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ABM Protocols

Clinical Protocol Number #19: Breastfeeding Promotion in the Prenatal Setting

The Academy of Breastfeeding Medicine Protocol Committee

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

Background

BREASTFEEDING PROVIDES ideal infant nutrition and is the physiologic norm for mothers and children.[1,2] Mothers often make a decision regarding breastfeeding early in prenatal care, and many have already decided whether to breastfeed prior to conception.[3] Encouragement and education from healthcare providers result in increased breastfeeding initiation and duration.[4–6] In addition, ongoing educational and support programs can improve initiation and duration of breastfeeding.[4]

Recommendations

1. Create a breastfeeding-friendly office
    - Staff must be educated and committed to promote, protect, and support breastfeeding.
    - The primary clinician should be involved, but he or she does not need to do each of the following steps. Tasks may be assigned to multiple office staff members (nurses, medical assistants, lactation consultants, health and breastfeeding educators) if adequate training and support are provided for them.
    - Offices providing prenatal care should have a written breastfeeding policy to facilitate such support.[5]
    - Literature and samples provided by artificial formula companies should not be used because this advertising has been demonstrated to decrease breastfeeding initiation and shorten duration rates.[7]
    - Information regarding the mother's intention to breastfeed should be included as part of all transfer-of-care materials, including prenatal records and hospital and birth center discharge summaries.
2. Integrate breastfeeding promotion, education, and support throughout prenatal care
    - Actively state support of breastfeeding early in prenatal care and acknowledge that breastfeeding is superior to artificial feeding. Consider a statement such as "As your doctor, I want you to know that I support breastfeeding. It is important for mothers and babies."
    - It is also helpful to let the prenatal patient know that her physician will actively help her with statements such as "I like to spend time helping my patients get the information, skills, and support they need to breastfeed successfully."
3. Take a detailed breastfeeding history as a part of the prenatal history[8]
    - For each previous child, ask about breastfeeding initiation, duration of exclusive breastfeeding, total breastfeeding duration, who provided breastfeeding support, perceived benefits of breastfeeding, breastfeeding challenges, and reason(s) for weaning.
    - For women who did not breastfeed, consider asking about the perceived advantages of artificial feeding, as well as the perceived disadvantages. Inquire about what may have helped her breastfeed previous children.
    - It is also important to determine any family medical history that may make breastfeeding especially helpful for this child, such as asthma, eczema, diabetes, and obesity.[1,2,9]
4. Consider the culture of individual women, families, and communities
    - Learn about the family structure of patients. In some cultures, enlisting the cooperation of a pivotal family member may greatly assist in the promotion of breastfeeding, whereas in others, the participation of a particular family member may be inappropriate.

- Understand the partner's perspectives and beliefs that may affect breastfeeding success and educate where appropriate.
- Ensure that parents from diverse cultures understand the importance of breastfeeding to their children's growth and development.
- Respect cultural traditions and taboos associated with lactation, adapting cultural beliefs to facilitate optimal breastfeeding, while sensitively educating about traditions that may be detrimental to breastfeeding.
- Provide all information and instruction, wherever possible, in the mother's native language and assessing for literacy level when appropriate.
- Understand the specific financial, work, and time obstacles to breastfeeding and work with families to overcome them.
- Be aware of the role of the physician's own personal cultural attitudes when interacting with patients."[2]

5. Incorporate breastfeeding as an important component of the initial prenatal breast examination[10]

- Observe for appropriate breast development, surgical scars, and nipple contour.
- Perform areolar compression if nipples are flat or inverted.
- Review the physiologic changes of pregnancy, such as volume growth and leakage of colostrum.
- Consider repeating the breast examination in the third trimester, as breast anatomy will change throughout pregnancy.
- Assure the expectant mother that her anatomy is sufficient for successful breastfeeding or discuss the availability of support and assistance if suggested by physical exam.
- If the history and or physical exam findings suggest that the woman is at high risk for breastfeeding problems, consider a prenatal lactation referral or early lactation support.

