

Trainer's Guide

BABY-FRIENDLY HOSPITAL INITIATIVE TRAINING COURSE FOR MATERNITY STAFF



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Baby-friendly Hospital Initiative training course for maternity staff: trainer's guide

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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 24 March 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 milk through various methods (i.e. hand expression, breast pump).

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 defence 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: 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 mother's own 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 albicans*. 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

Dotted lines for writing 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 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*². 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 guidance: protecting, promoting and supporting breastfeeding in facilities providing maternity and newborn services – the revised Baby-friendly Hospital Initiative* (BFHI)³.

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 HIV⁴.

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 age⁵.

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 communication and support skills for breastfeeding and infant feeding, in the pre-service curricula of doctors, nurses, midwives or other professionals.

² *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).

³ *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).

⁴ *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).

⁵ Rollins NC, Bhandari N, Hajeerhoy 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

Hence, there is an urgent need, in all countries, to train all those involved in breastfeeding in the immediate postnatal period 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 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 make her 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 have full responsibility for the care of newborn infants. It does not cover in-depth topics on the treatment, care and management of sick or low-birth-weight infants, those living with HIV, or those using antiretroviral (ARV) drugs, or undergoing 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. The trainer should make sure that the objectives are clearly defined when preparing a session.

Target audience

This course is suitable for staff and health-care workers who have contact with pregnant women, mothers and their newborn infants. The staff may include:

- doctors
- midwives
- nurses
- health-care assistants
- nutritionists
- peer supporters
- other staff.

It is also suitable for use in pre-service training so that students have the knowledge and skills to support breastfeeding when they begin work.

Course participants are not expected to have any prior knowledge of breastfeeding.

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

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

The trainers

The trainers should be health-care workers who have hands-on experience of caring for newborns and mothers/caregivers; they should be qualified by becoming familiar with the course material as participants and using it in their daily practice before training their peers.

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 | <ul style="list-style-type: none"> List the LISTENING AND LEARNING SKILLS Give an example of each skill | <ul style="list-style-type: none"> Use the LISTENING AND LEARNING SKILLS when counselling a mother or caregiver on feeding an infant | <ul style="list-style-type: none"> S3 |
| C2. Use skills for building confidence and giving support whenever engaging in a conversation with a mother | <ul style="list-style-type: none"> List the SKILLS FOR BUILDING CONFIDENCE AND GIVING SUPPORT Give an example of each skill | <ul style="list-style-type: none"> Use the SKILLS FOR BUILDING CONFIDENCE AND GIVING SUPPORT when counselling a mother or caregiver on feeding an infant | <ul style="list-style-type: none"> S4 |
| Breastfeeding | | | |
| BF1. Engage in antenatal conversation about breastfeeding | <ul style="list-style-type: none"> 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 | <ul style="list-style-type: none"> 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: <ul style="list-style-type: none"> 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 | <ul style="list-style-type: none"> S17, S18 |

| Competency | Knowledge | Skills | Session |
|--|--|---|--|
| BF2. Implement immediate and uninterrupted skin-to-skin | <ul style="list-style-type: none"> 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 | <ul style="list-style-type: none"> Help a mother to initiate skin-to-skin contact and breastfeeding | <ul style="list-style-type: none"> S6 |
| BF3. Facilitate breastfeeding within the first hour, according to cues | <ul style="list-style-type: none"> 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 | <ul style="list-style-type: none"> Help a mother to initiate skin-to-skin contact and breastfeeding Apply competencies C1, C2, BF5 | <ul style="list-style-type: none"> S6, S7 |
| BF4. Discuss with a mother how breastfeeding works | <ul style="list-style-type: none"> 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 | <ul style="list-style-type: none"> 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) | <ul style="list-style-type: none"> S2, S5, S14, S16 |
| BF5. Assist mother getting her baby to latch | <ul style="list-style-type: none"> 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 | <ul style="list-style-type: none"> 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 | <ul style="list-style-type: none"> S5, S8, S9, S10 |

| Competency | Knowledge | Skills | Session |
|--|---|---|--|
| BF6. Help a mother respond to feeding cues | <ul style="list-style-type: none"> 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 | <ul style="list-style-type: none"> Help a mother recognize her baby's feeding cues Help a mother feed her baby baby responding to the feeding cues | <ul style="list-style-type: none"> S7, S12, S13, S17, S19 |
| BF7. Help a mother manage milk expression | <ul style="list-style-type: none"> 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 | <ul style="list-style-type: none"> 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 | <ul style="list-style-type: none"> S13 |
| BF8. Help a mother to breastfeed a low-birth-weight or sick baby | <ul style="list-style-type: none"> 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 | <ul style="list-style-type: none"> 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 | <ul style="list-style-type: none"> S7, S9, S13 |
| BF9. Help a mother when baby needs fluids other than breastmilk | <ul style="list-style-type: none"> 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 | <ul style="list-style-type: none"> 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 | <ul style="list-style-type: none"> S13, S14 |
| BF10. Help a mother who is not feeding her baby directly at the breast | <ul style="list-style-type: none"> List the advantages of cup-feeding Describe how to cup feed a baby List the risks of using a feeding bottle, teat or pacifier | <ul style="list-style-type: none"> Teach a mother how to cup feed her baby safely Practise with a mother how to cup feed her baby safely | <ul style="list-style-type: none"> S13, S14, S17, S18 |

| Competency | Knowledge | Skills | Session |
|--|--|--|---|
| BF11. Help a mother prevent or resolve difficulties with breastfeeding | <ul style="list-style-type: none"> 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 <p>List the causes of why a baby may be reluctant to feed at the breast</p> <p>Explain the difference between flat and inverted nipples and about protractility and how to manage flat and inverted nipples</p> <p>Explain the reasons why breasts may become engorged and how to manage breast engorgement</p> <p>List causes of sore or cracked nipples</p> <p>List the causes of a blocked milk duct</p> <p>Explain how to treat a blocked milk duct</p> <p>List the causes of mastitis</p> <p>Explain how to manage mastitis, including indications for antibiotic treatment and referral</p> <p>Explain what is different when treating mastitis in a mother living with HIV</p> | <ul style="list-style-type: none"> 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. <p>Help a mother whose baby is reluctant to feed at the breast</p> <p>Recognize flat and inverted nipples</p> <p>Demonstrate how to use the syringe method for the treatment of inverted nipples</p> <p>Recognize engorged breasts</p> <p>Recognize sore and cracked nipples</p> <p>Recognize mastitis and refer to the appropriate level of care if necessary</p> <p>Manage a blocked duct appropriately</p> <ul style="list-style-type: none"> 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 <p>Apply competencies BF7 and BF10 to maintain breast- milk production and to feed the baby meanwhile</p> | <ul style="list-style-type: none"> S11, S15, S16, S12, S13 |

| Competency | Knowledge | Skills | Session |
|--|--|--|--|
| BF12. Ensure seamless transition after discharge | <ul style="list-style-type: none"> 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 | <ul style="list-style-type: none"> 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 | <ul style="list-style-type: none"> S16, S19 |

Policies and programmes related to breastfeeding

| | | | |
|---|---|--|--|
| PP1. Implement the <i>International code of marketing of breast-milk substitutes</i> in a health facility | <ul style="list-style-type: none"> Describe how commercial promotion of breast-milk substitutes undermines good breastfeeding practices List the major provisions of the <i>International Code of Marketing of Breast-milk Substitutes</i> and subsequent World Health Assembly resolutions (the Code) Describe health-workers' responsibilities for complying with the Code | <ul style="list-style-type: none"> Recognize common violations of the Code Indicate appropriate actions to take when violations are identified in the health facility | <ul style="list-style-type: none"> S20, S21 |
| PP2. Explain a facility's infant feeding policies and monitoring systems | <ul style="list-style-type: none"> 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 | <ul style="list-style-type: none"> 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 | <ul style="list-style-type: none"> S21 |

1.4 Checklist: Training skills

Practise using these skills when you conduct sessions, and comment on these points when you give feedback to other trainers.

Preparation

- Follow the session plan accurately and completely – use your *Trainer's guide*.
- Prepare thoroughly – read the text and practise.
- Prepare your helpers or co-facilitators (e.g. for role plays) before the session – practise if possible.
- Have the required supplies, equipment and teaching aids ready – check and arrange them before the session.
- If needed, place a table at the front of the room to set up visual aids and teaching materials.
- Arrange the room so that all participants can see clearly what is happening – if possible, arrange seats in a U-shape with no more than two rows of seats.
- Do not introduce too much extra material – give examples from local context when appropriate.

Audiovisuals and teaching aids

- Make sure audiovisual equipment is available and working.
- Make sure audiovisuals and teaching aids can be seen by all participants.
- Write clearly on the board or flipchart – arrange words carefully so there is enough room.
- Let participants handle teaching aids that you use for demonstrations.
- Cover, turn off or remove teaching aids that are not in use any more.

Presentations

- Stand in the centre of the room – do not hide behind a podium or desk.
- Follow the *Trainer's guide* – but talk in your own way.
- Face the audience when speaking – not the board or screen.
- Make eye contact with people in all sections of the audience.
- Speak slowly, clearly and loudly enough for everyone to understand and hear.
- Vary the tone and level of your voice.
- Use natural gestures and facial expressions.
- Avoid blocking the participants' view.

Interaction

- Involve all participants. Ask questions to quiet ones. Limit talkative ones.
- Move around the room – approach people to get their attention or response.
- Use participants' names.
- Allow time for participants to answer questions from the *Trainer's guide* – give hints when needed.
- Repeat responses from participants when it is likely that not everyone heard.
- Respond encouragingly and positively to all answers – correct errors gently.
- Reinforce participants by thanking them for comments and praising good ideas.
- Respond adequately to questions – offer to seek answers if not known.
- Handle incorrect or off-the-subject comments tactfully.

Demonstrations

- Follow the instructions in the *Trainer's guide*.
- State clearly the objective of the demonstration.
- Demonstrate the entire, correct procedure (no short-cuts).
- Describe the steps aloud while doing them.
- Project your voice so all can hear. Stand where everyone can see you.
- Encourage questions from participants.
- Ask participants questions to check their understanding.

Written exercises

- Give clear instructions and a time limit before starting the exercises.
- While participants work, look available, interested and willing to help.
- Give individual help quietly, without disturbing others in the group.
- Sit down next to the participant whom you are helping.
- Check answers carefully – listen as participants give reasons for their answers.
- Encourage and reinforce participants' efforts – give positive feedback.
- Help participants to understand any errors – give clear explanations.
- Remember to use your communication skills when giving feedback.

Clinical practice: Sessions and group work

- Before dividing into groups, explain clearly the purpose of the activity, what participants will do, and the time limit.
- If needed, demonstrate a skill before asking participants to do it on their own.
- Select suitable cases for the session's objectives.
- Observe participants carefully as they work with real mothers or stories.
- Use the CHECKLIST: CLINICAL PRACTICE DISCUSSION.
- Try to get participants to identify their own strengths and weaknesses. Ask questions like "What did you do well?" "What difficulties did you have?" "What would you do differently in the future?"
- Provide feedback on things that participants did well and on things that they need to improve on – be gentle and tactful when correcting errors.
- Keep participants busy by promptly assigning another mother or case scenario.

Role plays

- Set up role plays carefully. Obtain necessary props (e.g. dolls). Brief those who will play the roles and allow them time to prepare.
- Clearly introduce the role play by explaining its purpose, the situation and the roles to be enacted.
- Keep the role play brief and to the point.
- After the role play, guide a discussion. Ask questions of both the players and observers.
- Summarize what happened and what was learnt.

Time management

- Keep to time – not too fast or too slow. Don't take too long with the early part of a session.
- Do not lose time between sessions (e.g. going to practical session and group work). Before participants begin to move, explain clearly what they will do.

1.5 The course and the materials

Structure of the course

The course is divided into various sessions and will take different times, according to the sessions selected. The course can be conducted over three consecutive days or can be distributed in other ways. The sessions use a variety of teaching methods, including lectures, demonstrations and work in smaller groups, with classroom-based practical sessions and exercises, and clinical practice sessions in clinical facilities providing maternity and newborn services.

Order of sessions

Sessions can be moved, but it is necessary for some aspects of the sequence to be maintained. The main requirement is that you conduct the sessions that prepare participants for a particular clinical practice session before the practical session.

Director's guide

The *Director's guide* contains all the information that the course director needs to plan and prepare for a course, to decide which modules and sessions will be included in the training, and to select trainers and participants, starting several months before the actual training. It contains lists of the materials and equipment needed, examples of timetables, and copies of the forms that need to be photocopied before a course. It also describes the director's role during the course itself.

Trainer's guide

The *Trainer's guide* contains what you, the trainer, needs in order to lead participants through the course. The information includes detailed instructions on how to conduct each session, the exercises that participants will do, together with answers, and the summary sheets, forms, checklists and stories used during the practical sessions of the course. This is your most essential tool as a trainer of the course. It is recommended that you use it at all times and add notes to it as you work. These notes will help you in future courses.

Slides (PowerPoint)

Many sessions use slides. It is important that you are familiar with the equipment beforehand. All the slides are shown in your *Trainer's guide*, so that you can make sure you understand the information, pictures or graphs for your sessions. Colour printouts or transparencies of the slides can be made if slides are not available.

Participant's manual

A *Participant's manual* should be provided for each participant, using the sessions selected. This contains summaries of information and copies of worksheets and checklists for the practical sessions and exercises participants will do during the course (without the answers). This *manual* can be used for reference after the course, so it is not essential for participants to take detailed notes.

Answer sheets

These sheets are provided separately, and they give answers to all the exercises. Give them to the participants after they have worked through the exercises.

Forms and checklists

Loose copies of the forms and checklists needed for practical and clinical practice sessions and counselling exercises are provided. These are:

For general use, or specifically for clinical practice sessions

- CHECKLIST: LISTENING AND LEARNING SKILLS
- CHECKLIST: COUNSELLING SKILLS (includes listening and learning skills and skills for building confidence and giving support)
- CLINICAL PRACTICE DISCUSSION CHECKLIST (for trainers only)
- COMPETENCY PROGRESS FORM

Job aids and reference tools

- JOB AID: BREASTFEEDING SESSION OBSERVATION
- JOB AID: ANTENATAL CHECKLIST
- JOB AID: BIRTH PRACTICES FORM
- ASSESSING AND CHANGING PRACTICES FORM (for optional activity)

General assessment and follow-up

- LOG OF SKILLS PRACTISED (for participants only)
- DIFFICULTIES EXPERIENCED (for participants only)

Story cards

Copies of the histories and counselling stories are provided for some of the sessions.

Updates

Periodic updates on the topics covered on this course will be available on the WHO and UNICEF websites, which should be consulted when preparing a course.

Training aids

You will need a flipchart, and/or blackboard and chalk, or white a board and suitable markers for most sessions. You will also need a way to attach flipchart pages to the wall or notice board – such as with masking tape. You will also need approximately one life-size baby doll and one model breast for each small working group of three or four participants.

If dolls and model breasts are not available, follow the instructions below (tables 2 and 3) for making them very simply out of material that is readily available.

TABLE 2. HOW TO MAKE A MODEL DOLL

- Find any large fruit or vegetable, a towel or other strong thick cloth, and some rubber bands or string.
- Put the fruit or vegetable in the middle of the cloth and tie the cloth around it to form the baby's "neck" and "head".
- Bunch the free part of the cloth together to form the baby's legs and arms and tie them into shape.
- If the cloth is rather thin, you may like to stuff some other cloth inside to give the doll more of a "body".

TABLE 3. HOW TO MAKE A MODEL BREAST

- Use a pair of near skin-coloured socks, or stockings, or an old sweater or T-shirt.
- Make the cloth into a round bag shape, and stuff it with other cloth or foam rubber to make it breast shaped.
- Stitch a "purse string" around a circle in the middle of the breast to make a nipple.
- Stuff the nipple with foam or cotton.
- Colour the areola with a felt pen. You can also push the nipple in to make an "inverted" nipple.
- If you wish to show the inside structure of the breast with the larger ducts, make the breast with two layers, for example with two socks.
- Sew the nipple in the outer layer and draw the large ducts and ducts on the inside layer beneath the nipple.
- You can remove the outer layer with the nipple to reveal the inside structure.

1.6 Reference materials

As a trainer, you may wish to obtain the following reference materials to answer questions and provide additional information:

Breastfeeding:

- Bu'Lock F, Woolridge MW, Baum JD. Development of co-ordination of sucking, swallowing and breathing: ultrasound study of term and preterm infants. *Dev Med Child Neurol.* 1990;32:669–78.
- Butte N, Lopez-Alarcon M, Garza C. Nutrient adequacy of exclusive breastfeeding for the term infant during the first six months of life. Geneva: World Health Organization; 2002 (<http://apps.who.int/iris/bitstream/10665/42519/1/9241562110.pdf?ua=1>, accessed 13 March 2020).
- Campbell SH, Lauwers J, Mannel R, Spencer B. Core curriculum for interdisciplinary lactation care. LEAARC. Burlington, MA: Jones & Bartlett; 2018.
- 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
- Eglash A, Simon L, The Academy of Breastfeeding Medicine. ABM Clinical Protocol #8: human milk storage information for home use for full-term infants, revised 2017. *Breastfeed Med.* 2017;12:390–95. doi:10.1089/bfm.2017.29047.aje
- Foster JP, Psaila K, Patterson T. Non-nutritive sucking for increasing physiologic stability and nutrition in preterm infants. *Cochrane Database Syst Rev.* 2016;10:CD001071. doi:10.1002/14651858.CD001071.pub3
- Greene Z, O'Donnell CP, Walshe M. Oral stimulation for promoting oral feeding in preterm infants. *Cochrane Database Syst Rev.* 2016;9:CD009720. doi:10.1002/14651858.CD009720.pub2
- Jaafar SH, Ho JJ, Jahanfar S, Angolkar M. Effect of restricted pacifier use in breastfeeding term infants for increasing duration of breastfeeding. *Cochrane Database Syst Rev.* 2016;8:CD007202. doi:10.1002/14651858.CD007202.pub4
- Kramer MS, Kakuma R. The optimal duration of exclusive breastfeeding: a systematic review. Geneva: World Health Organization; 2001 (http://apps.who.int/iris/bitstream/10665/67208/1/WHO_NHD_01.08.pdf?ua=1, accessed 13 March 2020).
- Rollins NC, Bhandari N, Hajeebhoy N, Horton S, Lutter CK, Martines JC, 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
- Guideline: protecting, promoting and supporting breastfeeding in facilities providing maternity and newborn services. Geneva: World Health Organization; 2017 (<http://www.who.int/nutrition/publications/infantfeeding/9241561300/en/>, accessed 13 March 2020).
- Long-term effects of breastfeeding: a systematic review. Geneva: World Health Organization; 2013 (http://apps.who.int/iris/bitstream/10665/79198/1/9789241505307_eng.pdf?ua=1, accessed 13 March 2020).
- Short-term effects of breastfeeding: a systematic review of the benefits of breastfeeding on diarrhoea and pneumonia mortality. Geneva: World Health Organization; 2013 (http://apps.who.int/iris/bitstream/10665/95585/1/9789241506120_eng.pdf?ua=1, accessed 13 March 2020).
- Community-based strategies for breastfeeding promotion and support in developing countries. Geneva: World Health Organization; 2003 (<http://apps.who.int/iris/bitstream/10665/42859/1/9241591218.pdf>, accessed 13 March 2020).
- Statement on the effect of breastfeeding on mortality of HIV-infected women. Geneva: World Health Organization; 2001 (<http://ibfan.org/docs/Effect-of-Breastfeeding-on-Mortality-among-HIV-Infected-Women-WHO-statement.pdf>, accessed 13 March 2020).
- The optimal duration of exclusive breastfeeding, Report of an Expert Consultation. Geneva, Switzerland, 28–30 March 2001. Geneva: World Health Organization; 2001 (WHO/FCH/CAH/01.24; http://apps.who.int/iris/bitstream/10665/67219/1/WHO_NHD_01.09.pdf?ua=1, accessed 13 March 2020).

- Mastitis. Causes and management. Geneva: World Health Organization; 2000 (WHO/FCH/CAH/00.13; http://www.who.int/maternal_child_adolescent/documents/fch_cah_00_13/en/, accessed 13 March 2020).
- Breastfeeding and maternal tuberculosis. Geneva: World Health Organization; 1998 (http://www.who.int/maternal_child_adolescent/documents/breastfeeding_maternal_tb/en/, accessed 13 March 2020).
- Evidence for the ten steps to successful breastfeeding. Geneva: World Health Organization; 1998 (WHO/CHD/98.9; http://apps.who.int/iris/bitstream/10665/43633/1/9241591544_eng.pdf, accessed 13 March 2020).
- Hepatitis B and breastfeeding. Update No. 22. Geneva: World Health Organization; 1996 (http://www.who.int/maternal_child_adolescent/documents/pdfs/hepatitis_b_and_breastfeeding.pdf?ua=1, accessed 13 March 2020).
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- WHO, UNICEF. Global Nutrition Targets 2015. Breastfeeding Policy Brief 5. Geneva: World Health Organization; 2014 (WHO/NMH/NHD/14.7; http://apps.who.int/iris/bitstream/10665/149022/1/WHO_NMH_NHD_14.7_eng.pdf?ua=1, accessed 13 March 2020).
- WHO, UNICEF. Breastfeeding and maternal medication. Recommendations for drugs in the eleventh WHO model list of essential drugs. Geneva: World Health Organization; 2002 (<http://apps.who.int/iris/bitstream/10665/62435/1/55732.pdf>, accessed 13 March 2020).
- Yamauchi Y, Yamanouchi I. Breast-feeding frequency during the first 24 hours after birth in full-term neonates. *Pediatrics*. 1990;86:171–5.

Breast-milk substitutes:

- Kellams A, Harrel C, Omage S, Gregory C, Rosen-Carole C, Academy of Breastfeeding Medicine. ABM Clinical Protocol #3: supplementary feedings in the healthy term breastfed neonate, revised 2017. *Breastfeed Med*. 2017;12:188–98. doi:10.1089/bfm.2017.29038.ajk
- Maternal, infant and young child feeding. Guidance on ending the inappropriate promotion of foods for infants and young children. In: Sixty-ninth World Health Assembly, Geneva, 23–28 May 2016. Provisional agenda item 12.1. Geneva: World Health Organization; 2016 (http://apps.who.int/gb/ebwha/pdf_files/WHA69/A69_7Add1-en.pdf, accessed 14 March 2020).
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2. Making arrangements for the course

2.1 Where to hold the course

In order to hold a successful course, you need to arrange:

- classroom space for the course and classroom space for training the trainers
- lodgings and meals for the trainers and participants
- sites for the clinical practice sessions.

Ideally, a course should be residential, with the classroom and accommodation at the same site. If the course is not residential, allow adequate time for travel between the accommodation and the classroom.

It is essential that the course takes place near one or several facilities where participants can observe mothers, caregivers and newborns.

Classroom facilities

You need one large room available for seating all trainers, participants and visitors. You need additional table space to lay out the materials used during the course.

The classroom should be in a place where the participants are not disturbed by too much background noise and should have adequate lighting and ventilation.

Accommodation and meals

For a residential course, it is necessary to arrange suitable accommodation near the classroom and the health facility. Unsatisfactory accommodation can hinder participants' learning. If needed, suitable transportation needs to be available, from the accommodation to the classroom and to the facilities for the clinical practice sessions. If participants are travelling long distances, ensure the budget will cover the accommodation for the night before and the last night of the course.

Arrangements also need to be made for meals. This should include midday meals and refreshments, such as coffee and tea, near the classrooms.

2.2 Sites for clinical practice and practical sessions

The clinical practice sessions should take place in facilities providing maternity and newborn services. If there is no single facility in an area large enough to provide enough mothers and newborns, you may have to use another nearby facility and send some of the small groups of three or four participants to each site. As discussed earlier, for participants to become competent in the necessary skills, it is important for them to practise, under supervision, as many of the skills as possible during the course. It is important, therefore, that there be enough mother/newborn pairs for each of the clinical practice sessions.

If the facility is not close to the classrooms, make transport arrangements to ensure that the participants can commute between the classrooms and the health facility in the most efficient way, with minimal loss of time. Travel time may need to be included in the timetable for the sessions.

The course timetable cannot be planned until the times of the clinical practice sessions are decided, so their organization is a high priority.

Visit the health facility

Visit one or more possible health facilities to find out whether they are appropriate and to talk to the staff.

- Talk to the director of the health facility, and explain what the training consists of, what your needs are, and what you want to do.
- Ask whether they would be willing for the training to take place in the facility, and for their guidance on where different activities could take place.
- If the director agrees in principle, visit the department. Check the approximate number of mother and newborn pairs you could expect to see on an average day.
- Ask what times of the day are most suitable for holding the clinical practice sessions. This depends on when mothers and newborns are likely to be available, and on times convenient to the facility's routine.
- Talk to the staff, and try to find out whether they are interested in helping with the course; for example, if they are interested in infant feeding, would they be willing to share their experience with the course participants?
- Identify spaces or rooms near each clinic area where trainers and participants can have discussions out of the mothers' hearing.
- If the facility is suitable and the staff are interested and willing to help, arrange to make another visit nearer the date of the course to meet with the staff and prepare them.

Prepare the facility staff

It is important to prepare the health facility staff who will help during clinical practice sessions. If necessary, arrange to give them an appropriate orientation session, so that they understand the purpose of the course.

At the meeting, explain:

- about the course generally;
- that you need their help in preparing mothers and asking their permission before the participants arrive, and in introducing participants to mothers to whom they can talk;
- that you would like a responsible member of the facility staff to be available while the training team is there, in case a mother needs a specific intervention;
- interventions will only take place with the permission and knowledge of facility staff, which will also enable staff to provide follow-up for the mother and newborn;
- the days you would like to bring participants to the facility for the different sessions and check that these are convenient; and that mothers are expected to be available at that time.

Leave some copies of reference materials for staff to read. An example of an information sheet is provided below.

Table 4 is an example of an information sheet for a clinical practice site (to be adapted according to the content of the course).

| TABLE 4. BABY-FRIENDLY HOSPITAL INITIATIVE: A TRAINING COURSE FOR MATERNITY STAFF |
|---|
| <p>After completing this course, participants will be able to assess, promote and protect breastfeeding. They will be able to implement the Ten Steps to Successful Breastfeeding in their own place of work.</p> |
| <p>On completion of the course, participants should be able to assess breastfeeding for mothers and their newborn babies, provide help a mother and her baby with breastfeeding, and identify and manage common breastfeeding difficulties. Participants will also be able to talk to mothers in the antenatal and immediate postpartum periods and support them in their infant feeding decisions.</p> |
| <p>We would like your assistance with the clinical practice sessions of this course. During these sessions, participants practise counselling skills with mothers. In one clinical practice session, participants talk with pregnant women to help prepare them for infant feeding. In the other clinical practice sessions in the postpartum unit, participants talk to mothers and provide breastfeeding counselling and support.</p> |
| <p>Your help is needed to prepare mothers, to ask their permission before the participants arrive, and to introduce participants to mothers to whom they can talk.</p> |
| <p>If a mother/newborn needs a specific intervention, this will only take place with the permission and knowledge of health-facility staff. This will also enable staff to provide follow-up for the newborn or mother.</p> |
| <p>The visit to your facility would be on: (date) from (time)</p> |
| <p>Thank you for your assistance.</p> |
| <p>Course organizers:</p> |
| <p>Course venue:</p> |
| <p>Course dates:</p> |
| <p>Course contact person's name and address:</p> |

2.3 Selecting participants

Try to ensure that appropriate and motivated participants come to the course. This will make the training successful and may stimulate the interest of others in the Ten Steps to Successful Breastfeeding and the Baby-friendly Hospital Initiative, so that they will also want to acquire the skills and do the work. Participants should be free of other work during the course, so that they may fully participate.

The number of participants who can be invited for a course depends on:

- your budget
- classroom and residential accommodation
- the number of trainers available (you need a ratio of one trainer to four participants)
- the number of mother and newborn pairs who can be seen on an average day in the health facility where you will conduct the clinical practice sessions.

It is recommended that you do not invite more than 24 participants to a course. If possible, try to include one or more of the staff of the health facility in which the clinical practice sessions will be conducted. You may plan to hold a series of trainings for a number of people from a certain area, or to train all appropriate health workers in a given area or institution. You may ask health facilities in an area to select one to three participants to attend the course.

An example of a course announcement is provided in Table 5.

TABLE 5. EXAMPLE OF COURSE ANNOUNCEMENT

Date:

Venue:

Course organizers:

Objectives of the course: After completing this course, participants should be able to assess breastfeeding for mothers and their newborn babies, provide help to a mother and newborn with breastfeeding, and identify and manage common breastfeeding difficulties. Participants will also be able to communicate with mothers in the antenatal and immediate postpartum periods and support them in their infant feeding decisions.

Overall, participants will be able to implement the global recommendations of exclusively breastfeeding for six months with continued breastfeeding for up to two years and beyond. Participants will be competent in implementing the Ten Steps to Successful Breastfeeding in the facilities where they work.

Who should attend: The course is for health workers such as nurses and doctors. They should be fluent in (state required language).

Outline of course: (section to be completed according to the content selected)

Accommodation: Accommodation and meals will be available from (evening before course to morning after depending on travel arrangements). Participants should arrive by 08:00 hours on (first day of course) and are free to leave after 17:00 hours on (last day of course). Travel costs will be refunded.

Registering for the course: Send the names and contact details of candidates who wish to apply, to (name and address) before (date). When participants have been selected, further information will be sent to them and to their health facility.

3. Checklists for planning

3.1 Overall planning checklist

Initial planning

1. Decide on the course schedule. For example, a three-day course or one-day meeting each week for three weeks. Allocate eight teaching hours per day, with mealtimes in addition.
2. Choose a training venue. This must include a large classroom and a facility providing maternity and newborn services to conduct the clinical practice sessions. Ideally, these should be at the same site. Make sure that the following are available:
 - easy access from the classroom to the area for the clinical practice sessions;
 - a large room that can seat all participants and trainers for sessions, including space for guests invited to opening and closing ceremonies; there should be space for participants and trainers to sit at a table, with enough space for each to open up their course materials;
 - adequate lighting and ventilation, and wall space to post large sheets of paper in each of the rooms;
 - at least one table for each group of six to eight participants;
 - table space to hold the projector, display materials and for the trainer's use;
 - a blackboard, white board or flipchart (and chalk or markers) in the front of the room for writing;
 - a notice board or wall to display materials and tape or other means of attaching notices to the wall;
 - easy access to a data projector for the slides, extension cords, and screen or suitable wall or equipment to produce colour-printed overhead transparencies;
 - freedom from disturbances such as loud noises or music;
 - arrangements for providing refreshments;
 - space for at least one clerical or logistic support staff during training;
 - a place where supplies and equipment can be safely stored and locked up if necessary.

When you have chosen a suitable site, book it in writing and subsequently confirm the booking some time before the course, and again shortly before the course.

3. Choose lodgings for the participants. Ideally, the course should be residential. If the lodging is at a different site from the course, make sure that the following are available:
 - reliable transportation to and from the course site
 - meal service that is convenient for the course timetable.

When you have identified a suitable lodging, reserve it in writing and subsequently confirm it sometime before the course, and again shortly before the course.

4. Visit the health facility or other facilities that you will use for the clinical practice sessions.
 - Confirm the hours during which it is possible to see mothers and their newborn babies (if you plan to visit more than one facility at each session, it is important to make sure they are available at the same time).
 - When you have chosen a suitable site, confirm it in writing and reconfirm shortly before the course.
5. Decide the exact dates of the course.
6. Arrange for a responsible authority (for example ministry of health, national nutrition programme) to send a letter to the district/regional office or to health facilities asking them to identify participants.

This letter should:

- explain that the course will be held, and explain the aims of the course;
 - give the site and dates of the course;
 - state the total number of places for participants on the course (12–24), and suggest the number of places to offer to participants from each facility (this depends on how many facilities are involved);
 - state clearly that nominated participants should be people who are responsible for supporting and promoting breastfeeding in facilities providing maternity and newborn services;
 - explain the duration of the course and that individuals should arrive in time and attend the entire course;
 - give the date by which nominated course participants will be selected and to whom to send the names of nominated participants;
 - say that a letter of invitation will be sent to participants once they are selected.
7. Identify suitable participants, and send them letters of invitation, stating:
 - the objectives of the training and a description of the course
 - the desired arrival and departure times for participants
 - that it is essential to arrive in time and to attend the entire course
 - the administrative arrangements, such as accommodation, meals and payment of other costs.
 8. Obtain enough copies of the course materials.
 9. Organize delivery of:
 - necessary supplies and equipment
 - the items needed for demonstrations
 - the necessary background information for the area.
 10. Arrange for materials, equipment and supplies to be sent to the training venue.
 11. Arrange for travel authorizations to be sent to the trainers and participants.
 12. Invite officials to the opening and closing ceremonies.

Arrangements at the training venue before the course begins

The course director (or a designated trainer) should arrive at the course site early, to ensure that the arrangements described next are made. During the course, the course director needs to work with local staff to ensure that arrangements go well and that the work of both trainers and participants is not unduly interrupted.

13. Confirm arrangements for:
 - lodging for all trainers and participants;
 - classrooms;
 - daily transportation of participants from lodgings to their classroom and to and from the sites for clinical practice sessions;
 - meals and refreshments;
 - opening and closing ceremonies with relevant authorities; check that invited guests are able to come;
 - a course-completion certificate (if one will be given) and when a group photograph will be taken in time to be developed before the closing ceremony (optional);
 - arrangements for typing and copying of materials during the course (for example, timetables, lists of addresses of participants and trainers);
 - availability and delivery of course materials, supplies, and equipment to the course site;
 - welcoming trainers and participants at the hotel, airport, or railway/bus station, if necessary.

Actions during the course

- Post the list of participants assigned to the different pairs of trainers where everyone can see it (groups of four participants to one trainer is adequate).

- Provide all participants and trainers with a course directory, which includes the names and addresses of all participants and trainers and the course director.
- Arrange for a group photograph to be taken, if desired.
- Prepare a course-completion certificate for each participant (if one will be given).
- Make arrangements to reconfirm or change airline, train or bus reservations for trainers and participants, if necessary.
- Allocate a time for payment of per diem and for travel/lodging arrangements that does not take time from the course.

Trainers' meetings

- Trainers' meetings are usually conducted for about 30–60 minutes at the end of each day. Trainers will be tired, so keep the meetings brief. They should be led by the course director(s).
- Begin the meeting by encouraging the trainers – praising what they did well during the day. Trainers may become discouraged if they feel the session(s) they led did not go well.
- Continue by asking a trainer from each group to describe progress made by their group, to identify any difficulties impeding progress, and any skill, exercise or any section of the sessions that participants found especially difficult to do or understand.
- Identify solutions to problems related to any particular group's progress or related to difficult skills or sections of the sessions.
- Discuss teaching techniques that the trainers have found to be successful.
- Provide feedback to the trainers on their performance. Use the notes that you have taken while observing the groups during the day.
- Mention a few specific actions that were well done (for example, conducting a lecture session accurately and in an interesting way; keeping to time; providing participants with individual feedback; facilitating a practical session well; demonstrating practical skills carefully and accurately to the group).
- Mention a few actions that might be done better (for example, keeping to time; following the lecture sessions accurately without omitting any points; answering questions clearly; explaining more clearly which tasks should be practised during the clinical practice session).

Remind trainers of certain actions that you consider important. Examples are provided below.

- Discuss difficulties with a co-trainer. If co-trainers cannot solve problems together, go to the course director. The course director may be able to deal with these situations (for example, by discussing matters privately with concerned individuals).
- Speak softly while giving feedback, to avoid disturbing others. Put chairs out in the hall so that a participant and a trainer can talk without disturbing the rest of the group.
- Always be open to questions. Try to answer immediately, but if a question takes too long to answer, diverts the attention of the group from the main topic, or is not relevant at the moment, suggest that the discussion be continued later (for example, during free time). If a question will be answered later in the course, explain this. If unsure of the answer to a question, offer to ask someone else and then come back later with an explanation.
- Interact informally with participants outside of scheduled class meetings.
- For participants who cannot read the sessions and/or do not do the exercises as quickly as others, the trainers should:
 - avoid doing exercises for them
 - reinforce small successes
 - be patient (or ask another trainer to help).

3.2 Checklist of course materials

The checklist (Table 6) gives the materials needed for a course with 24 participants and six trainers plus a few spares. Some of the materials relate to specific sessions and should be used only if the session is included in the training.

| TABLE 6. CHECKLIST OF COURSE MATERIALS | | | |
|--|--------------|-----------------------|--------------|
| Item | Total copies | Director and trainers | Participants |
| <i>Director's guide</i> | 8 | ✓ | — |
| <i>Trainer's guide</i> | 8 | ✓ | — |
| Set of slides | 1 | per group | — |
| <i>Participant's manual</i> | 32 | ✓ | ✓ |

3.3 Items to be photocopied

Table 7 is a checklist of training materials that will need to be copied.

| TABLE 7. CHECKLIST OF ITEMS FOR PHOTOCOPYING | | | |
|---|-----------|-----------------------|--|
| Item | Total | Director and trainers | Participants |
| Course timetable for participants | 32 | ✓ | ✓ |
| Course registration form | 30 | ✓ | ✓ |
| Summary participant list | 1 | ✓ | — |
| Evaluation questionnaire for participants | 30 | — | ✓ |
| Evaluation form for participants and trainers | 30 | ✓ | ✓ |
| Evaluation form for trainers | 8 | ✓ | — |
| CHECKLIST: LISTENING AND LEARNING SKILLS | 32 | ✓ | ✓ |
| CHECKLIST: COUNSELLING SKILLS (including listening and learning skills and skills for building confidence and giving support) | 32 | ✓ | ✓ |
| CHECKLIST: CLINICAL PRACTICE DISCUSSION (with counselling skills on back) | 8 | ✓ | — |
| COMPETENCY PROGRESS FORM | 30 | ✓ | ✓ |
| JOB AID: BREASTFEEDING SESSION OBSERVATION | 64 | ✓ | ✓ |
| JOB AID: ANTENATAL CHECKLIST (OPTIONAL) | 32 | ✓ | ✓ |
| JOB AID: BIRTH PRACTICES FORM (OPTIONAL) | 32 | ✓ | ✓ |
| ASSESSING AND CHANGING PRACTICES FORM (IF USED) | 30 | ✓ | ✓ |
| LOG OF SKILLS PRACTISED | 26 | — | ✓ |
| DIFFICULTIES EXPERIENCED | 26 | — | ✓ |
| Copies of demonstrations | 2 of each | — | For participants helping with demonstrations |
| Answer sheets | 24 | — | 1 per participant |

3.4 Checklist of equipment and stationery

Table 8 lists the equipment and stationery you will need to conduct the course and table 9 the items needed for the demonstrations.

| TABLE 8. CHECKLIST OF COURSE EQUIPMENT AND STATIONERY | |
|---|---|
| Items needed | Number needed for the course |
| Laptop | 1 |
| PowerPoint projector | 1 |
| Equipment for typing/word processing | Access needed |
| Photocopying equipment | Access needed |
| Photocopying paper | Two reams (200 sheets) for timetables and other incidentals |
| Flipchart stands or blackboards | 3 |
| Markers for flipchart | 3 each of red, black and green |
| Chalk | 2 boxes |
| Chalk erasers | 2 |
| Name tags and holders | 32 |
| Pads or notebooks of ruled paper | 32 |
| No 2 pencils | 32 |
| Erasers | 32 |
| Ballpoint pens – blue or black | 32 |
| Highlighters | 32 |
| Hand-held staplers | 2 |
| Staples | 1 box |
| Scissors | 2 pairs |
| Pencil sharpeners | 5 |
| Paper clips, large | Approx. 100 |
| Masking tape to stick flipchart sheets onto walls or other surfaces | 2 rolls |
| Simple files for trainers to store papers | 10 |

TABLE 9. CHECKLIST OF ITEMS NEEDED FOR DEMONSTRATIONS

General

- Four chairs that can be brought to the front of the room for demonstrations
- Four life-size baby dolls – these can be made yourself, if necessary
- One model breast – this can be made yourself, if necessary

Individual sessions

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

- Poster with the TEN STEPS TO SUCCESSFUL BREASTFEEDING on it (provided at the end of Session 1 in the *Trainer's guide*)

Session 9. Clinical practice: Positioning a baby at the breast

- A doll
- Pillows and a blanket
- Somewhere for the “mother” to lie down, e.g. a bed or a table
- A model breast

Session 15. Alternative feeding methods

- Some examples of suitable containers to collect expressed breast milk, which would be available to mothers (for example, cups, jam jars)
- Optional: Some examples of locally available breast pumps (if any are used in your area)
- A small cup (available locally) that is suitable for cup-feeding a newborn. The cup should hold 60 mL of fluid
- A cloth or bib
- A doll
- A model breast

Session 11. Breast and nipple conditions

- A 20 mL disposable syringe
- A model breast

Session 21. Facility practices: Implementing the Ten Steps

- Breastfeeding policy for a local “baby-friendly hospital”, if available

3.5 Checklist of background information needed

- What are the follow-up plans for course participants?
- What are local breastfeeding rates, if available?
- What is the infant feeding policy for local hospitals and clinics (if available)?
- What is the prevalence of HIV? Are there regional differences?
- What is the national health authority infant feeding recommendation for mothers living with HIV?
- Are there ways that breast-milk substitutes are promoted, advertised, or marketed locally?
- Is there national legislation, regulations and monitoring systems surrounding The International Code of Marketing of Breast-milk Substitutes and subsequent relevant World Health Assembly (WHA) resolutions (the Code)?

4. Teaching the course

This section explains the teaching methodology used in the course. You should read it before you start conducting sessions.

Breastfeeding can be a very emotive topic. Be aware that participants may have strong feelings about these topics. Help the group to accept that there will be strong feelings and that there is a need to respect them all, without judgement. It can be useful to open the introductory session by asking participants about their own experiences on working with new mothers and newborns.

In areas where HIV is prevalent, it is possible that some participants are, themselves, living with HIV/AIDS, or have close family or friends who are living with HIV. Avoid comments that could sound **critical of people with HIV**.

4.1 Forming groups

Working in groups makes it possible for teaching to be more interactive and participatory, and it gives everybody more time to ask questions. Quieter participants have more chance to contribute.

As soon as possible after the introductory session, the course director and the trainers decide how the groups will be composed. Sometimes it is a good idea to make one participant who knows the others in the class responsible for arranging the groups.

Each group should have at least one person who can speak the local language. It may be appropriate to balance professional groupings and geographical areas.

Write the names of the trainer and participants in each group on a flipchart or board and post it up where both trainers and participants can check their group.

Some exercises are designed for groups of three or four people with a trainer. If there are enough trainers to have groups of three people with each trainer, then this is even better, as it gives all participants more opportunity to practise their counselling and practical skills.

During the course, the trainers should try to spend as much time as possible with their groups to learn from the participants where they feel most competent, and where they need more help and practice.

4.2 Motivating participants

Encourage interaction

During the first day, interact at least once with every participant, and encourage them to interact with you. This will help them to overcome their shyness, and they will be more likely to interact with you for the remainder of the course.

Make an effort to learn participants' names early in the course and use their names whenever it is appropriate. Use names when you ask participants to speak, or to answer questions, or when you refer to their comments, or thank them.

Be readily available at all times. Remain in the room and look approachable. For example, do not read magazines or talk constantly with other trainers. Talk to participants rather than trainers during tea breaks and be available after a session has finished.

Get to know the participants who will be in your group and encourage them to come and talk to you at any time, to ask questions or to discuss any difficulties, or even to tell you that they are interested and enjoying themselves.

Reinforce participants' efforts

Take care not to seem threatening. The following techniques may help.

- Be careful not to use facial expressions or comments that could make participants feel ridiculed.
- Sit or bend down to be on the same level as a participant to whom you are talking, particularly when you are going over individual written exercises.
- Do not be in a hurry, whether you are asking or answering questions.
- Show interest in what participants say. For example, say: "That is an interesting question/suggestion".

Praise or thank participants who make an effort, for example, when they:

- try hard
- ask for an explanation to a confusing point
- do a good job on an exercise
- participate in group discussion
- help other participants (without distracting them by talking about something irrelevant).

You may notice that many of the counselling skills taught during the course are also important for communicating with participants. In particular, you will find it helpful to use appropriate non-verbal communication, to ask open questions, to praise them and help them to feel confident in their work with mothers and new-borns. It is important that you, as a trainer, demonstrate these counselling skills throughout the course – not only during the relevant sessions, but also in your approach to the participants, mothers, caregivers, staff in the facilities, etc. This will demonstrate to the participants that counselling skills are useful in many situations and, with practice, become natural overtime.

Be aware of language difficulties

Try to identify participants who have difficulty understanding or speaking the language in which the course is conducted. Speak slowly and clearly, so that you can be more easily understood. Encourage participants in their efforts to communicate.

If necessary, speak with a participant in their own language (or ask someone else to do so for you) to clarify a difficult point.

Discuss with the course director any language problems that seriously hinder the ability of a participant to understand the material. It may be possible to arrange help for the participant, or for them to do some of the exercises in a different way.

4.3 Using your Trainer's guide

Before you lead any session

Look at your *Trainer's guide* and read the OBJECTIVES, to find out what participants should be able to do by the end of the session. Read the SESSION OUTLINE, to find out what kind of session it will be, and what your responsibilities are.

Read the PREPARATION box at the beginning of the text, so that you know what you have to do in advance to prepare for the session, and what training aids (and other kind of help) you need.

Read the text for the session, so that you are clear what you will have to do. The text includes detailed point-by-point instructions about how to conduct the session.

Consider splitting the session between two or more trainers, particularly if the session is long. Trainers can also work together, with one trainer writing on the flipchart or assisting with a demonstration while the other trainer is conducting the session.

When you lead a session

Keep your *Trainer's guide* with you and use it all the time. You do not need to try to memorize what you have to do. It is extremely difficult to do so. Use the guide as your session notes and follow it carefully.

The course director may explain at the beginning of the course that using the *Trainer's guide* is the appropriate method for this kind of teaching, in the same way that participants need to use their *Participant's manual*. You may wish to copy the necessary pages of the guide, to use as your notes during the session. This will not be so bulky as carrying the whole guide.

Remember that even the authors of the materials find it necessary to follow the *Trainer's guide* when they teach the course. If they do not, they find it difficult to keep to the planned sequence of teaching, and they miss out important steps.

If the participants seem tired, or their attention is wandering, pause for a short break. Encourage everyone to stretch and take some deep breaths. Perhaps a short activity, song or game, may revive them.

4.4 Giving a lecture or demonstration

Preparing to give a lecture

Study the material

Before you give one of the lecture presentations, read the notes through carefully, and study the slides that go with it.

You do not have to give the lecture exactly as it is written. It is preferable not to read it out, though this is acceptable if you feel that there is no other way you can do it. However, it is important that you are thoroughly familiar with the contents of the lecture, and with the order of ideas in the presentation. This is necessary even if you are an experienced trainer and knowledgeable about infant feeding.

Go through the text, mark it and add your own notes to remind you about points to emphasize, or points of special local importance. Try to think of ways to present the information naturally, in your own way.

Read the FURTHER INFORMATION sections at the end of the sessions. They give extra information about topics that are covered only briefly in the main text. You should not present them as part of the main presentation, but they may help you to answer questions that arise in the course of discussion.

Prepare your PowerPoint slides and flipcharts

Make sure that you have all the slides for the session. If you are projecting the PowerPoint slides, ensure that your projection equipment is working. If flipcharts need to be written beforehand, do this in plenty of time. During the session, when you are asking for responses from participants, another trainer can write items on the flipchart, thus allowing you to keep eye contact with the participants.

Shortly before the session, make sure that the audience will be able to see the images – that the room is dark enough, that the screen is well placed and that the chairs are arranged appropriately. You do not have to accept the arrangements from the previous session – it can be an advantage to move an audience around and present material in a new way. It may help to keep their attention.

Giving a lecture

Talk in a natural and engaging way

- Present the information as in a conversation, instead of reading it.
- Speak clearly and try to vary the pitch and pace of your voice.
- Move around the room and use natural hand gestures.

Explain the slides carefully

Remember that presentation slides do not do the teaching for you. They are aids to help you to teach and to help

participants to learn. Do not expect participants to learn from them without your help.

Explain to the audience exactly what each picture shows and tell them clearly the main points that they should learn from it. As you explain the information in the text, point out on the slide where it shows what you are talking about. Do not assume that participants automatically see what you want them to look at.

Remember to face the audience as you explain – do not keep looking at the screen yourself. Do not turn your back on the audience for more than a short time. Keep looking at them, and maintain eye contact, so that they feel that you are talking to them personally.

Be careful not to block participants' view of the screen. Either stand to the side or sit down, and check that they can see clearly. Look out for participants bending to see the screen or demonstration because you are in the way. Stop and adjust your position before you continue.

When you are familiar with the material, and you have taught it a few times, you will be able to explain it in your own way. You will be able to make it appropriate for the participants and answer their questions in a way that is most helpful for them.

It is sometimes helpful, when presenting photographs, to ask participants to come to the screen to point things out to the others. This technique is recommended for SESSION 11: BREAST AND NIPPLE CONDITIONS.

Involve the participants

You will have to give much of the information in lecture form. This is necessary to cover enough material in the limited time available.

It is also helpful during lectures and other sessions to ask questions, to check that participants understand, and to keep them thinking. This interactive technique helps to keep participants interested and involved and is usually a more effective way of learning. Ask open questions, (which you have learnt about in the sessions on counselling skills), so that participants have to give an answer that is more than a “yes” or “no”.

A number of questions are indicated in the text. The questions are asked in such a way that participants should be able to decide the answer either by looking at the figure that is displayed, or from their own experience, or from what has been covered previously in the course, without requiring new information that they may not have.

Sometimes you may want to give participants a hint to help them to answer. Sometimes asking the question again, in another way, can help. However, do not help them or give them the answer too quickly. It is important to wait, and to give them a genuine chance to think of the answer themselves.

Ask participants to keep their *Participant's manual* closed while answering discussion questions, so that they think about possible answers rather than reading the information from their manual.

Do not get involved in discussions that are distracting and waste a lot of time. Encourage participants to make a few suggestions, discuss their suggestions, and then continue with the section. You do not have to wait until they have given all the answers listed in the text. Notes are included with many of the questions to guide you.

Acknowledge all participants' responses, to encourage them to try again. Comment briefly on their answer, or say “Thank you”, or “Yes”. If participants give an incorrect answer, do not say “No – that is wrong!” or some may hesitate to make other suggestions. Accept all answers, and say something non-committal, such as “That is an interesting idea” or “I haven't heard that one before”. Ask them to say more to clarify the idea, or say, “What does anyone else think?” or ask for other suggestions. Make participants feel that it is good to make a suggestion, even if it is not the “correct” answer. Then clarify the information so that participants have the correct information.

When someone answers correctly, “hold onto” their answer; expand it if necessary, and make sure that everyone else has understood.

Do not let several participants talk at once. If this occurs, stop the talkers, and give them an order to speak in. For example, say “Let's hear Mary's comment first, then Anastasia's, then Siti's”. People will usually not interrupt if they know that they will have a turn to talk.

Do not let the same one or two people answer all the questions. If a talkative participant tries to answer several

questions, ask him or her to wait for a minute, or move away and focus attention on others. Try to encourage quieter participants to talk. Ask by name someone who has not yet spoken to try to answer a question, or walk towards someone to bring attention to them, and make them feel that they are being asked to talk.

Thank participants whose answers are short and to the point.

Preparing to give a demonstration

Some sessions include a number of short demonstrations of counselling techniques and other skills. You should practise these beforehand, in order for them to be effective and to demonstrate the relevant points to the participants.

Study the instructions and collect the equipment

Sometime before you give the demonstration, read through the instructions carefully, so that you are familiar with them and you do not forget any important steps. This is necessary even if you have already seen someone else give the demonstration. Make sure that you have the equipment that you need.

Prepare your assistant

You may need someone to help you to give the demonstration, for example, someone to role play being a mother. It is usually a good idea to ask a participant to help you. This can be a good learning experience for them. It increases the participant's involvement and helps them to learn about teaching methods. If the participant will be taking part in one of the role plays with a written scenario, give them the words before the session so that they can practise them.

If you feel that participants are not ready to demonstrate the counselling skills, do the demonstrations yourself with another trainer. This helps participants to understand what playing the part is about, and they can see that making mistakes does not matter, so they may feel more confident to try themselves next time.

Practise the demonstration

Practise giving the demonstration, by yourself, with your assistant, or with another trainer, so that you know how long it takes, what can go wrong, and if there is anything else that you need, such as an extra table or chairs. This will make the demonstration much more convincing, and it is a good idea even if you have done it before.

Giving a demonstration

Make sure that all the equipment is ready and prepare the space where you will give the demonstration. Arrange tables and chairs as you will need them. Make sure that you can use a board or flipchart, or an overhead projector, if you need to show a slide as part of the demonstration, without having to rearrange everything.

Demonstrate slowly, step-by-step, and make sure that the audience is able to see what you do. If necessary, ask them to move closer to you so that they can all see and hear clearly; or you can move closer to them, going to each part of the audience in turn.

As you give the demonstration, take every opportunity to let participants handle and examine the equipment that you use, and practise for themselves what you demonstrate. They will learn more if they try things out, rather than just watching you.

At the end of a lecture or demonstration

Leave time for participants to ask questions and do your best to answer them. You do not need to know the answer to every question. Other participants may be able to offer information, or you can refer them to a local source for further information.

Ask participants to find the summary notes for the session in their *Participant's manual*. Ask them to read the notes later on the same day.

4.5 Facilitating other methods of learning

Group work for written exercises

Groups are used for some sessions that involve written exercises.

Read the specific instructions for the group work sessions that you will lead, and plan how you will conduct them.

Individual written exercises

A number of exercises are individual written exercises. This is an important way for individual participants to learn and to find out for themselves what they are and are not clear about. It helps you to discover who easily understands what has been taught, and who needs more help. The participants who are most in need of help may not ask for it, and you may not discover who they are until they do these exercises. In addition, you may find that someone who is very quiet in fact understands much more than you expect. Giving feedback also helps you to discover which topics are easy and which are difficult for the group.

Make sure participants have found the correct page in their *Participant's manual*. Explain that they should read the questions and write the answers in their manuals. They should use pencils, so they can change their answer if needed.

Try to arrange for participants to sit a little away from each other, so they do not see or hear other people's answers and so that there is room for trainers to sit between them to give individual feedback. The trainers circulate and give individual feedback and personal attention to the participants as they do the exercises. Talk to each participant individually and as confidentially as possible. Try not to let other participants overhear what you are saying. Compare their answers with the suggested answers in your *Trainer's guide*. Praise them if they have a good answer. If an answer is incorrect, do not make them feel ridiculed. Ask them whether they have any other ideas and give them a chance to correct the answer. If they cannot do so, help them to decide on the correct answer and explain how they went wrong. Try not to give the answer too easily.

If a question causes difficulty for several participants, discuss it afterwards with the group together. At the end of the time, if there are unfinished questions in the exercise, suggest that they finish them in their own time and ask a trainer to review the answers later.

Clinical practice sessions

For Clinical practice sessions, each trainer takes his or her group of three or four participants to a ward or clinic to practise with mothers and newborns the skills they have learnt in the previous sessions. Use the CLINICAL PRACTICE DISCUSSION CHECKLIST to help you to discuss each mother and newborn with the participants. Remember to use your communication skills when you give feedback to the participants. Encourage other participants to use their counselling skills when giving feedback, and to recognize and praise what the participant who is practising did well, in addition to making suggestions about what they could do better. They should not just criticize, but they should not give only praise either.

Detailed instructions are given with the notes for each clinical practice session.

4.6 Additional training methodologies

Small working group

A small working group can be a group of four to seven participants who work together to perform a task or activity and report back to a larger group (plenary). The number of participants in the small working group can be defined based on the number of the overall group. This type of work:

- allows two-way communication
- allows group members learn each other's views and sometimes makes consensus easier
- involves active participation
- allows participants to ask and learn about aspects that are unclear
- can produce a strong sense of sharing or camaraderie
- often lets people who feel inhibited share
- challenges participants to think, learn and solve problems.

Leading a small working group

- Outline the purpose and tasks clearly, to provide focus and structure.
- Allow enough time for all groups to finish the task and give feedback.
- Announce the remaining time at regular intervals.
- Ensure that participants share or rotate roles.
- Be aware of possible conflicts and anticipate their effect on the group's contribution in plenary.
- Reach conclusions but avoid repeating points already presented in plenary.

Brainstorming

This is a spontaneous process through which group members' ideas and opinions on a subject are voiced and written for selection, discussion and agreement. All opinions and ideas are valid. This type of work:

- allows many ideas to be expressed quickly
- encourages open-mindedness (every idea should be acceptable, and judgement should be suspended)
- gives everyone an opportunity to contribute
- helps stimulate creativity and imagination
- can help make connections not previously seen
- is a good basis for further reflection
- helps build individual and group confidence by finding solutions within the group.

Leading a brainstorming session

- State clearly the brainstorming rule that there is no wrong or bad idea.
- Ensure a threat-free, non-judgmental atmosphere, so that everyone feels he or she can contribute.
- Ask for a volunteer to record brainstorming ideas.
- Record ideas in the speaker's own words.
- State that the whole group has ownership of brainstorming ideas.
- Give participants who haven't spoken a chance to contribute.

