Promoting Exclusive and Extended Breastfeeding

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Disclosure

Neither I, nor any member of my immediate family, have any commercial financial relationships, which relate directly or indirectly, to the content of this presentation.

At the end of the presentation, the learner will be able to:

1. Implement early post-discharge follow-up of nursing dyads to evaluate the successful onset of breastfeeding and ensure timely intervention for problems in the initiation of lactation.
2. Discuss common causes and appropriate management for sore nipples in breastfeeding women.
3. Provide targeted anticipatory guidance and ongoing support to help breastfeeding mothers achieve exclusive breastfeeding recommendations and reach their own breastfeeding goals.

Why Emphasize Exclusive Breastfeeding?

- The health benefits of breastfeeding are dose-related, with exclusive breastfeeding providing the maximum benefits for infants and mothers.
- Exclusive breastfeeding helps mothers establish and maintain an abundant milk supply.
- Supplementing with infant formula is linked with a shorter duration of any breastfeeding.
- Exclusive breastfeeding supports a unique "healthy" gut microbiota.

Breastfeeding Reduces the Risk of Adverse Infant Health Outcomes in a Dose-Response Manner

- Severe lower respiratory tract infections
- Otitis media
- Gastroenteritis
- Necrotizing enterocolitis
- Sudden Infant Death Syndrome
- Asthma, atopic dermatitis, and eczema
- Celiac disease
- Type 1 and type 2 diabetes
- Inflammatory bowel disease
- Adolescent and adult obesity
- Acute lymphocytic and acute myeloid leukemia
- Improved neurologic outcomes

AAP. Pediatr. 2012; 129:e827-e841

Breastfeeding Confers Short- and Long-Term Health Benefits for Mothers

- Cumulative breastfeeding experience is linked with a reduced risk of type 2 diabetes, rheumatoid arthritis, hypertension, hyperlipidemia, cardiovascular disease, breast cancer (predominantly premenopausal) and ovarian cancer in a dose-response manner.

AAP. Pediatr. 2012; 129:e827-e841

- More rapid uterine involution
- Increased child spacing
- Decreased postpartum blood loss
- Higher child abuse/neglect among mothers who do not breastfeed
**Exclusive Breastfeeding Recommendations**

- Exclusive breastfeeding is recommended for about 6 months, with continued breastfeeding through 12 months and beyond, as solid foods are added.  
  AAP. *Pediatrics.* 2012; 129;e827-e841
- In the 2005-2007 Infant Feeding Practices Study II (IFPS II), only 32% of mothers achieved their intended exclusive breastfeeding goal.  
- We have an obligation to reduce the personal and societal barriers that prevent women from beginning and continuing to breastfeed.

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**Healthy People Breastfeeding Objectives**

<table>
<thead>
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<th>Healthy People Breastfeeding Objectives</th>
<th>US and Idaho Breastfeeding Rates</th>
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<tr>
<td>% Breastfeeding at 6 Months</td>
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<tr>
<td>% Breastfeeding at 12 Months</td>
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<td>% Exclusive Breastfeeding at 3 Months</td>
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<td>% Exclusive Breastfeeding at 6 Months</td>
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* Preliminary 2013 data

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**2012 US National Immunization Survey Breastfeeding Rates**

<table>
<thead>
<tr>
<th>Percentage</th>
<th>Black Mothers</th>
<th>White Mothers</th>
<th>Hispanic Mothers</th>
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<tr>
<td>Ever breastfed</td>
<td>66.4%</td>
<td>83%</td>
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<td>55.8%</td>
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<td>16.9%</td>
<td>32.8%</td>
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<td>48.0%</td>
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<tr>
<td>Exclusively breastfed at 6 mos.</td>
<td>13.9%</td>
<td>24.4%</td>
<td>20.8%</td>
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**Racial and Ethnic Disparities in Breastfeeding**

- Mothers with lower breastfeeding rates tend to be young, low-income, AA, unmarried, less educated, on WIC, overweight/obese before pregnancy, and more likely to report unintended pregnancy.
- WIC participation is strongly associated with low rates of breastfeeding initiation and early breastfeeding discontinuation.
- AA women have the lowest rates of breastfeeding initiation and continuation at 6 and 12 months, compared with other US racial/ethnic groups.

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**Racial and Ethnic Breastfeeding Disparities**

- Hispanic breastfeeding rates tend to decrease with greater acculturation.
- Intention to breastfeed is strongly linked with breastfeeding initiation and continuation.
- Women who are encouraged by healthcare professionals are more likely to begin breastfeeding.
- Supportive maternity practices improve breastfeeding outcomes
- Peer counselor interventions are successful in increasing breastfeeding initiation, duration, and exclusivity, & delaying the introduction of solids.

