SESSION 25

Attachment of the Baby to the Breast

Time required: 1 hour 30 minutes

Purpose

The purpose of this session is to teach participants how to assess and observe a breastfeed.

Objectives:

By the end of this session MM's will be able to:

- 1. Identify poor attachment.
- 2. Help a woman to attach her baby correctly to the breast.

Materials

1. Slides 25/1 - 25/7

Preparation

Study the notes for the session so that you understand the content of the session and are clear about what to do.

Training Methods

Using the content of this session as a guide, open a discussion which addresses each area outlined in this session. You may ask trainees what they know about a certain area before filling in the gaps and explaining the remainder of the information to them. This will involve them in the discussion and make the session more interactive.

Go through the key messages and the objectives above (5 mins)

Key message 11:

Always assess and observe a breastfeed, especially on a newborn baby to observe attachment.

Key message 12:

Good attachment prevents sore nipples or cracked nipples and increases milk production

25.1 Suckling action (5 mins)

It is very important that participants understand this – Take time to make sure that they understand!

When a baby is well attached, he removes breast milk easily, and it is called <u>effective suckling.</u>

25.2 Does a baby need to learn to breastfeed? (5 mins)

There are three main reflexes which happen automatically without the baby having to learn them:

Rooting reflex,

Sucking reflex, and the

Swallowing reflex.

Rooting reflex: When something touches a baby's lips or cheek, he opens his mouth and may turn his head to find it. He puts his tongue down and forward. He is rooting for the breast

When something touches a baby's palate, he starts to suck it (sucking reflex) and when his mouth fills with milk, he swallows (swallowing reflex).

But these are some things that a mother and baby have to learn.

A mother has to learn how to **position her baby**, so that he can attach well. A baby has to learn how to **take the breast into his mouth** to suckle effectively.

Many mothers and babies do it easily. But some need help.

Ask participants who normally teaches or helps women with breastfeeding? Discuss what advice is normally given and what happens if the mother does not follow this advice.

25.3 Attaching baby to the breast (15 mins)

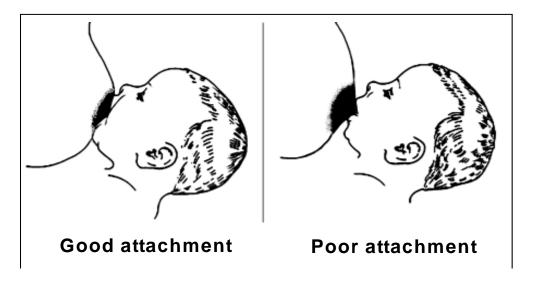
- It is important for the baby to be well attached to the breast for effective suckling to occur.
- Health workers need to be able to identify good and poor attachment when helping mothers to successfully initiate and sustain exclusive breastfeeding.

25.3.1 Good and poor attachment

Attachment – outside appearance

This picture shows the same two babies attached to a breast.

Attachment 4/1



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

In picture 1:

- The baby's chin touches the breast.
- His mouth is wide open.
- His lower lip is turned outwards.
- You can see more of the areola above his mouth and less below.
- This shows that he is reaching with his tongue under the lactiferous sinuses to press out the milk.
- If a baby is well attached, you also notice effective suckling that is, slow deep sucks, sometimes pausing; and you may hear swallowing.

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

In picture 2:

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

Make sure that participants understand and see the differences between pictures 1 and 2.

Poor attachment can make it SEEM as though a mother is not producing enough milk. In other words she has an <u>apparent</u> poor milk supply. Then, if the situation continues, her breasts may really make less milk.

In either situation, the result may be poor weight gain in her baby and breastfeeding failure. Mothers can resort to mixed feeding.

25.3.2 What causes poor attachment?

Activity 13:

There are many causes of poor attachment. Two main reasons are listed below. In pairs (or as a whole group if time is short) get participants to look at these two reasons and discuss why each reason or situation causes poor attachment. The answers are provided for you below.

Use of a feeding bottle

Why does this cause poor attachment?

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

Lack of skilled support

Whereas the swallowing, sucking and rooting reflexes come naturally to a baby the mother has to learn how **to hold her breast and position her baby**, so that he can attach well. The baby has to learn how to **take the breast** into his **mouth** to suckle effectively.

25.4 How to assess a breastfeed (15 mins)

Tell participants: 'There are several key points that should be observed when assessing a breastfeed: These are listed below and then explained in greater detail afterwards'.

Go through the key points with trainees.