Plenary or whole-group discussion

The entire group comes together to share ideas. This type of work:

- allows people to contribute to the whole group
- enables participants to respond and react to contributions
- allows facilitators to assess group needs
- enables people to see what other group members think about an issue
- allows individuals or groups to summarize contents.

Leading a plenary or whole-group discussion

- Appoint someone to record the main points of the discussion.
- Appoint a timekeeper.
- Pose a few questions for group discussion.
- Use buzz groups to explore a topic in depth.
- Ask for contributions from participants who have not shared their views.

Role play

Role play involves imitation of a specific life situation and giving participants details of the “person” they are asked to play. This type of work:

- helps start a discussion
- is lively and participatory, breaking down barriers and encouraging interaction
- can help participants improve skills, attitudes and perceptions in real situations
- is informal and flexible and requires few resources
- is creative
- can be used with all kinds of groups, regardless of their education levels
- can model certain kinds of interactions.

Leading a role play

- Structure the role play well, keeping it brief and clear in focus.
- Give clear and concise instructions to participants.
- Carefully facilitate to deal with emotions that arise in the follow-up discussion.
- Make participation voluntary.
- Rehearse the general direction of the role play before the session.

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

Case study

Pairs or small groups are given, orally or in writing, a specific situation, event or incident and asked to analyse and solve it. This type of work:

- allows rapid evaluation of trainees’ knowledge and skills
- provides immediate feedback
- increases analytical and thinking skills
- is the best realistic alternative to field practice.

Leading a case study

- Make the situation, event or incident real and focus on the topic.
- Initiate with simple case studies and gradually add more complex situations.
- Speak or write simply.

Example: mother, counsellor and observer

- The “counsellor” of each group asks the “mother” about her situation, and practises the “assess, analyse and act” steps with listening and learning skills, and building confidence and giving support skills.
- The “observer” records the skills of the “counsellor” using an observation checklist and then provides feedback after the case-study.

Interactive presentation

This involves imparting information quickly, with engagement of participants, supplemented with audio or visual aids. This type of work:

- facilitates structuring of the presentation of ideas and information
- allows the facilitator to pose questions
- is ideal for factual topics
- stimulates ideas for informed group discussion.

Leading an interactive presentation

- Use a lead-off story or interesting visual.
- Present an initial case problem.
- Give examples using real-life illustrations and, if possible, compare the material and the participants' knowledge and experience.
- Use visual backup (flipcharts, slides, brief handouts and demonstrations) to enable participants to see as well as hear what you are saying.
- Challenge participants to give examples of the concepts.
- Allow time for feedback, comments and questions.
- Apply the problem by posing a problem or question for participants to solve based on the information provided.

Small-group discussion

A small group of no more than seven participants discusses and summarizes a given subject or theme. The group selects a chairperson, a recorder and/or someone to report to participants in plenary. This type of work:

- allows two-way communication
- allows group members learn each other's views and sometimes makes consensus easier
- allows group members to take on different roles (e.g. leader, recorder) to practise facilitation techniques
- involves active participation
- allows participants to ask and learn about unclear aspects
- often lets people who feel inhibited share
- can produce a strong sense of sharing or camaraderie
- challenges participants to think, learn and solve problems.

Leading a small-group discussion

- Outline the purpose of the discussion and write questions and tasks clearly to provide focus and structure.
- Establish ground rules (e.g. courtesy, speaking in turn, ensuring everyone agrees with conclusions) at the beginning.
- Allow enough time for all groups to finish the task and give feedback.
- Announce the remaining time at regular intervals.
- Ensure that participants share or rotate roles.
- Be aware of possible conflicts and anticipate their effect on the group's contribution in plenary.
- Reach conclusions but avoid repeating points already presented in plenary.

Notes for an orientation session for non-clinical staff

Target audience

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

Time

15 to 20 minutes

Objectives

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

- indicate where a copy of the facilities infant feeding policy can be found;
- list two reasons why supporting breastfeeding is important;
- list two practices in the facility that support breastfeeding;
- list two things that they can do (or avoid doing) as part of their own work that can help;
- implement the policy and support breastfeeding.

Key points

- Breastfeeding is important for the short- and long-term health and well-being of mother and child.
- Exclusive breastfeeding is recommended for the first six months. This means no other food or drinks aside from breast milk. Following the introduction of other foods from six months, breastfeeding is still important. It is recommended that breastfeeding continue up to two years and beyond.
- Most women are able to breastfeed.
- If a pregnant woman or a mother has a question about feeding her baby, suggest that she talk to a relevant health worker in the facility (such as a midwife, clinic nurse or doctor).
- This health facility works to support breastfeeding and has a policy, which you are required to abide by (the same as you abide by policies about confidentiality, safety, timekeeping and other policies). This policy includes: ... (discuss some practices such as antenatal information, rooming-in, and responsive feeding).
- Hospital practices can help (or hinder) baby-friendly practices. Implementing the Baby-friendly Hospital Initiative helps good practices to happen. In your general work, this means:
 - No marketing or promotion of formula, bottles or teats will be allowed in the health facility. This includes no pens, calendars, magazines or other printed marketing materials, no samples, no equipment marketing a formula related product, no gifts, etc., from companies related to formula, bottles, teats or pacifiers.
 - All health facility materials will promote breastfeeding as the normal and optimal way to care for a baby.
 - Mothers will be supported to breastfeed if they are patients, staff or visitors.
 - No mother will be asked to leave a public area if she is breastfeeding.
 - If your work brings you into contact with a mother feeding her newborn, be supportive. A smile and maybe an offer of help such as a drink of water or a seat can show the mother that you know she is doing something good.
 - If you work in maternity or paediatric areas, more specific information will be provided on your role in supporting the policy (for example, what to say if a mother asks you to get her formula, if you notice a mother with difficulties, or about labour ward practices).
 - If you want further information or someone asks you a question, information is available from (give specific names).
 - Answer any questions from the participants.

NOTE: Keep the session very brief, informal and related to their work, rather than a theory classroom session. The participants do not need to know how breast milk is made, how to position a baby, detail on the Ten Steps, or the Code for their work role. If they want more information personally, this can be provided afterwards. Further information on the importance of breastfeeding and how supportive practices can be implemented is found in the main session of the course.

5. Symbols used in the guide

As you follow the text, remember:

- indicates an instruction to you, the trainer
- indicates what you say to participants.

Further information – these sections give extra information on topics in the text. You should not present them with the main presentation, but they may help you to answer questions that arise in the course of the discussion.

MODULE 1. GETTING STARTED

Session 1. BFHI: A 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.

Session outline

Suggested time: 30 minutes

Participants are all together for a lecture presentation by one trainer.

- 1) Introduce the session, present **Slide 1/1**
- 2) Present **Slides 1/2–1/13**
- 3) Discuss the Ten Steps to Successful Breastfeeding
- 4) Discuss your local context
- 5) Summarize the session
- 6) Time for Question and Answer

Preparation

- Study the notes for the session.
- Refer to the 'Introduction' for guidance on giving a presentation with slides.
- Study **Slides 1/1 to 1/12** and the text that goes with them.
- Prepare information for country or region showing:
 - current implementation of the Baby-friendly Hospital Initiative
 - any national programmes to implement the Global Strategy for Infant and Young Child Feeding
 - breastfeeding rates (initiation, exclusive and continued).
- Display the Ten Steps to Successful Breastfeeding poster.
- Give handout to each participant. This is provided at the end of this session.

Reference materials

- Global strategy for infant and young child feeding. Geneva: World Health Organization; 2003 (<http://apps.who.int/iris/bitstream/10665/42590/1/9241562218.pdf>, accessed 18 March 2020).
- WHO/UNICEF. Baby-friendly hospital initiative: revised, updated and expanded for integrated care. Geneva: World Health Organization; 2009 (<http://apps.who.int/iris/handle/10665/43593>).
- WHO/UNICEF. Global nutrition targets 2025: breastfeeding policy brief (WHO/NMH/NHD/14.7). Geneva: World Health Organization; 2014 (http://apps.who.int/iris/bitstream/handle/10665/149022/WHO_NMH_NHD_14.7_eng.pdf, accessed 18 March 2020).
- WHO/UNICEF. Implementation guidance: protecting, promoting and supporting breastfeeding in facilities providing maternity and newborn services – the revised Baby-friendly Hospital Initiative. Geneva: World Health Organization; 2018 (<http://apps.who.int/iris/bitstream/handle/10665/272943/9789241513807-eng.pdf?ua=1>, accessed 18 March 2020).
- WHO/UNICEF. Ten Steps to Successful Breastfeeding. Geneva: World Health Organization; 2018 (<http://www.who.int/nutrition/bfhi/ten-steps/en/>, accessed 18 March 2020).

Introduce the session



Session 1.

BFHI: A key component of quality maternal and newborn care

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1/1

- ☐ Show **Slide 1/2 – Objectives** and read objectives aloud.

Session 1. Objectives

BFHI: A key component of quality maternal and newborn care

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 (BFHI);
- list the TEN STEPS TO SUCCESSFUL BREASTFEEDING (TEN STEPS);
- outline how this course improves capacity building.

1/2

Exclusive and continued breastfeeding



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 intervention⁶.
- 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.⁶ The World Health Organization (WHO) and United Nations Children's Fund (UNICEF) recommend infants 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/caregivers/parents to establish and sustain exclusive breastfeeding for six months, WHO and UNICEF recommend:
 - immediate and uninterrupted skin-to-skin contact from birth and initiation of breastfeeding within the first hour of life;
 - exclusive breastfeeding – the infant only receives breast milk;
 - breastfeeding responsively – that is, as early and 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.

⁶ 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.

- Show **Slide 1/4 – To enable mothers.** Read aloud the key points.



- 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 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 from birth and initiation of breastfeeding within the first hour of life.
 - exclusive breastfeeding – the infant only receives breast milk and no other food or fluids
 - breastfeeding responsively – that is, as early and often, and as long as the baby wants, day and night.
 - counselling mothers on the risks and use of feeding bottles, teats or pacifiers.

Critical window

The first hours and days of a newborn’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, caregivers and other identified word choices globally. The term “mother/parent/caregiver” will be used when the method of breastfeeding is not being discussed.

Global strategy for infant and young child feeding

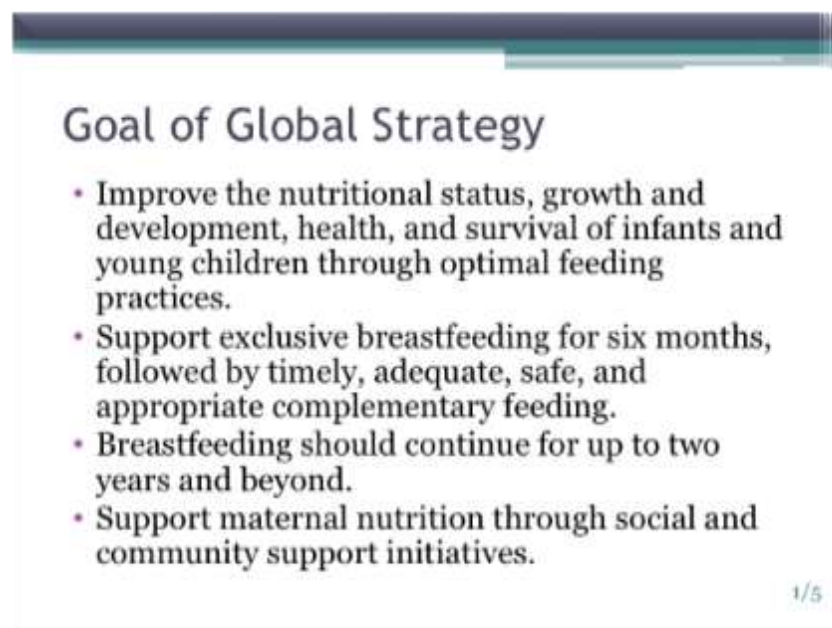
- Ask: *What are the effects of poor infant feeding practices on families, communities and health services?*

Wait for a few responses and then continue.

- Make these points.

- Improved breastfeeding practices would prevent an estimated 823 000 annual deaths in children younger than five years of age⁷. Many children suffer long-term effects from poor infant feeding practices including impaired development, malnutrition, 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.

- Show **Slide 1/5 – Goal of the Global Strategy**. Ask a participant to read the slide aloud.



- The Global Strategy does not replace, but rather builds upon existing programmes including the BFHI.

⁷ Rollins NC, Bhandari N, Hajeerhoy N, Horton S, Lutter CK, Martines JC et al. *The Lancet* Breastfeeding Series Group. Why invest, and what it will take to improve breastfeeding practices? *Lancet*. 2016;387:491–504. doi:10.1016/S0140-6736(15)01044-2

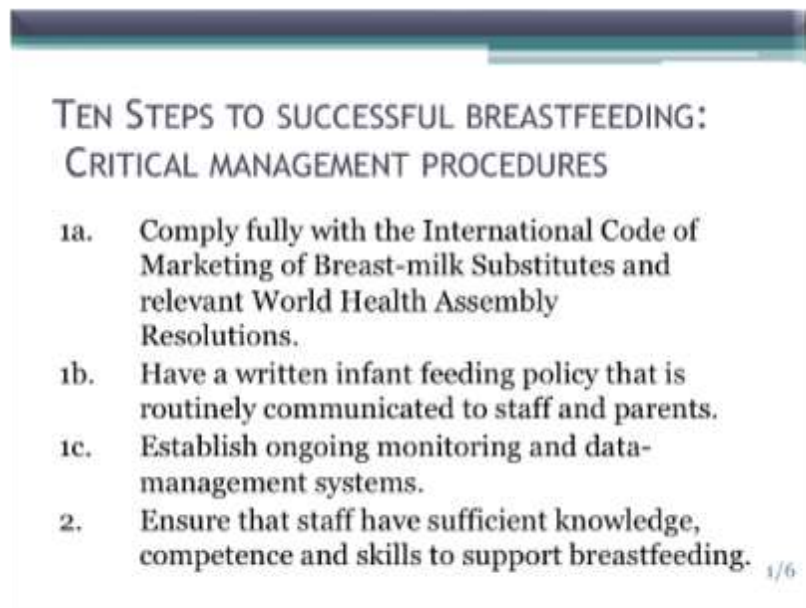
- The Global Strategy calls for:
 - further implementation of the BFHI
 - breastfeeding/lactation management curriculum for health-worker training
 - community support for breastfeeding mothers and babies
 - accurate and updated data on breastfeeding.

Outline the Baby-friendly Hospital Initiative (BFHI)

- Ask: *What does BFHI means?*
- Praise participants who are familiar with the BFHI and congratulate those who come from a hospital with a BFHI accreditation.
- Make these points.
 - 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 helps mothers acquire necessary skills to exclusively breastfeed for six months and continue breastfeeding for two years or beyond.
 - The Baby-friendly Hospital Initiative aims to promote universal implementation of all the Ten steps to Successful Breastfeeding. The Ten Steps were first written in 1989. In 2018, they were revised and continue to be valid throughout the world as the basis of the BFHI.
 - The BFHI supports women living with HIV⁸ in both contexts:
 - where national recommendations include avoidance of all breastfeeding
 - where national recommendations include breastfeeding plus antiretroviral therapy (ART).
- Briefly discuss the status of BFHI in the local country or area. Discuss how the Ten Steps are being implemented in facilities that have been “designated” as Baby-friendly and those that have not.
- Briefly explain local policy.
- Ask participants to close the *Participant's manual*.
- Ask participants whether they can think of any of the TEN STEPS TO SUCCESSFUL BREASTFEEDING.

⁸ 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 14 March 2020).

- ❑ Show **Slide 1/6 – Ten Steps to Successful Breastfeeding: Critical Management Procedures**. Ask participants to read out each step.

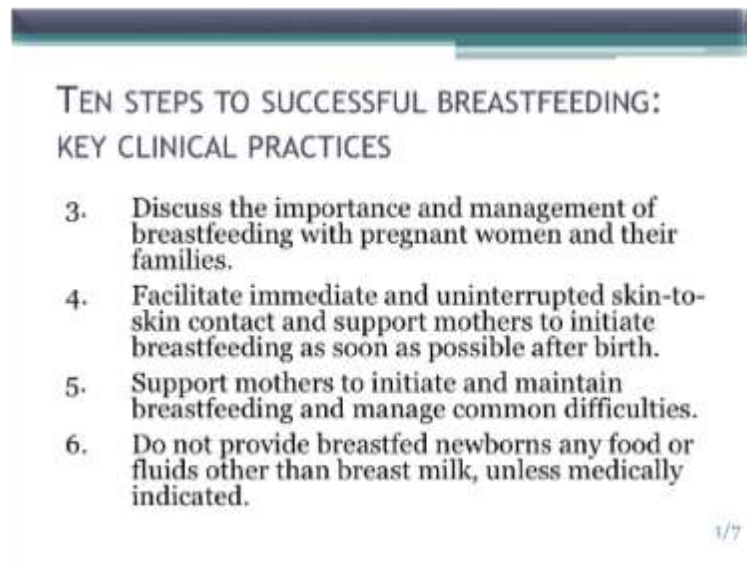


TEN STEPS TO SUCCESSFUL BREASTFEEDING:
CRITICAL MANAGEMENT PROCEDURES

- 1a. Comply fully with the International Code of Marketing of Breast-milk Substitutes and relevant World Health Assembly Resolutions.
- 1b. Have a written infant feeding policy that is routinely communicated to staff and parents.
- 1c. Establish ongoing monitoring and data-management systems.
2. Ensure that staff have sufficient knowledge, competence and skills to support breastfeeding.

1/6

- ❑ Show **Slides 1/7–1/8 – Ten Steps to Successful Breastfeeding: Key Clinical Practices**. Ask participants to read aloud together.



TEN STEPS TO SUCCESSFUL BREASTFEEDING:
KEY CLINICAL PRACTICES

3. Discuss the importance and management of breastfeeding with pregnant women and their families.
4. Facilitate immediate and uninterrupted skin-to-skin contact and support mothers to initiate breastfeeding as soon as possible after birth.
5. Support mothers to initiate and maintain breastfeeding and manage common difficulties.
6. Do not provide breastfed newborns any food or fluids other than breast milk, unless medically indicated.

1/7

TEN STEPS TO SUCCESSFUL BREASTFEEDING: KEY CLINICAL PRACTICES

7. Enable mothers and their infants to remain together, and to practice rooming-in 24 hours per day.
8. Support mothers to recognize and respond to their infants' cues for feeding.
9. Counsel mothers on the use and risks of feeding bottles, teats and pacifiers.
10. Coordinate discharge so that parents and their infants have timely access to ongoing support and care.

1/8

Outline how this course improves capacity building

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, use effective counselling skills, build mothers' confidence, give consistent messages and implement standards to protect, promote and support breastfeeding.

Course objectives

- This course will increase your competence, knowledge and skills to care for mothers and infants in everyday practice. This course will proceed over 2–3 days and cover 22 hours of learning and practice.

- ❑ Show **Slide 1/9 – BFHI Maternity Staff Course: Structure and Expectations**. Review with participants.

**BFHI Maternity Staff Course:
Structure and expectations**

- **Structure**
 - 22 hours
 - 3 days
 - Lecture, hands-on practice
 - Clinical sessions
- **Expectations**
 - Knowledge + Practice
 - Interaction
 - Problem-solving

© WHO/Yoshi Shimizu 1/9

- 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 breastfeeding situations. This includes (but is 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
16. explaining a facility's infant feeding policies and monitoring systems

Let's discuss the local and national context

- If time is available at the end of the session, please spend time discussing the local and national situation for breastfeeding.
- Please view the slides below as a template to insert your own local and national information.
- Resources:
 - **Global Breastfeeding Scorecard** <https://www.who.int/nutrition/publications/infantfeeding/global-bf-scorecard-2019/en/>
 - **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?

Show **Slides 1/10–1/13 – Let's discuss: Local and national context.** Review with participants.



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 feeding per live birth (USD) | |
| Legal status of the Code | |
| Compliance with CoB and RoB | |
| % 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 WHO 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

Summarize the session

Time for Question and Answer

- Ask participants if they have any questions.
- Explain the session summary can be found on **pages 10–17** of the Participant's manual.

The TEN STEPS to Successful Breastfeeding

1 HOSPITAL POLICIES

Hospitals support mothers to breastfeed by...



2 STAFF COMPETENCY

Hospitals support mothers to breastfeed by...



3 ANTENATAL CARE

Hospitals support mothers to breastfeed by...



4 CARE RIGHT AFTER BIRTH

Hospitals support mothers to breastfeed by...



5 SUPPORT MOTHERS WITH BREASTFEEDING

Hospitals support mothers to breastfeed by...



6 SUPPLEMENTING

Hospitals support mothers to breastfeed by...



7 ROOMING-IN

Hospitals support mothers to breastfeed by...



8 RESPONSIVE FEEDING

Hospitals support mothers to breastfeed by...



9 BOTTLES, TEATS AND PACIFIERS

Hospitals support mothers to breastfeed by...



10 DISCHARGE

Hospitals support mothers to breastfeed by...



Notes

A series of horizontal dotted lines for writing 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.

Session outline

Suggested time: 45 minutes

Participants are all together for a lecture presentation by one trainer.

- 1) Introduce the session, present **Slide 2/2**
- 2) Facilitate group work
- 3) Present **Slides 2/1–2/11**
- 4) Summarize the session
- 5) Time for Question and Answer

Preparation

- Refer to Introduction for guidance on giving a presentation with slides and facilitating group discussion.
- Make sure **Slides 2/1–2/11** are ready. Study the slides and the text that goes with them, so you are able to present them.
- Read the information sections, so you are familiar with the information.
- Set three flipcharts out round the room:
 - 1) IMPORTANCE OF BREASTFEEDING TO INFANT
 - 2) IMPORTANCE OF BREASTFEEDING TO MOTHER
 - 3) RISKS OF NOT BREASTFEEDING



☐ Make the following points.

- 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 that 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.

- Show **Slide 2/2 – Objectives** and read aloud together.

Session 2. Objectives
Benefits of breastfeeding

After completing this session, participants will be able to:

- state the advantages of optimal infant feeding (exclusive and continued breastfeeding);
- list the special properties of colostrum and why it is important;
- describe the main differences between breast milk and artificial milk;
- list the risks of artificial feeding.

2/2

- Make these points:
 - we will review the rationale for the breastfeeding recommendations, with an emphasis on exclusive breastfeeding for the first six months of life;
 - today we will have discussion groups, a plenary discussion and presentation to share up-to-date evidence on breastfeeding.


Facilitate group work and plenary discussion

- Divide participants into three groups. Each group will be with one trainer/facilitator. Allocate 15 minutes for this exercise.
- Make these points:
 - now you will work in groups
 - you will find three flipcharts set up throughout the room
 - each flipchart has a different title:
 - 1) IMPORTANCE OF BREASTFEEDING TO INFANT
 - 2) IMPORTANCE OF BREASTFEEDING TO MOTHER
 - 3) RISKS OF NOT BREASTFEEDING;
 - each group will have two minutes to write as many points on the flipchart. Do not repeat what is already listed.
- Groups will rotate to each flipchart until they have a chance to contribute to all three of them. At the end of the exercise, you will go back to your seats. We will begin the lecture session.

- ❑ Ask Group 1 representative to present the list on the first flipchart (IMPORTANCE OF BREASTFEEDING TO INFANT). Ask the other groups to contribute.
- ❑ Ask Group 2 representative to present the list on the second flipchart (IMPORTANCE OF BREASTFEEDING TO MOTHER). Ask the other groups to contribute additional ideas.

Benefits of breastfeeding

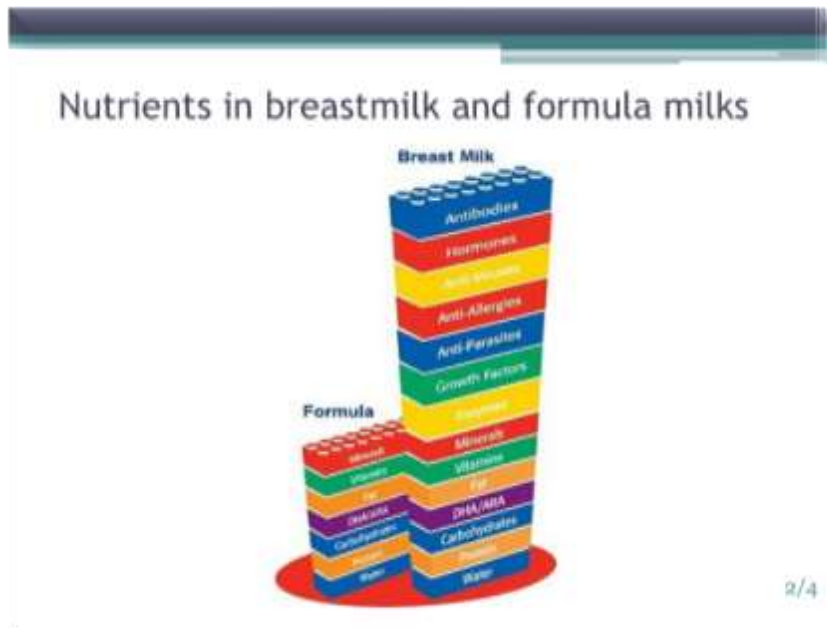
- ❑ Show **Slide 2/3 – Benefits of breastfeeding**. Make the key points.

| Breast milk | Breastfeeding |
|---|---|
| Complete nutrients | Helps bonding and development |
| Easily digested | Helps delay a new pregnancy |
| Efficiently used | Protects mothers' health |
| Protects against infection |  |
| Protects against long-term noncommunicable diseases | |
| Costs less than artificial feeding. | |

© UNICEF/UN722222/Winapost 2/3

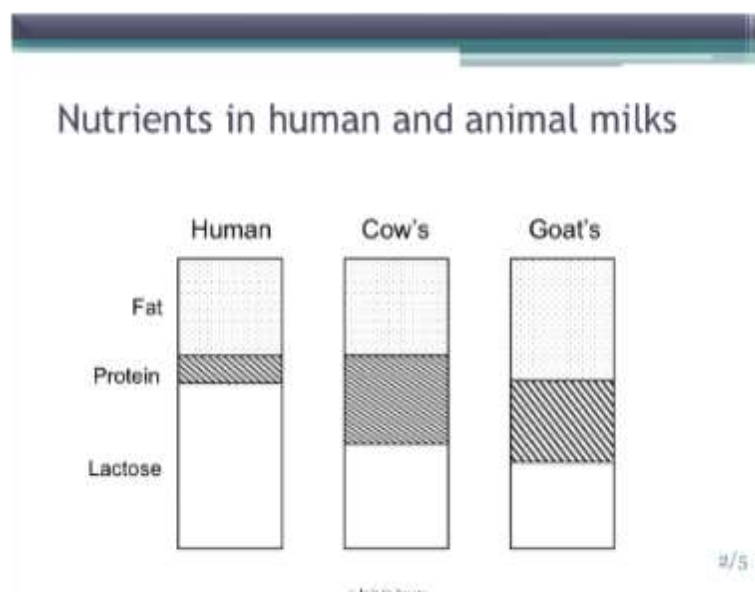
- ❑ This slide summarizes some of the benefits of breastfeeding. It is useful to think of the benefits of both breast milk (listed on the left) and the process of breastfeeding (listed on the right).
 - **Benefits of a baby having breast milk are:**
 - it contains the complete nutrients a baby needs
 - 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 noncommunicable 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.
 - In the next few slides, we will look at some of these advantages in more detail.

☐ Show **Slide 2/4 – Nutrients in breastmilk and formula milks**. Make the key points.



The tall bar in the coloured chart shows that the nutrients in breast milk, are complete for babies. 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.

☐ Show **Slide 2/5 – Nutrients in human and animal milks** and make the key points.



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.

□ Ask: *What is the difference between the amount of protein in human milk and the amount in animal milks?*

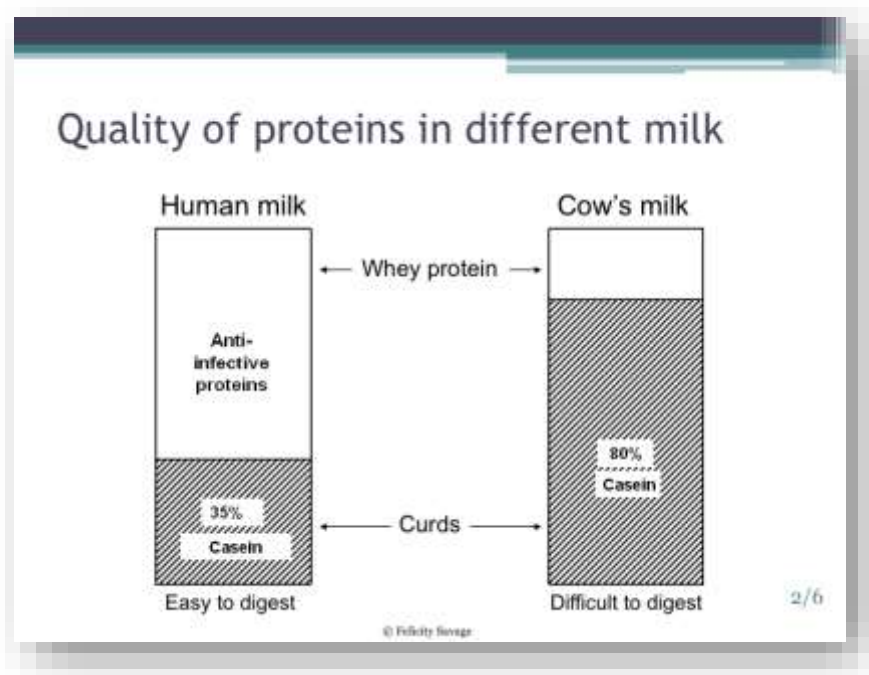
Wait for a few replies and then continue.

- 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 needed for a baby's growing brain, eyes, and healthy blood vessels, which are not present in animal milks but can be added to formula milk.

□ Ask: *What are the differences in milk proteins between human and cow's milk?*

Wait for a few answers and then proceed. Refer to the correct responses when reviewing the slide.

□ Show **Slide 2/6 – Quality of proteins in different milks** and make the key points.



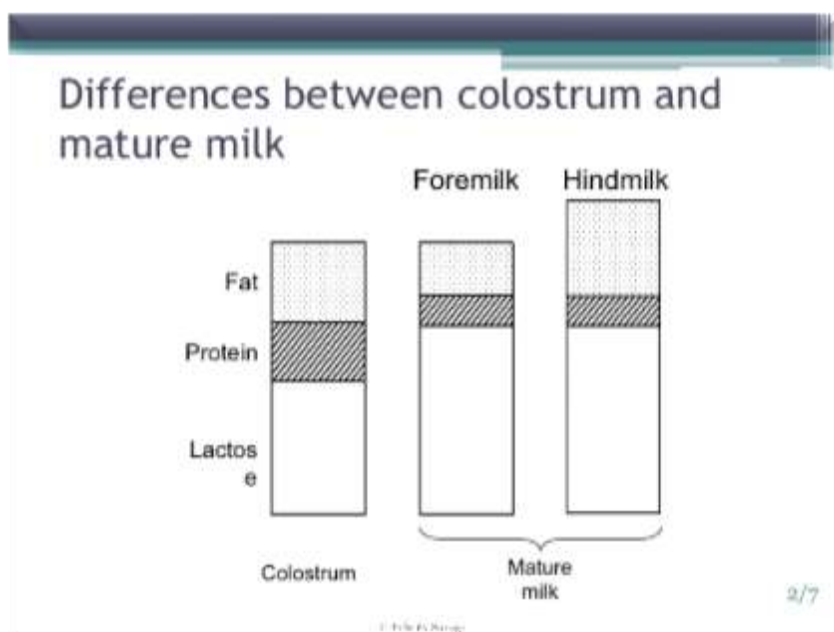
- Protein in different milks varies in quality, as well as in quantity. While the quantity of protein in cow's milk can be modified to make formula, the quality of the proteins cannot be changed.
- This chart shows that more of the protein in cow's milk is casein than in human milk. The amount of casein in human milk varies between 10 and 40% of the total protein⁹.
- Casein in cow's milk forms thick, indigestible curds in a baby's stomach. Casein in human milk is different and forms softer more easily digested curds.
- You can see in the diagram human milk contains more whey proteins.
- The whey proteins contain anti-infective proteins, which help to protect a baby against infection.

⁹ Kunz C, Lonnerdale B. Re-evaluation of the whey protein /casein ratio of human milk. *Acta Paediatrica*. 1992;81:107–12.

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.

The amount of casein in human milk varies between 10 and 40% of the total protein.

Show **Slide 2/7** and introduce colostrum.



Ask: Are there different types of breast milk? What are the differences between each type?

Wait for a few replies and then continue.

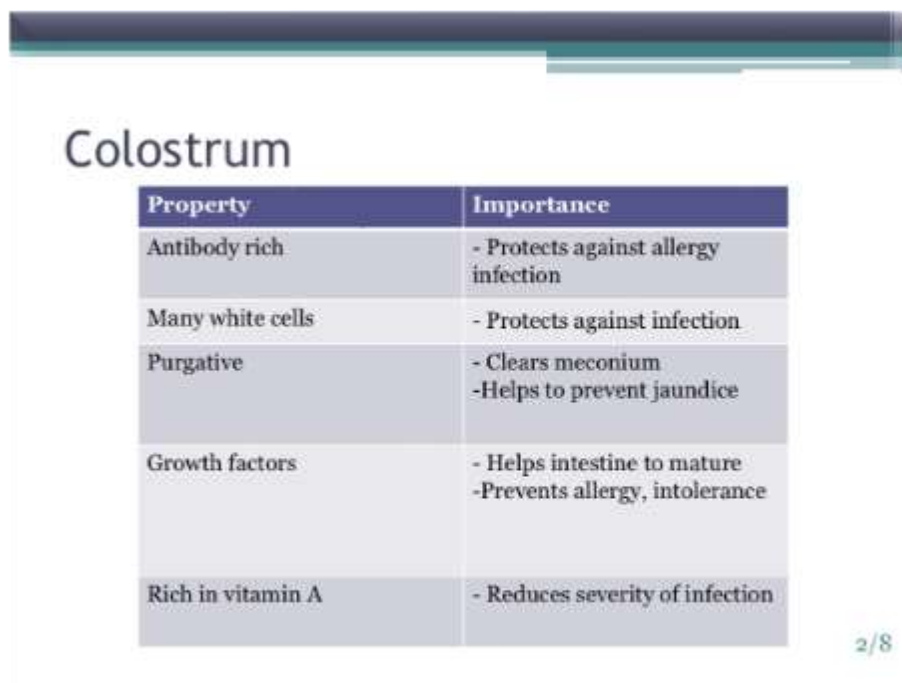
- The composition of breast milk varies from feed to feed and is based on a baby's age. **Colostrum** is the first breast milk women begin to produce at the end of pregnancy and in the first few days after delivery. It is thick yellowish or clear in colour. It contains higher protein than breast milk 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 which is produced in greater amounts early in a feed. It provides protein, lactose, water and other nutrients. Babies do not need extra 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.

- Ask: *Why is colostrum important?*

Wait for a few answers and continue with **Slide 2/8**.

- Show **Slide 2/8 – Colostrum** and make the key points.



| Property | Importance |
|-------------------|--|
| Antibody rich | - Protects against allergy infection |
| Many white cells | - Protects against infection |
| Purgative | - Clears meconium - Helps to prevent jaundice |
| Growth factors | - Helps intestine to mature - Prevents allergy, intolerance |
| Rich in vitamin A | - Reduces severity of infection |

2/8

- This slide shows 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 mL¹⁰. Remember, a baby is learning to suck, swallow and breathe. So, this small amount makes it less likely that the baby will choke.
- 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

- ☐ Show **Slide 2/9 – Protection against infection** and make the points.

Protection against infection

1. Mother infected
2. White cells in mother's body make antibodies to protect mother
3. Some white cells go to breast and make antibodies there
4. Antibodies to mother's infection secreted in milk to protect baby



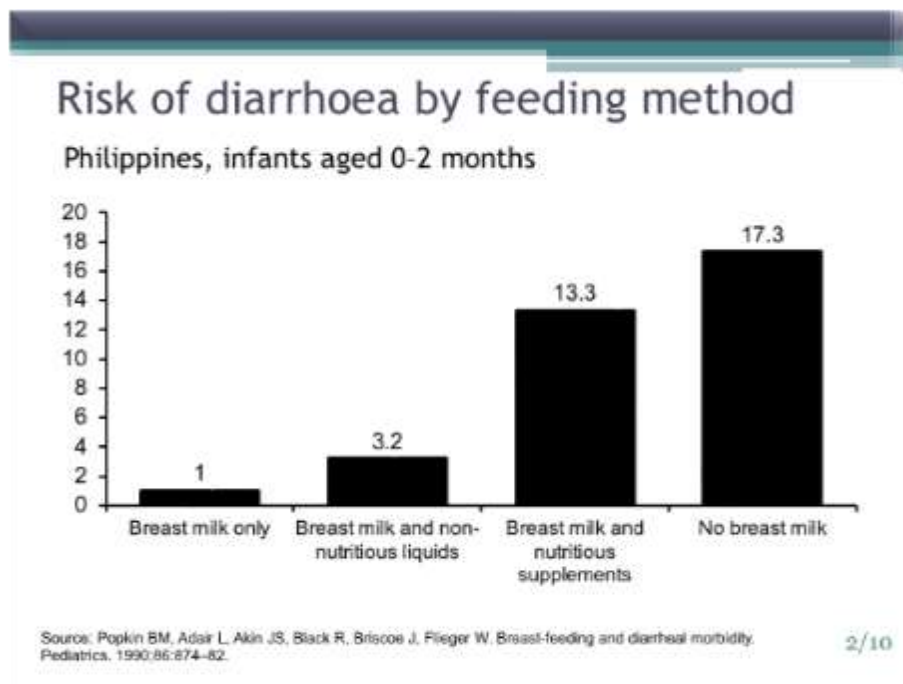
© 17/01/19/1758402648/Peterquill

2/9

- 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.

- Show Slide 2/10 – Case study: Risk of diarrhoea by feeding method. Ask discussion questions.



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?

- Show Slide 2/11 – Psychological benefits of breastfeeding and make the key points.

Psychological benefits of breastfeeding

Emotional bonding

- Close, loving relationship between mother and baby
- Mother more emotionally satisfied
- Baby cries less
- Baby may be more emotionally secure

Development

- Children perform better on intelligence tests



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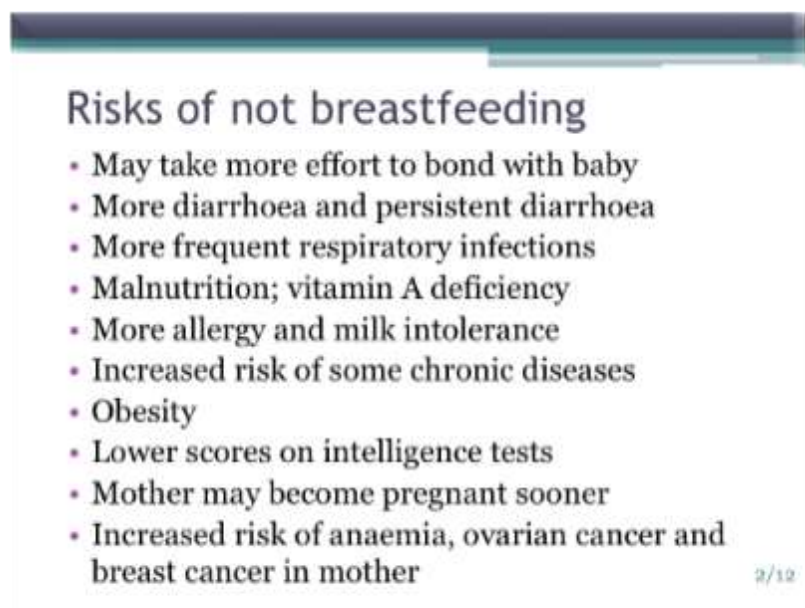
2/11

- 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

- ☐ Ask a representative of group 3 to present the list of the third flipchart (*RISKS OF NOT BREASTFEEDING*) and ask the other groups to contribute or make clarifications they consider necessary.

- ☐ Show **Slide 2/12 – Risks of not breastfeeding** and make the following key points.



- ☐ This slide 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 problems in the preparation of feeds including the baby 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.⁶ A mother who does not breastfeed may become pregnant sooner. She is

more likely to become anaemic after childbirth. She has increased changes of developing cancer of the ovary or of the breast.

Summarize the session

Time for Question and Answer

- Ask participants whether they have any questions.
- Explain the summary of this session that can be found on **pages 19–27** of the Participant's manual.

Further information

Carbohydrate

The sugar lactose is the main carbohydrate in milk. Breast milk contains more lactose than other milks. Breast milk does not contain the carbohydrate, *starch*. Starch is a very important nutrient for older children and adults. It is the main nutrient in staple foods, and in many complementary foods. Young babies cannot digest starch easily, so it is not appropriate to give them starchy foods in the first few months of life.

Protein

There is casein in human milk, but less than in cow's milk, and a different kind. Human casein forms softer curds which are easier to digest. Whey proteins in animal and human milks are different. Human milk contains alpha-lactalbumin and cow's milk contains beta-lactoglobulin.

In addition, protein in animal milks and formula contain a different balance of amino acids from breast milk, which may not be ideal for a baby. Animal milk and formula may lack the amino acid cystine. Formula may lack taurine that neonates need, especially for brain growth. Taurine is now sometimes added to formula milks.

The anti-infective proteins in human milk include: lactoferrin (which binds iron and prevents the growth of bacteria), lysozyme (which kills bacteria), and antibodies (immunoglobulin, mostly IgA).

Other important anti-infective factors include the bifidus *factor* (which promotes the growth of *Lactobacillus bifidus*. *L. bacillus* inhibits the growth of harmful bacteria, and gives breastfed babies' stools their distinct smell). Breast milk also contains antiviral and antiparasitic factors.

Babies may develop intolerance to animal proteins. Babies who are fed animal milks or formula are also more likely than breastfed babies to develop allergies, which may cause eczema. **A baby may develop intolerance or allergy after only a few artificial feeds given in the first few days of life.**

Vitamins

The amount of vitamins in breast milk and animal milks are different. Cow's milk has high amount of the B vitamins but does not contain as much vitamin A and vitamin C as human milk. Breast milk contains high amounts of vitamin A, if the mother has enough in her diet. Breast milk can supply much of the vitamin A that a child needs, even in the second year of life.

Vitamin A supplements for post-partum mothers

Do not give a mother high-dose capsules of vitamin A (over 10 000 units daily) for more than 4–6 weeks after she has given birth. After 6 weeks, there is a slight possibility that she could be pregnant. If a high dose of vitamin A is given in early pregnancy, it could damage the foetus. **High-dose vitamin A supplementation for post-partum mothers is no longer recommended by WHO or provided in all countries.**

B vitamins

The amount of B vitamins in human milk is the same as or more than in cow's milk. The amount in cow's milk is 2–3 times higher than in breast milk. These high levels are more than a baby needs. Goat's milk lacks the B vitamin folic acid, and this can cause anaemia.

Vitamin C

Health workers often recommend giving babies fruit juice from a very early age, to provide vitamin C. This is not necessary for breastfed babies. It may be necessary for artificially fed babies.

Iron

Different milks contain similar small amounts of iron. However, only about 10% of the iron in cow's milk is absorbed while 50% of the iron from breast milk is absorbed. Babies fed on cow's milk may not get enough iron, and they often become anaemic.

Some brands of formula have iron added. This added iron is not well absorbed, so a large amount has to be added to ensure that a baby gets enough iron to protect against anaemia. Added iron may make it easier for some kinds of bacteria to grow. This increases the chances of some kinds of infection, like meningitis and septicaemia.

Foremilk and hindmilk

There is no sudden change from “fore” to “hind” milk. The fat content increases gradually from the beginning to the end of a feed. **This is a controversial topic, so it is important to encourage a mother to give her baby a full feed and allow the baby to suckle as long as he or she wants.**

Protection against infection

The main immunoglobulin in breast milk is IgA, often called “secretory” immunoglobulin A. It is secreted within the breast into the milk, in response to the mother's infections. This is different from other immunoglobulins (such as IgG), which are carried in the blood.

Intolerance and allergies to milk proteins

Colostrum and breast milk contain many hormones and growth factors. Epidermal growth factor has been shown to stimulate growth and maturation of the intestinal villi. Undigested cow's milk proteins can pass through the immature infant gut into the blood, which may cause intolerance and allergy to milk protein. Epidermal growth factor helps to prevent the absorption of large molecules by stimulating rapid development of the gut. This “seals” the baby's intestine, so that it is more difficult for proteins to be absorbed without being digested.

The Lancet series on breastfeeding (2016)¹¹

The *Lancet* Breastfeeding series shows why breastfeeding is one of the highest-impact interventions, providing benefits for children, women, and society. Breastfeeding reduces infant morbidity and mortality. It increases intelligence quotient (IQ) scores, improves school achievement, and boosts adult earnings – all essential for reducing poverty. It also contributes to equity by giving all children a nutritional head start in life.

For many people living in poverty, malnutrition remains a prime contributor to stunted development. The *Lancet* series documents how breastfeeding can make a lasting difference. It suggests that, alongside other factors, breastfeeding could have an important role in addressing inequality. Breastfeeding can provide equal opportunity to all children to grow and contribute to national economies. Countries such as Bangladesh and Brazil show that it is possible to increase breastfeeding with comprehensive strategies. The evidence on breastfeeding leaves no doubt that it is a smart and cost-effective investment in a more prosperous future.

Special issue of *Acta Paediatrica*: Impact of breastfeeding on maternal and child health (2015)¹²

The papers presented here clearly demonstrate that breastfeeding protects against a spectrum of adverse health outcomes, over and above these traditional perspectives. In one of the papers, the authors document substantially higher rates of mortality among infants who were never breastfed, compared to those who were exclusively breastfed in the first six months of life and receiving continued breastfeeding beyond. Otitis media occurs nearly twice as frequently among those who are not exclusively breastfed in the first six months.

The papers in this supplement demonstrate that many of the benefits of breastfeeding are experienced well beyond the period that breastfeeding is stopped. Children who were breastfed have a lower risk of obesity, higher IQs, and less asthma. Breastfeeding mothers likewise benefit from having breastfed, with lower rates of breast cancer, ovarian cancer, type 2 diabetes and postpartum depression. These multiple benefits of breastfeeding demonstrate the contribution and relevance of breastfeeding as a global public health issue.

The mechanisms by which breastfeeding affect health are extremely varied. For example, many of the maternal benefits of breastfeeding are probably related to the hormonal effects of producing milk over a long period. For some outcomes in the child, the composition of the milk itself is probably important. Long-chain polyunsaturated fatty acids may be important for intellectual development; ghrelin and leptin in the milk may be important for appetite regulation; pathogen-specific antibodies may be important for protection against otitis media; and non-specific immune factors may be important for asthma.

Even when most of the infant's diet comes from breastfeeding, small amounts of breast-milk substitutes can substantially alter the intestinal flora, with health outcomes yet to be fully elucidated. Breastfeeding practices are responsive to interventions delivered in health systems, communities and homes. The largest effects are achieved when interventions are delivered in combination.

¹¹ Lancet series: Breastfeeding. *Lancet*. 2016;387:404–504.

¹² Special issue: Impact of breastfeeding on maternal and child health. *Acta Paed*. 2015;104(Suppl. 467):1–134.

Complementary feeding

WHO and UNICEF recommend breastfeeding for up to two years and beyond with complementary foods after six months. This course does not cover the topic of complementary feeding. However, participants may ask you about complementary feeding. You can provide them with following key messages.

Key messages for complementary feeding

1. Breastfeeding for two years of age or longer helps a child to develop and grow strong and healthy.
2. Starting other foods in addition to breast milk at six months helps a child to grow well.
3. Foods that are thick enough to stay in the spoon give more energy to the child.
4. Animal-source foods are especially good for children to help them grow strong and lively.
5. Peas, beans, lentils, nuts and seeds are good for children.
6. Dark-green leaves and yellow-coloured fruits and vegetables help the child to have healthy eyes and fewer infections.
7. A growing child needs two to four meals a day plus one to two snacks if hungry: give a variety of foods.
8. A growing child needs increasing amounts of food.
9. A young child needs to learn to eat. Encourage them and give help with lots of patience.
10. Encourage the child to drink and to eat during illness. Provide extra food after illness to help the child recover quickly.

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.

Session outline

Suggested time: 45 minutes

Participants are all together for a lecture presentation by one trainer.

- 1) Introduce the session with **Slide 3/1** and present **Slide 3/2**
- 2) Demonstrate listening and learning skills
- 3) Complete the written exercises
- 4) Summarize the session
- 5) Time for Question and Answer

Preparation


- Review the Introduction on how to give a demonstration and on giving a presentation with slides. As there are only two slides for this presentation, you might prefer to read aloud the objectives on Slide 3/2 without projecting them.
- Make a list of listening and learning skills (see session summary) on a flipchart or white board before the session. Keep the lists covered and uncover each point as you teach the skill.
- The concept of “judging words” can be explained more in the local language and culture. There is further information on this at the end of the session for discussion.
- Note: The written exercises can be a separate session. Briefly review the skills for listening and learning before starting the exercises.

Directions for role plays during sessions

- Goal of role play: The goal for the role play during these sessions is to interact in "real life" situations. Counselling and supporting a mother/parent/caregiver are interactions that take practice.
- Choosing participants: Make sure you choose participants ahead of time. Prepare them before the session and give them a copy of the role- play script. In some of the role plays, please use the same participant to save time in the session.
- Preparing for role play: Please read the script and prepare before your session. As the trainer, you will be leading the role play. Also, have the room set-up, as recommended, and have all props and dolls, available before the session begins.

Reference materials

- A doll is needed for the demonstrations.
- Make copies of all the demonstrations provided at the end of this session. Give each participant a copy of the demonstrations.
- Ask different participants to help you give the demonstrations. Explain what you want them to do.
- DEMONSTRATION 3.A – NON-VERBAL COMMUNICATION
- The participant sits with a doll in the breastfeeding position, pretending to be a mother while you demonstrate different ways of talking to her. Discuss and agree with her before the demonstration what you can do to demonstrate “appropriate touch” and “inappropriate touch”. This demonstration needs to be at the front of the room because participants need to see the actions.
- Give each of the participants a copy of the demonstrations.
- Ask participants to come to the front of the room to read the role play script. Bring two chairs to the front of the room for the demonstrations.
- These demonstrations are very short. The trainer introduces the participants focus points for each demonstration. After each demonstration, the trainer emphasizes the point of the demonstration.



Session 3.
Counselling skills:
Listening and learning

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3/1

Show Slide 3/2 – Objectives

Session 3. Objectives
Counselling skills: Listening and learning

After completing this session, participants will be able to:

- list the 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.

3/2

Make these points.

- In this session, you will learn about the counselling skills of listening and learning.
- Counselling is a way to understand how people feel and help them to decide what is best to do in their situation.
- In this course, we focus on counselling mothers who are feeding their newborn babies.
- Although we talk about “mothers” in this session, remember that these skills should be used when talking to other caregivers and parents about feeding, for example, fathers or grandmothers.
- Mothers feeding their newborns is one of the situations where 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, a mother may not talk easily about her feelings. You will need listening skills to show her that you are interested in her. This will encourage her to tell you more. She will be less likely to “turn off” and say nothing.

Explain listening and learning skills

Make these points.

- 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 that 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.

Refer to the board or flipchart with the list of SKILLS: LISTENING AND LEARNING. Uncover each skill as you introduce them.

Show **Slide 3/3 – Summary: Six listening and learning skills**

Summary:
Six 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

3/3

Skill 1. Use helpful non-verbal communication

- Uncover *NON-VERBAL COMMUNICATION* on the board or flipchart.
- Our non-verbal communication can help a mother feel calm and able to listen.
- Ask: *What are some examples of helpful non-verbal communication?*

Wait for a few replies and then continue.

- Show **Slide 3/4 – Non-verbal communication** and explain the skill.

Examples of non-verbal communication

- **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.
- **Barriers:** Remove any physical barriers.
- **Taking time:** Take time without hurrying or looking at your watch or mobile phone.
- **Touch:** Only touch her in an appropriate way. Do not touch her breasts or her baby without her permission.

3/4

- Explain the skill.
- Some helpful non-verbal communication skills include.
 - **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:** Touch her, but only in an appropriate way (such as a hand on her arm). Do not touch her breasts or her baby without her permission.
- Introduce the demonstration. Tell participants you will demonstrate five different kinds of non-verbal communication. In this demonstration, the health worker is greeting the mother using the same words in various ways. Look at the non-verbal communication with each greeting.
- Ask the participant to come forward. She sits with a doll in the breastfeeding position, pretending to be a mother. She can respond to your greeting but does not have to say anything else. It is important that you say the **same** words in the **same** tone of voice with each demonstration.

- Give the five pairs of demonstrations in *DEMONSTRATION 3.A*. With each pair, you approach the “mother” in two ways – one way helps communication and the other way hinders communication. Demonstrate the way that helps sometimes first, and sometimes second. This is so that the participants who are observing cannot guess just from the order of the demonstrations.

NOTE: To save time, please use the same participant for each demonstration.

- Ask other participants to:
 - identify the non-verbal communication skill you demonstrated.
 - say which form helps communication and which hinders it.

DEMONSTRATION 3.A – NON-VERBAL COMMUNICATION

With each demonstration, say **exactly the same** few words, and try to say them in the same way, for example:
“Good morning, Fatima. How is feeding going for you and your baby?”

1. Posture

Help: Sit so that your head is level with hers.

Hinder: Stand with your head higher than the mother's.

2. Eye contact

Help: Look at her and pay attention as she speaks.

Hinder: Look away at something else, or down at your notes, watch or mobile phone.

(Cultural note:

What does eye contact look like in your culture and with the mothers/parents/caregivers you are working with?

Eye contact may have different meanings in different cultures. Sometimes when a person looks **away** it means that he or she is ready to listen. If necessary, adapt this to your own situation.

3. Barriers

Help: Remove the table or the notes.

Hinder:

- Sit behind a table
- Write notes while you talk
- Look at your mobile phone.

4. Taking time

Help: Show the mother you have time. Sit down and greet her without hurrying. Stay quietly smiling at her, watching her breastfeed and waiting for her to answer.

Hinder:

- Be in a hurry
- Greet her quickly
- Show signs of impatience
- Look at your watch or mobile phone.

5. Touch

Help: Touch the mother appropriately.

Hinder: Touch her in an "inappropriate" way or poke the baby.

(Note: If you cannot demonstrate inappropriate touch, simply demonstrate not touching.)

- Discuss how the non-verbal communication has a positive effect. Ask the “mother” how she felt when greeted each way. Ask participants what they have learned from this demonstration about non-verbal communication.*
- Introduce Skills 2–6 by making the following points*
 - The following skills work with verbal communication, what is being said to mothers. Remember the tone of the voice is important during verbal communication. Always sound gentle and kind when talking to mothers/parents/caregivers.

Skill 2. Ask open questions.

- ASK OPEN QUESTIONS: Uncover on the board or flipchart.
- Explain the skill.
- When you are helping a mother/parent/caregiver, you need to know the following.
 - 1) What is the situation?
 - 2) Where is the difficulty?
 - 3) What has the mother done?
 - 4) What worked, and what did not work?

It is important to ask questions to encourage the mother to share information. This allows you to use the time available to learn her situation.

Open questions

- Open questions are the most helpful. They encourage a mother to give more information.
- Open questions usually start with “How?”, “What?”, “When?”, “Where?”, “Who?”
- Example: “How are you feeding your baby?”

Closed questions

- Closed questions are usually answered by a “yes” or “no” and may not give you very much information.
- Closed questions usually start with words like “Are you?” or “Did you?” or “Has the baby?”
- Example: “Did you breastfeed your previous baby?”
- You may think the mother is unwilling to talk to you. The mother may feel frightened that she will give the wrong answer. Sometimes the 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.

- Demonstrate the skill.

Ask a participant to read the words of the mother in DEMONSTRATIONS 3.B and 3.C, while you read the part of the health worker. After each demonstration, comment on what the health worker learnt. Ask the participant to decide on a name for herself and her baby.

- ❑ Introduce the demonstrations by making the following points.
 - We will now see this skill being demonstrated in two role plays.
 - The health worker is talking to a mother breastfeeding her baby.
 - **Listen:** Is the health worker asking open questions or closed questions? How does the mother respond to the questions?

DEMONSTRATION 3.B – CLOSED QUESTIONS

Health worker: Good morning, (name). I am (name), the midwife. Are you and your baby well today?
 Mother: Yes, we are well.
 Health worker: Are you breastfeeding him?
 Mother: Yes.
 Health worker: Are you having any difficulties?
 Mother: No.
 Health worker: Is he breastfeeding very often?
 Mother: Yes.

Ask: What did the health worker learn from this mother?

Comment: *The health worker got “yes” and “no” for answers and received less information. It can be difficult to know what to say next. Let us see another way of doing this.*

DEMONSTRATION 3.C – OPEN QUESTIONS

Health worker: Good morning, (name). I am (name), the midwife. How is (baby’s name)?
 Mother: She is well, and she is very hungry.
 Health worker: Tell me about how you are feeding her?
 Mother: She is breastfeeding. I am thinking of giving her a bottle of formula in the evenings.
 Health worker: What made you think of doing that?
 Mother: She wants to feed too much at that time, so I thought that my milk is not enough.

