



Complete Summary

GUIDELINE TITLE

Model breastfeeding policy.

BIBLIOGRAPHIC SOURCE(S)

Academy of Breastfeeding Medicine Protocol Committee. ABM clinical protocol #7: model breastfeeding policy. Breastfeed Med 2007 Mar;2(1):50-5. [22 references]
[PubMed](#)

GUIDELINE STATUS

This is the current release of the guideline.

COMPLETE SUMMARY CONTENT

SCOPE
METHODOLOGY - including Rating Scheme and Cost Analysis
RECOMMENDATIONS
EVIDENCE SUPPORTING THE RECOMMENDATIONS
BENEFITS/HARMS OF IMPLEMENTING THE GUIDELINE RECOMMENDATIONS
CONTRAINDICATIONS
QUALIFYING STATEMENTS
IMPLEMENTATION OF THE GUIDELINE
INSTITUTE OF MEDICINE (IOM) NATIONAL HEALTHCARE QUALITY REPORT
CATEGORIES
IDENTIFYING INFORMATION AND AVAILABILITY
DISCLAIMER

SCOPE

DISEASE/CONDITION(S)

Infant health/nutrition

GUIDELINE CATEGORY

Counseling
Evaluation
Management
Prevention
Risk Assessment

CLINICAL SPECIALTY

Family Practice
Nutrition
Obstetrics and Gynecology
Pediatrics
Preventive Medicine

INTENDED USERS

Advanced Practice Nurses
Allied Health Personnel
Nurses
Physician Assistants
Physicians

GUIDELINE OBJECTIVE(S)

- To facilitate optimal breastfeeding practices
- To promote a philosophy of maternal infant care that advocates breastfeeding and supports the normal physiological functions involved in the establishment of this maternal infant process
- To assist families choosing to breastfeed with initiating and developing a successful and satisfying experience

TARGET POPULATION

All pregnant women and their support people, new mothers and their healthy, term infants

INTERVENTIONS AND PRACTICES CONSIDERED

1. Active support of breastfeeding as the preferred method of providing nutrition to infants, including establishment of multidisciplinary team to identify and eliminate institutional barriers to breastfeeding
2. Establishment of a written breastfeeding policy
3. Education and counseling of all pregnant women, including information on latch and positioning, nutritive suckling, milk production, frequency of feedings and feeding cues, expression of milk, assessment of infant nourishment, and reasons to contact the clinician
4. Documentation of breastfeeding
5. Skin-to-skin contact and initiation of breastfeeding soon after birth
6. Encouragement of rooming in
7. Assessment of feeding at each shift
8. Referral to a lactation consultant or specialist, if necessary
9. Use of supplemental feedings only if specifically ordered or requested
10. Alternative feeding methods (syringe or spoon feeding), when necessary
11. Avoidance of pacifier use (unless as a method of pain management)
12. Assessment of infant for hypoglycemia and dehydration
13. Use of nipple shields (in conjunction with a lactation consultant)
14. Breast massage and hand expression of colostrums or milk, if no adequate latch within hours
15. Provision of discharge instructions
16. Post-discharge follow-up appointment schedule

17. Provision of information on community breastfeeding resources
18. Management of mothers who are separated from their sick or premature infants
19. Staff development

The following were considered but not recommended: routine glucose monitoring for full-term healthy infants, use of antilactation drugs, and routine use of nipple creams, ointments or other topical preparations.

MAJOR OUTCOMES CONSIDERED

- Breastfeeding initiated within one hour of birth
- Rate of exclusive breast feeding

METHODOLOGY

METHODS USED TO COLLECT/SELECT EVIDENCE

Searches of Electronic Databases

DESCRIPTION OF METHODS USED TO COLLECT/SELECT THE EVIDENCE

An initial search of relevant published articles written in English in the past 20 years in the fields of medicine, psychiatry, psychology, and basic biological science is undertaken for a particular topic. Once the articles are gathered, the papers are evaluated for scientific accuracy and significance.

