

Recommended Breastfeeding Practices

Excerpted from the 2005 Breastfeeding Policy Statement of the American Academy of Pediatrics

1. Pediatricians and other health care professionals should recommend human milk for all infants in whom breastfeeding is not specifically contraindicated and provide parents with complete, current information on the benefits and techniques of breastfeeding to ensure that their feeding decision is a fully informed one.
 - a. When direct breastfeeding is not possible, expressed human milk should be provided. If a known contraindication to breastfeeding is identified, consider whether the contraindication may be temporary, and if so, advise pumping to maintain milk production. Before advising against breastfeeding or recommending premature weaning, weigh the benefits of breastfeeding against the risks of not receiving human milk.
2. Peripartum policies and practices that optimize breastfeeding initiation and maintenance should be encouraged.
 - a. Education of both parents before and after delivery of the infant is an essential component of successful breastfeeding. Support and encouragement by the father can greatly assist the mother during the initiation process and during subsequent periods when problems arise. Consistent with appropriate care for the mother, minimize or modify the course of maternal medications that have the potential for altering the infant's alertness and feeding behavior. Avoid procedures that may interfere with breastfeeding or that may traumatize the infant, including unnecessary, excessive, and overvigorous suctioning of the oral cavity, esophagus, and airways to avoid oropharyngeal mucosal injury that may lead to aversive feeding behavior.
3. Healthy infants should be placed and remain in direct skin-to-skin contact with their mothers immediately after delivery until the first feeding is accomplished.
 - a. The alert, healthy newborn infant is capable of latching on to a breast without specific assistance within the first hour after birth. Dry the infant, assign Apgar scores, and perform the initial physical assessment while the infant is with the mother. The mother is an optimal heat source for the infant. Delay weighing, measuring, bathing, needle-sticks, and eye prophylaxis until after the first feeding is completed. Infants affected by maternal medications may require assistance for effective latch-on. Except under unusual circumstances, the newborn infant should remain with the mother throughout the recovery period.
4. Supplements (water, glucose water, formula, and other fluids) should not be given to breastfeeding newborn infants unless ordered by a physician when a medical indication exists.
5. Pacifier use is best avoided during the initiation of breastfeeding and used only after breastfeeding is well established.
 - a. In some infants early pacifier use may interfere with establishment of good breastfeeding practices, whereas in others it may indicate the presence of a breastfeeding problem that requires intervention.
 - b. This recommendation does not contraindicate pacifier use for nonnutritive sucking and oral training of premature infants and other special care infants.
6. During the early weeks of breastfeeding, mothers should be encouraged to have 8 to 12 feedings at the breast every 24 hours, offering the breast whenever the infant shows early signs of hunger such as increased alertness, physical activity, mouthing, or rooting.
 - a. Crying is a late indicator of hunger. Appropriate initiation of breastfeeding is facilitated by continuous rooming-in throughout the day and night. The mother should offer both breasts at each feeding for as long a period as the infant remains at the breast. At each feed the first breast offered should be alternated so that both breasts receive equal stimulation and draining. In the early weeks after birth, nondemanding infants should be aroused to feed if 4 hours have elapsed since the beginning of the last feeding.
 - b. After breastfeeding is well established, the frequency of feeding may decline to approximately 8 times per 24 hours, but the infant may increase the frequency again with growth spurts or when an increase in milk volume is desired.
7. Formal evaluation of breastfeeding, including observation of position, latch, and milk transfer, should be undertaken by trained caregivers at least twice daily and fully documented in the record during each day in the hospital after birth.
 - a. Encouraging the mother to record the time and duration of each breastfeeding, as well as urine and stool output during the early days of breastfeeding in the hospital and the first weeks at home, helps to facilitate the evaluation process. Problems identified in the hospital should be addressed at that time, and a documented plan for management should be clearly communicated to both parents and to the medical home.
8. All breastfeeding newborn infants should be seen by a pediatrician or other knowledgeable and experienced health care professional at 3 to 5 days of age as recommended by the AAP.

