.

Bridge: “To support children like Adeline, we need more than general guidance. We must be able to assess feeding practices, understand growth concerns and work with caregivers to find realistic solutions – even in extreme food insecurity. Let’s look at what we will learn in this session.”

3 Learning objectives (3 min)

Action:

- **Read learning objectives:**
 - Support a caregiver’s responsive feeding and caregiving practices
 - Assess nutritional risk and possible causes of poor growth in a child from 6 to 23 months
 - Counsel a caregiver on complementary feeding during extreme food insecurity
- **Highlight counselling skills focus:**
 - In this session, for learning and practice purposes, we are focusing on the three key skills:
 - Ask open questions
 - Avoid using words that sound judging
 - Make one or two suggestions, not commands

Bridge: *“With these objectives in mind, let’s move into Step 2, where we will build the knowledge and practical skills to help mothers and caregivers with complementary feeding in emergency settings.”*

STEP 2: Strengthen key knowledge, concepts and skills

 55 min



LEARNING OBJECTIVE 1:


Support a caregiver’s responsive feeding and caregiving practices

Time: 20 min

1

Responsive feeding and complementary feeding in emergencies (3 min)

Action:


- **Ask:**  *“When you observe a caregiver feeding a child 6–23 months, what tells you the feeding is responsive?”*
- **Take 3–4 quick answers**
- **Add if missing:**
 - Encouraging without forcing
 - Watching hunger and fullness cues
 - Giving time to explore food
 - Adjusting when child is ill, tired or distressed
 - Offering warmth and attention
- **Explain:**
 - Responsive feeding means noticing and responding to a child’s hunger and fullness cues in a calm, supportive way during meals. It focuses on the interaction between caregiver and child, not only the food.
 - A caregiver’s ability to feed responsively is shaped by their wellbeing, stress levels and amount/quality of support they have. When caregivers are overwhelmed, exhausted or unsupported, responsive feeding becomes more difficult. Supporting caregiver mental health is an important part of improving how children are fed.



Facilitator Tip

Invite participants to remember what was discussed in Session 3: Addressing stress in emergencies about responsive feeding and responsive caregiving. Here, we are focusing specifically on responsive feeding during complementary feeding (6–23 months).

- **Add:** In emergencies, responsive feeding becomes even more important because stress, illness and disruption can:
 - Reduce appetite
 - Increase tension during meals

- Change mealtime routines
- Reduce access to preferred or typical foods
- **Refer** participants back to Angela’s case (step 1).
- **Ask:**  “If you observed Adeline’s mealtime, what feeding behaviours might you see?”
- **Write** answers on a flipchart.
- **Probe** if needed:
 - Could the caregiver be patient or rushed?
 - Might there be pressure to eat?
 - Could the child refuse food?
 - Could the caregiver and/or child appear tired, stressed or distracted?
- **Wrap-up:** “What we are hearing shows that feeding behaviours change in emergencies. These changes are often linked to stress, fear and exhaustion. They do not suggest a lack of care or love. In many cases, they reflect how much caregivers are trying to support their children under difficult conditions. Supporting the caregiver is part of supporting responsive feeding. Responsive feeding becomes especially important during a crisis because it:
 - Helps protect food intake when appetite is low,
 - Reduces tension during meals,
 - Supports recovery after illness, and
 - Maintains caregiver–child connection during stress.”

Bridge: “In crisis settings, caregivers often adapt their feeding in response to stress. Let’s look at the common stress-adapted feeding responses we may encounter.”

2 Stress-adapted feeding responses (5 min)

Action:

- **Say:** “Under stress and scarcity, caregivers’ feeding behaviours often become protective coping strategies. We call these stress-adapted feeding responses. Our role is to understand which stress pathway may be influencing the feeding interaction, so we can support caregivers safely and realistically.”
- **Refer:** Table: Three general stress pathways (Participant Handbook)
- **Introduce 3 patterns:** There are three general stress pathways caregivers may experience. These descriptions help counsellors understand feeding responses commonly observed under stress.
- **Refer:** Table: Stress pathways: Caregiver experience, feeding pattern and risks (Participant Handbook)
- **Highlight:** These are common patterns, not diagnostic categories. Caregivers may move between these patterns depending on stress, resources and the child’s condition.
- **Say:** “Let’s look at each pathway briefly. I’ll highlight what it looks like in practice, why it happens in emergencies and the possible risks.”

Facilitator Tip

Go row by row, summarizing key points in your own words. Keep it conversational and use examples. Emphasize that caregivers may show **overlapping stress-adapted feeding patterns** during a single mealtime.

Key Points:

- **Pressure-based feeding**
 - Caregiver encourages or insists the child eat because they fear weight loss, illness or food being wasted.
 - Mealtimes may feel tense, and child may resist.
- **Reduced-engagement feeding**
 - Caregiver may be exhausted, grieving or managing multiple survival demands.
 - Less supervision and encouragement; meals may be missed or delayed.
- **Comfort-focused feeding**

- Caregiver may use food mainly to calm or reassure the child.
- Child may rely on preferred foods, and dietary variety may be limited.

Bridge: “These are stress responses. Our role is not to blame, but to understand what is driving the behaviour. With this in mind, we can think about how to assess a caregiver’s current pattern and choose practical, responsive strategies to support complementary feeding.”

3 Supporting responsive feeding (10 min)


Action:

- **Say:** “Let’s practise recognising these patterns and deciding how we might respond as counsellors.”



Activity: Recognizing stress-adapted feeding patterns

Instructions:

- **Refer:** Activity: Recognizing stress-adapted feeding patterns (Participant Handbook)
- **Ask**  “Which stress-adapted feeding pattern do you recognize in each case?”
- **Timing:** 3 minutes
- **Ask** a few participants to share their answers.


! Facilitator Tip Keep it brief. This is about pattern recognition, not deep analysis.

Debrief:

- **Say:** “Let’s look at each caregiver.”
 - **Sofia** → **Reduced-engagement:** concern about size, watching closely, returning spoon, scarcity concerns
 - **Amina** → **Comfort-focused:** exhaustion, inconsistency, low energy for mealtime interaction
 - **Lina** → **Pressure-based:** food used to calm distress, emotional regulation through food
- **Reinforce:** “Remember, these patterns can overlap. We are identifying the dominant response to better understand the situation, not labelling the caregiver. We meet the caregiver with an understanding of their context.”
- **Say:** “Now that we’ve recognized the patterns, let’s practise how to respond in a supportive way.”

Activity: What would you say?

Instructions:

- **Divide** participants into pairs.
- **Assign** each pair one caregiver (Sofia, Amina or Lina).
- **Ask:**  “What would you say to this caregiver to support more responsive feeding, without judging?”
- **Remind** participants to:
 - Acknowledge and empathize with the caregiver’s feelings.
 - Normalize the caregiver’s feeding-based stress response.
 - Suggest small, practical adjustments.
 - Avoid commands.
 - Offer only 1–2 suggestions.
- **Timing:** 3 minutes.

Debrief

- Ask 2–3 pairs to share their responses.
- Use the examples below. Notice how each response starts with understanding before suggesting any changes:
 - **Sofia – Reduced-engagement**
 - **Acknowledge:** “It sounds like you are very tired and managing many things.”
 - **Normalize:** “Many caregivers feel overwhelmed in these situations.”
 - **Suggest:** “Would it help to choose one consistent time each day to sit with him, even briefly?” “Sometimes gentle encouragement for a few extra minutes can make a difference.”
 - **Amina – Comfort-focused**
 - **Acknowledge:** “It sounds like you are trying to calm her and make things easier.”
 - **Normalize:** “That’s very understandable, especially during stressful times.”
 - **Suggest:** “You could try offering a small amount of another food alongside the biscuits.” “We can also think of other ways to comfort her that don’t rely on food.”
 - **Lina – Pressure-based**
 - **Acknowledge:** “You’re worried about her growth and want her to eat enough.”
 - **Normalize:** “Food scarcity makes feeding feel more urgent.”
 - **Suggest:** “You might try offering smaller amounts and allowing her to stop when she shows she’s full.” “Sitting calmly and watching her cues can reduce tension at meals.”
- **Say:** “Our goal is not to change everything at once. It is to reduce stress in the feeding interaction and support small, safer adjustments. Counselling is about working together with caregivers to find what is possible in their situation.”



- **Wrap up** while reinforcing core principles:
 - Avoid blame and judgment
 - Focus on understanding the caregivers situation
 - Reduce stress in the feeding interaction
 - Suggest small, realistic changes
 - If stress appears overwhelming, refer or link families to support

Bridge: “Let’s now summarize the key points and reflect on what we’ve learned.”

4 Key takeaways and questions (2 min)

Action:

- **Refer:** Key learning points – Objective 1 (Participant Handbook)



Facilitator Tip

Point participants to the Key learning points in their handbook. If needed, quickly summarize from the handbook to reinforce.

- Ask whether participants have any questions before moving on.



Facilitator Tip

If you have an extra minute or want more discussion, ask: “In your context, which stress-adapted feeding pattern do you think you encounter most often?”

Bridge: “So far, we have focused on supporting responsive feeding practices. Now, let’s look at how we can identify children over 6 months who may be at risk for poor growth or nutrition problems, and understand what might be contributing to this risk.”




LEARNING OBJECTIVE 2:

Assess nutritional risk and possible causes of poor growth in a child from 6 to 23 months

Time: 20 min

1 Priority Triage tool (4 min)

Action:

- **Say:** “In emergencies, children may face multiple challenges affecting their nutrition, including illness, reduced appetite, feeding difficulties or limited access to foods. In Session 2, we introduced several assessment tools used to identify infants and young children who may need additional support. Let’s go back to these tools and look specifically at what can help us identify nutrition risks in children over 6 months.”
- **Refer** participants to the *Priority Triage Tool* in their handbook in Session 2 (Individual Assessment in Emergency).
- **Add:** The Priority Triage Tool helps us quickly identify children who are in need of IMMEDIATE HELP or who are AT RISK.
- **Ask:**  “Looking at the tool, which indicators would you use to identify a child over 6 months who may be at nutritional risk?”
- **Give** them 2–3 minutes to review the tool in pairs.
- **Take** 3–4 answers.
- **Debrief:**
 - **Priority 1 indicators:**
 - Sick
 - Severely malnourished, identified by either clinical indicators or mid-upper arm circumference (MUAC)
 - Living with a disability that impacts feeding
 - Showing signs of extreme distress
 - Separated or unaccompanied
 - Maternal orphans
 - Having no access to or delayed start of complementary foods
 - **Priority 2 indicators:**
 - Recovering from recent infection or illness
 - Receiving limited diets with few nutrient-dense foods, especially animal-source foods
 - Having moderate acute malnutrition (MAM), indicated by moderate wasting (MUAC between 11.5 cm and 12.5 cm)
 - Caregivers who are
 - First-time mothers
 - Adolescent mothers
 - Struggling with food access and household food insecurity



Facilitator Tip

Encourage participants to share examples from their experience where these indicators were observed.



- **Explain:** These situations can quickly place a child at serious nutritional risk and may contribute to poor growth if not addressed rapidly.
- **Say:** “Let’s practise using what we just discussed with the scenario from Step 1. Look at the Priority Triage Tool in your handbook and determine Adeline’s priority for IYCF-E services.”
- **Prompt** participants:
 - **Priority 1:** Does Adeline appear sick? Is she not eating complementary foods? Is she severely malnourished?

- **Priority 2:** Is she recovering from recent illness? Is she not receiving enough dietary diversity? Does MUAC indicate moderate acute malnutrition?
- **Highlight** that more information is needed.
- **Emphasize:**
 - Recent illness or reduced appetite following illness is one of the biggest complementary feeding risks globally, and it must be explored fully.
 - Changes in feeding may reflect caregiver or child stress, exposure to violence or loss of support – not just lack of knowledge.
 - Not all risks are immediately visible → some require asking caregivers carefully.
 - This is an initial screening step using the Priority Triage Tool and Simple Rapid Assessment → a full assessment follows for children flagged as at-risk.

Bridge: “Now that we understand how the Priority Triage Tool helps identify children at risk, we move to the Simple Rapid Assessment, which provides a quick screening of feeding practices and caregiver factors before conducting a full assessment.”

2 Simple Rapid Assessment (4 min)

Action:

- **Say:** “The Simple Rapid Assessment (or SRA) Tool was also introduced in Session 2. It is used as a quick screening tool for all caregivers with children 0–23 months. The questions help us rapidly identify feeding practices, possible nutritional risks, and situations that may require further support or referral.”
- **Refer** participants to the Simple Rapid Assessment (SRA) Tool in their handbook (Session 2: Individual Assessment in Emergencies).
- **Ask:**  “Looking at the questions in the SRA, which ones could help you identify nutritional risks or possible causes of poor nutrition in a child over 6 months?”
- **Give** them 2–3 minutes to review the tool in pairs.
- **Take** 3–4 answers.
- **Debrief:**
 - **ASK**
 - Is the baby breastfed? If yes, are there any difficulties breastfeeding?
 - Is the baby drinking infant formula/milk powder?
 - Is the baby getting anything else to eat?
 - **OBSERVE**
 - Multiples (twins/triplets, etc.)?
 - Caregiver requested infant formula?
 - Baby looks very thin/lethargic/ill?
 - Baby has sunken eyes/sagging skin?
 - Caregiver/child has an impairment?
 - Caregiver looks very thin/ill?
 - Caregiver appears to be very anxious, stressed, sad or distressed?
- **Add:** You may notice that some of these questions are more relevant for infants under 6 months. This reflects a limitation of the SRA tool, which is designed as a rapid screening tool across age groups.
- **Ask:**  “For children 6–23 months, what additional questions or observations could help you better understand feeding practices before moving to a full assessment?”
- **Take a few answers**, then complement with:
 - **ASK**
 - What foods did the child eat yesterday?

- How often is the child fed during the day?
 - Has the child been ill recently? Did the child's feeding change during or after illness?
 - **OBSERVE**
 - Signs of acute malnutrition (visible wasting, sunken eyes)
- **Explain:** These questions help identify risks related to feeding, illness, caregiver capacity, and food access that might affect how a child is fed, how much they eat and their risk of poor growth.

! Facilitator Tip *If time allows, ask participants to compare SRA indicators with Priority Triage Tool findings to see overlaps.*

- **Emphasize:**
 - The SRA is a rapid screening tool, not a full assessment. While the SRA does not measure growth directly, it helps identify the feeding, illness and caregiver factors that commonly lead to poor growth.
 - It helps identify children and caregivers who need further counselling or referral.

Bridge: *“Children identified through triage or the SRA will need a full assessment to help you to better understand the causes of nutrition risk and to decide on appropriate support.”*

3 Full Assessment (10 min)

Action:

- **Say:** *“Now we move to the Full Assessment Tool, introduced in Session 2. This tool helps us explore nutritional risks in more detail, understand possible causes and guide appropriate support for children over 6 months.”*
- **Refer** participants to the Full Assessment in their handbook (Session 2: Individual Assessment in Emergencies).
- **Explain:** The Full Assessment includes several sections, but we will look at six key sections that help assess nutritional risk in children over 6 months:
 - MUAC measurement to identify acute malnutrition
 - Section 2: Check for danger signs
 - Section 7: Assess maternal/caregiver wellbeing
 - Section 8: (If 6-23 months) assess complementary feeding practices
 - Section 9: Note any known risk factors
 - Section 10: Note any observations made during the assessment

! Facilitator Tip *Keep the discussion interactive by asking participants to look at the Full Assessment in their handbook and to identify which sections or questions would help assess nutritional risk in children over 6 months.*

Key Points: Nutritional Status Screening with MUAC (at the top of the Full Assessment tool)

- MUAC is used to quickly identify acute malnutrition in children 6–59 months.
- MUAC classification (6–59 months):
 - < 11.5 cm → Severe acute malnutrition (SAM) → Immediate referral for treatment (RED)
 - 11.5–12.4 cm → Moderate acute malnutrition (MAM) → Nutrition rehabilitation and close follow-up (YELLOW)
 - ≥ 12.5 cm → Not acutely malnourished → Continue IYCF assessment and counselling (GREEN)
- A normal MUAC does not rule out feeding or nutritional risks.
- MUAC supports triage decisions but does not replace a full feeding assessment.
- Assessing feeding practices helps identify nutritional risks early, before malnutrition develops.

