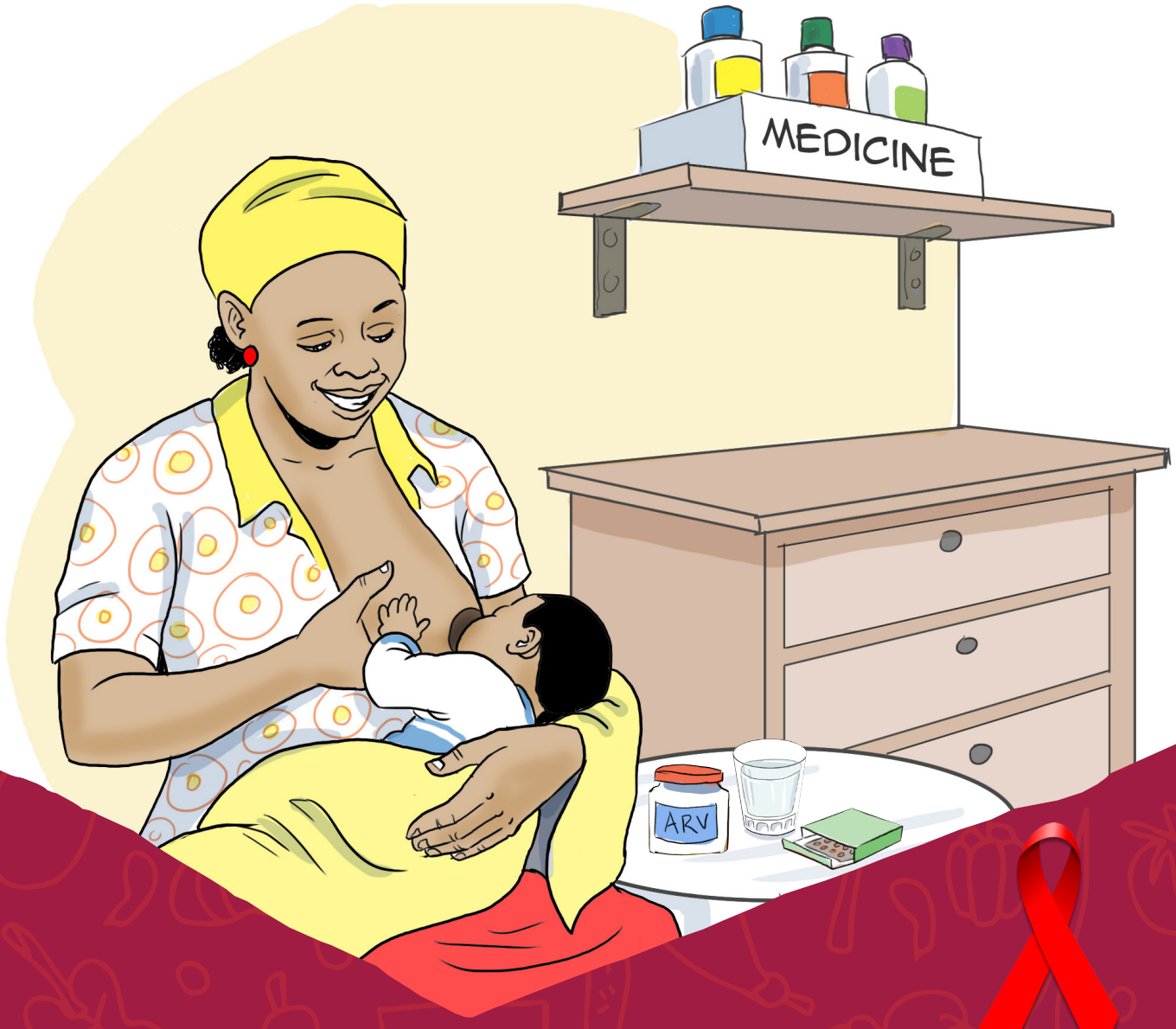
MINISTRY OF HEALTH



Infant and Young Child Feeding in the context of HIV: Frequently Asked Questions

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Foreword



The Ministry of Health through the Division of National AIDS and STI Control Program (NASCOP) and the Division of Nutrition and Dietetics with support from UNICEF, and other implementing partners is fast tracking the implementation of Maternal, Infant and Young Child Nutrition (MIYCN) strategies to improve maternal nutrition, child survival, growth, and development. Safe infant feeding for all infants including the HIV exposed ones, is a key part in addressing HIV free child survival. The appropriate practice and knowledge of infant and young child feeding are critical because of the major influence that feeding practices and nutrition have on child survival.

As guidelines evolve, there has been unclear messaging on infant feeding among health care providers and the community, reducing the uptake of optimum infant feeding practices. As a result, a recent analysis on the PMTCT cascade has shown a proportion of infants getting infected with HIV during the breastfeeding period hence the need of advocating for safe infant feeding in the context of HIV. The Ministry of Health therefore developed appropriate evidence-based communication messages on frequently asked operational questions regarding infant and young child nutrition in the context of HIV within health facilities and community settings.

It is my pleasure to present the first edition of ***"Frequently Asked Questions (FAQs) on Infant and Young Child Feeding (IYCF) in the context of HIV."*** This document outlines a series of questions and answers on Infant and Young child Feeding (IYCF) in the context of HIV on which a consensus has been reached by all the relevant stakeholders. It covers, but is not limited to, the following thematic areas: policy guidelines and recommendations; breastfeeding in the first six months; Complementary feeding; Communicating with mothers/community support structures/Challenges; Disclosure and stigma; social and economic influences on feeding practices; Monitoring and Evaluation and Breastfeeding in the context of COVID-19.

This document is intended for use by the policy makers, all the national and county multi-disciplinary health care workers, civil society organizations, communities and implementing partners.

I embolden all health professionals and communities involved at the national and county level to read, disseminate, and adapt the contents of this document as per the provided guidance.

Dr. Patrick Amoth, EBS
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Ministry of Health.

Acknowledgement



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We wish to recognize the head NASCOP, Dr. Rose Wafula for the overall motivation that kept the team focused and working. Her support to attend in person and provide strategic direction demonstrates her commitment towards realizing the objectives of the IYCF (HIV) FAQ booklet

Special thanks goes to UNICEF Kenya led by Chief, HIV/AIDS Pierre Robert and Chief, Nutrition, Patrick Codjia for the relentless commitment, provision of financial and technical support towards development and printing of this document.

We appreciate the team of consultants; Dr. Mike Mulongo (Lead Consultant), Ms. Joycelyn Kathembe (Lead Nutrition Consultant), Dr. Obat Odawo and Prof. Judith Kimiywe, for facilitating the collaborative compilation and finalization of the booklet.

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Abbreviations

ART	Antiretroviral Therapy
ARV	Antiretrovirals
AZT	Zidovudine
EBF	Exclusive Breastfeeding
EMTCT	Elimination of Mother To Child Transmission of HIV
HAART	Highly Active Antiretroviral Therapy
HEI	HIV Exposed Infant
HIV	Human Immunodeficiency Virus
IYCF	Infant and Young Child Feeding
MIYCN	Maternal Infant and Young Child Nutrition
NVP	Nevirapine
PEP	Post Exposure Prophylaxis
PLHIV	People Living with HIV
PrEP	Pre-Exposure Prophylaxis
PnP	Post-natal Prophylaxis
TPT	Tuberculosis (TB) Preventive Treatment
3TC	Lamivudine

1. Policy Guidelines and Recommendations

1.1. What prompted the change of guidelines from 1-year breastfeeding to 2 years breastfeeding for HIV positive mothers

There is sufficient evidence that prolonged breastfeeding to 2 years and beyond improves healthy survival of all children regardless of their HIV status.

Breast milk protects the child from death and hospitalization from diarrhea and chest infections. It also protects them from developing malnutrition, obesity, allergies, heart disease and diabetes as they grow and improves their immunity (body defences).

For the HIV Exposed Infants, safe breastfeeding (exclusive breastfeeding by mothers on appropriate Antiretroviral Therapy (ART), with baby on appropriate infant prophylaxis) further increases the chances of HIV free survival.



1.2. At which stage should the child born to a HIV positive mother be put on prophylaxis?

ARV prophylaxis should be initiated immediately at birth or as soon as the HIV exposed infant is identified (within 72 hours). This should be continued for upto 6 weeks after cessation of breastfeeding. Post-natal Prophylaxis (PnP) consists of 6 weeks of Zidovudine (AZT) + Nevirapine (NVP) and thereafter NVP continued until 6 weeks after complete cessation of breastfeeding. Infant prophylaxis can be discontinued after a minimum of 12 weeks on NVP if the child is not breastfeeding.



Cotrimoxazole prophylaxis should also begin from 6 weeks of age up to 18 months for infants who remain HIV negative. Infants who turn positive Septrin is continued for life. Infants who cannot tolerate Septrin can be started on dapsone with guidance of a qualified health worker.

Highlight: The best way to prevent breast milk transmission of HIV is by ensuring that the mother is on optimal treatment and virally suppressed (VL below 50 copies/ml) for the entire duration of breastfeeding and the baby on infant prophylaxis as recommended in the ART guidelines.

1.3. What is the dosage of ARV prophylaxis for HIV exposed infants up to 2 years?

All HIV Exposed Infants (HEI) and children must have their weight documented at every visit for correct weight-based dosing of the ARVs as per the recommended guidelines.

