Infant Feeding - Breastfeeding

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1. Introduction

Women's Health promotes exclusive breastfeeding as the norm, the optimum nutrition for babies as it provides nutritional, immunological, psychosocial, and financial benefits for the mother, her baby and family/ whānau.

To ensure that Women's Health staff and health care providers, and other relevant sectors protect, promote and support exclusive breastfeeding for six months and continued breastfeeding up to two years of age and beyond, while providing women access to the support they require – in the family/ whānau, community and workplace – to achieve this goal.

Women's Health recognizes the positive influence breastfeeding has on the health status and social wellbeing of the baby, mother, family/ whānau and community. We acknowledge that only 12% of NZ babies are exclusively breastfed during their first 6 months of life and that Māori and Pacific peoples, low-income families and young mothers have lower breastfeeding rates than other groups. As a maternity service, Women's Health is committed to making a difference and increasing exclusive breastfeeding rates.

Women's Health recognises and supports the Ten Steps to Successful Breastfeeding as the global standard for all maternity services to facilitate exclusive breastfeeding of the well baby in accordance to World Health Organisation (1989) Protecting, Promoting and Supporting Breastfeeding: The Special Role of Maternity Services. A Joint WHO/UNICEF Statement, Geneva, and the Global Strategy for Infant and Young Child Feeding (2003) WHO/UNICEF and the National Strategic Plan of Action for Breastfeeding 2008-2012.

Women's Health adheres to the WHO International Code on the Marketing of Breastmilk Substitutes (1981) and subsequent and ongoing resolutions of the World Health Assembly. This **Infant Feeding - Breastfeeding** policy complies with the global criteria to achieve the Baby Friendly Hospital Initiate award.

Scope

This policy applies to all Women's Health, Auckland District Health Board (ADHB) health professionals and employees, who provide care for mothers, during the antenatal, intrapartum and postnatal period, and/or their babies within Women's Health – both in hospital and in the community.

The policy also applies to contracted staff, holders of access agreements, midwifery and nursing students, voluntary and unpaid workers, and the medical faculty. There is an expectation that those who access our service are familiar with our policies and guidelines and follow them accordingly.

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2. New Zealand MOH breastfeeding definitions

Women's Health staff will use the following definitions to collect data for breastfeeding statistics, and enter the appropriate definition for each individual mother and baby on the ADHB maternity database. Data will be collected (at a minimum) on discharge from the maternity facility and on discharge from ADHB LMC postnatal care in the community.

Exclusive breastfeeding

The infant has never, to the mother's knowledge, had any water, infant formula or other liquid or solid food. Only breastmilk, from the breast or expressed, and prescribed* medicines have been given from birth.

*Prescribed as per the Medicines Act 1981.

Fully breastfeeding

The infant has taken breastmilk only, no other liquids or solids except a minimal amount of water or prescribed medicines, in the past 48hours.

Partial breastfeeding

The infant has taken some breastmilk and some infant formula or other solid food in the past 48 hours.

Artificial feeding

The infant has had no breastmilk but has had alternative liquid such as infant formula with or without solid food in past 48hours.

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3. WHO/UNICEF International Code of Marketing of Breastfeeding Substitutes

WHO Code

WHO/UNICEF International Code of Marketing of Breastmilk Substitutes (WHO Code) & Subsequent WHA Resolutions

Article 2: Summary of the scope of the WHO Code

The code applies to the marketing, and promotion of the following products: breastmilk substitutes, including infant formula: when marketed to be suitable for use as a partial or total replacement of breastmilk; feeding bottles and teats.

It also applies to their quality and availability, and to information concerning their use.

Key points from the WHO Code which apply to products within the scope of the Code

- Products should not be advertised or otherwise promoted to the public
- Mothers and pregnant women and their families should not be given free samples of products
- Health care providers should not be given free or subsidised supplies of products and must not promote products
- People responsible for marketing products should not try to contact mothers or pregnant women or their families
- Labels on products should not use words or pictures, including pictures of infants, to idealise the use of the products
- Health workers should not be given gifts
- Health workers should not be given samples of products except for professional evaluation or research at the institution level
- Materials for health workers should contain only scientific and factual information and must not imply or create a belief bottle-feeding is equivalent or superior to breastfeeding
- Materials for mothers should be non-promotional and should carry clear and full information and warnings
- All information and educational materials for pregnant women and mothers, including labels, should explain the benefits and superiority of breastfeeding, the social and financial implications of its use, and the health hazards of the unnecessary or improper use of formula
- All products should be of high quality and take into account of the climate and storage conditions of the country where they are used

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4. Ten steps to successful breastfeeding:

Every facility providing maternity services and care for newborn infants should follow the 10 steps below

i. Have a written breastfeeding policy that is routinely communicated to all health care staff.
ii. Train all health care staff in skills necessary to implement this policy.
iii. Inform all pregnant women about the benefits and management of breastfeeding.
iv. Help mothers initiate breastfeeding within a half-hour of birth.
v. Show mothers how to breastfeed, and how to maintain lactation even if they should be separated from their infants.
vi. Give newborn infants no food or drink other than breastmilk, unless **medically** indicated.
vii. Practice rooming-in – allow mothers and infants to remain together – 24 hours a day.
viii. Encourage breastfeeding on demand.
ix. Give no artificial teats or pacifiers (also called dummies or soothers) to breastfeeding infants.
x. Foster the establishment of breastfeeding support groups and refer mothers to them on discharge from the hospital or clinic.

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i. Policy responsibility

All Women's Health staff members are made aware of this **Infant Feeding - Breastfeeding** policy and have a role in implementing and working within it.

Consultation

The policy is written and has been developed in consultation with:

- Consumers
- Staff
- Lead maternity carers (LMC)
- Kaumatua and
- Auckland district Maori and Pacific community, and other ethnic representatives
- Well Child Providers/ Tamariki Ora
- La Leche League
- Plunket
- Birthcare
- Many other community groups.

The policy will be reviewed with further consultation at least every 3 years.

