WIC Breastfeeding Curriculum

Breastfeeding Training Handbook

Level 2

For Peer Counselors, CPAs, Breastfeeding Coordinators, and Designated Breastfeeding Experts

U.S. DEPARTMENT OF AGRICULTURE

WIC BREASTFEEDING SUPPORT

LEARN TOGETHER. GROW TOGETHER.

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Level 2

What It Covers
The Level 2 content in the *WIC Breastfeeding Curriculum* provides information on how to support normal breastfeeding, tips and solutions for getting off to a good start with breastfeeding, and how to prevent and manage common challenges that can sometimes arise.

Target Audience
Level 2 content is designed for all WIC staff except for support staff. While it is considered the scope of practice for peer counselors, it is also the role of Competent Professional Authorities (CPAs) and other WIC staff who counsel breastfeeding parents to help them prepare for breastfeeding, initiate it successfully, address their questions and concerns, and help them continue for as long as they wish. The content in Level 2 serves as a foundation of knowledge, as well as a springboard for deeper levels of understanding in Levels 3 and 4.

WIC and Breastfeeding—Breastfeeding Promotion

Sneak Preview:
In this section, you will learn about the scope of practice for WIC staff who counsel new families. You will also learn about ways to promote and support breastfeeding in various celebratory events.

Level 2 Competency:

- Provide breastfeeding support within a defined scope of practice.

Celebratory Events

Many WIC clinics host breastfeeding promotion and celebratory events to raise awareness about the importance of breastfeeding, to improve social norms and acceptance, and to recognize breast/chestfeeding participants. National Breastfeeding Month (celebrated annually in August) is observed annually in the U.S. as part of the global World Breastfeeding Week (celebrated annually from August 1-7). Activities often include such things as WIC clinic or community baby showers, breastfeeding proclamations, and special promotion in the clinic. In addition, the USDA Food and Nutrition Service awards the annual *WIC Breastfeeding Award of Excellence Program* to local WIC agencies during World Breastfeeding Week. The *WIC Works Resource System* website posts tools and resources that WIC clinics can consider when planning breastfeeding promotion activities.

WIC Staff Scope of Practice

A “scope of practice” is the range of services and support that can be provided. All healthcare professionals practice within a clearly defined scope of practice. This is like a “lane” of traffic. When drivers keep within their lane, each vehicle travels safely. In the same way, when all members of the care team understand their scope or lane and support parents

within that lane, WIC families have the best outcomes. Having a clearly defined scope of practice also helps local WIC agencies minimize liability risk.

- **Support staff** do not typically provide direct breastfeeding counseling to WIC participants. However, they do promote breastfeeding and encourage parents to consider it. Support staff also share information about WIC's breastfeeding support services and make referrals when new parents have questions or concerns.
- **Peer counselors** have a large role in sharing information about breastfeeding with new parents, helping them explore their barriers, preparing them for their hospital experience, and helping them get off to a great start once their baby is born. They also help new parents prevent and manage common breastfeeding challenges as part of the normal course of breastfeeding. Peer counselors make referrals when WIC participants experience more complex challenges with breastfeeding, or when they have questions or concerns that are beyond their scope of supporting normal breastfeeding.
- **Competent Professional Authorities (CPAs)** provide breastfeeding information and support as part of their breastfeeding assessment. They help WIC participants identify their breastfeeding goals, assign and tailor food packages based on their assessment, and develop an individualized care plan to help participants reach their infant feeding goals. They also make referrals when participants need advanced support. CPAs must operate within their State and/or local agency policies, as well as the scope of practice outlined for any professional certifications or credentials they may have.
- **WIC Designated Breastfeeding Experts (DBEs)** have a broader scope of practice focused on a more in-depth assessment and management of more complex breastfeeding challenges. CPAs, peer counselors, and other staff make referrals to DBEs when WIC participants experience a breastfeeding problem that is beyond their defined scope of practice. These more complex challenges might include such things as: low milk production, nipple soreness that does not resolve quickly, breastfed infants who do not gain weight adequately, preterm infants recently discharged from the NICU, maternal breast problems and prior surgery, difficulty with latch, maternal hormonal conditions, and supporting parents of infants with challenging medical conditions. DBEs refer WIC participants to other WIC staff and healthcare providers as needed. DBEs also must operate within their State and/or local agency policy, as well as the scope of practice outlined for any professional certifications or credentials they may have.

Bring It Home:
Review the peer counselor and DBE "Scope of Practice" handouts to clarify the range of services you may provide within your role at WIC. If you have a professional certification or credential, review that scope of practice, as well, to enhance your understanding of the type of breastfeeding care you are eligible to provide for WIC families. Note: The *WIC Breastfeeding Curriculum* clearly outlines WIC's role and the scope of practice for each level of WIC staff.

WIC and Breastfeeding—National Initiatives

Sneak Preview:
The "National Initiatives" section addresses national breastfeeding-related policies and legislation in the United States.

Level 2 Competency:

- Explain Federal and state legal rights for breastfeeding protection to WIC participants.

Federal Laws

Several Federal laws provide protection for breastfeeding parents and their infants. WIC participants may not be aware of some of these laws that protect their right to breastfeed.

Legislation	Protection	Provisions
Section 4207 of the Patient Protection and Affordable Care Act, which amended the Fair Labor Standards Act of 1938 (FLSA) (2010)	Workplace support	▪ Requires employers to provide reasonable time and private space that is not a bathroom to express milk at work ▪ Applies to employees who are not exempt from overtime pay
Affordable Care Act - Women's Preventive Services Guidelines (2010)	Preventive health services for women (including breastfeeding support)	▪ Requires private health plans to cover preventive services for women, including comprehensive breastfeeding support and counseling from trained providers ▪ Requires private health plans to provide access to breastfeeding equipment and supplies
National Defense Authorization Act (2015)	Health plan benefits for breastfeeding parents enrolled in TRICARE (Department of Defense health care program)	▪ Extends similar preventive services as ACA health plan benefits (which did not apply to military families)
21st Century Cures Act (2016)	Safe Medications for Moms and Babies Act	▪ Establishes a task force of Federal and medical experts to advance research and information on medication use during pregnancy and lactation.
Bottles and Breastfeeding Equipment Screening Act (BABES)	Transporting human milk and infant feeding equipment through airport security	▪ Requires the Transportation Security Administration (TSA) officers to enforce TSA Special Procedures related to breastmilk, formula, and infant feeding equipment across airport security checkpoints. [*See the language about the procedures enacted in the "National Policy Initiatives" section.]*
Friendly Airports for Mothers (FAM) Act (2018)	Access to private areas to breastfeed or express milk in airports	▪ Requires all large- and medium-sized airports to provide clean, accessible, private rooms in every terminal for breastfeeding or expressing milk. ▪ Baby-changing tables are required in all men's and women's bathrooms.
Fairness for Breastfeeding Mothers Act (2019)	Public breastfeeding rights	▪ Requires federal buildings open to the public to provide a shielded, hygienic space other than a bathroom for use by members of the public to express milk.

National Policy Initiatives

In addition to Federal legislation, there are many national policy initiatives underway to better address the needs of breast/chestfeeding families. A few of these include:

- **Childhood obesity prevention initiatives** which now include breastfeeding support as one way to lower the rates of obesity in children. The Centers for Disease Control and Prevention has information related to state initiatives and resources available at https://www.cdc.gov/obesity/data/childhood.html.
- **TSA regulations** provide standard security procedures that allow breastfeeding women to take their expressed milk through airport security checkpoints in amounts greater than 3.4 oz. Containers of expressed milk do not have to fit in a quart-sized bag as other liquids do. Ice packs required to keep the expressed milk cold are also allowed as part of carry-on items.

State Laws

Many states have enacted laws to protect the rights of breastfeeding parents. For example, all U.S. states have enacted laws that protect a parent's right to breastfeed in public, and many states exempt breastfeeding from public indecency laws. Some states exempt breastfeeding parents from jury duty, and some have laws requiring that public places be available in communities for breastfeeding and milk expression. Several states have laws requiring health facilities to provide evidence-based practices around breastfeeding, and some have protections for breast/chestfeeding parents who place their infant in a licensed childcare facility.

Bring It Home:
Visit the website of the National Conference of State Legislatures at https://www.ncsl.org/research/health/breastfeeding-state-laws.aspx and scroll to find the list of breastfeeding laws for your state. What additional protections are available to support breastfeeding families in your state?

WIC and Breastfeeding—Health Communication

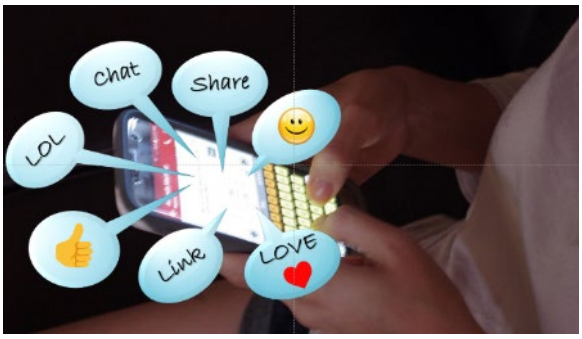
Sneak Preview:
The "Health Communication" section considers best practices when communicating via media technologies and group settings to promote and support breastfeeding parents. It also addresses training opportunities for WIC staff.

Level 2 Competencies:

- Follow State and local agency protocols in communicating to WIC participants via technology.
- Use best practices to assist with breastfeeding group education.

Technology

Social media is a dominant form of communication, especially among pregnant and new parents. In the U.S., nearly three out of four millennials (those born after 1982) use social networking sites. These sites help enlarge the world and create a sense of community among users.



Studies show that WIC participants prefer communication through social media. One study of Alaska WIC participants found that 80 percent had a "smartphone" and 95 percent use Facebook™, texting, and other technologies to communicate. Before starting a social networking site, State and local WIC agencies must establish guidelines that comply with Federal and State laws. WIC staff should follow any guidelines available from their State and/or local WIC agency before contacting WIC participants through social media sites. Some WIC agencies promote existing social networking sites already available in the community, such as those administered by a local hospital, breastfeeding coalition, La Leche League group, or other reputable organizations.

The Pew Research Center reports that 73 percent of Americans send and receive text messages regularly; young people between the ages of 18 and 24 are the most likely to prefer texting. Many WIC local agencies allow peer counselors and other WIC staff to use text messaging to communicate with participants. Follow all local and State agency policies and procedures when engaging in text message communication with WIC participants.

When sending texts, there are three simple suggestions to consider:

1. *Short* - Keep messages brief when possible...usually no more than around 160 characters.
2. *Simple* - Keep the message simple and focused on the main point.
3. *Pause* - Before sending the text, be sure the message is clear, the tone is appropriate, and there are no glaring typos.

Group Education

Small group learning opportunities with prenatal and postpartum participants are an effective way to encourage breastfeeding. Group education can build peer support and facilitate hands-on skills for confidence building. Group learning encourages idea sharing to help participants learn practical tips from one another for addressing common challenges that can arise. Strategies to enhance group learning may include:

- Participant-focused approaches (e.g., making them feel welcomed, focusing on their priorities, and activities for relationship-building).
- Games, videos, and fun activities to engage participants.
- Easily accessible locations and convenient hours to encourage attendance.
- Meaningful topics that the participants most want to address.
- Encouraging participants to share freely about their concerns and questions.

Staff Training

WIC regulations require State agencies to provide staff training on promoting and managing breastfeeding for all staff who counsel and assist WIC parents. Local agencies are also required to incorporate breastfeeding promotion and support training for all new staff specific to their role in WIC.

The *WIC Breastfeeding Curriculum* is the national USDA Food and Nutrition Service breastfeeding curriculum for staff training. The comprehensive curriculum addresses breastfeeding technique and management for all levels of WIC staff. Resources are available for both live in-person or virtual training, or for self-study.

In addition, the WIC Works Resource System contains "Breastfeeding 101" online courses specifically designed for new WIC staff. Other continuing education opportunities can include online webinars and webcasts, and breastfeeding conferences and workshops that enable WIC staff to network with community partners while learning new skills. The National WIC Association convenes an annual meeting and biennial nutrition and breastfeeding conference that include many breastfeeding topics to build knowledge and skills among WIC staff. Some agencies purchase breastfeeding texts for staff, or subscriptions to breastfeeding journals such as *Journal of Human Lactation, Clinical Lactation Journal,* or *Breastfeeding Medicine.*

Bring It Home: In addition to your *WIC Breastfeeding Curriculum* training, what other options could you include as part of your ongoing learning about breastfeeding?

WIC and Breastfeeding—Continuity of Care

Sneak Preview:
The "Continuity of Care" section describes ways to assure WIC families are connected to important support throughout their breastfeeding journey.

Level 2 Competencies:

- Yield appropriately to WIC breastfeeding staff.
- Support the WIC participant's circle of care.

Community Partnerships

WIC promotes breastfeeding by building awareness of breastfeeding and WIC services throughout the community. WIC also works to establish a seamless referral network from hospital discharge to WIC. This helps participants receive the timely information and support they need to continue breastfeeding when challenges and questions are most likely to arise. In some agencies, peer counselors are permitted to visit new parents in the hospital through a "Memorandum of Understanding" between the WIC agency and the hospital. Some important relationships to consider include:

- **Healthcare professionals** *(*prenatal and pediatric providers). WIC staff encourage new parents to discuss questions beyond WIC's role and scope with their healthcare providers to ensure that parents, infants, and children are healthy and growing and developing properly.
- **Hospital staff** such as lactation consultants, nurses, and other staff who care for new families.
- **Home visiting programs** (through the health department or other community programs). Home visiting programs are a pivotal way to intervene at vulnerable periods to provide immediate help

and support. Many WIC agencies invite home visiting programs to participate in staff training to ensure consistent messaging with new families.

- **Government programs** (particularly those that serve WIC eligible populations). Some examples are the *HHS Healthy Start Program* and *Early Head Start Program*, both of which have included breastfeeding as part of their mission of better health for participants. The *SNAP Education* program (Supplemental Nutrition Assistance Program Education) teaches nutrition and healthy food practices and can include breastfeeding as part of the nutrition education. The *Indian Health Service (IDH)* provides health services to American Indians and Alaska Natives and implements practices to improve maternity care among Indian Health Service (IHS) hospitals to better support breastfeeding families. *Federally Qualified Health Centers*, which provide primary care services in underserved areas of the country, are ideal partners to engage for breastfeeding promotion and referrals.
- **State and local breastfeeding coalitions** (advocacy with community leaders and groups to improve support for breastfeeding families). WIC staff often participate as members of community groups to provide information about WIC and breastfeeding support services.
- **Other community groups** (e.g., workplaces, childcare providers, faith-based organizations, schools and colleges, parent support organizations). Building relationships with community organizations that serve WIC participants can help normalize breastfeeding and amplify support.

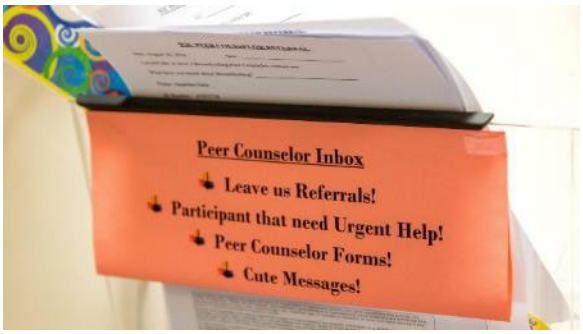
Referrals

WIC improves the health of participants by connecting them to resources for support both within WIC and in the community. The WIC breastfeeding peer counselor program uses the concept of the "yield" to identify the need to refer to other levels of support. Just as drivers in traffic wait and observe for when the way is clear before moving forward and merging into traffic, peer counselors observe and yield more complicated breastfeeding challenges to the CPA, DBE, or community healthcare professionals as appropriate. While the expert is assisting the participant in managing their complex problem, peer counselors continue to offer information and support to encourage them through the resolution of their challenges.

Parents experiencing breastfeeding problems should connect with staff who can assist them as quickly as possible. Small breastfeeding problems can quickly escalate and compromise milk production, cause further pain, and put infants at risk.

Referrals include:

Internal Referrals - with other WIC staff. Staff should refer to CPAs for questions about nutrition and dietary practices or questions about the food package. Staff should refer to DBEs when complex problems beyond the scope of practice of peer counselors and CPAs arise. Staff should make prompt and timely referrals to peer counselors when WIC participants need ongoing



support and encouragement and for basic problem-solving assistance. Each local agency should develop a system/procedure for internal referrals with timely follow up to WIC participants.

External Referrals - with groups beyond WIC. This may include encouraging parents to reach out to providers for medical issues and questions, hospital staff or outpatient breastfeeding clinics, and lactation consultants in private practice. External referrals can also be made with community groups such as local La Leche League groups, home visiting programs. Staff can also share State and/or local agency approved resources from websites, social media platforms, and online services.

Various reasons to yield can include questions about medications, medical problems and treatments, or infant concerns such as insufficient weight gain. Reasons to yield can also include complex breastfeeding problems that put parents and babies at risk, such as low milk production, sore nipples that are not healing properly, symptoms of a breast infection, or compromised infants.

*NOTE: The "Problem Solving" content section provides greater detail about specific situations that warrant an internal or external referral.

Bring It Home: Review the handout, "**When to Yield**," for a more detailed list of maternal and infant issues that should be yielded to the DBE or to the parent's healthcare provider.

Counseling—3-Step Counseling

Sneak Preview:
The Level 2 content in the "3-Step Counseling" section addresses strategies to help participants identify concerns and ways to educate them.

Level 2 Competency:

- Support parents based on their readiness to learn.

Using Probes

Most people do not give complete answers to initial questions they are asked. Instead, they engage in a conversation and more and more information is revealed throughout the discussion. Rather than taking the first response that participant may give to a question, it is often necessary to dig to learn more. "Probes" are ways to do that digging. Probes work best when they are framed as open-ended questions. There are four primary probes that can be helpful.

Probe	Purpose	Examples
Extending	Encourages parents to extend their answer or tell more.	▪ *Can you share a little more?* ▪ *What else have you heard about that?* ▪ *Tell me more about that.*
Clarifying	Helps you better understand the meaning behind something said. Often uses the words, "Do you mean" and can sometimes use the word "or" to ask the parent to choose between two meanings.	▪ *Do you mean breastfeeding will be painful?* ▪ *When you say, 'It's too hard," do you mean it will be too hard to learn how to breastfeed?* ▪ *Are you concerned breastfeeding will be embarrassing to you **OR** to someone who might see you?*
Reflecting	Reflects the parent's words back to them to show that they have been heard, and to encourage them to share more. It can sometimes begin with, "So you are saying," "What I hear you saying," or "It sounds as though..."	▪ *So, you are saying you don't think you will be able to breastfeed?* ▪ *You're concerned about your mother's reaction to you breastfeeding.* ▪ *It sounds as though you are concerned about your partner's reaction.*
Redirecting	Respectfully changes the subject or moves back to the main topic if the conversation has wandered off. This probe is most effective when it begins with the main concern verbalized by the parent.	▪ *Other than the shape of your breasts, is there anything else that worries you about breastfeeding?* ▪ *I can see your relationship with your partner is troubling you. Other than that concern, what other concerns do you have about breastfeeding?*

"Padding" your probe softens it to help parents feel safe in responding. Try these tips:

- **Use the parent's name:** *"Desiree, tell me more about that."*
- **Add extra words:** *"Tell me more about why you feel that way"* (instead of, "Why not?").
- **Pause before the probe.** *"...What do you mean?"*

Bring It Home!
Use handout, "Practice Probes" to devise four different probes to respond to a statement posted by a WIC participant, such as, "I need to start getting formula from WIC."

Education

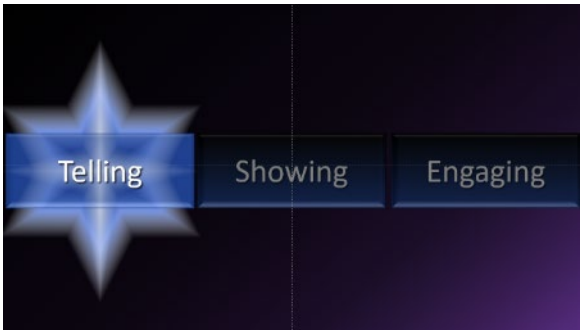
In Level 1, the first two steps of the 3-Step Counseling approach were covered: (1) Ask open-ended questions, and (2) Affirm. The third step in the 3-Step Counseling process is education. After identifying the parent's concerns through open-ended questions and probes and affirming or validating feelings, you can provide carefully targeted messages to help address their greatest needs and goals.

The following tips can help increase the likelihood your information will be received and heard.

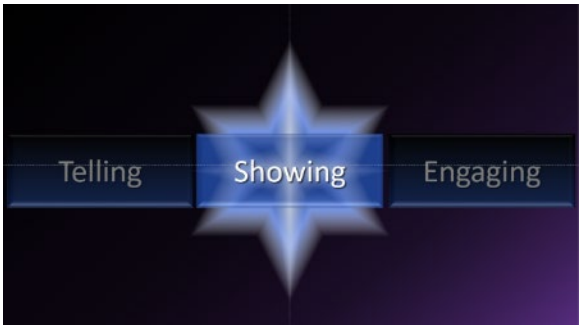
- *Keep it simple.* Use language that is familiar to parents and limit your suggestions to two or three simple ways to address the concern.
- *Target concerns.* Adults tend to tune out information that does not seem relevant to them. Parents are more likely to remember information they requested, so focus on the topic(s) they seem most interested in.
- *Give options.* Sharing more than one solution or option shows parents that there are multiple ways to resolve issues. It also helps them feel more empowered to select options they feel will work best for them.
- *Give resources.* Share follow-up resources from WIC to reinforce what you described. Make referrals to other WIC staff who can reinforce your education. This helps parents feel empowered to know they are not alone.

There are three ways of sharing information that range in effectiveness.

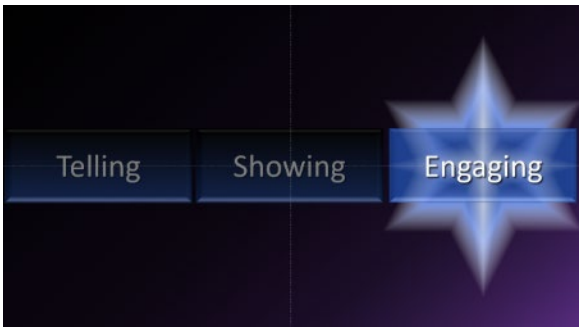
- **Telling** is the least effective way to share information because it focuses more on what you want to say. When you must share information, limiting it to a few suggestions increases the likelihood that your words will be heard. You can also watch for teachable moments, so the information is more relevant (e.g., "*See how your baby is sucking on his hands! He's telling you he is hungry.*")



- **Showing** is more effective than telling because it engages another side of the brain to reinforce the information in a more powerful way. Some examples of "showing" are doing a demonstration with a baby doll or breast model, sharing stories, and involving the participant's other senses (e.g., *"Let's hold the baby now and we can talk about why your baby loves to be in your arms."*)



- **Engaging** is the most powerful way to educate participants because they are more involved in the learning process. It also helps them to own the plan moving forward. One option is to allow the parent to do the demonstration or follow along as you lead it. A technique to build a sense of ownership is to ask the participant, *"What do YOU think might work?"* or *"What would you like to try?"*



Readiness to Change

Not all parents are at the same place of readiness to breastfeed. They may be **ready** to hear the information and to take action to breastfeed. They may be **unsure**, with ambivalence that has yet to be resolved. Or they may be **not ready** to consider breastfeeding due to information or previous experiences. Your conversation will change depending on where they are in the decision-making process.

Readiness	Parents Might Say	Possible Responses
Not Ready	*I don't see myself doing it.* They may need time to think about breastfeeding. They may feel overwhelmed or had a prior negative experience. Your power tool is *affirmation.*	▪ *Tell me some things you have been thinking about.* ▪ *That's a common reaction from new parents.* ▪ *It sounds like you've been giving this some thought.* ▪ *Would you be open to learning a little more?*
Unsure	*I might TRY it.* They may be aware of the importance of breastfeeding but are weighing pros and cons to imagine how it might work in their lives. Your power tools are *affirmation* and *probes.*	▪ *Tell me more about that.* ▪ *Who would be around to support you this time?* ▪ *it's great that you've been thinking about this!*
Ready	*I am ready to breastfeed today!* They have weighed the pros and cons and determined that they can integrate breastfeeding into their lives. Your power tools are *affirmation* and *education.*	▪ *It's great you are going to breastfeed.* ▪ *What are some things you feel will make it a good experience for you?* ▪ *Who will be supporting you?* ▪ *Let's talk about some ways to be prepared.*
NOTE: Basic active listening skills, including open-ended questions and affirmation, were covered in the Level 1 training. This content builds on the Level 1 content.		

Counseling—Difficult Counseling Situations

Sneak Preview:
The "Difficult Counseling Situations" section addresses strategies to help participants identify concerns and ways to educate them.

Level 2 Competencies:

- Understand the negative impact of "risk-based language."
- Use effective listening and communications skills in difficult situations.

Effective Language

Despite best intentions, it can be easy to use familiar approaches when counseling WIC participants about breastfeeding, especially when time is limited or when facing a difficult situation. We may want to use "scripted" messaging such as "why you should consider breastfeeding." However, this is not participant-focused and may not be well received. Another temptation is to ask participants how they plan to feed their baby. This can pressure them to decide before feeling informed.

Some people over recent years suggested using language that focuses on the risks of *not* breastfeeding instead of the "benefits" of breastfeeding. The thinking was that talking about "benefits" assumes that formula-feeding is the norm and breastfeeding only offers "a little something extra." It was believed that by presenting breastfeeding as the norm formula feeding could then be presented as a risk. However, this notion is not evidence-based, and recent studies show that risk-based language can cause low-income participants to be less likely to hear and accept messages about breastfeeding. One study found that

participants perceive risk-based language as less trustworthy, less accurate, and less helpful.

A participant-focused approach considers each participant's social and familial context and respects their experiences, hopes, and dreams for their family. Instead of telling them *WHY* breastfeeding is so important, it might be more effective to show them *HOW* to fit it into their life based on their goals, experiences, typical daily activities, and available support. The 3-Step Counseling approaches described in Level 1 can help establish rapport and produce a more participant-focused conversation.

Counseling Barriers

Communication is not always easy! Environmental, physical, and personal obstacles can make it challenging at times. A participant's personal attitudes, worries, experiences, family obligations, and life stresses can affect how they hear and receive information. They may lack time to talk, do not return phone calls, or do not answer their phone at all. Sometimes we ask participants to phone us when they have questions and then find that this does not happen, even when they experience challenges.

Sometimes we may be in a hurry to complete a certification or counseling encounter or become impatient when participants don't respond favorably. There might be cultural differences and we find it hard to relate to the participant. We might have strong personal beliefs about breastfeeding that can affect our ability to relate. Perhaps there are physical barriers in our WIC clinic office environment that prevent participants from feeling safe or relaxed. Barriers can occur naturally because of the context of our lives. For example, perhaps we must rely more on phone or virtual communications which can affect the natural flow of an in-person conversation. Perhaps distraction from the participant's other children interferes with communication.

Some possible solutions to barriers may include:

- **Ask questions.** If you are unsure of someone's cultural beliefs or experience, or you are unsure how breastfeeding will fit within the context of their lives, ask!
- **Give your undivided attention.** Do all you can to minimize barriers. Remove physical barriers so you can maintain eye contact. Listen to learn. Seek to understand without judgment.
- **Be proactive with follow-up.** Rather than wait for participants to phone, reach out at times they are most likely to have questions, such as early postpartum or around typical growth spurts (Enrolling participants in the Breastfeeding Peer Counseling Program provides an opportunity for participants to receive support during these critical times).
- **Use communication methods they prefer.** Consider whether participants prefer texting for conducting follow-up, for example.
- **Imagine!** When counseling participants on the phone, imagine that you are in person. Use the same body language you would in person, smile often, and focus on your tone of voice to communicate acceptance. Use picture words to describe breastfeeding concepts. Verify what you hear and what you share with participants to be sure they understand. Some examples of picture words might include:
  - Breastfed baby poop: *Your baby's poop should be yellow and runny and look a little like cottage cheese.*

- Open mouth in latch: *Your baby's mouth should be wide open, as though baby is yawning. Baby's lip should spread out around the breast like "fish lips."*
- Baby swallowing: *Listen for your baby swallowing, which might sound like a gulp or a rhythmic "cah" sound. You can also look at your baby's neck to notice movements as the baby swallows.*

Bring It Home!
Take a moment to examine the barriers you have experienced in communicating effectively with WIC participants. What changes could you make to improve your ability to reach them more effectively?

Difficult Situations

Difficult situations can be hard to manage, especially when there is limited time or there are many distractions. Affirmation is always a power tool when parents face a difficult situation. Validating their feelings is powerful in diffusing anger and engaging reluctant talkers. It also appeals to emotions and shows that we care. Here are some ideas to try.

Difficult Situation	Signs and Considerations	Things to Try
Not Interested	Disinterest may show through in lack of eye contact or short non-committal answers. They might be exhausted, worried, or unable to see the relevance of the information to their life.	▪ Use effective listening skills. ▪ Affirm their feelings and decisions. ▪ Offer continued support and encouragement. ▪ Provide peer counselor follow-up and check-ins.
Rude or Angry	Rudeness or anger could be related to cultural differences or other life experiences they brought to WIC.	▪ Try not to take it personally. Be sensitive to their personal life situation. ▪ React with kindness. ▪ Affirm to break down resistance (e.g., *You seem to be having a difficult day.*)
Shy	Shyness could be related to cultural differences or family experiences. They may be introverted or have a hard time talking about sensitive subjects.	▪ Create safe space with open questions and affirmation. ▪ Use nonverbal communication to communicate acceptance (lean in, smile, make eye contact). ▪ Ask open-ended questions.
Prior Abuse	Prior physical and sexual abuse can affect an interest in breastfeeding and lead to low confidence.	▪ If available, refer to State or local guidelines on this matter. If not, yield to DBE for breastfeeding assistance. ▪ Show kindness. ▪ Affirm.
Domestic Violence	Participants experiencing domestic violence often also face depression, fear, low self-esteem, and chronic medical conditions.	▪ Yield as appropriate following your local agency's guidelines and to the DBE for breastfeeding assistance.
Non-English Speaking	Participants place high value on having staff who speak their language, and that improves their perception of customer service.	▪ Use the clinic's language interpretation services or refer to staff who speak their language. ▪ If the interpreter is a family member, affirm them too! ▪ Avoid using a child as an interpreter. ▪ Use simple words and concepts that can be easily translated. ▪ Focus on the most important information and keep education to a minimum.
Cultural Differences	Practices can be different between cultures and even between participants in the same culture.	▪ Avoid making assumptions about cultural beliefs and practices. Treat each participant as a unique individual. ▪ Use active listening skills to learn more.

Difficult Situation	Signs and Considerations	Things to Try
Yes, *but...*	Participants might have a reason why every solution or option you offer will not work for them. While they may believe breastfeeding is important, they may have many barriers and be unable to see how it would work in their life.	▪ Help participants to articulate their goals, setting a small, easily achievable goal. ▪ Find out what the participant thinks would work or would like to try. ▪ Affirm! Participants may have very low self-esteem and affirmations build confidence.
Family Influence	Negative pressure to use formula can make it difficult for participants to consider breastfeeding. Family members may be misinformed or not knowledgeable or may have had negative breastfeeding experiences.	▪ Never contradict the family! Instead, work to strengthen the family relationship. ▪ Correct misinformation sensitively, e.g., *how do you feel about what they said?* ▪ Explore opportunities to educate family members.
Multiple Challenges	With multiple challenges, it can be hard to know what to address first. Challenges can be compounded by family concerns, social/economic issues, or health problems. Parents may feel stressed or overwhelmed.	▪ Affirm feelings! For example, *it sounds as though you are overwhelmed. That's understandable!* ▪ Find out what is most important to the participant. ▪ Break down solutions in simple, easy-to-manage steps with one or two simple solutions to bring some quick relief. ▪ Refer to the DBE for an in-depth assessment.
Over-Dependence	Building a relationship with someone can sometimes lead to over-dependence when parents lack a strong support network. They might phone often or want to talk about topics unrelated to breastfeeding.	▪ Affirm participants for their willingness to bring their questions to you. ▪ Let them know when a situation is beyond your scope or role at WIC. ▪ Connect them to resources to better address their concerns.

Bring It Home!
Think about a WIC participant who presented with some of the difficult situations listed above. How were you able to help them open up? What could you have tried that might have been more effective?

Preparing for Breastfeeding—Reasons to Breastfeed

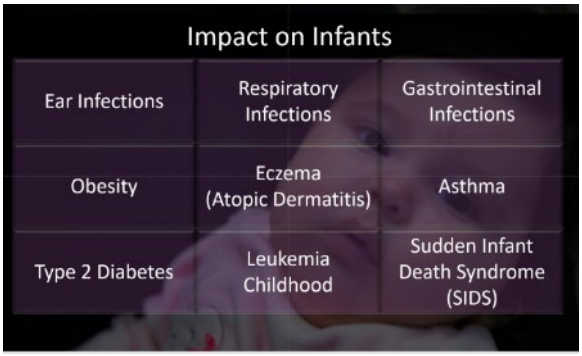
Sneak Preview:
The Level 2 content in the "Reasons to Breastfeed" sections looks at why human milk is important for families, and the basic components of human milk.

Level 2 Competencies:

- Support women to breastfeed as much as they can for as long as possible.
- Offer information to WIC participants about reasons to breastfeed.

Why It Matters—Infant Health

Human milk has cells, hormones, antibodies, and other components that help protect infants from illness and disease. This protection adapts to meet the individual growing needs of each baby. In many cases, the longer and more exclusively a baby breastfeeds, the greater the protection.



- **Ear infections** - The longer the duration and the more exclusively a baby breastfeeds, the greater the protection. Babies have a 23 percent reduced risk of ear infections. When exclusively breastfed for more than 3 months, they have a 50 percent reduced risk.
- **Respiratory infections** - Breastfeeding reduces the risk of respiratory infections such as bronchitis, pneumonia, and respiratory syncytial virus (RSV). The risk lowers by 72 percent when the baby breastfeeds at least until 3-4 months.
- **Gastrointestinal infections** - Breastfeeding reduces the risk of non-specific gastrointestinal infections during the first year of life.
- **Obesity** - There is an association between a history of breastfeeding and reduced risk of being overweight or obese in adolescence and adult life. The longer the baby breastfeeds, the lower the risk of obesity.
- **Eczema (atopic dermatitis)** - Breastfeeding reduces the risk of eczema in the infant and child, especially when the baby exclusively breastfeeds for more than 3 months. When there is a family history of allergies, the protection is even greater.
- **Asthma** - Breastfeeding may provide a protective effect against asthma, with the largest reduction in risk among infants with a family history of asthma.
- **Type 2 Diabetes** - Breastfeeding reduces the risk of Type 2 diabetes later in life by 40 percent.
- **Childhood leukemia** - Breastfeeding helps reduce the risk of childhood leukemia, with the greatest protection when breastfeeding exclusively and for longer durations.
- **Sudden infant death syndrome (SIDS)** - Breastfeeding at least 2 months can lower the risk of SIDS by 50 percent. The longer the baby breastfeeds, the greater the protection against SIDS.

Why It Matters—Preterm Infant Health

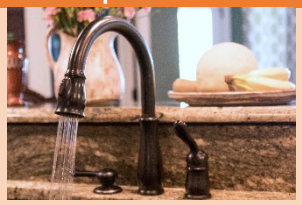
While nearly all babies benefit from receiving human milk, a sick or preterm baby needs it even more. When babies are born early, the birth parent's milk is higher in protein, fat, and sodium, and is very high in immune properties that help protect the preterm baby from life-threatening infections and disease. Human milk helps protect preterm babies from necrotizing enterocolitis (a severe infection that affects a preterm baby's gut), retinopathy of prematurity (a serious condition that can lead to lifelong visual impairment and blindness in the child), and other infections and diseases.

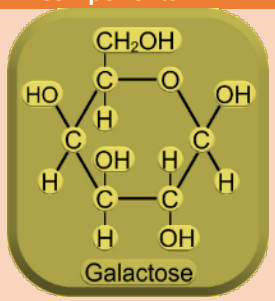
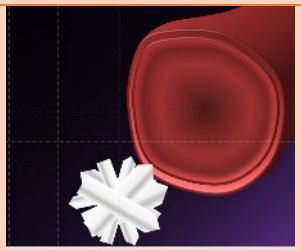
Why It Matters—Maternal Health

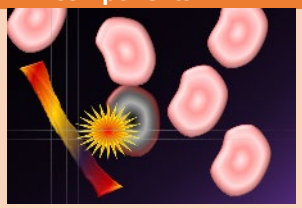
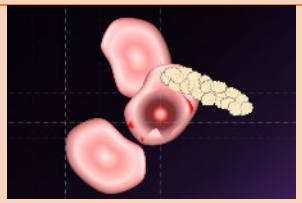
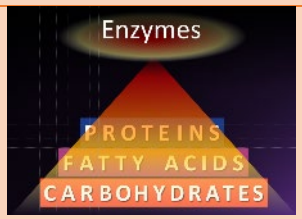
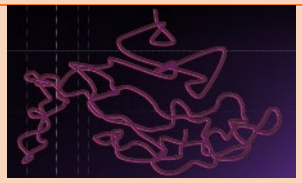
Human milk has a significant impact on the health of breastfeeding parents, who have a lower risk of breast cancer, ovarian cancer, Type 2 diabetes, and high blood pressure. They may miss less work since their baby is healthier, and they may have a lower risk of stress. They recover from childbirth more quickly since their uterus shrinks to its pre-pregnancy size much faster. Breastfeeding can also have a financial impact on the family since formula feeding supplies and additional formula not provided by WIC add to the family's costs. Breastfed babies are also sick less often, which helps reduce the baby's healthcare costs.

Constituents of Human Milk

Human milk contains a vast array of vitamins, minerals, and nutrients designed to help the newborn grow and develop properly. While human milk and formula share some common components, human milk contains many additional components that are perfectly suited to the nutrition needs of the newborn. Human milk also contains the perfect combination of fats, carbohydrates, proteins, vitamins, and minerals to meet the nutritional needs of infants and help them grow properly. These include:

Human Milk Components		What They Do
Water		▪ Human milk is around 88 percent water. ▪ Helps the body's joints and organ function. ▪ Regulates temperature. ▪ Helps nutrients travel throughout the body.
Protein		▪ Changes to meet the baby's growth and development needs. ▪ 90 percent whey protein/10 percent casein protein at birth; the ratio changes as the baby's needs change. ▪ Whey proteins form soft curds that are easy to digest. ▪ Produces stools that are thin and watery.
Vitamins and Minerals		▪ Well absorbed by the baby's body. ▪ Exact amount and types vary from parent to parent based on genetics and diet. ▪ AAP recommends all infants receive 400 IU/day Vitamin D beginning at birth. [Note: if babies are formula-feeding, they would not continue vitamin D supplements once they are daily consuming more than 27 ounces of formula with added vitamin D.) ▪ Our bodies produce vitamin D through sun exposure, which is why exposure to sunlight is good in moderation. However, children should wear sunscreen, hats, and protective clothing when outdoors for extended periods of time to prevent sunburn and reduce risk of skin cancer later in life. This is why vitamin D is recommended. ▪ Iron levels are low but well absorbed; AAP recommends iron supplementation around 4-6 months of age until appropriate iron-containing foods are introduced in their diet.
Fats		▪ Comprise half of the calories in human milk. ▪ Help the baby's brain develop properly and absorb vitamins. ▪ Different from parent to parent. ▪ Change throughout the feeding, throughout the day, and as baby grows. ▪ Tends to increase as the feeding continues.
DHA and ARA		▪ DHA and ARA are a type of fatty acids that are important in early infant development. ▪ They are often referred to as Omega-3 fatty acids that are important for brain development and vision.

Human Milk Components		What They Do
Carbohydrates		▪ Help with brain development. ▪ Help healthy microbes in the baby's gut to grow. ▪ Lactose (the main carbohydrate) helps the baby's body absorb minerals and fight disease by increasing healthy bacteria growth. ▪ Lactose is made up of two simple sugars, glucose, and galactose. The body needs the enzyme, lactase, to break down lactose into its simple sugars for digestion. Our body's ability to produce lactase decreases as we age. While many adults are lactose intolerant (meaning they do not produce sufficient lactase), it is very rare genetic condition in infants.
Probiotics and Prebiotics		▪ Living organisms considered "good bacteria." ▪ Work together to help baby's gut maintain a healthy balance among the organisms living there. ▪ Help the baby develop a healthy immune system.
Oligosaccharides		▪ Complex sugars known as "human milk oligosaccharides" (HMOs). ▪ More than 130 HMOs. ▪ No two lactating parents produce the same HMOs; each parent produces different HMOs for each infant. ▪ Serve as a prebiotic by promoting health gut colonization. ▪ Serve as food for good bacteria to help baby fight infections.
White Blood Cells		▪ Fight viruses, bacteria, and other pathogens that invade the body. ▪ More than 95 percent are "macrophages" that seek pathogens and destroy them. ▪ Produce antibodies.
Antibodies		▪ Created when a foreign substance (such as bacteria or viruses) is present. ▪ Created when the parent or baby are exposed to a foreign substance. ▪ Fights off a foreign substance by attaching to it to prevent the invader from attaching to good cells. This neutralizes the pathogen so it cannot grow or replicate. ▪ The highest amounts of antibodies are found in colostrum; however, the baby continues to receive antibodies throughout lactation.
Anti-Allergens		▪ Cells that help reduce allergies.

Human Milk Components		What They Do
HAMLET		▪ Cellular complex comprised of certain proteins and fatty acids. ▪ Causes around 40 different types of cancer cells to self-destruct.
Growth Factors		▪ Proteins that help cells grow properly in various organs of the baby's body ▪ Help repair injured or damaged human tissue.
Enzymes		▪ Help the baby digest nutrients. ▪ Break down proteins, carbohydrates, and fatty acids found in human milk.
Hormones		▪ Help reduce the risk of developing obesity and diabetes. ▪ Help the baby's thyroid to function properly.

Bring It Home:
What components in human milk were you not aware of? What component seems most amazing to you? How will you talk about some of these components with WIC participants?

Preparing for Breastfeeding—Barriers

Sneak Preview:
The Level 2 content in the "Barriers" section addresses common breastfeeding myths, as well as ways to assist WIC participants in overcoming common barriers.

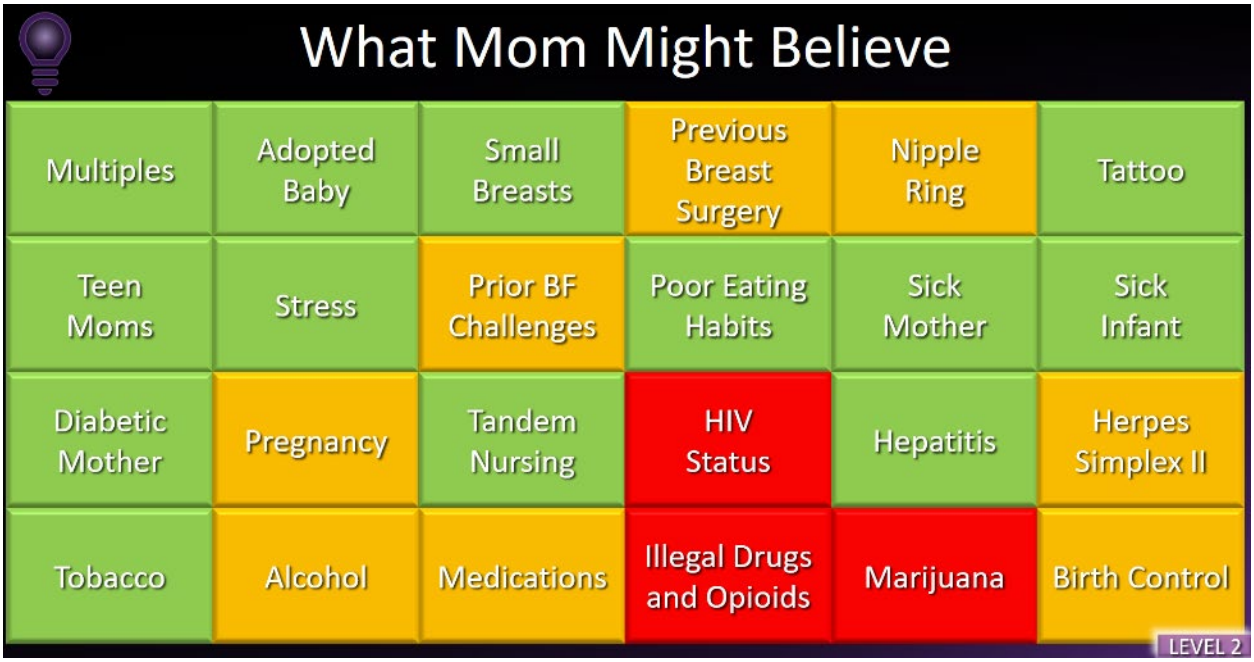
Level 2 Competencies:

- Provide accurate and relevant information to families about breastfeeding and emphasize that most parents can breastfeed.
- Discuss appropriate solutions to common breastfeeding barriers and provide support and yield as needed.

Can Mom Breastfeed?

In most situations, WIC participants can breastfeed, despite common myths that might exist. WIC staff can ask open-ended questions to identify some of these myths and provide support. In some cases, the

participant should be yielded to the CPA or DBE for follow-up assistance. Encourage parents to discuss with their healthcare provider potential concerns regarding whether it is okay to breastfeed. The chart below outlines situations that are usually okay to breastfeed (noted in green), those that are currently considered contraindicated (noted in red), and when it may be possible to breastfeed with caution or with certain conditions (noted in yellow).



- *Multiples* - Lactating parents of multiples can produce milk for both infants. Research shows that milk yield rises depending on the number of infants. These parents need plenty of support and their infants may need monitoring.
- *Adopted baby* - Inducing lactation can be considered for nursing an adopted baby. The DBE will provide targeted support to assist the parent with establishing and maintaining healthy milk production.
- *Small breasts* - Breast tissue grows during pregnancy and nearly all are able to produce sufficient milk, regardless of breast size.
- *Previous breast surgery* - The ability to produce sufficient milk depends on the type of surgery conducted and the reason for the surgery. Prior surgery is an indication for follow-up and referral to the DBE.
- *Nipple ring* – A nipple ring does not usually affect the quality or quantity of milk. However, it may obstruct a milk duct and lead to plugged ducts or mastitis. The ring must be removed before feeding the baby as it can be a choking hazard.
- *Tattoo* - Dyes used for tattoos are not believed to affect the milk. Direct questions to the healthcare provider.
- *Teen moms* – Adolescents can produce milk since the milk-making tissue grows during pregnancy. Young parents need special support.

