9L 1: HANDOUTS FOR CAREGIVERS AND COMMUNITIES – BREASTFEEDING TIPS

GETTING BABY TO LATCH: BABY'S CUES

Babies have distinct signs (or cues) that they use to show caregivers when they are hungry and full. Recognizing a baby's feeding cues can be incredibly helpful for successful breastfeeding. When mothers are able to notice early cues that a baby is hungry, breastfeeding is often much smoother.

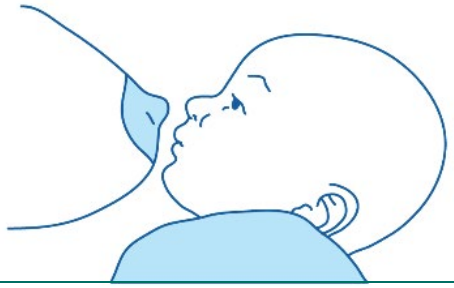
FEEDING CUES:

- ⇒ Hands to mouth
- ⇒ Sucking on their hands or fingers
- ⇒ Increased movement of the mouth and/or tongue
- ⇒ Rooting (turning the head to the side when the lips/cheeks are touched)
- ⇒ Subtle body movements
- ⇒ Increased alertness
- ⇒ Slight opening of the eyes
- ⇒ Flexed arms and/or legs and clenched fists

This baby is becoming more alert and mouthing his hand to show that he is hungry.

Crying is the last feeding cue that a baby provides when they are hungry. It will happen when all other subtler feeding cues have been missed by the caregiver.

GETTING BABY TO LATCH: BASIC STEPS FOR LATCHING

[17]STEPS	DESCRIPTIONS (WHAT IT LOOKS LIKE)
① *Nose to Nipple* 	○ Aim baby's nose to the nipple of the breast. ○ Once aligned, move baby 2.5-7.5 cm (1-3 inches) away from the nipple.
② *Head Tilt* 	○ After aiming, baby's head will slightly tilt back allowing her mouth to gape open for latching. ○ Gently bring baby back to the breast to latch.
③ *Latch On* 	○ Baby latches onto the breast and begins to suck. ○ Repeat above steps if baby does not gape mouth or latch well.

GETTING BABY TO LATCH: LIP STIMULATION

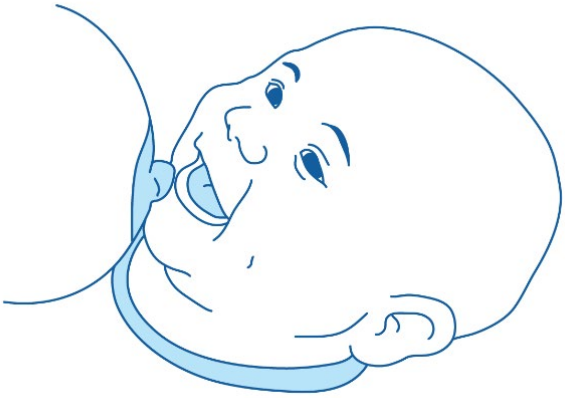
Sometimes babies will need gentle stimulation (or touch) to their lips using the nipple to encourage them to open their mouths widely and begin sucking. This is called lip stimulation.

Directions:

① Lightly touch the nipple to the baby's lower lip, gently moving it from side to side. This should stimulate a wide, open mouth (gape) from baby.

② Wait for baby to open her mouth widely.

