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BREASTFEEDING COUNSELLING

A TRAINING COURSE

TRAINER'S GUIDE

PART ONE

Sessions 1-9

WORLD HEALTH ORGANIZATION CDD PROGRAMME

UNICEF

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INTRODUCTION

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Why this course is needed

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

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

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

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

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

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

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

THE COURSE AND THE MATERIALS

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Structure of the course

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

Different kinds of session

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

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

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

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

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

Forming groups

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

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

Order of sessions

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

Most sessions can be moved, but it is necessary for some aspects of the sequence to be maintained. The main requirement is that you conduct the sessions which prepare participants for a particular clinical practice before that practice, (as indicated by the similar titles of class and clinical practice sessions). It is also important that Sessions 1-7 are completed before Clinical Practice 1, and that Session 10 `Positioning a baby at the breast' is held between Clinical Practice 1 and Clinical Practice 2.

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

The Trainer's Guide

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

Accompanying course materials

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

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

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

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

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

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

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

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

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

Reference materials

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

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

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

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

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

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

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

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

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

Training aids

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

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

HOW TO MAKE A MODEL DOLL

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

HOW TO MAKE A MODEL BREAST

Use a pair of near skin-coloured socks, or stockings, or an old sweater or tee shirt. Make the cloth into a round bag shape, and stuff it with other cloth or foam rubber to make it breast shaped. Stitch a `purse string' around a circle in the middle of the breast to make a nipple. Stuff the nipple with foam or cotton. Colour the areola with a felt pen. You can also push the nipple in, to make an `inverted' nipple.

If you wish to show the inside structure of the breast, with the lactiferous sinuses, make the breast with two layers, for example with 2 socks. Sew the nipple in the outer layer, and draw the lactiferous sinuses and ducts on the inside layer, beneath the nipple. You can remove the outer layer with the nipple to reveal the inside structure.

Motivating and managing participants

- *Encourage interaction*

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

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

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

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

- *Reinforce participants' efforts*

Take care not to seem threatening. These techniques may help:
- be careful not to use facial expressions or comments that could make participants feel ridiculed;
- sit or bend down to be on the same level as a participant whom you are talking to;
- do not be in a hurry, whether you are asking or answering questions;
- show interest in what participants say. For example, say: "That is a good question/suggestion."

Praise, or thank participants who make an effort. For example when they:
- try hard;
- ask for an explanation of a confusing point;
- do a good job on an exercise;
- participate in group discussion;
- help other participants (without distracting them by talking about something irrelevant).

You may notice that many of the counselling skills taught during the course are also important for communicating with participants. In particular you will find it helpful to use appropriate non-verbal communication, to ask open questions, and to help them to feel confident in their work with mothers and babies.

- *Be aware of language difficulties*

Try to identify participants who have difficulty understanding or speaking the language in which the course is conducted. Speak slowly and clearly so that you can be more easily understood. Encourage participants in their efforts to communicate.
If necessary, speak with a participant in her own language (or ask someone else to do so for you) to clarify a difficult point.

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

Using your Trainer's Guide

Before you lead a session:

- Look at your guide and read the `Objectives' and the `Session outline', to find out what kind of session it will be, and what your responsibilities are.
- Read the `Preparation' box at the beginning of the text, so that you know what you have to do in advance to prepare for the session, and what training aids (and other kind of help) you need.
- Read through the text for the session, so that you are clear what you will have to do. The text includes detailed point by point instruction about how to conduct the session.

When you lead a session:

keep your guide with you and use it all the time.

You do not need to try to memorize what you have to do. It is extremely difficult to do so. Use the guide as your session notes, and follow it carefully.

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

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

Preparing to give a presentation

- *Study the material*

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

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

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

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

- *Prepare your slides or overheads*

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

Shortly before the session, make sure that the audience will be able to see the images - that the room is dark enough, that the screen is well placed, and that the chairs are arranged appropriately.

You do not have to accept the arrangements from the previous session - it can be an advantage to move an audience around, and present material in a new way. It may help to keep their attention.

Giving a lecture

- *Talk in a natural and lively way*

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

- *Explain the overheads and slides carefully*

Remember that overheads and slides do not do the teaching for you.
They are *aids* to help you to teach and to help participants to learn. Do not expect participants to learn from them without your help.

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

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

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

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

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

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

- *Involve the audience*

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

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

A number of questions are indicated in the text. They ask participants to make observations on a slide or transparency, and to think what it means. The questions are carefully chosen, so that participants should be able to decide the answer either by looking at the picture, or from their own

experience, or from what has been covered previously in the course, without requiring new information that they may not have.

Sometimes you may want to give participants a hint to help them to answer. Sometimes asking the question again, in another way, can help. However, do not help them or give them the answer too quickly. It is important to wait, and to give them a genuine chance to think of the answer themselves. On the other hand, do not get involved in discussions which are distracting, and which waste a lot of time. Encourage participants to make a few suggestions; discuss their suggestions; and then continue with the session. You do not have to wait until they have given all the answers listed in the text. Notes are included with many of the questions to guide you.

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

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

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

Do not let the same one or two people answer all the questions. If a talkative participant tries to answer several questions, ask her to wait for a minute, and turn or walk away from her. Try to encourage quieter participants to talk. Ask someone by name who has not spoken before to answer, or walk towards someone to focus attention on her, and make her feel that she is being asked to talk.

Thank participants whose answers are short and to the point.

Preparing to give a demonstration

- *Study the instructions*

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

- *Collect the equipment*

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

- *Prepare your assistant*

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

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

- *Practise the demonstration*

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

Giving the demonstration

- Make sure that all the equipment is ready and together, and prepare the place where you will give the demonstration. Arrange tables and chairs as you will need them.
- Make sure that you can use a board to write things up, or an overhead projector if you need to show a transparency as part of the demonstration, without having to rearrange everything.
- Demonstrate slowly, step-by-step, and make sure that the audience are able to see what you do. If necessary, ask them to move closer to you so that they can all see and hear clearly; or move closer to them, going to each part of the audience in turn.
- As you give the demonstration, take every opportunity to let participants handle and examine the equipment that you use, and themselves practise what you demonstrate. They will learn more if they try things out, than if they just see you doing them.

At the end of a lecture or demonstration

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

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

Working in groups

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

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

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

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

- *Conduct discussions*

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

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

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

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

- *Develop lists and schema*

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

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

- *Reading*

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

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

- *Give short demonstrations*

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

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

- *Role-play*

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

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

- *Exercises*

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

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

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

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

Facilitating individual written exercises

- *Explain how to do the exercise*

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

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

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

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

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

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

Then start circulating, looking over their shoulders to see how they are getting on. Talk to each participant individually, and as confidentially as possible. Try not to let other participants overhear what you are saying. Compare their answers with the suggested answers in your guide. Compliment them if they have answered satisfactorily. If an answer is incorrect, do not make them feel ridiculed. Ask them if they have any other ideas, and give them a chance to try to correct the answer. If they cannot do so, help them to decide the correct answer, and explain their mistake. Try not to give them the answer too easily.

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

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

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

Conducting small group sessions

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

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

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

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

Clinical practice

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

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

WHAT THE SIGNS USED IN THE GUIDE INDICATE

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

WHY BREASTFEEDING IS IMPORTANT

Objectives

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

Session outline (60 minutes)

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

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

Preparation

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

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

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

As you follow the text, remember:

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

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

I. Introduce the topic (3 minutes)

☐ Make these points:

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

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

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

Overhead 1/1 The advantages of breastfeeding

- This diagram summarizes the main advantages of breastfeeding.

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

(listed on the right).

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

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

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

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

The other advantages of *breastfeeding* are that:

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

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

Overhead 1/2 Nutrients in human and animal milks

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

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

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

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

The animal milks contain more protein than human milk.

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

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

Further information
The sugar lactose is the main carbohydrate in milk. None of the milks contain the carbohydrate *starch*. Starch is a very important nutrient for older children and adults - it is the main nutrient in staple foods, and in many complementary foods. But young babies cannot digest starch easily, so it is not appropriate to give them starchy foods in the first few months of life.
Breastmilk contains more lactose than other milks.

Overhead 1/3 Quality of the proteins in different milks

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

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

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

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

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

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

Further information
- All the whey proteins in the various milks are different. Human milk contains *alpha*-lactalbumin and cow's milk contains *beta*-lactoglobulin.
- In addition, the proteins in animal milks and formula contain a different balance of amino acids from breastmilk, which may not be ideal for a baby. Animal milk and formula may lack the amino acid *cystine,* and formula may lack *taurine* which newborns need especially for brain growth. Taurine is now sometimes added to formula milks.
- The anti-infective proteins in human milk include lactoferrin (which binds iron, and prevents the growth of bacteria which need iron) and lysozyme (which kills bacteria) as well as antibodies (immunoglobulin, mostly IgA).
- Other important anti-infective factors include the *bifidus factor* (which promotes the growth of *Lactobacillus bifidus. L. bacillus* inhibits the growth of harmful bacteria, and gives breastfed babies' stools their yoghurty smell). Breastmilk also contains anti-viral and anti-parasitical factors.

