9:00-10:10 Assessing the Breastfeeding Dyad

I. Goals, objectives and outline
   A. Goal: Identify when babies are not sucking effectively.
   B. Objectives: At the end of this educational activity, the learner will be able to:
      1. Describe the appearances of the baby sucking at the breast that is indicative of an effective feeding.
      2. Describe visible signs of potential sucking problems.
   C. Outline:
      1. Effective sucking
      2. Ineffective sucking

II. Visible signs of sucking
   A. Effective sucking
      1. Watch for the eyes to be wide-open at the start of the feeding when the baby is a week old
      2. Look for a wide-open mouth, flanged lips, asymmetric latch, chin in close, the nose free (If nose is touching, be sure baby can breathe.)
      3. Count 10+ sucks in a row at the start of the feeding (Do not tell mom)
      4. Pauses should be shorter than 10 seconds, at the start of the feeding
      5. Baby should start sucking again on her own and continue this pattern for many minutes
      6. Cheeks should remain rounded, no dimpling
      7. No clicking sounds
      8. After the milk ejection reflex (MER) sucks should be one per second and audible swallows should occur before discharge
      9. Sucking should feel like tugging or pulling, not pinching or biting (feel like a pump)
     10. Mother should not feel pain after the first 30 seconds
     11. Baby is able to drink an appropriate amount of milk (pre and post feeding weights)
     12. Baby is calm or asleep at the end of the feeding (not always a good indication)
   B. Ineffective sucking
      1. Narrow angle at the corner of the baby’s mouth
      2. Sucks less than 10 times in a row before pausing at the start of the feeding
      3. Pauses greater than 10 seconds at the start of the feeding
      4. Dimples the cheeks, pulling in of the cheeks
      5. Over use of the lips to keep the seal, pulling of the breast
      6. Pain throughout the feeding/nipple misshapen
      7. Weak suck, falls off breast, no suction
         Try latching on again. Check palate and tongue. Try chin support or DANCER hand position to decrease intra-oral space and support the lower jaw, named by Sarah Dannen, CNM and Edward Cerutti, MD. Feed with cup/spoon/syringe until baby is stronger. At discharge switch to bottle, if the baby can suck some.
      8. Makes clicking sounds, breaks suction frequently.
      9. Wide jaw excursions
     10. Milk leaks out of the corner of baby’s mouth
      11. Cannot hear swallowing
      12. After one week, eyes closed at the start of the feeding
      13. Not enough milk is transferred during the feeding (pre and post feeding weights)
14. Baby fussy and unsettled at the end of the feeding while being held (not always a good indicator that the baby is not getting enough)
   a. Some babies are fussy after a feeding because they need to burp
   b. Or they drank too much and may spit up
   c. Parents cannot distinguish satiation from exhaustion

   **If weight issue, might try supplemeneter at the breast.**

15. Motion at the mouth, no movement of the ears or masseter and temporalis muscles (Allow to suck on parent’s finger with tip of finger at juncture of hard and soft palates.)
16. Sucking tongue on roof of mouth (Suck on parent’s thumb or provide chin support.)
17. Tongue not over the lower gum
   a. Charm hold
   b. Breastfeed in a prone position for the baby
   c. Imitate sticking tongue out and opening mouth wide
   d. Lip tapping
   e. Cup feed or place milk on baby’s chin to bring tongue forward
   f. Sucking on mom’s finger, so can feel when tongue comes forward

18. Incorrect tongue motion
   a. Reverse suck
   b. In and out sawing motion
   c. Up-down motion with center of tongue
   d. Rubbing along the breast with the tip of the tongue

   **Suck training**
Bibliography


Supplementing the Breastfeeding Infant

1. Inborn errors of metabolism, such as
   a. Maple syrup urine disease
   b. Galactosemia
   c. Tyrosinemia
   d. Phenylketonuria (PKU) in some cases plus breastmilk and careful monitoring

2. Infants for whom breast milk remains the best feeding option, but who may need other food in addition to breast milk for a limited period
   a. Very low birth weight—less than 1,500 grams
   b. Very preterm—less than 32 weeks of gestational age
   c. Hypoglycemia if baby does not respond to skin-to-skin, breastfeeding, and breast milk feeding
   d. Dehydration
   e. Weight loss greater than 10%
      If the baby has lost 15% or more, the baby’s electrolytes need to be checked immediately.