Infants and children depend on their caregivers for adherence to medication. It is therefore important for caregivers to be adequately prepared for their role of giving Anti-Retrovirals (ARVs) to infants and children. Caregivers should always be shown and then asked to demonstrate how to measure and administer ARVs. This should be done at the time of prescribing the ARV (by the clinician) and at the time of dispensing the ARV.

1.4. In the absence of Nevirapine (NVP) can we use AZT? If we do, should we do monthly blood level (Hemoglobin -HB) monitoring?

Yes, AZT can be used. A blood level check (Hemoglobin) is necessary if the use of AZT extends beyond six weeks. This should be done at week one, week 2, week 4 and week 12. Available evidence suggest that AZT related side effects are more prominent within the first three months of use.

1.5. If a Breastfeeding mother is exposed to HIV and she is put on Post Exposure Prophylaxis (PEP), should her child be put on prophylaxis too during that period?

No. When a breastfeeding mother starts PEP (within 72hours) because of HIV exposure, her child does not require PEP or infant prophylaxis as well.

But if in the course of taking PEP the breast-feeding mother is diagnosed with HIV, she should immediately start appropriate ART, giving extra attention to adherence support, Viral Load monitoring, and optimal retention in care. The child should immediately start ARV prophylaxis and receive Polymerase Chain Reaction (PCR) testing at first contact and subsequently be tested according to the care guidelines (PCR at age 6 weeks, 6 Months, 12 Months, and Antibody test at 18 Months).

The child should continue breastfeeding.

1.6. For mothers failing in the 1st and 2nd line of treatment, will the child also get resistant virus?

The child may be at high risk of HIV infection with the resistant virus. To ensure that children who get infected with the resistant virus are well treated, all children living with HIV are started on ART combinations that have lower chances of further resistance (Protease Inhibitors).

Adherence is most difficult during the first few months of treatment. This is also the riskiest period for development of resistance, when the viral load is still high which puts the child at high risk of HIV infection. Caregivers are advised to seek counsel in order to address any challenges that may be contributing to non-adherence.

1.7. Are there policies and guidelines for breastfeeding mothers who are employed?

Yes, there are policies and guidelines for breastfeeding mothers who are employed.

Policies:

I. Constitution of Kenya 2010: article 43 (1a&c) & 53 (1c)

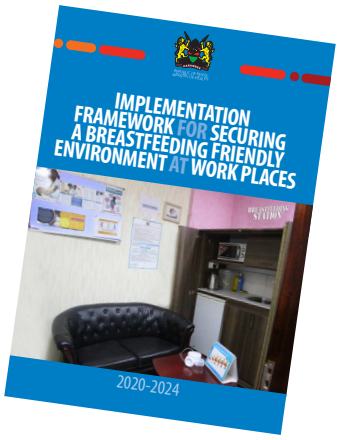
Under the Bill of Rights, the Constitution of Kenya guarantees every child the right to basic nutrition and health of the highest attainable standard.

ii. Health Act 2017: article 71 (1-3) & 72 (1-2)

All Employers are by this law required to provide the nursing employees necessary breastfeeding support including:

a) 3-month maternity leave and 10 days paternity leave.
b) Flexible work schedules.
c) Breaks outside the regular times off for mothers to breastfeed or express milk.
d) Private lactation stations.

Guideline:



I. Implementation framework for securing a breastfeeding friendly environment at the work-place (2020-2024).
II. Guideline for securing a breastfeeding friendly environment at the work-place (2018).

These guidelines developed by the Ministry of Health provide guidance on how to establish and implement the policy (Health Act 2017) at the workplace for nursing employees.

These give direction to the public and private institutions on how to secure a conducive environment for supporting female employees to combine work and breastfeeding including workplace policies, lactation station/room, flexi- time and how policy makers, employers, community and health workers can contribute to supporting workplace support for breastfeeding.

1.8. What is the role of the government in ensuring optimal nutrition and health for the child?

The government plays a key role in ensuring food security, food safety, capacity building and social protection through preparing, passing and implementation of laws, policies and guidelines to optimize nutrition for children for a healthier and better quality of life and improved productivity as they grow.

Some initiatives include cash transfers (e.g. orphans and vulnerable children cash transfers, hunger safety net programme and urban food subsidy); and food distribution (e.g. school feeding, and emergency relief).

2. Breastfeeding in the first six months

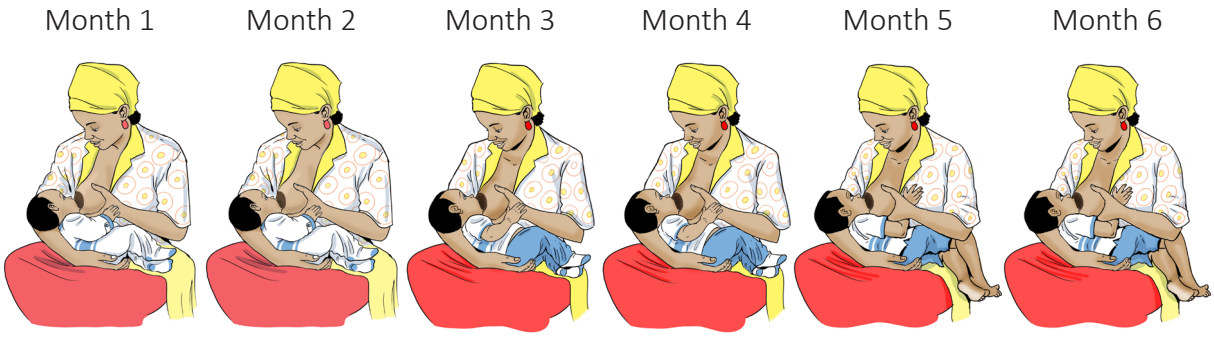
2.1. After delivery, should HIV+ mother's breast feed or start the child on replacement feeding?

Early initiation of breastfeeding within the 1st hour of life is recommended for all mothers irrespective of HIV status.

HIV positive mothers should exclusively breastfeed their infants for the first 6 months of life. They should also ensure timely introduction (at 6 months) of appropriate, adequate and safe complementary foods alongside continued breastfeeding up to 2 years or beyond.

All HIV positive breastfeeding mothers should correctly and consistently take their HIV medication as advised by their health care providers. They should ensure consistent and correct use of HIV prevention medicine for their infants throughout the breastfeeding period as it reduces the risk of passing the virus to the baby.

Exclusive breastfeeding 0-6 months





2.2. Why is exclusive breastfeeding encouraged despite mother's HIV status?

Exclusive breastfeeding has been shown to protect against damage of the intestinal lining hence reducing the chances of HIV transmission to the child. It also reduces the risk of breast conditions such as mastitis and breast abscess which are associated with increased breast milk viral load.

Exclusive breastfeeding has many benefits such as:

- It contains all nutrients to support child's growth and development.
- It contains antibodies that enhances the baby's immune system offering protection against deadly infections such as diarrhoea and pneumonia.
- Reduced risk of ovarian and breast cancer for the mother.
- It helps improve the baby's intellectual and mental development.

2.3. How sure are we that exclusive breastfeeding cannot transmit virus to the baby?

There is sufficient evidence that shows exclusively breastfeeding for the first 6 months while adhering to ART and prophylaxis for you and your baby will reduce the chances of HIV transmission from 20% to below 3%.

2.4. How possible is it to breastfeed for 2 years and beyond and not put the baby at risk of getting infected. Why is it important?

It is possible for a HIV positive mother to safely and exclusively breastfeed for 6 months and continue up to 2 years or beyond. Your baby is protected from HIV transmission as long as both mother and baby adhere to ART and prophylaxis throughout the breastfeeding period which will reduce the amount of virus in the breast milk.

Breastmilk contains antibodies that help to protect against infections such as diarrhoea and pneumonia. As your baby grows, breastmilk continues to provide an important source of energy and essential nutrients that they need to develop to their full cognitive and physical potential.

2.5. What can be done to make the expressed breastmilk HIV free for the infant?

How you can safely heat treat breast milk

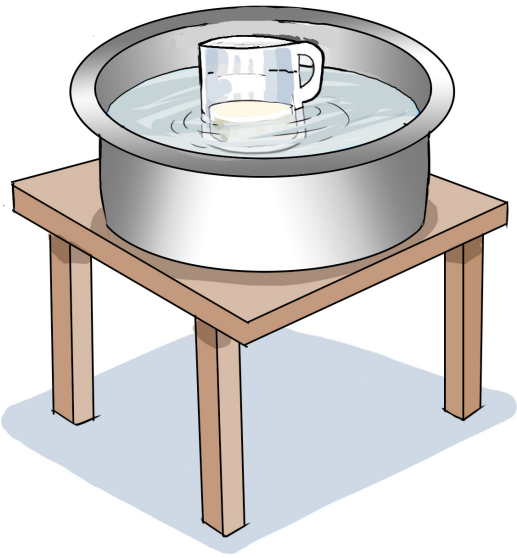


For safety, expressed breastmilk can be heat treated to destroy the HIV in the breast milk while retaining its important nutrients and protective agents. This is commonly done when a mother has breast conditions such as mastitis, cracked nipples, and breast candidiasis as a temporal method of feeding her baby as she seeks medical attention.

