Session H: Staffing Challenges and Solutions

# PARTICIPANT HANDOUT

## **Extract from:** IFE Core Group (2021) Operational Guidance – Breastfeeding Counselling in Emergencies. Table 2

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| * 1. **Human resource availability, motivation and individual capacity** * Lack of trained human resources (no pre-emergency counselling capacity, counsellors impacted by emergency, shortage of women on staff, shortage of staff with required language skills or cultural understanding or who are accepted by the emergency-affected population, high staff turnover) * Lack of health worker time (high needs for curative services override delivery of preventative services) * Low counsellor motivation   (de-prioritisation by personnel for whom counselling is one of many tasks, mothers’ resistance to recommended practices[[1]](#footnote-1), lack of incentives for peer counsellors) | 1. **Define roles and service standards** i.e., the time necessary for trained, skilled and motivated personnel to perform an activity to professional standards in the local circumstances. Where breastfeeding counselling is a defined part of a provider’s role, allocate an adequate amount of time for this workload component when planning services. 2. **Ensure adequate numbers of counsellors[[2]](#footnote-2)** by 1) recruiting trained counsellors (e.g., lactation consultants) or those who can be trained to deliver counselling (e.g., healthcare professionals, peers, traditional birth attendants (TBAs), 2) deploying surge counselling capacity from other areas/national or emergency response teams (see Chapter 5 – Counselling Capacity in Emergencies). 3. **Build the capacity of the available workforce to deliver counselling** Note this will only be effective if counselling is built into their role during service planning. Regular training is essential to address staff turnover (See Chapter 5 – Counselling Capacity in Emergencies). 4. **Build communities’ capacity to provide counselling** (e.g., train peer counsellors). This can increase resilience and reduce reliance on external resources and aid. 5. **Task shifting** e.g., hygiene promoters can teach cup feeding instead of counsellors, peer counsellors can provide basic counselling so that counsellors with more advanced competencies can focus on complex cases. 6. **Place dedicated breastfeeding counsellors within services** to provide in-depth counselling (see Chapter 5 - Provider of Breastfeeding Counselling). 7. **Raise awareness** of the importance/impact of breastfeeding in emergencies and the risks of neglecting breastfeeding in emergencies to address motivation. 8. **Include standard counselling indicators** in the indicator set used for monitoring provider/facility/implementing partner performance. 9. **Plan for adequate incentives/remuneration** (if appropriate and sustainable) and provide support and recognition for community volunteers and peer counsellors. 10. **Demonstrate duty of care** and support counsellors to work in a safe working environment. 11. **Put in place family/breastfeeding-friendly policies** to recruit and maintain a female workforce (see Box 8 for further guidance). |

1. **Sami et al., 2017** found that mothers’ resistance to practices such as exclusive breastfeeding and breastmilk expression lowered health workers’ intention to promote these practices. [↑](#footnote-ref-1)
2. Further guidance: Sphere staffing standard: 23 skilled birth attendants (doctors, nurses, midwives)/10,000 population. Note that these are *minimum* standards which are context dependent; where reproductive health consultation rates are high despite minimum standards being met, consider readjusted staffing levels. [↑](#footnote-ref-2)