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BREASTFEEDING COUNSELLING

A TRAINING COURSE

TRAINER'S GUIDE

PART ONE

Sessions 1-9

WORLD HEALTH ORGANIZATION CDD PROGRAMME

UNICEF

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INTRODUCTION

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Why this course is needed

Breastfeeding is fundamental to the health and development of children, and important for the health of their mothers.

The Programme for the Control of Diarrhoeal Diseases has long recognized the need for the promotion of exclusive breastfeeding in the first 4-6 months of life, and sustained breastfeeding together with adequate complementary foods up to 2 years of age or beyond, to reduce diarrhoeal morbidity and mortality.

Workers concerned with nutrition, and with maternal and child health, also recognize the importance of improved infant feeding practices. In 1991, UNICEF and WHO jointly launched the Baby Friendly Hospital Initiative, which aims to improve maternity services so that they protect, promote, and support breastfeeding, by putting into practice the "10 steps to successful breastfeeding". Many maternity facilities throughout the world are now striving to achieve "Baby Friendly" status.

The International Code of Marketing of Breastmilk Substitutes has been in place for more than a decade, and much effort to protect breastfeeding from commercial influences has followed. One requirement for being "Baby Friendly" is that a facility shall not accept or distribute free samples of infant formula.

However, even mothers who initiate breastfeeding satisfactorily, often start complementary feeds or stop breastfeeding within a few weeks of delivery. All health workers who care for women and children after the perinatal period have a key role to play in sustaining breastfeeding. Many health workers cannot fulfil this role effectively because they have not been trained to do so. Little time is assigned to breastfeeding counselling and support skills in the preservice curricula of either doctors, nurses or midwives.

Hence there is an urgent need to train all health workers who care for mothers and young children, in all countries, in the skills needed to both support and protect breastfeeding. The purpose of "Breastfeeding counselling: A training course" is to help to fill this gap. The materials are designed to make it possible for trainers with limited experience of teaching the subject to conduct up-to-date and effective courses.

The concept of `counselling' is new, and the word can be difficult to translate. Some languages use the same word as `advising'. However, counselling means more than simple advising. Often, when you advise people, you tell them what you think they should do. When you counsel a mother, you help her to decide what is best for her, and you help her to develop confidence. You listen to her, and to try to understand how she feels. This course aims to give health workers listening and confidence building skills, so that they can help mothers more effectively.

THE COURSE AND THE MATERIALS

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Structure of the course

The course takes a total of 40 hours, which can be conducted consecutively in a working week, or which can be spread out in other ways. The course is divided into 33 Sessions of between 30 and 120 minutes each, using a variety of teaching methods, including lectures, demonstrations, clinical practice, and work in smaller groups with discussion, reading, role-play, and exercises. The shorter sessions are arranged around four 2-hour clinical practice sessions. Participants progressively develop their support and counselling skills in the classroom, and then practise them with mothers and babies in wards or clinics.

Different kinds of session

Lectures and demonstrations
Seven sessions are lecture presentations, with slides or overhead transparencies, and four are demonstrations. Each of these should be conducted by one of the trainers, for the whole class together. The Course Director will assign the lectures and demonstrations to different trainers.

Group work
The main part of each clinical practice session, the sessions for practising history taking and counselling skills, and parts of three other sessions are conducted in small groups of 4-5 participants with one trainer. Each trainer is assigned to a group of 4-5 participants. The trainer has special responsibility for the participants in her group, and should follow their progress, and help them with difficulties.

Fourteen sessions are conducted in groups of 8-10 participants, each with two trainers. To make up the large groups, two of the smaller groups are combined. These sessions consist of a mixture of discussion, reading, demonstration, role-play, and exercises.

Clinical practice
There are four 2-hour clinical practice sessions. The whole class meets together for the first 20 minutes to prepare, and if possible for the last 20 minutes to discuss the session. For the clinical practice itself, participants work in their groups of 4-5 each with one trainer.

Class discussion
The session on the local breastfeeding situation is led by one trainer with the whole class together.

Forming groups

As soon as possible after the introductory session, the Course Director with the help of one or two of the trainers decides how the groups will be composed.

If language and gender may be a problem, each group should have at least one person who can speak the local language, and at least one woman. It may be appropriate to balance professional groupings. Sometimes it is a good idea to make a participant who knows the others in the class responsible for arranging the groups according to these considerations. The names of the trainer and participants in each group are written on a flipchart or board, and posted up where participants can check which group they belong to.

Order of sessions

The sessions are in a suggested sequence, but the order almost always needs to be adapted, for example, if mothers and babies are not available for clinical practice at the suggested times.

Most 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 which prepare participants for a particular clinical practice before that practice, (as indicated by the similar titles of class and clinical practice sessions). It is also important that Sessions 1-7 are completed before Clinical Practice 1, and that Session 10 `Positioning a baby at the breast' is held between Clinical Practice 1 and Clinical Practice 2.

Parts of some sessions are optional. The Course Director will decide whether or not to include these parts. Sessions 31, 32, and 33 are Additional Sessions. They are not part of the skills development sequence, so they can be arranged more flexibly, or fitted in at other times such as during the evening. These are key topics however, and it is strongly recommended that they are included in the course at some point.

The Trainer's Guide

The Trainer's Guide contains what you, the trainer, need in order to lead participants through the course. The guide contains the information that you need, detailed instructions on how to teach 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 on the course. Write your name on it as soon as you get it, and use it at all times. Add notes to it as you work. These notes will help you in future courses.

Accompanying course materials

Overhead transparencies and 35mm slides
Overheads and slides are provided for the lectures and for some other sessions, (see the list below). The figures for the overhead transparencies are also available in the form of a flipchart, which you can use to show to participants if facilities for projection are not available.

Participants' Manual
A copy is provided for each participant. This contains:
- Summaries of key information from the lectures and other sessions
- Copies of the forms and checklists from the practical sessions
- The exercises which participants will do during the course, but without answers
- A glossary of the terms used in the materials
- A Clinical Practice Progress Form, which enables trainers to follow the progress of individual participants

The manual can be used for reference after the course, so it is not essential for participants to take detailed notes.

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

Forms and checklists
Loose copies of the forms and checklists needed for clinical practice and counselling exercises are provided. These are:
- B-R-E-A-S-T-Feed Observation Form
- Breastfeeding History Form
- Listening and Learning Skills
- Confidence and Support Skills
- Counselling Skills Checklist
- Clinical Practice Discussion Checklist (for trainers only)
- Assessing and Changing Practices Form (for the final exercise)

The forms are printed on A4 sheets.
`Listening and Learning Skills', `Confidence and Support Skills', and `Counselling Skills Checklist' are all on one A4 card, to cut up as necessary.

Story cards
Copies of the Histories and Counselling Stories are provided for the History Practice and Counselling Practice exercises.

Videotapes
These are recommended as part of the course:
- *Helping a Mother to Breastfeed* (Royal College of Midwives, UK).
- *Feeding Low Birth Weight Babies* (UNICEF).

Other videos from UNICEF which may also be available, and which can be shown if time permits, for example, on a residential course, are:
Breastfeeding: A Global Priority
Breastfeeding Rediscovered
Mother Kangaroo.

Reference materials

These are given to participants as part of the course materials:

- *Helping mothers to breastfeed* (Revised Edition, African Medical and Research Foundation, 1992, or an adapted version.)

- *Protecting Infant Health: A Health Workers Guide to the International Code of Marketing of Breastmilk Substitutes* (Updated 1993, IBFAN Penang).

- Annex to the Global Criteria for Baby Friendly Hospitals: Acceptable Medical Reasons for Supplementation

- Annex on Breastfeeding and Maternal Medication: Recommendations for drugs in the Essential Drugs List.

- *Protecting, Promoting and Supporting Breastfeeding: The Special Role of Maternity Services*. A joint WHO/UNICEF Statement, 1989.

It is recommended that the following are also available during the course:
- *Infant Feeding: The Physiological Basis*, Bulletin of the World Health Organization, supplement to volume 67, 1989.
- Copies of the WHO newsletter *Facts about infant feeding*.

List of Overheads and Slides
(Total: 50 overhead transparencies; 50 35mm slides)

Session 1: `Why breastfeeding is important'	Overheads 1/1 to 1/16
Session 3: `How breastfeeding works'	Overheads 3/1 to 3/12
Session 5: `Observing a breastfeed'	Slides 5/1 to 5/15
Session 8: `Health care practices'	Slides 8/1 to 8/15
Session 11: `Building confidence and giving support'	Overheads 11/1 to 11/6
Session 14: `Breast conditions'	Slides 14/1 to 14/18
Session 26: `Low-birth-weight and sick babies'	Overheads 26/1 to 26/6
Session 27: `Increasing breastmilk and relactation'	Slides 27/1 and 27/2
Session 28: `Sustaining breastfeeding'	Overheads 28/1 and 28/2
Session 31: `Women's nutrition, health and fertility'	Overheads 31/1 to 31/8

Training aids

For each course, it is necessary to have four life size baby dolls and four model breasts, so that there is one for each small working group. If dolls and breasts are not available, try to make them.

Here are instructions for one way to make them simply and out of readily available materials.

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'.

HOW TO MAKE A MODEL BREAST

Use a pair of near skin-coloured socks, or stockings, or an old sweater or tee 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 lactiferous sinuses, make the breast with two layers, for example with 2 socks. Sew the nipple in the outer layer, and draw the lactiferous sinuses and ducts on the inside layer, beneath the nipple. You can remove the outer layer with the nipple to reveal the inside structure.

Motivating and managing participants

- *Encourage interaction*

During the first day or two, 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. These 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 whom you are talking to;
- do not be in a hurry, whether you are asking or answering questions;
- show interest in what participants say. For example, say: "That is a good question/suggestion."

Praise, or thank participants who make an effort. For example when they:
- try hard;
- ask for an explanation of 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, and to help them to feel confident in their work with mothers and babies.

- *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 her own language (or ask someone else to do so for you) to clarify a difficult point.

Discuss with the Course Director any language problems which seriously hinder the ability of a participant to understand the material. It may be possible to arrange help for the participant, or for her to do some of the exercises in a different way.

Using your Trainer's Guide

Before you lead a session:

- Look at your guide and read the `Objectives' and 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 through the text for the session, so that you are clear what you will have to do. The text includes detailed point by point instruction about how to conduct the session.

When you lead a session:

keep your 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.

If using the whole guide is unacceptable, for example because it might make some participants think that you do not know the material, decide what to do.
For example, you might ask the Course Director to explain at the beginning of the course that this is the correct method for this kind of teaching, in the same way that participants need to use their manual. Alternatively, for the sessions that you lead, copy the necessary pages of the guide, to use as your notes during the session. This will not be so bulky or conspicuous as carrying the whole guide.

Remember that even the authors of the materials find it necessary to follow the 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.

Preparing to give a presentation

- *Study the material*

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

You do not have to give the lecture exactly as it is written. You should not read it out, unless 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 breastfeeding.

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 your own stories, and ways to present the information naturally in your own way.

Read the **Further information** sections. They give extra information about topics that are covered only briefly in the main text. You should not present them with the main presentation, but they may help to answer questions that arise in the course of discussion.

- *Prepare your slides or overheads*

Make sure that you have all the slides or overheads for the session, and arrange them in the correct order.

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 lively 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 overheads and slides carefully*

Remember that overheads and 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, point out on the overhead or slide where it shows what you are talking about, and draw the participants' attention to the appearances. Do not assume that they automatically see what you want them to look at.

With slides, point to the screen. With overhead transparencies, either point to the screen, or point out the place on the projector.

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 in your own way. You will be able to make it appropriate for the participants, and answer their questions in the way which is most helpful for them.

It is helpful sometimes when presenting slides or overheads to ask participants to come to the screen to point things out to the others. This technique is recommended for Session 5, `Observing a breastfeed'.

- *Involve the audience*

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

However, it is also helpful during lectures and other sessions to ask questions, to check that participants understand, and to keep them thinking. This more interactive technique helps to keep participants interested and involved, and is usually a more effective way of learning. Ask open questions, (which you will have learned about in 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. They ask participants to make observations on a slide or transparency, and to think what it means. The questions are carefully chosen, so that participants should be able to decide the answer either by looking at the picture, 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. On the other hand, do not get involved in discussions which are distracting, and which waste a lot of time. Encourage participants to make a few suggestions; discuss their suggestions; and then continue with the session. 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.

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 given 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 her to wait for a minute, and turn or walk away from her. Try to encourage quieter participants to talk. Ask someone by name who has not spoken before to answer, or walk towards someone to focus attention on her, and make her feel that she is being asked to talk.

Thank participants whose answers are short and to the point.

Preparing to give a demonstration

- *Study the instructions*

You should already have seen the demonstration in the preparatory course. Some time before you give the demonstration, read through the instructions carefully, so that you are familiar with them. This is necessary even if you have already seen someone else give the demonstration. Even if you have given the demonstration before yourself, it is a good idea to re-read the instructions, so that you do not forget any important steps.

- *Collect the equipment*

Make sure that you have the dolls or other equipment that you need. Prepare those things that you can make yourself (for example, a model breast).

- *Prepare your assistant*

You may need someone to help you to give the demonstration, for example, someone to pretend to be a mother. It is usually a good idea to ask a participant to help you. This can be a good learning experience for her. It increases her involvement, and helps her to learn about teaching methods.
Ask for help a day or two before a demonstration, so that helpers have time to prepare themselves.

Discuss what you want them to do, and help them to practise.

- *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 the demonstration

- Make sure that all the equipment is ready and together, and prepare the place where you will give the demonstration. Arrange tables and chairs as you will need them.
- Make sure that you can use a board to write things up, or an overhead projector if you need to show a transparency as part of the demonstration, without having to rearrange everything.
- Demonstrate slowly, step-by-step, and make sure that the audience are 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 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 themselves practise what you demonstrate. They will learn more if they try things out, than if they just see you doing them.

At the end of a lecture or demonstration

Leave time for participants to ask questions, and do your best to answer them.

Ask participants to find the summary notes for the session in their manuals. Tell them the pages for the session. Ask them to read the notes later on the same day.
Tell them about any recommended reading from the reference material (see sections listed at the end of relevant sessions).

Working in groups

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

Work in groups of 8-10 with two trainers consists mostly of discussions, reading, short demonstrations, role-play, and exercises.
The two trainers are likely to have different strengths, and can support and learn from each other. They should plan together how to conduct the session.

Work in groups of 4-5 with one trainer is mainly for the practice of skills, such as positioning a baby at the breast, history taking, and counselling. The smaller groups give everybody a chance to practise the skills.

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

- *Conduct discussions*

Some discussions consist of simple questions which you ask the group, encouraging participants to suggest answers, and to give their ideas, in a way similar to that described for asking questions in lectures. It may help to write the main question, and the main points of answers on a flipchart.

Do not let a few more talkative participants dominate the discussion. If necessary, ask individuals in the group by name to suggest answers in turn. Encourage quieter members to say what they think, before you allow the talkative ones to speak.

To keep participants discussing the questions, from time to time summarise what has been said and restate the question in another way. When participants give an incomplete answer, ask them to try to clarify and complete what they are trying to say. Add any necessary explanation, and make sure that it is clear to all participants.

Give participants time to ask their own questions. Answer the questions willingly. Encourage participants to ask at the time that they have a question, and not to hold it for a later time. However, if they ask too many questions, and it interferes with the session, you may have to ask them to wait.

- *Develop lists and schema*

In some sessions, you and the participants together have to develop lists or schema for a topic, on boards or flipcharts.

Plan these lists and schema carefully. Make sure that you have enough flipcharts or sheets posted up. Plan the layout of the lists on each page, to make sure that you can fit the whole list onto one sheet.

- *Reading*

In some sessions, you ask participants to read a section of text to themselves. You then discuss the topic with them, to make sure that they understand what they have read. Later they practise using the information in an exercise.

If it is difficult for participants to absorb information when they read it to themselves, you can as an alternative ask them to read it aloud. Each participant takes it in turns to read one sentence or section of the text. You can discuss the ideas and ask questions after each point.

- *Give short demonstrations*

The group sessions include a number of short demonstrations of counselling techniques, and other skills. They do not need equipment other than dolls and model breasts, which should be available for every group.

Practise conducting these demonstrations. Make sure that you have a doll and a model breast available, if necessary. If you need a participant to help you, help her to prepare, and make sure that you give her a copy of what she has to say in advance.

- *Role-play*

Choose the players in advance, explain carefully what you want them to do, and give them written instructions to help them to remember what to do.

If you feel that participants are not ready to do role-plays themselves, do the role-play yourself with another trainer. This helps participants to understand what role-play is about, and they can see that making mistakes does not matter, so they may feel more confident to try themselves next time.

- *Exercises*

Some exercises are done by the whole group together. These take the form of a discussion.

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. It also helps you to discover which topics are easy and which are difficult for the group.

For written exercises, participants stay in the groups of 8-10, but work by themselves. The two trainers circulate, and give individual feedback and personal attention to the participants as they do the exercises. Pay particular attention to the members of your own small group, but it is good if both trainers talk to all participants.

An alternative, if participants have difficulty writing the answers, is to discuss the answers to the questions in pairs, or in small groups of participants with one trainer. However, it is preferable if possible for each participant to try to answer the questions for herself.

Facilitating individual written exercises

- *Explain how to do the exercise*

Tell participants which exercise to do, and on which page in their manuals they can find the exercise. Make sure that they have all found it.

Explain that they should read the questions, and write the answers in their manuals. They should use pencil, so that they can easily erase and correct their answer. Make sure that they have pencils and erasers to work with.

Ask them to read the instructions **How to do the exercise** and the **Example**. If you feel that it would be helpful, you can read the example aloud with the participants, and give them a chance to ask questions if they have not fully understood.

Explain that they should work at their own pace, and answer as many of the questions as they can. However, it is not essential to finish all the questions. You may wish to recommend a minimum number that they should try to complete. Let participants who work faster continue with all the questions, including the optional questions, if they can. Explain that the trainers will give individual feedback, and will help them as needed.

Try to arrange for participants to sit separately, so that they do not hear or see other peoples' answers.

When you are satisfied that participants know what to do, let them work by themselves for 5-10 minutes.

Then start circulating, looking over their shoulders to see how they are getting on. 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 guide. Compliment them if they have answered satisfactorily. If an answer is incorrect, do not make them feel ridiculed. Ask them if they have any other ideas, and give them a chance to try to correct the answer. If they cannot do so, help them to decide the correct answer, and explain their mistake. Try not to give them the answer too easily.

With participants who find the exercises easy, you should be able to give them feedback quite quickly. Spend extra time with participants who are having difficulty, to make sure that they understand the essential points that the exercise illustrates.

If a question causes difficulty for several participants, discuss it afterwards with the group together.

At the end of the session, give participants the Answer Sheet for the exercise. Suggest that they complete the questions that they have not finished in their own time, and correct their own answers. They should ask a trainer later if they do not understand any of the answers.

Conducting small group sessions

The sessions in which participants practise their history-taking and counselling skills are conducted in small groups with 4-5 participants and one trainer.

Each trainer has a set of story cards, **History 1-5** for Session 18 and **Counselling Story 1-10** for Session 25. For each session, select the most appropriate stories, and give one to each participant before the session so that they have time to study it. They should not show it to their colleagues.

During the session, participants work in pairs within the group to practise taking a history, or using the counselling skills. One of the pair plays the mother, following the story on her card. The other plays the counsellor, and uses the Breastfeeding History Form or the Counselling Skills Checklist. This is called `pair practice'.

You follow from the Trainer's Guide, which contains both the story and short comments to help you to guide the participants and make sure that they learn what is intended. Guide the group to discuss the practice, and help the counsellor to improve her skills. Detailed instructions are given in the notes for the session.

Clinical practice

Each trainer takes her group of 4-5 participants to a ward or clinic to practise with mothers and babies the skills that they have learnt in the previous sessions.
Use the **CLINICAL PRACTICE DISCUSSION CHECKLIST** to help you to discuss each mother and baby with the participants.

Follow the progress of each of the participants in your small group with the **CLINICAL PRACTICE PROGRESS FORM.** Each participant has a form, and she fills it in for each mother and baby that she sees. Check the form with the participant after Clinical Practice 2 and Clinical Practice 3, to see if she has seen mothers in a variety of different situations. If there are some important situations that she has not seen, try to help her to see them in Clinical Practice 4. Alternatively, arrange for her to practise counselling a mother in that situation in a role-play.
Detailed instructions are given with the notes for each clinical practice. The main instructions are with Clinical Practice 1.

WHAT THE SIGNS USED IN THE GUIDE INDICATE

- ❑ an instruction to you, the trainer.
- ▪ what you, the trainer, say to the participants.
- ☺ that you ask participants for their help.
- -> that you should write on a board or flipchart.
- ● a general instruction, for example how to do a task or a series of major points.

WHY BREASTFEEDING IS IMPORTANT

Objectives

At the end of this session, participants should be able to:
- state the advantages of breastfeeding, and the dangers of artificial feeding;
- describe the main differences between breastmilk and artificial milks;
- define the terms used to describe infant feeding;
- describe presently recommended infant feeding practices.

Session outline (60 minutes)

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

I.	Introduce the topic	(3 minutes)
II.	Present Overheads 1/1 to 1/10	(25 minutes)
III.	Answer participants' questions	(7 minutes)
IV.	Present Overheads 1/11 to 1/16	(15 minutes)
V.	Answer participants' questions	(10 minutes)

Preparation

Refer to pages 9-11 in the Introduction, for guidance on giving a presentation with overhead transparencies.

Make sure that Overheads 1/1 to 1/16 are in the correct order.
Study the overheads and the text that goes with them so that you are able to present them.

Read the **Further information** sections so that you are familiar with the ideas that they contain.

As you follow the text, remember:

☐ indicates an instruction to you, the trainer
▪ indicates what you say to participants

Do not present the **Further information** sections.
Use them to help you to answer questions.

I. Introduce the topic (3 minutes)

☐ Make these points:

- Before you learn how to help mothers, you need to understand why breastfeeding is important, and what its benefits are.
- You need to know the differences between breastmilk and artificial milks, and the dangers of artificial feeding.
- You will find a summary of the key points that we will discuss on pages 5-9 in your manuals.

II. Present Overheads 1/1 to 1/10 (25 minutes)

☐ As you show each overhead transparency, point on the projector or on the screen to the place which shows what you are explaining.

Overhead 1/1 The advantages of breastfeeding

- This diagram summarizes the main advantages of breastfeeding.

It is useful to think of the advantages of both *breastmilk* (listed on the left) and *breastfeeding*

(listed on the right).

The advantages of *breastfeeding* are more than just the advantages of feeding a baby on breastmilk. Breastfeeding protects a mother's health in several ways, and can benefit the whole family, emotionally and economically.

The advantages of a baby having *breastmilk* are that:

- It contains exactly the *nutrients* that a baby needs;
- It is easily digested and efficiently used by the baby's body;
- It protects a baby against infection.

All other milks are different, and not as good for a human baby.

The other advantages of *breastfeeding* are that:

- It costs less than artificial feeding;
- It helps a mother and baby to *bond* - that is, to develop a close, loving relationship;
- It helps a baby's development;
- It can help to delay a new pregnancy;
- It protects a mother's health:
  It helps the uterus to return to its previous size. This helps to reduce bleeding, and may help to prevent anaemia;
  Breastfeeding also reduces the risk of ovarian cancer, and possibly breast cancer, in the mother.

In the next few overheads, we will look at some of these advantages in more detail.

Overhead 1/2 Nutrients in human and animal milks

- First, look at the nutrients in breastmilk, to see why they are perfect for a baby.

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

All the milks contain fat, which provides much of the energy that a young human or a young animal needs; they contain protein, for growth; and they contain the special milk sugar *lactose*, which also provides energy.

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

The animal milks contain more protein than human milk.

Protein is an important nutrient, and you might think that more protein must be better. However, animals grow faster than humans, so they need milk with a higher concentration of protein. It is difficult for a baby's immature kidneys to excrete the extra waste from the protein in animal milks.

Formula milks are also different from breastmilk, although the quantities have been adjusted. Formula milks are made from a variety of products, including animal milks, soybean, and vegetable oils. They are far from perfect for babies.

Further information
The sugar lactose is the main carbohydrate in milk. None of the milks 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. But young babies cannot digest starch easily, so it is not appropriate to give them starchy foods in the first few months of life.
Breastmilk contains more lactose than other milks.

Overhead 1/3 Quality of the proteins in different milks

- The protein in different milks varies in *quality*, as well as in quantity.

This chart shows that much of the protein in cow's milk is *casein*, which forms thick, indigestible curds in a baby's stomach. There is less casein in human milk, and it forms softer curds which are easier to digest.

The soluble or *whey* proteins are also different. In human milk, much of the whey protein consists of *anti-infective* proteins, which help to protect a baby against infection. Animal milks do not contain the kinds of anti-infective protein which protect babies.

Artificially fed babies may develop *intolerance* to protein from animal milk. They may develop diarrhoea, abdominal pain, rashes and other symptoms when they have feeds which contain the different kinds of protein. Diarrhoea may become persistent, which can contribute to malnutrition.

Babies who are fed animal milks or formula are also more likely than breastfed babies to develop *allergies* which may cause eczema, and possibly asthma.

A baby may develop intolerance or allergy after only a few artificial feeds given in the first few days of life.

Further information
- All the whey proteins in the various milks are different. Human milk contains *alpha*-lactalbumin and cow's milk contains *beta*-lactoglobulin.
- In addition, the proteins in animal milks and formula contain a different balance of amino acids from breastmilk, which may not be ideal for a baby. Animal milk and formula may lack the amino acid *cystine,* and formula may lack *taurine* which newborns 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 which need iron) and lysozyme (which kills bacteria) as well as 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 yoghurty smell). Breastmilk also contains anti-viral and anti-parasitical factors.

Overhead 1/4 Differences in the fats of different milks.

- There are important differences in the quality of fat in different milks.

Human milk contains *essential fatty acids* that are not present in cow's milk or formula. These essential fatty acids are needed for a baby's growing brain and eyes, and for healthy blood vessels.

Human milk also contains an enzyme *lipase* which helps to digest fat. This enzyme is not present in animal milks or formula.

So the fat in breastmilk is more completely digested and more efficiently used by a baby's body than the fat in cow's milk or formula.

The faeces of an artificially fed baby are different from those of a breastfed baby. This is partly because an artificially fed baby's faeces contain more unused food.

Further information
Low-birth-weight babies fed on artificial feeds which lack these essential fatty acids have been shown to have less satisfactory mental development and eyesight.

Lipase in human milk
At birth a baby's gut has not developed all the enzymes which are needed to digest milk fat. The lipase in breastmilk helps to complete the digestion of the fat in the gut.
The lipase in breastmilk is called *bile salt stimulated lipase* because it starts working in the intestine in the presence of bile salts. The lipase is not active in the breast, or in the stomach before the milk mixes with bile.

Overhead 1/5 Vitamins in different milks

- This chart compares the amounts of vitamins in human and cow's milk.

It shows that human milk contains more of some important vitamins than cow's milk.
Cow's milk contains plenty of the B vitamins. But it does not contain as much vitamin A and vitamin C as human milk.

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

Breastmilk contains plenty of vitamin A, if the mother has enough in her food. Breastmilk can supply much of the vitamin A that a child needs even in the second year of life.

Ask: *What can you do if you are worried about a woman's diet, and you think that there may not be enough vitamins in her breastmilk?*

Give extra vitamins to the mother.

Further information

Vitamin A supplements for mothers
Do not give a mother high dose capsules of vitamin A (over 10,000 units daily) more than 4-6 weeks after she has given birth. After 6 weeks, there is a slight possibility that she could be pregnant. If high doses of vitamin A are given in early pregnancy, they can damage the foetus.

B vitamins in different milks
For some B vitamins, the amount in human milk is the same or more than in cow's milk, but for most of them the amount in cow's milk is 2-3 times higher than in breastmilk. These high levels are more than a baby needs.
Goat's milk lacks the B vitamin folic acid, and this can cause anaemia.

Overhead 1/6 Iron in milk

- Iron is important to prevent anaemia. Different milks contain similar very small amounts of iron (50-70 μg/100 ml, i.e. 0.5-0.7 mg/l). But there is an important difference.

Ask: *What does this chart show you about the absorption of iron from different milks?*

Only about 10% of the iron in cow's milk is absorbed, but about 50% of the iron from breastmilk is absorbed.

Babies fed cow's milk may not get enough iron, and they often become anaemic. Exclusively breastfed babies do get enough iron, and they are protected against iron deficient anaemia until at least 6 months of age, and often longer.

Further information
Some brands of formula have iron added. However, 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, which may increase the chances of some kinds of infection, for example, meningitis and septicaemia.

Overhead 1/7 Protection against infection

- Breastmilk is not just a food for babies. It is a living fluid, which protects a baby against infections.

For the first year or so of life, a baby's immune system is not fully developed, and cannot fight infections as well as an older child's or adult's. So a baby needs to be protected by his mother.

Breastmilk contains white blood cells, and a number of anti-infective factors, which help to protect a baby against infection. Breastmilk also contains antibodies against infections which the mother has had in the past.

This picture shows the special way in which breastmilk is able to protect a baby against new infections which his mother may have, or which are in the family's environment now.

When a mother becomes infected (1), white cells in her body become active, and make antibodies against the infection to protect her (2).
Some of these white cells go to her breasts and make antibodies (3) which are secreted in her breastmilk to protect her baby (4).

So a baby should not be separated from his mother when she has an infection, because her breastmilk protects him against the infection.

Artificial feeds are dead. They contain no living white cells or antibodies, and few other anti-infective factors, so they provide much less protection against infection.

Further information
The main immunoglobulin in breastmilk 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 IgG) which are carried in the blood.

Overhead 1/8 Variations in the composition of breastmilk

- The composition of breastmilk is not always the same. It varies according to the age of the baby, and from the beginning to the end of a feed. It also varies between feeds, and may be different at different times of the day. This chart shows some of the main variations.

Colostrum is the special breastmilk that women produce in the first few days after delivery. It is thick and yellowish or clear in colour.

After a few days, colostrum changes into *mature milk*. There is a larger amount of milk, and the breasts feel full, hard and heavy. Some people call this the milk `coming in'.

Foremilk is the bluish milk that is produced early in a feed.
Hindmilk is the whiter milk that is produced later in a feed.

Ask: *What differences does this chart show between these different kinds of breastmilk?*

Colostrum contains more protein than later milk.
Hindmilk contains more fat than foremilk.

The extra fat in hindmilk makes it looks whiter than foremilk. This fat provides much of the energy of a breastfeed. This is why it is important not to take a baby off a breast too quickly. He

should be allowed to continue until he has had all that he wants, so that he gets plenty of fat-rich hindmilk.

Foremilk is produced in larger amounts, and it provides plenty of protein, lactose, and other nutrients. Because a baby gets large amounts of foremilk, he gets all the water that he needs from it. Babies do not need other drinks of water before they are 4-6 months old, even in a hot climate. If they satisfy their thirst on water supplements, they may take less breastmilk.

Mothers sometimes worry that their milk is `too thin'. Milk is never `too thin'. It is important for a baby to have both foremilk and hindmilk to get a complete `meal', and all the water that he needs.

Further information
There is no sudden change from `fore' to `hind' milk. The fat content increases gradually from the beginning to the end of a feed.

Overhead 1/9 Colostrum

- This chart shows the special properties of colostrum, and why it is important.

- It contains more antibodies and other anti-infective proteins than mature milk. This is part of the reason why colostrum contains more protein than mature milk.

- It contains more white blood cells than mature milk.

These anti-infective proteins and white cells provide the first immunization against the diseases that a baby meets after delivery. Colostrum helps to prevent the bacterial infections that are a danger to newborn babies. The antibodies probably also help to prevent a baby from developing allergies.

- Colostrum has a mild purgative effect, which helps to clear the baby's gut of *meconium* (the first rather dark stools). This clears bilirubin from the gut, and helps to prevent jaundice.

- Colostrum contains *growth factors*, which help a baby's immature intestine to develop after birth. This helps to prevent the baby from developing allergies and intolerance to other foods.

- Colostrum is richer than mature milk in some vitamins - especially vitamin A. Vitamin A helps to reduce the severity of any infections the baby might have.

So it is very important for babies to have colostrum for their first few feeds. Colostrum is ready in the breasts when a baby is born. It is all that most babies need before the mature milk comes in.

Babies should not be given any drinks or foods before they start breastfeeding. Artificial feeds given before a baby has colostrum are especially dangerous.

Further information
Colostrum and breastmilk contain many hormones and growth factors. The function of all of them is not certain. However, *epidermal growth factor*, which is present in both, 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, and 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. Antibodies probably help to prevent allergies by coating the intestinal mucosa, and preventing the absorption of larger molecules.

Overhead 1/10 Psychological benefits of breastfeeding

- Breastfeeding has important psychological benefits for both mothers and babies.

Breastfeeding helps a mother and baby to form a close, loving relationship, which makes mothers feel deeply satisfied emotionally. Close contact from immediately after delivery helps this relationship to develop. This process is called *bonding*.

Babies cry less, and they may develop faster, if they stay close to their mothers and breastfeed from immediately after delivery.

Mothers who breastfeed respond to their babies in a more affectionate way. They complain less about the baby's need for attention and feeding at night. They are less likely to abandon or abuse their babies.

Some studies suggest that breastfeeding may help a child to develop intellectually. Low-birth-weight babies fed breastmilk in the first weeks of life perform better on intelligence tests in later childhood than children who are artificially fed.

III. Answer participants' questions (7 minutes)

☐ Ask participants if they have any questions on the information in Overheads 1/1 to 1/10. Try to answer them.

If they have questions about topics that will be covered in later sessions, give a brief answer, and explain that you will discuss the topic more fully later.

IV. Present Overheads 1/11 to 1/16 (15 minutes)

☐ Make this introductory point:

- The next few overheads will explain the present recommendations for infant feeding, and the reasons for them. They will also introduce the terms that are used to describe infant feeding practices.

Overhead 1/11 Protection against diarrhoea

- This chart shows how breastfeeding protects a baby against diarrhoea.

The chart shows the main findings of a study from the Philippines. It compares how often babies fed in different ways get diarrhoea.

The bar on the left is for babies who were fed only on breastmilk. This is called *exclusive* breastfeeding. The bar is very small, because very few exclusively breastfed babies get diarrhoea.

The bar on the right is for artificially fed babies, who received no breastmilk. This column is 17 times taller, because these babies were 17 times more likely to get diarrhoea than babies fed only on breastmilk.

Some of the babies were given breastfeeds and artificial feeds, here called `nutritious supplements'. This is *partial* breastfeeding. These babies were more likely to have diarrhoea than exclusively breastfed babies, but less likely than babies who received no breastmilk.

Some babies were breastfed, and also given non-nutritious liquids such as tea. They were *predominantly* breastfed. These babies were more likely to have diarrhoea than exclusively breastfed babies, but less likely than partially breastfed or artificially fed babies.

Artificially fed babies get diarrhoea more often partly because artificial feeds lack anti-infective factors, and partly because artificial feeds are often contaminated with harmful bacteria. Breastmilk is not contaminated.

Further information

This study was of babies of 0-2 months only. The risks of infection are greatest for young infants. However, other studies have shown that breastfeeding protects against death from diarrhoea in babies up to one year of age, and up to two years of age in children who are malnourished. Breastfeeding can protect against some forms of diarrhoea, for example cholera and shigellosis, up to the age of 2-3 years.

The dangers of artificial feeding are greatest when environmental hygiene is poor. However, studies in industrialized countries have shown that artificially fed babies suffer more infections than breastfed babies even when environmental hygiene is good.

Participants may ask when they see Overhead 1/12, why cow's milk appears to be less dangerous than formula. This has not been fully explained, but it may be because cow's milk does not have to be mixed with water, so it is less often contaminated.

Overhead 1/12 Protection against respiratory infection

- Breastfeeding also protects babies against respiratory infections.

This chart shows some of the findings from a study in Brazil, of babies aged 8 days to 12 months. It compares how many babies fed in different ways died from pneumonia. In this study, artificially fed babies were 3-4 times more likely to die from pneumonia than were exclusively breastfed babies. Partially breastfed babies came somewhere in between.

Other studies have shown that breastfeeding also protects babies against other infections, for example ear infections and meningitis.

Overhead 1/13 Breastmilk in the second year

- For the first 4-6 months of life, exclusive breastfeeding can provide all the nutrients and water that a baby needs.

From the age of 6 months, breastmilk is no longer sufficient by itself. From 6 months, all babies should receive other foods, known as *complementary foods*, in addition to breastmilk. A few babies need complementary foods at 4 or 5 months. Complementary foods can be given by cup or cup and spoon, and feeding bottles are not necessary.

However, breastmilk continues to be an important source of energy and high quality nutrients through the second year of life, and beyond.

This chart shows how much of a child's daily energy and nutrient needs can be supplied by breastmilk during the second year of life.

Ask: *How much of the protein and energy that a child needs in the second year can breastmilk provide?*

It can provide about one-third of what a child needs.

Ask: *How much of the vitamin A that a child needs can breastmilk provide?*

Breastmilk can provide about 45% of the vitamin A that a child needs. Breastfeeding can help to prevent xerophthalmia (vitamin A deficiency).

Ask: *How much of the vitamin C that a child needs can breastmilk provide?*

It can provide almost all of it, provided the mother herself is not deficient.

▪ So breastmilk can help to make sure that a child gets enough energy and high quality nutrients through at least the second year of life. These nutrients may not be easily available from the family diet. Continuing to breastfeed during the second year can help to prevent malnutrition, especially among children who are most at risk.

Further information
Vitamin A from breastmilk in the second year
There are different estimates of how much of a child's vitamin A requirements can be provided by breastfeeding in the second year, ranging from 38% to 75%. The amount depends on the mother's vitamin A status, and the volume of breastmilk consumed. However, what we do know is that breastfeeding in the second year provides useful protection to the child against vitamin A deficiency.

Overhead 1/14 Dangers of artificial feeding

▪ This diagram summarizes the dangers of artificial feeding.

- Artificial feeding may interfere with bonding. The mother and baby may not develop such a close, loving relationship.
- An artificially fed baby is more likely to become ill with diarrhoeal, respiratory, ear, and other infections.
- Diarrhoea may become persistent.
- He may get too little milk and may become malnourished, because he gets too few feeds, or because they are too dilute. He is more likely to suffer from vitamin A deficiency.
- An artificially fed baby is more likely to die from infections and malnutrition than a breastfed baby.
- He is more likely to develop allergic conditions such as eczema and possibly asthma.
- He may become intolerant of animal milk, so that the milk causes diarrhoea, rashes and other symptoms.
- The risk of some chronic diseases in the child, such as diabetes, is increased.
- A baby may get too much artificial milk, and become obese.
- He may not develop so well mentally, and may score lower on intelligence tests.
- A mother who does not breastfeed is more likely to become fertile again and can become pregnant more quickly.
- She is more likely to become anaemic after childbirth. She is more likely later on to develop cancer of the ovary and possibly of the breast.

So artificial feeding is harmful for children and their mothers. Breastfeeding is fundamental to child health and survival, and important for the health of women.

Overhead 1/15 Terms for infant feeding

☐ Ask participants to turn to page 10 of their manuals, and to find the list **TERMS FOR INFANT FEEDING**.

☺ Ask participants in turn to read out from the list the definition of each term after you mention it.

▪ This overhead illustrates the main terms to describe different ways of feeding infants.

Baby 1 is *exclusively breastfed*. (A participant reads the definition).

Baby 2 is *predominantly breastfed*. He is breastfeeding, but there is also a small cup on the table with some water in it. (A participant reads the definition).

Both Baby 1 and Baby 2 are *fully breastfed*. (A participant reads the definition).

Baby 3 is *bottle fed*. (A participant reads the definition.)

Baby 3 is also *artificially fed*. (A participant reads the definition.)

The terms "bottle fed" and "artificially fed" are both necessary, because a baby may be fed breastmilk from a bottle, or artificial feeds without a bottle, for example from a cup.

Baby 4 is breastfeeding, but his mother also has a bottle of an artificial feed for him. He is *partially breastfed*. (A participant reads the definition).

Baby 5 is more than 4-6 months old, and his mother is giving him some food in a bowl in addition to breastfeeding him. This is *timely complementary feeding*.
(A participant reads the definition).

TERMS FOR INFANT FEEDING

Exclusive breastfeeding:
Exclusive breastfeeding means giving a baby no other food or drink, including no water, in addition to breastfeeding (except medicines and vitamin or mineral drops; expressed breastmilk is also permitted).

Predominant breastfeeding:
Predominant breastfeeding means breastfeeding a baby, but also giving small amounts of water or water-based drinks - such as tea.

Full breastfeeding:
Full breastfeeding means breastfeeding either exclusively or predominantly.

Bottle feeding:
Bottle feeding means feeding a baby from a bottle, whatever is in the bottle, including expressed breastmilk.

Artificial feeding:
Artificial feeding means feeding a baby on artificial feeds, and not breastfeeding at all.

Partial breastfeeding:
Partial breastfeeding means giving a baby some breastfeeds, and some artificial feeds, either milk or cereal, or other food.

Timely complementary feeding:
Timely complementary feeding means giving a baby other food in addition to breastfeeding, when it is appropriate, from about 6 months of age.

Overhead 1/16 Recommendations

▪ This overhead summarizes the present recommendations for feeding infants and young children.

- Babies should start to breastfeed within ½-1 hour of birth. They should not have any food or drink before they start to breastfeed.
- Babies should be exclusively breastfed for *at least* the first four months of life.
- Between 4 and 6 months, give complementary foods only if the infant is not growing adequately, or if he appears hungry despite adequate breastfeeding. Most babies do not need complementary foods before 6 months of age.

- All children older than 6 months should receive complementary foods.
- Children should continue to breastfeed up to 2 years of age or beyond.

☐ Explain that participants can find a box with these **RECOMMENDATIONS** on page 9 of their manuals.

RECOMMENDATIONS

- Start breastfeeding within ½-1 hour of birth
- Breastfeed exclusively for at least 4 and if possible 6 months of age
- Give complementary between 4-6 months only if child is hungry or not growing
- Give complementary foods to all children from about 6 months of age
- Continue breastfeeding up to 2 years of age or beyond

V. Answer participants' questions (10 minutes)

☐ Ask participants if they have any questions about the material that you have presented, and try to answer them.

If they ask questions about topics that will be covered in later sessions, give a brief answer, and explain that you will discuss the topic more fully later.

☐ Recommended reading:
Helping Mothers to Breastfeed Chapter 3: `The composition of breastmilk and the disadvantages of artificial feeding'.

LOCAL BREASTFEEDING SITUATION

Objectives

At the end of this session, participants should be able to:
- describe the common patterns of infant feeding in the country, and common practices;
- describe what has been or is being done to promote breastfeeding.

Session outline (30 minutes)

Participants are all together for lecture presentation (I) or class discussion (II) led by one trainer.

I. Present local infant feeding data

Optional alternative if no local data available:

II. Discuss participants' experience

Preparation

Before course:
Decide which alternative (I or II) you will use for this session.

Try to obtain information about infant feeding in the country; for example, the results of any surveys or studies which have been done, or any information available from health service returns. Consult with local experts or researchers, and ministry of health officials.
Try to find data on exclusive breastfeeding, the use of water, teas, cereals, animal milk, formula, feeding bottles, and any other feeding methods, in both rural and urban areas.

You do not need large amounts of detailed information, but it is helpful to form a general picture of the situation.
If you cannot find enough local data, plan to use the Optional alternative II for this session.

Find out also what is being done or what has been done to promote breastfeeding.

Before the session:
Prepare your presentation.
Prepare overheads or a flipchart:
either with the data that you will present;
or with the questions and choice of answers that you want participants to discuss.

I. Present local infant feeding data (30 minutes)

☐ Present data which answers as many of the following key questions as possible.

If possible present data from different situations, for example, from rural and urban areas.

- *What percentage of mothers start breastfeeding?*
- *What percentage of babies breastfeed exclusively for 4-6 months?*
- *What percentage of babies have other drinks or food at 1, 2 and 3 months?*
- *What percentage of babies continue to breastfeed for more than 6, 12 and 24 months?*

Point out that these questions relate to the **RECOMMENDATIONS** presented in Overhead 1/16.

☐ Present data on the relationship between feeding practices and illnesses such as diarrhoea.

These might indicate whether particular practices cause health problems.

☐ Present data related to health care practices at the time of delivery (see also Session 8, `Health care practices'.)

- *What percentage of babies start to breastfeed within 1 hour of delivery?*
- *What percentage of babies are given other food or drink before they start to breastfeed?*

☐ Present data on reasons that mothers give for introducing other feeds, or for giving up breastfeeding early.

Present this information briefly. Make a list to post on the wall. Remember to discuss it again when the particular situations and difficulties are discussed in later sessions.

II. Discuss participants' experience (alternative: 30 minutes)

☺ Ask participants to find page 11 in their manuals, where they will find a list of questions.

☐ Explain what to do:

- In your manuals, next to each question there are three alternative answers:
  `few', `half', `most'.
  Choose the answer to each question that fits best with your experience, by putting a circle round it.

(Allow 5 minutes to answer.)

☐ Develop a list of `good' and `poor' practices.

→ Write these questions on an overhead or a flipchart:

		Good	Poor
How many babies start to breastfeed?		☐	☐
How many breastfeed within 1 hour of delivery?		☐	☐
How many have other foods or drinks before they start to breastfeed?		☐	☐
How many breastfeed exclusively for 4-6 months?		☐	☐
How many have other foods or drinks before:	1 month?	☐	☐
	2 months?	☐	☐
	3 months?	☐	☐
How many children continue to breastfeed for more than:	6 months?	☐	☐
	12 months?	☐	☐
	24 months?	☐	☐

☐ Discuss with the class for each practice which answer most of them circled, and whether the practice generally follows the recommendations from Overhead 1/16.

Decide with the class if the practice should be marked overall as `good' or `poor'. Mark `good' or `poor' on your list on the overhead or flipchart.

If you used a flipchart, post it on the wall.

☐ Develop a list of common reasons why mothers:
- give a baby other drinks or foods before 4-6 months;
- stop breastfeeding early.

→ Write on a flipchart the heading:
`REASONS FOR GIVING COMPLEMENTS OR STOPPING BREASTFEEDING EARLY'

Ask participants to suggest common reasons from their experience.
Write their suggestions on the list.
(Try not to have more than 10 reasons)

Post the list on the wall.

☐ Refer back to the list later, and remind participants what they included in it, when you discuss `Breast conditions' (Session 14), `Refusal to breastfeed' (Session 16), `Not enough milk' (Session 21), `Crying' (Session 22), and `Low-birth-weight and sick babies' (Session 26), and the Additional Sessions `Women's nutrition, health and fertility' (Session 31), and `Women and work' (Session 32).

Session 3

Back to CONTENTS

HOW BREASTFEEDING WORKS

Objectives

At the end of this session, participants will be able to:
- name the main parts of the breast, and describe their function;
- describe the hormonal control of breastmilk production and ejection;
- describe the difference between good and poor attachment of a baby at the breast;
- describe the difference between effective and ineffective suckling.

Session outline (60 minutes)

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

I. Introduce the topic (2 minutes)

II. Present Overheads 3/1-3/12 (45 minutes)

III. Summarize `How breastfeeding works' (5 minutes)

IV. Answer participants' questions (8 minutes)

Preparation

Refer to pages 9-11 of the Introduction, for general guidance on how to present overhead transparencies and how to use the accompanying notes and questions.

Make sure that Overheads 3/1 - 3/12 are in order.
Study each transparency and the text that goes with it, so that you are able to present them.

Read the **Further information** sections, so that you are familiar with the ideas that they contain, so that you can answer participants' questions.

As you follow the text, remember:

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

Do not present the **Further information** sections.
Use them to help you to answer questions.

I. Introduce the topic (2 minutes)

Ask participants to keep their <u>manuals closed</u> during the presentation.

□ Make these points:

- In this session, you will learn about the anatomy and physiology of breastfeeding. In order to help mothers, you need to understand how breastfeeding works.
- You cannot learn a specific way of counselling for every situation, or every difficulty. But if you understand how breastfeeding works, you can work out what is happening, and help each mother to decide what is best for her.

II. Present Overheads 3/1 - 3/12 (45 minutes)

□ As you show each overhead transparency, point on the projector or on the screen to the place which shows what you are explaining.

Overhead 3/1 Anatomy of the breast

- This diagram shows the anatomy of the breast.

First, look at the *nipple*, and the dark skin called the *areola* which surrounds it. In the areola are small glands called *Montgomery's glands* which secrete an oily fluid to keep the skin healthy.

Inside the breast are the *alveoli*, which are very 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.

Around the alveoli are muscle cells, which contract and squeeze out the milk. A hormone called *oxytocin* makes the muscle cells contract.

Small tubes, or *ducts*, carry milk from the alveoli to the outside. Beneath the areola, the ducts become wider, and form *lactiferous sinuses*, where milk collects in preparation for a feed. The ducts become narrow again as they pass through the nipple.

The secretory alveoli and ducts are surrounded by supporting tissue, and fat. It is the fat and other tissue which gives the breast its shape, and which makes most of the difference between large and small breasts. Small breasts and large breasts both contain about the same amount of gland tissue, so they can both make plenty of milk.

Overhead 3/2 Prolactin

- This diagram explains about the hormone *prolactin*.

When a baby suckles at the breast, *sensory impulses* go from the nipple to the brain. In response, the anterior part of the pituitary gland at the base of the brain secretes prolactin. Prolactin goes in the blood to the breast, and makes the milk secreting cells produce milk.

Most of the prolactin is in the blood about 30 minutes after the feed - so it makes the breast produce milk for the NEXT feed.
For this feed, the baby takes the milk which is already in the breast.

Ask: *What does this suggest about how to increase a mother's milk supply?*

It tells us that if her baby suckles more, her breasts will make more milk. So MORE SUCKLING MAKES MORE MILK.

Most women can produce more milk than their babies need or take. If a mother has two babies, and they both suckle, her breasts make milk for two. Most mothers can produce enough milk for at least two babies.

If a baby suckles less, the breasts make less milk. If a baby stops suckling, the breasts soon stop making milk.

Some special things to remember about prolactin are:

- More prolactin is produced at night; so breastfeeding at night is especially helpful for keeping up the milk supply.

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

- Hormones related to prolactin suppress ovulation; so breastfeeding can help to delay a new pregnancy. Breastfeeding at night is important for this.

Overhead 3/3 Oxytocin reflex

- This diagram explains about the hormone *oxytocin.*

When a baby suckles, sensory impulses go from the nipple to the brain. In response, the posterior part of the pituitary gland at the base of the brain secretes the hormone oxytocin. Oxytocin goes in the blood to the breast, and makes the muscle cells around the alveoli contract. This makes the milk which has collected in the alveoli flow along the ducts to the lactiferous sinuses. Sometimes the milk flows to the outside. This is the *oxytocin reflex* or the *milk ejection reflex*.

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 learns to expect a feed.

If the oxytocin reflex does not work well, the baby may have difficulty in getting the milk. It may seem as if the breasts have stopped producing milk. However, the breasts are producing milk, but it is not flowing out.

Another important point about oxytocin is that it makes a mother's uterus contract after delivery. This helps to reduce bleeding, but it sometimes causes uterine pain and a rush of blood during a feed for the first few days. The pains can be quite strong.

Further information
The oxytocin reflex is sometimes called the `let-down reflex'.

Overhead 3/4 Helping and hindering the oxytocin reflex

- This diagram shows how the oxytocin reflex is easily affected by a mother's thoughts and feelings and sensations.

Good feelings, for example feeling pleased with her baby, or thinking lovingly of him, and feeling confident that her milk is the best for him, can help the oxytocin reflex to work and her milk to flow. Sensations such as touching or seeing her baby, or hearing him cry, can also help the reflex.

But bad feelings, such as pain, or worry, or doubt that she has enough milk, can hinder the reflex and stop her milk from flowing. Fortunately, this effect is usually temporary.

Ask: *Why is it important to understand the oxytocin reflex?*

It explains these two **key points** about caring for mothers and babies:

- A mother needs to have her baby near her all the time, so that she can see and touch and respond to him. This helps her body to prepare for a breastfeed, and it helps her breastmilk to flow. If a mother is separated from her baby between feeds, her oxytocin reflex may not work so easily.

- You need to remember a mother's feelings whenever you talk to her. It is important that you try to make her feel good and build her confidence, to help her breastmilk to flow well. You must not say anything which may make her worry about or doubt her breastmilk supply.

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 find page 14 in their manuals, and to find the list **SIGNS AND SENSATIONS OF AN ACTIVE OXYTOCIN REFLEX**.

☺ Ask participants to read out the signs in turn.

SIGNS AND SENSATIONS OF AN ACTIVE OXYTOCIN REFLEX

- A mother may notice:
- 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 him crying
- Milk dripping from her other breast, when her baby is suckling
- Milk flowing from her breasts 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 breastmilk is flowing into his mouth

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▪ You may notice some of these signs when you observe a mother and baby, or you can ask a mother if she notices them.

If one or more of the signs or sensations are present, then a mother can be sure that her oxytocin reflex is active, and that her breastmilk is flowing. However, even if her reflex is active, she may not feel the sensations, and the signs may not be obvious.

Overhead 3/5 Inhibitor in breastmilk

▪ Breastmilk production is also controlled within the breast itself.

You may wonder why sometimes one breast stops making milk, while the other breast continues to make milk - although oxytocin and prolactin go equally to both breasts. This diagram shows why.

There is a substance in breastmilk which can reduce or *inhibit* milk production.
If a lot of milk is left in a breast, the inhibitor stops the cells from secreting any more. This helps to protect the breast from the harmful effects of being too full. It is obviously necessary if a baby dies or stops breastfeeding for some other reason.
If breastmilk is removed, by suckling or expression, the inhibitor is also removed. Then the breast makes more milk.

This helps you to understand why:
- 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.

It also helps you to understand why:
- For a breast to continue to make milk, the milk must be removed.
- If a baby cannot suckle from one or both breasts, *the breastmilk must be removed by expression* to enable production to continue.

Projector off

 Remove Overhead 3/5.

Ask: *From what you have learnt, can you suggest what controls the production of milk? What controls prolactin production, the oxytocin reflex, and the inhibitor within the breast?*
(Let participants suggest the answer. Give them a few minutes to think about it. Then continue.)

Key point: The baby's suckling controls them all. It is the baby's suckling which makes the breasts produce milk.

 Make these points:

- Sometimes people talk as though to make a mother produce more milk, we should give her more to eat, or more to drink, more rest, or medicines. It is important for a mother to eat and drink enough, but these things do not help her to produce milk if her baby does not suckle.

- For a mother to produce enough milk, her baby must suckle often enough, and he must also suckle in the right way.

Overhead 3/6 Attachment to the breast

- This diagram shows how a baby takes the breast into his mouth to suckle.

Notice these points:
- He has taken much of the areola and the underlying tissues into his mouth.
- The lactiferous sinuses are included in these underlying tissues.
- He has stretched the breast tissue out to form a long `teat'.
- The nipple forms only about one-third of the `teat'.
- The baby is suckling from the breast, not the nipple.

Notice the position of the baby's tongue:
- His tongue is forward, over his lower gums, and beneath the lactiferous sinuses. His tongue is in fact cupped round the `teat' of breast tissue. You cannot see that in this drawing, though you may see it when you observe a baby.

If a baby takes the breast into his mouth in this way, he can suckle in the right way. We say that he is *well attached* to the breast.

Overhead 3/7 Suckling action

- This is the same baby as in Overhead 3/6, and you can see what happens to his tongue when he suckles.

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 presses milk out of the lactiferous sinuses into the baby's mouth, from where he swallows it.

So a baby does not suck milk out of a breast, like drinking through a straw.
Instead:
- He uses suction to pull out the breast tissue to form a teat, and to hold the breast tissue in his mouth.
- The oxytocin reflex makes breastmilk flow to the lactiferous sinuses.
- The action of his tongue presses the milk from the lactiferous sinuses into his mouth.

When a baby is well attached, he removes breastmilk easily, and it is called *effective suckling.*

It is also helpful to understand that when a baby suckles in this way, his mouth and tongue do not rub the skin of the breast and nipple.

Overhead 3/8 Good and poor attachment

- Here you see two pictures. Picture 1 is the same baby as in Overhead 3/6. He is well attached to the breast. Picture 2 shows a baby suckling in a different way.

Ask: *In what way is picture 2 different from picture 1?*
(Let participants make as many observations as they can.
Then make sure that the three following points are clear.
If participants notice signs that are described with Overhead 3/9, accept their observations, but do not repeat or emphasize them yet.)

The most important differences to see in picture 2 are:
- Only the nipple is in the baby's mouth, not the underlying breast tissue.
- The lactiferous sinuses 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 lactiferous sinuses.

The baby in picture 2 is poorly attached. He is `nipple sucking'.

Overhead 3/9 Attachment - outside appearance

- This picture shows the same two babies from the outside.

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

In picture 1:
- The baby's chin touches the breast.
- His mouth is wide open.
- His lower lip is turned outwards.
- You can see more of the areola above his mouth and less below.
  This shows that he is reaching with his tongue under the lactiferous sinuses to press out the milk.

These are some of the signs that you can see from the outside which tell you that a baby is well attached to the breast.

In picture 2:
- The baby's chin does not touch the breast.
- His mouth is not wide open, and it points forwards.
- His lower lip is not turned outwards.
- You can see the same amount of areola above and below his mouth, which shows that he is not reaching the lactiferous sinuses.

These are some of the signs that you can see from the outside which show that a baby is poorly attached to the breast.

You may notice more areola outside the poorly attached baby's mouth.

Key point: Seeing a lot of areola is not a reliable sign of poor attachment. Some mothers have a very large areola, and you can see a lot even if the baby is well attached. It is more reliable to compare how much areola you see above and below a baby's mouth.

There are other differences which you can see when you look at a real baby, which you will learn about in Sessions 4 and 5.

Further information
The amount of areola that you see outside a baby's mouth may help you to compare the attachment of the same baby

before and after you correct it. However, the first time that 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; or a very large areola, so that you can always see a lot outside.

 Show Overhead 3/8 again.

Ask: *What do you think might be the results of a baby suckling in a poor position?*
(Let participants make 4-5 suggestions, from what they see in Overhead 3/8.
Then show Overhead 3/10 to complete the answer.)

Overhead 3/10 Results of poor attachment

 Do not show the whole overhead at once.

Use a piece of paper to cover everything except the title.
Pull the paper down to reveal the lines of text one by one.

Compliment participants on the points that they suggested correctly.
Make sure that the other points are quite clear.
Show Overhead 3/8 again if necessary to help to explain the points.

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

- *The baby may cause pain and damage to the nipple.*

If a baby is poorly attached, and he `nipple sucks', it is painful for his mother. Poor attachment is the most important cause of sore nipples.

As the baby sucks hard to try to get milk, he pulls the nipple in and out. This makes the nipple skin rub against his mouth. If a baby continues to suck in this way, he can damage the nipple skin, and cause *fissures* (cracks).
Suction on the tip of the nipple can cause a fissure across the tip. Rubbing the skin at the base of the nipple can cause a fissure around the base.

- *The baby does not remove breastmilk effectively.*

If a baby is poorly attached, he does not remove breastmilk effectively. The way that he suckles is called *ineffective suckling*. These can be the results:

- The breasts may become engorged.
- The baby may be unsatisfied, because the breastmilk comes slowly.
  He may cry a lot, and want to feed often, or for a very long time at each feed.
- The baby may not get enough breastmilk.
  He may be so frustrated that he refuses to feed altogether.
  He may fail to gain weight.
  If the oxytocin reflex works well, he may get enough breastmilk at least for a few weeks, by feeding very often. But it can exhaust his mother.
- The breasts may make less milk, because the milk is not removed.

So poor attachment can make it SEEM as though a mother is not producing enough milk. In other words she has an *apparent* poor milk supply. Then, if the situation continues, her breasts may really make less milk. In either situation, the result may be poor weight gain in her baby and breastfeeding failure.

Further information
The point about frequent suckling being a result of ineffective suckling may seem to contradict what was said about

`more suckling makes more milk'. More suckling makes more milk if a baby is well attached, suckling effectively, and allowed to finish a feed, so that he removes the milk. In this case, if he suckles more often, the breasts will make more milk.

A baby who is suckling effectively may not want to feed very often, though the interval between feeds may be irregular. If a baby wants to feed more often than about every 1-1 hours it is likely that he is either not well attached, or that he is having very short feeds, so that he is not removing much milk. Increased frequency of suckling will not make more milk for him, until the other conditions are corrected. See also Session 21 `Not enough milk'.

Overhead 3/11 Causes of poor attachment

Cover the overhead with a piece of paper, except for the title.
Reveal it line by line as you discuss each point.

- This overhead summarizes the common causes of poor attachment to the breast.

- *Use of a feeding bottle.*

If a baby feeds from a bottle before breastfeeding is established, he may have difficulty suckling effectively. Some babies who start bottle feeds after a few weeks may also begin to suckle ineffectively.

The action of sucking from a bottle is different from suckling from the breast. Babies who have had some bottle feeds may try to suck on the breast as if it is a bottle, and this makes them `nipple suck'. When this happens, it is sometimes called `sucking confusion' or `nipple confusion'. So giving a baby feeds from a bottle can interfere with breastfeeding. Skilled help is needed to overcome the problem.

- *Inexperienced mother.*

If a mother has not had a baby before, or if she bottle fed or 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.)

- *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* (difficult to stretch out to form a `teat' - see Session 14, `Breast conditions');
- If her breasts are engorged;
- 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.

- *Lack of skilled support.*

A very important cause of poor attachment is *lack of skilled help and 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.

Overhead 3/12 Reflexes in the baby

- Earlier overheads showed reflexes in a mother, but it is also useful to know about the reflexes in a baby.

There are three main reflexes - the *rooting reflex*, the *sucking reflex*, and the *swallowing reflex.*

When something touches a baby's lips or cheek, he opens his mouth and may turn his head to find it. He puts his tongue down and forward. This is the `rooting' reflex. It should normally be the breast that he is `rooting' for.

When something touches a baby's palate, he starts to suck it, and when his mouth fills with milk, he swallows. All these are reflexes, which happen automatically without the baby having to learn to do them.

But there are some things that a mother and baby have to learn. A mother has to learn how to hold her breast and position her baby, so that he can attach well. A baby has to learn how to take the breast into his mouth to suckle effectively.

Many mothers and babies do it easily. But some need help - especially in any of the situations mentioned with Overhead 3/11.

Notice in the drawing that the baby is not coming straight towards the breast. He is coming up to it from below the nipple. This helps him to attach well because:
- The nipple is aiming towards the baby's palate, so it can stimulate his sucking reflex.
- The baby's lower lip is aiming well below the nipple so he can get his tongue under the lactiferous sinuses.

III. Summarize `How breastfeeding works' (5 minutes)

 Summarize the session with these points and questions:

- To help mothers to breastfeed, it is important to understand how breastfeeding works.

Ask: *What does knowing about the oxytocin reflex help you to understand?*

Breastmilk flow depends partly on the mother's thoughts, feelings and sensations.
It is important to keep mothers and babies together day and night, and to help mothers to feel good about breastfeeding.

Ask: *What does knowing about how babies suckle help you to understand?*

Many common difficulties can be caused by poor attachment to the breast.
These difficulties can be overcome by helping the mother to correct her baby's position.
They can be prevented by helping a mother to position her baby in the first few days.

Ask: *What does knowing about the prolactin reflex help you to understand?*

The amount of milk that the breasts produce depends partly on how much the baby suckles. More suckling makes more milk.

Most mothers can produce more milk than their babies take, and they can produce enough for twins.

Ask: *What does knowing about the inhibitor in breastmilk help you to understand?*

The amount of milk that a breast produces depends partly on how much the baby removes. For a breast to continue to make milk, it is necessary to remove the milk.

 Ask participants to find the box **BREASTFEEDING WILL BE SUCCESSFUL IN MOST CASES IF:** on page 18 of their manuals.

Read out the box, and point out that it summarizes the main conclusions from the session.

BREASTFEEDING WILL BE SUCCESSFUL IN MOST CASES IF:

- The mother feels good about herself
- The baby is well attached to the breast so that he suckles effectively
- The baby suckles as often and for as long as he wants
- The environment supports breastfeeding

IV. Answer participants' questions (8 minutes)

 Ask participants if they have any questions, and try to answer them.

 Recommended reading:
Helping Mothers to Breastfeed Chapter 2 `The production of breastmilk and how a baby suckles'.

Session 4

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ASSESSING A BREASTFEED

This session must follow Session 3, `How breastfeeding works'.

Objectives

At the end of this session, participants will be able to:
- assess a breastfeed by observing a mother and baby;
- identify a mother who may need help.

Session outline (60 minutes)

Participants are all together for a demonstration led by one trainer.

I. Introduce the topic (5 minutes)

II. Demonstrate and explain how to assess a breastfeed (35 minutes)

III. Answer participants' questions (10 minutes)

IV. Explain the B-R-E-A-S-T-FEED Observation Form (10 minutes)

Preparation

Refer to pages 12-13 in the Introduction for general information about how to give a demonstration.
Study the notes for the session so that you are clear about what to do.

For Section II:
Points 1 and 2
Ask two participants to help you with the demonstration.
Explain what you want them to do, and help them to practise.
Make sure that they have dolls for the demonstration.
If you feel that participants cannot do this on the first day of the course, ask other trainers to help instead.

Points 5 and 6
Make sure that you have a model breast available. (See page 6 for instructions on `How to make a model breast'.)

Point 7
Have Overhead 3/9 ready to show again.

As you follow the text, remember:

☐ indicates an instruction to you, the trainer
▪ indicates what you say to participants

I. Introduce the topic (5 minutes)

☐ Make these points:

- Assessing a breastfeed helps you to decide if a mother needs help or not, and how to help her.
- You can learn a lot about how well or badly breastfeeding is going by observing, before you ask questions.
- This is just as important a part of clinical practice as other kinds of examination, such as looking for signs of dehydration, or counting how fast a child is breathing.
- There are some things you can observe when a baby is not breastfeeding. Other things you can only observe if a baby is breastfeeding.

