



Infant and Young Child Feeding Participant's Manual

Ministry of Health & Social Welfare – Lesotho Government

2010

Table of contents

Acknowledgements.....	ii
Introduction to the course.....	1
Materials for the course.....	2
Session 1: Introduction to infant and young child feeding.....	3
Session 2: Why breastfeeding is important.....	5
Session 3: How breastfeeding works.....	13
Session 4: Assessing a breastfeed.....	21
Session 5: Listening and learning counselling skills.....	30
Session 6: Practical Session 1—Using counselling skills to assess a breastfeed.....	37
Session 7: Positioning and attachment.....	41
Session 8: Growth charts.....	46
Session 9: Building confidence and giving support.....	53
Session 10: Taking a feeding history.....	58
Session 11: Breastfeeding difficulties.....	64
Session 12: Expressing breastmilk.....	71
Session 13: Cup feeding.....	76
Session 14: Breast conditions.....	78
Session 15: Overview of HIV and infant feeding.....	89
Session 16: Counselling for infant feeding decisions—Part 1.....	99
Session 17: Feeding options for HIV-positive mothers—Advantages of exclusive breastfeeding.....	107
Session 18: Feeding options for HIV-positive mothers—Advantages and disadvantages of exclusive replacement feeding with commercial infant formula.....	111
Session 19: Counselling for infant feeding decisions—Part 2.....	116
Session 20: Exclusive breastfeeding for the first 6 months.....	123
Session 21: Exclusive replacement feeding for the first 6 months.....	124
Session 22: Hygienic preparation of feeds.....	127
Session 23: Preparation of commercial infant formula—Measuring amounts.....	133
Session 24: Practical Session 2—Preparation of commercial infant formula.....	137
Session 25: Health care practices to support optimal infant feeding.....	142
Session 26: International Code of Marketing of Breast-milk Substitutes.....	152
Session 27: Importance of complementary feeding.....	158
Session 28: Foods to fill the energy gap.....	167
Session 29: Foods to fill the iron and vitamin A gaps.....	175
Session 30: Quantity, variety, and frequency of feeding.....	185
Session 31: Practical Session 3—Building confidence and giving support exercises.....	194
Session 32: Gathering information on complementary feeding practices.....	196
Session 33: Responsive feeding.....	211
Session 34: Practical Session 4—Gathering information on complementary feeding practices.....	216
Session 35: Checking understanding and arranging follow-up.....	219
Session 36: Food demonstration.....	222
Session 37: Feeding during illness and low-birthweight babies.....	231

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Introduction to the course

Why this course is needed

The World Health Organization (WHO) and the United Nations Children's Fund (UNICEF) jointly developed the Global Strategy for Infant and Young Child Feeding (IYCF) to revitalize the world's attention to the impact that feeding practices have on the nutritional status, growth, development, and health, and thus the very survival of infants and young children (WHO and UNICEF, 2002). The Global Strategy is intended as a guide for action; it is based on accumulated evidence of the significance of the early months and years of life on growth and development.

The Government of Lesotho has adopted the Global Strategy for IYCF and recognizes the impact that feeding practices have on the nutritional status, growth, development, health, and survival of infants and young children. The IYCF guidelines recommend the protection, promotion, and support of exclusive breastfeeding for 6 months. For infants older than 6 months, the guidelines call for provision of safe and appropriate complementary foods with continued breastfeeding until 2 years of age or beyond. However, many children are not fed in the recommended way. Many mothers who initiate breastfeeding satisfactorily start complementary feeds or stop breastfeeding within a few weeks of delivery. In addition, many children, even those who have grown well for the first 6 months of life, do not receive adequate complementary foods, which puts them at risk of malnutrition.

Poor nutritional status is currently one of the most important health and welfare problems in Lesotho. At the national level, nearly 42% of children younger than 5 years are stunted¹. Nearly half of children are receiving liquids and solid foods prematurely at 2 months. Conversely, 30% of children aged 6 to 7 months are still consuming a liquid diet at an age when solid foods should form an important part of their diet. Results from the 2004 National Demographic and Health Survey indicate that 23.2% of adults aged 15 to 49 in Lesotho are infected with HIV. HIV prevalence among pregnant women is 27%. Suboptimal IYCF practices increase the risk of mother-to-child HIV transmission.

It has often been difficult for health workers to discuss with families how best to feed their young children due to the confusing, and often conflicting, information available. Inadequate knowledge about how to breastfeed, the appropriate complementary foods to give, and good feeding practices are often a greater determinant of malnutrition than the availability of food. Hence, there is an urgent need to train all those involved in infant feeding counselling in the skills needed to support and protect breastfeeding and good complementary feeding practices.

Messages about infant feeding have become confused over recent years with the HIV pandemic. In Lesotho, the Ministry of Health and Social Welfare is finalising the *National Infant and Young Child Feeding Policy*, indicating that HIV-positive women should be counselled to make a fully informed decision about how best to feed their infants, and supported to carry out the method of their choice. This policy also emphasises the need to protect, promote, and support breastfeeding. There is an urgent need to train health workers to counsel women about infant feeding, according to this policy.

This 5-day *Infant and Young Child Feeding Curriculum for Health Workers* is based on WHO and UNICEF's *Infant and Young Child Feeding Counselling: An Integrated Course*. Given the urgency of training large numbers of health workers and counsellors, this integrated course has been adapted to respond to the specific needs in Lesotho by training those who

¹ National Nutrition Survey, 2007.

care for mothers and young children in the basics of good infant and young child feeding. Counselling is an extremely important part of this course, and the course will focus on practicing using job aids to improve counselling skills.

Course objectives

After completing this course, participants will be able to counsel and support mothers to carry out nationally recommended feeding practices for their infants and young children from birth up to 24 months of age. In addition, participants will be able to counsel and support HIV-infected mothers to choose and carry out an appropriate feeding method for the first 2 years of life. Each session of this course has a set of learning objectives.

Target audience

This course is aimed at the following groups of people:

- Dieticians and nutritionists.
- Doctors and nurses.
- Counsellors.
- Other health personnel.
- Health educators.

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

Materials

The following materials are included in this manual:

- BREASTFEEDING OBSERVATION JOB AID (Sessions 4, 6, and 7).
- Role plays (Sessions 4, 5, 9, and 18).
- COUNSELLING SKILLS CHECKLIST (Sessions 6, 9, 19, and 34).
- HOW TO HELP A MOTHER TO POSITION HER BABY (Session 7).
- Lesotho growth charts for boys and girls (Session 8).
- Growth charts with standard curves (Session 8).
- Demonstrations (Sessions 7, 9, 10, 12, 17, 18, 19, 23, 26, 32, 33, 35, and 36).
- GUIDE FOR EVALUATING INFANT FEEDING, 0–6 MONTHS (Session 10).
- Counselling stories 1–4 (Session 19).
- Five keys to safer food.
- ASSESS YOUR PRACTICES handout (Session 27).
- FEEDING RECOMMENDATIONS FOR THE FIRST 2 YEARS (Session 28).
- WHAT IS IN THE BOWL? handout (Session 29).
- Exercise: Amounts to offer (Session 30).
- QUANTITIES OF FOOD TO OFFER A YOUNG CHILD FOR A MEAL (Sessions 30 and 36).
- FOOD INTAKE REFERENCE TOOL, 6–24 MONTHS (Session 32).
- Instructions to complete the FOOD INTAKE JOB AID, 6–24 MONTHS (Session 32).
- FOOD INTAKE JOB AID, 6–24 MONTHS (Sessions 32 and 34).
- Stories for food intake practice (Session 32).
- Exercise: Preparing a young child's meal (Session 36).

Session 1: Introduction to infant and young child feeding

Learning objectives

After completing this session, participants will be able to:

- Describe the *National Infant and Young Child Feeding (IYCF) Policy*.
 - Explain how the *National IYCF Policy* applies to their work.
 - State the current recommendations for feeding children 0–24 months of age.
 - Define exclusive breastfeeding.
 - Define complementary feeding.
-

National Infant and Young Child Feeding Policy

The following are the major topics described in the *National IYCF Policy*:

1. Antenatal care practices.
2. Labour and delivery practices.
3. Optimal IYCF practices for the general population.
4. Feeding in difficult situations (including emergencies).
5. Complementary foods (timely, adequate, safe, and properly fed).
6. Training and capacity-building of service providers.
7. Community involvement and participation.
8. Creating an enabling environment for infant and young child feeding.

Exclusive breastfeeding

Exclusive breastfeeding is feeding an infant with breastmilk (including expressed breastmilk) only, without any other food or drink, not even water. However, drops of syrups consisting of vitamins, mineral supplements, or medicines can be given when medically prescribed.

Exclusive breastfeeding provides the ideal food for healthy growth and development of infants, and it is all that a child needs for the first 6 months.

Almost all mothers can breastfeed exclusively, provided they have accurate information and support within their families and communities. They should have access to skilled practical help from people trained in breastfeeding counselling who can help to build their confidence, improve feeding technique, and prevent or resolve breastfeeding difficulties. During this training, you will start to develop these skills, or build on skills you are already using in your daily work.

Complementary feeding

After 6 months of age, all babies require other foods in addition to breastmilk—we call these foods **complementary foods**. When complementary foods are introduced, breastfeeding should still continue until 2 years of age or beyond.

Infants are particularly vulnerable during the transition period when complementary feeding begins. Ensuring that their nutritional needs are met requires that complementary foods be:

- **Timely**—meaning that they are introduced when the need for energy and nutrients exceeds what can be provided through exclusive and frequent breastfeeding.
- **Adequate**—meaning that they provide sufficient energy, protein, and micronutrients to meet a growing child's nutritional needs.
- **Safe**—meaning that they are hygienically stored and prepared and fed with clean hands using clean utensils and not bottles or teats.

- **Properly fed**—meaning that they are given in response to a child's signals of hunger and satiety, and that meal frequency and feeding methods—actively encouraging the child, even during illness, to consume sufficient food using fingers, spoon, or self-feeding—are suitable for the child's age.

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Session 2: Why breastfeeding is important

Learning objectives

After completing this session, participants will be able to:

- Explain why breastfeeding is important.
- List advantages and disadvantages of breastfeeding.
- Describe the difference between breastfeeding and replacement feeding.

The importance of breastfeeding

Understanding why breastfeeding is important can help you to support mothers who may have doubts about exclusive breastfeeding.

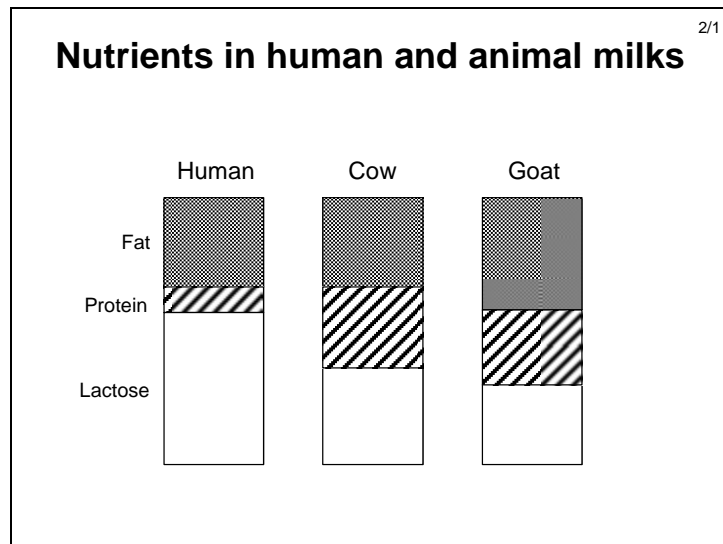
Advantages for babies	Advantages for mothers	Advantages for families and communities	Advantages for the country
<p>Colostrum</p> <ul style="list-style-type: none"> • Defends against infection • High in protein • First immunisation <p>Breastmilk</p> <ul style="list-style-type: none"> • Supplies all necessary nutrients in proper proportion • Digests easily without causing constipation • Protects against diarrhoea • Provides antibodies that protect against common illnesses • Protects against infection, including ear infections • During illness, helps keep baby well-hydrated • Reduces the risk of developing allergies • Is always ready at the right temperature • Increases mental development • Prevents hypoglycaemia (low blood sugar) • Promotes proper jaw, teeth, and speech development • Is comforting to fussy, overtired, ill, or hurt baby <p>Early skin-to-skin contact</p> <ul style="list-style-type: none"> • Stabilizes the baby's temperature • Promotes bonding 	<ul style="list-style-type: none"> • Reduces blood loss after birth (early/immediate breastfeeding) and helps expel the placenta • Saves time and money • Makes night feedings easier • Delays return of fertility • Reduces the risk of breast and ovarian cancer • Is available 24 hours a day • Ensures close physical contact • Makes mother calmer and more relaxed because of hormones 	<ul style="list-style-type: none"> • Is economical • Is accessible • Needs no preparation • Reduces cost for medicines for sick baby • Delays new pregnancy • Reduces time lost from work caring for a sick child 	<ul style="list-style-type: none"> • Reduces land pollution • Cuts down medication budget • Reduces morbidity and mortality • Improves children's IQ and reduces repeated classes (cuts down on education budget) • Intelligent and productive human resource

Disadvantage of breastfeeding

If a mother is HIV positive, her baby is exposed to HIV as long as the mother breastfeeds. This point will be discussed in greater detail in later sections.

The differences between breastfeeding and replacement feeding

Slide 2/1. Nutrients in human and animal milks.

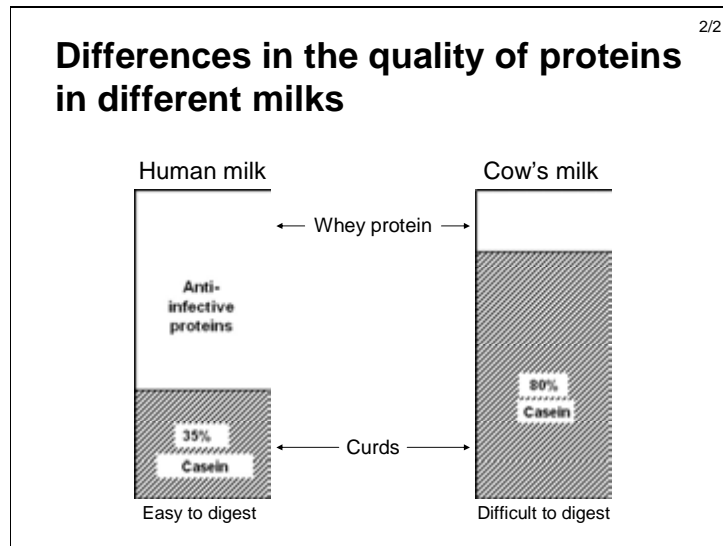


Formulas are made from a variety of products, including animal milks, soybean, and vegetable oils. Although they have been adjusted so that they are more like human milk, they are still far from perfect for babies.

In order to understand the composition of formula, we need to understand the differences between animal and human milk and how animal milks need to be modified to produce formula. This chart compares the nutrients in breastmilk with the nutrients in fresh cow's and goat's milk. All the milks contain fat, which provides energy, protein for growth, and a milk sugar called lactose, which also provides energy.

Animal milk contains more protein than human milk. It is difficult for a baby's immature kidneys to excrete the extra waste from the protein in animal milks. Human milk also contains essential fatty acids that are needed for a baby's growing brain and eyes, and for healthy blood vessels. These fatty acids are not present in animal milks, but may have been added to formula.

Slide 2/2. Differences in the quality of proteins in different milks.