Key Points: Check for danger signs (section 2 of the Full Assessment Tool)

- Section 2 of the Full Assessment Tool helps check for danger signs that require immediate medical attention, such as lethargy, vomiting everything, difficulty drinking/breastfeeding or severe respiratory problems.

- Danger signs take priority over all other assessments.
- Counsellors must refer immediately if any danger signs are present.

Key Points: Assess maternal/caregiver wellbeing (section 7 of the Full Assessment tool)

- Caregiver wellbeing strongly influences child feeding and care.
- Stress, anxiety, depression or lack of support may reduce a caregiver’s ability to feed and care for the child.
- Identifying these concerns allows referral to MHPSS or social support services.

Key Points: Assess complementary feeding practices (section 8 of the Full Assessment tool)

- For children 6–23 months, focus is more on diet, hygiene, food preparation and feeding difficulties, rather than on breastfeeding frequency or positioning.
- The purpose of this section is to:
 - Assess **diet quality**
 - Assess **feeding frequency**
 - Identify **feeding difficulties**
 - Identify **hygiene risks**
- Feeding difficulties (choking, coughing, refusal of solids) may indicate medical conditions, developmental differences or disabilities. They often become more visible during complementary feeding.
 - Some children refuse solid foods to protect their airway when swallowing feels unsafe.
 - Aspiration or choking that was not noticed during exclusive breastfeeding may become life-threatening when thicker foods are introduced.
 - Feeding challenges may become more visible during the complementary feeding period, as textures and feeding skills change.

Key Points: Note any known risk factors (section 9 of the Full Assessment tool)

- Certain child or caregiver situations increase vulnerability to nutritional problems.
- These risks may not be visible during feeding assessment.
- Identifying and making note of them helps determine priorities for counselling and referral.

Key Points: Note any observations made during the assessment (section 10 of the Full Assessment tool)

- Observing caregiver–child interaction helps understand how feeding and care occur in practice.
- Poor interaction, low responsiveness or developmental concerns may affect feeding and nutrition.
- Observations help guide **counselling and referral for additional support**.

Bridge: “Let’s summarize what we’ve learned and reflect on the key points before moving to the last learning objective.”

4 Key takeaways and questions (2 min)

Action:

- **Refer:** Key learning points – Objective 2 (Participant Handbook)

! Facilitator Tip

Point participants to the Key learning points in their handbook. If needed, quickly summarize them from the handbook for reinforcement.

- **Ask** whether participants have any questions before moving on.

! Facilitator Tip

If you have an extra minute or want more discussion, ask:
 “Thinking about the children you see in your context, which nutritional risks or caregiver/household factors do you most often encounter that could affect growth in children over 6 months?”

Bridge: “Having explored how to identify nutritional risks and possible causes of poor growth in children over 6 months, we will build on this by exploring how to support caregivers in providing safe and adequate complementary feeding, even in situations of extreme food insecurity. This will help us translate the assessment into practical, context-sensitive counselling.”




LEARNING OBJECTIVE 3:

Counsel a caregiver on complementary feeding during extreme food insecurity

Time: 15 min

1 Understand the reality that families face (3 min)

Action:


- **Explain:**
 - Complementary feeding is essential for children 6–23 months, but emergencies disrupt routines and access to age-appropriate and diverse food, safe water and hygiene supplies.
 - Recommended practices **don't change**, but priorities shift. The counsellor focuses on **child safety, intake and caregiver capacity**.
- **Ask:**  *"In situations of extreme food insecurity, what challenges or constraints might families face that make complementary feeding difficult?"*
- **Encourage** participants to brainstorm and share examples.
- **Write** answers on a flipchart.
- **Guide** the discussion towards these key points (add any missing):
 - Limited food availability or diversity
 - Limited water, hygiene and safe cooking facilities
 - Caregiver exhaustion, stress and limited time
 - Illness in children or other household members
- **Say:** *"In extreme food insecurity, the goal is not a perfect diet. Instead, it is about helping families take the safest, most realistic steps to protect the child's nutrition and wellbeing."*
- **Refer:** *Table: How Complementary Feeding Changes in Extreme Food Insecurity (Participant Handbook).*
- **Briefly** highlight how counselling priorities shift during emergencies.

Bridge: *"Now that we understand the challenges families face during extreme food insecurity, it's important to recognize that caregivers often adapt their feeding practices in response to these constraints. Our next step is to explore harmful coping patterns so that we can support caregivers safely, without blame, and help them to make small, realistic improvements."*

2 Recognize harmful coping patterns (4 min)

Action:

- **Say:** *"During extreme food insecurity, families often adapt feeding practices to cope with limited resources. These adaptations may increase nutritional risk for young children, but they reflect caregivers trying to do the best they can for their children under very difficult conditions, not a lack of care or knowledge. In these situations, counselling focuses on reducing harm, supporting caregiver capacity, and maintaining safety and dignity."*
- **Emphasize:**
 - Feeding challenges are rarely only about food. They are often shaped by stress experienced by both the child and caregiver, which can change how children are fed and how much they eat.
 - Preventing unsafe practices and maintaining regular intake helps protect children's nutrition while families work towards improved dietary quality.
 - There are many types of coping strategies families use during food insecurity. In this discussion, we are focusing on those that directly affect complementary feeding practices and young children's eating.

- **Ask:**  “In situations of extreme food scarcity, families often do what they can to cope and protect their children. What strategies might caregivers use that help them manage in the short term but that could, unintentionally, increase risk for young children?”
- **Write** answers on a flipchart.
- **Invite** participants to note key examples in their Participant Handbook.
- **Guide** discussion towards these key examples:
 - Diluting family foods or milk so it lasts longer (lower energy intake)
 - Adults or older children skipping meals or giving up more nutritious foods to prioritize younger children (which may affect caregiver strength, especially for pregnant or breastfeeding caregivers)
 - Relying on low-cost snack foods or sugary drinks because they are available, affordable or help calm children
 - Storing or reheating food in ways that might be less hygienic but reduce waste when fuel, time or safe storage are limited
 - Feeding less often because of limited food, fuel, time or caregiver exhaustion
 - Encouraging children to eat quickly or insisting they eat to avoid waste or conflict
- **Wrap up:**
 - These behaviours are **survival strategies, not neglect**. They reflect caregivers trying to protect their children under difficult conditions.
 - Feeding decisions are shaped by **resource constraints, household power dynamics and practical limitations**, rather than lack of knowledge.
 - Counsellors should **first understand the family’s context** before offering suggestions. This helps counsellors understand both what the child is eating and what pressures are shaping feeding decisions.
 - The counsellor’s role is not to judge caregivers but to understand what is driving them and support safer options where possible.



Facilitator Tip

- Reinforce empathy: caregivers are doing the best they can with what they have.
- Emphasize that these patterns are common and expected during periods of extreme food scarcity.

Bridge: “We’ve looked at the reality families face and the coping strategies they may use under extreme food insecurity. These adaptations can sometimes increase nutritional risk. Understanding these patterns is the first step. Now, let’s move to how we can use this understanding to guide practical counselling. Our goal is to help caregivers make safe, feasible decisions that protect the child’s nutrition and wellbeing, even when resources are limited.”

3 Applying a practical counselling approach in extreme food insecurity (6 min)

Action:

- **Explain:** In practice, counselling always begins by assessing the family’s current situation:
 - What food is available today
 - What the child is currently eating
 - What challenges the caregiver is facing
 - What support systems are available
- **Say:** “Once we know the situation, we focus on the actions that **protect the child most**, especially in extreme food insecurity. These five priorities guide our counselling:
 - Protect breastfeeding,
 - Ensure the child eats enough,
 - Improve nutrient value using available foods,
 - Reduce infection risks, and

- Link families to support and services.”
- **Refer:** *Table: Five counselling priorities for complementary feeding in extreme food insecurity* (Participant Handbook).

Key Points

- **Priority 1: Protect breastfeeding**
 - Encourage continued breastfeeding as much as possible.
 - Remind caregivers that breast milk:
 - Provides essential nutrients and immunity protection
 - Is especially important when complementary foods are limited or unsafe
 - Temporary increases in frequency may help children during acute food shortages.
 - Breastfeeding remains protective but does not replace complementary foods after 6 months.
- **Priority 2: Ensure the child eats enough**
 - Focus on practical ways to maximize intake given available resources:
 - Offer multiple small meals or snacks throughout the day.
 - Use available foods that the child will accept.
 - When foods are unfamiliar or less preferred, use small amounts of locally used ingredients to improve taste and acceptability, while avoiding very salty or highly processed seasonings.
 - Emphasize responsive feeding, extra encouragement and patience – especially for children recovering from illness.
 - In situations of extreme food scarcity, dietary diversity may be limited. The priority is to ensure the child eats enough, as safely as possible, using available and affordable foods. Even small increases in intake can help protect children during this period. Emphasize realistic goals: small improvements today are better than aiming for an ideal diet that is not feasible in context. As access improves, counsellors can support gradual increases in dietary diversity.
- **Priority 3: Improve nutrient value using available foods**
 - Support caregivers to make the most of limited foods:
 - Combine foods to increase protein and micronutrient intake.
 - Use nutrient-dense local foods where available: eggs, legumes, meat and fortified products if provided by programmes.
 - Make practical modifications to adapt family foods for young children, such as setting aside a portion before adding salt; mashing or chopping foods; offering soft or handheld pieces; and mixing foods to improve texture and nutrition.
 - Provide practical support where possible, such as providing sample foods; demonstrating recipes or food preparation techniques; or linking to food distribution and other food security and nutrition programmes (such as multiple micronutrient supplementation).
- **Priority 4: Reduce infection risks**
 - Emergencies often change hygiene and food preparation conditions. Counselling should focus on the most important hygiene actions that are realistic in the household:
 - Use the safest available water for cooking and drinking, including treating or boiling water.
 - Emphasize handwashing before food preparation and feeding, using soap where available or the safest alternative.
 - Prepare food fresh where possible and avoid keeping food at room temperature for long periods.
 - Safe storage and reheating of food.
 - Reducing contamination risks for donated or ready-to-eat foods.
 - Use a clean, dedicated bowl, cup and spoon for the child.
 - Keep feeding areas and surfaces as clean as possible, including where the child sits and eats.

- Focus on the most important hygiene actions that reduce infection risk and are feasible in the current setting, and coordinate with water, sanitation and hygiene (WASH) colleagues where needed to address barriers to safe water, hygiene and/or food preparation.
- **Priority 5: Link families to support and services**
 - Counsellors are critical in helping families access resources they may need in order to act on advice:
 - Food assistance, including supplementary rations, cash or vouchers
 - Health services, including malnutrition treatment
 - WASH services and related Non-Food Items
 - Mental health and psychosocial support (MHPSS) for both caregivers and children
 - Protection and GBV referral pathways
 - Infant and young child feeding-support services, such as counselling spaces or peer support where available
 - It is important that counsellors understand a caregiver’s access to services, recognizing that barriers such as distance, cost, safety or acceptability may limit uptake.
 - Counselling continues even as referrals are arranged, with practical guidance based on the family’s current constraints.
 - Supporting access to services is as important as counselling itself.

Bridge: *“We’ve explored the reality families face, common coping strategies under extreme food insecurity, and a practical approach to counselling that focuses on the five priorities to protect the child. Before we practise this in a demonstration, let’s take a moment to summarize the key points and answer any questions to make sure everyone is clear on the concepts and approach.”*

4 Key takeaways and questions (2 min)

Action:

- **Refer:** Key learning points – Objective 2 (Participant Handbook)

! Facilitator Tip Point participants to the Key learning points in their handbook. If needed, quickly summarize from the handbook to reinforce.

- **Ask** whether participants have any questions before moving on.

! Facilitator Tip If you have an extra minute or want more discussion, ask: *“Based on your experience, what challenges do caregivers face when trying to feed young children during times of food scarcity?”*

Bridge: *“Now that we’ve explored the reality families face, common coping strategies under extreme food insecurity, and practical counselling priorities, let’s watch a demonstration of group counselling with fathers, so you can see how these principles are applied in practice and how fathers can support young children’s feeding during difficult times.”*

STEP 3: Demonstrate

 25 min

1 Introduction (5 min)

Action:

- **Introduce:** *“In many emergencies, fathers or other family members influence food decisions, workload and caregiving support. In this session, we will demonstrate a support group discussion focused on helping fathers support young children’s eating during difficult times. We are:*
 - Showing how complementary feeding counselling works in a **group setting**
 - Demonstrating **how fathers can support caregiving and share responsibility for feeding**

! Facilitator Tip

If participants say that fathers are not usually involved in feeding:

- *That may be true in many contexts. Fathers may not be the ones directly feeding young children. At the same time, they often influence food decisions, resources and caregiver workload.*
- *In emergencies, roles within the household can shift owing to displacement, loss of livelihoods, or changes in daily routines. This may create new opportunities for fathers to support caregiving and feeding in ways that are practical and acceptable in their context. Even small changes can make a meaningful difference for young children.*

- **Emphasize** three key counselling skills to observe:
 - Ask open questions.
 - Avoid using words that sound judgmental.
 - Make one or two suggestions rather than giving commands.
- **Summarize** the scenario context:
 - We are continuing in the same context from Step 1, where families are recovering from illness and facing multiple caregiving and food security challenges, including food shortages and heavy workloads.
 - Focus is on supporting fathers to help ensure young children eat safely and adequately during extreme food insecurity.
- **Explain** roles:
 - **Facilitator:** IYCF-E Counsellor
 - **Participants:** Fathers from the community
 - Ask for **three volunteers** to actively participate in the demo as fathers
- **Distribute:** Hand out scripts to the volunteers:
 - Father 1 – script Annex 7.1
 - Father 2 – script Annex 7.2
 - Father 3 – script Annex 7.3
- **Invite** participants to observe:
 - How the counsellor asks questions and guides discussion
 - How fathers contribute ideas without being judged
 - How small, practical suggestions emerge collaboratively

2 Script (12 min)

Action:

- **Act out** the script below as a group discussion.
 - One facilitator plays the IYCF-E counsellor, and three volunteers play the fathers.

- A second facilitator pauses the demonstration at key moments to ask short reflection questions and guide the discussion.



Facilitator Tip

- *This demonstration models a group counselling discussion, not a lecture. The counsellor guides the conversation by asking open questions and building on fathers' experiences.*
- *Encourage volunteers playing the fathers to speak naturally rather than reading word for word. Short pauses or small variations are fine.*
- *The goal is to show how ideas and practical solutions can emerge from the group, with the counsellor gently guiding the discussion.*



Counsellor

Thank you for coming. Today we are talking about young children who are learning to eat in this situation. Many families tell me mealtimes have become more stressful lately. What changes have you noticed with the children's eating over the past few weeks?



Father 1

The children don't eat like before. They refuse food.



Counsellor

That sounds frustrating. What do you usually do when a child refuses?



Father 2

We insist. Food is expensive. There isn't much available. It cannot be wasted.



Counsellor

Many parents feel that way when food is scarce. Wanting children to eat is a sign of care and love. Sometimes when children are stressed or recovering from illness, their appetite becomes smaller.



Facilitator

- **Prompt:** What did you notice about how the counsellor responded to the fathers' concerns?

Explanation:

The counsellor normalized the fathers' feelings rather than correcting them.

By acknowledging their concern about food waste, the counsellor shows respect for the family's reality and keeps the discussion open.



Counsellor

When you feel stressed or unwell yourself, do you usually feel more hungry or less hungry?



Group

Less



Father 1

When I am worried or sick, I don't feel like eating at all.



Father 2

Yes, sometimes food is there but you just don't want it.



Counsellor

Young children often eat better when meals feel safe and relaxed. Who usually feeds the child in your homes?











Group

The mothers.



Counsellor

What happens to feeding when the mothers are tired or busy?