3. Non-latching baby or baby who is not breastfeeding effectively (e.g. Cleft palate, tongue-tie, maternal large, flat, or inverted nipples)

4. Maternal condition that may justify temporary avoidance of breastfeeding
   a. Severe illness that prevents the mother from caring for her infant, for example, sepsis
   b. Herpes simplex virus lesions on the mother’s breast until lesions have healed.
      Baby can breastfeed on the other breast, if there are no lesions.
      Women with herpes simplex virus type I or II may continue to breastfeed as usual, unless there are herpes lesions on the nipple or areola. Herpes is spread through contact, so the sores should be covered. If there are lesions on the nipple or areola, the mother should not breastfeed on that breast. She can pump or hand express milk from that breast until the sores clear.
      Pumping will keep up her milk supply and prevent the breasts from getting engorged or overly full. If the parts of the breast pump that contact the milk also touch the sores while pumping, the milk should be discarded (Lawrence, 7th ed. 2011, pp. 436, 599).

5. Maternal treatment with contraindicated medicine
   a. Chemotherapy, until medication is out of her system
   b. Radiation therapy
   c. Sedating psychotherapeutic drugs
   d. Drugs of abuse
   e. Alcohol abuse

5. Separation of mother and baby
   a. A mother with active, untreated tuberculosis (TB) should not be in the presence of her baby. At the hospital, they will be isolated from each other. Once she has been effectively treated, which usually takes about two weeks, the two of them can be together. During the time of isolation, the mother can express her milk and someone else can feed the infant the expressed milk. The mother can
express her milk because the tuberculosis infection is acquired through respiratory transmission – not via the milk. While being treated she should wash her hands well and mask for pumping and storing her milk. However, in the rare case of a mother with TB mastitis, she should neither breastfeed nor provide breast milk until the lesion is healed, which usually takes at least two weeks (Lawrence 2011, Table 13-1, p 424). She should pump and discard her milk to maintain her milk supply. Once she is no longer infected, she may breastfeed.

b. Active varicella virus (chicken pox) of the mother is only a contraindication “if the maternal rash develops 5 days or less before delivery or within 2 days after delivery” (Lawrence, 7th ed. pp. 452-454). In that case, the mother should be isolated and the infant should be given Varicella Zoster Immune Globulin (VZIG). Expressed milk can be fed to the baby, if there are no breast lesions. The mother can resume nursing when she is no longer contagious. For shingles (zoster virus), same as for herpes simplex virus type I and II, and consider VZIG for the baby.

c. Women with brucellosis, an extremely rare infection, should pump and discard their milk from both breasts until they have been appropriately treated for 48 to 96 hours (Lawrence 2011).

7. When the mother is (temporarily or permanently) not producing sufficient milk

   a. Maternal anatomical abnormalities (e.g. breast surgery, hypoplasia)

   b. Maternal conditions causing delayed lactogenesis II (e.g. diabetes, obesity, hormone imbalance, thyroid conditions)

8. Intolerable maternal pain during breastfeeding

9. Permanent contraindication to breastfeeding in the USA (not in a developing nation)
   When the mother has HIV

Milk Volumes
Volumes for supplementation recommended by the Academy of Breastfeeding Medicine

<table>
<thead>
<tr>
<th>Per feeding based on 8 feedings in 24 hours</th>
<th>TOTAL in 24 hours</th>
</tr>
</thead>
<tbody>
<tr>
<td>Day 1 – 2 to 10 mL/feed</td>
<td>Day 1</td>
</tr>
<tr>
<td>Day 2 – 5 to 15 mL/feed</td>
<td>Day 2</td>
</tr>
<tr>
<td>Day 3 – 15 to 30 mL/feed</td>
<td>Day 3</td>
</tr>
<tr>
<td>Day 4 – 30 to 60 mL/feed</td>
<td>Day 4</td>
</tr>
</tbody>
</table>