HOW TO ASSESS A BREASTFEED

- (a) Observe the baby
- (b) Observe how baby responds
- (c) Observe how the mother puts her baby on her breast?
- (d) Observe how the mother hold her breast during a feed?
- (e) Does the baby look well attached to the breast?
- (f) Is the baby suckling effectively?
- (g) How does the breastfeed finish?
- (h) Does the baby seem satisfied?

(i) What is the condition of the mother's breasts?

Key point: If a mother feels good about breastfeeding, and if her baby is positioned so that he can suckle effectively, exclusive breastfeeding is likely to be successful.

(a) Observe the baby

- Look at his general health, nutrition, and alertness.
- Look for signs of conditions which can interfere with breastfeeding such as:
- blocked nose
- difficult breathing
- thrush
- jaundice
- dehydration
- tongue tie
- a cleft lip or palate.

(b) Observe how baby responds

Look for these responses:

If the baby is young: rooting for the breast when he is ready for a feed. He may turn his head from side to side, open his mouth, put his tongue down and forward, and reach for the breast.

If the baby is older: turning and reaching for the breast with his hand. Both these responses show that a baby wants to breastfeed.

If the baby cries or pulls back or turns away from the mother, it shows that he does not want to breastfeed, and that there is a problem with breastfeeding.

If a baby is calm during a feed, and relaxed and content after a feed, this means that he is getting breast milk appropriately.

If the baby is restless and slips off the breast or refuses to feed, this may mean that he is not well attached and is not getting the breast milk and the mother may be tempted to give other foods or drinks to the baby.

(c) Observe how the mother puts her baby on her breast?

The mother needs to bring her baby into her breast.

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

(d) Observe how does the mother holds her breast during a feed?

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

(e) Does the baby look well attached to the breast?

The signs of good attachment are:

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

(f) Is the baby suckling effectively?

The baby taking **slow deep sucks** is an important sign that a baby is getting breast milk. He is well attached to the breast, and suckling effectively.

The baby swallowing so that you can see or hear it.

If a baby swallows, it means that he is getting breast milk. Sometimes you can hear swallowing; sometimes it is easier to see swallowing.

(g) How does the breastfeed finish?

Does the baby leave the breast by himself, feeling satisfied, or does the mother pull the baby off the breast?

(h) Does the baby seem satisfied?

If a baby releases the breast himself, and looks satisfied and sleepy. This shows that he has had all that he wants from that side. He may or may not want the other side too.

The exact length of time is not important. Feeds normally vary very much in length. But if breastfeeds are very long or very short, it may mean that there is a problem.

However, in the first few days, or with a low-birth-weight baby, breastfeeds may be very long and this is normal.

(i) What is the condition of the mother's breasts?

Does she have sore or cracked nipples? Are her breasts full? Engorged? Red and inflamed? Look also for these signs:

- Breasts which are full before and soft after a feed, show that the baby is removing breast milk.
- Breasts, which are very full or engorged all the time, show that the baby is probably not removing breast milk effectively.
- Looking at the condition of the nipples and the breast; condition such as:
 - o Red skin fissures, show that there is a problem.

25.5 Assessing and Observing a Breastfeed Exercises (45 mins)

Activity 14:

This can be done as a group session. Use session 25 slides from the Integrated course. Give participants a few minutes to look at each slide and tick the signs of good attachment or poor attachment present in each slide. They can use the forms that follow.

Once participants have had a chance to go through each slide, giving their assessment discuss each slide as a large group. Ask participants to take turns to volunteer their assessment of attachment and positioning. Discuss common mistakes and difficulties.

Before displaying the slides, point out to participants that:

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

- Remember that in a live baby, you will also be looking at the baby's suckling. If a baby takes slow deep sucks, then he is probably well attached.
- Always ask how breastfeeding feels to the mother. If she has discomfort or pain in her breasts, then her baby may not be well attached. If she is comfortable, then he is likely to be well attached.

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

The answers for the slides are listed below: Slides For Session 25: Numbered 25/1 to 25/7

Exercise

What to you think of this baby's position and attachment?

Slide 25/1

Signs that you can see clearly are:

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

The baby is well attached to the breast.

Slide 25/2

Signs that you can see clearly are:

- the baby's chin is not touching the breast:
- his mouth is wide open and lower lip is turned outwards
- There is more areola above than below the breast;
- his cheeks are pulled in although this may be because he is a lbw baby.

This baby is well attached.

