BABY-FRIENDLY HOSPITAL INITIATIVE

Revised Updated and Expanded
for Integrated Care

SECTION 3

BREASTFEEDING PROMOTION AND SUPPORT IN A BABY-FRIENDLY HOSPITAL

A 20-HOUR COURSE FOR MATERNITY STAFF

2009

Original BFHI Course developed 1993

WHO Library Cataloguing-in-Publication Data

Baby-friendly hospital initiative : revised, updated and expanded for integrated care. Section 3, Breastfeeding promotion and support in a baby-friendly hospital: a 20-hour course for maternity staff.

Produced by the World Health Organization, UNICEF and Wellstart International.

1.Breast feeding. 2.Hospitals. 3.Maternal welfare. 4.Maternal health services. I.World Health Organization. II.UNICEF. III.Wellstart International. IV.Title: Background and implementation.

ISBN 978 92 4 159498 1 (v. 3) (NLM classification: WQ 27.1)
ISBN 978 92 4 159495 0 (set)

© World Health Organization and UNICEF 2009

All rights reserved. Publications of the World Health Organization can be obtained from WHO Press, World Health Organization, 20 Avenue Appia, 1211 Geneva 27, Switzerland (tel: +41 22 791 3264; fax: +41 22 791 4857; email: bookorders@who.int).

The World Health Organization and UNICEF welcome requests for permission to reproduce or translate their publications — whether for sale or for noncommercial distribution. Applications and enquiries should be addressed to WHO, Office of Publications, at the above address (fax: +41 22 791 4806; email: permissions@who.int or to UNICEF email: pdimas@unicef.org with the subject: attn. nutrition section.

The designations employed and the presentation of the material in this publication do not imply the expression of any opinion whatsoever on the part of the World Health Organization or UNICEF concerning the legal status of any country, territory, city or area or of its authorities, or concerning the delimitation of its frontiers or boundaries. Dotted lines on maps represent approximate border lines for which there may not yet be full agreement.

The mention of specific companies or of certain manufacturers' products does not imply that they are endorsed or recommended by the World Health Organization or UNICEF in preference to others of a similar nature that are not mentioned. Errors and omissions excepted, the names of proprietary products are distinguished by initial capital letters.

The World Health Organization and UNICEF do not warrant that the information contained in this publication is complete and correct and shall not be liable for any damages incurred as a result of its use.

Printed by the WHO Document Production Services, Geneva, Switzerland

Cover image "Maternity", 1963.
© 2003 Estate of Pablo Picasso/Artists Rights Society (ARS), New York.

Acknowledgements

Development of the original 18-hour course was a collaborative effort among staff at the United Nations Children's Fund (UNICEF), the World Health Organization (WHO), Wellstart International, and Breastfeeding Support Consultants. *BEST Services* under the leadership of Genevieve Becker, prepared this course revision for UNICEF and WHO.

BEST Services, 2 Kylemore Park, Taylor's Hill, Galway, Ireland bestservices@iol.ie
providing Breastfeeding Education Support and Training

Acknowledgement is given to all the health professionals, scientific researchers, field workers, support groups, families, mothers, and babies who, through their diligence and caring, have contributed to the course content. Many BFHI national co-coordinators and their colleagues around the world responded to the initial User Needs survey and gave further input concerning revisions to the course. Extensive comments were provided by Ann Brownlee, Felicity Savage, Marianne Brophy, Camilla Barrett, Mary Bird, Gill Rapley, Ruth Bland, Diana Powell, and Nicola Clarke. Reviews of full drafts were provided by BFHI experts from the various UNICEF regions, including Pauline Kisanga, Swaziland; Ngozi Niepuome, Nigeria; Meena Sobsamai, Thailand; Azza Abul-fadl, Egypt; Sangeeta Saxena, India; Veronica Valdes, Chile; Elizabeth Zisovska, Macedonia; Elizabeth Horman, Germany; Elisabeth Tuite, Norway.

Miriam Labbok and David Clark of UNICEF, and Randa Jarudi Saadeh and Carmen Casanovas of the Department of Nutrition and Health Development and colleagues at the Department of Child and Adolescent Health and Development, particularly Peggy Henderson, Marcus Stahlhofer and Constanza Vallenas, WHO, provided technical and logistical support and feedback throughout the process.

The course materials were field tested in Zimbabwe with a multi-disciplinary group. Support was provided by the UNICEF and WHO Country Offices, the Ministry of Health and Child Welfare, the course facilitators, and the staff of Chitungwiza Hospital and Nurse-Midwifery Training School.

These multi-country and multi-organizational contributions were invaluable in helping to fashion a course designed to address the current needs of countries and their mothers and babies, facing a wide range of challenges in many differing situations.

In addition to pictures and illustrations from the UNICEF and WHO collections:
Jenny Corkery created the illustrations of the 'story mothers'.
Photographs were kindly provided by Dr Nils Bergman, Dr Ruskhana Haider,
Barbara Wilson-Clay and Kay Hoover.

Preface for the BFHI materials: Revised, Updated and Expanded for Integrated Care

Since the Baby-friendly Hospital Initiative (BFHI) was launched by UNICEF and WHO in 1991-1992, the Initiative has grown, with more than 20,000 hospitals having been designated in 156 countries around the world over the last 15 years. During this time, a number of regional meetings offered guidance and provided opportunities for networking and feedback from dedicated country professionals involved in implementing BFHI. Two of the most recent were held in Spain, for the European region, and Botswana, for the Eastern and Southern African region. Both meetings offered recommendations for updating the Global Criteria, related assessment tools, as well as the "18-hour course," in light of experience with BFHI since the Initiative began, the guidance provided by the new Global Strategy for Infant and Young Child Feeding, and the challenges posed by the HIV pandemic. The importance of addressing "mother-friendly care" within the Initiative was raised by a number of groups as well.

As a result of the interest and strong request for updating the BFHI package, UNICEF, in close coordination with WHO, undertook the revision of the materials in 2004-2005, with various people assisting in the process (Genevieve Becker, Ann Brownlee, Miriam Labbok, David Clark, and Randa Saadeh). The process included an extensive "user survey" with colleagues from many countries responding. Once the revised course and tools were drafted they were reviewed by experts worldwide and then field-tested in industrialized and developing country settings. The full first draft of the materials was posted on the UNICEF and WHO websites as the "Preliminary Version for Country Implementation" in 2006. After more than a year's trial, presentations in a series of regional multi-country workshops, and feedback from dedicated users, UNICEF and WHO[1] met with the co-authors above[2] and resolved the final technical issues that had been raised. The final version was completed in late 2007. It is expected to update these materials no later than 2018.

The revised BFHI package includes:

Section 1: Background and Implementation, which provides guidance on the revised processes and expansion options at the country, health facility, and community level, recognizing that the Initiative has expanded and must be mainstreamed to some extent for sustainability, and includes:

- 1.1 Country Level Implementation
- 1.2 Hospital Level Implementation
- 1.3 The Global Criteria for BFHI
- 1.4 Compliance with the International Code of Marketing of Breast-milk Substitutes
- 1.5 Baby-Friendly Expansion and Integration Options
- 1.6 Resources, References and Websites

1 Moazzem Hossain, UNICEF NY, played a key role in organizing the multi-country workshops, launching the use of the revised materials. He and Randa Saadeh, and Carmen Casanovas of WHO worked together with the co-authors to resolve the final technical issues.

2 Miriam Labbok is currently Professor and Director, Center for Infant and Young Child Feeding and Care, Department. of Maternal and Child, University of North Carolina School of Public Health.

Section 2: Strengthening and sustaining the Baby-friendly Hospital Initiative: A course for decision-makers, was adapted from WHO course "Promoting breast-feeding in health facilities a short course for administrators and policy-makers". This can be used to orient hospital decisions-makers (directors, administrators, key managers, etc.) and policy-makers to the Initiative and the positive impacts it can have and to gain their commitment to promoting and sustaining "Baby-friendly". There is a Course Guide and eight Session Plans with handouts and PowerPoint Slides. Two alternative session plans and materials for use in settings with high HIV prevalence have been included.

Section 3: Breastfeeding Promotion and Support in a Baby-Friendly Hospital, a 20-hour course for maternity staff, which can be used by facilities to strengthen the knowledge and skills of their staff towards successful implementation of the Ten Steps to Successful Breastfeeding. This section includes:

- 3.1 Guidelines for Course Facilitators including a Course Planning Checklist
- 3.2 Outlines of Course Sessions
- 3.3 PowerPoint Slides for the Course

Section 4: Hospital Self-Appraisal and Monitoring, which provides tools that can be used by managers and staff initially, to help determine whether their facilities are ready to apply for external assessment, and, once their facilities are designated Baby-friendly, to monitor continued adherence to the Ten Steps. This section includes:

- 4.1 Hospital Self-Appraisal Tool
- 4.2 Guidelines and Tools for Monitoring

Section 5: External Assessment and Reassessment, which provides guidelines and tools for external assessors to use to both initially, to assess whether hospitals meet the Global Criteria and thus fully comply with the Ten Steps, and then to reassess, on a regular basis, whether they continue to maintain the required standards. This section includes:

- 5.1 Guide for Assessors, including PowerPoint slides for assessor training
- 5.2 Hospital External Assessment Tool
- 5.3 Guidelines and Tool for External Reassessment
- 5.4 The BFHI Assessment Computer Tool

Sections 1 through 4 are available on the UNICEF website at http://www.unicef.org/nutrition/index_24850.html or by searching the UNICEF website at http://www.unicef.org/ and, on the WHO website at http://www.who.int/nutrition/publications/infantfeeding/9789241594950/en/index.html or by searching the WHO website at www.who.int/nutrition.

Section 5: External Assessment and Reassessment, is not available for general distribution. It is only provided to the national authorities for BFHI who provide it to the assessors who are conducting the BFHI assessments and reassessments. A computer tool for tallying, scoring and presenting the results is also available for national authorities and assessors. Section 5 can be obtained, on request, from the country or regional offices or headquarters of UNICEF and WHO, Nutrition Sections.

SECTION 3

BREASTFEEDING PROMOTION AND SUPPORT IN A BABY-FRIENDLY HOSPITAL

A 20-HOUR COURSE FOR MATERNITY STAFF

Page

3.1 Guidelines for Course Facilitators

Course objectives	1
Length of the course	2
Preparing for the course	3
Course materials	4
Presentation of the course	6
Annex 1: Course Planning Checklist	8
Annex 2: Example of a course timetable	11
Annex 3: Resources for further information	12
Annex 4: Instruction to make a cloth breast model	17
Annex 5: Assessment of Learning Tools	18
Annex 6: Picture credits	19
Annex 7: Notes for an orientation session for non-clinical staff	20

3.2 Session Outlines

3.3 PowerPoint Slides for the course

Each Section is a separate file and may be downloaded from UNICEF Internet at http://www.unicef.org/nutrition/index_24850.html, or the WHO Internet at www.who.int/nutrition

3.1 GUIDELINES FOR COURSE FACILITATORS

The original "18-hour" course was widely used and translated into many languages. This revision takes into account new research on supportive practices as well as the HIV situation. These are guidelines for experienced course facilitators and are not intended as a word-by-word course. This course focuses on the application of the health workers' knowledge and skills in their everyday practice rather than providing a large amount of theory and research findings.

The Key Points from this course are:

– Breastfeeding is important for mother and baby.
– Most mothers and babies can breastfeed.
– Mothers and babies who are not breastfeeding need extra care to be healthy.
– Hospital practices can help (or hinder) baby and mother friendly practices.
– Implementing the Baby-friendly Hospital Initiative helps good practices to happen.

Course objectives

The short-term objectives of this course are:

- To help equip the hospital staff with the knowledge and skill base necessary to transform their health facilities into baby-friendly institutions through implementation of the Ten Steps to Successful Breastfeeding, and
- To sustain policy and practice changes.

This course is suitable for staff who has contact with pregnant women, mothers and their newborn infants. The staff may include doctors, midwives, nurses, health care assistants, nutritionists, peer supporters and other staff. It is also suitable for use in pre-service training so that students are prepared with the knowledge and skills to support breastfeeding when they begin work. A hospital may use sections of the course to provide short in-service sessions for staff on specific topics.

The course by itself cannot transform hospitals, but it can provide a common foundation for basic breastfeeding management that will lay the basis for change. These health workers in contact with the women and her child, along with hospital administrators, policy makers, and government officials will then have the bigger task of ensuring long-term implementation of appropriate policies that support optimal infant feeding.

On completion of this course, the participant is expected to be able to:

- use communication skills to talk with pregnant women, mothers and co-workers;
- practice the Ten Steps to Successful Breastfeeding and abide by the International Code of Marketing of Breast-milk Substitutes;
- discuss with a pregnant woman the importance of breastfeeding and outline practices that support the initiation of breastfeeding;
- facilitate skin-to-skin contact and early initiation of breastfeeding;
- assist a mother to learn the skills of positioning and attaching her baby as well as the skill of hand expression;
- discuss with a mother how to find support for breastfeeding after she returns home;
- outline what needs to be discussed with a women who is not breastfeeding and know to whom to refer this woman for further assistance with feeding her baby;
- identify practices that support and those that interfere with breastfeeding;
- work with co-workers to highlight barriers to breastfeeding and seek ways to overcome those barriers.

This course is NOT designed to train trainers to teach courses, to provide training in on-going support for infant feeding after discharge from the maternity service, to train specialist workers in assisting with breastfeeding difficulties, to train infant feeding counsellors working with women who are HIV-positive, or to train administrator's and those involved in policy development. There are other specialised courses for those health workers that give fuller training than this short course can provide such as:
-*Breastfeeding Counselling: a training course,* WHO/UNICEF (1993).
-*HIV and Infant Feeding Counselling: a training course,* WHO,UNICEF,UNAIDS (2000).
-*Infant Feeding in Emergencies*, Emergency Nutrition Network (ENN) in conjunction with WHO/UNICEF (2003).
-*Integrated Infant Feeding Counselling: a training course*, WHO/UNICEF (2005).
-*Strengthening and sustaining the Baby-friendly Hospital Initiative: A course for decision-makers*, which forms Section 2 of this updated BFHI package of materials.

Some staff may not have a role in clinical care but would benefit from knowing more about why breastfeeding is important and how they can help support it. A 15-20 minute session in Appendix 7 can be used as an orientation to non-clinical staff. It can also be used for new clinical staff waiting to be scheduled for participating in the full 20-hour course.

Length of the course

The decision to develop the course to 20 hours is based on several factors. It is recognised that intensive in-service training such as this course necessitates some interruption of clinical care. The 20 hours may be presented in three intensive days or in shorter segments over a longer period, whichever is most suitable for the facility. It is intended that every hospital staff member who has direct patient care responsibility for mothers and babies will attend the course. It is kept short in anticipation that it will need to be repeated within the same hospital in order to reach all staff from all shifts.

A 20-hour syllabus allows much of the essential information to be presented. There are 15.5 hours of classroom time focused on skill-oriented training including discussion and pair practice. The 4.5 hours of clinical practice provides time with pregnant women and new mothers. A formal opening or closing, if needed, and breaks are not included in the 20 hours. Additional time needs to be added for the clinical practice if participants must travel from the classroom to another site where the mothers are available.

The amount of time anticipated for the individual topics within each session is indicated. This time allows the core material to be presented, however additional time will be needed if there is additional discussion and debate on the topic. Additional time will be needed for some of the activities printed in boxes, as indicated. Aim to allow a five-minute break between sessions for a 'stretch' if a longer break is not scheduled for that time.

At the end of the course, participants need to be clear about what action they need to take to implement the practices and skills into their every day work. Information on developing an "action plan" is given in the final session. However, additional time will be needed to develop a detailed plan, which is important for change to occur and be sustained.

If it is possible to arrange more than 20 hours, certain topics could be presented in greater depth, and more time would be available for discussion. Additional role-play practice would also be of benefit to the participants.

It is expected that clinical learning will continue with supervision by the more experienced and knowledgeable hospital staff. This ongoing clinical practice will be essential to providing

continuity of care to breastfeeding mothers and babies and to ensuring the implementation of the Ten Steps to Successful Breastfeeding.

Preparing for the course

An overall course planning checklist is provided in Annex 1.

Choosing facilitators

Facilitators should be knowledgeable about breastfeeding and health care practices (including birth procedures) that are baby-friendly. The facilitators should be experienced in presentation skills and in techniques of assisting learning. At least one of the course facilitators should have a high level of breastfeeding knowledge so they are able to answer questions and find further references. The number of facilitators will depend on the number of participants and the format of the course. Participation in this course does not qualify the person to become a facilitator for this course.

If this course is given as an intensive three days course, no one facilitator should have primary responsibility for teaching more than three sessions in a day. Aim for a change of facilitators frequently - at least for each session. Sessions may be divided with two or more facilitators taking different sections to provide variety. Each facilitator should have at least one hour of teaching responsibility daily. One facilitator can do all the teaching if only one session is held on a single day, as may be likely in hospital in-service training.

In order to learn effectively from the clinical practice and to safe guard the mothers and babies, there should be sufficient facilitators to supervise the practice. Additional facilitators may be available if there are skilled staff on the wards or clinic already who can assist. Each facilitator should ideally have four and no more than six participants to supervise during clinical practice. If the course is conducted in short sessions over a period in one facility, clinical practice can be done by a small group of not more than six people with a facilitator at a time convenient to their work.

Clinical practice requirements

A minimum of four and a half hours of clinical experience forms part of the training course. The facilitators will need to meet with hospital administration and maternity staff before the course begins to discuss the best way that each clinical practice can be carried out. Read the session through carefully to see how it can be conducted effectively in your setting.

Facilitators will need to help the hospital maternity staff decide how to select appropriate women for participants to talk with, to observe and to assist. It is likely that the nurse or physician in charge of the maternity ward will work together with the facilitators on this activity.

It is expected that this course will be used primarily for hospital in-service training, with the wards easily accessible for clinical practice. The clinical work is an essential part of the training and the three clinical practices allotted are an absolute minimum. It is anticipated that course participants will need ongoing supervised clinical practice to ensure that the new management becomes routine.

Preparing the timetable

Find out what are the best times to conduct the clinical practices and build the classroom sessions around these visits to the wards/clinics. If there are a large number of participants, it may be possible to divide the group so that some are talking with pregnant women while other participants are assisting breastfeeding or hand expression. Ensure the classroom knowledge on a topic comes before the clinical practice for that topic. For example, to talk to a pregnant woman about practices that support breastfeeding such as early contact and rooming-in, these sessions will need to be covered before the clinical practice with pregnant women.

The number of facilitators and their particular skills also needs to be taken into account. Planning the timetable may mean shifting facilitators or topics around so that no facilitator is overburdened at the start and unused later.

The timetable may also need to consider when equipment is available, when meal breaks need to be taken and whether travel time is needed for clinical practices. An example of a timetable is provided in Annex 2.

Room requirements

The course will need:

- A classroom big enough for the whole group.
- Tables and chairs that can be moved for individual learning activities.
- A blackboard, white board or flipchart (and chalk or markers) in the front of the room for writing.
- A notice board or wall to display materials and tape or other system for attaching notices to the wall.
- Easy access to data projector for PowerPoint, extension cords, and screen or suitable wall or equipment to produce colour printed overhead transparencies
- 2-3 large tables to hold the projector, display materials and for the facilitator's use;
- Simple room-darkening arrangements.

Course materials

Facilitator's materials

- Session Outlines containing the points to be covered for each topic and illustrations where relevant.
- PowerPoint containing the pictures and illustrations. Colour printouts or transparencies of the PowerPoint can be made if PowerPoint is not available.
- Annex 3: Resources for Further Information, which includes web sites for further information and resource materials.
- Section 4.1, which includes the Hospital Self-Appraisal Tool is a separate document in the set of Baby-friendly Hospital Initiative materials.

Other teaching aids

- Dolls. Choose or make dolls that range in size from newborn to a few months old. At least one doll is needed for each group of 3-4 participants.
- Cloth breast model. See Annex 4 for instructions on how to make a breast model. At least one breast is needed for each group of 3-4 participants.

The one to two page summaries of each session can be used as a Participants' Manual if required. Participants are not expected to need to take extensive notes.

Session Outlines

The cover page for each session sets out:

- The learning objectives for the session, which are numbered as section headings.
- The overall time allocated for the session.
- Any additional materials or preparation the facilitator will need for the session.
- A list of Further Reading for the facilitators. The items listed can be downloaded from the Internet unless stated otherwise. Details of the web sites are in Annex 3. Additional material may be available from local UNICEF or WHO offices.

Teaching outline

Topics are listed under each main heading. To the left of the main heading is the objective number that corresponds with the topic. To the right of the main heading is the time suggested for teaching that topic. Class activities appear in boxes. Facilitators are expected to check the material is still suitable and up-to-date before each session.

Knowledge check

A knowledge check appears at the end of each session. Participants can be asked to complete each test in their own time, in pairs or in groups. Facilitators may offer to review any material that is still unclear. If facilitators wish, and if time allows, the knowledge check may be used for class discussion. When preparing the session, facilitators should review these knowledge checks and prepare possible answers. Answers to the questions are generally provided in the text for that session.

Session summary

At the end of each session is a short summary of the main points. The summary may be given to participants at the start of the session so that the participants can refer to this page and add additional notes if needed. The summaries may be photocopied for use outside the course.

Additional information section

The core material in each session aims to cover the practice situations for the majority of participants. The facilitator may want additional information to answer questions or to cover a topic in greater depth. Presenting this additional information is not included in the session time.

Language of the course

The course can be translated into the native language of the country, but should always be reviewed by one or more people qualified in lactation management to ensure accuracy of the information provided.

Assessment of learning

A self-assessment of learning tool is included in Annex 5. This can be used as a post-test; or to assist the participants to continue to develop their knowledge and skills; or to assess if a new staff member has adequate knowledge and skill from a previous employment or training. This tool can be modified so the facilitator can assess the learning as well as the participant's self-assessment.

Presentation of the course

Interactive facilitation

The session outline provides the key points to include in each section. It is best if the facilitator does not read all the points word by word as a lecture but uses a more interactive style:

- The facilitator can ask participants a question that will lead into a section – for example, "How might birth practices affect breastfeeding?" Let participants comment first and then present the points in the text for this section.
- The facilitator can ask about their experiences to also involve participants - "When do women in this area have an antenatal discussion about feeding their baby"?
- It can be helpful to ask a question after the key points have been presented, - "How do you think this practice would work here?"
- Help participants to relate theory to practice, - "If a mother came to you with sore nipples, what might you watch for when you observe the baby feeding?"
- If you want participants to study a picture and comment on it, keep silent for a moment to give them time to think.

Keep in mind that the time is very limited and ensure the discussions are relevant to the topic, brief, and helpful to the group. Concentrate on covering the topics that apply to most women rather than spending a long time discussing unusual or rare situations.

If participants are looking for more information, direct them to the Further Reading materials, or encourage them to attend a more specialist course as listed earlier.

Babies are both male and female, therefore the phrase "she or he," is used when the baby is referred to in this course. Facilitators do not need to say she or he each time, they are encouraged to use "she" sometimes and "he" sometimes for the baby as they facilitate the course. In the story, one baby is a boy and one baby is a girl, therefore he or she is used depending on which baby is referred to.

Discussions

These discussions give an opportunity for participants to share ideas and raise questions. The facilitator will need to guide the discussion and keep participants focused. If one participant dominates discussion, the facilitator will need to intervene. If the facilitator dominates, it becomes a lecture or question-and-answer session, and is not a discussion.

Working in small groups gives participants an opportunity to share ideas and experiences. These small group discussions are very important for changing attitudes, not just to share facts. Facilitators can rotate from group to group to ensure the information shared supports baby-friendly practices. In general, do not spend time reporting back from the groups, especially if all groups were discussing the same topic.

Each group should have a reporter who summarizes the main points and questions on a large card or sheet of paper to post for all to see. The facilitator can provide relevant information as the course continues and discuss the questions raised.

Pair practice

Pair practice allows participants to practice communication skills with one another. Let participants choose their own partners or mix participants so that they have an opportunity to work with different people. If someone ends up alone, a facilitator can pair with the extra person. In addition to the activities identified as pair practice, this technique can be used with any of the Case Studies.

Role plays

When facilitators use role-plays and demonstrations as a learning tool, they should rehearse the general direction of the role-play before the session. As an alternative, selected participants can be asked to participate in a role play/demonstration with a facilitator. Role play/demonstrations should be informal, small dramas that take only a few minutes. Role play/demonstrations can be used to stimulate discussion, to model certain kinds of interaction, and to introduce a case study for further role playing between participants.

Role plays and demonstrations are suggested at several points throughout the course. However, it is hoped that individual facilitators will utilise their own teaching skills and talents to present material in creative ways. Have fun with role plays, and provide as many opportunities as possible for participants to join in.

Case studies

The case studies present a situation that the participants are asked to discuss or to use as the basis for a role-play. Participants may want to adapt their case study to fit particular national, cultural, or management situations. Names and character details can easily be changed. If class time does not permit the use of a case study, participants may be asked to do a homework assignment based on it.

Forms

Forms are used for activities in several sessions. One copy of each form is provided at the end of the session plan where it will be used. The necessary number of copies can be made for the session so that every person has one form. The forms may also be copied for clinical use outside the course.

Illustrations

Illustrations are referred to within the outlines. They may be used to make overhead transparencies or flipcharts if the PowerPoint is not available.

Photographs and illustrations

While topics may be presented without the use of PowerPoint slides, they are helpful whenever possible. The facilitator should explain what the participants are to look for in the picture. Participants can be asked to come to the front of the room to point out what they see in a picture. Where electricity and room darkening are available only in the evenings, scheduling of topics will need to be adjusted. If PowerPoint is not available, the pictures can be printed, preferably in colour, for the participants to look at as a group.

HIV and infant feeding

If the course is held where there is a high rate of HIV infection among pregnant women, and participants' knowledge on mother-to-child transmission of HIV is limited, additional information related to HIV may be provided as additional sessions. Sessions from *HIV and Infant Feeding Counselling: a training course,* UNAIDS/WHO/UNICEF (2000) or *Integrated Infant Feeding Counselling: a training course,* WHO/UNICEF (2005) can be used to provide information on:

-Basic facts on HIV and on Prevention of Mother-to-Child Transmission (PMTCT).
-Testing and counselling for HIV.
-Locally appropriate replacement-feeding options.
Risks of "spill over" of replacement feeding to the general population.

Annex 1: Course Planning Checklist

Initial planning

1. Visit the health facility that you will use for clinical practices.
   _ Confirm the hours during which it is possible to talk with pregnant women and new mothers. If you plan to visit more than one facility at each practice time, it is important to make sure they are available at the same time. Each participant will need to talk with at least one pregnant women and one breastfeeding mother. For example, in a course with 12 participants, there would need to be at least 20 pregnant women at the antenatal clinic and/or antenatal in-patient ward or waiting mother facility, to provide sufficient women to talk to allowing for some women to be unwilling to talk.

2. Choose a classroom site. Ideally, this should be at the same site as the clinical practice sites. Make sure that the following are available:
   _ Easy access from the classroom to the area for the clinical practice.
   _ A large room that can seat all participants and facilitators for sessions, including space for guests invited to opening and closing ceremonies. There should be space for a group of four participants and a facilitator to sit at a table.
   _ For the facilitators' preparation day before the participants' course, you will need one classroom that can accommodate 8 people.
   _ Adequate lighting and ventilation, and wall space to post up large sheets of paper in each of the rooms.
   _ At least one table for each group of 4 participants and additional table space for materials.
   _ Freedom from disturbances such as loud noises or music.
   _ Arrangements for providing refreshments.
   _ Space for at least one clerical or logistic support staff during participants' course.
   _ A place where supplies and equipment can be safely stored and locked up if necessary.
   _ When you have chosen a suitable site, book the classroom space in writing and subsequently confirm the booking some time before the course, and again shortly before the course.
   _ Confirm the times of the clinical practice visits with the clinical sites.
   _ Make arrangements for transporting participants and facilitators to the clinical practice site.

3. Decide exact dates of the course and prepare a timetable.
   _ Decide the course schedule, for example, a whole course on consecutive days or 1-day each week.
   _ Allow 1 day for the preparation of facilitators.
   _ Allow 3 days for the course for participants.
   _ Course Director available 1-2 days before the facilitators' preparation session, as well as during all of the facilitators' preparation session and the course itself.
   _ If the clinical practice site is a different venue than the classroom you need to allow extra time to travel to and from the clinical practice site.
   _ Ideally allocate no more than 6.5 teaching hours per day with meal and break times in addition.
   _ Prepare the course timetable allocating clinical practice times, classroom times, and meal and break times.

- If participants have long distance to travel, consider a later start on Day 1 and an early finishing time on Day 4, if the course is held on consecutive days.
- If there will be a formal opening or closing ceremony include these in the timetable so that these events do not take time away from the course sessions.

4. Choose lodging for the participants and facilitators if needed. If lodging is at a different site from the course, make sure that the following are available:
   - Reliable transportation to and from the course site.
   - Meal service convenient for the course timetable.
   - When you have identified suitable lodging, book it in writing and subsequently confirm the booking some time before the course, and again shortly before the course.

5. Select and invite facilitators. It is necessary that:
   - Facilitators are experienced in course facilitation and are knowledgeable about breastfeeding and health care practices that are baby-friendly.
   - Facilitators are able and willing to attend the entire course, including the preparatory day before the course.
   - Facilitators receive materials at least three weeks before the start of a course so they have an opportunity to read them.
   - There is at least one facilitator per 4 participants during the clinical practice visits. Additional facilitators may be available if there are skilled staff on the wards or clinic who can assist.

6. Identify suitable participants, and send them letters of invitation stating:
   - The objectives of the training and a description of the course.
   - The desired times of arrival and departure times for participants.
   - That it is essential to arrive in time and to attend the entire course.
   - Administrative arrangements, such as accommodation, meals, and payment of other costs.

7. Arrange to send travel authorisations to facilitators, course director, and participants.

8. Arrange to send materials, equipment, and supplies to the course site.

9. Invite outside speaker for opening and closing ceremonies, if needed.

Arrangements a week before the course begins

10. Confirm arrangements for:
    - Lodging for all facilitators and participants.
    - Classroom arrangements.
    - Daily transportation of participants from lodgings to classroom and to and from clinical practice sites.
    - The clinical practice site and that facility staff are briefed on the visits
    - Meals and refreshments.
    - Opening and closing ceremonies with relevant authorities. Check that invited guests are able to come.
    - A course completion certificate (if one will be given) and when a group photograph will be taken in time to be developed before the closing ceremony. (optional).
    - Arrangements for typing and copying of materials during the course (for example, timetables, lists of addresses of participants and facilitators).

11. Arrange to welcome facilitators and participants at the hotel, airport, or railway/bus station, if necessary.

12. Ensure course materials, supplies, and equipment, are available and ready to be delivered to the course site.

Actions during the course

13. After registration, assign groups of 4 participants to one facilitator. Post up the list of names where everyone can see it.

14. Provide all participants and facilitators with a Course Directory, which includes names and addresses of all participants, facilitators, and the Course Director.

15. Arrange for a course photograph, if desired, to be taken.

16. Prepare a course completion certificate for each participant.

17. Make arrangements to reconfirm or change airline, train, or bus reservations and transportation to stations for facilitators and participants, if necessary.

18. Allocate a time for payment of per diem and for travel/lodging arrangements that does not take time from the course.

Add any other points you need to check:

Equipment list:

_ Data projector and laptop for PowerPoint, extension cord, and screen or suitable flat white wall, or equipment to produce colour printed overhead transparencies and an overhead projector.

_ Dolls. Choose or make dolls that range in size from newborn to a few months old. At least one doll is needed for each group of 3-4 participants.

_ Cloth breast model. See Annex 3 for instructions on how to make a breast model. At least one breast is needed for each group of 3-4 participants.

_ Pens, pencils, erasers, and paper for the participants and facilitators.

_ A blackboard, white board or flipchart (and chalk or markers).

_ Flip chart paper and means to attach sheets to the wall, markers.

Annex 2: Example of a Course Timetable – held over 3 days

Time for core material is indicated, not including additional information sections or optional activities. Arrange clinical practices first and then fit the classroom sessions around these practices.

Day 1		
8.30-8.45	Welcome (allow extra time for a formal opening, if desired)	15 minutes
8.45-9.15	Session 1: BFHI: a part of the Global Strategy	30 minutes
9.15-10.15	Session 2: Communication skills	60 minutes
10.15-10.30	Break	*15 minutes*
10.30-12.00	Session 3: Promoting breastfeeding during pregnancy – Step 3	90 minutes
12.00-12.45	Session 4: Protecting breastfeeding	45 minutes
12.45-1.45	Break	*60 minutes*
1.45-3.00	Session 5: Birth practices and breastfeeding – Step 4	75 minutes
3.00-3.15	Break	*15 minutes*
3.15-4.00	Session 6: How milk gets from breast to baby	45 minutes
4.00-4.30	Session 7: Helping with a breastfeed – Step 5 – sections 1-3	30 minutes
4.30-4.45	Summary of the day and any questions	15 minutes
Day 2		
8.30-9.30	Session 7: Helping with a breastfeed – Step 5 – sections 4-7	60 minutes
9.30-10.00	Break (extra time if needed for clinical practice movement)	*30 minutes*
10.00-12.00	Clinical practice 1: observing and assisting breastfeeding	120 minutes
12.00-1.00	Session 8: Practices that assist breastfeeding – Steps 6, 7, 8 and 9	60 minutes
1.00-2.00	Break	*60 minutes*
2.00-2.45	Session 9: Milk supply	45 minutes
2.45-3.30	Session 10: Special infant situations	45 minutes
3.30-3.45	Break	*15 minutes*
3.45-4.45	Session 11: If baby cannot feed at the breast – Step 5	60 minutes
4.45-5.00	Summary of the day and any questions	15 minutes
Day 3		
8.30-9.30	Session 12: Breast and nipple concerns	60 minutes
9.30-10.30	Clinical practice 2:discussing breastfeeding with pregnant women	60 minutes
10.30-11.15	Break (extra time if needed for clinical practice movement)	*45 minutes*
11.15-12.45	Clinical practice 3: observing hand expression and cup feeding	90 minutes
12.45-1.45	Break	*60 minutes*
1.45-2.30	Session 13: Maternal health concerns	45 minutes
2.30-3.45	Session 14: On-going support for mothers – Step 10	75 minutes
3.45-3.55	Break	*10 minutes*
3.55-4.30	Session 15: Making your hospital Baby-friendly	35 minutes
4.30-4.45	Summary of the day and any questions	15 minutes
4.45-5.00	Closing (allow extra time for a formal closing, if desired)	15 minutes

Annex 3: Resources for further information

Web sites:

Remember – web sites change frequently. Search for the key words 'BFHI', baby-friendly, and breastfeeding in the sites search engine, and look under Resources, Publications and Links within the web site.

To download a PDF file without opening it, right click your mouse, then 'Save Target As' and file it in a suitable directory with a recognisable name.

Adobe Reader is free and can be downloaded from most sites that have PDF files or from http://www.adobe.com./

UNICEF Headquarters. Additional materials may also be available from Country Offices For more information on UNICEF's work on infant and young child feeding support of country efforts to implement the targets of the Innocenti Declaration and the Global Strategy for Infant and Young Child Feeding , or on the Baby-friendly Hospital Initiative as a whole, and to download copies as materials are updated, please refer to http://www.unicef.org/nutrition/index_breastfeeding.html

WHO Headquarters. Additional materials may also be available from Regional Offices
Documents listed may be downloaded unless stated otherwise.

Nutrition for Health and Development (NHD)
World Health Organization, 20 Avenue Appia, 1211 Geneva 27, Switzerland
Fax: +41 22 971 41 56, e-mail: nutrition@who.int
http://www.who.int/nutrition/publications/infantfeeding/en/index.html

Department of Child and Adolescent Health and Development (CAH)

World Health Organization
20 Avenue Appia, 1211 Geneva 27, Switzerland
Fax: +41-22 791 4853, e-mail: cah@who.int
http://www.who.int/child_adolescent_health/documents/en/

WHO/UNICEF. Global Strategy for Infant and Young Child Feeding. Geneva, World Health Organization. 2002. Available in English, Arabic, Chinese, French, Russian, Spanish.

WHO/LINKAGES. Infant and Young Child Feeding. A tool for assessing national practices, policies and programmes. Geneva, World Health Organization. 2003.

International Code of Marketing of Breast-milk Substitutes. Geneva, World Health Organization, 1981. Available in English and French

The International Code of Marketing of Breast-milk Substitutes. A common review and evaluation framework. 1996. Geneva, World Health Organization, 1996.

The International Code of Marketing of Breast-milk Substitutes: summary of action taken by WHO Member States and other interested parties, 1994-1998. 1998.

Infant formula and related trade issues in the context of the International Code paper. Geneva, World Health Organization.

Follow-up formula in the context of the International Code paper. Geneva, World Health Organization.

The Innocenti Declaration: Progress and achievements, Parts I, II and III. Weekly Epidemiological Record, 1998, 73(5):25-32, 73(13):91-94 and 73(19):139-144.

Diet, Nutrition and the Prevention of Chronic Diseases. Report of a Joint WHO/FAO Expert Consultation. Geneva, World Health Organization Technical Report Series, No. 916.

Nutrient requirements for people living with HIV/AIDS. Report of a technical consultation. World Health Organization, Geneva, 13–15 May 2003.

Feeding and Nutrition of Infants and Young Children. Guidelines for the WHO European Region, with Emphasis on the Former Soviet Countries. WHO Regional Publications, European Series No. 87. http://www.euro.who.int/InformationSources/Publications/Catalogue/20010914_21#Feeding_feeding

Infant Feeding in Emergencies. (English and Russian)WHO European Office 1997 http://www.euro.who.int/document/e56303.pdf

WHO/UNICEF. *Implementing the Global Strategy for Infant and Young Child Feeding: Report of a technical meeting, Geneva, 3-5 February 2003. Geneva, World Health Organization, 2003.*

Evidence for the Ten Steps to Successful Breastfeeding. Geneva, World Health Organization, 1999. Available in English, French and Spanish.

Butte, NF; Lopez-Alarcon MG and Garza C. *Nutrient adequacy of exclusive breastfeeding for the term infant during the first six months of life*. Geneva, World Health Organization, 2002.

The optimal duration of exclusive breastfeeding. Report of an expert consultation. Geneva, World Health Organization, 2001.

Kramer MS, Kakuma R and WHO.*The optimal duration of exclusive breastfeeding. A systematic review*. Geneva, World Health Organization, 2001.

Complementary feeding: Report of the Global Consultation, and Summary of Guiding Principles for complementary feeding of the breastfed child. Geneva, World Health Organization, 2003.

Guiding principles for complementary feeding of the breastfed child. WHO, PAHO, 2004. Available in English, French and Spanish.

Complementary feeding of young children in developing countries: A review of current scientific knowledge. Geneva, World Health Organization, 1998.

WHO/UNICEF. *Breastfeeding and maternal medication: Recommendations for drugs in the eleventh WHO model list of essential drugs* .Geneva, World Health Organization, 2002.

Breastfeeding and maternal tuberculosis UPDATE, N 23 February 1998. Geneva, World Health Organization, 1998.

Breastfeeding and the use of water and teas UPDATE, No. 9 November 1997. Geneva, World Health Organization, 1997.

Not enough milk UPDATE, No. 21 March 1996. Geneva, World Health Organization, 1996.

Hepatitis B and breastfeeding UPDATE, No. 22 November 1996. Geneva, World Health Organization, 1996.

Persistent diarrhoea and breastfeeding. Geneva, World Health Organization, 1997.

Mastitis. Causes and management. Geneva, World Health Organization, 2000. Available in English, Bahasa, French, Russian, Spanish.

Relactation. A review of experience and recommendations for practice. Geneva, World Health Organization, 1998. Available in English, French, Spanish.

Hypoglycaemia of the newborn. Review of the literature. Geneva, World Health Organization, 1997.

WHO/UNICEF. *Breastfeeding counselling: A training course*. Geneva, World Health Organization, 1993. Available in English, French, Russian, Spanish.

HIV and Infant Feeding: Framework for Priority Action. Geneva, World Health Organization, 2003. Available in Chinese, English, French, Portuguese, Spanish.

HIV transmission through breastfeeding. A review of available evidence. Geneva, World Health Organization, 2004.

WHO, UNICEF, UNAIDS and UNFPA.*HIV and Infant Feeding. Guidelines for decision-makers*. Geneva, World Health Organization, 2004. Available in English, French, Spanish.

WHO, UNICEF, UNAIDS and UNFPA. *HIV and Infant Feeding. A guide for health-care managers and supervisors*. Geneva, World Health Organization, 2004. Available in English, French, Spanish.

Thomas E, Piwoz E, WHO. HIV and infant feeding counselling tools. Geneva, World Health Organization, 2005. Available in English, French, Spanish.

Department of Reproductive Health and Research (RHR),
World Health Organization, 1211 Geneva 27, Switzerland
Fax: + 41 22 791 4189, e-mail: reproductivehealth@who.int
http://www.who.int/reproductive-health/publications/index.htm

Pregnancy, childbirth, postpartum and newborn care - a guide for essential practice Geneva, World Health Organization, 2006.
Kangaroo Mother Care - a practical guide. Geneva, World Health Organization,2003. Available in English, French, Spanish.
Health aspects of maternity leave and maternity protection. Geneva, World Health Organization, 2000.
Statement on the effect of breastfeeding on mortality of HIV-infected women, 7 June, 2001. Geneva, World Health Organization, 2001.

BFHI around the world

- → Australia: http://www.bfhi.org.au/
- → Canada (English and French): http://www.breastfeedingcanada.ca/
- → Belgium: http://www.vbbb.be/
- → France: http://www.coordination-allaitement.org/L%27IHAB.htm
- → Germany: http://www.stillfreundlicheskrankenhaus.de/home.html
- → Ireland: http://www.ihph.ie/babyfriendlyinitiative/index.htm
- → Italy: http://www.mami.org/
- → Netherlands: http://www.borstvoeding.nl/default.asp
- → Switzerland: http://www.allaiter.ch/
- → New Zealand: http://www.babyfriendly.org.nz/
- → United Kingdom: http://www.babyfriendly.org.uk/
- → USA: http://www.babyfriendlyusa.org/

WHO- Western Pacific Region:
http://www.wpro.who.int/health_topics/infant_and_young_child_feeding/general_info.htm

WHO European Office: http://www.euro.who.int/nutrition/Infant/20020730_1

Statistics on BFHI worldwide March 2002:
http://www.unicef.org/nutrition/files/nutrition_statusbfhi.pdf

Organisations, some with Protocols and Policies:

Academy of Breastfeeding Medicine (ABM) is a worldwide organization of physicians dedicated to the promotion, protection and support of breastfeeding and human lactation.
Web site: http://www.bfmed.org/
ABM Protocols include:

Hypoglycemia (English) Hypoglykämie (German) Hipoglucemia (Spanish)
Going Home/Discharge (English) Alta (Spanish)
Supplementation (English) Alimentación suplementaria (Spanish)
Mastitis (English) Mastitis (Spanish)
Peripartum BF Management (English) Manejo en el Periparto de la Lactancia (Spanish)
Cosleeping and BF
Model Hospital Policy
Human Milk Storage Information
Galactogogues
Breastfeeding the Near-term Infant
Neonatal Ankyloglossia
Transitioning from the NICU to Home

Coalition for Improving Maternity Services (CIMS)
Established in 1996, the Coalition for Improving Maternity Services (CIMS) is a collaborative effort of numerous individuals and more than 50 organizations representing over 90,000 members. Their mission is to promote a wellness model of maternity care that will improve birth outcomes and substantially reduce costs. http://www.motherfriendly.org/

The Cochrane Collaboration is an international non-profit and independent organisation, dedicated to making up-to-date, accurate information about the effects of health care readily available worldwide. It produces and disseminates systematic reviews of healthcare interventions and promotes the search for evidence in the form of controlled trials and other studies relevant to health care. Reviews related to breastfeeding are included. http://www.cochrane.org/

Emergency Nutrition Network (ENN) The Emergency Nutrition Network aims to improve the effectiveness of emergency food and nutrition interventions by providing a forum for the exchange of field level experiences between staff working in the food and nutrition sector in emergencies strengthening institutional memory amongst humanitarian aid agencies working in this sector helping field staff keep abreast of current research and evaluation findings relevant to their work better informing academics and researchers of current field level experiences, priorities and constraints thereby leading to more appropriate applied research agendas. http://www.ennonline.net/

European Union Project on Promotion of Breastfeeding in Europe, Protection, promotion, and support of breastfeeding in Europe: a blueprint for action. European Commission, Directorate Public Health and Risk Assessment, Luxembourg, 2004. Available in many European languages http://ec.europa.eu/health/ph_projects/2002/promotion/promotion_2002_18_en.htm

IBFAN - the International Baby-Food Action Network - consists of public interest groups working around the world to reduce infant and young child morbidity and mortality. IBFAN aims to improve the health and well being of babies and young children, their mothers and their families through the protection, promotion and support of breastfeeding and optimal infant feeding practices. Publications (not all can be downloaded) include *Protecting Infant Health: A Health Workers' Guide to the International Code of Marketing of Breastmilk Substitutes*, available in a variety of languages, and *The Code Handbook: A Guide to Implementing the International Code of Marketing of Breastmilk Substitutes. http://www.ibfan.org/site2005/Pages/index2.php?iui=1*

International Board of Lactation Consultant Examiners (IBLCE) are the certifying agency for International Board Certified Lactation Consultants, offering an internationally recognised examination each year at sites around the world. http://www.iblce.org/

International Lactation Consultant Association (ILCA) is the professional association for International Board Certified Lactation Consultants (IBCLCs) and other health care professionals who care for breastfeeding families. Their vision is a worldwide network of lactation professionals. Our mission is to advance the profession of lactation consulting. http://www.ilca.org/
The materials on the site include:

Evidence-Based Guidelines for Breastfeeding Management during the First Fourteen Days (1999) Translated into: Albanian, German, Lithuanian, Macedonian, and Serbian.
Position paper on HIV and Infant Feeding (Revised 2004).
Position paper on Infant Feeding (Revised 2000).
Position paper on Infant Feeding in Emergencies (2005).
Position paper on Breastfeeding, Breast Milk and Environmental Contaminants (2003).

Kangaroo Mother Care web site has downloadable resources on the research supporting Kangaroo Mother Care and experiences of implementing this practice. http://www.kangaroomothercare.com/

La Leche League International (LLLI) is a volunteer mother to mother support organisation. Materials, translations and links to groups around the world. http://www.llli.org//

LINKAGES is a USAID-funded program providing technical information, assistance, and training to organizations on breastfeeding, related complementary feeding and maternal dietary practices, and the

lactational amenorrhea method - a modern postpartum method of contraception for women who breastfeed. Linkages Project. http://www.linkagesproject.org/

Exclusive Breastfeeding: The Only Water Source Young Infants Need - Frequently Asked Questions. Languages Available: English (2004), French (2004), Spanish, Portuguese (2002).

Community-Based Strategies for Breastfeeding Promotion and Support in Developing Countries. Languages Available: English (2004).

Infant Feeding Options in the Context of HIV. Languages Available: English (2004).

Mother-to-Mother Support for Breastfeeding- Frequently Asked Questions. Languages Available: English (2004), French (1999), Spanish (1999).

World Alliance for Breastfeeding Action (WABA) was formed on 14 February, 1991. WABA is a global network of organizations and individuals who believe breastfeeding is the right of all children and mothers and who dedicate themselves to protect, promote and support this right. WABA acts on the Innocenti Declaration and works in liaison with UNICEF. http://www.waba.org.my/

Wellstart International's mission is to advance the knowledge, skills, and ability of health care providers regarding the promotion, protection, and support of optimal infant and maternal health and nutrition from conception through the completion of weaning.
http://www.wellstart.org/

Searching for journal references

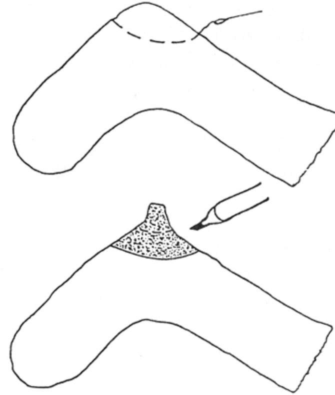
A university or other health training institute library, ministry of health library or health NGO library may be able to assist with finding references.
Medline-National Library of Medicine: http://www.ncbi.nlm.nih.gov/sites/entrez
EMBASE: http://www.embase.com/
Google are developing a free web searcher that searches research journals on open access.
http://scholar.google.com/
The publishers of most of the journals have a searchable web site where the abstract and sometimes the full text of an article can be viewed or downloaded.
Example, Journal of Human Lactation. http://jhl.sagepub.com/

There are additional Committees, National Authorities and other useful sources of information that may be identified by a local UNICEF or WHO office.
If your committee would like to be listed, please let UNICEF know by email: Subject line: Attn. Nutrition Section at: pdpimas@unicef.org

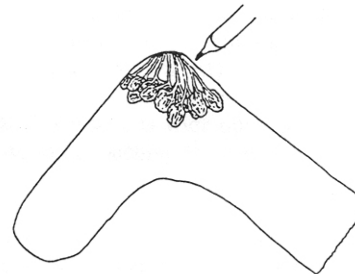
Annex 4: Instructions to make a cloth breast model

Use two socks: one sock in a light brown or other colour resembling skin to show the outside of the breast, and the other sock white to show the inside of the breast.

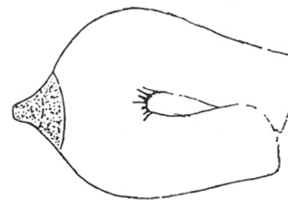
Skin-colour sock
Around the heel of the sock, sew a circular running stitch (= purse string suture) with a diameter of 4 cm. Draw it together to 1½ cm diameter and stuff it with paper or other substance to make a "nipple". Sew a few stitches at the base of the nipple to keep the paper in place.
Use a felt tip pen to draw an areola around the nipple.



White sock
On the heel area of the sock, use a felt tip pen to draw a simple structure of the breast: alveoli, ducts, and nipple pores. Be sure the main ducts will be in the areola area.



Putting the two socks together
Stuff the heel of the white sock with anything soft. Hold the two ends of the sock together at the back and form the heel to the size and shape of a breast. Various shapes of breasts can be shown. Pull the brown sock over the formed breast so that the nipple is over the pores.



Making two breasts
If two breasts are made, they can be worn over clothing to demonstrate positioning and attachment. Hold them in place with an old nylon stocking tied around the chest. The correct position of the fingers for hand expression and massage can also be demonstrated.

Annex 5: Assessment of Learning Tools

PARTICIPANT END OF COURSE ASSESSMENT

Please answer the following questions. Your answers will help us improve this course. Thank you.

1. **On completion of this course:** (please put a X in the chosen column)

	I am NOT able to	I am partly able to	I am fully able to
Discuss with a pregnant woman at least: 2 reasons why breastfeeding is important for babies 2 reasons why breastfeeding is important for mothers 4 practices that support the initiation of breastfeeding			
Help mothers and babies to have: skin-to-skin contact immediately after birth an early start of breastfeeding			
Assist a mother to learn the skills of: positioning and attaching her baby for feeding hand expression of her milk			
Discuss with a mother how to find support for feeding her baby after she leaves the maternity unit			
List what needs to be discussed with a women who is not breastfeeding and know to whom to refer this woman for further assistance with feeding her baby (if you are not trained in HIV Infant Feeding Counselling)			
Identify practices in your facility that support and those that interfere with breastfeeding			
Work with co-workers to highlight barriers to breastfeeding and seek ways to overcome those barriers			
Follow the Ten Steps to Successful Breastfeeding			
Abide by the International Code of Marketing of Breast-milk Substitutes			

2. Overall I would rate this course as: Excellent Good Poor

3. The educational level of these materials is: Too simple Suitable Too difficult

4. Participant's self-evaluation
   The work I did during this course was: Too much Suitable Very little
   I learned from this course: Very much Moderate Very little

5. What have you learned from this course that would be <u>most</u> useful in your work with pregnant women, new mothers, and newborn infants?

   ____

   ____

Your comments are very important to us. Please write any additional comments or observations that you have about the training, including suggestions for improvements, on the back. Thank you.

Annex 6: Picture credits

Cover image "Maternity", 1963, © 2003 Estate of Pablo Picasso/Artists Rights Society (ARS), New York

Slide 3/1: Original illustration by Jenny Corkery, Dublin, Ireland

Slide 5/1: ©UNICEF C107-2

Slide 5/2: UNICEF/HQ92-0369/ Roger Lemoyne, Thailand

Slide 5/3: Dr Nils Bergman, Cape Town, South Africa

Slide 6/1: Adapted from *Breastfeeding Counselling: a training course,* WHO/CHD/93.4, UNICEF/NUT/93.2

Slide 6/2: *Breastfeeding Counselling: a training course,* WHO/CHD/93.4, UNICEF/NUT/93.2

Slide 6/3: *Breastfeeding Counselling: a training course,* WHO/CHD/93.4, UNICEF/NUT/93.2

Slide 6/4: *Breastfeeding Counselling: a training course,* WHO/CHD/93.4, UNICEF/NUT/93.2

Slide 7/1: *Breastfeeding Counselling: a training course,* WHO/CHD/93.4, UNICEF/NUT/93.2

Slide 7/2: *adapted from Integrated Infant Feeding Counselling: a training course*, WHO/UNICEF (2005)

Slide 7/3: ©UNICEF C107-5

Slide 7/4: ©UNICEF C107-7

Slide 7/5: ©UNICEF C107-9

Slide 7/6: UNICEF/HQ91-0168/ Betty Press, Kenya

Slide 8/1: Original illustration by Jenny Corkery, Dublin, Ireland

Slide 9/2: *Breastfeeding Counselling: a training course,* WHO/CHD/93.4, UNICEF/NUT/93.2

Slide 10/1: Dr Nils Bergman, Cape Town, South Africa

Slide 10/2: Dr Nils Bergman, Cape Town, South Africa

Slide 10/3: UNICEF/HQ93-0287/ Roger Lemoyne, China

Slide 10/4: UNICEF/HQ92-0260/ Lauren Goodsmith, Mauritania

Slide 10/5: ©UNICEF C107-21

Slide 10/6: Kay Hoover and Barbara Wilson-Clay, from *The Breastfeeding Atlas*

Slide 11/1: ©UNICEF 910164F

Slide 11/2: *Promoting breastfeeding in health facilities: A short course for administrators and policy makers* WHO/NUT/96.3, Wellstart International

Slide 11/3: Dr Ruskhana Haider, Dhaka, Bangladesh

Slide 12/1: *Breastfeeding Counselling: a training course,* WHO/CHD/93.4, UNICEF/NUT/93.2

Slide 12/2: ©UNICEF C107-19

Slide 12/3: ©UNICEF C107-25

Slide 12/4: ©UNICEF C107-39

Slide 12/5: ©UNICEF C107-31

Slide 12/6: ©UNICEF C107-32

Slide 12/7: *Breastfeeding Counselling: a training course,* WHO/CHD/93.4, UNICEF/NUT/93.2

Slide 12/8: ©UNICEF C107-34

Slide 12/9: ©UNICEF C107-33

Slide 12/10: ©UNICEF C107-35

Slide 13/1: Institute for Reproductive Health, Georgetown, Washington, DC

Slide 14/1: Original illustration by Jenny Corkery, Dublin, Ireland

Slides 15/1-15/6: Originally developed by Genevieve Becker for BFHI in Ireland

Annex 7: Notes for an orientation session for non-clinical staff

Target audience: staff that do not have clinical responsibility for assisting breastfeeding. This may include clerical workers, catering staff, cleaners, laboratory staff, storeroom, porters or other staff.

Time: 15 to 20 minutes

Objectives: At the end of this session, participants will be able to:
Indicate where a copy of the facilities breastfeeding/infant feeding policy can be found;
List two reasons why supporting breastfeeding is important;
List two practices in the facility that support breastfeeding;
List two things that they can do (or avoid doing) as part of their own work that can help implement the policy and support breastfeeding.

Key points:

- Breastfeeding is important to the short and long term health and well being of mother and child. Exclusive breastfeeding is recommended for the first six months, this means no other food or drinks aside from breast milk. Following the introduction of other foods from six months, breastfeeding is still important. It can continue into at least the second year.
- Mothers and babies who are not breastfeeding need extra care to be healthy.
- Most women are able to breastfeed.
- If a pregnant woman or a mother has a question about feeding her baby, suggest that she talk to (who ever are relevant in this facility such as the midwife or clinic nurse or the doctor).
- This health facility works to support breastfeeding and has a policy which you are required to abide by (the same as you abide by policies about confidentiality, safety, timekeeping and other policies). This policy includes: … (discuss some practices such as antenatal information, rooming-in, and demand feeding).
- Hospital practices can help (or hinder) baby and mother friendly practices. Implementing the Baby-friendly Hospital Initiative helps good practices to happen.

In your general work, this means:

- No advertising/marketing of formula, bottles, or teats will be allowed in the health facility. This includes no pens, calendars, magazines or other printed marketing materials, no samples, no equipment marketing a formula related product, no presents, etc, from companies related to formula, bottles, teats, or pacifiers. No displays of bottles in ward areas, visible stores or returns area - watch for window sills that are visible from outside, and bottles stacked in wards. When parents see these products displayed in the hospital, they think the hospital supports their use. While the health facility realises these products are needed at times, it does not want to be seen as endorsing particular brands. Your help is requested to keep the health facility a marketing-free zone.
  Contact ... if you see marketing of these products in the health facility (main point to get across is marketing, not if the use of the product is good or bad).
- All health facility materials will promote breastfeeding as the normal and optimal way to care for a baby.

- Mothers will be supported to breastfeed if they are patients, staff or visitors. No mother will be asked to leave a public area if she is breastfeeding. Staff mothers will be supported to continue breastfeeding after returning to work by … (such as information during pregnancy on breastfeeding, maternity leave, time and a place to express milk on return, support group for staff, etc.) Discuss this with your supervisor before you go on maternity leave.
- If your work brings you into contact with a breastfeeding mother/child, be supportive. A smile and maybe an offer of help such as a drink of water or a seat can shown the mother that you know she is doing something good.
- If you work in maternity or paediatric areas more specific information will be provided on your role in supporting the policy (for example what to say if a mother asks you to get her formula, if you notice a mother with difficulties, or labour ward practices).
- If you want further information or someone asks you a question, information is available from .... (give specific names).

Answer any questions from the participants.

Notes:
Keep the session very brief, informal and related to their work, rather than a theory classroom session. The participants do not need to know how breast milk is made, how to position a baby, detail on Ten Steps, or the Code for their work role. If they want more information personally, this can be provided afterwards.

