

ABM Protocols

A central goal of **The Academy of Breastfeeding Medicine** is the development of clinical protocols for managing common medical problems that may impact breastfeeding success. These protocols serve only as guidelines for the care of breastfeeding mothers and infants and do not delineate an exclusive course of treatment or serve as standards of medical care. Variations in treatment may be appropriate according to the needs of an individual patient.

Protocol #5: Peripartum breastfeeding management for the healthy mother and infant at term

BACKGROUND

Hospital policies and routines greatly influence breastfeeding success.¹⁻³ The peripartum hospital experience should include adequate support, instruction, and care to ensure the successful initiation of breastfeeding. Such management is part of a continuum of care and education begun during the prenatal period that promotes breastfeeding as the optimal method of infant feeding and includes information about maternal and infant benefits. The following principles and practices are recommended for care in the peripartum hospital setting.

PRENATAL

All pregnant women must receive education about the benefits and management of breastfeeding to allow an informed decision about infant feeding.⁴⁻⁶ Prenatal education should include information about the stages of labor, drug-free ways to address labor pain, potential side effects of labor medications, and the benefits to mother and baby of exclusive breastfeeding initiated in the first hour after birth.⁴ Educational materials produced by formula manufacturers are inappropriate sources of information about infant feeding.⁷

Maternity care includes an assessment of any medical or physical conditions that could affect a mother's ability to breastfeed her infant. In some cases it may be helpful to obtain a prenatal consultation with the infant's physician or a lactation consultant or specialist and to develop a plan of follow-up to be instituted at the time of delivery.⁵ Women will benefit from moderated group discussions or referral to a lay support organization (e.g., La Leche League) prior to delivery.

LABOR AND DELIVERY

Women will benefit from the continuous presence of a close companion (e.g., doula) throughout labor and delivery. The presence of a doula is known to enhance breastfeeding initiation and duration. Many risk factors associated with early breastfeeding termination, including the mean length of labor, the need for surgical intervention, and the use of pain-reducing interventions such as epidurals and other medications, are reduced by the presence of a doula.⁸⁻¹¹

Immediate postpartum

The healthy newborn can be given directly to the mother for skin-to-skin contact until the first feeding is accomplished. The infant may be dried and assigned Apgar scores and the initial physical assessment performed as the infant is placed with the mother. Such contact provides the infant optimal physiologic stability, warmth, and opportunities for the first feeding.^{12,13} Delaying procedures such as weighing,

measuring, and administering vitamin K and eye prophylaxis (up to an hour) enhances early parent-infant interaction.

Infants are to be put to the breast as soon after birth as feasible for both mother and infant (within an hour of birth).¹⁴ This is to be initiated in either the delivery room or recovery room, and every mother is to be instructed in proper breastfeeding technique.^{4,6,15,16}

Mother-baby rooming-in on a 24-hour basis enhances opportunities for bonding and for optimal breastfeeding initiation. Whenever possible, mothers and infants are to remain together during the hospital stay.¹⁶ To avoid unnecessary separation, infant assessments in the immediate postpartum time period and thereafter are ideally performed in the mother's room. Evidence suggests that mothers get the same amount and quality of sleep whether infants room-in or are sent back to the nursery at night.^{17,18}

Education about the benefits of 24-hour rooming-in encourages parents to use it as the standard mode of hospital care for themselves and their baby. Adequate nursing personnel must be available to assess and document the status of the infant and infant feeding while the baby is in the family's room.^{4,6,19-21}

Women need help to ensure that they are able to position and attach their babies at the breast. Those delivered by cesarean section may need additional help from nursing staff to attain comfortable positioning. A trained observer should assess and document the effectiveness of breastfeeding at least once every 8 hours after delivery until mother and infant are discharged. Peripartum care of the couplet should address and document infant positioning, latch, milk transfer, baby's daily weight, clinical jaundice, and all problems raised by the mother, such as nipple pain or the perception of an inadequate breast milk supply. Infants who are breastfeeding well will feed 8 to 12 times or more in 24 hours, for a minimum of 8 feedings every 24 hours. Limiting the time at the breast is not necessary and may be harmful to the establishment of a good milk supply. Infants usually fall asleep or release the breast spontaneously when satiated.