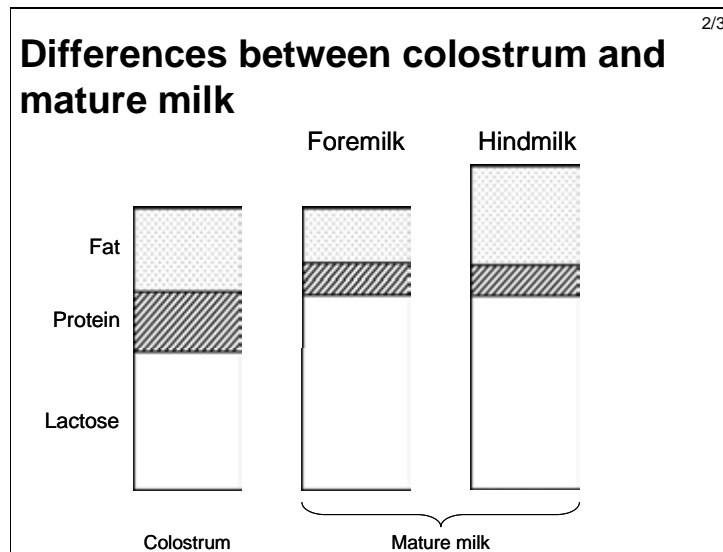
The protein in different milks varies in quality, as well as in quantity. Although the quantity of protein in cow's milk can be modified to make formula, the quality of proteins cannot be changed.

This chart shows that much of the protein in cow's milk is casein. Casein forms thick, indigestible curds in a baby's stomach.

Human milk contains more whey proteins. The whey proteins contain anti-infective proteins which help to protect a baby against infection.

Babies who are fed formula may develop intolerance to protein from animal milk. They may develop diarrhoea, abdominal pain, rashes, and other symptoms when they have feeds that contain the different kinds of protein.

Slide 2/3. Differences between colostrum and mature milk.



Colostrum is the special breastmilk that women produce in the first few days after delivery. It is thick and yellowish or clear in colour. It contains more protein than later milk.

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

Foremilk is the thinner milk that is produced early in a feed. It is produced in large amounts and provides plenty of protein, lactose, water, and other nutrients. Babies do not need other drinks of water before they are 6 months old, even in a hot climate.

Hindmilk is the whiter milk that is produced later in a feed. It contains more fat than foremilk, which is why it looks whiter. This fat provides much of the energy of a breastfeed, which is why it is important not to take the baby off a breast too quickly.

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', which includes all the water that he needs.

Colostrum 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. Colostrum helps to prevent the bacterial infections that are a danger to newborn babies and provides the first immunisation against many of the diseases that a baby meets after delivery.

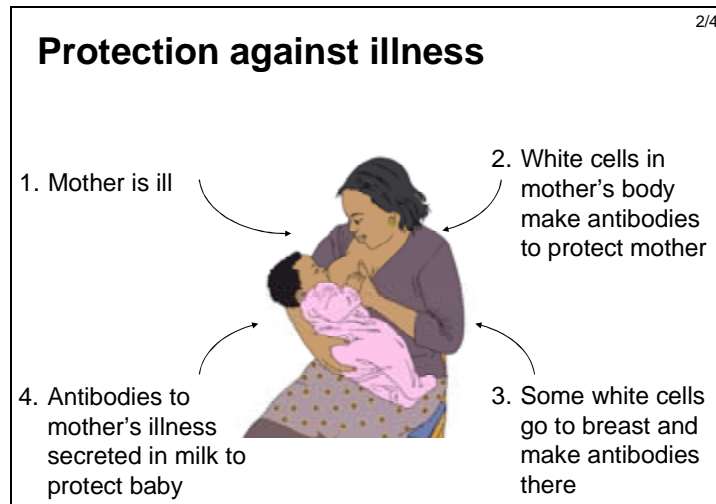
Colostrum has a mild purgative effect, which helps to clear the baby's gut of meconium (the first dark stools). This clears bilirubin from the gut, and helps to prevent jaundice from becoming severe.

Colostrum contains many 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 rich in vitamin A, which 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. Babies should not be given any drinks or foods before they start breastfeeding. Other feeds given before a baby has colostrum are likely to cause allergy and infection.

Slide 2/4. Protection against illness.



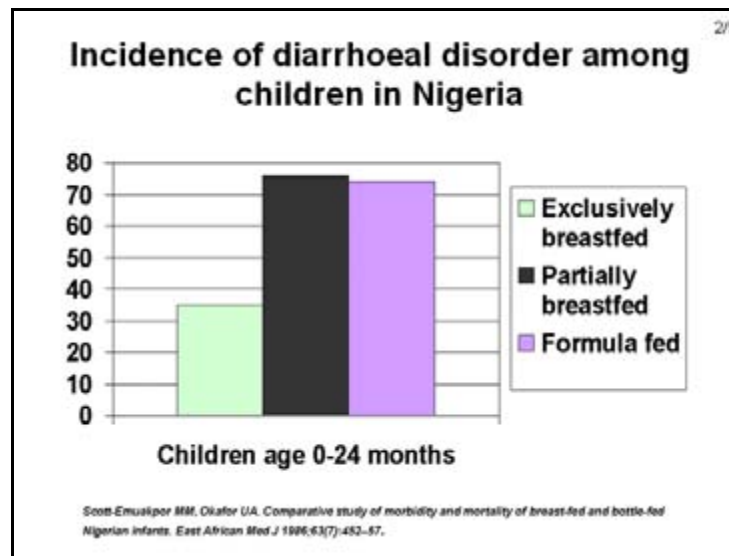
Breastmilk contains white blood cells and a number of anti-infective factors, which help to protect a baby against many infections. Breastmilk also contains antibodies against infections that the mother has had in the past.

This diagram shows that when a mother develops an illness (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). These antibodies 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. Other studies have shown that breastfeeding also protects babies against other infections (for example, ear infections, meningitis, and urinary tract infections).

The composition of breastmilk is not always the same. It changes according to the age of the baby, and from the beginning to the end of a feed, as we saw in Slide 2/3 that shows the differences between foremilk and hindmilk.

Slide 2/5. Incidence of diarrhoeal disorder by feeding method among children in Nigeria².



This chart shows how breastfeeding protects a baby against diarrhoea. The chart shows the main findings of a study from Nigeria. It compares how babies fed in different ways get diarrhoea. The bars show what percentage of babies had diarrhoea. The bar on the left is for babies who were exclusively breastfed. The bar is smaller because exclusively breastfed babies are much less likely to get diarrhoea. The bar on the right is for babies who were fed formula and is much taller, because these babies were more likely to get diarrhoea than babies fed only on breastmilk. The bar in the middle is for babies who were given breastmilk and other feeds or fluids. These babies were as likely to get diarrhoea as were formula-fed babies.

Babies who are not exclusively breastfed get diarrhoea more often, partly because artificial feeds lack anti-infective factors, and partly because artificial feeds are often made with ingredients and utensils that are contaminated with harmful bacteria.

Psychological benefits of breastfeeding

In addition to health benefits, there are many psychological benefits of breastfeeding.

Close contact from immediately after delivery helps the mother and baby to bond and helps the mother to feel emotionally satisfied. Babies tend to cry less if they are breastfed and may be more emotionally secure.

Some studies suggest that breastfeeding may help a child to develop intellectually.

Low-birthweight babies fed breastmilk in the first weeks of life perform better on intelligence tests in later childhood than children who are artificially fed. If mothers are not breastfeeding, for a medical reason, it is important to help them to bond with their babies in other ways apart from breastfeeding.

² Scott-Emuakpor MM, Okafor UA. Comparative study of morbidity and mortality of breast-fed and bottle-fed Nigerian infants. *East African Med J*. 1986; 63(7):452–57.

Disadvantages 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 diarrhoea, as well as respiratory and other infections. The diarrhoea may become persistent. He may get too little milk and become malnourished because he receives too few feeds or because they are too dilute. He is more likely to suffer from vitamin A deficiency.

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.

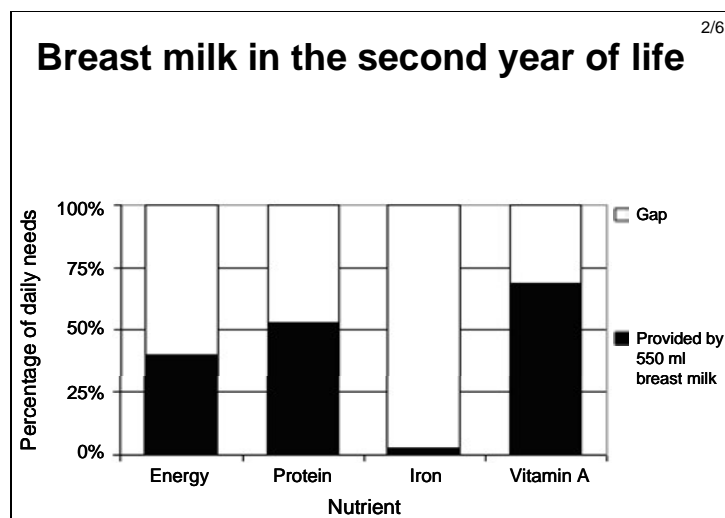
A mother who does not breastfeed may become pregnant sooner. She is more likely to become anaemic after childbirth, and later to develop cancer of the ovary and the breast.

Artificial feeding is harmful for children and their mothers.

Breastmilk in the second year of life

For the first 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. In Session 1, we discussed how all babies need complementary foods after completing 6 months, in addition to breastmilk. However, breastmilk continues to be an important source of energy and high-quality nutrients beyond 6 months of age. We will discuss this in more detail in the sessions on complementary feeding.

Slide 2/6. Breastmilk in the second year.



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.

Breastmilk can provide about one-third of the energy and half of the protein a child needs in the second year of life.

Breastmilk can provide about 75% of the vitamin A that a child needs, provided the mother is not deficient in vitamin A herself.

Breastmilk provides less than 5% of the iron that a child needs in the second year. After 6 months of age, it is especially important that children are fed iron-rich complementary foods in addition to continued breastfeeding.

Notes

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Session 3: How breastfeeding works

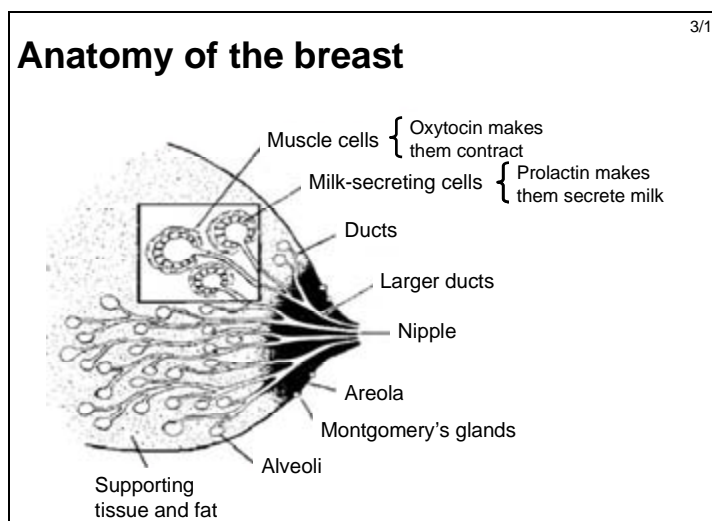
Learning objectives

After completing 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.

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.

Slide 3/1. Anatomy of the breast.



This diagram shows the anatomy of the breast.

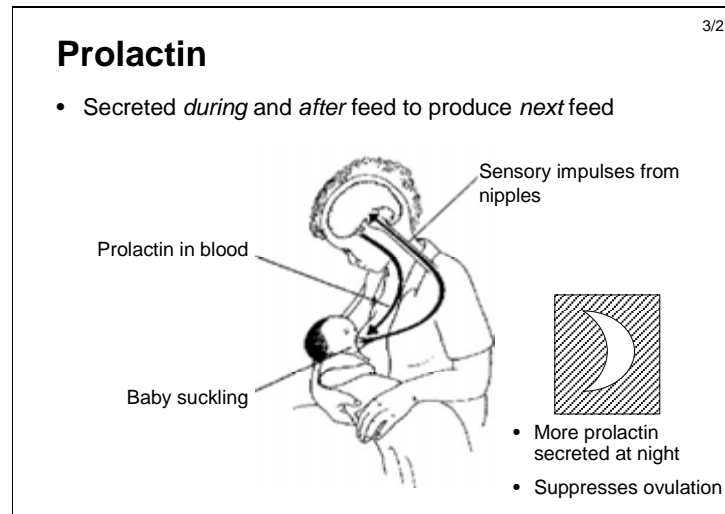
First, look at the nipple, and the dark skin called the areola which surrounds it. In the areola are small glands called Montgomery's glands which secrete an oily fluid to keep the skin healthy. Inside the breast are the alveoli, which are very small sacs made of milk-secreting cells. There are millions 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. Milk is stored in the alveoli and small ducts between feeds. The larger ducts beneath the areola dilate during feeding and hold the breastmilk temporarily during the feed. The secretory alveoli and ducts are surrounded by supporting tissue and fat.

Some mothers think their breasts are too small to produce enough milk. However, 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.

Breastmilk is produced as a result of the action of hormones (which send a message to the brain) and stimulated by suckling at the breast. When a baby suckles, the tongue and the mouth stimulate the nipple. The nerves in the nipple send a message to the mother's brain that the baby wants milk. The brain responds and orders the production of two hormones, prolactin and oxytocin.

Slide 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 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.

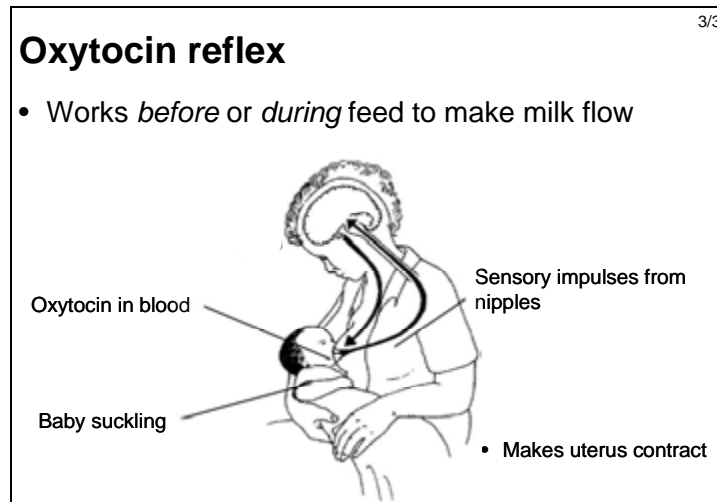
If the baby suckles more, the mother's breasts will make more milk. So, suckling makes more milk. If a mother has two babies, and they both suckle, her breasts make milk for two. If a baby stops suckling, the breasts soon stop making milk.

Sometimes people suggest that to make a mother produce more milk, we should give her more to eat, 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.

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

Slide 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 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 larger ducts beneath the areola. Here the milk is stored temporarily during the feed. This is the oxytocin reflex, the milk-ejection reflex, or the 'let-down' 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. In this situation, it may seem as if the breasts have stopped producing milk. However, the breasts are producing milk, but it is not flowing out.

Oxytocin also 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.

The oxytocin reflex (milk flow) is easily affected by a mother's thoughts and feelings. Good feelings (for example, feeling pleased with her baby, thinking lovingly of him, 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.

It is important to understand the oxytocin reflex in the way we care for mothers after delivery for several reasons. A mother needs to have her baby near her all the time, so that she can see, touch, and respond to him. 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. Try to make her feel good and build her confidence. Try not to say anything which may make her 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:

- 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.