- *Stress* – Stress does not affect milk quality or cause fussiness. It does not affect milk production, but it *can* affect the release of milk. Calming techniques that help the parent relax can help. Hormones released during breastfeeding can help lower stress levels in the parent and child.
- *Prior breastfeeding challenges* - In many cases, prior challenges do not mean a parent will experience the same challenges with a subsequent child. Challenges can arise from early practices, or from medical challenges of the parent or baby. Studies show many parents make more milk with subsequent babies. Yield parents who had prior breastfeeding challenges to the DBE for assessment.
- *Poor eating habits* – Normally, poor eating habits do not affect the quantity or quality of the milk. A healthy diet does help the lactating parent feel healthier and more energetic to care for their baby. Yield to the CPA for questions about diet during breastfeeding.
- *Sick parent* - In most cases, a parent who is ill can continue to breastfeed as the infant has already been exposed to what made the parent sick. The baby will receive antibodies through the milk to fight the illness. For most illnesses, medications are compatible.
- *Sick infant* - In most cases, infants who are ill will benefit from human milk because of its immune properties and how well it is absorbed and digested. Babies with some medical conditions (such as PKU or anatomical disorders) may need assistance to breastfeed from the CPA, DBE, or other professionals.
- *Diabetic parent* – Diabetes may cause a short delay in the initial milk surge, but breastfeeding should be encouraged. Gestational diabetics who breastfeed are less likely to develop Type 2 diabetes.
- *Pregnancy* – There can be a drop in milk production when the breast cycles through the production process. Some parents are advised not to continue breastfeeding during pregnancy. Yield to the DBE and the parent's provider.
- *Tandem nursing* - Nursing two babies of different ages is considered safe in most cases if the children's intake and growth are not adversely affected. Yield to the CPA and the children's provider. Yield to the DBE if there are milk production concerns.
- *HIV Positive* – Breastfeeding is contraindicated if the lactating parent is HIV positive in the United States, according to the CDC. Yield HIV positive parents to their healthcare provider. Refer to CPA/DBE to discuss breastfeeding recommendations with HIV positive status.
- *Hepatitis* – Breastfeeding is normally okay as the disease is not transmitted through the milk. Yield the parent to their healthcare provider if questions arise.
- *Herpes Simplex II* – It may be okay to breastfeed. If the lactating parent has an active herpes lesion or open sore on the breast, the baby should feed on the unaffected side. Cover the sore to minimize risk of direct contact, and express/discard milk from the affected side.
- *Tobacco* - It is best for parents not to use tobacco to minimize the infant's risk of respiratory problems, colic, lower weight, and sudden infant death syndrome. However, breastfeeding can help offset these risks and is normally considered safe even when the parent smokes. Yield the

parent to the CPA to discuss smoking cessation options and ways to avoid second-hand smoke around the baby. Yield to the DBE if smoking results in low milk production.

- *Alcohol* – It is best to avoid alcohol while breastfeeding. Alcohol enters the milk and can decrease milk production and affect a baby's suck and motor development. Consuming a single occasional alcoholic drink does not warrant stopping breastfeeding. After the parent consumes alcohol, the highest levels of alcohol occur in the milk around 30-60 minutes afterwards. The AAP recommends that the parent wait at least 2 hours after a single alcoholic drink before nursing or expressing milk that will later be fed to the baby. Consuming more than 2 standard alcoholic drinks daily is discouraged Yield a parent drinking more than this to the CPA or DBE and baby's healthcare provider. *(AAP policy updated June 27, 2022.)*
- *Medications* – Medications may be possible in many situations. Always yield to the parent's or baby's healthcare provider for advice about using medications. This includes over-the-counter medications, vitamins, and herbal remedies.
- *Illegal drugs and opioids* – These should never be used while breastfeeding as the drugs easily enter milk and can harm the baby. They can also pose long-term neurobehavioral development risks to the infant. Yield to the DBE and the parent's healthcare provider when a participant is using illegal drugs during breastfeeding.
- *Marijuana* – Marijuana is not recommended during breastfeeding. The active ingredient, THC, has been shown to enter the milk and is stored in body fat, which might increase the risk of neurological damage to the infant. Current data are insufficient to fully understand the effects on infants who are exposed to maternal marijuana during breastfeeding. Therefore, using marijuana and marijuana products while breastfeeding is discouraged. When parents want to continue using marijuana while breastfeeding or have questions about marijuana use during breastfeeding, peer counselors should yield parents to the healthcare provider and to the CPA or DBE.
- *Birth control* - Some contraceptive methods may be safe during breastfeeding, while others (such as combination pills containing estrogen) can affect milk production. Yield questions about birth control to the healthcare provider or family planning specialist. Yield to the DBE if milk production is compromised.

Addressing Barriers

WIC families often encounter barriers similar to non-WIC parents. Socio-economic challenges can magnify these challenges when parents are resource-deprived or living in vulnerable conditions.

Some common barriers to address include:

- **Busy life** - Remind parents that while breastfeeding can be more time-consuming in the early days, it often becomes easier. Provide information about expressing milk to use later, and offer solutions for how to balance breastfeeding with other priorities.

- **Employment** - Encourage parents to speak with their work supervisor during pregnancy about their desire to breastfeed and the time and space accommodations that will help them. Inform parents about their legal rights under Federal law to provide private space that is not a restroom, as well as "reasonable time" to express milk at work.
- **Breastfeeding in public** – This is now legal in every U.S. state. If parents are embarrassed or nervous about breastfeeding in public areas, show them options for discreet nursing (such as pulling their shirt up from the bottom instead of the top, wearing a tank top under their shirt to protect their stomach from exposure, and practicing in front of a mirror). Share options such as covering up with a blanket, seeking out lactation rooms, or using retail store dressing rooms.
- **Family support** – Family support is vital to helping new parents reach their infant feeding goals. Urge new parents to discuss their breastfeeding goals and plans during their pregnancy. Invite family members to attend prenatal classes and share ways they can bond and care for the baby.
- **Low milk production** - Whether real or perceived, low production is a leading reason parents supplement with formula. Parents often misinterpret a baby's fussiness to mean the baby is hungry. Educate parents during pregnancy about how their body works, and give anticipatory guidance about baby behaviors and hunger cues. Share ways to know their baby is receiving enough milk (e.g., wet and dirty diapers).
- **Lack of confidence** - Many barriers to breastfeeding result from low confidence. The greater a parent's confidence, the more likely it is they can visualize success and work through challenges. Affirm parents and point out what they are doing well to help build confidence. Provide solutions that are simple and doable and help them achieve smaller goals. Show photos of breastfeeding parents in the waiting room to help normalize breastfeeding.

Bring It Home!
What barriers do you feel might be most prevalent among WIC participants served by your agency? List some practical ways you could help parents overcome these barriers.

Preparing for Breastfeeding —Family Support

Sneak Preview:
The Level 2 content in the "Family Support" section explores positive ways to help participants engage and involve their family members in their breastfeeding journey.

Level 2 Competency:

- Give new parents effective strategies to improve familial support for breastfeeding.

Talking with Families

Breastfeeding does not happen in a vacuum. New parents rely on the support of close family members in making and reaching their infant feeding goals. Partners, grandparents, and other family members can have a strong influence on feeding decisions and should be respected for their important role. A parent's network of support often extends to friends, coworkers, and organizations (such as clinics and faith-based groups). Studies show that social media networks are also a dominant resource for new parents.

Active listening skills such as open-ended questions and affirmations will help engage and support family members and other key influencers, and help participants strengthen their support network. For example:

- *It's great your partner/family is involved!*
- *I can tell how important it is for you to have strong family support.*
- *You are lucky to have people close to you to help support you and the baby.*

Help participants talk with their partner and family members about their infant feeding decisions and goals. Suggest they invite them to attend prenatal classes and support group meetings. WIC staff can also create a welcoming environment where family members feel welcomed. Recognize that misinformation can be shared with a wide variety of people in the participant's support network, including family, health professionals, coworkers, and others. Resist the temptation to contradict misinformation. Use of active listening skills will affirm the importance of support from their family while offering gentle guidance.

Bring It Home!

Consider the following statements that a WIC participant might make. Write an affirming statement you could make for each, and education the participant might need.

1. *My mom says we don't make milk in our family.*
2. *My baby's healthcare provider said formula will be just as good as breastmilk.*
3. *I was thinking about breastfeeding, but my partner said it will make our baby boy a sissy later on.*
4. *My sister said she tried to breastfeed, but it hurt too much.*

Partner Support

A WIC participant's partner can include the baby's father, a different partner who is not biologically related to the baby, a same sex partner, or other close companion important in their life. WIC staff should be respectful of whoever the participant has identified as their primary support and work to strengthen that support so they can reach their feeding goals.

Multiple studies show that partners can have a profound impact on infant feeding decisions. Participants often report they feel more capable and confident when they perceive their partners as supportive. Studies also show that partner support contributes to increased breastfeeding initiation, duration, and exclusivity rates.

Barriers of Partners

Partners may lack knowledge about the importance of breastfeeding or have concerns about how breastfeeding might affect their relationship or the life of the family. Some partners worry about breastfeeding in public. They might worry about how breastfeeding will interfere with intimacy, whether

it will cause their partner pain, or whether it might negatively change their partner's breasts. Many partners report that they feel invisible when interacting with healthcare professionals or at WIC. Still others worry about their role and how they can contribute to a positive parenting relationship. One study found that while healthcare professionals often assume that partners do not wish to be involved, the reality is that they *do* want to be an active part of their child's life. They want to be part of the child's care and help their partner with fatigue and changing needs.

Role of Partners

Partners have a variety of important roles in the life of the new family. One of these is bonding and feeling close to the baby. Partners can hold the baby skin to skin in the hospital, cuddle with the baby, and comfort the baby between feedings. Partners can also help with practical support such as bathing, soothing the baby, playing with the baby, and taking care of mom. They can serve as an advocate for the lactating parent, assisting with monitoring visitors and seeking help from family and friends. They can also provide breastfeeding support. For example, they can:

- Observe the baby for feeding cues.
- Learn about breastfeeding to know the baby is getting sufficient milk.
- Reassure their partner that things are going well.
- Encourage their partner to seek help or identify and contact help when breastfeeding is not going well.
- Praise their partner and help them feel good about their decision to breastfeed.

Engaging Partners

Many WIC agencies conduct activities and outreach efforts to engage partners. They might include partners in counseling sessions, group classes, and support groups. They might display posters and images of dads supporting breastfeeding or conduct father-led support groups. They might share educational resources such as the FNS publication, "Breastfeeding Basics for Dads."

WIC staff can engage partners throughout the pregnancy, when possible, to help address potential barriers and concerns. When partners verbalize anxieties or issues about breastfeeding, staff can affirm their beliefs and experiences, and offer solutions to help them address those barriers.

Bring It Home!
Read the handout, "Breastfeeding Basics for Dads," available at the WIC Breastfeeding Support website at https://wicbreastfeeding.fns.usda.gov/sites/default/files/2018-08/Breastfeeding%20Basics%20for%20Dads_final%20508c_0.pdf

Grandparent Support

WIC participants in various cultures and socioeconomic groups often turn to their own parents for parenting advice. Female relatives are shown in the research to have a significant influence on the infant feeding decisions of first-time parents. They may offer advice about infant feeding, when to begin solid foods, infant care, and other parenting issues.

Studies show that a parent's perceptions of support from their own parents affects both breastfeeding duration and exclusivity rates. The strongest impact is among parents who are in frequent contact with their own parents. One study found that co-residence with the baby's grandparents is linked to lower breastfeeding rates among disadvantaged population groups. Another significant issue is that grandparents often provide free childcare support when the birth parent returns to work. U.S. Census data shows that 41 percent of infants in child care are cared for by family members, and 23 percent are cared for by the baby's grandparent.

Barriers of Grandparents

Grandparents share common barriers to breastfeeding. They may have formula-fed their own children due to lack of social norms around breastfeeding or lack of support from healthcare professionals. Grandparents often believe breastfeeding will be too difficult for the baby's parents or will tie them down and make their lives more stressful. They often hold many myths about breastfeeding, including believing that holding the baby might spoil them or cause colic, or that giving formula and/or cereal will help the baby sleep and gain weight faster. They might believe nipples should be "prepared" to avoid pain, or that newborns should breastfeed on a schedule. Many of these beliefs spring from both a lack of knowledge about breastfeeding and the grandparent's desire to care for and protect their children.

Roles of Grandparents

Grandparents have a crucial role as respected members of the family. There are many options for how they can contribute to the life of the new family. They can:

- Serve as an advocate for the new family to ensure their needs are met.
- Assist with caregiving duties with older siblings.
- Bond with and calm the new baby through holding and rocking.
- Help with household care.
- Nurture the parents to help them rest, preparing their favorite foods, and showing their love.

Engaging Grandparents

Some WIC agencies encourage parents to invite the baby's grandparents to attend prenatal classes, WIC clinic counseling and education, and postpartum support group meetings. Some clinics host special events to bring together new parents with their own parents.

Use of active listening skills can help honor and affirm the role of grandparents with participants. For example, they can say:

- *Tell me about your experiences feeding your own children.*
- *What are some feeding practices important in your family and culture?*
- *Your grandbaby is very lucky to have you to love!*
- *What a great parent you were with your own children.*
- *Your experiences were typical of what many new parents had at the time.*
- *I can see how much you love your family.*

WIC also provides resources for engaging grandparents, such as "Breastfeeding Basics for Grandparents." Another resource, "Breastfeeding: A Magical Bond of Love," targets strategies for grandparents in Hispanic families.

Bring It Home!
Read the handout, "Breastfeeding Basics for Grandmas," available at the WIC Breastfeeding Support website at https://wicbreastfeeding.fns.usda.gov/wic-partners. Identify two or three educational points you will include when counseling WIC participants about family support.

Preparing for Breastfeeding—Pregnancy

Sneak Preview:
The Level 2 content in the "Pregnancy" section addresses factors that influence infant feeding decisions, and ways to frame and time messaging about breastfeeding. It also addresses potential prenatal risk factors that can affect breastfeeding.

Level 2 Competencies:

- Identify a pregnant person's intention to breastfeed and foster open dialogue to encourage them to breastfeed.
- Provide appropriate anticipatory guidance on breastfeeding during pregnancy.

Feeding Intentions

WIC participants make their feeding decisions based on perceived benefits, as well as their confidence to breastfeed. According to the WIC *Infant and Toddler Feeding Practices Study 2,* WIC parents are more open to breastfeeding than ever before. WIC breastfeeding education, promotion, and peer support might help explain the changed attitudes. In addition, community norms around breastfeeding have changed, and national and state policies and laws that protect the rights of breastfeeding parents helps them begin to value the importance of breastfeeding. Several factors can affect a WIC participant's decisions about how to feed the baby, including:

- Cultural beliefs and practices.
- Demographics such as a high-school education, having previously breastfed, and being in a committed relationship.

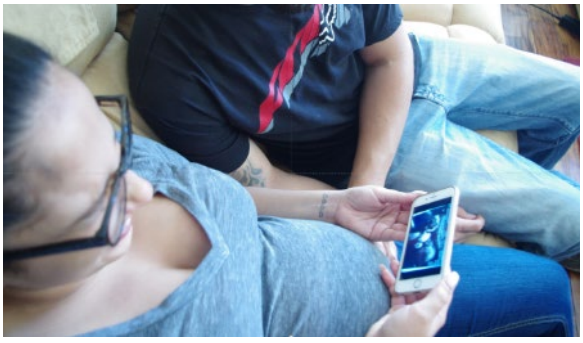
- Family influence and support from the pregnant parent's partner.
- Positive advice about breastfeeding from healthcare providers.
- Support from WIC staff (more than two-thirds of WIC participants say they talked about their infant feeding decisions with WIC staff).
- Breastfeeding self-efficacy (the parent's perception of their ability to breastfeed).
- Access to respected role models like peer counselors to demonstrate what breastfeeding is like.

Special Needs for Support

Pregnancy is the ideal period for WIC staff to determine the needs of new parents and to assess the level of support they will need. Factors to consider include:

- *First-time parents* - They often have greater needs for support, especially if they have few role models for support. Encourage parents to attend prenatal classes and connect them with peer counselors to explore concerns and provide targeted support.
- *Lack of breastfeeding support* – This can influence parents to choose formula, which may appear more familiar. Peer counselors and other WIC staff can help participants explore their barriers and provide information to help them make informed feeding decisions.
- *Previous negative experiences* – This can cause parents to lose confidence in their ability to successfully breastfeed with the next child. Praise them for their previous attempts to breastfeed and remind them that WIC will be with them every step of the way.

When Feeding Decisions Are Made



The timing and framing of messages - the right words at the right time - matter when participants make their infant feeding decisions.

- *Before pregnancy* - Many parents already have an idea about how they might feed their babies. They might be influenced by what others in the family or community have done.
- *During pregnancy* - Many participants make their infant feeding decision by the end of their first trimester. Early contacts can increase the likelihood they will breastfeed. Continued contacts can help them feel supported.
- *After the baby is born* - Some parents make their infant feeding decision in the hospital. Parents of sick or premature babies might be forced to decide sooner than they expected. Some decide after their breasts feel fuller with milk. Some decide when holding their baby skin to skin in the first hour and watching their baby latch.

Stages of Pregnancy

WIC uses a participant-focuses approach to meet participants where they are and to respond to their specific questions and concerns. One way staff can do this is by addressing certain topics at certain times

First Trimester

The early pregnancy period can bring mixed feelings to the family. Parents might feel joy but also worry about finances and familial issues. They might experience breast changes and tenderness, as well as nausea and fatigue. They may or may not feel they have support from their family. They might have health concerns or worry that certain activities could affect their baby's growth and development. Anticipatory guidance can focus on what to expect with breastfeeding and exploring possible barriers.

Messaging to consider:

- *Tell me what you have heard about breastfeeding and any concerns you might have about that.*
- *Your body is going through many changes to help you prepare for your baby's arrival. Contact your healthcare provider if you are worried about any of these changes.*
- *Your breasts may grow larger because glandular tissue is being built so you will make plenty of milk for your baby.*
- *It is normal for your breasts to feel a little tender during this time. It can also be normal not to feel any tenderness.*
- *WIC gives healthy foods and support during pregnancy.*
- *WIC counselors and experts can help you with your breastfeeding questions and concerns.*

Second Trimester

Many participants begin feeling better during mid-pregnancy as some of the early discomforts subside. Their clothes become tighter, and they may begin to wear maternity clothes. They may feel energetic. They might feel the baby's early movements and begin to get excited. Anticipatory guidance will help them learn what to expect with breastfeeding.

Messaging to consider:

- *Your breasts are continuing to get ready to feed your baby.*
- *By the end of your pregnancy, you will notice that the area behind your nipple gets darker, and little bumps appear on this area. These changes help your baby with breastfeeding.*
- *It is not necessary to "toughen" your nipples or prepare them in any way. Your body takes care of that for you.*
- *Your body is now making concentrated milk, or "colostrum." Any leaking you notice is normal.*
- *Even if you deliver your baby early, your breasts will be ready to make milk.*
- *WIC gives extra foods to participants who breastfeed.*
- *WIC counselors and experts can help you with your breastfeeding questions and concerns.*

Third Trimester

During the final trimester, pregnant parents can be tired, uncomfortable, and have trouble sleeping at night. They may be excited about the birth and preoccupied with getting the baby's things together. They can benefit from anticipatory guidance about how their body makes milk, the importance of skin-to-skin contact in the hospital, how to position and latch the baby comfortably, and tips for early success.

Messaging to consider:

- *Let's talk about some ways to get a great start with breastfeeding right from the beginning.*
- *Be sure to let your healthcare provider know your plans to breastfeed.*
- *Exclusive and frequent breastfeeding (8-12 times/24 hours) will help you make plenty of milk.*
- *WIC gives extra foods to participants who breastfeed.*
- *WIC peer counselors and breastfeeding experts can help you with your breastfeeding questions and concerns.*

Right Before Delivery

In the final days and weeks before delivery, new parents might be anxious, uncomfortable, and sleep deprived. Many experience Braxton-Hicks contractions (false labor pains) that can be painful. Anticipatory guidance might include how to get a good start with breastfeeding, reminding them to ask the hospital lactation experts to visit them to assure breastfeeding is going well, and alerting the WIC office they have delivered.

Messaging to consider:

- *Exclusive and frequent breastfeeding (8-12 times/24 hours) will help you make plenty of milk.*
- *WIC gives extra foods to participants who breastfeed.*
- *WIC peer counselors and breastfeeding experts can help you with your breastfeeding questions and concerns.*

Bring It Home:
Refer to the handout, "Conversation Starters" to note how parents might *feel* during each stage of pregnancy. Reflect on your own experience as a parent or that of family members, friends, or WIC participants. What messaging do you think is important for each of the feelings noted?

Breast Care During Pregnancy

Breasts go through many changes during pregnancy, including tissue growth, darkening of the areola, and possible colostrum leakage around or after 16 weeks. These changes can all indicate that the body is

getting ready to make milk and breastfeed. Parents may wonder what they should do to get their breasts ready. A few things to share with them include:

- Not all breast changes are noticeable throughout pregnancy. Refer any concerns to the DBE.
- It is not necessary to "toughen" nipples with a washcloth or another object. This can harm sensitive nipple and breast tissue.
- Breasts typically grow around a cup size or more as glandular tissue begins growing during pregnancy. If a larger sized bra is needed, select one with good support that is not too tight. Waiting until the last few weeks of pregnancy may help in finding a bra that fits well.
- Using lotions, creams, and other products on the breast is unnecessary and might irritate sensitive skin. Participants can, however, wash their breasts as part of normal hygiene.
- Some participants leak colostrum during pregnancy. While not all people experience this, it can be normal. If it occurs, the parent can wear cotton nursing pads inside the bra and change them when they become damp.

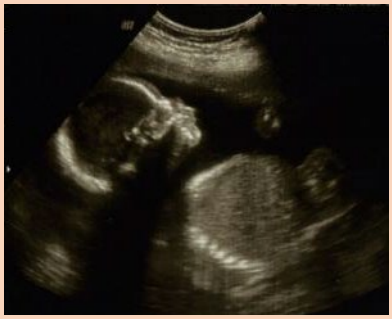
Preparing for Breastfeeding—How Milk Is Made

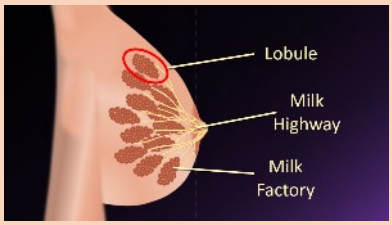
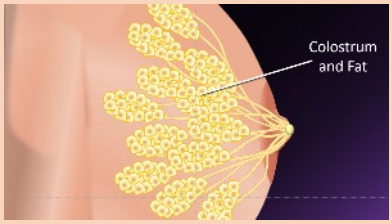
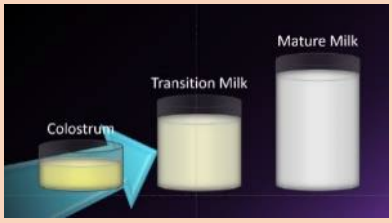
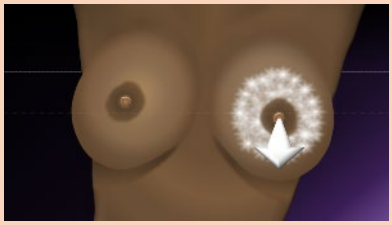
Sneak Preview:
The Level 2 content in "How Milk Is Made" explains the mechanics of how the breast makes milk, the phases of milk production, and practices to help establish healthy milk production.

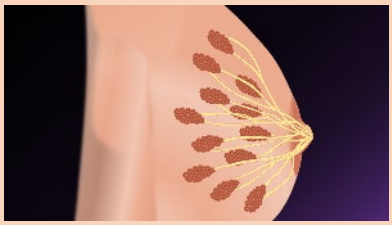
Level 2 Competencies:

- Explain how the breast makes milk.
- Help WIC participants build confidence in their ability to make plenty of milk for their babies.

Breast Development

Stage of Breast Development		What Is Happening	What Parents Need to Hear
Mammogenesis		▪ Breast development begins during fetal development at around 6 weeks gestation when initial mammary gland development begins. ▪ During puberty (around 10-12 years of age), breasts begin to enlarge when fat and connective tissue forms and the ductal system begins growing and branching out.	▪ Your body already started the process of getting you ready to make milk while you were still developing!

Stage of Breast Development		What Is Happening	What Parents Need to Hear
Early Pregnancy		▪ Glandular tissue responsible for making milk grows during pregnancy. This includes completion of the "ductal tree" or highway system and formation of milk-producing cells (*alveoli*) which cluster into "lobules." ▪ Most growth occurs during the first few months of pregnancy.	▪ The rapid growth of breast tissue can contribute to breast tenderness. ▪ These changes are normal and show that your body is preparing to make milk!
Mid-Pregnancy		▪ Alveoli fill with fat droplets and colostrum around 16-18 weeks. ▪ Colostrum is made continuously during the last half of pregnancy. The pregnancy hormone progesterone keeps colostrum from advancing to mature milk. ▪ Colostrum that does not leak out is reabsorbed into the bloodstream. ▪ Colostrum will continue to be made into the early days postpartum.	▪ You may leak colostrum, or you may not. Both are normal. ▪ Your body is ready to provide milk for your baby as soon as the baby is born.
Early Postpartum		▪ After delivery of the baby and placenta, pregnancy hormones decline dramatically and the body releases lactation hormones to make and release milk. ▪ Colostrum increases in volume around days 2-3 as transitional milk. The volume continues to increase until becoming mature milk around day 9.	▪ New parents commonly experience fullness when milk volume increases, due to extra fluids, blood, and milk. ▪ Because hormones drive the process, your body will transition to making milk whether you plan to breastfeed or not.
Maintaining Milk Production		▪ Once milk production begins, it will not be controlled by hormones any longer. Rather, milk removal tells the body to make more milk. ▪ The first month is critical for establishing milk production. Exclusive breastfeeding sets a high starting point for production. ▪ Milk volume tends to stabilize at around 800 mL (26.6 oz. per day) during months 1-6.	▪ As long as your baby feeds often (8-12 times every 24 hours) and transfers milk effectively, your body continues to make milk. ▪ Exclusive breastfeeding, especially in the first month, helps create a healthy capacity for making milk.

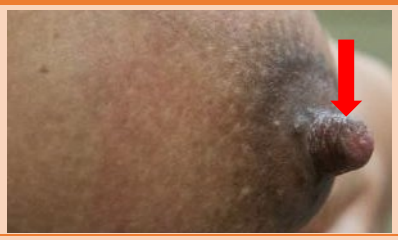
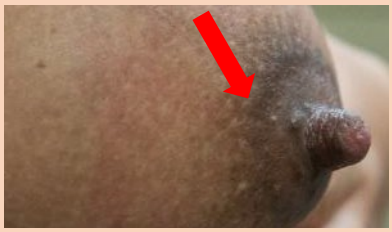
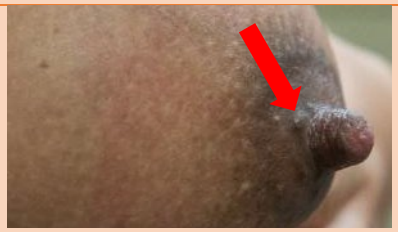
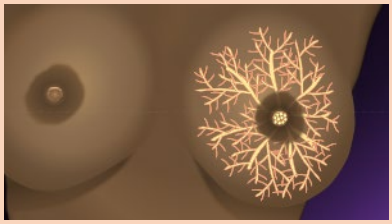
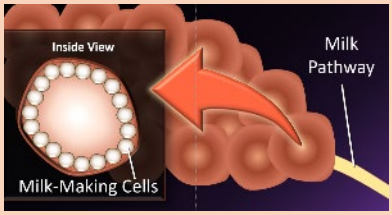
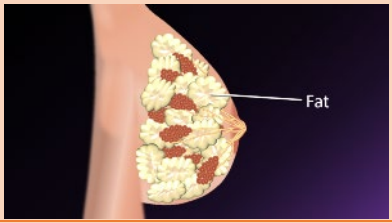
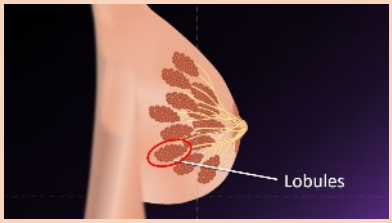
Stage of Breast Development		What Is Happening	What Parents Need to Hear
Involution		▪ When weaning begins and milk removal declines, cells in the glandular tissue begin to die off. ▪ Involution occurs when the milk-making cells have died, and the breast tissue returns to a pre-pregnant state. ▪ Milk production has now stopped, and the breast is dormant, waiting until another pregnancy occurs.	▪ Your body will gradually decrease milk production as your baby receives other foods and liquids.

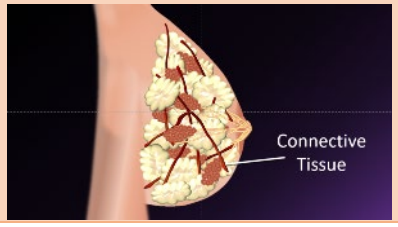
The process of making milk occurs in stages that are similar to seasons of the year. (Concept by Lisa Marasco and Diana West in Making More Milk: The Breastfeeding Guide to Increasing Your Milk Production, 2020)

- **Winter** - Trees are dormant and branches are visible. Before pregnancy, milk ducts are available in the breast but do not produce milk.
- **Spring** - Buds appear on the trees and leaves begin to sprout. In pregnancy, alveoli buds form and develop into milk-producing cells.
- **Summer** - Leaves take on a deep, rich color as they grow to their full capacity to provide shade and beauty. During lactation, alveoli fill with milk to nourish the baby.
- **Autumn** - Leaves change colors and begin to fall. When the baby begins to wean, alveoli begin to wither and die off. Just as trees are bare through another season of winter, the glandular tissue in the breast involutes until another pregnancy occurs.

Parts of the Breast

Each part of the breast has a special role in making milk and delivering it to the baby. Some changes are easier to see because they occur on the outside of the breast. Others occur inside the breast.

Parts of the Breast		Role in Making/Delivering Milk
Nipple		▪ The baby accesses milk through around 4-18 nipple pores, or openings. ▪ During pregnancy, the nipple becomes more elastic. The baby creates a teat with the nipple and tissue around it; elasticity helps it conform easily inside the baby's mouth. ▪ The nipple elongates to help the baby draw it far back to the juncture between the hard and soft palate.
Areola		▪ The darker circular area behind the nipple is called the *areola* (pronounced *air-ree-oh-la*). ▪ The areola may enlarge and become darker during pregnancy due to hormonal changes. ▪ Some believe this is because infants are better able to see contrasts between light and dark, and the darker areola is easier for baby to find the breast.
Montgomery Glands		▪ Small, pimple-like bumps on the areola called *Montgomery Glands* become more visible during pregnancy. ▪ These glands secrete an oily, lubricating substance that helps the baby find the breast through the sense of smell. ▪ Lotions are creams are unnecessary and could interfere with the scent secreted by the *Montgomery Glands.*
Milk Ducts (Highways)		▪ Milk ducts transport milk through the breast and out the nipple to the baby. ▪ Women have around 4-18 major ducts, with an average of 9. They branch off into a complex system of smaller ducts, like a highway system with major interstates branching out to connect highways to streets and smaller roads. ▪ When milk flows the ducts expand, allow milk to flow freely. ▪ Milk that remains at the end of a feeding flows back into the breast to be stored for the next feeding.
Milk Factories (*Alveoli*)		▪ Milk is made inside milk-producing glands called *alveoli* (pronounced *al-vee-**oh**-lie*). ▪ Alveoli (also referred to as the "milk factories") make milk when demand is high and slow down production when demand or need for milk is low. ▪ Tiny muscles surround each alveolus. When the hormone *oxytocin* (pronounced *ox-ee-**toe**-sin*) is released, these muscles tighten and push milk into the ducts.
Fat		▪ Fatty tissue weaves throughout the breast, including around the milk-production cells and highways. This helps provide a cushion to protect the *alveoli* when they fill with milk. ▪ The amount of fat varies from person to person and does not affect the ability to make milk. Even small breasts with lesser amounts of fat can make plenty of milk.
Lobules		▪ The milk factories, or *alveoli,* are organized into several grape-like clusters called *lobules* (pronounced ***lob**-ules*). ▪ Each breast has around 7-10 lobules comprised of milk-making cells.

Parts of the Breast		Role in Making/Delivering Milk
Connective Tissue		▪ Connective tissue helps support the breast and the milk-making tissue. ▪ This is especially helpful when the glandular tissue fills with milk and becomes heavier.

Bring It Home:
Use the handout, "Draw a Breast" to draw the parts of the breast as you review the content.

Storage Capacity

Milk production averages around 800 mL (26.6 ounces) of milk every 24 hours after the first month. Nonetheless, some babies need to feed more often than others. This is because breasts differ in storage capacity, or the amount of milk the breast can hold at one time. Breasts with a larger capacity release more milk at a time and babies might be able to feed a little less often. Breasts with a smaller storage capacity make the same amount of milk, but because the storage area is smaller, they might need to deliver the milk a little more often.

NOTE:

The **American Academy of Pediatrics** recommends that babies be fed whenever they show signs of hunger, or at least 8-12 times every 24 hours. Feeding babies when they show signs of hunger assures that baby gets enough, as long as latch and milk transfer are effective.

Hormones of Lactation

Many hormones are involved in making and delivering milk to the baby. The two primary lactation hormones are *prolactin* (pronounced *pro-**lack**-tin*), which makes the milk, and *oxytocin* (pronounced *ox-**ee**-toe-sin*), which releases the milk.

Prolactin

After the delivery of the baby and placenta, pregnancy hormone levels drop, which enables prolactin to surge. Once the milk volume begins to increase around days 2-3, prolactin is released every time the baby suckles at the breast to signal the breast to make more milk.

Oxytocin

Oxytocin causes muscles around the alveoli to squeeze to push the milk out through the alveoli into the ducts and out through the nipple. This process is called the *milk ejection reflex* (MER) or milk release. Some lactating parents experience a "tingling" sensation when this occurs. They might have two or three milk releases at every feeding, though they may only feel the first one. Oxytocin is sometimes called the "mothering" hormone because it helps parents relax and enhances bonding.

- *What helps:* Oxytocin is easily stimulated through a variety of conditioned responses. Skin-to-skin contact, contact with the baby, and being relaxed can all help oxytocin to flow. Oxytocin can also be released when parents see, smell, or hear their baby.
- *What inhibits:* Pain, fear, or stress can inhibit oxytocin release.

WIC staff can remind parents to get comfortable and relax when they feed the baby. This will help their milk flow more easily. Since oxytocin release can cause a feeling of thirst, suggest keeping a glass of water or other liquid handy at feedings.

How Hormones Work

The baby's suckling at the breast stimulates sensory nerves that send messages to the pituitary gland in the brain. The pituitary gland releases hormones that then go into the breast tissue to make and release milk.

Hormone Receptor

Hormone *receptors* allow lactation hormones to enter the breast cells to make and release milk. The more hormone receptors there are in the breast, the more milk a parent will produce. These receptors are typically grown during the first two weeks after the baby is born. Frequent milk removal helps increase these important receptors. WIC staff can urge parents to breastfeed exclusively and avoid supplements to maximize milk production capacity. If supplements are medically necessary or if the baby is unable to efficiently remove milk, yield the parent to the WIC DBE to assist with using a breast pump to remove milk and maximize the milk production process.

Talking with Parents

The best time to prepare parents for their breastfeeding journey is during pregnancy.

- **1st trimester** - Ask parents how their breasts *feel.* If they report breast tenderness, explain why it occurs and let them know their body is already working to grow the breast tissue needed to make milk.
- **2nd and 3rd trimesters** - Explain how the body makes milk. Talk about hospital practices that can help them create a good foundation for milk production.
- **After the baby's birth** - Remind parents that although the volume of colostrum is small, it is rich in antibodies needed to help the baby adjust to life outside the womb. Remind them to feed the baby at least 8 to 12 times every 24 hours. Let them know that babies want to be close to the parents, and exclusive breastfeeding helps them build and maintain milk production.

Normal Breastfeeding—Hospital Support

Sneak Preview:
The Level 2 content in the "Hospital Support" section examines ways to provide anticipatory guidance to help new parents get off to a great start with breastfeeding in the hospital setting.

Level 2 Competencies:

- Prepare participants for a positive hospital experience.
- Support WIC's role in the circle of care for breastfeeding participants.
- Inform WIC participants about practices that support optimal breastfeeding outcomes.

Preparing for the Hospital

Research shows that the hospital experience for new parents has a direct impact on breastfeeding initiation, duration, and exclusivity. Even the most confident and prepared parents can lose confidence after their baby arrives, especially if breastfeeding is not going well or they lack family support. Sometimes unanticipated events occur that affect breastfeeding. This might include birth complications, preterm birth, or medical problems that require separation from the baby, supplementation, or poor feeding practices.

Practices That Matter

The WIC *Infant and Toddler Feeding Practices Study 2* found that support from hospital staff contributes to breastfeeding outcomes. The study found that 92 percent of parents who received strong support in the hospital initiated breastfeeding, while only 48 percent of those who received weak support initiated breastfeeding.

Hospital practices that have the biggest impact on breastfeeding success include:

- Holding the baby skin to skin within the first hour after the birth.
- No formula supplementation.
- Rooming in with the baby.
- Feeding the baby on cue (when they show hunger signs).
- Avoiding the use of pacifiers.
- Giving parents breastfeeding information to refer to after discharge.

Supporting the Healthcare Team

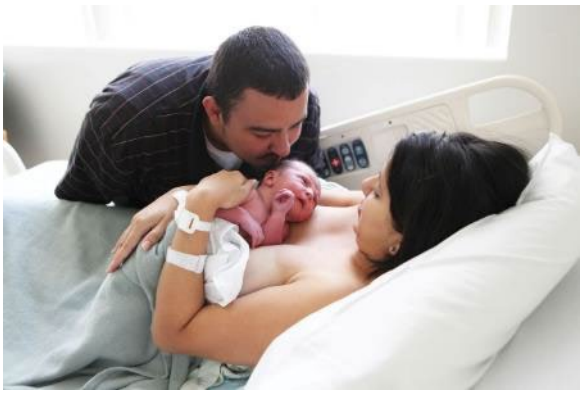
It can sometimes be tempting to find fault with hospital staff and medical providers if breastfeeding does not go well. Parents may misinterpret what a health professional has told them or misread a situation. Sometimes parents do not like breastfeeding or do not feel capable of handling challenges and wish to discontinue. WIC staff who learn about questionable advice given to WIC participants can discuss it with their supervisors. When talking with parents, assume the best intentions of those advising them. Ask open-ended questions to learn more about the situation. For example:

- *Tell me more about what the nurse said.*
- *How do you feel about what they told you?*
- *What are your breastfeeding goals?*
- *What next steps would you be comfortable taking?*

Use affirmation to build up parents' network of trusted providers. For example:

- *It sounds as though your provider is concerned about you and your baby.*
- *You are lucky you had a nurse who was looking out for you.*
- *It is great to have a healthcare team you can trust.*

Helping Parents Prepare



When helping new parents prepare for their hospital experience, urge them to learn all they can during the pregnancy. They can take a tour of the hospital to feel more comfortable and attend prenatal classes the hospital might offer. Help them set realistic expectations. Their most important job in the hospital is to rest and nurture their baby. Rest is how parents recover and heal from childbirth. Some hospitals provide formal "Quiet Hours" to enable new parents to rest and bond with the baby. If this is not provided, parents can request a few hours of quiet time on their own and ask their nurse to help minimize disruptions and visitors during this time. Limiting the number of visitors and the length of their visits will help parents get their needed rest so they have the strength to care for their baby once they are home from the hospital.

You can help parents learn what to expect from their baby. Because babies tend to sleep a lot on the first day, this is an ideal time for parents to rest. This helps everyone feel better able to cope with higher demands on the second day when babies tend to be more awake. If they were overstimulated on day one by too many visitors and interruptions, babies can be fussy and harder to manage on the second day.

Many parents select their partner, a family member, or close friend to serve as a support advocate while they are in the hospital. This person can stay with them at night, if possible, for extra help when they need it most. They can also help manage visitors.

NOTE:

The hospital nurse can be a great advocate for the new family. Nurses are there to help parents heal from the birth and to monitor both the parent and the infant. Urge parents to talk with their nurse about their needs and to help them manage interruptions and visitors so they can get their rest.

Baby-Friendly Hospital Initiative (BFHI)

The Baby-Friendly Hospital Initiative (BFHI) recognizes hospitals that implement optimal practices for supporting new families with breastfeeding. BFHI was launched by the World Health Organization (WHO) and UNICEF in 1991. More than 20,000 hospitals in 156 countries have attained BFHI designation, which requires that they comply with the WHO *Ten Steps to Successful Breastfeeding* to help all babies get off to a good start in life, no matter how they are fed. They include such things as:

- Allowing parents and babies to be together skin to skin right after the birth.
- Keeping parents and babies together throughout the postpartum stay.
- Teaching parents how to feed their infants on demand following the baby's cues.

Two of the steps are especially significant for WIC as they can help encourage active engagement.

- **Step 3** - Discuss the importance and management of breastfeeding with pregnant women and their families. Research shows that exclusive breastfeeding rates are higher when parents receive prenatal education about breastfeeding. Many hospitals work with WIC agencies, prenatal care providers, and other public health programs to assure that pregnant people are prepared for the practices that will help breastfeeding get off to a great start.
- **Step 10** - Coordinate discharge so that parents and their infants have timely access to ongoing support and care. This step gives WIC agencies an ideal opportunity to collaborate. Many hospitals establish agreements with WIC agencies to refer parents who deliver for immediate follow-up after discharge. Hospitals also refer new parents to community support such as WIC postpartum support group meetings, telephone hot lines, and other resources.

Baby-Friendly USA awards the Baby-Friendly designation to hospitals and birthing services in the United States that implement the 10 steps. Baby-Friendly USA also provides resources and guidance for hospitals and maintains an online list of all designated facilities.

Bring It Home:
Visit the website of Baby-Friendly USA at https://www.babyfriendlyusa.org/find-facilities/designated-facilities--by-state. Determine what hospitals in your state are designated as Baby-Friendly.

Talking with Parents

The last few weeks of pregnancy are vital to help prepare for the hospital experience and the early days of breastfeeding. Active listening skills will help WIC staff identify parents' primary concerns so they can relax to hear information. If your local agency's service delivery model policy allows, peer counselors might make hospital visits to congratulate the parents and help answer their questions and concerns. If hospital visits are not possible, peer counselors and other staff can phone participants to check on them and let them know WIC is there to help.

Key messaging to consider:

- Importance of rest for parent and baby, both day and night.
- Managing visitors to allow for rest and recovery.
- Value of support people to assist parents in the hospital.
- Importance of staying close to the baby in the first hour and beyond.
- Importance of exclusive breastfeeding in the hospital and early days to build milk production and help baby learn how to feed efficiently.

Bring It Home!
Use handout, "**Counseling Practice**" and "**Counseling Role Play**" to practice active listening skills as parents prepare for their hospital experience. Identify affirming statements that can help parents who feel vulnerable in the hospital to relax and hear information.

Normal Breastfeeding—Early Days

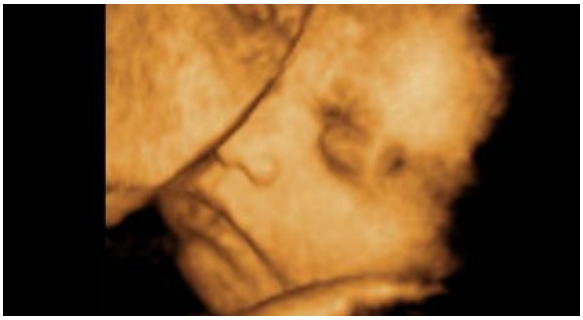
Sneak Preview:
The Level 2 content in the "Early Days" section of "Normal Breastfeeding" highlights key practices that help contribute to positive breastfeeding outcomes and improved confidence for new parents.

Level 2 Competencies:

- Utilize research-based breastfeeding education and support at critical points early postpartum.
- Assist WIC participants with practices that help them get off to a good start with breastfeeding.
- Teach parents how to hold their baby skin to skin safely.
- Help parents identify their baby's feeding cues.
- Help parents know when their baby is receiving sufficient milk.

First Hour

The first hour of a baby's life is a sacred moment. The warm, cozy environment in utero abruptly transitions to life outside the uterus. Skin-to-skin contact helps the baby snuggle in closely to the parent's chest to feel safe, warm, and calm again. This is "home" for the baby. Suggest that parents talk with their healthcare providers about being with their baby in the first hour immediately after the birth and holding the baby skin-to-skin right after the birth and beyond.



Baby's senses are at heightened alert after the birth.

- **Sight.** Babies can see a distance of 8-12 inches. The darker coloring of the areola serves as a target for finding the breast.
- **Hearing.** Babies listen for the sound of their parents' voices. They calm when they hear these voices after the birth.
- **Touch.** When the baby is in close contact to the parent's body, inborn sucking and feeding reflexes are triggered. Touch also triggers the release of the hormone *oxytocin* in the baby which helps calm and relax babies.

- **Smell.** Babies' strongly developed sense of smell helps them find the breast. The scent of colostrum and the fluid from the Montgomery glands on the areola resemble the scent of amniotic fluid. These familiar scents help babies salivate and make mouthing motions.
- **Taste.** When babies taste colostrum, the rich oral sensory stimulation experienced in utero continues. This taste also exposes babies to the unique flavors of the foods the parent takes in.

Babies have an inborn ability to use these senses to find the breast on their own. Breastfeeding in the first hour or two helps them latch, gain protective antibodies, increase milk production, and decrease early breastfeeding challenges. Remind parents that it takes around an hour or more for babies to find the breast by themselves to latch. They can be patient to allow baby to do it on "baby time."

