

Breastfeeding Policy

Policy Owner(s)

Service Manager Women's Health and Service Manager Child Health

Purpose

1. To promote a philosophy of mother and baby care which advocates, supports and protects exclusive breastfeeding and recognises the normal physiological functions involved in this mother and baby process.
2. To ensure the individual cultural needs of the woman and her family/whanāu are considered and respected. (Appendix 5)
3. To enable all women who make a decision to breastfeed to have a successful and satisfying experience.
4. To encourage a positive and supportive attitude among all staff toward breastfeeding and to facilitate the provision of consistent, correct, current information for all mothers.
5. To dispel misconceptions about the BFHI and to disseminate accurate information about the BFHI purpose which is to remove barriers to breastfeeding that may occur in maternity facilities while providing education for staff in breastfeeding management, breastfeeding support and protection, and best evidenced practice.

Policy

Women's & Children's Health (WCH) – Maternity & Neonatal Facilitiesⁱ recognise and support the Ten Steps to Successful Breastfeeding as the global standard for maternity services (page 3).

WCH protect, promote and support exclusive breastfeeding of babies in accordance with The World Health Organisation (WHO)/United Nations International Children's Emergency Fund (UNICEF) Joint Statement (1989).ⁱⁱ [The Baby Friendly Hospital Initiative](#) was developed by WHO/UNICEF to promote implementation of the [Innocenti Declaration](#) target which was to ensure that all maternity facilities fully practice The Ten Steps.

WCH supports the [WHO/UNICEF Global Strategy for Infant and Young Child Feeding](#) as a guide for action and recognises the responsibility to give 'tangible effect to the strategy's vital aim and practical objectives'.

WCH aims to protect and support breastfeeding by recognising and adhering to the [WHO International Code of Marketing of Breastmilk Substitutes \(1981\) and subsequent, relevant World Health Assembly resolutions](#). The NZ Ministry of Health (2007) requires all health facilities to develop a health worker code of practice for their facilities. The WCH Code

ⁱ Women's & Children's Health (WCH) – Maternity Facilities – The breastfeeding policy must be adhered in the Maternity facilities (Christchurch Women's Hospital, Burwood Birthing Unit, Rangiora hospital and Lincoln maternity hospital) and can be used as a resource throughout the Canterbury DHB.

ⁱⁱ WHO/UNICEF. (1989). *The Ten Steps to Successful Breastfeeding. Protecting, Promoting and Supporting Breastfeeding*, Geneva, WHO.

of Practice, based on the [WHO International Code](#), may be found in Appendix 1.

Scope

This policy applies to all staff working within WCH Maternity and Neonatal facilities.

This policy is underpinned by the WHO/UNICEF, Ten Steps to Successful Breastfeeding.ⁱⁱⁱ

Every facility providing maternity services and care for newborn infants should:

1. Have a written Breastfeeding Policy that is routinely communicated to all staff.
2. Train all health care staff in skills necessary to implement this policy.
3. Inform all pregnant women about the benefits and management of breastfeeding.
4. Help mothers initiate breastfeeding within half-hour of birth. Place babies in skin-to-skin contact with their mothers immediately following birth for at least an hour. Encourage mothers to recognise when their babies are ready to breastfeed, offering help if needed.
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 breastmilk 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 (also called dummies or soothers) to breastfeeding infants.
10. Foster the establishment of breastfeeding support groups and refer mothers to them on discharge from the hospital or clinic.

This policy is also aligned to the [Innocenti Declaration on the Protection, Promotion and Support of Breastfeeding 2005](#).^{iv}

ⁱⁱⁱ WHO/UNICEF. (1989). *The Ten Steps to Successful Breastfeeding. Protecting, Promoting and Supporting Breastfeeding*, Geneva, WHO.

^{iv} For the full Innocenti Declaration 2005 see <http://www.innocenti15.net/declaration.pdf.pdf>

The Ten Steps

STEP 1 Have a written Breastfeeding Policy that is routinely communicated to all staff.

This policy, which addresses all of the Ten Steps to Successful Breastfeeding, shall be routinely communicated to all staff working in Women's & Children's Health.