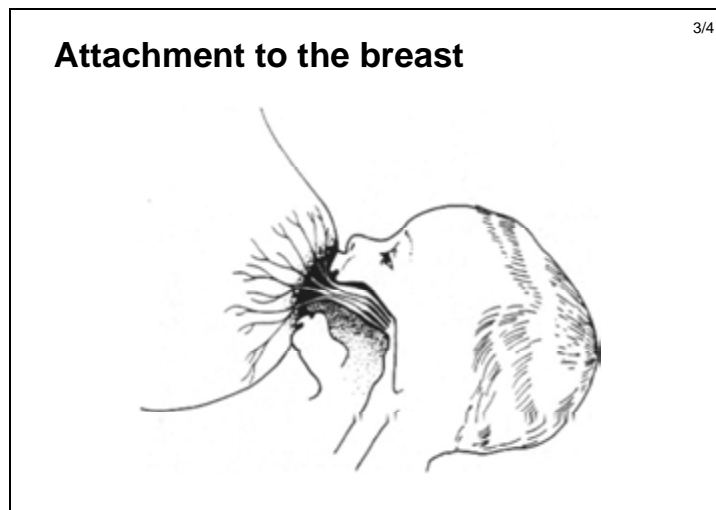
Breastmilk production is also controlled within the breast itself. Sometimes one breast stops making milk while the other breast continues to make milk, although oxytocin and prolactin go equally to both breasts.

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.
- For a breast to continue making 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. This is an important point, which we will discuss later in the course when we talk about expressing breastmilk.

Slide 3/4. Attachment to the breast.



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

He has taken much of the areola and the underlying tissues into his mouth. The larger ducts are included in these underlying tissues.

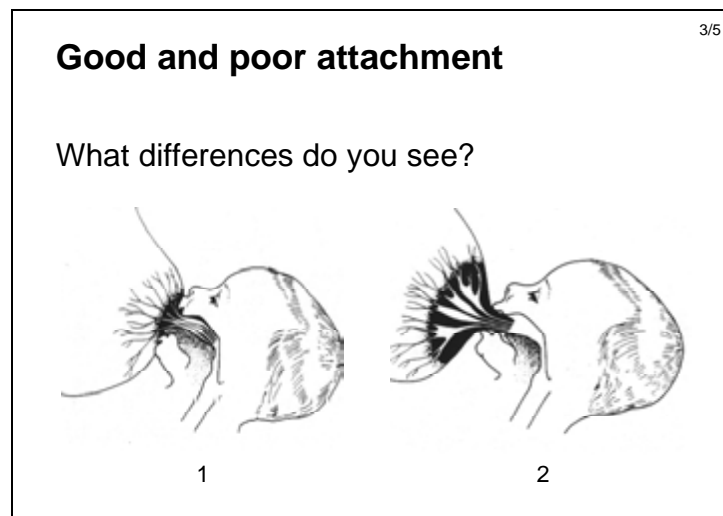
He has stretched the breast tissue out to form a long 'teat'. The nipple forms only about one-third of the 'teat'. The baby is suckling from the breast, not the nipple.

Notice the position of the baby's tongue:

- His tongue is forward, over his lower gums, and beneath the larger ducts.
- His tongue is cupped round the 'teat' of breast tissue. You cannot see that in this drawing, though you may see it when you observe a baby.
- The tongue presses milk out of the larger ducts into the baby's mouth.

If a baby takes the breast into his mouth in this way, we say that he is well attached to the breast. He can remove breastmilk easily and we say that he is suckling effectively. When a baby suckles effectively, his mouth and tongue do not rub the skin of the breast and nipple.

Slide 3/5. Good and poor attachment.

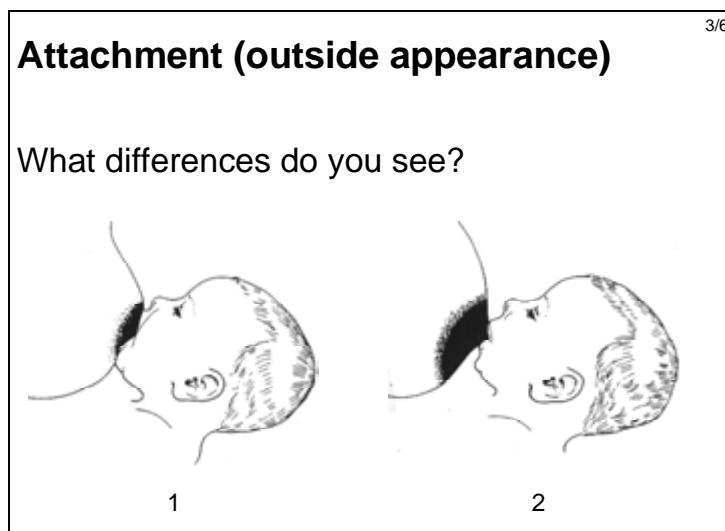


Here you see two pictures. Picture 1 is the same as in the previous slide. The baby is well attached to the breast. Picture 2 shows a baby suckling in a different way.

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 larger ducts are outside the baby's mouth, where his tongue cannot reach them.
- The baby's tongue is back inside his mouth, and not pressing on the larger ducts.
- The baby in Picture 2 is poorly attached. He is 'nipple sucking'.

Slide 3/6. Attachment (outside appearance).



This picture shows the same two babies from the outside. In Picture 1, you can see more of the areola above his top lip and less below his bottom lip. This shows that he is reaching with his tongue under the larger ducts to press out the milk. In Picture 2, you can see the same amount of areola above his top lip and below his bottom lip, which shows that he is not reaching the larger ducts.

In Picture 1, his mouth is wide open. In Picture 2, his mouth is not wide open and points forward. In Picture 1, his lower lip is turned outward. In Picture 2 his lower lip is not turned outward.

In Picture 1, the baby's chin touches the breast. In Picture 2, his chin does not touch the breast.

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. 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 the baby's top lip and below his bottom lip.

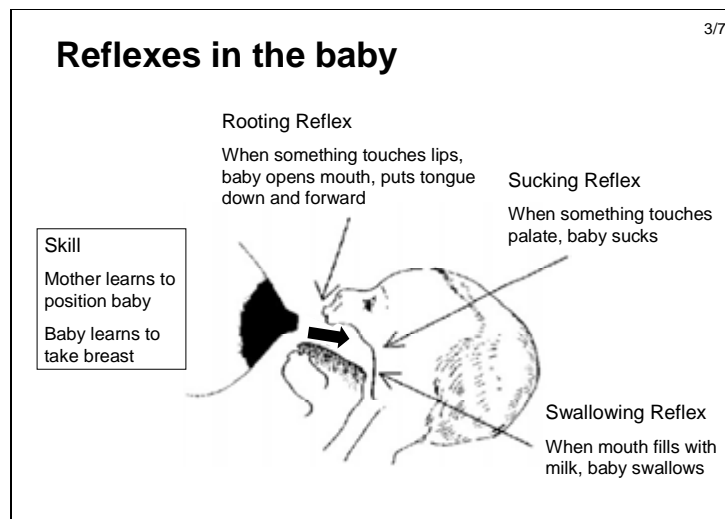
There are other differences that you can see when you look at a real baby; we will talk about these in Session 4.

Results of poor attachment

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 cracks (also known as fissures). As the baby does not remove breastmilk effectively, the breasts may become engorged. Because he does not get enough breastmilk, he may be unsatisfied and cry a lot. He may want to feed often or for a very long time at each feed. Eventually if breastmilk is not removed, the breasts may make less milk. A baby may fail to gain weight and the mother may feel she is a breastfeeding failure.

To prevent this from happening, all mothers need skilled help to position and attach their babies. Also, babies should not be given feeding bottles. If a baby feeds from a bottle before breastfeeding is established, he may have difficulty suckling effectively. Even babies who start bottle feeds after a few weeks may also begin to suckle ineffectively.

Slide 3/7. Reflexes in the baby.



Earlier slides 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. This is the sucking reflex. When his mouth fills with milk, he swallows. This is the swallowing reflex.

All these reflexes happen automatically without the baby having to learn to do them. Notice in the drawing that the baby is not coming straight toward the breast. He is coming up to it from below the nipple. This helps him to attach well because the nipple is aiming toward 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 larger ducts.

Notes

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Session 4: Assessing a breastfeed

Learning objectives

After completing this session, participants will be able to:

- Explain the four key points of attachment.
 - Assess a breastfeed by observing a mother and baby.
 - Identify a mother who may need help.
 - Recognise signs of good and poor attachment and positioning.
 - Explain the contents and arrangement of the BREASTFEEDING OBSERVATION JOB AID.
-

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. There are some things you can observe when a baby is not breastfeeding. Other things you can observe only when a baby is breastfeeding.

The BREASTFEEDING OBSERVATION JOB AID will help you to remember what to look for when you assess a breastfeed. The form is arranged in five sections: General, Breasts, Baby's Position, Baby's Attachment, and Suckling. The signs on the left all show that breastfeeding is going well. The signs on the right indicate a possible difficulty. As you observe a breastfeed, mark a tick in the box for each sign that you observe. If you do not observe a sign, you should not make a mark.

When you have completed the form, if all the ticks are on the left-hand side of the form, breastfeeding is probably going well. If there are some ticks on the right-hand side, then breastfeeding may not be going well. This mother may have a difficulty and she may need your help.

BREASTFEEDING OBSERVATION JOB AID	
<p>Mother's name _____</p> <p>Baby's name _____</p>	<p>Date _____</p> <p>Baby's age _____</p>
<p>Signs that breastfeeding is going well:</p> <p>GENERAL <i>Mother:</i> Mother looks healthy Mother relaxed and comfortable Signs of bonding between mother and baby</p> <p><i>Baby:</i> Baby looks healthy Baby calm and relaxed Baby reaches or roots for breast if hungry</p> <p>BREASTS Breasts look healthy No pain or discomfort Breast well supported with fingers</p> <p>BABY'S POSITION Baby's head and body in line Baby held close to mother's body Baby's whole body supported Baby approaches breast, nose to nipple</p> <p>BABY'S ATTACHMENT More areola seen above baby's top lip Baby's mouth open wide Lower lip turned outward Baby's chin touches breast</p> <p>SUCKLING Slow, deep sucks with pauses Cheeks round when suckling Baby releases breast when finished Mother notices signs of oxytocin reflex</p>	<p>Signs of possible difficulty:</p> <p>GENERAL <i>Mother:</i> Mother looks ill or depressed Mother looks tense and uncomfortable No mother/baby eye contact</p> <p><i>Baby:</i> Baby looks sleepy or ill Baby is restless or crying Baby does not reach or root</p> <p>BREASTS Breasts look red, swollen, or sore Breast or nipple painful Breast held with fingers on areola away from nipple</p> <p>BABY'S POSITION Baby's neck and head twisted to feed Baby not held close Baby supported by head and neck only Baby approaches breast, lower lip/chin to nipple</p> <p>BABY'S ATTACHMENT More areola seen below bottom lip Baby's mouth not open wide Lips pointing forward or turned in Baby's chin not touching breast</p> <p>SUCKLING Rapid, shallow sucks Cheeks pulled in when suckling Mother takes baby off the breast No signs of oxytocin reflex notice</p>

Role plays

Mother A (Mampho) sits comfortably and relaxed, and acts like she is happy and pleased with her baby. She holds her baby close, facing her breast, and she supports his whole body. She looks at her baby, and touches him lovingly. She supports her breast with her fingers against her chest wall below her breast, and her thumb above, away from the nipple.

Mother B (Malerato) sits uncomfortably, and acts like she is sad and not interested in her baby. She holds her baby loosely, and not close, with his neck twisted, and she does not support his whole body. She does not look at him or fondle him, but she shakes or prods him a few times to make him go on breastfeeding. She uses a 'scissor hold' to hold her breast.

Look at the mother to see if she looks well. Her expression may tell you something about how she feels—for example, she may be in pain.

Observe whether the mother looks relaxed and comfortable. 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. 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.

- Observing how a mother interacts with her baby whilst feeding is important. Remember from the last session that if a mother feels good about breastfeeding, this will help her oxytocin reflex to work well, and this will help her milk to flow.
- Look at the baby's general health, nutrition, and alertness. Look for conditions which may interfere with breastfeeding (for example, a blocked nose or difficult breathing).
- Notice whether the breasts look healthy. You may notice a cracked nipple, or may see that the breast is inflamed. We will talk about breast conditions in more detail later in the course.
- If breastfeeding feels comfortable and pleasant for the mother, her baby is probably well attached. Ask the mother how breastfeeding feels.
- Notice how the mother is holding her breast.

How a mother holds her breast during feeding is important.

- Does the mother lean forward and try to push the nipple into the baby's mouth, or does she bring her baby to the breast, supporting her whole breast with her hand?
- Does she hold the breast close to the areola? This makes it more difficult for a baby to suckle. It may also block the milk ducts so that it is more difficult for the baby to get the breastmilk.
- Does the mother hold her breast back from her baby's nose with her finger? This is not necessary.
- Does the mother use the 'scissor hold' (hold the nipple and areola between her index finger above and middle finger below)? This may make it more difficult for a baby to take enough of her breast into his mouth.
- Does the mother support her breast in an appropriate way:
 - With her fingers against the chest wall?
 - With her first finger supporting the breast?
 - With her thumb above, away from the nipple?

Baby's position

Observe how the mother holds her baby. Notice if the baby's head and body are in line.

Notice if she holds the baby close to the breast and facing it, making it easier for him to suckle effectively. If she holds him loosely, or turned away so that his neck is twisted, it is more difficult for him to suckle effectively.

If the baby is young, observe whether the mother supports his whole body or only his head and shoulders.

Suckling

Look and listen for the baby taking slow deep sucks. This is an important sign that the baby is getting breastmilk and is suckling effectively. If a baby takes slow, deep sucks, then he is probably well attached.

If the baby is taking quick, shallow sucks all the time, this is a sign that the baby is not suckling effectively.

If the baby is making smacking sounds as he sucks, this is a sign that he is not well attached.

Notice whether the baby releases the breast himself after the feed, and looks sleepy and satisfied.

If a mother takes the baby off the breast before he has finished (for example, when he pauses between sucks), he may not get enough hindmilk.

Practise using the job aid to assess a breastfeed

You will now see a series of slides of babies who are breastfeeding.

You will practise recognising the signs of good and poor attachment that the slides show, and you will practise using the BREASTFEEDING OBSERVATION JOB AID. There are also some signs of good and poor positioning, but not in all the slides.

You will not be able to see all of the signs in the slides. For example, you cannot see signs with movement in slides.

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.

As you look at each slide:

- Decide which signs of good or poor attachment you see.
- Decide if you think the baby's attachment is good or poor.
- Notice if there are any signs of good or poor positioning shown.

Slide 4/1.



Signs that you can see clearly are:

- There is more areola above the baby's top lip than below the bottom lip.
- His mouth is quite wide open.
- His chin is almost touching the breast.
- In addition, the baby is close to the breast and facing it.
- The baby is breathing quite well without his mother holding her breast back with her finger.
- These signs show that the baby is well attached to the breast.

Slide 4/2.



Signs that you can see clearly are:

- His mouth points forward.
- The baby's chin is not touching the breast.
- In addition, his cheeks are pulled in when suckling.
- The mother is holding her breast with the 'scissor hold'.
- This baby is poorly attached.

Slide 4/3.



Signs that you can see clearly are:

- There is as much areola below the baby's bottom lip as above his top lip.
- His mouth is not wide open and his lips point forward.
- His chin is not touching her breast.
- The baby's body is not close to his mother's.
- This mother's areola is very large, so it is likely that you would see a lot of it even if her baby were well attached. However, you should see more above the baby's top lip than below the bottom lip.
- This baby is poorly attached to the breast.

Slide 4/4.



Signs that you can see clearly are:

- There is more areola above the baby's top lip than below the bottom lip.
- His mouth is quite wide open.
- His chin is touching the breast.

- His lower lip is turned in, not outward, so he is not well attached, even if the other signs are not bad.
- In addition, his head and body are straight and he is facing the breast.
- This baby is not well attached.

