Participant's Manual

BABY-FRIENDLY HOSPITAL INITIATIVE TRAINING COURSE FOR MATERNITY STAFF

World Health Organization

unicef

Baby-friendly Hospital Initiative training course for maternity staff: participant's manual

ISBN (WHO) 978-92-4-000895-3 (electronic version)
ISBN (WHO) 978-92-4-000896-0 (print version)

Suggested citation. Baby-friendly Hospital Initiative training course for maternity staff: participant's manual. Geneva: World Health Organization and the United Nations Children's Fund (UNICEF), 2020. Licence: CC BY-NC-SA 3.0 IGO.

Cataloguing-in-Publication (CIP) data. CIP data are available at http://apps.who.int/iris.

Design by Thahira Shireen Mustafa
Photo credits: © WHO/Gato Borrero

CONTENTS

TRAINING MATERIALS

Acknowledgements

The development of this training curriculum was coordinated by the World Health Organization (WHO) Department of Nutrition and Food Safety, and the United Nations Children's Fund (UNICEF) Nutrition Section, Programme Division. Thahira Shireen Mustafa, Laurence Grummer-Strawn, and Maaike Arts oversaw the revision of this training curriculum.

This training curriculum is an update of the 2009 Baby-friendly Hospital Initiative (BFHI) training materials. Heather Rusi and Dana Hardy provided support in revising the package of the materials. We also thank the guidance and inputs provided the Advisory Commmittee members for this revision process (in alphabetical order): Decalie Brown, Felicity Savage, Hiroko Hongo, Marina Ferreira Rea, Mona Abdulrahman Alsumaie, Mudiwah Kadeshe.

The updated materials were used in a pilot training jointly organized by WHO and UNICEF in collaboration with Ministry of Health and Family Welfare, Government of India. The pilot training was held from 11 – 14 March 2019 at Postgraduate Institute of Medical Education and Research and Dr. Ram Manohar Lohia Hospital, New Delhi, India.

We appreciate the extensive support provided by Arti Maria, Angela de Silva, Gayatri Singh, and Rachita Gupta, along with the staff of WHO and UNICEF Country offices in India and Sri Lanka and the staff of Dr. Ram Manohar Lohia Hospital, New Delhi, India in organizing this pilot-training. Acknowledgement is given to all the resource persons who participated as trainers and facilitators during the training (in alphabetical order): Dana Hardy, Dhammica Rowel, Dulanie Gunesekera Siriwardene, Nethmini Thenuwara, Preethi Sainia, Shacchee Baweja, and Sila Deb.

Special thanks to the many colleagues who participated in the training and provided extensive and valuable comments and suggestions to improve the training materials (in alphabetical order): Alka Mathur, Amlin Shukla, Anita Gupta, Anita Rajorhia, Bahunshisha Kharkongor, Basant, Bhupinder Kaur, Isha Thapar, Jassal, Krishna Bhattacharya, Kriti Jain, Manathunga, Mutum Shanti, Navita, Nidhi Chopra, Preeti Sainia, Priya Gandhi, Pushpamma Sebastian, Reetu Singh, Rohini Sehgal, Ruchika Chugh Sachdeva, Sanarei Thangal, Sangeeta Rani, Sarita Bhagwat, Sebanti Ghosh, Shweta, Sonu Mishra, Sudha, Susan, Tapas Bandyopadhyay, and Veena Bahri.

We also greatly appreciate the technical input received from the members of the Baby-Friendly Hospital Initiative (BFHI) Network, International Baby Food Action Network (IBFAN), International Lactation Consultants Association (ILCA), La Leche League International (LLLI) and World Alliance for Breastfeeding Action (WABA) during the revision process of the training materials.

WHO gratefully acknowledges the financial contribution of the Bill & Melinda Gates Foundation, the Ministry of Health and Welfare, Republic of Korea and the United States Agency for International Development towards the preparation of this training curriculum.

Abbreviations

ART	antiretroviral therapy
ARV	antiretroviral
BFHI	Baby-friendly Hospital Initiative
HIV	human immunodeficiency virus
IgA	immunoglobulin A
IgG	immunoglobulin G
TB	tuberculosis
UNICEF	United Nations Children's Fund
WHA	World Health Assembly
WHO	World Health Organization

Glossary

Afterpains: Contraction of the uterus during breastfeeding in the first few days after childbirth, owing to release of oxytocin.

Allergy: Symptoms when fed even a small amount of a particular food (so it is not dose related).

Alveoli: Small sacs of milk-secreting cells in the breast.

Amenorrhea: Absence of menstruation.

Anaemia: Lack of red cells or lack of haemoglobin in the blood.

Antenatal preparation: Preparation of a mother for the delivery of her baby.

Antibodies: Proteins in the blood and in breast milk that fight infection.

Appropriate touch: Touching somebody in a socially acceptable way.

Areola: Dark skin surrounding the nipple.

Artificial feeding: Feeding an infant on a breast-milk substitute.

Artificial feeds: Any kind of milk or other liquid given instead of breastfeeding.

Artificial teat: The part of a feeding bottle from which a baby sucks.

Artificially fed: Receiving artificial feeds only, and no breast milk.

Attachment: The way a baby takes the breast into his/her mouth; a baby may be well attached or poorly attached to the breast.

Baby-friendly Hospital Initiative (BFHI): An approach to transforming maternity practices as recommended in the joint World Health Organization (WHO)/United Nations Children's Fund (UNICEF) statement on *Protecting, promoting and supporting breastfeeding: the special role of maternity services* (1989).[1]

Bilirubin: Yellow breakdown products of haemoglobin, which cause jaundice.

Blocked duct: A milk duct in the breast becoming blocked with thickened milk, so that the milk in that part of the breast does not flow out.

Bonding: Development of a close loving relationship between a mother and her baby.

Bottle-feeding: Feeding an infant from a bottle, whatever is in the bottle, including expressed breast milk, water, formula, etc.

Breast pump: Device for expressing milk.

Breastfeeding history: All the relevant information about what has happened to a mother and baby, and how their present breastfeeding situation developed.

Breastfeeding support: A group of mothers who help each other to breastfeed.

1 Protecting, promoting and supporting breastfeeding: the special role of maternity services. A joint WHO/UNICEF statement. Geneva: World Health Organization; 1989 (http://apps.who.int/iris/bitstream/10665/39679/1/9241561300.pdf, accessed 9 April 2020).

Breast-milk substitute: Any food being marketed or otherwise represented as a partial or total replacement for breast milk, whether or not it is suitable for that purpose.

Calories: Calories (or kilocalories) measure the energy available in food.

Candida: Yeast that can infect the nipple, and the baby's mouth and bottom. Also known as "thrush".

Casein: Protein in milk, which forms curds.

Cleft lip or palate: Abnormal division of the lip or palate.

Closed questions: Questions that can be answered with "yes" or "no".

Cold compress: Cloths soaked in cold water to put on the breast.

Colostrum: The special breast milk that women produce in the first few days after delivery; it is yellowish or clear in colour.

Confidence: Believing in yourself and your ability to do things.

Commercial infant formula: A breast-milk substitute formulated industrially, in accordance with applicable *Codex Alimentarius* standards, to satisfy the nutritional requirements of infants during the first months of life up to the introduction of complementary foods.

Complementary feeding: The child receives both breast milk, or a breast-milk substitute, and solid (or semi-solid) food.

Complementary food: Any food, whether manufactured or locally prepared, used as a complement to breast milk or to a breast-milk substitute.

Counselling: A way of working with people so that you understand their feelings and help them to develop confidence and decide what to do.

Cup-feeding: Feeding from an open cup without a lid, whatever is in the cup.

Chemotherapy: The use of anti-cancer drugs to destroy cancer cells.

Dehydration: Lack of water in the body.

Ducts, milk ducts: Small tubes that take milk to the nipple.

Dummy: An artificial nipple made of plastic for a baby to suck. Also known as a pacifier/soother.

Early contact: A mother holding her baby during the first hour or two after delivery.

Effective suckling: Suckling in a way that removes the milk efficiently from the breast.

Empathize: Show that you understand how a person feels from her/his point of view.

Engorgement: The breast is swollen with breast milk, blood and tissue fluid. Engorged breasts are often painful and oedematous and the milk does not flow well.

Exclusive breastfeeding: An infant receives only breast milk and no other liquids or solids, not even water, with the exception of drops or syrups consisting of vitamins, mineral supplements or medicines.
Expressed breast milk: Milk that has been removed from the breasts manually or by using a pump.

Express: To squeeze or press out.

Fissure: Break in the skin, sometimes called a "crack".

Flat nipple: A nipple that sticks out less than average.

Foremilk: The watery breast milk that is produced early in a feed.

Formula: Artificial milks for babies made out of a variety of products, including sugar, animal milks, soybean and vegetable oils. They are usually in powder form, to mix with water.

Full breasts: Breasts that are full of milk, and hot, heavy and hard, but from which the milk flows.

Gulp: Loud swallowing sounds due to swallowing a lot of fluid.

Herpes simplex virus type 1 (HSV-1): A virus causing contagious sores, most often around the mouth or on the genitals.

Hindmilk: The fat-rich breast milk that is produced later in a feed.

HIV: Human immunodeficiency virus.

HIV-negative: Refers to a person who has been tested for HIV with a negative result and who knows their result.

HIV-positive: Refers to a person who has been tested for HIV, whose results have been confirmed and who knows, and/or their parents know that they tested positive.

HIV testing and counselling: Testing for HIV status, preceded and followed by counselling. Testing should be voluntary and confidential, with fully informed consent. The expression means the same as the terms: "counselling and voluntary testing", "voluntary counselling and testing", and "voluntary and confidential counselling and testing". Counselling is a process, not a one-off event: for the HIV-positive client it should include life planning, and, if the client is pregnant or has recently given birth, it should include infant-feeding considerations.

Hormones: Chemical messengers in the body.

Immune system: Those parts of the body and blood including lymph glands and white blood cells, that fight infection.

Immunity: A defense system that the body has to fight diseases.

Ineffective suckling; Suckling in a way that removes milk from the breast inefficiently or not at all.

Infective mastitis: Mastitis resulting from bacterial infection.

Inhibit: To reduce or stop something.

Inverted nipple: A nipple that goes in instead of sticking out, or that goes in when the mother tries to stretch it out.

Jaundice: Yellow colour of eyes and skin.

Judging words: Words that suggest that something is right or wrong, good or bad.

Lactation: The process of producing breast milk.

Lactation amenorrhea method: Using the period of amenorrhea after childbirth as a method for family planning.

Lactose: The special sugar present in all milks.

Lipase: Enzyme to digest fat.

Low-birth-weight infant: A baby weighing less than 2.5 kg at birth.

Mastitis: Inflammation of the breast (*see* also Infective mastitis and non-infective mastitis).

Mature milk: The breast milk that is produced a few days after birth.

Meconium stools: The initial black and tarry stool of a newborn.

Micronutrients: Essential nutrients required by the body in small quantities (like vitamins and some minerals).

Micronutrient supplements: Preparations of vitamins and minerals.

Milk ejection: Milk flowing from the breast due to the oxytocin reflex, which is stimulated in response to the sight, touch or sound of the baby.

Milk stasis: Milk staying in the breast and not flowing out.

Milk expression: Removing milk from the breasts manually or by using a pump.

Mixed feeding: Feeding both breast milk and other foods or liquids.

Montgomery's glands: Small glands in the areola that secrete an oily liquid.

"Nipple confusion": A term sometimes used to describe the way babies who have fed from a bottle may find it difficult to suckle effectively from a breast.

Nipple sucking: When a baby takes only the nipple into his/her mouth so that he/she cannot suckle effectively.

Non-infective mastitis: Mastitis due to milk leaking out of the alveoli and back into the breast tissues with no bacterial infection.

Non-verbal communication: Showing your attitude through your posture and expression.

Nutrients: Substances the body needs that come from the diet. These are carbohydrates, proteins, fats, minerals and vitamins.

Mother-support group: A community-based group of women providing support for optimal breastfeeding and complementary feeding.

Open questions: Questions that can only be answered by giving information and not with just a "yes" or a "no".

Oxytocin: The hormone that makes the milk flow from the breast.

Pacifier: Artificial nipple made of plastic for a baby to suck (Also called a dummy).

Pneumonia: Infection of the lungs.

Poorly protractile: Used to describe a nipple that is difficult to stretch out to form a "teat".

Positioning: How a mother holds her baby at her breast; the term usually refers to the position of the baby's whole body.
Postnatal check: Routine visit to a health facility after a baby is born.

Prelacteal feeds: Artificial feeds given before breastfeeding is established.

Premature, preterm: Born before 37 weeks' gestation.

Prolactin: The hormone that makes the breasts produce milk.

Protein: Nutrient necessary for growth and repair of the body tissues.

Protractile: Used to describe a nipple that is easy to stretch out.

Psychological: Mental and emotional.

Reflect back: Repeat back what a person says to you, in a slightly different way.

Reflex: An automatic response through the body's nervous system.

Rejection of baby: The mother not wanting to care for her baby.

Reluctant to feed at the breast: A baby having difficulty to suckle from his/her mother's breast.

Replacement feeding: The process of feeding a child who is not receiving any breast milk with a diet that provides all the nutrients he/she needs until he/she is fully fed on family foods. During the first six months, this should be with a suitable breast-milk substitute.

Responsive feeding: Feeding infants directly and assisting older children when they feed themselves, being sensitive to their hunger and satiety cues.

Restricted breastfeeds: When the frequency or length of breastfeeds is limited in any way.

Retained placenta: A small piece of the placenta remaining in the uterus after delivery.

Rooming-in: A baby staying in the same room as their mother.

Rooting: A baby searching for the breast with their mouth.

Rooting reflex: A baby opening their mouth and turning to find the nipple.

Scissor hold: Holding the breast between the index and middle fingers while the baby is feeding.

Secrete: Produce a fluid in the body.

Sensory impulses: Messages in nerves that are responsible for feeling.

Sepsis: The body's life-threatening response to infection that can lead to tissue damage, organ failure, and death

Skin-to-skin contact: A mother holding her naked baby against her own skin.

Sore nipples: Pain in the nipple and areola when the baby feeds.

Sucking: Using negative pressure to take something into the mouth.

Sucking reflex: A reflex that allows a baby to automatically suck something that touches his/her palate.

Suckling: The action by which a baby removes milk from the breast.

Supplements: Drinks or artificial feeds given in addition to breast milk.

Support: Help.

Sustaining: Continuing to breastfeed up to two years or beyond; helping breastfeeding mothers to continue to breastfeed.

Swallowing reflex: A reflex whereby a baby automatically swallows when their mouth fills with fluid.

Sympathize: Show that you feel sorry for a person, from your point of view.

"Teat": Stretched out breast tissue from which a baby suckles.

Thrush: Infection caused by the yeast *Candida*. The infection occurs in the baby's mouth and forms white spots.

Unrestricted feeding: *See Responsive feeding.*

Warm compress: Cloths soaked in warm water to put on the breast.

Notes

1. Introduction to the course

1.1 Why this course is needed

The first few hours and days of a newborn baby's life are a critical window for establishing breastfeeding and for providing mothers with the support they need to breastfeed successfully. Since 1991, the Baby-friendly Hospital Initiative (BFHI) has helped to motivate facilities providing maternity and newborn baby services worldwide to better support breastfeeding. It has been adopted by many countries and organizations. The BFHI aims to provide a health-care environment that supports mothers to acquire the skills necessary to exclusively breastfeed for six months, and to continue breastfeeding for two years or beyond.

Breastfeeding and appropriate, safe and timely complementary feeding are fundamental to the health and development of children, and important for the health of their mothers. The World Health Organization (WHO) and the United Nations Children's Fund (UNICEF) have long recognized the need for the promotion of exclusive breastfeeding in the first six months of life and for sustained breastfeeding up to two years of age or beyond.

A hospital that is designated as baby-friendly must fully implement the TEN STEPS TO SUCCESSFUL BREASTFEEDING. These are a summary of the recommendations of *Protecting, promoting and supporting breastfeeding: the special role of maternity services*[1]. This was a joint WHO/UNICEF statement, published in 1989. The "Ten Steps" became part of the Baby-friendly Hospital Initiative in 1991, and the updated version in 2009. They were then revised in 2018 and continue to be valid throughout the world as the basis of the BFHI. There is substantial evidence to show that the Ten Steps improves breastfeeding rates.

This updated course is built upon the revised 2018 Ten Steps to successful breastfeeding, the latest version of the guidance for implementing the BFHI in facilities providing maternity and newborn services, and the World Health Organization (WHO) *Implementation guideline: protecting, promoting and supporting breastfeeding in facilities providing maternity and newborn services – the revised Baby-friendly Hospital Initiative* (BFHI)[2].

While the BFHI focuses on breastfeeding support, it also provides for integrated care to support all mothers including those who are not breastfeeding. In addition, the BFHI supports women living with HIV[3].

Many mothers have difficulty breastfeeding from the beginning, and health-care practices in many facilities hinder the process of establishing breastfeeding. However, even mothers who initiate breastfeeding satisfactorily often start supplements or stop breastfeeding within a few weeks of delivery. This may result in malnutrition, which is an increasing problem in many countries. It has been estimated that improved breastfeeding practices would prevent 823 000 annual deaths in children younger than five years of age[4].

Information on how to feed infants comes from family beliefs, community practices and information from health workers. Advertising and commercial promotion by food manufacturers is sometimes the source of information for many people, including families and health workers. It has often been difficult for health workers to discuss with families how best to feed their infants, owing to the confusing, and often conflicting information available.

All health workers who care for women and children during the postnatal period and beyond have a key role to play in establishing and sustaining breastfeeding. Many health workers cannot fulfil this role effectively because they have not been trained to do so. Little time is assigned to counselling and support skills for breastfeeding and infant feeding, in the pre-service curricula of either doctors, nurses, midwives or other professionals.

Hence, there is an urgent need, in all countries, to train all those involved in breastfeeding in the immediate postnatal period

[1] Protecting, promoting and supporting breastfeeding: the special role of maternity services. A joint WHO/UNICEF statement. Geneva: World Health Organization; 1989 (http://apps.who.int/iris/bitstream/10665/39679/1/9241561300.pdf, accessed 13 March 2020).

[2] Implementation guidance: protecting, promoting and supporting breastfeeding in facilities providing maternity and newborn services – the revised Baby-friendly Hospital Initiative. Geneva: World Health Organization; 1989 (https://apps.who.int/iris/bitstream/handle/10665/272943/9789241513807-eng.pdf?sequence=19&isAllowed=y, accessed 13 March 2020).

[3] Guideline: updates on HIV and infant feeding: the duration of breastfeeding, and support from health services to improve feeding practices among mothers living with HIV. World Health Organization and UNICEF; 2016. (http://apps.who.int/iris/bitstream/handle/10665/246260/9789241549707-eng.pdf?sequence=1, accessed 13 March 2020).

[4] Rollins NC, Bhandari N, Hajeebhoy N, Horton S, Lutter CK, Martines JC, Piwoz EG, et al. Why invest, and what it will take to improve breastfeeding practices? Lancet. 2016;387:491–504. doi:10.1016/S0140-6736(15)01044-2

in the skills needed to support and protect breastfeeding. The materials in this training course are designed to make it possible for trainers, even those with limited experience in teaching the subject, to conduct up-to-date and effective training.

The course materials available from WHO/UNICEF include modules related to:

- counselling skills
- breastfeeding and infant feeding
- breastfeeding support
- critical management procedures.

The course materials are intended to be conducted in their entirety. However, the course is organized in such a way that the course trainers can decide which sessions from which modules to cover, depending on the priorities and context of the country and the participants. The material could be thus used, for example, to hold a three-day course on the Ten Steps to successful breastfeeding, or courses on specific subjects, such as breastfeeding basics or breastfeeding support.

"Counselling" is an extremely important component of this course material. Counselling is more than just listening. You listen to a new mother, try to understand how she feels, and learn from what she is telling you. You can then help her decide for herself what is best for her, from various options or suggestions. This provides her with support and helps her to have the confidence to carry out their own decisions. This course aims to give health workers basic counselling skills, so that they can help mothers and caregivers more effectively.

The course material can be used to complement existing courses or as part of the pre-service education of health workers.

This course material does NOT prepare people to take full responsibility for caring for mothers breastfeeding their newborn babies. It does not cover in-depth topics on treatment, care and management of sick or low-birth-weight infants, those living with HIV, or those taking antiretroviral (ARV) drugs or antiretroviral therapy (ART). The material covers only aspects specifically related to the *Ten Steps to successful breastfeeding*.

1.2 Course objectives

After completing this course, participants will have the knowledge, skills and competence to protect, promote and support breastfeeding in the facilities where they work and understand the importance of the Ten Steps to Successful Breastfeeding and translate them into practice.

Each session of the course has a set of learning objectives that participants are expected to fulfil.

1.3 Course competencies

This course is based on a set of competencies that every participant is expected to learn during the course and subsequent practice, and to follow-up at their place of work. To become competent at something, you need a certain amount of knowledge and to be proficient in certain skills. The following table lists the competencies (column 1), and the knowledge (column 2) and skills required (column 3) for each competency.

The "knowledge" part of the competencies will be taught during this course and is contained in the *Participant's manual* for later referral and revision by participants. Most people find that they obtain the "knowledge" part of a competency more quickly than the "skills" part.

The "skills" part of the competencies will also be taught during this course. However, there may not be time for each participant to become proficient in every skill. This will depend on their previous experience. During the course, every participant should practise as many of the skills as possible, so that they know what to do when they return to their place of work.

The competencies are arranged according to area/session and in a certain order. The competencies at the beginning of table 1 are those that are most commonly used, and on which later competencies depend. For example, the competency USE LISTENING AND LEARNING SKILLS TO COUNSEL A MOTHER OR CAREGIVER is used in many of the other competencies.

TABLE 1. COURSE COMPETENCIES

Competency	Knowledge	Skills	Session
Counselling			
C1. Use listening and learning skills whenever engaging in a conversation with a mother	▪ List the LISTENING AND LEARNING SKILLS ▪ Give an example of each skill	▪ Use the LISTENING AND LEARNING SKILLS when counselling a mother or caregiver on feeding an infant	▪ S3
C2. Use skills for building confidence and giving support whenever engaging in a conversation with a mother	▪ List the SKILLS FOR BUILDING CONFIDENCE AND GIVING SUPPORT ▪ Give an example of each skill	▪ Use the SKILLS FOR BUILDING CONFIDENCE AND GIVING SUPPORT when counselling a mother or caregiver on feeding an infant	▪ S4
Breastfeeding			

BF1. Engage in antenatal conversation about breastfeeding	▪ Explain why exclusive breastfeeding is important for the first six months
	▪ Explain the importance of skin-to-skin contact immediately after delivery and the initiation of breastfeeding within one hour
	▪ List the special properties of colostrum and reasons why it is important
	▪ Explain good positioning and attachment
	▪ List the risks of not breastfeeding
		▪ Use counselling skills with a pregnant woman to listen to her questions and concerns about breastfeeding, and discuss how you may be able to help her
		▪ Reinforce her previous knowledge and give her additional information according to her needs including:
		  ▪ advantages of exclusive breastfeeding
		  ▪ the importance of skin-to-skin contact immediately after delivery
		  ▪ how to initiate and establish breastfeeding after delivery
		  ▪ the importance of colostrum
		  ▪ the optimal breastfeeding patterns
		  ▪ responsive feeding and feeding cues
		  ▪ rooming-in
		  ▪ health-care practices and the help that she will receive after delivery
		▪ Demonstrate good positioning and how to attach baby to the breast and ask her to practice with a doll
		▪ Apply competencies C1, C2 and parts of BF4
			▪ S17, S18

Competency	Knowledge	Skills	Session
BF2. Implement immediate and uninterrupted skin-to-skin	▪ Explain the importance of early contact after delivery and of the baby receiving colostrum ▪ Describe the procedure of putting the baby in skin-to-skin contact immediately after delivery	▪ Help a mother to initiate skin-to-skin contact and breastfeeding	▪ S6
BF3. Facilitate breastfeeding within the first hour, according to cues	▪ Describe how a baby moves to the breast and attaches by itself, and how to help the baby if needed ▪ Describe how health-care practices affect initiation of breastfeeding	▪ Help a mother to initiate skin-to-skin contact and breastfeeding ▪ Apply competencies C1, C2, BF5	▪ S6, S7
BF4. Discuss with a mother how breastfeeding works	▪ Describe the physiology of breast-milk production and flow ▪ Explain the physiology of lactation hormones ▪ Describe responsive feeding and implications for the frequency and duration of breastfeeds ▪ Describe the importance of exclusive breastfeeding for six months and continued breastfeeding for up to two years and beyond	▪ Explain to a mother the onset and stages of milk production including about colostrum and "coming in" of mature milk ▪ Explain to a mother about the optimal pattern of breastfeeding and responsive feeding, at different stages ▪ Talk to women individually or in groups about optimal infant feeding (includes referring a mother to community resources)	▪ S2, S5, S14, S16
BF5. Assist mother getting her baby to latch	▪ Describe the relevant anatomy and physiology of the breast and suckling action of the baby ▪ Describe effective and ineffective suckling ▪ Describe the difference between good and poor attachment of a baby at the breast ▪ Explain the FOUR KEY POINTS OF ATTACHMENT ▪ Explain the FOUR KEY POINTS OF POSITIONING ▪ Explain the main positions for the mother: sitting, lying down, side-lying ▪ Explain different ways to hold the baby: underarm, across, and others ▪ Describe how a mother should support her breast for feeding	▪ Recognize correct positioning, according to the FOUR KEY POINTS OF POSITIONING ▪ Assess a breastfeed using the JOB AID: BREASTFEEDING OBSERVATION ▪ Demonstrate how to assess a breastfeed ▪ Identify a mother who may need help ▪ Show a mother how to hold and position her baby, by demonstrating with a doll ▪ Help a mother to position her baby using the four key points, in different positions ▪ Show a mother how to support her breast for feeding ▪ Help a mother to find a comfortable position for breastfeeding ▪ Help a mother to get her baby to attach to the breast once they are well positioned ▪ Help the mother to recognize whether the baby is well attached or not	▪ S5, S8, S9, S10

Competency	Knowledge	Skills	Session
BF6. Help a mother respond to feeding cues	▪ Explain about a baby's feeding cues ▪ Describe how the use of a feeding bottle, teat or pacifier can prevent the mother from recognizing feeding cues of her baby	▪ Help a mother recognize her baby's feeding cues ▪ Help a mother feed her baby baby responding to the feeding cues	▪ S7, S12, S13, S17, S19
BF7. Help a mother manage milk expression	▪ Explain why expressing breast milk is useful for mothers or babies who have difficulty feeding at the breast, or who are separated from each other ▪ Describe the relevant anatomy of the breast and physiology of lactation ▪ List the steps of expressing breast milk by hand ▪ Explain how to stimulate the oxytocin reflex	▪ Demonstrate to a mother the steps of expressing breast milk by hand ▪ Apply competencies C1 and C2, and teach a mother how to express breast milk by hand	▪ S13
BF8. Help a mother to breastfeed a low-birth-weight or sick baby	▪ Describe alternative methods of feeding ▪ Explain how to feed a low-birth weight or sick baby by cup ▪ Explain how to introduce a LBW baby gradually to the breast, using the same principles of positioning and attachment	▪ Help a mother or caregiver to cup-feed the low-birth-weight baby. ▪ Apply competencies, especially BF7 and BF10, to manage these infants appropriately ▪ Help a mother to introduce her baby gradually to her breast	▪ S7, S9, S13
BF9. Help a mother when baby needs fluids other than breastmilk	▪ Explain the possible medical indications for supplementation ▪ Explain how to choose an appropriate supplement ▪ Describe the safe preparation of giving additional fluids other than mother's own milk ▪ List the risks of using a feeding bottle, teat or pacifier	▪ Explain to mother the risks of not breastfeeding exclusively using competencies C1 and C2 ▪ Help a mother understand the importance of avoiding any food or fluids other than breast milk, unless medically indicated ▪ Help support a mother whose baby needs fluids other than breastmilk	▪ S13, S14
BF10. Help a mother who is not feeding her baby directly at the breast	▪ List the advantages of cup-feeding ▪ Describe how to cup feed a baby ▪ List the risks of using a feeding bottle, teat or pacifier	▪ Teach a mother how to cup feed her baby safely ▪ Practise with a mother how to cup feed her baby safely	▪ S13, S14, S17, S18

Competency	Knowledge	Skills	Session
BF11. Help a mother prevent or resolve difficulties with breastfeeding	▪ Explain normal newborn feeding behaviour and intake. ▪ List the signs and symptoms that indicate a newborn may not be getting enough milk ▪ Explain the common reasons why a newborn may not get enough breast milk ▪ Explain how to prevent and manage milk insufficiency in newborns ▪ List different reasons why babies cry in the immediate postnatal period ▪ Describe the management of a crying baby in the immediate postnatal period List the causes of why a baby may be reluctant to feed at the breast Explain the difference between flat and inverted nipples and about protractility and how to manage flat and inverted nipples Explain the reasons why breasts may become engorged and how to manage breast engorgement List causes of sore or cracked nipples List the causes of a blocked milk duct Explain how to treat a blocked milk duct List the causes of mastitis Explain how to manage mastitis, including indications for antibiotic treatment and referral Explain what is different when treating mastitis in a mother living with HIV	▪ Decide whether a newborn is getting enough breast milk or not. ▪ Explain the cause of the difficulty to the mother ▪ Help a mother whose baby is not getting enough breast milk. ▪ Help a mother who thinks her baby is not getting enough milk. Help a mother whose aby is reluctant to feed at the breast Recognize flat and inverted nipples Demonstrate how to use the syringe method for the treatment of inverted nipples Recognize engorged breasts Recognize sore and cracked nipples Recognize mastitis and refer to the appropriate level of care if necessary Manage a blocked duct appropriately ▪ Apply competencies C1 and C2 and BF4 to BF7, and BF10 to overcome the difficulty, including explaining the cause of the difficulty to the mother Apply competencies BF7 and BF10 to maintain breast- milk production and to feed the baby meanwhile	▪ S11, S15, S16, S12, S13

Competency	Knowledge	Skills	Session
BF12. Ensure seamless transition after discharge	▪ Explain how to prepare a mother for discharge ▪ Explain the importance of follow-up care for a new mother and her baby ▪ Describe the available community resources to support breastfeeding	▪ Provide information to a mother about how to get continuing support and help after discharge ▪ Help a mother with support to ensure breastfeeding continues longer after discharge ▪ Help a mother recognize signs and symptoms that indicate a newborn may not be getting enough milk and to seek medical help when necessary ▪ mothers are given information about how to get continuing support and help after discharge	▪ S16, S19
Policies and programmes related to breastfeeding			
PP1. Implement the *International code of marketing of breast-milk substitutes* in a health facility	▪ Describe how commercial promotion of breast-milk substitutes undermines good breastfeeding practices ▪ List the major provisions of the *International Code of Marketing of Breast-milk Substitutes* and subsequent World Health Assembly resolutions (the Code) ▪ Describe health-workers' responsibilities for complying with the Code	▪ Recognize common violations of the Code ▪ Indicate appropriate actions to take when violations are identified in the health facility	▪ S20, S21
PP2. Explain a facility's infant feeding policies and monitoring systems	▪ Describe quality improvement in a facility, as part of the Ten Steps ▪ Explain the importance of infant feeding policies ▪ Explain the global standards from each of the TEN STEPS TO SUCCESSFUL BREASTFEEDING ▪ Outline the health-care practices summarized by the TEN STEPS TO SUCCESSFUL BREASTFEEDING	▪ Routinely administer client satisfaction surveys or exit interviews to each mother before being discharged if required as part of health-facility monitoring ▪ Record the care of each mother/baby pair (e.g. early initiation, rooming in), and also analyse the data over a period of time if necessary for quality improvement processes ▪ Collect and record data requested by the facility, to ensure standard of care in line with infant feeding policy, which can be evaluated and monitored	▪ S21

1.4 The course and the manual

The course is divided into various sessions and will take different times, according to the modules and sessions selected. It can be conducted over three working days or can be spread in other ways. The sessions use a variety of teaching methods, including lectures, demonstrations and work in smaller groups, including clinical practice sessions in clinical facilities. Sessions can be arranged in different ways to suit the local situation. Your course director and facilitators will plan the course that is most suitable for your needs and will give you a timetable.

This manual, the *Participant's manual,* is your main guide to the course, and you should keep it with you at all times, except during clinical practice sessions. You will be provided with the sessions selected for your training.

In the material provided, you will find a summary of the main information from each session, including descriptions of how to do each of the skills that you will learn. You do not need to take detailed notes during the sessions, though you may find it helpful to make notes of points of particular interest, for example from discussions. Keep your *Participant's manual* after the course and use it as a source of reference as you put what you have learnt into practice.

This *Participant's manual* also contains:

- copies of the key slides that you might want to memorize
- forms, lists and checklists for exercises, and practical and clinical practice sessions
- written exercises that you will be asked to do individually.

You will receive separate copies of the forms, lists and checklists to use for the clinical practice sessions, so that you do not have to carry your manual at these times.

You will receive answer sheets for each written exercise after you have done the exercise. These enable you to check your answers later, and to study any questions that you may not have had time to complete.

MODULE 1. GETTING STARTED

Session 1. BFHI: Key component of quality maternal and newborn care

Objectives

After completing this session, participants will be able to:

- describe the importance of exclusive and continued breastfeeding;
- discuss the WHO/UNICEF Global Strategy for Infant and Young Child Feeding;
- outline the Baby-friendly Hospital Initiative;
- list the Ten Steps to Successful Breastfeeding; and
- understand the outline of this course.

Exclusive breastfeeding

- Infant receives only breast milk for the first six months of life.
- No other food or water.
- It has the single largest potential impact on child mortality of any preventive intervention[5].

[5] Jones G, Steketee RW, Black RE, Bhutta ZA, Morris SS, Bellagio Child Survival Study Group. How many child deaths can we prevent this year? Lancet. 2003;362:65–71. doi.org/10.1016/S0140-6736(03)13811-1

- It is part of optimal breastfeeding practices including initiation within one hour of life and continued breastfeeding for up to two years of age or beyond.
- Breastfeeding has the single, largest potential impact on child mortality of any preventive intervention[5].

- The World Health Organization (WHO) and United Nations Children's Fund (UNICEF) recommend that infants should be exclusively breastfed for the first six months of life. Breastfeeding should continue for up to two years of age or beyond.
- To enable mothers/parents/caregivers to establish and sustain exclusive breastfeeding for six months, WHO and UNICEF recommend:
  - immediate and uninterrupted skin-to-skin contact and initiation of breastfeeding within the first hour of life;
  - exclusive breastfeeding – the infant only receives breast milk;
  - breastfeeding responsively – that is, as often and as long as the baby wants, day and night;
  - counselling mothers on the risks and use of supplementary feeding, bottles, teats or pacifiers.

Critical window

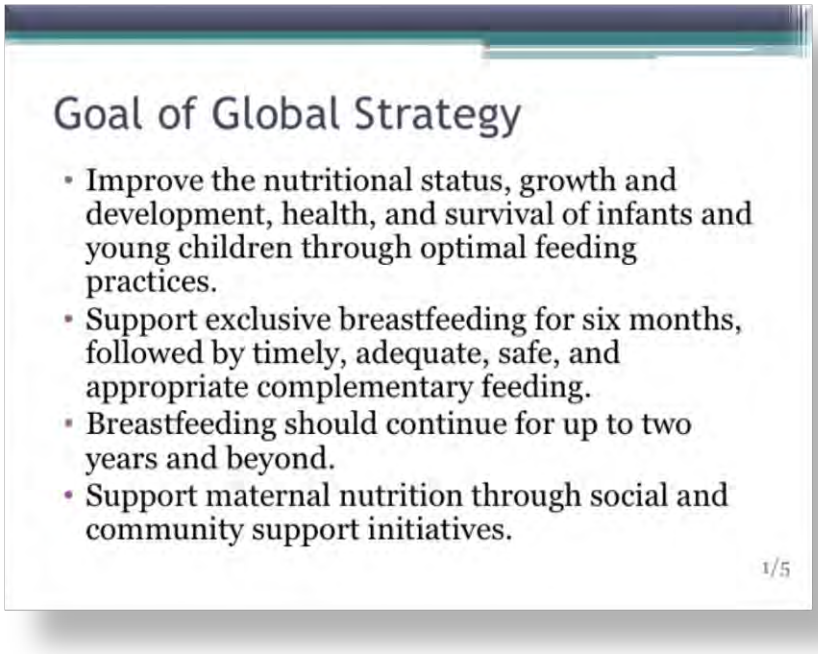
The first hours and days of a newborn infant's life are a critical window for providing mothers** with the support they need to establish and sustain breastfeeding. Therefore, policies, programmes and facilities must provide this support.

NOTE: **In this course, "mothers" will represent all options of lactation and breastfeeding including parents, partners, families, mothers, women and caregivers.

The Global Strategy for Infant and Young Child Feeding

Improved breastfeeding practices would prevent an estimated 823 000 annual deaths in children younger than five years of age[6]. Many children suffer long-term effects from poor infant feeding practices including impaired development, malnutrition, and increased infectious and chronic illness. Creating an empowering environment through policy and programmes can help to support exclusive and continued breastfeeding.

- 2002: WHO and UNICEF endorsed the Global Strategy for Infant and Young Child Feeding.
- 2012: WHO sets six global nutrition targets through a comprehensive implementation plan on maternal, infant and young child nutrition. As part of optimal breastfeeding practices, the plan aims to increase rates of exclusive breastfeeding.



This slide outlines the aim of the Global Strategy. The Global Strategy does not replace but rather builds upon existing programmes including the BFHI.

The Global Strategy calls for:

1) further implementation of the BFHI

2) breastfeeding and lactation management curriculum in health-worker training

3) accurate and up-to-date data on breastfeeding.

The Baby-friendly Hospital Initiative

- The BFHI started as a WHO and UNICEF initiative in 1991. Since then, it has been adopted by many countries and organizations. By 2007, there were already 20 000 hospitals in 152 countries that had achieved "baby-friendly" status.
- The BFHI aims to provide health-care environments that help mothers acquire the necessary skills to exclusively

[6] Rollins NC, Bhandari N, Hajeebhoy N, Horton S, Lutter CK, Martines JC, Piowz EG, et al. Why invest, and what it will take to improve breastfeeding practices? Lancet. 2016;387:491–504. doi:10.1016/S0140-6736(15)01044-2

breastfeed for six months and continue breastfeeding for two years or beyond.

- It aims to promote universal implementation of all of the Ten Steps to Successful Breastfeeding, which were first written in 1989. In 2018, they were revised and continue to be crucial throughout the world as the basis of the BFHI.
- The BFHI supports women living with HIV[7] in the following two contexts:

  1) where national recommendations include avoidance of all breastfeeding
  2) where national recommendations include breastfeeding plus antiretroviral therapy (ART).

Baby-friendly maternity facility

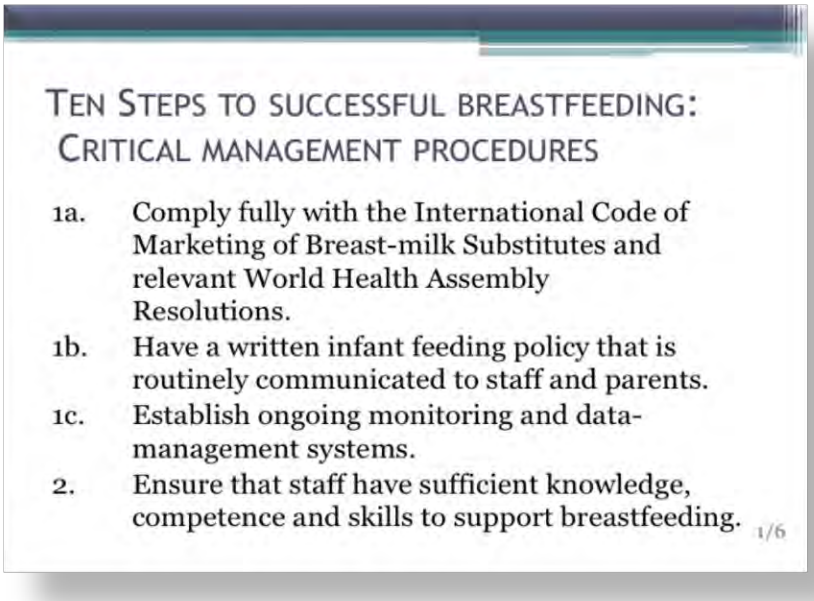
The facility must fully implement the Ten Steps to Successful Breastfeeding, which became part of the BFHI in 1991, and were updated in 2009. They were revised in 2018 and continue to be valid throughout the world as the basis of the BFHI.

The BFHI also provides integrated care to all mothers and families, including those who are not breastfeeding, to care for their babies as well as possible. In addition, the BFHI supports women living with HIV[8] in the contexts above.

The Ten Steps to Successful Breastfeeding

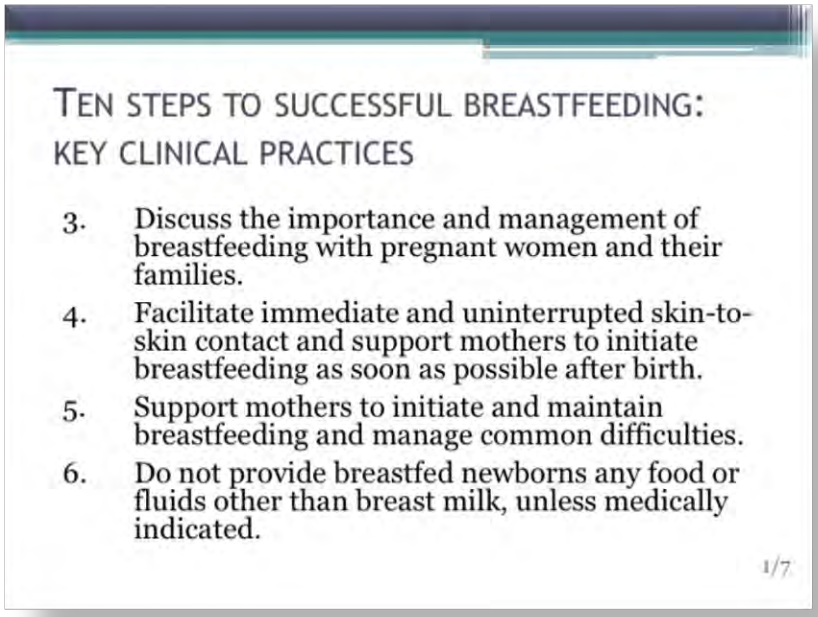
The revised Ten Steps include both critical management procedures and key clinical practices. The following two slides outline both these key procedures and clinical practices. We will learn more about these steps throughout the course.

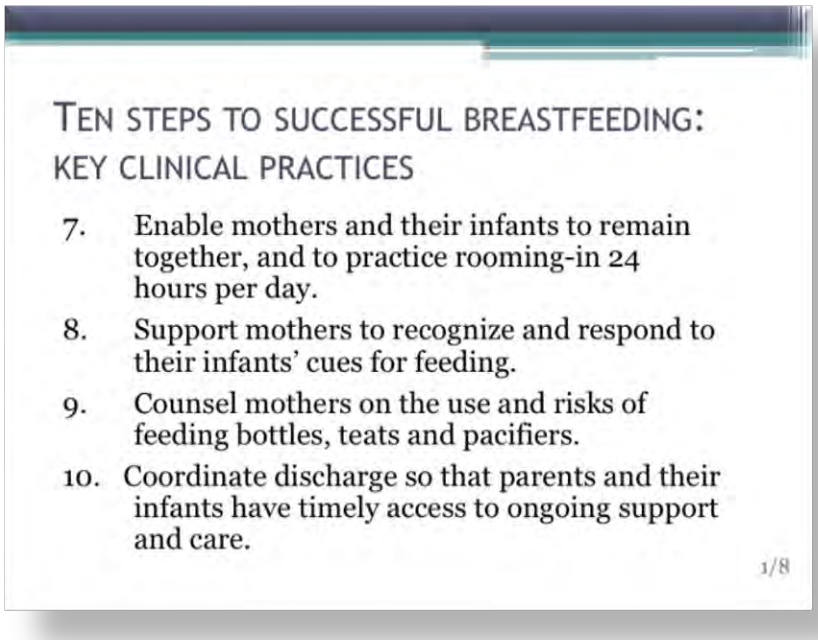
Ten Steps: Clinical management procedures



[7] WHO/UNICEF. Guideline: updates on HIV and infant feeding: the duration of breastfeeding, and support from health services to improve feeding practices among mothers living with HIV. Geneva: World Health Organization; 2016. (http://apps.who.int/iris/bitstream/handle/10665/246260/9789241549707-eng.pdf?sequence=1, accessed 3 April 2020).
[8] Ibid.

Ten steps: Key clinical practices





Improve capacity building

Timely and appropriate care for breastfeeding mothers can be provided by staff who possess the knowledge and skills. Training will enable you to develop competence, give consistent messages and implement standards to protect, promote and support breastfeeding.

Course objectives

This course will increase your confidence, knowledge and skills when caring for mothers and infants in everyday practice. It will be held over 2–3 days and provide 22 hours of information.

During this course, you will have an opportunity to learn and practice the following skills.

Overall skills

- Implement the Ten Steps to Successful Breastfeeding.
- Improve communication skills to counsel mothers and caregivers.
- Refer a mother to the appropriate community resources for ongoing support once she returns home.
- Abide by the International Code of Marketing of Breast-milk Substitutes and relevant WHA resolutions.

Breastfeeding/lactation management skills

During this course, participants will grow in skills and knowledge to manage a variety of lactations situations. These include, but are not limited to:

1. using listening and learning skills whenever engaging in a conversation with a mother;
2. using skills for building confidence and giving support whenever engaging in a conversation using listening and learning skills to counsel a mother;
3. engaging in antenatal conversation about breastfeeding;
4. implementing immediate and uninterrupted skin-to-skin;
5. facilitating breastfeeding within the first hour, according to cues;
6. discussing with a mother how breastfeeding works;
7. assisting a mother getting her baby to latch;
8. helping a mother respond to feeding cues;
9. helping a mother manage milk expression;
10. helping a mother to breastfeed a low-birth-weight or sick baby;
11. helping a mother whose baby needs fluids other than breast milk;
12. helping a mother who is not feeding her baby directly at the breast;
13. helping a mother prevent or resolve difficulties with breastfeeding;
14. ensuring seamless transition after discharge;
15. implementing the Code in a health facility; and
16. explaining a facility's infant feeding policies and monitoring systems.

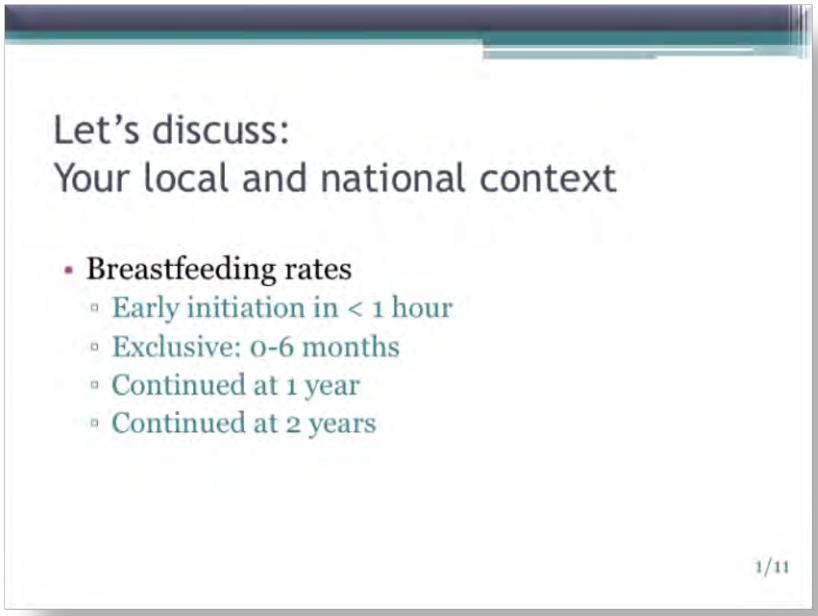
Let's discuss the local and national context

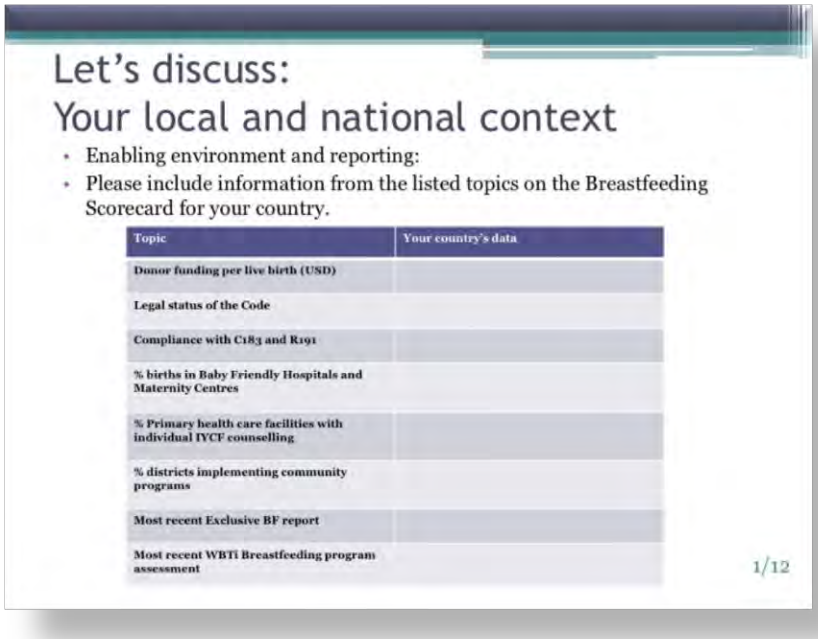
Resources:

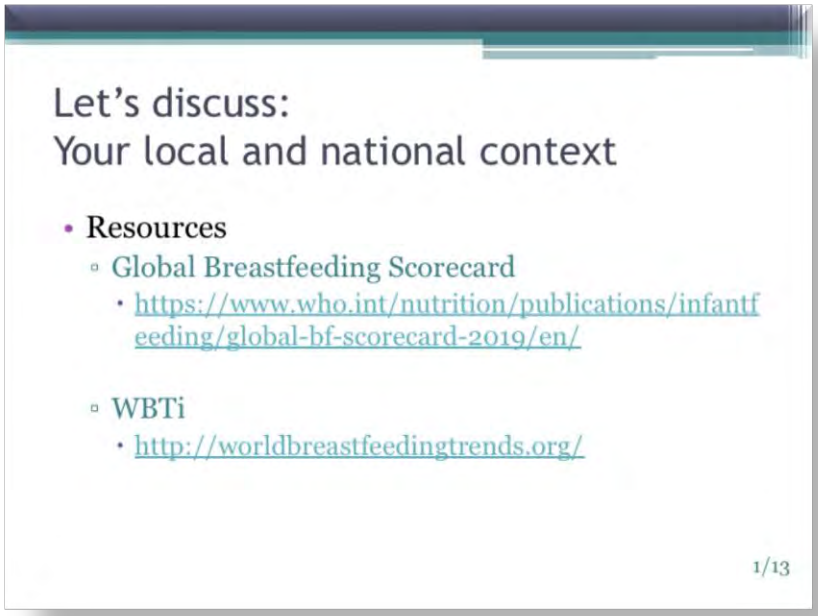
- Global Breastfeeding Scorecard https://www.who.int/nutrition/publications/infantfeeding/global-bf-scorecard-2019/en/
- World Breastfeeding Trends Initiative (WBTi) – http://worldbreastfeedingtrends.org/

Discussion questions:

- What did you learn about your own country's situation?
- How does this reflect your local context?
- What are areas of success?
- What are areas of improvement?


Let's discuss:
Your local and national context
Breastfeeding rates
Early initiation in < 1 hour
Exclusive: 0-6 months
Continued at 1 year
Continued at 2 years
1/11


Let's discuss:
Your local and national context
Enabling environment and reporting:
Please include information from the listed topics on the Breastfeeding Scorecard for your country.
Topic
Your country's data
Donor funding per live birth (USD)
Legal status of the Code
Compliance with C183 and R191
% births in Baby Friendly Hospitals and Maternity Centres
% Primary health care facilities with individual IYCF counselling
% districts implementing community programs
Most recent Exclusive BF report
Most recent WBTi Breastfeeding program assessment
1/12


Let's discuss:
Your local and national context
Resources
Global Breastfeeding Scorecard
https://www.who.int/nutrition/publications/infantfeeding/global-bf-scorecard-2019/en/
WBTi
http://worldbreastfeedingtrends.org/
1/13


The TEN STEPS to Successful Breastfeeding
1 HOSPITAL POLICIES
Hospitals support mothers to breastfeed by...
Not promoting infant formula, bottles or teats
Making breastfeeding care standard practice
Keeping track of support for breastfeeding
2 STAFF COMPETENCY
Hospitals support mothers to breastfeed by...
Training staff on supporting mothers to breastfeed
Assessing health workers' knowledge and skills
3 ANTENATAL CARE
Hospitals support mothers to breastfeed by...
Discussing the importance of breastfeeding for babies and mothers
Preparing women in how to feed their baby
4 CARE RIGHT AFTER BIRTH
Hospitals support mothers to breastfeed by...
Encouraging skin-to-skin contact between mother and baby soon after birth
Helping mothers to put their baby to the breast right away
5 SUPPORT MOTHERS WITH BREASTFEEDING
Hospitals support mothers to breastfeed by...
Checking positioning, attachment and suckling
Giving practical breastfeeding support
Helping mothers with common breastfeeding problems
6 SUPPLEMENTING
Hospitals support mothers to breastfeed by...
Giving only breast milk unless there are medical reasons
Prioritizing donor human milk when a supplement is needed
Helping mothers who want to formula feed to do so safely
7 ROOMING-IN
Hospitals support mothers to breastfeed by...
Letting mothers and babies stay together day and night
Making sure that mothers of sick babies can stay near their baby
8 RESPONSIVE FEEDING
Hospitals support mothers to breastfeed by...
Helping mothers know when their baby is hungry
Not limiting breastfeeding times
9 BOTTLES, TEATS AND PACIFIERS
Hospitals support mothers to breastfeed by...
Counsel mothers on the use and risks of feeding bottles, teats, and pacifiers
10 DISCHARGE
Hospitals support mothers to breastfeed by...
Referring mothers to community resources for breastfeeding support
Working with communities to improve breastfeeding support services
World Health Organization
unicef

Notes

Session 2. Benefits of breastfeeding

Objectives

After completing this session, participants will be able to:

- state the benefits of optimal infant feeding (exclusive and continued breastfeeding);
- list the importance and special properties of colostrum;
- describe the main differences between breast milk and artificial milks; and
- list the risks of artificial feeding.

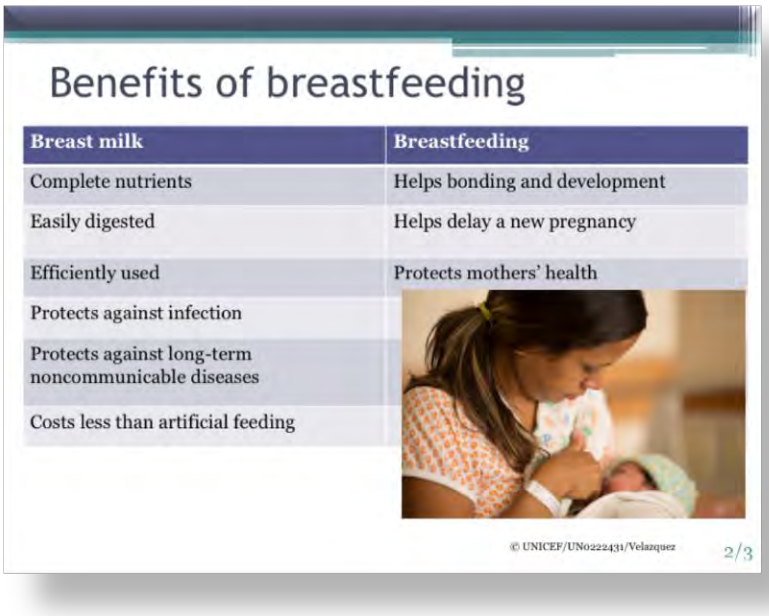
Introduction

As we discussed in Session 1, WHO and UNICEF recommend exclusive breastfeeding for the first six months of life. This means no other food or drinks, even water. Health workers must understand the benefits of breastfeeding. Whilst working with mothers, health workers can help mothers who have doubts about the value and sufficiency of breast milk.

