

Participant Handbook



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

2026

Welcome to your Participant Handbook

This handbook is your companion for the *Infant and Young Child Feeding in Emergencies (IYCF-E) Counselling Training*. It has been designed to guide you through each session, providing key messages, practical exercises, visuals and activity materials.

This training complements the *UNICEF Community IYCF Counselling Package*. Building on the skills that frontline workers already bring, the IYCF-E package strengthens the application of foundational counselling skills and introduces advanced competencies needed in emergency contexts.

By using this handbook, you will have practical guidance, role-play scenarios, job aids, and reference tools to help you develop confidence and competence in supporting caregivers and children in emergency contexts.

How to use this handbook

- **Follow along with the activities:** Each session is structured to include discussions, demonstrations, role plays and reflection exercises.
- **Highlight and take notes:** Use the handbook to capture key points, personal reflections and ideas for your practice.

Be an active participant

This is your training. Engage fully, ask questions, and share your experiences. The more you participate, the more you will learn. Use this opportunity to practice, reflect, and strengthen your skills—your contributions benefit both you and your peers.

Why this handbook matters

- It is your learning companion, not just a reading tool.
- It will help you build confidence and competence in counselling caregivers during emergencies.
- It allows you to link theory to practice, reinforcing skills you can immediately apply in your work.
- It supports ongoing reflection. Training is only the start; real learning happens as you apply the skills.

Tips for getting the most out of your handbook

- Keep it close at hand during sessions for easy reference.
- Engage fully with small group activities and role-plays. These are opportunities to learn by doing.
- Don't worry about mastering everything at once. Practice and repetition are key to becoming confident and effective.
- Use it to review key points and job aids after the training and as a reference for your daily work with caregivers and children.

By actively using this handbook, you will leave the training better equipped to deliver compassionate, responsive and effective support, helping caregivers improve feeding practices and promoting the wellbeing of infants and young children in emergencies.

Take charge of your learning, do your best at your own pace and enjoy the journey!

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ACRONYMS

3As: Assess, Analyse, Act

ANC: Antenatal Care

BMS: Breast Milk Substitute

ECCD: 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

WELCOME AND INTRODUCTION

The *Infant and Young Child Feeding in Emergencies (IYCF-E) Counselling Training* is designed to support you in strengthening your capacity to provide high-quality IYCF counselling in emergency contexts.

Box: Goal of the training

The aim of the training is to equip frontline workers with the essential competencies required to deliver IYCF counselling and other skilled support that is effective, contextually appropriate, inclusive and sensitive to diverse IYCF needs in emergencies.

The learning approach

The training consists of eight sessions. Each session lasts about two hours and follows the same five-step structure:

STEP 1 **Set the scene** Connect the topic to real emergency scenarios and introduce the learning objectives.

STEP 2 **Strengthen key knowledge, concepts, and skills** Present the technical information and considerations required to meet each learning objective.

STEP 3 **Demonstrate** Observe facilitators modelling skills in a scenario-based role-play.

STEP 4 **Participant role-play** Practise new skills in small groups through guided role-play and peer feedback.

STEP 5 **Self-reflection** Consolidate learning through self-reflection and group discussion.

The sessions focus on advanced counselling skills, building on the basic skills introduced in the 2024 UNICEF *Community IYCF Counselling Package* while strengthening their application in emergency contexts. Throughout the training, facilitators will integrate short refreshers on counselling skills as part of the discussions, demonstrations, and role-plays.

To support focused and effective practice, each session emphasizes three selected counselling skills. In day-to-day counselling, however, participants are expected to apply all foundational skills together to provide high-quality, responsive support to caregivers.

Practical ways to build confidence

Using encouraging, non-judgmental language may feel unfamiliar or uncomfortable at first, especially when conversations are emotional or sensitive. Like any counselling skill, it becomes easier with awareness and practise. The following suggested actions can help build confidence over time:

- **Role-play** common counselling scenarios with a colleague or supervisor.

- **Record yourself** saying supportive phrases and listen for tone, pace and warmth.
- **Start small by** choosing one or two neutral phrases to practise each session until they feel natural.
- **Reflect after sessions** on what worked well, what felt challenging and how you might adjust your wording accordingly for future sessions.
- **Observe others** who use calm, supportive language; learn from their phrasing, tone and body language.

With steady practice, supportive communication becomes more natural and effective, which helps to create a space where mothers, fathers and other caregivers feel **safe, respected and empowered**.

Sessions and learning objectives

Table: Sessions and learning objectives

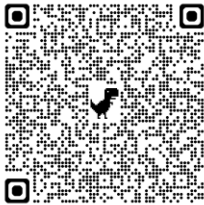
Session	Title	Learning objectives
Session 1	IYCF Counselling in Emergencies	<ol style="list-style-type: none"> 1. Describe the basic IYCF counselling skills and key definitions used in breastfeeding support 2. Explain how IYCF counselling is adapted in emergency contexts and why it is critical 3. Recognize 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 and 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

<p>Session 7</p>	<p>Complementary Feeding in Emergencies</p>	<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

Resources:

The following key guidance documents are key references for IYCF counselling and may be useful to you during and after the training.

- [2024 UNICEF Community IYCF Counselling Package](#)



- [ENN, IFE Core Group \(2021\) Operational Guidance: Breastfeeding Counselling in Emergencies](#)



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, responsive feeding and disability inclusion



LEARNING OBJECTIVE 1:

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

Counselling definition

IYCF counselling refers to an interaction between a trained counsellor and one or more pregnant women, mothers, fathers, or other caregivers of infants and young children (typically under 2 years of age). The process involves listening to caregivers' concerns, discussing questions, sharing practical information on infant and young child feeding, and supporting caregivers to apply recommended feeding and caregiving practice in ways that are feasible in their context.

The aim of IYCF counselling is to strengthen caregivers' confidence, skills and decision-making to support appropriate feeding that minimises risk alongside nurturing care practices, while respecting each family's context, experiences and wishes.

IYCF counselling may include:

- Breastfeeding support
- Complementary feeding
- Feeding of non-breastfed children – provide targeted, comprehensive feeding support
- Responsive caregiving

Counselling is different from education or sensitization because it involves a two-way process of listening, learning and skills-building to support caregivers' decision-making.


Mode of counselling

- Can be one-to-one or in groups
- Can be face-to-face or remote, especially during emergencies
- Group counselling is interactive and participatory. Lectures or classroom sessions are considered education, not counselling.

Counselling tool

You are encouraged to use the UNICEF IYCF Counselling Cards in your counselling sessions, as they are practical tools to support discussion and to reinforce key messages with caregivers.

Core counselling skills

Listening and Learning	Building Confidence and Giving Support
<ol style="list-style-type: none"> 1. Use helpful non-verbal communication: <ul style="list-style-type: none"> • Keep your head level with the mother or caregiver • Pay attention (eye contact) • Remove physical barriers (tables and notes) • Take time, and allow the mother or caregiver time to talk • Use appropriate touch 2. Ask open questions (allows the mother or caregiver to give detailed information). 3. Use responses and gestures that show interest. 4. Reflect back what the mother or caregiver says. 5. Show that you understand how the mother or caregiver feels (empathy). 6. Avoid words or tones that sound judgmental. 	<ol style="list-style-type: none"> 1. Accept what the mother or caregiver thinks and feels. Before providing new information, allow the mother or caregiver to share her or his concerns. 2. Recognize and praise what the mother or caregiver and baby are doing right. 3. Give practical help. 4. Share small, relevant pieces of information. 5. Use simple language. 6. Make one or two suggestions, not commands. 

UNICEF (2024). *Community Infant and Young Child Feeding Counselling Package: Counselling Cards*. New York: UNICEF.

The counselling process: Assess–Analyse–Act (3A)

The counselling process helps structure every interaction with a caregiver:



1. Assess:

Ask, observe and listen to the caregiver’s or group’s concerns and experience with infant or young child feeding.



2. Analyse:

Think about the caregiver or group’s concerns and prioritize what topics and counselling cards you can share.



3. Act:

Provide information and praise, and identify solutions together that the caregiver or group can try.

UNICEF (2024). *Community Infant and Young Child Feeding Counselling Package: Counselling Cards*. New York: UNICEF.

Refer to *Job Aid 1.1: Three-Step IYCF Counselling – Assess, Analyse and Act (3A)* for more detailed explanations.



LEARNING OBJECTIVE 2:

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

Counselling in emergencies

- Emergencies disrupt families, health services and social support networks.
- Pregnant women, women who have just given birth, infants, and young children under the age of 2 face more risks than the general population.
- Breastfeeding provides lifesaving nutrition, hydration, comfort and protection from disease.
- Counselling in emergencies is **critical**. It is supportive and helps caregivers practise feeding approaches that protect infant and young child health in emergency conditions.
- Skilled counselling requires empathy, active listening and non-judgment – especially under stress.

Scenario: Maternity care in hospital



Civil unrest is driving civilians out of several rural provinces towards the capital city, and many women have taken refuge in the nearby makeshift camps. Pressure on maternity services has increased, and IYCF Counsellors are brought into the city's largest hospital as surge support.

More women are arriving without prenatal care. Maternal deaths, miscarriages, stillbirths and infant deaths are increasing. Deliveries are more often complicated or surgical, and many women give birth alone. Their babies are more likely to be born early and/or small.

Question:

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

Write key points from the group discussion below:

Table: Overview of service delivery adaptations during emergencies

Recipients	Timing	Frequency	Mode	Providers	Qualities
Key recommendations for counselling women to improve breastfeeding practices					
ALL pregnant women and mothers / caregivers with infants and young children <2 years	Pregnancy Directly after birth and up to 2-3 days after birth Up to 28 days after birth (neonatal period) First 3-4 months of age At 5 months of age (just ahead of the start of complementary feeding at 6 months) After 6 months (late infancy and early childhood) Throughout breastfeeding period, as needed	At least six contacts and additional contacts as needed	In-person counselling Individual counselling is preferred Group counselling is useful as a complement to individual counselling Remote counselling may complement but not replace individual face-to-face counselling	Healthcare professionals <ul style="list-style-type: none"> Physicians Nurses Midwives Lactation consultants Nutritionists Paraprofessionals <ul style="list-style-type: none"> Peer counsellors Community-based health workers 	Person-centred <ul style="list-style-type: none"> Sensitive Culturally appropriate Trauma-informed Participatory Anticipatory Non-judgmental Quality-focused <ul style="list-style-type: none"> Timely Efficient Equitable
Adaptations of key recommendations for breastfeeding counselling in emergencies					
Prioritize caregivers identified through the triage and assessment process (Session 2), focusing first on those requiring immediate support and those at increased risk. Counselling for all other caregivers should continue as feasible.	Provide immediate, needs-based counselling to caregivers identified through the triage process as requiring urgent support or at increased risk. For other caregivers, provide counselling as feasible, with priority given to the period around birth and at the introduction of complementary feeding (around 6 months).	Provide counselling to caregivers identified through triage as requiring immediate support or at increased risk as often as needed. For other caregivers, provide counselling as feasible within available access, safety and programme capacity, recognizing that routine contact schedules may not be achievable in emergencies.	Individual counselling remains essential. Group counselling may be used to address increased demand and may be more appropriate for people not at high risk. Remote counselling may complement or partially replace face-to-face counselling when access or safety is limited.	Similar provider profiles as routine services, with possible surge capacity or dedicated counsellors. All providers should receive appropriate IYCF counselling orientation for emergency contexts.	Same as routine counselling, with additional emphasis on trauma-informed, flexible, and context-responsive support, including anticipation of feeding challenges related to the emergency.

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



LEARNING OBJECTIVE 3:

Recognize cross-cutting considerations in emergencies, including trauma-informed care, responsive feeding and disability inclusion

Trauma-Informed Care

Trauma is a response to a **threatening** experience that causes **overwhelming physical, emotional, or psychological distress or harm** – that is, beyond a person’s ability to cope. It can result from single events (e.g., accident, assault, disaster), prolonged events (e.g., conflict, kidnapping), or patterns (e.g., intimate partner violence).

Table: What can trauma look and feel like?

Emotional signs (Feelings)	Physical signs (Body Reactions)	Possible psychosocial impacts (changes in thinking, functioning and coping over time)
Sadness or grief	Nausea	Difficulty concentrating or remembering information
Fear or anxiety	Dizziness	Feeling confused or overwhelmed when making decisions
Anger or irritability	Poor sleep	Withdrawal from usual activities or relationships
Shame or guilt	Changes in appetite	Changes in coping behaviours (e.g., increased substance use)
Feeling numb or emotionally detached	Headaches	Reduced ability to manage daily tasks or caregiving routines
	Digestive issues	

Box: Trauma-informed care definition

Trauma-informed care is an approach that guides how counsellors support caregivers in a way that is sensitive to trauma’s ongoing impact on a person’s wellbeing, relationships and caregiving.

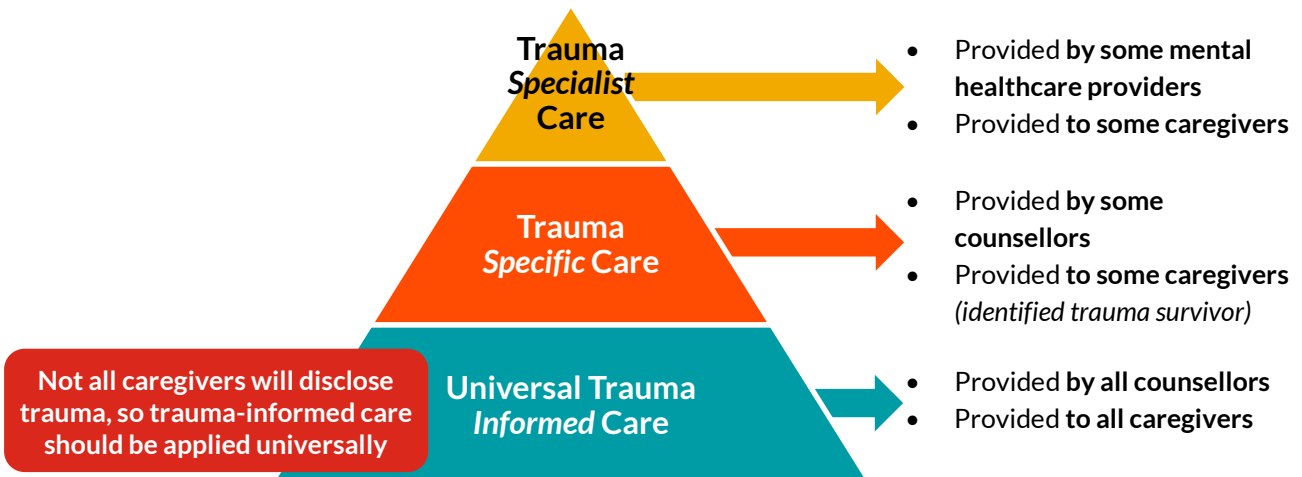
Trauma-informed care aims to avoid re-traumatization and to create safe, respectful and supportive interactions.

Why it matters in emergencies

- Emergency-affected populations often experience high levels of trauma
- Providing trauma-informed care prevents harm, improves access to services and supports recovery

Your role and trauma-informed care

Figure: Multi-tiered approach to trauma-informed care



Box: Five guiding principles for trauma-informed care

- **Safety:** ensuring physical, emotional and psychological safety
- **Trustworthiness:** being reliable, transparent, and consistent
- **Choice:** offering meaningful options and respecting decisions
- **Collaboration:** working with people, not for or on them
- **Empowerment:** recognizing strengths and supporting self-efficacy

Examples of trauma-informed care in practice:

- **Consent:** *Explain and obtain consent for any touch.*
- **Compassion:** *Respond with understanding when someone appears triggered; use inclusive and affirming language. For example, "It makes sense that this feels overwhelming right now."*
- **Care:** *Use verbal instructions or props rather than touch; protect modesty and dignity; support recommended alternative feeding options if needed.*

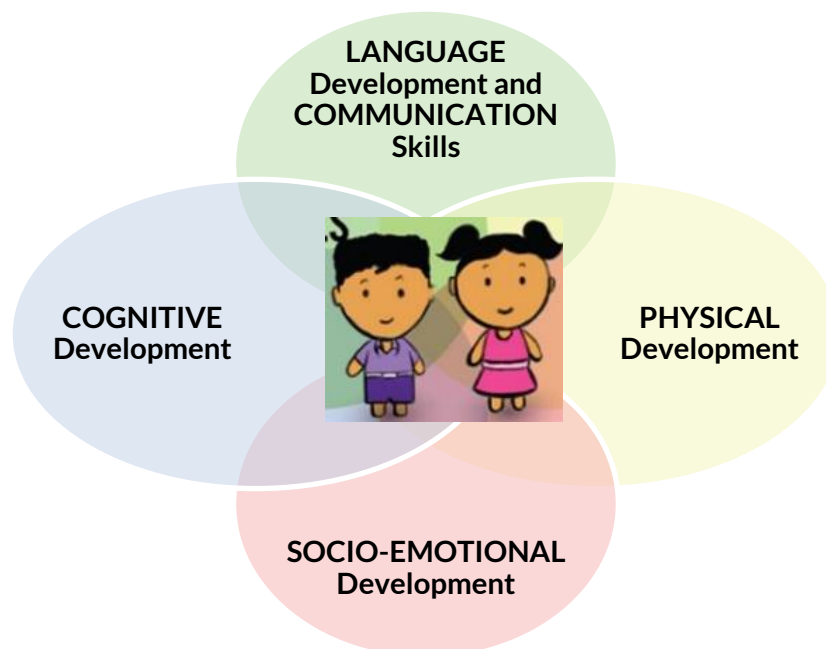
Many more examples of a trauma-informed care approach will be provided across all sessions.

Early Childhood Care and Development

Box: Early childhood care and development definition

Early childhood care and development (ECCD): The physical, cognitive, linguistic/language and socio-emotional development of a child from the prenatal stage to age 8, including the development that is happening within the child and the care that the child requires in order to thrive and grow.

Figure: The four domains of development



Responsive caregiving is the ability of a caregiver to identify, understand and respond to their child's early cues.

Responsive feeding is a form of responsive caregiving that includes providing a nutritious diet (including breastfeeding where relevant), responding to feeding cues, and encouraging independence and good hygiene.

Which category does each goal fall under?	ECCD	IYCF
Caregiver responds to the child’s hunger cues by identifying them and appropriately responding in a timely manner.		
Caregiver offers small amounts of food with eating utensils (e.g., cup, spoon) appropriate to the child’s developmental stage and nutritional needs.		
Caregiver interacts with the child using loving and stimulating language and actions, including eye contact.		

Disability Inclusion

Box: Disability definition

“...those who have long-term physical, mental, intellectual or sensory **impairments**, which in interaction with various **barriers** may hinder their full and effective participation in society on an equal basis with others.”
 United Nations Convention on the Rights of Persons with Disabilities (UNCRPD)

Figure: Relationship among impairments, barriers and disabilities

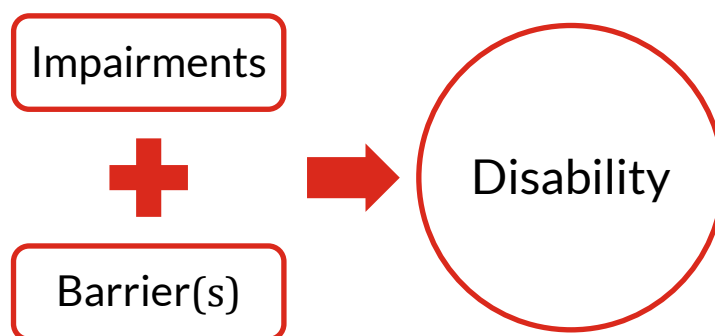


Figure: Models of disability

Three main approaches to understanding disability have been used throughout history:



Person-centred language

- Avoids defining a person by their diagnosis or impairment

Disabled person => Person with a disability

- Discourages assumptions about ability based on diagnosis

Twin track: Mainstreaming and disability-specific support

Mainstreaming	Disability-specific activities
Inclusion of children with disabilities in all IYCF-E counselling and activities: Ensure accessibility, communication and participation for all children and caregivers.	Some situations require targeted support, e.g., referrals to rehabilitation or specialized services, adaptive feeding techniques, or tailored counselling for children with complex needs.

Goal: Ensure children with disabilities benefit equally from nutrition and caregiving support while promoting inclusion in routine activities whenever possible.

Resources:

- [Counselling cards from 2024 UNICEF Community IYCF Counselling Package](#)



Job Aid 1.1: Three-Step IYCF Counselling – Assess, Analyse and Act (3As)

The Three-Step Counselling method – Assess, Analyse and Act – is often referred to as the “Triple A” method (or the 3As). Using this method will help you to counsel mothers and other caregivers about infant and young child feeding. The following is an explanation of each step:

Step 1: Assess: ask, listen and observe

- Greet the mother or caregiver using friendly language and gestures. Introduce yourself.
- Allow the mother or caregiver to introduce her or himself and baby.
- Ask some initial questions that encourage the caregiver to talk.
- Ask the age of the baby or young child.
- Listen to what is being said. Listen to concerns and observe what is going on using your skills of listening and learning, building confidence, and giving/offering support.
- Assess the age-appropriate feeding practice(s) and the condition or health of the child, as well as of the mother or caregiver.
- Accept what the mother or caregiver is doing without agreeing or disagreeing. Recognize helpful practices they are already using.

Step 2: Analyse: identify difficulty and, if there is more than one, prioritize the difficulties

- Decide whether the feeding you observe is age-appropriate and whether the child and the mother/caregiver are in good condition or health.
- If there are no apparent difficulties, praise the mother/caregiver and focus on providing information needed for the next stage of the child’s development.
- If multiple feeding difficulties are present, or if the condition or health of the child or mother/caregiver is poor, prioritize the difficulties and/or health condition(s).

Step 3: Act: discuss, suggest a small amount of relevant information, agree on doable action

- Depending on the factors analysed above, prioritize 1 or 2 challenges and select a small amount of information to share with the mother/caregiver that is most relevant to the situation.
- Be sure to praise the mother/caregiver for what she or he is doing well.
- Present options for addressing the feeding difficulty or health condition of the child or mother/caregiver in terms of small do-able actions. These actions should be time-bound (within a few days).
- Share key information with the mother/caregiver, using the appropriate counselling card(s) or other visuals and answering questions as needed.
- Help the mother/caregiver select one behaviour change option that she or he agrees to try in order to address or overcome the difficulty or condition that has been identified. This is called reaching an agreement.
- Suggest where the mother/caregiver can find additional support. Refer to the nearest health facility if appropriate and/or encourage participation in educational talks or IYCF groups in the community. Refer to other relevant services available in the community, as relevant.
- Confirm that the mother/caregiver knows where to find a community volunteer and/or other health worker.
- Thank the mother or caregiver for her or his time.
- Agree on when you will meet again, if appropriate.

UNICEF (2024). *Community Infant and Young Child Feeding Counselling Package: Counselling Cards*. New York: UNICEF.

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 select three skills is for practice and learning purposes.*

STEP 1: Set the Scene

IYCF counselling recipient

- **IYCF counselling recipients** are people who receive IYCF counselling. They are usually pregnant women, mothers or other caregivers or family members who are responsible for the care and feeding of infants and young children.
- In non-emergency settings, counselling aims to reach everyone who is pregnant or breastfeeding. In emergencies, however, reaching everyone immediately is often not possible and so prioritisation and triage is necessary.

Scenario: Health centre responding to flood displacement



Mudslides and flooding have caused widespread casualties and destroyed homes and infrastructure. Many families have fled their communities and arrived in the centre of town to seek safety. The health centre courtyard has been converted into an intake point where displaced families register and are referred to available services and care.

Question:

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

Write key points from the group discussion below:

Impact of an emergency on recipients of IYCF counselling demand and caseloads

Diagram: When needs exceed capacity



STEP 2: Strengthen key knowledge, concepts and skills



LEARNING OBJECTIVE 1:

Complete triage for IYCF counselling recipients in an emergency

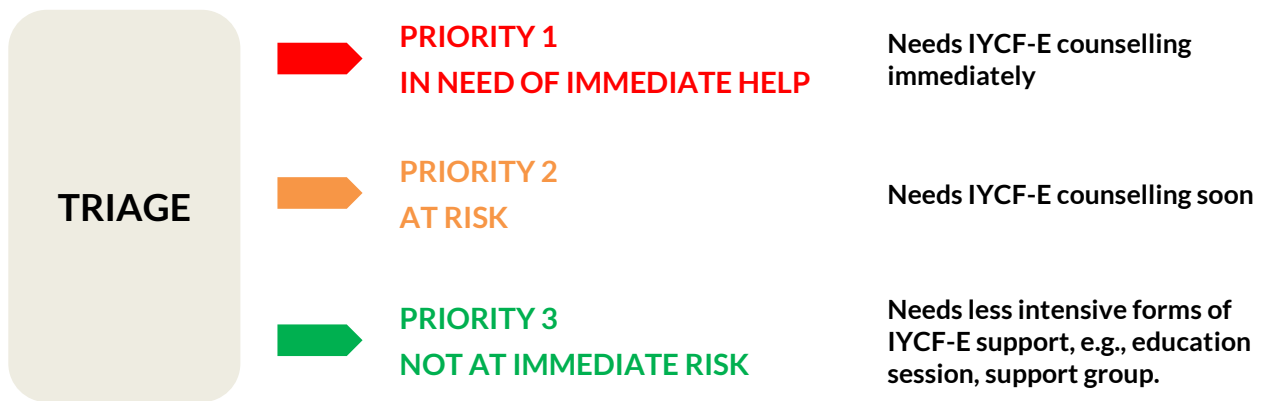
What triage means and why it matters

- Triage means sorting and prioritizing cases to save the most lives.
- It focuses on those in immediate need and those at high risk of developing feeding or nutrition problems.
- By acting early, triage helps to prevent future complications.

How triage works

Triage should be rapid, simple and accurate. Any frontline worker should be able to apply it. The triage process groups IYCF counselling recipients into **three priority levels** based on urgency of need.

Diagram: Triage overview



Important: All **Priority 1** and **Priority 2** cases must receive IYCF-E counselling. When time or resources are limited, Priority 1 cases are supported first.



Priority Triage Tool

Frontline Simple Rapid Assessment or referral from other services

Is the caregiver-child pair or child in need of IMMEDIATE HELP?

YES → PRIORITY 1

Pairs with urgent individual needs include:



Infants and young children who are:

- Infants who are dependent on breast milk substitutes (non-breastfed or mixed fed)
- Newborns (0-28 days)
- Premature/low birth weight (LBW)
- Less than 6 months with growth failure
- Multiples (e.g., twins)
- Sick
- Severely malnourished, identified by either clinical indicators or mid-upper arm circumference (MUAC)
- Living with a disability that impacts feeding
- Showing signs of severe distress
- Separated or unaccompanied
- Maternal orphans
- Receiving early complementary foods (under 6 months of age)
- With no access to or delayed start of complementary foods if over 6 months of age



Breastfeeding women who are:

- Malnourished, identified by either clinical indicators or MUAC
- Severely ill
- Survivors of gender-based violence (GBV)
- Living with a disability which impacts feeding, e.g., Limited upper-limb mobility, visual impairment or blindness)
- Breastfeeding someone else's child
- Living with mental illness or showing signs of distress/trauma
- Living with HIV
- Recovering from a caesarean section/traumatic birth
- Facing breastfeeding difficulties, e.g., engorgement, sore or cracked nipples, pain, thrush, mastitis, perceived/documentated low milk supply, breast refusal

NO

Is the mother-child pair or child AT RISK?

YES → PRIORITY 2

Vulnerable groups and groups who are at higher risk of feeding difficulties include:



Infants and young children who are:

- Under 6 months of age (excluding newborns)
- Recovering from recent infection or illness
- Receiving limited or monotonous diets with few nutrient-dense foods, especially animal-source foods
- Have 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



Pregnant women with risk factors identified during antenatal care, including:

- First-time mother (Nulliparous)
- Multiple pregnancy (twins, triplets, etc.)
- History of breastfeeding difficulties
- Has never breastfed before
- History of breast surgery
- Current / history of depression or anxiety
- Likely or confirmed caesarean delivery
- Diabetic, overweight or obese
- Has a disability impairment which may affect breastfeeding, e.g., limited upper-limb mobility, visual impairment or blindness
- GBV survivor
- HIV positive
- Maternal malnutrition

NO

NOT AT IMMEDIATE RISK

YES → PRIORITY 3

All other pregnant and breastfeeding women and caregivers with infants and young children.

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



Simple Rapid Assessment

Instructions:

- Use this Simple Rapid Assessment (SRA) form for all mothers/caregivers with children 0–23 months (under 2 years old).
- Once the SRA has been completed, decide what level of IYCF-E support is needed and take the corresponding action:
 - **Priority 1 (Red): Refer immediately for full assessment and urgent IYCF-E counselling** → Complete the *IYCF-E Referral Form* (Job Aid 2.1).
 - **Priority 2 (Orange): Refer for full assessment and IYCF-E counselling as soon as possible** → Complete the *IYCF-E Referral Form* (Job Aid 2.1).
 - **Priority 3 (Green): No immediate need for counselling** → Provide praise, encouragement and referral to supportive IYCF services (e.g., education sessions, mother-baby corners, peer support groups).

SIMPLE RAPID ASSESSMENT			
Staff name/ID		Date of assessment	
Child's name		Child's Gender	
Child's age			
Caregiver's name		Caregiver relationship	
Facility ID		Location	
ASK			
Age of baby	<input type="checkbox"/> 1 to 5.9 months <input type="checkbox"/> Newborn (<28 days)	<input type="checkbox"/> 6–12 months	<input type="checkbox"/> 12–24 months
Is the baby breastfed?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
(If yes) Are there any difficulties breastfeeding?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Is the baby drinking infant formula/milk powder?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Is the baby getting anything else to	<input type="checkbox"/> Yes <input type="checkbox"/> No	n/a	n/a
Is the baby getting anything else to eat?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Is it your first child?	<input type="checkbox"/> Yes <input type="checkbox"/> No	n/a	n/a
OBSERVE			
Multiples (twins/triplets/etc.)?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Caregiver requested infant formula?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Baby looks very thin/lethargic/ill?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Baby has sunken eyes/sagging skin?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Caregiver/child has an impairment?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Caregiver looks very thin/ill?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Caregiver appears to be very anxious, stressed, sad or distressed?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

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

Note: The SRA does not capture all criteria included in the Priority Triage Tool. Use the SRA for rapid screening; use the Priority Triage Tool to confirm priorities and guide triage decisions.

Hidden risks

Even with tools like the SRA, not all information may be identified during triage. Caregivers usually want help, but some situations may remain private, even when approached respectfully and without judgment. Triage focuses on identifying priority needs safely, not on collecting every detail.

Note on gender-based violence (GBV):

It is not the role of IYCF workers to ask whether someone is a survivor of GBV. This priority only applies if a caregiver voluntarily discloses GBV-related information.



Key learning points – Objective 1

- Emergency conditions increase the number and complexity of malnutrition cases *and* the number of caregivers and infants requiring IYCF support. This increases the risk of poor outcomes.
- **Simple, accurate, efficient triage** is critical to **protect life** within the necessary compromises and adaptations to recommended practices.
- **Triage** is about quickly identifying who needs **immediate or early support** – not about collecting every detail.
- **GBV-related information** should only inform priority if **voluntarily disclosed**. IYCF workers **do not ask about GBV**.



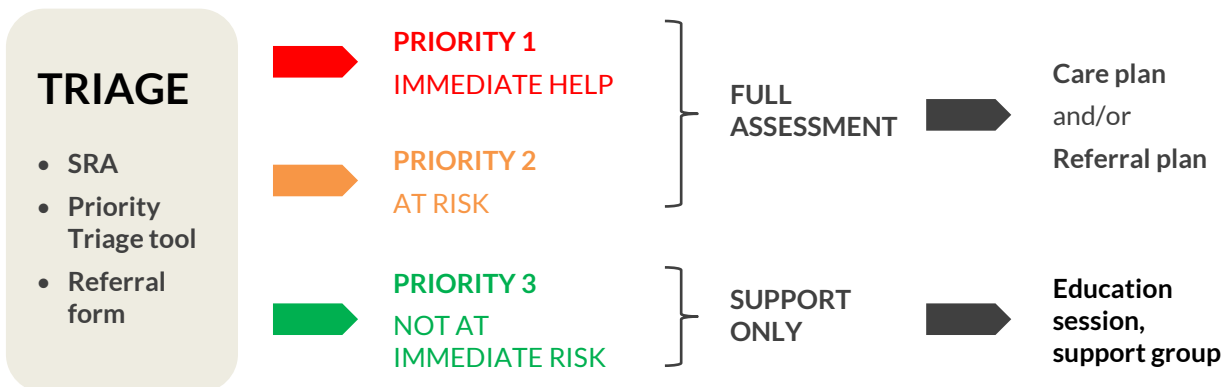
LEARNING OBJECTIVE 2:

Describe how to conduct an individual full assessment in an emergency

From triage to care

The diagram below shows how the SRA and the Priority Triage Tool identify mother–baby pairs for either full assessment, care planning and referral (for Priority 1 and 2), or routine IYCF support (for Priority 3).

Diagram: From triage to care



The IYCF-E Full Assessment Form is a structured tool used after triage to gather essential information about the caregiver–child pair and guide the recommended counselling, follow-up, and referrals.



IYCF-E Full Assessment Form

Note: The **2023 WHO guideline on wasting** introduces a new recommendation to use **mid-upper arm circumference (MUAC) (<110 mm)** to identify wasting in infants aged **6 weeks to under 6 months**, with referral for outpatient or inpatient management based on clinical assessment and risk. This reflects emerging evidence and may be new in some contexts. The **MAMI Care Pathway Package** uses **different MUAC cut-offs**, recommending **<115 mm for infants aged 6 weeks and above** and **<110 mm for infants under 6 weeks of age**. **Frontline workers should always follow local and national guidelines** on MUAC use, cut-offs and admission criteria for infants under 6 months, because implementation and policy adoption vary by country. <https://www.childwasting.org/guidance>

MUAC Measurement 6–59 months (to nearest cm)	Normal (green) ≥ 12.5 cm	Moderate (yellow) 11.5–12.4 cm	Severe (red) <11.5 cm	Oedema (Y/N)

1. COLLECT BASIC INFORMATION					
Counsellor's ID		Location		Date of assessment	/ /
Caregiver's name		Relationship to child	Mother/Father/Grandmother/Sibling/Other: _____		
Child's name		Sex	Male/Female	Child's ID No.	
Child's D.O.B.	/ /	Child's age	_____ months	Caregiver's age	_____ years
Caregiver's name		Relationship to child			
Facility ID		Facility name		District	
Source of referral	<input type="checkbox"/> Self-referral <input type="checkbox"/> SRA – from _____ service <input type="checkbox"/> No SRA – direct from _____ service				
2. CHECK FOR DANGER SIGNS ¹					
Lethargic/unconscious?			<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Vomits everything?			<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Unable to drink/breastfeed?			<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Difficulty breathing? (respiration rate, chest indrawing)			<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Low or high temperature? (< 35.5° or ≥ 38° C)			<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Bilateral pitting oedemata? (+/++/+++)			<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Caregiver appears out of touch with reality, or child appears to be at risk from caregiver's behaviour?			<input type="checkbox"/> Yes	<input type="checkbox"/> No	
ACTION: IF ANY MARKED AS YES → URGENT REFERRAL TO HEALTH SERVICES BEFORE CONTINUING IYCF ASSESSMENT					

¹ Adapted from IMCI Danger Signs. Please refer to national IMCI guidelines.

