EXECUTIVE SUMMARY

Breastfeeding is one of the foundations of child health, development and survival. For these reasons, the World Health Organization (WHO) recommends that breastfeeding should be initiated within the first hour after birth and that infants should exclusively breastfeed for the first 6 months; complementary foods should then be introduced, with continued breastfeeding until 24 months of age or older.

Despite extensive evidence that non-breastfeeding is associated with increased mortality and serious morbidity and other long-term adverse health outcomes, efforts at national level to increase exclusive breastfeeding and rates of continued breastfeeding have, in general, had only modest effect. In 2017, only about 41% of infants aged less than 6 months globally were exclusively breastfed and the rate of continued breastfeeding at 2 years was 45%.2

Prior to initiating the guideline process, a major review of approaches for improving breastfeeding practices noted multiple determinants and influences on practices at structural, community and workplace, and individual levels, which showed that several interventions can significantly improve rates of breastfeeding.3 Breastfeeding counselling, along with baby-friendly hospital support and community mobilization approaches, is one of the key interventions to improve breastfeeding rates. Guidelines related to breastfeeding counselling would potentially improve the quality and delivery of services to pregnant women and mothers who want to breastfeed and may improve monitoring of the quality of health systems by defining the expected services and competencies of staff.

This guideline examines the evidence and makes recommendations and remarks on the implementation of some of the details of breastfeeding counselling, such as frequency, timing, mode and provider of breastfeeding counselling, to improve breastfeeding practices. The scope of the guideline is limited to this intervention.

This guideline does not aim to be a comprehensive guide on all potential interventions that can protect, promote and support breastfeeding. For instance, it will not discuss breastfeeding support in facilities providing maternity and newborn services; potential medical contraindications to breastfeeding; community-based practices; peer support; or support for breastfeeding in the workplace. Neither will it review the articles of the International Code of Marketing of Breast-milk Substitutes4 and its subsequent related World Health Assembly resolutions.5
This guideline is consistent with and complements the interventions and guidance presented in Breastfeeding counselling: a training course, Infant and young child feeding counselling: an integrated course, Combined course on growth assessment and IYCF counselling, Integrated Management of Childhood Illness, Community management of at-risk mothers and infants under six months of age (C-MAMM) tool, Essential newborn care course, Caring for newborns and children in the community: a training course for community health workers, Guidelines on optimal feeding of low birth-weight infants in low- and middle-income countries, Guideline: protecting, promoting and supporting breastfeeding in facilities providing maternity and newborn services, Implementation guidance: protecting, promoting and supporting breastfeeding in facilities providing maternity and newborn services – the revised Baby-friendly Hospital Initiative, and Infant and young child feeding in emergencies, Operational guidance for emergency relief staff and programme managers, and does not supersede or replace them.

**Purpose of the guideline**

The objective of this guideline is to provide global, evidence-informed recommendations on breastfeeding counselling, as a public health intervention, to improve breastfeeding practices among pregnant women and mothers who intend to breastfeed, or are currently breastfeeding, and their infants and children.

The recommendations in this guideline are intended for a wide audience, including policy-makers, their expert advisers, and technical and programme staff at government institutions and organizations involved in the design, implementation and scaling up of programmes for breastfeeding counselling and nutrition-sensitive actions1 of infant and young child feeding programmes.

This guideline aims to help WHO Member States and their partners to make evidence-informed decisions on the appropriate actions in their efforts to achieve the Sustainable Development Goals,2 the resolutions of the World Health Assembly on Infant and young child feeding,3 and the global targets put forward in the Comprehensive implementation plan on maternal, infant and young child nutrition,4 The global strategy for women’s, children’s, and adolescents’ health (2016–2030)5 and the Global strategy for infant and young child feeding.6

**Guideline development methodology**

WHO developed the present evidence-informed recommendations using the procedures outlined in the WHO handbook for guideline development.7 The steps in this process included: (i) identification of priority questions and outcomes; (ii) retrieval of the evidence; (iii) assessment and synthesis of the evidence; (iv) formulation of recommendations, including research priorities; and planning for (v) dissemination; (vi) implementation, equity and ethical considerations; and (vii) impact evaluation and updating of the guideline. The Grading of Recommendations Assessment, Development and Evaluation (GRADE)8 methodology was followed, to prepare evidence profiles related to preselected topics, based on up-to-date systematic reviews. The Developing and Evaluating Communication Strategies to support Informed Decisions and Practice based on Evidence (DECIDE)9 framework, an evidence-to-decision tool that includes intervention effects, the quality

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1 Interventions or programmes that address the underlying determinants of fetal and child nutrition and development – food security; adequate caregiving resources at the maternal, household and community levels; and access to health services and a safe and hygienic environment – and incorporate specific nutrition goals and actions: (https://www.thelancet.com/series/foodsecurity/pdf/4.pdf).