Access

Access agreement holders, bureau and casual staff are to be informed of, and will undertake to work within the policy as a condition of access/employment.

Display

All staff and other personnel working in clinical areas are to have access to a copy of the policy, and be familiar with its contents.

All consumers using Women's Health Maternity and Newborn Services will be made aware, and have access to the policy.

The Ten Steps to Successful Breastfeeding and a summary of this **Infant Feeding - Breastfeeding** policy will be displayed in all departments in Women's Health which care for pregnant women, mothers, and babies, in staff workrooms, and in the common languages of the area.

Treaty of Waitangi principles

All staff members to be aware of the principles of the bicultural partnership, participation and protection, which form the basis of Maori policies upheld by the ADHB. ADHB acknowledges and supports the needs of Māori, Pacific and other ethnic communities; working together to promote exclusive breastfeeding that is tailored to our population.

Māori traditions

Te Uru (participation), Te Tiaki (protection) and Te Mahi Ngatahi (partnership) are acknowledged and reflected throughout our policy and practice. Women's Health recognizes that Māori have the right to enjoy a health status that is at least the same as that enjoyed by non-Māori.
Breastfeeding benefits tinana (physical health), wairua (spiritual), hinengaro (mental and emotional health), and whānau (health of the family).
For Maori, breastfeeding is a traditional and valued practice and embodies the importance of nourishment, protection, sustenance and continuity for Maori Health. Breastfeeding is viewed as an imperative in maintaining and sustaining child development and wellbeing. Whanau ora – recognising the importance of the interdependence of people, that health and wellbeing are influenced and affected by the collective as well as the individual, and the importance of working with people in their social contexts.

Pacific people traditions

For Pacific peoples, breastfeeding is a normal, traditional and valued practice. In Pacific societies and among families, Pacific women are used to seeing women breastfeeding as a natural way of life, and breastfeed their infants whenever they need to be fed. Pacific women are motivated to breastfeed because it is seen as

best for baby (and recommended by health practitioners) as natural, as building a stronger mother to child bond, and as a link to cultural heritage.
Breastfeeding is also felt to be more convenient and less expensive than the alternatives.

Breastfeeding is identified in *Healthy Eating Healthy Action: Oranga Kai – Oranga Pumau Implementation Plan:* 204-210 (HEHA) MOH 2004b). An outcome specified is that breastfeeding is promoted to New Zealand women and their families, particularly Māori and Pacific women.

Personal respect

All staff will be aware the cultural, personal and/or physical factors affecting breastfeeding need to be respected and staff are to support and assist mothers in making informed choices in breastfeeding management. Staff will be trained to seek permission and will minimize "hands on" assistance, and work with mothers to gain confidence in their ability to breastfeed their babies.

Responsibility to support breastfeeding

Health professionals have a responsibility to give current, accurate, consistent and non-judgmental breastfeeding information, and supportive encouragement to enhance successful breastfeeding.

Responsibility to be informed

Health professionals have a responsibility to be well informed about infant formula for all mothers who decide to artificially feed or for whom supplementation is clinically indicated.

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ii. Staff training

All Women's Health staff including Midwifery, Nursing, Medical and Allied Health and support staff who take care of or have contact with mothers and babies will be trained in the implementation of this **Infant Feeding - Breastfeeding** policy.

New staff will be orientated to this **Infant Feeding - Breastfeeding** policy on arrival, and will be scheduled for further breastfeeding education within six months

Orientation to this **Infant Feeding - Breastfeeding** policy will include:

- Location and review of this **Infant Feeding - Breastfeeding** policy
- The Ten Steps to Successful Breastfeeding
- The protection of breastfeeding including the International Code of Marketing of Breastmilk Substitutes and subsequent relevant WHA resolutions

The Charge Midwife / Nurse / Clinical Director will be responsible for scheduling the required training for new staff within six months.

Women's Health will maintain documentation of staff participating in Breastfeeding education.

A copy of the curricula or course outlines is available for review.

The hours of education completed will be retained on a data base for the appropriate number of years for each staff category.

Women's Health will provide evidence of breastfeeding education and certificates will be issued to those who complete the required education sessions.

The initial and ongoing hours of breastfeeding education are documented for the following staffing disciplines.

Midwifery & nursing staff

Midwifery and Nursing staff who work directly with pregnant, birthing and postnatal mothers and babies are expected to have completed 21 hours:

- 18 hours breastfeeding education plus
- 3 hours of supervised clinical tuition

Training may include training undertaken in the health professional's undergraduate programme, or their own time, and needs to be within the last 5 years.

Ongoing minimum annual update of 4 hours:

- 3 hours of breastfeeding/infant feeding education plus
- 1 hour of clinical assessment

- Reflective practice

Over 5 years the ongoing education programme equates to 20 hours tuition. There will be a focus on Māori women and breastfeeding, an inclusive awareness of all women's cultural and social circumstances and an understanding of how the principles of the Treaty of Waitangi impact on Māori and their health outcomes in this case breastfeeding.

The 18 hours of breastfeeding education provided by Women's Health will include review of the:

- **Infant Feeding - Breastfeeding** policy
- Ten Steps to Successful Breastfeeding
- International WHO Code

Plus

- Breastfeeding for Maori women, which reflects the Treaty of Waitangi
- The effect of medications administered during labour and birth on the newborn and the initiation of breastfeeding

The 3 hours of clinical tuition will include:

- All practical aspects of positioning, aligning and latching of baby for breastfeeding
- The teaching of hand expressing breastmilk
- Cup feeding technique

Medical staff

Medical staff (Obstetricians, Paediatricians, Consultants, Registrars and Senior House Officers) must complete a minimum of:

- 4 hours breastfeeding education
- Have completed at least 4 hours Breastfeeding education over the past 2 years

Ongoing breastfeeding education

A minimum of 2 hours annually

The 4 hours breastfeeding education will include the:

- **Infant Feeding - Breastfeeding** policy
- Ten Steps to Successful Breastfeeding
- International WHO Code

Plus

The effect of medications administered during labour and birth on the newborn and the initiation of breastfeeding

Anaesthetists

Anaesthetists, who have contact with women during pregnancy, labour and birth, must complete a minimum of 4 hours breast feeding education, every two years.