In the first six months of life, exclusive breastfeeding provides all the nutrients and water a baby needs. After six months, all babies need complementary foods, in addition to breast milk. However, breast milk continues to be an important source of energy and high-quality nutrients beyond six months of age.

NOTE: This is background for the health worker, not messages to give to mothers/parents/caregivers. This information serves to inform the health worker to better care for mothers/parents/caregivers during the antenatal period. When providing counselling and support to mothers/parents/caregivers, health workers must simplify the language and message to promote understanding.

Benefits of breastfeeding



This slide summarizes some of the benefits of breastfeeding. It is useful to think of the benefits of both breast milk (listed on the left) and the process of breastfeeding (listed on the right).

Benefits of a baby having breast milk are:

- it contains the complete nutrients a baby needs
- it is easily digested and efficiently used by the baby's body
- it protects a baby against infection
- it provides long-term protection against chronic non-communicable diseases (such as obesity, hypertension and diabetes).

The other benefits of breastfeeding are:

- it costs less than artificial feeding
- it helps a mother and baby to bond (to develop a close, loving relationship)
- it helps the baby's development
- it protects the mother's health
- it helps the uterus to return to its previous size which reduces bleeding and prevents anaemia
- it reduces the risk of ovarian cancer and breast cancer in the mother
- it helps delay a new pregnancy.

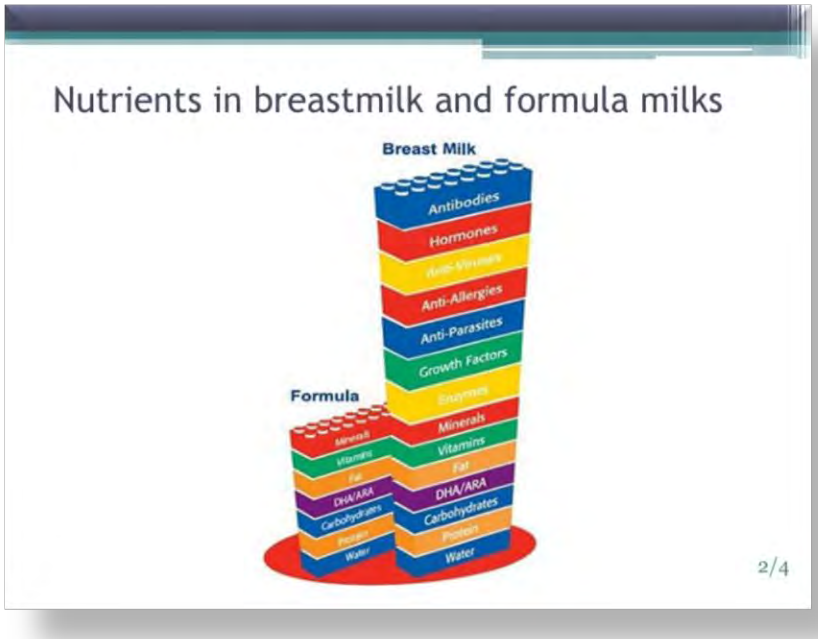
Counselling mothers/parents/caregivers

When counselling mothers/parents/caregivers about the benefits of breastfeeding,

remember to use the principals we will learn in the counselling sessions:

- accept what a mother/parent/caregiver thinks and feels
- recognize practices and praise a mother/parent/caregiver
- give practical help
- provide relevant information
- use simple language
- offer suggestions, not commands.

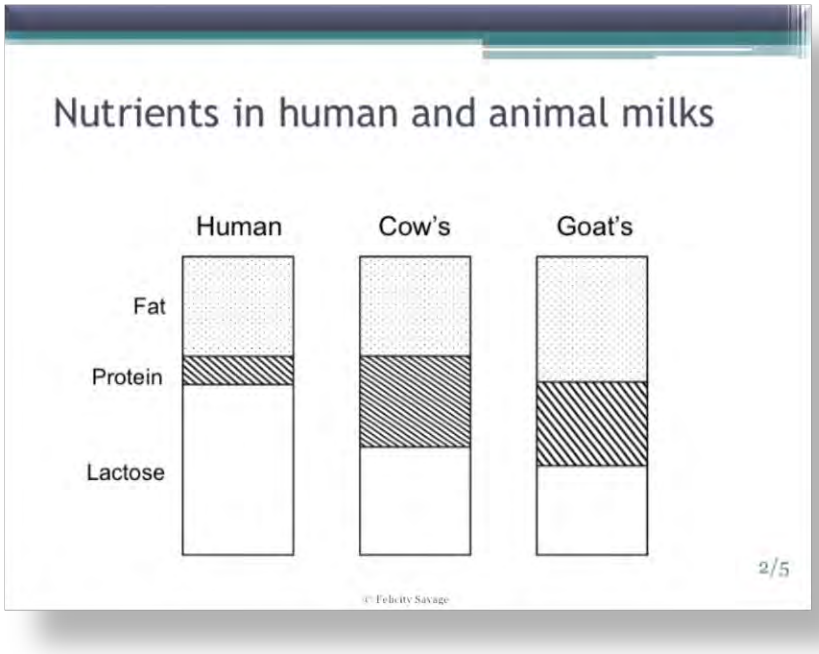
Composition of breast milk



By looking at the nutrients in breast milk, we can see how they are complete for babies.

NOTE: Formula milks are made from a variety of products, including animal milks, soybean and vegetable oils. The short bar shows that although the amounts been adjusted to be like human milk, they are still incomplete for babies as they lack all the other components shown in the tall breast milk bar. Formula milks lack many of the essential qualities present in breast milk, including special antibodies and other bioactive substances that protect babies from illness.

In order to understand the composition of artificial milk, we need to understand the differences between animal and human milk.



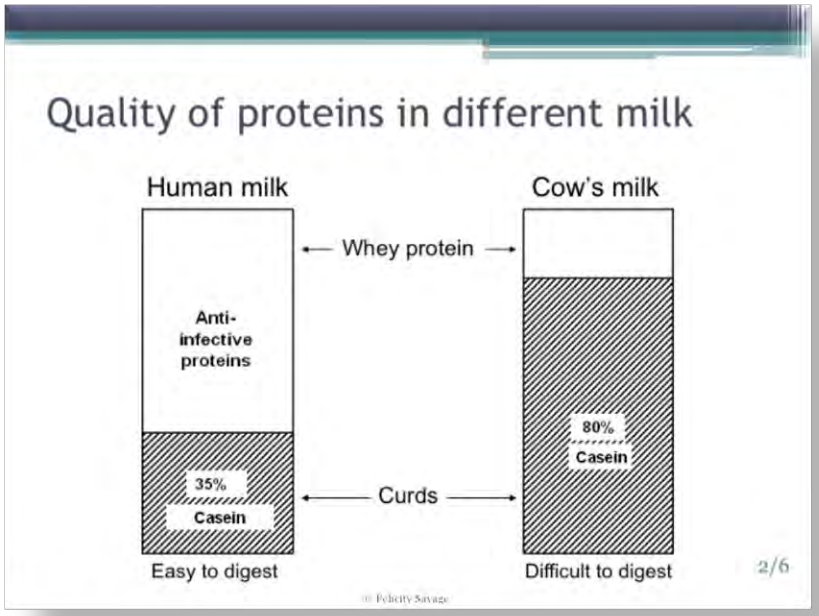
This chart compares the nutrients in breast milk with the nutrients in fresh cow's and goat's milk.

All the milks contain:

- fat: provides energy
- protein: growth
- lactose: a milk sugar which also provides energy.

Note

- Animal milk contains more protein than human milk.
- A baby's immature kidneys are unable to excrete the extra waste from the protein in animal milks.
- Human milk also contains essential fatty acids and are needed for a baby's growing brain, eyes, and healthy blood vessels. These fatty acids are not present in animal milks can be added to formula milk.



The above slide shows how proteins in different milks varies in quality as well as quantity.

- While the quantity of protein in cow's milk can be modified to make formula, the quality of proteins cannot be changed.
- The protein in cow's milk is casein. Casein forms thick, indigestible curds in a baby's stomach.
- Human milk contains more whey proteins. The whey proteins contain anti-infective proteins, which help to protect a baby against infection.

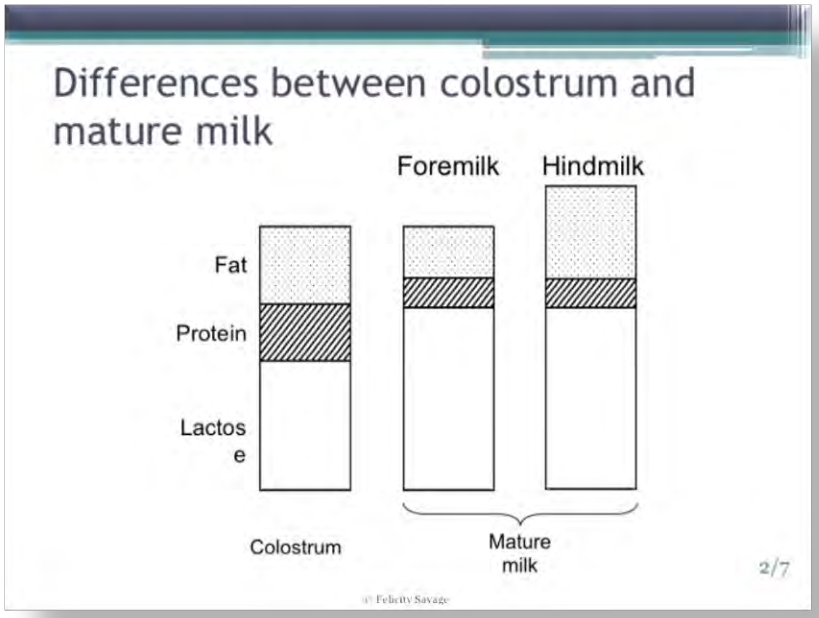
NOTE: Artificially fed babies can develop an intolerance to protein from animal milk. They may develop diarrhoea, abdominal pain, rashes and other symptoms when they have artificial feeds containing the different kinds of protein.

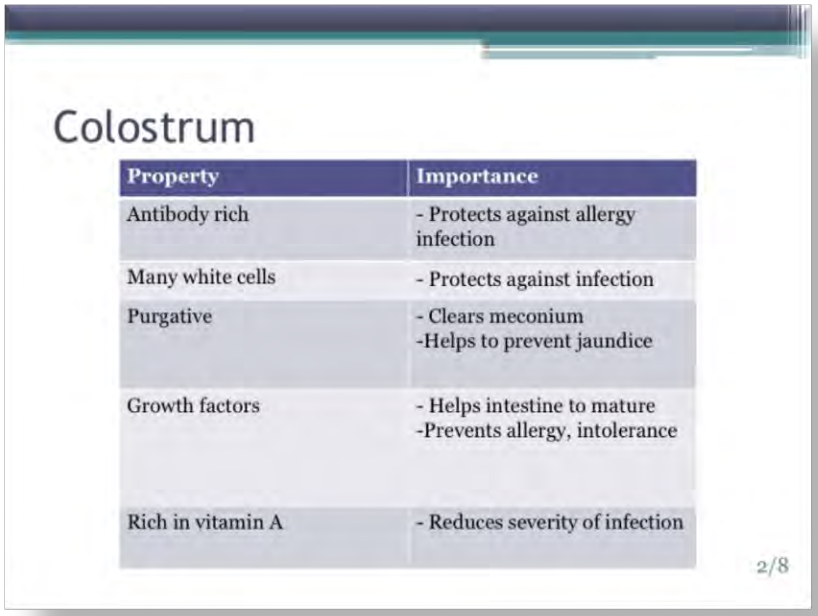
Composition of breast milk

- The composition of breast milk varies from feed to feed and is based on a baby's age. **Colostrum** is the first breast milk women begin to produce at the end of pregnancy and in the first few days after delivery. It is thick yellowish or clear in colour. It contains higher protein than breast milk later on.
- A few days after delivery, colostrum **changes** into mature milk. There is an increased amount of mature milk. A woman's breasts feel full, hard and heavy. Some people call this the milk "coming in," but this can be confusing to a new mother. It is better for health-care workers to describe the changes in her milk in the first week.
- *Foremilk* is the thinner milk and is produced in greater amounts early in a feed. It provides protein, lactose, water and other nutrients. Babies do not need water before six months old, even in hot climates.
- *Hindmilk* is the whiter milk produced later in a feed. It contains more fat than foremilk
- Fat provides the energy in a breastfeed, so it is important for a baby to get both types of milk.

NOTE: A common worry includes a mother's milk being "too thin" or "not enough." This is an opportunity for a health worker to build a mother's confidence and provide relevant information. When a baby has both foremilk and hindmilk, they get a complete "meal" including all the water they need.

Colostrum



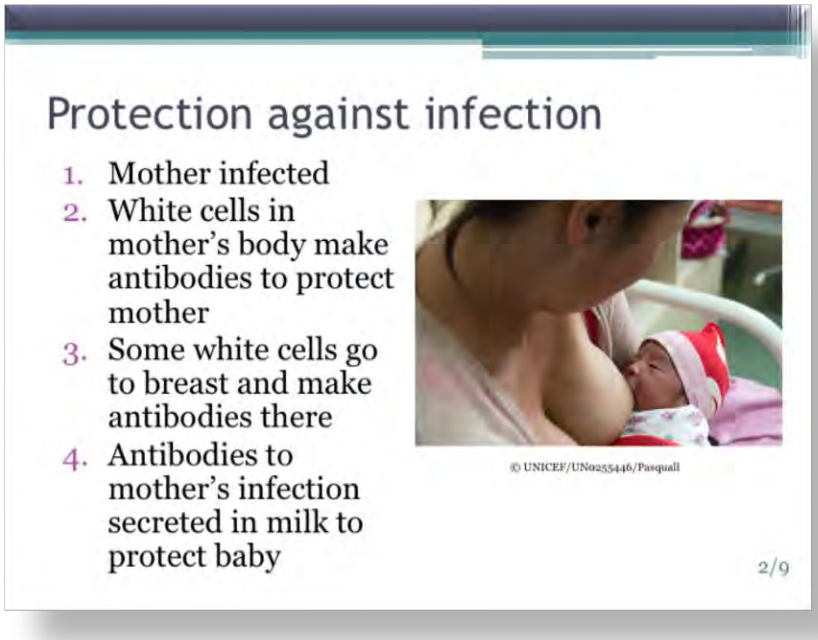


These slides show the special properties of colostrum and its importance.

- Colostrum is the first milk a newborn consumes immediately after birth. The amount of colostrum in the first few feeds is very small, approximately 2–10 mL[10]. Remember, a baby is learning to suck, swallow and breathe. So, these small amounts prevent them from choking.
- Colostrum contains immune factors to protect a baby. It has more antibodies and other anti-infective proteins than mature milk. This is part of the reason why colostrum contains more protein than mature milk.
- Colostrum contains more white blood cells than mature milk. Colostrum helps to prevent dangerous bacterial infections and provides the first immunization against many diseases.
- Colostrum has a mild laxative effect, which helps to clear the baby's gut of meconium (the first dark stools). This also clears bilirubin from the gut and helps to keep levels low preventing severe jaundice.
- Colostrum contains many growth factors to develop a baby's immature intestine. It also provides a protective lining to the baby's gut. This helps to prevent the baby from developing future allergies and intolerance to other foods.
- Colostrum is rich in vitamin A, which helps to reduce the severity of infections. The first feeds help this protection.
- Colostrum is present in the breasts before a baby is born. Babies should not be given any drinks or food before they start breastfeeding. Artificial feeds given before a baby has colostrum increase the risk of allergies and infection.

[10] Kellams A, Harrel C, Omage S, Gregory C, Rosen-Carole C, Academy of Breastfeeding Medicine. Feeding in the healthy term breastfed neonate, revised 2017. Breastfeeding Med. 2017;12:188–98. doi.org/10.1089/bfm.2017.29038.ajk

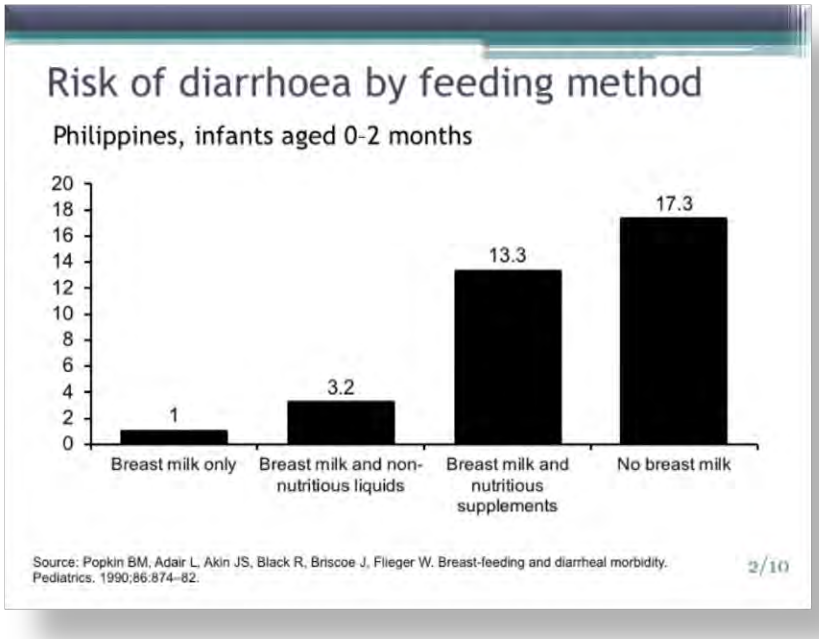
Protection against infection



Breast milk contains white blood cells and a number of anti-infective factors. Breastfeeding protects babies against:

- diarrhoeal and respiratory illness
- ear infections, meningitis and urinary tract infections
- breast milk also contains antibodies against infections that the mother has had in the past.

NOTE: A baby should not be separated from their mother when she has an infection because her breast milk helps to protect both of them against the infection.



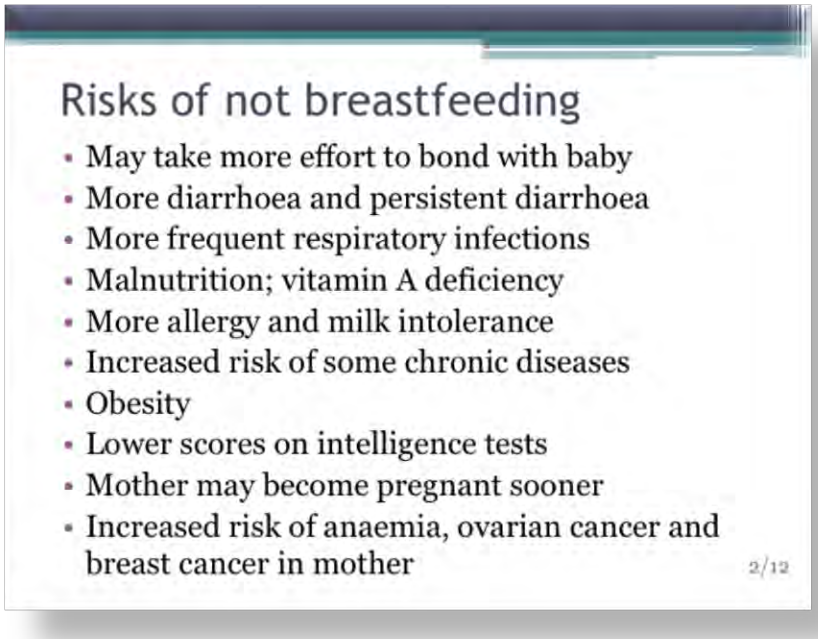
Discussion questions

1) What do you learn from this slide?
2) What do you observe about the correlation between the risk of diarrhoea and the feeding method?
3) What information could be shared with mothers/parents/caregivers from this slide?

Psychological benefits of breastfeeding

- Breastfeeding has important psychological benefits for both mothers and babies.
- Close contact immediately after delivery helps the mother and baby bond and helps the mother to feel emotionally satisfied.
- Babies tend to cry less if they are breastfed.
- Some studies suggest breastfeeding may help a child to develop intellectually. Low-birth-weight babies fed breast milk in the first weeks of life perform better on intelligence tests in later childhood than children who are artificially fed.
- If mothers decide not to breastfeed, it is important to help them to bond with their babies in other ways apart from breastfeeding.

Risks of not breastfeeding



The slide above summarizes the risks of not breastfeeding.

- Compared to breastfeeding, artificial feeding may take more effort for the mother to bond with her baby.
- An artificially fed baby is more likely to become ill with diarrhoea, respiratory and other infections. The diarrhoea may become persistent. Artificially fed babies get diarrhoea more often, partly because artificial feeds lack anti-infective factors Also, artificial feeds are often contaminated with harmful bacteria or prepared from unclean water sources.
- There are barriers in preparation including receiving too few feeds or too dilute feeds
- The baby may become malnourished and is more likely to suffer from vitamin A deficiency.
- The baby is more likely to develop allergic conditions including eczema and asthma.
- The baby may become intolerant of animal milk, so the milk causes diarrhoea, rashes and other symptoms.
- There is increased risk of some chronic diseases in the child, such as diabetes. A baby may be overfed and become obese later in life.[5]
- A mother who does not breastfeed may become pregnant sooner.
- She is more likely to become anaemic after childbirth.
- She has increased chances of developing cancer of the ovary or of the breast.

Notes

Session 3. Counselling skills: Listening and learning

Objectives

After completing this session, participants will be able to:

- list the six listening and learning skills
- give an example of each skill
- demonstrate the appropriate use of the skills when counselling a new mother on feeding her baby.

Introduction

Counselling goals are intended to provide:

- a way of working with people and understanding how they feel
- help to a person to decide what they think is best to do in their situation.

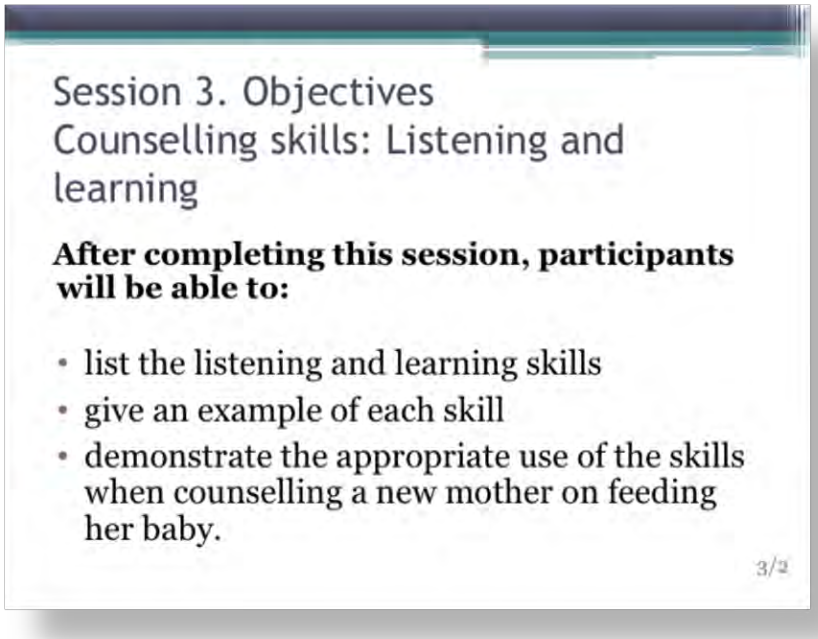
In this course, we look at counselling mothers who are feeding their newborn babies. Although we talk about "mothers" in this session, remember these skills should be used when talking to other caregivers and parents about feeding, for example fathers or grandmothers.

Counselling mothers about feeding their newborns is one of the situations in which counselling is useful. Counselling skills are useful when you talk to patients or clients in other situations. You may also find them helpful with your family, friends or your colleagues at work. Practise some of the techniques with them – you may find the result surprising and helpful.

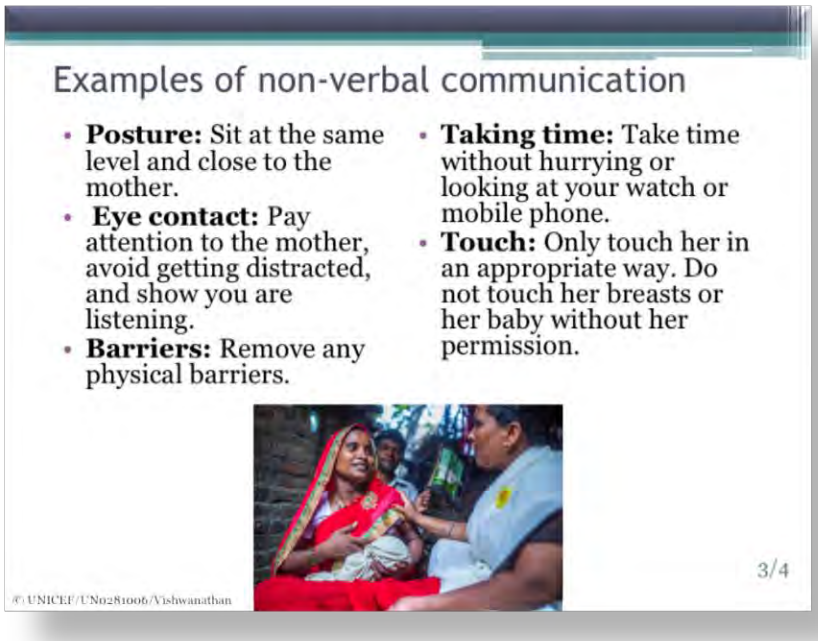
If a mother is shy or does not know you well, she may not talk easily about her feelings. You will need listening skills and to show her you are interested in her. This will encourage her to tell you more. She will be less likely to "turn off" and say nothing.

Listening and learning skills

Communication can include both verbal and non-verbal communication. Non-verbal communication includes the body language we use and what we observe of the mother's body language. We may observe a mother sitting in an uncomfortable position. She may be looking around concerned others are listening and not able to concentrate on feeding her baby. We are receiving these very useful non-verbal messages from the mother. If you talk with the mother in a comfortable and safe place, she will feel more open to talk with you and include you on her journey.



Skill 1. Use helpful non-verbal communication



Non-verbal communication can help a mother feel calm and able to listen. Some helpful non-verbal communication skills are listed below.

- Posture: Sit at the same level and close to the mother.
- Eye contact: Pay attention to the mother. Avoid getting distracted and show you are listening by nodding, smiling and other appropriate gestures.
- Barriers: Remove any physical barriers (a desk, folders, papers).
- Taking time: Take time without hurrying or looking at your watch or mobile phone.
- Touch: 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.

The other skills for listening and learning address the words we say to mothers. We call these words verbal communication. Remember the tone of our voice is important during verbal communication. We should always use a gentle and kind voice when talking to mothers.

Skill 2. Ask open questions

Asking open questions encourages a mother to talk to you and to share information. This saves you from asking too many questions and enables you to learn more in the time available. Open questions are usually the most helpful as they encourage a mother to give more information.

Open questions

These questions usually start with "How?", "What?", "When?", "Where?", "Who?"; for example, "How are you feeding your baby?"

Closed questions

These questions can be answered with a yes or no and may not give you much information. Closed questions usually start with words like "Are you?" or "Did you?" or "Has the baby?" For example: "Did you breastfeed your previous baby?"

You may think the mother is unwilling to talk to you. The mother may feel afraid that she will give the wrong answer. Sometimes a closed question suggests the "correct" answer. The mother may give this answer whether it is true or not, thinking this is what you want to hear.

Skill 3. Use responses and gestures that show interest

If you want the conversation to continue, you must show that you are both listening and interested in what she is saying. Important ways to show that you are listening and interested are:

- gestures like looking at her, nodding and smiling
- simple responses like saying "Aha," "Mmm," "Oh dear!".

Skill 4. Reflect back what the mother/parent/caregiver says

Reflection is a helpful way to show you are listening. This will help the mother feel secure with you and want to share more information. You can change your words slightly to vary the message. If a mother says: "I don't know what to do. My baby wants to breastfeed all night long." You can use reflection by saying: "Your baby is feeding often at night?" It is helpful to mix reflecting back with other responses. For example, "Oh, really, tell me more", or to ask an open question.

Skill 5. Empathy – show that you understand how the mother/parent /caregiver feels

Empathy

- Showing you hear what someone is saying and trying to understand how they feel.
- Looking at the situation from their point of view.
- Empathizing with both positive and negative feelings.

Sympathy

- Looking at it from your point of view.

When a mother says something to show her feelings, your response should help her feel heard. Showing empathy, you can empathize with her feelings from her point of view.
Mother says: “My baby wants to feed very often, and it makes me feel so tired".

Possible reflection: “You feel exhausted because your baby wants to feed very often.”

Showing sympathy: “Oh, I know how you feel. My baby wanted to feed often too, and I felt exhausted.” This brings the attention back to you and does not make the mother feel you understand her.

Skill 6. Avoid using judging words

Judging words

- Right, wrong, well, badly, good, enough, properly, adequate, problem.
- Identify words in your cultural context that causes mother/parents/caregivers to feel judged.
- Words like this can make a person feel she has not "reached a standard" or her "baby is not normal". A mother may decide to hide how things are going if she feels inadequate.

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?”

Example
Do not say: “Are you feeding your child properly?”
Say: “How are you feeding your child?”

- The mother and the health worker may have different ideas about what “feeding properly” means.
- Mothers may use judging words about their own situation. You may sometimes need to use them yourself, especially the positive ones, when building a mother's confidence. Try avoiding them as much as possible unless there is a really important reason.
- Judging questions often create closed questions. Replacing with open questions often helps to avoid using judging words.

Let's practise

Exercises – listening and learning

It's time to practise the skills learned in this session. Each exercise has an example and an exercise to complete.

You will have time to work independently. Then, together as a group, you will discuss the answer with the trainers. An "Answer sheet” will be available at the end of the session.

DEMONSTRATION 3.J – SUMMARY OF SIX LISTENING AND LEARNING SKILLS

	Health worker (with a smile) enters the room, finds a chair, puts her phone in her bag and sets down her clipboard. (Skill 1: Helpful non-verbal).
Health worker: *(Skill 2: Open question)*	Good morning. How is feeding going for you? He is a little boy isn't he? How is he?
Mother:	He is doing well. My breasts are full, and he is feeding very often. I am glad that I decided to breastfeed him.
	Mmmm... (smiles and nods).
Health worker: *(Skill 3)*	I was worried last night because he was crying a lot.
Mother:	You were feeling worried because he was crying a lot?
Health worker: *(Skill 4)*	Yes, he kept crying and wanted to keep feeding. My family was saying to give him baby formula, but I only want to give him my milk.
Mother:	It's not surprising you felt worried. You were wanting support to help with breastfeeding your baby!
Health worker: (Skill 5)	Yes, you understand. Can you help me today?
Mother:	Yes, of course. Can I watch your baby breastfeeding? We can see how he is suckling, and look at your breasts, and then we can talk more about what might help.
Health worker: (Skill 6)	

Exercise 3.A Asking open questions

Directions

Questions 1 and 2 are "closed" with a "yes" or "no" answer.
Write a new "open" question, which requires the mother to tell you more.

Example

"Closed" question	"Open" question
Are you breastfeeding your baby?	How are you feeding your baby?

Your turn

"Closed" questions	Possible "open" questions
1. Does your baby feed often?	
2. Are you having any feeding problems?	

Exercise 3.B Reflect back what the mother/parent/caregiver says

Directions

Statements 1 and 2 are examples of what mothers may tell you.
Underneath each statement are three responses. Mark the response that demonstrates "reflecting back" the statement.

Example

My mother says I don't have enough milk.

a) Do you think you have enough?
b) Why does she think that?
c) **She says you have a low milk supply?**

Your turn

1. It seems my baby does not want to suckle from me.
   a) He seems to be unable to suckle?
   b) How long has he been unable to suckle?
   c) Has he had any bottle feeds?

2. I tried feeding him from a bottle, but he spat it out.
   a) Why did you try using a bottle?
   b) He was unable to suck from a bottle?
   c) Have you tried to use a cup?

Exercise 3.C Empathizing – showing you understand how the mother/parent/caregiver feels

Directions

Statements 1 and 2 are examples of what mothers may say. The underlined words in each example show how the mother is feeling. Underneath each statement are three responses that the health worker may give. Choose the response showing the health worker understands how the mother/parent/caregiver feels.

Example

My baby wants to feed so often at night that I feel exhausted.

a. How many times does he feed?
b. Does he wake you every night?
c. You are really tired with the night feeding?

Your turn

1. My breast milk looks so thin. I am afraid it is not good.
   a. That's the foremilk. It always looks rather watery.
   b. You are worried about how your breast milk looks?
   c. Well, how much does the baby weigh?

2. I feel there is no milk in my breasts, and my baby is a day old already.
   a. You are upset because your breast milk has not come in yet?
   b. Has she started suckling yet?
   c. It always takes a few days for breast milk to come in.

Exercise 3.D – Avoid judging words

Directions

Underline the judging word. Then re-write each question to both avoid a judging word and to ask an open question.

Example

Closed question with judging word.	Open question without judging word.
Is your baby feeding well?	How is your baby feeding?

Your turn

Closed question with judging word.	Suggested answers for open question without judging word.
1. Does your baby feed often?	
2. Are you having any problems with feeding?	

Session summary

SUMMARY: LISTENING AND LEARNING SKILLS

- Use helpful non-verbal communication
- Ask open questions
- Use responses and gestures that show interest
- Reflect back what the mother/parent/caregiver says
- Empathize – show you understand how the mother/parent/caregiver feels
- Avoid using judging words

Notes

Module 2. Breastfeeding basics

Session 4. Counselling skills: Building confidence and giving support

Objectives

After completing this session, participants will be able to:

- identify the six skills for building confidence and giving support
- give an example of each skill
- demonstrate the skills when counselling a new mother on feeding her baby.

Introduction

In this session, we will learn counselling skills to build confidence and give support. The first weeks of her baby's life are a vulnerable time. A mother can easily lose confidence in herself. This may lead her to feel like she is a failure, especially if she does not have family support. You will need these skills to help her to feel confident and good about herself.

We are going to focus on skills to help build the confidence of a mother/parent/caregiver. Helping a mother to decide what is best for her and her baby increases her confidence. If you support her and her confidence, she will feel empowered to make the best decisions. It is important not to make a mother feel she is doing something wrong. At this vulnerable time, a mother may believe there is something wrong with herself, with how she is feeding her child, or with her breast milk. This reduces her confidence.

Skill 1. Accept what a mother/parent/caregiver thinks and feels

When we accept a mother's ideas and feelings, her self-confidence grows and she feels supported. We do not need to only disagree with her or tell her there is nothing to worry about. If you disagree or criticize a mother, you reduce her confidence. You can lose trust, and she may not want to seek help or support from you.

Showing acceptance allows you to respond in a neutral way, not agreeing or disagreeing. Accepting what a mother says helps her trust you and encourages her to continue the conversation. It is important not to agree with incorrect information or ideas. You may want to suggest something quite different. Instead, you just accept what she thinks or feels

Using reflection and simple responses are useful ways to show acceptance. Later in the conversation, you can give information to correct incorrect information or ideas. Using empathy can show acceptance of a mother's feelings. If a mother is worried or upset, and you were to say, "Oh, don't be upset, it is nothing to worry about", she may feel she was "wrong" to be upset. This may reduce a mother's ability to make her own decisions with confidence.

DEMONSTRATION 4.A – ACCEPTING WHAT A MOTHER THINKS

Mother: Health worker:	I want to give my baby a bottle of formula because I don't have enough milk for her. I am sure your milk is enough. Your baby does not need a bottle of formula.
Ask:	*Did the health worker agree, disagree or accept how the mother feels?*
Comment:	This response disagrees and dismisses what the mother is saying. The health worker is not building the mother's confidence.
Mother: Health worker:	I want to give my baby a bottle of formula because I don't have enough milk for her. Yes, a bottle can sometimes settle a baby.
Ask:	*Did the health worker agree, disagree or accept what the mother says?*
Comment:	This response agrees with incorrect information. It is not helpful and may discourage the mother from breastfeeding.
Mother: Health worker:	I want to give my baby a bottle of formula because I don't have enough milk for her. I see. You are worried about your milk?
Ask:	*Did the health worker agree, disagree or accept?*
Comment:	This response shows acceptance. The health worker accepts what the mother says and acknowledges her viewpoint. They can now continue to talk about breastfeeding and discuss correct information about milk supply.

DEMONSTRATION 4.B – ACCEPTING HOW A MOTHER FEELS	
Health worker:	Good morning (name), how is feeding going for you and (baby's name)?
Mother (in tears):	It is terrible. My baby's nose is completely blocked, and he can't breastfeed. He just cries, and I don't know what to do.
Health worker:	Don't worry, your baby is doing very well.
Ask:	*Was this an appropriate response?*
Comment:	This response does not address the mother's feelings and makes her feel wrong to be upset.
Health worker:	Good morning (name), how is feeding going for you and (baby's name)?
Mother (in tears):	It is terrible. My baby's nose is completely blocked, and he can't breastfeed. He just cries, and I don't know what to do.
Health worker:	Don't cry. It's not serious. (Baby's name) will soon be better.
Ask:	*Was this an appropriate response?*
Comment:	By saying words like "don't worry" or "don't cry," you may make a mother feel it is wrong to be upset. This can reduce her confidence.
Health worker:	Good morning (name), how is feeding going for you and (baby's name)?
Mother (in tears):	It is terrible. My baby's nose is completely blocked, and he can't breastfeed. He just cries, and I don't know what to do.
Health worker:	You feel upset about (baby's name) don't you?
Ask:	*Was this an appropriate response?*
Comment:	This response showed acceptance of how the mother felt and made her feel that it was alright to be upset. This is the best response in the situation. Note: In this example, empathizing was used to show acceptance. This is an example of using a listening and learning skill to show acceptance.

Skill 2. Recognize good practices and praise a mother/parent/caregiver

A new mother is working on many skills during the days after her child's birth. As health workers, we must come alongside her and recognize her hard work and effort. Before correcting her or trying to "fix" her practices, provide praise and encouragement. This type of recognition and praise will build her self-confidence.

Our goal as health workers is to observe and recognize successful practices. We praise these points and help build her confidence.

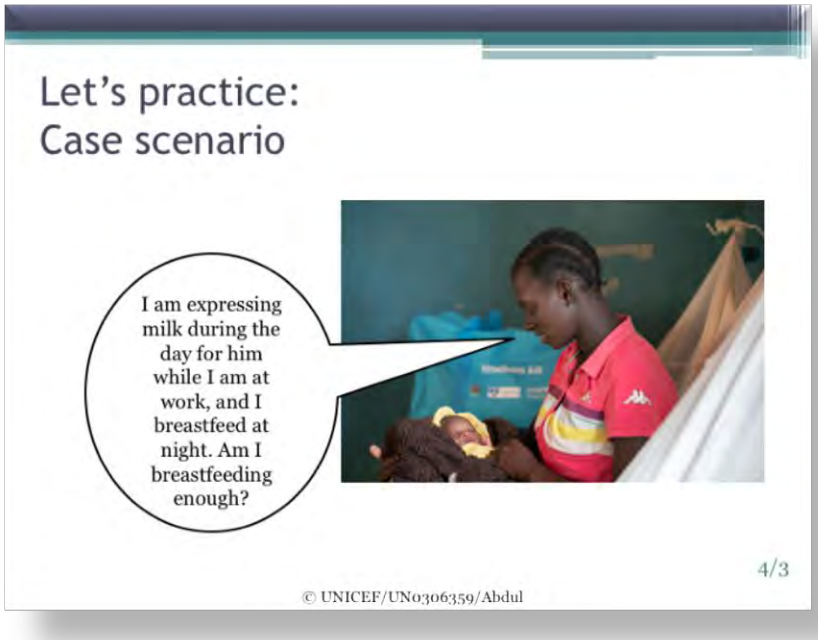
Giving praise has these benefits:

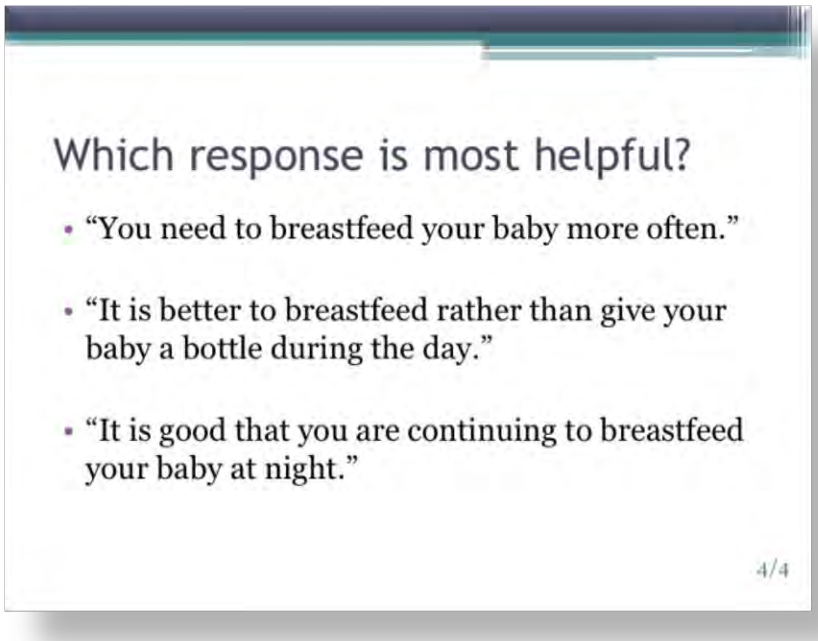
- it builds a mother's self-confidence
- it encourages her to continue those practices
- she will be open accept suggestions later.

You may find a situation where a mother has difficulty continuing with responsive breastfeeding. What should we do then? Can we still encourage this mother?

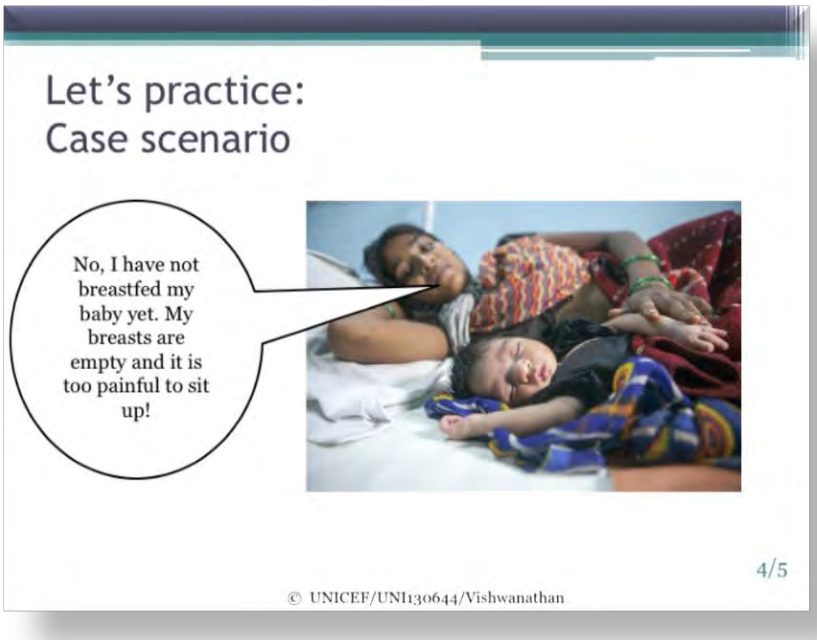
YES!! Some examples are included below.

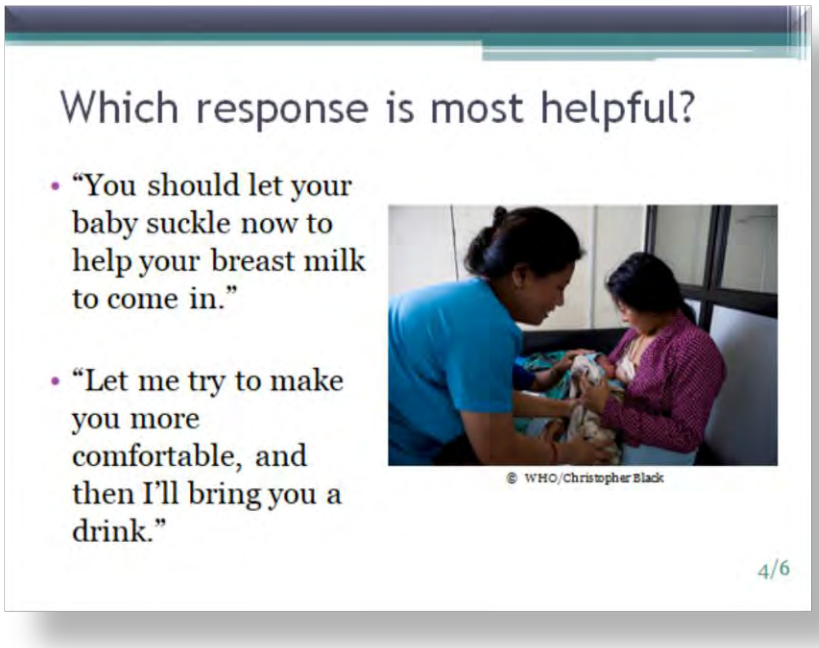
- A working mother who is separated from her baby some of the time: Praise the mother for continuing to breastfeed her baby when she can be with her baby.
- Negative family pressure: Praise her for exclusively breastfeeding her new baby, even though she is getting pressure from her family to feed the baby supplements.





Skill 3. Give practical help





As we will learn in later sessions, a mother's comfort is a high priority for her milk establishment and production. After birth, she maybe thirsty or hungry, or she may want another pillow. She may need someone to hold the baby while she goes to the toilet. If you can give this practical help, she will be able to relax and focus better on caring for and feeding her baby.

Practical help

- Help make her comfortable.
- Give her a drink.
- Provide her with something to eat.
- Hold the baby (this will allow her to get comfortable, wash, or go to the toilet.

- Support her with practical tips to begin breastfeeding.
- NOTE: Caregivers can also receive practical help and support.

Skill 4. Provide relevant information

Mothers often need information about breastfeeding. As a health-care worker, you have an important role that allows you to share knowledge with them. It is also important to correct incorrect information with respect and support. There is so much information you can share, but you do not want to overload her. **You must give information relevant to the mother's situation *at* that time.** Tell her what she can use today, not in a few weeks or months. A mother wants to know what is happening with her baby and her body. Explain the reason with the most relevant information.

Mothers are tired after a long labour and birth. Please do not overwhelm the mother/parent/caregiver. Give only one or two pieces of information that will ensure she listens, understands and applies the new knowledge. Give information in a positive way to build her confidence. As we learned earlier, do not be judgemental, or make the mother think she is doing something wrong. This is especially important if you want to correct incorrect information. Before giving information, take the opportunity to build her confidence. Accept what she says and praise what she is doing well. Remember, you do not need to give new information or to correct wrong information immediately.

Skill 5. Use simple language

When communicating with a mother/parent/caregiver, it is important to use simple and familiar terms. Our goal is not only sharing information but increasing the mother/parent/caregiver's understanding.

Let's discuss

What are words used in your context? Please give some examples and share with the group.

Example: Colostrum with anti-infective properties vs. your first milk that will protect the baby.

DEMONSTRATION 4.C – USING SIMPLE LANGUAGE AND PROVIDING RELEVANT INFORMATION	
Health worker:	Good morning (name). How is feeding going for you and your baby?
Mother:	It's going okay. I am going to start giving my baby formula because I heard that it protects against infections.
Health worker:	Breast milk is filled with anti-infective factors and immunoglobulin that provide your baby with protection from viral and bacterial infections. Artificially fed babies get diarrhoea more often, partly because artificial feeds lack anti-infective factors. Artificial feeds are often contaminated with harmful bacteria. If you give your baby breast milk, he will benefit from the anti-infective properties and immunoglobulin secreted through your breast milk.
Ask:	*What did you observe?*
Comment:	The health worker provided too much information. She used words that were unfamiliar and medically focused.

DEMONSTRATION 4.D – USING SIMPLE LANGUAGE AND PROVIDING RELEVANT INFORMATION	
Health worker:	Good morning (name). How is feeding going for you and your baby?
Mother:	It's going okay. But I am going to start giving my baby formula because I heard that it protects against infections.
Health worker:	You are wondering about what is best for your baby. I'm glad you have come to talk about it. Your breast milk will help protect your baby from infections, but formula will not. If you feed your baby formula, he will have less protection against illness.
Ask:	*What did you observe this time?*
Comment:	The health worker used simple terms and provided relevant information to the mother.

Skill 6. Make one or two suggestions, not commands

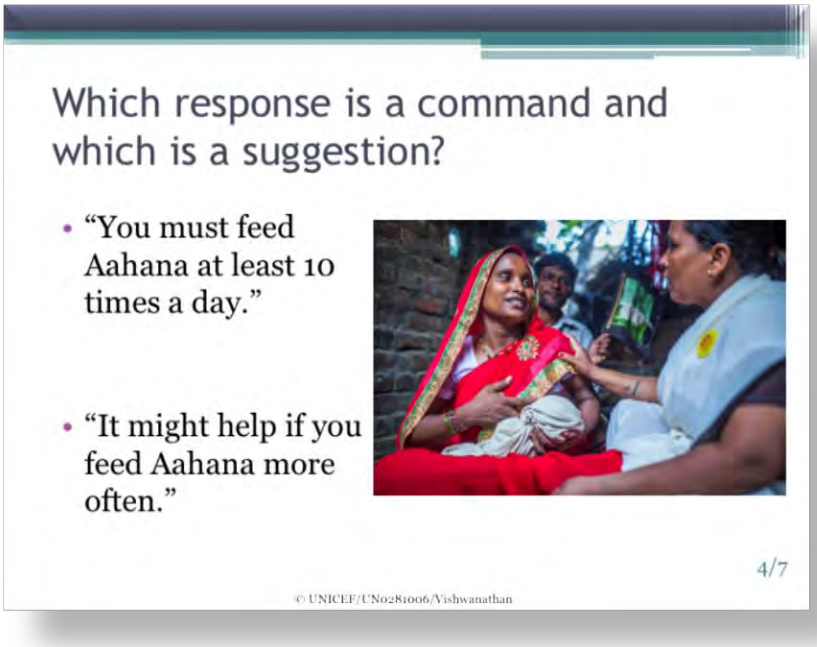
What is the difference between a suggestion or a command?

Suggestion: an idea or plan put forward for consideration

Command: information given as an order (Do this. Don't do that.)

Let the mother decide what will work for her by providing her with choices relevant to the situation.

Be careful not to tell her what she should or should not do as this may decrease her self- confidence. When provide counselling, you listen and observe. Only after this should you provide suggestions. Then she can decide whether she will try the suggestion. This leaves her feeling in control and helps her feel confident.



Let's practise

Exercises – building confidence and giving support

We will practice the skills from this session: building confidence and giving support. Please complete the exercises individually, then we will discuss together in groups with a trainer. Trainers will give feedback and give you "Answer sheets" at the end of the session.

Exercise 4.A – Accepting what a mother/parent/caregiver thinks and feels

Directions

Draw a line to link which response:
1) accepts
2) agrees with incorrect information
3) disagrees 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 (with incorrect information)
"Yes, babies need water in hot weather."	Disagreeing
"You feel the baby needs some water if it is hot?"	Accepting

Directions: Link 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 (with incorrect information)
"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 (with incorrect information)
"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

Exercise 4.B – Recognize skills and praise a mother/parent/caregiver and baby

Directions

In stories A and B below, create a response praising mother and/or baby. In your response, you only need to give ONE answer.

Example	Response
A mother had to return to work shortly after her baby was born. She expresses breast milk during the day to give to the baby while she is at work. She continues to breastfeed the baby at night. She is worried that she is not breastfeeding enough.	*It is good you are continuing to breastfeed your baby at night.*

Exercise

Story A	Response
A mother of a two-day old baby tells you that she is worried her baby is not getting enough breast milk. Her mother has told her the baby is crying because she is thirsty and needs water.	

Story B	Response
You are taking care of a new mother and her baby. She tells you she is breastfeeding, but her family said she needs to start giving the baby a bottle right away so that he gets used to it.	

Exercise 4.C – Provide relevant information using simple language

Directions

Re-write the statement using simple language to help the mother to understand.

Example

Statement	Simple language
Colostrum is all your baby needs in the first few days.	The first yellowish milk that comes is exactly what your baby needs for the first few days.

Exercise

Statement	Simple language
1. "Exclusive breastfeeding provides all the nutrients that your baby needs for the first six months."	
2. "The immunoglobulins in human milk provide your baby with protection from viral and bacterial infections."	

Exercise 4.D – Make one or two suggestions, not commands

Directions

Re-write each command to a suggestion.

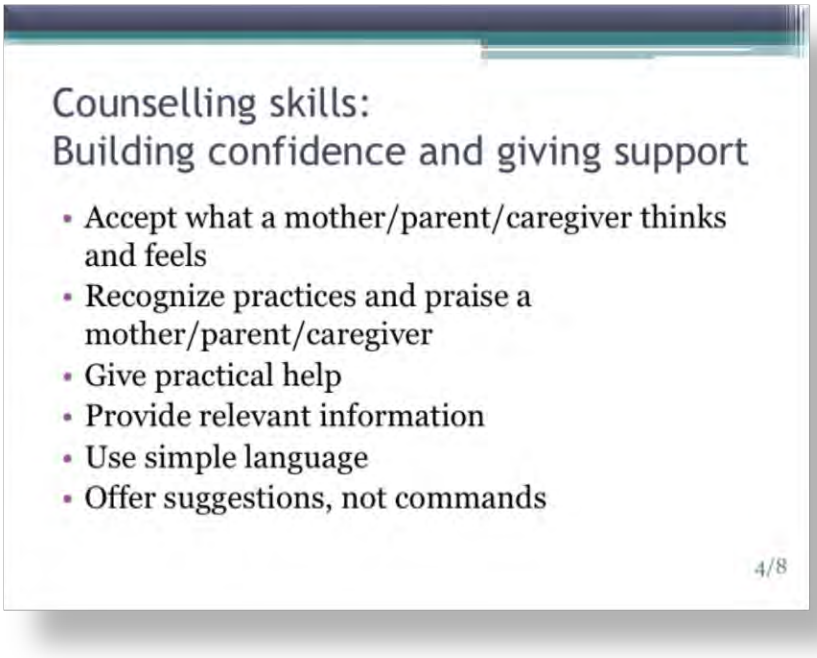
Example

Command	Suggestion
"Do not give your baby drinks of water"	*"Have you thought of giving only your milk?"*

Exercise

Command	Suggestion
1. "You must feed your baby more."	
2. "Do not give any foods to your baby until after six months."	

Session summary



Notes

Session 5. How breastfeeding works

Objectives

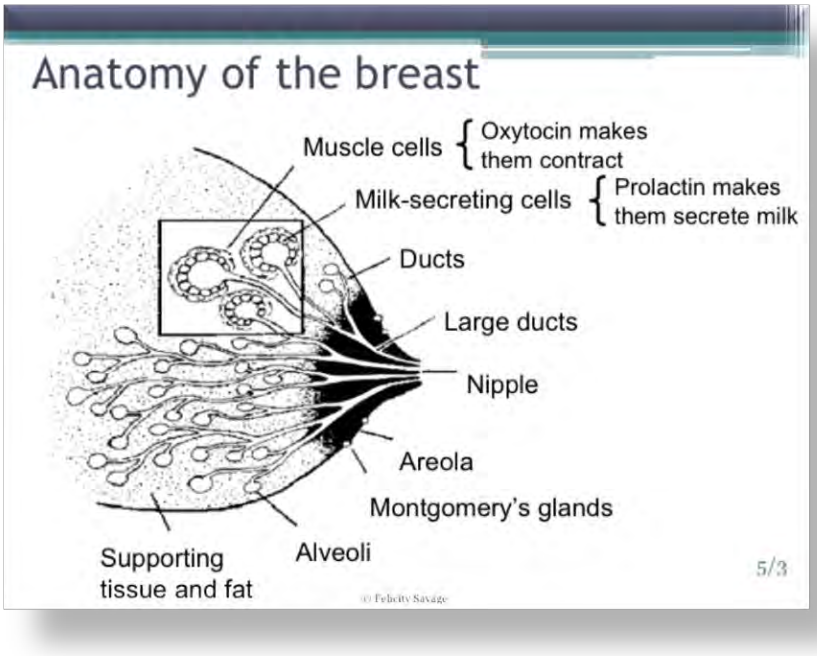
After completing this session, participants will be able to:

- the parts of the breast involved in lactation and their functions
- the physiology of the lactation hormones
- the physiology of breast-milk production and flow
- the difference between good and poor attachment of a baby at the breast
- the FOUR KEY POINTS OF ATTACHMENT
- the suckling action of the baby when well attached or poorly attached.