8 GRADE (http://www.gradeworkinggroup.org/).

of the evidence, values and preferences, resources, equity, acceptability and feasibility criteria, was used to guide the formulation of the recommendations by the guideline development group.

The scoping of the guideline and the prioritization of the outcomes was done by the guideline development group, 11–12 May 2017, in Geneva, Switzerland. The development and finalization of the evidence-informed recommendations were done by the guideline development group, in a meeting held in Geneva, Switzerland, 26–28 June 2018. Three options for types of recommendations were agreed, namely: (i) recommended; (ii) recommended in specific contexts only; and (iii) not recommended. Four experts served as technical peer-reviewers of the draft guideline.

Available evidence

The available evidence included systematic reviews that followed the procedures of the Cochrane handbook for systematic reviews of interventions1 and assessed the effects of breastfeeding counselling on pregnant women and mothers who are considering or already breastfeeding. All trials compared a group of participants who received breastfeeding counselling to a group that received standard care or no breastfeeding counselling, or were otherwise compared to breastfeeding counselling with a different timing, frequency or mode or by a different type of counsellor. For the trials to be included in the reviews, co-interventions other than breastfeeding counselling had to have been used for both the control and intervention arms. The overall quality of the available evidence was moderate to low for the critical outcomes on breastfeeding practices.2

Additional qualitative systematic reviews of evidence were conducted, to assess the values and preference of pregnant women and mothers in relation to the benefits and harms associated with each intervention, and the acceptability of each of the interventions to health-care staff and breastfeeding counsellors. The findings of the qualitative reviews were appraised using the GRADE Confidence in the Evidence from Reviews of Qualitative research (GRADE-CERQual)3 approach. Overall confidence in the evidence from reviews of qualitative research was based on four components: methodological limitations of the individual studies; adequacy of the data; coherence of the evidence; and relevance of the individual studies to the review finding. The overall confidence in the synthesis of qualitative evidence was high to moderate for maternal values and preferences and also high to moderate for acceptability to health facility staff.4

A decision-making framework was used to lead discussion and decision-making. This included the following considerations: (i) the quality of the evidence across outcomes critical to decision-making; (ii) the balance of benefits and harms; (iii) values and preferences related to the recommended intervention in different settings and for different stakeholders, including the populations at risk; (iv) the acceptability of the intervention among key stakeholders; (v) resource implications for programme managers; (vi) equity; and (vii) the feasibility of implementation of the intervention.

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2 According to GRADE, high-quality evidence indicates confidence that the true effect lies close to that of the estimate of the effect. Moderate-quality evidence indicates moderate confidence in the effect estimate; the true effect is likely to be close to the estimate of the effect, but there is a possibility that it is substantially different. Low-quality evidence indicates that confidence in the effect estimate is limited; the true effect may be substantially different from the estimate of the effect. Very-low-quality evidence indicates very little confidence in the effect estimate; the true effect is likely to be substantially different from the estimate of effect.
3 GRADE CERQual. Confidence in the evidence from reviews of qualitative research [http://www.cerqual.org/].
4 According to GRADE CERQual, high confidence indicates that it is highly likely that the review finding is a reasonable representation of the phenomenon of interest. Moderate confidence indicates that it is likely that the review finding is a reasonable representation of the phenomenon of interest. Low confidence indicates that it is possible that the review finding is a reasonable representation of the phenomenon of interest. Very low confidence indicates that it is not clear whether the review finding is a reasonable representation of the phenomenon of interest.
**Recommendations**

- Breastfeeding counselling should be provided to all pregnant women and mothers with young children *(recommended, moderate-quality evidence)*.
- Breastfeeding counselling should be provided in both the antenatal period and postnatally, and up to 24 months or longer *(recommended, moderate-quality evidence)*.
- Breastfeeding counselling should be provided at least six times, and additionally as needed *(recommended, low-quality evidence)*.
- Breastfeeding counselling should be provided through face-to-face counselling *(recommended, low-quality evidence)*. Breastfeeding counselling may, in addition, be provided through telephone or other remote modes of counselling *(context-specific recommendation, moderate-quality evidence)*.
- Breastfeeding counselling should be provided as a continuum of care, by appropriately trained health-care professionals and community-based lay and peer breastfeeding counsellors *(recommended, moderate-quality evidence)*.
- Breastfeeding counselling should anticipate and address important challenges and contexts for breastfeeding, in addition to establishing skills, competencies and confidence among mothers *(context-specific recommendation, low-quality evidence)*.

Common challenges and contexts include returning to work or school; the specific needs of mothers who are obese, adolescent girls, primiparous (first-time mothers) or carrying multiple pregnancies (when the mother is pregnant with two or more babies); mothers with mental health difficulties; mothers of infants with special needs, e.g. low birth weight or disability; mothers who deliver by caesarean section; breastfeeding in public spaces; and breastfeeding in humanitarian emergencies.