Skin-to-Skin Care

Holding the baby skin to skin during the first hour and beyond keeps baby and parent close. The baby wears only a diaper and lies against the parent's bare chest with his body facing the parent's. A warm blanket or towel placed over the baby's back maintains heat. Skin to skin is scientifically proven to benefit both the baby and the parent, no matter how the baby will be fed! Dads can hold their baby skin to skin as well, to release oxytocin in both the dad and the baby. This helps them bond and reduce stress levels. Skin to skin can bring the entire family together and provides the following benefits:

- Warms the baby after entering the world to bring their temperature into the neutral range.
- Helps baby relax and lower stress levels after the birth.
- Stabilizes the baby's heart and breathing.
- Raises blood sugar levels to keep them in a healthy range.
- Lowers pain levels in both the baby and the parent.
- Reduces infant crying.
- Improves bonding.
- Improves milk production.

Safe Skin to Skin

To ensure safe skin-to-skin practices in the hospital and at home, the American Academy of Pediatrics guidelines encourage families to hold their baby safely:

- Baby's face can be seen, and the mouth and nose are not covered.
- Baby's shoulders and chest directly face the parent.
- Baby's head is turned to one side.
- Baby's neck is straight, and not bent.
- Baby's back is covered with a warm, dry blanket or towel.
- The hospital nurse will monitor the baby continuously in the first hour.
- Once home, parents can continue to make sure baby's airway is free.
- If the parent becomes sleepy holding the baby skin to skin, place the baby on a safe surface or with another support person who is awake and alert.

Early Practices

There are many early practices in the hospital and at home that can help the baby breastfeed effectively and transition safely and comfortably to life with the family.

Rooming-In

Parents can ask that their baby stay in their room. There are many benefits, including:

- Babies cry less when they are with the parents.
- Babies and parents get more hours of deep sleep when they are together. (See the section on Baby Behavior.)
- Parents can learn their baby's unique feeding cues.
- Babies breastfeed more often, helping increase milk production.
- Parents learn how to care for their baby while nurses are nearby for help and support. This helps them feel more confident and empowered.

Rooming-in can be made safer with a few simple tips:

- Avoid bed-sharing with the baby.
- Keep the bassinet close to the bedside so baby can be easily accessed for feedings.
- Remove blankets and objects that can create an unsafe sleep environment.
- Return the baby to the bassinet when the parent becomes sleepy. Remember that the hormone oxytocin can cause drowsiness when nursing the baby.

NOTE: WIC staff should always ask parents about any beliefs or cultural practices related to rooming-in and other early practices. For example, some Native Indian tribal communities wrap newborns securely in a "cradleboard" rather than keeping them in a bassinet. In some cultures, parents may isolate in quarantine with the baby for a period of days or weeks. In some cultures, the extended family remains together throughout the postpartum period. WIC staff can affirm each person's beliefs and practices and share options for how to meet their breastfeeding goals within their cultural context.

Managing Nights

Limiting visitors in the early days can help parents keep the hospital room quiet so that everyone rests better. Rest is an important way the body heals from childbirth. Suggest that parents rest whenever the baby naps both day and night. A family member or friend might stay with the birth parent at night. Once home from the hospital, many babies become fussy as they cope with moving to a new environment. Babies rarely sleep on the parents' schedule and often want to be held more and nurse more often at night. Night feedings help babies get calories to grow and gain weight. Urge parents to seek ways to rest both day and night to continue to recover and have the energy they need to care for the baby.

Avoiding Supplementation

Exclusively breastfeeding in the hospital and beyond helps to establish a good milk production. Introducing supplements too early interferes with this process. If supplements have already been introduced, yield parents to the CPA and DBE for tips and solutions to help them return to exclusive breastfeeding if they wish. Yield parents requesting formula to the CPA. The American Academy of Pediatrics recommends avoiding pacifiers with a breastfed baby for the first month of life as they can interfere with the baby's ability to show feeding cues. Remind parents that if babies are fussy, they can hold the baby and feed often in the early days. They can also learn other ways to calm their fussy baby. (See *Baby Behavior*.)

Avoiding Nipples and Pacifiers

Remind parents that babies need time to learn how to breastfeed well before given other nipples. Offering artificial nipples before 3-4 weeks of age can make it harder for baby to learn to latch. The baby may also prefer the faster flow of milk from the bottle nipple. If the baby needs a supplement, yield parents to the DBE for safe alternative modes for supplementation, such as a dropper or spoon.

Feeding Cues and Reflexes

Newborns have inborn reflexes to help them feed well. Teach parents how to watch for these reflexes and feeding cues, which are an important part of a baby's language to tell parents what they need.

- **Rooting**. When their cheeks are stroked, babies turn their head in that direction and open their mouth searching for the breast to latch.
- **Sucking**. Placed babies against the parent's body triggers sucking reflexes to help the baby find the breast on their own and latch.
- **Early Feeding Cues**. When in a light sleep state, baby's eyelids might flutter, or the baby might make sucking motions with their tongue or cheek. These early cues tell parents the baby may wake soon for a feeding.
- **Later Cues.** If parents miss early cues while baby is still sleepy, babies may show stronger cues such as sucking on their fist, making mouthing movements, or moving their heads around to root and search for the breast.

- **Upset.** If parents miss the later cues, babies become upset and irritated. They may make grunting noises, suck more forcefully on their hands or fingers, or frown.
- **Crying.** Crying is an important form of communication that indicates distress. Babies may cry when feeding cues are ignored, alerting the parents they waited too long to meet the baby's needs.

Tips for Success

Several other tips can help get breastfeeding off to a great start.

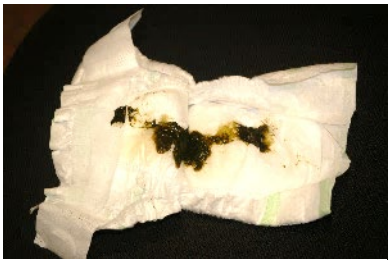
- Feed the baby in the first hour after the birth, if possible, to signal milk production. Babies are also alert and ready to learn how to breastfeed in the first hour.
- Feed the baby often in the hospital. Colostrum is small in volume (7-10 mL each feeding) but perfect for the baby's small tummy and bladder, which cannot handle larger volumes at first. Small frequent feeds help stretch the baby's tummy and bladder so they can gradually accommodate larger amounts.

- Once home, feed the baby at least 8-12 times every 24 hours. This helps baby get enough calories and helps with milk production.
- Watch the baby, not the clock. Human milk is fully digested in about an hour and a half. Storage capacity is also different between parents. The baby will show cues when it is time to eat again.
- Babies have their own unique feeding styles so let the baby take the lead. Feed on one breast, change the diaper, and offer the second breast. If baby is not interested, the second breast can be offered first at the next feeding.
- Many babies cluster or group several feedings back-to-back, especially in the evening, to deal with stimulation from the day as they prepare for longer sleep stretches at night.
- Help sleepy babies wake if they are not feeding at least 8 to 12 times in 24 hours. Breast compressions can help if baby gets sleepy at the breast. (See *Management Tools*.)
- Watch for signs of fullness, such as the baby's hands and toes beginning to relax. The baby may stop drinking and drift off to sleep at the breast or unlatches on their own.
- End the feedings by letting baby fall off the breast on their own.

Is Baby Getting Enough?

One of the most common questions of new parents is whether the baby gets enough milk. When parents worry, they often begin supplementing with infant formula or wean altogether. Because they often look for visual signs, it can be easy to misinterpret behaviors such as fussiness to mean baby is not getting enough. WIC staff can help parents feel confident by showing them visual ways to know their baby gets enough. These include:

- Breasts soften during the feeding.
- Baby breastfeeds at least 8 to 12 times every 24 hours, including at night.
- Baby awakens to feed.
- The parent can hear baby swallowing in a rhythmic way.
- Baby seems satisfied and content after feedings and parents observe signs of fullness.
- Baby gains weight (after the initial birthweight loss).
- Baby has appropriate number of pees and poops for their age.



Day 1 - at least 1 tarry *meconium* stool. Frequent colostrum feeds help eliminate the meconium.

Days 2-3 - at least two wet and three soiled diapers. Color transitions from black to green by day 3.

Day 4 and beyond - at least 6 wet and 3 soiled diapers daily. Stools are yellower and thinner.

Talking with Parents

In the early days, new parents often feel overwhelmed with sleep deprivation, pain from childbirth, early challenges, and dramatically shifting hormones. Active listening skills are an important way to help parents feel more relaxed to hear the important ways to get breastfeeding off to a good start.

Open-Ended Questions	Ways to Affirm
▪ What has been your biggest surprise as a new parent? ▪ What worries you most? ▪ How do you feel breastfeeding is going? ▪ How does your baby show you they're hungry? ▪ How is everyone sleeping with a new baby at home? ▪ What does your partner say about breastfeeding? ▪ Who is your greatest support?	▪ Wow! You are working so hard to make this work. ▪ It's obvious how much you love your baby. ▪ I can tell how much your baby loves being close to you. ▪ Your baby is lucky to have parents who care this much. ▪ Most new parents feel overwhelmed in the early days. ▪ You should be proud. You're doing a great job!

Bring It Home!
Use handout, "**Counseling Practice: Early Days**" to identify common feelings of new parents in the early days and consider open-ended questions and affirmations. Use the handout, "**Role Play: Early Days**" to consider scenarios from the early days and ways to use active listening skills to address concerns.

Normal Breastfeeding—Baby Behavior

Sneak Preview:
The Level 2 content in the "Baby Behavior" section addresses ways to help new parents better understand their baby's unique language of behaviors.

Level 2 Competencies:

- Promote exclusive breastfeeding by helping parents recognize their baby's infant behaviors.
- Help parents build confidence in their ability to understand their baby's needs.
- Assist parents in calming a fussy baby.

Normal Baby Behaviors

It is normal in the early days for new parents to feel overwhelmed and vulnerable, especially with so many changes in their lives. It can be stressful to hear their baby fuss and cry and to mistakenly believe they are not making enough milk. Although it might seem impossible to know what a baby wants, babies have a unique language and are able to communicate many things to parents, including when they want to breastfeed or be held close. The WIC Program provides training resources for how to better understand a newborn's needs.

Bring It Home!
Check out the WIC Works website at https://wicworks.fns.usda.gov/resources/modifying-and-extending-fit-wic-materials-start-obesity-prevention-infancy-baby-behavior to learn more about research into newborn behaviors and to access additional training resources.

Parents can quickly learn to interpret their baby's signals. Studies show that by four months of age, babies will help their parents by reinforcing certain behaviors (such as smiling) to elicit the desired

response. In time, parents will become skilled at recognizing and responding to these behaviors naturally. They will then increase their confidence with breastfeeding and caring for their child. Babies often show they are engaged, or they want something different.

Engaged. Baby's eyes may be open, and the face is relaxed. Baby might try to reach for the parent and smile (depending on their age). Baby is listening to the parent. Parents can smile, make faces, and talk to the baby. This is a good state to offer the breast as baby is ready and willing to learn.

I Want Something Different. When babies do not want to engage, they may turn away, stiffen their body, or even frown and fuss. They may yawn, rub their eyes, or show signs of fatigue. Babies can tire easily even if they were happily engaging moments before. When babies need a break and turn away, parents can change what is going on or offer repetitive sounds and movements to calm the baby. Offering the breast can sometimes help.

Infant States

Newborns move through a variety of states of consciousness or patterns of behavior that range from crying to deep sleep. Each state has visual cues to help parents understand what their baby wants and needs. Some states are helpful times for learning breastfeeding, and some are not teachable moments. Some are needed for brain growth. Each state has clues for parents about what babies need most.

What Parents See	Infant State	What to Look For	Learn More
	Deep Sleep	▪ No body movement ▪ Rhythmic breathing ▪ Bursts of sucking ▪ Startles, but does not wake easily ▪ Difficult to wake **Baby says: "*I need to rest!*"**	▪ Baby's brain rests during this phase. ▪ Parents can watch for this stage while breastfeeding before putting baby down.
	Active Sleep	▪ Moving periodically while asleep ▪ Variable breathing ▪ Facial twitches ▪ Rapid eye movement (REM) ▪ Small sucking movements ▪ Easy to wake **Baby says: "*I'll wake easily now.*"**	▪ Babies often dream in this state. ▪ This is an important time for brain development. ▪ Babies sometimes show early feeding cues in this state. ▪ Babies are more likely to awaken in this state.
	Drowsy	▪ Variable movement ▪ Irregular breathing ▪ Eyes open and close or are glazed ▪ Yawning ▪ Takes time to react ▪ Easily startled **Baby says: "*Don't bother me too much.*"**	▪ Baby begins moving from an active state into a sleepy state. ▪ Babies are also in a drowsy state when they begin to wake from a sleep state.

What Parents See	Infant State	What to Look For	Learn More
	Quiet Alert	▪ Little body movement ▪ Eyes open and wide ▪ Steady, regular breathing ▪ Highly responsive ▪ Wanting to learn and play ▪ Can be tiring for young babies **Baby says: "*I'm fascinated by you and ready to learn!*"**	▪ Baby is interested in the world around them. ▪ This is an ideal time for parents to talk with the baby or attempt to breastfeed.
	Irritable	▪ Stretching arms and hands ▪ Kicking ▪ Eyes darting back and forth ▪ Mild fussiness **Baby says: "*I might need something different soon!*"**	▪ Baby can move from quiet alert to active alert, moving their arms and legs with purpose. This activity can be tiring, and baby may fuss. ▪ Baby may show feeding cues such as grunting, fussiness, chewing on hands.
	Crying	▪ Tears ▪ Jerking motions ▪ Color changes ▪ Tight muscles ▪ Rapid breathing ▪ Responding slowly **Baby says: "*Do something different - NOW!*"**	▪ Movements are more disorganized and chaotic. Arms and legs flail; baby makes loud noises that intensify. ▪ Stress levels increase, raising the baby's heart rate and breathing. ▪ Babies take time to calm in this state. ▪ Baby might need to be held and calmed to relax enough to feed.

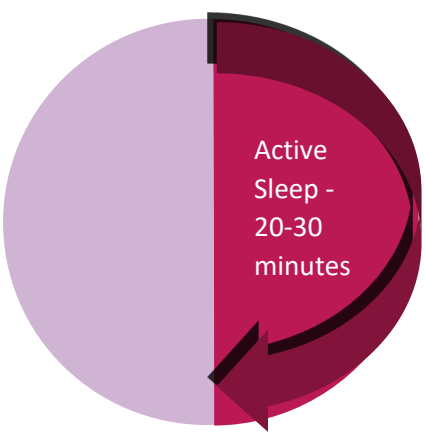
Infant Sleep Patterns

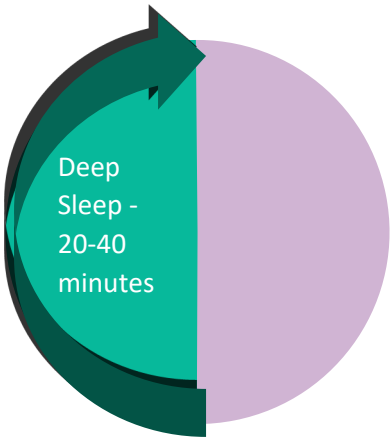
There are many myths around how babies sleep.

> **Myth:** *A "good baby" sleeps most of the time.* **Truth:** All babies have periods of wakefulness and sleep. A baby who sleeps too much might not feed enough to grow and gain weight.
> **Myth:** *Babies should sleep all night.* **Truth:** Babies are not built to go all night without eating. They need calories from nighttime feedings to grow and develop.
> **Myth:** *Babies wake because they are hungry.* **Truth:** Babies often wake simply because their brain has completed a sleep cycle.

Normal Infant Sleep

In the early days, newborn sleep cycles progress from active sleep to deep sleep. Each sleep cycle lasts around 60 minutes. The first half of the cycle, **Active Sleep,** lasts around 20-30 minutes. Baby is in active sleep (dreaming). Babies awaken easily in this cycle. If a parent puts the baby down too quickly after breastfeeding when the baby falls asleep, the baby might awake. Parents might misinterpret this to mean baby is hungry and not satisfied at the breast. The last half of the cycle, **Deep Sleep,** lasts around 20-40 minutes. Baby's brain rests and does not awaken easily. If baby moves into this state before being put down, baby is more likely to stay asleep.





In the early days, babies tend to sleep around 16 hours every 24 hours and wake every hour or so. This is important for survival because babies wake to eat, to breathe, and to keep warm. They also wake around 3-4 times during the night. Parents should breastfeed the baby if they wake and show hunger signs. As babies grow older, they will begin sleeping for longer periods at night and will wake less often.

Age of Baby	Nighttime Sleep Patterns
▪ 0 to 8 weeks ▪ 2 months ▪ 4 months ▪ 6 months	▪ Wake 3-4 times ▪ Wake 2-3 times ▪ Wake 1-2 times ▪ Wake 0-1 times

Should I Wake the Baby?

When babies feed 8 to 12 times every 24 hours in the early weeks and show signs of adequate growth, it is not necessary to wake them. If they are not gaining weight well, it might be necessary to wake the baby to feed at least 8 to 12 times every 24 hours. To wake a sleepy baby:

- Watch for signs that the baby is in the active sleep stage.
- Change the baby's breastfeeding position.
- Give skin-to-skin contact.
- Change the baby's diaper or clothing.
- Call the baby by name several times.

Fussing and Crying

Hearing a baby cry is stressful for new parents. Babies cry for many reasons, including:

- Dirty diaper
- Too hot or cold
- Tired
- Too loud or bright in the room
- Lonely - desire to be near the parent
- Desire for something different
- Hungry
- Uncomfortable

When hungry, baby will show feeding cues (bringing hands to mouth, flexing arms and legs, rooting, making sucking noises). If baby is crying, it may be hard for baby to calm enough to feed well.

Ways to calm the baby include:

- Check the baby's diaper and other things such as temperature to ease baby's comfort.
- Create a calm environment (e.g., soft voices, minimal visitors, etc.).
- Hold baby skin to skin.
- Use repetitive movements such as rocking, swaying with the baby, patting the baby's back, singing softly, saying the baby's name in a calm voice, etc.
- Feed the baby in a quiet area away from noises and distractions.

A baby who persistently cries for many hours may have digestion problems or be unable to regulate their states yet. They may be unable to handle the many stimulations in their environment or can be ill or injured. Yield parents who report persistent crying to the CPA or DBE for further assessment.

Talking with Parents

Active listening skills can be helpful when educating parents about their baby's behaviors.

Open-Ended Questions	Ways to Affirm
▪ What does your baby's behavior say to you? ▪ How do you feel when your baby becomes fussy? ▪ What does your partner/family say about what your baby seems to want? ▪ How do you feel about what they are saying? ▪ What are your goals for your baby?	▪ It sounds like you really love your baby. ▪ I can see that wanting your baby to be happy is important to you. ▪ Many parents are anxious about what their baby wants. ▪ In the beginning, it can be hard to tell what your baby needs or wants. ▪ Your baby is lucky to have so many people to love!

Bring It Home!
Use handout, "**Counseling Practice: Baby Behavior**" to identify common feelings of new parents, and to consider open-ended questions and affirmations. Use the handout, "**Role Play: Baby Behavior**" to consider scenarios about baby behaviors and ways to use active listening skills to address concerns.

Normal Breastfeeding—Position and Latch

Sneak Preview:
The Level 2 content in the "Position and Latch" section demonstrates ways to help new parents position and latch their babies effectively to get off to a good start with breastfeeding. It also addresses creative positioning strategies for breastfeeding in unique situations.

Level 2 Competencies:

- Assist with effective positioning and latch.
- Demonstrate various positions for breastfeeding.
- Assess appropriate latch and offer suggestions for improvements.
- Yield participants experiencing positioning and latch challenges to the DBE.

Basic Technique

A key to successful breastfeeding is assuring that the baby is held and attached properly. Effective positioning and latch can help prevent most breastfeeding concerns. In fact, ineffective position and

latch can create a domino effect that leads to further challenges, including sore nipples, nipple trauma, engorgement due to poor milk transfer, low milk production, and low infant weight gain.

Ready to Feed

Getting ready to breastfeed works best when both the parent and baby are relaxed, comfortable, and ready to feed.

- *Support Parents.* Ensure parents feel safe and comfortable. WIC staff can do this by providing a private space to learn breastfeeding. Suggest that they sit in a comfortable chair with arms. Pillows can be placed under their arm or behind their back for extra support. Keep a glass of water or other fluids nearby.
- *Support Babies.* Although babies are born with innate reflexes to latch, each baby and parent will learn together what works for them. A crying baby is not ready because stress hormones make it hard to learn. Suggest that the parent or other family member help rock the baby or calm with skin-to-skin contact. Sometimes dripping a little expressed milk under baby's nose or on the lips can interest the baby and encourage sucking behaviors.

Latch Basics

WIC staff can use a breast model and baby doll to demonstrate latch techniques to WIC participants. It is beyond the peer counselor's scope of practice to handle a participant's breasts.

Steps to Latch	Key Principles
	▪ Baby faces the breast and does not have to turn the head to reach it. ▪ It is hard for baby to swallow when their head is turned.
	▪ If desired, the parent can gently support the breast. ▪ The "C hold" is a common way of providing support. Place fingers around the breast to form a "C" shape, with thumb on top and fingers below the breast. Avoid covering the nipple and areola. ▪ Fingers can also shift below the areola to form a "U" shape if that is more comfortable.
	▪ Babies should angle in under the bottom part of the breast so that the baby's chin touches the breast. The baby's jaw compresses the bottom part of the areola. This tissue is designed to handle the strong compression of the baby's jaw. ▪ Leading in with their chin helps the baby open more widely since it is the bottom part of the jaw that opens and closes. ▪ Leading in with the chin also helps open the baby's airway when drinking.

Steps to Latch	Key Principles
	▪ When baby leads with the chin, the nose will be aligned with the nipple. This is called "nose to nipple." ▪ This helps the baby's head tilt back so the jaw can easily open wide. ▪ When baby's nose is near the nipple, baby smells the scent of colostrum, salivates, and prepares to latch. ▪ The parent can gently rub the nipple under the baby's nose to help elicit a wide-open mouth.
	▪ Once the baby's mouth opens in a wide gap as seen in this photo, the baby can be brought in close.
	▪ In an effective latch, the entire bottom part of the areola is in the baby's mouth; some of the top part of the areola may be visible because the baby is not compressing this area. ▪ Baby's lips flange outward like "fish lips." ▪ The baby's tongue forms a teat with the nipple and areola and compresses the tongue against the roof of the mouth. ▪ In rhythmic wavelike motions, the baby's tongue will continue the compression, releasing milk to swallow.

Position Basics

There are many ways to position and support the baby for breastfeeding. There is no one "right" position for every situation. What works for one feeding may not work well for another feeding. Parents can try different positions to find ones that are most comfortable for them.

Common principles for any position that help assure a comfortable latch and good milk transfer include:

- Baby's body faces the parent's body.
- Baby is held close. There are no gaps between the parent's and baby's bodies. If the baby's hands are in the way, the baby is not close enough.
- Baby's head faces the breast and is not turned to the side.
- Baby's body, head, shoulders, and hips are in a straight line. The neck is not bent.
- The parent does not have to lean over the baby to nurse.

Common Breastfeeding Positions		Position Mechanics
Laid-Back Breastfeeding		▪ Helps trigger natural feeding instincts and reflexes. Gravity helps baby get a much deeper latch. ▪ Helps parents relax and removes baby's weight off their shoulders, arms, and back when feeding the baby. 1. The breastfeeding parent should lie back semi-reclined. 2. Place baby on the chest of the breastfeeding parent with baby's face near the breasts. Turn baby's head to one side while making sure the shoulders and hips are still aligned, to keep the airway open unless the baby begins actively seeking the breast to latch. 3. Support baby's head and shoulders with the parent's arms forming a nest around the baby's body. Gravity holds the baby close. 4. Baby will gradually find the nipple and latch.

Common Breastfeeding Positions		Position Mechanics
Cradle Hold		▪ Comfortable for most nursing parents and babies. However, it may not be effective right at first, or when babies need support to latch. 1. Parent sits upright with back/forearms supported as needed. 2. Support the baby across the forearm, holding baby close. 3. Baby's head is cradled near the parent's elbow. 4. Baby's ears, shoulders, and hips are aligned in a straight line with the baby's face facing the parent's breast. 5. Baby should be at the level of the nipple. ▪ Use pillows to provide support for the parent's arm. A small footstool or stack of books can help raise the parent's lap to reduce any tension.
Cross-Cradle Hold		▪ A variation of the cradle hold that provides greater support and control to help a baby stay latched. ▪ Helpful for preterm babies or those with a weak suck. 1. Baby begins in a cradle hold. Place the arm opposite from the breast used for the feeding (when feeding from the right breast, use the left arm) around the back of the baby's neck to support the neck and shoulders. The baby's bottom is now resting in the crook of the elbow. 2. Keep the baby's body in a straight line with ear, hips, and shoulder aligned and baby's mouth at nipple level. 3. The opposite hand can support the breast to form a "C" shape, with the thumb on top and the fingers below the breast. Avoid covering the nipple and areola. ▪ Pillows can help support the parent's arm if needed. ▪ Keep the hand at the baby's neck and shoulder and avoid using hands to push against the baby's head.
Football or "Clutch" Hold		▪ Gives additional support during feeds, and is useful for parents who had a C-section, have large breasts, have flat/inverted nipples, or for feeding two babies at the same time. **1.** Place baby with their back on top of the parent's forearm on the side where the baby will be feeding (parent's left side for feeding from the left breast). The baby's bottom will be in the crook of parent's elbow and the baby's legs can be supported on a pillow at the parent's side. **2.** Raise the baby up over the breast from underneath. **3.** Keep baby's body in a straight line with ear, hips, and shoulder aligned and baby's mouth at nipple level. **4.** The opposite hand can support the breast to form a "C" shape, with the thumb on top and the fingers below the breast. Avoid covering the nipple and areola. ▪ If needed, place a pillow or rolled-up baby blanket under the arm for extra support to bring baby to breast level.
Side-Lying		▪ Helps parents relax while nursing. Helpful after a Cesarean delivery. 1. Parent lies on their side, with knees slightly bent. 2. Baby lies on their side. Parent's body can roll to raise or lower the breast. 3. Parent may rest on their elbow and use top arm bring the baby close to their body. Or they may support baby's head and back with their lower arm to bring the baby close to their body. ▪ It may be easier for parents to fall asleep with their baby in the side lying position. The AAP does not recommend bedsharing with infants. Safety is paramount! Urge parents to take precautions to create a safe sleep environment and prevent opportunities for entrapment and suffocation.

Other Latch Supports		
Sandwich Hold		▪ Helpful for a baby with a small mouth or breast with large areola. ▪ Helps "shape" the breast to make it easier for baby to take in large amount of areola with the nipple. ▪ Place fingers behind the areola, with thumb on top and index finger underneath. (Be careful not to place hands over areola.) ▪ Gently compress breast by bringing thumb and index finger together to help shape the breast to fit into baby's mouth.
Dancer Hand		▪ Helpful for baby having difficulty staying latched or sliding down the nipple. Also helpful for babies with low tone. ▪ Cup the breast with the first three fingers and rest the baby's chin between the thumb and index finger. ▪ Gently compress the baby's cheeks with pressure from the thumb and index finger to provide extra support to help baby stay latched.

Unique Situations

Breastfeeding After Cesarean Delivery

Breastfeeding after a Cesarean delivery can be uncomfortable, especially if baby presses against the incision. Pain medications can cause sleepiness and affect breastfeeding. Rest is crucial to recovery from surgery. Urge parents to rest as much as possible by accepting offers of help and to asking a family member to stay the night at the hospital to help with the baby. Holding the baby skin to skin helps breastfeeding get off to a great start.

Some breastfeeding positions to consider include:

- Laid-back, with the baby across the side of the parent's chest instead of over the belly.
- Football or clutch position to take pressure away from their painful incision.
- Side-lying to avoid pressure from the incision.

Multiples

Parents of multiples may have a variety of reactions and feelings, including feeling overwhelmed with demands of caring for more than one baby, worries about making enough milk, and sleep deprivation. Urge parents to accept offers of help and remind them that parents of multiples can produce plenty of milk. Research shows that parents of twins can make more than double the amount of milk in the early months than a parent of a singleton. Some parents prefer to feed the babies one at a time. Others prefer to save time by feeding them simultaneously. If this is the parent's goal, suggest:

- Double clutch, placing both babies in the football hold on each side of the breast.
- Cradle + clutch, with one baby in the cradle position and the other baby in the clutch position.
- Laid-back breastfeeding, with both babies in a laid-back position across the chest.

Tandem Nursing

Some parents continue nursing an older child when a newborn arrives, known as "tandem nursing." Because milk production is based on milk removal, it is possible to feed more than one child during the

same period of lactation. Yield the parent to the DBE if there are concerns about sufficient milk. Breastfeeding positions can vary. If the parent chooses to feed both children at the same time, the older child may stand or sit upright while the newborn is held in a more traditional position.

Disabilities

Parents with disabilities can experience various types of challenges based on the type of disability. It may be compounded with negative messaging about their ability to breastfeed by family members, friends, and even healthcare professionals. Parents of disabilities often report that what they need most is support. Positioning options will be based on the unique needs of each parent and their capabilities. Yield WIC participants who are disabled to the DBE.

Older Babies

As babies grow older, they become more active and easily distracted. Parents can become more uncomfortable when babies discover new ways to position themselves or when they begin teething. Sometimes patience and nursing in a quiet, dimly lit area can help minimize distractions. Some parents find that allowing the older baby to straddle their lap or nursing upright can help.

Large-Breastfed/Obese Parents

Large breasted and obese parents can face additional challenges with positioning and latch. It can be hard to see how the baby is latching, and many parents lack confidence they can breastfeed comfortably or easily. Obese parents may also experience a lower prolactin response, which can result in delayed milk production. Holding the baby skin to skin and feeding frequently is important for obese parents. Positioning options might include:

- Football or clutch hold, which enables the parent to raise or lower the breast as needed.
- Tucking a rolled-up baby blanket or towel under the breast to provide additional support.
- Making a “hammock” or “sling” for the breast with a scarf to help raise the breast.

Talking with Parents

Active listening principles can help WIC staff better tune in to the challenges of new parents when attempting to position and latch their baby. This helps them relax and be open to creative solutions.

Open-Ended Questions	Ways to Affirm
▪ What do you already know about how to position and latch your baby? ▪ What positions have you thought you might try? ▪ How do *you* feel breastfeeding is going? ▪ How does breastfeeding *feel* when your baby latches? ▪ Tell me how comfortable breastfeeding is for you. ▪ How do your breasts feel before and after the feeding?	▪ Most new parents find breastfeeding takes time to learn. ▪ Look at your baby! What a pro! ▪ It’s obvious how much your baby loves you. Look how the baby calms in your arms! ▪ Your baby really enjoys being at your breast. ▪ You’re a great parent to work so hard to get your baby to latch.

Bring It Home!
Use handout, "**Counseling Practice: Position and Latch**" to identify common feelings of new parents when they first learn to position and latch their newborn, and to consider open-ended questions and affirmations. Use the handout, "**Role Play: Position and Latch**" to consider scenarios related to positioning and latch, and ways to use active listening skills to address concerns.

Normal Breastfeeding—Ongoing Breastfeeding

Sneak Preview:
The Level 2 content in the "Ongoing Breastfeeding" section addresses strategies to help participants continue breastfeeding throughout the first year of their baby's life and beyond.

Level 2 Competencies:

- Use 3-Step counseling methods to address common questions and concerns that can affect breastfeeding in the first year.
- Yield participants with breastfeeding challenges in the first year to appropriate referral sources.
- Promote safe sleeping practices as they relate to breastfeeding.

Early Weeks

Feelings and challenges can surface in the early weeks as parents adapt to life with a new baby.

Baby Blues

"Baby blues" following delivery is common due to rapidly changing hormones, lack of sleep, and overwhelming demands of caring for a newborn. "Baby blues" can include tearfulness, anxiety, irritableness, mood fluctuations, increased sensitivity, and fatigue. This typically peaks around four to five days after delivery, may last for several days, and resolves by ten days postpartum. Urge parents to rest, take care of themselves, and get support from family and friends. Affirmation will reassure them that their feelings are normal, and things will get better. If parents are extremely depressed or their sadness lasts longer than a few days, yield them to the CPA or their healthcare provider.

Fatigue

Rest is a crucial way that birth parents recover from pregnancy, labor, and delivery. During rest, the body repairs and restores itself because hormones that repair and restore tissue are released during sleep. Yet fatigue is one of the most common complaints of new parents. It can interfere with the ability to recover and care for their baby. Sometimes breastfeeding is blamed for the fatigue. However, studies show that breastfeeding parents report more sleep than formula-feeding and mixed-feeding parents. Fatigue can be caused by lack of sleep, a difficult pregnancy and labor/delivery, hormonal changes, infections, poor diet, and medical situations. Strategies to suggest to parents include:

- Rest whenever baby sleeps. Even short naps throughout the day are helpful.
- Accept offers of help.
- Keep baby's bassinet near the parents' bed.
- Eat healthy foods and drink to quench thirst.
- Use relaxation techniques such as yoga, bath, meditation, or massage.

Family Planning

Many new parents wonder about safe and effective birth control options while breastfeeding. Decisions about birth control options should be made between parents and their healthcare providers or family planning specialists. Yield parents with questions to their healthcare provider.

Everyday Life

By the end of the first month after a baby's birth, many parents are resuming normal activities and might have questions around fitting breastfeeding into their daily life.

- *Going out in public* - Affirm concerns about breastfeeding discreetly in public. Offer options for breastfeeding discreetly such as pulling the shirt up from the bottom rather than the top, wearing a nursing top or tank top under the blouse to help block the abdomen when nursing, carrying baby in a sling, or using a blanket or scarf to cover the baby when nursing.
- *Weight loss* - Affirm the parent's desire to lose their extra pregnancy weight. Remind them that breastfeeding may help them lose the weight gained during pregnancy. Yield questions to the CPA.
- *Exercise* - Affirm the desire to exercise and become healthy again after the baby's birth. The *Dietary Guidelines for Americans* recommends 2.5 hours of physical activity per week. Parents can check with their healthcare provider about when it is safe to begin physical activity (usually around 6 weeks).

Safe Sleep

Medical and governmental organizations, as well as state health departments, have issued guidelines for safe infant sleep. There are more than 3,500 sleep-related infant deaths annually in the U.S. These include sudden infant death syndrome (SIDS) which is unexpected death, as well as deaths due to suffocation, asphyxia, entrapment, infection, ingesting something that obstructs the airway, metabolic diseases, cardiac problems, and trauma. A safe sleep environment can reduce the risk of sleep-related infant death. WIC staff reinforce or share information about how to make a baby's sleep environment safe following the state health department's policies.

Numerous studies show that breastfeeding helps reduce the risk of SIDS. The longer a baby is exclusively breastfed or fed breastmilk, the lower the risk of SIDS. Breastfeeding parents may report that they feed their baby in certain locations that could become an unsafe environment if the mother and baby fall asleep during or after the feeding. These environments include Couches, recliners, and beds with soft pillows and blankets. Encourage parents to select safe places to breastfeed. If parents become sleepy, they should place their baby in a separate, safe sleeping area after feedings. Yield parents with questions about safe sleep to the CPA or DBE and baby's healthcare provider.

WIC staff can offer affirming comments such as:

- *It sounds as though getting your rest is very important to you.*
- *Babies definitely want to be close to mom.*

Bring It Home!
Check out the WIC Infant Feeding Guide at https://wicworks.fns.usda.gov/resources/infant-nutrition-and-feeding-guide for further information on safe sleep practices.

Nutrition

Starting Solid Foods

The American Academy of Pediatrics recommends that babies be exclusively breastfed for the first six months of life, with other foods added around that time. These are referred to as *complimentary* foods because they complement breastfeeding, which remains a primary source of baby's nutrition. WIC staff can help parents know when their baby is ready for solid foods.

- The baby can sit alone or with support.
- The baby's head can be held steady and straight.
- The tongue thrust reflex has disappeared and the tongue no longer extends out of the mouth when something touches the baby's lips.
- The baby's lips can close over a spoon and scrape food off as the spoon is removed.
- The baby's mouth can retain food.

Solid foods do not have to introduced in a particular order. However, iron and zinc are important for exclusively breastfed babies. Fully breastfeeding babies will receive baby foods with iron and zinc as part of their food package at 6 months. Other foods to offer include strained vegetables and fruits. Remind parents that when solid foods begin, the baby's stools will change in both color and consistency.

Maternal Nutrition

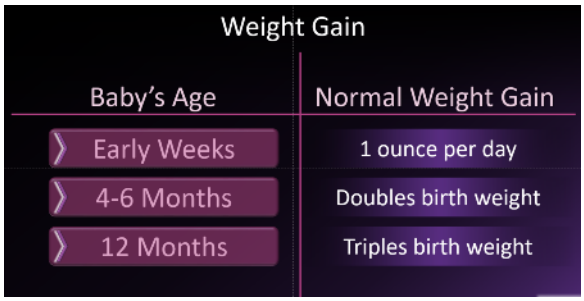
Many parents worry they must eat a special diet while breastfeeding, or they must avoid their favorite foods. Affirm the parents and let them know this is a common belief. Information you can share includes:

- WIC encourages all participants to eat a well-balanced diet to maintain their health.
- It's best to include foods from all food groups: fruits, vegetables, grains, dairy, and protein.
- If there is a concern about a particular food (such as milk products or eggs) speak with the CPA.
- Drink plenty of fluids in response to thirst.
- Keep coffee and other caffeinated beverages to a moderate amount (two to three per day). More might cause the baby to be fussy or not sleep well.

As Baby Grows

How long to breastfeed is an individual decision for each family based on their goals, needs, and social norms, as well as the information and support they receive. The AAP recommends that babies exclusively breastfeed for the first 6 months, with continued breastfeeding to 2 years and beyond. Social norms for how long to breastfeed have changed through the years and differ from country to country. Worldwide, breastfeeding is common in many cultures for up to 2-4 years. Breastfeeding continues to be a valuable source of nutrition and disease protection for as long as breastfeeding continues. Affirm parents who wish to continue breastfeeding as long as they feel is right for them.

Infant Growth Patterns



It is normal for both breastfed and formula-fed babies to lose a few ounces of weight in the first few days as they pass their first stools and eliminate extra fluids. After this initial weight loss, they will start gaining weight. By the time the baby is 14 days old, the baby should be back at birth weight. Thereafter, infants usually gain about 1 ounce per day in the first 6 months. They should double their birth weight by 4-6 months and triple the birth weight by the time they are 1 year old. If parents are concerned about the baby's growth, yield them to the CPA or the baby's healthcare provider.

Babies go through periods of rapid growth where they breastfeed more frequently for a day or more. These are called "growth spurts" which are based on a baby's individual needs. They typically occur around 2 weeks, 6 weeks, 3 months, and 6 months. Parents might misinterpret the baby's increased feeding demands to mean they are not making enough milk. WIC staff can affirm them:

- *It can feel overwhelming when the baby wants to breastfeed so often.*
- *I can tell how worried you are about your baby.*
- *It's obvious you care about your baby.*

Remind parents that growth spurts are normal. They can anticipate these spurts, so they are not surprised when they occur. They can keep baby close during this time of increased appetite and breastfeed as long as baby wishes. Avoid supplementation as this interferes with milk production. Yield parents to the DBE if a growth spurt lasts longer than a few days.

Teething

Parents are often concerned about teething long before the first teeth erupt and may assume they will need to wean. Assure parents they can continue to breastfeed when the baby has teeth. When babies are nursing, their tongue extends over the gum line, which prevents teeth from interfering with the

baby's latch. When biting occurs, it is usually at the end of a feeding session. Breaking suction and removing the baby from the breast teaches babies quickly not to bite down.

Oral Health

Oral health is important for all infants, including breastfeeding babies. It establishes a lifelong foundation for dental health. Early childhood caries is a specific form of severe tooth decay of an infant's primary teeth. Human milk contains Lactobacilli and other substances that can inhibit the growth of bacteria that causes caries; however, breastfed infants can also be vulnerable to childhood caries. Starting solid foods can contribute to dental caries. When a baby's teeth begin to emerge, urge breastfeeding parents to care for their infant's teeth and gums. Yield any questions about dental health to the CPA. The American Academy of Pediatric Dentistry and the AAP recommend that parents:

- Brush their baby's teeth with a soft toothbrush and a small smear (about the size of a grain of rice) of fluoride toothpaste.
- Continue breastfeeding.
- Schedule an oral health assessment with the primary healthcare provider by 6 months of age.
- Establish a dental provider for the infant by 12 months of age.

Beyond a Year

By the time a baby is a toddler, parents may find that breastfeeding is second nature and an easy way to help toddler sleep, feel close to a toddler who has become more mobile, and calm a toddler who is upset. Breastfeeding is more than food for children. It is a way to provide comfort and many young children nurse for comfort. They are also easily distracted by things going on around them and often end feedings quickly. They may be so intrigued by activity around them that they do not request many feedings. At other times, they might want to nurse more often. Breastfeeding a young child in public can be challenging. Many parents teach their young child that they will breastfeed "later" in a more discreet location.

New parents often hear well-meaning advice from family and friends questioning whether it is time to stop breastfeeding. Help parents explore their feelings about continuing to breastfeed. Even when feedings begin to diminish, antibodies continue to provide immune protection. Continued breastfeeding also provides comfort for young children. Some suggestions for responses parents use include:

- *My child is growing well.*
- *Our child has been so healthy. I want to keep protecting my child from illness with my milk.*
- *My healthcare provider recommends we keep breastfeeding.*
- *I appreciate your interest. This is a personal decision my partner and I will make together when the time is right.*

Weaning

Weaning begins whenever babies receive foods or liquids other than breastmilk. When other foods replace feedings at the breast, the breasts respond by making less and less milk until it eventually stops. Weaning occurs for many different reasons. Sometimes children show less interest, and sometimes parents lead the way. Sometimes weaning occurs in the early days due to breastfeeding problems such

as low milk production. Sometimes it occurs later as the child grows, begins taking other foods, and gradually takes less and less milk from the breast. Weaning sometimes happens abruptly because of a medical condition that is not compatible with breastfeeding.

Self-Weaning

When children lead the way, they gradually discontinue feedings at the breast on their own, often around the time complementary foods begin. They may continue to seek the breast for comfort, before bedtime, or when they are upset. "Don't offer, don't refuse" is a good strategy to encourage children beyond a year to lead the weaning process. Babies under 1 year of age do not typically self-wean, though offering formula supplements or other foods can cause them to lose interest in breastfeeding.

Parent-Led Weaning

With parent-led weaning, parents make the decision to discontinue breastfeeding. Gradual weaning is easier for both the nursing parent and baby. It helps the breasts remain more comfortable by adjusting to dropped feedings gradually. To wean gradually:

- Discontinue the breastfeeding session the baby is least interested in first.
- After several days or weeks, drop another breastfeeding session.
- Continue to drop breastfeeding sessions until weaning is complete.
- Replace the breastfeeding session with another way of being close with the baby such as reading or cuddling.

Abrupt Weaning

Sometimes parents must wean abruptly due to a medical problem or prolonged separation from the baby or young child. This transition can be stressful emotionally and physically. If possible, suggest that the parent express just enough milk to remain comfortable without draining the breast completely, and then gradually cut back on expressing until milk production ceases. Ice packs can provide comfort and reduce swelling. A firm, non-binding bra might give extra support. If weaning is needed for a medical condition, yield the parent to the healthcare provider about the safety of feeding the expressed milk to the baby. Yield to the DBE, as well, for additional follow-up support.

How Parents Might Feel

Just as there can be a variety of reasons why parents might choose to wean, there are also a variety of feelings that parents might have about the weaning process. They might feel:

- Anxious to wean the baby.
- Relief they will no longer be breastfeeding.
- Sad at the thought of ending this special relationship.
- Conflicted about weaning.
- Concerned about their health or the baby's health if they must wean for a medical reason.

WIC staff can affirm these feelings. For example, "*You have given your baby a special gift that will last a lifetime"* or "*You seem unsure about weaning. This is hard for a lot of new parents.*"

Talking with Parents

New parents tend to grow in their confidence with breastfeeding as time goes on. Nonetheless, they may have many questions as new situations arise. WIC staff can use active listening skills to help them feel confident they can continue to breastfeed as long as they wish.

Open-Ended Questions	Ways to Affirm
▪ Tell me how you feel now that you have a new baby in the house. ▪ What are your breastfeeding goals? ▪ What does/do your partner/family members tell you about how long you should breastfeed? ▪ What have you heard about how long a baby should be breastfed? ▪ What has your healthcare provider told you about giving your baby vitamins? ▪ What have you heard about when to start solid foods? ▪ What have you heard about the weaning process?	▪ The fact you are concerned shows how much you love your baby. ▪ I can tell wanting your baby to be happy is very important to you. ▪ I can see why you might be worried about that. ▪ Many parents wonder about the right time to start solid foods. ▪ Your baby is lucky to have so many people to love.

Bring It Home!
Use the handout, "**Counseling Practice: Ongoing Breastfeeding**" to identify common feelings of new parents throughout the first year of their baby's life and beyond, and to consider open-ended questions and affirmations. Use the handout, "**Role Play: Ongoing Breastfeeding**" to consider common scenarios throughout the continuum of breastfeeding and practice active listening skills to address concerns.

Normal Breastfeeding—Milk Expression

Sneak Preview:
The Level 2 content in the "Milk Expression" section examines reasons parents may wish to express their milk, strategies to remove milk effectively, and ways to build their confidence.

Level 2 Competencies:

- Help parents elicit a milk ejection reflex.
- Show parents how to hand express their milk.
- Advise parents on safe ways to store and handle their expressed milk.
- Teach parents how to use their hands to improve milk yield.
- Support parents who choose to exclusively pump their milk.
- Inform parents who wish to share or acquire milk from other parents about safety issues.

Preparing to Express

Some parents express occasionally such as when they are separated from their baby during the workday, while other parents may pump exclusively. No matter the frequency, parents can face a wide range of emotions and physical challenges. Using a breast pump or hand expressing milk is not always easy, especially in the beginning, and often requires time and patience. If the parent is pumping for many weeks or months (e.g., pumping for a hospitalized infant or pumping after returning to work)

Long-term milk expression can be challenging if milk production wanes or if other problems arise. Anticipatory guidance and ongoing support from WIC staff can make the difference in helping new parents continue their breastfeeding journey.