Steps for heat treating breast milk:

1. Always wash the utensils to be used for expressing and heat treating with clean water and soap.

2. Choose a cup, glass or jar with a wide mouth to use for expressing breastmilk.
3. Only heat enough expressed breastmilk for one feed.
4. Put expressed breast milk in a cup and place it in a sufuria with water. Make sure the water level is two fingers above the level of the milk in the jar.
5. Heat both water and milk to a boiling point. Make sure the lid is off when heating the milk.
6. After boiling, remove the cup from the boiling water.



7. Place the jar in a container of cool water until the temperature is warm enough for the baby to drink.
8. Store the boiled breastmilk in a clean, covered container in a cool place and use it within one hour.
9. A mother can store unheated breast milk for about 6-8 hours at room temperature or up to 24 hours in a refrigerator and for upto 6 months in the freezer.

10. Always feed your baby using a cup. Do not use teats or spouted cups as they are difficult to clean.



Feeding baby using a cup





2.6. How much breastmilk must I express to last my baby the whole day?

The amount of breastmilk required by the baby is dependent on age and weight of the baby. On average mothers may produce upto 1500 ml per day.

The amount is based on weight of the baby. Babies who weigh 2.5 kg or more are given 150 ml milk per kg body weight per day. For babies weighing less than 2.5kgs, refer to your health care provider.

Divide the total amount into eight feeds, every 3 hourly. However, if your baby wants more milk, it's okay to give them more to meet their demands especially as they are rapidly growing.

2.7. For mothers who chose not to breastfeed, what should they do when they don't have money?

It is recommended that all HIV positive mothers are supported to breastfeed their babies exclusively for the first 6 months and continue for 2 years or beyond. Mothers with challenges in breastfeeding should seek medical attention and psychosocial support from a health care provider. Referral for social protection programmes such as cash transfers could be done by health care providers where needed.

2.8. If a HIV+ mother dies, which foods or milk should the infant be fed on?

Infants < 6 months:

If a HIV + mother dies, the health care provider should provide the caregivers with information on feeding the baby using infant formula. The newborn should be provided with postnatal prophylaxis for 6 weeks after delivery and the prophylaxis should be discontinued after a minimum of 12 weeks. If newborn is positive, link to care and treatment.

For exclusive replacement feeding to be safe, caregivers should be counseled on following formula preparation instructions; use cup feeding instead of bottles/teats and maintaining proper hygiene of utensils through use of clean water and soap.

Your healthcare provider will assist you to determine what you will need.

Home-modified animal milk and other fruits and food are NOT recommended as replacement food in the first six months of life.

2.9. How sure are you that, if I practice exclusive breastfeeding and avoid mixed feeding my child will turnout HIV-?

There is sufficient evidence that shows exclusively breastfeeding for the first 6 months while adhering to ART and prophylaxis for you and your baby will reduce the chances of HIV transmission from 20% to below 3%.

Mixed feeding is NOT recommended to infants under 6 months of age. Giving other foods /liquids causes damage from the mouth to the gut of the infant which allows HIV transmission. It also increases chances of infants becoming sick from infections such as diarrhea and pneumonia.

2.10. Can I initiate breastfeeding if my child is not put on prophylaxis?

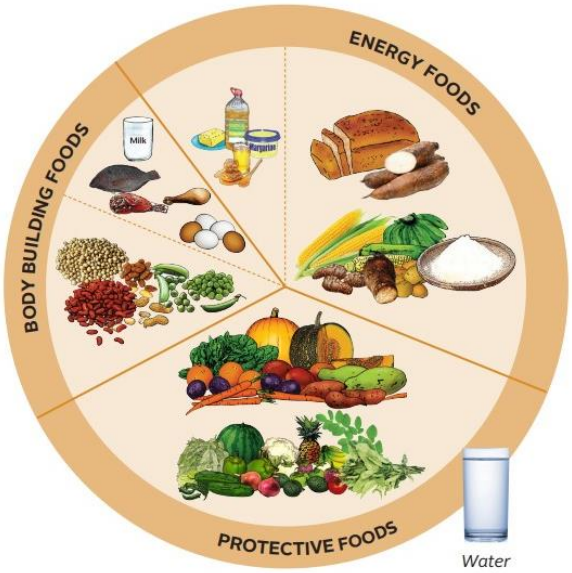
Yes. Early initiation of breastfeeding within the 1st hour of life is recommended for all mothers irrespective of HIV status. Similarly, ARV prophylaxis should be initiated immediately at birth or as soon as the HIV exposed infant is identified (within 72 hours) and the mother should be on appropriate ART.

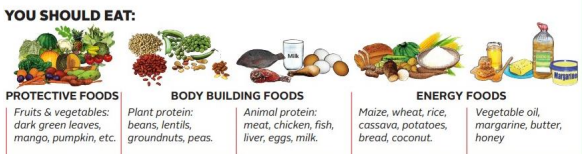
2.11. I do not have enough breastmilk, what do I do?

Almost all mothers can produce enough breast milk to feed multiple babies even when they feel like they don't. If you're having breastfeeding difficulties, consult your healthcare provider for breastfeeding support.

Tips to successful breastfeeding:

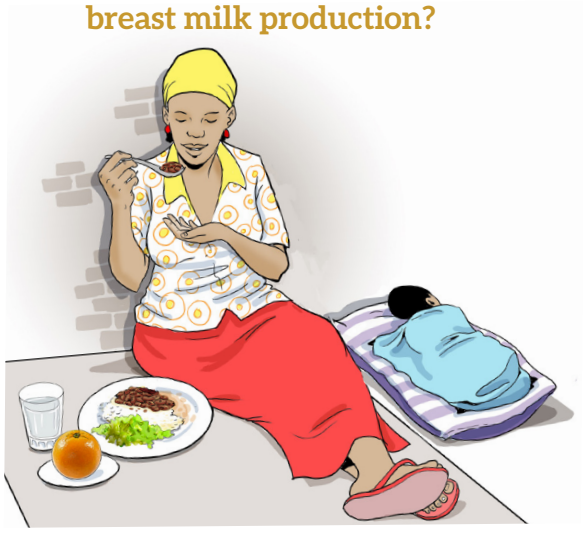
1. Breastfeed on demand (day and night).
2. Empty one breast at each feed.
3. Proper positioning, attachment and effective suckling.
4. Stimulate milk let down hormone by rubbing the mother's teats and her back, being relaxed, thinking lovingly of her baby, watching photos/videos of her baby.
5. Family and peer support i.e. with household chores, provision of food.
6. Linking mothers to support groups.





Source: USAID, FANTA III, fhi360.

2.12. What can I eat to increase my breast milk production?



Mother eating a healthy and balanced meal

Women of child bearing age, including mothers who are breastfeeding, should eat at least 5 of the 10 food groups each day to ensure they are in good nutritional status.

For example, eat protein food 2-3 times a day (meat, fish, eggs, poultry, beans, nuts, seeds). Eat vegetables at least 3 times a day (iron rich and Vitamin A rich-dark green leafy vegetables, yellow/red/purple (carrots, tomatoes, green beans, peas, bell pepper etc). Eat fruit at least 3 times a day (fruits in season and vitamin C rich fruits such as oranges, lemons). Eat whole grains, cereals, roots and tubers at least 3 times a day (whole maize and wheat, whole cereals e.g millet and sorghum, arrowroots, orange fleshed sweet potatoes, pumpkin).

Breastmilk production is increased by:

1. Breastfeeding on demand (by mother and baby).
2. Ensuring day and night feeds for the baby.

2.13. Do ARVs lead to low breastmilk production?

No, ARVs do not interfere with milk production, and you can produce enough breast milk to feed your baby safely while on ARVs.

2.14. What should I do if I have a breast condition (Sores nipples, blocked ducts, engorgement, cracked nipples, mastitis, Candidiasis)?

Condition	Causes	Prevention/ Treatment
Sore/cracked nipples. 	• Poor breast attachment.	• Proper breast attachment. • Avoid using soap or rubbing with a hard towel. Washing removes the natural oils from the skin. • Avoid using medicated lotions and ointments. • Mother can apply breastmilk over the nipple after breastfeeding.
Full and engorged breasts.  	• Delayed breastfeeding initiation after birth. • Poor drainage of breastmilk. • Infrequent breastfeeding (breastfeeding not on demand). • Poor positioning and attachment.	• Early initiation of breastfeeding. • Breastfeeding on demand. • Emptying the breast at each feed. • Correct positioning and attachment • Expressing breastmilk. • Applying a warm cloth before expressing and a cold cloth after to ease the pain. • Building mother's confidence in breastfeeding.
Blocked ducts and mastitis. 	• Wearing tight clothing and bras. • Poor drainage of breastmilk. • Scissor hold (breast held between 2 fingers).	• Avoid wearing tight clothing. • Ensure your child breastfeeds till the breast is empty at each feed. • Feed from the uninfected breast often and longer to increase milk production. • Support the breast with 4 fingers below the breast and place the thumb lightly on the top. • Express and heat treat breastmilk to feed your baby if mastitis is non-infective. • If infective mastitis, express breastmilk and discard it. • Refer to the healthcare provider for treatment.
Breast candidiasis. 	• Fungal infection.	• Refer to your healthcare provider for treatment of both baby and mother.

2.15. Do the ARVs taken by the mother affect the child negatively?

No, lifelong ARVs taken by the mother are safe towards her baby. ARVs safeguard the mother's health by restoring and maintaining her immunity and preventing mother to child HIV transmission during pregnancy, at birth and through breastfeeding.

