MALAYSIAN BREASTFEEDING PEER COUNSELOR PROGRAM

TRAINING MODULE

Preface to Second Edition

April 2019

It has been nine years since the first edition of this syllabus was published.
There have been several development in the breastfeeding world since then; particularly in these two areas (i) the knowledge on breastfeeding – new research, new concepts and updates; and (ii) the increasing public awareness on breastfeeding – the new wave of hope and expectation of new parents and grandparents. Development from these two areas alone brought about changes to the approach on breastfeeding management and how we support mothers, babies and their families.

We have also been receiving thoughtful feedback from trainees, peer counselors and reviewers using this syllabus. In addition to that, fellow trainers through their observation and experience facilitating the courses, have identified several key areas for improvement. Hence, it was timely to revise this syllabus.

This revised edition is intended for Malaysian Breastfeeding Peer Counselor (MBFPC) Entry Level Course trainees; to be used as a companion to the course. There are 11 modules including one on resources. Each module has its learning objectives.

New to this edition are :

a) Module 1: introduces MBFPC, its journey thus far and its goals;
b) Module 2 : expands section on giving effective breastfeeding help and highlights important key points in coloured text box;
c) Module 3, 4 and 8 : minor updates
d) Module 5, 6 and 9 : several sections updated to suit peer counselor's scope of practice; technical jargons removed or simplified to enhance clarity;
e) Module 7 and 10 : new content added for better understanding on the subject.
f) Module 11 : compiles a list of up-to-date and evidence based resources ie. recommended websites, books and handouts. There is also a shortlist of 5 reference books and to make it easier for the trainees, we have identified certain chapters in the reference books to the modules.

This syllabus is meant to be used as a companion to the MBFPC Entry Level Course. It is not to be regarded as a textbook. Trainees are encouraged to refer to module 11 and/or other credible resources for further reading and to complement their learning. Trainees and peer counselors are also welcome to discuss with their trainers.

This revision would not be possible without valuable feedback, suggestions, support and solid teamwork from peer counselors and fellow team members. We cannot thank you enough for all your priceless contribution.

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MALAYSIAN BREASTFEEDING
PEER COUNSELOR
TRAINING MODULE

May 2010

Acknowledgements

This syllabus is an adaptation of the **LLLI Breastfeeding Peer Counselor Program**. The **Malaysian Breastfeeding Peer Counselor Education Team** has done a great job reviewing and updating the syllabus, in order to make it more suitable for our local culture and needs. We gratefully acknowledge all of those whose tremendous contributions have made this syllabus what it is today. From text to technical, it is in a constant state of revision as new ways for supporting mothers and new information becomes available.

We will continue revising and updating the syllabus as and when needed. All newly updated versions of the syllabus and other relevant references will be uploaded to the official website at **http://www.malaysianbfpc.org**

Having current, accurate breastfeeding materials and references has been one of the hallmarks of this program. To that end, each syllabus is now numbered and remains the property of the **Malaysian Breastfeeding Peer Counselor Program.**

If you find any material you feel is missing or in error, we ask that you inform us as soon as possible so that we can investigate and let others know. You can send your submissions either by email or post to:

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Overview of Peer Counselor Training Curriculum

Introduction

Module 1: Introduction

Objective: Participant will be able to:

- Describe the Malaysian Breastfeeding Peer Counselor Program and it's goals
- List at least three peer counselor's scope of practice.
- Identify two benefits of mother to mother help.

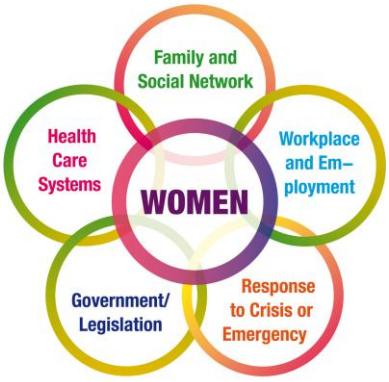
A. Malaysian Breastfeeding Peer Counselor Program

B. Breastfeeding Peer Counselor's Scope of Practice

C. Effectiveness of Mother-to-Mother Help

A. Malaysian Breastfeeding Peer Counselor Program (MBFPC Program)

1. The background scenario :
   - The World Health Organization and UNICEF recommendations for optimal breastfeeding are as follows: initiation of breastfeeding within the first hour after the birth; exclusive breastfeeding for the first six months; and continued breastfeeding for two years or more, together with safe, nutritionally adequate, age appropriate, responsive complementary feeding starting in the sixth month.[1]
   - Malaysian government has been taking steps to implement several strategies to promote breastfeeding in accordance with WHO and UNICEF's global recommendation. Since 1992, Baby Friendly Hospital Initiatives (BFHI) and Ten Steps to Successful Breastfeeding were implemented in all government hospitals, National Breastfeeding Policy was in place along with other promotional strategies throughout the country.[2]
   - In 2006, Malaysia's National Health Morbidity Survey (NHMS III) reported that the overall prevalence of infants initiated breastfeeding within one hour of birth was 63.7%, exclusive breastfeeding below 6 months was 14.5% and prevalence of continued breastfeeding up to 2 years was 37.4%[3]. In other words, even though two thirds of infants were initiated early for breastfeeding, only 14.5% of infants were still exclusively breastfed at 6 months of age, despite our government & health care system's huge efforts.
   - Clearly, a multifaceted approach from other agencies and members of the public is needed to promote, protect and support breastfeeding beyond hospital setting.



What can we do to help and support our mothers and babies ?

FIVE CIRCLES OF SUPPORT
CIRCLES represent the types of support a breastfeeding woman can call upon for help and encouragement. World Breastfeeding Week, 2008.[4]

2. Support beyond hospital setting :
    - Mother to mother support also known as peer support is one of the key factors found to be effective in extending the duration of exclusive breastfeeding. Women who received any form of support were less likely to stop exclusive breastfeeding before five months than those who received no support.
    - Combinations of peer support and professional support were more effective than professional support alone in prolonging any form of breastfeeding, especially in the first two months.[5]
    - In Malaysia, there was inadequate number of lactation counselors and lactation consultants in the community to meet the demands of our mothers and babies.

3. How MBFPC began :
    - A project was planned to train mothers and non medical personnels who were interested to become breastfeeding peer counselors, to help mothers.
    - This project which was managed by Susuibu.com, received full support from World Alliance for Breastfeeding Action (WABA) and UNICEF. UNICEF provided initial funding for the project that comprised of Train the Trainers course, the peer counselor trainings in 5 regions, and monitoring of the overall project until the end of 2010.
    - In January 2010, sixteen (16) Peer Counselor Program Administrators (PCPA) completed the 6 days training conducted by Kathy Baker and Pushpa Panadam from La Leche League International (LLLI).
    - This group of PCPAs then planned and scheduled a three (3) full day workshop for each region in Malaysia. The training syllabus adapted from LLLI was revised to suit our culture and local needs.
    - By the end of year 2010, a nationwide training program for Peer Counselors was successfully conducted in 5 regions.

4. The Journey Continues :
    - The network of MBFPC trained peer counselors continues to grow till date, reaching all states in West and East Malaysia.
    - Trained Peer Counselors volunteer within their capacity, participating in breastfeeding promotional activities, helping mothers in their local community either individually through one to one counseling or through mother to mother support group in various setting such as workplace, neighbourhood and/or health care facility.
    - In 2013, Malaysian Breastfeeding Peer Counselor Association (MBFPCA) was established and registered under Registry of Societies, Malaysia. MBFPCA is an independent non-profit organization.
    - MBFPCA has been actively involved in activities that promote, protect and support breastfeeding at the community level, national and international level.
    - MBFPCA has also been invited to participate and collaborate in breastfeeding related activities organized by health care facilities, government agencies and non-government organizations.

- MBFPC Trainings are on-going, with up-to-date breastfeeding knowledge and revised mode of training to enhance peer counselors' learning experience.
- Our mission is to train peer counselors and build a network of trained breastfeeding peer counselors to promote, protect, support and empower the breastfeeding communities in Malaysia.
- Our vision is : every mother in Malaysia have access to skilled help and effective breastfeeding support from a trained breastfeeding peer counselor within her community.

B. Breastfeeding Peer Counselor's Scope of Practice

1. Peer counselor may work from their home, a breastfeeding support centre, a health clinic or hospital setting.
2. Peer counselor should work in a way that respects the dignity of the mother, the healthcare support system and those with whom they work.
3. "Scope of practice" refers to the range of services a peer counselor can provide. This includes :
   a. support normal breastfeeding for new mothers and babies.
   b. helping mothers get off a good start and establish exclusive breastfeeding by giving them accurate information that is specific to their needs.
   c. encourage mothers to breastfeed by listening and helping them to explore their barriers and discover ways that allow breastfeeding to be part of their daily lives.
   d. Refer mothers to other breastfeeding experts when needed.
4. Peer counselor must know when they are unable to address a problem and when to refer. [6]
5. Peer counselor do not and will not accept funds or gifts from manufacturers or distributors of breast milk substitutes, related equipment such as feeding bottles and teats.

[1] Unicef. Breastfeeding. https://www.unicef.org/nutrition/index_24824.html (Accessed 2019-04-18)
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[5].WHO. Learning From A Large Scale Community Based Breastfeeding Programmes. 2008 https://www.unicef.org/Learning_from_Large_Scale_Community-based Breastfeeding_Programmes.pdf (Accessed 2019-04-21)
[6] WABA. World Breastfeeding Week. Breastfeeding Support – Close to Mothers. 2013. http://worldbreastfeedingweek.org/2013/pdf/wbw2013-af-eng.pdf (Accessed 2019-04-18)

MALAYSIAN BREASTFEEDING PEER COUNSELOR

BASIC JOB DESCRIPTION

The Peer Counselor offers information, encouragement and support for breastfeeding to mothers in their own communities.

REPORTING RELATIONSHIPS

The Peer Counselor is directly responsible to the Peer Counselor Program Administrator who trained her or to the direct supervisor of the agency she works for.

RESPONSIBILITIES

1. Contact or visit mothers (ante and post-natal) in the local community, discuss breastfeeding with them, using appropriate counseling skills;
2. Teach mothers practical skills for breastfeeding such as positioning and attachment, and breast milk expression, and help them to overcome common basic problems;
3. Be close to mothers, especially in the first weeks after birth or when there is any difficulty.
4. Respect and support mother's decision always.
5. Know local expertise in breastfeeding support and refer mothers to more experienced breastfeeding counselors or lactation consultant when necessary;
6. Lead support group meetings when and where appropriate.
7. Offer telephone support to mothers if appropriate.
8. Be ready to respond to questions about breastfeeding raised within the community, local schools or healthcare system.
9. Attend health events, exhibitions, answer questions and distribute information.
10. Speak on breastfeeding related issues when invited.
11. The Malaysian Breastfeeding Peer Counselor never charges a mother for her services, though the Peer Counselor may be paid by an agency or through a grant.
12. Do not and will not accept funds or gifts from manufacturers or distribution of breast milk substitutes, related equipment such as feeding bottles and teats.
13. Report to Peer Counselor Program Administrator on a regular basis.

Commitment Agreement

I, _____being fully aware of my responsibilities and my role as a Malaysian Breastfeeding Peer Counselor do commit to upholding and performing the above responsibilities to the best of my abilities.

_____

Name Date

C. THE EFFECTIVENESS OF MOTHER-TO-MOTHER HELP: Research On The La Leche League International Program by Marian Tompson

"Why such a fuss about breastfeeding?" "All you have to do is put the baby to the breast…" "Who needs an organization for that?" You will hear remarks like that today, usually made by someone who ever tried to breastfeed a baby. As many mothers have discovered, when you live in a predominantly bottle-feeding culture where breastfeeding is looked upon as a kind of substitute for formula feeding and something that can be handled in much the same fashion, desire is not enough to insure success.

Breastfeeding for all its apparent simplicity, is not so much an instinctive activity as it is an art that normally would be passed down from mother to daughter. Breastfeeding is not just used to satisfy hunger and thirst. It is used for comfort, warmth, and security. It is not just a method of feeding. It is a very special relationship. And like all relationships its course is determined by a host of factors which include the mother's own concept of her role, the support or lack of it from her husband and others close to her, and the very individual temperament and needs of her baby. When we add to this the general ignorance of and uneasiness with breastfeeding found in our society as a whole, we can appreciate that breastfeeding is more than just putting the baby to the breast and letting nature take its course.

This was certainly my experience as well as that of a friend of mine when we started having babies during the fifties. Though I had three different physicians with my first three children, I found that the solution offered for any problem, whether it was sore nipples or a fussy baby, was to put the baby on a bottle. My friend and her physician-husband were chagrined to discover that despite his medical training they found themselves going the same route. Fortunately, we learned with each child and soon, as experienced nursing mothers, found our friends running to us for help with their nursing babies.

This was the beginning in 1956 of La Leche League, a non-profit, non-sectarian organization, devoted to providing encouragement, information, and support to the mother who wants to breastfeed her baby. We never expected to be more than a group of mothers meeting with our friends. It was our impression from all the bottle feeding going on that not many women were really interested. We soon found out how wrong we were and that many women were bottle feeding as a second choice and that as soon as they learned there were women skilled in the art, who were willing to help them, they were eager to give it a try. So by word of mouth in the beginning, and always in response to the need, La Leche League grew until, now over thirty-five years later, we have over 3,000 groups and 8,000 accredited certified Leaders helping mothers in 60 countries around the world.

During this time there have been close to a dozen independent studies done on the work of the League--some of them very comprehensive and others zeroing in on one aspect of League work.They all show clearly that information and support of the kind offered to mothers through La Leche League is highly related to the outcome of breastfeeding. La Leche League members breastfeed their children longer and wean them more gradually. Ladas (6), in her study of 1,100 primiparas found that mothers receiving support from the League nursed their

babies an average of nine to twelve months while unaffiliated mothers nursed three to six months. Knalf and Marshall (5), in a four-year study of League members, discovered that 85% of League members nursed their babies for over nine months, while only 20% of unaffiliated mothers nursed their babies that long. Gerard (3), in measuring the effect of different kinds of help given to new mothers, took two groups of mothers, one given personal help and instruction by Mrs. Gerard while they were in the hospital; the other group were women who attended La Leche League meetings. These groups were compared with a control group of 300 women who were not given any particular kind of help postpartum. At the end of three months it was discovered that of the last group 32% were nursing, of the mothers getting personal help from Mrs. Gerard 62% were nursing, and in the La Leche League group 93% were breastfeeding. In Wemmer's study (9) of factors affecting successful lactation she found that successful breastfeeders had significantly more knowledge and that La Leche League members scored the highest. League members introduced solids into the diet later and were more likely to wean directly from the breast to a cup instead of a bottle. They showed less concern with feeding schedules and instead responded to the baby's expressed needs. Knafl found that 96% of League members introduced solid foods between four and six months of age. One effect of delaying solids was the firm establishment of the lactation process which enabled mothers to nurse their babies as long as they desired. Unaffiliated mothers, on the other hand, frequently mentioned problems with inadequate milk supplies after they began feeding solids, usually during the first eight weeks of life. Wemmer found that unsuccessful breastfeeders started solids before two months and La Leche League members at five and a half months.

It was shown that membership in the League **increased mother's feelings of competence and self-determination.** Members were better able to deal with hospital routines that might have a negative effect on breastfeeding. Indeed, the assurance that comes from belonging to a large organization with established principles and beliefs made the mothers feel less intimidated by the professional atmosphere. They found particular help in facing criticism from friends and relatives who could not understand why they were breastfeeding. All the respondents emphasized the importance of talking out feelings and problems with a sympathetic, supportive person who was having or had had some of the same problems. League Leaders were considered especially helpful because of their **careful personal and patient approach to each problem presented**. They **accepted the mother's feelings**, shared their own personal experiences and those of others, and **focused on the mother and child as unique individuals in a unique combination**. So I guess it isn't surprising that those interviewed agreed that they received help through the League which could be found no place else and which they felt was essential to their successful nursing experience.

Silverman and Murow (8), of Harvard Medical Schools Department of Psychiatry, after studying the League, suggest that the greatest pay-off for prevention of mental health emergencies may be in providing opportunities, as we do in the League, for new parents to learn how to assume their new roles. Opportunities to learn from professionals are very limited and the League, they think, helps people through complex critical transitions that come to all of us in the normal life cycle. They also found that group solidarity is important and that feelings of normalcy were reinforced. This goes along with Ladas' findings that

while information played an important role in the success a mother experienced while breastfeeding, information and support in the form of a group support has the greatest impact on the success factor. Hansell (4), postulated that the small group neighborhood setting in which this counseling occurs may increase the likelihood of its effectiveness.

Most of the information needed by a new mother is not medical. Anyway, mothers hesitate to bother their doctors, especially if it's outside of their calling hours. But they don't feel uncomfortable about calling another mother, so the League Leader is able to offer help at the moment that it is needed.

Most of today's nursing mother's worries are about the same things mothers have worried about during the past thirty years. The majority of phone calls received at our office from mothers who do not attend League meetings are about the fussy baby and frequent feedings. If a mother is nursing, the fussiness all too often becomes an indictment of her milk. Maybe her milk is too thin or too scanty, and how can she tell if the baby is getting enough? Is this why her baby is nursing every two hours or so instead of being on the four-hour schedule that was followed in the hospital? The next most frequent number of calls is about sore nipples. Also, mothers worry about that they are losing their milk, particularly once the initial engorgement subsides, and many mistake the loose unformed stool of the totally breastfed baby for diarrhea. We are being contacted by an increasing number of women who are trying to bring their milk in because of problems with formula feeding or because of a desire to experience some of the closeness of breastfeeding with an adopted baby.

While examining how the League works to help mothers, I do not mean to belittle the importance of the information and help mothers receive from their physicians and nurses. The influence of the medical professional is substantial. Mothers look to their doctors and to the nurses in the hospital for guidance. So before I close I will take this opportunity to discuss briefly a number of ways, suggested by the mothers themselves, how doctors and nurses could be helpful.

Talk to the mother before she has her baby about how she is going to feed that baby. **Give her enough information so that she can make an informed decision**. Recommend reading material, you might give her or lend her a copy of *The Womanly Art of Breastfeeding*. The small cost of a book is more than offset by the number of problems and worries it prevents.

I would strongly suggest she be put in touch with La Leche League so she would be sure to be in contact with at least one other breastfeeding mother through meetings, or telephone calls, or even correspondence.

If she is not sure whether or not she wants to breastfeed you might suggest that she give it a try for a few weeks. As Samuel Fomon said at our Physicians' Seminar, "Even one day of breastfeeding is better for both mother and baby than no breastfeeding at all." One pediatrician points out during his prenatal visits, "Breastfeeding is a very special relationship you might be sorry you missed." We have found this to be all too sadly true while talking with mothers.

If you have few breastfeeding patients in your practice you might like to color code each file folder. That way you would be reminded, at a glance, that this is a breastfeeding mother, so

you could ask her how everything is going with the nursing and establish good lines of communication which will be especially valuable when and if problems arise or if you have to prescribe medication for the mother.

Now once she's had her baby and is in the hospital it would be ideal if all the personnel were favorably disposed toward, if not knowledgeable, about breastfeeding, and if not knowledgeable, would suppress any urge to give advice. Simple statements like "Isn't it wonderful that you're breastfeeding" or "your baby is certainly lucky" can go a long way towards helping her through difficult times. She should be helped to find a comfortable position for breastfeeding so that she can relax and her milk will flow more easily. And this position will vary with each nursing couple.

Attendants should be sensitive to her feelings about nursing in front of people she doesn't know. It's not just the embarrassment a mother might feel about baring her breast in front of strangers, but also the pressure to perform and prove she can do it. This last situation is often mentioned by mothers of premature infants, who find themselves having to nurse their tiny infants under very trying circumstances.

The breastfeeding mother should **understand that it is the baby's sucking which determines the amount of milk she will have.** She should know what she can do to relieve engorgement when her milk comes in. She should understand how supplementary bottles not only interfere with milk production but might well mean the end of breastfeeding. Whether or not the hospital does have a positive program of support for the nursing mother does make a difference. In Meyer's (7), 1966 study it was found that in hospitals where such efforts were made, almost twice as many women left the hospital breastfeeding. A Chicago-area hospital set aside one wing, for breastfeeding mothers, with the idea that the more experienced breastfeeding mothers would provide support for the inexperienced mothers. Since babies could not be brought out on the floor for feedings on demand during visiting hours, a nursing mothers' lounge was set aside as a place mothers could feed their babies if it was needed even during visiting hours.

The mother is in the hospital only a short time, and we would hope that before she leaves **she would also be given some advice on what to expect when she gets home and where to go for continuing help**. At least for another generation, breastfeeding mothers living in a predominantly bottle-feeding culture are going to need a lot of extra help.

At this point at least 54% of mothers in the United States start our breastfeeding their babies. This is more than double the number nursing twenty years ago. There is growing interest among physicians; the American Academy of Pediatrics recommends that physicians encourage breastfeeding among mothers. I think we are going to see an even greater percentage of mothers eager to give their babies the very best start. **It is important we keep in mind that it is one thing to motivate or encourage a mother to breastfeed and quite another to make sure she has the kind of help she needs to succeed. If we could do the first, we also have the responsibility to follow through with the second.**

Help is available from La Leche League and others. We offer our help in putting you in touch with any resources you might need to insure that these mothers get the help they need to enjoy breastfeeding their babies.

References:

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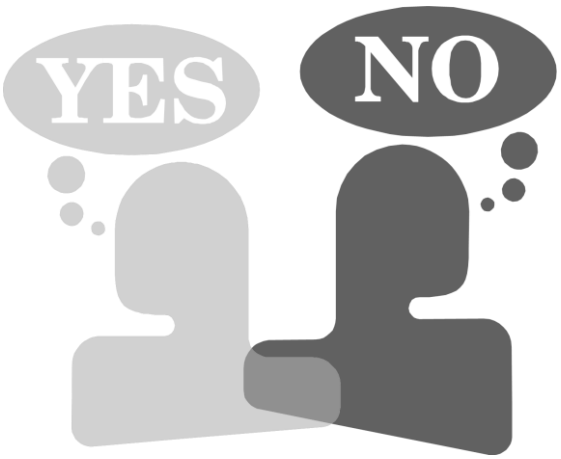
Marian Tompson, mother of seven children, is a founder of La Leche League International and was its president from 1956-1980. Her other activities include membership on the Family Committee of the Illinois Commission on the Status of Women and the Board of Directors of tile North American Society of Psychosomatic obstetrics and Gynecology (NASPOG). This address was presented at the North American Conference of NASPOG, April 10, 1976, Chicago IL. It is reprinted with permission from Birth Fam J, Vol. 3, no. 44 (winter 1976-77).