Introduction

Knowledge and understanding of how breastfeeding works will allow to you help mothers/parents/caregivers. In this session, we review the anatomy and physiology of breastfeeding. We will discuss milk production and milk transfer from mother to baby. Your goal as a health worker is to help a mother/parent/caregiver decide what is best for their situation. If you understand how breastfeeding works, you will have a deeper understanding and provide more specific support.

Anatomy of the breast



This diagram shows the anatomy of the breast. Let's notice some significant parts.

1) Nipple.

2) Areola: Dark skin surrounding the nipple, a baby needs to have a large amount of the areola in its mouth to feed well.

3) Montgomery's glands: Secrete an oily fluid to keep the skin healthy, clean and lubricated. They are the source of the mother's smell of the mother's breasts, helping the baby to find the breast and recognize her.

4) Alveoli: Small sacs made of milk-secreting cells. There are millions of alveoli – the diagram shows only a few. The box in the diagram shows three of the alveoli enlarged. A hormone called **prolactin** makes these cells produce milk.

5) Muscle cells: Surround the alveoli contracting and squeezing the milk out. A hormone called **oxytocin** makes the muscle cells contract.

6) Ducts: Small tubes, or ducts, carry milk from the alveoli to the outside. Between feeds, milk is stored in the alveoli and small ducts. The ducts join to form seven to 10 larger ducts that pass through the nipple. The larger ducts beneath the areola dilate during feeding and hold the breast milk temporarily during the feed. The secretory alveoli and ducts are surrounded by supporting tissue and fat.

Special note: Breast size

After reviewing the structures and the anatomy of the breast, we want to consider a special counselling point with mothers. Some mothers think their breasts are too small to produce enough milk. This is the moment to support them with knowledge and understanding.

How should the health worker counsel this mother?

Small breasts and large breasts both contain about the same amount of glandular tissue, so they can both make plenty of milk. It is the fat and other tissue that give the breast its shape, and make up most of the difference between large and small breasts.

Small breasts may have less milk storage between feeds than larger breasts. Babies of mothers with small breasts may need to feed more often. Ultimately, the amount of milk produced in a day is as much as from larger breasts.

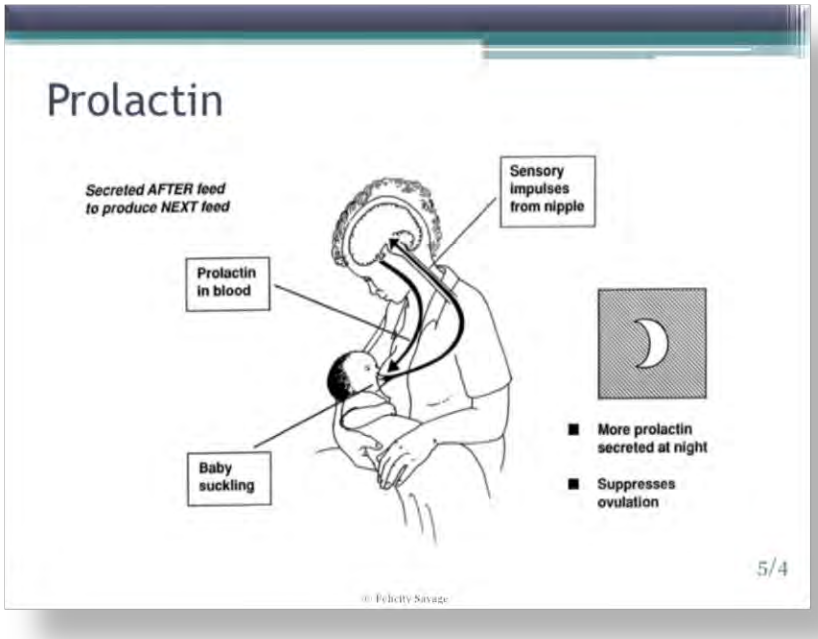
Physiology of breast-milk production and lactation hormones

What are hormones?

Hormones are chemical messengers in the blood that help control and regulate different processes in our bodies.

The first stage of milk production is under the control of hormones During pregnancy, hormones help the breasts to develop and grow in size. The breasts also begin making colostrum, which is present when the baby is born.

After birth, the hormones of pregnancy decrease. Two hormones – prolactin and oxytocin become important. Prolactin helps the production of milk and oxytocin makes milk flow.



Prolactin and production

This slide shows us about the hormone prolactin. Prolactin is important to start milk production after delivery and to sustain it.

- Prolactin level is high in pregnancy. However, it cannot make the cells secrete milk because the hormones, progesterone and oestrogen, block it. After delivery progesterone decreases, and prolactin can start working. This makes milk production increase immediately after delivery. The prolactin level increases when a mother and a baby are skin-to-skin.
- After two to three days postpartum, a mother notices that her breasts feel full. Health workers may call this milk "coming in," but it is more helpful to teach a mother about her changing milk (from colostrum to mature milk). This is when her milk supply increases and changes from colostrum.
- Remember breasts initially produce milk called colostrum. The amount is small, but it is all the baby needs after delivery.
- This slide also explains how prolactin sustains milk production. When a baby suckles at the breast, sensory impulses go from the nipple to the brain. In response, the pituitary gland at the base of the brain secretes prolactin. Prolactin goes from the blood to the breast and makes the milk-secreting cells produce milk.
- Most prolactin is in the blood about 45 minutes after the feed. This helps the breast to continue producing milk after the feed to be ready for the NEXT feed. For this current feed, the baby takes the milk already in the breast. The milk is stored in the alveoli and smaller ducts.

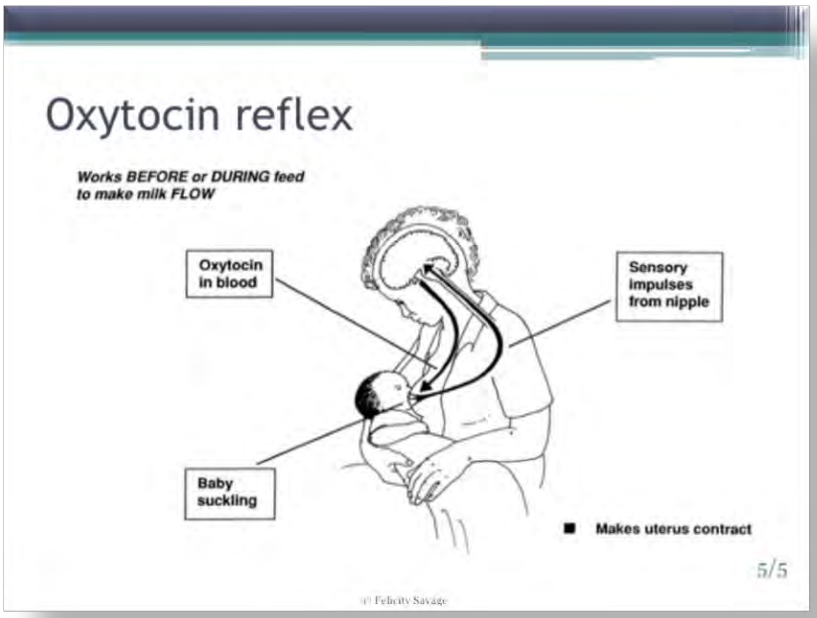
NOTE: In the first months after delivery, milk production is adjusting to the baby's needs. For a mother to increase her milk supply, the baby must continue to suckle. If a baby does not suckle enough, the prolactin level falls. The breasts will make less milk.

Important points about prolactin.

- More prolactin is produced at night, when the mother is relaxed. Breastfeeding at night is helpful for keeping the milk supply higher.

- Prolactin makes a mother feel relaxed, and sometimes sleepy. She usually rests well even if she breastfeeds at night.

Oxytocin



This slide explains the hormone oxytocin.

- When a baby suckles, sensory impulses go from the nipple to the brain. In response, the pituitary gland at the base of the brain also secretes oxytocin. Oxytocin goes from the blood to the breast and makes the muscle cells around the alveoli contract. The milk collected in the alveoli flows along the ducts to the larger ducts beneath the areola. This is the oxytocin reflex, the milk-ejection reflex or the “let-down” reflex. As the reflex works, the larger ducts beneath the areola fill with milk and increase in size. Sometimes the milk flows to the outside. Oxytocin enables the baby to get the milk.

- Oxytocin is produced more quickly than prolactin. It makes the milk in the breast flow for this feed. Oxytocin can start working before a baby suckles, when a mother expects to breastfeed.

- Oxytocin makes a mother's uterus contract after delivery and helps reduce bleeding. Sometimes the contractions cause uterine pain and a rush of blood during a feed for the first few days. The pains can be quite strong, sometimes called "after pains". This is an opportunity to counsel the mother/parent/caregiver about this process, so they do not worry.

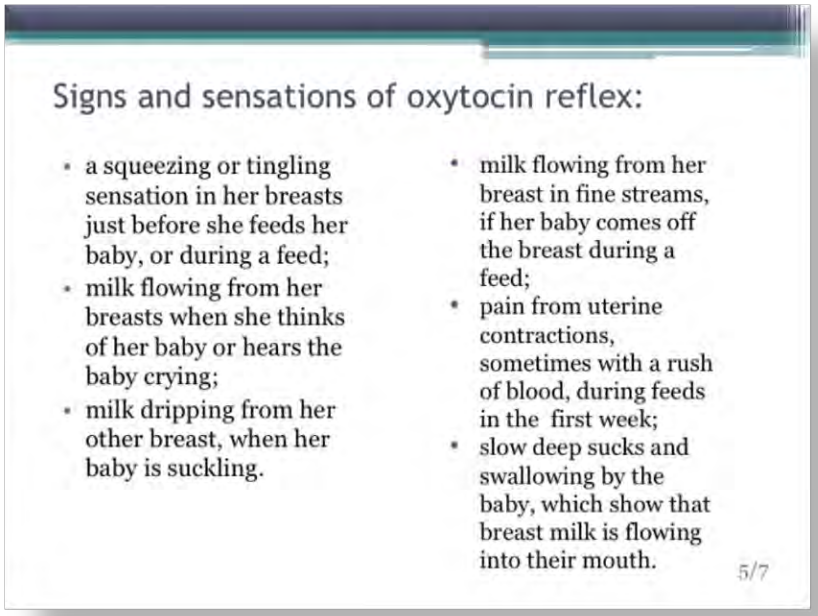
- Oxytocin is sometimes called "the love hormone" because of the role it plays in helping a mother bond with and love her baby. Because of lower oxytocin levels, mothers who bottle feed their babies may not have the same feelings.

- This slide shows how the oxytocin reflex is affected by a mother's thoughts and feelings. Positive feelings such as feeling happy about her baby or feeling confident can help the oxytocin reflex to work. Other feelings such as pain, worry and doubt can hinder the reflex. Also, a mother may experience pain from sore nipples or delivery, or she may doubt that she has enough breast milk. These can hinder the flow of her milk.

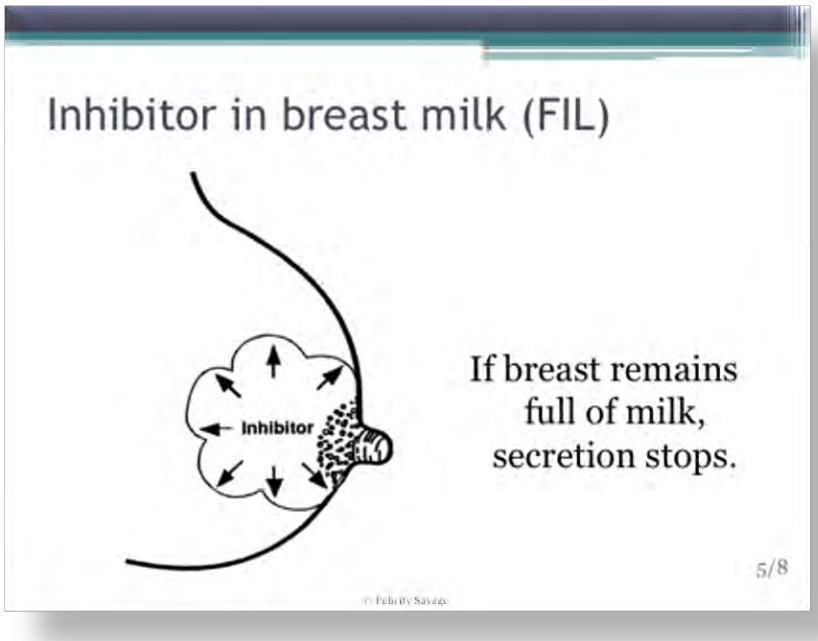
- Acute stress and trauma can also hinder the reflex. She may think her breasts have stopped producing milk. The breasts are producing milk, but it is not flowing out. Therefore, it is difficult for the baby to get the milk from the breast. Fortunately, this effect is usually temporary and can be overcome.

- A mother needs to have her baby near her all the time This allows her to see, touch and respond to the baby. This helps her body to prepare for a breastfeed, and for her breast milk to flow. If a mother is separated from her baby between feeds, her oxytocin reflex may not work as easily.

NOTE: How you talk to a mother can affect the flow of her breast milk. Try to make her feel supported and build her confidence to help her breast milk to flow well. Be careful not to criticize her or say anything that may make her doubt her breast milk supply. You can also help a mother relax and get comfortable for feeds. Mothers are often aware of their oxytocin reflex.



- You may notice some of these signs when you observe a mother and baby. Ask a mother if she notices them. If one or more of the signs or sensations are present, then a mother can be sure her oxytocin reflex is active. This means her breast milk should be flowing. But, even if her reflex is active, she may not feel the sensations or the signs may not be obvious.



Production of breast milk is also controlled within the breast itself. In some cases, one breast stops making milk, while the other breast continues to make milk. Oxytocin and prolactin are working in both breasts. This slide helps us understand why.

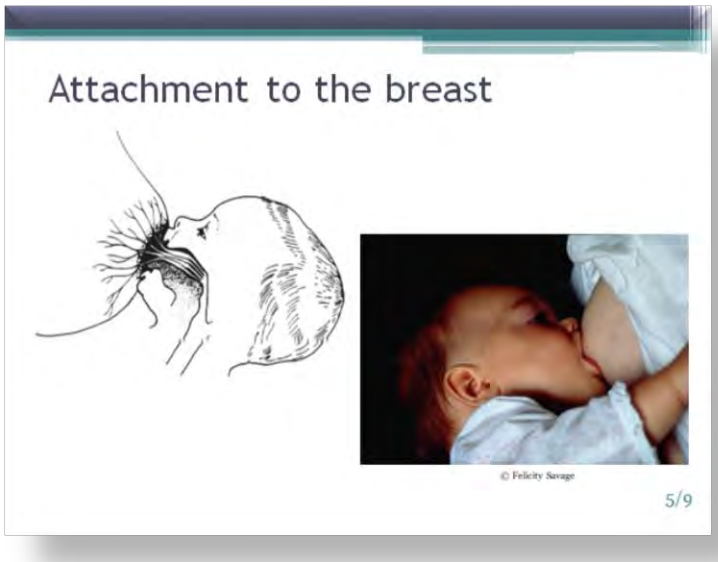
Milk contains different factors to control or inhibit milk production. One main factor is called the **feedback inhibitor of lactation (FIL)**. If milk is not removed and the breast is full, this inhibitor decreases production of milk. If milk is removed from the breast, then the inhibitor level falls and milk production increases. Thus, the amount of milk that is produced depends on how much is removed.

Key points

- If a baby stops suckling from one breast, that breast stops making milk.
- If a baby suckles more from one breast, that breast makes more milk and becomes larger than the other one.
- For a breast to continue to make milk, the milk must be removed.
- If a baby cannot suckle from one or both breasts, the breast milk must be removed by expression to enable production to continue.
- This local control of breast-milk production is especially important after the first few weeks, when the level of prolactin decreases.
- Milk production is a give and take process: The mother's body makes as much milk as the baby drinks. For a mother to produce enough milk, her baby must suckle often and remove the milk. Her breasts will respond and produce as much milk as the baby takes. To remove and transfer the milk efficiently, it is necessary for the baby to suckle effectively.

NOTE: If a baby cannot suckle, the breast milk must be removed by expression to enable production to continue. This is an important point that we will discuss later in the course when we talk about expressing breast milk.

Attachment to the breast



This slide shows how a baby takes the breast into their mouth to suckle.

Key points

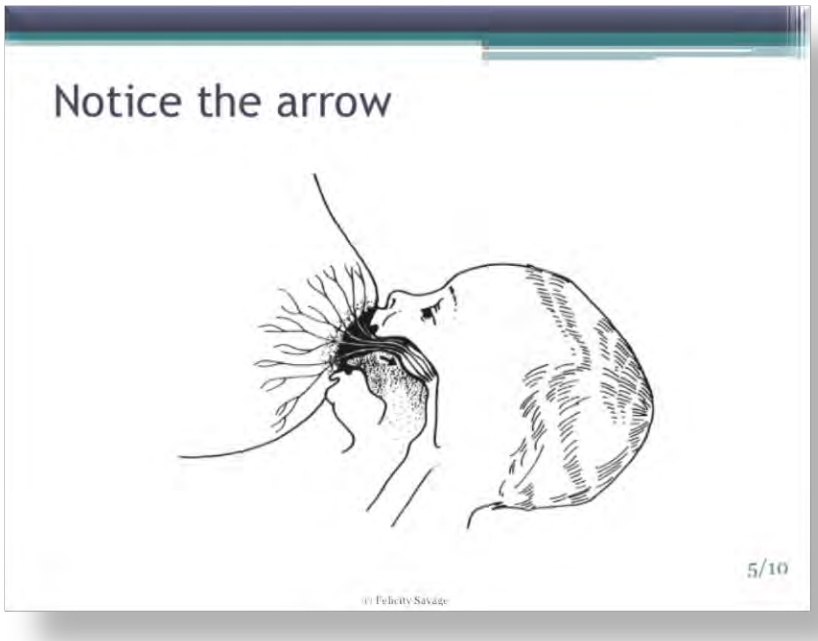
- The baby has taken much of areola and the underlying tissues into their mouth.
- The larger ducts are included in these underlying tissues.
- The baby has stretched the breast tissue out to form a long "teat".
- The nipple forms only about one third (1/3) of the "teat".
- The baby is suckling from the breast, not the nipple.

Notice the position of the baby's tongue.

- The baby's tongue is forward, over the lower gums, and beneath the larger ducts
- The baby's tongue is cupped round the "teat" of breast tissue – you cannot see that in this photo, though you may see it when you observe a baby.

Well attached

If a baby takes the breast into their mouth in this way, we say that they are well attached to the breast. The baby can remove breast milk easily, and they are suckling effectively. When a baby suckles effectively, their mouth and tongue do not rub the skin of the breast and nipple.

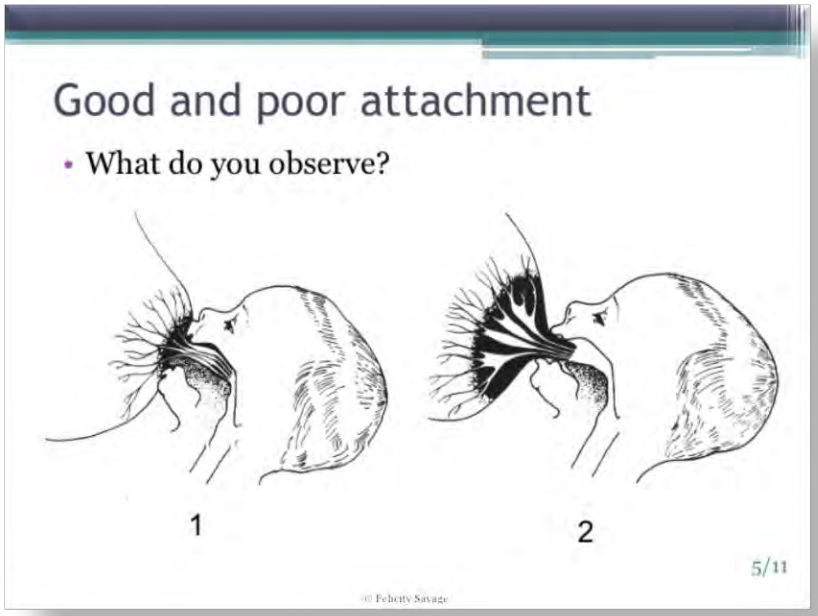


Notice the arrow

- This is the same baby as in the previous slide. You can see what happens to a baby's tongue when they suckle. The arrow shows a wave going along the baby's tongue from the front to the back. The wave presses the "teat" of breast tissue against the baby's hard palate. This action presses milk out of the larger ducts into the baby's mouth, from where he swallows it. So, a baby does not simply suck milk out of a breast, like drinking through a straw.
- Instead:
  - the baby uses suction to stretch out the breast tissue to form a teat and to hold the breast tissue in his mouth;
  - the oxytocin reflex makes breast milk flow and fill the ducts beneath the areola;
  - the action of the baby's tongue presses the milk from the ducts into their mouth.

Effective suckling

When a baby is well attached, they remove and transfer breast milk easily, and it is called *effective suckling*. You can often see and hear a baby swallowing the milk when they suckle effectively.



Here you see two pictures.:

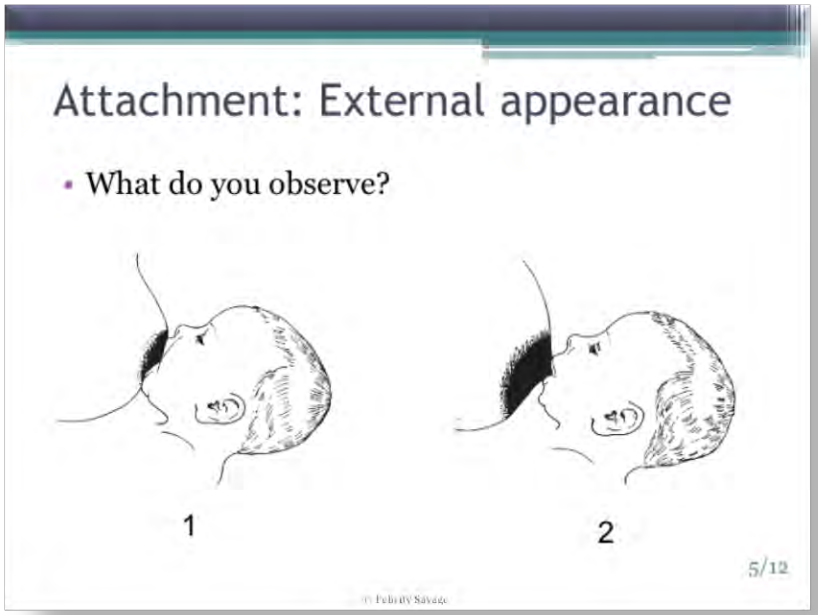
1) **picture 1** is the same baby as in Slide 5/7 – the baby is well attached to the breast;

2) **picture 2** shows a baby suckling in a different way – let us focus on what is happening inside the baby's mouth.

The most important differences in picture 2 are:

- only the nipple is in the baby's mouth, not the underlying breast tissue;
- the larger ducts are outside the baby's mouth, where his tongue cannot reach them;
- the baby's tongue is back inside his mouth and not pressing on the larger ducts.

The baby in picture 2 is poorly attached. He is "nipple sucking" and cannot suckle effectively.

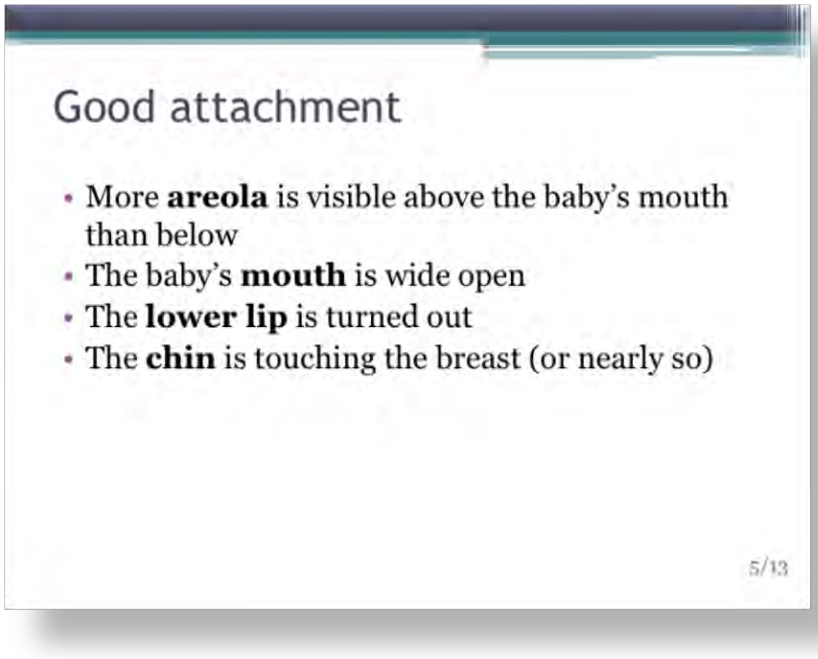


This picture shows the same two babies from the outside. You need to be able to decide about a baby's attachment by observing from the outside.

Picture 1 shows good attachment and Picture 2 shows poor attachment.

In Picture 1, the **four key signs for good attachment** are:

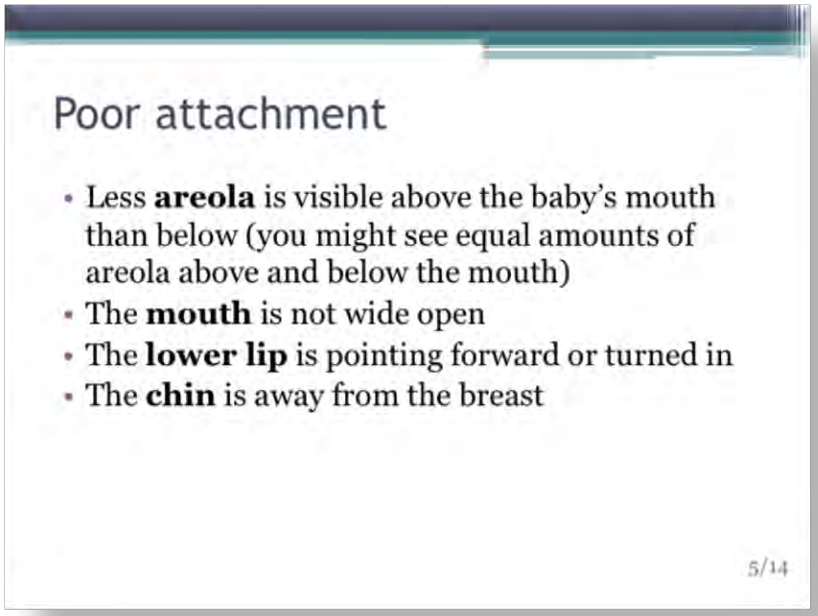
1. more **areola** is visible above the baby's mouth than below
2. the baby's **mouth** is wide open
3. the **lower lip** is turned out
4. the **chin** is touching the breast (or nearly so).



These are the key signs of good attachment. If you can see all these signs, then the baby is well attached.

In Picture 2 **(poor attachment)** we see that:

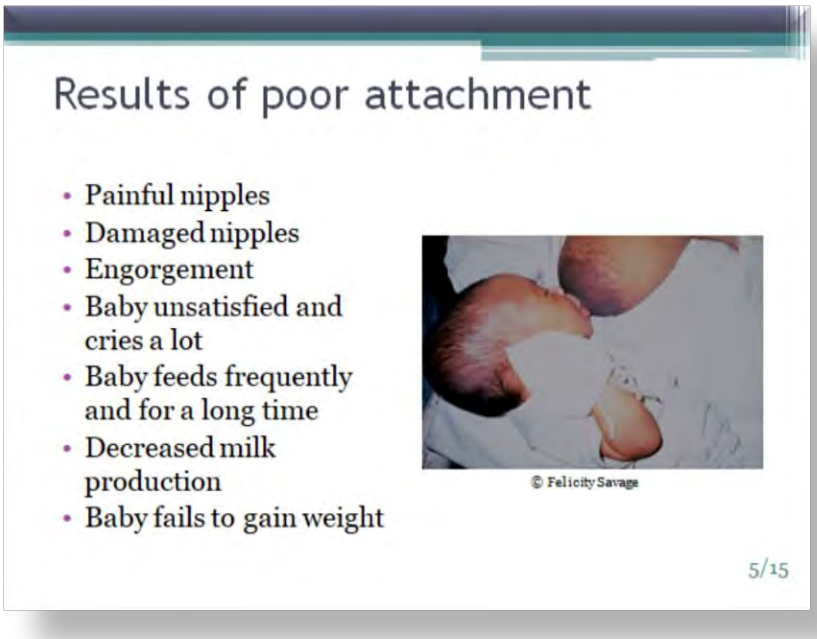
1. less **areola** is visible above the baby's mouth than below (you might see equal amounts of areola above and below the mouth)
2. the **mouth** is not wide open
3. the **lower lip** is pointing forward or turned in
4. the **chin** is away from the breast.



These are the signs of poor attachment. If you see any one of these signs, then the baby is poorly attached and cannot suckle effectively.

Seeing a lot or a little of the areola is not a reliable sign of attachment. Some women have a large areola and you see a lot even if the baby is well attached. Some have a small areola and you see very little even if the baby is poorly attached. It is more reliable to compare how much areola you see above and below a baby's mouth (if any is visible).

There are other differences that you can see when you look at a real baby, which you will learn about in SESSION 8: ASSESSING A BREASTFEED.

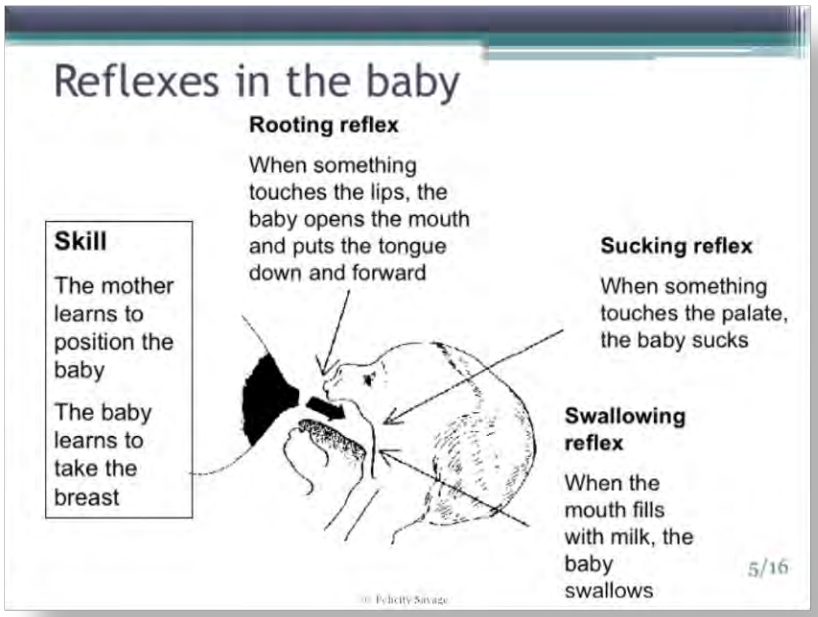


This slide summarizes what may happen when a baby is poorly attached to the breast.

If a baby is poorly attached, and "nipple sucks", it is painful for the mother. **Poor attachment is the main cause of sore nipples.** As the baby sucks hard to try to get milk, they pull the nipple in and out. This makes the nipple skin rub against their mouth. If a baby continues to suck in this way, they can damage the nipple skin and cause fissures (also known as cracks).

Costs of ineffective milk transfer

If the baby does not remove breast milk effectively, the breasts may become **engorged (breasts are painful and too full of milk).** Because the baby does not get enough breast milk, they may be unsatisfied and cry. They may want to feed often or for a very long time at each feed, or they may get frustrated and have difficulty to suckle. Eventually, if breast milk is not removed, the breasts may make less milk. A baby may fail to gain weight and the mother may feel she is a breastfeeding failure, which may lead her to stop breastfeeding.
To prevent this happening, all mothers need skilled help to position and attach their babies.



Baby's reflexes

A reflex happens automatically in response to a certain stimulus. There are three main reflexes related to suckling: the rooting reflex, the sucking reflex and the swallowing reflex.

The rooting, sucking and swallowing reflexes happen automatically in a healthy, term baby. However, taking the breast far enough into the baby's mouth is not completely automatic. A baby should be held close to the breast and approach the breast from underneath the nipple.

1. Rooting reflex

When something touches a baby's lips or cheek, they turn their head towards it. The baby then opens their mouth, especially if the upper lip is touched. This is the "rooting" reflex. It is normally the nipple or breast that the baby is "rooting" for.

2. Sucking reflex

When something touches a baby's palate, they start to suck it. This is the sucking reflex. When the mother moves the open-mouthed baby closer to the breast so that the nipple touches the soft palate, this stimulates the baby's sucking reflex.

3. Swallowing reflex

When the baby's mouth fills with milk, they swallow. This is the swallowing reflex.

Most healthy term infants can attach themselves to the breast instinctively in the first hour after birth. Mother and baby must be kept together in a comfortable, supportive environment that helps the reflexes. Mothers need to learn how to avoid uncomfortable positions and ways of holding the baby that inhibit the reflexes. Health workers need not interfere if things are going well. However, they should be aware of those mothers who do need help. Also, some babies need more help than others to learn to attach and suckle effectively.

Notice in the slide the baby is not coming straight towards the breast. He is coming up to it from below the nipple. The baby's chin should come close into the breast and the nose away from the breast. This helps the baby to attach well because:

- the nipple is pointing towards the baby's palate, which stimulates their sucking reflex;
- the baby's lower lip is pointed below the nipple;
- the baby can get the tongue under the nipple and larger ducts and suckle effectively.

Notes

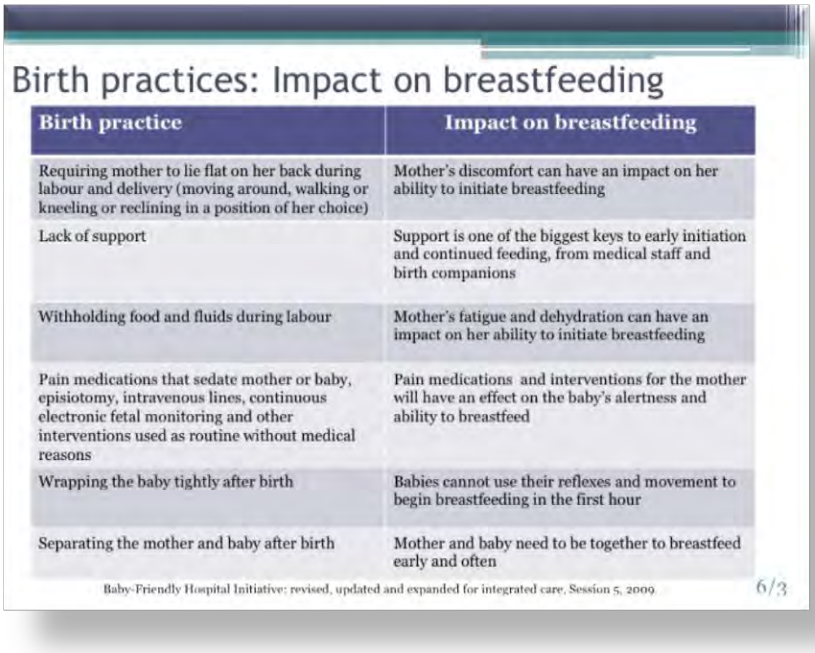
Session 6. Impact of birth practices

Objectives

After completing this session, participants will be able to:

- discuss the importance of early contact and the initiation of breastfeeding
- describe the procedure of putting the baby in skin-to-skin contact immediately after birth
- explain how a baby moves to the breast and attaches by themselves, and how to help the baby, if needed
- describe how health-care practices affect initiation of breastfeeding.

Birth practices: Impact on breastfeeding



Skin-to-skin contact and initiation of breastfeeding

Early skin-to-skin contact between mothers and infants should be initiated as soon as possible after birth. It should be uninterrupted for **at least 60 minutes**. Mothers should also be supported to initiate breastfeeding as soon as possible.

According to research, babies who start to breastfeed within the first hour are more likely to survive the first month of life. The longer the delay, the greater the risk of death.

Early initiation: Immediately after birth

Early skin-to-skin contact:

- promotes bonding
- maintains warmth
- lowers infection and mortality

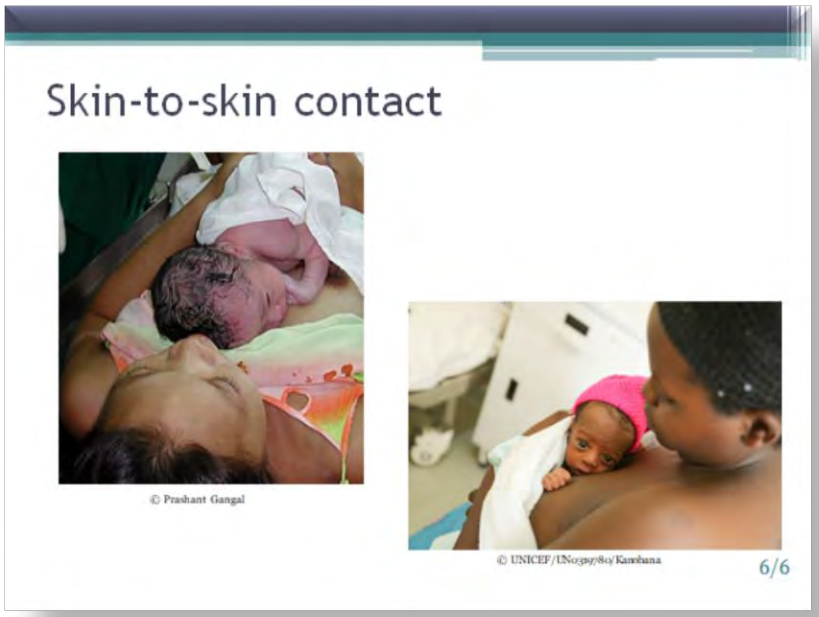
© WHO/Yoshi Shimizu

6/4

Benefits of early skin-to-skin contact:

- allows the baby to find the breast and self-attach;
- helps a mother to bond with her baby (develop a close, loving relationship);
- a mother will more likely start to breastfeed and will breastfeed for longer;
- helps to stimulate maternal milk production and supply;
- calms the mother and baby;
- helps to regulate the baby's breathing, heart rate, temperature, and glucose levels, which is especially valuable for low-birth-weight babies and premature babies;
- enabling the colonization of the baby with microbes from the mother's skin, mucosal surfaces and intestine, which helps to protect the baby from infection.

6/5

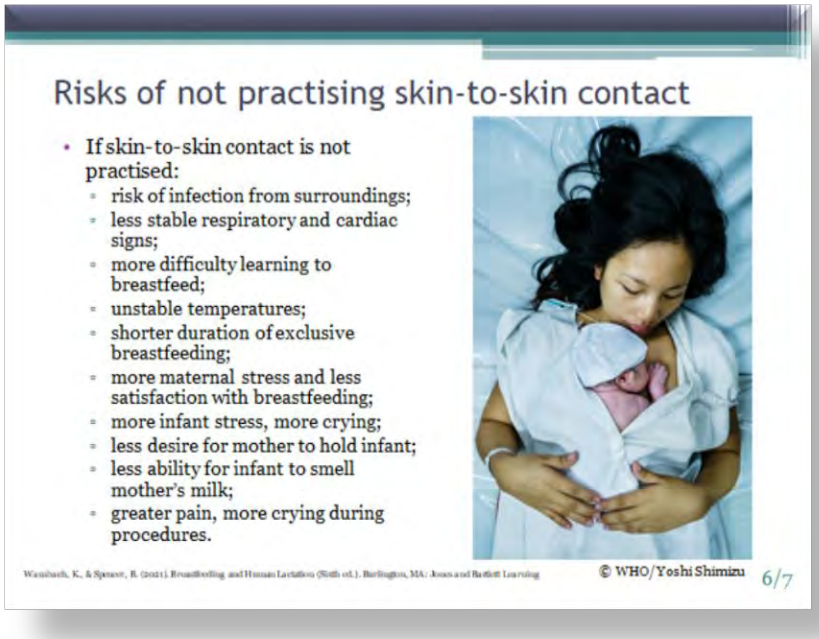


NOTE: What do you observe about how the mothers are holding the babies?

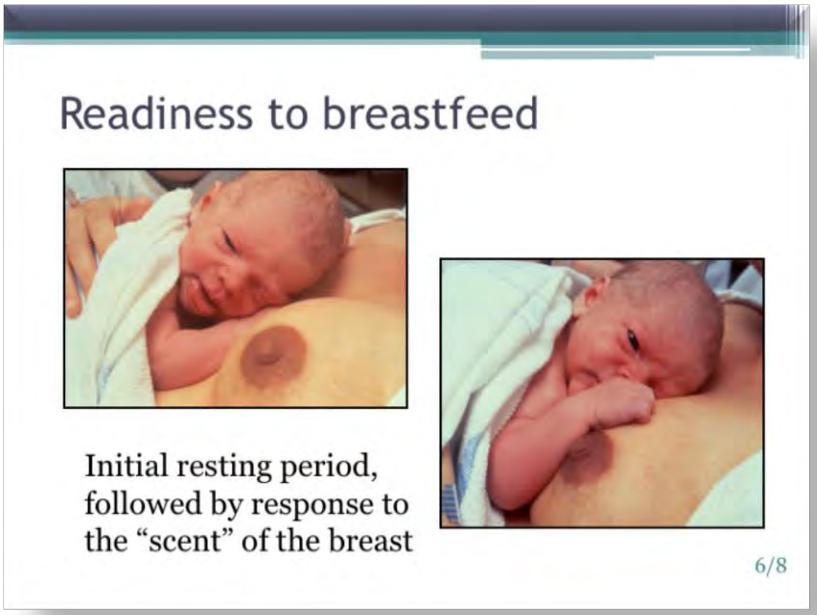
- In this picture, the baby has been placed on the mother's chest and abdomen, with no clothing separating them. The baby is naked, so that their body is in direct skin-to-skin contact with their mother.

- All babies should be quickly dried off as they are placed on the mother's skin and covered with a blanket or cloth to stay warm. Babies should not be wrapped tightly after birth. If the room temperature is cold, cover the baby's head with a hat or blanket to reduce heat loss.

- A mother should hold her baby like this as much as possible for at least one hour after delivery, without interruption. She does not have to lie flat during this time. She may be more comfortable sitting up or leaning back, holding the baby between her breasts, and letting them respond naturally.



NOTE: Skin to skin must be practiced in a way that maintains the safety of both mother and baby. If a mother has received medications that impair her ability to practice skin-to-skin, she must be monitored closely by health-care workers. Please monitor both hers and the baby's vital signs to make sure they will both remain safe and stable during the practice of skin-to-skin.



First hour behaviour

- Here are two pictures of a baby in skin-to-skin contact soon after birth. They show the instinctive behaviour and reflexes of a newborn baby in the first hour.
- In the **top picture,** the baby is just resting. Most babies do this for between 10 and 60 minutes. His mother should just let him take his time, until he is ready to suckle. A few babies take between one and two hours.
- In the **lower picture**, notice the baby has become more alert and is opening his eyes and starting to respond to the smell of his mother's breast. At this point, babies will try to self-attach to the breast.

Breast crawl

Most babies slowly crawl toward the breast while they are skin-to-skin with their mothers. When a baby is on their mother's chest (skin-to-skin), the breast odour will encourage the baby to move towards the nipple. Provided a mother has not received medication during labour, she and her baby respond naturally to each other after birth.

NOTE: If she has received medication, the baby may take much longer to respond.

When a mother and baby are skin-to-skin without interruption, the baby will typically work through a series of instinctual **pre-feeding behaviours** called the 9 stages. The 9 stages are: birth cry; relaxation; awakening; activity; crawling; first resting; familiarizing; suckling; sleeping. This may be over in a few minutes or an hour or more. A longer period of skin-to-skin contact is recommended if the baby has not suckled by one hour after birth.

What do you observe in this photo?

This baby has attached to the breast by himself and has started suckling. Many babies attach to the breast and suckle very well without help. What you have seen in these slides should be the normal care given to every mother with a healthy baby. They show how a mother and her baby respond naturally to each other after birth.

If the mother and baby are separated, the baby's pattern of behaviour changes. The baby is less organized and takes longer to start to breastfeed. This makes it more difficult to establish breastfeeding. Unless there is a known medical reason for not breastfeeding, all mothers should be encouraged to let their baby suckle at the breast.

NOTE: The first time the baby suckles at the breast should be considered an introduction to the breast rather than a feed. This is key in providing encouragement and building the mother's confidence. There should be no pressure on the mother or baby as to:

- how soon the first feed takes place
- how long a first feed lasts
- how well attached the baby is
- how much colostrum the baby takes.

More assistance with breastfeeding can be provided at the next feed. After the introduction to the breast, often mothers and babies will sleep for a few hours. When the baby wakes again a few hours later, it is a good time to help the mother with breastfeeding.

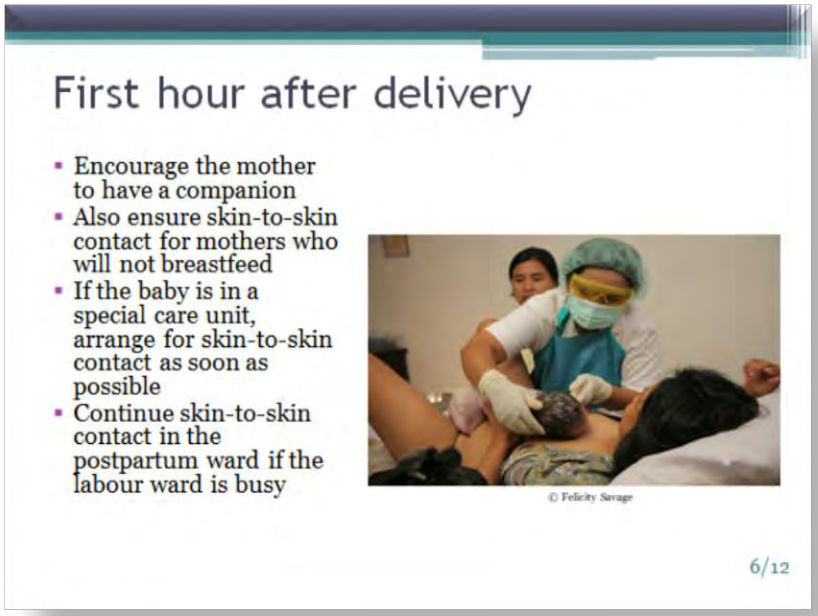
Special cases

Preterm infants

Early initiation of breastfeeding may be difficult for preterm infants. Encourage preterm babies to spend time at the breast as early as possible, even if they are not able to suckle well. This can help them to "get to know the breast". If the baby has the maturity to lick, root, suck and swallow at the breast, they will do so without harm. Do not expect a baby to take full feeds at the breast immediately.

Role of the health worker:

- 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.



What do you observe in this photo?

This slide shows a mother who has just delivered. The companion standing beside her, providing support and reassurance.

Do not leave a mother and baby alone for the first hour after birth. Encourage mothers to have a companion with them during labour and delivery, who can stay until at least after the first breastfeed. A companion can also help the mother and baby to find a comfortable position.

A health worker should monitor the mother and baby. Mothers who are sleepy or under the influence of medications will require closer observation. This is also to ensure the safety of the baby.

Sometimes the delivery room is very busy, and it is not possible for the mother to remain there. Move the mother and baby to the postnatal ward together without interrupting skin-to-skin contact. For example, in a wheelchair or on a bed.

Mother and baby should not be separated unless medically indicated. Routine procedures should wait, if possible, until afterward, or if essential, can be performed during skin-to-skin contact.

If a mother and baby have to be separated immediately after birth, skin-to-skin contact may be delayed, but should take place as soon as their condition allows.

Special cases: Unable to initiate in the first hour

Sometimes mothers or babies are unable to initiate breastfeeding during the first hour, especially if the birth has been difficult in any way or through operation. They should be supported to provide skin-to-skin contact longer than one hour, and to breastfeed as soon as they are able[11].

If a baby is not stable and needs immediate attention, skin-to-skin contact can be given when the baby is stable. If a baby is sleepy due to maternal medications, it is even more important that the baby has contact. Allow the contact to continue for longer until the baby shows interest in feeding.

[11] Kuyper E, Vitta B, Dewey K. Implications of caesarean delivery for breastfeeding outcomes and strategies to support breastfeeding. Washington (DC): Alive & Thrive; 2014 (A&T Technical Brief Issue 8, February, https://www.aliveandthrive.org/wp-content/uploads/2018/07/Insight-Issue-8-Cesarean-Delivery-English.pdf, accessed 16 March 2020).

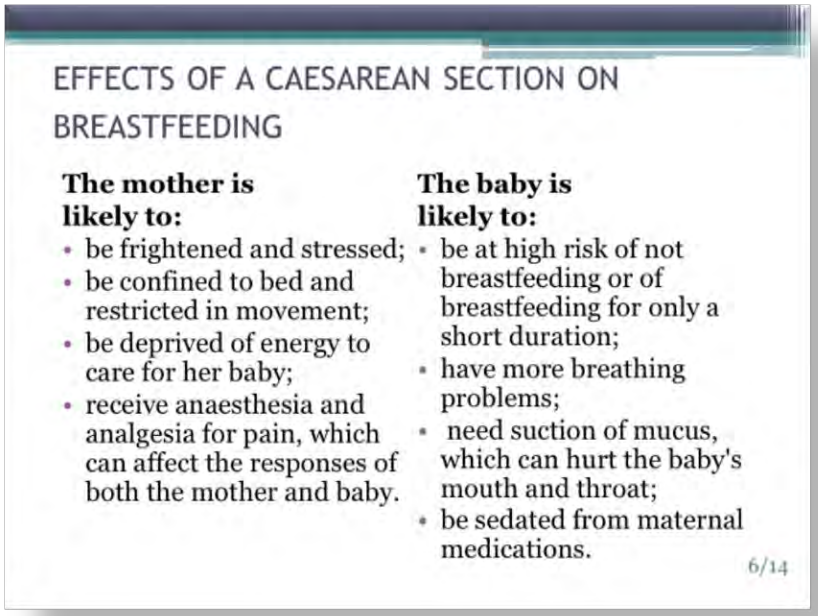
If a baby has to be in a special care unit, encourage the mother to visit, touch, and care for her baby as much as possible. Often these babies are wrapped tightly in one position. In these circumstances, care needs to be taken for mothers to recognize feeding cues. Skin-to-skin contact can encourage the mother to hold and put her baby to the breast.

Special cases: Caesarean section

A caesarean section should not prevent a mother and her baby from having early contact.

Mothers who have spinal or epidural anaesthesia are generally alert and able to respond to their baby immediately. Skin-to-skin contact and breastfeeding can begin when the baby is ready.

NOTE: In most cases, mothers and babies can initiate early and exclusively breastfeed following a C-section. Sometimes this may not be possible. Please refer to SESSION 14. MEDICAL INDICATIONS FOR SUPPLEMENTARY FEEDING for guidelines on options for supplementary feeding in these cases.



Support of health worker

A supportive health worker is important for helping a mother to initiate breastfeeding after a caesarean section. A mother does not need to move to be able to hold her baby to initiate breastfeeding. It is the baby who finds the breast and suckles (self-attachment). As long as there is a support person with the mother and baby, the baby can go to the breast. This can happen even if the mother is still sleepy from medications. If it is not medically possible for the mother, another family member can give skin-to-skin contact. This helps keep the baby warm and comforted.

Comfortable position

As a health worker, you can help mothers find a comfortable position to breastfeeding following a caesarean section.

- If the mother still has an intravenous line, adjust the line while the baby is on the mother's chest.
- The **side-lying position** for the mother helps to avoid pain. Lying flat with the baby on top of the mother can also be helpful.
- Provide support with a pillow (over the incision, under her knees when sitting, or under the top knee and behind her back when side-lying).

Let's practise

CASE STUDY: REMOVING BARRIERS TO EARLY BREASTFEEDING

As you read this case study, answer this question:

In Carole's case, which birth practices interfered with the establishment of breastfeeding?

Carole had a long labour for her first baby, and no-one from her family was allowed to be with her. When her baby was born, he was wrapped in a blanket and shown to her briefly. She saw her baby had a birthmark between his eyes. Then he was taken away to the nursery because it was night-time.

The staff gave him a bottle of infant formula for the next two feeds. Carole's baby was brought to her early the next morning – 10 hours after birth. The nurse told her to breastfeed. Carole started to take her baby while lying down, but the nurse told her she must always sit up to feed. Carole sat up with difficulty; the mattress sags and her back bent. She was sore from the birth and it hurt to sit. The nurse left Carole to feed her baby. She tried to help her baby to her breast and pushed the breast towards her baby's mouth with her hand. The baby was sleepy and suckled very weakly.

Carole wondered if the birthmark on the baby's face was caused by something she did wrong during the pregnancy. She was worried about what her husband and his mother will say about it. The nurses looked very busy, and Carole did not want to ask them questions. Her family was not allowed to visit until the afternoon.

The nurse returned and saw that the baby was not suckling well. The nurse said, "How can you go home tomorrow if you can't feed your baby properly?" The nurse then took the baby back to the nursery.

Which birth practices during this case study may have interfered with Carole establishing breastfeeding?

Notes

Session 7. Postnatal practices to support breastfeeding

Objectives

After completing this session, participants will be able to:

- describe the importance of avoiding prelacteal feeds and unnecessary supplementation
- outline advantages of rooming-in
- describe responsive feeding and why it is important
- answer common postnatal questions.

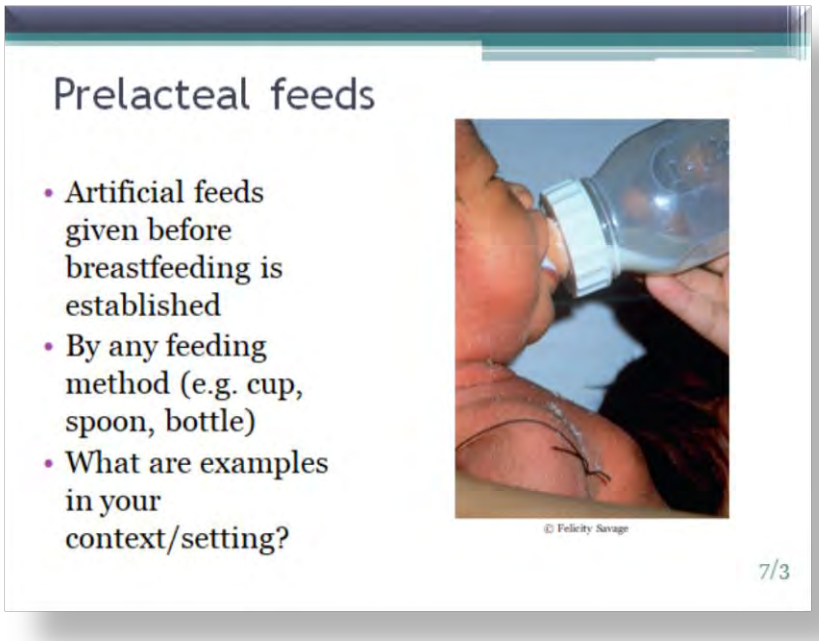
Introduction

Health-care practices can have a major effect on breastfeeding, both positive and negative.

Good practices support breastfeeding and make it more likely mothers will initiate breastfeeding successfully and will continue for a longer time. In this session, we will talk about practices to assist a mother/parent/caregiver with breastfeeding. Poor practices interfere with breastfeeding and contribute to the cessation of breastfeeding and increase of supplementation with artificial feeding. We will also discuss some practices that can interfere with breastfeeding.

Prelacteal feed

Any artificial feed given before breastfeeding is established or before the maternal milk supply "comes in" is called a "prelacteal feed."