3. ASK ABOUT FEEDING PRACTICES			
Please tell me about your experiences of feeding your child. What concerns or questions would you like to discuss today?			
What and how is the child fed? (Select all that apply)		<input type="checkbox"/> Breastfeeding – at mother’s breast <input type="checkbox"/> Expressed breast milk – mother’s own <input type="checkbox"/> Expressed breast milk – informally shared from another woman <input type="checkbox"/> Donor human milk from a milk bank <input type="checkbox"/> Breastfed directly by a woman who is not the child’s mother <input type="checkbox"/> Some non-breast milk feeding (BMS or other milk) <input type="checkbox"/> Fully non-breast milk fed (BMS or other milk) <input type="checkbox"/> Not receiving breast milk or other milk	
		<input type="checkbox"/> Breast <input type="checkbox"/> Bottle <input type="checkbox"/> Spoon <input type="checkbox"/> Cup	
Does the child eat or drink anything other than breast milk? ²		<input type="checkbox"/> Yes	<input type="checkbox"/> No
(If yes) What else do you give the child?		<input type="checkbox"/> Infant formula <input type="checkbox"/> Other milks <input type="checkbox"/> Water <input type="checkbox"/> Tea/coffee <input type="checkbox"/> Sugary drinks/soda <input type="checkbox"/> Juice: _____ ml/cups <input type="checkbox"/> Medicine <input type="checkbox"/> Food <input type="checkbox"/> Other ³ : _____	
No. of previous children:		No. of previous breastfed children:	
Does the child use a pacifier?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
Is the child currently sick?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
(If sick) Since your child became sick, have there been any changes in the way you have been feeding?			
Breastfeeding	<input type="checkbox"/> More/no change	<input type="checkbox"/> Less often	<input type="checkbox"/> Stopped
(If 6–23 months) Complementary feeding	<input type="checkbox"/> More/no change	<input type="checkbox"/> Less often	<input type="checkbox"/> Stopped
Extras	<input type="checkbox"/> Extra nutritious food	<input type="checkbox"/> Infant formula	
4. CHECK HYDRATION AND STOOL OUTPUT			
How many times has the baby passed urine in the last 24 hours?	_____ times		
Are there long gaps without urine, i.e., many hours being dry?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Does the urine have a strong smell or colour?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
How many times has the baby passed stool in the last 24 hours?	_____ times ⁴		

² Counsellor should be trained to probe (e.g., “how about water – do you give baby any water?”).

³ Contextualize with most commonly given liquids.

⁴ Counsellors need to be provided with job aids or reference materials and trained on what is considered acceptable in terms of stooling depending on the infant age and what they are fed.

Have there been any recent changes from usual?	<input type="checkbox"/> Less frequent stooling	<input type="checkbox"/> Loose or watery stools (Diarrhoea)	<input type="checkbox"/> No changes
Observe or ask about dehydration danger signs:	<input type="checkbox"/> Baby is very sleepy, difficult to wake, or unusually weak <input type="checkbox"/> Baby has a dry mouth or lips <input type="checkbox"/> Sunken eyes <input type="checkbox"/> Baby is not feeding well or refusing feeds <input type="checkbox"/> Skin looks dry or lacks elasticity		
ACTION: IF URINE OUTPUT IS LOW/CONCERNING → EXPLORE POSSIBLE LOW MILK SUPPLY ACTION: IF CHILD HAS DIARRHOEA → REFER TO HEALTH SERVICES			
5. ASK ABOUT BREASTFEEDING/BREAST MILK FEEDING			
How often do you breastfeed/feed your child breast milk?	_____ times total	_____ times in the night	
How do you decide when to feed your child?	<input type="checkbox"/> Responsive	<input type="checkbox"/> Scheduled	
(If breastfeeding) Do you experience any pain or discomfort while breastfeeding?	<input type="checkbox"/> Yes <input type="checkbox"/> Extreme <input type="checkbox"/> Moderate <input type="checkbox"/> Mild	<input type="checkbox"/> No	
6. REQUEST PERMISSION TO OBSERVE THE MOTHER BREASTFEEDING (IF APPLICABLE)			
Assess breast health:	Colour: <input type="checkbox"/> Normal <input type="checkbox"/> Redness Condition: <input type="checkbox"/> Normal <input type="checkbox"/> Shiny <input type="checkbox"/> Hard <input type="checkbox"/> Warm <input type="checkbox"/> Engorged <input type="checkbox"/> Damaged nipple <input type="checkbox"/> Suspected blocked duct <input type="checkbox"/> Suspected mastitis <input type="checkbox"/> Suspected thrush <input type="checkbox"/> Suspected breast abscess		
ACTION: IF THRUSH, BREAST ABSCESS OR MASTITIS → REFER TO HEALTH SERVICES FOR TREATMENT			
Breastfeeding Observation Guide (supportive assessment)			
Note: Not all signs need to be present. Use overall patterns to guide support. Always ask for consent to observe a feed. Observe without touching unless permission is given.			
Signs breastfeeding is going well		Signs that feeding support may be needed	
BODY POSITION <input type="checkbox"/> Mother relaxed and comfortable <input type="checkbox"/> Mother's back and arms are well supported <input type="checkbox"/> Baby's body close, facing breast <input type="checkbox"/> Starts feed with baby's nose opposite nipple <input type="checkbox"/> Baby's head free <input type="checkbox"/> Baby's head and body straight (in line) <input type="checkbox"/> Baby's chin touching breast		BODY POSITION <input type="checkbox"/> Shoulders tense/leaning over baby <input type="checkbox"/> Baby's body far away from mother's body <input type="checkbox"/> Starts feed with baby's mouth opposite nipple <input type="checkbox"/> Baby's head cannot move back freely <input type="checkbox"/> Baby's neck twisted/not in line with shoulder and hip <input type="checkbox"/> Baby's chin not touching breast	
Signs breastfeeding is going well		Signs of possible difficulty	
BABY RESPONSES <input type="checkbox"/> Baby reaches for breast if hungry <input type="checkbox"/> [Baby roots for breast] <input type="checkbox"/> Baby explores breast with tongue <input type="checkbox"/> Baby calm and alert		BABY RESPONSES <input type="checkbox"/> No response to breast <input type="checkbox"/> [No rooting observed] <input type="checkbox"/> Baby shows little interest in breast <input type="checkbox"/> Baby restless or crying	

<input type="checkbox"/> Baby stays attached to breast <input type="checkbox"/> [Signs of milk ejection] – leaking, afterpains EMOTIONAL STATE AND BONDING (note: These observations should always be interpreted in context. Stress, fatigue, illness or trauma may affect these behaviours and do not indicate poor caregiving.) <input type="checkbox"/> Secure, confident hold <input type="checkbox"/> Eye contact <input type="checkbox"/> Mirroring of facial expressions between parent and child <input type="checkbox"/> Much touching by mother <input type="checkbox"/> Responsive to baby’s needs SUCKLING/ATTACHMENT <input type="checkbox"/> Mouth wide open <input type="checkbox"/> Lower lip turned outwards <input type="checkbox"/> Tongue cupped around breast <input type="checkbox"/> Cheeks round <input type="checkbox"/> More areola above baby’s mouth <input type="checkbox"/> Slow deep sucks, bursts with pauses <input type="checkbox"/> Can see or hear swallowing END OF FEED <input type="checkbox"/> Baby releases breast <input type="checkbox"/> Nipple looks normal/round/erect <input type="checkbox"/> Baby suckled for several minutes <input type="checkbox"/> Mother keeps breast available and offers other breast if appropriate <input type="checkbox"/> Baby’s hands are relaxed/open <input type="checkbox"/> Baby looks relaxed/satisfied/sleepy <input type="checkbox"/> Breasts feel softer	<input type="checkbox"/> Baby slips off breast <input type="checkbox"/> [No signs of milk ejection] <input type="checkbox"/> Mother shows signs of pain/discomfort <input type="checkbox"/> Baby coughs/gags/chokes EMOTIONAL STATE AND BONDING (note: These observations should always be interpreted in context. Stress, fatigue, illness or trauma may affect these behaviours and do not indicate poor caregiving.) <input type="checkbox"/> Nervous/limp hold <input type="checkbox"/> No eye contact <input type="checkbox"/> Shaking or poking baby/breast <input type="checkbox"/> Little touching <input type="checkbox"/> Struggles to soothe baby when crying SUCKLING/ATTACHMENT <input type="checkbox"/> Mouth not wide open/points forwards <input type="checkbox"/> Lower lip turned in <input type="checkbox"/> Baby’s tongue not seen <input type="checkbox"/> Cheeks tense or pulled in <input type="checkbox"/> More areola below baby’s mouth <input type="checkbox"/> Rapid sucks only <input type="checkbox"/> Can hear smacking or clicking END OF FEED <input type="checkbox"/> Mother takes baby off breast <input type="checkbox"/> Nipple looks creased/squashed/flattened <input type="checkbox"/> Baby suckled for <5 minutes <input type="checkbox"/> Mother does not keep breast available or offer other breast <input type="checkbox"/> Baby’s hands are clenched/near face <input type="checkbox"/> Baby fusses/cries/appears unsatisfied
--	--

Time spent breastfeeding _____ minutes

7. ASSESS MATERNAL/CAREGIVER WELLBEING⁵

Over the last two weeks, have you experienced any of the following feelings?	(If yes) Frequency in the last two weeks?				
Feeling anxious or worrying uncontrollably	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Sometimes	<input type="checkbox"/> Often	<input type="checkbox"/> Almost every day
Difficulties coping with daily chores	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Sometimes	<input type="checkbox"/> Often	<input type="checkbox"/> Almost every day
Little interest or pleasure in doing things that you used to enjoy	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Sometimes	<input type="checkbox"/> Often	<input type="checkbox"/> Almost every day
Feeling down, depressed or hopeless	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Sometimes	<input type="checkbox"/> Often	<input type="checkbox"/> Almost every day
On a scale of 1 (very unsupported) to 5 (very supported), how supported do you feel by family and friends in caring for your baby?	1	2	3	4	5

⁵ Instead of questions, caregivers may also be shown drawings and asked which most accurately reflects their mood.

Who do you mostly rely on for support, if anyone?			
How does your family feel about you breastfeeding?			
ACTION: IF ANSWERED YES, OFTEN/ALMOST EVERYDAY OR SCORED 1-3 → REFER TO MENTAL HEALTH AND PSYCHOSOCIAL SUPPORT SERVICES			
Do you have any concerns about the baby's growth and development or level of alertness, compared to other babies of a similar age?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
ACTION: IF ANSWERED YES → REFER TO HEALTH AND ECD SERVICES			
How is your current health?			
8. (IF 6-23 MONTHS) ASSESS COMPLEMENTARY FEEDING PRACTICES			
Who helps/assists the child with eating?			
Yesterday, how many times did your child eat solid, semi-solid or soft foods during the day or at night?		_____times	
Yesterday, what did you give your child to eat during the day and night?		WHAT?	HOW MUCH? (cups/handfuls)
			TEXTURE? (thick/thin/ chopped/whole)
Grains, roots, tubers			
Legumes and nuts			
Dairy products (milk, yoghurt, cheese)			
Flesh foods (meat, fish, poultry, liver/organ meats)			
Eggs			
Fruits and vegetables rich in Vitamin A (i.e., that are bright green, orange, or yellow coloured)			
Other fruits and vegetables			
Check: ≥ 4 food groups?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
Did you give your child micronutrient powder?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
What do you use to feed your child liquids?		<input type="checkbox"/> Open cup <input type="checkbox"/> Cup with spout <input type="checkbox"/> Bottle	
At what important times in the day do you wash your hands with water and soap?		<input type="checkbox"/> Before preparing food <input type="checkbox"/> Before eating <input type="checkbox"/> Before feeding child	
Do you wash the child's hands with clean water and soap before they eat?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you noticed the child experiencing any difficulties when eating?		<input type="checkbox"/> Yes	<input type="checkbox"/> No

<input type="checkbox"/> Coughing/choking <input type="checkbox"/> “Wet”/“gurgly” voice breathing <input type="checkbox"/> Discomfort <input type="checkbox"/> Watery eyes <input type="checkbox"/> Changes in colour/breathing			
ACTION: IF SIGNS OF POSSIBLE ASPIRATION ARE PRESENT → REFER FOR PAEDIATRIC ASSESSMENT			
9. NOTE DOWN ANY KNOWN RISK FACTORS (e.g., noted when referred)			
Child	<input type="checkbox"/> Premature <input type="checkbox"/> Low birth weight <input type="checkbox"/> Under 6 months with growth failure <input type="checkbox"/> Sick <input type="checkbox"/> Multiple <input type="checkbox"/> Malnourished <input type="checkbox"/> Disability impacting feeding <input type="checkbox"/> Signs of extreme distress <input type="checkbox"/> Maternal orphan <input type="checkbox"/> Separated/unaccompanied		
Mother/caregiver	<input type="checkbox"/> Malnourished <input type="checkbox"/> Severely ill <input type="checkbox"/> Recovering from Caesarean birth/difficult birth <input type="checkbox"/> Disability impacting feeding Voluntary disclosure only: <input type="checkbox"/> MHPSS difficulties <input type="checkbox"/> SGBV survivor <input type="checkbox"/> HIV positive <input type="checkbox"/> First time mother <input type="checkbox"/> Adolescent mother		
ACTION: IF RISK FACTOR(S) ARE PRESENT → ENROLL FOR COUNSELLING + REFER TO REQUIRED SERVICES			
10. NOTE DOWN ANY OBSERVATIONS MADE DURING THE ASSESSMENT			
Mother’s/caregiver’s interaction with child (holding, touching, visual contact, verbal exchange, mirroring, playing)	<input type="checkbox"/> Poor	<input type="checkbox"/> Moderate	<input type="checkbox"/> Good
Child’s reaction to the mother’s/caregiver’s stimulation	<input type="checkbox"/> Poor	<input type="checkbox"/> Moderate	<input type="checkbox"/> Good
Mother’s/caregiver’s reaction to the child’s calls for attention and need for comfort	<input type="checkbox"/> Poor	<input type="checkbox"/> Moderate	<input type="checkbox"/> Good
Mother’s/caregiver’s awareness of child’s movements	<input type="checkbox"/> Poor	<input type="checkbox"/> Moderate	<input type="checkbox"/> Good
Mother’s/caregiver’s response to child needing correction	<input type="checkbox"/> Poor	<input type="checkbox"/> Moderate	<input type="checkbox"/> Good
Child moves both arms and legs equally	<input type="checkbox"/> Yes		<input type="checkbox"/> No
Normal tone and posture	<input type="checkbox"/> Yes		<input type="checkbox"/> No
Mother/caregiver requested infant formula	<input type="checkbox"/> Yes		<input type="checkbox"/> No
11. COUNSELLING ACTIONS/DECIDE ON CARE PLAN			
Possible problems:			
Counselling actions taken:	<input type="checkbox"/> Positioning and attachment: _____ <input type="checkbox"/> Stress management: _____ <input type="checkbox"/> Information given on: _____ <input type="checkbox"/> Supplies provided: _____ <input type="checkbox"/> Referrals made (health/nutrition/MHPSS/ECD/FSL/WASH/other): _____ _____ <input type="checkbox"/> Other: _____		
Further counselling needed?	<input type="checkbox"/> Yes		<input type="checkbox"/> No

ACTION: IF NO → REFER FOR OTHER IYCF SERVICES		<input type="checkbox"/> Education <input type="checkbox"/> Peer group support <input type="checkbox"/> Other: _____
Reason for further counselling (refer to triage tool)		
Support to be provided		
BASIC SUPPORT AND COUNSELLING <ul style="list-style-type: none"> <input type="checkbox"/> Positioning and attachment <input type="checkbox"/> Maternal confidence <input type="checkbox"/> Milk expression <input type="checkbox"/> Cup/spoon feeding <input type="checkbox"/> Flat or inverted nipples <input type="checkbox"/> Sore or damaged nipples <input type="checkbox"/> Engorgement <input type="checkbox"/> Increase/decrease milk production <input type="checkbox"/> Restorative care/emotional support <input type="checkbox"/> Wet nursing <input type="checkbox"/> Breastfeeding in public/crowded spaces <input type="checkbox"/> Breastfeeding at night <input type="checkbox"/> Infection prevention and control <input type="checkbox"/> Rejecting donations of BMS/feeding bottles/teats <input type="checkbox"/> Preparing for crisis/evacuation <input type="checkbox"/> Encourage age-appropriate feeding <input type="checkbox"/> Complementary feeding <input type="checkbox"/> Maternal diet <input type="checkbox"/> Other: _____ 	ADVANCE SUPPORT AND COUNSELLING <ul style="list-style-type: none"> <input type="checkbox"/> Manage mastitis/thrush <input type="checkbox"/> Manage tongue tie <input type="checkbox"/> Breastfeed LBW or preterm infant/kangaroo mother care (KMC) <input type="checkbox"/> Breastfeeding during maternal/child severe illness <input type="checkbox"/> Feeding with a disability impacting feeding <input type="checkbox"/> Feeding while experiencing mental health difficulties <input type="checkbox"/> Relactation <input type="checkbox"/> Suppress lactation (stillbirth/infant loss) <input type="checkbox"/> Maintaining lactation during separation <input type="checkbox"/> Breast refusal <input type="checkbox"/> Other: _____ 	
Follow-up date:		
Time spent today:		

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

Disability Focus:

If a disability that may affect feeding is suspected or confirmed and specialized services are not immediately accessible, this tool can help frontline workers assess needs and offer appropriate interim feeding support until referral is possible.



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

Referrals

Referrals link caregivers and infants to services that address needs beyond IYCF-E counselling. The specific referral form may vary by context (see *Job Aid 2.1: IYCF-E Referral Form*).

For referrals to work well, counsellors need clear information on:


- Admission criteria
- Location
- Opening days and hours
- Any costs

Challenges outside of feeding, such as missing family members, food insecurity or (if voluntarily disclosed) violence in the home, can affect a caregiver’s ability to care for their child. Identifying these issues and referring to appropriate services supports better IYCF outcomes.

Using the IYCF-E Full Assessment Form in practice

- Use open, conversational questions. The form supports the interaction; it should not replace natural dialogue.
- Avoid reading the form line by line.
- Start with broad, open questions. Then use the form to check what might be missing.

Table: Types of questions

Close-ended question	Open-ended question
“Are you breastfeeding or bottle-feeding?”	“How is your baby being fed?”
“In the last two weeks, have you felt: Angry? [pause] Sad? [pause] Hopeless? [pause]”	“Tell me how you’ve been feeling over the last two weeks.”
<ul style="list-style-type: none"> • Presents finite options • Requires many follow-up questions 	<ul style="list-style-type: none"> • Does not pre-define options • Allows the mother to expand on the aspect that is most urgent • Uses the checklist to identify clarification points
	
	Clarifying question
	“Feeling sad or down? Feeling worried all the time?”
	When an open-ended question does not elicit enough specifics, short leads of simple questions can encourage a more detailed response



Key learning points – Objective 2

- The Full Assessment is only for Priority 1 and 2 pairs after triage.
- It guides counselling, care planning, and referrals by gathering key information.
- Use observations and open-ended, conversational questions. This is not a checklist to be read aloud.
- Each assessment ends with a simple care plan focusing on the most urgent needs.
- Repeated practise will make your use of these tools more natural while you hone your counselling skills.

STEP 3: Demonstrate

Listen and watch the demonstration of a case study based on the scenario introduced in Step 1. The demonstration illustrates how to conduct a Simple Rapid Assessment (SRA).

You will observe the counsellor using three key counselling skills:

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

The counsellor is an IYCF-E Counsellor who has been referred to Hana.

Case study: Aunt Ayen and Deng



Caregiver: Ayen

Child: Deng, 2 months old

Location: Health Centre serving IDP Camp

Reason for contact: Screening of new arrival

Instructions:

- Follow the demonstration using the SRA from Step 2.
- As you watch, **check the Priority Triage Tool** and **complete the SRA form** based on the information shared by the caregiver.
- This demonstration is for learning. Don't worry about making your form perfect. The goal is to practise using the SRA in real time and to observe how the counsellor applies key counselling skills.
- Watch how the counsellor uses open-ended questions and reflects back what Ayen says.

STEP 4: Role-Play

Now it's your turn!



Timing: 10 minutes

Case study: Aunt Ayen and Deng

Mudslides and flooding have displaced many families, including Aunt Ayen and Deng, who have arrived at the health centre intake point.



Caregiver: Aunt Ayen

Child: Deng, 2 months old

Location: Health centre intake point

Reason for contact: Screening of new arrival. Deng's mother passed away, and Aunt Ayen is caring for him.

Information collected from triage:

- Deng is not currently breastfed and has been fed porridge only.
- Deng appears thin.
- Aunt Ayen appears tired, stressed and concerned about caring for Deng.

Next step: Based on the findings from the triage, Aunt Ayen has been referred for a full assessment.

Instructions:

1. The goal of this role-play is to practise conducting a **full assessment** for Deng and Aunt Ayen. **You are not expected to create a care plan at this stage.**
2. In your groups of three, divide into specific roles:
 - One person will play the **counsellor**.
 - One person will play **Aunt Ayen** (the facilitator will give you a short role-play card with Ayen's situation).
 - One person will be the **observer**. The observer should use the Counselling Skills Checklist (below) to note key strengths and areas for improvement rather than try to write everything.

During the role-play, counsellors should focus on practising three core counselling skills described below.



Reminders: Core counselling skills

- **Ask open-ended questions:** Open questions allow the mother to give more detailed information, without suggesting a pre-determined answer. For example:

“Are you breastfeeding?”	➡	“How are you feeding your baby?”
“How many times per day are you breastfeeding?”	➡	“Describe feedings through a typical day and night.”
“What kind of bottle are you using?”	➡	“How do you usually give the baby his feeds?”
“Is breastfeeding painful?”	➡	“How does breastfeeding feel?”

- Reflect back what the mother or caregiver says:** Reflecting serves the dual purpose of showing the mother that you are listening to her and checking your understanding. It should not be a transcript of every word said but a re-statement of the relevant points. Always pause after restating to allow the mother to correct or build on your response.

“It sounds like she has been crying a lot, and you’re worried she isn’t getting enough food.”

“So, you’ve been giving him porridge because that’s what has been available since the floods. Is that right?”
- Accept what a mother or caregiver thinks and feels:** The counsellor’s role is not to agree or disagree with but to understand the mother. Accepting what a mother thinks and feels validates her emotions and experiences. The mother’s feelings are always valid and must be respected – even when the goal of counselling is to change feeding practices or develop a different perspective on her situation.

“It makes sense that you’re feeling tired and unsure right now.”

“Many caregivers would feel the same in your situation.”

Counselling Skills Checklist for the observer

Instructions: Tick **Yes**, **Partially** or **No** for each skill or action you observe during the counselling session.

Counselling Skills Checklist			
	Yes	Partially	No
Uses existing SRA information appropriately. Does not repeat unnecessary questions already covered in the SRA.			
Skips non-relevant sections of the Full Assessment form			
Conducts assessment in a natural, conversational way. Does not read the form line by line.			
Records on form without interrupting frequently			
Asks open-ended questions to explore feeding, wellbeing, interaction, etc.			
Uses clarifying or follow-up questions when needed			
Paraphrases or restates key caregiver statements to show listening			
Pauses after reflecting to give caregiver space to confirm or correct			
Validates caregiver’s emotional state (stress, tiredness, worry)			
Does not judge, shame or dismiss the caregiver’s feelings			
Summarizes what was learned during the assessment			



Role-play debrief: Aunt Ayen and Deng

1. Use the SRA findings and avoid repeating questions

The SRA already tells us that Ayen appears stressed and that Deng is thin, not breastfed, and is currently fed porridge only. A full assessment should not start over from the beginning. Instead, it should **build on what is already known**, exploring what is missing and clarifying uncertainties through open questions.

Sample lines:

"I understand Deng has been taking porridge. Can you tell me how feeding has been going today?"

"I heard the last few days have been stressful. How are you managing with everything?"

→ **Remember:** Do not re-ask closed factual questions that the SRA already captured (age, name, feeding type). Use the assessment to deepen understanding, not duplicate work.

2. Conduct the assessment as a natural, conversational flow

A good assessment feels like a supportive conversation, not a form being read aloud. Counsellors should start broad, listen carefully and use the form only to check what still needs to be covered.

Sample lines:

"Walk me through a typical day and night with Deng."

→ **Remember:** Let the caregiver's story guide the order of questions. The form is a tool, not a script.

3. Use key counselling skills: open-ended questions, reflection and acceptance

Effective assessment depends as much on *how* questions are asked as on *what* is asked. Open questions help Ayen express her worries and practices. Reflecting back shows that the counsellor is truly listening. Accepting her feelings, without judgment, encourages honesty.

Sample lines:

"It sounds like you've been carrying this on your own." (reflection)

"Many caregivers feel unsure at first. It makes sense you're worried." (acceptance)

→ **Remember:** We are gathering information, not correcting or persuading. Acceptance increases accuracy and trust.

4. Observe the caregiver and caregiver-child interactions

The full assessment includes not only what caregivers say but also what counsellors can observe: eye contact, comfort handling the baby, responsiveness, and signs of stress or fatigue. These observations help identify additional needs.

→ **Remember:** Many caregivers under stress may not volunteer information about their own wellbeing unless asked gently.

STEP 5: Self-Reflection

Take a few minutes to think about the session. You can write your answers in the space below.

Questions:

1. How confident do I feel conducting a full assessment after completing the SRA? What parts felt clear, and what felt more challenging?

2. Did I use a natural, conversational style during the assessment, or did I rely too much on the form? What can I improve next time?

3. How well did I use the core counselling skills (open questions, reflection, acceptance, non-judgment)? Which skills do I want to strengthen?

Additional notes:

Resources:

- **Connecting Inclusive Feeding & Disability Resources to Nutrition Practices in Humanitarian Settings**
GNC Disability Inclusion Working Group (July 2024).



Document: <https://resourcecentre.savethechildren.net/document/connecting-inclusive-feeding-and-disability-resources-to-nutrition-practices-in-humanitarian-settings>

Job Aid 2.1: IYCF-E referral form

CHILD'S NAME: _____ CARETAKER NAME: _____ DATE OF BIRTH: _____ AGE (completed months): _____ GENDER (circle) F M Name of area: _____ Address: _____ Telephone number: _____
Date: _____ Reason for referral (please circle): a. Full mother-baby assessment needed: <ul style="list-style-type: none"> • Baby not breastfed • Breastfed but feeding not age appropriate • Under 6 months, not exclusively breastfed • Baby unable to suckle the breast • Mother has other difficulties with breastfeeding • Mother requests breast milk substitute (e.g. infant formula) • Over 6 months, given no complementary foods or complementary foods that are not recommended or appropriate • Baby visibly thin • Baby lethargic, perhaps ill b. Medical care needed (state reason: _____) c. Mother pregnant (ANC/ FOLLOW-UP) d. Child malnourished (circle) <6 months / 6-59 months: MUAC <11.5 cm MUAC <12.5 cm Oedema____ e. Pregnant and lactating mother malnourished MUAC <22cm f. Other (state reason _____)
Referred to (facility/service)_____ Location of facility/service_____
Focal point phone number:_____
When to attend (circle): Immediately / Date_____
Referred by:_____ Job title/Organization_____ Phone number:_____

Job Aid 2.2: CARE ACTION PLAN FOR MOTHER/CAREGIVER AND CHILD RECEIVING SKILLED SUPPORT AND/OR BREAST MILK SUBSTITUTES

For infants under 6 months, MUAC cut-offs differ, and use depends on local and national guidance (including MAMI protocols). Clinical assessment remains essential for this age group. This table can be adapted to include children under 6 months if conducting MUAC for that age group.

MUAC Measurement (to nearest cm)	Normal (green) ≥ 12.5 cm	Moderate (yellow) 11.5–12.4 cm	Severe (red) <11.5 cm	Oedema (Y/N)

Name of designated IYCF-E counsellor _____

Location: _____

IYCF-E Registration Number: _____

Child's name _____

Child's Gender M/F

Child's DoB _____ Age (completed months) _____

Mother/Caregiver's name _____

Relationship to child _____

Address/Shelter location _____

Phone number: _____

Date of initial full assessment of mother–baby pair: _____

Main findings of assessment:

Recommendations for feeding:

- (A) Continuing supportive care
- (B) Basic aid
- (C) Further help: baby refusing the breast
- (D) Further help: restorative care for the mother (needs emotional / extra support)
- (E) Further help: wet nursing
- (F) Further help: relactation
- (G) Further help: breast conditions

(H) Further help: supported with BMS

(I) Further help: complementary feeding

Referral / Specialized Support:

Medical treatment/Therapeutic feeding

Other - specify _____

FOLLOW-UP / MONITORING FOR EACH CONTACT:

Choose frequency of follow up according to each child/carer's situation, start more frequently and then aim for weekly contacts. Add new card if necessary, e.g. if continuing support to a breast milk substitute (BMS)-dependent infant. For a fully BMS-dependent child, this form MUST be used until BMS support is completed; until relactation or wet nursing is fully established; or until the child graduates from the BMS prescription programme at 6 months of age.

Date						
Health & Weight of child (kg) or MUAC						
Date / time / place of next contact						
Notes and Agreed Actions for next visit (1 or 2)						
Progress from last visit						

Checklist for counselling on BMS. Ensure that information from the Full Assessment of Mother–Baby Pair is used to inform the discussions below and to highlight any additional issues. Note: not all mother–baby pairs will require this section. This is only for those using or being prescribed BMS, either partly or in full.

Topic to explore during the first visit and revisit as needed	Date of check
What BMS will be given, when and where to receive it.	
What extra resources they will need to prepare BMS and how they will obtain these <i>(Always ensure a plan is in place for ALL resources required for BMS support)</i>	
How much and how often to feed BMS	
How to keep feeding utensils clean and stored in a hygienic way	
How to prepare and store the feeds	
The advantages of cup feeding and how to cup feed	
Warning of the potential hazards of using BMS	
Demonstrate	
Care worker should demonstrate appropriate preparation of a BMS feed in the home	
Check that	
The caregiver has been observed making a feed	
The caregiver has been observed cup feeding	

Checklist for follow-up visits (write findings in visit notes)

Check and discuss
Infant health status, weight and MUAC
Observe feed preparation: Check that BMS is prepared hygienically and is used in the recommended ways
Observe a feed: Check feeding is appropriate, including cup feeding
Find out any difficulties the caregiver may be facing, discuss practical solutions and/or refer for appropriate support
Check for warning signs of misuse of infant BMS (e.g. over-concentration, over-dilution, formula being shared, etc.)

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.*






STEP 1: Set the Scene

Why are we discussing stress in emergencies?

- Emergencies create **intense stress** for caregivers.
- Stress affects **decision-making, communication, and caregiving.**
- When caregivers feel overwhelmed, it can impact **feeding practices and child wellbeing.**

Figure: Sources of stress specific to emergencies

Emergencies often bring multiple stressors at once:

	Environmental factors	Overcrowding, poor shelter, unsafe conditions, decreased access to safe drinking water and hygiene items, higher disease risk
	Social factors	Breakdown of community structures; loss of social networks; isolation; loss of friends, family and loved ones
	Health system factors	Disrupted health services, longer distance to access, long wait times and overcrowding
	Financial factors	Loss of livelihood, lack of access to necessities
	Individual factors	Increased GBV risk, amplified challenges for individuals with a disability

These factors combine and increase stress, affecting caregivers' ability to care for and feed infants and young children.

Emergency context



Stress



Feeding practices



Scenario: Stress impacts feeding



Armed conflict has displaced thousands of civilians, who are staying for an average of two nights in a **crowded transit camp**. **Tents are shared**, **queues** for food and water **are long**, and sanitation is **inadequate**. A Mother-Baby Area (MBA) is available for pregnant and lactating women (PLW) and children 0–23 months.

Question:

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

Write key points from the group discussion below:

Consider caregivers with disabilities

Some caregivers or children may live with disabilities. In emergencies, their challenges can be magnified. For example:

- **Moving around is harder** in crowded camps.
- **Feeding in public spaces can feel additionally overwhelming** without privacy or quiet/calm.
- **Extra energy is needed for daily tasks**, adding to physical exhaustion.
- **Finding appropriate food or feeding support** can be difficult, especially for children with sensory needs or those who used a breast milk substitute (BMS) before the emergency.

STEP 2: Strengthen key knowledge, concepts, and skills



LEARNING OBJECTIVE 1:

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

Timing, duration, frequency of counselling in emergencies

When, how long, and how often you provide counselling needs to be adapted in emergencies.

Table: Adapting counselling in emergencies: timing, duration, frequency

When (timing)	How long (duration)	How often (frequency)
<p>Challenge: Counselling may happen too early or too late (e.g. discussing complementary feeding when the infant is a newborn) → caregivers feel overwhelmed or frustrated.</p>	<p>Challenge: Caregivers under stress have less focus; counsellors have little time.</p>	<p>Challenge: Six standard contacts (as recommended by WHO) are rarely possible in emergencies</p>
<p>Adaptations:</p> <ul style="list-style-type: none"> • Validate frustration from missed info • Focus on what caregivers can do now • Prioritize present needs • Avoid overload • Highlight strengths 	<p>Adaptations:</p> <ul style="list-style-type: none"> • Start with emotional connection • Set one clear goal • Break information into small steps, then repeat • End with next steps • Leave on a positive note 	<p>Adaptations:</p> <ul style="list-style-type: none"> • Seize opportunities (queues, distributions) • Keep sessions short and focused • Repeat key messages across contacts

Why stress matters, and small tips to adapt

- Stress reduces memory and decision-making capacity.
- Use **short, focused messages** repeated over time.
- Combine verbal, written and visual communication.
- **For caregivers with disabilities**
 - Use adapted written/visual formats: large print, pictorial cards, braille.
 - Involve a trusted support person if possible.
 - Adjust duration of sessions as needed, either allowing extra time or decreasing the duration based on the mother and child's specific needs.



Key learning points – Objective 1

- In emergencies, stay flexible as to **when, how long and how often** counselling happens.
- Always start each session by creating **emotional safety and connection**, even when time is limited.
- Counselling may happen too late or too early. Adapt by focusing on the most pressing current need.
- Use **shorter, more frequent contacts** and repeat key messages in multiple formats.
- Ensure **accessibility and inclusion** for caregivers with disabilities in all adaptations.



LEARNING OBJECTIVE 2:

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

Activity: Common beliefs and practices



TRUE or FALSE?

Milk production <i>can</i> continue, even in very stressful situations.	True	False
Maternal adrenaline inhibits the let-down reflex, slowing milk flow.	True	False
Infant behaviour, such as crying or acting unsettled, during emergencies does not necessarily mean the baby is not getting enough milk.	True	False
Breastfeeding while stressed or sad can harm the infant, physically or emotionally.	True	False
Fathers and other family members have little influence on feeding practices.	True	False

These beliefs can **increase maternal stress, reduce confidence and lead to behaviours that indirectly affect milk supply**. Understanding this helps the counsellor approach a mother **with empathy and practical guidance**.