Ways to Remove Milk

There are three primary ways milk can be removed from the breast:

- **The baby.** Milk needs to be removed at least 8 to 12 times every 24 hours to begin and maintain a healthy milk production. Ideally, the baby will efficiently remove the milk. This requires that they be positioned and latched well, and any complications be addressed (e.g., tongue tie or other medical problems).
- **Hand expression.** Another effective way to remove milk is by hand. It is an important skill for all new parents to learn. Not all parents have handled their breasts and might feel uncomfortable at first. Hand expression will become easier and more comfortable with practice.
- **Breast pump.** Many parents prefer to use a breast pump to remove milk, and feel it is more efficient since it can remove milk from both breasts simultaneously. Using a breast pump takes practice. If early attempts to pump do not yield much milk, parents can become easily discouraged. Reassure them that pumping gets easier with practice.

Indications for Expressing Milk

There are many situations in which expressing milk might be helpful, including:

- Medical situations that prevent directly breastfeeding the baby such as a preterm or sick baby, or medications the nursing parent must take that are not compatible with breastfeeding (i.e., the parent must “pump and dump”).
- Infant situations that make it hard for the baby to latch or transfer milk, such as infant tongue tie, a cleft lip or palate, sucking disorders, inverted nipples, or other issues.
- Rebuilding milk production. The more milk that is removed (either by the baby, by hand, or the pump) the more milk the breasts will make. If production has slowed, expressing milk frequently can help rebuild production.
- Returning to work or school. During any separation from the baby, nursing parents will need to regularly express milk to maintain production. Many parents find that practicing milk expression during maternity leave helps them begin getting comfortable with the technique.
- Parent’s wishes. There are various reasons that some parents prefer to express milk rather than putting the baby to the breast. WIC staff should honor each parent’s wishes and support them in reaching their goals.

Eliciting a Milk Ejection Reflex

No matter how milk is expressed, the key is getting the milk to flow, also called a "letdown" or "milk ejection reflex" (MER). This occurs when *oxytocin* is released. Once milk releases, it is much easier to express it. Some common principles can encourage milk flow.

- **Warmth.** Warmth helps relax the breast tissue and encourage fluids to flow. Apply a warm (*not* hot) wet washcloth or compress to the breast.
- **Massage.** Gentle massage helps stimulate milk flow. Demonstrate simple circular massage with a breast model, moving the fingers around the breast in a circular fashion and then gently stroking down the breast toward the nipple.
- **Relaxation.** Milk does not flow well when the parents feel stress. WIC staff can help them get comfortable relax at the WIC clinic by creating privacy to help them feel safe. If parents express milk at home or another location, encourage them to play calming music to help them relax.
- **Focus on the baby.** Oxytocin release is a conditioned response. The baby feeding directly at the breast stimulates sensory nerve endings to trigger oxytocin release. A conditioned response such as thinking about the baby can also trigger release of oxytocin. Parents can trigger the response by looking at a picture or video of the baby, listening to a recording of the baby's cries or happy noises, or smelling the baby's blanket or article of clothing with the baby's scent.

- **Nipple stimulation.** Gently rolling the nipple between the thumb and index finger may trigger oxytocin release.

Hand Expression

Hand expression is an important skill for breastfeeding parents to learn. Benefits of hand expression include:

- Remove milk when electrical power is not available. Hand expression does not require access to electricity or pump equipment.
- Remove small amounts of colostrum to feed the baby. Colostrum is thicker than mature milk and can be harder to remove with a breast pump. Hand expression assures that every drop can be expressed into a cup or spoon and fed immediately to the baby.
- Increase overall milk yield in the early days. The sensory response of the hand touching the breast triggers better oxytocin release and milk removal.

- Build parental confidence. One study found that in the early days, new parents are often more comfortable using their own hands to express milk. When they see the milk in their breast, it can become a visual cue to reassure them.
- Relieve engorgement. Overfull breasts flatten nipples and make it harder for the baby to latch. Hand expression helps soften the nipple and areola so the baby can latch and relieve fullness.
- Help baby to latch. Dribbling a small amount of hand-expressed milk can entice the baby to latch. Placed it between baby's nose and upper lip to arouse baby's sense of smell and taste.

Steps to Hand Expression

	Step 1 ▪ WIC staff should use a breast model to demonstrate the technique to parents. ▪ Parents can follow along on their own breast, if desired, while you demonstrate the technique. ▪ If "hands on" assistance is needed, yield to the DBE.
	Step 2 ▪ Place thumb and fingers behind the areola, approximately where the baby latches. ▪ If the parent has a large areola, it may be appropriate to place their fingers closer to the areola or within the areola. Some parents find that placing their fingers further back works better. Everyone has their own "sweet spot". ▪ Using a "C" shape, place the thumb on top of the breast where the dark part (areola) meets the lighter part of the breast, or around the 12 o'clock position. ▪ Place the index finger opposite the thumb below the breast where the dark part meets the lighter part of the breast, or around the 6 o'clock position.
	Step 3 ▪ **Press** the fingers back toward the chest wall without lifting them from the breast. ▪ **Compress** the fingers together by bringing the thumb and remaining fingers together and roll them toward the nipple. ▪ **Release** the compression and repeat the process.
	Step 4 ▪ Move hands to other areas of the breast and repeat to release milk from all ducts. ▪ For example, move the fingers to the 3 o'clock and 9 o'clock positions.
	Caution ▪ Do not squeeze the nipple (this is painful and unproductive as there is no milk there). ▪ Do not slide the fingers down the breast (this is not the best way to release milk and can increase inflammation).

Options

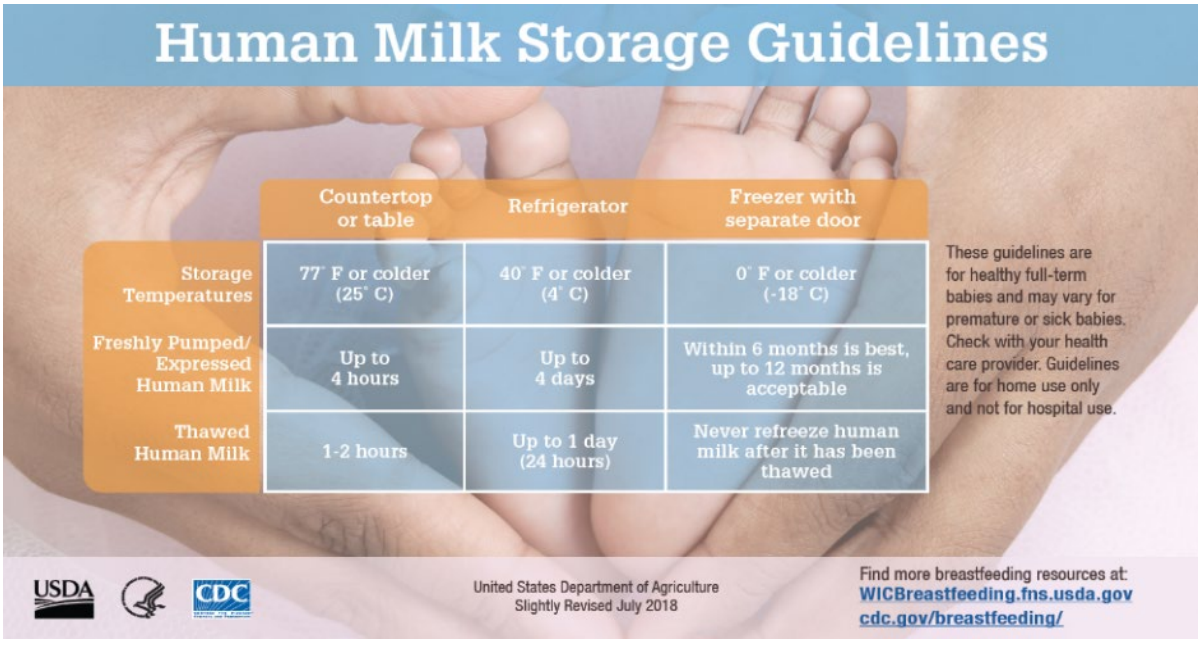
- Parents can express into a bowl or cup. This wide-mouth container can help capture the spray of milk to reduce waste.
- If expressing small amounts of colostrum for a newborn, a spoon or small medicine cup can work well.

Handling Milk

Human milk needs to be stored and handled safely to protect it and keep it from spoiling. Remind parents to always begin milk expression by washing their hands and using clean collection containers.

Storing Milk

Store expressed milk in clean glass or Bisphenol A (BPA)-free plastic bottles with tight-fitting lids. Sturdy polyethylene milk storage bags that seal well might work for storing milk when returning to work or school. If parents are expressing milk for a preterm baby, urge them to talk with the hospital's NICU nurse about the containers to use and any storage policies they want parents to follow.



Store milk in in small quantities (2-4 ounces), or less as appropriate. Milk for preterm babies may need to be stored in even smaller quantities based on guidance from the hospital. Label the milk with the

baby's name and date the milk was collected. The labels can help parents identify which milk should be used first (i.e., first in, first out method, so long as it is not past storage time frames).

Milk storage guidelines from the WIC Program and the Centers for Disease Control and Prevention (CDC) are available at the FNS WIC Work Resource System website. The guidelines are for storing milk for healthy full-term babies on the countertop or table, in the refrigerator, or in a freezer. Storage times may vary for preterm or sick babies. Urge parents to check with the baby's provider or hospital. Milk storage guidelines to consider:

- Keep frozen milk in the back of the freezer. Do not store it on the shelves of the freezer door.
- When adding freshly pumped milk to frozen milk, chill the expressed milk first.
- Thaw milk in the refrigerator overnight, under lukewarm running water, or in a warm water.
- Never thaw milk in a microwave as this creates hot spots that can burn the baby's mouth. It also breaks down important nutrients in the milk.
- Thawed frozen milk does not have to be warmed before feeding it to the baby.
- Test milk temperature by dropping some milk on the wrist.
- Use milk within one hour after it is thawed, or place in the refrigerator and use within 24 hours.
- Discard unused milk left in the bottle within 1-2 hours after the baby is finished feeding.
- Milk that has been thawed should never be refrozen, even if it has been refrigerated.

Bring It Home!
Visit the WIC Breastfeeding Support website at https://wicbreastfeeding.fns.usda.gov/storing-and-thawing-breast-milk to learn more about guidelines for handling and storing human milk.

Pumping

WIC participants might request a breast pump because they have a preterm baby, or the baby or parent are too ill to directly breastfeed. They may find breastfeeding painful or have returned to work or school. They may believe pumps are a WIC program benefit and feel entitled to one. The USDA Food and Nutrition Service guidance with priorities for providing breast pumps includes participants who:

- Are breastfeeding exclusively.
- Have difficulty establishing or maintaining adequate milk production.
- Will be separated from their babies (e.g., hospitalization or returning to work/school).
- Have a temporary breastfeeding problem such as engorgement.

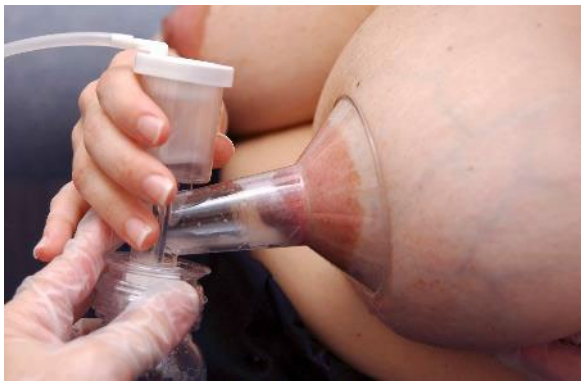
WIC staff should never promise a breast pump to WIC participants without first assessing their need for it. Staff should offer anticipatory guidance about using the pump within the context of the participant's situation, with detailed instruction and follow-up to ensure the pump is used appropriately. Once a participant meets the agency's criteria for receiving a pump, they will need ongoing support from a peer counselor or WIC staff to help prevent and address common challenges with using the pump.

Basic Steps to Pumping

1. **Explain instructions.** WIC staff who issue pumps should always explain the assembly and use of the pump, following manufacturer directions. Ask participants to demonstrate pumping to be

clear they understand. Remind them of the tips discussed in the "Eliciting a Milk Ejection Reflex" to help (e.g., warmth, massage, and relaxation).

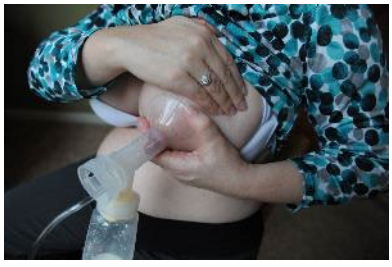
2. **Attach pump flanges**. Use a breast model to show how to attach the pump flanges to the breast. The flange (or "horn" part of the pump) should be centered over the nipple. The goal of pumping is comfort, efficiency, and best milk yield. Flange size is dependent on breast size and may even differ between breasts. The breast flange should not have space on their side and should be comfortable for the parent. If there are concerns, yield to the DBE to assess.
3. **Hold flanges gently against the breast**. Holding it too firmly can block milk ducts.



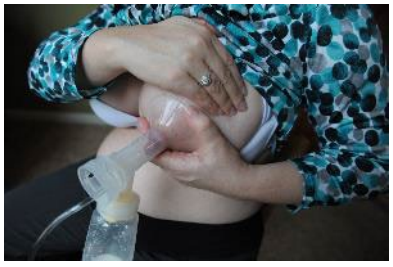
4. **Start the pump**. Turn on the pump. If it has adjustable vacuum options, start at a low vacuum, and increase to comfort. If pumping is painful, turn off the pump and yield to the DBE to assess.
5. **Pump for around 15-20 minutes**. If pumping is comfortable, the session can last around 15-20 minutes or until milk stops flowing. If using a manual pump or pumping one breast at a time, massaging the breast with the opposite hand will help increase milk flow. When milk no longer flows, switch to the second breast.
6. **Disconnect from the pump**. Turn off the pump *before* removing the flanges. After the pump motor stops, remove the flanges, and pour the milk into storage containers.

Hands-On Pumping

"Hands-on Pumping" is a technique that has been found in research to help double milk yield compared with regular pumping alone.



Stimulate milk flow. Massage breasts before and during pumping to help stimulate milk flow during the pumping session.



Breast compressions. Compress breasts by placing hands around the breast in a "C" shape. Gently compress to squeeze milk through the ducts.

Hand express. After pumping, remove additional milk by hand expression. This helps release the hormone oxytocin to release more milk.

Exclusive Pumping

Some participants prefer to exclusively pump their milk rather than directly feeding the baby at the breast. Others might wish to pump some of the time and directly feed at other times. Their reasons can vary. They might:

- Feel embarrassed to directly breastfeed.
- Have experienced breastfeeding problems and feel pumping is their only option.
- Have a strong need to know exactly how much milk the baby receives.
- Feel it will be easier to be away from the baby so others can help feed the baby.
- Feel it is more socially acceptable to use a breast pump.
- Have a prior history of sexual abuse.

No matter the reason, expressed milk still provides important nutrients and infection-fighting components for babies. When participants choose to exclusively pump, yield to the DBE to develop a plan for maintaining milk production within the parent's unique situation.

Milk Sharing

WIC participants often questions whether it is safe to use milk from other breastfeeding parents. Milk sharing has risen dramatically in the U.S. as more people have learned about the importance of human milk. When breastmilk is shared between mothers with extra milk to give, it is referred to as informal milk sharing. Breast milk that is informally shared between mothers is not pasteurized or tested like breastmilk that is donated to a Milk Bank accredited by the Human Milk Banking Association of North America (HMBANA).

The Food and Drug Administration's (FDA) guidelines urge that parents who wish to share or acquire milk from others consult with the baby's healthcare provider about its safety, consider possible risks, and not purchase or use milk acquired through the internet. If a WIC participant reports they want to give their baby milk from someone else, even a family member, advise them to consult their baby's healthcare provider. Yield also to the DBE to assess the reasons the participant feels they cannot provide their own milk and to help establish a care plan for increasing milk production, if needed.

Bring It Home!
Visit the FDA website at https://www.fda.gov/science-research/pediatrics/use-donor-human-milk to learn more recommendations around using donor milk.

Talking with Parents

Expressing milk is not always easy, whether doing so by hand or with a breast pump. WIC staff can encourage parents and reassure them that milk expression gets easier in time. Some parents find it is easier to learn to pump while the baby is nursing on the other breast. It can also help to express milk during a time of day when the breasts feel fuller. Suggest that participants express milk at similar times every day to help their body adjust to releasing milk during those times.

A participant's feelings about expressing milk can change over time. Some are anxious about breastfeeding in the beginning and grow more confident. Some are eager in the beginning and grow weary and frustrated over time. Active listening skills are an important way to help parents feel more relaxed to hear the important ways to get breastfeeding off to a good start.

Open-Ended Questions	Ways to Affirm
▪ What are your breastfeeding goals? ▪ What have you heard about expressing milk? ▪ How do you feel about using a breast pump? ▪ What do your family members say? ▪ What worries you most about expressing milk? ▪ Who is your greatest support? ▪ Describe a typical day for you and your baby.	▪ You are really working hard to make this work. ▪ It's obvious how much you love your baby to want to give your milk. ▪ What a priceless gift you are giving your baby! ▪ Your baby is lucky to have a parent who cares this much. ▪ Most parents worry about pumping enough milk. ▪ You should be proud. You are doing a great job!

Bring It Home!
Use handout, "**Counseling Practice: Milk Expression**" to identify common feelings of parents who are expressing milk and consider open-ended questions and affirmations. Use the handout, "**Role Play: Milk Expression**" to consider scenarios related to expressing milk and consider ways to use active listening skills to address concerns.

Normal Breastfeeding—Parent/Baby Separation

Sneak Preview:
The Level 2 content in the "Parent/Baby Separation" section addresses strategies to help participants combine breastfeeding when they must be separated from their baby.

Level 2 Competencies:

- Support participants to continue breastfeeding when they must be away from their baby.
- Assist participants in maintaining milk production when they are separated from their baby.
- Help participants identify solutions for time and space to express milk at work or school.
- Help participants prepare themselves and their baby for separation.

Reasons for Separation

A variety of situations may separate new parents from their baby. Parents may also have varied feelings about the separation. WIC staff can be sensitive to all participants and provide targeted support no matter their situation, regardless of whether milk expression is possible or desirable.

Reason for Separation	Reasons to Continue Breastfeeding	Supporting Parents
Sick or hospitalized parent	▪ Help keep breasts from becoming painfully full/engorged. ▪ The parent can continue to provide benefits of human milk to the baby. ▪ Expressing milk can be something important only the parent can do. ▪ Preserve connection with the baby.	▪ Parents might feel: • Too ill to consider breastfeeding • Sad at the loss of control • Worried about transferring the illness • Frustrated if staff are not supportive of breastfeeding ▪ Affirm the parent's feelings. ▪ Suggest discussing breastfeeding goals with their healthcare providers. ▪ Praise, even if parent unable to express milk. ▪ Urge contacts with the hospital lactation consultant. ▪ Yield to the DBE for any specialized assistance needed.
Sick infant	▪ Infection-fighting ingredients in human milk are important in helping a sick baby battle infection and disease.	▪ Parents might feel: • Fear for baby's well-being • Sadness at being separated • Exhausted with hospital trips to visit the baby • Anxious about medical treatments and procedures • Worries over ability to produce sufficient milk ▪ Affirm the parent's feelings. ▪ Remind that production can rise or drop depending on how the baby is doing. ▪ Encourage hands-on pumping to increase production. ▪ Suggest discussing breastfeeding goals with healthcare providers. ▪ Praise for any amount of milk provided to the baby. ▪ Peer counselors provide ongoing support under DBE guidance. ▪ Yield to the DBE for follow-up support and assistance.
Preterm infant	▪ Preterm human milk is higher in fat, proteins, certain minerals, and infection-fighting ingredients than term milk. ▪ Preterm babies receiving human milk are less likely to develop necrotizing enterocolitis, retinopathy of prematurity, and respiratory illnesses. ▪ Preterm babies receiving human milk have greater brain development. ▪ Kangaroo care helps preterm babies stabilize and develop better. ▪ Helps parents feel they are doing something vital for their baby's survival. ▪ Empowers parents when NICU team has taken over baby's care.	▪ Parents might feel: • Relief that the baby is cared for by experts • Anxious about medical equipment, tubes, etc. • Worried about baby's well-being • Sad at not completing the pregnancy ▪ Affirm the parent's feelings. ▪ Suggest expressing milk as soon as possible after the baby's birth (preferably within the first hour). ▪ Praise for expressing milk for the baby. ▪ Remind that milk production can rise or drop depending on how their baby is doing. ▪ Encourage hands-on pumping to help increase production. ▪ Suggest discussing breastfeeding goals with healthcare providers and nurses. ▪ Yield to the DBE for strategies to maintain and rebuild milk production if needed, and to assist with breastfeeding when baby is ready.

Reason for Separation	Reasons to Continue Breastfeeding	Supporting Parents
Returning to work	▪ Helps preserve an important connection between parent and baby. ▪ Better health for infants, especially if enrolled in child care. ▪ Healthier baby means parents less likely to miss work to care for a sick baby. ▪ Saves money for the family and employer. ▪ Expressing at work helps an employee relax.	▪ Parents might feel: • Fulfilled at being back at work • Sad or guilty for leaving the baby • Exhausted juggling the demands of work and home • Frustrated over time demands ▪ Affirm the parent's feelings. ▪ Inform about Federal and state laws that protect the right to express milk at work. ▪ Suggest discussions with supervisor during pregnancy about needs. ▪ Encourage exclusive breastfeeding when home with the baby to maintain strong milk production. ▪ Suggest connecting with other nursing employees. ▪ Praise for any amount of breastfeeding possible. ▪ Yield to the DBE if milk production diminishes or further help is needed.
Returning to school	▪ Breastfeeding helps parents recover from pregnancy faster by helping the uterus contract to its pre-pregnancy size. ▪ Empowers parent to care for their baby. ▪ Builds responsibility in the parent. ▪ Baby is healthier. ▪ Student is less likely to miss classes to care for a sick baby.	▪ Parents might feel: • Proud of the decision to continue their education • Envious of friends and want to return to former activities • Tired, especially if school policies do not allow for a long maternity leave • Shy to talk about breastfeeding needs with school officials • Frustrated over demands of school and caring for the baby ▪ Affirm the parent's feelings. ▪ Suggest discussing needs with a trusted teacher or counselor. ▪ Explore options for expressing milk while at school. ▪ If unable to express milk at work, offer suggestions to remain comfortable and breastfeed when with the baby. ▪ Praise for any amount of breastfeeding possible. ▪ Yield to the DBE if milk production drops or help needed with expressing milk.
Occasional outings	▪ Expressing milk for short separations can usually be managed easily. ▪ Breastfeeding is comforting for babies. ▪ Reconnection after the separation can be sweet.	▪ Parent might feel: • Excited at the chance to take a break from baby • Guilty over wanting the break • Worried about how baby will do when apart • Anxious about the baby taking a bottle or managing the logistics of expressing milk ▪ Affirm the parent's feelings. Provide assurance that they are good parents. ▪ Praise for any amount of breastfeeding. ▪ Encourage planning ahead to express milk before leaving so the caregiver will have milk to feed the baby. ▪ If away for more than 2-3 hours, suggest hand expression or pumping with a manual pump to keep breasts from becoming overly full. ▪ Follow agency guidelines for providing breast pumps for occasional outings.

Maintaining Milk Production

No matter the reason for the separation, parents sometimes need help maintaining their milk production. Sometimes they begin supplements because if they feel their production has declined. (See *Low Milk.*)

Keep the "Magic" number constant:

1. Suggest that parents keep track of the number of times the baby is breastfed every 24 hours. This number will be different from parent to parent depending on the size of the storage capacity in their breasts.
2. This number is the parent's "Magic" number.
3. Parents can use this guide for the number of times to breastfeed or express when separated from their baby.
4. If missing a feeding or milk expression time, parents should get back to the magic number as soon as possible to maintain production.

Returning to Work

Federal Legislation

The Fair Labor Standards Act (FLSA) requires employers to provide non-exempt breastfeeding employees with:

- **Private space** to express milk during their work period. The space does not have to be a room dedicated for the sole purpose of milk expression. Flexible spaces such as a conference room or manager's office can also be used. The space must be private, "shielded from view and free from intrusion from coworkers and the public." It also cannot be a bathroom.
- **Reasonable time** to express milk at work. The frequency of breaks needed to express milk will vary, as will the duration of each break. Employers are not required to compensate employees for breaks used to express milk. However, if paid breaks are provided to employees, they may not withhold compensation when the employee uses the break to express milk.

State Legislation

Many states have workplace breastfeeding laws that provide greater protection than the Federal law. Employers must follow either the Federal or State law, depending on which one provides the greater protection to breastfeeding employees.

Bring It Home!
Visit the website of the National Conference of State Legislatures at https://www.ncsl.org/research/health/breastfeeding-state-laws.aspx to learn about breastfeeding laws available in your state.

Talking with Supervisors

Encourage parents to discuss their breastfeeding plans with their supervisor during pregnancy. This gives the supervisor time to consider the parent's needs and prepare adequately. The HHS *Employee's Guide* suggests that parents focus on their needs for support when approaching supervisors, and that

they demonstrate a good faith effort to meet the requirements of their job. Suggest scripted language like the following:

It is important to me to be a good employee. It is also important for me to meet the needs of my new baby. My healthcare provider recommends that I breastfeed my baby. Your support will make it easier for me. I have been thinking about this, and I have some ideas we could discuss.

The HHS resource, *Outreach Marketing Guide,* includes a sample "Letter from the Employee's Physician to Employer" that parents could ask their healthcare provider to sign. This letter indicates that the healthcare provider has urged the parent to continue breastfeeding and asks the employer to provide basic support accommodations.

Bring It Home!
Visit the HHS Office on Women's Health website at https://owh-wh-d9-dev.s3.amazonaws.com/s3fs-public/documents/bcfb_outreach-marketing-guide.pdf to retrieve the sample letter from physicians to employers.

Breastfeeding and Milk Expression Options

Suggest that parents consider a gradual return to work, if possible. Returning to work slowly can give their bodies time to adjust physically and emotionally. Options could include working part-time for a week or more before returning to work full-time or taking a day off mid-week to give the body time to boost production. Returning to work toward the end of the workweek can also provide a long weekend to replenish milk production before being gone all week.

Parents can also explore options for how they will express milk at work, which might include:

- Exclusively breastfeed until the return to work, and express milk during the workweek when separated from the infant.
- Store expressed milk for use when they return to work.
- Bring the baby to work if the supervisor approves and the work environment is conducive for having a baby in the workplace as this will eliminate the need to pump.
- Ask a caregiver to bring the baby to the parent for direct feedings at work.
- Feed the baby directly at the childcare provider during the meal break and express milk at other times.
- Breastfeed when with baby and use formula when they are separated.
- Wait until they are ready to return to work to make decisions about continuing to breastfeed.

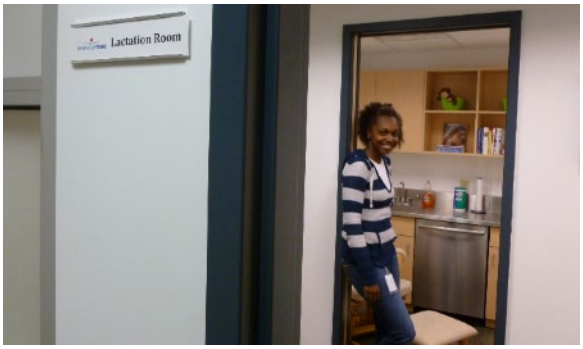
Talking with Coworkers

Many parents worry that their work colleagues may not support them taking milk expression breaks. Suggest they speak with their coworkers before their baby is born and let them know that the baby's provider has advised continued breastfeeding for both the employee and the baby's health. Remind parents to be sensitive if coworkers share their own stories of failed breastfeeding attempts. Everyone wants to be heard and to feel they are good parents.

Space Solutions

Solutions abound for supporting breastfeeding employees at work. The HHS Office on Women's Health has many ideas and solutions for milk expression in a wide variety of industry settings, including lower-wage job settings that many WIC participants might be employed in. Options include:

- **Dedicated lactation rooms.** Milk expression rooms created from converted office areas, storage rooms, closets, or other small spaces.
- **Flexible options**. Conference room, office of a colleague, or inexpensive dividers or partitions that create privacy within a larger area.
- **Outdoor options**. Pop-up tents, or access to the company's indoor office space at a worksite.



Bring It Home!
Visit the HHS Office on Women's Health website at https://www.womenshealth.gov/supporting-nursing-moms-work for solutions for supporting breastfeeding employees in a variety of industries.

Bring It Home!
Use the handout, "**Workplace Solutions**" to brainstorm creative options for space in various workplace settings. Or make a list of the workplaces you feel many WIC participants in your community are employed. Brainstorm creative options for space in each of those work environments.

Time Solutions

Most breastfeeding employees need to express milk around every 2-3 hours, or 2 to 3 times in a typical 8-hour work period. Most parents need around 15-20 minutes each time to express milk, plus time to get to and from the milk expression area, clean pump equipment, and store their milk. Parents should discuss the time they need with their supervisor. If extra time is needed beyond the usual breaks, some parents arrive a little early or stay a little late to make up the time. Some parents use accrued vacation or other leave time, if available. Some companies do not track extra time taken as long as the time is not abused.

Returning to School

Although there are no Federal laws around breastfeeding support or student parents, several states have enacted legislation. Some states have legislative, policy, and outreach initiatives underway to increase support for breastfeeding students.

Who to Approach

Encourage K-12 students to approach their school counselor and school nurse about their plans to breastfeed when they return to school. It's best to begin the conversation during pregnancy to allow time for officials to consider options. For college students, the work-life office may have policies around supporting both employees and students. Students should inform their department head and relevant faculty to identify solutions for milk expression schedules.

Milk Expression at School

Help WIC participants consider a milk expression schedule within the context of their school schedule that helps them maintain milk production. College and university students might have more flexible options if they can select their class schedule before the baby is born. High school students might find it challenging to express milk if they have a full class load throughout the day with courses required for graduation. Students should discuss options with school officials and teachers about any flexibility needed for class passes when arriving at a class late or leaving early.

Schools use a variety of options for milk expression locations, including:

- Student health clinic or nurse's office
- Empty or seldom used office
- Teacher resource library

Bring It Home!
Use the handout, "**Sample Pump Schedule at School**" to consider options for setting up time to express milk at school.

Child Care

Childcare options for parents who are separated from their baby are childcare centers, home-based childcare, family childcare, or a combination of options. The Child and Adult Care Feeding Program (CACFP) authorizes reimbursement to participating childcare providers when parents provide their expressed milk for their babies, and when they directly breastfeed their infants at the childcare facility.

Preparing Baby

Parents may worry that their breastfed baby will not take a bottle. Encourage exclusive feedings at the breast during the first 3-4 weeks to build production. Babies often accept a bottle or cup when offered before 6 weeks, or 2 weeks before returning to work or school, whichever comes soonest. Parents can try offering small practice feedings of an ounce or so when baby is not overly hungry or fussy. If baby resists the bottle, they can try again later. Reassure parents that most babies will accept a bottle from childcare providers or someone else besides the parent. Remind them that many babies "cluster feed" when they are reunited with the parents after the separation. Many babies may "reverse cycle feeding" where they breastfed more when they are with the parent and go longer periods without taking a bottle when they are with the caregiver. Both are normal.

Talking with Parents

Parents who are separated from their baby have a wide variety of emotions and sometimes challenges when attempting to continue to breastfeed. WIC staff can use active listening skills to help parents feel validated in their concerns and ready to hear strategies that can help.

Open-Ended Questions	Ways to Affirm
▪ What are your breastfeeding goals? ▪ What have you heard about expressing milk at work? ▪ What worries you most about expressing milk? ▪ Who is your greatest support? ▪ Describe a typical day for you and your baby. ▪ Describe your work/school situation. ▪ What solutions have you already thought of?	▪ It is obvious how much you love your baby. ▪ Most parents worry whether they can make enough milk when they are separated from their baby. ▪ It sounds like you are feeling overwhelmed about expressing milk when you are away from your baby. ▪ Many moms need a little practice expressing milk at work. ▪ You should be proud. You're doing a great job!

Bring It Home!
Use the handout, "**Counseling Practice: Mother/Baby Separation**" to identify common feelings of parents separated from their infants. Use the handout, "**Role Play: Mother/Baby Separation**" to consider scenarios related to separation and ways to use active listening skills to address concerns.

Problem Solving—Common Maternal Issues

Sneak Preview:
The Level 2 content in the "Common Maternal Issues" section addresses prevention of and strategies to address common maternal breastfeeding concerns such as breast and nipple pain. It also addresses when to yield to the DBE.

Level 2 Competencies:

- Recognize when nipple and breast pain occur with breastfeeding.
- Assist parents in preventing common breast and nipple pain concerns and make appropriate yields.
- Provide information to assist parents experiencing normal breast and nipple pain.
- Recognize factors that can compromise breastfeeding and make appropriate yields.
- Provide support to parents facing breastfeeding challenges.

Sore Nipples

Signs

Nipple pain is one of the most common breastfeeding concerns of WIC participants. It can range from mild discomfort or tenderness in the early days to more extreme pain. Sore nipples are a sign that something is not working properly. Parents will need support and easy solutions for quick pain relief.

Causes

- **Incorrect latch** is the most common cause for nipple pain. Often adjusting the baby's position or latch can alleviate discomfort and pain. When simple adjustments do not alleviate pain, yield to the DBE to assess other possible causes.

- **Poor feeding practices** (such as delaying or shortening feedings) can lead to nipple pain. Some common issues might be "holding the baby off" from feedings with a pacifier or not feeding the baby 8 to 12 times every 24 hours. This can cause the baby to become overly hungry and suck more vigorously. Ending the feeding too soon can prevent the baby from getting sufficient calories and continue to be hungry.
- **Bacterial infections** can occur when there are breaks in the skin. Signs include tender breasts, redness, or swelling of the nipple tissue. There might also be fluid oozing from the wound.
- **Yeast** can occur when *Candida* overgrows. This can cause a burning, shooting pain in the breast. Babies can sometimes pass *Candida* to the birth parent during the delivery. Or the parent might be at high risk of vaginal yeast infections or took an antibiotic that destroyed both bad bacteria and the good bacteria that keeps yeast in check.
- **Other common causes** can include:
  - Rash, eczema, or other skin condition
  - Using products such as perfumes, lotions, and scented soaps on the breast
  - Using a breast pump incorrectly or the wrong-sized pump flange

Questions to Ask

- Tell me when these concerns began.
- Describe how your breast or nipples feel.
- How long does the pain last?
- Describe any discoloration or signs of infection (such as pus or red streaks).
- Tell me how you are positioning and latching the baby.
- What have you already done to address the concerns?

Tips/Solutions

- **Prevention** – Strategies to avoid sore nipples include:
  - Feed the baby often - 8 to 12 times every 24 hours.
  - Assure good positioning and latch.
  - End feedings when baby independently detaches.
  - Seek help if there are concerns.
  - Allow breasts to air dry after feedings and keep nursing pads clean and dry.
- **Before feedings** – Strategies to help minimize or alleviate pain include:
  - Start the feeding on the breast that is *least sore.*
  - Try different breastfeeding positions to compress different areas of the breast.
  - Massage the breast to help milk begin flowing.
- **During feedings**
  - Position and latch the baby effectively to avoid further damage.
  - Do not limit feedings if the latch is comfortable and baby actively swallows.
  - Detach baby by slipping a finger in the corner of the mouth to break suction.
  - Remove milk by hand or with a breast pump if feedings have damaged the nipples.

- **After the feedings**
  - Hand express small amount of milk and gently rub into the nipple.
  - Avoid creams and lotions that must be removed before baby can feed.
  - Yield to the DBE to assess and recommend solutions.

Yield

Yield to the DBE if:

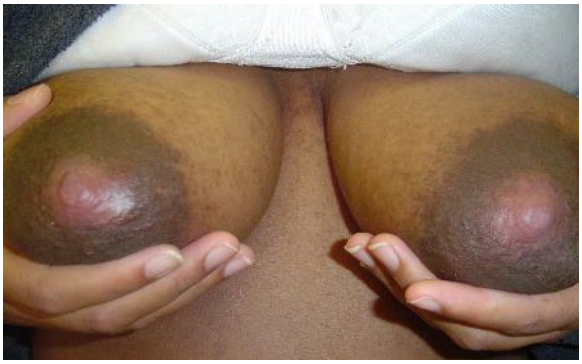
- Basic solutions have not improved sore nipples within 24 hours.
- Nipples are cracked and bleeding.
- Baby has white patches in mouth, or parent has a yeast infection or recently took antibiotics.
- There are other causes of sore nipples (e.g., tongue tie, pump use, skin conditions, etc.).

Engorgement

Most new parents experience changes in their breasts between days two and five as the transition to mature milk begins. The breasts become full as the volume of milk increases, blood flow increases, and extra fluids are carried to the breast. With normal fullness, milk continues to flow well, and the baby can latch and breastfeed. However, when breasts become *overly* full, they can become engorged.

Signs

The breasts are reported to be painful or feel "*as hard as a rock*." There might be a low-grade fever (101°F). The baby may suddenly refuse to latch. When the breast becomes overly full, the areola can become swollen and hard, and the nipple might flatten, making it harder for the baby to latch.



Causes

Engorgement can occur when extra blood flow and fluids are compounded by excess milk that is not removed from the breast. This might happen because:

- The baby has not had a good latch and did not remove enough milk.
- The baby is too sleepy to wake for feedings (especially at night).
- Parents might be busy and wait too long between feedings.
- Feedings might be scheduled instead of feeding the baby on cue.
- Parents might turn to other ways to soothe the baby, such as using a pacifier.
- The baby might be receiving supplemental formula.

Questions to Ask

- When did you first begin feeling full?
- Describe the fullness.
- What changes have you noticed in your breasts (e.g., redness, warm to the touch, shiny)?
- Describe any lumpy areas.
- Tell me about any issues you are experiencing with your baby latching.

- How often is your baby feeding at the breast? How long do feedings last?
- What measures have you already taken to try and alleviate the fullness?

Tips/Solutions

- **Prevention** – Strategies to prevent engorgement:
  - Educate parents on normal breast anatomy and the physiology of lactation.
  - Ensure there is a good latch and educate parents about the signs that the infant is transferring sufficient milk from the breast.
  - Feed the baby on demand, and do not aim to "empty" the breasts.
  - Wear an appropriately fitting supportive bra.

- **Before the feeding** – Strategies to soften the breast so the baby can latch include:
  - Heat can increase inflammation and worsen engorgement., but it may provide comfort to some patients.
  - Massage the breast gently.
  - If pumping, yield to a DBE to assess pumping to see if modifications in flange size, suction level, pumping duration, etc. are needed.

- **After the feeding**
  - If the breast remains overly full, express just enough milk for comfort, not to empty the breast.
  - Apply an ice pack (or a bag of frozen peas) on the breasts between feedings to help relieve swelling.
  - Avoid bras and clothing that constrict the breast or cause pressure.
  - Talk with the healthcare provider regarding pain management.

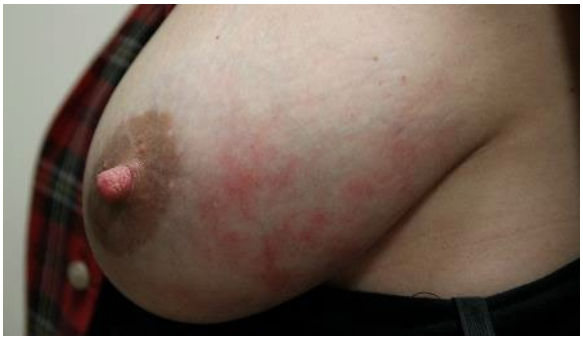
Yield to the DBE if:

- Basic solutions have not improved engorgement within 24 hours.
- There are fever, flu-like symptoms, or reddened area(s) on the breast.
- There is a breast infection, such as mastitis.
- The parent reports the breasts still feel uncomfortably full despite basic recommendations.

Plugged Ducts

Signs

Occasionally milk can collect in the milk ducts and form a tender, small lump. There may be a painful or reddened lump. If it is located close to the skin, a lump might be visible. A whitish plug can sometimes be seen at the opening of a nipple pore.



Causes

Plugged ducts typically result from inadequate milk removal or pressure placed against a milk duct. This can be caused by:

- Engorgement
- Overfullness

- Pressure from a tight-fitting or underwire bra, rolling the bra up over the breast while feeding, straps from a purse, backpack, or diaper bag

Questions to Ask

- Describe the lumpy area.
- Describe any other symptoms (such as fever, red skin, warm to the touch).
- Describe anything that might have put pressure on your breasts recently.
- What does it feel like when you press on the lumpy area?
- How often are you breastfeeding?
- What have you tried to address the concern?

Tips/Solutions

- **Before the feeding**
  - Place a warm (*not* hot) compress over the plugged area to help stimulate milk flow.
  - Gently massage over and behind the plugged area and stroke toward the nipple to help dislodge and loosen the plug.
  - A warm shower might help.
- **During the feeding:**
  - Feed the infant on demand.
  - Feed on the breast with the plugged duct first so vigorous sucking to help clear the plug.
  - Position the baby so the chin or nose is in line with the plug.
  - Alternate positions to drain other areas of the breast.
  - Assure the baby is positioned and latched well.
  - Gently massage the plugged area while the baby is feeding.
  - Allow the baby to feed for as long as desired on the affected breast.
- **After the feeding:**
  - Use basic strategies to alleviate pain and help the breast drain well.
  - If the breast remains full, express some milk by hand or with a breast pump to help loosen the plug and relieve fullness.
  - Avoid constricted clothing or objects that can press against the breast.

Yield

Yield the parent to the DBE for further assessment if:

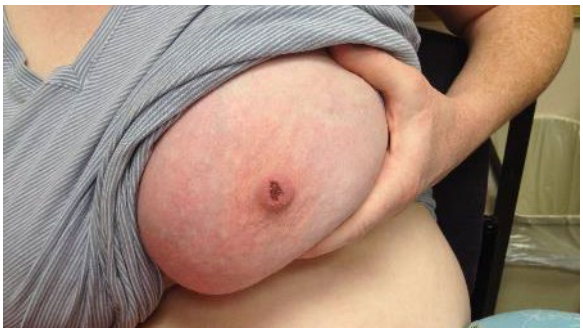
- Basic strategies do not dislodge the plug within 24 hours.
- There is fever, flulike symptoms, a reddened area on the breast, or other symptoms of a breast infection such as mastitis.
- The hardened area does not shrink after breastfeeding or removing milk, or it changes in size or shape.

Mastitis

Signs

Mastitis is a breast infection that can occur in the early weeks after delivery but can occur at any time during lactation. Signs include:

- Fever >101°
- Chills
- Body aches
- Painful breast(s) that might be red and hot to the touch



Causes

- Untreated engorgement or a plugged duct not properly treated
- Bacteria entering the breast through a cracked and bleeding nipple or nipple piercing.
- Excessive fatigue or stress
- Medical condition such as diabetes

Questions to Ask

- Tell me more about what you are feeling.
- Describe any fever you have.
- Tell me what your breasts look and feel like.
- Describe some of your recent activity.
- What does your healthcare provider say?

Tips/Solutions

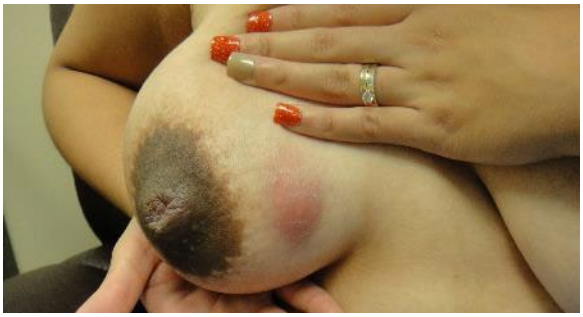
- **Prevention:**
  - Report cracked/bleeding nipples or breast trauma promptly to healthcare provider for evaluation and treatment.
  - Yield to the DBE evaluate the baby's latch.
  - Avoid practices that can cause inflammation to the breast including, but not limited to pumping with an incorrect flange size or with the suction too high, or deep massage of the lactating breast.
  - Avoid missing feeding sessions.
  - Feed on demand, keeping the breasts well drained to prevent engorgement if they remain full after feedings.
  - Avoid extra/unnecessary pumping sessions or breastfeeding sessions that could result in an oversupply.
  - Avoid excessive activity in the early days and get rest.
- **Comfort measures:**
  - Seek medical attention promptly.
  - Continue breastfeeding. The milk is safe for the baby.
  - To decrease inflammation and swelling, apply an ice pack (or a bag of frozen peas) on the breasts after or between feedings.
  - Refer to the participant's healthcare provider for pain management including any prescribed or over-the-counter medications.
  - Use a warm compress on the affected breast before feedings to help milk flow.
  - Feed the baby on demand. If the baby rejects the breast or does not remove milk efficiently, express milk to keep the breast comfortable and well drained.

Untreated mastitis can increase illness and more serious problems. Yield to the CPA/DBE for referral to healthcare provider and for further assessment if the parent reports signs or symptoms of mastitis.

Abscess

Signs

An abscess is a pocket of pus confined to one area in the body. It can occur anywhere on the breast. Some common signs:



- A reddened area that is raised and swollen (though it is not always visible if it occurs deep in the breast tissue).
- The area is hot to the touch.
- Breast tissue around the area is swollen.
- There is a high fever.

Causes

An abscess in the breast is often linked to mastitis. If milk is not removed from an infected breast, bacteria can grow. This can occur when the treatment for mastitis is not completed or resolved. An abscess can also be caused by bacteria entering through an opening in the skin, such as a cracked nipple.

Questions to Ask

- Tell me more about what is worrying you about your breast.
- What changes have you noticed?
- Describe any redness on your breasts, or fever you might have.
- When did you first begin noticing the concerns?
- Tell me about any sore or cracked nipples that you experienced before this occurred.
- What has your healthcare provider said?

Tips/Solutions

Parents experiencing an abscess should seek medical attention promptly for treatment. While undergoing treatment, parents should:

- Continue breastfeeding if the healthcare provider advises it is safe to do so on the affected breast. The milk is safe for the baby.
- Feed on demand, keeping the breasts well drained to prevent engorgement if they remain uncomfortably full after feeding. The DBE will assist with this.
- Report any issues of cracked, bleeding nipples, or breast trauma promptly to their healthcare provider.
- Follow the healthcare provider's treatment plan for managing the abscess.
- Rest to regain strength and heal.