February 1977 No. 138

Communication Skill for Peer Counselor



Module 2: Communication Skills for Peer Counselor

Objectives: Participant will be able to:

- List three components of effective breastfeeding help
- List two dangers of giving advice
- Describe the facilitator's role
- Identify two important things to remember when helping mothers
- Identify at least two telephone counseling tips
- List at least two communication hints when working with interpreter

A. Giving Effective Breastfeeding Help

B. Dangers Of Giving Advice

C. Counseling Situations Encountered By Peer Counselors

D. Communicating with the Health Care Professionals

E. Telephone Counseling

F. Guidelines for Working with Interpreter

Module 2 – Communication Skills for Peer Counselor

A. Giving Effective Breastfeeding Help

1. Helping mothers with breastfeeding goes far beyond giving information. Without effective communication and counseling skills, all of your knowledge and wisdom may fall on deaf ears. Mothers respond best to a person who has a warm and caring attitude and who shows deep and genuine concern and empathy.
2. Active Listening : is a counseling technique that you, a Malaysian Breastfeeding Peer Counselor, will be using.
   a. it involves communicating concern and empathy without prying or invading the mother's privacy.
   b. helps us to better understand and help mothers.
   c. helps us build connection with mother. When a mother knows you are really listening to her, she will feel cared for and important and will feel comfortable with sharing information with you, which will make it easier to effectively help her.
   d. helps you discover what each mother needs most from you - information, suggestions and ideas, or reassurance and encouragement. Sometimes all she will need is someone to tell her, "You're okay" or "That sounds normal."
   e. Active listening is a skill one needs to practice. With practice, active listening will become second nature to you. You will be able to use the technique without having to concentrate on doing it.

      NOTE : Active Listening is different from the “Social Listening” which we practice when we speak with friends.
3. Best Start 3-Step Counseling Strategy : focuses on three important principles of active listening that help you quickly determine a mother’s concerns so you can target information that will be most helpful to her. The 3 steps are :
   a. Asking open ended questions
   b. Affirming her feelings
   c. Educating her

      NOTE : See Handout #1 for further explanation.
4. Adult learning approach : a mother has more control over her care when peer counselors use an adult learning approach during counseling and discussion.
   a. this approach is one of active learning rather than passively being taught; peer counselor serves as a facilitator rather than a teacher.
   b. Simply telling a mother what to do is not as effective as including the mother in the learning process.
   c. Learning is most effective when mother not only listens to verbal instruction, but also sees a demonstration / visual aid and practices doing them.

A Special Survey Research Project by the Audio Visual Association reports that adults retain:

10% of what they **READ**
20% of what they **HEAR**
30% of what they **SEE**
50% of what they **SEE & HEAR**
80 % of what they **SAY**
90% of what they **SAY & DO**

5. Giving evidence based information :
   a. Give in small pieces, keep it simple.
   b. Get feedback; either verbal or bodily response.
   c. On phone, check for voice tone and pauses.
   d. Offering a couple of options may help the mother find a solution that will fit her lifestyle.
   e. Ask mother to restate information you gave her, as she understands it, for your clarification.
   f. Write down or have mother write down. Or send lengthy information in writing.
   g. Recommend a book, reprint or information sheet.
6. Concluding the discussion : ask the mother what she thinks of the suggestion, for example:
   - *"Which of these ideas might work for you ?"*
   - *"What was most helpful for you?"*
7. Mother's self esteem :
   a. Leave the mother feeling good about herself.
   b. Any mother with a living child is doing something correctly. Look for things she is doing well. Be specific and genuine.
      - *"It takes a lot of patience / courage / persistence to ....."*
      - *"I see you care a lot about ...."*
      - *"You've come up with some positive solutions yourself..."*
8. The ultimate goal of each individual counseling contact is increased satisfaction for the mother.
   a. Increased self awareness and understanding in turn will lead to the mother's personal growth.
   b. This enables her to take responsibility for her situation and to be self sufficient.

FACIAL EXPRESSIONS

Adapted from: http://smg.media.mit.edu/People/Judith/Thesis/CityAndBody.frame.html

FEELING WORDS LIST

Mostly up			Mostly down		
able	expressive	relieved	abandoned	drained	mean
accepted	fair	romantic	abused	dumb	melancholy
adequate	faithful	responsible	afraid	edgy	miserable
admired	fantastic	safe	aggravated	embarrassed	mistreated
affectionate	forgiving	satisfied	agitated	exhausted	misused
agreeable	free	secure	alienated	empty	mixed up
amused	friendly	seductive	alone	enraged	mournful
appreciative	frisky	sensitive	angry	envious	neglected
aroused	full	smug	annoyed	fat	nervous
aware	funny	stimulated	anxious	fearful	obligated
big-hearted	generous	strong	apologetic	flighty	painful
bouncy	genuine	super	apprehensive	foolish	paranoid
brave	giggly	superior	aroused	forgotten	perturbed
brotherly	giving	supported	baffled	frightened	pessimistic
bubbly	glad	sure	betrayed	frustrated	pressured
buoyant	glorious	sweet	battered	furious	pushed
calm	good	sympathetic	bitter	gloomy	resentful
capable	gratified	serene	bored	glum	rushed
cared for	great	sexy	cautious	grave	sad
carefree	happy	silly	cheapened	grumpy	scared
caring	helpful	tall	closed in	guilty	shy
charming	intense	tender	cold	harsh	sick
cheerful	concern	thrilled	competitive	hateful	sorry
comfortable	jolly	tickled	concerned	helpless	spaced out
compassion	joyful	tolerant	cornered	homeless	stranded
competent	joyous	tough	confused	hopeless	stubborn
competitive	kind	triumphant	cramped	hostile	stupid
compliment	kindhearted	trusted	crazy	humiliated	tearful
confident	liberated	understand	critical	hurt	tense
considerate	loveable	up	crushed	hysterical	threatened
content	loving	warm	cut-off	ignored	tied down
cooperative	magical	well	defeated	ill	trapped
coy	mellow	within	defensive	impotent	trivial
courteous	mischievous	wise	deflated	inadequate	troubled
crazy	neighborly	wonderful	degraded	impatient	uncertain
creative	nice	worthy	dejected	inferior	uneasy
cute	nostalgic	worthwhile	dependent	ineffective	unhappy
dedicated	open	zestful	depressed	inhibited	unloved
definite	optimistic	zany	deprived	insecure	upset
dreamy	pleasant		deserted	irritated	used
dynamic	pleased		devastated	isolated	useless
easy-going	powerful		disappointed	jealous	violent
ecstatic	pretty		discouraged	lazy	vulnerable
effective	protected		disgraced	left out	withdrawn
elated	proud		disgusted	lonely	worried
empathetic	quiet		dissatisfied	lost	worthless
encouraged	reasonable		disturbed	low	wounded
energetic	receptive		distresses	mad	
excited	reliable		down	manipulated	

B. Dangers of Giving Advice :

1. Peer counseling does not mean giving advice !
2. Many people resist taking advice. They may be skeptical that your advice may not work or they just may not want to do what someone else tells them to do.
3. Advice does not help your client solve her own problems.
4. If you give advice to a mother and she follows it and succeeds, she may become dependent upon you.
5. If you give advice to a mother and she follows it and fails, she may blame you.
6. If you give advice to a mother and she decides not to follow it and succeeds, you've lost your credibility.
7. If you give advice to a mother and she decides not to follow it and fails, she will see herself as incapable and powerless and you as unapproachable.

PEER COUNSELOR GOALS

1. To be a safe, non-judgmental, informative and helpful listener to whom mothers can talk about breastfeeding
2. To help a mother clarify and understand her situation and to assist her to find her own solution to her situation
3. To offer information and assist the mother in discovering options which might be helpful in her situation
4. To empower others and to show them the gift of themselves. To help them see themselves as capable people and boost their self-esteem

C. Counseling Situations Encountered by Peer Counselors

1. Peer Counselors encourage and support both pregnant women and breastfeeding mothers in their journey through parenthood, helping them gain confidence in their ability to breastfeed.
2. Breastfeeding peer support can be provided in many different ways. Some examples include :
   a. One-on-one support, which can be in person, over the telephone, by email or text.
   b. Group support, which can be a regular scheduled drop-in gatherings, planned meetings, antenatal or parenting class.
3. Breastfeeding support group meetings can be an integral part of supporting breastfeeding mothers.
   a. Women are often drawn to other women with whom they share life experiences, when those experiences relate to parenting.
   b. When new mothers have someone who can understand and identify with their experience, they can better enjoy and cope with parenthood. Thus, support groups for pregnant and/or breastfeeding mothers offer a unique opportunity for learning.
   c. Create a safe environment for learning. Adults, like children, learn best when they feel safe, not judged and comfortable. Use the adult learning approach.
   d. Set the standards or expectation for the group includes modeling the behavior you would like to see in the participants.
   e. Choose a format : conversation style format or round-robin format.
   f. Visual aid/or discussion aids – not necessary, but sometimes nice.
   g. Group facilitator's role :
      - Open and close the meeting
      - Stimulate discussion and encourage participation.
      - Offer information pertinent to participants needs and/or topic of discussion and/or to correct misinformation.
      - Guide the discussion and keep participants on topic.
      - Keep records.

THE WISE OLD OWL,
The wise old owl sat in an oak,
the more he heard, the less he spoke,
the less he spoke, the more he heard,
why aren't we all like that wise old bird?

TWO VERY IMPORTANT THINGS TO KEEP IN MIND AS YOU HELP MOTHERS

CONFIDENTIALITY

1. Any information a mother shares with you is confidential and is not to be shared with others.
2. If you need to consult with someone else regarding the mother's problem, do not use the mother's name.

KNOW YOUR LIMITATIONS

1. A MBfPC is not a health-care provider. **Do not give medical advice!**
2. A MBfPC should always feel free to say, "I need to check on that. Let me call you back."
3. Some ideas to help you as you listen to mothers who have medical concerns:
   - listen and ask open-ended questions.
   - avoid giving your personal opinion.
   - give the mother information from the sources you have available .
   - encourage the mother to talk with her doctor to work on a solution together.
   - refer the mother to lactation specialists, health care providers and other services when necessary.
   - inform the mother of her rights as a patient .
   - be an advocate for her baby.
   - remember that your role is **not** to tell her what to do, rather, it is to give her breastfeeding information, encouragement and support.

D. Communicating With Health-Care Professionals

1. Remain calm. It does not help to become angry at the health-care professional or to breakdown in tears.
2. Take a supportive person with you. Two heads are better than one, especially during stressful times. It can be easier to be brave if a partner is there.
3. Use as much eye contact as is comfortable. Speak slowly and with a low voice.
4. Speak as an individual rather than as a member of an organization or client of an agency or clinic. Explore various "I" statements to use such as: "I feel strongly about breastfeeding and want to find treatment options which will allow me to continue nursing."
5. State your needs in a positive way. Instead of "I think that formula is bad for babies", try "Human milk is the best food for babies."
6. If you are not a physician or trained health-care professional, don't compete with a physician on medical issues.
7. Ask for complete explanations of the treatment the health-care professional recommends and then repeat it back in your own words. Ask the health-care professional to please use language which you can understand.
8. Shift the focus to parental decision-making. Say, "You are asking my permission to...”
9. Use open-ended questions whenever possible. These questions do not limit the health-care professional to "yes" or "no" answers, but elicit complete explanations. Many open-ended questions begin with or contain the words who, what, how or describe.
10. Many health-care professionals have their own personal opinions about breastfeeding.Their recommendations may reflect their personal opinions rather than medical fact. One may want to ask if the health-care professional is offering facts or an opinion.
11. Ask the health-care professional if their recommendation is based on this particular baby and if this is what he or she does with all babies. It is important that treatment be prescribed individually and be geared to the child's needs.
12. Offer documentation to support your views. You may want to say, "I have references which discuss treatment which does not interrupt breastfeeding. I would like you to read them so that we can find a solution which will keep my baby breastfeeding."

Telephone Counseling Suggestions

- Remember, you cannot see the mother or her baby
- Always be supportive and positive
- Speak clearly
- Always give your name at the start of the call
- Ask if you called at a good time
- Ask the age of her baby
- Put the mother's needs before your own
- Get as many details as possible
- Suggest changes, don't give orders
- Never say "You should…"
- When in doubt, have the mother go to a baby friendly clinic / hospital or see a health care provider
- If the mother calls you at a bad time, politely ask for her name, phone number and let her know when you will call her back. Remember to call her back! You may also inform the mother to you call you back at a specified time which is convenient for both parties.
- Have a box of toys for your toddler or older child to play with while you are on the phone
- Take notes while talking to mothers
- Before ending the call, have her repeat suggestions you made
- Call the mother in a few days to see how things are going
- Refer mothers to needed resources

Telephone Role Play *(Inappropriate)*

PC : *(on the phone while chewing gum)*
Hi, Cindy! I know it's dinner time right now, but this is the only chance I've had all day to return your call. I know I told you I would get back to you a couple of days ago, but man - my life has been so busy and messed-up you wouldn't believe it.

My husband just lost his job and has been hanging around all day expecting me to be at his beckon call. I feel like I'm nothing more than a slave these days. You know what I mean?!? It's do this, do that!

And my 2 year-old is driving me crazy. He is constantly throwing temper tantrums. I don't think I can make anyone happy. I wish my husband would just take my 2 year-old to a park and give me a moments peace so that I could get my work done. Now that he lost his job, I need to work.

I have at least five other calls I need to make yet tonight. Now, what was the problem you were having?

Mother : My nipples have been sore and bleeding. It hurts when I try to breastfeed.

PC : Well, you know if you positioned the baby correctly your nipples wouldn't be sore. So, how are you positioning your baby?

Mother : I have my baby tummy to tummy and I wait until she opens her mouth wide before I put her on just like you said.

PC : If that is what you are doing you wouldn't have sore nipples. I don't think I can help you. You need to call the lactation specialist. Her number is 555-1212.

Telephone Role Play *(Appropriate)*

PC : Hi, Cindy. This is Laura, your peer counselor from WIC. I realize it's close to dinner time. Is this a good time for you to talk or would you like me to call back at another time?

Mother : No, this is a good time for me to talk; the baby is sleeping and my mother is bringing dinner over in a little while.

PC : I'm glad we can talk now. So, when we talked yesterday you said your nipples were sore. How are you doing today?

Mother : My nipples are still sore and it hurts when I put her on.

PC : Could you tell me more about your nipples and the pain you're having?

Mother : Well it has gotten a little better, but my nipples are still red and sore and it hurts when she latches on. I'm doing everything we talked about. I'm holding her tummy to tummy and waiting until her mouth opens wide before I put her on. She just doesn't seem to want to stay latched. I'm not sure breastfeeding is working for me.

PC : So, you're not sure that breastfeeding is working?

Mother : Yes, I didn't think it would be this difficult in the beginning, but I really do want to breastfeed my daughter. I want to make this work.

PC : You sound very frustrated. Breastfeeding isn't always easy in the beginning. I can tell you are working very hard to make this work. Since your nipples are still sore and she appears to be having trouble staying latched, I think it might be helpful for you to see the lactation specialist. Would you like me to call her and have her contact you?

Mother : Yes, if you think she will be able to help me. I don't want to give Lindy formula. I know breastfeeding is better for her.

PC : I can tell that you want to do what's best for your daughter. Congratulations for continuing to breastfeed even though it has not been easy for you. I will give the lactation specialist a call right now.

Do you think you will be okay until she can see you tomorrow?

Mother : Yes, Lindy is able to breastfeed and she is gaining weight. It's just, well I wish it was easier and didn't hurt.

PC : Yes, I can relate to how you feel. Let me give you the lactation specialist's phone number in case she has trouble reaching you. Do you have a pen and paper?

Mother : Yes, I'm ready.

PC : Her number is 555-1212. Is there any other way I can help you?

Mother : No, I think I will be fine until tomorrow.

PC : If you need anything, please feel free to call me at 555-1313. Would you mind if I call and see how things are going in the next couple of days?

Mother : No, I would like you to call. Hopefully, I'll have good news for you.

PC : Yes, the lactation specialist can be very helpful. I will talk to you soon. Bye.

Mother : Bye. Thank you for your help.

PC `: You're welcome.

D. Guidelines For Working With An Interpreter

What You Can Do:

1. Speak directly to the client. For example: Do not say: "Ask her how she is feeling." Do say: "How have you been feeling?"
2. Look at the client while talking instead of looking at the interpreter.
3. Ask the interpreter to speak in the first person if they are not already doing so.
4. Refrain from talking to or asking questions of the interpreter. The interpreter is there only to facilitate communication, not to participate, give opinions or advice.
5. Provide examples during your conversation. There is an enormous amount of "Implicit" meaning in any language. By using examples, the meaning becomes clearer in the second language. For example:
   - OK: "Do you have any allergies to medicine?"
   - Better: "When you have taken pills from the doctor, have itchy areas appeared on your skin?"
   - OK: "Are your eyes itchy, nose runny? Does your head feel hot?"
   - Better: "What symptoms are you having?"
6. Speak at your normal rate, unless you are asked to slow down.
7. Thank the interpreter at the end of the appointment.

THE INTERPRETER IS SUPPOSED TO:

1. Interpret everything you say.
2. Interpret everything the client says.
3. Use the language and/or mode of communication preferred by the client.
4. Let you know if he/she needs you to talk more slowly.
5. Take responsibility for correcting an interpreting error.
6. Adhere to the Interpreter Code of Ethics.

THE INTERPRETER IS NOT SUPPOSED TO:

1. Participate in the conversation by adding his/her opinion or advice.
2. Talk aside with either party leaving the other party out of the conversation.
3. Discuss the interpreting situation with anyone. The rights of the client must be protected. The information imparted during the conversation is confidential.

COMMUNICATION HINTS:

1. Speak more slowly, rather than louder.
2. Remember that there are 3 people involved: you, the interpreter and the client. Don't forget to address the client with your body language.
3. Speak in the first person to the client. Do not reduce the client to a non-entity who is being talked about rather than being talked with.
4. Give the interpreter time to restructure information in his/her mind and present it in a culturally and linguistically appropriate manner.

5. Have patience. Do not expect a word-for-word translation. Sometimes long interpretations may be needed in another language to communicate a seemingly simple point in your language.
6. Understand that you may feel uncomfortable and possibly out of control when first communicating through an interpreter. If you feel uncomfortable, just think how much more uncomfortable the client must feel. Relax!
7. Plan extra time for conversing with a client who does not speak a language you speak.

Excerpts from Metropolitan-Indochinese Children and Adolescent Services, Chelsea, Massachusetts
For more information on interpreter services contact: Institut Terjemahan Malaysia

Breastfeeding : There Is No Substitute

Module 3. Breastfeeding: There is No Substitute

Objectives**:** Participant will be able to:

- List three immediate breastfeeding benefits for baby
- List two long term benefits for baby
- List two benefits for mother
- List two benefits for father and society

A. Benefits of Colostrum

B. Benefits of Mature milk

C. Physical benefits for baby

D. Emotional benefits for baby

E. Physical benefits for mother

F. Emotional benefits for mother

G. Other benefits

Module 3 – Breastfeeding : There is No Substitute

A. Benefits of Colostrum

1. Concentrated immunities to protect baby from disease.
2. Contains natural laxative to clear baby's intestines and decrease chances for high bilirubin levels.
3. Contains enzymes which digest its own fat and protein, which help digestion in immature gut of the baby in early days.
4. Promote development of guts and prepares the gut for digestion. Contains growth hormone which promotes the proliferation of the microvilli.
5. High contents of anti-infective substances to protect newborn.

B. Benefits of Mature milk

1. Perfect for baby to digest easily.
2. "White blood"-- full of living cells.
3. All nutrients in ideal amounts for human growth and development
    a. Perfect balance of proteins, carbohydrates, and fat.
    b. Perfect balance of vitamins and minerals; will not overburden baby's kidneys.
4. Perfect food for the brain
    a. High in lactose; mammals with most highly developed brains have milk highest in lactose.
    b. High in cholesterol and omega-3 fatty acids essential for brain and nerve development.
    c. Contains taurine, amino acid essential for brain development.
    d. Breastfed children found to have higher IQs.
5. Always the right temperature.
6. Does not cause constipation.
7. Takes on flavors that are in mother's diet and introduces baby to different tastes.
8. Contains immune factors that protect baby from disease
    a. Every time a baby nurses, she is immunized.
    b. Reduces meningitis, pneumonia, and infections.
    c. Exclusively breastfed babies during first three months of life are nine times less likely to be hospitalized with infections than formula fed infants the same age.
    d. Reduces gastrointestinal and respiratory illness while breastfeeding and continues for a time after breastfeeding has stopped.
    e. Reduces the incidence of acute otitis media (ear infections).
    f. Reduces chances of urinary tract infections.
9. Reduces risks or severity of allergies

10. Gives protection against certain chronic diseases and conditions
    a. Crohn's disease
    b. Ulcerative colitis
    c. Insulin dependent diabetes
    d. Childhood lymphomas and Hodgkin's disease
    e. Obesity
    f. Heart disease

C. Physical benefits for baby

1. Quick digestion of human milk insures frequent feeding, giving baby plenty of interaction and skin contact with mother. Skin is largest organ of the body and frequent stimulation enhances digestion and total development of baby.
2. Switching breasts to feed both sides allows eye coordination to develop evenly.
3. Muscle action needed to nurse the breast helps develop strong jaws and healthy teeth.

D. Emotional benefits for baby

1. Frequent feeding helps to socialize baby and form a strong bond with the mother.
2. Relationship of breastfeeding and mother meeting the baby's needs builds a sense of trust and safety from which the child will move to explore other relationships and the world.
3. It's fun for the baby.
4. Sucking provides a release from tension.

E. Physical benefits for mother

1. Continues the normal reproductive cycle.
2. Hormones produced during lactation cause the uterus to contract and return to its normal size more quickly; reduces post-partum bleeding; lochia ends sooner.
3. Delays the return of the mother's fertility.
4. Decreases mother's chances for pre and postmenopausal breast cancer, cervical and ovarian cancer; osteoporosis; urinary tract infections.
5. Easy to feed baby in bed; mother can get more rest.
6. Because breastfed babies are healthier, less time is lost in caring for sick child, missing work/school, going to and from doctor appointments.
7. Breastfeeding makes babies smell sweeter and pleasant to be around.

F. Emotional benefits for mother

1. Biologically, hormones of lactation help mother feel and respond in motherly way toward baby; can bring a sense of calm.
2. Helps a woman learn to mother and be sensitive to her baby's cues.
3. Builds her self-esteem and confidence in her abilities to nourish and nurture.
4. Relieves mother of worrying how baby will eat during unexpected circumstances or crisis
5. Cheap--lessens money worries.
6. It's fun and easy; allows mother time to enjoy her baby.
7. Less worry about paying for health services.