Keep in mind to:

- Acknowledge and respect the caregiver's feelings and experiences: validate her concerns without judgment.
- Provide accurate information gently. Explain what the evidence says.

Refer to *Job Aid 3.1: Addressing common beliefs and practices in emergencies* for more detailed explanations and sample responses.

Responsive feeding

DEFINITION

Responsive feeding is the practice of feeding a child in response to their cues, such as signs of hunger/fullness or a need for comfort, rather than on a strict schedule or through pressure.

Examples in practice:

A mother notices her baby turning their head towards her chest and opening their mouth. She offers the breast calmly and makes eye contact. When the baby turns away or slows sucking, she pauses feeding, recognizing the baby is full. Responsive feeding is about mutual communication where caregivers observe, respond and adjust based on the child's signals.

Notice the baby's
call or cue

Understand the need

Respond calmly in an
appropriate and
timely manner

Key points:

- Responsive feeding = recognizing and responding promptly and warmly to feeding cues.
- Responsiveness helps the child feel safe, builds trust, and supports emotional and physical growth.
- These positive interactions can reduce stress for both the mother and the child.

How stress affects responsive feeding

- Stress affects how caregivers notice and respond to their children’s cues.
- When stressed, a caregiver may overlook early feeding cues, respond only to crying, shorten breastfeeding sessions, or try to rush or force-feed an older child.

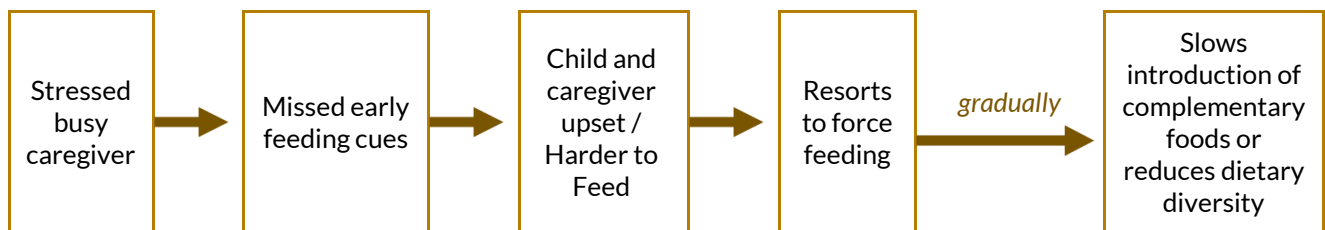
Diagram: How missed cues affect breastfeeding over time



Why does supply decrease? Breast milk production works on a supply-and-demand system: the less milk that is removed from the breast, the less milk that is made. When stress leads to shorter or fewer feeds, it can gradually reduce milk production over time. Stress itself does not stop milk production.

Additional ways stress impacts feeding behaviours

Diagram: How missed cues affect complementary feeding over time




- Stress can also cause:
 - Increased mother-child separation to attend to other priorities → reduced feeding opportunities
 - Misinterpretation of fussiness as ‘not enough milk’ or ‘hunger’ → introducing breast milk substitutes or complementary foods too early
 - Heightened anxiety or worry → disrupted routines or missed feeding cues
- Infant behaviours may include:
 - Disrupted sleep and feeding routines → missed or shorter feeds; additional fussiness
 - Seeking extra comfort (*feeding all the time*) → frequent but less effective feeds (short, shallow), overconsumption, and/or reliance on junk foods.
- All these behaviours reduce effective milk removal → can gradually reduce milk supply.

Key points:

- It is the behaviours caused by stress that impact milk supply, not the stress itself.
- Supporting caregiver behaviours is crucial in emergencies.

Strategies to mitigate impact

Activity: Strategies to support mothers and caregivers under stress

 **Timing:** 5 minutes



LEARNING OBJECTIVE 3:

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

Stress regulation

Just as stress can make feeding harder for mothers, **your own stress can affect how you support them**. Learning ways to regulate your stress will help you stay calm and focused and will improve the effectiveness of the counselling you provide.

Key points:

- When you are well regulated, you are calm and feel at ease, focused and able to respond effectively.
- When you are dysregulated, you feel stressed and may experience the following reactions:
 - Fight/flight response → irritable, anxious, frustrated
 - Freeze response → stuck, disengaged, uncertain

Table: Effects of regulation and dysregulation on counselling

When regulated, you can...	When dysregulated, you can...
Actively listen and empathize with caregivers	Feel impatient or frustrated when mothers don't follow advice, making connection harder
Build trust and rapport with caregivers (we are experienced as 'safe')	Struggle to communicate clearly or stay focused during sessions
Take in information, see the bigger picture, concentrate and remember details	Have difficulty analysing information, seeing options or solving problems
Communicate calmly and effectively	Avoid or withdraw from difficult conversations
Solve problems and make good decisions	Feel stuck when caregivers face many challenges; lose sense of purpose or effectiveness

Because stress affects how you connect, listen and make decisions, caring for your own mental health and practising regulation is essential for effective IYCF-E counselling.

Table: Self-regulation vs co-regulation

Self-regulation	Co-regulation
→ calming and grounding yourself first	→ using your calm presence to help others (caregivers/babies) feel calm
<ul style="list-style-type: none"> • Use when you notice signs of stress or disconnection. • Helps stabilize the nervous system, improving focus, emotional resilience and ability to support others. 	<ul style="list-style-type: none"> • Use with caregivers during counselling when they appear stressed or overwhelmed. • Can also be taught to mothers and caregivers to use with their children.

Remember: You cannot help others regulate if you are dysregulated yourself. Your calm presence supports caregivers, which in turn helps their children.

Regulation techniques

There are two main types of regulation practices. You can use them for self-regulation or to co-regulate with caregivers.

Two types of regulation practices

- **Soothing** → Use when tense, overwhelmed, nervous or worried (e.g., after emotionally heavy discussions). Examples: Slow breathing, grounding, self-hug.
- **Activating** → Use when tired, withdrawn, lethargic or sleepy (e.g., after lunch or long sessions). Examples: Stomping feet, shaking, gentle movement.

Different styles of practices

- **Orienting** → Create a sense of safety by noticing the present moment
- **Grounding** → Stabilize and anchor in the body and surroundings
- **Breathwork** → Calm and regulate the nervous system through breathing
- **Movement** → Release or boost energy through motion
- **Self-touch** → Notice the body and use hands for comfort and self-soothing (e.g., hand on chest, self-hold)
- **Resource-oriented** → Focus on internal and external strengths or supportive connections

Regularly practicing these techniques builds a “toolbox” you can draw on whenever you need to stay balanced. Refer to *Annex 1: Emotional regulation practices* for more examples at the end of the handbook.

Activity: Deep breathing

This exercise brings your focus to your breath and helps you to slow down.

ACTIVITY: DEEP BREATHING



- 1 Place one hand on your chest
- 2 Inhale for 4
- 3 Hold for 2
- 4 Exhale for 6

Repeat 3 time

How to use in daily work

- **Before counselling:** pause, take a breath, set aside distractions.
- **During sessions:** model calmness, speak slowly, listen fully. Your calm presence helps caregivers regulate, too (co-regulation).
- **After difficult moments:** reset using any practiced technique before moving to the next caregiver.



Key learning points – Objective 3

- A counsellor’s ability to **regulate stress** affects both the quality of counselling and their own wellbeing.
- **Co-regulation** can be used intentionally to strengthen counselling and can also be taught to mothers and caregivers to support their children.
- Practising **simple self-regulation exercises** builds a “toolbox” you can draw on when needed.

STEP 4: Role Play

Now, it is your turn!

Before beginning the role-play, take a moment to prepare yourself. Counselling in emergencies can feel intense, and it is important for counsellors to be calm and centred in order to support caregivers effectively. A simple regulation exercise can help you settle, focus and be more present.

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

This exercise brings your attention to the present moment and the sensation in your body. In your mind, think of the following:



5 things you see



4 things you can feel



3 things you hear



2 things you smell



1 thing you taste

Role-play: Continuation of Hana's story



Timing: 10 minutes

Hana returns to the Mother–Baby Tent the next day. Yesterday, it was agreed that she would:

- Try to make a little private space with a sheet.
- Keep Mariam close so she can notice her signals early.
- Breastfeed more often, especially before Mariam cries.

She has been trying some of the ideas discussed with the counsellor but still feels stressed and uncertain. Today, she is looking for more support and reassurance.

Instructions:

1. Review the Counselling Skills Checklist before beginning the role-play.
2. In your groups of three, divide into specific roles:
 - One person will play the **counsellor**.
 - One person will play **Hana**. The facilitator will give you a short role-play card with Hana's situation.
 - One person will be the **observer**. Use the Counselling Skills Checklist below to note key strengths and areas for improvement. Do not write everything.

As you role-play, counsellors should focus on practising the three core counselling skills described below.



Reminders: Core counselling skills

- Empathize:** Show that you understand how the mother or caregiver feels. This can be done by naming the emotions you hear and linking them to her situation. For example:
“What a difficult few weeks you’ve had.”
“You’re exhausted because you’ve had so much to do.”
- Recognize and praise:** Highlight what the mother or baby is doing well. Genuine praise builds confidence and encourages positive behaviours. For example:
“Mariam looks healthy and alert.”
“You’ve worked hard to keep breastfeeding through such stressful times.”
- Use simple language:** Avoid jargon or technical terms. Explain concepts clearly, using simple language. For example, instead of “responsive feeding,” say:
“Feed your baby as soon as you notice small signs of hunger, before she cries.”
“Stress does not stop your body from making milk.”

Counselling Skills Checklist for the observer

Instructions: Tick **Yes**, **Partially**, or **No** for each skill or action you observe during the counselling session.

Counselling Skills Checklist			
Core counselling skills	Yes	Partially	No
Greeted the mother warmly and created emotional safety			
Adjusted speed, tone, and language appropriately			
Expressed understanding and empathy for the mother’s feelings			
Praised positive behaviours observed in the mother or child			
Used simple, clear language, avoiding jargon			
Case-specific / Practical actions	Yes	Partially	No
Acknowledged the mother’s progress since the last visit			
Offered feasible solutions or options for the mother to consider			
Addressed the mother’s stress and concerns			
Corrected any beliefs or misinformation the mother may have			
Supported responsive feeding practices			
Discussed strategies for self-regulation and co-regulation			
Included family support in the discussion where appropriate			
Summarized a clear plan and agreed next steps with the mother			



Role-play debrief: Hana

1. **Acknowledge progress:** Hana has already made positive behaviour changes: using a sheet for privacy, feeding more often and watching Mariam's cues. A good counsellor notices and praises these steps.
Sample lines:
"It sounds like you made a real effort with the sheet, and it's helping you at night."
"You're already feeding Mariam more often. That's a great way to help her stay calm."
 → **Advice:** Praise builds confidence and shows the mother her actions matter. Small progress should always be recognized before moving to new challenges.

2. **Show empathy for Hana's stress:** Hana feels stuck in a cycle: stress → fussiness → more stress. Instead of dismissing her worry, the counsellor should validate her feelings.
Sample lines:
"It must feel exhausting when Mariam fusses and you're worried she isn't getting enough."
"Many mothers feel stressed in these moments. You are not alone."
 → **Advice:** Empathy means reflecting the mother's emotions back and normalizing them. It reduces shame and opens space for problem-solving.

3. **Address the stress myth:** Hana believes stress reduces her milk supply. The counsellor should gently correct this misconception while staying supportive.
Sample lines:
"Sometimes stress can slow the milk from coming at the very start of a feed, but it doesn't reduce the amount of milk you make."
"Your milk is still there. It may just take a moment longer to flow."
 → **Advice:** Use simple, clear explanations. Avoid technical terms like "responsive feeding" or "let-down reflex." The goal is reassurance.

4. **Support self-regulation and co-regulation:** Hana feels stressed before feeds, which makes Mariam fussier. The counsellor can suggest calming strategies Hana uses before a feed and explain how her calm helps Mariam.
Sample lines:
"Before you put Mariam to the breast, take a deep breath or hold her skin-to-skin for a moment. When you are calm, she feels it too."
"Babies often settle more easily when their mother feels a little more relaxed. You and Mariam can calm each other."
 → **Advice:** Link this advice back to Hana's cycle of stress and fussiness. Show that calming techniques can break the cycle.

5. **Involve family support and address the formula myth:** Hana's husband suggested formula after complaints from other men about Mariam's crying. The counsellor should validate his concern but also explain how he can help without formula.
Sample lines:
"It sounds like your husband just wants things to be easier for you and Mariam. He might be able to help by setting up your space or holding her after a feed so you can rest."
"It sounds like the nights have been difficult for you, Mariam. Babies often wake and cry at night, even when using infant formula. When that happens, responding early can sometimes help them settle more quickly. Is there someone who could support you at night, even in small ways, like bringing the baby to you?"
 → **Advice:** Shift the husband from critic to ally. Show how formula won't solve the problem, but his support will.

6. **Summarize clear next steps and follow-up:** The counsellor should end by pulling the pieces together, giving Hana a plan and scheduling follow-up.

Sample lines:

“You’ve made great progress already with the sheet and feeding more often. Let’s try calming before feeds and asking your husband to help notice Mariam’s early signs.”

“You can talk with your husband about how he can support you. He’s welcome to join the next session if he wants. Come back tomorrow, so we can talk about how the conversation with your husband went.”

- **Advice:** A clear plan with follow-up reassures Hana she is not alone, makes progress feel achievable, and encourages family support to help both mother and baby.

STEP 5: Self-reflection

Take a few minutes to think about the session. You can write your answers in the space below.

Questions:

1. What is one key thing I learned in this session that I can apply in my counselling sessions?

2. What would I do differently next time when supporting a stressed mother?

3. How can I make sure I include and support caregivers with disabilities, or those caring for children with disabilities, who may face additional stress?

Additional notes:

Job Aid 3.1: Addressing common beliefs and practices in emergencies

Facts	Common belief	Impact on mother / caregiver	Sample sentences to say
Stress does not stop milk production. Milk remains nutritious even when a mother is worried or upset.	Milk “dries up” when a mother is stressed	<ul style="list-style-type: none"> • Mother may worry excessively and/or feel anxious or guilty. • Could stop breastfeeding too soon or use formula unnecessarily. 	<i>“It is normal to feel worried or upset, but your milk is still good for your baby. Being stressed does not stop your milk from being healthy.”</i>
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.	Adrenaline slows milk flow / let-down	<ul style="list-style-type: none"> • Mother may think she’s doing something wrong. • May panic during feeds or try unproven remedies. 	<i>“Sometimes your milk may take a little longer to come out at the start of a feed. This is normal and your baby is still getting enough.”</i>
Crying is often a normal response to stress, change, or discomfort, not just hunger. Behaviours such as crying and fussing are not reliable signs of inadequate milk intake and hunger.	Crying means baby is not getting enough milk	<ul style="list-style-type: none"> • Mother may misinterpret normal baby behaviour and feel incompetent. • May feed too often or give supplements unnecessarily. 	<i>“Your baby may cry more when things are noisy or stressful. Crying does not always mean they are hungry.”</i>
Milk remains nutritious even if the mother feels stressed, sad or has experienced trauma. Breastfeeding can calm both mother and baby.	Breastfeeding while stressed harms the baby	<ul style="list-style-type: none"> • Mother may avoid breastfeeding when upset. • Leads to less responsive feeding and missed mother-child bonding. 	<i>“Even if you feel sad, scared, or worried, your milk is still good and feeding your baby will help both of you feel calmer.”</i>
Fathers and family members are exposed to many of the same common beliefs and practices as mothers themselves but may not have as many opportunities to correct their understanding.	Fathers and family have little influence on feeding practices	<ul style="list-style-type: none"> • Mother may feel isolated, pressured, or confused. • May follow family advice that conflicts with best practices. 	<i>“Sometimes family members give advice that isn’t correct. Your milk is still the best for your baby.”</i>

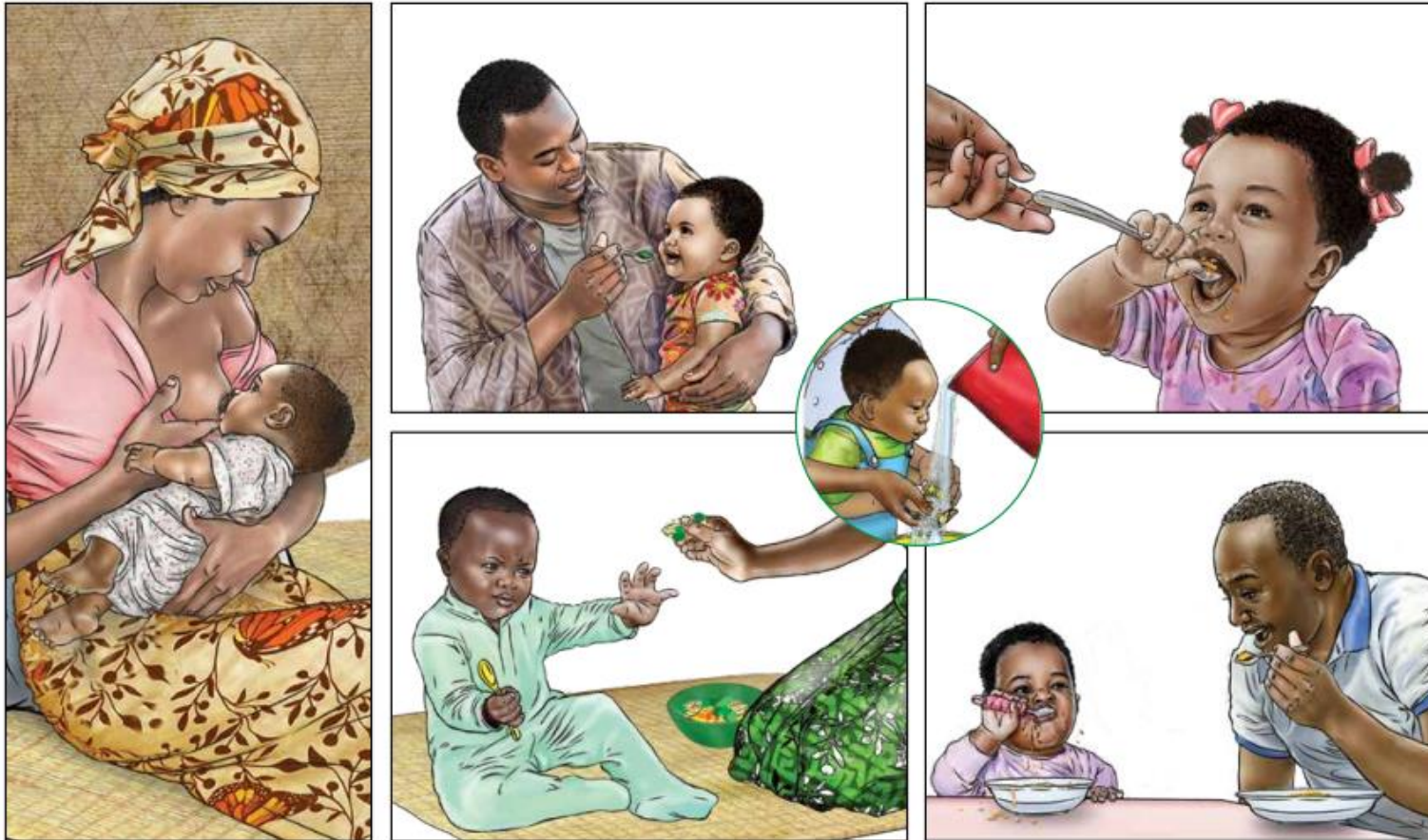
Job Aid 3.2: Practical strategies to support mothers under stress

Action area	Key strategies	Example phrases you can use
1. Support a mother / caregiver’s emotional state	<ul style="list-style-type: none"> • Sit in a calm, safe space with the caregiver. • Listen without judgment and validate her feelings. • Normalize stress response: “It’s normal to feel this way.” • Encourage calming techniques before feeding: deep breathing, grounding exercises. • Promote skin-to-skin to calm both mother and baby. • Reassure her that stress does not stop milk production. • Encourage care-seeking if feelings do not go away. • Link to peer support or mother groups. 	<ul style="list-style-type: none"> • <i>“You’re doing your best, and it’s normal to feel stressed in this situation.”</i> • <i>“Taking a few deep breaths before feeding can help both you and your baby feel calm.”</i> • <i>“If these feelings don’t go away, it’s okay to ask for help, many mothers feel this way.”</i>
2. Strengthen responsive feeding	<ul style="list-style-type: none"> • Explain early vs late hunger cues • Encourage watching and listening for cues during mealtimes. Keep the child close and attentive to signals of readiness or fullness. • Minimize distractions: find a quiet space or use a privacy screen. • Support comfortable and safe feeding positions. Make sure the child is seated securely and comfortably for eating. • Encourage skin-to-skin to help bonding and relaxation. • Suggest baby-wearing or safe room-sharing to keep the baby close. Staying physically close helps the caregiver notice and respond to the baby’s cues more easily, which supports bonding, comfort and emotional regulation for both. • Reassure the caregiver that frequent feeding is normal in stress. • Reassure that picky eating or slow intake is normal, especially under stress. Encourage patience and repeated food exposures. • Promote positive, relaxed mealtimes. Engage with the child, talk, and offer foods gently to support bonding and calm. 	<ul style="list-style-type: none"> • <i>“Look for early signs your baby is hungry before crying, like rooting or sucking hands.”</i> • <i>“Keeping your baby close helps you notice their signals more easily.”</i> • <i>“Feeding often, even for comfort, is okay right now.”</i>
3. Engage family and community	<ul style="list-style-type: none"> • Invite family members to counselling sessions if possible. • Address beliefs respectfully. 	<ul style="list-style-type: none"> • <i>“You can help by taking care of meals or older children, so she has time to feed the baby.”</i>

	<ul style="list-style-type: none"> • Encourage family members to provide emotional support and avoid pressuring the mother. • Suggest practical help with chores, cooking, caring for older children. • Invite older siblings or fathers to help prepare food, bring the child to the table or sit with the child during meals. • Promote positive messages: “Breastfeeding continues to provide important nutrition and comfort, even when you are stressed.” • Involve fathers in creating calm feeding spaces and supporting skin-to-skin. • Encourage the mother to reach out when feeling overwhelmed. • Suggest sharing experiences with a trusted confidant. • Link to mother-to-mother or peer-support groups. 	<ul style="list-style-type: none"> • <i>“Breastfeeding continues to provide important nutrition and comfort, even when you are stressed.”</i> • <i>“Your support makes a big difference. Just listening and being present helps.”</i>
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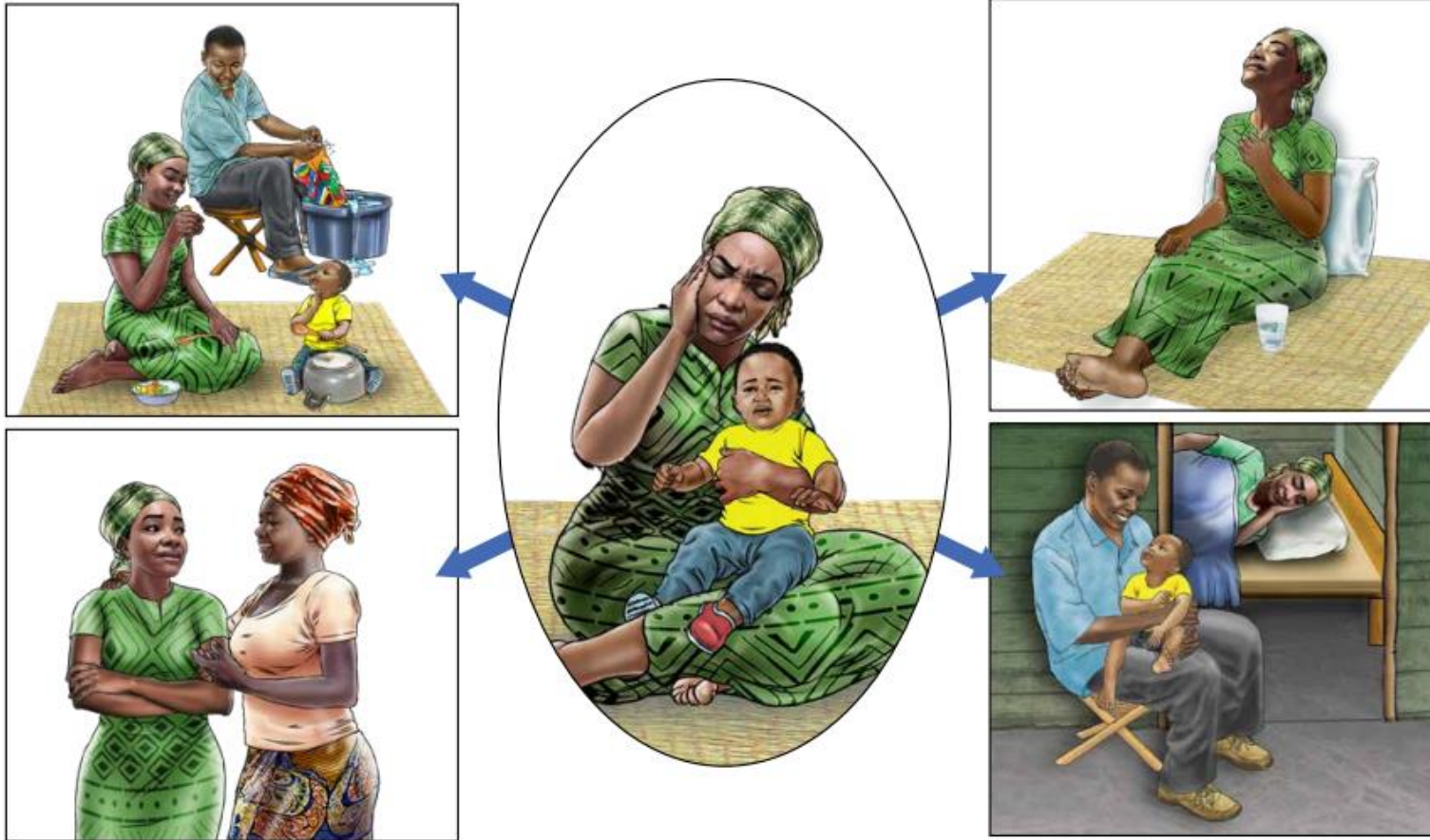
Job Aid 3.3: Counselling cards

Teach your child to eat with love and patience



Card 28

Take care of yourself to manage stress and fatigue



Card 33

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.*

STEP 1: Set the Scene

Important to remember

- This session may bring up strong feelings. **Take care of yourself.**
- You will not ever be asked to share personal experiences.
- You may **step out at any time** without explanation if you need a break.

Definitions: Gender-Based Violence and Intimate Partner Violence

Gender-Based Violence (GBV) refers to harmful acts directed at someone because of their actual or perceived gender. GBV is rooted in power imbalances and harmful social and gender norms. It can happen to anyone, but women, girls and people with diverse genders are disproportionately affected.

The term 'survivor' is preferred over 'victim' as it emphasizes strength, dignity and recovery. It recognizes each person's resilience and right to make choices about their care and safety. When translating into local languages, use words that convey this same sense of empowerment and endurance.

Intimate Partner Violence (IPV) is a pattern of abusive behaviour in an intimate relationship, used by one person to gain or maintain control over the other.


Figure: Types of GBV in emergencies

<p>Sexual Violence</p> <p>Any sexual act against a person’s will or without permission (e.g., rape, sexual assault, child sexual abuse, sexual exploitation).</p>	<p>Physical Violence</p> <p>Non-sexual acts that cause physical pain or injury (e.g., hitting, slapping, choking, burning).</p>	<p>Emotional / Psychological Violence</p> <p>Non-physical harm causing mental or emotional pain (e.g., verbal harassment, intimidation, controlling behaviour).</p>	<p>Social / Economic Violence</p> <p>Harm through denial of resources, opportunities or rights (e.g., education, income, property, social participation).</p>
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Why are we focusing on caregivers affected by GBV?

- Emergencies increase the risk of GBV.
- GBV is almost always under-reported.
- GBV affects infant and young child feeding practices.
- You may be **the first person** a GBV survivor talks to, but you are not a GBV case worker.
 - **Disclosures are more likely** in private, sensitive counselling spaces.
 - Your role is to listen **with empathy** and only **refer if the survivor wishes**.

Scenario: Leyla’s first hours after birth



An extended drought has caused widespread displacement, food insecurity, and economic disruption. Families are crowded into temporary settlements, with limited access to services.

Leyla has just given birth six hours ago. She declines skin-to-skin contact, breastfeeding and hand-expression.

Despite support from several IYCF-E counsellors. Leyla seems uncomfortable to accept the help that is being offered and unable to adopt any of the small, recommended behaviour changes. She avoids discussing her support at home and does not mention the father.

When she speaks with you during the counselling session, Leyla begins to share that she is experiencing violence at home. This helps to explain some of her distress and the difficulties she is having with feeding her newborn.

Questions:

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

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

Write key points from the group discussion below:

STEP 2: Strengthen key knowledge, concepts and skills





LEARNING OBJECTIVE 1:

Apply a survivor-centred approach while receiving a gender-based violence (GBV) disclosure

This content is adapted from the *GBV Pocket Guide (GBV Area of Responsibility, Global Protection Cluster)*, which is a practical, field-tested tool for frontline workers. See the *Resources* section at the end of this session to access the guide and download the Pocket Guide app.

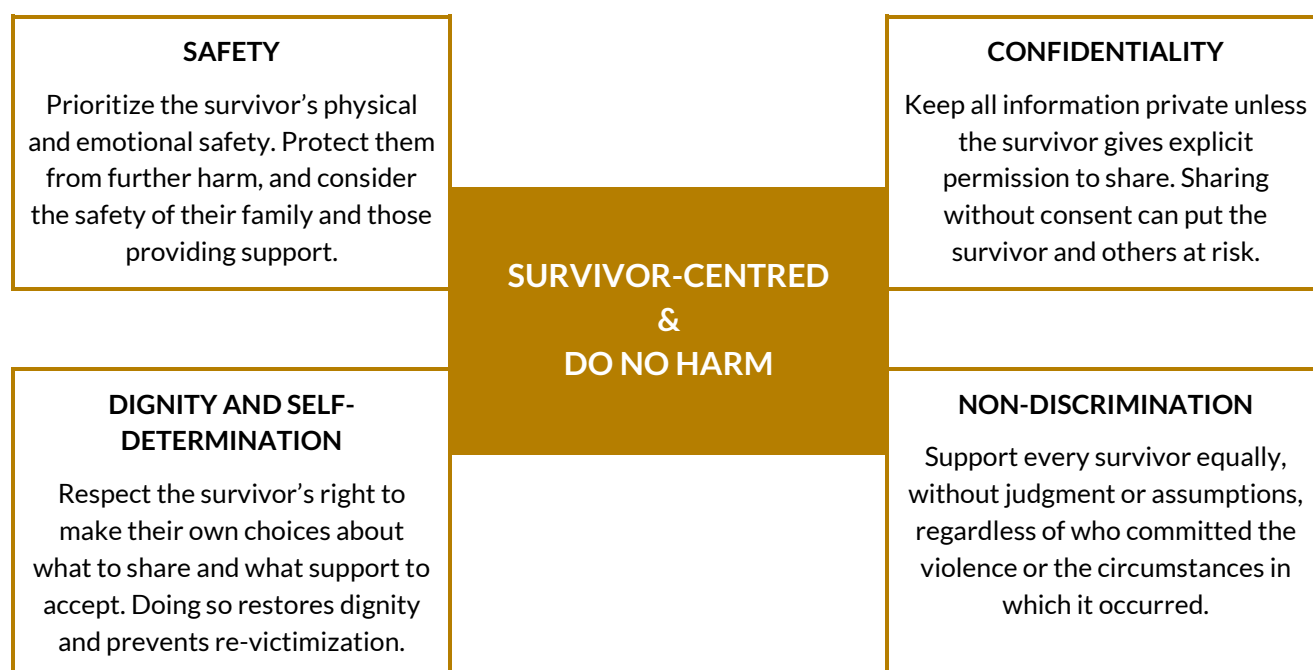
Your role in GBV disclosures

	<ul style="list-style-type: none"> ✗ Do not proactively identify or seek out GBV survivors. ✗ Do not provide GBV case management, conduct an interview, or inquire about what happened and the details 		<p>Be a supportive resource if someone chooses to approach you</p>
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Guiding principles: Survivor-centred and Do No Harm

A survivor-centred approach places the rights, needs and wishes of the survivor at the centre of all actions and decisions.

Figure: Key guiding principles to ensure we do no harm to survivors of GBV



These principles ensure that no further harm is caused and that any disclosure is met with respect, safety and appropriate support. If a caregiver discloses GBV and the counsellor responds insensitively or fails to provide appropriate support, the survivor may lose trust and never return for IYCF-E or other essential services. A poor response can therefore close the door to both nutrition and protection support.

Trauma-Informed Care

GBV often results in trauma. Trauma can also stem from experiences such as displacement, conflict, loss or disasters. Because we cannot always know what a caregiver has been through, applying trauma-informed care (TIC) as a universal precaution creates a safe, respectful environment for every caregiver, regardless of whether GBV or trauma is disclosed.

Think of it like wearing gloves in a healthcare setting. They are worn not because you know every patient has an infection, but because you assume there could be a risk and want to ensure everyone’s safety and dignity.

Table: How Trauma-informed care and the survivor-centred approach work together

Trauma-Informed Care	Survivor-Centred Approach
<p>An approach that recognizes the widespread impact of trauma and seeks to avoid re-traumatization.</p> <p>Applies to everyone: used in all counselling, regardless of whether GBV is disclosed.</p> <p>Guides how support is delivered: focuses on creating <i>safety, trust and empowerment</i> in every interaction.</p> <p>Assumes anyone may carry trauma; aims to prevent further harm and promote healing.</p>	<p>An approach that places the survivor’s rights, dignity and agency at the centre of all actions and decisions.</p> <p>Applies when GBV is disclosed: used to guide response and follow-up.</p> <p>Guides what support prioritizes: upholds <i>safety, dignity, choice and confidentiality</i>, placing the survivor’s rights and agency at the core.</p> <p>Responds to a known survivor’s experience, ensuring all actions respect their decisions and pace.</p>

In practice: These two approaches overlap and complement each other. Together, they help counsellors support caregivers in ways that **promote healing, restore trust and avoid harm.**

Check your own biases and assumptions

Activity: Decode your attitudes



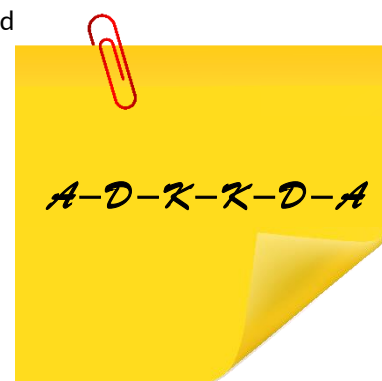
Timing: 5 minutes

This exercise will be completed anonymously. Read each statement below and truly consider how you feel about them. Perhaps think about what you have heard from others, and how it might make you feel towards a survivor of GBV.