Further information on the importance of breastfeeding and how supportive practices can be implemented can be found in the main session of the course: *Breastfeeding Promotion and Support in a Baby-friendly Hospital.*

BABY-FRIENDLY HOSPITAL INITIATIVE

Revised Updated and Expanded
for Integrated Care

SECTION 3.2 SESSION OUTLINES

BREASTFEEDING PROMOTION AND SUPPORT IN A BABY-FRIENDLY HOSPITAL

A 20-HOUR COURSE FOR MATERNITY STAFF

2009

Original BFHI Course developed 1993

SECTION 3.2: SESSION OUTLINES

3.1 Guidelines for Course Facilitators

3.2 Session Outlines

Welcome Session	23
Session 1: BFHI: a part of the Global Strategy	25
Session 2: Communication skills	33
Session 3: Promoting breastfeeding during pregnancy – Step 3	55
Session 4: Protecting breastfeeding	77
Session 5: Birth practices and breastfeeding - Step 4	85
Session 6: How milk gets from breast to baby	97
Session 7: Helping with a breastfeed - Step 5	105
Session 8: Practices that assist breastfeeding – Steps 6, 7, 8, & 9	123
Session 9: Milk supply	135
Session 10: Infants with special needs	145
Session 11: If baby cannot feed at the breast – Step 5	157
Session 12: Breast and nipple conditions	169
Session 13: Maternal health concerns	189
Session 14: On-going support for mothers – Step 10	199
Session 15: Making your hospital baby-friendly	213
Closing Session	233
Clinical practice 1 - Observing and assisting breastfeeding	235
Clinical practice 2 - Talking with a pregnant woman	239
Clinical practice 3 - Observing hand expression and cup feeding	243
Appendix 1: Acceptable medical reasons for use of breast-milk substitutes	249
Appendix 2: Knowledge Checks	255

3.3 PowerPoint slides for the course

Each Section is a separate file and may be downloaded from UNICEF Internet at http://www.unicef.org/nutrition/index_24850.html, or the WHO Internet at www.who.int/nutrition

WELCOME SESSION

Time:

15 minutes
If there are opening speeches or ceremonies, additional time is needed.

Materials:

Prepare a course timetable and make a copy for each participant or post a copy in the classroom.

Welcome participants to the course

- Introduce yourself and say what you would like to be called. Ask the other facilitators introduce himself or herself to the rest of the group.
- Ask each participant to introduce himself or herself to the rest of the group and to say what they hope to learn during the course.

Describe course methods and timetable:

- The course will include some talks and some discussion. We will also have role-plays and demonstrations. You will do some work in groups. There will be clinical practices when you work with pregnant women and breastfeeding mothers.
- During the course, you are expected to contribute to the learning of the whole group by sharing your ideas and comments.
- There will be a time for questions at the end of each section. However, if there is a point you need to clarify during the session, please ask. It is hard to learn if you have a question stuck in your mind.
- The course will run for three days[3]. Today we will finish at … with a break at …. Tomorrow, we will start at … until ….

- *Give out Course Timetable or indicate where it is posted.*
- *If there is a course evaluation sheet, explain it.*
- *Agree 'rules' such as cell/mobile phones turned off.*
- *Indicate facilities such as toilets, drinking water and highlight any safety issues.*
- *Check if there are any points that need to be clarified before moving to the next session.*

3 Adapt as needed to reflect the format of the course. It may be useful to 'negotiate' break times with the participants.

SESSION 1
THE BABY-FRIENDLY[4] HOSPITAL INITIATIVE: A PART OF THE GLOBAL STRATEGY

Session Objectives:

On completion of this session, participants will be able to:

1.	State the aim of the WHO/UNICEF Global Strategy for Infant and Young Child Feeding.	5 minutes
2.	Outline the aims of the Baby-friendly Hospital Initiative (BFHI).	5 minutes
3.	Describe why BFHI is important in areas of high HIV prevalence.	5 minutes
4.	Explain how this course can assist this facility at this time.	10 minutes
5.	Review how this course fits with other activities.	5 minutes
	Total session time	**30 minutes**

Materials:

Slide 1/1: Global Strategy

Slide 1/2: Aim of BFHI

Slide 1/3: Course Aims

Prepare slides or posters with country or region data showing:

- The number of baby-friendly hospitals accredited in the area/country, and what percentages of births are in baby-friendly accredited hospitals.
- Any national programmes to implement the Global Strategy.

Display a copy of the WHO/UNICEF Global Strategy for Infant and Young Child Feeding.

Display a copy of national or local health facility's breastfeeding policy.

Display a poster of the Ten Steps to Successful Breastfeeding and/or a handout for each participant.

Further reading for facilitators:

Global Strategy for Infant and Young Child Feeding. Geneva, World Health Assembly, May 2002.

WHO. *Protecting, Promoting and Supporting Breastfeeding - The special role of maternity services.* A joint WHO/UNICEF Statement, 1989.

WHO. *Evidence for the Ten Steps to Successful Breastfeeding.* WHO/CHD/98.9

UNAIDS/UNICEF/WHO *HIV and Infant Feeding: Framework for Priority Action (2003)*
HIV and Infant Feeding - Guidelines for decision-maker (updated 2005);
A guide for health care managers and supervisor (updated 2005);
A review of HIV transmission through breastfeeding (updated 2007).

Link session content to the opening speeches as relevant.

4 The terms Baby-friendly, Baby Friendly, and Baby-friendly hospital are trademarks of UNICEF, and can only be used as related to official designation or with expressed permission from UNICEF.

1. Global Strategy for Infant and Young Child Feeding 5 minutes

- About 5500 children die every day because of poor infant feeding practices. In addition, many children suffer long-term effects from poor infant feeding practices including impaired development, malnutrition, and increased infectious and chronic illness. Rising rates of obesity in children are also linked with lack of breastfeeding. Improved infant and young child feeding is relevant in all parts of the world.

Ask: What are the effects on families, communities and health services from poor infant feeding practices?

Wait for a few responses and then continue.

- The World Health Assembly and UNICEF endorsed the Global Strategy on Infant and Young Child Feeding in 2002.

- *Show Slide 1/1 and read it out*

> The aim of the Global Strategy is to improve – through optimal feeding – the nutritional status, growth and development, health, and thus the survival of infants and young children.
>
> It supports exclusive breastfeeding for 6 months, followed by timely, adequate, safe and appropriate complementary feeding, while continuing breastfeeding for two years and beyond.
>
> It also supports maternal nutrition, and social and community support.

- The Global Strategy does not replace, but rather builds upon existing programmes including the Baby-friendly Hospital Initiative.

2. Baby-friendly Hospital Initiative 5 minutes

- The BFHI is a global initiative of the World Health Organization and UNICEF that aims to give every baby the best start in life by creating a health care environment that supports breastfeeding as the norm.
- The Initiative was launched in 1991 and by the end of 2007 more than 20,000 health facilities worldwide had been officially designated baby-friendly.
- The Initiative includes a global assessment and accreditation scheme that recognises the achievements of health facilities whose practices support breastfeeding and encourages health facilities with less than optimal practices to improve[5].

- *State how many health facilities in the area/country are officially accredited as baby-friendly, and what proportion this is of births in the country.*
- *Show Slide 1/2 and read it out*

> The aim of the Baby-friendly Hospital Initiative is to implement the Ten Steps to Successful Breastfeeding and to end the distribution of free and low-cost supplies of breast milk substitutes to health facilities.

5 The Self-Appraisal and External Assessment are discussed further in Session 15.

- The BFHI provides a framework for enabling mothers to acquire the skills they need to breastfeed exclusively for six months and continue breastfeeding with the addition complementary foods for 2 years or beyond.
- A baby-friendly hospital also assists mothers who are not breastfeeding to make informed decisions and to care for their babies as well as possible.
- The Global Strategy calls for further implementation of BFHI, for breastfeeding in the curriculum for health worker training, and for better data on breastfeeding.

3. BFHI is important in areas of high HIV prevalence 5 minutes

- Some people are confused about the role of BFHI in areas where there is a high prevalence of HIV infection in mothers. BFHI is more important than ever in these areas. The special needs of HIV-positive women can be fully accommodated without compromising baby-friendly hospital status.
- The WHO/UNICEF/UNAIDS policy statement on HIV and infant feeding states that mothers have a right to information and support that will enable them to make fully informed decisions about infant feeding[6].
- In addition, it is important to continue to support breastfeeding for women who are HIV-negative or of unknown HIV status. If the emphasis is only on the risks of mother to child transmission of HIV through breastfeeding it may be forgotten that breastfeeding remains the best choice for most mothers and babies.

4. How this course can assist this health facility 10 minutes

- During this course we will discuss what the Ten Steps mean, how to implement them and the importance to staff members in making a health facility Baby-friendly. We will also talk about practices related to marketing of breast-milk substitutes later in the course and what the assessment process involves.

- *Show poster of the Ten Steps to Successful Breastfeeding and/or give a handout of the Ten Steps.*
- *Ask a participant to read out the first Step.*

- The first of the Ten Steps is to have a policy.
  Have a written policy that is routinely communicated to all health care staff.
- A policy helps to:
  - ensure consistent, effective care for mothers and babies;
  - provide a standard of practice that can be measured;
  - support actions.
- A policy is <u>not</u> a treatment protocol or a standard of care. "Policy" means that all staff agree to follow the protocols and standards, and that staff are required to do so by those in authority. It is not a personal decision to follow policy or not to follow it. This is similar to other policies – an individual does not decide whether to give a vaccine or what information to record on a birth certificate. If a policy is not followed on a specific occasion, the reason for not following it needs to be recorded.

6 This recommendation is discussed more in later sessions.

- A policy incorporates the Ten Steps and the International Code and expands on how the Steps are implemented in the health facility.

- *Refer to the health facility's breastfeeding or infant feeding policy briefly. Ask participants to look at the policy during the course (not during this session) and consider how it is implemented.*

- *Point to Step Two and ask a participant to read it out:*

- The second step is about training.
  Train all health care staff in skills necessary to implement the policy.
- The policy should support all of the Ten Steps and training assists to implement these Steps. This course aims to help you feel confident in your knowledge and skills to care for mothers and infants in everyday practice.

- *Show Slide 1/3 and read it out*

> The aim of this course is that
> every staff member will confidently support mothers
> with early and exclusive breastfeeding, and that this facility moves towards achieving baby-friendly designation.

- During this course we will discuss the rest of the Steps in detail. You will have an opportunity to learn and practice how to:
  - use communication skills to talk with pregnant women, mothers and co-workers;
  - implement the Ten Steps to Successful Breastfeeding and abide by the International Code of Marketing of Breast-milk Substitutes;
  - discuss with a pregnant woman the importance of breastfeeding and outline practices that support the initiation of breastfeeding;
  - facilitate skin-to-skin contact and early initiation of breastfeeding;
  - assist a mother to learn the skills of positioning and attaching her baby as well as the skill of hand expression;
  - discuss with a mother how to find support for breastfeeding after she returns home;
  - outline what needs to be discussed with a mother who is not breastfeeding and know to whom to refer this mother for further assistance with feeding her baby:
  - identify practices that support and those that interfere with breastfeeding;
  - work with co-workers to highlight barriers to breastfeeding and seek ways to overcome those barriers.
- Participation in this course helps to increase the level of knowledge, skill, and confidence, and provide consistency of information and practice throughout the health facility.
- This course provides a foundation in baby-friendly practices. There are further specialised courses available. In addition your local resource person has more information.

- *Give information regarding the local resource person.*

5. How the Global Strategy fits with other activities 5 minutes

- The Global Strategy is supported by national policies, laws and programmes to promote, protect and support breastfeeding, and protect the rights of working women to maternity protection.

- *List and briefly discuss, if time allows, any national programmes or activities to implement the Global Strategy, for example, national infant feeding policy and national authority, Code of Marketing of Breast-milk Substitutes, maternity leave laws, BFHI, data collection in the health system on breastfeeding, curriculum reform, community mobilization efforts, and other programmes, policies and activities.*

- *Ask if there are any questions. Then summarise the session.*

Session 1 Summary

- The Global Strategy of Infant and Young Child Feeding builds on existing programmes to assist optimal nutrition and thus give children a health start in life.

The aim of the Global Strategy is to improve – through optimal feeding – the nutritional status, growth and development, health, and thus the survival of infants and young children.

It supports exclusive breastfeeding for 6 months, followed by timely, adequate, safe and appropriate complementary feeding, while continuing breastfeeding for two years and beyond.

It also supports maternal nutrition, and social and community support.

- The Baby-friendly Hospital Initiative (BFHI) involves Ten Steps as well as protection from marketing of breast-milk substitutes, to help provide a supportive health facility.

The aim of the Baby-friendly Hospital Initiative is to implement the Ten Steps to Successful Breastfeeding and to end the distribution of free and low-cost supplies of breast-milk substitutes to health facilities.

- Support for exclusive breastfeeding and BFHI continue to be important everywhere, even in areas of high HIV prevalence.
- Participation in this course can help to ensure that you are confident in your skills in breastfeeding support and that best practice is consistent in the health facility. You will have an opportunity to learn and practice how to:
    - use communication skills to talk with pregnant women, mothers and co-workers;
    - implement the Ten Steps to Successful Breastfeeding and abide by the International Code of Marketing of Breast-milk Substitutes;
    - discuss with a pregnant woman the importance of breastfeeding and outline practices that support the initiation of breastfeeding;
    - facilitate skin-to-skin contact and early initiation of breastfeeding;
    - assist a mother to learn the skills of positioning and attaching her baby as well as the skill of hand expression;
    - discuss with a mother how to find support for breastfeeding after she returns home;
    - outline what needs to be discussed with a mother who is not breastfeeding and know to whom to refer this mother for further assistance with feeding her baby:
    - identify practices that support and those that interfere with breastfeeding;
    - work with co-workers to highlight barriers to breastfeeding and seek ways to overcome those barriers.

Session 1 Knowledge Check

A colleague asks you why this course is taking place and how it would help mothers and babies that you care for. What will you reply?

TEN STEPS TO SUCCESSFUL BREASTFEEDING
A Joint WHO/UNICEF Statement (1989)

Every facility providing maternity services and care for newborn infants should:

1. Have a written breastfeeding policy that is routinely communicated to all health care staff.
2. Train all health care staff in skills necessary to implement this policy.
3. Inform all pregnant women about the benefits and management of breastfeeding.
4. Help mothers initiate breastfeeding within a half-hour of birth.
5. Show mothers how to breastfeed, and how to maintain lactation even if they should be separated from their infants.
6. Give newborn infants no food or drink other than breast milk unless *medically* indicated.
7. Practise rooming in - allow mothers and infants to remain together - 24 hours a day.
8. Encourage breastfeeding on demand.
9. Give no artificial teats or pacifiers (also called dummies or soothers) to breastfeeding infants.
10. Foster the establishment of breastfeeding support groups and refer mothers to them on discharge from the hospital or clinic.

SESSION 2
COMMUNICATION SKILLS

Session Objectives:

On completion of this session, participants will be able to:

1.	Identify communication skills of listening and learning, and building confidence.	30 minutes
2.	Practice the use of these skills with a worksheet.	30 minutes
	Total session time	**60 minutes**

The practice of the skills can be a separate session. If this practice is some time after the first part, briefly review the communication skills before starting the worksheet.

Materials:

A doll for use in the demonstration.

Two chairs that can be brought to the front of the room.

Copy the parts to be read in the demonstrations. The text of the demonstrations is all together at the end of the session to make it easier to copy for those reading the lines.

Prepare a list of the communication skills (see session summary) and display on the wall or flip chart from the beginning of the session. Uncover each point as needed.

Copy the Communication Skills Worksheet 2.1 (without answers) – one for each participant.

The concept of 'judging words' may need to be explained more in the local language. Refer to Session 7 of Breastfeeding Counselling: a training course (WHO/UNICEF, 1993) or Session 5 of Infant and young child feeding counselling: an integrated course (WHO/UNICEF, 2006) for more information on translating judging words.

Preparation for the demonstrations:

These demonstrations are very short. The facilitator introduces each demonstration pointing out what the participants are to focus on. After each demonstration, the facilitator makes the comment indicated to emphasize or clarify what the point was in the demonstration.

The first demonstration of non-verbal communication needs to be at the front of the room because participants need to see the actions. Before the session ask a participant to assist with the demonstration of non-verbal communication.

To save time during the other demonstrations, do not ask participants to come to the front of the room. Distribute the lines for the roles that the people read for the parts to people sitting next to each other. Ask the participants in each demonstration to read the parts loudly from their seats, at the appropriate time.

Further reading for facilitators:

Session 7 and Session 11 in *Breastfeeding Counselling: a training course* WHO/UNICEF, (1993).

Session 5 and Session 10 of *Infant and young child feeding counselling : an integrated course* WHO/UNICEF, (2006).

1. Communication skills 30 minutes

- Often health workers are trained to look for problems and to fix those problems. Good communication means that you respect the women's own thoughts, beliefs, and culture. It does not mean that you tell or advise a person what you think they *should* do or to push a woman towards a particular action.
- Health workers need to be able to do more than just offer information. It is part of their job to help mothers look at the cause of any difficulties they have (diagnosis) and to suggest courses of action that can help fix the problem. Often there is no problem to be fixed; the mother just needs assurance that she is doing well.
- You can use communication skills to:
  - Listen and learn about the woman's beliefs, level of knowledge and her practices.
  - Build her confidence and praise practices that you want to encourage.
  - Offer information.
  - Suggest changes the woman could consider if changes are needed.
  - Arrange follow up with her.
- You can also use these skills to:
  - Communicate with co-workers who resist changing their practices towards baby-friendly.
  - Communicate with family members who are supporting the mother especially those that may negatively influence her feeding practices with her baby.
  - Communicate with policy makers to advocate towards baby-friendly workplaces.
- Communication skills are introduced at a basic level in this course. These skills feel more natural to use and improve as you use them. You can use these communication skills at home with your family and friends as well as in work situations.

Skills to Listen and Learn

- Communication can be what we say – verbal communication. Equally important is non-verbal communication – the body language that we use and what we observe of the mother's body language.
- We may observe that a mother is sitting in an uncomfortable position, or that she is looking around concerned that others are listening, and is not able to concentrate on feeding her baby. We are receiving these very useful non-verbal communications from the mother.
- When you talk with the mother in a place that is comfortable and where she feels safe, this helps her to feel more like talking with you.

1. Use helpful non-verbal communication.

- Our non-verbal communication to the mother can help her to feel calm and able to listen.

Ask: What are some ways of providing helpful non-verbal communication during a discussion?

Wait for a few responses.

- Some ways of providing helpful non-verbal communication during a discussion with a mother are:
  - Sit at the same level and close to the mother.
  - Remove any physical barriers such as a desk or folders of papers in your arms.
  - Pay attention to the mother, avoid getting distracted, and show you are listening by nodding, smiling, and other appropriate gestures.
  - Take time without hurrying or looking at your watch.
  - Only touch her in an appropriate way (such as a hand on her arm). Do not touch her breasts or her baby without her permission.

Demonstration 1:

- *Introduce the demonstration: In this demonstration the health worker is greeting the mother using the same words but in various ways. Look at the non-verbal communication in each greeting.*

A participant plays the part of the mother and sits on a chair in front of the group with a doll as her baby, held in a feeding position.

A facilitator plays the health worker and says exactly the same words several times:
"Good morning, how is breastfeeding going?"
but says them with different non-verbal communication each time. For example: stand over the mother or sit beside her; or look at your watch as you ask the question; or lean forward and poke at the baby feeding (discuss this touching with the participant first).

- *Discuss how the non-verbal communication makes a difference. Ask the "mother" how she felt when greeted each way. Ask participants what they have learned from this demonstration about non-verbal communication.*

---

2. Ask open questions

- When you are helping a mother, you want to find out what the situation is, if there is a difficulty, what the mother has done, what worked and what did not work. If you ask questions in a way that encourages the mother to talk to you, you do not need to ask too many questions.
- Open questions are usually most helpful. They encourage a mother to give more information. Open questions usually start with "How? What? When? Where? Why?". For example, "How are you feeding your baby?"
- Closed questions can be answered by a yes or no and may not give you very much information. Closed questions usually start with words such as "Are you? Did you? Has the baby?" For example, "Did you breastfeed your previous baby?"
- You may think the mother is not willing to talk to you. The mother may feel frightened that she will give the wrong answer. Sometimes the closed question suggests the 'correct' answer and the mother may give this answer whether it is true or not, thinking this is what you want to hear.

Demonstration 2A:

- *Introduce the demonstration: In this demonstration listen to whether the health worker is asking open questions or closed questions and how the mother responds to the questions.*

Health worker	Good morning. Are you and your baby well today?
Mother	Yes, we are well.
Health worker	Do you have any difficulties?
Mother	No
Health worker	Is baby feeding often?
Mother	Yes

Comment: The closed questions got replies of yes and no. The health worker did not learn much and it is difficult to continue the conversation.
Let us see another way of doing this.

Demonstration 2B:

- *Introduce the demonstration: In this demonstration listen to whether the health worker is asking open questions or closed questions and how the mother responds to the questions.*

Health worker	Good morning. How are you and your baby today?
Mother	We are well.
Health worker	Tell me, how are you feeding your baby?
Mother	I breastfeed her often with one bottle in the evening.
Health worker	What made you decide to give a bottle in the evening?
Mother	My baby wakes during the night, so my milk must not be enough for her/him.

Comment: The health worker asked open questions. The mother offered information in her reply. The health worker learnt more.

3. Encourage the mother to talk – show interest and reflect back

Ask: How can we show that we are interested in what a mother is saying?
Wait for a few replies.

- We can show we are interested in what a woman is saying by using responses such as nodding, smiling and phrases such as "Um Hmm", "or "Go on …".If you repeat or reflect back what the mother is saying this shows that you are listening and encourages the mother to say more. You can use slightly different words than the mother used so it does not sound like you are copying her.
- It is helpful to mix reflecting back with other responses, for example, "Oh, really, go on", or to ask an open question.

Demonstration 3:

- *Introduce the demonstration: In this demonstration, watch how the health worker is showing that she/he is listening to the mother and if using these skills helps the health worker to learn more from the mother.*

Health worker	Good morning, how are you both today?
Mother	I am very tired; the baby was awake a lot.
Health worker	Oh, dear *(looks concerned)*
Mother	My sister says he shouldn't be still waking at night, that I'm spoiling him.
Health worker	Your sister says you are spoiling him?
Mother	Yes, my sister is always making some comment about how I care for him.
Health worker	Mmm. *(Nods)*
Mother	I don't see why it is any of her business how I care for my baby.
Health worker	Oh, tell me more.

Comment: Responses such as Oh dear and Mmm show that you are listening. Reflecting back can help to clarify the person's statement. We see here that the waking baby may not be the main problem – it may be the sister's comments that are bothering the mother.

---

4. Empathise to show you are trying to understand her feelings

- Empathy shows that you are hearing what the mother is saying and trying to understand how she feels. You are looking at the situation from her point of view. Sympathy is different. When you sympathise with a person, you are looking at it from your point of view.
- It is helpful to empathise with the mother's good feelings too, not just her bad feelings.
- You might need to ask for more facts but do this after you have found out how she feels about the situation.

Demonstration 4A:

- *Introduce the demonstration: In this demonstration, watch to see if the health worker is showing empathy- that she/he is trying to understand how the mother feels.*

Health worker	Good morning (name). How are you and (child's name) today?
Mother	(Child's name) is not feeding well for the last few days. I don't know what to do.
Health worker	*I* understand how you feel. When *my* child doesn't feed *I* get worried too. *I* know exactly how you feel.
Mother	What do *you* do when *your* child doesn't feed?

Comment: What did they see? Here the focus has moved from the mother to the Health Worker. This was not empathy – it did not focus on how the mother was feeling.
Let us see another way of doing this.

Demonstration 4B:

- *Introduce the demonstration: In this demonstration, watch to see if the health worker is showing empathy- that she/he is trying to understand how the mother feels.*

Health worker	Good morning (name). How are you and (child's name) today?
Mother	(Child's name) is not feeding well for the last few days and I don't know what to do.
Health worker	You are worried about (name).
Mother	Yes, I am worried he/she might be sick if he/she is not feeding well.

Comment: In this second version, the mother is the focus of the conversation. This Health Worker showed empathy with the mother by picking up her feeling and reflecting back this emotion to show that she or he has really listened. This encourages the mother to share more of her own feelings and to continue talking with the health worker.

5. Avoid words which sound judging

- Words that may sound like you are judging include: right, wrong, well, bad, good, enough, properly, adequate, problem. Words like this can make a woman feel that she has a standard to reach or that her baby is not behaving normally.
- For example: "Is your baby feeding well?" implies that there is a standard for feeding and her baby may not meet that standard. The mother may hide how things are going if she feels she will be judged as inadequate. In addition, the mother and the health worker may have different ideas about what "feeding well" means. It is more helpful to ask an open question such as "How does your baby feed? or Can you tell me about your baby's feeding?"

Demonstration 5A:

- *Introduce the demonstration: In this demonstration, watch to see if the health worker is using judging words or avoiding them.*

Health worker	Good morning. Did your baby gain enough weight since she was last weighed?
Mother	Well, I am not sure. I think so.
Health worker	Well, does she feed properly? Is your milk good?
Mother	I don't know… I hope so, but I am not sure (looks worried)

Comment: The health worker is not learning anything and is making the mother very worried. Let us look at another way of doing this.

Demonstration 5B:

- *Introduce the demonstration: In this demonstration, watch to see if the health worker is using judging words or avoiding them.*

Health worker	Good morning. How is your baby growing this month? Can I see her growth chart?
Mother	The nurse said she has gained half a kilo this month, so I am pleased.
Health worker	She is obviously getting the breast milk she needs.

Comment: The health worker learnt what she needed to know without worrying the mother.

Skills to Build confidence and give support

- Your communication skills can help the mother to feel good about herself and confident that she will be a good mother. Confidence can help a mother to carry out her decisions and to resist pressures from other people. To help to build confidence and support, we need to:

6. Accept what a mother thinks and feels

- We can accept a mother's ideas and feelings without disagreeing with her or telling her there is nothing to worry about. Accepting what a mother says is not the same as agreeing that she is right. You can accept what she is saying and give correct information later. Accepting what a mother says helps her to trust you and encourages her to continue the conversation.

Demonstration 6A:

- *Introduce the demonstration: In this demonstration, watch to see if the health worker is accepting what the mother says, or disagreeing or agreeing.*

Mother	I give my baby a bottle of formula every evening because I don't have enough milk for her.
Health Worker	I am sure your milk is enough. Your baby does not need a bottle of formula.

Comment: Is this health worker accepting what the mother feels?
The health worker is disagreeing or dismissing what the mother is saying.

Let us look at another way of doing this.

Demonstration 6B:

- *Introduce the demonstration: In this demonstration, watch to see if the health worker is accepting what the mother says, or disagreeing or agreeing.*

Mother	I give my baby a bottle of formula every evening because I don't have enough milk for her.
Health Worker	Yes, a bottle feed in the evening seems to settle some babies.

Comment: Is this health worker accepting what the mother says? The health working is agreeing with a mistaken idea. Agreeing may not help the mother and baby.

Let us look at another way of doing this.

Demonstration 6C**:**

- *Introduce the demonstration: In this demonstration, watch if the health worker is accepting what the mother says, or disagreeing or agreeing.*

Mother	I give my baby a bottle of formula every evening because I don't have enough milk for her.
Health Worker	I see. You think you may not have enough milk in the evening.

Comment: Is this health worker accepting what the mother thinks or feels? The health working is accepting what the mother says but not agreeing or disagreeing. The health worker accepts the mother and acknowledges her viewpoint. This means the mother will feel she has been listened to. They can now continue to talk about breastfeeding in the evening and discuss correct information about milk supply.

7. Recognise and acknowledge what is right

- Recognise and praise what a mother and baby are achieving. For example, tell the mother how you notice that she waits for her baby to open his/her mouth wide to attach, or point out how her baby detaches him or herself when he or she is finished feeding on one breast and ready for the other breast.

8. Give practical help

- If the mother is comfortable, this will help her milk to flow. She may be thirsty or hungry; she may want another pillow; or for someone to hold the baby while she goes to wash or to the toilet. Or the mother may have a clear practical breastfeeding problem, for example that she wants to learn how to express her milk. If you can give this practical help, she will be able to relax and focus better on her baby.

9. Provide relevant information using suitable language

- Find out what she needs to know at this time.
- Use suitable words that the mother understands.
- Do not overwhelm her with information.

10. Make suggestions rather than commands

- Provide choices and let her decide what will work for her.
- Do not tell her what she should do or must not do.
- Limit your suggestions to one or two suggestions that are relevant to her situation.

Demonstration 7A:

- *Introduce the demonstration: In this demonstration, watch to see whether the health worker is giving relevant information using suitable language and making suggestions not commands.*

Health worker	Good morning. What can I do for you today?
Mother	I'm not sure if I should breastfeed my baby or not when he is born. I'm worried the baby might get HIV.
Health worker	Well now, the situation is this. Approximately 5-15% of mothers who are HIV-positive transmit the virus through breastfeeding. However, the rate varies in different places. It may be higher if the mother has acquired the infection recently or has a high viral load or symptomatic AIDS. If you have unsafe sex while you are breastfeeding, you can pick up HIV and then you are more likely to transmit it to your baby. However, if you don't breastfeed, your baby may be at risk of other potentially deadly illnesses such as gastrointestinal and respiratory infections. Now, you have left it very late to come for counselling, so if I were you, I would decide ...
Mother	Oh.

Ask: What do participants think about this communication? Is the health worker giving a suitable amount of information?
The health worker is providing too much information. It is not relevant to the woman at this time. She is using words that are unlikely to be familiar. Some information is given in a negative way and sounds critical. The health worker is telling her what to do rather than helping her to make her own decision.
Let us see another way of doing this.

Demonstration 7B: *(if testing is available)*

- *Introduce the demonstration: In this demonstration, watch to see if the health worker is giving relevant information using suitable language and making suggestions not commands.*

Health worker	Good morning. What can I do for you today?
Mother	I'm not sure if I should breastfeed my baby or not when he is born. I'm worried the baby might get HIV.
Health worker	If you have HIV there is a risk this could be passed to your baby. Have you had a test for HIV?
Mother	No. I don't know where to get the test.
Health worker	It is best to know if you have HIV or not before you decide how to feed your baby. I can give you the details of who to talk to about getting a test. Would you like that?
Mother	Yes, I would like to hear more about the test.

Comment: The health worker gave the information that was most important at that time – that it is important to know if you have HIV before you make a decision about feeding. The health worker used simple language, was not judgemental, and referred the woman to a HIV counselling and testing service.

Demonstration 7B: *(if testing is not available)*

- *Introduce the demonstration: In this demonstration, watch to see if the health worker is giving relevant information using suitable language and making suggestions not commands.*

Health worker	Good morning. What can I do for you today?
Mother	I'm not sure if I should breastfeed my baby or not when he is born. I'm worried the baby might get HIV.
Health worker	If you have HIV there is a risk this could be passed to your baby. There is no testing available here to find out for sure if you have HIV. When you don't know for sure if you have HIV and can't get tested, it is recommended that you breastfeed your baby.
Mother	Oh, I didn't know that.
Health worker	Yes, giving only breast milk, with no other foods or water, for the first six months, protects your baby from many other illnesses such as diarrhoea.

Comment: The health worker gave the information that was most important at that time and relevant to the situation – that if you do not know if a mother is HIV positive, the exclusive breastfeeding is the recommendation. The health worker used simple language and was not judgemental. It is likely that this woman and health worker can continue to communicate and discuss more information.

Arrange follow-up and on-going support

- Often when the discussion is over, the mother may still have questions that there was not time to discuss, she may think of something else she wanted to talk about or she may find it is difficult to put a practice into action. It is important to arrange follow-up and on-going support:
  - Learn what help may be available from her family and friends.
  - Offer a time when you will see her or talk with her again.
  - Encourage her to see you or another person for help if she has doubts or questions.
  - Refer her to a community support group if possible.
  - Refer her for more specialised counselling if needed.
- Many women are not able to do what they want to do or what you may suggest they do. A discussion needs to consider the woman's situation at home. Family members, the household's money and time, the mother's health and the common practices in the family and community are important influences on what a mother can do.
- Remember, you should not make a decision for a mother or try to make her do what you think is best. You can listen to her and build her confidence so that she can decide what is best for her and her baby.

2. Practice communication skills 30 minutes

Divide the participants into small groups or pairs and explain that each group will do the exercises that are on the worksheet.

Each exercise has an example and then an exercise for the group to complete. Read the first example and check that participants understand what to do.

Ask the other facilitators to circulate between the groups during the activity to see that the participants understand the activities and the skills. In each small group the facilitator can explain the other examples when the small group is ready. Ask the participants to try to say the words as well as writing them down.

Allow about 25 minutes for the worksheet.

At the end of the time, summarise the session and respond to any questions. You do not need the group to go through each item to 'correct' the exercises in the activity.

This is a vital part of the course as health workers adopt new ways of communicating with mothers. If possible extra time should be devoted to these skills.

Session 2 Summary

**Communication involves listening and building confidence,
and not just giving information.**

Listening and Learning

Use helpful non-verbal communication
Ask open questions
Show interest and reflect back what the mother says
Empathise to show that you understand her feelings
Avoid words that sound judging

Building Confidence and Giving Support

Accept what a mother thinks and feels
Recognise and acknowledge what a mother and baby are doing right
Give practical help
Give a little relevant information using suitable language
Make one or two suggestions, not commands

Arranging follow-up and support suitable to the mother's situation

Communication Skills Worksheet 2.1 *(with possible answers)*

Open questions:

For each closed question, **write** a new question that is an open question.

Example

Are you breastfeeding your baby? (closed) How are you feeding your baby? (open)

Re-write these questions as an open question:

Does your baby feed often? *When does your baby feed?*

Are you having any feeding problems? *How is feeding going?*

Is your baby gaining weight? *How is your baby's weight?*

Empathising with the mother's feelings:

The statements below are made by a mother. **Pick** the response that you might make to show empathy and understanding of the mother's feelings.

Example:

My baby feeds all night and I am exhausted.
- How many times does she feed?
- Does this happen every night?

√- You really feel tired.

Pick the response that shows empathy:

My breast milk looks thin – it cannot be good.
- Breast milk always looks thin.

(√**)**- You are worried about your milk?
- How much does your baby weigh?

I am afraid to breastfeed in case I have HIV.

(√**)**- You are concerned about HIV?
- Have you had a test?
- Then use formula instead.

Avoid judging words:

Re-write each question to avoid a judging word and to also ask an open question

Example:

Is your baby feeding well? How is your baby feeding?

Change to avoid a judging word:

Does your baby cry too much at night? *How is your baby at night?*

Do you have any problems with breastfeeding? *How is breastfeeding going?*

Is the baby's weight gain good? *How is your baby growing?*

Accepting what a mother thinks:
Draw a line to link which response is accepting, agreeing to a mistaken idea or disagreeing with the mother's statement.
Example:
Mother: "I give drinks of water if the day is hot."
Response:
"That isn't necessary! Breast milk has enough water." → Agreeing (to mistaken idea)
"Yes, babies need water in hot weather." → Disagreeing
"You feel the baby needs some water if it is hot?" → Accepting

Link with the answer with the type of response:
Mother: "My baby has diarrhoea, so I am not breastfeeding until it is gone."

Answer:	*Type of response*
"You don't like to give breast milk now?"	Agreeing (to mistaken idea)
"It is quite safe to breastfeed when he has diarrhoea."	Disagreeing
"It is best to stop breastfeeding during diarrhoea."	Accepting

Mother: "The first milk is not good, so I will need to wait until it has gone."

Answer:	*Type of response*
"First milk is very important for the baby."	Agreeing (to mistaken idea)
"You think the first milk is not good for the baby."	Disagreeing
"It will only be a day or two before the first milk is gone."	Accepting

Provide relevant information using suitable language:
Re-write the statement to use words that are easy for the mother to understand.

Example:
"You can tell that the hormone oxytocin is working if you notice the milk ejection reflex."
Using suitable language:
"You may notice the opposite breast leaks when the baby is suckling. This is a sign that the milk is flowing well."

Change these statements to words easy to understand:
"Exclusive breastfeeding provides all the nutrients that your baby needs for the first 6 months."
Breastfeeding alone is all your baby needs for health and growth in the first six months.

"The immunoglobulins in human milk provide your baby with protection from viral and bacterial infections."
Your milk helps protect your baby from illness.

Offer suggestions, not commands:
Re-write each command changing it to a suggestion rather than a command.

Example:
"Do not give your baby drinks of water." (command)
Change to a suggestion:
"Have you thought of giving only your milk?" (suggestion)

Change each command to a suggestion:
"Hold him close so that he takes enough of the breast into his mouth." (command)
"*Would you like to hold him close so that he can take more of the breast into his mouth?"*

"Feed her more often, then your milk supply will increase." (command)
"*Do you think you could feed her more often? This will help to make more milk.* "

"Do not give any foods to your baby until after 6 months." (command)
"*Most babies don't need any other foods or water until after 6 months. Does this sound like something you could try?* "

Communication Skills Worksheet 2.1

Open questions:
For each closed question, **write** a new question that is an open question.

Example
Are you breastfeeding your baby? (closed) How are you feeding your baby? (open)

Re-write these questions as an open question:
Does your baby feed often?

Are you having any feeding problems?

Is your baby gaining weight?

Empathising with the mother's feelings:
The statements below are made by a mother. **Pick** the response that you might make to show empathy and understanding of the mother's feelings.

Example:
My baby feeds all night and I am exhausted.
- How many times does she feed?
- Does this happen every night?
√- You really feel tired.

Pick the response that shows empathy:
My breast milk looks thin – it cannot be good.
- Breast milk always looks thin.
- You are worried about your milk?
- How much does your baby weigh?

I am afraid to breastfeed in case I have HIV.
- You are concerned about HIV?
- Have you had a test?
- Then use formula instead.

Avoid judging words:
Re-write each question to avoid a judging word and to also ask an open question.
Example:

Is your baby feeding well? How is your baby feeding?

Change to avoid a judging word:
Does your baby cry too much at night?

Do you have any problems with breastfeeding?

Is the baby's weight gain good?

Accepting what a mother thinks:
Draw a line to link which response is accepting, agreeing or disagreeing with the mother's statement.

Example:
Mother: "I give drinks of water if the day is hot."

Answer:	*Type of response*
"That isn't necessary! Breast milk has enough water."	Agreeing
"Yes, babies need water in hot weather."	Disagreeing
"You feel the baby needs some water if it is hot?"	Accepting

Link with the answer with the type of response:
Mother: "My baby has diarrhoea, so I am not breastfeeding until it is gone."

Answer:	*Type of response*
"You don't like to give breast milk now?"	Agreeing
"It is quite safe to breastfeed when he has diarrhoea."	Disagreeing
"It is best to stop breastfeeding during diarrhoea."	Accepting

Mother: "The first milk is not good, so I will need to wait until it has gone."

Answer:	*Type of response*
"First milk is very important for the baby."	Agreeing
"You think the first milk is not good for the baby."	Disagreeing
"It will only be a day or two before the first milk is gone."	Accepting

Provide relevant information using suitable language:
Re-write the statement to use words that are easy for the mother to understand.

Example:
"You can tell that the hormone oxytocin is working if you notice the milk ejection reflex."
Change to words easy to understand:
"You may notice the opposite breast leaks when the baby is suckling. This is a sign that the milk is flowing well."

Change these statements to words easy to understand:
"Exclusive breastfeeding provides all the nutrients that your baby needs for the first 6 months."

"The immunoglobulins in human milk provide your baby with protection from viral and bacterial infections."

Offer suggestions, not commands:
Re-write each command changing it to a suggestion rather than a command.

Example:
"Do not give your baby drinks of water." (command)
Change to a suggestion:
"Have you thought of only giving breast milk?" (suggestion)

Change each command to a suggestion:
"Hold him close so that he takes enough of the breast into his mouth." (command)

"Feed her more often, then your milk supply will increase." (command)

"Do not give any foods to your baby until after 6 months." (command)

Session 2 Demonstrations

Cut and give relevant parts to those playing the parts in the demonstrations.

Demonstration 1:

A participant plays the part of the mother and sits on a chair in front of the group with a doll as her baby, held in a feeding position.

A facilitator plays the health worker and says exactly the same words several times:

"Good morning, how is breastfeeding going?"

But says them with different non-verbal communication each time. For example: stand over the mother or sit beside her; look at your watch as you ask the question; lean forward and poke at the baby feeding (discuss this touching with the participant first).

Demonstration 2A:

Health worker	Good morning. Are you and your baby well today?
Mother	Yes, we are well.
Health worker	Do you have any difficulties?
Mother	No
Health worker	Is baby feeding often?
Mother	Yes

Demonstration 2B:

Health worker	Good morning. How are you and your baby today?
Mother	We are well.
Health worker	Tell me, how are you feeding your baby?
Mother	I breastfeed her often with one bottle in the evening.
Health worker	What made you decide to give a bottle in the evening?
Mother	My baby wakes during the night, so my milk must not be enough for her/him.

Demonstration 3:

Health worker	Good morning, how are you both today?
Mother	I am very tired; the baby was awake a lot.
Health worker	Oh, dear *(looks concerned)*
Mother	My sister says he shouldn't be still waking at night, that I'm spoiling him.
Health worker	Your sister says you are spoiling him?
Mother	Yes, my sister is always making some comment about how I care for him.
Health worker	Mmm. *(nods)*
Mother	I don't see why it is any of her business how I care for my baby.
Health worker	Oh, tell me more.

Demonstration 4A:

Health worker	Good morning (name). How are you and (child's name) today?
Mother	(Child's name) is not feeding well for the last few days. I am very worried.
Health worker	*I* understand how you feel. When *my* child doesn't feed *I* get worried too. *I* know exactly how you feel.
Mother	What do *you* do when *your* child doesn't feed?

Demonstration 4B:

Health worker	Good morning (name). How are you and (child's name) today?
Mother	(Child's name) is not feeding well for the last few days and I don't know what to do.
Health worker	You are worried about (name).
Mother	Yes, I am worried he/she might be sick if he/she is not feeding well.

Demonstration 5A:

Health worker	Good morning. Did your baby gain enough weight since she was last weighed?
Mother	Well, I am not sure. I think so.
Health worker	Well, does she feed properly? Is your milk good?
Mother	I don't know… I hope so, but I am not sure (looks worried)

Demonstration 5B:

Health worker	Good morning. How is your baby growing this month? Can I see her growth chart?
Mother	The nurse said she has gained half a kilo this month, so I am pleased.
Health worker	She is obviously getting the breast milk she needs.

Demonstration 6A:

Mother	I give my baby a bottle of formula every evening because I don't have enough milk for her.
Health Worker	I am sure your milk is enough. Your baby does not need a bottle of formula.

Demonstration 6B:

Mother	I give my baby a bottle of formula every evening because I don't have enough milk for her.
Health Worker	Yes, a bottle feed in the evening seems to settle some babies.

Demonstration 6C:

Mother	I give my baby a bottle of formula every evening because I don't have enough milk for her.
Health Worker	I see. You think you may not have enough milk in the evening.

Demonstration 7A:

Health worker	Good morning. What can I do for you today?
Mother	I'm not sure if I should breastfeed my baby or not when he is born. I'm worried the baby might get HIV.
Health worker	Well now, the situation is this. Approximately 5-15% of mothers who are HIV-positive transmit the virus through breastfeeding. However, the rate varies in different places. It may be higher if the mother has acquired the infection recently or has a high viral load or symptomatic AIDS. If you have unsafe sex while you are breastfeeding, you can pick up HIV and then you are more likely to transmit it to your baby. However, if you don't breastfeed, your baby may be at risk of other potentially deadly illnesses such as gastrointestinal and respiratory infections. Now, you have left it very late to come for counselling, so if I were you, I would decide ...
Mother	Oh.

Demonstration 7B: *(if testing is available)*

Health worker	Good morning. What can I do for you today?
Mother	I'm not sure if I should breastfeed my baby or not when he is born. I'm worried the baby might get HIV.
Health worker	If you have HIV there is a risk this could be passed to your baby. Have you had a test for HIV?
Mother	No. I don't know where to get the test.
Health worker	It is best to know if you have HIV or not before you decide how to feed your baby. I can give you the details of who to talk to about getting a test. Would you like that?
Mother	Yes, I would like to hear more about the test.

Demonstration 7B: *(if testing is not available)*

Health worker	Good morning. What can I do for you today?
Mother	I'm not sure if I should breastfeed my baby or not when he is born. I'm worried the baby might get HIV.
Health worker	If you have HIV there is a risk this could be passed to your baby. There is no testing available here to find out for sure if you have HIV. When you don't know for sure if you have HIV and can't get tested, it is recommended that you breastfeed your baby.
Mother	Oh, I didn't know that.
Health worker	Yes, giving only breast milk, with no other foods or water, for the first six months, protects your baby from many other illnesses such as diarrhoea.

SESSION 3
PROMOTING BREASTFEEDING DURING PREGNANCY – STEP 3

Session Objectives:

On completion of this session, participants will be able to:

1. Outline what information needs to be discussed with pregnant women.	20 minutes
2. Explain what kind of antenatal breast preparation women need for breastfeeding, what is effective and what is not effective.	5 minutes
3. Identify women who need extra attention.	5 minutes
4. Outline what information needs to discuss with pregnant women who are HIV-positive.	10 minutes
5. Practise communication skills to use to discuss breastfeeding with a pregnant woman.	50 minutes
Total session time	**90 minutes**

Materials:

Slide 3/1: mothers in antenatal clinic.
Slide 3/2: recommendation for mothers who are HIV-positive.
If possible, display the picture of two mothers in antenatal clinic (slide 3/1) as a poster and leave displayed during the session.

Write on a flipchart – acceptable, feasible, affordable, sustainable, safe, so that the first letter of each word forms AFASS.

Information on how to obtain HIV counselling and testing in the local area.

Information on how infant feeding counselling is provided for women who are tested and shown to be HIV-positive.

Antenatal checklist – one copy for each participant (optional).

Optional activity: Cost of Not Breastfeeding – find information before the session.

Further reading for facilitators:

*The optimal duration of exclusive breastfeeding. Report of an expert consultation.*Geneva, WHO March 2001.

The optimal duration of exclusive breastfeeding, A systematic review WHO/FCH/CAH/01.23

Butte, N et al, (2001) *Nutrient Adequacy of Exclusive Breastfeeding for the Term Infant during the First Six Months of Life.* WHO, Geneva.

Diet, Nutrition and the Prevention of Chronic Diseases. Report of a Joint WHO/FAO Expert Consultation. Geneva, WHO Technical Report Series, No. 916.

Related to HIV:

HIV and Infant Feeding Counselling : a training course WHO/UNICEF/UNAIDS, 2000.

Integrated Infant Feeding Counselling: a training course WHO/UNICEF, 2005.

UNAIDS/UNICEF/WHO. *HIV and Infant Feeding: Framework for Priority Action (2003).*
HIV and Infant Feeding - Guidelines for decision-makers (updated 2003).
A guide for health care managers and supervisors (updated 2005).
A review of HIV transmission through breastfeeding (updated 2007).

WHO/UNICEF/USAID. *HIV and infant feeding counselling aids (2005).*

Counsellors using the tools should have received specific training through such courses as the WHO/UNICEF *Breastfeeding Counselling: A training course* and the WHO/UNICEF/UNAIDS *HIV and Infant Feeding Counselling: A training course,* or the "*Infant and Young Child Feeding Counselling: An integrated course".* The tools consist of the following parts:

- A Flipchart (ISBN 92 4 159249 4) to use during counselling sessions with HIV-positive pregnant women and/or mothers.
- Take-home flyers. The counsellor should use the relevant flyer, according to the mother's decision, to teach the mother, and she can then use it as a reminder at home.
- A Reference guide (ISBN 92 4 159301 6) that provides more technical and practical details than the counselling cards. Counsellors can use it as a handbook.

Additional information related to emergency situations:

Guiding principles for feeding infants and young children during emergencies. Department of Nutrition for Health and Development, WHO 2003.

Infant Feeding in Emergencies. Nutrition Unit, WHO European Office 1997.

Infant Feeding in Emergencies, Module1, Emergency Nutrition Network. http://www.ennonline.net/

Additional information related to risks of formula use:

Guidelines for the safe preparation, storage and handling of powdered infant formula. Food Safety, WHO (2007).

- How to Prepare Powdered Infant Formula in Care Settings
- How to prepare formula for use at home

Introduction

- *Show Fatima and Miriam- slide 3/1or poster and introduce the 'story mothers'.*

It is important to be able to apply theory to everyday practice. Therefore, in this course we use a story about two women, Fatima and Miriam[7] who are coming to the health facility. Fatima is expecting her first baby and Miriam is expecting her second baby. We follow Fatima and Miriam through their pregnancy, the births of their babies and the early days after birth and look at the situations and practices that they encounter.

As we go through the course, think how a mother or baby would view the information and practices that we discuss.

1. Discussion of breastfeeding with pregnant women 20 minutes

- Step 3 of the Ten Steps to Successful Breastfeeding states:
  Inform all pregnant women of the benefits and management of breastfeeding.
- In many cultures, women assume that they will breastfeed. In other cultures, where breast milk substitutes are widely advertised and promoted, most women decide whether or not to breastfeed before their baby is born. It is important for health workers to educate women about breastfeeding as early as possible and to identify mothers and babies who may be at risk of breastfeeding difficulties.
- In order to make an informed decision about feeding her baby a woman needs:
  - Information that is accurate and factual about the importance of breastfeeding and the risks of replacement feeding - not the health worker's personal opinion or marketing information from a formula company.
  - Understanding of the information in her individual situation – this means giving information in words that are suitable for the woman and discussing the information in the context of her situation.
  - Confidence, which means building the woman's confidence in her ability to exclusively breastfeed. If she is not breastfeeding, she needs to be confident that she can find a replacement feeding method that is as safe as possible in her situation.
  - Support to carry out her feeding decision. This includes support to successfully feed her baby and to overcome any difficulties.
- The woman needs to believe that she can carry out her decision. It is not enough for the health worker to think that she or he has provided sufficient information or support; the health worker needs to check with the woman that her information and support needs are met.

Fatima and Miriam are at the antenatal clinic. While they are waiting, there is a nurse talking with a group of pregnant women about feeding their baby. Fatima and Miriam listen to the talk.

7 Use other names as culturally appropriate.

Group talk during pregnancy

Ask: What do you think are the main points to include in a group talk about feeding a baby?
Wait for participants to respond.

Give an antenatal group talk

- During a group talk to pregnant women, pregnant women in the group who breastfed before can be asked to discuss their positive experiences and identify causes why others had problems and how to prevent them.
- The pregnant women can be given more information on managing breastfeeding such as by using dolls to show how to position the infant for breastfeeding.

- *Facilitator presents the following information as if it was a talk to a group of pregnant women.*

Why breastfeeding is important

- Breastfeeding is important to children, to mothers and to families. Breastfeeding protects infant's health. Children who are not breastfed are more likely to be:
  - Ill or to die from infections such as diarrhoea and gastrointestinal infections, and chest infections.
  - Underweight and not grow well, if they live in poor circumstances.
  - Overweight and to have later heart problems, if they live in rich circumstances.
- Breastfeeding is important to mothers. Women who do not breastfeed are more likely:
  - To develop anaemia and to retain fat deposited during pregnancy, which may result in later obesity.
  - To become pregnant soon after the baby's birth.
  - To develop breast cancer.
  - To have hip fractures in older age.
- In addition:
  - Breast milk is readily available. There is nothing to buy and it needs no preparation or storage.
  - Breastfeeding is simple, with no equipment or preparation needed.
  - If a baby is not breastfed, the family will need to buy replacement milk for the baby and find time to prepare feeds and keep feeding equipment clean.
  - If a baby is not breastfed, there may be loss of income through a parent's absence from work to care for an ill child.
- Mother's milk is all a baby needs:
  - Exclusive breastfeeding is strongly recommended for the first six months. The baby does not need water, other fluids, or foods during this time.
  - Breastfeeding continues to be important after the first six months when other foods are given to the baby.
  - A mother's milk is especially suited for her own baby and changes from day to day, month to month, and feed to feed to meet the baby's needs. The baby learns the tastes of the family foods through the flavours of breast milk.

- Mother's milk is unique (special). Human milk is a living fluid that actively protects against infection. Artificial formula provides no protection from infections.

Practices that can help breastfeeding to go well

- Hospital practices can help breastfeeding to go well. These practices include to:
  - Have a companion with you during labour, which can help you to be more comfortable and in control.
  - Avoid labour and birth interventions such as sedating pain relief and caesarean sections unless they are medically necessary.
  - Have skin-to-skin contact immediately after birth, which keeps the baby warm and gives an early start to breastfeeding.
  - Keep the baby beside you (rooming-in or bedding-in), so that your baby is easy to fed as well as safe.
  - Learn feeding signs in your baby so that feeding is baby-led rather than to a schedule.
  - Feeding frequently, which helps to develop a good milk supply.
  - Breastfeeding exclusive with no supplements, bottles, or artificial teats.
- It is important to learn how to position and attach the baby for feeding and a member of staff will help after the baby is born. Most women can breastfeed and help is available if needed[8].

Information on HIV testing

- All pregnant women are offered voluntary and confidential HIV counselling and testing. If a woman is HIV-infected there is a risk of transmission to the baby during the pregnancy and birth, as well as during breastfeeding. If the pregnant woman knows that she is HIV-positive then she can make informed decisions.
- About 5-15% of babies (one in 20 to one in seven) born to women who are HIV-infected will become HIV-positive through breastfeeding[9].This means most infants born to women who are HIV-positive will not be infected through breastfeeding.
- In some settings, the risk to the child of illness and death from not exclusively breastfeeding is higher than the risk of HIV transmission from breastfeeding. One of the reasons that individual counselling is so important is that it gives mothers the information they need to make the informed choices about how to feed their babies in their own situations.
- The majority of women are not infected with HIV. Breastfeeding is recommended for:
  - women who do not know their status, and
  - women who are HIV-negative.

Assistance is available

- More information is available and a pregnant woman or mother can discuss any questions with a staff member.
- A skilled staff member will be available to assist with breastfeeding after the baby is born.

---

8 We will discuss these practices more in later sessions of this course.
9 To estimate the percentage of infants at risk of HIV through breastfeeding in the population, multiply the prevalence of HIV by 15%. For example, if 20% of pregnant women are HIV-positive, and every woman breastfeeds, about 3% of infants may be infected by breastfeeding. (*Infant Feeding in Emergencies, Module1*).

- Before a mother leaves the birth facility she will be told how to find on-going help and support with feeding her baby.

- *End of talk ask if there are any questions on the points in the talk.*

Individual discussion during pregnancy

Fatima goes in to see her pregnancy care provider. He or she does not know if Fatima heard the group talk on breastfeeding and if she has any questions.

Ask: How can the pregnancy care provider find out if a pregnant woman knows about the importance of breastfeeding or has questions?
Wait for participants to respond.

Start the discussion with an open question

- Begin with an open question such as:
  "What do you know about breastfeeding?"
  This type of open question gives an opportunity to reinforce a decision to breastfeed, to discuss any barriers that the woman may see to breastfeeding, or to discuss problems the woman may have had with previous breastfeeding.

Ask: If you asked a question such as "Are you going to breastfeed?" or "How do you plan to feed your baby?" what might the mother reply?
Wait for participants to respond.

- If you ask a question such as "Are you going to breastfeed your baby" it is difficult to continue the discussion if the pregnant woman says that she is not going to breastfeed.

Use your communication skills to continue the discussion

- Let the pregnant woman discuss her individual worries and concerns about feeding her baby. It is important that the discussion is two-way between the pregnant woman and the health worker, rather than a lecture to the woman.
- If the woman's comments tell you that she already knows much about early and exclusive breastfeeding, you can reflect and reinforce her knowledge. You do not need to give her information that she already knows.
- A woman's decision about how to feed her baby may be influenced by the baby's father, her own mother or another family member. It can be helpful to ask:
  "What people are there who are close to you who will support you to feed your baby?"
  You may suggest that a family member who is important to the woman comes with her to hear more about feeding her baby.

Antenatal discussion is an important part of care

- An individual discussion on breastfeeding does not need to take a long time. A short focused discussion for three minutes can achieve much.
- A pregnant woman may see different health workers during her antenatal care. All health workers have a role in promoting and supporting breastfeeding. Some hospitals use an Antenatal Check List[10] in the woman's file to record discussions and highlight points to discuss further at another visit.

[10] An example of an Antenatal Checklist is at the end of this session.

- *(Optional) Give participants a copy of the Antenatal Checklist and discuss if it would be useful in their work setting.*

2. Antenatal breast and nipple preparation 5 minutes

Fatima tells you that her neighbour told her that she must prepare her nipples for breastfeeding, as some women's breasts are not good for breastfeeding.

Ask: What can you say to Fatima who is concerned if her breasts will be 'correct' for breastfeeding?

Wait for participants to respond.

Reassure her that most women breastfeed with no problems.

- Other body parts, such as ears, nose, fingers, or feet, come in various shapes and sizes and no-one asks if big ears hear better than small ears. Breasts and nipples can look different and still work perfectly well, except in very rare cases.
- Antenatal practices such as wearing a bra, using creams, performing breast massage or nipple exercises, or wearing breast shells, do not assist breastfeeding.
- Practices such as 'toughening' of the nipples by rubbing with rough towel or putting alcohol on the nipples or excessive pulling are not necessary and may damage the skin and tiny muscles that support breastfeeding, and should not be encouraged.

Further information for the health worker:

- Breast examination during pregnancy can be helpful if it is used to:
  - Point out to a woman how her breasts are increasing in size, that there is more blood flow to them and changes in sensitivity, and how these are all signs that her body is getting ready to breastfeed.
  - Check for any previous chest or breast surgery, trauma or other problem (e.g. lumps in breast).
  - Talk to the mother about regular breast self-examination and why it can be useful.
- Breast examination during pregnancy can be harmful if it is used to judge a woman's nipples or breasts as suitable or unsuitable for breastfeeding. It is very rare for a woman to be unable to breastfeed due to the shape of her breasts or nipples.
- The ideal antenatal preparation is to use the time to discuss the woman's knowledge, beliefs and feelings about breastfeeding and to build the woman's confidence in her ability to exclusively breastfeed her baby.

3. Women who need extra attention 10 minutes

Ask: What pregnant women may need extra counselling and support on feeding their babies?
Wait for a few replies.