Slide 4/5.



Signs that you can see clearly are:

- There is as much or more areola below the baby's mouth as above it.
- His mouth is not wide open, and his lips point forward.
- His chin is not touching the breast.
- In addition, the baby is twisted and is not close to the breast.
- This baby is poorly attached. He looks as though he is feeding from a bottle.

Slide 4/6.



Signs that you can see clearly are:

- There is a little areola above the baby's top lip.
- His chin is touching the breast.
- As the baby is very close to the breast, it makes it difficult to see many other signs.

- This baby is well attached.
- Additional point: This is the same baby as in Slide 4/5, after the health worker helped the mother to position the baby better. In a better position, a baby can attach more easily.

Slide 4/7.



Slide 4/8.



Session 5: Listening and learning counselling skills

Learning objectives

After completing this session, participants will be able to:

- List the six listening and learning skills.
 - Give an example of each skill.
 - Demonstrate the appropriate use of the skills when counselling on infant and young child feeding.
-

Counselling is a way of talking with people to try to understand how they feel and help them to decide what they think is best to do in their situation. Sometimes it can mean offering advice, sometimes it means giving information, and sometimes it can just be listening and showing support.

In this training, we are talking about counselling mothers who are feeding infants and young children. They may be breastfeeding, giving complementary foods, or formula feeding. Although we talk about ‘mothers’ in this session, remember that these skills should be used when talking to other caregivers about infant feeding (for example, fathers or grandmothers).

Counselling mothers about feeding their infants is not the only situation in which counselling is useful. Counselling skills are useful when you talk with 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.

It may not be easy for a mother to talk about her feelings, especially if she is shy, and with someone whom she does not know well. You will 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 more likely to talk.

There are ways to make a mother or caregiver feel more comfortable when talking with them. We are going to talk about and practise using six different listening and learning skills to improve counselling skills.

Listening and learning skills:

1. Nonverbal communication.
2. Ask open questions.
3. Showing interest.
4. Reflect back what the mother says.
5. Empathy—Show that you understand how she feels.
6. Avoid words which sound judging.

Skill 1: Nonverbal communication

How we communicate is more than just how we talk. It also includes all the ways we communicate without speaking. This is called nonverbal communication.

Nonverbal communication means showing your attitude through how you stand or sit, how you move your body, your facial expressions, everything except through speaking.

Our nonverbal communication often demonstrates to a mother or caregiver our approval or disapproval of a situation. We should be careful to avoid allowing our own views on certain subjects (for example, religion) to be expressed in a counselling situation where it might appear as though we are judging a mother.

Skill 2: Ask open questions

To start a discussion with a mother, or to take a history from her, you need to ask some questions. It is important to ask questions in a way that 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? Who?' For example: 'How are you feeding your baby?'

Closed questions are usually less helpful and do not encourage discussion. 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. If you continue to ask questions to which the mother can only answer 'Yes' or 'No', you can become quite frustrated, and think that the mother is not willing to talk, or that she is not telling the truth.

We will now see this skill being demonstrated in two role plays. The health worker is talking to a mother who has a young baby whom she is breastfeeding.

Role play 1: Using closed and open questions

Health worker: 'Good morning, Lerato. I am (name), the nurse. Is (child's name) well?'

Mother: 'Yes, thank you.'

Health worker: 'Are you breastfeeding him?'

Mother: 'Yes.'

Health worker: 'Are you having any difficulties?'

Mother: 'No.'

Health worker: 'Is he breastfeeding very often?'

Mother: 'Yes.'

Health worker: 'Good morning, Lerato. I am (name), the nurse. How is (child's name)?'

Mother: 'He is well, and he is very hungry.'

Health worker: 'Tell me, how are you feeding him?'

Mother: 'He is breastfeeding. I just have to give him one bottle feed in the evening.'

Health worker: '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.'

A very general, open question is useful to start a conversation. This gives the mother an opportunity to say what is important to her. For example, you might ask a mother of a 9-month-old baby: 'How is your child feeding?'

Sometimes a general question like this receives an answer such as, '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: 'Can you tell me what your child ate for the main meal yesterday?' Sometimes you might need to ask a closed question. For example: 'Did your child have any fruit yesterday?' After you have received an answer to this question, try to follow up with another open question.

Skill 3: Showing interest

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. Common things we do to show that we are listening and interested include nodding, smiling, and simple responses such as 'Aha' or 'Mmm'.

Role play 2: Using responses and gestures to show interest

The health worker is talking to a mother who has a 1-year-old child.

Health worker: 'Good morning, (name). How is (child's name) now that he has started solids?'

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

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

Mother: 'Well, I was a bit worried the other day, because he vomited.'

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

Mother: 'I wondered if it was something in the stew that I gave him.'

Health worker: 'Aha!' (nods sympathetically)

Skill 4: Reflect back what the mother says

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. This is another way to show you are listening and encourages the mother or caregiver to continue talking and to say 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, 'I don't know what to feed my child, she refuses everything', you could reflect back by saying, 'Your child is refusing all the food you offer her?'

Role play 3: Asking for facts versus reflecting back

The health worker is talking to a mother who has a 6-week-old baby she is breastfeeding.

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

Mother: 'He wants to feed too much—he is taking my breast all the time!'

Health worker: 'About how often would you say?'

Mother: 'About every half an hour.'

Health worker: 'Does he want to suck at night, too?'

Mother: 'Yes.'

The same volunteers now act out the same scenario, but in a different way:

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

Mother: 'He wants to feed too much—he is taking my breast all the time!'

Health worker: '(Child's name) is feeding very often?'

Mother: 'Yes. This week he is so hungry. I think that my milk is drying up.'

Health worker: 'He seems more hungry this week?'

Mother: 'Yes, and my sister is telling me that I should give him some bottle feeds as well.'

Health worker: 'Your sister says that he needs something more?'

Mother: 'Yes. Which formula is best?'

Skill 5: Empathy—Show that you understand how she feels

Empathy or empathizing means showing that you understand someone's feelings from his/her point of view.

Empathy is a difficult skill to learn. It is difficult for people to talk about feelings. It is easier to talk about facts. 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 sympathise, you are sorry for a person, but you look at it from **your** point of view. If you sympathise, 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 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 empathise with a mother's good feelings. Empathy is not only to show that you understand her bad feelings.

Ask for two volunteers to demonstrate the skill: one will play the part of the mother, the other will play the part of the health worker. Introduce the role play by saying: The health worker is talking to a mother of a 10-month-old child. As you watch, look for empathy: Is the health worker showing she understands the mother's point of view?

Role play 4: Sympathy versus empathy

The health worker is talking to a mother who has a 6-week-old baby she is breastfeeding.

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

Mother: '(Child's name) is not feeding well, I am worried he is ill.'

Health worker: 'I understand how you feel. When my child was ill, I was so worried. I know exactly how you feel.'

Mother: 'What was wrong with your child?'

Let us hear this again with the focus on the mother and empathising with her feelings:

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

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

Health worker: 'You are worried about him?'

Mother: 'Yes, some of the other children in the village are ill and I am frightened he may have the same illness.'

Health worker: 'It must be very frightening for you.'

Now let us see two more demonstrations. This time the mother is HIV positive and pregnant and is coming to talk to the health worker about how she will feed her baby after birth. Again listen for empathy: Is the health worker showing she understands the mother's point of view?

Role play 5: Sympathy versus empathy

Round 1:

Health worker: 'Good morning, (name). You wanted to talk to me about something?'
(smiles)

Mother: 'I tested for HIV last week and am positive. I am worried about my baby.'

Health worker: 'Yes, I know how you feel. My sister has HIV.'

Round 2:

Health worker: 'Good morning, (name). You wanted to talk to me about something?'
(smiles)

Mother: 'I tested for HIV last week and am positive. I am worried about my baby.'

Health worker: 'You're really worried about what's going to happen.'

Mother: 'Yes I am. I don't know what I should do.'

Now we will see another demonstration. Watch to see if the health worker is really listening to the mother. The health worker is talking to a mother of a 7-month-old child who has recently started complementary feeds.

Role play 6: Asking facts versus empathy

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

Mother: 'He is refusing to breastfeed since he started eating porridge and other foods last week. He just pulls away from me and doesn't want me!'

Health worker: 'How old is (child's name) now?'

Mother: 'He is 7 months old.'

Health worker: 'And how much porridge does he eat during a day?'

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

Mother: 'He is refusing to breastfeed since he started eating porridge and other foods last week. He just pulls away from me and doesn't want me!'

Health worker: 'It's very upsetting when your baby doesn't want to breastfeed.'

Mother: 'Yes, I feel so rejected.'

Skill 6: Avoid words which sound judging

The words we use when talking with mothers and their families are important. 'Judging words' are words like right, wrong, well, badly, good, enough, properly. If you use judging words when you talk to a mother about feeding, especially when you ask questions, you may make her feel that she is wrong, or that there is something wrong with the baby. A breastfeeding mother may feel there is something wrong with her breastmilk.

For example:

- Do not say: 'Are you feeding your child **properly**?' Instead, say: 'How are you feeding your child?'
- Do not say: 'Do you give her **enough** milk?' Instead, say: 'How often do you give your child milk?'

We will see a demonstration of this skill. The health worker is talking to a mother of a 5-month-old baby. As you watch, listen for judging words.

Role play 7: Using judging words versus avoiding judging words

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

Mother: 'Well, I think so.'

Health worker: 'Do you think that you have **enough** breastmilk for him?'

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

Health worker: 'Has he gained weight **well** this month?'

Mother: 'I don't know...'

Health worker: 'May I see his growth chart?'

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

Mother: 'It's going very well. I haven't needed to give him anything else.'

Health worker: 'How is his weight? May I see his growth chart?'

Mother: 'Nurse said that he gained more than half a kilo this month. I was pleased.'

Health worker: 'He is obviously getting all the breastmilk that he needs.'

Mothers may use judging words about their own situation. You may sometimes need 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.

Avoiding judgement is important in both verbal and nonverbal communication.

Session 6: Practical Session 1—Using counselling skills to assess a breastfeed

Learning objectives

After completing this session, participants will be able to:

- Demonstrate appropriate listening and learning skills when counselling a mother on feeding her infant.
 - Assess a breastfeed using the BREASTFEEDING OBSERVATION JOB AID.
 - Demonstrate appropriate confidence and support skills when counselling a mother on feeding her infant.
 - Demonstrate how to help a mother to position and attach her baby at the breast.
-

Preparation for the practical session

- You are going to practise the following skills, which we learnt in the previous sessions:
 - Assessing a breastfeed with mothers.
 - Listening and learning skills.
 - Building confidence and giving support.
 - Positioning and attachment.
- It is important that all of you practise helping a mother to position her baby at the breast, or to overcome any other difficulty. Often you will find that the baby is sleepy. In this case, you could say to the mother something like: ‘I see your baby seems to be sleepy now, but can we just go through the way to hold him when he is ready?’ Then go through the four key points of positioning with the mother. If you do this, quite a few babies will wake up and want another feed when their nose is opposite the nipple.
- You will need to take with you one copy of the COUNSELLING SKILLS CHECKLIST, two copies of the BREASTFEEDING OBSERVATION JOB AID, and a pencil and paper to make notes.
- You will work in groups of three or four with one trainer.

Steps to follow in the ward

- Take turns talking with a mother whilst the other members of the group observe.
- Introduce yourself to the mother and ask her permission to talk with her. Introduce the group and say they are interested in infant feeding. If a mother is not feeding, ask the mother to give a feed in the normal way at any time that her baby seems ready.
- Try to find a chair or a stool to sit on.
- Practise as many of the listening and learning skills as possible. Try to get the mother to tell you about herself, her situation, and her baby. You can talk about ordinary life, not only about breastfeeding.
- The other participants should stand quietly in the background. Try to be as still and quiet as possible.
- Participants observing should note general observations of the mother and baby. Notice, for example: Does she look happy? Does she have formula or a feeding bottle with her?
- Participants observing should note 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 as she speaks to the mother.
- Mark an **X** on your COUNSELLING SKILLS CHECKLIST when she uses a skill, to help you to remember for the discussion. Notice if she uses helpful nonverbal 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'.
- When a mother breastfeeds, observe the feed using the BREASTFEEDING OBSERVATION JOB AID and put ticks in the applicable boxes.
- Remember that you are not helping the mother at this point. If a mother needs help, your trainer will take the opportunity to demonstrate to you how to help the mother.
- When you have finished, thank the mother.

Mistakes to avoid

- **Do not say that you are interested in breastfeeding.** The mother's behaviour may change. She may not feel free to talk about formula feeding. You should say that you are interested in 'infant feeding' or in 'how babies feed'.
- **Do not give a mother help or advice.** If a mother seems to need help, you should inform your trainer and a staff member 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 talking. Refer to the forms to remind you what to do, but if you want to write, you should do so afterward. The participants who are observing can make notes.

Practical discussion checklist	
Use the checklist below to help guide your feedback discussions.	
Questions to ask after each participant completes her turn practising (either in the clinic or using counselling stories):	
To the participant who practised: <ul style="list-style-type: none"> • What did you do well? • What difficulties did you have? • What would you do differently in the future? 	To the participants who observed: <ul style="list-style-type: none"> • What did the participant do well? • What difficulties did you observe?
Listening and learning skills (give feedback on the use of these skills in all practical sessions):	
<ul style="list-style-type: none"> • Which listening and learning skills did you use? • Was the mother willing to talk? • Did the mother ask any questions? How did you respond? • Did you empathise with the mother? Give an example. 	
Confidence and support skills (give feedback on the use of these skills during practical sessions after Session 10):	
<ul style="list-style-type: none"> • Which confidence and support skills were used? (Check especially for praise and for two relevant suggestions.) • Which skills were most difficult to use? • What was the mother's response to your suggestions? 	
Key messages for complementary feeding (give feedback on the use of these skills in practical Session 32):	
<ul style="list-style-type: none"> • Which messages for complementary feeding did you use? (Check especially for 'only a few relevant messages'.) • What was the mother's response to your suggestions? 	

General questions to ask at the end of each practical session (in the clinic or using counselling stories):

- What special difficulties or situations helped you to learn?
- What was the most interesting thing that you learned from this practical session?

COUNSELLING SKILLS CHECKLIST

Listening and learning skills:

- Use helpful non-verbal communication.
- Ask open questions.
- Use responses and gestures that show interest.
- Reflect back what the mother/caregiver says.
- Empathise—Show that you understand how she/he feels.
- Avoid words that sound judging.

Building confidence and giving support skills:

- Accept what the caregiver thinks and feels.
- Recognise and praise what a mother/caregiver and child are doing right.
- Give practical help
- Give relevant information.
- Use simple language.
- Make one or two suggestions, not commands.

Session 7: Positioning and attachment

Learning objectives

After completing this session, participants will be able to:

- Explain the four key points of positioning.
- Describe how a mother should support her breast for feeding.
- Demonstrate the main positions—sitting, lying, underarm, and across.
- Help a mother to position her baby at the breast, using the four key points in different positions.

We are going to learn how to position a baby at the breast. We will be using the four key points from the section on ‘Baby’s Position’ on the BREASTFEEDING OBSERVATION JOB AID. There are several steps to follow when helping a mother to position her baby at the breast.

Always assess a mother breastfeeding before you help her, using the points from the BREASTFEEDING OBSERVATION JOB AID.

In Session 4, we talked about the importance of observing a mother interacting with her baby and breastfeeding. 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.

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:

- Baby’s head and body should be in line.
- Baby held close to mother’s body.
- Baby’s whole body supported.
- Baby approaches breast, nose to nipple.

Show her how to support her breast:

- 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.
- 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 how.
- 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 the mother cannot.