NUMBER OF SOURCE DOCUMENTS

Not stated

METHODS USED TO ASSESS THE QUALITY AND STRENGTH OF THE EVIDENCE

Expert Consensus (Committee)
Weighting According to a Rating Scheme (Scheme Given)

RATING SCHEME FOR THE STRENGTH OF THE EVIDENCE

Levels of Evidence

I Evidence obtained from at least one properly randomized controlled trial

II-1 Evidence obtained from well-designed controlled trials without randomization

II-2 Evidence obtained from well-designed cohort or case-control analytic studies, preferably from more than one center or research group

II-3 Evidence obtained from multiple time series with or without the intervention. Dramatic results in uncontrolled experiments (such as the results of the

introduction of penicillin treatment in the 1940s) could also be regarded as this type of evidence.

III Opinions of respected authorities, based on clinical experience, descriptive studies and case reports; or reports of expert committees

METHODS USED TO ANALYZE THE EVIDENCE

Systematic Review

DESCRIPTION OF THE METHODS USED TO ANALYZE THE EVIDENCE

An expert panel is identified and appointed to develop a draft protocol using evidence based methodology. An annotated bibliography (literature review), including salient gaps in the literature, are submitted by the expert panel to the Protocol Committee.

METHODS USED TO FORMULATE THE RECOMMENDATIONS

Expert Consensus

DESCRIPTION OF METHODS USED TO FORMULATE THE RECOMMENDATIONS

Not stated

RATING SCHEME FOR THE STRENGTH OF THE RECOMMENDATIONS

Not applicable

COST ANALYSIS

A formal cost analysis was not performed and published cost analyses were not reviewed.

METHOD OF GUIDELINE VALIDATION

External Peer Review
Internal Peer Review

DESCRIPTION OF METHOD OF GUIDELINE VALIDATION

Draft protocol is peer reviewed by individuals outside of lead author/expert panel, including specific review for international applicability. Protocol Committee's subgroup of international experts recommends appropriate international reviewers. Chair (co-chairs) institutes and facilitates process. Reviews submitted to committee Chair (co-chairs).

Draft protocol is submitted to The Academy of Breastfeeding Medicine (ABM) Board for review and approval. Comments for revision will be accepted for three

weeks following submission. Chair (co-chairs) and protocol author(s) amends protocol as needed.

Following all revisions, protocol has final review by original author(s) to make final suggestions and ascertain whether to maintain lead authorship.

Final protocol is submitted to the Board of Directors of ABM for approval.

RECOMMENDATIONS

MAJOR RECOMMENDATIONS

Policy Statements

1. "*Name of institution*" staff will actively support breastfeeding as the preferred method of providing nutrition to infants. A multidisciplinary, culturally appropriate team comprising hospital administrators, physician and nursing staff, lactation consultants and specialists, nutrition staff, parents, and other appropriate staff shall be established and maintained to identify and eliminate institutional barriers to breastfeeding. On a yearly basis, this group will compile and evaluate data relevant to breastfeeding support services and formulate a plan of action to implement needed changes.
2. A written breastfeeding policy will be developed and communicated to all health care staff. The "*name of institution*" breastfeeding policy will be reviewed and updated routinely (biannually) using current research as an evidence-based guide.
3. All pregnant women and their support people as appropriate will be provided with information on breastfeeding and counseled on the benefits of breastfeeding, contraindications to breastfeeding, and risk of formula feeding.
4. The woman's desire to breastfeed will be documented in her medical record.
5. Mothers will be encouraged to exclusively breastfeed unless medically contraindicated. The method of feeding will be documented in the medical record of every infant.
 - Exclusive breastfeeding is defined as providing breast milk as the sole source of nutrition. Exclusively breastfed babies receive no other liquids or solids.
6. At birth or soon thereafter all newborns, if baby and mother are stable, will be placed skin-to-skin with the mother. Skin-to-skin contact involves placing the naked baby prone on the mother's bare chest. Mother-infant couples will be given the opportunity to initiate breastfeeding within 1 hour of birth. Post-Cesarean-birth babies will be encouraged to breastfeed as soon as possible. The administration of vitamin K and prophylactic antibiotics to prevent ophthalmia neonatorum should be delayed for the first hour after birth to allow uninterrupted mother infant contact and breastfeeding (Protocol Committee Academy of Breastfeeding Medicine, "Clinical Protocol #3," 2002).
7. Breastfeeding mother-infant couples will be encouraged to remain together throughout their hospital stay, including at night (rooming-in). Skin-to-skin contact will be encouraged as much as possible.
8. Breastfeeding assessment, teaching, and documentation will be done on each shift and whenever possible with each staff contact with the mother. After each feeding, staff will document information about the feeding in the infant's