- Identify women with special concerns. Help them to talk about issues that may affect their plans about feeding their baby. Offer to talk also to significant family members as needed so that they can support the woman. A woman may need special counselling and support if she:
  - Had difficulties breastfeeding a previous baby and gave up and started formula feeding quickly, or never started breastfeeding.
  - Must spend time away from her baby because she works away from home or is attending school. Assure women that they can breastfeed with separations[11].
  - Has a family difficulty. Help her to identify non-supportive family members, and try to meet with them to discuss their concerns.
  - Is depressed.
  - Is isolated, without a social support.
  - Is a young or single mother.
  - Has an intention to leave the baby for adoption.
  - Had previous breast surgery or trauma that could interfere with milk production.
  - Has a chronic illness or needs medication[12].
  - Is at high risk of her baby needing special care after birth, or twin pregnancy.
  - Is tested and shown to be HIV-positive.
- There is generally no need to stop breastfeeding an older baby during a succeeding pregnancy. If the woman has a history of premature labour or experiences uterine cramping while breastfeeding, she should discuss this with her doctor. Similar to all pregnant women, the mother who is breastfeeding and pregnant needs to take care of herself, which includes eating well and resting. Sometimes the breasts feel more tender, or the milk seems to decrease in the mid-trimester of the pregnancy; but these are not reasons of themselves to stop breastfeeding.
- Whether there is a shortage of food in the family or not, breast milk may be a major part of the young child's diet. If breastfeeding stops, the young child will be at risk, especially if there are no animal foods in the diet. Feeding the mother is the most efficient way of nourishing the mother, the unborn baby, and the young breastfeeding toddler. Abrupt cessation of breastfeeding should always be avoided.
- If a pregnant woman feels that exclusive breastfeeding is impossible for her to do, talk with her about why she feels exclusive breastfeeding is impossible. You can suggest that she start with exclusive breastfeeding. If it is too difficult in her situation to continue, then some breastfeeding is better than not breastfeeding at all. However, if the woman is HIV-positive, partial breastfeeding has been shown to carry a higher risk of HIV transmission than exclusive breastfeeding.
- If a mother is not breastfeeding, for a medical reason such as HIV or her informed personal decision, then it is important that she knows how to feed her baby. These women need individual discussion about replacement feeding and assistance to learn how to prepare feeds.

---

11 Continuing to breastfeed if there is separation will be discussed in Session 11.
12 Maternal illness and breastfeeding is discussed in Session 13.

4. Antenatal discussion with women who are HIV-positive 10 minutes

- Offer all pregnant women counselling and voluntary testing for HIV. Women who are tested and found to be HIV-positive need extra care and attention during their pregnancies.

Ask: How can a pregnant woman get counselling and testing for HIV in this local area?
Wait for participants to respond. Give further information as needed.

- In the situation where the woman is tested and found to be HIV-positive, the recommendation regarding infant feeding is:

- *Show slide 3/2*

Infant Feeding Recommendation for HIV-positive Women

Exclusive breastfeeding is recommended for HIV-infected mothers for the first six months of life unless replacement feeding is acceptable, feasible, affordable, sustainable and safe for them and their infants before that time. When replacement feeding is acceptable, feasible, affordable, sustainable and safe, avoidance of all breastfeeding by HIV-infected mothers is recommended.

- All HIV-positive women need counselling that includes:
  - ***information*** *about the risks and benefits of various infant feeding options;*
  - ***guidance*** *in selecting the most suitable option for their situation; and*
  - ***support*** *to carry out their choice.*
- Ideally, a woman is first counselled about infant feeding options during antenatal care, although it is possible that some will not learn their HIV status until they give birth or until their babies are a few months old.

- *Show flipchart with AFASS written on it*

- If after counselling, a woman who is HIV-positive decides that for her replacement feeding can be acceptable, feasible, affordable, safe, and sustainable (**AFASS**), then she needs help to learn how to obtain, prepare, store and feed it. She should learn before her baby is born, so that she is ready to give her baby replacement feeds immediately after birth.
- A woman who is not planning to breastfeed needs to discuss:
  - What are the replacement feeding options and which, if any, are acceptable, feasible, affordable, sustainable and safe in her situation.
  - What she will need in order to use the method she chooses – source of milk, water, equipment, cost, time.
  - If commercial formula is used, the difference between types of formula and what types are suitable for her infant.
  - If home-prepared formula is used, what are the available sources of milk and whether they are they suitable and safe?
  - Is the household water supply accessible and safe? If it is not safe, what water can the mother use?
  - Water will need to be boiled to mix formula and hot water is needed for washing the equipment. Is there fuel available?
  - How will she keep the equipment clean?
  - Who will help her learn to prepare and to feed the formula and when will she learn these things?

- The woman who is HIV-positive will also need to discuss avoidance of mixed feeding and care of her breasts until the milk is gone[13].
- If replacement feeding is not suitable, then the mother should not attempt it. Instead, she can consider "safer breastfeeding," which means exclusive breastfeeding, followed by safe transition to exclusive replacement feeding. A mother may decide to express her milk and heat-treat it to kill the HIV. If a woman decides on "safer breastfeeding," then she will need guidance and support on how to do that.
- Some women may decide to breastfeed exclusively and to stop breastfeeding as soon as a replacement feeding method becomes acceptable, feasible, affordable, sustainable and safe in her situation.
- Exclusive breastfeeding carries a lower risk of HIV transmission than mixed breastfeeding.

Ask: Where can a woman who is HIV-positive obtain infant feeding counselling in this local area?

Wait for responses. Provide further information as needed.

Detailed information on counselling women who are HIV-positive, how to assist them to decide on a feeding option and learn to use that option, are covered in the WHO/UNICEF course: *Infant and Young Child Feeding Counselling: An integrated course* and training on the use of *HIV and Infant Feeding job aids.* Job aids to counsel women who have already been tested and found to be HIV-positive are available to assist those who are trained in infant feeding counselling.

5. Discuss breastfeeding with a pregnant woman 50 minutes

Explain the activity – 5 minutes

Later the participants will have a clinical practice where they will talk with pregnant women. This activity is preparation for the clinical practice.

Divide the participants into groups of three. One person plays the role of the 'pregnant woman', one person is the 'health worker', and one person is the 'observer'. The health worker listens to the pregnant woman and her views and concerns about breastfeeding. The 'health worker' discusses with the pregnant woman the importance of breastfeeding and some practices that help establish breastfeeding in the first days. The Antenatal Checklist can help the 'health worker' to remember the points to discuss[14].

The 'observer' should watch and note when the 'health worker':

- Uses open questions to encourage the woman to talk.
- Responds to the woman by reflecting, praising and using other counselling skills as appropriate.
- Provides correct information in a way that is easy to understand, including the importance of breastfeeding for the mother as well as the baby and some information on why practices are recommended.
- Offers opportunities for the woman to ask questions or discuss the information further.

Then the three people discuss the skills used and information given.

13 Care of the breast for a non-breastfeeding woman is discussed in a later session.
14 The Antenatal Checklist is at the end of this session.

Pair practice – 30 minutes

About every 5 minutes, ask the participants to swap roles so that they all have a turn in each role. Facilitators stay with groups to see if they are managing the activity.

Class discussion – 10 minutes

How can women discuss breastfeeding if there is limited time in antenatal services or if the women do not come to the services?

When are individual talks appropriate and feasible?

When should group talks be given?

If group talks are given, how can the antenatal serviced help insure that pregnant women hear all they need to know about feeding their babies?

What do you say to a woman that you know has been tested and is HIV-positive about feeding her baby?

What if the woman does not want to listen to any information?

- *Ask if there are any questions. Then summarise the session.*

Session 3 Summary

- A pregnant woman needs to understand that:
  - breastfeeding is important for her baby and for herself;
  - exclusive breastfeeding for 6 months is recommended;
  - frequent breastfeeding continues to be important after complementary foods are added;
  - practices such as early skin to skin contact after birth, early initiation of breastfeeding, rooming-in, frequent baby-led feeding, good positioning and attachment, and exclusive breastfeeding without any supplements are beneficial and can assist in establishing breastfeeding;
  - support is available to her.

- The ideal antenatal preparation is that which builds the woman's confidence in her ability to breastfeed. Breast and nipple preparation are not needed and can be harmful.
- Some women will need extra attention if they have had previous poor experiences of breastfeeding or are at risk of difficulties.
- Offer all pregnant women voluntary and confidential HIV counselling and testing.
- A woman who is HIV-positive needs individual counselling to help her to decide the best way to feed her baby that is acceptable, feasible, affordable, sustainable, and safe (AFASS) in her circumstances.

Session 3 Knowledge Check

List two reasons why exclusive breastfeeding is important for the child.

List two reasons why breastfeeding is important for the mother.

What information do you need to discuss with a woman during her pregnancy that will help her to feed her baby?

List two antenatal practices that are <u>helpful</u> to breastfeeding and two practices that might be <u>harmful.</u>

If a woman is tested and found to be HIV-positive, where can she get infant feeding counselling?

Antenatal Checklist – Infant Feeding

All of the following should be discussed with all pregnant women by 32 weeks of pregnancy. The health worker discussing the information should sign and date the form.

Name:

Expected date of birth:

Topic	Discussed or note if mother declined discussion	Signed	Date
Importance of exclusive breastfeeding to the baby (protects against many illnesses such as chest infections, diarrhoea, ear infections; helps baby to grow and develop well; all baby needs for the first six months, changes with baby's needs, babies who are not breastfed are at higher risk of illness)			
Importance of breastfeeding to the mother (protects against breast cancer and hip fractures in later life, helps mother form close relationship with the baby, artificial feeding costs money)			
Importance of skin-to-skin contact immediately after birth (keeps baby warm and calm, promotes bonding, helps breastfeeding get started)			
Importance of good positioning and attachment (good positioning and attachment helps the baby to get lots of milk, and for mother to avoid sore nipples and sore breasts. Help to learn how to breastfeed is available from …)			
Getting feeding off to a good start - baby-led feeding; - knowing when baby is getting enough milk; - importance of rooming-in/keeping baby nearby; - problems with using artificial teats, pacifiers.			
No other food or drink needed for the first 6 months – only mother's milk **Importance of continuing breastfeeding after 6 months while giving other foods**			
Risks and hazards of not breastfeeding - loss of protection from illness and chronic diseases; - contamination, errors of preparation; - costs; - difficulty in reversing the decision not to breastfeed.			

Other points discussed and any follow-up or referral needed:

Additional Information - Session 3

Antenatal discussion

- Antenatal education is especially important with maternity stays of less than 24 hours because there is little time after birth to learn about breastfeeding. During antenatal visits, health workers can find out what women already know about breastfeeding and begin to help them learn breastfeeding management.
- In addition, a woman needs to be confident that she will be able to breastfeed. This means talking about the concerns she has and talking about the practices that assist breastfeeding to get well established.
- Pregnant women are not children in school who need a teacher at the front of the class. Adults learn best when the information is relevant to their needs, they can link it to other information they know, and they can talk about it with others in the group. Group discussion can also be a useful way to bring out cultural issues such as embarrassment in front of men, fear of losing their figure, worries about not being able to be away from the baby if breastfeeding, what parents/partners think, balancing work inside or outside of household with feeding. Some topics may be easier to discuss as part of a group with peers rather than one to one with a health worker.
- Remember to include women who are in-patients during their pregnancy in both individual and group discussions.
- If the baby is likely to need special care after birth, for example if a preterm birth expected, it is good to talk to the pregnant woman more about the importance of breastfeeding for her baby and about the supports that are available to help her feed her baby receiving special care.
- Unfortunately, some women do not come to many antenatal preparation sessions, and when they do come there may be little time for discussion.
- If a woman asks, information can be given on the difference between breast milk and infant formula[15], the cost of using formula, and the need to learn how to prepare it in a safe manner if it is used.
- An antenatal group session is NOT the place to teach preparation of formula. Mothers who decide not to breastfeed need to learn safe preparation of replacement feeds one-to-one with a health worker so that they are able to learn at their own speed and to ask questions about their own situation. They may learn best close to the time when they need to know this information (near the time of the baby's birth), not several weeks before the baby is born.
- In addition, teaching replacement feeding as a routine part of antenatal education gives women the impression that it is expected that they will prepare formula for their baby. This influences some women who might otherwise exclusively breastfeed to use formula.

The importance of breastfeeding and breast milk

- Breastfeeding is important for the short and long term health of children and women. Both the action of breastfeeding and the composition of breast milk are important.

The action of breastfeeding

- The action of breastfeeding helps the child's jaw to develop as well as muscles such as the tongue and muscles of the Eustachian tube. This development:
  - reduces the incidence of ear infections;
  - assists with clear speech;
  - protects against dental caries and reduces risk of orthodontic problems.

15 Remember to use breast milk as the ideal or norm and compare infant formula to breast milk, rather than comparing breast milk to formula. Formula may have a high level of a particular ingredient but this does not mean a high level is better than the level in breast milk.

- Infants appear to be able to self-regulate their milk intake. This may have an effect on later appetite regulation and obesity. This appetite control does not appear to happen with bottle-fed milks - where the person feeding the baby controls the feed, rather than the baby.
- Breastfeeding also provides warmth, closeness and contact, which can help physical and emotional development of the child. Mothers who breastfed are less likely abandon or abuse their babies.

Breast milk is important for children

- Human milk:
  - Provides ideal nutrition to meet the infant's needs for growth and development.
  - Protects against many infections, and may prevent some infant deaths.
  - Reduces risk of allergies and of conditions such as juvenile-onset diabetes, in families with a history of these conditions.
  - Programmes body systems that may assist in blood pressure regulation and reduction of obesity risk in later life.
  - Is readily available, needing no preparation.
- A mother's own milk is best suited to the individual child, changing to meet the baby's changing needs.
- Many of the effects of breastfeeding are 'dose responsive'. This means that longer and exclusive breastfeeding shows a greater benefit.
- Children who do not breastfeed or receive breast milk may be at increased risk of:
  - Infections such as diarrhoea and gastrointestinal infections, respiratory infections, and urinary tract infections.
  - Eczema and other atopic conditions.
  - Necrotising enterocolitis, in preterm infants.
  - Lower developmental performance and educational achievement, thus reducing earning potential.
  - Developing juvenile onset insulin dependant diabetes mellitus, higher blood pressure and obesity in childhood, all markers of later heart disease.
  - Dying in infancy and early childhood.
- The dangers of not breastfeeding occur with all social and economic circumstances. Many studies indicate that a non-breastfed child living in disease-ridden and unhygienic conditions is between six and 25 times more likely to die of diarrhoea and four times more likely to die of pneumonia than breastfed infants. These risks even lower with exclusive breastfeeding.
- If every baby were exclusively breastfed from birth for six months, an estimated 1.3 million additional lives would be saved world wide and millions more lives enhanced every year.

Breastfeeding is important for mothers, families and communities

- Compared to women who breastfeed, not breastfeeding may increase the risk of:
  - Breast cancer, and some forms of ovarian cancer.
  - Hip fractures in older age.
  - Retention of fat deposited during pregnancy which may result in later obesity.
  - Anaemia due to low contraction of the uterus following birth and early return of menses.
  - Frequent pregnancies due to lack of child spacing effect of breastfeeding.
  - Fewer opportunities to be close to their baby.
- Families are affected too. When a baby is not breastfed there may be:
  - Loss of income through a parent's absence from work to care for an ill child.
  - Higher family expenses to purchase and prepare artificial feeds as well as extra time needed to give these feeds, as well as extra expense of the child's illnesses.
  - Worry about infant formula shortages or about an ill baby.
- Children who are not breastfed have increased illness, therefore increased use of health care services, and increased health care costs, both as infants and later. In addition, healthy infants grow to become healthy, intelligent adults in the workforce, contributing to the well being of their community.

The risks of not breastfeeding

- The risks from not breastfeeding are due to:
  - The lack of the protective elements of breast milk, resulting in a higher illness rate.
  - The lack of optimal balance of nutrients, for example those needed for brain growth and intestinal development.
- In addition, there are the dangers from the use of breast-milk substitutes themselves. These dangers may include:
  - Infant formula may be contaminated through manufacturing error.
  - Powdered infant formula is not sterile and during manufacture may be contaminated with bacteria such as *Enterobacter sakazakii* and *Salmonella enterica*, which has been associated with serious illness and death in infants. WHO has developed guidelines[16] for careful formula preparation in order to minimize the risk to infants.
  - Infant formula may contain unsafe ingredients or may lack vital ingredients.
  - Water used for washing bottles or mixing infant formula may be contaminated.
  - Errors in mixing formula, over concentration or under concentration, may cause infant illness.
  - Families may dilute the formula to make it last longer.
  - Formula may be given to settle a crying baby which can lead to overweight and food being seen as the solution to unhappiness.
  - Water and teas may be given instead of breast milk or formula resulting in less milk consumed overall and low weight gain.
  - Purchase of infant formula creates unnecessary expenses for the family and means less food for other members.
  - Frequent pregnancies may burden the family and society.
  - Hospital costs are higher for staff and supplies to treat health problems.
- Some of the risks from using breast-milk substitutes can be reduced by attention to the *process* of using breast-milk substitutes - the preparation and hygiene elements. However, the differences in the constituents of breast milk and formula still remain.

Class discussion

Does it make a difference if you say, “Breastfed babies may have less illness” or if you say, “Babies who are not breastfed may have more illness”?
Bring out in the discussion that the first phrase implies that illness is normal in babies and breastfed babies have less illness than normal rates found in babies who are not breastfed. The second phrase implies that breastfeeding is the norm and not breastfeeding has the risk.

How would you reply to a colleague who says, “You make mothers feel bad if you tell them that there are dangers if they do not breastfeed”?
Health workers do not hesitate to tell women that there is a risk if they smoke during pregnancy or if do not have a trained person at the birth or if they leave their infant in the house alone. There are many risks to a baby that we tell women to try to avoid. Women have a right to know what is best for baby and may feel angry if you withhold information from them.

16 *Guidelines for the safe preparation, storage and handling of powdered infant formula.* Food Safety, WHO (2007)

> ***Optional Activity- additional time will be needed***
>
> Ask participants if they know the costs to a family of using breast-milk substitutes for six months. The Worksheet 3.1 at the end of this session can be used to discuss this further. Time is not allocated in this session for this discussion.

Breastfeeding and emergency situations

- Increasingly, mothers and infants are affected by emergency situations worldwide. Natural disasters, such as earthquakes, storms, and floods as well as armed conflicts displace millions of families and cut them off from their usual food supplies.
- In many cases the immediate problem of securing food is complicated by outbreaks of illnesses such as cholera, diphtheria and malaria following disruption of power, water and sewage services.
- In these emergency situations, breastfeeding, especially exclusive breastfeeding, is the safest and often the only reliable food for infants and young children. It provides both nutrition and protection from illness as well as having no financial cost or extra water needed for preparation.
- A mother does not need perfect calm to breastfeed. Many women breastfeed easily in extremely stressful situations. Some women find that breastfeeding soothes and helps them to cope with stress. However, stress may decrease a woman's ability to letdown, so it is important to create safe areas in emergency settings where pregnant and breastfeeding mothers may gather to support each other. If health workers are supportive and build a mother's confidence, this can help her milk to flow well.
- Any infant who is not breastfeed is at high risk in an emergency situation. Their mothers should be referred for full assessment of risk, for relactation if possible, and for other needed support.

How breast milk is unique

- Breast milk has over 200 known constituents as well as constituents that are not yet identified. Each animal has milk specific to the needs of that species – calves grow quickly with large muscles and bones, human babies grow slowly with rapid brain development.
- A mother's milk is especially suited for her own baby. It changes to provide nutrition suitable for the baby's needs. Colostrum and breast milk are adapted to gestational age, and mature breast milk changes from feed to feed, day to day, and month to month to meet the baby's needs. Breast milk is a living fluid that actively protects against infection.

How breast milk protects

- A child's immune system is not fully developed at birth and takes to age three or more to fully develop. Breast milk provides protection for the baby in a number of ways:
  - When the mother is exposed to an infection her body <u>produces antibodies</u> (infection fighting substances) to that infection. These antibodies are passed to the baby through her breast milk.
  - Mother's milk stimulates the baby's own immune system.
  - Factors in breast milk help the growth of the cell walls of the baby's gut thus <u>aiding the development of a barrier</u> to micro-organisms and allergens, as well as <u>aiding the repair of damage</u> from infections.
  - White cells present in breast milk are able to <u>destroy bacteria</u>.
  - Components in breast milk also <u>prevent the micro-organisms from attaching</u> to the cell walls. If they do not attach they pass out of the baby's system.
  - The growth of <u>beneficial bacteria</u> in the breastfed baby's system (*lactobacillus bifidus*) leaves little room for the growth of harmful bacteria.
  - <u>Nutrients are not available for harmful bacteria to grow</u>, for example, lactoferrin binds to iron preventing disease-causing bacteria from using this iron to multiply.

- Artificial formula contains no living cells, no antibodies, no live anti-infective factors and cannot actively protect the baby from infections.

What is breast milk

Colostrum: the first milk

- Colostrum is produced in the breasts by the seventh month of pregnancy and continues through the first few days after birth. In appearance, colostrum is thick, sticky, and clear to yellowish in color.
- Colostrum acts like a 'paint' coating the babies gut to protect it. If any water or artificial feeds are given, some of this 'paint' can be removed, allowing infections to get into the baby's system. Colostrum is a baby's first immunization against many bacteria and viruses. Colostrum helps to establish good bacteria in the baby's gut.
- Colostrum is the perfect first food for babies, with more protein and vitamin A than mature breast milk. Colostrum is laxative, and helps the baby to pass meconium (the first sticky black stools). This helps to prevent jaundice.
- Colostrum comes in very small amounts. This suits the baby's very small stomach and the immature kidneys that cannot handle large volumes of fluid. Breastfed newborns should not be given water or glucose water unless medically necessary.

Preterm breast milk

- The milk of a mother giving birth before 37 weeks gestation, preterm breast milk, has more protein, higher levels of some minerals including iron, and more immune properties than mature milk, making it more suited for the needs of a premature baby.
- A mother's milk can even be used before the baby is able to breastfeed. The mother can express her milk, and it can be fed to the baby with a cup, spoon or tube.

Mature breast milk

- Mature breast milk contains all of the major nutrients – protein, carbohydrates, fat, vitamins, minerals and water in the amounts the baby needs. It changes in relation to the time of day, the length of a breastfeed, the needs of the baby, and diseases with which the mother has had contact.
- The components of breast milk provide nutrients as well as substances that help in digestion, growth, development and provide protection from infections. Breast milk continues to provide these nutrients, protection, and other benefits as the child grows, these components do not disappear at a certain age.

Nutrients in breast milk

Protein

- The amount of protein in breast milk is perfect for infant growth and brain development. It is easy to digest and can thus quickly supply nutrients to the baby. Artificial formulas have different proteins from human milk that can be slow and difficult to digest, which can put a strain on the baby's system. Some babies can develop intolerance to the proteins in formula resulting in rashes, diarrhoea and other symptoms. The level of protein in breast milk is not affected by the mother's food consumption.

Fat

- Fat is the main source of energy (calories) for the infant. Enzymes in breast milk (lipase) start the digestion of the fat, so that it is available quickly to the baby as energy.
- Fat in breast milk contains very long-chain fatty acids for brain growth and eye development as well as cholesterol and vitamins. The high level of cholesterol may help the infant to develop body systems to handle cholesterol throughout life.
- The level of fat is low in the milk at the beginning of a feed — this is called foremilk, and quenches the baby's thirst. The level of fat is higher in the milk later in the feed — this is called hind milk, and gives satiety. Fat content can vary from feed to feed.
- Artificial formula does not change during the feed and lacks digestive enzymes. Artificial formulas have little or no cholesterol. Some brands may have fatty acids added; however these may come from fish oils, egg fat or vegetable sources.

- The type of fat in breast milk can be affected by the mother's diet. If a mother has a high level of polyunsaturated fats in her diet, her milk will be high in polyunsaturated fats. However the total amount of fat in the milk is not affected by the mother's diet unless the mother is severely malnourished with no body fat stores.

Carbohydrate

- Lactose is the main carbohydrate in breast milk. It is made in the breast and is constant through out the day. Lactose helps calcium absorption, provides fuel for brain growth and retards the growth of harmful organisms in the gut. It is digested slowly. Lactose in the breastfed baby's stool is not a sign of intolerance.
- Not all artificial formulas contain lactose. The effects of feeding healthy infants breast milk substitutes without lactose are unknown.

Iron

- The amount of iron in breast milk is low. However it is well absorbed from the baby's intestine if the baby is exclusively breastfed, partly because breast milk provides special transfer factors to help this process. There is a high level of iron added to formula because it is not absorbed well. The excess added iron can feed the growth of harmful bacteria.
- Iron-deficiency anaemia is rare in the first six to eight months in exclusively breastfed babies who were born healthy and full term, without premature cord clamping.

Water

- Breast milk is very rich in water. A baby, who is allowed to breastfeed whenever the baby wants, needs no supplemental water even in hot, dry climates. Breast milk does not overload a baby's kidneys and the baby does not retain unnecessary fluid.
- Giving water or other fluids such as teas, may disrupt the breast milk production, decrease the infant's nutrient intake, and increase the infant's risk of infections.

Flavour

- The flavour of breast milk is affected by what the mother eats. The variation in flavour can help the baby get used to the tastes of the family foods and ease the transition to these foods at after six months of age. Artificial formula tastes the same for every feed, and throughout the feed. The taste of formula is not related to any foods the baby will eat when older.

Exclusive breastfeeding for the first six months

- Exclusive breastfeeding provides all the nutrients and water that a baby needs to grow and develop in the first six months. This means to the end of six completed months – 26 weeks or 180 days, not the start of the sixth month.
- Exclusive breastfeeding means that no drinks or foods other than breast milk are given to a baby. Vitamins, mineral supplements or medicines can be given, if needed. Most exclusively breastfed young infants feed at least eight to twelve times in 24 hours, including night feeds.
- Any of the following interferes with exclusive breastfeeding:
    - A baby is given any drinks or foods other than breast milk.
    - A baby is given a pacifier/dummy/soother.
    - Limits are placed on the number of breastfeeds.
    - Limits are placed on suckling time or the length of a breastfeed.
- After six months, children should receive complementary foods in addition to breast milk. Breast milk continues to be important, often providing one-third to one-half the calories for the child at twelve months of age, and should be continued up to 2 years of age and beyond.

Recommendations related to breastfeeding for women who are HIV-positive

- If a woman is HIV-infected, there is a risk of transmission to the baby during the pregnancy and birth, as well as during breastfeeding. About 5-15% of babies (one in 20 to one in seven) born to women who are HIV-infected will become HIV-positive through breastfeeding[17]. To reduce this risk, mothers may choose to avoid breastfeeding altogether or to breastfeed exclusively and stop as soon as replacement feeding is feasible.
- In some settings, the risk of not exclusively breastfeeding is just as high or higher than the risk of HIV transmission from breastfeeding. This is part of the reason that individual counselling is so important.
- In the situation where the woman is tested and found to be HIV-positive, the recommendation is:

Infant Feeding Recommendation for HIV-positive Women
Exclusive breastfeeding is recommended for HIV-infected mothers for the first six months of life unless replacement feeding is acceptable, feasible, affordable, sustainable and safe for them and their infants before that time. When replacement feeding is acceptable, feasible, affordable, sustainable and safe, avoidance of all breastfeeding by HIV-infected mothers is recommended.

- This recommendation does not say that all women who are HIV-positive must avoid breastfeeding. A decision not to breastfeed has disadvantages, including increased risks to the infant's health.
- It is important to ensure that replacement feeding is
  - acceptable,
  - feasible,
  - affordable,
  - sustainable, and
  - safe, in the specific family.
- Each woman who is HIV-positive needs an individual discussion with a trained person to help her to decide the best way to feed her child in her individual situation.
- The majority of women are not infected with HIV. Breastfeeding is recommended for:
  - women who do not know their status, and
  - women who are HIV-negative.
- If testing for HIV is not possible, all mothers should breastfeed. Breastfeeding should continue to be protected, promoted, and supported as a general population recommendation.

Class discussion

What could you reply to a colleague who said, "It would be better if any mother at risk of being HIV-infected was advised not to breastfeed, this would protect more babies."

Modified breastfeeding

- If the mother is HIV-positive, her own expressed milk can be heat-treated, which kills the HIV virus. Expressed breast milk from another woman can also be used, either through an organised milk bank that tests and heat-treats the milk, or informally from a woman tested and HIV-negative.

17 To estimate the percentage of infants at risk of HIV through breastfeeding in the population, multiply the prevalence of HIV by 15%. For example, if 20% of pregnant women are HIV-positive, and every woman breastfeeds, about 3% of infants may be infected by breastfeeding. (*Infant Feeding in Emergencies, Module1*).

Replacement feeding options – sources of milk

- Replacement feeding options include:
    - Formula prepared from powder (or sometimes concentrated liquid) that needs only water added.
- Commercial infant formula is made from animal milk. The fat content is altered and often a vegetable fat is added, a form of sugar is added and micronutrients are added. You may have generic formula available; which is the same composition to commercial formula. It is simply labelled and distributed without marketing it.
- A commercial formula has been modified so that the proportions of different nutrients are appropriate for infant feeding, and micronutrients have been added. Formula needs only to be mixed with the correct amount of water.
- It is important to remember however, that although the *proportions* of nutrients in either commercial or home-prepared formula can be altered, their *quality* cannot be made the same as breast milk. Also, the immune factors and growth factors present in breast milk are not present in animal milk or formula, and they cannot be added.
- Other types of formula are available and should only be discussed with mothers if the infant has a medical need for these specialised products:
    - *Soy infant formula* uses processed soybeans as the source of protein and come in powdered form. Usually it is lactose-free and has a different sugar added instead. Infants who are intolerant of cows' milk protein may also be intolerant of soy protein[18].
    - *Low birth weight or preterm formula* is manufactured with higher levels of protein and certain minerals and a different mixture of sugars and fats than ordinary formula for full-term infants. Low birth weight formula is not recommended for healthy, full term infants. The nutritional needs of low birth weight infants should be individually assessed.
    - *Specialised formulas* are available to use in conditions such as reflux, high-energy need, lactose intolerance, allergic conditions and metabolic diseases like phenylketonuria. These formulas are altered in one or more nutrients and should only be used for infants with the specific conditions under medical/nutritional supervision.
    - *Follow-on (or follow-up) milks* are marketed for older infants (over six months). They contain higher levels of protein and are less modified than infant formula. Follow-on milks are not necessary. A range of ordinary milk products can be used over six months of age and micronutrients supplements also given if needed.
- Products that are not suitable for making infant formula include:
    - skimmed milk – fresh or dried powder;
    - condensed milk (very high in sugar and the fat content may be low);
    - creamers used for 'whitening' tea or coffee.

Water for preparing formula

- Infant formula requires water to be added. All water used for making infant formula needs to be boiled – brought to a full rolling, bubbling boil. Run the tap for a while to remove water standing in the pipe before boiling.
- Use water that has low levels of contamination from organisms that could cause illness as well as safe from pesticides, lead, and other contaminants. 'Mineral' water that is sold in bottles needs to be checked as it can have a high level of sodium (above 20 milligrams of sodium per litre of water is too high for infants) or other minerals. Do not use artificially softened water for making feeds.
- The correct proportions of water to formula powder are extremely important for child health.

18 There are also soy milks available that are not specially formulated for babies and if used, need special modification and the addition of micronutrients. Soy milk is not a good milk for young children as it does not include sufficient calcium and other animal products for good growth.

Optional Activity: Cost of Not Breastfeeding

The International Code of Marketing of Breast-milk Substitutes asks all health workers to know the financial implications of any decision not to breastfeed, and to inform parents. Do you know? This worksheet is based on a UNICEF/WHO training activity[19] and has been simplified to only include the direct cost of preparing feeds. The value of breastfeeding extends past the first six months. To make calculations easier this chart only relates to the first six months.

Milk costs
One tin of formula costs ______ for ______ grams.
For the first six months, about 20 kg. of powdered infant formula are needed.
That will cost Infant formula cost _______

Fuel costs
Following label instructions, the mother must give about _____ artificial milk feeds during the first six months. ____ litres of water will be boiled to make up these feeds, plus the extra water for warming and washing ______(approx. 1 litre per feed for washing and warming) It costs _____ to boil a litre of water x _____ litres per day, multiplied by 180 days. Fuel cost _____

Caregiver's time:
Following label instructions, the caregiver must prepare feeds____ times a day, and preparation takes ____ minutes each time, or a total of ___ hours per day.

Cost of preparing artificial feeds for a baby for six months ________
Minimum wage of a nurse is ________
Minimum wage of a female factory worker is ________
Artificial feeding for one six months costs ________ % of a nurse's wage
________ % of a factory worker's wage
plus the additional time in preparation that keeps mother from other family or financial pursuits.

There are also long term costs of not breastfeeding. Health care costs are increased by not breastfeeding, which affect the family, the health and social welfare services and the taxpayers. A monetary figure cannot be put on the psychological cost of illness or death of the baby or the mother, though this is obviously great, be it an acute infection or a chronic condition.

The use of feeding bottles is not recommended as they are difficult to keep clean. However if they are used additional costs are:
Equipment costs
____ feeding bottles, at ______ each, will cost Bottles ________
____ teats at ______ each, will cost Teats ________
____bottle brush for cleaning at ______ each, will cost Brush ________

Sterilising costs
Cost ____ per day to use chemical solution x 180 days. Sterilising ______
If chemical sterilising is used, another litre of boiled water will be needed per bottle to rinse the sterilant from the bottles and teats before use.
(or calculate other methods such as boiling bottles and teats)

19 Adapted from Helen Armstrong, *Training Guide in Lactation Management,* IBFAN/UNICEF. New York, 1992, p.43. Further activities on the cost of not breastfeeding can be found in *HIV and Infant Feeding Counselling: a training course*, Session 13. WHO/FCH/CAH/2000, UNICEF/PD/NUT/(J)2000.

SESSION 4
PROTECTING BREASTFEEDING

Session Objectives:

On completion of this session, participants will be able to:

1.	Discuss the effect of marketing on infant feeding practices.	5 minutes
2.	Outline the key points of International Code of Marketing of Breast-milk Substitutes.	15 minutes
3.	Describe actions health workers can take to protect families from marketing of breast-milk substitutes.	5 minutes
4.	Outline the care needed with donations of breast-milk substitutes in emergency situations.	5 minutes
5.	Discuss how to respond to marketing practices.	15 minutes
	Total session time	**45 minutes**

Materials:

Slide 4/1: Picture of mothers in antenatal clinic.

Slide 4/2: Aim of Code.

Gather examples of advertising of breast-milk substitutes to mothers and to health professionals.

Gather examples of presents/gifts to health workers from companies.

Further reading for facilitators:

The International Code of Marketing of Breast-milk Substitutes. WHO, 1981 and Relevant WHA resolutions at: http://www.ibfan.org/English/resource/who/fullcode.html

The International Code of Marketing of Breast-milk Substitutes. A common review and evaluation framework. Geneva, World Health Organization, 1996.

Infant Feeding During Emergencies – training manual. www.ennonline.net

Booklet (not on internet): *Protecting Infant Health. A Health Workers' Guide to the International Code of Marketing of Breastfeeding Substitutes*, 10th edition, IBFAN/ICDC, 2002.

Introduction

- *Show Picture 4/1 of Miriam and Fatima and tell the story.*

Miriam is expecting her second baby. Miriam's previous baby was born in a different hospital. In that hospital, Miriam received colourful leaflets about using formula including discount coupons during her pregnancy. She also received a tin of formula, and a high quality bottle and teat set when she was going home after the birth.

1. The effect of marketing on infant feeding practices 5 minutes

Ask: What might be the effect of these gifts on Miriam's infant feeding decisions?
Wait for a few responses

- The marketing and promotion of commercial breast-milk substitutes can undermine breastfeeding and has contributed substantially to the global decline in breastfeeding.

- *Ask participants to mention some ways that breast-milk substitutes are promoted, advertised, or marketed locally. The following is your checklist; only mention these strategies if the participants do not include them.*

MARKETING PRACTICES CHECK LIST
□ television and radio advertising □ newspapers and magazines advertising □ bill board advertising □ promotional websites □ special offers □ reduced prices □ mailings to pregnant women and mothers □ discount coupons □ phone help lines □ posters, calendars etc. in doctors offices and hospitals □ doctor's and nurse's endorsements □ free gifts □ free samples □ special offers □ educational materials

- Women are not able to make informed choices about infant feeding if they receive biased and incorrect information. A company provides information on its products with the aim of selling more of its products, so companies are biased sources of information.
- Moreover, if good breastfeeding information and education does not reach society as a whole, even well informed women will not get the personal and social support essential for exclusive breastfeeding. Badly-informed families, friends and health professionals can undermine the confidence even of a well-informed woman; conflicting advice and subtle pressures may make her doubt her ability to breastfeed her baby.

2. The International Code of Marketing of Breast-milk Substitutes 15 minutes

- A Baby-friendly hospital abides by the International Code of Marketing of Breast-milk Substitutes (the Code). The International Code was agreed at the World Health Assembly (WHA) in 1981 by Member States as one step to protect breastfeeding and to protect the minority of infants who might need artificial feeding. Subsequent resolutions (about every two years) are also agreed at WHA and have the same status as the original Code.
- The International Code is not a law; it is a recommendation based on the judgment of the collective membership of the highest international body in the field of health, the World Health Assembly.

- *Show slide 4/2 and read out the points below.*

- The overall aim of the International Code of Marketing of breast-milk Substitutes is the safe and adequate nutrition of all infants. To achieve this aim we must:
  - Protect, promote and support breastfeeding.
  - Ensure that breast-milk substitutes (BMS) are used properly when they are necessary.
  - Provide adequate information about infant feeding.
  - Prohibit the advertising or any other form of promotion of BMS.
- The Code does not aim to compel women to breastfeed against their will. The Code aims to ensure that everyone receives unbiased and correct information about infant feeding.
- The Code also protects artificially fed infants by ensuring that the choice of products is impartial, scientific and protects these children's health. The Code ensures that labels carry warnings and the correct instructions for preparation, so they are prepared in a safe manner if they are used.
- The Code is clear that the manufacture of BMS and making safe and appropriate products available are acceptable practices, but promoting them in the way most consumer products are marketed is unacceptable.

The Code and local implementation

- Member States (individual countries) are honour-bound to implement the Code, but they may implement it in the way that they think is best for their countries. If a Member State uses laws to enforce health protection practices, they can make their Code a law, but if their custom is to issue edicts from the head of state or to issue rules at Ministry level, then they may do so.
- The Code was adopted as a MINIMUM standard and Member States are expected to implement the basic principles and strengthen the provisions according to their society's needs. They may make the Code stronger in any way they see fit in order to protect infant and young child health and survival, but they may not weaken it or omit any provisions.
- The responsibility for monitoring the application of the Code lies with Governments, although manufacturers and distributors, professional groups and NGOs should collaborate with Governments to this end. The monitoring should be free from commercial influence.

- *Mention any national laws, decrees or other implementation of the International Code that apply in the country.*

Products that are covered by the Code (Scope of the Code)

- The Code applies to the marketing, and related practices, of the following products:
  - breast-milk substitutes, including infant formula;
  - other milk products, foods (cereals) and beverages (teas and juices for babies), when marketed or otherwise represented to be suitable for use as a partial or total replacement of breast milk;
  - feeding bottles and teats.
- According to recommendations for optimal infant feeding, infants should be exclusively breastfed for the first 6 months. That means that any other food or drink given to them before that age will replace breast milk and is therefore a breast-milk substitute.
- After the age of six months, anything that replaces the milk part of the child's diet, which would ideally be fulfilled by breast milk, is a breast-milk substitute, for example Follow-on milks or cereals promoted to be offered by bottle.
- The Code does not:
  - Prohibit the production and availability of breast-milk substitutes.
  - Affect the appropriate use of complementary foods after 6 months of age.

Promotion and providing information

- Product labels must clearly state the superiority of breastfeeding, the need for the advice of a health care worker, and a warning about health hazards. They may show no pictures of babies, or other pictures or text idealizing the use of infant formula.
- Advertising of breast-milk substitutes to the public is not permitted under the Code.
- Companies can provide necessary information to health workers on the ingredients and use of their products. This information must be scientific and factual, not marketing materials. This product information should not be given to mothers.
- If any educational materials are provided for parents, the materials must explain:
  - the importance of breastfeeding;
  - the health hazards associated with bottle-feeding;
  - the costs of using infant formula;[20] and
  - the difficulty of reversing the decision not to breastfeed.

Samples and supplies

- There should be no free or low-cost supplies of breast-milk substitutes in any part of the health care system. Health facilities should buy the small amount of formula needed for any babies who are not breastfeeding through regular purchasing channels.
- Free samples should not be given to mothers, their families or health care workers. Small amounts of formula given to mothers as a present or gift when going home from hospital or in the community are not allowed, as these are samples to encourage mothers to use those products.
- Sometimes the government procures breast-milk substitutes to be given for free or at a reduced price to mothers or caregivers for social welfare purposes (for example, mothers who have tested HIV-positive and have made an informed decision not to breastfeed). In this situation, the supply must be reliably sustained for each infant for as long as the infant needs it.

20 Mention the cost if using infant formula, if known.

- Supplies given for a baby should not be dependent on donations. Donations might stop at any time and then the baby would have no formula. A baby who is not breastfed will need 20 kg of powdered formula in the first 6 months and a suitable breast-milk substitute up until 2 years of age.
- All products should be of a high quality and take account of the climatic and storage conditions of the country where they are used. Out of date products should not be distributed.

3. How health workers can protect families from marketing 5 minutes

How promotion is channelled through Health Systems

- *Ask participants to mention some ways that breast-milk substitutes are promoted, advertised, or marketed through hospitals and health facilities. The following is your checklist; only mention methods of marketing if the participants do not include them.*

HEALTH SYSTEM MARKETING CHECK LIST
□ Free samples □ Free supplies to hospitals and to individual health professionals □ Small gifts such as pens, prescription pads, growth charts, calendars, posters and less expensive medical equipment □ Large gifts such as incubators, machines, fridges, air conditioners, computers □ Gifts of professional services such as architectural design of hospitals, organisation of events or legal services □ Personal gifts such as holiday trips, electrical goods, meals, and entertainment □ Sponsorship of hospitals, clinics or projects, health worker associations □ Funding of research grants and salaries □ Support to attend professional events and for professional associations □ Financial sponsorship of students and the presence of company representatives in health training establishments, which may include actual teaching in infant feeding courses □ Sponsorship of conferences, seminars and publications □ Advertisements in journals and similar publications, 'advertorial' articles that look like information but are advertising □ Research reports that are really promotional materials □ Friendly relations that encourage health workers to feel well disposed to the company, sending cards, bringing sweets or other food to the staff at work □ Close relationships with Ministries of Health and their employees □ Visits by company representatives to doctors in private practice, health institutions and ministries

Ask: What can you do to help protect babies and their families from marketing practices?
Wait for a few replies.

What health workers can do:

- Health workers as individuals and as a group can help to protect infants and their mothers from marketing. They can and should:
  - Remove posters that advertise formula, teas, juices or baby cereal, as well as any that advertise bottles and teats and refuse any new posters.
  - Refuse to accept free gifts from companies.
  - Refuse to allow free samples, gifts, or leaflets to be given to mothers.
  - Eliminate antenatal group teaching of formula preparation to pregnant women, particularly if company staff provides the teaching.
  - Do individual private teaching of formula use if a baby has a need for it.
  - Report breaches of the Code (and/or local laws) to the appropriate authorities.
  - Accept only product information from companies for their own information that is scientific and factual, not marketing materials.
- Hospitals must abide by the International Code and the subsequent resolutions in order to be recognised as baby-friendly.

4. Donations in emergency situations 5 minutes

- In emergencies the basic resources needed for safe artificial feeding, such as clean water and fuel, are scarce or nonexistent. Attempts at artificial feeding in such situations increase the risk of malnutrition, disease, and death. In addition, young children not breastfed miss its protective effects and are far more vulnerable to infection and illness.
- In emergencies, donations of infant formula, foods and feeding bottles may come from many sources, including well-intentioned but poorly informed small groups or individuals. Media coverage may have led these donors to believe that women cannot breastfeed in the crisis.
- These donations should be refused since they can result in:
  - Too much infant formula sent, which may result in babies who do not need formula receiving it, as well as problems with storage and disposal of excess formula and disposal of packaging waste.
  - Advertising brands, which mothers may then think are recommended brands.
  - Donations of out of date or unsuitable formula, making them unsafe to use.
- Additional problems can arise:
  - No instructions in local languages provided for the formula preparation.
  - Bottles and teats included though cup feeding is recommended in emergencies.

Additional dangers of unlimited supplies in emergencies

- If supplies of infant formula are widely available and uncontrolled, there may be *spillover*. **Spillover** means that mothers who would otherwise breastfeed lose their confidence and needlessly start to give artificial feeds.
- **Infants and their families become dependent** on infant formula. If the free supply is unreliable, they are put at risk of malnutrition in addition to the health risks of artificial feeding.
- Large donations may come from companies who, by donating formula to the area in crisis, intend to **create a new market** for later sale of their products to the emergency-affected population or the host population.
- If donations are unavoidable, they should be used to prepare cooked foods or porridges for older children or others, or be used with a relactation device to relactate or induce lactation.

5. How to respond to marketing practices 15 minutes

Class discussion

A company representative visits the nutritionists at a nutritional rehabilitation centre to promote the use of a new, improved infant formula. He says that this formula is especially useful for malnourished babies. He offers to provide enough so that every mother may be given two free tins. If the staff is implementing the Code, how can they respond?

- *Write responses on the blackboard or flipchart.*
- *Key points: Staff should refuse the donation. Breastfeeding should be encouraged for these babies. Two tins would only feed a baby for a short time. What would happen after the two tins were used up?*

Wambui runs a private maternity home. Her friend, Wanjike, works for an infant formula company and offers to give the home posters and leaflets on breast and bottle- feeding, and supplies of formula. What can Wambui say to her friend?

- *Write responses on the blackboard or flipchart.*
- *Key points: Wambui can explain to her friend that breastfeeding is important for the health of the babies and mothers. Posters and free formula undermine the importance of breastfeeding. If there are any mothers who do not breastfeed, free formula will only last a short time. These mothers need a discussion with an infant feeding counsellor about sustainable ways to feed their baby. The posters and free formula are not needed.*

Sam is training to be a paediatrician. He is very interested in infant nutrition. A formula company offers to fund his travel to a free conference that the company is holding and provide him with accommodation at the conference hotel. If Sam accepts this funding, what might happen?

- *Write responses on the blackboard or flipchart.*
- *Key points: Sam needs to think carefully about accepting this funding. At the conference, will he hear information that is scientific and factual, or information marketing the company's products? Will there be 'gifts' at the conference of pens, prescription pads, posters and other materials marketing the products from that company? Will Sam refuse to accept these 'gifts' or will he bring them back to his workplace? Will the company representatives come to visit Sam after the conference expecting that he will help them to get their products used in the health facility because they helped him to get to the conference? Article 7 of the Code states that no financial or material inducement to promote products should be offered to health workers or accepted by them. If funding is provided for a conference, the company should disclose this funding to the health facility where the person is employed and the health worker receiving the funding should also inform their supervisor.*
- *Ask if there are any questions. Then summarise the session.*

Session 4 Summary

- Marketing of breast-milk substitutes and bottles can undermine confidence in breastfeeding for mothers and the wider community.
- The International Code and its subsequent resolutions assist the safe and adequate nutrition of infants by reducing health worker and mothers' exposure to misinformation that undermines breastfeeding, ensuring that breast-milk substitutes are used properly when they are necessary, providing adequate information about infant feeding, marketing and distributing breast-milk substitutes appropriately.
- Health workers can help to protect families from marketing of breast-milk substitutes by following the Code, refusing to accidentally endorse formula by accepting gifts from companies and refusing to distribute items with brand markings, marketing materials and samples to mothers.
- Donations of breast-milk substitutes in emergencies need to be treated with extreme care as they can make the nutrition and health of infants worse.

***Session 4 Knowledge Check** - mark the answer True (T) or False (F)*

1. Giving mothers company-produced leaflets about breast-milk substitutes can affect infant feeding practices.	T	F
2. Breast-milk substitutes include formula, teas, and juices (as well as other products)	T	F
3. The International Code and BFHI prohibit the use of formula for infants in maternity wards	T	F
4. Health workers can be given any publication or materials by companies as long as they do not share these publications with mothers	T	F
5. Donations of formula should be given to mothers of infants in emergency situations	T	F

Answers:

1. T The purpose of company-produced leaflets is to increase sales of their products.
2. T Breast-milk substitutes include infant formula, other milk products, foods and beverages (teas and juices for babies); bottle-fed complementary foods, (cereals and vegetable mixes for use before 6 months of age) when marketed or otherwise represented to be suitable, with or without modification, for use as a partial or total replacement of breast milk.
3. F Infants who are not breastfed can be fed on formula that the maternity unit has purchased in a similar way to other food purchases, not donated by a formula company.
4. F Publications for health workers from companies should contain only information about products that are scientific and factual.
5. F Donations may increase ill health. They should not be generally distributed.

SESSION 5
BIRTH PRACTICES AND BREASTFEEDING - STEP 4

Session Objectives:

On completion of this session, participants will be able to:

1. Describe how the actions during labour and birth can support early breastfeeding.	30 minutes
2. Explain the importance of early contact for mother and baby.	15 minutes
3. Explain ways to help initiate early breastfeeding.	5 minutes
4. List ways to support breastfeeding after a caesarean section.	15 minutes
5. Discuss how BFHI practices apply to women who are not breastfeeding.	10 minutes
Total session time	**75 minutes**

Materials:

Slides 5/1 – 5/3: Skin to skin contact.

Birth Practices Checklist (optional).

Further Reading for Facilitators:

WHO, *Pregnancy, childbirth, postpartum and newborn care - a guide for essential practice.* **(**2003) Department of Reproductive Health and Research (RHR), WHO.

Coalition for Improving Maternity Services (CIMS)
National Office, PO Box 2346, Ponte Vedra Beach, FL 32004 USA
www.motherfriendly.org   info@motherfriendly.org

Optional book - Kroeger M, Smith L. *Impact of Birthing practices on breastfeeding – protecting the mother and baby continuum*. Jones & Bartlett Publishers, 2004.

1. Labour and birth practices to support early breastfeeding30 minutes

In an earlier session, the mother in our story, Miriam, was at the antenatal clinic. A few weeks have gone by and now her baby is ready to be born. She comes to the maternity facility.

Ask: What practices during labour and immediately after birth could help Miriam and her baby to start breastfeeding well?
Wait for a few responses.

- The care that a mother experiences during labour and birth can affect breastfeeding and how she cares for her baby.
- Step 4 of the Ten Steps to Successful Breastfeeding states:
  Help mothers to initiate breastfeeding within a half-hour of birth.
  To focus on the importance of skin-to-skin contact and watching for infant readiness, this step is now interpreted as:
  Place babies in skin-to-skin contact with their mothers immediately following birth for at least an hour and encourage mothers to recognise when their babies are ready to breastfeed, offering help if needed.

Ask: What practices may help a woman to initiate breastfeeding soon after birth?
Wait for a few replies

- Practices that may help a woman to feel competent, in control, supported and ready to interact with her baby who is alert, help to put this Step into action. These practices include:
  - Emotional support during labour.
  - Attention to the effects of pain medication on the baby.
  - Offering light foods and fluids during early labour.
  - Freedom of movement during labour.
  - Avoidance of unnecessary caesarean sections.
  - Early mother-baby contact.
  - Facilitating the first feed.

Ask: What practices may hinder early mother and baby contact?
Wait for a few replies.

- Practices that may hinder mother and baby early contact and the establishment of breastfeeding include:
  - Requiring the mother to lie in bed during labour and birth.
  - Lack of support.
  - Withholding food and fluids during early labour.
  - Pain medications that sedate mother or baby, episiotomy[21], intravenous lines, continuous electronic fetal monitoring and other interventions used as routine without medical reasons.
  - Wrapping the baby tightly after birth.
  - Separating the mother and baby after birth.

21 The perineum is cut to give more room for the baby's head. The perineum is then stitched after the birth.

- Take care that these practices that may hinder early contact are only used if medically necessary.

Miriam's sister comes with her to the maternity facility. Miriam wants her sister to stay with her during labour and the birth.

Ask: How might it make a difference to Miriam if her sister stays with her during labour and the birth?

Wait for a few responses.

Support during labour

- A companion during labour and birth can:
  - Reduce the perception of severe pain
  - Encourage mobility
  - Reduce stress
  - Speed labour and birth
  - Reduce the need for medical interventions
  - Increase the mother's confidence in her body and her abilities.
- The support can result in:
  - Increased alertness of baby as less pain relief drugs reach the baby
  - Reduced risk of infant hypothermia and hypoglycaemia because baby is less stressed and thus using less energy
  - Early and frequent breastfeeding
  - Easier bonding with the baby.
- The labour and birth companion can be a mother, sister, friend, family member or the baby's father or a member of the health facility staff. The support person needs to remain continuously with the woman through labour and the birth.
- The companion provides non-medical support that can include:
  - Encouragement to walk and move in labour
  - Offering light nourishment and fluids
  - Building the mother's confidence by focusing on how well she is progressing
  - Suggesting ways to keep pain and anxiety manageable
  - Providing massage, hand holding, cool cloths,
  - Using positive words.

Pain relief

Miriam asks about pain relief and its effect on the baby and breastfeeding.

Ask: What can you tell her about pain relief?

Wait for a few responses.

- Offer non-medication methods of pain relief before offering pain medications. These non-medication methods include:
  - Labour support
  - Walking and moving around
  - Massage
  - Warm water
  - Verbal and physical reassurances
  - Quiet environment with no bright lights and as few people as possible
  - Labouring and giving birth positioning a position of the mother's choice.

- Pain medications can increase the risk of:
  - Longer labour
  - Operative interventions
  - Delayed start to mother baby contact and breastfeeding
  - Separation of mother and baby after birth
  - Sleepy, hard to rouse baby
  - Diminished sucking reflex
  - Reduced milk intake increasing the risk of jaundice, hypoglycaemia, and low weight gain.
- Extra time and assistance may be needed to establish breastfeeding and bonding if pain medications are used.
- Discuss ways to cope with pain and discomfort and their risks and benefits during antenatal care. The need for pain relief is affected by stress, lack of support and other factors in the labour ward.

Light foods and fluids during labour

Miriam is progressing well in early labour and there are no medical problems. She asks you if she can continue to drink water.

Ask: What effect might giving fluid or withholding fluid have on Miriam's labour?
Wait for a few responses.

- Labour and birth are hard work. The woman needs energy to do this work. There is no evidence that withholding of light food and drink from low risk women in labour is beneficial as a routine practice. The desire to eat and drink varies and a woman should be allowed to decide if she wants to eat or drink. Restricting food and fluid can be distressing to the labouring woman.
- Intravenous (IV) fluids for woman in labour need to be used only for a clear medical indication. Fluid overload from the IV can lead to electrolyte imbalance in the baby, and high weight loss as the baby sheds the excess fluid. An IV drip may limit the woman's movement.
- Following a normal birth, a woman may be hungry and she should have access to food. If she gives birth during the night, some food should be available for her so that she does not need to wait many hours until the next meal is available.

Birth practices

Ask: What birth practices might help and what practices are better avoided unless there is a medical reason?
Wait for a few responses.

- When giving birth, all women need:
  - A skilled attendant present.
  - Minimal use of invasive procedures such as episiotomy[22].
  - Universal precautions to be followed to prevent transmission of HIV and blood-borne infections[23].

---

22 Invasive procedures include vaginal examinations, amniocentesis, cardiocentesis or taking a sample from the placenta, artificial rupture of membranes, episiotomy, and blood transfusions as well as suctioning of the newborn.
23 Universal Precautions protect the birth attendant so they do not need to fear the woman with HIV and also protect the woman from any infections that the birth attendant may have.

- Caesarean sections or any other intervention only used when medically required.

- Instrumental birth (forceps or vacuum extraction) can be traumatic, disrupt the alignment of the bones in the baby's head and affect nerve and muscle function, resulting in problems with feeding.
- Normal vaginal birth is assisted by the woman being mobile during early labour with access to fluids and food, and by being in an upright or squatting position for birth.
- Episiotomy will result in pain and difficulty in sitting during the early days after birth, which can affect early skin-to-skin contact, breastfeeding, and mother-baby contact. If the woman is sore, encourage her to lie down to feed and cuddle her baby.
- The cord should not be clamped until pulsing reduces and baby has received sufficient additional blood to boost iron stores.
- When considering birth practices remember that the practices have an effect on the baby as well as the mother.

2. Importance of early contact 15 minutes

Miriam has her baby. It is a healthy girl.

Ask: What are important practices immediately after birth that can help the mother and baby?

Wait for a few responses

Skin-to-skin contact

- Ensure uninterrupted, unhurried skin-to-skin contact between every mother and unwrapped healthy baby. Start immediately, even before cord clamping, or as soon as possible in the first few minutes after birth. Arrange that this skin-to-skin contact continue for at least one hour after birth. A longer period of skin-to-skin contact is recommended if the baby has not suckled by one hour after birth.

- *Show pictures of skin-to-skin contact and point out that the baby is not wrapped and both mother and baby are covered.*

- Skin-to-skin contact:
  - Calms the mother and the baby and helps to stabilise the baby's heartbeat and breathing.
  - Keeps the baby warm with heat from the mother's body.
  - Assists with metabolic adaptation and blood glucose stabilization in the baby.
  - Enables colonization of the baby's gut with the mother's normal body bacteria gut, provided that she is the first person to hold the baby and not a nurse, doctor, or others, which may result in their bacteria colonising the baby.
  - Reduces infant crying, thus reducing stress and energy use.
  - Facilitates bonding between the mother and her baby, as the baby is alert in the first one to two hours. After two to three hours, it is common for babies to sleep for long periods of time.
  - Allows the baby to find the breast and self-attach, which is more likely to result in effective suckling than when the baby is separated from his or her mother in the first few hours.

- All stable babies and mothers benefit from skin-to-skin contact immediately after birth. All babies should be dried off as they are placed on the mother's skin. The baby does not need to be bathed immediately after birth. Holding the baby is not implicated in HIV transmission. It is important for a mother with HIV to hold, cuddle and have physical contact with her baby so that she feels close and loving.
- Babies, who are not stable immediately after birth can receive skin-to-skin contact later when they are stable *(slide 5/3.)*

Ask: What could be barriers to ensuring early skin-to-skin contact is the routine practice after birth and how could these barriers be overcome?

Wait for a few responses.

