

## Session 5: Becoming “baby-friendly” in settings with high HIV prevalence

**Note:** This alternate Session 5 has been prepared for use in settings with high HIV prevalence. This version of the Session is identical to Session 5, except that additional content concerning HIV and infant feeding have been added, wherever useful.

Since the launch of the Baby-friendly Hospital Initiative in 1991 the growing HIV/ AIDS pandemic, especially in sub-Saharan Africa and parts of Asia, has raised concerns and questions about promoting protecting and supporting breastfeeding where HIV is prevalent. These concerns arise because breastfeeding is known to be one of the routes for infecting infant and young children with HIV. This session, revised in order to address these concerns, provides guidance on how to implement the Ten Steps to Successful Breastfeeding and the BFHI in settings where HIV is a major public health concern.

### Objective

At the conclusion of this session, participants will be able to:

- Develop a plan for building staff enthusiasm and consensus for working to become “Baby-friendly”
- Identify actions necessary to implement at least four of the “Ten steps to successful breastfeeding” in their health facilities
- Identify at least five common concerns related to instituting the Ten Steps and practical solutions for addressing them
- Identify at least five challenges to baby-friendly hospital promotion in a setting where there is a high prevalence of HIV/AIDS and how to overcome them.
- Describe the usefulness/need for counselling to help the HIV-infected mother to choose an infant feeding method of her choice which best suits her personal setting and circumstances.

### Duration

Presentation: 15 minutes

Work in pairs and discussion: 15 minutes

Discussion and brainstorming: 15 minutes

Introduction to group work: 5 minutes

Group work: 30-45 minutes

Presentations and discussion: 40-55 minutes

Total: 2 to 2½ hours

### Teaching methods

Small group work  
Presentations in plenary  
Discussion

### Preparation for session

- Review the WHO document, *Evidence for the ten steps to successful breastfeeding*. Geneva, Switzerland, 1998 (WHO/CHD/98.9). ([http://www.who.int/child-adolescent-health/publications/NUTRITION/WHO\\_CHD\\_98.9.htm](http://www.who.int/child-adolescent-health/publications/NUTRITION/WHO_CHD_98.9.htm)). Read the section on “combined interventions” (pp. 93-99) that gives evidence that the *Ten Steps* should be implemented as a package. Also review the WHO/UNICEF document, *Global Strategy for Infant and Young Child Feeding*. Geneva, Switzerland, 2003(<http://www.who.int/nut/publications.htm> - inf). Read in particular sections 30, 31 and 34, pages 13-19, which focus on the importance of continuing to support the *Baby-friendly Hospital Initiative* and implementation of the *Ten Steps to Successful Breastfeeding*, as well as monitoring and reassessing facilities that are already designated.
- The group work for this session should focus only on four to five of the *Ten Steps* since there is not enough time during either the group work or the reporting and discussion period to adequately cover the concerns and solutions for all Ten Steps. Preparation for this session should include an analysis, by the trainers, of which steps tend to be most difficult to implement and thus on which it would be most important to focus in a session of this type. Indications of which steps need the most work may come from trainers’ experience with BFHI assessments and training. A review of the forms participants were asked to complete prior to arriving at the course, indicating what difficulties they have had, or think they will have, in assisting their institutions to become Baby-friendly, considering HIV prevalence, should also be helpful. The steps most needing consideration in light of HIV and infection of infants and young children with HIV are Steps 1, 2, 3, 5, 6 and 10. Steps 3 and 5 may present the greatest challenges in that they may require changes in care routines and protocols. Step 10, community follow-up support, poses challenges for the original BFHI and will continue to be a challenge for BFHI in light of HIV.
- Countries (or hospitals) which have already implemented BFHI but who are now rethinking their strategies in light of providing care to HIV infected women, may need guidance by a master trainer who is experienced with BFHI in HIV-prevalent areas. It may be helpful to guide decision-making on which steps should be tackled in-group work based on what other countries have found most challenging in implanting BFHI in HIV-prevalent areas.
- Before the session, the trainers also need to organize the working groups and assign facilitators to each of them. Consideration should be given during the formation of working groups to insuring that each group includes some participants who are good at problem solving and supportive of BFHI. Facilitators should be made aware that their role is not to “lead” the working groups but rather to make sure the groups understand the assignment, offer help if the group is having difficulty, and make suggestions if there are important issues the group hasn’t considered. The facilitators should review the sections of Handout 5.4 HIV which deal with the steps the groups will be working on, as they may provide ideas on important points the facilitators should mention, if they are not discussed, during the group work or the group reports.

- Once the four or five Steps have been selected for the group work, it would be useful to make enough copies of the Handout 5.3 HIV “sample sheet” for each of the groups, with one of the Steps and wording for the Step inserted on each of the four or five sheets.
- Consider whether participants should be provided with copies of the completed Handout 5.3 HIV sheets developed by the working groups, so they can refer to them for ideas as they implement their action plans on their return home. The completed sheets can be copied “as is” or, if there is time, the course secretary can be asked to prepare typed versions for copying.
- Review Handout 5.4 HIV and decide whether to distribute it at the end of the session. If the Course will be given a number of times, consider adapting this Handout to the country situation, eliminating concerns and solutions that aren’t applicable and possibly adding others.

## Training materials

### *Handouts*

5.1 HIV Slide Presentation Handout – Session 5 HIV

5.2 HIV The ten steps to successful breastfeeding for settings where HIV is prevalent: Issues to consider

5.3 HIV The ten steps to successful breastfeeding for settings where HIV is prevalent: Actions, concerns and solutions – Sample Worksheet

5.4 HIV The ten steps to successful breastfeeding for settings where HIV is prevalent: Summary of experiences

### *Slides/Transparencies*

5.1-13 HIV The ten steps to successful breastfeeding for settings where HIV is prevalent – Issues to consider.

5.14-15 HIV The ten steps to successful breastfeeding for settings where HIV in prevalent: Actions, concerns and solutions – Worksheet, Example for Step 1: Have a written breastfeeding policy (blank copy)

5.16-21 HIV The ten steps to successful breastfeeding for settings where HIV in prevalent: Example for Step 7: Practice rooming-in

The website featuring this Course contains links to the slides and transparencies for this session in two Microsoft PowerPoint files. The slides (in colour) can be used with a laptop computer and LCD projector, if available. Alternatively, the transparencies (in black and white) can be printed out and copied on acetates and projected with an overhead projector. The transparencies are also reproduced as the first handout for this session, with 6 transparencies to a page.

**Note:** The slides for the basic Session 5 have been integrated with the additional HIV-related slides and included all together in both the slide and transparency files for this session, for ease of use.

**References**

Coutsoudis A, Pillay K, Spooner E, et al. Influence of infant feeding patterns on early mother-to-child transmission of HIV-1 in Durban, South Africa: a prospective cohort study. South Africa, Vitamin A Study Group. *Lancet*, 1999, 354(9177): 471-76.

Coutsoudis A, Pillay K, Kuhn L, et al. Method of feeding and transmission of HIV-1 from mothers-to-children by 15 months of age: prospective cohort study. South Africa, Vitamin A Study Group. *AIDS*, 2001, 15(3) 379-87.

DeCock KM, Fowler MG, Mercier E, et al. Prevention of mother-to-child HIV transmission in resource poor countries. *JAMA*, 2000, 238 (9):175-82.

LINKAGES. *World Linkages, Zambia. Pamphlet LINKAGES country programs series.* LINKAGES Project: Academy for Educational Development, Washington DC, 2000.

LINKAGES. *Breastfeeding and HIV/AIDS Frequently Asked Questions (FAQ Sheet 1)* LINKAGES Project: Academy for Educational Development, Washington DC, updated 2001 (<http://www.linkagesproject.org>).

LINKAGES. *Replacement Feeding.* Spotlight, Academy for Educational Development, Washington D.C., April 2004.

Madzima, R. Baby friendly Hospital Initiative in the context of HIV and AIDS: Africa Region. Geneva, World Health Organization, 2003

Ministry of Health. Zambia's National Policy Framework on Infant feeding practices and HIV /AIDS Transmission from Mother-to Child, Final Working Draft, Lusaka, Zambia, 1998.

UNICEF/UNAIDS/WHO. Review of HIV transmission through breastfeeding: HIV transmission through breastfeeding: a review of available evidence. New York, UNICEF, 2003.

US Committee for UNICEF, *Barriers and Solutions to the Global Ten Steps to Successful Breastfeeding:* Washington D.C., 1994. (To obtain a copy, send \$9.00 US to Baby-Friendly USA, 327 Quaker Meeting House Road, E. Sandwich, MA 02537, USA (Tel. 508-888-8092, Fax. 508-888-8050, e-mail: [info@babyfriendlyusa.org](mailto:info@babyfriendlyusa.org), (<http://www.babyfriendlyusa.org>).

Walley J, Whitter S, Nicholl A. Simplified antiviral prophylaxis with or and without artificial feeding to reduce mother-to-child transmission of HIV in low and middle income countries: modelling positive and negative impact on child survival. *Med Sci Monit*, 2001, 7(5): 1043-1051.

WHO. Thermal Protection of the Newborn. Geneva, World Health Organization, 1997 (WHO/INT/RH MSM.97.2) (<http://www.who.org/>).

WHO. *Evidence for the ten steps to successful breastfeeding.* Geneva, World Health Organization, 1998 (WHO/CHD/98.9) ([http://www.who.int/child-adolescent-health/publications/NUTRITION/WHO\\_CHD\\_98.9.htm](http://www.who.int/child-adolescent-health/publications/NUTRITION/WHO_CHD_98.9.htm)).

WHO. *HIV in Pregnancy: A Review,* Geneva, World Health Organization, 1999 (WHO/CHS/RHR/99.15).

WHO. New data on the prevention of mother-to-child transmission of HIV and their policy implications: conclusions and recommendations. WHO Technical Consultation on Behalf of the UNFPA/UNICEF/WHO/UNAIDS (2000) Interagency Task Force Team on Mother-to-Child

transmission of HIV, Geneva, 11-13 October 2000, Geneva, Switzerland: World Health Organization. Geneva, World Health Organization, 2000.

WHO. Formative research tool: What are the options? Using Formative Research to Adapt Global Recommendations on HIV and Infant Feeding to the Local Context. Geneva, World Health Organization, Child and Adolescent Health, 2003.

WHO/AED. *HIV and infant feeding counselling tools*. Geneva, World Health Organization and Washington D.C., The LINKAGES Project, 2003.

WHO/UNICEF. *Global Strategy for Infant and Young Child Feeding*. Geneva, World Health Organization, 2003 (<http://www.who.int/nut/publications.htm> - inf).

UNAIDS, FAO, UNHCR, UNICEF, WHO, WFP, World Bank, UNFPA, IAEA. *HIV and infant feeding: Framework for priority action*. Geneva, World Health Organization, 2003.

UNICEF. Report for the meeting on Baby-friendly Hospital Initiative (BFHI) in the context of HIV/AIDS, Gaborone, June 2<sup>nd</sup> – 4<sup>th</sup> 2003.