Slide 25/3

Signs that you can see clearly are:

- the baby is not close to the breast and his body is not close to the breast;
- his chin is not touching the breast
- his mouth is not wide open, his lips point forward;
- there is as much or more areola below the baby's mouth as above it.

The baby is poorly attached.

Slide 25/4

Signs that you can see clearly are:

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

This baby is not well attached

Slide 25/5

The signs that you can see are:

- the baby is close to the breast, although his neck may be twisted:
- his chin is not touching the breast
- his mouth is not wide open
- his lower lip is turned outwards
- his cheeks look round
- there is more areola below the baby's mouth than above it.

This baby's attachment can be improved

Slide 25/7

Signs you can see are:

- the baby is facing the mother
- his body is well supported
- his chin is touching the breast
- his mouth appears to be wide open
- difficult to say if his lower lip is turned outwards
- there is more areola above than below the baby

This baby is well attached

Slide 25/6

The signs that you can see are:

- the baby is close to the breast and facing it
- however his body is twisted
- his lower lip is turned inward
- the mother is holding the breast with a scissor grip
- the mother's back is not well supported
- the mother is not supporting the baby's bottom

The baby is not well attached and the mother is poorly positioned

This is a very important session and it is worth spending extra time on it if participants have any difficulty. (extra 30 mins over session)

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

Mother's name:	Date:		
Baby's name:			
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Notes:		

SESSION 26

Breast Conditions

Time required: 1 hour

Purpose

The purpose of this session is to teach participants how to detect painful breast conditions which need to be referred to the clinic.

Objectives

At the end of this session participants should be able to:

- 1. Identify common uncomfortable breast conditions.
- 2. Know when to refer a mother to the clinic for painful breast conditions.

Materials

None

Preparation

Study the notes for the session so that you understand the content of the session and are clear about what to do.

Training methods

Using the content of this session as a guide, open a discussion which addresses each area outlined in this session. You may ask trainees what they know about a certain area before filling in the gaps and explaining the remainder of the information to them. This will involve them in the discussion and make the session more interactive.

Go through the key messages, the objectives above and introduction (10 mins)

Key message 13:

Good attachment and positioning prevents harmful breast conditions

26.1 Introduction

Ask participants what breast conditions they have experienced or what their friends or relatives have experience? What are the different local / culturally appropriate words used for these conditions.

There are several common breast conditions, which sometimes cause difficulties with breastfeeding.

If you see a mother with the following features, you will need to refer her to the clinic for treatment:

- Nipples with a deep crack
- Bleeding nipples
- · Nipples oozing pus or bleeding
- Breast lump
- Painful breast with fever

26.2 What to do with mothers who have certain breast conditions (25 mins)

26.2.1 Full breasts and Engorged breasts

Full breast:

A few days after delivery when her milk has `come in' a mother's breasts may feel hot and heavy and hard. However, her milk flows well. This is normal fullness. Sometimes full breasts feel quite lumpy.

The only treatment that she needs is for her baby to breastfeed frequently, to remove the milk.

The heaviness, hardness, or lumpiness decreases after a feed, and the breasts feel softer and more comfortable. In a few days, her breasts will adjust to the baby's needs, and they will feel less full.

Engorgement:

Engorgement means that the breasts are overfull, partly with milk, and partly with increased tissue fluid and blood, which interferes with the flow of milk.

The breast in the picture looks shiny, because it is filled with milk – we say it is oedematous. The mother's breasts feel painful, and her milk does not flow well.

The nipple is flat, because the skin is stretched tight.

When a nipple is stretched tight and flat like this, it is difficult for a baby to attach to it, and to remove the milk.

Sometimes when breasts are engorged, the skin looks red, and the woman has a fever. This may make you think that she has mastitis. However, the fever usually settles in 24 hours.

It is important to be clear about the difference between full and engorged breasts. Engorgement is not so easy to treat.

Full and engorged breasts:

SUMMARY OF DIFFERENCES BETWE	EN FULL AND ENGORGED BREASTS
FULL BREASTS	ENGORGED BREASTS
Hot	Painful
Heavy	Oedematous
Hard	Tight, especially nipple
	Shiny
	May look red
Milk flowing	Milk NOT flowing
No fever	May be fever for 24 hours

The causes of engorgement are:

- o plenty of milk;
- delay starting to breastfeed;
- o poor attachment, so breast milk is not removed effectively;
- o infrequent removal of milk;
- o restricting the length of breastfeeds.