Overcoming barriers to early skin-to-skin contact

- Many of the barriers to skin-to-skin contact are related to common practices rather than to a medical concern. Some changes to practices can facilitate skin-to-skin contact.
  - **Concern that the baby will get cold.** Dry the baby and place baby naked on the mother's chest. Put a dry cloth or blanket over both the baby and the mother. If the room is cold, cover the baby's head also to reduce heat loss. Babies in skin-to-skin contact have better temperature regulation than those under a heater.
  - **Baby needs to be examined.** Most examinations can be done with the baby on the mother's chest where baby is likely to be lying quietly. Weighing can be done later.
  - **Mother needs to be stitched.** The infant can remain on the mother's chest if an episiotomy or caesarean section needs to be stitched.
  - **Baby needs to be bathed.** Delaying the first bath allows for the vernix to soak into the baby's skin, lubricating and protecting it. Delaying the bath also prevents temperature loss. Baby can be wiped dry after birth.
  - **Delivery room is busy.** If the delivery room is busy, the mother and baby can be transferred to the ward in skin-to-skin contact, and contact can continue on the ward.
  - **No staff available to stay with mother and baby.** A family member can stay with the mother and baby.
  - **Baby is not alert.** If a baby is sleepy due to maternal medications it is even more important that the baby has contact as he/she needs extra support to bond and feed.
  - **Mother is tired.** A mother is rarely so tired that she does not want to hold her baby. Contact with her baby can help the mother to relax. Review labour practices such as withholding fluid and foods, and practices that may increase the length of labour, which can tire the mother.
  - **Mother does not want to hold her baby.** If a mother is unwilling to hold her baby it may be an indication that she is depressed and at greater risk of abandonment, neglect or abuse of the baby. Encouraging contact is important as it may reduce the risk of harm to the baby[24].
- With twins the interval between the births varies. Generally, the first infant can have skin to skin contact until the mother starts to labour for the second birth. The first twin can be held in skin to skin contact by a family member for warmth and contact while the second twin is born. Then the two infants are held by the mother in skin to skin contact and assisted to breastfeed when ready.

24 If there is a risk of harm to the baby a support person needs to be present both to encourage the mother to hold her baby and for the baby's protection.

- It may be helpful to add an item to the mother's labour/birth chart to record the time that skin-to-skin contact started and the time that it finished. This is an indication that skin contact is as important as other practices of which a record is required.

- *Optional: Discuss Birth Practices Checklist (at end of this session).*

3. Helping to initiate breastfeeding 5 minutes

Miriam heard about skin-to-skin contact during her pregnancy and she is happy to have this contact. When Miriam had her previous baby in a different hospital, the baby was wrapped and taken to the nursery immediately, which she did not like. Miriam also heard that it was good to start breastfeeding soon after birth.

Ask: How can you help Miriam and her daughter to initiate breastfeeding?
Wait for a few responses.

How to assist to initiate breastfeeding

- When the baby is on the mother's chest with skin-to-skin contact the breast odour will encourage the baby to move towards the nipple.
- **Help a mother to recognise these pre-feeding behaviours or cues.** When a mother and baby are kept quietly in skin-to-skin contact, the baby typically works through a series of pre-feeding behaviours. This may be a few minutes or an hour or more. The behaviours of the baby include:
  - a short rest in an alert state to settle to the new surroundings;
  - bringing his or her hands to his or her mouth, and making sucking motions; sounds, and touching the nipple with the hand;
  - focusing on the dark area of the breast, which acts like a target;
  - moving towards the breast and rooting;
  - finding the nipple area and attaching with a wide open mouth.
- **There should be no pressure on the mother or baby** regarding how soon the first feed takes place, how long a first feed lasts, how well attached the baby is or how much colostrum the baby takes. The first time of suckling at the breast should be considered an introduction to the breast rather than a *feed.*
- More assistance with breastfeeding can be provided at the next feed to help the mother learn about positioning, attachment, feeding signs and other skills she will need.
- The role of the health worker at this time is to:
  - provide time and a calm atmosphere;
  - help the mother to find a comfortable position;
  - point out positive behaviours of the baby such as alertness and rooting;
  - build the mother's confidence;
  - avoid rushing the baby to the breast or pushing the breast into the baby's mouth.

4. Ways to support breastfeeding after a Caesarean section 15 minutes

Miriam and her baby are now happy with their early contact and breastfeeding. They are both resting on the postnatal ward. However, Fatima has now come to the maternity facility. Her baby is not due for a few weeks but there are some difficulties. The doctor decides that Fatima's baby needs to be born and that a caesarean section will be needed.

Ask: What effect could the caesarean section have on Fatima and her baby as regards breastfeeding?

Wait for a few responses.

- A Caesarean section is major abdominal surgery. The mother is likely to:
  - be frightened and stressed;
  - have an IV drip and urinary catheter inserted;
  - be confined to bed and restricted in movement;
  - have restricted fluid and food intake both before and after the birth, thus be deprived of energy to care for her baby;
  - receive anaesthetics and analgesia for pain, which can affect the responses of both the mother and baby;
  - have altered levels of oxytocin and prolactin, the hormones of lactation;
  - be at higher risk of infection, and bleeding;
  - be separated from her baby;
  - feel a sense of failure that her body was not able to work normally to give birth.
- The baby is also affected by a caesarean birth. The baby:
  - is a high risk of not breastfeeding or of breastfeeding for only short duration;
  - may have more breathing problems;
  - may need suction of mucus, which can hurt the baby's mouth and throat;
  - may be sedated from maternal medications;
  - is less likely to have early contact;
  - is more likely to receive supplements;
  - is more likely to have nursery care increasing the risk of cross-infection as well as restricting breastfeeding.

Fatima's baby is born. It is a boy. He is four weeks early and small but his breathing is stable. He is given to Fatima for skin-to-skin contact. This will help his breathing and temperature.

Ask: How can you help Fatima and her baby to initiate breastfeeding after a Caesarian section?

Wait for a few responses.

- The presence of a supportive health worker is important for helping a mother initiate breastfeeding after a Caesarean.
- Encourage the mother to have skin-to-skin contact as soon as possible.
  - In general, mothers who have spinal or epidural anaesthesia are alert and able to respond to their baby immediately, similar to mothers who give birth vaginally.
  - Following a general anaesthesia, contact can occur in the recovery room if the mother is responsive, though she may still be sleepy or under the influence of anaesthesia.

- The father or other family member can give skin-to-skin contact which helps keep the baby warm and comforted while waiting for the mother to return from the operating theatre.
- If contact is delayed, the baby should be wrapped in a way that facilitates unwrapping for skin-to-skin contact later when the mother is responsive.
- Babies who are premature or born with a disability also benefit from skin-to-skin contact. If a baby is not stable and needs immediate attention, skin-to-sin contact can be given when the baby is stable.

- **Assist with initiating breastfeeding** when the baby and mother show signs of readiness. The mother does not need to be able to sit up, to hold her baby or meet other mobility criteria in order to breastfeed. It is the baby that is finding the breast and suckling. As long as there is a support person with the mother and baby, the baby can go to the breast if the mother is still sleepy from the anaesthesia.
- **Help Caesarean mothers find a comfortable position for breastfeeding**. The I.V. drip may need adjustment to allow for positioning the baby at the breast.
  - Side-lying in bed. This position helps to avoid pain in the first hours and allows breastfeeding even if the mother must lie flat after spinal anaesthesia.
  - Sitting up with a pillow over the incision or with the baby held along the side of her body with the arm closest to the breast.
  - Lying flat with the baby lying on top of the mother.
  - Support (e.g. pillow) under her knees when sitting up, or under the top knee and behind her back when side lying.
- Provide rooming-in with assistance as needed until the mother can care for her baby.
- When staff are supportive and knowledgeable, the longer stay in hospital following a Caesarean section may assist in establishing breastfeeding.

5. BFHI practices and women who are not breastfeeding 10 minutes

- All mothers should have support during labour and birth. Harmful practices should be avoided. Early skin-to-skin contact benefits all mothers and babies.
- Unless there is a known medical reason for not breastfeeding, (for example that the woman has been tested and found to be HIV-positive and following counselling during pregnancy has decided not to breastfeed) all mothers should be encouraged to let their baby suckle at the breast. If a mother has a strong personal desire not to breastfeed, she can say so at this time.
- The breastfeeding baby receives colostrum in the first feeds in small amounts suitable for a newborn's stomach. If the baby is not breastfeeding, replacement feeds should start with small amounts[25]. Arrangements will need to be made to ensure there are replacement feeds available for any infants who are not breastfeeding.

- *Discuss how replacement feeds could be made and given in the first few hours after the woman has given birth.*

- *Ask if there are any questions. Then summarise the session.*

25 There is no research evidence to advise on when a full-term healthy baby who is not breastfed needs to get a first feed. Most healthy babies who are not breastfeeding do not need to be fed in the first hour or two after birth.

Session 5 Summary

- Step 4 of the Ten Steps to Successful Breastfeeding states: Help mothers to initiate breastfeeding within a half-hour of birth. This step is now interpreted as:
  Place babies in skin-to-skin contact with their mothers immediately following birth for at least an hour and encourage mothers to recognize when their babies are ready to breastfeed, offering help if needed.
- Practices that result in a woman feeling competent, in control, supported and ready to interact with her baby who is alert, help to put this Step into action. Encourage a family centred maternity care approach at birth with involvement of the father or close family member during labour and birth.
- Supportive practices include: support during labour, limiting invasive interventions, paying attention to the effects of pain relief, offering light food and fluids, avoiding unnecessary caesarean sections, and facilitating early mother and baby contact.
- Early contact and assistance with breastfeeding can be routine practice after a caesarean section also.
- Provide uninterrupted, unhurried skin-to-skin contact between every mother and her healthy baby. Start immediately or as soon as possible in the first few minutes after birth. The baby should be unwrapped, and the mother and baby both covered together. Provide this contact for at least one hour after birth.
- Encourage the mother to respond to the baby's signs of readiness to go to the breast.
- These supportive practices do not need to change for women who are HIV-positive.

Session 5 Knowledge Check

List four labour or birth practices that can help the mother and baby get a good start with breastfeeding.

List three ways to assist a mother following a caesarean section with breastfeeding.

Name three possible barriers to early skin-to-skin contact and how each might be overcome.

Additional information – Session 5

Initiation of breastfeeding

- Encourage the mother to breastfeed when the baby shows that she or he is ready (usually within an hour). It is unnecessary to hurry and force babies to the breast. A mother and her baby should be quietly kept in skin-to-skin contact until they are both ready to breastfeed. This may be a few minutes or an hour or more.
- Early touch of the nipple and areola results in a release of the hormone oxytocin. Oxytocin helps:
    - The uterus to contract more quickly which may control bleeding. Routine use of synthetic oxytocin and ergometrine are not necessary when a mother is breastfeeding after birth.
    - The mother to feel more loving and attached to her baby.
- Colostrum, the first milk in the breast, is vitally important to the baby[26]. It provides many immune factors that protect the baby, and it helps to clear meconium from the baby's gut, which can keep levels of jaundice low. Colostrum provides a protective lining to the baby’s gut, and helps the gut to develop. Thus it should be the only fluid the baby receives.
- Prelacteal feeds are any fluid or feed given before breastfeeding starts. They might include water, formula, traditional feeds such as honey, dates or banana, herbal drinks or other substances. Even a few spoonfuls of these fluids or feeds can increase the risk of infection and allergy to the infant. If prelacteal feeds are used in the area, during pregnancy discuss with the mother the importance of exclusive breastfeeding and how she might achieve this.
- Newborn infants do not need water or other artificial feeds to ‘test’ their ability to suck or swallow. In the rare situation where a baby has an abnormality of swallowing, colostrum (a natural physiological substance) is less risk to a baby’s lungs than a foreign substance such as water or artificial formula.
- A mother who breastfeeds in the delivery room is more likely to breastfeed for more months than when the first breastfeed is delayed.
- If a baby has not started to breastfeed in the delivery room, ensure that the postnatal ward staff know this. Ask them to ensure that skin-to-skin contact continues, and to watch for signs of readiness to feed.

Optional activity
Observe a mother and baby in skin-to-skin contact soon after birth. What behaviours of the baby do you see that are leading to the baby going to the breast?

26 See section on colostrum in the Additional Information section of Session 3.

Birth Practices Checklist

Mother's name: ____

Date and time of infant's birth: ___________________________________

Type of birth:
___ Vaginal : Natural ___ Vacuum ___ Forceps ___
___ C-section with epidural/spinal
___ C-section with general anaesthetic

Skin-to-skin contact:
Time started: ______ Time ended: _______ Duration of contact: ________

Reason for ending skin-to-skin contact: ________________________________

____

Time of baby's first breastfeed: ______________

Date and time help offered with second breastfeed: _______________

Notes:

____

Skin to skin contact immediately after birth:
- keeps the baby warm;
- calms mother and baby and regulates breathing and heart rate;
- colonises the baby with the mother's normal body bacteria;
- reduces infant crying, thus reducing stress and energy use;
- allows the baby to find the breast and self-attach to start feeding;
- facilitates bonding between the mother and her baby.

No additional foods or fluids are needed by the newborn baby – just breast milk

SESSION 6
HOW MILK GETS FROM BREAST TO BABY

Session Objectives:

On completion of this session, participants will be able to:

1.	Identify the parts of the breast and describe their functions.	5 minutes
2.	Discuss how breast milk is produced and how production is regulated.	15 minutes
3.	Describe the baby's role in milk transfer;	20 minutes
4.	Discuss breast care.	5 minutes
	Total session time	**45 minutes**

Materials:

Slide 6/1: Parts of the Breast.
Slide 6/2: Back massage.
Slide 6/3: What can you see – inside view.
Slide 6/4: What can you see – outside view.

Cloth breast model.

Doll (optional).

Further reading for facilitators:

Session 3, How breastfeeding works, in *Breastfeeding Counselling: a training course.* WHO/UNICEF.

Introduction

In order to assist Miriam and Fatima with breastfeeding you need to know how the breast produces milk and how the baby suckles.

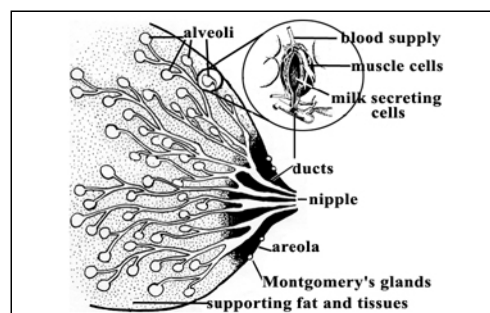
In normal breastfeeding, there are two elements necessary for getting milk from the breast to the baby:

- a breast that produces and releases milk, and
- a baby who is able to remove the milk from the breast with effective suckling.

The manner in which the baby is attached at the breast will determine how successfully these two elements come together. If the milk is not removed from the breast, more milk is not made.

1. Parts of the breast involved in lactation 5 minutes

- *Use slide 6/1 – to identify the parts of the breast*



- On the outside of the breast you can see the **Areola,** a darkened area around the nipple. The baby needs to get a large amount of the areola into his or her mouth to feed well. On the areola are the glands of Montgomery that provide an oily fluid to keep the skin healthy. The Montgomery glands are the source of the mother's smell, which helps the baby to find the breast and to recognise her.
- Inside the breast, are:
  - Fat and **supporting tissue** that give the breast its size and shape.
  - **Nerves**, which transmit messages from the breast to the brain to trigger the release of lactation hormones.
  - Little sacs of milk-producing cells or **Alveoli**[27] that produce milk.
  - Milk **ducts** that carry milk to the **nipple**. The baby needs to be attached to compress the milk ducts that are under areola in order to remove milk effectively.
- Surrounding each alveolus are little muscles that contract to squeeze the milk out into the ducts. There is also a network of blood vessels around the alveolus that brings the nutrients to the cells to make milk.
- It is important to reassure mothers, that there are many variations in the size and shape of women's breasts. The amount of milk produced does not depend on breast size[28]. Be sure to tell every mother that her breasts are good for breastfeeding, and avoid frightening words like "problem."

27 One gland is an alveolus and multiple glands are alveoli.
28 Small breasts may not be able to store as much milk between feeds as larger breasts. Babies of mothers with small breasts may need to feed more often, but the amount of milk produced in a day is as much as from larger breasts.

2. Breast milk production 15 minutes

- The first stages of milk production are under the control of hormones or chemical messengers in the blood.
  - During pregnancy, hormones help the breasts to develop and grow in size. The breasts also start to make colostrum.
  - After birth, the hormones of pregnancy decrease. Two hormones - prolactin and oxytocin become important to help *production* and *flow* of milk. Under the influence of prolactin, the breasts start to make larger quantities of milk. It usually takes 30-40 hours after birth before a large volume of milk is produced. Colostrum is already there when baby is born.

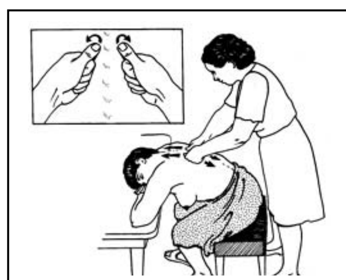
Prolactin

- Prolactin is a hormone that makes the alveoli produce milk. Prolactin works after a baby has taken a feed to make the milk for the next feed. Prolactin can also make the mother feel sleepy and relaxed.
- Prolactin is high in the first 2 hours after birth. It is also high at night. Hence, breastfeeding at night allows for more prolactin secretion.

Oxytocin

- Oxytocin causes the muscle cells around the alveoli to contract and makes milk flow down the ducts. This is essential to enable the baby to get the milk. This process is called the oxytocin reflex, milk ejection reflex, or letdown. It may happen several times during a feed. The reflex may feel different or be less noticeable as time goes by.
- Soon after a baby is born, the mother may experience certain signs of the oxytocin reflex. These include:
  - painful uterine contractions, sometimes with a rush of blood;
  - a sudden thirst;
  - milk spraying from her breast, or leaking from the breast which is not being suckled;
  - feeling a squeezing sensation in her breast.

  However, mothers do not always feel a physical sensation.
- When the milk ejects, the rhythm of the baby's suckling changes from rapid to slow deep, sucks (about one per second) and swallows.
- Seeing, hearing, touching and thinking lovingly about the baby, helps the oxytocin reflex. The mother can assist the oxytocin to work by:
  - Feeling pleased about her baby and confident that her milk is best.
  - Relaxing and getting comfortable for feeds.
  - Expressing a little milk and gently stimulating the nipple.
  - Keeping her baby near so she can see, smell, touch and respond to her baby.
  - If necessary, asking someone to massage her upper back, especially along the sides of the backbone.



- *Show slide 6/2*

- Oxytocin release can be inhibited <u>temporarily</u> by:
  - Extreme pain, such as a fissured nipple or stitches from a caesarean birth or episiotomy.
  - Stress from any cause, including doubts, embarrassment, or anxiet.,
  - Nicotine and alcohol.
- Remember that how you talk to a mother is important to help her milk flow – you learnt about this in the earlier session on communication skills. If you cause her to worry about her milk supply, this worry may affect the release of oxytocin.

Feedback Inhibitor of Lactation (FIL)

- You may have noticed that sometimes milk is produced in one breast but not the other – usually when a baby suckles only one side. This is because milk contains an **inhibitor** that can reduce milk production.
- If milk is not removed and the breast is full, this inhibitor decreases production of milk. If milk is removed from the breast, then the inhibitor level falls and milk production increases. Thus, the amount of milk that is produced depends on how much is removed. Therefore, to ensure plentiful milk production, make sure that milk is removed from the breast efficiently.
- To prevent the Feedback Inhibitor of Lactation from collecting and reducing milk production:
  - make sure that the baby is well attached;
  - encourage frequent breastfeeds;
  - allow baby to feed for as long as she or he wants at each breast;
  - let the baby finish the first breast before offering the second breast;
  - if baby does not suckle, express the milk so that milk production continues.

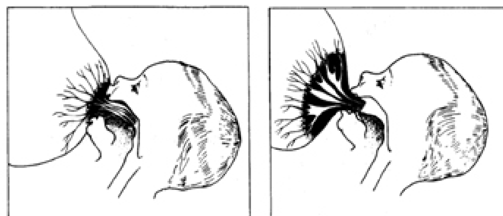
3. The baby's role in milk transfer 20 minutes

- The baby's suckling controls the prolactin production, the oxytocin reflex and the removal of the inhibitor within the breast. For a mother to produce the milk that her baby needs, her baby must suckle often and suckle in the right way. A baby cannot get the milk by sucking only on the nipple.

Good and poor attachment

- The next two pictures show what happens <u>inside</u> a baby's mouth, when she or he is breastfeeding.

Show slide 6/3

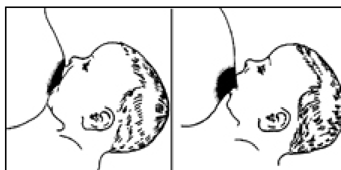


- In picture 1: Good attachment
  - The nipple and areola are stretched out to form a long “teat” in the baby’s mouth.
  - The large ducts that lie beneath the areola are inside the baby’s mouth.
  - The baby’s tongue reaches forward over the lower gum, so that it can press the milk out of the breast. This is called suckling.
  - When a baby takes the breast into his or her mouth in this way, the baby is well attached and can easily get the milk.
- In picture 2: Poor attachment
  - The nipple and areola are not stretched out to form a teat.
  - The milk ducts are not inside the baby’s mouth.
  - The baby’s tongue is back inside the mouth, and cannot press out the milk.
  - This baby is poorly attached. He or she is sucking only on the nipple, which can be painful for the mother. The baby cannot suckle effectively or get the milk easily.

How to decide if a baby is well or poorly attached

- You need to be able to decide about a baby’s attachment by looking at the outside. The next two pictures show what you can see on the outside.

Show figure 6/4



- In picture 1: Good attachment
  - The baby’s **mouth** is wide open.
  - The **lower lip** is turned out.
  - The **chin** is touching the breast (or nearly so).
  - More **areola** is visible above the baby’s mouth than below.
- Seeing a lot or a little of the areola is not a reliable sign of attachment. Some women have a large areola and some have a small areola. It is more reliable to compare how much areola you see above and below a baby’s mouth (if any is visible).
- These are the signs of <u>good attachment</u>. If you can see all these signs, then the baby is *well attached*. When the baby is well attached, it is comfortable and painless for the mother, and the baby can suckle effectively.
- In picture 2: Poor attachment
  - The **mouth** is not wide open.
  - The **lower lip** is pointing forward (it may also be turned in).
  - The **chin** is away from the breast.
  - More **areola** is below the baby’s mouth (you might see equal amounts of areola above and below the mouth).

  These are the signs of <u>poor attachment</u>. If you see *any one* of these signs, then the baby is *poorly attached* and cannot suckle effectively. If the mother feels discomfort, that is also a sign of poor attachment.

The action of suckling

- When the breast touches the baby's lips (or the baby smells the milk), he or she puts their head back slightly, opens their mouth wide, and puts their tongue down and forward, to seek the breast. This is the rooting reflex.
- When the baby is close enough to the breast, and takes a large enough mouthful, the baby can bring the nipple back until it touches the soft palate. This stimulates the sucking reflex.
- The muscles then move the tongue in a wave from the front to the back of the mouth, expressing the milk from the ducts beneath the areola into the baby's mouth. At the same time, the oxytocin reflex makes the milk flow along the ducts.
- The baby swallows when the back of the mouth fills with milk, (the swallowing reflex). The rooting, sucking and swallowing reflexes happen automatically in a healthy, term baby. Taking the breast far enough into his or her mouth is not completely automatic, and many babies need help.
- A baby who is sleepy from his or her mother's labour medications, a premature or ill baby may need more help to attach effectively.

Signs that a baby is suckling effectively

- If a baby is well attached, she or he is probably suckling well and getting breast milk during the feed. Signs that a baby is getting breast milk easily are:
  - The baby takes **slow, deep sucks,** sometimes pausing for a short time.
  - You can see or hear the baby **swallowing**.
  - The baby's **cheeks** are full and not drawn inward during a feed.
  - The baby finishes the feed and **releases the breast by himself or herself** and looks contented.

These signs tell you that a baby is "drinking in" the milk, and this is effective suckling.

Signs that a baby is NOT suckling effectively

- If a baby
  - makes only rapid sucks;
  - makes smacking or clicking sounds;
  - has cheeks drawn in;
  - fusses or appears unsettled at the breast, and comes on and off the breast;
  - feeds very frequently - more often than every hour or so EVERY day[29];
  - feeds for a very long time - for more than an hour at EVERY feed, unless low birth weight;
  - is not contented at the end of a feed.

These are signs that suckling is ineffective, and the baby is not getting the milk easily. Even one of these signs indicates that there may be a difficulty.

Artificial teats and suckling difficulties

- Artificial teats and pacifiers may cause difficulties for the breastfeeding baby.
  - After sucking on an artificial teat, a baby may have difficulty suckling at the breast because there is a different mouth action.
  - The baby may come to prefer the artificial teat and find it difficult to breastfeed.
  - Use of pacifiers may reduce the suckling time at the breast thus reducing the breast stimulation, milk production and milk removal.

29 Cluster feeding – when baby feeds very frequently for a few hours and then sleeps for a few hours, is normal.

Ask: Fatima asks you what she can do to have plenty of milk. What are the main ways to ensure a good milk supply?
Wait for a few replies.

- Teach mothers how they can keep milk production plentiful:
  - Help the baby to breastfed soon after birth.
  - Make sure the baby is well attached at the breast and do not give any artificial dummies or teats that would confuse his or her suckling and reduce stimulation of the breast.
  - Breastfeed exclusively.
  - Feed the baby as frequently as he or she wants, usually every 1-3 hours, for as long as he or she wants at a feed.
  - Feed the baby at night, when prolactin release in response to suckling is high.

4. Breast care 5 minutes

Ask: What do mothers need to know about caring for their breasts when breastfeeding?
Wait for a few responses.

- Teach mothers how to care for their breasts.
  - Clean the breasts with water only. Soaps, lotions, oils, and Vaseline all interfere with the natural lubrication of the skin.
  - Washing the breasts once a day as part of general body hygiene is sufficient. It is not necessary to wash the breasts directly before feeds. This removes protective oils and alters the scent that the baby can identify as his or her mother's breasts.
  - Brassieres are not necessary, but can be used if desired. Choose a brassiere that fits well and is not too tight.

Ask: Some mothers may not be breastfeeding. Is there anything they need to know about caring for their breast in the days after birth?
Wait for a few responses.

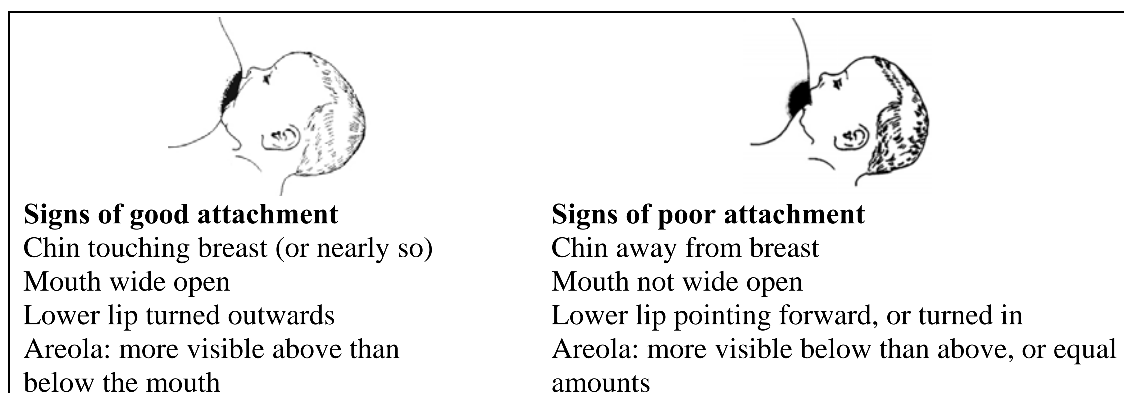
- A mother who is not breastfeeding also needs to care for her breasts. Her milk dries up naturally if her baby does not remove it by suckling[30], but this takes a week or more. She can express just enough milk to keep her breasts comfortable and healthy while her milk dries up. This milk can be given to the baby. If a mother is HIV-positive, she may decide to express and heat-treat her milk to give to her baby.

Ask if there are any questions. Then summarise the session.

30 The milk production stops because the Feedback Inhibitor of Lactation (FIL) stops the breast from producing milk if the breast is overfull. See Session 10 for information on relieving engorgement.

Session 6 Summary

- Size and shape of the breasts are not related to ability to breastfeed.
- Prolactin helps to produce milk and can make the mother feel relaxed.
- Oxytocin ejects the milk so that the baby can remove it through suckling. Relaxing and getting comfortable, and seeing, touching, hearing, thinking about baby can help to stimulate the oxytocin reflex. Pain, doubt, embarrassment, nicotine, or alcohol can temporarily inhibit oxytocin.
- If the breast gets overfull, feedback inhibitor of lactation will reduce milk production. Milk production only continues when milk is removed. The breasts make as much milk as is removed.
- Early feeding and frequent feeds help to initiate milk production.



Signs of good attachment	**Signs of poor attachment**
Chin touching breast (or nearly so)	Chin away from breast
Mouth wide open	Mouth not wide open
Lower lip turned outwards	Lower lip pointing forward, or turned in
Areola: more visible above than below the mouth	Areola: more visible below than above, or equal amounts

Signs of effective suckling

- Slow, deep sucks and swallowing sounds
- Cheeks full and not drawn in
- Baby feeds calmly
- Baby finishes feed by him/herself and seems satisfied
- Mother feels no pain.

Signs that a baby is not suckling effectively

- Rapid, shallow sucks and smacking or clicking sounds
- Cheeks drawn in
- Baby fusses at breast or comes on and off
- Baby feeds very frequently, for a very long time, but does not release breast and seems unsatisfied
- Mother feels pain.

Breast care is important

- Breasts do not need to be washed before feeds
- Mothers who are not breastfeeding need to care for their breasts until their milk dries up.

Session 6 Knowledge Check

Describe to a new mother how to tell if her baby is well attached and suckling effectively.

SESSION 7
HELPING WITH A BREASTFEED - STEP 5

Session Objectives:

At the end of this session, participants will be able to:

	Objective	Time
1.	List the key elements of positioning for successful and comfortable breastfeeding.	5 minutes
2.	Describe how to assess a breastfeed.	5 minutes
3.	Recognise signs of positioning and attachment.	20 minutes
4.	Demonstrate how to help a mother to learn to position and attach her baby for breastfeeding.	25 minutes
5.	Discuss when to assist with breastfeeding.	5 minutes
6.	Practice in a small group helping a 'mother'.	20 minutes
7.	List reasons why a baby may have difficulty attaching to the breast.	10 minutes
	Total session time	**90 minutes**

Materials:

Slide 7/1: Variety of positions for breastfeeding.
Slide 7/2: Breastfeeding Observation Aid.
Slide 7/3: Breastfeed Observation Aid Picture 1.
Slide 7/4: Wide mouth.
Slides 7/5: and 7/6: Breastfeed Observation Aid Pictures 2-3.

Breastfeed Observation Aid – a copy for each participant.

Helping a Mother to Position Her Baby – a copy for each participant.

Breastfeeding Positions - a copy for each participant (optional).

Cushions or pillows or rolled towel or cloth.

Low chair or ordinary chair and footstool or small box to support the 'mother's' feet.

Mat or bed for demonstrating lying down position.

One doll for each group of 4 participants or per pair.

Cloth breast model for each group of 4 participants or per pair.

Further reading for facilitators:

Session 10, Positioning the baby at the breast and Session 16, Breast refusal in *Breastfeeding Counselling: a training course.* WHO/UNICEF.

Preparation for the demonstration:

Ask two participants to help you with the demonstrations. Explain that you want the participants to play a mother who needs help to position her baby. One 'mother' will be sitting and one 'mother' will be lying down. Ask each 'mother' to decide on a name for herself and her 'baby'. She can use her real name if she likes. Always treat your 'doll' baby with gentleness as you are modelling the behaviour that you hope to promote.

Practice giving the demonstrations with the participants as it is given in the text, so that you know how to follow the steps. It may be easier if one facilitator explains the points as another facilitator assists the "mother" in the demonstration.

1. Positioning for breastfeeding 5 minutes

- Positioning means how the mother holds her baby to help the baby to attach well to the breast. If a baby is poorly attached, you can help the mother to position the baby so that she or he attaches better.
- If the baby is well attached and suckling effectively, do not interfere with the way she is breastfeeding. Tell the mother what key points you are observing, to build her confidence and her own ability to assess how breastfeeding is going.

Mother's position

- There are many positions that a mother may use – for example, sitting on the floor or the ground, or sitting on a chair, lying down, standing up, or walking. If the mother is sitting or lying down, she should be:
  - Comfortable with back supported.
  - Feet supported if sitting so that the legs are not hanging loose or uncomfortable.
  - Breast supported, if needed.

Baby's position (demonstrate with a doll)

- The baby also can be in different positions, such as along the mother's arm, under the mother's arm, or along her side. Whatever position is used, the same four key points are used to help the baby be comfortable. The baby's body needs to be:
  - **In line** with ear, shoulder and hip in a straight line**,** so that the neck is neither twisted nor bent forward or far back.
  - **Close** to the mother's body so the baby is brought to the breast rather than the breast taken to the baby.
  - **Supported** at the head, shoulders and if newborn, the whole body supported.
  -
  - **Facing** the breast with the baby's nose to the nipple as she or he comes to the breast.

- *Show slide 7/1 - pictures of variety of positions. Give handout (optional). Briefly point out how the mother is in a different position, however in each position the baby is in line, close, supported, and facing the breast.*

- You cannot help the mother well if you are in an uncomfortable position yourself. If your back is unsupported or your body is bent, you may try to hurry the process. Sit in a position where you are comfortable and relaxed in a convenient position to help.

2. How to assess a breastfeed 5 minutes

- Assessing a breastfeed can:
  - Help you to identify and praise what the mother and baby are doing well.
  - Give you information about current difficulties with breastfeeding.
  - Highlight practices that may result in problems later if not changed.
- Assessing a breastfeed involves watching what the mother and baby are doing and listening to what the mother tells you. It can help to put the mother at ease if you explain that you would like to watch the *baby* feeding, rather than saying you are watching what the *mother* is doing.

- If the baby is wrapped in heavy blankets, ask the mother to unwrap the baby so that you can see the baby's position.

- *Give out and explain the structure of the Breastfeed Observation Aid. Ask participants to look at it as you explain.*
- *Show slide 7/2*

- The Breastfeed Observation Aid can help health workers remember what to look for when observing and can help to recognise difficulties.
- The aid is divided into sections, each of which lists signs that breastfeeding is going well or signs of possible difficulty. A tick can be marked if the sign is observed. If all the ticks are on the left hand side then breastfeeding is probably going well. If there are ticks on the right hand side, there may be a difficulty that needs to be addressed.
- Look at the mother in general:
    - What do you notice about the mother – her age, general appearance, if she looks healthy or ill, happy or sad, comfortable or tense?
    - Do you see signs of bonding between mother and baby – eye contact, smiling, held securely with confidence, or no eye contact and a limp hold?
- Look at the baby in general:
    - What do you notice about the baby – general health, alert or sleepy, calm or crying, and any conditions that could affect feeding such as a blocked nose or cleft palate?
    - How does the baby respond – looking for the breast when hungry, close to mother or pulling away?
- As the mother prepares to feed her baby, what do you notice about her breasts?
    - How do her breasts and nipples look – healthy or red, swollen or sore?
    - Does she say that she has pain or act as if she is afraid to feed the baby?
    - How does she hold her breast for a feed? Are her fingers in the way of the baby taking a large mouthful of the breast?
- Look at the position of the baby for breastfeeding:
    - How is the baby positioned – head and body (spine) in line, body held close, body supported, facing the breast, and approaching nose to nipple? Or is the baby's body twisted, not close, unsupported, and chin to nipple?
- Observe the signs of attachment during the feed:
    - Can you see:
      more areola above the baby's top lip than below,
      mouth open wide,
      lower lip turned out, and
      chin touching breast?
- Observe the baby's suckling:
    - Can you see slow deep sucks? You may hear gentle swallowing or clicks and gulps, and see the baby's cheeks are rounded and not drawn inward during a feed.
    - Notice how the feed finishes - does baby releases the breast by himself or herself and look contented?
- Ask the mother how breastfeeding feels to her:
    - Can she feel any signs of oxytocin reflex, e.g. leaking or tingling?
    - Is there any discomfort or pain?

3. Recognise signs of positioning and attachment 20 minutes

- *Show the slides and ask the participants to go through the Breastfeed Observation Aid section by section looking for the signs. After they have described the signs that they can see, mention any that they missed.*
  You are not able to see all the signs in a picture; for example, you cannot see movement or see how the baby finishes a feed. When you see real mothers and babies, you can look for all the signs.

Slide7/3

Ask: Go through the sections of the Breastfeed Observation Aid. What can you see?
Give participants a few moments to look at the picture. Then go through each section and ask what they see. Suggest any points that they did not notice.

Signs that you can see are:
General:
Mother looks healthy overall.
She is sitting comfortably.
The mother is looking in a loving way at her baby
The baby looks healthy, calm, and relaxed.
Her breasts look healthy.
She is not supporting her breast. Her breast may be pushed out of line by her bra or a top that does not open wide.

Baby's position:
Baby's head and body are in a line.
Baby is not held close.
Baby is not well supported.
Baby is facing mother.

Baby's attachment:
This mother has a large areola. However, it looks like the baby does not have a large mouthful of breast.
The baby's mouth is open wide but not wide enough.
The baby's lower lip is turned out.
The baby's chin does not touch the breast.

We cannot see signs of suckling in a picture.

Ask: When talking to the mother remember to say something positive before suggesting changes. What positive signs could you point out to the mother?
- Her baby looks thriving and happy breastfeeding.
- She is looking lovingly at her baby.
- Baby's body is held in a line and facing mother.

Ask: What suggestions could you offer to the mother?
- You could suggest that the mother re-position and attach her baby again for more effective suckling.
- It may help if she takes off her top and bra so that the breast is less constrained.
- She can then easily support her breast with her one hand, use the other hand, and

arm to hold the baby close, so that the baby can take a large mouthful of breast.

- *Remind participants what a wide mouth looks like. Show slide 7/4.*

Slide 7/5

Ask: Go through the sections of the Breastfeed Observation Aid noting what you see.
Give participants a few moments to look at the picture. Then go through each section and ask what they see. Suggest any points that they did not notice.

Signs that you can see are:

General:
In this picture, you cannot see much of the mother or her position.
She is using two fingers to support her breast in a 'scissors hold'. It is difficult to keep fingers in this position for long and they may slip nearer the nipple, which could prevent the baby taking a big mouthful of the breast.
The baby looks healthy. However, the baby looks tense (note the hand in a tight fist).

Baby's position:
Baby's head and body are <u>not</u> in a line. The baby's head is far back.
Baby is <u>not</u> held close.
Baby is <u>not</u> well supported.
Baby is facing mother.

Baby's attachment:
You cannot see the areola well in this picture.
The baby's mouth is <u>not</u> open wide.
The baby's lower lip is <u>not</u> turned out.
The baby's chin does touch the breast.

We cannot see signs of suckling in a picture.

Ask: What positive signs could you point out to the mother?

- Her baby looks healthy.
- She is looking lovingly at her baby.
- Baby's body is held facing mother.

Ask: What suggestions could you offer to the mother?

- You could suggest that the mother re-position and attach her baby again for more effective suckling.
- If she held the baby closer and higher with his or her body supported (maybe with a rolled towel or pillow), the baby could reach the breast without straining and holding his or her head back.
- Holding her breast cupped in her hand might make it easier to help the baby to take a large mouthful of the breast.

Slide 7/6

Ask: Go through the sections of the Breastfeed Observation Aid noting what you see.
Give participants a few moments to look at the picture. Then go through each section and ask what they see. Suggest any points that they did not notice.

Signs that you can see are:

General:
In this picture, you cannot see much of the mother or her position.
She is using two fingers to support her breast, however they do not look like they are actually supporting her breast. It looks like the breast is hanging down to reach the baby rather than the baby is being brought up to the level of the breast.
This baby looks like there are some health concerns, so he or she may find it difficult to suckle for long at one time.

Baby's position:
Baby's head and body are in a line, the baby's neck is not twisted.
Baby is <u>not</u> held close.
Baby is supported, however he or she needs to be supported at the level of the breast and turned towards the mother.
Baby is <u>not</u> facing mother.

Baby's attachment:
You cannot see the areola well in this picture.
The baby's mouth is <u>not</u> open wide.
The baby's lower lip is turned out.
The baby's chin does <u>not</u> touch the breast.
We cannot see signs of suckling in a picture.

Ask: What positive signs could you point out to the mother?
- Her baby is being breastfed, which shows her care and love for her baby.

Ask: What suggestions could you offer to the mother?
- The mother may need to find a more comfortable position for herself so she is not bending over the baby. You could suggest that the mother re-position and attach her baby again for more effective suckling.
- If she held the baby closer, with the baby's whole body turned towards the breast, and higher with his or her body supported (maybe with a rolled towel or pillow), the baby could reach the breast easily and this might make it easier for the baby to take a large mouthful of the breast.

- These pictures showed a number of signs that could be improved. However, remember that many mothers and babies breastfeed with no difficulties. Notice the signs that breastfeeding is going well, not just the signs of possible difficulty.
- Later you will observe real mothers and babies.

4. Help a mother to learn to position and attach her baby 25 minutes

- *First explain these points:*

- The aim of helping the mother is so that she can position and attach her baby by herself. It does not help the mother's confidence if the health worker can position the baby but she is not able to herself.
- Remember these points when helping a mother:
  - Always observe a mother breastfeeding before you offer help. Offer a mother help only if there is a difficulty.
  - Help as much as possible in a "hands off" manner so that the mother attaches her own baby. If you need to show the mother, first try to show her by demonstrating with your hand on your own body. However, if necessary, you may need to use your hand to gently guide her arm and hand.
  - Talk about the key points the mother can see when breastfeeding – in line, close, supported, and facing, so that the mother is confident and effective on her own.
- All mothers are not the same. Some mothers and babies will need more time to learn to breastfeed and some mothers may only need a few words to build their confidence. The health worker needs to observe and listen to the mother so that practical help and psychological support are provided as appropriate.

Demonstrate how to help a mother who is sitting

- *Demonstrate helping a mother to position her baby. Explain to the 'mother' in a way that builds her confidence and helps her to understand, so the participants can see how good communication techniques are used. When you are explaining a point to the participants, move slightly away from the mother and face the participants to make it clear you are talking to them, not to the mother.*

Ask the participant or facilitator who is helping you to sit on the chair or bed that you have arranged. She should hold the doll across her body in the common way, but in a poor position as you practised previously: loosely, supporting only the baby's head, with his or her body away from hers, so that she has to lean forward to get her breast into the baby's mouth.
Tell her that you will ask her how breastfeeding is going, and she should say that it is painful when the baby suckles.

- *Make these points:*

- You will now see a demonstration of how to help a mother. First the mother will be in a sitting position.
- When you are helping a mother:
  - **Greet** the 'mother', introduce yourself, and ask her name and her baby's name.
  - **Ask her how she is** and ask one or two open questions about how breastfeeding is going.
  - **Ask her if you may see how her baby breastfeeds**, and ask her to put her baby to her breast in the usual way.
  - **Sit down yourself**, so that you also are comfortable and relaxed, and in a convenient position to help.
  - **Observe** her breastfeeding for a few minutes.

- *Go through these steps – greet, ask, observe – with the 'demonstration mother'.*
- *Then, explain to participants:*

- When you are observing the breastfeed, go through the Breastfeed Observation Aid. Observe:
  - the mother and baby in general;
  - the mother's breasts;
  - baby's position and attachment during the feed;
  - the baby's suckling.
- Ask the mother how breastfeeding feels to her.
- In this demonstration, we can see that the mother is bent over the baby, the baby is lying on his or her back away from the mother's body, and only the baby's head is supported. The mother says that it is painful when the baby suckles.
- After you have observed the breastfeed:
  - **Say something encouraging**. [for example: "Your baby really likes your milk, doesn't he/she?"].
  - **Explain what might help and ask if she would like you to show her.** If she agrees, you can start to help her. [for example: "Breastfeeding might be less painful if (baby's name) took a larger mouthful of breast when he/she suckles. Would you like me to show you how?"].

- *Go through these steps – say something encouraging, explain and offer help – with the 'demonstration mother'.*
- *Make these points that follow to the 'mother' and help her to do each suggestion before you offer the next suggestion or instruction. The 'mother' sits in a comfortable, relaxed position (as you decided when you practiced).*

- Mother's position is important. Sitting with back and feet supported is more comfortable. Bring the baby level with the breast, using a rolled up towel or clothes, cushion or pillow, if needed.
- There are **four key points** about the position of the baby:
  1. The baby's head and body should be in a line.
  2. Mother should hold baby's body close to hers.
  3. If the baby is newborn, support the whole body, and not just the head and shoulders.
  4. Baby's face should face the breast, with the baby's nose opposite the nipple.

- *Help the 'mother' to hold her baby straight, close, facing and supported.*
- *Then show her how to support her breast with her hand to offer it to her baby[31].*

- Many mothers support their breast by:
  - Resting the fingers on the chest wall under the breast, so that the first finger forms a support at the base of the breast.
  - Using the thumb to press the top of the breast slightly. This can improve the shape of the breast so that it is easier for the baby to attach well, however, this pressure should be light, and not always in the same spot.
  - Making sure that the fingers are not near the nipple so that they do not block the baby from getting a big mouthful of breast.

31 You may prefer to use a cloth model breast if the "mother" does not want to hold her breast in class.

- Then help the baby to come to the breast and attach by:
  - Touching the baby's lips with the nipple, so that the baby opens his or her mouth.
  - Waiting until the baby's mouth is opening wide, and then moving the baby onto the breast. Baby's mouth needs to be wide open to take a large mouthful of breast.
  - Aiming the baby's lower lip well below the nipple, so that his or her chin and lower lip will touch the breast first before the upper lip.
  - Bringing the baby to the breast. The mother should not move herself or her breast to her baby.

Explain to participants:

- Try not to touch the mother or baby if possible. But if you need to touch them to show the mother what to do:
  - Put your hand over her hand or arm, so that you hold the baby through her.
  - Hold the baby at the back of the baby's shoulders - *not the back of the baby's head.*
  - Be careful not to push the baby's head forward.
- A young infant needs their whole body supported, not just the head and neck. An older child may like to have his or her back supported even though he or she sits up to breastfeed. The mother's hand or arm should support the baby's head but she should not grip the head tightly. The baby needs to be able to bend his or her head back slightly as he or she latches on.
- The breast does not need to be held away from the baby's nose. The baby's nostrils are flared to help him or her breathe. If you are worried that the baby's nose is too close, pull the baby's hips closer to the mother's body. This tips the baby's head back slightly and the nose moves back from the breast.
- Notice how the mother responds to the changes that you are suggesting.

- *Ask the demonstration 'mother' how breastfeeding feels now. The participant playing the 'mother' should say, "Oh, that feels better!".*
- *Make these points to the participants:*

- If you improve a baby's poor attachment, a mother sometimes spontaneously says that it feels better.
- If suckling is comfortable for the mother, and she looks happy, her baby is probably well attached. If suckling is uncomfortable or painful, her baby is probably not well attached.
- Look for all the signs of good attachment (which of course you cannot see with a doll). If the attachment is not good, try again.
- It often takes several tries to get a baby well attached. You may need to work with the mother again at a later time, or the next day, until breastfeeding is going well.
- If she is having difficulty in one position, try to help her to find a different position that is easier or more comfortable for her.

- *Conclude the demonstration. Say to the demonstration mother something such as:*

  "That new position seems to be more comfortable for you and your baby. Will you try feeding that way for the next feed and let me know how it goes?"

- *Thank the demonstration mother for her assistance.*

Demonstrate how to help a mother who is lying down

Ask the participant who is helping you to demonstrate breastfeeding lying down, in the way that you practiced. She should lie down propped on one elbow, with the baby (doll) far from her body, loosely held on the bed.

- *Explain to the participants:*

- Now you will see how to help a mother who is breastfeeding lying down. Similar to the last demonstration:
  - greet the mother and introduce yourself;
  - ask her how breastfeeding is going;
  - ask if you can see her baby breastfeed;
  - observe a breastfeed.

Follow these steps when you demonstrate the 'mother':

Greet the mother, introduce yourself, ask her how breastfeeding is going. ['Mother' should say that it is painful]. Ask if you can see her baby breastfeeding.
Observe a breastfeed, say something encouraging, (for example, "Lying down to feed is a good way to get rest").

- *Explain to participants:*

- With this demonstration mother, we observe that the mother is lying with her head on her elbow. This position might be uncomfortable after a few minutes. The baby is lying away from the mother and is not supported well.
- After observing a feed,
  - say something encouraging;
  - explain what might help and offer to show her.

- *Speak to the demonstration 'mother':*

Explain what might help and offer to help (for example, "It might be more comfortable if you were in a slightly different position and your baby were nearer your body. Would you like me to show you how?").

- *Make these points to the 'mother' and help her to follow each suggestion before you offer the next suggestion or instruction.*

- To be relaxed, the mother needs to lie down on her side in a position in which she could sleep. Being propped on one elbow is not relaxing for most mothers.
- A rolled cloth or pillows, under her head and between her knees may help. Her back also needs support. This can be the wall next to the bed, a rolled cloth or her husband!

- *Show the mother how to hold her baby. Show her what to do if necessary.*

- Point out to the mother the same **four key points** about the baby's position: in line, close, facing, supported. She can support her baby's back with her lower arm.
- She can support her breast if necessary with her upper hand. If she does not support her breast, she can hold her baby with her upper arm.
- Show her how to help the baby to come to the breast and attach.
- A common reason for difficulty attaching when lying down, is that the baby is too 'high', (too near her shoulder) and the baby's head has to bend forwards to reach the breast.
- Notice how the mother responds to the changes that you are suggesting.

- *Ask the demonstration 'mother' how breastfeeding feels now. The participant playing the 'mother' should say, "Oh, that feels better!".*
- *Conclude the demonstration. Say to the demonstration mother such as:*

  "That new position seems to be more comfortable for you and your baby. Will you try feeding that way for the next feed and let me know how it goes?"
- *Thank the demonstration mother for her assistance.*

You can also demonstrate helping a mother in other positions such as holding baby in an underarm position, if you have time.

5. When to assist with breastfeeding 5 minutes

- The baby is finding the breast in the first hour after birth and may suckle at this time. This should be a relaxed time without emphasis on positioning the mother and baby or assessing a feed. Often the mother and baby will sleep for a few hours after this introduction time.
- When the baby wakes again a few hours later is a good time to help the mother to find a comfortable position and help her to position and attach her baby, if she needs help. Remember to observe first.
- Help the mother to position her baby rather than the health worker positioning the baby. The mother needs to be able to position the baby herself.
- If the baby is a full-term healthy baby there is no need to wake the baby in the first few hours. If the baby was exposed to sedation during labour, is preterm, or small for gestational age, or at risk of hypoglycaemia, the baby may need to be woken after 3-4 hours and encouraged to feed.

6. Practice in a small group helping a 'mother' 20 minutes

Divide the participants into small groups of four participants with one facilitator. Ask them to take turns working in pairs to help a mother position her baby.

Give each group or pair a doll and breast to work with. Give them a copy of the handout *Helping A Mother to Position Her Baby.*

The "health workers" should go through each step in the summary carefully so that they can remember them when they help a real mother in clinical practice later. The other participants in the small group observe and afterwards offer suggestions.

Make sure that each participant has a turn to play the part of the health worker helping the mother. Encourage the participants to use different positions.

7. Baby who has difficulty attaching to the breast 10 minutes

- A baby may seem reluctant to breastfeed for many reasons. The mother may feel that her baby is rejecting her and may be distressed. In the first few days, it may simply be that the mother and baby need time to learn how to breastfeed. Observe the mother and baby at a feed, including watching how the baby tries to attach.

Causes of reluctance to feed

Ask: Why might a baby be reluctant to breastfeed?
Wait for a few responses.

- **The baby may not be hungry at this time.** If a baby had a good feed recently, of course, he or she may simply not be hungry and ready for another feed – if this was a breastfeed, the mother will know. But you may need to check if someone else gave a bottle feed for some reason.
- **The baby may be cold, ill**, **or small and weak**. The baby may refuse to feed at all, or may attach without suckling, or may suckle very weakly or for only a short time.
- The mother may be **holding the baby in a poor position**, and the baby cannot attach properly. In this case, the baby may seem hungry and want to feed, but be unable to attach effectively.
- The mother may **move or shake the breast** or the baby, which makes it difficult for the baby to stay attached.
- The mother's **breast may be engorged** and hard, so it is difficult for the baby to attach to the breast.
- The milk may be **flowing too fast**, and the baby start to feed well but then come away from the breast crying or choking.
- The baby may have a **sore mouth or a blocked nose**, and suckle for a short time and then pull away, perhaps crying with frustration.
- The baby may **be in pain** when held in a certain way, for example after a forceps delivery, if there is pressure to a bruise on the baby's head, or if it hurts him to hold his head in a certain way.
- The baby may have **learned to suckle on an artificial teat**, and find it difficult to suckle on the breast.
- The mother may have used a different type of soap or have a new perfume on and the **baby does not like the smell**.
- If the **milk supply is very low**, the baby may not get any milk at first, and may stop feeding because he or she is frustrated.
- Sometimes a baby feeds well from one breast but **refuses the other breast.** The baby may find being held in one position painful, or the milk flow may be different, or one breast may be engorged.

Management of reluctance to feed

- Remove or treat the cause if possible:
  - Help the mother to position and attach the baby well.
  - Help the mother to express some milk before feeding if the milk is coming too fast or if the breast is too engorged.
  - Treat a sore mouth or thrush if you are able or refer the baby for medical help.
  - Provide pain relief if the baby is in pain.
  - Help the mother to hold the baby without causing pain, if the baby is bruised.
  - Avoid using artificial teats or pacifiers. If needed, give feeds by cup.
  - Stop using anything that is causing an unpleasant taste or smell to the breast.

- Encourage skin-to-skin contact between mother and baby in a calm environment when the baby is not hungry. This helps both the mother and baby to see the breast as a pleasant place to be. Then the baby can explore the breast and attach when he or she is ready. This may be an hour or more and may not happen on the first occasion there is skin-to-skin contact.
- Do not try to force the baby to the breast when the baby is crying. He or she needs to associate the breast with comfort. It may be necessary to express the milk and feed it by cup until the baby learns to breastfeed happily.

Prevention of reluctance to feed

- Many instances of breast refusal could be prevented by:
  - Early and frequent skin-to-skin contact that helps the baby to learn that the breast is a safe place from the first few hours.
  - Helping the mother to learn the skill of positioning and attachment in a calm unhurried environment.
  - Being patient while the baby learns to breastfeed.
  - Caring for the baby in a gentle confident manner.

- *Ask if there are any questions. Then summarise the session.*

Session 7 Summary

Positioning for breastfeeding

- Position for the mother:
  - Comfortable with back, feet, and breast supported, as needed.
- Position for the baby:
  - Baby's body in line.
  - Baby's body close to mother's body bring the baby to breast.
  - Baby supported – head, shoulders, and if newborn, whole body supported.
  - Facing the breast with baby's nose opposite the nipple.
- Position for the helper:
  - Comfortable and relaxed, not bending over.

Assessing a breastfeed

- Observe:
  - the mother and baby in general;
  - the mother's breasts;
  - the position of the baby;
  - attachment during the feed;
  - the baby's suckling.
- Ask the mother how breastfeeding feels to her.

Help a mother to learn to position and attach her baby

- Remember these points when helping a mother:
  - Always observe a mother breastfeeding before you help her.
  - Give a mother help only if there is a difficulty.
  - Let the mother do as much as possible herself.
  - Make sure that she understands so that she can do it herself.

Baby who has difficulty attaching to the breast

- Observe the baby going to the breast and if suckling. Ask open questions and determine a possible cause.
- Management:
  - Remove or treat the cause if possible.
  - Encourage skin-to-skin contact between mother and baby in a calm environment.
  - Do not force the baby to the breast.
  - Express and feed breast milk by cup if necessary.
- Prevention:
  - Ensure early skin-to-skin contact to help the baby learn that the breast is a safe place.
  - Help the mother to learn the skill of positioning and attachment in a calm unhurried environment.
  - Be patient while the baby learns to breastfeed.
  - Care for the baby in a gentle confident manner.

Session 7 Knowledge Check

What are the four key points to look for with regard to the baby's position?

You are watching Donella breastfeed her four-day old baby. What will you look for to indicate that the baby is suckling well?

Breastfeeding Positions

Lying down on side position
Helps a mother to rest. Comfortable after a caesarean section.
Take care that the baby's nose is on a level with mother's nipple, and that baby does not need to bend his or her neck to reach the breast.

Cradle position
The baby's lower arm is tucked around the mother's side. Not between the baby's chest and the mother.
Take care that the baby's head is not too far into the crook of the mother's arm that the breast is pulled to one side making it difficult to stay attached.

Cross arm position
Useful for small or ill baby. Mother has good control of baby's head and body, so may be useful when learning to breastfeed.
Take care that the baby's head is not held too tightly preventing movement.

Underarm position
Useful for twins or to help to drain all areas of the breast. Gives the mother a good view of the attachment.
Take care that baby is not bending his or her neck forcing the chin down to the chest.

Adapted from Breastfeeding Counselling: a training course,
WHO/CHD/93.4, UNICEF/NUT/93.2

BREASTFEED OBSERVATION AID

Mother's name ________________________________ Date ____________________

Baby's name __________________________________ Baby's age _______________

Signs that breastfeeding is going well:	Signs of possible difficulty:
GENERAL	
Mother:	*Mother:*
☐ Mother looks healthy	☐ Mother looks ill or depressed
☐ Mother relaxed and comfortable	☐ Mother looks tense and uncomfortable
☐ Signs of bonding between mother and baby	☐ No mother/baby eye contact
Baby:	*Baby:*
☐ Baby looks healthy	☐ Baby looks sleepy or ill
☐ Baby calm and relaxed	☐ Baby is restless or crying
☐ Baby reaches or roots for breast if hungry	☐ Baby does not reach or root
BREASTS	
☐ Breasts look healthy	☐ Breasts look red, swollen, or sore
☐ No pain or discomfort	☐ Breast or nipple painful
☐ Breast well supported with fingers away from nipple	☐ Breasts held with fingers on areola
☐ Nipple protractile	☐ Nipple flat, not protractile
BABY'S POSITION	
☐ Baby's head and body in line	☐ Baby's neck and head twisted to feed
☐ Baby held close to mother's body	☐ Baby not held close
☐ Baby's whole body supported	☐ Baby supported by head and neck only
☐ Baby approaches breast, nose to nipple	☐ Baby approaches breast, lower lip/chin to nipple
BABY'S ATTACHMENT	
☐ More areola seen above baby's top lip	☐ More areola seen below bottom lip
☐ Baby's mouth open wide	☐ Baby's mouth not open wide
☐ Lower lip turned outwards	☐ Lips pointing forward or turned in
☐ Baby's chin touches breast	☐ Baby's chin not touching breast
SUCKLING	
☐ Slow, deep sucks with pauses	☐ Rapid shallow sucks
☐ Cheeks round when suckling	☐ Cheeks pulled in when suckling
☐ Baby releases breast when finished	☐ Mother takes baby off the breast
☐ Mother notices signs of oxytocin reflex	☐ No signs of oxytocin reflex noticed

Notes:

HELPING A MOTHER TO POSITION HER BABY

- Greet the mother and ask how breastfeeding is going.
- Sit down yourself in a comfortable, convenient position.
- Observe a breastfeed.
- Notice something positive and say something to encourage the mother.
- If you notice a difficulty, explain what might help, and ask the mother if she would like you to show her.
- Make sure that she is in a comfortable and relaxed position.
- Explain how to hold her baby, and show her if necessary. The **four key points** are:
    - with baby's head and body straight;
    - with baby's body close to her body;
    - supporting baby's whole body (if newborn);
    - with baby's face facing her breast, and baby's nose opposite her nipple.
- Show her how to support her breast:
    - with her fingers flat against her chest wall below her breast;
    - with her first finger supporting the breast;
    - with her thumb above;
    - her fingers should not be too near the nipple.
- Explain or show her how to help the baby to attach:
    - touch her baby's lips with her nipple;
    - wait until her baby's mouth is opening wide;
    - move her baby quickly onto her breast, aiming baby's lower lip below the nipple.
- Notice how she responds and ask her how her baby's suckling feels.
- Look for signs of good attachment – more areola seen above baby's top lip, wide mouth, lip turned outwards, chin touching breast.