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

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

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

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

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

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

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

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

Overhead 1/5 Vitamins in different milks

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

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

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

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

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

Give extra vitamins to the mother.

Further information

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

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

Overhead 1/6 Iron in milk

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

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

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

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

Further information
Some brands of formula have iron added. However, this added iron is not well absorbed, so a large amount has to be added to ensure that a baby gets enough iron to protect against anaemia. Added iron may make it easier for some kinds

of bacteria to grow, which may increase the chances of some kinds of infection, for example, meningitis and septicaemia.

Overhead 1/7 Protection against infection

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

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

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

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

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

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

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

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

Overhead 1/8 Variations in the composition of breastmilk

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

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

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

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

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

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

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

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

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

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

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

Overhead 1/9 Colostrum

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

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

- It contains more white blood cells than mature milk.

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

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

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

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

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

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

Further information
Colostrum and breastmilk contain many hormones and growth factors. The function of all of them is not certain. However, *epidermal growth factor*, which is present in both, has been shown to stimulate growth and maturation of the intestinal villi. Undigested cow's milk proteins can pass through the immature infant gut into the blood, and may cause intolerance and allergy to milk protein. Epidermal growth factor helps to prevent the absorption of large molecules by stimulating rapid development of the gut. This `seals' the baby's intestine, so that it is more difficult for proteins to be absorbed without being digested. Antibodies probably help to prevent allergies by coating the intestinal mucosa, and preventing the absorption of larger molecules.

Overhead 1/10 Psychological benefits of breastfeeding

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

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

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

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

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

III. Answer participants' questions (7 minutes)

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

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

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

☐ Make this introductory point:

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

Overhead 1/11 Protection against diarrhoea

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

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

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

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

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

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

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

Further information

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

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

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

Overhead 1/12 Protection against respiratory infection

- Breastfeeding also protects babies against respiratory infections.

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

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

Overhead 1/13 Breastmilk in the second year

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

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

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

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

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

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

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

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

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

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

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

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

Overhead 1/14 Dangers of artificial feeding

▪ This diagram summarizes the dangers of artificial feeding.

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

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

Overhead 1/15 Terms for infant feeding

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

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

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

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

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

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

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

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

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

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

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

TERMS FOR INFANT FEEDING

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

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

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

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

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

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

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

Overhead 1/16 Recommendations

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

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

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

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

RECOMMENDATIONS

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

V. Answer participants' questions (10 minutes)

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

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

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

LOCAL BREASTFEEDING SITUATION

Objectives

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

Session outline (30 minutes)

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

I. Present local infant feeding data

Optional alternative if no local data available:

II. Discuss participants' experience

Preparation

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

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

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

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

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

I. Present local infant feeding data (30 minutes)

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

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

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

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

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

These might indicate whether particular practices cause health problems.

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

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

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

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

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

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

☐ Explain what to do:

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

(Allow 5 minutes to answer.)

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

→ Write these questions on an overhead or a flipchart:

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

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

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

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

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

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

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

Post the list on the wall.

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

Session 3

Back to CONTENTS

HOW BREASTFEEDING WORKS

Objectives

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

Session outline (60 minutes)

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

I. Introduce the topic (2 minutes)

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

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

IV. Answer participants' questions (8 minutes)

Preparation

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

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

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

As you follow the text, remember:

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

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

I. Introduce the topic (2 minutes)

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

□ Make these points:

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

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

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

Overhead 3/1 Anatomy of the breast

- This diagram shows the anatomy of the breast.

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

Inside the breast are the *alveoli*, which are very small sacs made of *milk secreting cells*. There are millions of alveoli - the diagram shows only a few. The box shows three of the alveoli enlarged. A hormone called *prolactin* makes these cells produce milk.

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

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

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

Overhead 3/2 Prolactin

- This diagram explains about the hormone *prolactin*.

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

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

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

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

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

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

Some special things to remember about prolactin are:

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

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

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

Overhead 3/3 Oxytocin reflex

- This diagram explains about the hormone *oxytocin.*

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

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

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

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

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

Overhead 3/4 Helping and hindering the oxytocin reflex

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

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

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

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

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

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

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

Mothers are often aware of their oxytocin reflex. There are several signs of an active reflex that they or you may notice.

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

☺ Ask participants to read out the signs in turn.

SIGNS AND SENSATIONS OF AN ACTIVE OXYTOCIN REFLEX

- A mother may notice:
- A squeezing or tingling sensation in her breasts just before she feeds her baby, or during a feed
- Milk flowing from her breasts when she thinks of her baby, or hears him crying
- Milk dripping from her other breast, when her baby is suckling
- Milk flowing from her breasts in fine streams, if her baby comes off the breast during a feed
- Pain from uterine contractions, sometimes with a rush of blood, during feeds in the first week
- Slow deep sucks and swallowing by the baby, which show that breastmilk is flowing into his mouth

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

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

Overhead 3/5 Inhibitor in breastmilk

▪ Breastmilk production is also controlled within the breast itself.

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

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

This helps you to understand why:
- If a baby stops suckling from one breast, that breast stops making milk.
- If a baby suckles more from one breast, that breast makes more milk and becomes larger than the other.

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

Projector off

 Remove Overhead 3/5.

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

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

 Make these points:

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

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

Overhead 3/6 Attachment to the breast

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

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

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

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

Overhead 3/7 Suckling action

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

The arrow shows a wave going along the baby's tongue from the front to the back. The wave presses the `teat' of breast tissue against the baby's hard palate. This presses milk out of the lactiferous sinuses into the baby's mouth, from where he swallows it.

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

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

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

Overhead 3/8 Good and poor attachment

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

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

The most important differences to see in picture 2 are:
- Only the nipple is in the baby's mouth, not the underlying breast tissue.
- The lactiferous sinuses are outside the baby's mouth, where his tongue cannot reach them.
- The baby's tongue is back inside his mouth, and not pressing on the lactiferous sinuses.

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

Overhead 3/9 Attachment - outside appearance

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

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

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

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

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

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

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

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

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

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

before and after you correct it. However, the first time that you see a baby, it is not a reliable sign. A mother may have a very small areola, which all goes inside the baby's mouth easily; or a very large areola, so that you can always see a lot outside.

 Show Overhead 3/8 again.

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

Overhead 3/10 Results of poor attachment

 Do not show the whole overhead at once.

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

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

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

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

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

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

- *The baby does not remove breastmilk effectively.*

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

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

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

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

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

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

Overhead 3/11 Causes of poor attachment

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

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

- *Use of a feeding bottle.*

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

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

- *Inexperienced mother.*

If a mother has not had a baby before, or if she bottle fed or had difficulties breastfeeding previous babies, she may have difficulty getting her baby well attached to her breast. (However, even mothers who have previously breastfed successfully sometimes have difficulties.)

- *Functional difficulty.*

Some situations can make it more difficult for a baby to attach well to the breast.
For example:
- If a baby is very small or weak;
- If a mother's nipples and the underlying tissue are *poorly protractile* (difficult to stretch out to form a `teat' - see Session 14, `Breast conditions');
- If her breasts are engorged;
- If there has been a delay in starting to breastfeed.

Mothers and babies can breastfeed in all these situations, but they may need extra skilled help to succeed.

- *Lack of skilled support.*

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

Some women are isolated, and lack support from the community. They may lack help from experienced women such as their own mothers; or from traditional birth attendants, who often are very skilled at helping with breastfeeding.

Women in `bottle feeding' cultures may be unfamiliar with how a breastfeeding mother holds and

feeds her baby. They may never have seen a baby breastfeeding.

Health workers who look after mothers and babies, for example doctors and midwives, may not have been trained to help mothers to breastfeed.

Overhead 3/12 Reflexes in the baby

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

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

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

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

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

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

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

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

 Summarize the session with these points and questions:

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

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

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

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

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

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

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

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

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

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

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

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

BREASTFEEDING WILL BE SUCCESSFUL IN MOST CASES IF:

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

IV. Answer participants' questions (8 minutes)

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

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

Session 4

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ASSESSING A BREASTFEED

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

Objectives

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

Session outline (60 minutes)

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

I. Introduce the topic (5 minutes)

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

III. Answer participants' questions (10 minutes)

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

Preparation

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

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

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

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

As you follow the text, remember:

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

I. Introduce the topic (5 minutes)

☐ Make these points:

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

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

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

HOW TO ASSESS A BREASTFEED

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

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

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

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

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

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

☐ Explain each point in turn.