For each one, write your response as:

- A = Agree
- D = Disagree
- K = Don’t Know/Not Sure

Write your own letter responses on a sticky note. As we go through this session, continue to refer to these letters and think of how our internal bias might influence how we respond to and support survivors of GBV.



Statement 1: A woman causes her husband’s violence because of her own behaviour.

Statement 2: Intimate partner violence is a family matter and should be handled within the family.

Statement 3: A GBV survivor should always report their case to the police or other justice authorities.

Statement 4: It is not considered rape if it is between a man and his wife.

Statement 5: GBV only happens to women and girls.

Statement 6: Sexual assault usually occurs between strangers.

Refer to *Job Aid 4.1: Survivor-Centred Attitudes* for more examples of GBV-related attitudes.

LOOK, LISTEN, LINK

There are three steps to follow when a caregiver approaches you: LOOK, LISTEN and LINK. Each step will guide you in responding safely and respectfully.



What it means: Observing the survivor and their situation to



- Address urgent basic needs
- Ensure safety

Important: Prioritize urgent needs and safety first before any discussion or questions.

Examples:

- Is the survivor injured or in physical danger?
- Is the survivor in a safe and private space to talk?
- Are there immediate needs like water, clothing or access to a bathroom?
- Are there cultural or gender considerations (e.g., female staff needed for a woman or girl)?

Follow these Do No Harm principles while observing the survivor:

 DO	 DONT
<ul style="list-style-type: none"> • DO allow the survivor to approach you. Listen to their needs. • DO ask the survivor whether they feel comfortable talking to you in your current location. If a survivor is accompanied by someone, do not assume it is safe to talk to the survivor about their experience in front of that person. • DO ask how you can support any basic urgent needs first. Some survivors may need immediate medical care or clothing. • DO provide practical support, like offering water, a private place to sit, a tissue, etc. 	<ul style="list-style-type: none"> • DO NOT ignore someone who approaches you and shares that they have experienced something bad, something uncomfortable, something wrong, and/or violence. • DO NOT make assumptions based on what you are seeing. • DO NOT force help on people by being intrusive or pushy. • DO NOT overreact. Stay calm.

What to say

- “You seem to be in a lot of pain right now. Would you like to go to the health clinic?”
- “Does this place feel OK for you? Is there another place where you would feel better? Do you feel comfortable having a conversation here?”
- “Would you like some water or tea?”





LISTEN

What it means: Actively hearing the survivor’s words, emotions and concerns without judgment or interruption.

1. Listen actively to what the survivor tells you about their experience, feelings and needs
2. Validate their feelings

Important: All survivors have different needs, so the key is listening and ensuring they are the ones making all decisions, while we provide supportive information that they can use or not, depending on their wishes.

Follow these key Do No Harm principles while listening to the survivor:

 DO	 DONT
<ul style="list-style-type: none"> • DO treat any information shared with confidentiality. • DO listen more than you speak. • DO say some statements of comfort and support; reinforce that what happened to them was not their fault. • DO understand that trauma may affect their communication or memory. 	<ul style="list-style-type: none"> • DO NOT write anything down, take photos of the survivor, record the conversation on your phone or other device, or inform others including the media. • DO NOT push for details. • DO NOT judge, blame or minimize the survivor’s experience. • DO NOT doubt or contradict what someone tells you.

What to say

- “How can I support you?”
- “You have every right to be upset.”
- “It’s okay to cry. I will sit with you until you’re ready.”
- “Please share with me whatever you want to share. You do not need to tell me about your experience for me to provide you with information or support available to you.”

Definition: Healing statements

Healing statements are things that helpers can say to a survivor immediately after they tell us what happened and throughout the helping process, in order to promote their healing and recovery.

- “I believe you.”
- “I am glad you told me.”
- “I am sorry this happened to you.”
- “This is not your fault.”
- “You are very brave to talk with me.”





What it means: Providing accurate information and support to help the survivor access available services safely, while respecting their dignity and choices.

1. Ensure the survivor knows what services exist and how to access them safely.
2. Support their autonomy to decide the next steps.

Important: Provide information, not advice. Respect the survivor’s right to choose whether to seek services.

Use *Job Aid 4.2: Service mapping sheet* to record and update key referral contacts for your area.

Follow these key Do No Harm principles while observing the survivor:

 DO	 DONT
<ul style="list-style-type: none"> • DO respect the rights of the survivor to make their own decisions. • DO prepare in advance by knowing the local referral pathways. Ensure this information is visible and accessible at the nutrition point. • DO share information on all services that may be available, even if not GBV specialized services. • DO ask whether there is someone – a friend, family member, caregiver or anyone else – whom the survivor trusts to provide support. • DO ask for permission from the survivor before taking any action. 	<ul style="list-style-type: none"> • DO NOT exaggerate your skills, make false promises, or provide false information. • DO NOT assume you know what someone wants or needs. Some actions may put someone at further risk of stigma, retaliation, or harm. • DO NOT try to make peace, reconcile or resolve the situation between someone who experienced GBV and anyone else, e.g., the perpetrator or any third person (such as a family member, community committee member, community leader, etc.)

What to say

- “Our conversation will stay between us.”
- “There are some people who/organizations that may be able to provide some support to you and/or your family. Would you like to know about them?”
- “Is there anyone whom you trust that you can go to for support outside of this clinic? Maybe a family member or a friend? Would you like to use my phone to call anyone you need at this moment?”
- “Do not feel pressure to make any decisions now. You can think about things and always change your mind in the future.”



Key learning points – Objective 1

- Your role is to provide a listening ear, respect confidentiality, and share accurate information. You are not an investigator or a case manager.
- Prioritize safety and urgent needs first. Always observe the environment and context before engaging in discussion.
- Listen without judgment, validate feelings and provide information (not advice).
- Survivors must make their own decisions about next steps; your role is to empower and support these choices.
- Be aware of available services and referral pathways. Know who the GBV focal point is in your area.
- Always protect confidentiality and maintain professional boundaries.
- Even when you cannot resolve a situation, your empathetic presence and careful response create safety, trust and dignity.



LEARNING OBJECTIVE 2:

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

Activity: Feeding challenges faced by GBV survivors



Timing: 4 minutes

Work in pairs. In the table below, the first column lists some consequences of GBV. In the second column, write what kinds of feeding challenges might occur owing to the various GBV consequences. Think of challenges that may come with breastfeeding practices while also considering the feeding needs of older infants, such as complementary feeding practices and responsive feeding.

	GBV consequences	Feeding challenges
1	<p>Psychological distress: Trauma, anxiety, depression, extreme stress.</p>	

2	Physical injuries: Pain, restricted movement or other physical injury from violence.	
3	Fear and safety concerns: Constant stress from danger or threats to the survivor's safety.	
4	Negative body image: Discomfort or disconnection from one's own body.	
5	Lack of support / isolation and control: Emotional or psychological abuse may isolate survivors or restrict their access to family, friends and essential services, increasing vulnerability and stress.	
6	Cultural and social stigma: Shame, judgment, or community-level stigma linked to GBV or feeding choices.	

Evidence Box: GBV and recommended IYCF-E practices **Reduced exclusive breastfeeding among GBV survivors**

According to UNICEF's 2022 evidence brief, women who experience IPV are less likely to engage in recommended breastfeeding practices, including exclusive breastfeeding. The brief highlights that maternal exposure to IPV negatively affects breastfeeding practices, making early initiation and exclusive breastfeeding less likely.

UNICEF. (2022, September). *Intimate partner violence and breastfeeding: A summary of the evidence base*. New York: UNICEF. Retrieved from https://www.unicef.org/media/128256/file/UNICEF_GBViE_Breastfeeding_Brief_September_2022.pdf

 **GBV and delays in complementary feeding**

A study published in *Public Health Nutrition* found that IPV during pregnancy negatively influences early complementary feeding practices. Specifically, IPV exposure was associated with delays in introducing appropriate complementary foods to infants, which can lead to nutritional deficiencies and developmental delays.

Caprara, G. L., Bernardi, J. R., Bosa, V. L., da Silva, C. H., & Goldani, M. Z. (2020). Does domestic violence during pregnancy influence the beginning of complementary feeding? *BMC Pregnancy and Childbirth*, 20(1), 447. Retrieved from <https://bmcpregnancychildbirth.biomedcentral.com/articles/10.1186/s12884-020-03144-y>

Focus: Babies born as a result of sexual assault and rape

- A mother who has survived sexual assault may experience mental health issues, such as depression, anxiety, trauma and extreme stress. These conditions can significantly hinder the bonding process between a mother and her child.
- Husbands, male partners, or family members may be absent, unsupportive or themselves struggling with distress related to the circumstances of conception, increasing the mother’s isolation and reducing emotional and material support.
- The baby might be a constant reminder of the sexual assault, complicating the mother’s feelings towards the child and creating emotional distance or abandonment.
- Social stigma and isolation related to the circumstances of conception can further limit support for both mother and baby, adding stress and negatively impacting the mother–child bond.

IYCF-E counselling challenges for GBV survivors

What it means:

GBV can affect how mothers, fathers, and caregivers engage with counselling, share information, and follow feeding guidance. Stress, trauma, stigma and fear of judgment can influence participation and responsiveness.

Examples of challenges:

- Survivors of GBV might not attend or accept IYCF-E services or support.
- Survivors of GBV might not allow IYCF-E counsellors into the home.
- Survivors of GBV might not be able to pay attention or may appear disengaged.
- Survivors of GBV might reject advice for reasons that are difficult to understand.
- Assessment may be more challenging due to trauma-related symptoms such as hypervigilance, hypersensitivity to pain or touch, avoidance, emotional numbing, or difficulty recalling events. Survivors may struggle to verbalize concerns, withhold information, or find it hard to name and express bodily sensations or symptoms. This can affect how they respond to questions, touch or routine assessments.

Key point:

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.

Adapting IYCF-E counselling for GBV survivors

Think back to the scenario: Leyla’s first hours after birth.

Discussion:

How could you support Leyla?

Write key points from the group discussion below:

Key points

- Apply trauma-informed care for EVERYONE to whom you provide support or services. Disclosure is not required.
- Create a safe, private and predictable space for counselling.
- Respect personal boundaries and let the mother guide physical interaction.
- Focus on flexible, realistic feeding solutions that preserve safety and dignity.
- Support connection and bonding through small, responsive caregiving acts.
- Believe what a survivor of GBV tells you about what they can manage.

Remember: Each survivor's experience and challenges are unique. Use what you have learned to think about how GBV can affect feeding and bonding, and how you can support the survivor in ways that are safe, practical and respectful. The goal is to support recommended feeding practices and bonding while respecting the GBV survivor's choices, privacy and pace.

GBV as an acceptable indication for BMS use

According to the World Health Organization (WHO) and the Operational Guidance on Infant and Young Child Feeding in Emergencies (OG-IFE), GBV resulting in the inability or unwillingness to breastfeed is considered an acceptable indication for the use of BMS.

In such cases:

- BMS provision should occur only as part of a coordinated, sustained, comprehensive and supported feeding plan, aligned with IYCF-E standards.
- Support should include ongoing, confidential counselling, hygienic preparation guidance, and follow-up to ensure the baby's ongoing nutritional and emotional needs are met.
- Decisions should be made with sensitivity, confidentiality and informed choice, respecting the mother's or caregiver's rights and circumstances.

Key point:

Survivors of sexual violence or GBV should never be pressured to breastfeed. When breastfeeding is not possible, appropriate, or desired, the use of commercial infant formula may be supported following individual assessment and with appropriate support to minimise risk.

**Key learning points – Objective 2**

- Not all survivors disclose when they have experienced GBV. Use a trauma-informed approach with every person with whom you interact.
- GBV can affect how a mother, father or caregiver feeds and bonds with a child. Survivors may find physical contact difficult, have trouble concentrating or seem unresponsive.
- IYCF-E counsellors can adapt their approach by:
 - Respecting the survivor's pace and boundaries.
 - Suggesting small, realistic behaviour changes instead of ideal practices.
 - Reinforcing the mother's strengths and positive moments with her baby.
- Responsive caregiving is key. Building a sense of trust and connection supports both feeding success and emotional recovery.
- Practical flexibility matters. If direct breastfeeding isn't possible now, support other ways of keeping the baby close (expressing milk, holding the baby, skin-to-skin later).
- When breastfeeding is not possible or appropriate owing to GBV, the use of BMS may be an acceptable option under WHO guidance.



LEARNING OBJECTIVE 3:

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

Secondary trauma and vicarious trauma

- **Secondary or vicarious trauma:** Counsellors can absorb the emotions and pain of the people they support. This can lead to compassion fatigue, or to burnout.
- **This is normal and should be expected.** Compassion fatigue is not a sign of weakness. The brain and body react as protective mechanisms, signalling stress and the need for rest and self-care.

How you can protect yourself

- | | | |
|----------|--------------------------------------|--|
| 1 | SELF-AWARENESS | Check how you feel after counselling sessions. |
| 2 | BOUNDARIES | Keep a clear line between professional and personal life. |
| 3 | GROUNDING AND RELAXATION | Use breathing or grounding techniques.
Refer: <i>Annex 1: Emotional regulation practices</i> |
| 4 | SMALL DAILY SELF-CARE ACTIONS | Rest, hydrate, move, connect with trusted people. |
| 5 | SELF-CARE TOOLBOX | Simple, practical tools to recharge.
Refer: <i>Job Aid 4.3: My self-care toolbox</i> |
| 6 | ROUTINE DEBRIEF | Talk with peers or supervisors to process experiences. |
| 7 | SEEK SUPPORT IF NEEDED | Reach out to supervisors, team leads, mental-health focal points, or peer support. Asking for help is a professional strength. |

Box: Peer debriefing for self-care

Why it matters: Talking about how you feel after challenging sessions helps release stress and prevent burnout.

How to do it safely:

- Meet with 1–3 trusted colleagues.
- Agree on confidentiality rules: no names or details that could identify a survivor (e.g., age, location, or personal story).
- Talk about *your own feelings and reactions*, not the details of your clients.
- Keep sessions short (about 30 minutes).
- Try this structure:
 - Take two deep breaths together.
 - Share: “What felt heavy this week?”
 - Listen without judgment or advice.
 - End with one thing that gave you hope or strength.
- If someone seems overwhelmed, encourage them to speak with a supervisor, team lead, or mental-health focal point.

Note: If debriefing isn’t currently offered where you work, consider suggesting it to your supervisor. Supporting staff wellbeing is part of your organization’s Do No Harm commitment – not only to avoid harm to families but to prevent harm to staff, as well.



Key learning points – Objective 3

- Listening to others’ trauma can affect your own emotional health.
- Self-awareness and regular self-care help prevent burnout.
- A simple, personal self-care toolbox supports wellbeing.
- When needed, reach out for help. Caring for yourself helps you care for others.

STEP 3: Demonstrate


Listen and watch the demonstration of a case study based on the scenario introduced in Step 1. The demonstration illustrates the application of knowledge and skills from Step 2, with a focus on the use of **LOOK, LISTEN and LINK** when a mother discloses or shows signs of GBV.

You will also notice the counsellor using three key counselling skills that support all IYCF-E interactions:

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

The counsellor is an IYCF-E Counsellor providing support in the maternity hospital.

Case study: Leyla and Salomon



Mother / Caregiver: Leyla
Child: Solomon, 6 hours old
Location: Maternity hospital
Reason for contact: Maternal refusal of skin-to-skin contact, breastfeeding and hand-expression since giving birth.
Current situation: Leyla appears withdrawn and unable to make small changes despite several counselling attempts.

Instructions:

- Focus on observing how the counsellor applies *LOOK, LISTEN, LINK* and uses a trauma-informed approach during IYCF-E counselling.
- Notice techniques, tone and phrasing that help Leyla feel safe, understood and supported, even when she is not ready to accept help or disclose details.

Use this space to write notes, reflections or key takeaways from the discussion

STEP 4: Role-Play

Now it's your turn!



Timing: 10 minutes

Case study: Tamara and Chikondi

After months of severe drought, many families have been displaced and are now living in crowded, temporary settlements with limited access to basic services.



Mother: Tamara

Child: Chikondi, 1 month

Location: A mobile health tent in a temporary settlement. The tent is run by a health and nutrition team linked to a nearby referral facility. A community health volunteer alerted the team that Tamara, who recently gave birth in her family tent, may need follow-up support. The counsellor meets Tamara privately in the tent to ensure a safe and quiet space for conversation.

Reason for contact: Tamara is struggling with breastfeeding. Chikondi frequently cries while breastfeeding, which makes Tamara feel tense and frustrated. She worries she does not have enough milk.

Current situation: Tamara is considering using infant formula and feels tired and unsure about her ability to care for her baby.

Instructions:

1. Review the Counselling Skills Checklist before beginning the role-play.
2. In your groups of three, divide into specific roles:
 - One person will play the **counsellor**.
 - One person will play **Tamara**. The facilitator will give you a short role-play card with Tamara's situation.
 - One person will be the **observer**. Use the Counselling Skills Checklist below to note key strengths and areas for improvement. Do not write everything.

As you role-play, counsellors should focus on practicing three core counselling skills described below.



Reminders: Core counselling skills

- **Use helpful non-verbal communication:** Non-verbal cues can make a mother feel heard and supported. For example:
 - Keep your head level with mother or caregiver.
 - Nod gently when she speaks.
 - Keep your body open and relaxed.
- **Accept what a mother or caregiver thinks and feels:** Mothers may express doubts, frustrations or fears. Accepting her thoughts and feelings without judgment builds trust and encourages her to speak honestly about her situation. For example:

- *“It sounds like you’re feeling very tired and unsure right now.”*
- *“Many mothers in difficult situations feel the same way.”*
- **Avoid using words that sound judgmental:** Judgmental words or tones can make a mother feel blamed or ashamed and may stop her from seeking help. Being judgmental doesn’t just mean making negative comments; it can also include statements that evaluate, label, or compare someone’s feelings or actions, even if they are meant to be positive. Terms like ‘good,’ ‘right,’ or ‘wrong’ can make a caregiver feel evaluated rather than supported. Focus on encouragement and understanding instead. For example:
 - Say: *“You’ve come here today to get support. It sounds like you care very much for Chikondi.”*
 - Avoid: *“You shouldn’t feel this way.”*

Counselling Skills Checklist for the observer

Instructions: Tick **Yes**, **Partially**, or **No** for each skill or action you observe during the counselling session.

Counselling Skills Checklist			
LOOK	Yes	Partially	No
Checked for urgent needs (water, comfort, safe/private space)			
Ensured the space felt safe for the caregiver			
LISTEN	Yes	Partially	No
Did not probe for details or investigate what happened			
Validated feelings			
Used healing statements (e.g., “I believe you,” “You are very brave to share this.”)			
Avoided minimizing, judgment, or rushing			
LINK	Yes	Partially	No
Shared clear and factual information on available services			
Did not give advice or push for action about the GBV situation (but may give feeding advice as relevant)			
Supported autonomy: let the caregiver decide on next steps.			
Core counselling skills	Yes	Partially	No
Used helpful non-verbal communication			
Accepted what the mother or caregiver thinks and feels			
Avoided using words that sound judging			
Summarized a clear plan and agreed on next steps with the mother			



Role-play debrief: Tamara and Chikondi

1. Build trust through acceptance and non-judgment

At the start, Tamara seems tense and distant. She may express frustration or even resentment towards her baby. The counsellor should focus on listening and creating a calm, safe space. This acceptance enables trust to grow.

Sample lines:

"You've had a lot to cope with. It's okay to feel mixed emotions."

"Many mothers in difficult situations feel unsure. You're not alone."

→ **Remember:** Validation reduces shame and opens space for trust. Apply trauma-informed care universally: assume any mother may have experienced trauma, create a safe and respectful environment, and respond with calm and empathy.

2. Respond sensitively to disclosure (LOOK / LISTEN / LINK)

As trust builds, Tamara may disclose that her pregnancy resulted from rape. The counsellor's role is not to investigate, but to ensure her safety and respond with empathy.

LOOK: Notice if she feels safe and has privacy before she shares more.

LISTEN: Stay calm, avoid probing for details, and use healing statements.

LINK: With her permission, share information about available GBV or psychosocial support services.

Sample lines:

"I believe you."

"You are very brave to tell me this."

"There are some people who can offer support if you'd like. Would you like to know about them?"

→ **Remember:** Maintain confidentiality and focus on safety. Even short, compassionate responses can restore a sense of dignity and control.

3. Support feeding without judgment or pressure

After disclosure, Tamara may feel ashamed or uncertain about her ability to care for or breastfeed Chikondi. She worries that she does not have enough milk and believes infant formula might be better. The counsellor should validate these feelings, provide simple factual information, and respect whatever decision Tamara makes about feeding. Emphasize supportive ways to feed and bond, without coercion.

Sample lines:

"It's understandable to feel unsure right now. But breastfeeding can help comfort both you and Chikondi."

"If you do not feel like that's possible right now, we can also talk about alternatives like hand-expression or explore wet nursing. If you chose to use infant formula, I could help you on the steps to take to reduce those risks as much as possible."

→ **Remember:** The aim is not to convince Tamara but to empower her. Babies born as a result of sexual assault or rape may trigger strong trauma-related feelings in the mother, which can significantly affect bonding and confidence in feeding. It is especially important not to pressure her to breastfeed, but to support her choices while providing factual information and reassurance.

At the same time, the baby's nutritional needs must be met. When needed, link the mother-baby pair to MAMI or IYCFE support services to ensure appropriate follow-up and coordinated care. The goal is to meet the mother and baby where they are, supporting both survival and emotional recovery with compassion and practicality.

4. Affirm her strengths and close gently

End the session by recognizing Tamara's courage and effort, summarizing any next steps, and confirming

that she is not alone.

Sample lines:

"You've taken a very brave step by coming here and sharing today."

"Let's take things one day at a time. You can always come back if you want to talk again."

- **Remember:** A warm, calm closure to the session reinforces safety and dignity. Summarize the next practical steps based on her choice, whether continuing breastfeeding or switching to formula, and reassure her that support is available for her and Chikondi. Avoid rushing, over-promising, or pushing a particular feeding method.

STEP 5: Self-reflection

Take a few minutes to think about the session. You can write your answers in the space below.

Questions:

1. What assumptions or biases about GBV survivors did I notice in myself, and how can I ensure I remain non-judgmental in counselling?

2. How confident am I to apply the LOOK / LISTEN / LINK approach if a GBV disclosure happens in my counselling practice?

3. What are my current strengths and areas for improvement in supporting a GBV survivor with feeding difficulties?

4. What could I add to my self-care toolbox after this session to manage the emotional impact of supporting survivors?

Additional notes:

Resources:

- **GBV Pocket Guide** (*GBV Area of Responsibility, Global Protection Cluster*): Practical guidance on responding to GBV in humanitarian settings.



<https://gbvguidelines.org/en/pocketguide/>

- **Video: “Survivor-Centred Approach”** (UNHCR, 4:38): Brief video illustrating key principles of a survivor-centred response.



<https://www.youtube.com/watch?v=Fk3pQyeobZE&t=51s>

Job Aid 4.1: Survivor-centred attitudes

NEGATIVE ATTITUDES AND BELIEFS	SUPPORTIVE AND TRUE ATTITUDES AND BELIEFS
If someone behaves inappropriately and is raped, it is their fault.	Rape is a choice made by the perpetrator to use their power over another person. It is never the fault of the survivor. GBV acts are always the fault of the perpetrator.
If a survivor can't answer the questions asked during an interview, they are making up the incident.	The psychological and physical responses to trauma may lead a survivor to be confused and unable to answer questions about the event.
A woman causes her husband's violence because of her own behaviour.	Violence is a choice by the perpetrator, and it never is justified to use in relationships.
A person who forces another person to have sex is just someone who cannot control their sexual desire.	Most rapists are motivated by power, anger, and control, not the desire to have sex. People can control their sexual impulses. Most rapes are planned in advance. The rapist is in control when they rape.
Intimate partner violence (IPV)/domestic violence is a family matter and should be handled within the family.	IPV is a significant safety and health concern for a community and is a crime in many countries. Thousands of women are killed every year due to IPV. IPV survivors require community support.
Most men beat their wives only after they have been drinking or using drugs.	Drugs and alcohol can be a contributing factor to GBV. However, it is the perpetrator's choice to use violence, power and control, which serves as the cause of GBV. Not all men who drink or use drugs beat their wives. Men who use alcohol and drugs make decisions about who they do beat, which shows that they are choosing who to be violent towards.
A GBV survivor should always report their case to the police or other justice authorities.	Survivors should be able to choose who knows about their case.
It is not considered rape if it is between a man and his wife.	Women should be allowed to communicate to their sexual partners when they do and do not want to have sex. Many countries now have laws against rape in marriage. Married women have the same right to safety as unmarried women. Most women who live with IPV have experienced some form of sexual abuse within their marriage.
It is the job of a humanitarian worker to determine whether a survivor is telling the truth.	It is the job of humanitarian workers to support the survivors and believe them.

Women are raped if they wear the wrong clothes or go to the wrong places.	Rapists look for victims they think are vulnerable, not women who dress in a particular way. No person, whatever their behaviour, “deserves” to be raped.
Women often lie about being raped.	Global research shows a very low percentage of rape reports are given falsely. This is the same as for other serious violent crimes.
Rape only occurs outside at night when the victim is alone.	Rape can and does occur anytime and anyplace. Many rapes occur during the day and in the victims’ homes (e.g., girls and women with disabilities can be raped when they are left at home alone).
If a person doesn’t “fight back,” she was not really raped.	Rape is potentially life-threatening. Whatever a person does to survive the assault is the appropriate action. This may include not fighting because of fear.
If a survivor does not show physical injuries from the rape, she was not raped.	Survivors may not show physical signs of the assault.
Incest (rape or sexual abuse by family members) is rare.	Incest happens in every community.
Sexual assault usually occurs between strangers.	By some estimates, over 80% of rape victims know their attackers. The rapist may be a relative, friend, co-worker, boyfriend or other acquaintance.
Commercial sex workers cannot be raped.	Commercial sex workers are even more exposed and subjected to rape and other forms of violence than other people.
A survivor should not think too much about the violence she has experienced. They should “forget it.”	Survivors who are not allowed to talk about the violence they experienced have a much more difficult time recovering from it. All survivors should be offered the opportunity to talk about the assault with those personally close to them if they wish to do so.
Gender-based violence only happens to women and girls.	Anyone, regardless of gender, can experience GBV. Men, boys, and people with diverse gender identities may also be affected, even if their experiences are less visible or less often reported.

Inter-Agency Standing Committee (IASC). (2019). *GBV Pocket Guide: How to Support Survivors of Gender-Based Violence in Humanitarian Settings*.

Job Aid 4.2: Service mapping sheet

Fill in this information sheet for services in your area and keep it in a place where it is easily accessible.

Work with a GBV specialist, the GBV Area Of Responsibility (AOR), GBV sub-working group, protection specialists, your team leader, and partners to identify (1) available services provided by humanitarian partners; (2) community-based services such as peer groups, religious groups/places of worship, women’s groups, disabled persons’ organizations, etc.

Child Protection	Information:	
	Focal points:	
Mental health/ psychosocial support	Information:	
	Focal points:	
Health	Information:	
	Focal points:	
Sexual and reproductive health	Information:	
	Focal points:	
Non-food items/WASH incl. dignity kits	Information:	
	Focal points:	
Shelter	Information:	
	Focal points:	

Legal	Information:	
	Focal points:	
Food and nutrition	Information:	
	Focal points:	
Services for adolescents/youth	Information:	
	Focal points:	
Services for people with disabilities	Information:	
	Focal points:	
Services for sexual and gender minorities	Information:	
	Focal points:	
Services for child or female-headed households	Information:	
	Focal points:	
Other	Information:	
	Focal points:	

Inter-Agency Standing Committee (IASC). (2019). *GBV Pocket Guide: How to Support Survivors of Gender-Based Violence in Humanitarian Settings*.

Job Aid 4.3: My self-care toolbox

Supporting mothers and caregivers in distress can be emotionally demanding. Taking care of yourself helps you stay grounded and effective. Use this page to reflect and plan small actions that protect your wellbeing.

Tips and ideas for building your toolbox:

→ Self-awareness

- Take a moment after each counselling session to notice how you feel, physically and emotionally.
- Recognize signs of stress (tension, irritability, exhaustion).

→ Connection

- Debrief with a trusted colleague or supervisor.
- Spend time with friends or family outside of work.

→ Grounding and relaxation

- Deep breathing or short mindfulness pause between sessions.
- Stretch, walk, or have a glass of water.
- Use grounding exercises from the *Stress* session.

→ Boundaries

- Leave work at work. Take a break from distressing stories after work hours.
- Say 'no' to extra tasks when you are exhausted.

→ Balance and restoration

- Do one thing daily that brings you calm or joy: music, nature, prayer, quiet time, etc.
- Write a simple gratitude or reflection note at the end of the day.

Your space: Add your own ideas

What helps me feel grounded or calm	What I want to try next week
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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

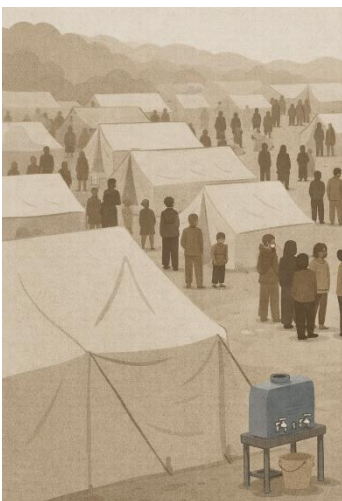
**Reminder: The full 3A process and counselling skill set remains essential. The focus on these particular three skills is for practice and learning purposes.*

STEP 1: Set the Scene

Why this topic?

- Infectious disease outbreaks add new difficulties to already challenging emergency conditions.
- They can affect how families care for and feed infants and young children.

Scenario: Outbreak in the transit centre



A respiratory disease outbreak has been confirmed in a crowded transit centre where displaced families are staying.

Health workers are overwhelmed, and some services have been paused. Misinformation is spreading. Some people say mothers must stop breastfeeding to avoid 'passing the disease'; others believe babies should be separated from mothers who develop symptoms.

Community leaders report increased donations of commercial milk formula, bottles and teats, which families are distributing informally. Some mothers feel pressured to use formula 'just in case.'

People are not using handwashing stations because access to clean water is inconsistent and they fear the spread of the illness.

Question:

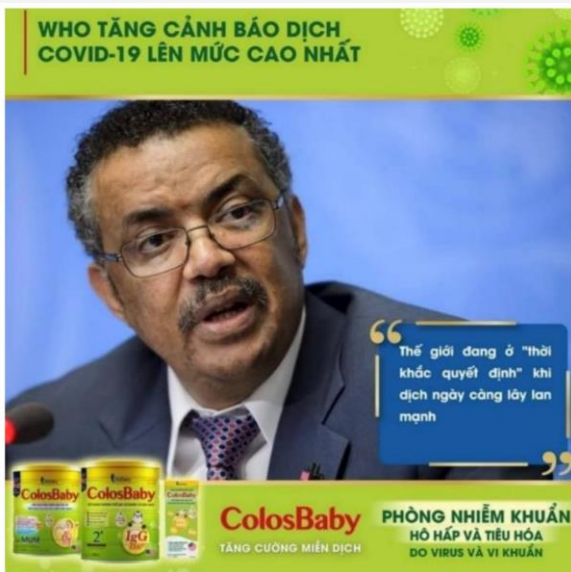
How could this outbreak negatively impact IYCF practices?

Write key points from the group discussion below:

Opportunistic marketing of breast milk substitutes

- Companies may exploit fear and uncertainty during outbreaks.
- They may promote products as ‘safer,’ ‘immune-boosting,’ or a solution to disease transmission.
- This misleads families, violates the International Code, and undermines breastfeeding.

Box: Examples of Code violations during the COVID-19 pandemic



A screenshot from Facebook of a ColosBaby advertisement in Vietnam that misappropriated the headshot of the World Health Organization’s (WHO’s) Director-General. The caption at the top, “WHO raises COVID-19 threat warning to its highest level,” makes it seem like WHO approves this specific formula for infection control.

Danone SN Indonesia Supports Central Java Government to Prevent Stunting During COVID-19 Pandemic

Olleh: Danone-AQUA PR © Selasa, 16 Juni 2020 15:23 WIB



A screenshot of a news article about Danone’s donation of formula products (including Bebelac and SGM) to Central Java government in Indonesia.

Ching, C.; Zambrano, P.; Nguyen, T.T.; Tharaney, M.; Zafimanjaka, M.G.; Mathisen, R. Old Tricks, New Opportunities: How Companies Violate the International Code of Marketing of Breast-Milk Substitutes and Undermine Maternal and Child Health during the COVID-19 Pandemic. *Int. J. Environ. Res. Public Health* 2021, 18, 2381. <https://doi.org/10.3390/ijerph18052381>

STEP 2: Strengthen key knowledge, concepts, and skills



LEARNING OBJECTIVE 1:

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

Introduction

Infectious disease outbreaks can disrupt IYCF practices, which can increase risks of illness and death for infants and young children.

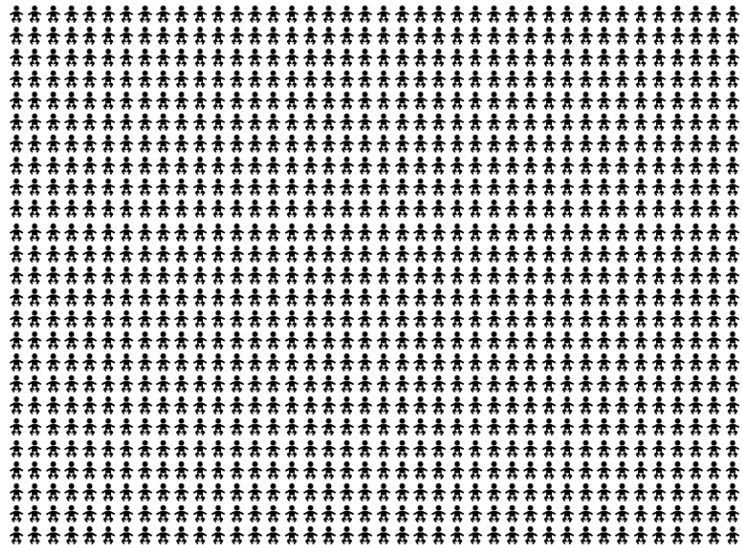
Key points

- **Follow guidance:** Use your national disease-specific IYCF-E guidance
- **Support breastfeeding:** In almost all outbreaks, mothers should continue breastfeeding, even if infected or symptomatic.
- **Avoid separation:** Mother–infant separation can cause serious harm.

Visual: Risks of separation compared to direct infection

1 Infant death from COVID-19

1000 Infant deaths from separation and 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.

Separation can also:

- Distress mothers and children
- Impair a child’s development
- Hinder the developing bond between a mother and her child
- Increase the risk of breastfeeding failure, which can cause negative health outcomes for mothers and infants

Protecting recommended IYCF practices

Activity: Case study: Anfisa and Nadia



Timing: 7 minutes

Read the case assigned to your group. Discuss the two questions below. Be prepared to share your reflections during the debrief.