The education will include the following:

- **Infant Feeding - Breastfeeding** policy
- Ten Steps to Successful Breastfeeding
- International WHO Code

Plus

- The potential effects of medications administered during labour and birth on the newborn
- Initiation of breastfeeding
- Rationale for skin-to-skin contact at birth

Lactation specialist support

Requires evidence the facility has arranged or supported appropriate ongoing annual education for this/these staff member/s.

Following ongoing annual education for the Lactation Specialist/s, staff education programmes will be updated and based on current research and best practice.

Allied Health & support staff

All Allied Health, ancillary and support staff, employed by the facility, which are in regular contact with pregnant women, mothers and their babies, e.g. Physiotherapists, Dietitians, Health Care Assistants, general operating room staff, Ward Clerks, Reception staff, cleaning staff and nutrition services staff require evidence of completion of a minimum of:

- 3 hours breastfeeding education
- Over the past 3 years

Ongoing breastfeeding training

1 hour minimum annually

Breastfeeding education will include the:

- **Infant Feeding - Breastfeeding** policy
- Ten Steps to Successful Breastfeeding
- International WHO Code

Plus

- Responsibilities of Allied Health staff contained in the policy
- Health care assistants, nutrition services, and cleaning staff will receive education on the importance of up to date, consistent information and advice to women

Women's Health will provide evidence of breastfeeding education and certificates will be issued to those who complete the required sessions.

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iii. Antenatal education & information

Pregnant women accessing Women's Health maternity services will receive education and/or information on the importance of exclusively breastfeeding their baby for the first six months, the management of breastfeeding and the risks of artificial feeding.

Staff and mothers will be aware of information on continuing breastfeeding for up to two years and beyond.

Enabling informed decisions

Health professionals will provide breastfeeding education to enable and promote informed decision-making by pregnant women.

Antenatal education will meet the standard set out by the New Zealand Breastfeeding Authority in the BFHI Global Criteria, and reflect the NWH RPB for Breastfeeding Antenatal Education.

Documentation

Individual education on breastfeeding should be documented in the antenatal Care Plan and postnatal Care Plan and clinical record.

Referral to antenatal classes & breastfeeding support groups

Information on antenatal classes and breastfeeding:

- Birthcare
- Parents Centre
- Pacific Groups
- La Leche League for mother-to-mother breastfeeding help and information. Regular meetings and coffee mornings. Telephone and email counselling by trained counsellors.
- Well Child Providers/ Tamariki Ora
- Lactation Consultants – in a private capacity will charge a fee

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iv. Initiate breastfeeding

Skin-to-skin contact

Place babies in skin-to-skin contact with their mothers immediately following birth for at least an hour (60 minutes) and encourage mothers to recognize when their well babies are ready to breastfeed, offering help if needed. (1)

A well baby is defined as a healthy term baby from 37 weeks gestation:

Immediately after delivery and before initiating skin to skin contact baby must have an initial assessment for normal respirations, skin colour and tone.

Once skin to skin contact has been commenced baby must be frequently observed and monitored for the duration of the skin to skin contact but especially during the first hour of life, for normal respirations, skin colour and muscle tone. This is to ensure baby has successfully adapted to ex-utero life. If the woman is in a high risk group i.e high BMI, unwell or heavily sedated then skin to skin may not be appropriate at that time. If skin to skin does occur in the high risk woman constant supervision should occur while baby is skin to skin. This supervision can be by a family member but there also needs to be supervision by a midwife

It is the midwives responsibility to teach and show the mother how to protect her baby's airway whilst the baby is positioned for skin to skin contact. This education should then be documented in the woman's clinical notes

During initial skin to skin contact the mother should not be left alone, assistance must be readily available to her if there are any concerns in relation to the baby.

- Staff will facilitate and maintain undisturbed skin-to-skin contact between mother and baby following an uncomplicated vaginal birth, except for brief bed-transfer interruption or if there were medically justifiable reasons for delayed contact.
- Their baby will be placed in skin-to-skin contact with them within 5 minutes after birth and staff will encourage continuous skin-to-skin contact for at least 1 hour or until after the first breastfeed, prior to interventions such as wrapping and weighing the baby.
- The mother will be supported to look for signs for when their baby is ready to breastfeed during this contact and offered help with breastfeeding, if needed.
- Following an operative birth in the operating room, skin to skin will briefly be interrupted while the mother is being transferred from the operating room bed to the ward bed. Baby will recommence skin to skin when the mother has safely transferred to PACU.
- In the case of mothers undergoing an operative birth under regional anaesthesia there will be discussion and consent obtained from the anaesthetist, surgeon, midwife and mother prior to skin to skin contact taking place. Neonates will be dried prior to skin to skin occurring to prevent unnecessary cooling of the infant and to prevent exposure of body fluids to staff. The anaesthetist is responsible for the safety of the mother while she is

in the operating room. The midwife or designated nurse will be responsible for the neonate during skin to skin contact.

- In the case of mothers undergoing operative birth with general anaesthesia as soon as the mothers are able to respond, their babies should be placed skin-to-skin for at least 1 hour uninterrupted and undisturbed.
- The time and length of skin-to-skin contact is documented in the mother's and baby's chart.

Skin-to-skin contact has ongoing benefits:

- Improving babies temperature control
- Improved infant metabolic stability
- Enhanced maternal-infant relationship
- Maternal oxytocin release by stimulation of areola and breast
- Prolactin released in response to nipple stimulation
- Receptors sites for prolactin within the breasts increase

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v. Breastfeeding support

Trained staff will support mothers to breastfeed and maintain lactation even if they are having difficulties or are separated from their baby.

Teaching & support

Following initiation of early breastfeeding the health professionals practice should reflect an ongoing teaching and supportive role. NWH maternity staff will work alongside a lactation consultant, where specialist assistance is required, in order to improve clinical skills.