Whai kaupapa tuhi mō te ūkaipō, mō ngā kai mahi haurora.¹

Consistent and sustained improvements in maternity facility practices are fostered if there is a specific institutional, written Breastfeeding Policy.^{2 3 4 5 6 7 8} Policies developed through appropriate, diverse, community and facility consultation are likely to be more robust.^{9 10 11} The existence of a policy document concerning breastfeeding increases general awareness of the normalcy and importance of breastfeeding.¹²

- 1.1 This policy has been developed in consultation with Māori, Pacific Island communities, other ethnic groups that comprise of 5% or more of clientele assessing the maternity facility, consumer organisations, facility staff and providers using this facility. Full documentation of the consultation process undertaken has been maintained and is available for BFHI assessors and other interested parties to view (Appendix 4).
- 1.2 All staff of WCH are aware of the principles of the Treaty of Waitangi, partnership, protection and participation, which underpin the Māori policies upheld by the WCH. (Appendix 5)
- 1.3 A full and complete copy of the Breastfeeding Policy will be kept as part of the WCH Policies
- 1.4 All consumers using WCH services will be made aware of and have access to the full Breastfeeding Policy on the internet.
- 1.5 All staff and access agreement holders have access to the full Breastfeeding Policy on the internet and are familiar with its contents.
- 1.6 An abridged Breastfeeding Policy is displayed in all areas of WCH. Note: Maternity and Neonatal facilities only.
- 1.7 The abridged Breastfeeding Policy is available in the languages and wording most commonly understood by the main ethnic groups using this facility.
- 1.8 Interpreters are available for translation and/or sign language when necessary.
- 1.9 The Breastfeeding Policy focuses on the protection of breastfeeding by recognising and supporting the International Code of Marketing of Breastmilk Substitutes and subsequent, relevant World Health Assembly resolutions. A facility health workers code covers the relevant issues. (Appendix 3)
- 1.10 The Breastfeeding Policy will be reviewed and updated every three years.
- 1.11 The effectiveness of the Breastfeeding Policy will be evaluated using audits of health care practice and chart reviews in relevant areas within WCH. Data collection of breastfeeding statistics, including initiation, exclusivity and discharge feeding methods will also be maintained and evaluated. Peer feedback/evaluation of breastfeeding

management and education and consumer satisfaction surveys will also be used.¹³

- 1.12 The person(s) responsible for midwifery or nursing services can at any time locate a copy of the policy and describe how all new staff are orientated and made aware of it.

STEP 2 Train all health care staff in the skills necessary to implement the Breastfeeding Policy

Whakaako ngā kaimahi hauora ki ngā pūkenga, kia whakatinanatia e rātou te kaupapa.

Breastfeeding and lactation education and training in breastfeeding management have demonstrated positive effects on staff knowledge and consequently staff ability to support breastfeeding mothers.^{14 15 16 17 18}

- 2.1 All (WCH) staff will receive orientation to the Breastfeeding Policy
- 2.2 The breastfeeding and infant feeding education courses are regularly updated, evaluated, research and evidence informed and copies of the curriculum are available for review.
- 2.3 A breastfeeding and infant feeding education schedule is available and all new staff are enrolled on the appropriate schedule.
- 2.4 The BFHI education compulsory requirements and the ongoing annual requirements for various staff designations are described fully in Appendix 6.
- 2.5 All (WCH) staff require education about the Ten Steps to Successful Breastfeeding as part of the compulsory educational requirements.
- 2.6 All (WCH) staff require education about the protection of breastfeeding (Appendices 2 and 3) as part of the compulsory education requirements.
- 2.7 Midwives and nurses are required to have documented clinical tuition as part of the compulsory educational requirements.
- 2.8 Midwives and nurses are required to complete an educational component on the subject of breastfeeding for Māori women as part of the educational requirements. This education will be done in consultation with appropriate Māori workers and Kaumātua.

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

Breastfeeding counselling is given to all pregnant women using antenatal services at this facility. The facility maybe provider of primary care or accepts handover of care during pregnancy or the pregnant women is referred for obstetric consultation only.

Pānui ki ngā wāhine hapū ngā painga o te ūkaipō, me te whakahaere hoki i taua kaupapa.

- 3.1 Research indicates that antenatal breastfeeding education has a positive impact on the initiation and duration of breastfeeding.^{19 20 21 22 23 24 25 26 27 28 29}
- 3.2 Small, informal group health education classes in the antenatal period can provide an effective intervention to increase breastfeeding

initiation rates, and in some cases breastfeeding duration, among women from different income or ethnic groups.³⁰

- 3.3 Antenatal breastfeeding education – please see Breastfeeding Education for Pregnant Women (Appendix 7).^{v,vi}

STEP 4 Help mothers initiate breastfeeding within a half-hour of birth.

This step is now interpreted as:

Place babies in skin-to-skin contact with their mothers immediately following birth for at least an hour. Encourage mothers to recognise when their babies are ready to breastfeed, offering help if needed.

All mothers, regardless of their feeding method decision, will be given the opportunity immediately following the birth (or within five minutes after birth) of their well babies, and prior to any baby intervention, such as weighing, bathing or wrapping, to have undisturbed skin to skin contact together for a minimum period of sixty minutes or until the first breastfeed is complete. As it is preferable that babies be left even longer than an hour, if feasible, as they may take longer than 60 minutes to breastfeed. A brief interruption for a bed transfer or if there were clinically justifiable reasons for separation is acceptable. During this time mothers, who intend to breastfeed, will be supported to recognise when their babies are ready to feed and supported to breastfeed their babies by staff. It is expected that mothers will have discussed skin-to-skin contact and early initiation of breastfeeding with their Lead Maternity Carers and/or other midwives prior to birthing. All care is given in consultation with the Lead Maternity Carer where applicable and always with the informed consent of the mother.