Group 1: Anfisa

'I've been sick and had to stay in the hospital for the past five days. The doctors told me I had cholera, but I'm finally feeling better. The doctors said it was safe for my four-month-old baby to continue receiving my breast milk while I was sick, but they also told me she couldn't stay with me in the hospital. So, I felt confused about what I was supposed to do. I also heard from other women in my village that my milk could infect her, which made me scared to breastfeed her. Now that I'm home and feeling better I want to start breastfeeding again. But I'm making much less milk now and am worried about how I'll be able to feed my baby.'

Question 1: What went wrong in this scenario?

Question 2: What steps should be taken to protect mothers in situations like Anfisa?

Table: Protecting recommended IYCF practices during an infectious disease outbreak

Situation	What frontline workers should do	Key messages for caregivers
<p>National outbreak guidance recommends continuing breastfeeding</p>	<ul style="list-style-type: none"> • Encourage and support women to continue breastfeeding, including when mothers are infected or symptomatic. • Reinforce correct information on IYCF-E practices, address fears and misinformation through Risk Communication and Community Engagement activities. • Prevent the unnecessary separation of mothers and children and support mothers who are hospitalized to continue breastfeeding. • Reinforce infection prevention measures recommended in the national outbreak guidance. • Help mothers express milk if temporarily weak or incapacitated • Support mothers who are unable to breastfeed due to severe illness to feed their child with recommended alternatives to the mother’s breast milk. • Provide relactation support to mothers who had stopped breastfeeding and wish to resume. • Ensure that inappropriate BMS products are not distributed. 	<ul style="list-style-type: none"> • <i>“Continue breastfeeding. You are protecting your baby from illness.”</i> • <i>“Your milk contains antibodies that help your baby fight infections.”</i> • <i>“Staying together and continuing to breastfeed is the recommended option for you and your baby.”</i>
<p>National outbreak guidance recommends using temporary alternatives to breastfeeding</p>	<ul style="list-style-type: none"> • Explain why breastfeeding is temporarily not advised, according to national outbreak guidance. • Support the use of mother’s expressed breast milk. If mother and child must be separated but the pathogen is not passed through breast milk, expressed milk is the preferred option. Provide lactation support and help mothers resume breastfeeding when medically able. • Explore wet nursing: a recommended alternative in some contexts, depending on availability and cultural acceptability. • Facilitate access to donor human milk if available, prioritizing vulnerable infants (low birthweight, premature, sick). Ensure hygienic storage and handling. • Use commercial milk formula only as a last resort. When other options are not feasible, ensure caregivers are counselled on risks, recommended preparation, appropriate storage and hygienic feeding practices. 	<ul style="list-style-type: none"> • <i>“This is temporary. We will help you return to breastfeeding when it is possible.”</i> • <i>“Here are ways to feed your baby in the recommended ways during this period.”</i> • <i>“Let’s make sure your baby gets enough milk while protecting them from infection.”</i>

<p>National outbreak guidance is not yet available (ie - novel disease outbreaks)</p>	<ul style="list-style-type: none"> • Prioritize continued breastfeeding. Breastfeeding provides critical protection, nutrition, hydration and immune support. Continue breastfeeding unless WHO guidance confirms it is unsafe. • Maintain recommended standards of care. Continue skin-to-skin contact; early initiation of breastfeeding; exclusive breastfeeding age 0–6 months; safe complementary feeding from 6 months of age, with continued breastfeeding up to age 2 and beyond; and responsive caregiving. • Apply infection prevention control (IPC) measures based on known or suspected modes of transmission. • Keep mothers and infants together, avoiding separation unless there is a clear medical reason. • Prevent harmful practices. Avoid unnecessary distribution of breast milk substitutes and address misinformation early. • Seek technical guidance. Escalate uncertainties and emerging concerns to supervisors or technical leads as evidence evolves. 	<ul style="list-style-type: none"> • <i>“Until more is known, breastfeeding should continue with hygiene precautions.”</i> • <i>“Staying together helps both mother and baby stay healthier.”</i>
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If mother–child separation is necessary:

- **Protect milk supply.** Support regular expression of breast milk whenever possible.
- **Confirm a caregiver.** Agree with the mother on who will care for the child, and ensure this individual is trained to feed the child in ways that minimise risk while using the recommended alternative.
- **Facilitate interaction:** visual contact through glass windows in the health facility; phone or video calls; when possible, exchange of personal items with the mother’s and baby’s scent.

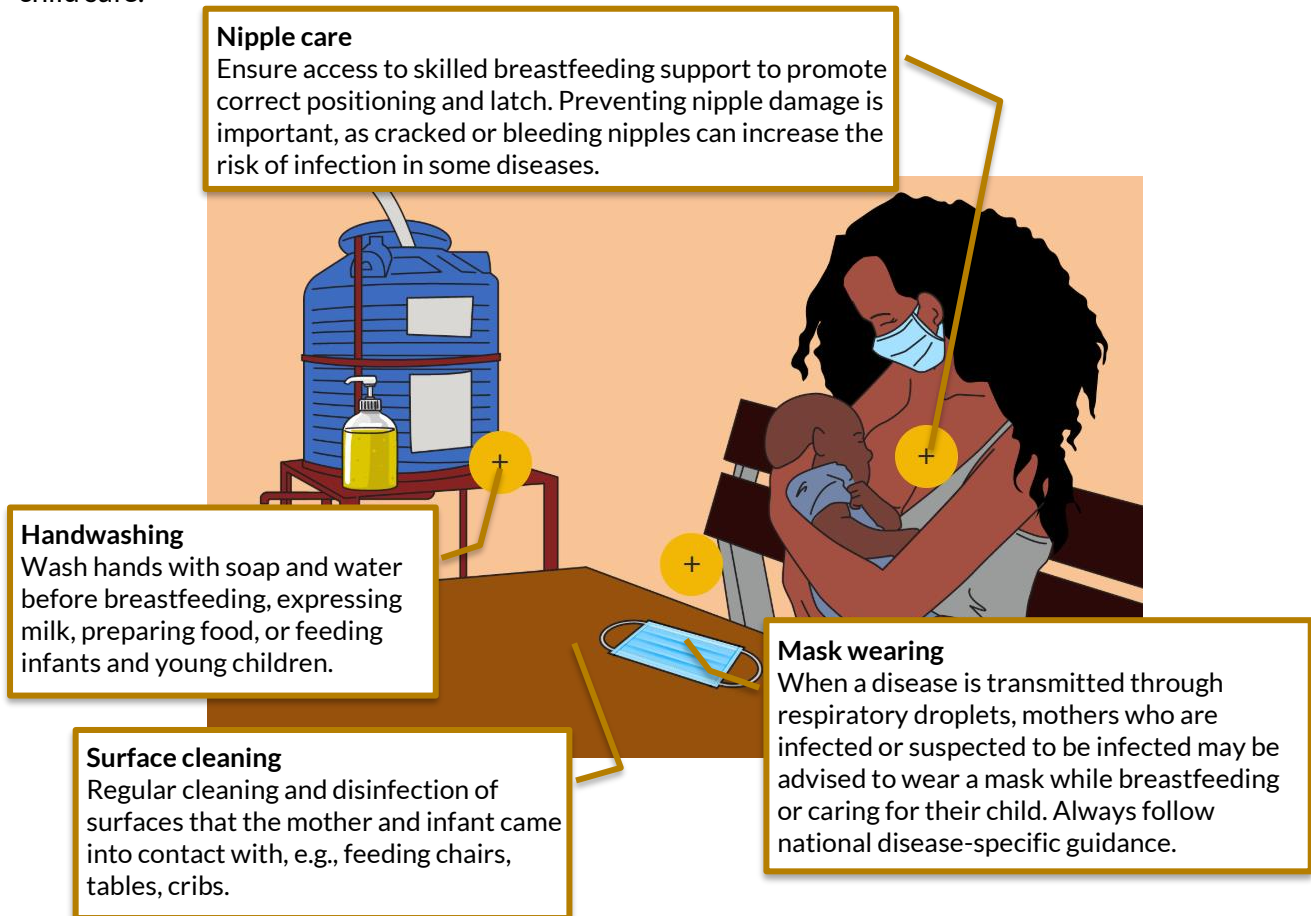
Remember: Separation of a mother and infant is an **exceptional measure** and should **only** occur when national, disease-specific guidance explicitly recommends it.

Non-breastfed infants are at higher risk

- Non-breastfed infants and young children face increased risks during infectious disease outbreaks because they lack the immune protection of breast milk and depend on safe water, sanitation, and reliable supplies for feeding.
- Counselling on appropriate BMS preparation, feeding and storage may need to be augmented from standard guidance according to the circumstances (e.g., boiling water mixed at a temperature of 70° C).

Infection prevention while continuing breastfeeding

When the recommendation is to continue breastfeeding when the mother is infected, you need to ensure she is aware and able to practise relevant and appropriate IPC measures to keep herself and her child safe.



Adapted from *Infant and Young Child Feeding in Emergencies during Infectious Disease Outbreaks*, READY Initiative, KAYA platform.

These measures help reduce transmission risk **without interrupting breastfeeding**, which remains the safest feeding option in almost all outbreaks.

Protecting complementary feeding during outbreaks (6 months and older)

- Maintain age-appropriate, recommended, and nutritionally adequate complementary feeding alongside continued breastfeeding.
- Strengthen hygiene practices related to food preparation, storage and feeding, based on the disease transmission risks.
- Avoid high-risk feeding equipment that is difficult to clean (e.g., bottles, spouted cups).



Key learning points – Objective 1

- **Follow guidance:** Always use your national disease-specific IYCF-E guidance.
- **Support breastfeeding:** In almost all outbreaks, mothers should continue breastfeeding, even if infected or symptomatic.
- **Avoid separation:** Mother–infant separation is rarely justified and can cause serious harm.

- **Protect non-breastfed infants:** Non-breastfed infants are particularly vulnerable. They lack immune protection from breast milk and therefore require careful feeding support to minimise risk.
- **Emphasize IPC:** When breastfeeding continues, appropriate infection prevention measures must be followed.
- **Prioritize complementary feeding:** Children over 6 months require adequate and diverse foods alongside hygiene practices that minimise risk to support growth and immune function, even during outbreaks.



LEARNING OBJECTIVE 2:

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

Adapting IYCF-E service delivery

During infectious disease outbreaks, IYCF-E counselling services require specific adaptations to reduce infection risks, respond to increased needs, and manage constrained capacity while continuing to uphold recommended standards of care.

Table: Key adaptations to IYCF-E counselling service delivery during an infectious disease outbreak

Category	Adaptations of IYCF-E counselling <u>before</u> infectious disease outbreak	Adaptations of IYCF-E counselling <u>during</u> infectious disease outbreak
Recipients*	Priority given to Priority Group 1 (immediate help) and Priority Group 2 (high risk). Others supported as feasible.	Priority Group 1 explicitly includes exposed, infected and recovering pregnant and lactating women (PLW); caregivers; and children.
Timing	Timely counselling prioritized for immediate and high-risk groups. Routine timing for others where possible.	Counselling adapted to each stage of illness: pre-exposure, incubation, infection and recovery.
Frequency	As often as needed for priority groups. Routine frequency for others if feasible.	Increase contact frequency, especially when disease course is uncertain or rapidly changing.
Mode	Face-to-face counselling in an individual or group setting. Remote counselling may partially or fully replace face-to-face until face-to-face sessions can be resumed.	Face-to-face counselling with necessary PPE and enhanced IPC measures (spacing, ventilation, cleaning); remote counselling, helplines and digital platforms where appropriate. Prioritize face-to-face for high-risk pairs and remote follow-up for lower-risk contacts
Providers	Routine IYCF-E counselling, with surge capacity and dedicated counsellors as needed.	All providers caring for infected and recovering pairs may support recommended IYCF-E practices. Utilize lactation consultants and specialized IYCF support for highest-risk groups
Quality	Same standards of quality apply as described in the table <i>Adapting counselling in emergencies</i> (Session 1), including anticipatory counselling related to the emergency.	Same standards apply, with strong attention to IPC, clear communication and continuity of care despite service adaptations.

*See Session 2: Individual Assessment in Emergencies

Communication adaptations during counselling in infectious disease outbreaks

Challenges

- Masks and other types of PPE – as well as physical distancing – may limit the visualization of facial expressions, touch and other typical ways of building rapport.
- High levels of stress in both caregivers and counsellors can affect communication, attention and decision-making.

Exercise: Can you tell which person is smiling?



Adapted from *Communicating with Children in Infectious Disease Outbreaks: Guidance for Effective One-to-One Communication*, READY Initiative, KAYA platform.

Key messages

- Even with PPE, **non-verbal communication** – tone of voice, eye contact, posture, gestures, pacing – still matters.
- You may need to **exaggerate positive body language**, speak more clearly and check understanding more frequently.
- Take extra time to **acknowledge emotions before moving to IYCF-related messages**.

Addressing fears and misinformation

Fear, rumours and misinformation are common during outbreaks, especially around breastfeeding, illness and vaccination. Low trust in authorities can increase reliance on informal or incorrect information sources.

Practical counselling tips:

- Invite caregivers to share what they've heard about breastfeeding during the specific outbreak.
- Respond with empathy and without judgment.
- Correct misinformation calmly, with clear explanations.
- Reinforce that recommendations may evolve as more is learned about the disease.

Vaccination:

- Disease risk is generally higher than vaccination risk.
- Vaccination during pregnancy/lactation can protect mother and infant.
- Breastfeeding should continue after vaccination unless explicitly contraindicated.

Special considerations

Maintaining lactation during mother–child separation

When mother–child separation is explicitly recommended for specific diseases (e.g., Ebola virus disease, when the mother is positive and the infant negative), support the mother to maintain lactation during separation whenever possible. In such cases where it is not recommended for the infant to be fed the mother’s breast milk, it is still important to support the mother to maintain her breast milk supply and relieve any discomfort during this temporary period.

Key points:

- Inability to express milk can lead to engorgement, mastitis and loss of milk supply.
- Supporting the mother to lactate through regular milk expression helps her to maintain her supply and thus to resume breastfeeding more easily once she is no longer separated from her child.
- Support regular milk expression 8–12 times per day, with hand-expression as the preferred method. Breast pumps may be used when clinically indicated and when their use, cleaning and follow-up support can be provided in ways that minimise risk.
- Assisted milk expression by a health worker, with proper consent, may be needed if the mother is too ill to express milk herself.
- Where the expressed milk cannot be given to the child, maintaining lactation preserves the option to resume breastfeeding after recovery.
- Maintaining milk production can provide a sense of control and purpose for mothers during separation.

Supporting a bereaved mother

Bereavement, including over stillbirths or the loss of infants or young children, may increase during infectious disease outbreaks.

Key points:

- Counselling should prioritize emotional support, comfort and breast health.
- Offer comfort measures for breast fullness or engorgement (e.g., cool compresses, pain relief, minimal expression for comfort).
- There are **no right or wrong choices**. Some mothers may wish to suppress lactation, while others may find continued lactation comforting.
- When a mother wishes to stop breast milk production, encourage gradual approaches and avoid lactation-suppressing medications unless clearly medically indicated, as these medicines can permanently stop milk production and may not be readily available in many settings.
- Facilitate referral to mental health and psychosocial support services.



Key learning points – Objective 2

- **Infectious disease outbreaks change how counselling happens**, not just what is recommended.
- **Counsellors must adapt communication** when PPE, physical distancing, stress and illness affect usual interactions.
- **Non-verbal communication remains important**, even when facial expressions or touch are limited.
- **Fear, rumours, and misinformation are common during outbreaks** and must be addressed with empathy, clarity and calm correction.
- **Some situations require additional counselling adaptations**, such as supporting lactation during mother–child separation or supporting bereaved mothers.
- **Counselling should remain respectful, evidence-informed and caregiver-centred** throughout outbreaks.



LEARNING OBJECTIVE 3:

Describe how to provide effective remote IYCF-E counselling

Introduction

What is remote counselling?

Any counselling not conducted face-to-face, including those conducted via:

- Telephone (voice only)
- Voice or video calls (e.g., WhatsApp, Zoom)
- Follow-up via text messages or email, when appropriate

PREPARE FOR A REMOTE COUNSELLING SESSION

Action 1 – Choosing the right technology

Key considerations:

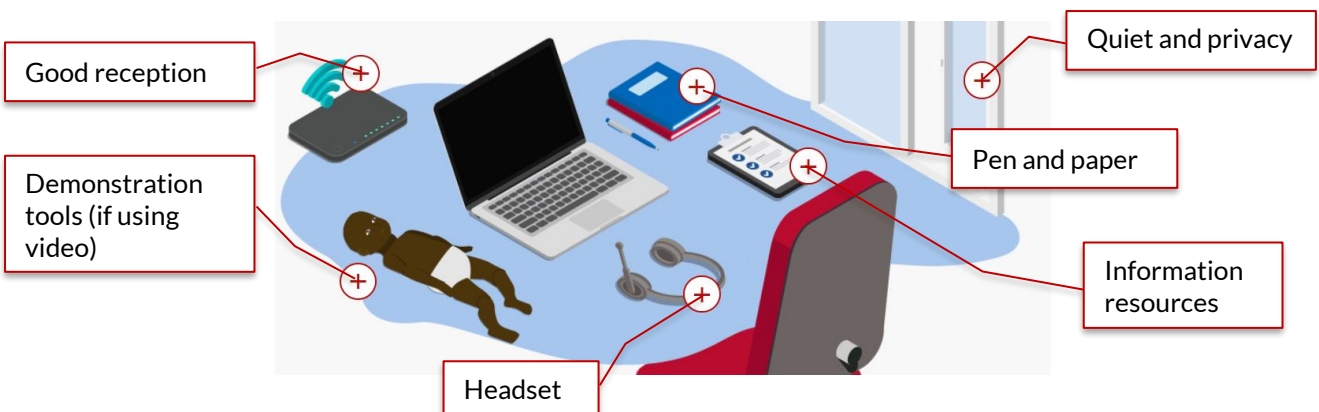
- Electricity, phone signal, internet coverage
- Access to a device (for both counsellor and client)
- Voice-only vs. voice-and-video
- Community access and emergency constraints
- Accessibility needs, including disability considerations
- Familiarity with the technology
- Costs (calls, data, devices)

Action 2 – Managing technology challenges

Before the session	During the session
<ul style="list-style-type: none"> • Agree on time and method of access • Ensure client knows how to join the session • Always have a backup phone number to contact the client, in case the video or call drops 	<ul style="list-style-type: none"> • Briefly explain the technology • Reassure the client that you will call back if disconnected • Switch to voice-only if video fails • Reschedule if connection is not workable

Action 3 – Setting up your counselling space and gathering supplies

In order to run an effective remote counselling session, you should make sure your space has the following elements:



Note that every counsellor is different, and you should set up your space in a way that makes you feel more comfortable and prepared for remote counselling.

Action 4 – Ensuring client privacy and confidentiality

Remote counselling does *not* lower confidentiality standards.

- Conduct sessions alone and uninterrupted in a private, non-shared space. Any windows or doors in the room should be closed to ensure others cannot hear the session.
- Do not use speaker mode. During video sessions, use headphones to ensure your hands are free for demonstrations and note-taking without needing to use speaker mode.
- Do not record sessions.
- Use secure, encrypted platforms.
- Follow local data protection laws.

ASSESS THE FEEDING SITUATION

Remote counselling requires adjusting how you assess feeding, since you may have limited or no visual information.

Action 1 – Start the session well

- Introduce yourself clearly and confirm it is a good time to talk. For voice calls, ask whether it is your client with whom you are speaking.
- Check that the caregiver can hear you well.
- Explain the session length and what will happen if the call is interrupted.
- Reassure confidentiality early.

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

Action 2 – Create a safe and supportive space

- Use a warm, calm tone of voice.
- Express empathy verbally, as body language may not be visible.
- Acknowledge feelings and concerns.
- Pause often and invite the caregiver to share their thoughts, experiences and perspectives.
- Listen closely for emotional cues in the caregiver’s voice.
- Give praise for what the caregiver is doing well.
- Avoid judgmental or technical language.

Remote assessment requires intentional emotional check-ins, not just questions.

Action 3 – Assess feeding challenges remotely

- Ask open-ended questions and descriptive questions.
- Ask caregivers to explain what you would normally observe. For video sessions, consider using visual tools such as food models, measuring cups and breast models.
- Use simple words and clear explanations.
- Ask more questions to compensate for limited visual information.
- Summarize often to confirm understanding.

Remote assessment relies more on listening, clarification and confirmation

Action 4 – Adapt your assessment to the technology

- **Voice-only:** Use descriptive questions. If possible, send images (e.g., breastfeeding positioning or attachment, complementary foods, serving sizes) by text message or email.
- **Voice-and-video:** Observe body language, use visual aids, demonstrate when helpful.

Adapt your approach based on what the technology allows.

Remote assessment builds on the same skills used in face-to-face counselling but requires greater attention to communication, empathy and clarity.

ANALYSE THE FEEDING CHALLENGES

After assessing the feeding situation, analyse the information to identify the main feeding challenges and prioritize what to address first.

Action 1 – Identify the feeding challenge(s)

- Review the information gathered during assessment.
- Identify what feeding challenges may be present.
- Remember that clients may raise more than one concern.

Analysis helps you move from listening to understanding by clarifying what the main feeding challenges are and how they may be connected.

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

- Use simple, non-technical language.
- Use descriptive questions to compensate for what you cannot see, especially in voice-only sessions.
- **See** (if video) the caregiver, the infant and the environment.
- **Hear** tone of voice, emotions, stress or distraction.
- **Ask** specific, clarifying questions to understand *why* the challenges are happening when open-ended questions do not provide enough detail.

Remote analysis relies on careful observation, attentive listening, and well-chosen questions to uncover causes that may not be immediately visible.

Action 3 – Prioritize issues to address

- Identify 2–3 priority issues to address during the session.
- Take the caregiver’s main worries into account.
- Avoid overwhelming the caregiver with too much information at once.

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

Remote analysis uses the same clinical reasoning as face-to-face counselling but requires greater intentionality in questioning, interpretation and prioritization.

ACT TO ADDRESS THE FEEDING CHALLENGES

Once you have assessed the situation and analysed the key feeding challenges, the next step is to **act**. Taking action means working with the caregiver to agree on practical solutions and small behaviour changes that are realistic in their context and feasible through remote counselling.

Action 1 – Discuss key feeding challenges and agree on solutions

- Discuss the priority feeding challenges.
- Agree on realistic actions the caregiver feels able to try.
- Use clear language and confirm understanding.
- Choose actions that fit the caregiver's context and resources.

Agree on clear, achievable actions that the caregiver feels confident trying at home.

Action 2 – Finish the session positively

- Summarize the agreed actions.
- Encourage the caregiver to practise and observe progress.
- Acknowledge positive behaviours to build confidence.

Follow-up and referrals

- Agree on follow-up sessions, if needed.
- Refer caregivers to additional services when appropriate, following local procedures.

Analysis helps you move from listening to understanding by clarifying what the main feeding challenges are and how they may be connected.

Action 3 – Support after the session

- Share educational materials (texts/handouts, images, videos).
- Let caregivers know how to reach you if needed.
- Share hotline or support contact information, if available.

Ongoing support helps reinforce key messages and strengthens caregiver confidence.

Remote counselling requires clear communication and shared decision-making. Small, mutually agreed actions can help caregivers make meaningful improvements.



Key learning points – Objective 3

- Remote counselling requires **adapting familiar IYCF-E skills for a virtual setting** while maintaining caregiver-centred communication, safety and effectiveness.
- **Effective remote counselling starts with proper preparation:** ensure you have the right environment, technology, materials and knowledge of the caregiver's context.
- **Assess: Collect information carefully.** Remote assessment relies on listening, asking clear questions, and observing what you can via video or caregiver description.
- **Analyse: Use the same analytical skills as face-to-face counselling.** Prioritize key feeding challenges and consider the household context but be intentional in interpreting verbal and visual cues.
- **Act: Work collaboratively with the caregiver to agree on practical, realistic solutions.** Provide guidance, resources and follow-up while maintaining clear communication and support remotely.

STEP 3: Demonstrate


Listen and watch the demonstration of a case study. This demonstration shows how IYCF-E counselling skills, can be applied during a remote counselling session in an infectious disease outbreak setting using the **Assess, Analyse and Act** approach.

You will also notice the counsellor using three key counselling skills that support all IYCF-E interactions:

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

The counsellor is an IYCF-E Counsellor providing remote support during an infectious disease outbreak.

Case study: Sofia and Sara

	<p>Mother/Caregiver: Sofia, in her 20s Child: Sara, 3 weeks old Context: Remote counselling via mobile phone due to COVID-19 restrictions Reason for contact: Mother struggling with breastfeeding; first-time counselling session remotely</p>
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Instructions:

- Observe how the counsellor assesses, analyses and acts on the feeding challenges.
- Notice the tone, pacing, and phrasing that help the caregiver feel supported and confident.

Use this space to write notes, reflections or key takeaways from the discussion

STEP 4: Role-Play

Now it's your turn!



Timing: 10 minutes

Case study: Miriam and Sam

During an Influenza A pandemic, many displaced families are staying in crowded transit centres with limited access to clean water and essential services. To reduce infection risk, remote counselling has been preferred.



Mother: Miriam

Child: Sam, 3 days old (born mildly premature at almost 36 weeks)

Reason for contact: First remote counselling session following discharge from the health facility

Current situation: Sam was born slightly early but with a healthy weight and did not require specialized medical care. As he was not yet fully able to suckle, Miriam was advised at the health facility to hand-express breast milk and feed him using a cup.

Instructions:

1. Review the Counselling Skills Checklist before beginning the role-play.
2. In your groups of three, divide into specific roles:
 - One person will play the **counsellor** (IYCF counsellor conducting a voice-only session).
 - One person will play **Miriam**. The facilitator will give you a short role-play card with Miriam's situation.
 - One person will be the **observer**. Use the Counselling Skills Checklist below to note key strengths and areas for improvement. Do not write everything.
 - The counsellor and Miriam should sit back-to-back so they don't see each other.

As you role-play, counsellors should focus on practising three core counselling skills described below.



Reminders: Core counselling skills

- **Use helpful non-verbal communication:** Non-verbal cues can make a mother feel heard and supported. For example:
 - Keep your head level with mother or caregiver. Nod gently when she speaks.
 - Keep your body open and relaxed.
- **Reflect back what the mother or caregiver says:** Reflecting serves the dual purpose of showing the mother that you are listening to her and checking your understanding. It should not be a transcript of every word said but a re-statement of the relevant points. Always pause after restating to allow the mother to correct or build on your response.
 - *"It sounds like hand-expressing your milk has been painful and you're worried you're not getting enough."*
 - *"So, you've been trying to feed Sam from a cup because he cannot fully suckle yet. Is that right?"*

- **Give relevant information:** Provide guidance and facts that address the mother’s specific challenges. Make sure the information is timely, clear and actionable. In a remote session, this may include verbal instructions, sending images, or referencing other resources.
 - *“It’s normal for very little milk to come out in the first few days after birth.”*
 - *“If you position your fingers just outside the dark area around the nipple, it can make expressing easier and less painful.”*
 - *“Washing your hands before expressing and wearing a mask can help protect Sam if you are unwell.”*
- **Use simple language:** Avoid jargon or technical terms. Explain concepts simply and clearly so they are easy to understand. For example, instead of ‘responsive feeding,’ say:
 - *“Try squeezing gently and releasing in a rhythm. That will help you get more milk with less pain.”*
 - *“Wash your hands before expressing and wear a mask while near Sam.”*

Counselling Skills Checklist for the observer

Instructions: Tick Yes, Partially, or No for each skill or action you observe during the counselling session.

Counselling Skills Checklist			
STARTING THE SESSION	Yes	Partially	No
Introduced self and organization clearly			
Confirmed identity of the caregiver			
Checked consent and availability to talk			
Informed how long the session will last			
Explained confidentiality			
Smiled			
ASSESS	Yes	Partially	No
Asked open-ended questions			
Reflected back the caregiver’s concerns			
Demonstrated empathy for Miriam’s feelings			
Praised Miriam			
Used simple, non-technical language			
ANALYSE	Yes	Partially	No
Asked clarifying questions to understand the feeding challenge			
Used descriptive language appropriate for a voice-only call			
Explored possible causes of pain or difficulty			
Identified more than one concern			

Prioritized 2–3 key challenges with the caregiver			
ACT	Yes	Partially	No
Gave clear, step-by-step guidance			
Sent digital resources (images or instructions) to support understanding			
Checked understanding			
Encouraged and praised efforts			
CLOSING THE SESSION	Yes	Partially	No
Summarized agreed actions and next steps			
Provided guidance on additional resources or referrals if needed			
Reassured caregiver that support is ongoing			
Closed the session calmly and supportively			



Role-play debrief: Miriam and Sam

1. Meeting Miriam: Setting the tone for a remote session

This is Miriam's first contact with an IYCF counsellor, and it takes place by telephone (voice only). How the counsellor starts the call strongly influences whether Miriam feels safe, respected and open to sharing.

At the start of the conversation, the counsellor establishes **clarity and choice** by briefly introducing herself, confirming who she is speaking with, explaining confidentiality and checking that Miriam is comfortable continuing the call. These simple steps help create a sense of safety and respect, especially when visual cues are absent.

A warm tone, unhurried pace and simple language help compensate for the lack of visual cues. Even though Miriam cannot see the counsellor, **smiling while speaking** can make the voice sound calmer and more welcoming.

Sample lines:

"My name is Nadia, and I'm an infant and young child feeding counsellor. Am I speaking with Miriam?"

"Is this still a good time for us to talk?"

"Everything we discuss is confidential, and you can pause or stop at any time."

→ **Remember:** In remote counselling, trust is built through clarity, consent and tone of voice.

2. Starting to assess: Listening and reflecting

As Miriam begins to share her experience, she expresses worry, pain and uncertainty. In a **voice-only counselling session**, the counsellor cannot observe Miriam's body language, facial expressions or feeding technique. This makes **active listening and reflection especially important**.

Rather than rushing into advice, the counsellor listens carefully, reflects back what she hears, and checks her understanding. By acknowledging Miriam’s feelings and efforts, the counsellor helps reduce anxiety and builds confidence.

Key skills to demonstrate here include:

- Empathy (“I understand this must be stressful”)
- Reflection (repeating Miriam’s concern in the counsellor’s own words)
- Praise for positive behaviours already in place

Sample lines:

“It sounds like expressing your milk has been painful and frustrating.”

“You’re doing the right thing by trying to feed Sam breast milk.”

“Many mothers find this difficult at first, especially in the early days.”

→ **Remember:** Validation encourages openness and makes it more likely that advice will be accepted later.

3. Understanding the feeding challenge in depth

Although it’s clear that Miriam is struggling with hand-expression, the counsellor needs to understand **why**. Because this is a **voice-only session**, the counsellor must rely on **clear, descriptive** questions to build an accurate picture of what Miriam is doing.

Instead of assuming the problem, the counsellor asks specific questions to narrow down the issue and eliminate possible causes, such as incorrect hand placement or squeezing the nipple.

At this stage, the counsellor may also identify **more than one concern** but should avoid overwhelming Miriam.

Sample lines:

“Where do you place your fingers when you express?”

“Are you squeezing the nipple or the darker area around it?”

“Is your hand cupped around the breast, like a ‘C’ shape?”

“Do you feel pain during or after expressing?”

→ **Remember:** In remote counselling, asking more detailed questions is often necessary to “see” the situation through the caregiver’s words.

4. Supporting Miriam with practical guidance

Once the counsellor has clearly understood the feeding challenge, she explains what she would like to focus on. Because the session is voice-only, she uses **digital resources** (images sent to Miriam’s phone) and **step-by-step verbal guidance** to compensate for the lack of visual demonstration. She checks regularly that Miriam understands and invites her to try the technique while they are still on the call.

As Miriam practises, the counsellor offers reassurance and encouragement, reinforcing Miriam’s confidence and helping reduce pain and frustration.

Sample lines:

“I’d like to work on your hand positioning to make this more comfortable. Does that sound OK?”

“Would you be happy for me to send you a few images on your phone?”

“Can you tell me if that makes sense, or if you’d like me to explain it again?”

“You’re doing really well! This can take practice, and you’re getting it.”

→ **Remember:** In remote counselling, acting is not about giving long explanations but about guiding; checking understanding; and encouraging small, achievable steps.

5. Addressing Miriam's other concern and prioritizing challenges

Later in the session, Miriam shares another concern: she worries that she might have Influenza A and fears passing it to her baby through breast milk.

The counsellor now needs to **prioritize**. While multiple concerns may arise, it is usually best to focus on **no more than two or three key issues** in one session.

Because this concern could directly affect feeding decisions, it is appropriate to address it during the same call. The counsellor provides **clear, factual information** while remaining calm and reassuring.

Sample lines:

"Breast milk does not pass the Influenza A virus to your baby."

"Your milk can actually help protect Sam."

"Washing your hands and wearing a mask can help keep him safe."

→ **Remember:** Address urgent concerns that may disrupt feeding, but keep explanations simple and focused.

6. Closing the session on a positive note

How the session ends is just as important as how it begins. The counsellor should close by:

- Summarizing what was practised and the agreed next steps;
- Sharing any additional educational materials or resources remotely (e.g., hand-expression tips, cup-feeding guidance, hygiene measures related to Influenza A);
- Offering referrals to health services or IYCF support groups, if needed; and
- Confirming how and when the next session will happen, and how Miriam can reach the counsellor if she needs support before then.

A calm, encouraging closing helps Miriam leave the session feeling capable and supported.

Sample lines:

"Today we worked on your hand positioning for expressing, and it seems more comfortable now."

"I'll send you additional tips and resources on cup feeding and recommended hygiene practices."

"We can check in again soon, and you can contact me anytime if you need support before then."

→ **Remember:** A supportive closure reinforces confidence and helps sustain behaviour change.

STEP 5: Self-reflection

Take a few minutes to think about the session. You can write your answers in the space below.

Questions:

1. How confident am I to protect recommended IYCF practices during an infectious disease outbreak? What might help me improve my confidence or skills?

2. How prepared am I to address fears, rumours and misinformation that caregivers may have during an outbreak?

3. What challenges do I anticipate when providing remote counselling to mothers/caregivers in emergency settings, and how can I address them effectively?

Additional notes:

Resources:

- **Infographic Series: Infant Feeding During Infectious Disease Outbreaks – 2021, IFE Core Group**

[A guide for national health authorities, health and nutrition policymakers, professional associations and other bodies and practitioners working in outbreak preparedness and response](#)



[A guide for decision makers and programmers working in emergency preparedness and response](#)



- **E-Learning Courses (READY Initiative, available on Kaya)**

[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](#)



SESSION 6: INCREASING BREAST MILK 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 3A process and counselling skill set remain essential. The focus on these particular three skills is for practice and learning purposes.*

STEP 1: Set the Scene

Concerns about not having enough milk are common in emergencies and, if not handled carefully, may lead to unnecessary introduction of alternatives or reduced breastfeeding, increasing the risk of illness and malnutrition.