2.16. Do drugs (ARVs) affect the quality of breast milk?

No, ARVs do not affect the quality of breastmilk. The main function of ARVs is to suppress the mother's viral load and reduce the risk of mother to child HIV transmission.

2.17. Should I stop breastfeeding my child when my viral load is high?

No, all mothers who are HIV positive should continue to breastfeed their babies exclusively for 6 months, introduce appropriate complementary foods as they continue breastfeeding up to 2 years or beyond. The baby should be on appropriate ARV prophylaxis and the mother on appropriate ART.

ART adherence is important to suppress a mother's viral load and reduce their risk of HIV transmission to their infants.

Where your viral load is high, adherence assessment and counseling should be done by your healthcare provider to assess for and address the potential barriers and provide the necessary support systems for the mother.

The healthcare provider may change your treatment in case treatment failure is confirmed.

2.18. Why is my baby constipated yet I only breastfeed?

Constipation isn't common because breast milk is easily digested and efficiently used as it contains factors that assist digestion and absorption of nutrients.

Exclusively breastfed babies may sometimes go several days, even a week without passing stool in the first few weeks after birth. If this happens and your baby is not having any severe abdominal pain or discomfort, continue to breastfeed frequently and on demand as breastmilk has enough water to help with the baby's digestion.

It is important to visit your healthcare provider for medical attention if your baby is exclusively breastfed and you notice the following signs:

a) Pain, firm, tight and distended stomach.
b) Straining with crying while passing stool.
c) Presence of blood due to passing hard stool.

2.19. Why does my baby have stomach aches yet I only breastfeed?

Some children may experience stomach discomfort such as colic pains. For colic pains, your baby cries a lot, in a particular pattern, either some hours during the day or night.

The cause of colic is not clear, however poor breast attachment may contribute as the baby swallows a lot of air while breastfeeding hence causing stomach discomfort.

You can best comfort and manage colic pains by:

1. Holding the baby against his/her chest.
2. Holding the baby along your forearm.
3. Applying pressure on their abdomen using your hands or against their shoulder.

How to calm a baby with colic pains



2.20. Why is my baby having loose stool and yet I only breastfeed him?

If you only breastfeed and your baby's stool is loose, yellowish, watery, you don't have to worry, it's normal. Exclusively breastfed babies may even pass stool after each feed. As long as your baby is alert, active, breastfeeding on demand and passing urine frequently, no other treatment is required. Breastfeeding should be continued.

If symptoms persist, seek medical attention. Your healthcare provider will assess your baby and offer appropriate treatment.

2.21. Why does my baby vomit when I breastfeed him/her?

It is unlikely for the baby to vomit after breastfeeding unless they are sick. However, immediately after breastfeeding, the baby can remove breastmilk if they are not suckling well, overfeeding or burping during breastfeeding.

You can help your baby with reflux by burping them frequently after feeding and try to hold them upright against your chest for as long as possible as this can help to keep the milk down.

In case you notice that your baby is having difficulty feeding, refusing to feed, bringing up milk too often, and experiencing abdominal pain, please seek immediate medical attention.

2.22. Should I breastfeed my baby if the baby has mouth sores?

Yes, continue breastfeeding despite the sores in your baby's mouth. Mouth sores may make it easier for the HIV virus to be transmitted from mother to baby during breastfeeding. The risk is however reduced as long as both mother and baby adhere to ART and prophylaxis which will suppress the viral load in the breast milk.

> ***NOTE:*** *You can also express breastmilk, heat treat it and give with a cup.*

Further, timely identification of mouth sores and immediate treatment are key to preventing HIV transmission during breastfeeding. Your healthcare provider may advise on appropriate treatment options.

2.23. Can I give another woman to breastfeed my child, if I do not have enough milk or I am sick and on medication? How safe is it?

No. It's not recommended to give another woman to breastfeed your child. This is because of the risk of hepatitis B & C and HIV transmission.



Mothers can continue to breastfeed even while sick. Seek treatment and inform your doctor that you are breastfeeding. Avoid purchase of over-the -counter drugs without a prescription. Getting enough rest, eating and drinking enough fluids helps with recovery. The antibodies that your body makes to fight the illness will be passed to your baby through breastmilk, helping to build their defenses/ immunity.

2.24. I have too much breastmilk, what can I do?

Mothers have plenty of breastmilk especially during the first few months after delivery and the baby may not be able to empty the breast during breastfeeding.

If a mother has excess breastmilk, she needs to express and store or discard.

- Ensure that proper hygiene is observed during storage.
- Before refrigeration, label containers well with dates when the milk was expressed.
- Remember, first in, first out for expressed breastmilk stored in the refrigerator/ freezer.

Expressing breastmilk will prevent her from getting breast engorgement and blocked ducts. Expressing breastmilk will also help to maintain milk production.

Storage time	Type of storage
8 hours	Room temperature in a cupboard
24 hours	Refrigerator
2 weeks	Freezer compartment with 1 door
3-6 months	Freezer compartment with 2 separate doors
6-12 months	Deep freezer

2.25. How do I tell the baby is getting satisfied with breast milk?

A baby who is taking enough breastmilk (exclusively breastfed) will be producing at least 6 wet nappies/ diapers more in a day which should be soaked with clear or pale yellow urine. If the urine is dark yellow, it shows that they may not be getting adequate breastmilk.

A weight gain of 500g or more every month in babies less than 6 months shows that the baby is getting adequate breastmilk.

2.26. I have swollen breasts that have no milk, just water. What might be the problem?

As your milk supply increases, your breast should feel heavier and full. This fullness should not prevent you from breastfeeding your baby. Your milk may seem watery because the breast milk in the first few days contain colostrum which is important for your baby's health and development. Additionally, breastmilk is in two forms; foremilk and hind milk. The watery fluid could be fore milk.

Mother needs to breastfeed frequently and on demand. Your healthcare provider should support you on how to have your baby properly positioned and attached to the breast to ensure efficient suckling, and on how to empty the breast.

Sometimes, health conditions including difficult deliveries, bleeding after birth, infections, severe stress, among others, may delay the large flow of milk expected in the first week after delivery. If this happens to you, don't feel discouraged. Continue to breastfeed frequently and you may also express. Your healthcare provider should provide appropriate treatment as may be necessary.

If your swollen breast persists with pain you may need to see your healthcare provider.

2.28. Can a HIV+ mother with tuberculosis breastfeed her child?

Yes, an HIV infected mother co-infected with tuberculosis should continue breastfeeding. The concentration of the drugs in breast milk cannot cause harm to the infant. The mother should be on treatment for TB while the child and any other children in the household aged 5 years and below should be put on Tuberculosis preventive therapy (TPT) if confirmed to be negative for TB. The mother may also be advised to wear a mask during breastfeeding when she has received treatment for less than 2 weeks, is sputum smear-positive, or has drug-resistant TB.

2.29. Can a HIV+ mother with breast cancer breastfeed her child?

Your health care provider can help you decide whether it's safer. However, caution and advice by your doctor is necessary during chemotherapy and radiotherapy treatment as some of the medicines can be passed to the baby through breast milk and may be unsafe for the child.

If you need surgery as part of treatment, your doctor might suggest that you stop breastfeeding. This will lower blood flow to your breasts and make them smaller, which helps during an operation. This may also prevent passing anesthesia drugs to the baby through breast milk.

Some women are able to breastfeed while they get radiation therapy. It depends on the type of radiation you need.

2.30. If a child turns out be HIV+ while another child turns out to be HIV- after the 6 months of Exclusive breastfeeding (EBF), which one should continue to be breastfeed and for how long?

Breastfeeding gives both children high chances of survival.

All infants irrespective of HIV status should be exclusively breastfed for the first 6 months of life, with timely introduction of appropriate complementary foods at 6 months, and continued breastfeeding up to 2 years or beyond.

The child that turns out to be HIV- after 6 months of EBF should continue on ARV prophylaxis until 6 weeks of complete cessation of breastfeeding. The child found to be HIV + should be started on HAART as soon as the HIV status is confirmed. The mother should be supported to ensure adherence for her and the child ARV treatment for life.

2.31. Should a HIV positive mother breastfeed directly or should she express and cup feed the child?

Mothers are encouraged to breastfeed directly at all times. Direct breastfeeding is beneficial for bonding, attachment and also promotes hygiene for the baby.

However, if the mother is away from the child, then she is allowed to express and the baby fed from a cup but should ensure that proper hygiene is observed.

2.32. Can you give both infant formula and breast milk?

No, do not give both infant formula and breastmilk as that amounts to mixed feeding if the baby is less than 6 months old.

Exclusive breastfeeding is recommended for all infants for the first 6 months of life, regardless of the maternal HIV status. Breastmilk confers nutritional benefits to the infant that the breast milk substitutes do not give.

2.33. What is mixed feeding and how does it increase the risk of mother to child transmission (MTCT) of HIV?

Mixed feeding is giving other liquids (including water) and/or foods together with breast milk to infants under 6 months of age. Mixed feeding is not recommended regardless of the mother's HIV status.

Before 6 months of age, the infant's intestinal lining is still immature and can easily be damaged by food.

The damage of the lining of the infant's intestines creates an avenue for entry of the virus into the infant's system and therefore increasing the risk of HIV transmission through breastfeeding.