2.5 x baby’s weight in pounds = oz/24 hours
165 x baby’s weight in kilograms = mL/24 hours

Use birth weight until back to birth weight; once beyond birth weight, use current weight
If the baby has been underfed, it might take up to 3 days to get to the total volume.
The Deem article said in 48 mothers less than 20 years of age on Day 4, infants took 7.4 oz.; Day 7, 11.8 oz.; Day 10, 14.4 oz. And in 52 primiparae over 20 years Day 4, 6.4 oz.; Day 7. 12.7 oz.; Day 10, 15.4 oz.

Villalpando said Day 3 milk production about 360 ml (12.8 oz.); Day 15 about 550 ml (19.6 oz.) The study was based on 30 women. By 74 hours after birth all babies had regained their birth weight.

“Measured intakes indicate that 850 ml is a reasonable average.” “Even in the second year of life, it is by no means unusual for a mother to give her baby approximately 500 ml of breast milk each day.” (Whitehead, 1995)

“725 to 850 ml/day during months 2 to 6” are average intakes for fully breastfed infants. p. 125 (Neville 1987)

“...there was an average increase in breast milk intake of about 24 ml/month from months 1 to 6 with an average intake around 760 ml/day over this period.” page 126 (Neville 1987)

“The amount of milk consumed by the breastfed group...was significantly lower than that consumed by the formula-fed group.” “Length and weight gains...were similar between breast and formula-fed infants during the first 24 weeks of life.” (Motil 1997)

Breastfed and artificially fed infants take in different quantities of milk and have different growth patterns. By 8 months breastfed infants have consumed 30,000 kcal less than artificially fed infants. (Garza 1987)

Milk volume in the first 24 hours
4 to 26 ml (Santoro, 2010)
3 to 32 ml (Casey, 1986) } average 13 mL

Average daily output in 98 mothers of term infants (Hill 2005)

<table>
<thead>
<tr>
<th>Week</th>
<th>Day</th>
<th>Volume</th>
<th>oz</th>
</tr>
</thead>
<tbody>
<tr>
<td>Week 1</td>
<td>6-7</td>
<td>494.6 mL</td>
<td>17.4 oz</td>
</tr>
<tr>
<td>Week 2</td>
<td>14</td>
<td>555.9 mL</td>
<td>19.6 oz</td>
</tr>
<tr>
<td>Week 3</td>
<td>21</td>
<td>612.4 mL</td>
<td>21.6 oz</td>
</tr>
<tr>
<td>Week 4</td>
<td>28</td>
<td>647.7 mL</td>
<td>22.8 oz</td>
</tr>
<tr>
<td>Week 5</td>
<td>35</td>
<td>665.9 mL</td>
<td>23.4 oz</td>
</tr>
<tr>
<td>Week 6</td>
<td>42</td>
<td>668.2 mL</td>
<td>23.5 oz</td>
</tr>
</tbody>
</table>

Volumes of milk consumed during the first year after birth (Heinig, 1993)

<table>
<thead>
<tr>
<th></th>
<th>Human milk</th>
<th>Formula</th>
</tr>
</thead>
<tbody>
<tr>
<td>3 months</td>
<td>812</td>
<td>905</td>
</tr>
<tr>
<td>6 months</td>
<td>769</td>
<td>941</td>
</tr>
<tr>
<td>9 months</td>
<td>646</td>
<td>806</td>
</tr>
<tr>
<td>12 months</td>
<td>448</td>
<td>732</td>
</tr>
</tbody>
</table>


The goal is to feed the baby and pump in an hour

Once baby is over 24 hours old
Feed your baby at least every 3 hours. Offer your breast whenever you see feeding cues.
Wake if necessary: spend 10 minutes or less trying to help baby latch-on.
Use an alternate feeding method if baby has not latched-on by 10 minutes.
Keep baby skin-to-skin between feedings as much as possible: sling, cuddling.
Picture the circle as one hour.
The goals is to feed the baby
…and pump your milk
…within one hour.
Then you have a break
…for two hours,
…before starting
…again.