Scenario: Aisha and Zainab in the transit camp



Aisha and her family have just arrived in a crowded refugee camp after walking for several days over rough terrain. Her only child, 5-month-old Zainab, had experienced some minor feeding challenges at home, but Aisha had been exclusively breastfeeding and managing well. Normally, Zainab was a cheerful and engaging baby, and Aisha believed that the traditional tea her mother-in-law used to prepare for Aisha at home helped support her milk supply.

Since the journey, Zainab has been sleeping longer than usual and crying more often. She seems harder to settle. Aisha is tired, has had limited access to food and clean water, and worries that her stress might be causing her breasts to 'dry up' or that her milk has 'gone bad'. She thinks Zainab no longer wants the breast and needs solids or formula instead.

Questions:

What might make Aisha think she does not have enough milk?

At the same time, what aspects of the emergency situation could affect milk production?

Write key points from the group discussion below:

STEP 2: Strengthen key knowledge, concepts and skills



LEARNING OBJECTIVE 1:

Assist a mother or caregiver to increase breast milk intake

Assess

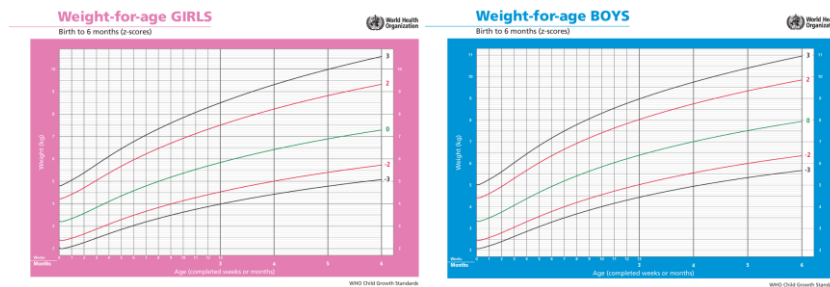
No single sign confirms low breast milk intake. Assessment should consider feeding observation, caregiver concerns, and the overall condition of the baby.

Signs that may suggest low breast milk intake:

- Feeding pattern and observation:
 - Baby is not taking deep suckles followed by a visible or audible swallow.
 - Baby appears unsatisfied after most feeds or shortly after feeding.
 - Baby falls asleep very quickly at the breast without effective suckling.
 - Baby frequently appears unsettled after feeds.
 - Baby feeds for very long periods without signs of effective milk transfer.
 - Baby refuses to breastfeed.
 - Frequency and duration of feeds is low (including night feeds).
 - Poor positioning or shallow attachment
 - Breasts remain very full or uncomfortable after feeds.
 - Mother reports little or no swallowing during feeds.
- Urine and stool output:
 - Caregiver reports that baby appears to urinate much less often than usual or produces very small amounts of urine.
 - Urine appears very dark or concentrated.
 - Baby is still passing black stools (meconium) four days after birth.
 - Stools remain dark or hard instead of becoming softer and lighter after the first week of birth.
 - Stools are very small or infrequent compared with the baby's usual pattern.
 - Note: Once infants begin receiving other foods or liquids, stool patterns can change and are no longer a reliable indicator of breast milk intake. In these cases, assessment should focus more on breastfeeding frequency, feeding observation, urine output, growth and the caregiver's concerns.
- Weight:
 - Baby is not gaining weight.
 - Growth curve is flat or slopes downward on the growth chart, especially in infants under 6 months who should normally show steady weight gain.



- WHO Growth Charts are used around the world to track how children grow from birth to 5 years. However, growth charts are not used in all settings, so assessment may also rely on feeding observation, the baby's overall condition and caregiver concerns.



WHO Growth Charts are global growth standards, divided by age and sex.

- Reported changes in behaviour or signs of illness.
- Caregivers often notice when something has changed in their baby. Their observations should be taken seriously.
 - Baby is unusually sleepy or difficult to wake for feeds.
 - Baby is unusually irritable or restless.
 - Baby shows reduced interest in breastfeeding.
 - Baby's behaviour has changed compared to usual patterns.
 - Also look for signs of illness or any condition in the baby or the mother that may make feeding more difficult (for example prematurity, disability or anatomical differences).

Also assess:

- Challenges in the caregiver-baby relationship or interaction that may affect feeding
- Signs of illness in the baby or mother

Note: In emergency settings, interpretation of these signs may be affected by stress, illness, disrupted routines, environmental conditions or limited access to measurement tools. Always consider the broader context when assessing intake.

Analyse

Analyse possible reasons for low breast milk intake

Based on the information you collected in the Assess step, consider what might be contributing to low intake:

- **Access:** Feeding opportunities may be inadequate, including night feeds.
- **Transfer:** Attachment, positioning or other conditions (for example oral differences or disability) may affect how effectively the baby removes milk from the breast.
- **Baby needs:** Medical conditions or illness may increase requirements.
- **Milk ejection:** Milk flow may be affected by stress.
- **Milk production:** Maternal factors such as illness, medications or pregnancy may reduce milk production.



Act

Based on the assessment and analysis, support the mother or caregiver to take practical steps that improve breastfeeding effectiveness and increase the baby's breast milk intake.

1. Optimize access to the breast (frequency)

Use the poster "Increasing Milk Supply is as Easy as 1-2-3" to support the mother to increase the infant's effective access to the breast.



Poster: Increasing Milk Supply is as Easy as 1-2-3

INCREASING BREAST MILK SUPPLY METHODS FOR BOOSTING PRODUCTION



In pregnancy, our bodies grow our babies, giving them exactly what they need to thrive. After birth, our bodies continue to grow our children by producing human milk for nutrition, immunity, food-security and nurturing care.

Milk production is driven by supply and demand. The more milk the baby drinks, the more milk our body makes.

A well-positioned/well-latched baby, frequently breastfeeding on demand, will produce plentiful milk – even during stressful times like emergencies. Lots of skin-to-skin contact reduces stress and increases breast milk supply.



Did you know that low milk supply is rare but is still one of the most common concerns of mothers, leading to formula use? If you've stopped breastfeeding and want to re-start through relactation – or are mixed-feeding and want to build up your milk supply – reach out to a breastfeeding counsellor for help.

INCREASING MILK SUPPLY IS AS EASY AS 1-2-3!



Follow baby's lead and respond to baby's need.

Do not force-feed baby.

1

SKIN-TO-SKIN CONTACT

Cuddle your undressed baby upright between your bare breasts, with a blanket to cover you both if the room is cool. Ensure baby's airway is clear.

Skin-to-skin contact stimulates the release of the "love hormone" in both you and your baby. It relaxes you and encourages milk to flow.

Stay skin-to-skin for as much of the day as you desire. The more, the better.

See the 'Skin-to-Skin Contact' handout for tips and important safety information.

2

FREQUENT BREASTFEEDING

While skin-to-skin, breastfeed often and whenever the baby is willing. Don't wait for the baby to cry or fuss to offer the breast.

Ensure that the baby has a deep and comfortable latch and good position: 'tummy-to-mummy, nipple-to-nose'.

Aim for at least 10–12 breastfeedings from sunset to sunset, including night feeds.

Keep baby feeding through compressions and swapping sides.

3

BREAST COMPRESSION

Emptying the breast more fully at each feeding makes more milk.

When you notice that your baby is sucking but not swallowing, you can help the milk flow by gently squeezing your breast.

Place your fingers under your breast with your thumb on top, behind the areola (darker skin). Press gently until you notice your baby begin to swallow.

Release when your baby stops drinking.

La Leche League International. *Increasing Breast Milk Supply*. Available at: <https://lila.org/news/increasing-breastmilk-supply/> (accessed 2026).

2. Improve transfer (attachment and effectiveness)

- Check positioning and attachment. Refer to *Job Aid 6.1: Counselling cards*.
- Observe swallowing.
- Support effective feeding until the breast is well drained.

3. Support let-down (stress)

- Encourage calming strategies. Refer to Annex 1: Emotional regulation practices.
- Encourage the mother's partner and/or other family members to support with childcare and other household duties.
- Promote skin-to-skin contact.
- Reassure that stress may slow milk flow but does not usually stop milk production.

4. Consider baby's needs (medical barriers)

- If prematurity, illness, or increased caloric needs are present, ensure appropriate referral and follow-up.
- Monitor weight gain. Refer if no improvement after seven days.



Key learning points – Objective 1

- Do not assume low milk supply without assessment. Use feeding observation, output, weight trends, and reported changes to guide your assessment.
- In emergencies, interpret signs cautiously and consider the broader context.
- After assessing and analysing, act according to the identified cause to meet one or more of the following objectives:
 - Improve frequency
 - Improve effective milk removal
 - Support let-down in stressful situations
 - Address medical barriers and refer when needed
- Milk production depends primarily on frequent and effective milk removal.



LEARNING OBJECTIVE 2:

Assist a mother or caregiver with relactation and induced lactation

Understanding relactation and induced lactation

Activity: What do you think?



YES or NO?

▪ Can a woman who has <u>stopped breastfeeding</u> resume milk production?	Yes	No
▪ Can a woman who has <u>not previously breastfed</u> stimulate breast milk production?	Yes	No
▪ Can a woman who has <u>gone through menopause</u> stimulate breast milk production?	Yes	No

Definition: Relactation and Induced lactation

Relactation: The resumption of breast milk production (lactation) in a woman who has stopped lactating, recently or in the past, in order to breastfeed her own or another infant.

Induced lactation: The stimulation of breast milk production in a woman who has not previously lactated (i.e., has not been pregnant or breastfed before). For example, a woman who adopts a baby may choose to induce lactation so that she can breastfeed the infant.

Reasons for relactation or induced lactation:

- Breastfeeding was interrupted or did not start after birth (owing to e.g., separation, illness or birth complications)
- Concerns about how the infant is tolerating formula (e.g., suspected or diagnosed intolerance or allergy)
- A mother wishes to return to breastfeeding after stopping or reducing breastfeeding
- A caregiver wishes to breastfeed an infant who is not their own (e.g., through wet nursing, or in adoption or foster care)
- An emergency situation creates a need or desire to breastfeed (e.g., limited access to BMS or increased health risks)
- A desire to support bonding, comfort or infant health

Testimony: The grandmother’s story



Aisha* is a grandmother from Borno State in north-east Nigeria.

My daughter died 40 days after giving birth to Aisha.* She had named the baby Aisha after me. Soon after, our village in northeast Nigeria was attacked, and Aisha’s father went missing. I was the only person left to care for my granddaughter.

As soon as my daughter died, I began putting Aisha to my breast. I had not breastfed in decades, and at first the milk was very slow to come. I had no money to buy milk and very little food myself.

When I arrived at the clinic, my granddaughter weighed only 1.9 kilograms. She was extremely small and weak.



Nutrition worker’s perspective:

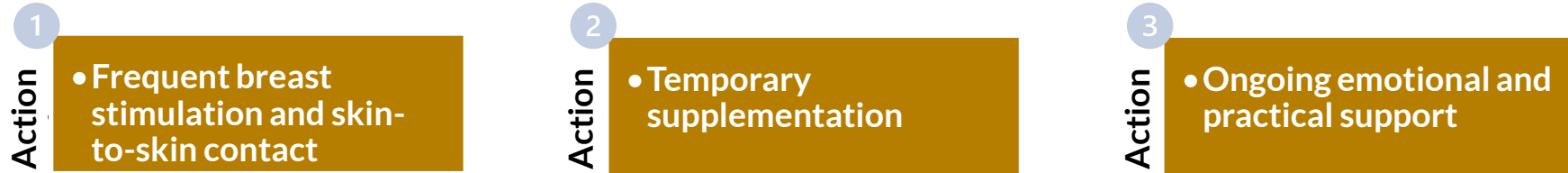
When Aisha arrived, she was already trying to breastfeed her granddaughter, Aisha. Because she had not breastfed in many years, her milk supply was not yet sufficient. We supported her using a Supplementary Suckling Technique that involved placing a small tube from a cup of milk beside the nipple. When the baby suckled, she received milk from the cup while simultaneously stimulating the grandmother’s own milk production. With regular suckling and support, her milk began to increase.

Now, Aisha breastfeeds her granddaughter. Without this support, the baby might not have survived.

* Name has been changed. This is a real story.

Supporting relactation and induced lactation in practice

Relactation and induced lactation works when three actions happen together.



Action 1: Frequent breast stimulation and skin-to-skin contact

WHAT: Regular stimulation of the breasts and close physical contact between caregiver and infant

WHY: Milk production works on demand and stimulation

<p>Skin-to-skin:</p> <ul style="list-style-type: none"> Stimulates oxytocin release Promotes bonding Encourages frequent suckling 	<p>Breast stimulation:</p> <ul style="list-style-type: none"> Helps the body produce more milk (prolactin production) Helps milk flow more easily during feeds (oxytocin release) Signals the body to restart milk production Builds supply through repeated demand
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HOW:

<p>Ways to stimulate:</p> <ul style="list-style-type: none"> Baby suckling at the breast: most effective Breast massage/Hand expression Using a breast pump (manual or electric) when feasible and when use and cleaning can be managed in ways that minimise risk. 	<p>Frequency:</p> <ul style="list-style-type: none"> 8–12 times in 24 hours, including night feeds 10–15 minutes per breast At least 100 minutes of total stimulation per day
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COMMON CHALLENGES:

<ul style="list-style-type: none"> No visible milk at first Baby may refuse or resist the breast Pain or discomfort due to positioning or attachment Interrupted routines or separation from the baby 	<ul style="list-style-type: none"> Limited privacy or suitable space for breastfeeding Caregiver may feel discouraged or lose confidence Lack of family or community support Pressure from others to use only formula or stop breastfeeding
---	---

These challenges are common and expected. Address them through early problem-solving and consistent support follow-up (see Action 3).

Action 2: Temporary supplementation

WHAT: Providing additional milk while breast milk supply is building. Continue to offer the breast frequently. The first and preferred option is always the mother’s own milk, through direct breastfeeding or expression. As supply increases, this can gradually replace other milk sources.

Temporary supplementation options (in order of preference):

- **Wet nursing:** preferred option if a suitable wet nurse is available, with informed consent and in a culturally appropriate and acceptable way
- **Donor human milk** from an established milk bank (where available)
- **Breast milk substitute:** only when human milk is not available or not feasible





WHY:

- The baby needs adequate nutrition while supply increases.
- Supplementation protects the baby’s growth.
- It reduces caregiver anxiety due to infant crying or weight loss.

Supplementation supports relactation; it does not replace it. In some specific situations (e.g., HIV), mixed feeding in early infancy is not recommended. Always follow current national guidance when advising on supplementation.

HOW:

At the breast		Feeding without a teat (cup, spoon or syringe)
These methods allow the baby to receive additional milk while suckling at the breast.		Use when at-breast supplementation is not possible (e.g., baby refuses the breast, caregiver is not ready or support is not available).
Drip-Drop Method	Supplementary Suckling Technique	
<p>Definition A mother’s expressed milk (if already producing), milk from a wet nurse or milk bank, or BMS is gently dripped over the breast towards the nipple while the baby is latched or attempting to latch, encouraging suckling.</p>	<p>Definition A thin feeding tube (typically 5–8 French) is taped alongside the nipple and connected to a container of expressed milk or commercial infant formula. As the baby suckles at the breast, they receive additional milk through the tube.</p>	<p>Definition Cup feeding: Milk is offered using a small open cup with a smooth edge. A small, clear cup, such as a medicine cup, can be used. The cup is brought to the baby’s lips, allowing the baby to sip or lap the milk at their own pace without using a teat, and can be used from birth.</p>

	<p>Note: Keep the milk container at or slightly below breast level to help control the flow. Observe the baby to ensure they are suckling and swallowing comfortably.</p>	<p>Use when the baby is alert and able to sip. Larger amounts of milk are needed. Refer: <i>Job Aid 6.3: Cup Feeding</i></p>
<p>Drip-drop with spoon</p>  <p>Drip-drop with syringe</p>  <p>Refer: <i>Job Aid 6.2: Drip-Drop feeding</i></p>	<p>Example of supplementary suckling technique</p>  <p>Home-made version, using a cup</p> 	<p>Spoon feeding: Small amounts of milk are offered using a spoon, allowing the baby to sip or lap the milk at their own pace. Use when very small amounts are needed. The baby is learning to feed or transitioning. Caregivers are more comfortable with small, gradual feeding.</p> <p>Syringe feeding: A small oral syringe (for example 1–5 mL, without a needle) can be used to give small amounts of milk slowly into the baby’s mouth, allowing time for swallowing. Use when small, measured amounts are needed. The baby is weak, sleepy or not able to sip well from a cup. More control over the amount and pace is needed.</p> <p>Note: Feed slowly and watch the baby for signs of swallowing. Do not force milk into the mouth. Choose the method that allows slow, responsive feeding and is acceptable and feasible for the caregiver. Continue to offer the breast frequently alongside these methods to stimulate and build milk production, even if no milk is visible yet.</p>
<p>Advantages to supplementing at the breast</p> <ul style="list-style-type: none"> • Encourages baby to latch; especially helpful for babies transitioning from bottle • Useful when baby refuses the breast • Stimulates the breast through suckling while receiving milk • Maintains emotional bonding • Supports nutrition and relactation at the same time 		<p>Advantages to feeding with a cup compared to bottle</p> <ul style="list-style-type: none"> • Reduces nipple confusion • Reduces preference for fast flow • Easier to clean in emergencies • Low-cost and widely available

<p>Drip-Drop Method advantages</p> <ul style="list-style-type: none"> • Simple equipment (cup + spoon) • Low cost and easy to implement in emergencies • Minimal hygiene complexity (no tubing to clean) • Less technically intimidating for caregivers 	<p>Supplementary Suckling Technique advantages</p> <ul style="list-style-type: none"> • Provides continuous milk flow during suckling • More suitable when larger supplement volumes are needed • Allows longer sustained feeding at the breast • May be more efficient once established • Particularly useful for very low milk supply or induced lactation 	<p>Advantages of spoon or syringe feeding</p> <ul style="list-style-type: none"> • Allows small, controlled amounts of milk to be given • Useful for babies who are weak, sleepy or learning to feed • Simple and widely available (especially spoon) • Can be easier for caregivers to control pace
<p>Challenges/Limitations</p> <ul style="list-style-type: none"> • Takes practice • Caregiver may need assistance initially • Flow must be steady (baby may get frustrated if too slow) • Requires patience and close observation <p>How to address: see Action 3</p>	<p>Challenges/Limitations</p> <ul style="list-style-type: none"> • Requires practice to position tube correctly • Hygiene considerations (tube must be cleaned carefully) • Materials may not always be available • Can feel technically intimidating at first <p>How to address: see Action 3</p>	<p>Challenges/Limitations</p> <ul style="list-style-type: none"> • Does NOT stimulate the breast • Appropriate feeding cups may not always be available <p>How to address:</p> <ul style="list-style-type: none"> • Continue breast stimulation 8–12 times per day • Continue skin-to-skin contact

To protect breastfeeding, including relactation and induce lactation, avoid bottles and pacifiers whenever possible

WHY



- Babies may develop a preference for faster flow, making it harder to feed at the breast
- Reduced breast stimulation can affect milk supply
- Increased risk of breast refusal
- Bottles and teats are difficult to clean in emergency conditions, increasing risk of contamination
- These factors can make relactation or continued breastfeeding more difficult

If bottles or pacifiers are already being used, work with the caregiver to gradually transition to breastfeeding-supportive methods.

- Sudden removal may cause distress
- Support transition step by step

Action 3: Ongoing emotional and practical support

WHAT: Consistent counselling and family support throughout the relactation or induced lactation process.

WHY: Relactation or induced lactation requires: **MOTIVATION – CONFIDENCE – PATIENCE – PHYSICAL ENDURANCE**

Milk production is hormonally sensitive:

- Oxytocin is influenced by emotional state. Stress can inhibit milk flow.
- Anxiety and fatigue reduce confidence and persistence.

Relactation or induced lactation is rarely successful without ongoing support and follow-up.

HOW:

Close follow-up	Hands-on practical support	Emotional and social support
<ul style="list-style-type: none"> • Daily follow-up at the beginning (if possible) • Frequent contact in the first 1–2 weeks • Early identification of challenges and proactive problem-solving before difficulties escalate 	<ul style="list-style-type: none"> • Help with positioning and attachment • Guide breast stimulation techniques • Support supplementation method: <ul style="list-style-type: none"> ○ Demonstrate and practise the methods (cup, drip-drop, supplementary suckling technique) ○ Observe a full feed and provide corrective guidance ○ Ensure the caregiver feels confident before practising alone • Monitor milk transfer and infant weight • Adjust the feeding plan gradually • If BMS is used: <ul style="list-style-type: none"> ○ Clear instructions on recommended preparation and hygiene ○ Ensure correct dilution and clean water use ○ Guide appropriate quantities and feeding frequency ○ Support with cup feeding and avoidance of bottle overuse ○ Close monitoring of infant growth and tolerance ○ Infant formula should never be provided on its own. Its use requires a full package of support to reduce risks, including access to appropriate supplies (such as clean water, fuel and feeding utensils), clear guidance, and ongoing follow-up. 	<ul style="list-style-type: none"> • Encourage and reassure the caregiver • Normalize slow and gradual progress • Reinforce that even small amounts of breast milk make a difference • Reduce pressure and unrealistic expectations • Acknowledge the caregiver’s feelings and experiences • Involve family members to: <ul style="list-style-type: none"> ○ Attend counselling sessions when possible ○ Understand the temporary nature of supplementation ○ Assist with drip-drop or supplementary suckling technique if needed ○ Help position the baby during feeds ○ Protect time for frequent breastfeeding ○ Reduce household workload ○ Provide encouragement and avoid pressuring the caregiver to stop

What to expect

- **For relactation:**
 - First drops of milk may appear after a few days
 - Small amounts of milk gradually increase over time
 - Noticeable changes may be seen within the first week
 - Milk supply may continue to increase over several weeks
- **For induced lactation:**
 - Early signs of milk production may appear after a few weeks
 - Usually, milk supply builds gradually over several weeks or longer

Key message: Progress is gradual and varies for each caregiver. Not all will reach a full milk supply, but every increase in breast milk matters.

Definition: Galactagogue

A galactagogue is a food, herb or medication that is believed to help increase breast milk production

Examples:

- **Lactogenic foods:** e.g., oats, moringa, ginger, green papaya
- **Herbal galactagogues:** e.g., fenugreek, fennel, cumin, milk thistle, nettle
- **Pharmaceutical galactagogues:** medications that may be used under medical supervision

Traditional galactagogues (foods, herbs) and breastfeeding:

Pros

- May increase caregiver confidence and sense of control over milk production.
- May support relaxation and psychosocial well-being, which can help caregivers continue frequent feeding.
- Part of local postpartum traditions, helping mothers feel supported and connected to their culture, routines and sense of home through familiar practices.
- Can complement recommended breastfeeding practices when used appropriately.

Cons

- Evidence for direct impact on milk production is limited or unclear.
- May shift attention away from practices that are known to support milk production, such as frequent feeding, effective milk removal and skin-to-skin contact.
- Not all natural products are safe, especially in large quantities or when used without guidance.
- May not be available, affordable or consistent in emergency settings.
- Relying on certain foods or drinks to increase milk supply may lead caregivers to feel breastfeeding depends on them, which can be challenging if they are not available.

Developing a feeding plan

Rima's story illustrates how relactation can progress gradually over several weeks. Each step combines frequent breast stimulation, supplementation, skin-to-skin contact and consistent support. Progress may vary for each caregiver, but small changes are biologically meaningful.

Rima is a 20-year-old mother in Jordan. This was her first child. Shortly after delivery, she experienced serious health complications that led to an interruption of breastfeeding.



Save the Children - Jordan

Note: This case reflects real practices that may occur in different contexts. Anise tea and other liquids are not recommended for infants under 6 months, as they can reduce breast milk intake and increase risk. Counselling should respond respectfully while supporting recommended practices that minimise risk.

Timeline: From birth to exclusive breastfeeding

Timeline	Key actions	Infant Feeding Method
Birth → First Days	<ul style="list-style-type: none"> Initial exclusive breastfeeding in the first few days after birth Rima developed puerperal fever and severe urinary tract infection 	Breastfeeding exclusively
First days → 40 days	<ul style="list-style-type: none"> Doctor advised Rima to stop breastfeeding Rima hospitalized for 40 days without baby Doctor recommended giving Adam anise tea to help with an upset stomach Counselling was provided on the recommended use of infant formula 	Family begins feeding commercial infant formula by bottle + 30 ml anise tea for Adam
2 Months	<ul style="list-style-type: none"> Breastfeeding counselling completes feeding assessment Relactation counselling begins 	Rima is feeding 90–120 ml/feed commercial infant formula, ~7 feeds/day (bottle) + 30 ml anise tea
RELACTATION STARTS		
Week 1	<ul style="list-style-type: none"> Rima stops anise feeds for Adam, as this is not recommended for infants 	Feeding commercial infant formula by bottle
Week 2	<ul style="list-style-type: none"> Counsellor encourages frequent suckling and breast massage to stimulate milk production Baby initially refuses → Rima supported to use drip-drop method To support return to breastfeeding, Rima stops bottle use. Cup feeding introduced; Rima prefers spoon. Rima initiates continuous skin-to-skin; night 'kangaroo care' initiated. Rima reports breast sensation changes. 	Continuing commercial infant formula via cup and spoon Increasing attempts at breastfeeding
Week 3	<ul style="list-style-type: none"> Rima continues frequent stimulation, drip-drop, skin-to-skin, and formula via spoon feeds Rima expresses first visible drops of milk Ongoing monitoring of feeding effectiveness, urine output and weight (where possible) 	Mixed feeding: attempts at breastfeeding + commercial infant formula supplementation
Week 4	<ul style="list-style-type: none"> Milk production increases with frequent stimulation, drip-drop and skin-to-skin Rima begins gradual reduction of formula 	Gradual reduction of formula based on feeding effectiveness, milk production, and baby's response Increasing breastfeeding

<p>After several follow-up visits</p>	<ul style="list-style-type: none"> • Ongoing counselling and monitoring • Breastfeeding in response to early hunger cues, day and night 	<p>Breastfeeding frequently in response to early hunger cues, day and night. Offering a top-up of commercial infant formula if the baby still appears hungry, gradually reducing it as breastfeeding increases.</p>
<p>By 3 Months</p>	<ul style="list-style-type: none"> • Counsellor continues follow-up and support 	<p>No formula; breastfeeding only</p>

EXCLUSIVE BREASTFEEDING

Refer: Job Aid 2.2: Care Action Plan for Mother/Caregiver and Child Receiving Skilled Support and/or Breast Milk Substitutes (Session 2: Individual Assessment in Emergencies)

This plan helps caregivers and providers systematically record:

- Assessment of the mother–baby pair
- Feeding recommendations
- Follow-up schedule and monitoring

The plan is **dynamic**: update at every visit based on progress and challenges.



Key learning points – Objective 2

- **Relactation:** restarting milk production in a woman who previously lactated
- **Induced lactation:** initiating milk production in a woman who never lactated
- **Potential for milk production:** even women who stopped breastfeeding long ago or have never breastfed can produce milk with appropriate stimulation and support
- **Reasons for relactation and/or induced lactation:** interrupted breastfeeding, mother–baby separation, adoption or foster care, perceived or reduced milk intake, or emergency situations
- **Progress is gradual:** first signs of milk may appear in days to weeks; building supply can take several weeks or longer
- **Partial supply benefits:** full milk supply is not always achieved; even partial breastfeeding provides important benefits
- **Support matters:** frequent breast stimulation, skin-to-skin contact, temporary supplementation and emotional/practical guidance are critical.
- **Small amounts count:** visible milk is not required initially; every drop contributes to supply

STEP 3: Demonstrate

Listen and watch the demonstration of a case study. This demonstration shows how the IYCF-E counsellor conducts a **first counselling session with Rima**, who wishes to breastfeed again after being separated from her baby, using practical relactation support techniques in an emergency setting.

You will see how technical knowledge about relactation is translated into counselling during an initial visit, including **starting a supportive feeding plan** and building the mother's confidence to relactate.

You will also notice the counsellor using three key counselling skills that support all IYCF-E interactions:

- Recognize and praise what a mother or caregiver and baby are doing right
- Give some relevant information
- Give practical help

Case study: Rima and Adam



Mother / Caregiver: Rima, 20 years old

Child: Adam, 2 months old

Context: Primary health facility serving displaced families

Reason for contact: Rima was separated from Adam following postpartum illness (puerperal fever and severe UTI) and hospitalization for 40 days. During this time, Adam was fed commercial infant formula by bottle. Rima has now returned home and wishes to relactate and breastfeed exclusively if possible. This is her first counselling session for relactation support.

Instructions:

- Observe how the counsellor introduces relactation in a supportive way.
- Notice how she helps Rima take the first steps towards a feeding plan. A partially filled care plan template is provided on the next page to illustrate what information is captured during this initial session.
- Pay attention to the counselling skills that build confidence, motivation and emotional support.

CARE ACTION PLAN FOR MOTHER/CAREGIVER AND CHILD RECEIVING SKILLED SUPPORT AND/OR BREAST MILK SUBSTITUTES

For infants under 6 months, mid-upper arm circumference (MUAC) cut-offs differ, and their use depends on local and national guidance. Clinical assessment remains essential for this age group. This table can be adapted to include children under 6 months if conducting MUAC for that age group.

MUAC Measurement (to nearest cm)	Normal (green) ≥ 12.5 cm	Moderate (yellow) 11.5–12.4 cm	Severe (red) <11.5 cm	Oedema (Y/N)

Name of designated IYCF-E counsellor: *Samah*

Location: *Primary Health Facility - IDP Camp*

Child's name *Adam*

Child's Gender **M**

Age/months *2 months*

Mother/ Caregiver's name *Rima*

Relationship to child *Mother*

Address/ Shelter location

Telephone

Date of initial full assessment of mother-baby pair: *1st March*

Main findings of assessment:

*Infant currently fed infant formula by bottle (~90-120 ml/feed, 7 feeds/day) plus 30 ml anise tea for the infant
Mother was separated from infant for 40 days due to puerperal fever and severe UTI*

Initial breastfeeding in first few days after birth went well and was successful
Mother is motivated to breastfeed again but is unsure about relactation
Emotional stress and sadness about time away from infant
Family support available: mother at home

Recommendations for feeding:

- (A) Continuing supportive care
- (B) Basic aid
- (C) Further help: baby refusing the breast
- (D) Further help: restorative care for the mother (needs emotional / extra support)
- (E) Further help: wet nursing
- (F) Further help: relactation
- (G) Further help: breast conditions
- (H) Further help: supported with BMS
- (I) Further help: complementary feeding

Referral / Specialized Support:

- Medical treatment/Therapeutic feeding
- Other - specify _____

FOLLOW UP / MONITORING FOR EACH CONTACT:

Choose frequency of follow-up according to each child/carer's situation. Start more frequently, then aim for weekly contacts. Add new card if necessary, e.g. if continuing support to a BMS-dependent infant. For a fully BMS-dependent child, this form **MUST** be used until BMS support is completed, until relactation or wet nursing is fully established or until the child graduates from the BMS prescription programme (at 6 months of age).

Date	1st March				
Health & Weight of child (kg) or MUAC					
Date / time / place of next contact	3rd March, Mother and Baby Area counselling room				
Notes and Agreed Actions for next visit (1 or 2)	<p>Stop anise feeds, Begin skin-to-skin contact, Start putting Adam at the breast several times a day, Start frequent breast massages Continue infant formula for now Meet next week with mother</p> <p><u>Plan for next week:</u> Check breast stimulation and teach hand expression if needed Explain cup feeding, spoon feeding, and drip drop method</p>				
Progress from last visit					

Use this space to write notes, reflections, or key takeaways from the discussion

STEP 4: Role-Play

Now it's your turn!



Timing: 10 minutes

Case study: Rima and Adam

Rima's baby, Adam, is 2 months old. Due to illness, Rima was separated from Adam for several weeks after birth and has been giving commercial infant formula and a small amount of anise tea to help digestion. Rima is now ready for her second counselling session, accompanied by her mother, to support relactation and reintroduction of breastfeeding.



Mother: Rima

Support person: Rima's mother

Child: Adam, 2 months old

Reason for contact: Second counselling session following the first session.

Current situation: Refer to the care plan started during the first visit for details on agreed actions and next steps.

Instructions:

1. Review the Counselling Skills Checklist before beginning the role-play.
2. In your groups of three, divide into specific roles:
 - One person will play the **counsellor** (leading the second counselling session).
 - One person will play **Rima** (the facilitator will give you a short role-play card with Rima's situation).
 - One person will be the **observer/Rima's mother** (the facilitator will give you a short role-play card for Rima's mother). Use the Counselling Skills Checklist below to note key strengths and areas for improvement. Do not write everything.

As you role-play, counsellors should focus on practicing three core counselling skills described below.



Reminders: Core counselling skills

- **Recognize and praise:** Highlight positive actions to build confidence and encourage progress.
 - “It sounds like you’ve been doing a lot of skin-to-skin with Adam. This can really help with bonding and support milk production.”
 - “Practising hand expression with your mother’s support shows great dedication.”
- **Give relevant information:** Provide guidance tailored to the mother’s specific challenges in a way she can follow.
 - “Hand expression can support milk production and help Adam get small amounts of breast milk.”
- **Give practical help:** Demonstrate or guide actions the mother can do immediately without being overwhelmed.
 - “Let’s try putting Adam to the breast for just a few minutes at a time.”
 - “We can practise the drip-drop method together if you’re ready.”

Counselling Skills Checklist for the observer

Instructions: Tick **Yes**, **Partially** or **No** for each skill or action you observe during the counselling session.

Counselling Skills Checklist			
ACTION 1 – FREQUENT BREAST STIMULATION & SKIN-TO-SKIN CONTACT	Yes	Partially	No
Encouraged and praised skin-to-skin contact			
Encouraged frequent attempts to put Adam to the breast (even if he refuses)			
Encouraged breast stimulation through hand expression			
ACTION 2 – TEMPORARY SUPPLEMENTATION	Yes	Partially	No
Addressed breast refusal with supplementation at the breast			
Demonstrated an appropriate supplementation-at-the-breast method (e.g., drip-drop with spoon or syringe; Supplementary Suckling Technique)			
Explained why bottle feeding is not recommended			
Explained and demonstrated cup feeding clearly			
Checked understanding with Rima and her mother			
ACTION 3 – ONGOING EMOTIONAL AND PRACTICAL SUPPORT	Yes	Partially	No
Used empathy and confidence-building to address Rima’s discouragement			
Avoided overwhelming Rima with too many changes at once			
Involved the mother appropriately as a support person			

Recognized and praised what Rima, her mother and Adam are doing right			
Gave relevant information			
Gave practical help			
CARE PLAN	Yes	Partially	No
Referred to the care plan from the first visit			
Updated the care plan based on Rima’s progress and challenges			
Summarized agreed next steps clearly at the end of the session			



Role-play debrief: Rima, her mother and Adam

1. Skin-to-skin contact

Counsellor checks that Rima is continuing frequent skin-to-skin with Adam and reinforces its benefits for bonding, milk stimulation and emotional comfort.

Sample line:

“How has it been going with skin-to-skin this week?”

→ **Remember:** Observing and praising skin-to-skin early builds confidence and sets a positive tone.