	Father 3	The children may not eat.
	Father 1	When my wife is exhausted, the children eat less. If I sit with them or help, they eat better.
	Father 2	Yes. When meals are rushed, nobody eats well.
	Father 3	That's the same in my house. Sometimes the child just wants someone to sit with them.
	Counsellor	It sounds like many of you have already noticed what helps children eat. One way fathers can help their children grow is by supporting calm mealtimes. By sitting with the child and encouraging gently, or by helping to reduce the mother's workload. When mealtimes feel calmer and shared, it often reduces stress for everyone in the household, for both children and adults.
	Father 1	Yes, that makes sense.
	Counsellor	Let's think together. If food is limited, what small things could help your children to eat enough?
	Father 1	Maybe giving the child food first, before others eat.
	Counsellor	That can help make sure the youngest child gets their portion first, which is important because they are most vulnerable. At the same time, we try to make sure everyone in the household eats something, even if portions are small, so the whole family can stay strong and continue caring for the child.
	Father 2	My child eats better when she has her own bowl. Otherwise, the older children take the food.
	Counsellor	That's a very practical idea. A child having their own bowl helps caregivers see how much they are eating and protects their portion.
	Father 3	Sometimes children don't finish meals, but they will eat again later. If food is kept for later, store it as safely as possible and reheat it thoroughly before feeding again.
	Counsellor	Exactly. Small, frequent meals can work better than expecting a child to eat a large amount at once, especially after illness.
	Facilitator	<ul style="list-style-type: none"> • Prompt: Did you notice where the ideas came from? Was it the counsellor or the fathers? <p>Explanation: <i>The counsellor created space for fathers to generate practical solutions themselves, such as giving children their own bowls or offering smaller amounts more often. At the same time, the counsellor helps guide these ideas to make sure they are safe, realistic, and support both the child and the wider family. This approach builds confidence while supporting families to make decisions for themselves that protect young children and maintain caregiver capacity.</i></p>
	Father 1	After sickness my son eats very slowly.


	Counsellor	Many children need extra patience while their appetite returns after illness. What have you noticed helps a child eat again?
	Father 1	We give smaller amounts.
	Father 2	Sometimes they eat better later in the day.
	Father 3	If we don't rush them.
	Counsellor	<i>Reflecting briefly</i> So smaller amounts, more time, and less pressure.
	Father 2	When we sit together, the child copies us and eats more.
	Counsellor	Eating together helps children feel calm. Anyone else noticed that?
	Father 1	Yes. When everyone is relaxed when we sit together and talk and relax, they all eat more.
	Counsellor	That's important. Right now, the goal is not perfect meals. We want to focus on helping your children to continue eating safely while your families manage the food shortages. <i>Short pause to give time for the fathers to absorb this.</i> During difficult times, do your younger children breastfeed more or less?
	Group	More.
	Father 3	When food is less, they want the breast more.
	Counsellor	Yes. Supporting the mothers to rest and continue breastfeeding helps protect young children during these periods.
	Father 3	Breastfeeding more is okay, even for older babies?
	Counsellor	Yes. Breastfeeding can increase during stress or food shortages and helps children stay strong while other foods are limited. It is recommended to breastfeed children up to 2 years or even older. This is even more important in a situation like this.
	Father 2	But if food is scarce, how can the mothers produce enough milk?
	Counsellor	That's an important question. Many families worry about this. Even when food is limited, breastfeeding can continue if the child feeds often. When others in the household help with meals, rest, and daily work, it makes it easier for breastfeeding to continue. So, you have an important role in supporting this within your family. <i>Pause</i> When fathers provide this kind of support, it can make breastfeeding easier for both the mother and the child.

	Facilitator	<ul style="list-style-type: none"> • Prompt: How did the counsellor involve fathers in supporting breastfeeding? <p>Explanation: <i>The counsellor linked male involvement to practical support, such as helping reduce the mother's workload or providing emotional support. This reinforces that fathers play an important role in protecting young children's nutrition.</i></p>
	Father 2	I thought breastfeeding more meant something was wrong. But maybe the child just needs it more now. That makes sense.
	Counsellor	<p><i>Nodding at Father 2's last comment</i> Yes, wonderful. It's time to wrap up the session now. But, before we finish, I'd like each of you to think about one small thing you might try this week to make mealtimes easier at home.</p>
	Father 1	I will try sitting with my daughter while she eats and not pushing her to finish quickly.
	Father 2	I will make sure the youngest has her own bowl.
	Father 3	I can help feed the children in the evening so their mother can rest.
	Counsellor	<p><i>Closing affirmation</i> Those are strong ideas. Small actions like these can make a big difference for children during difficult times. Thank you for sharing your experiences and supporting each other today. The nutrition team is here to help you with this or anything else that you might need.</p>

3 Debrief (8 min)

Action:

- **Ask:** "What did you notice about how the counsellor guided the discussion with the fathers?"
- **Possible answers may include:**
 - Asking open questions
 - Encouraging fathers to share their experiences
 - Avoiding judgmental language
 - Allowing ideas and solutions to come from the group
 - Offering one or two practical suggestions
- **Explain:** The counsellor did not lecture or give many instructions. Instead, the counsellor asked questions and built on the fathers' responses. This helps participants feel respected and encourages families to identify solutions that are realistic in their own context.
- **Ask:** "Have any of you facilitated or observed group counselling discussions like this before? What worked well?"
- **Collect** a few examples.
- **Explain:** Group discussions can be powerful because participants learn from each other's experiences. The counsellor's role is to guide the conversation and highlight helpful practices, rather than provide long explanations.

- **Ask:**  “In your communities, what roles do fathers or other family members play in supporting young children’s feeding?”
- **Collect** a few examples.
- **Explain:** Fathers and other family members often influence food decisions, caregiving and household workload. When they are involved in counselling discussions, they may better understand how they can support caregivers and help protect children’s nutrition during difficult times.

Bridge: “Thank you for sharing your observations and experiences. In the next step, you will have the opportunity to practice these counselling skills yourselves.”

STEP 4: Role-Play

 25 min

1 Introduction (5 min)

Action:

- **Explain:** “In this role-play, you will practise applying practical complementary feeding counselling skills during a home visit. The scenario picks up after Angela has been enrolled in the Blanket Supplementary Food Programme. During the exercise, you will practise how a frontline worker can guide caregivers to identify small, realistic actions that help support young children’s nutrition in a challenging context.”
- **Organize:** Ask participants to form groups of three: **Counsellor, Angela, Observer**. Participants stay in the same groups as previous sessions but rotate roles so that the previous observer is now a counsellor or Angela.
- **Distribute:** Hand out the role cards to each ‘Angela’ (*prepared in advance from Annex 7.4*).
- **Explain:** The observer uses the Counselling Skills Checklist to note strengths and areas for improvement.
- **Remind:** Counsellors should practise using the three key skills demonstrated in Step 3:
 - Ask open questions.
 - Avoid using words that sound judgmental.
 - Make one or two suggestions rather than giving commands.
- **Allow:** Give groups 2–3 minutes to get ready before beginning their role-plays. Participants can take a minute to review the Counselling Skills Checklist to refresh their memory of the key recommendations discussed during the session.
- **Time:** The role-play lasts around 10 minutes.

4 Role-play practice (10 min)




Action:

- **Encourage:** Ask groups to start quickly and use their full time.
- **Support:** Move quietly among groups, observe and answer questions if needed.
- **Manage time:** Give a **5-minute** and **2-minute** warning so participants can pace themselves.
- **End:** Stop the activity on time, even if some groups have not finished the full role-play.

4 Debrief (10 min)

Action:

- **Gather:** Bring everyone back together and thank participants for their role plays and effort.

- **Ask to “Angela’s”**  :
 - “How did it feel to be in Angela’s place?”
 - “What was most challenging about sharing your experiences or suggesting small changes for your child’s feeding?”
- **Ask to observers**  :
 - “What strengths did you notice in the counsellor’s approach?”
 - “What areas could be improved?”
- **Ask to counsellors**  :
 - “How did it feel to be in the counsellor role?”
 - “What was most challenging? What worked well?”
- **Refer:** Role-play debrief: Angela and Adeline (Participant Handbook).
- **Add:** Highlight key points if they do not come up. Use the debrief box from the Participant Handbook to add practical advice that should have been applied during the counselling session (asking open questions to understand the situation, avoiding blame when discussing feeding challenges, helping reduce stress during meals, suggesting one or two realistic actions, recognizing caregiver efforts and summarizing agreed next steps).

Bridge: “Supporting young children’s feeding during difficult times often requires understanding the caregiver’s situation and working together to find small, realistic solutions. In Step 5, you will reflect individually on what you learned in this session and how you can apply these counselling approaches in your daily work with caregivers.”

STEP 5: Self-reflection

 5 min

Action:

- **Invite:** Ask participants to take a quiet moment to reflect and note their answers in the Participant Handbook.
- **Guide:** Read the three questions (also in the Participant Handbook) out loud and give participants 2–3 minutes of silence to think/write.
- **Share (optional):** If time allows, invite 1–2 volunteers to share a key takeaway.
- **Close:** Thank participants for their reflections and emphasize that applying these insights in real-life counselling is where change happens.



Facilitator Tip

Keep the activity short and personal. This is not a group discussion but an opportunity for each participant to consolidate their own learning.









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ANNEX 7.1: Demo Script – Father 1

Cut the script below and provide it to the participant acting as Father 1.

	Counsellor	Thank you for coming. Today we are talking about young children who are learning to eat during difficult times. Many families tell me mealtimes have become stressful lately. What changes have you noticed with the children's eating since the drought and illness?
	Father 1	The children don't eat like before. They refuse food.
	Counsellor	That sounds frustrating. What do you usually do when a child refuses?
	Father 2	We insist. Food is expensive. There isn't much available. It cannot be wasted.
	Counsellor	Many parents feel that way when food is scarce. Wanting children to eat is a sign of care and love. Sometimes when children are stressed or recovering from illness, their appetite becomes smaller.
	Counsellor	When you feel stressed or unwell yourself, do you usually feel more hungry or less hungry?
	Group	Less
	Father 1	When I am worried or sick, I don't feel like eating at all.
	Father 2	Yes, sometimes food is there but you just don't want it.
	Counsellor	Young children often eat better when meals feel safe and relaxed. Who usually feeds the child in your homes?
	Group	The mothers
	Counsellor	What happens to feeding when the mothers are tired or busy?
	Father 3	The children may not eat.
	Father 1	When my wife is exhausted, the children eat less. If I sit with them or help, they eat better.
	Father 2	Yes. When meals are rushed, nobody eats well.
	Father 3	That's the same in my house. Sometimes the child just wants someone to sit with them.
	Counsellor	It sounds like many of you have already noticed what helps children eat. One way fathers can help their children grow is by supporting calm mealtimes. By sitting with the child and encouraging gently or by helping to reduce the mother's workload.

When mealtimes feel calmer and shared, it often reduces stress for everyone in the household, for both children and adults.
















	Father 1	Yes, that makes sense.
	Counsellor	Let's think together. If food is limited, what small things could help a young child eat enough?
	Father 1	Maybe giving the child food first, before others eat.
	Counsellor	That can help make sure the youngest child gets their portion first, which is important because they are most vulnerable. At the same time, we try to make sure everyone in the household eats something, even if portions are small, so the whole family can stay strong and continue caring for the child.
	Father 2	My child eats better when she has her own bowl. Otherwise, the older children take the food.
	Counsellor	That's a very practical idea. A child having their own bowl helps caregivers see how much they are eating and protects their portion.
	Father 3	Sometimes children don't finish meals, but they will eat again later.
	Counsellor	Exactly. Small, frequent meals can work better than expecting a child to eat a large amount at once, especially after illness.
	Father 1	After sickness my son eats very slowly.
	Counsellor	Many children need extra patience while their appetite returns after illness. What have you noticed helps a child eat again?
	Father 1	We give smaller amounts.
	Father 2	Sometimes they eat better later in the day.
	Father 3	If we don't rush them.
	Counsellor	<i>Reflecting briefly</i> So smaller amounts, more time, and less pressure.
	Father 2	When we sit together, the child copies us and eats more.
	Counsellor	Eating together helps children feel calm. Anyone else noticed that?
	Father 1	Yes. When everyone is relaxed when we sit together and talk and relax, they all eat more.


















	Counsellor	<p>That's important. Right now, the goal is not perfect meals. We want to focus on helping your children to continue eating safely while your families manage the food shortages.</p> <p><i>Short pause to give time for the fathers to absorb this.</i></p> <p>During difficult times, do your younger children breastfeed more or less?</p>
	Group	More.
	Father 3	When food is less, they want the breast more.
	Counsellor	Yes. Supporting the mothers to rest and continue breastfeeding helps protect young children during these periods.
	Father 3	Breastfeeding more is okay even for older babies?
	Counsellor	Yes. Breastfeeding can increase during stress or food shortages and helps children stay strong while other foods are limited. It is recommended to breastfeed children up to 2 years or even older. This is even more important in a situation like this.
	Father 2	But if food is scarce, how can the mothers produce enough milk?
	Counsellor	<p>That's an important question. Many families worry about this. Even when food is limited, mothers' bodies usually continue to make milk if the child breastfeeds often. What helps most is reducing stress and supporting the mother, like having helping with meals, rest, and daily work.</p> <p><i>Pause</i></p> <p>When fathers support mothers, breastfeeding becomes easier for both mother and child.</p>
	Father 2	I thought breastfeeding more meant something was wrong. But maybe the child just needs it more now. That makes sense.
	Counsellor	<p><i>Nodding at Father 2's last comment</i></p> <p>Yes, wonderful. It's time to wrap up the session now. But, before we finish, I'd like each of you to think about one small thing you might try this week to make mealtimes easier at home.</p>
	Father 1	I will try sitting with my daughter while she eats instead of rushing.
	Father 2	I will make sure the youngest has her own bowl.
	Father 3	I can help feed the children in the evening so their mother can rest.
	Counsellor	<p><i>Closing affirmation</i></p> <p>Those are strong ideas. Small actions like these can make a big difference for children during difficult times. Thank you for sharing your experiences and supporting each other today. The nutrition team is here to help you with this or anything else that you might need.</p>

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ANNEX 7.2: Demo Script – Father 2

Cut the script below and provide it to the participant acting as Father 2.

	Counsellor	Thank you for coming. Today we are talking about young children who are learning to eat during difficult times. Many families tell me mealtimes have become stressful lately. What changes have you noticed with the children's eating since the drought and illness?
	Father 1	The children don't eat like before. They refuse food.
	Counsellor	That sounds frustrating. What do you usually do when a child refuses?
	Father 2	We insist. Food is expensive. There isn't much available. It cannot be wasted.
	Counsellor	Many parents feel that way when food is scarce. Wanting children to eat is a sign of care and love. Sometimes when children are stressed or recovering from illness, their appetite becomes smaller.
	Counsellor	When you feel stressed or unwell yourself, do you usually feel more hungry or less hungry?
	Group	Less
	Father 1	When I am worried or sick, I don't feel like eating at all.
	Father 2	Yes, sometimes food is there but you just don't want it.
	Counsellor	Young children often eat better when meals feel safe and relaxed. Who usually feeds the child in your homes?
	Group	The mothers
	Counsellor	What happens to feeding when the mothers are tired or busy?
	Father 3	The children may not eat.
	Father 1	When my wife is exhausted, the children eat less. If I sit with them or help, they eat better.
	Father 2	Yes. When meals are rushed, nobody eats well.
	Father 3	That's the same in my house. Sometimes the child just wants someone to sit with them.
	Counsellor	It sounds like many of you have already noticed what helps children eat. One way fathers can help their children grow is by supporting calm mealtimes. By sitting with the child and encouraging gently or by helping to reduce the mother's workload.