WHO/UNICEF/UNAIDS/UNFPA. *HIV and infant feeding: guidelines for decision-makers*. Geneva, World Health Organization, 2003 revised.  
(<http://www.unaids.org/publications/documents/mtct/infantpolicy.html>)

WHO/UNICEF/UNAIDS/UNFPA. *HIV and Infant Feeding: A Guide for Health Care Managers and Supervisors*. Geneva, World Health Organization, 2003 revised.  
([http://www.unaids.org/publications/documents/mt ct/infantguide.html](http://www.unaids.org/publications/documents/mtct/infantguide.html))

Outline

Content	Trainer's Notes
<p><b>1. Discussion and work on strengthening the infant feeding policy and building consensus for “Becoming Baby-friendly” in the context of HIV</b></p>	<p><i>Presentation: 15 minutes</i></p> <p>Mention that a mini-version of the slides is reproduced in Handout 5.1 HIV and included in the participants’ folder.</p> <p>Indicate that finding ways of balancing BFHI, its original aims and goals with the threats from HIV and AIDS is crucial for the successful implementation of the Global Strategy for infant and young child feeding, especially as countries develop comprehensive policies. It is also important for the facilities to continue protecting, promoting and supporting breastfeeding while helping HIV-positive mothers to implement the infant feeding method that they chose. Introduce the “Ten steps to successful breastfeeding in the context of HIV” which provides guidance for implementing BFHI in the HIV context, using slides 5.1-9 HIV. Go through the 10 steps briefly, discussing what key issues administrators and policy makers need to consider. Pass out Handout 5.2 HIV as a reference.</p>
<ul style="list-style-type: none"> <li>■ Work in pairs and discussion on key issues related to HIV and infant feeding that need to be added to their hospitals’ infant feeding policies.</li> </ul>	<p><i>Work in pairs and discussion: 15 minutes</i></p> <p>Mention that it is very important to have a clear and technically strong infant feeding policies to guide implementation of BFHI in facilities with high HIV prevalence. Current policies may need to be strengthened to give added guidance both for implementing the 10 Steps in general and for doing this in light of the HIV pandemic. The issues in Handout 5.2 HIV, which was just presented and distributed, may be useful in providing ideas for how to strengthen breastfeeding or infant feeding policies to include needed HIV-related guidance.</p> <p>Ask the participants to form into pairs and review the issues in Handout 5.2 HIV, indicating which of these issues would be most important to feature in their hospitals’ policies, to strengthen guidance on HIV and infant feeding. After about 10 minutes work in pairs, ask for some examples of issues the pairs have identified as being most important. Mention that this Handout can be used further by hospital teams for guidance in strengthening the HIV content of their policies.</p>

Content	Trainer’s Notes
<ul style="list-style-type: none"> <li>■ Discussion and brainstorming session on strategies for gaining support within the health facility for becoming Baby-friendly and drafting a policy and plan of action.               <ul style="list-style-type: none"> <li>■ The importance of “thinking strategically”</li> <li>■ How best to gain support within the participants’ culture and institutional administrative system for a policy and plan of action</li> <li>■ How best to convince those staff members likely to be most resistant</li> <li>■ The special concerns about HIV and breastfeeding promotion in this setting</li> </ul> </li> </ul>	<p><b><i>Discussion and brainstorming: 15 minutes</i></b></p> <p>Mention the importance for health facility administrators and policy-makers of “thinking strategically” about how best to gain support within the health facility for making the changes necessary to become baby-friendly. (Note: If the facilities are already baby-friendly, concentrate on how support can be gained for adjusting the policy and BFHI approach to be most appropriate in a setting where mothers who may be HIV infected receive care.)</p> <p>Ask the participants to brainstorm concerning how, within their culture and institutional administrative system, they can best work to gain the support needed to develop a breastfeeding policy and plan (or to adjust the existing policy and plan in the light of high HIV prevalence).</p> <p>Before the session starts, review the “Actions” suggested for “Step 1” in Handout 5.5 HIV and, if necessary, mention the strategies suggested under the first four bullets as examples, to help get the participants thinking about what would work best in their own settings.</p> <p>Record the suggestions made by the participants either on a flip chart or board or on Transparencies 5.14-15 HIV. Emphasize that these strategies are part of the Actions needed to successfully implement “Step 1” in a way that is most likely to have full administrative and staff support.</p> <p>Briefly mention examples of policies adapted for settings with high HIV prevalence. Pass out Handout 5.3 HIV - an example of a policy for a hospital with high HIV prevalence, based on recommendations from a regional meeting on BFHI in the context of HIV/AIDS held in Gaborone in 2003 and briefly review key aspects of the policy. Mention the policy developed for Rusape Hospital in Zimbabwe serving a population with high risk of HIV as another example – Handout 4.7 HIV distributed during Session 4-HIV.</p>
<p><b>2. Group work on implementing the Ten Steps</b></p>	<p><b><i>Introduction: 5 minutes</i></b></p> <p>Describe the group work, explaining that</p>

Content	Trainer's Notes
<ul style="list-style-type: none"> <li>■ Small group work to identify actions necessary to implement four or five of the most challenging of the Ten Steps in the context of HIV and address common concerns.</li> </ul>	<p>participants will be divided into four or five small groups, with each group assigned one of the Ten Steps that experience has shown can be a challenge, as health facilities work to become baby-friendly in the context of HIV.</p> <p>(Note: Steps 1, 2, 3, 5, 6 and 10 are most challenging in the context of HIV. Steps 3 and 5 in particular present the challenges in that they may require changes in care routines and protocols. Step 10, community follow-up support, posed challenges for the original BFHI and will continue to be a challenge for BFHI in light of HIV. Thus the Steps to use in group work could be selected from among these, unless the facilitators feel that other Steps should be chosen because they are particularly challenging in general for the health facilities represented.)</p> <p>For the step it is assigned, each group should identify:</p> <ol style="list-style-type: none"> <li>1) common concerns or problems related to instituting the step and possible solutions, and</li> <li>2) actions necessary to implement the step.</li> </ol> <p>(The worksheet for each step starts with “Actions necessary to implement the step”, but ask the groups first to identify “Concerns and solutions” and record them on the back of the worksheet, as some of the “solutions” may be useful to include in their list of “actions”.</p> <p>If it seems necessary to use an example to show participants how to complete the group work, display transparencies showing how to complete Handout 5.3 HIV for one of the steps that will not be assigned to the working groups. Transparencies (5.16-20 HIV) have been prepared using “Step 7” (rooming-in) as an example, including concerns and solutions related to HIV. Then present Transparency 5.21 HIV that provides an example of “Actions” that could be taken to implement this Step in settings with high HIV prevalence. Mention that groups should start by identifying “concerns and solutions” for the Steps they have been assigned. Then, if they have time, they could also identify the “actions” needed to implement the Steps. If necessary, the trainer can prepare other transparencies, focusing</p>

Content	Trainer’s Notes
	<p>on a different step. Use the transparencies to explain how to complete the worksheet for both sections on “Concerns and solutions” and “Actions”.</p> <p>Emphasize that during this session the groups won’t be making “Action plans” for their own health facilities, but will be working to identify common concerns and solutions. Outline the actions that are necessary to implement the steps they are assigned to work on. Later in the course the participants from the same facility will work together to develop specific “Action plans” that identify the activities needed for BFHI in their own facilities.</p> <p>Ask if there are any questions.</p> <p><b>Group work: 30-45 minutes</b></p> <p>Divide participants into four or five working groups, assigning a facilitator to each group, if possible. Assign each working group one of the Ten Steps to work on. Distribute one of the Handout 5.3 HIV worksheets (with “Concerns and solutions” on one side and “Actions” on the other) to each group, with the Step and the wording for the Step that the group will be working on inserted at the top.</p> <p>Ask each group to record its work on the worksheet and summarize results on transparencies or flip charts, and to assign one of its members to present the work during the reporting and discussion period to follow.</p>
<p><b>3. Presentations and discussion</b></p> <ul style="list-style-type: none"> <li>■ Presentation of group work.</li> <li>■ Discussion of issues raised after each group’s presentation.</li> </ul>	<p><b>Presentations and discussion: 40-55 minutes</b></p> <p>Ask each group to present its work. Lead a discussion on each presentation, making sure major points are covered.</p> <p>Collect the group work on each step at the end of the session. If feasible and not too costly, make copies and distribute them to all participants before the course is over. In addition, include copies of this group work in the course report.</p> <p>Distribute Handout 5.4 HIV, which summarizes experience in a number of countries at the end of the session as a “reference document”. Explain</p>

<b>Content</b>	<b>Trainer's Notes</b>
	<p>that since the material in this handout comes from many countries not all the concerns and solutions will be relevant. The handout may be helpful, however, as its review of experience worldwide in implementing the Ten Steps in settings where HIV is prevalent may give participants some new and creative ideas concerning what to do in their own situations.</p>

■ Handout 5.1 (HIV)

## Presentation for session 5 (HIV)

### The ten steps to successful breastfeeding for settings where HIV is prevalent: Issues to consider

#### STEP 1: Have a written breastfeeding policy that is routinely communicated to all health care staff

- The hospital policy should promote, protect and support breastfeeding irrespective of the HIV infection rate within the population.
- The policy will need to be adapted so that providing appropriate support in the context of HIV is addressed.
- The policy should require the training of staff in HIV and infant feeding counselling.

Slide 5.1 (HIV)

#### STEP 1 (continued): Have a written breastfeeding policy that is routinely communicated to all health care staff

- The policy should include a recommendation that all pregnant and lactating women be offered or referred for HIV testing & counselling.
- The policy should require that the hospital offer counselling for HIV-positive pregnant women about feeding options.
- The policy should stress that full compliance with the "Code of Marketing of Breast-milk Substitutes" or a similar national measure is essential.
- The issue of confidentiality should be addressed in the policy.
- If there is a national level policy on infant feeding in the context of HIV the hospital policy should incorporate the national guidelines.

Slide 5.2 (HIV)

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

- Staff training needs may vary from facility to facility.
- If the hospital is already a baby-friendly hospital, then emphasis should be placed on refresher training related to HIV and infant feeding.
- If the facility has never implemented the BFHI then BFHI training will need to include guidance related to HIV and infant feeding, or additional training on this topic will need to be organized, requiring more time and training resources.
- Training may require a multi-sectoral training team from nutrition, HIV/AIDS and other MCH sections.
- If there are no master trainers available locally with experience in implementing BFHI in settings where HIV-positive mothers receive care, external trainers may be needed.

Slide 5.3 (HIV)

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

- WHO/UNAIDS recommends that pregnant women be offered VCT during antenatal care.
- Where VCT services do not yet exist, this will involve additional equipment, space, reagents, and staff time.
- Mothers may be HIV-infected but not know their status. They need to know their HIV status in order to make informed infant feeding choices.
- Pregnant women who are HIV-positive should be counselled about the benefits and risks of locally appropriate infant feeding options so they can make informed decisions on infant feeding.

Slide 5.4 (HIV)

#### Step 3 (continued): Inform all pregnant women about the benefits and management of breastfeeding.

- Mothers have to weigh the balance of risks: Is it safer to exclusively breastfeed for a period of time or to replacement feed, given the possibility of illness or death of a baby if not breastfed.
- Counsellors must be knowledgeable about the local situation relative to what replacement feeds are locally appropriate. They should be able to help mothers assess their own situations and choose feeding options.
- Counsellors need to recognize that the social stigma of being labelled as being "HIV-positive or having AIDS" may affect some mothers' decisions on infant feeding.
- Counselling should be individual and confidential.

Slide 5.5 (HIV)

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

- All babies should be well dried, given to their mothers to hold skin-to-skin and covered, whether or not they have decided to breastfeed.
- Staff may assume that babies of HIV infected mothers must be bathed and even separated from their mothers at birth.
- They need to understand that HIV is not transmitted by mothers while they are holding their newborns - mothers need to be encouraged to hold and feel close and affectionate towards their newborn babies.
- HIV-positive mothers should be supported in using the feeding option of their choice. They shouldn't be forced to breastfeed, as they may have chosen to replacement feed without knowledge of the delivery room staff.

Slide 5.6 (HIV)

**Step 5: Show mothers how to breastfeed and maintain lactation even if they should be separated from their infants.**

- Staff members will need to counsel mothers who have chosen to breastfeed (regardless of their HIV status) on how to maintain lactation by manual expression, how to store their breast milk safely, and how to feed their babies by cup.
- They will also need to counsel HIV-positive mothers on locally available feeding options and the risks and benefits of each, so they can make informed infant feeding choices.
- Staff members should counsel HIV-positive mothers who have chosen to breastfeed on the importance of doing it exclusively and how to avoid nipple damage and mastitis.
- Staff members should help HIV-positive mothers who have chosen to breastfeed to plan and implement early cessation of breastfeeding.

Slide 5.7 (HIV)

**Step 5 (continued): Show mothers how to breastfeed and maintain lactation even if they should be separated from their infants.**

- Staff members will need to counsel HIV-positive mothers who have chosen replacement feeds on their preparation and use and how to care for their breasts while waiting for their milk to cease and how to manage engorgement.
- Mothers should have responsibility for feeding while in the hospital. Instructions should be given privately.
- Breast milk is particularly valuable for sick or low birth weight infants. Heat treating breast milk is an option.
- If there is a breast-milk bank, WHO guidelines will need to be followed for heat treatment of breast milk. Wet nursing is an option as well, if the wet nurse is given proper support.
- Staff members should try to encourage family and community support of HIV-positive mothers after discharge, but will need to respect the mothers' wishes in regards to disclosure of their status.

Slide 5.8 (HIV)

**Step 6: Give newborn infants no food or drink other than breast milk unless medically indicated.**

- Staff members should find out whether HIV-positive mothers have made a feeding choice and make sure they don't give babies of breastfeeding mothers any other food or drink.
- Being an HIV-positive mother and having decided not to breastfeed is a medical indication for replacement feeding.
- Staff members should counsel HIV-positive mothers who have decided to breastfeed on the risks if they do not exclusively breastfeed. Mixed feeding brings both the risk of HIV from breastfeeding and other infections.
- Even if many mothers are giving replacement feeds, this does not prevent a hospital from being designated as baby-friendly, if those mothers have all been counselled and offered testing and made genuine choices.