SESSION 8
PRACTICES THAT ASSIST BREASTFEEDING – STEPS 6, 7, 8 AND 9

Session Objectives:

On completion of this session, participants will be able to:

	Objective	Time
1.	Describe their role in practices that assist rooming-in.	10 minutes
2.	Describe their role in practices that assist baby led (demand) feeding.	15 minutes
3.	Suggest ways to wake a sleepy baby and to settle a crying baby.	10 minutes
4.	List the risks of unnecessary supplements.	5 minutes
5.	Describe why it is important to avoid the use of bottles and teats.	5 minutes
6.	Discuss removing barriers to early breastfeeding.	15 minutes
	Total session time	**60 minutes**

Materials:

Slide 8/1 -Picture 2: mothers talking to nurse. If possible, display the picture as a poster through the session.

Further Reading for facilitators:

Breastfeeding and the use of water and teas. Division of Child Health and Development Update, No. 9 (reissued, Nov. 1997). World Health Organization.

Linkages/AED *Exclusive Breastfeeding: The Only Water Source Young Infants Need. Frequently Asked Questions* (FAQ) SHEET 5. Reprinted June 2004.

Academy of Breastfeeding Medicine. *Clinical Protocol Number 3 −Hospital Guidelines for the Use of Supplementary Feedings in the Healthy Term Breastfed Neonate* (2002).

1. Rooming-in 10 minutes

- Step 7 of the Ten Steps to Successful Breastfeeding states:
  Practise rooming-in – allow mothers and infants to remain together 24 hours a day.
  Routine separation should be avoided. Separation should only occur for an individual clinical need.

- *Show slide 8/1 -Picture 2: Mothers talking to nurse*

It is now a half day after the birth of Miriam's baby. Miriam has rested and now she has some questions for the nurse. When Miriam's previous baby was born, the baby stayed in a nursery most of the time. Miriam asks why her new baby is expected to stay with her on the ward.

Ask: What can you say to explain the importance of rooming-in to Miriam?
Wait for a few responses

Importance of rooming-in

- Rooming-in has many benefits:
  - Babies sleep better and cry less.
  - Before birth the mothers and infant have developed a sleep/awake rhythm that would be disrupted if separated.
  - Breastfeeding is well established and continues longer and the baby gains weight quickly.
  - Feeding in response to a baby's cues is easier when the baby is near, thus helping to develop a good milk supply.
  - Mothers become confident in caring for their baby.
  - Mothers can see that their baby is well and they are not worried that a baby crying in a nursery is their baby.
  - Baby is exposed to fewer infections when next to his or her mother rather than in a nursery.
  - It promotes bonding between mother and baby even if mother is not breastfeeding.

Ask: What barriers are sometimes seen to rooming-in as the routine practice?
Wait for a few responses. Also ask what might be solutions to these barriers.

Barriers to rooming-in and possible solutions

- Barriers to rooming-in may be raised that include:
  - Concerns that mothers are tired.
    Ward routines need to facilitate the mother's rest with quiet times during which there is no cleaning, and there are no visitors or no medical rounds or procedures. In addition, review birth practices to determine if long labours, inappropriate use of anaesthesia and episiotomies, lack of nourishment and stressful conditions are resulting in mothers being extra tired and uncomfortable.
  - Taking the baby to the nursery for procedures.
    Baby care should generally take place at the mother's bedside or with the mother present. This can provide reassurance and teaching opportunities for the mother as well as providing comfort for the baby if distressed.

- Belief that newborn babies need to be observed.
  A baby can be observed next to the mother as easily as in a nursery. A mother is very good at observing her own baby and often notices change before a busy nurse notices them. Close observation is not possible in a nursery with many babies.
- There is no space on the ward for the baby cots.
  Babies can share their mothers' bed. Bed sharing or co-sleeping can help a mother and baby to get more rest and to breastfeed frequently. The bed may need a side rail, chair against the bed or the bed against the wall, to reduce the risk of the baby falling out of bed.
- Staff do not know how to assist mothers in learning to care for their babies.
  Soothing and caring for a baby is an important part of mothering. Helping a mother to learn to care for her baby at night is more useful to the mother than taking her baby away to a nursery. Taking the baby away may reduce the mother's confidence that she can cope with being a mother.
- Mothers ask for their babies to be taken to the nursery.
  Explain to the mother why the hospital encourages rooming-in as a time to get to know her baby and as beneficial to her baby and herself. Discuss the reason why the mother wants the baby taken to the nursery and see if the difficulty could be solved without taking the baby away. Address the benefits of rooming-in during antenatal contacts.

- If separation of a mother and her infant is required because of a medical situation, document the reason for this separation in the mother/baby record. The need for separation should be reviewed frequently so that it is for as short a time as possible.
- During separation, encourage the mother to see and hold her baby if possible, and to express her milk[32].

Ask: How is rooming-in presented to mothers? Is it routine to have all babies with their mothers unless there is a medical reason for separation, or does a mother have to ask for her baby to be beside her – implying that the normal place for the baby is in the nursery or in a cot?

Wait for a few replies and then continue.

2. Baby-led feeding 15 minutes

- Step 8 of the Ten Steps to Successful Breastfeeding states:
  Encourage breastfeeding on demand.
- Demand feeding is also called baby-led feeding. This means the frequency and length of feeds is determined by the baby's needs and signs.

Miriam thought babies needed to be fed to a set schedule, but in this hospital she is told to feed in response to her baby's own needs.

Ask: How can you explain why baby-led feeding is recommended?

Wait for a few responses.

32 Expression of milk is discussed later in Session 11.

Importance of baby-led feeding

- Baby-led feeding results in:
  - Baby gets more immune rich colostrum and therefore more protection from illness.
  - Faster development of milk supply.
  - Faster weight gain.
  - Less neonatal jaundice.
  - Less breast engorgement.
  - Mother learns to respond to her baby.
  - Easy establishment of breastfeeding.
  - Less crying so less temptation to supplement.
  - Longer breastfeeding duration.
- Infants who are allowed to control the frequency and duration of a feed learn to recognise their own signs of hunger and satiety. This ability to self-regulate may be related to the lower rates of obesity in children who were breastfed.

Miriam says she understands the idea of baby-led feeding, but how will she know when to feed her baby and how long to feed her baby for each time if she doesn't go by the clock?

Ask: What are the signs to watch for in a newborn baby to indicate when to feed the baby?
Wait for a few responses.

Signs of hunger

- The time to feed a baby is when the baby shows early hunger signs. The baby:
  - Increases eye movements under closed eye lids or opens eyes.
  - Opens his or her mouth, stretches out the tongue and turns the head to look for the breast.
  - Makes soft whimper sounds.
  - Sucks or chews on hands, fingers, blanket or sheet, or other object that comes in mouth contact.
- If the baby is crying loudly, arches his or her back, and has difficult attaching to the breast, these are late hunger signs. The baby then needs to be held and calmed before the baby is able to feed.
- Some babies are very calm and wait to be fed or go back to sleep if not noticed. This can result in underfeeding. Other babies wake quickly and become very annoyed if not fed immediately. Help the mother to recognise her baby's temperament and learn how to best meet her baby's needs.

Ask: What indicates that the baby has finished feeding?
Wait for a few responses.

Signs of satiety

- At the start of a feed, most babies have a tense body. As they get full, their body relaxes.
- Most babies let go of the breast when they have had enough, though some continue to take small gentle sucks until they are asleep.
- Explain to the mother that she should let her baby finish one breast before she offers the other breast in order to feed the rich hind milk and to increase milk supply.

Feeding patterns

- Some babies feed for a short time at frequent intervals. Other babies feed for a long time and then wait a few hours until the next feed. Babies may change their feeding pattern from day to day or during one day.
- Teach mothers the typical feeding pattern for a full term healthy newborn:
  - Newborns want to breastfeed about every one to three hours in the first two to seven days, but it may be more frequent.
  - Night feeds are important to ensure adequate stimulation for milk production and milk transfer, and for fertility suppression.
  - Once lactation is established (the milk supply 'comes in'), eight to twelve breastfeeds in 24 hours is common. There are usually some longer intervals between some feeds.
  - During periods of rapid growth, a baby may be hungrier than usual and feed more often for a few days to increase milk production.
  - Let babies feed whenever they want. This satisfies the baby's needs if hungry or thirsty and the mother's needs if her breasts are full.
- Very long feeds (more than 40 minutes for most feeds), very short feeds (less than 10 minutes for most feeds) or very frequent feeds (more than 12 feeds in 24 hours on most days) may indicate that the baby is not well attached at the breast.
- Sore nipples are the result of poor attachment, not the result of feeding too often or too long. If a baby is well attached, it does not matter if she or he feeds often or for a long time at some feeds[33].

Special situations

- The mother may need to lead the feeding for a day or two and wake the baby for feeds if a baby is very sleepy due to prematurity, jaundice, or the effects of labour medication, or if the mother's breasts are overfull and uncomfortable.
- Babies who are replacement fed also need to be fed in response to their needs. Sometimes there is a tendency to push the baby to finish a feed because the milk is prepared. This can lead to overfeeding. A mother can watch her baby for signs of fullness – turning away, reluctance to feed. A replacement feed should be used within one hour of the baby starting the feed and not kept for later as bacteria will grow in the milk. If baby does not finish the milk in one feed, this can be mixed into older sibling's meal.

3. Ways to wake a sleepy baby and to settle a crying baby10 minutes

Wake a sleepy baby

- If the baby seems too sleepy to feed, suggest that the mother:
  - Remove blankets and heavy clothing and let her baby's arms and legs move.
  - Breastfeed with her baby in a more upright position.
  - Gently massage her baby's body and talk to her baby.
  - Wait half an hour and try again.
  - Avoid hurting the baby by flicking or tapping on the cheek or feet.

33 Sore nipples are discussed in Session 12.

Settle a crying baby

- A mother and her family may think that a crying baby means that the mother does not have enough milk or that her milk is not good milk. A crying baby can be difficult for a mother and reduce her confidence in herself, and her family's confidence in her.
- A baby who is 'crying too much' may really be crying more than other babies, or the family may be less tolerant of crying or less skilled at comforting the baby. It is not possible to say how much crying is 'normal'.
- If a baby is crying frequently, look for a cause. Listen to the mother and learn what her situation may be, observe a breastfeed, examine the baby and refer for further medical attention if needed. Babies may cry from hunger, pain, loneliness, tiredness or other reasons.
- Build the mother's confidence in her ability to care for her baby and give her support:
  - Listen and accept what the mother is feeling.
  - Reinforce what the mother and baby are doing right/what is normal.
  - Give relevant information.
  - Make one or two suggestions.
  - Give practical help.
- Suggestions and practical help can include:
  - Make the baby comfortable – dry, clean nappy, warm, dry bedding, not too warm.
  - Put the baby to the breast. The baby may be hungry or thirsty or sometimes just wants to suck because this makes the baby feel secure.
  - Put baby on the mother's chest, skin to skin. The warmth, smell, and heartbeat will help to soothe the baby.
  - Talk, sing and rock the baby while holding close.
  - Gently stroke or massage the baby's arms, legs and back.
  - Give one breast at each feed; give the other breast at the next feed. If the breast not used at that feed becomes overfull, express a small amount of milk.
  - Reduce the mother's coffee and other caffeine drinks.
  - Do not smoke around the baby and smoke after a feed, not before or during, if a smoker.
  - Have someone else carry and care for the baby for a while.
  - Involve other family members in the discussion so the mother does not feel pressure to give unnecessary supplemental feedings.
  - Hold the baby in a manner that wraps around and supports head, body, legs and arms so the baby feels secure.

4. Avoid unnecessary supplements 5 minutes

- Step 6 of the Ten Steps to Successful Breastfeeding states:
  Give newborn infants no food or drink other than breast milk unless medically indicated.
- Healthy full term babies rarely have a medical need for supplements or prelacteal feeds[34]. They do not require water to prevent dehydration. The needs of babies who are premature or ill and medical indications for supplements are discussed in a later session.

34 Prelacteal feeds are any fluid or feed given before starting to breastfeed.

Miriam gave her previous baby regular supplements from birth. Now she is hearing that supplements are not good for babies and wants to know why.

Ask: What can you say to Miriam as to why supplements are not recommended?
Wait for a few responses.

Dangers of supplements

- Exclusive breastfeeding is recommended for the first six months. Supplements can:
  - Overfill a baby's stomach so the baby does not suckle at the breast.
  - Reduce milk supply because the baby is not suckling, resulting in over fullness of the breasts.
  - Cause the baby to gain insufficient weight if feeds of water, teas, or glucose water, are given instead of milk feeds.
  - Reduce the protective effect of breastfeeding thus increasing the risk of diarrhoea, and other illnesses.
  - Expose the baby to possible allergens and intolerances that could lead to eczema and asthma.
  - Reduce the mother's confidence if a supplement is used as a means of settling a crying baby.
  - Be an unnecessary and potentially damaging expense.
- In addition to the points listed above that could be explained to a mother, there are more reasons why supplement use is not recommended:
  - A mother who is looking for a supplement may be indicating that she is having difficulties feeding and caring for her baby. It is better to help the mother to overcome the difficulties than to give a supplement and ignore the difficulties.
  - A health worker who offers a supplement as the solution to difficulties may be indicating a lack of knowledge and skill in supporting breastfeeding. Frequent use of supplements may indicate an overall stressful atmosphere where a quick temporary solution is chosen in preference to solving the problem.
  - *Prelacteal feeding* or offering formula to an infant of an HIV-positive woman who will breastfeed may alter the GI mucosa and allow the transmission of the virus. When we cannot test the HIV status of mother, it is important to emphasise that exclusive breastfeeding reduces the risk of HIV transmission during breastfeeding.
- If a mother has been counselled, tested and found to be HIV-positive and has decided not to breastfeed, this is an acceptable medical reason for giving her infant formula (replacement food).
- Even if many mothers are giving replacement feeds, this does not prevent a hospital from being designated as baby-friendly if those mothers have all been counselled, tested, and made genuine informed choices.

5. Avoid bottles and teats 5 minutes

- Step 9 of the Ten Steps to Successful Breastfeeding states:
  Give no artificial teats or pacifiers (also called dummies or soothers) to breastfeeding infants.

Ask: Why is it recommended to avoid using bottles and teats?
Wait for a few replies and then continue.

- Sometimes babies develop a preference for an artificial teat or pacifier and refuse to suckle on the mother's breast.
- If a hungry baby is given a pacifier instead of a feed, the baby takes less milk and grows less well.
- Teats, bottles, and pacifiers can carry infection and are not needed, even for the non-breastfeeding infant. Ear infections and dental problems are more common with artificial teat or pacifier use and may be related to abnormal oral muscle function.
- In the rare situation that a supplement is needed, feeding with an open cup is recommended, as a cup is easier to clean and also ensures that the baby is held and looked at while feeding. It takes no longer than bottle-feeding[35].

6. Discussion – removing barriers to early breastfeeding 15 minutes

- *Read the Case Study aloud in class. Ask participants to note practices that may help and those which may interfere with establishing breastfeeding. What might be the effect of this situation on breastfeeding?*

Case study

Carolina[36] has a long labour for her first baby and no-one from her family was allowed to be with her. When her baby is born, he is wrapped in a blanket and shown to her briefly. She sees that he has a birthmark between her baby's eyes. Then he is taken away to the nursery because it is night-time. The staff gives him a bottle of infant formula for the next two feeds.

Carolina's baby is brought to her early the next morning - 10 hours after birth. The nurse tells her to breastfeed. She is told to limit breastfeeding on each side to three minutes. The nurse says, "You don't want the pain of sore nipples, dear, do you?".

Carolina starts to take her baby while lying down, but the nurse tells her she must always sit up to feed. Carolina sits up with difficulty; the mattress sags and her back must be bent. She is sore from the birth and it hurts to sit. The nurse leaves Carolina to feed her baby.

She holds her baby to her breast, and pushes the breast towards her baby's mouth with her hand. But the baby is sleepy and suckles very weakly. Carolina thinks that she has no milk yet because her breasts are soft.

Carolina wonders if the birthmark on the baby's face was caused by something that she did wrong during the pregnancy. She is worried what her husband and his mother will say about it. The nurses look very busy and Carolina does not want to ask questions of them. Her family will not be allowed to visit until the afternoon.

35 How to cup feeding is discussed in Session 11.
36 Or other culturally appropriate name.

The nurse returns and takes the baby back to the nursery. She comes back in a few minutes and tells Carolina that she has weighed the baby and finds that he took only 25 g of milk, and that this was not an adequate feed. The nurse says, “How can you go home tomorrow if you can’t feed your baby properly?”.

Possible answers:

No support during labour may result in a longer labour and Carolina may be more tired and stressed.

No skin-to-skin contact means Carolina does not get time to be with her baby and all that she notices is his birthmark, which worries her.

Carolina and her baby are separated for many hours. The baby is given bottles of formula. The baby is not getting the valuable colostrum and Carolina’s breasts are not receiving stimulation to make milk.

Carolina is not given any help to breastfeed. The baby is full from formula and sleepy, so does not want to suckle. The nurse worries her by talking about sore nipples.

It is sore for Carolina to sit to feed the baby. This would inhibit the oxytocin release. Carolina could be helped to feed lying down.

Carolina feels that she is alone in the hospital with no one to help her or talk to her, which caused her stress.

The nurse frightens Carolina by saying she is not able to feed her baby and will not be able to go home.

The result is that Carolina is worried, sore, frightened and lonely as well as not knowing how to feed her baby. She is likely to go home thinking that she is not able to make milk and to feed her baby a breast-milk substitute.

Ask if there are any questions. Then summarise the session.

Session 8 Summary

Rooming in and baby-led feeding help breastfeeding and bonding

- Mothers can notice and respond to their babies with ease when they understand their baby's feeding cues.
- Babies cry less so there is less temptation to give artificial feeds.
- Mothers are more confident about caring for their babies and breastfeeding.
- Breastfeeding is established early, a baby gains weight well, and breastfeeding is more likely to continue for longer.

Help mothers to learn skills of mothering

- Help to learn how to wake a sleepy baby.
- Help to learn how to settle a crying baby.
- Help to learn how to look for hunger cues.

Prelacteal and supplemental feeds are dangerous

- They increase the risk of infection, intolerance and allergy.
- They interfere with suckling and make breastfeeding more difficult to establish.

Artificial teats can cause problems

- Use of teats, pacifier, or nipple shield may effect milk production.

Session 8 Knowledge Check

Give three reasons why rooming-in is recommended as routine practice.

Explain as you would to a mother, what is meant by 'demand feeding' or baby-led feeding.

List three difficulties or risks that can result from supplement use.

Additional information for Session 8

Rooming-in

- Rooming-in has benefits for the baby, mother and hospital. In addition to those listed earlier:
    - Babies are responded to more quickly with less crying, thus using less of the baby's energy stores, and reducing temptation to give artificial feeds.
    - Frequent feeding means jaundice is less frequent and does not reach such high levels.
    - Higher maternal attachment, less parental abuse and less abandonment are linked with rooming-in.
    - Reduced infection rates as fewer staff are in contact with the baby. In addition the mother's bacteria colonise her infant with her own flora at the same time as giving immune protection through her milk.
    - Reduced infection rates, reduced use of artificial feeds, and reduced need for nursery space all save the hospital money.
    - Confident mothers and well established breastfeeding at hospital discharge results in less use of post-discharge health services.
- Mothers who are HIV-positive, and mothers who are not breastfeeding also benefit from rooming-in. Rooming-in assists them to get to know their baby and become confident in caring for their baby.

Co-sleeping/bed-sharing/bedding-in

- Bed sharing or co-sleeping can help a mother and baby to get more rest and to breastfeeding frequently.
- Co-sleeping is NOT recommended if either the mother or the father is
    - a smoker;
    - under the influence of alcohol or drugs that cause drowsiness;
    - unusually tired and might not respond to the baby;
    - ill or has a condition with could alter consciousness, e.g. epilepsy, unstable diabetes;
    - very obese;
    - very ill or if the baby or any other child in the bed is very ill.
- Guidelines for safe bed-sharing/co-sleeping:
    - Discuss benefits of, and contraindications to bed-sharing so that parents are informed.
    - Use a firm mattress, not one that is sagging. Sleeping on a sofa or cushions with a baby is not safe.
    - Keep pillows well clear of baby.
    - Cotton sheets and blankets are considered safer than a soft quilt.
    - Dress the baby appropriately – do not swaddle in wraps or blankets if bed-sharing, or over dress. The mother's body provides warmth for the baby.
    - The mother should lie close to her baby, facing baby with the baby lying on his or her back except when feeding.
    - Ensure that the baby cannot fall out of bed or slip between the side of the bed and the wall.
- In addition to the above guidelines on bed-sharing in hospital:
    - Ensure that the mother can easily call for assistance if she has difficulty moving in bed.
    - Check the wellbeing of the mother and baby frequently, ensuring that the baby's head is uncovered and that the baby is lying on his or her back if not feeding.
    - When handing over care to another staff member, make them aware of those mothers and babies who are bed-sharing.

Causes of crying

Babies cry for a variety of reasons.

- Causes of crying and suggestions what to do include:
  - Boredom or loneliness – carry or talk to the baby.
  - Hunger – mothers may be reluctant to feed their babies frequently if their expectations are of 3-4 hourly feeds. Many babies do not follow the same feeding pattern all of the time. Encourage mothers to offer a crying baby the breast.
  - Discomfort – respond to baby's needs, e.g. clean nappy/diaper, too hot/cold.
  - Illness or pain – treat or refer accordingly.
  - Tiredness – hold or rock baby in a quiet place to help baby go to sleep. Reduce visitors, handling and stimulation.
  - Something in the mother's diet – this is not very common and there are no foods that it is possible to recommend for mothers to avoid. Suggest that the mother stop eating the food to see if the crying improves. She can check further by eating the food again to see if it causes the problem again.
  - Effect of drugs – if the mother takes caffeine or cola drinks, the caffeine can get into the milk and make a baby restless. Cigarette smoke (even someone else smoking in the household) can also act as a stimulant to the baby. The mother can avoid caffeine and cola containing drinks; ask smokers not to do so in the house or near the baby.
- 'Colic' does not have a precise definition and the term may mean different things to different people. Exclude other causes of crying first. A baby with 'colic' grows well and tends to cry at certain times of day, often in the evening, but is content at other times. Check the baby's feeding. Poor attachment can result in air being swallowed causing 'wind'. A very fast milk flow or too much high lactose foremilk can cause discomfort. Attention to breastfeeding management may reduce these problems.

SESSION 9
MILK SUPPLY

Session Objectives:

On completion of this session, participants will be able to:

1.	Discuss concerns about "Not enough milk" with mothers.	10 minutes
2.	Describe normal growth patterns of infants.	5 minutes
3.	Describe how to improve milk intake/transfer and milk production.	10 minutes
4.	Discuss a case study of "not enough milk".	20 minutes
	Total session time	**45 minutes**

Materials:

Slide 9/1: Picture 2 Mothers in bed talking to nurse.
Slide 9/2: Case study.

For the case study, you will need:

To ask 3 participants to help with the role play and to prepare and practice.

Chairs that can be brought to the front of the room.

A doll or bundle of cloth to act as the 'baby'.

Further reading for facilitators:

Not enough milk Update No. 21, March 1996, WHO.

RELACTATION: A review of experience and recommendations for practice. WHO/CHS/CAH/98.14

1. Concerns about "Not enough milk" 10 minutes

- *Show slide 9/1: picture of 2 mothers in bed talking to nurse*

Miriam felt that she did not have enough milk for her previous baby and she gave regular supplements from the early weeks. During this pregnancy, she has heard that exclusive breastfeeding is important for her baby. Miriam believes that it is important, but she is not sure that she can give only breast milk with nothing else.

- The most common reason for mothers to stop breastfeeding, or to add other foods as well as breast milk, is they believe that they do not have enough milk.

Ask: What signs might make a mother think she does not have enough milk, even if the infant is growing well?

Wait for a few responses.

- A mother, her health worker or her family may think she does not have enough milk if there are signs such as:
  - baby cries often;
  - baby does not sleep for long periods;
  - baby is not settled at the breast and is hard to feed;
  - baby sucks his or her fingers or fists;
  - baby is particularly large or small;
  - baby wants to be at the breast frequently or for a long time;
  - mother (or other person) thinks her milk looks 'thin';
  - little or no milk comes out when the mother tries to express;
  - breasts do not become overfull or are softer than before;
  - mother does not notice milk leaking or other signs of oxytocin reflex;
  - baby takes a supplementary feed if given.
- These signs *may* mean a baby is not getting enough milk but they are not reliable indications.

Ask: What are reliable signs that the mother can see for herself that show that her young baby is receiving sufficient breast milk?

Wait for a few responses.

- Reliable signs of sufficient milk intake are:
  - *Output – milk must be going in, if urine and stools are coming out.*
  - *After day 2, six or more wet diapers in 24 hours with pale, diluted urine. If drinks of water are given in addition to breast milk, urine output may be good but weight gain low.*
  - *Three to eight bowel movements in 24 hours. As babies grow older than 1 month, stooling may be less frequent.*
  - *Alert, good muscle tone, healthy skin and is growing too big for his or her clothes.*
- A consistent weight gain is a sign of sufficient milk intake; however the mother may not be able to have her baby weighed often. If there is doubt about the infant's milk intake, weigh the baby each week, if possible
- Knowing these signs will build the mother's confidence – point out the things that she is doing well and suggest ways that she can get support in mothering.

Causes of low milk production

- The common reasons for low milk production are related to factors that limit the amount of milk the baby removes from the breast. If the milk is not removed, less milk is made. These factors include:
  - infrequent feeds;
  - scheduled feeds
  - short feeds;
  - poor suckling;
  - poor attachment.
- Low milk production may be also related to psychological factors:
  - The mother may lack confidence; feel tired, overwhelmed, worried, or find it difficult to respond to her baby.
  - Physiological factors may lead to too little or ineffective breastfeeding practices. A mother who is in a stressful situation may feed less frequently or for a short time, be more likely to give supplementary feeds or a pacifier, and may spend less time caring for the baby.

***C*auses of low milk transfer**

- The mother may have a good supply of milk but the baby may not be able to remove the milk from the breast. Low milk transfer may result if:
  - The baby is poorly attached to the breast and not suckling effectively. The baby may seem restless during a breastfeed and may pull away or tug at the breast.
  - Breastfeeds are short and hurried or infrequent.
  - The baby is removed from one breast too soon, and does not receive enough hindmilk.
  - The baby is ill or premature and not able to suck strongly and for long enough to obtain the milk the baby needs.
- Milk transfer and milk production are linked. If the milk is not being removed from the breast, the milk production will decrease. If you help the baby to remove milk more efficiently then sufficient milk production will usually follow.

2. Normal growth patterns of babies 5 minutes

Miriam has listened to what you said about signs of sufficient milk. However she is concerned about what the baby should weigh. With her previous baby even though she thought the baby looked well and seemed to be getting bigger, she was told that the baby was not gaining enough weight when the baby was weighed.

Ask: What is a normal growth pattern for a baby?
Wait for a few responses.

- Most babies start to gain weight soon if they are exclusively breastfed from soon after birth, are well attached and feed frequently.
- Some babies lose weight in the first few days after birth. This weight loss is extra fluid that the baby has stored during uterine life. A baby should regain birth weight by two weeks.
- Babies usually double their birth weight by five to six months; and triple it by one year. Babies also grow in length and head circumference.

- A properly and regularly completed growth chart can show the baby's pattern of growth. There is a range of normal growth. There is not one 'correct' line that all babies should follow.
- Do not wait until the weight gain is poor to do a careful breastfeeding assessment. Start and continue with good breastfeeding practices.
- Practising the Ten Steps to Successful Breastfeeding helps to assure an abundant milk supply:
  - Discuss the importance of breastfeeding and basics of breastfeeding management during pregnancy (Step 3).
  - Facilitate skin to skin contact after birth (Step 4).
  - Offer the breast to the baby soon after birth (Step 4).
  - Help the baby to attach to the breast so the baby can suckle well (Step 5).
  - Exclusively breastfeed: Avoid feeds of water, other fluids or foods; give only breast milk (Step 6).
  - Keep baby near so feeding signs are noticed (Step 7).
  - Feed frequently, as often and for as long as the baby wants (Step 8).
  - Avoid use of artificial teats and pacifiers. (Step 9).
  - Provide on-going support to the mother and ensure that mother knows how to find this support (Step 10)[37].

3. Improving milk intake and milk production 10 minutes

- Use your communication skills:
  - Listen to the mother and ask relevant questions.
  - Look at the baby - alertness, appearance, behaviour, and weight chart if available.
  - Observe a breastfeed, using the Breastfeed Observation Aid.
  - Respond to the mother and tell her what you are finding. Use positive words and avoid criticism or judgments.
  - Give relevant information using suitable language.
  - Offer suggestions that may improve the situation and discuss whether the suggestions seem possible to the mother.
  - Build the mother's confidence.
  - Help her to find support for breastfeeding and mothering.

Improving milk intake/transfer

- Address the cause of the low milk intake and try to remedy it. This may require you to:
  - Help the baby to attach well to the breast.
  - Discuss how the mother would be able to feed the baby more frequently.
  - Point out feeding cues so the mother learns when the baby has finished one breast before moving to the other breast rather than relying on a clock.
  - Encourage skin contact and holding the baby close.
  - Suggest that pacifiers and artificial teats (including nipple shields) be avoided.
  - Suggest offering the breast for comfort if her baby is unsettled.
  - Suggest avoiding or reducing supplement use.
- If the milk supply is very low, another source of milk is needed for a few days while the supply improves. How to give these supplements without using a bottle and teat will be discussed in a later session[38].

[37] On-going support is discussed in Session 14.
[38] See Session 11: If a baby cannot feed at the breast.

Increasing milk production

- To increase milk production, the breasts need stimulation and the milk needs to be removed frequently. The suggestions listed earlier for improving milk transfer will help to increase production because the milk is being removed from the breast. In addition suggest that the mother:
  - Gently massage her breast while feeding to help the milk to flow.
  - Express breast milk between breastfeeds and feed the expressed milk to her baby with a cup or a nursing supplementer[39]. This is particularly important if the baby has a weak suck or is reluctant to feed often.
  - Talk with her family to see how she can manage the needs of caring for her baby with other demands on her time.
  - Use foods, drinks, or local herbs believed to increase milk production, if these are safe to take while breastfeeding. These may help if they build the mother's confidence in her ability to breastfeeding or if they help the mother to be cared for by eating special foods. Using special foods or medications does not replace the need for frequent feeding with good attachment.

Monitoring and follow-up

- Follow-up the mother and baby to check that the milk production/milk transfer is improving. The frequency of follow-up depends on the severity of the situation.
- Monitoring means more than just weighing the baby. Look for signs of improvement that you can point out to the mother – increased alertness, less crying, stronger suck, more urine and stooling, and changes in her breasts such as fullness and leaking.
- Monitoring also gives you an opportunity to talk with the mother and see how the changes are working. Build her confidence and encourage things that she is doing well.
- If the baby's weight was very low and supplements were needed, reduce supplements as the situation improves. Continue to monitor the baby for a few weeks after supplements have stopped to ensure milk supply is sufficient.

4. Discuss a case study 20 minutes

Ask three participants to role-play the Case Study below in front of the class. This role-play should reflect what the midwife will do now and how she will follow up. Follow up the role-play with a discussion among all the participants.

Characters:
The patient, Anna.
Her mother-in-law (husband's mother).
The midwife at the outpatient department.

- *Show slide 9/2 with the key points of the Case Study*

[39] Cup feeding is described in Session 11.

Case study

Anna gave birth to a healthy boy in the hospital two weeks ago. Today she, the baby, and her mother-in-law are returning to the hospital because the baby is "sleeping all the time" and has passed only three stools this week. When the outpatient clinic midwife weighs the baby, she finds him 12% under birth weight.

The midwife asks about the events of the last week, using good communication skills and learns that:

- Anna and the baby were discharged on the second postpartum day.
- Anna received very little instruction on breastfeeding while she was in the postpartum ward.
- Anna feels that her baby is refusing her breasts.
- Yesterday, the mother-in-law began offering tea with honey in a bottle twice a day.

Questions that the midwife might ask include:

Can you tell me a little about the first day or two after the birth?
How did the baby feed in the first few days?
How do you feel the baby is feeding now?
Does the baby get anything other than breast milk?

The midwife also observes a breastfeed and sees that the baby is held loosely and that he must bend his neck to reach the breast. The baby has very little of the breast in his mouth and falls off the breast easily. When he falls off the breast, he gets upset, moves his head around, crying and has difficulty getting attached again.

Discussion questions: *(with possible answers)*
What are the good elements in this situation that you can build upon?

- They have looked for help, the mother-in-law is caring, and the bottle has been given only for one day.

What are three main things this family needs to know now?

- How to position and attach the baby for effective feeding.
- To feed frequently (2 hourly or more often), waking the baby if necessary.
- To avoid giving water (or honey and tea) using a bottle and teat. If needed, how to express breast milk and give to the baby by cup.

Also useful to know:

- To use plenty of skin to skin contact to help the baby learn that the breast is a comfortable place to be and to help stimulate prolactin release.
- To allow the baby to finish one breast before going to the other breast.
- The removal of milk makes more milk.
- The signs of having enough milk.

What follow-up will you offer?

- See the mother and baby in 1-2 days if possible to check if feeding and weight gain has improved.
- Continue assistance and follow-up until baby is feeding and gaining well.

- *Ask if there are any questions. Then summarise the session.*

Session 9 Summary

Concerns about “Not enough milk”

- A mother or her family may lack confidence in breastfeeding and think that she does not have enough milk. Explain to mothers the reliable signs of enough milk: passing urine and stools, and seeing the baby as alert and growing. Weight gain is a reliable sign if there is an accurate scale available and consecutive weight checks are on the same scales.
- Build the mother’s confidence in her ability to breastfeed.
- Most common reason for low milk production is not enough milk is removed from the breast so less milk is made.
- Common causes of low milk transfer are:
  - Poor attachment, poor suckling; short or infrequent feeds; baby ill or weak.

Normal growth patterns of infants

- Infants may lose 7 - 10% of their birth weight in the first days after birth but should regain birth weight by 2 to 3 weeks.
- If they start breastfeeding exclusively soon after birth, they may lose very little weight or none at all.
- Babies generally double their birth weight by 6 months and treble it by 1 year old.
- The practices of the Ten Steps to Successful Breastfeeding help to ensure an abundant milk supply.

Improving milk intake and milk production

- Use your communication skills to listen, observe, respond, and build confidence.
- Address the cause of low milk transfer, offer possible solutions:
  - Improve attachment; increase frequency and duration of feed; avoid supplements and pacifiers.
- Increase milk production:
  - Breastfeed more often and for longer, express between feeds; talk with family about support.
- Monitor and follow-up until weight gain is adequate and mother is confident.

Session 9 Knowledge Check

Keiko tells you that she thinks she does not have enough milk. What is the first thing you will say to her? What will you ask her in order to learn if she truly does have a low milk supply?

You decide that Ratna's baby Meena is not taking sufficient breast milk for his needs. What things can you do to help Ratna increase the amount of breast milk that her baby receives?

Additional information for Session 9

Causes of low milk production

Common reasons

- The common reasons for low milk production are related to factors that limit the amount of milk the baby removes from the breast. If the milk is not removed, less milk is made. These factors commonly include:
  - Infrequent feeds, which may be due to:
  - Mothers not noticing signs of readiness to feed.
  - Baby being sleepy or 'quiet' and not looking to be fed.
  - Mother being busy and postponing feeds.
  - Baby sleeping away from the mother, so the mother does not see or hear feeding signs.
  - Other foods and drink being given to the baby, so the baby does not ask to be fed.
  - Baby being given a pacifier or distracted instead of being fed.
  - Belief that the baby does not need night feeds.
  - Mother has sore nipples or sore breast and does not want to feed.
  - Scheduled feeds – A schedule may not allow for frequent feeds. In addition, if the baby is left to cry until the scheduled time, he or she uses up energy and may be asleep at the scheduled feeding time.
  - Short feeds – Babies who are well attached usually end the feed when they are finished. If the mother ends the feed at a set time or because she thinks a pause in suckling indicates that the feed is finished, the baby may not get enough milk.
  - Not enough milk is removed. The inhibitor factor in milk collects and makes the breast stop producing milk.
  - Poor suckling – a baby who is weak or poorly attached to the breast is not able to remove the milk from the breast. The milk is not removed, so less milk is made.
  - A delayed start to breastfeeding – breastfeeding should start as soon as possible after birth.

Uncommon reasons for low milk production

- Medication of the mother – contraceptives that contain oestrogen can reduce milk supply. Diuretic therapy may also reduce milk supply.
- Alcohol and smoking may reduce milk supply.
- Breast surgery, which cuts milk ducts or nerves to the breast.
- If a mother becomes pregnant again, she may notice a reduction in milk supply.

Very rare reasons for low milk production

- Retained pieces of the placenta affect the hormones needed for milk production.
- Inadequate breast development during pregnancy, so that few or no milk producing cells develop.
- Severe malnutrition – milk is made from what the woman eats plus what is stored in her body. If a woman has used up her body stores, then it may affect her milk supply. However, she needs to be severely malnourished, and for a long time, to reach this state. A very restricted fluid intake may affect milk supply.

Weight gain

- Breastfeeding ensures healthy, normal weight gain for infants. Many breastfed babies are leaner (less fat) than artificially fed babies.
- Test weighing before and after one feed does not give a good indication of milk intake or production. The amount that a baby takes varies from feed to feed. Test weighing may worry the mother and can reduce her confidence in breastfeeding, tempting her to give supplements.
- A baby who is not gaining weight with good breastfeeding and good milk transfer may have an illness. If the baby is feeding poorly or showing signs of illness, refer for medical treatment. However, if the baby seems willing to feed and has no signs of illness, then poor weight gain can be the result of not getting enough milk, which is often due to poor feeding technique. This baby and mother need help with feeding.
- A baby with a condition such as congenital heart disease or a neurological difficulty may be slow to gain weight even if there is sufficient milk supply and transfer.
- There is a need for weight monitoring for all children including those who are not breastfeeding.

Relactation

Relactation definition: Re-establishing milk production in a mother who has a greatly reduced milk production or has stopped breastfeeding.

- If a mother has stopped producing breast milk and wishes to breastfeed, the health worker can help her to relactate. Relactation may be needed because:
  - The baby has been ill and not able to suck.
  - The mother did not express her milk when her baby was unable to suck.
  - The baby was not breastfed initially and now the mother wants to breastfeed.
  - The baby becomes ill on artificial feeds.
  - The mother was ill and stopped breastfeeding.
  - A woman has adopted a baby, having previously breastfed her own children.
- A woman who wishes to relactate should be encouraged to:
  - Let her baby suckle at the breast as often as possible, day and night for as long as the baby is willing.
  - Massage and express her breasts in-between feeds, especially if the baby is not willing to suckle frequently.
  - Continue to give adequate artificial feeds until the milk supply is sufficient to her infant's growth.
  - Seek support from her family, to ensure that she has enough time to spend relactating.
- Drug therapy is sometimes used to increase or develop a milk supply. It is only effective if there is also increased stimulation of the breasts.
- It is easier to relactate if:
  - The baby is very young (less than 2 months of age) and has not become accustomed to using an artificial tea.,
  - The mother gave birth recently or stopped breastfeeding recently.
- However relactation is possible at any age of baby or time since breastfeeding stopped. Grandmothers may even relactate to feed their grandchild.

SESSION 10
INFANTS WITH SPECIAL NEEDS

Session Objectives:

On completion of this session, participants will be able to:

1. Discuss breastfeeding of infants who are preterm, low birth weight or have special needs.;	20 minutes
2. Describe how to assist mothers to breastfeed more than one baby.	5 minutes
3. Outline prevention and management of common clinical concerns: neonatal hypoglycaemia, jaundice and dehydration, with regard to breastfeeding.	10 minutes
4. Outline medical indications for use of foods/fluids other than breast milk.	10 minutes
Total session time	**45 minutes**

Materials:

Slides 10/1 and 10/2: Pictures of kangaroo mother care.
Slide 10/3: Positioning a preterm baby.
Slide 10/4: Twins.
Slides 10/5 and 10/6: DANCER hand position. Baby in slide 10/6 has Down's Syndrome.

Two or three dolls (different size dolls to demonstrate feeding twins and feeding a preterm baby).

Does the baby need breast-milk substitutes? – One copy for each participant

Further reading for facilitators:

World Health Organization. *Breastfeeding and the use of water and teas.* Division of Child Health and Development Update No. 9 (reissued, Nov. 1997).

World Health Organization. *Persistent Diarrhoea and Breastfeeding.* Division of Child Health and Development Update; Geneva, 1997.

World Health Organization. *Hypoglycaemia of the Newborn – a review of the literature*. Division of Child Health and Development and Maternal and Newborn Health/Safe Motherhood, 1997.

World Health Organization. *Kangaroo Mother Care - a practical guide*. Department of Reproductive Health and Research, Geneva, 2003.

Integrated Management of Childhood Illness: A WHO/UNICEF Initiative, In Bulletin of the World Health Organization, supplement no 1, vol. 75, 1997.

WHO/UNICEF/USAID. *HIV and Infant Feeding Counselling Tools*. World Health Organization, Geneva: 2005; 2008.

WHO/UNICEF *Acceptable medical reasons for use of breast-milk substitutes* World Health Organization, Geneva 2009.

1. Breastfeeding infants who are preterm, low birth weight or ill 20 minutes

- *Continue with the 'story':*

We last saw Fatima and her son having skin-to-skin contact following an emergency caesarean section. Fatima's son was born four weeks early; however he was stable and started breastfeeding in the recovery room. Fatima was surprised that he was able to breastfeed and glad that he got some of her first milk that would help protect him. The nurse told her that breastfeeding is very important for a preterm baby.

Ask: Why is breastfeeding particularly important for a baby who is preterm, low birth weight, has special needs or any baby that is ill?

Wait for a few replies.

The importance of breast milk for preterm, low birth weight or special needs infants

- Breast milk contains:
  - Protective immune factors, which help to prevent infection.
  - Growth factors which help the baby's gut and other systems to develop as well as to heal after diarrhoea.
  - Enzymes which make it easier to digest and absorb the milk.
  - Special essential fatty acids that help brain development.
- In addition, breastfeeding:
  - Calms the baby and reduces pain from drawing blood or related to the baby's condition.
  - Gives the mother an important role in caring for her baby.
  - Comforts the baby and maintains the link with the family.
- Babies with special needs such as neurological conditions, cardiac problems or cleft lip/palate and babies who are ill, need breast milk as much if not more than babies who are well. Breastfeeding continues to benefit older babies and young children who are ill.
- The approach to feeding will depend on the individual baby and his or her condition. Overall, care can be divided into categories based on the baby's condition:
  - Baby not able to take oral feeds.
  - Baby able to take oral feeds but is not able to suckle.
  - Baby able to suckle but not for full feeds.
  - Baby can suckle well.
  - Baby is not able to receive any breast milk.

Fatima's baby is brought to the special care baby unit[40] because there is some concern about his breathing, and Fatima goes to the postnatal ward. She is worried about how she will breastfeed if she is separated from her baby.

Ask: What are some ways that a special care baby unit can support breastfeeding?

Wait for a few responses.

40 The term *special care baby unit* is used for any area that provides care for babies that are ill or have special needs. This unit may be part of the maternity unit or part of the paediatric unit or in a different hospital from the maternity unit.

Support for breastfeeding in the special care baby unit

- **Arrange contact** between mother and baby, day and night.
  - Encourage the mother to visit, touch, and care for her baby as much as possible.
  - A mother produces antibodies (one kind of protective factor) against bacteria and viruses (germs) that she is in contact with. When she spends time with her baby in a special care baby unit, her body is able to produce the protective factors against many of the germs that her baby is exposed to in the unit.

- *Show slides 10/1 and 10/2 - pictures of kangaroo mother care*

  - Skin to skin contact or 'kangaroo mother care' encourages the mother to hold her baby (dressed only in a diaper) beneath her clothing close to her breast. The baby can then go to breast whenever he or she wants. Skin-to-skin contact helps to regulate the baby's temperature and breathing, assists in development, and increases the production of milk.

- **Take care of the mother**. The mother is very important to the baby's well being and survival.
  - Help the mother to stay at the hospital while her baby is hospitalised
  - If the mother comes from a long distance to visit her baby, ensure she has a place to rest when she is at the hospital.
  - Make sure the mother has a suitable seat near the baby.
  - Encourage the health facility to provide food and fluids for the mother.
  - Answer the parents' questions and explain patiently. The parents may be upset, overwhelmed and frightened when their baby is ill.
  - Let the parents know that you believe breast milk and breastfeeding are important.
- **Help to establish breastfeeding:**
  - Assist the mother to express her milk, starting within 6 hours of birth, and expressing six or more times each 24 hours.
  - Encourage babies to spend time at the breast as early as possible even if they are not able to suckle well as yet. If the baby has the maturity to lick, root, suck and swallow at the breast, he or she will do so without harm.
  - Describe the early times at the breast as 'getting to know the breast' rather than expecting the baby to take full feeds at the breast immediately.
  - The baby can go to the breast while receiving a tube feed to associate the feeling of fullness with being at the breast.
  - Weight is not an accurate measure of ability to breastfeed. Maturity is a more important factor.
  - Until a baby is able to breastfeed, he or she may be fed expressed breast milk by tube or cup[41]. Avoid using artificial teats.

Putting a baby to breast

- Put a baby to the breast when the baby is just starting to wake up, as seen with rapid eye movements under the eyelids. When ready to feed, a baby may make sucking movements with his or her tongue and mouth. A baby may also bring her or his hand to her or his mouth. Help a mother learn how to anticipate feeding time to avoid her baby using up energy by crying.

41 Milk expression and cup feeding are discussed in Session 11.

- *Show picture 10/3: Positioning a preterm baby. Use a doll to demonstrate positions.*

- Show the mother how to hold and position her baby. One way to hold a small baby is with the baby's head supported – but not gripped - by the mother's hand. The mother's arm can support the baby's body. The baby can be to the mother's side (as in this picture), or the mother can use her hand from the opposite side to the breast that the baby is feeding at.
- The mother can support her breast with her other hand to help the baby keep the breast in his or her mouth. Show her how to put four fingers under the breast and her thumb on top.
- To increase milk flow, massage and compress the breast each time the baby pauses between suckling bursts (unless the flow is more than the baby can swallow already).

Explain to mothers what to expect at feeds

- Expect that the baby will probably feed for a long time, and that the baby will pause frequently to rest during a feed. Plan for quiet, unhurried, rather long breastfeeds (an hour or so for each feed).
- Expect some gulping and choking, because of the baby's low muscle tone and uncoordinated suckle.
- Stop trying to feed if the baby seems too sleepy or fussy. The mother can continue to hold her baby against her breast without trying to initiate suckling.
- Keep the feed as calm as possible. Avoid loud noises, bright lights, stroking, jiggling or talking to the baby during feeding attempts.

Prepare the mother and baby for discharge

- A baby may be ready to leave hospital if she or he is feeding effectively and gaining weight. Usually it is necessary for the baby to weigh at least 1800 – 2000 g before being discharged, but this varies with different hospitals.
- Encourage the health facility to provide a place for the mother to come and stay with the baby 24 hours a day for the day or two days before going home. This helps to build her confidence as well as helping her milk production to match her baby's needs.
- Ensure that the mother can recognise feeding signs, signs of adequate intake and that she is able to position and attach her baby well for breastfeeding.
- Make sure that the mother knows how she can get assistance with caring for her baby after she goes home. Arrange with the mother for follow-up care.

2. Breastfeeding more than one baby 5 minutes

- Mothers can make enough milk for two babies, and even three. The key factors are not milk production, but time, support and encouragement from health care providers, family, and friends.
- Encourage the mother to:
  - Get help with caring for other children and doing household duties.
  - Breastfeed lying down to conserve energy, when possible.
  - Eat a varied diet and take care of herself.
  - Try to spend time alone with each of the babies so that she can get to know them individually.

- *Show slide 10/4: Twins. Use a doll to demonstrate positions also*

- A mother of twins may prefer to feed each baby separately so that she can concentrate on the positioning and attachment. When the babies and mother are able to attach well, then the mother can feed them together if she wishes to reduce feeding time.
- If one baby is a good feeder and one baby less active, make sure to alternate breasts so that the milk production remains high in both breasts. The baby who feeds less effectively may benefit from breastfeeding at the same time as the baby who feeds more effectively, thereby stimulating the oxytocin reflex.

Breastfeeding a baby and older child

- There is generally no need to stop breastfeeding an older baby when a new baby arrives. The mother will produce enough milk for both is she is cared for herself, which includes eating well and resting.
- Whether there is a shortage of food in the family or not, breast milk may be a major part of the young child's diet. If breastfeeding stops, the young child will be at risk, especially if there are no animal foods in the diet. Feeding the mother is the most efficient way of nourishing the mother, the new baby, and the young breastfeeding toddler. Abrupt cessation of breastfeeding should always be avoided.

3. Prevention and management of common clinical concerns 10 minutes

- Many instances of hypoglycaemia, jaundice and dehydration can be avoided by implementing practices such as:
  - Early skin-to-skin contact to provide warmth for the baby.
  - Early and frequent breastfeeding.
  - Rooming-in so that frequent feeding is easy.
  - Encouraging milk expression and cup feeding if baby is unable to breastfeed effectively because he/she is too weak or sleepy.
  - Do not give water to the baby. Water is not effective at reducing jaundice and may actually increase it.
  - Observe all babies in the first few days to ensure that they are learning to suckle well.

Hypoglycaemia of the newborn

- Hypoglycaemia means a low blood glucose level. Babies who are born prematurely or small for gestational age, who are ill or whose mothers are ill may develop hypoglycaemia.
- There is no evidence to suggest that low blood glucose concentrations in the absence of any signs of illness are harmful to healthy, full term babies.
- Term, healthy babies do not develop hypoglycaemias simply through under-feeding. If a healthy full term baby develops signs of hypoglycaemia, the baby should be investigated for another underlying problem.

Jaundice

- It is common for babies to have a yellow colour (jaundice) to their skin in the first week of life due to high levels of bilirubin in the blood. The colour is most easily seen in the white part of the eyes. Colostrum helps infants to pass the meconium, and this removes excess bilirubin from the body.

Dehydration

- Healthy exclusively breastfed infants do not require additional fluids to prevent dehydration.
- Babies with diarrhoea should be breastfed more frequently. Frequent breastfeeding provides fluid, nutrients, and provides protective factors. In addition the growth factors in breast milk aid in the re-growth of the damaged intestine.

Babies who have breathing difficulties

- Babies with breathing difficulties should be fed small amounts frequently as they tire easily. Breastfeeding provides the infant with nutrients, immune bodies, calories, fluid and comforts the distressed baby and mother.

The baby with neurological difficulties

- Many babies with Down's syndrome or other neurological difficulties can breastfeed. If the baby is not able to breastfeed, breast milk is still very important. Some ways to assist include:
    - Encourage early contact and an early start to feeding.
    - The baby may need to be awakened for frequent breastfeeds and stimulated to remain alert during feeding.
    - Help the mother to position and attach the baby well.
    - It may help if the mother supports her breast and her baby's chin to stabilise the baby's jaw and maintain good attachment throughout the feed. She can gently cup the baby's chin between her thumb and first finger, and cup the remaining three fingers under her breast.

- *Show slide 10/5 and 10/6: Picture of DANCER hand position. Baby in slide 10/6 has Down's Syndrome*

- In addition,
    - Feedings may take a long time regardless of feeding method. Help the mother to understand that it is not breastfeeding of itself that is taking time.
    - The mother may need to express her milk and feed it to her baby in a cup.
    - Avoid artificial teats and pacifiers as these babies may find it very difficult to learn to suck from both a breast and an artificial teat.
    - Some babies with neurological difficulties gain weight slowly even if they receive enough breast milk.
    - Some babies with neurological difficulties may have other health challenges, e.g. cardiac problems.

4. Medical reasons for food other than breast milk 10 minutes

- Sometimes breastfeeding is not started or it is stopped without a clear medical indication. It is important to distinguish between:
  - Babies who cannot be fed at the breast but for whom breast milk remains the food of choice.
  - Babies who should not receive breast milk, or any other milk, including the usual breast-milk substitutes.
  - Babies for whom breast milk is not available, for whatever reason.
- Babies who cannot feed at the breast may be fed expressed milk by tube, cup, or spoon. Ensure the baby gets the hind milk that has a high fat content to help the baby grow.
- A very few babies may have inborn errors of metabolism such as galactosemia, PKU, or maple syrup urine disease. These infants may require partial or complete feeding with a special breast-milk substitute, which is appropriate to their specific metabolic condition.
- The mother may be away from the baby, severely ill, have died, or is HIV-positive and made an informed decision not to breastfeed. These babies will need replacement feeding. Situations related to maternal health that may require food other than breast milk will be discussed in a later session[42].
- Babies with medical conditions that do not permit exclusive breastfeeding need to be seen and followed-up by a suitably trained health worker. These infants need individualized feeding plans and the mother and family needs to be clear how to feed their baby.

- *Give handout:* Does the baby need breast-milk substitutes? *Discuss any points as needed.*

- *Ask if there are any questions. Then summarise the session.*

Session 10 Knowledge Check

Jacqueline has a 33-week preterm baby in the special care nursery. It is very important that her baby receive her breast milk. How will you help Jacqueline get her milk started? How will you help her with putting the baby to her breast after a few days?

Yoko gives birth to twin girls. She fears she cannot make enough milk to feed two babies and that she will need to give formula. What is the first thing you can say to Yoko to help give her confidence? What will you suggest for helping Yoko breastfeed her babies?

42 Further information on maternal health concerns and breastfeeding is in Session 13.

Session 10 Summary

Infants who are preterm, low birth weight, ill or have special needs

- Breast milk is important for babies who are preterm, low birth weight or have special needs. It protects, provides food, and aids in growth and development.
- The approach to feeding will depend on the individual baby and his or her condition. Overall, care can be divided into categories based on the baby's ability to suckle:
  - **Baby not able to take oral feeds.** Encourage the mother to express her milk to keep up her supply for when her baby can take oral feeds. If possible freeze her expressed breast milk and use it later.
  - Baby able to take oral feeds but is not able to suckle at the breast. Give expressed milk by tube and by cup if baby is able.
  - **Baby able to suckle but not for full feeds.** Let baby suckle whenever baby is willing. Frequent short feeds may tire the baby less than long feeds at long intervals. Give expressed milk by cup or tube in addition to what the baby can suckle.
  - **Baby can suckle well.** Encourage frequent feeds for milk, for protection from infection, and for comfort.
  - **Baby is not able to receive breast milk.** For example, if the baby has a metabolic disease such as galactosemia, and needs a specialized formula.

- Take care of the mother with fluid, food, rest, and help her to be in close contact with her baby.
- Expect that the baby will pause frequently to rest during the feed. Plan for quiet, unhurried, rather long breastfeeds. Avoid loud noises, bright lights, stroking, jiggling or talking to the baby during feeding attempts.
- Prepare the mother and baby for discharge by rooming-in, encouraging skin-to-skin contact, allowing time to learn to breastfeed and recognise feeding signs (cues), and to know how to get help when at home.
- Arrange early follow up for any baby that has special needs.

Breastfeeding more than one baby

- Mothers can make enough milk for two babies, and even three. The key factors are not milk production, but time, support and encouragement from health care providers, family, and friends.

Prevention and management of common clinical concerns

- Implementing practices such as early skin-to-skin contact, early and frequent breastfeeding, rooming-in, and milk expression and cup feeding if the baby is sleepy or weak and avoiding water supplements can avoid many instances of hypoglycaemia, jaundice and dehydration.

Medical indications for food other than breast milk

- Infants with medical conditions that do not permit exclusive breastfeeding need to be seen and followed-up by a suitably trained health worker.

Does the baby need breast-milk substitutes?

Exclusive breastfeeding in the first six months of life is the norm, and is particularly beneficial for mothers and infants. Nevertheless, a small number of health conditions of the infant or the mother may justify recommending that she does not breastfeed temporarily or permanently. These conditions concern very few mothers and their infants.

It is useful to distinguish between:

- Infants who should not receive breast milk or any other milk except specialized formula.
- Infants for whom breast milk remains the best feeding option but who may need other food in addition to breast milk for a limited period.

Infants who should not receive breast milk or any other milk except specialized formula may include infants with certain rare metabolic conditions such as galactosemia who may need feeding with a galactose free special formula, or Maple syrup urine disease: a special formula free of leucine, isoleucine and valine is needed, or phenylketonuria where a special phenylalanine-free formula is needed (some breastfeeding is possible, under careful monitoring).

Infants for whom breast milk remains the best feeding option but who may need other food in addition to breast milk for a limited period This group may include very low birth weight infants (those born weighing less than 1500 g) very preterm infants, i.e. those born less than 32 weeks gestational age, newborn infants who are at risk of hypoglycaemia by virtue of impaired metabolic adaptation or increased glucose demand (such as those who are preterm, small for gestational age or who have experienced significant intrapartum hypoxic/ischaemic stress), those who are ill and those whose mothers are diabetic if their blood sugar fails to respond to optimal breastfeeding or breast milk feeding.

Additional information for Session 10

Using expressed breast milk

- Milk from a mother giving birth preterm contains more protein, sodium and calcium than full term milk. Preterm infants often need extra protein, so this is helpful.
- Breast milk with an energy value of 65 kcal/100 ml at a volume of 200 ml/kg/day will result in an energy intake of 130 kcal/day. If the mother has more milk than her baby needs, the expressed breast milk can be left to stand for a short while and the fat rich hind milk will rise to the top. The 'cream' can be added to the regular milk feed, which will make it even higher in energy value.
- Some units add fortifiers and formula to the breast milk in order to make the baby grow more quickly. The long-term effect of early rapid growth is not known. These additions to her breast milk can make the mother worry that her milk is not good enough for her baby. Reassure her that her milk is good for her baby. If there is a medical need for additions to the breast milk, explain that for a short period her baby has extra needs.
- If both breast milk and formula are given, the formula will be better absorbed if it is mixed with the breast milk rather than giving alternate feeds of formula or breast milk. Additions to breast milk should be decided for each individual infant, not a standard policy for all infants in the unit[43].