II. Demonstrate and explain how to assess a breastfeed (35 minutes)

☐ Ask participants to turn to page 19 of their manuals, and to find the list of points **HOW TO**

HOW TO ASSESS A BREASTFEED

1. What do you notice about the mother?
2. How does the mother hold her baby?

3. What do you notice about the baby?
4. How does the baby respond?

5. How does the mother put her baby onto her breast?
6. How does the mother hold her breast during a feed?

7. Does the baby look well attached to the breast?
8. Is the baby suckling effectively?

9. How does the breastfeed finish?
10. Does the baby seem satisfied?

11. What is the condition of the mother's breasts?
12. How does breastfeeding feel to the mother?

☐ Explain each point in turn.

Read out the ***number and title*** of each point, or pair of points. Then give the demonstration, or explanation, or conduct the discussion as described.

Ask participants to keep the list in front of them and to refer to it as you explain the points.

Point 1: What do you notice about the mother?
Point 2: How does the mother hold her baby?

☺ Ask two participants to hold dolls to play the roles of mothers and babies.

Mother A sits comfortably and relaxed, and acts being happy and pleased with her baby. She holds it close, facing her breast, and she supports its bottom. She looks at her baby, and fondles or touches it lovingly.

Mother B sits uncomfortably, and acts being sad and not interested in her baby. She holds it loosely, and not close, with its neck twisted, and she does not support its bottom. She does not look at it or fondle it, but she shakes or prods the baby a few times to make it go on breastfeeding.

☐ Ask the other participants to observe the `mothers and babies'.

Ask the questions for Point 1 and Point 2.
Give them a few minutes to make some suggestions.
Help them to think of the points listed after the questions.
Indicate which points the `mothers' are acting.

Ask: *Point 1: What may you notice about a mother?*

- You may notice:

  - Her age, general health, nutrition, socioeconomic status:
    (Clothes may be misleading if women dress up to go to a health centre.)
    This may give you some clues about her life situation, and whether it is easy or difficult for her to care for and breastfeed her baby.

  - Her expression, which may tell you something about how she feels:
    If she is happy and pleased with her baby, she is more likely to breastfeed successfully (mother A).
    If she is miserable and not interested, she is less likely to breastfeed successfully (mother B).

  - Whether she looks comfortable and relaxed or uncomfortable and tense:
    If she is comfortable and relaxed, it helps breastfeeding (mother A).
    If she is uncomfortable and tense, it makes breastfeeding more difficult (mother B).

- There are many other things that you may notice in different situations, for example:

  - Any other family members who are present, such as the father or grandmother, and how they relate to the mother and baby.
  - Whether the mother is carrying a feeding bottle in her bag.
  - If she has clothes which make it difficult to breastfeed.

Ask: *Point 2: What may you notice about how a mother holds her baby?*

- You may notice whether:

  - She holds him close, facing her breast, or loosely and turned away:
    If she holds the baby close to the breast and facing it, it is easier for him to suckle effectively (mother A).
    If she holds him loosely, or turned away so that his neck is twisted, it is more difficult for him to suckle effectively (mother B).

  - She holds him securely and confidently, or nervously:
    If a mother holds her baby securely and feels confident, it is easier for her baby to suckle effectively, and her milk will flow more easily (mother A).
    If a mother is nervous and lacks confidence, she may show this by shaking or prodding the baby to make him go on feeding. This can upset her baby and interfere with suckling and breastmilk flow (mother B).

  - She shows signs of bonding to her baby:
    If she looks at him, touches him, and talks to him, these are signs of bonding, which help breastfeeding (mother A).
    If she does not look at the baby, and does not touch him or talk to him, these are signs that she has not bonded well. She is more likely to have problems with breastfeeding (mother B).

  - She supports his bottom, or only his head and shoulders:
    For a young infant, it is easier to attach to the breast if his bottom is supported, and not just his head (mother A).
    For older babies support of the upper part of the body is usually enough.

- Remember from Session 3 that if a mother feels good about breastfeeding, and if her baby is positioned so that he can suckle effectively, breastfeeding is likely to be successful.

☐ Thank the participants who played the two mothers.

Point 3: What do you notice about the baby?

- Look at his general health, nutrition, and alertness.

- Look for signs of conditions which can interfere with breastfeeding:

  - blocked nose;
  - difficult breathing;
  - thrush;
  - jaundice;
  - dehydration;
  - tongue tie;
  - a cleft lip or palate.

Point 4: How does the baby respond?

- Look for these responses:

  - If he is a young infant: rooting for the breast when he is ready for a feed.
    He may turn his head from side to side, open his mouth, put his tongue down and forward, and reach for the breast.
  - If he is an older baby: turning and reaching for the breast with his hand.
    Both these responses show that a baby wants to breastfeed.

  - The baby crying or pulling back or turning away from his mother.
    This response shows that a baby does not want to breastfeed, and that there is a problem with breastfeeding.

  - The baby being calm during a feed, and relaxed and contented after a feed.
    These are signs that he is getting breastmilk.

  - The baby being restless and slipping off the breast or refusing to feed.
    This may mean that he is not well attached and is not getting the breastmilk.

Point 5: How does the mother put her baby on her breast?

☐ Demonstrate these points with a model breast.

- Look for these signs:

  - The mother trying to push her nipple into her baby's mouth.
    She may lean forward or pinch up her nipple.
    This makes it more difficult for a baby to attach to the breast.

  - The mother bringing her baby to her breast.
    She may support her whole breast with her hand, and if necessary shape her breast with her thumb above the breast. This is helpful for a baby.

Point 6: How does the mother hold her breast during a feed?

☐ Demonstrate these points with a model breast.

- Look for these signs:

  - The mother holding her breast very close to the areola.
    This makes it more difficult for a baby to suckle. It may block the milk ducts so that it is more difficult for the baby to get the breastmilk.

  - The mother holding her breast back from her baby's nose with her finger.
    This is not necessary.

  - The mother holding her breast with the `scissor hold'.
    The `scissor hold' (sometimes called the `cigarette hold') means when she holds the nipple and areola between her index finger above and middle finger below. This can make it more difficult for a baby to take enough breast into his mouth. The pressure of her fingers may block the milk ducts.

  - The mother supporting her whole breast with her hand against her chest wall.
    This usually helps a baby to suckle effectively, especially if his mother has large breasts.

Point 7: Does the baby look well attached to the breast?

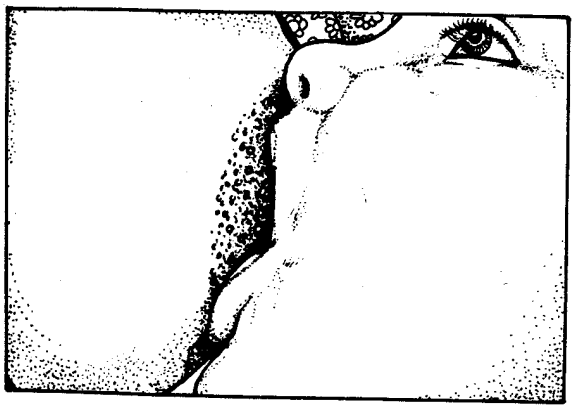
☐ Remind participants that this was explained in Session 3.
Show Overhead 3/9 again.

Ask: *Which signs of good attachment may you see?*

- The baby's chin touching the breast.
- His mouth wide open.
  (This is important with large breasts, but less important with thin breasts.)
- His lower lip turned outwards.
- His cheeks round, or flattened against his mother's breast.
- More areola above the baby's mouth than below it.
- The breast looking rounded during a feed.

Ask: *Which signs of poor attachment may you see?*

- The baby's chin not touching the breast.
- His mouth not wide open (especially with a large breast).
- His lips pointing forwards or his lower lip turned in.
- His cheeks tense or pulled in as he suckles.
- More areola below the baby's mouth than above it,
  or the same amount above and below.
- The breast looks stretched or pulled during a feed.



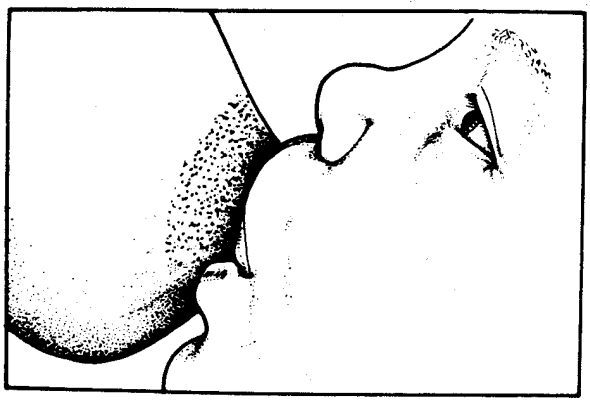


Fig.1 a. A baby well attached to his mother's breast

b. A baby poorly attached to his mother's breast

(Fig.19 in Participants' Manual)

Point 8: Is the baby suckling effectively?

☐ Give the following demonstrations as you explain:

To demonstrate good attachment:
Suck on your fist, with your mouth open wide, your tongue forward, and your lower lip curled back. Give slow deep sucks, about 1 per second.

To demonstrate poor attachment:
Suck on your thumb, with your mouth almost closed, your lips pointing forwards, and letting your cheeks pull in. Give quick, small sucks.

- Look for these signs:

- The baby taking slow deep sucks.
  This is an important sign that a baby is getting breastmilk. He is well attached to the breast, and suckling effectively.
  A baby usually takes a few quick sucks to start the oxytocin reflex. Then as the milk starts flowing and his mouth fills with milk, his sucks become deeper and slower. Then he pauses, and starts again with a few quick sucks.

- The baby taking quick shallow sucks all the time.
  This is a sign that he is not getting the breastmilk. He is not well attached, and not suckling effectively.

- The baby swallowing so that you can see or hear it.
  If a baby swallows, it means that he is getting breastmilk. Sometimes you can hear swallowing; sometimes it is easier to see swallowing.

- The baby making smacking sounds as he sucks.
  This is a sign that he is not well attached.

- The baby `gulping' as he swallows.
  Gulps are very loud swallowing sounds, when a lot of fluid is being swallowed at once.
  This is a sign that a baby is getting a lot of milk. It sometimes means that his mother has an oversupply, and her baby is getting too much milk too fast. Oversupply is sometimes the

cause of breastfeeding difficulties.

Point 9: How does the breastfeed finish?
Point 10: Does the baby seem satisfied?

- Look for these signs:

  - The baby releasing the breast himself, and looking satisfied and sleepy.
    This shows that he has had all that he wants from that side. He may or may not want the other side too.

  - The mother taking her baby off her breast before he has finished.
    A mother sometimes takes her baby off her breast quickly, as soon as he pauses, because she thinks he has finished; or because she wants to make sure that he suckles from the other side as well.
    A baby who comes off the breast too quickly may not get enough hindmilk.
    He may want to feed again soon.

- Notice how long the breastfeed continues:

  The exact length of time is not important. Feeds normally vary very much in length. But if breastfeeds are very long (more than about half an hour) or very short (less than about 4 minutes) it may mean that there is a problem.
  However, in the first few days, or with a low-birth-weight baby, breastfeeds may be very long and this is normal.

Point 11: What is the condition of the mother's breasts?
Point 12: How does breastfeeding feel to the mother?

- Notice the size and shape of the mother's breasts and nipples:

  All breasts are good for breastfeeding, but a mother may be worried that her breasts are not the best size. As a result, she may lack confidence in her ability to breastfeed. Sometimes the shape of a nipple makes it more difficult for a baby to attach to a breast, (see Session 14, `Breast conditions').

- Look and ask for signs of an active oxytocin reflex:

  - Milk dripping or spraying out of a mother's breasts.
    This shows that she has an active oxytocin reflex.
    If milk does not flow out, however, it does not mean that her reflex is not active.
  - Uterine pains during breastfeeds for the first few days.
    These are called *afterpains*. They are another sign of an active oxytocin reflex.

- Look also for these signs:

  - Breasts which are full before and soft after a feed, showing that the baby is removing breastmilk.
  - Breasts which are very full or engorged all the time, showing that the baby is probably not removing breastmilk effectively.
  - Healthy looking skin of the nipples and breast.
  - Red skin or fissures which show that there is a problem.
  - Nipple looking squashed or with a line across the tip or down the side as the baby releases the breast. This is a sign of poor attachment.

- Ask the mother how breastfeeding feels to her:

  If it is comfortable and pleasant, her baby is probably well attached.
  If it is uncomfortable or painful, the baby is probably not well attached.

III. Answer participants' questions (10 minutes)

☐ Ask participants if they have any questions about assessing a breastfeed, and try to answer them.

IV. Explain the B-R-E-A-S-T-FEED Observation Form (10 minutes)

Ask participants to turn to page 21 of their manuals, where they will find the B-R-E-A-S-T-FEED Observation Form.

☐ Introduce the form:

- This is called the B-R-E-A-S-T-FEED Observation Form. It summarizes the key points for assessing a breastfeed. You will use this form to practise observing breastfeeds with mothers and babies.

☐ Ask participants to read through the form, and to ask if there are any signs that they are not yet clear about. (Allow 5 minutes).

☐ Explain the form:

Ask participants to study the form as you make these points:

- The signs are grouped into 6 groups for **B**ody position, **R**esponses, **E**motional bonding, **A**natomy, **S**uckling and **T**ime spent suckling. The initial letters of the names of the groups spell the word B-R-E-A-S-T.
  This is to help you to remember what you have to look for, so that later on, when you have had more practice, you will not need to use the form all the time.

- The signs on the left all show that breastfeeding is going well. The signs on the right indicate a possible difficulty.

- Beside each sign is a box ☐ to mark with a tick ✔ if you have seen the sign in the mother that you are observing.

☐ Explain how to use the form:

- As you observe a breastfeed, mark a ✔ in the box for each sign that you observe. If you do not observe a sign, you should make no mark.

☐ Explain how to interpret the form:

- If all ✔s are on the left hand side of the form, breastfeeding is probably going well.

- If there are some ✔s on the right hand side, then breastfeeding may not be going well. This mother may have a difficulty, and she may need your help.

Further information

These points may help you to answer questions about the B-R-E-A-S-T-FEED Observation Form which arise later, as

participants practise using it in clinical practice sessions.

- The negative signs, such as "no signs of milk ejection", and "cannot see tongue", do not necessarily mean that there is a difficulty. However, the opposite positive signs are always helpful.

- If a mother says that breastfeeding is going well, but you see signs that indicate 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 to help her. Even if she is not aware of any difficulty now, you may prevent one occurring later.
  - If breastfeeding seems to be well established, you probably do not want to intervene immediately. It is usually more helpful to see her again soon, and follow the baby's growth, to make sure that breastfeeding continues to go well. Intervene only if a difficulty arises.

B-R-E-A-S-T-FEED OBSERVATION FORM

Mother's name: _____ Date: _____

Baby's name: _____ Age of baby: _____

[Signs in brackets refer only to newborn, not to older babies]

Signs that breastfeeding is going well	*Signs of possible difficulty*
BODY POSITION	
☐ Mother relaxed and comfortable	☐ Shoulders tense, leans over baby
☐ Baby's body close, facing breast	☐ Baby's body away from mother's
☐ Baby's head and body straight	☐ Baby's neck twisted
☐ Baby's chin touching breast	☐ Baby's chin not touching breast
☐ [Baby's bottom supported]	☐ [Only shoulder or head supported]
RESPONSES	
☐ Baby reaches for breast if hungry	☐ No response to breast
☐ [Baby roots for breast]	☐ [No rooting observed]
☐ Baby explores breast with tongue	☐ Baby not interested in breast
☐ Baby calm and alert at breast	☐ Baby restless or crying
☐ Baby stays attached to breast	☐ Baby slips off breast
☐ Signs of milk ejection, [leaking, afterpains]	☐ No signs of milk ejection
EMOTIONAL BONDING	
☐ Secure, confident hold	☐ Nervous or limp hold
☐ Face-to-face attention from mother	☐ No mother/baby eye contact
☐ Much touching by mother	☐ Little touching or
	☐ Shaking or poking baby
ANATOMY	
☐ Breasts soft after feed	☐ Breasts engorged
☐ Nipples stand out, protractile	☐ Nipples flat or inverted
☐ Skin appears healthy	☐ Fissures or redness of skin
☐ Breast looks round during feed	☐ Breast looks stretched or pulled
SUCKLING	
☐ Mouth wide open	☐ Mouth not wide open, points forward
☐ Lower lip turned outwards	☐ Lower lip turned in
☐ Tongue cupped around breast	☐ Baby's tongue not seen
☐ Cheeks round	☐ Cheeks tense or pulled in
☐ More areola above baby's mouth	☐ More areola below baby's mouth
☐ Slow deep sucks, bursts with pauses	☐ Rapid sucks only
☐ Can see or hear swallowing	☐ Can hear smacking or clicking
TIME SPENT SUCKLING	
☐ Baby releases breast	☐ Mother takes baby off breast
Baby suckled for ___ minutes	

Notes:

OBSERVING A BREASTFEED

Objectives

Participants practise:
- recognizing signs of good and poor positioning and attachment;
- using the B-R-E-A-S-T-FEED Observation Form.

Session outline (60 minutes)

Participants are all together for a slide presentation and exercise led by one trainer.
All trainers help to give individual feedback for the exercise.

I. Introduce the topic (5 minutes)

II. Show and discuss slides 5/1 to 5/11 (25 minutes)

III. Practise using the B-R-E-A-S-T-FEED Observation Form (Exercise I, Slides 5/12-5/15) (25 minutes)

IV. Conclude `Observing a breastfeed' (5 minutes)

Preparation

Refer to page 9 in the Introduction, for general guidance on showing slides.

Before the session:
Make sure that Slides 5/1 to 5/11 and 5/12 to 5/15 are in order.
Study the slides and the accompanying text together, so that you are familiar with what each slide shows, and the particular points to teach from it.

At the beginning of the session:
Ask participants to arrange their seats so that they are sitting in a half circle near to the screen, without tables or other obstruction in front of them. They need to be able to go to the screen to point out appearances on the slides.

Put a seat for yourself to sit with the participants, so that you do not stand up in front to lecture.

Make sure that participants all have a pencil and eraser to mark the forms.

As you follow the text, remember:

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

I. Introduce the topic (5 minutes)

□ Explain what will happen:

- ▪ You will now see a series of slides of babies breastfeeding.
- ▪ You will practise recognizing the signs of good and poor positioning and attachment that the slides show, and you will practise using the B-R-E-A-S-T-FEED Observation Form.
- ▪ You will not be able to see all of the signs in the slides.
  For example, you cannot see signs with movement in slides. In some slides a sign may not be clear. In some slides you cannot see the position of a baby's body, but you can see how he is attached.
- ▪ Observe the signs that are clear, and do not worry about signs that you cannot see.
  (However, when you see real mothers and babies, you should look for all the signs.)

II. Show and discuss Slides 5/1 to 5/11 (25 minutes)

□ Explain what to do:

- ▪ As you look at each slide:
  - Decide which signs of good or poor positioning and attachment you see.
  - Decide if you think the baby's position and attachment are good or poor.

. Ask a participant to come forward to the screen for each of the Slides 5/1 to 5/11.
Ask a different participant to come forward for each slide.

□ As you show each slide:

Ask: *What do you think of this baby's position and attachment?*

Give the participant at the screen a few moments to study the picture, and to describe and point to the signs that she sees.

Then ask other participants to describe the signs that they see.
Then point out any signs that they have missed.
Try not to repeat signs that they have already mentioned.

The text below lists the signs that each slide illustrates particularly well, and which can help the observer to make a decision.

Participants may describe more signs than are given in the text. There are other signs in the slides, but most of them are not very helpful. Accept participants' observations, or gently correct them if they are incorrect.

Slides 5/1 to 5/11 Recognising signs of good positioning and attachment

Slide 5/1

- Signs that you can see clearly are:
  - the baby is close to the breast, and facing it;
  - his mouth is quite wide open;
  - his lower lip is turned outwards;
  - his chin is almost touching the breast;
  - his cheeks are round;
  - there is more areola above the baby's mouth than below it.

- These signs show that the baby is well attached to the breast.

Additional points for Slide 5/1
The baby is breathing quite well without his mother holding her breast back with her finger.

Slide 5/2

- Signs that you can see clearly are:
  - the baby's chin is not touching the breast;
  - his mouth points forwards;
  - his cheeks are pulled in.

- This baby is poorly attached.

Additional points for Slide 5/2
The mother is holding her breast with the `scissor hold'.

Slide 5/3

- Signs that you can see are:
  - the baby is not close to the breast;
  - his chin is not touching the breast (you can see that this must be so, even though his chin is hidden behind his hand);
  - his mouth is not wide open, his lips point forward;
  - there is as much or more areola below the baby's mouth as above it.

- This baby is poorly attached.
  He looks as though he is feeding from a bottle.

Slide 5/4

- Signs that you can see are:
  - the baby is very close to the breast (which makes it difficult to see many other signs);
  - his chin is touching the breast;
  - his cheek is round and not pulled in (though it is somewhat flattened against his mother's breast);
  - there is a little areola above the baby's mouth.

- The baby is well attached.

Additional points for Slide 5/4
This is the same baby as in Slide 5/3, after the health worker has helped the mother to position the baby better.

Slide 5/5

- Signs that you can see are:
  - the baby's body is not close to his mother's;
  - his chin is not touching her breast;
  - his mouth is not wide open and his lips point forwards;
  - there is as much areola below the baby's mouth as above it.

- This baby is poorly attached to the breast.

Additional points for Slide 5/5
The areola on this mother's breast is very large, so it is likely that you would see a lot of it even if her baby was well attached. However, you should see more above the baby's mouth than below it.

Slide 5/6

- Signs that you can see clearly are:
  - the baby's chin is close to the breast;
  - his mouth is wide open;
  - his lower lip is turned outwards;
  - his cheek is round;
  - there is more areola above the baby's mouth than below it.

- This baby is well attached.

Additional points for Slide 5/6
This mother has a smaller areola than the mother in Slide 5/5, so you do not see much of it either above or below the baby's mouth.
Her baby's body is turned slightly away from her, and his neck is twisted slightly. So his body position is not very good, even though he seems to be well attached.

Slide 5/7

- Signs that you can see are:
  - the baby is facing the breast;
  - his head and body are straight;
  - his chin is touching the breast;
  - his mouth is quite wide open;
  - his lower lip is turned in and not outwards;
  - his cheeks are round;
  - there is more areola above the baby's mouth than below it.

(Slide 5/7 continued)

- This baby is not well attached.
  His lower lip is turned in, so he is not well attached, even if the other signs are not bad.

Slide 5/8

- Picture A shows a baby suckling, and picture B shows the same baby a few seconds later.

- Signs that you can in picture A are:
  - the baby's body is twisted away from his mother's;
  - his chin is touching her breast;

- his mouth is not wide open, and his lips point forwards;
- his cheeks are pulled in.

- Signs that you can see in picture B are:
  - the baby has pulled away from his mother's breast;
  - he is crying with frustration;
  - his mother's nipple is quite large and long.

- This baby was poorly attached to the breast, and was not getting the milk efficiently, so he pulled away in frustration.

Additional points for Slide 5/8
Sometimes when a mother has a large long nipple, her baby does not take enough breast into his mouth. Mother and baby need help to prevent problems (see Session 14, `Breast conditions').

Slide 5/9

- The signs that you can see are:
  - the baby is close to the breast, and facing it;
  - his chin is touching the breast;
  - his mouth is not wide open;
  - his lower lip is not turned outwards;
  - his cheeks look round;
  - there is more areola below the baby's mouth than above it.

- This baby is not well attached.

Additional points for Slide 5/9
This baby was not satisfied, and wanted to feed often, because he was not getting breastmilk efficiently. The mother has rather large breasts, and she may have put the baby onto the breast from above instead of from below. This can make it more difficult for a baby to take a good mouthful of breast (see Session 10, `Positioning a baby at the breast').

Slide 5/10

- The signs that you can see are:
  - the baby is close to the breast and facing it;
  - his chin is almost touching the breast;
  - his mouth is wide open;
  - his lower lip is turned outwards;
  - you can just see his tongue, which is cupped round the breast;
  - his cheeks are round (he has a dimple, but his cheek is not pulled in);
  - there is more areola above the baby's mouth than below it.

- This baby is well attached, though the signs are not perfect.

Additional points for Slide 5/10
Notice that the baby's nose is well away from the breast. When a baby is attached in a good position, there is usually plenty of room to breathe.

Slide 5/11

- Signs that you can see are:
  - the mother has no back support. She is leaning forward over the baby, and may be tense and uncomfortable;

- the baby's body is turned away from his mother's;
- his neck is twisted;
- his mother is supporting only his head and not his bottom.
  (He is only a few days old, so it would help if she supported his bottom.)

- This baby is poorly positioned.
  It is difficult to see any signs of good or poor attachment. However, his mother is holding her breast very close to the nipple, so it is likely that he is poorly attached.

III. Practise using the B-R-E-A-S-T-FEED Observation Form (25 minutes)

EXERCISE I. ***Using the B-R-E-A-S-T-FEED Observation Form***

 Explain what to do:

- With Slides 5/12 to 5/15, you will use your observations to practise filling in the B-R-E-A-S-T-FEED Observation Form.

  There are four copies of the form for this exercise in the Participants' Manual . Fill in one form for each slide.

 Remind participants:

- If you see a sign, make a ✔ in the box next to the sign.

- If you do not see a sign, leave the box empty.

- If you see something that you think is important, but there is not a box for it, you can make a note in the space `Notes' at the bottom of the form.

 Point to the sections for **B**ODY POSITION and **S**UCKLING and explain:

- With these slides, most of the signs that you will see are in these two sections for **B**ODY POSITION or **S**UCKLING. You only need to mark these for the exercise.

- When you see mothers and babies in clinical practice sessions, you should fill in all sections of the form.

 Demonstrate with these examples:

  - show where to put a ✔ if the baby's chin is touching the breast, and where to put a ✔ if his chin is not touching the breast;

  - show where to put a ✔ if the baby's mouth looks wide open, and where to put a ✔ if it does not look wide open.

 Ask all the trainers to help:

They should circulate and make sure that participants understand what to do. They give individual feedback on participants' observations of the slides.

 Show Slides 5/12 to 5/15.

Show each slide for about 4 minutes.

 Use these answers to give individual feedback:

On the next three pages, for each of the Slides 12, 13, 14 and 15, the two sections of the B-R-E-A-S-T-FEED Observation Form, **B**ODY POSITION and **S**UCKLING are copied. They have been marked with ✔s for the signs which participants should see in these slides.

Slide 5/12

Signs that breastfeeding is going well	*Signs of possible difficulty*
BODY POSITION	
✔ Mother relaxed and comfortable	☐ Shoulder's tense, leans over baby
☐ Baby's body close, facing breast	✔ Baby's body away from mother's
☐ Baby's head and body straight	✔ Baby's neck twisted
☐ Baby's chin touching breast	✔ Baby's chin not touching breast
☐ [Baby's bottom supported]	✔ [Only shoulder or head supported]
SUCKLING	
☐ Mouth wide open	✔ Mouth not wide open, points forward
☐ Lower lip turned outwards	✔ Lower lip turned in
☐ Tongue cupped around breast	✔ Baby's tongue not seen
☐ Cheeks round	✔ Cheeks tense or pulled in
☐ More areola above baby's mouth	✔ More areola below baby's mouth

Conclusion
Most of the ✔s are on the right side, under *Signs of possible difficulty*.
So the baby in Slide 5/12 is poorly positioned and poorly attached.

Slide 5/13

Signs that breastfeeding is going well	*Signs of possible difficulty*
BODY POSITION	
☐ Mother relaxed and comfortable	☐ Shoulder's tense, leans over baby
☐ Baby's body close, facing breast	✔ Baby's body away from mother's
☐ Baby's head and body straight	✔ Baby's neck twisted
☐ Baby's chin touching breast	✔ Baby's chin not touching breast
☐ [Baby's bottom supported]	✔ [Only shoulder or head supported]
SUCKLING	
☐ Mouth wide open	✔ Mouth not wide open, points forward
☐ Lower lip turned outwards	☐ Lower lip turned in
☐ Tongue cupped around breast	✔ Baby's tongue not seen
☐ Cheeks round	☐ Cheeks tense or pulled in
☐ More areola above baby's mouth	✔ More areola below baby's mouth

Conclusions
Most of the ✔s are on the right side, under *Signs of possible difficulty.*
So the baby in Slide 5/13 is poorly positioned and poorly attached.

Slide 5/14

Signs that breastfeeding is going well	*Signs of possible difficulty*
BODY POSITION	
✔ Mother relaxed and comfortable	☐ Shoulder's tense, leans over baby
✔ Baby's body close, facing breast	☐ Baby's body away from mother's
✔ Baby's head and body straight	☐ Baby's neck twisted
✔ Baby's chin touching breast	☐ Baby's chin not touching breast
✔ [Baby's bottom supported]	☐ [Only shoulder or head supported]
SUCKLING	
☐ Mouth wide open	☐ Mouth not wide open, points forward
☐ Lower lip turned outwards	☐ Lower lip turned in
☐ Tongue cupped around breast	☐ Baby's tongue not seen
✔ Cheeks round	☐ Cheeks tense or pulled in
☐ More areola above baby's mouth	☐ More areola below baby's mouth

Conclusions
The baby in Slide 5/14 is the same baby as in Slide 13, after a health worker has helped the mother to reposition her baby.
Most of the ✔s are on the left side, under *Signs that breastfeeding is going well.*
So the baby is now better positioned. He is probably well attached, though he is so close to the breast that it is difficult to see his mouth.

Slide 5/15

Signs that breastfeeding is going well	*Signs of possible difficulty*
BODY POSITION	
✔ Mother relaxed and comfortable	□ Shoulder's tense, leans over baby
✔ Baby's body close, facing breast	□ Baby's body away from mother's
✔ Baby's head and body straight	□ Baby's neck twisted
✔ Baby's chin touching breast	□ Baby's chin not touching breast
✔ [Baby's bottom supported]	□ [Only shoulder or head supported]
SUCKLING	
✔ Mouth wide open	□ Mouth not wide open, points forward
□ Lower lip turned outwards	□ Lower lip turned in
□ Tongue cupped around breast	□ Baby's tongue not seen
✔ Cheeks round	□ Cheeks tense or pulled in
□ More areola above baby's mouth	□ More areola below baby's mouth

Conclusions
Most of the ✔s are on the left side, under *Signs that breastfeeding is going well.*
So the baby in Slide 5/15 is well positioned and almost certainly well attached. It is difficult to see the baby's mouth, because he is so close to his mother's breast.
This mother has rather small breasts, so it is not necessary for her to support them.

IV. Conclude `Observing a breastfeed' (5 minutes)

□ Conclude with these points:

- You do not see all the signs with every baby.
  Sometimes you see one or two signs of poor positioning, but all the other signs are good. Then you may not be sure if the baby is well or poorly attached. You may not be sure if the mother needs help or not.

- Remember that in a live baby, you will also be looking at the baby's suckling. If a baby takes slow deep sucks, then he is probably well attached.

- Always ask how breastfeeding feels to the mother. If she has discomfort or pain in her breasts, then her baby may not be well attached. If she is comfortable, then he is likely to be well attached.

- Always ask about the baby's general health and his growth and behaviour. If the baby is satisfied, and growing well, he is probably suckling effectively.

Session 6

Back to CONTENTS

LISTENING AND LEARNING

Objectives

At the end of this session, participants should be able to:
- use non-verbal and verbal techniques to encourage a mother to talk without asking too many questions;
- respond to a mother's feelings with empathy;
- avoid using words which suggest judgement of the mother and baby.

Session outline (60 minutes)

Participants work in groups of 8-10 led by two trainers.

I. Introduce the topic (3 minutes)

II. Demonstrate listening and learning skills(45 minutes)

III. Answer participants' questions (7 minutes)

IV. Summarize `Listening and learning' (5 minutes)

Preparation

Refer to pages 13-15 in the Introduction for general guidance on how to conduct work in groups.
Study the notes for the session so that you are clear about what to do.

You need two boards or flipcharts to make two summary lists.
If it is difficult to get two flipchart boards, stick flipchart sheets to the wall. Make sure that participants can see them.

Make copies of all the Demonstrations (B to P). (An alternative would be to use another copy of this guide).
Ask three participants to help you to give the demonstrations. Explain what you want them to do.

Ask Participant 1 to help you with Demonstrations A, B, C and D (Skills 1 and 2).
For Demonstration A, all that she has to do is to sit and breastfeed a doll while you demonstrate different ways of talking to her. She can respond to your greetings, but need not say anything else.
Discuss and agree with her before the demonstration what you can do to demonstrate `appropriate touch' and `inappropriate touch'.
For Demonstrations B,C, and D, she reads out the words of the mothers.

Ask Participant 2 to read the mother's words in Demonstrations E, F, G, and H (Skills 3 and 4). Ask Participant 3 to read the words of the mothers in Demonstrations J,K, L, M, N, O, and P (Skills 5 and 6).

Give each of the participants a copy of the Demonstrations that she has to read.

If it is difficult for participants to help with the demonstrations for some reason, another trainer can play the part of the mother.
However, try to involve participants as much as possible, because it helps them to learn.

As you follow the text, remember:

☐ indicates an instruction to you, the trainer
▪ indicates what you say to the participants

I. Introduce the topic (3 minutes)

Ask participants to keep their manuals closed.

☐ Introduce the idea of counselling with these points:

- *Counselling is a way of working with people in which you try to understand how they feel and help them to decide what to do.*
  In these sessions we will discuss mothers who are breastfeeding and how they feel.

- *Breastfeeding is not the only situation in which counselling is useful.*
  Counselling skills are useful when you talk to patients or clients in other situations. You may also find them helpful with your family and friends, or your colleagues at work. Practise some of the techniques with them - you may find the result surprising and helpful.

- *The first two counselling skills sessions are about `listening and learning'.*
  A breastfeeding mother may not talk about her feelings easily, especially if she is shy, and with someone whom she does not know well.
  You need the skill to listen, and to make her feel 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.

II. Demonstrate listening and learning skills (45 minutes)

☐ Tell participants that in this session, you will explain and demonstrate six skills for listening and learning.

→ Write the heading `LISTENING AND LEARNING SKILLS' on a board or flipchart with room for a list of six points below it. List the six skills underneath as you demonstrate them.

Skill 1. Use helpful non-verbal communication

→ Write `Use helpful non-verbal communication' on the list of listening and learning skills.

→ Write `HELPFUL NON-VERBAL COMMUNICATION' on another board or flipchart with room for a list of five points below it.

☐ Explain the skill:

Ask: *What do you think we mean by "non-verbal communication"?*
(Let participants make one or two suggestions, and then give them the following answer.)

Non-verbal communication means showing your attitude through your posture, your expression, everything except through speaking.

☐ Demonstrate the skill:

Tell participants that you will demonstrate five different kinds of non-verbal communication.

☺ Ask Participant 1 to help you. She sits with a doll, pretending to be a mother breastfeeding. She can respond to your greeting, but she does not have to say anything else.

Give the five pairs of demonstrations in Demonstration A.

With each pair, you address the `mother' in two ways.

One way helps communication, and the other way hinders communication.

Demonstrate the way which helps sometimes first, and sometimes second, so that the participants who are observing cannot guess which is which just from the order of the demonstrations.

Demonstrate `appropriate touch' (socially acceptable) and `inappropriate touch' (not socially acceptable) in the way that you agreed with Participant 1 before the session.

Ask other participants to:

- identify the form of non-verbal communication that you demonstrate;
- say which form helps communication and which hinders it.

Demonstration A: Non-verbal communication

With each demonstration say <u>exactly the same</u> few words, and try to say them in the same way, for example:

"Good morning, Susan. How is breastfeeding going for you and the baby?"

1. Posture:

Hinders: stand with your head higher than the other person's
Helps: sit so that your head is level with hers.
→ Write - `KEEP YOUR HEAD LEVEL' on the flipchart.

2. Eye contact:

Helps: look at her and pay attention as she speaks
Hinders: look away at something else, or down at your notes
→ Write - `PAY ATTENTION' on the flipchart.

(Note: eye contact may have different meanings in different cultures. Sometimes when a person looks <u>away</u> it means that he or she is ready to listen. If necessary, adapt this to your own situation.)

3. Barriers:

Hinders: sit behind a table, or write notes while you talk
Helps: remove the table or the notes
→ Write - `REMOVE BARRIERS' on the flipchart.

4. Taking time:

Helps: make her feel that you have time. Sit down and greet her without hurrying; then just stay quietly smiling at her, watching her breastfeed, and waiting for her to answer
Hinders: be in a hurry. Greet her quickly, show signs of impatience, look at your watch
→ Write - `TAKE TIME' on the flipchart.

5. Touch:

Helps: touch the mother appropriately
Hinders: touch her in an inappropriate way
→ Write - `TOUCH APPROPRIATELY' on the flipchart.

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

☐ Discuss appropriate touch in this community.

Ask: *What kinds of touch are appropriate and inappropriate in this situation in this community?*

Does touch make a mother feel that you care about her?
For a man, if it is not appropriate to touch the woman, is it appropriate to touch the baby?
(Let participants give some examples from their experience.)

Ask: *Do you know any other kinds of non-verbal communication which could make a mother feel that you are interested in her, and care about her, so that she tells you more?*
(Let participants give some examples. For example smiling, nodding.)

☐ You now have the following list written on the flipchart. Post it up on the wall.

HELPFUL NON-VERBAL COMMUNICATION

Keep your head level
Pay attention
Remove barriers
Take time
Touch appropriately

Skill 2. Ask open questions

→ Write `Ask open questions' on the list of listening and learning skills.

☐ Explain the skill:

- To start a discussion with a mother, or to take a history from her, (Session 17, `Taking a breastfeeding history'), you need to ask some questions.

- It is important to ask questions in a way which encourages a mother to talk to you and to give you information. This saves you from asking too many questions, and enables you to learn more in the time available.

- *Open questions* are usually the most helpful. To answer them, a mother must give you some information.
  Open questions usually start with "How? What? When? Where? Why?"
  For example, "How are you feeding your baby?"

- *Closed questions* are usually less helpful. They tell a mother the answer that you expect, and she can answer them with a "Yes" or "No".
  Closed questions usually start with words like "Are you?" or "Did he?" or "Has he?" or "Does she?"
  For example: "Did you breastfeed your last baby?"

  If a mother says "Yes" to this question, you still do not know if she breastfed exclusively, or if she also gave some artificial feeds.
  You can become quite frustrated, and think that the mother is not willing to talk, or that she is not telling the truth.

☐ Demonstrate the skill:

☺ Ask Participant 1 to read the words of the mother in Demonstrations B and C while you read the part of the health worker (HW).

After each demonstration, comment on what the health worker learnt.

Demonstration B. Closed questions to which she can answer `yes' or `no'

HW: "Good morning, (name). I am (name), the community midwife. Is (name of baby) well?"
Mother: "Yes, thank you."
HW: "Are you breastfeeding him?"
Mother: "Yes".
HW: "Are you having any difficulties?"
Mother: "No".
HW: "Is he breastfeeding very often?"
Mother: "Yes".

Comment: The health worker got "yes" and "no" for answers and didn't learn much. It can be difficult to know what to say next.

Demonstration C. Open questions

HW: "Good morning, (name). I am (name), the community midwife. How is (name of baby)?"
Mother: "He is well, and he is very hungry."
HW: "Tell me, how are you feeding him?"
Mother: "He is breastfeeding. I just have to give him one bottle feed in the evening."
HW: "What made you decide to do that?"
Mother: "He wants to feed too much at that time, so I thought that my milk is not enough".

Comment: The health worker asked open questions. The mother could not answer with a "yes" or a "no", and she had to give some information. The health worker learnt much more.

☐ Explain how to use questions to *start* and to *continue* a conversation:

- You need to ask questions to *start* a conversation. For this, very general open questions are often helpful. They give a mother a chance to say what is important to her. For example:
  "How is breastfeeding going for you?"
  "Tell me about your baby."

- However, sometimes a mother just says "Oh, very well thank you."
  So then you need to ask questions to *continue* the conversation. For this, more specific questions are helpful. For example:
  "How old is your baby now?"
  "How many hours after he was born did he have his first feed?"

- Sometimes you might need to ask a closed question, for example: "Are you giving him any other food or drink?" or "Are you giving the other feeds by bottle?"

- When a mother has answered, you can follow up with another open question.
  For example:
  "What makes you feel that?"
  "What made you decide to do that?"

☐ Demonstrate the skill:

☺ Ask Participant 1 to read the part of the mother in Demonstration D. You read the part of the health worker (HW).

After the demonstration, comment on what the health worker learnt.

Demonstration D. Starting and continuing a conversation.

HW: "Good morning, (name). How are you and (name of baby) getting on?"
Mother: "Oh, we are both doing well thank you."
HW: "How old is (name) now?"
Mother: "He is 2 days old today."
HW: "What are you giving him to eat and drink?"
Mother: "He is breastfeeding, and having drinks of water."
HW: "What made you decide to give the water?"
Mother: "There is no milk in my breasts, and he doesn't want to suck."

Comment: The health worker asks an open question, which does not help much. Then she asks two specific questions, and then follows up with an open question. Although the mother at first

says that she and the baby are well, the health worker later learns that the mother needs help with breastfeeding.

Skill 3. Use responses and gestures which show interest

→ Write `Use responses and gestures which show interest' on the list of listening and learning skills.

☐ Explain the skill:

- If you want a mother to continue talking, you must show that you are listening, and that you are interested in what she is saying.

- Important ways to show that you are listening and interested are:
  - with gestures, for example, look at her, nod and smile;
  - with simple responses, for example, you say "Aha", "Mmm", "Oh dear!".

☐ Demonstrate the skill:

☺ Ask Participant 2 to read the words of the mother in Demonstration E, while you play the part of the health worker (HW). You give simple responses, and nod, and show by your facial expression that you are interested and want to hear more.

After the demonstration, comment on what it showed.

Demonstration E: Using responses and gestures which show interest

HW: "Good morning, (name). How is breastfeeding going for you these days?"
Mother: "Good morning. It is going quite well, I think."
HW: "Mmm." (nods, smiles.)
Mother: "Well, I was a bit worried the other day, because he vomited."
HW: "Oh dear!" (raises eyebrows, looks interested.)
Mother: "I wondered if it was something that I ate, so that my milk did not suit him."
HW: "Aha!" (nods sympathetically).

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

☐ Discuss locally appropriate responses:

- In different countries, people use different responses, for example, "Nnn", "Eeehh". They are part of the language.

Ask: *What responses do people use locally?*
Let participants give some examples of useful responses.

Skill 4. Reflect back what the mother says

→ Write `Reflect back what the mother says' on the list of listening and learning skills.

☐ Explain the skill:

- Health workers sometimes ask mothers a lot of factual questions. However, the answers to

factual questions are often not helpful. The mother may say less and less in reply to each question.

For example, if a mother says: "My baby was crying too much last night," you might want to ask: "How many times did he wake up?". But the answer is not helpful.

- It is more useful to repeat back or *reflect* what a mother says. It shows that you understand, and she is more likely to say more about what is important to her. It is best to say it in a slightly different way, so that it does not sound as though you are copying her.

  For example, if a mother says: "My baby was crying too much last night."
  You could say: "Your baby kept you awake crying all night?"

☐ Demonstrate the skill:

☺ Ask Participant 2 to read the words of the mother in Demonstrations F and G while you read the part of the health worker (HW).

After each demonstration, comment on what the health worker learnt.

Demonstration F. Continuing to ask questions

HW: "Good morning, (name). How are you and (name) today?"
Mother: "He wants to feed too much - he is taking my breast all the time!"
HW: "About how often would you say?"
Mother: "About every half an hour."
HW: "Does he want to suck at night too?"
Mother: "Yes".

Comment: The health worker asks factual questions, and the mother gives less and less information.

Demonstration G. Reflecting back

HW: "Good morning (name). How are you and (name) today?"
Mother: "He wants to feed too much - he is taking my breast all the time!"
HW: "(Name) is feeding very often?"
Mother: "Yes. This week he is so hungry. I think that my milk is drying up."
HW: "He seems more hungry just for about a week?"
Mother: "Yes, and my sister is telling me that I should give him some bottle feeds as well."
HW: "Your sister says that he needs something more?"
Mother: "Yes. Which formula is best?"

Comment: The health worker reflects back what the mother says, so the mother gives more information.

☐ Explain this other point:

- If you continue to reflect back what a mother says every time, it can begin to sound rather rude. It is better to mix up reflecting back with other responses.
  For example: "Oh really?" or "Goodness!", or an open question.

☐ Demonstrate the point:

☺ Ask Participant 2 to read the words of the mother in Demonstration H, while you read the part of the health worker (HW).

Demonstration H. Mixing reflecting back with other responses

HW: "Good morning. How are you and (name) today?"
Mother: "He wants to feed too much - he is taking my breast all the time."
HW: "(Name) is feeding very often?"
Mother: "Yes. This week he is so hungry. I think that my milk is drying up."
HW: "Oh dear!"
Mother: "Yes, it is exhausting. My sister tells me that I should give some bottle feeds and get some rest."
HW: "Your sister wants you to give some bottle feeds?"
Mother: "Yes - she says that I am foolish to struggle on like this."
HW: "How do you feel about that?"
Mother: "Well, I don't want to give bottle feeds."

Comment: The conversation sounds more natural, but the health worker is learning more about how the mother feels.

Skill 5. Empathize - show that you understand how she feels

→ Write `Empathize - show that you understand how she feels' on the list of listening and learning skills.

☐ Explain the skill:

- When a mother says something which shows how she feels, it is helpful to respond in a way which shows that you heard what she said, and that you understand her feelings *from her point of view*.
  For example, if a mother says:
  "My baby wants to feed very often and it makes me feel so tired!"
  you respond to what she *feels*, perhaps like this:
  "You are feeling very tired all the time then?"

- Empathy is different from sympathy. When you sympathize you are sorry for a person, but you look at it from YOUR point of view.
  If you sympathize, you might say: "Oh, I know how you feel. My baby wanted to feed often too, and I felt exhausted." This brings the attention back to you, and does not make the mother feel that you understand her.

- You might ask for more facts. For example, you might ask:
  "How often does he feed? What else are you giving him?"
  But these questions do not help a mother to feel that you understand.

- You could reflect back what the mother says about the baby.
  For example: "He wants to feed very often?"
  But this reflects back what the mother said about the baby's behaviour, and it misses what she said about how she feels. She feels tired.
  So empathy is more than reflecting back what a mother says to you.

- It is also helpful to empathize with a mother's good feelings. Empathy is not only to show that you understand her bad feelings.

☐ Demonstrate the skill:

☺ Ask Participant 3 to read the words of the mother in Demonstrations J, K, L, M, and N, while you read the part of the health worker (HW).

After each demonstration, comment on what the health worker learnt.

Demonstration J. Continuing to ask for facts

HW: "Good morning, (name). How are you and (name) today?"
Mother: "(Name) is refusing to breastfeed - he doesn't seem to like my milk now!"
HW: "How long has he been refusing?"
Mother: "Just this week."
HW: "How old is he now?"
Mother: "He is 6 weeks old."

Comment: The health worker asks about facts. She ignores the mother's feelings, so she learns only facts which are not very helpful.

Demonstration K. Sympathizing

HW: "Good morning, (name). How are you and (name) today?"
Mother: "(Name) is refusing to breastfeed - he doesn't seem to like my milk now!"
HW: "Oh! I know how you feel. My baby refused to breastfeed when I came back to work."
Mother: "What did you do about it then?"

Comment: The health worker sympathizes, and turns the attention to her own situation. This is not helpful - especially if the health worker ended up bottle feeding.

Demonstration L. Reflecting back

HW: "Good morning, (name). How are you and (name) today?"
Mother: "(Name) is refusing to breastfeed - he doesn't seem to like my milk now!"
HW: "He is refusing to breastfeed?"
Mother: "Yes he takes one suck and then just cries and turns away."

Comment: When the HW reflects back, the mother continues talking, but she talks about the baby, and not about her feelings.

Demonstration M. Empathizing

HW: "Good morning, (name). How are you and (name) today?"
Mother: "(Name) is refusing to breastfeed - he doesn't seem to like my milk now!"
HW: "You feel that he doesn't like you now?"
Mother: "Yes, it's as if he doesn't love me - it just started suddenly this week, after his grandmother came to live with us. She so much likes to give him a bottle feed!"
HW: "You feel that she wants to be the one to feed him?"
Mother: "Yes - she wants to take him over from me!"

Comment: The HW empathizes with the mother's feelings and learns some very important things - without asking direct questions.

Demonstration N. Empathizing with a mother's good feelings.

HW: "Good morning, (name). How is breastfeeding going for you and (name)?"
Mother: "He is suckling well and he seems quite contented after feeds now."
HW: "You must feel pleased that it is going so well".
Mother: "Yes, I am so happy that I don't have to give bottle feeds."
HW: "You really enjoy breastfeeding. That's wonderful."

Comment: It is important to make a mother feel that you are interested in her, even if she does not have a problem.

Skill 6. Avoid words which sound judging

→ Write `Avoid words which sound judging' on the list of listening and learning skills.

☐ Explain the skill:

- `Judging words' are words like: right, wrong, well, badly, good, enough, properly. If you use judging words when you talk to a mother about breastfeeding, especially when you ask questions, you may make her feel that she is wrong, or that there is something wrong with the baby.

- For example: Do not say: "Does the baby sleep <u>well</u>?"
  Instead say: "How is the baby sleeping?"

☐ Demonstrate the skill:

☺ Ask Participant 3 to read the words of the mother in Demonstrations O and P, while you read the part of the health worker (HW).

After each demonstration, comment on what the health worker learnt.

Demonstration O. Using judging words

HW: "Good morning, (name). Is (name) breastfeeding <u>normally</u>?"
Mother: "Well - I think so."
HW: "Do you think that you have <u>enough</u> breastmilk for him?"
Mother: "I don't know.....I hope so, but maybe not ..." (She looks worried.)
HW: "Has he gained weight <u>well</u> this month? May I see his growth chart?"
Mother: "I don't know....."

Comment: The health worker is not learning anything useful, but she is making the mother very worried.

Demonstration P. Avoiding judging words

HW: "Good morning, (name). How is breastfeeding going for you and (name)?"
Mother: "It's going very well. We both enjoy it!"
HW: "How is his weight? Can I see his growth chart?"
Mother: "Nurse said that he gained more than half a kilo this month. I was pleased."
HW: "He is obviously getting all the breastmilk that he needs."

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

☐ Make these additional points:

- Mothers can use judging words. You may need sometimes to use them yourself, especially the positive ones, when you are building a mother's confidence. But practise avoiding them as much as possible, unless there is a really important reason to use one.

- You may have noticed that judging questions are often closed questions. Using open questions often helps to avoid using a judging word.

III. Answer participants' questions (7 minutes)

☐ Ask participants if they have any questions about listening and learning and try to answer them.

IV. Summarize `Listening and learning' (5 minutes)

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

☐ Read the list through, to remind participants of the six skills.

Ask participants to find the list on page 29 of their manuals.
Ask them to try to memorize it.
Explain that they will use the list for Clinical Practice 1.

LISTENING AND LEARNING SKILLS

- ☐ Use helpful non-verbal communication
- ☐ Ask open questions
- ☐ Use responses and gestures which show interest
- ☐ Reflect back what the mother says
- ☐ Empathize - show that you understand how she feels
- ☐ Avoid words which sound judging

LISTENING AND LEARNING EXERCISES

Objectives

Participants practise the listening and learning skills that they learnt in Session 6.

Session outline (60 minutes)

Participants continue to work in groups of 8-10 with two trainers.

I. Introduce the session (3 minutes)

II. Facilitate the written exercises (Exercises 2-4) (42 minutes)

III. Conduct the group exercise (Exercise 5) (15 minutes)

Preparation

Refer to pages 15-16 of the Introduction for general guidance on how to facilitate a written exercise.
Study the notes for the session, so that you are clear about what to do.

For Exercises 2-4, make sure that Answer Sheets are available to give to participants at the end of the session.

For Exercise 5, prepare translations of the judging words, and of the examples of judging and non-judging questions. Work with the other trainers to do this. Write your translations in the spaces in the Table **USING AND AVOIDING JUDGING WORDS.**

As you follow the text, remember:

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

I. Introduce the session (3 minutes)

Ask participants to turn to page 30 of their manuals, and to find Exercises 2-5.

 Explain what they will do:

- You will now practise the six listening and learning skills that you learnt about in Session 6.

- Exercises 2-4 are individual written exercises.
  Write your answers in your manuals.
  If possible use pencil, so that it is easier to correct the answers.
  Trainers will give feedback individually as you do the exercises, and will give you Answer Sheets at the end of the session.

- Exercise 5 is a group exercise on judging words.

II. Facilitate the written exercises (42 minutes)

 Explain what to do:

- For each exercise, read the instructions **How to do the exercise** and the **Example** of what to do.
  Then answer the questions **To answer.**
  When you are ready, discuss your answers with the trainer.

EXERCISE 2. ***Asking open questions***

How to do the exercise:

Questions 1-3 are `closed' and it is easy to answer `yes' or `no'.
Write a new `open' question, which requires the mother to tell you more.
Question 4 is an Optional Short Story Exercise, to do if you have time.

Example:

Do you breastfeed your baby? *How are you feeding your baby?*

To answer: *(Suggested answer)*

1. Does your baby sleep with you? *(Where does your baby sleep?*)

2. Are you often away from your baby? *(How much time do you spend away from your baby?)*

3. Are your nipples sore? *(How do your breasts feel?)*

4. Optional Short Story Exercise

Joseph and Mabel bring 3-month-old Johnny to the clinic. They want to talk to you because he is not gaining weight.

Write two open questions that you would ask Joseph and Mabel.
The questions must be ones that they cannot say just `yes' or `no' to.

Possible answers include:
How are you feeding Johnny?
How is breastfeeding going for you?
What illnesses has Johnny had?
How is Johnny behaving?
Tell me how Johnny is feeding?

EXERCISE 3. ***Reflecting back what a mother says***

How to do the exercise:
Statements 1-5 are some things that mothers might tell you.
Beside 1-3 are three responses. Mark the response that `reflects back' what the statement says.
For statements 4 and 5, make up your own response which `reflects back' what the mother says.
Number 6 is an Optional Short Story Exercise, to do if you have time.

Example:

My mother says that I don't have enough milk.		a.Do you think you have enough? b.Why does she think that? c.She says that you have a low milk supply?

To answer:

1. My baby is passing a lot of stools - sometimes 8 in a day.	✔	a.He is passing many stools each day? b.What are the stools like? c.Does this happen every day, or only on some days?
2. He doesn't seem to want to suckle from me.		a.Has he had any bottle feeds? b.How long has been refusing?
	✔	c.He seems to be refusing to suckle?
3. I tried feeding him from a bottle, but he spat it out.		a.Why did you try using a bottle?
	✔	b.He refused to suck from a bottle?
		c.Have you tried to use a cup?

4. Sometimes he doesn't pass a stool for 3 or 4 days.

   (He doesn't pass a stool some days?)

5. My husband says that our baby is old enough to stop breastfeeding now.

   (Your husband wants you to stop breastfeeding your baby?)

6. Optional Short Story Exercise

You meet Cora in the market with her 2-month-old baby. You say how well the baby looks, and ask how she and the baby are doing. She says "Oh, we're doing fine. But he needs a bottle feed in the evening."

What do you say, to reflect back what Cora says, and to encourage her to tell you more?

Possible answers include:

He seems to need something extra in the evening?
He seems very hungry sometimes?

EXERCISE 4. ***Empathizing - to show that you understand how she feels***

How to do the exercise:

Statements 1-5 are things that mothers might say.
Next to statements 1-3 are three responses which you might make.
Underline the words in the mother's statement which show something about how she feels. Mark the response which is most empathetic.
For statements 4 and 5, underline the feeling words, and then make up your own empathizing response.
Number 6 is an Optional Short Story Exercise, to do if you have time.

Example:

My baby wants to feed so often at night that <u>I feel exhausted</u>.

a. How many times does he feed altogether?
b. Does he wake you every night?
✔ c. You are <u>really tired</u> with the night feeding.

To answer:

1. My nipples <u>are so painful</u>, I will have to bottle feed.

✔ a. The pain makes you want to stop breastfeeding?
b. Did you bottle feed any of your previous children?
c. Oh! don't do that - it's not necessary to stop just because of sore nipples.

2. My breastmilk looks so thin - I am sure it <u>cannot be good</u>.

a. That's the foremilk - it always looks rather watery.
✔ b. You are worried about how your breastmilk looks?
c. Well, how much does the baby weigh?

3. I <u>do not have any milk</u> in my breasts, and my baby is a day old already.

✔ a. You are upset because your breastmilk has not come in yet?
b. Has he started suckling yet?
c. It always takes a few days for breastmilk to come in.

4. My breasts leak milk all day at work - it is so <u>embarrassing.</u>

   (It must be embarrassing if it happens at work.)

5. I have <u>bad stomach pains</u> when he is breastfeeding.

   (You are really having bad pains, aren't you?)

6. Optional Short Story Exercise

Edna brings baby Sammy to see you. She looks worried. She says "Sammy breastfeeds very often, but he still looks so thin!"

What would you say to Edna to empathize with how she feels?

Possible answers include:
You are worried because Sammy looks thin to you?
You are worried about how Sammy looks?

□ Give participants the Answer Sheets for Exercises 2, 3 and 4.

III. Conduct the group exercise (15 minutes)

EXERCISE 5. ***Translating judging words***

 Ask participants to look at the list of **JUDGING WORDS** on page 34 of their manuals.

JUDGING WORDS

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		

 Make these points about the list:

- The words in **bold** at the top of each group are words that are used most commonly. These are the words that we will work with in the exercises.

- Below each of the common words is a list of other words with similar meanings. For example, `adequate' and `sufficient' appear below `enough'. Words with opposite meanings are in the same group. For example `good' and `bad'. All of these are judging words, and it is important to avoid them.

 Ask participants to look at the table **USING AND AVOIDING JUDGING WORDS**, also on page 34 of their manuals.

Ask them to suggest translations of the five common words in the local language.
They can write in their table the translations that you all agree about.

 For each word, read out the *Judging question*, and give your translation of it.

Then ask participants to think of a *Non-judging question*. This should be a similar question, which does not use the judging word.
Remind them that judging questions are often closed questions, and that they can often avoid using a judging word if they use an open question.

Ask them to write the translations into the table in their manuals.

USING AND AVOIDING JUDGING WORDS

English	*Local language*	*Judging question*	*Non-judging question*
Well	.....	Does he suckle well?	How is he suckling?
Normal	.....	Are his stools normal?	What are his stools like?
Enough	.....	Is he gaining enough weight?	How much weight did he gain last month?
Problem	.....	Do you have any problems breastfeeding?	How is breastfeeding going for you?
Crying too much	.....	Does he cry too much at night?	How does he behave at night?

Session 8

Back to CONTENTS

HEALTH CARE PRACTICES

Objectives

At the end of the session participants should be able to:
- describe the health care practices summarized by `The Ten Steps to Successful Breastfeeding';
- explain the reasons for the `Ten Steps';
- describe a breastfeeding support group.

Session outline (90 minutes)

Participants are all together as a class, for a presentation by one trainer.

I. Introduce the topic (10 minutes)

II. Present Slides 8/1 to 8/15 (40 minutes)

III. Answer participants' questions (10 minutes)

Participants are in groups of 4-5 each with one trainer
(This part of the session can be at a separate time if necessary)

IV. Conduct small group discussion (30 minutes)

Preparation

Refer to pages 9-11 of the Introduction, for general guidance on giving a presentation with slides.

Make sure that Slides 8/1 to 8/15 are in order.
Study the text and the slides, so that you can present them.
Read the **Further information** notes, so that you are familiar with the ideas that they contain.

Decide if you will conduct part IV of the session after the presentation, or at another time. If it is difficult to form groups for part IV, you may want to consider continuing with the whole class together.

Make sure that participants have copies of the Joint WHO/UNICEF Statement: *Protecting, Promoting and Supporting Breastfeeding: The Special Role of the Maternity Services* to refer to after the session.

Post `Ten Steps' posters on the wall of the classroom.

If there is a `Baby Friendly Hospital' in your area, try to obtain a copy of its Breastfeeding Policy for participants to study after the session if they wish.

As you follow the text, remember:

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

Do not present the **Further information** sections.
Use them to help you to answer questions.

I. Introduce the topic (10 minutes)

Ask participants to turn to page 36 of their manuals, where they will find **THE TEN STEPS TO SUCCESSFUL BREASTFEEDING**. Point out the poster on the wall.

□ Explain that in this session they will learn about the `Ten Steps', and the reasons for them.

□ Make these introductory points:

- Health care practices can have a major effect on breastfeeding.
  Poor practices interfere with breastfeeding, and contribute to the spread of artificial feeding.
  Good practices support breastfeeding, and make it more likely that mothers will breastfeed successfully, and will continue for a longer time.

- Maternity facilities help mothers to *initiate*, or start breastfeeding at the time of delivery; and they help them to *establish* breastfeeding in the post-natal period.

- Other parts of the health care service can play a very important part in helping to *sustain* breastfeeding up to 2 years or beyond. We discuss sustaining breastfeeding later in Session 28, `Sustaining breastfeeding'.

 Show a copy of the Joint Statement, and make these points:

- In 1989, WHO and UNICEF issued a Joint Statement called *Protecting, Promoting and Supporting Breastfeeding. The Special Role of Maternity Services*. This describes how maternity facilities can support breastfeeding.

- The `Ten Steps' are a summary of the main recommendations of the Joint Statement. They are the basis of the `Baby Friendly Hospital Initiative'. If a maternity facility wishes to be designated `baby friendly', it must follow all of the `Ten Steps'.

 Read through **THE TEN STEPS TO SUCCESSFUL BREASTFEEDING**.

☺Ask participants in turn to read out the `Ten Steps'.

Explain that you will go through each of the `Ten Steps' in more detail as you show the slides.

Explain that the policy in Step 1, and the training in Step 2, refer to the practices described in the other eight steps.

If you have an example of a hospital breastfeeding policy, tell participants that it will be available for them to study after the session.

THE TEN STEPS TO SUCCESSFUL BREASTFEEDING

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

1 Have a written breastfeeding policy that is routinely communicated to all health care staff.

2 Train all health care staff in skills necessary to implement this policy.

3 Inform all pregnant women about the benefits and management of breastfeeding.

4 Help mothers initiate breastfeeding within a half-hour of birth.

5 Show mothers how to breastfeed, and how to maintain lactation even if they are separated from their infants.

6 Give newborn infants no food or drink other than breastmilk, unless *medically* indicated.

7 Practise rooming-in - allow mothers and infants to remain together - 24 hours a day.

8 Encourage breastfeeding on demand.

9 Give no artificial teats or pacifiers (also called dummies or soothers) to breastfeeding infants.

10 Foster the establishment of breastfeeding support groups and refer mothers to them on discharge from the hospital or clinic.

II. Present Slides 8/1 to 8/15 (40 minutes)

 As you show each slide, point on the screen to the place which shows what you are explaining.

Slide 8/1 Antenatal preparation

- This slide summarizes Step 3: `Inform all pregnant women about the benefits and management of breastfeeding'.

It is important to talk to all women about breastfeeding when they come to an antenatal clinic. Show that you support breastfeeding, and that you want to help them.
It is especially important to talk to young mothers who are having their first baby. They are the ones who are most likely to need help.

There are some things that you can discuss with a group of mothers together, in an antenatal class, or health education session. There are other things that it is usually better to discuss with mothers individually.

The main points to remember when you talk to a group of mothers are to:

- *Explain the benefits of breastfeeding, and the dangers of artificial feeding.*
  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 bottle feed, she may not change her mind. But you may help mothers who are undecided, and give confidence to mothers who intend to breastfeed. You may encourage a mother to breastfeed exclusively instead of partially.

- *Give simple, relevant information on how to breastfeed.*
  The information that it is useful to include depends on the local breastfeeding practices and common difficulties. For example, it may be helpful to explain how frequent breastfeeds can help to ensure a good breastmilk supply.

- *Explain what happens after delivery.*
  Tell mothers about the first breastfeeds, and the practices in the hospital, so that they know what to expect. This is especially important if the practices in a hospital have changed recently.

- *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 will have on their figures. It may help them to discuss these worries together.

When you talk to mothers individually, make sure that each mother has heard about all the points that you discuss with groups.

In addition, when you talk to a mother individually, remember to:

- *Ask about her previous breastfeeding experience, if she has had other babies.*
  If she breastfed successfully, she is likely to do so again.
  If she had difficulties, or if she bottle fed, explain how she can succeed with breastfeeding this time. Reassure her that you will help her.

- *Ask whether she has any questions or worries.*
  Encourage her to tell you if she has any worries or doubts about breastfeeding, and try to answer them.

- *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 essential to examine breasts as a routine, if she is not worried about them.

- *Build her confidence and explain that you will help her.*
  Almost always you will be able to reassure her that her breasts are alright, and that her baby will be able to breastfeed.
  Explain that if she wants help, you or another health worker will help her.

 Tell participants that they can find a summary of these points in the box **ANTENATAL PREPARATION FOR BREASTFEEDING** on page 37 of their manuals.

Further information

It is not essential to examine women's breasts routinely, because it is not often useful, and it can make a woman worry about them when she was quite confident before. However, it may be the policy in your health service to do so. If so, it gives you an opportunity to talk to the mother about breastfeeding. Almost always you will be able to reassure her that her breasts are good for breastfeeding.

Preparing breasts physically for breastfeeding is not necessary.
Traditional ways of preparing the breasts, that are culturally important, may give a mother confidence. If you feel that they help mothers psychologically, there is no need to discourage them.

If a mother has flat or inverted nipples, doing stretching exercises, or wearing nipple shells during pregnancy, does 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 (see Session 15). 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 not sure about, such as previous breast surgery, or burns, try to get help from someone more experienced. Meanwhile, it may help to encourage her that babies often can breastfeed from a breast which has had surgery, or that a baby can get enough milk from just one breast if necessary.

