Supporting breastfeeding, one mother and baby at a time

Indira Lopez-Bassols is a lactation consultant with many years experience helping women to breastfeed successfully. Here she discusses some of the most common problems faced by mothers who struggle with breastfeeding and how they can be encouraged and supported to continue

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There are around 26,000 International Board Certified Lactation Consultants (IBCLCs) working around the world today, and approximately 423 of those are in the UK. IBCLCs are health professionals with many years of breastfeeding support and counselling experience, and a background in midwifery, breastfeeding counselling, medicine or health visiting. They have successfully completed a rigorous written examination at degree level, equivalent to a Master's degree in breastfeeding.

In this article I will look at some of the most common problems seen by IBCLCs when women start to breastfeed and explain how these can be overcome with the help of a knowledgeable health professional.

Anita Tiessen, Deputy Executive Director of UNICEF UK, said: 'We know that 90% of women who stop breastfeeding in the first six weeks discontinued before they had wanted to.' One of the biggest challenges we face as IBCLCs is the lack of good-quality breastfeeding support available to women.

The latest Infant Feeding Survey (Heath and Social Care Information Centre, 2012) shows an increase in breastfeeding rates at birth, but the figures after this fall dramatically. Across the UK 69% of mothers were exclusively breastfeeding at birth in 2010. At one week, less than half of all mothers (46%) were exclusively breastfeeding, and this had fallen to around a quarter (23%) by six weeks. By six months, levels of exclusive breastfeeding had decreased to 1%, indicating that very few mothers were following the UK Departments of Health and the World Heath Organisation (WHO) recommendations that babies should be exclusively breastfed until around the age of six months.

Another important challenge we face is helping mothers to find clarity in a sea of confusing information and advice. I have supported breastfeeding mothers who have been told contradictory things in the same postnatal ward from different professionals on different shifts, on the same day. *Guardian* journalist Annalisa Barbieri said recently: 'I got wildly conflicting breastfeeding advice from 12 midwives' (Barbieri, 2013).

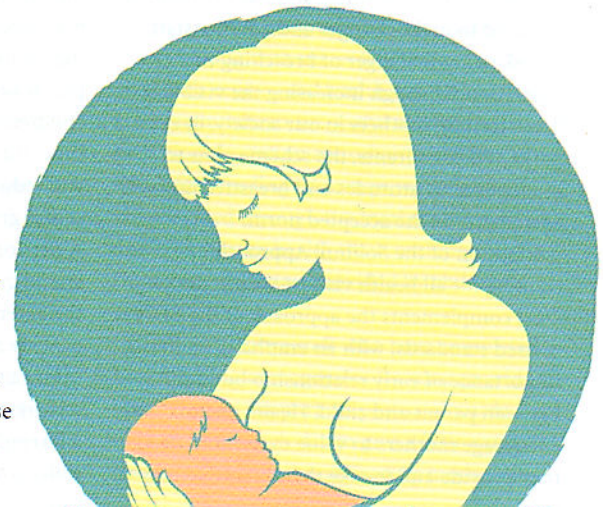
The following points are a few examples from my day-to-day practice that reflect all of the contradictory information breastfeeding mothers report they have been given.

'At risk' mothers

Women who have had past breast surgeries (reduction or augmentation), hypoplastic breasts or other health conditions that may require extra monitoring in the early days or weeks should be identified in pregnancy and signposted. They need extra information to help them best prepare for breastfeeding because they can sometimes have supply issues. If they are given the right information they can prepare antenatally (antenatal expression of colostrum, for example) or once they have had their baby (through use of galactogogues, substances that help increase milk production).

Myths surrounding 'attachment and positioning'

I have heard too many of these. In a nutshell, a 'good looking' latch does not necessarily mean that the baby is transferring milk effectively. We need to observe a full feed to make sure milk transfer is effective. Too many breastfeeding mothers are told to 'just get on with the pain'. However, pain is not normal; it is the body's natural mechanism trying to express that some adjustment is needed or that something else is going on, so more detective work is needed to find out what is causing it. It is helpful to spend more time with the mother to help her adjust the latch and work on position and attachment



in order to get the nipple into the baby's soft palate or 'comfort zone'.