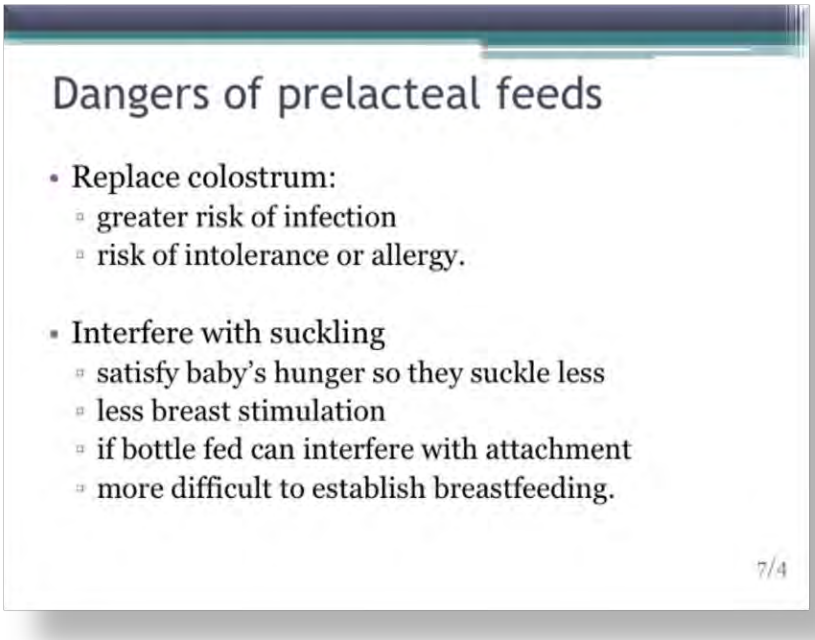


Avoiding prelacteal feeds and unnecessary supplementation

Some babies are given an artificial feed before starting to breastfeed. This can be from different methods including a bottle, a cup, a spoon, etc. How do people in your context/setting give an artificial feed?

Supplementary feed

Supplementary feeds are any foods or fluids given in addition to breast milk.



Risks of prelacteal feeds

1. Prelacteal feeds replace colostrum as the baby's earliest feeds.
    - A baby is more likely to develop infections such as diarrhoea and meningitis.
    - A baby is more likely to develop intolerance to the proteins.
    - This can lead to allergies, such as eczema.

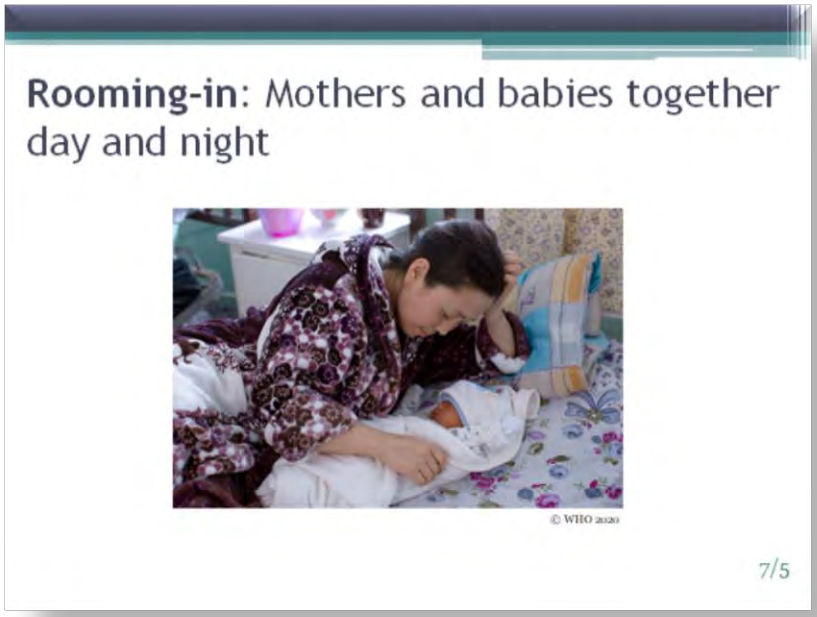
2. Prelacteal feeds interfere with suckling.
    - They satisfy a baby's hunger, so they suckle less and stimulate the breast less.
    - If a baby is fed from a bottle with an artificial teat, they may have more difficulty attaching to the breast (nipple confusion).
    - It is more difficult to establish breastfeeding.

If a baby has even a few prelacteal feeds, the mother/parent/caregiver is more likely to have difficulties. If the milk is not being removed from the breast, this could lead to conditions like engorgement. Breastfeeding duration is more likely to be shorter if prelacteal feeds have been given than when a baby has been exclusively breastfed from birth.

Prelacteal feeds and supplements should only be given if there is a **documented acceptable medical reason**, or the **mother has made a fully informed decision**. We will discuss this more in SESSION 14: MEDICAL INDICATIONS FOR SUPPLEMENTARY FEEDING.

Counselling a mother/parent/caregiver

Mothers and health workers should both understand the risks of prelacteal feeds and unnecessary supplementation. Use counselling skills (listening and learning) to understand a mother's motivation for the use of supplements. A mother who is thinking about using a supplement may have difficulties breastfeeding and caring for her baby. It is best first to help the mother to overcome her difficulties. Supplementation may make a mother lose confidence in her ability to breastfeed. She may be easily influenced by advice to give her baby the supplements. It is important to support the mother and build her confidence and skills to breastfeed.



Rooming-in

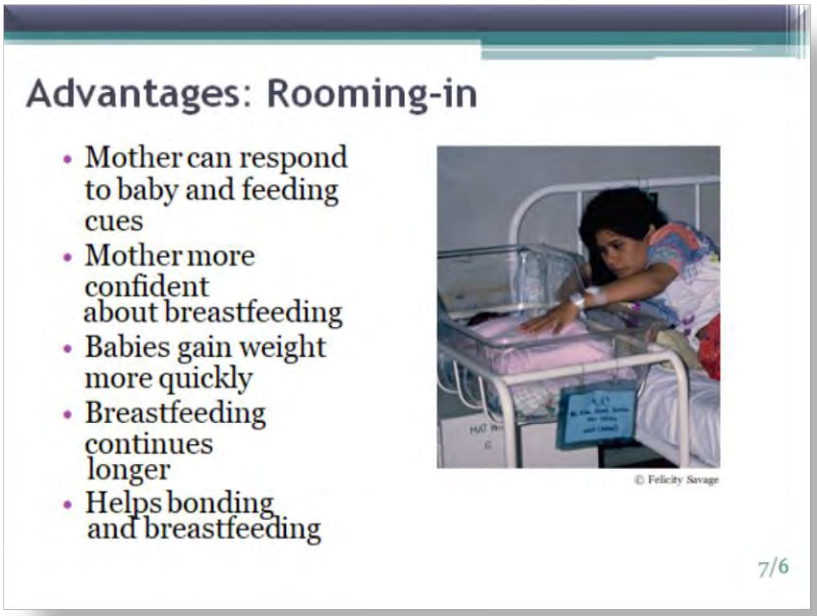
A baby stays in the same room as their mother/parent/caregiver, day and night, from immediately after birth. They should not be separated for more than one hour.

The baby is usually in a cot/bed beside the mother's bed. The baby is close to her, and she can touch the baby easily when she is lying down in bed. Cots are sometimes put at the foot of the mother's bed, where she cannot see or touch the baby easily. It is better for the cot to be beside the mother's bed.

Sometimes, the baby stays in the same bed as the mother. This is called "bedding-in." In some facilities “side-car” cots are used, fixed to the bed, to allow more space for the baby This is a safer option than “bedding-in” because there is no danger of the mother rolling on top of the baby when she is asleep, but keeps the baby close to the mother.

Babies should only be separated from their mothers/parents/caregivers for medical and safety reasons. Baby care and procedures should take place at the mother’s bedside and with the mother present. Preferably, the mother should care for her baby, to build her confidence and provide comfort to the baby.

Babies do not need to be put in a nursery, away from their mother, to be observed. A mother is very good at observing her own baby and often notices changes before a health worker in the nursery may notice. If a mother is tired, facilitate her rest with quiet times and minimize visitors, interruptions and procedures.



Advantages of rooming-in include:

- enabling a mother to recognize her baby's cues and respond to them – this is difficult when a mother and baby are separated, like if the baby is in a nursery;
- helping with both bonding and establishing breastfeeding;
- ensuring babies breastfeed more often and gain weight more quickly in the first week;
- promoting mother's confidence about breastfeeding and caring for their baby;
- breastfeeding continues longer after discharge.

If separation is necessary, the time of separation should be as short as possible.
If a baby is in a special care unit, their mother should be in the room or in a room as near as possible. Encourage the mother to visit and care for her baby as much as possible.
This is an important time to counsel her and assist her with the expression her milk.

Caring for the mother/parent/caregiver

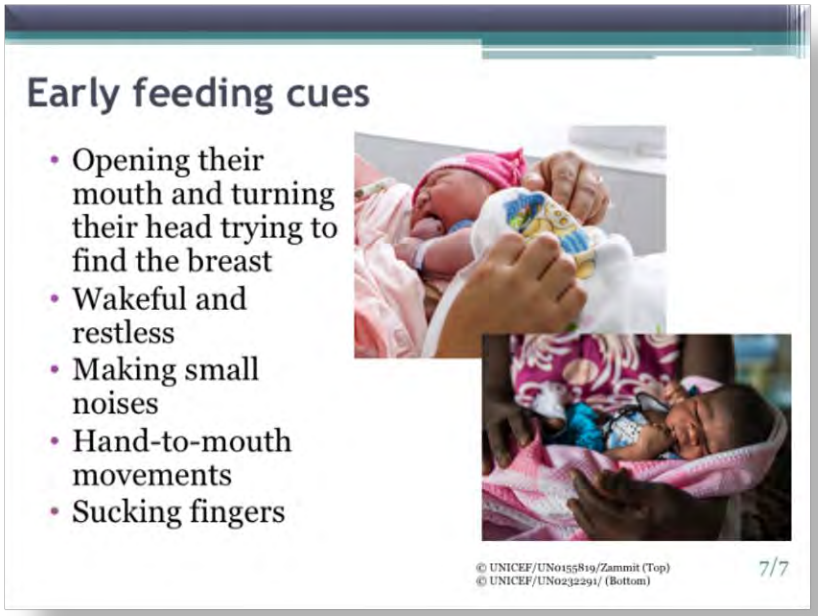
As a health care worker, provide care for the mother. She is very important to the baby's well-being and survival. Help her to stay at the facility while her baby is hospitalized, or ensure she has a place to stay/rest in proximity to the baby. Provide her with food and fluids. Listen to the mother and family and answer their questions. The parents may be upset, overwhelmed and frightened. If the mother has other children at home to care for, encourage her to find other family members to stay with them.

Responsive feeding

Responsive feeding[12]: a mother/parent/caregiver should feed her baby whenever the baby wants. She needs to learn to recognise her infant's signs of hunger and readiness to feed. These are called "feeding cues". She should respond to her baby's cues as soon and as often as the baby starts giving them, and let the baby suckle as long as the baby wants each time.

Health workers need to counsel and support mothers to recognize and respond to their infants' cues for feeding, closeness and comfort. This needs to be taught to all mothers, regardless of whether they choose to breastfeed.

[12] Responsive feeding is also called on-demand or baby-led feeding.

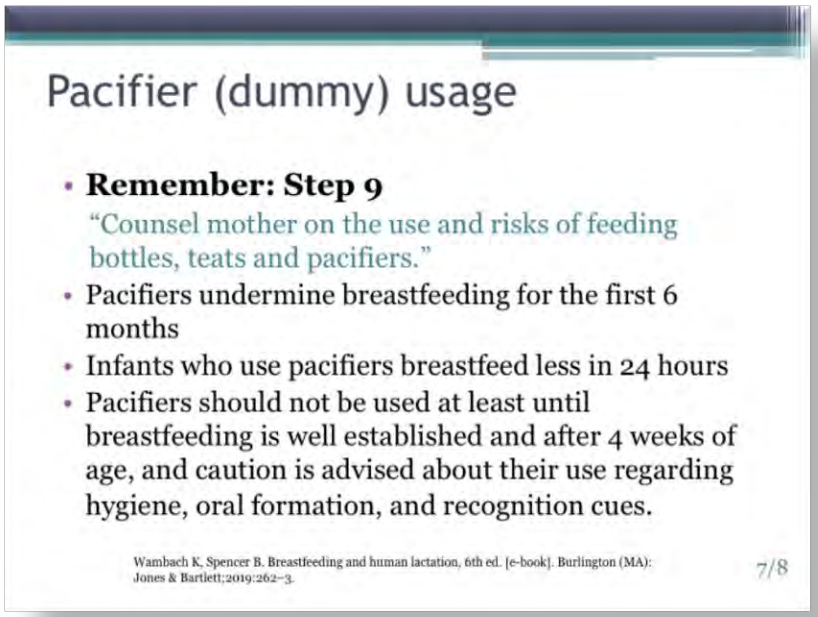


Feeding cues: early signs a baby is ready to feed include:

- opening the mouth and turning the head trying to find the breast ("rooting" or "searching")
- being wakeful and restless
- making small noises
- making hand-to-mouth movements and sucking movements
- sucking fingers.

Late sign

If a mother has not responded to earlier signs, her baby is likely to start crying – this is a late cue, and she will have to respond to it. As a new mother/parent/caregiver is learning a new skill, breastfeeding, this could increase the stress in the process. Therefore, it is important to teach them to recognize a baby's feeding cues.



Pacifiers

Sometimes families use pacifiers to soothe their babies. Pacifiers may interfere with the mother's ability to recognize feeding cues. Feeding may be delayed until the baby is crying and agitated. If a hungry baby is given a pacifier instead of a feed, the baby suckles less, takes less milk and may not gain weight as well. If a baby is given a pacifier instead of a feed, this will also reduce suckling time at the breast. The result is interference with establishing the breast milk supply.

NOTE: Pacifiers can carry bacteria if not cleaned regularly, and lead to increased ear infections and dental problems.

A baby's temperament

Every baby has a different personality. Some babies are very calm and wait to be fed. They may go back to sleep themselves without any help. Other babies wake quickly and become very annoyed if not fed immediately. Help the mother to recognize her baby's temperament and learn how to best meet her baby's needs.

Common postnatal questions

1. How long should I let my baby suckle at the breast?

- Let a baby suckle as long as they want, provided they are well-attached to the breast.
- Mothers should not be advised to feed a baby for any set length of time. This includes setting a time limit for each breast. Encourage them to "watch the baby" and not to "watch the clock."
- 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 (refer to SESSION 5: HOW BREASTFEEDING WORKS for signs of attachment).
- Usually, when a baby has had the breast milk they want, they release the breast. A mother should let the baby continue until they release the breast. They should not take them off before they are ready.
- If a baby is taken off the breast too soon, they may not get a complete meal with the fat rich hind milk[13]. So, they will be less satisfied and may get hungry again sooner.
- Once a baby has finished feeding on one breast, a mother can offer her second breast. Sometimes a baby may only feed from one breast per feeding, especially when the milk supply is high in the early weeks.
- It is not necessary to feed from both breasts at each feed. If a baby does not want the second breast, their mother can offer that side first next time. This way, both breasts get the same amount of stimulation.

2. How often should I feed my baby?

- Babies vary in the number of feeds they want, which may be anything from six to 12 times a day. The time between feeds also varies from less than one hour to several hours.
- In the first few weeks, let babies feed as often as they want. Mothers do not have to follow a feeding schedule, wait for a certain length of time, or follow the clock to decide when it is time for the next feed.
- Newborns typically want to breastfeed again after about one hour sometimes, or after three to four hours at other times in the first two to seven days. It may be less often in the first day, and more often in the second to third day.
- Once the milk supply increases, changes or "comes in", eight to 12 breastfeeds in 24 hours is common.

3. What if my baby is too sleepy to feed?

- Sometimes a baby is very sleepy, due to prematurity or the effects of labour medication. The mother may need to lead the feeding for a day or two and wake her baby for feeds. If a baby seems too sleepy to feed, suggest the mother:
  - removes blankets, heavy clothing or hat to wake and cool the baby;
  - gently massages her baby's body and talks to her baby;

[13] Hindmilk/foremilk is discussed in Session 4: why breastfeeding is important.

- waits half an hour and tries again;
- expresses a little breastmilk directly into the baby's mouth or offers it with a spoon or cup.
- NOTE: avoid hurting the baby by flicking or tapping on the cheek or feet.

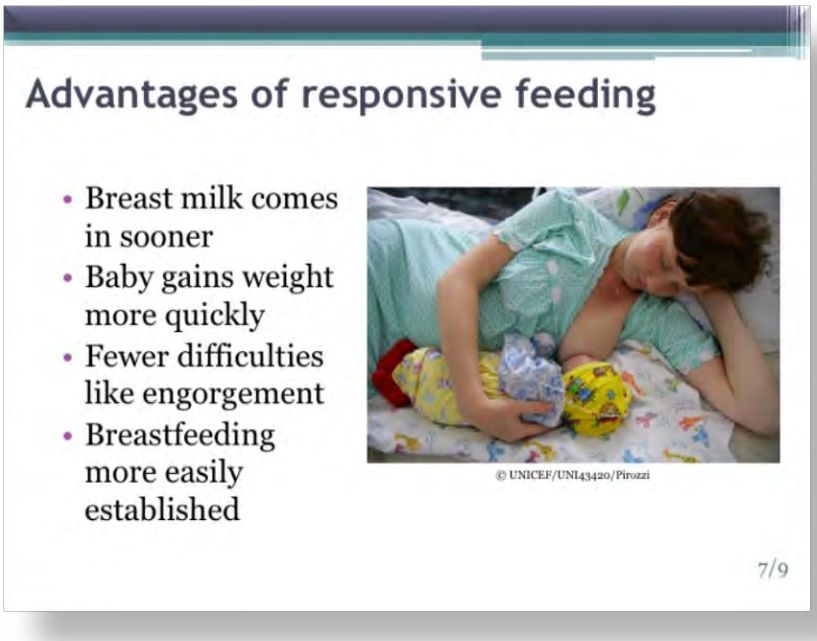
4. What if my baby is ill, premature or has a low-birth-weight?

Low-birth-weight or sick

- A low-birth-weight or sick baby will probably take very long feeds. They may pause frequently to rest and regain strength.
- It is important to plan for a calm, quiet, unhurried and long time for feeding (sometimes an hour or more).
- If the baby seems too sleepy or fussy, the mother can stop the feed. She can continue to hold her baby against her breast without trying to initiate suckling. Using skin-to-skin in this situation will support the process of bonding and feeding.
- The baby may not get as much milk as they need. Give additional expressed milk by cup if their weight gain is too slow[14].

5. What are the advantages of responsive feeding?

- the breast milk "comes in," increases or changes sooner.
- the baby gains weight more quickly.
- there are fewer difficulties, like engorgement.
- breastfeeding is more easily established.



6. What is the best way to feed my baby?

- The optimal pattern of breastfeeding is unrestricted and responding to a baby's needs.

[14] See Session 13: CHALLENGES TO FEEDING AT THE BREAST AND Alternative methods of feeding, for information on breast milk expression and cup feeding.

This includes:

- responding to signs a baby wants to feed (feeding cues);
- letting a baby continue to feed on each breast as long as they want;
- let them come off the breast by themselves, not taking them off before they have finished;
- offering the second breast if the baby wants it – however, let them decide whether they want one or two breasts at a feed.
- **Allowing a baby to feed as often and early as they want**.

Notes

Session 8. Classroom clinical practice – assessing a breastfeed

Objectives

After completing this session, participants will be able to:

- recognize the 4 KEY POINTS OF ATTACHMENT
- assess a breastfeed by observing a mother and baby
- identify a mother/parent/caregiver who may need assistance
- explain the contents and arrangement of the JOB AID: BREASTFEEDING SESSION OBSERVATION
- recognize signs of good and poor attachment, and positioning.

Introduction

Assessing a breastfeed can:

- help you to decide whether a mother needs assistance, and how to help her
- help you to identify and praise what the mother and baby are doing well together
- give you information about current difficulties with breastfeeding
- highlight practices which may result in problems later if not changed.

Assessing a breastfeed includes:

- observing what the mother and baby are doing
- listening to what the mother tells you.

NOTE: The mother will be more at ease if you explain you would like to watch the baby feeding. She may feel nervous if you tell her you are watching what she is doing.

Job aid: Breastfeeding session observation

This checklist will help you remember what to observe when you assess a breastfeed. The form is arranged in six sections: GENERAL, BREASTS, BABY'S POSITION, BABY'S ATTACHMENT, SUCKLING.

NOTE: The left-hand column shows breastfeeding is going well. The right-hand column indicates a possible difficulty. You will make a check mark in the box based on your observations.

If you do not observe on either column, you should make no mark.

After completing the form, view the check marks on the left-hand side of the form. If a majority are in this column, breastfeeding is most likely going well.

If there are some check marks in the right-hand column, then breastfeeding may not be going well. This mother may have challenges and will need your help.

JOB AID: BREASTFEEDING SESSION OBSERVATION

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, comfortable, back supported	☐ 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	☐ Breast held with fingers on areola
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 mouth above	☐ Baby approaches breast, lower lip/chin nipple to nipple
BABY'S ATTACHMENT	
☐ More areola seen above baby's top lip	☐ More areola seen below bottom lip
☐ Baby's mouth wide open	☐ Baby's mouth not open wide
☐ Lower lip turned outwards	☐ Lower 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

SECTION: MOTHER'S GENERAL APPEARANCE

Observe the mother's general appearance
What do you observe about the mother? Does she look healthy, ill or depressed?

Does the mother look relaxed or comfortable?
When a mother holds her baby securely and with confidence, her baby can suckle effectively. This will help her milk flow more easily. If she is sitting, it is important for her back to be supported.

Does the mother look nervous or without confidence?
When a mother is nervous and lacks confidence, she may show this by shaking or prodding the baby to encourage feeding. This can upset the baby and interfere with suckling and the flow of breast milk.

Do you see signs of bonding between mother and baby?
Are there signs of bonding: Eye contact, smiling, held securely with confidence?

Observing how a mother interacts with her baby while feeding is important. **Remember if a mother feels good about breastfeeding, this will help her milk to flow[15].**

SECTION: BABY'S GENERAL APPEARANCE

Observe the baby's general appearance, health, nutrition and alertness. What do you notice about the baby?

Possible descriptions: Alert, sleepy, calm, relaxed, restless, and crying.

How does the baby respond? Does the baby reach or root for the breast if hungry?

Observe any physical conditions that could affect feeding such as a blocked nose or cleft palate.

SECTION: BREASTS

As the mother prepares to feed her baby, what do you observe about her breasts?

How do her breasts and nipples appear? Possible descriptions: Healthy, red, swollen or sore?

NOTE: We will talk about breast and nipple conditions in more details in a later session.

Does she say she has pain or act as if she is afraid to feed the baby?

How does she hold her breast for feeding? Is her breast well supported with her fingers away from the nipple? Is she holding on to the areola with her fingers?

[15] Signs of the oxytocin reflex are discussed in Session 5: How breastfeeding works.

Section: Baby's position

Look at the position of the baby for breastfeeding

Note: We will learn more about the baby's position at the breast in the next session.

(1) Observe how the mother holds her baby. Notice whether the **baby's head and body (spine) are in line** and if the head and neck twisted.

(2) Observe whether she holds the **baby close to the breast**.

(3) Observe whether the mother **supports the baby's whole body** or whether only the baby's head and neck are supported.

(4) Observe whether the baby is **approaching the breast from below, with nose to nipple** or whether they approach it with the nipple going straight into the middle of the mouth.

Section: Baby's attachment

Observe the four key points of correct attachment. (Review from Session 5: How breastfeeding works.

Four key points:

(1) Is there **more areola above the baby's top lip than below?**

(2) Is the baby's **mouth open wide**?

(3) Is the **lower lip turned outwards**?

(4) Does the baby's **chin touch breast**?

Section: suckling

Signs of **effective** suckling:

- the baby takes slow deep sucks
- then they pause and wait for the ducts to fill up again
- then they take a few quick sucks to start the milk flow
- as the milk flows, the sucks become deeper and slower again
- you may see or hear swallowing
- the baby's cheeks are round.

Signs of effective suckling show the baby is getting sufficient breast milk.

Signs of **ineffective** suckling:

- the baby taking rapid, shallow sucks all the time
- the baby may make smacking sounds as they suck
- the baby's cheeks may be tense or pulled in as they suck.

Signs of ineffective suckling show the baby is not getting enough breast milk.

It is also important to notice how the breastfeed ends.

What might you observe at the end of a breastfeed?

- The baby usually releases the breast themselves and looks satisfied or sleepy. These are signs that the baby has taken enough milk from that breast. The baby may or may not want to suckle from the other side too
- A baby who is not well attached and not getting milk may stop breastfeeding and cry in frustration.

A mother sometimes takes her baby off her breast as soon as they pause because she may think her baby has finished. She may also want to make sure the baby suckles from the other side. A baby who is taken off the breast before they have finished may not get a full meal of foremilk/hindmilk. So, the baby may want to feed again soon.

Breastfeeding sessions can vary in length, from a few minutes to half an hour. If breastfeeds are long (more than about 40 minutes) or very short (less than about 4 minutes), it may mean there are some challenges. Make sure to observe the baby's attachment.

NOTE: In the first few days or with a low-birth-weight baby, breastfeeding sessions may be very long with many pauses. Make sure you complete a full assessment to evaluate where the baby's behaviour.

Ask the mother if she feels any signs of the oxytocin reflex

For example, milk leaking from her breasts or a tingling sensation.

Ask the mother how breastfeeding feels to her

- If it is comfortable and pleasant, her baby is probably well-attached.
- If it is uncomfortable or painful, the baby is probably not well-attached.
- If a mother says breastfeeding is going well, but you see signs indicating a possible difficulty, you must decide what to do.
- In the days soon after delivery while the mother is still learning, you may want to offer support and assistance. Even if she is not aware of any difficulty now, your assistance may prevent challenges later on.

Let's practise: Assessing a breastfeed

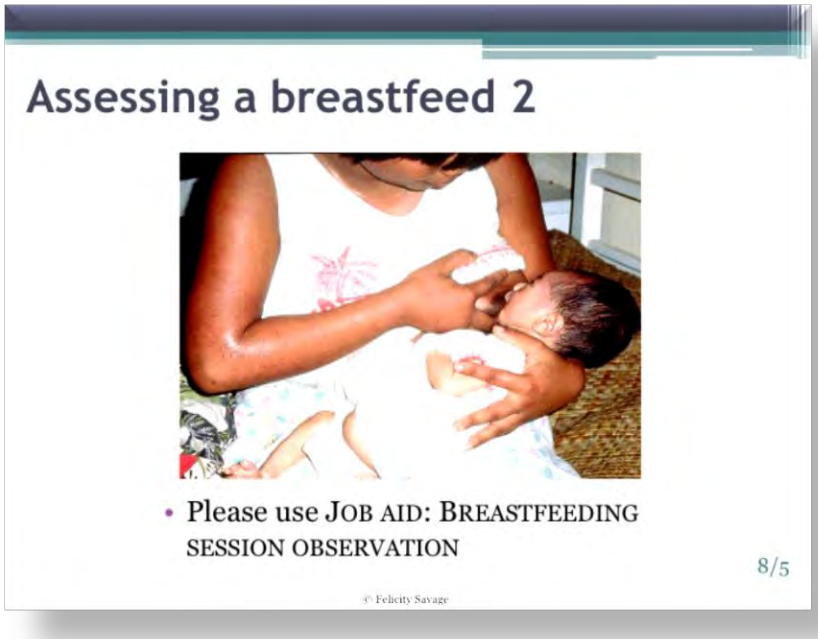
Please complete this activity with your trainer. There are three slides to practise assessing a breastfeed. Using the JOB AID: BREASTFEEDING SESSION OBSERVATION form, assess the mother and her baby breastfeeding. Make notes on each section of the form.

NOTE: You may not 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.

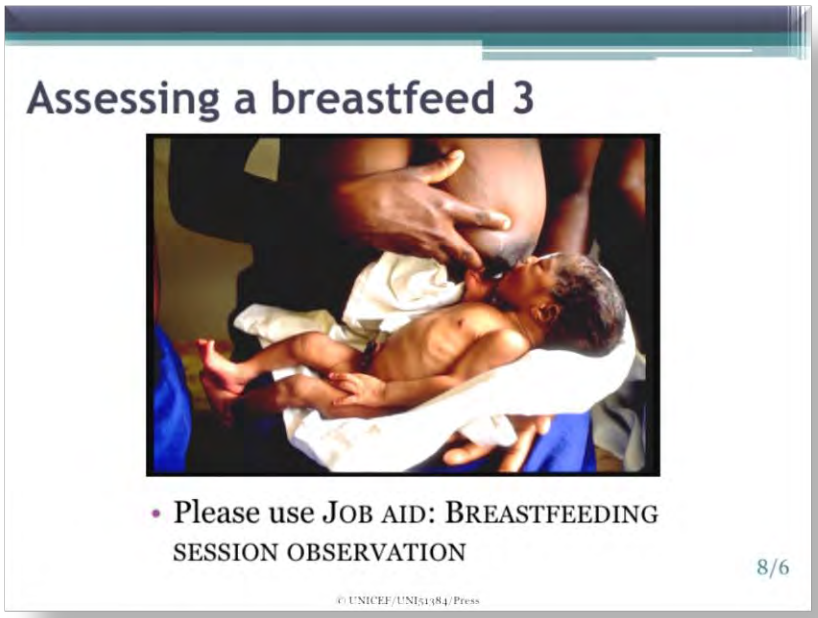
Assess a breastfeed (practice)

Assess a breastfeed 1

Assess a breastfeed 2



Assess a breastfeed 3



JOB AID: BREASTFEEDING SESSION OBSERVATION (PRACTISE)

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, comfortable, back supported	☐ 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	☐ Breast held with fingers on areola
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 mouth above	☐ Baby approaches breast, lower lip/chin nipple to nipple
BABY'S ATTACHMENT	
☐ More areola seen above baby's top lip	☐ More areola seen below bottom lip
☐ Baby's mouth wide open	☐ Baby's mouth not open wide
☐ Lower lip turned outwards	☐ Lower 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

JOB AID: BREASTFEEDING SESSION OBSERVATION 1

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	☐ Breast held with fingers on areola
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 to nipple	☐ Baby approaches breast, lower lip/chin
BABY'S ATTACHMENT	
☐ More areola seen above baby's top lip	☐ More areola seen below bottom lip
☐ Baby's mouth wide open	☐ 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

JOB AID: BREASTFEEDING SESSION OBSERVATION 2

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	☐ Breast held with fingers on areola
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 to nipple	☐ Baby approaches breast, lower lip/chin
BABY'S ATTACHMENT	
☐ More areola seen above baby's top lip	☐ More areola seen below bottom lip
☐ Baby's mouth wide open	☐ 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

JOB AID: BREASTFEEDING SESSION OBSERVATION 3

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	☐ Breast held with fingers on areola
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 to nipple	☐ Baby approaches breast, lower lip/chin
BABY'S ATTACHMENT	
☐ More areola seen above baby's top lip	☐ More areola seen below bottom lip
☐ Baby's mouth wide open	☐ 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

Session 9. Classroom clinical practice: Positioning a baby at the breast

Objectives

After completing this session, participants will be able to:

- explain the FOUR KEY POINTS OF POSITIONING of the baby;
- describe how a mother should support her breast for feeding;
- demonstrate the main breastfeeding positions for the mother: sitting, lying, underarm and across;
- demonstrate how to breastfeed in special cases: after caesarean section, low- birth-weight baby;
- help a mother position her baby at the breast, using the FOUR KEY POINTS OF POSITIONING of the baby.

Introduction

In this session, we will learn how to support mothers with breastfeeding by helping to position a baby at the breast.

Let the mother do as much as possible herself. Be careful not to "take over" for her. Always explain what you want her to do. If possible, demonstrate on your own body to show her what you mean. Use a doll to show her how to hold the baby. Make sure she understands what you do so that she can do it herself. **Your aim is to help her to position her own baby. It does not help if you can get a baby to suckle if the mother cannot.**

If a baby is well-attached and suckling effectively, do not interfere with the way they are breastfeeding. Tell the mother what key points you are observing to help build her confidence and her own ability to assess how breastfeeding is going.

How to help a mother position her baby

There are several steps to follow when helping a mother position her baby at the breast.

HOW TO HELP A MOTHER POSITION HER BABY

- Greet the mother and ask how breastfeeding is going.
- Assess a breastfeed.
- Explain what might help and ask whether she would like you to show her.
- Make sure that she is comfortable and relaxed.
- Sit down yourself in a comfortable, convenient position.
- Explain how to hold her baby and show her, if necessary, with a doll.
- The four key points:
  - baby's head and body in line
  - baby held close to mother's body
  - baby's whole body supported
  - baby approaches breast, nose to nipple.
- Show her how to support her breast only if needed:
  - 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 especially the upper lip
  - wait until her baby's mouth is opening wide
  - move her baby quickly onto her breast, aiming the lower lip below the nipple.
- Notice how she responds and ask her how her baby's suckling feels.
- Look for signs of good attachment. If the attachment is not good, try again.

FOUR KEY POINTS of positioning a baby

1. Baby's head and body in line

The baby's head and body are in a straight line (ear, shoulder and hip in a straight line). A baby cannot suckle or swallow easily if their head is twisted or bent.

2. Baby held close to mother's body

A baby cannot attach well to the breast if they are far away. The baby's whole body should almost face their mother's body. The baby should be turned away just enough to be able to look at her face. This is the best position for the baby to take the breast because most nipples point down slightly. If the baby faces the mother completely, they may fall off the breast.

3. Baby's whole body supported

The whole body should be supported, with the mother's arm along the baby's back. This is particularly important for neonates and young babies.

4. Baby approaches breast, nose to nipple.

The baby should approach the nipple with his nose, and can lick, search, and peck for the nipple. Aligning the baby's nose to the mother's nipple allows for a deeper asymmetrical latch.

How to help a mother who is sitting

Greet the mother and introduce yourself. 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.

Assess a breastfeed session

Ask whether you may see how (baby's name) breastfeeds and ask her to put him to her breast in the usual way. (If the baby has had a feed recently, you may have to arrange to come back later.) Observe the breastfeeding session.

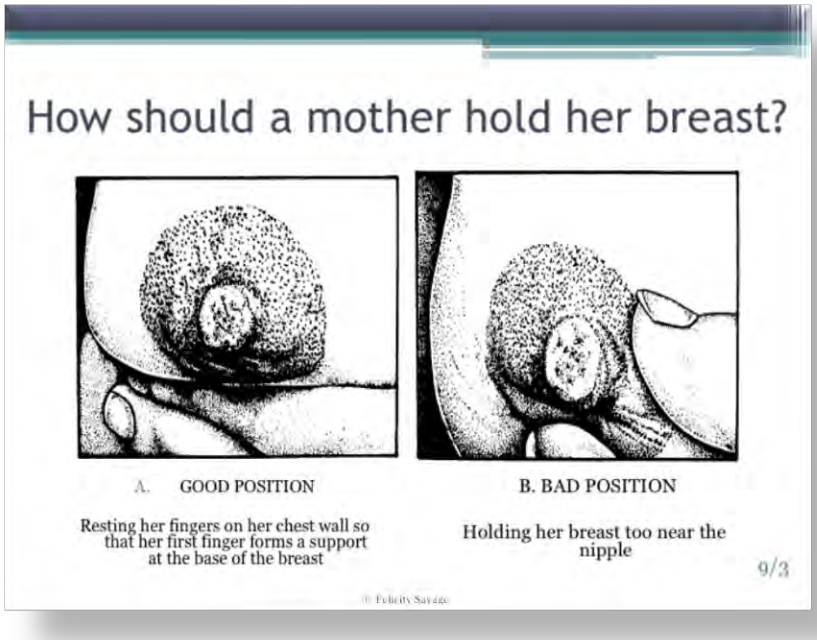
If you decide the mother needs help to improve her baby's attachment, you can begin with encouragement like: "He really wants your breast milk, doesn't he?"

Then explain what might help and ask whether she would like you to show her. For example, say something like: "Breastfeeding might be more comfortable for you if (baby's name) took a larger mouthful of breast when he suckles. Would you like me to show you how?" If she agrees, you can start to help her.

Make sure she is sitting in a comfortable, relaxed position. Sit down yourself, so you also are comfortable and in a convenient position to help.

Explain to the mother how to hold her baby. Show her what to do, if necessary.
Make these four key points about positioning a baby clear:

1. baby's head and body in line
2. baby held close to mother's body
3. baby's whole body supported
4. baby approaches breast, nose to nipple.



If needed, show the mother how to support her breast with her hand to offer it to her baby.

- She should place her fingers flat on her chest wall under her breast, so her first finger forms a support at the base of the breast.
- She can use her thumb to press the top of her breast slightly. This can improve the shape of the breast, so it is easier for her baby to attach well.
- She should not hold her breast too near to the nipple.

- The mother should not lean forward and try to push the nipple into the baby's mouth. She should bring the baby to the breast, supporting her whole breast with her hand.

Some ways of holding the breast may make it difficult for the baby to attach. These include:

- with the fingers and thumb close to the areola or nipple;
- pinching up the nipple or areola between your thumb and fingers and trying to push the nipple into a baby's mouth;
- holding the breast in the "scissor" hold – index finger above and middle finger below the nipple. This can make it more difficult for a baby to take enough breast into their mouth. It can also block milk flow.

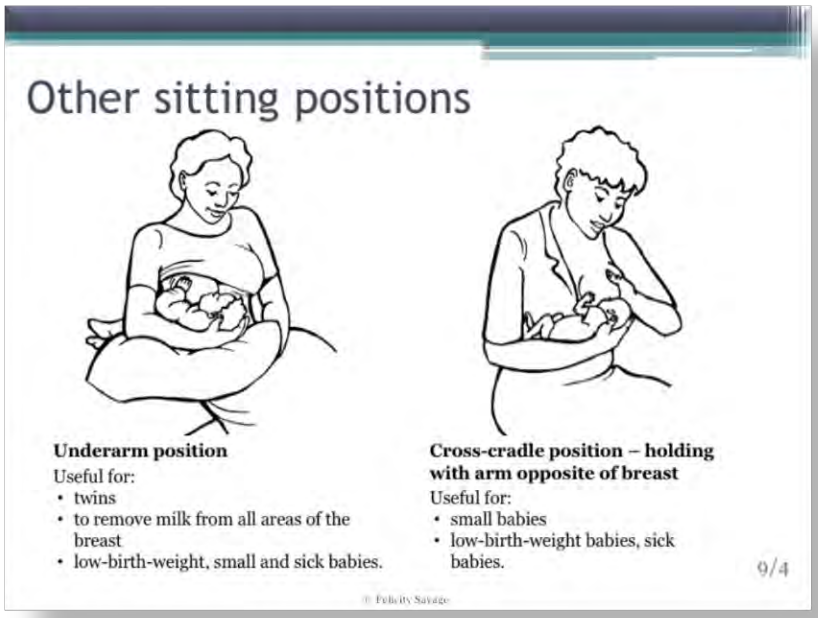
Explain or show her how to help the baby to attach.

- Explain that she should first hold the baby with his nose opposite her nipple, so that the baby approaches the breast from underneath the nipple.
- As she brings her baby to her breast, she should aim the baby's lower lip well below her nipple. This is so that the nipple aims towards the baby's palate, the tongue goes under the areola, and the baby's chin will touch the mother's breast.
- Explain how she should touch her baby's lips with her nipple, so that the baby opens their mouth, puts out their tongue, and reaches up.
- Explain she should wait until her baby's mouth is opening wide, before she moves them onto her breast. The baby's mouth needs to be wide open to take a large mouthful of breast ("big mouth").
- Explain or show her how to move her baby quickly to her breast when they open their mouth wide.
- She should keep her back straight and bring her baby to her breast. She should not move herself or her breast to her baby.
- Hold the baby at the back of his shoulders, not the back of his head. Be careful not to push the baby's head forward. Pushing the back of the baby's head will cause a reflex reaction, the baby will fight back and pull away from the breast, and this may lead to difficulty in feeding at the breast.

Notice how the mother responds. Does she seem to have pain? Does she say, "Oh that feels better!" If she says nothing, ask her how her baby's suckling feels. Look for all the signs of good attachment. If the attachment is not good, try again together.

Other sitting positions

Note: Mothers breastfeed in many different positions. What are common positions practiced in your context?



This slide shows two useful positions you may want to show mothers. These are:

- underarm
- cross-cradle: holding the baby with the arm opposite the breast.

These positions can be useful for any baby, especially one who is having difficulty attaching. However, they may be especially useful for the following:

- the underarm position is useful for twins or to drain all areas of the breast, such as with a blocked duct;
- both positions shown are the best ways for a mother to hold her very small, sick or low-birth-weight baby.

In both of these positions, the mother supports her baby's body on her arm and supports and controls the baby's head with her hand and the back of his neck. Low-birth-weight and sick babies need more support for the head than larger babies. However, the mother should be careful only to support the head and not to put pressure on it or push it forward.

How to help a mother who is lying down

Help the mother to lie down in a comfortable, relaxed position. It is better if she is not "propped up" on her elbow, as this can make it difficult for the baby to attach to the breast. If she has pillows, a pillow under her head and another under her chest may help.

Show her how to hold her baby. Exactly the same four key points are important, as for a mother who is sitting. She can support her baby with her lower arm. She can support her breast if necessary, with her upper arm. If she does not support her breast, she can hold her baby with her upper arm.

A common reason for difficulty attaching when lying down, is that the baby is too "high" near the mother's shoulders. In this way, their head has to bend forward to reach the breast.

This position can be useful when:

- when a mother is tired or wants to sleep, so that she can breastfeed without getting up;
- if a mother has pain after delivery or a caesarean section and lying on her side may help her to breastfeed more comfortably.

For a reclining position

Help the mother into a reclining position, leaning back support, if necessary, with pillows.
She needs to lean back far enough for the baby to be fully supported on her reclining body, but she should not be completely flat. The baby can be naked and lie prone on her naked chest, for skin-to-skin contact.

This is very useful if a baby has difficulty attaching at the breast, or is restless and crying. This position often calms the baby, and he may find his own way to the breast, in the same way as a newborn baby.

There are many other positions in which a mother can breastfeed. In any position, it is for the baby to take enough of the breast into their mouth so they can suckle effectively.

There are also some ways in which a mother holds a baby which can make it difficult to attach to her breast and suckle effectively. These include:

- too high (for example, sitting with your knees very high);
- too low (for example, with the baby unsupported, so you have to lean forward);
- too far to the side (with his head in the `crook' of the arm).

If a mother holds her baby too high, too low, or too far to the side, his mouth is not opposite her nipple. It will be difficult for him to take the breast into his mouth.

When a mother supports her baby's body, she should not grip their bottom, because this pulls his head too far out to the side. She should have her hand along his back, so that his head rests on her forearm, not in the crook of the arm.

Notes

Session 10. Clinical practice session 1: Listening and learning and assessing a breastfeed

Objectives

After completing this session, participants will be able to:

- demonstrate appropriate listening and learning skills when counselling a mother on feeding her infant
- assess a breastfeed using the JOB AID: BREASTFEEDING SESSION OBSERVATION
- discuss a mother's experience initiating breastfeeding after birth.

Introduction

The following notes are instructions about how to do the practical session. Please read them before the practical session, to remind you what to do during the session.

During the practical session

1) You will work in small groups.
2) Each person will take turns to talking to the mother.
3) The other members of the group will observe.

You will need

- Two copies: JOB AID: BREASTFEEDING SESSION OBSERVATION.
- One copy: SKILLS CHECKLIST: LISTENING AND LEARNING.
- Pencil and paper.

Please leave your books or manuals in the classroom.

Preparation

We will spend time today preparing for the clinical practice in the maternity wards. Remember the goal is for each health worker to practise with a mother/parent/caregiver and their baby. Each clinical practice session will have different goals. So, please be attentive during the preparation time and allow your trainer to assist you.

Counsellor

1) Introduce yourself to the mother and ask permission to talk to her.
2) Introduce the group and explain that you are interested in infant feeding.
3) Ask the mother if you may observe how her baby is feeding.
4) Try to find a chair or stool to sit on. If necessary and if allowed in the facility, sit on the bed.

If the baby is feeding

1) Ask the mother to continue as she is doing.
2) Ask the mother's permission for the group to watch the feed.
3) Remember: before making any suggestions, observe the breastfeeding session.

If the baby is not feeding

1) Ask the mother to give a feed in her usual way when the baby seems ready
2) If the baby is not feeding, you can ask the mother open-ended questions about her experience.

Examples of open-ended questions

1) How is she? How is the baby?
2) How is feeding going?
3) What is going well?
4) What challenges is she facing?

Please practise listening and learning skills, asking open-ended questions and providing positive encouragement.

Observer

1) Stand quietly in the background.
2) Try to be as quiet as possible.
3) Do not comment, or talk among yourselves.

Please make general observations of the mother and baby.

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. For example: Who does most of the talking? Does the mother talk freely, and seem to enjoy it?

Make specific observations of the participant's listening and learning skills, including their non-verbal communication. Mark a ✓ on your **SKILLS CHECKLIST: LISTENING AND LEARNING** when they use a skill, to help you to remember for the discussion. Observe whether they make a mistake. For example if they use a judging word, or if they ask a lot of questions to which the mother says "yes" and "no".

Stay quietly watching the mother and baby as the feed continues. While you observe, fill in a **JOB AID: BREASTFEEDING SESSION OBSERVATION**. Write the name of the mother and baby and mark a ✓ beside each sign that you observe. Note the time that the feed takes.

Thank the mother for her time and say something to praise and support her.

COMMON MISTAKES

1) Do not say you are interested in breastfeeding
The mother's behaviour may change. She may feel judged and not feel free to talk about formula feeding. You should say you are interested in "infant feeding" or in "how babies feed".

2) Do not give a mother help or advice
In Practical session 1 when a mother needs help, you should inform your trainer and a member of staff from the ward or clinic.

3) Do not allow the forms (JOB AID) to become a barrier
The participant who has the counsellor's role should not make notes while talking. They may refer to the forms to remind themselves what to do, but they should only write afterwards. The participants who are observing can make notes.

4) Do not ask a mother if you may observe *how the mother is breastfeeding*.
The statement may make the mother feel evaluated or judged. Instead, you can ask if you can observe *how her baby is feeding*.

.

JOB AID: BREASTFEEDING SESSION OBSERVATION

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	☐ Breast held with fingers on areola
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 to nipple	☐ Baby approaches breast, lower lip/chin
BABY'S ATTACHMENT	
☐ More areola seen above baby's top lip	☐ More areola seen below bottom lip
☐ Baby's mouth wide open	☐ 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

SKILLS CHECKLIST: LISTENING AND LEARNING

Name of counsellor: _____

Name of observer: _____

Date of visit: _____

(√ for Yes and × for No)

Counsellor:

Listening and learning skills

- ❑ Keep the head level with mother/parent/caregiver
- ❑ Pay attention (eye contact)
- ❑ Remove barriers (tables and notes)
- ❑ Take time? Allow the mother/parent/caregiver time to talk
- ❑ Use appropriate touch
- ❑ Ask open questions
- ❑ Use responses and gestures showing interest
- ❑ Reflect back what the mother/parent/caregiver said
- ❑ Empathize – showing he or she understood how the mother/parent/caregiver feels
- ❑ Avoid using judging words

COUNSELLING SKILLS

Listening and learning skills

- Use helpful non-verbal communication
- Ask open questions
- Use responses and gestures showing interest
- Reflect back what the mother/parent/caregiver says
- Empathize – show you understand how the mother/parent/caregiver feels
- Avoid using judging words

Building confidence and giving support skills

- Accept what a mother/parent/caregiver thinks and feels
- Recognize and praise what a mother/parent/caregiver and baby are doing well
- Give practical help
- Give specific, relevant information
- Use simple language
- Make one or two suggestions, not commands

Notes

Session 11. Breast and nipple conditions

Objectives

After completing this session, participants will be able to recognize and describe how to manage these common breast and nipple conditions:

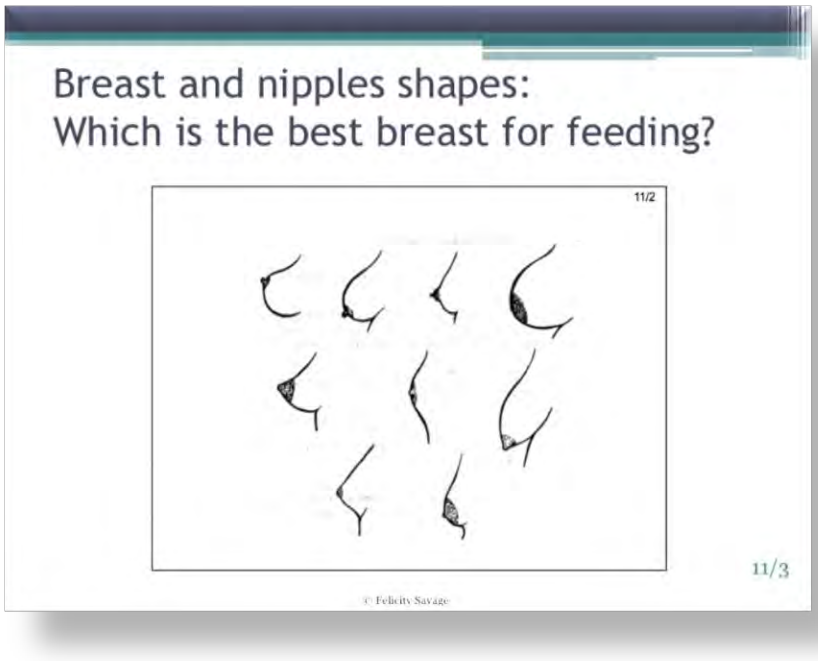
- flat or inverted nipples
- engorgement
- mastitis
- sore or cracked nipples.

Also, participants will identify when to refer to advanced medical providers for further treatment.

Introduction

As health-care workers, we must recognize breast conditions and help mothers/parents/ caregivers manage them. If a mother/parent/caregiver does not find healing and relief, breastfeeding could stop. Therefore, with right knowledge and practice you can help the treatment plan move forward.

Nipple size and shape



Breasts and nipples come in different sizes and shapes.

When a woman shows concern about the size of her breasts, what counselling should you provide?

Breast size differences are due to the amount of fat and not the amount of tissue that produces milk. This is a teaching point to reassure women that they can produce enough milk. A woman may need reassurance she can produce enough

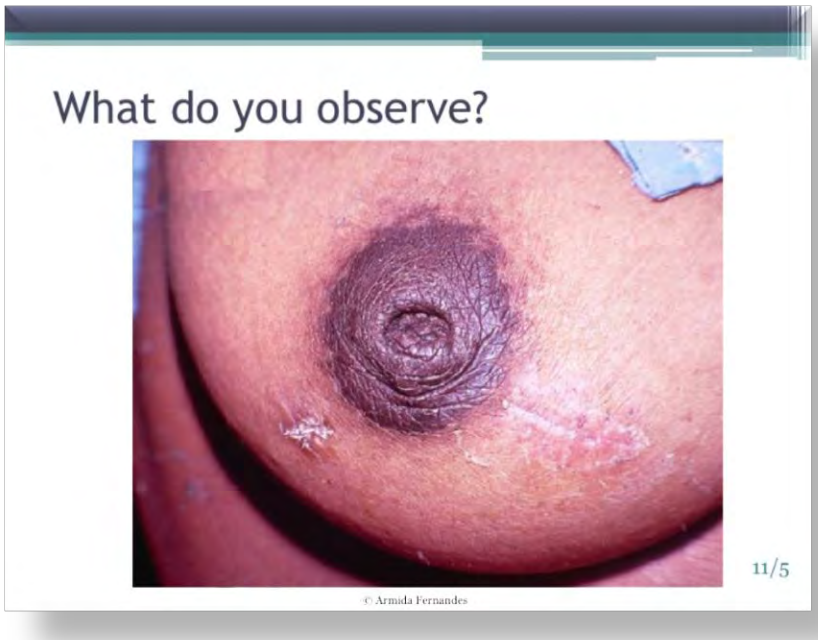
milk, regardless of the size of her breasts. We discussed in Session 5 why breast size does not impact the amount of milk produced. Breast size affects the amount of fat, not the amount of milk ducts to produce breast milk.

Nipples and areolas are different shapes and sizes too. Nipples can change shape during pregnancy and become more protractile or "stretchy". During pregnancy, there is no need to "diagnose" or treat a nipple that looks flat or inverted.

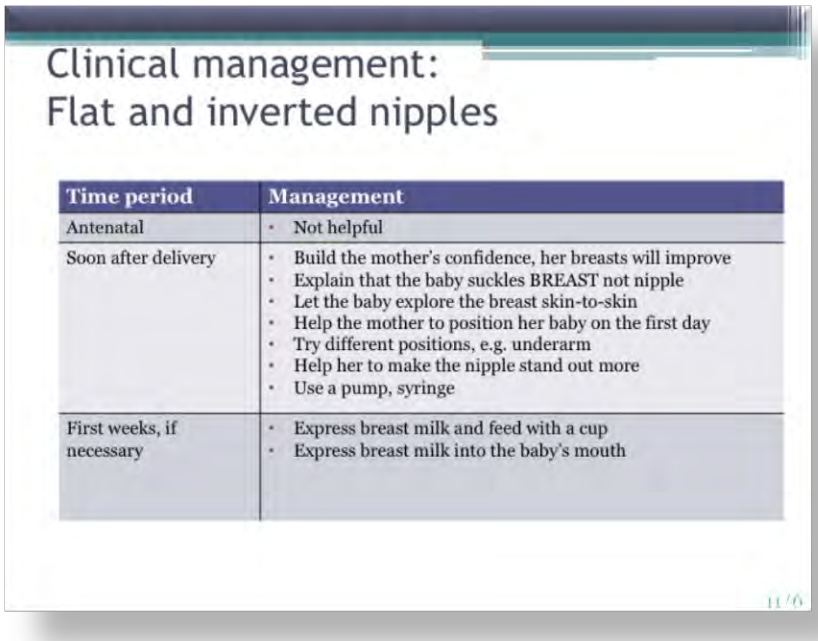
As with breast size, babies can breastfeed from almost any shape of nipple. It is important to reassure women that they can breastfeed, whatever the size or shape of their nipples.

NOTE: Sometimes the size or shape of a nipple makes it difficult for a baby to attach to the breast. The mother may need extra postnatal support to make sure her baby can suckle effectively.

Management of flat and inverted nipples



This slide explains the management of flat or inverted nipples.



1) Antenatal treatment is usually not helpful and can have risks. Most nipples improve around the time of delivery, without any treatment.

2) Help is most important soon after delivery when the baby starts breastfeeding.

3) It is important to build the mother's confidence. Explain the beginning maybe difficult, but she can succeed with patience and persistence.

4) Explain a baby suckles from the breast, not from the nipple. Her baby needs to take a large mouthful of breast ("big mouth"). Explain as her baby breastfeeds, the baby will stretch her breast and nipple out with suction.

5) Encourage skin-to-skin contact and allowing her baby to explore her breasts. Let the baby try to self-attach to the breast, whenever they are interested. Some babies learn best by themselves. Show her how to lean back in the reclining position to give the baby skin-to-skin contact ("laid back breastfeeding"). Some babies can attach more easily in this position.

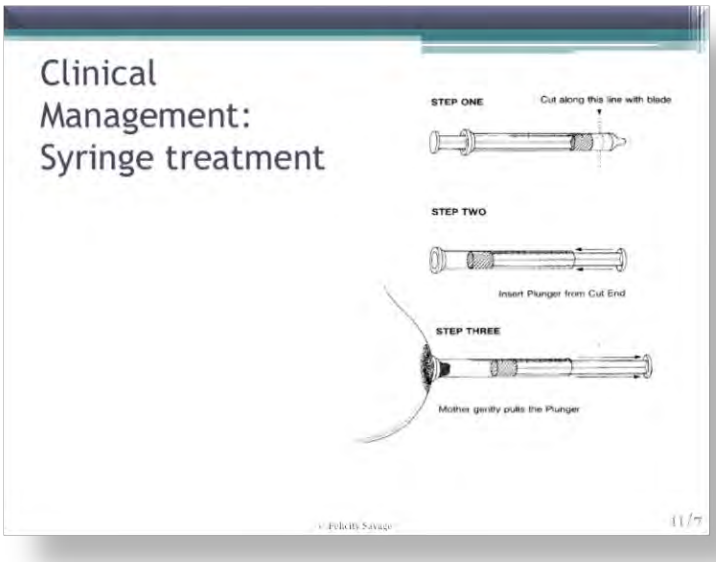
6) Help her to position her baby for a better attachment. If a baby does not self-attach well, help the mother position the baby for better attachment. Give this help early on, in the first day, before her breast milk "comes in" and her breasts are full. Try different positions to help with attachment.