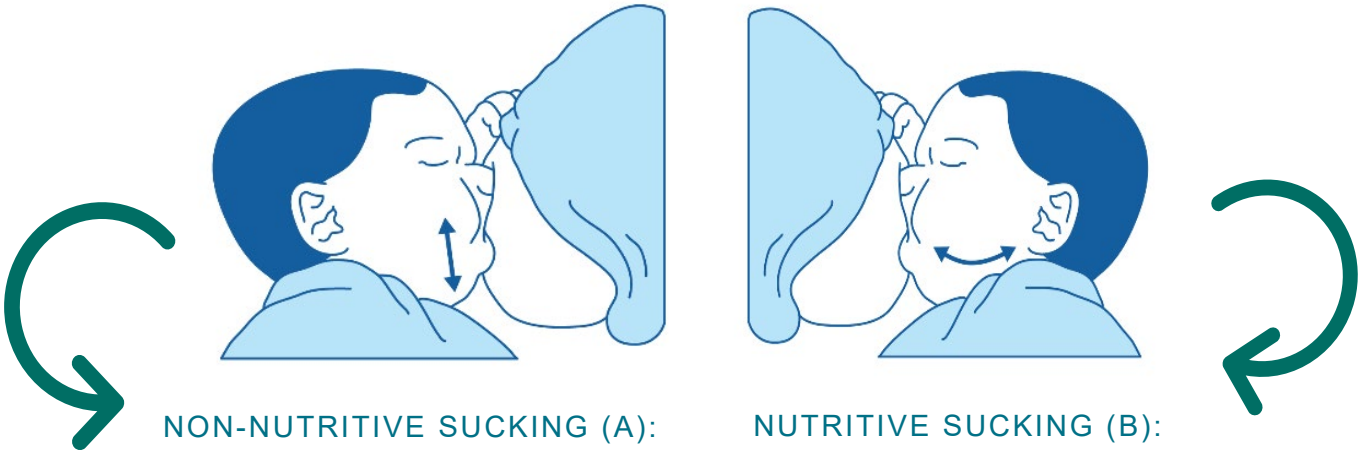
③ After opening her mouth, gently move baby toward you so she can latch onto the breast.



Bring baby to you instead of bringing the breast to baby.

GETTING BABY TO LATCH: SUCKING TO EAT? OR SUCKING FOR COMFORT?

Babies will use breastfeeding for nourishment (nutritive sucking). Babies will also use breastfeeding for comfort (non-nutritive sucking) where they are not seeking to receive breastmilk and become full. Sucking is a powerful movement that not only helps babies grow and be well nourished, but it also helps them become calm and happy. It is very common for babies to use both nutritive and non-nutritive sucking during the day and night. It is helpful to understand this difference and recognize when a baby is sucking for food or for pleasure, especially when there are concerns about if a baby is getting enough to eat from the breast.



NON-NUTRITIVE SUCKING (A):

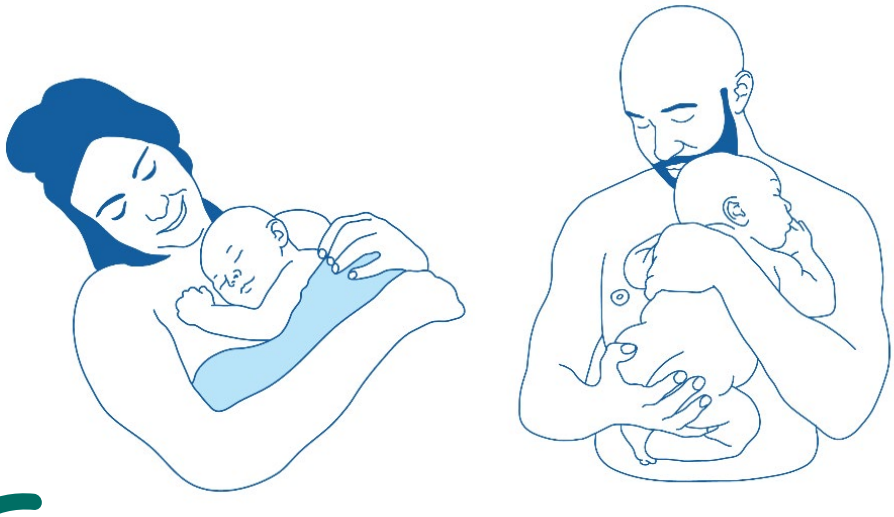
Jaw moves in an up and down (piston-like) motion.

NUTRITIVE SUCKING (B):

Jaw moves in a back and forth (rocker-like) motion.

GETTING BABY TO LATCH: SKIN TO SKIN

When a baby can be close to his mother and/or father and have his skin touch theirs, it is incredibly calming. It is also helpful for getting a baby ready to breastfeed. Skin to skin (also called "Kangaroo Care") is when a mother or father holds a bare baby to their own bare chest. This is a wonderful way for new babies to adjust to living outside of their mother's womb. It can be done as often as a baby needs and is typically most beneficial for newborn babies.



A mother and father practice skin to skin with their newborn babies.

9L 2: HANDOUTS FOR CAREGIVERS AND COMMUNITIES – FEEDING AND INTERACTION CUES

CHILD COMMUNICATION AROUND FEEDINGS[15]

Young babies and children have many ways they communicate their wants and needs. Through the use of sounds, body movements and facial expressions (also known as cues), children let caregivers know when they are ready to eat and are enjoying interactions, and also when they need a break or are full. Cues are important because they help caregivers understand the needs of children when they cannot speak. When caregivers recognize and respect these cues, feedings and interactions with children are much more successful. Use this chart and photos as a reference for identifying cues and letting them guide your responses to the children in your care.