Support & guidance

All mothers irrespective of previous breastfeeding experience will be offered support and guidance with breastfeeding.

Verbal guidance will be provided by postnatal staff to assist mothers to independently breastfeed their baby's following consultation with each woman and the birth care plan documented by her LMC.

Guidance will include supporting mothers to:

- Recognise and respond appropriately to early infant feeding cues:
  - Sucking movements or sounds, hand to mouth, searching
  - Head or eye movements, cooing or sighing sounds, fussiness
- Recognise crying is a late feeding cue
- Skin-to-skin contact will assist baby to demonstrate feeding cues
- Staff will report they teach mothers how to position, align and attach their babies and are able to describe or demonstrate correct techniques

- Mothers will recognise signs of a good latch and effective breastfeeding with signs of milk transfer
- Achieve comfortable feeds and nipples that are pain free
- Detach and reattach baby if nipple discomfort occurs
- Confirm knowledge of appropriate breastfeeding management
- Receive guidance on techniques to comfort an unsettled baby or rouse a sleepy infant, and safe sleeping position
- Confirm that baby is effectively breastfed - some babies may be feeding up to 12 times or more in 24hours in response to feeding cues

Assessment & assistance

Mother's who have had an operative delivery or mothers and babies affected by a medicated labour, and mothers of multiples may require further assistance.

Staff will make assessments and provide help when difficulties are experienced, involving the mother, her partner and supporters as appropriate.

The staff member documents clear concise and consistent notes in the clinical record. If a feeding plan is written this should be followed and updated at every feed or shift, until the mother is confident and achieving independence with latching and breastfeeding.

Review previous feed plan and outcome with the mother to guide practice which should reflect the contents of this policy and reduce the likelihood of conflicting advice being given.

Hands-off help

Effective breastfeeding help can often be given in a hands–off manner using diagrams, dolls or videos before considering hands-on help.

Hands-on help

Hands-on-help by staff may occasionally be necessary with the consent of the mother, to ensure a satisfactory feed. However the process to achieve this result must be a positive learning experience for the mother and baby. Document consent in her clinical record.

Breastfeeding difficulties

If breastfeeding difficulties are identified, including the use of nipple shields, refer to the **Infant Feeding – Infant Formula** policy, consult with LMC, CCM or ward/unit co-ordinator, and document a management plan in the clinical record.

Lactation consultant

Refer to the Lactation Consultant to access additional skills and to seek a teaching resource for staff and mothers.

Drug safety

Refer to the ADHB Intranet Pharmacy/Drugs In Breastfeeding.

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vi. Give only breastmilk

Exclusive breastfeeding is the norm.

Newborn babies will be exclusively breastfeeding or exclusively fed their mother's breastmilk from birth to discharge unless there are documented medical reasons or evidence of mother's informed decision for supplementary feeding.

Informed consent will always be obtained prior to breastfed babies being given breast milk substitutes.

Mothers will be supported to establish and maintain a breastmilk supply. Mother's own breastmilk will always be the preferred milk of choice for babies requiring supplementation.

Acceptable medical reasons for supplementation

Health professionals should be aware of the 'Acceptable Medical Reasons for Supplementation' using infant formula only when adequate colostrum or expressed breastmilk is unavailable.
A small number of medical indications in a maternity service may require individual newborns to be given fluids or food in addition to, or in place of breast milk.

Expressed breastmilk infant feeding indications

Infants who cannot be fed at the breast but for whom expressed breast milk is available may include infants who:

- Are very lethargic
- Have sucking difficulties or oral abnormalities, or functional or structural abnormalities
- Are separated from their mothers who are providing expressed breast milk

These infants may be fed expressed milk by naso/oral gastric tube, cup or spoon, and require an individualized feeding plan. Efforts should be made to sustain maternal milk production by encouraging expressing.

It is recognized that in some cultures, family members may offer to donate their breast milk. This is acknowledged and recognized to be a preferred option to supplementing with breast milk substitute.

Supplementary feeding indications

Infants who may need other nutrition in addition to breast milk / or for whom breast milk is not available, may include those with:

- Prematurity, very low birth weight, (less than 32 weeks gestation or less than 1500gms)

- Hypoglycaemia (bloods sugar less than 2.6 mml) where sufficient breast milk is not immediately available
- Clinically dehydrated babies – recognised by lethargy, skin turgor and tone and inadequate stooling (appropriate to age) and urine
- Weight loss – most neonates lose 5-10% of their birth weight (Riordan and Auerbach 2005). >10% loss of birth weight requires assessment of the individual baby and breastfeeding management plan which may include supplementation
- Phenylketonuria where some breastfeeding is possible, partly replaced by phenylalanine-free formula
- Severe hyperbilirubinaemia
- Maternal absence, where expressed breast milk cannot be regularly available

Severely ill babies, or babies requiring surgery, prematurity, or small for gestational dates with potentially severe hypoglycaemia, are likely to be in NICU and will receive individual feeding plans.

Infants for whom breast milk or stock infant formula is contraindicated

Infants who should not receive breast milk, or other milk, including the stock ready-to-feed infant formula may include rare metabolic conditions such as galactosemia, or maple syrup urine disease, which require a special formula.