Ask: What did the health worker learn from this mother?

Comment: The health worker asked open questions. The mother could not answer with a “yes” or a “no”, and she gave some information. The health worker learnt much more.

Skill 3. Use responses and gestures showing interest

Uncover on the flipchart: USE RESPONSES AND GESTURES THAT SHOW INTEREST

Explain the skill:

- if you want a mother to continue talking, you must show you are listening and are interested in what she is saying;
- important ways to show you are listening and interested are:
 - with gestures, for example, look at her, nod and smile.
 - with simple responses (“Aha”, “Mmm”, “Oh dear!”).

Demonstrate the skill:

Ask a participant to read the words of the mother in DEMONSTRATION 3.D, while you play the part of the health worker. You give simple responses, nod, and show by your facial expression you are interested and want to hear more.

Introduce the role play by making these points:

- we will now see a role play demonstrating this skill.

DEMONSTRATION 3.D – USING RESPONSES AND GESTURES SHOWING INTEREST

Health worker: Good morning, (name). How is (baby's name) feeding?

Mother: Good morning. She's fine, I think.

Health worker: Mmm... (nods, smiles.)

Mother: Well, I was a bit worried last night because she was crying a lot.

Health worker: Oh dear! (raises eyebrows, looks interested.)

Mother: I wondered if it was because she was in pain after she was born.

Health worker: Aha! (nods sympathetically.)

Ask: How did the health worker encourage the mother to talk?

Comment: The health worker asked a question to start the conversation. Then, she encouraged the mother to continue talking using responses and gestures.

Discuss appropriate responses (to local culture of health workers and mothers/parents/caregivers:

- in different countries and cultural contexts, people use varying responses.

Ask: *What responses do people use in your location?*

Wait for a few replies and then continue.

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

Uncover on the board or flipchart: REFLECT BACK WHAT THE MOTHER/CAREGIVER/PARENT SAYS.

Ask: *How can we show we are interested in what a mother is saying?*

Wait for a few responses, then explain the skill:

- if you repeat or reflect back what the mother is saying, this shows that you are listening and encourages the mother to say more; you can use slightly different words to those used by the mother so it does not sound like you are copying her.
- for example, if a mother says: “I don’t know what to do. My baby wants to breastfeed all night long.” You could say: “Your baby is feeding often at night?”
- it is helpful to mix reflecting back with other responses like, “Oh, really, tell me more.” You can also ask an open question.

Demonstrate skill:

ask a participant to read the words of the mother from DEMONSTRATIONS 3.E while you read the part of the health worker.

Introduce role play with these points:

- we will now watch a role play to demonstrate this skill
- watch how the health worker is showing that she/he is listening to the mother
- ask yourself if using these skills help the health worker learn more about the mother.

DEMONSTRATION 3.E – REFLECTING BACK

| | |
|----------------|---|
| Health worker: | Good morning, (name). How are you and (baby’s name) today? |
| Mother: | He wants to feed too much. He is taking my breast all the time! |
| Health worker: | Mmm... (Baby’s name) is feeding very often? |
| Mother: | Yes, my mother is telling me I should give him some bottle feeds as well. |
| Health worker: | Your mother says that he needs something more? |
| Mother: | Yes. Which infant formula is best? |

Ask: *What did the health worker learn from the mother?*

Comment: By reflecting back what the mother said, the mother gave more information. Responses like, “Mmm” show you are listening and following what the mother is saying. Reflecting back can help clarify the person’s statement. We see here the hungry baby may not be the main problem. The comments of the mother’s mother are confusing her.

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

- Uncover EMPATHY – SHOW YOU UNDERSTAND HOW THE MOTHER/PARENT/CAREGIVER FEELS on the board or flipchart.
- Explain the skill:
 - **empathy** shows you hear what someone is saying and are trying to understand how they feel – you are looking at the situation from their point of view;
 - **sympathy** is different. When you sympathize with a person, you are looking at it from your point of view:
 - ☺ all of a mother’s feelings are helpful information
 - ☺ empathy shows you understand both her positive and negative feelings
 - ☺ a mother may say something showing how she feels;
 - you must respond in a way that shows you hear what she is saying and understand her feelings from her point of view;
 - example:

mother says: “My baby wants to feed often, and it makes me feel so tired!”

you respond to what she feels, with **empathy**: “You feel exhausted because your baby wants to feed very often.”

your response with **sympathy**: “Oh, I know how you feel. My baby wanted to feed often too, and I felt exhausted.” Note: This brings the attention back to you and does not make the mother feel you understand her.
- Demonstrate the skill. Ask two participants you prepared to give DEMONSTRATIONS 3.F and 3.G to read the words of the mother and health worker.
- Introduce the role plays:
 - in this demonstration, observe if the health worker is showing empathy – is she/he trying to understand how the mother feels?

DEMONSTRATION 3.F – SYMPATHY

| | |
|----------------|--|
| Health worker: | Good morning, (name). How are you and (baby’s name) today? |
| Mother: | (baby’s name) is not feeding well. I am worried he is ill. |
| Health worker: | I understand how you feel. When my child was ill, I was so worried. I know exactly how you feel. |
| Mother: | What was wrong with your child? |
| Ask: | <i>Do you think the health worker showed sympathy or empathy?</i> |
| Comment: | Here the focus moved from the mother to the health worker. This was sympathy, not empathy. Let us hear this again, with the focus on the mother and empathizing with her feelings. |

DEMONSTRATION 3.G – EMPATHY

| | |
|----------------|---|
| Health worker: | Good morning, (name). How are you and (baby's name) today? |
| Mother: | He is not feeding well. I am worried he is ill. |
| Health worker: | This must be very frightening for you. |
| Ask: | <i>Do you think the health worker showed sympathy or empathy?</i> |
| Comment: | Here the health worker used the skill of empathy. She said, "This must be very frightening for you". In this second version, the mother and her feelings are the focus of the conversation. |

Skill 6. Avoid using judging words

- Uncover AVOID USING JUDGING WORDS on the board or flipchart.
- Explain the skill:
 - examples of judging words are right, wrong, well, badly, good, enough, properly, adequate, problem;
 - example of a question using a judging word:
"Are you feeding your child **properly**?";
 - questions with words like this can make a mother feel worried that she has not "reached a standard" or that her "baby is not normal", and she may decide to hide how things are going if she feels inadequate;
 - the mother and the health worker may have different ideas about what "feeding properly" means;
 - also, notice that it is a *closed* question;
 - open questions are more helpful and are less likely to be judging, for example: "How does your baby feed?" or "Can you tell me about your baby's feeding?"
- Introduce the role play with these points:
 - in this demonstration, observe if the health worker is using judging words.

DEMONSTRATION 3.H – USING JUDGING WORDS

| | |
|----------------|---|
| Health worker: | Good morning. Is (baby's name) breastfeeding normally ? |
| Mother: | Well – I think so. |
| Health worker: | Do you think that you have enough breast milk for him? |
| Mother: | I don't know ... I hope so, but maybe not ... (she looks worried). |
| Health worker: | Well, does she feed properly ? |
| Mother: | I don't know ... |
| Ask: | <i>What did the health worker learn about the mother's feelings?</i> |
| Comment: | The health worker has not learnt what she hoped but has instead made the mother very worried. Let us see another way of doing this. |

DEMONSTRATION 3.1 – AVOIDING JUDGING WORDS

| | |
|----------------|---|
| Health worker: | Good morning. How is breastfeeding going for you and (baby's name)? |
| Mother: | It's going very well. I haven't needed to give her anything else. My baby is eating and sleeping well. I am very pleased. |
| Ask: | <i>What did the health worker learn about the mother's feelings?</i> |
| Comment: | This time the health worker learnt what she needed to know without making the mother worried. The health worker used open questions to avoid using judging words. |

Make these additional points:

- mothers may use judging words about their own situation;
- you may sometimes need to use them yourself, especially the positive ones while building a mother's confidence;
- practise avoiding judging words as much as possible unless there is a really important reason to use one;
- remember that judging questions are often closed questions and that using open questions often helps to avoid using a judging word.

Let's practise

- Summary demonstration
- We will now see a demonstration using all the skills together. Please open your *Participants manual* at page 33 to review the "Six listening and learning skills".

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.

Health worker:
(Skill 5)

It's not surprising you felt worried. You were wanting support to help with breastfeeding your baby!

Mother:

Yes, you understand. Can you help me today?

Health worker:
(Skill 6)

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.

- Now it is your turn to practise.
- Ask participants to turn to **page 34** of the Participant's manual and find the exercises on communication skills.
- Explain directions:
 - you will now practise the skills for listening and learning from this session
 - the following exercises are individual
 - each exercise has an example and an individual exercise to answer
 - if possible, use pencil so that it is easier to correct the answers
 - when you are ready, discuss your answers with the trainer who will give feedback individually as you do the exercises, and will give you answer sheets at the end of the session.
- Read the first example and check the participants' understanding.
- Ask the trainers to circulate among the groups during the activity to check the participants' understanding of both the activity and the skills.
- To end the session, summarize the information and respond to questions.

Note: This is a vital part of the course to build health workers' ability to communicate more effectively with mothers. If possible, extra time should be devoted to these skills.

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

Are you breastfeeding your baby?

“Open” question

How are you feeding your baby?

To answer

“Closed” questions

1. Does your baby feed often?
2. Are you having any feeding problems?

Possible “open” questions

- When does your baby feed?
How is feeding going?
-

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?**

To answer

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?**

To answer

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.

Is your baby feeding well?

Open question without judging word.

How is your baby feeding?

To answer

Closed question with judging word.

1. Does your baby feed often?
2. Are you having any problems with feeding?

Suggested answers for open question without judging word.

- When does your baby feed?
How is feeding going?

-
- Give participants the ANSWER SHEETS.
 - If some participants are having difficulties or have not finished the exercises, arrange to help them later.

Summarize the session

Time for Question and Answer

- Ask participants if they have any questions.

You now have a list of the six skills on the flipchart.

Post it on the wall and read the list to remind participants of the six skills.

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

- Explain the summary of this session can be found on **pages 29–36** of the Participant's manual.

Further information

| Translating judging words | | | | |
|---|---------|------------|---------|-------------------|
| Can you give examples of judging words from your context? | | | | |
| Well | Normal | Enough | Problem | Crying “too much” |
| Good | Correct | Adequate | Fail | Unhappy |
| Bad | Proper | Inadequate | Failure | Happy |
| Badly | Right | Satisfied | Succeed | Fussy |
| | Wrong | Plenty of | Success | Colicky |
| | | Sufficient | | |

Copies of demonstrations

The following are copies of the demonstrations given during this session. These demonstrations can be copied and provided to participants who will help you with the demonstrations.

DEMONSTRATION 3.A – NON-VERBAL COMMUNICATION

With each demonstration, say **exactly the same** few words, and try to say them in the same way, for example:
“Good morning, Fatima. How is feeding going for you and your baby?”

1. Posture

Help: Sit so that your head is level with hers.

Hinder: Stand with your head higher than the mother's.

2. Eye contact

Help: Look at her and pay attention as she speaks.

Hinder: Look away at something else, or down at your notes, watch or mobile phone.

(Cultural note:

What does eye contact look like in your culture and with the mothers/parents/caregivers you are working with?

Eye contact may have different meanings in different cultures. Sometimes when a person looks **away** it means that he or she is ready to listen. If necessary, adapt this to your own situation.

3. Barriers

Help: Remove the table or the notes.

Hinder:

- Sit behind a table
- Write notes while you talk
- Look at your mobile phone.

4. Taking time

Help: Show the mother you have time. Sit down and greet her without hurrying. Stay quietly smiling at her, watching her breastfeed and waiting for her to answer.

Hinder:

- Be in a hurry
- Greet her quickly
- Show signs of impatience
- Look at your watch or mobile phone.

5. Touch

Help: Touch the mother appropriately.

Hinder: Touch her in an "inappropriate" way or poke the baby.

(Note: If you cannot demonstrate inappropriate touch, simply demonstrate not touching.)

DEMONSTRATION 3.B – CLOSED QUESTIONS

Health worker: Good morning, (name). I am (name), the midwife. Are you and your baby well today?
Mother: Yes, we are well.
Health worker: Are you breastfeeding him?
Mother: Yes.
Health worker: Are you having any difficulties?
Mother: No.
Health worker: Is he breastfeeding very often?
Mother: Yes.

Ask: What did the health worker learn from this mother?

Comment: *The health worker got “yes” and “no” for answers and received less information. It can be difficult to know what to say next. Let us see another way of doing this.*

DEMONSTRATION 3.C – OPEN QUESTIONS

Health worker: Good morning, (name). I am (name), the midwife. How is (baby’s name)?
Mother: She is well, and she is very hungry.
Health worker: Tell me about how you are feeding her?
Mother: She is breastfeeding. I am thinking of giving her a bottle of formula in the evenings.
Health worker: What made you think of doing that?
Mother: She wants to feed too much at that time, so I thought that my milk is not enough.

Ask: What did the health worker learn from this mother?

Comment: The health worker asked open questions. The mother could not answer with a “yes” or a “no”, and she gave some information. The health worker learnt much more.

DEMONSTRATION 3.D – USING RESPONSES AND GESTURES SHOWING INTEREST

Health worker: Good morning, (name). How is (baby's name) feeding?
Mother: Good morning. She's fine, I think.
Health worker: Mmm... (nods, smiles.)
Mother: Well, I was a bit worried last night because she was crying a lot.
Health worker: Oh dear! (raises eyebrows, looks interested.)
Mother: I wondered if it was because she was in pain after she was born.
Health worker: Aha! (nods sympathetically.)

Ask: How did the health worker encourage the mother to talk?

Comment: The health worker asked a question to start the conversation. Then, she encouraged the mother to continue talking using responses and gestures.

DEMONSTRATION 3.E – REFLECTING BACK

Health worker: Good morning, (name). How are you and (baby's name) today?
Mother: He wants to feed too much. He is taking my breast all the time!
Health worker: Mmm... (Baby's name) is feeding very often?
Mother: Yes, my mother is telling me I should give him some bottle feeds as well.
Health worker: Your mother says that he needs something more?
Mother: Yes. Which infant formula is best?

Ask: What did the health worker learn from the mother?

Comment: By reflecting back what the mother said, the mother gave more information. Responses like, "Mmm" show you are listening and following what the mother is saying. Reflecting back can help clarify the person's statement. We see here the hungry baby may not be the main problem. The comments of the mother's mother are confusing her.

DEMONSTRATION 3.F – SYMPATHY

Health worker: Good morning, (name). How are you and (baby's name) today?
Mother: (baby's name) is not feeding well. I am worried he is ill.
Health worker: I understand how you feel. When my child was ill, I was so worried. I know exactly how you feel.
Mother: What was wrong with your child?

Ask: Do you think the health worker showed sympathy or empathy?

Comment: Here the focus moved from the mother to the health worker. This was sympathy, not empathy. Let us hear this again, with the focus on the mother and empathizing with her feelings.

DEMONSTRATION 3.G – EMPATHY

Health worker: Good morning, (name). How are you and (baby's name) today?

Mother: He is not feeding well. I am worried he is ill.

Health worker: This must be very frightening for you.

Ask: Do you think the health worker showed sympathy or empathy?

Comment: Here the health worker used the skill of empathy. She said, "This must be very frightening for you". In this second version, the mother and her feelings are the focus of the conversation.

DEMONSTRATION 3.H – USING JUDGING WORDS

Health worker: Good morning. Is (baby's name) breastfeeding **normally**?

Mother: Well – I think so.

Health worker: Do you think that you have **enough** breast milk for him?

Mother: I don't know ... I hope so, but maybe not ... (she looks worried).

Health worker: Well, does she feed **properly**?

Mother: I don't know ...

Ask: What did the health worker learn about the mother's feelings?

Comment: The health worker has not learnt what she hoped but has instead made the mother very worried. Let us see another way of doing this.

DEMONSTRATION 3.I – AVOIDING JUDGING WORDS

Health worker: Good morning. How is breastfeeding going for you and (baby's name)?

Mother: It's going very well. I haven't needed to give her anything else. My baby is eating and sleeping well. I am very pleased.

Ask: What did the health worker learn about the mother's feelings?

Comment: This time the health worker learnt what she needed to know without making the mother worried. The health worker used open questions to avoid using judging words.

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)

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.

Session outline

Suggested time: 45 minutes

Participants are all together for a lecture presentation by one trainer.

- 1) Introduce the session with **Slide 4/1**, present **Slide 4/2**
- 2) Demonstrate the six skills for building confidence and giving support
- 3) Complete the written exercises
- 4) Summarize the session
- 5) Time for Question and Answer

Preparation


- Refer to Introduction for guidance on how to give a demonstration, and on giving a presentation with slides.
- Make sure the slides are ready.
- Prepare a list of the skills for building confidence and giving support (see session summary).
- Display on the wall or on a flip chart before the session. Keep the lists covered and uncover each point as you teach the skill.
- Note: The written exercises can be a separate session. Briefly review the skills of building confidence and giving support before starting the exercises.

Directions for role plays during sessions

- Goal of role play: The goal for the role play during these sessions is to interact in "real life" situations. Counselling and supporting a mother/parent/caregiver are interactions that take practice.
- Choosing participants: Make sure you choose participants ahead of time. Prepare them before the session and give them a copy of the role play script. In some of the role plays, please use the same participant to save time in the session.
- Preparing for role play: Please read the script and prepare before your session. As the trainer, you will be leading the role play. Also, have the room set-up, as recommended, and have all props and dolls available before the session begins.

Demonstration preparation

- Have a model doll ready for the demonstrations.
- Make copies of all the demonstrations provided at the end of this session.
- Ask different participants to help you to give the demonstrations. Explain what you want them to do.
- Give each of the participants a copy of the demonstrations they have to read.
- Ask participants to come to the front of the room to read the texts of their role plays. Have two chairs ready at the front of the room for participants to sit on.
- These demonstrations are very short. The trainer introduces each demonstration pointing out what the participants are to observe. After each demonstration, the trainer makes the comment indicated to emphasize or clarify what the point was in the demonstration.



Session 4.

Counselling skills:
Building confidence
and giving support

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4/1

- Show **Slide 4/2 – Objectives** and read aloud.

Session 4. Objectives
Counselling skills: Building confidence
and giving support

**After completing this session,
participants will be able to:**

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

4/2

- Make the following points.
 - In this session, you 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.
- It is important not to make a mother feel she has done something wrong.
- In 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.
- It is important to avoid telling a mother what to do. Helping each mother to decide for herself what is best for her and her baby increases her confidence.

Explain building confidence and giving support

- Tell participants you will now explain and demonstrate six skills for building a mother's confidence and giving her support.
- Explain that these skills are also important when counselling caregivers and other family members.
- Uncover the heading **SKILLS FOR BUILDING CONFIDENCE AND GIVING SUPPORT** on a board or flipchart. Uncover the skills on the board as you demonstrate them.

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

- UNCOVER. ACCEPT WHAT A MOTHER/PARENT/CAREGIVER THINKS AND FEELS on the list of skills for building confidence and giving support.
- Explain the skill.
 - 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. Give an example of accepting what a mother THINKS.
- Ask the two participants to give DEMONSTRATION 4.A. They will read the words of the mother and health worker. After each response from the health worker, ask the participants whether the response was agreeing, disagreeing or accepting.
- Introduce the role play with the points below.
- In this role play, watch to see if the health worker:
 - 1) accepts what the mother says
 - 2) disagrees
 - 3) agrees.

DEMONSTRATION 4.A – ACCEPTING WHAT A MOTHER THINKS

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

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: I want to give my baby a bottle of formula because I don't have enough milk for her.
Health worker: 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: I want to give my baby a bottle of formula because I don't have enough milk for her.
Health worker: 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.

- Make these additional points:
 - using reflection and simple responses are useful ways to show acceptance;
 - later in the conversation, you can give information to correct the incorrect information or ideas;
 - using empathy can show acceptance of a mother's feelings;
 - if a mother is worried or upset, you may say, "Oh, don't be upset, it is nothing to worry about";
 - in this case, she may feel she was "wrong" to be upset;
 - this may reduce a mother's ability to make her own decisions with confidence.

- Ask two participants to give DEMONSTRATION 4.B to read aloud the words of the mother and health worker.

- Introduce the role play by making the following points:
 - the last role play showed acceptance of what a mother *thinks*
 - we will now see a role play showing acceptance of how a mother *feels*.

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: | <i>Was this an appropriate response?</i> |
| 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: | <i>Was this an appropriate response?</i> |
| 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: | <i>Was this an appropriate response?</i> |
| 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

- Uncover. *RECOGNIZE SKILLS AND PRAISE A MOTHER/PARENT/CAREGIVER on the board or flipchart.*
- Explain the skill:
 - a new mother is working on many new practices 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.
- Ask: *How does it make a mother feel if you tell her she is doing something wrong, or her baby is not doing well?*
Wait for a few replies and then continue.
 - 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 to 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 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.

- Show **Slide 4/3** – Recognize and praise. Let's practise with a case scenario. Explain the situation and discuss together.

Let's practice:
Case scenario

I am expressing milk during the day for him while I am at work, and I breastfeed at night. Am I breastfeeding enough?

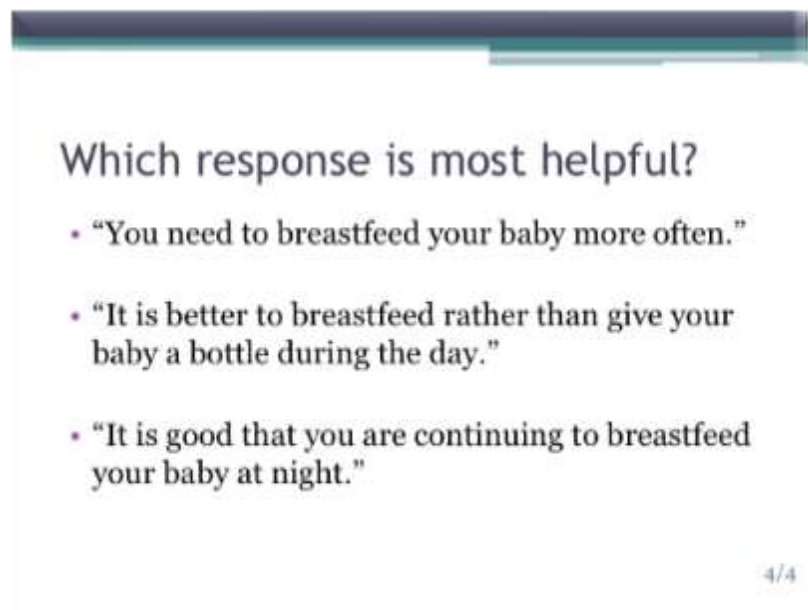
4/3

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- Explain the scenario **Slide 4/3**
 - This mother (Abebi) had to return to work shortly after her baby was born. She expresses breast milk during the day to give to her baby while she is at work. She continues to breastfeed the baby at night. She is worried that she is not breastfeeding enough.

Then show **Slide 4/4** and read the comment.

Ask participants to say which response is the helpful



Which response is most helpful?

- “You need to breastfeed your baby more often.”
- “It is better to breastfeed rather than give your baby a bottle during the day.”
- “It is good that you are continuing to breastfeed your baby at night.”

4/4

Give this explanation

- The most helpful response is the third one, in which the health worker recognizes and praises what the mother and baby are doing. This will help to build the mother’s confidence and will encourage her to continue expressing breast milk and breastfeeding her baby at night.

Skill 3. Give practical help

Uncover. GIVE PRACTICAL HELP on the list of skills for building confidence and giving support

Explain the skill.

- 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.

Ask: What kind of practical help might you offer?

Wait for a few replies and then continue.

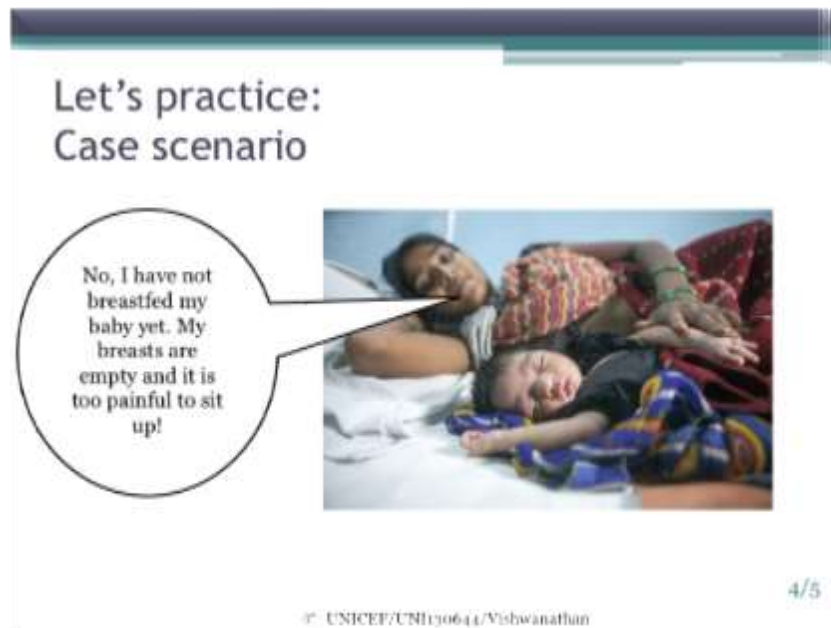
Practical help includes:

- making her comfortable
- giving her a drink

- providing her with something to eat
- holding the baby (this will allow her to get comfortable, wash, or go to the toilet)
- supporting her with practical tips to begin breastfeeding.
- helping a mother breastfeed.

NOTE: Caregivers can also receive practical help and support.

Show **Slide 4/5** – Practical help and explain the situation.



Explain the scenario **Slide 4/5**.

- This mother (Rita) is lying in bed soon after delivery. She looks miserable and depressed. She is saying to the health worker: “No, I haven't breastfed my baby yet. My breasts are empty, and it is too painful to sit up.”

Then show **Slide 4/6** and read out the remarks.

Ask participants to say which response is the more appropriate.

Which response is most helpful?

- “You should let your baby suckle now to help your breast milk to come in.”
- “Let me try to make you more comfortable, and then I’ll bring you a drink.”



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4/6

Give this explanation.

- The most helpful response is the second one, in which the health worker offers to give practical help. She will make the mother comfortable before she helps her to breastfeed.
- Of course, it is important for the baby to breastfeed soon. She will more likely be successful if she feels comfortable.

Skill 4. Provide relevant information

Uncover. PROVIDE RELEVANT INFORMATION on the list of skills for building confidence and giving support.

Explain the skill.

- 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 give information with respect and support. There is so much information you can share, but you do not want to give too much and 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 by giving her the most relevant information.
- Mothers are tired after a long labour and birth. If you give only one or two pieces of information, she is more likely to listen, understand and apply the new knowledge.
- Please do not overwhelm the mother/parent/caregiver. 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 quickly, 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

- Uncover. USE SIMPLE LANGUAGE on the list of skills for building confidence and giving support.*
- Explain the skill.*
 - When communicating with a mother/parent/caregiver, it is important to use simple and familiar terms. Our goal is not only to share information but to increase the mother/parent/caregivers 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.
- Ask the two participants to give DEMONSTRATION 4.C and to read the words of the mother and health worker. Discuss briefly what the participants have observed after each section.*

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: | <i>What did you observe?</i> |
| Comment: | The health worker provided too much information. She used words that were unfamiliar and medically focused. |

- Now we will see another mother receiving information in a different way. Again, listen for the skills listed.*
- Ask the two participants to give DEMONSTRATION 4.D and to read the words of the mother and health worker.*

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: | <i>What did you observe this time?</i> |
| Comment: | The health worker used simple terms and provided relevant information to the mother. |

Skill 6. Make one or two suggestions, not commands

- Uncover. MAKE ONE OR TWO SUGGESTIONS, NOT COMMANDS on the list of skills for building confidence and giving support.
- Explain the skill:
 - the difference between a suggestion and 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 providing 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.

Show **Slide 4/7** – Make suggestions, not commands.

- Read responses aloud.*
- Ask participants which is a command, and which is a suggestion.*

Which response is a command and which is a suggestion?

- “You must feed Aahana at least 10 times a day.”
- “It might help if you feed Aahana more often.”



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Give the following explanation.

- The first response is a command. It tells Aahana’s mother what she must do. She may feel bad and lose confidence if she cannot do it.
- The second response is a suggestion. It allows Aahana’s mother to decide if she will feed Amy more often or not.
- Another way to make a suggestion is to ask a question, for example, “Have you thought of feeding her more often? Sometimes that helps”.

Let's practise: Written exercises

- Participants will now practise six skills for building confidence and giving support with an emphasis on breastfeeding.
- Ask participants to turn to page 45 of the Participant’s manual and to find the exercises on building confidence and giving support.
- Explain what they will do.
 - You will now practise the skills you have learnt for building confidence and giving support.
 - The following exercises are individual.
 - Each exercise has an example and then an exercise to complete.
 - If possible, use pencil so that it is easier to correct the answers.
 - When you are ready, discuss your answers with the trainer. Trainers will give feedback individually as you do the exercises and will give you answer sheets at the end of the session.
- Read the first example and check participants understand directions.
- Ask the trainers to circulate among the groups during the activity to check the participants’ understanding of the activities and the skills.

- At the end of the time, summarize the session and respond to any questions. You do not need the group to go through each item to 'correct' the exercises in the activity.*
- This is a vital part of the course for health workers to practice new ways of building confidence and giving support to mothers/parents/caregivers. If possible, extra time should be devoted to these skills.*

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."

"Yes, babies need water in hot weather."

"You feel the baby needs some water if it is hot?"

Agreeing (with incorrect information)

Disagreeing

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:

"You don't like to give breast milk now?"

"It is quite safe to breastfeed when he has diarrhoea."

"It is best to stop breastfeeding during diarrhoea."

Type of response

Agreeing (with incorrect information)

Disagreeing

Accepting

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

Answer:

"First milk is very important for the baby."

"You think the first milk is not good for the baby."

"It will only be a day or two before the first milk is gone."

Type of response

Agreeing (with incorrect information)

Disagreeing

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. | <i>It is good you are continuing to breastfeed your baby at night.</i> |

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. | <i>Breast milk is all your baby needs right now. It is good that you are only giving your baby breast milk.</i> |

| 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. | <i>It is good you are breastfeeding your baby and not using a bottle.</i> |

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." | "Breastfeeding alone is all your baby needs for health and growth in the first six months." |
| 2. "The immunoglobulins in human milk provide your baby with protection from viral and bacterial infections." | "Your milk helps protect your baby from illness." |

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” | <i>“Have you thought of giving only your milk?”</i> |

Exercise

| Command | Suggestion |
|---|--|
| 1. “You must feed your baby more.” | <i>“Do you think you could feed your baby more often?”</i> |
| 2. “Do not give any foods to your baby until after six months.” | <i>“Most babies don’t need any other foods or water until after six months. Does this sound like something you could try?”</i> |

- Give participants the Answer Sheets.
- If some participants are having difficulties with the exercises, or have not finished them, arrange to help them later.

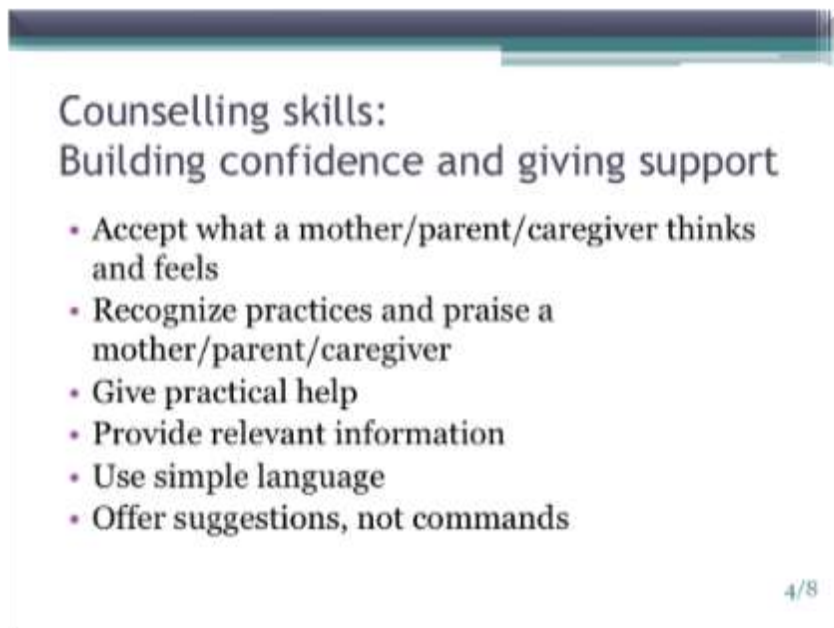
Summarize the session

Time for Question and Answer

- Ask participants if they have any questions.
- You now have a list of the six skills on the flipchart.
- Post it on the wall.
- Read the list to remind participants of the six skills.

[OR]

- Show **Slide 4/8** – Read the list to remind participants of the six skills.



Counselling skills:
Building confidence and giving support

- 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

4/8

- Explain a summary of this session can be found on **pages 38–48** of the Participant's manual.

Copies of demonstrations

- ☐ *The following are copies of the demonstrations given during this session. These demonstrations can be copied and provided to participants who will help you with the demonstrations.*

DEMONSTRATION 4.A – ACCEPTING WHAT A MOTHER THINKS

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

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: I want to give my baby a bottle of formula because I don't have enough milk for her.
Health worker: 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: I want to give my baby a bottle of formula because I don't have enough milk for her.
Health worker: I see. You are worried about your milk?

Ask: Did the health worker agree, disagree or accept what the mother says?

Comment: This response shows acceptance. The health worker accepts the mother 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: | <i>Was this an appropriate response?</i> |
| 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: | <i>Was this an appropriate response?</i> |
| 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: | <i>Was this an appropriate response?</i> |
| 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. |

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: | <i>What did you observe?</i> |
| 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. 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 and formula will not. If you feed your baby formula, he will have less protection against illness. |
| Ask: | <i>What did you observe this time?</i> |
| Comment: | The health worker used simple terms and provided relevant information to the mother. |

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.

Session outline


Suggested time: 45 minutes

Participants are all together for a lecture presentation by one trainer.

- 1) Introduce the session, present **Slide 5/2**
- 2) Group activity
- 3) Present **Slides 5/1–5/16**
- 4) Summarize the session
- 5) Time for Question and Answer

Preparation

- Refer to the Introduction for guidance on giving a presentation with slides.
- Study **Slides 5/1–5/16** and the explanation, so you can present them in the session.
- Read the Further information sections to prepare for the session.



Session 5.

How breastfeeding works

5/1

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Show Slide 5/2 – Objectives and read aloud.

Session 5. Objectives:
How breastfeeding works

After completing this session, participants will be able to describe:

- the parts of the breast involved in lactation and their function;
- 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.

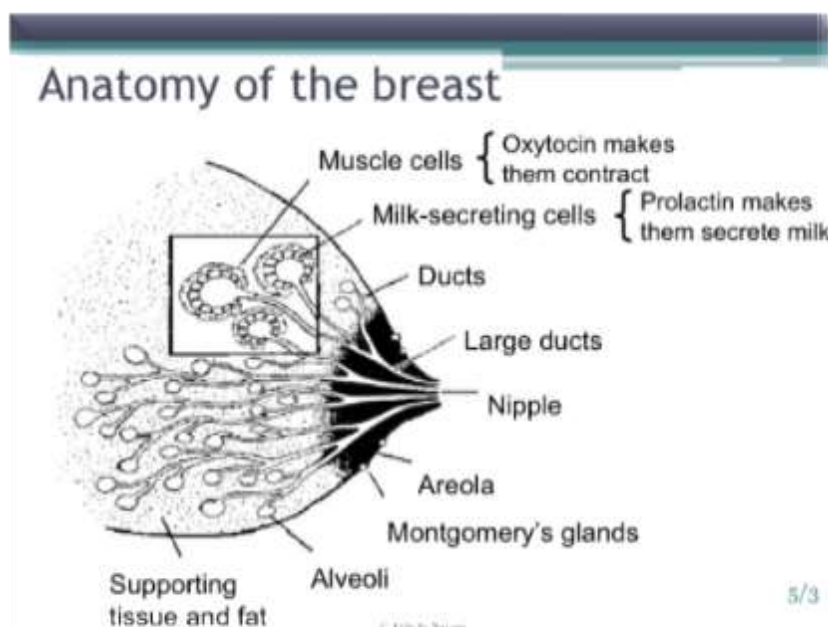
5/2

☐ *Make these points:*

- Through knowledge and understanding of how breastfeeding works, you will be able to help mothers/parents/caregivers more successfully.
- 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

☐ Show **Slide 5/3 – Anatomy of the breast** and make the key points.



☐ *Point to the relevant parts of the diagram on the slide as you explain them. Make the key points.*

- 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 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 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.

After studying the anatomy of the breast, you can notice the details of the breast. Many mothers/parents/caregivers will ask about breast size in the antenatal period.

Ask: Does breast size matter? Some mothers think their breasts are too small to make enough milk. What is the difference between large breasts and small breasts? How would you counsel this mother?

Wait for a few replies and then continue.

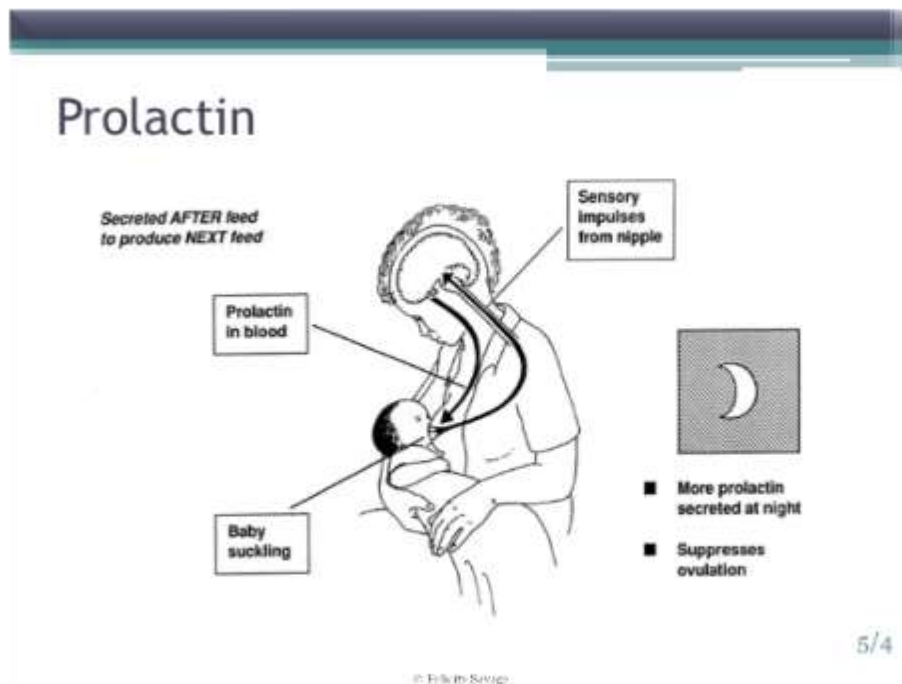
- Small breasts and large breasts both contain about the same amount of glandular tissue, so they can both make plenty of milk. It is the fat and other tissue that give the breast its shape, and make most of the difference between large and small breasts.
- Small breasts may have less milk storage between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

Make these points.

- 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.

Show **Slide 5/4 Prolactin** and make the key points.



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

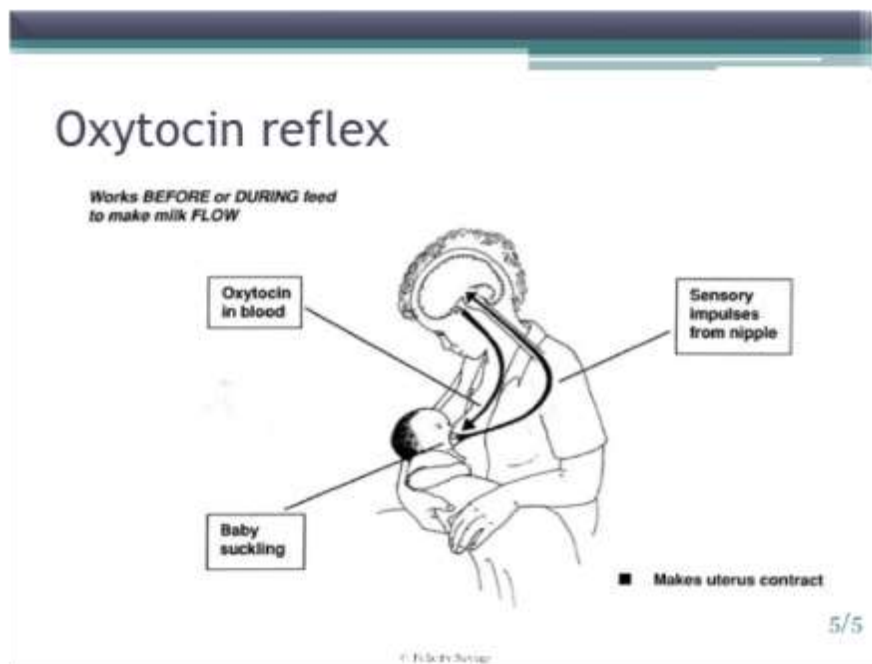
Ask: *What does this suggest about increasing a mother's milk supply?*

Wait for a few replies and then continue.

- To increase her milk supply, the baby must continue to suckle.
- If a baby does not suckle enough, the prolactin level falls, and the breasts make less milk. This is most important in the first month or two after delivery, when milk production is adjusting to the baby's needs.

- Key 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.

☐ Show **Slide 5/5 Oxytocin reflex** and make the key points.



☐ *Key points.*

- 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.

- ☐ Show **Slide 5/6 – Helping and hindering the oxytocin reflex** and make the key points.

Helping and hindering the oxytocin reflex

| | | |
|---|---|--|
| <p>These <i>help</i> the reflex</p> <ul style="list-style-type: none"> • Thinks lovingly of baby • Sounds of baby • Sight of baby • Touches baby • Confidence |  | <p>These <i>hinder</i> the reflex</p> <div style="border: 1px solid black; padding: 10px; width: fit-content; margin: 0 auto;"> <ul style="list-style-type: none"> • Worry • Stress • Pain • Doubt </div> |
|---|---|--|

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5/6

- Oxytocin is sometimes called “the love hormone” because of the role it plays in helping a mother to 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. For example, 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.

- ☐ *Ask: How does understanding the oxytocin reflex help us care for mothers after delivery? Wait for a few replies and then continue.*

- 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.
- 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 criticise 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. There are several signs of an active reflex that they or you may notice.

*Ask participants to turn to **page 55** of the Participant's manual and find the Slide 5/7 SIGNS AND SENSATIONS OF OXYTOCIN REFLEX.*

☐ Show **Slide 5/7 – Signs and sensations of oxytocin reflex** and make the key points.

Signs and sensations of oxytocin reflex:

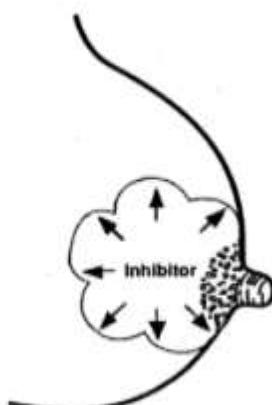
- a squeezing or tingling sensation in her breasts just before she feeds her baby, or during a feed;
- milk flowing from her breasts when she thinks of her baby or hears the baby crying;
- milk dripping from her other breast, when her baby is suckling.
- milk flowing from her breast in fine streams, if her baby comes off the breast during a feed;
- pain from uterine contractions, sometimes with a rush of blood, during feeds in the first week;
- slow deep sucks and swallowing by the baby, which show that breast milk is flowing into their mouth.

5/7

- 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 produced by the oxytocin or the signs may not be obvious.

☐ Show **Slide 5/8 – Inhibitor in breast milk** and make the key points.

Inhibitor in breast milk (FIL)



If breast remains full of milk, secretion stops.

5/8

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

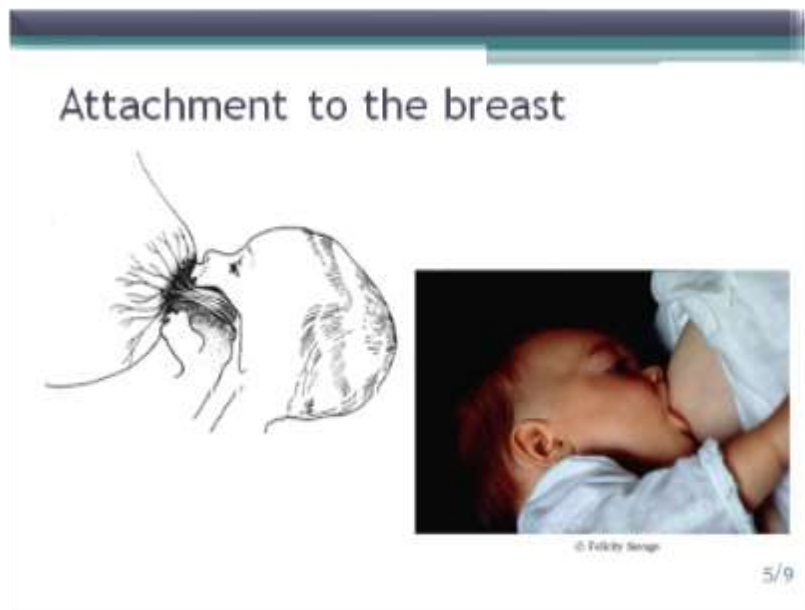
☐ *Make these key points.*

- Milk production is a responsive 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 milk¹³. 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.

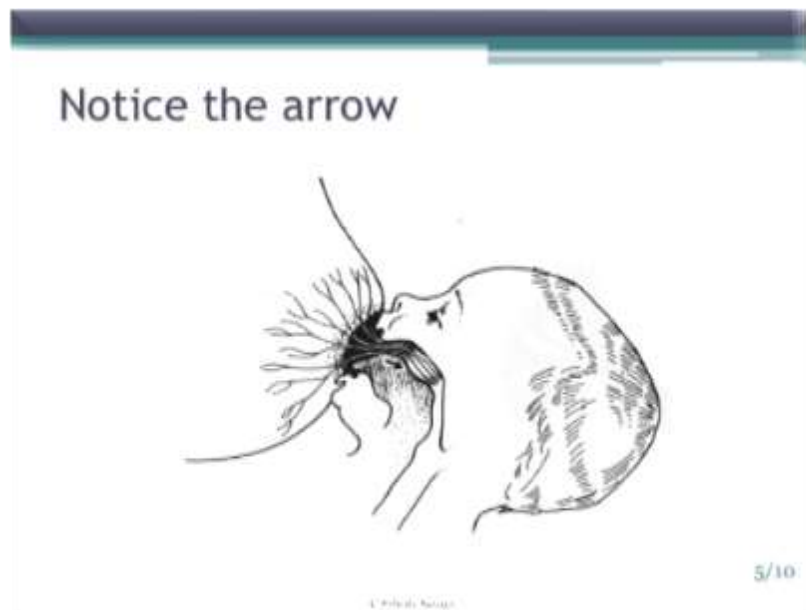
¹³ Responsive feeding is discussed in SESSION 7: POSTNATAL PRACTICES TO SUPPORT BREASTFEEDING.

- ❑ Show **Slide 5/9 – Attachment to the breast** and make the key points.



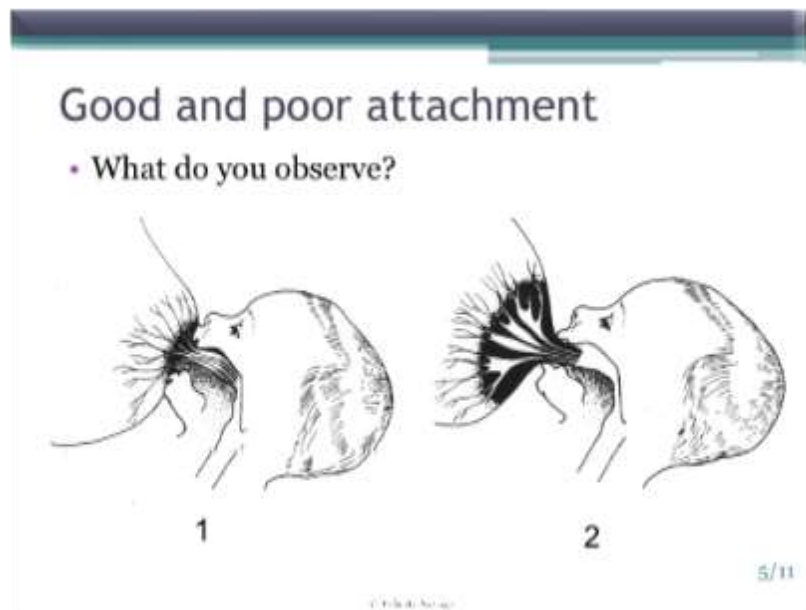
- ❑ This slide shows how a baby takes the breast into their mouth to suckle.
- ❑ Ask: *What do you observe?*
 - Notice these points.
 - The baby has taken much of the areola and the underlying tissues into their mouth.
 - The larger ducts are included in these underlying tissues.
 - The baby has stretched 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 slide, although you may sometimes see the tip of the tongue when you observe a baby.
 - If a baby takes the breast into their mouth in this way, they are *well attached* to the breast.

☐ Show **Slide 5/10 – Attachment to the breast** and make the key points.



- 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;
 - when a baby suckles in this way, their mouth and tongue do not rub the skin of the breast and nipple, which would make the nipple sore.
- 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.

- ❑ Show **Slide 5/11 – Good and poor attachment** and make the key points.



- ❑ 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.

- ❑ Ask: *In what ways is picture 2 different from picture 1?*

Let participants make as many observations as they can. Accept all their observations.

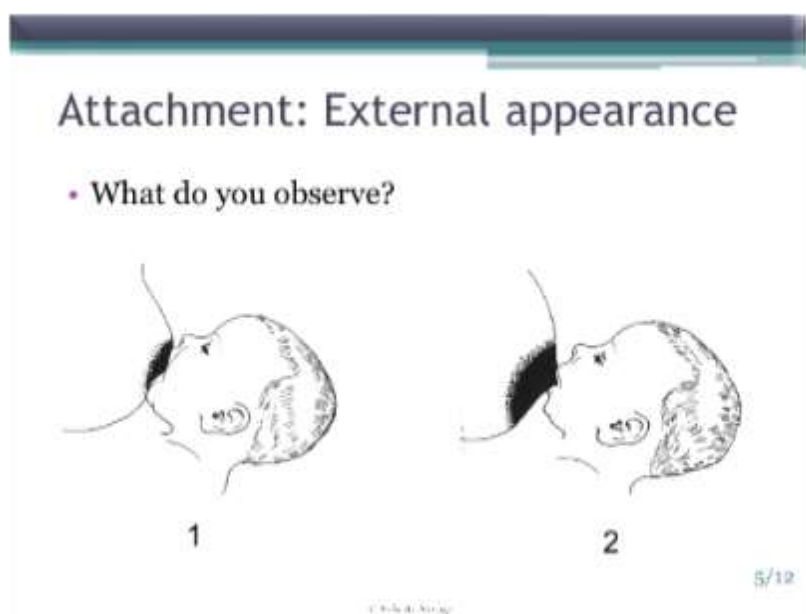
Then make sure the following three points are clear. Make the key points.

- ❑ *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.*

- ❑ Show **Slide 5/12 – Attachment (external appearance)** and make the key points.



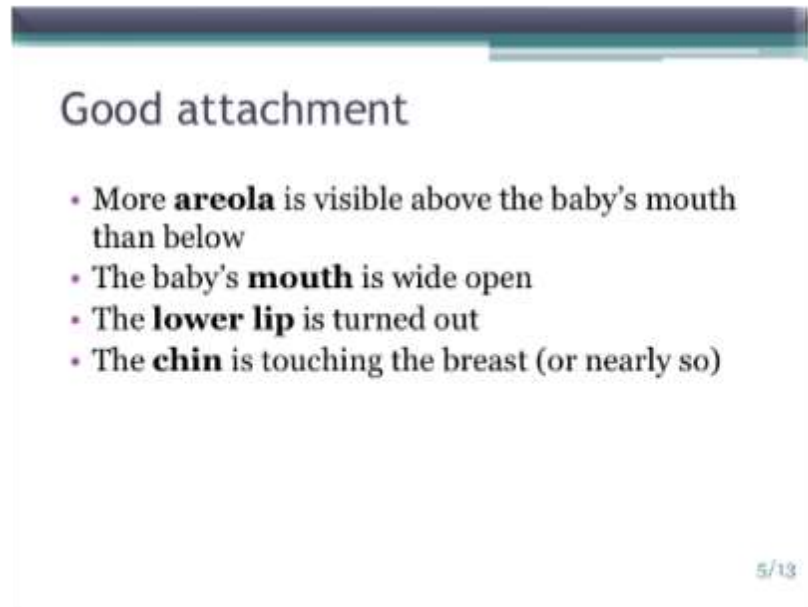
- ❑ This picture shows the same two babies from the outside. You need to be able to observe the baby's attachment by looking at the outside.

- ❑ Ask: *What differences do you see between pictures 1 and 2?*

Wait for a few replies and then continue.

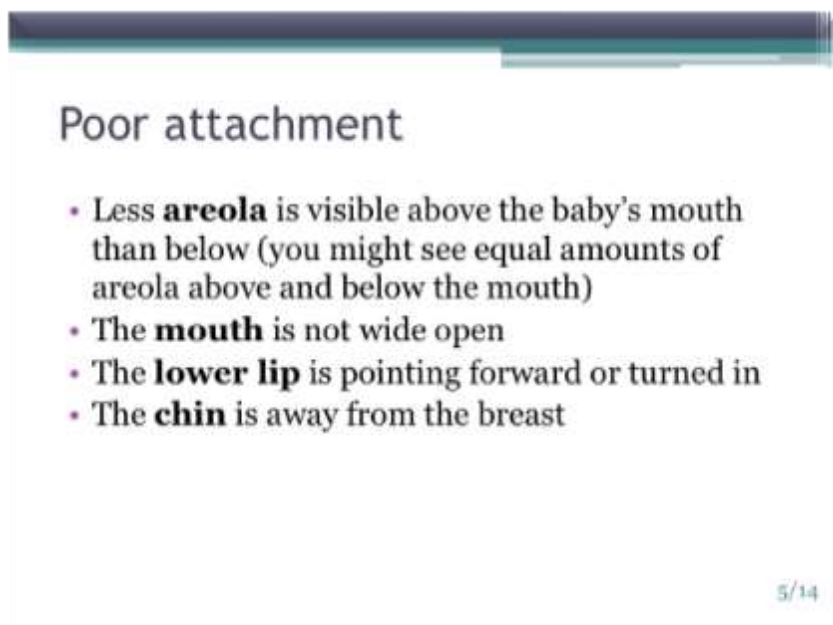
- Picture 1 shows good attachment and Picture 2 shows poor attachment.
- In Picture 1, the **four key signs showing good attachment** are (Slide 5/13):
 1. more **areola** is visible above the baby's mouth than below
 2. the baby's **mouth** is wide open
 3. the **lower lip** is turned out
 4. the **chin** is touching the breast (or nearly so).
- In Picture 2 (**poor attachment**) we see that (Slide 5/14):
 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.

- ☐ Show **Slide 5/13 – Good attachment** and make the key points.



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

- ☐ Show **Slide 5/14 – Poor attachment** and make the key points.



- 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 good or poor 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.

☐ Ask: *What do you think might be the results of poor attachment?*

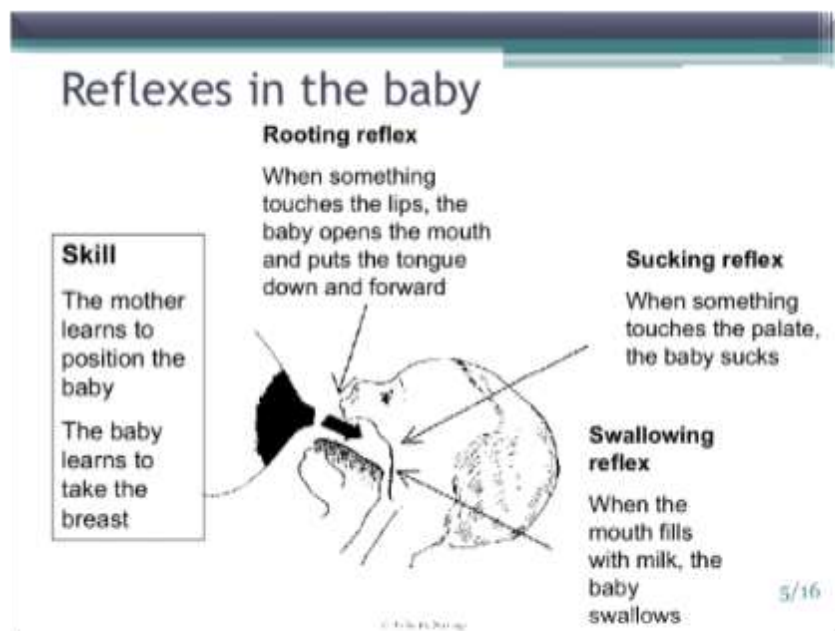
Let participants make four to five suggestions. Then, show **Slide 5/15**.