G. Other benefits

1. Environmentally sound practice; nothing to manufacture, buy, heat, wash, replace, throw away.
2. Provides a model of breastfeeding and healthy sexuality for children and others.
3. Easy to travel with baby without worry about feeding baby.

See also : WABA Activity Sheet 10 : Breastfeeding and Food Security.
https://www.waba.org.my/resources/activitysheet/acsh10.htm

ADVANTAGES OF BREASTFEEDING : A – Z

A – Helps **avoid allergies;** immediately **available; antibodies** are passed from mother to baby through her milk; nutrients are more easily **assimilated.**

B – Creates close **bonding** between mother and child; reduces risk of **breast** cancer; contributes to optimal **brain** development

C – Comforting for baby; convenient; changes as baby grows**;** no **constipation**; **colostrum** is the perfect first food

D – Digests more easily; cannot be **duplicated;** allows **delay** of solids; fewer **dental** problems (cavities and braces)

E – Easy, enjoyable; enhances relationship with your baby

F – Fulfilling; always **fresh**; gives you a **free**-hand for reading, etc; **fewer** health problems means a happier baby

G – Giving of yourself; a **great** way of meeting emotional and physical needs

H – Breastfed babies are **healthier;** babies are meant to have **human** milk

I – Inexpensive; immunity factors are only found in breast milk

J – Joyful experience; ready in a **jiffy**

K – Spend less time in the **kitchen** (mixing, washing, sterilizing, warming…)

L – Lots of living cells in breast milk – protects baby from infection, less spitting-up and stomach upsets

M – Delays the return of postpartum **menstruation;** something only **MOTHER** can do for her baby

N – Perfect balance of **nutrients; night** feedings are easier; **natural**

O – prevents **overfeeding;** less diaper **odor,** reduces the chance of **obesity** later in life

P – Prolactin helps you feel motherly; helps **prevent** serious health problems; **promotes** proper jaw, teeth and speech development, breast milk is **pure.**

Q – Quiet time together**,** best **quality** nutrition; practically unlimited **quantity**

R – Relaxing; less **rash; recommended** by World Health Organization, Malaysia's Ministry of Health & other international health organizations; completes the **reproductive** cycle - conception, pregnancy, birth, lactation

S – Satisfies all the **senses**; **superior** infant food; **saves** time; effort, money and resources

T – Always the right **temperature; travel** is easier**; time-tested** through the ages

U – Uniquely suited to each baby; contracts **uterus** helping to expel the placenta and control blood loss; **universality** of breastfeeding is a link with mothers all over the world

V – Especially **valuable** in special situations (prematurity, jaundice); taste of breast milk **varies** from skim to creamy during each feeding

W – Helps mother's **weight** loss by using extra calories; no need to **worry** about baby's food supply; encourages normal **weight** gain for baby; called "**white blood**" because of the live-giving properties

X – X-tra cuddling builds strong ties of love

Y – It's **yummy**, of course!

Z – These are only a few of the **zillions** of advantages to breastfeeding your baby!!!

Barriers That Confront Breastfeeding Mothers

Module 4. Barriers That Confront Breastfeeding Mothers

Objectives: Participant will be able to:

- Identify three external barriers to breastfeeding success and describe how to help a mother overcome them.
- Identify three personal barriers to breastfeeding success and describe how to help a mother overcome them.
- Relate four breastfeeding myths and explain the accurate information for each.

A. Barriers From The World Around The Breastfeeding Mother

B. Personal Barriers That Come From The Mothers Themselves

C. Breastfeeding Myths

Module 4. – Barriers That Confront Breastfeeding Mothers.

A. Barriers From The World Around The Breastfeeding Mother

1. Feeding-bottles
   a. Feeding-bottles are a symbol of upward mobility (moving from one social level to a higher one.)
   b. Feeding-bottles are seen as “more modern”.
2. Formula milk
   a. The use of the word "formula" perpetuates the idea that science has created something better than mother's milk; a more accurate term for this manufactured substance is "artificial baby milk".
   b. Health care professionals often do not educate women about the differences between formula milk and human milk; mothers are led to believe that there is no difference or that the differences are insignificant.
3. Access to formula milk for free
   a. Any health care agency that hands out formula milk for free also gives tacit recommendation for its use
   b. This fosters the attitude of "why should I put myself out, why should I nurse my baby when I can get this formula milk for free?"
   c. Only the cost of the supplemental formula milk is calculated as free; the cost of extra time and money spent caring for a sick baby, taking him to the doctor, buying medications, time lost from work or school, or long term health problems are overlooked; mothers are not encouraged to look at the total picture
4. Use of formula milk to solve problems the mother might be having with breastfeeding
   a. Rather than seek a solution to a problem that maintains the breastfeeding relationship, many health care providers automatically turn to formula milk.
   b. Breastfeeding is seen as a problem to women who are having a difficult time with the transition to motherhood; formula milk is seen as the solution.
5. Lack of positive role models from all cultural and economic groups and information that is culturally and economically sensitive
   a. Not many written materials available in local language.
   b. Successful breastfeeding mothers are often portrayed by mothers working in office / executive setting whom are financially stable to purchase breastfeeding gadgets.
6. Media focus and image
   a. Media coverage on breastfeeding is lacking.
   b. Media coverage that is given to breastfeeding is often negative and focuses on contaminants, perceived inconvenience of breastfeeding, the erroneous assumption that breastfeeding will lead to needy, clingy, and dependent babies, toddlers, and

children, or that mothers will automatically need to stop breastfeeding in the event of a disaster, "stressful" situation or returning to work/school.

c. Marketing of baby products and dolls usually includes a feeding-bottle.

7. Breast perceived as a sex symbol.

8. Lack of support and protection for breastfeeding within the social and economic structure of culture and society
   a. Lack of mother-baby friendly workplaces; many mothers either quit or do not begin breastfeeding because they will be returning to work or school.
   b. Workplaces that do not give women the flexibility they need to express and store their milk make continued breastfeeding very difficult.
   c. Lack of adequate maternity or family leave; it is not unusual for a mother to return to work at two weeks postpartum; breastfeeding is not 100% established nor is the mother adequately recovered from childbirth.
   d. Lack of support from the family; families are often spread far apart and help is not available.
   e. Family members express negative things to the pregnant or breastfeeding mother which imply that bottle feeding is better or that the mother is inadequate to breastfeed.
   f. If the father of the baby is not supportive of breastfeeding, the mother is less likely to breastfeed.

9. Disease and contaminants in human milk
   a. Based on current policy in Malaysia (Director General of Health Malaysia Directive No. 5/2002) HIV positive women are not allowed to breastfeed.
   b. There are hospitals that have policies on recreational drugs and users of those which often preclude the mother from breastfeeding.
   c. Debate continues over whether the many advantages of breastfeeding outweigh the possible dangers from disease or drugs.

10. Lack of knowledge about or inadequate promotion, support, and protection of breastfeeding by health care providers (HCP)
    a. Many HCPs believe that artificial baby milk is just as good as human milk.
    b. Many HCPs believe that the benefits of breastfeeding are short lived.
    c. HCPs who want to be in control of his/her clients' care.
    d. Lack of accurate and consistent information within health-care facilities.
    e. Health care philosophies which see the mother and baby as separate patients/individuals rather than as a couple.
    f. Lack of baby-friendly hospitals among private medical centres/clinics.
    g. Steps in baby-friendly hospitals are inadequately implemented.

11. Previous or current abuse: sexual, physical, or emotional.

12. Anomalies of the breast
    a. Genetic
    b. Breast surgery - the question of whether a woman can breastfeed when she has had previous breast surgery is answered by finding out which parts of the breast were involved. If her milk ducts and major nerves were not cut or damaged, her milk supply may not be affected. If her incisions are located exclusively in the fold under her breast, chances are no milk ducts or nerves were cut. If her incisions are near the armpits and the surgeon took care not to damage any major nerves, breastfeeding will probably not be affected. Incisions around the areola almost always indicate some cut milk ducts and possible nerve damage.

B. Personal barriers that come from the mothers themselves

1. Fear of failure and lack of confidence within the mother.
2. Embarrassment.
3. Loss of freedom; confusion surrounding the role of the mother and the role of breastfeeding in mothering; mothers and their milk are easily separated, but the mother still needs to be responsible for her baby whether she breastfeeds or not.
4. Concerns about dietary and health practices
    a. Many mothers believe that a "perfect diet" is required to breastfeed and some believe that they couldn't eat like that or perhaps afford to eat like that.
    b. Addictive lifestyles may require changes that many women don't believe they can or are unwilling to make.
    c. A belief that smoking, drinking any alcohol, or having any stress in a mother's life will make it impossible for her to breastfeed.
    d. A desire to take the kind of birth control pills which are contraindicated for breastfeeding mothers.
5. Fear of pain; may be after-pains or nipple pain.
6. Fear of losing round, shapely breasts (pregnancy changes the shape of a woman's breasts)
7. Lack of information .

C. Breastfeeding Myths - Falsehoods that are commonly accepted as true

	MYTH vs FACT
MYTH #1	Some formulas are better than breast milk because they have added vitamins and iron **FACTS** • *breast milk has all the natural vitamins and minerals that babies need.* • *researchers are still making discoveries* • *some of added vitamins and iron in formula may be harmful to baby* • *milk is species specific- whale for blubber and buoyancy, deer for running and survival*
MYTH #2	Breastfed babies should be fed on the same schedule as bottle-fed babies **FACTS** • *breast milk is readily digested* • *breastfeeding meets babies' emotional needs as well as nutritional needs*
MYTH #3	Some mothers may not be able to produce enough milk for their babies. **FACTS** • *this is true, although rare* • *the key is frequent nursing* • *breast milk is always available*
MYTH #4	It is possible for a baby to be allergic to his mother's milk. **FACTS** • *it is usually something the mother ate* • *it could also be outside allergens*
MYTH #5	If a mother is ill with a cold or the flu, she should quit breastfeeding. **FACTS** • *bottle-fed babies have twice as many infections* • *baby is already exposed to germs. So by the time the mother is sick, her body is making antibodies against the virus which go through her milk* • *risk engorgement if stop breastfeeding*
MYTH #6	It is not helpful for a baby to nurse before the "real milk" comes in. **FACTS:** • *benefits of colostrum,* • *nursing right away helps milk come in* • *nursing contracts uterus, helps mom bleed less after birth.*
MYTH #7	Breast milk looks just like formula. **FACT:** • *breast milk will look different at different times (thin, bluish, thick, yellowish)*

MYTH #8	Breastfeeding ruins a woman's figure**.** **FACTS:** • *causes uterus to contract, helps uterus shrink back to its normal size* • *muscle tone returns sooner* • *lose weight faster* • *changes in breasts*
MYTH #9	Nursing a baby during a menstrual period is unwise. **FACT:** • *hormones are natural*
MYTH #10	Small-breasted women cannot produce enough milk to feed a large baby. **FACT:** • *breast size does not affect milk supply*
MYTH #11	Babies should get used to a bottle as soon as possible. **FACTS:** • *nipple confusion can interfere breastfeeding and milk supply*
MYTH #12	It is okay to take any kind of birth control pills while breastfeeding. **FACTS:** • *combined oral contraceptives decrease quantity and quality of milk* • *progesterone only "mini pill" has not been shown to be harmful if use when baby is past 3 months, discuss with doctor*
MYTH #13	Mothers need to drink milk to make milk. **FACTS*:*** • *mammals (eg cows) don't drink milk* • *mothers need to drink to thirst*
MYTH #14	Nursing mothers need to be on a special diet. **FACTS:** • *need more protein, extra calories* • *aim for a balanced diet*
MYTH #15	Even breastfed babies need water in the early days and when it is hot. **FACTS:** • *no nutritional value* • *could cause nipple confusion* • *breast milk already contains water*
MYTH #16	A mother can never have too much milk. **FACTS:** • *engorgement common in early days* • *supply will eventually match demand*

MYTH #17	Nipples should be cleansed with soap and water before every feeding. **FACTS:** • *avoid soap* • *not necessary to cleanse nipple area*
MYTH #18	All babies will wake up to nurse when hungry enough. **FACTS:** • *wake baby at least every 3 hours in 1st week* • *jaundiced babies and small babies tend to be sleepy, need to wake them up and feed 2-3 hourly in the early weeks.*
MYTH #19	A mother younger than 16 years old cannot nurse. **FACTS:** • *milk production is part of pregnancy* • *if a girl is able to conceive and give birth, she is also able to breastfeed the baby*
MYTH #20	If a mother quits nursing**,** then changes her mind**,** she cannot go back. **FACTS:** • *relactation is possible* • *milk remains in breasts for several months*
MYTH #21	A mother should never breastfeed for more than 5 to 10 minutes on each side at a feeding. **FACTS:** • *Fast vs. slow eater* • *Nutritional vs. emotional nursing* • *sucking needs differ* • *baby may not get enough hind milk*
MYTH #22	Breastfed babies do not need to be burped. **FACTS:** • *some gulp air or are spitters* • *gentle patting or rubbing enough*
MYTH #23	If a mother picks up her baby every time he cries, she will spoil the baby. **FACTS:** • *meeting baby's emotional needs* • *respond to a baby's cry is provides baby with a sense of security and trust.*
MYTH #24	If a mother gets sore nipples, she should not nurse as often. **FACTS:** • *important to nurse often* • *feed on the least sore side first* • *check latch-on*

MYTH #25	If a baby is gaining slowly, the mother probably does not have enough milk. **FACTS:** • *refer to growth chart for breastfeeding babies* • *check baby's latch. Poor latch = ineffective milk transfer.* • *does baby have 6-8 wet diapers, 2-5 stools?* • *is baby nursing on demand?* • *is baby gaining 150 – 240 g a week?*
MYTH #26	Fat babies are healthier than thin ones. **FACTS:** • *babies can gain too much weight on formula or solid foods* • *healthy breastfed babies come in all sizes*
MYTH #27	A breastfed baby's bowel movements look just like a bottle-fed baby's. **FACTS:** • *breastfed babies have very loose bowel movements* • *sometimes will be just spot on diaper* • *can range in color from greenish to yellowish*
MYTH #28	A mother's social life is very limited if she breastfeeds her baby. **FACTS:** • *mother can take baby along* • *nurse before leaving* • *look at time in relationship to whole life*
MYTH #29	Starting a baby on cereal is the best way to get him to sleep through the night **FACTS:** • *normal for babies to wake at night* • *allergy possibility* • *substitution of inferior food* • *can nurse baby in bed to get sleep*
MYTH #30	If a mother needs to return to work, she should wean her baby. **FACTS:** • *can express and store for baby* • *breastfeeding helps bonding when mother and baby must be separated*
MYTH #31	Mother's milk is "hot" and not good when the mother becomes angry. **FACTS:** • *Milk Ejection Reflex (MER) may be delayed during maternal stress.* • *the mother's milk is the perfect food for the baby even if she is upset* • *some mothers may continue to believe the milk is "hot" and can be encouraged to express a small amount of milk, discard that "hot" milk and then nurse the baby*
MYTH #32	If a mother becomes chilled then her breast milk is bad. **FACTS:** • *bathing, having the back uncovered or drinking cold beverages does not affect the milk*

MYTH #33	The mother must eat certain foods in order to produce breast milk, such as: beer, dry cheese, chocolate. And she must avoid certain foods: eggs, beans, meat, avocados, onions, chillies **FACTS:** • *milk production is infant driven. Sucking produces milk.* • *nursing mothers should eat a balanced diet with adequate protein and calories.*
MYTH #34	It is easy to both breastfeed and bottle feed a newborn. **FACTS:** • *when bottles replace breastfeeding, engorgement is very likely* • *nipple confusion is common* • *bottles in the early weeks can interfere with establishing the milk supply* • *combination feeding (breast and bottle) works better after breastfeeding is well established (4 to 6 weeks, at least)*
MYTH #35	Breastfeeding and working outside the home is not possible. **FACTS:** • *many mothers combine employment and breastfeeding* • *things mothers can do:* – *delay return to work as long as possible, ideally at least 3 months* – *choose flexible work schedules* – *breastfeed at lunch breaks* – *pump once each day for two weeks prior to returning to work* – *pump at work and on days off* – *choose breastfeeding supportive child care situations*

Breast Anatomy, Hormones of Lactation & Human Milk Composition

Module 5. Breast Anatomy, Hormones of Lactation and Human Milk Composition

Objectives: Participant will be able to:

- Describe where milk is made in the breast
- List two hormones of lactation and what effect they have on milk ejection
- Discuss how milk is transferred from the breast into the baby's mouth
- List three important factors for lactational amenorrhea method to be effective.
- List three factors in human milk that are not present in formula

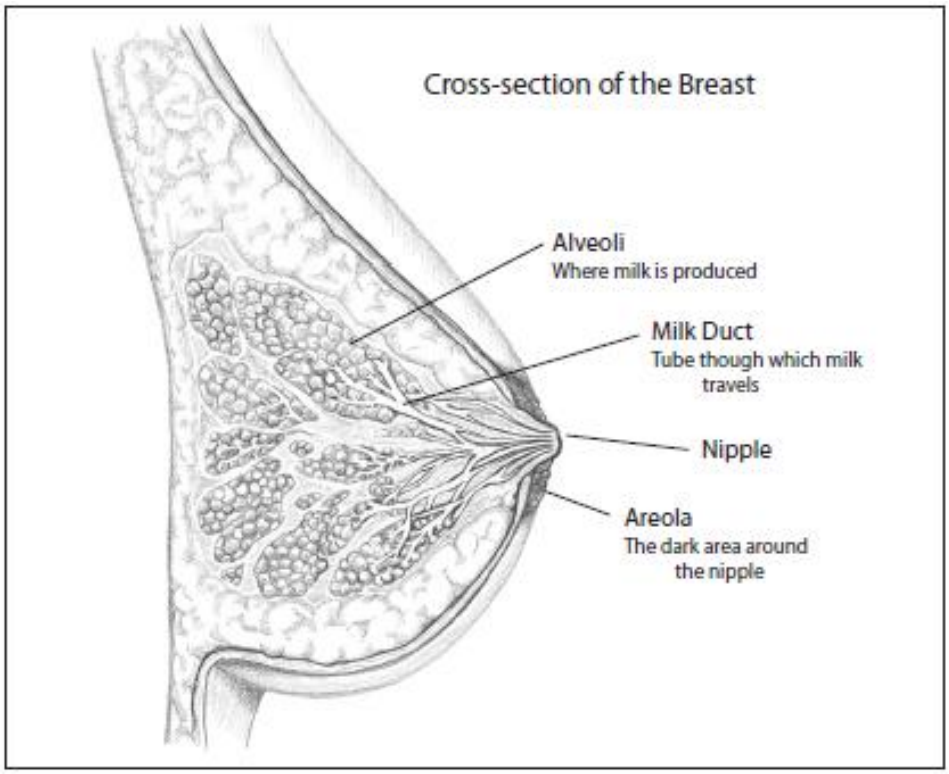
A. Breast Anatomy - Parts of the breast
B. Hormones of Lactation
C. Process of Lactation
D. Breastfeeding Hormones & Fertility
E. Human Milk Composition

Module 5. - Breast Anatomy, Hormones of Lactation & Human Milk Composition

A. Breast Anatomy-Parts Of The Breast

1. Skin--creates the container for all of the milk producing tissue.
2. Areola--the dark area of the breast which includes the nipple; provides baby with a target; no fat lies beneath the areola and the nipple and areola contain erectile smooth muscle tissue which contracts with stimulation causing the nipple to become firm and protrude. The nipple and areola are flexible and conform to the baby's palate, tongue and gums during feeding.
3. Montgomery glands--small raised areas appearing on the areola; secrete a lubricant for the nipple, keeps the pH of the skin acidic which discourages growth of harmful bacteria on the skin.
4. Nipple tissue
   a. Nipples can vary in size, shape, elasticity, degree of eversion; these variations are relevant only if they interfere with latch or suckling.
   b. A nipple's appearance at rest is not as important as how it functions when in infant's mouth.
   c. A compression or pinch test can help identify nipples that are truly flat or inverted. To assess nipples compress the areola about an inch behind the base of the nipple; if it protrudes, it isn't functionally flat or inverted no matter what it looks like at rest; if upon compression the nipple flattens or inverts, then it is truly a functionally inverted or flat nipple.
   d. Nipple pore--tiny openings on end of nipple which let the milk out into the baby's mouth; there are on average 7 to 10 of these pores on each nipple.
5. Connective tissue
   a. Fibrous connective tissue holds the breast to the chest wall; this tissue expands and grows during both pregnancy and lactation; tissue retracts after lactation has ended.
   b. Cooper's ligaments support breast tissue. All ligaments are affected by the hormone relaxin during pregnancy. This allows the ligaments in the pelvis to stretch for the passage of the baby through the birth canal. Relaxin relaxes the Cooper's ligaments, gravity pulls the heavier, pregnant breast and causes the postpartum breast to be softer and more elongated than a breast has ever been through a pregnancy. While many mothers worry that breastfeeding causes softer and more "saggy" breasts, they need to know that pregnancy is the cause**,** not breastfeeding.
6. Fat
   a. Gives the breast shape and provides protection and cushioning for internal tissues.
   b. The size of the breast is related to the amount of fatty tissue, not the milk producing tissue.

7. Circulatory and lymph system
   a. blood brings nutrients to the breast through the circulatory system
   b. lymph system carries away waste--trapped bacteria, dead cells and excess body fluids. When breast is engorged, the lymph system is constrained, slows, and is unable to remove fluid and waste from the breast, circulation slows and pressure builds from the milk in the ducts.
8. Nervous system
   a. Makes the breast sensitive to touch and allows the baby's suck to stimulate the release of hormones to trigger the let-down, or milk-ejection reflex and the production of milk.
   b. These factors may interfere with the stimulation of the nerves : injury to the nerve supplying the breast, breast surgery, a weak suck or use of nipple shield, particularly a thick, non-flexible nipple shield.
9. Milk ducts – branch like tubules extending from clusters of alveoli to the nipple pore.