Maternal conditions that may affect exclusive breastfeeding

- Serious maternal illness which precludes or temporarily precludes breastfeeding e.g. Psychosis, eclampsia or shock (WHO 1992)
- Primary glandular insufficiency

Previous breast reduction (Nicholson 1991) poor let-down reflex (Berlin et al., 1984) thyroid-deficient (Neville & Berga 1983) form a small group for whom supplementation may be appropriate while providing information and assistance to increase milk production (Riordan and Auerbach 2005)

Maternal breastfeeding contraindications

Maternal conditions where breastfeeding is not recommended are very few:

- New Zealand mothers with HIV should receive advice and counseling (ref. HIV- AIDS Information for Health Professionals – MOH 1999
- Cytotoxic chemotherapy usually requires that a mother stops breastfeeding permanently because alternatives are seldom available

Situations where mother should avoid breastfeeding temporarily:

- Radioactive iodine – 131 - a mother can resume breastfeeding about two months after receiving radioactive iodine 131
- A few maternal medications may cause side effects such as drowsiness and respiratory depression e.g. sedating psychotherapeutic drugs, some anti-

epileptic drugs and opioids and their combination - may review dose with reference texts, pharmacy and refer to paediatrician or neonatologist, or physician

- Substance abuse – Consumption of illicit drugs (such as cocaine, amphetamine & cannabis), alcohol carry risk to the infant and following consumption mothers are advised to express and discard, and use previously expressed or alternative milk source.
- Repeated substance abuse warrants individual assessment of both risk of breastfeeding and the capacity of the mother to care for the child.
- Mothers who smoke should continue to breastfeed (be encouraged to quit or reduce smoking) but are advised to reduce exposure of the infant to second hand smoke by not smoking in the house or the car.
- Lyme disease from a bite of a tick occurs in Europe and North America and treated by antibiotics – mother may wish to withhold breast milk until maternal treatment started or completed (Lawrence & Lawrence 2005)

Informed consent

For any breastfeeding baby to be given nutrients other than breastmilk there must be an acceptable medical reason, information discussed on potential risks of infant formula, and informed consent obtained from the mother/parents, the indications and the signed consent documented in the baby's clinical record.

Parental choice

Parents who request infant formula or supplementary feed should be made aware of the health implications and the potential risks associated with its use, and the impact this may have on initiating and establishing breastfeeding, so they are enabled to make an informed decision. The information is printed on the consent form.

Documentation of parental request

Their decision to use infant formula will be recorded on the consent form and documented in the baby's clinical record.

For the mother who decides to artificially feed

Where a mother makes a decision to use an infant formula to feed her baby she will be encouraged to provide the infant formula and feeding equipment for her baby, in order that she may be shown recommended practices for its safe preparation and use.

Refer to Breastmilk Substitutes policy for information on the safe preparation, storage, and use of infant formula.

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vii. Rooming-in

Staff will support mothers and well babies to be together 24 hours a day and encourage extensive skin-to-skin contact throughout the hospital stay and beyond.

Cue feeding

Rooming-in facilitates unrestricted access for breastfeeding and skin-to-skin contact which will assist the baby to demonstrate feeding cues and for the mother to learn to understand and respond to these cues.

Commences in delivery unit or operating room

Rooming-in should start in the labour and birthing suite or operating room recovery – that is, there should be no unnecessary separation of mother and baby unless medically indicated. All baby examinations and routine tests should be conducted where possible in the mother's room.

Document separation requests

Where a mother elects to be separated from her baby, and there is no medical reason for this, she should be given sufficient information to ensure an informed decision, and document mother had requested separation in the mother's and her baby's clinical records. Her baby should be returned to her for feeds.

If separation is required for clinical indications e.g. Ultrasound, X-ray, these should be justified and documented in the clinical records within informed consent obtained from the mother.

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viii. Baby-led breastfeeding

Staff will help mothers recognise their baby's feeding cues and encourage baby-led breastfeeding (cue, or demand feeding).

Discussion with each breastfeeding mother should convey the benefits of unrestricted feeding (provided that the baby is feeding effectively) in recognition of the individual nature of the baby's suckling response and the individual rate of milk transferring.

Unrestricted

Practice unrestricted breastfeeding; feed on the first breast until satisfied, before offering the second. No limit on the length or frequency of breastfeeds, as long as baby is feeding effectively.

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ix. No pacifiers or teats for well breastfeeding babies

Pacifiers, artificial teats or bottles will not be given to well breast- feeding babies. Staff will be trained in the use of alternative settling methods that are conveyed to mothers when this is appropriate.

The use of a dummy to substitute suckling on the breast will lead to decreased breast stimulation, contributing to a delay in establishing lactation, difficulties with baby's attachment to the breast, and may impact on the long term breastfeeding outcome.

- No **routine** use of bottles, teats, and pacifiers dummies or in well breastfed babies who are not in the Neonatal Intensive Care Unit, or well babies who have started to breastfeed and are for transfer to the post natal ward.
- Any breastfeeding mother wishing to use bottles, teats, or pacifier will be made aware of the risks to establishing breastfeeding and the reasons for avoiding their use to enable an informed decision. Her decision to use a bottle, teat or pacifier is documented.

Nipple shields

See the **Infant Feeding – Infant Formula** policy.

Methods of supplementary feeds

Practice should reflect the principles of the Breastmilk Substitute policy for the feeding of infant formula

All mothers or caregivers using a supplementary method of feeding including the use of a feeding cup, Supplemental Nursing System, disposable syringe, naso gastric tube used with a 10 ml. Syringe as a supplementary feeding device, or spoon, or soft cup feeder are to be informed of:

- The correct principles of usage
- (Where applicable) the manufacturer's instructions for use and sterilisation
- (Where applicable) the reason for recommending that particular method or piece of equipment.

Documentation

Clinical staff members are responsible for documenting information about the method of supplementary feeding that has been provided.

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x. Support groups

Before they are discharged all mothers will be given information and resources about breastfeeding as well as how to contact community breastfeeding support groups.

All mothers and babies on discharge from hospital must have a designated Midwife/Lead Maternity Caregiver. (LMC)

Women must be provided with information about how to contact Health Care Professionals in the community:

- her Midwife/ LMC
- Well Child Providers/ Tamariki Ora

The LMC responsible for postnatal care will provide (or arrange) on-going breastfeeding support in the community.

Where applicable, mothers of babies discharged from the NWH neonatal unit will receive follow up visits from the Home Care service, and/or be referred to a Well Child Provider / Tamariki Ora if the LMC is no longer involved.