Five day weight check

In the first few days women are advised to feed on demand – but it is more important to make sure there is optimal milk transfer. Professionals should be vigilant and be able to give parents suggestions to help arouse a sleepy baby and count nappy output, mainly to avoid problems with the 5 days routine weight check. During the weight check it is worth taking into account fluid intake during labour. That fluid intake could affect the baby's weight and cause a sudden loss after birth of more than 10%.

Formula or EBM supplementation

Too often breastfeeding mothers are told that their baby needs a top-up because they are not getting enough milk and are not putting on the desired weight. Sadly, too often they are advised to top up with formula. Breast milk should always be the number one recommendation and women should be advised to start expressing to top up with their own milk. This is the most breastfeeding friendly way to top up a baby in need, without compromising the mother's supply. This is crucial in the first two to three weeks as research has shown that prolactin receptors are primed and these are correlated to optimal milk supply.

It is also important to have a basic understanding of the size of a newborn baby's stomach at this point in their development. If supplementation is really needed in the first day or so it is better to start off with 5 ml/7 ml (day 1) and then gradually augment to higher quantities, such as 22/27 ml (day 3). Many parents of newborns are advised to start topping up with formula in hospital in quantities that are too great for these tiny babies' stomachs to process.

It is very simple to send parents home with formula, but it is crucial to give them ongoing support to help them transition to the breast fully, if they want to. This can be done gradually, by decreasing the amount of formula, adding more breastfeeds per day and using breast compression to maximise milk transfer. This does take time and support but mothers who are exclusively breastfeeding stand a higher chance of continuing with breastfeeding. Mothers who are doing daily pumping/expressing and topping up with formula are more likely to give up quicker as it so exhausting.

Medications

Many health professionals do not know enough about mothers using medications while breastfeeding and advise mothers to stop breastfeeding temporarily or wean their babies. The reality is that it is not always needed, as many medications are safe and compatible with breastfeeding. Every hospital and GP surgery should have the latest edition of Medications and Mothers' Milk by Thomas Hale and be able to sign post breastfeeding mothers to Wendy Jones' fantastic website: www.breastfeedingnetwork.org.uk

Nipple shields

I have supported too many breastfeeding mothers who have been advised to use nipple shields, with or without a truly valid reason. Nipple shields should never be the first recourse in problems with latch and positioning because they are not solving the problem but masking it. From our basic understanding of the anatomy of breastfeeding, babies do not 'nipple feed' they 'breastfeed' – so if they are able to get a deep latch they will be able to transfer milk optimally. What is even more important is that if a breastfeeding mother has been using nipple shields she is then helped to transition back to the breast fully. This will take time, patience and perseverance but it can be done.

Tongue-tie

According to the National Institute for Health and Clinical Excellence (NICE) guidelines, ankyloglossia (also known as tongue-tie) is a congenital anomaly characterised by an abnormally short lingual frenulum. Breastfeeding difficulties may arise as a result of the baby's inability to suck effectively, causing sore nipples and poor infant weight gain, among other problems. I have supported many breastfeeding mothers who have been told that there is no tongue-tie or that tongue-tie does not impact on breastfeeding, or even bottle-feeding. This is not always the case.

Hand expression

It is unfortunate that the art of hand expression is being lost in current practice. Many pregnant women are not shown how to hand express antenatally, which is sometimes really useful in the first few days. Hand expression has many advantages; for example, if the baby is a bit sleepy, or does not latch, or if there is separation between mother and baby. Being able to hand express a few mls of colostrum in the first hours can be useful to give to the baby via the preferred method. It is free, and you don't need to buy any equipment. Breastfeeding mothers can hand express a little to soften the breast tissue and make attachment easier for the baby. For most mothers it is also very reassuring to be able to see they have colostrum or milk.

Milk substitutes

Recently, a midwife in a London hospital said to a breastfeeding mother in the postnatal ward to give a bottle of water daily to her baby. We know this is not evidence-based practice, as fully breastfed babies need nothing more than breast milk to thrive – and, yet, this type of advice is still given to new breastfeeding mothers.

Conclusion

Building bridges with health professionals will help us all to provide quality, evidence-based and up-to-date breastfeeding support to those mothers who need it. It is crucial that we speak the same breastfeeding language so that, gradually and steadily, we can start to help reverse national breastfeeding trends, supporting one breastfeeding mother and baby at a time.

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