Some cues are obvious, and others are subtle. The two main types of cues shared in this manual are:

1. Engagement Cues – "ready to go" cues
2. Disengagement Cues – "ready to break" cues

ENGAGEMENT CUES	DISENGAGEMENT CUES
○ Eyes bright and wide ○ Eyebrows soft but raised ○ Facial brightening ○ Smiling ○ Gazing at others ○ Giggling ○ Cooing and babbling (making happy sounds) ○ Feeding sounds (sucking, smacking lips or tongue) ○ Turning head and body toward caregiver and food or liquid ○ Hands to mouth ○ Hands under chin ○ Hands on stomach ○ Hands open and fingers loosely flexed ○ Reaching arms toward caregiver and/or food or liquid ○ Smooth, slow body movements (not jerky, tight or flailing)	○ Dull looking eyes and face ○ Eyebrows furrowed or lowered ○ Facial grimacing (frowning), pouting, crying ○ Wrinkled forehead ○ Eyes blinking or closed tightly ○ Looking away from others ○ Lip compression (lips pressed tightly together) ○ Fast breathing ○ Increased sucking noises and movements ○ Fussing, whining or whimpering ○ Coughing, choking, gagging, spitting, spitting up or vomiting ○ Yawning or hiccupping ○ Head shaking ○ Turning head and body away from caregiver and food or liquid ○ Hand to ear, eye or back of head and neck ○ Halt hand ("no" signal with hands) ○ Joining hands together ○ Finger splaying and extension ○ Grabbing onto own clothes and/or body ○ Pounding on tray/table or waving arms up and down ○ Pushing or pulling away from food or caregiver ○ Arms and/or legs stiff or straightened ○ Leg kicking ○ Crawling or walking away ○ Falling asleep quickly during feedings

ENGAGEMENT CUES

Facial Brightening

Bright, Wide Eyed

Gazing at Others

Smiling and Hand to Mouth

Hand to Mouth

Turning Head to Caregiver

Engagement cues are signs that a child is becoming hungry and they are ready to interact with you.

When a child shows these cues, she is giving you the green light to offer her food and interaction.

DISENGAGEMENT CUES

Cry Face or Grimace

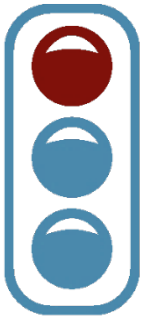
Finger Splaying and Extension

Yawning

Grabbing onto self

Head Turn and Furrowed Brow

Furrowed Brow and Hand to Ear



Disengagement cues are signs that a child is full or the interaction they are having is too overstimulating.

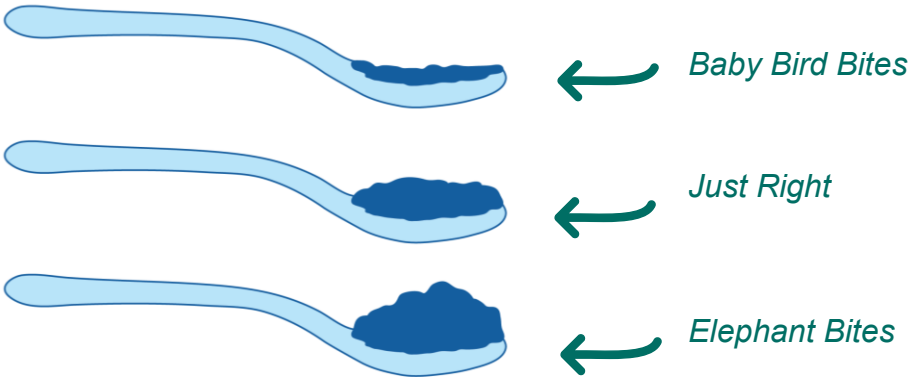
When a child shows these cues, he is giving you the red light to stop feeding him, give him a break and help him become calm. Incorporating calming activities can be helpful (refer to Appendix 9K).

Crying is the last cue that a baby uses to show when he is hungry. Catching early cues that a baby is hungry before they begin to cry, can lead to easier feedings and happier babies. Watch for cues — not the clock.