Discharge planning

Discharge planning for the breastfeeding mother and baby will aim to plan for a full range of accessible services for all mothers to meet the needs of all cultural groups. This will also incorporate the Breastfeeding Information booklet providing relevant information on breastfeeding practices, or additional information to meet the needs of each mother and her baby/babies and information about community resources to support continued breastfeeding success:

- Pregnancy and parenting courses run by Birthcare foster the establishment of support groups for all women who attend the antenatal classes
- La Leche League – provide breastfeeding support meetings, coffee mornings and contact numbers to be able to have mother-to-mother consultation with trained peer counsellors
- Birthcare Lactation Clinic – Parnell
- Private lactation consultants – there will be a fee for this service

Well Child Health Services

Well Child Health Services including:

- Te Puna Hauora o te Raki Paewhanau; Te Whanau o Waipareira
- Wai Health; Ngati Whatua o Orakei Health Clinic; Turuki Health; Tamariki Ora
- Pacific Star Health Trust; Tongan Health Society Inc.
- Plunket (including Plunket Family Centres and Plunket Line)

- ADHB Early Child Team
- ADHB Community Lactation Consultation Clinic – Mt.Roskill

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5. Implementing the WHO/UNICEF Code

Implementing the WHO/UNICEF International Code of Marketing of Breastmilk Substitutes and subsequent WHA resolutions (WHO code)

Display materials

Applies to the display, and presentation of material within Women's Health:

- No advertising or promotion of breast milk substitutes or infant formulas
- No contact between marketers of infant formula and mothers within Women's Health
- No free samples to be given to mothers or pregnant women
- No free or low cost samples of formula and infant feeding products such as bottles and teats will be accepted by Women's Health
- No display of products, placards, posters or distribution of material provided by a manufacturer, distributor or marketer of breastmilk substitutes, formula or any complementary foods, products, feeding bottles or teats, for use as partial or total replacement of breastmilk

Audit

Applies to the audit of material provided to mothers:

- Information, educational material, magazines and gift packs for mothers will be audited annually to ensure no advertising of infant formula or products and compliance with the intent of the WHO Code
- Auditing and documentation will be the responsibility of the Lactation Consultants/delegated staff familiar with the WHO Code

Antenatal education

Applies to education provided to antenatal women

- No group education on the use of infant formula is to be given to pregnant women
- No written materials on the use of infant formula are to be given unless the woman has decided not to breastfeed, or there are medical indications for the use of a breast milk substitute

Contact with staff

Applies to contact with ADHB staff and company marketing personnel:

- Staff will not accept any free gifts including pens, dairies, calendars, posters and pamphlets from infant formula company representatives or people responsible for

marketing products from the manufacturers and distributors of infant formulas or bottles and teats
- Educational material from company representatives for health professionals restricted to scientific and factual information

All contacts from company representatives for marketers of infant formula or associated products should be referred to staff that are familiar with the WHO Code, such as Lactation Consultant, Midwifery Leader, Dietician or Paediatrician.

Educational material

Educational material on the use of infant formula will provide consistent information on the following points:

- The benefits and superiority of breastfeeding
- Maternal nutrition, and the preparation for and maintenance of breastfeeding.
- The negative effect on breastfeeding and infant health of introducing partial bottle feeding
- The difficulty of reversing the decision not to breastfeed
- The ongoing financial implications

Where needed the proper use of infant formula, whether manufactured industrially or home prepared should be accessible and include the following information:

- The social and financial implications of their use
- The health hazards of inappropriate foods or feeding methods

The health hazards of unnecessary or improper use of infant formula and other breastmilk substitutes (from NZ Code)

Purchase of infant formula

Infant formula are to be purchased in the same manner used to purchase other commodities for Women's Health and no low-cost or free options are to be pursued. This also applies to the purchase of supplementary items such as bottles, teats, and nipple shields as documented in the WHO Code.

Rotation of infant formula

The New Zealand Breastfeeding Authority expects there to be rotation of breastmilk substitute products, if suitable alternatives are available, to demonstrate to staff and those using the product there is no product preference. Rotation of ready-made infant formula products at Women's Health has been implemented.

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6. Antenatal education content

Enabling informed decisions

As a minimum the antenatal educator will provide information on the following benefits of breastfeeding:

- Optimum nutrition
- Bonding and attachment - babies close for warmth, food, security
- Protection, including the role of colostrum
- The benefits of exclusive breastfeeding for the first six months
- Health advantages to the mother.

Other relevant information

- The facility breastfeeding policy
- The importance of early, and ongoing skin-to-skin contact
- Early initiation of breastfeeding – stimulates seeking response
- Rooming-in on a 24 hour basis, including safe sleeping
- Cue-based or baby-led feeding (or feeding on demand)
- Good positioning and attachment of baby at the breast
- Help to ensure enough breastmilk by frequent feeding
- The implications of using pacifier, teats and bottles on the establishment of breastfeeding
- The risks associated with offering supplements while breastfeeding in the first six months
- Discuss the Breastfeeding Information booklet
- Breastfeeding support services in the community
- The effect of drugs, used in labour, on both the newborn and the initiation of breastfeeding
- Returning to paid employment

Information provided to pregnant women should be ethically and culturally appropriate and relevant to specific needs. Free of advertising and comply with the WHO Code.

Health professional will have information and awareness of Pacific Peoples practices on how to share information with, and the learning styles and best-practice for Pacific People

Breastfeeding & working

- Ministry of Health see pamphlet Breastfeeding & Working
- Department of Labour
- Human Rights Commission
- Women's' Health Action
- La Leche League

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7. The first breastfeed

Staff will ensure that:

- Breastfeeding management includes initiating skin-to-skin contact. The baby and mother should not be forced to breastfeed, but rather supported to do so when ready
- All first breastfeeds are assessed and documented on the rooming-in chart

Staff will note that:

- A full term healthy baby who attaches well with evidence of colostrum/breast milk transfer within 1-2 hours following birth may sleep for 6 hours following the 1st feed, after which time the baby should be appropriately stimulated to breastfeed, and continue to breastfeed up to 12 times in 24 hours. Babies may cluster or group feeds together several times within a few hours, and longer breaks between feeds over other periods in 24 hours.
- If breastfeeding is not achieved within 2 hours of birth despite initiating skin-to-skin contact and the opportunity to suckle, assistance is to be given to the mother to start hand expressing and her colostrum given to baby via syringe, cup or spoon. (see Stimulating Breastmilk Production below)
- It may be appropriate to facilitate the support of the woman by whanau, family or significant others to assist with personal matters and breastfeeding

It is important to continue providing breastfeeding education, supervision and support while breastfeeding is being established.