The definition of mother-baby skin-to-skin contact is described as placing a naked baby prone on the mother's bare chest and then covering the baby with a warm, dry blanket or towel.³¹

- 4.1 Maternity hospital initiatives that promote early mother-baby contact increase successful breastfeeding initiation.³²
- 4.2 Babies who are skin to skin on their mother's chest will demonstrate pre-feeding behaviours which have a positive impact on breastfeeding initiation.³³

Note 1 – the WHO/UNICEF has stated that the wording of the Ten Steps to Successful Breastfeeding cannot be altered but the interpretation of Step Four has been clarified as above in the revised international BFHI documents 2009. New Zealand has adopted this interpretation.

Note 2 – recognising the practice of delayed cord clamping the wording of this step has been amended. Skin to skin contact does not necessarily always mean 'chest to chest' therefore maintaining skin-to-skin contact can occur from birth even if it is initially thigh to baby – as long as baby maintains skin-to-contact with its mother.

- 4.3 Most unmedicated, well term babies are very alert in the first two hours following birth and if undisturbed will self-attach to feed at the breast and do this at approximately fifty-five minutes post-birth.³⁴

^v WHO/UNICEF. (1990 & 2005). Innocenti Declaration on the protection, promotion and support of breastfeeding, Florence. WHO.

^{vi} WHO/UNICEF, (2003). Global Strategy for Infant and Young Child Feeding, Geneva, WHO.

- 4.4 Mothers have a rapid thermal response with baby skin to skin contact which reinforces the importance of the mother as the principal source of newborn thermal protection.³⁵
- 4.5 Baby temperature is not adversely affected when skin-to-skin care is practiced optimally.³⁶
- 4.6 Mothers report a high rate of satisfaction when early post-birth skin-to-skin practices are supported.³⁷
- 4.7 Skin-to-skin care has a positive effect on baby blood glucose levels.^{38 39}
- 4.8 There is no justification for forcing a baby to take the breast providing that the mother-baby are in close skin-to-skin contact and the baby is able to suckle when showing signs of readiness.⁴⁰
- 4.9 Mothers and babies should not be separated after birth unless there is an unavoidable medical indication.⁴¹
- 4.10 Maternal analgesia (particularly Pethidine) has been shown to reduce the alertness and consequently the suckling response in babies. (see references for 3.3.9) Babies who are less alert and who do not show interest in feeding initially should be enabled to have either a longer period of skin-to-skin contact post birth or be supported to recommence skin-to-skin care in the post-natal ward.⁴²
- 4.11 If the initial breastfeed is not achieved within six hours of birth, despite a baby being given the opportunity to suckle and have prolonged skin-to-skin contact with the mother, individual assessment of the situation is required. Hand expression should be commenced. It is preferable to empower the mother by teaching her this technique.^{43 44 45} (see Step Five and Appendix 12) The mother can be reassured that colostrum volume maybe minimal at the early stage. The colostrum obtained may be gently given to the baby via a syringe (the syringe should not enter the baby's mouth and only amounts less than 5 mLs may be given safely by this method), cup or spoon (Appendix 9).
- 4.12 A healthy full term baby who latches and suckles well within one to two hours after birth may then sleep for six to eight hours. After this time some babies may require stimulation to breastfeed again. Initiating further skin-to-skin contact may facilitate arousal, feeding responsiveness and further breastfeeding.^{46 47 48 49}
- 4.13 Documentation of mother-baby skin-to-skin contact, including the time and duration of this contact, and the initial breastfeed is made in the clinical notes and/or the multidisciplinary care pathway. It is also essential to include this information on transfer forms if mothers are moving facilities for postnatal care.
- 4.14 Staff will be aware of the potentially different cultural practices and traditions of women and families and will provide sensitive and supportive care which supports Step Four and the individual family/whanāu context. This also recognises the valuable contribution of family/whanāu and significant others to breastfeeding, parenting and mothering support.
- 4.15 For preterm or unwell, term babies who are admitted to neonatal services and separated from their mothers, skin-to-skin contact should be offered as soon as the baby is stable. If the mother is

unwell skin-to-skin contact should be facilitated as soon as the mother is stable.