Demonstration 1: How to help a mother who is sitting

Step 1: Greet the mother and ask how breastfeeding is going

- When you have greeted the 'mother' and asked how breastfeeding is going, the 'mother' should respond by saying that breastfeeding is painful.

Step 2: Assess a breastfeed

- Ask if you may see how (child's name) breastfeeds, and ask the 'mother' to put him to her breast in the usual way. She holds him loosely, away from her body, with his neck twisted, as you practised. Observe her breastfeeding for a few minutes.

Step 3: 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 (child'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.

Step 4: Make sure that she is comfortable and relaxed

- Make sure the 'mother' is sitting in a comfortable and relaxed position.
- Sit down yourself, so that you are also comfortable and relaxed, and in a convenient position to help. You cannot help a mother satisfactorily if you are in an awkward or uncomfortable position yourself or if you are bending over her.
 - 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 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.

Step 5: Explain how to hold her baby, and show her if necessary

1. **Baby's head and body in line:** A baby cannot suckle or swallow easily if his head is twisted or bent.
2. **Baby held close to mother's body:** A baby cannot attach well to the breast if he is far away from it. 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.
3. **Baby supported:** The baby's whole body should be supported with the mother's arm along the baby's back. This is particularly important for newborns and young babies. For older babies, support of the upper part of the body is usually enough. A mother needs to be careful about using the hand of the arm that supports her baby's back to hold his bottom. Holding his bottom may result in her pulling him too far out to the side, so that his head is in the crook (bend) of her arm. He then has to bend his head forward to reach the nipple, which makes it difficult for him to suckle.

4. **Baby approaches breast, nose to nipple:** We will talk about this a little later when we discuss how to help a baby to attach to the breast.
- 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.

Step 6: Show her how to support her breast

- Demonstrate how to help the mother to support her breast.
 - It is important to show a mother how to support her breast with her hand to offer it to her baby.
 - If she has small and high breasts, she may not need to support them.
 - She should place her fingers flat 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.
 - Holding the breast too near the nipple makes it difficult for a baby to attach and suckle effectively. The 'scissor hold' can block milk flow.
 - These ways of holding the breast can make it difficult for a baby to attach: holding the breast with the fingers and thumb close to the areola, pinching up the nipple or areola between the thumb and fingers, and trying to push the nipple into a baby's mouth while holding the breast in the 'scissor hold'—index finger above and middle finger below the nipple.

Step 7: Explain or show her how to help the baby to attach

- Demonstrate how to help the 'mother' to attach her baby.
 - Explain that she first holds the baby with his nose opposite her nipple, so that he approaches the breast from underneath the nipple.
 - Explain how she should touch her baby's lips with her nipple, so that he opens his mouth, puts out his tongue, and reaches up.
 - 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.
 - 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, and she should not try to open his mouth by pulling his chin down.
 - 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.
 - As she brings the baby to her breast, she should aim her baby's lower lip below her nipple, with his nose opposite the nipple, so that the nipple aims toward the baby's palate, his tongue goes under the areola, and his chin will touch her breast.
 - 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.

Step 8: Notice how she responds and ask her how her baby's sucking feels

- Ask the 'mother' how she feels. She should say something like 'Oh, much better, thank you.'
 - Notice how the mother responds.
 - Ask the mother how suckling feels.
 - If suckling is comfortable for the mother, and she looks happy, her baby is probably well attached.

Step 9: Look for signs of good attachment. If the attachment is not good, try again

- Look for all the signs of good attachment (which you cannot see with a doll). If the attachment is not good, try again.
- It often takes several tries to get a baby well attached. You may need to work with the mother again at a later time, or the next day, until breastfeeding is going well.
- Make sure 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.

Demonstration 2: How to help a mother who is lying down

- To be relaxed, the mother needs to lie down on her side in a position in which she can sleep. Being propped on one elbow is not relaxing for most mothers.
- If she has pillows, a pillow under her head and another under her chest may help.
- Exactly the same four key points on positioning are important for a mother who is lying down. She can support her baby with her lower arm. She can support her breast if necessary with her upper arm. If she does not support her breast, she can hold her baby with her upper arm.
- A common reason for difficulty attaching when lying down is that the baby is too 'high' (near the mother's shoulders), and his head has to bend forward to reach the breast.
- Breastfeeding lying down is useful:
 - When a mother wants to sleep, so that she can breastfeed without getting up.
 - Soon after a caesarean section, when lying on her back or side may help her to breastfeed her baby more comfortably.

Slide 7/1. How to hold and attach a baby for breastfeeding.



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.

This counselling card can be used with mothers who have chosen to breastfeed. It shows various ways a mother can sit or lie down comfortably to breastfeed her baby.

Session 8: Growth charts

Learning objectives

After completing this session, participants will be able to:

- Explain the meaning of the standard curves.
- Plot a child's weight on a growth chart.
- Interpret individual growth curves.

Growth curves are tools to promote and monitor the growth of an infant. Monitoring the growth of an infant in a regular manner is a way to see if a child is growing properly, and, if not, to make up for a slow growth rate as rapidly as possible so as to prevent the malnutrition or death of the infant.

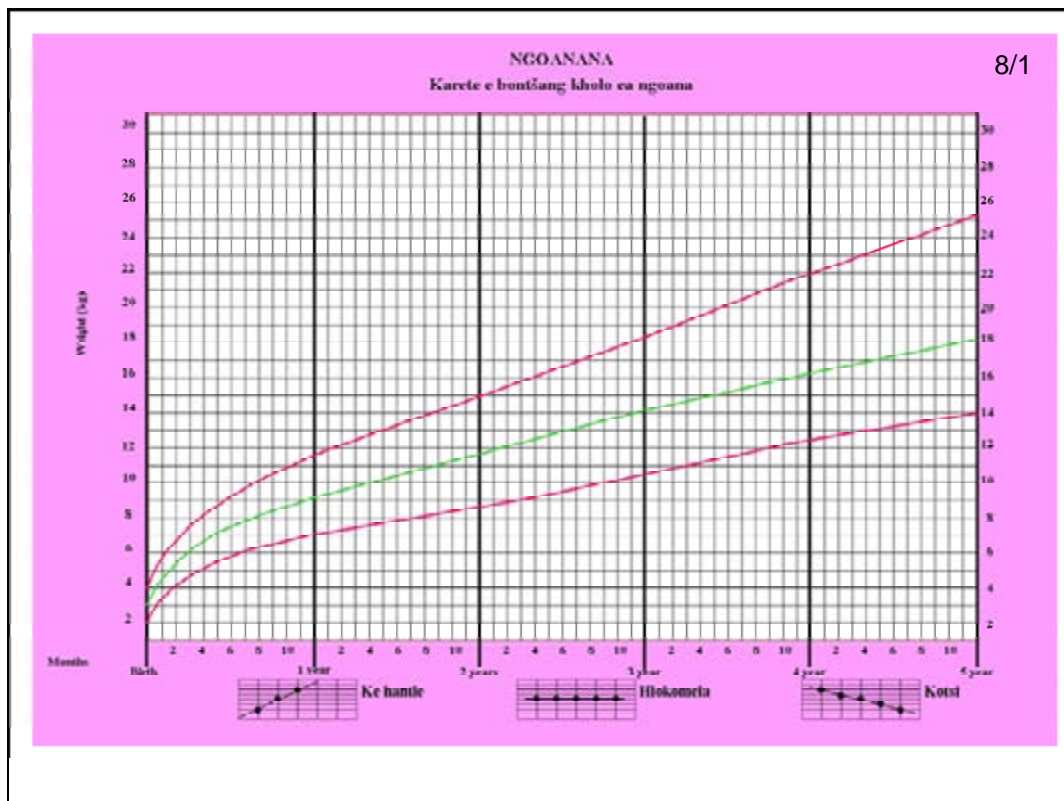
Growth curves can reflect past and present conditions regarding the feeding of an infant and its state of health. If growth curves are not correctly interpreted, incorrect information can be given to a mother, causing worry and loss of confidence.

Growth of an infant can be monitored from its weight and/or its size. Different growth curves exist for each of these measures. The simplest and most used way for monitoring an infant's growth is to compare its weight in relation to its age (weight-for-age).

A child who is undernourished for a long time will show slow growth in length or height. This is referred to as stunting or very short height for age.

Good feeding practices—both before the child is 6 months old and after complementary foods have been introduced—can help prevent growth faltering in both weight and length.

Slide 8/1.



This is a chart of ordinary growth developed by the Ministry of Health and Social Welfare (MOHSW) that indicates weight-for-age of girls from 0 to 5 years. The age of the infant in months is seen on the horizontal line on the bottom of the graph (abscissa axis). The weight of the infant is found on the vertical line on the left of the graph (ordinates axis).

There are three curves on the chart. The middle curve shows the average weight or median for infants of this age in good health. It is also called the 50th percentile because the weights of 50% of infants in good health are below this weight and 50% are above. Most infants in good health are close to the curve of the 50th percentile, either a little above or a little below.

The growth curve of a normally growing child will usually follow a track that is parallel to the median, although the track may be above or below the median.

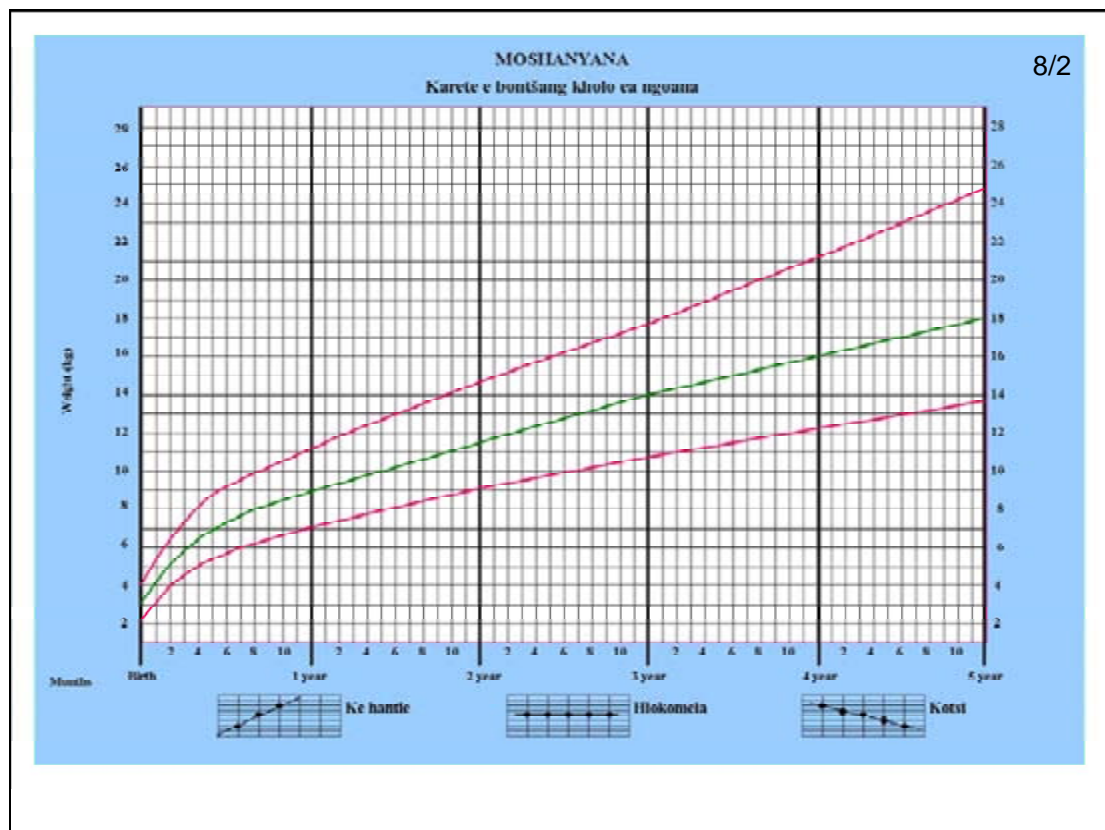
The other two lines, called 'Z-score lines', indicate distance from the average. A point or trend which is far from the median, such as +2 or -2, may indicate a growth problem (points or trends much farther from the median *usually* indicate a health problem).

The lowest line indicates a weight below the norm for the age of the infant. An infant below this line is underweight. A genetically small child may be near this curve but still be growing well. As long as the child is growing normally (curve parallel to the median or Z-score lines), all may be well. However, if the child is not growing normally, or if it is losing weight, then the child definitely is not in good health and needs attention. We can identify infants whose weight is below the lowest curve on the weight-for-age table. This has to do with infants with low weight-for-age.

When you see the growth curve for an infant, the most important matter is to determine that the curve is parallel to the median line, and especially that it is not staying level or descending.

Good feeding habits—both before the age of 6 months and after the introduction of complementary foods—can help improve size and weight and maintain both curves in the normal growth pattern.

Slide 8/2. The MOHSW's growth curve for boys.



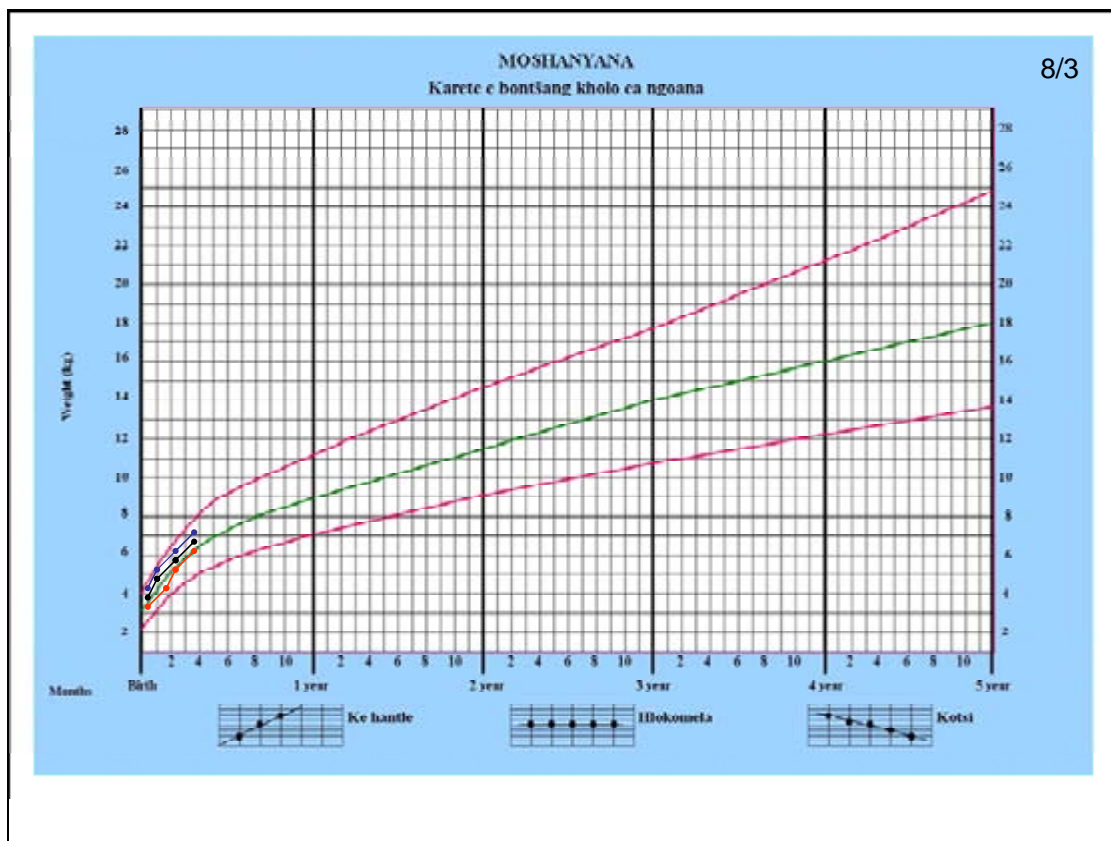
Lesotho currently uses a growth curve with two lines to determine the weight-for-age of an infant. An infant in good health will have a curve that falls somewhere between the two. These two lines are similar to the red lines (-2 standard deviation to +2 standard deviation) in the chart below.