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

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

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

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

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

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

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

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

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

- You may notice:

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

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

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

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

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

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

- You may notice whether:

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

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

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

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

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

☐ Thank the participants who played the two mothers.

Point 3: What do you notice about the baby?

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

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

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

Point 4: How does the baby respond?

- Look for these responses:

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

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

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

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

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

☐ Demonstrate these points with a model breast.

- Look for these signs:

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

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

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

☐ Demonstrate these points with a model breast.

- Look for these signs:

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

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

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

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

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

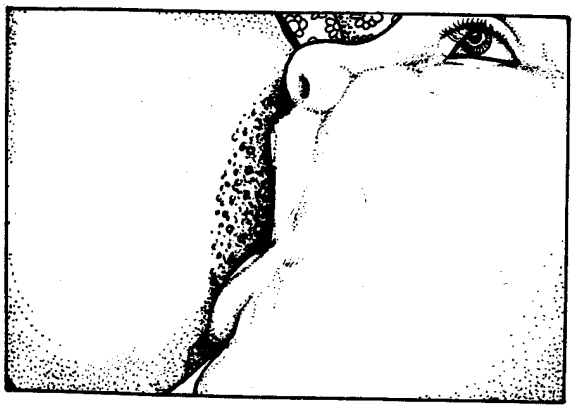
☐ Remind participants that this was explained in Session 3.
Show Overhead 3/9 again.

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

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

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

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



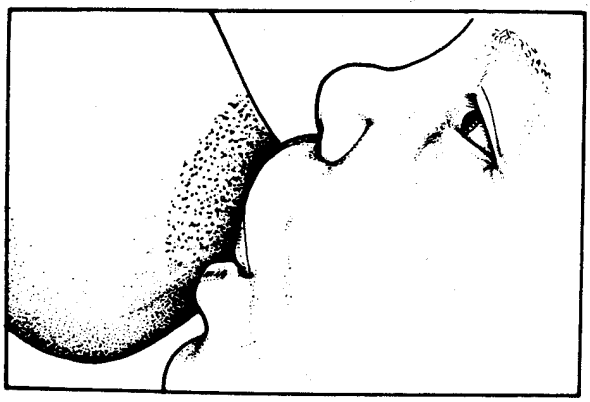


Fig.1 a. A baby well attached to his mother's breast

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

(Fig.19 in Participants' Manual)

Point 8: Is the baby suckling effectively?

☐ Give the following demonstrations as you explain:

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

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

- Look for these signs:

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

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

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

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

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

cause of breastfeeding difficulties.

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

- Look for these signs:

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

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

- Notice how long the breastfeed continues:

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

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

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

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

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

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

- Look also for these signs:

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

- Ask the mother how breastfeeding feels to her:

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

III. Answer participants' questions (10 minutes)

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

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

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

☐ Introduce the form:

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

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

☐ Explain the form:

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

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

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

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

☐ Explain how to use the form:

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

☐ Explain how to interpret the form:

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

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

Further information

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

participants practise using it in clinical practice sessions.

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

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

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

Mother's name: _____ Date: _____

Baby's name: _____ Age of baby: _____

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

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

Notes:

OBSERVING A BREASTFEED

Objectives

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

Session outline (60 minutes)

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

I. Introduce the topic (5 minutes)

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

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

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

Preparation

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

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

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

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

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

As you follow the text, remember:

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

I. Introduce the topic (5 minutes)

□ Explain what will happen:

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

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

□ Explain what to do:

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

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

□ As you show each slide:

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

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

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

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

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

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

Slide 5/1

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

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

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

Slide 5/2

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

- This baby is poorly attached.

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

Slide 5/3

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

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

Slide 5/4

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

- The baby is well attached.

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

Slide 5/5

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

- This baby is poorly attached to the breast.

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

Slide 5/6

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

- This baby is well attached.

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

Slide 5/7

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

(Slide 5/7 continued)

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

Slide 5/8

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

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

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

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

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

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

Slide 5/9

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

- This baby is not well attached.

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

Slide 5/10

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

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

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

Slide 5/11

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

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

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

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

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

 Explain what to do:

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

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

 Remind participants:

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

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

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

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

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

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

 Demonstrate with these examples:

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

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

 Ask all the trainers to help:

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

 Show Slides 5/12 to 5/15.

Show each slide for about 4 minutes.

 Use these answers to give individual feedback:

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

Slide 5/12

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

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

Slide 5/13

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

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

Slide 5/14

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

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

Slide 5/15

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

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

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

□ Conclude with these points:

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

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

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

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

Session 6

Back to CONTENTS

LISTENING AND LEARNING

Objectives

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

Session outline (60 minutes)

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

I. Introduce the topic (3 minutes)

II. Demonstrate listening and learning skills(45 minutes)

III. Answer participants' questions (7 minutes)

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

Preparation

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

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

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

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

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

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

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

As you follow the text, remember:

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

I. Introduce the topic (3 minutes)

Ask participants to keep their manuals closed.

☐ Introduce the idea of counselling with these points:

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

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

- *The first two counselling skills sessions are about `listening and learning'.*
  A breastfeeding mother may not talk about her feelings easily, especially if she is shy, and with someone whom she does not know well.
  You need the skill to listen, and to make her feel that you are interested in her. This will encourage her to tell you more. She will be less likely to "turn off", and say nothing.

II. Demonstrate listening and learning skills (45 minutes)

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

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

Skill 1. Use helpful non-verbal communication

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

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

☐ Explain the skill:

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

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

☐ Demonstrate the skill:

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

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

Give the five pairs of demonstrations in Demonstration A.

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

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

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

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

Ask other participants to:

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

Demonstration A: Non-verbal communication

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

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

1. Posture:

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

2. Eye contact:

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

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

3. Barriers:

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

4. Taking time:

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

5. Touch:

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

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

☐ Discuss appropriate touch in this community.

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

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

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

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

HELPFUL NON-VERBAL COMMUNICATION

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

Skill 2. Ask open questions

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

☐ Explain the skill:

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

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

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

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

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

☐ Demonstrate the skill:

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

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

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

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

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

Demonstration C. Open questions

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

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

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

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

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

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

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

☐ Demonstrate the skill:

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

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

Demonstration D. Starting and continuing a conversation.

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

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

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

Skill 3. Use responses and gestures which show interest

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

☐ Explain the skill:

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

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

☐ Demonstrate the skill:

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

After the demonstration, comment on what it showed.

Demonstration E: Using responses and gestures which show interest

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

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

☐ Discuss locally appropriate responses:

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

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

Skill 4. Reflect back what the mother says

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

☐ Explain the skill:

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

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

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

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

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

☐ Demonstrate the skill:

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

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

Demonstration F. Continuing to ask questions

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

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

Demonstration G. Reflecting back

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

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

☐ Explain this other point:

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

☐ Demonstrate the point:

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

Demonstration H. Mixing reflecting back with other responses

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

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

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

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

☐ Explain the skill:

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

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

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

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

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

☐ Demonstrate the skill:

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

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

Demonstration J. Continuing to ask for facts

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

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

Demonstration K. Sympathizing

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

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

Demonstration L. Reflecting back

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

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

Demonstration M. Empathizing

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

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

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

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

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

Skill 6. Avoid words which sound judging

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

☐ Explain the skill:

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

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

☐ Demonstrate the skill:

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

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

Demonstration O. Using judging words

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

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

Demonstration P. Avoiding judging words

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

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

☐ Make these additional points:

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

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

III. Answer participants' questions (7 minutes)

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

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

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

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

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

LISTENING AND LEARNING SKILLS

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

LISTENING AND LEARNING EXERCISES

Objectives

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

Session outline (60 minutes)

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

I. Introduce the session (3 minutes)

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

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

Preparation

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

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

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

As you follow the text, remember:

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

I. Introduce the session (3 minutes)

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

 Explain what they will do:

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

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

- Exercise 5 is a group exercise on judging words.