- 4.16 Extended skin-to-skin contact is also known as Kangaroo-Mother-Care (KMC) in neonatal and special care baby settings. Kangaroo Mother Care returns the baby back to the maternal environment and incorporates tactile, auditory, visual, rhythmic and vestibular components. It provides a buffer against over-stimulation and supports baby arousal regulation and stress reactivity. KMC plays an active, crucial role in baby care that reduces depression and increases maternal confidence, competence, responsiveness and connectedness. KMC has been actively and extensively researched and found to provide parental, lactational, developmental, and physiological benefits.^{50 51 52 53 54 55 56 57 58 59 60 61}
- 4.17 A Kangaroo-Mother-Care (KMC) protocol and guidelines for practice may be found in Appendix 10.
- 4.18 The hormone oxytocin plays a part in not only lactation but in the emergence of positive maternal behaviours. Skin-to-skin contact and KMC facilitate oxytocin responses.^{62 63 64 65}
- 4.19 Women who have caesarean births with either spinal or epidural anaesthesia will be supported to have skin-to-skin care with their well babies in theatre, and to initiate breastfeeding when the baby is showing signs of interest and readiness to breastfeed.
- 4.20 Women who have had caesarean section births with a general anaesthesia will be supported to have supervised skin-to-skin contact with their babies as soon as they are able to respond. A mother who has had general anaesthesia may breastfeed postoperatively as soon as she is alert enough to hold the infant and is not overly sedated. This contact should be continued until the baby has finished feeding unless there are justifiable medical reasons for delaying or interrupting contact.

STEP 5 Show mothers how to breastfeed and how to maintain lactation even if they are separated from their infants.

Tohutohu ngā kōkā ki te ūkaipo ā rātou pēpi, me pēhea hoki ka mau tonu te rere o te wai ū, ahakoa wehe rātou i a rātou pēpi.

Staff will offer mothers assistance with breastfeeding within six hours after birth.

If a mother is separated from her baby she will be shown how to hand express her breastmilk to initiate and maintain lactation, ideally in the first hour following birth. Written information may also be given. Consistent teaching about positioning and attachment will be given to mothers. Information about storage and use of breastmilk will also be given at an appropriate teaching moment in the postpartum period and prior to discharge from the facility. Care is given with the informed consent of the mother.

- 5.1 All mothers, irrespective of previous breastfeeding experience, will be offered support and guidance with breastfeeding.
- 5.2 Mothers with previous breastfeeding problems and mothers with indicators of potential breastfeeding problems and/or risk factors for a

delay in lactogenesis II will be offered extra care and support in the postnatal period (Appendix 11).

- 5.3 Guidance by maternity staff will assist and empower mothers to independently breastfeed their babies. Research indicates that individualised postnatal breastfeeding support, based on evidence, may have a positive impact on exclusive breastfeeding rates and duration.^{66 67 68 69} It is recognised that supporting breastfeeding is a 'dynamic, multidimensional process with relational, contextual and situational components' and that fostering strong collaborative relationships between maternity care practitioners is essential.⁷⁰
- 5.4 Breastfeeding women need emotional, empowering, informational and practical support in the postnatal period.^{71 72}
- 5.5 All positioning and latching assistance takes place within a mother-baby-breastfeeding supportive context. Breastfeeding women are empowered by consistent explanation and independent achievement. Demonstrations of positioning and technique are valuable. A 'hands-off' approach to assistance is preferable but if further assistance is occasionally necessary this will only occur with the full informed consent of the mother.
- 5.6 Colostrum is more effectively expressed from the breast using an accepted hand expressing technique. (Appendix 12) Hand expressing is a valuable skill for a mother to learn. Staff will ensure that every breastfeeding woman knows how to express her own breastmilk by hand prior to going home from the facility. This skill may not be required at time of discharge but may be required in the future, i.e. engorged/full breasts.
- 5.7 Mothers who are separated from their babies or whose babies are not latching effectively at the breast will be supported to initiate lactation by hand expression and to commence breastfeeding as soon as possible.
- 5.8 Written guidelines for the storage and use of breastmilk will be available for all breastfeeding mothers and this information will be supportive of breastfeeding and based on up to date information (Appendix 13). Provided in Breastfeeding Booklet also known as the 'green' book.
- 5.9 If it becomes necessary to use an electric breast pump mothers will be shown how to use this piece of equipment effectively and appropriately. In some circumstances breast pumps may be commenced within the first 6 hours of birth to aid with breast stimulation. Important to individualising care and the rationale for the electric breast pump. All level three and four staff assisting mothers with breastfeeding will understand the principles of using an electric pump and how to assemble the components correctly.
- 5.10 When a baby is admitted to Neonatal Services mothers will be supported to initiate lactation by hand expression within six hours of the baby's birth. For sick and preterm babies the importance of breastmilk cannot be overestimated, supporting growth and providing protection from infection. In particular, evidence suggests that the use of breastmilk decreases the incidence and severity of the life threatening disease necrotising enterocolitis. By providing her breastmilk a mother can be assured that she is uniquely contributing

to the wellbeing and development of her baby. However, expressing breastmilk over a long period of time is extremely demanding and if a mother is to succeed she needs the support from those involved with caring for her and her baby.