☐ Show **Slide 5/15 – Results of poor attachment** and make the key points.



- 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).
- As 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 make less milk.
- A baby may fail to gain weight and the mother may feel she is a breastfeeding failure. This may lead her to stop breastfeeding.
- **How can we as health workers help? To prevent this happening, all mothers need skilled help to position and attach their babies.**

□ Show Slide 5/16 – Reflexes in the baby and make the key points.



- **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.
- **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.
- **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 onto the breast so that the nipple touches the soft palate, this stimulates the baby's sucking reflex.
- **Swallowing reflex:** When the baby's mouth fills with milk, they swallow. This is 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.
- 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 baby¹⁴ 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 pointing well below the nipple;
 - the baby can get their tongue under the nipple and larger ducts and suckle effectively.

¹⁴ Refer to SESSION 9. CLASSROOM CLINICAL PRACTICE: POSITIONING A BABY AT THE BREAST.

Summarize the session

Time for Question and Answer

- Ask participants whether they have any questions.*
- Explain a summary of this session can be found on **pages 50–62** of the Participant's manual.*

Further information

Prolactin and milk volume

Prolactin is the most important hormone for regulating milk production in the months after delivery. At this time, the volume of milk being produced is adjusting to the baby's needs. After this time, prolactin levels decrease, and other factors become more important. A baseline prolactin level continues to be necessary to enable lactation to continue, and the level increases during feeds. However, the relationship between the prolactin level and the volume of milk produced is not close. The onset of milk production is dependent on the high levels of prolactin following pregnancy, and on the fall in oestrogen and progesterone levels. It is not dependent on the infant suckling. The continuation of milk production does depend on the infant suckling and removing the milk.

Suckling and ovulation

Prolactin itself does not suppress ovulation. Suckling suppresses production of gonadotrophin releasing hormone, or GnRH. This is needed for release of the hormones, which stimulate ovulation.

Causes of poor attachment

1. *Bottle feeding*: The action of sucking from a bottle is different from suckling from the breast. Babies who have had bottle feeds may try to suck on the breast as if it were a bottle, and this makes them “nipple suck”. When this happens, it is sometimes called “suckling confusion” or “nipple confusion”. So, giving a baby feeds from a bottle can interfere with breastfeeding. **Skilled lactation support is needed to overcome this problem.**
2. *Inexperienced mother*: If a mother has not had a baby before, or if she bottle-fed or she had difficulties breastfeeding previous babies, she may have difficulty getting her baby well attached to her breast. However, even mothers who have previously breastfed successfully sometimes have difficulties during the first few weeks.
3. *Functional difficulty*: Some situations can make it more difficult for a baby to attach well to the breast. For example, if a baby is very small or weak, if a mother's nipples and the underlying tissue are poorly protractile, if her breasts are engorged, or if there has been a delay in starting to breastfeed. Mothers and babies can breastfeed in all these situations, but they may need extra skilled help to succeed.
4. *Lack of skilled breastfeeding support*: A very important cause of poor attachment is lack of skilled breastfeeding support. Some women are isolated and lack support from the community. They may lack help from experienced women such as their own mothers, or from traditional birth attendants, who often are very skilled at helping with breastfeeding. Women in “bottle-feeding” cultures may be unfamiliar with how a breastfeeding mother holds and feeds her baby. They may never have seen a baby breastfeeding. Health workers who look after mothers and babies, for example doctors and midwives, may not have been trained to help mothers to breastfeed.

Areola and attachment

The amount of areola that you see outside a baby's mouth may help you compare the attachment of the same baby before and after you help with the attachment. However, the first time you see a baby, it is not a reliable sign. A mother may have a very small areola, which all goes inside the baby's mouth easily. If she has a very large areola, you can always see some of the areola outside.

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.

Session outline

Suggested time: 45 minutes

Participants are all together for a lecture presentation by one trainer.

- 1) Introduce the session, present **Slide 6/2**
- 2) Present **Slides 6/1–6/14**
- 3) Show suggested video
- 4) Summarize the session
- 5) Time for Question and Answer

Preparation


- Refer to the Introduction for guidance on giving a presentation with slides.
- Study **Slides 6/1–6/14** and the information, so you are able to present them.
- Arrange to show the video: (EARLY INITIATION OF BREASTFEED – BREASTFEEDING SERIES, GLOBAL HEALTH MEDIA PROJECT) either during or after the presentation.
 - The video can be found on the Global Health Media Project website or on YouTube at: <https://www.youtube.com/watch?v=hs7ai466toE>
 - **Suggested timing:** If time is limited, please only show the first segment (Time: 00–3:47).
 - The video is available in a variety of languages on the Global Health Media Project website and YouTube.

- The video shows three different mothers and babies from three different continents initiating breastfeeding. You can choose to play the entire video or only a segment of the video. The time segments for the different mother and baby pairs are as follows:
 - **baby and mother 1:** 00:00–3:47
 - **baby and mother 2:** 3:47–6:19
 - **baby and mother 3:** 6:19–8:03
- If possible, have participants observe a birth and assist with the immediate postnatal practices. Time is not included in the session for this activity.
- If needed, a copy of the **JOB AID: BIRTH PRACTICES CHECKLIST** is provided at the end of this session, and in the Participant’s manual. This can be reviewed as an example of a tool to use.

Reference materials

- WHO and UNICEF. Pregnancy, childbirth, postpartum and newborn care: a guide for essential practice. 3rd ed. Geneva: World Health Organization; 2015 (http://www.who.int/maternal_child_adolescent/documents/imca-essential-practice-guide/en/, accessed 16 March 2020).
- WHO recommendations: intrapartum care for a positive childbirth experience. Geneva: World Health Organization; 2018 (<https://www.who.int/reproductivehealth/publications/intrapartum-care-guidelines/en/>, accessed 16 March 2020).
- WHO and UNICEF. Quality of care network [website]. Geneva: World Health Organization; 2018 (http://www.who.int/maternal_child_adolescent/topics/quality-of-care/network/en/, accessed 16 March 2020).
- Kuyper E, Vitta B, Dewey K. Implications of cesarean delivery for breastfeeding outcomes and strategies to support breastfeeding. Washington (DC): Alive & Thrive; 2014 (A&T Insight, 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)). Global strategy for infant and young child feeding. Geneva: World Health Organization; 2003 (<http://apps.who.int/iris/bitstream/10665/42590/1/9241562218.pdf>, accessed 18 March 2020).
- Widstrom AM, Brimdyr K, Svensson K, Cadwell K, Nissen E. (2019). A plausible pathway of imprinted behaviors: Skin-to-skin actions of the newborn immediately after birth follow the order of fetal development and intrauterine training of movements. *Med Hypotheses*. 134:109432 doi:10.1016/j.mehy.2019.109432.
- Widstrom AM, Brimdyr K, Svensson K, Cadwell K, Nissen E. (2019). Skin-to-skin contact the first hour after birth, underlying implications and clinical practice. *Acta Paediatr*. 108(7):1192-1204 doi:10.1111/apa.14754.

Introduce the session



Session 6.
Impact of birth practices

6/1

© UNICEF/UN0280057/Viet Hung

□ Show **Slide 6/2 – Objectives** and read aloud.

Session 6. Objectives:
Impact of birth practices

After completing this session, participants will be able to:

- discuss the importance of early contact and the initiation of breastfeeding;
- describe the procedure of placing 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.

6/2

- ❑ Ask: *How do birth practices impact breastfeeding? How can birth practices act as barriers to early initiation and skin-to-skin?*

Wait for a few replies, and then explain the following chart.

- ❑ Show **Slide 6/3 – Birth practices: Impact on breastfeeding** and make the key points.

Birth practices: Impact on breastfeeding

| Birth practice | Impact on breastfeeding |
|--|---|
| Requiring mother to lie flat on her back during labour and delivery (moving around, walking or kneeling or reclining in a position of her choice) | Mother's discomfort can have an impact on her ability to initiate breastfeeding |
| Lack of support | Support is one of the biggest keys to early initiation and continued feeding, from medical staff and birth companions |
| Withholding food and fluids during labour | Mother's fatigue and dehydration can have an impact on her ability to initiate breastfeeding |
| Pain medications that sedate mother or baby, episiotomy, intravenous lines, continuous electronic fetal monitoring and other interventions used as routine without medical reasons | Pain medications and interventions for the mother will have an effect on the baby's alertness and ability to breastfeed |
| Wrapping the baby tightly after birth | Babies cannot use their reflexes and movement to begin breastfeeding in the first hour |
| Separating the mother and baby after birth | Mother and baby need to be together to breastfeed early and often |

Baby-Friendly Hospital Initiative: revised, updated and expanded for integrated care, Session 5, 2009.

6/3

Skin-to-skin contact and initiation of breastfeeding

- ❑ Show **Slide 6/4 – Early initiation** and make the key points.

Early initiation: Immediately after birth

Early skin-to-skin contact:

- promotes bonding
- maintains warmth
- lowers infection and mortality



© WHO/Yoshi Shimizu

6/4

Make these points.

- 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.

Ask: How are early skin-to-skin contact and early breastfeeding important to mother and baby?

Wait for a few replies, and then explain the following answers.

*List the benefits of skin-to-skin contact. Ask participants to turn to **page 65** of their Participant's manual, and take turns reading the points aloud from the **Slide 6/5 EARLY SKIN-TO-SKIN CONTACT**.*

Show **Slide 6/5 – Benefits of early skin-to-skin contact** and make the key points.



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

Show **Slide 6/6 – Skin-to-skin contact** and make the key points.



Ask: *What do you observe about how these mothers are holding their baby?*

Wait for a few replies and then continue.

- The babies have been placed on their chests 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.

Show **Slide 6/7 – Risks of not practicing skin-to-skin** and make the key points.

Ask: *What are the risks of not practicing skin-to-skin in the first hour?*

Wait for a few replies and then continue.

Review the answers on the slide together.

Risks of not practising skin-to-skin contact

- If skin-to-skin contact is not practised:
 - risk of infection from surroundings;
 - less stable respiratory and cardiac signs;
 - more difficulty learning to breastfeed;
 - unstable temperatures;
 - shorter duration of exclusive breastfeeding;
 - more maternal stress and less satisfaction with breastfeeding;
 - more infant stress, more crying;
 - less desire for mother to hold infant;
 - less ability for infant to smell mother's milk;
 - greater pain, more crying during procedures.



Wendrich, K., & Pagan, B. (2011). Breastfeeding and Human Lactation (3rd ed.). Burlington, MA: Jones and Bartlett Learning.

© WHO/ Yoshi Shumizu

6/7

- **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.

☐ Show **Slide 6/8 – Readiness to breastfeed** and make the key points.

Readiness to breastfeed



Initial resting period,
followed by response to
the “scent” of the breast



6/8

- 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.

Ask: *What is the baby in the top picture doing?*

Wait for a few replies and then continue.

- 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. Babies may take between one and two hours.

Ask: *What is the baby in the lower picture doing?*

Wait for a few replies and then continue.

- 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.

Show **Slide 6/9 – Breast crawl** and make the key points.



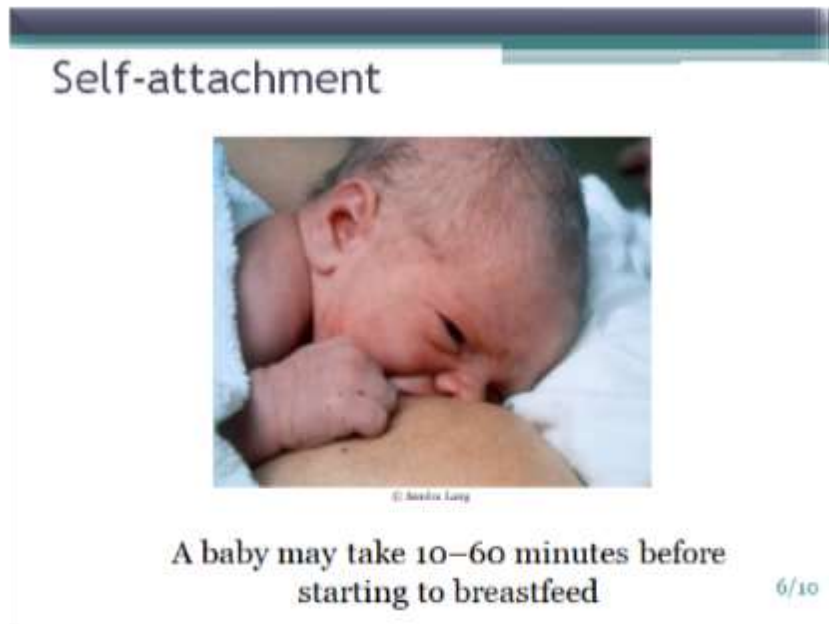
- Most babies slowly crawl toward the breast while they are skin-to-skin with their mothers. When a baby is on their mother's chest (skin-to-skin), the breast odour will encourage the baby to move towards the nipple.
- Provided a mother has not received medication during labour, she and her baby respond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

Ask: *Can anyone tell us their experience with the breast crawl?*

☐ *Wait for a few replies and praise the facilities' practice of early contact.*

☐ **Show Slide 6/10 – Self-attachment** and make the key points.

☐ *Ask: What do you observe in this photo? How is the mother assisting the baby to breastfeed?*



Wait for a few responses and then answer.

- This baby has attached to the breast by himself and has started suckling and touching the nipple with his hand.
- 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.

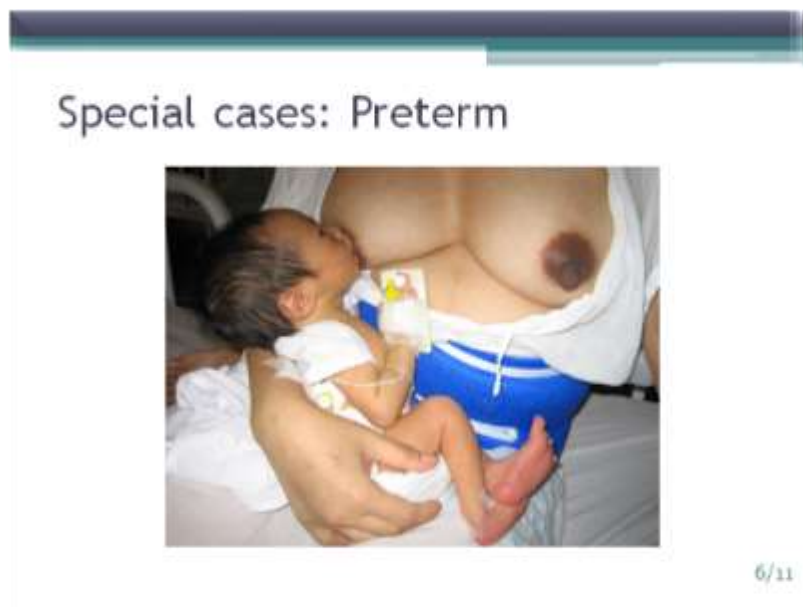
- **NOTE:** The first time the baby suckles at the breast should be considered an introduction to the breast rather than a feed. This is key in providing encouragement and building the mother's confidence. There should be no pressure on the mother or baby as to:
 - how soon the first feed takes place
 - 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, it is a good time to help the mother with breastfeeding.

□ Ask: *How can you (as a health worker) assist a new mother and her infant to initiate breastfeeding?*

Wait for a few responses, then read out the following points.

- **The role of the health worker at this time is to:**
 - provide time and a calm atmosphere
 - help the mother to find a comfortable position
 - point out positive behaviours of the baby such as alertness and rooting
 - build the mother's confidence
 - avoid rushing the baby to the breast or pushing the breast into the baby's mouth.

□ Show **Slide 6/11 – Special cases: Preterm** and make the key points.





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.

☐ **NOTE:** *This is a good time to show the video. While watching the video, ask participants to:*

- note how the skin-to-skin contact was being performed
- identify behaviours of the baby leading the baby to go to the breast.

☐ Show **Slide 6/12 – The first hour after delivery** and make the key points.

First hour after delivery

- Encourage the mother to have a companion
- Also ensure skin-to-skin contact for mothers who will not breastfeed
- If the baby is in a special care unit, arrange for skin-to-skin contact as soon as possible
- Continue skin-to-skin contact in the postpartum ward if the labour ward is busy

© Fidelity Group

6/12

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

☐ Make the following key points.

- 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. The companion should be given a chair or stool to sit on.
- 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, if possible, wait until afterwards, 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 by operation. They should be supported to provide skin-to-skin contact for longer than one hour, and to breastfeed as soon as they are able¹⁵.
- 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. Encourage the contact to continue for longer until the baby shows interest in feeding.
- 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 her baby and put them to the breast.

Optional: Discuss **JOB AID: BIRTH PRACTICES CHECKLIST**.

¹⁵ Kuyper E, Vitta B, Dewey K. Implications of cesarean 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).

Special cases: After a caesarean section

- Show **Slide 6/13 – After caesarean section** and make the key points.



Special cases: After 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. For a healthy full-term baby, the alternative is to wait until the mother is ready. Please refer to SESSION 13. CHALLENGES TO FEEDING AT THE BREAST AND ALTERNATIVE METHODS OF FEEDING for options of alternative feeding in these cases.

- Ask: *What effect could a caesarean section have on a mother and her infant with regards to breastfeeding?*

Wait for a few responses and continue.

☐ Show **Slide 6/14 – After caesarean section** and make the key points.

NOTE: A caesarean section is a major abdominal surgery.

EFFECTS OF A CAESAREAN SECTION ON BREASTFEEDING

| | |
|---|---|
| <p>The mother is likely to:</p> <ul style="list-style-type: none">• be frightened and stressed;• be confined to bed and restricted in movement;• be deprived of energy to care for her baby;• receive anaesthesia and analgesia for pain, which can affect the responses of both the mother and baby. | <p>The baby is likely to:</p> <ul style="list-style-type: none">• be at high risk of not breastfeeding or of breastfeeding for only a short duration;• have more breathing problems;• need suction of mucus, which can hurt the baby's mouth and throat;• be sedated from maternal medications. |
|---|---|

6/14

☐ Ask: *How can you help a mother and her infant to initiate breastfeeding after a caesarean section?*

Wait for a few responses, then read out the following points. Try not to repeat points that have been made by participants.

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 breastfeed 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).

Removing barriers to early breastfeeding: Case study

- ❑ Ask participants to turn to **page 74** of the Participant's manual and find the **Case study: REMOVING BARRIERS TO EARLY BREASTFEEDING**. Ask participants to take turns, reading the paragraphs out loud.
- ❑ While reading the case, ask participants to note practices interfering with establishing breastfeeding. What might be the effect of this situation on breastfeeding?
- ❑ Once participants have finished reading the case study, conduct a group discussion.

Ask participants to remember what they have learnt so far throughout the course and ask the following questions.

- Which practices in this story may have interfered with Carole establishing breastfeeding?
- How could this situation have been improved?

CASE STUDY

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 sagged 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.

Ask: What birth practices during this case study may have interfered with Carole establishing breastfeeding?

- Carole and her baby were separated for many hours, interfering with skin-to-skin contact and initiating breastfeeding. Carole and her baby should not have been separated unless medically necessary.
- Not having skin-to-skin contact interfered with Carole's time to bond with her baby and initiate breastfeeding immediately after birth. Carole noticed her baby's birthmark, which worried her.
- The baby was given bottles of formula without Carole's consent. The baby did not get the valuable colostrum, and Carole's breasts did not receive stimulation to make milk.
- Carole was not given any help to initiate breastfeeding. The baby was full of formula and sleepy and does not want to suckle. Carole needed encouragement and reassurance to breastfeed.
- Carole feels uncomfortable, and it was painful for her to sit up. This probably would inhibit the oxytocin release. Carole could have been encouraged to feed lying down.
- Without support from family or friends, Carole feels tired and stressed. She felt alone in the hospital, with no one to help her or talk to her. A supportive health worker or companion could have provided support to Carole.
- The nurse frightened Carole by saying she was not able to feed her baby and would not be able to go home. The result was Carole was worried, sore, frightened and lonely as well as not knowing how to feed her baby. She probably went home thinking she was not able to make milk and must feed her baby a breast-milk substitute.

Summarize the session

Time for Question and Answer

- Ask participants whether they have any questions.*
- Explain the summary of this session can be found on **pages 64–74** of the Participant's manual.*

JOB AID: BIRTH PRACTICES CHECKLIST

Date and time of birth: _____

Companion for delivery: yes/no Time started _____ Time ended _____

Type of birth:

___ Vaginal : Natural ___ Vacuum ___ Forceps ___

Position for vaginal delivery:

___ C-section with epidural/spinal
___ C-section with general anaesthetic

Skin-to-skin contact:

Position of mother:

Time started: _____ Time ended: _____ Duration of contact: _____

Reason for ending skin-to-skin contact: _____

Time of baby's first breastfeed: _____

Initiated by baby: _____ Helped by: _____

Date and time help offered with second breastfeed: _____

Notes:

Further information

Labour and birth practices

Participants may ask about other birth practices that assist a mother. There are several mother-friendly birthing and postnatal care practices important for the mother's well-being and respect of her dignity and rights. Many mother-friendly practices also help to establish breastfeeding.

Women should not be subjected to unnecessary or harmful practices during labour, childbirth and the early postnatal period. **Use of episiotomy, instrumental vaginal childbirth and caesarean section should only be used when medically necessary.**

Women should be encouraged to choose the position of their choice during labour and have a birth companion of their choice present. Both can improve a woman's confidence and provide comfort during labour and birth and may speed up the labour and birth process.

Food and fluids are also important during labour and the immediate postpartum period. There is no evidence that withholding of light food and drink from low risk women in labour is beneficial as a routine practice. A woman should be allowed to decide if she wants to eat or drink. Restricting food and fluid can be distressing to the labouring woman.

Various techniques can also be offered to assist with pain relief during labour and birth. These may include massage, verbal, physical reassurances, and a quiet environment. Pain medications can result in longer labour, a delayed start to early contact and initiation of breastfeeding, operative interventions, and others.

For more information, please review the resource list.

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.

Session outline


Suggested time: 45 minutes

Participants are all together for a lecture presentation by one trainer.

- 1) Introduce session, present **Slide 7/2**
- 2) Present **Slides 7/1–7/9**
- 3) Summarize the session
- 4) Time for Question and Answer

Preparation

- Refer to Introduction for guidance on giving a presentation with slides.
- Study **Slides 7/1–7/9**, so you are familiar with each slide and the particular teaching points.
- Refer to the Introduction for guidance on giving a presentation with slides.



Session 7.
Postnatal practices to support breastfeeding

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- ☐ Show Slide 7/2 – Objectives and read aloud.

Session 7. Objectives
Postnatal practices to support breastfeeding

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.

7/2

- 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.

Avoiding prelacteal feeds and unnecessary supplementation

- ☐ Show **Slide 7/3 – Prelacteal feeds** and make the key points.

Prelacteal feeds

- Artificial feeds given before breastfeeding is established
- By any feeding method (e.g. cup, spoon, bottle)
- What are examples in your context/setting?



7/3

- ☐ *Make the following key points.*

- 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?
- Any artificial feed given before breastfeeding is established or before the maternal milk supply “comes in” is called a "prelacteal feed".
- Supplementary feeds are any foods or fluids given in addition to mother’s own milk except for drops, syrups (vitamins, minerals, medicines).

- ☐ *Ask: In your health-care facility, are babies given any other fluids before breastfeeding is established?*

If the answer is YES, ask the next question.

If the answer is NO, continue with the second question.

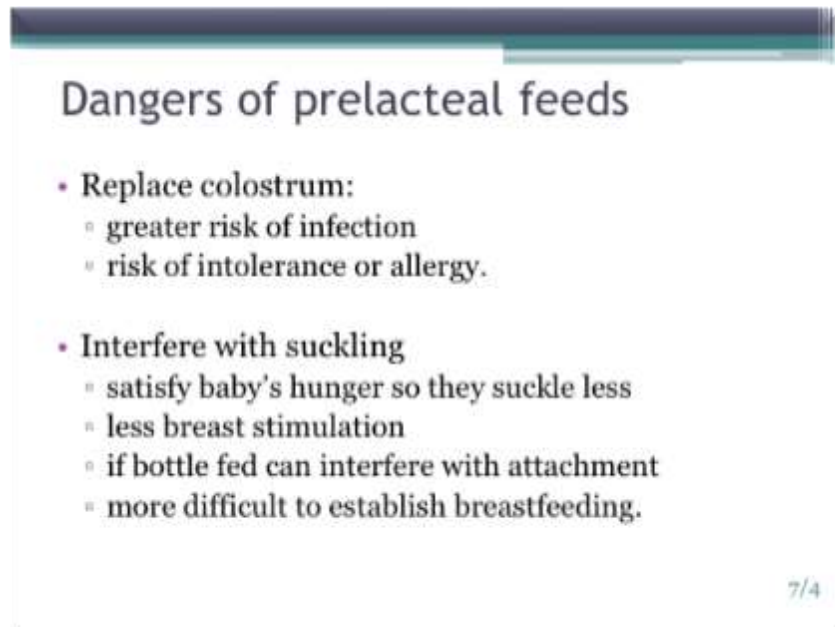
- ☐ *Ask: What is given to the baby and why?*

Wait for three or four responses and then continue.

- Ask: *What are the dangers of giving prelacteal feeds?*

Wait for a few responses and then continue.

- Show **Slide 7/4 – Dangers of prelacteal feeds** and make the key points.



- Review the list of dangers of prelacteal feeds on this slide.

- 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.
- 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.

- Ask: *When are prelacteal feeds necessary?*

Wait for a few replies and then continue.

- 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

- ☐ Show **Slide 7/5 – Rooming-in** and make the key points.



- ☐ *What do you observe in this slide?*
 - The baby and mother in this slide are “rooming-in”.
 - 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 mothers, 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.

Ask: *What are the advantages of rooming-in?*

Wait for a few replies and then continue.

Show **Slide 7/6 – Advantages of rooming-in** and make the key points.

Advantages: Rooming-in

- Mother can respond to baby and feeding cues
- Mother more confident about breastfeeding
- Babies gain weight more quickly
- Breastfeeding continues longer
- Helps bonding and breastfeeding

7/6

The 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, as when 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 the mother's confidence about breastfeeding and caring for their baby;
- ensuring breastfeeding continues longer after discharge.

Ask: *In your health-care facility, do mothers and infants stay together if the baby needs special care? If not, can you think of any practices that may help?*

Wait for a few responses, then make the following points:

- 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 of her milk.

Caring for the mother/parent/caregiver

- Take care of 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

Make the following points.

- Responsive feeding¹⁶: a mother/parent/caregiver should feed her baby whenever the baby wants. She needs to learn to recognize 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 whether or not they choose to breastfeed.


Ask: How could you counsel a mother about her baby's readiness to feed?

Wait for a few replies and then continue.

¹⁶ Responsive feeding is also called on-demand or baby-led feeding.

Early feeding cues

- Opening their mouth and turning their head trying to find the breast
- Wakeful and restless
- Making small noises
- Hand-to-mouth movements
- Sucking fingers

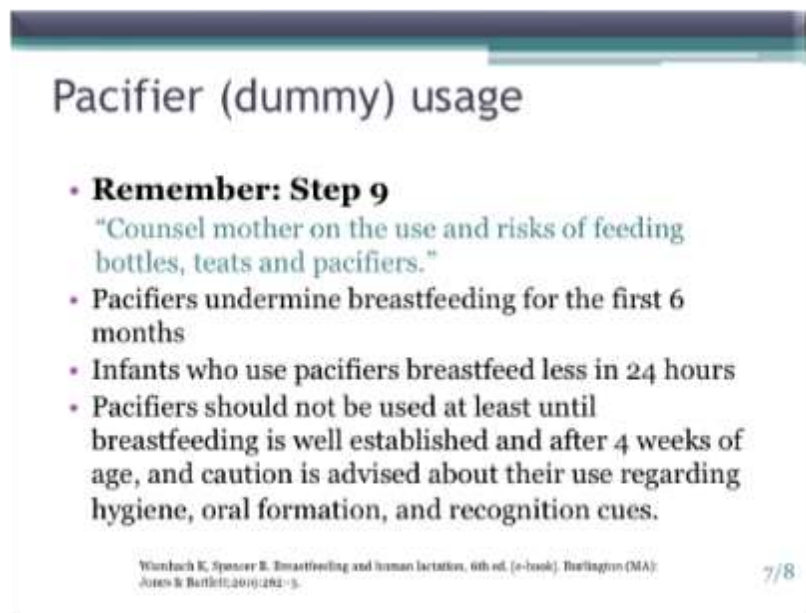


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© UNICEF/UN040920/Bottom

7/7

- **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.
- 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.
- When a baby starts crying, he may become quite stressed and difficult to breastfeed.
- 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 early feeding cues.

- ☐ Show **Slide 7/8 – Pacifier usage** and make the key points.



Pacifiers

- Sometimes families use pacifiers or dummies 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. The result is interference with establishing the breast-milk supply.
- Pacifiers can carry bacteria if not cleaned regularly, and lead to increased ear infections and dental problems.

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

- We are going to discuss some common postnatal questions mothers/parents/caregivers ask health workers in the first few days.

- ☐ *Ask: 1. How long should I let my baby suckle at the breast?*

Wait for a few replies and then continue.

- 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 fixed 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 suckling 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 milk¹⁷. 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 feed, 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.

Ask: How often should I feed my baby? Wait for a few responses, then make the following points:

- Babies vary in the number of feeds they want, which may be anything from six to more than 12 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.

Ask: 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 that the mother:
 - removes blankets, hats and heavy clothing, to wake and cool the baby
 - gently massages her baby's body and talks to her baby
 - waits half an hour and tries again
 - expresses a little breast milk 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.



Ask: What if my baby is premature or has a low-birth-weight?

- A low-birth-weight or ill baby will probably take very long feeds. They may pause frequently to rest and regain strength.
- It is important to plan for calm, quiet, unhurried, rather long breastfeeds (sometimes an hour or more).

¹⁷ Hindmilk/foremilk is discussed in SESSION 2. BENEFITS OF BREASTFEEDING.

- 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 contact 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 slow¹⁸.

Show **Slide 7/9 – Advantages of responsive feeding** and make the key points.

Advantages of responsive feeding

- Breast milk comes in sooner
- Baby gains weight more quickly
- Fewer difficulties like engorgement
- Breastfeeding more easily established



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Ask: *What are the advantages of responsive feeding?*

- The advantages of responsive feeding are:
 - the breast milk increases, changes, or “comes in” sooner
 - the baby gains weight more quickly
 - there are fewer difficulties, like engorgement
 - breastfeeding is more easily established.

Ask: *What is the best way to feed my baby?*

Wait for a few replies and then continue.

¹⁸ See SESSION 13. CHALLENGES TO FEEDING AT THE BREAST AND ALTERNATIVE METHODS OF FEEDING for information on breast-milk expression and cup feeding.

Summarize the session

Make the key points.

- The optimal pattern is unrestricted and responding to a baby's needs.
- 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 baby wants it but letting them decide whether they want one or two breasts at a feed;
 - allowing a baby to feed as early and as often as they want.

Time for Question and Answer

Ask participants if they have any questions.

*Explain the summary of this session can be found on **pages 76–83** of the Participant's manual.*

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.


Session outline

Suggested time: 45 minutes

- One trainer to give lecture presentation
- Participants are all together Participants are all together for a lecture presentation by one trainer.
 - 1) Introduce session, present **Slide 8/2**
 - 2) Explain JOB AID: BREASTFEEDING SESSION OBSERVATION
 - 3) Practice assessing a breastfeeding using: JOB AID: BREASTFEEDING SESSION OBSERVATION
 - 4) Summarize the session
 - 5) Time for Question and Answer

Preparation

- Refer to Introduction for guidance on giving a demonstration.
- Supplies needed: Model breast and a doll available.
- Have **Slides 8/1– 8/6** ready. Study the slides, so you are familiar with what each slide shows and the particular points for each slide.



Session 8.
Classroom Clinical
practice: Assessing a
breastfeed

8/1

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□ Show **Slide 8/2 – Objectives** and read aloud.

Session 8. Objectives
Classroom clinical practice: Assessing a
breastfeed

**After completing this session,
participants will be able to:**

- recognize the **FOUR KEY POINTS OF ATTACHMENT**;
- assess a breastfeeding session 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.

8/2

- 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.

Explain the JOB AID: BREASTFEEDING SESSION OBSERVATION

- Ask participants to turn to **page 86** of the Participant's manual, to find the **JOB AID: BREASTFEEDING SESSION OBSERVATION** form.
- Make the key points.
 - 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, SUCKLING¹⁹.
 - **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 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.
- Explain the sections of the **JOB AID: BREASTFEEDING SESSION OBSERVATION** form
- Explain the section: **MOTHER'S GENERAL APPEARANCE**
 - Look at the mother in general.
 - What do you observe about the mother? Does she look healthy, ill or depressed?
 - *Does the mother look relaxed and 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?*
 - Signs of bonding: eye contact, smiling, held securely with confidence.

¹⁹ Positioning a baby is discussed in SESSION 9, and baby's attachment and suckling in Session 5.

- Observing how a mother interacts with her baby while feeding is important. **Remember if a mother feels confident about breastfeeding, this will help her milk to flow²⁰.**

□ Explain the 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.

□ Explain the 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 that 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?

□ Explain the section: **BABY'S POSITION**

- **Observe the baby's position at the breast.**
- **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** or if the head and neck are twisted.
 - (2) Observe if she holds the **baby close to the breast**.
 - (3) Observe if the mother **supports the baby's whole body** or if only the baby's head and neck are supported.
 - (4) Observe if the baby is **approaching the breast, from below, with nose to nipple** or if they approach it with the nipple going straight into the middle of the mouth .

□ Explain the section: **BABY'S ATTACHMENT**

- Observe the four key points of correct attachment. Remember we learnt these in **SESSION 5. HOW BREASTFEEDING WORKS**.
- *Ask: what are the four key points of attachment?*
- Four key points.
 - (1) Is there **more areola visible above the baby's top lip than below?**

²⁰ Signs of the oxytocin reflex are discussed in **SESSION 5. HOW BREASTFEEDING WORKS**.

- (2) Is the baby's **mouth open wide**?
- (3) Is the **lower lip turned outwards**?
- (4) Does the baby's **chin touch the breast**?

Explain the section: SUCKLING

Ask: What did you learn about effective suckling from SESSION 5: HOW BREASTFEEDING WORKS.

Give the following demonstrations as you explain.

Demonstrate effective suckling

Follow these steps: Suck on your fist, with your mouth open wide, your tongue forward, and your lower lip curled back. Give slow deep sucks, about one per second.

Demonstrate ineffective suckling

Follow these steps: Suck on your thumb, with your mouth almost closed, your lips pointing forwards, and letting your cheeks pull in. Give quick, small sucks.

Ask: How can you tell if the baby is suckling effectively?

▪ Signs of **effective** suckling:

- the baby takes slow deep suck
- 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 takes 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.

Ask: What might you observe at the end of a breastfeed?

- Does the baby release the breast themselves or does the mother take her baby off of her breast before the baby has finished? Remember when a baby has had all the breast milk that they want, they usually release the breast themselves, and relax, looking contented. A baby who is not well attached and not getting milk may stop breastfeeding and cry in frustration.

Ask the mother: Can you feel any signs of the oxytocin reflex?

- For example, is there milk leaking from her breasts or a tingling sensation?

Ask her: How does breastfeeding feel to you?

- 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

- Explain to participants that they will now practise assessing a breastfeed and recognizing the signs of positioning and attachment. They will do this using the **JOB AID: BREASTFEEDING SESSION OBSERVATION** form.

Show Slides 8/3–8/6.

- Ask participants to observe each slide and assess the mother and her baby breastfeeding while using the **JOB AID: BREASTFEEDING SESSION OBSERVATION** form. Go through each section of the form together and ask participants what they observe.
 - **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.

Show Slide 8/3 – Assessing a breastfeed (practise).

- Let's practise together. Go through the sections of the **JOB AID: BREASTFEEDING SESSION OBSERVATION** noting what you can see from the slide. Remember, it is difficult in slides to see all the signs.
- Give participants a few moments to look at the picture. Then go through each section and ask what they see. Suggest any points that they did not notice.
 - Below are signs you can observe.

Practise: Assessing a breastfeed



- Please use JOB AID:
**BREASTFEEDING SESSION
OBSERVATION**

8/3

GENERAL

Mother:

- ✓ mother looks healthy overall
- ✓ she is sitting comfortably, her back supported
- ✓ the mother is looking in a loving way at her baby
- ✓ mother is sitting comfortably
- ✓ there are no pillows supporting her
- ✓ we cannot see if there is anyone supporting or assisting her.

Baby:

- ✓ baby looks healthy, calm, and relaxed.

BREASTS

- ✓ Her breasts look healthy.
- ✓ Her breast is available with no obstruction of clothes.

BABY'S POSITION

- ✓ Baby's head and body are in a straight line.
- ✓ Baby is held close.
- ✓ Baby is well supported.
- ✓ We cannot see if baby approached the breast, nose to nipple.

BABY'S ATTACHMENT

- ✓ There is more areola above the baby's mouth than below it.
- ✓ Baby's mouth is open wide.
- ✓ We do NOT see the baby's lower lip.
- ✓ It is not possible to tell if the baby's chin is touching the breast.

BABY'S SUCKLING

- ✓ We cannot see signs of suckling in a picture.

❑ Show **Slide 8/4 – Assessing a breastfeed 1**

- ❑ *Ask: Go through the sections of the **JOB AID: BREASTFEEDING SESSION OBSERVATION** noting what you can see from the slide. Remember, it is difficult in slides to see all the signs.*
- ❑ *Give participants a few moments to look at the picture. Then go through each section and ask what they see. Suggest any points that they did not notice.*
 - Below are signs you can observe.

Assessing a breastfeed 1

- Please use **JOB AID: BREASTFEEDING SESSION OBSERVATION**

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8/4

The slide features a photograph of a woman in a blue top breastfeeding a baby. The woman is looking down at the baby with a focused expression. The baby is wrapped in a colorful cloth. The background is dark, making the subjects stand out.

GENERAL

Mother:

- ✓ mother looks healthy overall
- ✓ she is sitting comfortably
- ✓ she is looking in a loving way at her baby
- ✓ she is sitting comfortably
- ✓ there are no pillows supporting her
- ✓ we cannot see if there is anyone supporting or assisting her.

Baby:

- ✓ baby looks healthy, calm, and relaxed.

BREASTS

- ✓ Her breasts look healthy.
- ✓ Her breast comes easily out of a top that opens wide.
- ✓ Mothers fingers too near nipple and getting in the way of baby's mouth (but not scissor hold which would have the breast/nipple between first and second fingers).

BABY'S POSITION

- ✓ Baby's head and body are in a straight line.
- ✓ Baby is held close but bundled up in clothes.
- ✓ Baby is only supported at the shoulders, and not the whole body, which is away from the mother.
- ✓ We cannot see if baby approached the breast, nose to nipple.

BABY'S ATTACHMENT

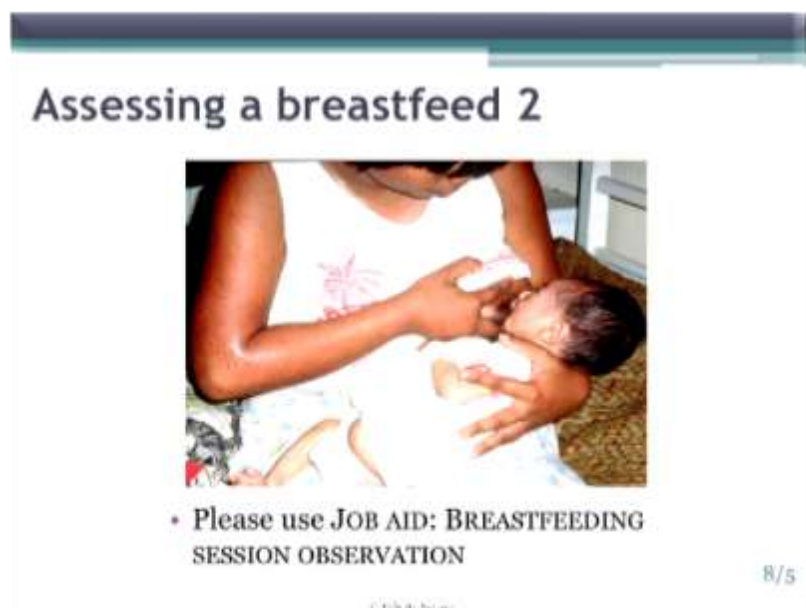
- ✓ There is more areola above the baby's mouth than below it.
- ✓ Baby's mouth is NOT open wide.
- ✓ Baby's lips are turned in.
- ✓ Baby's chin does NOT touch the breast.

BABY'S SUCKLING

- ✓ We cannot see signs of suckling in a picture.

- Ask: *Is the baby well or poorly attached? What signs indicate if baby is well or poorly attached to the breast?*
- Discuss *what to do about it and what to say to the mother.*
- Ask: *When talking to a mother, remember to first say something positive before suggesting changes. What positive signs could you point out to the mother?*
 - Her baby looks thriving and happy breastfeeding.
 - She is looking lovingly at her baby.
 - Baby's body is held in a straight line and facing the mother.
- Ask: *What suggestions could you offer to the mother?*
 - You could suggest that the mother re-position and attach her baby again for more effective suckling. Ask the mother to sit comfortably and hold the baby close. This will help position the baby, so they approach the breast, nose to nipple.
 - You could show her how to hold the baby so that they can get the milk more easily. Also remove some of the excess bundles of cloth to hold baby closer.
 - It may help if she takes off her top so that the breast is less constrained.

Show **Slide 8/5 – Assessing a breastfeed 2**



- Ask: *Go through the sections of the **JOB AID: BREASTFEEDING SESSION OBSERVATION** noting what you see from the slide. What can you observe? Remember, it is difficult in slides to see all the signs.*
- Give participants a few moments to look at the picture. Then go through each section and ask what they see. Suggest any points that they did not notice.
 - Below are signs that you can observe.

GENERAL

Mother:

- ✓ the mother looks like she may be leaning forward and bringing her breast to the baby
- ✓ she is sitting comfortably.
- ✓ we cannot see if there is anyone supporting or assisting her.

Baby:

- ✓ The baby looks healthy and calm.

BREASTS

- ✓ Her breasts look healthy.
- ✓ She is using a “scissor hold”.

BABY’S POSITION

- ✓ Baby’s neck and head are twisted.
- ✓ Baby is NOT held close.
- ✓ Baby is NOT supported by whole body – only by shoulders.

BABY’S ATTACHMENT

- ✓ More areola is seen below baby’s bottom lip.
- ✓ Baby’s mouth is NOT open wide.
- ✓ Baby’s lower lip is turned in.
- ✓ Baby’s chin is not touching the breast.

BABY’S SUCKLING:

- ✓ Baby’s cheeks look like they are pulled in.

Ask: *Is the baby well or poorly attached? What signs indicate if baby is well or poorly attached to the breast?*

Discuss what to do about it and what to say to the mother.

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

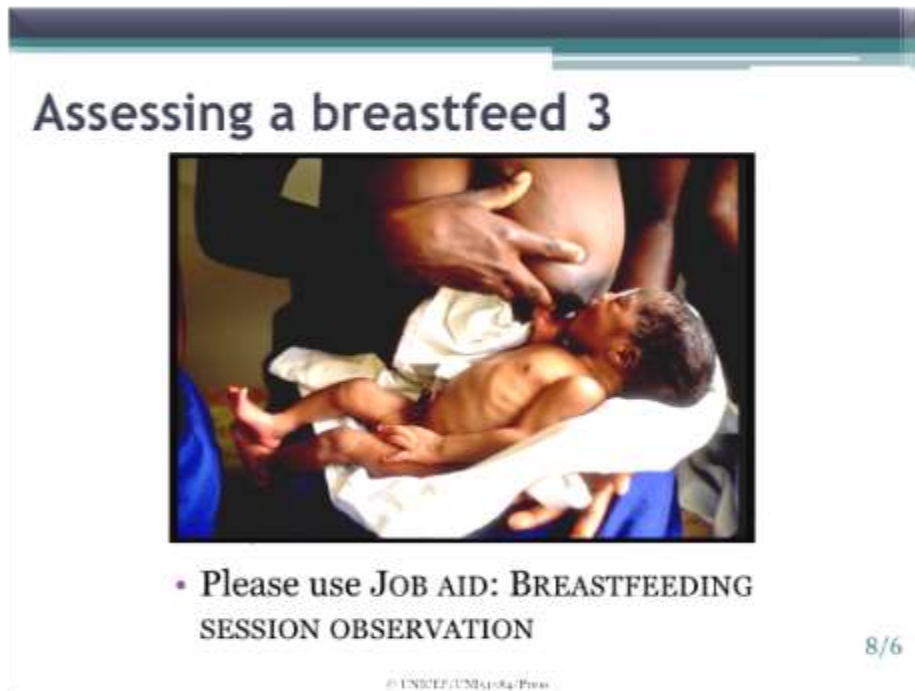
- Her baby looks healthy.
- Baby’s body is held close to the mother.

Ask: *What suggestions could you offer to the mother?*

- Possible suggestions:
 - “If your baby takes more of the breast into his mouth, he would get the milk more easily and you would have less pain.”
 - “If your baby could suckle in a slightly different way, he could get the milk more easily. Would you like me to show you how?”

- Suggest that the mother sits comfortably or reclines. This will help her bring her baby to her breast instead of bringing her breast to her baby.
- Suggest the mother uses a pillow to support her arm, if she wishes.
- Offer her help with supporting her breast rather than with the scissor hold. They are too near the nipple which prevents the baby from taking a big enough mouthful of the breast.

☐ Show **Slide 8/6 – Assessing a breastfeed 3**



- Below are signs you can observe.

GENERAL

Mother:

- ✓ in this picture, you cannot see much of the mother or her position
- ✓ she is not sitting comfortably
- ✓ there are no pillows supporting her
- ✓ we cannot see if there is anyone supporting or assisting her.

Baby:

- ✓ this baby looks very thin and may be low weight
- ✓ they may find it difficult to suckle for long at one time.

BREASTS

- ✓ Her breasts look healthy
- ✓ She is using two fingers in scissor hold to support her breast. Her fingers are not at this moment getting in the way of the baby taking the breast and areola into their mouth, as the baby is still too far away, but they could do if he was closer. It looks like the breast is hanging down to reach the baby. The baby should be brought up to the level of the breast.

BABY'S POSITION

- ✓ Baby's head and neck are twisted to the right.
- ✓ Baby is NOT held close.
- ✓ Baby is supported. However, the baby needs to be supported at the level of the breast and turned towards the mother.
- ✓ It is difficult to see if the baby approached the breast, nose to nipple. But probably mouth came onto nipple from above

BABY'S ATTACHMENT

- ✓ There is the same amount of areola above the baby's mouth as below it.
- ✓ Baby's mouth is NOT open wide.
- ✓ Baby's lower lip is NOT turned out.
- ✓ Baby's chin does NOT touch the breast.

BABY'S SUCKLING

- ✓ We cannot see signs of suckling in a picture.
- ✓ But cheek is drawn in.

- Ask: What signs indicate if baby is well or poorly attached to the breast?
- Discuss what to do about it and what to say to the mother.
- Ask: What positive signs could you point out to the mother?
 - Her baby is being breastfed, which shows her care and love for her baby.

- Ask: What possible suggestions could you offer to the mother?*
 - The mother may need to find a more comfortable position for herself, with her back supported so she is not bending over the baby. You could suggest the mother sits more upright and holds her baby differently so that he can suckle and get the milk more easily.
 - Suggest she holds the baby closer and higher supporting the baby's whole body supported and turning him towards the breast. This would help the baby reach the breast more easily and take a larger mouthful of the breast.
 - Suggest she holds her baby with the arm opposite the breast. This often makes it easier for small babies.
- Make the points.*
 - These slides showed a number of signs for improvement. However, remember many mothers and babies breastfeed with no difficulties. Notice the signs that breastfeeding is going well, not just the signs of possible difficulty.
 - We will use these skills to assess breastfeeding in a clinical practice session later.

Summarize the session

Time for Question and Answer

- Ask participants whether they have any questions.*
- Explain the summary of this session can be found on **pages 85–95** of the Participant's manual.*

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 looks healthy
- Mother relaxed, comfortable, back supported
- Signs of bonding between mother and baby

Mother

- Mother looks ill or depressed
- Mother looks tense and uncomfortable
- No mother/baby eye contact

Baby

- Baby looks healthy
- Baby calm and relaxed
- Baby reaches or roots for breast if hungry

Baby

- Baby looks sleepy or ill
- Baby is restless or crying
- Baby does not reach or root

BREASTS

- Breasts look healthy
- No pain or discomfort
- Breast well supported with fingers away from nipple

- Breasts look red, swollen or sore
- Breast or nipple painful
- Breast held with fingers on areola

BABY'S POSITION

- 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 mouth above

- Baby's neck and head twisted to feed
- Baby not held close
- Baby supported by head and neck only
- Baby approaches breast, lower lip/chin nipple to nipple

BABY'S ATTACHMENT

- More areola seen above baby's top lip
- Baby's mouth wide open
- Lower lip turned outwards
- Baby's chin touches breast

- More areola seen below bottom lip
- Baby's mouth not open wide
- Lower lips pointing forward or turned in
- Baby's chin not touching breast

SUCKLING

- Slow, deep sucks with pauses
- Cheeks round when suckling
- Baby releases breast when finished
- Mother notices signs of oxytocin reflex

- Rapid shallow sucks
- Cheeks pulled in when suckling
- Mother takes baby off the breast
- 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 looks healthy
- Mother relaxed and comfortable
- Signs of bonding between mother and baby

Mother

- Mother looks ill or depressed
- Mother looks tense and uncomfortable
- No mother/baby eye contact

Baby

- Baby looks healthy
- Baby calm and relaxed
- Baby reaches or roots for breast if hungry

Baby

- Baby looks sleepy or ill
- Baby is restless or crying
- Baby does not reach or root

BREASTS

- Breasts look healthy
- No pain or discomfort
- Breast well supported with fingers away from nipple

- Breasts look red, swollen or sore
- Breast or nipple painful
- Breast held with fingers on areola

BABY'S POSITION

- 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 to nipple

- Baby's neck and head twisted to feed
- Baby not held close
- Baby supported by head and neck only
- Baby approaches breast, lower lip/chin

BABY'S ATTACHMENT

- More areola seen above baby's top lip
- Baby's mouth wide open
- Lower lip turned outwards
- Baby's chin touches breast

- More areola seen below bottom lip
- Baby's mouth not open wide
- Lips pointing forward or turned in
- Baby's chin not touching breast

SUCKLING

- Slow, deep sucks with pauses
- Cheeks round when suckling
- Baby releases breast when finished
- Mother notices signs of oxytocin reflex

- Rapid shallow sucks
- Cheeks pulled in when suckling
- Mother takes baby off the breast
- 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 looks healthy
- Mother relaxed and comfortable
- Signs of bonding between mother and baby

Mother

- Mother looks ill or depressed
- Mother looks tense and uncomfortable
- No mother/baby eye contact

Baby

- Baby looks healthy
- Baby calm and relaxed
- Baby reaches or roots for breast if hungry

Baby

- Baby looks sleepy or ill
- Baby is restless or crying
- Baby does not reach or root

BREASTS

- Breasts look healthy
- No pain or discomfort
- Breast well supported with fingers away from nipple

- Breasts look red, swollen or sore
- Breast or nipple painful
- Breast held with fingers on areola

BABY'S POSITION

- 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 to nipple

- Baby's neck and head twisted to feed
- Baby not held close
- Baby supported by head and neck only
- Baby approaches breast, lower lip/chin

BABY'S ATTACHMENT

- More areola seen above baby's top lip
- Baby's mouth wide open
- Lower lip turned outwards
- Baby's chin touches breast

- More areola seen below bottom lip
- Baby's mouth not open wide
- Lips pointing forward or turned in
- Baby's chin not touching breast

SUCKLING

- Slow, deep sucks with pauses
- Cheeks round when suckling
- Baby releases breast when finished
- Mother notices signs of oxytocin reflex

- Rapid shallow sucks
- Cheeks pulled in when suckling
- Mother takes baby off the breast
- 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 looks healthy
- Mother relaxed and comfortable
- Signs of bonding between mother and baby

Mother

- Mother looks ill or depressed
- Mother looks tense and uncomfortable
- No mother/baby eye contact

Baby

- Baby looks healthy
- Baby calm and relaxed
- Baby reaches or roots for breast if hungry

Baby

- Baby looks sleepy or ill
- Baby is restless or crying
- Baby does not reach or root

BREASTS

- Breasts look healthy
- No pain or discomfort
- Breast well supported with fingers away from nipple

- Breasts look red, swollen or sore
- Breast or nipple painful
- Breast held with fingers on areola

BABY'S POSITION

- 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 to nipple

- Baby's neck and head twisted to feed
- Baby not held close
- Baby supported by head and neck only
- Baby approaches breast, lower lip/chin

BABY'S ATTACHMENT

- More areola seen above baby's top lip
- Baby's mouth wide open
- Lower lip turned outwards
- Baby's chin touches breast

- More areola seen below bottom lip
- Baby's mouth not open wide
- Lips pointing forward or turned in
- Baby's chin not touching breast

SUCKLING

- Slow, deep sucks with pauses
- Cheeks round when suckling
- Baby releases breast when finished
- Mother notices signs of oxytocin reflex

- Rapid shallow sucks
- Cheeks pulled in when suckling
- Mother takes baby off the breast
- No signs of oxytocin reflex noticed

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.

Session outline

Suggested time: 60 minutes


- Trainers (2)
- Participants are all together
- For the practical session on positioning using dolls, participants are in groups of three or four, with one trainer per group One trainer to give lecture presentation
 - 1) Introduce the session, present **Slide 9/2**
 - 2) Demonstrate helping a mother to position her baby
 - 3) Classroom practical: Positioning a baby using dolls (small groups)
 - 4) Summarize the session
 - 5) Time for Question and Answer

Preparation

- Prepare **Slides 9/1–9/5**.
- Refer to Introduction for guidance on giving a demonstration.
- Prior to the session:
 - arrange a low chair/ordinary chair and footstool/small box to support the demonstration mother's feet;
 - arrange a bed, a mat or a table that can be used for a bed, to demonstrate breastfeeding lying down;
 - have a cloth to cover the table and the demonstration mother's legs, if needed;
 - arrange to have cushions or pillows or a rolled towel or cloth;
 - you will need a doll and a model breast for the demonstration.
- **NOTE:** Please practice the demonstrations in this session. One trainer leads the session, while another trainer or a participant helps with the demonstration of helping a mother who is sitting and lying.
- Before the session, ask a trainer or participant to help you with the demonstration.
- Explain you want the participant to play a mother who needs help to position her baby. Ask the participant to decide on a name for herself and her baby. Ask the participant to wear clothes such as a long skirt or pants, so they feel comfortable lying down for this demonstration.
- Explain as follows.
 - 1) You will demonstrate how to help a mother who is sitting.
 - The 'demonstration mother' will sit holding the doll in the common way, with the doll across her front.
 - You will greet her and ask how breastfeeding is going. She will say it is painful and she has sore nipples.
 - You will ask her to "breastfeed" the doll, while you observe.
 - She will hold the doll in a poor position: loosely, with the body away from hers, its neck twisted, and supporting only the head. She will have to lean forward to get her breast to the doll's mouth. She will pretend breastfeeding is painful. You will then help her to sit more comfortably and to improve the doll's position.
 - When the position is better, she should say "Oh! That feels better," and look happier.
 - 2) You will demonstrate how to help a mother who is lying down.
 - She will lie down propped on her arm, with the doll far from her body, loosely held on the bed.
 - Practice giving the demonstration with the participant, so you know how to follow the steps.
 - Decide the "comfortable" position you will help her to lie in.
- For the practical classroom session at the end of this session, prepare:
 - one doll for each group of four participants or per pair
 - cloth breast model for each group of four participants or per pair.

Session 9.

Clinical practice:
Positioning a baby at
the breast



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9/1

- ☐ Show **Slide 9/2 – Objectives** and read aloud.

Session 9. Objectives

Clinical practice: Positioning a baby at the breast

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, and for low-birth-weight baby;
- help a mother to position her baby at the breast using the **FOUR KEY POINTS OF POSITIONING** of the baby.

9/2

- 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.
 - There are several steps to follow when helping a mother to position her baby at the breast.
- ☐ *Ask participants to turn to **page 98** of their Participant's manual, HOW TO HELP A MOTHER POSITION HER BABY. Ask participants to take it in turns to read aloud.*
- ☐ *After participants have read the FOUR KEYS POINTS OF POSITIONING, use a doll to demonstrate and explain in detail the following four points.*
- **Point 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.
 - **Point 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.
 - **Point 3: Baby supported:** the whole body should be supported, with the mother's arm along the baby's back. This is particularly important for neonates and small babies.
 - **Point 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 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.

Demonstrate helping a mother to position her baby

- Demonstrate how to help a mother to position her baby. (Demonstration 9.A – How to help a mother who is sitting).*
- Ask the other trainer or volunteer participant to help you. You will demonstrate each of the points. When you have demonstrated a point, make sure it is clear to the participants before you move to the next point.*

Demonstration 9.A – How to help a mother who is sitting.