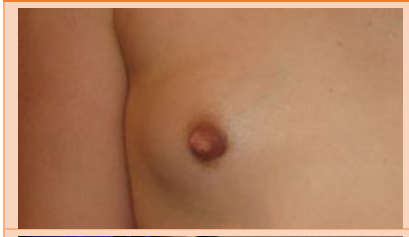
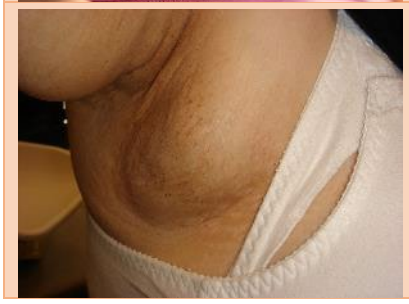
Yield

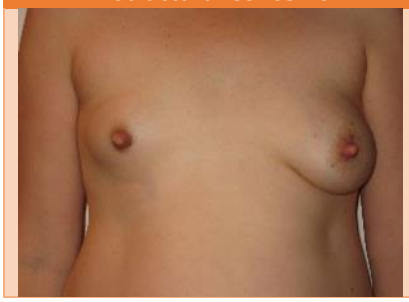
Yield to the DBE when parents report symptoms or issues related to an abscess. During treatment, the DBE will assist with continued breastfeeding. This may or may not include breastfeeding or milk expression on the affected breast(s).

Structural Concerns

Signs

Breasts come in many shapes, colors, sizes, and positions. Sometimes there are variations, but most breasts and nipples work fine. However, sometimes there can be structural issues with the breast or nipple that can make breastfeeding or milk production challenging.

Structural Concerns	Key Principles
	**No Breast Changes** ▪ The breasts should grow glandular milk-making tissue during pregnancy. ▪ Common signs of these changes include breast tenderness, increased breast size, darkened areola, eruption of small bumps around the areola ("Montgomery glands"), and occasional leaking of colostrum. ▪ Lack of breast development changes might occasionally indicate potential milk production concerns.
	**Nipple Size or Shape** ▪ A large nipple or areola can make it challenging for the baby to latch. ▪ A bulbous shape or a nipple that separates into two or three smaller nipples can also pose challenges for latch.
	**Flat/Inverted Nipple** ▪ A flat nipple does not easily protrude. This is common and often resolves by the end of the pregnancy. ▪ Sometimes the nipple inverts. This means that when the baby latches, the nipple retracts back into the breast rather than extending into the back of the baby's mouth. ▪ The incidence of true inverted nipples is rare (only about 3%).
	**Extra Mammary Tissue** ▪ Extra milk-making tissue can occur on the nipple(s) or in other places on the breast or under the armpit. ▪ A small extra nipple may excrete a little milk. ▪ The extra mammary tissue might become engorged. ▪ Extra mammary tissue or nipples do not usually affect the ability to breastfeed or produce milk but can be annoying to the parent until they subside.

Structural Concerns	Key Principles
	**Asymmetry** ▪ One breast is commonly slightly larger than the other. ▪ A dramatic size difference during pregnancy might indicate insufficient glandular tissue. ▪ Widely spaced breasts can be a marker for insufficient breast tissue.

Causes

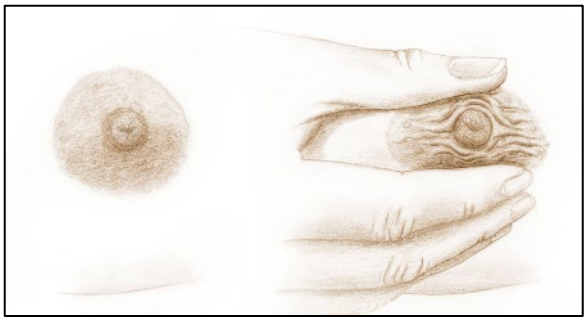
Variations in breasts and nipples can be caused by hormonal conditions, anatomical issues, or lack of breast development. Often these variations are beyond the control of the lactating parent. Occasionally a parent might report breast surgery. In most cases, the breasts can still produce at least some milk. Milk volume may depend on the type of surgery and the way the surgery was conducted.

Questions to Ask

- What worries you most about your nipples or breasts?
- What has your healthcare provider told you about your ability to breastfeed?
- Describe any changes you noticed in your breasts during your pregnancy.
- What have you learned about your ability to breastfeed with your nipple/breast condition?
- What are your breastfeeding goals?

Tips/Solutions

- **Deep latch.** Taking in the nipple and a large amount of the areola can help a baby to latch onto flat or inverted nipples. The nipple elongates during suckling to nearly twice its length at rest. Once the tissue is in the baby's mouth, sucking action helps draw out the nipple.
- **Check the nipple**. Simple steps to identify a possible flat or inverted nipple include:
  - Place the thumb and first finger slightly behind the base of the nipple.
  - Press the fingers together.
- The nipple should protrude when compressed. If it flattens or sinks in, yield to the DBE to assess.



- **Track wet and dirty diapers.** This can help parents know if baby is transferring milk given the structural concern.
- **Feed baby frequently.** Hold baby skin to skin right after the birth and continue feeding 8-12 time every 24 hours.
- **Watch the baby.** Common signs to determine milk transfer include:
  - Swallowing is heard.
  - Baby actively sucks throughout the feeding.

- Baby's hands and feet begin to relax.
- Baby slows down as the milk is drained and baby becomes full.
- Baby detaches from the breast independently.
- Baby falls asleep.

Yield

Yield the parent to the DBE for further assessment and additional referrals if:

- The parent did not experience normal breast changes during pregnancy.
- Parents have questions about the size, shape, or function of their breasts.
- The baby is unable to latch due to structural concerns.
- There is a history of breast surgery.
- There is evidence of insufficient or low milk production.

Yield to the CPA for food package tailoring and weight checks.

Talking with Parents

Parents experiencing early challenges often feel overwhelmed and frustrated, especially if they are also in pain or worried about the baby's well-being. Some parents blame themselves or feel they have failed their baby. Formula might seem like an easy and quick solution. Active listening skills can help parents identify and deal with their feelings. They also help WIC staff understand more so the parent can receive quick relief to these early concerns.

Sample Affirmations	Simple Education Points
▪ What a great parent you are to be breastfeeding through this challenge!	▪ The good news is there are some things we can do to get you some relief!
▪ I can see you are in pain. Many other parents would have given up by now.	▪ Let's find someone who can help you right away.
▪ Thank you for calling for help. It shows you really love your baby to want to work through this.	▪ Here are some quick simple things you can try.
▪ It can be very frustrating to deal with early problems.	▪ We're going to help you turn this around!

Bring It Home!
Use handout, "**Scenarios: Maternal Concerns**" and "**Tips/Solution Cards**" to practice applying the education learned in this section in various case examples. The "Tips/Solution Cards" handout provides a collection of possible solutions that could be considered in each of the scenarios.

Problem Solving—Common Infant Issues

Sneak Preview:
The Level 2 content in the "Common Infant Issues" section addresses causes and strategies for addressing infant concerns such as poor latch, signs of poor or slow weight gain, and other common concerns. It also addresses when to yield to the CPA or DBE.

Level 2 Competencies:

- Recognize common breastfeeding challenges and potential solutions.
- Give support and counseling to parents whose babies do not latch or who latch poorly.

- Give support to parents breastfeeding multiples.
- Make appropriate yields when common challenges are not resolved with basic tips/solutions.
- Build confidence in parents facing common breastfeeding challenges.

Latch Difficulties

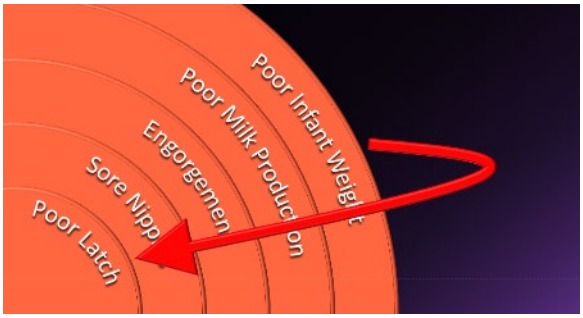
Signs

Many new parents and their babies need a little time in the early days to learn how to breastfeed. Patience and support can help them as they go through this period of learning. Latch issues can set in motion a downward cycle of additional challenges, such as sore nipples, engorgement, poor milk transfer, low milk production, and slow weight gain. Babies who have difficulties with latch might:

- Latch but do not stay latched very long.
- Latch but fall asleep shortly after latching.
- Struggle to get a good latch and fuss and cry.
- Turn their head and refuse to latch at all.

Causes

Some common causes for difficulty latching in the early days are:



- Poor latch or uncomfortable positioning.
- Use of artificial nipples. When sucking from a bottle the milk flows more quickly and requires a different way of sucking. Many babies become impatient when they are back at the breast.
- Discomfort when feeding in certain positions or on a particular side of the parent's body, or preference for a breast due to the flow of milk from that side.
- Overstimulation may cause fussiness. Newborns have heightened senses early postpartum. While this helps them learn how to breastfeed, it also means they can be especially sensitive to external stimuli (such as lights, noises, unique scents, and being handled by many people).
- Illness or congestion can make it hard for the baby to breathe since they require their noses to breathe while nursing.
- Oral thrush can make latching painful.
- Engorged breasts can make it hard to get an effective latch.
- Separation from the parent can cause a baby to reject breastfeeding when they are reunited.
- Distractibility is common in older babies and can cause them to be less interested in feedings.
- A nursing strike can occur and last from a few feedings to several days. It may be from illness, stress, overstimulation, or developmental changes in the baby. Sometimes the reason is unclear.

Questions to Ask

- Tell me how you know when to feed your baby.
- How are you positioning and latching your baby?

- Describe how your baby acts when you try to latch.
- What have you already tried?
- What concerns you most?
- What else does your baby receive besides your milk?
- Are you using bottles or pacifiers?
- Tell me about your baby's wet and dirty diapers.
- What are your breastfeeding goals?
- Who is available to support you?

Tips/Solutions

- Consider skin-to-skin contact to help the baby calm and self-attach when ready, which will release calming hormones in both parent and baby.
- Check for effective positioning and latch.
- Try other positions the baby might find more comfortable. For example:
  - Laid-back breastfeeding can help the baby work with gravity to get a deeper latch. When a baby's body is in full contact with their parent's body, it triggers sucking reflexes so the baby can instinctively latch.
  - Side-lying or a football hold might be helpful after a cesarean delivery. With large breasts, the football hold might work better. A baby who is ill might find an upright position more comfortable.
  - Use baby's preferred position first and then slide baby over to the other breast.

- Hand express a few drops of milk and allow it to dribble down the nipple for baby to taste.
- Avoid artificial nipples until breastfeeding is established and baby is nursing well.
- Maintain milk production while baby is having latch difficulties. Pump on one or both breasts to remove milk and feed to the baby in another way.
- Offer engorgement relief strategies if needed.
- Minimize distractions so baby is calmer and better able to learn how to latch.
- Be patient. Breastfeeding is a learned art, and parents and babies will learn together. Most families find that breastfeeding gets easier with time and practice.

Yield

Yield to the CPA for food package tailoring and assessment of weight trends.
Yield to the DBE for assessment if:

- There are concerns about the baby's weight and output.
- Basic suggestions have not improved latch or if baby continues to refuse to latch.

- There are unresolved sore nipples or engorgement as a result of poor latch.
- The parent needs alternative ways to soothe and feed the baby.

Slow Weight Gain

Signs

Weight gain is an important measure to determine if babies receive adequate nutrition to grow properly. It is normal for newborns to lose weight in the first few days after birth as they pass their first stools and eliminate extra fluids. Sometimes they regain that weight slowly. Signs of slow weight gain are that the baby:

- Is not back to birth weight by 2 weeks of age.
- Is stooling less than 3 times every 24 hours after the first 3 days.
- Is sleepy and must be awakened for feedings.
- Is not gaining approximately 1 ounce per day during the first 6 months.

Babies are at risk of slow or faltered weight if they:

- Are overly sleepy.
- Cannot wake to feed (which parents might misinterpret as a “good” baby).
- Have scant stools.
- Seem apathetic or lethargic.
- Have a weak cry.
- Avoid interacting with the parents.

Causes

Feeding the baby in the first hour after birth and at least 8 to 12 times every 24 hours can help establish milk production. When latched properly the baby can transfer plenty of milk. Frequent feedings (8 to 12 times every 24 hours) help assure proper weight gain. When babies do *not* gain weight well, it can be due to several factors:

- **Early practices**. Not feeding often or long enough, or poor positioning and latch.
- **Maternal factors**, such as:
  - Structural concerns such as anatomical breast issues (e.g., insufficient glandular tissue) or previous breast surgery. Certain medications
  - Medical conditions (such as thyroid disease, diabetes, or postpartum hemorrhage)
- **Infant factors**, such as:
  - Jaundice
  - Hypoglycemia
  - Preterm or late preterm (34-37 weeks) delivery, which can affect sucking skills maturity and energy levels needed to feed well
  - Tongue tie or other oral anomalies (such as cleft lip/palate or recessed chin)
  - Weak suck
  - Medical conditions (e.g., cardiac problems, metabolic disorders, Down syndrome, reflux)

- Illness or infection
- Allergies

Questions to Ask

- Tell me about your baby's feeding patterns.
- How do you know when you should feed your baby?
- How long does your baby usually breastfeed?
- How does the feeding end?
- Describe your baby's wet and dirty diapers.
- What is your biggest concern about your baby?
- What is your baby's healthcare provider telling you about the baby's weight?

Tips/Solutions

- **Correct poor positioning or latch.** Because positioning and latch are at the heart of many breastfeeding problems, assist parents with basic techniques to improve milk transfer.
- **Increase feeding frequency.** Offering skin-to-skin contact can give the baby more opportunities to breastfeed.
- **Offer both breasts at feedings**. Wake the baby between feedings to encourage interest in feeding again on the second breast.
- **Follow feeding cues**. This can help ensure that the baby is feeding often enough to receive the calories needed to gain weight.
- **Delay artificial nipples** (including pacifiers) until breastfeeding is established and the baby is feeding well.
- **Use breast compressions during the feeding** to help release more higher-fat milk to the baby.

Yield

No matter the cause of the baby's slow weight gain, babies who are not gaining well need to be properly assessed to identify any risks to their health and development.

- Yield to the baby's healthcare provider. Although the basic strategies described in this section can help improve milk transfer, a baby who is not gaining weight well needs to be properly assessed to identify any medical risks and treatment options.
- Yield to the CPA for food package tailoring and assessment of the baby's weight trends.
- Yield to the CPA or DBE for further assessment if:
  - The parents are concerned about the baby's weight or reports the baby is not gaining well.
  - There are concerns about milk production.
  - There are risk factors for low milk production (e.g., prior breast surgery, breast anomalies, or hormonal conditions that can compromise milk production).
  - Infant medical concerns or other conditions might compromise the baby's ability to remove milk efficiently.

- The baby's output is less than the recommended minimum of three stools per 24 hours in the early days and weeks.

Multiples

Multiples at Birth

Studies show that parents of twins or other multiples are less likely to breastfeed than those of singletons. Parents of multiples may need additional support and encouragement. Research shows that the lactating parent's body is designed to make enough milk for more than one baby. This is because milk production is based on the law of supply and demand. When demand is high, the breasts produce more milk. In fact, research shows that breastfeeding twins yields more than 2100 mL of milk per day in the first six months compared to about 800 mL for parents of singletons.

Tandem Nursing

Some parents become pregnant while breastfeeding and wish to continue breastfeeding both children after the new baby is born. This is called *tandem nursing* to describe nursing two children of different ages. Lactating parents might wonder if it is okay to do this or whether they will make enough milk for two. They may also wonder if they should feed the children simultaneously or separately. In most cases, tandem nursing is considered safe, and milk production is sufficient for both the children. Parents can discuss their wishes with the children's healthcare provider to ensure adequate weight gain for both.

Questions to Ask

- How are you positioning and latching your babies?
- What do you feel is most comfortable for you and your babies/children?
- Tell me how you know when to feed your children?
- Tell me about your babies' wet and dirty diapers.
- What are your breastfeeding goals?
- What kind of support do you have to help you right now?

Tips/Solutions

- **Anticipatory guidance:**
  - How to get milk production off to a great start.
  - Importance of positioning and latch. (It may be helpful to latch babies separately at first before attempting simultaneous feedings.)
  - Importance of expressing milk for preterm babies. Early milk expression helps set a strong foundation for a healthy milk production.

After the baby(ies) are born:

- Hold them skin to skin to remain close and increase milk production.
- Feed them often, following feeding cues.
- If the parent decides to use some formula, praise for any amount of breastfeeding and let them know they can continue to partially breastfeed for as long as they wish.

- **Creative positions for nursing two babies at one time:**
  - Place both babies in a football hold, with one on either breast.
  - Hold one baby in a football hold and the other baby in the cradle hold.
  - Allow both babies to breastfeed in the laid-back position.
  - Support parents no matter which position they use or whether they feed their babies at the same time or not.
- **Preterm multiples:**
  - Provide ongoing support and encouragement while the babies are in the hospital NICU.
  - Connect parents to resources from WIC and the community.

Yield

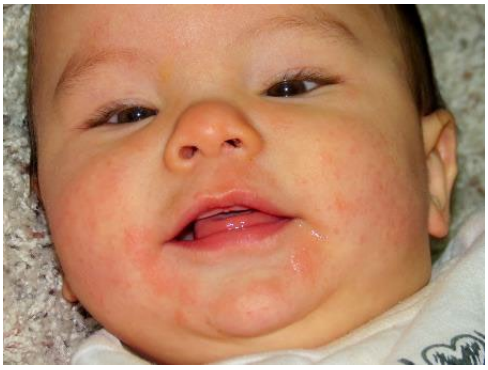
- Yield to the CPA for food package tailoring and assessment of weight trends.
- Yield to the DBE for further assessment if:
  - Further assistance is needed with positioning or latching their babies.
  - There are concerns about the babies' weight gain.
  - There is concern about sufficient milk yield for the babies.
  - The babies were born preterm and need specialized follow-up post discharge.
  - Help is needed with managing feeding schedules to assure their breasts are adequately stimulated to make sufficient milk.

Other Concerns—Allergies

Signs

Exclusive breastfeeding is especially beneficial for infants with a family history of allergies. Being aware of signs can help you know when it is appropriate to yield to the CPA. They include:

- Diaper rash
- Eczema (atopic dermatitis)
- Hives or other rashes
- Vomiting and/or diarrhea
- Wheezing or congestion
- Red, watery eyes
- Bloody or mucous stools



Causes

It is rare for an exclusively breastfed baby to have an allergic reaction. However, some babies may have reactions to new foods when they begin complementary foods. They may also develop sensitivities to certain foods the parent ingests.

Questions to Ask

- What changes have you noticed in your baby?
- Tell me about other children or family members who had allergies.
- What has the baby's healthcare provider said?

Tips/Solutions

Encourage parents to exclusively breastfeed as long as possible since this can provide a protective effect for eczema and asthma. It can also lessen the risk of food allergies when there is a strong family history.

Yield

- Yield to the CPA for food package tailoring and assessment of the infant.
- Yield to the CPA and/or DBE for further assessment if parents:
  - Report a family history or common symptoms of allergies in their baby.
  - Have questions about solid foods or food sensitivities.
  - Believe certain foods are causing problems in the baby.

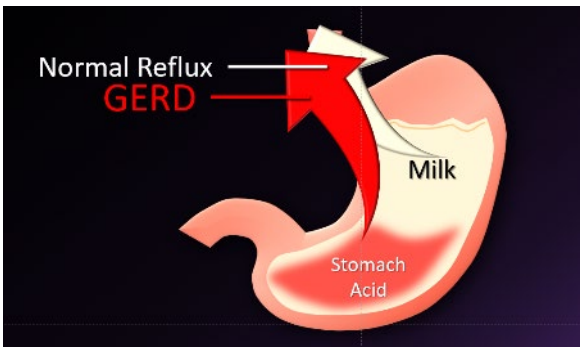
Other Concerns—Reflux

Signs

- Spitting up is normal and usually requires no intervention.
- Babies may spit up during or after feedings. The amount can vary. This is called reflux.
- Reflux may become GERD (gastroesophageal reflux disease) when symptoms worsen.
- The baby may be excessively fussy. Parents might think their baby has reflux.
- Parents may wonder if switching to formula would help.

Causes

Spitting up occurs because the valve between the baby's esophagus and stomach is not fully developed and does not always close after milk goes into the baby's stomach. This can allow milk to back up when it gets into the stomach. GERD is a more serious medical condition in which stomach acid comes up with the milk and irritates the baby's esophagus.



Questions to Ask

- How does your baby act after feedings?
- What do you think might be going on?
- How are you positioning your baby?
- How much does your baby spit up?
- What has your baby's healthcare provider said?

Tips/Solutions

Suggest that parents feed the baby in a more upright position. Also, keeping the baby upright for 15-20 minutes after the feeding helps keep the food and stomach acid from backing up.

Yield

Encourage parents to speak with their baby's healthcare provider regarding their concerns.
Yield to the CPA:

- For food package tailoring and assessment of the baby's weight trends.
- When the parent reports the baby is "gassy" or seems to be in pain.
- If parents worry about the baby's weight as a result of excessive spitting up.

Other Concerns—Jaundice

Signs

It is common for babies to develop jaundice in the early days after the birth. Jaundice is a yellowing of the baby's skin and eyes. Other signs may include excessive sleepiness or not staying interested in feedings long enough to transfer sufficient milk.

Causes

During pregnancy, babies have extra red blood cells to meet their oxygen needs. After birth, red blood cells that are no longer needed break down to form a substance called bilirubin, which is then released into the blood. The liver filters bilirubin and removes it through the baby's stools. Because a baby's liver does not fully function immediately after the birth, some babies remove this bilirubin more slowly. If it is not removed, the baby can become jaundiced. The first milk, colostrum, has a laxative effect to help the baby remove the bilirubin.

Questions to Ask

- Tell me more about how your baby acts during feedings.
- How often is your baby feeding?
- How do you know when your baby is ready to breastfeed?
- How do feedings end?
- Describe your baby's wet and dirty diapers.

Tips/Solutions

Encourage early and frequent breastfeeding (8 to 12 feedings in 24 hours) to provide enough colostrum to remove the bilirubin. Holding the baby skin to skin in the early days will give the baby frequent access to the breast. If the baby is hospitalized for treatment, WIC can support parents to provide encouragement and options for expressing milk.

Yield

Yield to the DBE and the baby's healthcare provider for further assessment if parents report:

- The baby has yellow eyes or skin.
- The baby does not arouse easily for feedings.The baby's stools are fewer than the recommended number, or baby is still excreting meconium (the first blackish tarry stools) after hospital discharge.
- The baby is very sleepy and does not actively suckle at the breast long enough to transfer milk.

Talking with Parents

Most new parents are concerned about their baby. Whether the concerns are common or more complex, they may worry if things are not going well. Sometimes parents blame themselves when their baby is not gaining weight or latching well and might feel they have failed. They might also feel overwhelmed and grieve for the "perfect" breastfeeding experience they had hoped for. Active listening acknowledges these fears, lets parents know they are not alone, and helps share tips and solutions.

Ways to Affirm
▪ You seem to have great instincts about your baby. Let's see if we can get you some answers. ▪ Most new parents worry about the same thing. ▪ What great parents you are to work through these early challenges! ▪ Your baby is lucky to have parents who care so much! ▪ Caring for a new baby can be overwhelming at first.

Bring It Home!
Use handout, "**Scenarios: Infant Concerns**" and "**Tips/Solution Cards**" to practice applying the education learned in this section in various case examples. The "Tips/Solution Cards" provides a collection of possible solutions that could be considered in each of the scenarios.

Problem Solving—Low Milk Production

Sneak Preview:
The Level 2 content in the "Low Milk Production" section addresses perceived vs. low milk production, and strategies to support WIC participants who doubt their ability to make milk. It also addresses when to yield to the CPA or DBE.

Level 2 Competency:

- Support parents who perceive they are not making enough milk.

Many new parents have concerns about their milk production. They may believe their milk will "come in" or increase immediately after the birth. They may be surprised at how small the volume of their first milk (*colostrum*) and may not know what babies need in the early hours and days. They may not understand why a baby needs to feed often, and assume they are not making sufficient milk. Since they cannot see the amount of milk their baby takes, they can worry, especially if their baby is fussy.

A 2012 study conducted with WIC participants in California found that new parents typically misunderstand their newborn's sleep and feeding patterns. When a baby wakes, parents often misinterpret it to mean the baby is hungry and they are not producing enough. They may also receive misinformation or pressure from family members to use formula. WIC families need ongoing support and encouragement. They can also benefit from knowing how their body works to make milk.

There are three types of milk production concerns:

- *Perceived low milk production,* when parents are making adequate milk, but worry they are not**.**
- *Delayed milk production,* when factors delay the timing of when their milk volume increases.
- *True low milk production,* when the breast truly is not making sufficient milk for the baby.

Perceived Low Milk Production

Signs

Perception is everything. Whether parents have low milk production or simply *perceive* they do not have sufficient milk, the effect can be the same if they begin supplementing with formula or discontinue breastfeeding altogether. Some common signs of *perceived* low milk production include:

- Baby stools often; 3 or more per day in the first 3-4 weeks.
- Baby gains around an ounce per day during the first 6 months.
- Baby breastfeeds 8 to 12 times per 24 hours and is transferring milk well.
- Breasts feel full or firm before feedings and softer afterwards.
- Parents receive negative messages from family or friends.
- Baby is fussy.
- Parents may have used a breast pump and only expressed a small amount.
- Parents may have given the baby a bottle of formula and observed that the baby eagerly took it.

Causes

Many parents may not be aware of how their breasts work to make milk and mistakenly assume they will have large amounts of milk after the birth. They may misunderstand their baby's behaviors and assume fussiness means they are not making enough milk to satisfy their baby. They may be unaware that babies have temporary increases in feeding frequency such as growth spurts, cluster feeding patterns, or responses to overstimulation.

Questions to Ask

- How often does your baby breastfeed, and for how long?
- How do you know when to feed your baby?
- Why do you think you are not making enough milk?
- How does your baby act after feedings?
- What else does your baby receive besides breastmilk?
- What are others telling you about your milk production?

Tips/Solutions

- Remind parents about normal infant feeding patterns.
- Provide visual ways to show parents they are making enough milk. For example, they can count wet and dirty diapers and track the baby's weight gain.
- Teach parents how their breasts make milk. Reassure them their body is designed to make milk.
- Follow the baby's feeding cues to breastfeed.
- Share ways to calm a fussy baby and wake a sleepy baby. (See *Baby Behavior*.)

Yield

- Yield to the CPA for assessment and food package tailoring if the parent requests formula.
- Yield to the CPA and/or DBE for further assessment if the parent:
  - Reports signs of delayed or true low milk production.
  - Continues to worry they are not making sufficient milk.

Delayed Milk Production

Milk volume begins to increase by around day 3 after the birth as the milk begins to transition from colostrum to mature milk. Occasionally, production can be delayed a day or two. Delayed milk production has been linked to early supplementation and discontinuing breastfeeding in the first month.

Signs

- Baby is not back to birth weight by 2 weeks postpartum.
- Baby stools less than 3 to 4 times every 24 hours after day 3.
- Baby still passes meconium stools after day 3.
- Breasts are not full.
- Baby is jaundiced.

Causes

- Early breastfeeding practices such as:
  - Delaying the first feeding.
  - Breastfeeding less than 8 to 12 times every 24 hours in the early hours/days after the birth.
  - Ineffective positioning or latch that prevents the baby from transferring milk.
  - Replacing breastfeeding sessions early on with formula or other liquids.
  - Not following the baby's feeding cues or using a pacifier to hold off feedings.
- Missed feedings due to pain, exhaustion, or discomfort breastfeeding in front of others.
- A medical condition that affects the timing of when milk production will begin.

Questions to Ask

- Tell me about your baby's first feedings. When did they occur and how did it go?
- How often are you able to hold your baby skin to skin?
- How often did you feed your baby in the early days?
- How often are you feeding your baby now? How do you know when to feed your baby?
- How does your baby act after feedings?
- How do your breasts feel before and after breastfeeding?

Tips/Solutions

- **Prevention**
  - Educate participants during pregnancy about how the breast works and how to get a good start with breastfeeding.
  - Demonstrate proper position and latch.
  - Discuss signs of efficient milk transfer.
- **Frequent feeds/milk expression**
  - Ensure effective positioning and latch.
  - Encourage breastfeeding at least 8 to 12 times/24 hours.
  - Express milk by hand or a breast pump as needed to help establish milk production.

Yield

- Yield to the CPA and/or DBE for further assessment if the parent reports:
  - No breast fullness after day 3.
  - Baby is not stooling 3-4 times every 24 hours by day 3.
  - Baby continues to lose weight.
  - Baby's skin or eyes are yellow.
  - Parent is obese or has diabetes or other medical condition.
  - Baby is already receiving formula.

Low Milk Production

True low milk production may occur beyond the early days when baby continues to lose weight.

Signs in Baby

- Continues to lose weight beyond the first few days or does not regain birth weight by 2 weeks postpartum.
- Stools less than 3 times every 24 hours in the first few weeks.
- Is sleepy and does not wake to feed 8 to 12 times every 24 hours.

Signs in Parent

- Breasts do not feel fuller before feedings.
- Sore nipples (which might indicate poor latch and subsequent poor milk transfer).
- Medication use that might interfere with milk production.
- Prior breast surgery.
- Separated from the baby and not expressing milk often enough to maintain production.

Causes

- Poor feeding practices (ineffective positioning and latch, delayed feedings, limiting the baby's time at the breast, not offering both breasts for feedings, supplementation).
- Unresolved engorgement.
- Medical concerns, such as:
  - Prior breast surgery
  - Hormonal conditions (such as polycystic ovary syndrome (PCOS) or hypothyroidism)
  - Medication use
  - Diabetes
  - Obesity
  - Pregnancy while breastfeeding
- Infant medical conditions that affect the baby's ability to remove milk (e.g., tongue tie, cleft lip, prematurity, weak suck, etc.)

Questions to Ask

- What makes you concerned about your milk production?
- How does your baby show you it is time to eat?
- How do feedings end?
- How often is your baby breastfeeding each 24 hours?
- How would you describe your baby's behaviors most of the time?
- Tell me about your baby's wet and dirty diapers every 24 hours.
- What do your family and friends tell you about your milk production?
- What do you know about how the breast makes milk?

Tips/Solutions

- Early practices already discussed that can help get breastfeeding off to a good start.
- Treat engorgement promptly if it occurs.
- Feed often or express milk to keep breasts comfortable and help build production.
- Be proactive! Contact participants early to encourage them.
- Encourage parents to attend a support group for new parents.
- Offer weight checks at WIC.
- Connect parents to other breastfeeding support in the community.

Yield

Yield to the CPA or DBE for further assessment if parents report:

- The baby is not gaining weight or stooling appropriately.
- Medical issues for low milk production.
- Medical concerns of the baby.

Talking with Parents

Real or perceived low milk production is the primary reason WIC parents begin supplementing soon after their baby's birth or wean altogether. Studies show that parents with low confidence are more likely to doubt their ability to make milk. WIC staff can use active listening to help participants examine their fears and worries and to reassure them that they are good parents.

Ways to Affirm - Perceived Low Production	Ways to Affirm - Low Milk Production
▪ It sounds like you are very worried about your baby. ▪ What great parents you are to be concerned! ▪ Your baby is so lucky to have parents who love him so much. ▪ Many new parents worry about their milk production. ▪ It's natural to wonder if your baby gets enough when you can't see how much milk goes in!	▪ It sounds like you want to do what is best for your baby. ▪ Your baby is so lucky to have parents who are working so hard to solve this problem! ▪ I can see you are very worried about your baby. ▪ It's great you are breastfeeding! ▪ A lot of parents would have given up. You obviously care about your baby a great deal!

Bring It Home!
Think back to your own experiences as a parent if you have children of your own. If not, consider things you have heard from WIC participants or friends and family members about parenting and breastfeeding. What are things that cause new parents to lose confidence as parents? What helped you or others build confidence in making plenty of milk?

Problem Solving—Supplementation

Sneak Preview:
The Level 2 content in the "Supplementation" section addresses ways to support WIC participants who wish to "combo feed" their infants (breastfeed and use formula supplements). It also addresses when to yield to the CPA or DBE.

Level 2 Competencies:

- Give accurate and relevant information on the impact of using formula on milk production.
- Support parents who choose to both breastfeed and use formula.

Combination Feeding

Reasons Participants May Combo Feed

Combination feeding refers to parents who decide to "do both" – breastfeed and use formula. The reasons can vary. For example:

- They may perceive they are not making sufficient milk.
- There may be physical or medical reasons why they are unable to make sufficient milk or successfully breastfeed.
- The baby may not be gaining weight appropriately and needs supplements to gain weight.
- Parents may be hesitant to share their reasons. These unspoken reasons can be hard to discern.

Impact of Formula Supplementation

- Creates a "downward spiral" in milk production.
- Contributes to plugged ducts and engorgement if the extra milk is not removed.
- Can cause latch problems due to babies preferring artificial nipples, especially if the supplements begin before breastfeeding is well established.
- Interferes with breastfeeding duration.

Questions to Ask

- What are some reasons you began giving your baby formula?
- What changes have you noticed since you started giving formula to your baby?
- How will formula help the situation?
- What are your family members saying about breastfeeding and using formula?
- What is your baby's healthcare provider saying about using formula?
- What are your breastfeeding goals?
- Describe any feeding plans if you are returning to work or school.

Tips/Solutions

- WIC staff can help empower WIC participants and build their confidence. Our own attitudes matter, too. We can:
  - Be optimistic and believe in our participants so they can believe in themselves!
  - Show respect and realize that it is the participant's decision.
  - Trust that parents know their families and situation better than we do and are trying to make the best decisions for their family.
  - Reassure parents to let them know other WIC parents have been in their shoes and we have solutions that have worked for others.
  - Non-judgment with a focus on listening so participants view us as supportive resources.

- Offer information on how the breast makes milk and ways to protect their milk production.
- Give options for dealing with their breastfeeding concerns.
- Help them get a good start with breastfeeding to build their milk production capacity.
- Remind them to remove milk often, either by the baby or be expressing it. Participants might not have thought about using their own milk as the supplement!
- Frequent feedings/milk removal will set a high starting point before returning to work or school.
- Offer support.
- They may be able to return to full breastfeeding, even if they began giving some supplements.

Yield

- Yield parents who ask about a food package related to formula to the CPA.
- Yield parents to the DBE for further assessment if they:
  - Report signs of low milk production.
  - Wish to rebuild production.
  - Are concerned about the baby's weight or output.
  - Need assistance with an alternative feeding method.
  - Want to return to full breastfeeding.

Talking with Parents

Breastfeeding is often called a "learned skill." Some parents need weeks or even months to grow comfortable and confident. Successful breastfeeding without supplementation often depends on the parent's confidence during the learning process. Throughout the journey, parents will experience a wide range of emotions, and their goals may change. A participant-focused approach helps them identify solutions that work best for them to meet their goals and encourages future conversation.

Ways to Affirm	Key Messages
▪ It's obvious how much you care about your baby. ▪ You're a great parent. You made a decision that works best for your family. ▪ WIC will continue to be here for you with breastfeeding support. ▪ It's great you are going to continue to breastfeed. Any amount is important for your baby.	▪ A birth parent's body is designed to make milk. ▪ Full-term healthy infants normally do not need supplements. ▪ Exclusive breastfeeding in the first month helps set a good foundation for milk production. ▪ Replacing feedings with supplements results in less milk being removed from the breast and a steady decline in production. ▪ Supplementing can prevent parents from reaching their breastfeeding goals. ▪ Many solutions besides formula may be available to help work through challenges. ▪ WIC staff support participants in reaching their goals for infant feeding.

Bring It Home!
Use handout, "**Supplementation Summary**" to review the key active listening skills involved in counseling new parents about combo feeding.

Problem Solving—Preterm Infants

Sneak Preview:
The Level 2 content in the "Preterm Infants" section lays a foundation for understanding the unique breastfeeding challenges of preterm and early term infants, and when to yield to the CPA or DBE.

Level 2 Competency:

- Yield parents appropriately when their preterm newborn faces breastfeeding challenges.

Feeding Challenges

All infants benefit from receiving their parent's milk. The important nutrients and immunological properties in human milk are even *more* important for babies who are born early. There are several categories of early births as defined by the American College of Obstetrics and Gynecology:

- Preterm – born before 34 weeks
- Late preterm – born between 34-36 weeks
- Early term – born between 37-39 weeks
- NICU grads – newly discharged from the NICU

Babies who are born early have a greater risk of infection and disease. They may be underdeveloped, which puts them at risk of breastfeeding challenges that require special care and monitoring. They benefit even more from the antibodies in human milk to help them prevent and battle infections that complicate their growth and development.

Preterm Infants

Studies show that preterm babies who receive human milk are less likely to develop dangerous infections common with preemies, such as necrotizing Enterocolitis and respiratory problems. These babies are cared for in the neonatal intensive care unit (NICU) with a highly specialized and qualified care team of neonatologists, pediatricians, NICU nurses, respiratory therapists, occupational therapists, and many others. This team will develop an individualized care plan for the baby's survival. Human milk is considered an important part of this care plan because of its importance in helping the baby grow, develop, and fight off infections and disease. WIC staff are also part of this continuum of care to connect parents to support, provide an appropriate food package, and share information.

NICU Grads

A preterm baby born before 34 weeks will often spend many weeks or even months in the hospital NICU. The parents might have been through emotional and financial stress. They might grieve their lack of ability to bond with their baby. They might have grown accustomed to allowing others to care for their infant during this fragile period of growth and survival and may worry about being responsible for the baby's care once they are home as a family. When the baby is discharged from the hospital, hospital social workers and case managers will help the family make a safe transition home. However, parents will continue to need support, especially if they are breastfeeding.

Some common challenges include:

- Weak suck and low tone that make it hard to stay latched or remove milk well.
- Being too sleepy or lacking the energy needed to wake often for feedings.
- Being easily overstimulated and fussy after leaving the hospital environment.
- Declining milk production if the lactating parent pumped for many weeks while the baby was in the NICU.

Early Term Infants

Babies born between 37 and 39 weeks might look much like a small full-term baby but often are not mature yet. About a third of the baby's brain develops in the last 6-8 weeks of the pregnancy. Their lack of final development can compromise their ability to breastfeed well. They can be more likely to experience:

- Jaundice (from very immature liver).
- Respiratory problems.
- Failure to thrive.
- Weak suck.
- Lack of muscle tone needed to stay latched through the feeding.
- Low energy and excessive sleepiness before and during feeding, resulting in poor milk transfer.
- Slow weight gain.
- Ineffective latch, causing sore nipples.
- Ineffective milk removal, causing low milk production.

Questions to Ask in the Hospital

- What concerns you about breastfeeding your baby?
- Tell me how you feel about the hospital experience.
- How often are you able to express milk?
- Tell me about any challenges you are facing with expressing milk or with your milk production.

Questions to Ask at Home

- How are you feeling now that you and your baby are home?
- What kind of help are you receiving now that your baby is home?
- How do you feel breastfeeding is going?
- How often is your baby going to the breast? How long does your baby stay latched?
- Tell me about your baby's soiled diapers.
- How do your breasts feel?
- What advice has the healthcare provider given you about feeding your baby?

Tips/Solutions

- **Support Strategies in the Hospital**
  - Affirm parents who worry about their baby's well-being.
  - Build their confidence by listening, praising, and encouraging communication with the baby's healthcare team.
  - Encourage frequent milk expression to maintain milk production. Suggest playing music while pumping to relax. Music might also help increase the calorie content of the milk.
  - Educate parents to expect fluctuations in milk production. Suggest they speak with the hospital lactation consultant if they are worried.
  - Suggest that parents visit with and hold their baby skin to skin in "kangaroo care" as often as possible. This helps them stay connected to their baby, helps their baby grow and thrive, and builds milk production.

- **Support Strategies at Home**
  - Both parents can hold the baby skin to skin to help the baby stay warm and the heart and breathing rates stable. It is especially helpful when babies are overstimulated.
  - Continued milk expression will maintain production when baby does not remove milk efficiently or often enough.
  - Baby will grow and mature soon, making feedings easier.
  - Suggest that parents rest as much as possible and accept offers of help from others.

Yield

Preterm and compromised infants can quickly get into trouble and experience serious consequences. It is important to make referrals promptly when issues arise. Yield the parent of a baby born before term to the CPA or DBE for assessment if:

- Parents are concerned about the baby's growth.
- Parents are concerned about milk production.
- Baby is unable to latch properly after basic tips are offered.
- Baby is not wetting or stooling appropriately.
- Baby has slow or faltered weight gain.

Talking with Parents

Parents of preterm babies need extra support and encouragement. They might not understand or even be afraid of the hospital environment and treatments that are happening to their baby. They might question their ability to care for their vulnerable baby. They might feel they are to blame for their baby's

condition. They might feel overwhelmed with the responsibility of caring for a baby at risk. Active listening skills can help parents relax and build their confidence.

Ways to Affirm	Key Messages
▪ This can be overwhelming for a new mom to manage. ▪ It is normal to worry about your baby. ▪ Many parents express milk for a preterm baby. ▪ I can see you really want what's best for your baby.	▪ Human milk is especially important for preterm babies. ▪ Early and frequent milk expression helps build strong milk production. ▪ Relaxing while expressing milk can help you remove more milk. ▪ Holding your baby skin to skin helps your baby calm and relax so they can use their energy to grow and develop. ▪ Follow the advice of your baby's medical team. ▪ If you are concerned, you can weigh your baby here at WIC to make sure your baby is growing well.

Problem Solving—Management Tools

Sneak Preview:
The Level 2 content in the "Management Tools" section provides instructions for helping WIC participants use massage and compression techniques to help milk flow.

Level 2 Competency:

- Assist parent with massaging and compressing their breasts to encourage milk flow.

Breast Massage

Breast massage is an easy, effective way to help parents relax and encourage milk flow. Touch helps release the hormone oxytocin, which contracts the muscles around the milk-making cells in the breast to release milk. Massage is especially helpful if the breasts are engorged or have a plugged milk duct. It helps improve blood flow and moves fluids through the breast when swelling is present. It has also been shown to increase milk volume and fat content because it helps release fattier portions of the milk that tend to stick to the milk ducts. Breast massage can be done before feedings or milk expression. It can also be done during the feeding to help increase the calorie content of the milk to the baby.

Breast Massage Techniques

Parents often have varying sensitivities about handling their breasts and may be uncomfortable discussing it. Be sensitive to their experiences and feelings and ask permission before demonstrating the techniques. WIC staff should never massage the participant's breast for them. Instead, ask permission to use a breast model to describe it. Suggest that the participant:

- Apply a warm compress or get in a warm shower to help relax the breast tissue.
- Moisten fingers with water or expressed milk so they glide easily over the breast skin.
- Apply gentle pressure in a circular motion around the breast or lightly tap with the fingertips around the breast.

- For a plugged duct, apply a warm compress and gently massage over and behind the plug to help dislodge and loosen it. Massage in a circular manner around the plug before stroking the breast toward the nipple.

Breast Compression

Breast compression is simply a gentle squeeze of the breast while the baby is latched during a feeding. Gentle breast compression, especially when combined with breast massage, is an easy and effective way to help stimulate milk flow and encourage a sleepy baby to continue suckling. Breast compressions can also help increase the amount of fat that the baby gets. WIC staff should NOT do the compression for the participant. Instead, teach parents the technique using a breast model. Allow the parent to compress their own breasts to comfort.

Breast Compression Technique

- Place hands around the breast in a "C" hold, with fingers well behind the areola to avoid interfering with the baby's latch.
- When baby stops suckling and swallowing, bring thumb and fingers together to gently compress the breast.
- Hold compression until baby starts to suckle again. Babies respond to milk flow and will rouse to swallow when there is something to drink.
- Release compression once baby is actively suckling. If baby slows again, repeat compression.
- Continue compressions throughout the feeding when baby is not sucking nutritively.

Bring It Home!
Use a breast model to practice the techniques for massage and breast compression.

Staff Roles: Peer Counselors—Roles and Responsibilities

Sneak Preview:
The "Roles and Responsibilities" section of Staff Roles: Peer Counselors addresses the primary job duties and scope of practice for the WIC peer counselor.

Level 2 Competencies:

- Encourage and support WIC participants with normal breastfeeding practices.
- Provide care within the established scope of practice for WIC peer counselors.
- Yield appropriately for situations beyond the peer counselor's scope of practice.

Becoming a WIC Peer Counselor

WIC peer counselors are current or former WIC participants with personal breastfeeding experience who provide information and support to pregnant and breastfeeding WIC participants. Research shows

that women are often drawn to other women with shared life experiences, especially when those experiences relate to parenting. Peer counselors are invaluable partners with WIC participants to help them gain confidence in their ability to breastfeed. WIC peer counselors everywhere say their job is rewarding and gives them a sense of accomplishment and pride because they are making a difference in the lives of others.

Qualities of an Effective Peer Counselor

Peer counselors build relationships with WIC participants by sharing their personal breastfeeding experiences, giving basic information about breastfeeding, and offering support. To foster good relationships with new parents, WIC programs seek peer counselors with the following ideal qualities:

- Previous experience breastfeeding their children
- Experience as a WIC participant
- From the target community served by WIC
- Ability to listen
- Communication skills
- Kindness and sensitivity to the needs of others
- Personal passion for breastfeeding
- Desire to help others reach their breastfeeding goals

Job Duties

Your role as a peer counselor is to support WIC parents and their babies. Basic job duties include:

- Providing information to help participants make educated decisions about feeding their babies.
- Sharing strategies to help participants get off to a good start with breastfeeding.
- Answering common questions about breastfeeding.
- Helping participants prevent and deal with common breastfeeding challenges.
- Encouraging participants when breastfeeding is challenging.
- Including other family members in education, when appropriate.
- Yielding participants for questions that are outside the peer counselor's scope of practice.

What Your Job Is NOT

It is not a peer counselor's role to convince WIC participants to breastfeed. Nobody wants to feel they are being persuaded to do something. Your role is to focus on the participant to build a relationship with them, help them identify any barriers to breastfeeding, provide them with solutions to address those barriers, share reasons to breastfeed, and help them get off to a great start to meet the goals they set for themselves and their babies.

Daily Activities

Peer counselors are an important part of the WIC team. Routine activities will be different from one peer counselor to another; however, common elements include:

- Making phone contacts to WIC pregnant and breastfeeding participants.
- Receiving phone, text, email, and other contacts from WIC participants who have questions about breastfeeding.
- Meeting participants and their babies in the WIC clinic or other one-on-one settings when allowed by the WIC agency.
- Yielding (or making referrals) to other WIC staff when participants need special support.
- Documenting all contacts made with WIC participants.