medical record. This documentation may include the latch, position, and any problems encountered. For feedings not directly observed, maternal report may be used. Every shift, a direct observation of the baby's position and latch-on during feeding will be performed and documented.

9. Mothers will be encouraged to utilize available breastfeeding resources including classes, written materials, and video presentations, as appropriate. If clinically indicated, the clinician or nurse will make a referral to a lactation consultant or specialist.
10. Breastfeeding mothers will be instructed about:
 - Proper positioning and latch on
 - Nutritive suckling and swallowing
 - Milk production and release
 - Frequency of feeding/feeding cues
 - Expression of breast milk and use of a pump if indicated
 - How to assess if infant is adequately nourished
 - Reasons for contacting the clinician

These skills will be taught to primiparous and multiparous women and reviewed before the mother goes home.

11. Parents will be taught that breastfeeding infants, including cesarean-birth babies, should be put to breast at least 8 to 12 times each 24 hours. Infant feeding cues (such as increased alertness or activity, mouthing, or rooting,) will be used as indicators of the baby's readiness for feeding. Breastfeeding babies will be breastfed at night.
12. Time limits for breastfeeding on each side will be avoided. Infants can be offered both breasts at each feeding but may be interested in feeding only on one side at a feeding during the early days.
13. No supplemental water, glucose water, or formula will be given unless specifically ordered by a physician or nurse practitioner or by the mother's documented and informed request. Prior to nonmedically indicated supplementation, mothers will be informed of the risks of supplementing. The supplement should be fed to the baby by cup if possible and will be no more than 10 to 15 mL in a term baby (Howard et al., 2003; Howard et al., 1999; Marinelli, Burke, & Dodd, 2001). Alternative feeding methods such as syringe or spoon feeding may also be used; however, these methods have not been shown to be effective in preserving breastfeeding. Bottles will not be placed in a breastfeeding infant's bassinet.
14. This institution does not give group instruction in the use of formula. Those parents who, after appropriate counseling, choose to formula feed their infants will be provided individual instruction.
15. Pacifiers will not be given to normal full-term breastfeeding infants. The pacifier guidelines at "*name of institution*" state that preterm infants in the Neonatal Intensive Care or Special Care Unit or infants with specific medical conditions may be given pacifiers for non-nutritive sucking. Newborns undergoing painful procedures (circumcision, for example) may be given a pacifier as a method of pain management during the procedure. The infant will not return to the mother with the pacifier. "*Name of institution*" encourages "pain-free newborn care," which may include breastfeeding during the heel stick procedure for the newborn metabolic screening tests.
16. Routine blood glucose monitoring of full-term healthy appropriate for gestational age (AGA) infants is not indicated. Assessment for clinical signs of