- 5.11 When a baby is admitted to Neonatal Services, mothers who intend to breastfeed will be given individualised advice and information about how to establish and maintain a breastmilk supply when a baby is not feeding at the breast. Breastfeeding mothers, with babies in NICU, will also be advised that breastmilk generally needs to be expressed eight times or more in a twenty-four hour period, and at regular intervals, to establish and maintain a milk supply. Individualised advice is necessary, however, to take into account different women and the context of their dyad situation – for example when a baby starts breastfeeding, when a mother's milk supply is decreasing, in the case of twins, or when baby discharge planning is taking place. This individualised advice will be regularly updated to take into account the difficulties of establishing lactation under conditions of mother-baby separation, without a baby feeding from the breast (Appendix 14). The Baby Friendly Initiative recommends that a formal review is carried out at least once within the first 12 hours following birth/delivery to support early expressing and at least four times within the first two weeks to ensure that mothers are expressing effectively and to address any issues or concerns they may have. Early (within the first 4-6 hours), frequent (at least eight times in 24 hours including once at night) and effective (combining hand and pump expression) expressing is crucial to ensuring a mother is able to maximise her milk production so that she can maintain her supply for as long as she wishes. With the correct support to express, a mother can aim to achieve an average milk volume of approximately 750-900 mLs in 24 hours at day 14. Delays in starting to express or any reduction in the frequency or effectiveness of expression will compromise her long term supply. Early detection and correction of problems will help her maintain confidence in her ability to produce milk for her baby.
- 5.12 When a term baby is admitted to Neonatal Services the mother will be supported to have contact with her baby and to breastfeed when the baby is stable and showing signs of feeding readiness (Appendix 15). Skin to skin is important even if baby is not showing signs of readiness to feed as baby may well be recovering from birth, but the contact with baby will support breastmilk production.
- 5.13 When a preterm baby is admitted to Neonatal Services the mother will be supported to have contact with her baby and to breastfeed when the baby is stable, mature enough to breastfeed and showing signs of breastfeeding readiness. Readiness to breastfeed in a preterm baby is not determined by actual gestational age, corrected gestational age or weight but rather assessed on an individual basis.^{73 74 75 76 77 78 79 80 81 82 83 84 85}
- 5.14 Where a mother is unwell and unable to care for her baby staff will assist the mother to express colostrum for her baby on a regular basis (with her consent) with collaboration between the appropriate staff members. If the mother is admitted to the AOU – birthing suite post birth, then a Lactation Consultant referral should be sent.
- 5.15 Midwives and nurses are available twenty-four hours a day and seven days a week to assist breastfeeding dyads. Level 4 staff are available

7 days a week 0730-1600 hours for breastfeeding dyads up until 6 weeks of age.

- 5.16 All breastfeeding mothers will be given advice about expressing sufficient breastmilk to achieve comfort when their breasts are engorged/overfull. This may then enable the baby to latch and transfer milk.

STEP 6 Give breastfeeding babies no food or drink other than breastmilk unless medically indicated

Tohutohu ngā kōkā, kua e whāngai ā rātou pēpi ki ētahi atu tūmomo kai, wai rānei, ko te wai ū anake, engari koa, mea i whakaritea ā tēhahi atu tikanga ē ngā tākuta.

A supplementary feed is defined as a feed given in place of breastfeeding. Expressed breastmilk from the mother is the first choice for supplemental feeding for a breastfeeding baby.⁸⁶

- 6.1 If a breastfeeding baby is given food or drink other than breastmilk, an informed consent process must be used at all times.^{87 88 89 90} A signature is required from the baby's mother (the father's consent, or appropriate family/whanāu member can be accepted in cases of severe maternal illness) and written documentation is necessary within the clinical notes. A consent form for supplemental infant formula feeds for a breastfeeding baby is used within WCH (Appendix 16). Appropriate documentation is made when breastfeeding mothers have made a decision to give their babies a supplemental feed of infant formula.
- 6.2 Parents who request non-medically indicated infant formula supplements for their breastfeeding baby will be made aware of the potential negative effects on breastfeeding continuation and duration that are associated with this practice.^{91 92 93 94 95 96 97 98 99 100 101 102 103 104 105} Parents will also be made aware of the importance of exclusive breastfeeding and the disadvantages associated with a shortened duration of breastfeeding (Refer references 34-68).
- 6.3 Small colostrum feeds are appropriate for the size of a newborn baby's stomach and are sufficient to prevent hypoglycaemia in the healthy, term, appropriate for gestational age baby.^{106 107 108}
- 6.4 Acceptable medical indications for the use of infant formula when colostrum or breastmilk (including donated) is unavailable are outlined in [BFHI document Part 2](#) and CDHB [Neonatal Clinical Resource](#) and include:
- 6.4.1 Hypoglycaemia. When blood sugar levels are below 2.6 mmol/litre and unresponsive to appropriate and frequent breastfeeding, in otherwise well term babies, expressed colostrum or breastmilk may be sufficient to correct the low blood sugar. (Also see [Hypoglycaemia of the newborn on birthing suite and the postnatal ward -WCH/GLM0056](#)).
- 6.4.2 Dehydration when clinical indicators, appropriate to the age of the baby, are present such as lethargy, skin turgor and tone, inadequate stools and poor urine output (Appendix 18). It is not appropriate to dilute expressed colostrum with sterile water or any other liquid. There is no documented evidence of