Peer counselors support participants in various settings based on the guidelines of the WIC local agency. They might work in the WIC clinic, from home, at the hospital, at the participant's home, or at an alternative community location. They might also:

- Attend peer counselor staff meetings.
- Attend WIC clinic staff meetings.
- Encourage participants to attend prenatal classes and support group meetings.
- Assist with prenatal education and postpartum support groups.
- Complete ongoing breastfeeding training opportunities.
- Assist in special activities and other tasks pertinent to their role.

Bring It Home!
Review the job description provided by your local agency, or the handout, "**Job Description for Peer Counselors.**" Talk with your supervisor about the specific activities pertinent to your peer counselor role in your WIC agency. Talk with other peer counselors about what their typical days are like.

Managing Your Job Duties

The Breastfeeding Peer Counseling program is available to WIC parents when problems arise, even if they occur outside the usual clinic hours and setting. Questions and concerns do not always arise during standard business hours, and it is important that participants have a way of accessing help when they need it most. Peer counselors also need to set realistic expectations and boundaries so they can manage their job duties with home and family commitments. Solutions include:

- Be proactive and initiate contact with new parents instead of waiting for them to call you so you learn how breastfeeding is going and can answer questions they might have.
- If you make phone calls from home, consider:
  - The best time of day for initiating calls.
  - Boundaries for receiving calls and texts, using an autoreply or leave a message feature.
  - A quiet area where you can relax, tune in to hear concerns, and maintain confidentiality.
- Your agency may rotate cell phones among peer counselors with peers "on call" on certain days.
- Discuss with your supervisor days of the week that are most workable for planning counseling days at the WIC clinic, local hospital, or other settings for counseling.
- Consider transportation options that ensure you get to your required locations in a timely way.

- Explore childcare options and backup arrangements in the event your child is ill or a family obligation occurs.

Avoid Burnout

Peer counselors are caring, compassionate people working in a profession that gives to others. It is important to take care of yourself to avoid burnout. Some ways to do that include:

- Talk with your partner and others who live with you about managing your job requirements.
- Take things slowly at first until you become more accustomed to your job.
- Be realistic about what you can and cannot do. Be careful about overcommitting too soon.
- Be sensitive to the needs of your family.
- Talk with other peer counselors to learn how they organize their time.
- Speak with your supervisor if you have questions about your job.

The WIC Team

As a peer counselor, you are not alone in your job! You are part of a larger team at WIC who will support you in your job. Together, these people will support your personal growth and assist you in caring for new families. Members of this team include:

- **Supervisor or Peer Counselor Program Manager**. They support you as you learn your job, review your contact documentation for WIC participants, and review your time sheets or other paperwork required by your agency.
- **Breastfeeding Coordinator.** Each agency has a breastfeeding coordinator who coordinates breastfeeding activities for the WIC clinic and community.
- **WIC Designated Breastfeeding Expert (DBE).** Agencies that have peer counselors must also have access to an expert to manage complex breastfeeding problems in a timely manner. The DBE might also provide training for peer counselors and work directly with providers when parents need to be referred.
- **Competent Professional Authority (CPA).** This person has expertise in nutrition and dietetics, certifies people for WIC, and counsels them about good nutrition for their family. CPAs prescribe food packages for participants and counsel new parents about breastfeeding and nutrition. They also make referrals to peer counselors to provide additional support and encouragement for pregnant and breastfeeding participants.
- **Office support staff.** Support staff may answer the telephone, make appointments, and process paperwork to begin the certification of a WIC parent and baby or children. They also make referrals to peer counselors when participants have breastfeeding questions.

Scope of Practice

All healthcare professionals follow a “scope of practice” when they care for patients and clients. A scope of practice is the range of services they are allowed to provide. It is similar to a traffic lane when you drive on a highway. Vehicles travel within a defined lane next to one another. Staying within your lane means that while you provide peer support, other health professionals and WIC staff travel alongside to give other levels of support.

A scope of practice ensures that parents receive care from professionals who have the expertise, knowledge, and training to provide that care. This leads to the best outcomes for the WIC families and protects you as a peer counselor. WIC agencies have liability policies with protections based on the premise that staff all operate within their defined scope of practice.

Peer Counselor Scope of Practice

The scope of practice for WIC peer counselors focuses on providing basic information and support throughout breastfeeding. When parents need more than basic support, other staff or experts have the scope of practice to provide that level of care. The peer counselor's scope focuses on:

- Working in a professional way that respects the dignity of the participant, WIC staff, and others who are part of the participant's circle of care.
- Encouraging parents to breastfeed by helping them explore any barriers and ways to fit breastfeeding into their lives.
- Helping new parents get a good start with breastfeeding.
- Helping parents continue to breastfeed when common challenges occur.
- Yielding parents to other experts when needed.

Hands Off!

It is beyond the peer counselor's scope of practice to touch or handle a mother's breasts. To demonstrate positioning and latch, use a breast model and/or a doll to demonstrate the techniques rather than directly handling the participant's breasts. This respects their dignity. Peer counselors also do not place their hands inside a baby's mouth or conduct an examination of the baby. If hands-on assistance is needed, yield to your clinic's DBE.

Milk Sharing

It is beyond the peer counselor's scope of practice to tell parents where to obtain milk from another parent or to share your own milk. The Food and Drug Administration has information on the risks and precautions when considering using milk from another parent. Yield parents who have questions about this to your DBE.

Yield

When in traffic and approaching a yield sign, drivers wait and watch for when the way is clear. Then they proceed into the road and merge with other traffic to travel alongside other drivers. In the same way,

peer counselors yield to the DBE, the CPA, and other healthcare providers when questions arise beyond their scope of practice. Some ideas for situations a peer counselor might yield include:

- To the healthcare provider for parents with questions about medications, their medical status, or medical problems that need treatment (such as mastitis).
- To the WIC CPA for parents with questions about their WIC food package or nutritional issues.
- To the WIC DBE when parents encounter complex breastfeeding problems that are beyond the normal course of breastfeeding.
- To the hospital staff when parents or their babies are in the hospital and face issues with breastfeeding.

Note: Peer counselors do not contact or work directly with medical providers or hospital staff. Instead, they would yield by suggesting that parents speak with their providers when needed. The WIC DBE typically has the established relationships as part of a structured referral network to make direct referrals when needed.

Yielding to the DBE

In helping parents with more complex challenges, DBEs do an in-depth assessment, assess a parent's breasts, identify and address breastfeeding concerns, and work with the CPA to develop care plans. The DBE also works directly with other WIC staff and healthcare providers as part of the care plan.

Examples of the kinds of situations you might yield to a DBE are:

- Nipple pain or engorgement that does not improve after trying the basic suggestions you share.
- Baby not latching well despite your help with positioning.
- Baby not gaining weight well.
- Preterm or sick infant after hospital discharge.
- Low milk production.
- Breast issues that make it hard to breastfeed.

Bring It Home!
Use handout, "**Scope of Practice for Peer Counselors**" or the scope of practice adopted by your agency to review the range of activities and services you can provide as a peer counselor in the WIC Program.

Staff Roles: Peer Counselors—Practice Settings

Sneak Preview:
The "Practice Settings" section of Staff Roles: Peer Counselors addresses options for contacting and connecting with WIC participants to counsel them about breastfeeding.

Level 2 Competency:

- Use technology, telephone, and in-person counseling effectively within the agency's guidelines.

Ways to Connect

Peer counselors use many options to reach new parents. Always follow your State and/or local agency guidelines on how you can reach WIC parents. It can be helpful to ask participants how *they* would like to be contacted. Some prefer text messages, if your agency allows this. Others prefer to meet in person or prefer email and messaging platforms. Always be sure your agency has consent from WIC participants regarding ways to reach them for communication.

Telephone

Many of your contacts with participants may be by telephone. You may make these calls from the WIC clinic or from home or other settings. Most calls last around 15 minutes or less to respect the participant's time and limited cell phone minutes they may have available. Many participants do not call, even when they need help. Initiate calls regularly to participants, particularly near their due date and early postpartum.

When making calls, remember to focus on your tone of voice. Participants cannot see your face and will need to rely on your tone of voice to hear your interest and helpfulness. Smile when you talk on the phone so that participants "see" it in your tone of voice that comes through. Also, using picture words helps participants visualize what you are referring to. For example, "Your baby's stools should be yellow and runny and may look like cottage cheese."

Cell Phones

Many WIC agencies provide cell phones for making calls with participants which protects your privacy and your time at home. Follow your agency's policies and guidelines for using a cell phone. If a WIC parent phones you and leaves a voicemail message, try to return calls promptly as they often do not phone unless there is a true need.

Texting

WIC participants may prefer text messages. Discuss with your supervisor your options for staying connected with participants via texting and for documenting your text contacts. Typically, texts are short and can be used for class invitations and regular check-ins with parents. Because a text is a permanent record of what you said, always pause before pushing "send" to review what you wrote, check spelling, and to be sure that your message is clear and that your tone is appropriate.

Electronic Communications

Not all WIC participants have access to computers or the internet. However, many have cell phones and check messages via email. Discuss with your supervisor the electronic communication methods you can use when contacting participants. Many peer counselors like to share links to websites, videos, and other online resources with WIC parents. Always be sure that you share only online material that has been approved by your agency.

Bring It Home!
Visit the WIC Breastfeeding Support website at https://wicbreastfeeding.fns.usda.gov/ to review the content, resources, and videos that cover a wide range of topics.

Social Media

Today's online world of rapidly growing technology means that most WIC participants have many ways of communicating through social media. It is a powerful way to connect. You might use social media in your personal life to communicate with family and friends. As opportunities continue to grow, you will need to stay in touch with your supervisor about which social media options are approved in your agency.

No matter what social media you use, there are some common tips to keep in mind:

- Be respectful. Share ideas and thoughts in a supportive and caring way.
- Keep messages short and simple.
- Always *pause* before posting. Reread your post and be sure that it is accurate, respectful, and does not breach confidentiality.
- Assume that anything you post could be circulated widely to many people and becomes a permanent record of what you said.

WIC Clinic

Many peer counselors see WIC parents during WIC clinic hours. They may meet a parent there to observe a feeding and assist with positioning and latch. They may come to the clinic on designated days and see all parents who come in that day. Many also see participants for clinic classes and support group meetings, or to attend important meetings.

Face-to-face conversation is extremely important in building a relationship with new parents. Some tips to make clinic conversations effective include:

- Greet participants warmly. Smile and show that you care.
- Ask participants if they are comfortable breastfeeding in front of you so you can observe how things are going.
- Include participants' family members if they accompanied them to the clinic.
- Affirm participants and their family members frequently.
- Share WIC approved resources.
- Document visits and any referrals you made.

Home Visits

Most breastfeeding concerns can be handled through phone or clinic counseling. Occasionally a participant might benefit from a home visit. Peer counselors normally do not make home visits, but they might accompany another WIC staff person or a home visiting nurse. Follow your agency's procedures for home visits. Be respectful of the family, introducing yourself to the family and your reason for visiting. Exercise common sense and safety tips, including:

- Contact parents beforehand and never show up unexpectedly.
- Set a time that works best for parents and plan for unexpected diversions such as traffic so you arrive when you say you will.

- Ask about pets and request that they be secured during your visit.
- Notify your supervisor of the plans, including the time you leave and when you return.
- Dress appropriately and wear your name badge to identify you as being with WIC.
- Travel with another WIC staff member when possible.
- Practice good hygiene, including hand washing or hand sanitizer, before and after entering the home. Wear a mask as required by your agency.
- Bring a fully charged cell phone and emergency numbers keyed into the "speed dial" function.
- Be alert to your surroundings and trust your instincts.
- Leave immediately if you feel uncomfortable at any time.

Hospital Visits

Many WIC agencies establish a relationship with the local hospital to allow peer counselors to visit participants in person after they deliver their baby. Never visit participants without supervisor approval. In the hospital setting, peer counselors do not replace the work of nurses and the lactation team. Instead, your role is to greet participants, congratulate them on the birth of their baby, and share information that can help them get off to a great start with breastfeeding. Peer counselors yield breastfeeding problems to hospital staff. The scope of practice for peer counselors in the hospital is no different from the standard scope of practice. The support is simply provided in the hospital setting rather than the phone or WIC clinic. Peer counselors also make referrals to WIC staff to alert support staff that the participant has delivered, and to yield for breastfeeding challenges that can be addressed after hospital discharge.

Bring It Home!
Use handout, "**Practice #1: Affirm!**" to practice affirming a participant. Use handout, "**Role Play**" to derive open questions and affirming statements in a counseling encounter.

Staff Roles: Peer Counselors—Documentation

Sneak Preview:
The "Documentation" section of Staff Roles: Peer Counselors addresses ways to document contacts with WIC participants.

Level 2 Competencies:

- Document interactions with WIC participants appropriately.
- Maintain confidentiality in all participant interactions.

Program Policies

Confidentiality

Peer counselors, like all WIC staff, have a responsibility to protect the confidentiality of participants. This includes names, personal information, and information about the person's situation. Peer counselors should always follow your agency's confidentiality policies. You may be asked to sign a Confidentiality Agreement which will be reviewed during your training and monthly staff meetings.

Key considerations include:

- Do not share *any* information about WIC participants with anyone (including your family members and friends) except for other WIC staff, your supervisor, or your DBE.
- Assume that ALL information you receive about a WIC participant is confidential. If you are unsure, confirm with your supervisor.
- Be aware of situations that might make it difficult to maintain a participant's confidentiality, such as calling participants at home or leaving phone messages, texts, or encountering a participant in a public location.
- Store your documentation and counseling notes in a safe, secure place. Your supervisor will share ideas for how they want you to store your notes.
- When leaving your computer, log off so others cannot see or access client information.
- Be careful about leaving voicemail messages that other family members could hear.

Documentation Forms

Documentation serves as a record of what has been done. The professional rule of thumb is: *If you didn't document, you didn't do it.* Document all contacts you have with new parents. Your supervisor will guide you on the types of things you should document. Documentation helps you remember what you told the parent, their concerns, the topics you discussed with them, what worked and what did not, and the next steps for support. Documentation protects you because it becomes a permanent record of the advice you gave. It also informs the rest of the WIC team about the participant's needs and how they can reinforce and follow up on the support you provided. Peer counselors document contacts in a variety of ways, such as a contact log or electronic charting. Your supervisor will review with you the required documentation forms and process for your agency.

WIC Breastfeeding Curriculum

Breastfeeding Training Handbook

Level 3

For CPAs, Breastfeeding Coordinators, and Designated Breastfeeding Experts

U.S. DEPARTMENT OF AGRICULTURE

WIC BREASTFEEDING SUPPORT

LEARN TOGETHER. GROW TOGETHER.

Table of Contents

Level 3

What It Covers
The Level 3 content in the *WIC Breastfeeding Curriculum* provides information on conducting an appropriate breastfeeding assessment, addressing breastfeeding challenges related to infant growth and development, and tailoring WIC food packages for new families to minimize infant formula and encourage optimal breastfeeding practices.

Target Audience
Level 3 content is designed for WIC Competent Professional Authorities (CPAs), breastfeeding coordinators, and WIC Designated Breastfeeding Experts (DBEs). It enables staff to understand their role in integrating breastfeeding into the assessment process and connecting families to the support they need to follow through on their breastfeeding goals.

WIC and Breastfeeding—Breastfeeding Promotion

Sneak Preview:
The Level 3 content for the "Breastfeeding Promotion" section addresses WIC program regulations and best practices to support pregnant and breastfeeding participants in the clinic setting, including integrating breastfeeding into all aspects of clinic services and collaborating with community partners. It also addresses ways to include peer counselors as part of clinic support services.

Level 3 Competencies:

- Identify gaps in breastfeeding support and set goals for improving support.
- Integrate breastfeeding support services as a standard part of WIC services.

Program Regulations

WIC regulations related to breastfeeding support are published by the Federal Register in the Code of Federal Regulations, 7 C.F.R. Part 246. The regulations related to breastfeeding include requirements for State and local WIC agencies, including:

- Designate a breastfeeding promotion coordinator at both the State and local agency levels to coordinate breastfeeding promotion activities for the agency.
- Train local agency staff on how to promote and manage breastfeeding with participants.
- Develop a breastfeeding plan.
- Promote a breastfeeding-friendly environment.
- Provide breastfeeding educational materials for participants.

Nutrition education plans must include nutrition education goals and action plans related to breastfeeding. This includes establishing standards that promote and support breastfeeding, including:

- Integrate breastfeeding promotion and support into standard clinic services.
- Create a positive clinic environment that endorses breastfeeding as the best source of infant nutrition.
- Designate staff responsibilities to coordinate breastfeeding promotion and support activities.

- Ensure that WIC participants can access breastfeeding services and support during the prenatal and postpartum periods.

WIC agencies help WIC participants make informed decisions about how they will feed their babies and make appropriate referrals when parents need support. Agencies also work with other healthcare programs and community partners to coordinate breastfeeding promotion and support activities. Staff support participants when they:

- Complete nutrition education at each appointment to enable ongoing support, ending with the breastfed infant's first birthday.
- Assign a food package based on the infant's age and amount of formula received from WIC.
- Identify or develop resources for participants that include promotional information and instruction on how to breastfeed. The materials should be available in language(s) other than English if a significant number of participants served by the agency speak that language.

Public Health

Breastfeeding is often considered a "public health priority." Charles Winslow, a leading public health official, defined it this way in 1920:

"...the **science and art** of **preventing disease,** prolonging life and promoting health through the **organized efforts** and informed choices of society, organizations, public and private, communities, and individuals."

Breastfeeding perfectly fits this definition. For example:

- **Science and art:** Breastfeeding is both a *science* and an *art*. Numerous scientific studies confirm the positive impact of breastfeeding on the health of both infants and parents. Each parent and infant learn the art of breastfeeding together and discover their own unique path.
- **Preventing disease:** The unique immunological properties in human milk help protect infants and parents from certain infections and diseases. The unique "microbiome" of the breastfeeding infant helps establish a strong immune system for long-term health.
- **Organized efforts:** Most breastfeeding parents find they are more likely to reach their infant feeding goals when they receive support. This can come from a wide variety of community partners with WIC.

Population Health

An important priority in public health is reducing disparities that make it more difficult for some groups within the population to achieve optimal health outcomes. Population health focuses on *social determinants of health,* the personal and societal factors that influence health decisions. Public health policies that focus on addressing social determinants of health can improve health for large numbers of people. The National Healthy People objectives include goals to address the social determinants of

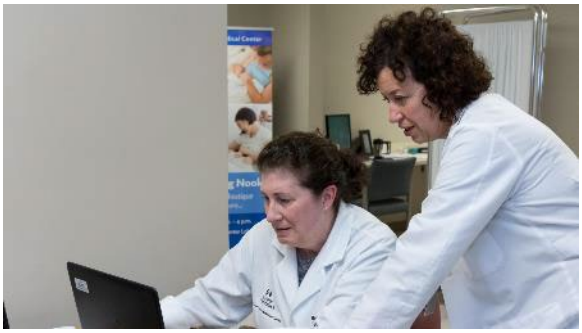
health and promote good health for all Americans. Examples of social determinants of health might include:

- *Social factors*
  - Poverty
  - Unemployment
  - Education
  - Social support
  - Language
- *Physical factors*
  - Worksite settings
  - Access to clean water and food
  - Housing
  - Transportation

Ways WIC Supports Breastfeeding

Collaboration with community partners helps improve WIC's visibility and increase referrals. It also helps increase consistent messaging. Partners to consider include:

- *Health Professionals:*
  - Health department staff.
  - Home visiting programs.
  - Hospital personnel.
  - Provider offices (e.g., pediatric, family practice, OB/GYN, general practice).
  - Medical chapters (e.g., American Academy of Pediatrics, American Academy of Family Physicians, American College of Obstetrics and Gynecology).
  - Health insurance companies.
  - Private practice lactation consultants.



Ideas for outreach might include:

  - Participate as a guest speaker at a hospital in-service with labor & delivery, postpartum, and newborn nursery staff.
  - Write a blog about WIC's breastfeeding promotion activities and support for a hospital newsletter or a medical professional chapter newsletter.
  - Speak at a university dietetic, nursing, or public health class.
  - Invite healthcare providers to WIC breastfeeding training events.
- *Community Partners:*
  - State and/or local breastfeeding coalitions.
  - Childcare facilities.
  - Workplaces that employ large numbers of the WIC audience.
  - Local media groups.
  - Colleges and universities.
  - Healthy Start agencies.
  - Early Head Start agencies.
  - La Leche League leaders/groups.

Ideas for outreach might include:

- Sponsor an information booth or nursing parents' "tent" at a community or state health fair.
- Work with a local television or radio station, social media networks, or other media to air public service announcements and WIC information about breastfeeding (following State and local agency guidelines for working with the media).
- Recognize community groups who support breastfeeding.
- Share WIC resources for groups who also engage WIC participants.

Bring It Home!
Visit the WIC Breastfeeding Support website to access the resource, "**Partnering with WIC to Support Breastfeeding**." This tip sheet has suggestions for partners to consider, as well as outreach ideas.
https://wicbreastfeeding.fns.usda.gov/wic-partners

Integrating Breastfeeding

Breastfeeding coordinators can work with agency clinic management and staff to identify ways to include breastfeeding support as a standard part of WIC clinic services, following State guidelines. These activities might include:

- Establish a clinic environment that promotes exclusive breastfeeding as the norm for infant feeding.
- Accommodate breastfeeding participants visiting the clinic.
- Assure that all staff are trained using the *WIC Breastfeeding Curriculum.*
- Establish structured internal and external referral networks for breastfeeding participants who experience challenges. (*See the section on "Continuity of Care"*).
- Examine potential touchpoints when participants are at the WIC clinic, to determine ways to integrate breastfeeding into care during each of those periods.

Bring It Home!
The National WIC Association publishes a document, "**Six Steps to Achieve Breastfeeding Goals Checklist**." This document is a framework that outlines simple steps to help local agencies set goals for fostering a breastfeeding supportive environment.
https://s3.amazonaws.com/aws.upl/nwica.org/Checklist_for_Six_Steps_to_Achieve_Breastfeeding_Goals.pdf

Bring It Home!
Use the handout, "**WIC Breastfeeding Support Services Worksheet**" to note current breastfeeding support activities and services provided by your WIC clinic and to identify additional ways to integrate breastfeeding support into the full range of clinic services.

WIC Staff

Peer counselors are an integral part of WIC agencies' breastfeeding support services. (*See the "Staff Roles: Peer Counselors" section in the Level 2 content for the full range of support services that peer counselors provide.*)

At the heart of peer counseling is building a trusting relationship with WIC participants that enables peer counselors to provide tailored support throughout each participant's parenting journey. Local agencies should examine State and local clinic policies and practices to ensure that peer counselors are available outside of WIC's usual operating hours and clinic environment, per the Food and Nutrition Service's *WIC Breastfeeding Model Components for Peer Counseling* (available at https://wicworks.fns.usda.gov/resources/wic-breastfeeding-model-components-peer-counseling). This model, based on research conducted with WIC agencies across the country, provides program requirements and guidance for managing a Breastfeeding Peer Counseling Program in WIC.

Ways to help participants access breastfeeding support when they need it most might include:

- Allow peer counselors to receive/make calls and/or texts beyond usual clinic hours.
- Enable peer counselors to visit new parents in the hospital.
- Enable peer counselors to assist with group education opportunities during weekends or evenings, as needed, to meet the availability needs of participants.
- Purchase cell phones for peer counselors to track and monitor calls made outside the clinic.
- Provide an "on call" phone that rotates among peer counselors beyond clinic hours.

Peer counselors are most effective when they are integrated into the full range of WIC clinic services from pregnancy through weaning. This includes making referrals to peer counselors when participants are enrolled in WIC at their initial certification and making referrals as questions and concerns arise. Many clinics bundle maternity and postpartum breastfeeding appointments on certain days so that peer counselors can be available on those days to maximize their time in the clinic. Peer counselors can also see new breastfeeding parents before food package tailoring to determine how breastfeeding is going.

WIC and Breastfeeding—Food Packages

Sneak Preview:
The Level 3 content in the "Food Packages" section addresses tips to keep in mind when tailoring food packages for breastfeeding participants.

Level 3 Competency:

- Tailor food packages to support breastfeeding.

Tailoring Food Packages

Conducting Assessments

CPAs should conduct a thorough breastfeeding assessment to help each participant meet their breastfeeding goals. Assessments help ensure that participants receive the appropriate food packages and strong breastfeeding support and counseling as part of WIC's overall breastfeeding promotion and support emphasis. Assessment is the foundation for planning and supporting participants to reach their

infant feeding goals. Staff assess nutritional status and risk, design appropriate nutrition and breastfeeding counseling, tailor and assign appropriate breastfeeding food packages, and make referrals. (*See the "Breastfeeding Assessments" content for more details on conducting a prenatal and breastfeeding dyad assessment.*)

Infant Formula Requests

When breastfeeding participants request formula, this is an opportunity for CPAs to use their critical thinking skills using Value Enhanced Nutrition Assessment (VENA) principles. Assessing infant formula requests involves collecting information on many levels and sharing information the parent needs to meet their feeding goals. (*See the "VENA" section as well as VENA resource page at the WIC Works Resource System at https://wicworks.fns.usda.gov/resources/value-enhanced-nutrition-assessment-vena-guidance for guidance on conducting a participant-focused, health outcome-based assessment.*)

When counseling new parents about formula use:

- Relate their breastfeeding goals with strategies to help them meet them. (For example, if a parent requesting formula had planned to breastfeed for 6 months, explain how supplementing before breastfeeding is well established might affect their ability to reach that goal. Offer options to help them continue maintaining production, such as expressing milk, to continue to establish a good production.)
- Counsel them about the impact of infant formula supplementation on milk production.
- Use open-ended questions to identify why the parent feels that infant formula is needed.
- Explain that including infant formula in the food package will affect the quantities and types of foods they and their infant receive and potentially how long they will receive WIC benefits.
- Communicate with WIC breastfeeding staff to help them address their breastfeeding challenges.
- Assign a food package that provides the minimal amount of formula to meet, but not exceed, the baby's nutritional needs.
- Remind them that it may be possible to resume full breastfeeding after using supplemental formula and that WIC staff can help them with the process if desired. The DBE can advise on strategies to gradually wean the baby from formula.
- Connect them to breastfeeding support to help them meet their breastfeeding goals.

Policies for Tailoring Food Packages

The State agency has policies and procedures to support breastfeeding parents and infants in fully or partial breastfeeding, along with procedures to tailor food packages. This includes ensuring that staff are trained in how to provide anticipatory guidance, conduct breastfeeding assessments, assign appropriate food packages, and provide counseling and support. Policies should also include the amount of formula to issue, the number of months of issuance of food packages, the ability to change packages, and support systems in place to assist participants to continue breastfeeding.

WIC and Breastfeeding—Health Communication

Sneak Preview:
The Level 3 content in the "Health Communication" section addresses best practices and participant-focused ways to conduct individual and group education with WIC families.

Level 3 Competencies:

- Apply adult learning principles when educating WIC participants about breastfeeding.
- Use effective client-centered techniques for group breastfeeding education.
- Assist WIC staff in developing breastfeeding competencies according to their staff role.

Technology

Virtual Technologies

Studies show that WIC parents are generally comfortable with web-based technologies for breastfeeding information. Virtual technologies are increasingly popular for creative ways to conduct certifications and education. Virtual technologies are also important ways to engage WIC participants who live in remote areas, where access to lactation support for complex issues might be limited, and for participants who lack transportation to the WIC clinic.

Lactation experts use virtual technologies to assist parents experiencing breastfeeding challenges. The Texas WIC Program uses a video conferencing platform to extend their reach to WIC parents who experience complex breastfeeding challenges and are unable to get to the clinic for direct assistance. The secure web-based platform allows a lactation consultant stationed in a regional support center to provide tele-consults and to coach WIC staff in the clinic on following up with the participant.

Considerations

State and local agencies are encouraged to establish guidelines for virtual education that comply with Federal and State laws and policies. This might include exploring virtual education options that are secure and protect the participant's confidentiality. Some agencies ask participants to sign an electronic or physical release form.

Social Media and Texting Protocols

Social media can effectively disseminate information in a timely manner and can leverage networks of people to make information sharing easy. According to the Centers for Disease Control and Prevention (CDC), social media encourages conversation and a sense of community while spreading key messaging and promoting behavior change in the community. Breastfeeding coordinators should be familiar with local agency and State social media policies.

Many WIC agencies allow staff to use text messages to reach participants. Texting can disseminate quick messages, issue appointment reminders, and check in with participants. Breastfeeding coordinators should ensure that policies are in place to assure confidentiality of participants. This might include conducting texting and phone conversations in locations that allow for confidentiality and respect for participant information.

Best practices for using texting include:

- Secure permission from the participant to communicate via text messages prior to texting.
- Keep text messages brief.
- Avoid personal or medical information or identifiable data (e.g., social security numbers, WIC ID numbers).
- Document contacts made via text.
- Share only approved websites, photos, and videos.
- Avoid personal messages and images.
- Keep cell phones used for texting in secure locations.
- Report lost or stolen cell phones immediately.
- Establish protocols to return agency-provided cell phones when staff are no longer employed with the agency.

Group Education

Adult Learning

WIC staff use adult learning principles to educate participants about breastfeeding. Adult learners:

- *Want to know why they should learn the information* ("What's in it for me?"). Show parents how breastfeeding will help them bond with their baby and help their baby get off to a healthy start.
- *Want to be in charge of their life.* Participant-focused techniques help them set their own health goals and select options that work for them to achieve their goals.
- *Bring their experiences to the learning situation.* Taking the time to find out what parents know and value respects them and their experiences. This can, in turn, make them receptive to education that allows them to build on their knowledge. Questions to consider include: *What have you tried already? Tell me about some things you have already learned about.*
- *Are ready to learn when the need arises.* When the information is relevant, adults are more likely to learn. For example, teaching parents about latch might be more relevant toward the end, rather than early, in pregnancy.
- *Want to apply the learning to particular tasks.* That might include showing a parent how to latch the baby or how to hold the baby skin-to-skin after the birth.

Health Literacy

The term "health literacy" refers to a person's ability to process and understand basic health information so they can make appropriate health decisions. People with low literacy skills are also more likely to have low health literacy. Studies show that people with low health literacy:

- Often misunderstand information.
- Are not as likely to act on the advice they receive.
- Are less likely to feel safe sharing personal information.
- Are less likely to read or use written materials.

Racial and ethnic minorities, people with less than a high school degree or GED certificate, low-income populations, and non-native English speakers are more likely to have low health literacy. Studies show that one in three adults has below basic or basic health literacy skills, which means they would find it difficult to read and follow simple instructions on a prescription medicine label.

Bring It Home!
Use the handout, "**Easy to Understand?**" to practice ways to convert complex statements to simpler, easier to understand language.

Group Learning

People learn in many ways: visual (what they see), auditory (what they hear), and kinesthetic (what they experience). When conducting group education, consider that adults are more likely to learn and retain information when it is presented through varied learning techniques. Learners typically have a short attention span (on average around 7-10 minutes!) when learning in a group situation. Breaking up learning content will keep things interesting and moving. Trainers can:

- Ask a question to invite discussion, (e.g., *What have you been learning about breastfeeding?*).
- Share a story or experience, (e.g., *What was it like to breastfeed for the first time?*).
- Do an interactive activity, (e.g., divide into pairs to make a list of reasons to breastfeed).
- Conduct an audience poll, (e.g., *How many of you know someone who has breastfed?*).
- Include stretch breaks.
- Move to a different side of the room.
- Focus content on the most important information new parents might want to know.

Participant-centered group discussion helps students learn in their own way rather than trying to pour information into them. This helps create a positive learning environment and a sense of community where each person has a role in learning. Facilitated discussion helps create a safe space where participants can feel free to share their thoughts and concerns about breastfeeding.

Facilitation tools that can contribute toward a participant-centered group discussion include:

- Use active listening skills such as open-ended questions and affirming learners, (e.g., *That's a great question! Many parents worry about that. I can tell what good parents you will be!*).
- Ask *feeling* questions, when possible, (e.g., *How do you feel when breastfeeding your baby?*).
- Let parents know the next steps, (e.g., follow-up with a peer counselor).
- Address group education barriers carefully (see table on next page).

Group Education Barriers	Ideas to Consider	Language to Consider
Misinformation	▪ Affirm attendees. ▪ Allow the group to correct misinformation.	▪ *Many parents have heard that, too!* ▪ *What have the rest of you heard?*
Getting the group back on track	▪ Summarize a few main points and move on.	▪ *It seems that everyone agrees on the role of family members. Let's shift now to ways you can talk with your family about breastfeeding.*
Overly talkative learners	▪ Affirm and ask for ideas from others.	▪ *Jim has had so many wonderful ideas. How do the rest of you feel?*
Quiet learners	▪ Carefully engage in a safe way.	▪ *We have not heard from Sally yet. Is there anything you would like to add?*
Distractions from children	▪ Provide toys and activities. ▪ Consider asking other WIC staff to assist. ▪ Use the opportunity to praise parents.	▪ *We are so happy to see these beautiful babies and children.*

Staff Training

The USDA Food and Nutrition Services *Nutrition Service Standards* require that State and local agencies ensure that staff receive sufficient orientation, competency-based training, and continuing education (quarterly, if possible), along with periodic performance evaluations. Didactic learning is knowledge-based, while competency-based learning is outcome-oriented and a preferred method of educating staff about breastfeeding. Breastfeeding coordinators must ensure that members of the WIC team can access appropriate breastfeeding education pertinent to their role. They can also arrange for additional learning opportunities through shadowing or observing skilled staff, providing feedback and practice opportunities, and recommending additional learning opportunities as needed.

The *WIC Breastfeeding Curriculum* provides competency training for all WIC staff. Competencies include:

- Support staff: how to promote and support breastfeeding, ways to empower and reassure new parents, and when to make referrals.
- Peer counselors: how to support parents through the normal course of breastfeeding.
- CPAs: how to support breastfeeding, tailor food packages for breastfeeding dyads, and conduct appropriate assessments.
- Breastfeeding coordinators: how to develop appropriate policies and practices for breastfeeding promotion and support activities, including staff training and coordination with community partners.
- DBEs: how to assist parents who experience complex breastfeeding challenges.

WIC and Breastfeeding—Continuity of Care

Sneak Preview:
The Level 3 content in the "Continuity of Care" section addresses strategies to build and improve referral networks with providers and community partners to strengthen the circle of care for WIC breastfeeding families.

Level 3 Competencies:

- Establish and build relationships and networks with community partners for breastfeeding support and continuity of care for breastfeeding parents.
- Establish a structured referral process for breastfeeding participants.

Community Partnerships

Medicaid

The Affordable Care Act (ACA) requires private insurance health plans to provide certain preventive services for women without cost sharing, including coverage for breastfeeding counseling, equipment, and supplies. The ACA does not include a mandate for lactation services in Medicaid; however, some State Medicaid programs may provide these services. Check with your State WIC Breastfeeding Coordinator to learn what breastfeeding services are provided by your State Medicaid program.

Promoting WIC

Some groups and individuals in the community may consider WIC to be primarily a food or formula program. Not everyone is aware that WIC is also a premier source of breastfeeding education and support. They may not know WIC's income guidelines and eligibility criteria and may therefore not refer eligible parents to WIC. Building partnerships can help increase awareness of WIC and the support provided for breastfeeding families. It can also strengthen the circle of care for new families and improve the continuity of care they need to meet their infant feeding goals.

Key messages to share with stakeholders might include:

- WIC provides participant-centered, tailored breastfeeding support.
- Knowledgeable WIC staff empower families to set goals that improve their health and that of their children.
- WIC parents can receive a comprehensive array of breastfeeding resources and support, including breastfeeding education, equipment and aids, peer counselors, and lactation experts.
- WIC's food packages provide nutritional support during critical times of infants' growth and development.
- Reciprocal referrals expand support so that new parents can reach their breastfeeding goals.

Needs Assessment

When identifying potential partners, it is helpful to examine the needs of pregnant and breastfeeding participants, as well as identify strengths, weaknesses, and gaps in services within both WIC and the community. A needs assessment can include both an internal and an external assessment.

- *Internal Assessment.* This examines the WIC agency's programs of support, such as peer counselors, DBEs, internal referral networks, staff training, breastfeeding aids available to participants, education, and available support.
- *External Assessment.* This identifies resources and support within the community. It can include organizations that serve the same population as WIC, existing and new relationships that could be nurtured, practices at hospitals, and post-discharge support.

Building Relationships

Community partners and stakeholders can assist by promoting breastfeeding, promoting WIC's benefits and support services, giving and receiving referrals, and connecting constituents to WIC support services. When building new relationships with community partners, WIC staff can:

- Participate in the local breastfeeding coalition.
- Invite potential partners to breastfeeding training events.
- Hold a community-wide breastfeeding summit to build networks of support.
- Meet with key stakeholders to offer ways to collaborate and support new parents.
- Share WIC resources.

Referrals

Breastfeeding coordinators work with clinic leadership to identify and establish referral networks among clinic staff and community stakeholders. For internal referrals, they determine when and how clinic staff should make breastfeeding referrals to DBEs, peer counselors, CPAs, and support staff. Referrals might be needed when participants request formula, breast pumps, a food package change, or help with breastfeeding challenges.

Breastfeeding coordinators also conduct outreach with community healthcare providers such as hospital staff, obstetric and pediatric clinics, neonatologists, outpatient clinics, private practice lactation consultants, and others who care for new families. Referrals may occur:

- At discharge when hospital staff notify WIC clinics that WIC participants have delivered.
- When providers see WIC participants who need ongoing breastfeeding support from WIC.
- When CPAs and DBEs alert providers about health questions and concerns, they or participants have.

Provider Engagement

The WIC Infant and Toddler Feeding Practices Study II found that WIC participants are more likely to breastfeed when they receive positive messages about breastfeeding from their healthcare providers. However, studies show that new parents do not always receive information or advice about breastfeeding from their healthcare providers. One study found that new parents commonly report receiving either no advice or inconsistent recommendations. Another study of prenatal providers found that breastfeeding was discussed in only 29 percent of visits for a brief period lasting an average of 39 seconds.

When reaching out to healthcare providers, breastfeeding coordinators can show them that:

- New parents are more likely to breastfeed and continue for longer durations when their providers encourage it.
- Parents depend on consistent, reinforced messaging to normalize breastfeeding.
- Many community resources, including WIC, are available to support new parents after hospital discharge.
- WIC accepts referrals from local healthcare providers and will make referrals when their patients experience complex breastfeeding challenges requiring medical treatment or care.

If participants report conflicting information from providers, hospital staff, and others, always assume the best intentions. Sometimes new parents misinterpret information they receive. Open-ended questions can help staff learn more. Staff can also provide affirmation. A statement such as, "*It sounds as though your provider cares about you and your baby"* helps strengthen the parent's relationship with their healthcare provider. Breastfeeding coordinators may consider inviting providers to a breastfeeding training event or share useful resources and peer-reviewed journal articles.

Bring It Home!
Review the FNS video, "Creating Community Partnerships for Breastfeeding Success" at https://wicbreastfeeding.fns.usda.gov/wic-partners to learn additional ideas for ways to engage community partners to help strengthen the referral network of support for WIC breastfeeding families.

Counseling—Difficult Counseling Situations

Sneak Preview:
The Level 3 content in the "Difficult Counseling Situations" section addresses common barriers and strategies to ensuring productive counseling encounters with WIC participants.

Level 3 Competencies:

- Address personal and clinic barriers to effective counseling.
- Demonstrate sensitivity to participants experiencing social barriers.

Counseling Barriers

Limited Time

Time is often limited to conduct participant-focused conversations with WIC participants. WIC staff must improve efficiency to support participants in meeting their goals. Solutions to consider include:

- Use active listening skills to focus on the participant's primary concerns. These include asking open-ended questions to get at the heart of their concerns. Affirming participants so they feel safe sharing more helps CPAs and DBEs spend less time asking unnecessary questions. (*See Levels 1 and 2 content on "3-Step Counseling Skills.*)
- Integrate breastfeeding into the full spectrum of services at the clinic to enable staff to reinforce and build on support provided by others. This helps participants feel broad support and breaks down their barriers.
- Make referrals to staff who can offer other levels of care and follow-up.

Environmental Barriers

Sometimes barriers within the clinic itself can hamper effective communications. Examples can include negative signage that communicates a non-welcoming environment, lack of private space, noise of crying babies, and physical barriers such as a desk or other furniture between the staff and participant. Even virtual communications can pose environmental barriers, such as lack of privacy, poor lighting, unstable internet connection, and interruptions from family members.

Some solutions to consider include:

- Replace negative signage with more positive messaging.
- Hang posters and other items that help participants feel welcomed.
- Provide safe activities for children.
- Consider privacy screens, cubicles, or other portable barriers, if needed, to improve privacy.
- Remove or rearrange furniture to enhance face-to-face communications.
- Use nonverbal communication such as leaning in, smiling, and eye contact to tune out environmental barriers both in the clinic and through virtual connections.

Social Barriers

Social barriers are "differences (or inequities) in gender, ethnicity, race, religion, health, or socio-economic status between individuals or groups that prevent them from achieving or accomplishing their goals or deny their opportunity to access resources to advance their interests." WIC participants might:

- Lack transportation to the WIC clinic, healthcare providers, and lactation resources.
- Be part of a family where formula feeding is the norm.
- Have lower education or reading levels, making it harder to understand new information.
- Lack exposure to information about infant feeding recommendations.
- Have chronic health issues (e.g., diabetes or obesity).
- Face ongoing racism and marginalization.
- Have depression, chronic stress, or other mental health issues.
- Live in unsafe or inadequate housing or worry about becoming homeless.
- Face domestic violence.

When WIC parents face difficult social barriers, breastfeeding can often appear too challenging or impractical. Probing questions and other active listening tools can help them explore possible solutions. Asking about available support can determine what participants might need to meet their breastfeeding goals. Staff can also make appropriate referrals to social workers and other resources as needed.

Bring It Home!
Consider any time, environmental, or social barriers faced by WIC staff and your participants that might affect effective communications. Meet with other agency staff to discuss the barriers identified. Brainstorm solutions that might help address the barriers you have identified.

Counseling—Advanced Counseling

Sneak Preview:
The Level 3 content in the "Advanced Counseling" section addresses Value Enhanced Nutrition Assessment (VENA) skills and motivational interviewing techniques to conduct participant-focused conversations.

Level 3 Competencies:

- Use participant-focused approaches to build rapport with WIC parents.
- Help WIC participants set S.M.A.R.T. goals for breastfeeding.
- Use motivational interviewing techniques to help WIC participants uncover their inner motivations and confidence to breastfeed.
- Determine a WIC participant's readiness to breastfeed and provide appropriate support to help them move to higher levels of readiness to breastfeed.

Value Enhanced Nutrition Assessment (VENA)

The Value Enhanced Nutrition Assessment (VENA) initiative was launched by the Food and Nutrition Service and the National WIC Association in 2003 as part of the Revitalizing Quality Nutrition Services initiative in WIC. VENA adds value to the WIC experience by keeping the participant at the center of the assessment process. This leads to a participant-centered experience that helps parents identify goals that can lead to positive health outcomes. VENA positions WIC staff as a resource for information and support to help parents reach their goals.

Key components of VENA include:

- Build a relationship with participants through rapport-building techniques.
- Collect relevant information as part of the assessment process.
- Use critical thinking skills to link the information obtained to the participant's individual needs and concerns.
- Engage participants in a conversation that helps them set personal goals.
- Assist the participant with developing a personalized nutrition plan.

Bring It Home!
Refer to the *VENA Guidance* document at https://wicworks.fns.usda.gov/wicworks/Learning_Center/VENA_Guidance.htm to learn more about conducting a comprehensive participant-focused nutrition assessment. Additional VENA training is available at WIC Learning Online at https://wicworks.fns.usda.gov/resources/wic-learning-online-wlol-getting-started.

Participant-Focused Techniques

It can be easy to fall into the trap of believing we know what is best for WIC families. When we operate from that perspective, we can slip into focusing on *persuasion* rather than *engagement* and honoring participants. A persuasive approach focuses on what the participant is doing wrong and identifies what staff believe will "fix" the deficiencies. Persuasion is based on assumptions about what we think people

need. It does not honor and respect where they are in their life and is unlikely to lead to behavior change.

Instead, a *participant-centered approach* places the parent at the heart of the conversation. It acknowledges that the parent is the true expert. After all, no one knows more about their lives, hopes, and dreams. With a participant-focused conversation, we talk *with* parents rather than *at* or *to* them. Instead of focusing on deficiencies, we help participants explore what they want so they can set their own priorities and goals.

Participant-focused techniques that can help include:

- Use open-ended questions and other active listening skills to engage parents in the conversation.
- Seek information about the parent's goals, abilities, concerns, and questions.
- Help parents decide which behaviors they want to adopt or change to fit their own personal goals, culture, and situation.
- Share information and ideas for how parents can accomplish the new behavior with small, doable action steps.
- Show how WIC and other resources for support can help parents reach their goals.

Rapport-Building Techniques	Other Things to Consider
Listening helps people feel valued and respected.	Go beyond listening to the parent's words only. Listen to their tone of voice. Observe their body language. Listen for their priorities.
Open-ended questions help set a positive tone for a participant-focused conversation.	Ask yourself: ▪ Why would this change be good for the parents? ▪ How might they go about making this change? ▪ What are the best reasons for doing so? ▪ What would they need to make it work?
Affirming participants helps them relax and builds confidence.	Affirmation works best when it amplifies parents' positive feelings so they can feel proud of their accomplishments.
(Note: this information builds on the Level 2 content found in the "3-Step Counseling" section.)	

Bring It Home!
Use the handout, "**Sample Affirmations**" to identify ideas for affirmations that can be tried with participants, as well as colleagues. Practicing affirmation skills with co-workers can help reinforce the principles and create a clinic-wide environment that demonstrates sensitivity and kindness.

Reflective Listening

Reflective listening is a brief response that mirrors back the parent's words. Reflection is a powerful way to help parents feel they have been heard. When reflection is shared, the parent might expand on the statement to offer more information. It can also help the parent correct you if you Interpreted their statement incorrectly.