		When mealtimes feel calmer and shared, it often reduces stress for everyone in the household, for both children and adults.
	Father 1	Yes, that makes sense.
	Counsellor	Let's think together. If food is limited, what small things could help a young child eat enough?
	Father 1	Maybe giving the child food first, before others eat.
	Counsellor	That can help make sure the youngest child gets their portion first, which is important because they are most vulnerable. At the same time, we try to make sure everyone in the household eats something, even if portions are small, so the whole family can stay strong and continue caring for the child.
	Father 2	My child eats better when she has her own bowl. Otherwise, the older children take the food.
	Counsellor	That's a very practical idea. A child having their own bowl helps caregivers see how much they are eating and protects their portion.
	Father 3	Sometimes children don't finish meals, but they will eat again later.
	Counsellor	Exactly. Small, frequent meals can work better than expecting a child to eat a large amount at once, especially after illness.
	Father 1	After sickness my son eats very slowly.
	Counsellor	Many children need extra patience while their appetite returns after illness. What have you noticed helps a child eat again?
	Father 1	We give smaller amounts.
	Father 2	Sometimes they eat better later in the day.
	Father 3	If we don't rush them.
	Counsellor	<i>Reflecting briefly</i> So smaller amounts, more time, and less pressure.
	Father 2	When we sit together, the child copies us and eats more.
	Counsellor	Eating together helps children feel calm. Anyone else noticed that?
	Father 1	Yes. When everyone is relaxed when we sit together and talk and relax, they all eat more.
	Counsellor	That's important. Right now, the goal is not perfect meals. We want to focus on helping your children to continue eating safely while your families manage the food shortages.

Short pause to give time for the fathers to absorb this.

During difficult times, do your younger children breastfeed more or less?



Group

More.



Father 3

When food is less, they want the breast more.



Counsellor

Yes. Supporting the mothers to rest and continue breastfeeding helps protect young children during these periods.



Father 3

Breastfeeding more is okay even for older babies?



Counsellor

Yes. Breastfeeding can increase during stress or food shortages and helps children stay strong while other foods are limited. It is recommended to breastfeed children up to 2 years or even older. This is even more important in a situation like this.



Father 2

But if food is scarce, how can the mothers produce enough milk?



Counsellor

That's an important question. Many families worry about this. Even when food is limited, mothers' bodies usually continue to make milk if the child breastfeeds often. What helps most is reducing stress and supporting the mother, like having helping with meals, rest, and daily work.

Pause

When fathers support mothers, breastfeeding becomes easier for both mother and child.



Father 2

I thought breastfeeding more meant something was wrong. But maybe the child just needs it more now. That makes sense.



Counsellor

Nodding at Father 2's last comment

Yes, wonderful. It's time to wrap up the session now. But, before we finish, I'd like each of you to think about one small thing you might try this week to make mealtimes easier at home.



Father 1

I will try sitting with my daughter while she eats instead of rushing.



Father 2

I will make sure the youngest has her own bowl.



Father 3

I can help feed the children in the evening so their mother can rest.



Counsellor
















Closing affirmation


















Those are strong ideas. Small actions like these can make a big difference for children during difficult times. Thank you for sharing your experiences and supporting each other today. The nutrition team is here to help you with this or anything else that you might need.















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ANNEX 7.3: Demo Script – Father 3

Cut the script below and provide it to the participant acting as Father 3.

	Counsellor	Thank you for coming. Today we are talking about young children who are learning to eat during difficult times. Many families tell me mealtimes have become stressful lately. What changes have you noticed with the children's eating since the drought and illness?
	Father 1	The children don't eat like before. They refuse food.
	Counsellor	That sounds frustrating. What do you usually do when a child refuses?
	Father 2	We insist. Food is expensive. There isn't much available. It cannot be wasted.
	Counsellor	Many parents feel that way when food is scarce. Wanting children to eat is a sign of care and love. Sometimes when children are stressed or recovering from illness, their appetite becomes smaller.
	Counsellor	When you feel stressed or unwell yourself, do you usually feel more hungry or less hungry?
	Group	Less
	Father 1	When I am worried or sick, I don't feel like eating at all.
	Father 2	Yes, sometimes food is there but you just don't want it.
	Counsellor	Young children often eat better when meals feel safe and relaxed. Who usually feeds the child in your homes?
	Group	The mothers
	Counsellor	What happens to feeding when the mothers are tired or busy?
	Father 3	The children may not eat.
	Father 1	When my wife is exhausted, the children eat less. If I sit with them or help, they eat better.
	Father 2	Yes. When meals are rushed, nobody eats well.
	Father 3	That's the same in my house. Sometimes the child just wants someone to sit with them.
	Counsellor	It sounds like many of you have already noticed what helps children eat. One way fathers can help their children grow is by supporting calm mealtimes. By sitting with the child and encouraging gently or by helping to reduce the mother's workload.

		When mealtimes feel calmer and shared, it often reduces stress for everyone in the household, for both children and adults.
	Father 1	Yes, that makes sense.
	Counsellor	Let's think together. If food is limited, what small things could help a young child eat enough?
	Father 1	Maybe giving the child food first, before others eat.
	Counsellor	That can help make sure the youngest child gets their portion first, which is important because they are most vulnerable. At the same time, we try to make sure everyone in the household eats something, even if portions are small, so the whole family can stay strong and continue caring for the child.
	Father 2	My child eats better when she has her own bowl. Otherwise, the older children take the food.
	Counsellor	That's a very practical idea. A child having their own bowl helps caregivers see how much they are eating and protects their portion.
	Father 3	Sometimes children don't finish meals, but they will eat again later.
	Counsellor	Exactly. Small, frequent meals can work better than expecting a child to eat a large amount at once, especially after illness.
	Father 1	After sickness my son eats very slowly.
	Counsellor	Many children need extra patience while their appetite returns after illness. What have you noticed helps a child eat again?
	Father 1	We give smaller amounts.
	Father 2	Sometimes they eat better later in the day.
	Father 3	If we don't rush them.
	Counsellor	<i>Reflecting briefly</i> So smaller amounts, more time, and less pressure.
	Father 2	When we sit together, the child copies us and eats more.
	Counsellor	Eating together helps children feel calm. Anyone else noticed that?
	Father 1	Yes. When everyone is relaxed when we sit together and talk and relax, they all eat more.

	Counsellor	<p>That's important. Right now the goal is not perfect meals. We want to focus on helping your children to continue eating safely while your families manage the food shortages.</p> <p><i>Short pause to give time for the fathers to absorb this.</i></p> <p>During difficult times, do your younger children breastfeed more or less?</p>
	Group	More.
	Father 3	When food is less, they want the breast more.
	Counsellor	Yes. Supporting the mothers to rest and continue breastfeeding helps protect young children during these periods.
	Father 3	Breastfeeding more is okay even for older babies?
	Counsellor	Yes. Breastfeeding can increase during stress or food shortages and helps children stay strong while other foods are limited. It is recommended to breastfeed children up to 2 years or even older. This is even more important in a situation like this.
	Father 2	But if food is scarce, how can the mothers produce enough milk?
	Counsellor	<p>That's an important question. Many families worry about this. Even when food is limited, mothers' bodies usually continue to make milk if the child breastfeeds often. What helps most is reducing stress and supporting the mother, like having helping with meals, rest, and daily work.</p> <p><i>Pause</i></p> <p>When fathers support mothers, breastfeeding becomes easier for both mother and child.</p>
	Father 2	I thought breastfeeding more meant something was wrong. But maybe the child just needs it more now. That makes sense.
	Counsellor	<p><i>Nodding at Father 2's last comment</i></p> <p>Yes, wonderful. It's time to wrap up the session now. But, before we finish, I'd like each of you to think about one small thing you might try this week to make mealtimes easier at home.</p>
	Father 1	I will try sitting with my daughter while she eats instead of rushing.
	Father 2	I will make sure the youngest has her own bowl.
	Father 3	I can help feed the children in the evening so their mother can rest.
	Counsellor	<p><i>Closing affirmation</i></p> <p>Those are strong ideas. Small actions like these can make a big difference for children during difficult times. Thank you for sharing your experiences and supporting each other today. The nutrition team is here to help you with this or anything else that you might need.</p>

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ANNEX 7.4: Role-play card – Angela Cut the cards below and provide one to each participant acting Angela.

Card: Angela

You tell the counsellor, if you are asked:

- You are worried about Adeline’s eating.
- Adeline often refuses food or eats only a few bites.
- Sometimes you insist that she eat. Food should not be wasted, and you’re worried she’s not eating enough.
- Meals can feel rushed or stressful.
- Usually you feed her, but you are busy and sometimes no one sits with her.
- Sometimes she eats better later in the day.
- You often feel very tired and have many responsibilities.
- You sometimes worry that Adeline isn’t getting enough to eat, even when she does eat a little.

Card: Angela

You tell the counsellor, if you are asked:

- You are worried about Adeline’s eating.
- Adeline often refuses food or eats only a few bites.
- Sometimes you insist that she eat. Food should not be wasted, and you’re worried she’s not eating enough.
- Meals can feel rushed or stressful.
- Usually you feed her, but you are busy and sometimes no one sits with her.
- Sometimes she eats better later in the day.
- You often feel very tired and have many responsibilities.
- You sometimes worry that Adeline isn’t getting enough to eat, even when she does eat a little.

Card: Angela

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Card: Angela

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- Usually you feed her, but you are busy and sometimes no one sits with her.
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Card: Angela

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Card: Angela

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- You sometimes worry that Adeline isn’t getting enough to eat, even when she does eat a little.

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SESSION 8: ASSESSING AND SUPPORTING INFANTS RECEIVING BREASTMILK SUBSTITUTES



LEARNING OBJECTIVES

1. Assess an infant's need for commercial infant formula and identify feeding options that minimize risk
2. Counsel caregivers on recommended feeding practices when using commercial infant formula
3. Identify & act on violations of the Code as a frontline worker



COUNSELLING SKILLS FOCUS*

- Reflect back what the mother/caregiver says
- Use simple language
- Give practical help

*Reminder: The full 3As process and counselling skill set remain essential. The focus on these particular three skills is for practice and learning purposes.



Material and preparation:

- **Role-play cards – Amina (Step 4):** Cut cards for approximately one-third of participants from Annex 8.1 (at the end of this session).
- **Familiarize yourself with the Code before the session:**
 - If you are not already familiar, review the [International Code of Marketing of Breast Milk Substitutes](#) and its key principles.
 - Review how the Code is applied in your country or context (e.g., national legislation, guidance, monitoring or enforcement mechanisms) so you can provide relevant, practical examples during the session.



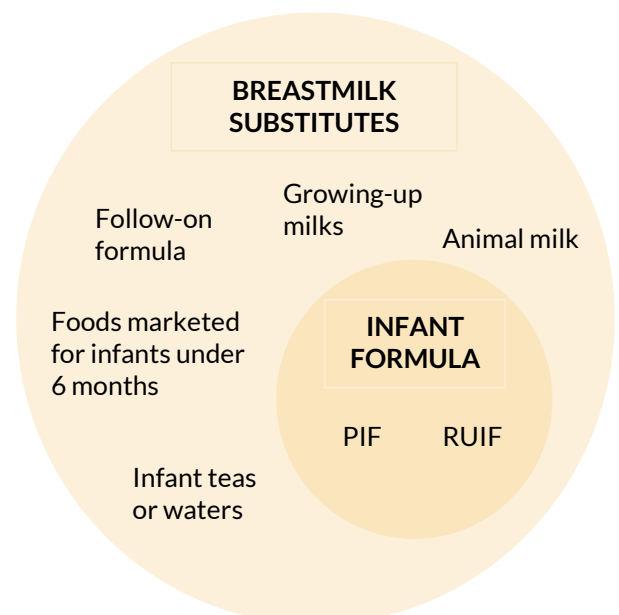
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Note on terminology:

- **Breast milk substitutes (BMS):** Any food or liquid used to replace breast milk, fully or partially (especially for infants under 6 months)
Examples: infant formula, follow-on formula, growing-up milks, animal milk, infant teas or waters, and foods marketed for infants under 6 months
- **Commercial infant formula:** A type of BMS specifically designed to meet the nutritional needs of infants
Examples: powdered infant formula (PIF) and ready-to-use infant formula (RUIF)

→ BMS is a broad term and should not be used as a synonym for infant formula.

In this session, we are focusing on commercial infant formula within our programmes.



STEP 1: Set the Scene

 15 min

1 Why this topic? (5 min)

Key Points:

- In emergencies, not all infants are fully or exclusively breastfed.
 - Some may be **non-breastfed**: receiving no breast milk at all.
 - Others may be **mixed fed**: receiving both breast milk and other milks or foods.
 - Some caregivers may request or already be using breast milk substitutes (BMS), such as commercial infant formula.
- BMS refers to any food or drink used to replace breast milk, either fully or partially. However, it is important to be specific: when programmes provide support, this refers to **commercial infant formula**, which is the only BMS that should be used in a targeted way, following individual assessment and guidance.
- These situations can be complex. While commercial infant formula can sometimes be necessary (e.g., for non-breastfed infants), it can also carry serious risks in emergency settings if not carefully assessed, provided and supported.
- Frontline workers play a critical role in identifying which infants need support and in ensuring that feeding practices – whether breastfeeding, mixed feeding or formula feeding – are as safe as possible.

Action:

- **Ask:** “What are some reasons why a mother or caregiver might request infant formula?”

! Facilitator Tip

Encourage participants to draw on previous sessions, particularly:

- *Session 3: Addressing Stress in Emergencies*
- *Session 4: Supporting Caregivers Affected by Gender-Based Violence*
- *Session 5: Supporting Caregivers during Infectious Disease Outbreaks*
- *Session 6: Increasing Breast Milk Intake*


- **Add:** Use key points if missing:
 - Concern about not having enough milk
 - Breastfeeding difficulties or pain
 - Lack of support or information
 - Stress or trauma
 - Fatigue or caregiver burden
 - Survivor of GBV who does not wish to breastfeed
 - Belief that infant formula is equivalent to or better than breast milk
 - Perception that infant formula is a high-value or desirable product
 - Negative experiences affecting breastfeeding
 - Mother is absent or deceased
 - Infant is unaccompanied or orphaned
- **Remind:** The use of infant formula is a last resort for non-breastfed infants and should be used only after exploring the viability of milk expression and relactation for the mother or breastfeeding by a healthy woman other than the child’s mother (wet nursing) and donor human milk through a formal system, where available.

Bridge: “Let’s consider what this can look like in real life.”

2 Scenario discussion (7 min)

Action:

- **Ask:** Volunteer reads Scenario: Untargeted infant feeding support in an evacuation setting (Participant Handbook).
- **Discuss:**

 **“What concerns you about this situation?”**

- **Probe** if needed:
 - “What risks might this create for infants?”
 - “What challenges might caregivers face?”
 - “What is missing here?”
- **Write:** Capture ideas on a flipchart.
- **Add:** Use key points if missing.
 - Increased risk of illness, malnutrition and death, especially in emergency settings
 - Untargeted distribution → infants may receive inappropriate or expired infant formula unnecessarily or in unsafe quantities
 - Unsafe or inappropriate products → look-alikes, expired products, sweetened drinks, evaporated milk
 - Use of bottle and teat → the use of bottles and teats is common in emergencies. However, these items carry high risk, as they are extremely difficult to keep clean in an emergency setting.
 - No assessment of need → no determination of whether infants truly require infant formula
 - No counselling or follow-up → caregivers may lack skills to safely prepare and feed their infants
 - Risk of unsafe preparation (water, hygiene) → caregivers lack access to equipment and facilities to properly prepare infant formula or to clean and sanitize feeding equipment. This increases illness risk from contaminated water or utensils.
 - Risk of undermining breastfeeding → caregivers may stop breastfeeding unnecessarily
 - No control of Code violations → potential exposure to inappropriate marketing

 **Facilitator Tip**

- Ask participants whether they are familiar with the **International Code of Marketing of Breast Milk Substitutes** (‘the Code’).
- If some are not, invite other participants to share what they know. Then, briefly explain:
 - The Code applies to the marketing and promotion of breast milk substitutes. It does not prohibit the sale or use of products.
 - Adopted by the World Health Assembly in 1981, the Code is updated and clarified by WHA resolutions every two years.
 - It sets the minimum standard for regulation of marketing practices to protect infants and caregivers.
- Reassure participants that this session will cover everything they need to know about the Code for their role.

Bridge: “From this discussion, it is clear that receiving infant formula without guidance can increase risks for infants and place additional burden on caregivers. Skilled support is essential to ensure that infants who truly need an alternative or supplementation to breast milk are identified appropriately; supported to access commercial infant formula when needed; and provided with counselling, monitoring and follow-up.”