Hypoglycaemia of the newborn

- Babies fed on breast milk may be better able to maintain their blood glucose levels than babies artificially fed on formulas. Babies compensate for low blood sugar by using their body fuels (e.g. glycogen stored in the liver).
- Term, healthy babies do not develop hypoglycaemia simply through under-feeding. If a healthy full term baby develops signs of hypoglycaemia, the baby should be investigated for an underlying problem. Signs of hypoglycaemia include reduced level of consciousness, convulsions, abnormal tone ('floppy'), and apnoea. A doctor should see any baby with these signs immediately.

Physiological jaundice

- This is the commonest kind of jaundice, and does not indicate an illness in the baby. It usually appears on the second or third day and clears by the tenth day. The fetal red blood cells, which are not needed by the baby after birth, break down faster than the baby's immature liver can handle. As the baby's liver matures, jaundice decreases. Bilirubin is mainly excreted in the stools, not in the urine; therefore water supplements do not help to reduce the level of bilirubin.

Prolonged jaundice

- Sometimes jaundice may persist for three weeks to three months. The baby should be checked to rule out abnormal jaundice. In an infant who is breastfeeding well with a good weight gain and only a mild level of jaundice, prolonged jaundice is rarely a problem.

Abnormal or pathological jaundice

- This type of jaundice is not usually related to feeding, and is evident at birth or within the first day or two. Usually the baby is ill. Breastfeeding should be encouraged, except in the very rare metabolic condition of galactosemia.

Treatment of severe jaundice

- Phototherapy is used in severe jaundice to breakdown the bilirubin. Very frequent breastfeeding is important to avoid dehydration. Give expressed milk if the baby is sleepy. Water or glucose water supplements do not help as they reduce the intake of breast milk and do little to reduce the jaundice.

43 Mothers who are HIV-positive should either exclusively breastfeed or exclusively formula-feed rather than do mixed feeding.

Cardiac problems

- Babies may tire easily. Short frequent feeds are helpful. The baby can breathe better when breastfeeding. Breastfeeding is less stressful and less energy is used so there is better weight gain. Breast milk provides protection from illness thus reducing hospitalization and helping growth and development.

Cleft lip and palate

- Breastfeeding is possible, even in extreme cases of cleft lip/palate. As babies with clefts are at risk for otitis media and upper respiratory infections, breast milk is especially important.
- Hold the baby so that his or her nose and throat are higher than the breast. This will prevent milk from leaking into the nasal cavity, which would make it difficult for the baby to breathe during the feed. Breast tissue or the mother's finger can fill a cleft in the lip to help the baby maintain suction.
- Feedings are likely to be long. Encourage the mother to be patient, as the baby tires easily and needs to rest. The mother probably will need to express her milk and supplement. She can feed expressed milk with a cup or breastfeeding supplementer[44]. Following surgery to repair the cleft, breastfeeding can resume as soon as the baby is alert.

Infants requiring surgery

- Breast milk is easily digested so requires a shorter fasting time than formula milk or other foods. In general, the baby should not need to fast for more than three hours. Discuss with the parents ways of comforting the baby during the fasting period. Breastfeeding can usually commence as soon as the baby is awake after the surgery.
- Breastfeeding soon after surgery helps with pain relief, comforts the baby and provides fluid and energy. If the baby is not able to take large amounts of breast milk immediately, the mother can express and let the baby suck on an ‘empty breast’ until the baby is more stable.

44 See Session 11.

SESSION 11
IF BABY CANNOT FEED AT THE BREAST – STEP 5

Session Objectives:

On completion of this session, participants will be able to:

1.	Describe why hand expression is useful and how to hand express.	15 minutes
2.	Practice assisting to learn how to hand express.	15 minutes
3.	Outline the safe use of milk from another mother.	5 minutes
4.	Explain how to cup feed an infant.	25 minutes
	Total session time	**60 minutes**

There is a demonstration of cup feeding during the Clinical Practice 3. If a mother and baby are available to come to the classroom, the demonstration can be done as a part of this session. Adjust the timetable accordingly.

Materials:

Slide 11/1: Hand Expression.
Slide 11/2: Cup feeding.
Slide 11/3: Breastfeeding supplementer (optional).

Breast model for demonstration plus some additional breast models for pair practice. If possible, have one breast model for each 2-3 participants.

Doll, small cup, cloth. The cup should be open, with no sharp edge – a medicine cup, egg cup or small tea cup or glass may be used. If a glass is used it may be easier to see the milk in the glass.

Handout – HOW TO CUP FEED A BABY, one copy for each participant (optional).

Handout – MILK EXPRESSION, one copy for each participant (optional).

Optional – breast pumps that are available locally. Make sure that you know how to use the pumps correctly before demonstrating them. Do NOT invite a representative from a pump company to give this demonstration as their job is to increase the use of their pump rather than give an unbiased review of pumping and expressing.

Breastfeeding supplementer for display, either home-made or a purchased device, if used locally.

Further reading for facilitators:

WHO/UNICEF/USAID. Chapter 3 Teach the mother how to practise the chosen feeding option. In: *HIV and Infant Feeding Counselling Tools: Reference Guide*. World Health Organization, Geneva: 2005.

RELACTATION: A review of experience and recommendations for practice. WHO/CHS/CAH/98.14

(Optional book) Lang, S. Breastfeeding Special Care Babies, Bailliere Tindall/Harcourt Publishers, 2002.

1. Learning to hand express 15 minutes

- Step 5 of the ten Steps to Successful Breastfeeding states:

  Show mothers how to breastfeed, and how to maintain lactation even if they should be separated from their infants.

Ask: Why might it be useful for a mother to know how to hand express?
Wait for a few responses.

Why learn to hand express?

- It may be useful to know how to hand express:
  - For breast comfort, such as to relieve engorgement or a blocked duct[45] or to rub a few drops of hind milk on the nipple area to soothe if the nipple is tender.
  - To encourage a baby to breastfeed. Express milk:
    - on to the nipple so that the baby can smell and taste it;
    - directly into the baby's mouth if the baby has a weak suck, or
    - to soften the areola of a full breast so that the baby can attach.
  - To keep up the milk production when the baby is not suckling or to increase milk production.
  - To obtain milk if the baby is unable to breastfeed, or if the baby is small and tires quickly, when mother and baby are separated, or to provide milk for a milk bank.
  - To pasteurise the milk for the baby, as an option if the mother is HIV-positive.
- Many mothers prefer hand expression to using a pump because:
  - Hands are always with you, and there are no parts to lose or break.
  - Hand expression can be very effective and quick when the mother is experienced.
  - Some mothers prefer the skin-to-skin stimulation from hand expression rather than the feel of plastic and sound of a pump.
  - Hand expression is usually gentler than a pump, particularly if the mother's nipple is sore.
  - There is less risk of cross-infection since the mother does not use equipment that may be also handled by others.

How to hand express

Fatima knows that breast milk is very important to her baby and wants to give her milk to him. However, he is not yet able to suckle well. The nurse helped her to begin expressing milk soon after her baby was born.

- It is easier to learn to hand express when the breast is soft rather than engorged and tender.
- The key steps in order to hand express are:
  - Encourage the milk to flow.
  - Find the milk ducts.
  - Compress the breast over the ducts.
  - Repeat in all parts of the breast.

- *Give out the Milk Expression handout (optional).*
- *Use the breast model as you explain the steps.*

45 See Session 12 for more information on blocked ducts and engorgement.

Encourage the milk to flow

- A mother can help her oxytocin reflex to work by:
  - Being comfortable and relaxed.
  - Thinking about her baby, looking at the baby (or even at a photograph).
  - Warming her breast and gently massaging or stroking it.
  - Gently rolling her nipple between her finger and thumb.
- Mothers can get their oxytocin reflex to work more easily with practice. When a mother is used to expressing her milk she may not need to encourage the milk to flow.

Find the milk ducts

- Ask the mother to gently feel the breast near the outer edge of the areola or about the length of her first thumb joint[46] back from the nipple until she finds a place where the breast feels different. She may describe it as feeling like a knotted string or a row of peas. These are the ducts of milk. Depending on what part of the breast it is, the mother should place her first finger over the duct, and her thumb on the opposite side of the breast, or her thumb on the duct and finger opposite. She can support her breast with the other fingers of that hand, or with her other hand.

Compress the breast over the ducts

- Ask the mother to gently press her thumb and fingers slightly back towards the chest wall. Then she presses the thumb and first finger together, compressing the milk duct between them. This helps the milk to flow towards the nipple. She releases the pressure and repeats the compress and release movement until milk starts to drip out (it may take a few minutes). Colostrum may come out in drops, as it is thick and a small amount. Later the milk may spray out in streams after the oxytocin reflex works.

Repeat in all parts of the breast

- When the milk flow slows, the mother moves her thumb and finger around the edge of her areola to another section and repeats the press and release movement. When flow ceases, she changes to the other breast and repeats, if both breasts are to be expressed. The mother can pause to massage her breast again if needed. She can go back and forth between her breasts a few times if needed.

When to express

- If the baby is not able to suckle, begin expressing as soon after birth as possible, by 6 hours preferably.

How long to express

- The length of time to express depends on why the mother is expressing.
  - If express to get colostrum for her baby who is not able to suck, she might express for 5-10 minutes to get a teaspoon of colostrum. Remember the newborn baby's stomach is very small and small amounts every 1-2 hours if what the baby needs.
  - If expression is used to increase milk production, aim to express for about 20 minutes at least six or more times in 24 hours including at least once at night, so that the total time expressing is at least 100 minutes per 24 hours.

46 About one and a half inches or 4 centimetres.

- If the mother is just softening the areola to help the baby attach, she may only need to compress 3 or 4 times.
- If the mother is clearing a blocked duct, she compresses and massages until the lump has cleared.
- If it is past the newborn stage and the mother is expressing milk to be given to her baby when she is at work, determine the length of time to express by the flow of milk and the amount needed to meet the baby's needs. Some mothers can get the amount of milk needed in 15 minutes and for some women it may take 30 minutes.
- A mother might express one breast and feed the baby from the other breast.

- Preterm babies and some sick babies may take only very small feeds at first. Encourage small frequent feeds of colostrum. Even very small feeds may be useful - do not dismiss small amounts that the mother expresses.
- Colostrum may only come in drops. These are precious to the baby. The mother may be able to express into a spoon, small cup or directly into the baby's mouth so that no drops of colostrum are lost. A useful way is for a helper to draw up the colostrum in a syringe directly from the nipple as the mother expresses it – 1 ml can look quite a lot in a small syringe.

Points to note:

- It is not necessary for the health worker to touch the mother's breasts when teaching hand expression.
- It may take a few tries before much milk is expressed. Encourage the mother not to give up if she gets little milk or no milk at the first try. The amount of milk obtained increases with practice.
- Explain to the mother that she should not squeeze the nipple itself. Pressing or pulling the nipple cannot express milk, but it is painful and it can damage the nipple.
- Explain to the mother that she should avoid sliding or rubbing her fingers along the breast when compressing. This can also damage the breast.
- With practice it is possible for a mother to express from both breasts at the same time.
- If a mother is both expressing and breastfeeding an older baby (for example, if she is working away from the baby), suggest that she express first and then breastfeed her baby. The baby is able to get the fat rich hind milk from deep in the breast more efficiently than expressing.
- Expressing should not hurt. If it does hurt, check the techniques listed above with the mother and observe her expressing.

2. Pair practice learning to hand express 15 minutes

Divide the group into pairs and give each pair a breast model. Participants take turns to help each other to learn how to hand express. Participants can be in a group of three with one person as the health worker, one person as the mother and one person observing.

REMEMBER YOUR COMMUNICATION SKILLS
Listen, praise, inform, suggest – Do not command or judge

3. Use of milk from another mother 5 minutes

- If a baby cannot feed at the breast, the next best choice is to receive his or her own mother's milk. If the baby's own mother's milk is not available, milk from another mother[47] is more suitable than milk from a cow, goat, camel or other animal, or milk from a plant (soy milk).
- When a woman breastfeeds a baby to whom she did not give birth, it is called *wet nursing.* Expressed milk from another mother is called *donor milk.*
- Some places may have breast milk banks to provide milk for babies who are preterm or ill. In a milk bank, the donor mothers are screened for HIV and other illnesses and the milk is also pasteurised (heat-treated). Using donor-banked milk is usually a short-term option, as the supply may be limited, and another way of feeding will need to be discussed.

- *If there is a milk bank in the area, tell participants that it is there.*

4. Feeding expressed breast milk to the baby 25 minutes

- Babies who are not fed at the breast can be fed by:
  - Naso-gastric or oro-gastric tube
  - Syringe or dropper
  - Spoon
  - Direct expression into the baby's mouth
  - Cup
- The need for alternative feeding methods and the most suitable method should be individually assessed for each mother and baby.
- **Tube feeding** is needed for babies who cannot suckle and swallow.
- **A syringe or dropper** can be used for very small amounts of milk, for example colostrum. Place a very small amount (not more than 0.5 ml at a time) in the baby's cheek[48] and let the baby swallow that before giving more.
- **Spoon-feeding** is similar to syringe feeding in that very small amounts are given. The baby cannot control the flow so there is a risk of aspiration if the milk is fed quickly. Spoon-feeding large amounts of milk takes a lot of time. This means the carer or baby may get tired before enough milk is taken. If a large spoon is used, then this is similar to cup feeding.
- **Direct expression into the baby's mouth** may encourage the baby to suck. Some mothers are able to use direct expression for a baby with a cleft palate.
- For all the above methods of supplementing, the caregiver decides how much and how fast the baby will drink.

Cup feeding

- Cup feeding can be used for babies who are able to swallow but cannot (yet) suckle well enough to feed themselves fully from the breast. They may have difficulty attaching well, or they may attach and suckle for a short time, but tire quickly before they have obtained enough milk. A baby of 30-32 weeks gestation can often begin to take feeds from a cup.

- *Show slide 11/1 – Cup Feeding*

---

47 The other woman should be HIV-negative.

48 If the syringe is placed in the centre of the baby's mouth there is a risk that the milk could accidentally squirt down the throat when the baby was not ready to swallow. Some babies suck the syringe as if it were a bottle teat if it is in the centre of their mouth. This may give more milk than the baby can cope with and the baby may find it harder to learn to suckle the breast.

- Cup feeding has some advantages over other methods of feeding:
  - It is pleasant for the baby – there are no invasive tubes in his or her mouth.
  - It allows the baby to use his or her tongue and to learn tastes.
  - It stimulates the baby's digestion.
  - It encourages coordinated breathing/suck/swallow.
  - The baby needs to be held close and eye-contact is possible.
  - It can allow the baby to control the amount and rate of feeding.
  - A cup is easier to keep clean than a bottle and teat.
  - It may be seen as a transitional method on the way to breastfeeding rather than as a 'failure' of breastfeeding.
- Cup feeding may have disadvantages:
  - Milk can be wasted if the baby dribbles.
  - Term babies can come to prefer the cup if they do not go to the breast regularly.
  - Cup feeding may be used instead of direct breastfeeding because it is easy to do. For example, a special care baby nurse may prefer to give a cup feed rather than bring the mother from the post-natal ward and help her to breastfeed her small baby.
- The amount a baby takes varies from feed to feed – this is true for any method of feeding. If a baby takes a small feed, offer the next feed a little earlier, especially if the baby shows signs of hunger. Measure the baby's intake over 24 hours, not feed by feed. Extra milk can be given by tube if the baby is too weak to take full cup feeds.
- If mothers are not used to cup feeding, they need information about it, and they need to see their babies feeding by cup. The method needs to be taught in a way that gives them confidence to do it themselves[49].
- A cup does not need to be sterilised in the same way as a bottle and teat. It has an open, smooth surface that is easy to clean by washing it in hot soapy water. Avoid tight spouts, lids or rough surfaces where milk may stick and allow bacteria to grow.
- A baby can progress from tube feeding to cup feeding to fully feeding at the breast. The baby does not need to 'learn' to feed from a bottle and teat as part of his or her development.

- *Give participants' the handout* – HOW TO CUP FEED A BABY.
  Demonstrate how to cup feed using a doll using the points on the handout.
- *There is a demonstration of cup feeding during the Clinical Practice 3 or it can be demonstrated at this time if suitable.*

- *Ask if there are any questions. Then summarise the session.*

49 A demonstration of how to teach a mother to cup feeding using communication skills is included in Chapter 3 of *HIV and Infant Feeding Counselling Tools: Reference Guide.*

Session 11 Summary

Learning to hand express

- It may be useful to know how to hand express for:
  - Breast comfort.
  - Helping a baby to breastfeed.
  - Keeping up the milk supply.
  - Obtaining milk if the baby is unable to breastfeed, where mother and baby are separated, or if milk is needed for another baby.
  - Pasteurising the milk for the baby, as an option if the mother is HIV-positive.
- Key steps in order to hand express are:
  - Encourage the milk to flow.
  - Find the milk ducts.
  - Compress the breast over the ducts.
  - Repeat in all parts of the breast.
- The amount of milk obtained increases with practice.

Use of milk from another mother

- If a baby's own mother's milk is not available, milk from another mother (who is HIV-negative) is more suitable than milk from a cow, goat, camel or other animal, or milk from a plant source (soy milk).

Feeding expressed breast milk to the baby

- Babies who are not fed at the breast can be fed by:
  - Naso-gastric or oro-gastric tube
  - Syringe or dropper
  - Spoon
  - Direct expression into the baby's mouth
  - Cup
- The need for alternative feeding methods and the most suitable method should be individually assessed for each mother and baby.
- Cup feeding can be used for babies who are able to swallow but cannot (yet) suckle well enough to feed themselves fully from the breast. A baby of 30-32 weeks gestation can often begin to take feeds from a cup.
- If mothers are not used to cup feeding, they need information about it, and they need to see babies feeding by cup. The method needs to be taught in a way that gives them confidence to do it themselves.

Session 11 Knowledge check

List four reasons why it is recommended that mothers learn to hand express.

List four reasons why cup feeding is preferred to feeding by other means if the baby cannot breastfeed.

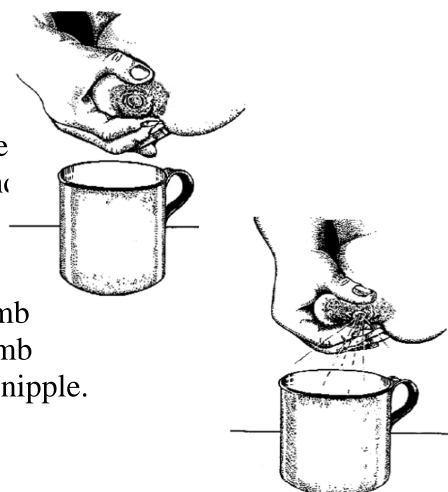
Milk Expression

Your milk is very important to your baby. It is useful to express your milk if:

- your baby cannot feed at the breast:
- you are away from your baby:
- you want drops of milk to encourage your baby to suck;
- your breasts are overfull or you have a blocked duct;
- you want some hind milk to rub on sore nipples, and other reasons.

You can help your milk to flow by:

- sitting comfortably, relaxed and thinking about your baby;
- warming your breast;
- massaging or stroking your breast, and rolling your nipple between your fingers;
- having your back massaged.



Feel back from your nipple to find a place where your breast feels different. This may feel like knots on a string or like peas in a pod. This is usually a good place to put pressure when expressing. Put your thumb on one side of the breast and 2-3 fingers opposite.

Compress the breast over the ducts. Try pressing your thumb and fingers back towards your chest, and then press your thumb and fingers towards each other, moving the milk towards the nipple. Release and repeat the pressure until the milk starts to come.

Repeat in all parts of the breast. Move your fingers around the breast to compress different ducts. Move to the other breast when the milk slows. Massage your breast occasionally as you move your hand around. If you are expressing to clear a blocked duct, you only need to express in the area that is blocked.

It takes practice to get large volumes of milk. First milk (colostrum) may only come in drops. These are precious to your baby.

How often to express depends on the reason for expressing. If your baby is very young and not feeding at the breast, you will need to express every 2-3 hours.

It is important to have clean hands and clean containers for the milk. Discuss milk storage if needed.

These points are suggestions not rules.

- Find what works best for you.
- Expressing should not hurt and to ask for help if it does.
- Ask if you have any questions. You can get information or help from:

Illustration from Breastfeeding Counselling: a training course,
WHO/CHD/93.4, UNICEF/NUT/93.2

Cup Feeding a Baby

Why cup feeding is recommended:

- It is pleasant for the baby – there are no invasive tubes in his or her mouth.
- It allows the baby to use his or her tongue and to learn tastes.
- It stimulates the baby’s digestion.
- It encourages coordinated breathing/suck/swallow.
- The baby needs to be held close and eye-contact is possible.
- It allows baby to control the amount and rate of feeding.
- A cup is easier to keep clean than a bottle and teat.
- It may be seen as a transitional method on the way to breastfeeding rather than as a ‘failure’ of breastfeeding.

HOW TO FEED A BABY BY CUP

Sit the baby upright or semi-upright on your lap; support the baby’s back, head and neck. It helps to wrap the baby firmly with a cloth, to help support his or her back, and to keep his or her hands out of the way.

Hold the small cup of milk to the baby's lips.

The cup rests lightly on the baby's lower lip, and the edges of the cup touch the outer part of the baby's upper lip.

Tip or tilt the cup so that the milk just reaches the baby's lips.

The baby becomes alert, and opens his or her mouth and eyes.
- A preterm baby starts to take the milk into his or her mouth with his or her tongue.
- A full term or older baby sucks the milk, spilling some of it.

DO NOT POUR the milk into the baby's mouth. Just hold the cup to the baby’s lips and let him or her take it himself or herself.

When the baby has had enough, the baby closes his or her mouth and will not take any more. If the baby has not taken the calculated amount, he or she may take more next time, or you may need to feed the baby more often.

Measure the baby’s intake over 24 hours - not just at each feed.

Additional information for Session 11

Use of milk from another mother

Wet nursing

- In some cultures, a family may look for a wet nurse if the mother dies or is very ill, if the mother will be away from the baby for a long period of time or if the mother is HIV-positive. If the reason for asking another woman to breastfeed a baby is to reduce the risk of the baby acquiring HIV, the wet nurse needs to be counselled, tested and shown to be HIV-negative.
- The wet nurse, if sexually active, also needs to be counselled about safer sex practices so that she does not acquire the virus during the breastfeeding period. The wet nurse needs access to breastfeeding support and assistance to establish good breastfeeding.
- It is important for the mother to stay close to the baby, and to care for him or her as much as possible herself, so that she bonds with her baby.

Donor milk and heat-treated milk

- Heat-treating destroys the HIV in the breast milk. A mother who is HIV-positive can also heat-treat her milk at home to reduce the risk of transmitting HIV to her baby. Breast milk should not be heat-treated unless necessary. Breast milk from an HIV-negative or untested mother does not need to be heat treated if the milk is for her own baby. Heating reduces some anti-infective components of breast milk and enzymes in the milk. However, heat-treated breast milk remains superior to breast-milk substitutes. Do not heat-treat the baby's own mother's milk just 'in case' the mother is HIV-positive.
- Information on using the milk from another mother and how to heat-treat breast milk to destroy HIV can be found in Chapter 3 of *HIV and Infant Feeding Counselling Tools: Reference Guide.*

Feeding expressed breast milk to the baby

- **Tube feeding -** Fat can stick to the side of the tube thus reducing the energy level of the feed received. If breast milk is fed continuously, angle the milk container and place the outlet tube at the highest point in the container so that the creamy part of the milk is fed first.
- **Bottle and artificial teats** come in a wide variety of sizes and shapes. There is not one teat that is 'best' or most like a mother's breast. Babies who use the bottle and teat method may lose interest in breastfeeding. A baby can progress from tube feeding, to cup feeding to fully feeding at the breast. The baby does not need to 'learn' to feed from a bottle and teat as part of his or her development.
- Clean water and extra fuel are not always available to clean bottles and teats. This places the baby's health at risk. If a mother plan to use bottles and teats, then the mother must be instructed on the health and safety issues associated with their use.

A Breastfeeding Supplementer

- A **breastfeeding supplementer** can be useful to ensure that the baby receives enough milk while encouraging the baby to suckle for longer or if the baby has a weak suck. To use a nursing supplementer the baby must be able to attach to the breast and suckle.

\- *Show slide 11/2: Breastfeeding supplementer*

- A breastfeeding supplementer is a device to allow extra milk to be given while the baby is at the breast, thus stimulating milk production, encouraging suckling, and enabling closeness of mother and baby. If the baby cannot attach to the breast and suckle, this method cannot be used.
- A breastfeeding supplementer device can be purchased or home-made. Read the instructions for using a purchased device.
- To use a home-made supplementer: The supplement is put into a cup, and a fine tube passes from the cup along the mother's breast to the baby's mouth. As the baby suckles on the breast, the baby draws up the supplement through the tube[50].

---

50 See additional information in *RELACTATION: A review of experience and recommendations for practice.* WHO/CHS/CAH/98.14 http://www.who.int/child-adolescent-health/NUTRITION/infant.htm

- The tube of the supplementer needs to be thoroughly rinsed with water immediately after use, and then sterilised each time it is used, especially if the baby is ill or preterm; or rinsed and then washed well in very hot soapy water for an older, healthy baby. Cleaning the tube makes extra work for the mother or hospital staff. The mother may need help to use this method. Consider if a simpler method such as cup feeding would be suitable.

- *Discuss this method more and show a supplementer if they are used in your hospital.*

Breast pumps

- *Demonstrate the use of breast pumps that are available to mothers in your community. Explain both the positive and negative sides of their use.*

- Breast pumps are not always practical, affordable or available, so it is preferable for mothers to learn how to express milk by hand. If breast pumps are available to mothers in your area and if a particular mother needs to use one, help her choose an effective pump, show her how to use the pump and go through the manufacturer's instructions with her.
- It is usually helpful to stimulate the oxytocin reflex before pumping by sitting comfortably with support for the back and the arm holding the pump, relaxing, massage and other techniques as described for hand expressing.
- It is possible with some large electric pumps to pump both breasts at the same time. Double pumping increases the mother’s prolactin level. It can help when large volumes of milk are needed or the mother has only a short time to pump.
- With all pumps use only a comfortable level of suction – more suction does not remove more milk and may damage the breasts. Mimic the baby’s action – short quick initial sucks followed by longer, slower suction. With a cylinder hand pump, extend the cylinder to create a comfortable level of suction and hold that suction until the milk flow slows. The mother does not need to keep pumping if the milk is flowing.
- If the mother is getting little or no milk from pumping, check that the pump is working and check her pumping technique (including stimulating the oxytocin reflex). Do not conclude that she “has no milk”.
- Ensure that the mother is able to sterilise the pump if she intends to feed the milk to her baby.
- Avoid the rubber bulb type hand pumps. These damage mother’s nipples, are difficult to clean and the milk cannot be used for feeding a baby.

Check list for choosing a pump

- Does the mother find it works well?
- Is it easily available at an affordable price?
- Is it comfortable to use – arm position, weight, adjustable suction?
- Is the size of the breast cup/funnel and insert if available, suitable for the size of the nipple and breast?
- Can milk be stored in a collection container, in standard thread containers, or is there a need to purchase special containers?
- What is the noise level when in use?
- Is it safe to use and easy to clean and sterilise?
- Is it easy to assemble with few parts?
- Are there clear instructions for use?

Storing expressed breast milk

- Choose a suitable container made of glass or plastic that can be kept covered. Clean it by washing in hot soapy water, and rinsing in hot clear water. If the mother is hand expressing, she can express directly into the container.
- If storing several containers, each container should be labelled with the date. Use the oldest milk first.
- The baby should consume expressed milk as soon as possible after expression. Feeding of fresh milk (rather than frozen) is encouraged.
- Frozen breast milk may be thawed slowly in a refrigerator and used within 24 hours. It can be defrosted by standing in a jug of warm water and used within one hour, as it is warm. Do not boil milk or heat it in a microwave as this destroys some of its properties and can burn the baby's mouth.

Breast milk Storage

Healthy baby at home
Fresh Milk

- At 25-37°C for 4 hours.
  At 15-25°C for 8 hours.
  Below 15°C for 24 hours.
  Milk should not be stored above 37° C.
- Refrigerated (2-4°C): up to 8 days.
  Place the container of milk in the coldest part of the refrigerator or freezer. Many refrigerators do not keep a constant temperature. Thus, a mother may prefer to use milk within 3-5 days or freeze milk that will not be used within 5 days, if she has a freezer.

Frozen Milk

- In a freezer compartment inside refrigerator: 2 weeks.
- In a freezer part of a refrigerator-freezer: 3 months.
- In a separate deep freeze: 6 months.
- Thawed in a refrigerator: 24 hours (do not re-freeze), or place the container in warm water to thaw quickly.

Ill baby in hospital
Fresh Milk

- At room temperature (up to 25°C): 4 hours.
- Refrigerated (2-4°C): 48 hours.

Frozen milk

- In a freezer compartment inside refrigerator: 2 weeks.
- In a freezer part of a refrigerator-freezer or a separate deep freeze (-20°C): 3 months.
- Thawed in a refrigerator: 12 hours (do not re-freeze).

SESSION 12
BREAST AND NIPPLE CONDITIONS

Session Objectives:

At the end of this session, participants will be able to:

1.	List the points to look for when examining a mother's breasts and nipples.	5 minutes
2.	Describe causes, prevention and management of engorgement and mastitis.	20 minutes
3.	Describe causes, prevention and management of sore nipples.	10 minutes
4.	Demonstrate through role-play assisting a mother with breast or nipple conditions.	25 minutes
	Total session time	**60 minutes**

Materials :

Cloth breast.
Slide 12/1: Breast and nipple size and shape
Slide 12/2: Full breast
Slide 12/3: Engorgement
Slide 12/4: Mastitis
Slides 12/5 and12/6: Sore nipples

Breastfeed Observation Aid - a copy for each person.
List of Communication Skills from Session 2 - a copy for each person.
Copy of the stories – one story for each group of 4-6 participants.

In Additional Information section
Slides 12/7: Syringe method for an inverted nipple
Slides 12/8 and12/9: Candida on nipples
Slide 12/10: Tongue-tie
Syringe and a sharp blade to cut it.

Further reading for facilitators:

Mastitis: causes and management WHO/FCH/CAH/00.13

1. Examination of the mother's breasts and nipples 5 minutes

- The earlier session on promoting breastfeeding during pregnancy mentioned that antenatal nipple preparation was generally not helpful. During antenatal checks, a woman can be reassured that most women's breasts produce milk well regardless of size or shape.
- After the baby is born, health workers do not need to physically examine every breastfeeding woman's breasts and nipples. They only need to do so if the mother has pain or a difficulty.
- Always observe the condition of the mother's breasts when you observe a breastfeed. In most cases this is all that you need to do, as you can see most important things when she is putting the baby onto the breast, or as the baby finished a feed.
- If you physically examine a women's breasts:
    - Explain what you want to do.
    - Ensure privacy to help the mother feel comfortable and consider customs of modesty.
    - Ask permission before breasts are exposed or touched.
    - Talk with the mother and look at the breasts without touching.
    - If you need to touch the breasts do so gently.
- Ask what has she noticed about her breasts – is there anything that worries her? If so ask her to show you.
- Talk to the mother about what you have found. Highlight the positive signs you see. Do not sound critical about her breasts. Build her confidence in her ability to breastfeed.

Nipple size and shape

- *Show slide 12/1: Breast and nipple size and shape*

- There are many different shapes and sizes of breast and nipple. Babies can breastfeed from almost all of them.
- Nipples can change shape during pregnancy and become more *protractile* or "*stretchy*". There is no need to 'diagnose' or treat a nipple that looks flat or inverted during pregnancy[51].
- Inverted nipples do not always present a problem. Babies attach to the breast, not to the nipple. If you think her nipples may be inverted, the best way to help is to build her confidence and provide good support from birth[52].
- Long or big nipples may also cause difficulties because the baby does not take the breast far enough back in his or her mouth. Help the mother to position and attach the baby so that there is a large amount of breast tissue in the mouth, not just the nipple.
- If the baby gags repeatedly because of a large nipple, ask the mother to express the milk and cup feed the baby for some days. Babies grow quickly and their mouths soon become bigger.

51 Wearing of breast shells or special exercises during pregnancy to help the nipples protrude are no longer recommended as they may be painful and can give a woman the impression that her breasts are not right for breastfeeding. Build her confidence and provide good support from birth.

52 Supportive practices such as skin to skin contact, encouraging the baby to find his/her own way to the breast, help with positioning and attachment and avoiding artificial teats and pacifiers, assist breastfeeding to be established. These practices were discussed in earlier sessions.

2. Engorgement, blocked ducts and mastitis 20 minutes

One of the mothers in our story, Fatima, has heard that breastfeeding mothers can have sore breasts. She is worried this might happen to her, as her breasts seem to be getting swollen.

Ask: What can you explain to a mother about normal breast changes during breastfeeding and changes that may indicate a difficulty?

Wait for a few responses.

Engorgement

What is engorgement?

- *Slide 12/2:Picture of full breast*

- **Normal breast fullness**: When the milk is "coming in," there is more blood supply to the breast as well as more milk. The breasts may feel warm, full, and heavy. This is normal. To relieve fullness, feed the baby frequently and use cool compresses between feeds. In a few days, the breasts will adjust milk production to the baby's needs.

- *Slide 12/3:Picture of engorgement*

- **Engorgement:** If the milk is not removed, the milk, blood and lymph become congested and stop flowing well, which results in swelling and oedema. The breasts will become hot, hard and painful, and look tight and shiny. The nipple may be stretched tight and flat, which makes it difficult for the baby to attach and which can result in sore nipples.
- If engorgement continues, the feedback inhibitor of lactation reduces milk production.
- Causes of breast engorgement include:
  - Delay in starting to breastfeed soon after baby's birth.
  - Poor attachment, so that milk is not removed effectively.
  - Infrequent feeding, not feeding at night or short duration of feeds.

Do your practices help to avoid engorgement?

- If much engorgement is seen in a maternity facility, the pattern of care for mothers should be reassessed. Implementation of the Ten Steps to Successful Breastfeeding prevents most painful engorgement. If you can answer "yes" to all of the following questions, there should be very little engorgement in your facility.
- Ask yourself:
  - Is skin-to-skin care practiced at birth? (Step 4).
  - Is breastfeeding initiated within one hour after birth? (Step 4).
  - Do staff offer help early and make sure that every mother knows how to attach her baby at the breast? (Step 5).
  - If the baby is not breastfeeding, is the mother encouraged and shown how to express milk from her breasts frequently? (Step 5).
  - Are babies and mothers kept together 24 hours a day? (Step 7).
  - Is every mother encouraged to breastfeed whenever and for as long as her baby is interested, day and night (at least eight to twelve feeds in 24 hours)? (Step 8).
  - Are babies given no pacifiers, artificial teats, or bottles that would replace suckling at the breast? (Step 9).

Help mothers to relieve engorgement[53]

- To treat engorgement, it is necessary to remove the milk from the breast. This will:
    - Relieve the mother's discomfort.
    - Prevent further complications such as mastitis and abscess formation.
    - Help to ensure continued production of milk.
    - Enable the baby to receive breast milk.
- How to help a mother to relieve engorgement:
    - Check attachment: Is baby able to attach well at the breast? If not:
        - *Help the mother to attach her baby at the breast well enough to remove the milk.*
        - *Suggest that she gently express milk*[54] *from her breasts herself before a feed to soften the areola and make it easier for the baby to attach.*
    - If breastfeeding alone does not reduce the engorgement, advise the mother to express milk between feeds a few times until she is comfortable.
    - Encourage frequent feeds: if feeds have been limited, encourage the mother to breastfeed whenever and for as long as her baby is willing.
    - A warm shower or bath may help the milk to flow.
    - Massage of the back and neck or other forms of relaxation may also help the milk to flow.
    - Help the mother to be comfortable. She may need to support her breasts if they are large.
    - Provide a supportive atmosphere; build the mother's confidence by explaining that soon the engorgement will be resolved.
    - Cold compresses may lessen pain between feeds.

Blocked milk ducts and mastitis (breast inflammation)

- Milk sometimes seems to get stuck in one part of the breast. This is **a blocked duct.**
- If milk remains in a part of the breast, it can cause inflammation of the breast tissue or **non-infective mastitis.** Initially there is no infection, however the breast can become infected with bacteria and is then **infective mastitis**.
- Blocked ducts and mastitis can be caused by:
    - Infrequent breastfeeding – maybe because the baby wakes infrequently, hunger signs are missed, or the mother is very busy.
    - Inadequate removal of milk from one area of the breast.
    - Local pressure on one area of the breast, from tight clothing, lying on the breast, pressure of the mother's fingers on the breast, or trauma to the breast.
- A woman with a **blocked duct** may tell you that she can feel a lump, and the skin over it may be red. The lump may be tender. The mother usually has no fever and feels well.
- A woman with **mastitis** may report some or all of the following signs and symptoms:
    - pain and redness of the area;
    - fever, chills;
    - tiredness or nausea, headache and general aches and pains.
- The symptoms of mastitis are the same for non-infective and infective mastitis.

- *Show slide 12/4:Picture of mastitis. Note that an area is red and there is swelling. This is severe. Participants and mothers need to learn to recognise blocked ducts and mastitis in an earlier stage so that it does not progress to this severity.*

---

53 Relieving engorgement when a mother is not breastfeeding is discussed in the Additional Information section for this session.
54 See Session 11 for details of how to express milk.

Assessment of a mother with a blocked duct or mastitis

- The important part of treatment is to improve the drainage of milk from the affected part of the breast.
  - Observe a breastfeed. Notice where the mother puts her fingers and if she presses inwards, perhaps blocking the milk flow.
  - Notice if her breasts are very heavy. If the blocked duct or mastitis is in the lower area, lifting the breast while feeding the baby may help that part of the breast to drain better.
  - Ask about frequency of feeds and if the baby is allowed to feed for as long as the baby wants.
  - Ask about pressure from tight clothes, especially a bra worn at night, or trauma to the breast.

Treatment of mastitis

- Explain to the mother that she MUST:
  - Remove the milk frequently (if not removed, an abscess may form).
  - The best way to do this is to continue breastfeeding her baby frequently.
  - Check that her baby is well attached.
  - Offer her baby the affected breast first (if not too painful).
  - Help the milk to flow.
  - Gently massage the blocked duct or tender area down towards the nipple before and during the feed.
  - Check that her clothing, especially her bra, does not have a tight fit.
  - Rest with the baby so that the baby can feed often. The mother should drink plenty of fluids. The employed mother should take sick leave if possible.

Rest the mother, not the breast!

- If the mother or baby is unwilling to feed frequently, it is necessary to express the milk[55]. Give this milk to the baby. If the milk is not removed, milk production can cease and the breast becomes more painful, possibly resulting in an abscess.

Drug treatment for mastitis

- Anti-inflammatory treatment is helpful in reducing the symptoms of mastitis. Ibuprofen is appropriate if available. A mild analgesic can be used as an alternative.
- Antibiotic therapy is indicated if:
  - The mother has a fever for twenty four hours or more.
  - There is evidence of possible infection, for example an obviously infected cracked nipple.
  - The mother's symptoms do not begin to subside within 24 hours of frequent and effective feeding and/or milk expression.
  - The mother's condition worsens.
- The prescribed antibiotic[56] must be given for an adequate length of time. Ten to fourteen days is now recommended by most authorities to avoid relapse.

55 See Session 11 for details on expressing milk.
56 Generally oral antibiotics are used - erythromycin, flucloxacillin, dicloxacillin, amoxacillin, cephalexin. See *Mastitis: causes and management* WHO/FCH/CAH/00.13 for further information.

Mastitis in the woman who is HIV-positive

- In a woman who is HIV-positive, mastitis or nipple fissure (especially if bleeding or oozing) may increase the risk of HIV transmission.
- If an HIV-positive woman develops mastitis, an abscess or a nipple fissure, she should avoid breastfeeding from the affected breast while the condition persists. She must express milk from the affected breast, by hand or pump, to ensure adequate removal of milk. This is essential to prevent the condition becoming worse, to help the breast recover, and to maintain milk production. The health worker should help her to ensure that she is able to express milk effectively.
- Antibiotic treatment is usually indicated in a woman with HIV. The prescribed antibiotic must be given for an adequate length of time. Ten to fourteen days is now recommended by most authorities to avoid relapse.
- If only one breast is affected, the infant can feed from the unaffected side, feeding more often and for longer to increase milk production. Most infants get enough milk from one breast. The infant can feed from the affected breast again when the breast has recovered.
- If both breasts are affected, the mother will not be able to feed from either side. The mother will need to express her milk from both breasts. Breastfeeding can resume when the breasts have recovered.
- The health worker will need to discuss other interim feeding options (AFASS). The mother may decide to heat-treat her expressed milk[57], or to give home prepared or commercial formula. The infant should be fed by cup[58].
- Sometimes a woman may decide to stop breastfeeding at this time, if she is able to give another form of milk safely. She should continue to express enough milk to allow her breasts to recover and to keep them healthy, until milk production ceases.

3. Sore Nipples 10 minutes

- Breastfeeding should not hurt! Some mothers find their nipples are slightly tender at the beginning of a feed for a few days. This initial tenderness disappears in a few days as the mother and baby become better at breastfeeding. If this tenderness is so painful that the mother dreads putting the baby to the breast, or there is visible damage to the nipples, this soreness is not normal, and needs attention.
- The most common early causes of nipple soreness are simple and avoidable. If mothers in your facility are getting sore nipples, make sure that all maternity staff know how to help mothers get their babies attached to the breast. If babies are attached well at the breast and breastfeed frequently, most mothers do not get sore nipples.

57 This milk can be heat treated and used for the baby. Small lumps may form in the milk after heating, but these lumps can be removed and the milk used.
58 Session 11 describes milk expression and cup feeding.

Observation and history taking for sore nipples

- Ask the mother to describe what she feels.
  - Pain at the start of a feed that fades when the baby lets go, is most likely related to attachment.
  - Pain that gets worse during the feed and continues after the feed has finished, often described as burning or stabbing, is more likely to be caused by *Candida albicans*[59].
- Look at the nipples and breast.
  - Broken skin is usually caused by poor attachment.
  - Skin that is red, shiny, itchy, and flaky, at times with loss of pigmentation, is more often seen with Candida.
  - Remember Candida and trauma from poor attachment can exist together.
  - Similar to other parts of the body, the nipple and breast can have eczema, dermatitis and other skin conditions.

- *Show slides of sore nipples:*
- *12/5:This nipple has an open sore in a line across the tip of the nipple. This is likely to be the result of poor attachment*
- *12/6:This nipple is red and sore. Notice the red marks and bruising around the areola. This is likely to be the result of poor attachment*

- Observe a complete breastfeed. Use the *Breastfeed Observation Aid*.
  - Check how the baby goes on the breast, and his or her attachment and suckling.
  - Notice if the mother ends the feed or if the baby lets go himself or herself.
  - Observe what the nipple looks like at the end of the feed. Does it look misshapen (squashed), red or have a white line?
- Check the baby's mouth for tongue-tie and Candida.
- Ask the mother about previous history of Candida or anything that might contribute to Candida such as recent use of antibiotics.
- If a mother is using a breast pump, check that it is appropriately positioned and the suction is not too high.
- Decide the cause of the sore nipple. The most common causes of sore nipples are:
  - Poor attachment.
  - Secondary to engorgement, or both caused by poor attachment.
  - Baby is 'pulled' off the breast to end a feed without the mother first breaking the seal between the baby's mouth and the breast.
  - A breast pump that may cause excess stretching of the nipple and breast or rub against the breast.
  - Candida that can be passed from the baby's mouth to the nipples.
  - The infant's tongue-tie (short frenulum), which prevents the tongue reaching over the lower gum thus causing friction on the nipple.
- There are many other less common causes of sore nipples. Arrange for a mother to be seen by someone who has training to investigate these less common causes, if needed[60].

59 Oral candida is also called thrush.
60 This course does not train participants to deal with complex or rare breastfeeding situations. Establish to whom participants could refer a mother if her breastfeeding difficulty is complex.

Management of sore nipples

- Reassure the mother that sore nipples can be healed and prevented in future.
- Treat the cause of the sore nipples:
  - Help the mother improve attachment and positioning. This may be all that is needed. If necessary, show the mother how to feed baby in different feeding positions. This helps to ease any pain mother is experiencing because baby will be putting pressure on a different area of the sore nipple and allows her to continue feeding while the nipple heals.
  - Treat skin conditions or remove source of irritation. Treat Candida both on the mother's nipples and in the baby's mouth.
  - If the baby's frenulum is so short that the tongue cannot extend over the lower gum, and the mother's nipples have been sore for two to three weeks, consider if the baby should be referred and the frenulum clipped.
- Suggest comfort measures while the nipples are healing:
  - Apply expressed breast milk to the nipples after a breastfeed to lubricate and soothe the nipple tissue.
  - Apply a warm, wet cloth to the breast before the feed to stimulate letdown.
  - Begin each breastfeed on the least sore breast.
  - If the baby has fallen asleep at the breast and is no longer actively feeding but remains attached, gently remove the baby from the breast.
  - Wash nipples only once a day, as for normal body hygiene, and not for every feed. Avoid using soap on nipples, as it removes the natural oils[61].

What <u>does not help</u> sore nipples

- DO NOT stop breastfeeding to rest the nipple. The mother may become engorged, which makes it harder for the baby to attach to the breast. The milk supply will decrease if milk is not removed from the breast.
- DO NOT limit the frequency or length of breastfeeds. Limiting feeds will not help if the basic problem is not addressed. One minute of suckling with poor attachment can cause damage to the breast. Twenty minutes of suckling with good attachment will not cause damage to the breast.
- DO NOT apply any substances to the nipples that would be harmful for the baby to take into his or her mouth, which requires removal before breastfeeding, or which can sensitise the mother’s skin and make the nipple more sore. An ointment is not a substitute for correct attachment.
- *(Include if nipple shields are available in the area)* DO NOT use a nipple shield as a routine measure. A nipple shield may cause more problems. Some shields result in less stimulation of the breast and reduce the amount of milk transferred, which may lead to reduced production. It can affect the way the baby sucks resulting in more soreness when it is stopped. It also presents a health risk to the baby from the possibility of contamination.

61 This is normal washing procedure, not just for when nipples are sore.

4. Small group work 25 minutes

Divide participants into groups of 4 people. Give each group one case study and ask them to discuss the questions. Encourage them to role-play so that they actually ask the questions and use communication skills. Remind them that practicing the actual phrases that they will use with the mother is useful even if they find it challenging at first.
Point to the list of Communication Skills and remind participants to use them. Facilitators can circulate to ensure that participants understand the exercise.
If there is time, you can ask each group to role-play their case study for the other groups.

- *Ask if there are any questions. Then summarise the session.*

Session 12 Summary

Examination of the mother's breasts and nipples

- Always observe the condition of the mother's breasts when you observe a breastfeed. In most cases, this is all that you need to do, as you can see most important things when she is putting the baby onto the breast, or as the baby finished a feed.
- Examine mothers' breasts only if a difficulty arises. Ensure privacy and ask permission before touching.
- Look at the shape of breasts and nipples. Look for swelling, skin damage or redness. Look for evidence of past surgery.
- Talk to the mother about what you have found. Highlight the positive signs you see. Build her confidence in her ability to breastfeed.

Preventing engorgement

- Fullness is normal in the early days. Over-fullness is not normal.
- Follow the practices of the Ten Steps:
  - Facilitate skin-to-skin contact immediately after birth and initiate exclusive, unlimited breastfeeding within one hour after birth (Step 4).
  - Show mothers who need help how to attach their baby at the breast (Step 5).
  - Show mothers how to express their milk (Step 5).
  - Breastfeeding exclusively with no water or supplements (Step 6).
  - Keep mothers and babies together in a caring atmosphere (Step 7).
  - Encourage babies to feed at least 8-12 times in 24 hours during the early days (Step 8).
  - Give no pacifiers, artificial teats, or bottles (Step 9).

Treating engorgement

- Remove the breast milk and promote continued lactation.
- Correct any problems with attachment.
- Gently express some milk to soften the areola and help the baby's attachment.
- Breastfeed more frequently.
- Apply cold compresses to the breasts after a breastfeed for comfort.
- Build the mother's confidence and help her to be comfortable.

Blocked milk ducts and mastitis (breast inflammation)

- May be caused by infrequent breastfeeding, inadequate removal of milk, or pressure on a part of the breast.

Treatment

- Improve milk flow:
  - Check the baby's attachment and correct/improve if needed.
  - Check for tight fitting clothing or pressure from fingers
  - Support a large breast to assist milk flow
- Suggest:
  - Breastfeed frequently. If necessary, express milk to avoid fullness.
  - Gently massage towards the nipple.
  - Apply a moist, warm cloth to the area before a breastfeed to help milk flow.
  - Rest the mother not the breast.
  - Anti-inflammatory treatment or analgesic if in pain.

- Antibiotic therapy is indicated if:
  - The mother has a fever for longer than 24 hours.
  - The mother's symptoms do not begin to subside after 24 hours of frequent and effective feeding and/or milk expression.
  - The mother's condition worsens.
- If a woman is HIV-positive and develops mastitis or an abscess she should:
  - Avoid breastfeeding from the affected breast while the condition persists.
  - Express the milk from that breast, which can be heat-treated and given to the baby.
  - Rest, keep warm, take fluids, pain relief and antibiotics.

Sore nipples

- Decide the cause, including observation of a feed. Examine the nipples and breasts.
- Reassure the mother.
- Treat the cause - poor attachment is the most common cause of sore nipples.
- Avoid limiting the frequency of feeds.
- Refer skin conditions, tongue-tie and other less common conditions to a suitably trained person.

Session 12 Knowledge Check

What breastfeeding difficulties would suggest to you that you need to examine a mother's breasts and nipples?

Rosalia tells you she became painfully engorged when she breastfed her last baby. She is afraid it will happen with the next baby too. What will you tell her about preventing engorgement?

Bola complains that her nipples are very sore. When you watch her breastfeed, what will you look for? What can you do to help her?

Describe the difference between a blocked duct, non-infective mastitis and infective mastitis. What is the most important treatment for all of these conditions?

Stories for small group practice

Mrs A. tells you her breast is sore. You look at her breast and see that a section of it is red, tender to touch and Mrs A. indicates a lump. She does NOT have a temperature. Her baby is 3 weeks old. Mrs. A probably has ......

What could you say to empathise with Mrs. A?

What are possible reasons this situation has occurred?

What questions might you want to ask?

What relevant information will you give Mrs. A?

What suggestions can you offer Mrs A so that this problem can be overcome and breastfeeding can continue?

What practices could be encouraged to avoid this problem re-occurring?

Mrs B. tells you that she feels as if she has had flu for the last two days. She aches all over and one breast is sore. When you look at the breast a part of it is hot, red, hard and very tender. Mrs B has a temperature and feels too ill to go to work.

Her baby is 5 months old and breastfeeding was going well. The baby feeds frequently at night. Mrs B expresses her milk before she goes to work to leave for the baby and feeds the baby as soon as she comes home from work. She is very busy at work and finds it hard to get time to express during the day.

Mrs B. probably has ......

What could you say to empathise with Mrs. B?

What are possible reasons this situation has occurred?

What questions might you want to ask?

What relevant information will you give Mrs. B?

What suggestions can you offer Mrs B so that this problem can be overcome and breastfeeding can continue?

What practices could be encouraged to avoid this problem re-occurring?

Mrs C's baby was born yesterday. She tried to feed him soon after birth, but he did not suckle well. Mrs C says her nipples are inverted and she cannot breastfeed. You examine her breasts and notice that her nipples look flat when not stimulated. You ask Mrs C to use her fingers to stretch her nipple and areola out a short way. You can see that her nipple stretches easily.

What could you say to accept Mrs C's idea about her nipples?

How could you build her confidence?

What practical suggestions could you give Mrs C to help her feed her baby?

Additional information Session 12

Breast examination

First *Ask*

- How did breasts change during pregnancy? If breasts become larger and the areola become darker during pregnancy this usually indicates that there is plenty of milk producing tissue.
- Has she had breast surgery at any time, which may have cut some milk ducts or nerves, or for a breast abscess?

Next *look*

- Are the breasts very large or very small? Reassure the woman that small and large breasts all produce plenty of milk, but sometimes a mother may need help with attachment.
- Are there any scars which may indicate past problems with breastfeeding such as an abscess or surgery?
- Is either breast swollen, with tight shiny skin? This suggests engorgement with oedema. Normal fullness, when the milk comes in, makes the breast larger, but not swollen with shiny oedematous skin.
- Is there redness of any part of the breast skin? If diffuse or generalised, this may be due to engorgement. If localised, this may be a blocked duct (small area) or mastitis (larger clearly defined area). Purple discoloration suggests a possible abscess.
- What is the size and shape of the nipples? (long or flat, inverted, very big). Could their shape make attachment difficult?
- Are there any sores or fissures (a linear sore)? This usually means that the baby has been suckling while poorly attached.
- Is there a rash or redness of the nipple?

Next *feel*

- Is the breast hard or soft? Generalised hardness, sometimes with several lumps, may be due to normal fullness or engorgement. The appearance of the skin (shiny with engorgement or normal with fullness) and flexibility of the skin (turgid) should tell you which it is.
- Talk to the mother about what you have found. Highlight the positive signs you see. Do not sound critical about her breasts. Build her confidence in her ability to breastfeed.

Assisting the mother with inverted nipples

- If the mother appears to have inverted nipples:
    - Ensure uninterrupted skin-to-skin contact immediately after birth and at other times, to encourage the baby to find his/her own way to the breast, in his/her own time.
    - Give extra help with positioning and attachment in the first day or two, before the breasts become full. Explain to the mother with an inverted nipple that the baby latches on to the areola not on to the nipple.
    - Help the mother to find a position that helps her baby to take the breast. For example, sometimes leaning over the baby on a table so that the breast falls towards his or her mouth can help.
    - Suggest that she gently change the shape of the areola into a cone shape or sandwich using C-shaped hold, so that baby can latch onto it.
    - Explain that babies may need time to learn and then will latch on spontaneously.
    - Suggest that the mother stroke her baby’s mouth with the nipple and wait until the baby opens with a very wide mouth before bringing the baby on to the breast. Teach the mother how to recognise effective attachment.
    - Encourage the mother to help her nipples protrude before a feed. She can gently stimulate her nipple; use a breast pump, another mild suction device, or someone else sucking (if acceptable) to draw out the nipple.

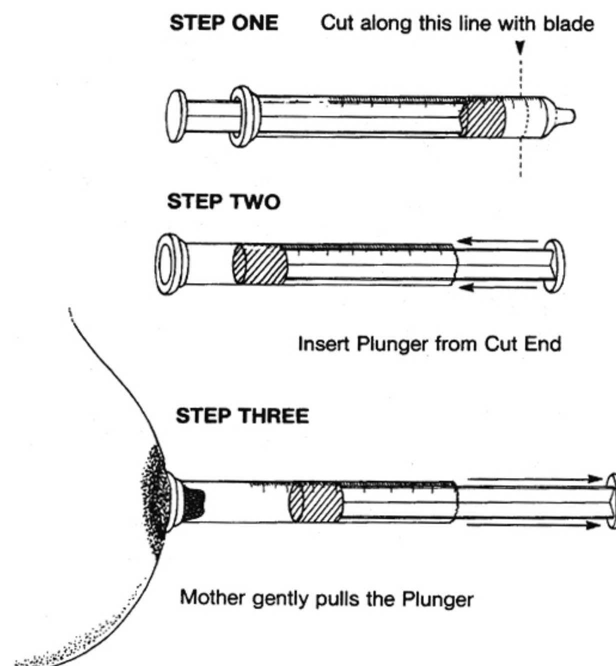
- Avoid artificial teats and pacifiers as these devices may make it more difficult for a baby to attach and take a large mouthful of breast.
- Prevent breast engorgement as this makes attachment difficult for the baby. If necessary, express and feed by cup while the baby learns to breastfeed.

Syringe method for treatment of inverted nipples

This method can help an inverted nipple to stand out and assist a baby to attach to the breast. The mother must use the syringe herself, so that she can control the amount of suction and avoid hurting her nipple.

- Take a syringe at least 10 ml in size and if possible 20 ml so that it is large enough to accommodate the mother's nipple.
- Cut off the adaptor end of the barrel (where the needle is usually fixed). You will need a sharp blade or scissors.
- Reverse the plunger so that it enters the cut (now rough) end of the barrel.
- Before she puts the baby to her breast, the mother:
    - Pulls the plunger about one-third of the way out of the barrel.
    - Puts the smooth end of the syringe over her nipple.
    - Gently pulls the plunger to maintain steady but gentle pressure for about 30 seconds.
    - Pushes the plunger back slightly to reduce suction as she removes the syringe from her breast.
- Tell the mother to push the plunger back to decrease the suction, if she feels pain. This prevents damaging the skin of the nipple and areola.

Slide 10/7: Syringe method for an inverted nipple



Adapted from: N. Kesaree, et al, (1993) Treatment of Inverted Nipples Using Disposable Syringe, *Journal of Human Lactation;* 9(1): 27-29

Class discussion: Engorgement (optional)

Maria gave birth three days ago to a healthy baby. Her baby is in the nursery and is only brought to her for feeding at scheduled times. As the midwife makes rounds in the postpartum ward, she finds that Maria's breasts are much engorged and Maria says they are painful.

What can the midwife do to help this mother?

How could her engorgement have been prevented?

How can Maria avoid becoming engorged again?

RELIEVING ENGORGEMENT WHEN A MOTHER IS NOT BREASTFEEDING

Support the breasts well to make her more comfortable (however, do not bind the breasts tightly, as this may increase her discomfort).

Apply compresses. Warmth is comfortable for some mothers, while others prefer cold compresses to reduce swelling and pain.

Express enough milk to relieve discomfort. Expression can be done a few times a day when the breasts are overfull. It does not need to be done if the mother is comfortable. Remove less milk than the baby would take, so as not to stimulate milk production.

Relieve pain. An analgesic, such as ibuprofen or paracetamol, may be used[62].
Some women use plant products such as teas made from herbs or plants, or raw cabbage leaves, placed directly on the breast to reduce pain and swelling.

The following are not recommended:
Pharmacological treatments to reduce milk supply[63]. The above methods are considered more effective in the long term.