Slide 8/1

ANTENATAL PREPARATION FOR BREASTFEEDING

With mothers in groups:

. Explain benefits of breastfeeding
. Give simple relevant information on how to breastfeed
. Explain what happens after delivery
. Discuss mothers' questions

With each mother individually

. Ask about previous breastfeeding experience
. Ask if she has any questions or worries
. Examine her breasts if she is worried about them
. Build her confidence, and explain that you will help her

Slide 8/2 Early contact

- The next two slides illustrate Step 4: `Help mothers initiate breastfeeding within a half-hour of birth'.

This mother is holding her baby immediately after delivery. They are both naked, so that they have skin-to-skin contact. A mother should hold her baby like this as much as possible in the first two hours after delivery. She should let him suckle when he shows that he is ready.

This is *early contact*, which helps a mother to bond with her baby - that is, to develop a close, loving relationship. Early contact also makes it more likely that a mother will start to breastfeed, and breastfeed for longer.

Ask: *What can you do to prevent a baby from getting cold?*

Dry the baby, and cover both him and his mother with the same blanket.

Slide 8/3 Separation of baby from mother after birth

- This baby was born about half an hour ago. He has been separated from his mother, while she is resting and being bathed.

Ask: *What is he doing with his mouth?*

He is opening his mouth and rooting for the breast. This shows that he is now ready to breastfeed.

He is separated from his mother, so she is not there to respond to him and put him to her breast when he roots for it.

Separating a mother and her baby in this way, and delaying starting to breastfeed, should be avoided. These practices interfere with bonding, and make it less likely that breastfeeding will be successful.

Ask: *What do you notice about the baby's eyes?*

His eyes are red. This is because silver nitrate drops were put into his eyes soon after delivery.

Putting drops into a baby's eyes, and other practices such as gastric suction, can alter a baby's behaviour and interfere with breastfeeding. These practices should be avoided if possible. However, if there is a high prevalence of sexually transmitted diseases, it is necessary to put drops or ointment into a baby's eyes, to prevent blindness.

Another practice which interferes with the success of breastfeeding is giving a mother analgesics and sedation during labour. These drugs can cross the placenta and make the baby unresponsive and unwilling to breastfeed. Their use should be kept to a minimum.

Further information

Bonding
Participants may need to discuss bonding at some length. Those who were separated from their own babies, or who did not breastfeed them, may feel that this implies that they do not love their children properly. Allow time to discuss this if necessary.

Mothers may not be aware of bonding happening immediately. Strong affectionate ties grow gradually. But early close contact gives them the best possible start. Separation makes bonding more difficult, especially in high risk families, for example, young mothers with poor support. However, the effects of early separation can be overcome, and bonding can also take place later, particularly during the first nine months of a baby's life. If initiation of breastfeeding is delayed, for example, if a mother or her baby is ill, or for cultural reasons, breastfeeding can still be successfully established. It is helpful if the mother and baby have prolonged skin-to-skin contact as soon as possible, and if the mother is well supported.

However, separation and delay put bonding and breastfeeding at risk, and should be avoided.

Bacterial colonization
Early skin-to-skin contact also enables harmless bacteria from the mother to be the first to colonize her baby. These harmless bacteria help to protect a baby against more harmful bacteria, such as those from the hospital and hospital staff.

Prophylaxis of eye infection
In countries with a high prevalence of sexually transmitted diseases, it may be health service policy to put either silver nitrate drops or tetracycline ointment into the eyes of all newborns to prevent gonococcal and chlamydial infection, which can lead to blindness. To be effective, the treatment must be given within one hour of delivery. To minimise any interference with breastfeeding, allow the baby to suckle if possible before putting in drops or ointment. Tetracycline ointment may be preferable, because it is less irritating than silver nitrate drops.

Slide 8/4 The first breastfeed

- This slide shows a baby having his first breastfeed. He is about one hour old.

Ask: *What do you think of his position and attachment?*

He is in a good position, and looks well attached.

Babies are normally very alert and responsive in the first 1-2 hours after delivery. They are ready to suckle, and easily attach well to the breast.

Most babies want to feed between half to one hour after delivery, but there is no exact fixed time. If the first feed is delayed more than about an hour, breastfeeding is less likely to be successful. A mother is more likely to stop breastfeeding early.

Sometimes in the past we have tried to force babies to breastfeed immediately after delivery, before they or their mothers were ready. This is not necessary or helpful.

It is best to keep a baby with his mother as in Slide 8/2, and let him breastfeed when he shows that he is ready. Help his mother to recognize rooting, as in Slide 8/3, and other signs that he is ready to breastfeed. If necessary, help her to put him to her breast - especially if this is her first baby.

Slide 8/5 Prelacteal feeds

- This slide illustrates Step 6 and Step 9.

Step 6 says: `Give newborn infants no food or drink other than breastmilk, unless medically indicated'.

Step 9 says: `Give no artificial teats or pacifiers (also called dummies or soothers) to breastfeeding infants'.

This baby is being given an artificial feed from a bottle, before starting to breastfeed.
Any artificial feed given before breastfeeding is established is called a *prelacteal feed*.

The dangers of prelacteal feeds are these:

- *They replace colostrum as the baby's earliest feeds.*
  - The baby is more likely to develop infections such as diarrhoea, septicaemia and meningitis;
  - He is more likely to develop intolerance to the proteins in the artificial feed, and allergies, such as eczema.

- *They interfere with suckling.*
  - The baby's hunger is satisfied, so that he wants to breastfeed less.
  - If he is fed the artificial feed from a bottle with an artificial teat, he may have more difficulty attaching to the breast, (nipple confusion).
  - The baby suckles and stimulates the breast less.
  - Breastmilk takes longer to `come in' and it is more difficult to establish breastfeeding.

If a baby has even a few prelacteal feeds, his mother is more likely to have difficulties such as engorgement. Breastfeeding is more likely to stop early than when a baby is exclusively breastfed from birth.

Babies who are given pacifiers to suck, are also more likely to stop breastfeeding early.

 Tell participants that they can find a summary of these points in the section **The dangers of prelacteal feeds** on page 37 of their manuals.

Further information
Participants may want to discuss further the medical indications for giving artificial feeds.
The commonest reasons for giving prelacteal and supplementary feeds are:
- To prevent low blood sugar, or *hypoglycaemia*;
- To prevent dehydration, especially if a baby is jaundiced, and needs phototherapy;
- Because the mother's breastmilk has not `come in'.

Full-term, normal weight babies are born with a store of fluids and glycogen. Breastfeeding, which provides first colostrum and then mature milk, is all that they need.
Sick or low-birth-weight babies may require special feeding, for example to prevent hypoglycaemia, or because they are unable to breastfeed. However even for these babies, breastmilk is usually the best kind of feed to give. Babies who are jaundiced need more breastmilk, which helps to clear jaundice. Other fluids, such as glucose water, do not help to clear jaundice, and are only needed if the baby is dehydrated. This is discussed further in Session 26, `Low-birth-weight and sick babies', and also in the reference document Annex to the Global Criteria for Baby Friendly Hospitals: Acceptable medical reasons for supplementation.

Slide 8/6 Putting babies in a nursery

- The next three slides are about Steps 7 and 8.

Step 7 says: `Practise rooming-in - allow mothers and infants to remain together - 24 hours a day.'

Step 8 says: `Encourage breastfeeding on demand.'

This baby is in a cot in a nursery. He is crying, but his mother is in another room and is not able to respond to him. His mother feeds him every 3 hours, when the nurses bring him to her.

When babies are separated from their mothers and put in a nursery, they cry more. Nurses are more likely to give bottle feeds to keep the babies quiet. Mothers feel less confident about breastfeeding. Mothers are more likely to have difficulties, and to stop breastfeeding sooner.

Separating a mother and her baby in this way can interfere with both bonding and breastfeeding, and it should not be permitted.

Further information
There are four common reasons why mothers and babies are separated in hospital. The intentions behind them are often good, but the reasons themselves are unsound.
Consider the reasons in turn:

1. *To allow the mother to rest.*
   Immediately after delivery, both mother and baby are usually alert and need close contact. After this period, they can rest quite well together.

2. *To prevent infection.*
   There is no evidence that putting babies in nurseries reduces infection. On the contrary, it may increase cross-infection between babies, which can be carried by health care staff.

3. *A lack of space in the wards for cots*.
   Administrators can often overcome the problem of space if they realize how important rooming-in is. In many hospitals, babies stay in the same bed with their mothers, so there is no need for extra space.

4. *To observe the baby.*
   Health care staff can observe babies with their mothers just as well as in a nursery. Mothers observe their babies very closely, and they often notice something wrong before busy health care staff. There is no justification for separating mother and baby while waiting for a doctor to examine a baby.

Slide 8/7 Rooming-in

- The babies in this slide are *rooming-in* with their mothers.

Rooming-in means that a baby stays in the same room as his mother, day and night, from immediately after birth.

The baby in picture 1 is in a cot beside his mother's bed. He is close to her, and she can reach him when she is lying down in bed. In some hospitals, cots are put at the foot of the mother's bed. It is better for the cot to be beside the mother's bed. She needs to be able to touch her baby easily.

The babies in picture 2 are in bed with their mothers. This is called `bedding-in'.
Bedding-in has extra advantages for breastfeeding, because it is easier for a mother to rest and breastfeed. A baby can breastfeed at night or at other times when the mother is asleep without disturbing her. Bedding-in also helps to overcome the problem of lack of space in a ward for cots.

Slide 8/8 Advantages of rooming-in

- Rooming-in has these advantages:

  - It enables a mother to respond to her baby and feed him whenever he is hungry. This helps both bonding and breastfeeding.
  - Babies cry less, so there is less temptation to give bottle feeds.
  - Mothers become more confident about breastfeeding.
  - Breastfeeding continues longer after the mother leaves hospital.

Slide 8/9 Demand feeding

- Rooming-in enables a mother to breastfeed her baby *on demand*. This slide summarizes what we mean by demand feeding. It means breastfeeding a baby whenever he wants, both day and night. A mother should not be made to give feeds only at fixed times, according to the clock.

A mother does not have to wait until her baby is upset and crying to offer him her breast. She should learn to respond to the signs that her baby gives, for example rooting, which show that he is ready for a feed.

Because of this, some people prefer the terms `unrestricted feeding' or `baby-led feeding' to `demand feeding'.

Ask: *What would you tell a mother about how long she should let her baby suckle?*
(Let participants give their opinions. Then make sure the answer is clear.)

Let a baby suckle as long as he wants, provided he is well attached.

There is no need to restrict the length of a breastfeed. If a baby is well attached to the breast, his mother will not get sore nipples.

Some babies take all the breastmilk they want in a few minutes; other babies take half an hour to get the same amount of milk, especially in the first week or two. They are all behaving normally. If a mother takes her baby off her breast before he has finished, he may not get enough hindmilk. Usually when a baby has had all that he wants, he releases the breast himself.

Ask: *Would you suggest that a mother lets her baby suckle from one breast, or from both breasts at each feed?*
(Let a few participants give their opinions. Then make sure the answer is clear.)

Let her baby finish feeding on the first breast, to get the fat-rich hindmilk. Then offer the second breast, which he may or may not want.

It is not necessary to feed from both breasts at each feed. If a baby does not want the second breast, his mother can offer that side first next time, so that both breasts get the same amount of stimulation.

Slide 8/10 Advantages of demand feeding

- Demand feeding has these advantages:

  - Breastmilk `comes in' sooner;
  - The baby gains weight faster;
  - There are fewer difficulties such as engorgement;
  - Breastfeeding is more easily established.

 Tell participants that they can find a summary of these points in the box **ADVANTAGES OF ROOMING-IN AND DEMAND FEEDING** on page 38 of their manuals.

Slides 8/8 and 8/10

ADVANTAGES OF ROOMING-IN AND DEMAND FEEDING

Rooming-in and demand feeding help both bonding and breastfeeding.

Advantages of rooming-in:
- Mother can respond to baby, which helps bonding
- Babies cry less, so less temptation to give bottle feeds
- Mothers more confident about breastfeeding
- Breastfeeding continues longer

Advantages of demand feeding:
- Breastmilk `comes in' sooner
- Baby gains weight faster
- Fewer difficulties such as engorgement
- Breastfeeding more easily established

Slide 8/11 The need for help with early breastfeeds

- The next four slides illustrate Step 5:
  `Show mothers how to breastfeed, and how to maintain lactation even if they are separated from their infants'.

This mother is having some difficulty getting her baby to breastfeed. There is no one available to help her. This is a common problem in many health facilities. Mothers are left to struggle by themselves, and this may result in problems and later failure.

Maternity ward staff often feel that they do not have enough time to help every mother. In many health facilities, mothers are discharged within a few hours of delivery, so there are few opportunities for their babies to breastfeed.

However, a more important reason is that few health workers have been trained to give help, and they lack the necessary skills. Hopefully in future, health workers will be trained to help mothers.

Slide 8/12 Helping a mother with an early breastfeed

- This slide shows a midwife coming to help a mother to put her baby to her breast.

A skilled, experienced midwife or other person should help a mother with an early feed. This may be the very first feed, soon after delivery, or the next time the baby is ready to feed, some time in the first 24 hours after delivery. It should be as early as possible, because it makes it easier to establish breastfeeding.

Many mothers do not need help, or they need very little. But a mother may not know if she needs help or not. It is a good idea for a midwife to spend time with each mother during an early breastfeed to make sure that everything is going well. This should be a routine in maternity wards before a mother is discharged. It need not take a long time.

Ask: *How would you suggest that this midwife helps this mother?*
(Let participants make some suggestions. Encourage them to think of:
- observing a breastfeed;
- helping the mother to position her baby;
- giving her relevant information.
Then show Slide 8/13 to summarise the answer.)

Slide 8/13 How to help with an early breastfeed

- This slide summarizes how to help a mother with an early feed.

- *Avoid hurry and noise.*
  Talk quietly, and be unhurried, even if you have only a few minutes.

- *Ask the mother how she feels and how breastfeeding is going.*
  Let her tell you how she feels, before you give any information or suggestions.

- *Observe a breastfeed.*
  Try to see the mother when she is feeding her baby, and quietly watch what is happening. If the baby's position and attachment are good, tell her how well she and the baby are doing. You do not need to show her what to do.

- *Help with positioning if necessary.*

If the mother is having difficulty, or if her baby is not well attached, give her appropriate help.

- *Give her relevant information.*
  Make sure that she understands about demand feeding, about the signs that a baby gives that show that he is ready to feed, and explain how her milk will `come in'.

- *Answer the mother's questions.*
  She may have some questions that she wants to ask; or as you talk to her, you may learn that she is worried about something, or not sure about something. Explain simply and clearly what she needs to know.

Ask: *What could you tell her about how a baby shows that he is ready for a feed?*
(Let participants make a few suggestions, then continue.)

A baby may be wakeful and restless, or make small noises; he may make hand-to-mouth movements, and sucking movements; he may suck his fingers, and root for the breast.

 Tell participants that they can find the list of the points **HOW TO HELP A MOTHER WITH AN EARLY BREASTFEED** on page 39 of their manuals.

Further information
Babies differ very much in how often they want to feed. These patterns are all normal.
- For the first 1-2 days, a baby may not want many feeds. Some babies sleep for 8-12 hours after a good feed. Provided a baby is warm and well and not low-birth-weight, and he has had at least one good breastfeed, it is not necessary to wake him at any fixed time for another feed.
- For the next 3-7 days, a baby may want to feed very often - as the milk supply becomes established. After that babies usually feed less often, but their habits continue to vary a lot. Any baby may want to feed more on some days and nights than on others.

Slide 8/14 Mothers who are separated from their infants

- Sometimes a baby has to be separated from his mother, because he is ill, or of low-birth-weight, and he needs special care.

While they are separated, a mother needs a lot of help and support. She needs help to express her milk as you see a mother doing here. This is necessary both to establish and maintain lactation, and to provide breastmilk for her baby. (See also Session 20, `Expressing breastmilk'). She may need help to believe that her breastmilk is important, and that giving it will really help her baby. She needs help to get her baby to suckle from her breast as soon as he is able.

The low-birth-weight baby in the other picture is fed with his mother's expressed breastmilk. At first, he was fed by nasogastric tube. Now, his mother can feed him her milk from a cup. There is no need to use a bottle for these babies. Feeding from a bottle is more difficult for them than feeding from the breast. Cups are more satisfactory. (See also Session 26, `Low-birth-weight and sick babies'.)

Slide 8/15 After Caesarian section

- The mother in this slide was delivered by Caesarian section. She is breastfeeding her baby.

It is usually possible for a mother to breastfeed within about 4 hours of a Caesarian section - as soon as she has regained consciousness. Exactly how soon depends partly on how ill the mother is, and partly on the type of anaesthetic used. After epidural anaesthesia, a baby can often breastfeed within -1 hour.

Ask: *Does a baby need a feed while he waits for his mother to breastfeed him?*

A healthy, term baby usually needs no food or drink before his mother can feed him. He can wait a few hours until she is ready.

A baby can `room-in' with his mother in the ordinary way, and she can feed him whenever he is hungry. Most mothers need help to find a comfortable position for the first few days.

Often a mother finds it easiest to breastfeed lying down at first.
- She may lie on her back, with her baby on top of her, like the mother in this slide.
- She may find it easier to lie on her side, with the baby lying beside her and facing her. This prevents the baby pressing on her wound. She may need help to turn over, and to move her baby from one side to the other.
- Later, she may like to sit and hold her baby across her abdomen above the operation wound, or under her arm.

Whatever position a mother uses, make sure that her baby is in a good position, facing her breast, so that he is well attached to her breast.

Further information
In one busy hospital, after Caesarian section, most mothers breastfeed in this way:
- for the first 24 hours, lying on their backs;
- for the second 24 hours, turning from side to side;
- from the third day onwards, sitting up with pillows for support.

III. Answer participants' questions (10 minutes)

Ask participants if they have any questions, and try to answer them.

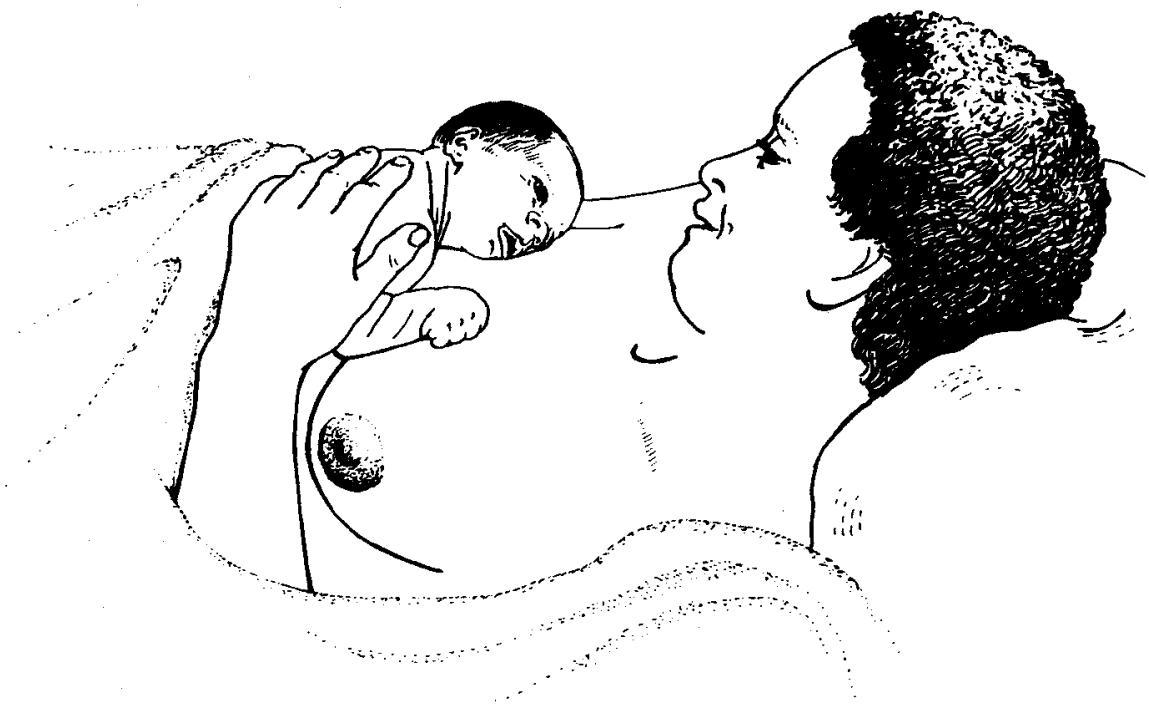


Fig.2 Skin-to-skin contact in the first hour after delivery helps breastfeeding and bonding
(Fig.20 in Participants' Manual)

IV. Conduct small group discussion (30 minutes)

(This section can be held at a separate time if necessary.)

 Gather your group of 4-5 participants, and find a part of the room where you can work together as a group. (Other trainers also gather their groups.)

Ask participants to keep their manuals closed until you tell them to open them.

 Introduce the topic with these points:

- Step 10 of the `Ten Steps to Successful Breastfeeding' is:
  `Foster the establishment of breastfeeding support groups, and refer mothers to them on discharge from the hospital or clinic'.

- Many *mothers give up breastfeeding or start complementary feeds in the early weeks.*
  Difficulties arise most often during this time. However, many mothers are discharged within a day or two after delivery, before their breastmilk has `come in', and before breastfeeding is established.

- *Even good hospital practices cannot prevent all the difficulties.*
  They cannot make sure that mothers will continue to breastfeed exclusively.
  So it is important to think about what happens to mothers after they go home.

Ask: *What difficulties may a mother have when she goes home?*
(Let participants suggest. Add to their suggestions any of the following that they have not included.)

She may have difficulties with breastfeeding;
She has to cope with the demands of the rest of the family;
She may have to listen to a lot of different advice about how to feed the baby;
She may be isolated, without help;
She may have to go back to work.

If she is to continue to breastfeed successfully, she will need continuing help and support.

Ask: *Where can a mother get continuing help and support, so that breastfeeding is established?*
(Let participants make a few suggestions.)

 Discuss participants' suggestions.

Use the ideas in the notes below, but relate the ideas to the local situation.
Which of these sources of support are already available?
Which are not feasible, and what is the reason?
Which sources of support could health workers encourage and strengthen?

Possible sources of help for breastfeeding mothers include:

- *Supportive family and friends.*
  This is often the most important source of support. Community support is often good where breastfeeding traditions are strong, and family members live near. However, some traditional ideas may be mistaken. Many women, especially in cities, have little support. Or they may have friends or relatives who encourage them to bottle feed.

- *An early postnatal check, within 1 week of discharge from hospital.*
  This check should include observation of a breastfeed, and discussion of how breastfeeding is going. You can help mothers with minor difficulties before they become serious problems.

- *A routine postnatal check at 6 weeks.*
  This check also should include observation of a breastfeed, as well as discussion of family planning (see Session 31, `Women's nutrition, health and fertility').

- *Continuing help from health care services.*
  At any time that a health worker is in contact with a mother and child under 2 years of age, she should support breastfeeding. (See Session 28 `Sustaining breastfeeding').

- *Help from community health workers.*
  Community health workers are often in a good position to help breastfeeding mothers, as they may live nearby. They may be able to see a mother more often, and give more time, than facility-based health workers. It may be helpful to train community health workers in some breastfeeding counselling skills.

- *A breastfeeding support group*.
  (To discuss mother support groups further, use the points in the box **BREASTFEEDING SUPPORT GROUPS**).

 Discuss breastfeeding support groups.

Ask participants to find the box **BREASTFEEDING SUPPORT GROUPS** on page 41 of their manuals. Ask them to read out the points in the box in turn.

Discuss each point in relation to the local situation and experience.

BREASTFEEDING SUPPORT GROUPS

- A group may be started by a health worker; by an existing women's group; by a group of mothers who feel that breastfeeding is important;
  or by mothers who meet in the antenatal clinic or maternity facility and who want to continue to meet and help each other.

- A group of breastfeeding mothers meets together every 1-4 weeks, often in one of their homes, or somewhere in the community. They can have a topic to discuss, such as "The advantages of breastfeeding" or "Overcoming difficulties".

- They share experiences, and help each other with encouragement and with practical ideas about how to overcome difficulties. They learn more about how their bodies work.

- The group needs someone who is accurately informed about breastfeeding to train them. They need someone who can correct any mistaken ideas, and suggest solutions to difficulties. This helps the group to be positive and not to complain. This person could be a health worker, until someone in the group has learnt enough to play this role.

- The group needs a source of information whom they can refer to if they need help. This could be a health worker trained in breastfeeding, whom they see from time to time. The group also needs up-to-date materials to educate themselves about breastfeeding. The health worker can help them to get these.

- Mothers can also help each other at other times, and not only at meetings. They can visit each other when they are worried or depressed, or when they don't know what to do.

- Breastfeeding support groups can provide an important source of contact for socially isolated mothers.
  They can be a source of support which builds mother's confidence about breastfeeding and which reduces their worries.
  They can give a mother the extra help that she needs, from women like herself, that health services cannot give.

 Ask participants to look at page 42 of their manuals, and to find the box **WHAT TO DO BEFORE A MOTHER LEAVES A MATERNITY FACILITY.**

Explain that this is a summary of what to do before they discharge a mother after delivery.

☺ Ask participants to read out the points in turn.

WHAT TO DO BEFORE A MOTHER LEAVES A MATERNITY FACILITY

Find out what support she has at home.

If possible, talk to family members about her needs.

Arrange a postnatal check in the first week, to include observation of a breastfeed (in addition to a routine check at 6 weeks).

Make sure that she knows how to contact a health worker who can help with breastfeeding if necessary.

If there is a breastfeeding support group in her neighbourhood, refer her to that.

- Recommended reading:

Helping Mothers to Breastfeed:

Chapter 4, `How breastfeeding should begin'

Chapter 11, `Counselling'

Chapter 12, section 12.3, `Women's groups' and section 12.4, `Direct mother-to-mother support groups'

Protecting, Promoting and Supporting Breastfeeding: The Special Role of Maternity Services, A Joint WHO/UNICEF Statement, 1989

- Annex to the Global Criteria for Baby Friendly Hospitals: Acceptable Medical Reasons for Supplementation
- Example of a hospital breastfeeding policy, if available

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CLINICAL PRACTICE 1

Listening and learning
Assessing a breastfeed

Objective

Participants practise `listening and learning' and `assessing a breastfeed' with mothers and babies in a ward or clinic.

Session outline (120 minutes)

Participants are together as a class led by one trainer to prepare for the session and to discuss it afterwards.

Participants work in small groups of 4-5 each with one trainer for clinical practice in a ward or clinic.

I.	Prepare the participants	(20 minutes)
II.	Conduct the clinical practice	(80 minutes)
III.	Discuss the clinical practice	(20 minutes)

Preparation

If you are leading the session:
Make sure that you know where the clinical practice will be held, and where each trainer should take her group. If you did not do so in a preparatory week, visit the wards or clinic where you will go, introduce yourself to the staff members in charge, and make sure that they are prepared for the session (see Director's Guide).

Study the instructions in the following pages, so that you can prepare the participants and conduct the clinical practice.

Make sure that there are copies of the **CLINICAL PRACTICE DISCUSSION CHECKLIST** available for each trainer.

Make sure that there are two copies of the B-R-E-A-S-T-FEED Observation Form and one copy of the list of **LISTENING AND LEARNING SKILLS** available for each participant and trainer.

If you are leading the group:
Study the instructions in 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 B-R-E-A-S-T-FEED Observation Form, and one copy of the list of **LISTENING AND LEARNING SKILLS**. Have one or two spare copies with you.

Find out where to take your group, and where to meet for the discussion afterwards.

As you follow the text, remember:

☐ indicates an instruction to you, the trainer
▪ indicates what you say to participants

I. Prepare the participants (20 minutes)

One trainer leads a preparatory session with all participants and the other trainers together.

If you have to travel to another facility for the clinical practice, hold the preparatory session in the classroom before you leave. If necessary, this can take place on the evening or the morning before.

☐ *Explain the objective of the exercise:*

▪ You practise `assessing a breastfeed' and `listening and learning', using the skills that you

learnt in Sessions 4, 5, 6 and 7.

☐ *Explain what each participant should take with her:*

- Take with you:
  - two copies of the B-R-E-A-S-T-FEED Observation Form;
  - one copy of **LISTENING AND LEARNING SKILLS**;
  - pencil and paper to make notes.

  You do not need to take books or manuals or anything else. These other things can interfere with the clinical practice.

☐ *Give each participant the forms that she needs.*

☐ *Make sure that trainers have these to take:*

- spare copies of the B-R-E-A-S-T-FEED Observation Form;
- spare copies of **LISTENING AND LEARNING SKILLS**;
- a copy of the **CLINICAL PRACTICE DISCUSSION CHECKLIST** (see page 136).

☐ *Explain how the participants will work:*

- You work in your groups of 4-5 each with a trainer. To start with, the whole group works together. The trainer demonstrates what to do, and then you practise. You take turns to talk to a mother, while the other members of the group observe. When everyone knows what to do, you can work in pairs, while the trainer circulates.

☐ *Explain what the participant who talks to the mother will do:*

- Introduce yourself to the mother, and ask permission to talk to her. Introduce the group, and explain that they are interested in infant feeding. Ask permission to watch her baby feed. (Avoid saying `breastfeeding': see the box **MISTAKES TO AVOID** on page 131 in this Guide, or page 44 in the Participants' Manual.)

  Try to find a chair or stool to sit on. If necessary, and if permissible, sit on the bed.

  If the baby is feeding, ask the mother to continue as she is doing. If the baby is not feeding, ask the mother to give a feed in the normal way at any time that her baby seems ready. Ask the mother's permission for the group to watch the feed.

  Before or after the breastfeed, ask the mother some open questions about how she is, how her baby is, and how feeding is going, to start the conversation. Encourage the mother to talk about herself and her baby. Practise as many of the listening and learning skills as possible.

☐ *Explain what the other participants will do:*

- Stand quietly in the background. (There are unlikely to be enough stools or chairs for the whole group.) Try to be as still and quiet as possible. Do not comment, or talk among yourselves.

  Make *general* observations of the mother and baby. Notice for example: does she look happy? Does she have formula or a feeding bottle with her?

  Make *general* observations of the conversation between the mother and the participant. Notice for example: who does most of the talking? Does the participant ask open questions? Does the

mother talk freely, and seem to enjoy it?

Make *specific* observations of the participant's listening and learning skills.
Mark a ✔ on your list of **LISTENING AND LEARNING SKILLS** when she uses a skill, to help you to remember for the discussion. Notice if she uses helpful non-verbal communication.

Notice if the participant makes a mistake, for example, if she uses a judging word, or if she asks a lot of questions to which the mother says `yes' and `no'.

☐ *Explain what participants do when they observe a breastfeed:*

- Stay quietly watching the mother and baby as the feed continues.
  While you observe, fill in a B-R-E-A-S-T-FEED Observation Form.
  Write the name of the mother and baby; mark a ✔ beside each sign that you observe; add the time that the feed takes.
  Under `Notes:' at the bottom of the form, write anything else that you observe which seems important for breastfeeding.

☐ *Explain what to do when they have finished observing:*

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

- Go with the group into another room or corner to discuss your observations.

☐ *Warn participants about* **MISTAKES TO AVOID**:

MISTAKES TO AVOID

- **Do not say that you are interested in <u>breastfeeding</u>.**
  The mother's behaviour may change. She may not feel free to talk about bottle feeding. You should say that you are interested in "infant feeding" or in "how babies feed".

- **Do not give a mother help or advice.**
  In Clinical Practice 1, if a mother seems to need help, you should inform your trainer, and a member of staff from the ward or clinic.

- **Be careful that the forms do not become a barrier.**
  The participant who talks to the mother should not make notes while she is talking. She needs to refer to the forms to remind her what to do, but if she wants to write, she should do so afterwards. The participants who are observing can make notes.

☐ Tell participants that there is a summary of these instructions in the Participants' Manual on page 44 to remind them of the main points of what you said.

II. Conduct the clinical practice (80 minutes)

☐ *Take your group to the ward or clinic:*

- Introduce yourself and your group to the staff member in charge.
- Ask which mothers and babies it would be appropriate to talk to, and where they are.
- Try to find a mother and baby who are breastfeeding, or a mother who thinks that her baby

may want to feed soon. If this is not possible, talk to any mother and baby.

☐ *Demonstrate to the group what to do:*

- Explain that you will first demonstrate what participants should do.
- Ask participants to stand quietly in the background, and to refer to their list of **LISTENING AND LEARNING SKILLS**, and the B-R-E-A-S-T-FEED Observation Form.
- Introduce yourself and the group to the mother.
- Ask her permission to talk to her and to watch the baby feed.
- Sit on a chair or stool, or the bed if permissible.
- Ask her a few open questions.
- Use as many listening and learning skills as possible to encourage the mother to tell you about herself and the baby. Follow the list of skills.
- Observe the baby breastfeeding, using the B-R-E-A-S-T-FEED Observation Form.
- Thank the mother, and say something to praise and support her.

If you cannot speak the mother's language, ask a participant who can speak it to interpret for the demonstration.

☐ *Discuss the demonstration:*

Take the group away from the mother, and discuss what they observed.
Ask them:
- What did they observe generally about the mother and baby?
- What signs from the B-R-E-A-S-T-FEED Observation Form did they observe?
- Which listening and learning skills did you demonstrate?

If the mother and baby showed any signs of good or poor positioning and attachment which participants did not see, point them out.

☐ *Arrange for a participant to talk to a mother:*

Find another mother, and ask a participant to talk to her. She should practise listening and learning skills, while the rest of the group observes. If the baby breastfeeds, they should all observe the feed.

☐ *Guide the participant who is practising:*

Keep in the background, and try to let the participant work without too much interference.
You do not need to correct every mistake that she makes immediately. If possible wait until the discussion afterwards. Then you can both praise what she did right and talk about anything she did not do right.
However, if she is making a lot of mistakes, or not making any progress, then you should help her. Try to help in a way which does not make her embarrassed in front of the mother and the group.
Also, if she starts to help or advise the mother, remind her that she should not do that during this practice session.
Additionally, if the mother and baby show something important that the participants may not have observed, you can quietly draw their attention to it.

You need to judge as participants work what will best help them to learn.
Use your confidence and support skills to correct participants and to help them to develop confidence in their own clinical and counselling skills.

☐ *Discuss the participant's performance:*

Take the group away from the mother, and discuss what they observed.
Use the **CLINICAL PRACTICE DISCUSSION CHECKLIST** to help you to lead the discussion.

Ask the general questions, and then ask the specific questions about `listening and learning' and about `assessing a breastfeed'.
(Ask the `building confidence' and `history taking' questions in later clinical practice sessions.)

Go through the **LISTENING AND LEARNING SKILLS** checklist, and discuss how the participant practised them. First ask the participant herself to say how well she thinks she did. Then ask the other participants.

Go through the B-R-E-A-S-T-FEED Observation Form, and discuss how many of the signs the group noticed. Ask them to decide if the baby was well or poorly positioned and attached.

☐ *Arrange for the other participants in turn to talk to mothers:*

Find another mother, and ask another participant to talk to her. Discuss the group's observations, and the participant's performance.
Work with the group together until you are sure that they know what to do. Make sure that you are present the first time that a participant talks to a mother.
Try to make sure that each participant talks to at least one mother.

☐ *Let participants work in pairs:*

When you have observed participants talking to at least one mother, and you are confident that they know what to do, let them work in pairs to talk to other mothers without you.

Circulate between the pairs to see how they do. When a pair has finished, move away from the mother, and discuss their observations with them.
☐ *Teach about mothers who need help:*

If at any time there is a mother who needs help, or who illustrates a particular situation, take the opportunity to teach about it.

Ask a participant who identifies a mother needing help to report it to you. Ask the staff of the ward or clinic if they would like you to help the mother. If they agree, give the mother the necessary help, together with the participant.
Ask the staff to be present if possible, and make sure that they understand what you suggest to the mother so that they can provide follow-up.
Explain and demonstrate the situation to the other participants. This may take you ahead of what has been covered in the course, but it is important not to miss a good learning opportunity.

If possible, suggest that participants revisit the mothers whom they talked to, to follow them up the next day.

☐ *Encourage participants to observe health care practices:*

Encourage participants, while they are in a ward or clinic, to notice:
- if babies room-in with their mothers;
- whether or not babies are given formula, or glucose water;
- whether or not feeding bottles are used;
- the presence or absence of advertisements for baby milk;
- whether sick mothers and babies are admitted to hospital together;
- how low-birth-weight babies are fed.

Encourage participants also to talk to staff in the health facility, to learn:

- their attitude to breastfeeding;
- how they care for breastfeeding mothers;
- if they have babies of their own, and how they feed them.

Explain that participants should not comment on their observations, or show any disapproval, while in the health facility. They should wait until the trainer invites them to comment privately, or in the classroom.

III. Discuss the clinical practice (20 minutes)

The whole class comes back together to discuss the clinical practice exercise, led by the trainer who led the preparatory session.

☐ *Ask one participant from each group to report briefly on what they learnt:*

Ask them to comment:

- on any special situations of mothers and babies from which they learnt;
- on their experiences using the B-R-E-A-S-T-FEED Observation Form and the list of **LISTENING AND LEARNING SKILLS**.

Do not allow participants to report on details of every individual mother. They should report only on points of special interest.

Use the **CLINICAL PRACTICE DISCUSSION CHECKLIST** to help you to guide the discussion.
However, do not go through the whole checklist, because this was done in the small groups.

☐ *Ask participants to fill in their* **CLINICAL PRACTICE PROGRESS FORM**:

Explain that the form is on page 182 (the last page) of their manuals .

On the form they should record each mother and baby that they talked to during the Clinical Practice 1. They record each mother twice. In Section 1 of the form, they record the skills that they practised with the mother; in Section 2 they record the mother's situation.

CLINICAL PRACTICE DISCUSSION CHECKLIST

General questions

- ☐ How did your clinical practice go?
  What did you do well? What difficulties did you have?
- ☐ Was the mother willing to talk? Did she seem to enjoy talking to you?
- ☐ Did the mother ask any questions? How did you respond?
- ☐ What was the most interesting thing that you learnt from her?
  Did she have a special difficulty or situation which helped you to learn?

Listening and learning

- ☐ How many of the listening and learning skills were you able to use?
- ☐ What mistakes did you make? Did you ask a lot of questions?
- ☐ Did using the skills encourage the mother to talk?

Assessing a breastfeed

- ☐ What did you learn by general observation?
- ☐ What did you learn using the B-R-E-A-S-T-FEED Observation Form?

Confidence and support

- ☐ How many of the confidence and support skills were you able to use?
  (especially praise 2 things, and give 2 pieces of relevant information)
- ☐ What mistakes did you make? Did you give the mother a lot of advice?
- ☐ Did using these skills help you to help the mother?

History-taking

- ☐ What did you learn by taking a breastfeeding history?
- ☐ Did you remember to ask something from each section of the form?
- ☐ Did using the form help you to understand the mother's situation?

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BREASTFEEDING COUNSELLING

A TRAINING COURSE

TRAINER'S GUIDE

PART TWO

Sessions 10-19

WORLD HEALTH ORGANIZATION CDD PROGRAMME

UNICEF

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Session 10

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POSITIONING A BABY AT THE BREAST

This session must come after Clinical Practice 1 and before Clinical Practice 2.

Objectives

At the end of this session, participants will be able to:
- help a mother to position her baby correctly at the breast;
- demonstrate alternative positions for mothers and babies with special needs.

Session outline (60 minutes)

Participants are all together for a demonstration led by one trainer.

I. Introduce the topic (5 minutes)

II. Demonstrate helping a mother to position her baby (35 minutes)

Participants are in groups of 4-5 with one trainer.

III. Help participants to practise positioning a baby (20 minutes)

If available and appropriate, show the video *Helping a mother to breastfeed* as soon as convenient after the session.
This requires 30 minutes additional time.

Preparation

The day before the demonstration:
Ask a participant to help you with the demonstration.
Explain that you want her to play a mother who needs help to position her baby. Ask her to decide on a name for herself and her `baby'. She can use her real name if she likes.
Explain what you want to happen as follows:

1. You will demonstrate how to help a mother who is sitting.
   She will sit holding the doll in the common way, with the doll across the front.
   You will greet her and ask how breastfeeding is going, and she will say that it is painful and that she has sore nipples.
   You will ask her to `breastfeed' the doll, while you observe.
   She will hold it in a poor position: loosely, supporting only its head, with its body away from hers, so that she has to lean forward to get her breast to its mouth. She will pretend that 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. She can rub the other breast, to show that now she is feeling the ejection reflex.

2. You will demonstrate other ways to hold a baby with the mother sitting - the underarm position, and using the opposite hand.

3. 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.

Practise giving the demonstration with the participant, so that you know how to follow the steps.
Decide the `comfortable' position that you will help her to sit in.
Ask her to wear clothes such as a long skirt or trousers so that she feels comfortable lying down for this demonstration.

Find a cloth to cover the table, and a cloth to cover the `mother's' legs. Find some pillows if these are appropriate in this community.

Early on the day of the demonstration:
Arrange chairs, a footstool, and a bed, or a table that can be used for a bed to demonstrate breastfeeding lying down.

As you follow the text, remember:

□	indicates an instruction to you, the trainer
▪	indicates what you say to participants

I. Introduce the topic (5 minutes)

Ask participants to find pages 45-49 of their manuals, where the technique `Helping a mother to position her baby at her breast' is described.

□ Explain what the session will be about:

- In this session you will learn how to help a mother to position her baby at the breast, so that he is well attached and can suckle effectively. The techniques are described in your manuals, for you to read again later.

- There are three main kinds of mother whom you may need to help:
  - new mothers, who are breastfeeding for the first time;
  - mothers who have some difficulty with breastfeeding;
  - mothers who bottle fed previously but now want to breastfeed.

□ Make these points:

- Always *observe a mother breastfeeding before you help her.*
  Take time to see what she does, so that you can understand her situation clearly. Do not rush to make her do something different.

- *Give a mother help only if she has difficulty.*
  Some mothers and babies breastfeed satisfactorily in positions that would make difficulties for others. This is especially true with babies more than about 2 months old. There is no point trying to change a baby's position if he is getting breastmilk effectively, and his mother is comfortable.

- *Let* the *mother do as much as possible herself.*
  Be careful not to `take over' from her. Explain what you want her to do. If possible, demonstrate on your own body to show her what you mean.

- Make *sure that 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 his mother cannot.

II. Demonstrate helping a mother to position her baby (35 minutes)

□ Give the four demonstrations described below.

As you follow each step:

- Demonstrate *how to talk to a mother.*

Be gentle. Explain what you do so that she understands, and talk in a way which builds her confidence.
(Although participants have not yet done the next session, `Building confidence and giving support', it is important to demonstrate good technique from the beginning).

- *Explain to participants what you are doing.*
  Sometimes you need to step out of your role of helping the mother, to make sure that participants understand what you are demonstrating.

1. Demonstrate how to help a mother who is sitting (15 minutes)

☺ Ask the participant who is helping you to sit on the chair or bed that you have arranged. She should hold the doll across her body in the common way, but in a poor position as you practised previously: loosely, supporting only his head, with his body away from hers, so that she has to lean forward to get her breast into his mouth.

Tell her that you will ask her how breastfeeding is going, and she should say that it is painful when the baby suckles.

 Follow these steps:

- Greet the `mother', introduce yourself, and ask her name and her baby's name.
  Ask her how she is and ask one or two open questions about how breastfeeding is going.

  The participant says that breastfeeding is painful.

- Assess a breastfeed.
  Ask her if you may see how (baby's name) breastfeeds, and ask her to put him to her breast in the usual way. Observe her breastfeeding for a few minutes.

- Explain what might help and ask if she would like you to show her.
  Say something encouraging, like:
  "He really wants your breastmilk, doesn't he?"

  Then 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 that the `mother' is sitting in a comfortable, relaxed position (as you decided when you practised).

  Explain to participants:
  - A low seat is usually best, 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 in bed, pillows may help (if available in this community).
  - 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 that she does not lean forward to put him onto her breast.

- Sit down yourself, so that you also are comfortable and relaxed, and in a convenient position to help.

  Explain to participants:
  You cannot help a mother satisfactorily if you are in an awkward, uncomfortable position yourself.

- Explain to the mother how to hold her baby. Show her what to do if necessary.

  Make sure that you make these **four key points** clear:
  1. The baby's head and body should be in a straight line.
  2. His face should face the breast, with his nose opposite the nipple.
  3. His mother should hold his body close to hers.
  4. If her baby is newborn, she should support his bottom, and not just his head and shoulders.

  Explain to participants:
  These **four key points** are the same as the points that you learnt to observe in the "B" section of the B-R-E-A-S-T-FEED Observation Form.
  For point 1: A baby cannot suckle or swallow easily if his head is twisted or bent.
  For point 2: The baby's whole body should almost face his mother's body. He should be turned away just enough to be able to look at her face.
  This is the best position for him to take the breast, because most nipples point down slightly. (If he faces his mother completely, he may fall off the breast.)
  For point 4: This is important for newborns. For older babies, support of the upper part of the body is usually enough.
  Sometimes the best way is to use a pillow, if available.
  Some mothers support the baby on their knees. Or they use the other hand.
  A mother needs to be careful about using the hand of the same arm which supports her baby's shoulders, to support his bottom. The result can be that the baby's head goes too far out to the side, which makes it difficult for him to suckle.

- Show her how to support her breast with her hand to offer it to her baby:
  - She should rest her fingers on her chest wall under her breast, so that 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 that it is easier for her baby to attach well.
  She should not hold her breast too near to the nipple.

  Explain to participants:
  If a mother has large and low breasts, support may help her milk to flow, because it makes it easier for the baby to take the part of the breast with the lactiferous sinuses into his mouth (see Session 3).
  If she has small and high breasts, she may not need to support them.

- Explain how she should touch her baby's lips with her nipple, so that he opens his mouth.

- Explain that she should wait until her baby's mouth is opening wide, before she moves him onto her breast. His mouth needs to be wide open to take a large mouthful of breast.

  Explain to participants:
  It is important to use the baby's reflexes, so that he opens his mouth wide to take the breast himself. You cannot force a baby to suckle.

- Explain or show her how to quickly move her baby to her breast, when he is opening his mouth wide.
  - She should bring her baby to her breast. She should not move herself or her breast to her baby.
  - She should aim her baby's lower lip below her nipple, so that his chin will touch her breast.

  Explain to participants:
  Try not to touch the mother or baby if possible. But if you need to touch them to show the mother what to do:
  - Put your hand over her hand or arm, so that you hold the baby through her.
  - Hold the baby at the back of his shoulders - *not the back of his head.* Be careful not to push the baby's head forward.

- Notice how the mother responds.
  (The participant playing the `mother' should say, "Oh, that feels better!".)

  Explain to participants:
  If you improve a baby's poor suckling position, a mother sometimes spontaneously says that it feels better.
  (Unfortunately, sometimes a mother says "Oh, that is uncomfortable, I could not breastfeed like that" even if her baby is now well attached. She goes back to her old position. Make sure that she has the information, but leave her to do it her way. Her position may improve, especially if the baby learns what to do.)

- If the mother says nothing, ask her how her baby's suckling feels.

  Explain to participants:
  If suckling is comfortable for the mother, and she looks happy, her baby is probably well attached.
  If suckling is uncomfortable or painful, her baby is probably not well attached.

- Look for all the signs of good attachment (which you cannot see with a doll).
  If the attachment is not good, try again.

  Explain to participants:
  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 that the mother understands about her baby taking enough breast into his mouth.
  If she is having difficulty in one position, try to help her to find a different position

that is more comfortable for her (for example, in one of the positions described below).

2. Demonstrate other ways for a mother who is sitting to position her baby

(5 minutes)

You can give this demonstration more briefly than the previous one. It is not necessary to repeat every step in detail.

 Follow these steps:

- Help the 'mother' to hold her baby in the underarm position, (Fig.3a).
  Exactly the same **four key points** are important.
  She may need to support the baby with pillows at her side.

  Explain to participants:
  The baby's head rests in the mother's hand, but *she does not push it at the breast.*
  The underarm position is useful:
  - for twins;
  - if she is having difficulty attaching her baby across the front;
  - to treat a blocked duct (see Session 14, `Breast conditions');
  - if a mother prefers it.

- Show the 'mother' how to hold her baby with the arm opposite to the breast (Fig.3b).
  Exactly the same **four key points** are important.
  If she needs to support her breast, she can use the hand on the same side as the breast.

  Explain to participants:
  The mother's forearm supports the baby's body.
  Her hand supports the baby's head, at the level of his ears or lower. She does not push at the back of the baby's head.
  This way of holding a baby is useful:
  - for very small babies;
  - for sick or disabled babies;
  - if the mother prefers it.

Fig.3 a. A mother holding her baby in the underarm position

Useful for:
- twins
- blocked duct
- difficulty attaching the baby

b. A mother holding her baby with the arm opposite the breast

Useful for:
- very small babies
- sick babies

(Fig.24 in Participants' Manual)

3. Demonstrate how to help a mother who is lying down (5 minutes)

☺ Ask the participant who is helping you to demonstrate breastfeeding lying down, in the way that you practised.
She should lie down propped on one elbow, with the doll far from her body, loosely held on the bed.

 Follow these steps:

- Help the 'mother' to lie down in a comfortable, relaxed position.

  Explain to participants:
  To be relaxed, she 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 and another under her chest may help.
- Show her how to hold her baby.
  Exactly the same **four key points** are important.
  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.

  Explain to participants:

A common reason for difficulty attaching when lying down, is that the baby is too `high', and his head has to bend forwards to reach the nipple.
Breastfeeding lying down is useful:
- when a mother wants to sleep, so that she can breastfeed without getting up;
- soon after a Caesarian section, when lying on her back or side may help her to breastfeed her baby more comfortably.

Fig.4 A mother breastfeeding her baby lying down
(Fig.25 in Participants' Manual)

 Make these points:

- There are many other positions in which a mother can breastfeed. In any position, the important thing is for the baby to take enough of the breast into his mouth so that he can suckle effectively.

- For example:
  - a mother can breastfeed standing up;
  - if a baby has difficulty attaching to the breast, it sometimes helps if the mother lies on her front, propped on her elbows, with the baby underneath her;
  - if she has an oversupply of milk, (and the baby gets too much milk too fast), lying on her back with the baby on top of her sometimes helps (see Session 16, `Refusal to breastfeed').

4. Demonstrate some common mistakes (10 minutes)

You can give these demonstrations quite quickly, holding a doll and a model breast yourself.

 Make this point:

- There are some ways in which a mother holds a baby which can make it difficult for him to attach to her breast and suckle effectively.

 Give the demonstration:

- Use a doll to show these ways of holding a baby:
  - 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 (for example, putting a small baby to far out in the `crook' of the arm, instead of on the forearm. This can happen if the mother holds her baby's bottom in the hand on the same side as the breast he is feeding from).

  Explain to participants:
  If a mother holds her baby in these ways, his mouth will not be opposite her nipple. It will be difficult for him to take the breast into his mouth.

- On your own clothed body, or on a model, show these ways of holding a breast:
  - holding the breast with fingers and thumb close to the areola;
  - 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' or `cigarette' hold (index finger above and middle finger below the nipple).

  Explain to participants:
  Holding the breast in these ways makes it difficult for a baby to attach and suckle effectively. The `scissor hold' can block milk flow.

- Demonstrate holding the breast back from the baby's nose with a finger.

  Explain to participants:
  This is not necessary, and can pull the nipple out of the baby's mouth. A baby can breathe quite well without the breast being held back.

 Make this point:

- There are some common mistakes that health workers make when they help mothers.

 Give the demonstration:

☺ Ask the participant to help you again. She should hold a doll in the same way as for the first demonstration. She should also hold a model breast in place as if the doll is trying to suckle.

- Take hold of the model breast in one hand and the doll in the other and push them together.

  Explain to participants:
  This shows what some health workers do. They try to put the baby onto the breast, instead of helping the mother to put him on herself.
  If you do it for the mother, she does not learn how to position her baby herself, and she does not gain confidence.

- Hold the doll at the back of his head, and demonstrate trying to push him onto the breast.

Explain to participants:
If you put pressure on the back of a baby's head, he may react by pushing his head back. The natural reaction of a health worker is then to push the baby onto the breast more strongly. The baby may fight back, and this may cause him to refuse to breastfeed.

 Ask participants if they have any questions, and try to answer them.

III. Help participants to practise positioning a baby (20 minutes)

 Gather your group of 4-5 participants into a corner of the classroom.

Give them a doll to work with.
Ask them to find the box **HOW TO HELP A MOTHER TO POSITION HER BABY** on page 49 of their manuals.
Explain that this summarises the main points of the demonstration.

(Other trainers do the same with the other groups.)

 Explain what to do:

- You will now work in pairs to practise helping a mother to position her baby.
  One of you plays the mother, and one plays the health worker. Other participants in the group observe.

- If you are the mother:
  Sit and hold the doll in the common way, across your front. Hold him in a poor position.
  When the health worker asks you how breastfeeding is going, say that it is very painful, and your nipples are sore.

- If you are the health worker:
  Follow all the steps in the box **HOW TO HELP A MOTHER TO POSITION HER BABY**.
  Try to use one or two listening and learning skills - for example, try to say something to empathize with the mother.

- If you are observing:
  Follow the steps in the box, and afterwards comment on the practice. Praise what the pair did right, remind them about steps that were left out, and correct any mistakes.

 Make sure that each participant has a turn to play the part of the health worker helping a mother to position her baby.

If you have enough time, let participants practise helping mothers in different positions, and with different stories.

HOW TO HELP A MOTHER TO POSITION HER BABY

- Greet the mother and ask how breastfeeding is going.

- Assess a breastfeed.

- Explain what might help, and ask if 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.
  The **four key points** are:
  - with his head and body straight;
  - with his face facing her breast, and his nose opposite her nipple;
  - with his body close to her body;
  - supporting his bottom (if newborn).

- Show her how to support her breast:
  - with her fingers against her chest wall below her breast;
  - with her first finger supporting the breast;
  - with her thumb above.

  Her fingers should not be too near the nipple.

- Explain or show her how to help the baby to attach:
  - touch her baby's lips with her nipple;
  - wait until her baby's mouth is opening wide;
  - move her baby quickly onto her breast, aiming his 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.

- Recommended reading:
  Helping Mothers to Breastfeed Chapter 2, section 2.8 `Helping a mother to put her baby on the breast'.

Session 11

Back to CONTENTS

BUILDING CONFIDENCE AND GIVING SUPPORT

Objectives

At the end of this session, participants will be able to build a mother's confidence and give her support in the following ways:

- Accept what a mother thinks or feels
- Recognize and praise what the mother and baby are doing right
- Give practical help
- Give information which is of immediate relevance
- Use simple language
- Make suggestions instead of giving commands

Session outline (60 minutes)

Participants work in groups of 8-10, with two trainers.

I. Introduce the topic (5 minutes)

II. Introduce the growth chart (7 minutes)

III. Demonstrate the six skills for building confidence and giving support (includes showing Overheads 11/1 to 11/6) (35 minutes)

IV. Answer participants' questions (10 minutes)

V. Summarize `Building confidence and giving support' (3 minutes)

Preparation

Refer to pages 13-15 of the Introduction for general guidance on how to conduct work in groups.

Prepare a flipchart on which to write the list of `Confidence and support skills'.

Make sure that you have Overheads 11/1 to 11/6, and that they are in order. If it is not possible to have an overhead projector for each group, show the copies of the overhead figures from the flipchart.

Study the instructions for Demonstrations Q to W, so that you are clear about the ideas they illustrate, and you know what to do.

For Demonstration R, ask a participant who can act well to help you. Write the words that she has to say on a piece of paper, and give it to her. Explain that you want her to play a mother who is very distressed, and in tears, even though her problem is not serious. Ask her to give her baby a name.

Have enough copies of the local growth chart available to give one to each participant.

Prepare to explain the growth chart briefly when you introduce the session.

On a copy of the chart, draw these lines to demonstrate to participants:
- a growth line which rises following the reference curves, to show satisfactory growth;
- three growth lines which show poor growth:
  a line which goes down; a line which is flat; and a line which rises too slowly.

As you follow the text, remember:

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

I. Introduce the topic (5 minutes)

□ Make these introductory points:

- *The third and fourth counselling skills sessions are about `building confidence and giving support'.*
  A breastfeeding mother easily loses confidence in herself. This may lead her to give unnecessary artificial feeds, and to respond to pressures from family and friends to give artificial feeds.
  You need the skill to help her to feel confident and good about herself.

  Confidence can help a mother to succeed with breastfeeding. Confidence also helps her to resist pressures from other people.

- *It is important not to make a mother feel that she has done something wrong.*
  She easily believes that there is something wrong with herself or with her breastmilk, or that she is not doing well. This reduces her confidence.

- *It is important to avoid telling a breastfeeding mother what to do.*
  Help each mother to decide for herself what is best for her and her baby. This increases her confidence.

II. Introduce the growth chart (7 minutes)

In this session, and in some later sessions, participants discuss weighing babies, and using growth charts.

If participants do not regularly use growth charts, explain them briefly now. If necessary, arrange for extra time to explain the charts in more detail.

 Give each participant a copy of the local growth chart.

Explain that before you start discussing confidence and support skills, it is necessary to make sure that participants know about growth charts.

 Ask participants to look at the chart as you point out the following things:

- The line of figures along the bottom is for the baby's age. Each column is for a month of the baby's life.

- The *line* of figures up the side is for the weight of the baby.

- When you weigh a baby, you put a dot in the column for his age, opposite the number for his weight.

- When *you* have weighed him a few times, you can join up the dots to make a line, which is his growth line.

- The two curves on the chart are reference curves, which show how healthy babies grow. They move up the chart, showing how a baby gets heavier as he grows.

- A *useful* rule of thumb is this: in the first six months of life a baby should gain at least 500 grams in weight each month.

- Show the charts that you have prepared with growth lines which show good and poor growth.

- *Compare* the baby's growth line with the reference curves on the chart.

  - If the baby's growth line goes up and follows the curves, he is growing well.
  - If the baby's growth line is flat or going down, he is not growing well.
  - If the baby's growth line is moving up, but more slowly than the curves, then he is not growing well.

- If a baby is not growing well, he may be ill, or he may not be getting enough food. A breastfed baby may not be getting enough breastmilk.

Further information

Growth curves of breastfed babies
The reference growth curves were developed by weighing babies most of whom were bottle fed. Exclusively breastfed babies may gain weight faster than the reference curves for the first 3-4 months, but they may gain weight a little more slowly from 4-6 months. They are healthy and getting all the milk that they need. Bottle fed babies may be slightly fatter at this age.

III. Demonstrate the six skills for building confidence and giving support

(35 minutes)

 Tell participants that you will now explain and demonstrate six skills for building a mother's confidence and giving her support.

->Write `CONFIDENCE AND SUPPORT SKILLS' on a board or flipchart. List the six skills on the board as you demonstrate them.

Skill 1.Accept what a mother thinks and feels

->Write `Accept what a mother thinks and feels' on the list of confidence and support skills.

 Explain the skill:

- Sometimes a mother thinks something that you do not agree with - that is, she has a *mistaken idea*.

- Sometimes a mother feels very upset about something that you know is not a serious problem.

Ask: *How will she feel if you disagree with her, or criticize, or tell her that it is nothing to be upset or to worry about?*
(Wait for 2-3 responses, and then continue.)

You may make her feel that she is wrong. This reduces her confidence. She may not want to say any more to you.

- So it is important not to disagree with a mother.

- It is also important not to *agree* with a mistaken idea. You may want to suggest something quite different. That can be difficult if you have already agreed with her.

- Instead, you just *accept* what she thinks or feels. Accepting means responding in a neutral way, and not agreeing or disagreeing.

 Give an example of accepting what a mother THINKS:

Read out the following example. Read the mistaken idea, the appropriate and inappropriate responses, and also the statements explaining which they are.

Demonstration Q: Accepting what a mother THINKS

Read out the explanations, the idea, and the responses:

This is a mistaken idea:
"My milk is thin and weak, so I have to give bottle feeds."

This is an inappropriate response, because it is DISAGREEING:
"Oh no! milk is never thin and weak. It just looks that way!"

This is an inappropriate response because it is AGREEING:
"Yes - thin weak milk can be a problem."

This is an appropriate response, because it shows ACCEPTANCE:
"I see. You are worried about your milk."

An alternative appropriate response might be:
"Ah-ha".

 Make these additional points:

- Notice how *reflecting back* and *simple responses* are both useful ways to show acceptance, as well as being good listening and learning skills.

- You may want to give information to correct a mistaken idea.
  In this example, you would want to explain to the mother that breastmilk always looks thin at the beginning of a feed, but it is full of nutrients.

- You can give this information later. Give it in a tactful way which does not sound critical. However, first, you want her to feel that you accept what she thinks.
  We will come back to this point with Skill 4.

 Give an example of accepting what a mother FEELS:

☺ Ask the participant who will help you, to hold a doll, and to play the part of the mother in Demonstration R.

She reads the words which you wrote down and gave to her, and she acts being very upset, and cries.

You read out the responses, with appropriate gestures. For example, you can put your hand on her shoulder to comfort her. Ask participants to say which response accepts what the mother feels. (The accepting response is marked ✔).

Demonstration R: Accepting what a mother FEELS

The `mother' (in tears) reads:

> "It is terrible! (Name) has a cold and his nose is completely blocked and he can't breastfeed - he just cries and I don't know what to do!"

Read these responses (with an appropriate gesture):

Ask: *Which response accepts what the mother feels?*

Response 1: "Don't worry - your baby is doing very well"
Response 2: "You are upset about (name) aren't you?" ✔
Response 3: "Don't cry - it is not serious - (name) will soon be better!"

 Explain the example, making these points:

- Responses 1 and 3 do not accept what she feels. If you say something like "Don't worry, there is nothing to worry about!" you make her feel that she is wrong to be upset. This *reduces* her confidence. (Yet that is just what many of us do!)

- Response 2 accepts what she feels. It makes her feel that it is alright to be upset, so it does not reduce her confidence.

- Notice how, in this example, empathizing was used to show acceptance. So this is another example of using a listening and learning skill to show acceptance.

Skill 2.Recognize and praise what a mother and baby are doing right

-> Write `Recognize and praise what a mother and baby are doing right' on the list of confidence and support skills.

 Explain the skill:

- As health workers, we are trained *to look for problems*. Often, this means that we see only what we think people are doing wrong, and try to correct them.

Ask: *How does it make a mother feel if you tell her that she is doing something wrong, or that her baby is not doing well?*
(Wait for 2-3 responses, and then continue.)

You make her feel bad, and it reduces her confidence.

- As counsellors, we must *look for what mothers and babies are doing right.*
We must first *recognize* what they do right; and then we should praise or show approval of the good practices.

- Praising good practices has these benefits:
- It builds a mother's confidence;
- It encourages her to continue those good practices;
- It makes it easier for her to accept suggestions later.

- It can be difficult to recognize what a mother is doing right - we have to learn to recognize good practices. But any mother whose child is living must be doing some things right, whatever her socioeconomic status or education.

- It is always helpful to recognize and praise what a baby is doing right. For example, that he is gaining weight, or that he is suckling well.

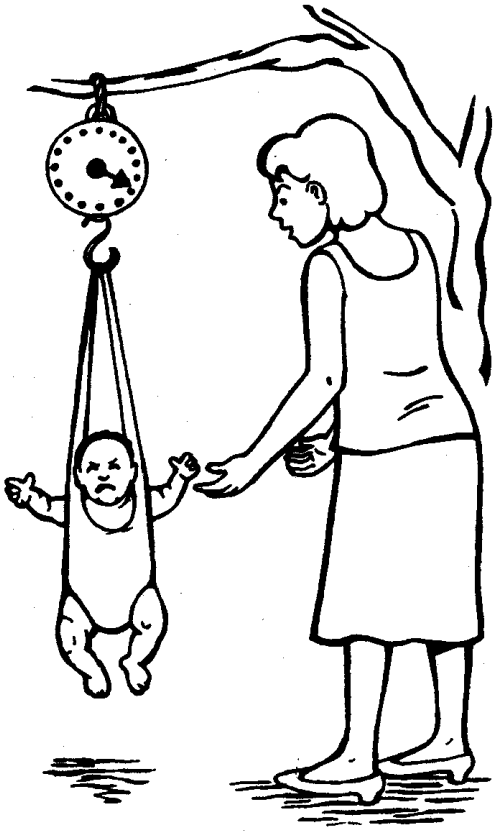
 Give an example:

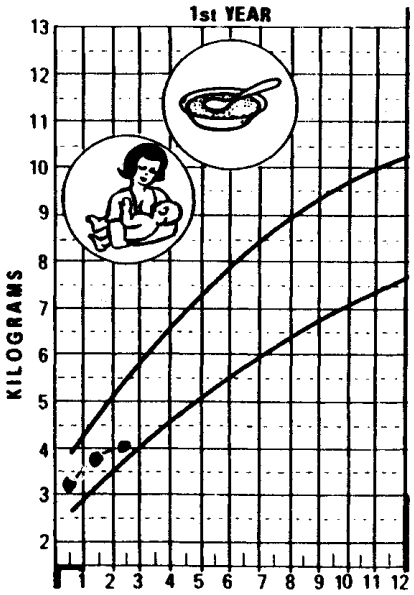
Show Overhead 11/1, and explain the situation that it illustrates.

Then show Overhead 11/2.
Read out the remarks, and ask participants to say which one helps to build the mother's confidence.

(The helpful remark is marked ✔).

Overhead 11/1





Demonstration S: Recognizing and praising what a mother and baby are doing right

Explain Overhead 11/1:

Here is a baby being weighed, and his mother. The baby is exclusively breastfed.
Beside the mother and baby is the baby's growth chart. His growth chart shows that he has gained a little weight between 1 and 2 months of age.
However, his growth line is not following the reference curves. It is rising too slowly. This shows that the baby's growth is slow.