- Greet the mother and ask how breastfeeding is going.***
- When you have greeted the demonstration mother and asked how breastfeeding is going, she should respond by saying that breastfeeding is painful.*
- Assess a breastfeed.***
- Ask whether you may see how (baby's name) breastfeeds and ask the "mother" to put him to her breast. She should lean forward to get her breast to the doll's mouth. She holds him: loosely, with the body away from hers, with his neck twisted, and only his head supported. She will pretend breastfeeding is painful. Observe her breastfeeding.*
- Explain what might help and ask whether she would like you to show her.***
- Begin with encouragement to the demonstration mother like: "He really wants your breast milk, doesn't he?"*
- Next say: "Breastfeeding might be less painful 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 comfortable and relaxed.***
- Make sure the demonstration mother is sitting in a comfortable and relaxed position, as you decided when you practised this demonstration beforehand.*
- Sit down yourself, so you are also comfortable and in a convenient position to help.*
- Point out to participants that you cannot help a mother well if you are in an uncomfortable position yourself. If your back is unsupported or your body is bent, you may try to hurry the process.*
- Demonstrate the following points to the participant using a doll, a highchair, a low-chair and a stool. Make sure the following points are clear.*
 - A low seat is usually best, and if possible one that supports the "mother's" back.
 - If the seat is rather high, find a stool for her to put her feet onto. However, be careful not to make her knees so high that her baby is too high for her breast.
 - If she is sitting on the floor, make sure that her back is supported.
 - If she supports her baby on her knee, help her to hold the baby high enough so she does not lean forward to put him onto her breast.
- Explain how to hold her baby and show her if necessary.***
- Demonstrate with a doll how to help the mother to position her baby, making sure that the four key points of positioning are clear to the mother and to the participants.*

Review the four key points with participants:

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.

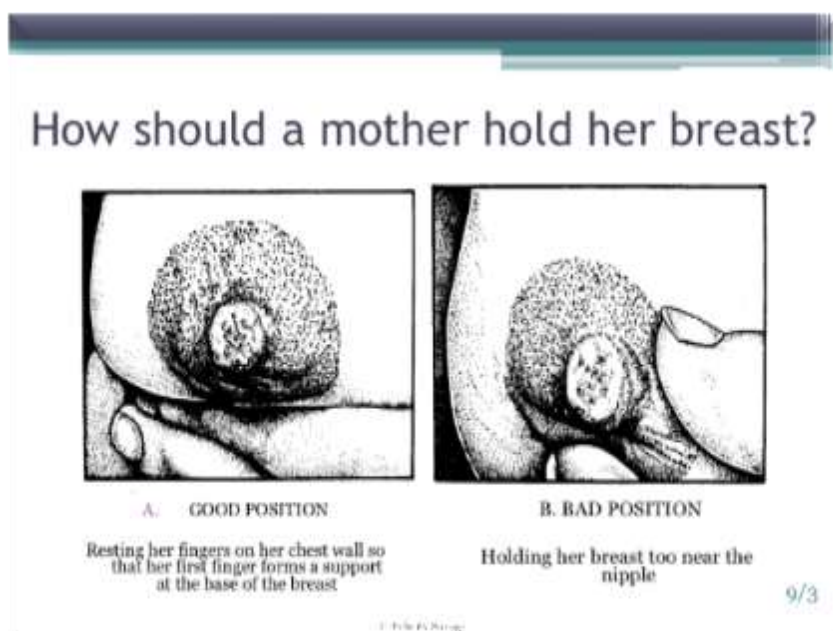
- Try not to touch the mother or baby if possible. If you need to touch them to show the mother what to do, put your hand over her hand or arm so that you hold the baby through her.
- Explain that she should support the baby's whole body with her arm, including his neck. She should not hold the baby's head or push it forward, but it should be slightly tilted backwards, and be free for the baby to move it and move his mouth to the nipple.

Show her how to support her breast, if needed.

Demonstrate how to help the mother to support her breast.

- When you have finished helping the demonstration mother to support her breast, make these points to the participants. Demonstrate on your own body or on a model breast.
- If needed, it is important to show a mother how to support her breast, to offer it to her baby.
- Depending on the size of breasts or how the mother is positioned, she may not need to support her breasts.

Show **Slide 9/3 – How does a mother hold her breast?**



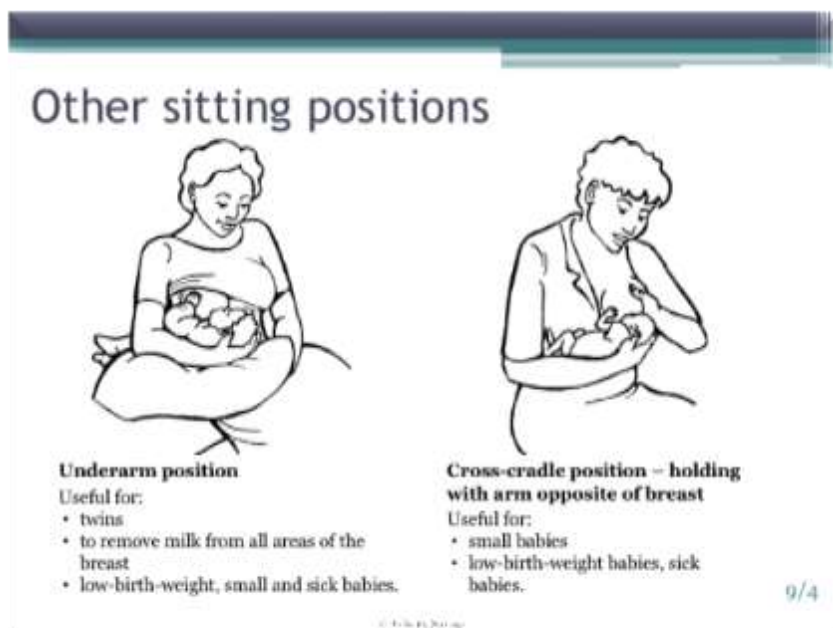
- She should place her fingers flat on her chest wall under her breast, so her first finger forms a support at the base of the breast.
- She can use her thumb to press the top of her breast slightly. This can improve the shape of the breast, so it is easier for her baby to attach well.
- She should not hold her breast too near 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.
- ☐ *Demonstrate to participants using your model breast or your own body the following unsatisfactory ways of holding a breast and explain how can make it difficult for a baby to attach.*
- Holding the breast 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.*
- ☐ *Demonstrate how to help the demonstration mother attach her baby. Make the following points as you demonstrate, using a doll, and your own body or a model breast.*
- 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 she responds and ask her how her baby's sucking feels.*
- ☐ *Ask the demonstration mother how she feels. She should say something like "Oh, much better thank you." Then explain to the participants:*
- notice how the mother responds
 - ask the mother how suckling feels
 - if suckling is more comfortable for the mother and she looks happy, her baby is well-attached.
- ☐ *Look for signs of good attachment. If the attachment is not good, try again.*
- ☐ *Make the following points to the participants.*
- Look for all the signs of good attachment (which you cannot see with a doll). If the attachment is not good, try again.

- It often takes several tries to get a baby well attached. You may need to work with the mother again at a later time, or the next day, until breastfeeding is going well.
- Make sure the mother understands about her baby taking enough breast into their mouth.
- If she is having difficulty in one position, try to help her to find a different position more comfortable for her.

Demonstration 9.B – Other sitting positions.

Show Slide 9/4 – Other sitting positions



- This slide shows two useful positions that you may want to show mothers. These are:
 - the underarm position
 - the cross-cradle hold: 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 remove milk from 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 the baby's head with her hand at 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 baby's head and not to put pressure on it or push it forward.

Demonstrate these positions using a doll.

Demonstration 9.C – How to help a mother who is lying down.

Show Slide 9/5 – Breastfeeding lying down



- This slide shows a mother breastfeeding while lying down. This position can be useful:
 - when a mother is tired or wants to sleep, so 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.
- Explain that you will now demonstrate a mother lying down to breastfeed. Ask the other trainer or participant, who is helping, to lie in the way that you practised. The demonstration mother should lie down propped on one elbow, with the doll far from her body, loosely held on the bed.
- Demonstrate helping the mother to lie down in a comfortable, relaxed position. Explain that the same steps will be followed.
- During or after the demonstration, make the following points clear to participants.
 - To be relaxed, the mother needs to lie down on her side in a position in which she can sleep. Being propped on one elbow is not relaxing for most mothers.
 - If she has pillows, a pillow under her head may help.
 - The same four key points on positioning are important for a mother who is lying down.
 - 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, so that he comes down on the nipple from above, causing poor attachment.

Demonstration 9.D – How to help a mother to use a reclining position.

- ❑ *Explain that you will now demonstrate a mother breastfeeding in a reclining position. Ask the mother who is helping to lean back into a reclining position, as you practised. If no suitable bed is available. Help her to support herself with pillows; or in the classroom you may be able to put a chair upturned on the floor with the legs in the air and the back making a sloping surface. The doll should be lying prone on the “mother’s” chest.*
- ❑ *Follow these steps:*
 - help the mother into a **reclining position**, leaning back, supported, if necessary, by 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 a baby, and he may find his own way to the breast, in the same way as a newborn.
- ❑ *Make these points.*
 - There are many other positions in which a mother can breastfeed, for example, by standing, walking about, or by sitting cross on the floor supporting the baby on her knee. In any position, the most important thing is for the baby to take enough of the breast into their mouth so that they can suckle effectively.
 - there are some ways in which a mother holds a baby which can make it difficult to attach to her breast and suckle effectively.
- ❑ *Give these demonstrations holding a doll and a model breast, and ask the participants what you are doing wrong:*
 - 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, at the elbow).
- ❑ *Explain to the participants.*
 - If a mother holds her baby too high, too low, or too far to the side, their mouth is not opposite her nipple. It will be difficult for the baby to take the breast into their mouth.
 - When a mother supports her baby’s body, she should not grip their bottom, because this pulls the baby’s head too far out to the side. She should have her hand along the baby’s back, so that their head rests on her forearm, not in the crook of her arm.

Let's practise: Positioning a baby using dolls

- Divide the participants into small groups (three to four participants with one trainer). Give each group a doll and a model breast (if available) with which to practice.*
- Explain to participants.*
 - You will now work in pairs to practise helping a mother to position her baby. One of you will be the mother, and one will be the health worker. Other participants in the group will observe.
 - If you are the mother:
 - sit and hold the doll in the common way, across your front and hold him in a poor position;
 - when the health worker asks you how breastfeeding is going, say it is painful, your nipples are sore, and think of another difficulty.
 - If you are the health worker:
 - follow all the steps: HOW TO HELP A MOTHER POSITION HER BABY on **page 97-102** of your *Participant's manual*;
 - use a doll to demonstrate to the mother what you want her to do;
 - use your listening and learning skills to talk to the mother.
 - If you are observing:
 - follow the steps in the box, and afterwards comment on the practice;
 - praise what the pair did well, remind them about steps left out, and discuss any weak points.
- Make sure each participant has a turn to play the part of the health worker helping a mother to position her baby.*
 - Practise helping mothers in all the different positions.
- Trainers should circulate among the groups and make sure that they understand what to do and are helping mothers correctly.*
- Approximately 30 minutes is allocated to this activity. Allocate additional time if needed.*

Summarize the session

Time for Question and Answer

- Ask participants whether they have any questions.*
- Explain a summary of this session can be found on **pages 100–106** of the *Participant's manual*.*
 - Remember the following points when helping a mother.
 - Always observe a mother breastfeeding before you offer help. Offer help only if there is a difficulty.
 - Help as much as possible in a “hands off” manner so the mother attaches and positions her own baby.
 - Talk about the key points the mother can see when breastfeeding, so the mother is confident and effective on her own.

Further information

Babies with special needs

Below are some practical suggestions about positioning for babies who have difficulty attaching or suckling. Try different techniques with a baby, until you find what is best for them.

Modified underarm position

This is helpful to babies who feed in an upright position, for example babies with a cleft palate. The baby sits upright facing their mother, with their legs along her side and their feet at her back. The baby may sit on the bed or be supported with a pillow. The mother supports the baby's back with her arm, and their head with her hand. However, some babies with cleft palate breastfeed satisfactorily in a more lying down position.

Straddle position

This is an alternative way for a baby to sit upright to breastfeed. The baby sits up facing their mother, with their legs on either side of her leg or abdomen.

Notes

A large area of the page is filled with horizontal dotted lines, providing a space for taking 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.

Session outline

Suggested time: 120 minutes

- Participants together in the classroom
- One trainer to prepare for the session
- Participants work in small groups of three to four each with one trainer for the practical session in a healthcare facility
 - 1) Prepare the participants (20 minutes)
 - 2) Conduct clinical practice (100 minutes)

Preparation

- Trainer leading the session:
 - make sure you know the location of the practical session, and where each trainer should take their group;
 - before the practical session, visit the wards or clinic to introduce yourself to the staff members in charge;
 - make sure they are prepared for the session (see Director's guide);
 - review the instructions on the following pages, so you can prepare the participants and conduct the practical session;
 - make copies of CLINICAL PRACTICE DISCUSSION CHECKLIST available for each trainer;
 - make two copies of the JOB AID: BREASTFEEDING SESSION OBSERVATION and one copy of the SKILLS CHECKLIST: LISTENING AND LEARNING for each participant and trainer.
- If you are leading a group:
 - review the instructions on the following pages, so you know how to conduct the clinical practice;
 - make sure you have a copy of the CLINICAL PRACTICE DISCUSSION CHECKLIST to help you to conduct discussions;
 - make sure that the participants in your group each have two copies of the JOB AID: BREASTFEEDING OBSERVATION, and one copy of SKILLS CHECKLIST: LISTENING AND LEARNING (keep one or two extra copies with you);
 - make sure you know your group's location.

Preparatory session: One trainer leads a session with all participants trainers together.

NOTE: If you have to travel to another facility for the clinical practice session, hold the preparatory session in the classroom before you leave. If necessary, this can take place on the evening or the morning before the clinical session.

Let's prepare

We will spend time today preparing for the clinical practice in the maternity wards. Remember the goal is for each health worker to practice 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.

Explain to the participants:

- today we will practise the listening and learning skills from **sessions 2 and 3** and assess a breastfeed with mothers in a facility providing maternity services;
- please take two copies of the **JOB AID: BREASTFEEDING SESSION OBSERVATION**, one copy of the **SKILLS CHECKLIST: LISTENING AND LEARNING**, and pencil and paper to make notes.

Process for health-care facility

- Each participant will take a turn talking to the mother, while group members observe.
- The counsellor should introduce themselves to the mother and ask her permission to talk to her. Introduce your group and say you are interested in "infant feeding." If a mother is not feeding, ask her to feed in the usual way at any time her baby seems ready.
- Find a chair or a stool to sit on.
- Please practise the listening and learning skills. Ask the mother questions about her situation and her baby. The other participants should be observers, standing quietly. Try to be as still and quiet as possible.
- Please make general observations of the conversation between the mother and the counsellor. For example: Who is talking the most? Does the counsellor ask open questions? Does the mother talk freely and seem to enjoy the conversation?
- The observers should make specific observations of the counsellor's listening and learning skills.
- Observers mark a ✓ on **SKILLS CHECKLIST: LISTENING AND LEARNING** when the counsellor uses one of the skills. Observe whether the counsellor uses helpful non-verbal communication.
- Observe whether the counsellor uses judging words, or if they ask a lot of questions to which the mother says "yes" and "no".
- When a mother breastfeeds, observe the feed using the **JOB AID: BREASTFEEDING SESSION OBSERVATION** and fill-in with check marks.
- Remember: You are not helping the mother. If a mother needs help, your trainer will take the opportunity to demonstrate to you how to help the mother.
- When you have finished, thank the mother.

Review *COMMON MISTAKES*

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*.

Clinical practice (all trainers)

100 minutes

Trainers should read the notes to prepare for the clinical practice session. Please do not read notes to the participants.

Clinical practice instructions.

- Divide the group into three to four participants at a clinical practice site. Groups should be determined before the clinical practice session begins.
- Take your group to the ward or clinic.
- Introduce yourself and your group to the staff member in charge.
- Ask for the appropriate mothers and babies and where they are.
- Find a breastfeeding mother and baby, or a mother who thinks her baby may want to feed soon. If this is not possible, talk to any mother.
- Participants will work in groups of three to four (one participant will be the counsellor and remaining members will observe). Please remind them to use the **SKILLS CHECKLIST: LISTENING AND LEARNING**.
- Ask the observers to fill out the **SKILLS CHECKLIST: LISTENING AND LEARNING** while observing the counsellor.
- When the mother begins feeding her baby, observers should fill out the **JOB AID: BREASTFEEDING SESSION OBSERVATION**.
- Each time the participants have finished a session with a mother, take the participants to another area to discuss their feedback. More detailed instructions on are provided on the next page.
- The group members should switch roles. Try to make sure each participant talks to at least one mother.
- Take spare copies with you of the **SKILLS CHECKLIST: LISTENING AND LEARNING**, the **JOB AID: BREASTFEEDING SESSION OBSERVATION** and the **CLINICAL PRACTICE DISCUSSION CHECKLIST**.

Guide the counsellor.

- Remain in the background, and let the participants work without much interference.
- Please do not feel the need to correct every mistake a participant makes immediately. If possible, wait until the discussion afterwards. Then you can praise what they did right and talk about mistakes or challenges.
- **If help is required, try to help in a way that does not make them embarrassed in front of the mother and the group.** Also, if the counsellor starts to help or advise the mother, **gently remind** them they should not offer assistance during this practical session.
- Additionally, if you notice something that the participants missed, you can quietly draw their attention to it.
- **You are leading the session and must help facilitate the best learning experience. Use the building confidence and giving support to help participants.** Your end goal is help them to develop confidence in their own clinical and counselling skills.

Let's debrief – discussing participant's experience.

- Leave the mother's room and discuss observations together. The group should move out of hearing range of the mother, as well as other mothers and families for confidentiality's sake.
- Use the **CLINICAL PRACTICE DISCUSSION CHECKLIST** to help lead the discussion. It is important that everyone has a chance to practise their skills. Use your counselling skills when giving feedback.
- Ask the **GENERAL QUESTIONS**, and then ask the specific questions about **SKILLS CHECKLIST: LISTENING AND LEARNING** and about **ASSESSING A BREASTFEED**.
- Ask the questions on building confidence and giving support in later clinical practice sessions.
- Review the **SKILLS CHECKLIST: LISTENING AND LEARNING** and discuss how each participant used the skills. First, ask the counsellor to how the experience was for them. Then, ask the other observers. Try to encourage the participants to use their counselling skills in the way they give feedback to other participants.

*Review the **JOB AID: BREASTFEEDING SESSION OBSERVATION** and discuss what the group noticed. Ask them to decide the baby's position and attachment.*

- If there is a mother who needs help, take the opportunity to teach the group together. Ask participants who identify a mother needing help to report to you first. Ask the staff of the ward or clinic whether they would like you to help the mother. If they agree, give the mother the necessary help with the participant.
- Ask the staff to be present if possible, and make sure you report to them the suggestions provided for future follow-up. Explain and demonstrate the situation to the other participants. Take the opportunity to learn together.

Remind participants to observe facility practices.

- Remind participants, while they are in a ward or clinic, to notice:
 - whether babies are rooming-in with their mothers
 - whether or not babies are given formula, glucose water or other supplements
 - whether there is a presence or absence of advertisements for baby milk
 - whether sick mothers and babies are admitted to hospital together
 - any posters or other information on feeding in the area.
- **NOTE:** Participants should not comment on their observations or show any disapproval while in the health facility. They should keep their observations until back in the classroom for discussion.

At the end of the clinical practice session, ask participants whether they have any questions.

*Explain a summary of this session can be found on pages **104–109** of the Participant's manual.*

CHECKLIST: CLINICAL PRACTICE DISCUSSION

Practical skills are best developed by:

- 1) Introducing and demonstrating the skills
- 2) Observing participants as they practise the skills
- 3) Giving feedback to participants on how well they performed.

Feedback should include:

- 1) Praising participants for things done well
- 2) Giving gentle suggestions for how to overcome difficulties.

Use the checklist below to help guide your feedback discussions

Questions to ask each counsellor

To the counsellor:

- What did you do well?
- What difficulties did you have?
- What would you do differently in the future?

To the observer:

- What did the counsellor do well?
- What difficulties did you observe?

Listening and learning skills

- Which listening and learning skills did you use?
- Was the mother willing to talk?
- Did the mother ask any questions? How did you respond?
- Did you empathize with the mother? Give an example.

Skills for building confidence and giving support

- Which confidence and support skills were used?
- (Check especially skills to praise and for two relevant suggestions)
- Which skills were most difficult to use?
 - What was the mother's response to your suggestions?

General questions

- What special difficulties or situations helped you to learn?
- What was the most interesting thing you learned from this practical session?

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

Name of counsellor: _____

Name of observer: _____

Date of visit: _____

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 looks healthy
- Mother relaxed and comfortable
- Signs of bonding between mother and baby

Mother:

- Mother looks ill or depressed
- Mother looks tense and uncomfortable
- No mother/baby eye contact

Baby:

- Baby looks healthy
- Baby calm and relaxed
- Baby reaches or roots for breast if hungry

Baby:

- Baby looks sleepy or ill
- Baby is restless or crying
- Baby does not reach or root

BREASTS

- Breasts look healthy
- No pain or discomfort
- Breast well supported with fingers away from nipple

- Breasts look red, swollen or sore
- Breast or nipple painful
- Breast held with fingers on areola

BABY'S POSITION

- 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 to nipple

- Baby's neck and head twisted to feed
- Baby not held close
- Baby supported by head and neck only
- Baby approaches breast, lower lip/chin

BABY'S ATTACHMENT

- More areola seen above baby's top lip
- Baby's mouth wide open
- Lower lip turned outwards
- Baby's chin touches breast

- More areola seen below bottom lip
- Baby's mouth not open wide
- Lips pointing forward or turned in
- Baby's chin not touching breast

SUCKLING

- Slow, deep sucks with pauses
- Cheeks round when suckling
- Baby releases breast when finished
- Mother notices signs of oxytocin reflex

- Rapid shallow sucks
- Cheeks pulled in when suckling
- Mother takes baby off the breast
- No signs of oxytocin reflex noticed

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.

Session outline

Suggested time: 75 minutes

Participants are all together for a lecture presentation by one trainer.

- 1) Introduce the session
- 2) Present **Slides 11/1–11/22**
- 3) Complete exercises
- 4) Summarize session
- 5) Time for Question and Answer

Preparation

- Refer to Introduction for guidance on giving a presentation with slides and giving a demonstration.
- Study the slides, so you are able to present them.
- There is a lot of information in the Further information section. Make sure that you have read this, as it may help you to answer participants' questions.


For the Syringe method for treatment of inverted nipples do as follows.

- Prepare a 20 mL disposable syringe as shown in SLIDE 11/7. Take out the plunger, cut off the end of the barrel with the adaptor (you may find it helpful to use a hot knife to do this). Then, put the plunger back into the barrel backwards.

Reference materials

- Mastitis: causes and management. World Health Organization, Geneva; 2000 (http://apps.who.int/iris/bitstream/handle/10665/66230/WHO_FCH_CAH_00.13_eng.pdf;jsessionid=89F49EBC3C06EEEE349F661D13DEC4F3?sequence=1, accessed 17 March 2020).

Introduce the session



Session 11.
Breast and nipple conditions

© WHO/Yoshi Shimizu 11/1

- Show **Slide 11/2 – Objectives – Breast conditions** and read aloud.

Session 11. Objectives
Breast and nipple conditions

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

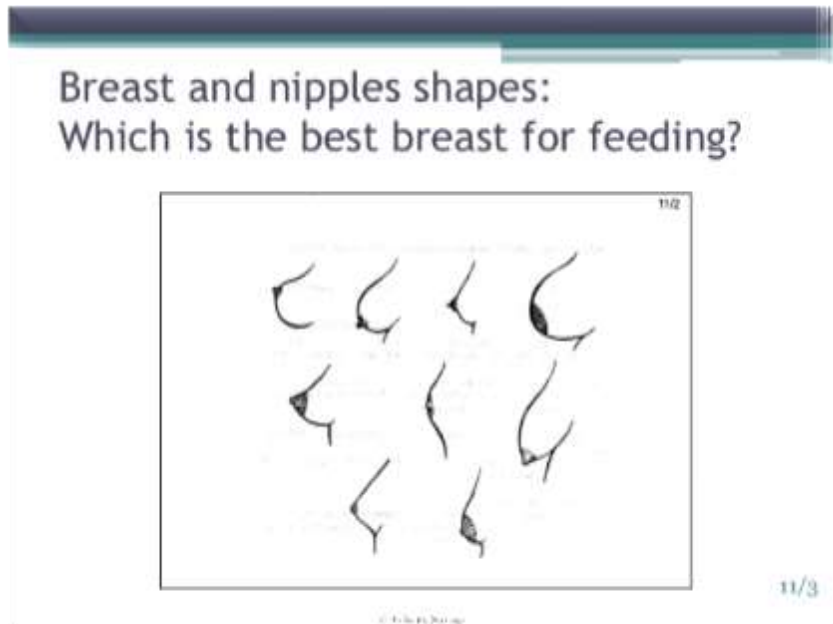
- flat or inverted nipples
- engorgement
- mastitis
- sore or cracked nipples
- also, participants will identify when to refer to advanced medical staff for further treatment.

11/2

- As health-care workers, we must recognize breast conditions and help mothers/parents/ caregivers manage them. If a mother 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

- ☐ Show Slide 11/3 – Different breast shapes and make the key points.



- 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 milk-producing tissue in the breast. **A woman may need reassurance that she can produce enough milk, regardless of the size of her breasts.** We discussed in SESSION 5. HOW BREASTFEEDING WORKS why breast size does not determine the amount of milk produced
- 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 more difficult for a baby to attach to the breast. The mother may need extra postnatal support to make sure her baby can suckle effectively.

Flat and/or inverted nipples

- ❑ Show Slide 11/4 – Flat nipple and protractility.



- ❑ Ask: *What do you observe about the nipple in picture 1?*

Wait for a few replies and then continue.

- The nipple looks flat.
- However, remember from **SESSION 5: HOW BREASTFEEDING WORKS**. A baby does not suck from the nipple. They take the nipple and the breast tissue underlying the areola into their mouth to form a "teat".
- In picture 2, the mother is testing her breast for "protractility". She is finding out how easy it is to stretch out the tissues underlying the nipple. This nipple is quite protractile, and it should be easy for her baby to stretch it to form a "teat" in their mouth. The baby should be able to suckle from this breast with no difficulty.
- Nipple protractility is more important than the shape of a nipple.
- Protractility improves during pregnancy, and in the first week or so after a baby is born. So even if a woman's nipples look flat in early pregnancy, her baby may be able to suckle from the breast without difficulty.

- ❑ Show **Slide 11/5 – Inverted nipples** and make the key points.



- ❑ Ask: *What do you observe about this nipple?*

Wait for a few replies and then continue.

- The nipple is inverted.
- If this woman tests her breast for protractility, her nipple will go in instead of coming out.
- Inverted nipples do not always present a problem. Remember, babies attach to the breast, not to the nipple. If you think her nipples may be inverted, the best way to help is to build her confidence and provide good support from birth.

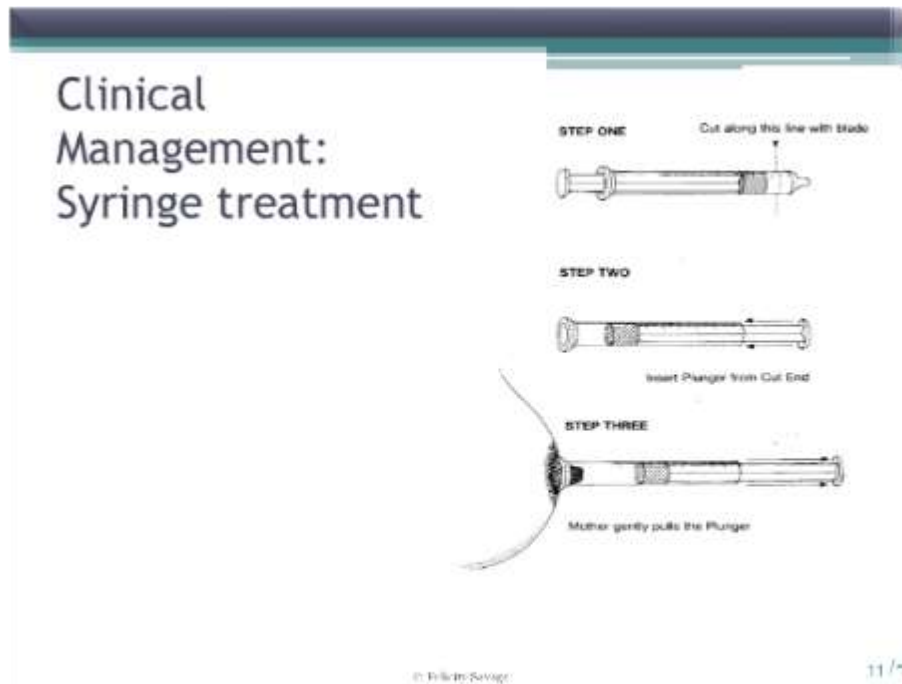
Clinical management: Flat and inverted nipples

| Time period | Management |
|---------------------------|---|
| Antenatal | <ul style="list-style-type: none"> • Not helpful |
| Soon after delivery | <ul style="list-style-type: none"> • Build the mother's confidence, her breasts will improve • Explain that the baby suckles BREAST not nipple • Let the baby explore the breast skin-to-skin • Help the mother to position her baby on the first day • Try different positions, e.g. underarm • Help her to make the nipple stand out more • Use a pump, syringe |
| First weeks, if necessary | <ul style="list-style-type: none"> • Express breast milk and feed with a cup • Express breast milk into the baby's mouth |

- **Antenatal treatment is usually not helpful and can have risks.** Most nipples improve around the time of delivery, without any treatment.
- Help is most important soon after delivery when the baby starts breastfeeding.
- **It is important to build the mother's confidence.** Explain the beginning maybe difficult, but she can succeed with patience and persistence.
- **Explain that a baby suckles from the breast, not from the nipple.** Her baby needs to take a large mouthful of breast ("big mouth"). Explain that as her baby breastfeeds, the baby will stretch her breast and nipple out with suction.
- **Encourage skin-to-skin contact and allow 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.
- **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 or two, before her breast milk "comes in" and her breasts are full. Try different positions to help with attachment.
- **Help her to stimulate her nipple before a feed.** If she massages her nipple until it hardens, then a baby usually attach better. There are products to help this (breast pump or syringe), but often her hand is sufficient and least costly.
- **Shaping the breast.** This can make 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.
- **Cup feeding.** If a baby cannot suckle effectively in the first week, help the mother to express her milk and feed it to her baby by cup. Expressing milk also helps to keep the breasts soft, so the baby attaches more easily.

Expressing milk also helps to keep her milk supply sufficient. She should not use a bottle because that can make it more difficult for her baby to attach (nipple confusion).

Show **Slide 11/7 – Syringe method.**



- Demonstrate the syringe method for treating inverted nipples. Show **Slide 11/7** on the screen while you give the demonstration. Tell participants that the method is also included on **page 114** of the Participant's manual. Allow participants to practise the technique, if time permits.

DEMONSTRATION 11.A – SYRINGE METHOD FOR INVERTED NIPPLES

- Explain this method is for treating inverted nipples postnatally, and helping a baby to attach to the breast. It is not certain whether it is helpful antenatally.
- You need a large syringe – at least 20 ml size – a smaller syringe can damage the nipple
- Show participants the 20 mL syringe that you have prepared and explain how you cut off the adaptor end of the barrel.
- Put the plunger into the cut end of the barrel (that is, the reverse of its usual position).
- Use a model breast and put the smooth end of the barrel over the nipple. Pull out the plunger to create suction on the nipple.
- Explain with a real breast, there is an airtight seal, and the nipple is drawn out into the syringe.
- Explain the mother must use the syringe herself.
- Explain you would teach her to:
 - put the smooth end of the syringe over her nipple, as you demonstrated;
 - 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.

- Demonstrate how the syringe creates suction, by trying it on the front of your forearms. Usually, the syringe will stick there for a few minutes.*
- Pass the prepared syringe around among the participants and let them try on their own forearms.*

Help a mother with engorged breasts

- Show **Slide 11/8 – Full vs. engorged breasts** and make the key points.

Differences:
Full vs. engorged breasts

| Full | Engorged |
|--------------|---|
| Hot | Painful |
| Heavy | Oedematous |
| Hard | Tight, especially nipple Shiny May look red |
| Milk flowing | Milk NOT flowing |
| No fever | May be fever for 24 hours |

- Show **Slide 11/9 – Full and engorged breasts** and make the key points.



Ask: *What do you observe about the woman's breasts in Picture 1?*

Wait for a few replies and then continue.

- This is a few days after delivery. Her breasts look large and are filled with milk. Her breasts most likely feel hot, heavy and hard. However, her milk is flowing well.
- This is normal fullness. Sometimes full breasts feel quite lumpy.
- The only treatment she needs is for her baby to breastfeed frequently, to remove the milk.
- The heaviness, hardness or lumpiness decreases after a feed, and the breasts feel softer and more comfortable.
- In a few days, her breasts will adjust to the baby's needs, and they will feel less full.

Ask: *What do you observe about the breast in Picture 2?*

Wait for a few replies and then continue.

- The mother's breasts are engorged.
- Engorgement means the breasts are overfull and swollen, partly with milk and partly with increased tissue fluid and blood. This blocks the flow of milk, so the milk stays there and builds up – this is called *stasis*²¹.
- The breasts in this picture look shiny because they are oedematous, because of the increased tissue fluid. Her breasts feel painful and her milk does not flow well.

Ask: *What do you observe about the nipple in this picture?*

Wait for a few replies and then continue.

- The nipple is flat because the skin is stretched tight.
- When a nipple is stretched tight and flat, the baby has difficulty attaching to it and removing the milk.
- When breasts are engorged, the skin looks red. If the woman has a fever, you may think that she has mastitis. However, the fever usually settles in 24 hours.

Ask: *What are reasons breasts become engorged? How can we prevent this?*

Wait for a few replies and then continue.

²¹ Berens P, Brodribb W. ABM Clinical Protocol #20: engorgement, revised 2016. *Breastfeeding Med.* 2016;11:159–63.

- ❑ Show **Slide 11/10 – Causes and prevention of breast engorgement**. Ask one participant to read the causes and another participant to read prevention columns.

| Causes | Prevention |
|--------------------------------|--|
| Plenty of milk | Frequent removal of milk, early initiation |
| Delayed start to breastfeed | Start breastfeeding soon after delivery |
| Poor attachment to breast | Ensure good attachment |
| Infrequent removal of milk | Encourage unrestricted breastfeeding |
| Restriction of length of feeds | Encourage unrestricted breastfeeding |

- 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.
- The slide shows the three important ways to prevent engorgement are:
- Other helpful practices include:
 - skin-to-skin contact
 - showing the mother how to express her breast milk
 - keeping babies and mothers together 24 hours a day
 - counselling mothers on the use and risks of pacifiers, artificial teats or bottles so they do not replace suckling at the breast.

- ☐ Show **Slide 11/11 – Treatment of breast engorgement** and make the key points.

**Treatment:
Breast engorgement**

Do not “rest the breast”

| Assessment | Treatment |
|--|--|
| If baby is able to suckle | Hold baby skin-to-skin, help with attachment and allow to suckle frequently. This stimulates oxytocin. |
| If baby is unable to suckle | Express milk by hand or with a pump |
| Before feed to stimulate oxytocin reflex | <ul style="list-style-type: none"> • Warm compresses or warm shower • Massage to neck and back • Light massage of breast • Stimulate nipple skin • Help mother to relax |
| After feed to reduce oedema | Cold compress |

- ☐ This slide summarizes the treatment of breast engorgement.

- To treat engorgement, it is essential to remove milk. This will:
 - relieve the mother's discomfort
 - prevent complications, such as mastitis or abscess formation
 - help to ensure continued milk production
 - enable the baby to receive breast milk.

- ☐ Ask: *How can a health worker help a mother to relieve engorgement?*

Wait for a few responses, then make the following points.

- **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, the baby 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 you can do to help her, or she can do 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 engorgement²².
- **Build the mother's confidence.** Explain she will soon be able to breastfeed comfortably again, and the engorgement will be resolved.

Helping a mother with mastitis

- ☐ Show **Slide 11/12 – Mastitis** and make the key points.



- ☐ *Ask: What do you observe about this breast?*

Wait for a few replies and then continue.

- Part of the breast looks red and swollen.

- ☐ *Ask: What is the cause?*

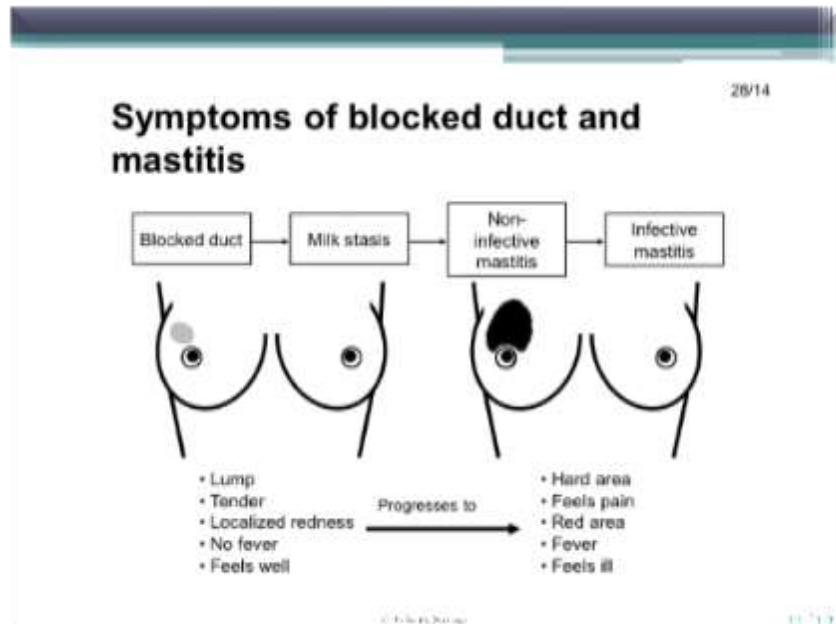
Wait for a few replies and then continue.

- This is mastitis.
- The woman has severe pain, a fever, and she often feels ill, with headache and nausea. Part of the breast is swollen and hard, with redness of the overlying skin. The other parts of the breast look normal. The red area is clearly marked and is surrounded by normal breast tissue. Health workers and mothers need to learn to recognize blocked ducts and mastitis in an earlier stage, before progressing to this severity.
- Mastitis can be confused with engorgement.

²² Berens P, Brodribb W. ABM Clinical Protocol #20: engorgement, revised 2016. Breastfeeding Med. 2016;11:159–63.

- 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.

□ Show Slide 11/13 – Symptoms of blocked duct and mastitis and make the key points.



- Mastitis may develop in an engorged breast, or it may follow a condition called "blocked duct".
- This slide shows how mastitis develops from a 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.
- Blocked duct symptoms:
 - 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 due to a blocked duct or engorgement, it is called milk stasis.
- If the milk is not removed, it can cause inflammation of the breast tissue called **non-infective mastitis**.
- Sometimes a breast becomes infected with bacteria, this is called **infective mastitis**.
- The symptoms of mastitis are the same for non-infective and infective mastitis.
- It is not possible to tell from the symptoms alone whether mastitis is non-infective or infective.
- If the symptoms are all severe, as indicated below:
 - the mother has a fever for 24 hours or more;
 - there is evidence of possible infection, for example an obviously infected cracked nipple;

- the mother's symptoms do not begin to subside within 24 hours of frequent and effective feeding and/or milk expression;
- the mother's condition worsens.

Then, please refer her to an appropriate health-care provider, as the woman is more likely to need treatment with antibiotics.

☐ Show Slide 11/14 – Causes of blocked duct and mastitis and make the key points.

| Causes: Blocked ducts and mastitis | |
|---|---|
| Symptom | Causes |
| Infrequent or short breastfeeds | <ul style="list-style-type: none"> • Mother being very busy • Baby sleeping through night • Changed routine • Mother stressed |
| Inefficient removal of milk from part or all the breast | <ul style="list-style-type: none"> • Ineffective suckling • Pressure from clothes • Pressure from fingers during feeds • Large breast draining poorly |
| Damaged breast tissue | Trauma to breasts |
| Bacteria gaining entry | Nipple fissure |

- This slide summarizes the causes of blocked duct and mastitis.
- **The main cause is not removing the milk adequately from all or part of a breast.**
- Reasons for failure to remove the milk include 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** caused by 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.

Treatment: Blocked ducts and mastitis

- **Improve milk removal**
- **Look for cause and correct**
 - Poor attachment
 - Pressure from clothes
 - Large breast draining poorly
- **Advise**
 - Frequent breastfeeds
 - Gentle massage towards nipple
 - Warm compress
 - Analgesics (ibuprofen)
- **Suggest, if helpful**
 - Vary position

11/15

Treatment: Blocked ducts and mastitis

- **If any of these symptoms continue:**
 - Symptoms severe (high fever, large area affected)
 - Fissure
 - No improvement in 24 hours
- **Advanced treatment required**
 - Complete rest
 - Refer to an appropriate medical provider for antibiotic treatment

11/16

- This slide summarizes the treatment of blocked duct and mastitis.
- The most important part of treatment is to improve the removal of milk from the affected part of the breast.
- **If possible, ask the mother to breastfeed her baby, and observe the breastfeed.**
- Look for the cause of poor drainage and provide suggestions. 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 that 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 the 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:
 - symptoms are severe 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 to the mother 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.

Mastitis in an HIV-infected woman

Make the key points.

- In a woman who is HIV-infected, mastitis or nipple fissure (especially if bleeding or discharging 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 and developing into an abscess; to help the breast recover, and to maintain milk production. The health worker should help her to ensure that she is able to express milk effectively.
- 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 antibiotics 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.

Helping a mother with sore or cracked nipples

- Show **Slide 11/17 – Sore nipple** and make the key points.



- This slide shows a sore nipple with bruising on the bottom of the areola. There may also be a dilated blood vessel. **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.
- If a woman has sore nipples or a fissure, observe the baby breastfeeding. Help her to improve her baby's position and attachment. If the pain is relieved, the baby can continue breastfeeding. Her nipples will heal rapidly when they are not being damaged anymore.
- Also recommend the following:
 - after breastfeeding, she can smooth expressed breast 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;
 - help her to improve her baby's position, so that the baby is well attached;
 - the baby can continue breastfeeding and the nipples will heal rapidly when they are not being damaged anymore.

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

☐ Show **Slide 11/18 – Breast engorgement and nipple fissure** and make the key points.



☐ Ask: *What do you observe about this breast?*

Wait for a few replies and then continue.

- There is a fissure across the tip of the nipple. You can also see that the breast skin is tight and shiny (oedematous). This mother waited to put her baby to her breast until her milk had “come in” and her breasts felt full, after three days. The skin was so tight her nipples were flat, and her breast was poorly protractile. Her baby could suck only on the nipple, which damaged the nipple skin.
- This shows some of the reasons why it is important to breastfeed within an hour after delivery. It is easier for a baby to attach well at this time, when the breasts are still soft. So, there is less chance of nipple damage. Also, breastfeeding early helps to prevent the milk pressure from building up, which helps to prevent engorgement.

- ❑ Show **Slide 11/19 – Pressure line on nipple** and make the key points.



- ❑ Ask: *What do you observe about this breast?*

Wait for a few replies and then continue.

- There is a ridged line across the tip of the nipple (compression stripe). This is because of pressure, which has squashed the nipple. It is a sign of poor attachment.
- You may see a line like this as a baby releases the breast. It stays for a few seconds, and then the nipple returns to its usual shape. The mother may not feel pain at this stage. If the baby continues to suckle in this way, the line will become a painful fissure.
- You may also observe the redness of the skin of the lower part of the breast. This is due to mastitis, another result of poor attachment.

- ❑ Show **Slide 11/20 – Candida infection** and make the key points.



- This mother has sore nipples.

Ask: *What do you see that can explain the soreness?*

- There is a red, shiny area of skin on the nipple and areola, and it looks flaky. The nipple and areola have lost some of their pigmentation.
- This mother has *Candida* infection, or thrush, which makes the skin sore and itchy. Such infections often follow the use of antibiotics to treat infections like mastitis.

Sometimes with *Candida* the nipple and areola skin may look normal.

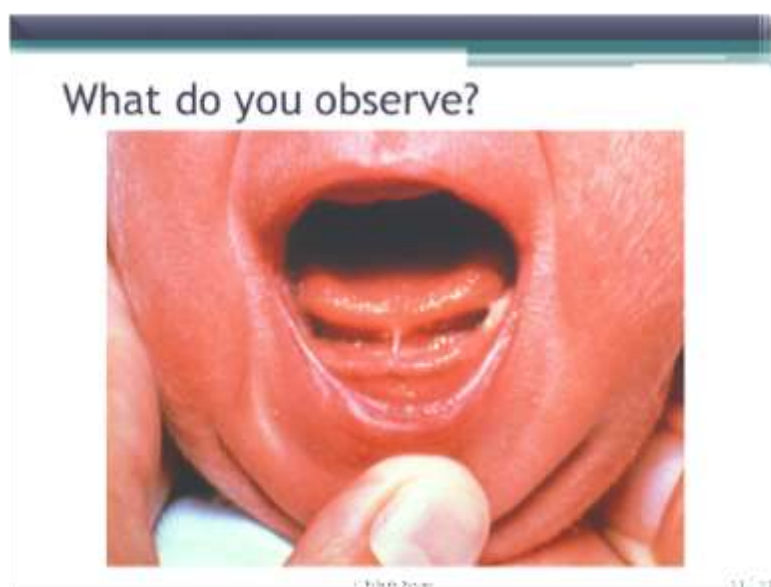
Ask: *what other symptoms may Candida cause?*

- Some mothers describe burning or stinging pain that continues after a feed. It may be worse between feeds than 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?

Explain.

- Suspect thrush if sore nipples persist even when a baby's attachment is good. Check the baby for thrush. 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.** If treatment is not effective, recommend using fluconazole, which is given orally.
- Advise the mother to stop using pacifiers (dummies). Help her to stop using teats, and nipple shields. 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.

Show **Slide 11/21 – Short frenulum or “tongue-tie”** and make the key points.

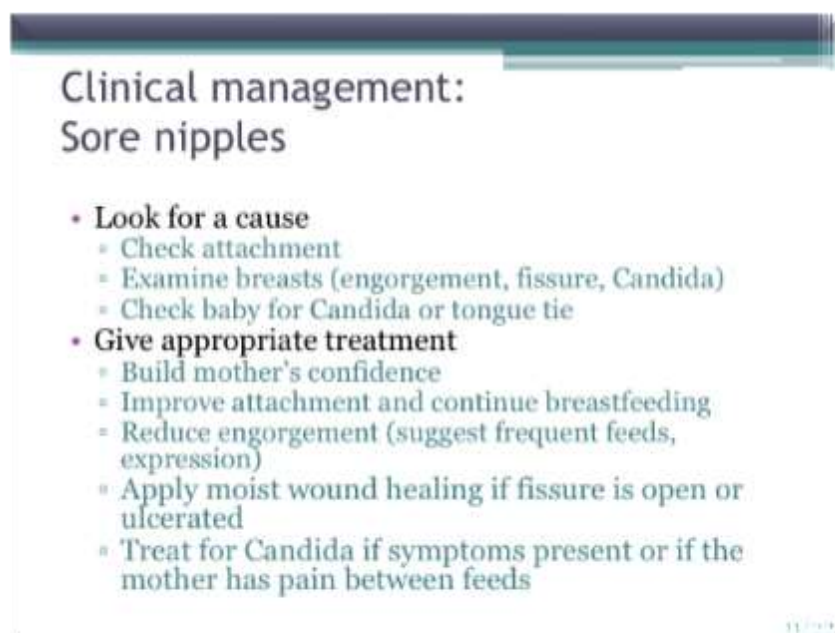


- Ask: *What do you observe about this baby's mouth?*

Wait for a few replies and then continue.

- This is not a breast condition, but it can sometimes be a cause of sore nipples.
 - Many babies with a condition called tongue-tie (ankyloglossia) 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 latch. 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 (which results in 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.
 - What type of health-care providers for treatment do you have in your context?

- Show **Slide 11/22 – Management of sore nipples** and make the key points.



- 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 a Candida 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).

Summarize the session

Time for Question and Answer

- Ask participants whether they have any questions.
- Explain the summary of this session can be found on **pages 111–130** of the Participant's manual.

Let's practise: Case studies

- Divide participants into small groups. Provide each group with a copy of the case studies below or ask participants to turn to **pages 127–130** of Participant's manual.
- Each small group discusses the case studies together. Trainers can assist groups with feedback. Provide participants with answer sheets (see Director's guide) at the end of the session. Alternatively, allocate additional time to review answers as a large group.

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?*
(Engorgement.)
- *What can you say to empathize with Mrs G?*
(*You are very uncomfortable, aren't you?*)
- *What is the cause of Mrs G's difficulties?*
(Her breasts are engorged, her nipples are stretched tight, and her baby cannot attach well. This is also causing her nipple to be sore.)
- *What practical help can you give Mrs G?*
(Help her to express some of her milk, by hand or pump, to make the breasts softer. Then help her to attach her baby to her breast better. Suggest that she breastfeeds her as often as she is willing so that she removes more of the milk. She may need to express again until the engorgement has cleared.)

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 is able to stretch the nipple out a short way, showing that the nipple and areola are protractile.

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

(Something like: *You feel worried because you think your baby may not be able to breastfeed with your nipples?*)

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

(Stretchy when pulled with fingers.)

- ***How could you build her confidence?***

(Give her relevant information. For example: explain if her baby suckles from the breast not the nipple, she stretches the nipple out. She can get the milk if she takes a big mouthful of breast.)

- ***What practical help could you give Mrs B?***

(Offer to help her to get her baby to take more of her breast into her mouth, that is, to improve the attachment.)

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?***

(You are having a lot of pain and feeling ill.)

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

(Praise her for breastfeeding her baby at night and expressing milk to leave for him.)

- ***What is the diagnosis?***

(Mastitis. It is not possible to say if it is infective or non-infective. Her nipple is also cracked and looks as though it may be infected.)

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

(She is very busy, and she feeds and expresses in a hurry. There is a long time between feeds during the day.)

- ***How would you treat Mrs C?***

(Suggest that she takes sick leave for a few days and breastfeeds her baby more often. Help her to get a sick-leave certificate so that she can do this. Ask her about family members and friends who could help her with some of her tasks at home.

- She should rest as much as possible.
- Give her analgesics (ibuprofen) for a few days.
- If the mastitis is not improving by tomorrow, refer her to an appropriate health-care provider for antibiotics.

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

(Discuss the reasons why the condition has occurred. Help her to think of ways to breastfeed her baby more, and to take more time to express her milk, especially during the day.)

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?**

(You are having a lot of pain, aren't you?)

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

(Candida infection. Her baby is well attached to her breast.)

(Check and treat her baby's mouth and bottom for Candida.)

- **How would you build Mrs F's confidence?**

(Possibilities include:

- praising the way in which her baby is suckling
- giving relevant information and explaining the reason for the sore nipples
- referring her to an appropriate health-care provider for treatment
- explaining that breastfeeding should be comfortable again after treatment with Nystatin.)

Further information

Breast examination

A women's breasts do not need to be examined routinely. However, it may be the policy in your health service to do this. If so, it gives you an opportunity to talk to the mother about breastfeeding. During the antenatal period, a health-care worker should examine a women's breasts in order to build her confidence. Almost always you will be able to reassure her that her breasts are good for breastfeeding.

Preparation of breasts for feeding

Preparing breasts physically for breastfeeding is not necessary. Traditional ways of preparing the breasts which are culturally important may build a mother's confidence. If a mother has flat or inverted nipples, doing stretching exercises or wearing nipple shells during pregnancy will not help. Most nipples improve towards the end of pregnancy and in the first week after delivery. A nipple that looked difficult in pregnancy may not be a problem after the baby is born. The most important time to help a mother is soon after delivery. If a mother is worried about inverted nipples, explain that they will improve and that you can help her to breastfeed. Explain about how a baby suckles from the breast behind the nipple, not from the nipple itself. If a mother has a problem with her breasts that you are unsure about, such as previous breast surgery or burns, try to get help from someone more experienced. Meanwhile, it may help to encourage her by explaining that babies often can breastfeed from a breast that has had surgery or that a baby can get enough milk from just one breast, if necessary.

Bonding

Participants may have questions about bonding. Mothers may not be immediately aware of bonding happening. Strong emotional ties grow gradually. Early close contact (skin-to-skin) gives them the best possible start. Separation makes bonding more difficult, especially in high-risk families. However, if separation does occur, bonding can take place later. The first nine months of a baby's life are crucial for bonding. Although breastfeeding initiation may be delayed, , breastfeeding can still be successfully established (baby and mother ill, cultural reasons). When the mother is supported and has prolonged skin-to-skin contact with the baby, this is the best start for both of them.

Management of inverted nipples

Participants may have heard of different ways to treat inverted nipples. These notes may help you to answer questions. However, it is not necessary to give all the participants this information.

Breast shell

This is a glass or plastic hemisphere with a hole in the base to put over a nipple. The nipple is pressed through the hole, to make it stand out more. There is no evidence these shells help, and they may cause oedema. If a mother wants to try to use one for inverted nipples, let her continue. It may make her feel she is doing something, and it may help her to feel confident.

Nipple shields

These are artificial nipples with a broad plastic or glass base to put over a nipple for a baby to suck through. Mothers sometimes use them if they have conditions such as inverted nipples or sore nipples. Nipple shields are no longer recommended because they can cause problems.

Risks of using nipple shields:

- can reduce the flow of milk
- can cause breast infections, including candida
- can cause “nipple confusion”
- may make it more difficult for a baby to learn to suckle directly from the breast.

Some mothers find it difficult to stop using them. Nipple shields are not useful except in rare cases for a short time with careful supervision, for example, when there is persistent difficulty attaching or persistent soreness. If used as a temporary measure for a clinical need, ensure the mother has follow-up assistance to enable her to discontinue using the shield.

Hoffman's exercises

Some women have heard of exercises to stretch nipples. These exercises have not been shown to help antenatally. They are unlikely to make much difference to severely inverted nipples. Nipple exercises can sometimes traumatize the breast, so do not recommend them.

Management of long nipples

Long nipples can cause difficulties for breastfeeding. A baby is likely to suck only the nipple, and they may not take the breast with the large ducts into their mouth. It is important to help the baby to take more breast into their mouth, not just the nipple.

Management of large nipples

A baby may have difficulty attaching if the nipple is large. If the mother holds her baby in a good position and touches the baby's mouth so it opens wide, the baby may open wide enough to attach to the breast. This mother needs extra help and patience to do this.

The mother can lean over her baby, on a bed or table, so that her breast falls towards the baby's mouth. This may make it easier for the baby.

Skin-to-skin contact and letting the baby self-attach to the breast can help with both long and large nipples.

A mother can hand express her milk to sustain milk production. She can also feed her baby the expressed milk with a cup until they have grown, and their mouth is big enough to attach well and suckle more easily.

Management of large breasts

Sometimes breasts can be too large for a baby to attach to the nipple easily. It is important to help the mother to find a comfortable position, such as the reclining position (laid back breastfeeding), or sitting at the side of a bed or table with the breasts and the baby both on the table. This may make it easier for the baby to attach well.

Non-infective mastitis

- The main cause of non-infective mastitis is milk under pressure leaking back into the surrounding tissues.
- The tissues treat the milk as a “foreign” substance.
- Also, milk contains substances causing inflammation.
- The result is pain, swelling and fever, even when there is no bacterial infection.
- Trauma which damages breast tissue can also cause mastitis. This may also be because milk leaks back into the damaged tissues.

Infective mastitis

NOTE: Please refer to an appropriate medical provider if antibiotics are needed to treat mastitis.

| RECOMMENDED ANTIBIOTIC TREATMENT FOR INFECTIVE MASTITIS | | |
|--|--|---|
| The most common bacterium found in breast abscesses is <i>Staphylococcus aureus</i> . Therefore, it is necessary to treat breast infections with a penicillinase-resistant antibiotic such as either flucloxacillin or erythromycin. | | |
| Drug | Dose | Instructions |
| Flucloxacillin | 250 mg orally Every 6 hours for 7–10 days | Take dose at least 30 minutes before food |
| Erythromycin | 250–500 mg orally Every 6 hour for 7–10 days | Take dose 2 hours after food |
| Alternatives if the above antibiotics are not available | | |
| Amoxicillin/clavulanate (Augmentin) | 875 mg orally Twice daily 7–10 days | |
| Cephalexin | 250–500 mg orally Every 6 hours for 7–10 days | |
| Clindamycin | 300 mg orally Every 6 hours for 7–10 days | |
| Dicloxacillin | 500 mg Every 6 hours for 7–10 days | |
| Cloxacillin | 250–500 mg Every 6 hours for 7–10 days | |

Breast abscess

Participants may wish to discuss breast abscesses in more detail.