Settle baby

Breastfeed
or
Use alternate method
By cup, finger-feeding,
or slow flow nipple

PUMP if necessary:
If feeding with alternate method
If used nipple shield
If baby had a poor feeding

TIPS TO
LATCH BABY ON:
Drip milk
Pump 1 to 2 minutes
Prefeed 5 to 15 ml
Nipple shield

Goals:
At least 8 to 10 feedings in 24 hours with 20+ minutes of sucking
Urine after the 3rd day: 6+ wet diapers
Bowel movements after the 3rd day: 3 to 4 yellow seedy stools

Barbara L. Boston 1994
Milk Volumes


UNICEF: Feeding low birth weight babies. (video) 3 UN Plaza, New York, NY 10017


Supplementation Policy

Academy of Breastfeeding Medicine Clinical Protocol #3: Hospital Guidelines for the Use of Supplementary Feedings in the Healthy Term Breastfed Neonate, Revised 2009


World Health Organization. Acceptable medical reasons for use of breast-milk substitutes
1:00-2:10 Hospital Practices that Support Breastfeeding

I. Goals, objectives and outline
   A. Goal: To be aware of the large body of literature supporting changes in hospital practices to improve breastfeeding initiation, duration and exclusivity
   B. Objectives: At the end of this educational activity, the learner will be able to:
      1. Enumerate labor and delivery practices that affect breastfeeding.
      2. Describe skin-to-skin care to improve breastfeeding outcomes
      3. List the evidence-based Ten Steps to Successful Breastfeeding
      4. Explain ways WIC can help hospitals to support breastfeeding
   C. Outline
      1. Labor and delivery practices that affect breastfeeding
      2. Skin-to-skin care to improve breastfeeding outcomes
      3. Ten Steps to Successful Breastfeeding
      4. How WIC can help hospitals

II. Birth practices that affect breastfeeding
   A. Doula support during labor (positively affects breastfeeding)
      1. Reduces the perception of pain (Kennell 1991)
      2. Shortens the length of labor
      3. Decreases Cesarean deliveries
      4. Increases exclusive breastfeeding (Hofmeyr 1991)
      5. Experience fewer breastfeeding problems
      6. Socially disadvantaged mothers more likely to initiate breastfeeding (Gruber, 2013)
   B. In the past, epidural and narcotic analgesia have been implicated in (negative affect)
      1. Reducing sucking ability
      2. Increases the time to effective feeding
      3. Can affect neurobehavioral status
   C. Routine suctioning (negative affect)
      Gastric suctioning is associated with delayed sucking and rooting movements (Widstrom 1987)
      “When the newborn is vigorous…there is no evidence that nasopharyngeal suctioning is necessary.” (AAP 2012)
   D. Instrumental deliveries (vacuum or forceps) increases feeding difficulties (Demissie 2004)
   E. Kind of birth
      1. Cesarean birth
         a. Experience delay in milk increasing in volume
         b. More likely to be separated
      2. Epidural
         “In post hoc analyses stratified by Baby Friendly Hospital (BFH) status, epidural anesthesia significantly predicted breastfeeding cessation” Dozier, 2013
   F. Waiting to clamp the cord (positive affect)
      1. Would bring about these results in full-term babies
         a. Reduction in iron deficiency anemia
         b. Increased duration of early breastfeeding
         c. Lower blood lead concentrations at 6 months
2. Would bring about these results in preterm babies
   a. Decreased intraventricular hemorrhage
   b. Decreased need for blood transfusion
   c. Higher circulating blood volume
   d. Increased iron (milk deficiency may be associated with cognitive deficits)
   e. Improved cerebral oxygenation (fewer days of ventilation)
   f. Reduced late-onset infections
   g. Better cardiopulmonary adaptation
   h. Higher blood pressure
   i. Less likely to be discharged on oxygen
   j. Higher initial glucose levels