Source : WIC Peer Counselor Training Manual,2010

10. Milk producing tissue
    a. Alveoli--tiny milk producing cells clustered together like bunches of grapes in groups of ten to one hundred. They grow and develop rapidly during pregnancy. Alveoli at center of clusters degenerate to form part of the colostrum. Most of the alveoli are to the side and lower part of the breast. Alveoli are surrounded by capillaries they receive a rich supply of blood.
    b. Myoepithelial cells--these form a band of smooth muscle tissue around the alveoli. When oxytocin tells the body to give or let down the milk, these smooth muscle squeeze on the alveoli and eject the milk down the ducts toward the nipple openings.
11. Lobes of the breast : 7 -10 lobes per breast. Mammary glands which consist of a single major branch of alveoli and milk ducts which end at a nipple pore.
12. Breast storage capacity
    a. A mother's breast storage capacity refers to the maximum volume of milk available to her baby when her breast is at its fullest.
    b. It is determined by the amount of room in mother's alveoli, the milk-making glandular tissue. The maximum volume of milk in the breasts each day can vary greatly among mothers and it may change from one baby to the next.
    c. Breast storage capacity is NOT related to breast size (breast size is determined mainly by the amount of fatty tissue in breasts).
    d. Mothers with large or small storage can produce plenty of milk for baby. A mother with larger storage capacity may be able to go longer between feedings without impacting milk supply and baby's growth. A mother with a smaller storage capacity however, will need to nurse baby more often to satisfy baby's appetite and maintain milk supply.

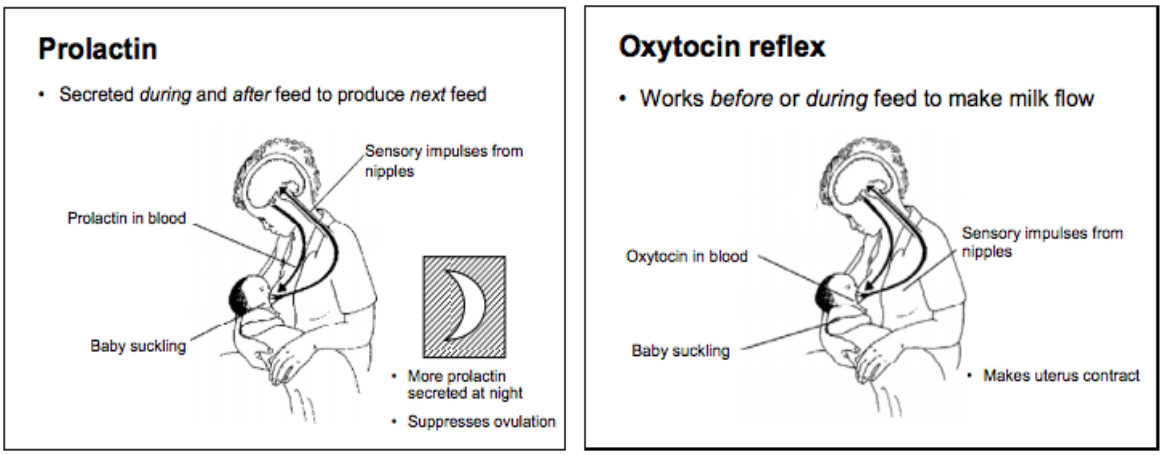
B. Hormones of Lactation

1. Estrogen : causes the growth of the milk ducts and the connective tissues within the breast. During pregnancy it causes the duct system to multiply.
2. Progesterone : aids in development of alveoli and along with estrogen. Causes the duct system to multiply and develop during pregnancy.
3. Human placental lactogen : released by the placenta during pregnancy and encourages nipple and areolar growth.
4. Prolactin :
    a. signals the alveoli to produce milk;
    b. also known as "the mothering hormone" - makes mother want to hold and breastfeed infant;
    c. keeps mother's menstrual cycle from coming back right away.

5. Oxytocin :
    a. contracts the smooth muscles surrounding the alveoli and makes milk flow out;
    b. contracts the smooth muscle of the uterus. Helps the uterus to shrink back to its normal size and causes mothers to bleed less after birth.
    c. also known as the "love hormone" – it helps mothers have warm, loving feelings for their babies (mother-baby bonding).

C. Process of Lactation

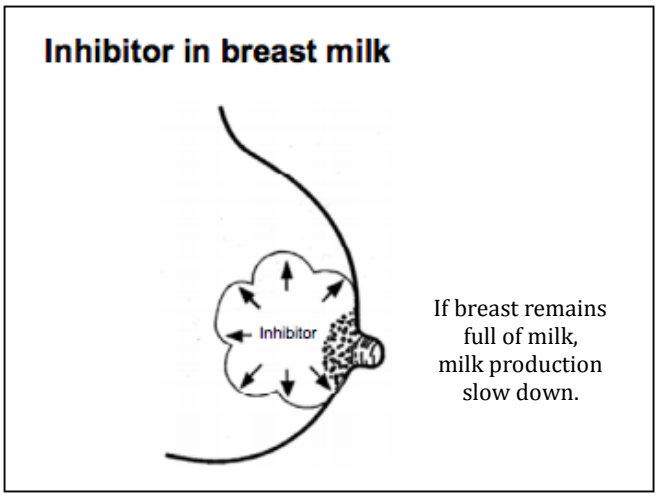
1. Baby's suckling stimulates nerves in the nipple which, through the nervous system, sends the message to the pituitary glands in the mother's brain to secrete Prolactin and Oxytocin hormones into the mother's bloodstream.
2. Prolactin signals the alveoli to produce milk. Oxytocin causes the smooth muscles (myoepithelial cells) surrounding alveoli to contract which ejects high-fat milk into the milk. This is called the Milk-Ejection Reflex (MER) or Letdown Reflex.



Source : WHO, Infant & Young Child Feeding – An Integrated Course, 2006

3. Milk Ejection Reflex (MER) or Letdown Reflex :
    a. Signs of let-down: uterine cramps, pain or fullness in the breasts, leaking milk, feelings of relaxation in the mother, change in the baby's sucking pattern - from several sucks per swallow to suck-swallow, suck-swallow, gulping; baby's eyes will often get bigger when the milk lets-down.
    b. Several let-downs per nursing session.
    c. Ideas to help the milk to let-down: back or neck rub, warm drinks--non-alcoholic, deep breathing, lots of skin contact with baby.

4. Feedback Inhibitor of Lactation (FIL):
   a. FIL is a substance in breast milk which decreases the rate of milk production when the breast is full. When FIL is absent from the breast, the rate of milk production increases.
   b. In other words : when the breast is well drained, the rate of milk production will increase, if the breasts becomes full the rate of milk production slows down.



Source : WHO, Infant & Young Child Feeding – An Integrated Course, 2006

5. Autocrine control of milk production :
   a. During pregnancy and until the first few days after birth, milk production is hormonally driven – also known as endocrine control system.
   b. Subsequently, it switches to autocrine or local control of milk production within each breast. This means milk production depends on how often and how much milk is effectively removed from the breast. The more often baby breastfeeds and remove milk from mother's breast, the more milk will be produced (also known as supply and demand process). If the baby does not breastfeed, mother needs to express her milk out to maintain her milk supply and to reduce breast engorgement.

D. How Breastfeeding Hormones Affect Fertility

   a. The hormones of lactation delay the return of a woman's fertility after childbirth. In addition to suppressing ovulation, the hormones of breastfeeding may decrease a mother's ability to support a pregnancy during the first cycle or more after menses return.
   b. The baby's frequent and effective sucking, day and night, is primarily responsible for the delay in the mother's return to fertility. Research has shown that fertility will be reliably suppressed during amenorrhea as long as the vast majority of feedings are at the breast (supplements comprise no more than 5-15% of the baby's intake and are

given after breastfeeding) and mother and baby go no longer than four hours during the day or six hours at night between feedings.

c. While the pattern of breastfeeding is a key factor in the length of infertility, the woman's individual body chemistry also influences the duration of infertility. Some women who nurse their babies without supplements resume their menses within the first three months postpartum and some women go as long as two years or more without menstruating even though the child is eating solid foods.

d. Lactational Amenorrhea Method (LAM) is an effective alternative to other family planning methods **during the first six months** as long as the mother can answer "no" to the following questions:

   i. Have your menses returned?
   ii. Are you supplementing regularly or allowing long periods without breastfeeding either during the day (more than four hours) or at night (more than six hours)?
   iii. Is your baby more than six months old?

NOTE: If the mother answers "yes" to any of these questions, her risk of pregnancy is increased; she should consider using an additional method if she wants to avoid pregnancy.

E. Human Milk

1. Stages of Breast Milk

There are three stages : colostrum, transitional breast milk and mature breast milk. Although many think of these stages as three separate and distinct types of milk, they actually reflect a continuum of changes that occur after birth as the mother's hormones shift and her breasts begin making more milk.

a. Colostrum :

- The production of breast milk begins at 16th to 20th weeks of pregnancy, making the first milk, called colostrum. Until during the first few days after the baby is born, breast milk consists of colostrum only.
- It is concentrated milk that is thick and typically yellowish in color and contains many beneficial properties.
- Colostrum has higher protein content and lower in fat compared to mature milk.
- It contains a high concentration of antibodies, specifically Immunoglobulin A (IgA), as well as white blood cells, to fight off infections.
- It is high in fat soluble vitamins, zinc, growth factors and sodium choride (salt).
- The amount of colostrum is small, but that small volume contains everything essentials a newborn needs in the first few days of life.

b. Transitional Breast Milk

- At around 3rd to 5th day after birth, breast milk production starts to increase and gradually transition into mature milk composition. This milk still has some colostrum mixed in, but less in concentration.

- It is during this time when mothers experience "more milk comes in", where breast starts to feel fuller and heavier.
- Although transitional milk becomes lighter in colour, it continues to give natural protection and contain essential active enzymes, hormones and nutrients for baby's growth and development.

c. Mature Breast Milk
- Breast milk is completely changed into mature milk by the time baby is about two to three weeks old.
- The distinguishing characteristic of mature milk is that it is formulated for sophisticated development of the baby's brain and nervous system (species specificity).

2. Composition of Breast Milk

Composition of breast milk is dynamic; it changes over the course of lactation. It is different from mother to mother, and in the same mother in different stages of breastfeeding. It even varies within each feeding (from beginning to the end of one feed), and from one feeding to another feeding on same day for a mother. It is tailored to specifically meet the demands and needs of a growing child.

Breast milk consists of over 200 different substances including carbohydrate, enzymes, fat, hormones, mineral, protein and other nutrients. Some of the major components of human milk and their function are as follows :

a. Anti-infective properties such as:
   i) Living cells - breast milk is full leukocytes, macrophages and lymphocyte that engulf and digest disease organism.
   ii) Lactoferrin – binds with iron to prevent bacteria from feeding on iron and multiplying.
   iii) Interferon – protects again viral infection
   iv) Bifidus factor – produces an acid that prohibits growth of bacteria in baby's gut.
   v) Immunoglobulins (Ig) :
      - Ig A : secreted and stored in mother's breast. It stimulates baby to produce own antibodies, protects baby from infection directly where germs enter (throat lungs, intestine). It is the most important Ig because it coats mucosal surfaces to prevent adherence and penetration by germs.
      - Ig G : babies are born with this blood circulating antibody. It works together with IgA.
      - IgM : antiviral factor which is active against rubella, cytomegalovirus, respiratory syncytial virus (RSV)

b. Carbohydrate : lactose is the main carbohydrate in human milk. Supply of lactose is more constant among other factors in breast milk and it is slowly digested for a steady release of energy into the baby's body. It helps body absorb calcium, promotes growth of friendly bacteria, provides energy to baby's brain and hence vital to baby's

brain development. There is more lactose in human milk than other mammal's milk.

c. Enzymes : baby's immature gut does not yet produce enzyme in adequate quantities. Breast milk contains enzymes to help digest its own fat, protein and other nutrients in milk. Some enzymes attack pathogens – for example : lysozyme enzyme attacks cell walls of bacteria, bile salt stimulated lipase is anti-protozoan; it acts on *Giardia* and other organisms that cause diarrhea.
d. Fat content : varies throughout the day and varies with mother's diet. Breast milk is high in cholesterol for nerve and brain tissue development, creation of new cell walls, and to maintain immunological booster cells. It also has omega-3 fatty acids for brain and nerve cell development. Enzyme lipase in breast milk breaks down fat before it reaches baby's gut, releasing energy from fat sooner which benefits the baby.
e. Growth factors such as epidermal growth factor – aids gut and other tissue maturity; nerve growth factor – may help heal central nervous system from birth related injury.
f. Protein : two basic proteins - whey & casein.
    - Whey : easily digested, soft curd protein, digests in intestine.
    - Casein : forms tougher curds, digests in stomach and harder to digest than whey protein.
    - Human milk has more whey protein, cow milk has more casein protein.
    - Has essential amino acids (building blocks of protein). Taurine needed for brain development and maturation.
g. Vitamins and mineral : everything baby needs is present in human milk. Example :
    - Iron in human milk, though in small amounts, is efficiently used.
    - Vitamin D : present both in foremilk and hindmilk.
    - Vitamin E : important to protect against anemia; colostrum is especially high in E.
h. Water : breast milk provides all the water a baby needs, even in hot and dry climate. Breast milk contains 87.5% of water and all other components are dissolved, dispersed or suspended in it.

See also : WABA Activity Sheet 10 : Breastfeeding and Food Security.
https://www.waba.org.my/resources/activitysheet/acsh10.htm

Basic Breastfeeding Management

Module 6. Basic Breastfeeding Management

Objectives: Participant will be able to:

- Explain the importance of the first feeding in getting breastfeeding off to good start
- Demonstrate three common breastfeeding positioning holds
- List the steps for a good latch-on
- Explain the importance of frequent, unscheduled breastfeeding
- Describe how to tell if an exclusively breastfeeding baby is getting enough milk
- Describe five common breastfeeding problems, their prevention, and treatments.

A. The Key Elements Of Management
   1. Breastfeed early and often
   2. Nurse the breast and not the nipple (positioning and latch)
   3. Watch the baby and not the clock

B. Situations That Interfere With Breastfeeding
   1. Engorgement
   2. Sore nipples
   3. Breast infections and plugged ducts
   4. Sleepy baby – rousing techniques
   5. Nipple confusion
   6. Low milk supply
   7. Slow weight gain

Module 6. - Basic Breastfeeding Management

1. The Key Elements Of Management

1. Breastfeed early and often - offer the newborn baby the breast as early as possible after delivery and frequently thereafter
   a) Baby awake and ready to learn to breastfeed. Baby's sucking instinct peaks in the first hour after birth, baby imprints on suckling at breast.
   b) Sucking stimulates the uterus to contract and hastens the delivery of the placenta; thus prevents excess bleeding.
   c) Breastfeeding raises baby's blood sugar and temperature.
   d) Early breastfeeding builds mother's confidence and lessens temptation to use bottles.
   e) After an early alert period, many infants are sleepy the rest of the first 24 hours. The first breastfeed may be the best one for awhile.
   f) Colostrum is laxative and flushes out the meconium stool. Early passage of meconium stool reduces risk of elevated bilirubin levels in normal physiologic jaundice.
   g) Baby receives 'first immunization'.
   h) Early, frequent feeds promote high prolactin levels and, some researchers believe, promote the formation of more prolactin receptors which stimulates an abundant milk supply in the early weeks and throughout the entire breastfeeding experience.
   i) Baby learns to breastfeed on a soft breast. When baby is able to breastfeed early, it reduces the risk of maternal engorgement.

2. Nurse at the breast and not just at the nipple - the nipple serves as the target behind which the baby must place his jaws
   a) **Positioning** - support and comfort are key factors. There is no one "right" breastfeeding position for every situation because babies and mothers come in many sizes, shapes and personalities. Encourage mother to try different breastfeeding positions. This will help mother select options she feels work best for her. She can try other ways to position her baby once both mother and baby become more practiced at birth. Peer Counselor can help demonstrate positioning using dolls or stuffed animals as models. When helping mother position her baby, remember that she learns more by doing it herself. Guide and give her some gentle suggestions on the side as needed.
      i) Mother – laid back position or "biological nurturing"
         - Mother is in a semi-reclined position and be well supported.
         - Mother comfortably leans back and put baby on her chest, gravity will keep him in position with his body molded to mother's body.
         - This position helps trigger baby's natural instinct to move towards mother's breast. It also triggers baby's sucking and feeding reflexes and makes it easier for baby to latch properly.
         - Mother and baby can be skin-to-skin, or with light clothing.

ii) Mother – sitting

- Sit upright with back comfortably straight
- Use pillows, rolled up towels, blankets, or other articles which will support the mother's body, including her arms and elbows, so that infant's nose and top lip is level with and directly in front of nipple
- If mother is sitting in a chair, a low foot stool, stacks of phone books or a small box can give support to her legs and lower back
- Where the infant's head rests on mother's arm will depend on her breast size and shape. Some will have the head near the crook, some at mid forearm, others closer to the wrist.
- She may need to use her hand to support and/or shape the breast for the nipple to be more accessible and stay in infant's mouth once attached.

iii) Mother – lying down on her side

- Use pillows, rolled blankets, towels, or wall to support mother's back
- Bending upper leg toward tummy, perhaps placing a pillow under it can ease back strain
- Lower arm can be under mother's head for support or can be wrapped around baby
- Upper arm can be used to guide baby to breast, support the breast, or hold baby in place on his side. Pillows, rolled blankets or towels can be used to support baby's back

iv) Baby--key factors for any position

- Baby's head needs to be in alignment with the rest of his body; head should not be turned. Baby's entire body needs to be facing mother's body and pulled in close.
- Weight of baby's body should be continually supported by mother's arm, pillows, rolled blankets, and / or towels.

b) **Latch / Attachment**

(i) Getting a good latch

- Infant's buttocks should be pulled tight to mother's body thereby bringing the chin closer to the breast than the nose. This not only facilitates breathing, but also makes it easier for baby's tongue to effectively milk the nipple and breast.
- Baby needs to get a full mouthful of the areola; jaws need to be well behind the nipple.
- Baby's outer lips need to be visible; outer lip tissue is abrasive to the areola; baby cannot get a good latch-on if his lips are in the way.
- Baby's tongue has a peristaltic or wave-like motion that compresses the nipple and areola against the palate, thus milking the ducts.

- Mother should maintain support of both baby's head and body position and good support of the breast to ensure baby is able to maintain latch.

(ii) To unlatch, gently insert clean finger between baby's gums.

(iii) If nipple hurts during breastfeeding, something is wrong. Unlatch and start over. If mother can't get infant to latch comfortably, she needs to seek skilled help.

(iv) Difficult latch-on may be temporary (for example - disorganized and sleepy baby from labor medications, engorgement) or intrinsic (for example - flat nipples, receding chin). Sometimes mothers need help in shaping the nipple so babies have an easier time latching-on. Suggestions :

- Unwrap, stimulate baby to be sure he is awake.
- Use clutch position; mother can better assist infant as she will be able to stabilize and position his head in the palm of her hand; similarly she can hold her breast in place for the baby. Clutch position helps baby get chin closer to breast for more effective latch.

3. <u>Watch the Baby and Not the Clock</u>

a) Nursing cues—mother to look for these cues. These clues will let her know that her baby wants to nurse.
- Baby opens mouth, makes sucking motions, roots around
- Tongue movements
- Furrowed eyebrows; tension in face
- Fists clenching and unclenching
- Arm flexing
- Hands going to mouth
- Increasing restlessness of body
- **Crying--the last resort**

b) Frequency and duration
- Babies nurse between eight and twelve times per twenty-four hour period.
- Let baby finish nursing on the first side first before switching to the second side. Long deep sucking on the first side ensures that the baby will be getting his full complement of fat.
- Babies need at least ten minutes of strong, consistent sucking and swallowing per side or twenty minutes on one side per feeding.
- Use breast compression for babies who fall asleep at the breast or who lose interest in suckling before they've had enough milk.
- Strict scheduling undermines the lactation process.

c) Nursing '*on demand'* or "*supply and demand*" are different terms

- '*On demand'* means the baby usually knows how much and how often he needs to breastfeed in order to stimulate enough milk.
- "*Supply and demand*" means the more frequently a baby breastfeeds, the faster milk is produced. The more milk is removed from the breast, the more milk it will produce.

d) Adequate milk production

- The breast is not a warehouse, it is a factory. Babies will get enough food from almost any breast if allowed to suckle frequently. Suckling at the breast, and milk removal triggers milk production.
- Count diapers to be sure baby is getting enough milk. In the first few days baby may have only one or two wet diapers per day; by day 4 or 5 a totally breastfed infant should produce 5-6 wet disposable (6-8 cloth) diapers in 24 hours, with very pale urine.
- While frequency of bowel movements varies from baby to baby and even week to week in the same baby, there will usually be 3 – 5 per day for the under six week old baby. Babies older than 6-8 weeks can go several days without a bowel movement: the longer baby goes between bowel movements the larger the movement will be. Breastfeeding stool is soft, unformed, yellow colored with an occasional green stool.
- Many babies seem to have "growth spurts" or "frequency days" when they nurse very frequently, thereby increasing mother's milk production; these spurts usually occur at around 10 days of age, between three and six weeks of age, and around three and six months of age.

e) Normal growth patterns

- Infants typically lose weight during the first 3 or 4 days after birth; weight loss of 5% to 7% is considered normal.
- Most babies regain birth weight within 10 days to two weeks after birth.
- Average weight gain for the first 3 to 4 months is about 180 grams per week, although it is considered acceptable for some babies to gain 150 to 240 grams per week.
- Growth in length averages 2.5 cm per month.
- Growth in head circumference is about 6cm per month during the first 3 months, then 3cm in second 3 months and 3cm in last 6 months.

2. Situations That Interfere With Breastfeeding

1. Engorgement vs. lactogenesis (initiation of milk secretion)

a. Somewhere between the second and fourth day postpartum the milks begins the transition from colostrum to mature milk; this is called lactogenesis (stage II) and is signaled by more blood, lymph and greater volume of milk coming into the breasts. Mother may notice her breasts are heavier, fuller, firmer. This a normal part of the breastfeeding process.

b. If mother doesn't either breastfeed or express milk regularly during the first 10-14 days, her breasts may very quickly become overfull, painful and hard. This is engorgement - breast may be so over distended the nipple flattens making latch difficult to impossible; tissue in breast is so swollen, it is difficult to get milk out, even with a breast pump.

c. Causes of engorgement - anything that interferes with regular frequent breast emptying or excess fluid retention in the mother, such as :
- Sleepy baby
- Supplementary feedings
- Poor latch or ineffective suck
- Sudden decrease in breastfeeding frequency (baby sleeping a long time at night)
- Excessive IV fluids with oxytocin (induced labor)

d. Engorgement prevention
- Breastfeeding early and often in the first days helps baby practice and gain good latch and suckle skills while the breast is still soft. If infants are receiving bottles in the first days, often their breastfeeding skills are poor and when the breast becomes fuller, they can't effectively latch or suckle; mother's breasts becomes engorged
- Be sure position and latch are optimal so baby can effectively milk the breast.

e. Engorgement remedies
- If breasts are too full/swollen and painful, use cool compress to reduce the pain and reduce the swelling.
  - ✓ Put whole raw, green cabbage leaves in bra next to skin; when they get warm and soft, throw the leaves away and put fresh cold ones in bra
  - ✓ Apply ice packs to breasts on top of clothing, 20 minutes on, 20 minutes off; this will reduce swelling and slows milk production.
- If breasts are not too full and not painful, apply warm compress wet cloths before breastfeeding to assist milk flow; a warm shower can help also.
- Anti-inflammatory medication
- Areolar compression or reverse pressure softening method.

f. Severe Engorgement -- Peer Counselors should refer a mother with severe engorgement for immediate treatment. However, if mother is not able to get immediate treatment, the following information is provided in detail to assist Peer Counselors in helping mothers with severe engorgement.
   - Breasts are rock hard, very painful, lumpy, shiny, red; mother may have a fever; infant usually can't latch as nipple has flattened due to breast distension; no dripping milk.
   - Use areolar compression or reverse pressure softening method.
   - Use hand expression instead of breast pump.
   - If milk will not flow, apply cool compress to the breasts, 20 minutes on, 20 minutes off for an hour to reduce swelling; alternating ice with heat may help.
   - Warm water bath/gentle shower.
   - Try to figure out why mother became so engorged; supplementing? poor latch? poor suck? Correct the underlying problem - otherwise engorgement will reoccur.