The curve of an infant should always follow the normal growth pattern. If it is flat or goes down, there is a problem with feeding practices or with the infant's health.

If the weight-for-age is below the lower red curve, the infant's weight is below the norm for its age. If the weight-for-age is above this curve, the weight of the infant is not low for its age.

If the child's *pattern of growth* (growth curve) parallels the pattern of the median curve, the child is growing normally even if the child is low weight-for-age.

Slide 8/3.

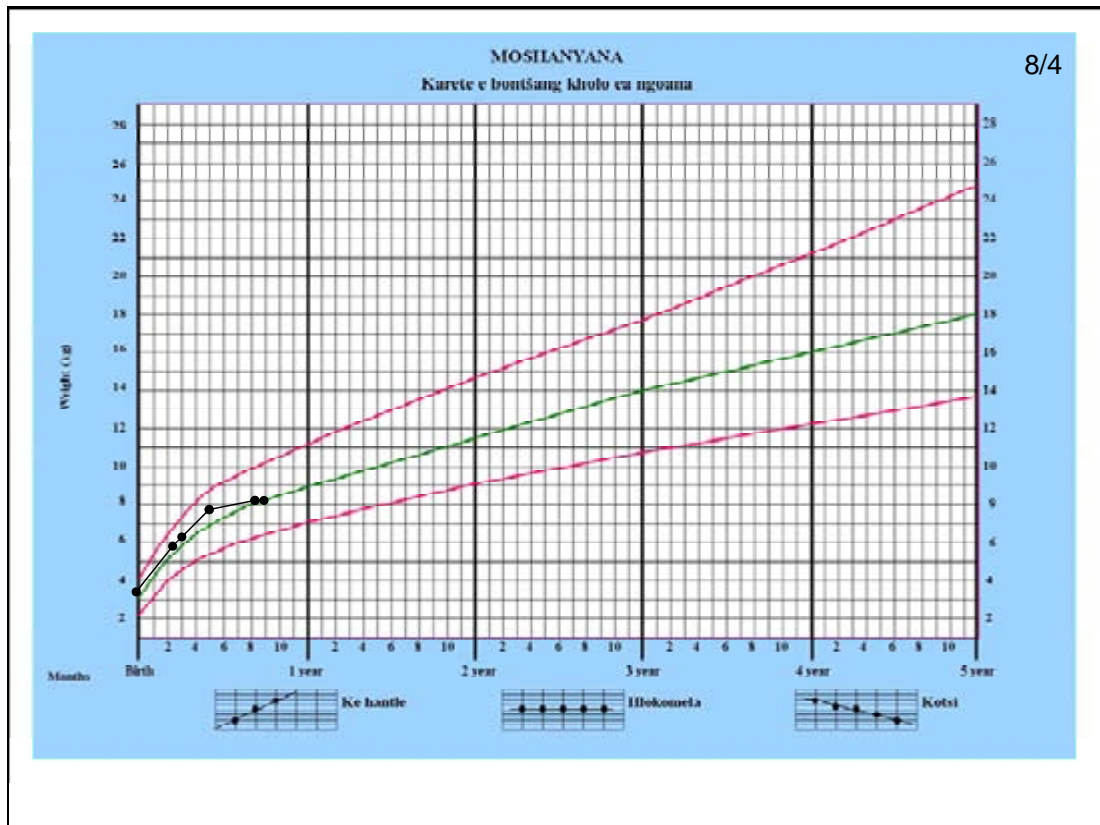


This is a growth chart for three infants who have been weighed regularly.

The growth chart of these three infants shows that all of the infants have a curve similar to the reference curve (median curve, 0). Nevertheless, each grows according to its individual curve. Notice that they all have different weights at birth. Weight alone does not give a lot of information. You need a set of indicators before interpreting the trend of the curve.

One infant can grow more at a given time than another, so that there can be highs and lows on the curve. It is therefore important to look for the general pattern. If the growth of an infant is delayed, it is important to identify the causes so that you can help the mother.

Slide 8/4. Curve of stationary growth.



Here is the growth curve for Masupha, who has been regularly weighed.

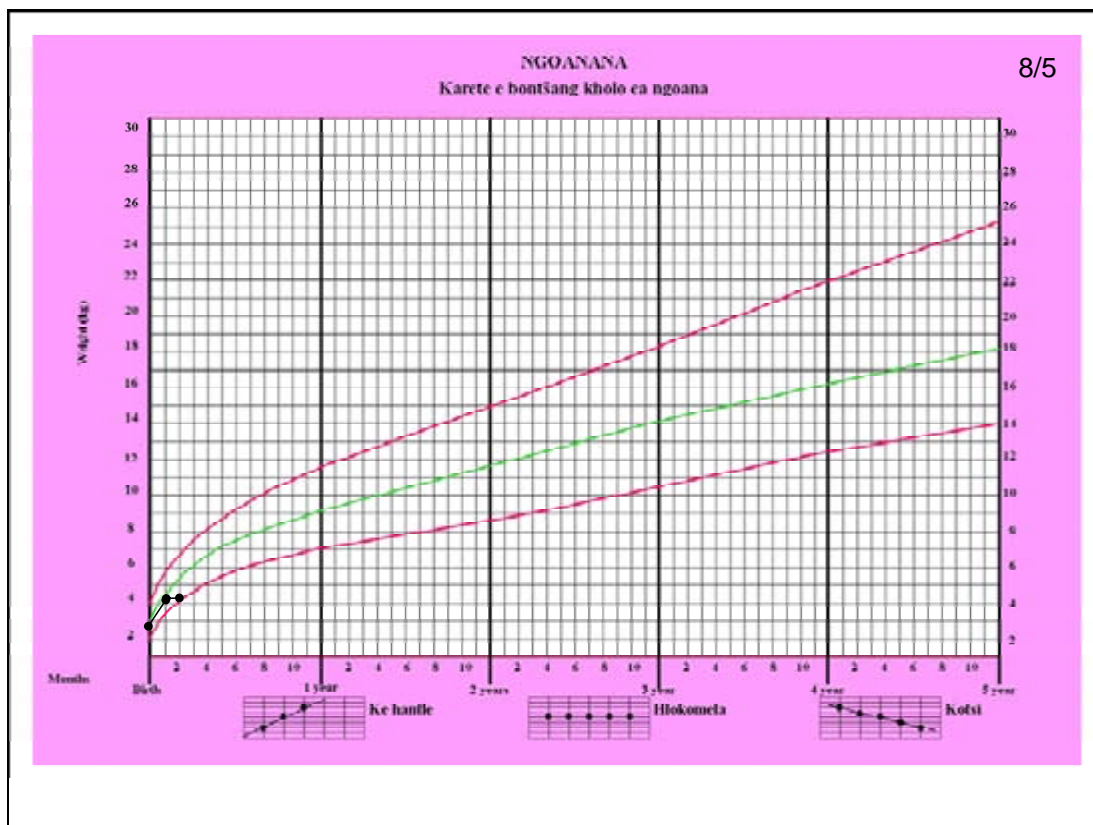
Masupha developed well during the first 6 months but not since then. His weight is currently stationary (his curve has become horizontal). You need to ask his mother some questions to know the causes for this.

Here are certain questions that you can ask about him:

- How was Masupha fed during the first 6 months of his life?
- What type of milk is Masupha consuming now?
- What meals does Masupha receive now? How many meals does he have each day?
- What amount does he eat? What types of food does he eat?
- What was the health of Masupha over the past months?

You can find out that Masupha was breastfed exclusively during the first 6 months of his life and that his mother continues to breastfeed him frequently during day and night. At 6 months, his mother began to give him a light cereal twice a day. He has not been sick since his last visit. His weight does not increase because he needs other foods that are more nourishing (an enriched porridge, for example) and he needs to eat more often every day.

Slide 8/5. Stationary growth curve.



Here is the growth curve of Thithili, who comes regularly to the health centre.

This infant is developing slowly. You may need to ask certain questions of the mother to see how Thithili is fed.

Some questions you might ask Thithili's mother:

- How is Thithili fed?
- How frequently is she fed?
- Who does Thithili sleep with?
- If the mother says that she breastfeeds: How is the breastfeeding going?

Notes

A series of 30 horizontal dotted lines for writing notes.

Session 9: Building confidence and giving support

Learning objectives

After completing this session, participants will be able to:

- List the six confidence and support skills.
- Give an example of each skill.
- Demonstrate the appropriate use of the skills when counselling on infant and young child feeding.

Introduction

A mother can easily lose confidence in herself. This may lead to her feeling that she is not successful and cause her to give into pressure from family and friends. You can use confidence and support skills to help her to feel confident and good about herself.

It is important not to make a mother feel that she has done something wrong. A mother can easily believe that there is something wrong with herself, how she is feeding her child, or with her breastmilk if she is breastfeeding. This reduces her confidence.

It is important to avoid telling a mother what to do. Help each mother to decide for herself what is best for her and her baby. This increases her confidence.

Skill 1: Accept what a mother thinks and feels

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.

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.

We will now see a role play showing acceptance of what a mother thinks. This mother has a 1-week-old baby.

Role play 1: Accepting what a mother thinks

Mother: 'My milk is thin and weak, so I have to give bottle feeds.'

Health worker: 'Oh no! Milk is never thin and weak. It just looks that way' (nods, smiles)

Mother: 'My milk is thin and weak, so I have to give bottle feeds.'

Health worker: 'Yes, thin milk can be a problem.'

Mother: 'My milk is thin and weak, so I have to give bottle feeds.'

Health worker: 'I see. You are worried about your milk.'

Reflecting back and giving simple responses are useful ways to show acceptance. Later in the discussion, you can give information to correct a mistaken idea. In a similar way, empathising can show acceptance of a mother's feelings.

If a mother is worried or upset, and you say something like, 'Oh, don't be upset, it is nothing to worry about', she may feel that she was wrong to be upset. This reduces a mother's confidence in her ability to make her own decisions.

The last role play showed acceptance of what a mother thinks. We will now see a role play showing acceptance of what a mother feels. This mother has a 9-month-old baby.

Role play 2: Accepting what a mother feels

Mother (in tears): 'It is terrible, (child's 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.'

Health worker: 'Don't worry, your baby is doing very well.'

Mother (in tears): 'It is terrible, (child's 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.'

Health worker: 'Don't cry, it's not serious. (Child's name) will soon be better.'

Mother (in tears): 'It is terrible, (child's 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.'

Health worker: 'You are upset about (child's name), aren't you?'

Skill 2: Recognize and praise what a mother and baby are doing right

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.

If you tell a mother that she is doing something wrong or that her baby is not doing well it may make a mother feel bad, and this can reduce her confidence. As counsellors, we must look for what mothers and babies are doing right.

We must first recognise 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.

In some situations, it can be difficult to recognise what a mother is doing right. But any mother whose child is living must be doing some things right, whatever her socioeconomic status or education.

Skill 3: Give practical help

Sometimes giving practical help is better than saying anything. For example:

- When a mother feels tired or dirty or uncomfortable.
- When she has had a lot of information already.
- When she has a clear practical problem.

Some ways to give practical help are these:

- Help her to feel comfortable or give her a bed to rest on, if appropriate.
- Hold the baby yourself while she gets comfortable, or washes, or goes to the toilet.
- It also includes practical help with feeding, such as helping a mother with positioning and attachment, expressing breastmilk, relieving engorgement, or preparing complementary foods.

Skill 4: Give the key messages

Mothers often need information about feeding. It is important to share your knowledge with them. It may also be important to correct mistaken ideas. However, sometimes health workers know so much information that they think they need to tell it all to the mother. It is a skill to be able to listen to the mother and choose just two or three pieces of the most important information to give at one time.

When you give a mother information, remember these points:

- Try to give information that is relevant and important to her situation now. Tell her things that she can use today, not in a few weeks' time.
- Explaining the reason for difficulty is often the most relevant information when it helps a mother to understand what is happening.
- 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 information.
- 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.
 - For example, instead of saying 'Thin porridge is not good for your baby', you could say: 'Thick foods help the baby to grow.'
- Before you give information to a mother, build her confidence. Accept what she says, and praise what she does well. You do not need to give new information or to correct a mistaken idea immediately.

Skill 5: Use simple language

- 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.
- It is important to use simple, familiar terms to explain things to mothers.

We will now see a demonstration.

Demonstration 1: Using technical language

Health worker: 'Good morning, (name). What can I do for you today?'

Mother: 'Can you tell me what foods to give my baby now that she is 6 months old?'

Health worker: 'I'm glad that you asked. Well now, the situation is this. Most children need more nutrients than breastmilk alone when they are 6 months old because breastmilk has less than 1 milligram of absorbable iron and breastmilk has about 450 calories, so it provides less than the 700 calories that are needed. The vitamin A needs are higher than what is provided by breastmilk and also the zinc and other micronutrients. However, if you add foods that aren't prepared in a clean way, it can increase the risk of diarrhoea, and if you give too many poor-quality foods, the child won't get enough calories to grow well.'

Now we will see another mother receiving information in a different way. Again, listen for the skills listed.

Demonstration 2: Using simple language

Health worker: 'Good morning Me. How can I help you?'

Mother: 'Can you tell me what foods to give my baby, now that she is 6 months old?'

Health worker: 'You are wondering about what is best for your baby. I'm glad you have come to talk about it. It is usually a good idea to start with a little porridge to get him used to the taste of different foods. Just two spoons twice a day to start with.'

Skill 6: Make one or two suggestions, not commands

- 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.

Review of confidence and support skills

- Accept what a mother thinks and feels.
- Recognise and praise what a mother and baby are doing right.
- Give practical help.
- Give the key information.
- Use simple language.
- Make one or two suggestions, not commands.

Session 10: Taking a feeding history

Learning objectives

After completing this session, participants will be able to:

- Take a feeding history of an infant 0–6 months old.
- Demonstrate appropriate use of the GUIDE FOR EVALUATING INFANT FEEDING, 0–6 MONTHS.

Introduction

We have discussed how to evaluate infant growth using the growth curve. When an infant is not growing well, we need to find the reason why very quickly to help the baby grow well again. If an infant is growing well, it is important to continue asking the mother questions about how the baby is eating, to reinforce the positive practices of the mother, so the baby stays healthy.

A mother should discuss feeding her baby with a health worker at least once a month when she brings her baby to be weighed.

There are several reasons why it is important to evaluate the feeding of a baby so often:

- Mothers benefit from regular, positive reinforcement of appropriate feeding practices for their babies. Problems linked to feeding practices can be identified early, before causing malnutrition, growth problems, and other illnesses. Mothers may need help to understand the amount of food their babies need and how often they should feed them.
- Breastfeeding mothers need to be reminded to breastfeed them exclusively. Mothers who breastfeed may need assistance and support to resist family or community pressure to introduce other foods besides breastmilk during the first 6 months after birth.
- HIV-positive mothers who choose to give their babies infant formula may need assistance in preparing it well. HIV-positive mothers who choose to give their babies infant formula may need support to resist community pressure to breastfeed their babies.
- Poor feeding techniques often lead to growth problems. There are a number of practices that influence the quality of an infant's feeding.

THE GUIDE FOR EVALUATING INFANT FEEDING, 0–6 MONTHS, is a tool that can help you to help a mother with all of these practices.