Slide 5.9 (HIV)

**Step 7: Practice rooming in — allow mothers and infants to remain together — 24 hours a day.**

- In general it is best that HIV-positive mothers be treated just like mothers who are not HIV-positive and provided the same post partum care, including rooming-in/bedding-in. This will be best for the mothers and babies and will help protect privacy and confidentiality concerning their status.
- HIV-positive mothers who have chosen not to breastfeed should be counselled as to how to have their babies bedded in with them, skin-to-skin, if they desire, without allowing the babies access to the breast. General mother-to-child contact does not transmit HIV.
- Staff members who are aware of an HIV-positive mother's status need to take care to ensure that she is not stigmatised or discriminated against. If confidentiality is not insured, mothers are not likely to seek the services and support they need.

Slide 5.10 (HIV)

**Step 8: Encourage breastfeeding on demand.**

- This step applies to breastfeeding mothers regardless of their HIV status.
- Babies differ in their hunger. The individual needs of both breastfed and artificially fed infants should be respected and responded to.

Slide 5.11 (HIV)

**Step 9: Give no artificial teats or pacifiers.**

- This step is important regardless of mothers' HIV status and whether they are breastfeeding or replacement feeding.
- Teats, bottles, and pacifiers can carry infections and are not needed, even for the non-breastfeeding infant. They should not be routinely used or provided by facilities.
- If hungry babies are given pacifiers instead of feeds, they may not grow well.
- HIV-positive mothers who are replacement feeding need to be shown ways of soothing other than giving pacifiers.
- Mothers who have chosen to replacement feed should be given instructions on how to cup feed their infants and the fact that cup feeding has less risk of infection than bottle-feeding.

Slide 5.12 (HIV)

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

- The facility should provide information on MTCT and HIV and infant feeding to support groups and others providing support for HIV-positive mothers in the community.
- The facility should make sure that replacement-feeding mothers are followed closely in their communities, on a one-to-one basis to ensure confidentiality. In some settings it is acceptable to have support groups for HIV-positive mothers.
- HIV-positive mothers are in special need of on-going skilled support to make sure they continue the feeding options they have chosen. Plans should be made before discharge.
- The babies born to HIV-positive mothers should be seen at regular intervals at well baby clinics to ensure appropriate growth and development.

Slide 5.13 (HIV)

**The Ten Steps to successful breastfeeding for settings where HIV is prevalent:  
Actions, concerns and solutions - worksheet  
Example**

**STEP 1: Have a written breastfeeding policy that is routinely communicated to all health care staff**

**Actions necessary to implement the step**

Slide 5.14 (HIV)

**STEP 1: Have a written breastfeeding policy that is routinely communicated to all health care staff**

**Common concerns and solutions**

Concerns	Solutions

Slide 5.15 (HIV)

**The ten steps to successful breastfeeding for settings where HIV is prevalent :  
Actions, concerns and solutions - worksheet  
Example**

**STEP 7: Practice rooming-in.**

**Common concerns and solutions**

Concern	Solutions
It's difficult to supervise the condition of a baby who is rooming-in. In the nursery one staff member is sufficient to supervise several babies.	<ul style="list-style-type: none"> <li>■ Assure staff that babies are better off rooming-in with their mothers, with the added benefits of security, warmth, and feeding on demand.</li> <li>■ Stress that 24-hour supervision is not needed. Periodic checks and availability of staff to respond to mothers' needs are all that are necessary.</li> </ul>

Slide 5.16 (HIV)

Concern	Solutions
Infection rates will be higher when mothers and babies are together than when they are in a nursery.	<ul style="list-style-type: none"> <li>■ Stress that danger of infection is reduced when babies remain with mothers than when in a nursery and exposed to more caretakers.</li> <li>■ Provide staff with data showing that infection rates are lower with rooming-in and breastfeeding, for example, from diarrhoeal disease, neonatal sepsis, otitis media, and meningitis.</li> </ul>

Slide 5.17 (HIV)

Concern	Solutions
Babies will fall off their mothers' beds.	<ul style="list-style-type: none"> <li>■ Emphasize that newborns don't move.</li> <li>■ If mothers are still concerned, arrange for beds to be put next to the wall or, if culturally acceptable, for beds to be put in pairs, with mothers placing babies in the centre.</li> </ul>

Slide 5.18 (HIV)

Concern	Solutions
Full rooming-in, without more than half-hour separations, seems unfeasible because some procedures need to be performed on the babies outside their mothers' rooms.	<ul style="list-style-type: none"> <li>■ Study these procedures well. Some are not needed. (Example: weighing baby before and after breastfeeding.) Other procedures can be performed in the mothers' rooms.</li> <li>■ Review advantages to mother and time saved by physician when infant is examined in front of mother.</li> </ul>

Slide 5.19 (HIV)

Concern	Solutions
A mother in the postnatal ward may be seen by others while she is replacement feeding her infant, and confidentiality will be hard to protect.	<ul style="list-style-type: none"> <li>■ For an HIV-positive mother who chooses replacement feeding it is likely others will notice, but she has been counselled and has already decided how she will make this change in her life even after she has left the maternity.</li> <li>■ For an HIV-positive mother who chooses breastfeeding, she should be supported to exclusively breastfeed and there should be no obvious difference in her care.</li> </ul>

Slide 5.20 (HIV)

**The ten steps to successful breastfeeding for settings where HIV is prevalent :**  
**Actions, concerns and solutions - worksheet**  
**Example**

**STEP 7: Practice rooming-in.**

**Actions necessary to implement the step**

- Make needed changes in physical facility. Discontinue nursery. Make adjustments to improve comfort, hygiene, and safety of mother and baby.
- Require and arrange for cross training of nursery and postpartum personnel so they all have the skills to take care of both baby and mother.
- Institute individual or group education sessions for mothers on mother-baby postpartum care. Sessions should include information on how to care for babies who are rooming-in.
- Protect privacy and confidentiality of a mother's HIV status by providing the same routine care to ALL mothers and babies, including rooming-in/bedding-in, so that no one is stigmatised or set apart as different.

Slide 5.21 (HIV)

## The ten steps to successful breastfeeding for settings where HIV is prevalent: Issues to consider 1

### **Step 1: Have a written breastfeeding policy that is a routine communicated to all health care staff.**

- The hospital policy should promote, protect and support breastfeeding irrespective of the HIV infection rate within the population.
- The hospital policy will need to be adapted so that providing appropriate support in the context of HIV is addressed.
- The hospital policy should include a recommendation that all pregnant and lactating women be offered or referred for HIV testing and counselling.
- The hospital policy should require that the hospital offer counselling for HIV-positive pregnant women about feeding options.
- The hospital policy should require the training of staff in HIV and infant feeding counselling.
- The issue of confidentiality should be addressed in the policy. Confidentiality is a challenge in settings where many staff members handle patient charts, where storage of charts is not secure, and where shortage of staffing interferes with supervision and quality assurance in care.
- The hospital policy should stress that full compliance with the “Code of Marketing of Breast-milk Substitutes” or similar national measures is essential.
- There may or may not be a national level policy on infant feeding in the context of HIV. Where one exists, the hospital policy should incorporate the national guidelines.

### **Step 2: Train all health care staff in skills necessary to implement this policy.**

- Staff training needs may vary from facility to facility.

1 See the Session on “Integrated care for the HIV-positive Woman and her Baby” and the discussion and exercise on implementing BFHI in settings with high HIV prevalence in *HIV and Infant Feeding Counselling: A Training Course*, pp. 45-56, for further information on this topic. Points marked with an asterisk (\*) are adapted from this document.

- If the hospital is already a BF hospital, then the breastfeeding knowledge and skills should be in place and the issues of adapting for a high HIV prevalence will be foremost in planning for refresher training. If the facility has never implemented the BFHI then BFHI training will need to include guidance related to HIV and infant feeding in the context of BFHI, or additional training on HIV and infant feeding will need to be organized. This will require more time and training resources.
- Staff needs to be trained on such topics as how HIV is transmitted from mother to child and how to prevent it, voluntary counselling and testing (VCT), the risks and benefits associated with various feeding options, how to help mothers make informed choices, how to teach mothers to prepare and give replacement feeds, how to maintain privacy and confidentiality, and how to minimize the “spill over” effect, causing mothers who are HIV negative or of unknown status to choose replacement feeding when breastfeeding has less risk.
- Training may require a multi-sectoral training team from nutrition, HIV/AIDS and other MCH sections.
- If there are no master trainers available locally with knowledge and experience in implementing BFHI in settings where HIV-positive mothers receive care, external trainers may need to be figured into the training budget.

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

- This step will involve considerable thought and planning for implementation. Pregnant women need general information on HIV and breastfeeding and those that are HIV-positive need additional counselling and assistance.
- WHO/UNAIDS recommends that pregnant women be offered voluntary testing and counselling (VCT) during antenatal care.
- Where VCT services do not yet exist in the antenatal/MCH service setting, their organization will involve additional equipment, space, reagents, and staff time, including for specialized training.
- Mothers may be infected but not know their HIV status. They need to know their HIV status in order to make informed infant feeding choices on the most feasible infant feeding method.
- Pregnant women who are HIV-positive should be counselled about the benefits and risks of locally appropriate infant feeding options so they can make informed decisions on infant feeding before they deliver.
- Mothers have to weigh the balance of risks: Is it safer to exclusively breastfeed for a period of time or to replacement feed, given the risk of illness or death of a baby if not breastfed?
- Staff members who serve as infant-feeding counsellors must be knowledgeable about the local situation relative to what replacement feeds are locally appropriate. They should also be able to help mothers in assessing their own situations to choose the best feeding options for themselves.

- Counsellors need to recognize that other factors such as the social stigma of being labelled as being “HIV-positive” or “having AIDS” may affect some mothers’ decisions on infant feeding. Some mothers may become victims of physical abuse or ostracized if they are suspected of being HIV-positive because they are known to have gone for testing or are not breastfeeding.
- Any discussion of feeding options should be only with HIV-positive mothers. Counselling should be individual and confidential. No group discussion on feeding options is recommended.

### **Step 4: Help mothers initiate breastfeeding within a half hour of birth.**

- All babies should be well dried, covered and given to their mothers to hold skin-to-skin after delivery, whether or not they have decided to breastfeed.
- Staff may assume that babies of HIV-positive mothers must be bathed and even separated from their mothers at birth. They need to understand that HIV is not transmitted by a mother while she is holding her newborn (after drying and covering) and that, in fact, an HIV-positive mother needs to be encouraged to hold and feel close and affectionate towards her newborn baby.
- The HIV-positive mothers may either breastfeed or not, depending on the choices they have made. VCT should be made available to help them make these choices. HIV-positive mothers should be supported in using the infant feeding option of their choice.
- Mothers should not be forced to breastfeed, since they may have chosen to replacement feed without the knowledge of the delivery room staff.

### **Step 5: Show mothers how to breastfeed, and how to maintain lactation even if they should be separated from their infants.**

- Staff members will need to counsel mothers who have chosen to breastfeed (regardless of their HIV status) on how to maintain lactation by expression, how to store their breast milk safely, and how to feed their babies by cup.
- They will also need to counsel HIV-positive mothers on locally available feeding options and the risks and benefits of each, so they can make informed infant feeding choices.
- Staff members should counsel HIV-positive mothers who have chosen to breastfeed on the importance of doing it exclusively, to avoid the increased risks of HIV that come with mixed feeding, and how to use good techniques to avoid nipple damage and mastitis.
- Staff members should help HIV-positive mothers who have chosen to breastfeed to plan and implement early cessation of breastfeeding.
- Staff members will need to counsel mothers who are HIV-positive and who have chosen locally appropriate replacement feeding methods, on their preparation and use. They will also need to teach mothers about breast care while waiting for their breast milk to cease and about managing engorgement at home. Mothers should have responsibility for preparing feeds and cup feeding their infants while in the hospital, with staff assistance. The importance of giving instructions privately and confidentially should be emphasized.

- Breastmilk is particularly valuable for sick or low birth weight infants. Expressing and heat treating breastmilk is an option for HIV-positive mothers and they will need help to do this.\*
- If there is a breast milk bank, WHO guidelines will need to be followed for heat treatment of breast milk.
- If a mother has decided to use a wet nurse who is HIV-negative, the staff will need to discuss breastfeeding with the wet nurse and help her to get started or to relactate.\*
- Staff members should try to encourage family and community support of HIV-positive mothers after discharge, but will need to respect the mothers’ wishes in regards to disclosure of their status.