3 Learning objectives (3 min)

Action:

- Read learning objectives:
 - Assess an infant’s need for infant formula and identify feeding options that minimize risk.
 - Counsel caregivers on recommended feeding practices when using commercial infant formula.
 - Identify & act on violations of the Code as a community health worker.
- Highlight counselling skills focus:
 - In this session, for learning and practice purposes, we are focusing on the three key skills:
 - Reflect back what the mother/caregiver says
 - Use simple language
 - Give practical help

Bridge: “With these objectives in mind, let’s move into Step 2, where we will explore how to assess infants’ needs for infant formula; counsel caregivers; and ensure recommended feeding practices, while protecting breastfeeding and following the Code.”

STEP 2: Strengthen key knowledge, concepts and skills

 55 min



LEARNING OBJECTIVE 1:

Assess an infant’s need for commercial infant formula and identify feeding options that minimize risk.

Time: 25 min

1 Carefully check eligibility for commercial infant formula support through 1–1 full assessment (10 min)

Action:

- **Say:** “When a mother or caregiver expresses interest in using commercial infant formula, our first step is not to provide it but to understand the situation using a full one-to-one assessment. A request for commercial infant formula often reflects an underlying challenge that may be resolved with the right support.”
- **Add:** As part of the one-to-one full assessment, we explore the situation by understanding:
 - The caregiver’s reasons and concerns for the request
 - Whether breastfeeding challenges can be addressed
 - Whether alternatives that carry less risk are possible
- **Give examples:**
 - If there are breastfeeding difficulties → support positioning and attachment
 - If the mother is separated → explore expressing breast milk
 - If breastfeeding has stopped → consider relactation
 - Explore wet-nursing or donor human milk where appropriate
- **Refer** to Session 2: Individual Assessment in Emergencies for the full assessment.
- **Say:** “Only when these options are not possible do we consider the targeted use of commercial infant formula. When we provide commercial infant formula, our goal is to protect infants while supporting caregivers. Commercial infant formula is not the default solution but an intervention for those who truly need it. Eligibility is determined through a careful, one-to-one assessment by trained health or nutrition workers. Let’s review the eligibility criteria together.”
- **Refer:** Visual: Criteria for commercial infant formula eligibility (Participant Handbook)
- **Explain:** The visual shows a hierarchy of alternatives and eligibility criteria:

- Options that carry **less risk are prioritized**. These include direct breastfeeding, the mother’s expressed breast milk, relactation, wet nursing and donor human milk. Commercial infant formula is only considered when none of these options are possible, feasible or acceptable.
- **Eligibility categories** – short-term versus long-term needs:
 - **Short-term:** Temporary supplementation when a mother is ill, while relactation is ongoing, or while transitioning to a lower-risk feeding option.
 - **Long-term:** including infants who were not breastfed before the emergency; when the mother is absent or deceased; when an infant is rejected or separated, without alternatives; when a caregiver has experienced GBV and chooses not to breastfeed; or when medical conditions prevent breastfeeding.
- Eligible age range depends on pre-emergency practices, resources available, adequacy of complementary foods, and government policies. Priority is given to infants under 6 months, with decisions guided by the national nutrition cluster or national IYCF coordination body.
- **Check understanding:** Pause to confirm that participants follow the categories.



Eligibility in action activity: Who is eligible for commercial infant formula?

Instructions:

- **Explain:** “I’ll read short caregiver/infant scenarios. Based on the eligibility criteria:
 - **Stand** if the case meets long-term eligibility criteria,
 - **Raise your hand** if the case meets short-term eligibility criteria, and
 - **Cross your arms** if the case is not eligible.”
- **Read:** Each case aloud, pause for participants to respond with the movement.
- **Explain:** After each case, share the correct answer using the facilitator notes below.

Eligibility in action activity: Who is eligible for commercial infant formula? – Facilitator notes

Case	Response	Key points
Infant under 6 months; mother present, and relactation is ongoing; no donor milk or wet nursing available	Short-term → raise hand	Commercial infant formula may be used temporarily while relactation is actively supported. Lower-risk options have been explored and are not currently feasible. Requires close follow-up and transition plan.
Infant under 6 months; mother deceased; no wet nursing or donor milk available	Long-term → stand	No access to breast milk and no feasible alternatives. Commercial infant formula is required ongoing feeding , with full package of support (supplies, counselling, monitoring).
Infant under 6 months; mother temporarily ill; expressed milk available from another caregiver	Not eligible → cross arms	A lower-risk option (expressed breast milk) is available and feasible. Do not introduce commercial infant formula. Support continuation of breast milk feeding.
Infant over 6 months; breastfeeding and growing well; mother available	Not eligible → cross arms	Breastfeeding is established and adequate. Commercial infant formula is not indicated . Focus on continued breastfeeding and appropriate complementary feeding.
Infant under 6 months; mother present, survivor of GBV and chooses not to breastfeed; no	Long-term → stand	Caregiver decision to not breastfeed. No feasible lower-risk feeding options identified. Infant is eligible for ongoing support with

relactation, donor milk or wet nursing possible		commercial infant formula, with close follow-up and monitoring.
Infant under 6 months; mother separated due to emergency; relactation possible on return; donor milk unavailable	Short-term → raise hand	Commercial infant formula may be used temporarily during separation. Plan for reunification and relactation. Requires active follow-up and transition support.

- **Wrap up:**

- Eligibility for commercial infant formula depends on first exhausting lower-risk feeding options and determining whether the need is short-term or long-term.
- Priority for commercial infant formula is typically given to infants under 6 months of age. In some contexts, a response-level decision may be made to extend support up to 12 months, depending on resources, complementary feeding practices and context.
- Provision beyond 12 months should only occur for individual children with a specific medical indication from a trained health professional (e.g., metabolic disorders, specific feeding needs related to disability).
- Inclusion criteria should be clear, consistent and communicated with caregivers to help reduce mistrust or perceptions of unfairness.
- If a mother or caregiver chooses to purchase and use commercial infant formula outside of these criteria and within their own means, respect their decision and shift to harm-reduction support. Provide appropriate guidance and the necessary hygiene, feeding supplies and follow up, even if infant formula itself is not provided.
- This approach helps protect infants while supporting caregivers in a way that is practical, respectful and fair.
- Decisions are context-specific, based on established criteria and coordinated with relevant actors. Decisions should never be made in an ad hoc or subjective manner.

Bridge: “Now that we understand who may be eligible, the next area of assessment is whether commercial infant formula can be used in a way that minimizes risk at home in an emergency setting.”

2 Assessing commercial infant formula use at home to minimize risk (4 min)

Action

- **Say:** “When an infant is eligible for commercial infant formula support, the next critical question is: **Can it be used in this environment in a way that minimizes risk?** If not, providing commercial infant formula may put the infant at even greater risk.”
- **Clarify** the two main types of commercial infant formula used for infants under 6 months in an emergency response:
 - **Powdered Infant Formula (PIF):** requires heat and mixing with clean water
 - **Ready-to-Use Infant Formula (RUIF):** pre-prepared liquid, no mixing needed
- **Emphasize:** “The type of commercial infant formula matters because it changes what is required in order to use it in a way that minimizes risk.”
- **Refer:** Visual: *Requirements for commercial infant formula use* (Participant Handbook)
- **Explain:** Walk participants briefly through the table:
 - For **PIF:**
 - Access to clean (potable) water for preparation
 - Handwashing facilities
 - Clean and dry storage
 - A heat source to boil water
 - Washing facilities for utensils
 - For **Ready-to-Use Infant Formula (RUIF):**

- Does not require water or fuel for preparation
- Washing facilities for utensils
- Clean and appropriate storage
- **Add:** You can also observe what feeding items are available in the home.
 - If bottles and teats are available, explain that these are **not recommended**, owing to the higher risk of contamination and illness.
 - Instead, check whether safer alternatives – such as a **clean cup, spoon or other recommended feeding device** – are available, and plan to support the caregiver to use these.
- **Emphasize:** Commercial infant formula should only be provided if all required conditions for hygienic preparation and feeding are in place.
- **Refer to Job Aid 8.1: Counselling Card: Conditions needed to feed the non-breastfed infant** (Participant Handbook).
- **Add:** If these conditions are **not met**, commercial infant formula should **not be used at home**.
- **Explain** decision pathway:
 - If conditions **ARE met** → Provide commercial infant formula + full BMS kit
 - If conditions **ARE NOT met** → Arrange **on-site feeding with 24/7 access**
- **Explain** on-site feeding using the facilitator notes below.

On-site feeding with 24/7 access – Facilitator notes

- On-site feeding refers to the on-site preparation and feeding of commercial infant formula in a facility and under supervision, where all required conditions, equipment and trained support are available.
- It is used when commercial infant formula cannot be prepared or used at the household level in a way that minimizes risk. Caregivers come to the site to prepare and feed the infant, with controlled access, support and ongoing monitoring.
- *Note: This is sometimes referred to as a 'wet feeding' programme. This is different from wet nursing, which means breastfeeding by any woman other than the mother.*

Programmatic considerations for on-site feeding support


- On-site feeding is a last-resort approach.
- It is used only when feeding at home cannot be supported in a way that minimizes risk.
- It requires dedicated staffing and supervision.
- Trained personnel must be present to support preparation, feeding, counselling and monitoring.
- Access must be discreet, controlled and targeted.
- Only infants who have been individually assessed should be enrolled.
- Caregivers must be able to access the site consistently.
- Distance, safety, mobility and time burden must be considered.
- Continuity must be ensured: This includes uninterrupted supply, consistent access to the site and ongoing follow-up.
- Plan for transition: From the start, there should be a plan for how the infant will transition as they grow to e.g., breastfeeding support, complementary feeding, or another appropriate pathway.

- **Wrap-up:** *“Eligibility alone is not enough. We must always ensure that commercial infant formula can be used in the caregiver’s environment in a way that minimizes risk before providing it.”*

Bridge: *“Now that we’ve identified when commercial infant formula may be appropriate and what conditions are required, let’s look at what needs to be provided to support feeding.”*

3 Provision of targeted commercial infant formula and associated supplies (BMS kit) (8 min)

Action

- **Say:** “Once eligibility is confirmed and conditions allow for commercial infant formula to be used in the home in a way that minimizes the risk to the infant, you need to provide the product and all required supplies. The goal is to protect infants, support caregivers and reduce risks associated with any infant formula use.”
- **Refer:** Visual: Appropriate BMS and required supplies (Participant Handbook)
- **Explain:** “This visual helps us identify which products are appropriate depending on the child’s age. It is not your role as a frontline worker to decide which types of BMS are provided in your setting. However, it is important to understand the different types of products available and when their specific use is recommended – or not.”
- **Emphasize appropriate BMS:**
 - For infants under 6 months, the only appropriate BMS options are:
 - Powdered Infant Formula (PIF)
 - Ready-to-Use Infant Formula (RUIF)
 - These products must meet international quality standards (Codex Alimentarius) and comply with the Code. They should have clear labelling in a language the caregiver understands, including preparation instructions; and they must not be marketed or promoted in ways that could harm infant feeding practices.
- **Ask:**  “What differences do you know between powdered and ready-to-use formula?”
- **Take** a few responses and summarize:
 - **PIF:**
 - Not sterile and may contain harmful bacteria
 - Requires water, heating to the correct temperature and careful preparation
 - Higher risk where hygiene conditions are poor or where fuel and clean water are limited
 - More affordable, easier to store, most commonly available in shops
 - Often more familiar to caregivers
 - Requires consistent follow up and ongoing support to reduce risks
 - **RUIF:**
 - No mixing required (reduces risks where water is unsafe)
 - Lower risk of contamination during preparation
 - Does not require fuel or heating
 - More expensive and bulkier to transport and store
 - Requires careful handling after opening
 - Shorter shelf life once opened; must be used promptly
 - Less familiar to caregivers; not commonly available in local markets
 - Requires similar considerations for hygiene during feeding and ongoing support
- **Explain** programme-level considerations and the role of the frontline worker:
 - Frontline workers do **not decide programme-level support**, but it’s helpful to understand these factors:
 - Continuity of supply: can commercial infant formula be provided consistently?
 - Follow-up and support: are systems in place for regular counselling and monitoring?
 - Contextual risks: overcrowding, displacement, limited storage or other barriers to safe feeding
 - Equitable support: are breastfeeding caregivers also supported, so formula use isn’t seen as a requirement to access assistance?
 - The type of commercial infant formula provided is decided at the programme level. Your role is to:
 - Support caregivers to use the product safely, reducing risks.
 - Identify challenges caregivers face in your context.

- If recommended practices cannot be followed or risks cannot be reduced, report this to your supervisor, team or IYCF-E coordination body.
- **Clarify what is NOT appropriate for under 6 months:**
 - In emergencies, many products may be available that are **not suitable for young infants**, including:
 - Animal milk (fresh or ultra-high temperature [UHT] milk)
 - Reconstituted evaporated milk
 - Sweetened condensed milk
 - Fermented milk/yoghurt
 - Powdered milks not designed for infants (e.g., full-cream milk powders such as Nido)
 - Toddler / follow-on / growing-up milks
 - Teas, water, herbal drinks or other liquids
 - Any foods, including commercial complementary foods, that are labelled for under 6 months
 - These products:
 - Do not meet infants' nutritional needs
 - Can interfere with feeding and intake of needed nutrients
 - Increase the risk of illness and malnutrition
 - Using these products can lead to malnutrition, illness or even death.
 - Caregivers may use these products because they are available, affordable or familiar.
 - If you see these being used, provide supportive, non-judgmental counselling and follow programme guidance to support caregivers to transition to lower-risk feeding options.
- **Add for infants aged 6 months and older who are not receiving breast milk:**
 - Full-fat animal milk (fresh or UHT) can be used.
 - Where possible, milk should be boiled before use to minimize risk, particularly in emergency settings.
 - Caregivers do not need to purchase specialized or commercial milk products unless medically indicated and directed by a healthcare professional. Animal milk should be given alongside appropriate complementary foods.
 - Other commercial milk products (such as powdered milks, toddler or growing-up milks, and sweetened milks):
 - Are not necessary
 - Can be more costly
 - Can become contaminated
 - May be prepared incorrectly and carry risks
 - May replace more appropriate foods, such as diverse complementary foods
- **Link to earlier discussion:**
 - This is why **untargeted distribution is risky**. Caregivers may receive or choose products that are not appropriate for infants. Milk powder and liquid milk products should **NOT be included in general distributions**, as they are often misused and can create harm.
 - Commercial infant formula must always be provided **discretely and in a targeted way** to avoid:
 - Undermining breastfeeding
 - Creating unnecessary demand
 - Increasing risks at population level



Facilitator Tip

*If possible, show real examples (**through images rather than purchasing**) of locally available products, both appropriate and inappropriate, to help participants recognize risks in real settings.*

- **Explain provision as a package:** Commercial infant formula should never be provided as a single item (e.g., a single tin of infant formula). This is often seen in untargeted distributions and carries high risk. Instead, it must be provided through targeted support, with a full package of care, supplies and ongoing follow-up.
- **Refer:** Visual: BMS kit (Participant Handbook)
- **Emphasize key components of the kit:**

- **Appropriate commercial infant formula** → correct type for the infant’s age, meets quality standards and is clearly labelled in a language the caregiver understands
- **Correct quantity** → based on infant age, weight and feeding needs, with a reliable and continuous supply to avoid practices that increase risk
- **Storage, preparation and cleaning equipment** → all materials needed to prepare, store and clean feeding items (e.g., containers, utensils)
- **Feeding method** → Cups are preferred over bottles, as they are easier to clean and help reduce risk. Other feeding methods, such as spoons or syringes, may also be appropriate depending on the infant and context (*Link back to Session 6: Increasing Breast Milk Intake*).
- **Clean water** → essential for preparing powdered infant formula and for handwashing, cleaning utensils, and maintaining hygiene for all feeding methods, including when using RUIF
- **Clear instructions, hygiene support and counselling** → ensuring the caregiver has what is needed and understands how to maintain hygiene during preparation, feeding and storage with simple, practical guidance and opportunities to ask questions and to practise (*further developed in Objective 2*)
- **Follow-up and monitoring** → Regular follow-up to check feeding practices, monitor the infant’s condition, and provide ongoing support and problem-solving
- **Add key operational points:**
 - **Check that all products:**
 - Have sufficient shelf life (at least 6 months)
 - Are not expired, damaged or compromised (e.g., dented, leaking or previously opened)
 - Are clearly labelled and understandable
 - Include preparation instructions that caregivers can follow (in an appropriate language and format)
 - For RUIF:
 - It is sterile until opened
 - After opening, it must be used quickly or safely stored
 - Small-volume units are preferred to reduce contamination and waste
 - **Distribution guidance:** Commercial infant formula and BMS kits must be provided in a way that protects the caregiver and reduces risk:
 - **Keep distributions discrete:** Avoid drawing attention to caregivers receiving commercial infant formula. Use plain bags or packaging where possible.
 - **Consider safety and security:** Carrying commercial infant formula or supplies may increase risk of theft, sharing pressure or harm. Assess whether caregivers can safely transport and store items. Work with protection or GBV teams to identify and mitigate these risks and support safer access.
 - **Provide manageable quantities:** Give amounts that caregivers can realistically carry and store, while still ensuring continuity of supply.
 - **Reduce risk of resale or diversion:** Where appropriate, consider opening or modifying packaging before distribution, in line with programme guidance.
 - **Link distribution with follow-up:** Targeted distribution should always be connected to scheduled follow-up, monitoring and continued support.
- **Wrap up:** *“How we provide targeted commercial infant formula matters as much as what we provide. Untargeted distributions increase risk – not only nutritionally but also socially and physically. Providing commercial infant formula is not about handing over a product. It requires a full package of support: the appropriate product in the appropriate quantity, with clear labelling, all necessary supplies, and attention to safety and protection risks. This is how we minimize risk and support both infant and caregiver.”*

Bridge: *“Let’s now summarize the key points and reflect on what we’ve learned.”*

4 Key takeaways and questions (3 min)

Action:

- **Refer:** Key Learning Points – Objective 1 (Participant Handbook).