3. Studies vary in research protocols for defining the timing of delayed cord clamping
   a. 1 to 1.5 minutes
   b. At least 2 minutes
   c. At least 3 minutes
   d. Within 30 seconds vs 3 minutes
   e. 10 seconds vs 2 minutes
   f. 5-10 seconds vs 30-45 seconds
   g. Before 30 seconds after 30 seconds max of 120 seconds
   h. 5 to 10 seconds vs 30 to 45 seconds
   i. 15 seconds, 1 minute, 3 minutes

4. Temperature change causes the umbilical cord to clamp down on itself to stop the
   blood flow from the mother to the baby by about 5 minutes after birth

5. ACOG December 2012 Timing of Umbilical Cord Clamping after Birth
   Committee Opinion—wait at least 30 to 60 seconds

G. Separation of newborn and mother
   (negative affect)
   1. Interrupts the ability to self-attach and suck correctly (Righard 1990)
   2. “Maternal separation may be a stressor the human neonate is not well-evolved to
      cope with and may not be benign.” (Morgan BE, Horn AR, Bergman NJ. Should
      neonates sleep alone? Biol Psychiatry 70(9):817-825, 2011)
   3. Identification (e.g. bands and foot prints) can be done while baby is skin-to-skin and
      breastfeeding.
   4. Routine care can be done after the first breastfeeding and while baby is skin-to-skin
      with mother (e.g. vitamin K, eye treatment)

H. Delay the first bath 12+ hours increases breastfeeding exclusivity in the hospital (Preer 2013)
   (positive affect)

I. Reducing infant pain
   (positive affect)
   1. Vaccination—breastfeeding vs. topical EMLA (Gupta 2013)
   2. Vaccination—breastfeeding vs. vapocoolant spray (Boroumandfar 2013)
   3. Heel stick (McNair 2013)
   4. Heel stick—sucrose vs. SSC vs. sucrose + SSC vs breastfeeding + SSC
      (Marin Gabriel 2013)
   5. Heel stick in preterm babies—breast milk lowered pain scores (Ou-Yang 2013)
   6. Brain activity with breastfeeding not with glucose (Bembich 2013)
III. Ten Steps to Successful Breastfeeding: A global hospital initiative using evidenced-based practices

A. What is wrong with this picture? —A mother’s request as she enters our hospital
   I want to formula feed my baby—100% get what they want.
   I want to combination feed my baby—100% get what they want.
   I want to exclusively breastfeed my baby—less than 50% get what they want.

B. Following the Ten Steps increases breastfeeding exclusivity
   (Martis 2013, Forrester-Knauss 2013)

C. 20-hours of education makes a difference in the breastfeeding supportive practices of health care professionals (Zakarija-Grkovic 2010)

D. Transforming care—Exclusive breastfeeding is defined as providing nothing other than human milk feedings. Exclusivity rates rose from 6% to 44% (Magri 2013)

E. Maine hospitals, BFHI vs. not; BFHI designated hospitals were not keeping their practices up-to-date (Hawkins 2014)

F. Sending home formula decreases exclusivity (Feldman-Winter 2012, Sadacharan 2014)

G. None of the hospitals had a searchable system for feedings (Labbok 2013)

H. From research to practice takes 17 years.

I. Women who experienced all 4 hospital practices had higher odds of breastfeeding at one month and 4 months than women who experienced fewer than 4, being BFHI designated did not make a difference. (Brodribb 2013)

J. Breastfeeding within the 1st hour compared to more than one hour reduces risk of early-onset feeding problems in term neonates (DiFrisco 2011, Carberry 2013, Raghavan 2013)

K. Skin-to-skin for 2+ hours after birth (Thukral 2012)

L. Still breastfeeding at 6 months higher in group who had skin-to-skin in the first hour; more formula use when first time mother or C-birth and shorten duration (Augustin 2014)

M. Visitors are a barrier to skin-to-skin care (Ferarrello 2014)

N. Cost analysis, no significant difference in the cost of following the Ten Steps (DelliFraine 2011, Allen 2013)

O. If 90% of women breastfed exclusively for 6 months and continued with appropriate complementary foods for over one year over 900 fewer deaths in the first year (Bartick 2010) and 4,000 fewer maternal deaths (Bartick 2013)