9L 3: HANDOUTS FOR CAREGIVERS AND COMMUNITIES – BITE AND SIP SIZES

BITE SIZES

Bite sizes for children should be a size that is easily and safely manageable for them. No matter a child's age or the food texture they are eating, the size of a bite must match a child's capabilities. Too big of a bite can lead to difficulty eating, choking, food refusals and even aspiration. It is always best to start small and gradually increase bite size as a child shows readiness.



SMALLEST

LARGEST

[15]BITE SIZES	DESCRIPTIONS (WHAT IT LOOKS LIKE)
Baby Bird Bites 	○ A very small amount of food on the spoon. ○ Works well for children in the early stages of feeding or children with feeding and swallowing challenges, who are safest and most successful with small amounts of food at a time.
Just Right Bites 	○ A small to moderate amount of food on the spoon. ○ Works well for children with typical feeding skills or adequate spoon feeding experience, who can handle a little more food at a time.
Elephant Bites 	○ Too much food on the spoon — a heaping amount. ○ Challenging for all children with or without feeding challenges. Too much food at a time is unsafe and should be avoided.

SIP SIZES

Just as with bite sizes, sip sizes for children should be a size that is easily and safely manageable for them. No matter a child's age or the liquid consistency they are drinking, the size of a sip must match a child's capabilities. Gulping (too big of a sip) or offering consecutive sips (lots of sips and swallows of a liquid without a break) for a child can lead to difficulty drinking, frequent coughing and choking, refusals to drink and even aspiration. It is always best to start small and gradually increase sip size as a child shows readiness.

DO ENCOURAGE

- ✓ Small sips that require only one swallow
- ✓ Single sips at a time
- ✓ Breaks between sips — especially for children with feeding and swallowing challenges who need more time to swallow
- ✓ A forward head position for drinking from a bottle, cup or straw
- ✓ Slowly increasing sip size and/or rate of drinking as a child shows readiness

DON'T ENCOURAGE

- Ø Gulping (large sips) that require multiple swallows
- Ø Consecutive (multiple) sips one after another
- Ø Drinking entire contents from a bottle or cup all at once without a break
- Ø An over extended head or neck tilt backward when drinking from a bottle, cup or straw
- Ø Drinking large sips at a fast rate when a child shows they are having trouble by coughing, choking, turning a different color, frequent illness, etc.

The Best Way to Keep a Child Safe is by offering food and liquids in small amounts and at a slow rate. Always follow a child's lead, letting them guide you when they are ready for a larger bite and sip or a somewhat faster pace.

9L 4: HANDOUTS FOR CAREGIVERS AND COMMUNITIES — POSITIONING CHECKLISTS

FEEDING POSITIONING CHECKLIST FOR THE CHILD 0-6 MONTHS OLD

Follow these positioning guidelines when feeding babies 0-6 months old to decrease the risk of aspiration, illness and to increase safety and comfort during feedings.

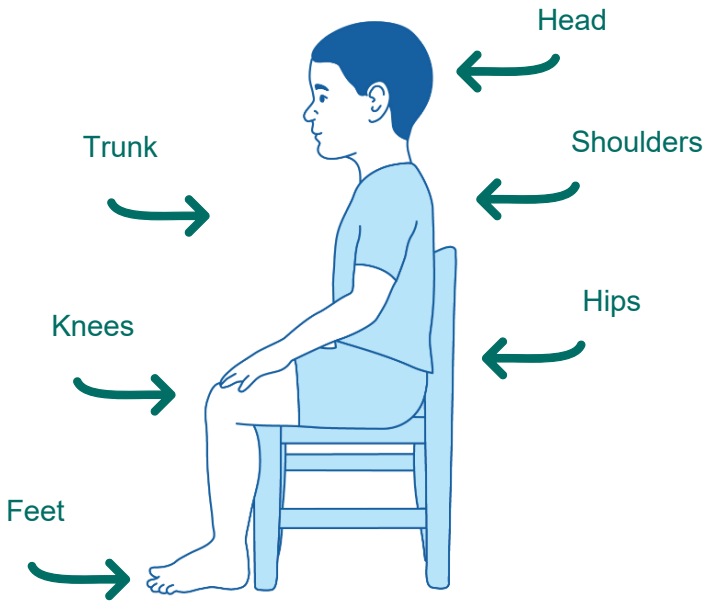
AT 0-6 MONTHS A BABY'S:

- ☐ head is centered and in midline position
- ☐ body is swaddled (0-4 months)
- ☐ chin is slightly tucked forward
- ☐ shoulders are naturally rounded
- ☐ body is supported firmly by a caregiver's body, arms and chest
- ☐ hips should be lower than their head

FEEDING POSITIONING CHECKLIST FOR THE CHILD 6 MONTHS AND OLDER

Follow these positioning guidelines when feeding children 6 months and older to decrease the risk of aspiration and illness and to increase safety and comfort during feedings.