3. Complementary Feeding

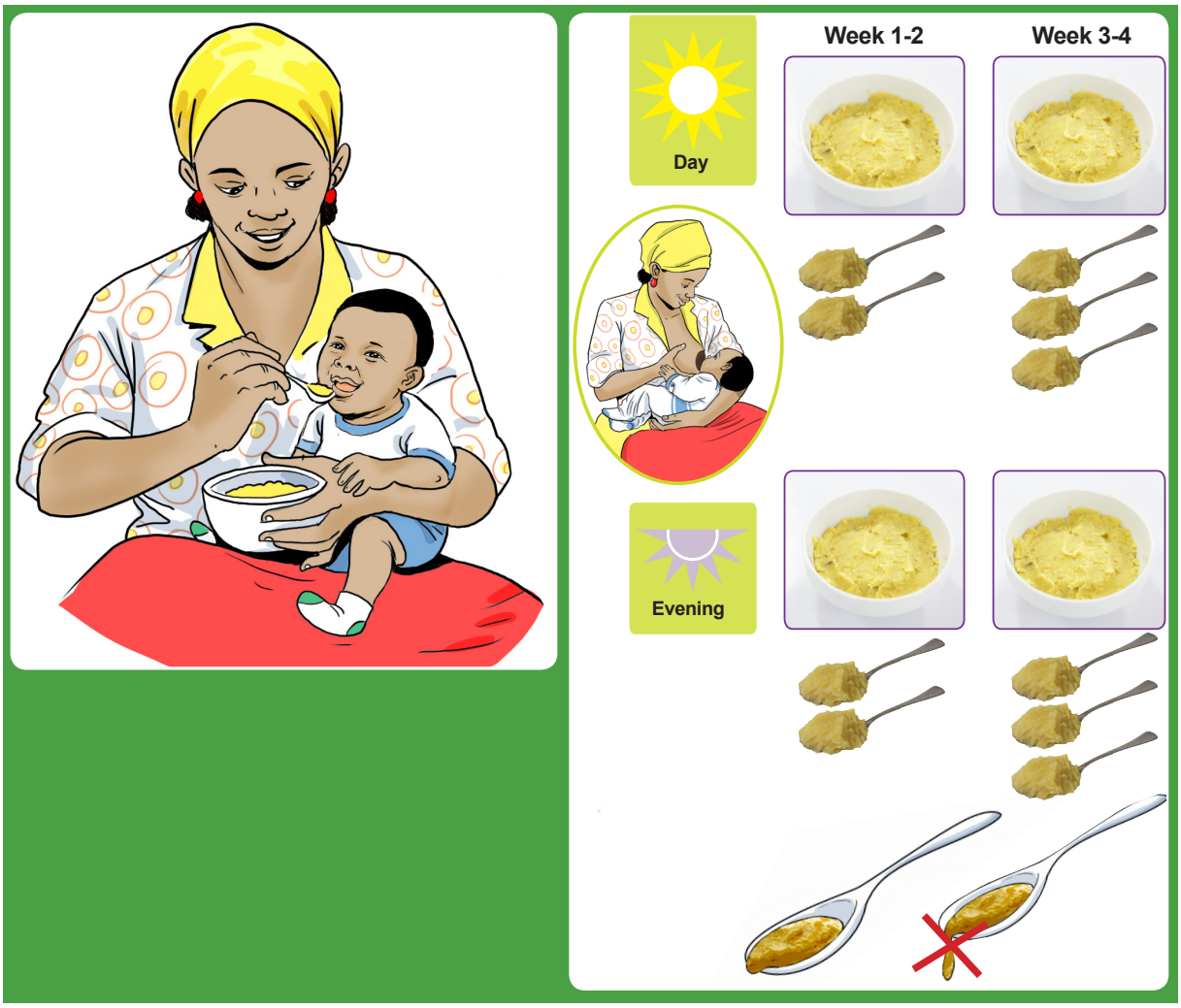
3.1. When exactly should complementary feeding start?

Complementary feeding should ONLY be introduced at 6 months (180 days) of the baby's life, as the baby continues breastfeeding.

Complementary feeds provide additional nutrients to meet the child's increasing nutritional needs for growth.

Complementary feeding helps the child to gradually become accustomed to eating family foods while breastfeeding continues to be an important source of nutrients.

Complementary feeding at 6 months

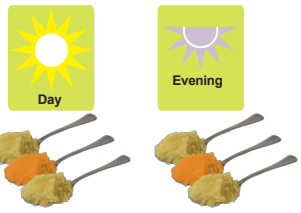


3.2. What are the appropriate complementary foods to start with at 6 months and at subsequent age groups that would be sufficient to meet growth and development needs of my child?

Complementary Foods for Children 6-23 Months Old



6 Months

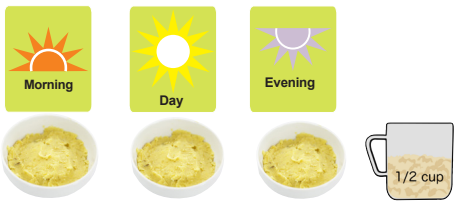


- 2 times per day
- 2-3 tablespoons at a time
- Breastfeed at least 8 times per day





7-8 Months

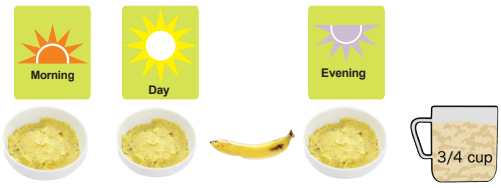


- 3 times per day
- Half bowl at a time
- Breastfeed at least 8 times per day



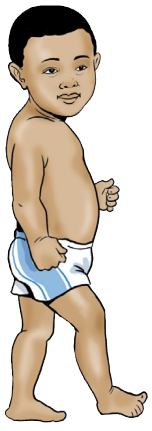


9-11 Months



- 3 times per day
- 3⁄4 bowl at a time
- A snack between meals
- Breastfeed at least 6 times per day





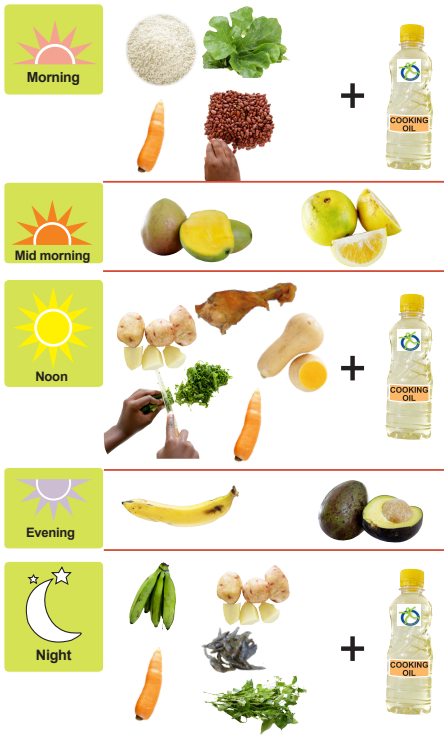
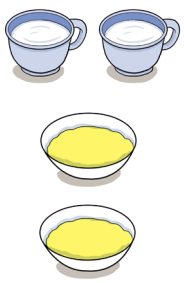
12-24 Months



- 3 times per day
- 1 bowl at a time
- 2 snacks between meals
- Breastfeed at least 3 times per day



Complementary Foods for Children 24-59 Months Old

Age	Texture	Frequency	Amount of food per meal
24-59 months 	Cut food into small, soft pieces that child can pick up, chew and swallow comfortably.    	3 meals and 2 snacks, plus breastfeeds if still breastfeeding.  	1 ½ - 2 cups of 250ml cup/ bowl. Use a separate plate/bowl. 

3.3. Is water part of complementary foods?

Water is part of the liquids recommended during complementary feeding from 6 months of age.

NOTE: *Do not give the baby water before 6 months of age.*

3.4. My child is 6 months old; I have stopped breastfeeding him exclusively and I just introduced him to complementary feeding but he refuses to eat. What can I do?

Continue to breastfeed the child as you introduce complementary feeding gradually, one food at a time and in small bits as you learn what the baby likes and what they are allergic to.

Additionally, the following can encourage active and responsive feeding during complementary feeding:

- Serve the child in his/her own bowl.
- During meal times, sit with your child, be patient, feed slowly and encourage them to eat.
- Stay with the child through the meal and be attentive.
- Respond positively to the child with smiles, eye contact and encouraging words.
- Give finger foods that the child can feed him/herself.





- Avoid force feeding as it may cause a child to learn that feeding is unpleasant
- Do not feed the child when he/she is sleepy or too tired.
- Make the baby's food appealing to the eye (color, texture).
- Try different food combinations, tastes and textures to encourage eating.
- Allow the child to swallow before offering more food.
- As much as possible, the child should eat with the family in order to create an atmosphere promoting his/her psycho-social development.

3.5. Should more food be given to a HIV+ child than the HIV- child in the household?

Yes, the energy requirements from food for a child living with HIV are slightly higher than those of a non-infected child and should be adjusted as indicated below:

- A child who has no signs or symptoms of HIV requires 10% more kilocalories to maintain growth (1 extra snack).
- If the child is symptomatic with no weight loss, the energy needs increase by about 20-30% more per day (2-3 extra snacks).
- If they are symptomatic and experiencing weight loss: 50-100% more kilocalories per day as advised by your health provider.

- Protein intake remains the same for both HIV infected and uninfected children.
- Mother/caregiver should provide food from at least five food groups in a day.