62 Aspirin is not the first choice for breastfeeding women as it has been linked with Reye's condition in the infant.
63 Pharmacological treatments which have been tried include:
—Stilboestrol (diethylstilbestrol) - side effects include withdrawal bleeding, and thromboembolism.
—Oestrogen - breast engorgement and pain decreases but may recur when the drug is discontinued.
—Bromocriptine - inhibits prolactin secretion. Side effects including maternal deaths, seizures and strokes. Withdrawn from use for postpartum women in many countries.
—Cabergoline - inhibits prolactin secretion. Considered safer than bromocriptine. Possible side effects include headache, dizziness, hypotension, nose bleed.

Treatment of a breast abscess

- If mastitis is not treated early, it may develop into an abscess. An abscess is a collection of pus within the breast. It produces a painful swelling, sometimes with bruising discoloration.
- An abscess needs to be aspirated by syringe or surgical drainage by a health worker.
- The mother[64] may continue breastfeeding if the drainage tube or incision is far enough from the areola not to interfere with attachment.
- If the mother is unable or unwilling to breastfeed on that breast because of the location of the abscess, she needs to express her milk. Her baby can start to feed again from that breast as soon as it starts to heal (usually 2-3 days).
- The mother can continue to feed from the unaffected breast as normal.
- Good management of mastitis should prevent formation of an abscess.

Nipple shields

- Sometimes a nipple shield is offered as a solution for a baby who does not suck well or if the mother has sore nipples. Nipple shields may cause difficulties. They can:
  - Reduce stimulation of the breast and nipple and thus can reduce milk production and the oxytocin reflex.
  - Increase the risk of low weight gain and dehydration.
  - Interfere with the baby suckling at the breast without a shield.
  - Harbour bacteria or thrush and infect the baby.
  - Cause irritation and rub the mother's nipple.
- The mother, baby and health worker may become dependent on the shield and find it difficult to do without it.
- Stop and think before recommending a nipple shield. If used as a temporary measure for a clinical need, ensure that the mother has follow-up assistance to enable her to discontinue using the shield.

Candida (Thrush) infection

- Thrush is an infection caused by the yeast Candida albicans. Candida infections often follow the use of antibiotics to treat mastitis, or other infections, or if used following a caesarean section. It is important to treat both the mother and the baby so that they will not continue to pass the infection back and forth.
- Soreness from poor positioning can occur at the same time as Candida; before starting treatment for Candida, check for other causes of nipple pain such as poor attachment.

- *12/8: Candida on a dark-skinned nipple*
- *12/9: Candida on a light-skinned nipple*

- Signs of a thrush infection are:
  - The mother's nipples may look normal or red and irritated. There may be deep, penetrating pain and the mother may state that her nipples "burn and sting" after a feed.
  - The nipples remain sore between feeds for a prolonged time despite correct attachment. This may be the only sign of the infection.
  - The baby may have white patches on the skin in his or her mouth.
  - The baby may have a fungal diaper rash.
  - The mother may have a vaginal yeast infection.

64 If the mother is HIV-positive, it is not recommended that she continue to breastfed from a breast with an abscess.

Treatment for thrush

- Use a medication for the nipples and for the baby's mouth according to local protocols. Continue to use for 7 days after soreness has gone. Use medication that does not need to be washed off the nipples before a breastfeed.

- *Name some commonly used treatments for Candida.*

- Some women find it helpful to air dry and expose the nipples to sunlight after each breastfeed. Change bra daily and wash it in hot soapy water. If breasts pads are worn, replace them when they become moist.
- If a vaginal Candida infection is present, treat it. The woman's partner may need to be treated also.
- Wash hands well after changing the baby's diapers and after using the toilet.
- Stop the use of any dummies, pacifiers, teats, or nipple shields; if they are used, they must be boiled for 20 minutes daily and replaced weekly.

Tongue-Tie

- An infant may have "tongue-tie" because of a short frenulum, which restricts tongue movement to the extent that the tongue cannot extend over the lower gum. The tongue then rubs against the base of the nipple causing soreness *(slide 12/10).*

SESSION 13
MATERNAL HEALTH CONCERNS

Session Objectives:

On completion of this session, participants will be able to:

1.	Discuss nutritional needs of breastfeeding women.	10 minutes
2.	Outline how breastfeeding assists in child spacing.	10 minutes
3.	Discuss breastfeeding management when the mother is ill.	15 minutes
4.	Review basic information on medications and breastfeeding.	10 minutes
	Total session time	**45 minutes**

Materials:

Slide 13/1: Lactation Amenorrhea Method LAM
Slide 13/2: Recommendation for women who are HIV-positive

MATERNAL ILLNESS AND BREASTFEEDING – a copy for each participant (optional).

BREASTFEEDING AND MOTHER'S MEDICATION SUMMARY – a copy for each participant (optional).
Full copy for display of WHO/UNICEF *Breastfeeding and Maternal Medications* (2002).

Further Reading for facilitators:

Hepatitis B and breastfeeding, UPDATE No.22, November 1996 CHD, WHO Geneva.

Breastfeeding and maternal tuberculosis, UPDATE No. 23, Feb 1998 CHD, WHO Geneva.

WHO. *Nutrient requirements for people living with HIV/AIDS – report of a technical consultation.* (May 2003) Geneva.

WHO/UNICEF *Breastfeeding and maternal medication: Recommendations for drugs in the eleventh WHO model list of essential drugs* (2002) CHD, WHO, Geneva.

WHO/UNICEF *Acceptable medical reasons for use of breast-milk substitutes*. World Health Organization, Geneva 2009.

1. Nutritional needs of breastfeeding women 10 minutes

- *Show picture of two mothers in bed talking to nurse or at table talking to each other.*

Fatima's mother told her that she needs to eat special foods to make good milk and that some foods can affect her baby.

Ask: What can you say to a woman who asks about what she should eat or avoid eating when she is breastfeeding?

Wait for a few responses.

- All mothers need to eat enough foods and drink enough liquids to feel well and be able to care for their family. If a mother eats a variety of foods in sufficient amounts, she will get the proteins, vitamins and minerals that she needs. Mothers do not need to eat special foods or avoid certain foods when breastfeeding.
- A woman's body stores fat during pregnancy to help make milk during breastfeeding. She makes milk partly from these stores and partly from the food that she eats.
- A mother needs to be in a state of severe malnutrition for her breast milk production to decrease significantly. If there is a shortage of food, she first uses her own body stores to make milk. Her milk may be reduced in quantity and slightly lower in fat and some vitamins compared to that of a well-nourished mother, but it is still good quality.
- Poor food choices or missing a meal does not reduce milk production. However, a mother who is overworked, lacks time to eat, and does not have sufficient food or who lacks social support may complain of tiredness and a low milk supply. Care for the mother and time to feed the baby frequently, will help to ensure adequate milk production.
- Breastfeeding is important for food security for the whole family. If resources are limited, it is better to give the mother food so that she can care for her baby than to give artificial feeds to the baby. Discuss this with the family.
- Breastfeeding mothers are often encouraged to drink large quantities of fluid. Drinking more fluid than is needed for thirst will not increase milk supply, and may even reduce it. A mother should drink according to her thirst or if she notices that her urine output is low or concentrated.

- *Mention any food assistance programmes that are available in the area for pregnant or breastfeeding women.*

2. How breastfeeding helps to space pregnancies 10 minutes

Fatima has heard that breastfeeding helps to space her pregnancies, but she wants to know if this is true.

Ask: What can you tell a mother about how breastfeeding helps to space children?

Wait for a few responses.

- Breastfeeding can delay the return of ovulation and menstruation; and thus can help to space pregnancies. The Lactation Amenorrhea Method (LAM) helps women who wish to use breastfeeding for child spacing.

- *Show slide 13/1: LAM*

- The LAM method is 98% effective in preventing conception if three conditions are met:
  - the mother is not menstruating, and
  - the mother is exclusively breastfeeding, (day and night) with no very long intervals between feeds, and
  - baby is less than 6 months old.
- If any of these three conditions are not met, it is advisable for the mother to use another method of family planning to achieve pregnancy delay.
- Most family planning methods are compatible with breastfeeding with exception of oestrogen containing contraceptive pills.

3. Breastfeeding management when the mother is ill 15 minutes

Fatima has heard from a neighbour that if a breastfeeding mother gets a fever or needs to take any medications that she must stop breastfeeding.

Ask: What can you tell a mother about breastfeeding if the mother is ill?
Wait for a few responses.

- Women can continue to breastfeed in nearly all cases when they are ill. There are many benefits to continuing breastfeeding during illness:
  - A woman's body makes antibodies against her infections, which go into the breast milk and which can help to protect the baby from the infection.
  - Suddenly stopping breastfeeding can lead to sore breasts[65] and the mother may develop a fever.
  - A baby may show signs of distress, such as crying a lot, if breastfeeding suddenly stops.
  - It may be difficult to return to breastfeeding after the mother has recovered as her milk production may have decreased.
  - Stopping breastfeeding leaves the baby exposed to all the hazards of artificial feeding.
  - Breastfeeding is less work than preparing formula, sitting up to feed and sterilising bottles. The baby can lie beside the mother and feed as needed without her moving.
  - Mother and baby can stay together, so she knows her baby is safe and happy.
  - The baby continues to receive the benefits of breastfeeding: protects health, best nutrition, optimal growth, and development, less risk of obesity and later health problems.
- Mothers with chronic illness may need extra help to establish breastfeeding. For example, a mother with diabetes may experience complications during birth, which can interfere with establishing breastfeeding, but with appropriate help she can breastfeed normally.

Ask: What kind of help with breastfeeding may be needed if a mother is ill?
Wait for a few responses.

65 Mastitis was covered in Session 12.

To assist breastfeeding when a mother is ill:

- Explain the value of continuing to breastfeed during her illness.
- Minimise separation, keeping mother and baby together.
- Give plenty of fluids, especially if she has a fever.
- Assist the mother to find a comfortable position for feeding or show someone else how to help her to hold the baby comfortably.
- If breastfeeding is difficult or the mother is too unwell, she may be able to (or helped to) express her milk and the baby can be feed breast milk by cup until she is better.
- Choose treatments and medications that are safe for breastfeeding.
- Assist the mother to re-establish breastfeeding after she recovers, if there has been an interruption during the illness.

Ask: Are there any situations related to the mother's health that may require the use of foods other than breast milk?

Wait for a few responses.

- There are very few situations related to maternal health that require the use of artificial feeds. It is important to distinguish if it is the illness that is a contraindication to breastfeeding or the situation surrounding the illness that makes breastfeeding difficult.
- **Hospitalisation** of itself is not a contraindication to breastfeeding. If a mother is hospitalised, the baby should be kept with the mother. If the mother is not able to care for her infant, a family member can be asked to stay and help her with the infant. **Maternal use of substances**: Maternal use of nicotine, alcohol, ecstasy, amphetamines, cocaine and related stimulants has been demonstrated to have harmful effects on breastfed babies; alcohol, opioids, benzodiazepines and cannabis can cause sedation in both the mother and the baby. Mothers should be encouraged not to use these substances and given opportunities and support to abstain.
- If a mother has a **common contagious illness** such as a chest infection, sore throat, or gastrointestinal infection, there is a risk to the baby from being near the mother and exposed to the infection though contact, coughing and such. When the mother continues to breastfeed, the baby receives some protection from the infection. If breastfeeding stops at this time, the baby is at higher risk of contracting the mother's infection. For most maternal infections, including tuberculosis, hepatitis B, and mastitis, breastfeeding is not contraindicated.
- If a mother is not able to breastfeed, efforts should be made to find a wet-nurse (of known HIV-negative status) or to obtain heat-treated breast milk from a breast-milk bank.

- *Give participants a copy of* MATERNAL ILLNESS AND BREASTFEEDING *and let them read through the list in their own time. Clarify any points as needed.*

If the mother has HIV/AIDS

- *Show slide 13/2*

- As we said Session 1, in the situation where the woman is tested and found to be HIV-positive, the recommendation is:

> **UNICEF/WHO Infant Feeding Recommendation for HIV-positive Women**
>
> Exclusive breastfeeding is recommended for HIV-infected mothers for the first six months of life unless replacement feeding is acceptable, feasible, affordable, sustainable and safe for them and their infants before that time. When replacement feeding is acceptable, feasible, affordable, sustainable and safe avoidance of all breastfeeding by HIV-infected mothers is recommended

- Each woman who is HIV-positive needs a one-to-one discussion with a trained person to help her to decide the best way to feed her child in her individual situation.

4. Medications and breastfeeding[66] 10 minutes

- If a mother requires medication, it is often possible for the doctor to prescribe a drug that may be safely taken during breastfeeding. Most drugs pass into breast milk only in small amounts and few affect the baby. In most cases, stopping breastfeeding may be more dangerous to the baby than the drug.
- A medication the mother takes is more likely to affect a premature baby or a baby less than two months old than an older baby. If there is a concern, it is usually possible to find a drug or treatment that is more compatible with breastfeeding.
- If a breastfeeding mother is taking a drug that you are not sure about:
  - Encourage the mother to continue breastfeeding while you find out more.
  - Watch the baby for side effects such as abnormal sleepiness, unwillingness to feed, and jaundice, especially if the mother needs to take the drug for a long time.
  - Check the WHO list, (explain where to get this list or other locally available list that is breastfeeding supportive).
  - Ask a more specialized health worker, for example a doctor or pharmacist for more information, and to find an alternative drug that is safer if needed.
  - If the baby has side effects and the mother's medication cannot be changed, consider a replacement feeding method, temporarily if possible.
- Traditional treatments, herbal medicines and other treatments may have effects on the baby. Try to find out more about them if they are commonly used in your area. Meantime encourage the mother to continue breastfeeding and to observe the baby for side effects.

- *Give participants the summary of "BREASTFEEDING AND MOTHER'S MEDICATION" or tell them where they can obtain the full text of the booklet. Point out the categories of drugs in the summary – contraindicated, and continue breastfeeding with monitoring.*
- *Ask if there are any questions. Then summarise the session.*

66 The target audience for this course are not expected to recommend medications.

Session 13 Summary

Nutritional needs of breastfeeding women

- All mothers need to eat enough foods so that they will feel well and be able to care for their families.
- Mothers do not need to eat special foods or avoid certain foods when breastfeeding.
- If the food supply is limited, it is better for the health and nutrition of both mother and baby and less expensive to give the mother food so that she can care for her baby than to give artificial feeds to the baby.

How breastfeeding helps to space births

- The LAM method is 98% effective if three conditions are met:
  - the mother is not menstruating;
  - the mother is exclusively breastfeeding, with no very long intervals between feeds;
  - baby is less than 6 months old.
- If any of these three conditions are not met it is advisable for the mother to use another method of family planning.

Breastfeeding management when the mother is ill

- You can assist breastfeeding during maternal illness by:
  - Explaining the value of continuing to breastfeed during illness.
  - Minimising separation, keeping mother and baby together.
  - Giving plenty of fluids, especially if there is a fever.
  - Assisting the mother to find a comfortable position for feeding.
  - Assisting mother to express, and feeding the baby breast milk by cup if the mother is too unwell to breastfeed.
  - Choosing treatments and medications that are safe for breastfeeding.
  - Assisting mother and baby to re-establish breastfeeding when the mother recovers, if she has not breastfed during her illness.

Medications and breastfeeding

- Often, if a medication is needed, one can be used that is safe for her baby. Most drugs pass into breast milk only in small amounts and few affect the baby. In most cases, stopping breastfeeding may be more dangerous to the baby than the drug.
- Watch the baby for side effects and find out more about the drug if you are worried. Babies under 2 months of age are more likely to show side effects.
- Know where to get more information or advice on medications.

Session 13 Knowledge Check

A pregnant woman says to you that she cannot breastfeed because she would need to buy special foods for herself that she could not afford. What can you say to her to help her see that breastfeeding is possible for her?

A co-worker says to you that a mother will need to stop breastfeeding because she needs to take a medication. What can you reply to this co-worker?

Maternal Illness and Breastfeeding

Exclusive breastfeeding in the first six months of life is particularly beneficial for mothers and infants and is the norm. Nevertheless, a small number of health conditions of the infant or the mother may justify recommending that she does not breastfeed temporarily or permanently. These conditions, which concern very few mothers and their infants, are listed below together with some health conditions of the mother that, although serious, are not medical reasons for using breast-milk substitutes.

Mothers who are affected by any of the conditions mentioned below should receive treatment according to standard guidelines.

Mothers who may need to avoid breastfeeding

This category includes women with HIV infection: if replacement feeding is acceptable, feasible, affordable, sustainable and safe (AFASS).

Mothers who may need to avoid breastfeeding temporarily

Includes mothers with severe illness that prevents a mother from caring for her infant, for example sepsis; Herpes simplex virus type 1 (HSV-1): direct contact between lesions on the mother's breasts and the infant's mouth should be avoided until all active lesions have resolved;

In this group are also included those with ***maternal medication***:

- Sedating psychotherapeutic drugs, anti-epileptic drugs and opioids and their combinations may cause side effects such as drowsiness and respiratory depression and are better avoided if a safer alternative is available.
- Radioactive iodine-131 is better avoided given that safer alternatives are available - a mother can resume breastfeeding about two months after receiving this substance.
- Excessive use of topical iodine or iodophors (e.g. povidone-iodine), especially on open wounds or mucous membranes, can result in thyroid suppression or electrolyte abnormalities in the breastfed infant and should be avoided.
- Cytotoxic chemotherapy requires that a mother stops breastfeeding during therapy.

Mothers who can continue breastfeeding, although health problems may be of concern *This group includes:*

- Breast abscess: breastfeeding should continue on the unaffected breast; feeding from the affected breast can resume once treatment has started.
- Hepatitis B: infants should be given hepatitis B vaccine, within the first 48 hours or as soon as possible thereafter.
- Hepatitis C;
- Mastitis: if breastfeeding is very painful, milk must be removed by expression to prevent progression of the condition.
- Tuberculosis: mother and baby should be managed according to national tuberculosis guidelines.

Substance use:

- Maternal use of nicotine, alcohol, ecstasy, amphetamines, cocaine and related stimulants has been demonstrated to have harmful effects on breastfed babies.
- Alcohol, opioids, benzodiazepines and cannabis can cause sedation in both the mother and the baby.

Mothers should be encouraged not to use these substances and given opportunities and support to abstain.

References

HIV and infant feeding: update based on the technical consultation held on behalf of the Inter-agency Task Team (IATT) on Prevention of HIV Infection in Pregnant Women, Mothers and their Infants, Geneva, 25–27 October 2006. Geneva, World Health Organization, 2007 (http://whqlibdoc.who.int/publications/2007/9789241595964_eng.pdf, accessed 23 June 2008).

Breastfeeding and maternal medication: recommendations for drugs in the Eleventh WHO Model List of Essential Drugs. Geneva, World Health Organization, 2003.

Mastitis: causes and management. Geneva, World Health Organization, 2000 (WHO/FCH/CAH/00.13; http://whqlibdoc.who.int/hq/2000/WHO_FCH_CAH_00.13.pdf, accessed 24 June 2008).

Hepatitis B and breastfeeding. Geneva, World Health Organization, 1996 (Update No. 22).

Breastfeeding and Maternal tuberculosis. Geneva, World Health Organization, 1998 (Update No. 23).

Background papers to the national clinical guidelines for the management of drug use during pregnancy, birth and the early development years of the newborn. Commissioned by the Ministerial Council on Drug Strategy under the Cost Shared Funding Model. NSW Department of Health, North Sydney, Australia, 2006.

Further information on maternal medication and breastfeeding is available at the following United States National Library of Medicine (NLM) website:
http://toxnet.nlm.nih.gov/cgi-bin/sis/htmlgen?LACT

Breastfeeding and Mother's Medication - Summary

Breastfeeding contraindicated:
- Anticancer drugs (antimetabolites).
- Radioactive substances (stop breastfeeding temporarily).

Continue breastfeeding:

Side-effects possible; monitor baby for drowsiness:
- Selected psychiatric drugs and anticonvulsants (see individual drug).

Use alternative drug if possible:
- Chloramphenicol, tetracyclines, metronidazole, quinolone antibiotics (e.g. ciprofloxacin).

Monitor baby for jaundice:
- Sulfonamides, dapsone, sulfamethoxazole+trimethoprim (cotrimoxazole), sulfadoxine+pyrimethamine (fansidar).

Use alternative drug (may decrease milk supply):
- Estrogens, including estrogen-containing contraceptives, thiazide diuretics, ergometrine.

Safe in usual dosage:

Most commonly used drugs:
- Analgesics and antipyretics: short courses of paracetamol, acetylsalicylic acid, ibuprofen; occasional doses of morphine and pethidine.
- Antibiotics: ampicillin, amoxicillin, cloxacillin and other penicillins, erythromycin.
- Antituberculosis drugs, anti-leprosy drugs (see dapsone above).
- Antimalarials (except mefloquine, fansidar), anthelminthics, antifungals.
- Bronchodilators (e.g. salbutamol), corticosteroids, antihistamines.
- Antacids, drugs for diabetes, most antihypertensives, digoxin.
- Nutritional supplements of iodine, iron, vitamins.

(Adapted from "Breastfeeding counselling: A training course", WHO/CDR/93.3-6)

More information on specific medications can be found in the publication:
WHO/UNICEF Breastfeeding and Maternal Medications (2003)
www.who.int/child-adolscent-health/

SESSION 14
ON-GOING SUPPORT FOR MOTHERS – STEP 10

Session Objectives:

On completion of this session, participants will be able to:

1.	Describe how to prepare a mother for discharge.	15 minutes
2.	Discuss availability of follow-up and support after discharge.	10 minutes
3.	Outline ways of protecting breastfeeding for employed women.	10 minutes
4.	Discuss sustaining breastfeeding for the second year or longer.	10 minutes
5.	Discuss group support for breastfeeding.	30 minutes
	Total session time	**75 minutes**

Materials and Preparation:

Slide 14/1: Mother-to-mother support

Contact details for support in the area, such as mother's groups, community support or feeding clinics in the health centre.

Information on any national legislation or directives on workplace support for breastfeeding.

Information on any national complementary feeding guidelines and policies – check that these materials support exclusive breastfeeding for six months.

Flip chart of Communication Skills from Session 2.

Ask two participants to play the part of 'mothers' in the group support activity and give them the questions to ask.

Further reading for facilitators:

Community based strategies for breastfeeding promotion and support in developing countries. WHO, Department of Child and Adolescent Health and Development (CAH), 2003.

Green, C P. *Mother Support Groups: A Review of Experience in Developing Countries*. BASICS II. 1998 http://www.basics.org/publications/pub/msg/contents.htm

Guiding principles for complementary feeding of the breastfed child . PAHO/WHO, 2003.

1. Preparing a mother for discharge 15 minutes

- Step 10 of the Ten Steps to Successful Breastfeeding states:
  "Foster the establishment of breastfeeding support groups and refer mothers to them on discharge from the hospital or clinic".
- The health facility where the baby is born can do much to initiate and establish breastfeeding or safer replacement feeding if necessary. However, the need for support continues after she is discharged.
- In some communities, mothers are well supported by friends and family. Where this is not available, for example if the mother is living away from her own family, the health facility needs to arrange some alternative follow up. This must be discussed with mothers before discharge.

\- *Tell the next point in the "story":*

Fatima and Miriam are preparing to go home from the hospital with their babies.

Ask: What does a mother need before she leaves the hospital to go home with her baby?
Wait for a few responses.

- Before a mother leaves a maternity facility, she needs to:
  - Be able to feed her baby.
  - Understand the importance of exclusive breastfeeding for 6 months and continued breastfeeding after the introduction of complementary foods to two years and beyond.
  - Be able to recognize that feeding is going well.
  - Find out how to get the on-going support that she needs.

Be able to feed her baby

- A health worker trained in breastfeeding support should observe every mother and baby at a breastfeed and make sure that the mother and baby know how to breastfeed.
- A mother should:
  - Know about baby-led, or demand feeding, and how babies behave.
  - Be able to recognise her baby's feeding signs.
  - Be able to position her baby for good attachment at the breast.
  - Know the signs of effective breastfeeding and a healthy baby.
  - Know what to do if she thinks that she does not have enough milk.
  - Be able to express her milk.
- If a mother is not breastfeeding, a health worker trained to assist with replacement feeding needs to check the mother knows:
  - What type of replacement feeding to use that is acceptable, feasible, affordable, sustainable and safe for her situation.
  - How to obtain the replacement milk in sufficient quantities.
  - How to reduce the risks associated with replacement feeding**.**
- A health worker should observe that the mother (or other caregiver) is able to prepare a replacement feed and feed the baby in a safe manner before the mother and baby are discharged from the maternity unit.

Understand the importance of exclusive breastfeeding and continued breastfeeding

- When a mother returns home there may be pressures on her to supplement her baby with foods or fluids other than breast milk. Before she leaves the maternity facility, remind her of the importance of exclusive breastfeeding for the first six months.
- After six months, a baby needs foods in addition to breast milk. Breast milk continues to provide good nutrition and protection from illness as well as closeness to the mother. Breast milk is valuable for health and nutrition for two years and longer.
- If the mother is HIV-positive and is breastfeeding, it is best if the baby is exclusively breastfeeding. Mixed feeding, giving both breastfeeding/breast milk and other foods and fluids has been shown to increase the risk of transmission of HIV.

Be able to recognize that feeding is going well

- Sometimes we might say to a mother to contact us if there is a problem. A new mother may not know what is normal and what is a problem. Signs that a mother with a young baby can look for that indicate breastfeeding is going well include:
  - Baby is alert and active, feeding at least 8 times in 24 hours.
  - Baby settles and sleeps for some periods in 24 hours.
  - Baby has six or more wet diapers/nappies in 24 hours with pale, diluted urine and is passing stools three or more times a day[67].
  - Breasts are fuller before feeds than after feeds. Breasts and nipples are comfortable and not sore.
  - Mother feels confident caring for her baby in general.

Discuss how to get the support that she needs

- Mothers need support. When a mother goes home she needs a family member, friend, health worker or other person who will help her to become confident as she learns about caring for her baby. A mother needs help particularly if she:
  - Has many demands on her time such as caring for other children and household tasks.
  - Is a first time mother.
  - Has difficulty feeding her baby.
  - Needs to work outside the home and leave her baby.
  - Is isolated with little contact with supportive people.
  - Receives confusing and conflicting advice from many people.
  - If she or the baby has a health problem.
- Sometimes a mother thinks that she should be able to do everything without needing any help. She may think that if she looks for help it will be thought that she is a bad mother or cannot cope.
- When any of us learn a new job or skill we need to take time to learn it and we may need to ask for help from other people. It is similar with learning to be a mother; there are new skills to learn. It may not be enough that support services exist in the area. A new mother may need encouragement to look for help and to use support that is available.
- Follow-up of the mother who is replacement feeding is very important to ensure that she is using the option properly and if she should want to change feeding option at any time she is assisted.

67 In an older baby, stooling may be less frequent. Stools should be soft.

- When talking to a woman during her pregnancy it can be helpful to mention that there are support services available in case she has any difficulty. This may help her to feel confident from the beginning.

2. Follow-up and support after discharge 10 minutes

Resources available in the local community

- *Show slide 14/1: Mother-to-mother support*

Fatima and Miriam meet sometimes, sit, and talk about their babies. Fatima likes to hear what Miriam has to say because this is Miriam's second child and Fatima values Miriam's experience and knowledge.

Ask: Who in the community could provide ongoing support for a mother in feeding and caring for her baby?

Wait for a few replies.

Family and friends

- Families and friends can be an important source of support for breastfeeding in general. However, support for exclusive breastfeeding through six months is often lacking in families where other women have always given early supplements and foods.
- Mothers who are replacement feeding need support from family and friends also. The mother who is HIV-positive may need support to replacement feed exclusively, and avoid mixing breastfeeding and replacement feeding.

Primary Care and community health workers

- Any time a health worker is in contact with a mother and young child, the health worker can help and support the mother in feeding and caring for her baby. If the health worker cannot do so themselves, they may be able to refer the mother to someone else who can provide support.
- Community health workers are often nearer to families than are hospital-based health workers and may be able to spend more time with them. To be effective, community health workers need to be trained to support mothers to feed and care for their babies.
- Community health centres can have "lactation clinics" which means that there are trained staff who will help a breastfeeding mother at the time that she contacts the clinic rather than waiting for an appointment. It may be effective to see more than one mother together so they can exchange experiences. A mother support group can come out of these clinics.
- Health workers can set an example in their own communities by exclusive breastfeeding their own babies with the addition of appropriate complementary foods after six months of age.

Mother to mother support

- This support is usually community-based and may be provided one-to-one or group-based. An experienced mother can provide individual support to a new mother. Ask the experienced mother for permission to give her name to new mothers in her area.
- A group may be started by a few mothers themselves or by a health or community worker. There may be special support groups for women who are HIV-positive.

- The help is easily accessible and free or very inexpensive. Ideally mothers who have been trained to give support are available at any time to help a mother with difficulties[68].
- In a mother-to-mother support group:
  - Help can be available in the mother's own community.
  - Women's traditional patterns of getting information and support from relatives and friends are reinforced.
  - Feeding and caring for a baby are seen as normal activities rather than problems that need to be solved by a health worker.
  - Discussion groups are led and help is given by experienced mothers.
  - Mothers feel reassured and become more self-confident.
  - Pregnant women as well as more experienced mothers are welcome.
  - Mothers can help each other outside of group meetings and build friendships.
- Some mother-to-mother support groups are part of larger networks that provide training, written materials and other services. The experienced mothers leading or facilitating the groups can be invited to contribute to health worker training, and to visit wards and clinics to introduce themselves to pregnant women and new mothers.

When formal support is not available

- If there are no existing support groups available in your area, before the mother leaves the maternity facility:
  - Discuss what family support she has at home.
  - If possible, talk with family members about how they can help.
  - Give the mother the name of a person to contact at the hospital, or at a clinic. She should go for a follow-up check for her and her baby in the first week after birth, which should include observation of a breastfeed. She should also go at any other time if she has any difficulties or questions.
  - She should also go for her routine postpartum 6-week check-up, and take her baby with her, so that she or he can be followed-up too.
  - Remind mothers of the key points about optimal feeding.
  - It is often helpful to give written materials as a reminder. These must be accurate, and not from companies that produce or distribute breast-milk substitutes, bottles or teats.
  - If possible, contact mothers after they are home to learn how feeding is going.
- Some hospitals establish mother support groups that are lead by a health worker and meet in the hospital. There may also be a feeding clinic where the mother can attend if she has a feeding difficulty.

- *Give any specific information such as contact details for any sources of support in the area.*

Baby-friendly communities

- Some communities have established the concept of "baby-friendly communities." Your facility may wish to foster this concept in the surrounding area. While there is no internationally recognized approach, the basic elements include community discussion of needs as reflects all applicable Ten Steps to Successful Breastfeeding.

68 Support may also be provided by telephone, letter and in some areas by e-mail.

- Baby-friendly communities may include:
  - Health system, or local health care provision, is designated "baby-friendly" and actively supports both early and exclusive breastfeeding.
  - Access to a referral site with skilled support for early, exclusive and continued breastfeeding is available and community approved.
  - Support is provided for age-appropriate, frequent, and responsive complementary feeding with continued breastfeeding.
  - Mother-to-mother support system, or similar, is in place.
  - No practices, distributors, shops or services that violate the International Code are present in the community.
  - Local government or civil society creates and supports the implementation of change that actively supports mothers and families to succeed with optimal infant feeding practices. Examples of this change could be time-sharing of tasks, granting authority to transport a breastfeeding mother for referral if needed, identification of "breastfeeding advocates or protectors" among community leaders, and breastfeeding supportive workplaces.

3. Protecting breastfeeding for employed women 10 minutes

- Many mothers introduce early supplements or stop breastfeeding because they have to return to work. Health workers can help mothers to continue to give their babies as much breast milk as possible when they return to work.

Ask: Why is continuing to breastfeed after return to employment recommended?
Wait for a few replies.

- As well as the general importance of breastfeeding discussed earlier in the course, a woman who works outside the home may value breastfeeding because of:
  - Less illness in the baby, so she misses less time from work to care for a sick child.
  - Ease of night feeds, thus mothers gets more sleep.
  - Opportunity to spend time with the baby and continue the closeness to the baby.
  - A chance to a rest while she feeds the baby.
  - A special, personal relationship with her baby.

Ask: If an employer asked you why she or he should support a woman to breastfeed after she returns to employment, what could you say?
Wait for a few replies.

- Employers who support women to continue breastfeeding benefit also:
  - Mothers are away from work less because their children are healthy.
  - Mothers can concentrate on their work because they have less concern about their babies' health.
  - Employers retain skilled workers.
  - Women are more interested in working for employers who are supportive.
  - Families and the community think well of the employers that are supportive.
  - Breastfed babies grow up to be a healthy future workforce.

Ask: What are the key points to discuss with a mother preparing to return to employment?
Wait for a few replies.

- Some weeks before the mother is due to go back to work, discuss:
  - Could the baby go to work with her?
  - Could the baby be cared for near her workplace so that she could go to feed the baby at break times or could the baby be brought to her?
  - Could the mother work shorter hours or fewer days until the baby is older?
- If it is not possible to breastfeed the baby during the working day, suggest:
  - Breastfeed exclusively and frequently during maternity leave.
  - Continue to breastfeed whenever mother and baby are together – nights, early morning, and days off.
  - Do not start other feeds before needed – a few days before going back to work is enough.
  - Learn to express milk and leave it for the carer to give to the baby.
  - Express milk about every 3 hours at work, if possible. This keeps up the milk supply and keeps the breasts more comfortable. The breasts will make more milk when the milk is removed[69].
  - Teach the carer to give feeds in a safe and loving way, by cup rather than by bottle, so that the baby wants to suckle from the breast when mother is home.
  - Have contact and support from other mothers who are working and breastfeeding.
- Much of the information about breastfeeding and working also applies to mothers who are students.

- *(Optional) Most health workers are women and many are likely to be mothers of young children. How could your health facility be a breastfeeding supportive workplace?*
- *Mention any national laws or policies that protect working mothers.*

4. Sustaining continued breastfeeding for 2 years or longer 10 minutes

- There is no specific age at which breastfeeding is no longer important. Breastfeeding continues to provide closeness to the mother, protection from illness and good nutrition.
- Breastfeeding an older baby/young child can be valuable if the child becomes ill. Often the child will be able to breastfeed when they are not interested in eating other foods. This helps the child to get fluids as well as helping to avoid weight loss during the illness.
- Breastfeeding can be soothing to a child who is in pain or upset.
- Breastfeeding an older baby is different from breastfeeding a newborn. As a baby becomes more alert, she or he may be distracted easily during breastfeeds by noises and activity. A mother may find that feeding in a quiet place limits distractions.
- Young children may breastfeed once or twice a day or more frequently. Some may breastfeed only if they are hurt or upset.
- Mothers may need special support to overcome competing pressures on her, whether from the workplace or family, as the child gets older. A discussion can help her identify what might work in her situation.

69 See Session 11 for how to express and store milk.

Complementary feeding[70]

- After six months of age, the baby needs other foods while continuing to receive sufficient breast milk. This is called *complementary feeding* because it complements the breastfeeding; it does not replace it.
- Until a baby is year old, breast milk (or breast-milk substitutes if not breastfed) should provide the main part of the baby's diet. Continue to offer the breast frequently as well as offering suitable foods from the family meals. The period from 6-12 months of age is a time for learning how to eat a wider range of foods and textures.
- To maintain the milk supply, encourage the mother to continue to offer the breast before the complementary food.
- A child stops breastfeeding when they are ready as a natural part of their development. A child should not be stopped suddenly from breastfeeding, as this can cause distress to the child and the mother, sore breasts for the mother, as well removing a source of food from the child. Allow the child to decrease the number of feeds gradually, and be sure he or she gets plenty of other foods each day as well as continued attention from the mother.

Other national health programs for mother and child (include those that are locally in place)

- Continued support for breastfeeding can occur through other national health and nutrition programs including:
    - Safe Motherhood Programmes: mothers are seen through pregnancy to ensure safe birth.
    - The Integrated Management of Childhood Illness (IMCI): child seen for recurrent illness.
    - The Expanded Programme of Immunization (EPI): child is seen at frequent intervals
    - Micronutrient supplementation programs for iron and vitamin A supplementation.
    - Neonatal screening programmes: usually done at 6-10 days after birth, which is an important time to ensure that breastfeeding is going well.
    - Early child development programmes: child is monitored for growth and development during the routine checks ups in child welfare.
    - Family planning programmes: mother seen for family planning at any point of time, usually through health visitors.

5. Group support - class activity 30 minutes

Introduce the activity:

- The facilitators in a mother to mother support group need to use good communication skills and have adequate infant feeding knowledge. These experienced mothers may attend a training course to gain these skills.
- In this activity we can see how the communication skills can be used to help new mothers in a group.

Ask 6-8 participants to sit in a circle. Give two of these participants questions to ask as 'new mothers'. The other participants in the 'mother-to-mother group' are the experienced mothers providing support to the new mothers. Chose one of the participants to be the trained peer 'facilitator' i.e. an experienced breastfeeding mother who will help guide the discussion and ensure all 'mothers' have a chance to contribute.

70 Detailed information on complementary feeding is in *Infant and Young Child Feeding Counselling: An integrated course.*

Ask the remaining participants to form an outer circle and to be observers.

Ask the participants to talk with the mother who is asking the question and to help her, playing the part of other mothers in the group. No one should lecture. Try to keep it like a friendly conversation. Remember the communication skills practiced in this course.

Sample discussion questions for the group discussion are given or other questions can be suggested by the group. Discussion points are included if the facilitator needs to provide information that is not coming from the group. However, if the group is responding well, do not turn it into a lecture. This is mother-to-mother group support, not a clinical case study.

Encourage the 'experienced mothers' in the group to briefly share how they overcame similar concerns when their babies were the same age. This sharing helps takes some of the 'focus' off the 'new mother'. It also helps bring out the essence of peer support where mothers learn from each other and common breastfeeding concerns are shown to have many solutions.

Sample "problem" 1:

James is eight months old and healthy. He eats two meals of porridge every day and he breastfeeds whenever I am at home from my job. Yesterday he refused to breastfeed during the evening and the night. This morning when he woke up he also did not want the breast at all. He gets four bottle feeds a day of formula, so maybe I should stop breastfeeding.

Possible discussion points

Remember to listen to the mother and to respond in a way that encourages her to talk and to explore her own situation.

What would the mother like the situation to be?

What has the mother tried already? Has the mother any thoughts on what she could try?

- *Sometimes babies of this age refuse the breast due to teething or a sore mouth, do you think this might be happening?*
- *What is the feed like? Some babies can be distracted when breastfeeding. A busy mother may rush breastfeeding.*
- *How often is 'whenever I am home'? Could more time be spent with the baby, e.g. is the baby with her and breastfeeding on her day off if she is shopping or visiting?*
- *Where do the mother and baby sleep? (together?) How does the baby feed during the night?*
- *How much does the baby take in the feeds when she is away, could this be reduced, especially in the afternoon so the baby is ready for a breastfeed when the mother comes home?*
- *Giving some vegetable, fruit, or meat would give a wider range of foods and the baby may not be as full as when he has just porridge. What does she think about offering more variety of foods rather than only porridge?*
- *Breast milk continues to be an important source of food into the second year.*

Sample "problem" 2:
Clara is three months old and she is breastfeeding quite frequently. But she doesn't get satisfied. Sometimes after I finish feeding her, she cries again very soon. I think my milk is going away. Will I need to start giving her foods from a spoon or other milk?

Possible discussion points
Remember to listen to the mother and to respond in a way that encourages her to talk and to explore her own situation.
What would the mother like the situation to be?
What has the mother tried already? Has the mother any thoughts on what she could try?

> *Sometimes a baby needs some help to feed well. Has the mother asked a knowledgeable person to look at the way that the baby is feeding?*
>
> *Sometimes a baby wants to be fed, to have contact or wants to be more comfortable before the clock says that it is time to feed. What does the mother think about carrying the baby more and giving the breast when the baby is unsettled to sooth the baby?*
>
> *If the baby is growing well, what are some suggestions for soothing a crying baby?*

Conclude the activity:
Ask the 'mothers' in the group how they felt their concerns were discussed. Ask the 'experienced mothers' how they felt they used their communication skills. Then ask the 'observers' what they noticed. Remember to also reinforce skills that were well used.

- *Ask if there are any questions. Then summarise the session.*

Session 14 Summary

Preparing mothers for discharge

- Before the mother leaves the maternity facility, she needs to:
    - Be able to feed her baby.
    - Know the importance of exclusive breastfeeding for 6 months and continued breastfeeding after the introduction of complementary foods.
    - If replacement feeding, know how to get suitable milk and prepare the feed in a safe manner.
    - Be able to recognize that feeding is going well.
    - Find out how to get the on-going support that she needs.

Follow-up and support after discharge

- Before the mother leaves the maternity facility:
    - Discuss what family support she has at home.
    - If possible, talk with family members about how they can provide help and support.
    - Give the mother the name of a person to contact at the hospital/clinic or in the community to arrange a follow-up check in the first week at home, to include observation of a breastfeed. Arrange for the routine 6-week check-up as well.
    - Tell mother about any mother support groups in her area or the names of experienced mothers willing to support a new mother
    - Remind the mother of the key points about how to breastfeed and practices that help.
    - Be sure that the mother receives no written materials that market breast-milk substitutes or bottles.
    - Contact the mother after she is home to learn how feeding is going,

Protecting breastfeeding for employed women

- Breastfeeding continues to be important when the mother returns to employment.
- Supporting breastfeeding has benefits to the employer.
- Some weeks before the mother is due to go back to work, discuss:
    - Could the baby go to work with her?
    - Could the baby be cared for near her workplace?
    - Could the mother work shorter hours or fewer days until the baby is older?
- If it is not possible to breastfeed the baby during the working day, suggest:
    - Breastfeed exclusively and frequently during maternity leave.
    - Learn to express the milk and leave it for the carer to give to the baby.
    - Have contact and support from other mothers who are working and breastfeeding.

Sustaining continued breastfeeding for 2 years or longer

- Breastfeeding continues to provide closeness to the mother, protection from illness and good nutrition to the older baby and young child.
- Until a baby is a year old, breast milk (or breast-milk substitutes if not breastfed) should provide the main part of the baby's diet. After six months of age, the baby needs continued frequent breastfeeding and other foods in addition to breast milk or replacement milk. Giving these foods is called *complementary feeding* because it complements the breastfeeding; it does not replace it.
- Recommend that the mother continue to offer the breast frequently, preferably before complementary foods, to maintain her milk supply. If she wishes to wean, suggest that she allow the baby to reduce the number of feeds gradually and be sure he or she gets plenty of food each day.

Session 14 Knowledge Check

List three sources of support for mothers in your community.

Give two reasons why mother-to-mother support may be useful to mothers.

Give two reasons why breastfeeding is important to the older baby and the mother.

Additional information for Session 14

Developing a mother-to-mother support group

- Mothers in many communities are best helped where there are mother-to-mother support groups. These groups do not need to be big or have highly trained facilitators. They do need warm-hearted and kind facilitators, who know how to breastfeed and who can help other women. If there is not such a support group in your community, perhaps you can help to establish one, and foster its growth.
  - Identify experienced breastfeeding mothers and learn if they would be acceptable to other mothers as "facilitators". Young mothers can help each other well.
  - Provide accurate information and help to the facilitators, but let them lead the group.
  - Encourage the group to meet rather frequently, in a mother's home or other community location. At meetings, mothers can share how they feel, difficulties they have had, and how they solved them. You can suggest special topics that could be discussed.
  - Tell every mother about the nearest support group and introduce her to a facilitator if possible.
  - Be available to the facilitators to give accurate information and support when asked.
  - Include facilitators in some training activities at the hospital or lactation clinic.
  - Provide training in communication and listening skills to facilitators.

SESSION 15
MAKING YOUR HOSPITAL BABY-FRIENDLY

Session Objectives:

On completion of this session, participants will be able to:

1.	Explain what Baby-friend practices mean	20 minutes
2.	Describe the process of BFHI assessment	10 minutes
3.	Discuss how BFHI can be included in existing programmes.	5 minutes
	Total session time	**35 minutes**

Activities are included in this session that require additional time. The needs of the group of participants will help you decide which activities to include.

The Self-Appraisal Tool can be completed for the health facility. This will take 1-2 hours or more depending on how many people (mothers and staff) are asked for their views.

A plan can be made using the planning questions listed. A plan will take an hour or more to write in addition to the session time, and more time will be needed for discussion with those involved with and affected by the plan.

Materials:

Slide 15/1: Course Aims

List of the *Ten Steps to Successful Breastfeeding* from Session 1.

Hospital Self-Appraisal Tool for the WHO/UNICEF Baby-friendly Hospital Initiative and The Global Criteria – one copy for each group of 4-6 participants. If the optional activity to complete the tool is done, more copies will be needed.

For optional policy activity:

Copies of the hospital policy or example policy and *The Hospital Infant Feeding Policy Aid* – one for each group of 4-6 participants.

For optional planning activity:
Planning slides (5)
Example of a plan – one copy for each small group.

Further reading for facilitators:

Other sections in this set:
BFHI materials: Revised, Updated and Expanded for Integrated Care

Section 1: Background and Implementation

Section 4: Hospital Self-Appraisal and Monitoring

1. What Baby-friendly practices mean 20 minutes

- In the first session, we saw that the aim of this course was:

- *Show slide 15/1 and read it out*

> The aim of this course is that
> every staff member will confidently support mothers
> with early and exclusive breastfeeding, and that this facility moves towards achieving
> Baby-friendly designation

- A Baby-friendly Hospital:
  - Implements the Ten Steps to Successful Breastfeeding.
  - Accepts no free supplies or samples and no promotional material from companies that manufacture or distribute breast-milk substitutes.
  - Fosters optimal feeding and care for those infants that are not breastfed.

- *Point to Ten Steps list on display or remind participants that they received a handout, if they received it in Session 1.*
- *Ask a participant to read out **Step 1**.*

Ask: Why is it important for a hospital to have a written policy that is visible?
Wait for a few replies.

- A policy defines what the staff and service are required to do as their routine practice, and should be mandatory. It helps parents to know what care they can expect to receive.
- To satisfy the requirements of the BFHI, a policy has to cover all the Ten Steps, as well as prohibiting free supplies of breast-milk substitutes, bottles and teats and promotional materials.
- In high HIV prevalence areas, the policy must clearly define what the staff and services are required to do as their routine practice as related to mothers who are not breastfeeding.

- *Ask if there are any questions on this Step.*
- *Ask a participant to read out **Step 2**.*

Ask: Why is it important for a hospital to train their staff?
Wait for a few replies.

- If staff are used to working in a facility that does not use baby-friendly practices, they will need training to learn about these practices.
- Knowledgeable staff together can make the necessary changes, eliminate unsupportive practices, and develop baby-friendly practices that assist mothers and babies to breastfeed.

- *Ask if there are any questions on this Step.*

- *Ask a participant to read out* ***Step 3****.*

Ask: Why is it important for a hospital to talk with pregnant women?
Wait for a few replies.

- Pregnant women need accurate information that does not promote a commercial product such as infant formula. This information should be relevant to the specific woman. If pregnant women do not discuss the information with a knowledgeable health worker, they may make decisions based on incorrect information.

- *Ask if there are any questions on this Step.*

- *Ask a participant to read out* ***Step 4****.*

- This Step is now interpreted as:
  Place babies in skin-to-skin contact with their mothers immediately following birth for at least an hour and encourage mothers to recognise when their babies are ready to breastfeed, offering help if needed.

Ask: Why is it important to help mothers and babies to have immediate contact?
Wait for a few replies.

- Skin to skin contact helps:
  - To keep the baby warm, and to stabilize breathing and heat rate.
  - Breastfeeding to get started
  - The mother and baby to get to know each other.
- If the baby or mother need immediate medical care at birth, this skin to skin contact can start as soon as they are stable.

- *Ask if there are any questions on this Step.*

- *Ask a participant to read out* ***Step 5****.*

Ask: Why is it important to show mothers and babies how to feed?
Wait for a few replies.

- Some mothers have seen little breastfeeding among their family and friends. Showing them some main points can help breastfeeding to go well.

Ask: What are the main points to look for regarding the position of a baby?
Wait for a few replies.

- The baby's body needs to be:
  - **In line** with ear, shoulder and hip in a straight line**,** so that the neck is neither twisted nor bent forward or far back;
  - **Close** to the mother's body so the baby is brought to the breast rather than the breast taken to the baby;
  - **Supported** at the head, shoulders and if newborn, the whole body supported.
  - **Facing** the breast with the baby's nose to the nipple as she or he comes to the breast.

Ask: What are the main points to look regarding the attachment of the baby to the breast?
Wait for a few replies.

- Signs of good attachment are:
  - Chin touching breast (or nearly so)
  - Mouth wide open
  - Lower lip turned outwards
  - Areola: more visible above than below the mouth

Ask: What are the main signs of effective suckling?
Wait for a few replies.

- Signs of effective suckling are:
  - Slow, deep sucks and swallowing sounds
  - Cheeks full and not drawn in
  - Baby feeds calmly
  - Baby finishes feed by him/herself and seems satisfied
  - Mother feels no pain

Ask: If the mother is expressing milk for her baby, what points can help her to express?
Wait for a few replies.

- It can help hand expression if the mother can:
  - Encourage the milk to flow
  - Find the milk ducts
  - Compress the breast over the ducts
  - Repeat in all parts of the breast.

Ask: If a baby is not breastfeeding, what does the mother need to learn about feeding?
Wait for a few replies.

- The mother needs to know:
  - What kind of replacement feeding is acceptable, feasible, affordable, sustainable and safe (AFASS) in her situation.
  - How to obtain, prepare and feed the replacement feeds safely.

- *Ask if there are any questions on this Step.*

- *Ask a participant to read out **Step 6**.*

Ask: Why is it important to give newborn infants only breast milk?
Wait for a few replies.

- Breast milk coats the baby's system like a paint to protect it. Other fluids or foods can wash away this protection. Other fluids and foods can introduce infections to the baby.
- There is information available to discuss if it is thought there is a medical reason to not encourage exclusive breastfeeding.

- *Ask if there are any questions on this Step.*

- *Ask a participant to read out **Step 7** and **Step 8**.*

Ask: Why is it important for mothers and babies to be together 24 hours a day?
Wait for a few replies.

- Rooming-in helps a mother to learn the feeding cues of her baby and how to care for her baby. It helps to feed in response to those cues (demand feeding) rather than to feed by a clock. Babies who have to cry to be fed use up energy crying and may fall asleep without feeding well.

- *Ask if there are any questions on this Step.*

- *Ask a participant to read out **Step 9**.*

Ask: Why is it important to avoid giving artificial teats and pacifiers?
Wait for a few replies.

- The use of artificial teats or pacifiers may:
  - Interfere with the baby learning to breastfeed.
  - Affect milk production.
  - Indicate the mother (or health worker) finds it hard to care for the baby and needs assistance.

- *Ask if there are any questions on this Step.*

- *Ask a participant to read out **Step 10**.*

Ask: Where in this community could a mother get support for breastfeeding after she leaves the birth facility?
Wait for a few replies.

- Support for breastfeeding and other aspects of caring for a baby, may be available from:
  - Family and friends
  - Health workers
  - Organised support groups and counsellors
  - Informal or volunteer support groups and counsellors
  - Other community services
- The need for support and where to find support should be discussed with each mother before she is discharged after birth.

- *Ask if there are any questions on this Step.*

- Hospitals must abide by the International Code and the subsequent resolutions in order to be recognised as baby-friendly.
- The overall aim of the **International Code** of Marketing of Breast-milk Substitutes is the safe and adequate nutrition of all infants.

Ask: How can you help to achieve this aim?
Wait for a few replies.

- To achieve this aim we must:
  - Protect, promote and support breastfeeding.
  - Ensure that breast-milk substitutes (BMS) are used properly when they are necessary.
  - Provide adequate information about infant feeding.
  - Prohibit the advertising or any other form of promotion of BMS.
  - Report breaches of the Code (and/or local laws) to the appropriate authorities.

- *Ask if there are any questions on the Code.*

- **Mother friendly birth practices** assist a woman to feel competent, in control, supported and ready to interact with her alert and responsive baby who.

Ask: What labour and birth practices can help to achieve this aim?
Wait for a few replies.

Supportive practices include:
- support during labour,
- limiting invasive interventions,
- paying attention to the effects of pain relief,
- offering light food and fluids,
- avoiding unnecessary caesarean sections, and
- facilitating early mother and baby contact.

- When health facilities work to implement the practices of the Baby-friendly Initiative, the aim is to not only gain a plaque or award. More importantly, it is to increase the well being of mothers and babies and thus benefit the wider community.
- The Initiative is a *Baby* friendly rather than *Breastfeeding* friendly initiative. Most of the practices in a baby-friendly hospital also benefit babies and mothers who are not breastfeeding.

2. The process of Baby-friendly Assessment 10 minutes

Self-Appraisal

- The BFHI process begins when the hospital decides to make the changes, and forms a group or committee with a co-coordinator to take responsibility. Usually this consists of senior people in the hospital who can make decisions, and staff who are interested in breastfeeding and who know something about it.
- The committee arranges for 2-3 people to use the Self-Appraisal Tool to review their policies and practices that may help or hinder breastfeeding. The experiences of the mothers and staff are a key source of information to assess if practices are in place.

- *Show participants the Self-Appraisal Form and give them a few minutes to look the layout – there are questions and to answer yes or no about each practice. They do not need to look at it in detail.*

- The yes/no boxes on the form should be filled in honestly with regard to a normal day. Items for which it is hoped that they will be in place soon, or practices that happen on a perfect day, do not reflect the current situation. Imagine an external assessor came today, what would they find?
- Once the hospital can see which of its practices are supportive and which are not, it can make a plan of action that will lead to a service that is more supportive. A plan with a timetable is necessary to keep the project moving forward. It can also assist in setting a budget and to obtain funding[71].
- Training, such as this course, is usually needed early in the process. When all staff have received the required training, and the new practices are in place, the hospital can conduct a repeat self-appraisal.
- When a hospital can answer "yes" to all the questions in the Self-Appraisal Tool, they can request an external assessment.

Optional activity (additional time needed)

The Self-Appraisal Tool can be completed for the health facility before the course or as a separate activity and discussed here. This will take 1-2 hours or more depending on how many people (mothers and staff) are asked for their views.

External assessment

- After the Self-Appraisal is completed, the committee and the co-coordinator have to work to help other staff to make the necessary changes. When changes are thought to be satisfactory, the national baby-friendly authority can carry out an external assessment using The Global Criteria. The Global Criteria are the same all over the world. The criteria cannot be made easier to meet an individual country's or hospital's standards, although some countries have made the criteria stricter.
- Often, one or more external assessors come for a preliminary visit, to explain the assessment process, to check about the policy and training process that the hospital has been through, to make sure that they really are ready for assessment, and to help them to plan what else they may need to do. This helps to ensure that the process is educational, and not disciplinary, in case they are not yet ready. It is very discouraging when a hospital that has worked hard to improve practices does not succeed in an assessment.
- For the external assessment, a multi-disciplinary assessment team visits the maternity services and interviews staff and mothers, observes practices and reviews documentation. The external assessment can take two or more days (and nights) depending on the size of the hospital.
- When possible, documents such as the staff training curriculum, the hospital policy, breastfeeding statistics, and antenatal information, are reviewed before the assessment team arrives at the hospital.
- Interviews with pregnant women and new mothers are key to the assessment. It is also important to interview staff members who have direct contact with mothers in the maternity services, to assess their knowledge and practices. It is not sufficient that senior management report on activities.
- The external assessment team does not designate a hospital as baby-friendly. The team completes a report that goes to the national authority responsible for BFHI, a national breastfeeding committee, or other designated body.

71 The optional activity on Planning for Change addresses this point.

- The national authorities, consulting with WHO and UNICEF as necessary, determine if the hospital will be awarded baby-friendly designation. If the hospital does not meet the criteria, it may receive a Certificate of Commitment to becoming baby-friendly and guidance on how to make the improvements needed.

On-going monitoring

- When a hospital is awarded baby-friendly status, it is required to maintain the standards of The Global Criteria and to abide by the International Code to remain designated as a baby-friendly hospital. To help maintain standards between assessments, practices need to be monitored.
- To monitor, you need to collect information about practices. It is better to collect information about an *outcome or result* rather than about *activities.* For example, it is better to measure the number of babies and mothers who have skin-to-skin contact soon after birth, rather than to measure if an information sheet listing the benefits of skin-to-skin contact is available.

Ask: What practices do you think would be useful to monitor so a hospital could see how it was doing?

Wait for a few responses.

- Monitoring is easier to do when a hospital policy is written in a way that is measurable. For example, the following statement is very difficult to monitor - "Offer mother skin to skin contact with her baby as soon as it is feasible following delivery, preferably within half an hour." How could "as soon as it is feasible," and "preferably" be measured?
- The following policy statement is easier to monitor: "Within 5 minutes of birth, all mothers regardless of feeding intention will be given their babies to hold with skin-to-skin contact for at least 60 minutes".

External re-assessment

- It is also important that hospitals that have been designated "baby-friendly" be reassessed on a regular basis. This reassessment helps to ensure that they maintain their adherence to the "Ten Steps" and the Code over time and thus continue to give mothers and babies the support they need.
- UNICEF recommends that hospitals be reassessed approximately every 3 years, but suggests that the national authority responsible for BFHI in each country make the final decisions concerning the timing and process to be followed.
- Reassessment should be conducted, as with the assessment, by an external team. Although the country can use the full assessment tool for this process, it is often more cost-effective to use a simpler, less time-consuming tool, and a small assessment team. UNICEF provides guidelines for planning for reassessment, as well as several tools that the national authority can consider using.
- Once a hospital has been reassessed, its status as baby-friendly can be renewed or, if it has slipped, it may be asked to work on any of the Steps that need improvement, before official re-designation as a baby-friendly hospital.

3. Including BFHI in existing programmes 5 minutes

- Some hospitals participate in a national or international accreditation process, quality assurance or improvement programme that identifies equity of access, quality of service and accountability as the approach to quality of care.

- The BFHI can fit into these quality assurance programmes. BFHI has measurable criteria and international standards. There are tools to assess how a hospital meets those standards and criteria. If a hospital already has a quality or accreditation system in place, the planning and monitoring tools of that system can be used.
- In a hospital, BFHI may be the responsibility of the mother and child services, a breastfeeding or infant feeding committee, or it may be part of a quality committee. Including BFHI in the responsibility of a hospital-wide quality committee can assist in raising awareness of the importance of supportive practices for breastfeeding, as well as assisting in obtaining resources to implement BFHI.
- The expertise of staff in the maternity services is usually in the care of the mother and baby. The expertise of staff in a quality office is measuring and improving the quality of the care. For example, the quality office may not know that BFHI exists and that standards and tools are available. The maternity staff may not know what the quality office can do to assist with using the Self-Appraisal Tool, with developing or fitting into an existing regular audit process, and with planning for improvement. Both these areas of expertise can be used to provide a better service, however each group will need to be aware of the other group's expertise and work together.
- BFHI can also be integrated with Safe Motherhood and/or IMCI[72] programmes. However for a hospital to be designated as a *baby-friendly hospital* it must be assessed using the specific Global Criteria of the Initiative.