Prevent engorgement:

- o let the baby start breastfeeding soon after delivery;
- o make sure that the baby is well attached to the breast;
- encourage unrestricted breastfeeding.

You can see that prevention is closely related to the causes of engorgement. A baby should suckle effectively from soon after delivery, without restrictions on the length or frequency of feeds. Then the milk pressure does not build up in the breasts. Engorgement is less likely to occur.

Treat breast engorgement:

To treat engorgement it is essential to remove milk. If milk is not removed, mastitis may develop, an abscess may form, and breast milk production decreases.

So do not advise a mother to "rest" her breast.

If the baby is able to suckle, he should feed frequently.

This is the best way to remove milk. Help the mother to position her baby, so that he attaches well. Then he suckles effectively, and does not damage the nipple.

- If the baby is not able to suckle, help his mother to express her milk.

 She may be able to express by hand or she may need to use a breast pump, or a warm bottle. (See session on `Expressing breast milk').

 Sometimes it is only necessary to express a little milk to make the breast soft enough for the baby to suckle.
- Before feeding or expressing, stimulate the mother's oxytocin reflex.
- After a feed, put a cold compress on her breasts. This may help to reduce oedema.
- Build the mother's confidence.

 Explain that she will soon be able to breastfeed comfortably.

26.2.2 Mastitis:

Symptoms of blocked duct and mastitis

The woman has severe pain and a fever. She feels sick. Part of the breast is swollen and hard and the overlying skin is red. Mastitis is often confused with engorgement; however engorgement affects the whole breast, and often both breasts. Engorgement is not usually associated with a fever.

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

Causes of blocked duct and mastitis:

The main cause is poor drainage of all or part of a breast.

Poor drainage of the whole breast may be due to

• Infrequent breastfeeds.

For example:

- when a mother is very busy;
- when her baby starts feeding less often because he sleeps through the night, or feeds irregularly;
- o because of a changed feeding pattern for any other reason, for example, a journey.
- <u>Ineffective suckling</u> if the baby is poorly attached to the breast.
- Pressure from tight clothes, usually a bra, especially if she wears it at night;
- or from lying on the breast, which can block one of the ducts.
- <u>Pressure of the mother's fingers</u>, which can block milk flow during a breastfeed.
- <u>The lower part of a large breast draining poorly,</u> because of the way in which the breast hangs.

Trauma to the breast which damages breast tissue sometimes causes mastitis, for example, a sudden blow, or an accidental kick by an older child.

If there is a nipple fissure, it provides a way for bacteria to enter the breast tissue. This is another way in which a poor suckling position can lead to mastitis.

Treat blocked duct and mastitis

- Refer the mother to the clinic if you suspect mastitis. A blocked duct can be managed at home.
- Provide supportive care for all women with blocked duct and mastitis.
- Look for a cause of poor drainage, and correct it:
 - Look for poor attachment.
 - Look for pressure from clothes, usually a tight bra, especially if worn at night; or

pressure from lying on the breast.

- Notice what the mother does with her fingers as she breastfeeds. Does she hold the areola, and possibly block milk flow?
- Notice if she has large, pendulous breasts, and if the blocked duct is in the lower part of her breast.
- Suggest that she lifts the breast more while she feeds the baby, to help the lower part of the breast to drain better.

Whether or not you find a cause, advise the mother to do these things:

- Express breast milk frequently and discard the expressed breast milk. It is necessary to express the milk. If the milk stays in the breast, an abscess is more likely.
- Gently massage the affected breast while her baby is suckling from the
 unaffected one. This helps to remove milk from different parts of the affected
 breast more equally. Show her how to massage over the blocked area, and
 over the duct, which leads from the blocked area, right down to the nipple.
 This helps to remove the block from the duct. She may notice that a plug of
 thick material comes out with her milk. Discard the expressed breast milk.
- <u>Apply compresses</u>. Warmth is comfortable for some mothers while others prefer cold compresses to reduce swelling.
- <u>Support the breasts well</u> to make her more comfortable. (However, do not bind the breasts tightly, as this may increase her discomfort.)
- Sometimes it is helpful to start the feed on the unaffected breast.
 This may help stimulate the oxytocin reflex to facilitate drainage from the affected breast. Massage and express the affected breast after the reflex starts working.
- <u>Bed rest.</u> Advise her to take sick leave, if she is employed, or to get help at home with her duties. Talk to her family if possible about sharing her work; If she is stressed and overworked, encourage her to try to take more rest; Resting with her baby is a good way to increase the frequency of breastfeeds from the **unaffected breast**, and to improve drainage through expressing breast milk from the affected side.
- Relieve pain. Some women use plant products such as teas made from herbs or plants, such as raw cabbage leaves, placed directly on the breast to reduce pain and swelling

Usually, blocked duct or mastitis improves within a day when drainage to that part of the breast improves. Start breastfeeding the baby from this breast once it has improved.