**Best practice statement**

- Protection, promotion and support of breastfeeding, in accordance with international guidance, are essential in emergencies. Breastfeeding counselling should be an integral part of emergency preparedness plans for infant and young child feeding, and both initial and sustained responses.

**Remarks**

The remarks in this section are intended to give some considerations for implementation of the recommendations, based on the discussion of the guideline development group.

- Counselling is a process and interaction between counsellors and pregnant women or mothers. Breastfeeding counselling is therefore not intended to be a “top-down” intervention of “telling women what to do”. The aim of breastfeeding counselling is to empower women to breastfeed, while respecting their personal situations and wishes. Breastfeeding counselling is, therefore, never to be forced upon any woman. This would be contrary to the concept of counselling. Rather, counselling is made available and accessible to all pregnant women and mothers, particularly those who are considering or already breastfeeding.
- Breastfeeding counselling for pregnant women can enable them to have the best start at breastfeeding, with support to allow mothers and their neonates to initiate breastfeeding as soon as possible after birth, stay together throughout the day and night, and establish and maintain breastfeeding with proper attachment and positioning.
- Sensitive and effective counselling can assist mothers who are considering or are already breastfeeding to overcome challenges. By emphasizing that breastfeeding provides protection and comfort as well as food, counselling can respond to the particular barriers that individual mothers face.
Mothers who may not be considering breastfeeding could be supported to make informed choices about feeding their infants and children. Counselling can highlight the extensive and resounding evidence on the benefits of breastfeeding, as well as providing mothers with scientific, unbiased and factual information about other infant and young child feeding choices, so that they can safely and responsively feed their child.

Those who are breastfeeding as well as giving additional foods or fluids (such as infant formula milk or other breast-milk substitutes) are encouraged to continue breastfeeding as much as they are able to, while they are supported with sensitivity and care to address challenges that they may be facing around feeding their child.

**Timing of breastfeeding counselling**

- Counselling during pregnancy or soon after birth includes encouraging mothers and their families to start a nurturing, caring and responsive relationship with their infant. Feeding decisions at this time may be shaped by experiences, contexts and various influences around them, as well as having short- and long-term consequences. Breastfeeding counselling at this time aims to enable a positive and loving environment in which the neonate can thrive.

- Postnatal breastfeeding counselling further supports mothers and their families in enabling them to build closeness, with skin-to-skin contact and responsive feeding. Mothers may need extra support in establishing and boosting their confidence in breastfeeding, recognizing the milk ejection reflex (or let-down) and effective feeding, and understanding feeding patterns and growth spurts.

- Parents and caregivers need to be enabled to access appropriate help when they have concerns about feeding. This may be particularly important in the first few weeks after birth when breastfeeding is being established, and during potential changes in their situation (such as the mother’s return to school or work), when they may have concerns about maintaining breastfeeding, according to their individual circumstance. An assessment of breastfeeding effectiveness may be valuable in reassuring parents and addressing issues around feeding.

**Frequency of breastfeeding counselling**

- Provision of at least six breastfeeding counselling contacts allows for a full range of support to breastfeeding mothers and their families, beginning in the antenatal period through to the introduction of complementary feeding and beyond. Policy-makers and implementers are duty-bound to ensure that breastfeeding counselling contacts are of sufficient quality and quantity to be effective, while ensuring that their use does not expose the mothers and their families to financial hardship.

- People-centred breastfeeding counselling means that the counselling responds to the individual mothers’ and families’ needs, preferences and values. If individual family situations preclude them from accessing at least six counselling contacts, they are, nonetheless, encouraged and enabled to go to as many as they can, and maximize the benefit of this resource with meaningful engagement without stigma or recrimination.

- The minimum of six breastfeeding counselling contacts may occur at the following time points: before birth (antenatal period); during and immediately after birth (perinatal period up to the first 2–3 days after birth); at 1–2 weeks after birth (neonatal period); in the first 3–4 months (early infancy); at 6 months (at the start of complementary feeding); and after 6 months (late infancy and early childhood), with additional contacts as necessary (for instance, when planning to return to school or work, or any time that concerns or challenges related to breastfeeding arise) or when opportunities for breastfeeding counselling occur (such as during child immunization visits).
Breastfeeding counselling during the perinatal period and during the stay in the facility providing maternity and newborn services is done in conjunction with other interventions that protect, support and promote breastfeeding, as outlined in the Baby-friendly Hospital Initiative\(^1\)\(^2\) and in the Essential newborn care course\(^3\).