Show Overhead 11/2:

Ask: *Which of these remarks will help to build the mother's confidence?*

"Your baby's growth line is going up too slowly."
"I don't think your baby is gaining enough weight."
✔ "Your baby gained weight last month just on your breastmilk."

Skill 3. Give practical help

-> Write `Give practical help' on the list of confidence and support skills.

 Explain the skill:

- Sometimes practical help is better than saying anything. For example:
  - When a mother feels tired or dirty or uncomfortable;
  - When she is hungry or thirsty;
  - When she has had a lot of advice already;
  - When you want to show support and acceptance;
  - When she has a clear practical problem.

Ask: *What kind of practical help might you offer?*
(Wait for 2-3 suggestions from participants, and then continue.)

Some ways to give practical help are these:
- Help to make her clean and comfortable.
- Make it easier for her to hold the baby, with pillows, or a lower or more comfortable seat.
- Give her a warm drink, or something to eat.
- Hold the baby yourself, while she gets comfortable, or washes, or goes to the toilet.

- Practical help also includes practical help with breastfeeding, such as positioning the baby or relieving engorgement. This is considered separately later.

 Give an example:

Show Overhead 11/3, and explain the situation that it illustrates.

Give participants a moment to read what the mother is saying.
Then read out the two responses.
Ask participants to say which response is appropriate and which is not appropriate. (The appropriate response is marked with a ✔.)

 Tell participants that they will find Overhead 11/3 and the responses in their manuals, (Fig.26, page 51).

☺Ask them to ✔ the appropriate response.

Overhead 11/3

Demonstration T: Giving practical help

Explain Overhead 11/3:

This mother is lying in bed soon after delivery. She looks miserable and depressed. She is saying: "No, I haven't breastfed him yet. My breasts are empty and it is too painful to sit up."

Read these responses:

Ask: *Which response is more appropriate?*

"You should let the baby suckle now, to help your breastmilk to come in."
✔ "Let me try to make you more comfortable, and then I'll bring you a drink."

□ Give this explanation:

- The appropriate 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. But it is more likely to be successful if the mother feels comfortable.

Skill 4. Give a little, relevant information

-> Write `Give a little, relevant information' on the list of confidence and support skills.

 Explain the skill:

- Mothers often need information about breastfeeding. It is important to share your knowledge with them. It may also be important to correct mistaken ideas.

- However it is important to:

  - Give information which is relevant to her situation NOW. Tell her things that she can use today, not in a few weeks' time.

  - Try to give only one or two pieces of information at a time, especially if a mother is tired, and has already received a lot of advice.

  - Give information in a positive way, so that it does not sound critical, or make the mother think that she has been doing something wrong. This is especially important if you want to correct a mistaken idea.

  - Wait until you have built the mother's confidence, by accepting what she says, and praising what she does well. You do not need to give new information or to correct a mistaken idea immediately.

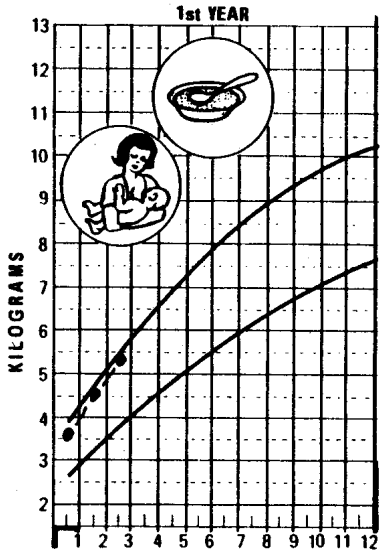
 Give an example:

Show Overhead 11/4, and explain the situation which it illustrates.

Give participants a moment to read what the mother is saying.

Then read out the responses, and ask participants to say which response gives the most relevant information. (The response which gives relevant information is marked with a ✔.)

Overhead 11/4



Demonstration U (i): Giving relevant information

Explain Overhead 11/4:

James is 2 months old, breastfeeding exclusively, and gaining weight healthily. Now he suddenly seems hungry, and he wants to feed more often. His mother thinks that she does not have enough milk.

Read these responses:

Ask: *Which response gives the most relevant information?*

Response 1: "Oh, James is growing well. Don't worry about your breastmilk supply. It is best to breastfeed exclusively for 6 months, and then you can start complementary foods."

Response 2: "James is growing fast. Healthy babies have these hungry times when they grow fast. James' growth chart shows that he is getting all the breastmilk that he needs. He will settle in a few days." ✔

□ Give this explanation:

- Response 2 explains James present behaviour, and her worries, so the information is relevant now. The information in Response 1 does not explain James behaviour and is not relevant now. Telling her not to worry does not help.

 Give another example:

Show Overhead 11/5, and explain the situation which it illustrates.
Then read out the two responses.
Ask participants which they think is more positive, and therefore more appropriate. (The positive, appropriate response is marked with a ✔.)

Overhead 11/5

Demonstration U (ii): Giving information in a positive way

Explain Overhead 11/5:

This baby is 3 months old. His mother has recently started giving some bottle feeds in addition to breastfeeding. The baby has developed diarrhoea.

Read these responses:

Ask: *Which response gives positive information?*

Response 1: "It is good that you asked before deciding. Diarrhoea usually stops sooner if you continue to breastfeed." ✔

Response 2: "Oh no, don't stop breastfeeding. He may get worse if you do that."

 Give this explanation:

- Response 2 is critical, and may make her feel wrong and lose confidence. Response 1 is positive, and should not make her feel wrong or lose confidence.

Skill 5. Use simple language

-> Write `Use simple language' on the list of confidence and support skills.

 Explain the skill:

- Health workers learn about diseases and treatments using technical or scientific terms. When these terms become familiar, it is easy to forget that people who are not health workers may not understand them.

- Health workers often use these technical terms when they talk to mothers, and mothers do not understand.

- It is important to use simple, familiar terms, to explain things to mothers.

 Give an example:

Read the statements in Demonstration V, and ask participants to say which is easier for mothers to understand.

Demonstration V: Using simple language

Read these statements:

Ask: *Which statement is easier for a mother to understand?*

Statement 1: "Your baby needs to be able to reach the lactiferous sinuses to get your breastmilk effectively."

Statement 2: "Your baby can get your breastmilk more easily if he takes a big mouthful of breast." ✔

 Give this explanation:

- Statement 2 is easier to understand. Statement 1 uses the terms *`lactiferous sinuses'* and *`effectively'* which many mothers would not understand.

Skill 6. Make one or two suggestions, not commands

-> Write `Make one or two suggestions, not commands' on the list of confidence and support skills.

 Explain the skill:

- You may decide that it would help a mother if she does something differently - for example, if she feeds the baby more often, or holds him in a different way.
  However, you must be careful not to *tell* or *command* her to do something. This does not help her to feel confident.

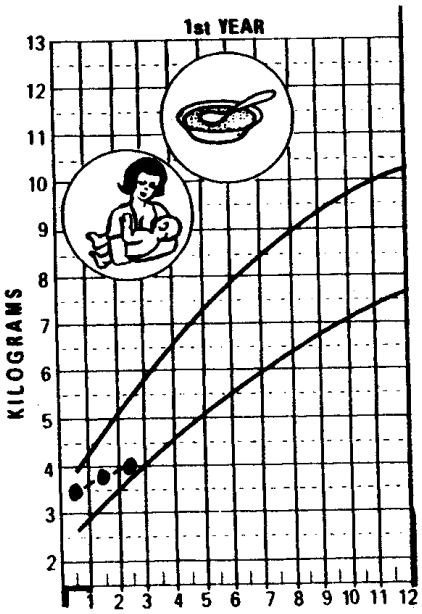
- When you counsel a mother, you *suggest* what she could do. Then she can decide if she will try it or not. This leaves her feeling in control, and helps her to feel confident.

 Give an example:

Show and explain Overhead 11/6.

Then read out the two responses and ask participants to say which is a command and which is a suggestion. (The suggestion is marked with a ✔.)

Overhead 11/6



Demonstration W: Making one or two suggestions

Explain Overhead 11/6:

Aimée breastfeeds only 4 times a day, and she is gaining weight too slowly. Her mother thinks that she does not have enough breastmilk.

Read these responses:

Ask: *Which of these responses is a command, and which is a suggestion?*

Response 1: "You must feed Aimée at least 10 times a day!"

Response 2: "It might help if you fed Aimée more often." ✔

 Give this explanation:

- Response 1 is a command. It tells Aimée's mother what she must do. She will feel bad and lose confidence if she cannot do it.

- The second response is a suggestion. It allows Aimée's mother to decide if she will feed Aimée 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."

IV. Answer participants' questions (10 minutes)

 Ask participants if they have any questions about the six confidence and support skills, and try to answer them.

V. Summarize `Building confidence and giving support' (3 minutes)

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

 Read the list through, to remind participants of the six skills.

Ask participants to find the list on page 52 of their manual.
Ask them to try to memorize it.
Explain that they will use the list for Clinical Practice 2.

CONFIDENCE AND SUPPORT SKILLS

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

Session 12

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BUILDING CONFIDENCE EXERCISES

Objectives

Participants practise the six skills for building confidence and giving support that were demonstrated in Session 11.

Session outline (60 minutes)

Participants work in groups of 8-10, with two trainers.

I. Introduce the session (3 minutes)

II. Conduct the group exercise (Exercise 6) (12 minutes)

III. Facilitate the written exercises (Exercises 7 - 12) (45 minutes)

Preparation

Refer to pages 13-16 of the Introduction for general guidance on how to conduct group work, and how to facilitate written exercises.

Make sure that Answer Sheets for Exercises 7-12 are available to give to participants at the end of the session.

As you follow the text, remember:

 indicates an instruction to you, the trainer
▪ indicates what you say to the participants

I. Introduce the session (3 minutes)

Ask participants to turn to page 53 of their manuals, and to find Exercises 6-12.

 Explain what they will do:

- You will now practise the six confidence and support skills that you learnt about in Session 11.
- Exercise 6 is a group exercise on accepting what a mother thinks.
- Exercises 7-12 are individual written exercises.

II. Conduct the group exercise (12 minutes)

EXERCISE 6. ***Accepting what a mother THINKS***

 Explain Examples 1-3.

- These are mistaken ideas, which mothers might hold.
- Beside each mistaken idea are three responses. One agrees with the idea, one disagrees, and one accepts the idea, without either agreeing or disagreeing.

 Read out the mistaken ideas.

☺ Ask participants in turn to read the responses.
Ask each participant to say if the response that she reads *disagrees, agrees*, or *accepts* the mistaken idea.

Examples 1-3:

Trainer reads:	**Participant reads:**
1. "I give him drinks of water, because the weather is so hot now."	*"Oh, that is not necessary! Breastmilk contains plenty of water."* (Disagrees) *"Yes, babies may need extra drinks of water in this weather."* (Agrees) *"You feel that he need drinks of water sometimes?"* (Accepts)
2. "I have not been able to breastfeed for two days, so my milk is sour."	*"Breastmilk is not very nice after a few days."* (Agrees) *"You are worried that your breastmilk may be sour?"* (Accepts) *"But milk never goes sour in the breast!"* (Disagrees)
3. "My baby has diarrhoea, so it is not good to breastfeed now."	*"You do not like to give him breastmilk just now?"* (Accepts) *"It is quite safe to breastfeed a baby when he has diarrhoea."* (Disagrees) *"It is often better to stop breastfeeding a baby when he has diarrhoea."* (Agrees)

□ Make this point:

- You may notice that when you agree with the mother, you find yourself saying something that is incorrect.

□ Now look at Examples 4-10.

These are some more mistaken ideas, written as statements by mothers.
Beside them are some possible responses. They are not the "right" answer - they are just to give you an idea. There are no responses written in the Participants' Manual.

Read out each mistaken idea.
☺ Ask participants in turn to make up a response which accepts what the mother says, without disagreeing or agreeing. (Participants do not have to "guess" the exact suggested response, provided their response accepts what the mother says.)

Examples 4-10:	**Participants respond:**
Trainer reads:	*Possible responses:*
4. "I need to give him formula now he is two months old. My breastmilk is not enough for him now."	*"I see....."*
5. "I am pregnant again, so I shall have to stop breastfeeding immediately."	*"Ah ha."*
6. "I cannot breastfeed for the first few days, because I will have no milk."	*"You do not want to breastfeed yet?"*
7. "The first milk is not good for a baby - I cannot breastfeed until it has gone."	*"You do not want him to have the first milk?"*
8. "I cannot eat spicy food - it will upset my baby."	*"Oh dear! Have you had that experience?"*
9. "I don't let him suckle for more than ten minutes, because it would make my nipples sore."	*"You are frightened that you might have sore nipples?"*
10. "I don't have enough milk, because my breasts are so small."	*"Mm. Mothers often worry about the size of their breasts."*

III. Facilitate the written exercises (45 minutes)

Ask participants to turn to page 55 of their manuals, and to find Exercises 7-12.

 Explain what to do:

- These are individual written exercises.
  Write your answers in your manuals.
  If possible use pencil, so that it is easier to correct the answers.
  Trainers will give feedback individually as you do the exercise, and will give you Answer Sheets at the end of the session.

- For each exercise, read the instructions **How to do the exercise** and the **Example** of what to do.
  Then write your answers to the questions **To answer.**
  When you are ready, discuss your answers with the trainer.

EXERCISE 7. ***Accepting what a mother FEELS***

How to do the exercise:

After the Stories A, B, and C, below, there are three responses.
Mark with a □ the response which shows acceptance of how the mother feels.
For Story D make up your own response which shows acceptance.

Example:

Purla's baby boy has a cold and a blocked nose, and is finding it difficult to breastfeed. As Purla tells you about it, she bursts into tears.
Mark with a ✔ the response which shows that you accept how Purla feels.

a. Don't worry - he is doing very well.
b. You don't need to cry - he will soon be better.
✔ c. It's upsetting when a baby is ill, isn't it?

To answer:

Story A.
Marion is in tears. She says that her breasts have become soft again, so her milk must be less, but the baby is only three weeks old.

a. Don't cry - I'm sure you still have plenty of milk.
✔ b. You are really upset about this, I know.
c. Breasts often become soft at this time - it doesn't mean that you have less milk!

Story B.
Dora is very bothered. Her baby sometimes does not pass a stool for one or two days. When he does pass a stool, he pulls up his knees and goes red in the face. The stools are soft and yellowish brown.

a. You needn't be so bothered - this is quite normal for babies.
b. Some babies don't pass a stool for 4 or 5 days.
✔ c. It really bothers you when he does not pass a stool, doesn't it?

Story C.
Susan is crying. She takes off her baby's clothes, and shows you a rash on the baby's buttocks, which looks like a nappy rash.

✔ a. You are really miserable about this rash, aren't you?
b. Lots of babies have this rash - we can soon make it better.
c. Don't cry - it is not serious.

Story D.
Marta looks very worried. She is sure that her baby is very ill. His tongue is covered in white spots, which you see are thrush. You know that this is not serious and it is easy to treat.

Write down what you would say to her, to show that you accept how worried she is.

Possible answers:
It is quite frightening when you see those white spots, isn't it?
You are very worried about the spots, aren't you?

EXERCISE 8. ***Praising what a mother and baby are doing right***

How to do the exercise:

For Stories E, F, and G below, there are three responses. They are all things that you might want to say to the mother.
Mark with a ✔ the response which praises what the mother and baby are doing right, to build the mother's confidence.
(You may give her some of the other information later.)
For Stories H and I, make up your own response which praises what the mother and baby are doing right.

Example:

A mother is breastfeeding her 3-month-old baby, and giving drinks of fruit juice. The baby has slight diarrhoea.

Mark the response which praises what she is doing.

a. You should stop the fruit juice - that's probably what is causing the diarrhoea.
✔ b. It is good that you are breastfeeding - breastmilk should help him to recover.
c. It is better not to give babies anything but breastmilk until they are about 6 months old.

To answer:

Story E.
A mother has started bottle feeding her baby by day while she is at work. She breastfeeds as soon as she gets home, but the baby does not seem to want to suckle as much as he did before.

✔ a. You are very wise to breastfeed whenever you are at home.
b. It would be better if you gave him artificial feeds by cup and not by bottle.
c. Babies often do stop wanting breastfeeds when you start giving bottles.

Story F.
The mother of a 3-month-old baby says that he is crying a lot in the evenings, and she thinks that her milk supply is decreasing. The baby gained weight well last month.

a. Many babies cry at that time of day - it is nothing to worry about.
✔ b. He is growing very well - and that is on your breastmilk alone.
c. Just let him suckle more often - that will soon build up your milk supply.

Story G.
A 15-month-old child is breastfeeding and having thin porridge and sometimes tea and bread. He has not gained weight for 6 months, and is thin and miserable.

a. He needs to eat a more balanced diet.
✔ b. It is good that you are continuing to breastfeed him at this age, as well as giving him other food.
c. You should be giving him more than breastmilk and thin porridge at this age.

Story H.
A 4-month-old baby is completely bottle fed, and has diarrhoea. The growth chart shows that he weighed 3.5 kilos at birth, and that he has only gained 200 grams in the last two months. The bottle smells very sour.

Possible answer:
I am glad that you came to the clinic, and it is very helpful that you brought his weight chart.

Story I.
Neera comes to the clinic to learn how to take her 3-month-old baby Ravi off the breast. She is going back to work soon. But Ravi is refusing bottles, so she asks you to advise her. Ravi is alert and active.

Possible answers:
It is very good that you have breastfed him exclusively for 3 months.
He is very healthy and growing well on your breastmilk.
Thank you for coming to discuss what to do now. It is good that you are considering what will be best, ahead of time.

EXERCISE 9. *Giving a little, relevant information*

How to do the exercise:

Below is a list of six mothers with babies of different ages.
Beside them are six pieces of information (a, b, c, d, e and f) that those mothers may need; but the information is not opposite the mother who needs it most.
Match the piece of information with the mother and baby in the same set for whom it is MOST RELEVANT AT THAT TIME.

After the description of each mother there are six letters.
Put a circle round the letter which corresponds to the information which is most relevant for her. As an example, the correct answer for Mother 1 is already marked in brackets.

For Mothers 7 and 8, make up a sentence with relevant information.

To answer:

Mothers 1-6	Information
1. Mother returning to work a b c d (e) f	a.Foremilk normally looks watery, and hindmilk is whiter
2. Mother with 12-month-old baby a b c d e (f)	b.Exclusive breastfeeding is best until a baby is 4-6 months old
3. Mother who thinks that her milk is too thin (a) b c d e f	c.More suckling makes more milk
4. Mother who thinks that she does not have enough breastmilk a b (c) d e f	d.Colostrum is all that a baby needs at this time
5. Mother with 2-month-old baby who is exclusively breastfed a (b) c d e	e.Night breastfeeds are good for a baby and help to keep up the milk supply
6. A newly delivered mother who wants to give her baby prelacteal feedsa b c (d) e f	f.Breastfeeding is valuable for two years or more

Mother 7:.

A mother one day after delivery with soft breasts who wants her milk to `come in':

(Your baby's suckling will help your milk to `come in'.)

Mother 8:.

A mother with a healthy 5-6-month-old baby, who is exclusively breastfed:

(Babies of this age are usually ready to start taking other foods.)

EXERCISE 10. ***Giving information in a positive way***

How to do the exercise:

Below are some mistaken ideas, including some from Exercise 7, and what you might say to accept what the mother thinks.
Write what you would say to the mother later to correct the mistaken idea.
Give the information in a positive way which does not sound critical.

Example:

A mother says: "I don't have enough milk, because my breasts are so small."

Accept what she says:

"Mm. Mothers often worry about the size of their breasts."

Give correct information in a positive way:

"You know, bigger breasts only contain more fat. The part of the breast that makes the milk is the same in all breasts."

To answer:

1. A mother says: "I don't let him suckle for more than 10 minutes, because it would make my nipples sore."

Accept what she says:
"Yes, that can be a worry."

Give correct information in a positive way:
("If he takes enough of the breast into his mouth, the nipples should not get sore.")

2. A mother says: "I give him drinks of water, the weather is so hot now."

Accept what she says:
"You feel that he needs more to drink sometimes?"

Give correct information in a positive way:
("You know, breastmilk contains plenty of water, and it is usually enough for a baby even in this hot weather.")

3. A mother says: "I will give him a bottle in the evening, and save up my breastmilk for the night."

Accept what she says:
"You feel that he is not satisfied in the evening?"

Give correct information in a positive way:
("Your breasts make as much milk as your baby takes. If he suckles less, they may make less milk.")

EXERCISE 11. ***Using simple language***

How to do the exercise:

Below are five pieces of information that you might want to give to mothers, including some from Exercise 9.
The information is correct, but it uses technical terms that a mother who is not a health worker might not understand.
Rewrite the information in simple language that a mother could easily understand.

Example:

Information: Colostrum is all that a baby needs in the first few days.

Using simple language:
The first yellowish milk that comes is exactly what a baby needs for the first few days.

To answer:

1. Information: Exclusive breastfeeding is best up to 4-6 months of age.

   Using simple language:
   (A baby does not need any other food or drink until he is at least 4 months old.)

2. Information: Foremilk normally looks watery, and hindmilk is whiter.

   Using simple language:
   (The breastmilk that comes at the beginning of a feed looks more watery. The breastmilk that comes later in a feed looks whiter.)

3. Information: When your baby suckles, prolactin is released which makes your breasts secrete more milk.

   Using simple language:
   (When your baby suckles, your breasts make more milk.)

4. Information: To suckle effectively, a baby needs to be well attached to the breast.

   Using simple language:
   (To get the milk, your baby needs to take a big mouthful of breast.)

EXERCISE 12. ***Making one or two suggestions, not commands***

How to do the exercise:

Below are some commands which you might want to give to a breastfeeding mother.

Rewrite the commands as suggestions.
Questions 4 and 5 are optional, to do if you have time.

Example:

Command: Keep the baby in bed with you so that he can feed at night!

Suggestion:
It might be easier to feed him at night if he slept in bed with you.

Some alternative examples of how to make a suggestion:
(In your answer, you only need to give ONE answer.)

- Suggestion in the form of a question:
  Would it be easier to feed him at night if he slept with you?
  Have you thought about letting him sleep in bed with you?

- Question followed by some information:
  How would you feel about letting him sleep in bed with you? It might be easier to feed him that way.

To answer:

1. Command: Do not give your baby any drinks of water or glucose water, before he is at least 4 months old!

   Suggestion:
   (You may find that breastfeeding is all that he needs - extra water is not usually necessary.)
   (Have you thought of giving him just breastfeeds? Babies can get all the water that they

need from breastmilk.)

2. Command: Feed him more often, whenever he is hungry, then your milk supply will increase!

   Suggestion:
   (A good way to build up your milk supply is to breastfeed your baby more often.)
   (Would you be able to breastfeed him more often? That is a good way to build up your milk supply.)

3. Command: You should feed him from a cup. Don't give him any feeds from a bottle, or he will refuse to breastfeed!

   Suggestion:
   (Some mothers feed their babies from a cup. Cup feeding does not interfere with breastfeeding.)
   (Would you like to try feeding him from a cup? Then he will enjoy suckling even more when you breastfeed him.)

Optional:

4. Command: You must hold him closer or he won't take enough of the breast into his mouth!

   Suggestion:
   (It may be easier for him to take the breast if you hold him a bit closer.)
   (Do you think you could hold him a bit closer? It might help him to take more of the breast into his mouth.)

5. Command: You must sit on a lower chair to breastfeed, or you will not be able to relax!

   Suggestion:
   (You might be more comfortable sitting on a lower chair, so that you could relax more.)
   (Do you have a lower chair? It might make it easier for you to relax.)

 Give participants the Answer Sheets for Session 12.

Session 13

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CLINICAL PRACTICE 2

Building confidence and giving support
Positioning a baby at the breast

Objectives

Participants practise `building confidence and giving support' and `positioning a baby at the breast' with mothers and babies in a ward or clinic.

Participants continue to practise the skills from Clinical Practice 1.

Session outline (120 minutes)

Participants meet together as a class led by one trainer to prepare for the session, and to discuss it afterwards.

Participants work in small groups of 4-5 each with one trainer, or in pairs for clinical practice in a ward or clinic.

I.	Prepare the participants	(20 minutes)
II.	Conduct the clinical practice	(80 minutes)
III.	Discuss the clinical practice	(20 minutes)

Preparation

Study the instructions in the following pages, and ask all trainers who will lead groups to study the instructions also. You conduct Clinical Practice 2 in a similar way to Clinical Practice 1, but there are some differences. Make sure that you and the other trainers are clear about the differences.

Make available a copy of the list of **CONFIDENCE AND SUPPORT SKILLS** for each participant and trainer.

Make available spare copies of the B-R-E-A-S-T-FEED Observation Form and the list of **LISTENING AND LEARNING SKILLS**.

Make sure that all trainers have a copy of the **CLINICAL PRACTICE DISCUSSION CHECKLIST**.

I. Prepare the participants (20 minutes)

☐ *Explain the objectives of the clinical practice:*

- During this session, you practise building confidence and giving support, using the six confidence and support skills that you learnt in Sessions 11 and 12.

  You also continue to practise `assessing a breastfeed' and `listening and learning'.

  If there is an opportunity, you will practise helping a mother to position her baby at the breast, or to overcome any other difficulty.

☐ *Explain what participants should take with them:*

- Take with you:
  - One copy of **CONFIDENCE AND SUPPORT SKILLS**;
  - One copy of **LISTENING AND LEARNING SKILLS**;
  - Two copies each of the B-R-E-A-S-T-FEED Observation Form;
  - pencil and paper to make notes.

☐ *Give each participant the forms and lists that she needs.*

☐ *Explain how participants will work:*

- You work in groups of 4-5 each with a trainer, in the same way as in Clinical Practice 1.

  When you feel ready, you can start working in pairs, while the trainer circulates.

If you meet a mother who needs help positioning her baby at the breast, or with any other difficulty, inform the trainer, so that she can demonstrate how to help the mother.

☐ *Explain what participants should do when they talk to a mother:*

- Practise as many of the six confidence and support skills as possible.
  In particular, try to do these things:
  - praise two things that the mother and baby are doing right;
  - give the mother two pieces of relevant information that are useful to her now.
  Be careful not to give a lot of advice.

- In addition, continue to practise `assessing a breastfeed' and `listening and learning'.

  The participant who is observing, can mark a ✔ in the box on the **CONFIDENCE AND SUPPORT SKILLS** checklist for every skill that she observes her partner practising.

☐ *Discuss any difficulties from Clinical Practice 1:*

Discuss especially things that participants found difficult or forgot to do in Clinical Practice 1.

II. Conduct the clinical practice (80 minutes)

☐ *Take your group to the ward or clinic:*

Conduct the session in the same way as Clinical Practice 1, except that participants may now work in pairs, if you feel that they are ready to do so.

If they work in pairs, circulate between the pairs. Observe and comment on their performance, and help where appropriate.

The first time that a pair finds a mother who needs help positioning her baby at the breast, ask the other members of the group to join you. Demonstrate to the whole group how to help the mother to position her baby.

On other occasions, participants practise, while you observe them, and help if necessary.

☐ *Discuss the participants' performance:*

When a pair have finished, take them away from the mother for a discussion.

Let participants comment on their own performance first.
Then go through the list of **CONFIDENCE AND SUPPORT SKILLS**, and discuss how the participants practised them.

Use the **CLINICAL PRACTICE DISCUSSION CHECKLIST** to guide you in your discussions.

☐ *Help participants to find another mother and baby to talk to.*

III. Discuss the Clinical Practice (20 minutes)

The whole class comes back together to discuss the clinical practice, led by the trainer who led the preparatory session.

☐ *Ask one participant from each group to report briefly on what they learnt.*

Participants may not have finished seeing mothers and babies at the end of the 80 minutes allowed for `II. Conduct the clinical practice'. If you feel that finishing the clinical practice is more valuable, let them continue and finish, and if necessary omit the class discussion.

You must decide what is the most useful way to spend this time.

☐ *Ask participants to fill in their* **CLINICAL PRACTICE PROGRESS FORM.**

On the form, they should record each mother and baby that they talked to in Clinical Practice 2.

Session 14

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BREAST CONDITIONS

Objectives

At the end of the session, participants should be able to diagnose and manage these common breast conditions:

- Flat, inverted, and long nipples;
- Engorgement;
- Blocked duct and mastitis;
- Sore nipples and nipple fissure.

Session outline (60 minutes)

Participants are all together for a slide presentation and demonstration by one trainer.

I. Introduce the topic (2 minutes)

II. Present Slides 14/1 to 14/18 (45 minutes)
(including demonstration of syringe method for treating inverted nipples - 5 minutes)

III. Answer participants' questions (10 minutes)

IV. Summarize `Breast conditions' (3 minutes)

Preparation

Refer to pages 9-13 in the Introduction for general guidance on how to present slides and give a demonstration.

Make sure that Slides 14/1 to 14/18 are in the correct order.
Study the slides and the text that goes with them, so that you can present them.
Read the **Further information** sections, so that you are familiar with the ideas that they contain.
Have Overhead 3/6 to show after Slide 14/2, and Overhead 3/8 to show after Slide 14/13.

For Demonstration X: Syringe method for treatment of inverted nipples
Prepare a 10-ml or 20-ml disposable syringe as shown in Fig.5.

As you follow the text remember:

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

Do not present the **Further information** sections.
Use them to help you to answer questions.

I. Introduce the topic (2 minutes)

□ Make these points:

- There are several common breast conditions which sometimes cause difficulties with breastfeeding:
  - Flat or inverted nipples, and long or big nipples;
  - Engorgement;
  - Blocked duct and mastitis;
  - Sore nipples and nipple fissure.

- Diagnosis and management of these breast conditions are important both to relieve the mother, and to enable breastfeeding to continue.

II. Present Slides 14/1 to 14/18 (45 minutes)

□ As you show each slide, point on the screen to the place which shows what you are explaining.

Slide 14/1 Different breast shapes

- Here are some breasts of different shapes and sizes. These breasts are all normal, and they can all produce plenty of milk for a baby - or two or even three babies.

Many mothers worry about the size of their breasts. Women with small breasts often worry that they cannot produce enough milk. But differences in the sizes of breasts are mostly due to the amount of fat, and not the amount of gland tissue. It is important to reassure women that they can produce enough milk, whatever the size of their breasts.

The nipples and areolas are different shapes and sizes too.

Ask: *Does the shape of the nipple affect breastfeeding?*

Sometimes the shape makes it difficult for a baby to get well attached to the breast. The mother may need extra help at first to make sure that her baby can suckle effectively.

However, babies can breastfeed quite well from breasts of any size, with almost any shape of nipple. Remember also that a baby can attach poorly whatever the shape of his mother's nipple - if he has been given bottle feeds, or if there is no one to help his mother to improve her technique.

Further information
Breast shape and size is partly inherited. Breasts may be long in girls who have had no children, and small or flat in women who have breastfed several children.
Occasionally a woman's breasts may fail to develop normally, so that they are unable to produce enough milk, but this is very rare.

Slide 14/2 Flat nipple and protractility

Ask: *What do you think of the nipple in picture 1?*

The nipple looks flat.

- A doctor told this mother that her baby would not be able to suckle from it. She lost confidence that she could breastfeed successfully.

However, remember from Session 3 that a baby does not suck from the nipple. He takes the nipple and the breast tissue underlying the areola into his mouth to form a `teat'. The nipple only forms about one-third of the `teat' of breast tissue in the baby's mouth.

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 breast is quite protractile, and it should be easy for her baby to stretch it to form a `teat' in his mouth. He should be able to suckle from this breast with no difficulty.

Key point: Breast 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 Overhead 3/6 again.
(If it is difficult to show an overhead at this stage, ask participants to look at Figure 12 in their manuals.)

Remind participants how a baby forms a `teat' of breast tissue in his mouth.

Slide 14/3 Inverted nipples

Ask: *What do you think of this nipple?*

The nipple is *inverted.*

- If this woman tests her breast for protractility, her nipple will go in instead of coming out.

You can see from the scar on her breast, that she has had a breast abscess. This was probably because her baby did not attach well to the breast and remove the milk effectively. With skilled help, she probably could have breastfed successfully.

Fortunately, nipples as difficult as this are rare.

Slide 14/4

MANAGEMENT OF FLAT AND INVERTED NIPPLES

Antenatal treatment	Probably not helpful
Soon after delivery	Build mother's confidence - breasts will improve Explain baby suckles BREAST not nipple Let baby explore breast, skin-to-skin Help mother to position baby early Try different positions - e.g. underarm Help her to make nipple stand out more Use pump, syringe
For first week or two if necessary	Express breastmilk and feed with cup Express breastmilk into baby's mouth

Slide 14/4 Management of flat and inverted nipples

- This slide summarizes the management of flat and inverted nipples.

- *Antenatal treatment is probably not helpful.*
  For example, stretching nipples, or wearing nipple shells does not help.
  Most nipples improve around the time of delivery without any treatment.

Help is most important soon after delivery, when the baby starts breastfeeding:

- *Build the mother's confidence.*
  Explain that it may be difficult at the beginning, but with patience and persistence she can succeed. Explain that her breasts will improve and become softer in the week or two after delivery.

- *Explain that a baby suckles from the breast - not from the nipple.*
  Her baby needs to take a large mouthful of breast. Explain also that as her baby breastfeeds, he will stretch her breast and nipple out.

- *Encourage her to give plenty of skin-to-skin contact, and to let her baby explore her breasts.*
  Let him try to attach to the breast on his own, whenever he is interested. Some babies learn best by themselves.

- *Help her to position her baby.*
  If a baby does not attach well by himself, help his mother to position him so that he can attach better. Give her this help early, in the first day, before her breastmilk `comes in' and her breasts are full.

- *Help her to try different positions to hold her baby.*
  Sometimes putting a baby to the breast in a different position makes it easier for him to attach. For example, some mothers find that the underarm position is helpful (see demonstration in Session 10).

- *Help her to make her nipple stand out more before a feed.*
  Sometimes making the nipple stand out before a feed helps a baby to attach. Stimulating her nipple may be all that a mother needs to do. Or she can use a hand breast pump, or a syringe to pull her nipple out. (The syringe method will be demonstrated after this slide.)

  Sometimes shaping the breast makes it easier for a baby to attach.
  To shape her 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. (See Session 10, `Positioning a baby at the breast'.)

  If it is acceptable to both partners, the woman's husband can suck on her nipples a few times to stretch them.

If a baby cannot suckle effectively in the first week or two, help his mother to:

- *Express her milk and feed it to her baby with a cup.*
  Expressing milk helps to keep breasts soft, so that it is easier for the baby to attach to the breast; and it helps to keep up the supply of breastmilk.
  She should not use a bottle, because that makes it more difficult for her baby to take her breast.

- *Express a little milk directly into her baby's mouth.*
  Some mothers find that this is helpful. The baby gets some milk straight away, so he is less frustrated. He may be more willing to try to suckle.

- *Let her baby explore her breasts frequently.*
  She should continue to give him skin-to-skin contact, and let him try to attach to her breast on his own.

Further information

Participants may have heard of different ways to treat inverted nipples, and they may wish to discuss the topic further - especially if they have known of a case which they found difficult to help. These notes may help you to answer questions. However, it is not necessary to give participants this information if they have not heard of these techniques.

Nipple shell
This is a glass or plastic hemisphere, with a hole in the base, to put over a nipple, under the clothes. The nipple is pressed through the hole, to make it stand out more. There is no evidence that these shells help, and they may cause oedema. However, if a mother is worried about inverted nipples, and she has heard of nipple shells and wants to try to use one, let her continue. It may make her feel that she is doing something, and it may help her to feel confident.

Hoffman's exercises
Some women have heard of exercises to stretch nipples. These exercises have not been shown to really help. They are unlikely to make much difference to severely inverted nipples. Nipple exercises can sometimes traumatize the breast, so do not recommend them. However, if a woman has heard about exercises and wishes to do them, let her continue.

Nipple shields
These are teats 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, (see Slides 14/13 to 14/18). Nipple shields are no longer recommended because they can cause problems and they do not remove the cause of the condition. Nipple shields can reduce the flow of milk; they can cause breast infections, including *Candida*; they can cause `nipple confusion', and 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 and with careful supervision.

 Demonstrate the syringe method for treating inverted nipples.

Demonstration X: Syringe method for treatment of inverted nipples

See Fig.5

Explain that this method is for treating inverted nipples postnatally, and to help a baby to attach to the breast. It is not certain whether it is helpful antenatally.

- *Show* participants the 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 that with a real breast, there is an airtight seal, and the nipple is drawn out into the syringe.)

- Explain that the mother must use the syringe herself.
  Explain that 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 1 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.

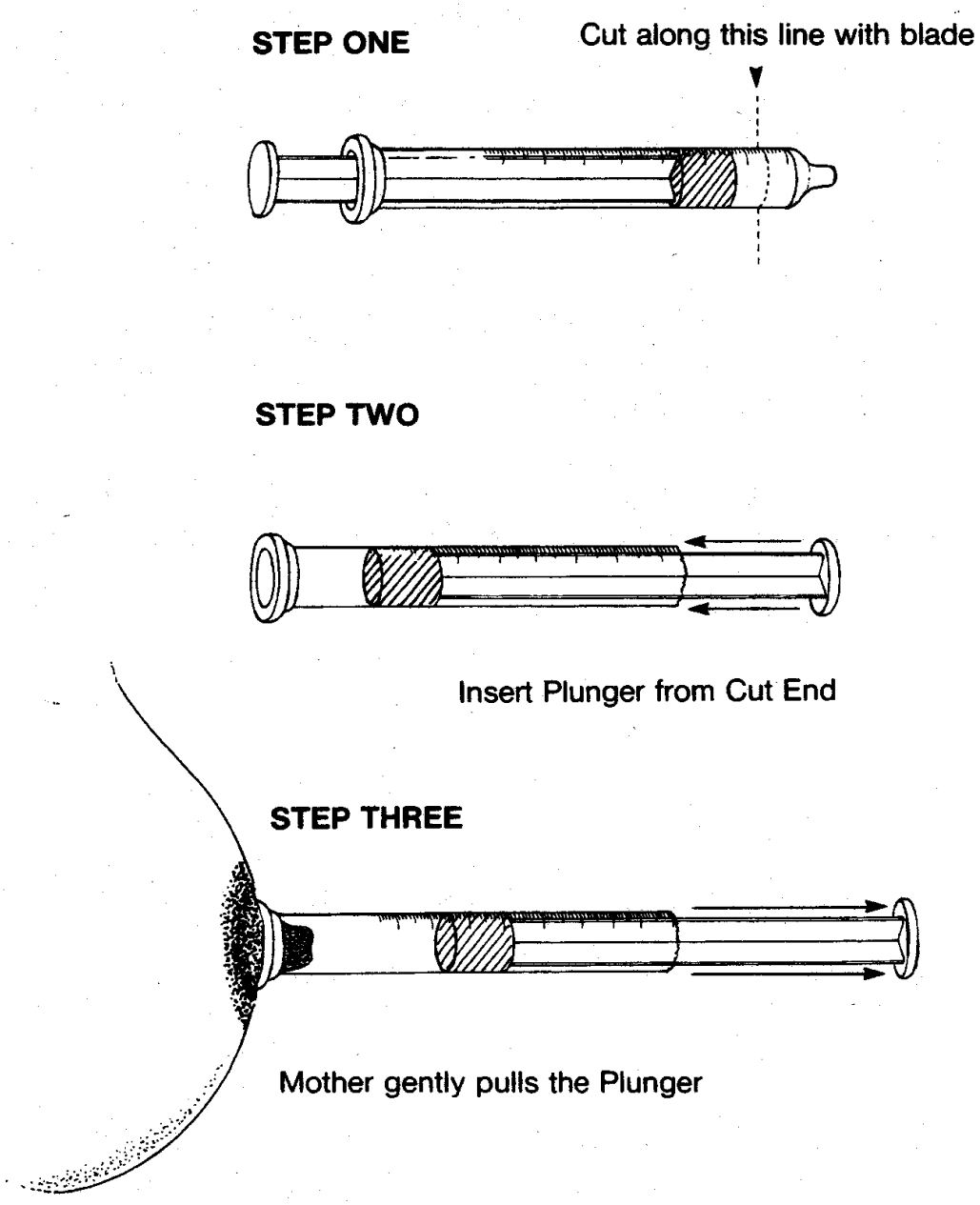

Fig.5 Preparing and using a syringe for treatment of inverted nipples.

(Fig.28 in Participants' Manual)

Slide 14/5 Long nipple

Ask: *What do you think of the nipple in picture 1?*

It is long.

Ask: *What do you think of the baby's attachment in picture 2?*

He is poorly attached. His chin is far from the breast, his mouth is closed, and the breast looks pulled out.

- You might think that long nipples are an advantage, and that they are easy for a baby to suckle from. But this slide shows that long nipples too can cause difficulties. A baby is likely to suck only the nipple, and he may not take the breast with the lactiferous sinuses into his mouth.

It is important to be ready to help this mother with her breastfeeding technique. Help her to get her baby to take some of her breast into his mouth - and not just her nipple.

Slide 14/6

SUMMARY OF DIFFERENCES BETWEEN FULL AND ENGORGED BREASTS

FULL BREASTS	*ENGORGED BREASTS*
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

Slide 14/6 Full and engorged breasts

- The woman in picture 1 has *full* breasts.

This is a few days after delivery, and her milk has `come in'. Her breasts feel hot and heavy and hard. However, her milk is flowing well. You can see that milk is dripping from her breasts.

This is normal fullness. Sometimes full breasts feel quite lumpy.

The only treatment that 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.

The woman in picture 2 has *engorged* breasts.

Engorgement means that the breasts are overfull, partly with milk, and partly with increased tissue fluid and blood, which interferes with the flow of milk.

The breast in this picture looks shiny, because it is oedematous. Her breasts feel painful, and her milk does not flow well.

Ask: *What do you notice about the nipple?*

It is flat, because the skin is stretched tight.

When a nipple is stretched tight and flat like this, it is difficult for a baby to attach to it, and to remove the milk.

Sometimes when breasts are engorged, the skin looks red, and the woman has a fever. This may make you think that she has mastitis. However, the fever usually settles in 24 hours.

It is important to be clear about the difference between full and engorged breasts. Engorgement is not so easy to treat.

Further information
When breasts are engorged, the milk does not flow well, partly because of the pressure of fluid in the breast, and partly because the oxytocin reflex does not work well.

- Ask participants to have their <u>manuals closed</u> for the next few slides.

Slide 14/7

CAUSES AND PREVENTION OF BREAST ENGORGEMENT

CAUSES	*PREVENTION*
. Plenty of milk	
. Delay starting 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	

Slide 14/7 Causes and prevention of breast engorgement

- This slide shows the causes of breast engorgement.

The causes of engorgement are:
- plenty of milk;
- delay starting to breastfeed;
- poor attachment, so breastmilk is not removed effectively;
- infrequent removal of milk;
- restricting the length of breastfeeds.

The slide also shows the three most important ways to prevent engorgement.
These are:
- to let the baby start breastfeeding soon after delivery;
- to make sure that the baby is well attached to the breast;
- to encourage unrestricted breastfeeding.

You can see that prevention is closely related to the causes of engorgement. A baby should suckle effectively from soon after delivery, without restrictions on the length or frequency of feeds. Then the milk pressure does not build up in the breasts. Engorgement is less likely to occur.

This can be achieved by following steps 4-8 of the `Ten steps'.

Slide 14/8

TREATMENT OF BREAST ENGORGEMENT

Do not "rest" the breast

If baby able to suckle:	Feed frequently, help with positioning.
If baby not able to suckle:	Express milk by hand or with pump
Before feed to stimulate oxytocin reflex:	Warm compress 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 on breasts

Slide 14/8 Treatment of breast engorgement

- This slide summarizes the treatment of breast engorgement.

To treat engorgement it is essential to remove milk. If milk is not removed, mastitis may develop, an abscess may form, and breastmilk production decreases.
So do not advise a mother to "rest" her breast.

- *If the* baby *is able to suckle, he should feed frequently.*
  This is the best way to remove milk. Help the mother to position her baby, so that he attaches well. Then he suckles effectively, and does not damage the nipple.

- *If the* baby *is not able to suckle, help his mother to express her milk.*
  She may be able to express by hand or she may need to use a breast pump, or a warm bottle (see Session 20, `Expressing breastmilk').
  Sometimes it is only necessary to express a little milk to make the breast soft enough for the baby to suckle.

- *Before* feeding *or expressing, stimulate the mother's oxytocin reflex.*
  These are things that you can do to help her, or that she can do:
  - put a warm compress on her breasts, or take a warm shower;
  - massage her neck and back;
  - massage her breast lightly;
  - stimulate her breast and nipple skin;
  - help her to relax.

  Sometimes a warm shower or warm bath makes milk flow from the breasts, so that they become soft enough for the baby to suckle.

- *After a* feed*, put a cold compress on her breasts.*
  This may help to reduce oedema.

- *Build* the *mother's confidence.*
  Explain that she will soon be able to breastfeed comfortably.

Slide 14/9 Mastitis

Ask: *What do you notice about this breast?*

Part of the breast looks red and swollen. There is a fissure on the tip of the nipple.

Ask: *What condition is this?*

This is *mastitis.*

- The woman has severe pain, and a fever, and she feels ill. Part of the breast is swollen and hard, with redness of the overlying skin.

Mastitis is sometimes confused with engorgement. However, engorgement affects the whole breast, and often both breasts. Mastitis affects part of the breast, and usually only one breast. However, if engorgement is not relieved, it may lead to mastitis.

Slide 14/10

SYMPTOMS OF BLOCKED DUCT AND MASTITIS

Blocked ----------> Milk ----------> Non-infective ----------> Infective
duct stasis mastitis mastitis

Lump	progresses	Hard swelling
Tender	---------->	Severe pain
Localized redness	to	Red area
No fever		Fever
Feels well		Feels ill

Slide 14/10 Symptoms of blocked duct and mastitis

- This slide shows how mastitis develops.

Mastitis may develop in an engorged breast, or it may follow a condition called *blocked duct*.

Blocked duct occurs when the milk is not removed from part of a breast. Sometimes this is because the duct to that part of the breast is blocked by thickened milk. The symptoms are a lump which is tender, and often redness of the skin over the lump. The woman has no fever and feels well.

When milk stays in part of a breast, because of a blocked duct, or because of engorgement, it is called *milk stasis*. If the milk is not removed, it can cause inflammation of the breast tissue, which is called *non-infective mastitis*. Sometimes a breast becomes infected with bacteria, and this is called *infective mastitis*.

It is not possible to tell from the symptoms alone if mastitis is non-infective or infective. If the symptoms are all severe, however, the woman is more likely to need treatment with antibiotics.

Further information

The cause of non-infective mastitis is probably milk under pressure leaking back into the surrounding tissues. The tissues treat the milk as a "foreign" substance. Also, milk contains substances which can cause 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.

Slide 14/11

CAUSES OF BLOCKED DUCT AND MASTITIS

. Infrequent or short breastfeeds	due to	- mother being very busy - baby sleeping at night - changed routine - mother stressed
. Poor drainage of part or all of breast	due to	- ineffective suckling - pressure from clothes - pressure from fingers during feeds - large breast draining poorly
. Damaged breast tissue	due to	- trauma to breasts
. Bacteria allowed entry	due to	- nipple fissure

Slide 14/11 Causes of blocked duct and mastitis

- This slide summarizes the causes of blocked duct and mastitis. The main cause is poor drainage of all or part of a breast.

Poor drainage of the whole breast may be due to:
- *Infrequent breastfeeds.*
  For example:
  - when a mother is very busy;
  - when her baby starts feeding less often - because he sleeps through the night, or feeds irregularly;
  - because of a changed feeding pattern for any other reason, for example, a journey.
- *Ineffective suckling* if the baby is poorly attached to the breast.

Poor drainage of part of the breast may be due to:
- *Ineffective suckling,* because a baby who is poorly attached may empty only part of the breast.
- *Pressure from tight clothes*, usually a bra, especially if she wears it at night;
  or from lying on the breast, which can block one of the ducts.
- *Pressure of the mother's fingers*, which can block milk flow during a breastfeed.
- *The lower part of a large breast draining poorly*, because of the way in which the breast hangs.

Another important factor is stress and overwork of the mother, probably because it causes her to breastfeed her baby less often, or for shorter times.

Trauma to the breast which damages breast tissue sometimes causes mastitis, for example, a sudden blow, or an accidental kick by an older child.

If there is a nipple fissure, it provides a way for bacteria to enter the breast tissue. This is another way in which a poor suckling position can lead to mastitis.

Slide 14/12

TREATMENT OF BLOCKED DUCT AND MASTITIS

FIRST:

- Improve drainage of breast

Look for cause and correct:
- poor attachment
- pressure from clothes or fingers
- large breast draining poorly

Advise:
- frequent breastfeeds
- gentle massage towards nipple
- warm compresses

Suggest if helpful:
- start feed on unaffected side
- vary position

THEN:

If any of these:
- symptoms severe, or
- fissure, or
- no improvement after 24 hours

Treat in addition with:

- Antibiotics

- Complete rest

- Analgesics (paracetamol)

Slide 14/12 Treatment of blocked duct and mastitis

▪ This slide summarizes the treatment of blocked duct and mastitis.

The most important part of treatment is to improve the drainage of milk from the affected part of the breast.

- Look for a cause of poor drainage, and correct it:
  - Look for poor attachment.
  - Look for pressure from clothes, usually a tight bra, especially if worn at night; or pressure from lying on the breast.
  - Notice what the mother does with her fingers as she breastfeeds. Does she hold the areola, and possibly block milk flow?
  - Notice if she has large, pendulous breasts, and if the blocked duct is in the lower part of her breast.
    Suggest that she lifts the breast more while she feeds the baby, to help the lower part of the breast to drain better.

- Whether or not you find a cause, advise the mother to do these things:
  - *Breastfeed frequently*.
    The best way is to rest with her baby, so that she can respond to him and feed him whenever he is willing.
  - *Gently massage the breast while her baby is suckling.*
    Show her how to massage over the blocked area, and over the duct which leads from the blocked area, right down to the nipple. This helps to remove the block from the duct. She may notice that a plug of thick material comes out with her milk. (It is safe for the baby

to swallow the plug.)
- *Apply warm compresses to her breast between feeds.*

- Sometimes it is helpful to do these things:
  - *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.
  - *Breastfeed the baby in different positions at different feeds.*
    This helps to remove milk from different parts of the breast more equally. Show the mother how to hold her baby in the underarm position, or how to lie down to feed him, instead of holding him across the front at every feed. However, do not make her breastfeed in a position that is uncomfortable for her.

Sometimes a mother is unwilling to feed her baby from the affected breast, especially if it is very painful. Sometimes a baby refuses to feed from an infected breast, possibly because the taste of the milk changes. In these situations, it is necessary to express the milk. If the milk stays in the breast, an abscess is more likely.

Usually, blocked duct or mastitis improves within a day when drainage to that part of the breast improves.

However, a mother needs additional treatment if there are any of the following:
- severe symptoms when you first see her, OR
- a fissure, through which bacteria can enter, OR
- no improvement after 24 hours of improved drainage.

Treat her, or refer her for treatment with the following:

- Antibiotics.
  Give either flucloxacillin or erythromycin (see Table 1 for dosage).
  Ask participants to find Table 1 on page 77 of their manual.
  Other commonly used antibiotics, such as ampicillin, are not usually effective.
  Explain that it is very important that she completes 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.

- Complete *rest.*
  Advise her to take sick leave, if she is employed, or to get help at home with her duties. Talk to her family if possible about sharing her work.
  If she is stressed and overworked, encourage her to try to take more rest.
  Resting with her baby is a good way to increase the frequency of breastfeeds, to improve drainage.

- Analgesics.
  Give her paracetamol for the pain.

Explain that she should continue with frequent breastfeeds, massage and warm compresses. If she is not eating well, encourage her to take adequate food and fluids.

Table 1: ANTIBIOTIC TREATMENT FOR INFECTIVE MASTITIS

The commonest bacterium found in breast abscess is *Staphylococcus aureus*. 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 6 hourly for 7-10 days.	Take dose at least 30 minutes before food.
Erythromycin	250-500 mg orally 6 hourly for 7-10 days	

Further information

Breast abscess
Participants may wish to discuss breast abscess in more detail.
An abscess is when a collection of pus 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, and let her baby start to feed from it again as soon as the pain is less - usually in 2-3 days. Meanwhile, continue to feed from the other breast. Good management of mastitis should prevent the formation of an abscess.

Alternative antibiotics for treatment of infective mastitis
The following antibiotics can be used if necessary:
- Cloxacillin 250-500 mg 6 hourly for 7-10 days;
- Cephalexin 250-500 mg 6 hourly for 7-10 days.

Slide 14/13 Nipple fissure

- Picture 1 shows a mother's breast, and picture 2 shows the same mother feeding her baby on the breast.

Ask: *What do you notice about her breast?*

There is a fissure, or crack, around the base of the nipple. You may be able to see that the breast is also engorged.

Ask: *What do you notice about the baby's position and attachment?*

The baby is poorly positioned. His body is twisted away from his mother, and he is not close to the breast. His mouth is closed, and his lips are pointing forwards, so he is poorly attached.

- This poor attachment may have caused both the breast engorgement and the fissure.

Remember from Session 3, that the commonest cause of sore nipples is poor attachment. If a baby is poorly attached, he pulls the nipple in and out as he sucks, and rubs the skin of the breast against his mouth. This is very painful for his mother. At first there is no fissure. The nipple may

look normal; or it may look squashed with a line across the tip when the baby releases the breast. If the baby continues to suckle in this way, it damages the nipple skin, and causes a fissure.

 Show Overhead 3/8 again, to remind participants about poor attachment. If it is difficult to project an overhead, show the overhead figure from the flipchart.

Slide 14/14 Improved attachment

- If a mother has sore nipples, help her to improve her baby's position, so that he is well attached.

Often, as soon as the baby is well attached, the pain is less. The baby can continue breastfeeding normally - there is no need to rest the breast to allow the nipples to heal.

This slide shows the same mother as in Slide 14/13. A nurse helped the mother to express some of the milk, and to improve the baby's position. This picture shows the baby suckling after the nurse helped the mother.

Ask: *What do you think of his position and attachment now?*

His position is better. He is facing the breast and closer to it.
His attachment is still not quite right. His mouth is not very wide open, and his lower lip is not turned outwards.

When the mother understands what she needs to do, leave her to practise the position for a while. Then come back and see if she needs more help. If a baby has `nipple sucked' for a number of feeds, it can take time to get it right.

Slide 14/15 Breast engorgement and nipple fissure

Ask: *What do you think of this breast?*

There is a fissure across the tip of the nipple. You can also see that the breast skin is tight and shiny. It is oedematous. The breast is engorged.

This mother waited to put her baby to her breast until her milk had `come in' - at about 3 days. The skin was so tight that 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 from soon after delivery. Starting to breastfeed early helps to prevent the milk pressure from building up in the breasts, so it helps to prevent engorgement. Also, it is easier for a baby to attach well when the breasts are still soft. There is less chance of nipple damage.

Slide 14/16 Candida infection

- This mother has very sore, itchy nipples.

Ask: *What do you see that might explain the soreness?*

There is a shiny red area of skin on the nipple and areola.

This is a *Candida* infection, or *thrush*, which can make the skin sore and itchy. *Candida* infections often follow the use of antibiotics to treat mastitis, or other infections.

Some mothers describe burning or stinging which continues after a feed. Sometimes the pain shoots deep into the breast. A mother may say that it feels as though needles are being driven into her breast.

The skin may look red, shiny and flaky. The nipple and areola may lose some of their pigmentation. Sometimes the nipple looks normal.

Suspect *Candida* if sore nipples persist, even when the baby's attachment is good. Check the baby for thrush. He may have white patches inside his cheeks or on his tongue, or he may have a rash on his bottom.

Treat both mother and baby with gentian violet, or nystatin (see Table 2).

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.

 Ask participants to find Table 2 on page 78 of their manuals.

Table 2: TREATMENT OF CANDIDA OF THE BREAST

Gentian violet paint:
To baby's mouth: 0.25% apply daily or alternate days for 5 days
or until 3 days after the lesions have healed.
To mother's nipples: 0.5% apply daily for 5 days.

OR:

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.

Stop using pacifiers, teats, and nipple shields.

Slide 14/17 Short frenulum (`tongue-tie')

Ask: *What do you notice about this baby's mouth?*

He has a *short frenulum*, or `tongue-tie'.

This is not a breast condition, but it can sometimes be a cause of sore nipples.

Many mothers worry that their babies have tongue-tie. In most cases, the baby's tongue is normal, but a little short. Most babies with tongue-tie can breastfeed without any difficulty. This baby needed help to attach well, but he soon learned. Sometimes however, a baby cannot get his tongue far enough over his lower gum to reach the lactiferous sinuses, so he has difficulty suckling effectively. He may not get enough breastmilk, and he may make the nipples sore.

If a baby has difficulty with breastfeeding, and you or his mother thinks that a short frenulum may be the cause, try to get him to take more of the breast into his mouth. In most cases, that 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 doctor to consider cutting the frenulum surgically.

Slide 14/18

MANAGEMENT OF SORE NIPPLES

Look for a cause:
- Check attachment
- Examine breasts - engorgement, fissures, *Candida*
- Check baby for *Candida,* and tongue-tie

Give appropriate treatment:
- Build mother's confidence
- Improve attachment, and continue breastfeeding
- Reduce engorgement - suggest feed frequently, express
- Treat for *Candida* if skin red, shiny, flaky;
  if there is itchiness, or deep pain, or if soreness persists.

Advise the mother to:
- Wash breasts only once a day, and avoid using soap
- Avoid medicated lotions and ointments
- Rub hindmilk on areola after feeds

Slide 14/18 Management of sore nipples

- This slide summarizes the management of sore nipples.

First look for a cause:

- Observe the baby breastfeeding, and check for signs of poor attachment.

- Examine the breasts.
  Look for signs of *Candida* infection; look for engorgement; look for fissures.

- Look in the baby's mouth for signs of *Candida* and for tongue tie; and baby's bottom for *Candida* rash.

Then give appropriate treatment:

- Build the mother's confidence.
  Explain that the soreness is temporary, and that 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 breastmilk.

- Consider treatment for *Candida* if the skin of the nipple and areola is red, shiny, or flaky; or if there is itchiness, or deep pain, or if the soreness persists.

Then advise the mother:

- Advise her not to wash her breasts more than once a day, and not to use soap, or rub hard with a towel.
  Breasts do not need to be washed before or after feeds - normal washing as for the rest of the body is all that is necessary. Washing removes natural oils from the skin, and makes soreness more likely.

- Advise her not to use medicated lotions and ointments, because these can irritate the skin, and there is no evidence that they are helpful.

- Suggest that after breastfeeding she rubs a little expressed breastmilk over the nipple and areola with her finger. This promotes healing.

Further information

Ointments for nipple fissure
Sometimes a plain cream such as lanolin may help a fissured nipple to heal after the suckling position has been corrected. However, plain creams are often not available, and they are not usually necessary.

Clothes
In warm weather, a cotton bra may be 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 that she leaves her bra off for a day or two.

Nipple shields
These are no longer recommended for the treatment of fissured nipples, see Further information after Slide 14/4.

III. Answer participants' questions (10 minutes)

 Ask participants if they have any questions, and try to answer them.

IV. Summarize `Breast conditions' (3 minutes)

 Ask participants to turn to pages 67-79 in their manuals. They will find the following summaries of the different conditions shown in the slides:

Management of flat and inverted nipples
Summary of differences between full and engorged breasts
Causes and prevention of breast engorgement
Treatment of breast engorgement
Causes of blocked duct and mastitis
Symptoms of blocked duct and mastitis
Treatment of blocked duct and mastitis
Antibiotic treatment for infective mastitis
Treatment of *Candida* of the breast
Management of sore nipples

 Refer back to the list of reasons for stopping breastfeeding or for giving complementary feeds early that you developed in Session 2, `Local breastfeeding situation'.

Remind participants about any of the above conditions that they identified as important in their situation.

 Recommended reading:
Helping Mothers to Breastfeed Chapter 5.

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BREAST CONDITIONS EXERCISE

Objective

Participants practise using the information from Session 14.

Session outline (30 minutes)

Participants work in groups of 8-10, with two trainers.

I. Introduce the session (2 minutes)

II. Facilitate the written exercise (Exercise 13)(28 minutes)

Preparation

Refer to pages 15-16 in the Introduction for notes on how to facilitate a written exercise.

Make sure that you have Answer Sheets for Exercise 13 available to give to participants at the end of the session.

I. Introduce the session (2 minutes)

 Ask participants to turn to page 80 of their manuals, and to find Exercise 13.

Explain that the exercise contains short stories about mothers with various breast conditions, followed by some questions.
Participants should answer the questions using the information from Session 14.
They can look back at the notes for Session 14 in their manuals if they wish.

II. Facilitate the written exercise (28 minutes)

 Explain what to do:

- Read the instructions **How to do the exercise** and the **Example** of what to do. Then answer the questions for the stories **To answer**.

EXERCISE 13. ***Breast conditions***

How to do the exercise:

Read the stories and write your answers to the questions in pencil in the following space. When you have finished, discuss your answers with the trainer.

Example:

Mrs A says that both her breasts are swollen and painful. She put her baby to her breast for the first time on the third day, when her milk `came in'. This is the sixth day. Her baby is suckling, but now it is rather painful, so she does not let him suck for very long. Her milk is not dripping out as fast as it did before.

What is the diagnosis?

(Engorged breasts.)

What may have caused the condition?

(Delay starting to breastfeed.)

How can you help Mrs A?

(Help her to express her milk, and help her to position her baby at her breast, so that he can attach better.)

To answer:

Mrs B says that her right breast has been painful since yesterday, and she can feel a lump in it, which is tender. She has no fever and feels well. She has started to wear an old bra which is tight, because she wants to prevent her breasts from sagging. Her baby now sometimes sleeps for 6-7 hours at night without feeding. You watch him suckling. Mrs B holds him close, and his chin is touching her breast. His mouth is wide open and he takes slow, deep sucks.

What could you say to empathize with Mrs B's worries about her figure?

("You are worried that breastfeeding may change your figure?")

What is the diagnosis?

(Blocked duct.)

What may be the cause?

(Tight clothes, and a long interval between feeds at night.
The baby's attachment to the breast is good.)

What three suggestions would you give Mrs B?

(1. Breastfeed her baby more often for a day or two.
2. Massage the lump gently while her baby is feeding.
3. Try to find a larger bra, that supports her breasts without blocking the ducts.)

Mrs C has had a painful swelling in her left breast for three days. It is extremely tender, and the skin of a large part of the breast looks red. Mrs C has a fever and feels too ill to go to work today. Her baby sleeps with her and breastfeeds at night. By day, she expresses milk to leave for him. She has no difficulty in expressing her milk. But 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 really feel ill, don't you?")

What is the diagnosis?

(Mastitis. It is not possible to say if it is infective or non-infective.)

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?

(Discuss the reasons why the condition has occurred. Help her to think of ways to breastfeed her baby more or to take more time to express her milk, especially during the day.

Because the symptoms are all severe, treat her in addition with antibiotics, rest, and analgesics.)

Mrs D complains of nipple pain when her 6-week-old baby is suckling. You examine her breasts while her baby is asleep, and can see no fissures. When he wakes, you watch him feeding. His body is twisted away from his mother's. His chin is away from the breast, and his mouth is not wide open. He takes rapid, shallow sucks. As he releases the breast, you notice that the nipple looks squashed.

What is the cause of Mrs D's nipple pain?

(Her baby is poorly attached to her breast.)

What could you say to build Mrs D's confidence?

(Possibilities include:
Praise her for breastfeeding exclusively;
Give relevant information, in a positive way, using simple language:
"If your baby takes a bigger mouthful of breast, breastfeeding should soon be more comfortable".)

What practical help could you give her?

(Offer to help her to improve her baby's suckling position.)

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

What could you say to accept Mrs E's idea about her nipples?

(Something like: "I see" or "You are worried about your nipples?")

How could you build her confidence?

(Praise the protractility of her breasts.
Give her relevant information. For example, explain how a baby suckles from the breast not the nipple, and he stretches the nipple out. He can get the milk if he takes a big mouthful of breast.)

What practical help could you give Mrs E?

(Offer to help her to get her baby to take more of her breast into his mouth.)

Mrs F's baby is 3 months old. She says that her nipples are sore. They have been sore on and off since an attack 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 whenever her baby suckles. You watch her baby breastfeeding. 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 might be the cause of Mrs F's sore nipples?

(*Candida* infection. Her baby's is well attached to her breast.)

What treatment would you give to her and her baby?

(Give gentian violet or nystatin for her nipples.
Check and treat her baby's mouth and bottom for *Candida*.)

How would you build Mrs F's confidence?

(Possibilities include:
Praise the way in which her baby is suckling.
Give relevant information. Explain why her nipples are sore, and explain that breastfeeding should be comfortable again after the treatment.)

Optional

Mrs G says that her breasts are painful. Her baby is 5 days old. Both Mrs G's breasts are swollen, and the skin looks shiny. There is a fissure across the tip of her right nipple. You watch her breastfeeding her baby. She holds him loosely, with his body away from hers. His mouth is not wide open, and his chin is not near the breast. He makes smacking sounds as he suckles. After a few sucks, he pulls away and cries.

What has happened to Mrs G's breasts?

(They are engorged, and her right nipple is damaged.)

What are Mrs G and her baby doing right?

(They are both trying to breastfeed. She has plenty of milk. She has not started bottle feeds.)

What practical help can you give Mrs G?

(Help her to express some of her milk, by hand or pump.
Then help her to attach her baby to her breast in a better position.)

 Give participants the Answer Sheets for Exercise 13.

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REFUSAL TO BREASTFEED

Objectives

At the end of this session, participants should be able to:
- diagnose why a baby is refusing to breastfeed;
- help a mother and baby to breastfeed again.

Session outline (60 minutes)

Participants work in groups of 8-10, with two trainers.