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**The Cultural Practice of “Los Dos”**

- Among low-income Latina women, “Los Dos,” or combination feeding, often is misperceived as offering both the benefits of breastfeeding and the advertised “innovations” in infant formula.
  “I want her to have the formula too because it has vitamins, just in case.”
- Moms get mixed messages through hospital discharge packs and distribution of formula through WIC.
- “Breastfeeding: A Magical Bond of Love”
  https://lovingsupport.fns.usda.gov/content/magical-bond-love-video
The Decision to Breastfeed

Benefits / Barriers

Product / Process

We must not only promote the benefits of human milk, we must partner with expectant mothers to reduce their personal and societal breastfeeding barriers.

The Best Start 3-Step Counseling Strategy

Step 1. Ask an Open-Ended Q
This will probably elicit a mother’s particular barrier to breastfeeding.

Step 2. Affirm Mother’s Concerns
This proves you are listening and normalizes her concerns.

Step 3. Provide Targeted Education Directed at the Mother’s Specific Concerns
This informs, empowers, and reassures the mother.

Optimizing Support for Breastfeeding as Part of Obstetric Practice

- Since lactation is an integral part of reproductive physiology, all OB/GYNs should have skills in anticipatory guidance, breastfeeding physiology, and the management of common lactation concerns.
- The prenatal breast exam can identify surgical scars, as well as widely spaced, tubular breasts that may indicate insufficient glandular tissue.
- The BFHI’s Ten Steps to Successful Breastfeeding should be integrated into maternity care to increase the likelihood that a woman will begin breastfeeding and achieve her personal breastfeeding goals.

Using Motivational and Self-Efficacy Supporting Communication with Prenatal Clients

- What do you know about breastfeeding?
- What are the three most important reasons that you would want to breastfeed?
- What breastfeeding barriers might you encounter?
- What sources of support can you count on?
- On a scale of 1 to 10, how important is breastfeeding to you?
- Why are you at a "5" instead of "4.5"?
- What have you done to prepare for breastfeeding?
- How long would you like to continue breastfeeding?

Breastfeeding Messaging for Prenatal Clients

- "I strongly recommend breastfeeding because of its many health benefits for your baby and you."
- "Exclusive breastfeeding provides the maximum health benefits for your baby and you, and it helps you maintain a plentiful milk supply."
- "Your breasts and nipples appear normal, and the breast growth that you have noticed indicates that your body is preparing to make milk for your baby."
- "Because breastfeeding is a learned art, I encourage all expectant mothers to attend a prenatal breastfeeding class with their partner or support person."

Why Women Stop Breastfeeding

- Many women stop breastfeeding within the first month after giving birth due to:
  - "My baby had trouble sucking or latching on"
  - "I didn’t have enough milk"
  - "Breast milk alone did not satisfy my baby"
  - "My nipples were sore, cracked, or bleeding"
- Concerns about their milk supply and their baby’s dissatisfaction with breast milk alone consistently were cited by mothers as important reasons for weaning, regardless of infant age.

Biological Nurturing (BN)
- British midwife, Dr. Suzanne Colson, has identified BN (semi-reclined positioning with the baby prone and in full close contact with the mother's body) as the optimal positioning to trigger infants' and mothers' reflexive breast-feeding behaviors that help the newborn reach and self-attach to the breast.
- Starting with BN helps babies to transition to upright nursing and maintain a deep latch.
- A book and DVD are available at: www.biologicalnurturing.com

Early Infant Feeding Cues
- Rapid eye movements
- Rousing from sleep
- Increased alertness
- Flexing arms and legs
- Squirming
- Wrinkling the forehead
- Bringing hand to mouth
- Turning the head
- Moving mouth or tongue
- Upset or crying is a late hunger sign

Guidelines for an Effective Latch
- Mother is leading back, comfortable and relaxed.
- Infant is well supported throughout the feeding.
- Infant is elevated to the level of the breast.
- Baby's body is turned to face mom: chest-to-chest, with baby's mouth lined up with Mom's nipple.
- Baby is angled, with head higher than buttocks.
- Support and compress the breast, with fingers and thumb far from the nipple.
- Lightly touch the baby's upper lip with the nipple.
- When infant opens mouth wide, bring her to breast.

Common Nursing Positions
- Laid-Back Breastfeeding
- Cradle Hold
- Cross Cradle Hold
- Football Hold
- Side-Lying Position

“Asymmetric,” or Deep Latch, Technique
With infant's mouth open wide, like a yawn, bring baby to the breast chin first. Aim baby's lower lip as far from the base of the nipple as possible. Baby's chin and mandible should make contact with the breast first.

Breast Compressions
- Breast compressions can be used to keep the baby drinking milk after his sucking has slowed down or becomes ineffective. The technique also can help remove more milk when using a breast pump.
- Support the breast during feedings, with the fingers below and thumb above, far back from the areola.
- When the baby stops his slow, deep sucking and begins “nibbling,” compress the breast to deliver a spray of milk to entice him to start drinking again.