6. Discuss breastfeeding at each prenatal visit

- Breastfeeding can be addressed by clinicians and/or health care staff.
- Consider use of the Best Start 3-Step Counseling Strategy[10] by:

1. Encouraging open dialogue about breastfeeding by beginning with open-ended questions.
2. Affirming the patient's feelings.
3. Providing targeted education.[11,12]
   - Address concerns and dispel misconceptions at each visit.

During the first trimester

- Incorporate and educate partners, parents, and friends about the benefits of breastfeeding for mothers and babies.[13]
- Address known common barriers such as lack of self-confidence, embarrassment, time and social constraints, dietary and health concerns, lack of social support, employment and child care concerns, and fear of pain.[10,14]
- Continue to ask open-ended questions.

During the second trimester

- Encourage women to identify breastfeeding role models by talking with family, friends, and colleagues who have breastfed successfully.
- Recommend attending a formal breastfeeding course for the patient and her partner in addition to office education.[15]
- Encourage participation in a breastfeeding peer support group. Provide a list of local educational options and breastfeeding resources for patients.[16,17]
- The second trimester visits often provide time for discussion of breastfeeding basics such as the importance of exclusive breastfeeding and supply/demand, feeding on demand, frequency of feedings, feeding cues, how to know an infant is getting enough to eat, avoiding artificial nipples until the infant is nursing well, and the importance of a good latch.
- The mother working outside the home should be encouraged to begin thinking about if and when she will return to work after the baby is born. If she is planning on returning to work, encourage the woman to consider what facilities are available for pumping and storage of breastmilk, how much time she will take for maternity leave, and what company policies and legislation is available to support her.

During the third trimester

- At the 28-, 30-, or 32-week visits have the prenatal patient and her support persons use props such as dolls, balls, and balloons. Demonstrate how to hold the breast and positions of the baby such as cradle, cross-cradle, and the clutch hold.[18]
- Discuss what will happen in the delivery room under normal conditions. What will the mother do? What will the doctor do?
- Review the physiology of breastfeeding initiation and the impact of supplementation.
- Repeat the breast and nipple examination.
- Recommend the purchase of properly fitting nursing bras.
- Encourage another visit to a breastfeeding support group as the mother's interest and goals of attending may be different than when she attended early in the pregnancy.[19]
- Recommend the mother discuss plans for infant health care and breastfeeding support with her pediatric care provider.[20]

7. Empower women and their families to have the birth experience most conducive to breastfeeding
   - Confirm postpartum follow-up plans.
   - Assure the mother has an adequate support system in place during the postpartum period.
   - Recommend the infant see a healthcare provider within 48 hours of discharge from the hospital to assure well-being and optimal breastfeeding.
   - Assure that the patient has information on how to get breastfeeding help.
   - Provide anticipatory guidance on topics such as engorgement, growth spurts, and nighttime feedings.
   - Inform patients about the Ten Steps to Successful Breastfeeding and how to advocate for breastfeeding friendly hospital care.[20]

- Discuss support of breastfeeding in the event of a cesarean section.

Recommendations for Further Research

1. There are currently no studies examining only physician interaction in support of breastfeeding during prenatal visits and its effect on initiation, exclusivity, and maintenance.
2. Studies are needed that examine prenatal interventions alone and in combination and their effects on initiation, exclusivity, and duration of breastfeeding.
3. Studies examining the cost-effectiveness of making an outpatient practice breastfeeding-friendly are needed.
4. Research on specific challenges to providing support for breastfeeding during prenatal care (e.g., lack of community resources, cultural barriers, etc.) is needed.
5. Additional research is needed on the effect of varying prenatal breastfeeding interventions on multiple populations, including with women of different socioeconomic status and cultural backgrounds.