An abscess is when a collection of pus which forms in part of the breast. The breast develops a painful swelling, which feels full of fluid. An abscess needs surgical incision and drainage. If possible, let the baby continue to feed from the breast. There is no danger to the baby.

However, if it is too painful or if the mother is unwilling, show her how to express her milk. Allow the baby to feed from it again as soon as the pain is less, usually in two to three days. Meanwhile, continue to feed from the other breast.

NOTE: Good management of mastitis should prevent the formation of an abscess.

Treatment of nipple fissures

Ointments for nipple fissure

Sometimes a plain cream, like lanolin, may help a fissured nipple to heal after the attachment has been corrected. However, plain creams are often not easily available. Remember to recommend applying her own breast milk and allowing it to air dry.

Clothes

In warm weather, a cotton bra is better for fissured nipples than a nylon bra. However, cotton is not essential, and you should not recommend it to a mother who cannot afford it. If necessary, suggest she leaves her bra off for a day or two.

Nipple shields

These are no longer recommended for the treatment of fissured nipples.

Treatment of *Candida* of the breast

NOTE: Please refer to an appropriate medical provider if antibiotics are needed to *Candida*.

RECOMMENDED TREATMENT OF *CANDIDA* OF THE BREAST

- **Gentian violet paint:**
 - apply to baby's mouth: 0.25%, apply daily or alternate days for 5 days, or until 3 days after the lesions have healed
 - apply to mother's nipples: 0.5%, apply daily for 5 days.
- **Nystatin** cream 100 000 IU/g:
 - apply to nipples 4 times daily after breastfeeds
 - continue to apply for 7 days after lesions have healed.
- **Nystatin** suspension 100 000 IU/mL:
 - apply 1 mL by dropper to child's mouth 4 times daily after breastfeeds for 7 days, or as long as mother is being treated.

OR

- For mother: **Fluconazole** 150–300 mg orally once, followed by 50–100 mg twice daily for 2–3 weeks.
- For infant, oral candida: **Fluconazole** 6 mg/kg orally once, followed by 3 mg/kg per day for 14 days.
- **Stop** using pacifiers, teats, and nipple shields.

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.

Session outline

Suggested time: 60 minutes

Participants are all together for a lecture presentation by one trainer.

- 1) Introduce the session, present Slide 12/2
- 2) Present slides 12/1–12/15
- 3) Summarize the session
- 4) Time for Question and Answer


Preparation

- Study the notes for the session.
- You will need a board or a flipchart to write the participants' responses.
- Make sure the chairs are arranged so that participants can see the flipchart.

Reference materials

- Campbell SH, Lauwers J, Mannel R, Spencer B. Core curriculum for interdisciplinary lactation care. LEEARC: Burlington (MA); 2019.
- Kellams A, Harrel C, Oimage S, Gregory C, Rosen-Carole C. Academy of Breastfeeding Medicine. ABM Clinical Protocol #3: supplementary feedings in the healthy term breastfed neonate, revised 2017. Breastfeed Med. 2017;12:188–98. doi:10.1089/bfm.2017.29038.ajk.
- WHO/UNICEF Infant and young child feeding counselling: Training course. Session 70: Growth Charts .
- The WHO Child Growth Standards. Geneva: World Health Organization; 2018 (<https://www.who.int/childgrowth/standards/en/>, accessed 18 March 2020).

Introduce the session



Session 12.
Milk supply challenges

© WHO/Yeshe Sibanda 12/1

- ☐ Show **Slide 12/2 – Objectives** and read aloud.

Session 12. Objectives
Milk supply challenges

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.

12/2

- ☐ *Make these points.*
 - Two of the most common worries of a new mother/parent/caregiver are: “Is my baby getting enough milk?” “Can 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 her baby is getting enough or not. Mothers and their families also need to know how to decide if the baby is getting enough milk.
- The health worker and mother together may decide that the baby is not getting enough milk. This does not mean that the mother is *unable to produce enough milk*, but that the baby is not *getting, enough* perhaps because, for example, they are not suckling enough or are poorly attached. The health worker and mother must monitor the baby's feeding and output (counting wet and stool nappies). It is important to find out if the baby could get more milk by 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.
- 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?*** Milk production begins in pregnancy, around the 14th week, and colostrum is available for the baby at 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 it is rarely the case that a 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.

☐ Show Slide 12/3 – First few weeks and read aloud.

First weeks of newborn's life

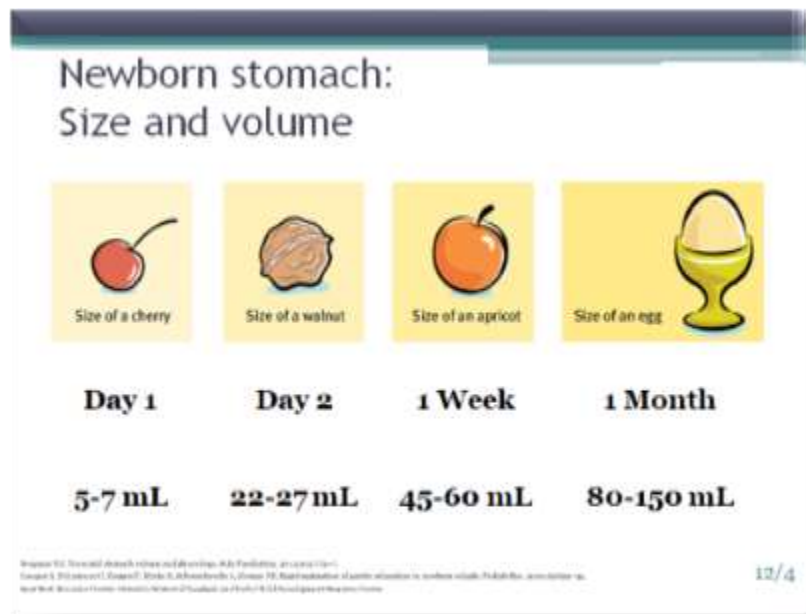
- Day 1-3
 - Baby gets colostrum
 - Breasts feel soft
- Day 3-4
 - Milk “comes in”, changes
 - Volume produced increases
 - Breasts feel full
- Day 6-7
 - Baby loses weight
 - Fluid and glucose needs covered by extra in infant's body from before birth
 - Once breastfeeding established, weight increases
- Day 10-14
 - Infant regains birth weight

12/3

- This slide explains what normally happens with a newborn 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 Standards²³.

Show **Slide 12/4 – Size and volume of a newborn's stomach** and make the key points.



- 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 milk²⁴. A stomach capacity of 20 mL translates to a feeding interval of approximately 1 h for a term neonate²⁵.
- 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.

Show **Slide 12/5 – Normal newborn feeding behaviour**.

²³ Use of the WHO Child Growth Standards are taught in: WHO/UNICEF. Infant young child feeding counselling: an integrated course. Geneva: World Health Organization; 2006 (<https://www.who.int/nutrition/publications/infantfeeding/9789241594745/en/>, accessed 18 March 2020).

²⁴ 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.

²⁵ Bergman NJ. Neonatal stomach volume and physiology. *Acta Paediatrica.* 2013;102:773–7.

Normal newborn feeding behaviour

- **First 24 hours**
 - Breastfeed in the first hour, may be followed by a long sleep
 - Breastfeed then 5-12 times in the first 24 hours - babies vary and can depend on skin-to-skin and rooming-in
- **Day 2-3**
 - Frequency often increases to 10-12 times, still variable
- **After day 3**
 - Milk "comes in," changes
 - Maybe longer intervals between feeds, as feeds become larger
 - Feeds on average about 8 times in 24 hours
 - **Mothers should keep babies close and respond as they show signs of readiness**
 - Alert and moving, turning head, hand to mouth, moving mouth
 - **A baby who rooms-in with a mother who responds, gains more weight over the first 7 days**

12/5

- This slide explains the normal feeding behaviour of a newborn.
 - In the first 24 hours of life, newborns are often sleepy, and some babies may feed 5 to 12 times^{26,27,28}. This may be more depending on the skin-to-skin contact at birth and rooming-in²⁹.
 - 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 but 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.
- Ask: Sometimes newborn do not get enough milk, or the mother thinks her baby is not getting enough milk. How do we know if a newborn is not getting enough milk?
- List participants' ideas on a flipchart or board.
- Praise participants for their responses.

²⁶ 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.

²⁷ Kellams A, Harrel C, Ormance S, et al. (2017). ABM clinical protocol #3: supplementary feedings in the healthy term breastfed neonate. Breastfeeding Medicine, 12 (3), DOI: 10.1089/bfm.2017.29038.ajk.

²⁸ 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.

²⁹ 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.

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.
 - 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 four 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 baby does pass a stool, it is usually large and semi-liquid. Small dry stools may be a sign the baby 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 that 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.
- There are other signs which may make a mother think she does not have enough milk for her baby or that her baby is not getting enough milk.

Ask: Can you think of other signs which causes a mother think she does not have enough milk?

Show **Slide 12/7 – Signs which make mothers think** and make the following key points.



- This slide shows signs, which may make a mother **think** her baby is not getting enough milk. Her baby may or may not be 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.
- **NOTE:** One way a mother can "see" she is making milk is through hand expression³⁰. 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.

³⁰ Hand expression is covered in SESSION 15: ALTERNATIVE METHODS OF FEEDING.

☐ Show Slide 12/8 – Common causes and make the following points.



- This slide lists the common causes of insufficient milk in the first two weeks of a newborn’s life.
 - 1) Delayed initiation and contact: 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:
 - complications of delivery
 - maternal illness
 - maternal diabetes.
 - 3) Poor attachment and ineffective suckling by the baby are two of the most common causes of insufficient milk.

☐ Show **Slide 12/9 – Other common reasons** and make the following key points.

Common breastfeeding factors

- Feeding at fixed times
- Short feeds
- Supplementary feeding
- No nighttime feeding
- Infrequent feeds



12/9

☐ Make these points.

- 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 thus 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 once the mother's milk increases.
 - *Supplementary feeds*: a baby who receives supplementary feeds (artificial formula, sugar water) suckles less at the breast because they have a full stomach; they then do not receive enough breast milk and the milk supply will also decrease.
 - *No night feeding*: a mother is still establishing breastfeeding in the first few weeks and 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 infrequent.

□ Show **Slide 12/10 – Psychological factors of the mother** and make the following key points.

Psychological factors

- Lack of confidence
- Worry and stress
- Dislike of breastfeeding
- Tiredness
- Lack of bonding, rejection of newborn



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12/10

- This slide lists psychological factors of a mother which may affect an infant's milk intake.
- For example, 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 and help with attachment of the baby at the breast. 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.

□ Show **Slide 12/11 – After two weeks of age** and make the following key points.

**After 2 weeks of age:
Actual or perceived insufficiency**

- **Perceived insufficiency**
 - The most common reason for a mother giving up exclusive breastfeeding is because they **think** they do not have enough milk.
 - Almost all mothers are able to produce as much milk as their baby needs.
 - Often there is an issue in the interaction between mother and infant
 - How many mothers could continue breastfeeding if they had skilled support and help?
- **Actual insufficiency**
 - In some cases, the mother does have a supply issue.
 - Assess the possible causes: physical, psychological or other causes.

12/11

- 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 giving up exclusive breastfeeding is because they think they 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.

Ask for questions and check clarity.

Prevention and management

Ask: *During this course, we have learned practices to assist with establishing or improving breastfeeding. Which practices could you implement to prevent and help manage a baby who is not getting enough milk?*


Wait for a few responses, then make the following points.

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

Show **Slide 12/12 – Prevention and management** and make the following key points

Practices:
To prevent and manage insufficient milk intake and transfer

- Early skin-to-skin contact at delivery and initiation of breastfeeding as soon as possible
- Skilled support of breastfeeding after delivery to ensure good attachment and effective suckling
- Practice rooming-in 24 hours a day
- Exclusive breastfeeding, unless supplements medically indicated



12/12

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: ICMHC (2014) *Guidelines for breastfeeding practice* (2nd edn). Wellington: NZIC.

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: ICMHC (2014) *Guidelines for breastfeeding practice* (2nd edn). Wellington: NZIC.

12/14

Not enough milk: Helping the mother

- **If there is a problem**
 - Make sure baby is adequately fed. This may require supplementation.
 - Try to determine the cause. Has the problem been present since birth? When did the problem become apparent?
 - Screen for breastfeeding management problems and factors related to the mother.
 - If milk remained in the breast after feeding, determine the cause for the baby's inability to remove milk.
- **Support milk production as needed and address any problems as soon as possible**

Adapted from LEAARC Core curriculum for interdisciplinary lactation care. Burlington, MA 2019.

12/15

- The above slides explain the practices started at birth to prevent and manage insufficient milk intake and transfer. We have learned these practices throughout the course.
- 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. Positioning should also be assessed. 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 that a 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 they want. 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.

□ Ask participants to turn to **page 142** of the *Participant's manual* and find the **Slide 12/13**³¹.

³¹ Adapted from: Hetzel Campbell S, Lauwers J, Mannel R, Spencer B, Lactation Education Accreditation and Approval Review Committee. Core curriculum for interdisciplinary lactation care. Burlington (MA): LEAARC; 2019.

Let's practise: Helping a mother make sure her baby gets enough milk

- Separate into groups of four participants.
- Explain you will now work together on two different case studies to help a mother make sure her baby is getting enough milk. Ask participants to turn **pages 144–145** of the Participant's manual.
- Explain to participants they will read through the cases within their groups and answer the questions together. Trainers should circulate among the groups, and answer questions as needed. A short discussion can be held at the end if needed.

CASE 1

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*?

- Listen and learn – to learn about psychological factors, and how she feels.
- Assess a breastfeed – assess the baby's attachment and suckling.
- Examine the baby – for alertness, appearance, behaviour, illness or abnormality.
- Examine the mother's breasts – for any breast or nipple conditions.

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.

- The baby is poorly attached at the breast, and not suckling effectively.

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

Encourage participants to remember their skills for building confidence and giving support might help.

Use skills for building confidence and giving support.

- Praise her for expressing her colostrum to give to her baby.
- Empathize with her that the baby was not given the colostrum – that was very bad! But her breasts already have more colostrum. Expressing her milk while her baby was in the special care unit will also help her milk supply to “come in”.
- Explain there is enough milk for her baby. Her nipples are sore because he is not taking enough of the breast into his mouth. Offer to help her to attach him better.
- When you are sure that the attachment is better, ensure that the baby seems satisfied after he feeds.
- Encourage her to continue breastfeeding, and to feed the baby often and for as long as he is willing to feed to help build up her supply.
- Refer her to resources in the community for follow-up and additional support.

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?

- You think that there is no milk in your breasts?
- You are worried about your breast milk?

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

- She lacks confidence, and she lacks knowledge.
- Her milk has not “come in” yet – but this is normal.

3. What relevant information would you give her?

- Her breasts already have some milk, a special kind called “colostrum”. This is what her baby needs just now. Her baby doesn’t need formula – it will just fill up the baby and she won’t want to suckle at the breast. This will make it more difficult for her baby to be good at breastfeeding.
- Explain that if her baby suckles more often, it will help more milk to come in. In a day or two, her breasts will feel full.
- A pacifier may interfere with her baby establishing breastfeeding. She may miss the baby’s cues for feeding because the baby is sucking on a pacifier.

4. What practical help could you give Mrs P?

- Offer to help her to put her baby to her breast.
- Start by showing her how to position the baby and see if she will attach and have a feed. Then explain about feeding cues when her baby shows, by restlessness or mouthing, that she is ready for a feed.

Summarize the session

Time for Question and Answer

- Ask participants whether they have any questions.
- Explain that a summary of this session can be found on **pages 132–145** of the Participant's manual.

Further information

Growth patterns

For the first six months of life, WHO growth charts for infants aged zero to six months are used. Basic growth assessment involves measuring a child's weight and length or height, comparing these measurements to growth standards. The purpose is to determine whether a child is growing "normally" or has a growth problem or trend that should be addressed.

The steps include: measuring weight, length and height; plotting these measurements on growth charts; and interpreting growth indicators. Correct measurement, plotting and interpretation are essential in identifying growth problems.

Growth patterns are taught in the Infant and Young Child Feeding Counselling Course.

Weight changes in babies

- Breastfeeding ensures healthy, normal weight gain for infants. Many breastfed babies are leaner (less fat) than artificially fed babies.
- A consistent weight gain is a sign of sufficient milk intake. However, the mother may not be able to have her newborn weighed often. If there is doubt about the infant's milk intake, weigh the newborn each week, if possible.
- Test weighing before and after one feed does not give a good indication of milk intake or production. The amount that a newborn takes varies from feed to feed. Test weighing may worry the mother and can reduce her confidence in breastfeeding, tempting her to give supplements.
- A newborn who is not gaining weight with good breastfeeding and good milk transfer may have an illness. If the newborn is feeding poorly or showing signs of illness, refer for medical treatment. However, if the newborn seems willing to feed and has no signs of illness, then poor weight gain can be the result of not getting enough milk, which is often due to poor attachment. This newborn and mother need help with feeding.
- A newborn with a condition such as congenital heart disease or a neurological difficulty may be slow to gain weight even if there is sufficient milk supply and transfer.
- There is a need for weight monitoring for all children including those who are not breastfeeding.

Disposable diapers (nappies)

These absorb urine and make it difficult to decide whether a newborn has passed enough urine. If a mother is worried about her milk supply, it is better to use cloth nappies or to put paper tissue in the disposable diaper to monitor the newborn's urine output.

Unreliable signs of "not enough milk"

Participants may have suggested some of the following signs that make a mother think she does not have enough milk. They are all unreliable and do not by themselves indicate that her newborn is not getting enough:

- abdomen not rounded after feeds
- breasts not full immediately after delivery
- not feeling her oxytocin reflex
- family members ask whether there is enough milk
- health worker said there was not enough milk
- told too young or too old to breastfeed
- told newborn is too small or too big
- poor previous experience of breastfeeding
- breast milk looks thin
- breasts softer than before
- breast milk not dripping out.

Factors which do not affect the supply of breast milk

Some things are commonly thought to be reason for insufficient breast milk. However, they do not in fact affect the milk

supply. These include:

- age of mother
- sexual intercourse
- returning to a job (if newborn continues to suckle often and mother is relaxed, etc)
- caesarean section
- preterm delivery
- simple, ordinary diet
- breast size.

Mother: physical condition

Contraceptive pill

Contraceptive pills containing oestrogens may reduce the secretion of breast milk.

Pregnancy

If a mother becomes pregnant again, she may notice a decrease in her breast-milk supply

Severe malnutrition

Severely malnourished women may produce milk that is affected in quality and quantity. If a mother is deficient in micronutrients, the micronutrient content in her breast milk may be reduced. However, a woman who is mildly or moderately undernourished continues to produce milk at the expense of her own tissues, provided her newborn suckles often enough. This depletes her own body stores.

Alcohol and smoking

Alcohol and cigarettes can reduce the amount of breast milk that a newborn takes.

Smoking may reduce breast-milk production, possibly by reducing prolactin production.

Retained piece of placenta

This is RARE. A small piece of placenta remains in the uterus and makes hormones, which prevent milk production. The woman bleeds more than usual after delivery, her uterus does not decrease in size, and her milk does not “come in.” After the placenta is removed, her milk supply increases.

Poor breast development

This is VERY RARE. Occasionally, a woman's breasts do not develop and increase in size during pregnancy, and she does not produce much milk. If the mother noticed an increase in the size of her breasts during pregnancy, then poor breast development is not her problem. It is not necessary to ask about this routinely. Ask only if there is a problem.

Breast surgery (breast reduction and enlargement) and breast cancer

May have affected the milk ducts or nerves and therefore make breastfeeding difficult or impossible.

Hormonal problems

Women with conditions of the pituitary gland, polycystic ovaries, and other endocrine disorders may also fail to produce enough breast milk.

Newborn conditions

Illness

A newborn who is ill and unable to suckle strongly does not get enough breast milk. If this continues, their mother's milk supply will decrease. The newborn fails to gain weight, or loses weight, both because of the illness and because of low milk intake.

Abnormality

A newborn who has a congenital problem, such as a heart abnormality, may fail to gain weight. This is partly because they take less breast milk, and partly because of other effects of the condition.

Babies with a deformity such as a cleft palate, or with a neurological problem, or mental disability, often have difficulty in suckling effectively, especially in the first few weeks.

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.

Session outline

Suggested time: 90 minutes

Participants are all together for a lecture presentation by one trainer.

- 1) Introduce the session, present **Slides 13/1–13/10**
- 2) Discuss causes of difficulty to feed at the breast
- 3) Read and discuss **MANAGEMENT OF THE CHALLENGES TO FEED AT THE BREAST**
- 4) Read **WHEN A BABY CRIES A LOT: HOW TO HELP A MOTHER**
- 5) Facilitate the written exercises
- 6) Summarize the session
- 7) Time for Question and Answer

Preparation


- Study the Trainer's notes for the session.
- Have two flipcharts or boards available. If not, put flipchart sheets on the wall where participants can see them.
- There is further information at the end of this to help you answer participants' questions. You may read this information prior to the session.
- You will need a breast model for demonstration plus some additional breast models for practice in groups. If possible, have one breast model for each two to three participants. Doll models for each two to three participants are also needed. Refer to the Introduction of the Trainer's guide for instructions on how to make a breast and doll model.
- This module has video content. Ensure that video capabilities are available. Prepare the video before the session begins to ensure that it works.

- There are two suggested videos for this session:
 - 1) “HOW TO EXPRESS BREAST MILK – BREASTFEEDING SERIES” from Global Health Media Project. The video can be found online on the Global Health Media Project website or on the Global Health Media Project YouTube page at the following link: <https://www.youtube.com/watch?v=axQi5PqRZOM>.
NOTE: Play the video from time 00:50 until 04:12. If time allows, you can play the entire video.
 - 2) “CUP FEEDING YOUR SMALL BABY (FOR MOTHERS) – SMALL BABY SERIES” from Global Health Media Project. The video is provided in several languages on the Global Health Media Project website if translation is needed. The video can be found online or downloaded at Global Health Media or on YouTube at the following link: <https://www.youtube.com/watch?v=-6AU6y6qatc&feature=youtu.be>.
Play the video from the beginning until 03:12. Throughout the video, there are different babies being fed by cup. If time allows, you can play the entire video.
- *Optional or if video capabilities are not available:* Ask a mother who is expressing her milk to demonstrate expression. If this is culturally acceptable, and if a mother is available and willing to come to the classroom, ask her to demonstrate expressing her milk. There may also be time to observe a mother during another clinical practice session, but this should not take up the entire session.
- There is a demonstration of cup feeding in this session. If a mother and baby are available to come to the classroom, the demonstration can be done as a part of this session. Adjust the timetable accordingly. Alternatively, show the recommended video above.
- Obtain some examples of suitable containers to collect expressed breast milk, which would be available to ordinary mothers (for example, cups, jam jars). Look particularly for suitable container with lids or covers.
- To demonstrate how to feed a baby by cup:
 - Obtain some small cups that could be used to feed low-birth-weight babies and are easily available in the community. Medicine measures or egg cups are suitable. Use small teacups if nothing smaller is available.
 - They should be easy to clean, without ridges if possible.
 - Have some water (for “milk”) and a teaspoon available to demonstrate cup feeding and spoon-feeding with a doll.
- Optional – breast pumps that are available locally. Make sure that you know how to use the pumps correctly before demonstrating them. **Do NOT invite a representative from a pump company to give this demonstration. This is a conflict of interest.**
- If used locally, have a breastfeeding supplementer for display. There is information on this in the FURTHER INFORMATION section.

Reference materials

- Becker GE, Cooney F, Smith HA,. Methods of milk expression for lactating women. Cochrane Database Syst Rev. 2016;7:CD006170. doi:10.1002/14651858.CD006170.pub5.
- WHO/UNICEF. Infant and young child feeding counselling: training course. Session 38: Feeding low-birth-weight and sick babies. Geneva: WHO; 2018.
- Essential newborn care course: Trainer’s guide, module 4, session 12: Alternative methods of feeding a baby. Geneva: WHO;2010 (https://www.who.int/maternal_child_adolescent/documents/newborncare_course/en/, accessed 18 March 2020).
- Campbell SH, Lauwers J, Mannel R, Spencer B. Core curriculum for interdisciplinary lactation care. LEEARC: Burlington (MA); 2019.

Introduce the session



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

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13/1

- Show **Slide 13/2 – Objectives** and read aloud.

Session 13 Objectives
Barriers to breastfeeding

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.

13/2

- *Make the following introductory points.*
 - In most cases, babies have no difficulty in feeding at the breast after birth.
 - A small number of babies may not be able to suckle adequately at this time. They may need to be temporarily or permanently fed their mother's milk using alternative methods of feeding.

- A mother's own breast milk is the milk of choice when using any alternative methods of feeding. Breast milk is especially important for babies who are preterm, low-birth-weight or sick as they are at particular risk of infection.
- The need for alternative feeding methods and the most suitable method should be individually assessed for each mother and baby.

This session is about the challenges faced by a newborn in feeding at the breast and how to manage the same.

Discuss the challenges faced by a baby in feeding at the breast

Ask: Have you heard mothers/parents/caregivers say the newborn was not feeding at the breast?

Let participants share their experience for two to three minutes. Thank them and continue.

Continue with the following points.

- There are many reasons why mothers stop breastfeeding or start to mix feed.
- A newborn's perceived challenge to feed at the breast is a common reason.
- With counselling and support from the health worker, this can often be overcome and does not necessarily lead to cessation of breastfeeding.
- This can cause great distress to the baby's mother. She may feel rejected and frustrated by the experience. In the first few days, 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 help her decide why her newborn seems to be unable to feed at the breast, and how to support her.

Is the newborn's challenge actual or perceived?

- Sometimes a newborn behaves in a way that makes their mother think that they are reluctant to feed at the breast. When a newborn baby "roots" (or searches) for the breast, they may move their head from side to side. Sometimes an inexperienced mother thinks that they are saying "no" especially if she is having difficulty attaching him to the breast. But they are not reluctant – this is normal rooting behaviour and means quite the opposite!
 - Sometimes a baby starts feeding but then pulls off the breast crying.
 - Sometimes he may be reluctant to feed on one breast but not the other.

Discuss the causes of a newborn's challenge to feed at the breast in the immediate postnatal period.

Ask: Why newborns seem reluctant and appear to be unable to feed at the breast in the immediate postnatal period?

Write the replies up on a flipchart.

- ❑ Show **Slide 13/3 – Reasons why babies may be reluctant to feed at the breast** and make the key points.

| Why babies may be reluctant to feed at the breast | |
|---|--|
| Possibility | Description |
| Illness, small or weak | <ul style="list-style-type: none"> • 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 reluctance | Newborn reflexes – rooting |

- ❑ 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.

- ❑ Use the notes presented next: *WHY A NEWBORN MAY BE RELUCTANT TO FEED AT THE BREAST.*

- **Is the newborn ill, small or weak?**

- The newborn may be ill because of a difficult delivery or an infection and not want to feed. A newborn may also be weak or small and have difficulty with attaching or suckling.

- **Is the newborn in pain or sedated?**

Pain

- 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 baby may cry and fight and pull away as she tries to put them to the breast.
- Blocked nose. The baby starts suckling, but then has to pull away to breathe.
- Sore mouth (*Candida* infection [thrush]). The newborn may suckle a few times, and then stop and cry, because of the soreness, and not want to try again.

Sedation

- 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. Mastitis may make the milk taste salty.
- Oversupply of milk, 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.

▪ **Is the “reluctancy” real?**

Remember the discussion earlier. Sometimes a mother perceives “reluctancy” when actually the newborn is displaying normal newborn behaviour.

The crying baby

Make the following points.

- We will now look at another common reason for a mother to stop breastfeeding or to begin supplementation, the crying baby.
- Babies cry when they are hungry – but this is a late sign of hunger, which can cause stress for the baby, and it is much better to respond to their feeding cues.
- Babies cry when they are in pain, ill, frightened, and wanting comfort, or when their nappy (diaper) is wet or dirty, too hot or cold. Sometimes it is difficult to know why.
- A mother and her family may quickly think a crying baby means the mother's milk is not enough or not good. Some 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, and they may pressure her to give the baby a bottle and formula. An important way to help a breastfeeding mother is to provide counselling and support about why babies cry. Develop a list of reasons why babies may cry a lot.

- Ask: *Why do you think some babies cry a lot?*

Write the replies up on a flipchart.

Try to develop a list similar to **Slide 13/4**.

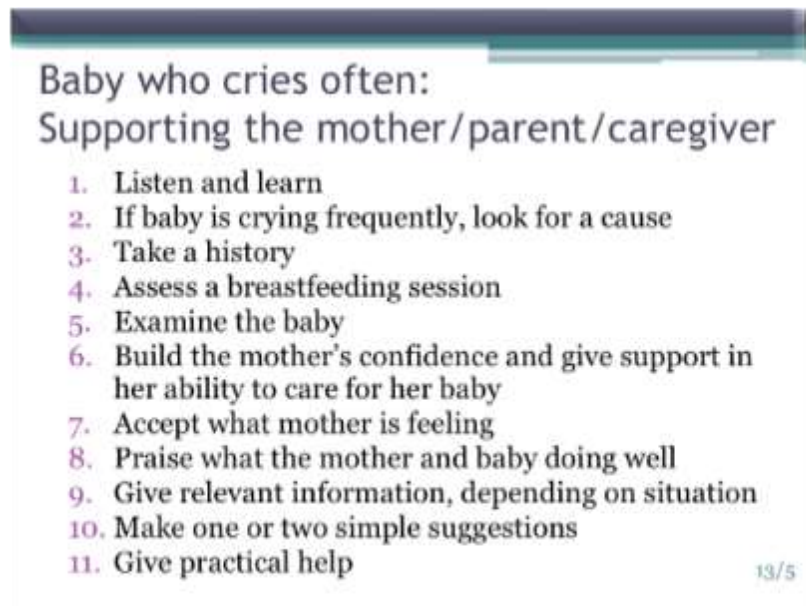
- Show **Slide 13/4 – Reasons why a baby may cry** and make the key points.

| Reason | Description |
|-----------------|---|
| Discomfort | Dirty diaper/ nappy, hot, cold |
| Tiredness | too many visitors and stimulation |
| Illness or pain | pain from delivery, reflux in babies who have been tube fed |
| Hunger | poor attachment, not getting enough milk |
| Mother's food | Any food, check mother's cow's milk intake |
| Mother's drugs | caffeine, cigarettes |

Can you think of other reasons? 13/4

- Add reasons from the discussion. to the list on the board or flipchart.
 - Usually when a baby cries for these reasons, and is comforted by their mother or other carer, they will settle down and sleep for a time. However, some babies seem to cry more often than others, in the day and at night, which can cause distress and extra tiredness to their parents, especially their mother. This may make a family decide to bottle feed the baby.
- Ask participants to find the section **WHEN A BABY CRIES A LOT: HOW TO HELP A MOTHER** on **pages 149–151** of the *Participant's manual*.
- Ask them to read the section aloud, taking turns sentence by sentence.

- Show **Slide 13/5 – Baby who cries often: Supporting the mother/parent/caregiver** and make the key points.



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.
- 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 takes 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. There are many ways to carry and comfort a crying baby, standing, walking about, sitting down, on your outstretched legs, in a sling. Ask participants what methods they have heard of in their communities.
- 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

- ❑ Ask: *Have you helped a mother with a newborn who is unable to feed at the breast?*

Wait for a few responses.

- ❑ Tell participants there are different ways to help a mother with a newborn baby who is unable to feed at the breast. Ask participants to turn to **page 151** of the Participant's manual.

- ❑ Show **Slide 13/6–13/7 – Management of the challenges to feed at the breast** and make the key points.

Management of the challenges to feed at the breast

Treat the cause, where possible

- Breast, nipple conditions (candida, mastitis, engorged breasts and other conditions) and other challenges as discussed in Session 11
- Treat a sore mouth or blocked nose
- Stop using anything that is causing an unpleasant taste or smell to the breast

Help the mother to do these things

- Let her hold the baby close in skin-to-skin as much as possible
- Let the baby explore the breast and learn to feel comfortable there, but do not try to attach him too soon
- Express her breastmilk to feed the baby *and keep up her milk supply*
- Feed the baby her expressed milk with a cup or spoon NOT with a bottle
- Care for the baby in a gentle and confident manner
- Offer her breast whenever her baby is willing to suckle
 - When her baby is sleepy, or after a cup feed
 - In different positions
 - When she feels her oxytocin reflex working ("let down")

13/6

Management of the challenges of feeding at the breast

- **Help her baby to take the breast**
 - Let her position her baby in a calm and unhurried way
 - Show her the reclining position
 - Avoid pressing the back of the baby's head, or pressing on a painful place
 - If the baby is rooting let the baby continue and explain that the baby is trying to find the breast
 - When the baby is near the breast, express a little milk into his mouth
 - When the baby seems interested, help the baby to attach to the breast – be patient – do not hurry

13/7

- ☐ Ask participants if they have any questions, then continue to the next section.

Helping a mother to hand express her breast milk

- ☐ Show **Slide 13/8 – Hand expression** and make the key points.



- ☐ Make the following points.
 - 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 for the mother.
 - Explain how to prepare a container for the expressed breast milk. (Do this demonstration quickly. Do not let it take a long time.)
 - Show participants some of the containers to hold the expressed breast milk that you have collected. Go through the following points.

HOW TO PREPARE A CONTAINER FOR EXPRESSED BREAST MILK

- Choose a small cup, jug or jar with a wide mouth.
- Wash the cup in soap and water (she can do this the day before).
- Pour boiling water into the cup and leave it for a few minutes. Boiling water will kill most of the germs.
- When ready to express milk, pour the water out of the cup.
- Use a small syringe (without a needle) or a spoon if colostrum is being expressed. If a mother can only express a few drops, it can be difficult to collect in a cup. A helper can collect it with a syringe directly from the nipple and it can be given to the baby directly from the syringe.

Give the demonstration of how to express breast milk by hand. Demonstrate as much as possible on your own body. If you prefer not to use your own breast, use a model breast, or practise on the soft part of your arm or cheek. You can draw a nipple and areola on your arm. Follow the steps in the box HOW TO EXPRESS BREAST MILK BY HAND, explaining what you do.

"HOW TO EXPRESS BREAST MILK – BREASTFEEDING SERIES" from Global Health Media Project. The video can be found online on the Global Health Media Project website or on the Global Health Media Project YouTube page at the following link: <https://www.youtube.com/watch?v=axQi5PqRZOM>.

NOTE: Play the video from time 00:50 until 04:12. If time allows, you can play the entire video.

Please encourage the participants to use the "How to Express Breast Milk by Hand" chart and determine the steps are being followed. Discuss together after reviewing the video.

HOW TO EXPRESS BREAST MILK BY HAND

Teach a mother as follows.

- Wash her hands thoroughly.
- Sit or stand comfortably and hold the container near her breast.
- Put her thumb on her breast **above** the nipple and areola, and her first finger or first two fingers on the breast **below** the nipple and areola, opposite the thumb. She supports the breast with her other fingers.
- Press her thumb and first finger or first two fingers slightly inwards towards the chest wall. She should avoid pressing too far, or she may block the milk ducts.
- Press her breast behind the nipple and areola between her first finger or first two fingers and thumb. She should press on the larger ducts beneath the areola. Sometimes in a lactating breast, it is possible to feel the ducts. They are like pods, or peanuts. If she can feel them, she can press on them.
- Press and release, press and release. This should not hurt – if it hurts, the technique is wrong. At first no milk may come, but after pressing a few times, milk starts to drip out. It may flow in streams if the oxytocin reflex is active.
 - Press the areola in the same way from the **sides**, to make sure that milk is expressed from all segments of the breast.
 - Avoid rubbing or sliding her fingers along the skin. The movement of the fingers should be more like rolling.
 - Avoid squeezing close to the nipple press behind it. Pressing or pulling the nipple itself cannot express the milk. It is the same as the baby sucking only the nipple.
 - Express one breast for at least three to five minutes until the flow slows; then express the other side; and then repeat both sides. She can use either hand for either breast or change when they tire.
 - Explain that to express breast milk adequately takes 20–30 minutes, especially in the first few days when only a little milk may be produced. It is important not to try to express in a shorter time.

Key points

- 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 practice.
 - Remind the mother 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.
- If you plan to show the video on hand expression, it can be shown here.*
- The video is: "How to express breast milk – Breastfeeding series." The link can be found at the beginning of the session.*

Ask: How can a mother help her milk to flow?

- A mother needs to be relaxed for her milk to flow. If she is tense, expressing her milk can be much more difficult.
- There are a number of ways a mother can be helped to relax.

Ask: How can you help a mother relax so her milk flows more easily?

Discuss suggestions given by participants. Continue and discuss the following:

- applying warm compresses to the breast (e.g. warm towels)
- breast or nipple massage
- massage to the back and neck before expressing
- being near to her baby so she can see him and think of him
- being in a quiet place or listening to music.

Ask: How often should a mother should express her breast milk?

Wait for a few replies and praise correct answers. Then make the following points.

- If a baby is not able to breastfeed, a mother should begin expressing her milk as soon as possible after delivery. This should be ideally within one hour, and not later than six hours after birth. The newborn can then receive their mother's milk by an alternative method of feeding. This also helps the mother stimulate her milk production.
 - She should express six or more times in 24 hours, including at night and during the day, approximately every three hours. This will help to stimulate her milk production.
 - A mother might need to express for five to 10 minutes to get a teaspoon of colostrum. The newborn's stomach is very small and small amounts every one to two hours are what the baby needs. She can also express for longer to store colostrum for a later time or to stimulate milk production.
 - It is easier to hand express when the breasts are soft. It is more difficult when the breasts are engorged and tender. So, teach a mother how to express her milk in the first and second day after delivery. Do not wait until the third day, when her breasts are full.
 - She may need help to believe that her breast milk is important, and that giving it will really help her baby
 - She should express as much milk as she is able to, each time.
 - If she is expressing to relieve symptoms, such as engorgement or softening the areola to help the baby attach, she should express only as much as is necessary³².
 - Freshly expressed milk should, whenever possible, be given immediately to the baby.
 - If this is not possible, the milk should be stored in a cool, clean and safe place in a container with a well-fitting lid.

She needs help to get her baby to suckle from her breast as soon as they are able.

Ask: How long can expressed breast milk be stored?

Wait for a few responses, then make the following points.

- Breast milk can be stored³³: At room temperature for a maximum of six hours in the coolest place in the room.

³² If the mother is clearing a blocked duct, she compresses and massages until the lump has cleared.

³³ More information on storage of breast milk is provided in the Further information section.

Alternative methods of feeding

□ Ask: What other methods of feeding can be used if feeding at the breast is not possible?

Write responses on a flipchart at the front of the room:

- tube feeding
- spoon, syringe or dropper
- direct expression of breast milk
- cup
- bottles.

- 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 cheek³⁴ 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 a risk of infection if not cleaned properly
 - they can lead to increased ear and dental problems
 - they may cause "nipple confusion" in some babies
 - if bottles, teats and pacifiers replace suckling at the breast, the breast is less stimulated and milk production may decrease.

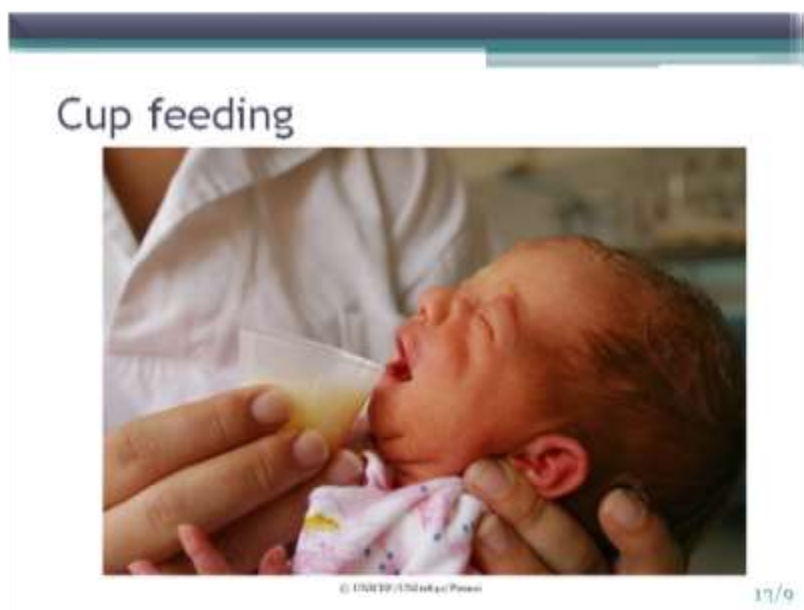


Preterm infants

- 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 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.

³⁴ 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 they may find it harder to learn to suckle the breast.

☐ Show Slide 13/9 – Cup feeding and make key points.



☐ Ask: *Why is cup feeding such a useful method to feed a newborn?*

Discuss participants' responses then give the following information, if it has not been covered already.

- Cup feeding is a safe and useful method of feeding breast milk to a newborn baby. A baby can take the amount of milk they want, at their own pace.
- A cup is a simple piece of equipment. Cups are easy to clean with soap and water, if boiling is not possible.
- It allows the baby to use his or her tongue and to experience tastes.
- It encourages coordinated breathing/sucking/swallowing.

☐ *Demonstrate cup feeding. Ask participants to turn to **page 154** of their Participant's Manual and refer to the table HOW TO FEED A BABY BY CUP. Ask participants to take turns reading aloud each point. Demonstrate each point (using a doll).*

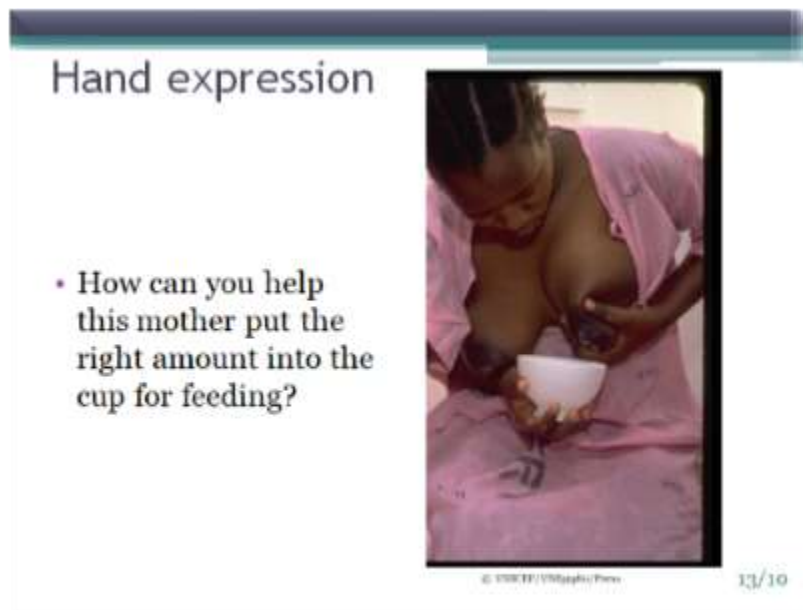
- Mothers should be taught how to safely cup feed their babies. They need to be taught the method in a way that gives them confidence to do it themselves. If a mother and baby are separated, teach a family member such as the father or grandmother to cup feed the newborn.
- "CUP FEEDING YOUR SMALL BABY (FOR MOTHERS) – SMALL BABY SERIES" from the *Global Health Media Project*. The video is provided in several languages on the Global Health Media Project website if translation is needed. The video can be found online or downloaded at *Global Health Media* or on YouTube at the following link:
<https://www.youtube.com/watch?v=-6AU6y6qatc&feature=youtu.be>
- Play the video from the beginning until 03:12. Throughout the video, there are different babies being fed by cup. If time allows, you can play the entire video.

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.

☐ Show **Slide 13/10 – Hand expression** and make key points.



☐ Ask: *How can you help this mother to put the right amount of milk into the cup?*

- If an exact amount of expressed milk is required, a health worker should use a syringe to put the right amount of milk into the cup.
- The mother can measure the milk by using a tablespoon that holds approximately 15 mL of liquid.
- If she needs approximately 30 mL, she can put two spoonfuls into the cup every two to three hours. The mother can put a little extra milk in each day.
- The baby is likely to take different amounts at each feed.
- A health worker can also mark the outside of a small glass or cup with a 10 mL scale up to 50 mL. This will provide a guide for the mother.

☐ *Key points.*

- Cup feeding can be used for babies who are able to swallow but cannot (yet) suckle well enough to feed themselves fully from the breast.
- A baby of 30–32 weeks' gestation can often begin to take feeds from a cup.
- Babies can start to suckle at the breast while cup feeding. A baby can suckle as much as they want and is then topped up by cup. They can gradually increase the time they spend breastfeeding and decrease the amount taken by cup.
- To help with learning to suckle at the breast for preterm, low-birth-weight and sick infants, oral stimulation can be useful. The infant can suck on the mother's clean finger, or a gloved finger. A pacifier may also be useful in this situation.
- If a baby takes a small feed, offer the next feed a little earlier, especially if the baby shows feeding cues.
- A baby is cup feeding well when they take the required 24-hour amount of milk, gains weight, and does not spill too much milk.

- If you plan to show the video on cup feeding, it can be shown here. The video is: “CUP FEEDING YOUR SMALL BABY (FOR MOTHERS) – SMALL BABY SERIES”. The link can be found at the beginning of this Session.

Let's practise: Written exercises

- Ask participants to turn to **page 156–157** of the Participant's manual and to find Exercise 13.
Explain the exercise: this exercise contains two case studies (13A and 13B).
- Ask the participants to answer the questions after the case studies using information from this session, and from the sessions on counselling skills. You can look at the notes in your manuals from these sessions if you wish.
- Directions*
 - Read the instructions.
 - Read the case studies and write your answers to the questions in pencil in the space provided.
 - After at least 10 minutes, go through the questions with the group.
- Ask the participants to write in the correct answers, so they have them for reference.

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?

The baby has a bruise on their head from the vacuum extraction. The baby is in pain when Mrs B presses her hand on the baby's bruise. This is causing Mrs B's baby to cry loudly and have difficulty in feeding at the breast.

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

- A possible response is given below but praise participants if they have an alternative response that empathizes with the mother.
- A possible response is: You are really upset, aren't you?

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

- Praise: It is great that you want to breastfeed your baby.
- Relevant information: At the moment, the bruise is making breastfeeding painful for your baby. That is why she is crying and having difficulty to feed at the breast.

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

- Offer to help to find a way for Mrs B to hold her baby that is not painful for the baby.
- Offer to provide pain relief to the baby if necessary. (But breastfeeding itself helps with pain.)
- Encourage skin-to-skin contact for Mrs B and her baby. This can be comforting to Mrs B's baby and allow the baby to suckle at the breast.

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 is Mrs M's baby reluctant to feed at the breast?*

The baby had difficulty attaching, and Mrs M did not receive help at first. Now a nurse has come to help her, but the nurse's technique is not good. She is pushing on the back of the baby's head, which makes the baby want to fight back.

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

The mother: *It is good that you have tried so hard to breastfeed.*

The nurse: *It is good that you are trying to help Mrs M to attach her baby.*

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

Suggest that a different technique might help.

- Try to guide the mother to position and attach her baby by herself, without touching.
- Show her what to do using a doll or a rolled-up towel.
- Explain that the mother should support the baby by his shoulders and back, and not by pressing on his head. Pressing on the baby's head may make feeding more of a challenge for the baby.
- If you need to help her to position the baby, put your hand over her hand to guide her – do not hold the baby yourself.

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

- Do not try to make the baby take the breast any more now.
- Let him enjoy skin-to-skin contact, and explore your breast with his mouth, until he is willing to try to suckle.
- It would be helpful to express your breast milk to feed him by cup until he suckles. Let me show you how to do it.

Summarize the session

Time for Question and Answer

- Ask participants whether they have any questions.
- Explain that the summary of this session can be found on **pages 147–157** of the Participant's manual.

Further information

Crying

- A baby who is “crying too much” may not (?) really be crying more than other babies.
- Their family may be less tolerant of the crying or less skilled at comforting the baby.
- Families' response to crying is different in different cultures.
- For example, in societies where babies are carried around more, they cry less.
- Yet babies themselves vary a lot in how much they cry.
- So, it is impossible to say that some patterns are “normal”, and some are not.

Reasons why babies may cry

- **Hunger due to not getting milk easily**
 - A baby who is poorly attached and not getting milk easily, may demand to be fed very often. They may suckle for a long time at each feed.
 - The baby may get enough milk and grow by feeding often but is not satisfied.
- **Hunger due to growth spurt**
 - In this situation, a baby seems very hungry for a few days, possibly because they are growing faster than before.
 - The baby demands to be fed very often.
 - If the baby suckles often for a few days, the breast milk supply increases, and the baby breastfeeds less often again.
- **Substances the mother takes**
 - Caffeine in coffee, tea and colas, can pass into breast milk and upset a baby.
 - If a mother smokes cigarettes or takes drugs or certain medications, her baby may be more likely to cry than other babies.
 - If someone else in the family smokes, that can also affect the baby.
- **Reflux**
 - Babies sometimes cry a lot because of gastro-oesophageal reflux.
 - Reflux is when milk and acid from the stomach pass back into the oesophagus, making it sore.
 - The baby may regurgitate milk (small vomits).
 - Reflux is more common in babies who have been tube fed.

Tube feeding

Fat can stick to the side of the tube, thus reducing the energy level of the feed received. If breast milk is fed continuously, angle the milk container and place the outlet tube at the highest point in the container. This is so that the creamy part of the milk is fed first.

Weight as a guide to feeding method

Gestational age is a better guide to a baby's feeding ability than weight. However, it is not always possible to know gestational age. Many babies start to take milk from the breast when they weigh about 1300–1500 g. Many can breastfeed fully when they weigh about 1600–1800 g or less.

Development of coordinated suckling

Babies can already swallow and suck long before 32 weeks. From about 32 weeks, many babies can suckle from the breast, and some can breastfeed fully from this age. They may have difficulty in coordinating suckling, swallowing and breathing. They need to pause during a breastfeed to breathe. They can suckle effectively for a short time, but they often cannot suckle long enough to take all the breast milk that they need. By about 36 weeks, most babies can coordinate suckling and breathing, and they can take all that they need by breastfeeding. However, a baby may feed well sometimes, but tire and feed poorly at other times. If a baby suckles poorly, offer a cup feed after the breastfeed. If they are hungry, they will take milk from the cup. If the baby has had enough, they will not take milk from the cup.

Amount of milk to give to babies

It is useful clinical practice to provide *low-birth-weights infants*³⁵.

- **Weighing <1500 g**
80 ml/kg for the first day of life and increase fluids by about 10–15 ml/kg/day to a maximum of 160 ml/kg/day by the end of the first week of life.
- **Weighing >1500 g**
About 60 ml/kg for the first day of life. The fluid intake is increased by about 15–20 ml/kg/day to a maximum of 160 ml/kg/day by the end of the first week.

*Healthy, term infants*³⁶

Based on limited research available, suggested intake for healthy, term infants should reflect normal amounts of colostrum available, size of the newborn's stomach, and the age and size of the infant. Intake increases over the first few days based on the infant's demand.

| Average reported intakes of colostrum by healthy, term breastfed infants | |
|--|------------------|
| Time (hours) | Intake (mL/feed) |
| First 24 | 2–10 |
| 24–48 | 5–15 |
| 48–72 | 15–30 |
| 72–96 | 30–60 |

Once the maternal milk supply is established for babies who weigh 2.5 kg or more:

- 150 mL/kg body weight per day
- divide the total into eight feeds and give every three hours.



Low-birth-weight babies

Whenever possible, low-birth-weight babies should be under the care of a health worker with specialist training. However, this information may help you if specialist care is not easily available.

Extra nutrients

Breast milk contains all the nutrients that a low-birth-weight baby needs, if they weigh 1500 g or more. Babies who weigh less than 1500 g need supplements of calcium, phosphorous and vitamin D. All low-birth-weight babies need iron from the age of six weeks after birth.

Very low-birth-weight (1000–1500 g) or extremely low-birth-weight (less than 1000 g) babies need extra nutrients in addition to breast milk for a time, in particular calcium, phosphorus, and vitamin D. Breast milk with additional nutrients protects against infection better than formula feeds. Breast milk contains essential nutrients and protective factors that are not available in any formula.

“Learning” to feed from a bottle

Some health workers believe that a low-birth-weight baby has to learn to feed from a bottle before they can feed from the breast. They are suggesting that sucking from a bottle is an earlier and easier stage of development. However, this is not recommended. Research has shown that breastfeeding is less stressful for a low-birth-weight baby than sucking from a bottle. Bottle feeding can make it more difficult for a baby to progress to suckling from the breast, particularly for a

³⁵ Edmond K, Bahl R. Optimal feeding of low-birth-weight infants: technical review. Geneva: World Health Organization; 2006.

(http://apps.who.int/iris/bitstream/handle/10665/43602/9789241595094_eng.pdf;jsessionid=0509098B55F5B9B61C0584C1E951D383?sequence=1 accessed 19 March 2020).

³⁶ Kellams A, Harrel C, Omage S, Gregory C, Rosen-Carole C. Academy of Breastfeeding Medicine. ABM Clinical Protocol #3: supplementary feedings in the healthy term breastfed neonate, revised 2017. *Breastfeed Med.* 2017;12:188–98. doi:10.1089/bfm.2017.29038.ajk

preterm baby.

Time of first oral feed

If oral feeding is possible as soon as a baby is born, the first feed should be given within the first two hours, and every two to three hours thereafter to prevent hypoglycaemia (low blood sugar).

Babies with special needs

Participants may ask about babies with special needs, such as twins, Down syndrome, or cleft lip. Breastfeeding these babies can take extra time and patience, and their mothers need extra help and support. Some babies need to be stimulated to breastfeed often enough and for long enough at each feed. Some babies gain weight slowly, even if they receive enough breast milk. Breastfeeding and bonding may be even more important for babies with special needs than for other babies. The topic is not covered at length in this course, because it is important for health workers to learn how to care for healthy babies before they try to help in more difficult situations, and all the same skills are necessary.

The principles of caring for babies with special needs are the same as for all babies:

- encourage the mother to begin breastfeeding as soon as possible after birth;
- position and attach the baby well and help them to take a big mouthful of breast;
- if the baby cannot suckle strongly, show the mother how to express her milk;
- feed the expressed breast milk with a cup or spoon until the baby is able to suckle well.

It is important to let a baby explore the breast and try to attach in his own way. Some babies with disabilities manage much better than we expect them to.

Storing expressed breast milk

Milk storage guidelines³⁷

| MILK STORAGE GUIDELINES | | |
|----------------------------|--------------------|---|
| <i>Location of storage</i> | <i>Temperature</i> | <i>Maximum recommended storage duration</i> |
| <i>Room temperature</i> | 16–29°C (60–85°F) | 4 hours is optimal 6–8 hours is acceptable under very clean conditions |
| <i>Refrigerator</i> | ~4°C (39.2°F) | 4–8 days is optimal 5–8 days under very clean conditions |
| <i>Freezer</i> | <-4°C (24.8°F) | 6 months is optimal 12 months is acceptable |

- If storing several containers, each container should be labelled with the date. Use the oldest milk first.
- Put the expressed breast milk into a container, cover it, and put it in as cool a place as possible. The amount of expressed breast milk put into one container should not be more than the amount needed for one feed.
- If the amounts of milk expressed are small, add more to the same container during that one day, but not after that.
- A baby should consume expressed milk as soon as possible after expression. Feeding of fresh milk (rather than frozen) is encouraged.
- Frozen breast milk may be thawed slowly in a refrigerator and used within 24 hours. It can be defrosted by standing in a jug of warm water and used within one hour, as it is warm. Do not boil milk or heat it in a microwave as this destroys some of its properties and can burn the baby's mouth.

³⁷ Eglash A, Simon L, The Academy of Breastfeeding Medicine. ABM Clinical Protocol #8: human milk storage information for home use for full-term Infants, revised 2017. *Breastfeed Med.* 2017;12:390–395. doi: 10.1089/bfm.2017.29047.aje

Colostrum

A pregnant woman can start expressing, collecting and freezing colostrum before delivery so that there is some ready for the baby when born. This can be especially helpful if the mother were unable to breastfeed immediately after the baby is born.

Breast pumps

- Breast pumps are not always practical, affordable or available. If breast pumps are available to mothers in your area and if a particular mother needs to or chooses to use one, help her choose an effective pump. Also, show her how to use the pump and go through the manufacturer's instructions with her.
- It is usually helpful to stimulate the oxytocin reflex before pumping.
- It is possible with some large electric pumps to pump both breasts at the same time. Double pumping increases the mother's prolactin level. It can help when large volumes of milk are needed, or the mother has only a short time to pump.
- With all pumps, use only a comfortable level of suction – more suction does not remove more milk and may damage the breasts. Mimic the baby's action – short quick initial sucks followed by longer, slower suction. With a cylinder hand pump, extend the cylinder to create a comfortable level of suction and hold that suction until the milk flow slows. The mother does not need to keep pumping if her milk is flowing.
- If the mother is getting little or no milk from pumping, check that the pump is working and check her pumping technique (including stimulating the oxytocin reflex). Do not conclude that she “has no milk”.
- Ensure that the mother is able to sterilize the pump if she intends to feed the milk to her baby.
- Avoid the rubber bulb type hand pumps. These damage mother's nipples, are difficult to clean and the milk cannot be used for feeding a baby.