Review of counselling techniques

Effective nonverbal communication techniques <ul style="list-style-type: none">• Maintain visual contact.• Stay attentive.• Be confident.• Take your time.• Keep a suitable attitude.	Listening and learning techniques <ul style="list-style-type: none">• Greet the woman in a gentle and friendly manner.• Use the names of mother and baby if appropriate.• Ask open questions.• React simply when showing your interest.• Paraphrase or restate what the mother says.• Show that you understand what she feels.• Avoid judgemental words.
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There is guidance you can follow to ensure that your evaluation addresses the situation of each mother and her infant. The table below provides general ideas on how to proceed with an evaluation.

Steps for conducting an infant feeding evaluation	
GREET	The mother gently and in a friendly manner. (Call the mother and baby by their names if appropriate.)
EXPLAIN	<p>Why you want to ask her questions about the feeding of her infant.</p> <p>For example:</p> <ul style="list-style-type: none"> • <i>Your infant is here today for its regular monitoring visit or to receive its vaccines at 10 weeks. I can see from its growth curve that it is growing well. I would like to ask some questions about the baby's feeding and to talk with you a little about how you plan to feed it in the coming months.</i> • <i>Your baby is here today because she has diarrhoea. I can see on the basis of her growth curve that she has not gained sufficient weight the past month. I would like to ask you some questions about how you are feeding her. I hope that together we will be able to help your daughter start to grow well again.</i> • <i>Your baby is here today because he has a fever. Part of my exam will be to ask you some questions about his feeding. What I learn about how he is eating will help me better counsel you regarding his health.</i>
ASK	Try to ask questions that will give you the most information. Use the guide for choosing questions to ask.
BE CAREFUL	Not to appear too critical and not to pass judgement.
TAKE	<p>The time to discuss the most difficult and sensitive questions.</p> <p>For example:</p> <ul style="list-style-type: none"> • <i>What does the father say about the infant? Its mother? The mother-in-law?</i> • <i>Is the mother happy to have a baby now?</i> • <i>Is she pleased with the sex of the infant?</i> <p>Certain mothers say things spontaneously. Others speak when you emphasise things and show that you understand them. Yet others take some time. If a mother does not speak easily, wait a bit and ask the question later or on another day, perhaps in a more private place.</p>
PRAISE	The mother that she has done well.
SUGGEST	One or two things that the mother can do to resolve the problems at hand.
PLAN	The next meeting with the mother and baby, or refer the mother to other services if they are needed.

GUIDE FOR EVALUATING INFANT FEEDING, 0–6 MONTHS

Each time a mother visits, ask these questions about infant feeding:

- Do you have any concerns about feeding the infant? If so, what are they?
- What does the infant eat or drink? (Answers include breastmilk, infant formula, other foods, and milks and liquids, including water.)

If the answer is breastmilk, then ask:	If the answer is formula, then ask:	If the answer is other foods, then ask:
<ul style="list-style-type: none"> • How many times during the day does the infant breastfeed? • How many times during the night does the infant breastfeed? • How long does each breastfeed last? • Does the infant eat or drink anything other than breastmilk? • Does the infant take water? • Are there other persons besides you who feed the baby? If so, what do they give the baby? • Do they use a baby bottle or a cup? 	<ul style="list-style-type: none"> • What formula does the infant drink? • What do you use to feed the infant—a baby bottle or a cup? • How many times does the infant drink during the day? • How many times does the infant drink during the night? • How much does the infant drink at each meal? • Does the infant eat or drink anything other than formula? • Does the infant take water? • Does anyone else feed the baby? 	<ul style="list-style-type: none"> • Why do you give this food? • Do you continue to breastfeed? (Can you change and exclusively breastfeed?) • Have you chosen this food for a particular reason? (Can you change and use commercial replacement milk?) • Does the infant take water? • Do you give other liquids (tea, juice, other) to your infant? • When did you start giving other liquids to your infant? • Do you give other foods to your infant? • When did you start giving other foods to your infant? • Why do you give liquid or foods to your infant besides breastmilk or commercial replacement milk? • Can you nurse the infant more often or increase the amount of milk and not give other liquids or foods before the age of 6 months?

Ask the mother questions about her situation:

- How old are you?
- What is the status of your health?
- How did your pregnancy go?
- How did your delivery go?
- Are you feeding your infant the way you planned before its birth?
- If you breastfeed, do you have problems with your breasts?
- Have you received help in feeding your infant?
- Is this your first infant? If no, how many children do you have?
- How did you feed your other children? Is this way agreeable to you?
- What do other persons in your household think of the way that you feed your infant?
- Do you use family planning, or do you plan to use it?

Ask questions about any infant growth or health problems:

- During a whole day, how many times does the infant urinate (day or night)?
- During a whole day, how many times does the infant have a bowel movement (day or night)? What is the consistency of its stools?
- Has the infant had a recent illness? (Examples are malaria, diarrhoea, and respiratory infection.) Has the infant seen a doctor or taken medicines?
- How did you feed your infant during and after his illness?

Demonstration: Evaluating the feeding of Mampho

- Nurse:* 'Good morning, I am the nurse, Limpho. May I ask your name and your baby's name?'
- Mother:* 'Good morning, Nurse. I am Mathabo and this is my daughter Mampho.'
- Nurse:* 'She is cute—how old is she?'
- Mother:* 'She is three and a half months now.'
- Nurse:* 'Okay—and she's interested in what's going on, right? Tell me, what milk have you been giving her up to now?'
- Mother:* 'Well, I started by breastfeeding, but she was so hungry that I never seemed to have enough milk, so I had to add milk from a baby bottle, too.'
- Nurse:* 'My dear, that can be really disturbing when an infant is always hungry. So did you start feeding with a baby bottle? What did you give her?'
- Mother:* 'Well, I put some milk in the bottle.'
- Nurse:* 'When did she start to eat these meals?'
- Mother:* 'When she was about 2 months old.'
- Nurse:* 'About 2 months old. How many bottles do you give her a day?'
- Mother:* 'Oh, usually two—I prepare one in the morning and one in the evening, and she drinks each time she wants to—each bottle lasts a long time.'
- Nurse:* 'So she drinks from the bottle gradually? What sort of milk do you use?'
- Mother:* 'Yes. Well, if I have formula, I use it. If not, I simply use cow's milk, adding some water or milk with sugar because it's less expensive. She really likes milk with sugar!'
- Nurse:* 'Formula is very expensive, isn't it? Tell me more about breastfeeding. How often does she take the breast now?'
- Mother:* 'Oh, she eats when she wants to. Very often at night, four or five times. During the day, I don't count. She likes being comfortable.'
- Nurse:* 'She nurses at night?'
- Mother:* 'Yes, she sleeps with me.'
- Nurse:* 'Oh, it's easier that way, right? Have you had any other difficulties with breastfeeding besides the fear that you don't have enough milk?'
- Mother:* 'No, it hasn't been difficult at all.'
- Nurse:* 'Have you given her anything else? Food or drinks?'
- Mother:* 'No—I am not going to breastfeed her much longer. She is perfectly happy to take bottles.'
- Nurse:* 'Can you tell me how you clean the bottles?'
- Mother:* 'I just rinse them with hot water. If I have soap, I use it. Otherwise, just water.'
- Nurse:* 'Okay, now can you tell me how Mampho is doing? Does she have a growth curve? May I see it? (The mother gives her the health card.) Thanks, I'll look at it... She weighed 3.5 kg when born, 5.5 kg when she was 2 months, and now she weighs 6.0 kg. You can see that she gained weight quickly during the first 2 months but a bit more slowly since then. Can you tell me what illnesses she has had?'
- Mother:* 'Yes, she had diarrhoea twice last month, but she seems better. Her stools have become normal now.'
- Nurse:* 'How old are you?'
- Mother:* 'I'm 22.'
- Nurse:* 'How is your health? How are your breasts?'

Mother: 'I am well—my breasts have no problems.'

Nurse: 'May I ask if you think that you are pregnant right now? Have you thought about family planning?'

Mother: 'No—I have not thought about it—I was thinking that I could not get pregnant if I was breastfeeding.'

Nurse: 'In fact, it's possible to become pregnant if you also give other foods. We will talk about that later if you want. Is Mampho your first baby?'

Mother: 'Yes. I don't want another right now.'

Nurse: 'Tell me, how are things going at home now? Are you working outside of the home?'

Mother: 'No—right now I am at home with Mampho. I could look for work later when Mampho is bigger.'

Nurse: 'Who else at home helps you?'

Mother: 'My husband works as a taxi driver, so he is not home very much. Mampho's grandmother is with me during the day. She loves Mampho very much, and thinks that she is very thirsty and needs to be given water. Sometimes when she is watching her, she gives her water and the milk from the bottle.'

Session 11: Breastfeeding difficulties

Learning objectives

After completing this session, participants will be able to:

- Identify the causes of, and help mothers with, the following difficulties:
 - 'Not enough milk'.
 - A crying baby.
 - Breast refusal.
-

Introduction

There are many reasons why mothers stop breastfeeding or start to give other foods and liquids before a child completes 6 months, even if they decided during pregnancy to breastfeed exclusively. When helping mothers with difficulties, you will need to use all the skills you have learnt so far. Infant and young child feeding counsellors and community health workers have an important role to play in supporting mothers through these difficulties, as mothers may not visit a health facility to seek help.

We are going to look at three common difficulties women face:

1. 'Not enough milk'.
2. A crying baby.
3. Breast refusal.

Insufficient milk

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 1 month of age. Then the mother needs help to maintain breastmilk production. She should be counselled to breastfeed more often.

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 to all situations.

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.

Unreliable signs of 'not enough milk'

The following signs that may make a mother think that she does not have enough milk 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 she has enough milk.
- Health worker said that she does not have enough milk.
- She was told that she is too young or too old to breastfeed.
- She was told that the baby is too small or too big to breastfeed.
- Poor previous experience with breastfeeding.
- Breastmilk looks thin.

Guidelines, not rules

Using weight gain and urine output as reliable signs as to whether or not a baby is getting enough breastmilk 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 feeding 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.

Reasons why a baby may not get enough breastmilk

Breastfeeding factors

Delayed start: If a baby does not start to breastfeed on 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 eight times a day in the first 4 weeks, or less than five to six 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 a feed, but should wake him to breastfeed every 3 to 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 blankets.

Poor attachment: If a baby suckles ineffectively, he may not get enough milk.

Bottles and pacifiers (dummies): 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 foods: A baby who has complementary foods (artificial milks, solids, or drinks, including plain water) before 6 months suckles less at the breast, so the breastmilk supply decreases.

Psychological factors of the mother

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 or 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 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 (dummy) when he cries instead of breastfeeding him.

Physical condition of the mother

Contraceptive pill: Contraceptive pills, which contain estrogens, may reduce the secretion of breastmilk. However, progesterone-only pills and Depo-Provera should not reduce the breastmilk supply.

Diuretics: Diuretics may reduce the breastmilk supply. Diuretics increase the amount of urine that is excreted. They include caffeine (coffee, tea) and alcohol.

Pregnancy: If a mother becomes pregnant again, she may notice a decrease in her breastmilk supply because of hormonal changes associated with pregnancy.

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.

Alcohol and smoking: Drinking alcohol and smoking cigarettes can reduce the amount of breastmilk that is produced by a mother. Drinking alcohol decreases prolactin yield, blocks release of oxytocin, and can result in a reduction in milk. Drinking large amounts of alcohol can also affect the infant and is associated with deep sleep, drowsiness, decrease in linear growth, and abnormal weight gain. Studies have shown that smoking can reduce the prolactin levels in breastfeeding mothers and interfere with the 'let-down' (or oxytocin) reflex. If a mother smokes, she should not do so when feeding the baby. Smoking also significantly increases the infant's risk of respiratory illness³.

Other very rare conditions

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.

³ La Leche League International. The Womanly Art of Breastfeeding. Schaumburg, IL: Penguin; 1991. Riordan J, Auerbach K (eds). Breastfeeding and Human Lactation. Sudbury, MA: Jones and Bartlett Publishers; 1999.

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. 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 6 months of age should be RARE. A woman should be tested for HIV before suggesting a complement. If she is positive, giving breastmilk and a complement should be strongly discouraged as this can significantly increase the risk of transmission to the baby.

Crying

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' responses to crying are different in different societies. So also are the ways 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.

Allergies: 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 that a 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.

Reasons why a baby may refuse the breast

Is the baby ill, in pain, or sedated?

- **Illness:** The baby may attach to the breast, but suckle 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, thrush (Candida infection), teething of an older baby. 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 or drugs that she is taking for psychiatric treatment.

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.
- 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.

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 most common when a baby is aged 3 to 12 months. He suddenly refuses several breastfeeds. This behaviour is sometimes called a 'nursing strike'. Possible causes include:

- Separation from his mother (for example, when she starts a job).
- A new caregiver or too many caregivers.
- 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).

It may look like refusal but is not 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.

Management of breast refusal

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.

Step 1: Treat or remove the cause if possible

- *For 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.
- *For 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 nystatin.
- *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.
- *For 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.

- *Changes which upset a baby:* Discuss the need to reduce separation and changes if possible. Suggest that the mother stop 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 quieter 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.

Step 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 or 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 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.

Session 12: Expressing breastmilk

Learning objectives

After completing this session, participants will be able to:

- List the situations when expressing breastmilk is useful.
 - Explain how to stimulate the oxytocin reflex and demonstrate by rubbing a mother's back.
 - Demonstrate how to select and prepare a container for expressed breastmilk.
 - Describe how to store breastmilk.
 - Explain to a mother the steps of expressing breastmilk by hand.
-

There are many situations in which expressing breastmilk is useful and important to enable a mother to initiate or to continue breastfeeding.

Expressing milk is useful to:

- Leave breastmilk for a baby when his mother goes out or goes to work.
- Feed a low-birthweight baby who cannot breastfeed.
- Feed a sick baby who cannot suckle enough.
- Keep up the supply of breastmilk when a mother or a baby is ill.
- Prevent leaking when a mother is away from her baby.
- Help a baby to attach to a full breast.
- Help with breast health conditions (for example, engorgement) (see Session 14).
- Facilitate the transition to another method of feeding or to heat-treat breastmilk (see sessions on HIV and infant feeding).

All mothers should learn how to express their milk, so that they know what to do if the need arises. Certainly all those who care for breastfeeding mothers should be able to teach mothers how to express their milk.

Breastmilk can be stored for about 8 hours at room temperature or up to 24 hours in a refrigerator. Store expressed breastmilk in the coolest part of the home and away from any heat source.

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.

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.

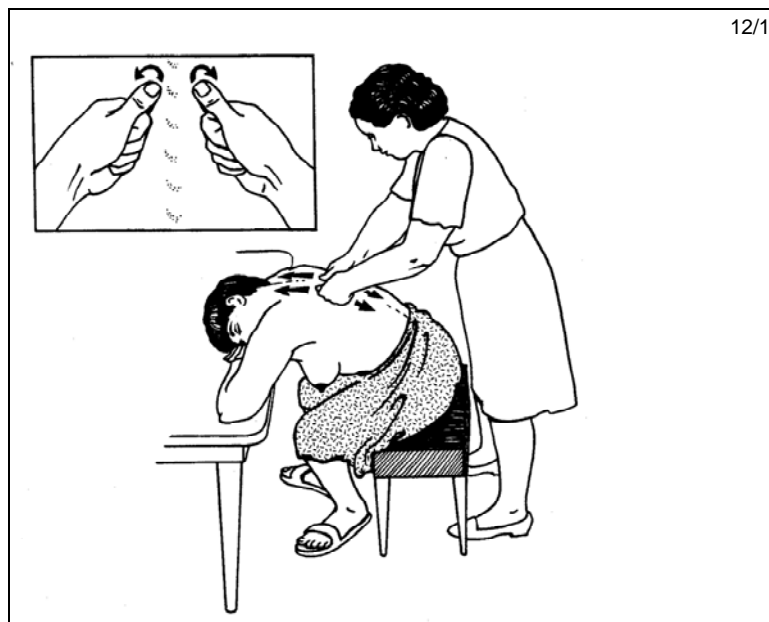
Help the mother practically. Help or advise her to:

- Sit quietly and privately or with a supportive friend. Some mothers cannot 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.