Supplemental feeding should not be given to breastfed infants unless there is a medical indication for such feedings. Supplementation can prevent the establishment of maternal milk supply and have adverse effects on breastfeeding (e.g., delayed lactogenesis, maternal engorgement). Supplements may alter infant bowel flora, sensitize the infant to allergens (depending on the content of the feeding and method used), and interfere with maternal-infant bonding.²² Before any supplementary feedings are begun, it is important that a formal evaluation of each mother-baby dyad, including a direct observation of breastfeeding, is completed.²³

In general, acute infectious diseases, undiagnosed fever, and common postpartum infections in the mother are not a contraindication to breastfeeding, if such diseases can be readily controlled and treated. Infants should not be breastfed in the case of maternal HIV infection (in a developed country), untreated active tuberculosis, or herpes simplex when there are breast lesions.²⁴ Infectious peripartum varicella may require separation of the mother and newborn, limiting direct breastfeeding. The listing of all contraindications is beyond the scope of this document, but reliable sources of information are readily available and include information about medications and radioactive compounds.²⁴⁻²⁶

PROBLEMS AND COMPLICATIONS

Mother-baby couplets at risk for breastfeeding problems benefit from early identification and assistance. Consultation with an expert in lactation management may be helpful in situations including but not limited to the following:

- a) Maternal request/anxiety
- b) Previous negative breastfeeding experience
- c) Mother has flat/inverted nipples
- d) Mother has history of breast surgery
- e) Multiple births (twins, triplets)
- f) Infant is premature (<37 weeks gestation)
- g) Infant has congenital anomaly, neurological impairment, or other medical condition that affects the infant's ability to breastfeed
- h) Maternal or infant medical condition for which breastfeeding must be temporarily postponed or for which milk expression is required
- i) Documentation, after the first few feedings, that there is difficulty in establishing breastfeeding (e.g., poor latch-on, sleepy baby, etc.)

Early discharge from the hospital (<48 hours) of mothers and babies mandates that risks to successful breastfeeding be identified quickly so that the time spent in the hospital is used to maximal benefit.²⁷ All breastfed infants should be seen by a health care provider within 48 to 72 hours of discharge to evaluate the infant's well being and the successful establishment of breastfeeding.^{6,28}

If a neonate needs to be transferred to an intermediate or intensive care area, steps must be taken to maintain lactation in the mother. When possible, transport of the mother to the intermediate or intensive care nursery to continue breastfeeding is optimal. If breastfeeding is not possible, arrangements can be made to continue human milk feeding for the neonate. Mothers must be shown how to maintain lactation through breast pumping or manual expression when they are separated from their infants.^{4,6}

If an infant is not consistently feeding at the breast effectively at the time of hospital discharge, the mother should be shown how to maintain lactation through breast pumping or manual expression. The possible need for supplemental feedings for the infant must be addressed, with consideration given to the choice of supplement to be used and the method of feeding. Expressed breast milk should be used if maternal supply is adequate, and cup feeding may help preserve breastfeeding duration among those that require multiple supplemental feedings.²⁹ The mother-infant dyad will need referral to a professional competent in lactation management for continued assistance and support.

Copyright protected © 2003 The Academy of Breastfeeding Medicine, Inc.

Approved November 16, 2002

The Academy of Breastfeeding Medicine Protocol Committee

Caroline J. Chantry MD, FABM, Co-Chairperson

- Cynthia R. Howard MD, MPH, FABM, Co-Chairperson

- Rosha Champion McCoy MD

Supported in part by a grant from the Maternal and Child Health Bureau, Department of Health and Human Services.

- lead author(s)