- hypoglycemia and dehydration will be ongoing (Protocol Committee Academy of Breastfeeding Medicine, "Protocol #1," 1999).
17. Antilactation drugs will not be given to any postpartum mother.
 18. Routine use of nipple creams, ointments, or other topical preparations will be avoided unless such therapy has been indicated for a dermatological problem. Mothers with sore nipples will be observed for latch-on techniques and will be instructed to apply expressed colostrum or breast milk to the areola after each feeding.
 19. Nipple shields or bottle nipples will not be routinely used to cover a mother's nipple to treat latch-on problems or prevent or manage sore or cracked nipples or when a mother has flat or inverted nipples. Nipple shields will be used only in conjunction with a lactation consultation.
 20. After 24 hours of life, if the infant has not latched on or fed effectively, the mother will be instructed to begin breast massage and hand expression of colostrum into the baby's mouth during feeding attempts. Skin-to-skin contact will be encouraged. (Parents will be instructed to watch closely for feeding cues and whenever these are observed to awaken and feed the infant.) If the baby continues to feed poorly, pumping with skilled hand expression or a double set-up electric breast pump will be initiated and maintained approximately every 3 hours or a minimum of eight times per day. Any expressed colostrum or mother's milk will be fed to the baby by an alternative method. The mother will be reminded that she may not obtain much milk or even any milk the first few times she pumps her breasts. Until the mother's milk is available, a collaborative decision should be made among the mother, nurse, and clinician regarding the need to supplement the baby. Each day clinicians will be consulted regarding the volume and type of the supplement. Pacifiers will be avoided. In cases of problem feeding, the lactation consultant or specialist will be consulted (Protocol Committee Academy of Breastfeeding Medicine, "Clinical Protocol #3," 2002).
 21. If the baby is still not latching on well or feeding well when going home, the feeding/pumping/supplementing plan will be reviewed in addition to routine breastfeeding instructions. A follow-up visit or contact will be scheduled within 24 hours. Depending on the clinical situation it may be appropriate to delay discharge of the couplet to provide further breastfeeding intervention, support, and education.
 22. All babies should be seen for follow-up within the first few days postpartum. This visit should be with a pediatrician or other qualified health care practitioner for a formal evaluation of breastfeeding performance, a weight check, assessment of jaundice and age appropriate elimination:
 - For infants discharged at less than 2 days of age (<48 hours): Follow-up at 2 to 4 days of age
 - For infants discharged at more than 2 days of age (>48 hours): Follow-up at 4 to 5 days of age
 - All newborns should be seen by 1 month of age.
 23. Mothers who are separated from their sick or premature infants will be
 - Instructed on how to use skilled hand expression or the double set up electric breast pump—instructions will include expression at least eight times per day or approximately every 3 hours for 15 minutes (or until milk flow stops, whichever is greater) around the clock and the importance of not missing a pumping session during the night
 - Encouraged to breastfeed on demand as soon as the infant's condition permits
 - Taught proper storage and labeling of human milk

- Assisted in learning skilled hand expression or obtaining a double set up electric breast pump prior to going home
24. Before leaving the hospital, (Protocol Committee Academy of Breastfeeding Medicine, "Clinical Protocol #2," 2002) breastfeeding mothers should be able to:
- Position the baby correctly at the breast with no pain during the feeding
 - Latch the baby to breast properly
 - State when the baby is swallowing milk
 - State that the baby should be nursed approximately 8 to 12 times every 24 hours until satiety
 - State age-appropriate elimination patterns (at least six urinations per day and three to four stools per day by the fourth day of life)
 - List indications for calling a clinician
 - Manually express milk from their breasts
25. Prior to going home, mothers will be given the names and telephone numbers of community resources to contact for help with breastfeeding, including (the support group or resource recommended by "*name of institution*").
26. "*Name of institution*" does not accept free formula or free breast milk substitutes. Nursery or neonatal intensive care unit (NICU) discharge bags offered to all mothers will not contain infant formula, coupons for formula, logos of formula companies, or literature with formula company logos.
27. "*Name of institution*" health professionals will attend educational sessions on lactation management and breastfeeding promotion to ensure that correct, current, and consistent information is provided to all mothers wishing to breastfeed.