- *Ask if there are any questions. Then summarise the session.*
- *There is a Closing Session Outline after the optional activity pages.*

72 Integrated Management of Childhood Illness.

Session 15 Summary

- The BFHI Self-Appraisal helps a health facility to see what practices are in place and what areas need attention. A structured plan for improvement can assist change.
- External assessment is requested when supportive practices are fully in place.
- On-going monitoring and re-assessment are needed to keep standards high.
- BFHI can be integrated into other programmes such as a hospital quality improvement programme, if one exists.

Session 15 Knowledge Check

List two reasons why a hospital might seek BFHI external assessment.

Explain, as if to a co-worker, why achieving baby-friendly designation is not the end of the process and the importance of on-going monitoring.

<u>Optional Activity:</u> Assess a Policy at least 30 minutes

- There may be an existing breastfeeding policy that needs to be reviewed. Often there is no policy and one has to be developed.
- A policy consists of a set of rules that people who are in a position to make decisions have agreed to follow. This is usually senior people from all relevant departments including midwifery, nursing, obstetrics, paediatrics, and hospital management. All need to agree to the policy before it can be implemented. This requires that they meet and discuss it. This may take a number of months.
- The policy does not need to be very long and detailed. There may be additional protocols, guidelines or information sheets to assist staff to implement the required practices.
- The policy needs to use words that are understood easily. The statements should be measurable. For example, if a policy said that "staff will do everything possible to assist breastfeeding", how would you monitor if this was happening? We say more about this below when we discuss monitoring.

Small group activity

If the course is in a hospital, review the policy of that hospital. If the course is elsewhere, review one of the sample breastfeeding policies in the Appendix to this session. Evaluate whether the policy addresses all of the *Ten Steps to Successful Breastfeeding*, includes non-acceptance of free supplies and promotional materials, and supports mothers who are not breastfeeding.

Use the *Hospital Infant Feeding Policy Checklist*. Mark any changes that could be suggested to make the policy more supportive.

To use the time well, divide the group so that small groups each look at 2-3 of the headings in the Policy Checklist, and then tell the other groups what they found. Remember to check if the policy statements are clearly written and the activities are measurable so that they are easy to monitor.

Allow 2 minutes to explain the activity, 10 minutes for the small groups to look at how the Steps are or are not included in the policy and 15 minutes for feedback to the group and discussion.

- *The policy checklist is on the next page.*

You can use the policy of the hospital where the course is taking place or there are policies to use in the following pages.
In the sample Happy Hospital Policy, items to discuss include:

- *Phrasing such as "do everything possible", "as soon as is feasible" that are difficult to monitor;*
- *There is no need for every antenatal women to have a through breast examination.*
- *Women should not be asked to choose how they would feed their baby before the importance of breastfeeding is discussed.*
- *The baby does not need to be 'put to the breast'. The baby can self-attach to his/her mother's breast. The emphasis at this time needs to be skin-to-skin contact and time, rather than taking a feed.*

Hospital breastfeeding/infant feeding policy checklist

(Note: A hospital policy does not have to have the exact wording or points as in this checklist, but should cover most or all of these key issues. Care should be taken that the policy is not too long. Shorter policies (3 to 5 pages) have been shown to be more effective as longer ones often go unread).

The policy should clearly cover the following points:		YES	NO
Step 1:	The policy is routinely communicated to all (new) staff.		
	A summary of the policy that addresses the Ten Steps and support for non-breastfeeding mothers is displayed in all appropriate areas in languages and with wording that staff and mothers can easily understand.		
Step 2:	Training for all clinical staff (according to position) includes: Breastfeeding and lactation management (20 hours minimum or covering all essential topics, including at least 3 hours of clinical practice).		
	Feeding the infant who is not breastfed.		
	The role of the facility and its staff in upholding the International Code of Marketing and subsequent WHA resolutions.		
	New staff members are trained within 6 months of appointment.		
Step 3:	All pregnant women are informed of: Basic breastfeeding management and care practices.		
	The risks of giving supplements to their babies during the first six months.		
Step 4:	All mothers and babies receive: Skin-to-skin contact immediately after birth for at least 60 minutes.		
	Encouragement to look for signs that their babies are ready to breastfeed and offer of help if needed.		
Step 5:	All breastfeeding mothers are offered further help with breastfeeding within 6 hours of birth.		
	All breastfeeding mothers are taught positioning and attachment.		
	All mothers are taught hand expression (or given leaflet and referral for help).		
	All mothers who have decided not to breastfeeding are: Informed about risks and management of various feeding options and helped to decide what is suitable in their circumstances.		
	Taught to prepare their feedings of choice and asked to demonstrate what they have learned.		
	Mothers of babies in special care units are: Offered help to initiate lactation offered help to start their breast milk coming and to keep up the supply within 6 hours of their babies' births.		
	Shown how to express their breast milk by hand and told they need to breastfeed or express at least 6-8 times in 24 hours to keep up their supply.		
	Given information on risks and benefits of various feeding options and how to care for their breasts if they are not planning to breastfeed.		
Step 6:	Supplements/replacement feeds are given to babies only: If medically indicated.		
	If mothers have made a "fully informed choices" after counselling on various options and the risks and benefits of each.		

	Reasons for supplements are documented.		
Step 7:	All mothers and babies room-in together, including at night.		
	Separations are only for justifiable reasons with written documentation.		
Step 8:	Mothers are taught how to recognize the signs that their babies are hungry and that they are satisfied.		
	No restrictions are placed on the frequency or duration of breastfeeding.		
Step 9:	Breastfeeding babies are not fed using bottles and teats.		
	Mothers are taught about the risks of using feeding bottles.		
	Breastfeeding babies are not given pacifiers or dummies.		
Step 10:	Information is provided on where to access help and support with breastfeeding/ infant feeding after return home, including at least one source (such as from the hospital, community health services, support groups or peer counsellors).		
	The hospital works to foster or coordinate with mother support groups and/or other community services that provide infant feeding support.		
	Mothers are provided with information about how to get help with feeding their infants soon after discharge (preferably 2-4 days after discharge and again the following week).		
The Code:	The policy prohibits promotion of breast-milk substitutes.		
	The policy prohibits promotion of bottles, teats, and pacifiers or dummies.		
	The policy prohibits the distribution of samples or gift packs with breast milk substitutes, bottles or teats or of marketing materials for these products to pregnant women or mothers or members of their families.		
Mother-friendly care:	Policies require mother-friendly practices including: Encouraging women to have constant labour and birthing companions of their choice.		
	Encouraging women to walk and move about during labour, if desired, and to assume the positions of their choice while giving birth, unless a restriction is specifically required for a complication and the reason is explained to the mother.		
	Not using invasive procedures such as rupture of membranes, episiotomies, acceleration or induction of labour, caesarean sections or instrumental deliveries, unless specifically required for a complication and the reason is explained to the mother.		
	Encouraging women to consider the use of non-drug methods of pain relief unless analgesic or anaesthetic drugs are necessary because of complications, respecting the personal preferences of the women.		
HIV*:	All HIV-positive mothers receive counselling, including information about the risks and benefits of various infant feeding options and specific guidance in selecting what is best in their circumstances.		
	Staff providing support to HIV-positive women receive training on HIV and infant feeding.		

* The **HIV-related content** in the policy should be assessed only if national authorities have made the decision that the BFHI assessment should include HIV criteria.

Policies for activity

Note that these policies may have areas that can be improved. They are not examples of policies acceptable to BFHI.

EXAMPLE A for Analysis
HAPPY HOSPITAL BREASTFEEDING POLICY

Aims

1. To increase the incidence and duration of breastfeeding.
2. To assist mothers and infants in achieving successful breastfeeding by standardising teaching, eliminating contradictory advice, and implementing practices conductive to breastfeeding success.

POLICY

ANTENATAL PERIOD

Staff should be committed to the promotion of breastfeeding and should do everything possible to enhance the woman's confidence in her ability to breastfeed.
At first antenatal visit:
(a) Perform thorough breast examination.
(b) Ascertain choice of feeding method; if undecided encourage breastfeeding.
(c) Give information leaflet that describes the benefits and management of breastfeeding.

DELIVERY ROOM

Put baby to breast as soon as it is feasible following delivery, preferably within half an hour as the infant suck is strongest at or during the first hour after birth. A nurse should be present at the first feed to offer instruction in correct technique and positioning.

POSTNATAL WARD

Demand Feeding - There should be no limit to the maximum number of feeds, but a full-term neonate is expected to need at least 5/6 feeds in a 24-hour period - with intervals of not longer than five hours.

Practice rooming in.

Avoid rigid ward routine - do not waken baby for bath/weight/temperature between feeds. Advise mother to call staff member when baby wakens, for these tasks.

Efficient communication between mother and midwives and between staff at changeover is essential if consistency of approach and advice is to be achieved.

Document feeds as follows - long good feed, short good feed, poor feed.

Give no artificial teats or pacifier (also called "dummies" or "soothers") to breastfeeding infants while breastfeeding is being established.

All mothers need to be taught while in hospital how to express and store breast milk

DISCHARGE

Give information on community based support groups, community clinic, and the availability of follow-up clinic at the hospital.

EXAMPLE B for Analysis

Note that these policies may have areas that can be improved. They are not examples of policies acceptable to BFHI.

QUALITY CARE HOSPITAL BREASTFEEDING POLICY

Staff of the Quality Care Hospital are committed to Protecting, Promoting and Supporting Breastfeeding because breastfeeding is important for both the mother and her baby. This policy helps us to provide effective and consistent information and support to pregnant women, mothers and their families.

Adherence to the Ten Steps to Successful Breastfeeding (WHO/UNICEF) and the adherence to the International Code of Marketing of Breast-milk Substitutes (1981) and its subsequent resolutions are the foundation for our practices.

1. All staff will receive orientation on our breastfeeding policy relevant to their role when joining the hospital.
2. A minimum of 18 hours training in breastfeeding management is mandatory for all staff and students caring for pregnant women, infants and young children. New staff are facilitated to avail of training, within 6 months of commencing work if not already trained. Refresher courses are offered on a regular basis.
3. Midwives must discuss the importance and basic management of breastfeeding in the antenatal period and record this discussion in the pregnant women's chart.
4. Within 30 minutes of birth, all mothers regardless of feeding intention will be given their babies to hold with skin-to-skin contact for at least 30 minutes. A family member may provide skin-to-skin when the mother is unable to do so and skin-to-skin contact later encouraged in the postnatal ward or special care when baby and/or mother are stable.
5. All mothers will be offered help to initiate breastfeeding within 30 minutes of birth. Further assistance will be offered within 6 hours by a midwife to position and attach baby on breast.
6. Rooming-in is hospital policy and unless medically/clinically indicated a mother and her baby will not be separated. Where separation of baby from mother is necessary, lactation will be encouraged and maintained.
7. Baby-led feeding will be practiced for all babies although in the early days the baby may need to be woken if sleepy or if the mother's breasts become overfull. When baby has finished feeding on one side the second breast will be offered.
8. Breastfeeding mothers will be shown by the midwife how to express their breast milk by hand, and by pump if necessary.
9. Supplements will only be given for clinical/medical need. All supplementary feeds/fluids will be recorded in the baby's hospital notes with the indication for giving the feed. Prescribed supplementary fluids will be given by cup or NG tube.
10. No teats/dummies/soothers will be given to babies while breastfeeding is being established.
11. No advertising of breast-milk substitutes, feeding bottles, teats or dummies is permissible. Mothers choosing to formula feed their infants will be individually instructed on safe formula use during the postnatal period by the midwife before discharge.
12. Before discharge, support services available in the community will be discussed with each mother.

Any deviations to this policy as regards patient care will be recorded in the mother's/baby's chart with the reason for the deviation. The staff member will sign this with the date and time.

The Quality Office will audit compliance with the hospital breastfeeding policy at least once a year.
Policy effect date:
Policy review date:

Optional activity – Planning for Change

How planning can assist change[73] at least 30 minutes

- If change is planned in a systematic way, it is more likely to result in progress. A plan helps to focus the project activities towards reaching the goal. It can form a timetable to keep the project moving forward. It can also assist in setting a budget and to obtain funding.
- There are many different systems used for planning, though most are similar and just have different names.

- *Show slides 15/1 to15/5 for each stage of planning and read it out*

Where are we now? Slide 15/1

- The Self-Appraisal Tool will help to answer this question. List any barriers or difficulties to health workers or families in carrying out appropriate practices. Remember to make a note of activities that are going well and that can be reinforced in your plan.

Where do we want to be? Slide 15/2

- This step involves setting your goals or targets. Set a target that is specific, measurable, achievable, relevant and with a time limit. (SMART goals).
- If the target is too easy, some people may sit back and do nothing because they feel it will happen anyway. If it is too difficult or the target seems not relevant to them, people may decide they can never achieve it and so they will not try. Aim for something that is realistic to achieve within the period.

How will we get to where we want to be? Slide 15/3

- When you have decided on your goals or targets, you then need to decide the best actions to reach those goals. Many different activities can be undertaken. What you choose depends on the needs of the service, the resources available and the ability to implement and sustain the changes. There is no one best activity for every setting.
- It is important to assign to each goal or action a person who is responsible to check on progress towards reaching that goal. Large goals can be broken down into smaller goals and divided among a number of people. One person does not need to do it all.
- Set a time period for the tasks needed to achieve your targets. It can help to divide the tasks into activities that can be achieved in a few weeks. A target that is due in a year tends not to be worked on until late in the year.
- Plan ways to involve your co-workers, the families you serve and community leaders in setting and achieving the goals.

73 Originally developed by Genevieve Becker and used with permission in Session15, Sustaining Practices, in the *Complementary Feeding Counselling Course.* WHO/UNICEF 2004.

- When you are working on this step, also consider what resources are needed to carry out the actions.

How will we know we are going in the right direction? Slide 15/4

- Are you going in the right direction? Have you achieved your target or goal? If your targets and activities are specific and measurable, it is easier to know you have reached them.
- This step is also called monitoring and evaluation. Monitoring can be carried out during a project or activity to check that the activity is going in the right direction. Evaluation can be carried out during or after the project or activity is completed to measure the effectiveness of the activity. However, your evaluation measures need to be decided as part of setting your goals, not after the project is finished.

How will we sustain the practice? Slide 15/5

- The word "sustain" means to keep something going into the future. Sustained practices are achieved by making the new practices part of the regular service rather than special activities that are only in place for a short time.
- In your planning, try to find a way to connect each new activity to an existing activity or process. It is often easier to expand an existing activity than to start a completely new activity.

- *Discuss the Sample Plan. Highlight each of the planning steps.*

An additional activity is to make a plan specific to an action chosen by the participants. Developing a detailed plan may take an hour or more depending on the practice to be implemented.

Developing an Action Plan for a BFHI project[74]

Rooming-in **Example**[75]

Aim is to improve the number of mothers and babies with 24-hour rooming-in

Where are we now? What is the current situation?

Audit of rooming-in carried out on (date) ___________ showed:

___ % of mothers and babies remained together 24 hours a day.

___ % of mothers and babies remained together during the day but not rooming-in at night.

___ % of mothers and babies did not remain together 24 hours a day for medical indications.

___ % started rooming-in immediately after a normal birth.

___ % of c-section mothers started rooming-in within a half-hour of when they were able to respond to their baby.

What would we like the situation to be? What is our goal or target?

On (date) ____________, an audit of rooming-in will show:

___ % of mothers and babies remained together 24 hours a day.

___ % of mothers and babies remained together during the day but not rooming-in at night.

___ % started rooming-in immediately after a normal birth.

___ % of c-section mothers started rooming-in within a half-hour of when they were able to respond to their baby.

Any mothers and babies who did not remain together 24 hours a day will be recorded in the _____________________ with the reason for rooming-*out*.

This record will be examined every 3 months to see if there are any contributing factors to rooming-*out* that could be addressed.

How will we get to our goal? (Method)

Action	Person (s) Responsible	Start and Completion Date
All staff, professional and ancillary, **will be informed** that rooming-in is the standard policy for all mothers by means of a posted notice.		
All staff will be educated as to the reasons behind this policy appropriate to their areas of responsibility, by means of attendance at a 20-minute session on the ward.		
All relevant staff will be **taught means of assisting mothers** to settle their babies themselves, and how to explain the importance of rooming-in to mothers/parents. Staff will be educated by means of a 20-minute session on the ward and this topic addressed during the 20-hour course.		
Antenatal classes and other information sources will explain to parents the importance of rooming-in and that it is the hospital policy.		

74 Used with permission from the Baby-friendly Hospital Initiative in Ireland.

75 This Action Plan focuses on rooming-in. Other Action Plans would need to be made for other practices/Steps that needed attention.

Any mother and baby **not rooming-in** for a medical indication or by mother request will be **recorded** in the ___________________ including the reason. Completion of this **record** will be **checked** weekly for the first month of the project and any non-completion addressed.		
This **record will be analysed** at the end of (one month from start) and each 3 months afterwards to see if there are any contributing factors to rooming-*out* that could be addressed. (addressing them would be a separate plan)		
The (designated person) will carry out an audit of rooming-in one night per month, randomly chosen, during the next 4 months. The results of this audit will be recorded in ___________________________ and **posted** at the nurses' desk on the ward.		

How will we know we are going in the right direction? (Evaluation)
At (date, perhaps 4 months from start), the monthly random audits show an increase in rooming-in to the levels of the targets above.

For one week (date about 4 months from start), further data collected to ascertain the statistics regarding degree of rooming-in and how soon it starts as outlined above. This data collection is the responsibility of ________________

The record of rooming-*out* will be filled in with the occurrence, length of time and reason for the rooming-*out*.

A list of reasons for rooming-*out* and the number of occurrences of each reason will be complied by ______________________________

A sample of mothers (all the mothers in one week - date) asked on discharge to complete a short form regarding their experiences of rooming-in. Person responsible for designing this form ___________________, checking completion of forms _________________ and analysing and reporting on findings _________________.

How will you sustain the practice? (Sustainability)
Compliance with the rooming-in policy audited one night per month by random check by (person) _________ and results recorded in ______________________ and posted on the ward.
Reasons for rooming-*out* recorded in _____________________ and examined on a three monthly basis for contributing factors that need to be addressed. Responsibility ____
Importance of rooming-in explained to women during their antenatal contacts (not just at classes) Responsibility ____________________________
New staff orientated to the rooming-in policy. Responsibility _________________

Budget (What resources are required to implement the action?)
Equipment: bed sides may be needed if bedding-in is used and beds are narrow, or bigger beds

Staff: initial -replacement staff for staff attending training; staff member at ½ day per week for x weeks for project co-ordinator or other person to educate staff (depends on number of staff to educate), develop recording system, and evaluate project.
On-going - 15 minutes per month for person to count numbers rooming-out; 1 hour per month to monitor whether the improvements are being sustained and to orient new staff.
May need additional antenatal staff to ensure there is time to discuss rooming-in with women.

Photocopying/printing of information leaflet for staff.

Overall project responsibility: ___________________________________

Start date: **Target completion date:**

CLOSING SESSION

Session Time:

The length of the closing will depend if an outside person is coming to make a speech and present certificates of attendance.
If there is no outside person, the closing will take about 15 minutes.

Preparation for session:

- If certificates of attendance are to be given, ensure that they are prepared.
- Make a list of people who need to be thanked.
- Remind participants before this session to complete course evaluation forms.
- Find out if there are plans to follow up after this course, to arrange further training, hospital assessments of other activities.

Session Outline:

- Thank you for participating and sharing your experiences, your thoughts, and your ideas during this course.

The Key Points from this course are:

- *Breastfeeding is important for mother and baby.*
- *Most mothers and babies can breastfeed.*
- *Mothers and babies who are not breastfeeding need extra care to be healthy.*
- *Hospital practices can help (or hinder) baby and mother friendly practices.*
- *Implementing the Baby-friendly Hospital Initiative helps good practices to happen.*

- *Ask if there are any questions on the course information.*

- I hope that participation in this course has increased your knowledge, skill, and confidence in supporting mothers. When you return to work, you can help to provide consistency of information and practice throughout your health facility.

- *Discuss here plans to follow-up on the course and continuing activities.*

- *Thank other people such as organisers.*

- *Present certificates if needed.*

CLINICAL PRACTICE 1–
OBSERVING AND ASSISTING BREASTFEEDING

Session Objectives:

On completion of this session, participants will be able to:

1. Observe a breastfeed using the Breastfeed Observation Checklist.
2. Assist a mother to learn to position and attach her baby for breastfeeding.
3. Use communication skills when assisting a mother.

Total time **120 minutes**

Travel time to and from the clinical practice area is NOT included in this time.

Materials:

Breastfeed Observation Aid from Session 7 – two copies for each participant.
List of Communication Skills from Session 2 – a copy for each participant.

Preparation for Clinical Practice:

Make sure that you know where the clinical practice will be held, and where each facilitator should take her group. If you did not do so in a preparatory week, visit the wards or clinics where you will go, introduce yourself to the staff members in charge, and make sure that they are prepared for the session.

The session time does not include time for travel to a clinical practice site. Add extra time to the timetable if participants must leave the building to go to another site.

1. Explain the clinical practice 20 minutes

- This clinical practice will give you an opportunity to:
  - Practice assessing a breastfeed using the Breastfeed Observation Aid.
  - Practice using your communication skills.
  - Help a mother to position and attach her baby for breastfeeding.
- You work in groups of four plus a facilitator with each group. To start with, the whole group of four people works together. One person talks to a mother, while the other members of the group observe. When everyone knows what to do, you can work in pairs, while the facilitator circulates.
- The midwife will tell us which women are suitable to talk with and who have their breastfeeding babies with them on the ward.
- One participant will talk to a mother:
  - Introduce yourself to the mother, and ask permission to talk to her. If she does not want to be observed, thank her and find another mother. Introduce your partner/small group, and explain that you are interested in infant feeding.
  - Ask permission to watch her baby feed. Avoid saying that you want to watch how she is 'breastfeeding' as this may make her feel nervous. If the baby is heavily wrapped in blankets ask the mother to unwrap the blankets so that you can see.
  - Try to find a chair or stool to sit on. If necessary, and if permissible, sit on the bed so that you are at the mother's level.
  - If the baby is feeding, ask the mother to continue as she is doing. If the baby is not feeding, ask the mother to offer a feed in the normal way at any time that her baby seems ready. If the baby is willing to feed at this time, ask the mother's permission to watch the feed. If the baby is not interested in feeding, thank the mother and go to another mother.
  - Before or after the breastfeed, ask the mother some open questions about how she is, how her baby is, and how feeding is going, to start the conversation. Encourage the mother to talk about herself and her baby. Practise as many of the listening and learning skills as possible.
  - Remember to praise what mothers are doing right and offer a small amount of relevant information if appropriate.
- The partner or rest of the small group (of four people) will observe:
  - Stand quietly in the background. Try to be as still and quiet as possible. Do not comment, or talk among yourselves.
  - Make *general* observations of the mother and baby. Notice for example: does she look happy? Does she have formula or a feeding bottle with her?
  - Make *general* observations of the conversation between the mother and the participant. Notice for example: Who does most of the talking? Does the participant ask open questions? Does the mother talk freely, and seem to enjoy it?
  - Make *specific* observations of the participant's communication skills. Notice if she or he uses helpful non-verbal communication, if she or he uses judging words, or if she or he asks many closed questions to which the mother says 'yes' and 'no'.

- When you observe a breastfeed:
  - Stay quietly watching the mother and baby as the feed continues.
  - While you observe, fill in a Breastfeed Observation Aid. Explain to the mother that you are using an Aid to help you remember the new skills that you are learning.
  - Mark a tick beside each sign that you observe.
  - Under 'Notes:' at the bottom of the form, write anything else that you observe which seems important for breastfeeding.
- When you have finished observing a mother:
  - Thank the mother for her time and cooperation, and say something to encourage and support her.
  - Go with the group into another room or private area to discuss your observations.
  - Discuss what you noticed about the breastfeed and what you noticed about the communication skills that the participant used.

If the mother needs help

- When a pair finds a mother who needs help positioning her baby at the breast, tell the facilitator of your small group. Then practice helping the mother, while your facilitator observes you, and helps if necessary.
- When a pair has finished helping a mother, if needed, move away from the mother for a discussion. The participant should comment on her or his own performance first. Then the facilitator can praise what they did well, give them relevant information and suggest changes that could be made the next time they help a mother.
- Before you leave the ward or clinic, tell the staff member which mothers you have suggested to change their positioning and attachment so that the staff member can follow-up with these mothers.
- Each participant should talk to at least one mother and observe a breastfeed. Not all mothers will need help to position and attach their babies.
- While you are in a ward or clinic, notice:
  - if babies room-in with their mothers;
  - -whether or not babies are given formula, or glucose water;
  - -whether or not feeding bottles are used;
  - -the presence or absence of advertisements for baby milk;
  - -whether sick mothers and babies are admitted to hospital together;
  - -how low-birth-weight babies are fed.
- Do not comment on your observations, or show any disapproval, while in the health facility. Wait until the facilitator invites participants to comment privately, or in the classroom.

- *Ask if the participants understand what they are to do during the clinical practice and answer any questions. Give directions how to reach the clinical practice area.*

2. Conduct the clinical practice 80 minutes

- *For the facilitator of each small group:*

- When you arrive at the clinical practice area:
  - Introduce yourself and your group to the staff member in charge.
  - Ask which mothers and babies it would be appropriate to talk to, and where they are.
  - Try to find a mother and baby who are breastfeeding, or a mother who thinks that her baby may want to feed soon. If this is not possible, talk to any mother and baby.
  - Remember to praise what mothers are doing right and offer a small amount of relevant information if appropriate.
- When a participant finds a mother who needs help with positioning and attaching her baby, observe the participant assisting that mother, giving any necessary help as needed.
- When the participant has finished talking with the mother, take the group away from the mother, and discuss what the participants observed. Ask them:
  - What did they observe generally about the mother and baby?
  - What signs from the Breastfeed Observation Aid did they observe?
  - Which communication skills did they observe?
- If the mother and baby showed any signs of good or poor positioning and attachment that participants did not see, point them out.
- Before your group leaves the ward or clinic, tell the staff member which mothers you have suggested to change their positioning and attachment so that the staff member can follow-up with these mothers.

3. Discuss the clinical practice 20 minutes

- *The whole class comes back together to discuss the clinical practice.*

Ask one participant from each group to report briefly on what they learnt.

- Ask them to comment:
  - On their experiences using the Breastfeed Observation Aid and the list of Communication Skills.
  - On any special situations of mothers and babies and what they learnt from these situations.

  Encourage participants report only on points of special interest; they do not need to report on details of every individual mother.
- Participants may continue to practice their skills of observing and assisting mothers at other times if this is acceptable to the mothers and to the hospital ward or clinic. Encourage participants to practice in pairs so that one can observe the skills used and discuss them afterwards with the other participant.
- Review any points about the clinical practice that will help the next clinical practice to go better.

- *Ask if there are any questions.*

CLINICAL PRACTICE 2-
TALKING WITH A PREGNANT WOMAN

Session Objectives:

On completion of this session, participants will be able to:
1. Talk with a pregnant woman about her feeding her baby;
2. Discuss with a pregnant woman practices that assist in establishing breastfeeding;
3. Use communication skills of listening and learning, and building confidence.

Total session time: 60 minutes

Travel time to and from the clinical practice area is NOT included in this time.

Materials:

ANTENATAL CHECKLIST – a copy for each participant (optional).
List of Communication Skills from Session 2 – a copy for each participant.
Flip chart page with Communication Skills from Session 2.

Preparation for Clinical Practice:

Make sure that you know where the clinical practice will be held, and where each facilitator should take her group. If you did not do so in a preparatory stage, visit the antenatal ward or clinic where you will go, introduce yourself to the staff members in charge, and make sure that they are prepared for the session.

The session time does not include time for travel to a clinical practice site. Add extra time to the timetable if participants must leave the building to go to another site.

1. Explain the clinical practice 10 minutes

- This clinical practice gives you an opportunity to:
  - Talk with a pregnant woman about her feeding intentions.
  - Discuss with a pregnant woman practices that assist in establishing breastfeeding, such as early skin to skin contact, rooming-in, baby led feeding, and exclusive breastfeeding without supplements and artificial teats.
  - Use your communication skills of listening and learning, and building confidence.
- You work in groups of 4 with a facilitator with each group. To start with, the whole group works together. You take turns to talk to a pregnant woman, while the other members of the group observe. When everyone knows what to do, you can work in pairs, while the facilitator circulates.
- <u>One participant in each small group will talk to a mother:</u>
  - Introduce yourself to the pregnant woman and ask permission to talk to her about feeding her baby.
  - Introduce the group or your partner, and explain that you are interested in infant feeding.
  - Try to find a chair or stool to sit on.
  - Ask the pregnant woman some open questions, such as “What are your thoughts on feeding your baby?” or “What do you know about breastfeeding?” to start the conversation.
  - Encourage the mother to talk by using your communication skills. *Refer to list of Communication Skills.* Practise using as many of the listening and learning skills as possible.
  - If the woman’s comments tell you that she already knows much about breastfeeding, you can reflect her knowledge and praise her. You do not need to give her information that she already knows.
  - Provide information in a way that is easy to understand. Include the importance of breastfeeding for the woman as well as her baby and some information on why practices are recommended.
  - Offer opportunities for the woman to ask questions or discuss the information more. You can ask about previous breastfeeding experiences if the woman already has children.
  - Remember to praise what the woman is doing right and offer a small amount of relevant information if appropriate.
- If the pregnant woman tells you that she is not going to breastfeed because she has a medical condition – do NOT ask about her condition. You do not need to know her personal details. You can ask her if anyone has talked to her about feeding her baby if she is not breastfeeding.

- *Check that participants know where they can refer a mother for infant feeding counselling if needed.*

- <u>The rest of the small group observe:</u>
  - Stand quietly in the background. Try to be as still and quiet as possible. Do not comment, or talk among yourselves.
  - Make *general* observations concerning the conversation between the pregnant woman and the participant. Notice for example: who does most of the talking? Does the participant ask open questions? Does the pregnant woman talk freely, and seem to enjoy it?
  - Make *specific* observations concerning the participant's communication skills. Notice if she or he uses helpful non-verbal communication, uses judging words, or asks a lot of questions to which the mother says `yes' and `no'.
- <u>When you have finished talking with the pregnant woman:</u>
  - Thank the pregnant woman for her time and cooperation and say something to encourage and support her.
  - Go with the group into another room or private area to discuss your observations.
  - Discuss what you noticed about the discussion and what you noticed about the communication skills that the participant used.
- Each participant should talk with at least one pregnant woman.
- <u>While you are in the ward or clinic notice:</u>
  - The presence or absence of advertisements for baby formula, free samples, or pens or other equipment advertising baby formula
  - Any posters of leaflets for mothers on the importance of breastfeeding or how to breastfeed.
- Do not comment on your observations or show any disapproval while in the health facility. Wait until the facilitator invites you to comment privately, or in the classroom.

- *Ask if the participants understand what they are to do during the clinical practice and answer any questions. Give directions how to reach the clinical practice area.*

2. Conduct the clinical practice 40 minutes

- *For the facilitator of each small group:*

- Ensure that your group has the Antenatal Checklist (if using this) and a list of Communication Skills to practice using and to watch for when observing colleagues.
- When you arrive at the clinical practice area:
  - Introduce yourself and your group to the staff member in charge.
  - Ask which pregnant women it would be appropriate to talk with and where they are.
- When the participant is finished talking with a pregnant woman, take the group away from the pregnant woman, and discuss what they observed. Ask them:
  - Which communication skills did they observe?
  - Was the information provided accurate and in a suitable amount?

3. Discuss the clinical practice 10 minutes

- *The whole class comes back together to discuss the clinical practice.*

Ask one participant from each group to report briefly on what they learnt.

- Ask them to comment on:
  - What the main issues were that women wanted to discuss when they offered information.
  - Their experiences using the list of Communication Skills to talk with the pregnant women.

  Encourage participants to report only on points of special interest. They do not need to report on details of every individual pregnant woman.
- Review any points about the clinical practice that will help the next clinical practice to go better.

- *Ask if there are any questions.*

CLINICAL PRACTICE 3 –
OBSERVING HAND EXPRESSION AND CUP FEEDING

Session Objectives:

On completion of this session, participants will be able to:

1. Assist a mother to learn the skills of hand expression.
2. Observe a cup feeding demonstration.

Session time:

- **60 minutes** for hand expression practice.
- **30 minutes** for cup feeding demonstration.

The session time does not include time for travel to a clinical practice site(s). Add extra time to the timetable if participants must leave the building to go to another site.

Materials:

List of Communication Skills from Session 2 – a copy for each participant.
MILK EXPRESSION handout from Session 11– a copy for each participant.
HOW TO CUP FEED A BABY handout from Session 11.

Cup feeding demonstration:
Small sterile cup and a small cloth to catch any dribbles while cup feeding
Remind participants to bring their handout on Cup Feeding a Baby from the earlier session.

Preparation for the clinical practice:

The hand expression clinical practice and the cup feeding demonstration may be done at separate times.

A mother may be willing to bring her baby to the classroom for the cup feeding demonstration. In some places, mothers may be willing to come to the classroom to learn about hand expression.

This demonstration might be done in an outpatients' clinic for well-baby visits or immunisations. If the baby is preterm or ill, the group is a possible infection risk to the baby. Try to find a young healthy baby to demonstrate cup feeding.

If the clinical practice is to be held in a clinic or ward, make sure that you know where this is and where each facilitator should take her group. If you did not do so in a preparatory week, visit the wards or clinic where you will go, introduce yourself to the staff members in charge, and make sure that they are prepared for the session.

If needed, ensure there is somewhere private to teach/observe hand expression.

Discuss with the staff on the ward or clinic what containers they use for expressed milk that will be fed to a baby. Ensure there are some clean containers available if the mother wishes to keep the milk that she expresses.

Conduct the cup feeding demonstration in small groups so everyone can see and the mother and the baby are not overwhelmed.

1. Explain the clinical practice – hand expression 5 minutes

Explain the instructions to the participants

- This clinical practice gives you an opportunity to:
  - Assist a mother to learn the skills of hand expression.
  - Practice using your communication skills.

- *Briefly review the four key points of expressing. Remind participants that it does not matter what quantity of milk is expressed in this practice.*

- Each group of four divides into two pairs of participants. Each pair works separately. One person of the pair talks to a mother, while the other observes. The facilitator circulates between the pairs observing and assisting as needed. Mothers may be unwilling to hand express with a group observing.
- To begin:
  - Introduce yourself to the mother and ask permission to talk to her.
  - Introduce your partner and explain that you are interested in learning about hand expression of breast milk.
- Ask the mother some open questions about how she is, how her baby is, and how feeding is going, to start the conversation. Encourage the mother to talk about herself and her baby. Be aware that the mother may be hand expressing for reasons that she does not want to discuss – do not push her to explain. If her baby is ill, show empathy, however you do not need to discuss her baby's condition in detail. Practice as many of the listening and learning skills as possible.
- Ask the mother if she expresses her milk by hand.
  - If she does hand express, ask her if she can show you how she hand expresses. Let her show you without interruption while you observe the way that she does it – do not stop her and tell her that she is doing something wrong, even if you think that she is.
  - If she is comfortable hand expressing, there is milk flowing and she is happy with her technique, praise her for what she is doing, reinforce that breast milk is best for babies and thank her for helping you to learn.
  - If the mother has difficulty with hand expressing, make some positive comments and then ask her if you can suggest some ways that might be easier for her. Explain in simple words the reason for any suggestions you make, for example, if you suggest that she move her fingers around the breast, explain that there is milk in all areas of the breast and moving her fingers helps the milk to flow from these areas.
  - If the mother does not know about hand expression, ask her if you can tell her why it might be useful to learn hand expression. If she agrees, explain some of the reasons why hand expression might be useful to her. Then ask if you can help her to learn how to hand express.
- Try to find a chair or stool to sit on, so that you are at the mother's level. Ensure the mother is comfortable and has some privacy if needed.
- The mother can either just express a small amount to show you how she does it or she can express a full feed for her baby if her baby receives expressed breast milk regularly. If the mother is feeding the milk to the baby, she needs to wash her hands and prepare a suitable container for the milk.
- The first time that a pair finds a mother, who needs help with hand expression, ask the mother for her permission for the facilitator to join you. The participant helps the mother to learn how to hand express, while the facilitator observes and assists if needed.

- The partner will observe:
  - Stand quietly in the background. Try to be as still and quiet as possible. Do not comment.
  - Make *general* observations of the hand expression – does the mother seem comfortable or does it seem to hurt; does the milk flow? You can use the Hand Expression Aid to help you remember the key points to look for.
  - Make *general* observations of the conversation between the mother and the participant. Notice for example: Who does most of the talking? Does the participant ask open or closed questions? Does the mother talk freely, and seem to enjoy the discussion or does she find it hard to talk?
  - Make *specific* observations of the participant's communication skills. Notice if she or he uses helpful non-verbal communication, uses judging words, or asks a lot of questions to which the mother says `yes' and `no'.
- When you have finished observing each mother:
  - Thank the mother for her time and cooperation and say something to praise and support her.
  - Go with your partner into another room or private area away from the mothers to discuss your observations.
  - Discuss with your facilitator what you noticed about the hand expression and what you noticed about the communication skills that the participant used.
- Each participant will observe at least one mother hand expressing. Not all mothers will need help to learn how to hand express.
- While you are in a ward or clinic, notice:
  - if babies room-in with their mothers;
  - the presence or absence of breast pumps[76];
  - how breast milk is handled/stored for later feeding to a baby in special care;
  - how low-birth-weight or ill babies are fed if they are unable to breastfeed.
- Do not comment on your observations, or show any disapproval, while in the health facility. Wait until the facilitator invites you to comment privately, or in the classroom.

- *Ask if the participants understand what they are to do during the clinical practice and answer any questions. Give directions how to reach the clinical practice area.*

76 Breast pumps are not required to express milk. If you see no pumps on the ward, this may indicate that the staff are very skilled at helping the mothers to learn to hand express, which is a positive practice.

2. Conduct the clinical practice – hand expression 45 minutes

Instructions for the facilitator of each small group:

- When you arrive at the clinical practice area:
  - Introduce yourself and your group to the staff member in charge.
  - Ask which mothers it would be appropriate to talk to and where they are.
  - Ask that if you find a mother who needs help with hand expression, is it all right to help the mother or do they need to check individually for each mother before they assist her.
  - Remember to praise what mothers are doing right and offer a small amount of relevant information if appropriate.
- Mothers may need something to catch the expressed milk in – a cloth, cotton wool, or if keeping the milk a clean container. If the milk is to be given to the baby, the mother will need to wash her hands first.
- Go between the two pairs in your group. Observe their communication skills and how they assist a mother to learn. If needed, you can demonstrate to the pair, if the mother is willing.
- When the pair of participants is finished talking with the mother, take the group away from the mother, and discuss what they observed. Ask them:
  - What did they observe generally about the mother and baby?
  - What signs from the Hand Expression Aid did they observe?
  - Which communication skills did they observe?
- Let participants comment on their own performances first. Then you can reinforce what they did well, give them relevant information and suggest changes that could be made for the next time they help a mother.
- If the mother has any good techniques of hand expressing that participants did not see, point them out.

3. Discuss the clinical practice – hand expression 10 minutes

- *The whole class comes back together to discuss the clinical practice.*

Ask participants to report briefly on what they learnt.

- Ask them to comment on:
  - Any special situations of mothers and babies and what they learnt from these situations with regard to expressing milk or feeding expressed milk to the baby.
  - Their experiences using the Communication Skills.

  Because of time limits, participants should report only on points of special interest, rather than on details of every individual mother and baby.
- Participants may continue to practice their skills of observing and assisting mothers at other times if this is acceptable to the mothers and to the hospital ward or clinic. Encourage participants to practice in pairs so that one can observe the skills used and discuss them afterwards with her partner.
- Review any points about the clinical practice that will help the next clinical practice to go better.

- *Ask if there are any questions.*

4. Clinical practice – cup feeding demonstration[77] 30 minutes

- Most babies will be able to feed at the breast and not need to cup feed. Health workers need to know the basic technique of how cup feeding is done so that they are aware that it works.
- Not every mother needs to know how to cup feed her baby, and you are not practicing teaching this skill to all the mothers. You will see a demonstration of cup feeding so that you understand how it works[78].

- *Review the main points of cup feeding from Session 11.*

Instructions for facilitator

- Conduct the cup feeding demonstration in small groups so everyone can see and to avoid overwhelming the baby and the mother.
- Ask a mother if you may demonstrate cup feeding with her baby. This may be a baby who is already receiving expressed breast milk or replacement milk already by cup or a mother who would like to learn how this is done.
- Use open questions to ask about her baby and how the baby is feeding. Explain to the mother why cup feeding is used sometimes.
- Demonstrate to the group how to cup feed. When you are finished, ask the mother what she thought about cup feeding. Answer questions that the mother may have about cup feeding.
- Then move away from the mother and baby before you discuss what the participants observed and learnt about cup feeding.

- Review any points about the clinical practice that will help the next clinical practice to go better.

- *Ask if there are any questions.*

77 If the baby is preterm or ill, the group is a possible infection risk. Try to find a healthy baby to demonstrate cup feeding.
78 Additional clinical practice time can be arranged to provide an opportunity for participants to practice teaching mothers the skill of cup feeding. This skill is explained in more detail in *HIV and Infant Feeding Counselling Tools*, as cup feeding is a skill many mothers who are replacement feeding need to know.

Appendix 1 :

WHO/NMH/NHD/09.01
WHO/FCH/CAH/09.01

Acceptable medical reasons for use of breast-milk substitutes

© World Health Organization 2009

All rights reserved. Publications of the World Health Organization can be obtained from WHO Press, World Health Organization, 20 Avenue Appia, 1211 Geneva 27, Switzerland (tel.: +41 22 791 3264; fax: +41 22 791 4857; e-mail: bookorders@who.int). Requests for permission to reproduce or translate WHO publications – whether for sale or for noncommercial distribution – should be addressed to WHO Press, at the above address (fax: +41 22 791 4806; e-mail: permissions@who.int).

The designations employed and the presentation of the material in this publication do not imply the expression of any opinion whatsoever on the part of the World Health Organization concerning the legal status of any country, territory, city or area or of its authorities, or concerning the delimitation of its frontiers or boundaries. Dotted lines on maps represent approximate border lines for which there may not yet be full agreement.

The mention of specific companies or of certain manufacturers' products does not imply that they are endorsed or recommended by the World Health Organization in preference to others of a similar nature that are not mentioned. Errors and omissions excepted, the names of proprietary products are distinguished by initial capital letters.

All reasonable precautions have been taken by the World Health Organization to verify the information contained in this publication. However, the published material is being distributed without warranty of any kind, either expressed or implied. The responsibility for the interpretation and use of the material lies with the reader. In no event shall the World Health Organization be liable for damages arising from its use.

Preface

A list of acceptable medical reasons for supplementation was originally developed by WHO and UNICEF as an annex to the Baby-friendly Hospital Initiative (BFHI) package of tools in 1992.

WHO and UNICEF agreed to update the list of medical reasons given that new scientific evidence had emerged since 1992, and that the BFHI package of tools was also being updated. The process was led by the departments of Child and Adolescent Health and Development (CAH) and Nutrition for Health and Development (NHD). In 2005, an updated draft list was shared with reviewers of the BFHI materials, and in September 2007 WHO invited a group of experts from a variety of fields and all WHO Regions to participate in a virtual network to review the draft list. The draft list was shared with all the experts who agreed to participate. Subsequent drafts were prepared based on three inter-related processes: a) several rounds of comments made by experts; b) a compilation of current and relevant WHO technical reviews and guidelines (see list of references); and c) comments from other WHO departments (Making Pregnancy Safer, Mental Health and Substance Abuse, and Essential Medicines) in general and for specific issues or queries raised by experts.

Technical reviews or guidelines were not available from WHO for a limited number of topics. In those cases, evidence was identified in consultation with the corresponding WHO department or the external experts in the specific area. In particular, the following additional evidence sources were used:
-*The Drugs and Lactation Database* (LactMed) hosted by the United States National Library of Medicine, which is a peer-reviewed and fully referenced database of drugs to which breastfeeding mothers may be exposed.
-*The National Clinical Guidelines for the management of drug use during pregnancy, birth and the early development years of the newborn*, review done by the New South Wales Department of Health, Australia, 2006.

The resulting final list was shared with external and internal reviewers for their agreement and is presented in this document.

The list of acceptable medical reasons for temporary or long-term use of breast-milk substitutes is made available both as an independent tool for health professionals working with mothers and newborn infants, and as part of the BFHI package. It is expected to be updated by 2012.

Acknowledgments

This list was developed by the WHO Departments of Child and Adolescent Health and Development and Nutrition for Health and Development, in close collaboration with UNICEF and the WHO Departments of Making Pregnancy Safer, Essential Medicines and Mental Health and Substance Abuse. The following experts provided key contributions for the updated list: Philip Anderson, Colin Binns, Riccardo Davanzo, Ros Escott, Carol Kolar, Ruth Lawrence, Lida Lhotska, Audrey Naylor, Jairo Osorno, Marina Rea, Felicity Savage, María Asunción Silvestre, Tereza Toma, Fernando Vallone, Nancy Wight, Anthony Williams and Elizabeta Zisovska. They completed a declaration of interest and none identified a conflicting interest.

Introduction

Almost all mothers can breastfeed successfully, which includes initiating breastfeeding within the first hour of life, breastfeeding exclusively for the first 6 months and continuing breastfeeding (along with giving appropriate complementary foods) up to 2 years of age or beyond.

Exclusive breastfeeding in the first six months of life is particularly beneficial for mothers and infants.

Positive effects of breastfeeding on the health of infants and mothers are observed in all settings. Breastfeeding reduces the risk of acute infections such as diarrhoea, pneumonia, ear infection, *Haemophilus influenza*, meningitis and urinary tract infection (1). It also protects against chronic conditions in the future such as type I diabetes, ulcerative colitis, and Crohn's disease. Breastfeeding during infancy is associated with lower mean blood pressure and total serum cholesterol, and with lower prevalence of type-2 diabetes, overweight and obesity during adolescence and adult life (2). Breastfeeding delays the return of a woman's fertility and reduces the risks of post-partum haemorrhage, pre-menopausal breast cancer and ovarian cancer (3).

Nevertheless, a small number of health conditions of the infant or the mother may justify recommending that she does not breastfeed temporarily or permanently (4). These conditions, which concern very few mothers and their infants, are listed below together with some health conditions of the mother that, although serious, are not medical reasons for using breast-milk substitutes.

Whenever stopping breastfeeding is considered, the benefits of breastfeeding should be weighed against the risks posed by the presence of the specific conditions listed.

INFANT CONDITIONS

Infants who should not receive breast milk or any other milk except specialized formula

- Infants with classic galactosemia: a special galactose-free formula is needed.
- Infants with maple syrup urine disease: a special formula free of leucine, isoleucine and valine is needed.
- Infants with phenylketonuria: a special phenylalanine-free formula is needed (some breastfeeding is possible, under careful monitoring).

Infants for whom breast milk remains the best feeding option but who may need other food in addition to breast milk for a limited period

- Infants born weighing less than 1500 g (very low birth weight).
- Infants born at less than 32 weeks of gestation (very preterm).
- Newborn infants who are at risk of hypoglycaemia by virtue of impaired metabolic adaptation or increased glucose demand (such as those who are preterm, small for gestational age or who have experienced significant intrapartum hypoxic/ischaemic stress, those who are ill and those whose mothers are diabetic (5) if their blood sugar fails to respond to optimal breastfeeding or breast-milk feeding.

MATERNAL CONDITIONS

Mothers who are affected by any of the conditions mentioned below should receive treatment according to standard guidelines.

Maternal conditions that may justify permanent avoidance of breastfeeding

- HIV infection[79]: if replacement feeding is acceptable, feasible, affordable, sustainable and safe (AFASS) (6). Otherwise, exclusive breastfeeding for the first six months is recommended.

Maternal conditions that may justify temporary avoidance of breastfeeding

- Severe illness that prevents a mother from caring for her infant, for example sepsis.
- Herpes simplex virus type 1 (HSV-1): direct contact between lesions on the mother's breasts and the infant's mouth should be avoided until all active lesions have resolved.
- Maternal medication:
  - sedating psychotherapeutic drugs, anti-epileptic drugs and opioids and their combinations may cause side effects such as drowsiness and respiratory depression and are better avoided if a safer alternative is available (7);
  - radioactive iodine-131 is better avoided given that safer alternatives are available - a mother can resume breastfeeding about two months after receiving this substance;
  - excessive use of topical iodine or iodophors (e.g., povidone-iodine), especially on open wounds or mucous membranes, can result in thyroid suppression or electrolyte abnormalities in the breastfed infant and should be avoided;
  - cytotoxic chemotherapy requires that a mother stops breastfeeding during therapy.

Maternal conditions during which breastfeeding can still continue, although health problems may be of concern

- Breast abscess: breastfeeding should continue on the unaffected breast; feeding from the affected breast can resume once treatment has started (8).
- Hepatitis B: infants should be given hepatitis B vaccine, within the first 48 hours or as soon as possible thereafter (9).
- Hepatitis C.
- Mastitis: if breastfeeding is very painful, milk must be removed by expression to prevent progression of the condition(8).
- Tuberculosis: mother and baby should be managed according to national tuberculosis guidelines (10).
- Substance use[80] (11):
  - maternal use of nicotine, alcohol, ecstasy, amphetamines, cocaine and related stimulants has been demonstrated to have harmful effects on breastfed babies;
  - alcohol, opioids, benzodiazepines and cannabis can cause sedation in both the mother and the baby.

  Mothers should be encouraged not to use these substances, and given opportunities and support to abstain.

---

79 The most appropriate infant feeding option for an HIV-infected mother depends on her and her infant's individual circumstances, including her health status, but should take consideration of the health services available and the counselling and support she is likely to receive. Exclusive breastfeeding is recommended for the first six months of life unless replacement feeding is AFASS. When replacement feeding is AFASS, avoidance of all breastfeeding by HIV-infected women is recommended. Mixed feeding in the first 6 months of life (that is, breastfeeding while also giving other fluids, formula or foods) should always be avoided by HIV-infected mothers.

80 Mothers who choose not to cease their use of these substances or who are unable to do so should seek individual advice on the risks and benefits of breastfeeding depending on their individual circumstances. For mothers who use these substances in short episodes, consideration may be given to avoiding breastfeeding temporarily during this time.

References

(1) *Technical updates of the guidelines on Integrated Management of Childhood Illness (IMCI). Evidence and recommendations for further adaptations.* Geneva, World Health Organization, 2005.

(2) *Evidence on the long-term effects of breastfeeding: systematic reviews and meta-analyses.* Geneva, World Health Organization, 2007.

(3) León-Cava N et al. *Quantifying the benefits of breastfeeding: a summary of the evidence*. Washington, DC, Pan American Health Organization, 2002 (http://www.paho.org/English/AD/FCH/BOB-Main.htm, accessed 26 June 2008).

(4) Resolution WHA39.28. Infant and Young Child Feeding. In: *Thirty-ninth World Health Assembly, Geneva, 5–16 May 1986. Volume 1. Resolutions and records. Final.* Geneva, World Health Organization, 1986 (WHA39/1986/REC/1), Annex 6:122–135.

(5) Hypoglycaemia of the newborn: review of the literature. Geneva, World Health Organization, 1997 (WHO/CHD/97.1; http://whqlibdoc.who.int/hq/1997/WHO_CHD_97.1.pdf, accessed 24 June 2008).

(6) *HIV and infant feeding: update based on the technical consultation held on behalf of the Inter-agency Task Team (IATT) on Prevention of HIV Infection in Pregnant Women, Mothers and their Infants, Geneva, 25–27 October 2006.* Geneva, World Health Organization, 2007 (http://whqlibdoc.who.int/publications/2007/9789241595964_eng.pdf, accessed 23 June 2008).

(7) *Breastfeeding and maternal medication: recommendations for drugs in the Eleventh WHO Model List of Essential Drugs.* Geneva, World Health Organization, 2003.

(8) *Mastitis: causes and management.* Geneva, World Health Organization, 2000 (WHO/FCH/CAH/00.13; http://whqlibdoc.who.int/hq/2000/WHO_FCH_CAH_00.13.pdf, accessed 24 June 2008).

(9) *Hepatitis B and breastfeeding*. Geneva, World Health Organization, 1996. (Update No. 22).

(10) *Breastfeeding and Maternal tuberculosis.* Geneva, World Health Organization, 1998 (Update No. 23).

(11) *Background papers to the national clinical guidelines for the management of drug use during pregnancy, birth and the early development years of the newborn.* Commissioned by the Ministerial Council on Drug Strategy under the Cost Shared Funding Model. NSW Department of Health, North Sydney, Australia, 2006. http://www.health.nsw.gov.au/pubs/2006/bkg_pregnancy.html

Further information on maternal medication and breastfeeding is available at the following United States National Library of Medicine (NLM) website:
http://toxnet.nlm.nih.gov/cgi-bin/sis/htmlgen?LACT

For further information, please contact:

Department of Nutrition for Health and Development
E-mail: nutrition@who.int
Web: www.who.int/nutrition

Department of Child and Adolescent Health and Development
E-mail: cah@who.int
Web: www.who.int/child_adolescent_health

Address: 20 Avenue Appia, 1211 Geneva 27, Switzerland

Appendix 2: Knowledge Checks

Session 1 Knowledge Check

A colleague asks you why this course is taking place and how it would help mothers and babies that you care for. What will you reply?

Session 3 Knowledge Check

List two reasons why exclusive breastfeeding is important for the child.

List two reasons why breastfeeding is important for the mother.

What information do you need to discuss with a woman during her pregnancy that will help her to feed her baby?

List two antenatal practices that are helpful to breastfeeding and two practices that might be harmful.

If a woman is tested and found to be HIV-positive, where can she get infant feeding counselling?

Session 4 Knowledge Check *- mark the answer True (T) or False (F)*

1.Giving mothers company-produced leaflets about breast milk substitutes can affect infant feeding practices.	T	F
2.Breast-milk substitutes include formula, teas, and juices (as well as other products)	T	F
3.The International Code and BFHI prohibit the use of formula for infants in maternity wards	T	F
4.Health workers can be given any publication or materials by companies as long as they do not share these publications with mothers	T	F
5.Donations of formula should be given to mothers of infants in emergency situations	T	F

Session 5 Knowledge Check

List four labour or birth practices that can help the mother and baby get a good start with breastfeeding.

List three ways to assist a mother following a caesarean section with breastfeeding.

Name three possible barriers to early skin-to-skin contact and how each might be overcome.

Session 6 Knowledge Check

Describe to a new mother how to tell if her baby is well attached and suckling effectively.

Session 7 Knowledge Check

What are the four key points to look for with regard to the baby's position?

You are watching Donella breastfeed her four-day old baby. What will you look for to indicate that the baby is suckling well?

Session 8 Knowledge Check

Give three reasons why rooming-in is recommended as routine practice.

Explain as you would to a mother, what is meant by ‘demand feeding’ or baby-led feeding.

List three difficulties or risks that can result from supplement use.

Session 9 Knowledge Check

Keiko tells you that she thinks she does not have enough milk. What is the first thing you will say to her? What will you ask her in order to learn if she truly does have a low milk supply?

You decide that Ratna's baby Meena is not taking sufficient breast milk for his needs. What things can you do to help Ratna increase the amount of breast milk that her baby receives?

Session 10 Knowledge Check

Jacqueline has a 33-week preterm baby in the special care nursery. It is very important that her baby receive her breast milk. How will you help Jacqueline get her milk started? How will you help her with putting the baby to her breast after a few days?

Yoko gives birth to twin girls. She fears she cannot make enough milk to feed two babies and that she will need to give formula. What is the first thing you can say to Yoko to help give her confidence? What will you suggest for helping Yoko breastfeed her babies?

Session 11 Knowledge check

List four reasons why it is recommended that mothers learn to hand express.

List four reasons why cup feeding is preferred to feeding by other means if the baby cannot breastfeed.

Session 12 Knowledge Check

What breastfeeding difficulties would suggest to you that you need to examine a mother's breasts and nipples?

Rosalia tells you she became painfully engorged when she breastfed her last baby. She is afraid it will happen with the next baby too. What will you tell her about preventing engorgement?

Bola complains that her nipples are very sore. When you watch her breastfeed, what will you look for? What can you do to help her?

Describe the difference between a blocked duct, non-infective mastitis and infective mastitis. What is the most important treatment for all of these conditions?

Session 13 Knowledge Check

A pregnant woman says to you that she cannot breastfeed because she would need to buy special foods for herself that she could not afford. What can you say to her to help her see that breastfeeding is possible for her?

A co-worker says to you that a mother will need to stop breastfeeding because she needs to take a medication. What can you reply to this co-worker?

Session 14 Knowledge Check

List three sources of support for mothers in your community.

Give two reasons why mother-to-mother support may be useful to mothers.

Give two reasons why breastfeeding is important to the older baby and the mother.

Session 15 Knowledge Check

List two reasons why a hospital might seek BFHI external assessment.

Explain, as if to a co-worker, why achieving baby-friendly designation is not the end of the process and the importance of on-going monitoring.

The Baby-friendly Hospital Initiative (BFHI) is a global effort launched by WHO and UNICEF to implement practices that protect, promote and support breastfeeding. It was launched in 1991 in response to the Innocenti Declaration. The global BFHI materials have been revised, updated and expanded for integrated care. The materials reflect new research and experience, reinforce the International Code of Marketing of Breast-milk Substitutes, support mothers who are not breastfeeding, provide modules on HIV and infant feeding and mother-friendly care, and give more guidance for monitoring and reassessment.

The revised package of BFHI materials includes five sections: 1. Background and Implementation, 2. Strengthening and Sustaining the BFHI: A course for decision-makers, 3. Breastfeeding Promotion and Support in a Baby-friendly Hospital: a 20-hour course for maternity staff, 4. Hospital Self-Appraisal and Monitoring, and 5. External Assessment and Reassessment. Sections 1 to 4 are widely available while section 5 is for limited distribution.

For further information please contact:

Department of Nutrition for Health and Development (NHD)
World Health Organization
20 Avenue Appia
1211 Geneva 27
Switzerland
Fax: +41 22 791 41 56
e-mail: nutrition@who.int
website: www.who.int/nutrition

Nutrition Section - Programme Division
UNICEF
3 United Nations Plaza
New York, New York 10017, United States of America
Tel: +1 212 326 7765
e-mail: nutrition@unicef.org
website: www.unicef.org

ISBN 978 92 4 159498 1