benefit and the potential of interference with the natural properties of colostrum exist.

- 6.4.3 Baby weight loss of 7% or more is a time to consider whether formula is required or question as to whether timely management strategies could prevent its usage. Care must be individualised along with an assessment of a breastfeed as well as ongoing evaluation of baby output, changes in the mother's breast 'fullness', and assessment of breastfeeding establishment, effectiveness and progress.
- 6.4.4 Severe Hyperbilirubinaemia which requires treatment with phototherapy. This is only relevant when breastfeeding is not establishing well and baby fluid requirements appear to exceed the amounts of expressed breastmilk available. Baby urine and stool outputs should be evaluated. (Also see [High Risk Infant On Postnatal Ward](#)).
- 6.4.5 Preterm babies may require infant formula when breastfeeding is not possible and/or expressed breastmilk is not available in sufficient amounts. Ideally human milk from screened donors and human milk banking is the optimal choice. Pasteurised Donor milk is now available for babies admitted to the Neonatal Unit. A Recipient Babies Prioritisation tool is used. Donor milk availability is based on the Neonatal Unit Milk bank status ranging from minimal supply to plentiful supply.
- 6.4.6 When maternal medications are incompatible with breastfeeding (Appendix 19).
- 6.5 There is a negative association between breastfeeding outcomes and giving breastfeeding babies infant formula in maternity facilities.^{109 110 111 112 113 114 115 116}
- 6.6 Supplementation may be necessary in cases of severe maternal illness resulting in mother-baby separation. Supplementation maybe necessary for babies whose mothers have been assessed to be at a high risk of delayed or failed lactogenesis II.
- 6.7 There will be no promotion of other baby or infant foods or drinks in WCH. This includes posters, leaflets, handouts and branded products in all aspects of display and/or distribution (Appendix 1).
- 6.8 WCH receives no free or low cost infant formula products (Appendix 1).
- 6.9 WCH has a policy about visiting infant formula industry representatives (Appendix 1).
- 6.10 WCH maintains records of how much infant formula is used to enable evaluation of increases or decreases in usage (Appendix 1).
- 6.11 WCH has a policy relating to selection of infant formula for use in the maternity facility which takes into account up to date research into infant formula products and health and safety considerations (Appendix 1). This is particularly relevant in the NICU environment.
- 6.12 WCH is committed to ensuring that any branding relating to infant formula products is not visible, as prescribed by the BFHI, but also appreciates that parents are entitled to enquire about infant formula products their babies are consuming and to have that information provided to them on their request, on an individual basis (Appendix 1).

STEP 7 Practice rooming-in – allow mothers and well babies to remain together for twenty-four hours a day.**All mothers with babies in the postnatal wards should have their babies with them in their rooms.****Whakamahia te tikanga nohotahi ā te kōkā mē tana pēpi i rūma kotahi, mō te rua tekau mā whā hāora ia rangi.**

- 7.1 There should be no routine delays between birth and continuous mother-baby contact for healthy mothers and their well/term babies.
- 7.2 Wherever possible baby examinations or procedures should be conducted in the mother's postnatal room with the mother present. If a baby is removed from the mother's room the mother should have the option of going with the baby for the medical procedure and this should only be for a period of one hour only.
- 7.3 Mother-baby closeness and contact are associated with positive early breastfeeding outcomes.^{117 118 119 120 121}
- 7.4 There are no reported adverse consequences related to rooming-in practices in maternity facilities.
- 7.5 When mothers are with their babies in a rooming-in situation this enables responsiveness to early baby feeding cues.
- 7.6 When babies are separated from their mothers due to illness of the mother or the baby, rooming-in should commence as soon as possible.
- 7.7 Mother-baby contact and non-separation alleviates anxiety in mothers and babies.¹²²
- 7.8 Mother-baby attachment is promoted and supported by enabling the mother and baby to stay together.^{123 124 125}
- 7.9 Baby exposure to the mother's breast aromas and pheromones is positively associated with not only lactation onset, but improved baby arousal and motor activity which reinforce latching and suckling behaviours.^{126 127 128 129}
- 7.10 Mother-baby separation which is either prolonged or intermittent may lead to lack of baby feeding responsiveness.¹³⁰
- 7.11 Rooming-in practices are positively associated with an increase in intestinal colonisation of babies with maternal micro-organisms rather than potentially pathogenic strains.¹³¹
- 7.12 Rooming-in is associated with a significant decrease in the need for treatment of neonatal abstinence syndrome.¹³²

