

# **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.

## **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.

## **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.

### **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.

### **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.

## **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.

## **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.

## **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.



**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.

## **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.

## **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.**

- 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.

**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.

**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**

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

**Common concerns and solutions**

<b>Concerns</b>	<b>Solutions</b>

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

**Common concerns and solutions**

<b>Concern</b>	<b>Solutions</b>
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>



<b>Concern</b>	<b>Solutions</b>
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 data-bbox="926 435 1791 760">■ Stress that danger of infection is reduced when babies remain with mothers than when in a nursery and exposed to more caretakers.</li><li data-bbox="926 769 1791 1230">■ 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>

<b>Concern</b>	<b>Solutions</b>
Babies will fall off their mothers' beds.	<ul style="list-style-type: none"><li data-bbox="909 431 1780 553">■ Emphasize that newborns don't move.</li><li data-bbox="909 553 1854 956">■ 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>

<b>Concern</b>	<b>Solutions</b>
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 data-bbox="894 440 1822 824">■ 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 data-bbox="894 841 1829 1089">■ Review advantages to mother and time saved by physician when infant is examined in front of mother.</li></ul>

<b>Concern</b>	<b>Solutions</b>
<p>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.</p>	<ul style="list-style-type: none"><li data-bbox="888 431 1866 894">■ 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 data-bbox="888 894 1866 1229">■ 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>

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**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.