II. Facilitate the written exercises (42 minutes)

 Explain what to do:

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

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

How to do the exercise:

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

Example:

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

To answer: *(Suggested answer)*

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

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

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

4. Optional Short Story Exercise

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

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

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

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

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

Example:

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

To answer:

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

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

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

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

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

6. Optional Short Story Exercise

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

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

Possible answers include:

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

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

How to do the exercise:

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

Example:

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

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

To answer:

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

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

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

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

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

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

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

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

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

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

6. Optional Short Story Exercise

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

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

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

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

III. Conduct the group exercise (15 minutes)

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

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

JUDGING WORDS

Well	**Normal**	**Enough**	**Problem**	**Crying `too much'**
good	correct	adequate	fail	unhappy
bad	proper	inadequate	failure	happy
badly	right	satisfied	succeed	fussy
	wrong	plenty of	success	colicky
		sufficient		

 Make these points about the list:

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

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

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

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

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

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

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

USING AND AVOIDING JUDGING WORDS

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

Session 8

Back to CONTENTS

HEALTH CARE PRACTICES

Objectives

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

Session outline (90 minutes)

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

I. Introduce the topic (10 minutes)

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

III. Answer participants' questions (10 minutes)

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

IV. Conduct small group discussion (30 minutes)

Preparation

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

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

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

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

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

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

As you follow the text, remember:

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

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

I. Introduce the topic (10 minutes)

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

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

□ Make these introductory points:

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

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

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

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

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

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

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

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

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

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

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

THE TEN STEPS TO SUCCESSFUL BREASTFEEDING

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

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

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

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

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

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

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

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

8 Encourage breastfeeding on demand.

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

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

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

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

Slide 8/1 Antenatal preparation

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

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

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

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

- *Explain the benefits of breastfeeding, and the dangers of artificial feeding.*
  Most mothers decide how they are going to feed their babies a long time before they have the child - often before they become pregnant. If a mother has decided to bottle feed, she may not change her mind. But you may help mothers who are undecided, and give confidence to mothers who intend to breastfeed. You may encourage a mother to breastfeed exclusively instead of partially.

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

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

- *Discuss mothers' questions.*
  Let the mothers decide what they would like to know more about. For example, some of them may worry about the effect that breastfeeding will have on their figures. It may help them to discuss these worries together.

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

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

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

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

- *Examine her breasts if she is worried about them.*
  She may be worried about the size of her breasts, or the shape of her nipples.
  It is not essential to examine breasts as a routine, if she is not worried about them.

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

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

Further information

It is not essential to examine women's breasts routinely, because it is not often useful, and it can make a woman worry about them when she was quite confident before. However, it may be the policy in your health service to do so. If so, it gives you an opportunity to talk to the mother about breastfeeding. Almost always you will be able to reassure her that her breasts are good for breastfeeding.

Preparing breasts physically for breastfeeding is not necessary.
Traditional ways of preparing the breasts, that are culturally important, may give a mother confidence. If you feel that they help mothers psychologically, there is no need to discourage them.

If a mother has flat or inverted nipples, doing stretching exercises, or wearing nipple shells during pregnancy, does not help. Most nipples improve towards the end of pregnancy, and in the first week after delivery. A nipple that looked difficult in pregnancy, may not be a problem after the baby is born. The most important time to help a mother is soon after delivery. If a mother is worried about inverted nipples, explain that they will improve, and that you can help her to breastfeed (see Session 15). Explain about how a baby suckles from the breast behind the nipple, not from the nipple itself.

If a mother has a problem with her breasts that you are not sure about, such as previous breast surgery, or burns, try to get help from someone more experienced. Meanwhile, it may help to encourage her that babies often can breastfeed from a breast which has had surgery, or that a baby can get enough milk from just one breast if necessary.

Slide 8/1

ANTENATAL PREPARATION FOR BREASTFEEDING

With mothers in groups:

. Explain benefits of breastfeeding
. Give simple relevant information on how to breastfeed
. Explain what happens after delivery
. Discuss mothers' questions

With each mother individually

. Ask about previous breastfeeding experience
. Ask if she has any questions or worries
. Examine her breasts if she is worried about them
. Build her confidence, and explain that you will help her

Slide 8/2 Early contact

- The next two slides illustrate Step 4: `Help mothers initiate breastfeeding within a half-hour of birth'.

This mother is holding her baby immediately after delivery. They are both naked, so that they have skin-to-skin contact. A mother should hold her baby like this as much as possible in the first two hours after delivery. She should let him suckle when he shows that he is ready.

This is *early contact*, which helps a mother to bond with her baby - that is, to develop a close, loving relationship. Early contact also makes it more likely that a mother will start to breastfeed, and breastfeed for longer.

Ask: *What can you do to prevent a baby from getting cold?*

Dry the baby, and cover both him and his mother with the same blanket.

Slide 8/3 Separation of baby from mother after birth

- This baby was born about half an hour ago. He has been separated from his mother, while she is resting and being bathed.

Ask: *What is he doing with his mouth?*

He is opening his mouth and rooting for the breast. This shows that he is now ready to breastfeed.

He is separated from his mother, so she is not there to respond to him and put him to her breast when he roots for it.

Separating a mother and her baby in this way, and delaying starting to breastfeed, should be avoided. These practices interfere with bonding, and make it less likely that breastfeeding will be successful.

Ask: *What do you notice about the baby's eyes?*

His eyes are red. This is because silver nitrate drops were put into his eyes soon after delivery.

Putting drops into a baby's eyes, and other practices such as gastric suction, can alter a baby's behaviour and interfere with breastfeeding. These practices should be avoided if possible. However, if there is a high prevalence of sexually transmitted diseases, it is necessary to put drops or ointment into a baby's eyes, to prevent blindness.

Another practice which interferes with the success of breastfeeding is giving a mother analgesics and sedation during labour. These drugs can cross the placenta and make the baby unresponsive and unwilling to breastfeed. Their use should be kept to a minimum.

Further information

Bonding
Participants may need to discuss bonding at some length. Those who were separated from their own babies, or who did not breastfeed them, may feel that this implies that they do not love their children properly. Allow time to discuss this if necessary.

Mothers may not be aware of bonding happening immediately. Strong affectionate ties grow gradually. But early close contact gives them the best possible start. Separation makes bonding more difficult, especially in high risk families, for example, young mothers with poor support. However, the effects of early separation can be overcome, and bonding can also take place later, particularly during the first nine months of a baby's life. If initiation of breastfeeding is delayed, for example, if a mother or her baby is ill, or for cultural reasons, breastfeeding can still be successfully established. It is helpful if the mother and baby have prolonged skin-to-skin contact as soon as possible, and if the mother is well supported.

However, separation and delay put bonding and breastfeeding at risk, and should be avoided.

Bacterial colonization
Early skin-to-skin contact also enables harmless bacteria from the mother to be the first to colonize her baby. These harmless bacteria help to protect a baby against more harmful bacteria, such as those from the hospital and hospital staff.

Prophylaxis of eye infection
In countries with a high prevalence of sexually transmitted diseases, it may be health service policy to put either silver nitrate drops or tetracycline ointment into the eyes of all newborns to prevent gonococcal and chlamydial infection, which can lead to blindness. To be effective, the treatment must be given within one hour of delivery. To minimise any interference with breastfeeding, allow the baby to suckle if possible before putting in drops or ointment. Tetracycline ointment may be preferable, because it is less irritating than silver nitrate drops.

Slide 8/4 The first breastfeed

- This slide shows a baby having his first breastfeed. He is about one hour old.

Ask: *What do you think of his position and attachment?*

He is in a good position, and looks well attached.

Babies are normally very alert and responsive in the first 1-2 hours after delivery. They are ready to suckle, and easily attach well to the breast.

Most babies want to feed between half to one hour after delivery, but there is no exact fixed time. If the first feed is delayed more than about an hour, breastfeeding is less likely to be successful. A mother is more likely to stop breastfeeding early.

Sometimes in the past we have tried to force babies to breastfeed immediately after delivery, before they or their mothers were ready. This is not necessary or helpful.

It is best to keep a baby with his mother as in Slide 8/2, and let him breastfeed when he shows that he is ready. Help his mother to recognize rooting, as in Slide 8/3, and other signs that he is ready to breastfeed. If necessary, help her to put him to her breast - especially if this is her first baby.

Slide 8/5 Prelacteal feeds

- This slide illustrates Step 6 and Step 9.

Step 6 says: `Give newborn infants no food or drink other than breastmilk, unless medically indicated'.

Step 9 says: `Give no artificial teats or pacifiers (also called dummies or soothers) to breastfeeding infants'.

This baby is being given an artificial feed from a bottle, before starting to breastfeed.
Any artificial feed given before breastfeeding is established is called a *prelacteal feed*.

The dangers of prelacteal feeds are these:

- *They replace colostrum as the baby's earliest feeds.*
  - The baby is more likely to develop infections such as diarrhoea, septicaemia and meningitis;
  - He is more likely to develop intolerance to the proteins in the artificial feed, and allergies, such as eczema.