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References

1. American Academy of Pediatrics Section on Breastfeeding. Breastfeeding and the use of human milk. *Pediatrics* 2005;115: 496–506.
2. American Academy of Family Physicians. Family Physicians Supporting Breastfeeding. Position Paper, 2008. http://www.aafp.org/online/en/home/policy/policies/b/breastfeedingpositionpaper.html (accessed February 8, 2009).
3. Izatt SD. Breastfeeding counseling by healthcare providers. *J Hum Lact* 1997;13:109–113.
4. Primary Care Interventions to Promote Breastfeeding, Topic Page. October 2008. U.S. Preventive Services Task Force. Agency for Healthcare Research and Quality, Rockville, MD. http://www.ahrq.gov/clinic/uspstf/uspsbrfd.htm.
5. Shaikh U and the Academy of Breastfeeding Medicine Protocol Committee. ABM clinical protocol #14: Breastfeeding-friendly physicians office, part 1: Optimizing care for infants and children. *Breastfeed Med* 2006;1:115–119.
6. Mansbach IK, Palti H, Pevsner B, et al. Advice from the obstetrician and other sources: do they affect women's breastfeeding practices? A study among different Jewish groups in Jerusalem. *Soc Sci Med* 1984;19:157–162.
7. Howard CR, Howard FM, Lawrence RA, et al. The effect on breastfeeding of physicians' office-based prenatal formula advertising. *Obstet Gynecol* 2000;95:296–303.
8. American Academy of Pediatrics, American College of Obstetricians and Gynecologists. Breastfeeding: Management before and after conception (Chap. 5). In: *Breastfeeding Handbook for Physicians*. Schanler RJ, sr. ed. American Academy of Pediatrics, Elk Grove Village, IL, pp. 55–65, 2006.
9. Ip S, Chung M, Raman G, et al. *Evidence Report/Technology Assessment No. 153: Breastfeeding and Maternal and Infant Health Outcomes in Developed Countries.* AHRQ Publication Number 07-E007. Agency for Healthcare Research and Quality, Rockville, MD, 2007.
10. Issler H, de Sa MB, Senna DM. Knowledge of newborn healthcare among pregnant women: Basis for promotional and educational programs on breastfeeding. *Sao Paulo Med J* 2001;119:7–9.
11. United States Department of Agriculture National Breastfeeding Promotion Campaign: Loving Support Makes Breastfeeding Work. http://www.fns.usda.gov/wic/breastfeeding/lovingsupport.htm (accessed February 8, 2009).
12. Humenick SS, Hill PD, Spiegelberg PL. Breastfeeding and health professional encouragement. *J Hum Lact* 1998;14: 305–310.
13. Ingram J, Johnson D. A feasibility study of an intervention to enhance family support for breastfeeding in a deprived area in Bristol, UK. *Midwifery* 2004;20:367–379.
14. Hartley BM, O'Connor ME. Evaluation of the 'Best Start' breast-feeding education program. *Arch Pediatr Adolesc Med* 1996;150:868–871.
15. Reifsnider E, Eckhart D. Prenatal breastfeeding education: Its effect on breastfeeding among WIC participants. *J Hum Lact* 1997;13:121–125.
16. Chapman DJ, Damio G, Perez-Escamilla R. Differential response to breastfeeding peer counseling within a low-income, predominantly Latina population. *J Hum Lact* 2004; 20:389–396.
17. Chapman DJ, Damio G, Young S, et al. Effectiveness of breastfeeding peer counseling in a low-income, predominantly Latina population: A randomized controlled trial. *Arch Pediatr Adolesc Med* 2004;158:897–902.
18. Duffy EP, Percival P, Kershaw E. Positive effects of an antenatal group teaching session on postnatal nipple pain, nipple trauma and breastfeeding rates. *Midwifery* 1997;13: 189–196.
19. De Oliveira MI, Camacho LA, Tedstone AE. Extending breastfeeding duration through primary care: A systematic review of prenatal and postnatal interventions. *J Hum Lact* 2001;17:326–343.
20. Loh NR, Kelleher CC, Long S, et al. Can we increase breastfeeding rates? *Ir Med Jr* 1997;90:100–101.
21. American Academy of Pediatrics Section on Breastfeeding. *Ten Steps to Support Parents' Choice to Breastfeed Their Baby*. American Academy of Pediatrics, Elk Grove Village, IL, 2003. http://www.aap.org/breastfeeding/tenSteps.pdf (accessed February 8, 2009).

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