CLINICAL ALGORITHM(S)

None provided

EVIDENCE SUPPORTING THE RECOMMENDATIONS

REFERENCES SUPPORTING THE RECOMMENDATIONS

[References open in a new window](#)

TYPE OF EVIDENCE SUPPORTING THE RECOMMENDATIONS

The type of evidence supporting the recommendations is not specifically stated.

This policy is based on recommendations from the most recent breastfeeding policy statements published by the Office on Women's Health of the U.S. Department of Health and Human Services, the American Academy of Pediatrics, the American College of Obstetricians and Gynecologists, the American Academy of Family Physicians, the World Health Organization, the American Dietetic Association, and the Academy of Breastfeeding Medicine, and the UNICEF/WHO evidence-based "Ten Steps to Successful Breastfeeding."

The recommendations were based primarily on a comprehensive review of the existing literature. In cases where the literature does not appear conclusive, recommendations were based on the consensus opinion of the group of experts.

BENEFITS/HARMS OF IMPLEMENTING THE GUIDELINE RECOMMENDATIONS

POTENTIAL BENEFITS

Improved breastfeeding outcomes for mothers and infants

POTENTIAL HARMS

Not stated

CONTRAINDICATIONS

CONTRAINDICATIONS

Breastfeeding is contraindicated in the following situations:

- Human immunodeficiency virus (HIV)-positive mother in developed countries (e.g., United States, Europe)
- Mother using illicit drugs (for example, cocaine, heroin) unless specifically approved by the infant's health care provider on a case by case basis
- A mother taking certain medications. Although most prescribed and over-the-counter drugs are safe for the breastfeeding infant, some medications may make it necessary to interrupt breastfeeding. These include radioactive isotopes, antimetabolites, cancer chemotherapy, and a small number of other medications.
- Mother has active, untreated tuberculosis
- Infant has galactosemia
- Mother has active herpetic lesions on her breast(s)—breastfeeding can be recommended on the unaffected breast (the Infectious Disease Service will be consulted for problematic infectious disease issues.)
- Mother with varicella that is determined to be infectious to the infant
- Mother has human T-cell leukemia virus type 1 (HTLV1)

QUALIFYING STATEMENTS

QUALIFYING STATEMENTS

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.

IMPLEMENTATION OF THE GUIDELINE

DESCRIPTION OF IMPLEMENTATION STRATEGY

An implementation strategy was not provided.

INSTITUTE OF MEDICINE (IOM) NATIONAL HEALTHCARE QUALITY REPORT CATEGORIES

IOM CARE NEED

Staying Healthy

IOM DOMAIN

Effectiveness
Patient-centeredness

IDENTIFYING INFORMATION AND AVAILABILITY

BIBLIOGRAPHIC SOURCE(S)

Academy of Breastfeeding Medicine Protocol Committee. ABM clinical protocol #7: model breastfeeding policy. Breastfeed Med 2007 Mar;2(1):50-5. [22 references]
[PubMed](#)

ADAPTATION

This guideline was partially adapted from the following sources:

- U.S. Department of Health and Human Services. HHS Blueprint for Action on Breastfeeding. U.S. Department of Health and Human Services, Office on Women's Health, Washington, DC, 2000.
- The American Academy of Pediatrics, Work Group on Breastfeeding. Breastfeeding and the use of human milk. Pediatrics 1997;100:1035–1039.
- American College of Obstetricians and Gynecologists and Committees on Health Care for Underserved Women and Obstetric Practice, Queenan JT (ed). Breastfeeding: Maternal and Infant Aspects. ACOG Educational Bulletin. The American College of Obstetricians and Gynecologists, Washington, DC, 2000.
- The American Academy of Family Physicians. Family Physicians Supporting Breastfeeding: Breastfeeding Position Paper 2002. The American Academy of Family Physicians. Compendium of AAFP positions on selected health issues. The American Academy of Family Physicians, Kansas City, MO, 2002. Available at: <http://www.aafp.org/online/en/home/policy/policies/b/breastfeedingpositionpaper.html>.
- World Health Organization, United Nations Children's Fund. Protecting, promoting and supporting breastfeeding: The special role of maternity services (A joint WHO/UNICEF statement). Int J Gynecol Obstet 1990;31:171–183.