Signs that a Breastfed Baby is Drinking Milk
- The baby’s eyes are open.
- The baby’s jaw moves in wide, slow motions, as she sucks deeply and rhythmically.
- When baby opens her mouth to the widest point while nursing, you see a pause as her mouth fills with milk. This pause in the movement of her jaw is a helpful indicator that she is getting milk.
- You hear the baby swallow regularly (a soft “cuh,” “cuh,” “cuh,” sound when the baby exhales).
Common Latch-On Errors

- Bending the infant’s head forward instead of allowing it to slightly tilt back ("sniff" position)
- Placing the index finger too close to the margin of the areola
- Attempting to latch the infant before he opens his mouth WIDE
- Bringing the infant’s lower lip too close to the base of the nipple
- Settling for a “shallow” latch instead of ensuring that the infant grasps a large mouthful of breast
- Having the infant’s lips curled in, instead of flanged outward
- Pulling the infant off the breast, instead of breaking the suction first
- Assuming discomfort is a normal part of breastfeeding

What Do We Know About Milk Production Between Birth and 6 Months Postpartum?

- For mothers of both term and preterm infants, the average milk volume at days 6 and 7 is predictive of week 6 milk volume. The study findings emphasize the importance of interventions to promote an adequate milk supply by the end of the 1st week postpartum. A good start matters!
  

- Exclusively breastfed infants drink about 788 g (26 - 28 oz.) of breast milk daily between 1 and 6 months (with a wide range of normal). Nighttime and morning feedings are larger than daytime and evening feedings.
  

Examples of Newborns At Risk for Ineffective Breastfeeding

- Small (< 6 lbs.), IUGR, late-preterm (34, 35, and 36 weeks) and early-term (32 and 38 weeks) infants
- Twins or higher multiples (often late-preterm)
- Infants with neuromotor problems
- Infants with medical problems, such as cardiac, respiratory, or infectious illnesses or jaundice
- Infants with oral abnormalities, such as cleft palate or severe micrognathia (receded chin)
- Infants with minor oral variations that can affect feeding, i.e. tongue-tie or high-arched palate
- Infants with latch-on problems

The Early Assessment of Breastfeeding

- All newborns should be seen by a pediatrician at 3 to 5 days of age, which is within 48 to 72 hours after discharge from the hospital.
- The evaluation should include assessment of infant hydration and elimination, observation of a feeding, and a discussion of maternal and infant issues. Evaluate infant weight loss > 7% or continued weight loss by day 5.
- Have infant sleep in the same room as mother to facilitate breastfeeding and reduce the risk of sleep-related infant death.
  
  Pediatr. 2012;129;e827

Early Assessment of Breastfeeding

Mother’s Breasts

- Milk has come in (Lactogenesis II) by 4 days postpartum and is flowing easily.
- Mother’s breasts feel full before feedings and softer afterwards.
- Infant latches effectively and comfortably to both breasts, sucks actively, & swallows often.
- Any nipple tenderness that was present has started to decrease by day 5. No nipple wounds are visible.

Initial Infant Weight Loss & Onset of Weight Gain

- Magnitude: Most infants will not lose more than 8% - 10% of birth weight. Smaller infants typically lose less. Evaluate infant weight loss > 7%.
- Duration: Initial weight loss stops after mother’s milk comes in. Evaluate continued weight loss by day 5.
- Onset of wt. gain: By 4 - 5 days, expect baby to start gaining about 1 oz./day for the first several months.
- Return to birth weight: Expect baby to surpass her birth weight by 10 - 14 days and to double her birth weight by 4½ months.
Early Assessment of Breastfeeding
Newborn Feeding Routines

- Feed 8 to 12 times each 24 hours (whenever baby gives cues)—typically about 10 - 15 minutes per breast.
- Expect to nurse every 1 1/2 to 3 hrs., with a single interval of no longer than 4-5 hrs. in a 24-hr period.
- Expect periods of more frequent “cluster feeds,” esp. in the evenings.
- Offer both breasts at each feeding; begin on alternate sides to ensure equal drainage. Switch sides when baby's sucking/swallowing slow down.
- Avoid non-nutritive sucking on a pacifier; wake non-demanding babies to nurse.

Early Assessment of Breastfeeding
Newborn Stooling Pattern

- “Neifert’s Rule of 4” (after mother’s milk comes in)
- Breastfed newborns can be expected to pass 4 or more loose, yellow “milk” stools daily between about 4 days and 4 weeks.
- Transition stools, infrequent, or scant volume of stools suggest inadequate milk intake.
- After 4 weeks of age, expect baby’s stooling frequency gradually to diminish.