I. Introduce the topic (5 minutes)

II. Discuss causes of refusal to breastfeed (15 minutes)

III. Read and discuss `Management of refusal to breastfeed' (15 minutes)

IV. Facilitate the written exercise (Exercise 14)(25 minutes)

Preparation

Refer to pages 13-15 in the Introduction for general guidance on how to conduct work in groups.
Study the notes for the session, so that you are clear about what to do.
Make sure that there are two flipcharts or boards available. If not, put flipchart sheets on the wall where participants can see them.

Have Answer Sheets for Exercise 14 ready to give to participants at the end of the session.

As you follow the text remember:

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

I. Introduce the topic (5 minutes)

Ask participants to keep their manuals closed until asked to refer to them.

□ Explain what the session is about:

- ▪ This session is about the problem of a baby refusing to breastfeed, or being unwilling to suckle.

Ask: *Have you heard of babies who refused to breastfeed?*
(Let participants relate their experience for 2-3 minutes. Thank them, and continue).

- ▪ Refer back to the list of reasons for giving complements or stopping breastfeeding early from Session 2, `Local breastfeeding situation'. Remind participants if they identified refusal to breastfeed as a common reason in their situation.

Then continue with these points:

- ▪ In some communities refusal is a common reason for stopping breastfeeding. However, it need not lead to complete weaning, and can often be overcome.

- ▪ Refusal can cause great distress to the baby's mother. She may feel rejected and frustrated by the experience.

- ▪ There are different kinds of refusal.
  - Sometimes a baby attaches to the breast, but then does not suckle or swallow, or suckles very weakly.
  - Sometimes a baby cries and fights at the breast, when his mother tries to breastfeed him.
  - Sometimes a baby suckles for a minute and then comes off the breast choking or crying. He may do this several times during a single feed.
  - Sometimes a baby takes one breast, but refuses the other.

- ▪ You need to know how to decide why a baby is refusing to breastfeed, and how to help the mother and baby enjoy breastfeeding again.

II. Discuss causes of refusal to breastfeed (15 minutes)

->Write the heading `WHY BABIES REFUSE TO BREASTFEED' on a flipchart or board.

Ask participants to suggest why a baby may refuse to breastfeed.

->Write their suggestions on the board under the heading.

->Make the following list on another board or flipchart:

Baby ill, in pain or sedated
Difficulty with breastfeeding technique
Change which upsets baby
Apparent, not real, refusal

Explain that most causes of breast refusal fall into one or other of these groups.

 Discuss the four groups of causes.

Use the notes **WHY A BABY MAY REFUSE TO BREASTFEED**.
Discuss which group each of the participant's suggestions belongs to.
Add to the participants' list reasons that they did not think of. Try not to repeat what they have already suggested.

WHY A BABY MAY REFUSE TO BREASTFEED

1. Is the baby ill, in pain or sedated?

Illness:
The baby may attach to the breast, but suckles less than before.

Pain:
Pressure on a bruise from forceps or vacuum extraction.
- The baby cries and fights as his mother tries to breastfeed him.

Blocked nose:
Sore mouth (*Candida* infection (thrush), an older baby teething).
- The baby suckles a few times, and then stops and cries.

Sedation:
A baby may be sleepy because of:
- drugs that his mother was given during labour;
- drugs that she is taking for psychiatric treatment.

2. Is there a difficulty with the breastfeeding technique?

Sometimes breastfeeding has become unpleasant or frustrating for a baby.

Possible causes:
- Feeding from a bottle, or sucking on a pacifier (dummy).

- Not getting much milk, because of poor attachment or engorgement.
- Pressure on the back of the baby's head, by his mother or a helper positioning him roughly, with poor technique. The pressure makes him want to `fight'.
- His mother holding or shaking the breast, which interferes with attachment.
- Restriction of breastfeeds; for example, breastfeeding only at certain times.
- Too much milk coming too fast, due to oversupply. The baby may suckle for a minute, and then come off choking or crying, when the ejection reflex starts. This may happen several times during a feed. The mother may notice milk spraying out as he comes off the breast.
- Early difficulty coordinating suckling. (Some babies take longer than others to learn to suckle effectively).

Refusal of one breast only:
Sometimes a baby refuses one breast, but not the other. This is because the problem affects one side more than the other.

3. Has a change upset the baby?

Babies have strong feelings, and if they are upset they may refuse to breastfeed. They may not cry, but simply refuse to suckle.
This is commonest when a baby is aged 3-12 months. He suddenly refuses several breastfeeds. This behaviour is sometimes called a `nursing strike'.

Possible causes:
- Separation from his mother, for example when she starts a job.
- A new carer, or too many carers.
- A change in the family routine - for example, moving house, visiting relatives.
- Illness of his mother, or a breast infection.
- His mother menstruating.
- A change in his mother's smell, for example, different soap, or different food.

4. Is it `apparent' and not `real' refusal?

Sometimes a baby behaves in a way which makes his mother think that he is refusing to breastfeed. However, he is not really refusing.

- When a newborn baby `roots' for the breast, he moves his head from side to side as if he is saying `no'. However, this is normal behaviour.
- Between 4 and 8 months of age, babies are easily distracted, for example when they hear a noise. They may suddenly stop suckling. It is a sign that they are alert.
- After the age of 1 year, a baby may wean himself. This is usually gradual.

 Ask participants to find the box **CAUSES OF BREAST REFUSAL** on page 90 of their manuals. Read the titles of the sections, and point out that they are the same four groups of causes. Point out that they also have the notes **WHY A BABY MAY REFUSE TO BREASTFEED** on pages 88-90 in their manuals.

CAUSES OF BREAST REFUSAL

Illness, pain, or sedation	Infection Brain damage Pain from bruise (vacuum, forceps) Blocked nose Sore mouth (thrush, teething)
Difficulty with breastfeeding technique	Bottle feeds, pacifiers Not getting much milk (poor attachment, engorgement) Pressure on back of head when positioning Mother shaking breast Restricting feeds Oversupply of breastmilk Difficulty coordinating suckle
Change which upsets baby (especially aged 3-12 months)	Separation from mother New carer, too many carers Change in family routine Mother ill, or mastitis Mother menstruating Change in smell of mother
Apparent refusal	Newborn - rooting Age 4-8 months - distraction Above 1 year - self-weaning

III. Read and discuss `Management of refusal to breastfeed' (15 minutes)

☺ Ask participants to read the section **MANAGEMENT OF REFUSAL TO BREASTFEED** on pages 91-93 of their manuals.

If you feel that it would be more helpful, let the group read the section aloud together. Ask participants to take turns, and each to read one sentence.

MANAGEMENT OF REFUSAL TO BREASTFEED

If a baby is refusing to breastfeed:

1. Treat or remove the cause if possible.
2. Help the mother and baby to enjoy breastfeeding again.

1. Treat or remove the cause if possible

Illness:

Treat infections with appropriate antimicrobials and other therapy.
Refer if necessary.
If a baby is unable to suckle, he may need special care in hospital.
Help his mother to express her breastmilk to feed to him by cup or by tube, until he is able to breastfeed again (see Session 20, `Expressing breastmilk').

Pain:

For a bruise: help the mother to find a way to hold the baby without pressing on a painful place.
For thrush: treat with gentian violet or nystatin (see Table 2 in Session 14, `Breast conditions', page 209 in this Guide.).
For teething: encourage her to be patient and to keep offering him her breast.
For a blocked nose: explain how she can clear it. Suggest short feeds, more often than usual for a few days.

Sedation:

If the mother is on regular medication, try to find an alternative.

Breastfeeding technique:

Discuss the reason for the difficulty with the mother. When her baby is willing to breastfeed again, you can help her more with her technique.

Oversupply

This is the usual cause of too much milk coming too fast.
Oversupply can result from poor attachment. If a baby suckles ineffectively, he may breastfeed frequently, or for a long time, and stimulate the breast so that it produces more milk than he needs.
Oversupply may also result if a mother tries to make her baby feed from both breasts at each feed, when he does not need to.

To reduce oversupply:

- Help the mother to improve her baby's attachment.
- Suggest that she lets him suckle from only one breast at each feed.
  Let him continue at that breast until he finishes by himself, so that he gets plenty of the fat-rich hindmilk.
  At the next feed, give him the other breast.

Sometimes a mother finds it helpful to:
- express some milk before a feed;
- lie on her back to breastfeed (if milk flows upwards, it is slower);
- hold her breast with the scissor hold to slow the flow (see Session 10, `Positioning a baby at the breast').
However, these techniques do not remove the cause of the problem.

Changes which upset a baby:
- Discuss the need to reduce separation and changes if possible.
- Suggest that she stops using the new soap, perfume, or food.

Apparent refusal:
If it is *rooting*:
Explain that this is normal. She can hold her baby at her breast to explore her nipple. Help her to hold him closer, so that it is easier for him to attach.

If it is *distraction*:
Suggest that she try to feed him somewhere more quiet for a while. The problem usually passes.

If it is *self-weaning:*
Suggest that she:
- makes sure that the child eats enough family food;
- gives him plenty of extra attention in other ways;
- continues to sleep with him because night feeds may continue.
This is valuable at least up to the age of 2 years.

2. Help the mother and baby to enjoy breastfeeding again

This is difficult and can be hard work. You cannot force a baby to breastfeed.
The mother needs help to feel happy with her baby and to enjoy breastfeeding. They have to learn to enjoy close contact again. She needs you to build her confidence, and to give her support.

Help the mother to do these things:

- *Keep her baby close to her all the time.*
  - She should care for her baby herself as much of the time as possible.
  - Ask grandmothers and other helpers to help in other ways, such as doing the housework, and caring for older children.
  - She should hold her baby often, and give plenty of skin-to-skin contact at times other than feeding times. She should sleep with him.
  - If the mother is employed, she should take leave from her employment - sick leave if necessary.
  - It may help if you discuss the situation with the baby's father, grandparents, and other helpful people.

- *Offer her breast whenever her baby is willing to suckle.*
  - She should not hurry to breastfeed again, but offer the breast if her baby does show an interest.
    He may be more willing to suckle when he is sleepy or after a cup feed, than when he is very hungry. She can offer her breast in different positions.
  - If she feels her ejection reflex working, she can offer her breast then.

- *Help her baby to breastfeed in these ways:*
  - Express a little milk into her baby's mouth.
  - Position him well, so that it is easy for him to attach to the breast.
  - She should avoid pressing the back of his head, or shaking her breast.

- *Feed her baby by cup until he is breastfeeding again.*
  - She can express her breastmilk and feed it to her baby from a cup (or cup and spoon). If necessary, use artificial feeds, and feed them by cup.
  - She should avoid using bottles, teats and pacifiers (dummies) of any sort.

 Tell participants that they can find a summary of this information in the box **HELPING A MOTHER AND BABY TO BREASTFEED AGAIN** on page 93 of their manuals.

Give them 2 minutes to read the box through, to remind them of the main points in the preceding section.

HELPING A MOTHER AND BABY TO BREASTFEED AGAIN

Help the mother to do these things:

- *Keep her baby close - no other carers*
  Give plenty of skin-to-skin contact at all times, not just at feeding times
  Sleep with her baby
  Ask other people to help in other ways

- *Offer her breast whenever her baby is willing to suckle*
  When sleepy, or after a cup feed
  In different positions
  When she feels her ejection reflex working

- *Help her baby to take the breast*
  Express breastmilk into his mouth
  Position him so that he can attach easily to the breast
  Avoid pressing the back of his head or shaking her breast

- *Feed her baby by cup*
  Give her own expressed breastmilk if possible, if necessary give artificial feeds
  Avoid using bottles, teats, pacifiers

IV. Facilitate the written exercise (25 minutes)

Ask participants to turn to page 94 of their manuals, and to find Exercise 14.

 Explain what the exercise is about:

- This exercise contains short stories about mothers whose babies are refusing to breastfeed.

- Answer the questions after the stories using information from this session, and from Session 6, `Listening and learning' and Session 11, `Building confidence and giving support'. You can look at the notes in your manuals from these sessions if you wish.

- Explain what to do:

- Read the instructions **How to do the exercise**.
  Then answer the questions **To answer** in the same way as for Exercise 13.

EXERCISE 14. ***Breast refusal***

How to do the exercise:

Read the stories, and write your answers to the questions in pencil in the following space. When you have finished, discuss your answers with the trainer.
The stories of Mrs K and Mrs L are optional, to do if you have time.

To answer:

Mrs H's baby was delivered by vacuum extraction 2 days ago. He has a bruise on his head. When Mrs H tries to feed him, he screams and refuses. She is very upset, and feels that breastfeeding will be too difficult for her. You watch her trying to feed him, and you notice that her hand is pressing on the bruise.

What can you say to empathize with Mrs H?

("You feel that it is all too difficult at the moment?")

What praise and relevant information can you give to build Mrs H's confidence?

(Praise her for trying to breastfeed.
Relevant information: at the moment his bruise is making breastfeeding painful for him.)

What practical help can you give her?

(Offer to help her to find a way to hold him that is not painful.)

Mrs I says that her 3-month-old baby is refusing to breastfeed. He was born in hospital and roomed-in from the beginning. He breastfed without any difficulty. Mrs I returned to work when her baby was 2 months old. Her baby has 2-3 bottle feeds while she is at work. For the last week, he has refused to breastfeed when she comes home in the evening. She thinks that her milk is not good, because she works hard and feels hot all day.

What could you say to accept Mrs I's ideas about her milk?

("Aha." Or: "You think that your milk is bad now?")

What might be the cause of her baby's refusal to breastfeed?

(He is separated from his mother for a large part of the day. Also, he has bottle feeds while she is away.)

What praise and relevant information could you give to build Mrs I's confidence?

(Praise her for breastfeeding up till now, and for her baby's good health.
Relevant information: breast refusal is quite common when a baby's routine changes, and can be overcome.)

What could you suggest that she does to breastfeed again, if she decides to try?

(Suggest that if possible, she takes sick leave, and cares for him herself, with plenty of skin-to-skin contact, offering him her breast when he is willing. She should give the other feeds from a cup and not a bottle, so that her baby wants to suckle when she is with him.)

Mrs J has a baby who is 1 month old. The baby was born in hospital, and was given three bottle feeds before he started to breastfeed. When Mrs J went home, her baby wanted to breastfeed often, and he seemed unsatisfied. Mrs J thought that she did not have enough milk. She continued to give bottle feeds, in addition to breastfeeding, and hoped that her breastmilk supply would increase. Now her baby is refusing to breastfeed. When Mrs J tries to breastfeed, he cries and turns away. Mrs J wants very much to breastfeed, and she feels rejected by her baby.

What could you say to empathize with Mrs J?

("You are very upset that he seems not to want your breastmilk.")

Why is Mrs J's baby refusing to breastfeed?

(He started having bottle feeds before breastfeeding was established.)

What relevant information might be helpful to Mrs J?

("Your baby is having difficulty getting the milk, so he is frustrated. He still wants you near him.")

What four things would you offer to help Mrs J to do, so that she and her baby can enjoy breastfeeding again?

(1. Stop using the bottle - feed him by cup.
2. Keep her baby close, with skin-to-skin contact, and offer her breast whenever he is willing.
3. Express her milk, and feed it to her baby.
4. Make sure that she positions her baby so that he can attach well.)

Optional

Mrs K had her baby 3 days ago. She says that he is refusing to breastfeed, and she will have to bottle feed. A nurse is helping her to try to position the baby. The nurse puts the baby to face Mrs K's breast. The nurse then holds Mrs K'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.

What could you say to praise the nurse?

("It is good that you are helping Mrs K to position her baby.")

Why does Mrs K's baby refuse to breastfeed?

(Because the nurse's technique is not good. She is pushing on the back of his head, which makes the baby want to fight back.)

What would you suggest that the nurse does differently?

(Suggest that a different technique might help:
- support the baby by his shoulders and neck, not the back of his head;
- wait until he opens his mouth before moving him to the breast;
- let the mother do more herself.)

What could you suggest that Mrs K does?

(Do not try to make the baby take the breast any more now. Let him enjoy skin-to-skin contact, and explore the breast with his mouth, until he is willing to try to suckle. Express her breastmilk to feed him until he suckles.)

Mrs L says that her 6-month-old baby suddenly refused to breastfeed. He was born in hospital, and started to breastfeed within an hour. He has never had any bottle feeds, but he recently started solids from a spoon. Last month the family moved to stay with relatives in town while the father looked for a job. There is an aunt in the house who likes to take care of the baby, and who criticizes Mrs L.

What might be the cause of Mrs L's baby refusing to breastfeed?

(Events in the family - moving house, a critical aunt.)

What can you suggest that Mrs L does, to breastfeed again?

(Suggest that she keeps her baby with her and cares for him as much as possible herself. She should give him plenty of skin-to-skin contact, and offer her breast whenever he is willing to suckle.)

What practical help can you give?

(Offer to talk to the aunt, and ask her to help Mrs L in other ways.)

 Give participants the Answer Sheets for Exercise 14.

 Refer back to the list of reasons for stopping breastfeeding or for starting complementary foods early that you developed in Session 2, `Local breastfeeding situation'.

Remind participants if they identified breast refusal as an important cause in their situation.

 Recommended reading:
Helping Mothers to Breastfeed Chapter 5, section 5.7.

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TAKING A BREASTFEEDING HISTORY

Objectives

At the end of this session, participants should be able to take a breastfeeding history to help them to diagnose a breastfeeding difficulty.

Session outline (50 minutes)

Participants work in groups of 8-10, with two trainers.

I. Introduce the topic (5 minutes)

II. Explain how to take a breastfeeding history (15 minutes)

III. Explain the Breastfeeding History Form (10 minutes)

IV. Demonstrate how to use the Breastfeeding History Form (15 minutes)

V. Summarize `Taking a breastfeeding history' (5 minutes)

Preparation

Refer to pages 13-15 in the Introduction for general guidance on how to conduct work in groups.
Study the session notes so that you are clear about what to do.

For Demonstration Y: Using the Breastfeeding History Form.
Arrange with the other trainer in your group how to do the demonstration. Decide who will be Mrs Green, and who will be Nurse Jane.
Fill in a local growth chart for Lucy, and have it ready for the demonstration.

As you follow the text remember:

 indicates an instruction to you, the trainer
▪ indicates what you say to the participants

I. Introduce the topic (5 minutes)

 Explain why it is necessary to take a history:

▪ If a mother asks for your help, you need to understand her situation.
You cannot learn everything that you need to know by observing and listening and learning. You need to ask some questions.

Ask: *What things can you only learn if you ASK the mother?*
(Let participants make 5-6 suggestions. Then continue.)

Examples include:
- when the baby was born;
- what happened at the time of delivery;
- what else she feeds her baby;

 Explain these points about taking a history:

▪ Taking a history means asking relevant questions in a systematic way.
You will use a special form, the Breastfeeding History Form, to help you to remember what questions to ask.

▪ When you first learn to use the form, you need to ask all the questions.
As you become more experienced, you learn which questions are relevant for which mothers. Then you do not need to ask all the questions every time.

II. Explain how to take a breastfeeding history (15 minutes)

Ask participants to find the box **HOW TO TAKE A BREASTFEEDING HISTORY** on page 100 of their manuals.

☺ Ask them to read the box aloud, taking turns. Discuss each point to make sure that it is clear.

HOW TO TAKE A BREASTFEEDING HISTORY

. *Use the mother's name and the baby's name (if appropriate).*
Greet the woman in a kind and friendly way. Introduce yourself, and ask her name and the baby's name. Remember and use them, or address her in whatever way is culturally appropriate.

. *Ask her to tell you about herself and her baby in her own way.*
Let her tell you first what she feels is important. You can learn the other things that you need to know later.
Use your listening and learning skills to encourage her to tell you more.

. *Look at the child's growth chart.*
It may tell you some important facts and save you asking some questions.

. *Ask the questions that will tell you the most important facts.*
You will need to ask questions, including some closed questions, but try not to ask too many. The Breastfeeding History Form is a guide to the facts that you may need to learn about. Decide what you need to know from each of the six sections.

. *Be careful not to sound critical*.
Ask questions politely. For example:
Do not ask: "Why are you bottle feeding?"
It is better to say: "What made you decide to give (name) some bottle feeds?"
Use your confidence and support skills.
Accept what the mother says, and praise what she is doing well.

. *Try not to repeat questions.*
Try not to ask questions about facts which either the mother or the growth chart has told you already.
If you do need to repeat a question, first say: "Can I make sure that I have understood clearly?" and then, for example "You said that (name) had both diarrhoea and pneumonia last month?"

. *Take time to learn about more difficult, sensitive things.*
Some things are more difficult to ask about, but they can tell you about a woman's feelings, and whether she really wants to breastfeed.
- What have people told her about breastfeeding?
- Does she have to follow any special rules?
- What does the baby's father say? Her mother? Her mother-in-law?
- Did she want this pregnancy at this time?
- Is she happy about having the baby now? About the baby's sex?

Some mothers tell you these things spontaneously. Others tell you when you empathize, and show that you understand how they feel. Others take longer. If a mother does not talk easily, wait, and ask again later, or on another day, perhaps somewhere more private.

III. Explain the Breastfeeding History Form (10 minutes)

Ask participants to look at the Breastfeeding History Form, on page 101 of their manuals.

 Explain the form, with these points:

- This is a guide, to help you to organize your thoughts, so that you do not get lost when you talk with a mother.
  It lists the main points that you may need to ask about a mother and baby. You may need to follow up some questions with more detailed questions.

- The points are grouped into six sections to help you to remember what you need to ask about.
  - The first two sections are about the baby and how he is feeding now.
  - The third section is about the mother's pregnancy and delivery.
  - The fourth section is about the mother and her health and family planning.
  - The fifth section is about her previous experience of feeding infants.
  - The sixth section is about the family and their social situation.

- Often, questions about points in the first two sections give you the answer to a problem. Sometimes you need to find out more about the mother, her pregnancy and delivery, her previous babies, or the family's situation, before you can understand her difficulties.

  Key point. Start with the first two sections. They are the most important. Then continue through the other sections until you are clear about the problem. When you are clear, you need not continue to ask about all the other points.

- However, it is a good idea to ask each mother about something from each section. Think quickly through all the six sections, and ask yourself what might be important for this family.

- If at any time a mother wants to tell you about something that is important to her, let her tell you that first. Ask about the other things afterwards.

 Ask participants to make themselves familiar with the form:

- Study the form and try to memorize the six sections. When you know the sections, you will find it easier to remember the different points in each.

- When you first use it, go through the whole form. This will help you to learn how to take a breastfeeding history. As you gain experience, you will find it easier to choose which questions to ask.

BREASTFEEDING HISTORY FORM

Mother's name_____ Baby's name_____ Date of birth_____
Reason for consultation _____

1.*Baby's feeding now (ask all these points)*	*Breastfeeds* How often Length of breastfeeds Longest time between feeds (time mother away from baby) One breast or both breasts	Day	Night
	Complements (and water) What given When started How much How given	*Pacifier* Yes/no	
2.*Baby's health and behaviour (ask all these points)*	Birth weight Premature Urine output (more/less than 6 times per day) Stools (soft and yellow/brown; or hard or green; frequency) Feeding behaviour (appetite, vomiting) Sleeping behaviour Illnesses	Weight now Twin Abnormalities	Growth
3.*Pregnancy, birth, early feeds*	Antenatal care (attended/not) Delivery Rooming-in Prelacteal feeds What given Formula samples given to mother Postnatal help with breastfeeding	Breastfeeding discussed? Early contact (first □-1 hour) Time first breastfeed How given	
4.*Mother's condition and family planning*	Age Health Family planning method	Breast condition Motivation to breastfeed Alcohol, smoking, coffee, other drugs	
5.*Previous infant feeding experience*	Number of previous babies How many breastfed Any bottles used	Experience good or bad Reasons	
6.*Family and social situation*	Work situation Economic situation Father's attitude to breastfeeding Other family members attitude to breastfeeding Help with child care What others say about breastfeeding	Literacy	

IV. Demonstrate how to use the Breastfeeding History Form (15 minutes)

 Explain that you will demonstrate how to use the Breastfeeding History Form.

Ask participants to follow the form on page 101 of their manual as you give the demonstration.
Ask them to point it out if you make a mistake, for example, if you use a judging word, or ask a lot of closed questions.

 Give the demonstration.

Follow the story of Mrs Green and her baby Lucy in the story below. One trainer plays the part of Mrs Green, and the other trainer is Nurse Jane.

Nurse Jane greets the mother, asks her name, and asks how she is doing. Mrs Green tells Nurse Jane her `complaint', and then Nurse Jane takes her `history'. She asks to see the baby's growth chart. Try to demonstrate some listening and learning and confidence building skills.

Go through the Breastfeeding History Form, asking questions from sections 1 to 6. Mrs Green responds following the story, which is arranged in the same six sections. If Mrs Green adds information, it must fit with the story.

DEMONSTRATION Y: USING THE BREASTFEEDING HISTORY FORM

Mrs Green's complaint: *"Lucy is really feeding too much"*

Mrs Green's story:

1. Lucy is 3 months old and breastfeeds about 10-12 times a day - sometimes every 1-2 hours, sometimes after 5-6 hours. She breastfeeds about twice in the night. You (Mrs Green) do not give any complementary milk feeds, but you sometimes give drinks of water from a spoon.
2. Lucy is gaining weight well, and she is very healthy. She passes urine 6-8 times a day. Her growth chart shows that she is gaining weight.
3. Lucy was born in hospital, and started breastfeeding soon after delivery. She roomed-in with you, and did not have any prelacteal feeds. The midwife helped you and you had no difficulties.
4. You are aged 25 years, and healthy. You are not using any family planning method. You think that breastfeeding is very healthy, and you want to continue.
5. Lucy is your first baby.
6. You stay at home, and do not go out to work. Lucy's father works as a clerk. Lucy's father thinks that it is time the baby stopped having night feeds.

 Discuss the demonstration.

The group may have become interested in Mrs Green's problems, and they may want to discuss that. Allow them to do so briefly. Ask them:

- What do you think is the cause of Mrs Green's difficulty?
  (Mr Green wants her to stop breastfeeding.)
- Is Mrs Green's idea of the problem correct? *(No - anyway, not what she says.)*
- What misunderstanding may have given her this idea?
  (The baby sometimes wants to feed again quite soon. But this is normal.)

Now ask the group to think about the technique of taking a breastfeeding history.

Ask them these questions:

- Did Nurse Jane ask questions from all 6 sections of the Breastfeeding History Form?
- Did she leave out any important questions?
- Did asking questions from each section of the form help her to understand the problem?

Point out that continuing to Section 6 helped Nurse Jane to remember to ask about the father's attitude. It is clear that it is the father's attitude to Lucy's breastfeeding which is making Mrs Green worry about how often Lucy breastfeeds.

V. Summarize `Taking a breastfeeding history' (5 minutes)

Ask participants to find the box **SUMMARY: HOW TO TAKE A BREASTFEEDING HISTORY** on page 99 of their manuals.
Read through the list, and ask participants to try to learn it.

SUMMARY: HOW TO TAKE A BREASTFEEDING HISTORY

Use the mother's and baby's names (if appropriate)
Ask her to tell you about herself and her baby in her own way
Look at the child's growth chart
Ask the most important questions
Be careful not to sound critical
Try not to repeat questions
Take time to learn about difficult, sensitive things.

Session 18

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HISTORY PRACTICE

Objectives

Participants practise taking a breastfeeding history, using the Breastfeeding History Form.

Session outline (70 minutes)

Participants work in groups of 4-5, each with one trainer.

I. Prepare for the exercise (10 minutes)

II. Conduct the pair practice (Exercise 15) (60 minutes)

Preparation

Refer to pages 16-17 in the Introduction for general guidance on how to conduct work in small groups.

Make sure that copies of Histories 1-5 are available (on cards or paper). They should not have the Comments with them. Each group of
4-5 participants needs one set of copies.
Fill in a local growth chart for the baby in each of the histories.

Have loose copies of the Breastfeeding History Form available for participants.

Study section **I. Prepare for the exercise** so that you can explain to participants what to do.

Study the section **How to conduct the exercise** at the beginning of Exercise 15, so that you can guide the pair practice and the discussion.

Read the **Comments** at the end of each history, to help you with the discussion of each pair practice.

Decide how you will conduct the exercise.
In some situations, participants may have difficulty in reading the history quickly. An alternative way to conduct the exercise is for a trainer to play the part of the mother, while one of the participants takes her history.

As you follow the text, remember:

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

I. Prepare for the exercise (10 minutes)

□ Give each participant a copy of the Breastfeeding History Form.
Explain that this is exactly the same form as they studied in Session 17.

□ Give each participant a copy of one of the histories and a growth chart filled in for the baby in the history.

Explain what they will do:

- Use role-play to practise taking a breastfeeding history. Follow the Breastfeeding History Form.

- Work in pairs, and take it in turns to be a `mother' or a `counsellor'. When you are a `mother', play the part of the mother in the history on your card. Your partner takes your history.

- You are the only one in the group who has a copy of your history. Conceal it from the others. Look only at your own history.

- Give yourself and your baby a name, either your own real name, or another if you prefer.

- Other participants in the group observe the pair practice, until it is their turn.

 Explain how the histories are arranged:

- First there is the *Reason for visit* including the mother's complaint, if she has one.

- Then there is the *History,* with six sections, which are the same as the six sections in the Breastfeeding History Form. There is some information in each section, so it is important to ask questions relating to each section of the form.

 Ask participants to read their histories through, and to study the growth chart. Allow 3 minutes.

They can ask you questions about anything that they do not understand.

 Explain how to do the pair practice:

- If you are the `counsellor':
  - Greet the `mother' and ask her how she is. Use her name and her baby's name.
  - Ask one or two open questions about breastfeeding to start the conversation.
  - Ask the `mother' questions from all six sections of the Breastfeeding History Form, and look at the baby's growth chart to learn about the situation.
  - You can make brief notes on the form, but try not to let it become a barrier.
  - Use your listening and learning skills.
  - Do not give information or suggestions, or give any advice.

- If you are the `mother':
  - Read out the *Reason for visit* in response to the `counsellor's' open questions.
  - Answer the `counsellor's' questions from the information in your history.
  - If the information to answer a questions is not in your history, make up information to fit with the history.
  - If your `counsellor' uses good listening and learning skills, give her the information more easily.

- If you are observing:
  - Follow the pair practice with your Breastfeeding History Form, and observe if the

`counsellor' takes the history correctly.
- Notice if she asks relevant questions, if she misses important questions, and if she asks questions from all sections of the form.
- Try to decide if the `counsellor' has understood the mother's situation correctly.
- During discussion, be prepared to praise what the players do right, and to suggest what they could do better.

II. Conduct the pair practice (60 minutes)

EXERCISE 15. ***Taking a breastfeeding history***

How to conduct the exercise

☺ Ask one pair in the group to practise taking a history. Ask the pair to sit on two chairs, next to each other, and slightly separate from the group.

 Let the pair continue for a while, without interrupting.

Follow the story in your copy of the Trainer's Guide. If the pair are doing well, let them go on until they finish. If they make many mistakes, or get confused, or do not follow the history, stop them, and give them a chance to correct themselves. Ask them how they feel they are doing, and what they think they should do differently.

Ask other participants in the group to say what they have observed. Then say what you think.
Praise what the pair did right, and then comment on these things:
- How well the `counsellor' took the history.
- If she understood the `mother's' situation correctly.

Use the **Comments** at the end of each history to help the discussion. They tell you:
- The main points that the story illustrates, and which the `counsellor' should conclude.
- How taking a history helps you to understand the mother's situation better, so that you can help her more effectively.

 If necessary, let the pair try again, at least for a short time.

Try to finish the exercise with participants doing some things well.
Thank them and congratulate them for their efforts.

 Ask another pair to practise.

Make sure that each member of the group has a chance to be a `counsellor' at least once.
If a pair has practised satisfactorily, give them another story to work with by themselves, while you help others in the group. You can join the pair for part of the time to observe how they are doing. Praise what they do right, and help them if they are having difficulties.

History 1.

Reason for visit: "I have brought (baby's name) for immunization. Everything is fine."

History: 1. I give him formula, about 3 bottles a day, with 2 spoonfuls of milk powder in each bottle. He had difficulty in suckling when he was born, so I gave him bottle feeds while I tried to breastfeed. He has refused to breastfeed for 2 weeks.

2. He is 6 weeks old and weighs 2.5 kilos. He was born in hospital and weighed 2.0 kilos. He has 2-3 soft stools a day.
3. No-one discussed breastfeeding in the antenatal clinic. In hospital, he was in the nursery for 6 hours. The midwives did not help me to breastfeed. I was discharged after 24 hours. I started trying to breastfeed after 2 days. This is my first visit to a health centre.
4. I am 19 years old, and healthy. I had plenty of milk, and I wanted to breastfeed. But my nipples are flat, so I could not.
5. This is my first baby.
6. I am a housewife, and my husband bought the tins of formula. I have not thought about family planning. My mother lives a long way away.

Comments The baby refused to breastfeed because he was given bottle feeds. The mother did not **History 1** have early contact, or help to breastfeed in the first day. She needed help for flat nipples, this is her first baby, and her baby was small. She did not complain about her difficulties, and you only learn about this serious situation by taking a history.

History 2.

Reason for visit: "(Baby's name) has diarrhoea".

History: 1. I breastfeed him often, and he sleeps with me at night. I give him thin cereals in a bottle, 2-3 times a day. I started this when he was 6 weeks old.

2. He was born in hospital, and weighed 3.0 kilos. He weighed 4.5 kilos at 2 months, and weighs 4.8 kilos now, at the age of 4 months.
   When he was 6 weeks old, he cried to be fed often; that is why I started cereal feeds. But now he has less appetite, and is passing watery stools.
3. He started to breastfeed soon after delivery. The midwife helped me and I had no difficulties.
4. I am aged 30, and well. I rely on breastfeeding for family planning until my periods start again.
5. I had two previous children. I breastfed both without any difficulty.
6. I work on a small farm with my husband and his parents. My mother-in-law helps me very much. She advised me to start cereals, because of the crying.

Comments Her baby was hungry with a growth spurt. She gave dilute cereal feeds but they were not
History 2 necessary. This has caused diarrhoea. You know the reason for the diarrhoea by the end of Section 1. However, in Section 6, you learn that it is her mother who advises her.

History 3.

Reason for visit: "I have sore nipples."

History: 1. I breastfeed my baby many times a day, for about 20-30 minutes each time.
2. She weighed 4.0 kilos when she was born. Now she is 3 weeks old and weighs 4.5 kilos. She is well.
3. She was born by Caesarian section, and was kept in the nursery and bottle fed for 2 days. Since then I have been trying to breastfeed, but my baby had difficulty in learning to suckle. The midwives suggested bottles, but I did not want to bottle feed. I persisted with breastfeeding until now. Nobody asked me about breastfeeding at the antenatal clinic.
4. I am 26, and healthy. I am disappointed because I really want to breastfeed, but my nipples hurt so much that I will have to give up. They bleed sometimes.
5. I had one baby before. I breastfed him, but I never had enough milk and he was never satisfied. I gave up after a few weeks.
6. I am divorced, but my mother stays with me and helps me with the children.

Comments She did not receive the necessary help from the hospital staff to enable her to breastfeed.
History 3 Her baby is suckling in a poor position, which is causing sore nipples. She is growing, so she must be getting plenty of milk, but she is suckling inefficiently, and needs to suckle often and for a long time. You know her main problem early in the history. But it is important to know that she had problems breastfeeding her previous baby.

History 4.

Reason for visit: "I have come for my six weeks check-up. Everything is fine."

History: 1. I breastfeed her quite often. I don't give her anything else, but I have bought a pacifier which I give her to suck when she cries.
2. I don't know her birth weight. She weighs 4.9 kilos today. She cries a lot, and doesn't seem satisfied. She passes soft stools several times a day. Otherwise she is well.
3. She was born at home, and started breastfeeding soon after delivery. She had some water for the first few days. My mother helped me to breastfeed.
4. I am 15 years old, and have had to stop going to school. I am worried that breastfeeding will spoil my figure. I want to bottle feed, like the advertisements. I will get some milk, when I have some money.
5. I have not had a baby before.
6. I live at home with my mother, who farms. She says that the baby cries a lot because I am too young and I probably don't have enough milk. She wants to give him bottle feeds, too.

Comments The mother is very young, and not very motivated to breastfeed. She says that everything
History 4 is fine, but the grandmother is making her lose confidence in her milk.
You only learn about these important things quite late in the history, so it is useful to check through all the sections.

History 5.

Reason for visit: "I have a painful swelling in my breast, and I feel feverish."

History: 1. I breastfeed my baby whenever I am at home, about once in the morning, twice in the evening, and once or twice at night. She suckles for about 5 minutes each time. I am too busy to breastfeed her for long. While I am working, my helper gives her bottle feeds of formula. This started when I went back to work about 1 month ago. Before that I just breastfed.

2. My baby is healthy. She weighed 3.5 kilos at birth. Now she is 4 months old and weighs 5.9 kilos. I don't know how often she passes urine - I am not at home.
3. She was born at home, and I breastfed her straight away. The community midwife helped me.
4. I am 27 years old, and healthy. I had a painful swelling in the other breast soon after I went back to work. It was at the weekend, I continued breastfeeding, and it got better by itself. This time it is worse.
5. I have one older child. I breastfed him for 4 months, until my milk dried up. I started work when he was 2 months old, and bottle fed him when I was out. I was very disappointed when I had to stop breastfeeding.
6. I work in a factory, and I am away from home for about 10 hours every day. I am exhausted when I get home. I have a helper who cares for the children. My parents live a long way away.

Comment: She has mastitis, probably because her baby is only feeding for a short time, and not **History 5** often enough, so he is not emptying the breasts properly. It is important not to stop when you make the diagnosis of mastitis, but to continue to section 6, so that you learn how busy and tired this mother is. That is important for the management.

Session 19

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BREAST EXAMINATION

Objectives

At the end of this session, participants should be able to:
- examine a woman's breasts correctly and gently;
- talk to her about their findings.

Session outline (30 minutes)

Participants are in groups of 8-10, with two trainers.

I.	Introduce the topic	(3 minutes)
II.	Demonstrate how to examine a woman's breasts	(15 minutes)
III.	Discuss what to say to the woman	(12 minutes)

Preparation

Refer to pages 12-13 of the Introduction for general guidance on how to give a demonstration; and to page 6 for instructions `How to make a model breast'.
Study the notes for the session, so that you are clear about what to do.

Before the course:
Obtain or make several cloth models of breasts.

Before the session:
Ask a participant to help you to give the demonstration.
Explain that she will sit on a chair, and pretend to be the woman whom you are examining. (Reassure her that she will remain dressed.) She can if she wishes wear an old tee-shirt with breasts drawn on it.

As you follow the text, remember:

 indicates an instruction to you, the trainer
▪ indicates what you say to the participants

I. Introduce the topic (3 minutes)

Ask participants to find the box **HOW TO EXAMINE A WOMAN'S BREASTS** on page 103 of their manuals.

 Explain that you will demonstrate breast examination, and then they can practise on a model breast. You will also discuss talking to the woman about your findings.

 Make these points:

- It is not necessary to examine breasts routinely, antenatally or postnatally. However, it may be the practice in your facility to examine breasts antenatally.

- You need to examine the breasts, either antenatally or postnatally, if you suspect a breast problem, or if the woman is worried about her breasts.

II. Demonstrate how to examine a woman's breasts (15 minutes)

 Discuss the technique:

- It is important to examine breasts gently and modestly, because they are a sensitive part of the body.

- To examine the breasts, first look at or *inspect* them. After delivery, you often learn all that you need by inspection while you observe a breastfeed and before or after it.

- Sometimes you need to feel or *palpate* a woman's breasts. This is only necessary if you suspect a breast problem. It is not necessary as a routine.

Ask: *What can you learn by inspecting breasts?*
(Let participants suggest. Then mention any of the following points that they did not think of.)

- The size and shape of the breasts.
  (A mother may lack confidence because of the size or shape of her breasts.)
- The size and shape of the nipple and areola.
  (Women may worry about this. Some nipple shapes can cause more difficulty with attachment than others.)
- Whether milk is dripping from one or other breast.
  (A sign of the oxytocin reflex.)
- If the breasts look soft, full or engorged.
- Fissures around the base or across the tip of the nipple.
- Redness, suggesting inflammation and possibly infection.
- Scars from breast surgery, for example, if she had a breast abscess.

(This tells you that she had problems previously.)

Ask: *What may you notice as a baby finishes a feed?*

- If you see the baby release the breast, you may see the nipple pulled out long, showing that it is *protractile* (easily stretched, remember Slide 14/2).
- You may notice that the nipple looks squashed, or that there is a line across the tip or down the side. This suggests that the baby was poorly attached.

Ask: *What may you learn by palpating a breast?*
(Let participants suggest. Then add any of the following that they did not think of.)

- If the breast is full, hard or engorged.
- If there are any lumps, hard areas, hot patches, or tenderness.
- If the nipple is protractile.

 Give the demonstration:

As you follow each step:

- *Demonstrate how to talk to and touch the mother.*
  Explain what you want to do, and ask her permission before you do it.
  Be gentle, and talk in a way which builds her confidence.
  Be careful not to sound critical.
  (Do NOT say things like "Oh, your nipples are rather flat!")

- *Explain to participants what you are doing.*

☺ Ask the *participant* who is helping you to sit on a chair facing the class. She should be `breastfeeding' a doll, and holding a model breast.
When you greet her, and ask how she is, she says "I have a swelling in my breast".

 Follow these steps:

- As this *is* a *postnatal* examination, wait until the baby has finished breastfeeding. Do not interrupt the feed. Take the opportunity to observe the breastfeed.

- Explain to *the* mother that you would like to look at her breasts, and ask her permission.

- *Inspect* her *breasts*, without touching.
  (Tell participants what you are looking for, and what you see.)

- Ask her *what* symptoms she has had, and if she has had any pain or tenderness. Ask her to point to the place. (She points to the swelling.)

- Explain that you would now like to feel her breasts.
  Before you touch them, ask her permission.

- Demonstrate palpation using the model breast.
  If you do not have a model, use the soft part of your forearm.

  Explain what you are doing as you do it:
  - hold your hand flat with the fingers together and straight;
  - feel gently all over the breast with the flat of your hand;
  - watch the mother's face as you palpate, so that you notice any tenderness.

- Show what NOT to do.
  Pinch and poke the model breast. Explain that this is painful for the mother, and does not tell you what you need to know.

 Demonstrate testing for protractility:
  (For example, if a mother is worried about the shape of her nipples.)

- Explain to the mother that you would now like to see how easily her nipples pull out. Explain that you would like her to do this herself.
  Ask her to place a finger and thumb on the areola either side of the nipple, and gently try to pull the nipple out.

- Thank the `mother', and talk to her about what you have found.

☺ Ask participants to practise palpating a breast:

They can practise either on a model breast, or on the soft part of their forearm.
They should use the flat of their hand, and palpate all parts of the breast.

III. Discuss what to say to the mother (12 minutes)

 Make these points:

- When you have examined a woman's breasts, you need to decide what you will say to her.

- Use your confidence and support skills.

☺ Ask participants to practise what they would say to a woman at an antenatal visit in these situations:

1. Her breasts are perfectly alright;
2. There is something that worries the mother, but which should not cause any difficulty with breastfeeding;
3. You find something that could cause difficulties with breastfeeding.

Ask: *What would you say if her breasts are perfectly alright?*
(Ask a few participants in turn to practise what they would say.)

Praise her. Say something like this:
"Your breasts are very good for breastfeeding."

Ask: *What would you say to a woman who has very small areolas, and she thinks that they will make it difficult for the baby to breastfeed?*
(Let participants practise what they would say.)

They should say things to build her confidence in this way:
- Accept her worries.
- Give praise - for example, that her breasts are protractile, or full of milk.
- Give relevant information:
  "Breasts come in many shapes and sizes - but the part inside where the milk comes from is the same."
  "If he takes a good mouthful of breast tissue, he will be able to get the milk."

Ask: *What would you say to a woman who has inverted nipples?*
(Let participants practise what they would say.)

They should try to build her confidence in this way:

If she is not worried:
- Praise her for wanting to breastfeed.
- It may be better to say nothing about her nipples.
- Wait and see how breastfeeding goes, and be ready to help her if she does have difficulties.

If she is worried:
- Give her accurate, relevant information about her condition.
  (Babies suckle from the breast, not the nipple; nipples improve after delivery; it may take a little longer for the baby to learn to breastfed.)
- Be positive, and encourage her to believe that breastfeeding is possible.
  (Many babies breastfeed from breasts of this shape.)
- Suggest what she can do to help her baby to breastfeed.
  (Let him explore the breast and try to suckle soon after delivery. Help him to take a big mouthful of breast. If necessary, express her milk and feed it from a cup while he learns to suckle.)
- Explain that you or your colleagues will help her.

HOW TO EXAMINE A WOMAN'S BREASTS

Not necessary as a routine - only if you or the woman are concerned.
If postnatal, examine before breastfeed, or wait until baby finishes.
Do the examination gently and modestly.

. Explain what you want to do. Ask the mother's permission.

. Inspect her breasts without touching. Look for:
- size and shape of breast (may affect confidence)
- size and shape of nipple (may affect attachment)
- dripping milk (sign of active oxytocin reflex)
- full, soft, engorged
- fissures around base or across tip
- redness (inflammation or infection)
- at end of feed, protracted or squashed
- scars (breast surgery, previous abscess)

. Ask if she has noticed anything wrong.
If "yes", ask her to point to the place.

. If it is necessary to palpate, ask her permission.

. Palpate gently all parts of both breasts.
Use the flat of your hand (fingers together and straight).
Do not pinch or poke.
Watch mother's face for signs of pain or tenderness.
Feel for:
- generalized fullness, hardness, engorgement
- localized hardness, hot areas, lumps

. Ask mother to show how easily her nipples stretch out (protract).
(She places her finger and thumb on the areola either side of her nipple, and tries to stretch the nipple out).

. Talk to the mother about what you have found.
Use confidence and support skills.
Do not say anything critical, and do not tell her things that will worry her, when it is not necessary to do so.

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BREASTFEEDING COUNSELLING

A TRAINING COURSE

TRAINER'S GUIDE

PART THREE

Sessions 20-30

WORLD HEALTH ORGANIZATION CDD PROGRAMME

UNICEF

CONTENTS

Total time for sessions 1-30 (+ 2 videos)

33½ + 1 hr

Session 20

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EXPRESSING BREASTMILK

Objectives

At the end of this session, participants should be able to:
- explain when it is useful for a mother to express breastmilk;
- help a mother to stimulate her oxytocin reflex;
- teach a mother an effective technique for hand expression.

Session outline (40 minutes + 30 minutes optional)

Participants are together as a class for a demonstration by one trainer.

I. Introduce the topic (7 minutes)

II. Demonstrate how to stimulate the oxytocin reflex (15 minutes)

III. Demonstrate how to express breastmilk by hand (15 minutes)

Optional (IV - VI)

IV. Ask a mother to demonstrate expressing breastmilk (10 minutes extra)

V. Demonstrate breast pumps (10 minutes extra)

VI. Demonstrate the warm bottle method for expressing breastmilk (10 minutes extra)

VII. Summarize `Expressing breastmilk' (3 minutes)

Preparation

Refer to pages 12-13 of the Introduction for general guidance on how to give a demonstration, and to page 6 for instructions `How to make a model breast'.
Study the notes for the session so that you are clear what to do.

Before the course:
Obtain some examples of suitable containers to collect expressed breastmilk, that would be available to ordinary mothers (for example, cups, jam jars).

Decide if you will do any of the optional demonstrations.

If possible, ask a mother who regularly expresses her milk to come and demonstrate to participants (for example, a mother who works outside the home, or a mother of a low-birth-weight baby).

To demonstrate breast pumps:
Collect samples of any breast pumps that are available in the area, from hospitals, or from shops.
(If none are available or used, do not give this demonstration.)

To demonstrate the warm bottle method:
Give this demonstration only if you have had experience using the method and you know which locally available bottles are appropriate.
Find a suitable wide-necked glass (not plastic) bottle, that is readily available in the area.
The bottle should be large (1-3 litres is suitable, not less than 700 ml), with a wide neck (at least 2 cm and if possible 4 cm diameter).
Clean it thoroughly.
Have a pan of hot water available. (In the mother's home, you would ask the family to heat some water.)

Before the session:
Ask a participant to help you to demonstrate back massage to stimulate the oxytocin reflex. Explain what you want her to do.

As you follow the text, remember:

☐ indicates an instruction to you, the trainer
■ indicates what you say to participants

I. Introduce the topic (7 minutes)

Ask participants to keep their manuals closed.

☐ Explain the purpose of the session:

■ In this session you will learn how to express breastmilk effectively. Expressing breastmilk is helpful in a number of situations. Difficulties can arise, but they are often due to poor technique.

■ Many mothers are able to express plenty of breastmilk using rather strange techniques. If a mother's technique works for her, let her continue to do it that way. But if a mother is having difficulty expressing enough milk, teach her a more effective technique.

☐ Discuss when it is useful to express breast milk.

Ask: *In which situations is it useful for a mother to express her breastmilk?*
(Let participants suggest.)
(Remind them that it was mentioned in Session 14, `Breast conditions', and Session 16, `Refusal to breastfeed'. Other situations when it is useful will be discussed in Session 26, `Low-birth-weight and sick babies' and Session 32, `Women and work'.)

→ Write participants' ideas on a board.

Try to develop a list with most of the ideas below.
After a few minutes, if participants cannot think of any more, complete the list for them.
Expressing milk is useful to:
- relieve engorgement;
- relieve blocked duct or milk stasis;
- feed a baby while he learns to suckle from an inverted nipple;
- feed a baby who has difficulty in coordinating suckling;
- feed a baby who `refuses', while he learns to enjoy breastfeeding;
- feed a low-birth-weight baby who cannot breastfeed;
- feed a sick baby, who cannot suckle enough;
- keep up the supply of breastmilk when a mother or baby is ill;
- leave breastmilk for a baby when his mother goes out or to work;
- prevent leaking when a mother is away from her baby;

- help a baby to attach to a full breast;
- express breastmilk directly into a baby's mouth;
- prevent the nipple and areola from becoming dry or sore.

- So there are many situations in which expressing breastmilk is useful and important to enable a mother to initiate or to continue breastfeeding.

- Some experts consider that all mothers should learn how to express their milk, so that they know what to do if the need arises. Certainly all health workers who care for breastfeeding mothers should be able to teach mothers how to express their milk.

II. Demonstrate how to stimulate the oxytocin reflex (15 minutes)

☐ Discuss why stimulating the oxytocin reflex is helpful:

Ask: *Why is it helpful to stimulate a mother's oxytocin reflex before she expresses milk?*
(Encourage participants to recall what they learnt about how breastfeeding works. Give them a minute to think and make a few suggestions, then continue.)

It is important that the oxytocin reflex works to make the milk flow from her breasts.

- The oxytocin reflex may not work as well when a mother expresses as it does when a baby suckles. A mother needs to know how to help her oxytocin reflex, or she may find it difficult to express her milk.

Ask: *What ways can you think of to stimulate the oxytocin reflex?*
(Ask participants to remember what they know about the oxytocin reflex, and what helps it. Let them make a few suggestions, and then continue.
Ask them to refer to Fig.9 (Overhead 3/3) and Fig.10 (Overhead 3/4) on pages 13-14 in their manuals, to remind them what helps and hinders the oxytocin reflex.)

☐ Ask participants to turn to page 105 of their manuals and to find the box **HOW TO STIMULATE THE OXYTOCIN REFLEX**.

Read through the box, explaining anything that is not clear.

Demonstrate with a model breast how a mother can stimulate her nipples or massage or stroke her breasts.

Ask: *What techniques for making breastmilk flow do you know of in your community?*
(Let participants describe any methods that they have heard of. These may be useful to remember.)

HOW TO STIMULATE THE OXYTOCIN REFLEX

Help the mother *psychologically:*

- Build her confidence
- Try to reduce any sources of pain or anxiety
- Help her to have good thoughts and feelings about the baby

Help the mother *practically.* Help or advise her to:

- *Sit quietly and privately or with a supportive friend.*
  Some mothers can express easily in a group of other mothers who are also expressing for their babies.

- *Hold her baby with skin-to-skin contact if possible.*
  She can hold her baby on her lap while she expresses. If this is not possible, she can look at the baby. If this is not possible, sometimes even looking at a photograph of her baby helps.

- *Take a warm soothing drink*.
  The drink should not be coffee.

- *Warm her breasts.*
  For example, she can apply a warm compress, or warm water, or have a warm shower.

- *Stimulate her nipples.*
  She can gently pull or roll her nipples with her fingers.

- *Massage or stroke her breasts lightly*.
  Some women find that it helps if they stroke the breast gently with finger tips or with a comb.
  Some women find that it helps to gently roll their closed fist over the breast towards the nipple.

- *Ask a helper to rub her back.*
  The mother sits down, leans forward, folds her arms on a table in front of her, and rests her head on her arms. Her breasts hang loose, unclothed.
  The helper rubs down both sides of the mother's spine. She uses her closed fist with her thumbs pointing forwards. She presses firmly making small circular movements with her thumbs. She works down both sides of the spine at the same time, from the neck to the shoulder blades, for two or three minutes (Fig.6).

☐ Demonstrate how to rub a mother's back:
Fig.6 (Fig.30 in the Participants' Manual) illustrates the technique.

☺ Ask the participant who will help you to sit at the table resting her head on her arms, as relaxed as possible.

She remains clothed, but explain that with a patient it is important for her breasts and her back to be naked.
Make sure that the chair is far enough away from the table for her breasts to hang free. Explain what you will do, and ask her permission to do it.

Rub both sides of her spine with your thumbs, making small circular movements, from her neck to her shoulder blades (see box inset in Fig.6).
Ask her how she feels, and if it makes her feel relaxed.

☐ Participants practise rubbing a mother's back:

☺ Ask participants to work in pairs and briefly practise the technique of rubbing a mother's back.

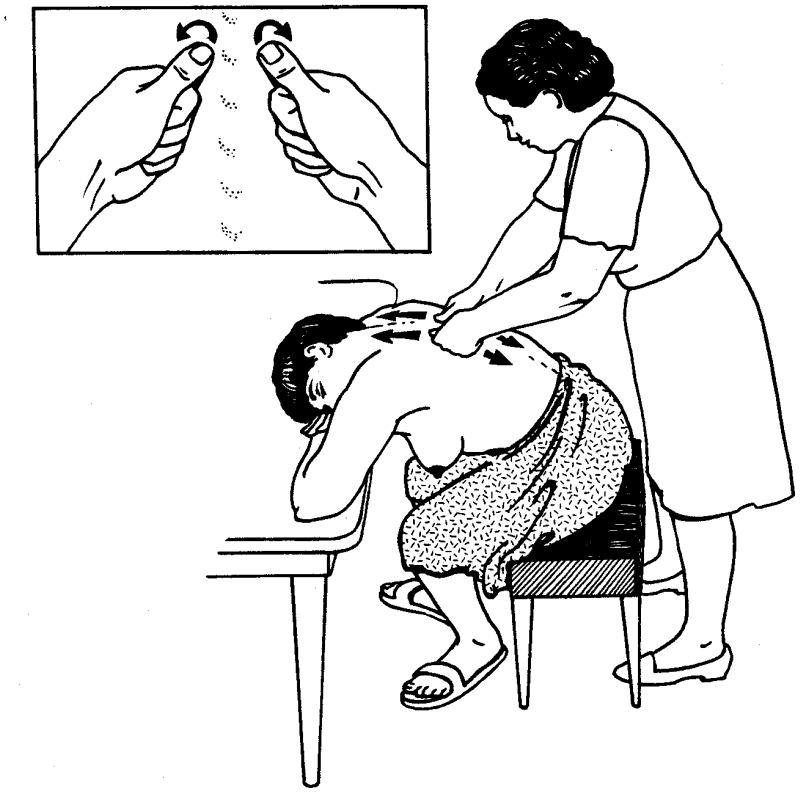

Fig.6 A helper rubbing a mother's back to stimulate the oxytocin reflex
(Fig.30 in Participants' Manual)

III. Demonstrate how to express breastmilk by hand (15 minutes)

☐ Make these points:

- Hand expression is the most useful way to express milk. It needs no appliance, so a woman can do it anywhere, at any time.

- It is easy 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 or second day after delivery. Do not wait until the third day, when her breasts are full.

- **Key point:** *A woman should express her own breastmilk.* The breasts are easily hurt if another person tries. If you are showing a woman how to express, show her on your own body as much as possible, while she copies you. If you need to touch her to show her exactly where to press her breast, be very gentle.

☐ Explain how to prepare a container for the expressed breastmilk (EBM).
(Do this demonstration quickly. Do not let it take a long time.)

Show participants some of the containers to hold the expressed breastmilk that you have collected. Go through the following points:

HOW TO PREPARE A CONTAINER FOR EXPRESSED BREASTMILK (EBM)

- Choose a cup, glass, 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.

☐ Give the demonstration of how to express breastmilk by hand:

Demonstrate as much as possible on your own body. If you prefer not to use your own body, 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 BREASTMILK BY HAND**, explaining what you do.

HOW TO EXPRESS BREASTMILK BY HAND

Teach a mother to do this herself. Do not express her milk for her.
Touch her only to show her what to do, and be gentle.

Teach her to:

- 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 on the breast BELOW the nipple and areola, opposite the thumb. She supports the breast with her other fingers (see Fig.7).

- Press her thumb and first finger 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 finger and thumb.
  She must press on the lactiferous sinuses beneath the areola
  (see Overhead 3/1).
  Sometimes in a lactating breast it is possible to feel the sinuses. 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 the nipple itself. Pressing or pulling the nipple cannot express the milk. It is the same as the baby sucking only the nipple.

- Express one breast for at least 3 - 5 minutes until the flow slows; then express the other side; and then repeat both sides. She can use either hand for either breast, and change when they tire.

  Explain that to express breastmilk 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.

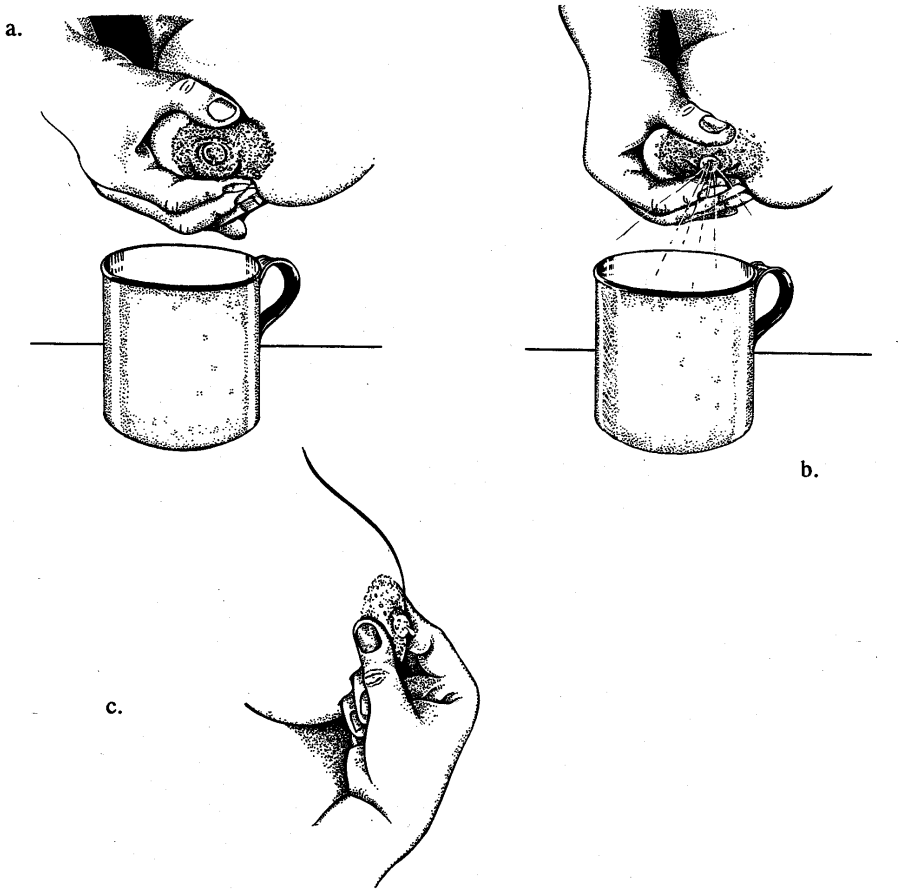

Fig.7 How to express breastmilk.

(Fig.31 in Participants' Manual)

a. Place finger and thumb each side of the areola and press inwards towards the chest wall.
b. Press behind the nipple and areola between your finger and thumb.
c. Press from the sides to empty all segments.

☐ Tell participants that they can find the box **HOW TO EXPRESS BREASTMILK BY HAND** on page 107 of their manuals, and the figures on page 108.

☐ Discuss how often to express milk:

Ask: *How often should a mother express her breastmilk?*
(Let participants give their ideas. Praise them for correct ideas, and make sure that the following points are clear.)

It depends on the reason for expressing the milk, but usually as often as the baby would breastfeed.

- To establish lactation, to feed a low-birth-weight (LBW) or sick newborn:
  - *She should start to express milk on the first day, within six hours of delivery if possible.* She may only express a few drops of colostrum at first, but it helps

breastmilk production to begin, in the same way that a baby suckling soon after delivery helps breastmilk production to begin.

- *She should express as much as she can as often as her baby would breastfeed.*
  This should be at least every 3 hours, including during the night.
  If she expresses only a few times, or if there are long intervals between expressions, she may not be able to produce enough milk.

- To keep up her milk supply to feed a sick baby:
  She should express at least every 3 hours.

- To build up her milk supply, if it seems to be decreasing after a few weeks:
  Express very often for a few days (every ½-1 hour), and at least every 3 hours during the night.

- To leave milk for a baby while she is out at work:
  Express as much as possible before she goes to work, to leave for her baby. It is also very important to express while at work to help keep up her supply (see Session 32, `Women and work').

- To relieve symptoms, such as engorgement, or leaking at work:
  Express only as much as is necessary.

- To keep nipple skin healthy:
  Express a small drop to rub on nipple after a bath or shower.

☺ Ask participants to practise the technique.

Ask them to practise the rolling action of the fingers on a model breast or on their arms. Ask them to make sure that they avoid pinching.

Ask them to practise on their own bodies privately later.

IV. Ask a mother to demonstrate expressing breastmilk (10 minutes extra)

If you have found a mother who is willing to give this demonstration to the group, ask her to do so now.

☐ Give her a comfortable place to sit where she can be modest and private. If possible give her a pleasant drink.

Let participants observe her in groups of 4-5.
Ask her to express her milk, and to explain her technique to the participants.

☐ Discuss the mother's technique.

Hold the discussion after the mother has finished, and where she cannot hear you.
She may not have used the exact technique described in the manual. However, if she manages to express enough milk, then her technique is good enough for her.

If you have not found a mother who is willing to give a demonstration, suggest that

participants try to observe mothers expressing their breastmilk when they are on the wards during clinical practice sessions.

V. Demonstrate breast pumps (10 minutes extra)

☐ Display the breast pumps available in the area:

Pass them round for participants to examine. Ask if they have used them, and what their experiences are.
- Do they find the pumps useful?
- Do mothers find them useful?
- What problems have they encountered?
- Do they find them more or less satisfactory than hand expression?

☐ Explain the need for breast pumps:

- If breasts are engorged and painful, it is sometimes difficult to express milk by hand. It can be helpful to express with a pump. A pump is easier to use when the breasts are full. It is not so easy to use when the breasts are soft.

☐ Demonstrate how to use a rubber bulb pump:

Point out the rubber bulb which creates suction. Point out the glass tube with a wide opening to fit over the nipple, and a swelling in the side to collect milk.

Use a model breast to demonstrate how a mother should use the pump.
Follow these steps, and explain what you do:

- Compress the rubber bulb to push out the air.
- Place the wide end of the tube over the nipple.
- Make sure that the glass touches the skin all around, to make an airtight seal.
- Release the bulb. The nipple and areola are sucked into the glass.
- Compress and release the bulb again, several times.
  After compressing and releasing the bulb a few times, milk starts to flow. The milk collects in the swelling on the side of the tube.
- Break the seal to empty out the milk, and start again.

☐ Explain the disadvantages of rubber bulb pumps:

- They are not suitable for collecting milk to feed a baby.
  They are difficult to clean properly. Milk may collect in the rubber bulb and it is difficult to clean out. The milk which collects is often contaminated.

- They are not very efficient, especially when the breasts are soft.
  They are useful mainly to relieve engorgement, when hand expression is difficult. That is why they are often called `breast relievers'.

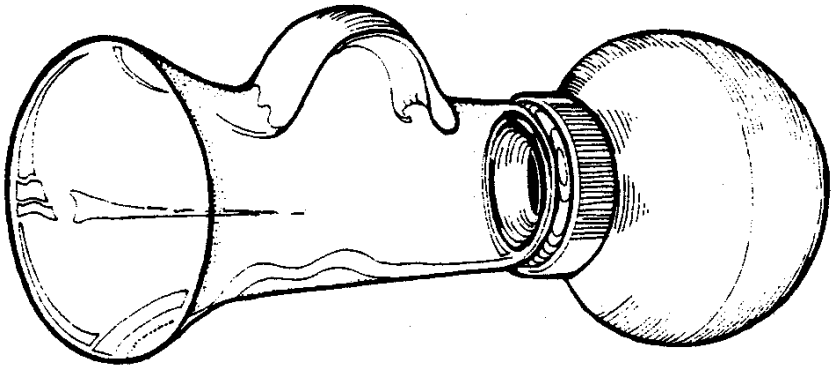

Fig.8 Rubber bulb breast pump

(Fig.32 in Participants' Manual)

☐ Demonstrate how to use a syringe pump:

Point out the funnel-shaped wide end that fits over the nipple. The funnel is attached to the inner plunger of the body of the pump, which fits inside an outer cylinder. Milk collects in the larger, outer cylinder.