P. NICU at Boston Medical Center ten years after Baby-Friendly designation initiation rates rose from 74% to 85% (1999-2009) (Parker M 2013)

Q. More hospitals designated as BFHI in 2011 than any previous year in USA (CDC 2013)

R. October 2014 there are 199 Baby-Friendly Hospitals in the USA

S. Missouri Hannibal Regional Hospital, Hannibal, MO (07/09)

VII. What can WIC do to help hospitals

A. Breastfeeding in-service program

B. Educational materials on state website

C. Make bulletin boards for the hospital maternity unit, ultrasound unit, etc.

D. Peer counselors who come to the hospital to see WIC clients

E. Give feedback from your clients about how the hospital is doing

F. Provide a list of local breastfeeding resources and up-date regularly

G. Conduct a breastfeeding mothers’ group at the hospital

H. Send an employee to be a member of the hospital breastfeeding committee and the local and state breastfeeding coalitions

I. Run a breastfeeding mothers’ group at the hospital
J. Find free patient handouts that may be copied and are translated into many languages
K. Start a hospital collaborative—get several hospitals in an area to meet together to help support each other in making changes.
L. Provide classes for fathers and grandmothers
Mother's Breastfeeding Checklist

☐ I know holding my baby skin to skin is a good for both of us.

☐ I know how the baby tells me it is time for a feeding.

☐ I know how to latch my baby onto both breasts.

☐ I know I should take turns with the breast I feed from first.

☐ I know when my baby is finished breastfeeding that he or she will let go on his or her own and be relaxed. And I know that my baby needs to finish on the first breast before I feed the baby on the other breast.

☐ I can hear my baby swallowing milk during the breastfeeding sessions.

☐ I know breastfeeding should not hurt after 30 seconds.

☐ I know when and where to call if I have any breastfeeding questions.

☐ I know how to squeeze milk out of my breasts.

☐ I know my baby should eat only my milk for the first six months.

☐ I know how to tell that my baby is getting enough milk.
   ☐ I know how to fill out the feeding record for the first week.
   ☐ I know a wet diaper is as heavy as 3 tablespoons of water.
   ☐ I know my baby should be back to birth weight by 14 days.
   ☐ I know when my baby is back to birth weight, I no longer need to keep a feeding record
      ☐ Once my baby is back to birth weight, I know my baby should gain at least 5 to 8 ounces each week (for the first 2 months).

☐ I have an appointment to see the pediatrician or family doctor in 2 or 3 days after we leave the hospital.

☐ I know I can bring the baby’s feeding record with us to the doctor’s appointment.

Baby’s birth weight  ____________________________________________
Baby’s discharge weight __________________________________________
Baby’s weight 2-3 days after discharge ____________________________
Baby’s weight at 10 to 14 days _________________________________

Adapted with permission from Marsha Walker
Complete this questionnaire as if you were one of the mothers who recently delivered at your hospital or the closest hospital to you.

<table>
<thead>
<tr>
<th>Question</th>
<th>YES</th>
<th>NO</th>
<th>?</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Before my baby was born, I was told why and how to breastfeed.</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>2. The staff were knowledgeable and supportive of breastfeeding.</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>3. I was shown how to breastfeed my baby.</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>4. I was encouraged and helped to breastfeed without the use of any other liquids for my baby.</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>5. My breasts were examined before and after my baby’s birth.</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>6. I was instructed to breastfeed whenever my baby wanted to suck or cried.</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>7. At birth, my baby’s weight was recorded and given to me.</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>8. My baby and I had skin-to-skin contact immediately after the birth.</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>9. I offered my baby the breast for the first time within:</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>30 minutes</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>one hour</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>more than one hour</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>10. My baby was not given anything to drink by the staff.</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>11. My baby and I were not separated at any time during our hospital stay unless requested by me.</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>12. My baby was not given a pacifier by the staff.</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>13. I was not given any formula, bottles, or rubber nipples when I left the hospital.</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>14. I was told when my baby would need to be examined and weighed and how to schedule an appointment for her/him.</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>15. I was told how to contact a breastfeeding mother’s support group before I left the hospital.</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>16. Overall, I believe my breastfeeding experience was improved by this facility.</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>