7) Help her to stimulate her nipple before a feed. If she massages her nipple until it hardens, then a baby can usually attach better. There are products to help this (breast pump or syringe), but often her hand is sufficient and costs nothing.

8) Shaping the breast: Shaping the breast can makes it easier for a baby to attach. To shape the breast (*refer to* Slide 3 in SESSION 9. CLASSROOM CLINICAL PRACTICE: POSITIONING A BABY AT THE BREAST), a mother supports it from underneath with her fingers and presses the top of the breast gently with her thumb. She should be careful not to hold her breast too near the nipple. If it is acceptable to both partners, the woman's husband can suck on her nipples a few times to stretch them.

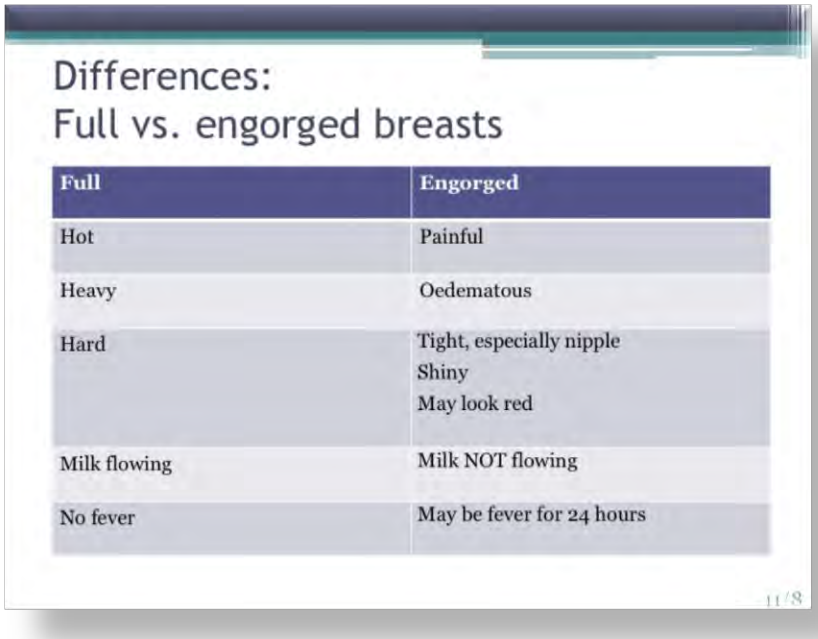
9) Cup feeding: If a baby cannot suckle effectively in the first week, help the mother to try to express her milk and feed it to her baby by cup. Expressing milk also helps to keep the breasts soft, so that the baby attaches more easily. Expressing milk also helps to keep her milk supply sufficient. She should not use a bottle because that makes it more difficult for her baby to take her breast (nipple confusion).

Inverted nipples: Preparing a syringe



SYRINGE METHOD FOR INVERTED NIPPLES

- This method is for treating inverted nipples postnatally and help a baby to attach to the breast. It is not certain whether it is helpful antenatally.
- The mother must use the syringe herself.
- Teach her to:
  - put the smooth end of the syringe over her nipple;
  - gently pull the plunger to maintain steady but gentle pressure;
  - do this for 30 seconds to one minute several times a day;
  - push the plunger back to decrease the suction if she feels pain; this prevents damaging the skin of the nipple and areola;
  - push the plunger back to reduce suction when she removes the syringe from her breast;
  - use the syringe to make her nipple stand out just before she puts her baby to the breast.

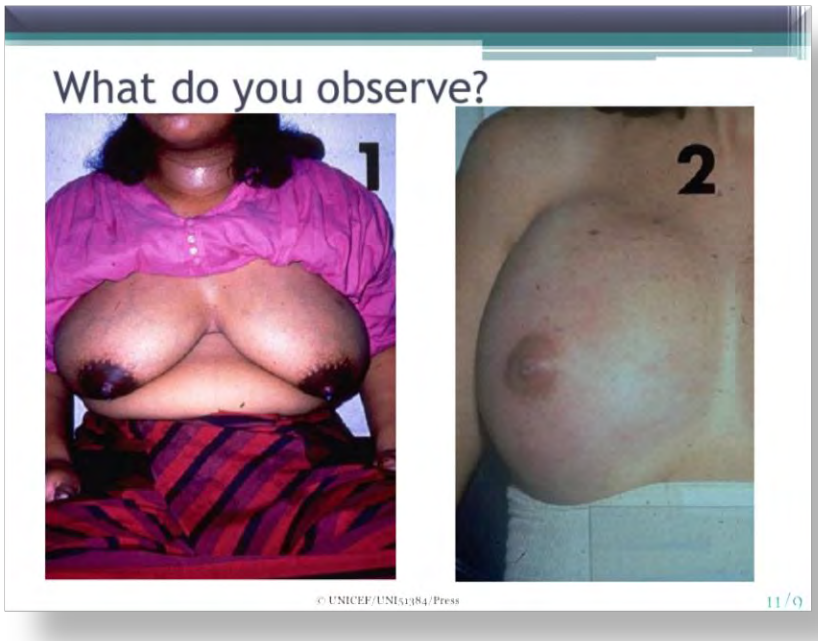


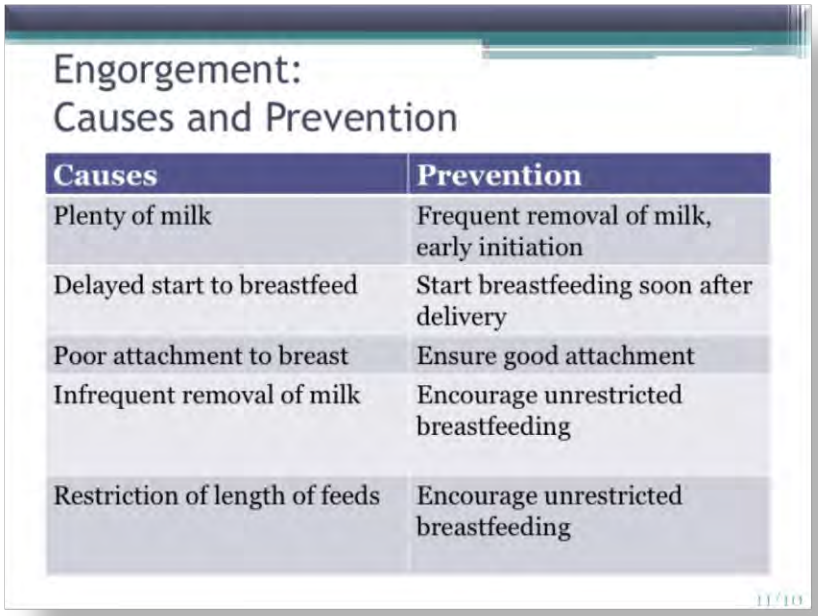
Full versus engorged breasts

The causes of engorgement are:

- production of a lot of milk
- delayed breastfeeding initiation after birth
- poor attachment to the breast and breast milk is not removed effectively
- infrequent removal of milk (not feeding at night or short duration of feeds)
- restricting the length of breast feeds.

Prevention is closely related to the causes of engorgement. A baby should suckle effectively soon after delivery without restrictions on the length or frequency of feeds. Then, the milk pressure is less likely to build up in the breasts. Therefore, engorgement is less likely to occur.





To treat engorgement, it is essential to remove milk. This will:

- relieve the mother's discomfort
- prevent infection such as mastitis or abscess formation
- help to ensure continued milk production
- enable the baby to receive breast milk.

If the baby is able to suckle, they should feed frequently. This is the best way to remove milk. Keep the baby skin-to-skin and let him suckle. This helps the oxytocin reflex. The health-care worker should check the baby's attachment. If the baby is attached well, he can suckle effectively and not damage the nipple. If baby is not well attached, assist the mother to try again.

If breastfeeding alone does not reduce the engorgement, advise the mother to express milk between feeds a few times for comfort. Suggest she gently express milk from her breasts before a feed to soften the areola and make it easier for the baby to attach.

Before feeding or expressing, stimulate the mother's oxytocin reflex. Some things she or a health worker or companion can do to help her include:

- massaging her back and neck (refer to SESSION 13: CHALLENGES TO FEEDING AT THE BREAST AND ALTERNATIVE METHODS OF FEEDING)
- massaging her breast lightly
- stimulating her breast and nipple skin
- helping her to relax and feel comfortable
- putting a warm compress on her breasts – sometimes this will help milk flow from the breasts so that they become soft enough for the baby to suckle.

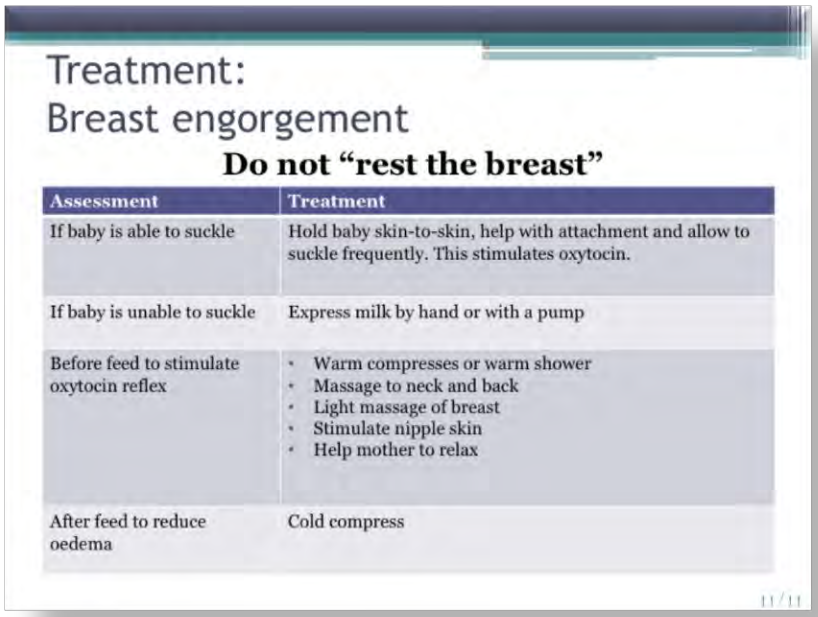
After a feed, putting a cold compress on her breasts will help to reduce oedema and pain.

The reverse pressure softening technique is especially useful for breast oedema. It uses gentle positive pressure to soften an area (~3–4 cm) near the areola surrounding the base of the nipple. Moving the oedema away from the areola can improve the infant's attachment during engorgement[16].

Build the mother's confidence. Explain she will soon be able to breastfeed comfortably again, and the engorgement will

[16] Berens P, Brodribb W. ABM Clinical Protocol #20: engorgement, revised 2016. Breastfeeding Med. 2016;11:159–63.

be resolved.



Mastitis

Mastitis can be confused with engorgement. However, engorgement affects the whole breast and often both breasts. Mastitis affects part of the breast and usually only one breast. A woman with mastitis has severe pain, fever and feels ill. Part of the breast is swollen and hard with redness of the overlying skin. Other parts of the breast skin often look normal.

Blocked duct

Mastitis may develop in an engorged breast. Another cause may be a called **blocked duct.** A blocked duct occurs when the milk is not removed from part of a breast. Sometimes this is because the duct connected to a part of the breast is blocked by thickened milk.

Symptoms include:

- a tender lump
- redness of the skin over the lump
- often, the woman has no fever and feels well.

Milk stasis

When milk stays in part of a breast because of a blocked duct or engorgement, it is called milk stasis.

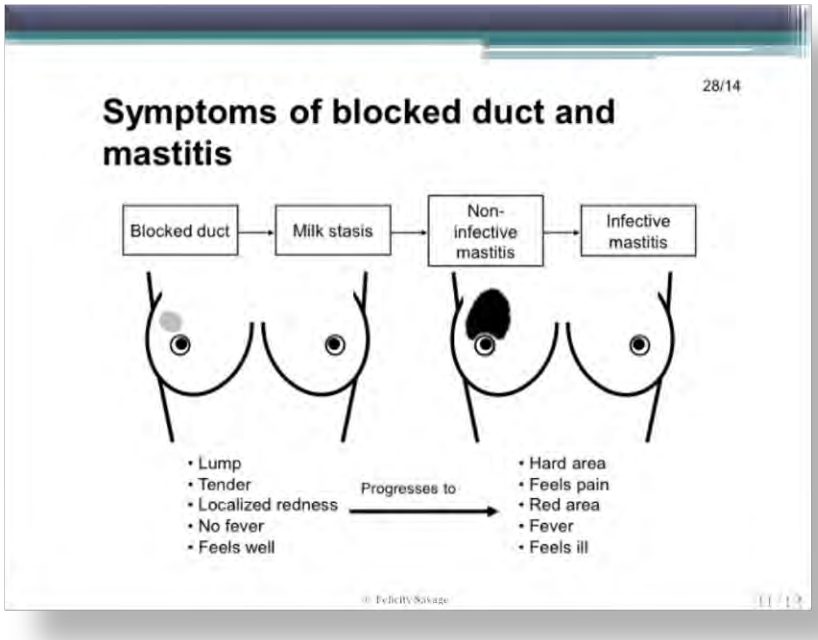
Non-infective mastitis

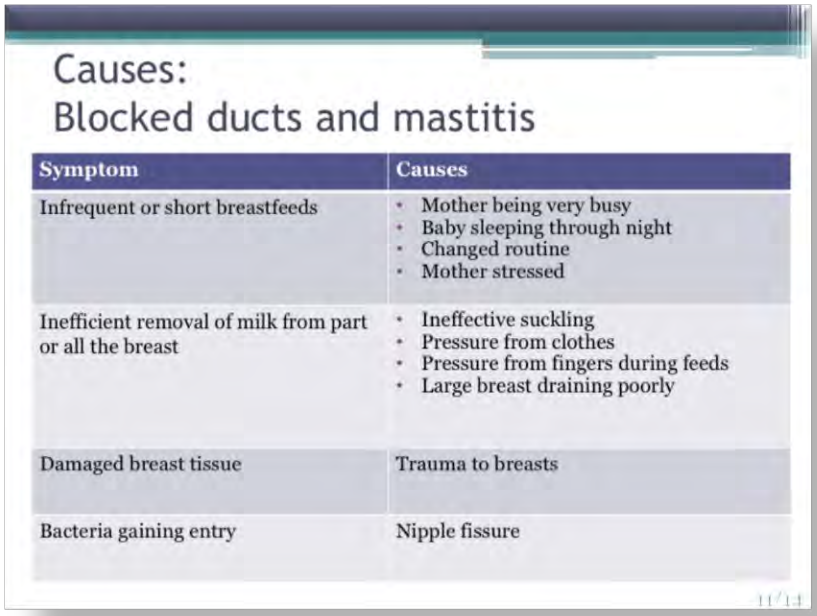
If the milk is not removed, it can cause inflammation of the breast tissue called non-infective mastitis.

Infective mastitis

When a breast becomes infected with bacteria, this is called infective mastitis.

NOTE: A health-care worker cannot tell from the symptoms alone whether mastitis is non-infective or infective. If the symptoms are all severe, the woman is more likely to need treatment with antibiotics. **Please refer to an appropriate health-care provider for antibiotics treatment.**





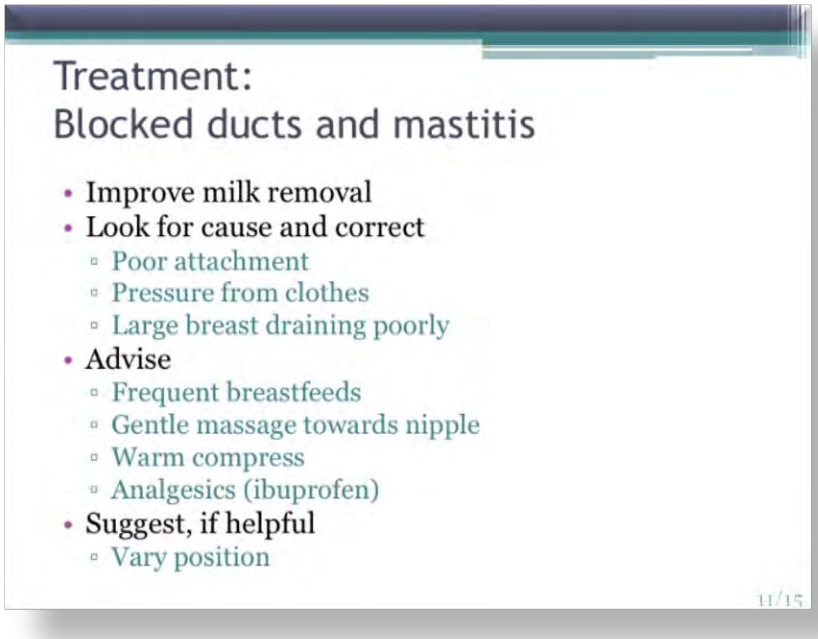
The above slide summarizes the causes of blocked ducts and mastitis.

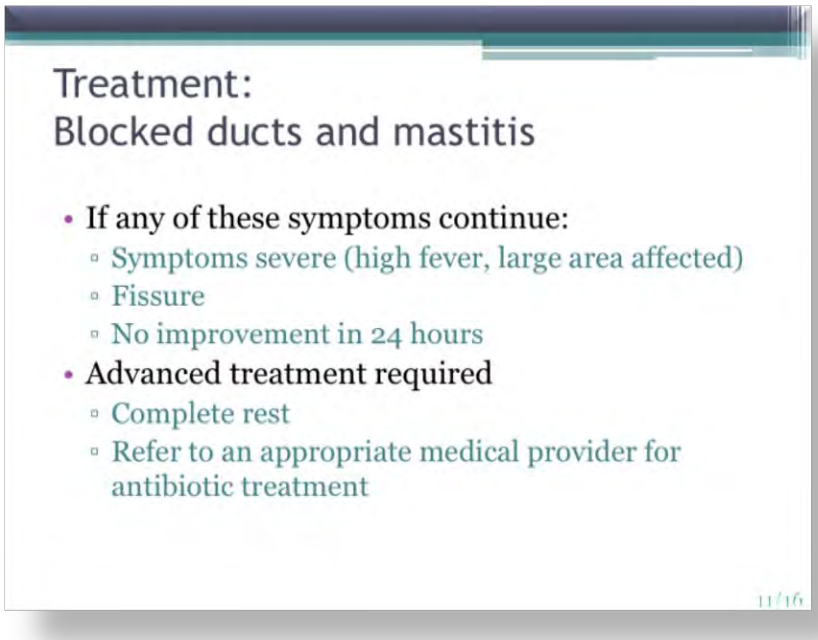
- The main cause of a blocked duct is not removing the milk adequately from all or part of a breast.
- Reasons for failure to remove the milk includes infrequent or short breastfeeds, and inefficient removal of milk from part or all of the breast.
- **Infrequent breastfeeds** may occur when a mother is very busy, the baby wakes infrequently or hunger signs are missed.
- **Inefficient removal of milk** from part or all the breast usually occurs when a baby is poorly attached to the breast.
- **Local pressure on one area of the breast:** Tight clothes or lying on the breast can block milk ducts. If a mother's fingers put pressure on the breast, milk flow is blocked during a breastfeed.
- **Damaged breast tissue**, for example, caused by trauma, sometimes results in mastitis.

A woman with a blocked duct can feel a lump and the skin over it may be red. The lump may be tender and painful. The mother usually has no fever and feels well.

A woman with mastitis may report the following signs and symptoms:

- pain and redness of the area.
- fever and chills.
- tiredness or nausea, headache and general aches and pains.





These slides summarize the treatment of blocked duct and mastitis.

Treatment plan

The most important part of treatment is to improve the removal of milk from the affected part of the breast. While observing a breastfeed, look for the cause of poor drainage and correct it. Check and help improve the baby's attachment. Observe what the mother does with her fingers as she breastfeeds. Does she hold the areola and possibly block milk flow? Observe whether the blocked duct is in the lower part of her breast. Suggest she lifts the breast more while she feeds the baby, to help the lower part of the breast to drain better. Ask about trauma to the breast or pressure from tight clothing, especially a bra worn at night.

Suggestions for the mother.

- **Breastfeed frequently**. The best way is to rest with her baby, so she can respond to the baby and feed whenever they want.
- **Gently massage the breast while the baby is suckling**. Show her how to massage over the blocked area right down to the nipple. This helps to remove the block from the duct.
- **Apply warm compresses to the breast immediately before feeds.**
- **Treat symptoms of pain and fever**. Give an analgesic, preferably ibuprofen, which decreases the inflammation. An alternative is paracetamol.
- Sometimes it is helpful to start the feed on the unaffected breast. This may help if pain seems to be preventing the oxytocin reflex. Change to the affected breast after the reflex starts working.
- Try feeding the baby in **different positions at different feeds**. This helps to remove milk from different parts of the breast more effectively.
- Sometimes a mother has difficulty feeding her baby from the affected breast, especially if it is very painful. A baby may have difficulty to feed from an infected breast because the taste of the milk changes. If a mother cannot feed directly from the affected breast, she must express milk. The expressed milk can be fed to the baby. **If the milk is not removed, it may result in an abscess. Milk production may cease.**
- Usually blocked ducts or mastitis improves within a day or two, when drainage to that part of the breast improves.

However, a mother needs additional treatment if:

- severe symptoms when you first see her
- there is a fissure of the nipple through which bacteria may enter
- there is no improvement after 24 hours of improved drainage.

Treat her or refer her for treatment with antibiotics. Explain that she must complete the course of antibiotics, even if she feels better in a day or two. If she stops the treatment before it is complete, the mastitis is likely to recur.

In addition to antibiotics:

- she needs complete rest and resting with her baby is a good way to increase the frequency of breastfeeds, to improve drainage;
- she should continue with frequent breastfeeds, massage and warm compresses;
- encourage her to eat well and drink fluids;
- remember the most important part of treatment is removal of milk from the breast.

Treatment of mastitis in an HIV-infected woman

In a woman who is HIV-infected, mastitis or nipple fissure (especially if bleeding or oozing) may increase the risk of HIV transmission. Therefore, the recommendation to increase the frequency and duration of feeds in mastitis is not appropriate.

She should avoid breastfeeding from the affected side while the condition persists. It is the same if she develops an abscess.

She must express milk from the affected breast, 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 she is able to express milk effectively.

If only one breast is affected, the infant can feed from the unaffected side, and feeding more often and for longer increases milk production. Most infants get enough milk from one breast. The infant can feed from the affected breast again when it has recovered.

If both breasts are affected, she 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.

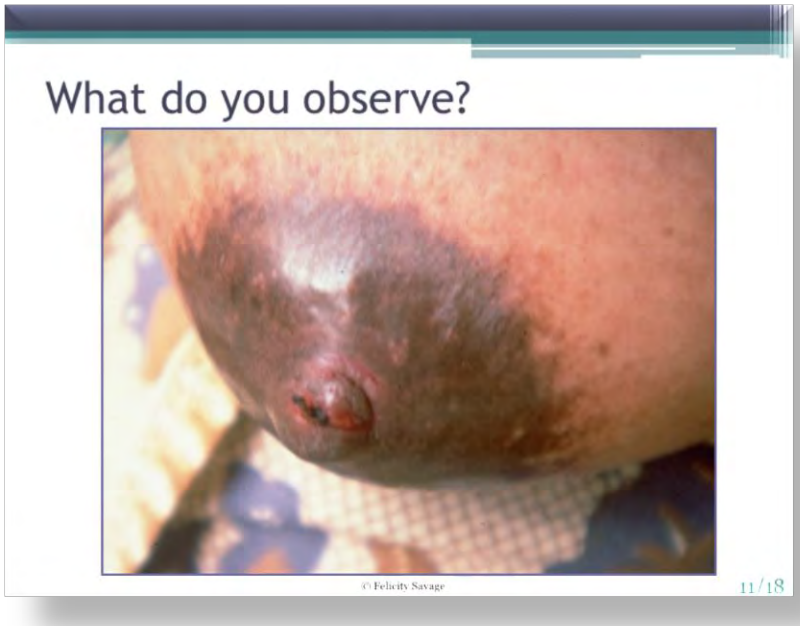
The health worker may need to discuss other feeding options for her to use in the meantime. The mother can feed the baby with her expressed breast milk, if she is able to heat-treat the milk or she can give commercial formula. Please refer her to an appropriate health-care provider for antibiotic treatment and pain relief, and counselling about alternative methods of feeding.

Sometimes a woman may decide to stop breastfeeding, 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 stay healthy until milk production ceases.

Sore and cracked nipples

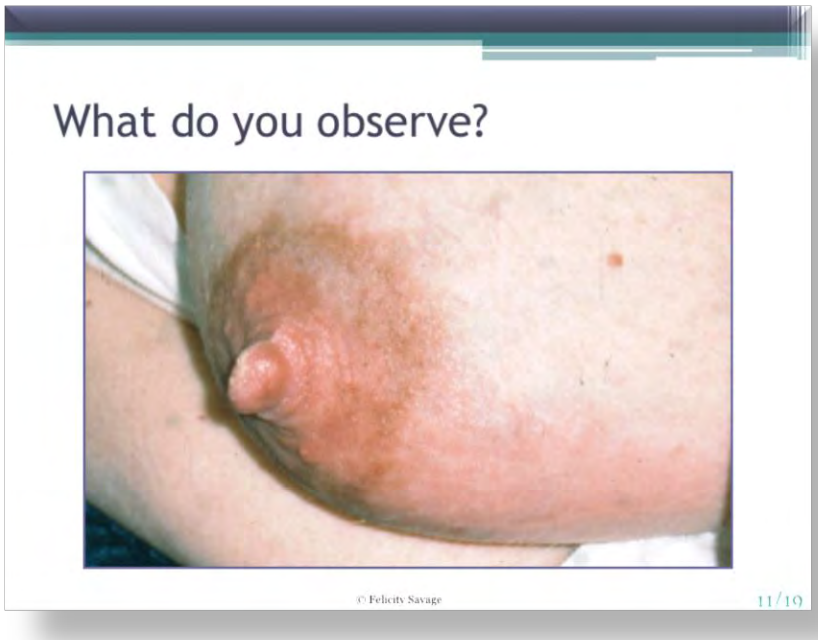
The most common cause of sore nipples is poor attachment. If a baby is poorly attached, the nipple pulls in and out as they suck. The skin of the breast rubs against their mouth which is very painful for the mother. At first, there is no crack (fissure) and the nipple may look normal. Sometimes it may look squashed with a line across the tip of the nipple when the baby releases the breast (compression stripe). If the baby continues to suckle in this way, it damages the nipple skin and causes a fissure across the tip of the nipple. There may also be a fissure around the base of the nipple.

Exception: When nipples are cracked or damaged, washing them with soap and water may help to stop infection. Refer the mother to a health-care provider if she needs more help.



If a woman has sore nipples or a fissure, please suggest:

- after breastfeeding, she rubs expressed milk over the nipple and areola with her finger – this promotes healing;
- not to wash her breasts more than once a day;
- not to use soap or rub hard with a towel – washing removes natural oils from the skin and makes soreness more likely;
- not to use medicated lotions and ointments because these can irritate the skin, and there is no evidence that they are helpful;
- help her to improve her baby's position, so that the baby is well attached;
- the baby continue breastfeeding and the nipples will heal rapidly when they are not being damaged anymore.



Candida infection (thrush)

The second most common cause of sore nipples is infection with *Candida albicans*, also known as "thrush". *Candida* infection can make the skin sore and itchy. Such infections often follow the use of antibiotics for infections such as mastitis.

Some mothers describe a burning or stinging that continues after a feed. It may be worse between feeds that during them. This is different from soreness due to poor attachment, which is mostly during feeds. Sometimes the pain shoots deep into the breast. A mother may say it feels, "as though needles are being driven into her breast". How have you heard mothers describe this?

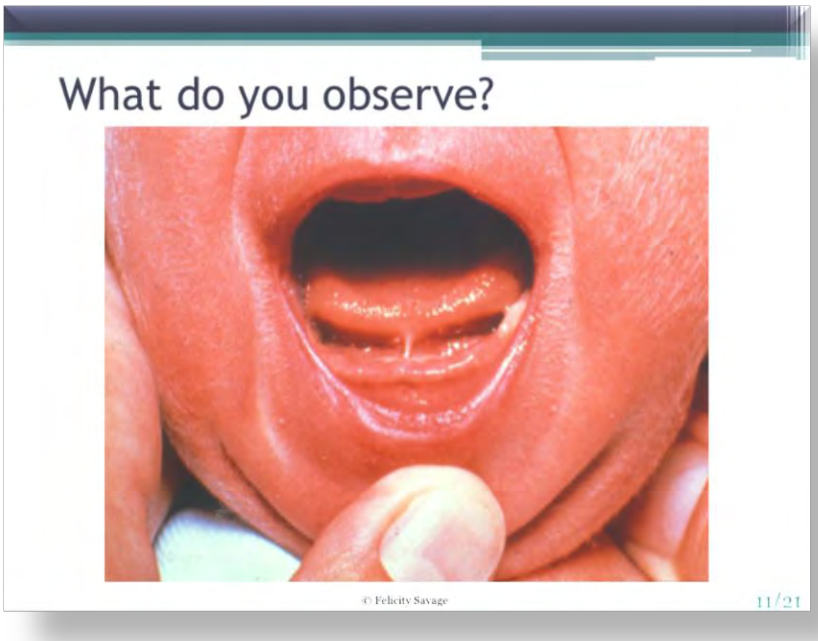
Suspect *Candida* if sore nipples persist even when the baby's attachment is good. Check the baby for Candida. They may have white patches inside their cheeks or on their tongue or they may have a red rash on their bottom.

REFER both mother and baby to an appropriate health-care provider for treatment with Nystatin.

Suggest that the mother stop using pacifiers (dummies) and nipple shields and help her to stop. If these are used, they should be boiled for 20 minutes daily and replaced weekly.

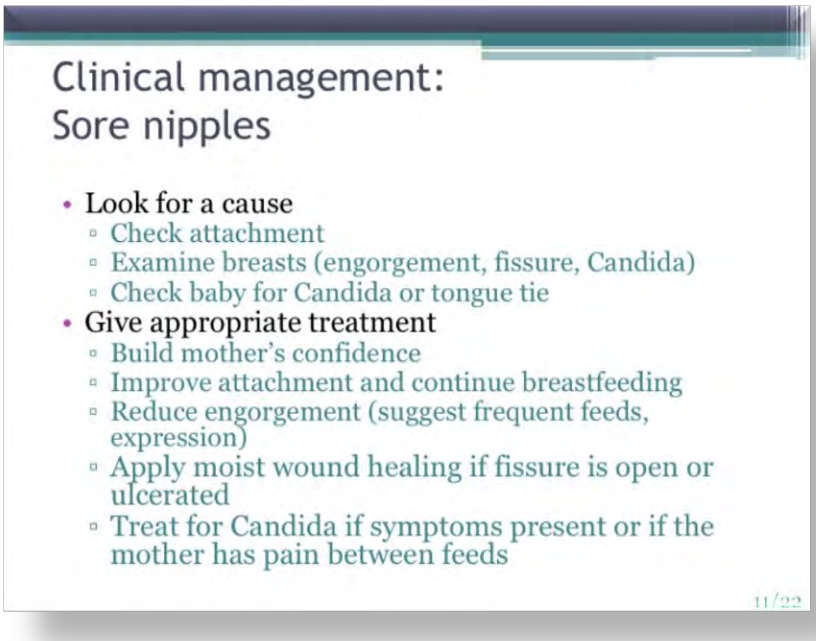
In women who are HIV-infected, it is particularly important to treat breast thrush and oral thrush in the infant promptly.

Tongue-tie



Tongue-tie (ankyloglossia) can also be a cause of sore nipples. Many babies with tongue-tie can breastfeed without any difficulty. However, sometimes a baby cannot get their tongue far enough over their lower gum to reach the large ducts beneath the areola. This causes the baby to have difficulty attaching and suckling effectively. The baby may not get enough breast milk from each feed. Mothers may complain of sore nipples because of the friction caused by a shallow attachment. Even though the baby's attachment may improve, they may have difficulty suckling effectively.

If a baby has difficulty with breastfeeding due to a short frenulum (tongue-tie), try to help the baby to take more of the breast into their mouth. In some cases, this is all that is necessary. However, if the tongue-tie is severe or if the difficulties continue, you may need to refer the baby to a specialist.



This slide summarizes the management of sore nipples.

1) Look for a cause

- Observe the baby breastfeeding, and check for signs of poor attachment.
- Examine the mother's breasts. Look for signs of *Candida* (thrush) infection; look for engorgement; look for fissures.
- Look in the baby's mouth for signs of *Candida* and for tongue tie; and the baby's bottom for *Candida* red rash.

2) Give appropriate treatment

- Build the mother's confidence.
- Explain the soreness is temporary, and soon breastfeeding will be completely comfortable.
- Help her to improve her baby's attachment. Often this is all that is necessary. She can continue breastfeeding and need not rest her breast.
- Help her to reduce engorgement, if necessary. She should breastfeed frequently or express her breast milk.
- Consider referring for treatment if the pain is deep in the breast, if it continues between feeds, if it persists after attachment is corrected, or if there is itchiness (possible Candida infection).

Advise the mother

- Breasts do not need to be washed before or after feeds. Normal washing, as for the rest of the body, is all that is necessary.

Let's practise. Case studies

CASE 1

Mrs G says her breasts are painful, and her right nipple is sore. Her baby is four days old. Both Mrs G's breasts are swollen, and the skin looks shiny. The nipples are stretched flat. You watch her breastfeeding. Her baby is restless and makes smacking sounds as she tries to suckle. After a few sucks, she pulls away and cries.

- *What is the diagnosis?*

- *What can you say to empathize with Mrs G?*

- *What is the cause of Mrs G's difficulties?*

- *What practical help can you give Mrs G?*

CASE 2

Mrs B's baby was born yesterday. She tried to feed her soon after delivery, but she did not suckle very well. She says her nipples are inverted, and she cannot breastfeed. You examine her breasts, and notice her nipples look flat. You ask Mrs B to use her fingers and to stretch her nipple and areola out. She stretches the nipple out a short way, showing the nipple and areola are protractile.

- *What could you say to accept Mrs B's idea about her nipples?*

- *What does it mean for her nipples to be protractile?*

- *How could you build her confidence?*

- *What practical help could you give Mrs B*

CASE 3

Mrs C notices a painful swelling in her left breast over the last three days. Her nipple is very sore. The skin of a large part of the breast looks red, and it is hard and extremely tender. Mrs C has a fever and feels too ill to go to work today. She is a teacher in the local primary school. She breastfeeds her baby at night. During the day, she expresses milk to leave for him. She has no difficulty in expressing her milk. She is very busy, and it is difficult for her to find time to express milk or to breastfeed her baby during the day.

- *What could you say to empathize with Mrs C?*

- *What could you say to build Mrs C's confidence?*

- *What is the diagnosis?*

- *Why do you think that Mrs C has this condition?*

- *How would you treat Mrs C?*

- *What could you suggest to prevent the same problem occurring again?*

CASE 4

Mrs F's baby is three months old. She says her nipples are sore. They have been sore on and off since a case of mastitis several weeks ago. The mastitis cleared up after a course of antibiotics. This new pain feels like needles going deep into her breast when her baby suckles. The pain continues between feeds, and her nipples are sometimes itchy.

You watch her baby breastfeeding. You can see areola above his mouth but not below. His mouth is wide open, his lower lip is turned back, and his chin is close to the breast. He takes some slow deep sucks and you see him swallow.

- What could you say to empathize with Mrs F?

- What might be the cause of Mrs F's sore nipples?

- How would you build Mrs F's confidence?

Notes

Session 12. Milk supply challenges

Objectives

After completing this session, participants will be able to:

- explain normal newborn feeding behaviour and intake;
- list the signs and symptoms a newborn may not be getting enough milk;
- explain the common reasons why a newborn may not get enough breast milk;
- explain how to prevent and manage milk insufficiency in newborns;
- explain the difference between perceived and actual milk insufficiency;
- help a mother whose baby is not getting enough breast milk;
- help a mother who thinks her baby is not getting enough milk.

Introduction

Two of the most common worries of a new mother/parent/caregiver are: "Is my baby getting enough milk?" "Will I make enough milk?" As health workers, we must build confidence and offer support to help the family during the first hours, days and weeks after birth.

Often a new mother worries she does not have enough breast milk, but her baby is in fact getting all that they need. We call this perceived milk insufficiency.

You need to understand why she thinks this and decide whether or not her baby is getting enough. Mothers and their families also need to know how to decide if the baby is getting enough milk.

What is the difference between perceived and actual milk insufficiency?

Perceived milk insufficiency

Many times a new mother **thinks** she does not have enough breast milk, but her baby is in fact getting all that they need. You need to understand why she thinks this and assess if her baby is getting enough. Mothers and their families also need to know how to assess if the baby is getting enough milk.

Actual milk insufficiency

If the health worker and mother together decide that the baby is not getting enough milk, then this is an actual milk insufficiency. The health worker and mother must monitor the baby's feeding and output (by counting wet and stool nappies). It is important to find out if the baby could get more milk feeding differently, or if the mother really cannot produce enough. We will learn about this later in the session and how to support and counsel the mother/parent/caregiver.

When is breast milk made?

Milk production begins in pregnancy, around the 14th week. Due to the hormone transition after birth, milk production increases and colostrum is available for the baby. As we learned in an early session, colostrum is all that babies need in the first days after birth. Due to the hormone transition after birth, milk production increases and the milk "comes in" in the next few days. If the coming in of the milk is delayed, a baby may not get enough breast milk for a few days. But this is rarely because their mother cannot produce enough milk.

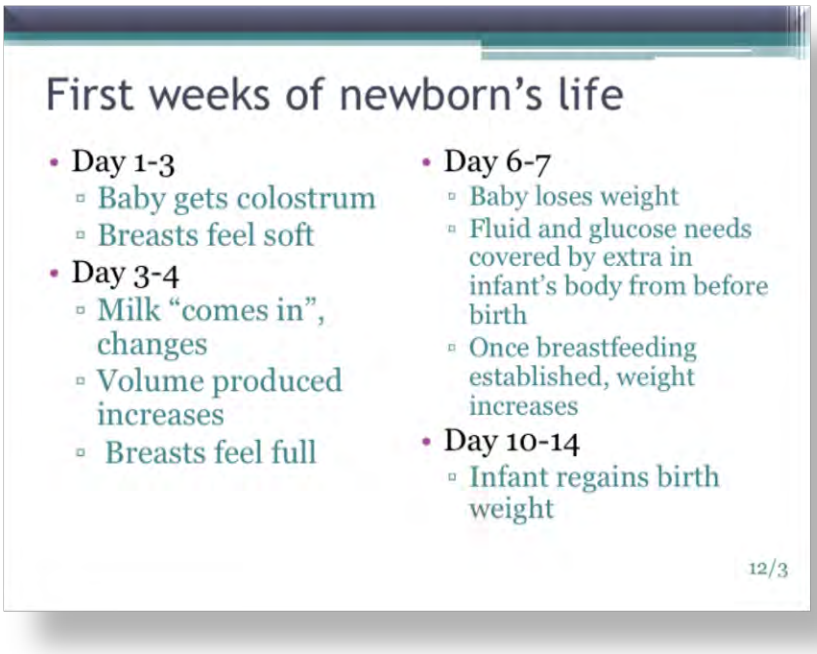
Health workers may assume mothers do not have enough milk in the hours after birth. As a result, babies are often

routinely given a supplement like infant formula or sugar water.

Supplements interfere with the establishment of breastfeeding. An important point to remember is when is breast milk made?

A baby does not get enough breast milk if the milk is delayed "coming in". Some causes include not being attached correctly or not suckling effectively (see SESSION 5: HOW BREASTFEEDING WORKS). It is rarely because their mother cannot produce enough milk.

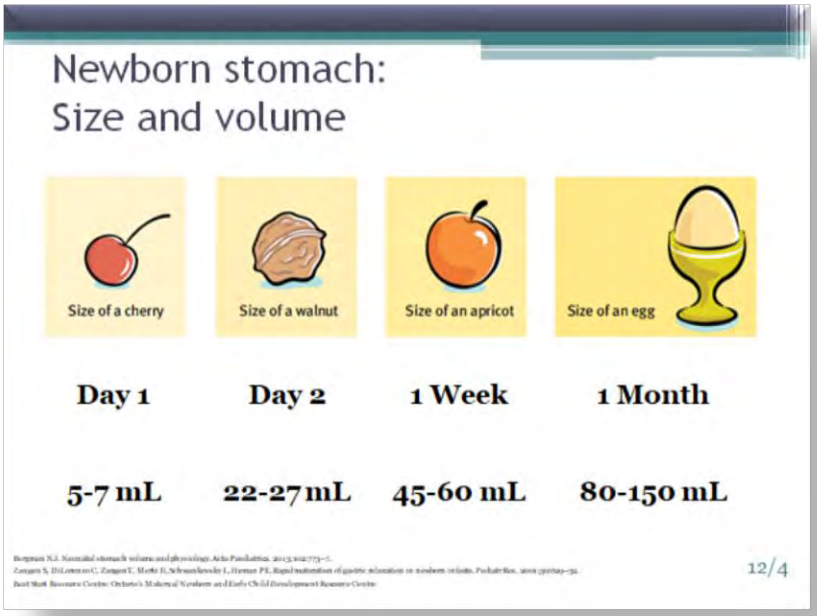
NOTE: As this course focuses on the TEN STEPS, we know that adherence to these steps will further assist mothers and babies in achieving their breastfeeding goals. These steps help the mother and baby to succeed in early initiation and exclusive breastfeeding, which in turn prevent milk insufficiency.



This slide explains the normal process for the newborn baby and the maternal milk supply in the first few weeks of life.

- Day one to three: A newborn gets colostrum and the mother's breasts feel soft.
- Day three to four: The mother's milk increases, and her breasts feel full.
- Day six to seven: The newborn usually loses some weight. However, fluid and glucose needs are covered by the extra supply already in the newborn's body from before birth. As breastfeeding is established, the newborn's weight increases.
- Day 10–14: An infant regains their birth weight by about 10 days, and 14 days at the latest.
- After two weeks: After two weeks of age, an infant should continue to grow and gain weight according to the World Health Organization's Child Growth Standards[17].

[17] Use of the WHO Child Growth Standards are taught in: WHO/UNICEF. Infant and young child feeding counselling: an integrated training course. Geneva: World Health Organization; 2006 (https://www.who.int/nutrition/publications/infantfeeding/9789241594745/en/, accessed 6 April 2020).



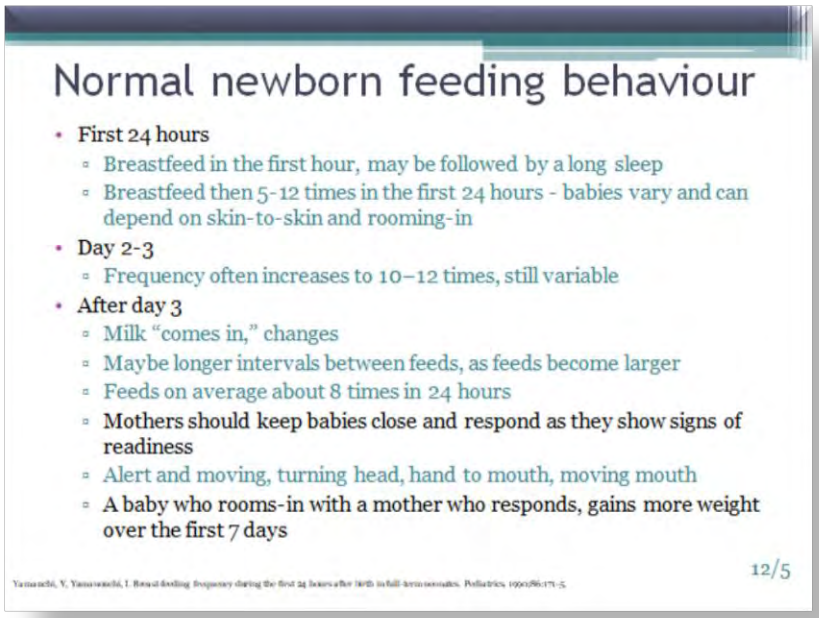
Newborn's stomach size

This slide shows the size and volume of a newborn's stomach. As you can see, a newborn's stomach is very small and cannot hold much milk. At day one of life, a newborn's stomach wall is firm and does not stretch. By day three, the stomach starts to expand more easily to hold more milk[18]. A stomach capacity of 20 mL translates to a feeding interval of approximately 1 h for a term neonate[19]. Colostrum is complete as newborns need only small volumes of milk in the first days of life.

This is an important teaching point for mothers/parents/caregivers. If health workers reassure them that colostrum is complete, then they will be less likely to supplement in the first days. We have seen that if mothers leave the health-care facility breastfeeding exclusively, the rates of exclusive breastfeeding continue to remain high for the first six months of life.

[18] Zangen S, DiLorenzo C, Zangen T, Mertz H, Schwankovsky L, Hyman PE. Rapid maturation of gastric relaxation in newborn infants. Pediatr Res. 2001;50:629–32.
[19] Bergman NJ. Neonatal stomach volume and physiology. Acta Paediatrica. 2013;102:773–7.

Normal newborn feeding behaviour



In the first 24 hours of life, newborns are often sleepy and may feed 5 - 12 times[20,21,22]. This may be more depending on the skin-to-skin contact at birth and rooming-in[23].

Note: If the baby looks well, pink and warm with good tone but is sleepy, they can be left until next time for breastfeeding.

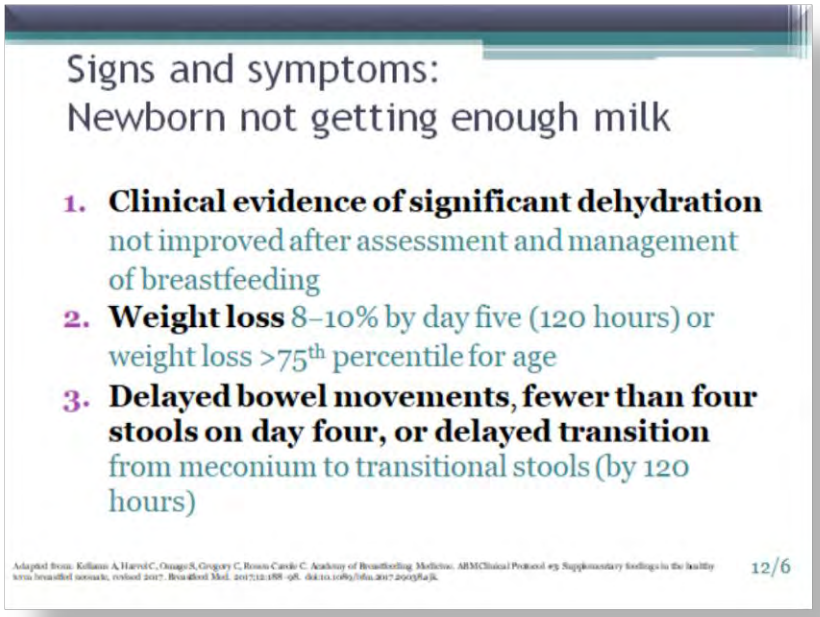
By day two to three, the frequency of feeding increases with variations. It may increase to 10 to 12 times in 24 hours.

By day three, the milk supply usually increases and changes from colostrum to transition breast milk. There may be longer intervals between feeds as the feeds become larger. Usually, at day three and onwards, a baby will feed about eight times in 24 hours.

Mothers and babies should stay together so they learn their babies' cues and respond to them. A baby who rooms-in with a mother who responds to them gains more weight over seven days.

[20] Wight N, Marinelli KA, and the Academy of Breastfeeding Medicine (2014). ABM clinical protocol #1: Guidelines for blood glucose monitoring and treatment of hypoglycemia in term and late-preterm neonates. Breastfeeding Medicine, 9 (4), 173-179.
[21] Kellams A, Harrel C, Omage S, et al. (2017). ABM clinical protocol #3: supplementary feedings in the healthy term breastfed neonate. Breastfeed Medicine, 12 (3), DOI: 10.1089/bfm.2017.29038.ajk.
[22] Holmes AV, McLeod AY, and Bunik M. (2013). ABM clinical protocol #5: peripartum breastfeeding management for the healthy mother and infant at term. Breastfeeding Medicine, 8(6), 469-473. doi:10.1089/bfm.2013.9979..
[23] Skin-to-skin contact is discussed in Session 6: IMPACT OF birth practices. Rooming-in is discussed in Session 7: POSTNATAL practices TO SUPPORT breastfeeding.

Signs and symptoms that a newborn may not be getting enough breast milk



This slide shows the signs and symptoms indicating a newborn is not getting enough milk in the first days and weeks of life.

1. Clinical evidence of significant dehydration

    - decreased urine output
    - high sodium
    - poor feeding and attachment
    - lethargy
    - If these symptoms do not improve with assessment and management of breastfeeding, then this becomes a serious situation.

    During the first 6 days
    Urine passed: Once in the first 24 hours, twice on day two, three times on day three, four times on day four, and five times on day five.

    After six days
    By the age of six days, babies normally pass urine six or more times a day. This can tell you quickly whether an exclusively breastfed newborn is getting enough milk. If the baby is also having supplementary feeding, you cannot be sure because these signs may not apply. **When a baby has no urine output in a 24-hour period, they should be assessed by a health-care provider immediately.**

2. Weight loss

    - 8–10% by day 5 (120 Hours)
    - Weight loss >75th percentile for age.
    - **Weight loss of 8–10% by day five** may be normal if the newborn is otherwise doing well. However, it is an indication for assessment and breastfeeding assistance, if necessary. Weight loss higher than this range may indicate low-milk production or inadequate milk transfer. A medical provider should evaluate the newborn before initiating supplementary feeding.

Weight gain

- Infants may lose up to 10% of their birth weight in the first days after birth but should regain birth weight by 14 days.
- If an infant continues to lose weight beyond 10 days, this is cause for concern. A newborn who weighs less than their birth weight at two weeks of age, is not gaining enough weight.
- After two weeks, a baby should continue to gain weight according to the WHO Child Growth Standards.
- **If weight gain is less than 200 grams per week, the baby should be assessed by a health-care provider.**

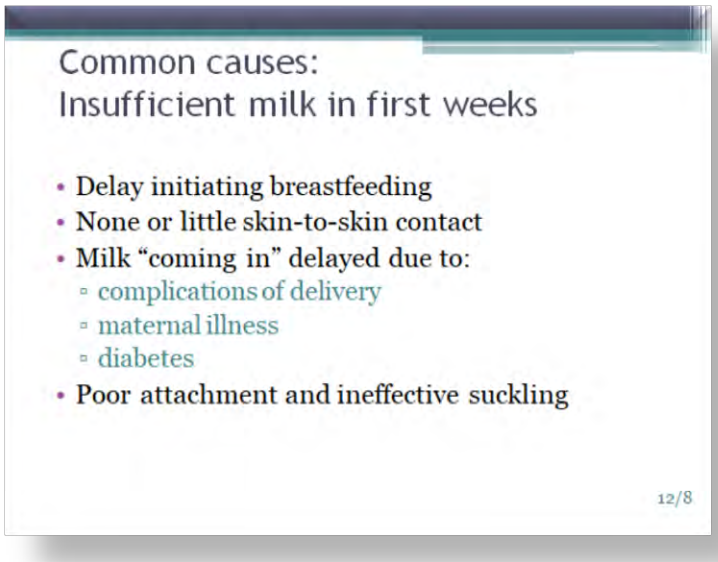
3. **Delayed bowel movements, fewer than three stools on day four of life, or continued meconium on day five** (by 120 hours).
   - The newborn passes thick, tarry, black **meconium** during the first three to four days. Note: If the newborn is passing meconium after day four to five, they may not be getting enough milk.
   - After four days when the milk supply increases, the stools change to brown or yellow in colour. The newborn then usually passes two to three substantial stools each day. Some newborns pass a small stool with each feed. A delay in the transition from meconium may indicate a more serious medical concern.
   - After three to four weeks, some babies start to pass stools less often. They may only pass a stool once every three or four days, or even not for a week or more. However, when the newborn does pass a stool, it is usually large and semi-liquid. Small dry stools may be a sign the newborn is not getting enough milk.
   - These signs and symptoms are important in understanding if a newborn is getting enough milk or not.
   - When mothers are discharged from a health-care facility, it is important they take note of their baby's urine and stool output. This can help them know if there is a problem and seek medical help if necessary.

Other signs

A health-care worker must teach and counsel a mother/parent/caregiver about normal newborn behaviour. The following slide shows signs which may make a mother think her baby is not getting enough milk. If a mother is concerned and thinks her baby is not getting enough milk, she should visit a health worker for evaluation.

Hand expression

One way a mother can "see" she is making milk is through hand expression[24]. All mothers should be taught hand expression before discharge. There may develop a need for expression later on, due to engorgement or other causes. We will learn more about hand expression in a future session.



[24] Hand expression is covered in SESSION 13: CHALLENGES TO FEEDING AT THE BREAST AND ALTERNATIVE METHODS OF FEEDING.

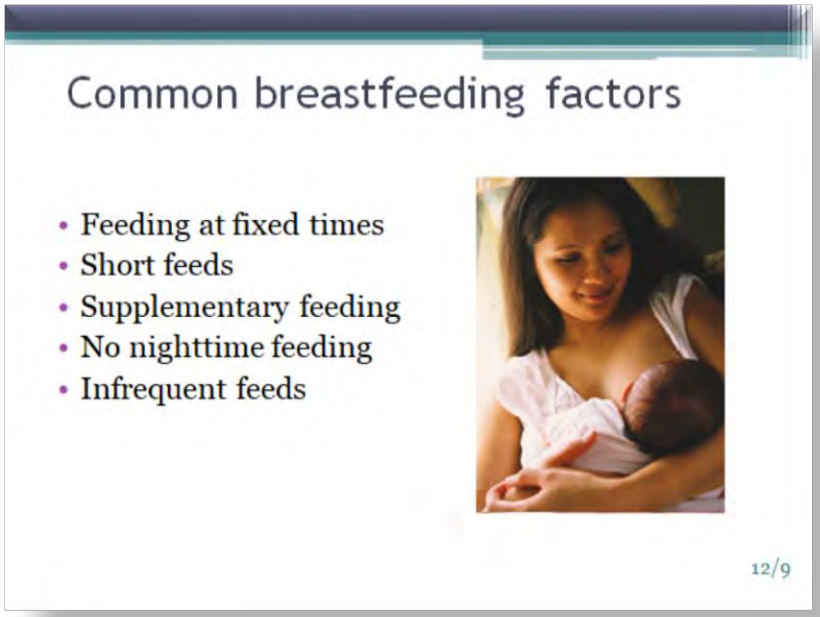
First two weeks: Causes of insufficient milk

This slide lists the common causes of insufficient milk in the first two weeks of a newborn's life.

1) Delayed initiation of breastfeeding and early contact: This is critical for establishing the maternal milk supply. If initiation of breastfeeding is delayed or there is little to no skin-to-skin contact, the milk supply can be affected.

2) Maternal causes: The increase in milk can be delayed due to:
   i. complications of delivery
   ii. maternal illness
   iii. maternal diabetes

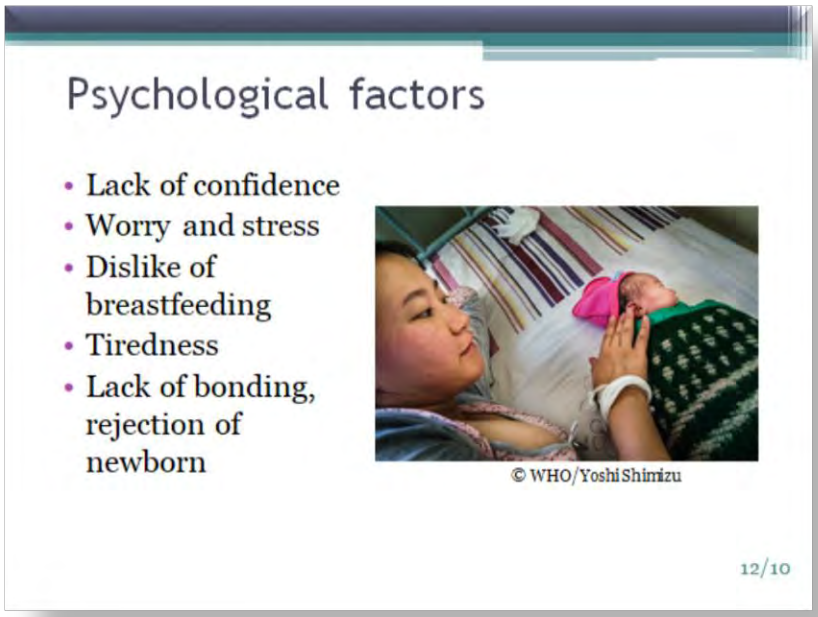
3) Poor attachment and ineffective suckling of the baby is one of the most common causes of insufficient milk.