- Position of the American Dietetic Association. Breaking the barriers to breastfeeding. J Am Diet Assoc 2001;01:1213–1220.
- Academy of Breastfeeding Medicine Board of Directors. ABM Mission Statement, 2003. Available at: www.bfmed.org.
- WHO/UNICEF Joint Statement. Meeting on Infant and Young Child Feeding. J Nurse-Midwifery 1980;25: 31–38.
- World Health Organization and United Nations Children's Fund. Innocenti Declaration on the Protection, Promotion and Support of Breastfeeding. UNICEF, New York, 1990.

DATE RELEASED

2004 (published 2007)

GUIDELINE DEVELOPER(S)

Academy of Breastfeeding Medicine - Professional Association

SOURCE(S) OF FUNDING

Academy of Breastfeeding Medicine

A grant from the Maternal and Child Health Bureau, US Department of Health and Human Services

GUIDELINE COMMITTEE

Academy of Breastfeeding Medicine Protocol Committee

COMPOSITION OF GROUP THAT AUTHORED THE GUIDELINE

Committee Members: Caroline J. Chantry, MD, FABM (Co-Chairperson); Cynthia R. Howard, MD, MPH, FABM (Co-Chairperson); *Barbara L. Philipp MD, IBCLC, FABM

**Lead author(s)*

FINANCIAL DISCLOSURES/CONFLICTS OF INTEREST

None to report

GUIDELINE STATUS

This is the current release of the guideline.

GUIDELINE AVAILABILITY

Electronic copies: Available in Portable Document Format (PDF) from the [Academy of Breastfeeding Medicine Web site](#).

Print copies: Available from the Academy of Breastfeeding Medicine, 140 Huguenot Street, 3rd floor, New Rochelle, New York 10801.

AVAILABILITY OF COMPANION DOCUMENTS

The following is available:

- Procedure for protocol development and approval. Academy of Breastfeeding Medicine. 2007 Mar. 2 p.

Print copies: Available from the Academy of Breastfeeding Medicine, 140 Huguenot Street, 3rd floor, New Rochelle, New York 10801.

PATIENT RESOURCES

None available

NGC STATUS

This NGC summary was completed by ECRI Institute on October 30, 2007. The information was verified by the guideline developer on November 12, 2008.

COPYRIGHT STATEMENT

This NGC summary is based on the original guideline, which is subject to the guideline developer's copyright restrictions.

Single copies may be downloaded for personal use. Copyright permission to be requested for use of multiple copies by e-mailing requests to abm@bfmed.org. An official request form will be sent electronically to person requesting multiple copy use.

DISCLAIMER

NGC DISCLAIMER

The National Guideline Clearinghouse™ (NGC) does not develop, produce, approve, or endorse the guidelines represented on this site.

All guidelines summarized by NGC and hosted on our site are produced under the auspices of medical specialty societies, relevant professional associations, public or private organizations, other government agencies, health care organizations or plans, and similar entities.

Guidelines represented on the NGC Web site are submitted by guideline developers, and are screened solely to determine that they meet the NGC Inclusion Criteria which may be found at <http://www.guideline.gov/about/inclusion.aspx>.

NGC, AHRQ, and its contractor ECRI Institute make no warranties concerning the content or clinical efficacy or effectiveness of the clinical practice guidelines and related materials represented on this site. Moreover, the views and opinions of developers or authors of guidelines represented on this site do not necessarily state or reflect those of NGC, AHRQ, or its contractor ECRI Institute, and inclusion or hosting of guidelines in NGC may not be used for advertising or commercial endorsement purposes.

Readers with questions regarding guideline content are directed to contact the guideline developer.

© 1998-2008 National Guideline Clearinghouse

Date Modified: 12/8/2008