- *They interfere with suckling.*
  - The baby's hunger is satisfied, so that he wants to breastfeed less.
  - If he is fed the artificial feed from a bottle with an artificial teat, he may have more difficulty attaching to the breast, (nipple confusion).
  - The baby suckles and stimulates the breast less.
  - Breastmilk takes longer to `come in' and it is more difficult to establish breastfeeding.

If a baby has even a few prelacteal feeds, his mother is more likely to have difficulties such as engorgement. Breastfeeding is more likely to stop early than when a baby is exclusively breastfed from birth.

Babies who are given pacifiers to suck, are also more likely to stop breastfeeding early.

 Tell participants that they can find a summary of these points in the section **The dangers of prelacteal feeds** on page 37 of their manuals.

Further information
Participants may want to discuss further the medical indications for giving artificial feeds.
The commonest reasons for giving prelacteal and supplementary feeds are:
- To prevent low blood sugar, or *hypoglycaemia*;
- To prevent dehydration, especially if a baby is jaundiced, and needs phototherapy;
- Because the mother's breastmilk has not `come in'.

Full-term, normal weight babies are born with a store of fluids and glycogen. Breastfeeding, which provides first colostrum and then mature milk, is all that they need.
Sick or low-birth-weight babies may require special feeding, for example to prevent hypoglycaemia, or because they are unable to breastfeed. However even for these babies, breastmilk is usually the best kind of feed to give. Babies who are jaundiced need more breastmilk, which helps to clear jaundice. Other fluids, such as glucose water, do not help to clear jaundice, and are only needed if the baby is dehydrated. This is discussed further in Session 26, `Low-birth-weight and sick babies', and also in the reference document Annex to the Global Criteria for Baby Friendly Hospitals: Acceptable medical reasons for supplementation.

Slide 8/6 Putting babies in a nursery

- The next three slides are about Steps 7 and 8.

Step 7 says: `Practise rooming-in - allow mothers and infants to remain together - 24 hours a day.'

Step 8 says: `Encourage breastfeeding on demand.'

This baby is in a cot in a nursery. He is crying, but his mother is in another room and is not able to respond to him. His mother feeds him every 3 hours, when the nurses bring him to her.

When babies are separated from their mothers and put in a nursery, they cry more. Nurses are more likely to give bottle feeds to keep the babies quiet. Mothers feel less confident about breastfeeding. Mothers are more likely to have difficulties, and to stop breastfeeding sooner.

Separating a mother and her baby in this way can interfere with both bonding and breastfeeding, and it should not be permitted.

Further information
There are four common reasons why mothers and babies are separated in hospital. The intentions behind them are often good, but the reasons themselves are unsound.
Consider the reasons in turn:

1. *To allow the mother to rest.*
   Immediately after delivery, both mother and baby are usually alert and need close contact. After this period, they can rest quite well together.

2. *To prevent infection.*
   There is no evidence that putting babies in nurseries reduces infection. On the contrary, it may increase cross-infection between babies, which can be carried by health care staff.

3. *A lack of space in the wards for cots*.
   Administrators can often overcome the problem of space if they realize how important rooming-in is. In many hospitals, babies stay in the same bed with their mothers, so there is no need for extra space.

4. *To observe the baby.*
   Health care staff can observe babies with their mothers just as well as in a nursery. Mothers observe their babies very closely, and they often notice something wrong before busy health care staff. There is no justification for separating mother and baby while waiting for a doctor to examine a baby.

Slide 8/7 Rooming-in

- The babies in this slide are *rooming-in* with their mothers.

Rooming-in means that a baby stays in the same room as his mother, day and night, from immediately after birth.

The baby in picture 1 is in a cot beside his mother's bed. He is close to her, and she can reach him when she is lying down in bed. In some hospitals, cots are put at the foot of the mother's bed. It is better for the cot to be beside the mother's bed. She needs to be able to touch her baby easily.

The babies in picture 2 are in bed with their mothers. This is called `bedding-in'.
Bedding-in has extra advantages for breastfeeding, because it is easier for a mother to rest and breastfeed. A baby can breastfeed at night or at other times when the mother is asleep without disturbing her. Bedding-in also helps to overcome the problem of lack of space in a ward for cots.

Slide 8/8 Advantages of rooming-in

- Rooming-in has these advantages:

  - It enables a mother to respond to her baby and feed him whenever he is hungry. This helps both bonding and breastfeeding.
  - Babies cry less, so there is less temptation to give bottle feeds.
  - Mothers become more confident about breastfeeding.
  - Breastfeeding continues longer after the mother leaves hospital.

Slide 8/9 Demand feeding

- Rooming-in enables a mother to breastfeed her baby *on demand*. This slide summarizes what we mean by demand feeding. It means breastfeeding a baby whenever he wants, both day and night. A mother should not be made to give feeds only at fixed times, according to the clock.

A mother does not have to wait until her baby is upset and crying to offer him her breast. She should learn to respond to the signs that her baby gives, for example rooting, which show that he is ready for a feed.

Because of this, some people prefer the terms `unrestricted feeding' or `baby-led feeding' to `demand feeding'.

Ask: *What would you tell a mother about how long she should let her baby suckle?*
(Let participants give their opinions. Then make sure the answer is clear.)

Let a baby suckle as long as he wants, provided he is well attached.

There is no need to restrict the length of a breastfeed. If a baby is well attached to the breast, his mother will not get sore nipples.

Some babies take all the breastmilk they want in a few minutes; other babies take half an hour to get the same amount of milk, especially in the first week or two. They are all behaving normally. If a mother takes her baby off her breast before he has finished, he may not get enough hindmilk. Usually when a baby has had all that he wants, he releases the breast himself.

Ask: *Would you suggest that a mother lets her baby suckle from one breast, or from both breasts at each feed?*
(Let a few participants give their opinions. Then make sure the answer is clear.)

Let her baby finish feeding on the first breast, to get the fat-rich hindmilk. Then offer the second breast, which he may or may not want.

It is not necessary to feed from both breasts at each feed. If a baby does not want the second breast, his mother can offer that side first next time, so that both breasts get the same amount of stimulation.

Slide 8/10 Advantages of demand feeding

- Demand feeding has these advantages:

  - Breastmilk `comes in' sooner;
  - The baby gains weight faster;
  - There are fewer difficulties such as engorgement;
  - Breastfeeding is more easily established.

 Tell participants that they can find a summary of these points in the box **ADVANTAGES OF ROOMING-IN AND DEMAND FEEDING** on page 38 of their manuals.

Slides 8/8 and 8/10

ADVANTAGES OF ROOMING-IN AND DEMAND FEEDING

Rooming-in and demand feeding help both bonding and breastfeeding.

Advantages of rooming-in:
- Mother can respond to baby, which helps bonding
- Babies cry less, so less temptation to give bottle feeds
- Mothers more confident about breastfeeding
- Breastfeeding continues longer

Advantages of demand feeding:
- Breastmilk `comes in' sooner
- Baby gains weight faster
- Fewer difficulties such as engorgement
- Breastfeeding more easily established

Slide 8/11 The need for help with early breastfeeds

- The next four slides illustrate Step 5:
  `Show mothers how to breastfeed, and how to maintain lactation even if they are separated from their infants'.

This mother is having some difficulty getting her baby to breastfeed. There is no one available to help her. This is a common problem in many health facilities. Mothers are left to struggle by themselves, and this may result in problems and later failure.

Maternity ward staff often feel that they do not have enough time to help every mother. In many health facilities, mothers are discharged within a few hours of delivery, so there are few opportunities for their babies to breastfeed.

However, a more important reason is that few health workers have been trained to give help, and they lack the necessary skills. Hopefully in future, health workers will be trained to help mothers.

Slide 8/12 Helping a mother with an early breastfeed

- This slide shows a midwife coming to help a mother to put her baby to her breast.

A skilled, experienced midwife or other person should help a mother with an early feed. This may be the very first feed, soon after delivery, or the next time the baby is ready to feed, some time in the first 24 hours after delivery. It should be as early as possible, because it makes it easier to establish breastfeeding.

Many mothers do not need help, or they need very little. But a mother may not know if she needs help or not. It is a good idea for a midwife to spend time with each mother during an early breastfeed to make sure that everything is going well. This should be a routine in maternity wards before a mother is discharged. It need not take a long time.

Ask: *How would you suggest that this midwife helps this mother?*
(Let participants make some suggestions. Encourage them to think of:
- observing a breastfeed;
- helping the mother to position her baby;
- giving her relevant information.
Then show Slide 8/13 to summarise the answer.)

Slide 8/13 How to help with an early breastfeed

- This slide summarizes how to help a mother with an early feed.

- *Avoid hurry and noise.*
  Talk quietly, and be unhurried, even if you have only a few minutes.