Use a model breast to demonstrate how a mother should use the pump:

- Make sure that the plunger is inside the outer cylinder.
- Make sure that the rubber seal is in good flexible condition.
- Put the funnel over the nipple.
- Make sure that it touches skin all round, to make an airtight seal.
- Pull the outer cylinder down. The nipple is sucked into the funnel.
- Release the outer cylinder, and then pull down again.
  After a minute or two milk starts to flow, and collects in the outer cylinder.
- When milk stops flowing, break the seal, pour out the milk, and then repeat the procedure.

☐ Explain the advantages of syringe pumps:

- A syringe pump is more efficient than a rubber bulb pump, and it is easier to clean and to sterilize.

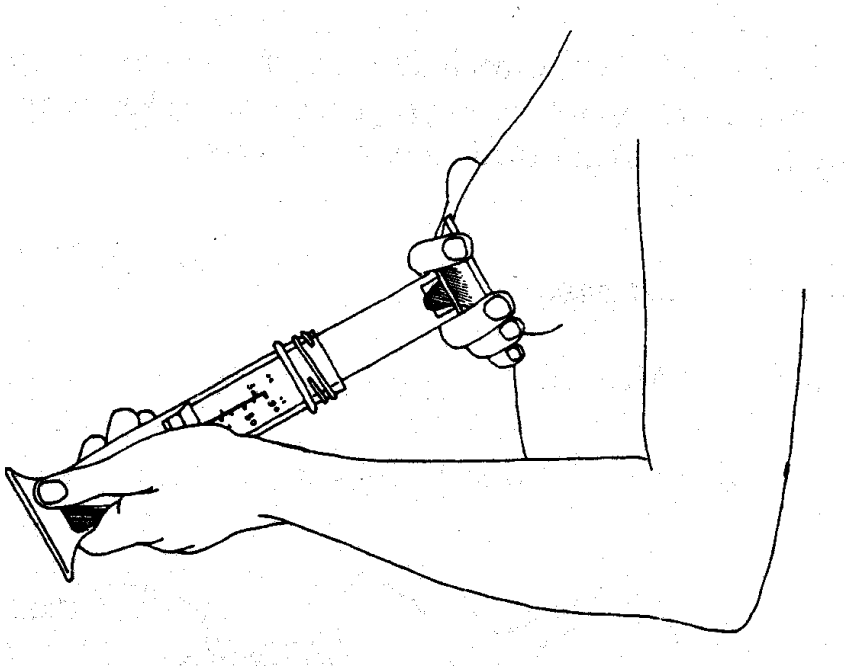

Fig.9 Syringe breast pump (Fig.33 in Participants' Manual)

☐ Discuss electric breast pumps briefly:

- Electric pumps can be used in hospital.
  However, they are not practical for routine use, or for mothers at home.
  They can easily carry infection, which is especially dangerous if more than one woman uses the same pump.

VI. Demonstrate the warm bottle method for the expression of breastmilk

(10 minutes extra)

Demonstrate this method only if you have experience of using it.

Prepare a wide-necked glass bottle, and a pan of hot water (see the ***Preparation*** box for this session, on page 258).

☐ Explain the reasons for the technique:

- This is a useful technique to relieve severe engorgement, when a breast is very tender, and the nipple is tight, so that hand expression is difficult.

☐ Explain what you need for this method:

- You need a suitable bottle:
  - made of glass, not plastic;
  - 1-3 litres in size - not smaller than 700 ml;
  - with a wide neck - at least 2 cm diameter, if possible 4 cm - so that the nipple can fit into it easily.

- You also need:
  - a pan of hot water, to warm the bottle,
  - some cold water, to cool the neck of the bottle;
  - a thick cloth, to hold the hot bottle.

☐ Demonstrate the method:

- Pour a little of the hot water into the bottle to start warming it up. Then almost fill the bottle with hot water. Do not fill it right up too quickly or the glass will crack.

- Let the bottle stand for a few minutes to warm the glass.

- Wrap the bottle in the cloth, and pour the hot water back into the pan.

- COOL THE NECK OF THE BOTTLE with cold water, inside and outside. (If you do not cool the neck of the bottle, you may burn the nipple skin.)

- Put the neck of the bottle over the nipple, touching the skin all round to make an airtight seal.
  For the demonstration, use the soft part of your hand or forearm.

- Hold the bottle steady. After a few minutes the whole bottle cools, and makes gentle suction, which pulls the nipple into the neck of the bottle.
  Sometimes when a woman first feels the suction, she is surprised and pulls away. You may have to start again.

- The warmth helps the oxytocin reflex, and milk starts to flow, and collects in the bottle. Keep the bottle there as long as the milk flows.

- Pour out the breastmilk, and repeat if necessary, or do the same for the other breast.
  After some time, the acute pain in the breasts becomes less, and hand expression or suckling may become possible.

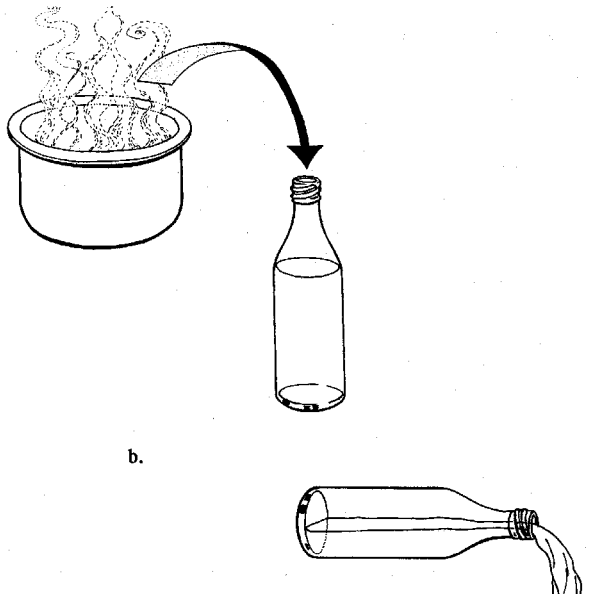

Fig.10 The warm bottle method
a. Put hot water into a bottle
b. Pour out the water
(Fig.34 in Participants' Manual)

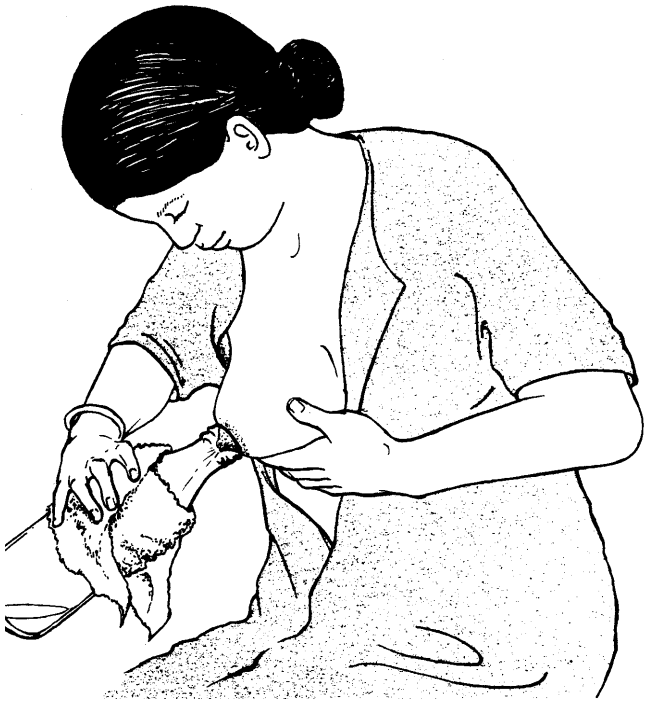

Fig.10 contd.
The warm bottle method

c. The mother holds the warm bottle over her nipple.

VII. Summarize `Expressing breastmilk' (3 minutes)

☐ Make these points:

- Hand expression is the most useful way to express breastmilk. It is less likely to carry infection than a pump, and is available to every woman at any time.

- It is important for women to learn to express their milk by hand, and not to think that a pump is necessary.

- To express milk effectively, it is helpful to stimulate the oxytocin reflex and to use a good technique. Stimulating the oxytocin reflex is helpful with pump expression, as well as with hand expression.

☐ Recommended reading
Helping Mothers to Breastfeed Chapter 10, sections 10.1, 10.2, and 10.3

Session 21

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"NOT ENOUGH MILK"

Objectives

At the end of this session, participants should be able to:
- decide if a baby is getting enough breastmilk or not;
- help mothers whose babies are not getting enough milk;
- help mothers who think that they do not have enough breastmilk.

Session outline (70 minutes)

Participants work in groups of 8-10, with two trainers.

I. Introduce the topic (5 minutes)

II. Discuss how to decide if a baby is getting enough milk or not (15 minutes)

III. Discuss the reasons why a baby may not get enough breastmilk (15 minutes)

Participants work in groups of 4-5, with one trainer.

IV. Discuss how to help a mother whose baby is not getting enough breastmilk (15 minutes)

V. Discuss how to help a mother who thinks that she does not have enough milk (15 minutes)

VI. Conclude "Not enough milk" (5 minutes)

Preparation

Refer to pages 13-15 of the Introduction for general guidance on how to conduct work in groups.
Study the notes for the session so that you are clear about what to do.

Prepare flipcharts or boards to write up lists of ideas.
You will need either a large board and a flipchart, or two flipcharts.
The board should be large enough for the schema **REASONS WHY A BABY MAY NOT GET ENOUGH BREASTMILK**. If there is no large board, use two flipcharts, one for `common reasons' and one for `less common reasons'.

If you do not have enough flipchart stands, post up sheets of flipchart paper of the wall to write on. Make sure that the room is arranged so that participants can see the lists.

Before the session, decide how you will write the schema out.

As you follow the text, remember:

☐ indicates an instruction to you, the trainer
■ indicates what you say to the participants

Do not present the **Further information** sections.
Use them to help you to answer questions.

I. Introduce the topic (5 minutes)

Ask participants to keep their <u>manuals closed</u>.

☐ Make this introductory point:

■ One of the commonest reasons that mothers give for starting bottle feeds, or for stopping breastfeeding, is that they think that they "do not have enough milk".

☐ Refer back to the list of reasons for stopping breastfeeding or for starting complementary foods early that you developed in Session 2, `Local breastfeeding situation'.

Remind participants if they identified "not enough milk" as an important cause in their

situation.

☐ Continue with these points:

- Usually, even when a mother thinks that she does not have enough breastmilk, her baby is in fact getting all that he needs. Almost all mothers can produce enough breastmilk for one or even two babies. They can almost all produce more than their baby needs.

- Sometimes a baby does not get enough breastmilk. But it is usually because he is not suckling enough, or not suckling effectively (see Session 3, `How breastfeeding works'). It is rarely because his mother cannot produce enough.

- So it is important to think not about *how much milk a mother can produce*, but about *how much milk a baby is getting*.

Further information
The problem of "not enough milk" may arise before breastfeeding has been established, in the first few days after delivery. Then the mother needs help to establish breastfeeding.
The problem may arise after breastfeeding has been established, after the baby is about a month of age. The mother needs help to maintain breastmilk production.
Some mothers worry that they do not have milk at a certain time of day, usually in the evening.
The causes of the problem and the needs of mothers in these different situations are sometimes different. It is important to be aware of this. However the same principles of management apply, so we will consider the three situations together.

II. Discuss how to decide if a baby is getting enough milk or not (15 minutes)

☐ Develop a list of signs that make mothers think that they do not have enough milk:

Ask: *What makes mothers think that they do not have enough milk?*

→ Write participants' ideas in a list on a flipchart or board.

Continue until you have a list of at least 10 signs, and if possible until someone has said "poor weight gain".

☐ Explain which signs are ***reliable*:**

- There are only two signs which show reliably that a baby is not getting enough milk. These are:

  - Poor weight gain.
  - Passing small amounts of concentrated urine.

→ If either sign is on the participants' list, <u>underline</u> it, and praise the participants for thinking of it.

→ Write the heading `RELIABLE SIGNS' on another flipchart or board.
Write the two signs below the heading.

RELIABLE SIGNS

Poor weight gain
Small amount of concentrated urine

☐ Explain which signs are ***possible*:**

→ Mark with a ✔ on the participants' list of signs, any of the following:

✔ Baby not satisfied after breastfeeds
✔ Baby cries often
✔ Very frequent breastfeeds
✔ Very long breastfeeds
✔ Baby refuses to breastfeed
✔ Baby has hard, dry, or green stools
✔ Baby has infrequent small stools
✔ No milk comes out when mother expresses
✔ Breasts did not enlarge (during pregnancy)
✔ Milk did not `come in' (after delivery)

- These are *possible signs.*
  They *may* mean that a baby is not getting enough milk.
  However, you cannot be sure, and you need to check for reliable signs.

☐ Praise participants for the signs that they thought of.

Read out any that are not on their list.
Explain that participants can find the complete list of `Reliable' and `Possible' signs on page 113 of their manuals.

→ Mark with an X all the other signs on the participants' list.

- All the other signs are unreliable.
  They may worry a mother, but they do not mean that her baby is getting insufficient milk.

You will not need the list of signs again. You can use the board and flipcharts for later lists.

Further information

Stool frequency
The stool frequency of infants is very variable. A baby may not pass a stool for several days, and this is quite normal. However, when the baby does pass a stool, it is usually large and semi-liquid. Small dry stools may be a sign that a baby is not getting enough milk.
It is also normal for a baby to pass eight or more semi-liquid stools in a day. If the baby has diarrhoea, the stools are watery.

Disposable nappies
These absorb urine and make it difficult to decide if a baby has passed enough urine. If a mother is worried about her milk supply, it is better to use towelling nappies.

Unreliable signs of "not enough milk"
Participants may have suggested some of the following signs that make a mother think that she does not have enough milk. They are all unreliable and do not indicate that her baby is not getting enough:

Baby sucks fingers
Baby sleeps longer after bottle feed
Baby's abdomen not rounded after feeds
Breasts not full immediately after delivery
Breasts softer than before
Breastmilk not dripping out
Not feeling her oxytocin reflex
Family members ask if enough milk
Health worker said not enough milk
Told too young or too old to breastfeed
Told baby too small or too big
Poor previous experience of breastfeeding
Breastmilk looks thin

SIGNS THAT A BABY MAY NOT BE GETTING ENOUGH BREASTMILK

RELIABLE

- Poor weight gain (Less than 500 g a month) (Less than birth weight after 2 weeks)
- Passing small amount of concentrated urine (Less than 6 times a day, yellow and strong smelling)

POSSIBLE

Baby not satisfied after breastfeeds
Baby cries often
Very frequent breastfeeds
Very long breastfeeds
Baby refuses to breastfeed
Baby has hard, dry or green stools
Baby has infrequent small stools
No milk comes when mother tries to express
Breasts did not enlarge (during pregnancy)
Milk did not `come in' (after delivery)

☐ Explain how to find out if a baby is getting enough breastmilk or not:

- ***Check the baby's weight gain.*** This is the most reliable sign.

  For the first six months of life, a baby should gain at least 500 g in weight each month, or 125 g each week. (One kilogram per month is not necessary, and not usual.) If a baby gains less than 500 g in a month, he is not gaining enough weight.

  Look at the baby's growth chart if available, or at any other record of previous weights. If no weight record is available, weigh the baby, and arrange to weigh him again in one week's time.

  If the baby is gaining enough weight, he is getting enough milk.
  However, if no weight record is available, you cannot get an immediate answer.

- ***Check the baby's urine output.*** This is a useful quick check.

  An exclusively breastfed baby who is getting enough milk usually passes dilute urine at least 6-8 times in 24 hours.
  A baby who is not getting enough breastmilk passes urine less than 6 times a day (often less than 4 times a day).
  His urine is also concentrated, and may be strong smelling and dark yellow to orange, especially in a baby more than 4 weeks old.

  Ask the mother how often her baby is passing urine. Ask her if the urine is dark yellow or `strong' smelling.
  - If a baby is passing plenty of dilute urine, he is getting enough breastmilk.
  - If he is passing concentrated urine less than 6 times a day, then he is not getting enough breastmilk.

  This can tell you quickly if an exclusively breastfed baby is getting enough milk. However, if he is having any other drinks, you cannot be sure.

Further information

Guidelines, not rules

The signs of weight gain and urine output are guidelines, not rules. They can help you to diagnose and correct a clinical breastfeeding problem. However, do not apply them rigidly to all mothers - especially if there is no problem. Experience will guide you.

Weight changes in newborn babies

A newborn baby may lose a little weight in the first few days of life. He should regain his birth weight by the age of 2 weeks. If babies demand feed from the first day, they start gaining weight more quickly than babies who delay. A baby who weighs less than his birth weight at 2 weeks of age is not gaining enough weight.

III. Discuss the reasons why a baby may not get enough breastmilk

(15 minutes)

☐ Ask participants to suggest possible reasons why a baby may not get enough

breastmilk.

→ List their suggestions on a board.

Continue if possible until they have suggested at least one `breastfeeding factor', and at least one `psychological factor'.

→ Put the following four headings onto a board or onto two flipcharts.

Breastfeeding factors	*Mother: psychological factors*	*Mother: physical condition*	*Baby's condition*

☐ Try to list all the participants' correct reasons for a baby not getting enough breastmilk under one of the headings.

As you mention each reason:
- explain it briefly;
- give a local example if possible.

☐ Develop a list of reasons which looks similar to the schema **REASONS WHY A BABY MAY NOT GET ENOUGH BREASTMILK** on the next page.

Add important reasons which participants have not thought of.
Leave out reasons which are not important in your area - for example, in some areas, women may not smoke or drink alcohol.

REASONS WHY A BABY MAY NOT GET ENOUGH BREASTMILK

Breastfeeding factors	*Mother: psychological factors*	*Mother: physical condition*	*Baby's condition*
● Delayed start	●Lack of confidence	●Contraceptive pill, diuretics	●Illness
● Feeding at fixed times	●Worry, stress	●Pregnancy	●Abnormality
● Infrequent feeds	●Dislike of breastfeeding	●Severe malnutrition	
● No night feeds	●Rejection of baby	●Alcohol	
● Short feeds	●Tiredness	●Smoking	
● Poor attachment		●Retained piece placenta (rare)	
● Bottles, pacifiers		●Poor breast development (very rare)	
● Other foods			
● Other fluids (water, teas)			
These are COMMON		**These are NOT COMMON**	

☐ Make these points:

- The reasons in the first two columns (`Breastfeeding factors' and `Mother: psychological factors') are common.
  Psychological factors are often behind the breastfeeding factors, for example, lack of confidence causes a mother to give bottle feeds.
  Look for these common reasons first.

- The reasons in the second two columns (`Mother: physical condition' and `Baby's condition') are not common.
  So it is not common for a mother to have a physical difficulty in producing enough breastmilk.
  Think about these uncommon reasons only if you cannot find one of the common reasons.

☐ Ask participants to look at the list for 2-3 minutes.

Ask if there are any points that they are not clear about.

Use the following **Further information** section to help you to answer their questions.

However, do not go through the whole section, because it is likely to be repetitive, and to take too much time.

Further information

These notes may help you to explain the reasons why a baby may not get enough milk, or they may help you to think of a local example.

Breastfeeding factors

Delayed start:

If a baby does not start to breastfeed in the first day, his mother's breastmilk may take longer to come in, and he may take longer to start gaining weight.

Infrequent feeds:

Breastfeeding less than 8 times a day in the first 4 weeks, or less than 5-6 times a day at an older age, is a common reason why a baby does not get enough milk. Sometimes a mother does not respond to her baby when he cries, or she may miss feeds, because she is too busy or at work. Some babies are content and do not show that they are hungry often enough. In this case, a mother should not wait for her baby to `demand', but should wake him to breastfeed every 3-4 hours.

No night feeds:

If a mother stops night breastfeeds before her baby is ready, her milk supply may decrease.

Short feeds:

Breastfeeds may be too short or hurried, so that the baby does not get enough fat-rich hindmilk.

Sometimes a mother takes her baby off her breast after only a minute or two. This may be because the baby pauses, and his mother decides that he has finished. Or she may be in a hurry, or she may believe that her baby should stop in order to suckle from the other breast.

Sometimes a baby stops suckling too quickly, for example if he is too hot, because he is wrapped in too many clothes.

Poor attachment:

If a baby suckles ineffectively, he may not get enough milk.

Bottles and pacifiers:

A baby who feeds from a bottle or who sucks on a pacifier may suckle less at the breast, so the breastmilk supply decreases.

Complementary feeds:

A baby who has complementary feeds (artificial milks, solids, or drinks including plain water), before 4-6 months suckles less at the breast, so the breastmilk supply decreases.

Mother: psychological factors

Lack of confidence:

Mothers who are very young, or who lack support from family and friends, often lack confidence. Mothers may lose confidence because their baby's behaviour worries them. Lack of confidence may lead a mother to give unnecessary supplements.

Worry, stress:

If a mother is worried or stressed or in pain, her oxytocin reflex may temporarily not work well.

Dislike of breastfeeding, rejection of the baby, and tiredness:

In these situations, a mother may have difficulty in responding to her baby. She may not hold him close enough to attach well; she may breastfeed infrequently, or for a short time. She may give her baby a pacifier when he cries instead of breastfeeding him.

Mother: physical condition

Contraceptive pill:

Contraceptive pills which contain estrogens may reduce the secretion of breastmilk.

Progestagen-only pills and depo-provera should not reduce the breastmilk supply.

Diuretics may reduce the breastmilk supply (see Session 31, `Women's nutrition, health, and fertility').

Pregnancy:

If a mother becomes pregnant again, she may notice a decrease in her breastmilk supply.

Severe malnutrition

Severely malnourished women may produce less milk. However, a woman who is mildly or moderately undernourished continues to produce milk at the expense of her own tissues, provided her baby suckles often enough (see Session 31, `Women's nutrition, health, and fertility').

Alcohol and smoking:

Alcohol and cigarettes can reduce the amount of breastmilk that a baby takes.

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'.

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.

Baby's condition

Illness:

A baby who is ill and unable to suckle strongly does not get enough breastmilk. If this continues, his mother's milk supply will decrease.

Abnormality:

A baby who has a congenital problem, such as a heart abnormality, may fail to gain weight. This is partly because he takes less breastmilk, 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 handicap, often have difficulty in suckling effectively, especially in the first few weeks.

☐ Review misconceptions about the causes of a poor milk supply:

Read quickly through the list in the box **THESE DO NOT AFFECT THE BREASTMILK SUPPLY**.

Do not spend much time on this. However, be ready to answer participants' questions, if they have difficulty in believing that these are not important reasons.

- Some things are commonly thought to be a reason for insufficient breastmilk. However, they do not in fact affect the milk supply.

THESE DO NOT AFFECT THE BREASTMILK SUPPLY

Age of mother
Sexual intercourse
Menstruation
Disapproval of relatives and neighbours
Returning to a job (if baby continues to suckle often)
Age of baby
Caesarian section
Preterm delivery
Many children
Simple, ordinary diet

☐ Summarize the causes of "not enough milk":

Emphasize these points:

- The common reasons for a baby not getting enough milk are:
  - breastfeeding factors;
  - psychological factors.

- A physical difficulty in producing breastmilk is only occasionally the cause.

☐ Tell participants that they can find a summary of what you have discussed, including the schema **REASONS WHY A BABY MAY NOT GET ENOUGH BREASTMILK** on page 115 of their manuals.

IV. Discuss how to help a mother whose baby is not getting enough breastmilk

(15 minutes)

☐ Gather your group of 4-5 participants into a corner of the classroom. (Other trainers do the same).

Ask participants to keep their manuals closed.

☐ Discuss the need to find the cause of the problem:

- If a baby is not getting enough milk, you need to find out *WHY*.

Ask: *How could you find out the cause of a baby not getting enough milk?*
(Let participants think for a short time and make a few suggestions.
Encourage them to think of the skills that they have learnt in the course so far.
Then continue.)

- To find the cause, go through the following steps:

- Listen and learn (to learn about psychological factors, and how the mother feels)
- Take a history (to learn about breastfeeding factors, and the mother's medication)
- Assess a breastfeed (to learn about the baby's attachment and suckling and about bonding or rejection)
- Examine the baby (for illness or abnormality, and for his growth).

- Examine the mother and her breasts
  (to learn about her health, her nutrition, and any breast condition)

☐ Discuss how to help a mother:

- When you have some idea why a baby is not getting enough milk, you can decide how to help him and his mother.

Ask: *How might you help a mother if her baby is not getting enough milk?*
(Let participants think and make a few suggestions. Encourage them to think of what they have learnt in this course about how to help mothers. Then continue.)

- To help a mother, use your confidence and support skills.
  Help her to give her baby more breastmilk, and help her to believe that she can produce enough.

Ask: *How could you use each of the six confidence and support skills to help a mother?*
(Let participants suggest something for each skill.)

Use the box **HOW TO HELP A MOTHER WHOSE BABY IS NOT GETTING ENOUGH MILK** for some ideas about using each of the six skills.

Encourage participants to think of examples from experience, before the course, or from clinical practice sessions.

Further information

Occasionally you may not be able to find the cause of a poor milk supply; or the milk supply does not improve (the baby does not gain weight) even though you have done everything you can to help the mother. Then you may need to look for one of the less common causes, and help or refer the mother accordingly.

Occasionally you may need to help a mother to find a suitable complement for her baby. Encourage her to:

- continue breastfeeding as much as possible;
- give only the amount of complement that her baby needs for adequate growth;
- give the complement by cup;
- give the complement only once or twice a day, so that her baby suckles often at the breast.

Remember that the need for complements before 4-6 months of age should be RARE.

HOW TO HELP A MOTHER WHOSE BABY IS NOT GETTING ENOUGH MILK

● Look for a cause

Steps to take:	What you may learn about:
Listen and learn	Psychological factors, how mother feels
Take a history	Breastfeeding factors, contraceptive pill, diuretics
Assess a breastfeed	Baby's position at breast, bonding or rejection
Examine the baby	Illness or abnormality, growth
Examine the mother and her breasts	Her nutrition and health Any breast problem

● Build confidence and give support

Help the mother to give her baby more breastmilk, and to believe that she can produce enough.

Accept	Her ideas about breastmilk supply Her feelings about breastfeeding and her baby
Praise (as appropriate)	She is still breastfeeding Her breasts are good for making milk
Give practical help	Improve baby's attachment to breast
Give relevant information	Explain how baby's suckling controls milk supply Explain how baby can get more breastmilk
Use simple language	"Breasts will make more milk if baby takes more"
Suggest (as appropriate)	Breastfeed more often, longer, at night Stop using bottles or pacifiers (use cup if necessary) Reduce or stop other feeds and drinks (if baby aged less than 4-6 months) Ideas to reduce stress, anxiety Offer to talk to family

● Help with less common causes

Baby's condition:	If ill or abnormal, treat or refer
Mother's condition:	If taking estrogen pills or diuretic, help her to change Help as appropriate with other conditions

● Follow-up

See daily, then weekly until baby gaining weight and mother confident.
It may take 3-7 days for the baby to gain weight (see Session 27).

V. Discuss how to help a mother who thinks that she does not have enough breastmilk

(15 minutes)

☐ Make these points:

- Many mothers worry about their breastmilk supply, but their babies are getting all the milk that they need.

- These mothers lack confidence in their breastmilk. It is very important to help them, otherwise they may decide to start artificial feeds.

☐ Discuss how to help a mother:

Ask: *What could you do to help a mother who thinks that she does not have enough breastmilk?*
(Let participants think, and make some suggestions.)

Go through the same steps as for helping a mother whose baby is not getting enough milk.

- To understand the situation:

  - Listen and learn (to understand why she lacks confidence. Empathize with how she feels.)

  - Take a history (to learn about the pressures that she is under from other people to give artificial feeds.)

  - Assess a breastfeed (to see if poor attachment could be the problem. If a baby is suckling very often, or for a long time, it may be because he is poorly attached and getting the breastmilk inefficiently. He may be getting enough breastmilk.)

  - Examine the mother and her breasts (to see the shape of her breasts, nipples, and areola. She may lack confidence if they are small or flat, or very large or of unusual shape.)

- To help a mother, use your confidence and support skills.

Ask: *How could you use each of the six confidence and support skills to help a mother who thinks that she does not have enough milk?*
(Let participants try to think of an example for each step.)

Encourage participants to think of examples from their experience or from the clinical practice sessions.

Use the box **HOW TO HELP A MOTHER WHO THINKS THAT SHE DOES NOT HAVE ENOUGH BREASTMILK** for ideas.

HOW TO HELP A MOTHER WHO THINKS THAT SHE DOES NOT HAVE ENOUGH BREASTMILK

- ***Understand her situation***

Listen and learn	To understand why she lacks confidence, empathize
Take a history	To learn about pressures from other people
Assess a breastfeed	To check baby's attachment at breast
Examine mother	Breast size may cause lack of confidence

- ***Build confidence and give support***

Accept	Her ideas and feelings about her milk
Praise (as appropriate)	Baby growing well, her milk supplies his needs Good points about her breastfeeding technique Good points about baby's development
Give practical help	Improve attachment if necessary
Give relevant information	Correct mistaken ideas, do not sound critical Explain about babies' normal behaviour Explain how breastfeeding works (what you say depends on her worries)
Use simple language	"Some babies do like to suckle a lot"
Suggest	Ideas for coping with tiredness Offer to talk to family

VI. Conclude "Not enough milk" (5 minutes)

Ask participants to look at the summary boxes on pages 113-117 of their manuals.

Ask them to study these boxes, and to try to become familiar with them.

Signs that a baby may not be getting enough breastmilk
Reasons why a baby may not get enough breastmilk
These do not affect the breastmilk supply
How to help a mother whose baby is not getting enough milk
How to help a mother who thinks that she does not have enough breastmilk

☐ Recommended reading:
Helping Mothers to Breastfeed Chapter 6, especially sections 6.1 to 6.4

Session 22

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CRYING

Objectives

At the end of this session, participants will be able to:
- list different reasons why babies may cry;
- help families with babies who cry a lot to continue exclusive breastfeeding and not to start unnecessary complementary feeds.

Session outline (30 minutes)

Participants work in groups of 8-10, with two trainers

I. Introduce the topic (5 minutes)

II. Discuss the reasons why babies cry (10 minutes)

III. Participants read `How to help a family with a baby who cries a lot' (10 minutes)

IV. Demonstrate how to hold and carry a colicky baby (5 minutes)

Preparation

Refer to pages 13-15 in the Introduction for general guidance on how to conduct work in groups.
Study the session notes so that you are clear about what to do.

Ask a male participant to help you to demonstrate how to comfort a baby.

As you follow the text, remember

☐ indicates an instruction to you, the trainer
■ indicates what you say to the participants

Do not present the **Further information** sections.
Use them to help you to answer questions.

I. Introduce the topic (5 minutes)

Ask participants to keep their manuals closed.

☐ Make these points:

- A common reason why a mother may think that she does not have enough breastmilk, is that she, or her family, thinks that her baby is `crying too much'.
- Many mothers start unnecessary complements because of their baby's crying. Complements often do not make a baby cry less. Sometimes a baby cries more.
- A baby who cries a lot can upset the relationship between him and his mother, and can cause tension among other members of the family.
- An important way to help a breastfeeding mother is to counsel her about her baby's crying.

☐ Refer back to the list of reasons for stopping breastfeeding or starting complements early that you developed in Session 2, `Local breastfeeding situation'. Remind participants if they identified crying as one of the common reasons.

Further information
A baby who is `crying too much' may really be crying more than other babies, or his family may be less tolerant of the crying, or less skilled at comforting the baby.
Families' response to crying is different in different societies. So also is the way in which parents handle children. For example, in societies where babies are carried around more, they cry less. If babies sleep with their mothers they are less likely to cry at night. 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.

II. Discuss the reasons why babies cry (10 minutes)

☐ Develop a list of reasons why babies may cry a lot:

Ask: *What reasons can you think of why babies may cry a lot?*

(Let participants make 5-6 suggestions, then continue.)

→ Write participants' ideas on a board or flipchart.

Try to develop a list which looks something like this:

REASONS WHY BABIES CRY

Discomfort	(dirty, hot, cold)
Tiredness	(too many visitors)
Illness or pain	(changed pattern of crying)
Hunger	(not getting enough milk, growth spurt)
Mother's food	(any food, sometimes cow's milk)
Drugs mother takes	(caffeine, cigarettes, other drugs)
Oversupply of breastmilk	
Colic	
`High needs' babies	

→ Add to the list on the board reasons which participants have not thought of.

☐ Explain the following causes of crying, which may be new to participants:

- *Hunger due to growth spurt:*
  A baby seems very hungry for a few days, possibly because he is growing faster than before. He demands to be fed very often. This is commonest at the ages of about 2 weeks, 6 weeks and 3 months, but can occur at other times. If he suckles often for a few days, the breastmilk supply increases, and he breastfeeds less often again.

- *Mother's food:*
  Sometimes a mother notices that her baby is upset when she eats a particular food. This is because substances from the food pass into her milk. It can happen with any food, and there are no special foods to advise mothers to avoid, unless she notices a problem.

  Babies can become allergic to the protein in some foods in their mother's diet.
  Cow's milk, soy, egg, and peanuts can all cause this problem. Babies may become allergic to cow's milk protein after only one or two prelacteal feeds of formula.

- *Drugs mother takes:*
  Caffeine in coffee, tea, and colas, can pass into breastmilk and upset a baby. If a mother smokes cigarettes, or takes other drugs, her baby is more likely to cry than other babies. If someone else in the family smokes, that also can affect the baby.

- *Oversupply:*
  This can occur when a baby is poorly attached. He may suckle too frequently or for

too long and stimulate the breast too much, so that the milk supply increases.
Oversupply can occur if a mother takes her baby off the first breast before he has finished, and makes him take the second breast.
The baby may get too much foremilk, and not enough hindmilk. He may have loose green stools and a poor weight gain; or he may grow well but cry and want to feed often. Even though she has plenty of milk, the mother may think that she does not have enough for her baby.

- *Colic:*
  Some babies cry a lot without one of the above causes. Sometimes the crying has a clear pattern. The baby cries continuously at certain times of day, often in the evening. He may pull up his legs as if he has abdominal pain. He may appear to want to suckle, but it is very difficult to comfort him. Babies who cry in this way may have a very active gut, or wind, but the cause is not clear. This is called `colic'. Colicky babies usually grow well, and the crying usually becomes less after the baby is 3 months old.

- *`High needs' babies:*
  Some babies cry more than others, and they need to be held and carried more. In communities where mothers carry their babies with them, crying is less common than in communities where mothers like to put their babies down to leave them, or where they put them to sleep in separate cots.

III. Participants read `How to help a family with a baby who cries a lot'

(10 minutes)

☺ Ask participants to read the section **HOW TO HELP A FAMILY WITH A BABY WHO CRIES A LOT** on pages 120-121 of their manuals.

If you prefer, ask participants to read the section aloud, taking turns sentence by sentence.

HOW TO HELP A FAMILY WITH A BABY WHO CRIES A LOT

- **Look for a cause**

Listen and learn

Help the mother to talk about how she feels. Empathize with her feelings.
- She may feel guilty and a poor mother. She may feel angry with her baby.
- Other people may make her feel guilty, or they may make her feel that her baby is bad, or naughty, or undisciplined.
- Other people may advise her to give the baby complements or pacifiers.

Take a history
- Learn about the baby's feeding and behaviour.
- Learn about the mother's diet, and if she drinks a lot of coffee, or smokes, or takes any drugs.
- Learn about the pressures that she is under from the family and other people.

Assess a breastfeed
- Check the baby's suckling position, and the length of a feed.

Examine the baby
- Make sure he is not ill or in pain. Check his growth.
- If the baby is ill or in pain, treat or refer as appropriate.

● **Build confidence and give support**

Accept
- Accept what the mother thinks about the cause of the problem.
- Accept what she feels about the baby and his behaviour.

Praise what the mother and baby are doing right
- Explain that her baby is growing well, he is not sick.
- Her breastmilk is providing all that her baby needs - there is nothing wrong with it, or with her.
- Her baby is fine - he is not bad or naughty, or in need of discipline.

Give relevant information
- Her baby has a real need for comfort. He is not sick, but he may have real pain.
- The crying will become less when the baby is 3-4 months old.
- Medicines for colic are not now recommended. They can be harmful.
- Complements are not necessary, and often do not help. Artificially fed babies also have colic. They may develop cow's milk intolerance or allergy and become worse.
- Suckling at the breast for comfort is safe, but bottles and pacifiers are not safe.

Make one or two suggestions
What you suggest depends on what you have learnt about the cause of the crying. Common causes may be different in different countries.

- If she has an oversupply of breastmilk:
  - Help her to improve her baby's attachment to the breast;
  - Suggest that she lets him suckle from one breast only at each feed.
    Let him continue at the breast until he finishes by himself.
    Give the other breast at the next feed.

  Explain that if her baby stays on the first breast longer, he will get more fat-rich hindmilk, (see also Session 16, `Refusal to breastfeed'.)

- It might help if she takes less coffee and tea, and other drinks which contain caffeine, such as colas. If she smokes, suggest that she reduces her smoking, and that she smokes after breastfeeds, not before or during them.
  Ask other members of the family not to smoke in the same room as the baby.

- It might help if she stops taking cow's milk and other milk products, or other foods which can cause allergy, (soy, peanuts, eggs).
  She should stop taking the food for a week. If the baby cries less, she should continue to avoid the food. If the baby continues to cry as much as before, then that particular food is not the cause of the crying. She can take the food again.

Do not suggest that she stops these foods if her diet is poor. Make sure that she can eat another energy- and protein-rich food instead, for example, beans.

Give practical help

- Explain that the best way to comfort a crying baby is to hold him close, with gentle movement and gentle pressure on his abdomen.
  Offer to show her some ways to hold and carry her baby.

- Sometimes it is easier for someone not the mother to carry the baby, so that he cannot smell the breastmilk.

- Show her how to bring up her baby's wind. She should hold him upright, for example in a sitting position, or upright against her shoulder.
  (It is NOT necessary to teach `winding' routinely - only if the baby has colic.)

Offer to discuss the situation with her family, to talk about the baby's needs and about her need for support.

It is important to try to help to reduce family tensions, so that she does not start giving unnecessary complements.

☐ Ask participants if they have any questions about `Crying' and try to answer them.
Point out the summary of this section in the box **HOW TO HELP WITH A BABY WHO CRIES A LOT** on page 122 of their manuals.

HOW TO HELP WITH A BABY WHO CRIES A LOT

● ***Look for a cause***

Listen and learn	Help mother to talk about feelings (guilt, anger) Empathize
Take a history	Learn about baby's feeding and behaviour Learn about mother's diet, coffee, smoking, drugs Pressures from family and others
Assess a breastfeed	Position at breast, length of feed
Examine baby	Illness or pain (treat or refer as appropriate) Check growth

● ***Build confidence and give support***

Accept	Mother's ideas about the cause of the crying Her feelings about baby and his behaviour
Praise (as appropriate)	Her baby is growing well, not sick Her breastmilk provides all that baby needs Her baby is fine, not naughty or bad
Give relevant information	Baby has real need for comfort Crying will decrease when baby is 3-4 months old Medicines for colic not recommended Complements not necessary or helpful artificially fed babies also have colic Comfort suckling at breast is safe, bottles and pacifiers not safe
Suggest (as appropriate)	Give only one breast at each feed give other breast next feed Reduce coffee and tea Smoke after not before or during breastfeeds Stop milk, eggs, soy, peanuts (1-week trial, if mother's diet adequate)
Practical help	Show mother and others how to hold and carry baby with close contact, gentle movement, gentle abdominal pressure Offer to discuss situation with family

IV. Demonstrate how to hold and carry a colicky baby (5 minutes)

☐ Make this introductory point:

- Babies are most often comforted with closeness, gentle movement, and gentle pressure on the abdomen. There are several ways to provide this.

☐ Give the demonstration:

- Hold a doll along your forearm, pressing on its back with your other hand. Move gently backwards and forwards (Fig.11a).

- Sit down and hold the doll lying face down across you lap. Gently rub the doll's back.

- Sit down and hold the doll sitting on your lap, with its back to your chest. Hold it round the abdomen, gently pressing on the abdomen (Fig.11b).

☺ Ask a man to help with this demonstration if possible (Fig.11c). Ask him to hold the doll upright against his chest, with the doll's head against his throat. He should hum gently, so that a baby would hear his deep voice.

☐ Ask participants if they know of other ways to comfort a crying baby that are common in their community. Ask them to demonstrate with a doll.

Fig.11 Some different ways to hold a colicky baby (Fig.36 in Participants' Manual)

a. Holding the baby along your forearm

b.Holding the baby round his abdomen, on your lap

c.Father holding the baby against his chest

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"NOT ENOUGH MILK" AND CRYING EXERCISE

Objective

Participants practise using the information from Sessions 21 and 22.

Session outline (50 minutes)

Participants work in groups of 8-10, with two trainers.

I. Introduce the session (2 minutes)

II. Facilitate the written exercise (Exercise 16) (48 minutes)

Preparation

Refer to pages 15-16 in the Introduction for general guidance on how to facilitate a written exercise.
Study the notes for the session so that you are clear about what to do.

Make sure that you have Answer Sheets available for Exercise 16 to give to participants at the end of the session.

As you follow the text remember

☐ indicates an instruction to you, the trainer
■ indicates what you say to participants

I. Introduce the session (2 minutes)

Ask participants to turn to page 124 of their manuals, and to find Exercise 16.

☐ Explain what the exercise is about:

- This exercise contains short stories about mothers who are worried about their breastmilk supply, or about their babies' crying, followed by some questions.

- Answer the questions using the information from Session 21, `Not enough milk' and Session 22, `Crying', and also from Session 11, `Building confidence and giving support'. You can look back at the notes for these sessions in your manuals if you wish.

II. Facilitate the written exercise (48 minutes)

☐ Explain what to do:

- Read the instructions **How to do the exercise** and the **Example**.
  Then answer the questions for the stories **To answer**.

EXERCISE 16. ***"Not enough milk" and Crying***

How to do the exercise:

Read through the following short stories about mothers who feel that they do not have enough milk, or whose babies are crying `too much'.
Write in pencil a brief answer to the questions which follow.
The stories of Mrs T, Mrs U, and Mrs V are optional to do if you have time.
When you have finished, discuss your answers with the trainer.

Example:

Mrs M says that she does not have enough milk. Her baby is 3 months old and crying `all the time'. A nurse told her that he had not put on enough weight (he gained 200 g last month). Mrs M manages the family farm by herself, so she is very busy. She breastfeeds her baby about 2-3 times at night, and about twice a day, whenever she has time. She does not give her baby any other food or drink.

What could you say to empathize with Mrs M?

("You are very busy, it is difficult to find time to feed a baby.")

What do you think is the cause of Mrs M's baby not getting enough milk?

(Mrs M is not breastfeeding him often enough.)

Can you suggest how Mrs M could give her baby more breastmilk?

(Could she take her baby with her so that she could breastfeed him more often?)
(Could someone bring her baby to her where she is working?)
(Could she express her breastmilk to leave for her baby?)

To answer:

Mrs N says that her baby is always hungry in the evenings. Since the age of 2 weeks he has cried and doesn't want to settle. Her sister told Mrs N that she probably does not have enough milk when she is tired in the evening. Her sister suggested that Mrs N give a bottle feed in the evening, so that she can save up her milk for the night feeds. Mrs N drinks tea once or twice a day. She does not smoke cigarettes, and she does not drink milk or coffee.

Mrs N's baby is 5 weeks old, and weighs 4.5 kilos. He weighed 3.7 kilos when he was born.

Why do you think Mrs N's baby is crying?

(This is probably colic.
She drinks only a little tea, so this is unlikely to be the cause.)

What are Mrs N and her baby doing right, that you could praise?

(Her baby is gaining weight well. He is getting all that he needs from her breastmilk.)

What three pieces of information would you give to her?

(1. This colicky crying decreases after 3-4 months.
2. Supplements are not necessary, and might make the breastmilk decrease.
3. Medicines for colic are not recommended.)

What could you suggest that Mrs N might do, to help her baby?

(Discuss different ways to carry and comfort her baby more.)

Mrs O is 16 years old. Her baby was born 2 days ago, and is very healthy. She has tried to breastfeed him twice, but her breasts are still soft, so she thinks that she has no milk, and will not be able to breastfeed. Her young husband has offered to buy her a bottle and some formula.

What could you say to accept what Mrs O says about her breastmilk?

("You think that there is no milk in your breasts?")

Why does Mrs O think that she will not be able to breastfeed?

(She lacks confidence, and she lacks knowledge.
Her milk has not `come in' yet - but this is normal.)

What relevant information would you give her, to build her confidence?

(Her breasts already have some milk, in the form of colostrum.
Explain that if her baby suckles more often, it will help more milk to come.
In a day or two, her breasts will feel full.)

What practical help could you give Mrs O?

(Offer to help her to put her baby to her breast. Help her when her baby shows, by restlessness or mouthing, that he is ready for a feed.)

Mrs P's baby is 3 months old. She says that for the last few days he has suddenly started crying to be fed very often. She thinks that her milk supply has suddenly decreased. Her baby breastfed exclusively until now, and has gained weight well.

What can you say to empathize with Mrs P?

("You must be worried that he is crying more than before.")

What can you praise to build Mrs P's confidence?

("He has grown so well on your breastmilk.")

What relevant information can you give Mrs P?

("At this age, many babies have a growth spurt, and become very hungry. If you feed him more often for a few days, your breastmilk supply will increase, and he will settle down again.")

Mrs Q says that her breastmilk seems to be decreasing. Her baby is 4 months old, and has gained weight well from when he was born. Last month she started giving him cereal three times a day. She says that he is breastfeeding less often, and for a shorter time than before she started cereal feeds. Mrs Q is at home all day, and her baby sleeps with her at night.

Why do you think that Mrs Q's breastmilk seems to be decreasing?

(Her baby is suckling less, because she is giving the cereal feeds.)

What are Mrs Q and her baby doing right?

(Her baby is gaining weight well.
She is breastfeeding him as much as he wants, and at night.)

What could you suggest to Mrs Q, so that she continues to breastfeed?

(Breastfeed her baby first, before giving cereal feeds.
Make sure that he finishes a breastfeed, before she offers cereal. He may not need so much cereal before he is 6 months old.)

Mrs R's baby is 7 weeks old. She says that her breastmilk is not good. Her baby does not seem satisfied after breastfeeds. He cries and wants to feed again very soon, sometimes in half an hour, or an hour. He cries and wants to breastfeed often at night too, and Mrs R is exhausted. He passes urine about 6 times a day. When he breastfeeds, you notice that his lower lip is turned in, and there is more areola visible below his mouth than above it.

The baby weighed 3.7 kilos at birth. He now weighs 4.8 kilos.

Is Mrs R's baby getting as much breastmilk as he needs?

(Yes, he is getting as much as he needs.)

What may be the reason for his behaviour?

(He is poorly attached to the breast, so he is not suckling effectively.
He needs to feed very often to get enough breastmilk.)

What could you praise, to build Mrs R's confidence?

(Her baby is getting all the breastmilk that he needs, and is growing well.)

What practical help would you offer to Mrs R?

(Offer to show her how to improve her baby's attachment at the breast.)

Mrs S says that she is exhausted, and will have to bottle feed her 2-month-old baby. He does not settle after breastfeeds, and wants to feed very often - she cannot count how many times in a day. She thinks that she does not have enough breastmilk, and that her milk does not suit her baby. While she is talking to you her baby wants a feed. He suckles in a good position. After about two minutes, he pauses, and Mrs S quickly takes him off her breast.

The baby's growth chart shows that he gained 250 g last month.

What could you say to show that you accept Mrs S's ideas about her milk?

("Yes, I see.")

Is Mrs S's baby getting enough breastmilk?

(No. He is gaining weight very slowly.)

What is the reason for this?

(She does not let him suckle for long enough.)

What can you suggest to help Mrs S?

(Suggest that she lets her baby stay at the breast for longer at each feed.
She should let her baby continue suckling until he releases the breast himself.
If he pauses, let him just stay at the breast until he suckles again.
If he stays at the breast longer at each feed, he will not need to feed so often.)

Optional

Mrs T's baby is 6 weeks old. He wants to feed about every 2-3 hours - sometimes after 1½ hours, sometimes he sleeps for 5 hours. He has gained 800 g since he was born. Mrs T's mother says that the baby is crying too much, and looks too thin. She says that Mrs T does not have enough milk, and should give some bottle feeds.

What are the good things that are happening?

(Mrs T is breastfeeding her baby on demand. She is not yet giving bottle feeds.)

Do you think that Mrs T's baby is getting enough milk?

(Yes. Her baby is gaining weight well, and his behaviour is quite normal.)

What would you do to help Mrs T?

(Offer to talk to Mrs T's mother, to discuss how well the baby is doing, and to explain the dangers of bottle feeds.)

Mrs U says that her milk is drying up, and she will have to stop breastfeeding. She would like to continue. Her baby is 6 months old, and she has been back at work for three months. Mrs U's sister cares for the baby during the day. Mrs U breastfeeds morning and evening. She expresses her breastmilk before she goes to work, but she doesn't usually get more than half a cupful. Her baby needs 1 or 2 bottles of formula during the day. Mrs U is very tired when she gets home, and her sister often gives him another bottle during the night.

The baby weighed 3.0 kilos at birth, and now weighs 6.5 kilos.

Why do you think Mrs U's breastmilk may be `drying up'?

(She breastfeeds only morning and evening. This is not enough to keep up her milk supply.)

What is Mrs U doing right, that you would praise?

(She continues to breastfeed when she is at home, and she is expressing some breastmilk.)

What could you suggest that Mrs U could do to continue breastfeeding?

(Suggest that she breastfeeds more often, and that she let her baby sleep with her to breastfeed at night. She could give her baby complementary foods from a cup or spoon, and not use a bottle. Her baby may be more interested in breastfeeding if he has not sucked on a bottle while she is out.)

Mrs V's baby is 10 weeks old. She says that her breastmilk is decreasing. She has given her baby juice from a bottle and one cereal feed a day since he was 4 weeks old. A midwife recommended this because the baby was crying a lot. Mrs V breastfeeds about 4-5 times a day, and sometimes once in the night. The baby still cries a lot but usually settles when he suckles on a pacifier.

He weighed 2.8 kg at birth, 3.4 kg at one month, and now weighs 3.8 kg.

Is Mrs V's baby getting enough breastmilk? Why?

(He is not getting enough breastmilk. He has only gained 400 grams in 6 weeks. This is because Mrs V has given supplements early, and uses a pacifier, so that her baby does not breastfeed often enough.)

What three things would you suggest that Mrs V does?

(Suggest that she:

1. Breastfeeds more often, including at night.
2. Stops using a pacifier, and offers her breast for comfort instead.
3. Gives the complementary feeds by cup, not bottle, and tries to reduces the amount.)

☐ Give participants Answer Sheets for Exercise 16.

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CLINICAL PRACTICE 3

Taking a breastfeeding history

Objectives

Participants practise `taking a breastfeeding history' with mothers and babies in a ward or clinic.

Participants continue to practise the skills from Clinical Practice 1 and 2.

They practise using these skills with mothers in some of these situations:
- after normal deliveries;
- after Caesarian section;
- with difficulty in breastfeeding;
- with different breast conditions;
- with low-birth-weight babies and twins;
- with sick children;
- who have brought a baby for immunization or growth monitoring;
- in family planning clinics;
- in antenatal clinics.

Session outline (120 minutes)

Participants meet together as a class led by one trainer to prepare for the session, and if time permits, to discuss it afterwards.

Participants work in pairs in a ward or clinic. Each trainer supervises the 2-3 pairs in her group.

I.	Prepare the participants	(10 minutes)
II.	Conduct the clinical practice	(90 minutes)
III.	Discuss the clinical practice	(20 minutes)

Preparation

Make sure that you know where the clinical practice will be held. Visit the various wards or clinics that you will go to if you have not done so before.

Study the instructions in the following pages, and ask other trainers to study them also. Make sure that you are clear about how this clinical practice differs from Clinical Practice 1 and 2.

Arrange for different groups to see mothers in different situations - for example, some can go to maternity wards, to see mothers after normal or Caesarian deliveries, or to paediatric wards, or special care units; some can go to outpatient clinics or health centres to see mothers with sick or well children, or women receiving antenatal care or family planning services.

Make available a copy of the Breastfeeding History Form for each participant and trainer.

Make a copy of the **COUNSELLING SKILLS CHECKLIST** available for each participant and trainer, and also have some spares.

Make sure that trainers have a copy of the **CLINICAL PRACTICE DISCUSSION CHECKLIST**.

I. Prepare the participants (10 minutes)

☐ *Explain the objectives of the clinical practice:*

- During this session, you practise taking a breastfeeding history.

  You continue to practise `assessing a breastfeed', `listening and learning', and `building confidence and giving support'.

  If there is an opportunity, you will practise helping a mother to position her baby at the breast, or to overcome any other difficulty.

☐ *Give each participant a copy of the* **COUNSELLING SKILLS CHECKLIST** *and explain what it is:*

- This checklist is a summary of all the counselling, assessing and history-taking skills that you have learnt.

  Refer to it during clinical practice and counselling exercises to remind you of the different skills to practise.

COUNSELLING SKILLS CHECKLIST

Listening and learning

☐ Helpful non-verbal communication
☐ Ask open questions
☐ Respond showing interest
☐ Reflect back
☐ Empathize
☐ Avoid judging words

Assessing a breastfeed

☐ **B**ody position
☐ **R**esponses mother and baby
☐ **E**motional bonding
☐ **A**natomy of breast
☐ **S**uckling
☐ **T**ime spent suckling

Confidence and support

☐ Accept what mother says
☐ Praise what is right
☐ Give practical help
☐ Give relevant information
☐ Use simple language
☐ Make one or two suggestions

Taking a history

☐ Baby's feeding now
☐ Baby's health, behaviour
☐ Pregnancy, birth, early feeds
☐ Mother's condition and FP
☐ Previous infant feeding
☐ Family and social situation

☐ *Explain what participants should take with them:*

- Take with you:
  - one copy of the Breastfeeding History Form;
  - one copy of the **COUNSELLING SKILLS CHECKLIST**;
  - pencil and paper to make notes.

  You do not need to take anything else.

- Use the Breastfeeding History Form for taking a history.
  Use the **COUNSELLING SKILLS CHECKLIST** instead of the other three forms (the lists of **LISTENING AND LEARNING SKILLS** and **CONFIDENCE AND SUPPORT SKILLS**, and the B-R-E-A-S-T-FEED Observation Form).

☐ *Explain how participants will work*:

- You work in pairs in a ward or clinic. Each trainer circulates between the pairs in her group, to observe, comment and help where necessary.

☐ *Explain what participants should do when they talk to a mother:*

- Take a full breastfeeding history from the mother, using the Breastfeeding History Form.
  Try to ask the most relevant questions, and ask something from each section of the form.

Use your listening and learning skills, and try not to ask too many questions.
Practise your confidence and support skills, and avoid giving a lot of advice.

If a mother has a breastfeeding difficulty, try to decide the reason, and how to help the mother. However, before you give the mother any help, or suggest what she should do, talk to the trainer.

II. Conduct the clinical practice (90 minutes)

☐ *Take your group to a ward or clinic:*

Different groups go to different parts of the health facility to meet breastfeeding mothers and babies in as many situations as possible. Depending on the numbers of mothers available, and the distance between different areas, a group may visit more than one area during the session.

Conduct the session in the same way as Clinical Practice 1 and 2, except that participants work in pairs from the beginning.

Help pairs to find mothers in different situations to talk to. Look out for any situation in which you may find a mother with a breast condition which would help participants to learn.

☐ *Discuss how to help mothers*

If a mother needs help with breastfeeding, let participants help her. However, first discuss with them what they plan to do, to make sure that it is appropriate.
If necessary, take participants where the mother cannot hear what you are saying while you discuss what to do. Then return to the mother to give the help.

Discuss the difficulty and its management with the staff in charge of the ward or clinic. It is important that you and the staff say the same things to the mother, so that you do not confuse her. The staff will be responsible for following up the mother and baby.

☐ *Discuss the participants' performance:*

When a pair have finished, take them away from the mother, and discuss what they did, and what they learnt.

- Ask them to tell you about the mother, what she is doing well, if she has any difficulties, and what they would suggest to help her.

- Go through the **CLINICAL PRACTICE DISCUSSION CHECKLIST** to help you to conduct the discussion.

- Discuss what they learnt from the mother, and if her situation is common or unusual. Discuss what else it might be possible to do in other, similar situations.

III. Discuss the clinical practice (20 minutes)

The whole class comes back together to discuss the clinical practice, led by the trainer who led the preparatory session.

☐ *Ask one participant from each group to report briefly on what they learnt:*

Ask them to report on the most interesting situations that they observed among the mothers and babies whom they saw, and what they learnt from them.

If participants have not finished seeing mothers and babies at the end of the 90 minutes allowed for `II. Conduct the clinical practice', they can continue and finish, and if necessary omit the class discussion.
You must decide what is the most useful way to spend this time.

☐ *Ask participants to fill in their* **CLINICAL PRACTICE PROGRESS FORM:**

They record on the form each mother and baby that they talked to during the Clinical Practice 3.

☐ *Check individual participants' progress:*

By the end of the next clinical practice, (Clinical Practice 4), each participant should have seen mothers in as many as possible of the different situations listed in the Objectives for Clinical Practice 3 and 4.

To follow the progress of individual members of your group, go through their **CLINICAL PRACTICE PROGRESS FORM** sometime during or after the session.
Check that they have practised all the different skills.
Help them to meet mothers in as many different situations as possible.

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COUNSELLING PRACTICE

Objectives

Participants practise the counselling skills that they have learnt in Session 6, `Listening and learning', and Session 11, `Building confidence and giving support'; and combining them with the skill of `Taking a breastfeeding history', Session 17.

Session outline (75 minutes)

Participants work in pairs within the groups of 4-5 with one trainer.

The session is given 75 minutes, but it is useful to take longer if time is available.
If there are not enough mothers and babies in any of the Clinical Practice sessions, use the time to do more Counselling Skills Practice exercises.

I.	Prepare for the exercise	(15 minutes)
II.	Conduct the pair practice (Exercise 17)	(60 minutes)

Preparation

Refer to pages 16-17 in the Introduction for general guidance on how to conduct work in small groups.

Make sure that copies of Counselling Stories 1-10 from Exercise 17 are available, on cards or paper. You will need one set of copies for each group of participants.
Choose the stories most relevant to your situation.
Stories 1-8 are the most important at this stage in the course. The situations in them have been covered in previous sessions.
Stories 9-10 present situations that would be more appropriate after Sessions 31 and 32.

Fill in a local growth chart for the baby in each of the histories, to give to the participant with that story.

Make available some spare copies of the **COUNSELLING SKILLS CHECKLIST**.

Study the section **`I. Prepare for the exercise'** so that you can explain to participants what to do.

Study the section **How to conduct the exercise** at the beginning of Exercise 17, so that you can guide the pair practice.

Read the section **Comments on the counselling stories** which you will find after Story 10. These comments may help you to guide the pair practice, and the discussion afterwards.

Decide how you will conduct the exercise.
In some situations, participants may have difficulty in reading the story quickly. An alternative way to conduct the exercise is for a trainer to play the part of the mother, while one of the participants takes her history.

As you follow the text remember:

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

I. Prepare for the exercise (15 minutes)

☐ Give each participant a copy of one of the counselling stories and a growth chart for the baby in the story.

Explain what they will do:

- You will now use role-play to practise the counselling skills `Listening and learning' and `Building confidence and giving support'.
  You will also practise deciding how to help a mother using the skill `Taking a breastfeeding history'.

- You will work in pairs, and take it in turns to be a `mother' or a `counsellor'.
  When you are the `mother', play the part of the mother in the story on your card. You consult your partner, who counsels you about your situation.

- You do not need to practise observation of a breastfeed in this exercise. You will find all that you need to know in the written story. In a real situation, you should always observe as well.

- You are the only one in the group who has a copy of your story. Conceal it from the others, especially from your `counsellor'.

- Give yourself and your baby a name, either your own real name, or another if you prefer.

- Other participants in the group observe the pair practice, until it is their turn.

☐ Ask participants to read their stories through, and to study the growth chart.
Allow 5 minutes.

They can ask you questions about anything that they do not understand.

☐ Make sure that each participant has a copy of the **COUNSELLING SKILLS CHECKLIST.**

☐ Explain how to do the pair practice:

- If you are the `counsellor':
  - Greet the `mother' and ask her how she is. Use her name and her baby's name.
  - Ask one or two open questions about breastfeeding to start the conversation.
  - Use your counselling skills. Try to use at least one example of each of the skills.
  - Use your history-taking skills. Practise asking the most relevant questions. Ask at least one question from each section of the history.
  - Practise learning all about the mother and baby, and giving her whatever help you decide is necessary.

- If you are the `mother':
  - Answer one of the `counsellor's' open questions with your reason for coming. This is the sentence at the top of the story. For example, for Counselling Story 1, say "My milk is not good. (Baby's name) cries too much."

- Then respond to what your `counsellor' says. If she asks you some questions, answer them from what is written. If you cannot answer a question from what is written, make up an answer to fit with your story.
- If your `counsellor' uses good listening and learning skills, and makes you feel that she is interested, you can tell her more.

- If you are observing:
  - Use your **COUNSELLING SKILLS CHECKLIST**, and observe which skills the `counsellor' uses, and which she does not use. Mark on your checklist in pencil when you observe the `counsellor' using a skill correctly.
  - Try to decide if the `counsellor' has understood the `mother's' situation correctly, and if she has asked the most relevant questions and given appropriate help.
  - During discussion, be prepared to praise what the players do right, and to suggest what they could do better.

II. Conduct the pair practice (60 minutes)

EXERCISE 17. *Counselling skills practice*

How to conduct the exercise

☺ Ask one pair in the group to practise one of their stories. Ask them to sit on two chairs, next to each other, and slightly separate from the group.

☐ Let the pair continue for a while, without interrupting.

Follow the story in your copy of the Trainer's Guide. If they are doing well, let them go on until they finish. If they make a lot of mistakes, or get confused, or do not follow the story, stop them, and give them a chance to correct themselves. Ask them how they feel they are doing, and what they think has gone wrong.

Ask other participants in the group to say what they have observed. Then say what you think.
Praise what they do right, and then comment on these things:
- How well the `counsellor' used her counselling and history-taking skills.
- If she understood the mother's situation correctly, and gave appropriate help.

Use the **Comments on the counselling stories** to help the discussion. They tell you:
- The main points in the story that the participants should learn about.
- The most important skills that the `counsellor' should practise.

☐ If necessary, let the pair try again, at least for a short time.

Try to finish with them doing some things well.
Thank them and congratulate them for their efforts.
☐ Ask another pair to practise.

Make sure that each member of the group has a chance to be a `counsellor' at least once.

Counselling Story 1 **"My milk is not good. (Baby's name) cries too much."**

Age of baby:	3 months	Weight aged 2 weeks:	2.9 kg
		Weight today:	3.7 kg

Baby's feeding now: Exclusive breastfeeding. Baby sleeps with you at night, and breastfeeds when he can during the day - maybe 3 times.

Baby's health and behaviour: He is well. He seems to cry a lot. Your 7-year-old daughter carries him round a lot, and he sucks on a pacifier. You have no idea how many times he urinates - you are not there to see. You wash about 3 or 4 nappies or cloths a day, but he may not get changed every time he wets.

Pregnancy, delivery, early feeds: Baby born at home. Breastfed from soon after delivery.

Mother's condition: You are aged 32, and healthy. You do not smoke or drink. You are not using any family planning method. You feel tired, and think that bottle feeding might help.

Previous infant feeding: 5 babies, all breastfed. 3 at present under 5 years of age.

Family and social situation: You are very busy with housework and work in the fields. Your mother-in-law expects you to do everything, and it is difficult to find time to feed the baby.

Counselling Story 2 **"I will bottle feed this next baby. I am not able to breastfeed."**

Antenatal visit.

Mother's condition: You are aged 28, and healthy. You are 6 months pregnant. Before you had your first baby you wanted very much to breastfeed. Your breasts and nipples are average in size.

Previous infant feeding: You have 2 children already.
Your first baby was born by Caesarian section, after an obstructed labour. The baby was put into the nursery for 5 days, and was given some bottle feeds. You tried to breastfeed him after 5 days, but he did not want to suckle, and cried every time you put him to the breast. You could not get him to suckle properly, and the nurses advised you to continue giving bottles. You were very disappointed, and felt that you had failed. The baby was often ill with diarrhoea during the first year of life.

Your second baby was born vaginally. You put him to the breast during the first day, but you had very sore nipples. You struggled on despite the pain, for 4 weeks. Then your nipples were so cracked and bleeding that you gave him a bottle for a few days to allow the nipples to heal. Then he refused to start breastfeeding again.

Family and social situation: You are a nurse in a children's ward. You will take your maternity leave, and you have saved up some more leave, so that you can stay home for 4 months after the baby is born. You live very near the hospital, and your sister stays with you and looks after the children while you work.

Counselling Story 3 "(Baby's name) is always crying and my breastmilk is drying up."

Age of baby:	3 months	Weight aged 1 month:	4.0 kg	Weight now: 4.8 kg
Birth weight:	3.0 kg	Weight aged 2 months:	5.0 kg	

Baby's feeding now: You breastfeed 4-5 times a day and sometimes once in the night. You also give two bottle feeds of formula each day. You put 1-2 scoops of milk powder into each bottle. You started this when the baby was 2 months old.

Baby's health and behaviour: The baby cried a lot when he was small. He still cries a lot, but usually quietens when you give him a bottle. He had diarrhoea for a few days last month, but that has stopped. He suckles less at the breast now than he did before.

Pregnancy, delivery, early feeds: Delivered at home. Breastfed from the first day.

Mother's condition: You are aged 17 and healthy. You had an IUD fitted at 6 weeks.

Previous infant feeding: This is your first baby.