2. Retained placenta or product can cause delay in lactogenesis

3. Sore nipples - A common but not normal part of breastfeeding; a sign something is wrong and problem solving should occur.

   (I) Possible causes of sore nipples are as follows :

   a) Positioning problems
      - Baby not well supported and falling off breast.
      - Baby not in alignment and having a hard time getting and keeping a good latch-on.
      - Baby not snug against mother's body.
      - Mother should support her breast throughout the feed if breast is heavy or pendulous.

   b) Latch-on problems - often related to infant not opening wide to latch
      - Baby's lips turned inside against the areola; lips need to be flanged out over areola
      - Baby's tongue not down over lower jaw; look for dimpling in of cheeks while breastfeeding, clicking sounds.
      - Baby doesn't have a full mouth-full of the areola; ends up chewing on the nipple

   c) Baby has sucking problems which need attention of health care provider, lactation consultant or physical or occupational therapist.

   d) Thrush (Candida albicans) or yeast infection
      i. Possible symptoms in the mother include
         - Pink, flaky, itchy, red, and, or burning nipples
         - Nipples are sore during and after feedings
         - Nipples can look normal

- Soreness lasts throughout the feeding and does not improve with better latch and positioning
- Cracked nipples
- Vaginal infection
- Shooting or deep breast pains
- Can occur after treatment with antibiotics
- Nipple or breast pain while correctly using a hospital grade electric breast pump

ii. Possible symptoms in the baby include
- Diaper rash
- May or may not have white patches in mouth which cannot be rubbed away and/or a whitish sheen to the inside of baby's lips or saliva
- Baby repeatedly pulling off the breast, making a clicking sound while nursing, or refusing the breast (because mouth is sore)
- Gassiness or fussiness
- Can occur after treatment with antibiotics
- The baby may be without visible symptoms

iii. Health care provider(s) need(s) to be contacted for simultaneous treatment of both mother and baby

iv. Home remedies to prevent re-infection include:
- Follow doctor's treatment recommendations diligently;
- Boil pacifiers, pumps, bottles, teats, and toys for 20 minutes every day,
- Use nursing pad only once,
- Do not allow the areola to remain wet,
- Avoid use of breast shells,
- Do not freeze milk for later use;
- Rinse nipples with water and air dry after nursing

(II) Suggested remedies for sore nipples

a) Modify positioning to correct latch-on, or sucking problems
b) Moist wound healing
- Provides a moisture barrier to slow evaporation of internal skin moisture
- Skin cells are able to reproduce in their normal watery environment; accelerates wound healing and brings pain relief

c) Wounds heal without crusty scabs; little or no scarring
- Rub milk into nipples and areola after feedings
- Use ice on nipples before and after feedings
- Rest severely cracked nipples and pump; can feed baby from just one side if one side is less sore than the other

4. Plugged ducts and Breast infections (Mastitis)

a) Plugged duct is a tender spot in the breast, sometimes accompanied by a lump, where the milk isn't draining freely and pressure has built up in the ductal system; this causes inflammation in the surrounding tissues. Mother otherwise feels well.

b) A breast infection differs in that not only is the breast sore, but often mother feels flu-like; she runs a fever or may be nauseous; breast may have red streaks, generalized redness, be swollen; she may need medical treatment and antibiotics.

c) Emphasize that the breast tissue is infected, not the milk; nursing can and should continue.

d) Treatment for both breast infection and plugged duct include
   (i). REST
   (ii). Frequent breastfeeding on affected side. Mother to hand express her milk if breastfeeding is too painful.
   (iii). Vary breastfeeding positions; breastfeed infant in a position where his chin is pointing to the affected area of the breast as he drains that area most effectively.
   (iv). Massage if not too painful.
   (v). Apply warm, moist compresses or cold as comfortable for mother.
   (vi). Seek medical treatment if:
      - Mother runs a fever
      - If there is no improvement in 24 hours
      - Breast has red streaks; milk has pus or blood
      - Both breasts are affected

e) Ways to avoid plugs and infections include:
   - Make sure that baby is well positioned and latched-on
   - Heal sore and cracked nipples
   - Regular, consistent nursing—don't miss nursings and become overfull, hand express or pump when baby is unavailable for nursing.
   - Wear bras and clothing that allow for non-restrictive support and coverage.
   - Mother should change positions sleeping at night.
   - Beware of baby carriers which restrict shoulder and arm movement or cause baby to put pressure on the breast.
   - Get adequate rest.
   - Drink plenty of fluids.
   - Slow down at first sign of plug and begin treatment;
   - Protect breasts from blows, bruises, or tugs from gymnastic nursers
   - Make sure nothing constricts or binds breast such as bra, nightgown, baby carrier, diaper bag, sleeping position

5. Sleepy baby--rousing techniques

a) Skin-to-skin contact.
b) Dim lights, tone down noise, reduce stimulation.
c) Try to wake baby during rapid eye movement phase of sleep.
d) Loosen blankets on baby; unwrap blankets; undress baby to diaper and undershirt (mother can put a hat on baby if she is afraid he'll get cold or drape a light blanket over baby).
e) Talk and make eye contact with baby.
f) Hold baby upright.
g) Walk up baby's spine with fingertips while holding baby in a sitting position on lap.
h) Gently sit baby up and lay back down on mother's lap using one hand on baby's belly and one hand behind his back and neck for support.

6. Nipple confusion-- can be caused by any artificial teat, bottles, pacifiers, nipple shields

a) Babies need to learn basic breastfeeding before getting any artificial nipples; best to wait until at least four weeks of age.
b) If supplement is necessary, use cup, spoon, dropper. Healthcare professionals may teach mother to supplement by finger feeding or tube feeding device.
c) Nipple confused babies often do several things that make breastfeeding difficult :
   - They don’t open wide to latch.
   - They use their tongue to push the nipple out, rather than draw it in.
   - Their tongue doesn’t make the wave like motion to compress the areola against the palate.
   - The effect is that they may not be able to draw nipple in to latch, or if they do latch, their suck is wrong so they get no milk and quickly become frustrated.
d) Remedies
   (i). Position and latch technique are critical; use clutch position so mother can assist baby more.
   (ii). Eliminate all artificial teats - no bottles, no pacifiers.
   (iii). Feed infant when he is sleepy, well before he is hungry. Hungry babies have no patience.
   (iv). Lots of happy skin to skin time; not to let baby associate breast with frustration.
   (v). Offer expressed milk with a cup, spoon, dropper until baby is breastfeeding well.
   (vi). Some babies may need no breast or bottle for 24 hours

(vii). Cup feeding

- Be sure baby is awake and alert.
- Swaddle baby to keep his hands from bumping the cup.
- Protect baby's and mother's clothing from spills with a cloth.
- Hold the baby in an upright position.
- Fill the cup at least half full with the supplement.
- Bring the container to the baby's lips, gently tilting it so that when he opens his mouth the cups rests lightly on his lower lip and the milk just touches his lips.
- Tip the cup slightly so that a few drops of the milk flow onto the baby's lips.
- Leave the cup in this position and let the baby set his own lapping rhythm, pause when needed, and end the feeding when ready

(viii). If infant isn't breastfeeding, be sure mother express her milk regularly to maintain milk supply.

(ix). Pump a minute or two just before offering the breast so infant gets instant gratification.

(x). Mother will need increased support and cheerleading to overcome the frustrations and feelings of rejection that nipple confusion can bring

7. <u>Low milk supply</u>

a) False alarms: Is milk supply really low? Or is mother worrying unnecessarily? If baby is totally breastfed and gaining at least 180g/week, producing lots of wet and poopy diapers then the following are **not** signs of low milk supply;

(i). Baby nurses very often; seems hungry soon after feeds : may be a growth spurt or baby's individual pattern.

(ii). Baby is fussy : may be colic.

(iii). Mother's breasts feel soft : extra breast fullness is usually only present from day 3 to day 14 postpartum; before and after that period breasts are often soft.

(iv). Breasts never leak : some women never leak but produce plenty of milk.

(v). Mother never feels the milk ejection reflex (MER) : not all mothers feel the MER.

(vi). Baby breastfeeds for very short periods of time : he may be very efficient.

(vii). Baby will accept bottle after breastfeeding : in young babies this is reflexive

b) Valid concerns

(i). Supplementing with formula, teas, juices, early solids reduces sucking at the breast and will reduce milk supply.

(ii). Poor positioning and latch will lead to ineffective breastfeeding;

(iii). Nipple confusion can cause baby to suck ineffectively at breast.

(iv). Pacifiers and thumb sucking: both replace sucking that baby could be doing at the breast, stimulating the milk supply.

(v). Nipple shields: these can interfere with nerve stimulation and limit the signals the brain receives that the body needs to produce milk; some of the newer shields are lighter and interfere less with the nerve stimulation but weight gain, urine and bowel movement output still need to be monitored.

(vi). Scheduled feedings: interfere with the supply and demand system of milk production.

(vii). Sleepy or placid baby: does he suck enough, often enough, or vigorously enough to adequately stimulate the breast to produce milk?

(viii). Feedings too short: cutting feedings can prevent mother's supply from increasing to baby's needs; baby may not get enough milk to be satisfied and thrive

(ix). Mother using one breast per feeding with poor weight gain.

(x). Smoking cigarettes can interfere with her milk ejection reflex (MER) and prolactin levels leading to a reduced milk supply.

(xi). Some medications and herbs can temporarily reduce the milk supply. Some mothers have found hormonal conception control will adversely affect their milk supply.

(xii). Fatigue, poor diet, lack of adequate fluids can affect milk supply.

(xiii). Certain medical conditions

(xiv). The mother may be pregnant.

(xv). Conception Control

- Oral contraceptives which contain both estrogen and progestin are not compatible with breastfeeding; they reduce a mother's milk supply, change the composition of the mother's milk, and lead to slow weight gain, early supplementation, and the abandonment of breastfeeding.
- Depo-Provera as progestin-only preparation is considered compatible with nursing; however, wait until the milk supply is well established, before considering use.

- Tubal ligation performed a day or two after women have given birth has sometimes caused difficulties with lactation due to separation of the mother and infant during and after surgery, mother feeling unwell after the procedure, baby receiving supplemental bottles in the nursery.

c) Possible solutions
   (i) Keep baby skin-to-skin.
   (ii) Check baby's position and latch-on; make sure baby is snug against mother's body and has a mouthful of her breast (areola).
   (iii) Offer both breasts per feeding until the milk supply is meeting the need.
   (iv) Nurse more often for as long as your baby is willing; switch nurse to keep baby interested in nursing longer.
   (v) Make sure all of baby's sucking is at the breast.
   (vi) Give baby only breast milk; avoid all supplements; if baby has been receiving supplements regularly, the mother should keep in contact with health care provider if cutting back on regular formula supplement; keep an eye on the number of wet and dirty diapers to make sure baby is getting enough.
   (vii) Get adequate rest; cut out excessive and non-essential activities.

7. <u>Slow Weight Gain</u>
   a) Review the basics
      (i) Early and often
      (ii) Nurse the breast and not the nipple
      (iii) Watch the baby, not the clock

   b) Discuss guidelines for determining if baby is growing at a reasonable rate
      (i) Baby has regained birth weight by 10 days to 2 weeks postpartum; if baby has not regained birth weight in two weeks, review basic breastfeeding management with the mother, check the baby's positioning, latch-on, temperament, i.e., sleepy, placid, irritable, and talk with the mother about how she is feeling physically and emotionally
      (ii) Baby is gaining weight and growing well according to WHO's growth chart.
      (iii) Baby is alert and active with good muscle tone, color is good and skin feels resilient.
      (iv) Baby is wetting 6-8 cloth diapers per day--24 hours--and usually has three bowel movements per 24 hours during the first six to eight weeks of age; after six to eight weeks it is normal for the breastfed infant to go 10-14 days without

having a bowel movement; this is of no concern unless the baby is not gaining well or acting upset.

c) Problems that can lead to slow weight gain: Most weight gain difficulties can be solved by improving the management of breastfeeding. Some of the problems include:

(i) Infant sucking on pacifier instead of breast.

(ii) Poor latch : check to see that the baby is positioned well and latched securely to the breast. A baby or mother who is uncomfortable when nursing may not nurse long enough per feeding. A poor latch can decrease the nerve stimulation and cause mother to produce less milk and can inhibit mother's let-down. Poor latch can make mother's nipples sore which can decrease the frequency and duration of feedings.

(iii) Baby has a sucking problem that needs the help of a health care provider. Baby may have been born "a little early" but too late to be considered premature and have a suck that is not well developed.

(iv) Baby is sleepy or nurses with his eyes closed. Sleepy babies nurse less vigorously and do not nurse long enough or often enough to get an adequate supply, and do not stimulate the breast enough to produce the amount of milk needed.

(v) Fussy babies may push and shove at the breast and pull away before finishing a feeding. Nursing becomes unpleasant for all and can cause both frequency and duration to decrease.

(vi) Mother may be taking birth control pills or other medications that could interfere with her milk supply.

(vii) Mother may smoke and have difficulty with her let-down.

(viii) Baby may have an infection or other health problem; refer to health care professional.

d) **How the Peer Counselor can help the mother**

(i) Find out if mother has consulted her doctor or health care provider. If she has not, encourage her to seek medical advise for further evaluation.

(ii) Listen to the mother's fears about her baby's growth, offer reassurance that her milk is the best thing for her baby, and support the mother if she chooses to wean her baby.

(iii) Review basic breastfeeding management with the mother to discover where the problem lies. Refer to lactation consultant as needed.

(iv) Give mother information about increasing her milk supply, positioning and latch-on, frequency and duration of feeding.

(v) Reassure mother that her milk is the best possible food for her baby in any circumstance, listen to her concerns, help her dialogue with her health care provider to protect breastfeeding and milk supply while the problem gets solved; support whatever decisions she makes.

(vi) If health care provider suggest to supplement baby's feeding, discuss with mother and guide her to explore the option of alternative feeding method - ie paced feeding method & lactation aid.

(vii) Advice mother to continue follow up with health care provider to monitor baby's growth and development.

Ideas to Make Breastfeeding Work in Day-to-Day Living

Module 7. Getting Ready for Baby — Ideas to Make Breastfeeding Work in Day to Day Living

Objectives: Participants will be able to:

- List four things a mother needs to know about breastfeeding before she delivers
- List two essential items a mother needs to breastfeed
- List two types of support the Peer Counselor can give a new mother

A. Preparations For Home And Hospital

B. Making Breastfeeding Work In Everyday Life

C. Preparations To Sustain Breastfeeding When Separated From Baby

Module 7. Getting Ready for Baby : Ideas to Make Breastfeeding Work in Day to Day Living

A. Preparations For Home And Hospital

1. Pregnancy is the best time for mothers-to-be to prepare for their breastfeeding journey. For many women, breastfeeding is not instinctive, but rather a learned process. Studies have shown that a mother's knowledge and skills can help mother get through the challenging early weeks of motherhood and breastfeeding and increase the rate and duration of breastfeeding.
2. To breastfeed with success mothers needs to learn about proper position, latch, sucking and signs of milk transfer, hunger cues, and the infant's receptiveness to breastfeeding.
3. A peer counselor helps mother from pregnancy until throughout her breastfeeding journey. Among things peer counselor help during pregnancy time:
   a) Focus early discussions on mothers' decision on infant feeding, her individual goals and visions for breastfeeding
   b) Discuss practical aspect of breastfeeding management closer to the time of delivery.
   c) Encourage mothers to attend prenatal classes and breastfeeding classes
   d) Encourage her to discuss with her health care provider and find out about how they will support her decision to breastfeed.
   e) Share the benefits of breastfeeding
   f) Give simple relevant information on how to breastfeed.
   g) Help mothers to understand where milk supply comes from i.e supply and demand.
   h) Ask if she has any questions or worries
   i) Find out if she has good breastfeeding supports from her partner or close family members.
   j) Offer support and help if she needs in the early days after delivery.

B. Making Breastfeeding Work in Everyday Life

1. Breastfeeding can be an overwhelmed journey with emotionally demanding and physically exhausting for some mothers especially in the early days. Many mothers give up breastfeeding or start complementary feeds in the early weeks after birth. Difficulties arise most often during this time.
2. Challenges between mothers can be different. Amongst most commonly challenges faced by mother in the early days includes low milk supply/perceived low milk supply, breast engorgement and nipple pain.

3. Many common difficulties can be caused by poor attachment to the breast. These difficulties can be overcome by helping a mother to correct her baby's position. They can be prevented by helping a mother to position her baby in the first few days.
4. The amount of milk that the breasts produce depends partly on how much the baby suckles, and how much milk he removes. More suckling makes more milk. During first 2 weeks of life, the breasts are best stimulated if the baby is fed about every 1.5 to 2 hours, preferably at both breasts.
5. How to help a mother in early days :
   a) Ask the mother how she feels and how breastfeeding is going.
   b) Let her tell you how she feels, before you give any information or suggestions.
   c) Reminding her what she is feeling is normal for many mothers.
   d) Observe a breastfeed.
   e) 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.
   f) Help with positioning if necessary.
   g) If the mother is having difficulty, or if her baby is not well attached, give her appropriate help.
   h) Give her relevant information and practical supports.
   i) 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'.
   j) 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.
   k) Reminding her to eat healthy food and take care of herself.
   l) Encourage her to ask for help and supports from family and friends.

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 the baby wants
- ✓ The environment supports breastfeeding

C. Preparations to Sustain Breastfeeding When Separating From Baby

1. There are many reasons a baby and mother may be apart. This can include returning to work or school, hospitalization of the mother or the baby, or occasional outings when the mother is away for a short period. Whatever the reason for separation, mothers may need help maintaining milk production. Mothers who are separated from their baby often begin formula supplements because they believe their milk production has dropped.
2. You can support mothers by showing them how they can continue to breastfeed even when they must be away from their babies. A rule of thumb is to keep her "magic" number constant.
3. Here's how to maintain milk production:
   a) Suggest the mother keep track of the number of times she typically breastfeeds every 24 hours. This number, which will be different from one mother to another, is her "magic" number.
   b) This number is her guide. She will need to either breastfeed the baby or remove milk by hand or with a breast pump this many times every 24 hours. For example, if her magic number is 10, and she is feeding the baby 7 times at home after returning to work, she will need to pump at least 3 times at work to equal 10 feeding sessions.
   c) If she has a day when she misses a feeding or milk expression time, she can try to get back to her magic number as soon as she can.
   d) If mothers have a supply of milk in their freezer, urge them to be careful about using this without also expressing milk to replace it. Using the stored milk without replacing it through milk expression or breastfeeding will reduce her overall production.

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Understanding Baby's Needs From Infancy into Toddlerhood

Module 8. Understanding Baby's Needs from Infancy into Toddlerhood

Objectives: Participant will be able to:

- List two reasons that infants nurse besides for food
- Explain the benefits of nighttime breastfeeding
- Describe two helpful ideas for parents to soothe a fussy baby
- Name three indicators that the baby is ready to start solids
- Describe two tactics that mothers may use to prevent infant biting
- Explain two possible reasons for a nursing strike
- Describe three parenting strategies that promote high self-esteem in young children
- List three advantages of nursing beyond infancy

A. Defining The Needs Of The Infant.
   1. Nursing on cue vs schedule
   2. Night time nursings
   3. Parenting the fussy baby

B. Defining The Needs Of The Older Baby/Toddler
   1. Starting Solids
   2. Teething and biting
   3. Nursing strikes
   4. Separation anxiety
   5. Setting limits
   6. Weaning
   7. Nursing while pregnant
   8. Tandem breastfeeding

Module 8- Understanding baby's needs from infancy into toddlerhood

A. Defining The Needs Of The Infant

1. Nursing on cues vs schedule

Stages of feeding/ hunger cues	Baby shows these signs
Baby's Early Hunger Cues	• Hands near face or mouth • Turning to face mother • Sucking movements/sounds • Fussiness
Baby's Late Hunger Cues	• Fingers making a fist over chest, tummy, or face • Stiff, straight arms and legs • Crying
Baby's Full Cues	• Less sucking • Hands opened and relaxed • Arms relaxed over chest or tummy • Legs relaxed • Fingers relaxed • Mouth lets go of the breast • Baby is relaxed or falls asleep

a) Remember the supply and demand concept, when and how the breast makes milk, and why babies need to nurse frequently.

b) As a baby grows and the milk supply becomes well established, the baby may become more regular about when he needs to breastfeed. During growth spurts, periods of low supply, or illness, babies will nurse more frequently than usual.

2. Night time nursing

a) Some babies will consume twenty-five percent or one quarter of their food intake at night through nursing
b) Sleeping a five hour stretch is considered sleeping through the night
c) Babies do not have a concept of night and day
d) For families who are comfortable doing so, bringing the baby to bed with them is a perfectly acceptable thing to do;
   - mother can respond to baby's cue for nursing quickly before baby needs to cry;
   - night times can remain quieter;
   - saves parents from getting up in the night to tend to a crying baby and having their sleep totally disrupted.
   - Baby should sleep on his back or side to avoid having his face buried in the bedding.

- Parents should not sleep with their babies if they are under the influence of drugs, alcohol, tranquilizers or cold medications that may diminish their awareness of baby's presence.

e) Parents of toddlers can try to set limits on how often their toddlers nurse at night; this works with varied success, but may be worth a try for the mother who finds herself nursing a toddler every hour or two during the night.