Many mothers with mastitis need antibiotics, therefore, refer a mother to the clinic or health centre for treatment of mastitis.

26.2.3 Candida infection:

Candida infection, or thrush, can make the skin sore and itchy. Candida infections often follow the use of antibiotics to treat mastitis, or other infections.

Some mothers describe burning or stinging, which continues after a feed. Sometimes the pain shoots deep into the breast. A mother may say that it feels as though needles are being driven into her breast.

The skin may look red, shiny and flaky. The nipple and areola may lose some of their pigmentation. Sometimes the nipple looks normal.

Suspect *Candida* if sore nipples persist, even when the baby's attachment is good. Check the baby for thrush. He may have white patches inside his cheeks or on his tongue, or he may have a rash on his bottom.

Refer the mother and baby to the clinic for treatment. .

Advise the mother to stop using pacifiers (dummies); help her to stop using teats, and nipple shields. If these are used, they should be boiled for 20 minutes daily and replaced weekly.

26.2.4 Management of sore nipples:

 If a mother has sores on the nipple or cracked nipples, the baby may suckle blood that has more HIV in it than breast milk if allowed to suckle from the affected breast. It is better for the mother to express the breast milk and feed the baby using a cup.

First look for a cause:

- Observe the baby breastfeeding, and check for signs of poor attachment.
- Examine the breasts: Look for signs of *Candida* infection; look for engorgement; look for fissures.
- Look in the baby's mouth for signs of Candida and for tongue tie; and baby's bottom for Candida rash.

Then give appropriate treatment:

• Build the mother's confidence.

Explain that the soreness is temporary, and that soon breastfeeding will be completely comfortable.

Help her to improve her baby's attachment on the unaffected breast. Often this is all that is no apparent.

Often this is all that is necessary.

She need not rest her breast. She should express the breast milk and cup feed or discard the milk if there is a lot of blood coming out during expressing. Mother should not bleed from the nipple if the technique of expressing breast milk is good.

Help her to reduce engorgement if necessary.

She should express her breast milk frequently and use this to feed her baby by cup.

• <u>Consider referral</u> for treatment for *Candida* if the skin of the nipple and areola is red, shiny, or flaky; or if there is itchiness, or deep pain, or if the soreness persists.

Advise the mother:

- not to wash her breasts more than once a day, and not to use soap, or rub hard with a towel. Breasts do not need to be washed before or after feeds normal washing as for the rest of the body is all that is necessary. Washing removes natural oils from the skin, and makes soreness more likely.
- not to use medicated lotions and ointments, because these can irritate the skin, and there is no evidence that they are helpful.

Suggest that she rubs a little expressed breast milk over the nipple and areola with her finger. This promotes healing.

Key points

- Breast conditions such as sores on the nipples, cracked nipples, mastitis and breast abscesses may increase the risk of HIV through breastfeeding.
- Do not feed the baby from the affected breast.
- Express breast milk from the affected breast and discard.
- It is important to prevent these conditions from occurring.
- A mother should seek medical care quickly if these conditions occur.

Activity 15: 25 mins

There will be 3 role plays. For each role play one person should be mother and the other should be the Mentor Mother.

The Mentor Mother has been trained using this course in newborn care. She needs to address the mothers concerns and encourage her to exclusively breastfeed.

The other participants should observe the role play and provide constructive criticism about the way the Mentor Mothers speaks to the mother: In particular check whether the Mentor Mother uses the listening and learning skills and confidence building skills:

At the end of the role play suggest ways in which the Mentor Mother can improve the way she speaks to the mother. Remember there is no correct answer. This activity is about us helping each other to become better communicators with mothers.

Role play 1:

The mother has cracked nipples

Role play 2:

The mother has hot, heavy, hard breasts but no fever. The milk flows well

Role play 3:

The mother has painful, swollen breasts that are tight – especially at the nipple and shiny. One of the breasts looks a little red. Milk is not flowing well. The mother does not have a fever.