**Step 6: Give newborn infants no food or drink other than breast milk unless medically indicated.**

- Staff members should find out whether HIV-positive mothers have decided to breastfeed or replacement feed and make sure they don’t give babies of breastfeeding mothers any other food or drink.
- Being an HIV-positive mother and having decided not to breastfeed is a medical indication for replacement feeding.
- Staff members should counsel HIV-positive mothers on the risks if they do not exclusively breastfeed or replacement feed their babies. Mixed feeding brings with it both the risk of HIV transmission from breastfeeding and the risk of other infections and malnutrition.
- Even if many mothers are giving replacement feeds, this does not prevent a hospital from being designated as baby-friendly, if those mothers have all been counselled and offered testing and made genuine choices.\*

**Step 7: Practice rooming in – allow mothers and infants to remain together – 24 hours a day.**

- In general it is best that HIV-positive mothers be treated just like mothers who are not HIV-positive and provided the same post partum care, including rooming-in/bedding-in. This will be best for the mothers and babies as it will help with bonding and will also help protect privacy and confidentiality concerning their status.
- HIV-positive mothers who have chosen not to breastfeed should be counselled as to how to have their babies bedded in with them, skin-to-skin, if they desire, without allowing the babies access to the breast. General mother-to-child contact does not transmit HIV.\*
- Staff members who are aware of an HIV-positive mother’s status need to take care to ensure that she is not stigmatised or discriminated against. If privacy and confidentiality are not insured, mothers are not likely to seek the services and support they need for optimal infant feeding.

**Step 8: Encourage breastfeeding on demand.**

- This step applies to breastfeeding mothers regardless of their HIV status.

- Babies differ in their hunger. The individual needs of both breastfed and artificially fed infants should be respected and responded to.\*

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

- This step is important regardless of mothers' HIV status and whether they are breastfeeding or replacement feeding. Teats, bottles and pacifiers can carry infections and are not needed, even for the non-breastfeeding infant and thus should not be routinely used or provided by facilities.\*
- If hungry babies are given pacifiers instead of feeds, they may not grow well.\*
- HIV-positive mothers who are replacement feeding need to be shown ways of soothing other than giving pacifiers.
- Mothers who have chosen to replacement feed should be given instructions on how to cup feed their infants and the fact that feeding by cup has less risk of infection than bottle-feeding.

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

- The facility should provide information on mother-to-child transmission of HIV and HIV and infant feeding to support groups and others providing support for HIV-positive mothers and their babies in the community.
- The facility should make sure that follow-up support exists for HIV-positive breastfeeding mothers in their communities. This may be in the form of support groups or individuals, home visiting, and other ways to ensure safe, optimal breastfeeding.
- The facility should make sure that HIV-positive mothers that have chosen to replacement feed are followed closely in their communities. This should be done on a one-to-one basis to ensure confidentiality and privacy. In some communities it is acceptable to have support groups for HIV-positive mothers.
- HIV-positive mothers are in special need of on-going skilled support to make sure they continue the feeding options they have chosen. Appropriate follow-up care plans should be prepared before they are discharged.
- The babies born to HIV-positive mothers need to be seen at regular intervals at well baby clinics to ensure appropriate growth and development.

Handout 5.3 HIV

**The ten steps to successful breastfeeding  
for settings where HIV is prevalent:  
Worksheet: Concerns and solutions**

<b>STEP ____:</b>	
<b>Concern</b>  (List concerns, problems or challenges your maternity services face in implementing this Step.)	<b>Solutions</b>  (List possible solutions to each of the concerns, including both actions that have been successful and other approaches you think might be useful.)

**The ten steps to successful breastfeeding  
for settings where HIV is prevalent:  
Worksheet: Actions necessary to implement the step**

**STEP \_\_\_\_:**

**(List key actions you think are necessary to successful implement this Step within maternity services that do not yet follow the Step.)**

Handout 5.4 (HIV)

## The ten steps to successful breastfeeding for settings where HIV is prevalent: Summary of experiences<sup>2</sup>

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

### Actions necessary to implement the step

- Identify a core group of people who will provide the primary source of support for developing a hospital breastfeeding policy and plan and addresses the issues of infant feeding in the presence of maternal HIV infection. The core group may include officers from various MOH units including Nutrition, MCH, Primary Health Care, RH, HIV/AIDS programs and others. Many countries have revised their national breastfeeding policy to a broader *infant and young child feeding policy* that encompasses HIV infected mothers.
- Ask the core group to develop a rough first draft of a new infant feeding policy that follows national breastfeeding and young child nutrition guidelines; National Code of Marketing Breastmilk Substitutes; and national HIV and/or MTCT guidelines. If an infant feeding policy exists, plan for making the necessary changes to reflect support for breastfeeding and also enabling mothers of known HIV status to make informed decisions about the safest infant feeding option for them. Work with the group as they develop the first draft, providing whatever guidance is needed.
- Establish a multi-disciplinary in-house committee or task force to whom the policy and plan will be presented for input. Include representatives from all appropriate units or departments. When the policy and plan are discussed, ask committee members to identify barriers to implementing specific policies, as well as potential solutions. If necessary, form smaller working groups to work on specific barriers or problems.
- Finalize and display written hospital breastfeeding policy and work with designated staff to initiate changes needed to implement it.
- Policy may include guidelines on topics such as:
  - How the “Ten steps to successful breastfeeding” will be implemented in the context of HIV and in coordination with other existing national guidelines.
  - Maternal nutrition issues that should be addressed
  - Breastfeeding of low-birth-weight infants and infants delivered by C-section

<sup>2</sup> This handout summarizes experiences from a variety of countries.

- Purchase and use of breast-milk substitutes
- Acceptable medical reasons for supplementation (See WHO/UNICEF list — and refer to the balance of risks for HIV-positive mothers of NOT breastfeeding versus replacement feeding)
- The importance of providing voluntary testing and counselling (VCT) for HIV to pregnant women
- The importance of providing individual counselling and education on replacement feeding to HIV-positive mothers who choose not to breastfeeding, rather than group education, which violates confidentiality
- Hazards of bottle-feeding education. How to provide counselling for women who choose to formula-feed without lessening hospital support for breastfeeding.
- Code related issues (e.g., prohibiting donations of free and low-cost [under 80% of retail price] breast-milk substitutes, distribution of samples of breast-milk substitutes, gifts or coupons, use of materials distributed by formula companies). Many countries are choosing to strengthen their national codes in the face of HIV.
- Prohibiting the practice, if it exists, of giving names of pregnant or recently delivered mothers to companies producing or distributing breast-milk substitutes
- Storing any necessary hospital supplies of breast-milk substitutes, bottles, etc., out of view
- Allocating staff responsibilities and time related to the implementation of the breastfeeding policy
- Work with designated staff to develop plans for monitoring implementation of the policy and the effects of the initiative on staff knowledge and practices, patient satisfaction and quality of care. Publicize positive results to reinforce support for changes made, and use information concerning problem areas to assist in determining whether further adjustments are needed.

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

**Common concerns and solutions**

Concern	Solutions
<p>Considerable evidence documents that some health administrators and care providers are uncertain about promotion of breastfeeding in the face of HIV. They have heard that breastfeeding is a major route of mother to child transmission (MTCT) and are not well informed on basics facts of HIV and infant feeding.</p>	<ul style="list-style-type: none"> <li>▪ Strengthened infant feeding policy in the face of HIV and training in the implementation of this policy is essential. Provide information on MTCT.</li> </ul>
<p>Resistance to introducing new breastfeeding policies. Concern that policies will be inappropriate, dangerous to infant health, difficult to implement considering other tasks, etc.</p>	<ul style="list-style-type: none"> <li>▪ Provide the latest global guidelines and policies on infant feeding and HIV such as the WHO/UNAIDS/UNICEF global recommendations on HIV and infant feeding (See websites such as: <a href="http://www.who.int/child-adolescent-health/NUTRITION/HIV_infant.htm">http://www.who.int/child-adolescent-health/NUTRITION/HIV_infant.htm</a> <a href="http://www.unicef.org/pubsgen/hiv-infantfeeding/">http://www.unicef.org/pubsgen/hiv-infantfeeding/</a> <a href="http://linkagesproject.org/pubs.html">http://linkagesproject.org/pubs.html</a>); <a href="http://www.linkagesproject.org/hiv.html">http://www.linkagesproject.org/hiv.html</a>; <a href="http://www.unaids.org/publications/documents/mtct/infantpolicy.pdf">http://www.unaids.org/publications/documents/mtct/infantpolicy.pdf</a>.)</li> <li>▪ Provide scientific evidence of the soundness of the new policies through presentations such as one on “The Scientific Basis of the Ten Steps” or shorter session on key concerns (See Session 4) and the balance of risks of breastfeeding versus replacement feeding in resource poor settings. (See UNICEF/UNAIDS/WHO (2003) Review of HIV transmission through breastfeeding)</li> <li>▪ Organize a task force to develop the policies, including representatives of all the departments that will be affected. If necessary, provide orientation for the task force so it is well informed about potential policies, their scientific basis, and how they will affect hospital practices before beginning work.</li> <li>▪ Arrange for presentations by administrators or department heads from hospitals that have model breastfeeding policies or have key staff visit other institutions with good policies in place.</li> <li>▪ As the policies are being developed, make sure that input is obtained from all influential parties, even if opposition is anticipated, so that plans can be made</li> </ul>

Concern	Solutions
	<p>to address concerns identified.</p> <ul style="list-style-type: none"> <li>▪ Present the new policies as the “current state of the art” and highlight other hospitals in the country or region that have already successfully implemented the BFHI.</li> <li>▪ If resistance is high, make just a few changes at a time, starting with those for which support is greatest. Consider addressing just a few of the “steps” at a time to prevent staff from becoming overwhelmed.</li> </ul>
<p>Economic concerns related to potential costs of policy changes (e.g. costs of conversion to rooming-in, loss of formula company support, cessation of free and low-cost supplies, refusal of donations of breast-milk substitutes for HIV-positive mothers.)</p>	<ul style="list-style-type: none"> <li>▪ Work with key staff to identify both the costs and savings to hospital and larger health system that will result from the changes and weigh the trade-offs. (See Session 6.)</li> <li>▪ Work with staff members so they fully understand that the balance of risks for donated formulas to mothers who cannot guarantee sanitary conditions and afford to continue to buy replacement feeds after donations are discontinued.</li> <li>▪ Work with staff to understand the dangers of “spillover”<sup>3</sup> to the community at large if free &amp; low cost formula is made available to “some” mothers.</li> </ul>

■ \_\_\_\_\_

<sup>3</sup> Spillover: a term used to designate the feeding behaviour of new mothers who either know that they are HIV-negative or are unaware of their HIV status – they do not breastfeed, or they breastfeed for a short time only, or they mix-feed, because of unfounded fears about HIV or of misinformation or of the ready availability of breast milk substitutes (HIV and infant feeding: Guidelines for decision makers, 2003.)

## **The ten steps to successful breastfeeding for settings where HIV is prevalent: Summary of experiences**

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

### **Actions necessary to implement the step**

- Identify who will be responsible for planning and implementing an on-going training program for breastfeeding and lactation management and on counselling on infant feeding and HIV including locally appropriate replacement feeding. Work with the designated individual or group to develop a training strategy which will include:
- Identifying who needs to be trained in departments providing maternal/infant services and what their training needs are (both knowledge and clinical skills)
- Identifying the types and content of training for each target group
- Obtain existing training materials. Available courses include, for example:
  - “Breastfeeding “Breastfeeding Promotion and Support in a Baby-Friendly Hospital: A 20-hour Course for Maternity Staff” (Section 3 of the revised BFHI documents), New York, UNICEF.
  - “Breastfeeding Counselling: A Training Course”. (40 hours) Geneva, World Health Organization.
  - “Infant and Young Child Feeding Counselling: An Integrated Course”. (5 days) Geneva, World Health Organization.
  - “HIV and Infant Feeding Counselling: A Training Course”. (3 days) Geneva, WHO, UNICEF, UNAIDS
  - “HIV and Infant Feeding Counselling Job Aids” (Flipchart, Take home flyers, Reference guide and Orientation guide), Geneva, World Health Organization.
  - “Integrating Counseling on HIV and Infant feeding into MCH and Community Services”. Basic Course; MOH Zambia and LINKAGES Project. (12 days)
  - “Integrating Counseling on HIV and Infant feeding into MCH and Community Services, Training of Trainers for the Basic Course”, MOH Zambia and LINKAGES Project. (12 days)
  - “Integrating Counselling on HIV and Infant feeding into MCH and Community Services, Comprehensive Counselling Course”; MOH Zambia and LINKAGES Project. (5 weeks)
  - “Integrated BFHI and MTCT course for MCH and Community Services”, Malawi. Basic Course, LINKAGES Malawi (12 days)
- Other training materials developed within the country or region

- Select appropriate training materials and make any necessary adaptations to them.
- Identify trainers with the help of appropriate government breastfeeding, nutrition, MCH, and HIV/AIDS authorities
- Develop a training schedule, considering the need for initial training, refresher training and training of new staff, as well as for training of trainers.
- Allot the necessary budget and staff time.