- Warm her breasts. For example, she can apply a warm compress, or warm water, or have a warm shower. Warn her that she should test the temperature to avoid burning herself.
- 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. Some women find that it helps to gently roll their closed fist over the breast toward the nipple.
- Ask a helper to rub her back.

Demonstration 1: How to rub a mother's back to stimulate the oxytocin reflex

Slide 12/1. A helper rubbing a mother's back.



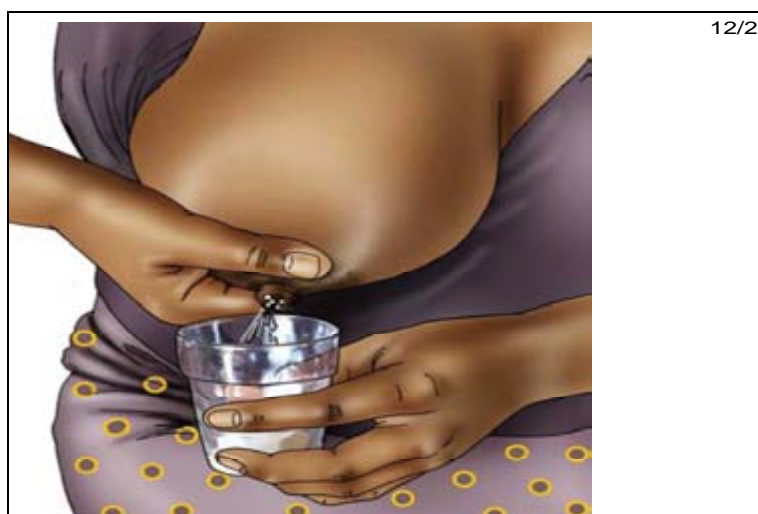
- She should sit at the table, resting her head on her arms, as relaxed as possible.
- She should remain clothed, but you should explain to the mother that it is important for her breasts and her back to be naked.
- Make sure that the chair is far enough away from the table for her breasts to hang free.
- 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.

Hand expression is the most useful way to express milk. It needs no appliance, so a woman can do it anywhere, at any time.

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.

Slide 12/2. How to express breastmilk.



- Place finger and thumb on each side of the areola and press inward toward the chest wall.
- Press behind the nipple and areola between your finger and thumb.
- Press from the sides to empty all segments.

Demonstration 2: How to express breastmilk

How to prepare a container for expressed breastmilk

- 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.

Health workers should 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.

Steps for a mother expressing breastmilk:

- 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 Slide 12/2).
- Press her thumb and first finger slightly inward toward 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 should press on the larger ducts beneath the areola. Sometimes in a lactating breast, it is possible to feel the ducts. They are like pods, or peanuts. If she can feel them, she can press on them.
- Press and release, press and release. This should not hurt—if it hurts, the technique is wrong.
- At first no milk may come, but after pressing a few times, milk starts to drip out. It may flow in streams if the oxytocin reflex is active.
- Press the areola in the same way from the SIDES, to make sure that milk is expressed from all segments of the breast.

- Avoid rubbing or sliding her fingers along the skin. The movement of the fingers should be more like rolling.
- Avoid squeezing 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.

How often a mother should express milk depends on the reason for expressing the milk, but usually as often as the baby would breastfeed.

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 establish lactation, to feed a low-birthweight or sick newborn: She should start to express milk on the first day, as soon as possible after delivery. She may express only 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.

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 2 hours or even every 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.

To relieve symptoms such as engorgement or leaking at work: Express only as much as is necessary.

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.

Session 13: Cup feeding

Learning objectives

After completing this session, participants will be able to:

- List the advantages of cup feeding.
 - Estimate the amount of milk to give to a baby according to weight.
 - Demonstrate how to cup feed safely.
-

Why cups are safer and better than bottles for feeding a baby

- 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. Bottles that are carried around give bacteria time to breed.
- Cup feeding is associated with less risk of diarrhoea, ear infections, and tooth decay.
- 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.

How to feed a baby by cup

- Wash your hands.
- Hold the baby sitting upright or semi-upright on your lap.
- Place the estimated amount of milk for one feed into the cup.
- 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 low-birthweight 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.

Session 14: Breast conditions

Learning objectives

After completing this session, participants will be able to recognise and manage these common breast conditions:

- Flat and inverted nipples.
- Engorgement.
- Blocked duct and mastitis.
- Sore nipples and nipple fissure.

Slide 14/1.



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.

Differences in the sizes of breasts are mostly due to the amount of fat, not the amount of tissue that produces milk. 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.

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.

Slide 14/2.



A doctor told the mother in Picture 1 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'.

In Picture 2, the mother is testing her breast to see how easy it is to stretch out the tissues underlying the nipple. This nipple is quite 'protractile', and it should be easy for her baby to stretch it to form a 'teat' in his mouth. He should be able to suckle from this breast with no difficulty. Nipple protractility (if the nipple can be stretched or lengthened) 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.

Slide 14/3.



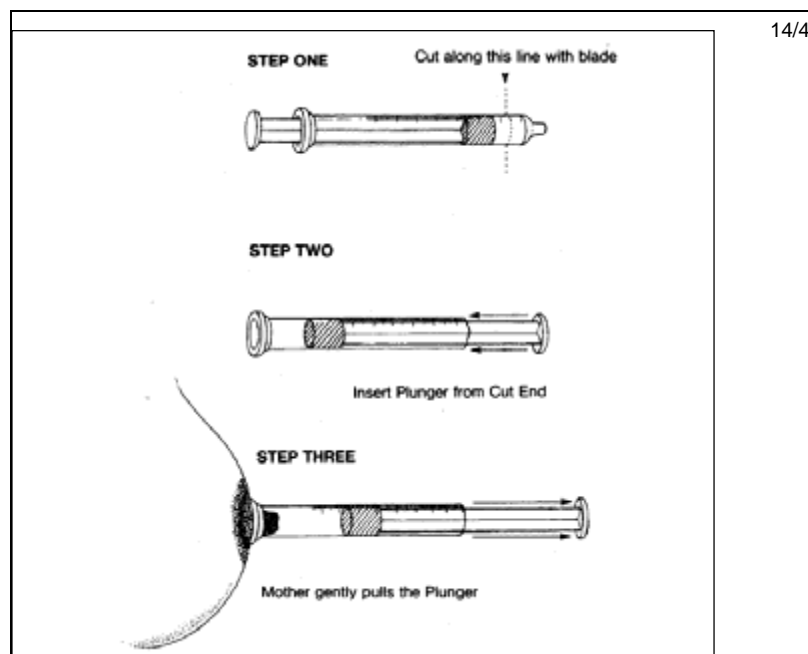
This nipple is **inverted**. If this woman tests her breast for protractility, her nipple will go in instead of coming out.

You can see a scar on her breast. This mother 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.

How to help a woman with inverted nipples

- Antenatal treatment is probably not helpful. Most nipples improve around the time of delivery without any treatment. Help is most important soon after delivery when the baby starts breastfeeding.
- It is important to build the mother's confidence. Explain that with patience and persistence, she can succeed. Explain that her breasts will become softer in the week or two after delivery, and that the baby suckles from the breast and not from the nipple. Encourage her to give plenty of skin-to-skin contact (we will be discussing this further later in this training).
- 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. Sometimes putting a baby to the breast in a different position (for example, the underarm position) makes it easier for him to attach.
- If a baby cannot suckle effectively in the first week or two, help his mother to try to express her milk and feed it to her baby by cup. Expressing milk also helps to keep the breasts soft so that it is easier for the baby to attach. Expressing milk also helps to keep up the supply of milk. She should not use a bottle because that makes it more difficult for her baby to take her breast.

Slide 14/4.



The syringe method for treating inverted nipples can be used after a woman gives birth to help a baby to attach to the breast. It is not certain whether it is helpful during antenatal care.

Slide 14/5.



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, 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.

The nipple 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 as easy to treat.

Slide 14/6.

DIFFERENCES BETWEEN FULL AND ENGORGED BREASTS	
Full Breasts Hot Heavy Hard Milk flowing No fever	Engorged Breasts Painful Oedematous Tight, especially nipple Shiny May look red Milk NOT flowing May be fever for 24 hours

Breasts may become engorged if:

- There has been a delay in starting breastfeeding after birth.
- There is poor attachment to the breast so breastmilk is not removed effectively.
- There is infrequent removal of milk; for example, if breastfeeding is not on demand.
- The length of breastfeeds is restricted.

Engorgement can be prevented by letting babies feed as soon as possible after delivery, making sure that the baby is well positioned and attached to the breast, and encouraging unrestricted breastfeeding so that milk does not then build up in the breast.

Slide 14/7.

14/7

TREATMENT OF BREAST ENGORGEMENT

- Do not 'rest' the breast. To treat engorgement it is essential to remove milk. If milk is not removed, mastitis may develop, an abscess may form and breast milk production decreases.
- If 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 baby is not able to suckle help his mother to express her milk. 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. Some things that you can do to help her, or she can do are:
 - put a warm compress on her breasts
 - massage her back and neck
 - massage her breast lightly
 - stimulate her breast and nipple skin
 - help her to relax
 - sometimes a warm shower or 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 will help to reduce oedema.
- Build the mother's confidence. Explain that she will soon be able to breastfeed comfortably again.

We have just discussed the management of engorgement in a woman who wishes to continue breastfeeding.

Engorgement may occur in an HIV-positive woman who stops breastfeeding; for example, if replacement feeding becomes acceptable, feasible, affordable, sustainable, and safe when her baby is 6 months or older and she decides to stop breastfeeding. When an HIV-positive mother is trying to stop breastfeeding, she should only express enough milk to relieve the discomfort and not to increase the milk production. Milk may be expressed a few times per day when the breasts are overfull to make the mother comfortable. You may have heard of pharmacological treatments to reduce the milk supply. These are not recommended. However, a simple analgesic (for example, ibuprofen) may be used to reduce inflammation and help the discomfort whilst the mother's milk supply is decreasing. If ibuprofen is not available, then paracetamol may be used.

Slide 14/8.



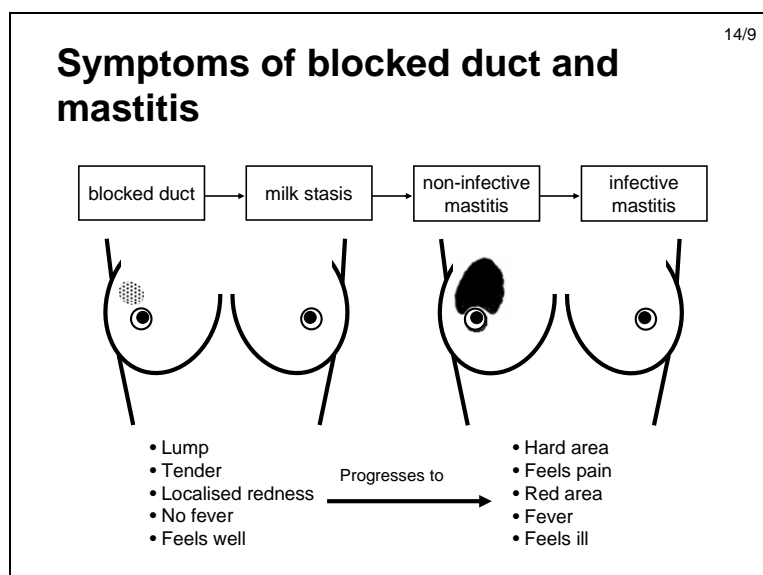
This is mastitis.

A woman with **mastitis** 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.

Mastitis may develop in an engorged breast, or it may follow a condition called blocked duct.

Slide 14/9.



This slide shows how mastitis develops from a blocked duct. A blocked duct occurs when the milk is not removed from part of a breast. Sometimes this is because the duct to that part of the breast is blocked by thickened milk.

The symptoms are a lump that 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.

The main cause of a blocked duct is poor drainage of all or part of a breast. Poor drainage of the whole breast may be due to infrequent breastfeeds or ineffective suckling. Infrequent breastfeeds may occur when a mother is very busy, when a baby starts feeding less often (for example, when he starts to sleep through the night), or because of a changed feeding pattern for another reason (for example, the mother returning to work). Ineffective suckling usually occurs when the baby is poorly attached to the breast.

Poor drainage of part of the breast may be due to ineffective suckling; pressure from tight clothes, especially a bra worn at night; or pressure of the mother's fingers, which can block milk flow during a breastfeed.

Remember that if a baby is poorly attached and positioned and is suckling at the breast, this may cause a nipple fissure, which provides a way for bacteria to enter the breast tissue and may lead to 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, pressure from clothes (particularly a tight bra), and notice what the mother does with her fingers as she breastfeeds. Does she hold the areola and possibly block milk flow?

Whether or not you find a cause, there are several suggestions to offer to the mother:

- Breastfeed frequently. The best way is to rest with her baby, so 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 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. This is safe for the baby to swallow.
- Apply warm compresses to her breast between feeds.
- Sometimes it is helpful to start the feed on the unaffected breast. This may help if pain seems to be preventing the oxytocin reflex. Change to the affected breast after the reflex starts working. Try feeding the baby in different positions.

Sometimes a mother is unwilling to feed her baby from the affected breast, especially if it is very painful. In this situation, it is necessary to express the milk. If the milk stays in the breast, an abscess is more likely to develop.

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.
- A fissure through which bacteria may enter.

- No improvement after 24 hours of improved drainage

Treatment of mastitis in an HIV-infected woman

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

If an HIV-infected woman develops mastitis or a fissure, she should avoid breastfeeding from the affected side while the condition persists. It is the same if she develops an abscess.

She must express milk from the affected breast, to ensure adequate removal of milk. This is essential to prevent the condition from becoming worse, to help the breast recover, and to maintain milk production. The health worker should help her to ensure that she is able to express milk effectively.

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

If both breasts are affected, she will not be able to feed from either side. The mother will need to express her milk from both breasts. Breastfeeding can resume after the breasts have recovered.

The health worker will need to discuss other feeding options for her to give meanwhile. The mother may decide to heat-treat her expressed milk, or to give commercial formula. The infant should be fed by cup.

Give antibiotics for 10–14 days to avoid relapse. Give pain relief and suggest rest as in the HIV-uninfected woman.

Sometimes a woman may decide to stop breastfeeding at this time, if she is able to give another form of milk safely. She should continue to express enough milk to allow her breasts to recover and to keep them healthy, until milk production ceases.

Slide 14/10.



Picture 1 shows a mother's breast, and Picture 2 shows the same mother feeding her baby on the 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.

Also, the baby is poorly positioned.

- His body is twisted away from his mother so his head and body are not in line.
- His body is not held close to his mother's.
- His body is unsupported.
- He is poorly attached.
- There is more areola seen above the baby's top lip.
- His mouth is closed, and his lips are pointing forward.
- His lower lip is pointing forward.
- His chin is not touching the breast.

This poor attachment may have caused both the breast engorgement and the fissure. **The most common 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.

If a woman has sore nipples:

- Suggest to the mother not to wash her breasts more than once a day, and not to use soap or rub hard with a towel. Washing removes natural oils from the skin and makes soreness more likely.
- Suggest to the mother 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 rub a little expressed breastmilk over the nipple and areola with her finger. This promotes healing.

Slide 14/11.



The mother in Slide 14/11 has very sore, itchy nipples. 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 nystatin.

Advise the mother to stop using pacifiers (dummies). Help her to stop using teats and nipple shields.

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

