GUIDELINE

Breastfeeding protection, promotion and support

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<th>Scope (Staff):</th>
<th>Child Health</th>
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<td>Scope (Area):</td>
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This document should be read in conjunction with this DISCLAIMER

Aim

This document is a guideline for all community health professional staff who undertake who work with pregnant women and families with young children. The aim of the document is to outline how the community health professional can protect, promote and support breastfeeding.

Background

The World Health Organization (WHO) and the National Health and Medical Research Council emphasise the unequalled value of breast milk as the sole food for infants.\(^1\) WHO recommends protecting, promoting and supporting exclusive breastfeeding for around the first six months of life, and continued breastfeeding, with appropriate complementary solid foods, for two years (and beyond if mother and infant desire).\(^1\) In Australia, NHMRC recommends that infants are exclusively breastfed until around 6 months of age when solids foods are introduced, and that breastfeeding is continued until 12 months of age and beyond.\(^2\) The Australian National Breastfeeding Strategy 2010-2015 (ANBS) also recognises the biological, health, social, cultural, environmental and economic importance of breastfeeding.\(^3\)

There are many factors that influence the initiation and duration of breastfeeding, including societal factors such as the availability of paid maternity leave, cultural and family expectations, maternal age, education level and socio-economic status.\(^2\) On a personal level, initiation and duration of breastfeeding is strongly influenced by fathers’ attitudes and knowledge.\(^2,3\) The initiation, establishment and continuation of breastfeeding requires active support for the mother and her infant from family, friends, and health professionals.\(^3\)

In Australia, whilst the breastfeeding initiation rates are quite high there is a sharp decline in both full and any breastfeeding with each month post birth and at six months only 15 per cent are fully breastfed.\(^4\)

There are sub-groups in the community who are especially vulnerable to early cessation, and who require targeted breastfeeding information and support. The specific needs of Aboriginal and Torres Strait Islander families and culturally and linguistically diverse (CALD) families may require special attention.\(^2\)

Other vulnerable clients include infants who live in the areas of highest economic and social disadvantage, young non-tertiary educated mothers, infants born from a multiple pregnancy and low birth weight infants.\(^6\) Timely, skilled, effective assistance with breastfeeding difficulties is essential for the continuation of breastfeeding for all, but especially these families.
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It is has been demonstrated that approximately one third of mothers and babies experience one or more breastfeeding difficulties in the first months of life. Situations that signify a higher risk of early breastfeeding cessation are where there has been a difficult birth that has impacted on infant or maternal health, separation of mother and child, and low birth weight infants. Special attention should be paid to families in these situations.

The proportion of infants exclusively breastfed at four months of age has been identified in the Australian National Breastfeeding Strategy 2010-2015 and the Australian Headline Indicators as an important measure of Australian breastfeeding data collection. Four, rather than six months, was chosen because exclusive breastfeeding at six months is not a stable indicator as solid foods are often introduced at this time.

Exclusive breastfeeding duration rates are a key performance indicator for community child health nurses (CCHN) with an aspiration to achieve an increase in the percentage of infants being exclusively breast fed at the 3-4 month contact.

CCHNs are required to collect and document the infant feeding status for all clients on electronic data collection systems or paper based audits, including two current key indicators:

- exclusive breastfeeding at the first universal postnatal contact
- exclusive breastfeeding at the 3-4 month contact
- NB: Measurement to improve breastfeeding rates is recorded as the percentage difference between the two rates being no greater than 30%.

There is evidence to suggest that a combination of levels of support have a positive impact on breastfeeding, especially at around the time the baby is four months old.

A range of community health professionals (CHP) may be involved in working with families from the early days of a child’s life through to school entry. Contact with families occurs in a wide range of settings such as the family home, child health centres and in the community. CCHNs are a skilled workforce, with training in lactation support. They are also able to refer families to specialist services as needed. For many parents, the child health services are their primary link to health services. CCHNs are ideally placed to provide skilled lactation support to families in the early days at the universal postnatal contact through to the process of introducing complementary foods and beyond.