2. Breast stimulation

Counsellor encourages attempts at putting Adam to the breast, explaining that refusal is normal.

Sample lines:

“Even if Adam doesn’t attach to the breast right away, you can continue to gently offer the breast.”

“His suckling, even if brief, signals your body to produce milk.”

→ **Remember:** Gradual exposure prevents frustration and keeps Rima motivated.

3. Provide emotional support and build confidence

The counsellor notices that Rima feels discouraged because Adam has been refusing the breast. It is important to pause and address her feelings before moving to technical guidance. The counsellor acknowledges her worry, normalizes the challenge of relactation, and reinforces the progress she has already made with skin-to-skin contact and hand expression. The presence of her mother as a supportive figure is highlighted, and the counsellor reassures Rima that she is not alone and can gradually achieve success.

Sample lines:

“Many mothers see progress gradually. What you’re doing now is helping your milk production.”

“I can see this has been a bit discouraging for you, Rima. Many mothers face this at first, and it’s completely normal. I’m going to give you some new tips that will help you, and your mother is here to support you.”

→ **Remember:** Checking and validating Rima’s feelings reduces stress, reinforces her motivation and sets a positive tone for introducing new practices.

4. Reassurance and hand expression

Reassure Rima that Adam's refusal is normal. Check whether she knows hand expression and praise her skill.

Sample lines:

"It's normal that Adam might be refusing the breast at first. This is new for him, too, but you're doing everything right."

"You can express milk by hand. Let's review how confident you feel doing it."

→ **Remember:** Recognizing her existing skills reinforces motivation; hand expression ensures milk stimulation while Adam adjusts.

5. Rima mother's support

Congratulate Rima's mother for her support, especially in hand expression. Encourage her involvement in demonstrations.

Sample lines:

"It's wonderful that you helped Rima with hand expression. Would you like to demonstrate again?"

→ **Remember:** Involving Rima's mother provides practical and emotional support.

6. Drip-drop method demonstration

Explain the drip-drop method (to help Adam accept the breast), demonstrate the method and involve Rima's mother as Rima practises. Explain advantages.

Sample lines:

"To help Adam accept the breast, we can try the drip-drop method. I'll show you, and your mother can practise with you."

"This helps Adam to attach to the breast and, combined with hand expression, will help your milk come in."

→ **Remember:** Hands-on demonstration with Rima's mother ensures correct technique and builds confidence.

7. Bottle use and cup feeding

Explain why the bottle is not recommended and introduce cup feeding. Check understanding.

Sample lines:

"We want to stop using the bottle because it is very difficult to clean properly, and it can make Adam prefer the bottle over your breast, which can slow down relactation."

"Using a cup is less risky for him and helps him learn to drink in a way that supports breastfeeding."

→ **Remember:** Clear, simple guidance avoids confusion and encourages adherence.

8. Summarize next steps

Counsellor summarizes actionable next steps in line with the care plan and checks Rima's confidence in practising them.

Sample lines:

"Encourage frequent suckling to stimulate milk production."

"Try to use the drip-drop method."

"Introduce cup feeding this week, if you can."

"Continue skin-to-skin regularly."

"Do you feel comfortable trying these steps? Is there anything you'd like me to explain again?"

→ **Remember:** Summarizing ensures clarity and helps Rima feel confident about what to practise before the next session.

STEP 5: Self-reflection

Take a few minutes to think about the session. You can write your answers in the space below.

Questions:

1. How confident am I in supporting a mother or caregiver to increase her baby's breast milk intake? What might help me improve my confidence or skills?

2. How prepared am I to support a mother or caregiver with relactation or induced lactation, including providing emotional support and step-by-step guidance?

3. What challenges do I anticipate when supporting mothers with supplementation methods (cup, drip-drop, hand expression), and how can I address them effectively?

Additional notes:

Job Aid 6.1: Counselling cards

There are many breastfeeding positions



Card 7

Good attachment helps milk production



Card 8

Job Aid 6.3: Cup Feeding

CUP FEEDING

A BABY NOT FED AT THE BREAST CAN BE FED WITHOUT A BOTTLE



Cup feeding can be used from birth. It is suitable for both expressed breastmilk and infant formula. You can use any clean, open cup with a smooth surface.


Cup feeding has no notable difference to bottles for average time per feed.

Cups are safer than bottles. Bottle teats and screw tops trap germs that can get into the milk and make babies ill. Cups are easily cleaned with washing in hot soapy water, and do not need sterilising like bottles.

In emergencies, use disposable cups.


Feeding time is bonding time - lots of cuddles, eye-contact, talking, smiling, humming and singing.

CUP FEEDING IS AS EASY AS 1-2-3!



1

Sit baby upright on your lap and support their back and neck. With small babies it can help to wrap them with a cloth, to keep their hands from knocking the cup.



2

Hold a small cup of milk to rest the rim lightly on baby's lower lip. Then tilt the cup, keeping the milk at the rim of the cup, just in reach of baby's lips. Baby should be alert, and open both their mouth and eyes.



3

Go Slow. **DO NOT POUR** the milk into baby's mouth. Always let baby lead the pace of sips, swallows and pauses. Still keep the milk just at the cup's rim. When baby is full, they will close their mouth and will not take anymore.



Babies will suck or sip the milk, or may use their tongue to lap it up like in this picture on the left.

Cup feeding gives babies freedom to move their tongue in a way that is closer to the 'suckle' reflex used for breastfeeding.


Did you know you can re-establish breastfeeding through a process called relactation?

Breastfeeding saves lives, especially in emergencies.

Reach out to a breastfeeding counsellor to learn more.

Adapted from The World Health Organization - Infant Feeding in Emergencies: A Guide for Mothers and UNICEF/WHO 20-hour Baby Friendly Hospital Initiative Course by Magdalena Whoolery (PhD Health Studies, BSc Nursing, Dip HE Nursing) and Julie Fogarty (BFA, GradDipTchg), January 2020 (updated April 2020). Poster endorsed by the following:






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.*

STEP 1: Set the Scene

Why this topic?

Children 6–23 months are particularly vulnerable during emergencies. While breastfeeding may continue, complementary feeding practices are often disrupted.

Emergencies can affect:

- Access to sufficient, appropriate and diverse foods
- Familiarity and acceptability of available foods
- Availability of clean water and hygiene supplies
- Conditions for food preparation and hygiene that minimise risk
- Caregiver workload, with time and resource demands often falling heavily on the women responsible for care and feeding
- Household stress (including loss of livelihoods), which can affect caregivers' emotional wellbeing and family dynamics
- Access to health and nutrition services, including counselling and treatment
- Meal routines and feeding frequency
- Illness and recovery patterns

Complementary feeding may be overlooked during crisis response, yet it is critical for growth, immunity and development.

In emergencies:

- The goal is not a perfect diet.
- The goal is recommended, feasible and protective feeding practices.
- Counselling focuses on realistic, harm-reducing actions.
- Joint problem-solving with caregivers is essential.

STEP 2: Strengthen key knowledge, concepts and skills



LEARNING OBJECTIVE 1:

Support a caregiver's responsive feeding and caregiving practices

Responsive feeding and complementary feeding in emergencies

Responsive feeding means:

- Encouraging a child to eat without forcing them
- Watching hunger and fullness cues
- Giving time to explore food
- Adjusting when child is ill or distressed
- Offering warmth and attention
- Focusing on how (not merely what) the child is fed and supporting the child to eat safely and adequately.

In emergencies, stress, illness and disruption may:

- Reduce appetite
- Increase tension during meals
- Disrupt routines
- Reduce access to preferred or typical foods

Responsive feeding helps protect food intake, reduces tension and supports the caregiver–child relationship – especially during crisis. It helps children continue eating even when appetite is low, food is limited or routines are disrupted.

In emergencies, caregivers often adapt their feeding practices in response to stress and constraints. These patterns are common and reflect caregivers' efforts to care for their children and do the best they can under difficult conditions.

The most common adaptations are shown below. Caregivers may move between these patterns depending on stress, available resources and the support around them.

Stress-adapted feeding responses

Table: Three general stress pathways

Stress experience	Feeding pattern
Anxiety about intake	Pressure-based
Exhaustion / overload	Reduced-engagement
Emotional soothing	Comfort-focused

Table: Stress pathways: Caregiver experience, feeding pattern and risks

Caregiver experience	Feeding pattern	Why it increases in emergencies	Possible risks for the child
Anxiety about intake → Pressure-Based Feeding			
<ul style="list-style-type: none"> • Worry about weight loss or illness 	<ul style="list-style-type: none"> • Insisting, urging, rushing feeding • Repeated prompting 	<ul style="list-style-type: none"> • Reduced food availability and uncertainty about future meals 	<ul style="list-style-type: none"> • Increased tension during meals and food refusal • Higher risk of choking or unsafe swallowing

<ul style="list-style-type: none"> • Concern about wasting limited food • Strong responsibility to ensure the child eats • Stress when the child refuses or eats slowly 	<ul style="list-style-type: none"> • Forcing or pressuring the child to eat 	<ul style="list-style-type: none"> • Higher cost of food and pressure to avoid waste • Increased child illness and reduced appetite • Disrupted routines and feeding schedules • Limited time and competing demands on caregivers • Lack of access to support, services or feeding guidance 	<ul style="list-style-type: none"> • Distress or negative experiences during feeding • More conflict between caregiver and child • Negative associations with food and mealtimes • Greater risk for children with disabilities, who may need adapted textures, more time or specialized support
Exhaustion or reduced capacity to engage in feeding → Reduced-Engagement Feeding			
<ul style="list-style-type: none"> • Physical exhaustion • Grief or emotional distress • Competing survival priorities • Food insecurity and uncertainty • Caregiver illness or poor health 	<ul style="list-style-type: none"> • Less engagement and supervision during meals • Reduced encouragement or interaction • Delayed, skipped or limited complementary feeding • Reliance on breastfeeding alone beyond 6 months as a protective strategy 	<ul style="list-style-type: none"> • Increased caregiver workload and competing demands • Household stress and loss of livelihoods • Limited time, energy or support for feeding • Disrupted routines and caregiving structures • Reduced access to services or feeding support 	<ul style="list-style-type: none"> • Missed meals or reduced feeding frequency • Low overall intake • Delayed introduction or insufficient complementary feeding • Growth faltering and increased nutritional risk • Higher risk of illness and slower recovery • Young children being unintentionally overlooked
Emotional Soothing → Comfort-Focused Feeding			
<ul style="list-style-type: none"> • Wanting to reduce distress or crying • Maintaining emotional connection with the child • Avoiding conflict during meals • Wanting to provide comfort or joy despite difficult conditions 	<ul style="list-style-type: none"> • Offering preferred foods only • Using food to calm or soothe distress • Reliance on limited variety of foods • Increased use of ultra-processed, salty, sugary snack foods or drinks 	<ul style="list-style-type: none"> • Stressful or unstable environments • Disrupted routines and feeding patterns • Limited availability of diverse or familiar foods • Food becoming one of the few available sources of comfort or reassurance 	<ul style="list-style-type: none"> • Limited dietary diversity and nutrient intake • Digestive discomfort (e.g., constipation or diarrhoea) • Increased dependence on specific foods • Frustration or distress when preferred foods are unavailable • Longer-term challenges with varied and balanced eating

Supporting responsive feeding

Activity: Recognizing stress-adapted feeding patterns

Instructions: Read each caregiver quote. Draw a line to match it with the feeding pattern you recognize.

Sofia	Amina	Lina
<p><i>“By the time I prepare food, I am already exhausted. Sometimes he eats, sometimes he doesn’t. If he refuses, I leave it. There is too much happening to insist.”</i></p>	<p><i>“She gets very upset in the afternoons. The only thing that works quickly is giving her the sweet biscuits from the distribution. At least she calms down and eats something.”</i></p>	<p><i>“My daughter is small for her age. I watch her closely during meals. If she turns her head away, I bring the spoon back. She needs to eat properly. Food is not easy to get here.”</i></p>
<p style="text-align: center;">○</p> <p style="text-align: center;">○</p>	<p style="text-align: center;">○</p> <p style="text-align: center;">○</p>	<p style="text-align: center;">○</p> <p style="text-align: center;">○</p>
Pressure-based	Reduced engagement	Comfort-focused

What would you say to this caregiver to support more responsive feeding, without judging?



Key learning points – Objective 1

- Responsive feeding focuses on the interaction between caregiver and child, not only the food.
- In emergency situations, stress, illness and disruption can change feeding behaviours.
- Stress-adapted feeding responses are coping strategies, not signs of poor parenting.
- The three common patterns are:
 - Pressure-based
 - Reduced-engagement
 - Comfort-focused

These patterns may overlap or change depending on stress, resources and support.
- Counsellors should:
 - Respond without blame and acknowledge caregivers’ efforts
 - Understand what is driving the feeding behaviour
 - Reduce stress and tension during feeding interactions
 - Work with caregivers to identify small, realistic changes
 - Link families to additional support when needed (e.g., food assistance, health services, MHPSS or protection services)
- Responsive feeding helps protect food intake and growth and supports the caregiver–child relationship during a crisis.

LEARNING OBJECTIVE 2:

Assess nutrition risk and possible causes of poor growth in a child over 6 months

See *Session 2: Individual Assessment in Emergencies* for the **Priority Triage Tool**, the **Simple Rapid Assessment Tool** and the **Full Assessment Tool**



Key learning points – Objective 2

- **Priority Triage Tool:** identifies children in need of immediate help (Priority 1) or at risk (Priority 2).
 - Priority 1: Children who are maternal orphans or who are sick, severely malnourished (MUAC <11.5 cm), living with a disability affecting feeding, under extreme distress, separated/unaccompanied, and/or receiving delayed/no complementary feeding (>6 months).
 - Priority 2: Children who are recovering from illness, have limited dietary diversity, are identified with moderate acute malnutrition (MUAC 11.5–12.4 cm), are parented by first-time/adolescent mothers or are living in a household with food insecurity.
- **Simple Rapid Assessment (SRA):** rapid screening for feeding practices, child illness, caregiver stress and possible nutritional risks.
- **Full Assessment (FA):** detailed review including MUAC, danger signs, maternal/caregiver wellbeing, complementary feeding status, known risk factors and caregiver–child interaction.
 - Danger signs (lethargy, vomiting everything, difficulty drinking, severe respiratory problems) take priority. Refer immediately.
 - Feeding difficulties (choking, coughing, refusal of solids) may indicate medical, developmental or disability-related issues. These are often visible while observing complementary feeding.
 - MUAC alone does not rule out nutritional risks; a full assessment is essential.
 - Caregiver stress, illness, violence exposure or lack of support can affect feeding more than knowledge alone.
 - Observing caregiver–child interactions provides insight into real-life feeding practices and helps guide support or referral.



LEARNING OBJECTIVE 3:

Counsel a caregiver on complementary feeding during extreme food insecurity

Understand the reality families face

Table: How complementary feeding changes in extreme food insecurity

Area of change	In stable settings	In emergencies / extreme food insecurity
Family practices	Aim for dietary diversity	Aim for enough food, safely prepared
	Introduce new foods regularly	Use familiar, available foods
	Build structured meal routines	Use flexible feeding opportunities
	Caregiver has time and support for feeding	Limited time, high workload, stress affecting feeding
	Access to cooking, storage and safe preparation	Limited fuel, water or safe preparation space

Applying a practical counselling approach in extreme food insecurity

Counselling begins by understanding the family's situation:

- What food is available today?
- What is the child currently eating?
- What challenges is the caregiver facing in terms of safety, stress, and household decision-making?
- What support systems are available?

After assessing the situation, counsellors focus on the five priorities that protect the child most. Counsellors prioritize actions that protect the child most immediately before focusing on diet quality.

Table: Five counselling priorities for complementary feeding in extreme food insecurity

Priority	Explanation
1. Protect breastfeeding	Encourage continued breastfeeding. It provides critical nutrition and immunity protection, especially when complementary foods are limited.
2. Ensure the child eats enough food each day	Focus on safe ways to maximize intake of whatever foods are available, including multiple small meals or snacks if needed.
3. Improve nutrient value using available foods	Support caregivers to make small, realistic changes that improve nutrient intake, for example by combining available foods for better protein or micronutrient content, using locally acceptable and feasible options.
4. Reduce infection risks	Highlight practical hygiene and food-safety actions feasible in a household or shelter context, e.g., clean water, handwashing, hygienic storage and reheating.
5. Link families to support and services	Connect families to available assistance: food/cash distributions, WASH, health, protection, MHPSS, early-childhood care and development, additional nutrition services.

Counselling reminder: Focus on small, realistic improvements that are feasible for the family and help minimise risk. Avoid suggesting changes that are not feasible given the family's current resources and conditions.



Key learning points – Objective 3

- Complementary feeding recommendations remain the same. In emergencies, counselling prioritizes protecting intake, safety and caregiver capacity and working within tighter constraints/more limited options, rather than focusing on achieving ideal diets.
- Breastfeeding remains protective, and should continue alongside the introduction of complementary foods from 6 months, for up to 2 years and beyond.
- Focus on small, realistic improvements that are achievable in the current context, rather than aiming for diets that may not be possible.
- Understanding the family's context, available foods and caregiver constraints is critical.
- Responsive feeding focuses on the interaction between caregiver and child, not only on the food, and supports children to continue eating during difficult conditions.

STEP 3: Demonstrate

Listen and watch the demonstration of a **group counselling session with fathers**. This demonstration shows how an **IYCF-E counsellor guides a discussion** on complementary feeding during difficult times, using practical strategies to support young children’s nutrition in situations of extreme food insecurity.

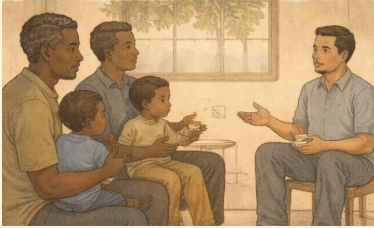
You will see how the counsellor:

- Encourages fathers to share experiences and observations about children’s eating
- Helps fathers identify small, feasible actions to support young children’s feeding and caregiving within the household, including how they can support and share caregiving roles
- Facilitates discussion without lecturing, letting **solutions emerge from the group**

You will also notice the counsellor using three key counselling skills that support all IYCF-E interactions:

- Asks open questions
- Avoids using words that sound judgmental
- Makes one or two suggestions rather than giving commands

Context:

	<ul style="list-style-type: none"> • Setting: Community or primary health facility serving families affected by drought and illness • Participants: Fathers from the community • Focus: Young children learning to eat, maintaining intake after illness and supporting calm mealtimes
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Instructions:

- Observe how the counsellor guides discussion and encourages fathers’ participation
- Notice how fathers share practical ideas and solutions to support mothers and children
- Take note of techniques, tone and phrasing that help fathers understand their role in complementary feeding

Use this space to write notes, reflections or key takeaways from the discussion

STEP 4: Role-Play

Now it's your turn!



Timing: 10 minutes

Case study: Angela and Adeline

Many families are managing multiple stressors, including illness, drought and competing responsibilities. Young children may eat less or irregularly during these times.



Mother/Caregiver: Angela

Child: Adeline, 21 months

Location: Home visit. Angela has recently enrolled Adeline in the Blanket Supplementary Feeding Programme, which provides additional food rations for young children. The counsellor visits her at home to provide support with feeding Adeline.

Reason for contact: Angela has mentioned that she is concerned about Adeline's eating. During this visit, the counsellor will explore the situation with Angela and work with her to identify practical ways to support Adeline's feeding at home.

Instructions:

1. Review the Counselling Skills Checklist before beginning the role-play.
2. In your groups of three, divide into specific roles:
 - One person will play the **counsellor**.
 - One person will play **Angela** (the facilitator will give you a short role-play card with Angela's situation).
 - One person will be the **observer**. Use the Counselling Skills Checklist below to note key strengths and areas for improvement. Do not write everything.

As you role-play, counsellors should focus on practicing three core counselling skills described below.



Reminders: Core counselling skills

- **Ask open-ended questions.** Open questions allow the caregiver to give more detailed information, without suggesting a pre-determined answer. For example:
 - “Do you feed her three times a day?” → “Can you describe how you feed Adeline throughout the day?”
 - “Does she eat enough?” → “What happens when Adeline eats her meals?”
 - “Do you give food with a spoon?” → “How do you usually offer food to Adeline?”
 - “Does she finish her food?” → “What happens if Adeline doesn't finish a meal?”
- **Avoid using words that sound judging.** Judgmental words or tones can make a caregiver feel blamed or ashamed, which may stop them from sharing concerns. Avoid statements that evaluate, label or compare behaviours, even if intended positively. Focus on encouragement and understanding instead. For example:
 - Say: “It sounds like you are trying your best to help Adeline eat, even when meals feel rushed.”
 - Avoid: “You shouldn't force her to eat.”

- **Make one or two suggestions, not commands.** Offer practical ideas without giving orders. This encourages caregivers to choose what works best in their context.
 - Say: *“Sometimes it helps if someone sits calmly with Adeline while she eats. Would you like to try that this week?”*
 - Avoid: *“You must sit with her at every meal.”*

Counselling Skills Checklist for the observer

Instructions: Tick **Yes**, **Partially** or **No** for each skill or action you observe during the counselling session.

Counselling Skills Checklist			
EXPLORE AND UNDERSTAND THE SITUATION	Yes	Partially	No
Asked open-ended questions about the child’s current feeding			
Asked about what foods are available today			
Explored challenges the caregiver faces in feeding the child			
Asked about caregiver’s support system (other family members, helpers)			
Reflected back caregiver’s responses to check understanding			
Identified patterns in feeding (pressure-based, reduced-engagement, comfort-focused) without blaming			
Avoided judgmental words or tones			
SUPPORT THE CAREGIVER TO IDENTIFY PRACTICAL ACTIONS	Yes	Partially	No
Encouraged the caregiver to share ideas or experiences about what helps the child eat			
Helped caregiver identify realistic ways to increase child intake (e.g., multiple small feeds, offering food calmly, sitting with the child)			
Encouraged shared responsibility for feeding where possible			
Prioritized 1–2 manageable actions rather than giving multiple commands			
Checked caregiver understanding of and agreement with suggested approaches			
Summarized agreed next steps clearly at the end of the session			



Role-play debrief: Angela and Adeline

1. Explore the caregiver's situation with open questions

The counsellor begins by asking open questions to understand Angela's experience feeding Adeline. Rather than assuming the problem, the counsellor explores what Adeline is currently eating, what foods are available and what happens during meals. The counsellor also asks about Angela's daily responsibilities and who helps with childcare.

Sample lines:

"How have meals been going for Adeline lately?"

"Can you describe what a typical mealtime looks like in your home?"

"What foods are available for Adeline these days?"

→ **Remember:** Open questions help caregivers share their experience in their own words. This allows the counsellor to understand the situation more fully before suggesting solutions.

2. Understand feeding challenges without blame

As Angela describes the situation, the counsellor listens carefully and recognizes possible feeding patterns, such as insisting that the child eats, rushing meals or limiting time to sit with the child. Instead of criticizing these behaviours, the counsellor focuses on understanding what drives them: stress, food scarcity, exhaustion, etc.

Sample lines:

"It sounds like you are trying hard to make sure Adeline eats enough."

"Many families feel worried about food being wasted, especially when food is limited."

→ **Remember:** Feeding challenges during emergencies are often linked to stress and difficult circumstances. Avoiding blame helps caregivers feel respected and more willing to consider new approaches.

3. Reduce stress in the feeding interaction

The counsellor helps Angela reflect on how the atmosphere during meals can affect a child's appetite. Young children often eat better when mealtimes feel calm and unhurried. The counsellor gently encourages small adjustments that may make meals less stressful for both the caregiver and the child.

Sample lines:

"Sometimes children eat better when someone sits calmly with them during meals."

"Giving the child a little more time can sometimes help them eat more comfortably."

→ **Remember:** Reducing pressure during meals can improve a child's willingness to eat and make feeding a more positive experience for both the child and the caregiver.

4. Suggest small, realistic actions

The counsellor offers one or two practical suggestions that fit Angela's situation. These suggestions are simple and achievable within the family's daily routine. The goal is to support Angela to try making small changes rather than overwhelming her with many instructions.

Sample lines:

"One idea could be offering smaller portions and letting Adeline ask for more if she wants."

"Would it be possible for someone to sit with her during meals when you are busy?"

→ **Remember:** Small, realistic actions are more likely to be tried and sustained. Giving too many instructions at once can make caregivers feel overwhelmed.

5. Recognize the caregiver’s efforts and strengths

The counsellor acknowledges Angela’s efforts to care for her children despite managing her many responsibilities. Recognizing what the caregiver is already doing well helps build confidence and strengthens the counselling relationship.

Sample lines:

“You are doing a lot to care for your children, even with so many responsibilities.”

“It’s clear you care very much about helping Adeline eat well.”

→ **Remember:** Positive feedback helps caregivers feel respected and supported, which increases their confidence and motivation.

6. Summarize and agree on next steps

At the end of the visit, the counsellor summarizes the discussion and confirms one or two actions Angela would like to try. This helps ensure that both the counsellor and the caregiver have a clear understanding of the next steps.

Sample lines:

“So today we talked about trying to make mealtimes a little calmer and giving Adeline smaller portions.

How do you feel about trying these this week?”

“We can talk again next time about what worked well and what was difficult.”

→ **Remember:** Ending the session with clear, agreed next steps helps caregivers leave the conversation feeling supported and confident about what to try next.

STEP 5: Self-reflection

Take a few minutes to think about the session. You can write your answers in the space below.

Questions:

1. How confident am I to support a caregiver like Angela in improving her child’s feeding patterns? What might help me improve my confidence or skills?

2. How prepared am I to guide a caregiver in an emergency setting towards making small, realistic changes to increase a child's intake and nutrient variety, while reducing stress during meals?

3. What challenges do I anticipate when supporting caregivers in a home setting with limited resources, and how can I address them effectively?

Additional notes:

SESSION 8: ASSESSING AND SUPPORTING INFANTS RECEIVING BREAST MILK 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 and act on violations of the Code as a frontline worker



COUNSELLING SKILLS FOCUS*

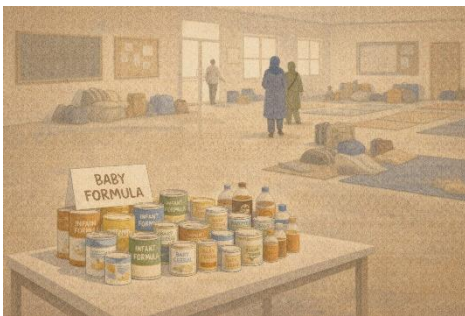
- Reflect back what the mother/caregiver says
- Use simple language
- Give practical help

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

STEP 1: Set the Scene

In crisis situations, caregivers may turn to commercial infant formula or other breast milk substitutes when breastfeeding is disrupted or perceived as insufficient. If not guided properly, this can lead to feeding practices that are high risk and carry serious health concerns for infants.

Scenario: Untargeted infant feeding support in an evacuation setting



Following an industrial accident that released toxic gas into residential areas and contaminated the town's main water supply, residents have been evacuated. Most evacuees are now staying in a former school building with no kitchen facilities.

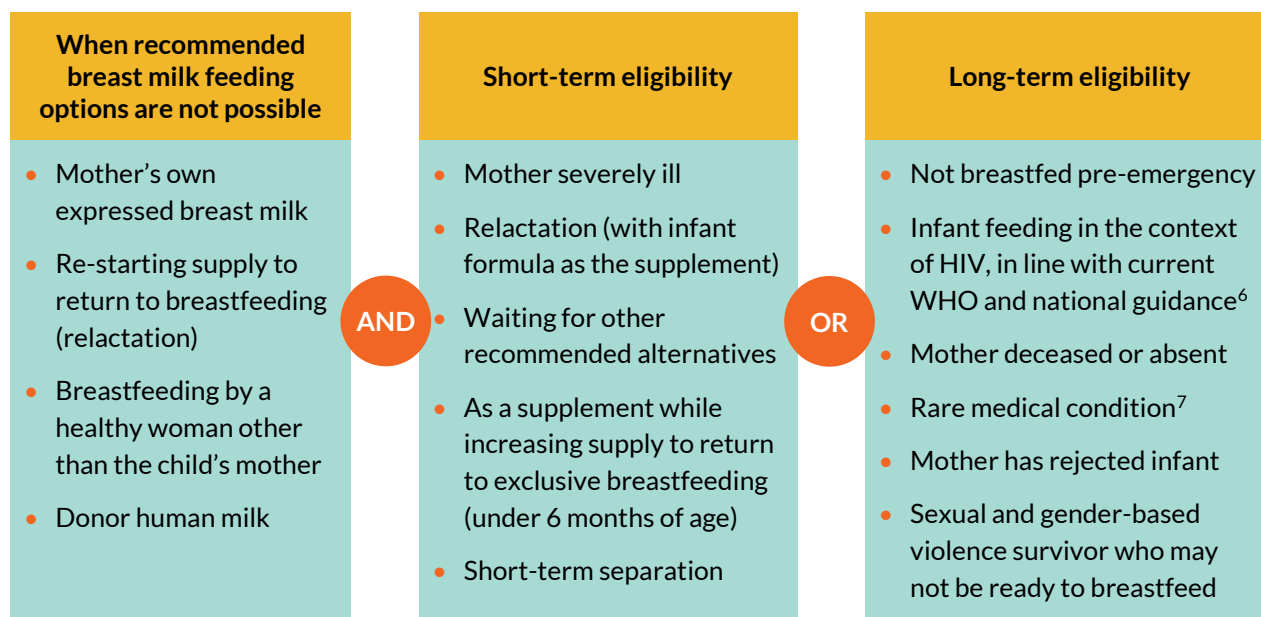
As you arrive to set up a Mother-Baby Area, you notice a table in the main reception area labelled 'BABY FORMULA'. It is piled high with different tins of infant formula, baby cereals, evaporated milk and sweetened drinks.

You overhear a staff member telling a family with a very young baby, "Take whatever you need."

Question:

What concerns you about this situation?

Visual: Criteria for commercial infant formula eligibility





Infographic Series: *Supporting Infants Dependent on Artificial Feeding During Emergencies* – 2021, IFE Core Group

Determine whether commercial infant formula can be used hygienically at home

Can commercial infant formula be used as recommended?

Before providing commercial infant formula, it is essential to determine whether it can be used in the recommended way in the caregiver’s environment.

Visual: Requirements for commercial infant formula use

What is needed	 Powdered Infant Formula (PIF)	 Ready-to-Use Infant Formula (RUIF)
Potable water for reconstitution	YES	
Handwashing facilities	YES	YES
Clean and dry storage	YES	YES
Heat source	YES	YES
Washing facilities (clean water and sink/washing-up bowl)	YES	YES Use disposable cups if heat source and washing facilities are not available.

⁶Refer to WHO guidance on HIV and infant feeding for global recommendations. Always follow your national protocol. <https://www.who.int/tools/elena/interventions/hiv-infant-feeding>

⁷ Refer to WHO for a small number of acceptable medical reasons: https://apps.who.int/iris/bitstream/handle/10665/69938/WHO_FCH_CAH_09.01_eng.pdf

Can a BMS kit be provided to ensure hygienic preparation at home?

YES

Provide the kit

NO

Provide on-site feeding with 24/7 access

Infographic Series: *Supporting Infants Dependent on Artificial Feeding During Emergencies* – 2021, IFE Core Group

Refer to *Job Aid 8.1: Counselling Card: Conditions needed to feed the non-breastfed infant* for additional explanations.

Provision of targeted commercial infant formula and associated supplies (BMS Kit)

Provide BMS only to eligible infants, ensuring the right product; correct quantity; and all necessary supplies for hygienic preparation, feeding and household hygiene.

Visual: Appropriate BMS and required supplies

Specify appropriate BMS

An appropriate commercial infant formula is Codex Alimentarius-compliant and meets the provisions of the WHO International Code.

	Ready-to-Use Infant Formula	Powdered Infant Formula	Pasteurized/boiled full-cream animal milk	Ultra-High-Temperature (UHT) milk	Reconstituted evaporated milk	Fermented milk/ yoghurt	Toddler/follow-on/growing-up milks/powdered milks (like Nido) and sweetened, condensed milks
0–5 months Priority group	✓	✓	✗	✗	✗	✗	✗
6–11 months	✓	✓	✓	✓	✓	✓	✗
12–23 months	✗	✗	✓	✓	✓	✓	✗

- Products with **generic labelling** are preferred, followed by commercial (branded) products.
- Each individual container should be **labelled** with information dictated by the WHO International Code, in the language understood by the end user. If the label violates the Code, consider relabelling.



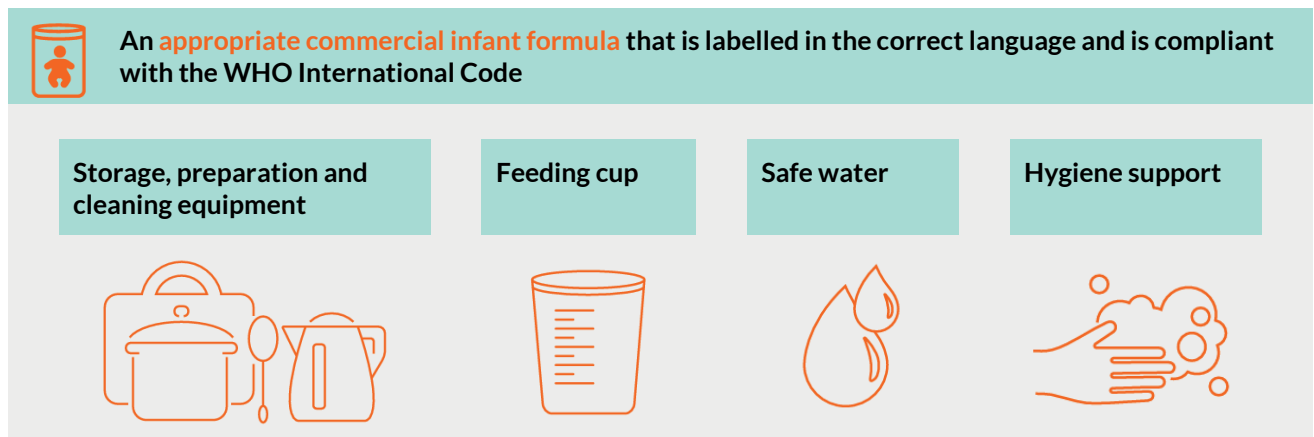
- Supplies should have a **six-month shelf life** from point of delivery. **Check expiry date.**
- Ready-to-Use Infant Formula is a sterile product only until opened and requires refrigeration afterwards.
- For Ready-to-Use Infant Formula, **small volume** units are preferred to prevent re-use and wastage.

Infographic Series: *Planning and Managing Artificial Feeding Interventions in Emergencies* – 2021, IFE Core Group

Distribution guidance:

- **Keep distributions discreet:** Avoid drawing attention to caregivers receiving commercial infant formula.
- **Consider safety and security:** Ensure caregivers can safely transport and store supplies.
- **Provide manageable quantities:** Balance what can be carried with continuity of supply.
- **Reduce risk of resale or diversion:** Follow programme guidance to minimize resale or diversion.