3. Parenting fussy baby

Ways to Calm a Fussy Baby:

a) Burp the baby, if needed.
b) Change the baby's diaper (check the wet diaper counts - if low, possibility of low milk supply causing fussiness; review breastfeeding management)
c) Use deep, soothing sounds when talking to the baby
d) Hold the baby upright and stroke the baby's back and head
e) Hold the baby close and gently sway with the baby side to side
f) Parent sits on a rocking chair with the baby, holds baby in her/his arms/lap and rock gently.
g) Let the baby suck on a clean finger
h) Swaddle the baby
i) Lie the baby tummy side down on your lap or bed and gently pat. (If the baby falls asleep on the bed, be sure to place the baby on their back to sleep. Never leave the baby on the bed alone.)
j) Carry the baby in a sling or front pack and go for a walk
k) Take the baby for a stroller ride
l) Take the baby into a quieter room
m) Take a bath or shower together

B. Defining The Needs Of The Older Baby/Toddler

1. Starting solids

a) Babies do not need solid food until they are about **six months of age**
b) Three true signs of readiness include:
   - baby is able to stay in sitting position with good head control.
   - baby is able to coordinate his eyes, hand and mouth; able to look at food, pick it up and self feed.
   - tongue coordination has developed to swallow solid food rather than push it out; more food in the mouth than on the face.
c) Introduce foods slowly; one at a time. Look for allergic reaction towards certain food.

d) Recommendations about what foods to start with; mashed ripe bananas, mashed cooked sweet potato, whole grain cereals, and cooked squash are good first choices. Meat, fresh fruits and vegetables are also recommended.
e) Home-prepared baby food is cheaper and usually more nutritious than commercial foods. Parents can cook up a small quantity of food and freeze portions in ice cube tray, thaw a food cube as needed; baby food grinders are handy but a fork can be just as useful.
f) Emphasize fresh fruits and vegetables and whole grain products over processed foods; read labels to find out what exactly is in the product.
g) Avoid a fruit drink, pop, or fruit flavored beverage/cordial. Choose whole grain breads and cereals over white breads and refined cereals; choose fresh and frozen vegetables and fruits than their canned/processed foods because the heat required to process the cans destroys some vitamins.
h) Wait until baby is one year old for honey, dairy products such as milk or cheese, and eggs.
i) Babies can drink water from cups when they are ready, about nine or ten months; this is just a guide, some will be sooner, some later.
j) It's important to remind mothers that weaning begins the moment something other than mother's nipple is put into the baby's mouth; however, weaning from the breast can take another year or two if mother and baby are willing.
k) Remind mothers that it is not necessary to wean to a bottle; babies can go right to a cup and bypass the bottle completely.

2. Teething and biting

a) The eruption of teeth is the time many mothers wean their babies from the breast.
b) While babies are nursing they need to keep their tongues over their lower jaw; in order to bite they need to pull their tongues back. This happens either purposely or during sleep.
c) If a baby bites purposely, mother can usually see it coming. Quite often baby will smile sweetly at the end of a nursing and then chomp down. Mother needs to be attentive to this and be ready to take baby off breast before it happens or issue a firm "no" before it happen.
d) Most babies try this trick a few times and then forget about it. A firm "no biting" or "stop" and setting baby down to do other things usually solves the problem after a few times; some babies are more persistent and their mothers need to be more diligent.
e) Sometimes having a toy, wash cloth, or toothbrush handy that the baby can bite is helpful; mother can take the baby off the breast and say, "You can bite on this".
f) Babies who bite during sleep do it unconsciously and clamp down very hard; mother needs to wedge a finger in the baby's mouth and pry it open.
g) In the event that baby bites hard enough to cause injury, mother should rest the injured side, nurse only from the other side and hand express or pump to relieve fullness and maintain milk supply; this rarely happens as most babies learn quickly not to bite.

h) While it is natural to scream or show a similar strong reaction to a bite, sudden strong reactions can cause a baby to go on a nursing strike; likewise, hitting the baby or biting back are inappropriate reactions on the part of the mother.

i) Biting may be the first time a mother needs to say no to her baby and can be a difficult time; mother may wonder why baby wants to hurt her; she needs reassurance that baby needs to see what will happen when he uses his teeth; he is unaware that biting hurts.

3. Nursing strike

a) Identified when a baby who had been happily nursing suddenly quits for no apparent reason; baby usually getting all or most of his food from nursing, and had showed no sign of weaning.

b) Nursing strike is way of baby telling mother that something is wrong; usually lasts from two to four days if mother is encouraging baby to take the breast, although some go on for longer.

c) This does not mean baby has weaned, and through patience and persistence, mother can get baby back to breast.

d) Common causes of a nursing strike include:
   - mouth pain, ear infection, cold or stuffy nose;
   - too many bottles, pacifiers, or frequent thumb sucking, which may have decreased milk supply;
   - regular distractions and interruptions while nursing,
   - an unusually long separation from mother,
   - mother's strong reaction to baby biting,
   - major change in routine such as traveling, moving, arguing in the house or other loud, stress causing noise,
   - repeatedly putting baby off when he asks to nurse.

e) Mother will probably feel rejected and need lots of support from her Peer Counselor; remind mother that the baby does not reject her, but is responding strongly to a situation which causes him distress.

f) Mother will need to make sure that her breasts do not become overly full; she does not need a plugged duct or infection on top of this worry.

g) Mother can give her baby her expressed breast milk by cup or spoon; it is best to avoid bottles to make going back to the breast easier; keep track of diapers to make sure baby is getting enough

h) Ideas to get baby back to the breast include:
   - try nursing when the baby is sleepy, instinct kicks in and the baby may nurse quite happily when not awake;
   - vary positions; nurse while in motion--stand and walk around or rock;
   - nurse baby where there are no distractions;
   - give baby extra skin-to-skin contact without making any effort to nurse;
   - extra focused attention can help;
   - try nursing with extra skin contact, mother could undress to waist and have baby only in diaper, cover with blanket if cold;
   - nurse baby in vertical position with baby's legs straddling mother's body (like bouncing baby on your knee and pulling the baby straight into the breast)

4. Separation anxiety
   a) Normal part of babyhood; baby feels distressed when mother disappears; can happen suddenly in second half of first year even if baby had separated well previously.
   b) Not pushing separations can help reassure baby and build trust.
   c) Mother needs empathic ear to help her through this time; reassure mother that responding to baby's need for her will not make baby over-dependent on her; responding to baby's need builds the trust that babies need in order to become independent as they mature
   d) Mother may feel that she is being held hostage to her baby, not even able to go to the bathroom without him; assure her that this too shall pass.

5. Setting limits
   a) The parents' job is making sure that their children are safe themselves and are acting safely around others: that is what setting limits is about; giving a child boundaries within which they have the freedom to do what they would like safely.
   b) Parenting is not a spectator sport; it requires action and involvement on the part of the parents.
   c) When children are very young they need a lot of direction, re-direction, and distraction, all of which requires parents' insight and creativity.
   d) Child-proofing the house is one way to minimize the amount of direction an distraction parents need to provide;
      - set out of reach things that are not okay for a baby, toddler, or young child to get;
      - lock up hazardous materials--cleaning solutions, home maintenance and repair products, medications and vitamins, auto supplies;
      - secure things that could easily be knocked over, keep pan handles turned in on the stove, push items on counters or tables away from the edge and from little exploring fingers
   e) Let the child know verbally where he can and cannot be; physically and gently remove a child from off limits areas.

f) Learn about normal child development and provide safe opportunities for exploring new skills and movements; provide opportunities for success.

6. Weaning

a) Weaning begins when supplements to breast milk are started; weaning can take a matter of days or years, depending on the needs and desires of the mother, baby, and their family.

b) Gradual, natural weaning is beneficial because it allows time for baby to get used to other ways of having emotional and physical needs met and allows the mother's body to adjust slowly to making less and less milk.

c) As baby grows into toddlerhood, nursing takes on a larger role in fulfilling emotional needs. Many toddlers will run over to mother to nurse just until the milk lets down and be off again to play and explore; they just need to check-in for an emotional energy boost and grounding.

d) Nursing is a relationship and both parties ideally will have some say in when the relationship ends; if mother is ready to wean before the baby/child is. It is best if she can still keep the child's needs for her in focus. When trying to cut down on the number of times a baby/child nurses, she should do so gradually and replace the nursings with activities that still involve mother such as story time, bathing, walks, play time. If the weaning involves using more bottles, it is important that mother hold her baby when giving a bottle.

e) Some mothers think that weaning needs to be all or nothing; compromises can be reached; find out from the mother what level of nursing she would be happy with; for example: sometimes the mother would feel okay about nursing just during the night but not in the day. Help her figure out strategies for daytime weaning; help the mother understand that if the baby/child still has a strong need to suck, then her baby may not be ready to wean as quickly as she might desire.

f) Babies and toddlers have a "sucking quota," that needs to be met; if they cannot reach their quota during the day, they will often wake up more at night

g) Toddlers need to learn "nursing etiquette" or manners. Mother will need to set limits on when and where it is okay to nurse, Mother may need to be creative with distractions if toddler needs to nurse when it isn't appropriate; many mother-toddler nursing couples find a code word to use for nursing such as “nursie time,” “noo-noos,” “other side,” “milk time,” or “neenie”. Mother needs to feel comfortable with the word in public so she should discourage anyone trying to teach the toddler words for nursing which are unacceptable for the mother

h) Nursing etiquette also includes what toddlers may do while nursing. Some want to play with the other side, or pinch mother's skin, or try to pull up her shirt or pinch her nipples in public. The mother needs to let her child know what is okay and what isn't okay. Setting limits with the nursing toddler is necessary; it is not okay for a toddler to hurt, irritate, or repeatedly embarrass his mother through nursing.

7. Nursing when pregnant

a) There is no sudden need to wean. Many mothers decide to keep breastfeeding for the security and emotional needs of the older child. In general, there is no proven danger to the mother or developing fetus in allowing a child to nurse when a mother is pregnant.

b) Medical reasons to consider weaning are:
- uterine pain or bleeding
- a history of premature delivery and miscarriages
- continued weight loss by mother during pregnancy

c) Concerns :

(i). Nutrition :
- A well nourished mother should have no difficulty providing for both the unborn baby and the nursing child if the nursing child is more than one year old.
- Younger breastfeeding babies may need some supplementation if indicated by drop in weight gain. Mother needs to be sure to get enough calories for proper weight gain during pregnancy.

(ii). Mother's feelings
- some mothers may feel a type of emotional discomfort, restlessness, or antsy feeling.
- Suggestions : listen to music, read a book, watch TV during nursing sessions.

(iii). Sore nipples or breast tenderness.
- Breast and/or nipple tenderness is one of the most common symptoms of pregnancy. Breastfeeding may not be comfortable or pleasant during pregnancy.
- Suggestions: use breathing techniques, change positions, had express to start milk flow before beginning to nurse, limit the length of the nursing sessions, usually disappears immediately after birth.

(iv). Feeling tired: due to pregnancy itself,
- Suggestion : nurse while lying down with the child to get extra rest

(v). Decrease in milk supply
- Most breastfeeding mothers who are nursing through pregnancy notice a decrease in milk supply by mid-pregnancy. Some, as early as the first month.
- During pregnancy, the mature milk is also making a gradual change to the colostrum which is present at birth. Supply may increase toward the end of pregnancy as colostrum production kicks in.

- Suggestions: offer the child more table food. Remember the child may wean himself, but may nurse again once the baby is born.

(vi). Worry that the older child will use up all the colostrum before the baby is born.

- Remember: no matter how much he nurses, colostrum will still be available to the new baby. Offer the newborn the breast first during the first weeks.

(vii). Nursing while experiencing nausea

(viii). Benefits

- Meeting the child's needs
- Toddler not displaced by baby
- Still providing superior nutrition and immunities

8. Tandem nursing

a) Tandem nursing is when a mother breastfeeds 2 or more children of different ages at the same time.

b) Expectations - some mothers approach tandem nursing with positive feelings, other with trepidation. Take one day at a time and see how it goes.

c) Concerns

(i). Newborn getting enough milk

- Have newborn breastfeed first most of the time
- Let the newborn breastfeed for as long as he wants
- Have both children use both breasts, not one breast for each child

(ii). Maternal health

- Increase fluids
- Nutritious foods
- Rest

(iii). Mother's feelings

- "Touched out" mothers needs to take a few minutes each day for themselves
- If mother feels restless or erotic sensations (common) then try changing positions, limit older child's time at the breast
- If mother resents older child nursing, wean slowly, breastfeed the baby when the older child is busy, substitute other activities for nursing
- Tandem nursing can be a lovely lesson in sharing and touching

Breastfeeding In Situations of a Medical Nature

Module 9. Breastfeeding in Situations of a Medical Nature

A. **Jaundice – What it Is and How it Affects Breastfeeding**
Objective: Participant will be able to:
- Compare and contrast colostrum and water feeds in jaundice
- Identify the three ways a peer counselor can help mothers with jaundiced infants.

B. **Hypoglycemia and Breastfeeding**
Objective: Participant will be able to:
- Define hypoglycemia and list three symptoms
- Identify three ways to prevent or minimize its effects on breastfeeding

C. **Illness and Hospitalizations**
Objective: Participant will be able to:
- Examine several ways to support breastfeeding when mother / infant is ill or hospitalized.

D. **Premature Babies – A Brief Overview & Breastfeeding.**
Objective: Participant will be able to:
- Share three ways to support mothers of premature infants

E. **Cesarean Birth**
Objective: Participant will be able to:
- Identify two reasons how breastfeeding is beneficial to mothers who have a cesarean birth.

F. **Multiple Births**
Objective: Participant will be able to:
- Identify ways to assist mothers of multiples

G. **Relactation and Adoptive Nursing**
Objective: Participant will be able to:
- Offer ideas on how to get a baby back to suckle at the breast when breastfeeding has been interrupted or never initiated.

H. **Medications, Recreational Drugs and Environmental Contaminants and Human Milk**
Objective: Participant will be able to:
- Identify common risky behaviors breastfeeding mothers may be engaged in and resources to help them.

Module 9A - Jaundice--What it Is and How it Affects Breastfeeding

1. Physiologic - also called normal, newborn jaundice
   a) Characteristics
      - Happens because the liver takes a few days to process the excess bilirubin.
      - Usually occurs on the second to fourth day after birth.
      - Bilirubin count usually peaks between the third and fifth day postpartum.
      - Most of the time physiologic jaundice will gradually disappear on its own within a few weeks.
      - Jaundice that lasts for more than 2 weeks will require further investigation.

   b) Physiologic jaundice and breastfeeding
      - Breastfeeding should begin early and babies should breastfeed frequently (10-12 times in 24 hrs.).
      - Colostrum acts as a laxative which flushes the meconium out of the baby's intestine, helping to prevent the bilirubin in the meconium from being reabsorbed into the bloodstream.
      - Frequent breastfeeding gives assurance that the baby will be well hydrated and receive enough food to keep stooling and thus flush out the bilirubin regularly
      - Jaundiced babies are often sleepy and need encouragement to waken and remained interested in nursing.
      - Lack of early and frequent breastfeeding can result in higher bilirubin levels.
      - Giving water to the jaundiced infant does not help to flush out the bilirubin as water increases urination not stooling; bilirubin is excreted through the stool.

2. Pathological jaundice
   a) Characteristics
      - High or rapidly rising bilirubin levels appearing at birth or within one or two days postpartum
      - Caused by a physical problem unrelated to feeding.
      - Some types occur later and may be confused with late onset jaundice.
      - Causes include disease that causes an increase of red blood cell breakdown, blood incompatibilities or other causes; condition or disease that interferes with the liver processing the bilirubin.

   b) Pathological jaundice and breastfeeding: Breastfeeding frequently can continue during treatments for most kinds of pathologic jaundice: exception being if jaundice is caused by galactosemia

3. Late-onset or "breast milk" jaundice
   a) Characteristics
      - Occurs in less than four percent of babies.
      - Usually appears between the fifth and seventh days postpartum and can last ten weeks or more.
      - Other causes of jaundice need to be ruled out.
      - Usually will clear on its own - may take up to three months.
   b) Late-onset jaundice and breastfeeding
      - Breastfeeding should continue; rare for bilirubin levels to reach toxic levels.
      - Bilirubin processing is just slowed down in these babies, not stopped.
      - Rapidly rising bilirubin levels without signs of slowing usually will mean some intervention is needed.

4. All jaundiced infants need to be assessed by doctor / health care worker. Treatment may be necessary depending on baby's health condition and bilirubin levels. Types of treatment may include :
   a) Frequent, effective breastfeeding - 10 to 12 times in each 24 hour period
   b) Phototherapy
      - Use of a specific type of light to break down bilirubin through the skin
      - Baby can be removed from lights for nursing or mother can nurse baby while under the lights
      - Need to watch for dehydration; frequent breastfeeding is crucial
   c) If mother's milk supply is low, she may need to supplement with donor breast milk or formula milk while increasing her supply.
   d) Exchange transfusion

5. How to help the mother
   a) Let her know that while you are not a health care professional and cannot tell her whether or not a certain treatment is necessary, you can provide information for the mother to take back to her doctor, and you can provide emotional support and help with continuing or re-establishing breastfeeding.
   b) Help her understand what jaundice is and why it happens.
   c) Remind her of the importance of her milk to her baby. Remind her that the more human milk her baby gets, the more her baby nurses, the more bowel movements her baby will have. Frequent bowel movements will help excrete more bilirubin.
   d) Assure her that continuous phototherapy is not necessary; her baby's treatment will not be compromised when she removes him from the lights for breastfeeding.
   e) Assure her that if breastfeeding is interrupted, she can express her milk and resume exclusive breastfeeding when the doctor says it's okay.
   f) Encourage the mother to touch and speak to her baby often if phototherapy is the treatment choice. Encourage her to stay with her baby as much as possible, looking for cues that her baby needs to nurse.

Module 9B - Hypoglycemia and Breastfeeding

1. Hypoglycemia: definition and symptoms
   a) Hypoglycemia is a technical term for low blood sugar.
   b) When the amount of glucose used by the body is greater than production, a deficiency results.
   c) Symptoms include: lethargy, limpness, sweating, shivering, tremors, refusal to eat, feeding difficulties, rapid respiration, and pallor.

2. Potential causes of hypoglycemia
   a) Delayed or inadequate feeding; baby receives no food to break down into simple sugar--glucose.
   b) Routine glucose supplements: give rapid rise to baby's glucose levels which stimulates the pancreas to secrete insulin, causing a rapid drop in glucose levels.
   c) Glucose IVs given to the mother during labor. At birth, baby cut off from the high supply of glucose he received via the placenta and must depend on his own resources. Unless he receives colostrum right away his glucose levels will fall.
   d) Difficult labor or stressful separation from mother, getting chilled, being left to cry. Stress depletes glucose.
   e) Diabetic mother whose diabetes was uncontrolled during pregnancy. Baby may be born with other health problems causing a separation from the mother and perhaps inadequate feeding at the breast. Note: baby of diabetic mother whose diabetes was controlled during pregnancy is not likely to have serious problems.
   f) Prematurity or post maturity.
   g) Small or large for gestational age.
   h) Oxygen deprivation.
   i) Infection.
   j) Metabolic disorders.

3. What mother can do to prevent or minimize hypoglycemia and its affects on breastfeeding:
   a) Nurse early and often; make sure baby nurses regularly; wake baby up if he's very sleepy. Small, frequent, high protein meals are a treatment for hypoglycemia. Breastfeeding provides just that.
   b) Keep baby warm, with the mother, and respond to his cries and cues by putting him to the breast.
   c) Request that baby not be given glucose water unless medically indicated.
   d) If baby needs supplement, request that it be given with syringe, small cup, or dropper.

Module 9C – Illness and Hospitalizations--How They Affect Breastfeeding

1. When the mother has difficulties with her health
   a) For minor illnesses breastfeeding can and should continue. Breastfeeding will provide baby with needed antibodies to prevent or lessen the illness in the baby. Mother needs to keep well hydrated and rest when necessary to help her recovery. Asking friends or family to help with household duties or care for the baby while mother takes a nap can be very helpful. Baby can also be tucked into bed with mother and both can get some much needed rest.
   b) If the mother experiences a drop in her milk supply, the Peer Counselor can reassure her that her milk supply will increase when she is feeling better. Allow the baby to nurse as often as he is willing, drink plenty of fluids, and get adequate nutrition. Baby will nurse more often to stimulate more milk.
   c) If mother is hospitalized and able to breastfeed, sometimes the baby can be with her, especially if someone can stay and care for the baby. If that is not possible and nursing can continue, the mother can express her milk and send it home with visitors or the baby can be brought to the mother regularly for nursing. Many hospitals have electric breast pumps which the mother can use. Mother or her advocate need to make sure that milk expression is not neglected, as overly full breasts can lead to infections and a reduced milk supply.
   d) If mother has received a recommendation to discontinue breastfeeding because of illness, drug treatments, or diagnostic procedures, she has several options:
      (i). Delay treatment or procedures for as long as possible, IF allowed by the attending physician.
      (ii). Search for alternate treatments or medications compatible with breastfeeding.
      (iii). Get the opinion of another physician.
      (iv). Wean temporarily and continue breastfeeding once it is safe again to do so; resuming breastfeeding after temporary weaning depends on the willingness and age of the baby and the willingness of the mother to endure possible extra frustration and her commitment to continuing.
      (v). If she has time and her baby is of an age that weaning would be okay, she can work at weaning her baby gradually.
      (vi). If there is no time and there is no alternative to weaning, the mother will need to wean abruptly; she will need considerable support from family, friends, and her Peer Counselor who may be the only person who will understand her devastation and loss from the weaning. It is essential that the mother continue expressing her milk enough to relieve fullness, otherwise she risks an infection. Mother needs to continue to drink to thirst.

2. When the baby has health difficulties
   a) Breastfeeding is best in health and in sickness. Mother's breast will produce needed antibodies to disease organisms which the baby passes to the mother during nursing> Antibodies are freshly produced and passed immediately back to the baby.
   b) A sick infant or toddler will generally want to nurse more frequently than usual. This keeps a steady flow of antibodies coming into his system to fight infection and keeps baby well hydrated.
   c) Breast milk digests so quickly and easily that the baby can conserve his energy for getting well again; even if a baby vomits after feeding, enough milk will have been absorbed to help prevent dehydration. Short frequent feedings are best to replenish fluids lost to vomiting or diarrhea.
   d) As long as baby has clear coloured urine with two or three wet diapers per twenty four-hour period, he is usually not in danger of dehydration.
   e) Babies who have already started solid food generally will not want them when ill.
   f) If a sick baby/toddler can take anything by mouth, the best food for him is his mother's milk.
   g) For the baby who is very sick and cannot take anything by mouth, the mother will need to express her milk to keep up her supply until her baby can nurse again.
   h) In contrast to the baby who is weaned temporarily for the mother's health condition and may be reluctant to resume nursing. If the baby has weaned temporarily because of his own sickness, he will nearly always want to resume nursing again when he is well.
   i) Hospitalized babies who are allowed to continue nursing often recover more quickly, are emotionally comforted by the presence of their mothers and continued access to the breast. They are also easier for the hospital personnel to care for.
   j) Many babies who have had surgery are allowed to nurse as soon as they wake up in recovery. This continued breastfeeding speeds their physical recovery and contributes to keeping them emotionally secure.
   k) Mother needs to advocate for her baby's well-being and insist on her right to be near her baby.