- *Ask the mother how she feels and how breastfeeding is going.*
  Let her tell you how she feels, before you give any information or suggestions.

- *Observe a breastfeed.*
  Try to see the mother when she is feeding her baby, and quietly watch what is happening. If the baby's position and attachment are good, tell her how well she and the baby are doing. You do not need to show her what to do.

- *Help with positioning if necessary.*

If the mother is having difficulty, or if her baby is not well attached, give her appropriate help.

- *Give her relevant information.*
  Make sure that she understands about demand feeding, about the signs that a baby gives that show that he is ready to feed, and explain how her milk will `come in'.

- *Answer the mother's questions.*
  She may have some questions that she wants to ask; or as you talk to her, you may learn that she is worried about something, or not sure about something. Explain simply and clearly what she needs to know.

Ask: *What could you tell her about how a baby shows that he is ready for a feed?*
(Let participants make a few suggestions, then continue.)

A baby may be wakeful and restless, or make small noises; he may make hand-to-mouth movements, and sucking movements; he may suck his fingers, and root for the breast.

 Tell participants that they can find the list of the points **HOW TO HELP A MOTHER WITH AN EARLY BREASTFEED** on page 39 of their manuals.

Further information
Babies differ very much in how often they want to feed. These patterns are all normal.
- For the first 1-2 days, a baby may not want many feeds. Some babies sleep for 8-12 hours after a good feed. Provided a baby is warm and well and not low-birth-weight, and he has had at least one good breastfeed, it is not necessary to wake him at any fixed time for another feed.
- For the next 3-7 days, a baby may want to feed very often - as the milk supply becomes established. After that babies usually feed less often, but their habits continue to vary a lot. Any baby may want to feed more on some days and nights than on others.

Slide 8/14 Mothers who are separated from their infants

- Sometimes a baby has to be separated from his mother, because he is ill, or of low-birth-weight, and he needs special care.

While they are separated, a mother needs a lot of help and support. She needs help to express her milk as you see a mother doing here. This is necessary both to establish and maintain lactation, and to provide breastmilk for her baby. (See also Session 20, `Expressing breastmilk'). She may need help to believe that her breastmilk is important, and that giving it will really help her baby. She needs help to get her baby to suckle from her breast as soon as he is able.

The low-birth-weight baby in the other picture is fed with his mother's expressed breastmilk. At first, he was fed by nasogastric tube. Now, his mother can feed him her milk from a cup. There is no need to use a bottle for these babies. Feeding from a bottle is more difficult for them than feeding from the breast. Cups are more satisfactory. (See also Session 26, `Low-birth-weight and sick babies'.)

Slide 8/15 After Caesarian section

- The mother in this slide was delivered by Caesarian section. She is breastfeeding her baby.

It is usually possible for a mother to breastfeed within about 4 hours of a Caesarian section - as soon as she has regained consciousness. Exactly how soon depends partly on how ill the mother is, and partly on the type of anaesthetic used. After epidural anaesthesia, a baby can often breastfeed within -1 hour.

Ask: *Does a baby need a feed while he waits for his mother to breastfeed him?*

A healthy, term baby usually needs no food or drink before his mother can feed him. He can wait a few hours until she is ready.

A baby can `room-in' with his mother in the ordinary way, and she can feed him whenever he is hungry. Most mothers need help to find a comfortable position for the first few days.

Often a mother finds it easiest to breastfeed lying down at first.
- She may lie on her back, with her baby on top of her, like the mother in this slide.
- She may find it easier to lie on her side, with the baby lying beside her and facing her. This prevents the baby pressing on her wound. She may need help to turn over, and to move her baby from one side to the other.
- Later, she may like to sit and hold her baby across her abdomen above the operation wound, or under her arm.

Whatever position a mother uses, make sure that her baby is in a good position, facing her breast, so that he is well attached to her breast.

Further information
In one busy hospital, after Caesarian section, most mothers breastfeed in this way:
- for the first 24 hours, lying on their backs;
- for the second 24 hours, turning from side to side;
- from the third day onwards, sitting up with pillows for support.

III. Answer participants' questions (10 minutes)

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

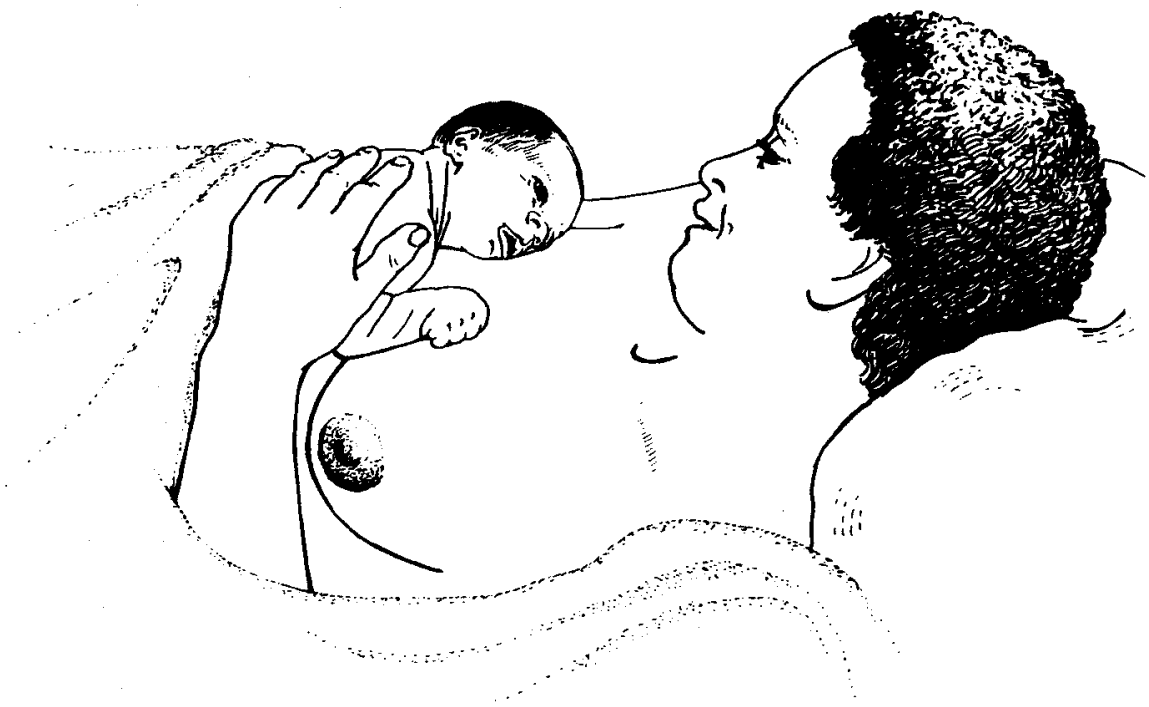


Fig.2 Skin-to-skin contact in the first hour after delivery helps breastfeeding and bonding
(Fig.20 in Participants' Manual)

IV. Conduct small group discussion (30 minutes)

(This section can be held at a separate time if necessary.)

 Gather your group of 4-5 participants, and find a part of the room where you can work together as a group. (Other trainers also gather their groups.)

Ask participants to keep their manuals closed until you tell them to open them.

 Introduce the topic with these points:

- Step 10 of the `Ten Steps to Successful Breastfeeding' is:
  `Foster the establishment of breastfeeding support groups, and refer mothers to them on discharge from the hospital or clinic'.

- Many *mothers give up breastfeeding or start complementary feeds in the early weeks.*
  Difficulties arise most often during this time. However, many mothers are discharged within a day or two after delivery, before their breastmilk has `come in', and before breastfeeding is established.

- *Even good hospital practices cannot prevent all the difficulties.*
  They cannot make sure that mothers will continue to breastfeed exclusively.
  So it is important to think about what happens to mothers after they go home.

Ask: *What difficulties may a mother have when she goes home?*
(Let participants suggest. Add to their suggestions any of the following that they have not included.)

She may have difficulties with breastfeeding;
She has to cope with the demands of the rest of the family;
She may have to listen to a lot of different advice about how to feed the baby;
She may be isolated, without help;
She may have to go back to work.

If she is to continue to breastfeed successfully, she will need continuing help and support.

Ask: *Where can a mother get continuing help and support, so that breastfeeding is established?*
(Let participants make a few suggestions.)

 Discuss participants' suggestions.

Use the ideas in the notes below, but relate the ideas to the local situation.
Which of these sources of support are already available?
Which are not feasible, and what is the reason?
Which sources of support could health workers encourage and strengthen?