SESSION 27

Expressing Breast milk

Time required: 50 minutes

Purpose

The purpose of this session is to teach participants about expressing breast milk so that they can support breastfeeding mothers.

Objectives

At the end of this session participants should:

- 1. Know when and why expressing breast milk is useful.
- 2. Be able to help a mother to express breast milk.

Materials

1. Balloons for each participant.

Preparation

The balloons should be blown up before participants can practice milk expression. You can let participants blow up their own balloons. Try and get participants to blow up their balloons to different dimensions, signifying different sizes and shapes of breasts. Study the notes for the session so that you understand the content of the session and are clear about what to do.

Training methods

Using the content of this session as a guide, open a discussion which addresses each area outlined in this session. You may ask trainees what they know about a certain area before filling in the gaps and explaining the remainder of the information to them. This will involve them in the discussion and making the session more interactive.

Key Message 14:

Expressing breast milk is useful when the mother has to go to work or has to go out for the day.

27.1 Introduction (10 mins)

Expressing milk is useful to:

- relieve engorgement;
- relieve blocked duct or milk stasis;
- feed a baby as he learns cup feeding for safe transition;

- feed a baby while he learns to suckle from an inverted nipple;
- feed a baby who has difficulty in coordinating suckling;
- feed a baby who `refuses', while he learns to enjoy breastfeeding;
- feed a low-birth-weight baby who cannot breastfeed;
- feed a sick baby, who cannot suckle enough;
- keep up the supply of breast milk when a mother or baby is ill;
- leave breast milk for a baby when his mother goes out or to work;
- · prevent leaking when a mother is away from her baby;
- help a baby to attach to a full breast;
- express breast milk directly into a baby's mouth;
- prevent the nipple and areola from becoming dry or sore.

27.2 Stimulating The Oxytocin Reflex (10 mins)

It is important that the oxytocin reflex works before milk expression to make sure the milk flow from the mother's breasts.

How To Stimulate The Oxytocin Reflex

Help the mother psychologically:

- Build her confidence
- Try to reduce any sources of pain or anxiety
- Help her to have good thoughts and feelings about the baby

Help the mother practically. Help or advise her to:

- Sit quietly and privately or with a supportive friend.
- Some mothers can express easily in a group of other mothers who are also expressing for their babies.
- Hold her baby with skin-to-skin contact if possible.
 She can hold her baby on her lap while she expresses. If this is not possible, she can look at the baby. If this is not possible, sometimes even looking at a photograph of her baby helps.
- Take a warm soothing drink.
 The drink should not be coffee.
- Warm her breasts.

For example, she can apply a warm compress, or warm water, or have a warm shower.

- Stimulate her nipples.
 She can gently pull or roll her nipples with her fingers.
- Massage or stroke her breasts lightly.

Some women find that it helps if they stroke the breast gently with finger tips or with a comb)

Some women find that it helps to gently roll their closed fist over the breast towards the nipple.

27.3 Expressing breast milk by hand (30 mins)

Each participant should have their own balloon which they should blow up. The balloons do not have to be the same size or shape. As you go through the following explanation on milk expression, let trainees practice what they hear on the balloon.

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

It is easy to hand express when the breasts are soft. It is more difficult when the breasts are engorged and tender. So teach a mother how to express her milk in the first or second day after delivery. Do not wait until the third day, when her breasts are full.

Key point: A woman should express her own breast milk. The breasts are easily hurt if another person tries. If you are showing a woman how to express, show her on your own body as much as possible, while she copies you. If you need to touch her to show her exactly where to press her breast, be very gentle.

Choose a cup, glass, jug or jar with a wide mouth.

Wash the cup in soap and water and pour boiling water into the cup, and leave it for a few minutes. Boiling water will kill most of the germs.

When ready to express milk, pour the water out of the cup.

Teach a mother to do this herself. Do not express her milk for her. Touch her only to show her what to do. Be gentle. Teach her to:

- Wash her hands thoroughly.
- Sit or stand comfortably, and hold the container near her breast.

Now let participants practice on their balloons:

 Put her thumb on her breast above the nipple and areola, and her first finger on the breast below the nipple and areola, opposite the thumb). She supports the breast with her other fingers (see fig.2).

- Press her thumb and first finger slightly inwards towards the chest wall. She should avoid pressing too far because that can block the milk ducts.
- Press her breast behind the nipple and areola between her finger and thumb) She must press on the lactiferous sinuses beneath the areola)
 Sometimes in a lactating breast it is possible to feel the sinuses. They are like pods or peanuts. If she can feel them, she can press on them.
- Press and release, press and release.