Facilitator Tip Point participants to the Key Learning Points in their handbook. If needed, quickly summarize from the handbook to reinforce.

- **Ask** whether participants have any questions before moving on.

Facilitator Tip If you have an extra minute or want more discussion, ask: “Do you regularly conduct infant formula assessments in your work? What challenges or experiences have you encountered when determining eligibility for infant formula?”

Bridge: “Now that we know more about eligibility criteria for targeted commercial infant formula programmes and the recommended practices around it, the next step is to learn how to counsel caregivers on preparing and feeding infants with commercial infant formula in the recommended way.”



LEARNING OBJECTIVE 2:

Counsel caregivers on recommended feeding practices when using commercial infant formula

Time: 15 min

1 Counsel and demonstrate how to feed the child in a way that reduces risks and follows recommended practices (8 min)

Action:

- **Say:** “When an infant is receiving commercial infant formula, how the caregiver feeds the child is just as important as what is given. Even caregivers who are familiar with commercial infant formula may not know how to use it in an emergency context. Our role is to provide clear, practical counselling and hands-on support to reduce risks. Before we look at how to counsel, we also need to consider where counselling takes place.”

Where counselling should take place

- **Explain:**
 - **Ensure privacy and confidentiality:** Counselling on infant feeding should take place in a private or discreet space, where caregivers feel safe to ask questions and share concerns.
 - **Avoid public or group counselling for commercial infant formula support:** Group settings are not appropriate for discussing commercial infant formula use, as this may expose or influence breastfeeding caregivers. Provide individual counselling to ensure accurate assessment and reduce pressure or stigma.
 - **Be mindful of visibility and movement:** Consider how caregivers enter, exit and move through the space. Avoid drawing attention to those receiving commercial infant formula support, and ensure the setup does not increase risk or unwanted attention.
 - **Coordinate with facility flow and protection teams:** Work with colleagues to organize space and flow in a way that supports confidentiality and reduces risk. Where needed, include separate or discrete areas.
- **Say:** “Where and how we provide counselling can affect caregiver safety, dignity and willingness to engage. Now that we’ve considered where counselling should take place, let’s look at how to provide effective counselling and support to caregivers.”

How to provide effective counselling

- **Emphasize:**

- In-depth counselling and follow-up are essential.
- Feeding in emergencies is different to non-emergencies: Disruptions to environment, supplies, water, time, support systems and access to healthcare increases risk and can make feeding more difficult.
- Caregivers need practical, hands-on support: Simple guidance, demonstration and the opportunity to practise are more effective than instructions alone.
- Include other caregivers where possible: Invite other household members involved in feeding (e.g., fathers, grandparents, older siblings) to participate in counselling and demonstration, as they may share responsibility for feeding.
- **Refer:** *Visual: Counsel and demonstrate how to feed an infant using commercial infant formula* (Participant Handbook)

1. Correct, hygienic preparation

- **Say:** *“Correct preparation of commercial infant formula is essential. Small mistakes can have serious consequences for the infant. As counsellors, our role is to ensure caregivers can prepare feeds confidently and correctly, in line with recommended practices.”*
- **Add:**
 - Show first → then ask the caregiver to demonstrate back
 - Ensure materials are available for demonstration: Where possible, have the necessary supplies on hand (e.g., cup, water, utensils) to demonstrate preparation and feeding steps clearly.
 - Adapt your counselling to the caregiver’s situation, skills and environment.
 - Address practices that carry risk without blame. Focus on practical solutions.
- **Go through** the nine steps of *Instructions for preparation section of the visual* (Participant Handbook).
- **Ask** volunteers to read aloud the preparation steps from the visual.
- **Emphasize** critical points:
 - **Hygiene is essential** (for all feeding methods):
 - Wash hands with soap before preparation and feeding
 - Use clean and sterilized equipment
 - Prepare feeds on a clean surface
 - Store BMS in a clean, dry place
 - Keep containers closed and protected
 - **Correct use and preparation** (very important):
 - Follow the product instructions exactly
 - Use the correct amount of water and powder
 - Water must be hot enough (for powdered formula)
 - Mix and cool safely before feeding
 - Discard any formula left in the cup after feeding – **do not** store or reuse.
 - If refrigeration is available, store opened-but-unused product in the original container and use within 24 hours.
 - If refrigeration is not available, use immediately after opening and avoid storing for later use.

Facilitator Tip

Caregivers may be reluctant to discard unused formula. Acknowledge the difficulty first, then give a practical alternative:

- *Recommend pouring small amounts at a time to reduce waste.*
- *Emphasize that formula exposed to a cup or infant can quickly become unsafe.*
- *Acknowledge pressure to share with others, then explain that the formula is for the specific infant.*
- *Consistent access is important for the infant’s feeding and growth.*

- **Refer:** *Job Aid 8.2: Counselling Card: Feeding the non-breastfed infant 0 up to 6 months* (Participant Handbook).

- **Add:** *“Use the counselling card in your handbook to describe your demonstration to caregivers. These tools help ensure you cover all key steps clearly and consistently.”*

! Facilitator Tip

Explain that participants will practice these counselling and demonstration skills in Step 3 and Step 4, including observing and supporting caregivers directly.

- **Emphasize the key messages:**
 - Over-dilution → not enough nutrients → risk of malnutrition
 - Under-dilution → too concentrated → risk of dehydration and kidney stress
- **Explain simply:**
 - Caregivers also need guidance on how much to give
 - Always follow product instructions first
 - Use general guidance as a reference:
 - ~150 ml per kg per day
 - Offer feeds 8–12 times per day
 - Feed based on infant cues, not rigid schedules
- **Clarify:** When infant formula is used alongside breastfeeding, we focus on the child receiving breast milk first.
 - Where breastfeeding is possible, encourage the mother to feed directly from the breast first, followed by commercial infant formula if needed.
 - Rather than calculating an exact amount, support caregivers to use responsive feeding, offering commercial infant formula after breastfeeding based on the infant’s cues.
 - General guidance on volumes can be used as a reference, but intake should be adjusted based on the infant’s appetite, satisfaction and growth, while breastfeeding support continues.
 - Start with small amounts after breastfeeding; increase only if the infant continues to show hunger cues.

2. Responsive Feeding

- **Say:** *“Using commercial infant formula is not only about preparation. It is also about how the infant is fed.”*
- **Explain:**
 - When feeding at the breast, the infant can control the pace, flow and amount of milk taken. When commercial infant formula is used, feeding is provided by the caregiver using a cup, spoon or other feeding method, and the feed is prepared in set amounts. This can make it harder to recognize and respond to the infant’s hunger and fullness cues.
 - Therefore, when an infant is not feeding exclusively at the breast, responsive feeding becomes even more important.
- **Emphasize key practices:**
 - Recognize hunger cues (rooting, sucking, restlessness)
 - Recognize satiety cues (turning away, slowing down, falling asleep)
 - Feed based on cues. Do not force the infant to finish feeds.
 - Encourage close interaction (eye contact, holding, skin-to-skin where possible)
- **Add:**
 - Use expected volumes as a guide, not a strict rule
 - Support caregivers to balance guidance with responsiveness

3. Cup feeding (1–1 practical demonstration)

- **Say:** *“Cup feeding is the preferred method for feeding infants in emergency settings, whether they are receiving breast milk, expressed milk or BMS.”*
- **Explain why:**
 - Cups are easier to clean
 - Lower risk of contamination compared to bottles
 - Reduce risk of infection in emergency settings

- **Emphasize:**
 - Feeding bottles are **not recommended**
 - Bottles are difficult to clean and easily contaminated
 - They increase the risk of diarrhoea and illness
- **Add:** Watch the caregiver feed the infant using a cup and provide support as needed.

4. Where and when to seek medical care

- **Say:** “Caregivers need to know when to seek help.”
- **Explain:**
 - If the infant is not feeding well
 - If there is vomiting, diarrhoea or fever
 - If the infant is not gaining weight or appears weak
 - If there are any concerns about feeding or health
- **Emphasize:** Seeking care early can prevent serious complications.

5. Store in a clean and dry location

- **Say:** “Storage in a clean and dry location is essential to prevent contamination.”
- **Explain:**
 - Store infant formula in a clean, dry place
 - Keep containers closed and protected
 - For RUIF:
 - Sterile until opened
 - Once opened, RUIF should be used immediately and not stored unless refrigeration is available
 - Discard any prepared feed after 2 hours
- **Wrap up:** “Counselling on commercial infant formula is not just about giving instructions. It is about building caregiver confidence and skills. By demonstrating, observing and supporting caregivers, we help to ensure that infants are fed in a way that minimizes risk.”

Bridge: “Counselling and demonstration are essential, but one session is not enough. Caregivers need ongoing support to continue feeding using recommended practices. Let’s look at how to establish regular follow-up.”

2 Establish a regular follow-up schedule (5 min)

Action:

- **Say:** “Providing commercial infant formula is not a one-time action. It requires close and regular follow-up to ensure the infant remains healthy and well.”
- **Refer:** Visual: *Follow-up visits* (Participant Handbook)
- **Explain:** During each follow-up visit, there are several key things we need to check and support:
 - **Monitor infant growth and health:**
 - Check weight, growth and overall condition
 - Identify early signs of illness or malnutrition
 - **Continue counselling:**
 - Reinforce recommended practices around preparation, feeding and hygiene
 - Address any challenges the caregiver is facing
 - **Check caregiver wellbeing:**
 - Assess stress, fatigue or other difficulties
 - Provide support or refer if needed
 - **Reassess eligibility:**
 - Check whether commercial infant formula is still needed
 - Explore alternatives again (e.g., relactation, breastfeeding support)

- **Resupply commercial infant formula:**
 - Provide the correct quantity based on updated needs: Adjust based on the infant’s age, feeding pattern and caregiver capacity.
 - Link resupply to follow-up: The amount provided should align with the timing of the next follow-up visit, to support regular monitoring and reduce risk.
 - Avoid over- or under-supply: Too little may lead to harmful coping practices; too much may increase sharing, resale or misuse.
- **Refer to additional services (if needed):**
 - Health services
 - Nutrition support
 - Psychosocial support
- **Emphasize key message:** Targeted distribution of commercial infant formula should be managed like any medical intervention: as necessary (in some cases) but requiring careful control, monitoring and follow-up.
- **Explain:**
 - Commercial infant formula support is **temporary and must be reviewed regularly**.
 - From the start, there should be a **clear plan for transition or exit** based on the infant’s age and situation.
 - At each follow-up, reassess whether the infant can move to **safer feeding options**:
 - For infants under 6 months: prioritize return to breastfeeding where possible
 - For older infants: support transition to appropriate complementary feeding with continued milk feeding
 - Continue commercial infant formula for as long as it is needed, with regular reassessment, and plan for a gradual transition when it is no longer required. Do not stop support abruptly.
- **Wrap up:** *“Regular follow-up is critical to supporting appropriate use of commercial infant formula and reducing risk. It allows us to monitor the infant, support the caregiver and adjust the plan as needed.”*
- **Add:** To support caregivers through this process – from initial counselling to follow-up and transition – we use the *Checklist for counselling on BMS*. This tool was introduced in *Session 2: Individual Assessment in Emergencies*, and it guides both the initial counselling session and follow-up visits, helping ensure that all key topics are covered.
- **Refer:** *Job Aid 2.2: Care Action Plan for Mother/Caregiver and Child Receiving Skilled Support and/or Breast Milk Substitutes* (Session 2 – Participant Handbook).
- **Explain:** The Checklist for counselling on BMS:
 - Lists what to discuss with caregivers
 - Supports consistency and quality of counselling
 - Helps to monitor progress and identify any issues



Facilitator Tip

- Invite participants to go back to *Session 2* and review the checklist briefly.
- Explain that the checklist will be used during the role-play in *Step 4* to practise counselling and follow-up.

Bridge: *“We’ve now covered how to counsel caregivers and provide ongoing support to reduce risks associated with commercial infant formula use. Let’s summarize the key points from this objective before moving on.”*

3

Key takeaways and questions (2 min)

Action:

- **Refer:** Key Learning Points – Objective 2 (Participant Handbook).



Facilitator Tip

Point participants to the Key Learning Points in their handbook. If needed, quickly summarize from the handbook to reinforce.

- Ask whether participants have any questions before moving on.



Facilitator Tip

If you have an extra minute or want more discussion, ask: “What do you think will be most challenging when counselling caregivers on the use of commercial infant formula in your context?”

Bridge: “We’ve seen how to support recommended, targeted use of commercial infant formula. Another critical role is preventing inappropriate promotion and distribution of all types of BMS, including untargeted distribution of commercial infant formula. Let’s now look at how to identify and act on violations of the Code.”



LEARNING OBJECTIVE 3:

Identify & act on violations of the Code as a frontline worker

Time: 15 min



1 Understanding the Code (6 min)

Action:

- **Say:** “During emergencies, we must not solicit, donate, accept or distribute donations of BMS or related products. These products can put infants at serious risk. Up to now, we have focused on how to support infants who need commercial infant formula through targeted programmes. In this next section, we are shifting to a different role, which is preventing inappropriate use, promotion and distribution of these products.”



Facilitator Tip

- The Code is a global framework adopted by the World Health Assembly, but it is implemented through national laws, regulations and policies, which vary by country.
- You are encouraged to review the status of the Code in the participants’ country or context – including any national legislation, guidance, and monitoring or enforcement mechanisms – so they can provide relevant examples during the session.

- **Conduct** a quick quiz: List a few products (one at a time) and ask participants to raise their hand if they think it is **prohibited**:

- Infant formula → **Prohibited**
- Follow-on formula → **Prohibited**
- Baby teas or juices marketed for infants under 6 months → **Prohibited**
- Water → **Not prohibited, but prohibited if marketed for infants <6 months**
- Evaporated milk → **Prohibited**
- Soy milk → **Prohibited**
- Baby teas or juices marketed for infants <6 months → **Prohibited**
- Bottles and teats → **Prohibited**
- Commercial complementary food → **Not prohibited, but prohibited if marketed for infants <6 months**



Facilitator Tip

Ask participants not to open their handbook. They should rely on their current knowledge and experience. This short activity is to spark engagement and discussion.