REFERENCES

1. Wright A, Rice S, Wells S: Changing hospital practices to increase the duration of breastfeeding. *Pediatrics* 97:669–675, 1996.
2. World Health Organization: Evidence for the Ten Steps to Successful Breastfeeding, Revised Ed. WHO/CHD/98.9. Geneva, World Health Organization, 1998.
3. Kramer MS, Chalmers B, Hodnett ED, et al: Promotion of breastfeeding intervention trial (PROBIT): A cluster-randomized trial in the republic of Belarus. *JAMA* 285:4–15, 2001.
4. World Health Organization, United Nations Children’s Fund. Protecting, promoting and supporting breastfeeding: The special role of maternity services (A joint WHO/UNICEF statement). *Int J Gynecol Obstet* 31(suppl 1):171–183, 1990.
5. American College of Obstetricians and Gynecologists, Committees on Health Care for Underserved Women and Obstetric Practice, Queenan JT (ed): Breastfeeding: Maternal and Infant Aspects. Washington, DC, The American College of Obstetricians and Gynecologists. ACOG Educational Bulletin, 2000, 1–15.
6. The American Academy of Pediatrics, Work Group on Breastfeeding: Breastfeeding and the use of human milk. *Pediatrics* 100:1035–1039, 1997.
7. Howard CR, Howard FM, Lawrence RA, et al: The effect on breastfeeding of physicians’ office-based prenatal formula advertising. *Obstet Gynecol* 95:296–303, 2000.
8. Sosa R, Kennell J, Klaus M, Robertson S, Urrutia J: The effect of a supportive companion on perinatal problems, length of labor, and mother-infant interaction. *New Engl J Med* 303:597–600, 1980.
9. Klaus MH, Kennell JH: The doula: an essential ingredient of childbirth rediscovered. *Acta Paediatr* 86:1034–1036, 1997.
10. Zhang J, Bernasko JW, Leybovich E, Fahs M, Hatch MC: Continuous labor support from labor attendant for primiparous women: a meta-analysis. *Obstet Gynecol* 88(4:Pt 2):1–44, 1996.
11. Kennell J, Klaus M, McGrath S, Robertson S, Hinkley C: Continuous emotional support during labor in a US hospital. A randomized controlled trial [see comments]. *JAMA* 265:2197–2201, 1991.
12. Christensson K, Siles C, Moreno L, et al: Temperature, metabolic adaptation and crying in healthy full-term newborns cared for skin-to-skin or in a cot. *Acta Paediatr* 81:488–493, 1992.
13. Varendi H, Christensson K, Porter RH, Winberg J: Soothing effect of amniotic fluid smell in newborn infants. *Early Hum Dev* 51:47–55, 1998.
14. Righard L, Alade MO: Effect of delivery room routines on success of first breast-feed. *Lancet* 336(8723):1105–1107, 1990.
15. Righard L, Alade MO: Sucking technique and its effect on success of breastfeeding. *Birth* 19:185–189, 1992.
16. University of California at San Diego, Wellstart International. Model hospital breastfeeding policies for full-term normal newborn infants. In Woodward-Lopez G, Creer AE (eds): Lactation Management Curriculum: A Faculty Guide for Schools of Medicine, Nursing, and Nutrition. San Diego, CA: Wellstart International, 94 A.D.

17. Keefe MR: The impact of infant rooming-in on maternal sleep at night. *J Obstet Gynecol Neonat Nurs* 17:122–126, 1988.
18. Waldenstrom U, Swenson A: Rooming-in at night in the postpartum ward. *Midwifery* 7:82–89, 1991.
19. Perez-Escamilla R, Pollitt E, Lonnerdal B, Dewey KG: Infant feeding policies in maternity wards and their effect on breast-feeding success: An analytical overview. *Am J Public Health* 84:89–97, 1994.
20. Powers NG, Naylor AJ, Wester RA: Hospital policies: crucial to breastfeeding success. [Review]. *Semin Perinatol* 18:517–524, 1994.
21. Saadeh R, Akre J: Ten steps to successful breastfeeding: a summary of the rationale and scientific evidence. [Review]. *Birth* 23:154–160, 1996.
22. Blomquist HK, Jonsbo F, Serenius F, Persson LA: Supplementary feeding in the maternity ward shortens the duration of breast feeding. *Acta Paediatr* 83:1122–1126, 1994.
23. Protocol Committee Academy of Breastfeeding Medicine: Clinical Protocol #3: Hospital Guidelines for the Use of Supplementary Feedings in the Healthy Term Breastfed Newborn. www.bfmed.org. Academy of Breastfeeding Medicine, 2002.
24. Lawrence RA: A review of the medical benefits and contraindications to breastfeeding in the United States (Maternal and Child Health Technical Information Bulletin). Arlington, Va, National Center for Education in Maternal and Child Health, 1997.
25. Lawrence RA, Lawrence RM: Breastfeeding: A guide for the medical profession, 5th ed. St. Louis: Mosby, 1999.
26. Committee on Drugs, The American Academy of Pediatrics: The transfer of drugs and other chemicals into human milk. *Pediatrics* 108:776–789, 2001.
27. Naylor A, Wester R: Providing professional lactation management consultation. *Clin Perinatol* 14:33–38, 1987.
28. Protocol Committee Academy of Breastfeeding Medicine. Clinical Protocol #2: Guidelines for Hospital Discharge of the Breastfeeding Term Infant and Mother, “The Going Home Protocol.” www.bfmed.org. Academy of Breastfeeding Medicine, 2002.
29. Howard CR, Howard FM, Lanphear BP, et al: A randomized clinical trial of pacifier use and bottle or cupfeeding and their effect on breastfeeding. *Pediatrics* 111:511–518, 2003.