This questionnaire was taken from a WABA folder for World Breastfeeding Week.
10 Steps to Successful Breastfeeding

According to WHO/UNICEF, every facility providing maternity services and care for newborns should:

1. Have a written breastfeeding policy that is routinely communicated to all health care staff.

2. Train all health care staff in the skills necessary to implement this policy.

3. Inform all pregnant women about the benefits and management of breastfeeding.

4. Place babies immediately skin-to-skin to stabilize the newborn and help the baby initiate breastfeeding within an hour of birth.

5. Show mothers how to breastfeed, and how to maintain lactation even if they should be separated from their infants.

6. Give newborn infants no food or drink other than breast milk, unless medically indicated.

7. Practice rooming-in—allow mothers and infants to remain together—24 hours a day.

8. Encourage breastfeeding on demand.

9. Give no artificial teats or pacifiers to breastfeeding infants.

10. Organize and provide follow-up in the community after discharge.
Visually Promote Breastfeeding

On you
- Button
- Name tag
- Bumper sticker
- Carry a breastfeeding book
- Tote bag

In your space
- Posters
- Photos of staff with baby and positive message
- Videos playing in waiting area
- Bulletin board of photos of clients who breastfed
- Wall of clients who breastfed for one year

Items you use
- Pens
- Mugs
- Paper
- Water bottle

Mail to send out
- Stickers
- Envelopes

In your organization
- Peer counselors
- Employee pumping station

Handouts with accurate information
- Culturally appropriate
- Language appropriate
- Colorful and attractive

Ad specialty items with positive breastfeeding information
- Bookmarkers
- Magnets
- Bags

Education of entire staff
- In-service programs
- Attend conferences
- College courses
- Library of resource books
- Local breastfeeding resources file

The words we use
- When (not if)
- Ask, “What do you know about breastfeeding?” (not breast or bottle, she can do both)
- Discuss advantages to the mother. (People know about the advantages to the baby.)

Incentives
- Gift basket
- Large gift
- Monthly gift
- Payment
- Certificates

Encourage breastfeeding in the waiting room
- Comfortable chairs
- Others to set an example

Encourage staff to talk about breastfeeding with clients
- Dispel myths
- Take care of potential problems

Education outside of your walls
- Establish lending library of books and videos for parents
- Classes on breastfeeding for mother and her family members
- Get pregnant together with breastfeeding women
- Telephone numbers to call if have questions
Establishing Practices that Promote, Protect, and Support Hospital Breastfeeding Policies


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**Pain for the newborn**


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Delayed Cord Clamping


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van Rheenen PF, Brabin BJ: Late umbilical cord-clamping as an intervention for reducing iron deficiency anaemia in term infants in developing and industrialised countries: a systematic review. Ann Trop Paediatr 24(1):3-16, 2004

Skin-to-skin to increase the blood glucose level


Unexpected Collapse of Healthy Newborns


Videos

Boston Medical Center, The Breastfeeding Center: From Bottles to Breast to Baby-Friendly: The Challenge to Change. DVD
Richard L: Delivery Self-Attachment. Available from Health Education Associates, www健康的cc and Geddes Productions:
http://www.geddesproductions.com/breast-feeding-delivery-selfattachment.html
UNICEF: Learning to be Baby-Friendly
Bergman N: Kangaroo Mother Care, Geddes Productions: http://www.geddesproductionscom/breast-feeding-delivery-selfattachment.html
Special Delivery, Injoy Productions, Boudor, CO

U-Tube

Skin-to-skin after a birth http://www.youtube.com/watch?v=m5RkcaK98Yg

Association Statements

Academy of Breastfeeding Medicine: Clinical Protocol #5: Peripartum Breastfeeding Management for the Healthy Mother and Infant at Term. Revision, June 2008
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