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

**Common concerns and solutions**

Concern	Solutions
Little or no time for training.	<ul style="list-style-type: none"> <li>■ Reassess priorities.</li> <li>■ Consider time saved by staff in the long run if breastfeeding problems as well as HIV transmission are prevented and health of infants improved, thus decreasing time and resources necessary for caring for sick infants and reducing the risks of mother to child transmission (MTCT).</li> <li>■ Consider scheduling breastfeeding-related training, including training on infant feeding in the context of HIV, in conjunction with staff meetings or other on going training activities or integrating training into daily routines through apprenticeships or on-the-job training when appropriate.</li> <li>■ Consider requiring staff to read selected materials or complete a self-guided course and then test their knowledge. Combine with clinical practice sessions and performance assessment.</li> <li>■ Provide a resource collection where staff can borrow books, articles, and videos on breastfeeding, lactation management, and related topics.</li> </ul>
Lack of faculty/trainers/resources	<ul style="list-style-type: none"> <li>■ Identify training resources. Contact national, regional, or international organizations such as UNICEF; WHO; IBFAN; LINKAGES, Wellstart and its Associate network; Institute of Child Health, University of London; La Leche League International, ILCA, WABA, etc., for assistance, if necessary. (See list of addresses on page 5-36.)</li> <li>■ Consider initiating a training strategy in which key health staff members are first trained as trainers and then used to train the rest of the staff. Choose strong candidates to be the trainers, if possible including staff from the various service units and shifts.</li> <li>■ Ask the training coordinator to identify good training videos already prepared or videotape training sessions and have new employees view the tapes. Supplement with clinical practice sessions.</li> </ul>
Staff members do not understand the	<ul style="list-style-type: none"> <li>■ Consider holding an orientation or advocacy session</li> </ul>

<b>Concern</b>	<b>Solutions</b>
<p>importance of breastfeeding support nor the need for voluntary testing and counselling (VCT) or HIV and infant feeding counselling and support and thus see little need for training in this area.</p>	<p>for staff before the training cycle begins. Introduce the hospital's breastfeeding policy and review evidence of the importance of breastfeeding support, linking the policies with increased breastfeeding and lowered morbidity and mortality and balance of risks for HIV-positive mothers to replacement feed in this setting. It may also be helpful to review the national (or hospital's) current rates of mother-to-child transmission of HIV.</p> <ul style="list-style-type: none"> <li>■ Identify times when staff can gather for informal reviews of case studies of mothers with breastfeeding problems and how they were resolved. Follow by discussion on how to address similar situations in the future.</li> <li>■ Identify times when staff can gather for informal reviews of case studies of mothers with replacement feeding problems and how they were resolved. Follow by discussion on how to address similar situations in the future.</li> <li>■ Arrange for bulletin board displays or include items in newsletters featuring BFHI progress, new articles, letters from patients, results from surveys, etc.</li> <li>■ Establish an employee HIV and infant feeding support program to increase the number of staff members with positive personal breastfeeding experiences.</li> </ul>
<p>Stigmatisation and prejudice by health providers creates a barrier for mothers to learn their HIV status and from seeking the care they need (i.e. prevents mothers from seeking breastfeeding counselling, voluntary counselling and testing for HIV, and infant feeding counselling (BF/VCT/IF).</p>	<ul style="list-style-type: none"> <li>■ Training of health providers must address not only the basic facts about HIV generally and MTCT and infant feeding in particular, but it must allow the opportunity for staff to share their own fears and misunderstandings about HIV.</li> <li>■ Training must include field experiences where they can visit VCT services, breastfeeding mothers, groups of people living with HIV /AIDS in order to become sensitised to the problem and to help them to become more understanding of mothers who are HIV-positive.</li> <li>■ Training on HIV and infant feeding counselling must allow for experiential sessions wherein staff feel safe to air their own biases, misconceptions, prejudices, and fears. Only in this way will these not translate to care of mothers and babies.</li> </ul>

Concern	Solutions
<p>Health staff have poor knowledge and clinical skills on HIV in general, and on prevention of mother-to-child transmission of HIV (PMTCT) and on breastfeeding and HIV, and infant feeding counselling</p>	<ul style="list-style-type: none"> <li>■ Train staff on breastfeeding and the BFHI.</li> <li>■ Train staff on basic facts on HIV and on PMTCT.</li> <li>■ Train staff on locally appropriate replacement feeding options.</li> <li>■ Train staff on the balance of risks of breastfeeding versus replacement feeding in the mother’s own setting.</li> </ul>
<p>Attendance at training sessions is low or health staff members are pulled out of the training to go back to the unit.</p>	<ul style="list-style-type: none"> <li>■ Stress the importance of HIV and infant feeding counselling and support skills along with other areas of expertise and require attendance at training sessions.</li> <li>■ Bring the training to staff on each shift.</li> <li>■ Offer continuing education credits for the training or other incentives such as recognition for new skills.</li> <li>■ Arrange for several hospitals to sponsor joint training in an attractive site.</li> <li>■ Work with hospital management to insure that training is considered a priority.</li> </ul>
<p>Hospital and its health staff members rely on funding from companies selling breast-milk substitutes for training activities, conference attendance, etc.</p>	<ul style="list-style-type: none"> <li>■ Convince staff of the hidden agenda of the formula industry and the moral issues involved in accepting its funding. In settings that are resource poor and hard hit by the HIV pandemic, families are even more financially compromised than in the past and household food security is very weak.</li> <li>■ Calculate the cost to hospital and families of illnesses due to feeding breast-milk substitutes.</li> <li>■ Search for alternative sources of funding.</li> </ul>

**List of training resources**

Institute of Child Health  
University of London  
30 Guilford Street  
London WCN 1EH  
United Kingdom  
Tel: [44] (171) 242-9789  
Fax: [44] (171) 404-2062

International Baby Food Action Network  
(IBFAN)  
P.O. Box 781  
Mbabane  
Swaziland  
Tel: [268] 45006  
Fax: [268] 44246

International Lactation Consultant  
Association (ILCA)  
200 North Michigan Avenue, Suite 300  
Chicago, IL 60601-3821  
USA  
Tel: (312) 541-1710  
Fax: (312) 541-1271  
Email:  
71005.1134@COMPUSERVE.COM

La Leche League International  
1400 N. Meacham Road  
P.O. Box 4079  
Schaumburg, IL 60168-4079  
USA  
Tel: (847) 519-7730  
Fax: (847) 519-0035

LINKAGES Project  
Academy for Educational Development  
1825 Connecticut Avenue, N.W.  
Washington, DC. 20009  
Tel: (202) 884-8086  
Fax: (202) 884-8977  
E-mail linkages@aed.org  
Website: www.linkagesproject.org

UNICEF Headquarters  
3 United Nations Plaza  
New York, NY 10017  
USA  
Tel: (212) 326-7000  
Fax: (212) 326-7336

Wellstart International  
PO Box 80877  
San Diego, CA 92138-0877  
Tel: (619) 295-5192  
Helpline: (619) 295-5193  
Fax: (619) 574-8159  
E-mail: info@wellstart.org  
Website: www.wellstart.org

World Health Organization  
Department of Nutrition for Health and  
Development  
20, Av. Appia  
CH-1211 Geneva 27  
Switzerland  
Tel: [41] (22) 791-3315  
Fax: [41] (22) 791-4156  
E-mail: nutrition@who.int  
Website: <http://www.who.int/nutrition>

World Health Organization  
Department of Child and Adolescent  
Health and Development  
20, Av. Appia  
CH-1211 Geneva 27  
Switzerland  
Tel: [41] (22) 791-2633  
Fax: [41] (22) 791-4853  
E-mail: cah@who.int  
Website: <http://www.who.int/child-adolescent-health/>

World Alliance for Breastfeeding Action  
PO Box 1200 19850  
Penang, Malaysia.  
Tel: [60]-(4)-658-4816  
Fax: [60]-(4)-657-2655  
Websites: www.waba.org.my  
www.waba.org.br

## The ten steps to successful breastfeeding for settings where HIV is prevalent: Summary of experiences

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

#### Actions necessary to implement the step

- Insure routine scheduling of prenatal classes that cover essential topics related to breastfeeding and infant feeding in the context of HIV. Ask the staff to keep records of the classes held and their content.
- Review (or prepare) written guidelines for individual prenatal counselling to insure that key breastfeeding/infant feeding in the context of HIV topics are covered and time is allowed to address concerns of individual mothers. (“HIV and Infant Feeding Counselling Job Aids”, 2005, are available from the World Health Organization. These include a flipchart and take-home flyers that can be used as tools to help counsel HIV-positive women on feeding options.)

Essential topics that are important to address during prenatal education and counselling include:

- Benefits of breastfeeding
- Early initiation
- Importance of rooming-in (if new concept)
- Importance of feeding on demand
- How to assure enough milk
- Positioning and attachment
- Importance of exclusive breastfeeding
- Risks of artificial feeding and use of bottles and pacifiers
- Basic facts on HIV and prevention of mother-to-child transmission of HIV (PMTCT)
- Voluntary testing and counselling (VCT) for HIV
- Locally appropriate replacement feeding options
- Balance of risks of breastfeeding versus replacement feeding in the mother’s own setting

(Prenatal education should **not** include group education on formula preparation. HIV-positive mothers who have chosen replacement feeding should be given individualized instruction on preparation of the feed of their choice.)

- Determine if any special strategies are needed to encourage women to attend prenatal classes or counselling sessions (for example, holding late-evening classes for working mothers, providing special incentives for attendance, etc.)
- Take away all literature and posters about bottle-feeding and promotion of breast-milk substitutes.
- Ensure that formula companies do not provide breastfeeding promotion materials.
- Discontinue distribution in prenatal clinics of samples of breast-milk substitutes or coupons.

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

**Common concerns and solutions**

Concern	Solutions
<p>Promotional materials are free from the formula industry. It’s difficult to find replacement materials and the funds to purchase them.</p>	<ul style="list-style-type: none"> <li>■ Determine what promotional materials are available free or at low cost from the government, NGOs or other agencies. If there is a BFHI national authority, ask what materials it has available.</li> <li>■ Pressure local and national health authorities to make materials available.</li> <li>■ Ask the health facility staff to develop low-cost promotional materials with appropriate breastfeeding messages, adapting materials from elsewhere, when appropriate.</li> <li>■ Seek other sources of support, including donations from local businesses and volunteer organizations to support the development and production of educational materials.</li> </ul>
<p>There’s no staff time in busy prenatal clinics for individual counselling or group sessions related to breastfeeding, voluntary testing and counselling and HIV and infant feeding counselling.</p>	<ul style="list-style-type: none"> <li>■ Convince staff of importance of such sessions.</li> <li>■ Show how this will save time in the future, due to fewer breastfeeding and other infant feeding problems and reduction in levels of illness.</li> <li>■ Seek volunteer help from local NGOs, mother-support groups, etc., for conducting classes or providing counselling.</li> <li>■ Integrate breastfeeding and infant feeding material into other prenatal classes such as those on childbirth education, infant care, and nutrition.</li> </ul>
<p>Promotional and educational materials are often not well adapted to different educational, cultural and language groups.</p>	<ul style="list-style-type: none"> <li>■ Ask the staff to produce or adapt promotional or educational materials to meet local needs, as necessary.</li> <li>■ Form a network with other health facilities in the area and share materials or work together to develop them.</li> </ul>
<p>Busy mothers are reluctant to spend time to receive information or instructions, or don’t know the information is available.</p>	<ul style="list-style-type: none"> <li>■ Ask the staff to arrange group counselling while mothers are waiting to be seen.</li> <li>■ Ask the receptionist or registrar at the health facility to encourage participation in breastfeeding classes.</li> <li>■ Obtain support of clinical staff in assuring time</li> </ul>

Concern	Solutions
	<p>allocation for counselling and stressing its importance during consultations.</p> <ul style="list-style-type: none"> <li>■ Ask the staff to prepare written materials that mothers can take with them when they leave the health facility. Include breastfeeding guidelines, overview of the “Ten steps” and hospital breastfeeding support services, invitation/announcement of breastfeeding classes, list of mother-support groups and other community resources, etc.</li> <li>■ For HIV-positive mothers, HIV and infant feeding education groups may not be appropriate. Provide mothers with a list of individual peer counsellors, including HIV-positive mothers who are trained as HIV and infant feeding counselling volunteers, and other community resources who will visit the HIV-positive mother in her home or where she wishes.</li> <li>■ Hold an extra prenatal class in late evening for working women.</li> <li>■ Arrange for a resource centre or area where mothers can look at or borrow breastfeeding-related books, articles, videos, or other materials, at their own convenience.</li> <li>■ Hold a “breastfed baby parade” or a “beautiful breastfed baby contest” at a park, marketplace, or other public area.</li> <li>■ Ask private practitioners to refer their clients to breastfeeding classes and other support services and, when appropriate, to HIV and infant feeding education support services.</li> </ul>
<p>Pregnant mothers are afraid or unwilling to undergo voluntary testing and counselling (VCT). Therefore they are unable to made informed decisions about feeding options other than breastfeeding.</p>	<ul style="list-style-type: none"> <li>■ Counsel all pregnant mothers concerning the reasons why VCT will be valuable to them and their unborn babies.</li> <li>■ Conduct formative research to determine the local barriers to accepting VCT</li> <li>■ If a mother knows that she is HIV-positive, arrange for a private room for infant feeding to ensure a mother can make appropriate infant feeding choice while still maintainer her confidentiality.</li> <li>■ Determine staffing and time needed for counselling women on these issues. Weigh various options for</li> </ul>