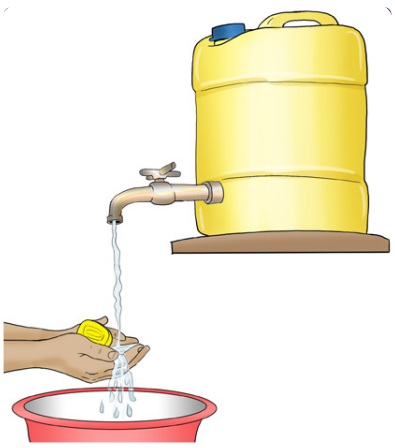
3.6. Will food alone be enough for a child whose mother is HIV + if she stops breastfeeding?

All infants, regardless of the maternal HIV status should be exclusively breastfed for the first 6 months of life and breastfeeding should be continued until the child is 2 years or beyond. At 6 months of age, introduce timely, appropriate, adequate and safe complementary foods with continued breastfeeding for 2 years or beyond.

Food alone is not enough for non-breastfed children. They require extra meals and infant formula milk as advised by the health care provider.

How to feed a child who may not be able to breastfeed while receiving complementary feeding (special cases);

- Practice good hygiene and food safety during meal preparation and feeding to prevent illnesses such as diarrhea.
- Wash your hands with clean water and soap before, during and after meal preparation, feeding and other critical times.

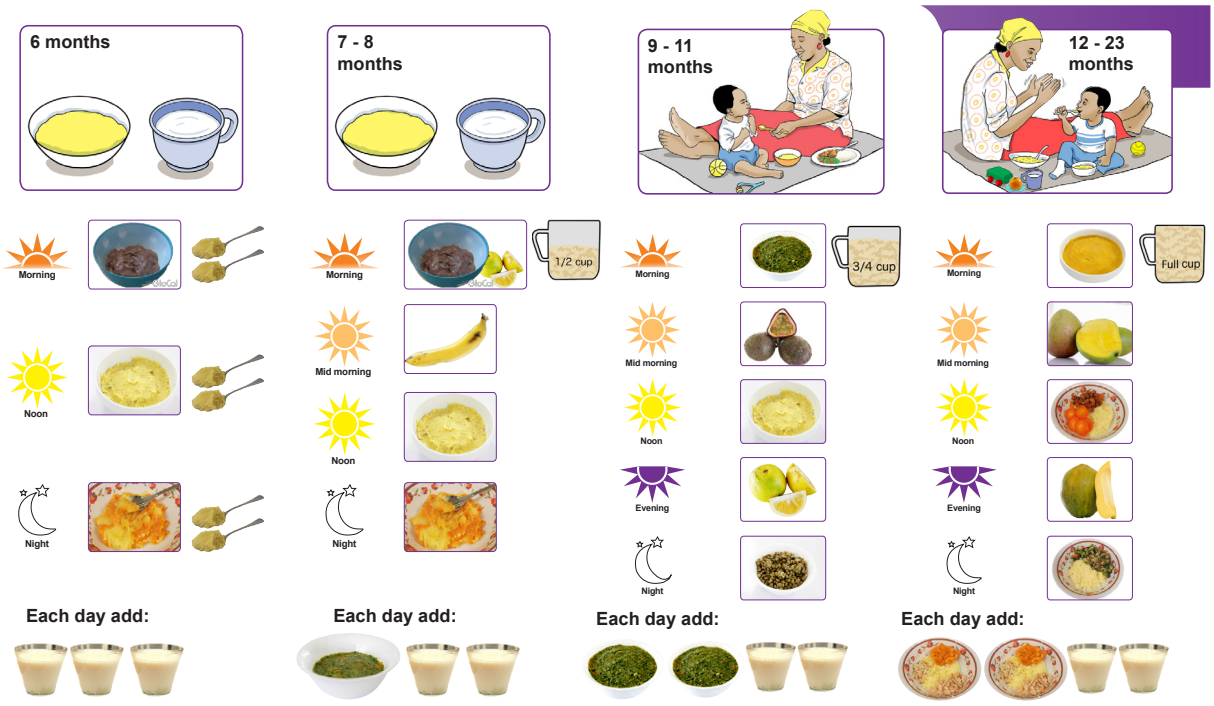


- Increase frequency of feeding as the child grows. Provide a separate feeding bowl for the baby.
- Increase the amount of food as your baby grows to meet their nutrient needs.
  a. At 6 months start with 2 tablespoons at each feed and increase to 3 tablespoons in the 3rd to 4th week.
  b. Baby needs time to get used to new food, give 3-4 cups of infant formula milk.
  c. 7-8 months feed the baby 3 times a day, add one snack depending on appetite, one extra meal and 1-2 cups of infant formula milk.
  d. 9-11 months feed the baby 3 meals, 2 snacks provide 1-2 meals and 1-2 cups of infant formula milk depending on the baby's appetite.
  e. 12-23 months, feed the baby with 3 meals, 2 snacks and an extra 1-2meals and 1-2 cups of milk.
- Food should be thick enough not to run off the spoon at 6 months of age. Modify the foods with age, similar to that of the breastfed child.
- Cook and feed from at least 5 out 8 food groups in a day.
  a. Include animal source foods (eggs, dairy, fish), grains, grain products and other starch foods, legumes, nuts and seeds, Vitamin A rich fruits and vegetables, other fruits and vegetables).
  b. Begin with the staple foods like porridge (corn, wheat, rice, millet, and sorghum), pureed banana or potato.
  c. When making porridge only mix 2 cereals not more.
- Don't force your baby to feed. Be patient, engage the child in 'playing' during feeding to make it enjoyable.

Give the child small sips of safe drinking water, as the child gets older offer 2-3 cups of safe drinking water in temperate climate and 4-6 cups in hot climate.



How to feed non-breastfed children from 6-23 months



3.7. What to do in a case where the baby stops breastfeeding on its own immediately when complementary feeding is introduced?

Encourage the mother to reinitiate breastfeeding the baby. She can also express the breast milk and feed the baby by cup. Always breastfeed the baby before giving the complementary feeds.

Continue providing the recommended age specific complementary feeds.

3.8. How to deal with a picky eater or poor feeders?

Mothers should be encouraged to adopt responsive feeding with small but frequent meals.

The mother should try different food combinations, tastes and textures.

Responsive feeding refers to where a mother or caregiver notices their child's cues or signals of hunger or fullness and responds appropriately to the cue without force.

Responsive feeding



3.9. What is the effect of stopping breastfeeding at 1yr?

Children, HIV exposed or not, who are breastfed beyond 12 months, have been shown to have less hospitalizations and deaths that arise due to common childhood illnesses.

Additionally, breastmilk continues to provide nutritional benefits (up to 1/3 of the nutritional requirements) to the baby between the ages of 1 to 2 years. Early stopping of breastfeeding therefore denies them these benefits.

3.10. When I introduce my baby to food and they develop an allergy, how will I know the exact cause of the allergy?

Introduce complementary foods gradually, one at a time. Once introduced, monitor the child for around 48-72 hours before introducing another type. This way you may be able to know the exact cause of allergy.

3.11. How can I meet the nutrition needs of my child if I do not have a reliable income?

Continue to breastfeed the child as you provide complementary foods. Introduce the child to the family meals and provide different food that are locally available, and affordable.

You are encouraged to have a reliable social support system including family and friends essential in providing support in times of financial hardship.

The health facilities can also link needy mothers to additional support services such as household food support, home-based care, social protection programs, agricultural extension services, and income generation and livelihood support.

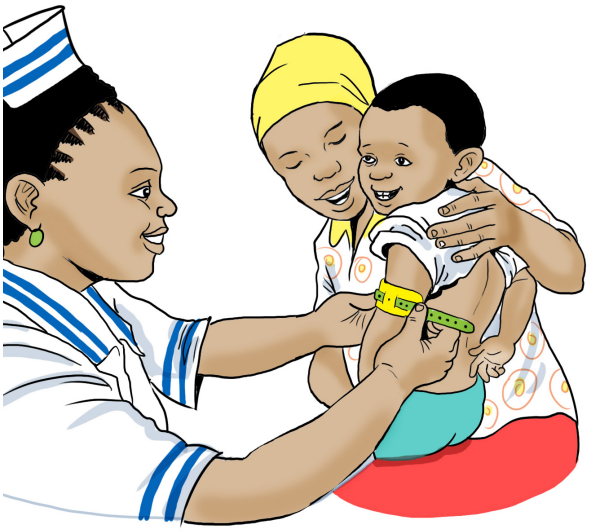
3.12. I have three children who are HIV positive. How can I take care of them in terms of infant and young child feeding practices?

First, ensure they are all on Highly Active Anti-Retroviral Therapy (HAART), and you are giving them their medications daily and as instructed by the health care provider.

Exclusively breastfeed for the first 6 months of life, introduce complementary feeds at 6 months, providing them with recommended variety of foods, amounts and frequency for optimal growth and development. Also, ensure you take your ARVs and stay healthy.

Monthly growth monitoring for children under five years is important to ensure that they are growing well.

Your healthcare provider will give you more information on optimal nutrition for your children to maintain their health and wellbeing.



4. Communicating with mothers

4.1. Will giving same information to all mothers including the positive ones not deny the HIV mothers specialized information?