Possible sources of help for breastfeeding mothers include:

- *Supportive family and friends.*
  This is often the most important source of support. Community support is often good where breastfeeding traditions are strong, and family members live near. However, some traditional ideas may be mistaken. Many women, especially in cities, have little support. Or they may have friends or relatives who encourage them to bottle feed.

- *An early postnatal check, within 1 week of discharge from hospital.*
  This check should include observation of a breastfeed, and discussion of how breastfeeding is going. You can help mothers with minor difficulties before they become serious problems.

- *A routine postnatal check at 6 weeks.*
  This check also should include observation of a breastfeed, as well as discussion of family planning (see Session 31, `Women's nutrition, health and fertility').

- *Continuing help from health care services.*
  At any time that a health worker is in contact with a mother and child under 2 years of age, she should support breastfeeding. (See Session 28 `Sustaining breastfeeding').

- *Help from community health workers.*
  Community health workers are often in a good position to help breastfeeding mothers, as they may live nearby. They may be able to see a mother more often, and give more time, than facility-based health workers. It may be helpful to train community health workers in some breastfeeding counselling skills.

- *A breastfeeding support group*.
  (To discuss mother support groups further, use the points in the box **BREASTFEEDING SUPPORT GROUPS**).

 Discuss breastfeeding support groups.

Ask participants to find the box **BREASTFEEDING SUPPORT GROUPS** on page 41 of their manuals. Ask them to read out the points in the box in turn.

Discuss each point in relation to the local situation and experience.

BREASTFEEDING SUPPORT GROUPS

- A group may be started by a health worker; by an existing women's group; by a group of mothers who feel that breastfeeding is important;
  or by mothers who meet in the antenatal clinic or maternity facility and who want to continue to meet and help each other.

- A group of breastfeeding mothers meets together every 1-4 weeks, often in one of their homes, or somewhere in the community. They can have a topic to discuss, such as "The advantages of breastfeeding" or "Overcoming difficulties".

- They share experiences, and help each other with encouragement and with practical ideas about how to overcome difficulties. They learn more about how their bodies work.

- The group needs someone who is accurately informed about breastfeeding to train them. They need someone who can correct any mistaken ideas, and suggest solutions to difficulties. This helps the group to be positive and not to complain. This person could be a health worker, until someone in the group has learnt enough to play this role.

- The group needs a source of information whom they can refer to if they need help. This could be a health worker trained in breastfeeding, whom they see from time to time. The group also needs up-to-date materials to educate themselves about breastfeeding. The health worker can help them to get these.

- Mothers can also help each other at other times, and not only at meetings. They can visit each other when they are worried or depressed, or when they don't know what to do.

- Breastfeeding support groups can provide an important source of contact for socially isolated mothers.
  They can be a source of support which builds mother's confidence about breastfeeding and which reduces their worries.
  They can give a mother the extra help that she needs, from women like herself, that health services cannot give.

 Ask participants to look at page 42 of their manuals, and to find the box **WHAT TO DO BEFORE A MOTHER LEAVES A MATERNITY FACILITY.**

Explain that this is a summary of what to do before they discharge a mother after delivery.

☺ Ask participants to read out the points in turn.

WHAT TO DO BEFORE A MOTHER LEAVES A MATERNITY FACILITY

Find out what support she has at home.

If possible, talk to family members about her needs.

Arrange a postnatal check in the first week, to include observation of a breastfeed (in addition to a routine check at 6 weeks).

Make sure that she knows how to contact a health worker who can help with breastfeeding if necessary.

If there is a breastfeeding support group in her neighbourhood, refer her to that.

- Recommended reading:

Helping Mothers to Breastfeed:

Chapter 4, `How breastfeeding should begin'

Chapter 11, `Counselling'

Chapter 12, section 12.3, `Women's groups' and section 12.4, `Direct mother-to-mother support groups'

Protecting, Promoting and Supporting Breastfeeding: The Special Role of Maternity Services, A Joint WHO/UNICEF Statement, 1989

- Annex to the Global Criteria for Baby Friendly Hospitals: Acceptable Medical Reasons for Supplementation
- Example of a hospital breastfeeding policy, if available

Session 9

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CLINICAL PRACTICE 1

Listening and learning
Assessing a breastfeed

Objective

Participants practise `listening and learning' and `assessing a breastfeed' with mothers and babies in a ward or clinic.

Session outline (120 minutes)

Participants are together as a class led by one trainer to prepare for the session and to discuss it afterwards.

Participants work in small groups of 4-5 each with one trainer for clinical practice in a ward or clinic.

I.	Prepare the participants	(20 minutes)
II.	Conduct the clinical practice	(80 minutes)
III.	Discuss the clinical practice	(20 minutes)

Preparation

If you are leading the session:
Make sure that you know where the clinical practice will be held, and where each trainer should take her group. If you did not do so in a preparatory week, visit the wards or clinic where you will go, introduce yourself to the staff members in charge, and make sure that they are prepared for the session (see Director's Guide).

Study the instructions in the following pages, so that you can prepare the participants and conduct the clinical practice.

Make sure that there are copies of the **CLINICAL PRACTICE DISCUSSION CHECKLIST** available for each trainer.

Make sure that there are two copies of the B-R-E-A-S-T-FEED Observation Form and one copy of the list of **LISTENING AND LEARNING SKILLS** available for each participant and trainer.

If you are leading the group:
Study the instructions in the following pages, so that you are clear about how to conduct the clinical practice.

Make sure that you have a copy of the **CLINICAL PRACTICE DISCUSSION CHECKLIST**, to help you to conduct discussions.

Make sure that the participants in your group each have two copies of the B-R-E-A-S-T-FEED Observation Form, and one copy of the list of **LISTENING AND LEARNING SKILLS**. Have one or two spare copies with you.

Find out where to take your group, and where to meet for the discussion afterwards.

As you follow the text, remember:

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

I. Prepare the participants (20 minutes)

One trainer leads a preparatory session with all participants and the other trainers together.

If you have to travel to another facility for the clinical practice, hold the preparatory session in the classroom before you leave. If necessary, this can take place on the evening or the morning before.

☐ *Explain the objective of the exercise:*

▪ You practise `assessing a breastfeed' and `listening and learning', using the skills that you

learnt in Sessions 4, 5, 6 and 7.

☐ *Explain what each participant should take with her:*

- Take with you:
  - two copies of the B-R-E-A-S-T-FEED Observation Form;
  - one copy of **LISTENING AND LEARNING SKILLS**;
  - pencil and paper to make notes.

  You do not need to take books or manuals or anything else. These other things can interfere with the clinical practice.

☐ *Give each participant the forms that she needs.*

☐ *Make sure that trainers have these to take:*

- spare copies of the B-R-E-A-S-T-FEED Observation Form;
- spare copies of **LISTENING AND LEARNING SKILLS**;
- a copy of the **CLINICAL PRACTICE DISCUSSION CHECKLIST** (see page 136).

☐ *Explain how the participants will work:*

- You work in your groups of 4-5 each with a trainer. To start with, the whole group works together. The trainer demonstrates what to do, and then you practise. You take turns to talk to a mother, while the other members of the group observe. When everyone knows what to do, you can work in pairs, while the trainer circulates.

☐ *Explain what the participant who talks to the mother will do:*

- Introduce yourself to the mother, and ask permission to talk to her. Introduce the group, and explain that they are interested in infant feeding. Ask permission to watch her baby feed. (Avoid saying `breastfeeding': see the box **MISTAKES TO AVOID** on page 131 in this Guide, or page 44 in the Participants' Manual.)

  Try to find a chair or stool to sit on. If necessary, and if permissible, sit on the bed.

  If the baby is feeding, ask the mother to continue as she is doing. If the baby is not feeding, ask the mother to give a feed in the normal way at any time that her baby seems ready. Ask the mother's permission for the group to watch the feed.

  Before or after the breastfeed, ask the mother some open questions about how she is, how her baby is, and how feeding is going, to start the conversation. Encourage the mother to talk about herself and her baby. Practise as many of the listening and learning skills as possible.

☐ *Explain what the other participants will do:*

- Stand quietly in the background. (There are unlikely to be enough stools or chairs for the whole group.) Try to be as still and quiet as possible. Do not comment, or talk among yourselves.

  Make *general* observations of the mother and baby. Notice for example: does she look happy? Does she have formula or a feeding bottle with her?

  Make *general* observations of the conversation between the mother and the participant. Notice for example: who does most of the talking? Does the participant ask open questions? Does the

mother talk freely, and seem to enjoy it?

Make *specific* observations of the participant's listening and learning skills.
Mark a ✔ on your list of **LISTENING AND LEARNING SKILLS** when she uses a skill, to help you to remember for the discussion. Notice if she uses helpful non-verbal communication.