**General principles**

The relationship between the community health professional and the family plays an important role in promoting healthy outcomes for children. Protecting, promoting and supporting breastfeeding has been identified as a core activity for staff to work towards this goal. CHPs should provide mothers and their support networks with information and help to deal with the day to day practicalities of breastfeeding through:

- Provision of antenatal information and counselling to all expectant mothers, fathers and primary carers on:
  - the benefits and practical aspects of breastfeeding
  - expressed breast milk and mixed feeding (breast milk and infant formula)
  - the risks of not breastfeeding
  - postnatal breastfeeding support information
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- Supporting mothers in developing breastfeeding confidence
- Assisting with comfortable positioning and attachment for the infant and the mother
- Identification and management of breastfeeding deviations from normal, using evidenced based information
- Informing parents of the benefits of breastfeeding and the risks of not breastfeeding when a change from breastfeeding is being considered
- Offering support and counselling or referral where issues regarding smoking, medication, alcohol, other drugs, or infant and maternal health issues may impact on lactation and breastfeeding.

Role of community health professionals

All community health professionals who have contact with families of young children should offer a level of breastfeeding support, assessment, management and referral, appropriate to their role and level of expertise. This can be achieved through:

- offering all mothers support and encouragement to exclusively breastfeed their baby for around the first six months of life
- wherever possible, discouraging families from introducing dummies during the time that breastfeeding is being established (first 4 weeks) and giving babies anything other than breast milk or medications in the first six months
- when required, initiating referrals to appropriate services and facilitating access to follow-up for the family
- encouraging continued breastfeeding beyond six months with the appropriate introduction of complementary foods and giving families information about the benefits of continued breastfeeding to twelve months and beyond
- ensuring that all information given to families regarding feeding practices and the introduction of complementary foods is consistent with WHO/UNICEF baby friendly best practice guidelines and the NHMRC Infant Feeding Guidelines2
- linking families with recognised support agencies and promote the services of the Australian Breastfeeding Association (ABA), Ngala and other local support groups
- conforming to the WHO international Code of Marketing of Breast Milk Substitutes
- supporting parents who are not breastfeeding by providing factual information regarding the preparation, sterilisation and use of formula on an individual basis
- provision of a welcoming atmosphere for the promotion of breastfeeding for all families within health centres.

In addition to the above community health nurses should:

- provide parents with accurate and timely breastfeeding education, especially in regard to recognising infant feeding cues, recognising the infant’s reflexes, allowing self-attachment to the breast with maternal assistance, assessing efficient feeding including infant milk transfer and recognising deviations from normal
- regularly monitor progress of the establishment of breastfeeding in the early weeks and months, offer strategies and support to overcome common breastfeeding
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problems within the scope of nursing practice and using a family partnership approach

- give mothers who are returning to work information regarding the safe expression, storage and transport of breast milk and maintaining their supply.

*Lactation Consultants* (LCs) provide a targeted specialist clinical service where available. CCHNs may refer infant-mother dyads to a Lactation Consultant for advanced lactation assessment and management when they encounter complex breastfeeding challenges outside their scope of practice. LCs use evidence-based information and technical skills within a family partnership approach, in order to increase breastfeeding duration rates.

*Key considerations for each Universal child health scheduled contact*

The following key points are specific to breastfeeding families and should be read in conjunction with the guidelines for the Universal Birth to School Entry Contact Schedule in section in the Community Health Manual. Many of these points are also relevant to unscheduled contacts, or additional contacts within the Enhanced Aboriginal Child Health Schedule.

CCHNs have been identified as a primary source of information, education and support for breastfeeding mothers and their families. There are at least five scheduled universal contacts during the first eight months of a child’s life, and many parents have additional contacts with CCHNs during this time through attendance at early parenting groups and drop-in clinics or additional unscheduled contacts as required.