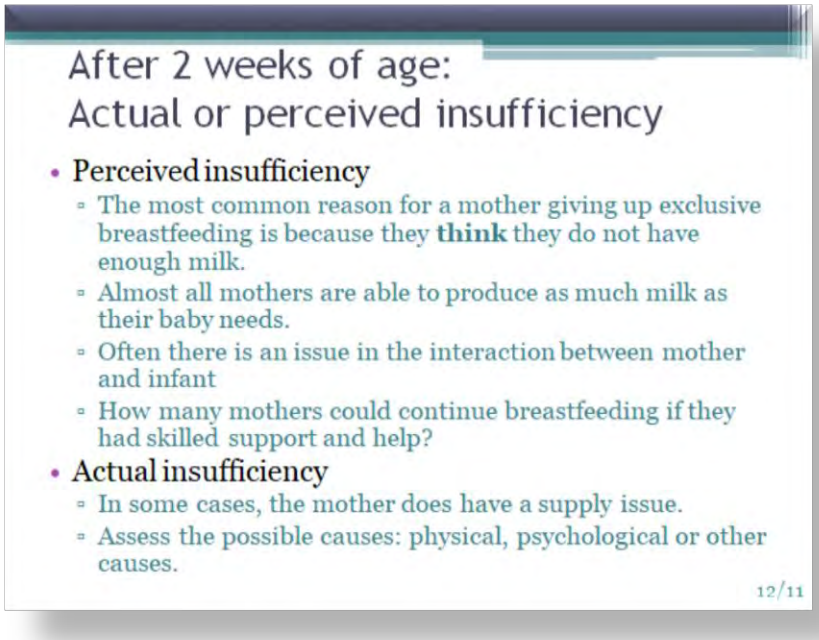
After the first two weeks

After the first two weeks, there may be other common reasons why a baby is not getting enough breast milk. Breastfeeding factors include the following.

- *Feeding schedule: Fixed times* can interfere with the newborn's milk intake and the mother's milk production.
- *Short feeds*: If breastfeeds are too short or hurried, the baby does not get enough complete foremilk/fat-rich hindmilk.
- *Supplementary feeds*: A baby who receives supplementary feeds (artificial formula, sugar water, etc.) suckles less at the breast because they have a full stomach. They then do not receive enough milk and the mother's supply will also decrease,
- *No night feeding*: A mother is still establishing breastfeeding in the first few weeks. Once the milk supply is established, if she stops night breastfeeds before her baby is ready her milk supply may decrease.
- *Infrequent feeds:* If a mother is working or too busy, feeds may be more infrequent;
- *Psychological factors:* Worry and stress, dislike of breastfeeding, and lack of confidence may cause a mother to give artificial feeds, or tiredness may result in a mother feeding her baby less often.



Note: There are times when you cannot find the cause of a poor milk supply. The milk supply does not improve or the newborn does not gain weight, even with support and counselling. A very small proportion of women seem to have an unexplained low-milk supply, typically about 1–2% of women. Then you may need to look for one of the less common causes and help or refer the mother accordingly.

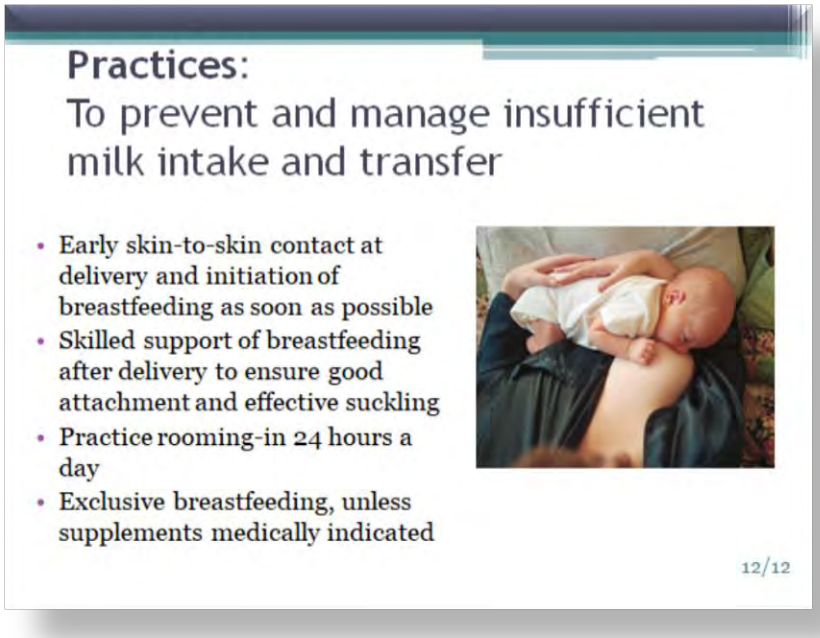


After 2 weeks

After two weeks of age, the concern of a baby not getting enough milk is often a question of low milk intake or the mother thinking she does not have enough milk.

The most common reason for a mother not exclusively breastfeeding is because they think do not have enough milk. However, almost all mothers are able to produce as much milk as their baby needs.

Often there is an attachment or position issue which needs support and counselling. With skilled breastfeeding support and management, a mother's confidence may be restored. Before mothers are discharged from a health-care facility, they must be assessed for proper attachment and positioning to ensure their baby is breastfeeding well. With Step 10, mothers are given information about how to get continuing support and help after discharge.



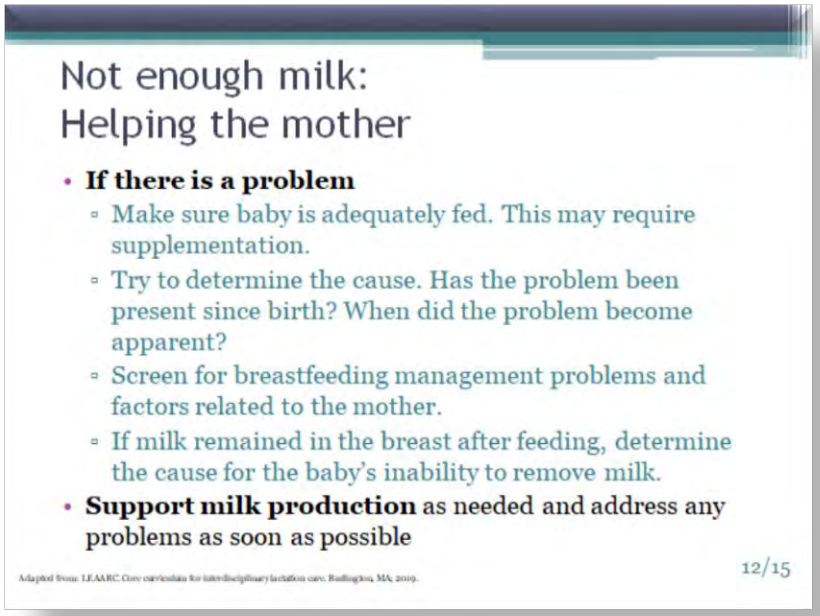
Prevention and management

Practices can be implemented from birth to prevent an infant from having an insufficient milk intake.

- Ensuring early skin-to-skin contact at delivery and initiation of breastfeeding can help to establish breastfeeding.
- Mothers and their babies should practise rooming-in 24 hours a day. This allows the mother to respond to her baby's cues.
- Skilled support of breastfeeding before a mother is discharged can help to ensure good attachment and effective suckling.
- Assess position. Help the mother to find a comfortable position, especially if she is having pain following delivery. Providing support to the mother and baby for breastfeeding is very important to ensure a baby is getting milk.
- Breastfeed exclusively unless supplements are medically indicated. This allows a mother and her newborn to establish breastfeeding and for the milk supply to increase. Supplementary feeding will fill the newborn's small stomach and they will less likely want to suckle at the breast.
- In the rare cases, when the baby is not getting enough milk due to a low supply, it is important to help the mother increase her milk production. To increase milk production, the breasts need stimulation and the milk needs to be removed frequently.
- The suggestions listed earlier for preventing and managing milk intake will help to increase production. If the infant is removing milk from the breast more efficiently, this will stimulate milk production. Encourage the mother to let her newborn suckle often, and for as long as the newborn wants. This will stimulate her breasts and her milk production.
- Sometimes babies are not getting enough milk. Sometimes babies are getting enough milk, but their mother thinks they are not. In all cases, it is important to determine whether the baby is getting enough milk and support the mother to breastfeed with confidence.


Not enough milk:
Helping the mother
• Listen to the mother and take a detailed history
▫ If she is doubting her milk supply, try to learn why. In this way, you can help her to build her confidence.
▫ Explore the mother's ideas and feelings about her milk and pressures she may be experiencing. This pressure can come from family and friends.
• Assess the infant's health
▫ Determine whether the baby is getting milk or not, using the signs and symptoms we have discussed.
▫ Determine whether the baby is being fed exclusively at the breast or is being supplemented.
Adapted from: LEAARC Core curriculum for interdisciplinary lactation care. Burlington (MA); 2019.
12/13


Not enough milk:
Helping the mother
• Assess the big picture
▫ Is the baby's weight within the expected range?
▫ Has supplementation played a role?
▫ Is baby removing milk from the breast?
▫ What is the baby's output (urine and stooling pattern)?
• Assess the mother's health
▫ Does the mother have risk factors for lactation problems?
• Observe one or more feeds
▫ Assess latch, milk transfer and positioning to check positioning and attachment, as well as the condition of the mother and baby.
Adapted from: LEAARC Core curriculum for interdisciplinary lactation care. Burlington (MA); 2019.
12/14



Using counselling skills

Whether or not a baby is getting enough milk or a mother thinks her baby is not getting enough milk, it is important to use your counselling skills[25].

1) Help to build the mother's confidence.
2) Use positive words and avoid criticism or judgements.
3) Offer simple suggestions to improve her situation and discuss whether the suggestions seem possible to the mother.
4) Praise the mother on positive points about her breastfeeding technique and about her newborn's development.
5) Correct mistaken ideas without sounding critical.

[21] Refer SESSION 3. COUNSELLING SKILLS: LISTENING AND LEARNING

Case studies: Helping a mother make sure her baby gets enough milk

CASE 1

Part A

Mrs M gave birth to her baby boy two days ago. She had a caesarean section. When the baby was delivered, he had a medical complication and was taken to the special care unit for babies. Mrs M had expressed colostrum prior to delivery, but her baby didn't receive it. Instead, Mrs M's baby was given bottles of infant formula in the special care unit.

When Mrs M and her baby were finally able to be together today, she tried to breastfeed him. Mrs M says she feeds him for a few minutes, but then he cries and is hungry again. When her baby is breastfeeding, her nipples become very sore.

1. *How can you find the cause of Mrs. M's difficulty?*

Part B

When you assess a breastfeed, you see: less areola above the baby's mouth, and more below, and his chin is not touching the breast. The baby is not ill or abnormal, and Mrs M is healthy.

2. *How can you help Mrs. M and her baby?*

CASE 2

Mrs P is 20 years old. Her baby was born yesterday and is very healthy. She has tried to breastfeed twice, but her breasts are still soft. She thinks she has no milk and will not be able to breastfeed. When her baby cries, she puts her to the breast. The baby has suckled at her breasts several times. Her husband has offered to buy her a bottle and some formula. He also tells her a pacifier will stop the baby from crying and plans to bring one to her today.

1. *What could you say to accept what Mrs P says about her breast milk?*

2. *What is the reason why Mrs P doubts her ability to breastfeed?*

3. *What relevant information would you give her?*

4. *What practical help could you give Mrs P?*

Notes

Session 13. Challenges to feeding at the breast and alternative methods of feeding

Objectives

After completing this session, participants will be able to:

- describe the challenges for a baby to feed at the breast
- list different reasons why a baby may cry often
- discuss the alternative feeding methods until the baby can feed at the breast again
- help a mother to overcome these difficulties and help her feed her baby using different methods.

Introduction

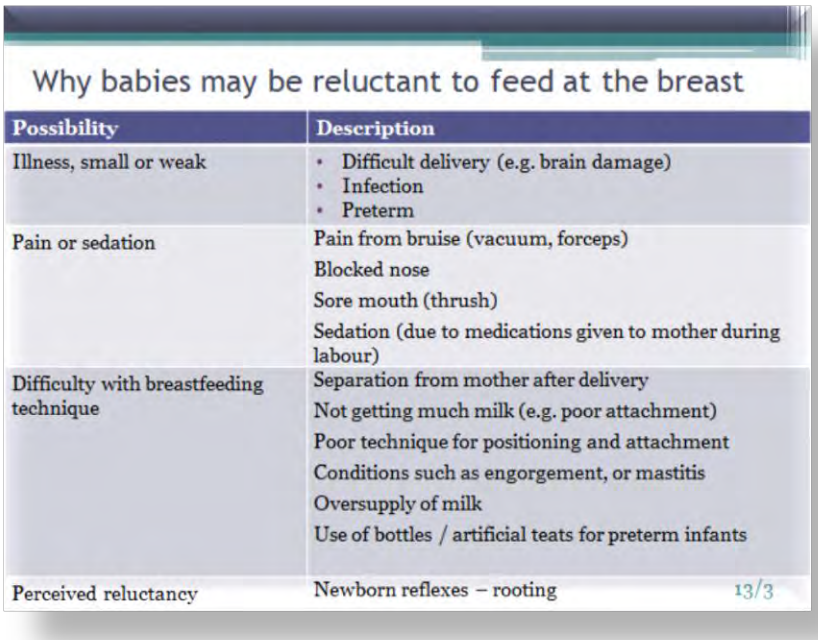
Many mothers decide antenatally during pregnancy to exclusively breastfeed. There are many reasons why mothers stop breastfeeding or start to mix feed. A newborn's perceived reluctancy to feed at the breast is a common reason for stopping breastfeeding. With counselling and support from the health worker, this can be overcome and should not lead to cessation of breastfeeding.

Being unable to feed at the breast can cause great distress to the baby's mother. She may feel rejected and frustrated by the experience. In the first few days, it may be a mother and her newborn need time to learn how to breastfeed. She may have concerns which need to be resolved. You need to know how to decide why a newborn is having difficulty to feed at the breast, and how to support the mother/parent/caregiver.

Is the reluctancy real or perceived?

Sometimes a newborn behaves in a way that makes their mother think that they are unable to feed at the breast. However, the newborn is not really reluctant. When a newborn baby “roots” (or searches) for the breast, they move their head from side to side as if they are saying “no”. This is normal rooting behaviour.

Why newborns may be reluctant to feed at the breast



Why babies may be reluctant to feed at the breast

Possibility	Description
Illness, small or weak	• Difficult delivery (e.g. brain damage) • Infection • Preterm
Pain or sedation	Pain from bruise (vacuum, forceps) Blocked nose Sore mouth (thrush) Sedation (due to medications given to mother during labour)
Difficulty with breastfeeding technique	Separation from mother after delivery Not getting much milk (e.g. poor attachment) Poor technique for positioning and attachment Conditions such as engorgement, or mastitis Oversupply of milk Use of bottles / artificial teats for preterm infants
Perceived reluctancy	Newborn reflexes – rooting 13/3

Most reasons why newborns seem reluctant to breastfeed fall into one of these categories:

- the newborn is ill, weak or small
- the newborn is in pain or sedated
- there is a difficulty with breastfeeding or breastfeeding technique
- the mother's smell or the taste of the milk has changed
- supposed, not real, reluctancy – this is the most common.

Is the newborn ill, weak or small?

The newborn is ill because of a difficult delivery or has an infection. A newborn may also be weak or small and have difficulty with attaching or suckling.

Is the newborn in pain or sedated?

The newborn has a painful place, such as a bruise on their head, from vacuum extraction or forceps. If the mother presses the painful place, the newborn may cry and pull away as she tries to put them to the breast.

The newborn may have a blocked nose. The baby starts suckling, but then has to pull away to breathe.

A sore mouth (*Candida* or thrush infection). The newborn may suckle a few times, and then stop and cry because of soreness, and not want to try again.

The newborn may be sleepy because of:

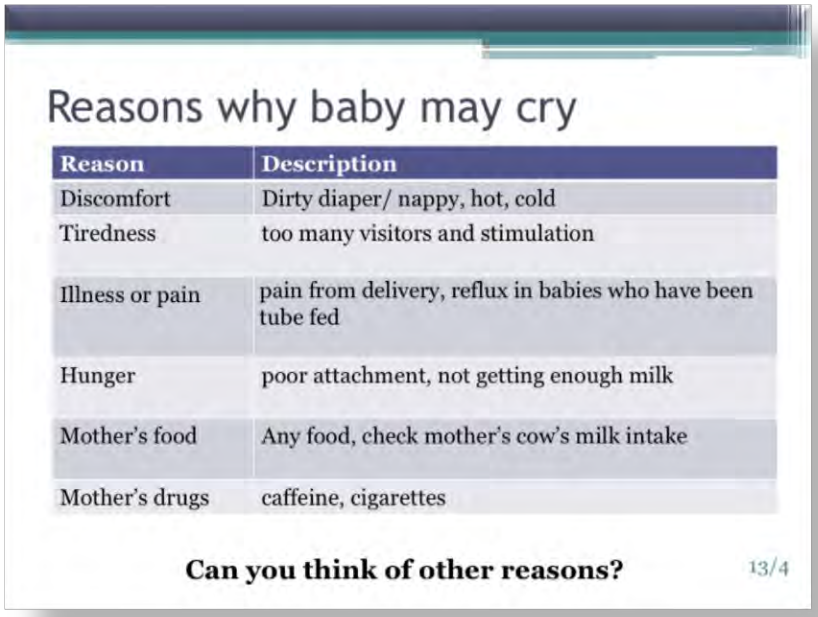
- sedating medications the mother was given during labour
- medications the mother is taking for psychiatric treatment or epilepsy.

Is there a difficulty with breastfeeding?

Possible causes

- Separation of the mother and newborn after delivery.
- Poor attachment, so the baby does not get much milk when trying to feed.
- Poor technique of positioning and attaching the newborn. This includes putting pressure on the back of the newborn's head, which stimulates a reflex making the baby pull away from the breast.
- Conditions causing swelling, such as engorgement, making it difficult for the newborn to attach. Mastits may make the milk taste salty.
- Oversupply, when it flows out in a fast stream due to the oxytocin reflex, the baby may suckle briefly for a minute, and then come off the breast choking or crying with milk spraying out.
- The use of artificial teats especially for preterm infants can interfere with learning to suckle at the breast. If a preterm infant learns to suckle from an artificial teat in the immediate postnatal period, they may have difficulty taking the breast into their mouth.
- Sometimes a newborn may be reluctant to feed on one breast, but not the other. The newborn may find being held in one position painful, or may have more difficulty attaching to one side, because the nipple is different, or because of mastitis.

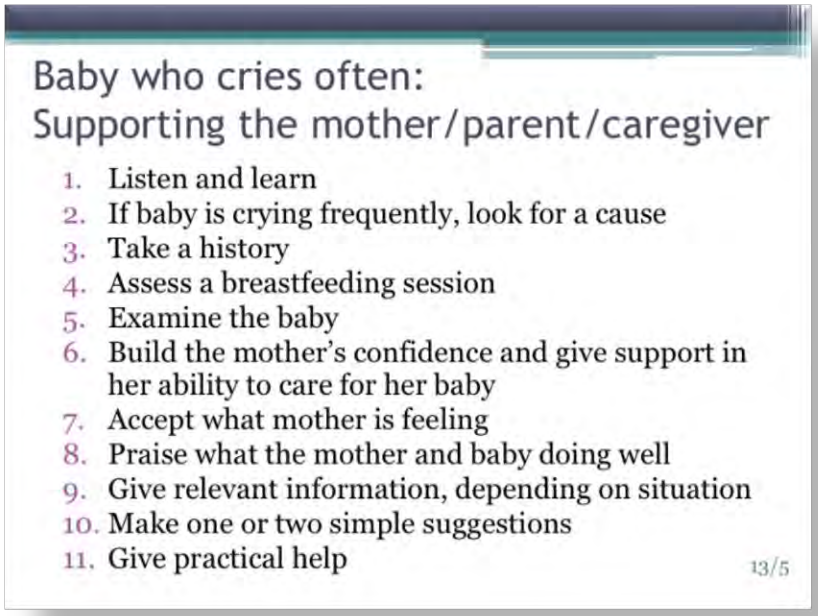
The crying baby



We will now look at another common reason for a mother to stop breastfeeding or to begin supplementation, the crying baby.

Babies only have one way to communicate, crying. They cry when they are happy, when they are sad, when they are hungry and sometimes for no reason at all. A mother and her family may quickly think a crying baby means the mother's milk is not enough or not good. Many mothers start unnecessary foods or fluids because of the baby's crying. These additional foods and drinks often do not make a baby cry less. Sometimes a baby cries more.

A baby who cries a lot can disturb the relationship and bonding between the baby and their mother. She may lose self-confidence and her family's support. An important way to help a breastfeeding mother is to provide counselling and support about why babies cry.



Baby who cries often: Supporting the mother/parent/caregiver

1. Listen and learn

- Understand why the mother thinks her baby is crying a lot.
- Help the mother to talk about how she feels. Empathize with her feelings.
- She may feel guilty and think she is a poor mother. She may feel angry with her baby.
- Other people may make her feel guilty or there is something wrong with her breast milk.
- Other people may advise her to give the baby supplements or pacifiers.

2. If the baby is crying frequently, look for a cause

3. Take a history

- Learn about the baby's feeding and behaviour and if he sleeps near to his mother.
- Learn about the mother's diet, if she eats a lot of dairy products, if she drinks coffee, or smokes, or takes any medicine or drugs.

4. Assess a breastfeed

Check the baby's attachment, positioning, and the length of feeds.

5. Examine the baby

- Check the baby's weight.
- Make sure the baby is not ill or in pain.
- If the baby is ill or in pain, treat or refer as appropriate.

6. Build the mother's confidence and give support in her ability to care for her baby

Accept

Listen and accept what the mother is feeling.

Praise what the mother and baby are doing well

Her breast milk is providing all that her baby needs. Address the shame she is feeling: there is nothing wrong with it or with her.

Give relevant information, depending on the situation

- Her baby has a real need for comfort; the baby may be in pain.
- Most babies do not need supplementary feeding.
- Suckling at the breast for comfort is safe, but inappropriate use of artificial teats and pacifiers may interfere with breastfeeding.

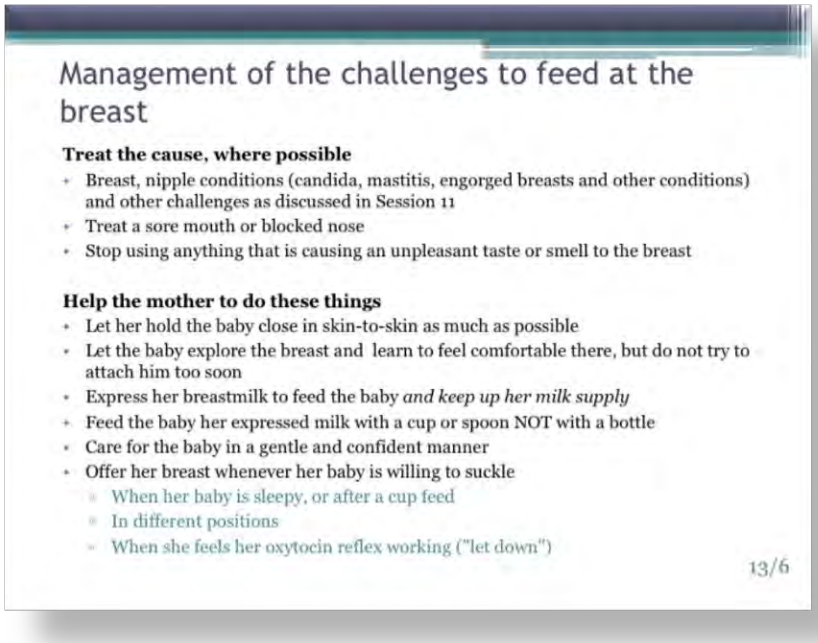
Make one or two suggestions

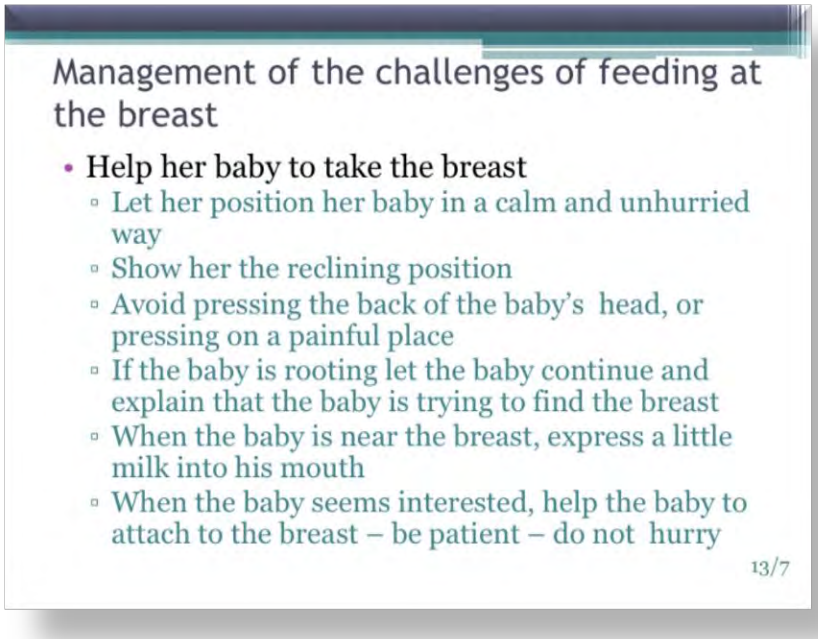
What you suggest depends on what you learned about the cause of the crying. Common causes may be different in different countries.

Give practical help

- Make sure the baby is well attached at the breast. Improving attachment may alter the baby's behaviour.
- Encourage skin-to-skin contact. The warmth, smell, and heartbeat of the mother will help to soothe the baby.
- Make the baby comfortable – dry, clean diaper (nappy), and not too warm or cold.
- Allow the baby to suckle at the breast. The baby may be hungry or thirsty. Sometimes babies want to suck to feel secure. Do not force the baby to the breast. They need to associate the breast with comfort.
- Explain the best way to comfort a crying baby is to hold them close, with gentle movement and gentle pressure on their abdomen.
- Ask someone else such as the father or partner or grandmother to take turns holding the baby sometimes.
- Involve other family members in the discussion so the mother does not feel pressure to give unnecessary supplemental feedings.

Management of the challenges to feed at the breast





Hand expression

- It is important to remember that all mothers should be taught hand-expression, not only those with babies who are unable to breastfeed.
- All health-care workers who care for breastfeeding mothers should be able to teach mothers how to express their milk.
- It is not necessary for the health worker to touch a mother's breasts when teaching hand expression. You can use a breast model to demonstrate to the mother.
- The mother will need to practice before much milk is expressed. Encourage the mother not to give up if she gets little milk or no milk on the first attempt. The amount of milk obtained increases with practise.
- Remind the mother that colostrum is expressed in the first two to four days. Colostrum is thicker than later milk. Because it is thicker, she will notice it does not "spurt or spray" from the breast. The mother will also notice that she expresses about a teaspoon of colostrum at each expression. This is normal and is very valuable to the baby.

- The amount of milk the mother expresses will increase quickly after day two or three and she will find expression easier. The milk will come more quickly and in spurts.
- Expressing should not hurt. If it does hurt, check the techniques listed above with the mother and observe her expressing.

Alternative methods of feeding

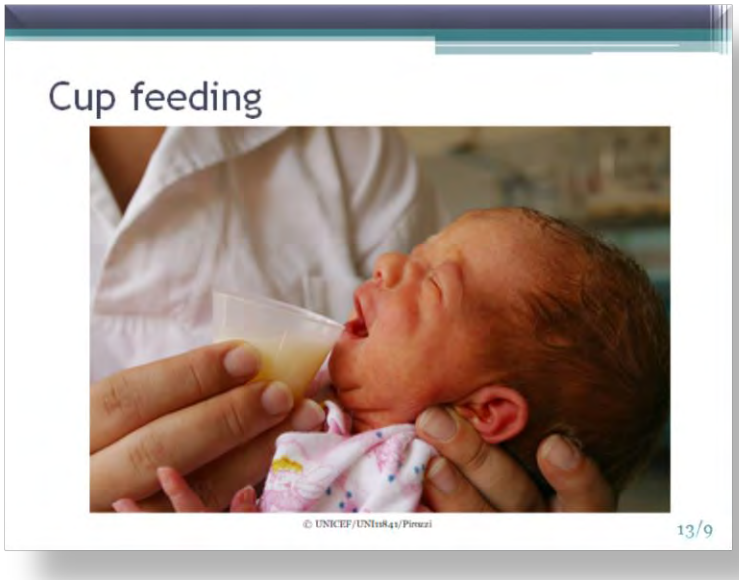
- Tube feeding is needed for babies who cannot suckle and swallow. A baby can progress from tube feeding to alternative methods of feeding to fully feeding at the breast.
- If a baby can swallow, but not suck, a syringe or dropper can be used for very small amounts of milk or colostrum. Place a very small amount (not more than 0.5 mL at a time) in the baby's cheek[26] and let the baby swallow that before giving more.
- With spoon feeding, 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 caregiver or baby may get tired before enough milk is taken. If a large spoon is used, then this is similar to cup feeding.
- A cup and spoon are easy to clean with soap and water.
- Direct expression of milk into the baby's mouth is useful because it can be used by a weak baby. It can be done before the baby can coordinate sucking, swallowing and breathing. It can be done any time by the mother and needs no equipment. It also encourages skin-to-skin contact and breastfeeding. It also does not require the baby to use a lot of energy. Some direct expression can be combined with cup feeding.
- For all the above methods of supplementing, the caregiver decides how much and how fast the baby will drink.
- **"Learning" to feed from a bottle is not necessary in order to transition from other feeding methods to the breast.**
- The World Health Organization does not prohibit the use of feeding bottles, teats or pacifiers for term infants. However, there are a number of reasons for caution about their use including:
  - they can carry bacteria and risk of infection if not cleaned properly.
  - They can lead to increased ear and dental problems.
  - They may cause "nipple confusion" on some babies,
  - if bottles, teats and pacifiers replace suckling at the breast, the breast is less stimulated and milk production may decrease.

Preterm infants

- For preterm infants, the use of feeding bottles and teats is not recommended as it interferes with learning to suckle at the breast. If expressed milk or other feeds are medically indicated, feeding methods such as cups or spoons are preferable to feeding with bottles and teats.
- For preterm infants who are unable to breastfeed directly, non-nutritive suckling (such as with a pacifier) may be beneficial until breastfeeding is established.

[26] 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 is not ready to swallow. Some babies suck the syringe as if it were a 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



- Mothers should be taught how to safely cup feed their babies. They need to be taught the method in a way that gives them confidence to do it themselves. If a mother and baby are separated, teach a family member such as the father or grandmother to cup feed the newborn.

HOW TO FEED A BABY BY CUP

Ask the mother to:

- wash her hands;
- place the estimated amount of milk for one feed into the cup;
- put a cloth on the front of the baby to protect the baby's clothes from spilled milk:
    - wrap the baby in a shawl to restrict arm movement to avoid knocking the cup;
    - hold the baby sitting upright or semi-upright on your lap;
    - hold the cup of milk to the baby's lips;
    - rest the cup lightly on the baby's lower lip;
    - touch the edge of the cup to the outer part of the baby's upper lip;
    - tip the cup so that the milk just reaches the baby's lips;
    - do not pour milk into the baby's mouth – this can cause aspiration;
    - when babies smell breast milk, they become alert, and open their mouth and eyes – they often put their tongue into the milk to start the feed;
    - when a term baby is used to cup feeding, they sip or suck the milk;
    - preterm babies take milk into their mouths with their tongue, using a lapping movement;
    - preterm babies do not dribble as much as older babies because they have less active tongue movements.
- When the baby has had enough, they close their mouth and will not take any more. If the baby has not taken the calculated amount, they may take more next time, or you may need to feed them more often.
- It is normal for babies to take different amounts at each feed. Measure the baby's intake over 24 hours – not just at each feed.

Hand expression

- How can you help this mother put the right amount into the cup for feeding?

© UNICEF/UNI153811/Press

13/10

Let's practise: Written exercises

Read the cases below. Write your answers to the questions in pencil in the space after each case.

EXERCISE 13.A

Mrs B delivered a baby by vacuum extraction yesterday. Her baby has a bruise on her head. When Mrs B tries to feed her, she cries loudly and pulls away. Mrs B is very upset and feels breastfeeding will be too difficult for her. You watch her trying to feed her baby, and you notice that her hand is pressing on the bruise.

1. *Why does Mrs B's baby cry loudly and is unable to feed at the breast?*

2. *What could you say to empathize with Mrs B?*

3. *What praise and relevant information could you give to build Mrs B's confidence?*

4. *What practical help could you give to Mrs B?*

EXERCISE 13.B

Mrs M had her baby boy yesterday. She says she has been trying by herself to put her baby to her breast, but he could not attach well, and now he is having difficulty to feed at the breast. She says she will have to bottle feed.

A nurse has now come to help Mrs M to attach the baby. The nurse puts the baby to face Mrs M's breast. The nurse then holds Mrs M's breast with one hand, and the back of the baby's head with her other hand. The nurse then tries to push the baby onto the breast. The baby pushes his head back and cries.

1. *Why does Mrs M's baby reluctant to feed at the breast?*

2. *What could you say to praise the mother and the nurse?*

3. *What would you suggest the nurse does differently?*

4. *What three things could you suggest that Mrs. M does?*

Notes

Session 14. Medical indications for supplementary feeding

Objectives

After completing this session, participants will be able to:

- list the possible medical indications for supplementation
- explain how to choose an appropriate supplement
- discuss how to support mothers who have decided to feed their babies artificially
- describe the safe preparation of supplements.

Introduction

As discussed in Session 1, The World Health Organization (WHO) and United Nations Children's Fund (UNICEF) recommend infants be exclusively breastfed for the first six months of life. Although this is the goal for all children, sometimes supplements are medically indicated in certain cases.

What is supplementary feeding?

Supplementary feeding is additional fluids, other than the mother's own milk, provided to a breastfed infant before six months of age. These fluids may include donor human milk, infant formula, glucose water or other breast milk substitutes.

What is given in your local community?

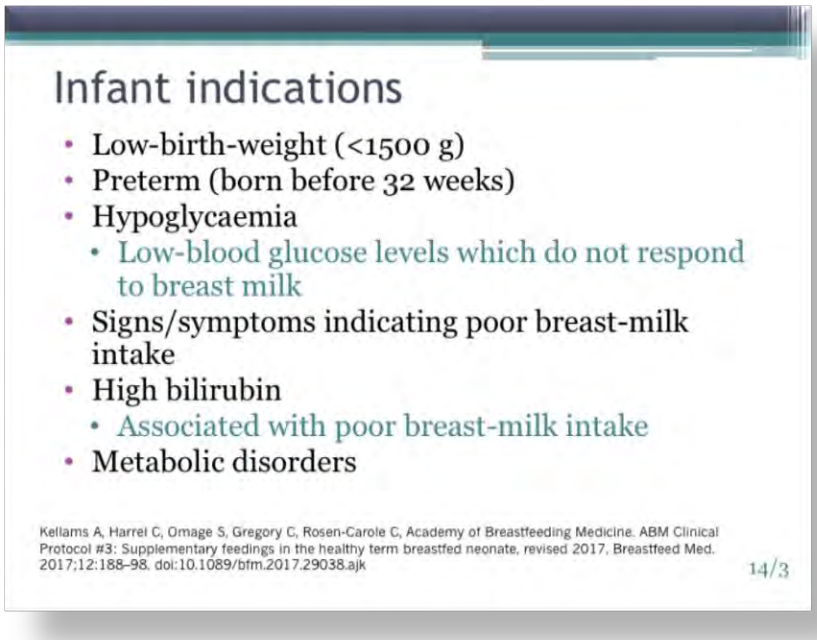
- **Giving newborns any foods or fluids other than mother's own milk interferes with establishing and continuing breastfeeding.** As we have learned, newborn stomachs are small and easily filled. Newborns who are fed other foods or fluids will suckle less at the breast. This will interfere with stimulating breast milk production. This could result in breastfeeding failure due to the cycle of poor breast milk production and supplementation.

- Babies who are given supplementation before discharge from a facility are twice as likely to stop breastfeeding altogether in the first six weeks of life[27]. Supplementation may also contain harmful bacteria and carry a risk of disease. **Therefore, infants should only receive supplementation if there is a medical indication.**

[27] DiGirolamo AM, Grummer-Strawn LM, Fein SB. Effect of maternity-care practices on breastfeeding. Pediatrics. 2008;122(Suppl. 2):S43–9. doi:10.1542/peds.2008-1315e

Medical indications for supplementation

We will now discuss the medical indications for supplementation, for conditions in both the infant and mother.



Infant indications

Infants may need supplementation for a limited time due to medical conditions. This is usually only temporary, until they can feed at the breast.

Low-birth-weight or preterm infants

Low-birthweight (<1500 g) or preterm (born before 32 weeks) infants may require supplementation. These babies may be weak and tire easily at the breast. They may also lack the ability or the reflexes to swallow and suckle effectively. Supplementation may be necessary until they are able to feed at the breast. If possible, they should be encouraged to suckle at the breast.

Hypoglycaemia

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. **Full-term, healthy babies do not develop hypoglycaemias simply through under-feeding.** If a healthy full-term breastfeeding baby develops signs of hypoglycaemia, the baby should be investigated for another underlying problem. However, if an infant's blood sugar does not respond to breastfeeding or breast milk, they may require supplementation. Supplementary feeding is not needed to prevent low-blood sugar in healthy, term babies.

Jaundice

It is common for babies to have jaundice, a yellow colour to their skin in the first week of life. This is 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 which removes excess bilirubin from the body. A baby who is breastfeeding well and whose bilirubin levels are within a normal range should not require supplementation. Babies who are jaundiced may need phototherapy because the mother's breast milk has not increased. However, a baby who has high-bilirubin levels associated with poor breast milk intake may need supplementary feeding.

Poor intake

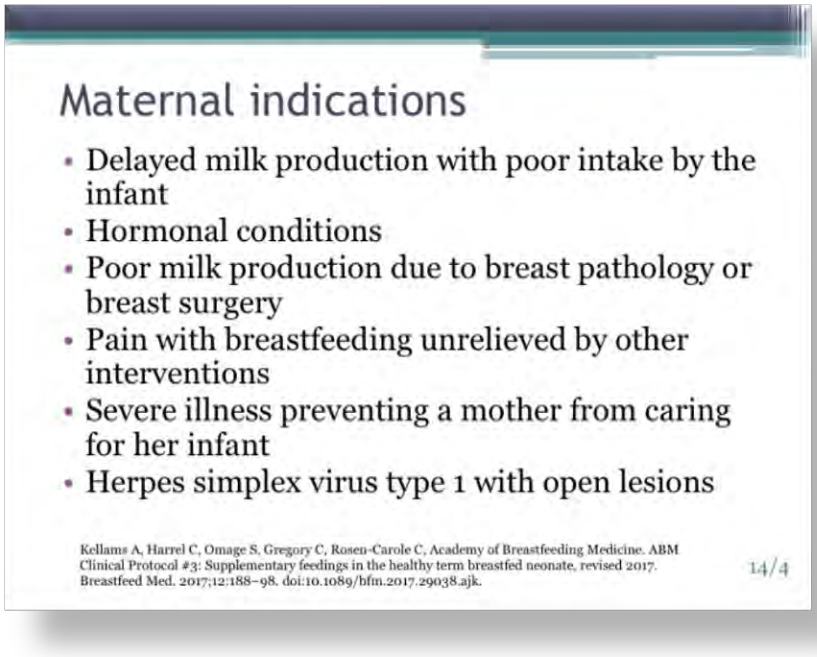
An infant showing signs and symptoms of poor breast milk intake may require supplementation. However, they must be assessed to determine the cause of poor breast milk intake.

These signs and symptoms include the following.

- **Significant dehydration**. If a baby has signs and symptoms of dehydration, then temporary supplementation maybe needed. Healthy exclusively breastfed infants do not require additional fluids or supplements to prevent dehydration. Babies with diarrhoea should be breastfed more frequently. Frequent breastfeeding provides fluid, nutrients, and provides protective factors.
- **Weight loss** of greater than or equal to 8–10% by day five or weight loss greater than 75% percentile for age. An infant should regain their birth weight by two weeks.
- **Delayed bowel movements, fewer than four stools on day four of life, or continued meconium stools on day five**.
- **Metabolic disorders**. For infants with metabolic disorders such as phenylketonuria (PKU), breastfeeding may be contraindicated. However, some of these infants may require specialized supplementary feeding in addition to breast milk.

Maternal indications

There are also maternal indications for supplementary feeding.



1) Delayed milk production
As we have already learned in previous sessions, a mother's milk typically increases by day three. Sometimes a mother's milk production may be delayed. If it is delayed by day three to five or later and the infant is showing signs of poor milk intake, the infant may need supplementary feeding.

2) Glandular conditions
Glandular conditions of the breasts or problems with the milk making glands can sometimes cause poor milk production. Poor milk production can also be related to breast pathology or a prior breast surgery. These conditions may require supplementary feeding if the maternal milk supply is not enough.

3) Pain with breastfeeding
A mother may have intolerable pain during breastfeeding that is unrelieved with other interventions. If positioning and attachment at the breast are correct, supplementation may be necessary until a cause or solution is found.

4) Maternal illness
A mother may have a severe illness, such as sepsis, preventing her from caring for her infant. Depending on the severity of her illness, she may be able to express breast milk for her infant.

5) Herpes simplex virus (type 1)
If a mother has herpes simplex virus (type 1) with open lesions on her breast or nipples, the infant may require supplementation. There should not be direct contact between the mother's breasts and the infant's mouth until the open lesions have healed. If it is only on one breast, the mother should feed from the unaffected side.

Special cases
In few cases, an infant will not only require additional fluids, but will require breast-milk substitutes in place of all breast milk. These situations include:

- a mother may be away from her baby for whatever reason or she may have died.
- some maternal medications such as chemotherapy require a mother to temporarily stop breastfeeding during therapy.
- if a mother living with HIV[28] will not exclusively breastfeed (either due to the national health authority policy or she decides not to for her own reasons), this is an acceptable medical reason for breast-milk substitutes.

NOTE: The WHO/UNICEF document, "*Acceptable medical reasons for use of breast-milk substitutes"* describes the few conditions for which breastfeeding is contraindicated[29].

When supplementary feeding is medically necessary, the main goals are to feed the infant and to establish or sustain the milk supply. It is also necessary to determine the cause of low-milk supply, poor feeding, or inadequate milk transfer.

Supplementation should be performed in ways to preserve breastfeeding including:

- limiting the volume to what is necessary
- stimulating the mother's breasts with hand expression or pumping
- allowing the infant to continue to practice at the breast.

Infants with medical conditions that do not permit exclusive breastfeeding need to be seen and followed-up by a trained health worker. These infants need individualized feeding plans and the mother and family need to be clear how to feed their baby. A clinical situation should be assessed on an individual basis. A decision should be made by a qualified health professional whether supplementation is indicated or not.

Common clinical situations where supplementary feeds are given

There are common clinical situations where supplementary feeds are often given, even if they are not medically indicated. These include the following.

- Cluster feeding[30]: This is a normal newborn behaviour and does not require supplementation.

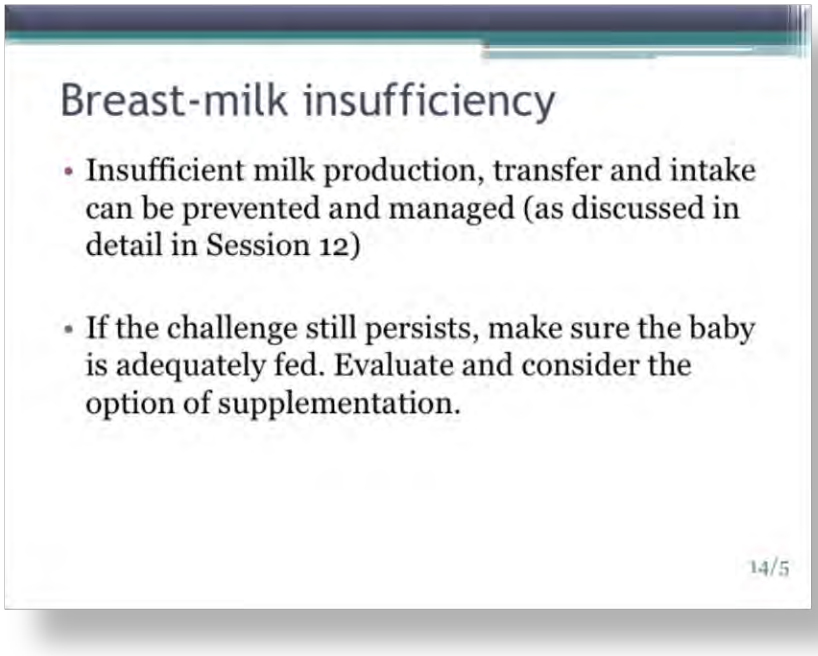
[28] Even when ARV drugs are not available, mothers should be counselled to exclusively breastfeed in the first six months of life and continue breastfeeding thereafter, unless the national authority does not support breastfeeding for women living with HIV.

[29] WHO/UNICEF. Acceptable medical reasons for use of breast-milk substitutes. Geneva: World Health Organization; 2009 (http://apps.who.int/iris/bitstream/10665/69938/1/WHO_FCH_CAH_09.01_eng.pdf , accessed 8 April 2020).

[30] Cluster feeding is when the baby has several short feeds at the breast close together.

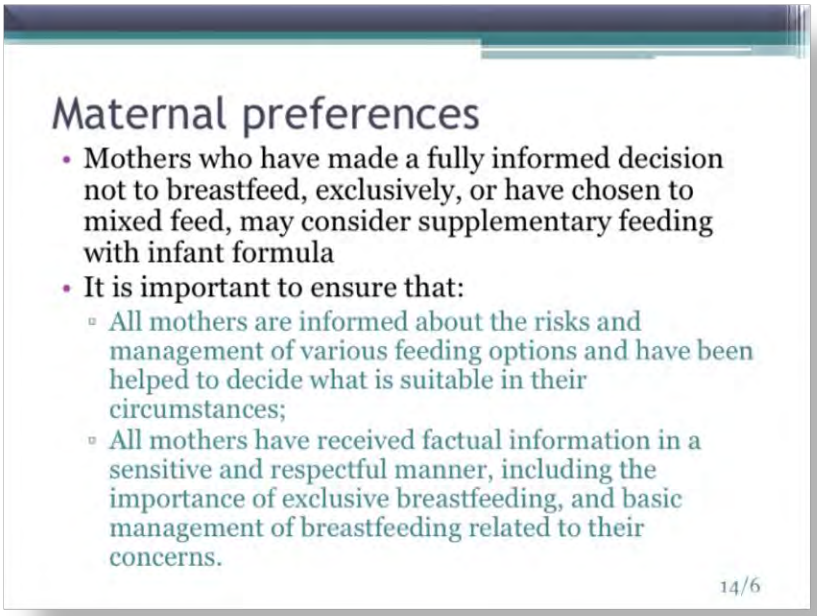
- The mother is tired after giving birth: Giving the baby supplementation to allow the mother to sleep rather than breastfeed discourages responsive feeding and exclusive breastfeeding.
- Perceived low supply: A mother or health worker may think the maternal milk supply is inadequate. Unless an infant shows signs and symptoms of poor milk intake, supplementation is not necessary. A full assessment of the mother, infant and breastfeeding must be done to determine if supplementation is needed.
- Sick or low-birth-weight babies: This may require supplementation. Examples include prevention of hypoglycaemia or inability to breastfeed. Even for these babies, breast milk is usually the best kind of feed to give.
- Supplementation: This is sometimes given to prevent dehydration, hypoglycaemia, and jaundice. However, as we discussed earlier in the session, this is not necessary for healthy, term babies.

Breast milk insufficiency



This has been discussed in detail in SESSION 12. MILK SUPPLY CHALLENGES.

Maternal preferences



Mother's choice

- All mothers should be discouraged from giving any food or fluids other than breast milk, unless medically indicated. However, some mothers choose not to breast feed at all, while some mothers choose "mixed feeding"[31].
- All mothers who choose not to exclusively breast feed should be counselled on the importance of exclusive breastfeeding. The health worker should:
  - listen to the mother's reasons for not breastfeeding exclusively and reflect back to her to confirm that she understands her concerns and the circumstances for her choosing mixed-feeding;
  - provide factual information in a sensitive and respectful manner, including the importance of exclusive breastfeeding, and basic management of breastfeeding related to her concerns.
- If, after listening to the information, the mother still chooses not to breastfeed exclusively, feeding with breast-milk substitutes will be necessary.
- After counselling and support, some mothers may choose to feed their babies with infant formula or breast-milk substitutes. It is important to provide support and education to these mothers to minimize the risks of doing so.
- The health worker should discuss the various feeding options with the mother and help her to decide on the most suitable option. Women who choose mixed feeding should also be counselled on establishing a milk supply and ensuring the infant is able to suckle and transfer milk from the breast. Supplementation can also be introduced at a later time, if the mother chooses.

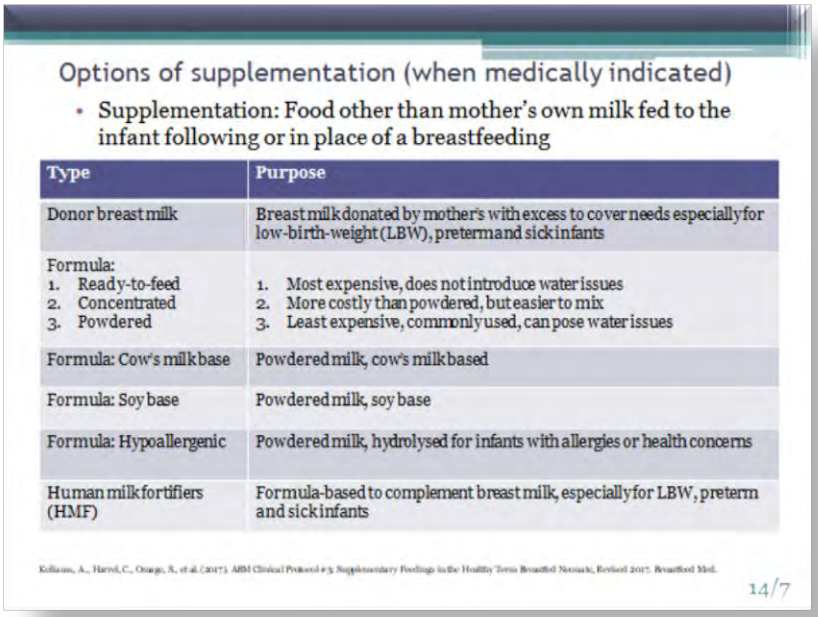
Practices that help avoid the need for supplementation

The need for supplementation can be prevented by implementing practices such as the following.

- Early skin-to-skin contact. This helps to establish breastfeeding.
- Early and frequent breastfeeding. Delaying the time between birth and initiation of breastfeeding can lead to the need for supplementation.
- Rooming-in so that responsive feeding can be practised.

[31] Mixed feeding is a combination of breastfeeding and feeding with breast-milk substitutes.

Options of supplementation



Options of supplementation (when medically indicated)

- Supplementation: Food other than mother's own milk fed to the infant following or in place of a breastfeeding

Type	Purpose
Donor breast milk	Breast milk donated by mother's with excess to cover needs especially for low-birth-weight (LBW), preterm and sick infants
Formula: 1. Ready-to-feed 2. Concentrated 3. Powdered	1. Most expensive, does not introduce water issues 2. More costly than powdered, but easier to mix 3. Least expensive, commonly used, can pose water issues
Formula: Cow's milk base	Powdered milk, cow's milk based
Formula: Soy base	Powdered milk, soy base
Formula: Hypoallergenic	Powdered milk, hydrolysed for infants with allergies or health concerns
Human milk fortifiers (HMF)	Formula-based to complement breast milk, especially for LBW, preterm and sick infants

14/7

- **Giving newborns any foods or fluids other than mother's own milk interferes with establishing and continuing breastfeeding.** As we have learned, newborn stomachs are small and easily filled. Newborns who are fed other foods or fluids will suckle less at the breast. This will interfere with stimulating breast milk production. This could result in breastfeeding failure due to the cycle of poor breast milk production and supplementation.

- Babies who are given supplementation before discharge from a facility are twice as likely to stop breastfeeding altogether in the first six weeks of life[32]. Supplementation may also contain harmful bacteria and carry a risk of disease. **Therefore, infants should only receive supplementation if there is a medical indication or reason as discussed earlier.**

[32] DiGirolamo AM, Grummer-Strawn LM, Fein SB. Effect of maternity-care practices on breastfeeding. Pediatrics. 2008;122(Suppl. 2):S43–9. doi:10.1542/peds.2008-1315e

Guidelines for choosing a supplement

If supplementation is medically indicated, please choose an appropriate supplement. In most cases, supplementation is temporary until the newborn can breastfeed and/or the mother is available and able to breastfeed.

Expressed milk

If an infant requires extra feeding, give **expressed breast milk from the infant's mother.**

However, if the mother's breast milk or colostrum does not meet the infant's needs, supplementation may be required.

Donor milk

If supplementary feeding is indicated, donor breast milk should be the first choice of supplement, if available. Some areas have milk banks where donor milk is available for infants who cannot be fed their mother's own milk or who need to be supplemented.

Infant formula

If donor human milk is unavailable or culturally unacceptable, **breast-milk substitutes** in the form of commercially prepared infant formula are necessary. The type of infant formula will depend on the needs of the infant:

- low-birth-weight or preterm infants require specific formulas designed for their needs;
- infants with certain metabolic disorders may require specialized formula in addition to breastmilk.

Glucose water is not an appropriate supplement since it does not provide adequate nutrition.

For some conditions, breastfeeding or breast milk is contraindicated. In these cases, full replacement of breast milk with breast-milk substitutes is necessary.

Safe preparation and storage of supplements

Mothers who are not breastfeeding, as well as mothers who are supplementing with a breast-milk substitute, must be taught about safe preparation and storage of breast-milk substitutes. Like all mothers, it is important that they understand their baby's feeding cues, and how to respond.

The risk of illness is increased when supplements are handled or stored incorrectly. This is even more important for preterm, low-birth-weight or immuno-compromised infants. All equipment used for feeding infants and for preparing supplements need to be thoroughly cleaned and sterilized before use. Surfaces where supplements are prepared should be cleaned and disinfected. The person preparing the feed should wash their hands with soap and water prior to preparation.

If infant formula is to be used for infants at greatest risk, use a sterile ready-to-feed liquid, if possible. Its use may not always be possible, and powdered infant formula may be required.

Powdered breast-milk substitutes are not sterile and can pose further risks to infants.

- Powdered infant formula requires hot water to be added. All water used for making infant formula needs to be brought to a full boil. Tap water and bottled water are not sterile and must be boiled before use. Powdered infant formula is also not sterile and must be mixed with hot water (higher than 70°C) to kill bacteria.
- Allow the water to cool to not less than 70°C. To achieve this temperature, the water should be left for no more than 30 minutes after boiling. The water is then poured into a cleaned and sterilized container to feed the baby.
- The correct proportions of water to formula powder are extremely important for the baby's health.

Cooled unused commercial breast-milk substitutes can be stored in a refrigerator for up to 24 hours, at a temperature no higher than 5 degrees Celsius if prepared in advance. However, it is best to use powdered infant formula immediately as it provides ideal conditions for the growth of bacteria. After a baby is fed, leftover formula should be discarded immediately.