Reflection typically begins with words such as:

- *It sounds as though you...*
- *I hear you saying that...*
- *You are concerned about...*
- *You are feeling...*

Simple reflection and deeper reflection are two powerful types of reflective listening.

Type of Reflection	What It Is	Examples
Simple Reflection	Restating the parent's words so they can confirm, expand, or correct what they said.	Parent says: *Nobody in my family was able to make milk.* Response: ▪ ***I hear you saying*** *that some women in your family breastfed but were not able to make enough milk.*
Deeper Reflection	Paraphrases the parent's response by guessing the meaning of what was said.	Response: ▪ ***You are feeling*** *that you will not make milk since others in your family were not able to, and that worries you.*

Bring It Home!
Use the handout, "Reflective Listening" to practice identifying both simple and deeper reflections.

Critical Thinking Skills

A key part of the VENA assessment is using critical thinking skills. This involves several steps:

1. Identify pertinent information and data from all sources.
2. Distinguish accurate and relevant information, and identify additional information needed.
3. Discard irrelevant information.
4. Set priorities that align with the participant's goals.
5. Develop a counseling intervention plan with the participant.

Setting S.M.A.R.T. Goals

Baseball player Yogi Berra once said, "If you don't know where you are going, you'll end up someplace else." Setting goals helps WIC parents become more purposeful about their breastfeeding decisions. It can improve their confidence when they see themselves achieving goals they set for themselves. The CPA does not set goals *for* participants. Instead, the CPA guides participants through the process.

Participants will be more likely to reach goals when the goals are S.M.A.R.T. In other words, they are *specific, measurable, achievable, realistic,* and *timely.*

- **Specific:** states what they want to achieve.
  - General goal: I will breastfeed more often.
  - Specific goal: I will breastfeed at least 8 times per day.
- **Measurable:** able to track to know when it has been achieved.
  - Unmeasurable goal: I will breastfeed my baby when possible.
  - Measurable goal: I will record the number of times I breastfeed my baby during the first week.
- **Achievable:** attainable given their situation, life, and resources.
  - Difficult to achieve goal: I will breastfeed for 3 years.
  - Achievable goal: I will breastfeed exclusively during the hospital stay.
- **Realistic:** small enough that it is doable and there is a good chance it can be met.
  - Unrealistic goal: I will position and latch my baby properly for all feedings.
  - Realistic goal: I will ask the hospital lactation expert to observe a feeding to be sure my baby is latched well.
- **Timely:** has a target date for completion.
  - Non-timely goal: I will breastfeed as many times as I can.
  - Timely goal: I will breastfeed at least 8 times per day during my baby's first 2 weeks of life.

Bring It Home!
Use the handout, "Setting Breastfeeding Goals" to practice helping participants set S.M.A.R.T. goals.

Motivational Interviewing

Motivational interviewing (MI) is a participant-centered, directive method of encouraging change. It focuses on helping people explore and resolve any ambivalence in an atmosphere of acceptance and compassion. Since change is not always easy, MI helps nudge people from indecision to positive decision by helping them discover their inner motivations and resolve the things they are uncertain about. The MI approach is used in a wide variety of health settings, including WIC. Studies demonstrate that it can bring about positive behavior changes among WIC participants.

Ambivalence

Nearly everyone who considers a change feels at least some degree of ambivalence, or mixed feelings. It is normal to weigh the pros and cons of change, and to balance benefits against perceived cost of making the change. The higher the perceived cost of a change, the harder it is to embrace it. When participants have mixed feelings about breastfeeding, MI helps them better understand their inner motivations and set priorities of what is most important to them.

Bring It Home!
Think about a change in your life that you had mixed feelings about. Perhaps it was buying a house or a car, losing weight, taking a vacation to an unfamiliar place, or changing jobs. How did you resolve that ambivalence?

What Motivates Change

Research shows that focusing on the risks of certain behaviors does not usually motivate people to change. For example, focusing on the risks of *not* breastfeeding has not been found to be effective in convincing people to breastfeed, and can actually have the opposite effect.

What *does* motivate change? The MI approach helps people find their intrinsic value in adopting new behaviors. Asking yourself, "*Why isn't this person more motivated?"* focuses on the person's deficiencies. Instead, consider, "*What motivates this person?"* When we can help participants articulate out loud what they find important (also known as "self-talk"), we help them begin to imagine success and visualize the positive feelings that might come along with that success.

Stages of Change

When counseling participants and building rapport, it is helpful to remember that change often happens gradually. The "Stages of Change" model helps staff determine a participant's readiness to adopt positive breastfeeding behaviors. This builds on the simple "Readiness" content discussed in Level 2 by taking a deeper approach to understanding the level of support participants might need as they journey through the various phases toward positive change.

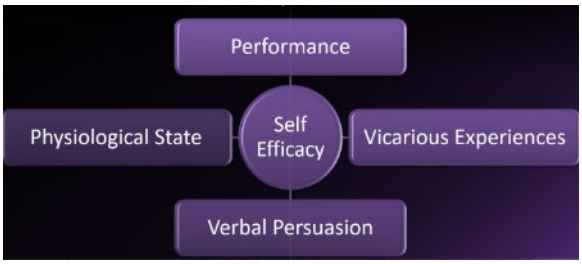
Stage of Change	Common Characteristics	How Staff Can Respond
Precontemplation 	▪ Lack knowledge or family experience. ▪ Prior negative experience. Words participants might use: ▪ *I'm not sure I would want to do that.* ▪ *I cannot see myself doing it.* ▪ *Everyone in my family used formula.*	▪ Listen. ▪ Avoid giving advice. ▪ Take the time to learn.
Contemplation 	▪ Consider possibly breastfeeding. ▪ Ambivalent or "on the fence" and not ready to make a commitment. Words participants might use: ▪ *I have heard breastfeeding is best, but it might be too hard for me.* ▪ *I might "try" to breastfeed.*	▪ Help the participant consider inner motivations and possible concerns. ▪ Strengthen self-efficacy by showing ways to fit breastfeeding into their lives. ▪ Encourage them to learn more.
Preparation 	▪ Takes steps toward a positive outcome, such as holding baby skin to skin. ▪ May still have lingering ambivalence. Words participants might use: ▪ *I wish I had at least tried last time.* ▪ *I would like to learn more!*	▪ Help participant to explore concerns and goals. ▪ Discuss options to help gain more confidence.

Stage of Change	Common Characteristics	How Staff Can Respond
Action 	▪ Ready to put the plan into action. ▪ Eager to learn more. ▪ Attends a prenatal class or discusses plans with their healthcare provider. Words participants might use: ▪ *I would love to talk with a peer counselor.* ▪ *I'll breastfeed for as long as I can.*	▪ Affirm the participant's decisions. ▪ Help them make plans for actions to move them toward success.
Maintenance 	▪ Breastfeeding and meeting early goals. ▪ Builds on each successful goal and increases confidence. Words participants might use: ▪ *I am proud I decided to breastfeed.* ▪ *It is not as easy as I thought, but I am still hanging in there.* ▪ *I plan to continue breastfeeding until I go back to work.*	▪ Continue to support the participant by identifying ways to overcome challenges that might arise. ▪ Remind participants that a relapse (e.g., giving formula) is not failure but an opportunity to learn and renew their goals.

Motivational Interviewing Approaches

Key Approaches	Why It Matters	Language or Content to Consider
Engagement	Builds rapport and helps participants feel comfortable and relaxed. [*See active listening skills in Levels 1 and 2 Counseling section, along with VENA content in this section.*]	▪ *What is your biggest priority?* ▪ *What is most important to you now that you and your baby are home?* ▪ *As you think about your new baby, what do you find yourself thinking about most?*
Evoking Motivation	Calls forth inner motivation so participants can visualize success and imagine the feelings that come with that success.	▪ *What would be some of the best reasons for you to breastfeed?* ▪ *How do you think you might feel if you successfully breastfed?* ▪ *What would be your hopes and dreams about breastfeeding?*
Flipping the Conversation	When negative comments are stated, flipping the conversation can help participants visualize other perspectives.	Comment: *"It would be too hard for me."* ▪ Flipped: *If it were easy for you, how would that make you feel? What would it look like?*
Building Confidence	To achieve goals, participants need to feel confident they can adopt breastfeeding behaviors. Parents with high motivation *and* high confidence are most likely to reach their goals.	▪ *You should be so proud of what you have accomplished!* ▪ *What would it take for you to feel more confident in your ability to breastfeed?*
Summarizing	When the participant is ready for information, summarizing what has been discussed helps them organize the content and know what their next steps might be.	▪ Ask permission to summarize key points. ▪ Offer practical, doable solutions. ▪ Avoid "*you should*" or "*you must*". ▪ *Many parents have found...*

Self-Efficacy Framework



When an initial assessment reveals that the participant has low confidence, the "self-efficacy" framework can help increase confidence. This framework has four major components:

- Performance accomplishments (experiencing repeated successes)
  - Point out what parents are doing well.
  - Encourage parents to discuss their goals with family members.
  - Help parents work toward simple, doable solutions to build early small successes.
- Vicarious experiences (positive role modeling/peer support and observational learning)
  - Provide peer counselors to serve as a positive role model.
  - Post photos of WIC breastfeeding parents in high traffic areas of the WIC clinic.
  - Invite breastfeeding participants nurse their babies in main waiting areas through signage welcoming breastfeeding parents.
- Verbal persuasion (praise and encouragement)
  - Point out what parents are doing well so they can build pride.
  - Encourage attendance at small group classes and support group meetings.
- Physiological and affective states (reducing pain, discomfort, and anxiety while enhancing positive feelings of calm and relaxation)
  - Provide quick solutions for pain relief as needed.
  - Encourage skin-to-skin contact to lower stress and pain levels.
  - Affirm parents to help them feel relaxed and confident.

Bring It Home!
Use handout, "**Putting it All Together**" with scenarios to practice using the basic MI techniques.

Preparing for Breastfeeding—Reasons to Breastfeed

Sneak Preview:
The Level 3 content in the "Reasons to Breastfeed" section addresses ways breastfeeding helps contribute to a healthy microbiome and immune system in the baby.

Level 3 Competency:

- Inform WIC participants about ways breastfeeding contributes to a healthy microbiome in the baby.

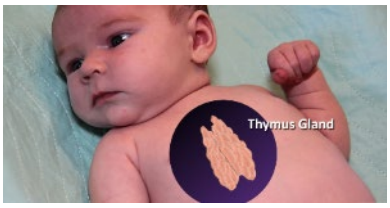
Constituents of Human Milk

Human Milk Microbiome

The human microbiome is a collection of living organisms that live inside the body. Thousands of different species of microbes live in our mouth, nasal passages, gut, skin, lungs, and other parts of the body. These microbes live in balance with one another to help prevent infection and disease.

Babies are exposed to their parent's microbiome in many ways. This important microbiome exposure helps the baby begin to colonize to the environment of the family. This exposure occurs during pregnancy, during the labor process as the baby passes through the birth canal, in skin-to-skin contact, and through breastfeeding. Research shows that the gut bacteria play a critical role in immune function and prevention of autoimmune diseases. The microbiota of the exclusively breastfed baby is much different from the microbiota of the formula-feeding baby. The microbiota of a breastfed baby is much more diverse, preparing the baby to fight diseases in the environment.

Thymus



The central organ of the baby's immune system is the thymus, located between the lungs behind the sternum. The thymus helps produce lymphatic tissue, including lymph nodes, which are responsible for protecting the body from bacteria and foreign pathogens. It also helps certain cells mature into lymphocytes, or white blood cells, and to create killer T-cells that aggressively fight bacteria. Studies show that the thymus of the exclusively breastfed infant is substantially larger than that of a formula-fed infant. Scientists believe a larger thymus and an enhanced immune system directly affect a baby's long-term ability to fight disease and infection.

Preparing for Breastfeeding—Barriers

Sneak Preview:
The Level 3 content in the "Barriers" section addresses contraindications to breastfeeding and ways to help participants identify concerns and educate them.

Level 3 Competency:

- Identify contraindications to breastfeeding.

Systemic Barriers

Systemic barriers can arise from policies or practices that result in limiting access of certain groups to resources or services. These barriers may not always be obvious and can appear "neutral." Yet they can sometimes have an impact on certain groups and increase perceived barriers to breastfeed. CPAs and breastfeeding coordinators work with other WIC staff to identify and address any systemic barriers within the agency, health unit, or clinic.

A few systemic barriers and questions to consider include:

- **Clinic space for breastfeeding**. Breastfeeding parents may be uncomfortable asking for a place to breastfeed in private. Provide space and signage that normalizes breastfeeding.

- **Positive images**. Are there posters and photos of breastfeeding families displayed in the clinic to normalize breastfeeding? Do the images reflect the populations served by WIC? Are informational materials in languages that your participants speak?
- **Language**. Is there an effective plan for reaching participants who do not speak English? Do staff keep language simple when talking with participants about breastfeeding? Using jargon and unfamiliar terms can make it more challenging for participants with limited English skills or basic health literacy to understand.
- **Counseling**. Do CPAs sit "eye to eye" with participants, and do staff use active listening skills to ensure a true participant-focused conversation? Are all participants given equal access to information and support, or are assumptions and judgments made about certain groups (e.g., "teens should focus on finishing school rather than bothering with breastfeeding" or "African American parents don't breastfeed")? Are appropriate referrals made when parents encounter breastfeeding challenges, and are those referral sources accessible and affordable?
- **Administrative issues**. Are clinic hours suitable for participants who are employed or have transportation difficulties during usual working hours? Can WIC participants access peer counselors beyond the usual clinic hours and setting (per the *WIC Breastfeeding Model Components for Peer Counseling)*?

Contraindications

The CPA might be the first WIC staff to identify a potential contraindication to breastfeeding. CPAs should follow State and local agency protocols when encountering contraindications and advise participants about recommendations from the CDC. CPAs should ask participants if they have discussed their condition with their healthcare provider and learn how the provider advised the participant and discussed their infant feeding goals. The healthcare provider will manage the participant's health condition and advise whether breastfeeding is possible. CPAs should also consult with the DBE if the parent needs to wean abruptly or maintain lactation while temporarily discontinuing direct breastfeeding.

CDC guidelines are consistently updated regarding the safety of breastfeeding related to infectious diseases. The CDC addresses the following conditions:

Condition	CDC Advice on Breastfeeding
Tuberculosis	▪ Breastfeeding is contraindicated in the case of active, untreated tuberculosis.
West Nile Virus	▪ There is no evidence that when a breastfeeding parent is infected with West Nile Virus that it will harm the breastfeeding infant. ▪ In the very few cases of transmission through breastfeeding, none resulted in recognizable illness to the baby. ▪ The benefits of breastfeeding are believed to outweigh any theoretical risks.

Condition	CDC Advice on Breastfeeding
Zika Virus	▪ There are no known reports of transmission of Zika virus infection through breastfeeding. Although the Zika virus has been detected in breastmilk, the benefits of breastfeeding appear to outweigh any possible risk. ▪ Parents are encouraged to breastfeed even in areas where Zika virus is found.
Influenza	▪ Everyone 6 months of age and older should get a flu vaccine each season. It is considered safe for both pregnancy and lactation. ▪ Being vaccinated reduces parents' risk of getting sick and passing influenza to their children. ▪ Since infants are not advised to receive a flu shot until after they are 6 months old, the influenza vaccine given to the parent is an important way to transmit maternal antibodies created in response to the vaccine. ▪ A breastfeeding parent who develops influenza should receive standard antiviral medications and other treatments and continue breastfeeding. If the parent is too sick to feed the infant at the breast, they should be encouraged and supported to regularly express milk, so the infant continues to receive breastmilk.
Hepatitis B (HBV)	▪ Breastfeeding is safe for a parent infected with hepatitis B (HBV). The theoretical risk of parent-child transmission through breastfeeding is negligible if infants born to HBV-positive mothers receive the HBIG/HBV vaccine at birth. ▪ Infants born to HBV-infected parents should receive the hepatitis B immune globulin and the first dose of hepatitis B vaccine within 12 hours of the birth. The second dose of vaccine is given at age 1-2 months, and the third dose at age 6 months.
Hepatitis C (HCV)	▪ There is no documented evidence that hepatitis C spreads through breastmilk or feeding an infant at the breast since the virus is transmitted by infected blood, not by human milk. ▪ If the nipples are cracked and bleeding, however, the parent should suspend breastfeeding and consider expressing and discarding milk until the nipples heal.
HIV	▪ Breastfeeding is contraindicated if a parent has been diagnosed with human immunodeficiency virus (HIV). ▪ U.S. parents should not breastfeed since safe infant feeding alternatives exist.
Environmental Toxins	▪ For the vast majority of dyads, the benefits of breastfeeding appear to outweigh the potential risk of exposure to chemical agents. ▪ To date, effects on the breastfeeding infant have only been seen when the parent was clinically ill from toxic exposure.
Lead	▪ Although lead in maternal plasma can be transferred through the breast, studies indicate little plasma lead is transferred into the breastmilk. ▪ Parents with blood levels less than 40 micrograms per deciliter (ug/dL) should be encouraged to breastfeed. Parents with confirmed blood levels greater than or equal to 40 ug/dL should breastfeed once their levels drop below 40 ug/dL. ▪ Infants with blood levels greater than or equal to 5 ug/dL can continue to breastfeed unless there are indications that the milk is contributing to the elevated blood levels. ▪ The baby' healthcare provider will provide continued recommendations for ongoing monitoring of the infant and the safety of breastfeeding.

Curriculum Update: Centers for Disease Control guidelines on COVID-19 and monkeypox

Current evidence suggests that human milk is not likely to spread the SARS-CoV2 virus to babies. Parents who are sick with COVID should practice normal hygiene practices (including washing hands) and wear a mask while breastfeeding or within 6 feet of the baby. The COVID-19 vaccination is considered safe and effective during both pregnancy and lactation. Staff should consult the CDC for current recommendations around the safety of breastfeeding when the parent has monkeypox.

Bring It Home!
Visit the CDC website at https://www.cdc.gov/breastfeeding/breastfeeding-special-circumstances/maternal-or-infant-illnesses/index.html?CDC_AA_refVal=https%3A%2F%2Fwww.cdc.gov%2Fbreastfeeding%2Fdisease%2Findex.htm for more information about breastfeeding in a wide variety of other illnesses and situations.

Preparing for Breastfeeding—Pregnancy

Sneak Preview:
The Level 3 content in the "Pregnancy" section addresses prenatal risk factors that might compromise breastfeeding, as well as ways to help pregnant participants set doable goals for breastfeeding.

Level 3 Competencies:

- Help WIC pregnant participants set realistic, practical goals for breastfeeding.
- Identify parents with a history of lactation challenges/prenatal risk factors that can affect breastfeeding and refer.

Feeding Decisions

According to the theory of planned behavior, the pathway to setting a behavioral goal begins with beliefs. These beliefs are influenced by how desirable the behavior is to the individual, as well as their belief in their ability to carry out that behavior. Some factors that influence breastfeeding decisions include information received from trusted sources, trends within the family, support from WIC and healthcare providers, and knowledge about benefits and ways to overcome barriers.

Social-Ecological Model

The social-ecological model is a prevention framework that describes these influencers. The primary influencers may include:

- **Individual factors**: knowledge, attitudes, beliefs, cultural practices, prior experiences, and practices common in the family. It may include beliefs about what others think about breastfeeding, self-efficacy, or beliefs about one's control over breastfeeding success.

- **Interpersonal**: family, peers, social networks, and associations. This includes the influence of grandparents, partners, friends, coworkers, and other interpersonal relationships formed through social media and other sources.
- **Institutions/organizations**: rules, regulations, policies, and informal structures by hospitals, medical practices, and other organizations that directly affect a participant's pregnancy and postpartum experience.
- **Community**: social networks, norms, and practices of community groups such as worksites, faith-based organizations, childcare facilities, shopping areas, and other public settings.
- **Societal**: local, State, Federal policies and laws that regulate or support healthy actions. This includes Federal and State laws around such things as public breastfeeding, worksite support for breastfeeding parents, and maternity care practices.

Setting Goals

CPAs help participants set goals for breastfeeding. Setting S.M.A.R.T. goals (described in the "Advanced Counseling" section) is a model for helping pregnant participants find doable goals that have a good chance of being achieved. Short-term goals may be more realistic, depending on the participant's knowledge and beliefs about breastfeeding.

In setting goals:

- Help participants recognize that exclusive breastfeeding, especially in the early days, helps establish healthy milk production to meet their infant feeding goals.
- Tell parents about the WIC food packages.
- Help parents set small, incremental goals. For example:
  - Breastfeed exclusively for the first month or the first week.
  - Call for help if they worry whether they are making enough milk.
  - Breastfeed exclusively in the hospital. Even some breastfeeding in the early hours/days is better than no breastfeeding.
  - Hold the baby skin to skin to help baby colonize to the parent's skin microbes and trigger the infant's feeding reflexes.

Risk Factors

Breastfeeding is possible for most participants. However, in some cases, risk factors might be identified during pregnancy that can potentially impact breastfeeding success. These can include:

Type 1 or Type 2 Diabetes

Diabetic women, including those with gestational diabetes, are at risk for delayed onset of lactogenesis II, the onset of copious milk production. Research shows there can be up to a 24-hour delay. One large study found that women with gestational diabetes are up to seven times more likely to develop type 2

diabetes later in life. However, breastfeeding can mitigate risk of developing type 2 diabetes by half for pregnant parents who had gestational diabetes. Exclusive breastfeeding and longer duration provide the highest protection. CPAs should provide information about the importance of breastfeeding in lowering the risk of diabetes postpartum for both the parent and the baby. Staff should provide parents with anticipatory guidance on the potential delay of lactogenesis II and develop a plan. CPAs should also refer to the DBE if there are concerns about milk production and to discuss a postpartum follow-up plan.

Obesity

Studies show that pre-pregnancy obesity (BMI>30 kg/m^2) and excessive gestational weight gain are associated with an increased risk of delayed onset of lactogenesis. BMI>26kg/m^2 is associated with lower amounts of prolactin, a hormone needed for the initial surge in milk production. CPAs should counsel obese women about the importance of early feeding practices (e.g., staying together skin to skin in the first hour after the birth, continued skin-to-skin contact throughout the hospital stay, and breastfeeding often in response to hunger cues). This can help get breastfeeding off to a good start and help prevent potential delays in milk production.

Hormonal Conditions

Various hormonal conditions, such as polycystic ovary syndrome (PCOS) and hypothyroidism, can affect milk production. PCOS is an endocrine disorder that occurs when multiple active cysts on the ovary interfere with ovarian function. Abnormal breast development is one of the outcomes. Hypothyroidism is a lack of thyroid hormones, which potentially delays lactogenesis. Participants who report hormonal conditions during pregnancy should be referred to the DBE for further assessment.

Breast Anomalies

Occasionally, participants may have questions about the size of their breasts or a flat or inverted nipple. In rare cases, breasts can be underdeveloped, tubular in shape, or have wide spaces between them. This might indicate a potential lactation problem. If parents report questions about their breasts, the CPA can remind them that in most cases, breastfeeding can occur. Refer to the DBE for further assessment and to establish a feeding and monitoring plan to help assure the participant gets off to a good start.

No Breast Changes

Most pregnant people will report breast tenderness and growth during pregnancy (about a cup size). However, not all will *feel* these changes. Sometimes there are no outward signs of breast changes, and they may wonder if they will produce milk. CPAs can reassure them that breast growth and changes vary from one parent to another. Breast growth can occur after the baby is born in response to milk removal. If there were no reported breast changes or growth, consult the DBE for further assessment and to help develop a follow-up plan.

Breast Surgery

Prior breast surgery, especially reduction mammoplasty, can affect milk production, depending on how the surgery was conducted. Even augmentation surgery can affect production depending on how the surgery was conducted and the reason for the surgery. CPAs can counsel participants that in many cases,

breastfeeding is possible. The CPA can also refer to the DBE to take a more detailed history and breast assessment and monitor the baby closely in the early postpartum period.

Normal Breastfeeding—Hospital Support

Sneak Preview:
The Level 3 content in the "Hospital Support" section addresses ways to build important partnerships with hospitals to improve support for WIC parents.

Level 3 Competencies:

- Conduct effective outreach with local hospitals.
- Connect WIC parents to sources of support within the community as part of a continuum of care.

Partnerships

WIC agencies often partner with local hospitals and birthing centers to build collaborative support for new families. WIC is uniquely poised for partnership since support services begin in pregnancy and continue long after delivery. WIC prepares participants for their hospital experience during pregnancy, provides information and support post discharge, and gives ongoing support throughout the breastfeeding journey. WIC often serves as a representative on a hospital's breastfeeding task force and brings an important community voice to the table. A partnership with the hospital helps assure that WIC participants receive prompt care after discharge, as many hospitals send lists of new deliveries to the local WIC clinic for follow-up.

When planning an outreach visit to the local hospital or providers, consider these steps:

- Contact the director of nursing and/or lactation department.
- Plan the goals for the visit and the primary outcome desired.
- Ask hospital staff about their breastfeeding goals and activities, and affirm their support.
- Share information about WIC eligibility requirements and breastfeeding support services.
- Discuss action plans that are mutually beneficial.
  - Structured referral mechanism for WIC participants at discharge.
  - Formal agreement to allow WIC peer counselors to support WIC participants in the hospital.
  - Engaging healthcare providers to increase referrals.
  - Providing resources.
  - Inviting staff to visit a WIC clinic to learn more about support services.

(Note: The "Staff Roles: Peer Counselor Management" section of the curriculum has more information for peer counselor program managers on setting up an agency agreement with the local hospital to provide on-site peer support for WIC participants.)

Post-Discharge Follow-Up

Continuum of care is a proactive system of tracking patients through a comprehensive array of services and support. Multiple studies in the healthcare field show that these linkages are an important part of patient-centered care that leads to improved health outcomes. Consider various periods when assessing potential partnerships to improve continuity of care for WIC families.

- **Pregnancy**: hospitals, community prenatal education options, primary healthcare providers, community groups, social media groups, home visiting programs, Healthy Start and other Federal programs, and WIC resources.
- **Hospital**: maternity care nurses, lactation experts, WIC peer counselors who visit with parents, healthcare providers, and community support services, such as WIC.
- **Post-discharge**: outpatient clinic, hospital follow-up, hotline/warm line, primary healthcare providers, WIC services, postpartum support groups, insurance coverage of lactation support services, social media groups, home visiting programs, Federal programs, and social workers.

Bring It Home!
Use handout, "**Continuum of Care Worksheet**" to identify existing support services in your community, and potential gaps. Breastfeeding coordinators can use this worksheet as part of program planning to establish or strengthen partnerships to improve support for new families.

Normal Breastfeeding—Ongoing Breastfeeding

Sneak Preview:
The Level 3 content in the "Ongoing Breastfeeding" section addresses nutrition and other common questions that may arise during a parent's breastfeeding journey.

Level 3 Competency:

- Explain maternal and infant nutritional needs during breastfeeding.

Early Weeks—Depression

Studies show that postpartum depression can negatively affect both new parents and their infants. Depressed parents can be less responsive to hunger cues or be less likely to bond with their infants. They are less likely to initiate breastfeeding or do so exclusively and are more likely to discontinue. They can have lower self-efficacy when dealing with breastfeeding challenges. Breastfeeding can offer a protective effect on maternal mental health. The hormone oxytocin, which releases milk, also promotes nurturing, relaxation, and lowers stress. This may act as a buffer against the effects of stress. If a CPA suspects that a participant may be depressed, refer to their healthcare provider. CPAs should also follow any State or local agencies policies or protocols regarding depression screening and referrals.

Bring It Home!
Learn more about the symptoms of postpartum depression and the difference between depression and normal baby blues. Visit the website of the U.S. Department of Health and Human Services, Office on Women' Health at https://www.womenshealth.gov/mental-health/mental-health-conditions/depression.

Safe Sleep

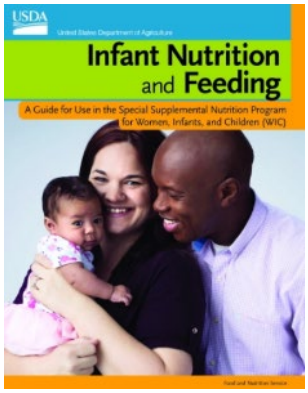
The CPA assesses for risk factors related to the baby's sleeping arrangements. Some areas include:

- Smoking by the parents or others in the household.
- Alcohol use by the parents or others.
- Illicit drug use by the parent or other adults.
- Overheated environment.
- Infant concerns, such as respiratory problems or preterm/early delivery.

As part of this assessment, the CPA can ask probing questions to identify the sleeping patterns for the parent and breastfed baby, including:

- What have you heard about sleeping arrangements with your baby?
- What has your healthcare provider told you about safe sleeping arrangements for the baby? How do you feel about what your healthcare provider said?
- What is nighttime like at your house?
- Tell me about places around your home where you breastfeed your baby.
- Where does your baby sleep at night? During the daytime?
- Who is around to help you during the day and at night?
- What do you do when you become sleepy while you are nursing your baby?

Recommendations for Safe Sleep



The CPA may receive referrals from the peer counselor or other WIC staff about safe sleep questions. CPAs should follow State health department guidelines on safe sleep. The CPA can share information with the participant about safe sleep practices based on the *WIC Infant Feeding Guide,* available at https://wicworks.fns.usda.gov/resources/infant-nutrition-and-feeding-guide.

Suggestions to recommend include:

- Baby sleeps in the parent's room but not in the parent's bed.
- Baby's bed is clear of pillows, blankets, bumpers, toys, and other soft objects.
- Baby is returned to the bassinet or crib after feedings or when the parent becomes tired.
- Baby is placed on the back for every sleep session.

Curriculum Update: The American Academy of Pediatrics (AAP) updated their recommendations for safe sleep in their policy document, Sleep-Related Infant Deaths: Updated 2022 Recommendations for Reducing Infant Deaths in the Sleep Environment | Pediatrics | American Academy of Pediatrics (aap.org). Recommendations include:

- Human milk feeding to reduce the risk of sudden infant death syndrome (SIDS).
- Delay a pacifier in breastfed babies until breastfeeding is "firmly established," defined as "having sufficient milk supply."
- Consistent, comfortable, and effective latch for milk transfer.
- Appropriate weight gain in the infant by established normative growth curves.

The AAP acknowledges that if a parent falls asleep while feeding their infant, it is "relatively less hazardous (but still not recommended) to fall asleep with the infant in the adult bed than on a sofa or armchair." The AAP advises that the adult bed should be clear of any items that can obstruct infant breathing (e.g., pillows, blankets, pets, and sheets) or cause overheating, and that parents should place the baby in a separate sleep surface as soon as the parent awakens.

Nutrition

Milk Quality

Most studies show little relationship between the amount or quality of foods a parent eats and the amount of milk they will produce. In fact, human milk of well-nourished parents contains nearly all the nutrients necessary for infant growth and development. Maternal nutrition appears to have little or no effect on many of the nutrients found in human milk (e.g., proteins and carbohydrates). Some types of fatty acids the parent consumes can, however, affect, the types of fats found in human milk. When maternal intake of certain vitamins is low (e.g., vitamins B and D), the levels in the milk may also be lower. Most parents can continue to eat the foods they like and are used to. CPAs can inform them that an inadequate diet can cause them to feel tired and run-down. Eating a healthy diet will help them maintain good nutritional status for their own health, and for future pregnancies.

Vitamin D

Vitamin D is important for all people as it helps with bone health and helps prevent rickets, a serious bone disease. Because most people do not receive sufficient sunlight exposure, they may be deficient in vitamin D stores. Studies show that infants need a minimum daily intake of 400 International Units (IU) of vitamin D daily, beginning in the first days of life. CPAs should refer participants who have questions about vitamin D supplementation to their baby's healthcare provider.

Curriculum Update: The American Academy of Pediatrics (AAP) published a 2022 update of their position paper on *Breastfeeding and the Use of Human Milk*. The AAP recommends that all infants consuming less than 28 ounces of commercial infant formula per day routinely receive vitamin D 400 IU per day, beginning at hospital discharge. This applies to both exclusively and partially breastfeeding infants. The AAP also suggests that an alternative strategy to vitamin D supplementation of the infant is to supplement the breastfeeding parent with 6400 IU of vitamin D daily.

Iron

The AAP reports that lack of iron is the world's most common nutrient deficiency. Iron-deficiency anemia has been linked to long-term neurodevelopmental problems in children, which can be irreversible. Full-term infants have sufficient iron for at least the first 4 months of life. Iron in human milk tends to be well absorbed; however, the AAP advises that a baby's need for iron increases around 4 months of age.

The AAP recommends:

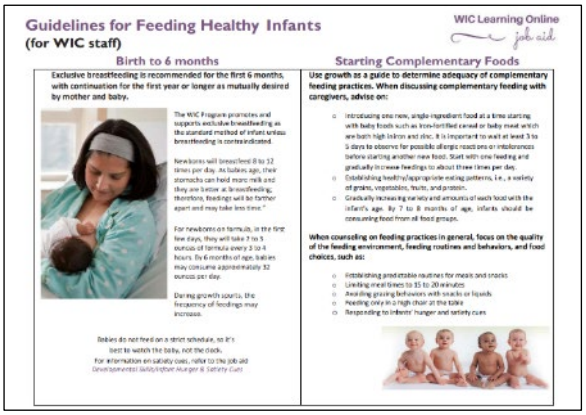
- Exclusively breastfed term infants should receive an oral iron supplementation of 1 mg/kg per day, beginning at 4 months and continuing until the baby begins receiving iron-containing complementary foods.
- Babies who receive formula, with more than one-half of their daily feedings as human milk and are not yet receiving iron-containing complementary foods, should receive 1 mg/kg per day of supplemental iron.
- The iron needs of babies between 6 and 12 months are 11 mg/day with complementary foods, including meats.

Curriculum Update: The AAP's 2022 update to their *Breastfeeding and the Use of Human Milk* position paper confirms the above recommendations, and also notes:

- Delayed cord clamping after the birth increases iron stores in healthy term newborn infants.
- Preterm infants should receive both a multivitamin preparation and an oral iron supplement until they are ingesting a mixed diet and their growth and hematologic status are normalized.

Nutrition Resources

FNS provides several resources to assist CPAs with counseling parents about their dietary and nutrition needs during breastfeeding. These include the WIC Learning Online modules and resources available at the WIC Works Resource System at https://wicworks.fns.usda.gov/. Topics include infant nutrition, breastfeeding basics, baby behavior, and Value Enhanced Nutrition Assessment.


Guidelines for Feeding Healthy Infants
(for WIC staff)
WIC Learning Online
job aid
Birth to 6 months
Exclusive breastfeeding is recommended for the first 6 months, with continuation for the first year or longer as mutually desired by mother and baby.
Starting Complementary Foods
Use growth as a guide to determine adequacy of complementary feeding practices. When discussing complementary feeding with caregivers, advise on:

Weaning

Most infants are developmentally ready to consume complementary foods at around 6 months of age. Breastfeeding should continue once complementary foods begin. The USDA *Guidelines for Feeding Healthy Infants* provides guidance for complementary feeding. It is available at https://wicworks.fns.usda.gov/sites/default/files/media/document/Guidelines_for_Feeding_Healthy_Infants_Job_Aid.pdf. FNS recommends that mealtimes be supervised and that new foods be introduced slowly and in small amounts. This helps parents watch for signs of food intolerance or allergy. Food should be prepared in a consistency appropriate to the developmental stage of the infant.

Normal Breastfeeding—Milk Expression

Sneak Preview:
The Level 3 content in the "Milk Expression" section addresses considerations when assessing and assisting WIC participants who need to use a breast pump.

Level 3 Competencies:

- Assess a WIC participant's need for a breast pump.
- Determine the appropriate pump for a parent's milk expression needs based on WIC policies.
- Instruct parents on the effective use of a breast pump.

Pumping

Breast pumps, nursing supplementers, and nipple shields are allowable in WIC under certain circumstances. Policies should be in place to assure that breast pumps and aids are used judiciously and issued by trained staff. (*See the Level 4 section for further instructions for using and issuing breastfeeding aids and instructing participants in their use.*)

Assessing Need for a Breast Pump

Before issuing breast pumps, staff should conduct a breastfeeding assessment to determine need and potential benefit. In addition, staff should assess availability of breast pumps from other sources (e.g., the parent's insurance provider or Medicaid) and available funding for breast pumps. Following assessment, appropriate counseling, education, and follow-up should be conducted by trained staff under the guidance of the DBE, as necessary. State agency protocols will determine who on staff can screen participants and issue pumps.

Assessment Areas	Priorities for Issuing
Parental goals for breastfeeding	▪ Parents who are exclusively breastfeeding.
How breastfeeding is going	▪ Parents who are working through challenges.
Parent's desire to use the pump	▪ Parents who express an interest or need to use a pump.
Baby's or parent's medical needs	▪ Babies at higher risk of illness if they do not receive human milk (e.g., babies who are preterm or sick). ▪ Parent with medical conditions such as history of breast cancer or diabetes who are higher risk of disease if not breastfeeding.
Reason the breast pump is needed	▪ Parents who will be separated from the baby. ▪ Parents experiencing breastfeeding challenges (e.g., low milk production, inverted nipples, engorgement, or other issues).

Breast Pump Options

Many types of breast pumps are available to meet the diverse needs of new parents. The FDA, which regulates breast pumps, has guidance when selecting breast pumps at https://www.fda.gov/consumers/consumer-updates/what-know-when-buying-or-using-breast-pump.

WIC State agencies determine the types of breast pumps for various circumstances based on costs to the program and participant needs. States also develop guidance for local agencies to follow when issuing breast pumps. The following pump options are commonly issued to WIC participants:

Type of Pump	Key Features	Considerations
Multi-User Electric Pump 	▪ Electrically powered. ▪ Can remove milk from both breasts simultaneously (which can help make more milk). ▪ Adjustable features (vacuum and speed) help mimic the suckling patterns of the nursing baby. ▪ Milk cannot reach the working parts of the pump, so multiple users can use them, provided each user has their own kit.	▪ Ideal for assisting parents who need to establish or increase milk production. ▪ Some WIC agencies own or rent these pumps to loan to participants. ▪ May be available for rent through medical supply outlets.
Single-User Electric Pump 	▪ Electrically powered. ▪ Able to express milk from both breasts simultaneously to minimize overall pumping time. ▪ Some models have battery attachment features for times when parents are not near a power source.	▪ Ideal for parents who are returning to work or school. ▪ Typically issued to parents whose milk production is already established.
Manual Pump 	▪ Limited to expressing milk from one breast at a time. ▪ Requires the parent to use both hands to express milk.	▪ Ideal for occasional needs to express milk. ▪ Designed for single users only, The FDA says they should *never* be shared with other users.

Pumping Guidelines

Parents often have many varied emotions throughout their pumping journey. They may be nervous or anxious about pumping, or feel it is unnatural. Friends or family members might tease them and liken their experience to "milking a cow." They might be eager to use a pump but grow to resent it if they feel it complicates their life. Parents experiencing breastfeeding challenges might find the use of a pump overwhelming as they deal with the many facets of problem solving required. WIC staff can reassure parents that it is normal to have ambivalent feelings. They can also praise them for giving their baby a precious gift. When issuing a breast pump, the following considerations are important.

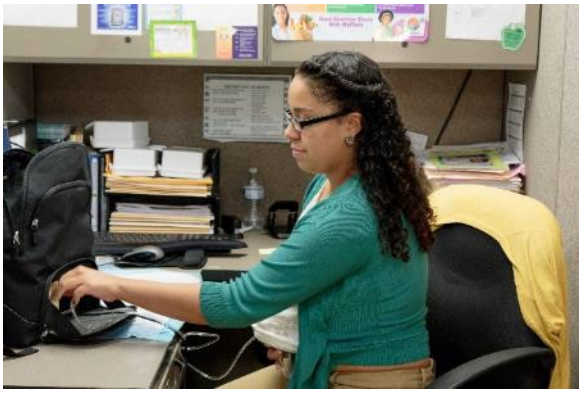
- **Attachment kits.** Electric breast pumps require an attachment kit, which includes plastic tubing that attaches to the pump, milk collection containers, and a set of flanges that are placed over

the nipples. When issuing a multi-user pump, staff should provide participants with a personal attachment kit. Single-user breast pumps normally come with the proper attachments needed.

- **Correct flange size.** The standard, medium-sized flange (around 24 mm in diameter) in most attachments kits works for most women. Flanges come in a wide range of sizes since some parents need a larger or a smaller size. Having the right sized flange helps parents express milk efficiently and prevents pain. If the parent reports pain with pumping, assess to see if an alternative flange size might help. You can also refer to the DBE, who can help the parent with a nipple measurement, if necessary.

  - *Flange that is too small:* When pumping begins, the nipple expands in size. If the flange is too small, the sides of the flange tunnel may cause discomfort and break down the sensitive nipple tissue. If the nipple turns red, the flange may be too small. The right-sized flange should have a little space between the expanded nipple and the sides of the flange tunnel.
  - *Flange that is too large:* If the flange is too large, poor vacuum can result, which minimizes the amount of milk that can be expressed because milk ducts are not adequately compressed. There may also be an uncomfortable pulling or tugging sensation. The right-sized flange will feel comfortable, and milk is released well.

- **Vacuum and Speed Controls.** If the electric pump has separate controls for vacuum and speed, suggest beginning with the lowest setting first and then increase based on comfort. For best pumping outcomes, show parents how to mimic the way their baby suckles. For example:



  - Babies typically take short, rapid sucking bursts at the beginning of the feed to trigger milk release. When pumping, speed up the pump on a slower vacuum at the beginning to mimic this pattern until they feel the milk flowing.
  - Once the milk begins flowing, babies slow down and take longer sucking bursts. When pumping, slow down the speed and increase vacuum to comfort.
  - Some pumps have automatic cycling adjusting the speed to mimic the baby's sucking cycles.
- **Defective or Ineffective Pump.** Occasionally a parent might receive a pump that is defective. This can occur with a new pump or when using a borrowed pump. A battery-charged pump can also decrease effectiveness when batteries are weak. Sometimes, the incorrect sized flange is the reason for ineffective pumping. Refer to the DBE when problems persist.

- **Cleaning the Pump.** Instruct WIC parents to follow the manufacturer's instructions on how to clean their pump. Germs can quickly grow on milk residue that remains on pump parts. Both the FDA and the CDC have general guidelines for cleaning breast pumps and attachment parts. General guidelines include:
  - Immediately after pumping, disassemble all breast pump parts and rinse them under running water to remove milk residue.
  - Clean breast pump parts that are in contact with the breast or milk in a dishwasher (if they are dishwasher safe) or by hand in a separate washbasin used only for infant feeding items. (Note: this is because germs in sinks or drains can contaminate the pump parts.)
  - Add dishwashing soap and hot water to the basin and scrub the pump parts with a clean brush used only for infant feeding items.
  - Air dry thoroughly by placing the parts and cleaning brush on a clean, unused dishtowel or paper towel.
  - Clean the washbasin and brush used to clean the pump parts. Rinse well and air dry.
  - For extra protection, sanitize pump parts daily using steam, boiling water, or a dishwasher with a sanitize setting. Check manufacturer's instructions about whether items may be steamed or boiled.
  - If the tubing begins to look moldy, replace it immediately.
  - A multi-user pump needs to be cleaned after each use. Disinfectant wipes can be used to clean the outside of the pump, including dials, power switch, and the countertop or pump stand.

Bring It Home!
Check out the FDA (https://www.fda.gov/medical-devices/breast-pumps/cleaning-breast-pump) and CDC (https://www.cdc.gov/hygiene/childcare/breast-pump.html) websites to learn more about cleaning breast pumps. The CDC website also has patient instructional materials in English and Spanish.

Milk Sharing

The WIC Policy Memorandum #2000-2, "Use of Banked Breast (Human) Milk in the WIC Program," disallows banked human milk in the WIC program due to lack of Federal health and safety standards to govern human milk banks. Milk banks and milk depots do not fall within the mission of the WIC Program and are therefore beyond the scope of WIC-authorized services.

WIC participants often have questions about donating their excess milk to benefit other babies. Milk banks and depots (collection stations) are available in many communities. WIC staff can praise parents for their desire to help others and for being successful at making enough milk to share. Staff should refer parents to available milk banks or depots in the state or community for instructions on how to donate their milk.

Normal Breastfeeding—Parent/Baby Separation

Sneak Preview:
The Level 3 content in the "Parent/Baby Separation" section addresses strategies to help new parents navigate challenges when separated from their baby.

Level 3 Competencies:

- Assist breastfeeding parents with navigating challenging worksite issues.
- Provide information and resources to childcare staff about ways to support nursing families.

Solutions at Work

Parents may need special support when working in challenging worksite settings, such as manufacturing plants, restaurants, farms, retail stores, or hospitals. Some parents might need to wear protective clothing that must be removed during milk expression. They might face rigid schedules that make it challenging to express milk in a reasonable amount of break time.

Counseling Employed Parents

Most parents have legal rights to express milk at work if they meet certain eligibility requirements. (*Refer to the Level 2 section for information about Federal requirements*.) Learning about the participant's work situation will enable you to provide tailored assistance to help them navigate any worksite challenges. For example:

- Ask about their typical workday, including when they take breaks.
- Encourage them to talk with their human resource (HR) department regarding lactation policies that might be in place at the company.
- Learn what solutions they already considered.
- Ask if they know of other breastfeeding employees in the workplace.
- Identify their breastfeeding goals.

Lack of Support from Employers

When counseling employed parents, remember that it can be difficult for some to speak up with supervisors about their needs. Some may be hesitant or shy, while others may fear risking their job or approval from their supervisor and colleagues. Some might lack language skills to articulate their needs. Some might have discussed their needs and were met with resistance or lack of support. WIC staff can encourage participants to discuss their fears and concerns and help them identify a strategy. For example, they might contact their company's HR or work-life department. You can also refer them to the Federal Department of Labor website or appropriate State labor office and help them access resources to share with their supervisors.

Bring It Home!
Learn about both Federal and State resources for employed breastfeeding families. The HHS office on Women's Health provides resources at their site, "Supporting Nursing Moms at Work," at https://www.womenshealth.gov/supporting-nursing-moms-work.

Supporting Student Parents

Many student parents find it challenging to continue breastfeeding after returning to school. They may lack knowledge about breastfeeding and infant development or lack family support. School officials may not understand the importance of breastfeeding, and locations to express milk in the school environment may not be available. Students on college campuses may have additional challenges of a rigid class schedule and lack of accessible milk expression spaces across a large campus setting.