Concern	Solutions
	<p>addressing these needs, given resource constraints. Community volunteers may be helpful in sensitising mothers in advance of their attendance at antenatal clinic.</p>
<p>Health administrators say there are not enough funds to create new confidential counselling space and/or for additional staff for VCT or HIV and infant feeding counselling.</p>	<ul style="list-style-type: none"> <li>■ Meetings can be held with district and national health decision makers to leverage funding for these activities</li> <li>■ Creative, low cost ways can be looked at to better utilize existing space, to build inexpensive barriers to make smaller counselling rooms, and to rearranging timing of clinic services.</li> </ul>
<p>Health staff members have poor knowledge and clinical skills on HIV, MTCT and HIV and infant feeding counselling.</p>	<ul style="list-style-type: none"> <li>■ Train staff on how to provide appropriate counselling and care related to these issues. (See Step two above).</li> </ul>

## The ten steps to successful breastfeeding for settings where HIV is prevalent: Summary of experiences

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

#### Actions necessary to implement the step

- Work with staff to reprioritise perinatal routines for infant care immediately after birth to allow time for immediate mother/baby contact.
- Institute temperature control in labour, delivery, and recovery areas to insure infant temperature regulation.
- Arrange for continuous mother/baby contact after delivery.
- Assign staff responsibility for seeing that early initiation occurs for mothers who have chosen to breastfeed and insure that staff has the skills to give mothers required support.
- Train staff in the importance of suctioning a normal newborn only if necessary (if initial assessment [APGAR] are good and baby is crying lustily it is NOT necessary). If necessary to suction, do so gently as micro trauma to the mucus membranes of the newborn's throat and upper airway (oropharynx) can interfere with breastfeeding and can potentially risk HIV transmission if the mother is breastfeeding.
- Allot staff time if necessary for breastfeeding support.
- Allow support person (family member, "doula", etc.) to stay with the mother during and immediately after delivery and participate in providing breastfeeding, as appropriate.
- When reviewing delivery-room policies, consider issues such as the mother/baby pair's need for privacy, a tranquil environment, subdued lighting, a minimal number of health personnel in room, reduced reliance on sophisticated technology for low-risk births, etc. Assuring confidentiality and privacy for an HIV-positive mother who has chosen replacement feeding may be a challenge, but can be accomplished with staff and administrative commitment.

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

**Common concerns and solutions**

Concern	Solutions
<p>It is routine to suction all babies immediately after delivery and this is what health staff learned in school.</p>	<ul style="list-style-type: none"> <li>■ Discuss the anatomic and physiologic reasons for why a normal, crying, newborn will clear its own airway.</li> <li>■ Review with the head of the maternity, what the current protocol is for babies who do need suctioning and what equipment is used. Suggest that a mucus “bulb” (ear) syringe, may be the cheapest, most effective and least traumatic to use for this purpose.</li> </ul>
<p>Not enough staff or personnel time to assist with breastfeeding initiation, considering number of deliveries and other procedures scheduled immediately after birth. Prescribed duration of skin-to-skin contact (at least 30 minutes) is of special concern.</p>	<ul style="list-style-type: none"> <li>■ Ask key staff to reassess which procedures are necessary immediately after birth. Reorganize “standing orders” to allow time for immediate contact and breastfeeding for mothers who have chosen to breastfeed. For example, review with staff the 5 Steps of the WHO “Warm Chain” recommendations for newborn care that include “immediate drying, skin-to-skin contact, breastfeeding, and postponing weighing and bathing”</li> <li>■ Reinforce the positive aspects of this change: time savings, no need to warm infant up, minimal separation of the mother and infant, etc.</li> <li>■ Arrange for staff to be taught how to examine the baby right on the mother’s chest.</li> <li>■ Arrange for a voluntary breastfeeding counsellor to help mothers to breastfeed right after birth, if staff is too busy. The mother and baby can be left by themselves, part of the time, to get to know each other, while the staff continues its work. A mother who has chosen not to breastfeed can still be encouraged to have skin-to-skin contact and hold and cuddle her newborn.</li> <li>■ If space in labour and delivery is needed right away for another birth, determine if staff can move mother and baby to a nearby empty room and have nurse do charting and exam there, if necessary.</li> </ul>

<b>Concern</b>	<b>Solutions</b>
<p>Mother is too tired after delivery to feed infant.</p>	<ul style="list-style-type: none"> <li>■ Explain that this is often a misconception. If the mother is given her baby to hold, and encouraged, she will almost always become engaged.</li> <li>■ Arrange to have a breastfeeding support person help her.</li> <li>■ Ensure that breastfeeding mothers receive instruction during pregnancy about the importance of early feeds and the fact that mother and baby usually remain alert during this period.</li> </ul>
<p>The beds in the delivery room are too narrow. If the infant is placed with the mother (who may be very tired) and there is not constant supervision, the infant may fall.</p>	<ul style="list-style-type: none"> <li>■ Place the infant on the mother’s chest. Elevate the mother’s head with pillow, blanket or even her own clothing. If there is danger of the infant falling from a narrow bed, consider wrapping the mother and baby together, lightly, with a sheet or cloth.</li> <li>■ Alternatively, roll the mother on her side and tuck the newborn next to her to breastfeed.</li> </ul>
<p>Need to monitor mothers and babies -- therefore need light, personnel, equipment.</p>	<ul style="list-style-type: none"> <li>■ Ask that delivery room staff consider clustering procedures, for example, assessing maternal and infant condition and vital signs all at the same time and then leaving mother and infant alone.</li> </ul>
<p>If the delivery room is cold, it is too chilly for immediate breastfeeding and the baby must be transferred either to the nursery or mother’s room for the first feeding.</p>	<ul style="list-style-type: none"> <li>■ Review with staff the 5 Steps of the WHO “Warm Chain” recommendations (see Step 4 above)</li> <li>■ Show staff, by using a thermometer under the baby’s arm, that skin-to-skin contact with the mother provides enough heat to keep baby warm.</li> <li>■ If the delivery room is cold, consider whether it is possible to raise the temperature.</li> </ul>
<p>Perinatal personnel think that breastfeeding within 30 to 60 minutes after birth is a lower priority than other procedures.</p>	<ul style="list-style-type: none"> <li>■ Briefly review with the staff the key research on WHY the very early first breastfeeds are linked to ongoing breastfeeding success, (i.e., baby is awake, alert state in first hour, baby’s keen sense of smell and crawling reflexes, mother’s readiness in first hour, etc.</li> <li>■ Convince delivering physicians to routinely suggest to mothers “Let’s get you started with breastfeeding right now”.</li> <li>■ Ask the staff responsible to add “time of breastfeeding initiation” to the baby’s chart.</li> </ul>

Concern	Solutions
	<ul style="list-style-type: none"> <li data-bbox="762 353 1445 555">■ Make sure that the physiologic and psychological advantages of early breastfeeding are stressed during staff training. When labour and delivery staff are trained, emphasize their critical link to breastfeeding management and that the first hour is a very important and special time in this connection.</li> </ul>

## The ten Steps to successful breastfeeding for settings where HIV is prevalent: Summary of experiences

**STEP 5: Show mothers how to breastfeed and maintain lactation even if they should be separated from their infants.**

### Actions necessary to implement the step

- Train staff on milk-expression techniques and safe handling and storage of breast milk.
- Designate staff time for individual or group counselling of mothers on breastfeeding management and maintenance of lactation when mother and baby are separated.
- Designate areas for mothers to breastfeed and for milk expression and milk storage. Purchase equipment (e.g. milk-storage containers, cups and spoons).
- Facilitate sleeping accommodations that allow mothers to stay with their babies if hospitalised. Likewise, allow healthy breastfed babies to stay with hospitalised breastfeeding mothers.
- Designate staff time for individual counselling of HIV-positive mothers on infant feeding options. If a mother wishes, involve a family member of the mother's choice in this counselling.
- Train staff on preparation and storage of replacement feeds so that they can confidently train the HIV-positive mothers who choose this option in preparation, storage and use of the replacement feed of her choice.
- Train staff on how to show HIV-positive mothers, who will replacement feed, how to suppress lactation and how to manage engorgement at home.
- Train staff to care for mothers who are very ill with advanced HIV/AIDS. They will need special counselling, along with a designated relative or support person (if that is the woman's choice) , on replacement feeding for the baby and the need for close monitoring of the baby's growth and development.
- Train staff on how to counsel guardians of an infant-who is orphaned on replacement feeding and on the need for close monitoring of the baby's growth and development.
- Help staff to understand the dangers of "spillover" to the community if all mothers see replacement feeding demonstrations and get the wrong message about breastfeeding. Here again it is also important that staff understand the dangers if donated formula is made available to "some" mothers. The spillover effect can be minimized if BFHI is strong and if ONLY mothers who are of known HIV-positive status are counselled on feeding options other than breastfeeding.

**STEP 5: Show mothers how to breastfeed and maintain lactation even if they should be separated from their infants.**

**Common concerns and solutions**

Concern	Solutions
<p>In hospitals where the postpartum stay is very short or staffing is minimal, there’s very little time for counselling.</p>	<ul style="list-style-type: none"> <li>■ Emphasize counselling during prenatal period.</li> <li>■ Reassign nursery staff to do counselling.</li> <li>■ If minimal time is available for individual counselling, arrange that most of the instruction is provided through group classes.</li> <li>■ Require that hospital staff members observe at least one breastfeed before discharging each mother/baby pair.</li> <li>■ Use infant feeding volunteers to make rounds and provide advice. Arrange to train volunteers and provide them with guidelines concerning their roles and any restrictions.</li> <li>■ Have infant feeding (breastfeeding and the locally available and appropriate replacement feeding methods) education handouts available after delivery.</li> <li>■ Have the staff arrange to show videos to reinforce proper preparation and storage of the chosen replacement feeding methods and lactation suppression techniques. Bedside instruction may or may not be the appropriate place for this counselling.</li> </ul>
<p>Reluctance on the part of staff to provide breastfeeding counselling because of lack of competence.</p>	<ul style="list-style-type: none"> <li>■ Training must include basic facts on MTCT and review of the global and national infant feeding/MTCT guidelines and policies.</li> <li>■ Provide short instruction sheets concerning what advice to give for common breastfeeding problems including guidelines for counselling mothers who are HIV-positive or of unknown status.</li> <li>■ Post a list of staff members that have completed breastfeeding practicums. Encourage other health personnel that ask for their assistance to watch as these experienced staff members give mothers advice.</li> <li>■ Make sure an integral part of training includes clinical experience in working with breastfeeding mothers and dealing with common problems, as well as on locally appropriate replacement feeding,</li> </ul>

Concern	Solutions
	lactation suppression, management of engorgement, and increased risks of MTCT if there is ANY breastfeeding.
Lack of understanding among staff of the importance of breastfeeding in the immediate postpartum period and the problems caused by inaccurate or inconsistent messages.	<ul style="list-style-type: none"> <li>■ In discussions with staff, emphasize the importance of patient-centred care and the role breastfeeding education plays in this connection.</li> <li>■ Encourage trainers, first, to conduct focus groups with nursing staff on what they were taught and why they do what they do, and then to tailor training to address identified problems.</li> </ul>
Fear on the part of staff and mothers of wet-nursing and use of stored breast milk for feeding other babies because of HIV transmission.	<ul style="list-style-type: none"> <li>■ Wet nursing and using breast milk from other mothers is acceptable in some settings and not acceptable in others. Local formative research will show whether or not mothers will choose these as alternative feeding methods.</li> <li>■ Expressed breast milk from a donor will need to be heat treated per most current WHO recommendations.</li> <li>■ Generally wet nursing is no longer encouraged as a feeding option, although there are exceptions to this in the case of a family member who is known to be HIV negative.</li> </ul>
Lack of milk storage area and equipment.	<ul style="list-style-type: none"> <li>■ No sophisticated equipment is needed for milk storage. Only a refrigerator and clean collection containers for expressed milk are required.</li> <li>■ Milk storage may not be needed if mothers have day-and-night access their hospitalised infants for breastfeeding.</li> </ul>
Healthy infants will get sick if kept with their mothers when their mothers become sick and are admitted to the hospital.	<ul style="list-style-type: none"> <li>■ Offer information regarding the protective effects of breastfeeding and the health risks to newborns if <u>not</u> kept with their mothers and breastfed even if their mothers are ill and hospitalised..</li> </ul>
Breastfeeding/replacement feeding mothers who are sick in the hospital will not be able to take care of their newborn infants who room in with them.	<ul style="list-style-type: none"> <li>■ Ask the staff to evaluate this problem case by case. Perhaps a relative or friend will need to room-in to care for the infant in some situations.</li> </ul>
Counselling on replacement feeding will give a “mixed” message to all mothers and may undermine breastfeeding. (spillover)	<ul style="list-style-type: none"> <li>■ Help staff to understand the dangers of “spillover” to the community if all mothers see replacement feeding demonstrations and get the wrong message about breastfeeding. Here again it is also important that staff understand the dangers if donated formula</li> </ul>