Family and social situation: You are a housewife. Your mother lives nearby and helps. Your husband complains when the baby cries. He wants you to give bottle feeds to keep the baby quiet so that he can sleep at night. A friend of his at work suggested it.

Counselling Story 4 "(Baby's name) is very thin and he is constipated."

Age of baby:	2 months	Weight at 1 month:	3.0 kg
Birth weight:	2.8 kg	Weight now:	3.1 kg

Baby's feeding: You feed the baby tinned milk from a bottle. You make about 3-4 bottles a day. You put about 2 spoons of tinned milk into each bottle. When you do not have any tinned milk, you make a feed from cereal and water. You breastfeed the baby sometimes, for comfort, but there is only a little milk coming out.

Baby's health and behaviour: Your baby cries a lot, but he is very small and weak. He does not pass stools very often, and they are small and dry. You think he is constipated. He urinates about 3-4 times a day. Sometimes only twice, and his urine is dark yellow.

Pregnancy, delivery, early feeds: Normal. Baby delivered in hospital at night. You put him to the breast the next morning, after the doctor checked him. There was no milk coming out, and the baby was not very interested in suckling. So you started bottle feeds while you waited for your breastmilk to come, but it did not come in properly.

Mother's condition: You are aged 19, and healthy. You do not smoke or drink. You will start on contraceptive pills when your periods start again.

Previous infant feeding: This is your first baby.

Family and social situation: You are a housewife. Your husband is a driver and is away from home a lot. Your mother has been helping you to bottle feed the baby.

Counselling Story 5 **"(Baby's name) cannot suckle properly."**

Age of baby:	4 weeks	Weight aged 3 weeks:	1.80 kg
Birth weight:	1.5 kg	Weight today:	1.95 kg

Baby's feeding now: Breastfeeding only.

Baby's health and behaviour: He suckles slowly and takes a long time, and he keeps stopping to rest in the middle of a feed.

Pregnancy, delivery, early feeds: He was born preterm, very weak, at about 32 weeks, and was in the special care unit for 2 weeks. He was fed by nasogastric tube for 1 week, and then by cup. You stayed in the hospital, and expressed your milk 3-hourly for your baby. You expressed enough for him at that time. He started breastfeeding about 1 week ago.

Mother's condition: You are 24 and only become pregnant after 3 years of marriage. You think that you do not have enough breastmilk - your breasts do not seem very full. You are very upset, and feel that you are failing as a mother.

Previous infant feeding: This is your first baby.

Family and social situation: Your husband is a farmer, and wants lots of children. He has not shown much interest in this sick, small baby.

Counselling Story 6 **"My milk is drying up, and I will have to bottle feed (baby's name). Which formula is best?"**

Age of baby:	2 months	Weight today:	5.0 kg
Birth weight:	3.5 kg		

Baby's feeding: Breastfeeding only until now.

Baby's health and behaviour: Very healthy. Now sleeps in a cot. You get up to feed him about once in the night, if he cries. He passes urine at least 6 times a day.

Pregnancy, delivery, early feeds: Normal pregnancy; delivered in hospital. Your baby stayed in the nursery. You did not see him for 24 hours. Then he was brought to you for 3-hourly for breastfeeding. He may have had a bottle while he was in the nursery.

Mother's condition: You are aged 18. You would not mind breastfeeding, if it is easy. But your friend bottle feeds and tells you that you are silly to bother. You are worried that if you continue to breastfeed your breasts may sag, and your boyfriend will lose interest in you. You want to be able to go out at night.

Previous infant feeding: This is your first baby.

Family and social situation: You live in town. Your baby's father has a job as a labourer, and he gives you money, but not very regularly. Your parents live far away, and you do not see them often.

Counselling Story 7 **"(Baby's name) often has diarrhoea - should I stop breastfeeding?"**

Age of baby:	11 months		
Weight at 2 months of age:	4.5 kg	Weight at 8 months:	7.5 kg
Weight at 6 months of age:	7.5 kg	Weight today:	8.2 kg

Baby's feeding now: He breastfeeds on demand. He sleeps with you and breastfeeds at night. He is also taking rice and vegetables 3 times a day.

Baby's health and behaviour: Several times he has had diarrhoea, and the health worker has shown you how to make oral rehydration fluids. She has advised you to continue giving him rice and other food. The diarrhoea is better now, but you think that it is time to stop breastfeeding. Perhaps breastfeeding causes the diarrhoea.

Pregnancy, delivery, and early feeds: Born at home, and started breastfeeding soon after delivery. No problems.

Mother's condition: You are aged 29 and healthy. You have depo-provera injections for family planning. You are not worried about being pregnant.

Previous infant feeding: 4 previous children, all breastfed for about 2 years.

Family and social situation: Your husband is a subsistence farmer, and you live on cereals and vegetables. You get water from a nearby stream.

Counselling Story 8 **"My milk is drying up, so I will have to stop breastfeeding."**

Age of baby:	4 months	Weight aged 3 months:	5 kg
Birth weight:	3.2 kg	Weight today:	5.3 kg

Baby's feeding now: Exclusive, unrestricted breastfeeding.

Baby's health and behaviour: Very well until now. Now he seems rather hungry and not satisfied after feeds. He passes urine about 3-4 times a day.

Pregnancy, delivery, early feeds: Normal delivery in hospital. You held him straight away, and he breastfed within half an hour. Breastfeeding has gone well until now.

Mother's condition: Aged 24, very healthy. You do not smoke, and only drink alcohol occasionally. You started to take contraceptive pills when your baby was 10 weeks old. Nobody asked if you were breastfeeding when you went for family planning advice. You think it may be the `combined pill'. Your breasts do not seem full, even before a feed.

Previous infant feeding: You have one other child aged 18 months. You stopped breastfeeding at 5 months, when you became pregnant again. You want a longer space before you have another baby.

Family and social situation: You sell in the market, and take both children with you.

Optional Counselling Stories (to do now or after Sessions 31 and 32).

Counselling Story 9 **"I cannot breastfeed (baby's name) because I have asthma."**

Age of baby: 2 days Birth weight: 2.9 kg

Baby's feeding: Bottle feeding, so far has only had glucose water.

Baby's health and behaviour: Normal so far.

Pregnancy, delivery, and early feeds: Normal delivery in hospital. Baby has not suckled at the breast at all.

Mother's condition: You often have to take medicines for asthma. A doctor said that the medicines would pass into your breastmilk and might make your baby sick. You would like to breastfeed very much.

Previous infant feeding: You bottle fed your previous baby, and he died of diarrhoea and malnutrition at 5 months of age.

Family and social situation: You are poor, and cannot afford to buy enough formula. You are hoping that the counsellor will give you a free sample of formula to help you to start off.

Counselling Story 10 **"My breastmilk is getting less. What can I do?"**

Age of baby: 3 months Weight at 1 month: 5.0 kg Weight now: 6.2 kg
Birth weight: 4.0 kg Weight at 2 months: 5.6 kg

Baby's feeding now: You breastfeed whenever you are at home. When you are at work, he has bottle feeds of formula. You started bottle feeds when you went back to work last month. Sometimes he has bottle feeds at night too.

Baby's health and behaviour: He is very well at the moment.

Pregnancy, delivery, early feeds: He was born in hospital, delivered by forceps. He was kept in the nursery for about 6 hours, but then roomed in with you. You needed help to start breastfeeding, but since then there have been no problems.

Mother's condition: You are aged 23, and healthy. You smoke about 15 cigarettes a day.
You had an IUD fitted soon after delivery. You want very much to breastfeed longer.

Previous infant feeding: You had one previous child now aged 5 years old. You tried to continue breastfeeding while you were at work. But you had leaking of breastmilk when you were on duty, and then your baby refused to suckle. You were really upset about this, and feel that you failed your baby, even though he did not get ill.

Family and social situation: You returned to work in an office when your baby was 2 months old. Your sister cares for your children while you are at work.

Comments on the counselling stories

These notes emphasize the main points of each story, to help you to comment on participants' pair practice.

Counselling Story 1.
The baby is gaining less than 500 g a month, so he is not getting enough milk. The mother is too busy to respond to the baby, so she does not breastfeed him often enough.
Participants practise empathizing about the difficulties she is under at home, and they should learn that she is thinking of giving bottle feeds. They can practise making suggestions - for example that she takes her baby with her, or that the 7-year-old bring the baby to her mother instead of giving him a pacifier. They may offer to talk to her family about her baby's needs.

Counselling Story 2.
This story emphasizes the importance of finding out about a mother's previous experience of breastfeeding during an antenatal visit. This mother has had bad experiences and is at risk of failing to breastfeed, so she needs extra support. Participants practise giving the mother information, and building her confidence that she can breastfeed this time, without making her feel criticized.

Counselling Story 3.
This baby gained weight well when exclusively breastfed, but has not done well since he started bottle feeds. The mother is very young, and at special risk of failing, so she needs extra help. She is also under pressure from the baby's father to bottle feed. Participants practise suggesting that the mother stops bottle feeding, without making her feel criticized. They should also offer to discuss the situation with the family. Talking to the mother alone may not help.

Counselling Story 4.
This baby is `failing to thrive' because breastfeeding was not established in the postnatal period. The mother and baby were both perfectly healthy.
Participants practise encouraging a young and inexperienced mother to try to relactate. They practise giving her confidence that she can have enough breastmilk to feed her baby without using tinned milk.

Counselling Story 5.
This is a low-birth-weight baby who is getting enough milk, and doing well. His slow suckling is normal, but it worries his mother. She lacks confidence partly because she has a fertility problem, and this baby took a long time to conceive. She needs lots of extra support, especially as her husband is not very helpful.
Participants practise building her confidence that she does have enough milk, and that her baby is growing and will be bigger and stronger before long. It is important to avoid telling her that everything is alright, and that she should not worry. They should empathize with her worry.

Counselling Story 6.
This is another young mother. Her baby is doing well, but she is at risk of pressures to bottle feed, this time from her friend. She feels insecure in her relationship with the baby's father, and is worried about not being able to go out at night, and about losing her

figure. Participants practise giving support, and talking about the mother's social concerns. The counsellor should not just explain the benefits of breastfeeding.

Counselling Story 7.
This story illustrates the need to encourage mothers to continue and increase breastfeeding both when a child is sick and until a child is 2 years old or more. The diet of this family is poor, and breastmilk is helpful both to provide essential nutrients, and to help the baby to recover from diarrhoea.
Participants practise accepting the mother's ideas about her child's illness, informing her that breastfeeding is helpful for a child with diarrhoea, to encourage her to continue.

Counselling Story 8.
This mother has a genuinely poor breastmilk supply because she is taking an oestrogen-containing contraceptive.
Participants practise thinking this situation through logically. They should ask all the questions about how the mother feeds her baby, and find that she is doing everything right. Then they should think about possible physical reasons for a poor milk supply, in this case, the oestrogen-containing contraceptives.

Counselling Story 9.
This story illustrates the problems that can result from being too cautious about letting mothers breastfeed when they are taking medication. Asthma treatment for a mother is not harmful for her breastfeeding baby.
Participants practise giving a mother confidence that she can safely breastfeed, even when she does need treatment, and despite what the doctor said. They practise being careful not to make her feel criticized or guilty about her first baby.

Counselling Story 10.
This story illustrates some of the problems of working mothers. A mother's breastmilk supply may decrease when her baby starts having bottles of formula. This mother had problems with a previous baby also. She is well motivated to try to express breastmilk for this baby, and to ask her sister to feed him by cup.
Participants practise explaining to the mother how to express her breastmilk and feed it by cup; and about the importance of expressing while she is at work to help keep up the supply, even if she cannot save it for her baby. The counsellor can also suggest that the mother tries to give up smoking.

Session 26

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LOW-BIRTH-WEIGHT AND SICK BABIES

Objectives

At the end of this session, participants will be able to describe:
- why breastmilk is the best food for low-birth-weight babies;
- why it is important to continue breastfeeding or giving breastmilk when an infant is sick or jaundiced.

Participants will also be able to:
- help a mother of a low-birth-weight or sick baby to give her baby breastmilk;
- help a mother to feed her baby by cup.

Session outline (65 minutes + 10 minutes optional)

Participants are all together for presentation by one trainer.
All trainers needed to give individual feedback for the exercise.

I.	Introduce the topic	(5 minutes)
II.	Present Overheads 26/1 to 26/6	(25 minutes)
III.	Demonstrate how to feed a baby by cup	(10 minutes)
IV.	Optional Explain how much milk to give to a baby	(10 minutes extra)
V.	Facilitate the written exercise (Exercise 18)	(25 minutes)

If available and appropriate, show the video *Feeding Low Birth Weight Babies* as soon as convenient after the session.
This requires 30 minutes additional time.

Preparation

Refer to pages 9-13 of the Introduction for general guidance about presenting overheads, and giving a demonstration.

Make sure that Overheads 26/1 to 26/6 are in order.
Study the overheads and the text that goes with them, so that you are able to present them.
Read the **Further information** sections, so that you are familiar with the ideas they contain.

Read the reference: `Annex to the Global Criteria for Baby Friendly Hospitals: Acceptable Medical Reasons for Supplementation', so that you can discuss these with participants, and refer them to their own copy of the reference.

Try to find out what percentage of babies are born with a low-birth-weight in this country or region.

To demonstrate how to feed a baby by cup:
- Obtain some small cups that could be used to feed low-birth-weight babies, and which are easily available in the community. Medicine measures or egg cups, are suitable. Use small tea-cups 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.

Decide if you will include section **IV. Explain how much milk to give to a baby**. This may not be relevant for some groups of participants.

Make sure that Answer Sheets for Exercise 18 are available to give to participants at the end of the session.

As you follow the text, remember:

☐ indicates an instruction to you, the trainer
■ indicates what you say to the participants

Do not present the **Further information** sections.
Use them to help you to answer questions.

I. Introduce the topic (5 minutes)

☐ Make these points:

- The term *low-birth-weight* (LBW) means a birth weight of less than 2,500 grams. This includes babies who are born before term, and who are *premature*, and babies who are *small for gestational age*. Babies may be small for both these reasons.

- In many countries 15-20% of all babies are low-birth-weight.
  In this country ..... % of all babies are low-birth-weight.

- Low-birth-weight babies are at particular risk of infection, and they need breastmilk more than larger babies. Yet they are given artificial feeds and bottle feeds more often than larger babies.

☐ Refer back to the list of reasons for stopping breastfeeding or starting complementary foods early, that you developed in Session 2, `Local breastfeeding situation'. Remind participants if they identified LBW as a common reason in their situation.

Ask: *Why is it sometimes difficult for LBW babies to breastfeed exclusively?*
(Let participants suggest answers. Then discuss the following.)

Possible answers that participants might suggest include:
- LBW babies are not able to suckle strongly at the breast.
- They need more of some nutrients than breastmilk can provide.
- It can be difficult for mothers to express enough breastmilk.

- There is some truth in all these statements, and they are reasons why in many hospitals LBW babies are fed artificially.

- However, many LBW babies can breastfeed without difficulty. Babies born at term, who are small-for-dates, usually suckle effectively. They are often very hungry and need to breastfeed more often than larger babies, so that their growth can catch up.

- Babies who are born preterm may have difficulty suckling effectively at first. But they can be fed on breastmilk by tube or cup, and helped to establish full

breastfeeding later. Breastfeeding is easier for these babies than bottle feeding.

- If a mother is given enough skilled help and support, she can express her breastmilk, and feed it to her baby by tube or cup, until he can breastfeed. She can breastfeed her LBW baby fully much earlier than we used to think possible.

Further information

Extra nutrients
Babies with very low-birth-weight (1,000 to 1,500g) or extremely low-birth-weight (less than 1,000g) may need extra nutrients in addition to breastmilk for a time. Some need extra calcium, some may need extra protein or energy. This is an individual decision, usually made by a specialist. However, breastmilk with additional nutrients protects against infection better than artificial feeds. Breastmilk can protect against infection, which artificial feeds cannot do. Breastmilk contains essential nutrients that are not available in any formula.

`Learning' to feed from a bottle
It is not necessary for a baby to `learn' to feed from a bottle before breastfeeding.
Research has shown that breastfeeding is less stressful for a LBW baby than sucking from a bottle. Bottle feeding can make it more difficult for a baby to learn to suckle from the breast.

Giving a baby breastmilk from another mother
If a mother cannot express as much breastmilk as her baby needs, you may need to give the baby supplements. It is often useful to give supplements of breastmilk from another mother, which has many advantages over artificial feeds. If HIV infection is a concern in the area, one possibility is to boil the donated milk. Boiling destroys any HIV virus, which is very sensitive to heat. However, boiling also destroys many of the anti-infective factors in the breastmilk. If you give a baby supplements of either formula or boiled donated breastmilk, continue to give as much as possible of the mother's own breastmilk. Even a small amount of fresh breastmilk can give a baby anti-infective factors which give valuable protection.

II. Present Overheads 26/1 to 26/6 (25 minutes)

☐ As you show each overhead transparency, point on the projector or the on the screen to the place which shows what you are explaining.

Overhead 26/1 Full-term and preterm breastmilk

- This chart compares full-term and preterm milk.

Ask: *What difference does it show?*

It shows that preterm milk contains more protein than full-term milk.

- Much of the extra protein consists of anti-infective proteins. To grow well, preterm babies need milk with more protein than full-term babies. Preterm babies also need extra protection from infection.

So preterm milk is specially adapted to the needs of a preterm baby. The best food for a low-birth-weight baby is his own mother's milk.

Mothers sometimes have difficulty in expressing enough breastmilk. However, if they have a good technique and enough support, it is usually possible (see Session 20, `Expressing breastmilk'). It is important to start expressing on the first day, within six hours of delivery if possible. This helps to start breastmilk flow, in the same way that suckling from soon after delivery helps breastmilk to `come in'. If a mother can express just a few millilitres of colostrum it is valuable for her baby.

If necessary, give a baby pasteurized donated breastmilk until his mother can produce enough of her own milk.

Overhead 26/2 Methods of feeding LBW babies

- This chart shows the different ways to feed low-birth-weight babies.

For the first few days, a baby may not be able to take any oral feeds. He may need to be fed intravenously. Oral feeds should begin as soon as the baby tolerates them.

Babies who are less than about 30-32 weeks gestational age usually need to be fed by nasogastric tube. Give expressed breastmilk by tube. The mother can let her baby suck on her finger while he is having the tube feeds. This probably stimulates his digestive tract, and helps weight gain.
If possible, let the mother hold her baby and give him skin-to-skin contact against her body for part of every day from this age. Skin-to-skin contact helps bonding, and it helps a mother to produce breastmilk, so it helps breastfeeding.

Babies between about 30-32 weeks gestational age can take feeds from a small cup, or

from a spoon. You can start trying to give cup feeds once or twice a day while a baby is still having most of his feeds by tube. If he takes cup feeds well, you can reduce the tube feeds. Another way to feed a baby at this stage is by expressing milk directly into the baby's mouth.

Babies of about 32 weeks gestational age or more are able to start suckling on the breast. Let the mother put her baby to her breast as soon as he is well enough. He may only root for the nipple and lick it at first, or he may suckle a little. Continue giving expressed breastmilk by cup or tube, to make sure that the baby gets all that he needs.

When a LBW baby starts to suckle effectively, he may pause during feeds quite often and for quite long periods. For example, he may take 4-5 sucks, and then pause for up to 4 or 5 minutes. It is important not to take him off the breast too quickly. Leave him on the breast so that he can suckle again when he is ready. He can continue for up to an hour if necessary. Offer a cup feed after the breastfeed. Or offer alternate breast and cup feeds.

Make sure that the baby suckles in a good position. Good attachment may make effective suckling possible at an earlier stage.

The best positions for a mother to hold her LBW baby at her breast are:
- across her body, holding him with the arm on the opposite side to the breast;
- the underarm position.

In both of these positions, she supports her baby's body on her arm and supports and controls his head with her hand. This is important with LBW babies, but not with larger babies (see Session 10 `Positioning a baby at the breast').

Babies from about 34-36 weeks gestational age or more (sometimes earlier) can often take all that they need directly from the breast. However, supplements from a cup continue to be necessary occasionally.

For example, 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 he is hungry, he will take milk from the cup. If he had enough, he will not take milk from the cup.
Continue to follow babies up and weigh them regularly to make sure that they are getting all the breastmilk that they need.

Further information

Whenever possible, LBW 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.

Participants may find it difficult to accept that it is possible to feed LBW babies in the way described with Overhead 26/2. They may need to ask questions, and to discuss the matter further. These points may help you.

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 2 hours, and every 2-3 hours thereafter to prevent hypoglycaemia (low blood sugar).
Until the mother has produced colostrum, give feeds of donated breastmilk. If breastmilk is not available, give glucose water or formula. Glucose water is not necessary for well, term babies who are not at risk of hypoglycaemia.

Cup feeds
Cup feeds give a baby valuable experience of taking food by mouth, and the pleasure of taste. They stimulate the baby's digestion. Many babies show signs of wanting to take things into their mouths at this stage, yet they are not able to suckle effectively at the breast.

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, but 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 breastmilk that they need. By about 36 weeks, most babies can coordinate suckling and breathing, and they can take all that they need by breastfeeding.

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 1,300-1,500 grams. Many can breastfeed fully when they weigh about 1,600-1,800 grams or less.

Skin-to-skin contact and kangaroo care
Skin-to-skin contact between a mother (or father) and baby has been found to help both bonding and breastfeeding, probably because it stimulates the secretion of prolactin and oxytocin.
If a baby is too sick to move, contact can be between the mother's hand and the baby's body. If a baby is well enough, let his mother hold him next to her body. Usually the best place is between her breasts, inside her clothes. This is called *kangaroo care.* It has the following advantages:
- The warmth of the mother's body keeps her baby warm. He does not get cold, and he does not use up extra energy to keep warm. There is less need for incubators.
- The baby's heart works better, and he breathes more regularly.
- The baby cries less and sleeps better.
- It is easier to establish breastfeeding.

Overhead 26/3 Early jaundice

▪ A common reason for a baby to have supplements, or to stop breastfeeding is because of *jaundice.* Jaundice is a yellow colour of the skin and eyes, due to high levels of *bilirubin* in the blood. The commonest kind of jaundice is early jaundice, which occurs between the 2nd and 10th days of life.

Ask: *In your experience, how do health workers feed babies with jaundice?*
Are they given feeds of glucose water? Artificial feeds?
Are their mothers advised to stop breastfeeding?
(Let participants report briefly on their experience. Then continue.)

It is routine in some hospitals to give babies fluids such as glucose water to clear jaundice. But research has now shown that extra fluids do not help.

▪ Jaundice is more common and worse among *babies who do not get enough breastmilk.* Extra fluids such as water or glucose water do not help, because they reduce breastmilk intake. If there is a delay starting to breastfeed, or if breastfeeds are infrequent or restricted in any way, jaundice is more likely. Artificial milk feeds may interfere with breastfeeding in all the ways discussed earlier, (see Session 8, Slide 8/5).

To help prevent jaundice from becoming severe, babies need *more breastmilk.*

- They should start to breastfeed early, soon after delivery.
- They should have frequent, unrestricted breastfeeds.
- Babies fed on expressed breastmilk should have 20% extra EBM.

Early feeds are particularly helpful, because they provide colostrum. Colostrum has a mild purgative effect, which helps to clear meconium (the baby's first dark stool). Bilirubin is excreted in the stool, so colostrum helps to both prevent and clear jaundice.

Further information
Participants may ask about other kinds of jaundice. They may have heard of `breastmilk jaundice'. The following notes may help you to answer their questions.

Prolonged jaundice
Prolonged jaundice starts after the 7th day of life, and continues for some weeks. Sometimes it is due to a serious illness in the baby. Sometimes it is due to substances in the mother's milk - then it is called `breastmilk jaundice'. Breastmilk jaundice is not common. It is mild, and usually harmless. It clears by itself after some weeks.

If a baby has prolonged jaundice, check his weight, look for signs of infection (especially urinary infection) and feel for liver enlargement.
- If the baby is well, feeding well, and gaining weight, and his liver is not enlarged, he probably has breastmilk jaundice. This is harmless, and it is quite safe to continue breastfeeding.
- If the baby is ill, with poor weight gain or an enlarged liver, then the jaundice is likely to be due to a more serious illness. Breastmilk is not the cause. Refer the baby to hospital, and continue breastfeeding.

Haemolytic jaundice
Jaundice is sometimes due to haemolysis of the baby's blood, for example if there is ABO incompatibility. This more serious kind of jaundice may appear on the first day of life, and the bilirubin may rise above 20 mg percent, and the baby may need light treatment (phototherapy). Breastfeeding should continue, and it is important to help the mother to enable her to breastfeed while her baby is receiving treatment.

Phototherapy may make a baby dehydrated, so he needs extra fluids. The best fluid is breastmilk, so help the mother to give the baby extra breastmilk by cup or tube. If possible, she should breastfeed more often. Sometimes jaundiced babies are sleepy and suckle less at the breast. If necessary, she can express her milk and give extra milk by cup. Give other fluids only if extra breastmilk fails to prevent dehydration.

Overhead 26/4 Why babies stop breastfeeding when they are ill

☐ Discuss these questions before you show the overhead:

Ask: *Why do babies often stop breastfeeding when they are ill?*
(Let participants suggest a few reasons, then continue.)

Ask: *Is it necessary to stop breastfeeding a baby for these reasons?*
(Let participants who wish give their opinions briefly. Then continue.)

☐ Show the top half of the overhead, and review the following points:

- Sometimes a baby has difficulty with breastfeeding, for example:
  - A respiratory infection, or sore mouth, for example, infection with *Candida* (thrush) may make suckling difficult.

- An infection may make him lose his appetite, and refuse to breastfeed, or suckle less than before.
- Very sick newborns, or babies requiring surgery may be unable to take oral feeds.

☐ Show the lower half of the overhead, and review the following reasons:

- Sometimes mothers stop breastfeeding because they have been misinformed, for example:
  - Someone says that breastfeeding caused the illness.
    However, breastmilk does not make a baby ill (though occasionally substances in the mothers food cause colicky crying, see Session 22, `Crying').
  - A health worker advises a mother to stop breastfeeding. This is especially likely when a baby has diarrhoea.

Overhead 26/5 Breastfeeding of sick babies

☐ Show the left half of the overhead and review these points:

- If a baby stops breastfeeding when he is ill:
  He gets less nourishment.
  He loses more weight.
  He takes longer to recover.
  He lacks the comfort of suckling.
  His mother's breastmilk is likely to decrease.
  He may refuse to start breastfeeding again when he is well.

☐ Show the right half of the overhead, and review these points:

- If a baby continues to breastfeed when he is ill:
  He gets the best nourishment.
  He loses less weight.
  He recovers more quickly (especially from diarrhoea).
  He is comforted by suckling.
  Breastmilk production continues.
  The baby is more likely to continue breastfeeding when he is well.

Overhead 26/6 How to help breastfeeding if a baby is sick

- This overhead summarizes how to help a mother continue to breastfeed her sick baby.

If a baby is in hospital:
Admit his mother too so that she can stay with him and breastfeed him.

If a baby can suckle well:
Encourage his mother to breastfeed more often. She can increase the number of feeds up to 12 times a day or more for her child when he is sick. Sometimes a baby loses his appetite for other foods, but continues to want to breastfeed. This is quite common with children who have diarrhoea. Sometimes a baby likes to breastfeed more when he is ill than before, and this can increase the supply of breastmilk.

If a baby suckles, but less than before at each feed:
Suggest that his mother gives more frequent feeds, even if they are shorter.

If a baby is not able to suckle, or refuses, or is not suckling enough:
Help his mother to express her milk, and give it by cup or spoon. Let the baby continue to suckle when he is willing. Even babies on intravenous fluids may be able to suckle, or to have expressed breastmilk.

If a baby is unable to take expressed milk from a cup:
It may be necessary to give the EBM through a nasogastric tube for a few feeds.

If a baby cannot take oral feeds:
- Encourage his mother to express her milk to keep up the supply for when her baby can take oral feeds again. She should express as often as her baby would feed, including at night (see Session 20, `Expressing breastmilk'). She may be able to store her milk, or donate it to another baby.
- As soon as her baby recovers, she can start to breastfeed again. If he refuses at first, help him to start again (see Session 16, `Refusal to breastfeed').
- Encourage his mother to breastfeed often to build up her breastmilk supply (see Session 27, `Increasing breastmilk and relactation').

Further information

Special needs babies
Participants may ask about babies with special needs, such as twins, Down's 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 breastmilk.
However, breastfeeding and bonding may be even more important for special needs babies than for other babies.

These situations have not been discussed in detail in this course, because there is not time. Also, it is important for health workers to learn how to care for healthy babies before they try to help in more difficult situations.

The principles of caring for special needs babies 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 him to take a big mouthful of breast.
- If he cannot suckle strongly, show the mother how to express her milk.
- Feed him the EBM with a cup or spoon until he 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.

Below are some practical suggestions about positioning that may be helpful for babies who have difficulty attaching or suckling. You may need to try different techniques with a baby, until you find what is best for him.

1. *The modified underarm position.*
   This may be helpful with babies who feed more easily in an upright position, for example, babies with a cleft palate.
   The baby sits upright, facing his mother, with his legs along her side, and his feet at her back. He

may sit on the bed, or be supported with a pillow. His mother supports his back with her arm, and his head with her hand.
However, some babies with cleft palate breastfeed satisfactory in a more lying down position.

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

3. *The Dancer hand position.*
Some workers find this method useful to help a baby to attach to the breast if he has a disability which causes muscular weakness.
The mother supports her breast with the palm of her hand, and the three outside fingers. Her index finger and thumb are free in front of her nipple to support the baby's chin and cheeks (see Fig.12).

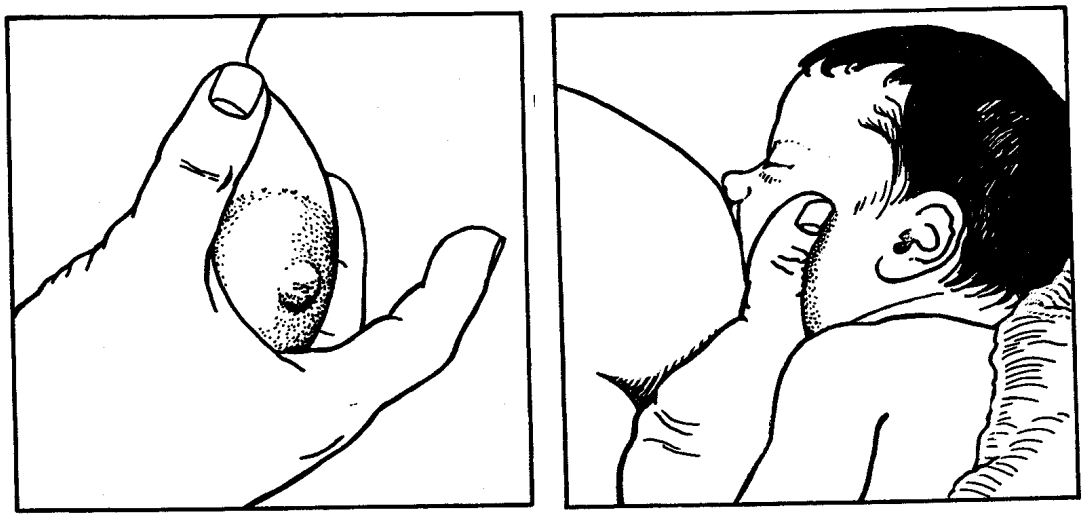

Fig.12 The Dancer hand position to help a baby with muscular weakness to attach to the breast.
(Not in Participants' Manual)

a. The mother supports her breast with the palm of her hand and the three outer fingers

b. Her finger and thumb are free to support the baby's chin and and cheeks

III. Demonstrate how to feed a baby by cup (10 minutes)

☐ Discuss why cup feeding is safer than bottle feeding:

Ask: *Why are cups safer and better than bottles for feeding a baby?*
(Let participants suggest a few answers. Then go through any of the following points that they have not mentioned.)

- Cups are easy to clean with soap and water, if boiling is not possible.
- Cups are less likely than bottles to be carried around for a long time, giving bacteria time to breed.
- A cup cannot be left beside a baby, for the baby to feed himself. The person who feeds a baby by cup has to hold the baby and look at him, and give him some of the contact that he needs.
- A cup does not interfere with suckling at the breast.
- A cup enables a baby to control his own intake.

☐ Explain why cup feeding is usually better than feeding with a spoon and cup:

- Spoon feeding takes longer than cup feeding.
  You need three hands to spoon feed: to hold the baby, the cup of milk and the spoon. Mothers often find it difficult, especially at night.

- Some mothers give up spoon feeding before the baby has had enough. Some spoon fed babies do not gain weight well.
  Mothers are more likely to continue with cup feeding.

- However, spoon feeding is safe if a mother prefers it, and if she gives the baby enough. Also, if a baby is very ill, for example with difficult breathing, it is sometimes easier to feed him with a spoon for a short time.

☐ Make these points about the volume of breastmilk:

- If a mother is expressing more than her LBW baby needs:
  Let her express the second half of the milk from each breast into a different container. Let her offer the second half of the EBM first. Her baby gets more hindmilk, which helps him to get the extra energy that he needs. This helps a baby to grow better.

- If a mother can only express very small volumes at first:
  Give whatever she can produce to her baby. Even very small amounts help to prevent infection. Help the mother to feel that this small amount is valuable. This helps her confidence, and will help her to produce more milk. Supplement if necessary with donated breastmilk.

☐ Give the demonstration of cup feeding:

Follow these steps:

- Put some water into one of the small cups.

- Hold a doll on your lap, closely, with it sitting upright or semi-upright. Explain that a baby should not lie down too much.

- Hold the small cup or glass to the doll's lips. Tip it so that the water just reaches the lips. Point out that the edges of the cup touch the outer part of the baby's *upper* lip, and the cup rests lightly on his lower lip. This is normal when a person drinks.

- Explain that at this point, a real baby becomes quite alert, and opens his mouth and eyes. He makes movements with his mouth and face, and he starts to take the milk into his mouth with his tongue. Babies more than about 36 weeks gestation try to suck.

- Some milk may spill from the baby's mouth. You may want to put a cloth on the baby's front to protect his clothes. Spilling is commoner with babies of more than about 36 weeks gestation, and less common with smaller babies.

- You should not pour the milk into a baby's mouth - just hold the cup to his lips.

- Explain that when a baby has had enough, he closes his mouth and will not take any more this feed. If he has not taken the calculated amount, he may take more next time, or he may need feeds more often. Measure his intake over 24 hours, not just at each feed.

- Demonstrate with a doll what happens when you try to feed a baby with a spoon. You need to hold the cup and the spoon, or you need to put the cup down and take milk from it. The procedure is more awkward.

☐ Tell participants that the technique is described in the box **HOW TO FEED A BABY BY CUP** on page 136 of their manuals.

HOW TO FEED A BABY BY CUP

- Hold the baby sitting upright or semi-upright on your lap.
- Hold the small cup of milk to the baby's lips.
  Tip the cup so that the milk just reaches the baby's lips.
  The cup rests lightly on the baby's lower lip, and the edges of the cup touch the outer part of the baby's upper lip.
- The baby becomes alert, and opens his mouth and eyes.
  - A LBW baby starts to take the milk into his mouth with his tongue.
  - A full term or older baby sucks the milk, spilling some of it.
- DO NOT POUR the milk into the baby's mouth. Just hold the cup to his lips and let him take it himself.
- When the baby has had enough, he closes his mouth and will not take any more. If he has not taken the calculated amount, he may take more next time, or you may need to feed him more often.
- Measure his intake over 24 hours - not just at each feed.

Fig.13 Feeding a LBW baby by cup

(Fig.37 in Participants' Manual)

IV. Explain how much milk to give a baby (10 minutes extra)

Ask participants to turn to page 139 of their manuals, where they will find the box **AMOUNT OF MILK FOR BABIES WHO CANNOT BREASTFEED**.

☐ Read through the box while they follow in their manuals.

→ Write on a flipchart or board:

Babies 2500 g or more-	150 ml per kg per day	
Babies less than 2500 g	-	60 ml per kg for the first day Each day add 20 ml per kg up to 200 ml

AMOUNT OF MILK FOR BABIES WHO CANNOT BREASTFEED

What milk to give

Choice 1: Expressed breastmilk (EBM) (if possible from the baby's mother)
Choice 2: Formula made up according to the instructions
Choice 3: Animal milk
(Dilute cow's milk with 1 cup of water to 3 cups milk, and add 1 level teaspoon of sugar to each cup of feed)

Amount of milk to give

Babies who weigh 2.5 kg or more:
150 ml milk per kg body weight per day.
Divide the total into 8 feeds, and give 3-hourly.

Babies who weigh less than 2.5 kg (Low-birth-weight)
Start with 60 ml/kg body weight.
Increase the total volume by 20 ml per kg per day, until the baby is taking a total of 200 ml per kg per day.
Divide the total into 8-12 feeds, to feed every 2-3 hours.
Continue until the baby weighs 1800 g or more, and is fully breastfeeding.

Check the baby's 24-hour intake.
The size of individual feeds may vary.

☐ Make these points:

- It is normal for the amount of milk that a baby takes at each feed to vary, whatever the method of feeding, including breastfeeding.

- Babies feeding by cup or breastfeeding supplementer (see Session 27, `Increasing breastmilk') may take more or less than the calculated amount. If possible, offer a

little extra, but let the baby decide when to stop.

- If a baby takes a very small feed, offer extra at the next feed, or give the next feed early, especially if the baby shows signs of hunger.

- Assess a baby's 24-hour intake. Give extra by nasogastric tube only if the 24-hour total is not enough.

- LBW babies need only very small volumes during the early days. If the mother can express even a small amount of colostrum, it is often all that her baby needs.

V. Facilitate the written exercise (25 minutes)

☐ Explain what to do:

Ask participants to read the section **How to do the exercise**.
If they are going to answer the optional Question 1, they should also read the **Example**.
Then they should answer the questions **To answer.**

EXERCISE 18. ***Feeding low-birth-weight and sick babies***

How to do the exercise:

For Question 1 (optional), use the information in the box **AMOUNT OF MILK FOR BABIES WHO CANNOT BREASTFEED** to calculate how much milk the baby needs. Read the **Example.**

For Questions 2, 3, and 4, explain briefly how you would advise the mother about feeding her baby.

Example: (optional)

Mabel's baby was born 8 weeks early, and cannot yet suckle strongly. Mabel is expressing her milk and feeding her baby 3-hourly by cup. He weighs 1.6 kilos, and it is the 5th day.

How much milk should Mabel give at each feed?

A LBW baby needs 60 ml per kg on the first day.
On the fifth day he will need (60 + 20 + 20 + 20 + 20) ml/kg = 140 ml/kg
Mabel's baby weighs 1.6 kg, so he will need:
1.6 x 140 = 224 ml on the 5th day.
He feeds 3-hourly, so he has 8 feeds each day.
So at each feed he needs 224 ml divided by 8 = 28 ml of EBM.
(Mabel should offer a little more than this if possible, for example, 30 ml. This also allows for spillage.)

To answer:

Question 1 (optional)
Baby Anna was born at 31 weeks gestation and cannot yet suckle. She weighs 1.5 kg and you are tube feeding her with her mother's EBM. This is the second day she has taken oral feeds. You are feeding her 2-hourly.

How much will you give at each feed?

Baby Anna needs 1.5 x (60 + 20) ml = 120 ml/day
If she has 12 feeds per day, she needs 10 ml per feed.
(You are tube feeding, so you do not need to give extra.)

Question 2
Mona has just delivered a baby 6 weeks before her expected date. He weighs 1,500 grams, and is being observed in the special care unit. Mona wants to breastfeed, but she is worried that her baby will not be able to.

What could you say to empathize with Mona?

("You are worried about your baby, aren't you?")

What could you say to build her confidence?

(Possibilities include:
"Many babies as small as your baby can breastfeed."
"It is good that you want to breastfeed - your milk will help your baby."

Question 3
Sammy is 8 months old. He was exclusively breastfed until 5 weeks ago. Now his mother gives him 3 feeds of enriched porridge a day in addition to breastfeeding. He has had diarrhoea for 2 days and does not want to eat porridge. Sammy is not dehydrated. You explain to his mother about giving ORS, and about when to come back for follow-up.

What could you say to praise what Sammy's mother is doing right?

"You did well to breastfed him exclusively for 6 months."
"Six months is a good age to start a baby on solid foods."

What two things would you advise her about feeding Sammy?

1. Breastfeed Sammy more often - as often and as long as he wants.
2. Give Sammy porridge again as soon as he is able to take it.

Question 4
Tsitsi is 4 months old, and is being treated in hospital for severe pneumonia. Before she was ill, she was exclusively breastfed. Now she is unable to suckle, and has to be fed by nasogastric tube.

What would you ask Tsitsi's mother to do, to feed Tsitsi?

Ask her to express her breastmilk, to feed to Tsitsi by tube.

How often would you ask her to do this?

Ask her to express as often as Tsitsi would normally feed, or about every 3 hours, including during the night. There should be no long intervals between expressions.

Question 5
Baby Zora is 3 days old and today her eyes and skin look slightly yellow. Her mother breastfeeds her 3-4 times a day, and she also gives Zora glucose water between breastfeeds.

What relevant information would you give to Zora's mother?

Jaundice at this age is common and not usually serious.
Breastmilk can help jaundice to clear.

How would you advise her mother to feed Baby Zora now?

Advise her to breastfeed Zora more often.
Suggest that she stops giving the feeds of glucose water, and gives extra breastfeeds instead.

☐ Give participants Answer Sheets for Exercise 18.

☐ Recommended reading:
Helping Mothers to Breastfeed Chapter 7.

Session 27

Back to CONTENTS

INCREASING BREASTMILK AND RELACTATION

Objectives

At the end of this session, participants will be able to:
- help a mother to increase her breastmilk;
- help a mother to start breastfeeding again if she has stopped (*relactation*).

Session outline (45 minutes + 15 minutes optional)

Participants are together as a group led by one trainer.

I. Introduce the topic (5 minutes)

II. Discuss how to help a mother to increase her breastmilk (15 minutes)

III. Demonstrate how to use a breastfeeding supplementer (15 minutes)

IV. Demonstrate other ways to give supplements (10 minutes)

Optional - alternative 1:

V. Talk to a mother with experience of relactation (15 minutes extra)

Optional - alternative 2:

VI. Facilitate the written exercise (Exercise 19)
(All trainers give individual feedback) (10 minutes extra)

VII. Show Slides 27/1 and 27/2 (5 minutes extra)

Preparation

Refer to pages 12-13 of the Introduction for guidance on how to give a demonstration.
Study the notes for the session, so that you are clear what to do.

Before the course:
Find out if anyone in the area (either a health worker or another mother) has experience of relactation, or of using a supplementer. If so, ask her if she would be willing to come and talk about her experiences.
Make sure that she knows the time when the session will be, where to come, and any other necessary arrangements.

Find out what methods are used locally to give babies extra milk if they cannot get all that they need directly from the breast - e.g. dripping milk down the breast, dipping a cotton swab in milk for the baby to suck.

Before the session:
Obtain the following items for the demonstration:
- a fine feeding-tube, some tape for dressings (e.g. zinc oxide tape);
- a cup or other container for milk;
- a 5-ml or 10-ml syringe, with a short length (about 5 cm) of fine tubing attached to the adaptor;
- a dropper, if locally available.

Ask a participant to help you to demonstrate the breastfeeding supplementer. Explain what you want her to do.

If you will show Slides 27/1 and 27/2, decide how to arrange this. It may not be possible in the small groups, and you may need to wait until the next time that the class is together again, and a projector and screen are available.

Make sure that Answer Sheets for Exercise 19 are available to give to participants at the end of the session.

As you follow the text remember:

☐ indicates an instruction to you, the trainer
■ indicates what you say to participants

Do not present the **Further information** sections.
Use them to help you to answer questions.

I. Introduce the topic (5 minutes)

☐ Make these points:

- If a mother's breastmilk supply is reduced, she needs to increase it.
  This often happens when there is a breastfeeding difficulty and the baby does not get enough milk.

- If a mother has stopped breastfeeding, she may want to start again. This is called *relactation*.

- The situations in which mothers may want to relactate include when:
  - A baby has been sick and has not suckled for a time.
  - A baby has been artificially fed, but the mother wants now to try breastfeeding.
  - A baby becomes ill or fails to thrive on artificial feeds.
  - The mother has been sick and stopped feeding her baby.
  - A woman adopts a baby.

- The same principles and method apply for increasing a reduced supply, and for relactation, so we describe them both together.

- Relactation is more difficult and takes longer. The mother must be well motivated and she needs a lot of support to succeed. Sometimes it is also necessary to use the methods described in **MANAGEMENT OF REFUSAL TO BREASTFEED** in Session 16, `Refusal to breastfeed'.

II. Discuss how to help a mother to increase her milk (15 minutes)

☐ Discuss the principles of the method:

Ask: *What is the most important thing for a woman to do to increase her breastmilk supply?*
(Let participants make two or three suggestions. Ask them to refer back to the diagram of **PROLACTIN** on page 13 of their manuals.
Then continue with the answer below.)

The most important thing for her to do is to *let her baby suckle often* to stimulate her breast. If her baby does not suckle often, her breastmilk will not increase, whatever else you do.

- In the past, people often advised mothers to `rest more, eat more, drink more'. These are not effective by themselves.

- Eating more does not by itself increase a woman's milk supply. However, if she is undernourished, she needs to eat more to build up her strength and energy. If she is not undernourished, food and warm nourishing drinks may help her to feel confident and relaxed.

- Many mothers notice that they are more thirsty than usual when they are breastfeeding, especially near the time of a feed. They should drink to satisfy their thirst. However, taking more fluid than they want does not increase their breastmilk supply. Drinking too much can sometimes reduce the milk supply.

- In most communities, experienced women know of some form of *lactogogue*. Lactogogues are special foods, drinks or herbs which people believe increase the breastmilk supply. They do not work like drugs, but may help a woman to feel confident and relaxed.

Further information
Doctors sometimes prescribe drugs (chlorpromazine, or metoclopramide) to increase breastmilk.
These drugs may help in difficult situations, but they should not be used routinely. Even if drugs are used, it is necessary for the baby to suckle frequently to establish a good supply of breastmilk.

☐ Ask participants to find the box **HOW TO HELP A WOMAN TO INCREASE HER BREASTMILK SUPPLY** on page 144 of their manuals.

☺ Ask participants in turn to read out the steps of the method.
After each step, explain points which are not clear and answer any questions.

HOW TO HELP A WOMAN TO INCREASE HER BREASTMILK SUPPLY

- Try to help the mother and baby at home if possible. Sometimes it is helpful to admit them to hospital for a week or two so that you can give enough help - especially if the mother may feel pressure to use a bottle again at home.

- Discuss with the mother the reason for her poor milk supply.

- Explain what she needs to do to increase her supply. Explain that it takes patience and perseverance.

- Use all the ways you have learnt to build her confidence. Help her to feel that she can produce breastmilk again or increase her supply. Try to see her and talk to her often - *at least twice a day*.

- Make sure that she has enough to eat and drink.

- If you know of a locally valued lactogogue, encourage her to take that.

- Encourage her to rest more, and to try to relax when she breastfeeds.

- Explain that she should keep her baby near her, give him plenty of skin-to-skin contact, and do as much as possible for him herself. Grandmothers can help if they take over other responsibilities - but they should not care for the baby at this time. Later they can do so again.

- Explain that the most important thing is to *let her baby suckle more*
  - at least 10 times in 24 hours, more if he is willing.

  She can offer her breast every two hours.
  She should let him suckle whenever he seems interested.
  She should let him suckle longer than before at each breast.
  She should keep him with her and breastfeed at night.
  Sometimes it is easiest to get a baby to suckle when he is sleepy.

- Make sure that her baby attaches well to the breast.

- Discuss how to give other milk feeds, while she waits for her breastmilk to come, and how to reduce the other milk as her milk increases. For amounts see box **AMOUNT OF MILK FOR BABIES WHO CANNOT BREASTFEED** in Session 26.

- Show her how to give the other feeds from a cup, not from a bottle. She should not use a pacifier.

- If her baby refuses to suckle on an `empty' breast, help her to find a way to give the baby milk while he is suckling. For example, with a dropper or a *breastfeeding supplementer* (see below).

- To start with, she should give the full amount of artificial feed for a baby of his weight or the same amount that he has been having before. As soon as a little breastmilk comes, she can reduce the daily total by 30-60 ml each day.

- Check the baby's weight gain and urine output, to make sure that he is getting enough milk.
  - If he is not getting enough, do not reduce the artificial feed for a few days.
  - If necessary, increase the amount of artificial milk for a day or two.
  Some women can decrease the amount by more than 30-60 ml each day.

☐ Explain the following points:

- The length of time that it takes for a woman's breastmilk supply to increase varies very much. It helps if the mother is strongly motivated, and if her baby is willing to suckle frequently. But the mother should not worry if it takes longer than expected.

- If a baby is still breastfeeding sometimes, the breastmilk supply increases in a few days. If a baby has stopped breastfeeding, it may take 1-2 weeks or more before much breastmilk comes.

- It is easier to relactate if a baby is very young (less than 2 months) than if he is older (more than 6 months). However, it is possible at any age.

- It is easier if a baby stopped breastfeeding recently, than if he stopped a long time ago. However, it is possible at any time.

- A woman who has not breastfed for years can produce milk again, even if she is post-menopausal. For example, a grandmother can breastfeed a grandchild.

Further information

Induced lactation
Even a woman who has never breastfed, or who has never even been pregnant, can produce breastmilk if she suckles an adopted child. This is called *induced lactation*. The amount of breastmilk that such a mother can produce varies, and she may not be able to breastfeed the child fully.
If participants ask, assure them that it is well established that this is possible. However, they may find it difficult to believe, and discussing it may take up a lot of time. This can be very distracting, so you may prefer not to introduce the subject.

III. Demonstrate how to use a breastfeeding supplementer (15 minutes)

☐ Explain why a supplementer is useful:

- A *breastfeeding supplementer* is a device for giving a baby a supplement while he is suckling at a breast which is not producing enough milk.

- A hungry baby may suckle at an `empty' breast a few times; but he may become frustrated and refuse to suckle any more - especially if he has become used to sucking from a bottle.

- To stimulate a breast to produce milk, it is necessary for a baby to suckle. A breastfeeding supplementer helps to get him to continue suckling.

☐ Give the demonstration

☺ Ask the participant who will help you, to sit comfortably holding a doll as if she is breastfeeding.

Follow these steps:

- Show this equipment to the group:
  - A cup or other container for milk (expressed breastmilk, or artificial milk.)
  - A fine plastic tube, for example a nasogastric tube. If the tube has an `adaptor' end, cut it off. Also, at the end of the tube which will go into the baby's mouth, cut a small hole in the side, in addition to the hole at the end.
  - Tape, such as zinc oxide tape, to hold the end of the tube in place on the breast.

- Ask the `mother' to hold one end of the tube along her breast, so that it goes into the `baby's' mouth with her nipple.
  If it is possible with her clothed, help her to tape the tube in place on her breast. (Alternatively, demonstrate taping the tube to a model breast.)

- Put the free end of the tube into the cup (which would normally have milk in it).
  Find a convenient place for the cup. It may be possible to put it on a table nearby, or it may be easier for the `mother' to hold it.

- Explain that the tube works like a drinking straw. As the baby suckles on the breast, he gets milk from the cup through the tube.
  If the baby gets milk, he continues to suckle, and stimulates the breast. This starts the production of breastmilk. As breastmilk is produced, the amount of milk taken from the cup decreases, and eventually the supplementer is no longer needed.

- Explain that it is important that the baby gets the milk fast enough to reward him for stimulating the breast; but not too fast, or he will not stimulate the breast for long enough.

- Raise the cup, and explain that this makes the milk flow faster, so it is easier for the baby to get. Lower the cup, and explain that this makes the milk flow more slowly.

- Tie a knot in the tube. Explain that a common problem is not being able to find a very fine tube. If the tube is not fine enough, the milk flows too fast. Tying a knot in the tube is a useful way to slow the flow. (Other possibilities include pinching the tube, or putting a paper-clip on it.)

☐ Ask participants to turn to page 146 of their manuals, where they will find the box **HOW TO HELP A MOTHER TO USE A BREASTFEEDING SUPPLEMENTER** which describes the method.

HOW TO HELP A MOTHER TO USE A BREASTFEEDING SUPPLEMENTER

Show the mother how to:

- Use a fine nasogastric tube, or other fine plastic tubing, and a cup to hold the milk. If there is no very fine tube, use the best available.
- Cut a small hole in the side of the tube, near the end of the part that goes into the baby's mouth (this is in addition to the hole at the end).
- Prepare a cup of milk (expressed breastmilk or artificial milk) containing the amount of milk that her baby needs for one feed (see page 343 in this Guide, or page 139 in the Participants' Manual).
- Put one end of the tube along her nipple, so that her baby suckles the breast and the tube at the same time.
  Tape the tube in place on her breast.
- Put the other end of the tube into the cup of milk.
- Tie a knot in the tube if it is wide, or put a paper-clip on it, or pinch it. This controls the flow of milk, so that her baby does not finish the feed too fast.
- Control the flow of milk so that her baby suckles for about 30 minutes at each feed if possible. (Raising the cup makes the milk flow faster, lowering the cup makes the milk flow more slowly.)
- Let her baby suckle at any time that he is willing - not just when she is using the supplementer.
- Clean and sterilise the tube of the supplementer and the cup each time she uses them.

IV. Demonstrate other ways to give supplements (10 minutes)

☐ Show participants some of these other ways to give a baby a supplement while he is suckling at the breast.

These methods are useful if a baby does not suckle strongly at the breast, or if a mother finds a supplementer difficult.

● *Show and explain how to use a syringe*

Use a 5-ml or 10-ml syringe.
Fix a length of fine tubing to the adaptor, about 5 cm in length.
For example, a piece cut from a fine feeding tube, including the adaptor end of the feeding tube.

Explain that the mother measures the milk for a feed into a small cup.
She fills the syringe with milk from the cup.

She puts the end of the tube into the corner of her baby's mouth, and presses out the milk slowly as he suckles.

She refills the syringe and continues until her baby has had the complete feed.
She should try to make the feed continue for 30 minutes (about 15 minutes at each breast).

● *Show and explain how to use a dropper*

The mother measures the milk for a feed into a cup.
She drops the milk into her baby's mouth from the dropper as he suckles.

● *Show and explain how to drip milk down the breast*

Drip expressed breastmilk down the breast and nipple, using a spoon or small cup. Position the baby at the breast so that he licks the milk drops. Slowly put the nipple into his mouth, and help him to attach to the breast. You may need to continue for 3-4 days before he can suckle strongly.

<u>Optional - alternative 1:</u>

V. Talk to a mother with experience of relactation (15 minutes extra)

Ask the mother and baby whom you have invited, to join the class. Introduce them, thank the mother for coming, and ask her again if she is willing to talk to the class.

Ask one participant to talk to the mother, to ask about her experience, why she needed to relactate, and how long it took for her milk to come.
(This is an opportunity for the participant to practise her counselling and history-taking skills.)

Ask the mother to demonstrate the method that she used, or that she still uses.

Compare her experience to the method described.

Optional - alternative 2:

VI. Facilitate the written exercise (10 minutes extra)

☐ Explain what to do:

Ask participants to read the instructions **How to do the exercise** and the **Example** of what to do. Then they should answer the question **To answer.**

EXERCISE 19. ***Relactation***

How to do the exercise:

Use the information in the box **AMOUNT OF MILK FOR BABIES WHO CANNOT BREASTFEED** (page 139) to calculate the total amount of milk the baby needs.

Use the information in the box **HOW TO HELP A WOMAN TO INCREASE HER BREASTMILK SUPPLY** (page 144) to decide how to decrease the milk as the mother relactates (see second point from the bottom in the box).

Example:

Ada died soon after her baby was born. Ada's mother will look after the baby, and she wants to breastfeed him. She breastfed all her own children. The youngest is 12.
Ada's baby is now 4 weeks old and weighs 4.5 kilos. Ada's mother will let the baby suckle, and she will feed the baby formula with a supplementer, while she waits for her breastmilk to come back.

How much artificial milk should Ada's mother give to the baby in total each day at the beginning?

Each day the baby needs 150 ml/kg.

So she needs (150 x 4.5) = 675 ml milk in total each day.

After a few days, when Ada's mother starts to produce a little milk, she will start to reduce the amount of artificial milk by 30 ml each day.
How much milk will she give on the first day that she reduces the amount?

She will give (675-30) ml = 645 ml.

How much milk will she give the next day?

She will give (645-30)ml = 615 ml.

To answer:

A baby of 2 months has been bottle fed for one month. He has become very ill with diarrhoea, and formula feeds make the diarrhoea worse. His mother breastfed satisfactorily for the first 4 weeks, and wants to relactate. The baby seems willing to suckle at the breast. You will feed the baby donated EBM by cup while his mother's breastmilk supply builds up. You will reduce the volume of EBM by 30 ml per day. The baby weighs 4.0 kilos.

How much EBM will you give the baby by cup each day at the beginning?
(Give a total of 600 ml each day.)

How much EBM will you give the baby on the first day that you reduce the amount?
(570 ml.)

How much EBM will you give on the tenth day of reducing the amount?
(300 ml.)

How many days should it take from when you start to reduce the amount to when you stop giving EBM altogether?
(Cup feeds should stop after about 20 days.)

VII. Show Slides 27/1 and 27/2 (5 minutes extra)

Slide 27/1 Breastfeeding supplementer (1)

This slide shows a mother breastfeeding her baby and using a breastfeeding supplementer. She bottle fed her baby, and he became ill with diarrhoea, and then refused to breastfeed again. The mother decided to start breastfeeding again, and to use the supplementer to get her baby to suckle.

You can see the cup which has formula in it, and the tube going from the cup to the mother's breast, and into the baby's mouth. After about 10 days, the mother was producing enough breastmilk, and she was able to stop giving formula.

Slide 27/2 Breastfeeding supplementer (2)

This slide shows another mother using a breastfeeding supplementer, in a similar way. This time you see the arrangement from above.

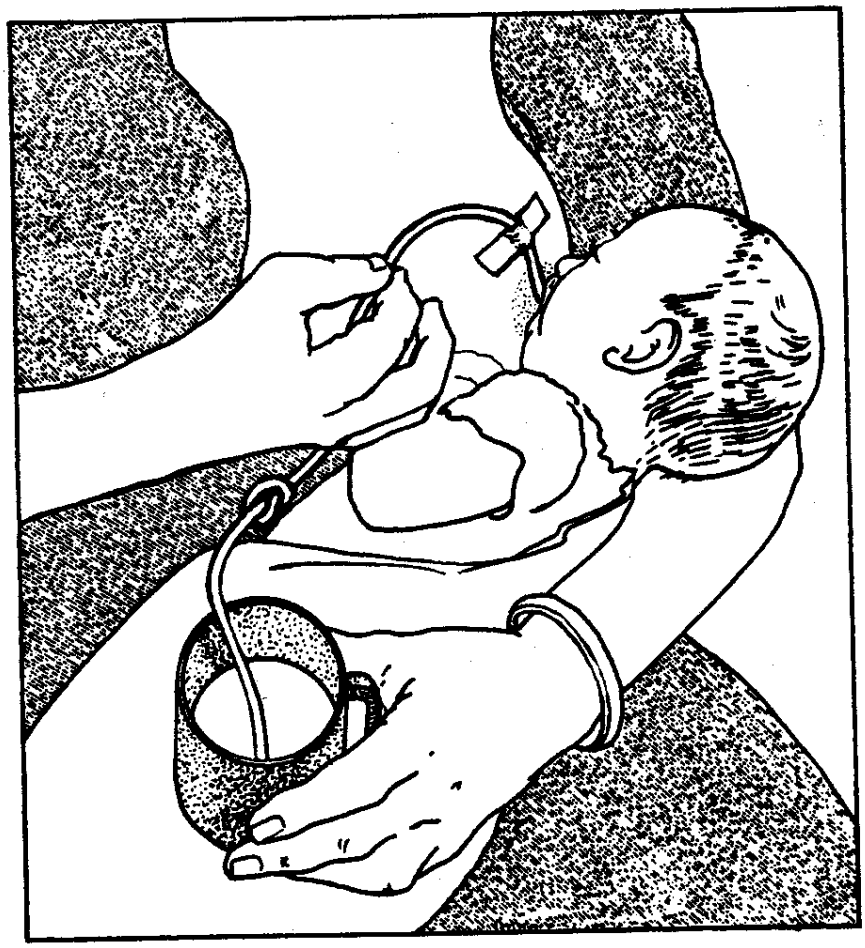

Fig.14 Using a breastfeeding supplementer

(Fig.38 in Participants' Manual)

☐ Recommended reading:
Helping Mothers to Breastfeed Chapter 10, sections 10.5, 10.6, and 10.7.

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SUSTAINING BREASTFEEDING

Objectives

At the end of this session, participants will be able to:
- help mothers to continue to breastfeed for up to 2 years or beyond;
- support breastfeeding when they see mothers and babies for other reasons.

Session outline (60 minutes)

Participants work in groups of 8-10, with two trainers.

I. Introduce the topic (8 minutes)

II. Demonstrate how health workers can help to sustain breastfeeding (Includes showing Overheads 28/1 and 28/2) (12 minutes)

III. Review health workers' opportunities to sustain breastfeeding (10 minutes)

IV. Facilitate the written exercises (Exercises 20 and 21) (30 minutes)

Preparation

Refer to pages 13-15 of the Introduction, for general guidance on how to conduct work in groups.
Study the notes for the session, so that you are clear about what to do.

For Overheads 28/1 and 28/2, decide which alternative is most suitable for your situation, alternative 1 or alternative 2.
Have the overheads ready to show.
If it is not possible to have an overhead projector for each group, show the copies of the overhead figures from the flipchart.

Ask a participant to help you with Demonstrations Z (i) and Z (ii), to play the part of Ester. Explain what you want her to do. Prepare a growth chart for Ester's baby.

As you follow the text remember:

☐ indicates an instruction to you, the trainer
■ indicates what you say to participants

I. Introduce the topic (8 minutes)

Ask participants to keep their <u>manuals closed</u> until asked to open them.

☐ Make these points:

- In the postnatal period, health care practices, family support, and breastfeeding technique are the main factors which determine whether or not breastfeeding is successfully initiated and established.

→ Write this list on the board:

Health care practices
Family support
Breastfeeding technique

- After breastfeeding is established, technique is less likely to cause problems. Social factors become more important.

→ Put brackets around (Breastfeeding technique), and add `Social factors' to the list on the board.

Health care practices
Family support
(Breastfeeding technique)
Social factors

- But health care practices continue to have an important influence on breastfeeding throughout the first two years of life. It is important for all health facilities to support breastfeeding. It is not only maternity wards which have a responsibility.

→ Underline Health care practices on the board.

- In some communities, many mothers stop breastfeeding after a few weeks.

Ask: *Why do you think that breastfeeding is sustained much longer in some communities than in others?*
(Let participants make a few suggestions, then continue.)

Because of the attitude of society to breastfeeding and to mothers.

- Breastfeeding is likely to continue longer if:
  - most people think that it is natural, healthy and important;
  - people think that it is normal and good to breastfeed for two years or more;
  - it is acceptable to breastfeed in public;
  - children who will become parents see babies breastfeeding;
  - women who work outside the home receive support to breastfeed.

- Changes in people's attitude may be made with school and public education, and with social mobilization, which are outside the job of most health workers.

- However, health workers can do a lot to support and encourage women who want to breastfeed their babies. They can help to protect remaining good practices.
  If they do not actively support breastfeeding, they may hinder it by mistake.

- Every contact that a health worker has with a mother may be an opportunity to encourage and sustain breastfeeding.

II. Demonstrate how health workers can help to sustain breastfeeding

(12 minutes)

☐ Explain what health workers can do:

- When a mother brings her baby to a health facility for a routine procedure, for example, weighing, or immunization, and if everything is satisfactory, the health worker often says nothing. She only tells a mother if something is wrong.

- Mothers are sometimes confused or even upset if a health worker says nothing, or sounds critical. They may not feel encouraged to come again.

- Health workers are often short of time, but they can use the time that they have to say something encouraging and supportive.

- Every time you see a mother, try to build her confidence.
  Praise her for what she and her baby are doing right.
  Give relevant information, and suggest something appropriate.

→ Write on the board:

Praise
Inform
Suggest

☐ Give an example:

Show Overhead 28/1

Ask: *What do you think of how this health worker is talking to the baby's mother?*
(Let participants give their opinions. They should be able to give the answer.)

The health worker is criticising and making the mother feel stupid. She is reducing the mother's confidence.

Show Overhead 28/2

Ask: *What do you think of how the health worker is talking to the baby's mother now?*
(Let participants give their opinions. They will probably think of the answer below.)

The health worker is praising the mother's good practice.
Later she can suggest starting complementary foods, in addition to continuing to breastfeed.

☐ Demonstrate the skill:

☺ Ask a participant to play the part of Ester in Demonstrations Z (i) and Z (ii), while you read out her story and play the part of the health worker.

Ask her to stand near you, while you weigh the baby, fill in his growth chart and give it to her.

Demonstration Z (i): Saying too little

Read out the story:

Ester has brought her baby Dan for weighing at 5 months. He is exclusively breastfed, and perfectly well. He has gained 800 g in the last month, and now weighs 7 kg.

Play the health worker:

HW: (Pretend to weigh Ester's baby and mark his growth chart. Do not say anything while you do this. When you have finished, hand Ester the growth chart and say what follows.)

HW: "All right Ester, thank you. Make sure that you keep Dan's growth chart carefully and come back next month."

Ask: *Is what the health worker said to Ester helpful?*
Will Ester think that it is worth coming back, especially if Dan is well?
(Let participants give their opinions briefly.)

What the health worker said did not help Ester or encourage her to come back.

Explain that you will now see Ester again, and this time you will say three things to her. After weighing Dan and filling in his growth chart, you will praise Ester, you will give her some relevant information, and you will suggest something.