- **Antenatal contact**

  CHPs may encounter pregnant women and their partners in a number of situations. When CHPs provide formal or opportunistic antenatal breastfeeding education to expectant parents, information provided should include the benefits of breastfeeding and the potential health risks of formula feeding, guidelines for the use of alcohol in pregnancy and breastfeeding, and the identification of where to get help for common early breastfeeding problems.

  The antenatal period presents an opportunity to engage with fathers, who have a strong influence on their partners’ decision to initiate and continue breastfeeding. During the antenatal period, CCHNs can encourage expectant parents to discuss infant feeding with their maternity service providers.

- **The initial interaction**

  The first contact with a family is usually via a telephone call to arrange for a home (preferable) or centre visit. The nurse or health worker should enquire about infant feeding progress and document the infant feeding status and frequency of feeding, and the infant’s behaviour and output and any parental concerns. The information gained will assist staff to prioritise scheduling of appointments and offer interim strategies, contact details for support services or immediate referrals as required.

  For parents who are not exclusively breastfeeding, the child health nurse should ensure that parents are knowledgeable about correct formula preparation, sterilisation and feeding practices.

- **Birth to 10 days**
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This contact provides the opportunity to review a mother’s lactation history, infant feeding history and growth trajectory, provide anticipatory guidance, identify any current concerns and initiate strategies or referrals as appropriate.

Maternal health should be assessed, including breast comfort and nipple integrity, general health, emotional wellbeing, diet and fluid intake, and rest and sleep.

As this contact is often offered as a home visit, fathers may be present. There may be opportunity to explore the father’s beliefs around breastfeeding, to discuss ways that they can provide practical support, and to reinforce the value of their role.

Many partners express a desire to feed their baby expressed breast milk to enable their partners to have a longer sleep at night. It is important to reinforce the effect this may have on milk production, and inform parents of signs of engorgement and appropriate corrective action to take if needed.

Parent education in the early days may include information about early cues for feeding, frequency and length of feeds, signs of adequate milk transfer, expected growth patterns, normal sleeping and crying patterns in the neonate, and strategies for settling.

- 6-8 weeks

For most breastfeeding women, lactation is usually established at this contact. A primary concern of many parents at this time is the amount of time their baby spends crying. Mothers may be concerned that their breast milk supply is inadequate for their child’s needs. CHPs can inform parents about the normal peaks in crying at 6-8 weeks and 3-4 months, reinforce the signs of adequate milk transfer, and encourage parents to identify and implement their coping strategies and support networks.

Maternal physical and mental health should be assessed at this contact. Physical health issues, such as anaemia and thyroid dysfunction, may impact on breastfeeding and are relatively common in the postnatal period. Early detection and treatment of these conditions can increase breastfeeding duration.

Breastfeeding support should also be assessed. Social support and well intentioned advice from family and friends can either act as a barrier to, or provide encouragement for, breastfeeding. Mothers who are not receiving positive breastfeeding support from their social networks should be encouraged to contact the Australian Breastfeeding Association (ABA), Ngala or local breastfeeding support group.

- 3-4 months

The primary concern of mothers at this time is insufficient breast milk supply (real or perceived). Usually, at around three to four months, infant feeding patterns change. Feeds may take less time, and/or are may be less frequent. Growth begins to slow as well. There is often another peak in crying. Infants become very interested in their environments and often pull off and reattach to the breast several times during a feed. This is normal behaviour for infants of this age.

Mothers may incorrectly interpret these changes as a sign that their breast milk supply is inadequate to meet their baby’s needs, and consider introducing infant formula or complimentary feeds and/or ceasing breastfeeding.

The CHP should conduct a holistic assessment of feeding efficiency and non-feeding issues that may present as breastfeeding deviations. Assessment should incorporate relevant history and clinical observation.
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For all breastfeeding families, this contact should include information about normal changes in feeding, sleeping and settling, and the principles of supply and demand for maintenance of breast milk supply. Mothers should be reminded about being alert for any signs of engorgement or breast lumps around the times of changing feeding patterns.