If refrigeration is not available, supplements should be prepared fresh and consumed immediately rather than prepared in advance.

Notes

Session 15. Clinical practice session 2: Building confidence and giving support – assisting with a breastfeed

Objectives

After completing this session, participants will be able to:

- demonstrate appropriate skills for building confidence and giving support when counselling a mother on feeding her infant
- assist a mother to position and attach her baby at the breast.

The following notes are instructions about how to do the practical session. Please read them before the practical session to remind you what to do during the session.

During the practical session

1) You will work in groups of three to four with one trainer.
2) Each person will take turns talking to a mother.
3) The other members of the group will observe.

You will need

- Two copies of the JOB AID: BREASTFEEDING SESSION OBSERVATION.
- One copy of the CHECKLIST: COUNSELLING SKILLS.
- Pencil and paper.

Please leave your books or manuals in the classroom.

Preparation

We will spend time today preparing for the clinical practice in the maternity wards. Remember the goal is for each health worker to practise with a mother/parent/caregiver and their baby. Each clinical practice session will have different goals. So, please be attentive during the preparation time and allow your trainer to assist you.

Counsellor

1) Introduce yourself to the mother and ask permission to talk to her.
2) Introduce the group and explain that you are interested in infant feeding.
3) Ask the mother if you may observe how her baby is feeding.
4) Try to find a chair or stool to sit on. If necessary, and if allowed in the facility, sit on the bed.

If the baby is feeding

1) Ask the mother to continue as she is doing.
2) Ask the mother's permission for the group to watch the feed.
3) Remember: before making any suggestions, observe the breastfeeding session.

If the baby is not feeding

1) Ask the mother to give a feed in her usual way at when the baby seems ready.
2) If baby is not feeding, you can ask mother open-ended questions about her experience.

Practise the six skills for building confidence and giving support. In particular, try to do these things:

- praise two things the mother and baby are doing well
- give the mother two pieces of relevant information useful to her now.

Help a mother to position and attach her baby to her breast, if needed. When you find a mother who needs help positioning her baby at the breast, you can practise assisting the mother while your trainer observes you. Your trainer will help you, if necessary.

Observer

1) Stand quietly in the background.
2) Try to be as quiet as possible.
3) Do not comment, or talk among yourselves.

Make general observations of the mother and baby.

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.
For example: Who does most of the talking? Does the mother talk freely, and seem to enjoy it?

Make specific observations of the participant's (the counsellor) counselling skills. Mark a ✓ on your **CHECKLIST: COUNSELLING SKILLS** when the counsellor uses a skill, to help you remember for the discussion.

When a mother and her baby breastfeed, observe the feed using the **JOB AID: BREASTFEEDING SESSION OBSERVATION** and put ticks in the boxes.

Thank the mother for her time and say something to praise and support her.

When you have finished helping a mother, if discussion with your trainer is needed, move away from the mother.

COMMON MISTAKES

1) Do not say you are interested in breastfeeding
The mother's behaviour may change. She may feel judged and not feel free to talk about formula feeding. You should say you are interested in "infant feeding" or in "how babies feed".

2) Do not give a mother help or advice
In Practical session 2 when a mother needs help, you should inform your trainer and a member of staff from the ward or clinic. You then practise helping the mother and baby while they observe, and they can guide you, and, if necessary, give you feedback on how you did.

3) Do not allow the forms (JOB AID) to become a barrier
The participant who has the counsellor's role should not make notes while talking. They may refer to the forms to remind themselves what to do, but they should only write afterwards. The participants who are observing can make notes.

4) Do not ask a mother if you may observe how she is breastfeeding.
The statement may make the mother feel evaluated or judged. Instead, you can ask if you can observe how her baby is feeding.

.

CHECKLIST: COUNSELLING SKILLS

Name of counsellor: _____

Name of observer: _____

Date of visit: _____

(√ for Yes and × for No)

Did the counsellor

Use listening and learning skills

- ❑ Keep the head level with mother/parent/caregiver?
- ❑ Pay attention (eye contact)?
- ❑ Remove barriers (tables and notes)?
- ❑ Take time? Allow the mother/parent/caregiver time to talk?
- ❑ Use appropriate touch?
- ❑ Ask open questions?
- ❑ Use responses and gestures that showed interest?
- ❑ Reflect back what the mother/parent/caregiver said?
- ❑ Empathize – showing that he or she understood how the mother/parent/caregiver feels?
- ❑ Avoid using words that sound judging?

Use skills for building confidence and giving support

- ❑ Accept what the mother/parent/caregiver thinks and feels?
- ❑ Recognize and praise what the mother/parent/caregiver and baby are doing well?
- ❑ Give practical help?
- ❑ Give a little, relevant information?
- ❑ Use simple language?
- ❑ Make one or two suggestions, not commands?

COUNSELLING SKILLS

Listening and learning skills

- Use helpful non-verbal communication
- Ask open questions
- Use responses and gestures showing interest
- Reflect back what the mother/parent/caregiver says
- Empathize – show you understand how the mother/parent/caregiver feels
- Avoid using judging words

Building confidence and giving support skills

- Accept what a mother/parent/caregiver thinks and feels
- Recognize and praise what a mother/parent/caregiver and baby are doing well
- Give practical help
- Give specific, relevant information
- Use simple language
- Make one or two suggestions, not commands

JOB AID: BREASTFEEDING SESSION OBSERVATION

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	☐ Breast held with fingers on areola
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 to nipple	☐ Baby approaches breast, lower lip/chin
BABY'S ATTACHMENT	
☐ More areola seen above baby's top lip	☐ More areola seen below bottom lip
☐ Baby's mouth wide open	☐ 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

Module 3. Breastfeeding support

Session 16. Maternal health

Objectives

After completing this session, participants will be able to:

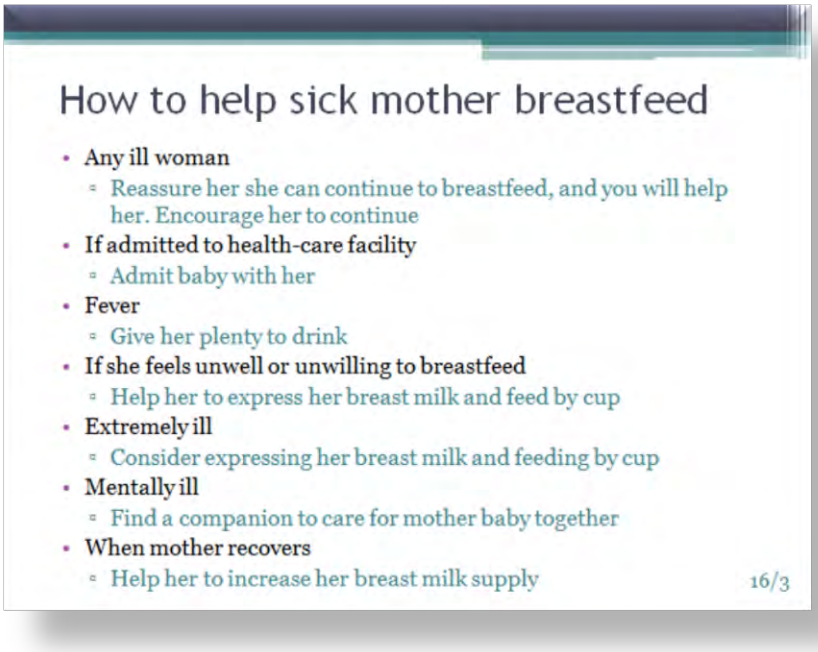
- help a mother who is too ill to continue breastfeeding
- describe how to help a mother who is taking medications while breastfeeding

Introduction

When helping a mother breastfeed, health-care workers must also remember her health. Health-care workers must care for both the mother and the baby.

A mother may have many concerns and questions. If she is ill, you can support her so that she can continue breastfeeding. She may be concerned about whether her illness or the drugs she is taking can affect her baby. In this session, we will discuss these situations, so you are better prepared to counsel women during this time.

Helping a mother who is too ill to breastfeed



For many reasons, a woman may have tried to stop breastfeeding when she is ill. She may fear her baby will catch the illness. Someone may have advised her to stop, or she may be admitted to hospital and separated from her baby. However, it is rarely necessary for an ill mother to stop breastfeeding. With most common infections, breastfeeding does not increase the chance of the baby becoming ill. Antibodies in breast milk are the best protection for the baby.

TB or leprosy

It is no longer considered necessary to separate mothers with tuberculosis (TB) or leprosy from their infants. If necessary, treat both mother and baby together. The main difficulty arises when a mother is so sick it is difficult for her to care for her baby.

Helping an ill mother to breastfeed

When you treat a woman who is ill, reassure her that she can continue to breastfeed and that you will help her. Also, offer her support and encouragement during this time. If a mother is ill in the hospital, keep her baby with her so she can continue to breastfeed. If she has a fever, encourage her to drink fluids. This will prevent her breast milk from decreasing because of dehydration.

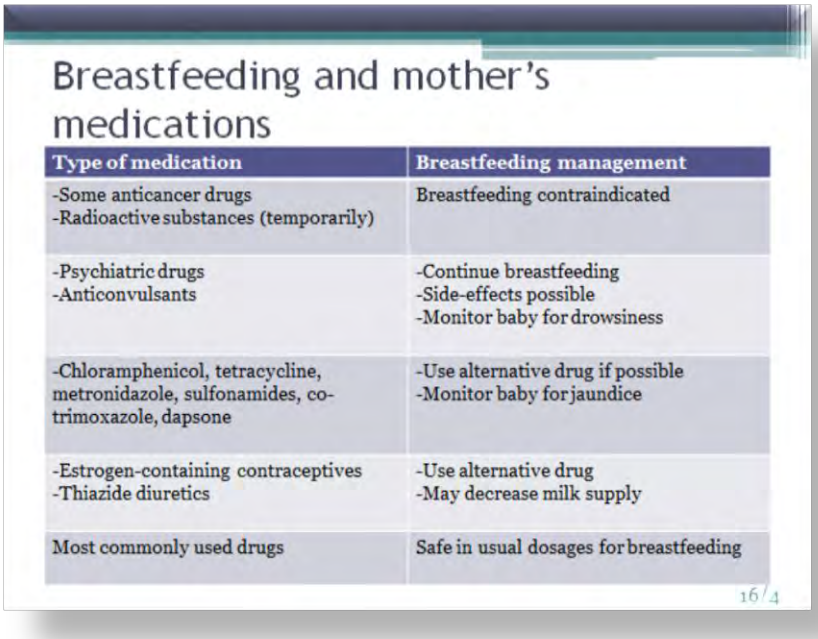
Expressing milk when ill

If she is unwilling to breastfeed or feels too unwell, suggest that she express her breast milk. Help her to express her milk as often as her baby would feed (about every three hours) or as often as possible This will help to establish or keep up the milk supply, and keep her breasts healthy, even if she cannot express enough to completely feed the baby. The expressed breast milk can be fed to the baby.

Mental illness

If the mother has a mental illness, try to keep the baby with her and care for them together. Let the mother breastfeed if she can. If possible, find a support person who can stay with her to make sure she does not neglect or injure her baby. When the mother is well again, help her to increase her breast milk or re-lactate, if necessary.

Breastfeeding and maternal medications



If a mother requires medication, it is often possible for the health-care provider to prescribe a drug which may be safely taken during breastfeeding. Most drugs pass into breast milk only in small amounts and few affect the baby. In most cases, to stop breastfeeding is likely to be more dangerous than the medicine. Therefore, health workers should be aware of safe medications during breastfeeding.

There are a few medications which cause side effects. Please ask the health-care provider to give the mother an alternative, less likely to cause a problem. It is rarely necessary to stop breastfeeding because of a mother's medication. If the baby is premature or less than two months old, a medication the mother takes is more likely to affect the baby. If there is a concern, please explore other possibilities more compatible with breastfeeding.

In a very few situations, breastfeeding is contraindicated. If the mother is taking anticancer drugs, it may be necessary to stop breastfeeding temporarily if she is being treated with radioactive substances. These drugs are not used commonly.

A few drugs can cause side effects which sometimes make it necessary to stop breastfeeding. If a mother is taking psychiatric drugs or anticonvulsants, these drugs may make her breastfed baby drowsy or weak and unwilling to suckle. Sometimes, it is possible to change to an alternative drug less likely to affect the baby. However, it can be dangerous to change a mother's treatment quickly, especially for conditions such as epilepsy.

If there is no alternative, continue breastfeeding and observe the baby. If side effects occur, it may be necessary to stop breastfeeding.

Most commonly used medicines are safe in the usual dosage.

Most antibiotics given to a breastfeeding mother are safe for her baby. However, some antibiotics should be avoided, if possible. Please check with a health-care provider.

If a breastfeeding mother is taking a drug you are not sure about:

- Check the WHO list of essential drugs: *Breastfeeding and maternal medication: recommendations for drugs in the eleventh WHO model list of essential drugs.* This can be found on the WHO website.
- Check whether the drug is used for treating infants – if so, it is probably safe with breastfeeding.
- Encourage the mother to continue to breastfeed while you try to find out more.
- Watch the baby for side-effects. These include abnormal sleepiness, unwillingness to feed and jaundice.
- Ask the advice of a specialized health worker, for example, a pharmacist.
- If possible, try to find an alternative drug you know is safe.
- If the baby has side effects and the mother's medication cannot be changed, consider donor human milk or a breast-milk substitute, temporarily, if possible.

Traditional treatment

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. Encourage the mother to continue breastfeeding and to observe the baby for side effects.

Drugs that may decrease the supply of breast milk should be avoided if possible. Avoid using contraceptives containing oestrogens and certain diuretics.

Notes

Session 17. Antenatal preparation for breastfeeding

Objectives

After completing this session, participants will be able to:

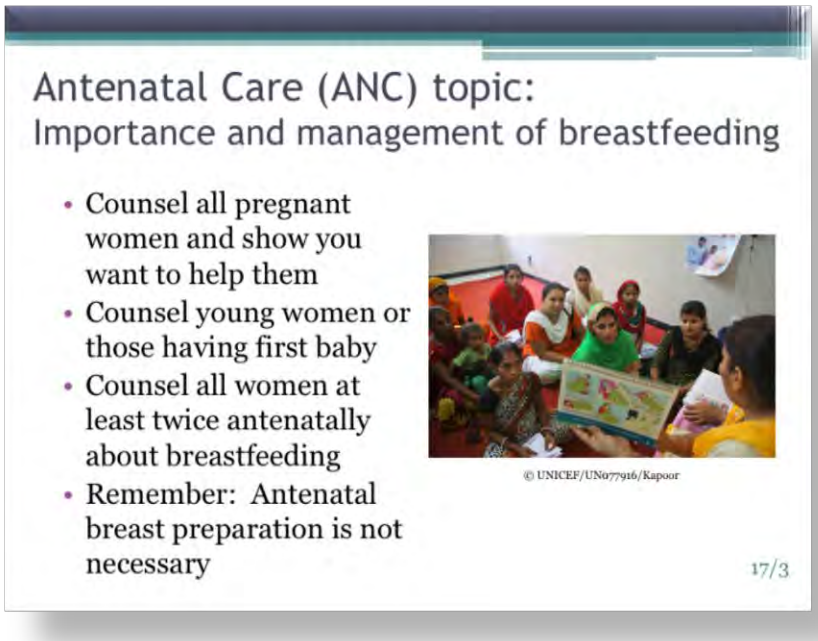
- outline information to be discussed with pregnant women
- explain the difference between individual and group antenatal sessions
- practise counselling skills to discuss breastfeeding with a pregnant woman

Introduction

Pregnancy is a key time to discuss with women about the importance and management of breastfeeding. As a health worker, you should ask women about their plan to feed their baby. You should show your support of breastfeeding and willingness to help. Remind them that this is their choice, so you will not be critical if they choose to not breastfeed. Talk to all pregnant women about how they will feed their babies.

Women who are having their first baby need special encouragement and support. During antenatal appointments, discuss practical management and answer questions. Depending on your context, some women have less antenatal care. If this is the case, discuss feeding options at her first visit.

Use this time to discuss the woman's knowledge, beliefs and feelings about breastfeeding. These sessions can help increase a woman's confidence to breastfeed. Through these conversations, you can identify who may need extra support.



Antenatal preparation for breastfeeding

In some cultures, women are expected to prepare their breasts for breastfeeding. These practices may include massage, stretching or "toughening" the nipples, wearing breast shells, or applying special creams. We now know these techniques are not effective, and it is not necessary to recommend them.

ANTENATAL PREPARATION FOR BREASTFEEDING

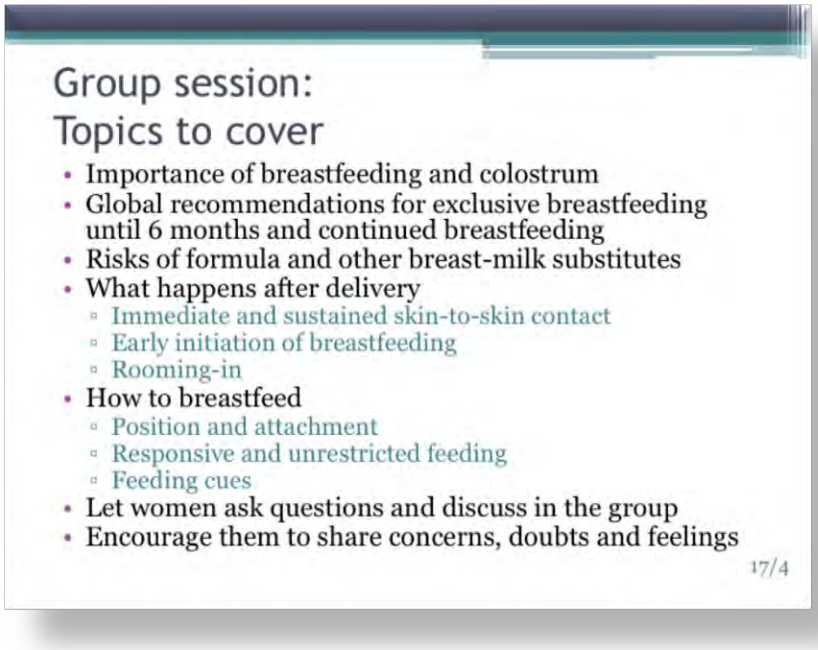
With mothers in groups

- Explain the benefits of breastfeeding, especially exclusive breastfeeding.
- Most mothers decide how they are going to feed their babies a long time before they have the child – often before they become pregnant. If a mother has decided to use breast-milk substitutes, she may not change her mind. But you may help mothers who are undecided and give confidence to others who intend to breastfeed. You may encourage a mother to breastfeed exclusively instead of partially.
- Talk about early initiation of breastfeeding and what happens after delivery; explain about the first breastfeeds, and the practices in the hospital, so that they know what to expect.
- Give simple relevant information on how to breastfeed, e.g. responsive feeding and positioning a baby.
- Discuss mothers' questions.
- Let the mothers decide what they would like to know more about. For example, some of them may worry about the effect that breastfeeding may have on their figures. It may help them to discuss these worries together.

With each mother individually

- Ask about previous breastfeeding experience.
- If the mother breastfed successfully, she is likely to do so again. If she had difficulties, or if she formula fed, listen to her story and empathize with her. Give her relevant information to help build her confidence in breastfeeding. Explain how she could succeed with breastfeeding this time. Reassure her that you will help her.
- Ask whether she has any questions or worries.
- Examine her breasts only if she is worried about them. Give her positive feedback if you examine her breasts.
- She may be worried about the size of her breast or the shape of her nipples. It is not essential to examine breasts as a routine if she is not worried about them.
- Build her confidence and explain that you will help her.
- Mostly you will be able to reassure that her breasts are alright, and that her baby will be able to breastfeed. Explain that you or another counsellor will help her.

NOTE: Antenatal education should not include group education on formula preparation.



Group sessions for pregnant women

Please find important topics to discuss with a group of pregnant women, in an antenatal or health-education class.

Other topics may be discussed with women on a one-on-one basis. Whereas, some topics may be easier to discuss in a group with peers rather than individually with a health worker.

The information included in a class depends on local breastfeeding practices and common difficulties.

Main points to remember

- Explain the importance of breastfeeding and colostrum. Explain the mother's first milk, colostrum, arrives before the baby is born. Women should understand that colostrum is the baby's first milk.
- Please explain the global recommendations: exclusive breastfeeding for six months and continued breastfeeding for up to two years and beyond.
- Pregnancy is a key time to discuss with women about the importance and management of breastfeeding. As a health worker, you should ask women about their plan to feed their babies. You should show your support of breastfeeding and willingness to help. Remind them that is their choice, so you will not be critical if they choose to not breastfeed. Explain the risks of giving formula and other breast-milk substitutes. Reassure them that breast milk is all that their baby needs for the first six months.
- Discuss what happens after the delivery. Explain the hospital practices so they know what to expect:
  - immediate and sustained skin-to-skin contact
  - early initiation of breastfeeding
  - rooming-in.
- Using demonstrations, give simple relevant information on how to breastfeed.
- Demonstrate positions and attachments of the baby, using a baby doll.
- Describe responsive and unrestricted breastfeeding, which can ensure a good supply of breast milk.
- Explain about a baby's feeding cues.

Encourage women to share their concerns, doubts, and feelings. Pregnant women in the group who have breastfed before can share their experiences.

Ask mothers whether they have other concerns, or what they would like to know more about. In some communities, women may worry about their body image after birth. Other women have witnessed difficult breastfeeding experiences, so they may have questions regarding challenges.

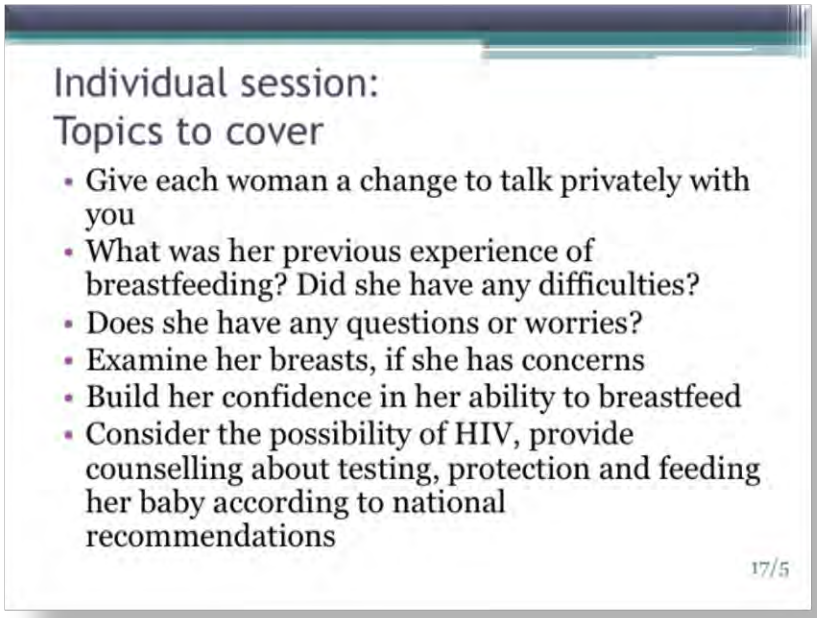
Group sessions provide a space to discuss concerns together. Reassure pregnant women that a health worker will assist them with breastfeeding after the baby is born. Encourage them to ask for help after delivery, if needed.

Before a mother leaves the facility, she should have further information on community resources. It is important to discuss which types of support the mother will have after delivery and at home.

You can also encourage mothers to talk with their health-care provider about mother-friendly labour practices. Certain practices can affect early contact and breastfeeding.

Encourage mothers to have a companion during labour who can stay with them after the baby is born. This support during and after labour can help a woman feel more comfortable and supported.

Discuss interventions, such as sedating pain relief and caesarean section with their care provider before delivery.



Individual sessions with pregnant women

After the group session, please allow each woman to talk with you individually. Ask about her previous feeding experience, if she has had other babies.

Note: If she breastfed successfully before, she is likely breastfeed again. If she had difficulties, explore possible reasons (such as poor advice or negative influence of her friends or relatives). If she gave breast-milk substitutes or formula feeds, explain how she can exclusively breastfeed this time. Reassure her that you will help her.

Address common worries in pregnancy

- Encourage her to tell you if she has any worries or doubts about breastfeeding.
- Examine her breasts, if she is worried about them.
- She may be worried about the size of her breasts or the shape of her nipples.
- It is not necessary to examine breasts as a routine, if she is not worried about them.
- Build her confidence and explain you will help her.
- Remind her, with support, she can have a positive breastfeeding experience. Explain if she wants help, a health worker will help her when she has her baby.

Concerns for HIV infection

- There is a risk of transmission of HIV from mother to baby during pregnancy, birth, and while breastfeeding.
- Therefore, it is important all pregnant women are offered voluntary and confidential HIV counselling and testing.
- Encourage women at risk of HIV to protect themselves from HIV infection during their pregnancy and breastfeeding.
- Pregnant women living with HIV can be counselled according to the national authority's recommendations on infant feeding for women living with HIV.
- If the national authority supports antiretroviral therapy (ART), the woman should receive counselling and support for breastfeeding and ART adherence. She can start antiretroviral treatment as soon as possible and receive information about the medicines the baby needs after birth.
- If the national authority recommends avoiding breastfeeding for all women living with HIV, the pregnant woman should be counselled on safe replacement feeding choices.

An individual discussion is also a good time to determine where a woman may need additional counselling and support. You can 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 family members to help them support the woman.

Special Counselling And Support

A woman may need special counselling and support as follows.

- She had difficulties breastfeeding a previous baby or never started breastfeeding.
- Has family difficulties. Help the woman to identify non-supportive family members and try to meet with them to discuss their concerns.
- Is overweight or obese.
- Is depressed or isolated, without social support.
- Had previous breast surgery or trauma which may interfere with milk production.
- Has an illness or needs medication which may interfere with her pregnancy or breastfeeding.
- Is at high risk of her baby needing special care after birth or had a twin pregnancy.
- Is breastfeeding during pregnancy. Reassure her that she can continue breastfeeding while pregnant and once the new baby arrives. She will feed the newborn first, followed by the older child.
- Similar to all pregnant woman, encourage her to take care of herself, eat well, and rest.
- If she experiences uterine cramping while breastfeeding, she should discuss this with a health worker.

Notes

Session 18. Clinical practice session 3: Antenatal counselling

Objectives

After completing this session, participants will be able to:

- counsel a pregnant woman about breastfeeding and about feeding her baby
- discuss with a pregnant woman practices to establish breastfeeding
- demonstrate counselling skills when talking with a pregnant woman about feeding her infant.

Before the clinical session, please review these notes and the summary. During the practical session, you will work in small groups. Each person will take turns being the counsellor and the observer.

Please bring

- Two copies of the **JOB AID: ANTENATAL CHECKLIST.**
- One copy of the **CHECKLIST: COUNSELLING SKILLS**
- Pencil and paper.

Please leave your books and manuals in the classroom.

Counsellor

1) Introduce yourself to the mother and ask permission to talk to her.
2) Introduce the group and explain that you are interested in infant feeding.
3) Try to find a chair or stool to sit on. If necessary, and if allowed in the facility, sit on the bed.
4) Ask open-ended questions to assess the mother's situation. Ask about her experiences and views on breastfeeding and infant feeding:
   - What are your thoughts on feeding your baby?
   - "What do you know about breastfeeding?
5) Practise using counselling skills: listening and learning, building confidence and giving support.

NOTE: If the woman is knowledgeable about breastfeeding, please reflect her statements and offer her praise.

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 recommended practices. Allow the woman to discuss her concerns and answer her questions. Ask about her previous breastfeeding experiences, and if she has children. Remember to praise what the woman is doing well and offer simple relevant information.

When a pregnant woman shares 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. Provide support and encouragement.

When a pregnant woman discloses that she has chosen mixed feeding, you can ask open questions on what her concerns or reasons are. Listen and reflect back to her to confirm your understanding. Providing information in a sensitive and respectful manner, with support and encouragement.

Use the **JOB AID: ANTENATAL CHECKLIST** to remind you of the important topics to be discussed with a pregnant woman.

When you have finished talking with the pregnant woman, thank her for her time and cooperation. Offer encouragement and support her.

When your conversation is finished, go with your group for a time of discussion.

Observer

1) Stand quietly in the background.
2) Try to be as quiet as possible.
3) Do not comment, or talk among yourselves.

During the conversation, make general observations. Please observe: Who is talking the most? Does the pregnant woman talk freely and seem open?

Make specific observations of the participant's counselling skills. Mark a ✓ on your **CHECKLIST: COUNSELLING SKILLS** to remember for the discussion.

Please thank the mother for her time and offer praise and support.

CHECKLIST: COUNSELLING SKILLS

Name of counsellor: _____

Name of observer: _____

Date of visit: _____

(√ for Yes and × for No)

Did the counsellor

Use listening and learning skills

- ❑ Keep the head level with mother/parent/caregiver?
- ❑ Pay attention (eye contact)?
- ❑ Remove barriers (tables and notes)?
- ❑ Take time? Allow the mother/parent/caregiver time to talk?
- ❑ Use appropriate touch?
- ❑ Ask open questions?
- ❑ Use responses and gestures that showed interest?
- ❑ Reflect back what the mother/parent/caregiver said?
- ❑ Empathize – showing that he or she understood how the mother/parent/caregiver feels?
- ❑ Avoid using words that sound judging?

Use skills for building confidence and giving support

- ❑ Accept what the mother/parent/caregiver thinks and feels?
- ❑ Recognize and praise what the mother/parent/caregiver and baby are doing well?
- ❑ Give practical help?
- ❑ Give a little, relevant information?
- ❑ Use simple language?
- ❑ Make one or two suggestions, not commands?

COUNSELLING SKILLS

Listening and learning skills

- Use helpful non-verbal communication
- Ask open questions
- Use responses and gestures showing interest
- Reflect back what the mother/parent/caregiver says
- Empathize – show you understand how the mother/parent/caregiver feels
- Avoid using judging words

Building confidence and giving support skills

- Accept what a mother/parent/caregiver thinks and feels
- Recognize and praise what a mother/parent/caregiver and baby are doing well
- Give practical help
- Give specific, relevant information
- Use simple language
- Make one or two suggestions, not commands

JOB AID: 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
Listening to mother's ideas, previous experience and anxieties regarding infant feeding			
Importance of exclusive breastfeeding to the baby No other foods or drink needed for the first 6 months – only mother's milk **Importance of continuing breastfeeding after 6 months** while giving other foods (protects against many illnesses; helps baby to grow and develop well; 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)			
Early initiation of breastfeeding (helps establish breastfeeding, baby receives colostrum)			
Importance of good positioning and attachment (good positioning and attachment helps the baby to get milk, and for mother to avoid sore nipples and sore breasts, practice with a doll, help is available from community resources)			
Getting feeding off to a good start - responsive feeding; - knowing when baby is getting enough milk; - importance of rooming-in/keeping baby nearby; - risks of using artificial teats, bottles and pacifiers.			
Risks of not breastfeeding - loss of protection from illness and chronic diseases; - contamination, errors of preparation; - risks of bottles and artificial teats difficulty in reversing the decision not to breastfeed.			

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

Notes

Session 19. Discharge

Objectives

After completing this session, participants will be able to:

- describe how to prepare a mother for discharge
- explain the importance of follow-up care for a new mother and her baby
- identify community resources to support breastfeeding.

Introduction

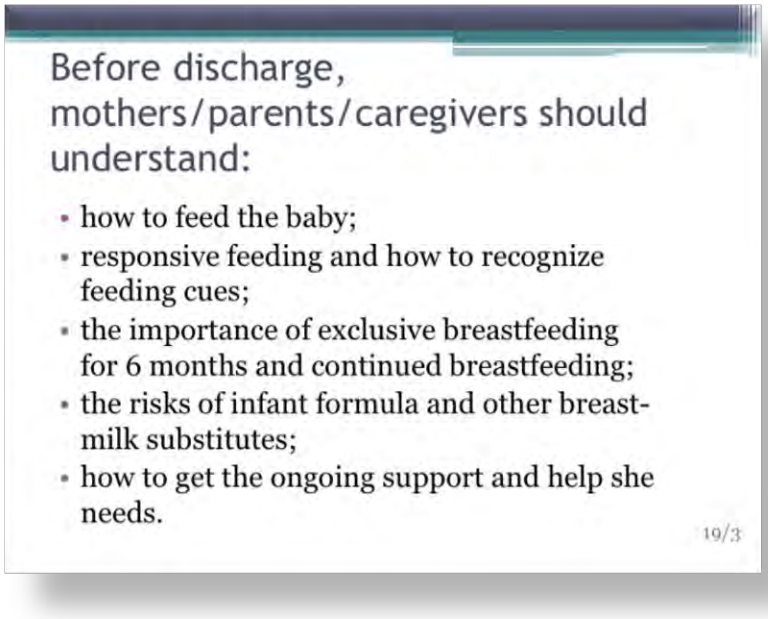
All mothers need support to breastfeed after they are discharged. Research shows the more support a mother has from a health worker or peer counsellor trained in breastfeeding counselling, the more likely she is to continue breastfeeding.

In some communities, many mothers stop breastfeeding exclusively, or they may stop breastfeeding completely after a few weeks or months. Difficulties arise in the first weeks and months, and if there is no support it may lead them to stop breastfeeding. If they have negative family pressure to use supplements or need to return work, these mothers will need extra support.

Mothers/parents/caregivers need preparation for feeding and caring for their newborns prior to being discharged from a facility. After discharge, they need ongoing support to continue breastfeeding.

Discharge preparation

This slide summarizes what is important for a new mother to understand before she is discharged.



Prior to discharge, a trained health worker in breastfeeding support should observe every mother and baby during a

breastfeeding session. This ensures the mothers and babies know how to breastfeed. If a mother is artificially feeding her baby, she also needs to know how to feed her baby.

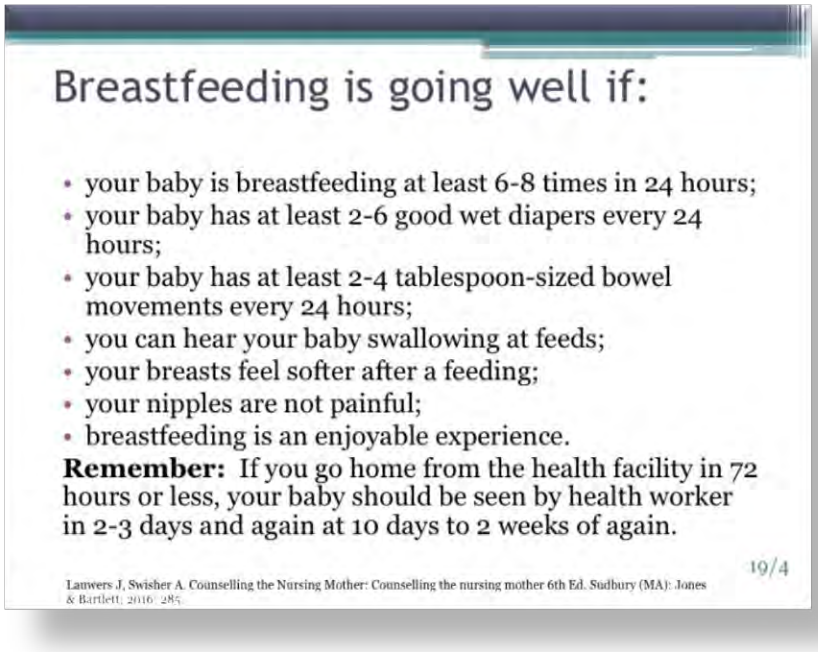
Mothers should be able to recognize feeding cues and feed their babies responsively. It is often helpful to give written materials as a reminder.

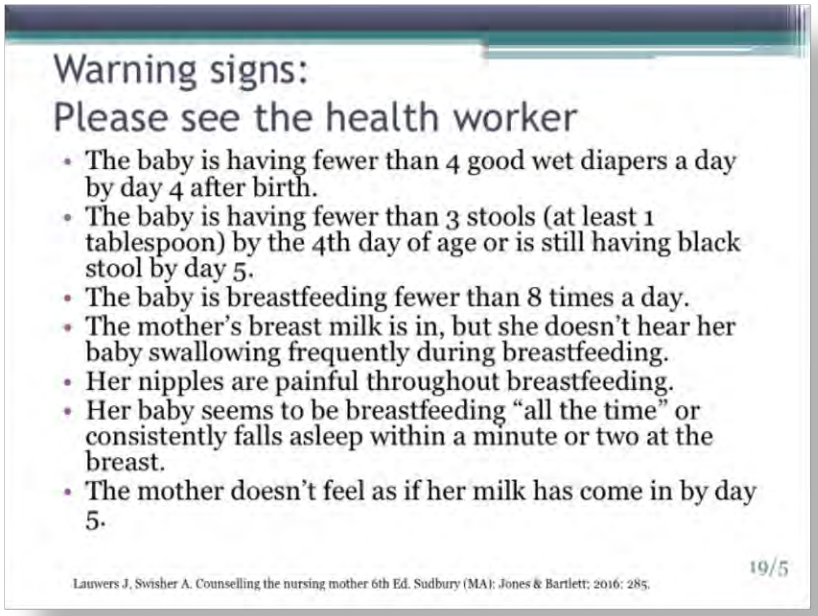
Note: The materials must be accurate, and not from companies who produce or distribute breast-milk substitutes, bottles or teats.

Before a mother/parent/caregiver leaves the facility, remind them of the importance of exclusive breastfeeding for the first six months.

If a mother is discharged before her milk "comes in", provide her with the following information about how her breast milk changes over the first few days after delivery.

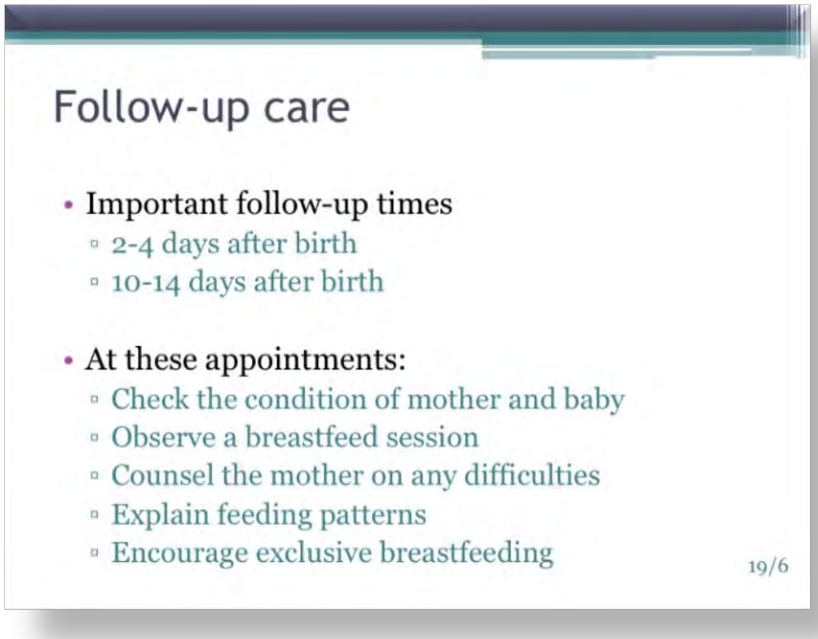
- Day 1–2: Colostrum looks yellow, thick and is only produced in small amounts. If a mother expresses her milk at this time, a small amount (like a teaspoonful) is all that she may get. But this is exactly what the baby needs.
- Day 3–4: The appearance of the milk changes as the quantity increases. The milk looks thinner and whiter; it may even look more watery. This is quite normal. Reassure the mother that her milk continues to be nutritionally complete for her baby.





There may be pressure on a mother once she returns home to supplement her baby's feeds. Remind her of the risks of infant formula and other breast-milk substitutes. Also, once they return home, they sometimes think their baby is not getting enough milk. They should know where to find ongoing breastfeeding support once they are discharged.

Health workers should identify community resources for new mothers to help them continue breastfeeding. This support should be culturally and socially sensitive to each mother's needs. When talking to a woman during her pregnancy, it can be helpful to mention there are community resources available. This may help her to feel confident from the beginning. Mothers with other priorities, such as other children or work, can often find support through community resources.



Follow-up care

Mothers and babies are in a health facility for a limited time. A mother cannot remember everything she has been taught during her stay. Breastfeeding support is especially important in the early days and weeks after discharge. This can help address any early breastfeeding challenges that occur.

A mother's experience will change from day-to-day and week-by-week. She will encounter several different phases in milk production, her infant's growth and her own circumstances. Therefore, she will need additional support during this time. Support should be given to all mothers at specified times. Health workers should not wait until challenges arise or until a mother has completely stopped breastfeeding.

Note: There is evidence that regular scheduled contacts for breastfeeding counselling do increase breastfeeding rates and are better than waiting for problems to arise.

When a new mother is discharged, she should have a scheduled check-up for her and her baby by a health worker. If she has questions or difficulties, she should schedule another follow-up evaluation. A new mother and her baby should be referred for two different appointments.

At least four additional scheduled appointments will be necessary after this time, arranged with the relevant community services, with additional contacts, if necessary.

- Follow-up contact 1: 2-4 days after birth.
- Follow-up contact 2: 10–14 days after birth.

Tell a mother what she can expect at these follow-up appointments and reassure her that they are necessary. They are important to:

- check the condition of the mother and baby
- observe breastfeeding and help with positioning and attachment
- counsel the mother about any challenges
- explain feeding patterns and encourage exclusive breastfeeding.

Health workers can also provide mothers with online or printed information. Please provide key information to the mother and her family on these topics:

- breastfeeding and care of the mother and baby
- a list of abnormal signs in the baby or mother which require help
- clear instructions for her follow-up appointments.

NOTE: While information may be useful for the mother, it should not replace follow-up care for her and her baby.

Community resources for breastfeeding

A new mother may need encouragement from the health worker to look for help and to use the resources and support available. Sometimes a mother thinks she should be able to do everything without needing any help. She may think if she looks for help it will be thought that she is a bad mother. Please encourage all mothers and remind them that to seek support in the beginning is a part of caring for themselves and their baby.

Families and friends are an important source of support for breastfeeding. If possible, discuss with family members about how they can help. However, not all new mothers have family or community support. For example, a woman may be living away from her family. Sometimes support for exclusive breastfeeding is lacking in families where women have always given early supplements and foods. So, it is important for the health worker to assess the support available at home before a women is discharged, and, if possible, talk to the family.

Community support

Providing mothers with community support for breastfeeding is helpful. Each mother should be linked to breastfeeding support resources in their community. Primary health-care centres and community health workers are often nearer to families and may be able to spend more time with them. Community nurses and midwives will make home visits to follow-up with the mother and her baby. Any time a health worker trained in breastfeeding is in contact with a mother and young child, they can help and support the mother in feeding and caring for her baby. If a health worker assesses a more complicated situation, they should refer the mother to an appropriate health care provider.

Skilled lactation support

In some communities, skilled lactation support is provided by various health workers. Trained lactation workers (IBCLC lactation consultants, lactation counsellors, lactation educators, etc.) provide support either through home-based visits, breastfeeding clinic follow-up or classes.

Community groups

Community groups such as mother-to-mother support groups or breastfeeding support groups help new mothers. Health workers can identify existing groups to work with or encourage women to form groups in their community. Phones can also be useful in providing mothers with information or answer their questions or concerns.

Notes

.....

.....

Module 4. Critical management procedures

Session 20. The International Code of Marketing of Breast-milk Substitutes and subsequent relevant World Health Assembly (WHA) resolutions (the Code)

Objectives

After completing this session, participants will be able to:

- explain how manufacturers promote breast-milk substitutes
- outline the major provisions of the International Code of Marketing of Breast-milk Substitutes and subsequent relevant World Health Assembly resolutions (the Code)
- explain the difficulties with donations and samples of breast-milk substitutes milk
- recognize violations of the Code and indicate actions when violations are identified.

Introduction

All manufacturers promote their products and try to persuade people to buy more of them. Manufacturers of breast-milk substitutes also promote their products, to persuade mothers/parents/caregivers to buy more. This promotion undermines the confidence of mothers in their ability to breastfeed. It also idealizes the products through misleading health claims. This harms breastfeeding practices and negatively impacts a mother's perception of the quality of her breast milk.

Breastfeeding must be protected from the effects of promotion of breast-milk substitutes. One essential way to protect breastfeeding is to regulate the promotion of breast-milk substitutes, both internationally and nationally. Individual health facilities and health workers can also protect breastfeeding. They can refuse to allow companies to use them to promote breast-milk substitutes. This is an important responsibility.

Promotion to pregnant women and mothers

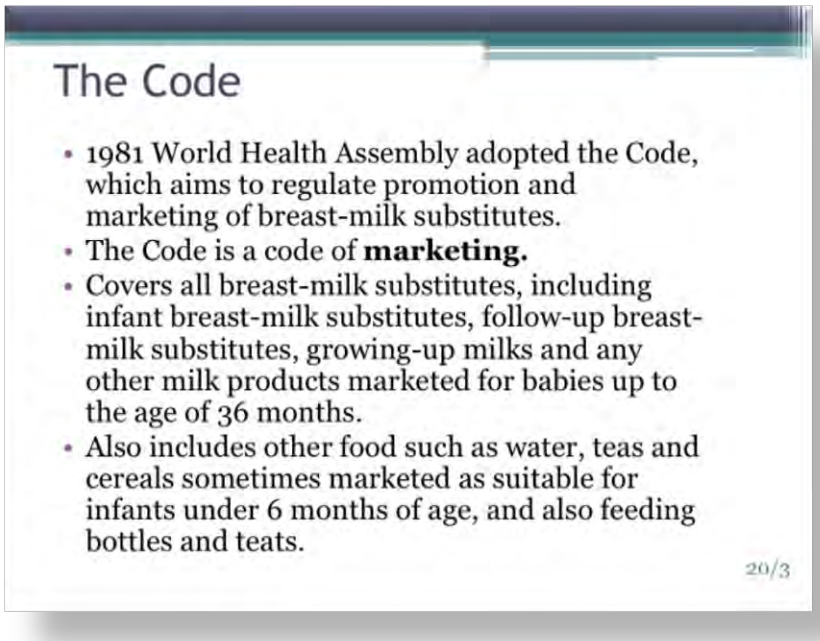
- Manufacturers and distributors use promotions and point-of-sale advertising to encourage mothers to purchase breast-milk substitutes and feeding bottles.
- Manufacturers use cross promotion by launching products with labels that create a link between the infant formula and other subsequent formulas. This encourages mothers to later purchase the company's follow-up formula or growing-up milk. It also may be a strategy to indirectly promote infant formula where there are national laws against direct promotion.
- Manufacturers and distributors promote sales of breast-milk substitutes and feeding bottles to mothers, through special displays and discount coupons. They give free samples of breast-milk substitutes to mothers.
- If given a free sample, even mothers who intend to breastfeed are more likely to start using breast-milk substitutes. As we learned in previous sessions, unnecessary supplementation may interfere with breastfeeding, and may affect the mother's milk supply. This can lead to mothers giving up breastfeeding.
- Manufacturers and distributors give coupons to mothers for a discount on breast-milk substitutes.
- They also advertise through different means including: billboards, buses, internet, magazines, radio, television, social media groups, SMS (text) messages and videos.

Promotion through health services

Manufacturers and distributors promote their products through health services in several ways.

- They give posters and calendars to health facilities to display on the walls. These are very attractive and make the place look better, while promoting the company's brand.
- They give attractive information materials to health facilities to distribute to families. Although some of the information may seem useful, it often undermines breastfeeding.
- They give useful items, such as pens or growth charts, with the company logo on them. Sometimes they give larger items such as television sets, or incubators to health facilities.
- They give free samples and free supplies of breast-milk substitutes to maternity units.
- They give free gifts to health workers.
- They advertise in medical journals and other literature.
- They pay for meetings or conferences, workshops or trips, or they give free lunches to medical, nutrition, or midwifery schools.
- They fund and sponsor health services in many other ways and give grants.

The International Code of Marketing of Breast-milk Substitutes and WHA resolutions



In 1981, the World Health Assembly (WHA) adopted *The International Code of Marketing of Breast-milk Substitutes*[33], which aims to regulate the promotion and marketing of breast-milk substitutes. This Code (short form) is a minimum requirement to protect infant feeding.

Subsequent WHA resolutions (about every two years) are also agreed at the WHA and have the same status as the original Code.

[33] International code of marketing of breast-milk substitutes. Geneva: World Health Organization; 1981 (http://www.who.int/nutrition/publications/code_english.pdf, accessed 8 April 2020).

The Code is a code of marketing. It does not ban breast-milk substitutes or bottles. The Code allows baby foods to be sold everywhere, and it calls on every country to make its own specific rules and regulations to implement the Code.

The Code covers all breast-milk substitutes – including infant formula, follow-up formula, growing-up milks and any other milk products marketed for babies up to the age of 36 months. It also includes other foods such as water, teas and cereal foods if they are marketed as suitable for infants under six months of age. It also includes feeding bottles and teats.

If breastmilk substitutes are promoted, there is a risk that breastfeeding women will want to use them. They may lose confidence in breastfeeding and decide to feed their babies artificially. This spread is called "spillover."

So, implementing the Code is also important to protect those women who are already breastfeeding. Supplies of breast-milk substitutes (where needed) should be distributed in an accessible and sustainable manner. They should be distributed individually, in a way that avoids spillover to women who are breastfeeding.

In May 2016, the World Health Organization published *Guidance on ending the inappropriate promotion of foods for infants and young children*[34]. The World Health Assembly urged all countries to implement the *Guidance*.

It helps to further clarify some specific aspects of the Code. Key points in this guidance are as follows.

- It clarifies the Code applies to all breast-milk substitutes, which includes all milk products specifically marketed for feeding infants and young children up to the age of three years (including follow-up breast-milk substitutes and growing-up milks).
- The messages used to promote foods for infants and young children should support optimal feeding, and inappropriate messages should not be included.
- There should be no cross-promotion to promote breast-milk substitutes indirectly via the promotion of foods for infants and young children.
- Health workers and health facilities should avoid conflicts of interest with companies who market foods for infants and young children. Therefore, they should not accept donation of equipment or services; gifts or incentives; hosting of events; provision of education to parents and other caregivers on infant and young child feeding; or sponsorship of scientific meetings by such companies.
- Health workers and health facilities should not engage in any form of promotion or sponsorship by industry. They should not permit the display of any type of advertising of breast-milk substitutes. They should not accept discount coupons or provide samples of breast-milk substitutes to mothers to use in the facility or to take home.
- Discuss national legislation, regulations and monitoring systems.

[34] Guidance on ending the inappropriate promotion of foods for infants and young children. In: Sixty-ninth World Health Assembly, Geneva, 23–28 May 2016. Resolutions and decisions, annexes. Geneva: World Health Organization; 2016 (http://apps.who.int/gb/ebwha/pdf_files/WHA69/A69_7Add1-en.pdf, accessed 8 April 2020).

SUMMARY: INTERNATIONAL CODE OF MARKETING OF BREAST-MILK SUBSTITUTES

1. No advertising or promotion of any breast-milk substitutes (including any product marketed or represented to fully or partially replace breast milk), feeding bottles or teats.
2. No free samples, free or low-cost supplies (including donations).
3. No promotion of products in or through health-care facilities.
4. No contact between marketing personnel and mothers (including health workers paid by a company to advise or teach).
5. No gifts or personal samples to mothers and their families, or health workers.
6. Labels should be in an appropriate language and have no words or pictures idealizing artificial feeding.
7. Only scientific and factual information to be given to health workers.
8. Governments should ensure that objective and consistent information is provided on infant and young child feeding.
9. All information on artificial feeding, including labels, should explain the benefits of breastfeeding and warn of the costs and hazards associated with artificial feeding.
10. Health-care workers and health systems should comply with the Code (and all subsequent WHA resolutions on infant feeding) independently of any government action to implement it.

If breastmilk substitutes are promoted, there is a risk that breastfeeding women will want to use them. They may lose confidence in breastfeeding and decide to feed their babies artificially. This spread is called "spillover."

So, implementing the Code is also important to protect those women who are already breastfeeding. Supplies of breast-milk substitutes (where needed) should be distributed in an accessible and sustainable manner. They should be distributed individually, in a way that avoids spillover to women who are breastfeeding.

Notes

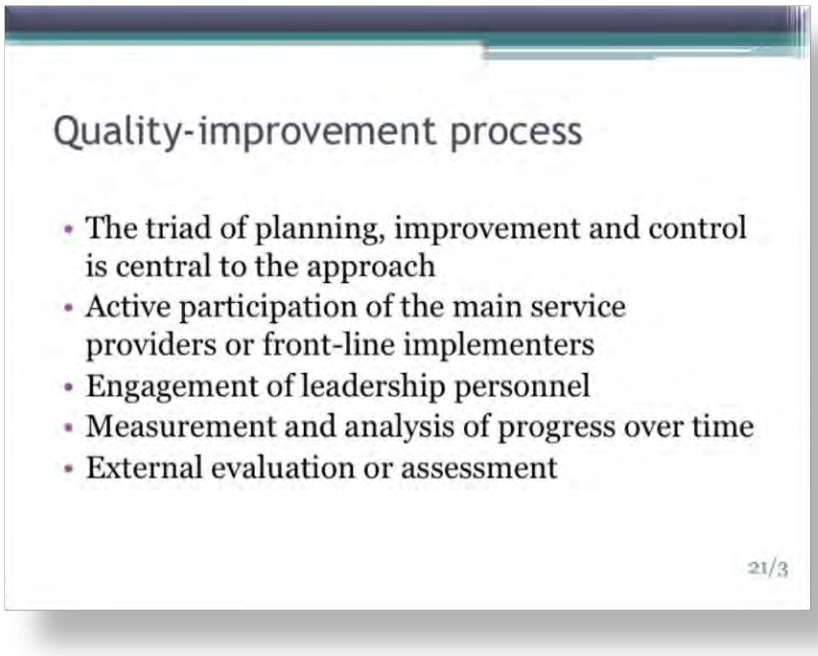
Session 21. Facility practices: Implementing the Ten Steps

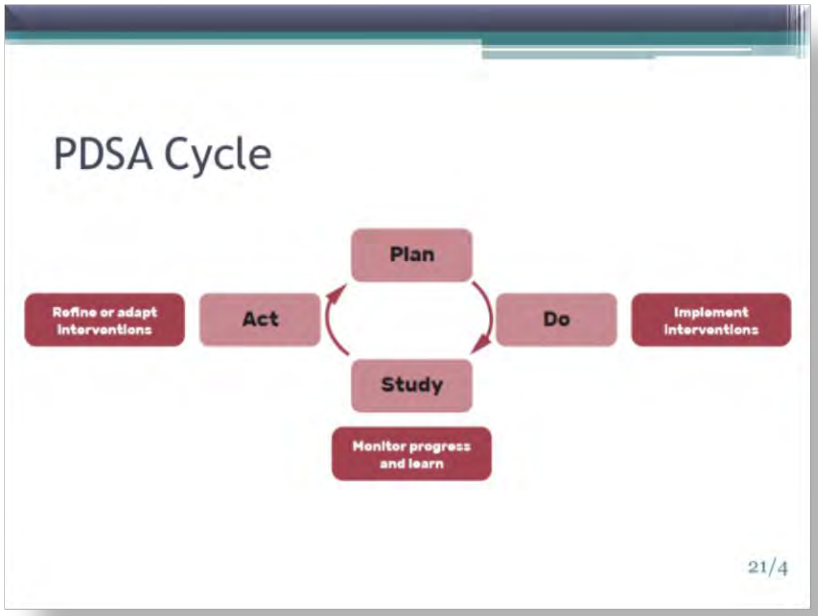
Objectives

After completing this session, participants will be able to:

- describe quality improvement in a facility, as part of the Ten Steps
- explain the importance of infant feeding policies
- explain the global standards from each of the TEN STEPS TO SUCCESSFUL BREASTFEEDING
- outline the health-care practices summarized by the TEN STEPS TO SUCCESSFUL BREASTFEEDING

Quality improvement as part of the Ten Steps





Quality improvement is a systematic process of improving quality of health services over time. The process of changing and improving health-care practices takes time. The Ten Steps to Successful Breastfeeding are a matter of quality of care. The clinical practices of the Ten Steps should be continually improved upon in the facilities where they are implemented.

Health workers play an important role in improving the quality of care for mothers and babies. Since health workers work directly with mothers and their babies, they see first-hand how practices can be improved. Therefore, they can have in important influence in improving quality of care and following the Ten Steps.