- **Refer:** Visual: Prohibited Donations and Visual: A Quick Guide to WHO Code Basics (Participant Handbook)
- **Ask** volunteers to read aloud different sections of the visuals.
- **Check** whether participants have any questions about what products are covered or prohibited.
- **Say:** “Now that we understand which products are covered under the Code and that some of these products can be used in programmes, it is important to remember that it is not only about the product but about how it is used. We have seen that these products can be used in targeted programmes; yet, they are prohibited when promoted, donated,


or distributed without assessment and support. Let's look at some examples of targeted, appropriate support and untargeted, prohibited use of these products."

- **Conduct a quick quiz:** Read the scenarios below.

Facilitator Tip Where relevant, adapt or replace them with examples from your context.

- **Say:** "I will read a short scenario. Raise your hand if you think this is appropriate and allowed in a programme. Keep your hand down if you think it's not appropriate and a Code violation.
 - A health worker provides commercial infant formula after individual assessment, with counselling, supplies and follow-up. (Appropriate/Allowed)
 - A truck arrives with donated infant formula and distributes it to all families with infants. (Prohibited)
 - A clinic uses posters with a brand of infant formula displayed to educate caregivers. (Prohibited)
 - A caregiver is given bottles and teats along with formula during a general distribution. (Prohibited)
 - A programme provides complementary foods for infants 6–23 months as part of targeted support, alongside counselling on age-appropriate feeding. (Appropriate/Allowed)
 - A caregiver purchases commercial infant formula from the market and asks for help using it. The health worker provides counselling and support. (Appropriate/Allowed)
 - A caregiver who is mixed-feeding receives support from a health worker to continue breastfeeding, with small amounts of commercial infant formula provided based on need and with follow-up provided. (Appropriate/Allowed)
 - A general food distribution includes commercial infant formula in family food baskets given to all households. (Prohibited)
 - A distribution provides commercial complementary foods labelled for infants from 4 months of age to all households in an area. (Prohibited)

Say: "It is not just the product that matters. It is how, why and under what conditions the product is used. The Code helps us prevent practices that increase risk, while still allowing us to support infants who need it through targeted, well-supported programmes. Many Code violations are unintentional and often come from goodwill within communities. They can happen through everyday actions, such as accepting donations or using branded materials. Understanding the Code helps us protect infants and caregivers, even in complex situations."

- **Ask:**  "What could happen if donations or marketing of these products are uncontrolled?"

Facilitator Tip Keep the discussion short. Focus on the most important consequences.



- **Summarize** the key points:
 - Inappropriate donations and untargeted distribution of BMS can influence caregivers to introduce BMS, even when breastfeeding is possible.
 - Introducing BMS can reduce breast milk production and increase risks for the infant, including diarrhoea, illness and malnutrition.
 - These practices can also undermine breastfeeding at a population level, contributing to increased infant morbidity and mortality over time.
- **Add:** Donated products are often:
 - In violation of the Code
 - Unsafe (e.g., expired, the wrong type, unreliable quality)
 - Excessive in quantity
 - Labelled in the wrong language
 - Not supplied in a reliable manner
 - Not possible to use hygienically in an emergency context
 - Lacking the instructions, supplies and support that caregivers of formula-dependent infants need to feed safely

- **Wrap up:** *“The Code sets minimum standards for marketing these products. It does **not** prevent the use of BMS when needed. It protects infants and caregivers from unnecessary harm and unsafe practices.”*

Bridge: *“Now that we understand what the Code covers and why it is important, let’s move to the next section: your role as a frontline worker and how to act when you encounter Code violations.”*

2 Your role: How to act (6 min)

Action:

- **Ask:**  *“Now that we’ve reviewed what constitutes a violation of the Code, has anyone encountered such a situation in your work? What happened?”*
- **Allow discussion.** Emphasize that it’s okay if they haven’t experienced it yet.
- **Ask:**  *“What did you do at the time or what would you do now, based on what we’ve discussed?”*
- Encourage participants to share practical solutions and approaches. If no one has an example, use the **scenario from Step 1** as a discussion starter.
- **Say:** *“As frontline workers, you are the last line of defence when the Code is not fully enforced or when donations occur.”*
- **Refer:** *Table: Dos and Don’ts* (Participant Handbook)
- **Explain** the actions they should take to protect the Code:
 - **Document and report violations:** If you see donations, promotions or distributions that do not follow guidance, record what you observe, then report it through your organization or the lead IYCF agency.
 - **Do not accept or distribute untargeted donations:** If donations of BMS or related products (like bottles, teats or dummies/pacifiers) arrive, do not distribute them. Follow programme guidance to set them aside and inform the appropriate focal point.
 - **Avoid promotion through materials or items:** Do not use branded materials, gifts or promotional items from BMS companies in counselling or programme activities.
 - **Do not accept gifts or samples from companies:** This includes items such as free products, materials or incentives from BMS companies.
 - **Do not distribute samples to caregivers:** Free samples of BMS products should never be given, even if received.
 - **Do not mention or promote specific brands.**
 - **Be aware of indirect promotion:** Branding from BMS companies on materials, equipment or supplies can act as promotion and should be avoided.



Facilitator Tip

Emphasize that this is a professional responsibility. Protecting infants and caregivers is part of their role.

- **Say:** *“Violations of the Code are common in emergencies, and they can create serious risks for infants and caregivers. As frontline workers, your role is essential in identifying these situations and taking appropriate action to prevent harm.”*
- **Emphasize:** By following the Code, refusing inappropriate donations and reporting violations, you help protect breastfeeding; support safe infant feeding; and reduce risks for the most vulnerable.

Bridge: *“Let’s now review the Key Learning Points to help you remember what to look for and how to act in practice.”*

3 Key takeaways and questions (2 min)

Action:

- **Refer:** Key Learning Points – Objective 3 (Participant Handbook).

**Facilitator Tip**

Point participants to the Key Learning Points in their handbook. If needed, quickly summarize from the handbook to reinforce.

- Ask whether participants have any questions before moving on.

**Facilitator Tip**

If you have an extra minute or want more discussion, ask:

“Based on your context, what do you think will be the most challenging part of identifying or responding to Code violations?”

Bridge: “Now it’s time to see the counselling in action. In Step 3, we will demonstrate a complete first counselling session, from assessing a mother and infant to preparing the BMS safely and providing key guidance to the caregiver.”

STEP 3: Demonstrate

20 min

1 Introduction (3 min)

Action:

- **Introduce:** “In this demonstration, we will meet Amina and her baby Sara during a counselling session on BMS use in an emergency setting. She has already had a full assessment from a nutrition worker in another clinic and was referred here for the BMS programme to meet with the IYCFE BMS programme counsellor. You are not trying to solve everything in one session. Focus on one or two key changes that reduce the greatest risks. The focus is on providing practical, supportive guidance while minimizing risk, using the following counselling skills:
 - Reflect back what the mother or caregiver says,
 - Use simple language, and
 - Give practical help.”
- **Refer:** Case study: Amina and Sara (Participant Handbook).
- **Summarize** the case:
 - **Setting:** Temporary shelter in a displacement camp
 - **Mother/Caregiver:** Amina, 26 years old
 - **Child:** Sara, 3 months old
 - **Reason for contact:** Sara is not breastfed. Amina has been using PIF, purchased locally, and is seeking support.
 - **Counsellor:** Referral from a full assessment to the IYCF-E counsellor providing support for feeding with infant formula

2 Script (7 min)

Action:

- **Act out** the script below as a team of three.

**Facilitator Tip**

- This demonstration includes practical and technical guidance on infant formula use. Focus on how the counsellor balances giving correct information with using counselling skills and adapting to the caregiver’s reality.
- Avoid reading word-for-word. Keep the interaction natural and supportive.



Counsellor

Hello Amina, my name is [Counsellor]. Welcome. Please have a seat. I understand you've been feeding Sara with the infant formula that you are buying from the shop. How has that been going for you?



Amina

It's been difficult. I try my best, but sometimes I worry if I am doing it right. Water is not always easy to get, and I don't always have wood to make a fire.



Counsellor

(Reflect back) It sounds like you are doing everything you can in a very difficult situation, and you are worried about whether the feeding is appropriate, especially with limited water and fuel. Thank you for sharing that with me.

I also understand from the previous counsellor that you already explored breastfeeding options, including relactation and trying to find someone who could breastfeed Sara, but that was not possible. Is that right?



Amina

Yes, we tried, but there was no way. So now I am just using the formula.



Counsellor

Thank you. That helps me understand your situation clearly.

So right now, Sara depends on infant formula feeding, and our role is to support you to reduce risks as much as possible and make feeding manageable in your situation.

Before we go into that, I'd like to understand a bit more about how you are feeding Sara day to day. Are you able to tell me how many times Sara is feeding in a day and how much do you usually give at each feed?



Amina

She feeds many times... maybe six or seven times. I fill the bottle like this (*gestures*) about halfway each time. The formula is the powder one from the shop that we always have used.



Counsellor

So, she is feeding several times a day, and you are using the bottle to measure how much she drinks. Thank you, that's helpful.

I can see you brought the bottle with you. Would it be okay if we look at how you prepare the feeds together?



Amina

Yes, we can do that.



Counsellor

Before we do that, I want to share something important.

In these conditions, bottles are very difficult to clean well, especially when water and fuel are limited. This can increase the chance of Sara becoming sick.

So we usually recommend using a small cup instead, because it is easier to clean and can reduce some of those risks in this environment.

Have you ever seen cup feeding before?



Amina

No, I have only used the bottle.



Counsellor

That makes a lot of sense because it's what you've always used. In this situation, we want to think about all the ways that we can reduce any risk for Sara.

Would it be alright if I show you another way, using a small cup, and then you can see how it feels for you?



Amina

I didn't realize it wasn't safe. I would like to try a cup. Can she do it when she is this small?



Counsellor

(Give practical help) What we recommend instead is using a clean cup. Cups are easier to clean and better for feeding in these conditions. I can show you how to use a cup so it feels comfortable for you and for Sara.



Amina

I've never used a cup before... will she be able to drink like that when she's so small?



Counsellor

Babies this young can drink from the cup, yes. It's new for you and for Sara, so it might feel unfamiliar at first, but she can learn. We will go slowly, and I'll show you how to do it, step by step.

We hold Sara upright, like this.

We bring the cup gently to her lips.

We let her sip slowly. We don't pour.

This way, it can be easier to keep things clean and lower some of the risks linked to feeding in these conditions.



Amina

Okay... I can try. It looks quite different.



Counsellor

You're willing to try, even though it's not easy. You are doing the best for Sara in this situation. Would you like to try while I sit with you?



Amina

(Amina tries cup feeding Sara).

Oh, I think she's doing it!



Counsellor

You're doing that very well, and she is doing it well! Sara is able to take the milk at her own pace. Great work.

We can keep practising this together, and I can also come to your home to support you there.

I would like to talk about how you prepare the formula, if that's ok.

Can you tell me how you usually make it?



Amina

I mix the powder with water. Sometimes I boil the water, sometimes I cannot.



Counsellor

So sometimes the water is boiled, and sometimes it is not, depending on what is available.

Here are a few things to remember when we are preparing infant formula. We have to make sure to follow the instructions on the infant formula tin and prepare it as they recommend. Otherwise she might get too much or too little of the nutrition.

Another one of the most important steps to reduce the chance of Sara becoming sick is to use water that has been boiled and then cooled slightly, before mixing the formula.

I understand this is not always easy. Let's think together about what might be possible in your situation.

When are you able to boil water?

Is there a place nearby where water is already boiled?



Amina

I think the community kitchen nearby often has boiling water, but it would be easier if we had the firewood ourselves.



Counsellor

Great. We can also support you with this by giving you a BMS kit today. Because Sara depends on formula, you should not have to manage this alone. We will work to ensure that:

You have access to the correct infant formula.

You have appropriate items for feeding, like fuel, a cup and storage equipment; and you are washing everything before and after you use it

You receive ongoing support and follow-up

We can arrange a home visit to go through everything, step by step, in your space.



Amina

That would really help because I don't have all of those things for her.



Counsellor

You are already doing a lot to care for Sara in a very difficult situation.

We will continue to support you to reduce risks as much as possible and make feeding more manageable.

Before we finish today, let's agree on a few steps that feel possible for you this week.

Try cup feeding for some feeds

Prioritize boiling water when possible before preparing feeds

Arrange a follow-up visit



Amina

Yes, that would be very helpful.



Counsellor

Are you able to meet again in two days to see how things are going and practise together? Would that work for you?






Amina

Yes, I feel better knowing I will have that support. Thank you.

3 Debrief (10 min)

Action:

- **Ask:**  “What did you notice about how the counsellor supported Amina during this session?”
- **Possible answers to include:**
 - Reflecting back Amina’s concerns
 - Using simple, clear language
 - Asking questions to understand her situation
 - Acknowledging challenges without judgment
 - Offering practical, realistic suggestions
 - Demonstrating feeding techniques (cup feeding)
 - Involving Amina in trying the technique herself
- **Explain:** The counsellor did not overwhelm Amina with instructions. Instead, they listened, reflected her concerns and worked with her to find practical solutions that fit her situation. This helps build trust and confidence, especially in difficult environments.
- **Ask:**  “What did you notice about how technical information was shared?”
- **Possible answers may include:**
 - Information was given step by step
 - Information given was based on Amina’s situation (water, fuel, bottle use)
 - Focused on reducing risk rather than giving many rules
 - Combined explanation with demonstration
- **Explain:** Technical information on commercial infant formula use is important; but so, too, is how the information is shared. The counsellor provided clear, relevant information and combined it with practical support, helping Amina to understand and apply it.
- **Ask:**  “How did the counsellor help Amina feel supported and involved in the process?”
- **Possible answers may include:**
 - Praising her efforts
 - Asking permission before demonstrating
 - Encouraging her to try
 - Making a plan together
 - Offering follow-up support
- **Explain:** Caregivers are more likely to follow guidance when they feel respected and supported. Involving them in decisions and building on what they are already doing well helps to make changes more realistic and sustainable.
- **Wrap up:** *“Supporting infants who receive commercial infant formula requires non-judgmental interactions, correct guidance, and comprehensive and ongoing support for the mother or caregiver to make an informed decision based on their situation. As frontline workers, your role is to provide practical, respectful, consistent support that helps caregivers reduce risks and care for their infants in challenging conditions.”*

Bridge: “Now, in the next step, you will practise conducting a follow-up counselling session with Amina and Sara.”

STEP 4: Role-Play

 25 min

1 Introduction (5 min)

Action:

- **Explain:** Participants will now practise leading a counselling session with Amina, building on what was discussed in the demonstration: use of PIF; risks identified; introduction of cup feeding; and agreed practical steps, such as using heated water and preparing commercial infant formula for each feed.
- **Add:** Amina is caring for Sara using commercial infant formula that she is buying from the local shop. She needs ongoing support to reduce risks and adapt feeding practices to her environment.
- **Organize:** Ask participants to form groups of three: Counsellor, Amina, Observer. Participants stay in the same groups as previous sessions but rotate roles.
- **Distribute:** Hand out the role cards to each 'Amina' (see Annex 8.1).
- **Explain:** The observer uses the Counselling Skills Checklist to note strengths and areas for improvement.
- **Remind:** Counsellors should practise using the three key skills demonstrated in Step 3:
 - Reflect back what the mother/caregiver says
 - Use simple language
 - Give practical help
- **Allow:** Give groups 3–4 minutes to get ready before beginning their role-plays. Participants can take a minute to review the Counselling Skills Checklist to refresh their memory of the key recommendations discussed during the session.
- **Time:** The role-play lasts around 10 minutes.

! Facilitator Tip

- *Encourage participants to focus on small, achievable changes, prioritizing the actions that reduce the greatest risks (e.g., feeding with a cup instead of bottles; boiling water where possible).*
- *Remind them that commercial infant formula use is limited. As the child approaches 6 months, there is a natural transition to complementary foods and other milks, so reliance on infant formula is reduced.*
- *Also consider the wider context. Amina is purchasing the commercial infant formula, which may affect household food security. Counselling should consider what is realistic and sustainable for the family and refer to programmes like Cash and Voucher Assistance or additional food to reduce that burden.*
- *Support should be provided step-by-step, with follow-up; it is not a one-time solution.*




4 Role-play practice (10 min)

Action:

- **Encourage** groups to start quickly and use their full time.
- **Support:** Move quietly among groups, observe, and answer questions if needed.
- **Manage time:** Give **5-minute** and **2-minute** warnings so participants can pace themselves.
- **End** the activity on time, even if some groups have not finished the full role-play.