3. Medications and the breastfeeding couple
   a) Many medications have been found to be compatible with breastfeeding; however, a **Peer Counselor cannot tell a mother that it is okay for her to take a particular drug**; the Peer Counselor is not trained as a health care professional and does not know the baby's or mother's health history; she cannot make a diagnosis.
   b) The affect of a medication on the breastfeeding baby depends on many things including the age and size of the baby, the frequency of nursing, the dose of the medication, the timing of the dose--when the mother takes the medicine, the medication's half life, it's molecular size, its ph and how it is metabolized, and how the drug is administered.

c) There are lists and books about many different drugs and their effects on the breastfeeding baby. Peer Counselors need to consult with their Trainers. Peer Counselors might also recommend that the mother get a second opinion if she is not satisfied with the information and recommendations of her physician; THE PEER COUNSELOR MUST WORK VERY CLOSELY WITH HER TRAINERS IN EVERY SITUATION OF THIS TYPE.

4. Contraindications for breastfeeding: all the following conditions necessitate consultation with a health care provider:
   a) Active TB
   b) Cancer chemotherapy
   c) HIV positive mother
   d) Drug abuse
   e) Some medications
   f) Active Hepatitis C

5. The Peer Counselor's role in helping the ill or hospitalized mother and baby :
   a) The Peer Counselor is a lay-helper and is not qualified to diagnose or recommend treatment for either a mother or baby.
   b) The Peer Counselor can listen to the mother's concerns and support her in her decision to wean or continue breastfeeding and give her information and ideas which will enable the mother to do either.
   c) The Peer Counselor can give the mother information which the mother can then take back to her physician and work together to come up with a course of action which will best meet everyone's needs.
   d) The Peer Counselor can give the mother some communication tools to use with her doctor so that she feels like an active partner in her or her baby's health care.

6. Immunization of the breastfeeding mother or baby
   a) According to the U.S. Center for Disease Control "Neither killed nor live vaccines affect the safety of breastfeeding for mothers and infants. Acceptable vaccines include: chicken pox, smallpox, typhus, typhoid, yellow fever, oral and injected polio, tetanus, diphtheria, pertussis, rabies, measles, rubella, cholera and influenza. Hepatitis B vaccine is also safe for nursing mothers."
   b) The same schedule of immunizations is usually followed for the breastfed baby as for the formula fed baby.
   c) There is no need to delay breastfeeding before or after any vaccine, including the oral polio vaccine.
   d) Some studies indicate breastfed babies respond to immunizations by producing more immunities in their blood than formula-fed babies.

Module 9D - A Brief Overview of Premature Babies and Breastfeeding

1. Ways the Peer Counselor can be supportive and encouraging
   a) Listen to the mother's concerns about the health of her baby, the possibility that the baby will die, the difficulties in having a life at the hospital with the baby and also with the rest of her family; the fear of not being able to produce enough milk.
   b) Empathize with the mother and help the mother clarify and confirm in her own mind what she needs to do; offer ideas and information without overloading her.
   c) Reassure the mother how important providing her breast milk will be for both her baby and herself; milk will provide the best nutrition and protection from disease. Providing baby with her milk will make the mother an active, essential partner in her baby's care. The hospital staff can provide the medical expertise necessary to keep her baby alive but she can provide the very substance that will help keep her baby growing and healthy.
   d) Help her establish some routines for expressing her milk and getting it to her baby; provide information on how often and how long to express her milk; teach her how to hand express and if required share basic information on using a breast pump; have the hospital give the mother its guidelines on how to store the milk, the kinds of containers to use, sterilization procedures, and labeling.
2. Major concerns surrounding the premature baby and breastfeeding
   a) The baby's sucking ability, size, and general health will determine when he is ready to actually breastfeed.
   b) Until baby is ready to nurse, he will be fed by tube and then probably with a bottle;
   c) Finger feeding and cup feeding are options to use in place of a bottle to feed a baby.
   d) Some babies go directly from tube feeding to the breast and bypass bottle nipples and potential nipple confusion.
   e) First nursings: encourage the mother to be patient and take time to let the baby just nuzzle and get used to being by the breast. Encourage mother to ask nurses to provide a suitable space for nursing--somewhere private, without a lot of bright lights or noise if possible. Experiment with positions--generally the premature baby will need much more support for his head and may nurse better in a more upright position. Baby may need extra support for his chin--Dancer or “U” hold. As with all babies, breastfeeding is a learned skill; babies are born with a sucking instinct but some need practice and training in how to use their jaws and tongues.
   f) Keeping up the mother's milk supply; the Peer Counselor can be the mother's cheerleader and praise her for any amount of milk that she is able to express; the Peer Counselor can remind the mother about healthy habits such as eating well or cutting down/stopping smoking, getting enough fluids and rest, and encouraging exercise to relieve stress.

g) The transition from the hospital to home can be very stressful. Mother may have concerns about her milk supply and her baby's ability to nurse or how to manage supplements. She may also have fears about caring for a tiny baby. The Peer Counselor can help by reassuring the mother that any amount of breastfeeding and human milk the baby gets is a great thing and that her milk supply can be increased and will meet the baby's growing need for more milk. She can also remind the mother that learning to care for any baby can be a fearful time and that practice and living with the baby 24 hours a day is the best teacher; the baby will thrive on the mother's loving care and good milk.

3. Kangaroo care

a) This natural method of caring for premature babies is being used more and more frequently.

b) Baby is held skin-to-skin against mother’s (or father’s) chest under clothing or a blanket.

c) Kangaroo care helps regulate the baby’s heart rate and breathing rate.

d) Kangaroo care helps in the transition to breastfeeding - while being held, baby may attempt to nuzzle, lick or suckle at the breast.

e) Peer Counselors can encourage mothers to ask the doctors and nursery staff “how soon can I start Kangaroo Care?” if it has not already been suggested by the baby’s doctor.

Module 9E - Cesarean Birth and Breastfeeding

1. Advantages of breastfeeding after a cesarean birth
   a) Oxytocin produced during lactation makes mother's uterus contract which speeds her healing.
   b) Closeness of breastfeeding can help mother and baby bond and heal some of the emotional trauma if the cesarean was an emergency, the mother received general anesthesia, or mother and baby were separated at birth.
   c) Breastfeeding can help the woman feel capable and competent as a mother.

2. Circumstances that affect nursing early and often
   a) Anesthesia--general
      (i). If mother received general anesthesia, she will probably be unconscious and groggy after the birth; breastfeeding might be delayed.
      (ii). As soon as mother feels able, she should be encouraged to nurse her baby.
      (iii). Mother needs reassurance that the delay will not prevent her from breastfeeding.
   b) Anesthesia-- regional--spinal or epidural
      (i). Mother can begin nursing on the delivery table.
      (ii). She will still be pain free at this point and this will be a good time to begin.
   c) Anesthesia will linger in the baby a bit and may cause him to be sleepy or lack interest in nursing. Mother will need encouragement to keep trying, to keep offering the breast, and to continue to hold her baby at the breast (skin-to-skin if at all possible) even if he isn't very interested.

3. Mother will need help if the baby is to room-in; she'll need help with diapering, picking the baby up, putting the baby to her breast, switching sides.

4. If a helper is not available or hospital policies make it difficult to room in. Mother needs reassurance that breastfeeding will work anyway; she needs to have her baby brought to her when baby is asking to nurse. Step-by-step guide to getting into side-lying position (if mother is able to): Bed flat, side rails up. Extra pillows behind mother for support. Grasp side rail, relax abdominal wall and slowly and carefully roll to one side. Cover abdomen with pillow, blanket, towel, etc. to protect incision. Flex the legs and place a pillow between them. Lean back into pillows behind the mother.

5. If mother or baby are having medical problems postpartum, nursing may be delayed. If mother is fine but baby is unable to nurse, mother can express her milk and save for her baby. Expressing her milk will also stimulate her milk to come in more quickly. A fever in the mother caused by a urinary tract infection from the catheter or an infection of the mother's incision should not be a cause for separating mother and baby.

6. Positioning
   a) Mother will probably be lying on her back for the first nursing and for several hours after that; if mother has had a spinal, she'll need to lie flat to prevent headache.
   b) Mother will need help picking up baby, positioning him at breast, and switching sides.
   c) Mother will be hooked up to IV tubes for a while and she will need help working around them.
   d) Keys to positioning are still the same: keep baby snug against mother's body, baby needs to open it's mouth wide, his tongue needs to be kept down, and he needs to get a large mouthful of breast.
   e) Pillows or rolled towels can be used to protect the mother's incision from baby's feet; also use them for supporting mother's body--under her knees, head, behind her back, wherever she is needing support.
   f) Side-lying, football hold, or cradle hold all work well; use the latter two once mother is able to sit upright.
   g) Mother needs to ask for help when she needs it; she has just had major surgery and she will be in pain.

7. Things to consider during the early postpartum period
   a) Mother needs encouragement to use the minimum amount of pain medication for her comfort because it can cause drowsiness in her baby.
   b) Help at home will be important; if no one is available to be there 24 hours a day for a few days, then have someone come in and set things up so mother can concentrate on healing and caring for her baby.

8. Food: prepare several sandwiches, wash and slice carrots, celery, and fruit; make a bowl full of salad; slice cheese, meats for snacking; have thermos of hot tea, apple cider, containers of water available for mother; use cooler for food if available and put near mother's bed.

9. Baby things: stack of diapers, pail for used diapers, wet wash cloths in a plastic bag or covered dish, clothes, blankets where mother can reach easily.

10. Things for mother: books, telephone, address book, paper, pens, envelopes and stamps, reading lamp, tape recorder, etc.; whatever will help mother feel prepared and comfortable
    - Mother will need help with laundry, errands, older children, house cleaning, and transportation.

Module 9F - Breastfeeding Multiple Birth Babies

1. Coordinating the nursings of two or more infants
   a) Breastfeeding two babies at once has some advantages
      (i). Saves time
      (ii). Stimulates increased prolactin production in mother and increases her milk production
      (iii). If one baby is a less vigorous nurser or if one baby is nipple confused, that baby can take advantage of the more vigorous nurser stimulating a strong let-down reflex and thus gets more milk; strong milk flow can stimulate baby to suck correctly and more vigorously
   b) Breastfeeding two babies at once has some disadvantages
      (i). Can be hard for mother to manage positioning two small infants and keeping them well attached to the breast simultaneously. Sometimes it is better to nurse together once babies are older and can hold themselves to the breast on their own.
      (ii). If one baby is not as vigorous at the breast or is nipple confused, the mother may need to give him undivided attention at the breast. He may need to work at stimulating the let-down on his own without a sibling making it easy for him.
      (iii). Mother may want to spend time with each baby separately at the breast for individual attention and bonding.
   c) Mother does not need to choose one way or the other; she can nurse babies separately sometimes and at others nurse them together.
   d) Likewise, some mothers will assign each baby to one side while others rotate their babies from side to side; reminding the mother that her breast is making milk while the babies are breastfeeding will reassure her that her babies can get plenty of milk either way.
   e) If one baby has a weak suck, switching baby from side to side keeps both sides well stimulated.
   f) Switching sides also stimulates the babies' vision equally.

2. Positioning babies at the breast
   a) Mother will probably need an extra pair of hands to help her position the babies when they are very young.
   b) Mother needs to be creative and open-minded; she doesn't need to nurse only in a chair or in bed. Sometimes lying on the floor or reclining on a couch will be most comfortable. Since she will be spending considerable time breastfeeding, she might welcome the variety of locations and positions.
   c) Comfort of the mother and the important keys to positioning and latch-on are the priorities.

d) Possible positions include
   (i). Holding one baby in a cradle position and one in a football position.
   (ii). Criss-cross babies, holding each in a cradle position.
   (iii). Hold one baby in a cradle position and hold the sibling's body in the same direction as the first baby but on the other breast; babies will form a straight line with one's feet near the other baby's head.
   (iv). Both babies are in a football hold, one on each side.
   (v). Mother lies on her back with pillows for head support, babies' heads are at mother's breasts with their knees coming together at her stomach to form the point of a "V".

3. Night time considerations
   a) Nursing babies in the "V" position or while lying on her side can help mother get more rest.
   b) Some mothers will wake one baby after the other has nursed to give themselves a little more uninterrupted sleep.
   c) Babies will often sleep better if they are touching each other.
   d) Some mothers keep babies in a crib at night next to their own bed; some have the babies on a mattress on the floor so mother can lie down to nurse; others take babies to bed with them.
   e) Keeping all diapering needs close to the bed as well as water for mother and a night light can simplify night time feedings.

4. Taking care of mother
   a) Because many multiple birth babies are born prematurely, mother may need to express her milk to establish and continue her milk supply; she may need encouragement to do that, plus information to help her express her milk easily.
   b) If her babies have had supplements and have become nipple confused, she will need much support and encouragement to put up with the frustration of getting her babies back on the breast.
   c) She may need someone to vent her fears, frustrations, and feelings of being overwhelmed.
   d) Mother's needs for food, rest, plenty of liquids, exercise, and help with household responsibilities will be at least double that for any other new mother of a single baby.
   e) Mother may need a gentle reminder that people's needs come first; encourage mother to set priorities in concert with her partner.

Module 9G - Relactation and Adoptive Nursing

1. Factors affecting baby's willingness to return to breastfeeding
    a) Length of time baby has been off the breast : the longer a baby has been off the breast, the more the mother's milk supply will have decreased; the milk producing tissue will actually start to involute, compromising the mother's ability to produce milk
    b) Nipple confusion : if baby has had many bottles, he may have forgotten how to use his jaws and tongue at the breast; a baby who will not latch-on cannot return to breastfeeding. Baby will need to be retrained to suck at the breast; a health care provider who can do that will need to be consulted for retraining.
    c) Baby's age : the older a baby is, the less likely it is for him to return to the breast.
    d) Prior experience with breastfeeding : was it a positive experience or negative?

2. Factors affecting mother's role in relactating
    a) Mother's frustration level : in order to relactate, the mother will need to prepared for and endure fussing and crying from her baby. She may find that the emotional energy expended on both their parts is greater than the eventual benefits of breastfeeding
    b) Mother's available time for expressing milk and giving baby exposure to the breast as well as attempting to get the baby to latch-on. If mother has not nursed for several days or weeks, her milk supply will be low and milk expression would be advised. She may not have time express her milk, particularly if she has other children to care for or a very busy schedule
    c) Is mother taking any medications or oral contraceptives that may affect lactation ? Does the mother smoke?
    d) If the mother's nipples are inverted, the baby may have a harder time latching on.
    e) Misinformation about breastfeeding : mother may have had an unsuccessful breastfeeding experience because she did not understand basic management. She needs to improve her knowledge of management if she is to succeed.

3. Ideas for getting the baby on the breast
    a) Give baby exposure to the breast without offering to nurse, give baby more skin contact in general. Carry baby often and keep baby with mother between feedings.
    b) Offer to nurse when baby is sleepy : baby may suck instinctively in a sleepy state.
    c) Try nursing while walking around, in a darkened room, in the bath, in a distraction free place.
    d) Use alternative feeding methods, such as a cup, spoon, or medicine dropper, for several days rather than bottles to encourage the baby to forget how to use a bottle; then try getting the baby to the breast.

e) Use a lactation aid to encourage baby to latch-on and nurse. Lactation aid gives baby an incentive to nurse: food

f) Make sure positioning and latch-on are effective, review technique as necessary.

g) Work with baby's doctor to decrease the amount of supplementation baby receives; a baby who is not eating enough will be fussy, could lack energy, and may refuse to nurse on a breast that doesn't give him enough food quickly enough; mother will quickly lose confidence and abandon her efforts to relactate.

4. Adoptive nursing or induced lactation

a) Differs from relactation. A mother relactating is trying to bring back a milk supply which has recently decreased. Induced lactation is bringing in a milk supply without the benefit of pregnancy - used by women who are adopting infants.

b) Some mothers start to induce their milk in preparation while waiting for their baby to arrive. Hand expression or pumping is beneficial if advance notice of baby's birth is known.

c) Other mothers don't bother to induce / express milk and wait until they have their baby.

d) Adoptive mothers do not have the benefit of hormonal changes that take place for lactation during pregnancy. Breast stimulation (via hand expression or pumping) and a baby's suck may not be as effective as the hormones for stimulating growth of lactation tissue.

e) A mother can expect to spend about four to six weeks stimulating her breasts with hand expression or pumping before she sees any results; whether or not a mother has lactated previously does not seem to influence how much milk a mother produces. A few women will be able to produce a full supply for their baby, but most will not; some will produce no milk at all.

f) Nipple rolls and elongation, exposing nipples to sunlight and air, breast massage, hand expression and partner stimulation are all beneficial in preparing the nipple for baby.

g) Factors affecting amount of milk produced

(i). Baby's willingness to suck and spend time at the breast

(ii). Frequency and effectiveness of breast stimulation

(iii). Mother's response to breast stimulation

(iv). How long mother has been nursing or expressing; a mother may have a slow increase over a long period of time or reach a plateau and then continue to increase again after a while.

h) Even if mother does not produce much milk, breastfeeding can be emotionally gratifying for both her and her baby.

i) Focus of an adoptive mother should be on the emotional benefits of breastfeeding, not the nutritional benefits - hence there is no room for failure.

5. The Lactation Aid
   a) A lactation aid is a device that allows a breastfeeding mother to support her baby with expressed breast milk or formula milk without using a bottle.
   b) Baby continues to get the mother's milk even while being supplemented. Supplementing at the breast encourages the baby to continue breastfeed and reduces the risk of breast refusal.
   c) Lactation aid allows both mother and baby learn to breastfeed by breastfeeding.
   d) Lactation Aid device consist of a container for the supplement – usually a feeding bottle with an enlarged nipple hole, and a long thin tube leading from this container.
   e) Basic guidelines for usage
      (i). Mother sizes the length of tubing to extend one quarter inch beyond the tip of her nipple when securing the tubing to her breast with tape. NOTE : Do not cut off the end of the tube as cutting it makes the end sharp.
      (ii). When baby latches on, nipple will extend to the end of the tubing
      (iii). Tape to secure tubing should be applied parallel to the tubing on the breast a bit beyond the areola
      (iv). Mother can adjust the position of the container; low position makes the milk flow more slowly, while a higher position allows the milk to flow more rapidly
      (v). Mother positions baby as she normally would; some babies need more encouragement to take the breast with the tubing; others don't even notice it.
      (vi). For the lactation aid to work, baby needs to be able to have a good, deep latch and to suckle.
   f) Milk flows through the tubing when baby is sucking. The flow of milk into the baby's mouth stimulates the baby to continue to suckle. When sucking he also receives his mother's milk and stimulates her milk production. When the mother's milk is flowing freely, the supplement from the tube stops flowing until the mother's milk is no longer coming out.
   g) As the mother's milk production increases, the baby will need less supplement; mother needs to work in concert with her health care provider on how much supplement to offer and when to wean baby from the lactation aid.

6. Helpful Resources
   a) Talking with another mother who has successfully nursed an adopted infant is helpful before and after the mother starts nursing her adopted baby.
   b) Mother's partner needs to be supportive and understanding.

Module 9H - Medications, Recreational Drugs and Environmental Contaminants in Human Milk and How They Affect Breastfeeding

1. Prescription, over-the-counter drugs and herbal medications
   a) A breastfeeding mother should always check with her health-care professional before taking any medication or herbs.
   b) If a particular prescription or over-the-counter drug is contraindicated for the breastfeeding mother, another drug is probably available for use that is less risky.
   c) Many people think that herbal remedies are not harmful at all. This is not always true. Some herbs may increase or decrease a mother's milk supply. Encourage mothers to check with a lactation specialist before using any herbs.

2. Recreational Drugs
   a) Nicotine (smoking cigarettes)
      (i). Women who smoke cigarettes should be encouraged to breastfeed.
      (ii). Human milk protects babies from respiratory infections. Breastfed infants of smokers have fewer respiratory infections than their formula-fed counterparts.
      (iii). The fewer cigarettes or equivalent tobacco products a mother smokes, the better it is for her baby.
      (iv). Nicotine is not readily absorbed through baby's intestinal tract and is quickly metabolized.
      (v). Smoking more than a pack per day increases the risks; mother's prolactin levels will decrease.
      (vi). Smoking can interfere with the mother's let-down reflex; mother needs encouragement to not smoke right before or during nursing.
      (vii). Women who smoke tend to wean sooner than non-smokers; heavy smokers wean sooner still; decreased prolactin levels may inhibit mother's desire to nurse.
      (viii). Second-hand smoke is a major concern. No one should smoke while holding baby. Smoking should be limited to outside or in one room of the house. Higher rates of respiratory disease and SIDS are reported in babies exposed to secondhand smoke.
      (ix). Babies who are affected by smoke can have nausea, vomiting, abdominal cramps, and diarrhea.
      (x). Practical hints for smokers.
         - Smoke outside away from baby whenever possible.
         - Wear a smoking jacket to keep smoke off clothing where baby's nose is.

b) Alcohol

(i). Alcohol has been found to peak in the mother's bloodstream and in her milk about 30-90 minutes after consumption.

(ii). The alcohol level in the mother's milk will equal the amount in the mother's blood. Baby metabolizes alcohol more slowly than an adult. Baby's blood alcohol content will generally remain lower than the mother's because the milk he receives will be diluted with his body water.

(iii). Breastfeeding should be suspended until the mother is sober.

(iv). Milk expression may be necessary during this time to maintain milk supply.

(v). An occasional drink or regular light drinking (one or fewer drinks per day) has not been found to be harmful to the nursing baby.

(vi). Heavy drinking can interfere with the mother's release of oxytocin and inhibit her let-down (MER) and result in infant low weight gain or failure-to-thrive.

(vii). A mother who is regularly under the influence of alcohol may not be able to mother her baby adequately. She may not nurse the baby often or long enough and the baby may become sleepy from the alcohol he receives from breastfeeding and not request to nurse frequently enough.

c) Cocaine

(i). Cocaine passes into the milk in significant amounts and can cause cocaine intoxication. Cocaine can stay in mother's milk and baby's urine for as long as sixty hours after exposure.

(ii). Infants do not have the necessary metabolites in their systems to metabolize the drug; leads to drug accumulating in baby.

(iii). Intoxication symptoms include: irritability, vomiting, dilated pupils, tremors, and increased heart and respiration rates.

(iv). Mother's ability to mother and care for her infant are of great concern.