STEP 8 Encourage breastfeeding that is responsive to a babies early feeding cues. Ensure that all mothers recognise early baby feeding cues and know when their babies are effectively breastfeeding.**Whāngai te pēpi taua wā tonu e tangi kai ana.**

- 8.1 Baby-led responsive or cue based breastfeeding is encouraged. Breastmilk production directly reflects baby breastfeeding behaviours and appetite,^{133 134 135} and restricting feeds or using prescriptive routines may result in a lactation insufficiency and compromised breastfeeding and baby outcomes.

- 8.2 Breastfeeding schedules and enforced feeding routines may lead to breastfeeding problems and insufficient milk supply.^{136 137}
- 8.3 All mothers, including mothers who have had caesarean births, are advised to breastfeed their babies when they display a readiness to feed. All mothers, including mothers who have had caesarean births, are informed about baby hunger cues and how to recognise early cues (Appendix 15).
- 8.4 Latching a crying baby on the breast is difficult, particularly for first time mothers in the early post-birth period. Utilising early feeding cues may assist in avoiding this occurrence.¹³⁸
- 8.5 Traumatised nipples in the mother, who is establishing breastfeeding, are not caused by frequent breastfeeding or duration of suckling, but mainly by incorrect attachment at the breast, or by removing the baby from the breast incorrectly.^{139 140 141}
- 8.6 Signs of effective breastfeeding must be assessed by a midwife, nurse or Lactation Consultant and mothers informed about how to recognise breastfeeding effectiveness (Appendix 20).
- 8.7 Observing a breastfeed in its entirety and methodically appraising the breastfeed contributes to breastfeeding success and meets maternal expectations and satisfaction with feeding support.^{142 143 144 145}
- 8.8 Evidence shows that informing mothers about their baby's individual cues makes a positive difference to adaptive mothering behaviours and mother sensitivity to baby cues.^{146 147}
- 8.9 Midwives, nurses and Lactation Consultants do not place restrictions on the frequency or duration of effective breastfeeds in well babies.
- 8.10 Mothers are encouraged to rouse their well babies for feeding if their breasts become overfull. If a baby is disinterested in breastfeeding the mother will be advised to hand express sufficient breastmilk to achieve breast comfort (Appendix 12).
- 8.11 Mothers with babies in the NICU will also be informed about early feeding cues to enable them to recognise when their babies are showing interest in feeding.
- 8.12 Mothers with babies in the NICU will also be informed about how to recognise effective breastfeeding (Appendix 20).

STEP 9 Give no artificial teats or pacifiers (also called dummies or soothers) to breastfeeding babies.

Policies and/or guidelines are available for the use of alternative feeding methods (Appendix 9), pacifier use and non-nutritive sucking in NICU (Appendix 21), and nipple shields (Appendix 22).

Tohutohu ngā kōkā, kaua e hōatu tētahitūmomo tītī tāwhaiwhai, ki ngā pēpi kai ū.

- 9.1 Midwives, nurses and Lactation Consultants working with breastfeeding mothers of well babies will try and prevent situations where alternative feeding methods become necessary.¹⁴⁸
- 9.2 Mothers of well babies who may be at risk for breastfeeding difficulties and lactation delay will be given extra support during their

postnatal stay in an attempt to avoid the necessity of alternative feeding interventions (Appendix 11).