The timing of introducing complementary foods should also be discussed at this visit, and information given.

Information should also be provided for mothers who are planning to return to work. Parents may wish to explore their options for continuing to breastfeed while working. Information about the expressing, storing and safe transport of expressed breast milk should be given to the family. The Australian Breastfeeding Association (ABA), Ngala or a local breastfeeding support group may offer additional support at this time.

- 8 months

The introduction of complementary foods and gradual transition to the family diet is the key nutritional issue at this visit. Parents may require specific information about the timing and spacing of breast feeds and complementary foods. CHPs can refer to the Infant Feeding Guidelines for this information.²

As for the three to four month visit, mothers who are returning to work may require support, encouragement and information to continue breastfeeding their child or expressing breast milk. The eight month contact is an ideal opportunity to provide information to parents about the benefits of breastfeeding to twelve months and beyond.

Documentation

The breastfeeding status of all clients should be recorded in the birth register and in the electronic or paper based child health record at the first contact, and the 3-4 month contact.

All relevant breastfeeding assessment findings are to be recorded on the CHS012 Breastfeeding assessment guide, and retained within the child health record.

Summary information should also be entered into relevant electronic record systems according to local protocols. CHPs should refer to the appropriate record keeping guidelines for documentation storage and use.

For those CHPs using HCARe clinical services data collection, routine breastfeeding assessment is recorded as a component of each scheduled universal contact from birth to 8 months using the health issue code for that contact.

For non-universal contacts or assessments where deviations from normal are identified, dedicated codes are used. These are outlined on the CACH website, under HCARe coding guidelines.

Should a referral be required, a copy of the CHS012 should accompany referral forms, to provide more relevant information.

Lactation Consultants (LC) should use the relevant sections of the CHS013 for detailed breastfeeding assessment and management. The LC should return the completed CHS013 form to the referring CHN when the client is discharged from the Lactation Service, and this should be retained within the paper based child health record. A copy must also be retained by the LC in accordance with record keeping guidelines.
Follow-up

Where breastfeeding issues have been identified, and additional monitoring is required, parameters should be determined in relation to the needs of the mother and child, and for the duration required. The CHP, together with the parent, should develop a plan outlining any follow up and referral needs ensuring service provision is coordinated and comprehensive.

Where referral to specialist services is indicated, families should be directed to appropriate public or private services as available. CCHNs should maintain links with the referral services to ensure the needs of the client are being met. When specialist services are unavailable or inappropriate, the client may be offered continuing community health contact as appropriate and where resources are available.

Where there are no significant concerns, the universal contact schedule should be continued.

CCHNs should refer to other guidelines within the Breastfeeding section of the Community health policies, procedures and guidelines manual for guidance in determination of monitoring needs and referral pathways.

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<td>Breastfeeding community health policy</td>
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<td>Breastfeeding deviations from normal - clinical referral pathway</td>
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<td>Breastfeeding assessment guide (CHS012)</td>
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<td>Lactation consultant assessment form (CHS013)</td>
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<td>Guidelines for Universal meeting schedule</td>
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<td>Growth Guideline</td>
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<td><a href="https://www.kemh.health.wa.gov.au">KEMH breastfeeding self-directed learning</a> for health professionals</td>
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<td>Breastfeeding core knowledge and skills</td>
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<td>Child and Antenatal Nutrition Manual</td>
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Useful resources

KEMH Breastfeeding Centre

Australian Breastfeeding Association

A series of videos on Raising Children Network

Ngala

Healthy WA website

- CALD specific breastfeeding resources Queensland Health
- UNICEF UK
- The Royal Women’s Hospital Victoria Multilingual Fact Sheets (scroll to very bottom of page to select language)
- Le Leche League International
- MedlinePlus

Aboriginal specific resources

- CACH Aboriginal Resource Matrix
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- Australian Indigenous HealthInfoNet

CACH Early Parenting Groups
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This document can be made available in alternative formats on request for a person with a disability.

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