(v). Women who use one drug may also use others as well as smoke and drink; combination of things a great concern.

(vi). Nursing mothers should avoid using cocaine.

d) Heroin and methadone

(i). Heroin passes into the milk in great amounts and will cause addiction in baby.

(ii). Mothers in well-supervised methadone programs could be encouraged to breastfeed; mother and baby should be closely monitored.

NOTE : Methadone is compatible with breastfeeding. [1.2]

e) Marijuana
   (i). The active ingredient in marijuana, THC, concentrated in milk; lingers for weeks (per Hale) after exposure, and is detected in baby's stool and urine.
   (ii). Marijuana use can decrease a mother's levels of prolactin.
   (iii). Baby would be exposed to second-hand smoke, increasing amount of drug received.
   (iv). Can cause structural changes in the baby's brain cells and impair the DNA and RNA formation and proteins needed for proper growth and development.
   (v). Breastfeeding mothers should avoid using marijuana (Contraindicated by the AAP).

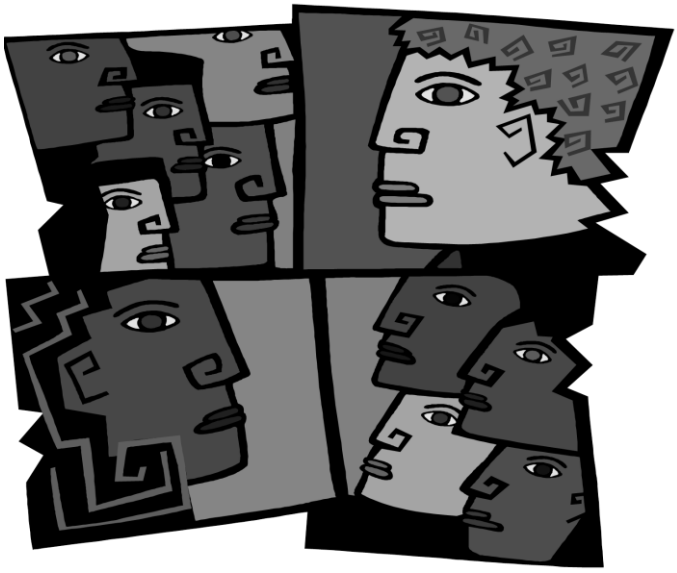
3. Environmental Contaminants
   a) Traces of the contaminants to which we have been exposed can be found in human milk.
   b) Contaminants are also found in cow's milk and in formula milk. Also in the water used to prepare the formula milk and there may be concern regarding contamination from the feeding bottles and nipples (teats) used.
   c) No evidence exists that a breastfed baby has ever been harmed by contaminants in his mother's milk.
   d) We need to consciously limit our exposure to contaminants.

4. Peer Counselor's Role
   a) If Peer Counselor encounters a mother who she thinks may be having a problem with substance abuse, she should consult her Trainers or her supervisors at the agency /centre for assistance.

[1] Bhg Perkhidmatan Farmasi. Garis Panduan Kaunseling Methadone. Kementerian Kesihatan Malaysia, 2010

[2] Hale, Thomas. Medication & Mother's milk. Springer Publishing Co., 2019

Working with Diverse Population Examining Attitudes



Module 10. Working with Diverse Populations: Examining Attitudes

Objectives: Participant will be able to:

- Identify personal beliefs and attitudes that relate to breastfeeding and mothering.
- Describe the importance of understanding and respecting a mother's belief and practices.
- Describe at least two important points to remember about working with teenagers.

A. Identifying Our Beliefs and Attitudes
B. Looking At Our Experiences Both Past And Present
C. Respecting Our Differences
D. Working with Teenage Mothers

Appendix :

Quick Guide fro Cross-Cultural Counseling

Module 10. Working with Diverse Population – Examining Attitudes

A. Identifying our beliefs and attitudes

- We all have our own values, beliefs and attitudes that we have developed throughout the course of our lives. Our family, friends, community and the experiences we have had all contribute to our sense of who we are and how we view the world.[1]
- To be a more effective peer counselor, we need to be aware of our own personal values, beliefs and attitudes and not to impose them on mothers receiving our support.

B. Looking at our experiences both past and present

- There are some incidents or experiences, both past and present that have helped shape our attitudes and assumptions about different people. A difficult interaction with a person from another group typically leads to negative or judgemental reaction.
- This unpleasant experience generates "faulty data" leading to generalizing to all people from that particular group, thus setting ourselves up for further difficult interactions with anyone from that group.
- If you encounter a situation that seems different from what you are used to, consider the possibility that the mother's response may be a cultural practice that is different from yours. Rather than making assumptions because of a woman's cultural group, it is better to be curious and learn as much as you can about each mother. [2]

C. Respecting Our Differences

- An important aspect of being a Peer Counselor is respecting the different opinions and beliefs of others even when they are not the same as our own. To understand the beliefs of others, we must first understand why we think the way we do.
- Many factors, especially culture and family, play a role in who we are. A mother's beliefs and family will affect how she feeds her baby more than anything else. Other factors that may influence whether we breastfeed or not include : religion, age, education, income, social support and/or health / medical issues.
- Understanding and respecting a mother's beliefs and practices will help in gaining her trust and in beginning a positive relationship.
- Keep in mind that not every mother from the same group shares the same beliefs about breastfeeding and raising her children.[3]

D. Working with Teenage Mothers

- Learning how to approach a teen mother sensitively and respectfully will enable you to be a positive influence in her life.
- Young mothers wish to be treated as adults and do not respond well to lecturing, advice, or a patronizing manner that suggests an adult-child relationship. They need you to listen to their concerns and respond as you would with an older mother.
- Because she is in the process of learning to think abstractly, it is normal for her adolescent focus to be self-centered. Talking to a teen mother about the benefits of breastfeeding for her (or the risks of not breastfeeding for her) may carry more weight than a litany of information about the baby's health.
- A pregnant teenager may be fearful and unhappy about the physical changes that occur with her body during pregnancy. She may feel apprehensive about the impending labour and delivery. Depending on the degree of her emotional adjustment to pregnancy, she might doubt her self worth and have a poor self image.
- Childbirth is a time of vulnerability for all new mothers. For a teen mother, whose confidence is very fragile, it may be the first realization of the responsibility ahead of her.
- Teens who see other women breastfeed and who were breastfed as babies are more inclined to breastfeed.
- A teenage mother usually has a great need for a one to one relationship with someone who cares about her and understands her needs. She wants consistency and personal involvement in this relationship.
- Demonstrating interest in her as a person will help build rapport and develop trust in the relationship. Help her see how she will benefit from breastfeeding her baby. [4]

[1] Department of Education and Training, States of New South Wales. Personal Values, Beliefs and Attitudes. 2009. https://sielearning.tafensw.edu.au/MCS/CHCAOD402A/chcaod402a_csw/knowledge/values/values.htm (Accessed 2019-04-16)

[2] WIC Works Resource System, USDA. Loving Support© Through Peer Counseling: A Journey Together – FOR PEER COUNSELORS" https://wicworks.fns.usda.gov/wicworks/Learning_Center/PC/Handbook/TrainingModules.pdf\ (Accessed 2019-04-16)

[3] Trainer, Erika. et al. California WIC Breastfeeding Peer Counseling Program Manual – Facilitator Guide. California Dept of Public Health. 2010

[4] Lauwers, Judith and Swisher, Anna. Counseling the Nursing Mother – A Lactation Consultant's Guide. Jones and Bartlett Publishers, Inc. 2005

Quick Guide for Cross-Cultural Counseling

Preparing for Counseling

- Understand your own cultural values and biases.
- Acquire basic knowledge of cultural values, health beliefs, and nutrition practices for client groups you routinely serve.
- be respectful of, interested in, and understanding of other cultures without being judgmental

Enhancing Communication

- Determine the level of fluency in English and arrange for an interpreter, if needed.
- Ask how the client prefers to be addressed.
- Allow the client to choose seating for comfortable personal space and eye contact.
- Avoid body language that may be offensive or misunderstood.
- Speak directly to the client, whether an interpreter is present or not**.**
- Choose a speech rate and style that promotes understanding and demonstrates respect for the client.
- Avoid slang, technical jargon, and complex sentences.
- Use open-ended questions or questions phrased in several ways to obtain information.
- Determine the client's reading ability before using written materials in the process.

Promoting Positive Change

- Build on cultural practices, reinforcing those which are positive, and promoting change only in those which are harmful.
- Check for client understanding and acceptance of recommendations.
- Remember that not all seeds of knowledge fall into a fertile environment to produce change. Of those that do, some will take years to germinate. Be patient and provide counseling in a culturally appropriate environment to promote positive health behavior.

Resources

Module 11 – UTILIZING RESOURCES

A. Websites

Here are some reputable and recommended websites that can be sources for up-to-date, evidence based breastfeeding information.

Note : Website links are current as of April 2019.

1. La Leche League International
   - This organization help mothers worldwide to breastfeed through mother-to-mother support, provides encouragement, information, and education, and to promote a better understanding of breastfeeding as an important element in the healthy development of the baby and mother.
   - Website : https://www.llli.org/resources

2. World Alliance for Breastfeeding Action (WABA)
   - WABA is a global network of individuals and organisations who dedicate themselves to protect, promote and support breastfeeding worldwide. WABA is based in Penang, Malaysia.
   - Website : http://waba.org.my/

3. UNICEF : The Baby Friendly Initiative - Support for Parents
   - This website offers a range of useful resources for parents on infant feeding and relationship building, as well as information on Baby Friendly care and overcoming common breastfeeding challenges.
   - Website : (i) https://www.unicef.org.uk/babyfriendly/support-for-parents/
     (ii) https://www.unicef.org/breastfeeding/

4. Global Health Media Project (GHMP)
   - GHMP develops user-friendly videos to meet the basic learning needs of health workers and communities. Their videos are clear, accurate and practical to convey health care information in a way that's easy to understand and remember.
   - The Breastfeeding Series "shows and tells" this important information to help health workers and mothers achieve greater breastfeeding success worldwide.
   - Website : https://globalhealthmedia.org/videos

5. Kellymom website
   - provides evidence-based information on breastfeeding and parenting.
   - Website : https://kellymom.com/

6. International Breastfeeding Centre
   - This website provides reliable and well researched breastfeeding information, creates videos for women to learn about breastfeeding.
   - Website : https://ibconline.ca/

7. International Lactation Consultant Association® (ILCA®)
   - ILCA® is the member association for International Board Certified Lactation Consultants® (IBCLC®) and other healthcare professionals who care for breastfeeding families.
   - This organization also provides several resources such as Journal of Human Lactation (a quarterly peer reviewed official journal of ILCA) and Inside Track articles for members and others who care for breastfeeding families.
   - ILCA membership is open to all who support and promote breastfeeding.
   - Website : https://www.ilca.org/main/home

B. Reference Books

There are several local and international well-written breastfeeding books that serves as a guide to those who help breastfeeding families. These 5 books listed below are among the recommended resources.

1. Bahagian Pemakanan, Kementerian Kesihatan Malaysia. *Manual Pembimbing Penyusuan Susu Ibu - Untuk Kegunaan Kumpulan Sokongan Penyusuan Susu Ibu*, 2019. E-book (http://nutrition.moh.gov.my/manual/mobile/index.html#p=2)
2. Idris, Faridah. *Membesarkan Anak Hebat dengan Susu Ibu*, PTS Millinnea Sdn Bhd, 2013.
3. Mohrbacher, Nancy. *Breastfeeding Answers Made Simple - A Guide for Helping Mothers*, Hale Publishing LP, 2010.
4. Sulaiman, Zaharah et al. *KIT Multimedia Pendidikan Penyusuan Susu Ibu*, Universiti Sains Malaysia, 2017.
5. Wessinger, Dianne., West, Diana and Pittman, Teresa. *The Womanly Art of Breastfeeding*, 8th edition, La Leche League International, 2010.

The following table shows chapters in the reference book which complements each MBfPC Training module.

Reference Book / **Module**	**Manual Pembimbing Penyusuan Susu Ibu** - Untuk kegunaan Kumpulan Sokongan Penyusuan Susu Ibu.	**Membesarkan Anak Hebat dengan Susu Ibu**.	**KIT Multimedia Pendidikan Penyusuan Susu Ibu**.	**The Womanly Art of Breastfeeding**.	**Breastfeeding Answers Made Simple** - A Guide to Helping Mothers.
Module 1 : Introduction to MBFPC	**Bab 1** : Apa itu Sokongan Penyusuan Susu Ibu ?	-	-	**Chapter 2**: Building Your Network **Chapter 19**: About La Leche League	-
Module 2: Communication Skills for Peer Counselors	**Bab 2** : Bagaimana untuk membantu Ibu ?	-	-	-	**Chapter 1**: Basic Breastfeeding Dynamics - Supporting Versus Teaching
Module 3 : Breastfeeding - There is No Substitute	**Bab 3** : Apakah risiko yang dapat dikurangkan dengan penyusuan susu ibu ?	**Bab 7** : Bayiku sihat dengan susu ibu	**Topik 1** : Kepentingan penyusuan susu ibu kepada bayi **Topik 2** : Kepentingan penyusuan susu ibu kepada ibu **Topik 12** : Risiko kepada bayi yang tidak diberi susu ibu	**Chapter 1**: Nesting	**Chapter 2** : Breastfeeding Rhythms

Reference Book / **Module**	**Manual Pembimbing Penyusuan Susu Ibu** - Untuk kegunaan Kumpulan Sokongan Penyusuan Susu Ibu.	**Membesarkan Anak Hebat dengan Susu Ibu**.	**KIT Multimedia Pendidikan Penyusuan Susu Ibu**.	**The Womanly Art of Breastfeeding**.	**Breastfeeding Answers Made Simple** - A Guide to Helping Mothers.
Module 4 : Barriers that Confront Breastfeeding Mothers	**Bab 12** : Salah Tanggap dan kepercayaan berkaitan penyusuan susu ibu.	**Bab 17** : Penyusuan Ibu, Stress & Pemakanan **Bab 18** : Susu Tidak Banyak **Bab 27** : Penyusuan di Tempat Awam **Bab 28** : Menangani Kritikan & Persekitaran Negatif	-	**Chapter 17** : Alternate routes	**Chapter 5** : Weaning from the Breast - The Decision to Wean
Module 5 : Breast Anatomy, Hormones of Lactation & Human Milk Composition	**Bab 4** : Bagaimana Susu Dihasilkan?	**Bab 2** : Kenali Payudara Wanita **Bab 3** : Fisiologi Penyusuan Ibu **Bab 24** : Puting Tenggelam	**Slaid 1** : Struktur payudara ? **Slaid 2** : Bagaimanakah susu ibu dihasilkan ? **Slaid 3** : Bagaimana susu ibu dikeluarkan ? **Slaid 42** : Bagaimana menjaga payudara ibu ?	-	**Chapter 10**: Making Milk **Chapter 12**: Sexuality, Fertility, and Contraception **Chapter 13**: Nutrition, Exercise, and Lifestyle Issues

Reference Book / **Module**	**Manual Pembimbing Penyusuan Susu Ibu** - Untuk kegunaan Kumpulan Sokongan Penyusuan Susu Ibu.	**Membesarkan Anak Hebat dengan Susu Ibu**.	**KIT Multimedia Pendidikan Penyusuan Susu Ibu**.	**The Womanly Art of Breastfeeding**.	**Breastfeeding Answers Made Simple** - A Guide to Helping Mothers.
Module 6 : Basic Breastfeeding Management	**Bab 6** : Bagaimana bayi disusukan ?	**Bab 1** : Semua Bayi Dilahirkan bagi Menyusu **Bab 4** : Lekapan dan Posisi Kasih Sayang **Bab 5 :** Sentuhan kulit penjana cinta sejati **Bab 19** : Payudara Bengkak **Bab 20** : Bayi Menolak Payudara **Bab 21** : Putting Sakit dan Luka **Bab 22** : Saluran Susu Tersumbat & Keradangan Payudara	**Topik 3** : Kepentingan sentuhan kulit ke kulit **Topik 4** : Kepentingan memulakan penyusuan awal **Topik 5** : Kepentingan ibu bersama bayi sepanjang masa **Topik 6** : Kepentingan menyusu mengikut kehendak bayi **Topik 7** : Kepentingan menyusu sekerap mungkin **Topik 8** : Kepentingan posisi dan pelekapan yang betul **Topik 9** : Kepentingan penyusuan eksklusif	**Chapter 4**: Latching and Attaching	**Chapter 2**: Breastfeeding Rhythms- Establishing Breastfeeding **Chapter 3**: Challenges at the Breast **Chapter 17**: Nipple Pain and Other Issues **Chapter 18**: Breast Issues **Appendices: A** & B

Reference Book / **Module**	**Manual Pembimbing Penyusuan Susu Ibu** - Untuk kegunaan Kumpulan Sokongan Penyusuan Susu Ibu.	**Membesarkan Anak Hebat dengan Susu Ibu**.	**KIT Multimedia Pendidikan Penyusuan Susu Ibu**.	**The Womanly Art of Breastfeeding**.	**Breastfeeding Answers Made Simple** - A Guide to Helping Mothers.
Module 7 : Ideas to Make Breastfeeding Work in Day to Day Living	**Bab 5 :** Bagaimana memulakan penyusuan dengan lancar ? **Bab 7** : Bagaimana memerah dan memberi susu perahan ? **Bab 13** : Pemakanan Ibu menyusu **Bab 14** : Persediaan Penyusuan Susu Ibu bagi ibu yang bekerja	**Bab 6** : Mulakan Dengan Betul **Bab 9** : Merancang Mahu Berjaya **Bab 10** : Berpantang, Masa Rehat dan Belajar **Bab 11:** Perlukah Pam Susu Yang Mahal? **Bab 12** : Memerah dan Menyimpan Susu Ibu sebelum Kembali Bekerja **Bab 13** : Memberi Susu Perahan kepada Bayi **Bab 14** : Kembali Bekerja **Bab 15** : Memerah Susu dalam Pelbagai Keadaan **Bab 16** : Berurusan	**Topik 11** : Cara memastikan penyusuan awal dapat dimulakan **Topik 13** - Menyokong kelahiran dan mengamalkan penjagaan mesra ibu	**Chapter 14**: When you can't be with your baby **Chapter 15**: Milk to go **Chapter 17**: Alternate routes	**Chapter 2**: Breastfeeding Rhythms **Chapter 3:** Challenges at the Breast **Chapter 11**: Milk Expression and Storage **Chapter 15**: Employment **Appendices: B**. Tools and Products

Reference Book / **Module**	**Manual Pembimbing Penyusuan Susu Ibu** - Untuk kegunaan Kumpulan Sokongan Penyusuan Susu Ibu.	**Membesarkan Anak Hebat dengan Susu Ibu**.	**KIT Multimedia Pendidikan Penyusuan Susu Ibu**.	**The Womanly Art of Breastfeeding**.	**Breastfeeding Answers Made Simple** - A Guide to Helping Mothers.
		dengan Penjaga Anak			
Module 8 : Understanding Baby's Needs from Infancy to Toddlerhood	**Bab 9** : Bagaimana mengenali ragam bayi dan cara mengatasinya	**Bab 10** : Berpantang, Masa Rehat dan Belajar **Bab 26** : Penyusuan pada Waktu Malam	**Topik 10** : Kepentingan meneruskan penyusuan susu ibu selepas enam bulan di samping pemberian makanan pelengkap	**Part II**: Ages and Stages **Chapter 12**: Sleeping like a baby **Chapter 13**: The scoop on solids **Chapter 16:** Everybody weans	**Chapter 1**: Basic Breastfeeding Dynamics **Chapter 2**: Breastfeeding Rhythms **Chapter 3**: Challenges at the Breast **Chapter 4**: Solid Foods **Chapter 6:** Weight Gain and Growth
Module 9 : Breastfeeding in Situations of a Medical Nature	**Bab 10** : Jaundis dan penyusuan **Bab 11** : Bagaimana membantu ibu yang memerlukan bimbingan khusus **Bab 15** : Apakah peranan pembimbing	**Bab 5 :** Sentuhan kulit penjana cinta sejati **Bab 23** : Bayiku Kuning **Bab 24** : Puting Tenggelam **Bab 25** : Penyusuan	-	**Chapter 18**: Tech Support	**Chapter 6:** Weight Gain and Growth **Chapter 7:** Hypoglycaemia and Jaundice **Chapter 8**: Health Issues – Baby

Reference Book / **Module**	**Manual Pembimbing Penyusuan Susu Ibu** - Untuk kegunaan Kumpulan Sokongan Penyusuan Susu Ibu.	**Membesarkan Anak Hebat dengan Susu Ibu**.	**KIT Multimedia Pendidikan Penyusuan Susu Ibu**.	**The Womanly Art of Breastfeeding**.	**Breastfeeding Answers Made Simple** - A Guide to Helping Mothers.
(cont'd) **Module 9** : Breastfeeding in Situations of a Medical Nature	penyusuan susu ibu semasa bencana	Anak Pramatang			**Chapter 9**: The Preterm Baby **Chapter 16**: Relactation, Induced Lactation, and Emergency **Chapter 19**: Health Issues - Mother **Appendices: D**. Working with Healthcare Professionals

C. Handouts

The following is a list of handouts which supplements the MBFPC Training module.

Handout #	Title (pages)	Module
#1	Best Start 3 Step Counseling Strategy (4)	2
#2	Open Ended Question (1)	
#3	Crossword Puzzle (1)	5
#4	LLLC : Preparing to Breastfeed (2)	
#5	WIC : How Does Formula Compare to Breast milk (1)	
#6	ILCA : Managing Your Milk Supply - Going with the Flow (2)	
#7	WIC : First Week of Breastfeeding (2)	6
#8	ILCA : Breastfeeding - Learning the Dance to Latching (2)	
#9	ILCA : Engorgement (2)	
#10	ILCA : Breastfeeding was Going Well and Now My Nipple Hurt – Could My Baby or I Have A Yeast Infection ? (2)	
#11	ILCA : Dealing with Mastitis (2)	
#12	Best Start Table (1)	
#13	Infant Feeding Plan (1)	7
#14	LLI : Bed sharing Quick Start (1)	
#15	LLI : The safe surface checklist (1)	
#16	ILCA : What Grandparents Can Do to Support a Breastfeeding Mother (2)	
#17	ILCA : Using Your Hands to Express Your Milk (2)	
#18	ILCA : Breastfeeding and Returning to Work (2)	
#19	ILCA : Eating for Two (2)	
#20	WHO : How To Prepare Formula for BottleFeeding at Home (4)	
#21	ILCA : Only a Few Babies Have Problems with Foods Their Mothers Eat (2)	8
#22	ILCA : Expecting the Unexpected. (2)	9