### Mode of breastfeeding counselling

- Individual face-to-face counselling may be complemented but not replaced by telephone counselling and/or other technologies.
- Preferences for different methods of counselling will vary with context. Health workers around the world are increasingly using other technologies. Telephone counselling and other technologies are very useful options as adjuncts and may empower end-users, as well as health workers and lay or peer counsellors.
- Telephone counselling will depend on the availability and accessibility of telephones for pregnant women and mothers.
- Telephone counselling and/or other technologies may be very useful in certain contexts where face-to-face counselling capacity or access may be limited or absent, such as emergencies.

### Provider of breastfeeding counselling

- What works best in terms of staff allocation will vary considerably, depending on the context and national health-care system. At country level, it is important to have a system that enables, where necessary, continuity of care and integration of lay and peer counsellors with non-lay counsellors. Continuity of care is best brought about within a system of collaboration and communication between all providers.
- For breastfeeding counselling to be effective, a good training and mentoring programme, for both lay and non-lay counsellors, will be an essential first step. Careful planning and leadership will be important for those responsible for developing the skills, knowledge and confidence of counsellors in enabling mothers to achieve their goals for breastfeeding.
- A systems-based approach within the health-care system and at community level, with cascade training and support or supervision, may be a constructive way forward, with clearly defined skills, training and supervision for different levels of counsellors, and referral systems. Lactation consultants and other highly trained breastfeeding counsellors can play useful roles in training and supervision.

### Anticipatory breastfeeding counselling

- To some extent, all breastfeeding counselling is anticipatory. The goal of the counselling contact is to support mothers in achieving their individualized goals for breastfeeding, whether they are considering initiating breastfeeding, or they are already breastfeeding and are facing particular challenges for continuation of breastfeeding. Anticipatory counselling therefore refers to evaluating and assessing potential and existing challenges that may impact the mothers’ breastfeeding goals. The anticipatory nature of breastfeeding counselling helps to reduce potential risks, problems or complications, for optimal breastfeeding.
- In difficult or complicated circumstances, positive feedback and emotional support are especially needed to support the mothers’ confidence and self-efficacy in breastfeeding.

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Using the principles of person-centred and quality-focused care, each Member State may need to identify which circumstances will require additional training and skills-building, based on their assessment of the primary challenges to optimal breastfeeding in their contexts.

Advice and information for women who do not intend to breastfeed needs to be considered as a potential component of anticipatory counselling for pregnant women.

During emergencies, appropriate and timely support to infant and young child feeding saves lives; protects child nutrition, health and development; and benefits mothers. Breastfeeding counselling is a vital intervention in emergency response and needs to be protected. Emergency preparedness is critical to a timely, efficient and appropriate response.

Emergency preparedness includes training of personnel likely to be involved in providing support to mothers in an emergency, and building the capacity of those delivering services during a response. As a minimum, staff in contact with mothers and children aged under 2 years are trained to be sensitive to psychosocial issues, on nutrition screening and on referral pathways to more specialist support.

More specialist capacity to counsel mothers with heightened needs, such as stressed or traumatized mothers, malnourished infants and mothers, low-birth-weight infants, and infants with disability and feeding difficulties, may be needed.

**Research gaps**

Discussions between the members of the WHO guideline development group and the external resource group highlighted the limited evidence available in some knowledge areas, meriting further research, particularly in the following areas:

- different modes, frequency or intensity of breastfeeding counselling that would best protect, support and promote breastfeeding among specific population groups, such as adolescent girls, obese women and those with multiple pregnancies;
- complex multi-component interventions to protect, support and promote breastfeeding among women returning to school or work;
- the nature of breastfeeding counselling with stressed, traumatized or malnourished mothers or infants and young children, such as in humanitarian emergencies;
- the nature of breastfeeding counselling of mothers of preterm, low-birth-weight or sick infants, or those admitted to the neonatal intensive care unit;
- different durations, content (including clinical and practical skills) and modes of training delivery, in order to meet minimum competency to address breastfeeding challenges;
- capacity-building methodologies to develop the advanced competencies required to address persistent or complex breastfeeding problems;
- studies across different regions, countries and population groups (e.g. by income levels, educational levels, cultural and ethnic backgrounds) and contexts (e.g. in areas where breastfeeding is the norm and where breastfeeding practices are not optimal), in order to adequately and sensitively protect, promote and support breastfeeding.
Plans for updating the guideline

The WHO steering group will continue to follow research developments in the area of breastfeeding counselling, particularly for questions in which the quality of evidence was found to be low or very low. If the guideline merits an update, or if there are concerns about the validity of the guideline, the Departments of Maternal, Newborn, Child and Adolescent Health and Nutrition for Health and Development will coordinate the guideline update, following the formal procedures of the *WHO handbook for guideline development*.1

As the guideline nears the 10-year review period, the Departments of Maternal, Newborn, Child and Adolescent Health and Nutrition for Health and Development at the WHO headquarters in Geneva, Switzerland, along with its internal partners, will be responsible for conducting a search for appropriate new evidence.

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