Recommended Breastfeeding Practices (continued)

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- a. This visit should include infant weight; physical examination, especially for jaundice and hydration; maternal history of breast problems (painful feedings, engorgement); infant elimination patterns (expect 3–5 urines and 3–4 stools per day by 3–5 days of age; 4–6 urines and 3–6 stools per day by 5–7 days of age); and a formal, observed evaluation of breastfeeding, including position, latch, and milk transfer. Weight loss in the infant of greater than 7% from birth weight indicates possible breastfeeding problems and requires more intensive evaluation of breastfeeding and possible intervention to correct problems and improve milk production and transfer.
9. Breastfeeding infants should have a second ambulatory visit at 2 to 3 weeks of age so that the health care professional can monitor weight gain and provide additional support and encouragement to the mother during this critical period.
 10. Pediatricians and parents should be aware that exclusive breastfeeding is sufficient to support optimal growth and development for approximately the first 6 months of life† and provides continuing protection against diarrhea and respiratory tract infection. Breastfeeding should be continued for at least the first year of life and beyond for as long as mutually desired by mother and child.
 - a. Complementary foods rich in iron should be introduced gradually beginning around 6 months of age. Preterm and low birth weight infants and infants with hematologic disorders or infants who had inadequate iron stores at birth generally require iron supplementation before 6 months of age. Iron may be administered while continuing exclusive breastfeeding.
 - b. Unique needs or feeding behaviors of individual infants may indicate a need for introduction of complementary foods as early as 4 months of age, whereas other infants may not be ready to accept other foods until approximately 8 months of age.
 - c. Introduction of complementary feedings before 6 months of age generally does not increase total caloric intake or rate of growth and only substitutes foods that lack the protective components of human milk.
 - d. During the first 6 months of age, even in hot climates, water and juice are unnecessary for breastfed infants and may introduce contaminants or allergens.
 - e. Increased duration of breastfeeding confers significant health and developmental benefits for the child and the mother, especially in delaying return of fertility (thereby promoting optimal intervals between births).
 - f. There is no upper limit to the duration of breastfeeding and no evidence of psychologic or developmental harm from breastfeeding into the third year of life or longer.
 - g. Infants weaned before 12 months of age should not receive cow's milk but should receive iron-fortified infant formula.
11. All breastfed infants should receive 1.0 mg of vitamin K₁ oxide intramuscularly after the first feeding is completed and within the first 6 hours of life.
 - a. Oral vitamin K is not recommended. It may not provide the adequate stores of vitamin K necessary to prevent hemorrhage later in infancy in breastfed infants unless repeated doses are administered during the first 4 months of life.
 12. All breastfed infants should receive 200 IU of oral vitamin D drops daily beginning during the first 2 months of life and continuing until the daily consumption of vitamin D-fortified formula or milk is 500 mL.
 - a. Although human milk contains small amounts of vitamin D, it is not enough to prevent rickets. Exposure of the skin to ultraviolet B wavelengths from sunlight is the usual mechanism for production of vitamin D. However, significant risk of sunburn (short-term) and skin cancer (long-term) attributable to sunlight exposure, especially in younger children, makes it prudent to counsel against exposure to sunlight. Furthermore, sunscreen decreases vitamin D production in skin.
 13. Supplementary fluoride should not be provided during the first 6 months of life.
 - a. From 6 months to 3 years of age, the decision whether to provide fluoride supplementation should be made on the basis of the fluoride concentration in the water supply (fluoride supplementation generally is not needed unless the concentration in the drinking water is <0.3 ppm) and in other food, fluid sources, and toothpaste.
 14. Mother and infant should sleep in proximity to each other to facilitate breastfeeding.
 15. Should hospitalization of the breastfeeding mother or infant be necessary, every effort should be made to maintain breastfeeding, preferably directly, or pumping the breasts and feeding expressed milk if necessary.

SOURCE:

American Academy of Pediatrics Section on Breastfeeding. Breastfeeding and the Use of Human Milk. *Pediatrics*. Feb 2005;115(2): 496-50.