AT 6 MONTHS AND OLDER A CHILD'S:
☐ hips should be positioned at 90-degrees and lower than the head
☐ body (trunk) should be upright and well supported by caregiver's body or chair – not leaning forward, backward or to either side
☐ shoulders should be level and facing forward
☐ head is centered and in midline, neutral position with chin slightly tucked
☐ knees should be at a 90-degree angle
☐ feet flat on floor, foot rests or against caregiver's body



9L.5: HANDOUTS FOR CAREGIVERS AND COMMUNITIES – DENTAL (ORAL) CARE AND TOOTHBRUSHING[9,30]

HEALTHY TEETH AND HEALTHY CHILDREN

All children can have problems with their teeth; however, children with disabilities are much more vulnerable. Specific problems may include cavities, tooth decay or rot and diseases of the teeth and gums. Oral health or hygiene is the preventative practice of keeping the mouth (teeth, tongue, cheeks and lips) clean and healthy by using regular routines such as brushing, flossing and rinsing.

A primary health need for every child is having a clean mouth. Children with disabilities or medical needs often rely on others to maintain good oral health. This means caregivers play a critical role in sustaining healthy mouths for the children in their care.

PROBLEMSASSOCIATED WITH UNHEALTHY TEETH AND GUMS

- ⇒ Increased risk of cardiac (heart) disease
- ⇒ Increased risk of pneumonia and other respiratory illnesses
- ⇒ Increased pain or discomfort in the mouth (with or without eating/drinking)
- ⇒ Reduced intake of food or liquid due to pain or discomfort
- ⇒ Misalignment or loss of teeth

WHY ARE CHILDREN WITH DISABILITIES MORE VULNERABLE?[37]

Children with disabilities or medical needs are at greater risk of developing poor oral health compared to other children for many reasons. Certain conditions have higher associations such as behavioral, cognitive (thinking) or mobility (movement) challenges or problems with swallowing, gagging or gastroesophageal reflux. These difficulties can be obstacles for maintaining appropriate oral health.

SPECIFIC CONDITIONS THAT PLACE CHILDREN AT RISK

- ⇒ Cleft lip and/or palate or other structural differences of the mouth, face or head
- ⇒ Cerebral palsy
- ⇒ Down syndrome
- ⇒ Visual impairments
- ⇒ Hearing impairments
- ⇒ Seizure disorders
- ⇒ Developmental/learning disabilities
- ⇒ HIV infection

OTHER FACTORS

When a child …

- cannot easily move his lips, tongue and cheeks for eating and drinking, he will miss out on the natural cleaning that occurs with these structures.
- cannot move or coordinate her arms and hands, she may have trouble brushing or flossing.
- does not have enough saliva, she may have trouble moving food pieces out of her mouth.
- is on a restricted diet or does not take food or liquid orally, his mouth may be dry and grow unhealthy bacteria that can make him sick.
- is on certain medications, she may experience bleeding or swelling of the gums and tooth decay.
- is using bottles for a prolonged time, he may have excessive rotting of the teeth and/or issues with alignment.
- is given excessive amounts of sticky or sweet food/liquid, she may have rotting and teeth that are falling out.

SIGNS OF ORAL HEALTH PROBLEMS

- ⇒ Food or liquid refusals
- ⇒ Preference for softer foods over harder, textured foods
- ⇒ Teeth grinding
- ⇒ Teeth discoloration
- ⇒ Bad breath
- ⇒ Sensitivity to touch in or around the mouth

Introduce oral hygiene and toothbrushing routines as early as possible with babies and children. When the first tooth appears, a child is ready for toothbrushing. Oral hygiene can be taught even sooner.

BASIC ORAL CARE AND TOOTHBRUSHING

Every child deserves a clean and healthy mouth. Developing a basic oral care plan for each child does not need to take lots of extra time. Just as washing hands before and after meals, cleaning a child's mouth can smoothly be incorporated into a routine.