Notice if the participant makes a mistake, for example, if she uses a judging word, or if she asks a lot of questions to which the mother says `yes' and `no'.

☐ *Explain what participants do when they observe a breastfeed:*

- Stay quietly watching the mother and baby as the feed continues.
  While you observe, fill in a B-R-E-A-S-T-FEED Observation Form.
  Write the name of the mother and baby; mark a ✔ beside each sign that you observe; add the time that the feed takes.
  Under `Notes:' at the bottom of the form, write anything else that you observe which seems important for breastfeeding.

☐ *Explain what to do when they have finished observing:*

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

- Go with the group into another room or corner to discuss your observations.

☐ *Warn participants about* **MISTAKES TO AVOID**:

MISTAKES TO AVOID

- **Do not say that you are interested in <u>breastfeeding</u>.**
  The mother's behaviour may change. She may not feel free to talk about bottle feeding. You should say that you are interested in "infant feeding" or in "how babies feed".

- **Do not give a mother help or advice.**
  In Clinical Practice 1, if a mother seems to need help, you should inform your trainer, and a member of staff from the ward or clinic.

- **Be careful that the forms do not become a barrier.**
  The participant who talks to the mother should not make notes while she is talking. She needs to refer to the forms to remind her what to do, but if she wants to write, she should do so afterwards. The participants who are observing can make notes.

☐ Tell participants that there is a summary of these instructions in the Participants' Manual on page 44 to remind them of the main points of what you said.

II. Conduct the clinical practice (80 minutes)

☐ *Take your group to the ward or clinic:*

- Introduce yourself and your group to the staff member in charge.
- Ask which mothers and babies it would be appropriate to talk to, and where they are.
- Try to find a mother and baby who are breastfeeding, or a mother who thinks that her baby

may want to feed soon. If this is not possible, talk to any mother and baby.

☐ *Demonstrate to the group what to do:*

- Explain that you will first demonstrate what participants should do.
- Ask participants to stand quietly in the background, and to refer to their list of **LISTENING AND LEARNING SKILLS**, and the B-R-E-A-S-T-FEED Observation Form.
- Introduce yourself and the group to the mother.
- Ask her permission to talk to her and to watch the baby feed.
- Sit on a chair or stool, or the bed if permissible.
- Ask her a few open questions.
- Use as many listening and learning skills as possible to encourage the mother to tell you about herself and the baby. Follow the list of skills.
- Observe the baby breastfeeding, using the B-R-E-A-S-T-FEED Observation Form.
- Thank the mother, and say something to praise and support her.

If you cannot speak the mother's language, ask a participant who can speak it to interpret for the demonstration.

☐ *Discuss the demonstration:*

Take the group away from the mother, and discuss what they observed.
Ask them:
- What did they observe generally about the mother and baby?
- What signs from the B-R-E-A-S-T-FEED Observation Form did they observe?
- Which listening and learning skills did you demonstrate?

If the mother and baby showed any signs of good or poor positioning and attachment which participants did not see, point them out.

☐ *Arrange for a participant to talk to a mother:*

Find another mother, and ask a participant to talk to her. She should practise listening and learning skills, while the rest of the group observes. If the baby breastfeeds, they should all observe the feed.

☐ *Guide the participant who is practising:*

Keep in the background, and try to let the participant work without too much interference.
You do not need to correct every mistake that she makes immediately. If possible wait until the discussion afterwards. Then you can both praise what she did right and talk about anything she did not do right.
However, if she is making a lot of mistakes, or not making any progress, then you should help her. Try to help in a way which does not make her embarrassed in front of the mother and the group.
Also, if she starts to help or advise the mother, remind her that she should not do that during this practice session.
Additionally, if the mother and baby show something important that the participants may not have observed, you can quietly draw their attention to it.

You need to judge as participants work what will best help them to learn.
Use your confidence and support skills to correct participants and to help them to develop confidence in their own clinical and counselling skills.

☐ *Discuss the participant's performance:*

Take the group away from the mother, and discuss what they observed.
Use the **CLINICAL PRACTICE DISCUSSION CHECKLIST** to help you to lead the discussion.

Ask the general questions, and then ask the specific questions about `listening and learning' and about `assessing a breastfeed'.
(Ask the `building confidence' and `history taking' questions in later clinical practice sessions.)

Go through the **LISTENING AND LEARNING SKILLS** checklist, and discuss how the participant practised them. First ask the participant herself to say how well she thinks she did. Then ask the other participants.

Go through the B-R-E-A-S-T-FEED Observation Form, and discuss how many of the signs the group noticed. Ask them to decide if the baby was well or poorly positioned and attached.

☐ *Arrange for the other participants in turn to talk to mothers:*

Find another mother, and ask another participant to talk to her. Discuss the group's observations, and the participant's performance.
Work with the group together until you are sure that they know what to do. Make sure that you are present the first time that a participant talks to a mother.
Try to make sure that each participant talks to at least one mother.

☐ *Let participants work in pairs:*

When you have observed participants talking to at least one mother, and you are confident that they know what to do, let them work in pairs to talk to other mothers without you.

Circulate between the pairs to see how they do. When a pair has finished, move away from the mother, and discuss their observations with them.
☐ *Teach about mothers who need help:*

If at any time there is a mother who needs help, or who illustrates a particular situation, take the opportunity to teach about it.

Ask a participant who identifies a mother needing help to report it to you. Ask the staff of the ward or clinic if they would like you to help the mother. If they agree, give the mother the necessary help, together with the participant.
Ask the staff to be present if possible, and make sure that they understand what you suggest to the mother so that they can provide follow-up.
Explain and demonstrate the situation to the other participants. This may take you ahead of what has been covered in the course, but it is important not to miss a good learning opportunity.

If possible, suggest that participants revisit the mothers whom they talked to, to follow them up the next day.

☐ *Encourage participants to observe health care practices:*

Encourage participants, while they are in a ward or clinic, to notice:
- if babies room-in with their mothers;
- whether or not babies are given formula, or glucose water;
- whether or not feeding bottles are used;
- the presence or absence of advertisements for baby milk;
- whether sick mothers and babies are admitted to hospital together;
- how low-birth-weight babies are fed.

Encourage participants also to talk to staff in the health facility, to learn:

- their attitude to breastfeeding;
- how they care for breastfeeding mothers;
- if they have babies of their own, and how they feed them.

Explain that participants should not comment on their observations, or show any disapproval, while in the health facility. They should wait until the trainer invites them to comment privately, or in the classroom.

III. Discuss the clinical practice (20 minutes)

The whole class comes back together to discuss the clinical practice exercise, led by the trainer who led the preparatory session.

☐ *Ask one participant from each group to report briefly on what they learnt:*

Ask them to comment:

- on any special situations of mothers and babies from which they learnt;
- on their experiences using the B-R-E-A-S-T-FEED Observation Form and the list of **LISTENING AND LEARNING SKILLS**.

Do not allow participants to report on details of every individual mother. They should report only on points of special interest.

Use the **CLINICAL PRACTICE DISCUSSION CHECKLIST** to help you to guide the discussion.
However, do not go through the whole checklist, because this was done in the small groups.

☐ *Ask participants to fill in their* **CLINICAL PRACTICE PROGRESS FORM**:

Explain that the form is on page 182 (the last page) of their manuals .

On the form they should record each mother and baby that they talked to during the Clinical Practice 1. They record each mother twice. In Section 1 of the form, they record the skills that they practised with the mother; in Section 2 they record the mother's situation.

CLINICAL PRACTICE DISCUSSION CHECKLIST

General questions

- ☐ How did your clinical practice go?
  What did you do well? What difficulties did you have?
- ☐ Was the mother willing to talk? Did she seem to enjoy talking to you?
- ☐ Did the mother ask any questions? How did you respond?
- ☐ What was the most interesting thing that you learnt from her?
  Did she have a special difficulty or situation which helped you to learn?

Listening and learning

- ☐ How many of the listening and learning skills were you able to use?
- ☐ What mistakes did you make? Did you ask a lot of questions?
- ☐ Did using the skills encourage the mother to talk?

Assessing a breastfeed

- ☐ What did you learn by general observation?
- ☐ What did you learn using the B-R-E-A-S-T-FEED Observation Form?

Confidence and support

- ☐ How many of the confidence and support skills were you able to use?
  (especially praise 2 things, and give 2 pieces of relevant information)
- ☐ What mistakes did you make? Did you give the mother a lot of advice?
- ☐ Did using these skills help you to help the mother?

History-taking

- ☐ What did you learn by taking a breastfeeding history?
- ☐ Did you remember to ask something from each section of the form?
- ☐ Did using the form help you to understand the mother's situation?