This should not hurt - if it hurts, the technique is wrong.

At first no milk may come, but after pressing a few times, milk starts to drip out. It may flow in streams if the oxytocin reflex is active.

- Press the areola in the same way from the sides, to make sure that milk is expressed from all segments of the breast.
- Avoid rubbing or sliding her fingers along the skin. The movement of the fingers should be more like rolling.
- Avoid squeezing the nipple itself. Pressing or pulling the nipple cannot express the milk. It is the same as the baby sucking only the nipple.
- Express one breast for at least 3-5 minutes until the flow slows; then
 express the other side; and then repeat both sides. She can use either
 hand for either breast, and change when they tire.
- To express breast milk adequately takes 20 30 minutes, especially in the first few days when only a little milk may be produced. It is important not to try to express in a shorter time.

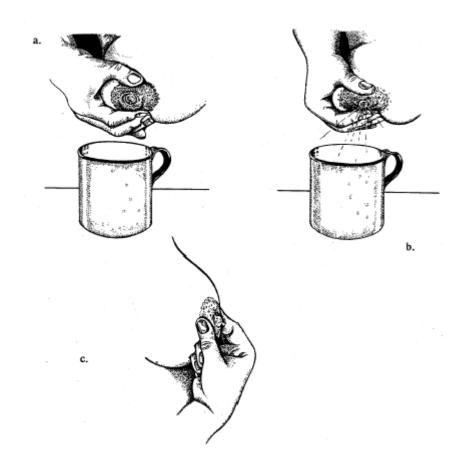


Fig.2: How to express breast milk.

- a) Place finger and thumb each side of the areola and press inwards towards the chest wall.
- b) Press behind the nipple and areola between your finger and thumb
- c) Press from the sides to empty all segments.

How often should a mother express her breast milk?

It depends on the reason for expressing the milk, but usually as often as the baby would breastfeed.

- To establish lactation, to feed a low-birth-weight (LBW) or sick newborn:
 - She should start to express milk on the first day, within six hours of delivery if possible. She may only express a few drops of colostrum at first, but it helps breast milk production to begin, in the same way that a baby suckling soon after delivery helps breast milk production to begin.
 - She should express as much as she can as often as her baby would breastfeed.
 - This should be at least every 3 hours, including during the night. If she expresses only a few times, or if there are long intervals between expressions, she may not be able to produce enough milk.

- To keep up her milk supply to feed a sick baby: She should express at least every 3 hours.
- To build up her milk supply, if it seems to be decreasing after a few weeks: Express very often for a few days (every _-1 hour), and at least every 3 hours during the night.
- To leave milk for a baby while she is out at work:
 Express as much as possible before she goes to work, to leave for her baby.
 It is also very important to express while at work to help keep up her supply.
- To relieve symptoms, such as engorgement, or leaking at work: Express only as much as is necessary.
- To keep nipple skin healthy: Express a small drop to rub on nipple after a bath or shower.

SESSION 28

Practising Exclusive Breastfeeding

Time required: 2 hours

Purpose

This session aims to discuss common concerns and difficulties with exclusive breastfeeding and how these can be addressed.

Objectives

At the end of this session MM's will be able to:

- 1. Understand common concerns about exclusive breastfeeding which they are likely to encounter in their work.
- 2. Know how to address these common concerns.

Materials

1. MM manuals

Preparation

Study the notes for the session so that you understand the content of the session and are clear about what to do.

Training methods

For facilitator: This is a very important session. It is short but you need to spend much time on it because most women do not exclusively breastfeed because of their concerns, beliefs and difficulties with exclusive breastfeeding. There is one main activity during this session (Activity 16).

Ask participants to work in groups of 4-5 for this activity.

Activity 16 revolves around the table: On the left hand side of the table is a list of common traditional beliefs, concerns and difficulties that women face when they breastfeed. There may be other beliefs, concerns and difficulties not included in this table. Ask participants to write down any additional beliefs / concerns / difficulties with exclusive breastfeeding that they know of in the extra rows of the first column. They can add more rows if they are needed.

Once participants have been through and added all the common beliefs concerns about EBF listed in the first column, ask them to discuss how each of these can be addressed i.e. what can we say to mothers, without criticizing them or their beliefs, so that EBF is practiced? Now ask them to write down the response to each belief in the column next to that belief (second column).

Allow participants about 30 minutes to fill in the 2 columns of the table.