In a facility, BFHI or the Ten Steps may be the responsibility of a certain department or quality committee. These committees usually include leaders and professionals of various disciplines. Health workers themselves can actively participate in these committees and help with quality improvement. They can have an important influence on improving quality of care, and the Ten Steps.

Regular internal monitoring of clinical practices is also an important part of quality improvement. This is used to assess clinical practices and what needs to be done to achieve the Ten Steps. It can also help to ensure that the Ten Steps are practiced over time. One way to monitor health-worker performance is through mentorship programmes and day-to-day supportive supervision.

Infant feeding policy

Policies are important for quality health-care practice and care. They keep health workers accountable for their practices and outline their responsibilities. Therefore, development of policies should include all staff who are involved in the work. Having an infant feeding policy helps establish consistent care for mothers and babies. The policy can establish a standard of care, which can be evaluated and monitored. An infant feeding policy may be a separate document, a part of a broader policy document, or incorporated into other policy documents.

Facilities should have an infant feeding policy that:

- includes detailed guidelines on what to do and how to do it;
- is clearly written and routinely communicated to all staff;
- includes the key clinical practices from the TEN STEPS TO SUCCESSFUL BREASTFEEDING;
- includes details on how management procedures will be implemented including internal monitoring in the facility;
- addresses how the International Code of Marketing of Breast-milk Substitutes (the Code) is implemented in the facility;
- outlines how regular competency assessment of staff is performed;
- is visible to pregnant women, mothers and their families, which helps families know what care they can expect to receive.

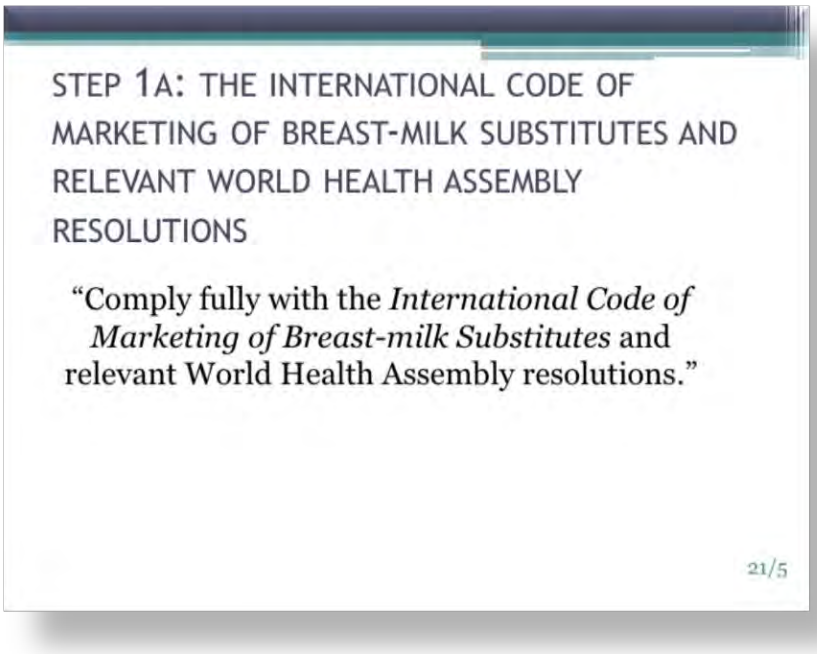
It is important that all health workers understand the infant feeding or breastfeeding policy of their facility. They should also understand how they are responsible for implementing the policy.

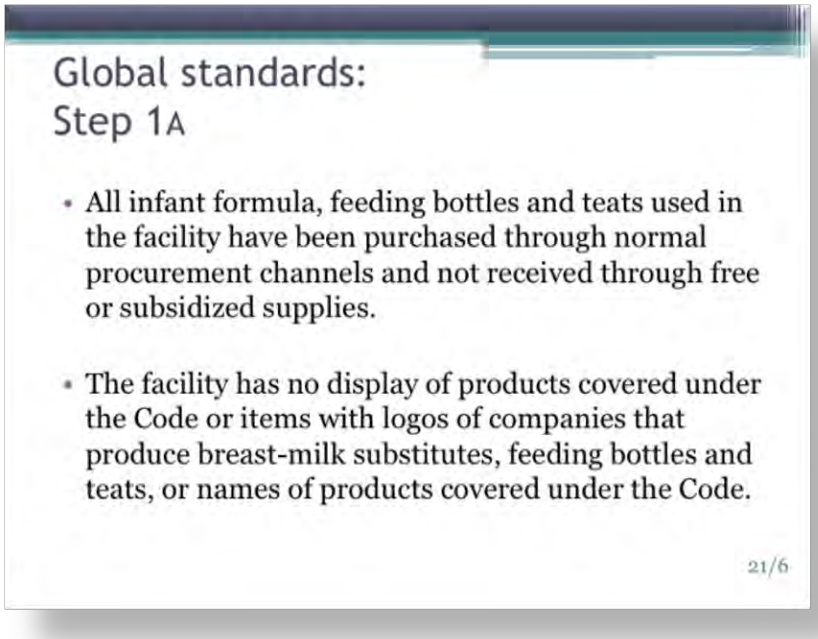
Health-care practices summarized by the Ten STEPS TO SUCCESSFUL BREASTFEEDING

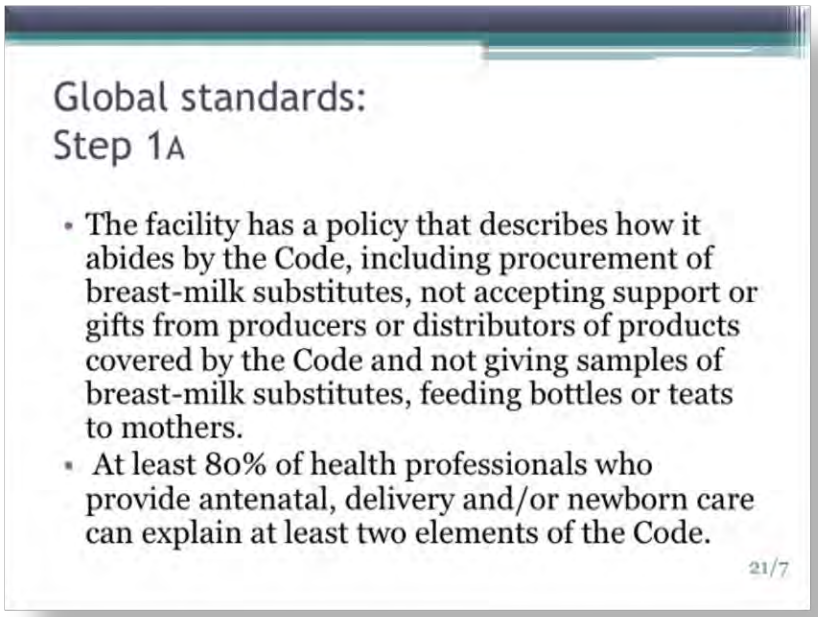
A facility that implements the Ten Steps to Successful Breastfeeding:

- provides an optimal level of care for mothers and infants
- protects, promotes, and supports breastfeeding and infant feeding.

Throughout this course we have learned different parts of the Ten Steps. We will now go through each of the Ten Steps to summarize how they are put into practice in a facility. The first two steps include critical management procedures. The following eight steps are key clinical practices.







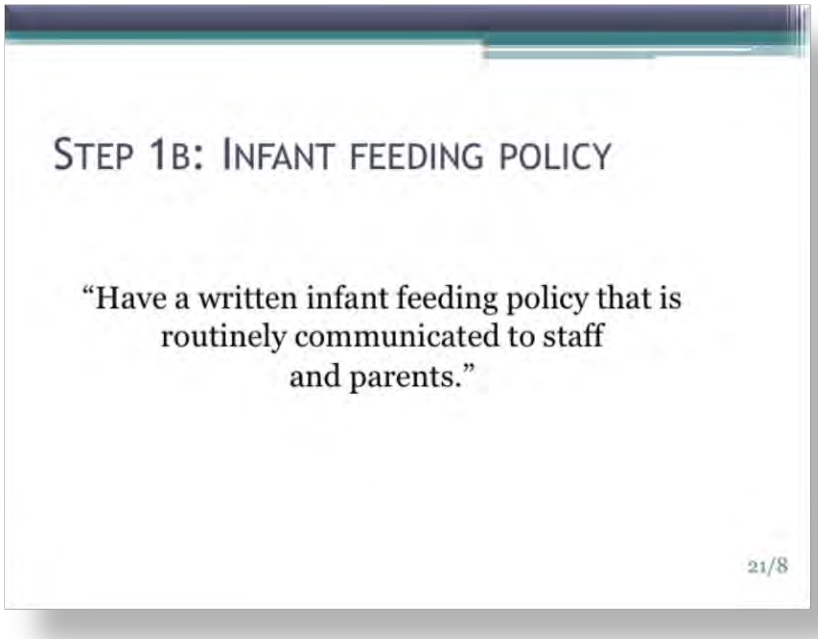
Step 1a: The International Code of Marketing of Breast-milk Substitutes and relevant World Health Assembly resolutions

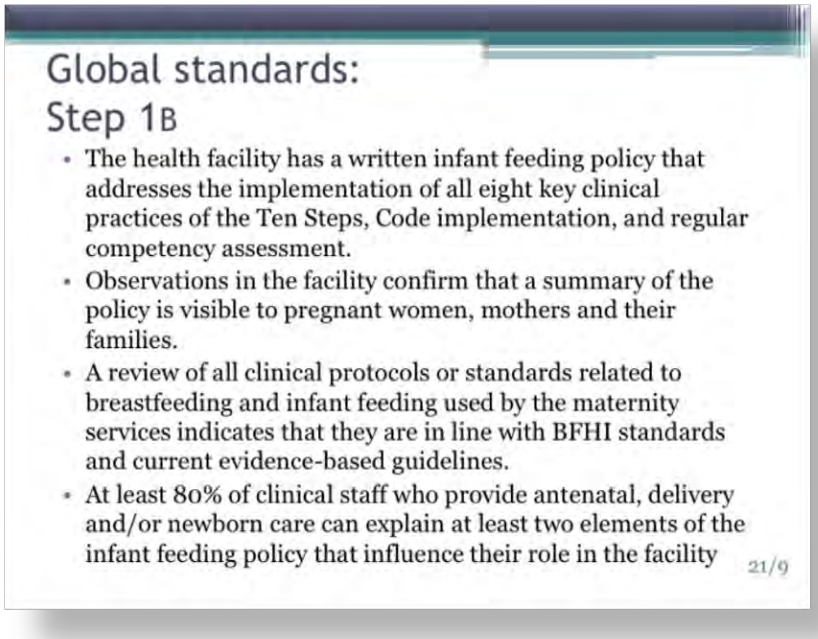
"Comply fully with the International Code of Marketing of Breast-milk Substitutes and relevant World Health Assembly resolutions."

Remember we discussed the Code in detail in the previous session. Promotion of breast-milk substitutes, bottles and teats may undermine women's confidence in their breast milk and makes them think it is not the best for their babies. It also idealizes the products through misleading health claims. This harms breastfeeding. Breastfeeding needs to be protected from the effects of the promotion of breast-milk substitutes, bottles and teats.

One essential way to protect breastfeeding is to regulate the marketing of breast-milk substitutes, both internationally and nationally. Individual health facilities and health workers can help protect breastfeeding by complying with the Code. This

means not allowing companies to use them to promote breast-milk substitutes, bottles and teats. They need to make sure breast-milk substitutes are used only when medically indicated or if the mother has made an informed choice. Free or subsidized supplies of infant formula, bottles and teats (including donations) should be not allowed in health facilities. This type of promotion can undermine breastfeeding. The facility should have a policy which describes how it follows the Code.

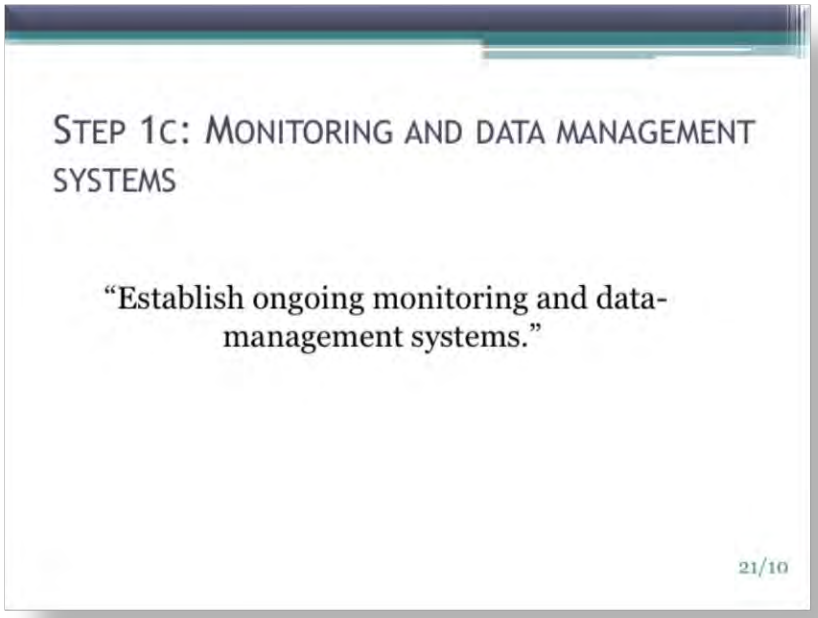


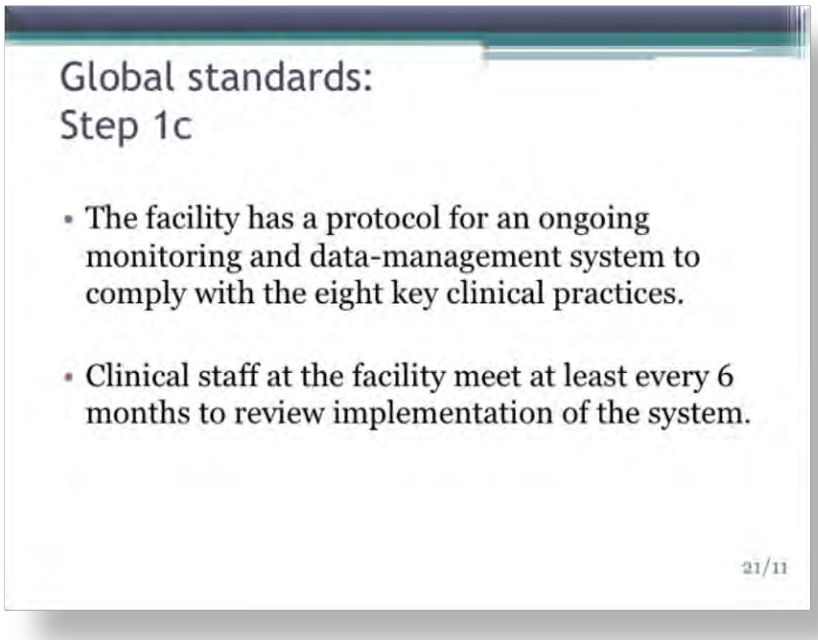


STEP 1B: INFANT FEEDING POLICY

"Have a written infant feeding policy routinely communicated to staff and parents."

Earlier in this session, we learned about the importance of infant feeding policies in the context of the Ten Steps. An infant feeding policy should cover the TEN STEPS TO SUCCESSFUL BREASTFEEDING.

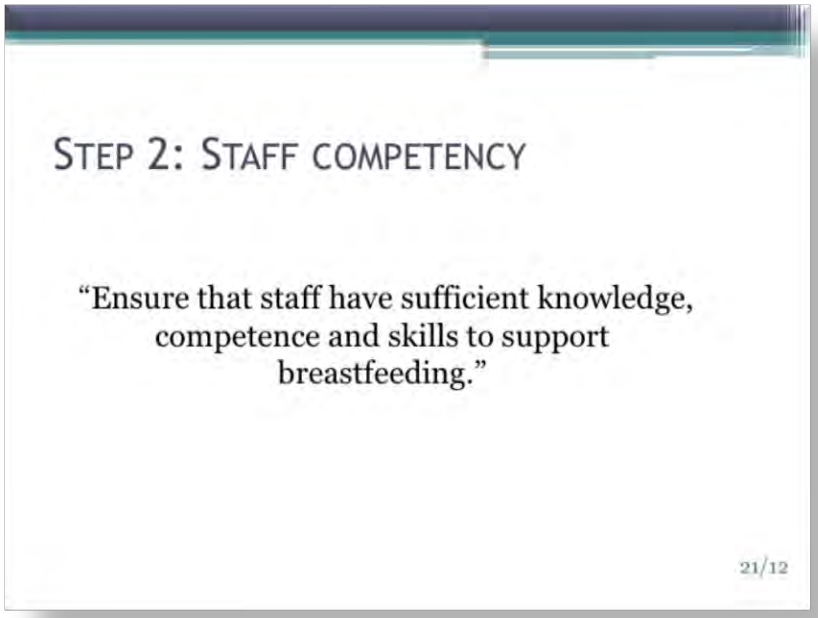


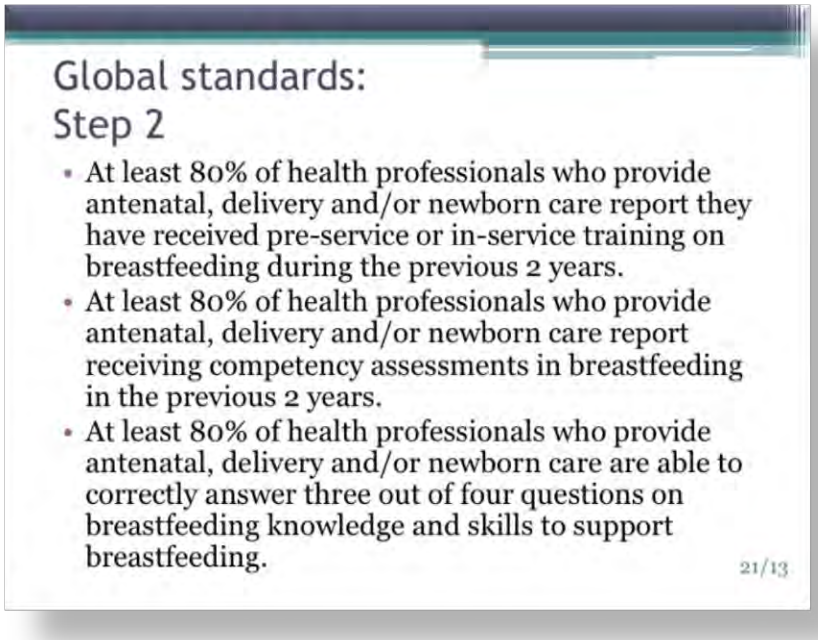


STEP 1C: MONITORING AND DATA MANAGEMENT SYSTEMS

"Establish ongoing monitoring and data-management systems."

Monitoring of key clinical practices is an important part of improving quality of care in a health facility. Facilities need to track data on key clinical practices. These data can help to assess the standards of care and implementation of the Ten Steps. Health workers often have a role in monitoring by collecting and recording data requested by the facility. This can include giving client satisfaction surveys to each mother/parent/caregiver before being discharged. It can also include recording the care of each mother/baby pair (e.g. early initiation, rooming-in), and also analysing the data over time.

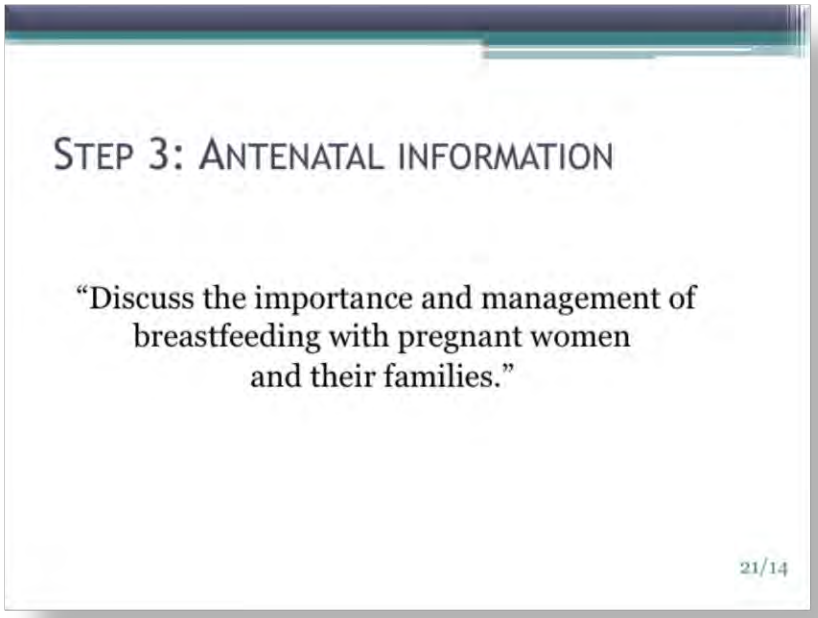


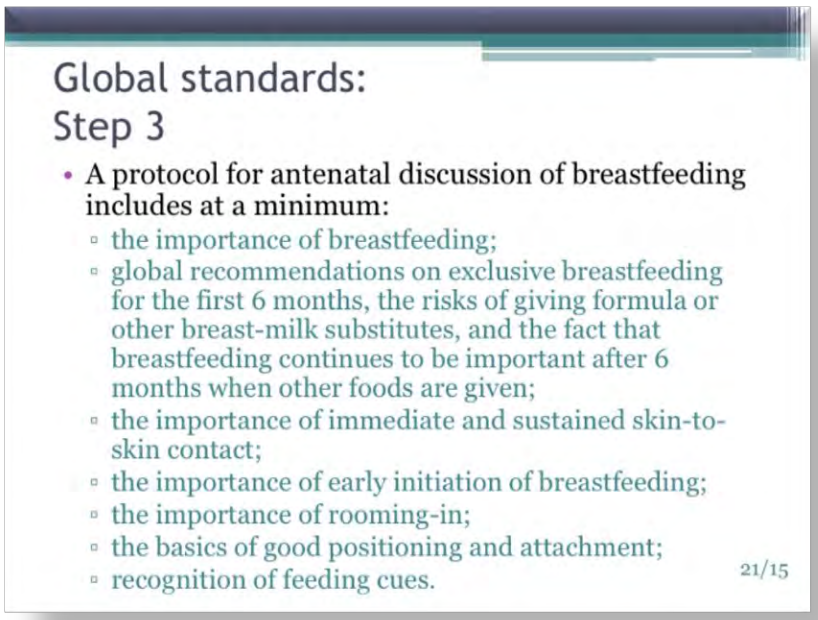


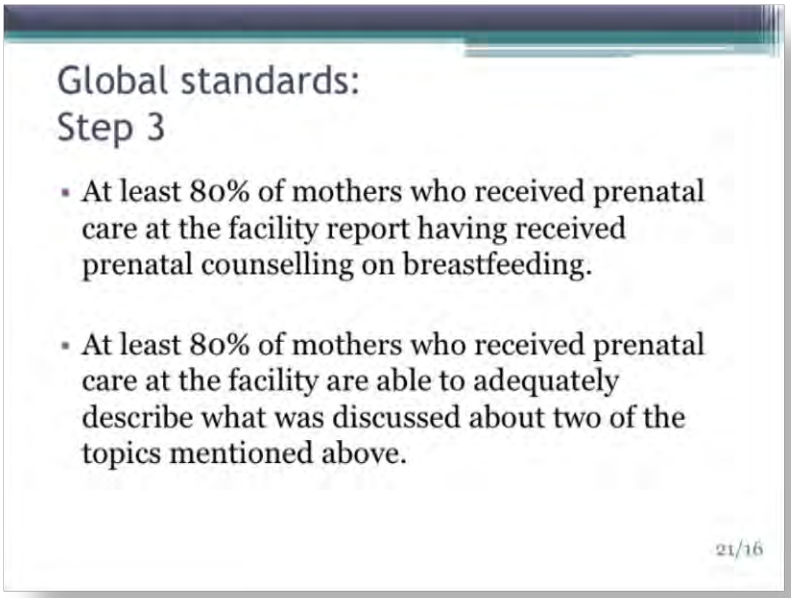
STEP 2: STAFF COMPETENCY

"Ensure staff have sufficient knowledge, competence and skills to support breastfeeding."

Staff can become competent and/or update their competencies either via pre-service training or via in-service training and refresher trainings. Competent staff together can make the necessary changes. This includes eliminating unsupportive practices and implementing standards of care to assist breastfeeding mothers and babies. Adequate training is important to improve health-care practices.





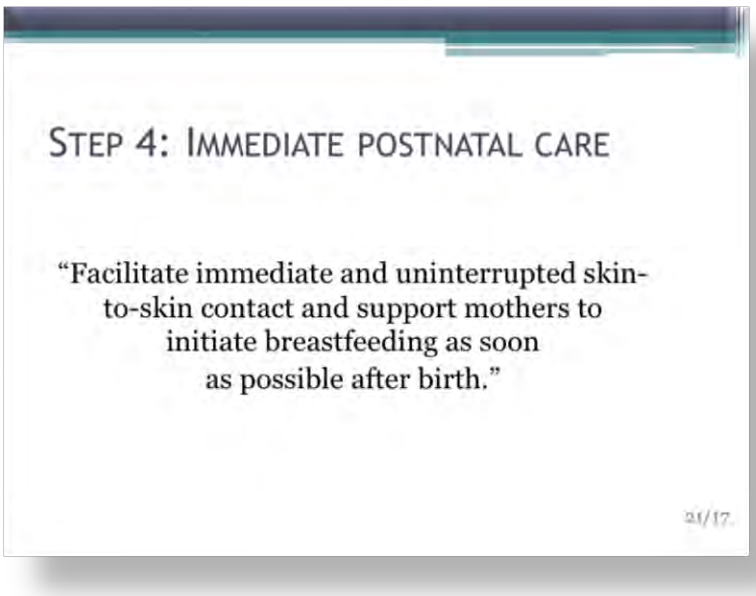


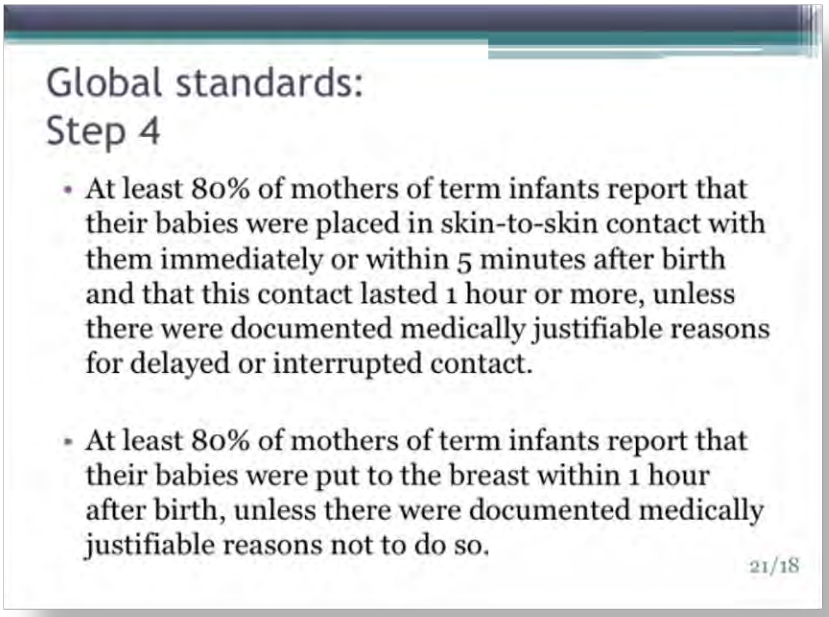
STEP 3: ANTENATAL INFORMATION

"Discuss the importance and management of breastfeeding with pregnant women and their families."

All mother should be provided with antenatal counselling on breastfeeding. Show you support breastfeeding and you want to help them. There are some topics you can discuss with a group of mothers together in an antenatal class. Other topics are better discussed with mothers individually. All pregnant women and their families should be counselled on:

- the importance of breastfeeding
- the importance of exclusive breastfeeding for the first six months
- the risks of giving formula or other breast-milk substitutes
- continued breastfeeding after six months when complementary foods are given
- the importance of immediate and sustained skin-to-skin contact
- the importance of rooming-in
- the basics of good positioning and attachment
- recognition of feeding cues.



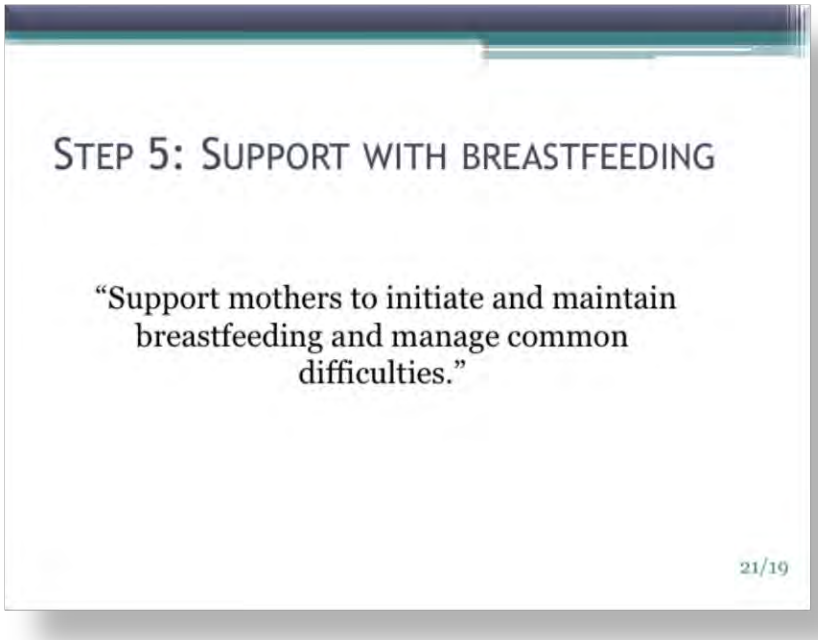


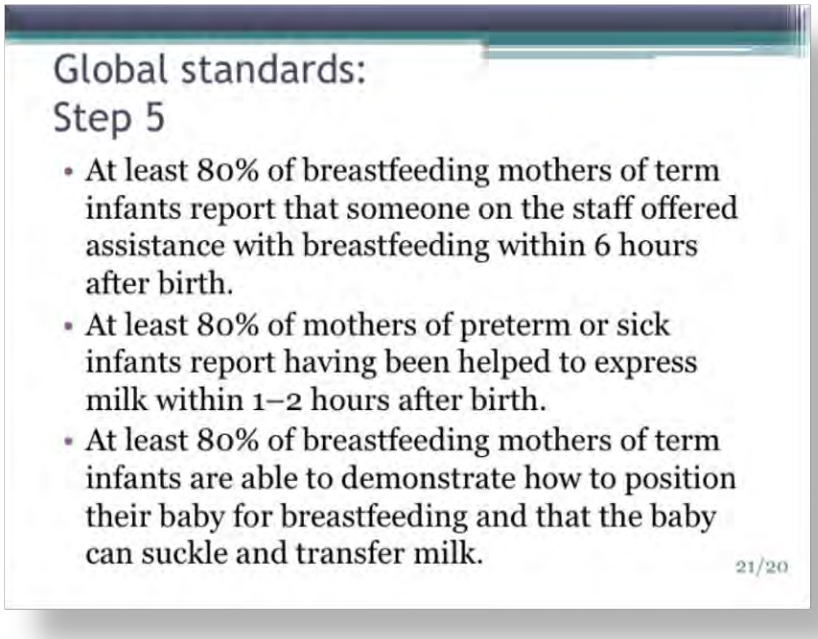
STEP 4: IMMEDIATE POSTNATAL CARE

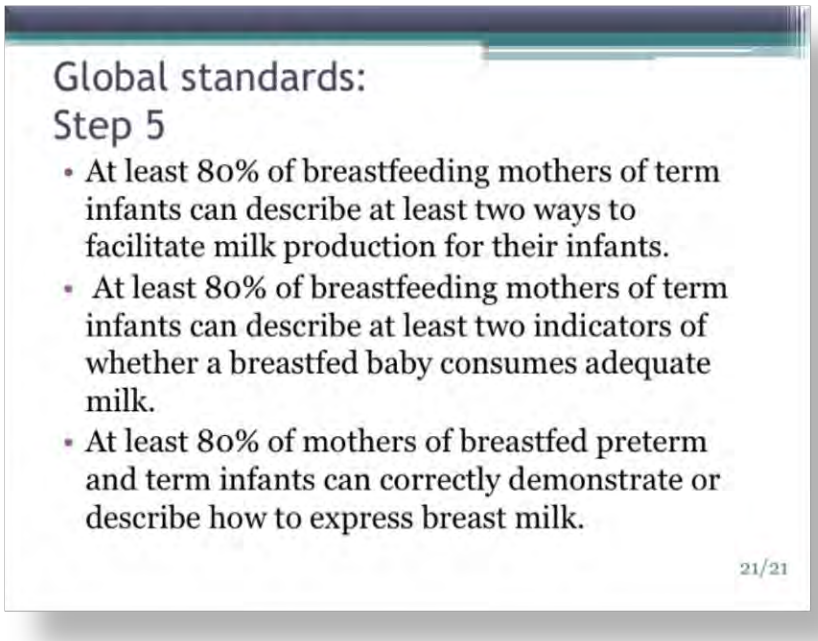
"Facilitate immediate and uninterrupted skin-to-skin contact and support mothers to initiate breastfeeding as soon as possible after birth."

All mothers and their infants should be placed in skin-to-skin contact immediately, or within five minutes after birth. This should be uninterrupted for at least 60 minutes. Mothers should be supported to initiate breastfeeding as soon as possible after birth. This should be within the first hour after delivery. Skin to skin contact helps:

- to keep the baby warm, and stabilize the baby's breathing and heart rate
- breastfeeding to get started
- the mother and baby to get to know each other.







STEP 5: SUPPORT WITH BREASTFEEDING

"Support mothers to initiate and maintain breastfeeding and manage common difficulties."

- A skilled health worker who has been trained in breastfeeding counselling should assess each mother during an early breastfeeding session. If necessary, they should help with positioning, attachment and suckling of the baby. This should be within six hours of delivery. Keep a baby with their mother and let them breastfeed early and often. Help the mother to recognize feeding cues which show the baby is ready to breastfeed.
- All mothers need to be taught how to express their breast milk. This is necessary both to establish and maintain lactation and to provide breast milk for their babies. If a baby is sick or unable to feed at the breast, the mother needs to know how to feed the baby safely and may need help to continue breastfeeding. Mothers of low-birth-weight, preterm or sick infants should be helped to express breast milk within one to two hours after delivery. Sometimes a baby has to be separated from their mother if they are ill, low-birth-weight, or needs special care. While they are separated, a mother needs a lot of help and support.

STEP 6: SUPPLEMENTATION

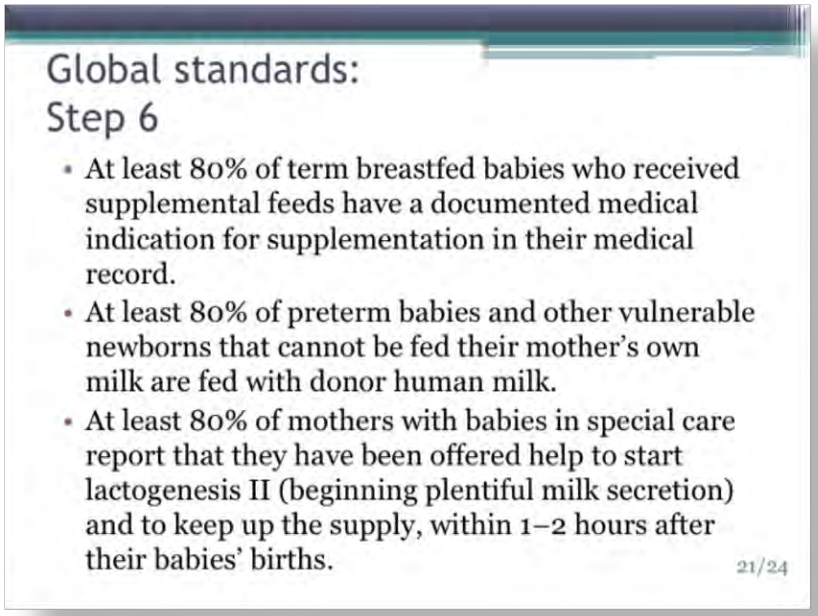
"Do not provide breastfed newborns any food or fluids other than breast milk, unless medically indicated."

21/22

Global standards: Step 6

- At least 80% of infants (preterm and term) received only breast milk (either from their own mother or from a human milk bank) throughout their stay at the facility.
- At least 80% of mothers who have decided not to breastfeed report that the staff discussed with them the various feeding options and helped them to decide what was suitable in their situations.
- At least 80% of mothers who have decided not to breastfeed report that the staff discussed with them the safe preparation, feeding and storage of breast-milk substitutes.

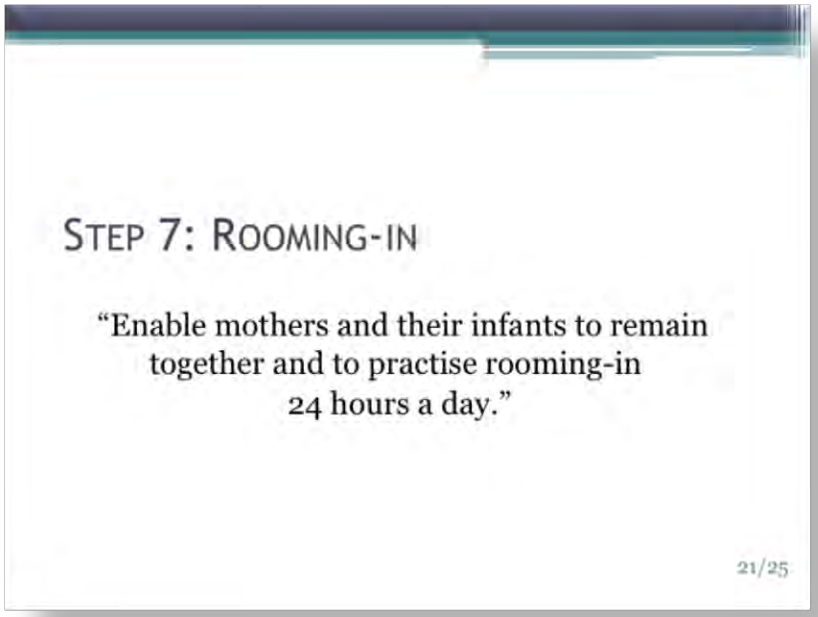
21/23

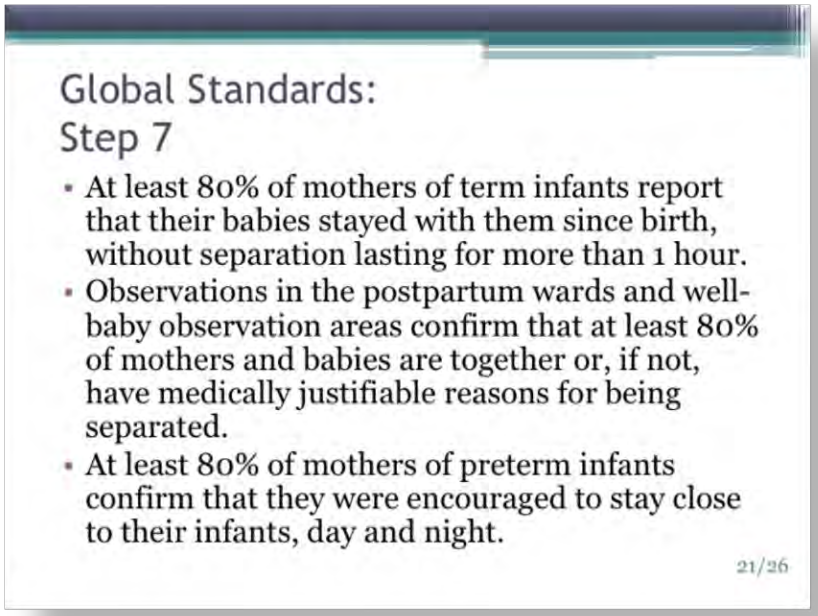


Step 6: Supplementation

"Do not provide breastfed newborns any food or fluids other than breast milk, unless medically indicated."

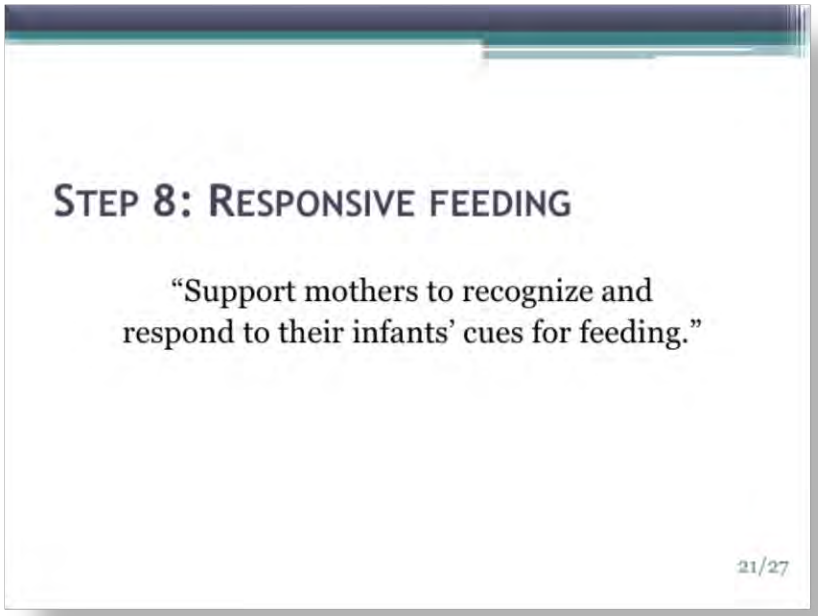
Breast milk protects the baby's digestive system through a special coating. Other fluids or foods can wash away this protection and introduce infections to the baby. They can also interfere with establishing the breast milk supply. Babies do not need other foods or fluids unless there is a medical reason. Mothers who decide to formula feed their babies should be taught how to do it safely.

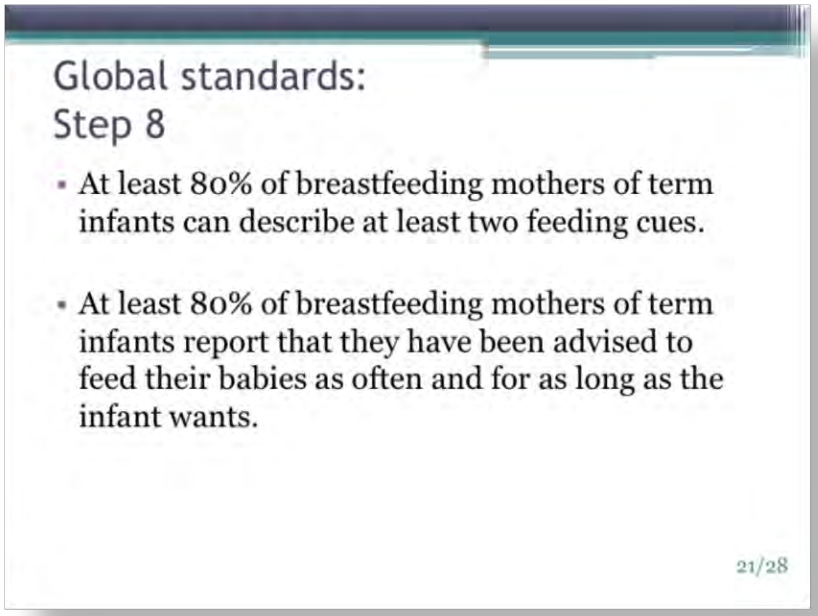




Step 7: Rooming-in

"Enable mothers and their infants to remain together and to practise rooming-in 24 hours a day."



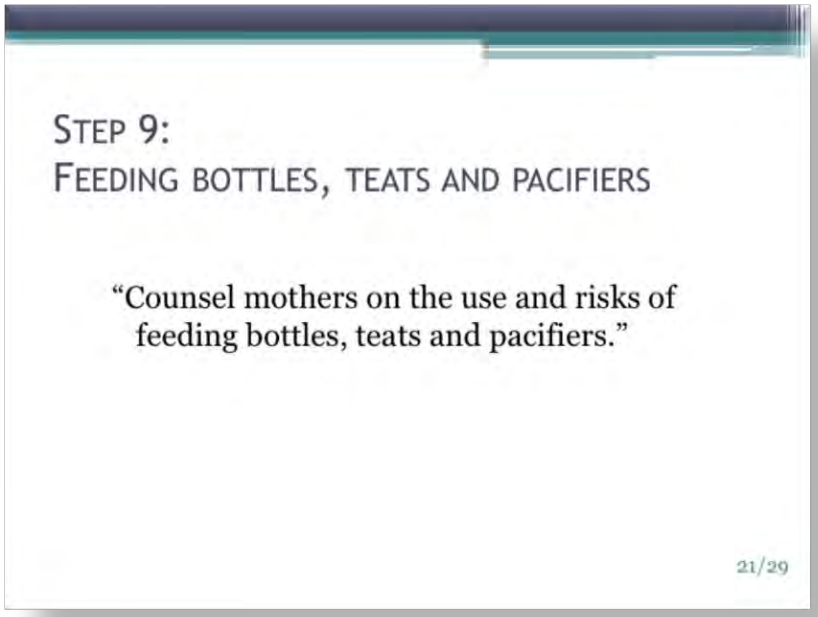


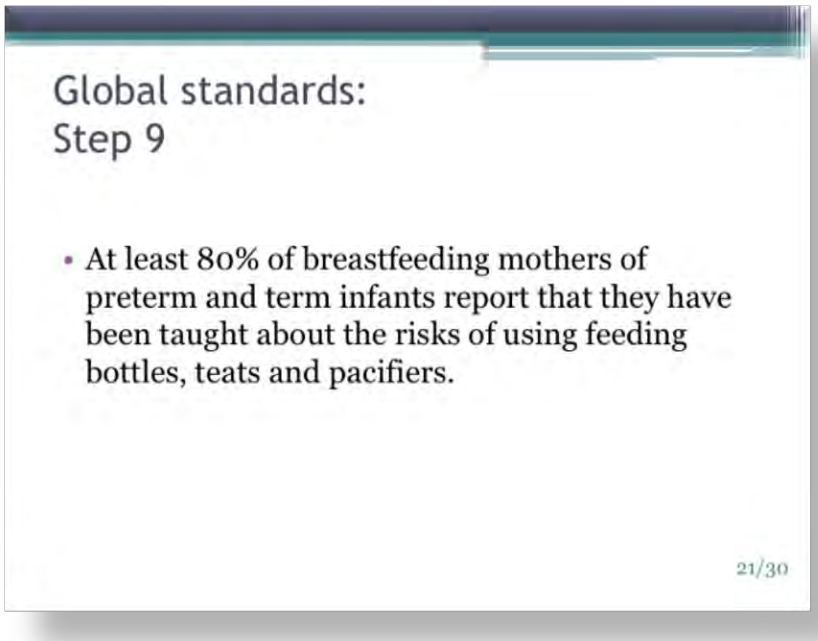
Step 8: Responsive feeding

"Support mothers to recognize and respond to their infants' cues for feeding."

Mothers and their infants should remain together day and night. Mothers of low-birth-weight, preterm and sick babies should stay near their babies. Facilities may need to make accommodations for this. Rooming-in has several advantages including the following.

- It enables a mother to practise responsive feeding. She can learn to respond to her baby's feeding cues and feed whenever the baby wants. This means there is no restriction on the length or frequency of foods. This also helps both bonding and breastfeeding.
- Babies cry less, so there is less temptation to give bottle feeds.
- A baby becomes colonized by mother's safe bacteria, which helps to protect against dangerous ones.
- Breastfeeding continues longer after the mother leaves hospital.



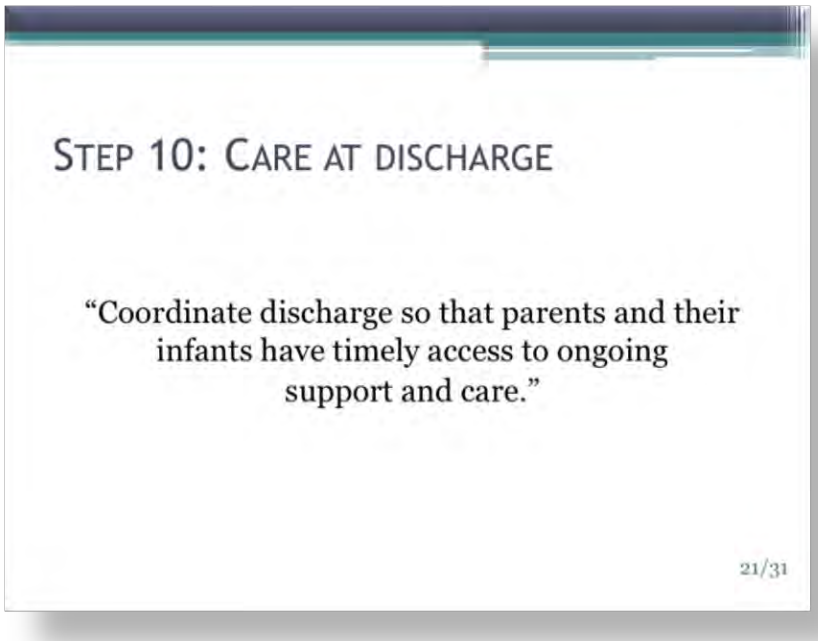


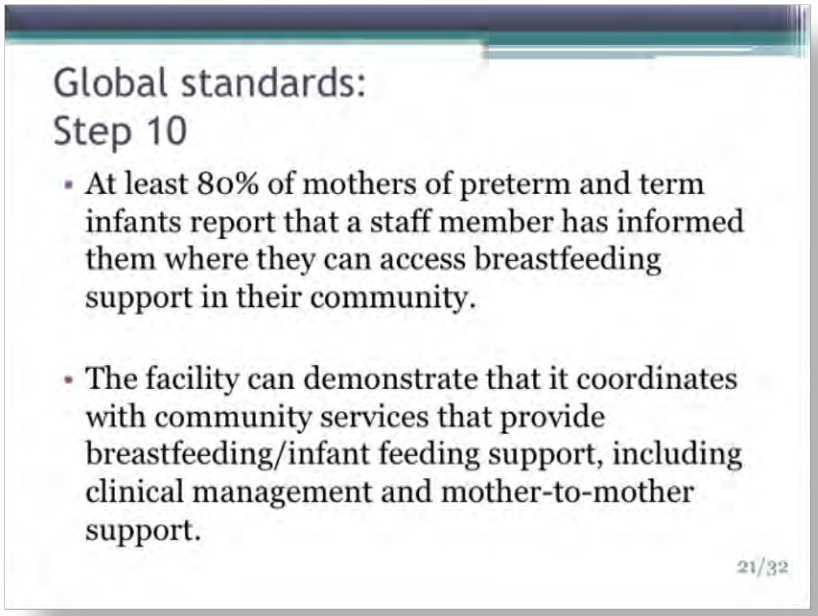
Step 9: Feeding bottles, teats and pacifiers

"Counsel mothers on the use and risks of feeding bottles, teats and pacifiers."

It is important to counsel mothers on the use and risks of feeding bottles, teats and pacifiers for several reasons. The use of feeding bottles, teats and pacifiers can:

- increase ear infections and dental problems
- interfere with the preterm baby learning to breastfeed
- prevent the mother from recognizing feeding cues of her baby
- decrease the mother's milk production if they replace suckling at the breast
- carry infection and make a baby ill.





STEP 10: CARE AT DISCHARGE

"Coordinate discharge so parents and their infants have timely access to ongoing support and care."

Mothers/parents/caregivers need ongoing support to continue breastfeeding once they leave the health-care facility. This is especially important in the days and weeks following discharge. This will help mothers with any early breastfeeding challenges. The need for support and where to find support should be discussed with each mother before she is discharged after birth. Staff members should provide information to new mothers on where they can access breastfeeding support in their communities.

Facilities should understand what kind of resources are available in the community. Before they are discharged, mothers and babies should be referred for follow-up with a health worker in the community. The health worker in the facility should make sure that the mother has this information. Each mother should be connected with resources to support infant feeding before she is discharged. Resources in the community include:

- community services that provide breastfeeding/infant feeding support, such as organized support groups or counsellors
- clinical support such as through health workers or primary health clinics
- mother-to-mother support.

This summarizes how the Ten Steps are practiced in facilities providing maternity and newborn services. It is important all of the Ten Steps are implemented together as a complete package. In this way, we can contribute to optimal infant feeding practices and maternal and child well-being.

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 all of these key issues. Care should be taken that the policy is not too long. Shorter policies (3–5 pages) have been shown to be more effective as longer ones often go unread). Detailed guidelines specific to the facility can be useful in addition to the policy.

The points the policy should cover		YES	NO
Step 1a:	The policy prohibits promoting or giving samples of breast-milk substitutes, feeding bottles or teats to mothers.		
	The policy describes how it abides by the Code, including procurement of breast-milk substitutes.		
	The policy prohibits accepting support or gifts from producers or distributors of products covered by the Code.		
Step 1b:	The infant feeding policy is written		
	The policy addresses the implementation of all 8 key clinical practices of the Ten Steps, Code implementation, and regular competency assessment.		
	A summary of the policy that addresses the Ten Steps and support for non-breastfeeding mothers is visible to pregnant women, mothers and their families.		
	The policy is routinely communicated to staff and parents.		
	The policy describes how it abides by the International Code of Marketing of Breast-milk Substitutes.		
Step 2:	All health workers receive a competency assessment at least every 2 years.		
	All health workers have received pre-service or in-service training on breastfeeding during the previous 2 years.		
Step 3:	All pregnant women receive prenatal counselling.		
	All pregnant women and their families are informed on: - the importance of breastfeeding - the importance of exclusive breastfeeding for the first 6 months - the risks of giving formula or other breast-milk substitutes - continued breastfeeding after 6 months when complementary foods are given - the importance of immediate and sustained skin-to-skin contact - the importance of rooming-in - the basics of good positioning and attachment - recognition of feeding cues.		
Step 4:	All mothers of term infants are placed in skin-to-skin contact with them immediately or within five minutes after birth. This contact is NOT interrupted for at least 60 minutes.		
	Mothers are supported to initiate breastfeeding as soon as possible after birth. This should be within the first hour after birth.		

Step 5:	All breastfeeding mothers are offered further help with breastfeeding within six hours of birth.		
	All breastfeeding mothers are helped with positioning and attachment.		
	All mothers are taught hand expression (or given leaflet and referral for help).		
	Mothers of preterm or sick infants are helped to express breast milk within one to two hours after birth.		
	Mothers with babies who are sick or unable to feed at the breast are helped to continue breastfeeding.		
	All mothers who have made a fully informed decision not to breastfeed are: - informed about risks and management of various feeding options and helped to decide what is suitable in their circumstances		
	- taught to prepare formula feeding and asked to demonstrate what they have learned.		
Step 6:	Supplementary feeding is only given: - if medically indicated		
	- if mothers have made a "fully informed choice" after counselling on various options and the risks and benefits of each.		
	Reasons for supplementation are documented.		
Step 7:	All mothers and their babies' room-in together, 24 hours a day.		
	Separations is only for justifiable reasons with written documentation.		
Step 8:	Mothers are taught how to recognize and respond to the feeding cues of their baby, and the signs that they are satisfied.		
	No restrictions are placed on the frequency or duration of breastfeeding.		
Step 9:	Mothers are counselled on the use and risks of feeding bottles, teats and pacifiers.		
Step 10:	Mothers are linked to breastfeeding-support resources in the community upon discharge. These include at least one source (such as from the hospital, community health services, support groups or peer counsellors).		
	Referrals are provided for mothers and babies to be in contact with a health worker two to four days after birth and again in the second week, to assess the feeding situation.		
HIV*:	All mothers living with HIV receive counselling and specific guidance in selecting what is best in their circumstances and according to the national authority guidelines.		
	Staff providing support to women living with HIV 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.

Notes

For more information, please contact:

Department of Nutrition and Food Safety
World Health Organization

Avenue Appia 20
CH-1211 Geneva 27
Switzerland

Email: nutrition@who.int
www.who.int/nutrition

World Health Organization

9789240008953