4 Debrief (10 min)

Action:

- **Gather:** Bring everyone back together and thank participants for their role-plays and effort.
- **Ask the ‘Aminas’**  :
 - “How did it feel to be in Amina’s place?”
 - “Did the counsellor’s approach make it easier or harder to manage feeding?”
 - “Did you feel supported in a situation where feeding is difficult?”
- **Ask the observers**  :
 - “What strengths did you notice in the counsellor’s approach?”
 - “How did the counsellor apply the counselling skills that we were focusing on?”
 - “What areas could be improved?”
- **Ask the ‘counsellors’**  :
 - “How did it feel to conduct this counselling session?”
 - “What was most challenging?”
 - “How did you decide what to prioritize?”
- **Refer:** Role-play debrief: Amina and Sara (Participant Handbook).
- **Wrap up:**
 - In these situations, it is not possible to address everything at once. Effective counselling focuses on a small number of priority actions that reduce the greatest risks and are realistic for the caregiver.
 - Counselling should be practical, step-by-step and adapted to the caregiver’s environment. Consider constraints such as water, fuel, time and cost.
 - Support does not end in one session. Caregivers using commercial infant formula often need ongoing support and follow-up to adjust their practices over time.
 - Planning follow-up, such as home visits or return sessions, is essential to continue reducing risks and supporting the caregiver.

Bridge: “In real situations, caregivers using commercial infant formula often face ongoing challenges related to water, fuel and resources. Support is not a one-time conversation. It requires follow-up, practical help and adapting to the caregiver’s reality over time. At each follow-up, we reassess whether feeding options that include breast milk may be possible.”

STEP 5: Self-reflection

 5 min

Action:

- **Invite** participants to take a quiet moment to reflect and to note their answers in the Participant Handbook.
- **Guide:** Read the three questions (also in the Participant Handbook) out loud and give participants 2–3 minutes of silence to think/write.
- **Share (optional):** If time allows, invite 1–2 volunteers to share a key takeaway.
- **Close:** Thank participants for their reflections and emphasize that applying these insights in real-life counselling is where change happens.



Facilitator Tip

Keep the activity short and personal. This is not a group discussion but an opportunity for each participant to consolidate their own learning.

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ANNEX 8.1: Role-play card – Amina Cut the cards below and provide one to each participant acting Amina.



Card: Amina

You tell the counsellor, if you are asked:

- You have tried using the cup. It was difficult at first, but it is getting a bit easier, though you are not always confident.
- The home visit helped you understand how to prepare the formula and use the cup.
- You try to boil water more often, but fuel is still limited.
- You usually feed Sara when she cries and are not sure how to recognize early hunger signs.
- You are worried about the cost of formula and how long you can continue buying it.
- You are unsure of what to do as Sara gets older and starts needing other foods.

Card: Amina

You tell the counsellor, if you are asked:

- You have tried using the cup. It was difficult at first, but it is getting a bit easier, though you are not always confident.
- The home visit helped you understand how to prepare the formula and use the cup.
- You try to boil water more often, but fuel is still limited.
- You usually feed Sara when she cries and are not sure how to recognize early hunger signs.
- You are worried about the cost of formula and how long you can continue buying it.
- You are unsure of what to do as Sara gets older and starts needing other foods.

Card: Amina

You tell the counsellor, if you are asked:

- You have tried using the cup. It was difficult at first, but it is getting a bit easier, though you are not always confident.
- The home visit helped you understand how to prepare the formula and use the cup.
- You try to boil water more often, but fuel is still limited.
- You usually feed Sara when she cries and are not sure how to recognize early hunger signs.
- You are worried about the cost of formula and how long you can continue buying it.
- You are unsure of what to do as Sara gets older and starts needing other foods.

Card: Amina

You tell the counsellor, if you are asked:

- You have tried using the cup. It was difficult at first, but it is getting a bit easier, though you are not always confident.
- The home visit helped you understand how to prepare the formula and use the cup.
- You try to boil water more often, but fuel is still limited.
- You usually feed Sara when she cries and are not sure how to recognize early hunger signs.
- You are worried about the cost of formula and how long you can continue buying it.
- You are unsure of what to do as Sara gets older and starts needing other foods.

Card: Amina

You tell the counsellor, if you are asked:

- You have tried using the cup. It was difficult at first, but it is getting a bit easier, though you are not always confident.
- The home visit helped you understand how to prepare the formula and use the cup.
- You try to boil water more often, but fuel is still limited.
- You usually feed Sara when she cries and are not sure how to recognize early hunger signs.
- You are worried about the cost of formula and how long you can continue buying it.
- You are unsure of what to do as Sara gets older and starts needing other foods.

Card: Amina

You tell the counsellor, if you are asked:

- You have tried using the cup. It was difficult at first, but it is getting a bit easier, though you are not always confident.
- The home visit helped you understand how to prepare the formula and use the cup.
- You try to boil water more often, but fuel is still limited.
- You usually feed Sara when she cries and are not sure how to recognize early hunger signs.
- You are worried about the cost of formula and how long you can continue buying it.
- You are unsure of what to do as Sara gets older and starts needing other foods.

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Card: Amina

You tell the counsellor, if you are asked:

- You have tried using the cup. It was difficult at first, but it is getting a bit easier, though you are not always confident.
- The home visit helped you understand how to prepare the formula and use the cup.
- You try to boil water more often, but fuel is still limited.
- You usually feed Sara when she cries and are not sure how to recognize early hunger signs.
- You are worried about the cost of formula and how long you can continue buying it.
- You are unsure of what to do as Sara gets older and starts needing other foods.

Card: Amina

You tell the counsellor, if you are asked:

- You have tried using the cup. It was difficult at first, but it is getting a bit easier, though you are not always confident.
- The home visit helped you understand how to prepare the formula and use the cup.
- You try to boil water more often, but fuel is still limited.
- You usually feed Sara when she cries and are not sure how to recognize early hunger signs.
- You are worried about the cost of formula and how long you can continue buying it.
- You are unsure of what to do as Sara gets older and starts needing other foods.

Card: Amina

You tell the counsellor, if you are asked:

- You have tried using the cup. It was difficult at first, but it is getting a bit easier, though you are not always confident.
- The home visit helped you understand how to prepare the formula and use the cup.
- You try to boil water more often, but fuel is still limited.
- You usually feed Sara when she cries and are not sure how to recognize early hunger signs.
- You are worried about the cost of formula and how long you can continue buying it.
- You are unsure of what to do as Sara gets older and starts needing other foods.

Card: Amina

You tell the counsellor, if you are asked:

- You have tried using the cup. It was difficult at first, but it is getting a bit easier, though you are not always confident.
- The home visit helped you understand how to prepare the formula and use the cup.
- You try to boil water more often, but fuel is still limited.
- You usually feed Sara when she cries and are not sure how to recognize early hunger signs.
- You are worried about the cost of formula and how long you can continue buying it.
- You are unsure of what to do as Sara gets older and starts needing other foods.

Card: Amina

You tell the counsellor, if you are asked:

- You have tried using the cup. It was difficult at first, but it is getting a bit easier, though you are not always confident.
- The home visit helped you understand how to prepare the formula and use the cup.
- You try to boil water more often, but fuel is still limited.
- You usually feed Sara when she cries and are not sure how to recognize early hunger signs.
- You are worried about the cost of formula and how long you can continue buying it.
- You are unsure of what to do as Sara gets older and starts needing other foods.

Card: Amina

You tell the counsellor, if you are asked:

- You have tried using the cup. It was difficult at first, but it is getting a bit easier, though you are not always confident.
- The home visit helped you understand how to prepare the formula and use the cup.
- You try to boil water more often, but fuel is still limited.
- You usually feed Sara when she cries and are not sure how to recognize early hunger signs.
- You are worried about the cost of formula and how long you can continue buying it.
- You are unsure of what to do as Sara gets older and starts needing other foods.

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ANNEX 1: Pre- and Post-Training Knowledge Test

This annex contains the pre- and post-training knowledge test for the IYCF-E Counselling Training. The test includes 16 technical questions, with two questions per session, covering the key topics addressed throughout the training.

The purpose of the pre- and post-test is to:

- Identify areas that may need additional emphasis during the training
- Support facilitators in assessing how well the training meets its objectives

This is not an exam and is not used to assess individual performance. Instead, it helps improve the quality and effectiveness of the training.

Confidentiality and use of results

- Pre- and post-test responses are matched using a participant code to ensure anonymity
- Results are not used for individual evaluation or performance assessment
- Individual responses will not be shared or used for any other purpose

Guidance for Facilitators

- The pre-test should ideally be completed before the training begins. If not feasible, it can be administered during the Welcome and Introduction session on Day 1.
- The post-test should be administered at the end of the training.
- Tests can be conducted on paper or online, depending on the context.
- Facilitators are encouraged to review pre-test results as early as possible (ideally on the same day) to identify common gaps, misunderstandings or priority areas for emphasis during the training.
- Post-test results are used to assess overall learning progress and to inform follow-up support or refresher training as needed.

Test structure

- The test includes 16 questions, aligned with the eight training sessions (two questions per session).
- Questions are designed to assess key knowledge and applied understanding related to IYCF-E counselling.
- The same set of questions is used for both the pre- and post-test to allow comparison of results.

Question 1: Which statement is TRUE about trauma-informed care (TIC)?

- TIC should be applied only to caregivers who explicitly disclose trauma
- Not all caregivers will disclose trauma, so TIC should be applied universally
- TIC is only necessary for caregivers with known mental health conditions
- TIC focuses mainly on providing medical treatment for trauma

Correct answer: b) Not all caregivers will disclose trauma, so TIC should be applied universally

Question 2: Which option correctly identifies the four domains of child development?

- Language/Communication, Physical, Socio-Emotional, Cognitive
- Language/Communication, Physical, Socio-Emotional, Feeding
- Cognitive, Socio-Emotional, Gross Motor, Fine Motor
- Physical, Cognitive, Social, Motor Skills

Correct answer: a) Language/Communication, Physical, Socio-Emotional, Cognitive

Question 3: In an emergency setting, how should a mother with a newborn (0–28 days) be prioritized in IYCF-E triage?

- a) Priority 1 – Immediate help
- b) Priority 2 – At risk
- c) Priority 3 – Not at immediate risk
- d) No priority classification needed

Correct answer: a) Priority 1 – Immediate help

Question 4: What is the appropriate action for Priority 3 (not at immediate risk) IYCF-E recipients?

- a) Let them go
- b) Provide individual counselling
- c) Refer to education sessions or to support groups
- d) Refer for medical treatment

Correct answer: c) Refer to education sessions or to support groups

Question 5: Which statement is TRUE regarding stress and breastfeeding in emergencies?

- a) Stress stops milk production, so infants may not get enough milk
- b) Maternal adrenaline can slow milk flow but does not reduce overall milk production
- c) Breastfeeding while stressed or sad harms the infant physically and emotionally
- d) Infant crying always indicates insufficient milk intake

Correct answer: b) Maternal adrenaline can slow milk flow but does not reduce overall milk production

Question 6: Which of the following is the most effective way to support a stressed caregiver in an emergency while promoting responsive feeding?

- a) Encourage strict feeding schedules to maintain routine and reduce stress
- b) Teach a simple self-regulation practice to help the caregiver stay calm
- c) Suggest she focus only on feeding when the baby cries to save energy
- d) Give several practical feeding tips in the same counselling session so the mother can try them at home

Correct answer: b) Teach a simple self-regulation practice to help the caregiver stay calm

Question 7: When a caregiver discloses gender-based violence (GBV) during an IYCF-E counselling session, what is the most appropriate first step for the counsellor?

- a) Ask detailed questions to understand exactly what happened
- b) Ensure the caregiver's immediate safety and basic needs are addressed
- c) Report the disclosure immediately to local authorities
- d) Seek advice from your supervisor once you have collected information about the GBV case

Correct answer: b) Ensure the caregiver's immediate safety and basic needs are addressed

Question 8: Which approach best supports a caregiver who is a GBV survivor and feels unable to breastfeed because it is distressing?

- a) Explain why breastfeeding is strongly recommended and why she should aim to continue to meet the baby's needs
- b) Provide factual information about feeding options and respect the survivor's choices
- c) Avoid discussing feeding to prevent triggering trauma and wait until the next appointment
- d) Suggest temporary separation from the baby as a solution to her distress

Correct answer: b) Provide factual information about feeding options and respect the survivor's choices

Question 9: In a novel infectious disease outbreak with no specific guidance yet, what is the recommended feeding approach for infants?

- a) Stop breastfeeding until WHO issues guidance
- b) Continue breastfeeding with hygiene precautions and avoid unnecessary separation
- c) Replace breast milk with commercial infant formula for all infants
- d) Follow feeding guidance from a similar infectious disease outbreak

Correct answer: b) Continue breastfeeding with hygiene precautions and avoid unnecessary separation

Question 10: Which statement is true when providing counselling in a voice-only call?

- a) Smiling can be heard and helps convey friendliness and warmth
- b) Focus mainly on delivering instructions, as assessment is too difficult remotely
- c) Silence should always be avoided; keep talking to fill gaps
- d) Speak quickly to cover all points since the caregiver might not pay attention

Correct answer: a) Smiling can be heard and helps convey friendliness and warmth

Question 11: Which statement best reflects correct understanding of relactation and induced lactation?

- a) Only women who recently stopped breastfeeding can restart milk production
- b) Women who never gave birth cannot produce milk
- c) Milk production can be stimulated even in women who have not breastfed before, with appropriate support
- d) Relactation is only possible if the baby is under 1 month old

Correct answer: c) Milk production can be stimulated even in women who have not breastfed before, with appropriate support

Question 12: How does at the breast supplementation support relactation or induced lactation?

- a) It replaces breastfeeding so the baby receives enough milk without needing the breast
- b) It provides additional milk while encouraging the baby to suckle directly from the breast to build up supply
- c) It should only be used if the baby refuses the breast
- d) It is only recommended for babies under 1 month old

Correct answer: b) It provides additional milk while encouraging the baby to suckle directly from the breast to build up supply

Question 13: In emergencies, what should a counsellor prioritize when supporting complementary feeding?

- a) Encouraging the caregiver to insist that the child finishes all food at every meal to prevent malnutrition
- b) Supporting the caregiver to observe the child's cues and practice responsive feeding
- c) Focusing on teaching caregivers a good range of new recipes to improve dietary variety
- d) Encouraging the caregiver to offer preferred foods only to reduce crying or fussiness

Correct answer: b) Support the caregiver to observe the child's cues and practice responsive feeding

Question 14: Which three actions are key counselling priorities for complementary feeding in extreme food insecurity?

- a) Protect breastfeeding → Ensure the child eats enough → Improve nutrient value using available foods
- b) Introduce new foods regularly → Build structured meal routines → Focus on caregiver behavior change
- c) Limit breastfeeding to avoid caregiver fatigue → Focus on diet quality only → Link families to services
- d) Encourage occasional fast feeding → Rely on available foods without modification → Increase water intake to avoid dehydration

Correct answer: a) Protect breastfeeding → Ensure the child eats enough → Improve nutrient value using available foods

Question 15: Which of the following infants would be eligible for commercial infant formula support in an emergency setting? Select all that apply.

- a) A 2-month-old infant whose mother is present, relactation is ongoing, but milk production is not yet fully established and no donor milk or wet nursing is available
- b) A 4-month-old infant whose mother has died, and no wet nursing or donor milk is available
- c) A 2-month-old infant whose mother says the baby cries often and she thinks her milk is not enough
- d) A 5-month-old infant whose mother is a survivor of GBV, struggling with breastfeeding, and considering stopping

Correct answer: a), b), d)

Question 16: During follow-up visits for infants receiving commercial infant formula in an emergency setting, which of the following actions should the counsellor perform? Select all that apply.

- a) Monitor infant growth and health
- b) Reinforce safe feeding and hygiene practices
- c) Check caregiver wellbeing and provide support if needed
- d) Resupply commercial infant formula immediately based on previous prescription

Correct answers: a), b), c)