Options to share with breastfeeding WIC participants who are students could include:

- Feed the baby before and after school at the childcare provider's home or facility.
- Ask the childcare provider to bring the baby to the parent for direct feedings.
- Use a meal period at school for milk expression or direct breastfeeding.
- Consider study hall or library periods, if available, to express milk.
- Schedule milk expression sessions between classes. Some students may be able to leave class a few minutes early to begin expressing milk.

WIC breastfeeding coordinators often work collaboratively with local breastfeeding coalitions to conduct outreach with schools to provide onsite support for WIC participants. State and local coalitions also conduct advocacy with Federal and State agencies, as well as legislators, to advocate for support for students.

Childcare Support

Childcare providers can have a significant impact on breastfeeding duration. A CDC/FDA study examined the association between childcare provider support and breastfeeding rates at 6 months. "Support" was defined as:

- Feeding expressed milk to the baby.
- Allowing the parent to directly breastfeed at the childcare facility before and after work.
- Allowing the parent to directly breastfeed the baby during the meal period.
- Thawing and preparing expressed milk.
- Keeping extra milk in a freezer.

The study found that parents who received all five levels of support were three times more likely to be breastfeeding at 6 months compared with parents who received less than three levels of support. Another study found that 79 percent of childcare facility staff want to better support breastfeeding parents but lacked education to do so. Some common misconceptions among providers included:

- It would be hard for breastfed babies to leave their mothers.
- Breastfed babies eat more frequently.
- Handling human milk is uncomfortable for staff.
- There are more diaper changes for breastfed babies.

- Formula is easier to manage than breastmilk.
- Staff lack knowledge about breastfeeding and how to support families.

Childcare providers might benefit from information about breastfeeding as part of your agency's community outreach. Information to share could include:

- The importance of breastfeeding for both babies and parents.
- Normal infant feeding patterns.
- Infant feeding and satiety cues.
- How to prepare, handle, and store human milk.
- How to help breastfed babies take a bottle.
- The importance of avoiding pacifiers in the early weeks for breastfeeding babies.
- How to calm a fussy baby.
- Delaying feedings right before the parent is due to pick up the baby.

Bring It Home!
Visit the FNS website at https://www.fns.usda.gov/tn/breastfed-babies-welcome-here to review the "**Breastfed Babies Welcome Here**" resources.

Breastfeeding Assessment—Prenatal Assessment

Sneak Preview:
The Level 3 content in the "Breastfeeding Assessment" section addresses key areas to assess when counseling pregnant participants about breastfeeding.

Level 3 Competencies:

- Identify potential factors prenatally that may affect the decision to breastfeed.
- Make appropriate referrals when prenatal participants face social challenges or factors to establishing breastfeeding.

Prenatal Factors

Intention to Breastfeed

The breastfeeding decision may be made before, early in, or toward the end of pregnancy. Or it may occur after the baby is born. Peer counselors help participants explore barriers and prepare for breastfeeding during pregnancy. CPAs address parental knowledge and feelings about breastfeeding and help them set realistic goals. Questions the CPA can consider might be:

- What have you heard about breastfeeding?
- What has your healthcare provider told you about breastfeeding?
- What are your family/friends telling you about how to feed your baby?
- What health concerns or practices do you think might influence your feeding decisions?

Social Supports

The prenatal assessment might include the participant's available social support network, as well as other social issues that could affect their ability to reach their breastfeeding goals. This may include the

living environment, lack of support from family members, and community support from employers, childcare providers, local health professionals, and others who may influence their decisions.

Health Concerns

As part of the prenatal nutrition assessment, CPAs might discover certain health conditions that could impact the ability to breastfeed or make milk. These conditions might indicate a referral to the DBE or to the healthcare provider. In addition to making referrals to the DBE for assessment and a care-plan for close monitoring after the baby is born, CPAs can refer to the peer counselor to help parents get off to a good start with breastfeeding. CPAs may also refer to social services when participants need special assistance. See the Pregnancy section for more details about health concerns that can affect breastfeeding.

Bring It Home!
Use handouts, "**Knowledge Assessment Questions**" and "**Social Support Assessment Questions**" with suggested questions to consider when conducting a prenatal assessment of participants.

Breastfeeding Assessment—Breastfeeding Dyad

Sneak Preview:
The Level 3 content in the "Breastfeeding Assessment" section highlights key areas to assess the postpartum breastfeeding parent and baby.

Level 3 Competency:

- Describe the components of a breastfeeding assessment.

General Assessment

In WIC, an assessment is the foundation from which all nutrition services are designed, to develop the most appropriate education and counseling, including food package tailoring, breastfeeding support, and referrals for follow-up. An assessment is a systematic approach to collecting and synthesizing information about a participant. It enables CPAs and DBEs to identify potential causes of the participant's concerns and to develop an appropriate care plan.

Components of a breastfeeding assessment include:

- Active listening to conduct an effective conversation with the participant.
- Build rapport so the participant feels comfortable engaging in the conversation.
- Collect relevant information, including a breastfeeding history and data.

- Identify signs of adequate milk transfer, position and latch, and infant growth trends.
- Understand the parent's goals and experiences with breastfeeding.
- The parent's social supports.
- Provide appropriate referrals for health and social support.

Data to Collect

Data to collect as part of the assessment may include:

- Anthropometrics and physical characteristics
- Feeding patterns
- Wet and dirty diapers as a sign of adequate intake
- Infant sleeping patterns
- Existing maternal or infant medical conditions
- Breastfeeding aids used
- Breastfeeding concerns
- Diet concerns
- Healthcare provider recommendations
- Documentation from other WIC staff, including peer counselors

Foundational Questions

Questions that can be used as part of the breastfeeding dyad assessment might include:

- *How is breastfeeding going?*
- *Tell me how your breasts feel.*
- *What health or medical concerns do you have that might affect breastfeeding?*
- *What questions or concerns do you have about breastfeeding?*
- *Tell me about your baby's feeding patterns over a 24-hour period.*
- *Tell me about your baby's wet and dirty diapers.*
- *What else does your baby receive besides your milk?*
- *Who is your biggest support?*
- *What has your healthcare provider told you about breastfeeding?*

Bring It Home!
Use the handout, "**Touchpoints for Breastfeeding Assessment**" to identify sample questions that can be used as part of a breastfeeding assessment for a variety of situations that might arise.

Observation

CPAs and DBEs make general observations of the participant and baby to observe for any potential problems. They might observe for parental fatigue, engagement with the baby, or infant behaviors. Observing a feeding can also help identify potential breastfeeding problems.

Bring It Home!
Using the handout, "General Observation Worksheet" identify key maternal and infant characteristics to note during a breastfeeding assessment for each of the pictures below.

Breastfeeding History

The DBE will take an in-depth breastfeeding history to identify issues that might contribute to complex challenges. The CPA can conduct a general breastfeeding history as part of the nutrition assessment process. Areas for the CPA to assess might include:

- Previous experiences with breastfeeding
- The birth experience
- The early days of breastfeeding
- Whether supplements were begun and why
- Any healthcare provider concerns

Breastfeeding Assessment—Care Plans and Case Studies

Sneak Preview:
The Level 3 content in the "Care Plans and Case Studies" section addresses components of a care plan for breastfeeding dyads experiencing challenges.

Level 3 Competency:

- Conduct an appropriate breastfeeding assessment and develop a care plan for WIC parents experiencing breastfeeding challenges, with input from the DBE.

Care Plan Components

WIC CPAs and DBEs develop care plans to support breastfeeding parents with meeting their infant feeding goals. The key components to a care plan include:

- Assess to gather information.
- Identify nutrition risk(s), needs, and concerns.
- Critical thinking skills to help identify causes or problems.
- Participant-focused counseling to help the parent take an active role in determining next steps and setting goals.

- Nutrition education and breastfeeding support to address concerns and participant goals.
- Tailor the food package to address nutritional needs.
- Appropriate referrals.
- Follow-up plan to monitor progress.

Integrating Breastfeeding Education

CPAs can integrate breastfeeding education at multiple points. Discussion at each period could include:

Initial WIC Certification	Prenatal Nutrition Education	Postpartum Recertification	Postpartum Nutrition Education
WIC priorities for breastfeeding support.	Reasons to breastfeed.	WIC food packages for breastfeeding parents.	How to know breastfeeding is going well.
Reasons to breastfeed.	Tips/solutions for identified barriers to breastfeeding.	Establishing milk production and getting a good start.	Preventing common challenges.
Tips/solutions for identified barriers to breastfeeding.	Prenatal factors that might affect breastfeeding.	Signs of adequate intake.	Breastfeeding after return to work or school.
Availability and role of peer counselors.	Preparing for the hospital and early days at home.	Making breastfeeding comfortable.	Breastfeeding in public.
	Setting breastfeeding goals.	Addressing early challenges.	Nutrition during breastfeeding.
	Impact of formula supplementation on milk production.	Role of the DBE and peer counselor.	
	WIC food packages for breastfeeding parents.		

Referrals

Appropriate referrals and follow-up are an important component of the care plan. The referral process varies based on each WIC clinic's policies and practices. A structured referral plan will help ensure parents receive appropriate and timely follow-up. (*See the Continuity of Care section for more details*.)

When breastfeeding issues are beyond the scope of the CPA, refer to the DBE, who will conduct a more advanced breastfeeding assessment and follow-up plan. In many cases, the DBE and CPA work together on the care plan. CPAs also refer to peer counselors for ongoing encouragement and support.

Bring It Home!
Use the handout, "Case Examples-Level 3" to practice critical thinking skills to conduct an appropriate assessment of a breastfeeding dyad experiencing challenges. Work with your supervisor or preceptor to review your responses and discuss correct answers.

Problem Solving—Common Infant Issues

Sneak Preview:
The Level 3 content in the "Common Infant Issues" section addresses ways to assess common infant issues that can affect breastfeeding success.

Level 3 Competency:

- Conduct an appropriate general assessment.

Latch Difficulties

Working as a Team
When a baby has difficulty latching, the CPA will work with other WIC breastfeeding staff as a team to develop a care plan that helps the parent meet their breastfeeding goals.

WIC Staff	Role
CPA	▪ Assess the baby. ▪ Assess the participant's breastfeeding experience. ▪ Tailor the food package to meet the parent's goals.
DBE	▪ Work with CPA to identify strategies. ▪ Assist with improving the baby's latch. ▪ Help maintain milk production.
Peer Counselor	▪ Provide ongoing support and encouragement. ▪ Provide basic position and latch suggestions.

Assessment

Before tailoring the food package, the CPA will assess the situation, including:

- Baby's latch.
- Participant's breastfeeding knowledge, experiences, and goals.
- Potential complications, such as low milk production.
- Baby's weight gain/loss patterns.
- Baby's output (wet and poopy diapers).
- Baby's ability to transfer milk.
- Formula supplementation practices.
- Advice from the baby's healthcare provider.

Tips and Solutions

- Work with the DBE to develop an appropriate care plan.
- If supplementing, help the baby transition back to the breast, if desired.

- Tailor the food package, as needed, to ensure sufficient infant intake. The tailored amount will reflect information from the baby's healthcare provider and/or DBE.
- The DBE helps to express milk as the supplement, and to provide the required supplement in an alternative way (e.g., nursing supplementer, dropper, spoon, etc.) if needed.

When to Refer

Refer to the DBE for further assessment when:

- Basic suggestions for improving the baby's latch do not resolve the latch issues.
- The parent expresses interest in transitioning the baby back to fully breastfeeding.
- Milk production needs to be increased.
- There are unresolved sore nipples or engorgement because of the poor latch.

Refer to the baby's healthcare provider if the baby is at risk for slow/'faltered growth. Refer to the peer counselor for ongoing support while the latch issues are being addressed.

Slow Weight Gain

Working as a Team

When a baby has trouble gaining weight, WIC staff work as a team to develop and implement a care plan.

WIC Staff	Role
CPA	▪ Assess the baby's weight trends. ▪ Tailor the food package.
DBE	▪ Work with CPA to assess causes of baby's slow weight. ▪ Address infant issues leading to the slow weight gain. ▪ Help the parent maintain or build milk production.
Peer Counselor	▪ Provide ongoing support and encouragement. ▪ Encourage frequent breastfeeding and effective positioning and latch to improve milk transfer.

Assessment

Before tailoring the food package, the CPA will assess the situation, including:

- Infant weight trends.
- Parental concerns about the baby's weight.
- Baby's feeding history including feeding routines/behaviors, environmental factors, early practices, or medical situations that arose in the early days.
- Parent's medical conditions or breast abnormalities.
- Recommendations of the baby's healthcare provider.
- Parental goals for breastfeeding.

Tips and Solutions

- Work with the DBE to develop an appropriate care plan.
- Tailor the food package to ensure adequate nutrition while protecting milk production.
- If supplements are needed, suggest expressed breastmilk, if possible.
- The DBE can assist with feeding the baby in an alternative way, if desired.

When to Refer

Refer to the baby's healthcare provider if the baby is at risk for slow/faltered growth. Refer to the peer counselor for ongoing follow-up support. Refer to the DBE for further assessment and assistance as needed.

Multiples

Working as a Team

WIC staff work as a team to support parents of multiples with breastfeeding. The care plan should consider the reality and demands of caring for more than one baby and available support.

WIC Staff	Role
CPA	▪ Assess the baby's weight trends. ▪ Develop a plan of care for addressing breastfeeding concerns along with DBE, as needed. ▪ Tailor the food package.
DBE	▪ Work with CPA to help the parent build or maintain milk production.
Peer Counselor	▪ Provide ongoing support and encouragement. ▪ Offer positioning and latch suggestions. ▪ Encourage frequent feedings to build and maintain milk production.

Assessment

Before tailoring the food package, the CPA will assess the situation, including:

- Birth weight and weight trends of the babies.
- Feeding history, including early practices or medical issues that arose in the hospital or at home.
- Feeding frequency, feeding patterns, and babies' output.
- Milk production concerns.
- Medical conditions of the parent or babies.

Tips and Solutions

During Pregnancy

- Develop a care plan for addressing any concerns for breastfeeding multiples.
- Address questions about making sufficient milk for more than one baby.
- Educate about frequent feedings and milk removal to establish and build production.
- Discuss food packages for parents of multiples.
- Discuss WIC support options (such as breast pumps) should the parent deliver early.

After Babies Are Born

- Connect the parent to postpartum support as soon as possible (including peer counselors, community-based groups for parents of multiples, and other online group support options).
- Encourage frequent feedings to build milk production capacity.
- Suggest hands-on feedings/milk expression to deliver higher-fat milk and to increase yield.
- Tailor the food package to give the least amount of formula needed to sustain growth while maximizing milk production.
- Remind parent that their nutritional needs are increased. Breastfeeding parents need an extra 500-600 calories per day for each baby they are exclusively breastfeeding (i.e., 1,000-1,200 extra calories per day when nursing twins).
- Encourage the parent to stay well hydrated, drinking fluids to thirst. They should also eat a nutritious diet to maintain their own nutritional status.
- Offer strategies for rest, if needed. Encourage parents to accept offers of help.

When to Refer

Refer to the baby's healthcare provider for close monitoring if there are concerns about the babies' growth and development. Refer to the peer counselor for ongoing follow-up support. Refer to the DBE for further assessment and assistance with milk production concerns or learning how to feed the babies in an alternative way while learning how to breastfeed.

Bring It Home!
Use the handout, "**Common Infant Issues Summary-Level 3**" as a handy resource tool.

Problem Solving—Low Milk Production

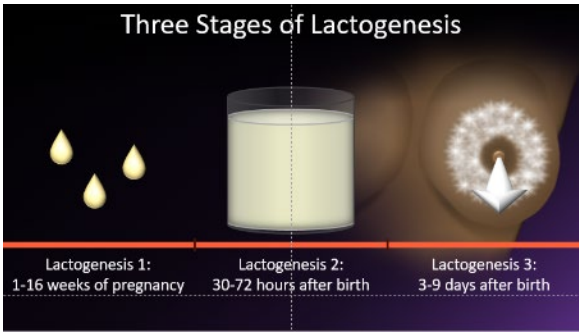
Sneak Preview:
The Level 3 content in the "Low Milk Production" section reviews assessment strategies for parents who are experiencing delayed or true low milk production.

Level 3 Competencies:

- Identify parents at risk for delayed onset of lactogenesis.
- Assess real vs. perceived low milk production in new parents.
- Provide appropriate referrals for parents at risk for low milk production.

Delayed Milk Production

Stages of Lactogenesis



Lactogenesis, the process of producing milk, is divided into three primary phases:

- **Lactogenesis I** occurs during early pregnancy when secretory activity begins in the breast tissue, around 16-18 weeks.
- **Lactogenesis II** occurs between 30-72 hours after the baby is born when copious milk production begins.
- **Lactogenesis III** (also called *galactopoiesis*) occurs around 9 days after the birth with mature milk production and is maintained throughout the course of lactation based on frequent milk removal.

Signs of Delayed Onset of Lactogenesis (DOL)

When Lactogenesis II does not occur by 72 hours, it is referred to as "delayed onset of lactogenesis," or DOL. In most cases, DOL is temporary, and parents will go on to make plenty of milk. However, some risk factors for DOL can affect long-term milk production.

Causes of DOL

- Physiological factors around the birth. For example, a long Stage 2 labor (after dilating to 10 cm until the delivery of the baby), or a cesarean delivery (especially an emergency).
- Retained placenta which may inhibit the progesterone levels from falling. The normal decline in progesterone levels after the birth signal the body to release prolactin and transition from colostrum to larger milk volume. If a portion of the placenta is retained, heavy bleeding and low milk production may occur. Refer to the healthcare provider if milk volume has not increased by days 5-7.
- Medical condition, such as:
  - Diabetes, which can delay lactogenesis by around 24 hours or more.
  - Pre-pregnancy obesity (BMI >30 kg/m^2) and excessive gestational weight gain.
  - Hormonal condition such as PCOS and hypothyroidism.

Assessment

Before tailoring the food package, the CPA will conduct an assessment to determine the level of support needed. Areas of assessment might include:

- Timing of the first breastfeed and frequency of feedings during the early days.
- Medical conditions of the birth parent.

- The birth experience.
- Any problems that occurred with breastfeeding.
- Postpartum bleeding.
- Baby's weight patterns.
- Potential jaundice in the early days (since jaundice can be a symptom of insufficient milk intake).
- Baby's behaviors (e.g., lethargy, fussiness).

Tips and Solutions

- Provide anticipatory guidance about the normal course of lactation (especially if assigning the food package before milk production is established).
- Assess the parent's goals and willingness to address causes of the DOL.
- Encourage frequent feedings and/or milk expression 8 to 12 times every 24 hours.
- Demonstrate positions that might be comfortable and review signs of adequate milk intake.

When to Refer

Refer parents symptoms of delayed milk production to the DBE for further assessment for:

- Physiological conditions that could affect long-term milk production.
- Need for temporary supplements with an alternative feeding method.
- Need for an electric breast pump as part of the overall care plan.

Refer to the healthcare provider if there are signs of retained placental fragments or the baby is at risk of inadequate growth. Refer to the peer counselor for ongoing support and encouragement.

Low Milk Production

Causes

In addition to the basic causes of low milk described in Level 2 (e.g., ineffective positioning/latch or infrequent milk removal), other factors can contribute to low milk production.

Causes of Low Production	Considerations	Action Ideas
Factors leading to poor milk transfer	▪ Weak suck. ▪ Infant low tone. ▪ Infant congenital issues. ▪ Engorged breasts.	▪ Refer to DBE for assistance when the baby is unable to remove milk sufficiently.
Replacing feedings at the breast with formula or other foods	▪ When milk is not removed, a whey protein called *Feedback Inhibitor of Lactation* (FIL) is released, which slows down production and can eventually involute the glandular tissue.	▪ Advise parents that formula and other foods are unnecessary during the first 6 months of life. ▪ Educate parents about the impact of supplements on milk production. *(See the "Supplementation" section.)*
Medications	▪ Estrogen-based contraception. ▪ Certain decongestants. ▪ Some herbs and herbal teas.	▪ Refer to the parent's healthcare provider for questions about medication use.

Causes of Low Production	Considerations	Action Ideas
Tobacco use	▪ More than one pack of cigarettes per day can contribute to low milk production. ▪ Smoking impairs the milk ejection reflex and can prevent milk release.	▪ Recommend smoking cessation options available through the health department.
Subsequent pregnancy	▪ The birth parent's body begins preparing for the new baby by producing small amounts of colostrum around mid-pregnancy. (*See more information in the "Complex Maternal Problems" section.*)	▪ Parents discuss breastfeeding through pregnancy with the healthcare provider. ▪ Monitor the older child to be sure they are receiving sufficient calories for weight gain.
Insufficient glandular tissue	▪ Breasts did not enlarge prenatally. ▪ Breasts differ in size. ▪ Breasts are widely spaced apart. ▪ Surgery removed much breast tissue. ▪ PCOS affected breast glandular growth during pregnancy.	▪ CPA work closely with DBE.
Prior breast surgery	▪ Severing important nerve endings or milk ducts can affect production. ▪ Breast augmentation might pose challenges, depending on the reason (e.g., to correct a breast anomaly such as those listed above).	▪ Explore the reason for augmentation surgery. ▪ Most parents who had prior breast surgery can often produce at least some milk.
Other conditions	▪ Hormonal factors (e.g., PCOS or hypothyroidism).	▪ CPA refer to the parent's healthcare provider for treatment as needed.

Assessment

Before tailoring the food package, the CPA will conduct an assessment to determine the level of support needed. Areas of assessment might include:

- Medical conditions that might affect milk production.
- Prior breast surgery.
- Health practices, such as smoking.
- Baby weight patterns.
- Feeding frequency and milk removal.
- Supplementation practices.
- Participant's breastfeeding goals.

Tips and Solutions

When a participant is suspected to have issues with low milk production, WIC staff should consider three important rules.

- **#1 - Feed the Baby**. Babies need sufficient calories for energy to adopt appropriate feeding behaviors and wake for feedings. The baby's well-being is always the first priority. Extra milk can be used as supplements, when needed and the most calorie-rich milk can be expressed at the

end of the feeding. The DBE can assist with methods to feed small amounts of the milk to the baby. Iron-fortified formula may be needed temporarily while rebuilding milk production.

- **#2 - Protect Milk Production**. The DBE will assist with recovering or rebuilding milk production. A variety of breastfeeding aids and equipment can help stimulate production, including a breast pump or hand expression.
- **#3 - Address Causes of Low Milk Production.** WIC staff will help identify the cause of low milk production and establish a care plan to address the causes. The DBE and CPA will work together to ensure that the care plan addresses the needs of both the parent and the infant. The care plan may also include referrals to the healthcare provider.

The CPA tailors the food package to minimize formula to meet but not exceed the infant's nutritional needs. Use critical thinking skills. For example:

- If the parent is experiencing perceived vs. actual low milk production, the CPA might issue a one-month food package while ramping up support to help meet their goals.
- If the parent has a medical condition that is unlikely to change the outcome of low milk production, some formula supplementation might be needed for sufficient nourishment.
- If the baby is gaining weight steadily after a delay in milk production, formula might not be needed, though close monitoring is advised.
- If the goal is to fully breastfeed despite supplementation and compromised milk production, the CPA works with the DBE to gradually reduce the amount of formula while rebuilding production.

When to Refer

Prompt referrals are indicated when a participant faces low milk production. The CPA refers to the peer counselor for ongoing support and encouragement. Other referrals are:

DBE	Baby's Healthcare Provider	Parent's Healthcare Provider
▪ No breast changes during pregnancy.	▪ Not regained birth weight by 2 weeks or gains slowly.	▪ Symptoms of mastitis or breast abscess.
▪ Hormonal or breast concern (e.g., inverted nipple, breast surgery).	▪ Infant medical problem that affects milk transfer.	▪ Hormonal or medical condition (e.g., PCOS or hypothyroidism).
▪ Inadequate stooling or weight gain.	▪ At risk of inadequate growth.	▪ Medications that affect milk production.
▪ Suspected tongue tie or other sucking/feeding disorder.		
▪ Desire to increase production.		

Bring It Home!
Use the handout, "Low Milk Production Summary-Level 3" as a handy resource tool.

Problem Solving—Supplementation

Sneak Preview:
The Level 3 content in the "Supplementation" section addresses ways to support parents who choose to supplement or return to breastfeeding.

Level 3 Competencies:

- Help participants maintain their milk production when supplementing.
- Tailor food packages appropriately for participants who choose to supplement with formula.

Combination Feeding

Assessment

Before tailoring the food package, the CPA will conduct an assessment to determine the level of support needed. Areas of assessment might include:

- Early practices that may have led to the desire to supplement.
- Reason for supplementing.
- Timing and amounts of formula given.
- Breastfeeding concerns.
- Advice from family and friends about using formula.
- Changes in breastfeeding patterns as a result of supplementing.

Tailoring Food Packages

When participants use formula either some or most of the time, the CPA tailors the amount of formula issued based on the assessed needs of the baby to meet, but not exceed, the infant's nutritional needs.

Tips and Solutions

CPAs can suggest that parents:

- Express milk to maintain production and prevent engorgement, using expressed milk as the supplement, when possible.
- Breastfeed directly as much as possible, offering both breasts, to maintain production.
- Breastfeed before offering the supplement, so most vigorous sucking is at the breast to help remove more milk. If baby is too fussy to latch, suggest they give 5-10 mL *before* the feeding to remove the hunger edge before attempting to feed at the breast.
- Exclusively breastfeed when with the baby, reserving supplements for others to feed or when not with the baby.
- Consider resuming full breastfeeding, if desired.

When to Refer

Refer to the DBE for further assessment if the baby is not gaining weight or stooling appropriately, or if the parent wishes to transition back to full breastfeeding.

Returning to Breastfeeding

Occasionally a participant may wish to discontinue or reduce formula use to increase breastfeeding or to return to full breastfeeding. Possible reasons include:

- Desire to give the baby the full benefits of breastmilk.
- Baby is fussy or not doing well on formula.
- Miss the bond enjoyed with breastfeeding.
- Health care provider recommended increasing human milk feedings due to health concerns.
- Milk production declined and wish to rebuild it.
- Not ready to wean the baby fully to formula.

Assessment

Before tailoring the food package, the CPA will conduct an assessment to determine the level of support needed. Areas of assessment might include:

- Feeding history and reason supplements began.
- Any issues with milk production, and factors that could affect production.
- Any medical concerns of the baby (e.g., tongue-tie).
- Any concerns about hormonal conditions or prior breast surgery.
- Frequency, timing, and amounts of supplement being given to the baby.
- Factors that might affect a safe transition back to the breast (e.g., baby's ability to transfer milk or parent's ability to express milk frequently to boost milk production).
- Realistic expectations about the process and the time commitment needed.

Tips and Solutions

The CPA works with the DBE to develop a care plan to assist with resuming full breastfeeding. Three key factors are weaning from formula, rebuilding milk production, and monitoring the baby. The CPA uses critical thinking skills to assign the appropriate food package and monitor the infant. The DBE assists with rebuilding production.

Wean from Formula	Rebuild Milk Production	Monitor the Baby
▪ With very young baby (i.e., 4-5 days old) or minimal formula supplementation, it may be safe to reduce formula more quickly.	▪ The DBE will assist with rebuilding milk production.	▪ Parents monitor the baby's wet and dirty diapers. ▪ A baby older than 4-6 weeks may not have as many stools as early days.
▪ For older baby or large amounts of formula supplement, or if baby is underweight, gradually discontinue 1-2 ounces over a 24-hour period every other day.	▪ Use a breast pump to remove milk and stimulate breasts to produce more milk.	▪ Monitor any changes in baby's output (e.g., transition to looser, yellowish stools).

Wean from Formula	Rebuild Milk Production	Monitor the Baby
▪ Discontinue formula supplements when there is more milk or when baby is less interested.	▪ The DBE will assist with aids or devices that can help the parent rebuild production.	▪ Offer to weigh the baby at the WIC clinic to assure adequate weight.
▪ Space out decreased formula supplements over the day if desired (e.g., ½ oz. over four feedings).	▪ The DBE will assist with coaxing the baby back to the breast if the baby is reluctant to nurse.	▪ Assess whether breasts feel fuller before feedings and softer afterwards.

When to Refer

Prompt referrals are indicated when a participant is returning to full breastfeeding.

DBE	Baby's Healthcare Provider	Peer Counselor
▪ Assist with rebuilding milk production.	▪ When baby experiences slow or faltered growth.	▪ Ongoing encouragement and support.
▪ Recommend appropriate breastfeeding aids to assist in the transition.		
▪ Assist with coaxing the baby back to the breast.		
▪ Identify potential complex problems that might arise during the transition.		

Bring It Home!
Use the handout, "**Supplementation Summary-Level 3**" as a handy resource tool.

Problem Solving—Complex Maternal Problems

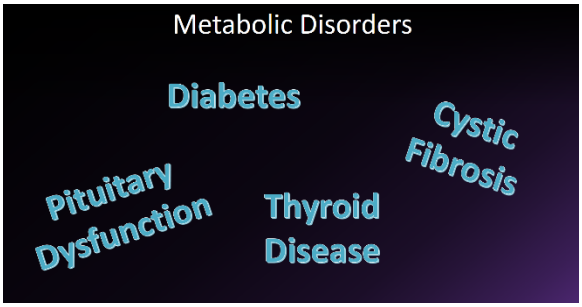
Sneak Preview:
The Level 3 content in the "3-Step Counseling" section addresses strategies to help participants identify concerns, and ways to educate them.

Level 3 Competencies:

- Support parents experiencing metabolic disorders with breastfeeding.
- Support parents who become pregnant while breastfeeding.

Metabolic Disorders

The human body relies on a healthy metabolism to convert or use energy. Various chemical reactions break down substances within the body. A metabolic disorder can occur when the usual metabolism fails, and the body has too much or too little of essential substances. These disorders can relate to genetic



factors or other conditions. Because metabolic disorders affect the endocrine system, they have the potential to affect milk production. In some cases, breastfeeding can help reduce the infant's risk of some of these disorders.

Diabetes

Maternal type 2 diabetes can contribute to a delay in the onset of lactogenesis. Parents might report they are worried they are not making enough milk, their baby is extremely fussy and does not seem satisfied on their milk, or the baby has become jaundiced or developed hypoglycemia in the hospital. Studies show that babies of diabetic mothers are at risk for being large for gestational age and are more likely to be supplemented with formula. Babies are also at higher risk for developing type 2 diabetes.

Areas of Assessment

- Previous gestational diabetes history.
- Previous maternal breastfeeding challenges (e.g., DOL or low milk production).
- Previous infant breastfeeding challenges (e.g., slow weight gain, jaundice, hypoglycemia, or need for supplements).
- Parent's breastfeeding goals.
- Support network.

(Note: If the parent has already delivered and reports problems with low production, refer to the section on Low Milk Production for further areas of assessment to consider.)

Tips and Solutions

The CPA works with the DBE to determine an appropriate breastfeeding care plan, including:

- Nutritional counseling during pregnancy to address diet concerns.
- Skin-to-skin contact during the first hour after birth and beyond to stabilize glucose levels and keep the baby warm.
- Frequent feedings, offering both breasts.
- Tracking feedings, baby's output, and baby's growth and development trends.
- Expressing milk to help build milk production.
- Tailoring the food package if temporary supplementation is necessary.

When to Refer

DBE	Baby's Healthcare Provider	Peer Counselor
▪ Signs of low milk production.	▪ Signs of inadequate growth and development.	▪ Ongoing support and encouragement.
▪ Baby is at risk for insufficient milk.		
▪ Baby is too sleepy or unable to transfer milk efficiently.		
▪ A breastfeeding aid or device is needed.		

Other Metabolic Disorders

Thyroid Disease

Hypothyroidism, a deficiency of the thyroid hormone, can cause parents to feel sluggish and tired and lead to insufficient milk production. *Hyperthyroidism*, an overactive production of thyroid hormones, can affect the heart and blood pressure. Hyperthyroidism does not appear to affect milk production, but if untreated it can lead to postpartum hemorrhage and impair the milk ejection reflex.

Pituitary Dysfunction

The pituitary gland is a small endocrine gland at the base of the brain which is responsible for controlling several hormone glands in the body. It releases lactation hormones such as prolactin and oxytocin. A pituitary dysfunction can cause postpartum hemorrhage (*Sheehan's Syndrome)* which inhibits blood flow to the gland, hypothyroidism, and even breast tissue atrophy.

Cystic Fibrosis

Cystic Fibrosis (CF) is a progressive hereditary disorder that affects the exocrine glands. The exocrine glands secrete substances that leave the body such as sweat, saliva, mucous, digestive juices, and mammary secretions. In CF, normal bodily secretions are thick and sticky, causing them to clog ducts throughout the body. Breastfeeding is considered safe for women with CF, and maternal milk has not been shown to be adversely affected.

Areas of Assessment

- Baby's weight trends.
- Changes in the baby's breastfeeding patterns or frequency.
- Baby's behaviors at the breast.
- Infant output.
- Signs of delayed or low milk production.
- Advice parents received about breastfeeding with their condition from the healthcare provider.

Tips and Solutions

The CPA's role is to:

- Monitor the baby's growth and weight trends.
- Educate the participant about getting sufficient rest and any diet adjustments needed to improve their nutritional status.
- Suggest that parents track the baby's wet and dirty diapers.
- Encourage frequent breastfeeding (8-12 times every 24 hours), offering both breasts, and minimizing formula use.
- Tailor the food package if temporary supplementation is necessary.

When to Refer

DBE	Baby's Healthcare Provider	Peer Counselor
▪ Risk for low milk production.	▪ Signs of inadequate growth and development.	▪ Ongoing support and encouragement.
▪ Need for breastfeeding device to help build milk production.	▪ Questions about medications used to treat the condition.	
▪ Alternative feeding device.		

Obesity

Obesity is defined as having a body mass index (BMI) of 30 or greater, a figure that is calculated from a person's weight and height. Obesity adds to the burden of chronic disease and disability. Research shows that obese parents may experience DOL because obesity appears to blunt the prolactin response during the early postpartum period. Birth parents who are obese are more likely to have a more complex pregnancy and delivery, which can also affect early lactation. They might also be uncomfortable latching their baby if their breasts are large or they cannot find a comfortable position.

Areas of Assessment

- Baby's weight trends and output.
- Signs of delayed or low milk production.
- Comfort of feeding sessions for the parent and the baby.
- Formula supplementation.
- Parent's goals for weight loss and continued breastfeeding.
- Available support and advice received from family, friends, and healthcare providers.

Tips and Solutions

The CPA's role is to:

- Monitor baby's growth and weight trends.
- Educate about early practices to help mitigate DOL (such as skin to skin in the first hour; early and frequent feedings 8-12 times every 24 hours; rooming-in; offering both breasts at feedings).
- Positioning options to remove weight of breasts from baby (e.g., football or side-lying position).
- Tailor the food package to meet but not exceed the baby's nutritional needs.

When to Refer

DBE	Baby's Healthcare Provider	Peer Counselor
▪ Delayed or low milk production.	▪ Signs of inadequate growth and development.	▪ Ongoing support and encouragement.
▪ Assistance with position/latch.		

Breastfeeding While Pregnant

It is not uncommon for a parent to become pregnant again while breastfeeding an older baby. They may not even realize they are pregnant but notice signs such as tender nipples, overwhelming fatigue,

decreased milk production (by around the middle of the pregnancy), or changes in the taste of the milk. For many parents, a subsequent pregnancy becomes a natural weaning time for the older infant. Other parents may wish to continue breastfeeding while pregnant.

Areas of Assessment

- Baby's weight trends.
- Changes in the baby's breastfeeding patterns/frequency.
- Baby's behaviors at the breast.
- Other foods the baby might also be receiving.
- Nipple discomfort or pain.
- Signs of low milk production.
- Advice from the healthcare provider about continuing to breastfeed while pregnant.
- Concerns during pregnancy (e.g., increased number or intensity of contractions, bleeding).
- Available support and advice from family and friends.
- Goals for breastfeeding the new baby.

Tips and Solutions

The CPA's role is to:

- Monitor the baby's growth and weight trends.
- Educate about food package options (i.e., receiving 1.5 times the fully breastfeeding food package).
- Share options for continuing to breastfeed based on the healthcare provider's advice:
  - Breastfeed during the pregnancy and continue with both babies after the birth.
  - Taper off breastfeeding during pregnancy until the older child is weaned before the birth.
  - Abruptly discontinue breastfeeding due to discomforts or healthcare provider.
- Share anticipatory guidance about changes that might occur.
  - Baby's stools looser due to the laxative effect of colostrum.
  - Baby increasingly dissatisfied at the breast.
  - Increased labor contractions while breastfeeding.
  - Colostrum production throughout the pregnancy and continues because baby is nursing.
- Offer strategies to introduce formula supplements if the baby is growing insufficiently and is less than 12 months old. Share ways to introduce solid foods around 6 months.

DBE	Healthcare Provider	Peer Counselor
▪ Sore nipples that are cracked/bleeding or are not alleviated by basic measures.	▪ Signs of inadequate growth and development.	▪ Ongoing support and encouragement.
▪ Baby is fussy and disinterested in feedings at the breast.	▪ Preterm birth or risk of preterm labor. ▪ Increased intensity and number of contractions.	

Bring It Home!

Use the handout, "**Complex Maternal Problems Summary-Level 3**" as a handy resource tool.

Problem Solving—Complex Infant Problems

Sneak Preview:
The Level 3 content in the "Complex Infant Problems" section addresses strategies to help babies with GI/nutritional issues, such as food sensitivities and lactose overload.

Level 3 Competency:

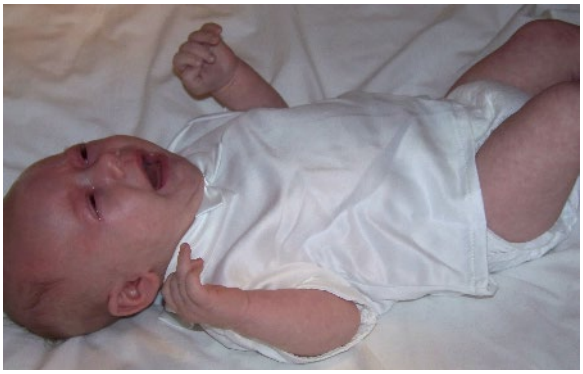
- Assess breastfed babies with GI/nutrition issues.

Food Sensitivities/Allergies

Many new parents worry that their babies are allergic to something they are eating and have passed on to their baby. Human milk does not typically cause allergic reactions in breastfeeding infants. Some babies demonstrate sensitivities to certain foods such as dairy products, eggs, soy, fish, or other foods. Only two or three out of every 100 exclusively breastfed demonstrate an allergic reaction.

Common Signs of Food Sensitivities

Food sensitivities may cause excessive or inconsolable crying, gassiness, vomiting, diarrhea, blood in the stools, or rashes. Some of these symptoms can also occur with lactose overload or when a baby is ill, so they do not always indicate food sensitivities. However, parents may interpret the behaviors to mean the baby is allergic or "hates" their milk.



Areas of Assessment

- Parent's description of the baby's behaviors and discomfort.
- Breastfeeding frequency, length of feedings, how the feedings end, and how the parent feels feedings are going.
- Baby's growth and weight trends.
- Baby's output (including color, consistency, and frequency).
- Other foods or fluids the baby might be receiving.
- Concerns about food sensitivities with previous children.

Tips and Solutions

- Consider limiting maternal intake of milk and dairy products or other foods that are suspected to contribute to the baby's discomfort.
- Provide nutritional counseling to ensure proper nutritional status throughout breastfeeding if certain foods will be minimized.
- Monitor baby's growth.
- Be sensitive to parents who are exhausted, frustrated, and overwhelmed with their baby's unhappiness. Affirm!

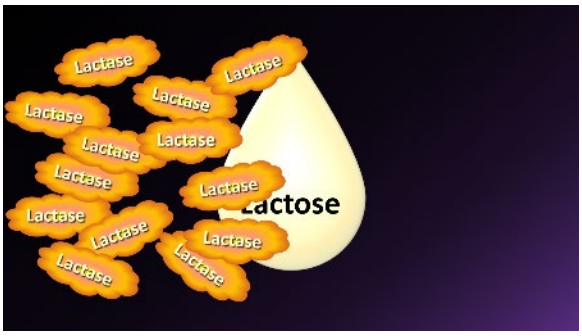
When to Refer

The CPA refers to the baby's healthcare provider if the baby is at risk for insufficient growth and development, or if basic suggestions do not alleviate the baby's discomfort. The baby's provider will also advise on when to reintroduce foods into the maternal diet again.

Lactose Overload

Lactose overload can produce symptoms similar to food sensitivity. However, instead of a particular food as the cause, lactose overload occurs when the baby gets a large volume of high lactose, lower-fat milk. This can cause excess gas that leads to pain. With lactose overload, the baby may have greenish, explosive, and/or frothy stools. The baby may cry or scream in pain and cannot be calmed.

Causes



Babies take in high amounts of lactose in the higher-volume milk toward the beginning of the feeding, when fat content is low.The enzyme lactase, which is produced in the baby's small intestine, helps break down the lactose. Fat helps slow down the digestive process to give lactase time to break down lactose. If the parent ends the feedings too quickly or switches sides before the baby accesses the higher-fat milk, the thinner milk moves through the digestive process so quickly that the lactase cannot properly break down the lactose. This creates lactose overload.

Common causes of lactose overload include:

- Not feeding the baby on cue.
- Minimizing the baby's time at the breast.
- Overproduction of milk as a result of excessive puming, or frequent, short feedings.

Areas of Assessment

- Parent's description of the baby's behaviors.
- Healthcare provider advice (e.g., need for medications or concerns about baby's weight).
- How and when feedings end.
- Baby's growth and weight trends.
- Baby's output (including color, consistency, and frequency).
- Other foods the baby is receiving.

Tips and Solutions

- Encourage feeding the baby on cue and watch for signs of hunger.
- Allow the baby to remain at the breast until the baby ends the feeding on his own.
- Assess for issues such as dairy sensitivity that might be affecting the baby's behaviors.
- Increase the fat content in the milk through breast massage and breast compressions. (*See the Level 2 "Management Tools" section.*)

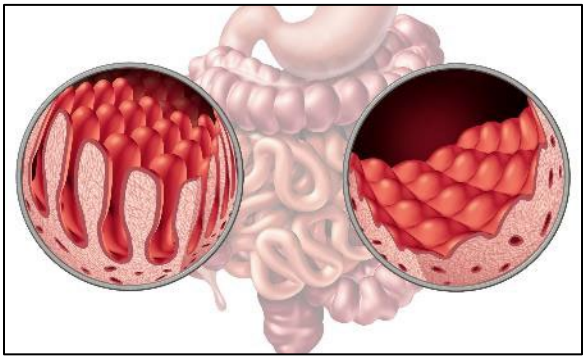
When to Refer

DBE	Baby's Healthcare Provider	Peer Counselor
▪ Basic tips do not resolve the issue.	▪ Rule out other medical concerns.	▪ Ongoing support and encouragement.
▪ Advise about alternative feeding patterns to help the baby gain higher fat milk.		
▪ Baby is unable to latch due to discomfort and distress.	▪ Risk of insufficient growth and development.	
▪ Assist with therapeutic breast massage techniques.		

Celiac Disease

Celiac disease occurs when gluten (a combination of proteins found in wheat, rye, and barley) damages the small intestine lining and interferes with absorption of nutrients from food. Common signs of celiac disease are cramps/abdominal pain, diarrhea, vomiting, foul-smelling stools, weight loss, and irritability.

The small intestine is lined with small, finger-like projections, called villi (see image on the left) which help nutrients in the food to be absorbed. When they are damaged because of gluten exposure (see image on the right), they cannot absorb nutrients properly.



Breastfeeding is an effective prevention strategy and can reduce the risk of celiac disease by 52 percent. The AAP recommends continued breastfeeding when gluten foods are first introduced to the baby's diet to help reduce the risk of celiac disease in infants at risk.

Bring It Home!
Use the handout, "**Complex Infant Problems Summary-Level 3**" as a handy resource tool.

Problem Solving—Preterm Birth

Sneak Preview:
The Level 3 content in the "Preterm Birth" section addresses components of a breastfeeding care plan for parents of preterm infants.

Level 3 Competency:

- Develop an appropriate care plan with input from WIC staff to help meet the parent's breastfeeding goals.

Feeding Challenges

Care Plan

The CPA will work with other WIC staff and the healthcare team to develop an appropriate care plan to assist parents of preterm or early term infants. The care plan components might include:

- Assess the baby's weight patterns after discharge from the NICU.
- Teach the parents safe ways to feed any supplements the baby might need.
- If formula is needed, tailor the food package to meet the baby's growth needs.
- Monitor the baby's weight trends through appropriate follow-up.
- Refer to the DBE to address milk production needs and using any alternative feeding devices.

Assessment

The level of support provided by CPAs will vary depending on the status of the baby.

Hospitalized Preterm Infant	NICU Grad	Early-Term Infant
▪ How pumping is going.	▪ Healthcare provider's advice about infant feeding including any supplementation or fortification.	▪ Baby's gestational age at birth and ability to show feeding cues.
▪ How the baby is progressing.	▪ Overstimulation affecting baby's sleep or feeding patterns.	▪ Any concerns that might affect breastfeeding.
▪ Plans for breastfeeding post-discharge.	▪ Baby's growth and weight trends.	▪ Parental knowledge about common feeding behaviors of early term infants.
▪ Need for ongoing support.	▪ Parent's available support network.	▪ Skin-to-skin practices.

Tips and Solutions for Hospitalized Preterm Infants

- Access to a multi-user electric breast pump.
- Frequent skin-to-skin contact, when possible (by both parents!).
- Express milk 8 times/24 hours to maintain production.
- Rest and eat nutritious foods to enhance well-being.

Tips and Solutions for NICU Grads and Early-Term Infants

- Frequent weight checks to assure baby is gaining weight adequately.
- Breastfeed 8-12 times every 24 hours, waking the baby every 2-3 hours if baby does not wake independently.
- Minimize home distractions that can overstimulate the baby.
- Express milk to maintain production until baby is feeding well and gaining weight appropriately.
- Skin-to-skin contact, keep baby warm with a cap and blanket per healthcare provider advice.
- Cross-cradle hold to provide support for latch.
- "Dancer hand" hold to support baby's chin when latching.

When to Refer

DBE	Baby's Healthcare Provider	Peer Counselor
▪ Baby unable to latch properly or unable to transfer milk well.	▪ Signs of inadequate growth and development.	▪ Ongoing support and encouragement.
▪ Signs of low milk production.		
▪ Alternative feeding device education and issuance.		