Stimulating breastmilk production

If early establishment of effective suckling behaviour is not achieved then breast stimulation has not occurred. To stimulate appropriate oxytocin and prolactin response to assist milk production (Lactogenisis II) initiate milk expression by hand or pump. Tactile breast stimulation and expressing colostrum provides nutrients for baby while evaluating the breastfeeding technique and any risk factors that may delay milk production or milk transfer, or attachment by baby.

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8. Expressing

Where babies are separated from their mothers for medical indications (e.g. on admission to NICU) or baby is not demonstrating a satisfactory breastfeeding response, staff will provide mothers with the opportunity to initiate and commence breastmilk expression.

It is acknowledged that there are some cultural practices that do not agree with the 10 steps of breastfeeding e.g. discarding colostrum. Whilst every effort will be made to encourage the 10 steps to be fulfilled, respect will always be given to traditional cultural practices.

Staff will ensure that the mother knows:

- How to express her own milk by hand
- Hand expressing can commence within two hours, or 6hours from when they are able to respond, after the birth
- Colostrum is best expressed by hand rather than by using a breast pump until drops are easily obtained
- Emphasise the importance of early, frequent expressing, 8 or more times, at regular intervals, every 24 hours, to stimulate milk production, and establish and maintain their supply

Express sufficient milk for comfort when their breasts are overfull and the baby is disinterested in breastfeeding.

Expressing information

All mothers whose baby is unable to breastfeed for any reason will be provided with assistance and written information on:

- Breast massage and hand expressing, and the safe handling and storage of breastmilk, discuss and show the section in the *Breastfeeding Information* booklet
- Appropriate use of electric breast pump equipment
- How to maintain lactation by frequent and ongoing expressing
- Advise mothers where they can get additional help if required

Unwell mothers

Mothers who are unwell or require admission to HDU should be given the opportunity for assistance to express as their condition allows.

Documentation

Clinical staff members are responsible for documenting information about expressing that has been provided and to record expressing outcomes.

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9. Infant Feeding - Breastfeeding policy SUMMARY

Display of policy and summary

The Ten Steps to Successful Breastfeeding and this summary of the **Infant Feeding - Breastfeeding** policy will be displayed in all departments in Women's Health which care for pregnant women, mothers and babies, in staff workrooms, and in the common language of the area.

Policy responsibility

All Women's Health staff /access agreement holders, bureau and casual staff are made aware of the **Infant Feeding - Breastfeeding** policy and have a role in implementing and working within the policy as a condition of access/employment.

Staff training

Staff will be trained in the skills necessary to implement this policy. A course curricula and a data base of completed breastfeeding education is maintained for each staff category.

Education & information

Pregnant women accessing Women's Health maternity services will receive education and/or information on the importance of exclusively breastfeeding their baby for the first six months and ongoing breastfeeding up to 2+ years, the management of breastfeeding and the risks of artificial feeding.
Staff will be aware of information on continuing breastfeeding for up to two years and beyond, the importance of early skin-to-skin practices and the rooming-in policy.

Initiation of breastfeeding

Well babies will be placed in skin-to-skin contact with their mothers immediately following birth for at least 60 minutes and mothers will be encouraged to recognise when their babies are ready to breastfeed, staff will offer help if needed.

Breastfeeding support

Trained staff will support mothers to breastfeed and maintain lactation even if they are having difficulties or are separated from their baby.

Give only breast milk

Well newborn babies will be exclusively breastfeeding or exclusively fed on their mother's breastmilk from birth to discharge unless there are documented medical reasons or evidence of mother's informed decision for supplementary feeding. Informed consent will always be obtained if baby requires food or drink other than breastmilk. Mothers will be supported to establish and maintain a breastmilk supply

and her own breastmilk will always be the preferred milk of choice if her baby requires supplementation.

Rooming-in

Staff will support mothers and well babies to be together 24 hours a day and encourage extensive skin-to-skin contact throughout the hospital stay **and beyond.**

Baby-led feeding

Staff will help mothers recognise their baby's feeding cues and encourage baby-led breastfeeding (cue feeding).
Discussion with each breastfeeding mother should convey the benefits of unrestricted feeding (provided that the baby is feeding effectively) in recognition of the individual nature of the baby's suckling response and the individual rate of milk transferring.

No dummies or pacifiers

Pacifiers, dummies, artificial teats, bottles will not be given to well breastfeeding babies. Staff will be trained in the use of alternative methods when this is appropriate.

Support groups

Before they are discharged all mothers will be made aware of their Breastfeeding Information booklet and resources about breastfeeding as well as how to contact community breastfeeding support groups.

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10. Breastfeeding after contrast media - iodinated

Generally iodine from iodinated contrast media (either oral or injectable types) is distributed in very small quantities into the breastmilk. Based on kinetic studies, it is unlikely that these agents will reach therapeutic levels in breastmilk, and no adverse effects in infants have been observed following maternal use of iodinated radio contrast agents.

Both the American Academy of Paediatrics (AAP) and the American College of Radiology (ACR) consider that the use of iodinated contrast media is compatible with breastfeeding.

Omnipaque™ (iohexol injection)

Continue breastfeeding uninterrupted.
Manufacturers recommend breastfeeding may continue without interruption.

Visipaque™ (iodixanol injection)

Continue breastfeeding uninterrupted.
Manufacturers recommend breastfeeding may continue without interruption.