Demonstration Z (ii): Sustaining breastfeeding

HW: (As you pretend to weigh the baby.) "How are you feeding Dan?"
Ester: "Just breastfeeding, whenever he wants to."
HW: "Oh, that's good."
(As you fill in his growth chart.)
"Look at Dan's growth line now! What do you think of that?"
Ester: "It is going up, isn't it? Does that mean that he is gaining weight?"
HW: "Yes, Dan gained quite a lot of weight last month - and that is just on your breastmilk" *(praise)*.
"You know, breastfeeding helps to keep a child healthy up to the age of 2 years or more" *(information).*
"Have you thought about starting some other food yet, as well as continuing to breastfeed?" *(suggestion)*.

Ask: *Is it helpful to say these things to Ester?*
Did weighing Dan and talking to Ester take much longer than weighing and saying nothing?
(Let participants give their opinions. Then give yours.)

Saying these things to Ester is helpful and supports breastfeeding.
It does not take much longer than weighing and saying nothing.

III. Review health workers' opportunities to sustain breastfeeding

(10 minutes)

Ask participants to turn to page 151 of their manual, where they will find the box **HOW HEALTH SERVICES CAN SUSTAIN BREASTFEEDING**.

☐ Explain:

- This box lists the main opportunities that health workers (other than in the maternity services) have to help breastfeeding mothers.

☺ Ask participants in turn each to read aloud one point from the list.
Discuss any points that are not clear.

HOW HEALTH SERVICES CAN SUSTAIN BREASTFEEDING

- *Praise all mothers who are breastfeeding*
  Encourage them to continue, and to help other mothers.
  Remember to praise mothers who breastfeed through the second year.

- *Help mothers to breastfeed in the most healthy way*
  For example, to breastfeed exclusively for 4-6 months.
  Help them to improve practices which may cause problems.

- *Encourage mothers to come for help before they decide to start artificial feeds*
  For example, if they are worried about their breastmilk supply.
  Or if they have a breastfeeding difficulty or question.

- *Refer mothers to a breastfeeding support group if appropriate.*
  (See Session 8, `Health care practices'.)

- *Provide appropriate family planning advice for women who are breastfeeding*
  Encourage a mother not to start a new pregnancy until this child is 2 years old or more.

- *Remember to encourage breastfeeding when you see a mother for:*
  - her postnatal check (in the first week, and at 6 weeks);
  - family planning;
  - growth monitoring (especially poor weight gain of baby);
  - nutrition education;
  - immunization (including for measles at 9 months).

  At the 9 months visit, encourage her to continue breastfeeding the child, with complementary foods, for another 12-15 months or more.

- *Help mothers to continue breastfeeding in these difficult situations:*
  - because they have to return to work;
  - with twins or low-birth-weight babies;
  - with a disabled baby;
  - if a mother is ill or disabled.

- *Help mothers to breastfeed sick babies and young children*
  A mother can increase her breastfeeds to 12 or more per day.
  If her baby cannot suckle, help her to express her breastmilk to feed him (see Session 20, `Expressing breastmilk').

- *Inform your colleagues about what you are trying to do*
  Make sure that health workers in other sectors understand about breastfeeding. Ask for their support, and offer to help them if they are caring for mothers and babies.

☐ Make these additional points:

- It is especially important to discuss breastfeeding when you weigh a baby. Growth monitoring is a helpful way to know if a baby is getting enough breastmilk. Poor growth is an important sign that a mother and baby need help.

- If a mother does not have a growth chart, or if you cannot weigh a baby, you can still talk about breastfeeding. You should have a good idea if breastfeeding is going well or not from the baby's appearance and behaviour. You can ask about his urine output.

IV. Facilitate the written exercises (30 minutes)

☐ Ask participants to do Exercises 20 and 21, on pages 152-158 of their manuals.

☐ Explain what to do:

Ask participants, for both Exercise 20 and Exercise 21, to read the instructions **How to do the exercise**, and the **Example** of what to do. Then answer the questions **To answer**.

Note: The answers are not the only `right' answers. Participants may think of something else, which is just as good. You must judge if a different answer is satisfactory.

EXERCISE 20. ***Sustaining breastfeeding***

How to do the exercise:

The mothers in these stories are coming to see you for some reason other than breastfeeding. First you will help them for the other reason, then think what you can say about breastfeeding.

In the space after the case details, write something to praise the mother, give some relevant information, and suggest something useful.

Number 3 is optional, to do if you have time.

When you are ready, discuss your answers with the trainer.

Example:

Linnet brings her 9-month-old baby for measles immunization. He has started eating complementary foods about 4 times a day, and still breastfeeds. He has no weight chart, but today weighs 8.0 kg.

Praise: It is good that you are continuing to breastfeed at the same time as giving other foods.

Inform: Breastfeeding up to 2 years of age or beyond is recommended these days.

Suggest: At this age, it is a good idea to breastfeed before you give a meal of food, then he gets plenty of breastmilk.

To answer:

1. Celia brings her 14-week-old baby for his third DPT and polio immunizations. He is exclusively breastfed, and has gained 2.5 kg since birth.

Praise: You must be pleased that he is gaining weight so well on your breastmilk alone.

Inform: Breastfeeding helps to protect a baby against illnesses, rather like immunization.

Suggest: It is a good idea to give nothing but breastmilk for 6 months.

2. Ines brings her 12-month-old child with fever and diarrhoea. He has no weight chart, but today weighs 8.5 kg. He has lost his appetite, and does not want to eat much food. He still breastfeeds, mostly at night.

You have given appropriate advice and treatment for fever and diarrhoea. What will you say to Ines about breastfeeding?

Praise: It is good that you are still breastfeeding, especially as he does not want other food.

Inform: Breastmilk helps diarrhoea to get better, and it gives him some of the food and fluids that he needs while he is eating so little.

Suggest: Would you be able to breastfeed him more often? Breastfeeding up to 12 times a day or more can be helpful for a sick child.

Optional (to do if you have time)

3. Mona brings her 15-month-old son for treatment of a cough and difficult breathing. He has a fever, and is not eating well. He breastfeeds, but pulls away to breathe before he has suckled for long.

After you have examined the child, counted his breathing, and given appropriate treatment, what would you do to support breastfeeding?

Praise: Breastfeeding is very comforting for a sick child.

Inform: His breathing may be making it difficult for him to suckle for more than a short time, but breastmilk helps a baby when he is sick.

Suggest: He may find it easier if he feeds more often and for a shorter time for a few days, until his breathing is easier.

Or:

Would you like me to show you how to express your milk and give it to him by cup for a day or two?

EXERCISE 21. ***Breastfeeding and growth charts***

How to do the exercise:

Study the growth charts of the following babies, and the short notes that go with them. Then answer the questions briefly.

When you are ready, discuss your answers with the trainer.

Example:

Baby 1 is exclusively breastfed. He slept with his mother until 8 weeks ago. Now he sleeps in a separate bed.
What is Baby 1's mother doing that you could praise?

His mother has breastfed exclusively all this time.

What do you think about Baby 1's recent weight gain?

His growth is slowing down.

Why may this have happened?

He stopped having night feeds.

What would you suggest to his mother about feeding him now?

Let her baby sleep with her again, to breastfeed at night.
Soon she should add complementary foods.

To answer:

Baby 2 has come for immunization. His mother says that he is well. He is a very good baby and cries very little. He only wants to feed about 4-5 times a day, which his mother finds helpful, because she is very busy.

What could you say to show that you accept how Baby 2's mother feels?

("You find it helpful to have a contented baby?")

What do you think of Baby 2's weight gain?

(He is gaining weight too slowly.)

What is the reason?

(He does not breastfeed often enough.)

What would you like to suggest to Baby 2's mother about feeding him?

(Could she feed him more often? She need not wait for him to show signs of hunger.)

Baby 3 was exclusively breastfed until last month. Now his mother gives him drinks of water, because the weather is hot and he seems so thirsty.

What do you think of Baby 3's weight gain?

(He gained very well for the first 2 months, but last month he has gained too slowly.)

What is the reason for his weight this month?

(He has been having drinks of water.)

(Note: Giving water may make a baby suckle less at the breast, so he takes less breastmilk.)

What relevant information could you give to Baby 3's mother? Try to give positive information.

(Breastmilk contains all the water that a baby needs even in hot weather.)

What would you suggest to his mother?

("Could you breastfeed more often if he is thirsty, instead of giving drinks of water?")

Baby 4 has come for measles immunization. He breastfeeds frequently by day, and sleeps with his mother and breastfeeds at night. Two months ago his mother started to give him thin cereal porridge once a day.

What is Baby 4's mother doing right?

(She is breastfeeding frequently by day and by night.)

What do you think of Baby 4's weight gain?

(He gained weight well for the first six months of life, but since then he has stopped growing.)

What do you think is the reason for the change?

(He is not getting enough complementary food.)

(Note: At this age breastmilk alone is not enough.)

What two things would you suggest to his mother?

(1. Give him energy-rich and nutrient-rich complementary foods 4-5 times a day.
2. Continue breastfeeding day and night, in addition to giving more food. Think of continuing to breastfeed until he is 2 years old).

Baby 5's mother has come for help with family planning. When you have given her this help, you ask about the baby. He was exclusively breastfed until the age of 6 months. Since then he has had complementary food at first twice, and more recently four times, a day. He continues to breastfeed at night and several times during the day.

What do you think about Baby 5's growth?

(He is growing very well.)

(Note: He is not `overweight'. His growth line is following the reference curve.)

What can you say to praise his mother?

("You must be pleased that he is doing so well, mainly because you are feeding him in such a healthy way.")

What would you suggest to his mother about breastfeeding?

(It would be a good idea to continue breastfeeding until he is at least 2 years old.)

☐ Give participants Answer Sheets for Exercises 20 and 21.

☐ Recommended reading:
Helping Mothers to Breastfeed Chapters 11 and 12.

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CLINICAL PRACTICE 4

Counselling mothers in different situations

Objectives

Participants practise all the skills from Clinical Practices 1, 2, and 3.

When they have completed Clinical Practice 3 and 4, they will have seen mothers in as many of these situations as possible:
- after normal deliveries;
- after Caesarian section;
- with difficulty breastfeeding;
- with different breast conditions;
- with low-birth-weight babies and twins;
- with sick children;
- who have brought a baby for immunization or growth monitoring;
- in family planning clinics;
- in antenatal clinics.

Session outline (120 minutes)

Participants are together as a class led by one trainer to prepare for the session, and if time permits to discuss it afterwards.

Participants work in pairs in a ward or clinic. Each trainer supervises the 2-3 pairs in her group.

I.	Prepare the participants	(10 minutes)
II.	Conduct the clinical practice	(90 minutes)
III.	Discuss the clinical practice	(20 minutes)

Preparation

Make sure that you know where the clinical practice will be held. Visit the wards or clinic if you have not done so before.

Study the instructions in the following pages, and ask other trainers to study them also. Make sure that you are clear about how this session differs from previous clinical practices.

Arrange for each group of participants to meet mothers in different situations from those that they met in Clinical Practice 3, so that by the end of the session they have met mothers in as many different situations as possible.

Make available spare copies of the **COUNSELLING SKILLS CHECKLIST**, the Breastfeeding History Form and the B-R-E-A-S-T-FEED Observation Form.

Make sure that you and other trainers each have a copy of the **CLINICAL PRACTICE DISCUSSION CHECKLIST**.

I. Prepare the participants (10 minutes)

☐ *Explain the objectives of the exercise:*

You practise all the clinical and counselling skills that you have learnt.

You will work as far as possible with mothers in different situations from those that you met in Clinical Practice 3.

☐ *Explain what participants should take with them:*

- Take with you:
  - one copy of the **COUNSELLING SKILLS CHECKLIST**;
  - pencil and paper to make notes.
  - copies of the B-R-E-A-S-T-FEED Observation Form and the Breastfeeding History Form to refer to if necessary.

You do not need to take anything else.

☐ *Make sure that participants have copies of the checklist and other forms.*

☐ *Explain how participants will work:*

You work in pairs, as in Clinical Practice 3. Each trainer circulates between the pairs in her group, to observe, comment, and help where necessary.

☐ *Remind participants what to do when they talk to a mother:*

- Learn all that you can about the mother's situation, her breastfeeding experiences and practice, using your listening and learning skills, and history-taking skills.
  Assess a breastfeed, and examine the mother and baby if necessary.
  Practise building the mother's confidence, and giving her support.
  Help the mother, or suggest something helpful if you can.

II. Conduct the clinical practice (90 minutes)

☐ *Take your group to the ward or clinic:*

Conduct the session in the same way as Clinical Practice 3.

Groups should go to different parts of the health facility, so that they see mothers in different situations.

Help pairs of participants to find mothers and babies to talk to and work with.

Circulate between the pairs, to help them if necessary.

If a mother has a difficulty, participants can help her. Discuss with them what they do, to make sure that they give appropriate help.

If possible ask a responsible member of staff of the facility to be with when you help a mother.

Discuss the mother's situation with the staff who are caring for her. This helps to ensure that suggestions and help are consistent, and that the difficulty is followed up.

☐ *Discuss the participants' performance:*

When a pair have finished talking to a mother, take them away from the mother, and discuss what they did, and what they learnt.

- Ask them to tell you about the mother, what she is doing well, if she has any difficulties, and what they would suggest to help her.

- Go through the **CLINICAL PRACTICE DISCUSSION CHECKLIST** to help you to conduct the discussion.

- Discuss what they learnt from the mother, and if her situation is common or unusual. Discuss what else it might be possible to do in other similar situations.

☐ *Check participants' progress*

Follow the progress of the participants in your group. Go through each participant's **CLINICAL PRACTICE PROGRESS FORM** with her. Help them to find mothers in the different situations so that they can complete all the suggested skills practices.

By the end of this session, participants should have practised all the skills, and they should have seen mothers in most of the situations listed in the Objectives for Clinical Practice 3 and 4.

III. Discuss the clinical practice (20 minutes)

The whole class comes back together to discuss the clinical practice, led by the same trainer who led the preparatory session.

☐ *Ask one participant from each group to report briefly on what they learnt.*

☺ Ask them to report on the most interesting situations that they observed among the mothers and babies whom they saw, and what they learnt from them.

If participants have not finished seeing mothers and babies at the end of the 90 minutes allowed for `II. Conduct the clinical practice', they can continue and finish, and if necessary omit the class discussion.
You must decide what is the most useful way to spend this time.

However, try to have a class discussion at the end of either Clinical Practice 3 or Clinical Practice 4.

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CHANGING PRACTICES

Objectives

Participants review the practices in the health facility where they work, and decide whether or not those practices support breastfeeding.

Participants will identify practices which need to change.
They will list practices that they can change themselves, and practices which can only be changed with administrative help.

Session outline (90 minutes)

Participants work in groups of 4-5 according to their type of work situation. Trainers act as resources.

I. Introduce the session (5 minutes)

II. Conduct the group work (Exercise 22) (55 minutes)

Participants are together as a class for discussion led by one trainer.

III. Conclude the session (30 minutes)

Preparation

Make available spare copies of the **ASSESSING AND CHANGING PRACTICES FORM** on which groups and individuals can write their conclusions. Have one copy for each participant and each trainer, and a few spares.
Ask the course secretary to be available to copy or type up the groups' suggestions.

Divide participants into groups of 4-5 according to their type of work situation.
For example, health workers from maternity hospitals can be grouped together; health workers from health centres can be grouped together. If several participants are from the same institution, ask them to work together.
Write the names of participants in the different groups onto a board or flipchart, so that they can all see which groups they belong to.

As you follow the text, remember:

☐ indicates an instruction to you, the trainer
■ indicates what you say to participants

I. Introduce the session

☐ Give each participant a loose copy of the **ASSESSING AND CHANGING PRACTICES FORM**. Explain that this is the same form that they will find in Exercise 22 on pages 160-165 of their manuals.

☐ Explain what the session is about:

- During this session you will review the practices in your own health facility, or other working situation, and consider whether or not the practices support breastfeeding.

- You will identify practices which need to change. You will make a list of changes that you can make yourself, and another list of changes for which you need administrative help. Your suggestions may be used when the course is followed up, to see if you have been able to change practices in this way.

II. Conduct the group work (55 minutes)

EXERCISE 22. ***Assessing and changing practices***

☐ Read through the instructions **How to do the exercise** with the participants.

How to do the exercise:

- Go through the **ASSESSING AND CHANGING PRACTICES FORM**.
  The first four 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 loose 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 a maternity facility and do not deliver babies) leave the questions about that activity blank.

- Then look at the short forms on the last page.
  - In the top form, list 5-10 changes that you could make immediately, by changing your own practice.
  - In the bottom form, list 1-4 useful changes that require an administrative decision.

- If you wish to keep a personal copy, copy the answers onto the form in your manual.

☐ Let the groups work by themselves.

You and the other trainers act as resource people. You can help to start the discussion in a group, or you can help to keep a group working, or you can sort out difficulties. However, you should not lead the discussion.

ASSESSING AND CHANGING PRACTICES FORM

Practice	**YES / NO**	**What is done well and/or main improvement needed**
Policy ● Does your health facility have a breastfeeding policy? ● Is this a written policy? Does it cover the `Ten Steps to Successful Breastfeeding?		
Antenatal preparation ● Do you inform all pregnant women about: - the benefits of breastfeeding - the management of breastfeeding		
Initiating breastfeeding (if normal, vaginal) ● Are women routinely sedated during normal labour? ● Do you give mothers their babies to hold, with skin-to-skin contact, within half an hour of delivery? ● Do the babies stay with their mothers at this time for at least 30 minutes? ● Does a member of staff offer mothers help to initiate breastfeeding within 1 hour of delivery? (if Caesarian Section) ● Do mothers hold and breastfeed their babies within 4-6 hours of the operation, or as soon as they are conscious?		

Practice	**YES/NO**	**What is done well and/or main improvement needed**
Establishing breastfeeding		
● Do nursing staff offer all mothers further assistance with breastfeeding within 6 hours of delivery?		
● Do you make sure that mothers are able to position and attach their babies well?		
● Do you show breastfeeding mothers how to express their breastmilk?		
● Do you help mothers of babies in special care to establish and maintain lactation by frequent expression of breastmilk, from the first day?		
● Do mothers and infants remain together 24 hours a day?		
● Do you restrict the frequency or length of breastfeeds?		
● Do you encourage mothers to breastfeed their babies `on demand'?		
● Do babies receive food or drink other than breastmilk, (except when medically indicated) - formula? - glucose water or water?		
● Do you use feeding bottles for babies whose mothers intend to breastfeed?		
● Do you allow breastfed babies to use pacifiers?		
● Are free supplies of formula available?		
● Do you check on the support that mothers will have when they go home? Are you able to refer mothers to a breastfeeding support group?		

Practice	YES/NO	What is done well and/or main improvement needed
Sustaining breastfeeding		
● Is there a follow-up visit for mothers within 1 week of delivery, to make sure that breastfeeding is going well, and to give early help with any difficulties?		
● Do you check on breastfeeding and observe a breastfeed at the 6-week postnatal visit?		
● Do you praise and support all mothers who are breastfeeding?		
● Do you praise and support mothers who are breastfeeding in the child's second year?		
● Do you help mothers to improve practices which may cause problems?		
● Do you help mothers who have questions about breastfeeding, even if they have no serious difficulty?		
● Are you able to help mothers who are worried about their breastmilk supply, so that they continue to breastfeed, without unnecessary complements?		
● Are you able to help mothers with breast conditions and common breastfeeding difficulties, so that they continue to breastfeed?		
● Do you remember to discuss breastfeeding when mothers and babies come to you for another reason: - growth monitoring - immunization (including measles at 9 months) - treatment when baby is ill - family planning		
● Do you help mothers to continue breastfeeding if the child is sick?		

Practice	YES/NO	What is done well and/or main improvement needed
● When you give family planning advice to breastfeeding mothers, do you make sure that the method they choose is suitable with breastfeeding?		
● Are you able to give extra help and support to mothers and babies with special needs, so that they can continue to breastfeed? e.g.: - low-birth-weight babies - twins - babies with disabilities - if the mother is sick or disabled		
● Are you able to help women who work away from home, but who wish to continue breastfeeding?		
● Do you inform your colleagues about breastfeeding, so that they also know that it is important?		
Health education		
● Is breastfeeding included in your health education talks and materials?		
● Is breastfeeding included in your talks on nutrition, and in your talks on the introduction of complementary foods to children?		
● Do you encourage women to breastfeed exclusively for at least 4, and if possible, 6 months?		
● Do you encourage women to continue to breastfeed for up to 2 years of age and beyond?		

CHANGES THAT HEALTH WORKERS COULD MAKE THEMSELVES
(Make 5-10 practical suggestions)

1.

2.

3.

4.

5.

6.

7.

8.

9.

10.

CHANGES THAT NEED ADMINISTRATIVE HELP
(List 1-4 helpful administrative changes)

1.

2.

3.

4.

IV. Conclude the session

☺ Ask groups to present their conclusions briefly to the whole class.

☐ 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.

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BREASTFEEDING COUNSELLING

A TRAINING COURSE

TRAINER'S GUIDE

PART FOUR

Sessions 31-34

WORLD HEALTH ORGANIZATION CDD PROGRAMME

UNICEF

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Additional sessions

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WOMEN'S NUTRITION, HEALTH AND FERTILITY

Objective

At the end of this session, participants will be able to:
- advise a breastfeeding mother what to eat;
- help a mother who is ill to continue breastfeeding;
- decide if a drug that a breastfeeding mother is taking may be unsafe for her baby;
- inform mothers about how breastfeeding can help family planning;
- help breastfeeding mothers to find a method of contraception which does not interfere with breastfeeding.

Session outline (60 minutes)

Participants all together for presentation by one trainer

I.	Introduce the topic	(3 minutes)
II.	Present Overheads 31/1 to 31/8	(30 minutes)
III.	Answer participants' questions	(7 minutes)

Participants work in small groups of 4-5 with one trainer

IV.	Group discussion (Exercise 23)	(20 minutes)

Preparation

Refer to pages 9-11 in the Introduction, for general guidance about how to show overhead transparencies, and to pages 13-14 for guidance on conducting discussion in groups.

Make sure that Overheads 31/1 to 31/8 are in the correct order.
Study the overheads and the text that goes with them so that you are able to present them.
Read the **Further information** sections. so that you are familiar with the ideas that they contain.

As you follow the text, remember:

☐ indicates an instruction to you, the trainer
■ indicates what you say to participants

Do not present the **Further information** sections.
Use them to help you to answer questions.

I. Introduce the topic (3 minutes)

☐ Explain what the session will be about:

- When you help a mother to breastfeed, it is important to remember her own health, and to care for her as well as her baby.

- You need to think about the mother's nutrition, because this affects her health, energy and well-being.

- You need to know how to help a mother to breastfeed if she becomes sick. You may be concerned about whether her illness or the drugs that she is taking can affect her baby.

- Breastfeeding and family planning help each other. You need to be able to give mothers the information that they need about breastfeeding and family planning.

☐ Refer back to the list of reasons for stopping breastfeeding or for starting complementary feeds early from Session 2, `Local breastfeeding situation'. Remind participants if they identified factors such as pregnancy, sickness or malnutrition of the mother as important in their situation.

II. Present Overheads 31/1 to 31/8 (30 minutes)

☐ As you show each overhead transparency, point on the projector or on the screen to the place where it shows what you are explaining.

Overhead 31/1 Source of energy and nutrients in breastmilk

- This diagram shows a woman's body, with an extra layer of fat drawn around it.

This is the extra fat that a well-nourished woman builds up during pregnancy. The fat will be used during the first few months of lactation to make breastmilk.

A poorly nourished woman builds up a smaller store of fat.

Making breastmilk uses about 700 Calories a day. The diagram next to the woman shows that in a well-nourished woman about 200 Calories come from her fat stores, and about 500 Calories must come from the food that she eats during breastfeeding.

In addition to energy, breastmilk contains protein, minerals, and vitamins.

If a woman eats a variety of foods, and is not hungry, she will normally eat more protein, minerals and vitamins than her body needs. A breastfeeding mother uses these extra nutrients to make breastmilk.

If a mother is on a very poor diet, there may not be enough extra nutrients. If she has any stored nutrients, she uses these to make breastmilk. If she has no stores, the nutrients come from her own body tissues, and she becomes malnourished.

Overhead 31/2 Effect of mother's nutrition on breastmilk production

- This overhead shows the probable effect of malnutrition of the mother on breastmilk production.

Ask: *What differences do you see in the amount of breastmilk produced by well nourished and malnourished mothers?*

With moderate malnutrition, breastmilk production is adequate and of good quality. It is only with severe malnutrition that breastmilk production is reduced.

A severely malnourished woman may continue to produce perhaps 500 ml of breastmilk if her baby suckles frequently. Her breastmilk may contain less fat and less of some vitamins than breastmilk from a well nourished mother, but is otherwise of good quality.

Key point:

- *Even when there are smaller amounts of some nutrients, breastmilk is always better than any artificial food.*

Overhead 31/3 Mothers' nutrition needs for breastfeeding

▪ A breastfeeding mother should eat enough food to provide nutrients to make breastmilk, and to prevent her own body tissues from being used up. She needs enough food to help her to feel well and strong enough to care for her family.

This overhead gives an example from one country of the extra food that a breastfeeding mother is advised to eat, in addition to her usual food.

She needs to eat food which provides about 500 Calories extra. If this is from a variety of foods, then the extra protein and vitamins and minerals will automatically be provided.

Women who can afford to eat freely, increase their food intake in response to their appetite. They do not usually need advice to eat more, though they may need advice to eat a variety of foods.

Women who are poor may need help if they are to eat any extra food at this time. Probably the most useful recommendation for a mother is to eat an extra helping of her usual food each day. Different or special foods are unlikely to be available.

If you give any food or vitamin supplements during breastfeeding, give them to the mother, and not to the baby. Give them to the mother through the whole breastfeeding period - not just for the first few months.

It is equally important for a woman to eat enough before and during pregnancy. This will help her to keep strong, and to build good stores of energy and nutrients which her body can use to make breastmilk. Also if she is well nourished, her baby is less likely to be low-birth-weight.

Further information
It is not certain whether or not increased food intake during breastfeeding increases breastmilk production. The purpose of giving supplements to the mother is to improve her own nutrition, and to ensure that there are enough vitamins in her breastmilk. Encourage her to build up her breastmilk supply by feeding her baby often. Try to avoid suggesting early complements for a baby, especially in a family which may be having difficulty in buying enough food.

Overhead 31/4 Breastfeeding when a mother is ill

☐ Discuss the question for a few minutes before you show the overhead.

Ask: *Is it necessary for a mother to stop breastfeeding when she is ill?*
(Let a few participants give their opinions, or mention experiences. Then continue.)

▪ It often happens that a mother stops breastfeeding when she is ill, for a variety of reasons. She may fear that her baby will catch the illness; someone may have advised

her to stop; 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 breastmilk may be the best protection for the baby.
It is no longer considered necessary to separate mothers with 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.

☐ Show Overhead 31/4. Reveal it line by line, starting from the top.

▪ This overhead summarizes what you can do to help a sick mother to continue to breastfeed.

1. When you treat a sick woman, remember to ask if she has a breastfeeding baby. Reassure her that she can continue to breastfeed, and that you will help her.

2. If a mother is admitted to hospital, admit her baby with her, so that she can continue to breastfeed.

3. If she has a fever, encourage her to drink plenty, so that her breastmilk does not decrease because of dehydration.

4. If she is unwilling to breastfeed, or feels too unwell, suggest that she expresses her breastmilk to keep up the supply. Help her to express her milk as often as her baby would feed, or about every 3 hours. Feed the baby his mother's EBM if possible, or artificial milk if necessary. Feed him from a cup, so that he is willing to breastfeed again when she is well.

5. If she is so ill that she is unable to care for her baby at all (for example if she is unconscious) it may be possible to express her milk for her. Feed the baby by cup, until his mother is well enough to start breastfeeding again.

6. If she is mentally ill, try to keep the baby with her, and look after them together. Let the mother breastfeed if she can. If possible find a helper who can stay with her to make sure that she does not neglect or injure her baby.

7. When the mother is well again, help her to increase her breastmilk or relactate if necessary.

Further information
The question of advising a mother with HIV infection about breastfeeding will be discussed separately, according to recent WHO recommendations. If participants ask, give them the following information. There is a small risk of transmitting HIV infection by breastfeeding. For most mothers and babies, the risk of artificial feeding is greater than the risk of transmitting HIV. Only mothers who can bottle feed safely, and who can afford to buy enough formula, should be advised to stop breastfeeding if they know

that they are HIV positive. Women who cannot bottle feed safely, and women who do not know their HIV status, should breastfeed normally.

Overhead 31/5 Mother's medications

▪ If a mother is taking medicines, a health worker sometimes advises her not to breastfeed. The health worker fears that the medicine may pass into the mother's breastmilk and harm her baby.

However, most drugs pass into breastmilk in only small amounts. Few of them affect the baby. In most cases, to stop breastfeeding is more likely to be dangerous than the medicine. There are a few drugs which may cause side-effects. Problems are more likely with babies less than one month old, and less likely in older babies.

It is usually possible to give the mother an alternative which is less likely to cause a problem. It is rarely necessary to stop breastfeeding because of a mother's medication.

This overhead 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 makes it necessary to stop breastfeeding.*
  If a mother is taking psychiatric drugs or anticonvulsants, these sometimes make her breastfed baby drowsy or weak. This is especially likely with barbiturates and diazepam, and if the baby is less than one month old.

  Sometimes it is possible to change to an alternative drug which is 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.

- *Some antibiotics should be avoided if possible.*
  Most antibiotics given to a breastfeeding mother are safe for her baby. It is better to avoid chloramphenicol and tetracycline if possible, and also metronidazole.
  However, if one of these antibiotics is the drug of choice for treating a mother, continue breastfeeding, and observe her baby. In most cases there will be no problem.

  Avoid giving a mother sulphonamides, especially if her baby is jaundiced. If treatment with cotrimoxazole, Fansidar, or dapsone is necessary, give the drug and continue breastfeeding. Consider an alternative method of feeding if the baby is jaundiced, especially if he becomes jaundiced while his mother is taking the drug.

- *Drugs which may decrease breastmilk should be avoided if possible.*
  Avoid using contraceptives which contain estrogens (but see also Overhead 31/8).

Avoid using thiazide diuretics, such as chlorthiazide. These drugs may reduce the breastmilk supply. Use an alternative if possible.

- *Most other commonly used medicines are safe in the usual dosage.*

If a breastfeeding mother is taking a drug that you are not sure about:

- Check the list in your manual (see page 170)
- Encourage the mother to continue to breastfeed while you try to find out more.
- Watch the baby for side-effects such as abnormal sleepiness, unwillingness to feed, and jaundice, especially if the mother needs to take the drug for a long time.
- Try to ask the advice of a more specialized health worker, for example, a doctor or pharmacist.
- If you are worried, try to find an alternative drug that you know is safe.
- If a baby has side-effects and you cannot change his mother's medication, consider an alternative feeding method, temporarily if possible.

☐ Ask participants to look at the table **BREASTFEEDING AND MOTHERS' MEDICATION** on page 170 of their manuals. This is similar to Overhead 31/5, but with more details. It includes a list of the kinds of commonly used drugs that are usually safe.

BREASTFEEDING AND MOTHERS' MEDICATION

Breastfeeding contraindicated	Anticancer drugs (antimetablites); Radioactive substances (stop breastfeeding temporarily)

Continue breastfeeding:

Side-effects possible *Monitor baby for drowsiness*	Psychiatric drugs and anticonvulsants
Use alternative drug if possible	Chloramphenicol, tetracyclines, metronidazole quinolone antibiotics (e.g. ciprofloxacin)
Monitor baby for jaundice	Sulphonamides, cotrimoxazole, Fansidar, dapsone
Use alternative drug (may decrease milk supply)	Estrogens, including estrogen-containing contraceptives Thiazide diuretics
Safe in usual dosage *Monitor baby*	Most commonly used drugs: analgesics and antipyretics: short courses of paracetamol, acetyl salicylic acid, ibuprofen; occasional doses of morphine and pethidine; most cough and cold remedies. antibiotics: ampicillin, cloxacillin and other penicillins erythromycin, anti-tuberculars, anti-leprotics (see dapsone above) antimalarials (except mefloquine), antihelminthics, antifungals; bronchodilators (e.g. salbutamol), corticosteroids, antihistamines, antacids, drugs for diabetes, most antihypertensives, digoxin, nutritional supplements of iodine, iron, vitamins.

☐ Tell participants that this table is a summary of the most important information. Explain that the reference "Annex on Breastfeeding and Maternal Medication: Recommendations for Drugs in the Essential Drugs List" contains a more detailed list of drugs, which they can refer to if necessary. Make sure that participants all have a copy of this annex.

Overhead 31/6 Breastfeeding to delay a new pregnancy

- The next three overheads are about breastfeeding and family planning.

Breastfeeding can delay the return of ovulation and menstruation, so it can be a useful way to help space pregnancies.

Breastfeeding can protect against a new pregnancy only if the mother is not menstruating, that is, while she still has *amenorrhoea* after delivery. If she is menstruating, her fertility is back to normal, and breastfeeding does not protect her.

Breastfeeding can give good protection for the first 6 months after delivery, if the mother breastfeeds fully. If she gives complementary feeds, protection is less. Protection is probably best if she breastfeeds frequently, both during the day and at night.

After the age of 6 months, breastfeeding gives less protection. At this age, all babies should have complementary food. However, if a baby continues to breastfeed frequently, in addition to complementary food, his mother is partly protected against a new pregnancy. This partial protection can be useful, if she is unable for social or other reasons to use another family planning method.

Further information
In most women, menstruation returns before conception. So menstruation is the main sign that a woman is fertile again. However, a few women ovulate and can conceive BEFORE they start to menstruate again. This is more likely to happen when the baby is more than 6 months old. This is why the risk of pregnancy before menstruation is greater after a baby is 6 months old.

Overhead 31/7 The Lactational Amenorrhoea Method (LAM)

- This overhead summarizes the *Lactational Amenorrhoea Method* of child spacing, or *LAM*.

If a mother's menstruation has not returned, AND her baby is less than 6 months old, AND he is fully breastfed, and breastfeeding on demand, the chances of a new pregnancy are very small (less than 2%). In this situation, it is not necessary to use another family planning method.

If a mother's menstruation has returned, OR if her baby is more than 6 months old, OR if he has started to have complementary feeds, it is advisable for her to use another method of family planning.

If a woman does not want to rely on breastfeeding for family planning (for example, because she is returning to work, and she does not breastfeed her baby while she is away from home) she should be prepared to start another method *not later than six weeks after delivery* - that is, no later than her final postnatal check.

Overhead 31/8 Other methods of family planning and breastfeeding

- This overhead summarizes other family planning methods which can be used while a mother is breastfeeding.

Family planning is important to help breastfeeding to continue. Many mothers stop breastfeeding if they become pregnant again. So it is important to discuss family planning with breastfeeding mothers. Make sure that the method that a mother chooses is suitable to use with breastfeeding.

All *non-hormonal methods* are suitable. They have no effect on lactation. The IUD is very suitable. Condoms, diaphragms, and spermicides are also suitable, provided the couple can use them correctly. They may help to supplement the partial protection provided by breastfeeding after the baby is 6 months old.

The *progestogen-only* hormonal methods are also suitable with breastfeeding. These include *depo-provera*, and the newer *norplant*, or the progestogen-only pill. These have either no effect on lactation, or they possibly increase the breastmilk supply slightly.

The least suitable group are the *combined estrogen-progestogen* hormonal methods, such as the `combined pill', or the newer monthly injection. These methods sometimes decrease the breastmilk supply, so it is best to avoid them during breastfeeding if possible. Avoid them at any time, including after the baby has started complementary foods. However, if no other method of family planning is available, it is better for both mother and child if the mother uses the combined pill, than that she risks an early pregnancy. Encourage her to continue breastfeeding frequently, to make sure that her breastmilk supply does not decrease.

No hormonal method should be used during the first 6 weeks after delivery.

Further information

Sterilization
This is another method of family planning that it is important to consider. Sterilization does not affect lactation. However, it is important not to interrupt breastfeeding while a mother is undergoing the operation. Keep the baby near her, and let her breastfeed as soon as possible after the operation.

Natural methods
Methods such as the rhythm method are complicated to use during breastfeeding, when menstruation has not returned.

III. Answer participants' questions (7 minutes)

☐ Ask participants if they have any questions, and try to answer them.

IV. Group discussion (20 minutes)

☐ Gather your group of 4-5 participants in a corner of the classroom.
(Other trainers do the same).

☐ Explain what you will do:

- For Exercise 23, you will read and discuss some stories about breastfeeding mothers who need family planning help.

- First read **How to do the exercise**. Then read one of the **Stories to discuss**.
Then discuss the questions after the story.

EXERCISE 23. ***Breastfeeding and family planning***

How to do the exercise:

Read the following short stories about women who have come for help with family planning.
After each story, discuss with the group how to answer the questions.
When you are ready, discuss your suggestions with the trainer.

Stories to discuss:

Meena had her second baby two weeks ago. Her firstborn son Arun is 12 months old. Meena breastfed Arun partially, but also gave him 3 bottles of formula a day from the age of 1 month, because she thought that she did not have enough milk. She wants a rest now, and does not want to get pregnant again for a long time. But her husband is unwilling to use family planning. She does not have a job, and stays at home.

What could you say to empathize with how Meena feels?
("You feel tired with two babies so close together."
"You want a rest from being pregnant now.")

What information would you give Meena, about how to delay another pregnancy?
(Explain the LAM method of family planning. Explain that if her periods have not returned, and if she breastfeeds her new baby fully, with no complementary feeds, she will have good protection against another pregnancy for 6 months.
She will continue to have partial protection as long as her menstruation has not returned.)

What could you say to give her confidence that she has enough breastmilk?
(Frequent breastfeeding should ensure that her baby gets plenty of breastmilk, so artificial feeds should not be necessary.)

What would you suggest that she does about family planning at the end of 6 months, or if her menstruation returns?
(Suggest that she thinks again about using another method. Offer to talk to her husband.)

Donna has to go back to work in 2 weeks' time. Her baby will then be 8 weeks old. She will be away from her baby for 9-10 hours each day. She will breastfeed when she is at home. Her helper will give the baby expressed breastmilk and some formula feeds by cup while Donna is at work. She wants another baby one day, but not for at least 3 years.

What information would you give Donna about breastfeeding and family planning?

(She cannot rely on breastfeeding to prevent a pregnancy, as she will be away from her baby for most of each day.)

What would you suggest that she does about family planning?

(Suggest that she starts another method soon. An IUD or a progestogen-only contraceptive would be suitable, and should not interfere with breastfeeding.)

What would you suggest that she does to keep up her milk supply?

(Breastfeed her baby whenever she is at home, and sleep with him so that he can breastfeed at night. Express her breastmilk while she is at work.)

Lisa has a 7-month-old baby, whom she breastfeeds exclusively. Her menstruation has not returned. She sells fruit in the market and takes her baby with her all the time, so that she can breastfeed frequently. She could not cope with another baby until this one can walk and no longer needs to be carried.

What information would you give Lisa about breastfeeding and family planning?

(Breastfeeding is not a reliable method of family planning after the baby is 6 months old. She only has partial protection, and could conceive before her menstruation returns.)

What could you say to praise what she is doing well?

(Frequent breastfeeding is a good idea, and her baby has grown well on her breastmilk alone for six months.)

What information would you give about feeding?

(Babies of this age are usually ready for food as well as breastmilk.)

What would you suggest to her about family planning?

(Suggest that she consider another family planning method, if she wants to be sure of not becoming pregnant. An IUD, or one of the progestogen-only methods would be suitable, and should not affect breastfeeding.)

☐ Give participants Answer Sheets for Exercise 23.

☐ Recommended reading:
Helping Mothers to Breastfeed Chapter 8.
Annex on Breastfeeding and maternal medication: Recommendations for drugs in the Essential Drugs List.

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WOMEN AND WORK

Objectives

At the end of this session, participants will be able to:
- counsel women about continuing to breastfeed when they return to work;
- show women how to give their babies as much breastmilk as possible when they are away from home;
- explain how to give any necessary supplements safely.

Session outline (60 minutes)

Participants work in groups of 8-10 with two trainers.

I.	Introduce the session	(3 minutes)
II.	Discuss participants' own experiences	(15 minutes)
III.	Read and discuss `Advice to give to mothers who work away from home'	(20 minutes)
IV.	Conduct the role-play `Helping a mother who works away from home'	(12 minutes)
V.	Conduct the discussion	(10 minutes)

Preparation

Before the course
Find out about local maternity entitlements (such as the duration of paid and unpaid maternity leave) and about how the legislation works in practice.
Find out also about whether any places of employment have creches.
Find out what happens to shift workers, such as nurses, when they return from maternity leave. All these are important for long-term improvement.

Before the session
Ask participants to review Session 1, `Why breastfeeding is important', especially the benefits of breastfeeding and partial breastfeeding, and the dangers of complete artificial feeding.

Ask two participants to do the role-play of Sophie and her counsellor, in the role-play `Helping a mother who works away from home' which they will find on page 177 of their Participants' Manual. Ask them a day or two before, so that they can think about it and prepare.
Adapt the story if you wish, or if the participants wish, to fit your local situation better.

Decide how you will conduct section **III. Read and discuss `Advice to give to mothers who work away from home'**. You can either ask participants to read it, and then discuss it, or you can read it out aloud together and discuss it.

As you follow the text, remember:

☐ indicates an instruction to you, the trainer
■ indicates what you say to participants

I. Introduce the session (3 minutes)

☐ Explain what the session is about:

- Many mothers introduce early supplements or stop breastfeeding because they have to return to work.

- This is something that many of us have had to deal with in our own lives.
  So it is a very important issue for all of us.

- There are ways in which health workers can support working mothers, and help them to give their babies as much breastmilk as possible.
  We will discuss what health workers can do now, under existing conditions.

- We cannot discuss changing maternity entitlements. That is desirable, but it is not something that it is easy to do anything about immediately.

☐ Refer back to the list of reasons for stopping breastfeeding or giving complementary foods early from Session 2, `Local breastfeeding situation'.

Remind participants if they identified employment outside the home as an important reason in their situation.

(Note: If participants want to discuss maternity entitlements further, try to arrange another time in an evening or a lunch break, outside the course hours.)

II. Discuss participants' own experiences (15 minutes)

☺ Ask participants if they are willing to talk about their own experiences.

Put these questions to participants who agree:

How long was your maternity leave?
What arrangements were you able to make about child care?
How did you decide to feed your children?
How do you feel about that now?
Is there anything that could have made your experience more satisfactory?

Encourage the group to use their counselling skills as they talk, so that participants who share their experiences feel supported and not criticized.

☐ Summarize the information that you have collected about local maternity leave, child care facilities, and the conditions of employment for women.

Discuss with the group how this relates to their own experience.

III. Read and discuss `Advice to give to mothers who work away from home'

(20 minutes)

☺ Ask participants to read **ADVICE TO GIVE TO MOTHERS WHO WORK AWAY FROM HOME**, on pages 175-177 of their manuals.

Let them take 10 minutes to read it to themselves, and then discuss the points.

If you and the participants prefer, read the section aloud together and discuss it. Let participants take turns and read aloud the first three paragraphs, and the first line after the bullet (●) of the other paragraphs. You read and explain the notes, which follow each of the first lines.

Discuss how practical the ideas are for the local situation.

ADVICE TO GIVE TO MOTHERS WHO WORK AWAY FROM HOME

If possible, take your baby with you to work. This can be difficult if there is no creche near your work place, or if the transport is crowded.

If your work place is near to your home, you may be able to go home to feed him during breaks, or ask someone to bring him to you at work to breastfeed.

If your work place is far from your home, you can give your baby the benefit of breastfeeding in the following ways:

- *Breastfeed exclusively and frequently for the whole maternity leave.*
  This gives your baby the benefit of breastfeeding, and it builds up your breastmilk supply. The first two months are the most important.

- *Do not start other feeds before you really need to.*
  Do NOT think "I shall have to go back to work in 12 weeks, so I might as well bottle feed straight away."
  It is not necessary to use a bottle at all. Even very small babies can feed from a cup. Wait until about a week before you go back to work. Leave just enough time to get the baby used to cup feeds, and to teach the carer who will look after him.

- *Continue to breastfeed at night, in the early morning, and at any other time that you are at home.*
  - This helps to keep up your breastmilk supply.
  - It gives your baby the benefit of breastmilk - even if you decide to give him one or two artificial feeds during the day.
  - Many babies `learn' to suckle more at night, and get most of the milk that they need then. They sleep more and need less milk during the day.

- *Learn to express your breastmilk soon after your baby is born.*
  This will enable you to do it more easily.

- *Express your breastmilk before you go to work, and leave it for the carer to give to your baby:*
  - Leave yourself enough time to express your breastmilk in a relaxed way. You may need to wake up half an hour earlier than at other times. (If you are in a hurry, you may find that you cannot express enough milk.)
  - Express as much breastmilk as you can, into a very clean cup or jar. Some mothers find that they can express 2 cups (400-500 ml) or more even after the baby has breastfed. But even 1 cup (200 ml) can give the baby 3 feeds a day of 60-70 ml each. Even ½ cup or less is enough for one feed.
  - Leave about ½ cupful (100 ml) for each feed that the baby will need while you are out. If you cannot express as much as this, express what you can. Whatever you can leave is helpful.
  - Cover the cup of expressed breastmilk with a clean cloth or plate.
  - Leave the milk in the coolest place that you can find, in a refrigerator if you have one, or in a safe, dark corner of the house.
  - Do not boil or reheat your breastmilk for your own baby. Heat destroys many of the anti-infective factors.

  EBM stays in good condition longer than cow's milk, because of the anti-infective factors in it. Germs do not start growing in EBM for at least 8 hours, even in a hot climate, and outside the refrigerator. It is safe to give to the baby at least throughout one working day.

- *Breastfeed your baby after you have expressed.*
  Suckling is more efficient than expressing, so he will get breastmilk that you cannot express, including some hindmilk.

- *If you decide to use cow's milk for some or all of the feeds:*
  - To make 1 cup (200 ml) of feed, boil 3/4 cup (150 ml) of cow's milk and 1/4 cup (50 ml) of water. Add 1 level spoonful of sugar (15 g).
  - Leave 1/2 to 1 cup (100-200 ml) of mixture for each feed.
  - Leave the mixture in a clean covered container.

- *If you decide to use formula:*
  - Measure the powder for a feed into one clean cup or glass.
  - Measure the water to make up the feed into another clean glass.
  - Cover them both with a clean cloth, or put them in a covered pan.
  - Teach the baby's carer to mix the milk powder and water when she is going to feed the baby. She must mix and use the formula immediately, because it spoils quickly after it is mixed.

Note: There are many different ways to leave milk for a baby. These are satisfactory methods. You may find that a different method is better for you in your situation.

- *Teach the carer properly and carefully:*
  - Teach her to feed your baby with a cup, and not to use a bottle. Cups are cleaner, and they do not satisfy the baby's need to suckle. So, when you come home, your baby will want to suckle at the breast, and this will stimulate your breastmilk supply.
  - Teach her to give all of one feed at one time. She must not keep it to give later;

and she must not give a small amount every now and again.
- Teach her not to give the baby a pacifier but to calm him with other attention.

- *While you are at work express your breastmilk 2-3 times (about 3-hourly):*
  - If you do not express, your breastmilk supply is more likely to decrease. Expressing also keeps you comfortable, and reduces leaking.
  - If you work where you can use a refrigerator, keep your expressed breastmilk there. Carry a clean jar with a lid to store your breastmilk, and to take it home for the baby. If you can keep it cold at home, it will be safe to use the next day.
  - If you cannot keep your EBM, throw it away. Your baby has not lost anything - your breasts will make more milk.

If you are a health worker, make sure that your patients know and see how you manage. Then, they can follow your example.

IV. Conduct the role-play (12 minutes)

☺ Ask two participants to role-play Sophie and her counsellor, as they discuss how to express breastmilk, and how to feed it to the baby when Sophie is at work.
If you or the participants wish, adapt the story to illustrate the local situation better.

Ask the role-players to emphasize these points:

- The practical difficulties faced by Sophie, with so much to do, getting to work, and looking after her family.
- How the counsellor helps Sophie to think through what she will do that is really possible for her.
- The value of breastfeeding at night, and of cup feeding instead of bottle feeding when Sophie is away from the baby.
- How the counsellor supports Sophie, using confidence building techniques. She should help Sophie to feel good about whatever she can manage.

Role-play: Helping a mother who works away from home

Sophie had her third baby 4 weeks ago.

Sophie works in a shop. She will have to return to work when her baby is 2 months old. She stopped breastfeeding her other children at 6 weeks, and bottle fed them, because of returning to work. They were often ill, and she missed the closeness of breastfeeding.

Sophie would prefer to breastfeed this baby, and a friend said that some women do, but Sophie does not know how. She is worried about leaking and smelling at work - it would be embarrassing, and might upset her employers and customers. She is worried about trying to breastfeed, work, and care for her other children and their father.

She will be away from home for about 10 hours altogether, five days a week. Her younger sister will be caring for the baby, and is quite reliable. There is no refrigerator. Sophie has bought two new feeding bottles.

V. Conduct the discussion (10 minutes)

☐ Ask the group to discuss these questions:

1. What did the story of Sophie suggest about how health workers can help a mother who works away from home to breastfeed?

2. What could you in your situation do to help mothers who work away from home to breastfeed as much as possible?

☐ Recommended reading:
Helping Mothers to Breastfeed Chapter 6, section 6.5, and Chapter 12.

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COMMERCIAL PROMOTION OF BREASTMILK SUBSTITUTES

Objectives

At the end of this session, participants will be able to:
- describe the dangers of commercial promotion of formula;
- calculate the cost to a family of using the common brands of formula;
- list the major provisions of the International Code of Marketing of Breastmilk Substitutes, including the resolution on free supplies and follow-on milks;
- list their own responsibilities for complying with the code.

Session outline (60 minutes)

Participants work in groups of 8-10 with two trainers.

I. Introduce the topic (3 minutes)

II. Discuss how manufacturers promote formula (10 minutes)

III. Describe the International Code of Marketing of Breastmilk Substitutes

IV. Conduct the role-play `Choosing the best formula' (15 minutes)

V. Facilitate the written exercise (Exercise 24) (15 minutes)

VI. Summarize `Commercial promotion of breastmilk substitutes' (2 minutes)

Preparation

Refer to pages 13-15 in the Introduction for general guidance on how to conduct work in groups.
Study the session notes so that you are clear about what to do.

Before the course:
Find out the status of the International Code of Marketing of Breastmilk Substitutes in the country. Learn all that you can and be prepared to explain its status to participants. If possible, ask an expert on the subject to help you to prepare what to say.

Obtain six tins of commonly used brands of formula, or other complementary foods used as breastmilk substitutes. Empty tins would be suitable, and should be kept for reuse at future courses. Find out the current price of each brand, and mark each tin with its price.

Obtain copies of local magazines or papers which advertise formula, or any other materials distributed by formula manufacturers, for example, health education materials for mothers, posters, calendars, or free gifts such as pens with the brand name on it.

Find out the minimum wages for agricultural and urban workers in the country.

Before the session:
Ask three participants to prepare the role-play `Choosing the best formula'.
They will find the scene on page 180 of their manuals. Make sure that they have time to prepare.

Make sure that participants have copies of *The Health Worker's Guide to the International Code of Marketing of Breastmilk Substitutes*.

As you follow the text remember:

☐ indicates an instruction to you, the trainer
■ indicates what you say to participants

I. Introduce the topic (3 minutes)

☐ Tell participants what the session is about:

- All manufacturers *promote* their products, to try to persuade people to buy more of them. Formula manufacturers also promote their products, to persuade mothers to buy more formula.

- This promotion undermines women's confidence in their breastmilk, and makes them think that it is not the best for their babies. This harms breastfeeding.

- If formula is available in maternity hospitals, or easily available to mothers in shops or health centres from soon after delivery, this also can reduce a mother's confidence and interfere with breastfeeding.

- Breastfeeding needs to be *protected* from the effects of formula promotion. One essential way to protect breastfeeding is to regulate the promotion of formula, both internationally and nationally.

- Individual health facilities and health workers can also protect breastfeeding, if they resist letting companies use them to promote formula. This is an important responsibility.

II. Discuss how manufacturers promote formula (10 minutes)

☐ Develop lists of ways in which manufacturers promote formula to the public and to health workers.

Ask: *In what ways do manufacturers promote formula to the public?*
(Let participants give their ideas.)

→ Write on the board the title `PROMOTION TO THE PUBLIC' and make a list of participants' ideas.

The list should include most of the following:

- Manufacturers *stock shops and markets with formula* and feeding bottles, so that mothers can always see them when they go shopping.
- They *give free samples of formula* to mothers. Sometimes this is part of another gift. We know that even mothers who intend to breastfeed, are more likely to give

up if they receive a free sample.
- They give *coupons* to mothers for a discount on formula.
- They *advertise* on radio, television, videos for hire, billboards, buses, and magazines.

Ask: *In what ways do manufacturers use health workers and health facilities to promote formula?*
(Let participants give their ideas.)

→ Write on the board the title `PROMOTION THROUGH HEALTH SERVICES' and make a list of participants' ideas.

The list 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.
- They give *attractive information materials* to health facilities to distribute to families. Often, there are no other materials to give to families, and some of the information is useful.
- They give *useful bits of equipment*, such as pens or growth charts, with the company logo on it. Sometimes they give larger items such as television sets, or incubators to doctors or health facilities.
- They give *free samples* and *free supplies of formula to maternity units*.
- They give *free gifts to health workers* which are sometimes very big.
- They advertise in *medical journals* and other literature.
- They *pay for meetings or conferences,* workshops or trips, or they give free lunches for medical, nutrition, or midwifery schools.
- They *fund and sponsor* health services in many other ways, and give grants.

☐ Show examples of the promotional material that you have collected.

If you do not have a complete set for each group, circulate what you have between the groups. Put all the materials on display after the session.

III. Describe the International Code of Marketing of Breastmilk Substitutes

(15 minutes)

☐ Introduce the idea of the Code with these points:

- Breastmilk and breastfeeding need to be protected from formula promotion activities. This requires regulation of the promotion and sale of formula.

- In 1981, the World Health Assembly (WHA) adopted The International Code of Marketing of Breastmilk Substitutes, which aims to regulate promotion and sale of formula. This Code is not extreme - it is a minimum requirement to protect breastfeeding.

- The Code is a code of *marketing*. It does not ban infant formula or bottles, or punish people who bottle feed. The Code allows baby foods to be sold everywhere, and it allows every country to make its own specific rules.

- The Code covers both breastmilk substitutes, and bottles and teats used to feed babies.
  Breastmilk substitutes include:
  - infant formula;
  - any other milks or foods which mothers perceive or use as breastmilk substitutes.

☐ Summarize the Code:

Ask participants to find page 178 of their manual, where they will find the box **SUMMARY OF THE MAIN POINTS OF THE INTERNATIONAL CODE**.

☺ Ask participants to read out each point in turn.

With each point, ask participants to say if they have ever observed the Code's being broken in this way.

Explain any points which are not clear.

SUMMARY OF THE MAIN POINTS OF THE INTERNATIONAL CODE

1. No advertising of breastmilk substitutes and other products to the public.
2. No free samples to mothers.
3. No promotion in the health service.
4. No company personnel to advise mothers.
5. No gifts or personal samples to health workers.
6. No pictures of infants, or other pictures idealizing artificial feeding, on the labels of the products.
7. Information to health workers should be scientific and factual.
8. Information on artificial feeding, including that on labels, should explain the benefits of breastfeeding and the costs and dangers associated with artificial feeding.
9. Unsuitable products, such as sweetened condensed milk, should not be promoted for babies.

☐ Read and explain **NO MORE FREE SUPPLIES.**

Ask participants to look at the box **NO MORE FREE SUPPLIES** on page 179 of their manuals.

☺ Ask participants to read out each point in turn.

Explain any points which are not clear.

NO MORE FREE SUPPLIES

In May 1986, governments at the World Health Assembly urged a ban on donated supplies of baby milk. They urged ministries of health:

"To ensure that the small amounts of breastmilk substitutes needed for the minority of infants who require them in maternity wards and hospitals are made available through the normal procurement [that is, purchasing] channels and *not through free or subsidized supplies."* (WHA 39.28)

Ending of free supplies in all countries is a target of the WHO/UNICEF `Baby Friendly Hospital Initiative'. A hospital cannot be `Baby Friendly' if it receives free supplies of breastmilk substitutes.

☐ Make these points:

- This new resolution became necessary because of confusion about when it was and was not permitted to give free supplies to hospitals. Originally the Code allowed free supplies to be given to orphanages, or in cases of serious need.

- However, some companies gave free supplies to hospitals, which were sometimes used as samples. Samples are not permitted under the Code.

- The same new resolution also states that follow-on milks are not necessary. Some companies were promoting follow-on milks, which mothers sometimes use for feeding younger babies.

☐ Introduce the idea of a national code, with these points:

- WHO and UNICEF recommend that countries prepare a national code based on the International Code.

- To be legal, a national code must be adopted by the nation as law. There should be sanctions written in to punish manufacturers who break the law, and there should be specific mechanisms to enforce the code. In the meantime, however, companies are required to follow the International Code even if governments have not passed a law.

☐ Describe the status of the national code in this country.

Use the information that you found out about and prepared before the course.

☐ Discuss health workers' responsibility in relation to the code:

Ask: *What can individual health workers do about the International Code?*
(Let participants look at the box **SUMMARY OF THE MAIN POINTS OF THE INTERNATIONAL CODE** and give their ideas. Help them to think of the ways listed below.)

Health workers should resist all commercial promotion of formula in the following ways:

- Remove from the health facility and destroy any advertisements, and/or promotional literature or other items bearing a brand name, including old formula tins used for other purposes.

- Refuse to accept free samples of formula, or of equipment such as bottles, pacifiers, and toys.

- Refuse to accept or to use other gifts, for example pens, calendars, or diaries.

- Avoid using growth charts and other equipment with a brand name on it, especially if mothers may see it.

- Avoid eating meals provided by formula companies.

- Do not give free samples or promotional material to mothers.

- Make sure that any formula that is used in a hospital (for example, for orphans) is kept out of sight of other mothers.

  (Participants may think of or find other ways to resist commercial promotion of formula, relevant to their own situation.)

IV. Conduct the role-play (15 minutes)

☺ Ask the three participants whom you have prepared to role-play the following scene:

Role-play: Choosing the best formula

Pearl and Stan are parents of 4-week-old baby Andy. Stan has a job in town.

Stan comes home from work, and Pearl tells him that she wants to buy some formula. She thinks that her breastmilk is not enough for Andy. Andy was given bottle feeds at night in hospital, so that Pearl could rest. Pearl saw some tins of formula in the nurses' office. Pearl wants to buy the same brand, because it is likely to be good and safe if the hospital uses it.

Stan does not know much about breastfeeding or formula. He is mainly worried about the cost, because his wages are low. He would prefer Pearl to breastfeed, because it is cheaper. If she does buy formula, he wants her to buy the cheapest brand, because he thinks they are all the same.

Stella is the shop assistant, who is selling the formula. She is a friend of Pearl's. She has the brand that they use in the hospital. She also has a different brand that the local doctor recommends to his patients. She says that he gives them

free samples. There is also a cheaper, locally made brand that Stella gave to her baby, and he is now a healthy child. And there is a more expensive brand that is for children with diarrhoea.

Stella tells Pearl and Stan the prices, and tries to point out advantages of each brand - that it is sweeter, or that it is easier to mix in cold water. She points to the lovely picture of a smiling baby, the attractive label, or the convenient ant-proof tin or the measuring scoop that has so many uses.

Pearl and Stan discuss which would be best for Andy, and forget all about breastmilk. They wonder if they should buy the brand that the doctor recommends. However, they have not been to that doctor, and do not know him. Pearl wonders if they should buy the brand that is good for diarrhoea? It is expensive, so may be very good. It might prevent Andy from getting diarrhoea. Stan continues to argue that the cheap one is just the same. Stella used it. In the end, Pearl insists on buying the brand that they use in the hospital.
Pearl says that she will use the formula slowly, and that she will make one tin last for two months.

☐ Discuss the role-play:

Ask participants what they think the role-play showed.

Try to bring out the following points in discussion:

- What happened in hospital had an important influence on Pearl's decision. Giving Andy bottle feeds at night reduced her confidence in her breastmilk. Also, it made her think that bottles and the formula they used in hospital must be good.
- Nobody thought about counselling Pearl to give her confidence, and to help her to breastfeed successfully.
- Nobody had talked to Stan about the dangers of bottle feeding, so he could not motivate Pearl to breastfeed exclusively. He only thought of the cost, and felt bad that he could not afford something important for his baby.
- Pearl and Stan found it difficult to decide which formula was best. There was no important difference between the brands except their prices. Stella, who is a friend, uses the cheapest brand, but the hospital and the doctor do not seem to recommend it. Is a brand that is more expensive really better?
- These points make it clear that the question of the cost of formula, as a reason for breastfeeding, is quite complicated.
- If a doctor gives free samples, he may influence the mothers who are in his care to bottle feed, and they are likely to buy the brand that he gives them. So manufacturers like to give free samples to doctors to give away. The manufacturers of the doctor's brand, and the manufacturer of the hospital's brand are competing with each other. Both give free samples, to get more mothers to use their brand.
- The manufacturers say that they are only competing for a *share* in the market. But whatever they say, the result will be that more mothers give their babies artificial feeds.

☐ Conclude with these points:

- Health services have a responsibility not to promote formula, or the names of manufacturers. They should not appear to endorse the use of any brand of formula or bottles.

- They should use formula only when there is a clear medical indication, and they should do so without displaying the product to staff or mothers and families. They should use cups and not bottles to feed the babies.

- Health services have a responsibility to support exclusive breastfeeding, and to inform families about its benefits, and about the dangers of artificial feeding. They should inform all members of a family, including fathers, and not only mothers.

V. Facilitate the written exercise (15 minutes)

☐ Explain the purpose of the exercise:

- The purpose of this exercise is to find out what percentage of the minimum wage is needed to feed a baby artificially for six months.

☐ Give each group of 8-10 participants 2-3 formula tins. Make sure that each tin has the price on it. Make sure that each participant knows which tin or brand they should use for the exercise.

→ Write on the board the minimum monthly wage for:
1) a female agricultural worker;
2) a female urban labourer or domestic worker.

EXERCISE 24. ***The cost of formula***

☐ Explain what to do:

- Read the instructions **How to do the task,** and then do the calculations
  To answer.
  When you are ready, discuss your answers with the trainer.

How to do the task

On average, to feed a baby artificially for the first 6 months, you need 44 x 500g tins of formula.
(You need about 5 tins in the first month, 7 tins in the second month, and 8 tins a month for the next 4 months.)

- From the price on your tin, calculate the cost of 44 x 500g tins of the formula.
- Compare the cost of 44 tins with the minimum wage for 6 months for a female agricultural worker, and for a female urban labourer or domestic worker.
- Discuss your answers with the trainer and the group.

To answer:

Brand of formula:

Cost of one 500g tin of formula =

Cost of 44 x 500g tins of formula =

Minimum wage	*Agricultural*	*Urban*
1 month:		
6 months:		

Cost of 44 x 500g tins formula ..... x 100 = ...%
Agricultural wage for 6 months .....

Cost of 44 x 500g tins formula ..... x 100 = ...%
Urban wage for 6 months .....

To feed a baby on ..... formula costs:

.....% of the female agricultural wage.

.....% of the female urban wage.

VI. Summarize `Commercial promotion of breastmilk substitutes' (2 minutes)

☐ Make these points:

- To feed a baby on formula costs a large part of an average woman's wages, which many families cannot afford.
- The promotion of formula to the public is not permitted under the Code.
- It is the responsibility of health services to ensure that they do not in any way promote or endorse the use of breastmilk substitutes.

☐ Recommended reading: *Protecting Infant Health: A Health Worker's Guide to the International Code of Marketing of Breastmilk Substitutes*.

CHECKLIST OF TRAINING SKILLS

Give each trainer a copy of this list. Ask them to practise using these skills when they are conducting sessions, and to comment on these points when they give each other feedback.

Movements

Take centre stage – do not get stuck in a corner or behind a desk
Face the audience – do not face the board or screen when speaking
Make eye contact with people in all sections of the audience
Use natural gestures and facial expression – (but try to avoid mannerisms)
Move around the room – approach people to get their attention and response
Avoid blocking the audience's view – watch for craning necks

Speech

Slow and clear, and loud enough for everyone to hear
Natural and lively – varied
Write difficult new words on the board, pronounce and explain them

Interaction

Try to interact with all participants – use names as appropriate
Ask the questions suggested in the text – ask different participants
Allow time for the participant to answer – don't give the answer too quickly – drop hints
Respond encouragingly and positively to all answers – correct errors gently
Involve all participants – include quiet ones – control talkative ones
Avoid discussions which are off the point or distracting – postpone them if necessary
Try to give satisfactory answers to questions from participants

Visual aids

Have the required aids and equipment ready – check and arrange them before the session
Make sure that everyone can see clearly – arrange the room so that they can
Point to what you are talking about on the projector, or on the screen
Cover, turn off, or remove aids that are not in use any more
Let people handle aids that you use for demonstrations
Write large and clear on the board – arrange words carefully so that there is enough room
Put slides and overheads away tidily ready for next time, at end of session

Use of materials

Prepare thoroughly – read the text, and obtain any aids that you need before
Prepare your helpers (eg for role-play) before the session – practise if possible
Do not learn the session by heart – follow the Guide but talk in your own way
Follow the session plan accurately and completely – use your Trainer's Guide
Emphasise important points – do not leave important points out
Do not introduce too much extra material – but give a few local examples
Try to avoid repetition unless really useful
If you find it necessary to read from the guide, look at the audience sometimes

Time management
Keep to time – not too fast or too slow; don't take too long with the early part of a session
Don't lose time between sessions (eg going to Clinical Practice) – explain clearly what to do