No. There are advantages of giving all pregnant and breastfeeding mothers, who may be HIV Infected or not, the same information on appropriate feeding practices in the setting of HIV. This includes;

- Improved knowledge and practices on infant feeding.
- Reduced stigma and discrimination due to shared awareness.

However, clarifications and timely updates on HIV care can be provided to HIV infected mothers during their clinic visits.

4.2. Which is the most confidential and effective way of educating women about HIV?

The educator or counsellor should ensure there is adequate space to enhance confidentiality and privacy. These may include hospital triage stations, consultation rooms, pharmacy or any other clinic station where confidentiality and privacy is assured and providers are adequately trained.

These awareness sessions should also be incorporated into health talks, peer support group activities, one on one counseling sessions and group counselling sessions.

A non-judgmental attitude will contribute towards open conversations where clients will be free to share accurate information on risk.

The following measures can also help ensure effective education:

- Introductions of all participants
- Key messages on HIV should be presented using simple terms that the women will understand, using analogies(examples) as appropriate.
- Use communication aids such as Information, Education and Communication material (IEC) such as charts, booklets, posters etc when available.
- Allowing for questions from the women and providing appropriate responses during the awareness sessions.
- Allowing the mothers to explain main points discussed to confirm they have understood.
- Reviewing key messages with the women in subsequent follow-up education sessions.
- Use peer mothers with positive experiences to share their experiences through support groups and adherence clubs.

4.3. Who should provide the answers/ responses to the frequently asked questions on HIV?

Appropriate answers for the frequently asked questions can be found from different

sources. The primary sources should be qualified health workers trained on HIV care, peer educators, social workers, and community health volunteers as guided by relevant policies and guidelines. Other possible sources include: Peers living with HIV and Mentor mothers; Informed community members such as community support groups, Community Based Organizations.

4.4. Are there charts or fliers with details on IYCF in context to HIV specifically for communities?

Yes. There are charts, Maternal Infant and Young Child Nutrition counselling cards and the first 1000 days booklets at health facilities and with some community health workers with details on appropriate feeding practices in the context of HIV/AIDS. These may not be widespread across the country to reach all community health units.

5. Community Support Structures

5.1. What form of support is given to HIV positive mothers and HIV Exposed Infant (HEI)?

As part of the standard care package for People living with HIV (PLHIV), the mothers should receive nutritional services which include nutrition assessment individualized nutrition care plans, counselling and support. Besides the nutritional support, the standard package for PLHIV includes the following:

- Antiretroviral Therapy: Nutrition improves the immunity and appropriate ARV drugs reduce the viral load and prevents transmission of the virus to the infant.
- Counselling and support for disclosure of HIV status; partner/ family testing and engagement; treatment adherence and screening for Intimate Partner Violence (IPV).
- Provision of child welfare services such as immunization, early infant diagnosis, growth monitoring as outlined in the national guidelines.
- Screening for and Prevention of Specific Opportunistic Infections such as Tuberculosis (TB) and Cryptococcal Meningitis.
- Reproductive Health Services such as family planning; and screening for STIs and cervical cancer.
- Screening for and Management of Non-Communicable Diseases such as hypertension (high blood pressure), diabetes mellitus (high blood sugar), and kidney disease.
- Mental Health Screening and Management including depression and alcohol and drug use/abuse.
- Linkage to support groups, mentor mothers and to social protection such as Orphan and Vulnerable Children (OVC) support as may be necessary.



6. Challenges

6.1. What can be done to help young mothers take care of their children and also to manage depression?

People Living with HIV are 3-6 times more likely to suffer from depression than the general population, and may suffer bad outcomes if it is not identified and managed.

Depression can be a significant contributing factor to poor adherence, poor breastfeeding practices and HIV treatment failure.

Young mothers who may present with signs of depression need to be assessed by a professional at the health facility, preferably by the mental health team.

6.2. Discordant couple: If the lady is not infected, should her breastfeeding child get prophylaxis?

Sero-discordant couples are couples in which one partner is living with HIV and the other is HIV-negative. Pregnant or breastfeeding women whose sexual partners are HIV positive or who are at high risk of HIV infection may benefit from Pre-exposure Prophylaxis (PrEP) as part of combination prevention of HIV infection.

If a breastfeeding mother starts PrEP, her child does not require infant prophylaxis as well.

But if in the course of taking PrEP the breastfeeding mother is diagnosed with HIV, she should immediately start appropriate ART, giving extra attention to adherence support, Viral Load monitoring, and optimal retention in care. The child should immediately start ARV prophylaxis and receive PCR testing.

The child should continue breastfeeding.

6.3. Why do HIV exposed infants get 3 measles injections but other children get two?

HIV-exposed infants (HEI) are at higher risk of contracting Measles during infancy because mothers with HIV-infection may have weaker immunity that results in lower concentrations of measles antibodies being transferred to their fetuses. As a result, the HEIs get an early dose of the vaccine at 6 months then at 9 months and at 18 months unlike unexposed infants who get their first dose at 9 months andsecond dose' at 18 months.

6.4. Is there medication to heal HIV?

No, there is currently no confirmed cure for HIV and AIDS but there is highly effective treatment that significantly lowers the viral load to below detectable levels if one takes the ART appropriately. When the viral load is undetectable (a VL< 50 copies/ml), the virus is untransmissible therefore one cannot pass it on to others.

7. Disclosure and Stigma

7.1. Are there legislations that protect women against stigmatization?

Yes there are. The Constitution of Kenya (2010) guarantees the right to equality and freedom from discrimination (Article 27 (1-8) and Human Dignity (Article 28) to all citizens under the Bill of Rights.

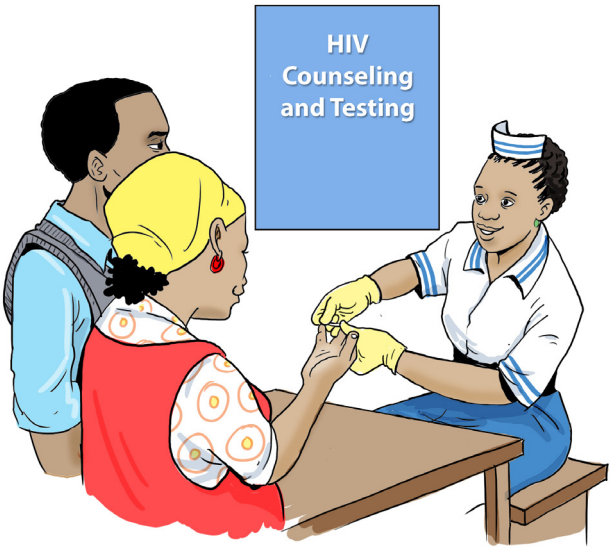
A person shall not discriminate directly or indirectly against another person on any of the grounds specified or contemplated in clause (27-4).

Every person has inherent dignity and the right to have that dignity respected and protected. (Article 28)

Additionally, the HIV and AIDS Prevention and Control Act 2006 (31-38) further protects PLHIV against any form of discrimination and stigmatization.

7.2. What can be done to stop stigma and address issues of disclosure?

Everyone has a role to play in stopping stigma and discrimination around HIV and in supporting disclosure of HIV status.



Disclosure to a trusted 'significant other' promotes linkage and adherence to treatment. Benefits of disclosure of HIV -positive status include safer sexual practices among partners, increased trust, support, understanding and kindness.

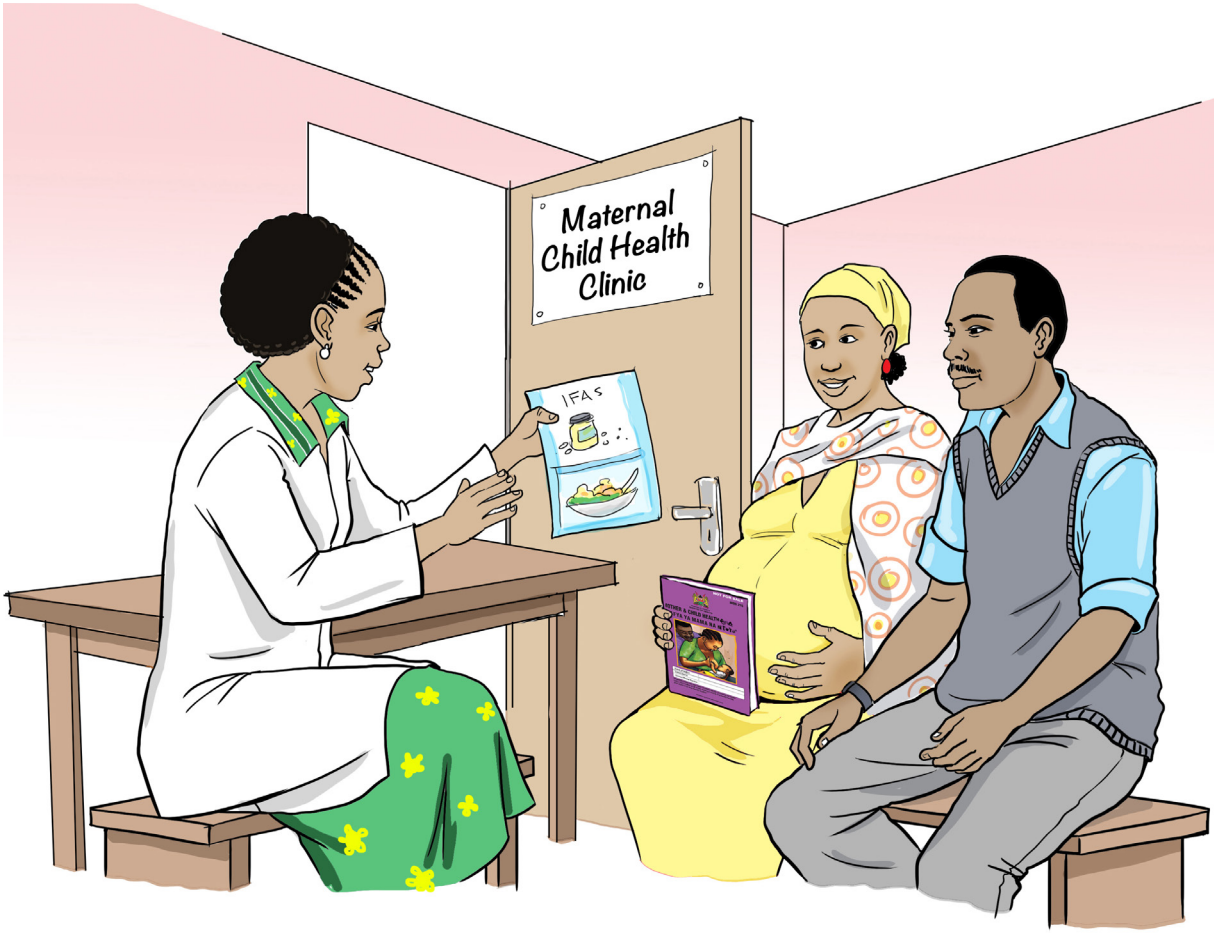
Possible ways of reducing stigma and improving disclosure include the following:

a. HIV Education and counselling.
b. Conducive Environment for HIV services.
c. Respect for client privacy and confidentiality.
d. HIV self-testing (HIVST).
e. Targeted community- based HIV Testing Services.

Tips on Disclosure

- Carefully consider whom to tell. Begin with people you can trust to respect your confidentiality.
- Think about a time and place where you can both be relaxed and feel safe as you disclose your status.
- While you can't control how others react, remember, that negative reactions are normally based on poor knowledge of HIV. Have some information on hand to share with them such as the facts about HIV and how it can be prevented.
- Maintain contact with your healthcare provider and social support system.

8. Social and Economic Influences on Feeding Practices



8.1. What can be done to increase male involvement in the care of mothers and children?

Low level of involvement of husbands/ male partners in the care of mothers and children has been shown to reduce the acceptance of efforts to prevent mother to child transmission of HIV. Most often, the mothers consider the low level of male involvement as disapproval of PMTCT measures.

No single approach will resolve this but multiple options that target the male partners as well as changes in how health services are delivered, can be considered to help improve male involvement in PMTCT. These include:

i. Create a safe environment where men can freely share their experiences or expectations and receive male friendly services.

ii. Use of male champions who are considered to be role models in the community.

iii. Use of HIV Positive Peer Counsellors.

iv. Use of trained gender matched counsellors and facilitators.

v. Community mobilization and education.

9. Monitoring and Evaluation

9.1. How does the government monitor Infant and Young Child Feeding Initiatives?

The government routinely monitors infant and young child feeding initiatives at the health facilities and at the community level through the health workers and community health volunteers by using standardized data collection tools. The data is used for decision making at all levels hence ensuring sustainability of IYCF interventions.

For this to work well, the health workers and community health volunteers have to consistently report using the available tools.

Communities of people living with and affected by HIV can also be involved in monitoring service delivery by collecting and using their data to improve their health and to hold decision-makers and service providers accountable for reaching their HIV commitments.



Mothers and care givers should regularly and promptly attend the well baby clinics to ensure timely intervention for the baby's wellbeing.

10. Breastfeeding and COVID-19

10.1. If I have confirmed or suspected COVID-19, is it safe to continue breastfeeding?

Yes, you should continue breastfeeding. Current evidence has shown that it's unlikely that COVID-19 infection can be transmitted through breast milk. The benefits of breastfeeding, skin-to-skin contact and bonding with your baby through rooming-in most likely outweigh the risks of not breastfeeding. Continued breastfeeding helps with maintaining milk flow.



Breastfeeding mothers should be encouraged to follow COVID-19 hygiene precautions, particularly washing hands before and after handling the baby, breast hygiene and wearing a medical mask when handling the baby or breastfeeding. If a mother wants to visually interact with her baby through smiling or facial expressions, she can remove her mask while at a safe distance (2M).

Do NOT put a mask on babies or children below 2 years due to the high risk of suffocation.

10.2. Is it safe to take the COVID-19 vaccine if I am breastfeeding?

Yes, it's safe to take the vaccine while breastfeeding. The COVID-19 vaccines approved by Ministry of Health and WHO don't contain the live virus thus it cannot be passed to your baby through breast milk.

10.3. If I have confirmed or suspected COVID-19, and I'm too sick to breastfeed, what can I do?

If a mother is too sick to continue breastfeeding due to COVID-19 or other complications, she can be supported to express breastmilk using hand or by pump as this will help to maintain milk flow. Healthcare providers or family members at home should follow COVID-19 hygiene protocols, wear a mask before feeding expressed milk to the baby.

- Hygiene protocol before each breastfeeding session:
  1. Wash hands with soap and water.
  2. Wash your breasts with soap and water, rinse well ONLY when one has coughed on the chest. No need to keep washing your breasts before every feed.
- Hygiene protocols when expressing Breast Milk;
  1. Hand Hygiene before every expressing exercise.
  2. Clean breast pump parts and milk storage containers.
  3. Clean feeding cup/spoon.

If a mother is too unwell to express breastmilk, your healthcare provider will guide you on the use of an appropriate breast milk substitute.

10.4. Is giving my baby infant formula safer if I have confirmed or suspected COVID-19?

No, there are always risks such as increased hospitalization due to diarrhea and pneumonia associated with use of infant formula compared to breastfeeding.

The risk is higher in-home situations where there is reduced access to clean and safe water. Infant formula is also associated with reduced sustainability due to affordability and availability.

Breastfeeding remains the best and safest option to feed your baby as it's unlikely that COVID-19 can be transmitted through breast milk.

Have a discussion with your healthcare provider for more guidance.

Appendix 1: Dosages for ARVs

Table 1: Dosing of ARVs for Infant Prophylaxis below 12 Weeks of Age

Dosing of ARVs for Infant Prophylaxis from Birth to 12 Weeks of Age		
Age/Weight	**Dosing of NVP (10mg/ml) Once Daily**	**Dosing of AZT (10mg/ml) Twice Daily**
a. Birth to Six Weeks		
Birth Weight below 2000g	2mg/kg per dose, Once Daily	4mg/kg per dose, Twice Daily
Birth Weight 2000g to 2499g	10mg (1ml), Once Daily	10mg (1ml), Twice Daily
Birth Weight above 2500g	15mg (1.5ml), Once Daily	15mg (1.5ml), Twice Daily
b. From Six Weeks to 12 Weeks of Age		
Any Weight	20mg (2ml), Once Daily	60 mg (6ml), Twice Daily

Table 2: Dosing of AZT for Infant Prophylaxis Beyond 12 Weeks of Age

Dosing of AZT for Infant Prophylaxis Beyond 12 Weeks of Age	
Weight (Kgs)	**Dosing of AZT (10mg/ml) Twice Daily**
3.0 to 5.9	6mls of Syrup
6.0 to 9.9	9mls of Syrup
10.0 to 13.9	12mls of Syrup
14.0 to 19.9	15mls of Syrup

Table 3: Dosing of NVP for Infant Prophylaxis Beyond 12 Weeks of Age

Dosing of NVP for Infant Prophylaxis Beyond 12 Weeks of Age	
Age	**Dosing of NVP (10mg/ml) Once Daily**
12 to 14 Weeks	20mg (2mls of Syrup)
15 Weeks to 6 Months	25mg (2.5mls of Syrup)
7 to 9 Months	30mg (3mls of Syrup)
10 to 12 Months	40mg (4mls of Syrup)
Over 12 Months	50mg (5mls of Syrup)

Table 4: Dosing of 3TC for Infant Prophylaxis

Dosing of 3TC for Infant Prophylaxis	
Age	**Dosing of 3TC (10mg/ml) Twice Daily**
Birth to 4 Weeks	2mg/kg per dose
Over 4 Weeks	4mg/kg per dose
Weight (Kgs)	**Dosing of 3TC (10mg/ml) Twice Daily**
3.0 to 5.9	3mls of Syrup
6.0 to 9.9	4mls of Syrup
10.0 to 13.9	6mls of Syrup
Weight (Kgs)	**Dosing of 3TC (150mg Tab) Twice Daily**
14.0 to 19.9	Half Tablet

Table 5: Dosing of Cotrimoxazole for Infant Prophylaxis Beyond 12 Weeks of Age

Dosing of Cotrimoxazole for Infant Prophylaxis Beyond 12 Weeks of Age			
Weight (Kgs)	**If using oral suspension (240mg/5ml)**	**If using Single Strength (SS) Tablet (480mg)**	**If Using Double Strength (DS) Tablet (960mg)**
1 to 4	2.5mls of Syrup	1/4 SS Tab	NA
5 to 8	5mls of Syrup	1/2 SS Tab	1/4 DS Tab
9 to 16	10mls of Syrup	1 SS Tab	1/2 DS Tab

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