Visual: BMS kit



Infographic Series: *Supporting Infants Dependent on Artificial Feeding During Emergencies* – 2021, IFE Core Group

Necessary supplies	
✓ Feeding cup and spoon (open, without spout, easy to clean)	✓ Large storage container
✓ Detergent	✓ Clean water
✓ Paper towel	✓ Cooking pot with lid
✓ Measuring tool for commercial infant formula	✓ Heat source

Infographic Series: *Planning and Managing Artificial Feeding Interventions in Emergencies* – 2021, IFE Core Group



Key Learning Points – Objective 1

- Commercial infant formula is **used only when recommended breast milk feeding options are not possible**.
- **Eligibility for commercial infant formula** requires a one-on-one full assessment by a trained health or nutrition worker.
- **Explore recommended first-line feeding options first** (mother’s own milk, relactation, wet-nursing, donor human milk).
- **Commercial infant formula is only provided when** no alternative is possible and when the environment allows for recommended use.
- Commercial infant formula provision requires a complete package:
 - Appropriate commercial infant formula (PIF or RUIF)
 - Correct quantity
 - Storage, preparation and cleaning equipment
 - Feeding cup
 - Clean water
 - Hygiene support
- **Untargeted distribution is extremely high risk:** can undermine breastfeeding, increase population-level risk and create unnecessary demand.

LEARNING OBJECTIVE 2:

Counsel caregivers on recommended feeding practices when using commercial infant formula

Counsel and demonstrate how to feed the child in a way that reduces risks and follows recommended practices

Using commercial infant formula to reduce risk depends not only on the product but on how it is prepared, fed to the infant and managed over time. Caregivers need clear, practical guidance and hands-on support to feed infants in the recommended way to reduce risks.

Visual: Counsel and demonstrate how to feed an infant using commercial infant formula

				
Correct, hygienic preparation 1-1 practical demo	Responsive feeding	Cup feeding 1-1 practical demo	Where and when to seek medical care	Clean and appropriate storage in a dry location
Remember!		Remember!		
Over- and under-dilution is DANGEROUS		Feeding bottles are NOT recommended		
Instructions for preparation				

Steps	Actions	PIF	RUIF
1	Wash hands thoroughly with soap and water for at least 20 seconds.	✓	✓
2	Carefully sterilize the feeding (e.g., cup) and preparation equipment. Ensure a clean preparation surface.	✓	✓
3	Boil fresh, clean water. Leave the covered water to cool to no less than 70°C. <i>Tip:</i> It takes 1 litre of water about 30 minutes to cool to 70°C; do not wait longer.	✓	✗
4	Following the product's instructions, combine the correct amount of hot water with the exact amount of powder in a cleaned and sterilized measuring jug (using the measuring scoop provided with the product).	✓	✗
5	Mix well with a cleaned and sterilized spoon.	✓	✗
6	Cool the prepared formula until it feels lukewarm, not hot, when dripped on the inside of a wrist.	✓	✗
7	Pour the infant formula into a cleaned and sterilized feeding cup and offer it to the infant.	✓	✓
8	Throw away any feed that has not been consumed within 2 hours.	✓	✓
9	Thoroughly clean feeding and preparation equipment after use.	✓	✓

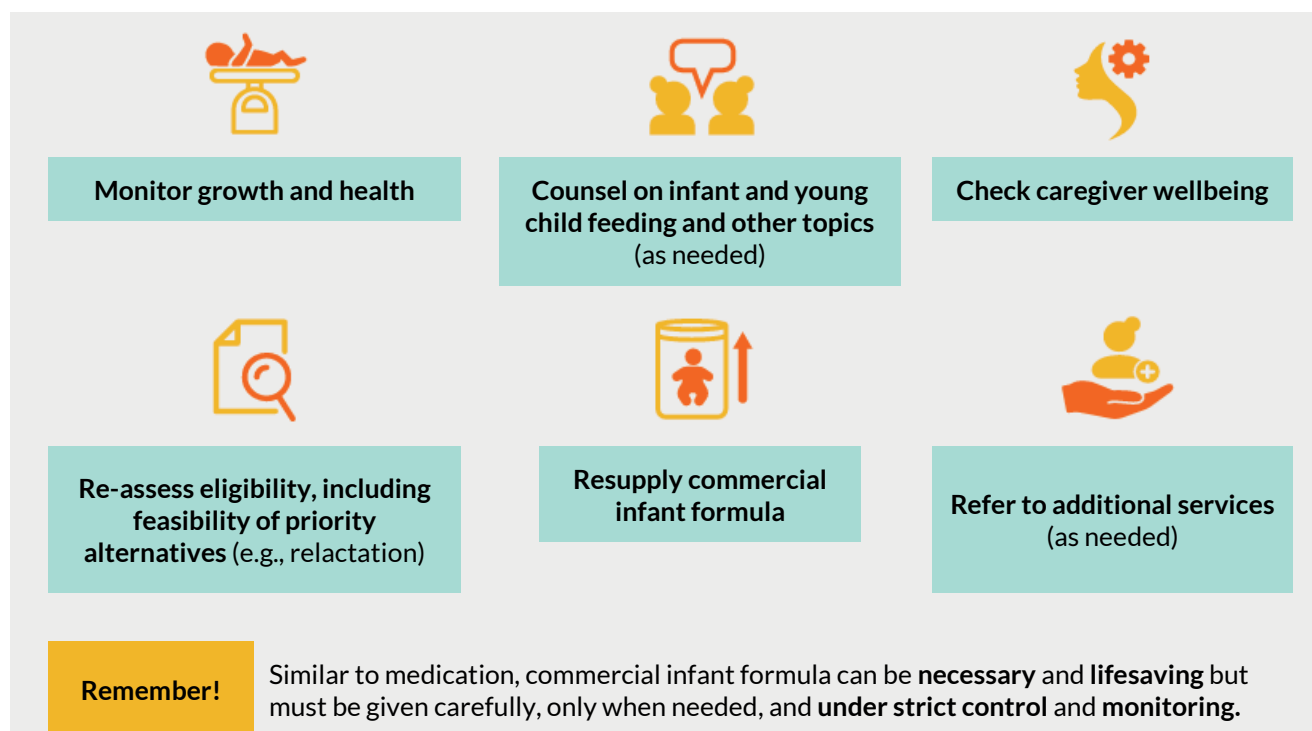
Infographic Series: Supporting Infants Dependent on Artificial Feeding During Emergencies – 2021, IFE Core Group

Refer to *Job Aid 8.2: Counselling Card: Feeding the non-breastfed infant 0 up to 6 months*. You can use this card as a practical guide when counselling caregivers to demonstrate preparation and cup feeding.

Establish a regular follow-up schedule (every 2 weeks or more frequently)

Regular follow-up is essential to ensure that infants receiving commercial infant formula are monitored and fed in a way that reduces risk. It also allows caregivers to receive ongoing support, for feeding plans to be adjusted as needed, and to reassess whether priority feeding recommendations can be used.

Visual: Follow-up visits



Infographic Series: *Supporting Infants Dependent on Artificial Feeding During Emergencies* – 2021, IFE Core Group

Repeat follow-up visits regularly, until the infant can be fed with breast milk or transitions to recommended feeding for their age. Ensure caregivers are supported throughout the transition, particularly when their infant is around 6 months.

Commercial infant formula should be provided only for as long as needed, with regular reassessment. In humanitarian response commercial infant formula is generally prioritised for infants under six months however, in some programmes, support may continue up to 12 months based on programme criteria and context. Use beyond this should only occur if medically indicated.

For infants 6 months and older who are not breastfed, other milks (e.g., full-fat fresh or UHT animal milk) may be used alongside appropriate complementary feeding rather than commercial infant formula.

Refer: *Job Aid 8.2: Counselling Card: Feeding the non-breastfed infant 0 up to 6 months* (Session 2: Individual Assessment in Emergencies). This tool lists the main items to discuss with caregivers during counselling and follow-up visits.



Key Learning Points – Objective 2

- Correct use of commercial infant formula depends on correct preparation according to the specific product, feeding practices and ongoing support.
- Caregivers need **practical, hands-on counselling**, including demonstration and observation of feeding practices.
- Hygienic preparation of commercial infant formula and cleaning of feeding utensils is critical: incorrect dilution or poor hygiene can lead to serious illness, malnutrition or death.
- **Responsive feeding is essential:** Caregivers should follow infant cues and maintain close interaction with the child.
- **Cup or spoon feeding is recommended**, as it is more hygienic and easier to clean than bottles in emergency settings. Cups and spoons can be used from birth.
- Caregivers should know when and where to seek medical care if concerns arise.
- Hygienic storage and handling of commercial infant formula is necessary to prevent contamination.
- **Regular follow-up (at least every 2 weeks or more)** is required to monitor the infant, support the caregiver, adjust the feeding plan and provide more supplies.
- Commercial infant formula support should be treated as a **temporary, carefully monitored intervention** and continued only as long as needed.
- At each visit, reassess eligibility and prioritize feeding options that include breast milk whenever possible.



LEARNING OBJECTIVE 3:

Identify & act on violations of the Code as a frontline worker

Understanding the code

During emergencies, we must not solicit, donate, accept, or distribute donations of BMS and other related products. These products can put infants at serious risk.

Visual: Prohibited Donations



Prohibited donations

Donations and uncontrolled distributions of the following products put infants at risk:

Breast milk substitutes, including

- Infant formula (all types)
- Follow-on formula and growing-up milk
- Other milk products, e.g., dried or liquid cow's milk, soya milk, evaporated or condensed milk, fermented milk or yoghurt
- Baby teas, juices and waters marketed as suitable for infants under 6 months
- Any commercial complementary food marketed for use for infants under 6 months

Feeding products used with BMS, including:

- Bottles, teats, breast pumps
- Dummies or pacifiers

Adapted from Infographic Series: *Preventing and Managing Inappropriate Donations Breast Milk Substitutes and Other Prohibited Products* – 2021, IFE Core Group

Visual: A Quick Guide to WHO Code Basic

A Quick Guide to WHO Code Basics

What products does the Code cover?

- BMS for babies, toddlers and young children up to 36 months, including follow-on and growing-up milks
- Any food or drink marketed for babies under 6 months
- Commercial baby foods or drinks that do not meet global and national standards (marketed for babies, toddlers and young children 6–36 months)
- Bottles, teats or nipples

Who is expected to follow the Code?

- Everyone, even if it is not written into national law
- Manufacturers, distributors and retailers of any of the above items
- Healthcare workers, both professionals and volunteers
- Healthcare facilities, e.g., hospitals, clinics

What must be on the label?

- Labels must be in the local language
- Information must include the risks associated with not breastfeeding and with the use of commercial infant formula
- Labels cannot use idealizing language or images, such as a happy baby sleeping or a protective shield (i.e., suggesting baby is protected by this product)

What is allowed under the Code?

- ✓ Use of commercial infant formula for babies who require it after a one-to-one full assessment
- ✓ Scientific and factual information for healthcare professionals (e.g., “contains Arachidonic acid [AA]”)
- ✓ Accurate information on hygienic and recommended commercial infant formula preparation (required on all labels)

What is NOT allowed under the Code?

- ☒ Promotion to parents, health professionals or in health facilities: advertising, free supplies of formula or free samples, gifts, posters
- ☒ Health claims not substantiated by scientific evidence (e.g., “promotes excellent visual development”)
- ☒ Promotion of unsuitable products for babies (such as sweetened condensed milk)
- ☒ Donations of BMS or feeding equipment in emergencies. Cash donations for local agencies to support families are the acceptable alternative.

Adapted from Infographic – A Quick Guide to WHO Code Basics (2020), [International Code - La Leche League International](#)

Why this matters

- The Code is designed to protect breastfeeding and ensure that breast milk substitutes are only used when necessary and with appropriate support.
- Inappropriate promotion, donations or untargeted distribution can influence feeding decisions, reduce breastfeeding and increase risks for infants.
- Even well-intentioned actions can cause harm. Following the Code helps protect infants and caregivers, even in complex emergency settings.

Your role: how to act

Table: Dos and Don'ts

DO	DONT
<ul style="list-style-type: none"> • Securely store BMS or other related products. Manage them in coordination with your supervisor or designated focal point. • Inform your supervisor or organization about any donations or distributions. • Report any untargeted donations or distributions to the IYCF coordination body. • Provide factual, neutral guidance to caregivers if they are using BMS through a programme. • Ensure confidentiality and discretion when managing products. • Be aware of protection risks, including pressure to share, theft or tension within the community. 	<ul style="list-style-type: none"> • Do not accept or distribute donations of BMS or related products outside of targeted, assessed programmes. • Do not use or display materials or equipment with BMS company branding. • Do not promote BMS in any way, including through visible storage, displays or advertising. • Do not give caregivers free samples, gifts or incentives from BMS companies. • Do not allow BMS companies to contact or advise caregivers. • Do not provide information that is linked to brands or promotional messages.



Key Learning Points – Objective 3

- The WHO International Code of Marketing of Breast Milk Substitutes sets minimum standards for the marketing and distribution of BMS and related products.
- The Code does not prohibit the use of BMS when needed; it protects infants and caregivers from inappropriate marketing and unsafe practices.
- In emergencies, do not solicit, accept, donate, or distribute BMS and related products.
- Uncontrolled donations and marketing can:
 - Undermine breastfeeding
 - Increase inappropriate use of BMS
 - Raise the risk of diarrhoea, malnutrition, illness and death
- Products covered by the Code include:
 - Infant formula, follow-on and growing-up milks
 - Other milk products and drinks marketed for infants
 - Bottles, teats and feeding equipment
 - Foods and drinks marketed for infants under 6 months
- Frontline workers play a critical role as the last line of defence.
- Follow the Code at all times:
 - Refuse inappropriate donations
 - Document and report violations
 - Avoid use of branded or promotional materials in counselling

STEP 3: Demonstrate

Listen and watch the demonstration of a case study. This demonstration shows how the IYCF-E counsellor conducts a counselling session with Amina, following a full assessment and referral for support with feeding her 3-month-old baby Sara using powdered infant formula she bought from a local shop. The focus is on providing practical, supportive guidance to reduce risks and adapt feeding practices to her environment.

You will see how technical knowledge about feeding infants who are not receiving breast milk is translated into counselling, including identifying key risks; reinforcing recommended practices; and agreeing on small, achievable actions with the caregiver.

You will also notice the counsellor using three key counselling skills that support all IYCF-E interactions:

- Reflect back what the mother or caregiver says
- Use simple language
- Give practical help

Case study: Amina and Sara



Mother / Caregiver: Amina, 26 years old

Child: Sara, 3 months old

Context: Temporary shelter in a displacement camp

Reason for contact: Amina is living in a displacement camp with her 3-month-old daughter, Sara. They are staying in a temporary shelter with limited privacy and difficult living conditions. Access to water, fuel and hygiene supplies is inconsistent.

Sara is currently being fed with commercial infant formula; she is not breastfed. Amina is purchasing the commercial infant formula herself, and she is increasingly worried about the cost and whether she can continue to afford it. Amina is trying to care for Sara in a challenging environment and is unsure of how to prepare and give the commercial infant formula correctly with the resources available to her. She is worried about Sara's feeding and health, and she is seeking support on how to feed her infant in a way that follows recommended practices.

This is Amina's first session with the counsellor who manages the commercial infant formula programme. She has already had a full assessment to explore other breast milk options. These were not possible, so she was referred here.

Instructions:

- Observe how the counsellor engages Amina in a respectful, non-judgmental way.
- Notice how she explores Amina's current feeding practices, challenges and concerns, including cost and access to resources.
- Pay attention to how the counsellor provides practical guidance on feeding that follows recommended practices and reduces risks in the current environment.
- Observe the counselling skills used to build Amina's trust and confidence and to support her in caring for Sara.

Use this space to write notes, reflections, or key takeaways from the discussion

STEP 4: Role-Play

Now it's your turn!



Timing: 10 minutes

Case study: Amina and Sara

- **Mother:** Amina
- **Child:** Sara, 3 months old
- **Reason for contact:** Second counselling session and follow-up



Amina continues to feed Sara with powdered infant formula that she is purchasing herself. Since the last session, she has started to apply some of the agreed steps, including preparing each feed when needed and trying to cup-feed. However, she is finding it difficult to follow all the recommendations consistently because water, fuel and time are all limited. She remains concerned about the cost of formula and whether she can continue to afford it.

Amina has returned for follow-up support to review progress, address challenges and adjust the feeding plan based on what is realistic in her situation.

Instructions:

3. Review the Counselling Skills Checklist before beginning the role-play.
4. In your groups of three, divide into specific roles:
 - One person will play the **counsellor** (leading the second counselling session).
 - One person will play **Amina** (the facilitator will give you a short role-play card with Amina's situation).
 - One person will be the **observer**. Use the Counselling Skills Checklist below to note key strengths and areas for improvement. Do not write everything.

During the role-play, counsellors should focus on practising the three core counselling skills described below.



Reminders: Core counselling skills

- **Reflect back what the mother/caregiver says:** Show you are listening and understand her situation.
 - *“It sounds like you’re worried about the cost of the infant formula and whether it will last.”*
 - *“You’re trying to follow the steps we discussed, but it’s difficult with limited water and fuel.”*
- **Use simple language:** Give clear, easy-to-follow information that fits the caregiver’s situation.
 - *“Prepare each feed just before giving it to the infant. Bring water to a rolling boil, then let it cool slightly. Use while it is still very hot.”*
 - *“Using a cup instead of a bottle can help reduce problems with cleaning.”*
- **Give practical help:** Demonstrate or guide actions the mother can do immediately without being overwhelmed.
 - *“Let’s practise cup feeding together. We’ll use this cup.”*
 - *“I can show you how to prepare the feed, step by step, using what we have here.”*

Counselling Skills Checklist for the observer

Instructions: Tick **Yes**, **Partially** or **No** for each skill or action you observe during the counselling session.

Counselling Skills Checklist			
	Yes	Partially	No
Monitored infant growth and health			
Checked weight, growth and overall condition			
Identified early signs of illness or malnutrition			
Continued counselling			
Reinforced recommended practices around preparation, feeding and hygiene			
Addressed any challenges the caregiver is facing			
Checked caregiver wellbeing			
Assessed stress, fatigue or other difficulties			
Provided support or referred if needed			
Reassessed eligibility			
Checked whether BMS is still needed			
Explored alternatives again (e.g., relactation, breastfeeding support)			
Summarized next steps clearly at the end of the session			
Resupplied BMS			
Provided the correct quantity based on updated needs			
Ensured no over- or under-supply			

Referred to additional services (if needed)	Yes	Partially	No
Cash and Voucher Assistance, health services, MHPSS, protection, GBV			



Role-play debrief: Amina and Sarah

1. Review of feeding practices and progress

Counsellor checks what Amina has been able to apply since the last session (cup feeding, preparing feeds individually, boiling water when possible) and acknowledges her efforts.

Sample lines:

“How has it been going since we last met? What changes have you been able to try?”

“I hear that you’ve started using the cup and preparing feeds more carefully. That’s a big step.”

→ **Remember:** Starting with what is going well builds confidence and creates a supportive environment before addressing challenges.

2. Reinforce recommended preparation and feeding practices

Counsellor reviews key practices: preparing each feed fresh, correct measurement of formula, using boiled water, feeding with a cup. Adjust guidance based on Amina’s constraints.

Sample line:

“Can you walk me through how you are preparing the formula now?”

“Using boiled water and preparing each feed fresh helps reduce the risk of illness.”

→ **Remember:** Reinforcement and gentle correction are essential to reduce health risks, especially in emergency conditions.

3. Address challenges and problem-solve barriers

Counsellor explores difficulties Amina is facing (limited fuel, inconsistent water access, time constraints) and works with her to identify realistic solutions.

Sample lines:

“I understand fuel is still limited. When is it easiest for you to boil water?”

“Let’s think together about what feels possible in your situation.”

→ **Remember:** Counselling should be practical and adapted to the caregiver’s reality – not to ideal but unachievable recommendations.

4. Support cup-feeding practice and confidence

Counsellor checks Amina’s experience with cup feeding, acknowledges that it is new and reinforces continued practise, all while offering support.

Sample lines:

“You mentioned it was difficult at first, but that it’s getting easier now. That’s very normal.”

“Would you like to practise again together, so you feel more confident?”

→ **Remember:** Skill-building takes time; encouragement and follow-up support are key to sustained change.

5. Monitor infant health and growth

Counsellor checks Sara’s condition, growth, and any signs of illness or feeding difficulties.

Sample lines:

“How has Sara been since we last met? Has she been unwell at all?”

“Let’s also check how she is growing and feeding overall.”

→ **Remember:** Regular monitoring helps identify early risks and ensures appropriate follow-up.

6. Address caregiver concerns about cost and sustainability

Counsellor explores Amina’s concern about the cost of formula and discusses what is realistic and sustainable, linking to available support where possible.

Sample lines:

“I hear that you are worried about the cost of formula. That is an important concern.”

“We will continue to support you so you don’t have to manage this alone. I can refer you to our Cash and Voucher Assistance team, and we can make sure you are linked with the distributions available in the area.”

→ **Remember:** Financial burden can affect feeding practices and household food security. It must be acknowledged and addressed, and the risk must be mitigated.

7. Reassess feeding plan and future needs

Counsellor briefly revisits whether infant formula remains necessary and prepares Amina for upcoming transitions (e.g., approaching 6 months and introduction of complementary feeding).

Sample lines:

“As Sara grows, her feeding needs will change. We will support you as she approaches 6 months and starts other foods.”

“For now, let’s look at what’s working and see where we can make small changes to support you.”

→ **Remember:** Follow-up visits are an opportunity to reassess and anticipate next steps, including transitioning from commercial infant formula use to feeding options that include breast milk (where possible) or to appropriate complementary feeding as the child grows.

8. Check caregiver wellbeing

Counsellor checks how Amina is feeling, including how she is experiencing stress and fatigue, and offers support or referral if needed.

Sample lines:

“How have you been managing with everything? It sounds like a lot to handle.”

“We are here to support you, not only with feeding but also with any difficulties you’re facing.”

→ **Remember:** Caregiver wellbeing directly affects infant care and should always be part of counselling, including identifying needs and making referrals where appropriate.

9. Summarize and agree on practical next steps

Counsellor summarizes key actions, focusing on a few achievable priorities, and checks Amina’s confidence.

Sample lines:

“Let’s agree on a few steps for this week:

Continue practising cup feeding.

Come back for follow-up, so we can keep supporting you.

Do these steps feel manageable for you?”

→ **Remember:** Clear, realistic action points help ensure continuity of care and build caregiver confidence.

STEP 5: Self-reflection

Take a few minutes to think about the session. You can write your answers in the space below.

Questions:

1. How confident am I in assessing eligibility for commercial infant formula and supporting a caregiver to use it in the recommended ways at home? What would help me improve my confidence or skills?

2. How prepared am I to counsel a caregiver on correct preparation, responsive feeding, cup feeding and hygienic storage of infant formula?

3. What challenges do I anticipate when supporting caregivers using infant formula in an emergency context, and how can I address them effectively?

Additional notes:

Resources:

- **Infographic Series: Infant Feeding During Infectious Disease Outbreaks – 2021, IFE Core Group**

[Planning and Managing Artificial Feeding Interventions in Emergencies](#)

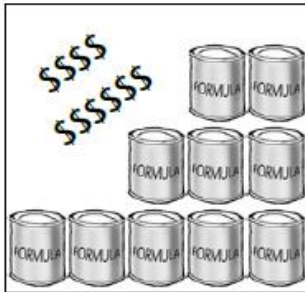


[Preventing and Managing Inappropriate Donations Breast Milk Substitutes and Other Prohibited Products](#)

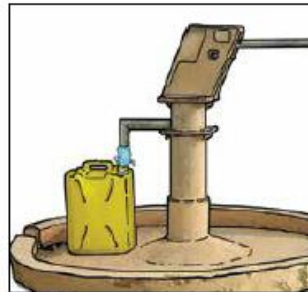


Job Aid 8.1: Counselling card: Conditions needed to feed the non-breastfed infant

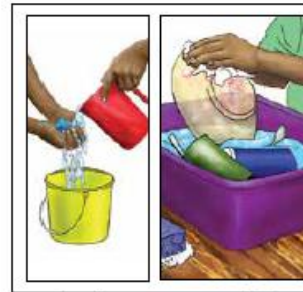
Conditions needed to feed the non-breastfed infant



Money to buy sufficient infant formula



Reliable source of safe water



Hand washing stations and clean utensils



Adequate fuel to boil water



Safe place to store water and infant formula



Ability to mix infant formula - day and night



Adequate sanitation facilities

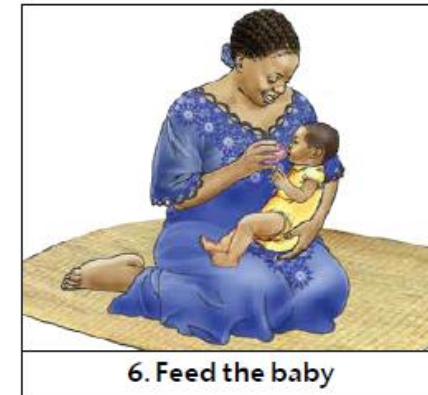
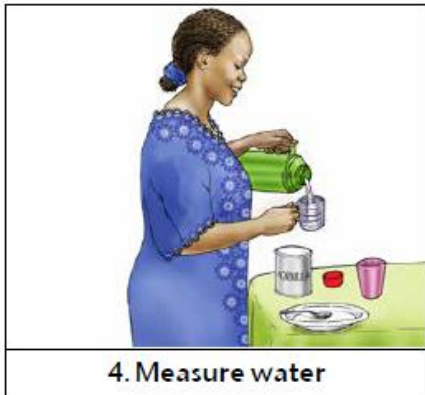
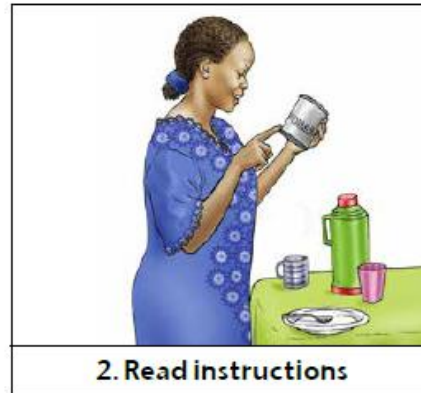


Access to health care facilities

Card 37

Job Aid 8.2: Counselling Card: Feeding the non-breastfed infant 0 up to 6 months

Feeding the non-breastfed infant 0 up to 6 months



Card 36

ANNEX 1: Emotional regulation practices

This annex provides simple techniques to help you both in managing stress related to your work and in supporting caregivers who may feel overwhelmed. Practising these techniques regularly helps you stay calm, focused and effective in your counselling.

1 Why emotional regulation matters

When you experience stress, your body and mind can shift out of balance. You may feel anxious, tense or disconnected. This is called **dysregulation**.

When you are **regulated**, you are calm, grounded and able to think clearly. Regulation allows you to listen well, make good decisions and help others feel safe.

During counselling, both **self-regulation** and **co-regulation** are important:

- **Self-regulation** → calming and grounding yourself first. These practices help you stabilize your nervous system, which improves focus, emotional resilience and your capacity to support others.
- **Co-regulation** → using your calm presence to help others feel calm and safe. Once you are regulated, you can model calmness and help caregivers or children regulate in turn.

Regulation practices help bring you or someone you are supporting back to a state of calm and balance.

2 Types of regulation practices

There are two main types of regulation practices:



Soothing

Calms and settles when tense, overwhelmed or worried
→ e.g. after an argument

Examples: Slow breathing, grounding, self-hug



Activating

Boosts energy when tired, withdrawn or sluggish
→ e.g. after lunch or long sessions

Examples: Stomping feet, shaking, gentle movement

3 Different styles of practice

Each regulation technique fits into one of several styles, depending on what you are addressing (e.g., feelings of being overwhelmed, low energy) and how you are working (e.g., with yourself, with a caregiver, with a child). Choosing the right style helps you more directly support regulation.

- **Orienting:** Noticing your surroundings and connecting with the present moment. This helps signal to your nervous system that *we are safe now*.
- **Grounding:** Anchoring into your body or your environment (feet on floor, contact with chair, noticing body weight). This stabilizes and settles the system when you feel disconnected or floating.
- **Breathwork:** Using your breath intentionally to calm and regulate. Slow, steady or patterned breathing helps shift your nervous system from 'alert' to 'rest & digest.'
- **Movement:** Using gentle motion (or stronger motion if needed) to either release built-up energy (activating) or create gentle flow when energy is low. The body moves, and the system relaxes or re-energizes.

- **Self-touch / Interoception:** Bringing awareness to your internal state through contact (hands on heart, chest, belly) or noticing sensations inside your body. This fosters self-soothing, reconnecting you to your internal safety signals.
- **Resource-oriented:** Drawing on internal strengths (you have done this before, you are capable) or external support (colleague, safe space) to build resilience and regulation. Regulation isn't only about calming; it's also about anchoring in strength and support.

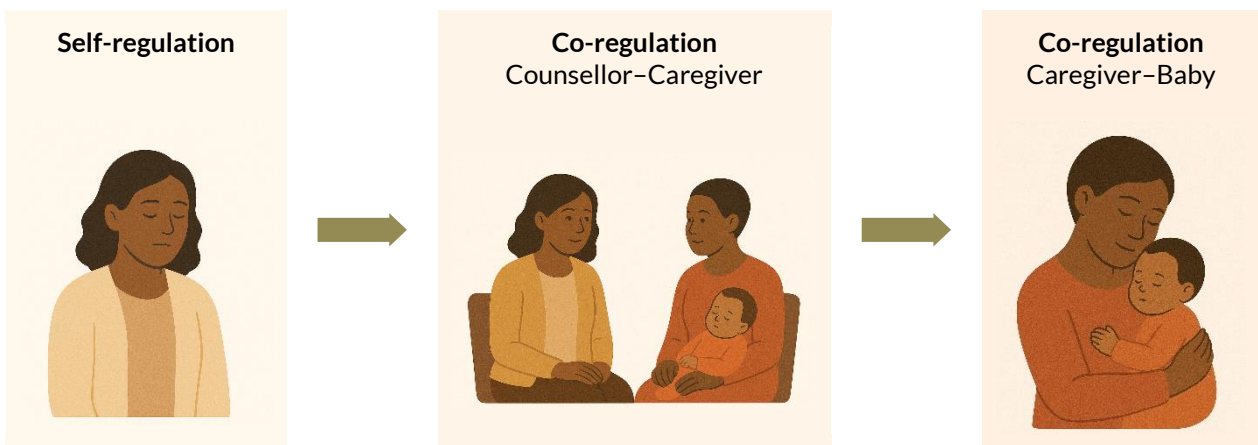
4 Your practice

A. Start with self-regulation practices

Regulation takes practise. Try one or two techniques each day and notice which ones work best for you. Over time, these practices become part of your personal 'toolbox,' ready to use whenever you need to regain balance.

B. Gradually progress from self-regulation to co-regulation practices

Once you are comfortable regulating yourself, you can extend these skills to help others.



Self-regulation practices

Orienting practices

♥ Orienting (Soothing):

- Gently look around and name three neutral or pleasant objects in your surroundings.
- State your name, location and the date to bring awareness to the present moment.
- To anchor yourself, focus on your feet touching the floor or the weight of your body in a chair.

Grounding practices


♥ Physical grounding (Soothing):

- Notice the sensation of your feet pressing firmly into the ground.
- Feel the contact of your hands on your thighs or the surface you are sitting on.
- Slowly roll your feet side to side, focusing on the sensation.


 **5-4-3-2-1 senses check (Soothing):**

- Identify 5 things you can see, 4 you can feel, 3 you can hear, 2 you can smell, and 1 you can taste (or imagine tasting).


Breathwork practices

 **Connecting with the breath (Soothing):**


- Observe your natural breathing rhythm without trying to change it.
- Place a hand on your chest or belly and notice the rise and fall with each breath.

 **Doubling the exhale (Soothing):**

- Inhale for a count of 2, 3 or 4, then exhale for double the count (i.e., 4, 6 or 8).


 **Candle breath (Soothing):**

- Imagine softly blowing out a candle. Exhale through pursed lips with a slow, steady breath.

 **Physiological sigh (Soothing):**

- Take two quick inhales through the nose (the second deeper) and exhale slowly through the mouth.

Movement-based practices

 **Shaking (Activating):**

- Shake out your hands, feet, or body to release tension and discharge energy.

 **Stomping feet (Activating):**

- Firmly stomp your feet on the ground and feel the connection with the floor.


 **Thumping thighs (Activating):**

- Gently thump your thighs with your fists, moving rhythmically up and down your legs.

Interoception and self-touch practices

 **Self-holding (Soothing):**

- Possible self-holds:
 - One hand on the heart, the other on the belly
 - One hand on the forehead, the other on the brainstem (back of the neck)
 - Hands gently cupping the ribs or resting on the thighs
 - One hand on the sternum, the other on the upper back

 **Dialogue with sensations (Soothing):**

- Acknowledge physical sensations by observing and naming them (e.g., “I notice tightness in my shoulders”).
- Use compassionate language, such as “I hear you, I notice this feeling.”

 **Bilateral patting (Butterfly hugs) (Soothing):**

- Cross your arms over your chest and alternately tap your upper arms.

Co-regulation practices

Orienting practices

 **Orienting together (Soothing):**

- Guide caregivers to notice neutral or positive objects in their surroundings.
- Invite them to state their name or their baby’s name as a grounding exercise.


With children: Encourage caregivers to observe their child’s features, such as tiny fingers or their breathing rhythm.

Grounding together

 **Physical grounding (Soothing):**

- Support caregivers in noticing their feet on the floor or their body in a chair.

With children: Help caregivers focus on the weight of their child on their lap or the warmth of skin-to-skin contact.

 **Present-moment awareness (Soothing):**

- Encourage caregivers to observe colours, textures or other small, neutral details in their environment.

With children: Invite caregivers to notice the smell, movement or sound of their child.

Breathwork

 **Breathing together (Soothing):**

- Model slow, steady breathing and invite caregivers to follow your rhythm.

With children: Encourage caregivers to breathe deeply while observing or holding their child, using the connection to calm both the child and themselves.

Movement-based co-regulation



Swaying together (Activating):

- Gently sway side to side with a caregiver to release tension and create connection.

Group practice: Learners stand in a circle, place one hand on the centre of their neighbour's back, and sway together.

With children: Support caregivers in rocking or swaying with their child, noticing the shared rhythm and connection.

Resource-oriented practices



External resource awareness (Soothing):

- Guide caregivers to focus on their connection to their baby as a source of grounding and strength.

Resources:



Mind My Peelings. *Understanding the Window of Tolerance and How It Affects You.*
Available at: <https://www.mindmypeelings.com/blog/window-of-tolerance>



Irene Lyon. *How to De-Stress in 7 Steps.*
Available at: <https://irenelyon.com/7steps/>



Irene Lyon. *A Field Guide to Your Nervous System.*
Available at: <https://irenelyon.com/wp-content/uploads/2023/03/IL-Field-Guide-to-your-NS.pdf>



Irene Lyon. *20-Minute Neurosensory Exercise (Audio Practice).*
Available at: <https://irenelyon.com/20-min-exercise>