Gastrografin™ (meglumine amidotrizoate and sodium amidotrizoate)

Continue breastfeeding uninterrupted.
The manufacturer advises that due to low enteral absorption no adverse effects are expected in breastfeed infants whose mothers receive usual doses of Gastrografin.

Ioscan™ (diatrizoic acid)

Continue breastfeeding uninterrupted.

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11. Breastfeeding after gadolinium - containing radio-contrast agents

These agents are used in MRIs. Although free gadolinium is nephrotoxic, it is considered safe when bound to the parent molecule in the contrast medium.

The AAP considers that the use of gadopentetic acid is usually compatible with breastfeeding; the ACR concludes that it is safe to continue breastfeeding after administering a gadolinium-containing contrast medium.

Magnevist™ (gadopentetic acid)

Continue breastfeeding uninterrupted.
The manufacturer considers harm to the infant unlikely. Only a tiny fraction of administered dose is excreted into breastmilk, and poor oral bioavailability further limits infant exposure. This is considered compatible with breastfeeding by the AAP and the ACR.

MultiHance™ (gadobenic acid)

Continue breastfeeding uninterrupted.
Studies are lacking, however contrast is unlikely to accumulate to therapeutic levels in the infant.
The manufacturer recommends cautious approach of suspension of breastfeeding from prior to the agent being administered, until 24 hours later. The need for this has been refuted and the ACR concludes that it is safe to continue breastfeeding after administering a gadolinium-containing contrast medium.

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12. Breastfeeding after technetium - containing scans

Technetium is a radionuclide used in scintillation scans. As use of technetium-containing compounds has been reported to result in radioactivity being present in the breastmilk for 15 to 72 hours, temporary cessation of breastfeeding is necessary.

The half-life of technetium is 6 hours. The dose used in scintillation scanning is significantly less than that used in other types of scan, and it has been reported that acceptable residual levels of technetium in breastmilk can be reached by pumping and discarding the breastmilk for 12-hours post-technetium at scintillation scanning doses. The International Atomic Energy Agency recommends cessation of breastfeeding for a period of 12 hours following the administration of technetium-99m MAA.

The period of withholding breastfeeding should be discussed with the woman as far in advance as possible, to allow her time to express and store milk for the period following the scan if she so desires.

Technetium-99m tin colloid (ventilation)

Pump and discard milk for 12 hours following scan.

Technetium-99m MAA (macro-Aggregated Albumin) (perfusion)

Pump and discard milk for 12 hours following scan.

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13. Supporting evidence

- Clinical Guidelines for the Establishment of Exclusive Breastfeeding June 2005 International Lactation Consultant Association
- Aotearoa New Zealand BFHI New Zealand Breastfeeding Authority (2008)
- National Breastfeeding Committee
- National Breastfeeding Promotion Campaign
- National Strategic Plan of Action for Breastfeeding 2008-2012
- Hale TW. Medications and Mothers' Milk. 14th edition. Amarillo (TX): Hale Publishing; 2010
- American Academy of Paediatrics. The transfer of drugs and other chemicals into human milk. Paediatrics 2001; 108: 776–89.
- Sweetman SC, editor. Martindale: The Complete Drug Reference. 36th edition. London: Pharmaceutical Press; 2009.
- Omnipaque (iohexol injection) [data sheet online]. GE Healthcare. [updated 23 April 2008]. http://www.medsafe.govt.nz/
- Visipaque (iodixanol injection) [data sheet online]. GE Healthcare. [updated 5 May 2010]. http://www.medsafe.govt.nz/
- Gastrografin (gastroenteral solution – sodium amidotrizoate 100mg/mL and meglumine amidotrizoate 660mg/mL) [data sheet online]. Bayer. [updated 01 December 2007]. http://www.medsafe.govt.nz/
- Magnevist (gadopentetic acid injection) [data sheet online]. Bayer. [updated 04 September 2007]. http://www.medsafe.govt.nz/
- Multihance (gadobenic acid injection) [data sheet online]. Regional Health Ltd. [updated 14 November 2007]. http://www.medsafe.govt.nz/
- Schaefer C, Peters P, Miller RK. Drugs During Pregnancy and Lactation. Treatment options and risk assessment. 2nd edition. London: Elsevier; 2007
- International Atomic Energy Agency. Applying Radiation Safety Standards in Nuclear Medicine. Vienna (Austria): International Atomic Energy Agency; 2005

WHO/UNICEF

- International Code of Marketing of Breastmilk Substitutes, 1981 (WHO Code) and Relevant World Health Assembly (WHA) Resolutions 2005
- Innocenti Declaration on the Protection, Promotion and Support of Breastfeeding 1990
- Ten Steps to Successful Breastfeeding, 1991 (the interpretation of Step Four was clarified by WHO/UNICEF in the BFHI Revised, Updated and Expanded for Integrated Care documents Jan. 2006 and adopted by New Zealand)
- Baby Friendly Hospital Initiative (BFHI) (1992)
- Promoting Breastfeeding In Health Facilities, WHO/Wellstart Intl. 1996
- Global Strategy for Infant and Young Child Feeding 2003

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14. Associated ADHB documents

- Infant Feeding – Infant Formula
- Breastfeeding & breastmilk expression in the workplace (breastfeeding staff only)
- Bicultural policy
- Informed Consent
- Tikanga - RBP

Newborn Services Clinical Guidelines

- Cleft Lip and Palate
- Feeding
- Feeding Newborn Babies on Postnatal Wards
- Infants of Diabetic Mothers' on Postnatal Wards
- Infants Born to HIV Positive Mothers

Women's Health pamphlet

- Breastfeeding information booklet

15. Ministry of Health pamphlets

- Breastfeeding your Baby (in Te Reo Maori, English, Chinese, Tongan and Samoan)
- Breastfeeding and Working (in English, Tongan and Samoan)
- Eating for Healthy Breastfeeding Women

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16. Corrections and amendments

The next scheduled review of this document is as per the document classification table (page 1). However, if the reader notices any errors or believes that the document should be reviewed ***before*** the scheduled date, they should contact the owner or the Clinical Policy Advisor without delay.

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