Concern	Solutions
	<p>is made available to “some” mothers. The spillover effect can be minimized if BFHI is strong and if ONLY mothers who are of known HIV-positive status are counselled on feeding options other than breastfeeding.</p>

## The ten steps to successful breastfeeding for settings where HIV is prevalent: Summary of experiences

**STEP 6: Give newborn no other food or drink other than breast milk unless medically indicated.**

### Actions necessary to implement the step

- Examine routine policies concerning the use of breast-milk substitutes. Make sure they conform with the WHO/UNICEF list of “acceptable medical reasons for supplementation”. (Should be included in hospital policy. See Step #1.)
- Examine current national and global policies on the mother-to child transmission of HIV and infant feeding (See WHO Summary of New Recommendations on the USE of ARV in preventing MTCT of HIV, October 2000)
- Ensure that staff members caring for HIV-positive mothers are counselled so they can make informed infant feeding choices best for their own setting and circumstances and that they understand the risks of ANY mixed feeding. This applies to BOTH breastfeeding mothers who should exclusively breastfeed and replacement feeding mothers who should exclusively replacement feed.
- Arrange that small amounts of breast-milk substitutes be purchased by the hospital for use if medically indicated.
- Store breast-milk substitutes and related equipment and supplies out of sight.
- Develop policies that facilitate early breastfeeding of low-birth-weight infants and infants delivered by C-section and for HIV-positive mothers who have chosen to breastfeed, when there are no medical contraindications. (Can be included in hospital policy. See Step #1.)
- Ensure that adequate space and equipment is available for milk expression and storage. (See Step #5.)

**STEP 6: Give newborn no other food or drink other than breast milk unless medically indicated.**

**Common concerns and solutions**

Concern	Solutions
<p>Staff members or mothers are worried or confused about what is the safest feeding option for HIV-positive mothers and may think that replacement feeding and/or mixed feeding is safer than exclusive breastfeeding.</p>	<ul style="list-style-type: none"> <li>■ Review with staff the current research on the relative safety of different feeding options (Coutsoudis 1999, 2001 and WHO Oct 2000)</li> <li>■ Review with staff the balance of risks that an HIV-positive mother must weigh in deciding on what infant feeding method is best for her (WHO/UNICEF/UNAIDS/UNFPA (HIV and infant feeding: A guide for health-care managers and supervisors) 2004, pp. 5-7 – Session 4 HIV Handout, Overview: Infant and young child feeding in the context of HIV)</li> </ul>
<p>HIV-positive mothers are afraid that if they are seen NOT breastfeeding they will be stigmatised and labelled as having AIDS or being promiscuous. Some are afraid of physical abuse.</p>	<ul style="list-style-type: none"> <li>■ Antenatal counselling for all mothers on HIV is essential. This counselling helps dispel myths about HIV and MTCT and also helps HIV-positive mothers weigh the stigma issues for themselves and their families <i>before</i> delivery.</li> <li>■ Follow-up support for HIV-positive mothers, regardless of their infant feeding choice, is as important as follow-up for breastfeeding mothers.</li> </ul>
<p>Staff members or mothers worry that mothers’ milk is insufficient for babies in the first few hours or days after birth because of delay in the “true milk” coming in.</p>	<ul style="list-style-type: none"> <li>■ Make sure that staff and mothers are provided information about the sufficiency and benefits of colostrums and the fact that nothing else is needed (e.g. water, tea, or infant formula) in addition to breast milk. Include the fact that it is normal for a baby’s weight to drop during the first 48 hours.</li> <li>■ For HIV-positive mothers who have chosen to breastfeed it is essential that they understand that NO other feeds other than their own breast milk (including colostrum) should be given to their babies.</li> </ul>
<p>Staff members or mothers fear that babies will become dehydrated or hypoglycaemic if given only breast milk.</p>	<ul style="list-style-type: none"> <li>■ Establish a literature review committee and present findings related to this issue at a staff meeting.</li> <li>■ Make sure that staff members are reminded of the signs that babies are getting all they need from breastfeeding, and encourage them to pass on this information to mothers who are worried that their milk is insufficient.</li> <li>■ Consider arranging for brief in-service training sessions to demonstrate how to assess the</li> </ul>

Concern	Solutions
	<p>effectiveness of a breastfeed and give nurses supervised practice in making their own assessments.</p> <ul style="list-style-type: none"> <li>■ Remove glucose water from the unit, so it is more difficult to use routinely.</li> </ul>
<p>Mothers request supplements.</p>	<ul style="list-style-type: none"> <li>■ Arrange for mothers to be informed during the prenatal and early postpartum period concerning the problems that arise from supplementation.</li> <li>■ Depending on the national policy and hospital there may or may not be small stocks of replacement feeds for HIV-positive mothers.</li> </ul>
<p>Mothers who are HIV-positive request replacement feeds.</p>	<ul style="list-style-type: none"> <li>■ Counsel the mother about the risks of mixed feeding and that either exclusive breastfeeding or replacement feeding is the best way for her to reduce risks of HIV transmission.</li> <li>■ For mothers who have chosen replacement feeding it is best that she begin from birth to buy her own replacement feeding supplies. She will need to sustain this feeding method for as long as the baby needs breast milk substitutes.</li> <li>■ Depending on the national policy and hospital policy there may or may not be small stocks of replacement feeds for HIV-positive mothers, but the point above is important to consider.</li> </ul>
<p>Some mothers are too malnourished to breastfeed.</p>	<ul style="list-style-type: none"> <li>■ Make sure that staff members realize that even malnourished mothers produce enough milk for their infants if their infants feed on demand.</li> <li>■ In cases where the family provides food for the mother while she is in the hospital, use the opportunity to inform family members about the importance of sound nutrition for the mother and inexpensive, nutritious dietary choices.</li> </ul>
<p>The counselling and support necessary to achieve exclusive breastfeeding is too expensive.</p>	<ul style="list-style-type: none"> <li>■ Stress that costs will be more than offset by savings to the hospital when purchase, preparation and provision of breast-milk substitutes is minimized. Emphasize that savings will also accrue from reduction in neonatal infections, diarrhoea, etc.</li> </ul>
<p>Medications are being given to the mother that are considered contraindications to breastfeeding.</p>	<ul style="list-style-type: none"> <li>■ Ensure that staff members are familiar with the list of acceptable medical reasons for supplementation that are included in the revised Annex to the Global Criteria for the Baby-friendly Hospital Initiative and</li> </ul>

Concern	Solutions
	<p>as Handout 4.5 in Session 4 of this course.</p> <ul style="list-style-type: none"> <li>■ Ask the pharmaceutical department to prepare a list of drugs that are compatible and incompatible with breastfeeding.</li> </ul>
<p>Mothers will feel they have been denied something valuable if distribution of samples or discharge packs is discontinued.</p>	<ul style="list-style-type: none"> <li>■ Consider replacing samples of breast-milk substitutes with a “breastfeeding pack”, which includes information on breastfeeding and where to get support and may include samples of products that don’t discourage breastfeeding.</li> </ul>

## The ten steps to successful breastfeeding for settings where HIV is prevalent: Summary of experiences

### STEP 7: Practice rooming-in.

#### Actions necessary to implement the step

- Make needed changes in physical facility. Discontinue nursery for normal newborns. Make adjustments to improve comfort, hygiene, and safety of mother and baby.
- Require and arrange for cross training of nursery and postpartum personnel so they all have the skills to care for both baby and mother. (See Step # 2)
- Institute individual or group education sessions for mothers on mother-baby postpartum care. Sessions should include information on how to care for baby who is rooming-in.
- Protect privacy and confidentiality of a mother's HIV status by providing the same routine care to ALL mothers and babies including rooming-in/bedding –in, so that no one is stigmatised or set apart as different.

STEP 7: Practice rooming-in – allow mothers and infants to remain together – 24 hours a day.

**Common concerns and solutions**

Concern	Solutions
<p>It is difficult to supervise the condition of a baby who is rooming-in. In the nursery one staff member is sufficient to supervise a number of babies.</p>	<ul style="list-style-type: none"> <li>■ Assure staff that babies are better off close to their mothers, with the added benefits of security, warmth, and feeding on demand. “Bedding-in”, if culturally acceptable, provides the best situation for gaining all these benefits and eliminates the need to purchase bassinets or cots. Mothers can provide valuable assistance when their infants are rooming-in or bedding-in, alerting staff if problems arise.</li> <li>■ Stress that 24-hour supervision is not needed. Periodic checks and availability of staff to respond to mothers’ needs are all that is necessary.</li> </ul>
<p>Mothers need to get some rest after delivery (especially at night) and babies still need to eat. Especially after caesarean sections, mothers need time to recuperate. Babies should be fed breast-milk substitutes during this period.</p>	<ul style="list-style-type: none"> <li>■ Ask staff to assure mothers that by “rooming-in” they are doing the best for their babies, that not much extra work is involved, and that health workers are available in the unit to assist them if needed.</li> <li>■ Ask staff to discuss with mothers the fact that the more babies are with them the more they’ll understand what is normal and abnormal and how to provide good care. It is best to practice being with their babies (even during the night) while still in the hospital, when staff is around to help if necessary.</li> <li>■ Suggest to the staff that after good breastfeeds mothers may even sleep better when their babies are with them.</li> <li>■ Make sure that staff knows how to help mothers who have had Caesarean sections choose breastfeeding techniques and positions that are comfortable and effective.</li> <li>■ If regional or local anaesthesia is used during Caesarean sections, early breastfeeding will be less of a problem. However, a mother who has had general anaesthesia can breastfeed as soon as she is conscious if a staff member supports her.</li> </ul>
<p>Mothers in the postnatal ward may worry if they room-in in close proximity to HIV-positive mothers because of misconception about how HIV is spread.</p>	<ul style="list-style-type: none"> <li>■ Staff members can be sensitive to this concern and reassure mothers that HIV is not spread through casual contact. Explain to mothers that requests that HIV-positive mothers be “isolated” may contribute to “stigmatisation” of people with HIV/AIDS and help perpetuate misconceptions about how HIV is spread. (See Step 2 above).</li> </ul>

Concern	Solutions
<p>Infection rates will be higher when mothers and babies are together than in a nursery.</p>	<ul style="list-style-type: none"> <li>■ Stress that the danger of infection is less when babies remain with their mothers than when in the nursery and exposed to more caretakers.</li> <li>■ Provide staff with data that show that with rooming-in and breastfeeding, infection rates are lower, for example, from diarrhoeal disease, neonatal sepsis, otitis media, and meningitis.</li> </ul>
<p>If visitors are allowed in the rooming-in wards, danger of infection and contamination will increase. In situations where visitors are allowed to smoke, it is a health hazard to mother and baby. Some mothers feel they need to entertain their visitors and that they will have time for their babies after discharge.</p>	<ul style="list-style-type: none"> <li>■ Emphasize that babies receive immunity to infection from colostrum, and that studies show infection is actually less in rooming-in wards than in nurseries.</li> <li>■ To support mothers further in doing the best for their babies, limit visiting hours and the number of visitors, and prohibit smoking.</li> </ul>
<p>The rooms are too small.</p>	<ul style="list-style-type: none"> <li>■ No need to have bassinets for infants. No extra space is necessary for “bedding-in”.</li> </ul>
<p>Babies will fall off the mothers’ beds.</p>	<ul style="list-style-type: none"> <li>■ Emphasize that newborns don’t move. If mothers are still concerned, arrange for the beds to be put next to the wall or, if culturally acceptable, for the beds to be put in pairs, with mothers keeping their babies in the centre.</li> </ul>
<p>Full rooming-in, without more than half hour separations, seems unfeasible because some procedures and routines need to be performed on the babies outside their mothers’ rooms.</p>	<ul style="list-style-type: none"> <li>■ Study these procedures well. Some are not needed. (Example: Weighing baby before and after breastfeeding.) Other procedures can be performed in the mother’s room.</li> <li>■ Review advantages to mother and time saved by physician when he examines the infant in front of the mother.</li> </ul>
<p>Private patients feel they have the privilege to keep their babies in nurseries and feed them breast-milk substitutes, receive expert help from nursery staff, etc.</p>	<ul style="list-style-type: none"> <li>■ Whatever is best for public patients is also best for private patients.</li> <li>■ Consider pilot projects to “test” rooming-in in private as well as public wards.</li> </ul>
<p>Some private hospitals make money from nursery charges and thus are reluctant to disband these units.</p>	<ul style="list-style-type: none"> <li>■ Explore the compensatory savings from rooming-in due to less frequent use of breast-milk substitutes, less staff time for bottle preparation and nursery care, less infant illness, etc.</li> <li>■ Consider continuing to charge the same fees when the nursery is disbanded, reallocating the charges for mother/baby care on the wards.</li> </ul>