- 9.3 When an alternative feeding method to breastfeeding becomes necessary, decisions regarding the method of feeding will be made on an individual basis in a breastfeeding supportive and protective way wherever possible.¹⁴⁹ Decisions about alternative feeding methods will be made with the full informed consent of the mother (Appendix 9).
- 9.4 Methods of alternative feeding that provide breastfeeding experiences for the baby such as a supplementary feeding tubes SFT (nasogastric tubes) or a nipple shield (See Appendix 9 for alternative feeding methods and Appendix 22 for appropriate indications for nipple shield use) may be appropriate if the mother is available and the baby is able to breastfeed. A supplementary feeding line may be useful in situations where delayed lactation is the challenge and the baby is able to latch at the breast.¹⁵⁰
- 9.5 Nipple shields used appropriately can be a useful tool in maintaining breastfeeding when other techniques have not been effective.^{151 152 153} However, they should be used with caution, and with ongoing assessment of breastfeeding and the mother and baby. Nipple shield guidelines are provided for staff and mothers. Nipple shields are used with the full informed consent of the mother (Appendix 22).
- 9.6 Evidence indicates that nipple shields may be useful in transitioning some preterm babies from tube feeding to breastfeeding and they may be utilised as an aid to latching, maintaining a latch at the breast and improving milk transfer.^{154 155 156}
- 9.7 If the mother is not available or the baby is unable to breastfeed effectively, factors such as gestational age, baby medical condition and how long an alternative method of feeding will be necessary require consideration, as does mother/parental consent.
- 9.8 Breastfeeding babies should be introduced to breastfeeding before any other oral feeding method is used whenever possible (See references 150-162).
- 9.9 To fully support and protect breastfeeding, bottle-feeding and pacifiers should be avoided in term babies who are well and who are establishing breastfeeding.^{157 158 159}
- 9.10 Bottle-feeding and pacifier usage are potentially associated with shortened duration of breastfeeding due to reducing suckling time at the breast, resulting in a risk of insufficient lactation.^{160 161}
- 9.11 Teats and pacifiers have been associated with infection in the neonate.^{162 163}
- 9.12 Pacifier use during the first four weeks following birth is associated with a decrease in the rates of exclusive breastfeeding at one month of age.¹⁶⁴
- 9.13 Daily pacifier use is associated with a reduced duration of exclusive breastfeeding. It is recognised that this is a controversial topic with conflicting research available,¹⁶⁵ but to fully support the principles and spirit of the BFHI and to protect potentially longer durations of

breastfeeding, pacifiers are not available in CWH, except for in neonatal services.

- 9.14 Evidence indicates that bottle-feeding with infant formula and the use of pacifiers is related to an earlier return to menses and therefore reduced lactation amenorrhoea in breastfeeding mothers.¹⁶⁶
- 9.15 Pacifiers, used in a developmentally and breastfeeding supportive way, to provide non-nutritive sucking for preterm babies are appropriate in the neonatal intensive care unit.^{167 168} Evidence indicates that the non-nutritive sucking experience is beneficial for preterm baby development.^{169 170 171 172 173} (Appendix 21)
- 9.16 Pacifiers used to soothe and calm babies in the NICU who are unable to take oral fluids by mouth, due to a medical or surgical condition or other clinical condition, are appropriate.^{174 175 176} However, if possible, skin to skin contact or contact between the baby and the mother or father is recommended as another potential option for soothing (Appendix 10).
- 9.17 If breastfeeding mothers request a feed to be given by bottle and teat an informed consent process must be used at all times.
- 9.18 If a breastfeeding baby is using a pacifier, information will be given to the mother regarding the potential negative effects of pacifier usage on breastfeeding. Staff will not give pacifiers to well, full term breastfeeding babies.

STEP 10 Foster the establishment of breastfeeding support groups and refer mothers to them when they leave the maternity facility.

Tautoko ngā rōpū whakahaere, ūkaipō, ka whakaatu hoki ki ngā kōkā kei whea rātou, nā puta atu ana ki waho o te hōpihera.

- 10.1 Staff will discuss feeding plans with mothers before they leave the facility and follow up support for breastfeeding will be provided by either the facility or the LMC (Lead Maternity Carer).
- 10.2 All mothers will be given information about personally and culturally (when available) appropriate breastfeeding support groups in the community. WCH recognise the importance of good liaison between the maternity facility and health professional and voluntary breastfeeding, peer counsellors, child health support groups and community health services.¹⁷⁷
- 10.3 Mothers may be referred to appropriate support groups verbally and also must be given up to date written information. Contact details of support groups will be regularly checked and updated to ensure correct information is always given to mothers. Contact details for breastfeeding support groups will also be displayed in public areas in WCH.
- 10.4 Evidence indicates that community based support for mothers and breastfeeding results in a longer duration of breastfeeding.^{178 179 180 181 182}
- 10.5 Evidence indicates that mother to mother support and peer support for breastfeeding results in mother satisfaction and a longer duration of breastfeeding.^{183 184 185 186 187 188 189}

- 10.6 External providers of support and counselling for breastfeeding mothers are welcome throughout the WCH division. These providers may be voluntary or professional.
- 10.7 Wherever possible family/whanāu members will be included in breastfeeding education and mother support information. It is recognised that partners and significant others play a role in decisions related to infant feeding and in support for breastfeeding women.¹⁹⁰
191 192
- 10.8 Breastfeeding mothers who are visitors to WCH are welcome to breastfeed in the public areas within WCH and a private room with comfortable facilities is also provided for mothers' use on the ground floor of CWH within the Maternity Outpatient's Department.

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