Basic Oral Care and Toothbrushing Directions

BEST FOR: All babies and children

WHEN TO DO:

- Daily, recommended 2-3 times a day. Usually after daily meals/snacks or after waking up and before going to bed.

HOW TO DO:

- Hold the child upright in arms or have them positioned upright in a comfortable seated position.

- Use clean water with a toothbrush, finger brush or a soft warm cloth.
- Show the child the brush or cloth and offer it for sucking, mouthing or biting with supervision. (This may need to happen many times before attempting to clean a child's mouth.)
- As the child shows acceptance, gradually begin massaging her lips, tongue, cheek pockets and exposed teeth and gums using the brush or cloth. This may be very brief at first (5-10 seconds) or up to 2 minutes.
- Repeat as necessary before and after meals during the day.
- Repeat following other events when the mouth may need to be cleaned (for example: following illness or vomiting).

Ideally, children should be provided proper oral care at a minimum of three times each day. Children with disabilities or medical needs require care more often. It is recommended to clean their entire mouths before and after every single meal. This can prevent illness and disease as well as aspiration if they are laid down too soon following a meal and have food left in their mouths.

THE 1-2-3 GAME[38]

This is a helpful method that works well with children with sensitive sensory systems, discomfort with oral care or for those who have had limited oral care experiences. This game helps a child build trust in their caregiver during oral hygiene routines. They learn that the touch, or experience, will never go beyond "3."

Directions:

1. Show the child the brush or cloth.
2. Touch the area of the body that the child is most comfortable with (for example: the lips, a hand, a shoulder or inside the mouth).
3. For each touch with the brush or cloth, count out loud to the child "1-2-3." Never count to 4!
4. At "3" the touching stops and the brush or cloth is removed from the child's body.
5. The brush or cloth is placed on the child's body again (same body part or slightly closer to the target — inside of the mouth) and the counting starts again "1-2-3."
6. Repeat this process as the child allows, moving closer to the inside of the mouth.
7. Once in the mouth, this process stays the same. Count out loud "1-2-3" while touching or brushing the tongue, cheeks and teeth.
8. HINT: Start by counting quickly to make the touch brief. As the child allows, gradually begin counting more slowly ("1 … 2 … 3 …" → "1 ..... 2 ..... 3 ....." → "1 ..... 2 ..... 3 .....".

For babies and children with sensitive sensory systems or those who have limited oral care experience, it is important to start with short cleanings in order to keep the experience positive.

TIPS FOR SUPPORTING HEALTHY MOUTHS AND TEETH

1. Lend a hand. Children with disabilities will most likely need some type of support (from minimal to total) for oral hygiene (mouth/teeth cleaning) routines. Proper oral care should be provided every day and multiple times for each child.

2. Get creative. Choose a toothbrush that fits each child's physical abilities and sensory preferences. For children who may have trouble holding a toothbrush, choose one with a shorter and thicker handle. Modify a brush by making the handle thicker using foam or tape. If a child shows dislike of brushes, try a cloth or finger brush instead.

3. Offer lots of practice. Allow lots of opportunities for a child to or participate in oral hygiene routines each day. The more often a child uses a toothbrush, the easier these routines will become and the sooner he will be able to take over this care himself.

4. Slow and brief. When first starting to incorporate oral care with a child, offer short experiences and slowly work toward the inside of a child's mouth. A child may not allow touch to the mouth or even the face. Respect what she can tolerate and gradually grow the length and quality of their oral hygiene routine.

5. Don't start at the mouth. Some children may not be receptive to touch on or in the mouth. Offering touch/massage to other parts of the body first such as the hands and arms and gradually working toward the face and mouth is a helpful strategy. Respect what a child can tolerate and gradually grow the length and quality of their oral hygiene routine.

6. Have fun. Make oral care fun by being playful each time. Going slowly and respecting what a child is able to tolerate in each moment will also keep things positive.

7. Offer healthy options. Limit a child's exposure to sweet foods or drinks that may contain lots of ingredients that are harmful for the teeth and gums (for example: sugar).

8. Limit bottles. Children who use bottles for a long time are more likely to have tooth decay. If a child needs a bottle for rest, try offering water instead of milk or formula — clean her mouth directly after she's finished drinking milk or formula from the bottle.

9. Find a dentist. A child should see a dentist (tooth/mouth doctor) as soon as his first tooth appears. After that, every child should receive regular dental care throughout the year. This way, if problems arise, they can be quickly addressed before they become serious.