Concern	Solutions
<p>Babies more easily kidnapped when rooming-in than in the nursery.</p>	<ul style="list-style-type: none"> <li>■ Suggest to the staff that they ask mothers to request that someone (e.g., other mothers, family members, or staff members) watch their babies if they go out of the room.</li> <li>■ Mothers need to know that there is <u>no</u> reason a baby should be removed without the mother’s knowledge.</li> </ul>
<p>An HIV-positive mother in the postnatal ward may be seen by others replacement feeding her infant, and confidentiality will be hard to protect.</p>	<ul style="list-style-type: none"> <li>■ For an HIV-positive mother who chooses replacement feeding, confidentiality <b>WILL</b> be an issue, but optimally a mother will have already been counselled in the antenatal period and have made an informed decision that replacement feeding is most appropriate for her and her baby.</li> <li>■ For an HIV-positive mother who chooses breastfeeding, she should be supported to exclusively breastfeed, just like the other mothers, and there will be no obvious difference in her care.</li> <li>■ Staff who care for mothers in HIV prevalent settings will <b>ALL</b> need to be trained to be sensitive to confidentiality issues at all times, including in record keeping.</li> </ul>

## The ten steps to successful breastfeeding for settings where HIV is prevalent: Summary of experiences

### STEP 8: Encourage breastfeeding on demand.

#### Actions necessary to implement the step

- Introduce rooming-in. (See Step # 7.)
- Examine routine policies concerning infant procedures (e.g., blood drawing, physical examination, weighing, bathing, circumcision, cleaning of rooms, etc.) that separate mother and baby; conduct the procedures on the ward, whenever possible.
- Ensure that staff training includes the definition and benefits of on-demand feeding and key messages concerning this issue that mothers should receive during breastfeeding counselling. (See Step # 2.)

**STEP 8: Encourage breastfeeding on demand.**

**Common concerns and solutions**

Concern	Solutions
<p>On-demand feeding is good, but does not provide enough milk for the baby. Colostrum is insufficient and supplementation is necessary.</p>	<ul style="list-style-type: none"> <li>■ Remind staff that the infant’s stomach capacity is 10 - 20 ml at birth and the quantity of colostrum is physiologically matched.</li> </ul>
<p>In situations where rooming-in is not practised, it saves on staff time and effort if babies are fed in the nursery instead of taking babies to mothers to breastfeed at unpredictable times.</p>	<ul style="list-style-type: none"> <li>■ Consider rooming-in, which will take less staff time than keeping babies in the nursery and feeding them breast-milk substitutes or transporting them back and forth for breastfeeding.</li> </ul>
<p>When babies are taken out of the rooms for exams, lab tests, and measurement procedures this interferes with feeding on demand.</p>	<ul style="list-style-type: none"> <li>■ Encourage physicians to examine babies in mothers’ rooms. Emphasize that it is a time-saver since mothers’ questions can be answered and any education provided at the same time. Stress that patient satisfaction also increases as a result.</li> <li>■ Arrange for staff to complete other procedures in mothers’ rooms, when feasible. For example, the weighing scale might be wheeled from room to room.</li> <li>■ Ask the staff to try to schedule after feedings procedures that must be performed outside the rooms, or allow mothers to accompany their babies so they can breastfeed when required.</li> <li>■ Inform the staff that babies are not to be supplemented while they are away for procedures. If necessary, mothers should be called to breastfeed.</li> </ul>
<p>Visiting hours that are too long or unrestricted interfere with breastfeeding on demand. Mothers may be embarrassed to breastfeed in front of visitors, may be too busy entertaining visitors, or may be too exhausted afterwards to feed their babies.</p>	<ul style="list-style-type: none"> <li>■ Shorten visiting hours or limit them (i.e. 2 visitors per patient or only immediate family and grandparents).</li> <li>■ Arrange for the staff to provide mothers with signs they can place on their doors (if they have private rooms) to ask that they not be disturbed if resting or feeding their babies.</li> <li>■ Ask instructors in prenatal classes to emphasize the importance of limited visiting hours to allow more time for mother/baby learning, feeding and rest.</li> </ul>

## The ten steps to successful breastfeeding for settings where HIV is prevalent: Summary of experiences

### STEP 9: Give no artificial teats or pacifiers.

#### Actions necessary to implement the step

- Examine routine policies. Hospital policies should:
  - discourage mothers or family members from bringing pacifiers from outside for their babies' use;
  - prohibit use of bottles and teats or nipples for infant feeding within the hospital;
  - provide guidance for use of alternative feeding methods, for example, use of cups and spoons if breast-milk substitutes are used;
- Purchase supplies (e.g. cups, syringes, spoons) for use in feeding breast-milk substitutes to infants (without using teats or bottles) in cases where there are acceptable medical reasons for supplementation. (See Step # 5.)

**STEP 9: Give no artificial teats or pacifiers.**

**Common concerns and solutions**

Concern	Solutions
When infants are upset, pacifiers will help quiet them. Also, infants may not be hungry, but still need to suck.	<ul style="list-style-type: none"> <li>■ Babies may cry for a variety of reasons. Ask staff to explore alternatives to pacifiers (e.g. encouraging mother to hold baby, offering the breast, checking for soiled diaper), possibly through a group discussion.</li> </ul>
The nursing staff and/or mothers do not believe that pacifier use causes any problems.	<ul style="list-style-type: none"> <li>■ Make sure that staff and mothers are educated concerning problems with pacifier use (e.g. interferes with oral motor response involved in breastfeeding, easily contaminated.)</li> <li>■ Establish an ad hoc committee to review the literature and make a presentation to the administrative and medical staff on issues related to pacifier use.</li> <li>■ Post a notice visible to both staff and patients -- “no more pacifiers for breastfed infants” -- and list the reasons why.</li> <li>■ If the mother requests a pacifier, have staff discuss with her the problems it may cause. Consider asking her to sign a written informed consent form that discusses the risks of nipple confusion, impaired milk supply and contamination.</li> <li>■ In settings where contamination of pacifiers can lead to diarrhoea and other illness, it is best to encourage calming the bay in other ways or to use a mother’s or family member’s washed finger as a pacifier.</li> </ul>
Pacifiers are provided free of charge for mothers requesting them.	<ul style="list-style-type: none"> <li>■ Calculate the savings to the hospital from not buying pacifiers or artificial teats.</li> <li>■ Establish a policy stating that the hospital will not supply free pacifiers and mothers, if they wish to use them, must bring their own.</li> </ul>
Infants may aspirate if fed by cup.	<ul style="list-style-type: none"> <li>■ Provide the staff with examples (through video, slides, or visit) of infants being successfully fed by cup in other health facilities.</li> <li>■ Emphasize the feasibility and safety of cup feeding.</li> </ul>
Purchasing cups, syringes, and spoons may be expensive.	<ul style="list-style-type: none"> <li>■ Special types of cups, syringes and spoons are not necessary. They just need to be clean.</li> </ul>

## The ten steps to successful breastfeeding for settings where HIV is prevalent: Summary of experiences

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

### Actions necessary to implement the step

- Work with key hospital staff to identify hospital and community resources for mothers that are both breastfeeding and replacement feeding.
- Make sure that the hospital provides follow-up support for breastfeeding and replacement feeding, for example, through a postnatal clinic, and schedules the first visit within a week of discharge and insures that infant feeding is assessed and any problems are identified and addressed.
- Explore ways to link mothers with community-level breastfeeding support resources, such as health centres, MCH clinics, and breastfeeding support groups (NGOs such as local La Leche League groups). One means would be to send a discharge/referral slip to the community clinic where the mother can go for postnatal care and at the same time tell the mother where she can receive breastfeeding support.
- Explore ways to link HIV-positive mothers with community-level resources for people living with HIV/AIDS, including health centres, MCH clinics, NGOs, churches, and home based care groups. Optimally referrals will be done in such a way as to preserve privacy and confidentiality. In some settings support groups of HIV-positive mothers and their babies may be appropriate, in others not and support may need to be one-on-one.
- Consider arranging for mother-support groups to make contact with mothers while still in the hospital. For example, volunteers can offer refreshments to mothers on the wards and at the same time provide information on where to go for breastfeeding support. Volunteers can help conduct hospital lactation clinics, give breastfeeding advice on wards, etc. For HIV-positive women it will depend on individual circumstances as to how this initial contact is made.
- Consider asking hospital personnel to organize breastfeeding or replacement feeding support groups for which, at least initially, hospital staff serve as facilitators. Arrange training for hospital staff on organizing and facilitating mother-support groups and consider similar training for other potential mother-support group leaders.
- Make information (verbal and written) on breastfeeding support resources available to mother, family and community.
- Make information (verbal and written) on locally appropriate replacement feeding options and resources available to the HIV-positive mother, and, if she wishes, her family and community.

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

**Common concerns and solutions**

Concern	Solutions
<p>The hospital staff members are unfamiliar with good sources of breastfeeding support to which they can refer mothers.</p>	<ul style="list-style-type: none"> <li>■ Form an ad hoc group with a representative from the hospital, the local MCH clinics, and any mother support groups that can be identified. Ask groups to develop a resource list and make it available to hospital staff, local physicians and mothers.</li> <li>■ Encourage local mother-support groups to meet occasionally at the hospital, which can provide space and publicity free of charge.</li> <li>■ Arrange for community breastfeeding support groups to provide a mini-training session to the staff on the services they offer.</li> <li>■ Arrange for community HIV support groups to provide a mini-training session to the staff on the services they offer related to HIV-positive mothers and their families.</li> </ul>
<p>There is a mistaken impression that health professionals aren't supposed to be involved in organizing or facilitating mother-support groups.</p>	<ul style="list-style-type: none"> <li>■ If lay leaders are not available to organize and facilitate mother-support groups, explore using health staff for this purpose. If health staff members are involved, they need to be trained not to direct or dominate the groups, but to facilitate sharing and support among mothers. As lay leaders come forward, they can receive additional training and take over the group work.</li> </ul>
<p>Lay group leaders and their members may provide incorrect information.</p>	<ul style="list-style-type: none"> <li>■ Make sure that potential mother-support group leaders are provided with adequate training and that the mothers themselves receive accurate prenatal and postnatal education on breastfeeding/locally appropriate replacement feeding from the hospital staff.</li> </ul>
<p>Hospital administrators and staff already have too much to do; organizing support groups would be a serious imposition.</p>	<ul style="list-style-type: none"> <li>■ Explore whether knowledgeable volunteer groups or individuals can help in, or even take full responsibility for, this activity.</li> </ul>
<p>Mother-to-mother support doesn't work in the local culture.</p>	<ul style="list-style-type: none"> <li>■ Explore culturally appropriate support mechanisms for breastfeeding/replacement feeding mothers. For example:</li> <li>■ involving traditional or religious organizations for women in providing breastfeeding or more general</li> </ul>

Concern	Solutions
	<p data-bbox="810 353 999 383">mother support,</p> <ul style="list-style-type: none"> <li data-bbox="762 421 1410 517">■ involving existing community-based HIV support groups in providing breastfeeding, replacement feeding or more general mother support,</li> <li data-bbox="762 555 1410 680">■ reinforcing the extended family role in supporting breastfeeding/replacement feeding by providing updated information on breastfeeding to family members most likely to provide advice.</li> </ul>
<p data-bbox="229 723 724 882">Post-discharge hospital follow-up is too costly. Home visits are either impossible or only possible in emergencies or for very high-risk patients. Phone contact is either not possible or, at best, unreliable.</p>	<ul style="list-style-type: none"> <li data-bbox="762 723 1445 819">■ Examine what follow-up mechanisms are most feasible in the local situation, considering constraints. For example: <ul style="list-style-type: none"> <li data-bbox="810 857 1430 920">■ arranging for breastfeeding/replacement feeding assessment and support during postnatal visits;</li> <li data-bbox="810 958 1445 1050">■ arranging home visits at least for the mother at highest risk of breastfeeding/replacement feeding failure;</li> <li data-bbox="810 1088 1445 1214">■ referring mothers to community health centres, outreach workers, and/or volunteer groups that <u>can</u> provide support (following the caveats above about preserving privacy and confidentiality).</li> </ul> </li> </ul>