Then allow about 45 minutes to 1 hour for discussion, feedback and finding the best solutions to common concerns, beliefs and difficulties.

Key message 15:

Exclusive breastfeeding should begin within the first half an hour of birth and should continue on demand – whenever the baby wants to feed, during the day and night – for the first 6 months of life.

Activity 16a:

COLUMN 1 COMMON CONCERNS / BELIEFS / DIFFICULTIES WITH EXCLUSIVE BREASTFEEDING	COLUMN 2: YOUR RESPONSES TO ADDRESS WOMEN'S FEARS / CONCERNS
Breast milk alone is not enough for the baby's growth.	Breast milk alone contains all the nutrients the baby needs for the first 6 months of life: protein, fatty acids, lactose, vitamins, iron and other minerals. These nutrients in breast milk are easily digestible. Breast milk alone is enough for baby's growth: The baby does not need additional foods or fluids.
2. Breast milk alone is not enough to protect a baby from illness and infection.	
3. Babies need traditional medicines to keep them well.	
4. A mother does not produce enough milk for a growing child.	
5. A young baby with diarrhoea needs traditional medicine to clean the stomach and stop diarrhoea	
6. The first milk, colostrum, produced by the mother is bad and should be thrown away.	
7. A baby who cries is not getting enough milk and needs other fluids.	
8. A fat baby is a healthy baby.	

COLUMN 1	COLUMN 2:
COMMON CONCERNS / BELIEFS / DIFFICULTIES WITH EXCLUSIVE BREASTFEEDING	YOUR RESPONSES TO ADDRESS WOMEN'S FEARS / CONCERNS
9. Babies need water in the 1st 6 months, especially to quench thirst.	
10.A breastfeeding baby needs enemas to prevent constipation.	
11.Sore nipples are caused because a baby sucks too long.	
12.Breastfeeding spoils a woman's breasts and her shape.	
13. Women with small breasts cannot breastfeed	
14.	
15.	
16.	
17.	

COLUMN 1 COMMON CONCERNS / BELIEFS / DIFFICULTIES WITH EXCLUSIVE BREASTFEEDING	COLUMN 2: YOUR RESPONSES TO ADDRESS WOMEN'S FEARS / CONCERNS
18.	
19.	
20.	
21.	
22.	
23.	
24.	

Once participants have filled in the table allow 1.5 hours for discussion and pooling of ideas. Mentor Mothers should discuss in great detail solutions and ways of addressing common concerns, beliefs and difficulties about exclusive breastfeeding.

Activity 16b: 30 mins

Now in a large group discuss the following scenarios and what advice can be given to each mother.

Scenario 1:

Maria and Zinhle are sitting together under the tree. Maria's baby, Themba is 4 months and 3 days old. Zinhle's baby Thabo is 4 months and one week old. Maria is exclusively breastfeeding Themba. Zinhle feeds Thabo some breast milk and some formula milk. The average weight of a 4-month old baby is 6.5kg. Themba weighs 6.6kg and Thabo weighs 8kg. Maria thinks that her baby is not fat enough.

Answer: Themba's weight is acceptable – he is not malnourished, even though Thabo is heavier. Formula fed babies may be heavier than breastfed babies and breastfed babies usually drink as much milk as they want, whereas formula fed babies are given fixed quantities of milk. A fatter baby is not necessarily a healthier baby. Thabo is growing well and Maria should continue exclusively breastfeeding him for 6-months.

Scenario 2:

Zandile is HIV positive. She has a 1 month old baby, Toby. Zandile was counselled about her HIV status, and she has disclosed to her boyfriend and her mother. She does not meet all the AFASS criteria and is thus exclusively breastfeeding Toby. However when Toby is 3 months Zandile has to go back to work. She will not be able to take Toby with her and does not know how she will breastfeed him. What advice would you give her?

Answer:

At 6 weeks Toby should be tested for HIV. If Toby tests HIV positive then Zandile should continue breastfeeding as much as she can – any breast milk is better than no breast milk for Toby.

If Toby tests HIV negative and Zandile cannot continue exclusive breastfeeding, then, although not ideal, we need to help Zandile to stop breastfeeding before 6 months —Can we help her to meet the AFASS criteria? Can we give her free formula milk from the clinic?

Heat treating expressed breast milk

This is additional information that should not routinely be covered during a session.

Heat-treating expressed breast milk can be used when the mother is trying to stop breastfeeding at 6 months.