Notes

Dotted lines for writing 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.

Session outline

Suggested time: 45 minutes

Participants are all together for a lecture presentation by one trainer.


- 1) Introduce the session, present **Slide 14/2**
- 2) Provide lecture and discuss, using **Slides 14/1–14/5**
- 3) Summarize the session
- 4) Time for Question and Answer

Preparation

- Refer to the Introduction for guidance on giving a presentation with slides.
- Prepare a flipchart with the heading MEDICAL INDICATIONS FOR SUPPLEMENTATION.
- Divide the flipchart into two columns.
- Write a subheading for each column: 1. INFANT CONDITIONS AND 2. MATERNAL CONDITIONS.
- This flipchart will be used in SECTION II: MEDICAL INDICATIONS FOR SUPPLEMENTATION.
- Post the flipchart where participants can see it during the discussion.

References

- Kellams A, Harrel C, Omage S, Gregory C, Rosen-Carole C. Academy of Breastfeeding Medicine. ABM Clinical Protocol #3: supplementary feedings in the healthy term breastfed neonate, revised 2017. *Breastfeed Med.* 2017;12:188–98. doi:10.1089/bfm.2017.29038.ajk.
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- 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/10665/246260/1/9789241549707-eng.pdf>, accessed 19 March 2020).
- WHO/FAO. Safe preparation, storage and handling of powdered infant formula: guidelines. World Health Organization; 2007 (http://www.who.int/foodsafety/publications/micro/pif_guidelines.pdf, accessed 19 March 2020).



Session 14.
Medical indications for supplementary feeding

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14/1

- Show **Slide 14/2 – Objectives** and read aloud.

Session 14. Objectives
Medical indications for supplementary feeding

After completing this session, participants will be able to:

- list the possible medical indications and reasons for supplementation;
- explain how to choose an appropriate supplement;
- discuss how to support mothers who have decided to feed their babies with infant formula;
- describe the safe preparation of the supplementation.

14/2

- As discussed in Session 1, WHO and UNICEF recommend infants be exclusively breastfed for the first six months of life. Although this is the goal for all children, in certain cases alternative feeds are medically indicated. We will discuss the indications for supplementation in this session.*
- Ask: What does supplementary feeding mean?*

Wait for a few responses, then explain definition of supplementary feeding.

- Supplementary feeding giving additional fluids, other than the mother's own milk, 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 are some examples given in your community?

Medical indications for supplementation

- Make the points below.*
- We will now discuss the medical indications for supplementation, both conditions of the infant and mother. Display prepared flipchart with the heading MEDICAL INDICATIONS FOR SUPPLEMENTATION. Make sure all participants can see it.*
- Ask: In what situations are fluids, in addition to the mother's own milk, medically indicated for infants and/or their mothers?*
- Ask participants to offer suggestions on infant indications first. Once participants have given two to three suggestions, move on to maternal indications. Wait for two to three suggestions. Write participants' answers on the flipchart under each sub-heading for INFANT INDICATIONS and MATERNAL INDICATIONS.*

- Show **Slide 14/3 – Infant indications** and read aloud.

Infant indications

- Low-birth-weight (<1500 g)
- Preterm (born before 32 weeks)
- Hypoglycaemia
 - Low-blood glucose levels which do not respond to breast milk
- Signs/symptoms indicating poor breast-milk intake
- High bilirubin
 - Associated with poor breast-milk intake
- Metabolic disorders

Kellams A, Harrel C, Ormrod S, Gregory C, Rosen-Carole C, Academy of Breastfeeding Medicine. ABM Clinical Protocol #3: Supplementary feedings in the healthy term breastfed neonate, revised 2017. Breastfeed Med. 2017;12:188-96. doi:10.1089/bfm.2017.29038.ajk

14/3

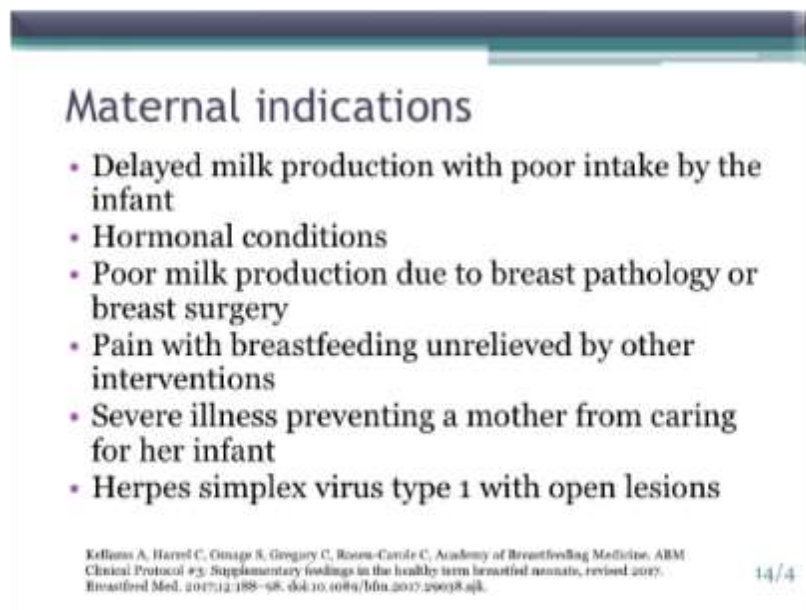
- Explain the possible medical indications for supplementation.*
This slide shows the possible infant medical indications for supplementation.
 - Infants may need supplementation for a limited time due to a medical condition. This is usually only temporary, until they can feed at the breast.

- Low-birth-weight (<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. This should, if possible, be with expressed breast milk from their own mother. If for some reason, mother's own milk cannot be provided, then supplementation may be necessary until they are able to feed at the breast
- 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 and should be given supplements as medically recommended
- Full-term, healthy babies do not develop hypoglycaemia simply through temporary under-feeding. Supplementary feeding is not needed to prevent low blood sugar in healthy, term babies.
- If a healthy full-term breastfeeding baby develops signs of hypoglycaemia, the baby should be investigated for another underlying problem, such as infection.
- If an infant's low blood sugar does not respond to more frequent breastfeeding or expressed breast milk, they may require other supplementation.
- 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.
- A baby who has high bilirubin levels associated with poor breast milk intake may need supplementary feeding.
- An infant showing signs and symptoms of poor breast milk intake must be assessed to determine the cause of poor breast-milk intake. These signs and symptoms have already been discussed in detail in Session 12. If insufficient breast milk intake continues to persist, despite management measures, then consider the need for other supplements.



Sick or low-birth-weight babies

- These babies may require supplementation.
- Examples include prevention of hypoglycaemia or inability to breastfeed. Even for these babies, breast milk is usually the best feed to give.
- Supplementation 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**.



- This slide shows the possible maternal medical indications for supplementary feeding of an infant. Usually this will be temporary until the mother recovers.

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 four to five or later and the infant is showing signs of poor milk intake, the infant may need supplementary feeding until the milk comes in.

2) Hormonal conditions

Hormonal conditions of the breasts or problems with the milk making glands can sometimes cause poor milk production, such as polycystic ovaries, low prolactin levels. Poor milk production can also be related to breast pathology or a prior breast surgery.

Retained piece of placenta may delay onset of milk production until the placenta is removed.

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. If not, the baby will need breast-milk substitutes until she has recovered, and her milk supply has built up again.

5) Herpes simplex virus (type 1)

If a mother has herpes simplex virus (type 1) with open lesions on her breast or nipples, 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 baby can feed from the unaffected side.

- Ask: *There may be circumstances where it may not be possible for an infant to breastfeed or receive their mother's*

expressed breast milk. Can you think of any of these situations?

Wait for one or two responses, then continue.

- In a few cases, an infant will require breast-milk substitutes in place of all breast milk.
- These situations include the following.
 - 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 HIV³⁸ will not exclusively breastfeed (either due to the national health authority policy or because she decides not to for her own reasons), this is an acceptable medical reason for breast-milk substitutes.
- The WHO/UNICEF document, "*Acceptable medical reasons for use of breast-milk substitutes*" describes the few conditions for which breastfeeding is contraindicated³⁹.

Ask: When supplementary feeding is medically necessary, what are the main goals for the infant and mother?

Wait for one or two responses, then continue.

- Each clinical situation should be assessed on an individual basis. A decision should then be made by a qualified health professional whether supplementation is indicated or not.
- If supplementary feeding is medically necessary, the main goals are to feed the infant and to establish or sustain the breast milk supply.
- Supplementation should be performed in ways to help preserve breastfeeding including the following.
 - Limiting the volume to what is necessary.
 - Stimulating the mother's breasts with hand expression or pumping.
 - Allowing the infant to continue to practise at the breast if possible.
- 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 about how to feed their baby.

Ask: Can you think of any situations where supplementation is sometimes given but is not medically indicated?

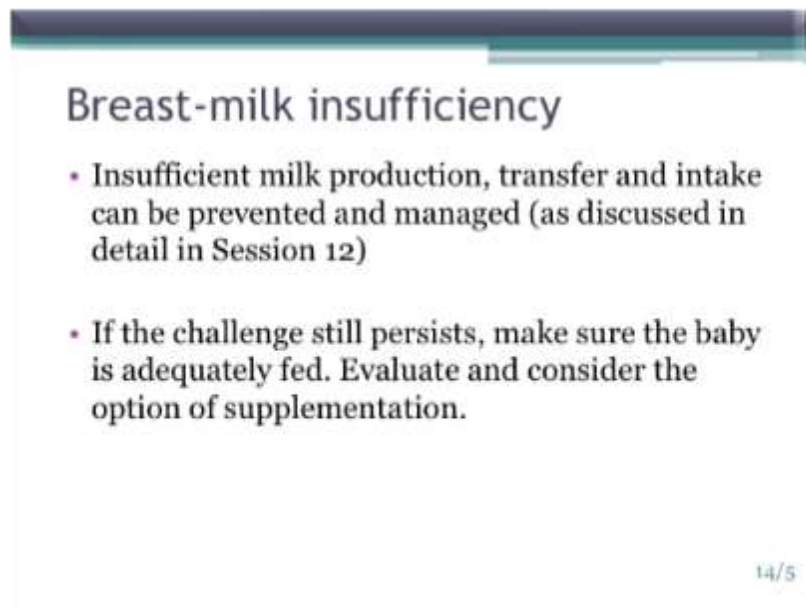
- There are common clinical situations where supplementary feeds are often given, even if they are not medically indicated.
 - ☞ Cluster feeding⁴⁰: This is a normal newborn behaviour and does not require supplementation.
 - ☞ The mother is tired after giving birth: Giving the baby supplementation to allow the mother to sleep rather than breastfeed discourages responsive feeding and exclusive breastfeeding.
 - ☞ Perceived low supply: A mother or health worker may think that 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.

³⁸ 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.

³⁹ 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 19 March 2020).

⁴⁰ "Cluster feeding" is when the baby has several short feeds at the breast close together.

- ☐ Show **Slides 14/5–14/6 – Breast-milk insufficiency** and read aloud.



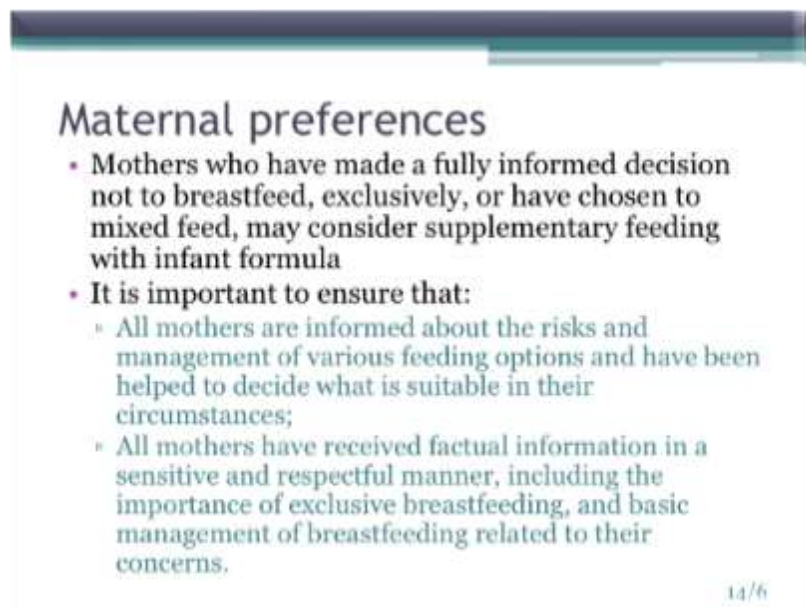
Breast-milk insufficiency

- Insufficient milk production, transfer and intake can be prevented and managed (as discussed in detail in Session 12)
- If the challenge still persists, make sure the baby is adequately fed. Evaluate and consider the option of supplementation.

14/5

- ☐ *Remind the participants that this has been discussed in detail in Session 12.*

- ☐ Show **Slide 14/6 – Maternal preferences** and read aloud.



Maternal preferences

- Mothers who have made a fully informed decision not to breastfeed, exclusively, or have chosen to mixed feed, may consider supplementary feeding with infant formula
- **It is important to ensure that:**
 - All mothers are informed about the risks and management of various feeding options and have been helped to decide what is suitable in their circumstances;
 - All mothers have received factual information in a sensitive and respectful manner, including the importance of exclusive breastfeeding, and basic management of breastfeeding related to their concerns.

14/6

- ☐ *Make these points.*
 - All mothers should be discouraged from giving any food or fluids other than breast milk, unless medically indicated. However, some mothers choose not to breastfeed at all, while some mothers choose “mixed

feeding⁴¹.

- All mothers who choose not to exclusively breastfeed should be counselled on the importance of doing so.
 - ☞ Listen to her reasons for not breastfeeding exclusively and reflect back to her to confirm that you understand her concerns and the circumstances for her choosing mixed feeding.
 - ☞ Providing factual information in a sensitive and respectful manner, including the importance of exclusive breastfeeding, and basic management of breastfeeding related to her concerns.
- If 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.

Ask: *If a mother chooses not to exclusively breastfeed, what are important points that you as the health worker should consider?*

Wait for a few responses, then make the following points.

- The health worker should discuss the various feeding options with them and help them to decide on the most suitable option.
- Women who intend to mixed feed should also be counselled on establishing a milk supply and ensuring that 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. Encourage her to continue breastfeeding as much as she is able to.

Ask: *Which practices can help avoid the need for supplementation?*

- The need for supplementation can be prevented by implementing practices such as:
 - early skin-to-skin contact, which helps to establish breastfeeding;
 - early and frequent breastfeeding;
 - delaying the time between birth and initiation of breastfeeding can lead to the need for supplementation;
 - ensuring good positioning and attachment of the baby at the breast;
 - rooming-in so that responsive feeding can be practised.

⁴¹ Mixed feeding is a combination of breastfeeding and feeding with breast-milk substitutes.

- Show Slide 14/7 – Option of supplementation and discuss together.

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 breastmilk | Breast milk donated by mothers 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 |

Delaney, A., Harris, J., Deigo, R., et al. (2011). WHO Global Prevalence of Supplementation: Evidence for the Health Care Provider. *Maternal, Infant, and Child Nutrition*. Available at: <http://www.who.int/nutrition/publications/infantfeeding/9789281001111.pdf>

14/7

- Make these points,
 - 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 life⁴². 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.

Guidelines for choosing supplementation

- If supplementation is medically indicated, please choose an appropriate supplement.

- Ask: Which types of supplements are used in your health-care facility?

Wait for a few replies, then make the following points.

- In most cases, supplementation is temporary until the newborn is capable of breastfeeding and/or the mother is available and able to breastfeed.
- **BEST OPTION:** 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, other supplementation may be required.

⁴² 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

- 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.

Discuss whether there are milk banks in the local or national area that are used by facilities and/or mothers.

- 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 breast milk.
- 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.

Ask: *What are ways to safely prepare and store supplements?*

Wait for a few replies, then make the following points:

- All mothers who are feeding supplements to their babies must be taught how to safely prepare and store them.
- Risk of illness is increased when supplements are handled or stored incorrectly. This is even more important for infants who are preterm, low-birth-weight or immuno-compromised.
- 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 available, and the use of 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 boiled, 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. Then pour the water into a cleaned and sterilized container you will use to feed the baby.
 - The correct proportions of water to formula powder are extremely important for child health.
- Cooled 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 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.

Summarize the session

Time for Question and Answer

- Ask participants if they have any questions.*
- Explain the summary of this session can be found on **pages 159–167** of the Participant's manual.*

Further information

Commercially prepared infant formulas

- Many commercially manufactured infant formulas are made from animal milk. The fat content is altered and often a vegetable fat is added. A form of sugar is added as well as micronutrients.
- It is important to remember that although the *proportions* of nutrients in commercial formula can be altered, their *quality* cannot be made the same as breast milk. Also, the immune factors and growth factors present in breast milk are not present in animal milk or formula, and they cannot be added.
- Other types of commercially manufactured formula are available and should only be discussed with mothers if the infant has a medical need for these specialized products.
 - *Soy infant formula* uses processed soybeans as the source of protein and comes in powdered form. Usually it is lactose-free and has a different sugar added instead. Infants who are intolerant of cows' milk protein may also be intolerant of soy protein.
 - *Low-birth-weight or preterm baby formula* is manufactured with higher levels of protein and certain minerals and a different mixture of sugars and fats than ordinary formula for full-term infants. Low-birth-weight baby formula is not recommended for healthy, full-term infants. The nutritional needs of low-birth-weight infants should be individually assessed.
 - *Specialized formulas* are available to use in conditions such as reflux, high-energy need, lactose intolerance, allergic conditions and metabolic disorders like phenylketonuria (PKU). These formulas are altered in one or more nutrients and should only be used for infants with the specific conditions under medical/nutritional supervision.
 - *Follow-on (or follow-up) milks* are marketed for older infants (over six months). They contain higher levels of protein and are less modified than infant formula. Follow-on milks are not necessary. A range of ordinary milk products can be used over six months of age and micronutrients supplements also given, if needed.
- Products that are not suitable for making infant formula include:
 - skimmed milk – fresh or dried powder
 - condensed milk (very high in sugar and the fat content may be low)
 - creamers used for 'whitening' tea or coffee

Conditions needed to safely artificially feed infants

Specific conditions need to be met in order to safely feed infants with commercial infant formula milk. These conditions are⁴³:

- (a) safe water and sanitation should be available in the household and in the community;
- (b) the mother/parent/caregiver can reliably provide sufficient infant formula to support the normal growth and development of the infant;
- (c) the mother/parent/caregiver can prepare it cleanly and frequently enough so that it is safe and carries a low risk of diarrhoea and malnutrition;
- (d) the mother/parent/caregiver can exclusively give infant formula milk in the first six months;
- (e) the family is supportive of the practice of feeding infant formula;
- (f) the mother/parent/caregiver can access health-care that offers comprehensive child health services.

⁴³ 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/am/10665/246260/1/9789241549707-eng.pdf>).

Mothers with HIV

For mothers living with HIV who decide not to breastfeed or who live in countries where the national authority does not recommend breastfeeding, alternatives to breastfeeding include:

- commercially prepared breast-milk substitutes
- expressed, heat-treated breast milk.

Heat-treatment of breast milk kills the HIV virus. Expressed breast milk from another woman can also be used, either through an organized milk bank that tests and heat-treats the milk, or informally from a woman who has tested HIV-negative.

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.

Session outline

Suggested time: 120 minutes

- Participants are together led by one trainer, to prepare for the session
- Practical session
- Participants work in small groups of three to four, each with one trainer, for the practical
 - 1) Prepare the participants (20 minutes)
 - 2) Conduct the clinical practice (100 minutes)

Preparation

- If you are leading the session:
 - Study the instructions and ask all trainers who will lead groups to study the instructions also. You conduct this clinical practice in a similar way to **CLINICAL PRACTICE SESSION 1: LISTENING AND LEARNING – ASSESSING A BREASTFEED**. Make sure that you and the other trainers are clear about the differences.
 - Make sure you know where the practical session will be held, and where each trainer should take their group. If you did not do so in a preparatory week, visit the wards or clinic where you will go, introduce yourself to the staff members in charge, and make sure that they are prepared for the session (see Director's guide).
 - Make sure that there are copies of the **CLINICAL PRACTICE DISCUSSION CHECKLIST** for each trainer.
 - Make sure that there are copies of the **COUNSELLING SKILLS CHECKLIST** and the **JOB AID: BREASTFEEDING SESSION OBSERVATION** available for each participant and trainer.
 - Make sure each small group has a doll and a model breast to help demonstrate how to position and attach a baby to the breast, and how to express breast milk.
- If you are leading a small group:
 - study the instructions on the following pages, so that you are clear about how to conduct the clinical practice;
 - make sure that you have a copy of the **CLINICAL PRACTICE DISCUSSION CHECKLIST**, to help you to conduct discussions;
 - make sure that the participants in your group each have two copies of the **JOB AID: BREASTFEEDING SESSION OBSERVATION**, and one copy of the **COUNSELLING SKILLS CHECKLIST** – have one or two extra copies with you;
 - find out where to take your group.

As you follow the text, remember:

- indicates an instruction to you, the trainer
- indicates what you say to participants.

Preparatory session: One trainer leads a session with all participants trainers together.

Note: If you have to travel to another facility for the clinical practice session, hold the preparatory session in the classroom before you leave. If necessary, this can take place on the evening or the morning before the clinical session.

Let's prepare

We will spend time today preparing for the clinical practice in the maternity wards. Remember the goal is for each health worker to practice 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.

Explain the following to the participants.

- You are going to practise the skills from Session 3:
 - 1) building confidence and giving support learned
 - 2) helping a mother to position her baby
 - 3) assessing a breastfeed
 - 4) listening and learning.
- In this clinical session, you will all practice helping a mother position her baby at the breast. If there are any challenges, please support her and offer assistance.
- In the first days after birth, babies are often sleepy. In this case, you could say: "I see your baby seems to be sleepy now, but can we just go through the way to hold him when he is ready". Please review the four key points of positioning with the mother. This may cause the baby to wake up and want to feed, when their nose is opposite the nipple.
- Please take: two copies of the **JOB AID: BREASTFEEDING SESSION OBSERVATION**, one copy of the **CHECKLIST: COUNSELLING SKILLS** and pencil and paper to make notes.
- Please work in groups of three to four with one trainer.

While in the health-care facility

Process for the visit to the health-care facility as follows.

- Each participant will take a turn talking to a mother, while group members observe.
- The counsellor should introduce themselves to the mother and ask her permission to talk to her. Introduce your group and say you are interested in "infant feeding." If a mother is not feeding, ask her to feed in the usual way at any time her baby seems ready.
- Find a chair or a stool to sit on.
- Please practise the listening and learning skills. Ask questions about the mother, her situation and her baby. The other participants should be observers, standing quietly. Try to be as still and quiet as possible.
- If a mother is not feeding, ask her to give a feed in the normal way at any time that her baby seems ready. If she does not want to be assisted or observed, thank her and find another mother with the help of your trainer.
- Try to find a chair or a stool to sit on.
- 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 simple relevant information that are useful to her now.
- The other participants (observers) should stand quietly in the background while you are assisting a mother. Try to

be as still and quiet as possible.

- Make specific observations of the participant's (the counsellor's) 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 check marks in the boxes.
- Help a mother to position and attach her baby to her breast, if needed.
- If the mother needs help:
 - when you find a mother who needs help positioning her baby at the breast, you can practice assisting her while your trainer observes you – your trainer will help, if necessary.
- When you have finished, thank the mother.
- When you have finished helping a mother, if discussion with your trainer is needed, please move away from the mother.

Let's discuss **COMMON MISTAKES**

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.

Trainers should read the notes to prepare for the clinical practice session. Please do not read notes to the participants.

Clinical practice instructions.

- Divide the group into three to four participants at a clinical practice site. Groups should be determined before the clinical practice session begins.
- Take your group to the ward or clinic.
- Introduce yourself and your group to the staff member in charge.
- Ask for the appropriate mothers and babies and where they are.
- Find a breastfeeding mother and baby, or a mother who thinks her baby may want to feed soon. If this is not possible, talk to any mother.
- Participants will work in groups of three to four (one participant will be the counsellor and remaining members will observe). Please remind them to use the **SKILLS CHECKLIST: LISTENING AND LEARNING**.
- Ask the observers to fill out the **SKILLS CHECKLIST: LISTENING AND LEARNING** while observing the counsellor.
- When the mother begins feeding her baby, observers should fill out the **JOB AID: BREASTFEEDING SESSION OBSERVATION**.
- Each time the participants have finished a session with a mother, take the participants to another area to discuss their feedback. More detailed instructions on this are provided on the next page.
- The group members should switch roles. Try to make sure each participant talks to and helps at least one mother.
- Take spare copies with you of the **SKILLS CHECKLIST: LISTENING AND LEARNING**, the **JOB AID: BREASTFEEDING SESSION OBSERVATION** and the **CLINICAL PRACTICE DISCUSSION CHECKLIST**.

Guide the counsellor.

- Remain in the background and let the participants work without much interference.
- You do not need to correct every mistake a participant makes immediately. If possible, wait until the discussion afterwards. Then you can praise what they did right and talk about mistakes or challenges.
- **If help is required, please try to help in a way that does not make them embarrassed in front of the mother and the group.**
- Additionally, if you notice something the participants missed, you can quietly draw their attention to it.
- **You are leading the session and must help facilitate the best learning experience. Use the building confidence and giving support to help participants.** Your goal is help them to develop confidence in their own clinical and counselling skills.

Let's debrief: Discussing participant's experience together.

- Leave the mother's room or bedside and discuss observations together. The group should move out of the mother's hearing, as well as other mothers and families for confidentiality.
- Use the **CHECKLIST: CLINICAL PRACTICE DISCUSSION** to help lead the discussion. It is important that everyone has a chance to practise their skills. Use your counselling skills when giving feedback.
- Ask the **GENERAL QUESTIONS**, and then ask the specific questions about **LISTENING AND LEARNING** and about **ASSESSING A BREASTFEED**.
- Also ask the questions on **building confidence and giving support** and discuss how they helped the mother position and attach the baby, and any other help they gave.

- Review the **SKILLS CHECKLIST** and discuss how each participant used the skills. First, ask the counsellor how the experience was for them. Then, ask the other observers. Try to encourage the participants to use their counselling skills in such a way that they give feedback to the other participants.
- Review the **JOB AID: BREASTFEEDING SESSION OBSERVATION** and discuss what group noticed. Ask them to decide the baby's position and attachment.
- Explain that the summary of this session can be found on **pages 169–174** of the Participant's manual.

CHECKLIST: CLINICAL PRACTICE DISCUSSION

Practical skills are best developed by:

- 1) Introducing and demonstrating the skills
- 2) Observing participants as they practise the skills
- 3) Giving feedback to participants on how well they performed.

Feedback should include:

- 1) Praising participants for things done well
- 2) Giving gentle suggestions for how to overcome difficulties.

Use the checklist below to help guide your feedback discussions

Questions to ask each counsellor

To the counsellor:

- What did you do well?
- What difficulties did you have?
- What would you do differently in the future?

To the observer:

- What did the counsellor do well?
- What difficulties did you observe?

Listening and learning skills

- Which listening and learning skills did you use?
- Was the mother willing to talk?
- Did the mother ask any questions? How did you respond?
- Did you empathize with the mother? Give an example.

Skills for building confidence and giving support

- Which confidence and support skills were used?
- (Check especially skills to praise and for two relevant suggestions)
- Which skills were most difficult to use?
 - What was the mother's response to your suggestions?

Discuss how they helped the mother practically

- What difficulties did the mother have with breastfeeding or other aspects of her situation?
- Which situations helped you to learn?
- What practical help did you give her? Was it successful?
- What could you have done differently?
- Give them feedback on the practical help that they gave?
- What was the most interesting thing that you learned from this practical session?

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 looks healthy
- Mother relaxed and comfortable
- Signs of bonding between mother and baby

Mother:

- Mother looks ill or depressed
- Mother looks tense and uncomfortable
- No mother/baby eye contact

Baby:

- Baby looks healthy
- Baby calm and relaxed
- Baby reaches or roots for breast if hungry

Baby:

- Baby looks sleepy or ill
- Baby is restless or crying
- Baby does not reach or root

BREASTS

- Breasts look healthy
- No pain or discomfort
- Breast well supported with fingers away from nipple

- Breasts look red, swollen or sore
- Breast or nipple painful
- Breast held with fingers on areola

BABY'S POSITION

- 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 to nipple

- Baby's neck and head twisted to feed
- Baby not held close
- Baby supported by head and neck only
- Baby approaches breast, lower lip/chin

BABY'S ATTACHMENT

- More areola seen above baby's top lip
- Baby's mouth wide open
- Lower lip turned outwards
- Baby's chin touches breast

- More areola seen below bottom lip
- Baby's mouth not open wide
- Lips pointing forward or turned in
- Baby's chin not touching breast

SUCKLING

- Slow, deep sucks with pauses
- Cheeks round when suckling
- Baby releases breast when finished
- Mother notices signs of oxytocin reflex

- Rapid shallow sucks
- Cheeks pulled in when suckling
- Mother takes baby off the breast
- No signs of oxytocin reflex noticed

Notes

Lined area for notes, consisting of multiple horizontal dotted lines.

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

Session outline

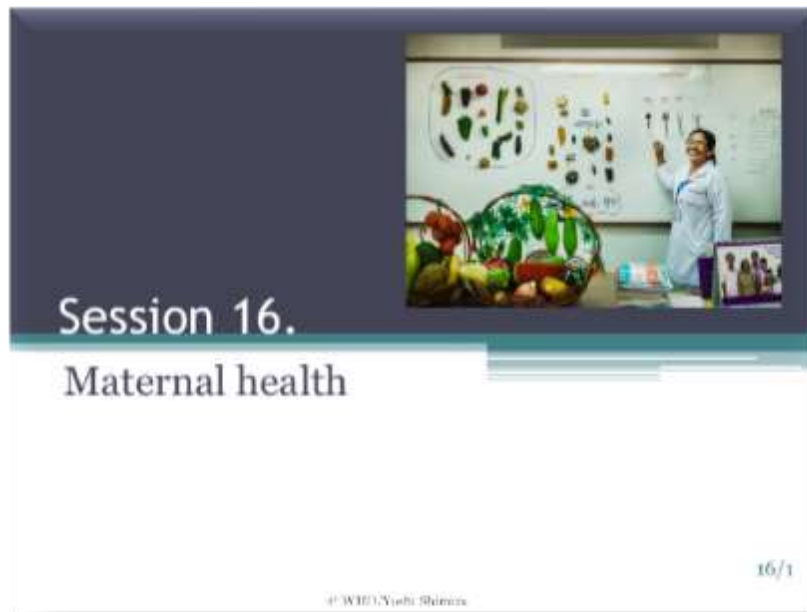
Suggested time: 30 minutes

- 1) Introduce the session, present **Slide 16/2**
- 2) Present **Slides 16/1 –16/4**
- 3) Summarize the session
- 4) Time for Question and Answer

Preparation

- Refer to the Introduction for guidance on giving a presentation with slides
- Study the **Slides 16/1–16/4**
- Read the Further information section

Introduce the session



Introduce the session.

- 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.
- Please consider a mother's nutrition which affects her health, energy and well-being.
- 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.

- Show **Slide 16/2 – Objectives** and read aloud.

Session 16. Objectives
Maternal health

After completing this session, participants will be able to:

- help a mother who is ill continue breastfeeding;
- describe how to help a mother who is taking medications while breastfeeding;

16/2

Helping a mother who is ill to breastfeed

- Ask: *Is it necessary for a mother to stop breastfeeding when she is ill?*
Wait for a few replies and then continue.
- Make these points.
 - 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 a sick mother to stop breastfeeding. With most common infections, breastfeeding does not increase the chance of the baby becoming ill. Antibodies in breast milk are 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 that it is difficult for her to care for her baby.



- This slide summarizes what you can do to help an ill mother to continue 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 support and encouragement to her 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 is to prevent her breast milk from decreasing because of dehydration.
 - 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 milk can be fed to the baby.
 - 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

- Health workers should be aware that if mothers are taking medications during breastfeeding, and they can affect the baby.
- Most drugs pass into breast milk only in small amounts and few affect the baby. If the baby is premature or less than two months old, a drug is more likely to affect the baby. However, in most cases, to stop breastfeeding is likely to be more dangerous than the medicine.
- There are a few medications which cause side effects.** If you are concerned, ask the doctor or other health-care provider if the medicine that a mother is receiving is safe. If not, is it possible to give her an alternative, less likely to affect the baby.
- It is rarely necessary to stop breastfeeding because of a mother's medication

□ Show **Slide 16/4 – Breastfeeding and maternal medications** and make key points.

| Type of medication | Breastfeeding management |
|---|---|
| -Some anticancer drugs -Radioactive substances (temporarily) | Breastfeeding contraindicated |
| -Psychiatric drugs -Anticonvulsants | -Continue breastfeeding -Side-effects possible -Monitor baby for drowsiness |
| -Chloramphenicol, tetracycline, metronidazole, sulfonamides, cotrimoxazole, dapsons | -Use alternative drug if possible -Monitor baby for jaundice |
| -Estrogen-containing contraceptives -Thiazide diuretics | -Use alternative drug -May decrease milk supply |
| Most commonly used drugs | Safe in usual dosages for breastfeeding |

16/4

- This slide summarizes the information available.
- In a very few situations, breastfeeding is contraindicated.**
- If a mother is taking anticancer drugs, it may be necessary to stop breastfeeding. If she is treated with radioactive substances, she should stop breastfeeding temporarily. 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 that you are unsure 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 that 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.
 - .ts, 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.
 - Tell participants if they require information on specific medications used while breastfeeding, they can refer to:
 - Breastfeeding and maternal medication: recommendations for drugs in the Eleventh WHO Model List of Essential Drugs.*
 - This is found on the WHO website.

Summarize the session

Time for Question and Answer

- Ask participants whether they have any questions.
- Explain the summary of this session can be found on **pages 176–178** of the Participant’s manual.

Further information

Maternal illness and breastfeeding

If a woman is so ill that she is unable to care for her baby at all (for example if she is unconscious), it may be necessary to give the baby milk from another source – such as milk donated by another mother, or a wet nurse. If these are not available, breast-milk substitutes will need to be used. Sometimes, it is possible to express the mother's milk for her. Feed the baby by cup until the mother is well enough to start breastfeeding again.

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

Session outline

Suggested time: 45 minutes

- Participants are all together
- Group activity led by one trainer
- All trainers give individual feedback on the exercise
 - 1) Introduce the session, present **Slide 17/2**
 - 2) Show and discuss slides **17/1–17/6**
 - 3) Complete the group activity
 - 4) Summarize the session
 - 5) Time for Question and Answer


Preparation

- Refer to the Introduction for guidance on giving a presentation with slides.
- Study the **Slides 17/2–17/6**, so that you are familiar with what each slide shows and the particular points to teach from them.
- At the beginning of the session, ask participants to arrange their seats so they are sitting in a half circle near to the screen.
- Prepare information on how to obtain HIV counselling and testing in the local area. Be aware of the national authority recommendations for breastfeeding for women living with HIV.
- Prepare copies of the **JOB AID: ANTENATAL CHECKLIST**, provided at the end of this session.

References

- WHO recommendations on antenatal care for a positive pregnancy experience. Geneva: World Health Organization; 2016 (https://www.who.int/reproductivehealth/publications/maternal_perinatal_health/anc-positive-pregnancy-experience/en/, accessed 19 March 2020).
- WHO recommendations: intrapartum care for a positive childbirth experience. Geneva: World Health Organization; 2018 (<https://www.who.int/reproductivehealth/publications/intrapartum-care-guidelines/en/>, accessed 19 March 2020).
- Maternal, newborn, child and adolescent health. What is the quality of care network? World Health Organization; 2018 (https://www.who.int/maternal_child_adolescent/topics/quality-of-care/network/en/, accessed 19 March 2020). Refer to the Introduction for guidance on giving a presentation with slides.

Introduce the session



Session 17.

Antenatal preparation for breastfeeding

17/1

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- Show **Slide 17/2 – Objectives** and read aloud.

Session 17. Objectives
Antenatal preparation for breastfeeding

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.

17/2

- Show **Slide 17/3 – Antenatal care** and make the key points.

Antenatal Care (ANC) topic:
Importance and management of breastfeeding

- Counsel all pregnant women and show you want to help them
- Counsel young women or those having first baby
- Counsel all women at least twice antenatally about breastfeeding
- Remember: Antenatal breast preparation is not necessary



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17/3

- 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 it 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.
 - Show clearly that you support breastfeeding, and that you want to help them. Do not make them feel that you will be critical or blame them if they do not breastfeed.
 - Talk especially to women who are having their first baby. They are the ones who are most likely to need help.
 - Talk to each woman at two antenatal contacts, if possible, including about practical management on at least one occasion.
 - 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.
- Ask: Do women need to prepare their breasts for breastfeeding?*
Wait for a few replies and then continue.
 - 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 that these techniques are not effective, and it is not necessary to recommend them.
 - Organize participants in groups of three or four, and ask them to brainstorm:
 - (1) topics for antenatal breastfeeding preparation with a group of mothers
 - (2) topics for antenatal breastfeeding preparation with mothers individually.
 - In plenary session, ask one group to report their discussion for groups sessions. Ask all other participants to add anything missing.

- ❑ Then ask another group to report their discussion on individual sessions. Ask all other participants to add anything missing.
- ❑ Discuss groups' responses. Review and provide any missing information. Tell participants the information is in the *Participant's manual (page 181)* in the box **ANTENATAL PREPARATION FOR BREASTFEEDING**.

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.

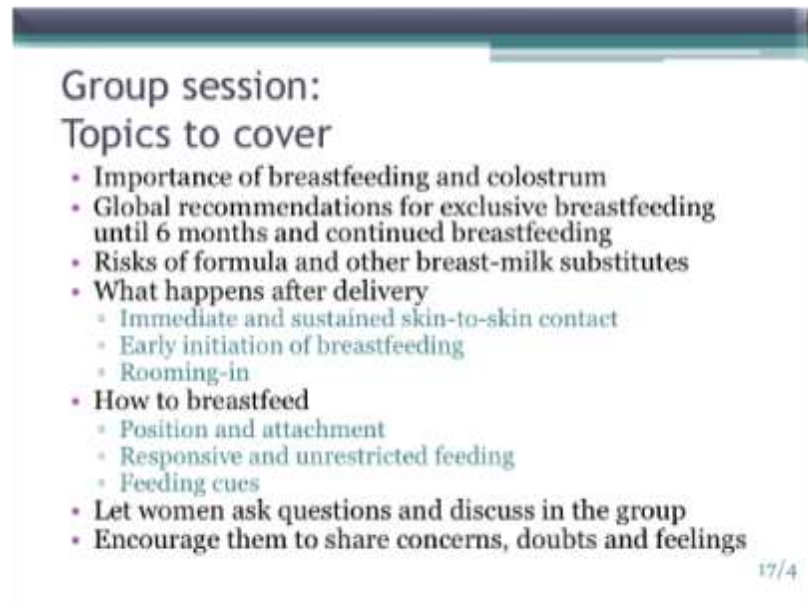
With each mother individually

- 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

- Show **Slide 17/4 – Group sessions for pregnant women** and make the key points.



- 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.

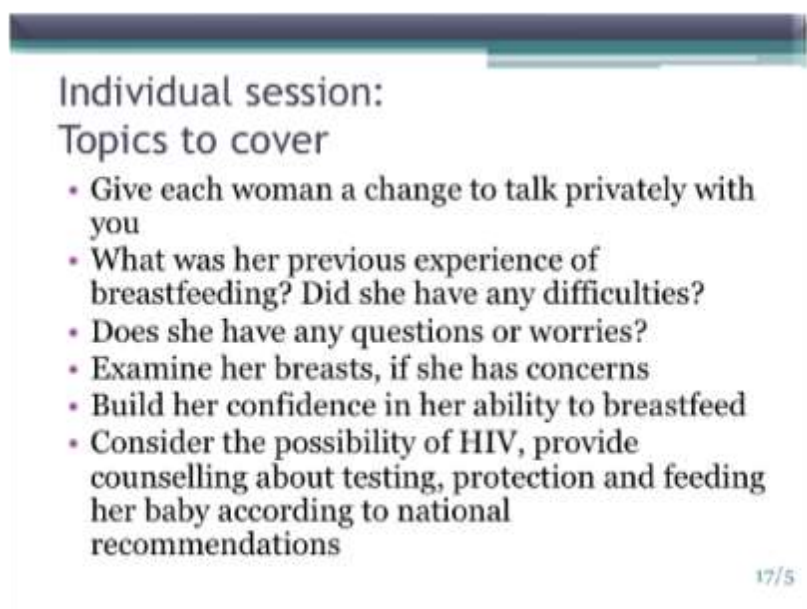
Main points to remember

- Explain the importance of breastfeeding and colostrum. Explain the mother's first milk, "colostrum", arrives before the baby is born. Women should understand 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 baby. 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 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 challenging.
- 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 she leaves the facility, she should have further information and 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

- ☐ Show **Slide 17/5 – Individual sessions with pregnant women** and make key points.



- 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 fed, explain how she can exclusively breastfeed this time. Reassure her you will help her.

Address common worries in pregnancy

- Encourage her to tell you if she has any worries or doubts about breastfeeding, and if she intends to mix feed.
- 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.
- If the national authority supports antiretroviral therapy (ART), the woman should received 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.

Ask: *Which pregnant women may need extra counselling and support on feeding their babies?*

Wait for a few replies. Use the box **SPECIAL COUNSELLING AND SUPPORT** below.

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.
- 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.

Discuss breastfeeding with a pregnant woman

Show Slide 17/6 – Antenatal counselling



- Ask: What questions could you ask to find out if a pregnant woman knows about the importance of breastfeeding or has questions about breastfeeding?

- ❑ *Wait for participants to respond, then make the following points.*
 - Start the discussion with an open question such as:
“What do you know about breastfeeding?” or “How do you plan to feed your baby?”
 - This type of open question gives an opportunity to:
 - praise the woman for her knowledge about breastfeeding or her plans to breastfeed;
 - discuss any barriers the woman may see to breastfeeding;
 - discuss problems the woman may have had with previous breastfeeding.
 - If you ask a question like, “Are you going to breastfeed your baby?” the woman may answer no. This makes it difficult to continue the discussion.
 - Use your counselling skills to continue the discussion.
 - Listen to the pregnant woman discuss her individual worries and concerns about feeding her baby. It is important the discussion be two-way, rather than a lecture.
 - If the woman’s comments tell you that she already knows much about early and exclusive breastfeeding, you can reflect and reinforce her knowledge. You do not need to give her information she already knows.
 - As we discussed earlier, these discussions are very important to help a mother build her confidence for breastfeeding.
- ❑ *Tell participants they will now complete an activity where they will practice having a discussion with a pregnant woman.*
- ❑ ***JOB AID: ANTENATAL CHECKLIST**, found at the end of this session can be used by participants as practice for the clinical practice session.*
- ❑ *This activity should take approximately 15 minutes in total. Additional time can be taken if needed.*
- ❑ *Participants will practice in groups of three. After five minutes, the participants will swap roles so they all have a turn in each role. Trainers stay with groups to see if they are managing the activity.*
- ❑ *Divide the participants into groups of three. One person plays the role of the “pregnant Woman”, one person is the “health worker”, and one person is the “observer”. The health worker listens to the pregnant woman.*
- ❑ *The health worker discusses with the pregnant woman about her feeding plan. The observer should watch and note when the health worker:*
 - uses open questions – “What do you know about breastfeeding?” or “What is your plan to feed your baby?”;
 - responds to the woman by reflecting, praising and using other counselling skills;
 - provides correct information according to her needs, in a way easy to understand;
 - offers opportunities for the pregnant woman to ask questions or discuss the information.
- ❑ *Hold a brief discussion with the participants to discuss the activity.*

Summarize the session

Time for Question and Answer

- Ask participants whether they have any questions.*
- Explain the summary of this session can be found on **pages 180–185** of the Participant's manual.*

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:

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.

Session outline

Suggested time: 90 minutes

Participants together

- One trainer
- The trainer will prepare the participants for the session
- Participants work in small groups of three or four and one trainer for the practical session in a clinic or facility
- If possible, participants can work in pairs

1) Prepare the participants (15 minutes)

2) Conduct clinical practice (75 minutes)

Preparation

- Please know where the clinical practice will be held. Visit the facility or clinic, if you have not done so before.
- Prepare for the session ahead of time. Ask all trainers who will lead groups to study the instructions.
- Make sure you are clear about how this clinical practice differs from previous clinical practices.
- Have copies of the JOB AID: ANTENATAL CHECKLIST AND COUNSELLING SKILLS CHECKLIST available for each participant.
- Have a copy of the CHECKLIST: CLINICAL PRACTICE DISCUSSION CHECKLIST for each trainer.
- Bring dolls and model breasts during the clinical practice session to demonstrate positioning and milk expression to mothers.

One trainer leads a preparatory session with all participants and trainers together.

If you are travelling to another facility for the clinical practice session, prepare together in the classroom before you leave. If necessary, this can take place on the evening or the morning before the clinical session.

Let's prepare

We will spend time today preparing for the clinical practice in an antenatal clinic. The goal is for each health worker to practice with a pregnant woman.

Explain the objectives of the exercise.

- This clinical practice session gives you an opportunity to:
 - use your counselling skills: listening and learning, building confidence and giving support;
 - ask a pregnant woman about her knowledge of infant feeding, and her previous experience with any other pregnancies;
 - discuss with a pregnant woman:
 - the importance and management of breastfeeding and colostrum
 - exclusive and continued breastfeeding
 - the risks of giving formula and other breast-milk substitutes
 - the importance of immediate and sustained skin-to-skin contact, early initiation of breastfeeding, and rooming-in
 - the basics of good positioning and attachment (this should be demonstrated with a doll)
 - how to recognize baby's feeding cues.

*Please have participants bring: one copy of the **JOB AID: ANTENATAL CHECKLIST**, one copy of the **CHECKLIST: COUNSELLING SKILLS**, pencil and paper to make notes.*

- Doll and model breast for teaching mothers (for each group or pair of participants).
- Please leave handbags or books in the classroom.

Explain to participants.

- Each group will have three to four participants with a trainer. Each trainer will observe their group and give feedback. Each participant will talk with a pregnant woman, while the other group members will observe.
- Each participant should have a conversation with at least one pregnant woman.
- Observers should stand quietly in the background. Try to be as still and quiet as possible.
- Use the **CHECKLIST: COUNSELLING SKILLS** while you are observing the interaction between the mother and the participant.

Remind the participants of the following when they are with a pregnant woman.

- 1) Introduce themselves to the mother and ask permission to talk to her.
- 2) Introduce the group and explain that you are interested in how she will feed her baby.

- 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 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?”
 - 5) Ask her what she has been shown about positioning and attaching her baby at the breast. Then ask if she would like you to show her with your doll and offer her to try herself.
 - 6) Practise using counselling skills: listening and learning, building confidence and giving support.
- **NOTE:** If the woman has knowledge 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 says 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 her intention to mixed feed, 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 discussion.
 - If you are observing the discussion, try to be as quiet as possible.

Please review the trainer's notes before the clinical session. Participants do not need to read these notes.

- Please take your group to the assigned clinic or health facility.
- For each trainer: Make sure your group has the **JOB AID: ANTENATAL CHECKLIST** (if you plan to use this) and the **CHECKLIST: COUNSELLING SKILLS**.
- Introduce yourself and your group to the staff member in charge. Ask which pregnant women to talk with and where they are.
- Help each group to find a pregnant woman with whom to work.
- Debrief with the participants.

When a group is finished talking to the woman, move to a private area. Review how the discussion went with the pregnant woman. Ask them:

- Which counselling skills did you observe?
- Was the information provided accurate and simple?

Ask questions about the mother:

- How does she feel about breastfeeding?
- What was her previous knowledge on breastfeeding and infant feeding?
- Does she have any concerns? If so, how would you suggest helping her and addressing her concerns?

- Review the **CLINICAL PRACTICE DISCUSSION CHECKLIST** to help you to conduct the discussion.
- Review the **JOB AID: ANTENATAL CHECKLIST** to see which tasks participants completed.
- Discuss what they learned about the pregnant woman.
- At the end of the clinical practice session, ask participants whether they have any questions.
- Explain that the summary of this session can be found on **pages 187–191** of the *Participant's manual*.

CHECKLIST: CLINICAL PRACTICE DISCUSSION

Practical skills are best developed by:

- 1) Introducing and demonstrating the skills
- 2) Observing participants as they practise the skills
- 3) Giving feedback to participants on how well they performed.

Feedback should include:

- 1) Praising participants for things done well
- 2) Giving gentle suggestions for how to overcome difficulties.

Use the checklist below to help guide your feedback discussions

Questions to ask each counsellor

To the counsellor:

- What did you do well?
- What difficulties did you have?
- What would you do differently in the future?

To the observer:

- What did the counsellor do well?
- What difficulties did you observe?

Listening and learning skills

- Which listening and learning skills did you use?
- Was the mother willing to talk?
- Did the mother ask any questions? How did you respond?
- Did you empathize with the mother? Give an example.

Skills for building confidence and giving support

- Which confidence and support skills were used?

(Check especially skills to praise and for two relevant suggestions)

- Which skills were most difficult to use?
- What was the mother's response to your suggestions?

General questions to ask at the end of each practical session

- What special difficulties or situations helped you to learn?
- What was the most interesting thing that you learned from this practical session?

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:

Session 19. Discharge care

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.

Session outline

Suggested time: 90 minutes

- 1) Introduce the session, present Slide 19/2
- 2) Present and discuss slides 19/1–19/5
- 3) Summarize the session
- 4) Time for Question and Answer

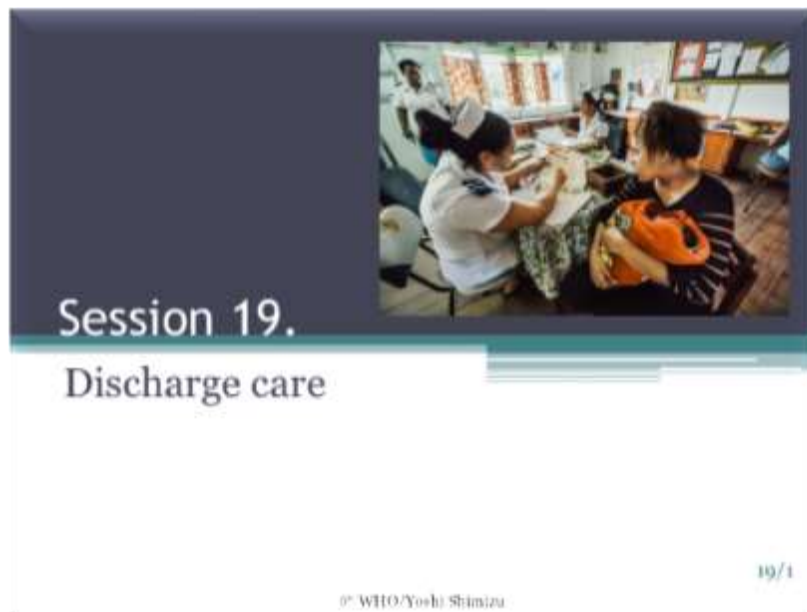
Preparation

- Review the Introduction for guidance on giving a presentation with slides
- Study the slides 19/2–19/5, so you are familiar with each slide and the teaching points
- Provide a list of local community resources which provide support for breastfeeding

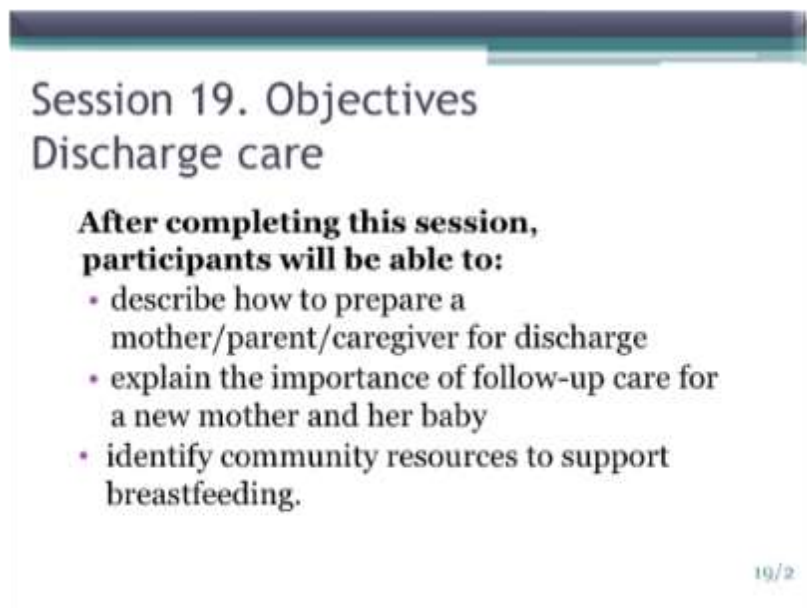
References

- Community based strategies for breastfeeding promotion and support in developing countries. WHO, Department of Child and Adolescent Health and Development; 2003
- (http://www.who.int/maternal_child_adolescent/documents/9241591218/en/, accessed 19 March 2020).

Introduce the session



- Show **Slide 19/2 – Objectives** and read key points aloud.



- *Make these points.*

- All mothers need help and support to breastfeed after they are discharged. Research shows that the more support and help 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. This may be because difficulties arise in the first weeks and months, and if they have no help 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.

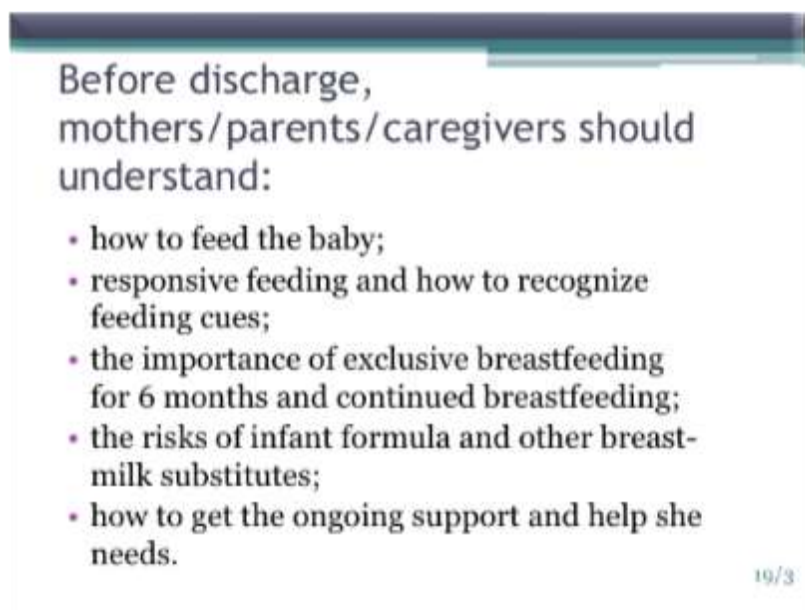
- Mothers/parents/caregivers need preparation for feeding and caring for their newborns prior to being discharged from a facility. After discharge, they need ongoing help and support to continue breastfeeding.

Discharge preparation

- ☐ Ask: *Before discharge, how can you help a mother prepare before her return home?*

Wait for a few responses.

- ☐ Show **Slide 19/3** – Before a mother is discharged.



- ☐ *Make these points.*

- Prior to discharge, a health worker skilled in breastfeeding support should observe every mother and baby during breastfeeding and help them if they have a problem. This should ensure that they know how to breastfeed.
- If a mother is artificially feeding her baby, she also needs to know how to feed the 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 one to two:** 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 to 4:** The appearance of the milk changes and 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 the 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 that 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.

☐ Show Slide 19/4 – **Breastfeeding is going well** and discuss together.

Breastfeeding is going well if:

- your baby is breastfeeding at least 6-8 times in 24 hours;
- your baby has at least 2-6 good wet diapers every 24 hours;
- your baby has at least 2-4 tablespoon-sized bowel movements every 24 hours;
- you can hear your baby swallowing at feeds;
- your breasts feel softer after a feeding;
- your nipples are not painful;
- breastfeeding is an enjoyable experience.

Remember: If you go home from the health facility in 72 hours or less, your baby should be seen by health worker in 2-3 days and again at 10 days to 2 weeks of again.

Lanones J, Swisher A. Counseling the Nursing Mother: Counseling the nursing mother 6th Ed. Sudbury (MA): Jones & Bartlett; 2010: 293.

19/4

☐ Show Slide 19/5 – **Warnings** and discuss together.

Warning signs:
Please see the health worker

- The baby is having fewer than 4 good wet diapers a day by day 4 after birth.
- The baby is having fewer than 3 stools (at least 1 tablespoon) by the 4th day of age or is still having black stool by day 5.
- The baby is breastfeeding fewer than 8 times a day.
- The mother's breast milk is in, but she doesn't hear her baby swallowing frequently during breastfeeding.
- Her nipples are painful throughout breastfeeding.
- Her baby seems to be breastfeeding "all the time" or consistently falls asleep within a minute or two at the breast.
- The mother doesn't feel as if her milk has come in by day 5.

Lanones J, Swisher A. Counseling the nursing mother 6th Ed. Sudbury (MA): Jones & Bartlett; 2010: 295.

19/5

Follow-up care

- Ask participants: Why is it important for new mothers to have follow-up care after they are discharged?*

Wait for two or three responses. Then make the following points:

- Mothers and babies are in a health facility often for a very short time.
- A mother cannot remember everything she has been taught during her stay. Breastfeeding help and support are especially important in the early days and weeks after discharge. This can help address any early breastfeeding challenges which 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.

- Ask: How do you refer new mothers for follow-up care in your community?*

Wait for a few responses.

- Praise participants who work in facilities that refer mothers for follow-up after birth.*

☐ Show Slide 19/6 – Follow-up care and make the key points.



- When a new mother is discharged, she should have a scheduled follow-up appointment 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 contacts 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.

Identifying 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 that 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 from the beginning is a part of caring for themselves and their baby.
- Ask: *What types of community resources are available in your community for breastfeeding?*
- Make a list similar to the one in the slide. Share any other important resources in your local community for breastfeeding support with the group.*

- Show **Slide 19/7 – Community resources** and make key points.



- Ask: *What can health workers do to provide support to mothers once they return home?*

Allow participants to make some suggestions, then continue with the following points.

- 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 woman 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, the health worker 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 can provide breastfeeding support to new mothers.
- Health workers can identify existing groups to work with or encourage women to form groups in their community.
- Phone lines can also be useful and can be used to provide mothers with information or answer their questions or concerns.

Note: The BFHI program managers and staff must make themselves aware of all the possible sources for follow-up contacts for mothers in the local community and develop collaborative arrangements with them. Then they can arrange to refer new mothers to the appropriate Primary Health Care centre or community group for follow up contacts after discharge from hospital. It is also helpful if there is a reciprocal arrangement for referring mothers in the community who have problems that need referral back to a health facility.

Summarize the session

Time for Question and Answer

- Ask participants whether they have any questions.
- Explain the summary of this session can be found on **pages 193–197** of the Participant's manual.

Further information

MOTHER TO MOTHER SUPPORT / BREASTFEEDING SUPPORT GROUPS

- These support groups can provide an important source of contact for pregnant women and mothers. They can be a source of support that builds mothers' confidence about breastfeeding and reduces their worries. They can give a mother the extra help she needs, from women like herself, that health services can often not provide.
- This help can be available in a mother's own community. Women's traditional patterns of getting information and support from relatives and friends are reinforced.
- Who can start a group? A health worker, an existing women's group, a group of mothers who feel breastfeeding is important, or by mothers who meet in the antenatal clinic or maternity facility and want to continue to meet and help each other.
- A group of breastfeeding mothers can meet together every one to four weeks, often in one of their homes or somewhere in the community. They have a topic to discuss, such as "The advantages of breastfeeding" or "Overcoming difficulties."
- They share experiences and help each other with practical ideas about how to overcome difficulties. Mothers can also help each other at other times, not only at meetings. Mothers can help each other outside of group meetings and build friendships.

Some mother-to-mother and breastfeeding support groups are part of larger networks to provide training, written materials and other services. Discussion groups led by experienced mothers offer help.

Notes

A series of horizontal dotted lines for taking notes, spanning the width of the page.

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.

Session outline

Suggested time: 45 minutes

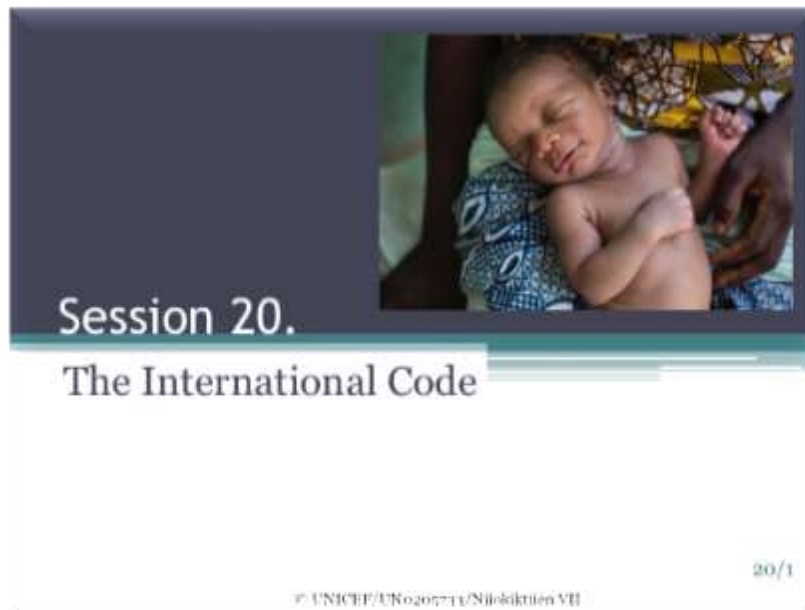
- Participants
- One trainer (lecture presentation)
- Working group for activity

- 1) Introduce the session, present **Slide 20/2**
- 2) Discuss how manufacturers promote breast-milk substitutes
- 3) Describe the International Code of Marketing of Breast-milk Substitutes (**Slide 20/3**)
- 4) Group discussion
- 5) Summarize the session
- 6) Time for Question and Answer

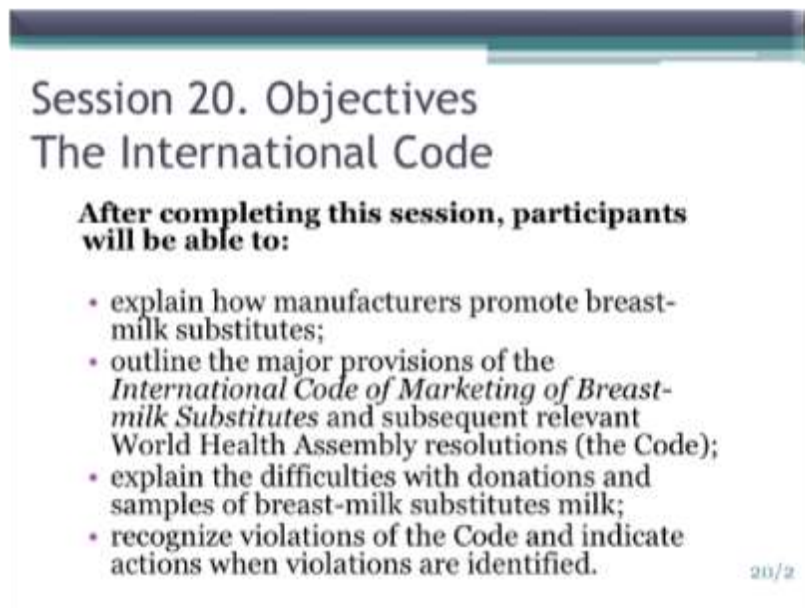
Preparation

- Refer to the Introduction for guidance on giving a presentation with slides
- Prepare **Slides 20/1–20/3**
- Research national laws, regulations and monitoring systems related to marketing of breast-milk substitutes
- If possible, gather some examples of promotional materials from manufacturers of breast-milk substitutes.
- You will need a flipchart and marker. Prepare two flipcharts with the titles: **PROMOTION TO PREGNANT WOMEN AND MOTHERS** and **PROMOTION THROUGH HEALTH SERVICES**.
- Review the Introduction for guidance on giving a presentation with slides
- Study the **Slides 19/2–19/5**, so you are familiar with each slide and the teaching points
- Provide a list of local community resources which provide support for breastfeeding

Introduce the session



- Show **Slide 20/2 – Objectives** and make the key points aloud.



- 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.

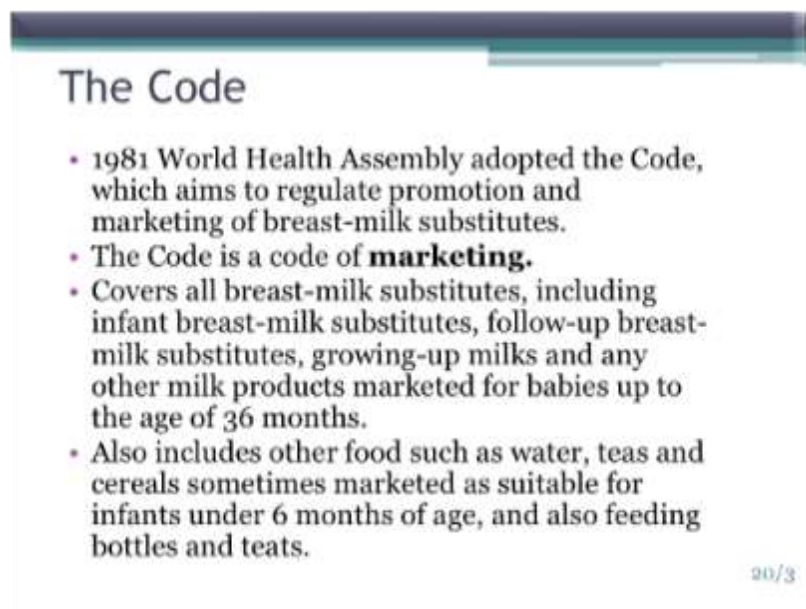
Discuss how manufacturers promote breast-milk substitutes

- Allocate 15 minutes for this activity, including five minutes for the group activity and 10 minutes for the discussion afterwards.
- Post two flipcharts on the wall: One with the heading **PROMOTION TO PREGNANT WOMEN AND MOTHERS** and the other **PROMOTION THROUGH HEALTH SERVICES**.
- Divide participants into two groups. Ask participants to keep their Participant's manual closed. Assign each group one of the following questions.
 - In what ways do manufacturers and distributors promote breast-milk substitutes to pregnant women and mothers?
 - In what ways do manufacturers and distributors use health workers and health facilities to promote breast-milk substitutes?
- Ask the groups to think of as many points as they can and write them on their flipchart. Add any missing points on the flipchart summaries, **PROMOTION TO PREGNANT WOMEN AND MOTHERS** and the other **PROMOTION THROUGH HEALTH SERVICES**.
- The list of **PROMOTION TO PREGNANT WOMEN AND MOTHERS** should include most of the following.
 - 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, the internet, magazines, radio, television, social media groups, SMS (text) messages, and videos.
- The list of **PROMOTION THROUGH HEALTH SERVICES** should include most of the following.
 - 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 it. 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 provide free lunches for medical, nutrition, or midwifery schools.
 - They fund and sponsor health services in many other ways and give grants.
- If you have any examples of promotional material from manufacturers of breast-milk substitutes, show them to the participants at the end of the session or during the next break.
- If time permits, discuss ways breast-milk substitutes are promoted, advertised, or marketed locally.

Describe the International Code of Marketing of Breast-milk Substitutes and relevant WHA resolutions

- Show **Slide 20/3 – The International Code of Marketing of Breast-milk Substitutes** and make the key points.



- In 1981, the World Health Assembly (WHA) adopted *The International Code of Marketing of Breast-milk Substitutes*⁴⁴, which aims to regulate the promotion and marketing of breast-milk substitutes. This Code (shorter form) is a minimum requirement to protect infant feeding.
- Subsequent World Health Assembly resolutions (about every two years) are also agreed and have the same status as the original Code.
- 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 without aggressive marketing that undermines the importance of breastfeeding, 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

⁴⁴ International code of marketing of breast-milk substitutes. Geneva: World Health Organization; 1981 (http://www.who.int/nutrition/publications/code_english.pdf, accessed 19 March 2020).

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.

- Ask participants to turn to **page 202** of the *Participant's manual* and find the box **SUMMARY OF THE MAIN POINTS OF THE INTERNATIONAL CODE OF MARKETING OF BREAST-MILK SUBSTITUTES**.
- Ask participants to take turns to read out the points.
- Ask participants to say whether they have ever observed the Code being broken in these ways.

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.

- Continue with the following points.
 - If breast-milk 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*⁴⁵. The World Health Assembly urged all countries to implement the guidance. This guidance document helps to further clarify some specific aspects of the Code. Key points in this guidance are as below.
 - It clarifies that the Code applies to all breast-milk substitutes, which includes all milk products that are specifically marketed for feeding infants and young children up to the age of three years (including follow-up formula and growing-up milks). 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 donations 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.

⁴⁵ 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 19 March 2020).

- 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.

Discussion: The role of health workers in monitoring the Code

- Participants will now have a group discussion about the role of health workers in the monitoring of the Code in health facilities. There are two short case studies with questions to answer as a group. Ask a participant to volunteer to read the case aloud. Then ask the question to the group.

CASE 1

- A company representative from a foreign breast-milk substitute company visits the nurses at a maternity facility. He is promoting the use of a new, improved ready-to-feed infant formula. He says his product is especially useful for malnourished babies. He offers to provide enough so every mother may be given a dozen (12) bottles. He also leaves several information pamphlets to provide to mothers, as well as pens with the company logo for the nursing staff.

Ask: How should the staff respond?

Write responses on the blackboard or flipchart at the front of the room where participants can see.

Key points include.

- Staff should refuse the donation as well as the pens.
- The pamphlets should not be provided to mothers.
- One dozen bottles would only feed a baby for a short time. What would happen after the bottles were used up?

CASE 2

- Maria runs a private maternity facility. Her friend works for a breast-milk substitute company and offers to sponsor the facility in several ways:
 - supplying equipment with the company logo
 - providing education sessions on breast-milk substitutes for new mothers
 - donating supplies of breast-milk substitutes and bottles to Maria's facility
 - funding research for the facility.

What can Maria say to her friend?

Write responses on the blackboard or flipchart.

Key points include.

- Maria can explain to her friend that breastfeeding is important for the health of the babies and mothers.
- Donations of breast-milk substitutes and bottles undermine the importance of breastfeeding.
- Maria is unable to accept the offers of equipment, supplies, and funding.
- Mothers in the facility receive factual and scientific education from health workers. Receiving education from a breast-milk substitute company would be biased.

Summarize the session

Time for Question and Answer

- Ask participants whether they have any questions.*
- Explain the summary of this session can be found on **pages 199–202** of the Participant's manual.*

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

Session outline

Suggested time: 45 minutes

- 1) Introduce the session, present **Slide 21/2**
- 2) Present **Slides 21/1–21/32**
- 3) Summarize the session
- 4) Time for Question and Answer


Preparation

- Refer to the Introduction for guidance on giving a presentation with slides.
- Study the **Slides 21/1–21/32**, so you are familiar with what each slide shows and the particular points to teach from them.
- Optional activities are included in this session which require additional time. The needs of the group of participants will help you decide whether to include the activity.
- Optional activities include:
 - Assessing a Policy
 - Improving and changing practices.
- For the optional activity **IMPROVING AND CHANGING PRACTICES**, make available spare copies of the **ASSESSING AND CHANGING PRACTICES FORM** where groups and individuals can write their conclusions. Have one copy for each participant and each trainer. Copies are available in the Director's guide.
- Display a copy of the national or local health facility's infant feeding policy.

References

- Hernández-Aguilar M, Bartick M, Schreck P, Harrel C, Academy of Breastfeeding Medicine. ABM Clinical Protocol #7: model maternity policy supportive of breastfeeding. *Breastfeed Med.* 2018;13:559–74. doi: 10.1089/bfm.2018.29110.mha.

Introduce the session



Session 21.

Facility practices:
Implementing the Ten
Steps

21/1

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Show **Slide 21/2 - Objectives** and read aloud.

Session 21. Objectives

Facility practices: Implementing the
Ten Steps

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.**

21/2

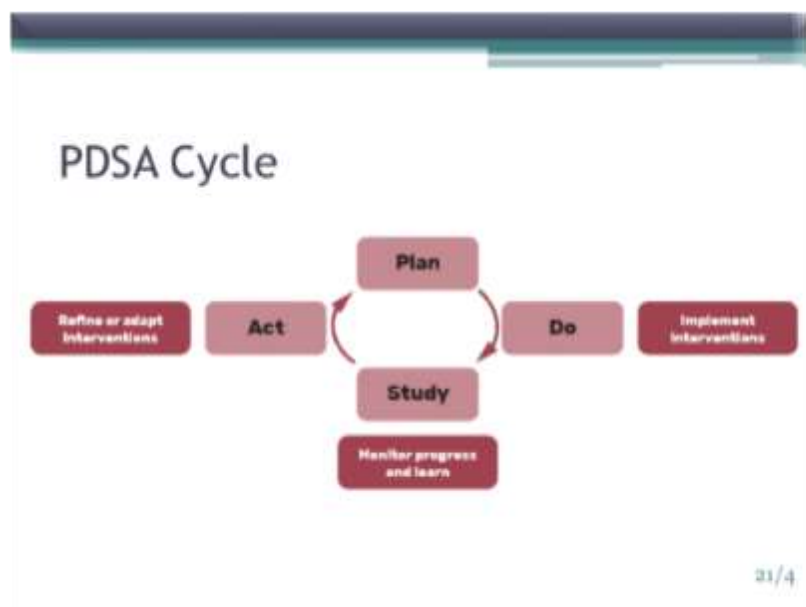
Describe quality improvement as part of the Ten Steps

- Show Slides 21/3–21/4 – Quality-improvement process, PDSA cycle.

Quality-improvement process

- The triad of planning, improvement and control is central to the approach
- Active participation of the main service providers or front-line implementers
- Engagement of leadership personnel
- Measurement and analysis of progress over time
- External evaluation or assessment

21/3



- Ask participants: *How does quality improvement relate to the Ten Steps?*

Wait for two or three responses, then make the following points.

- Quality improvement is a systematic process of improving the 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.
 - 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. It 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 practised over time. One way to monitor health worker performance is through mentorship programmes, and day-to-day supportive supervision.
- Ask participants if they are aware of any quality improvement practices or committees in the facilities where they work.
- If known, discuss a local or national monitoring and data management system. Outline for participants how the system monitors the key clinical practices of the Ten Steps.

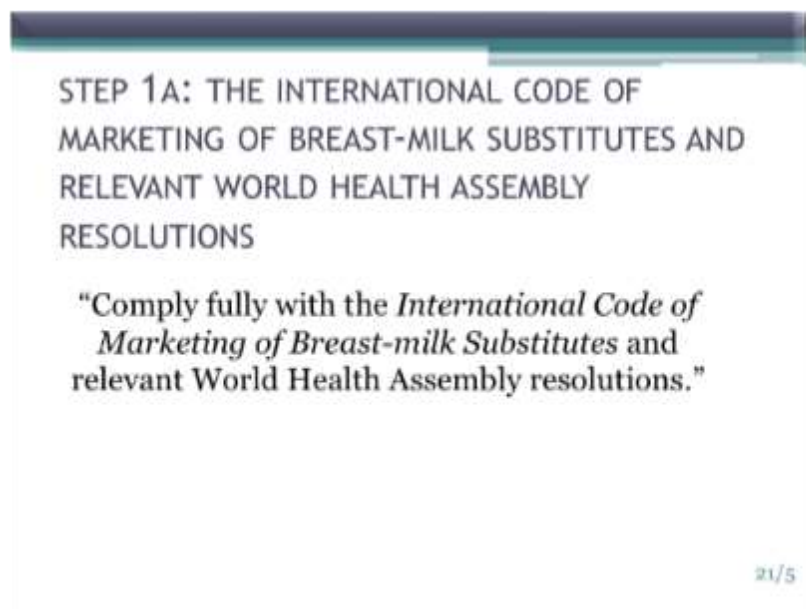
Explain the importance of an infant feeding policy

- 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 health workers understand the infant feeding or breastfeeding policy of their facility. They should also understand how they are responsible for implementing the policy.
- If time permits, have a brief discussion with an example of a breastfeeding or infant feeding policy.
- NOTE:** At the end of this session, there are two *OPTIONAL* activities on assessing a policy. Time is not allocated for this activity.

Outline the 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.
- We will now go through each of the Ten Steps to summarize how they are put into practice into a facility.
- The following slides illustrate the TEN STEPS TO SUCCESSFUL BREASTFEEDING.
- The first two steps include critical management procedures. The following eight steps are key clinical practices.
- Following each step, we will discuss the global standards related to the specific step.

Show **Slides 21/5–21/7 – Step 1A**. Ask a participant to read aloud and then discuss the global standards.



Global standards: Step 1A

- All infant formula, feeding bottles and teats used in the facility have been purchased through normal procurement channels and not received through free or subsidized supplies.
- The facility has no display of products covered under the Code or items with logos of companies that produce breast-milk substitutes, feeding bottles and teats, or names of products covered under the Code.

21/6

Global standards: Step 1A

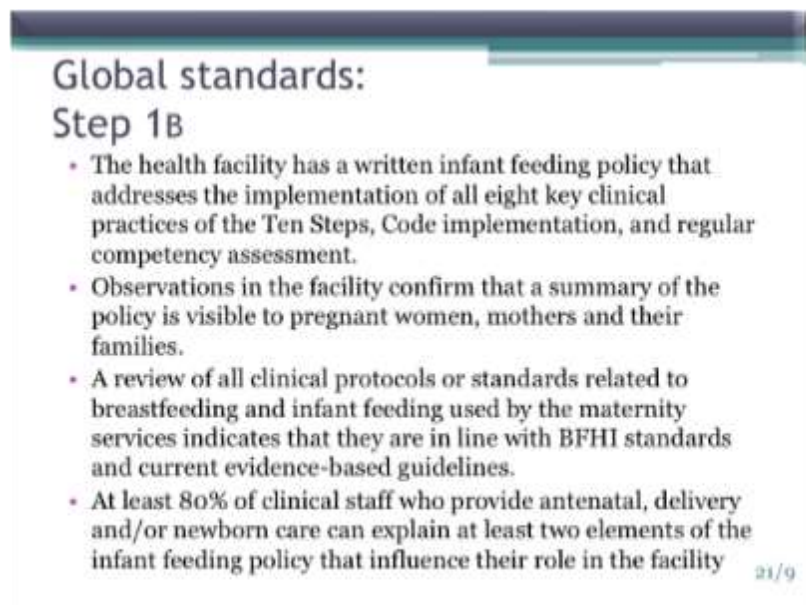
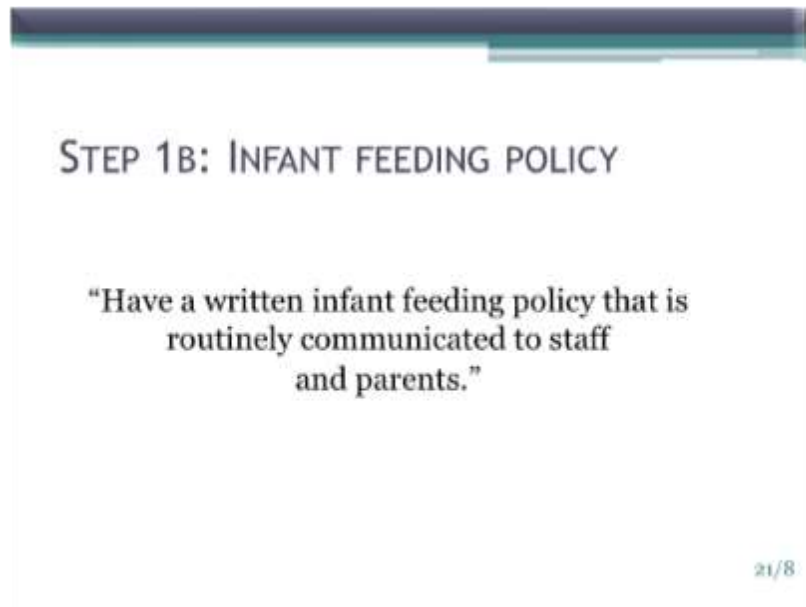
- The facility has a policy that describes how it abides by the Code, including procurement of breast-milk substitutes, not accepting support or gifts from producers or distributors of products covered by the Code and not giving samples of breast-milk substitutes, feeding bottles or teats to mothers.
- At least 80% of health professionals who provide antenatal, delivery and/or newborn care can explain at least two elements of the Code.

21/7

- Remember we discussed the Code in detail in the previous session.
- Promotion of breast-milk substitutes, bottles and teats undermines 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 promotional effects of breast-milk substitutes, bottles and teats. One essential way to protect breastfeeding is to regulate the marketing of breast-milk substitutes, both nationally and internationally.
- 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 that 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.

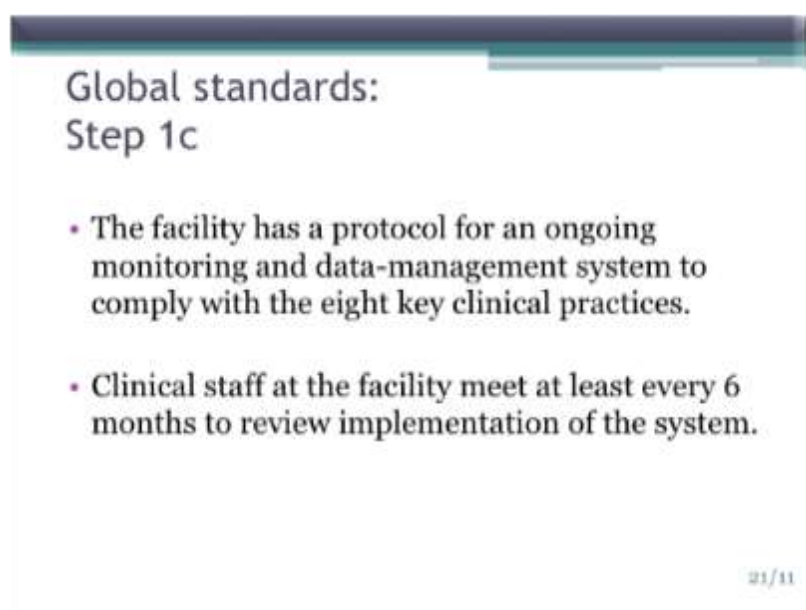
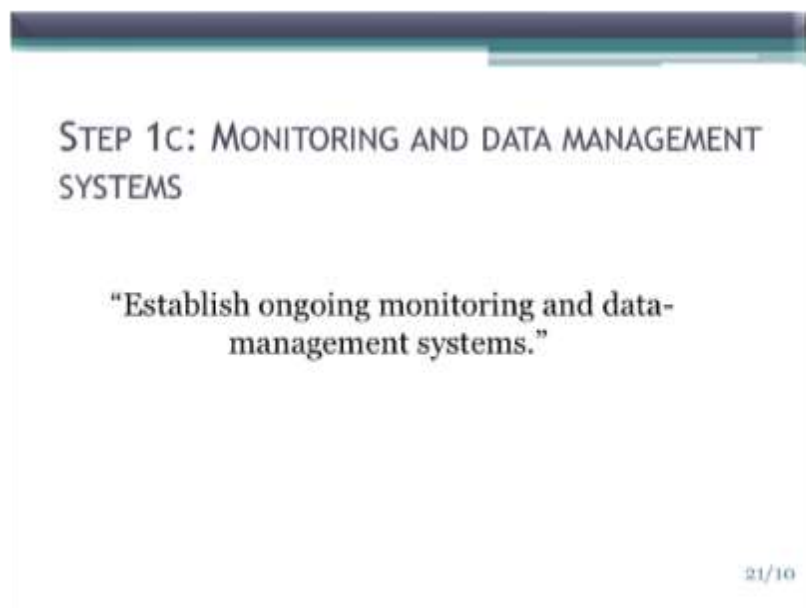
Show **Slides 21/8–21/9 – Step 1B**. Ask a participant to read aloud, and then discuss the global standards.



- 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.

Ask if participants have any questions on infant feeding policies.

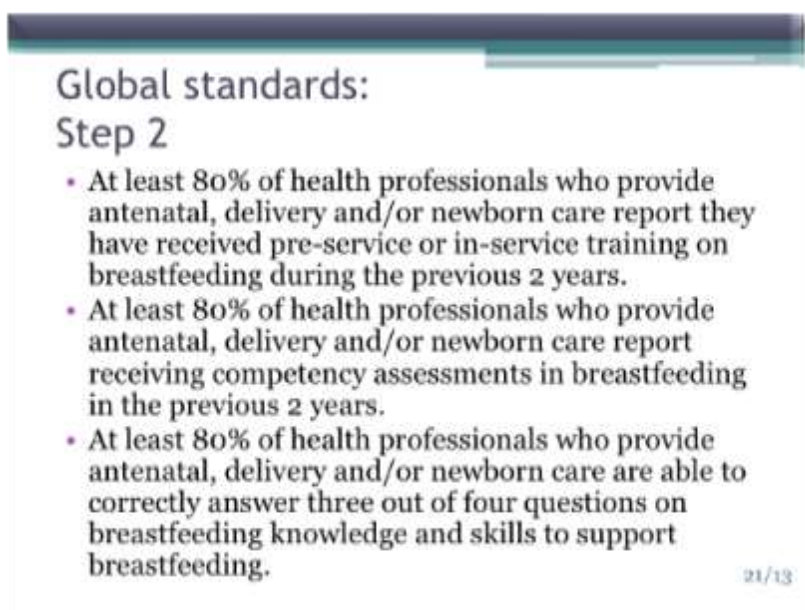
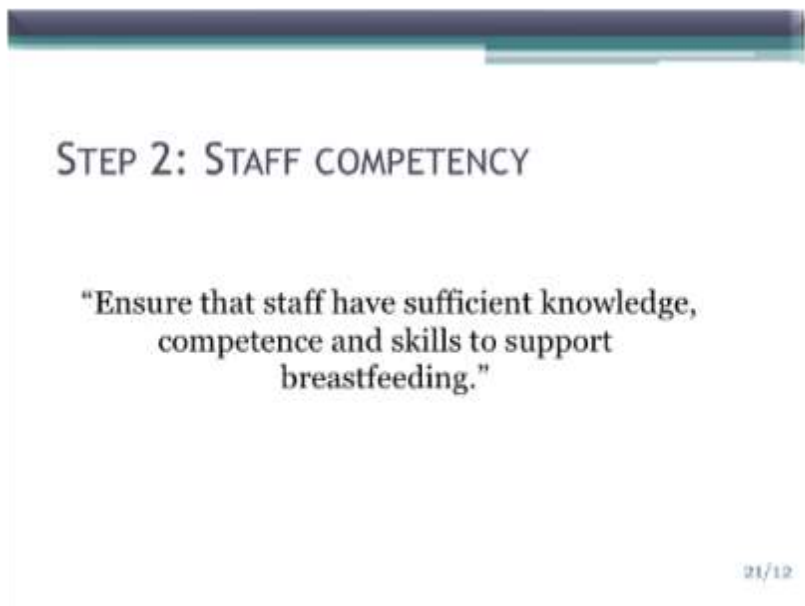
- ❑ Show **Slides 21/10–21/11 – Step 1c**. Ask a participant to read aloud, and then discuss the global standards.



- 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. This can help to assess the standards of care, and whether the Ten Steps are being practised.
- 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 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 a period of time.

- Show **Slides 21/12–21/13 – Step 2**. Ask a participant to read aloud and then discuss the global standards together.



- 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 practice.

- Show **Slides 21/14–21/16 – Step 3**. Ask a participant to read aloud and then discuss the global standards together.

STEP 3: ANTENATAL INFORMATION

“Discuss the importance and management of breastfeeding with pregnant women and their families.”

21/14

Global standards: Step 3

- **A protocol for antenatal discussion of breastfeeding includes at a minimum:**
 - the importance of breastfeeding;
 - global recommendations on exclusive breastfeeding for the first 6 months, the risks of giving formula or other breast-milk substitutes, and the fact that breastfeeding continues to be important after 6 months when other foods are given;
 - the importance of immediate and sustained skin-to-skin contact;
 - the importance of early initiation of breastfeeding;
 - the importance of rooming-in;
 - the basics of good positioning and attachment;
 - recognition of feeding cues.

21/15

Global standards: Step 3

- At least 80% of mothers who received prenatal care at the facility report having received prenatal counselling on breastfeeding.
- At least 80% of mothers who received prenatal care at the facility are able to adequately describe what was discussed about two of the topics mentioned above.

21/16

- All mothers 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 to discuss with mothers individually. All pregnant women and their families should be informed 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.

- Show **Slides 21/17–21/18 – Step 4**. Ask a participant to read aloud and then discuss the global standards together.

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.”

21/17

Global standards:
Step 4

- At least 80% of mothers of term infants report that their babies were placed in skin-to-skin contact with them immediately or within 5 minutes after birth and that this contact lasted 1 hour or more, unless there were documented medically justifiable reasons for delayed or interrupted contact.
- At least 80% of mothers of term infants report that their babies were put to the breast within 1 hour after birth, unless there were documented medically justifiable reasons not to do so.

21/18

- All mothers and their infants should be placed in skin-to-skin contact immediately, or within five minutes after birth. It 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.
- Ask: *Why is it important to help mothers and babies to have immediate contact?*
Wait for a few replies.
 - Skin-to-skin contact helps:

- to keep the baby warm, and stabilize the baby's breathing and heart rate
- breastfeeding to get started
- the mother and baby to get to know each other and to bond
- the baby to be colonised with the mothers' skin and gut bacteria to help prevent infection.

☐ Show **Slides 21/19–21/21 – Step 5**. Ask a participant to read aloud and then discuss the global standards together.

STEP 5: SUPPORT WITH BREASTFEEDING

“Support mothers to initiate and maintain breastfeeding and manage common difficulties.”

21/19

Global standards:

Step 5

- At least 80% of breastfeeding mothers of term infants report that someone on the staff offered assistance with breastfeeding within 6 hours after birth.
- At least 80% of mothers of preterm or sick infants report having been helped to express milk within 1–2 hours after birth.
- At least 80% of breastfeeding mothers of term infants are able to demonstrate how to position their baby for breastfeeding and that the baby can suckle and transfer milk.

21/20

Global Standards:

Step 5

- At least 80% of breastfeeding mothers of term infants can describe at least two ways to facilitate milk production for their infants.
- At least 80% of breastfeeding mothers of term infants can describe at least two indicators of whether a breastfed baby consumes adequate milk.
- At least 80% of mothers of breastfed preterm and term infants can correctly demonstrate or describe how to express breast milk.

21/21

- *Remind participants of the knowledge and skills they have learned on assessing a breastfeed, helping the mother to position the baby, and giving her praise and relevant information.*
 - Keep a baby with their mother and let them breastfeed when they show that they are ready. Help the mother to recognize feeding cues that show the baby is ready to breastfeed.
 - 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 her baby.
 - 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 an ill or low-birth-weight baby or one who needs special care has to be separated from their mother. While they are separated, a mother needs a lot of help and support.

- ☐ Show **Slides 21/22–21/24 – Step 6**. Ask a participant to read aloud and discuss the global standards together.

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

Global standards:

Step 6

- At least 80% of term breastfed babies who received supplemental feeds have a documented medical indication for supplementation in their medical record.
- At least 80% of preterm babies and other vulnerable newborns that cannot be fed their mother's own milk are fed with donor human milk.
- At least 80% of mothers with babies in special care report that they have been offered help to start lactogenesis II (beginning plentiful milk secretion) and to keep up the supply, within 1–2 hours after their babies' births.

21/24

- Ask: *Why is it important to give newborn babies only breast milk?*

Wait for a few replies.

- 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.

- Show **Slides 21/25–21/26 – Step 7**. Ask a participant to read aloud and discuss the global standards together.

STEP 7: ROOMING-IN

“Enable mothers and their infants to remain together and to practise rooming-in 24 hours a day.”

21/25

Global standards:

Step 7

- At least 80% of mothers of term infants report that their babies stayed with them since birth, without separation lasting for more than 1 hour.
- Observations in the postpartum wards and well-baby observation areas confirm that at least 80% of mothers and babies are together or, if not, have medically justifiable reasons for being separated.
- At least 80% of mothers of preterm infants confirm that they were encouraged to stay close to their infants, day and night.

21/26

- Mothers and their infants should remain together day and night.
- Mothers of low-birth-weight, preterm and sick babies are encouraged to stay near their babies. Facilities may need to make accommodations for this.

Ask: *What are the advantages of rooming-in?*

Wait for a few replies and then continue.

- Rooming-in has several advantages some of which are listed below.
 - It enables a mother to practise responsive feeding. She can learn to respond to her baby's feeding cues and feed them whenever they want. This means there is no restriction on the length or frequency of feeds. This also helps both bonding and breastfeeding.
 - Babies cry less, so there is less temptation to give bottle feeds.
 - Baby becomes colonized by mother's safe bacteria, which helps to protect against dangerous ones.
 - Breastfeeding continues longer after the mother leaves hospital.

- ☐ Show **Slides 21/27–21/28 – Step 8**. Ask a participant to read aloud and discuss the global standards together.

STEP 8: RESPONSIVE FEEDING

“Support mothers to recognize and respond to their infants’ cues for feeding.”

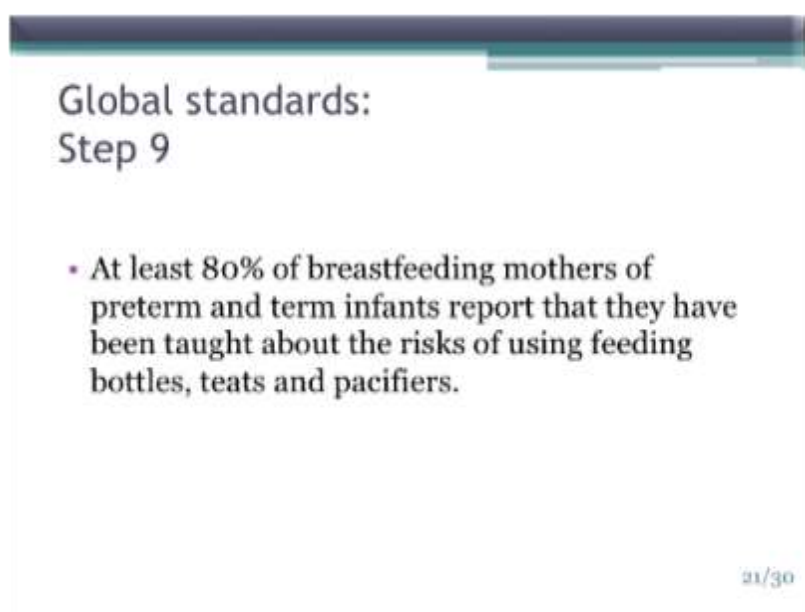
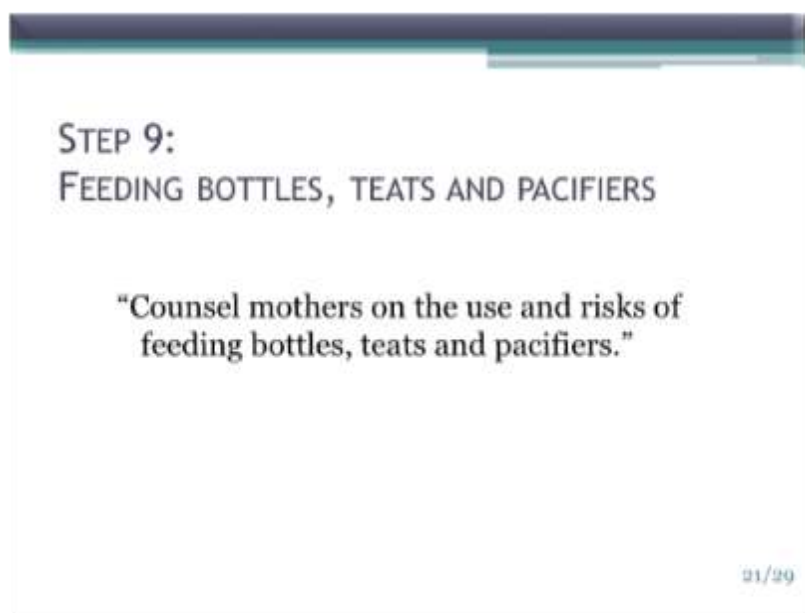
21/27

Global standards: Step 8

- At least 80% of breastfeeding mothers of term infants can describe at least two feeding cues.
- At least 80% of breastfeeding mothers of term infants report that they have been advised to feed their babies as often and for as long as the infant wants.

21/28

- Show **Slides 21/29–21/30 – Step 9**. Ask a participant to read aloud and discuss the global standards together.



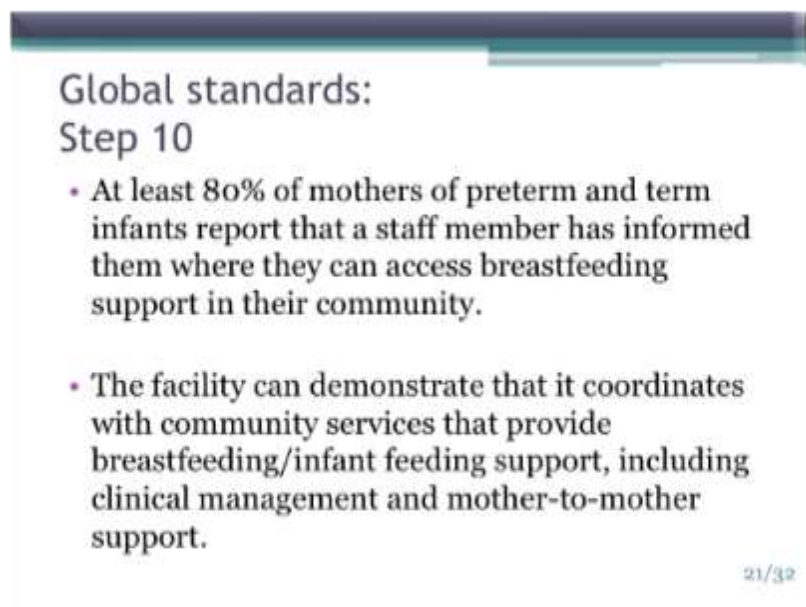
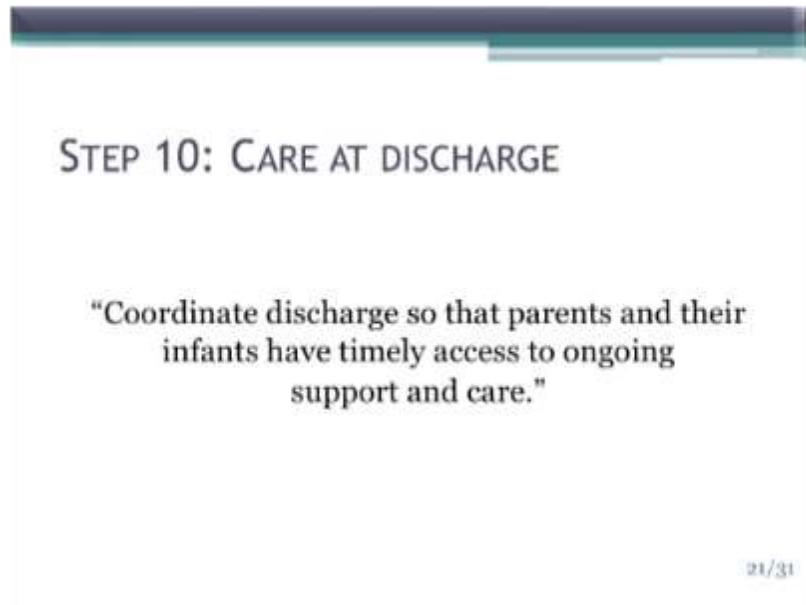
- Ask: *Why is it important to counsel mothers on the use and risks of feeding bottles, teats and pacifiers?*

Wait for a few replies.

- The use of feeding bottles, teats and pacifiers can:
 - increase ear infections and dental problems
 - interfere with the pre-term 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.

☐ Show **Slides 21/31–21/32 – Step 10**. Ask a participant to read aloud and discuss the global standards together.



- Mothers/parents/caregivers need ongoing support and help to continue breastfeeding once they leave a facility. This is especially important in the days and weeks following discharge. This will help mothers to overcome any early breastfeeding challenges.

- The need for support and where to find it 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 are encouraged to understand what kind of resources are available in the community.
- Before being discharged, mothers and babies should be referred for at least two follow-up contacts 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.

Make the point.

- This summarizes how the Ten Steps are practised in facilities providing maternity and newborn services. It is important that 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.

Summarize the session

Time for Question and Answer

- Ask participants whether they have any questions.
- Explain the summary of this session can be found on **pages 204–222** of the Participant's manual.

Further information

Infant feeding policy

There may be an existing infant feeding policy which needs to be reviewed. Often there is no policy and one needs to be developed.

This is usually the responsibility of senior people from relevant departments. All need to agree to the policy before it can be implemented. This requires that they meet and discuss it.

The policy needs to use words which are understood easily. The statements should be measurable. For example, if a policy says, “staff will do everything possible to assist breastfeeding,” how could this be monitored?

Internal monitoring and data management systems

To monitor practices, you need to collect and record information. **Information should be measurable.** For example, it is not useful to monitor whether educational pamphlets were provided to new mothers. It is better to measure the number of babies and mothers who have skin-to-skin contact soon after birth.

Two important indicators for monitoring are: early initiation of breastfeeding and exclusive breastfeeding. These should be monitored throughout the stay of a mother and her newborn in a facility.

Data can be collected in several ways in facilities. Some examples are below.

- **Client satisfaction surveys or exit interviews.** These can be routinely conducted.
- **Reports based on clinical records or perception of clinical practices and facility policies.** The reports can be used to document the percentage of babies receiving the recommended care. They can also show the percentage of facilities that are meeting the key clinical practices of the Ten Steps.

SMALL GROUP ACTIVITY

- If the course is in a hospital, review the policy of the hospital. If the course is elsewhere, review one of the sample breastfeeding policies in the Appendix. Evaluate whether the policy addresses all Ten Steps to Successful Breastfeeding.*
- There are two sample policies provided. The group can also be divided into two smaller groups and one policy can be provided to each group to assess.*
- Use the "Hospital Infant Feeding Policy Checklist," which is provided at the end of this activity. Mark any changes that could be suggested to make the policy more supportive.*
- Divide the group into small groups. Each group should look at two to three of the headings in the Policy Checklist and then report their findings. Remember to check if the policy statements are clearly written and the activities are measurable for easy monitoring.*
- Allow five minutes to explain the activity, 10 minutes for the small groups to look at how the Ten Steps are or are not included in the policy, and 15 minutes for feedback to the group and discussion (total: 30 mins).*
- In the sample Happy Hospital Policy, items to discuss include:*
 - *phrasing such as "do everything possible", "as soon as is feasible" that are difficult to monitor;*
 - *there is no need for every antenatal woman to have a thorough breast examination;*
 - *women should not be asked to choose how they would feed their baby before the importance of breastfeeding is discussed.*

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: <ul style="list-style-type: none"> - 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 <u>not</u> to breastfeed are: <ul style="list-style-type: none"> - 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: <ul style="list-style-type: none"> - 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.

Policy for activity

Note: These policies have areas for improvement. They are not examples of policies acceptable to BFHI.

EXAMPLE A for Analysis HAPPY HOSPITAL BREASTFEEDING POLICY

AIMS

1. To increase the prevalence and duration of breastfeeding.
2. To assist mothers and infants in achieving successful breastfeeding by standardizing teaching, eliminating contradictory advice, and implementing practices conducive to breastfeeding success.

POLICY

ANTENATAL PERIOD

Staff should be committed to the promotion of breastfeeding and should do everything possible to enhance the woman's confidence in her ability to breastfeed.

At first antenatal visit:

- (a) every woman must have a thorough breast examination
- (b) ascertain choice of feeding method; if undecided encourage breastfeeding
- (c) give information leaflet that describes the benefits and management of breastfeeding.

DELIVERY ROOM

Initiate breastfeeding as soon as possible after birth, preferably within the first 60 minutes.

POSTNATAL WARD

- Demand feeding – there should be no limit to the maximum number of feeds, but a full-term neonate is expected to need at least five to six feeds in a 24-hour period – with intervals of no longer than five hours.
- The nurse should encourage the mother and assist her at the second feed to help with correct technique and positioning, if needed.
- Practise rooming in.
- Avoid rigid ward routine – do not waken baby for bath/weight/temperature between feeds.
- Advise mother to call staff member when baby wakens, for these tasks.
- Efficient communication between mother and midwives and between staff at changeover is essential if consistency of approach and advice is to be achieved.
- Document feeds as follows – long good feed, short good feed, poor feed.
- Counsel mothers on the use of bottles, teats and pacifiers (also called “dummies” or “soothers”) for pre-term infants.
- All mothers need to be taught while in hospital how to express and store breast milk.

DISCHARGE

Link mothers to community-based resources including the community clinic, and the availability of follow-up clinic at the hospital.

Policy for activity

Note: These policies have areas for improvement. They are not examples of policies acceptable to BFHI.

EXAMPLE B for Analysis QUALITY CARE HOSPITAL BREASTFEEDING POLICY

Staff of the Quality Care Hospital are committed to protecting, promoting and supporting breastfeeding because breastfeeding is important for both the mother and her baby. This policy helps us to provide effective and consistent information and support to pregnant women, mothers and their families.

Adherence to the Ten Steps to Successful Breastfeeding (WHO/UNICEF) and adherence to the International Code of Marketing of Breast-milk Substitutes and its subsequent resolutions are the foundation for our practices.

1. All staff will receive orientation on our infant feeding policy relevant to their role when joining the hospital.
2. A minimum of 20 hours training in breastfeeding management is mandatory for all staff and students caring for pregnant women, infants and young children. New staff will receive training, within six months of commencing work if not already trained. Refresher courses are offered on a regular basis.
3. Midwives must discuss the importance and basic management of breastfeeding in the antenatal period and record this discussion in the pregnant women's chart.
4. Within five minutes of birth, all mothers regardless of feeding intention will be given their babies to hold in skin-to-skin contact for at least 60 minutes. A family member may provide skin-to-skin when the mother is unable to do so, and skin-to-skin contact later encouraged in the postnatal ward or special care when baby and/or mother are stable.
5. All mothers will be offered help to initiate breastfeeding within one hour of birth. Further assistance will be offered within 6 hours by a midwife, or as soon as is feasible.
6. Rooming-in is hospital policy and unless medically/clinically indicated, a mother and her baby will not be separated. Where separation of baby from mother is necessary, lactation will be encouraged and maintained.
7. Responsive feeding will be practised for all babies.
8. Breastfeeding mothers will be shown by the midwife how to express their breast milk.
9. Supplements will only be given for a medical indication. All supplementary feeds/fluids will be recorded in the baby's hospital notes with the indication for giving the feed. Prescribed supplementary fluids will be given by cup or NG tube.
10. All mothers will be counselled on risks and use of feeding bottles, teats, and pacifiers.
11. No advertising of breast-milk substitutes, feeding bottles, teats or pacifiers is permissible. Mothers choosing to formula feed their infants will be individually instructed on safe formula use during the postnatal period by the midwife before discharge.
12. Before discharge, support services available in the community will be discussed with each mother.

NOTE: Any deviations to this policy will be recorded in the mother's/baby's chart with the reason for the deviation. The staff member will sign this with the date and time. The Quality Office will audit compliance with the hospital breastfeeding policy at least once a year.

- Divide participants into groups according to their type of work. For example, health workers from maternity hospitals and health workers from health centres can be grouped together. If several participants are from the same institution, ask them to work together.*
- Explain the activity.*
 - During this activity, you will reflect on the practices in your own health facility, community or other workplace and consider whether those practices support breastfeeding.
 - You will also:
 - review whether you practice the **TEN STEPS TO SUCCESSFUL BREASTFEEDING**
 - identify practices that need to change or need improvement
 - make a list of changes you can make yourself
 - make another list of changes for which you need help from managers.
- Read through the instructions with the participants.*

Instructions

- Go through the **ASSESSING AND CHANGING PRACTICES FORM**.
 - The first pages contain a number of questions.
 - On the last page, there are two blank forms.
 - First, go through the questions.
 - Answer “Yes” or “No” for each question, as it applies to your health facility.
 - Write a few words about what is done well or what needs to be improved.
 - Write your answers on the copy of the form, to hand in to the course organizers.
 - If several members of the groups are from the same health facility, fill in one form together to hand in. Otherwise, each of you should fill in your own form.
 - If some questions are not relevant to your facility (for example, you are not from a maternity facility and do not deliver babies, or you do not work in the community), leave the questions about those activities blank.
 - Then look at the short forms on the last page.
 - In the top form, list five to 10 changes you could improve or make immediately, by changing your own practice.
 - In the bottom form, list one to four useful improvements or changes that require a management decision.
 - If you wish to keep a personal copy, copy the answers onto the form in your *Participant’s manual*.
 - You will have approximately 30 minutes to complete the exercises. This will be followed by another 30 minutes to present conclusions.
- Let the groups work by themselves.*
 - Trainers act as resource people. Make sure the groups understand how to do the exercise. You can help to start the discussion in a group, help to keep a group working, or help sort out difficulties. However, you should not lead the discussion.*
 - Once the activity has finished, ask groups to present their conclusions briefly to the whole class. Then, summarize the conclusions.*

- Comment on how the suggestions will be used for the follow-up of the course and to help guide the future work of the participants.*
- Make copies of the ASSESSMENT and SUGGESTIONS available to the organizers of the course. They should later be typed, and available for the course evaluation.

ASSESSING AND CHANGING PRACTICES FORM

| PRACTICE | YES/NO | What is done well, and/or main improvement needed |
|--|--------|---|
| Critical management procedures | | |
| <p><i>The International Code of Marketing of Breast-milk Substitutes (the Code)</i></p> <p>Step 1a</p> <ul style="list-style-type: none"> • Does your facility prohibit the display or promotion of products covered under the Code (breast-milk substitutes, feeding bottles and teats)? • Does your facility prohibit items with logos of companies that produce breast-milk substitutes, feeding bottles and teats? • Does your facility prohibit receiving free or subsidized supplies of infant formula, feeding bottles and teats? | | |
| <p>Infant feeding policy</p> <p>Step 1b</p> <ul style="list-style-type: none"> • Does your facility have an infant feeding policy? • Is this a written policy? • Does it cover the eight key clinical practices of the TEN STEPS TO SUCCESSFUL BREASTFEEDING? • Does the policy cover the Code? • Is the policy routinely communicated to staff and parents? • Is the policy visible to pregnant women, mothers and their families? | | |
| <p>Step 1c</p> <p><i>Monitoring and data-management systems</i></p> <ul style="list-style-type: none"> • Does your facility have a protocol for ongoing monitoring of the eight key clinical practice of the Ten Steps? | | |
| <p>Staff Competency</p> <p>Step 2</p> <ul style="list-style-type: none"> • Are staff provided with training on supporting mothers to breastfeed? • Is there an assessment of knowledge and skills for health workers on supporting breastfeeding? | | |

| | | |
|--|--|--|
| <p><i>Antenatal information</i></p> <p><i>Step 3</i></p> <ul style="list-style-type: none"> • Do you offer/provide antenatal counselling on breastfeeding? • Do you inform all pregnant women and their families about: <ul style="list-style-type: none"> - 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? | | |
| <p><i>Immediate postnatal care</i></p> <p><i>Step 4</i></p> <ul style="list-style-type: none"> • Are mothers of term infants placed in skin-to-skin contact with them immediately or within five minutes after birth? • Does this contact last for one hour or more unless there are documented medically justifiable reasons for delayed contact? • Are mothers of term infants put to the breast within one hour after birth? | | |
| <p><i>Supplementation</i></p> <p><i>Step 6</i></p> <ul style="list-style-type: none"> • Are babies only given breast milk (unless medically indicated?) <ul style="list-style-type: none"> - Is donor human milk prioritized if a supplement is needed? • Are mothers who want to formula feed helped to do so safely? | | |
| <p><i>Rooming-in</i></p> <p><i>Step 7</i></p> <ul style="list-style-type: none"> • Do mothers and infants remain together day and night? • Are mothers of low-birth-weight and sick babies encouraged to stay near their babies? | | |

| | | |
|---|--|--|
| <p><i>Responsive feeding</i></p> <p><i>Step 8</i></p> <ul style="list-style-type: none"> • Do you encourage mothers to practise responsive feeding with their infants <ul style="list-style-type: none"> - as often as the baby wants to feed - no restrictions on length of breastfeeds? | | |
| <p><i>Feeding bottles, teats and pacifiers</i></p> <p><i>Step 9</i></p> <ul style="list-style-type: none"> • Are mothers counselled on the use and risks of feeding bottles, teats and pacifiers? • Do you use feeding bottles for babies whose mothers intend to breastfeed? | | |
| <p><i>Care at discharge</i></p> <p><i>Step 10</i></p> <ul style="list-style-type: none"> • Do you discuss with mothers the support they have when they are at home? • Do you refer all mothers for follow-up care two to four days after delivery, to make sure that breastfeeding is going well, and to give early help with any difficulties? • Do you refer all mothers for follow-up in the second week after delivery, to make sure that breastfeeding is going well, and to give early help with any difficulties? • Are you able to refer mothers to lactation support resources in the community? | | |
| <ul style="list-style-type: none"> • Are you able to give extra help and support to mothers and babies with special needs, so that they can continue to breastfeed, for example: <ul style="list-style-type: none"> - low-birth-weight babies or sick babies - babies with disabilities - if the mother is sick or has a disability - if the mother is living with HIV and has decided to breastfeed (if this is national policy)? | | |
| <ul style="list-style-type: none"> • Do you encourage women to breastfeed exclusively for six months? • Do you encourage women to continue breastfeeding for up to two years and beyond with complementary feeding? | | |

Changes that health workers could make themselves

(Make 5–10 practical suggestions)

1.

2.

3.

4.

5.

6.

7.

8.

9.

10.

Changes that require management support

(List 1–4 helpful management changes)

1.

2.

3.

4.

Notes

Dotted lines for note-taking.

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