Early Assessment of Breastfeeding
Newborn Urination Pattern

- After mother’s milk comes in, breastfed newborns should pass colorless urine at least 6 to 8 times daily (typically after every feeding).
- The presence of “brick dust” (urate crystals) in the diaper after mother's milk has come in, scant volume of urine, or dark yellow urine suggest inadequate milk intake.

Early Assessment of Breastfeeding
Behavior During and After Feedings

- Signs that baby is getting enough milk: Infant gives regular feeding cues; baby latches effectively; rhythmic sucking; frequent swallowing is heard.
- Baby acts satisfied after nursing and sleeps contentedly between feedings.
- Infant may not be getting enough milk if: Baby seldom gives feeding cues; has difficulty latching or falls asleep shortly after latching; persistent crying or excessive need for pacifier after nursing; either very long (>45 mins.) or very brief (< 5 mins.) nursing sessions suggest a problem with milk transfer.

Seek Help Right Away for Early Breastfeeding Problems

- Early breastfeeding problems can prevent the establishment of an abundant milk supply and may quickly become complicated by inadequate infant weight gain.
- Getting help right away is far preferable to taking a passive “wait-and-see” approach, while hoping that the situation self-corrects.
- Using an electric breast pump to achieve regular and effective milk removal often is necessary in the management of breastfeeding difficulties.

Early Breastfeeding Concerns and Feeding Status at 2 Months

- In a study of first-time mothers, early breastfeeding concerns were almost universal.
- The greatest contributors to stopping breastfeeding by 60 days were day 3 or day 7 “infant feeding difficulty” concerns and day 14 “milk quantity” concerns.
- Priority should be given to lowering maternal breast-feeding concerns resolving, in particular, infant feeding and milk quantity concerns occurring within the first 14 days postpartum.

Severe or Chronic Sore Nipples
- Severe nipple pain, cracks or visible wounds, discomfort that continues throughout a feeding or pain not improving toward the end of the first week should not be considered normal, and warrants investigation.
- Severe nipple pain usually is linked to incorrect infant latch or sucking, which not only causes pain, but also may limit milk transfer. The result can be a diminished milk supply and inadequate infant weight gain.
- Nipple wounds readily can become infected with bacteria and/or Candida, which delays healing.

Common Sore Nipple Contributing Factors
- Mechanical trauma: improper infant latch or dysfunctional sucking; abnormally high infant sucking vacuum; incorrect pump flange size; excessive pump suction; breast engorgement; low milk supply
- Infected nipple wounds: bacterial and/or Candida (yeast) infection
- Nipple vasospasm: Raynaud phenomenon
- Inappropriate nipple care: over-drying; excess moisture; lack of appropriate wound hygiene
- Nipple dermatitis: atopic or contact dermatitis, etc.

Prevention/Treatment of Sore Nipples
- Ensure correct infant positioning, latch, suck.
- Try frequent, shorter feeds. Start on least sore side to trigger the milk ejection reflex.
- Ensure correct pump flange size and vacuum level.
- Wear breast shells; change wet breast pads.
- Use moist wound healing (hydrogel dressings and/or medical grade lanolin).

Prevention/Treatment of Sore Nipples
- Prescribe antibiotics/antifungals for nipple wounds likely to be infected with bacteria and/or Candida.
- Address nipple vasospasm and nipple dermatitis.
- Consider temporarily interrupting breastfeeding and using an effective electric breast pump.
- Think multi-factorial!

Bacterial Infection and Sore Nipples
- Three factors make it very likely that a mother’s sore nipple is infected with pathogenic bacteria: 1) the infant is < 1 month old; 2) mother complains of moderate to severe nipple pain; 3) the nipple has a visible crack, fissure, open wound, or drainage.


Because breastfeeding mothers with a Staph aureus nipple infection have a high likelihood of developing mastitis within 7 days, antibiotic therapy is warranted.


Infection of Nipples with Candida albicans
- Burning nipple/areola
- Sore nipples, without burning
- Shooting, stabbing breast pain
- Shiny or flaky skin of nipple/areola
- Infant oral thrush or yeast diaper rash
- Recent treatment of mother with antibiotics
- Maternal history of vaginal yeast

ABM Clinical Protocol #26: Persistent Pain with Breastfeeding

See: http://www.bfmed.org/Media/Files/Protocols/
**Nipple Candidiasis: Treatment**

- While Candidiasis of the nipples does occur, the presumed diagnosis is seldom confirmed by culture, and "over diagnosis" is common.
- No controlled trials of treatments have been reported. First-line treatment usually includes a topical antifungal preparation, such as ketoconazole, nystatin, or miconazole, applied to the nipples after nursing. If there is no response to topicals, oral fluconazole may be prescribed.
- It is likely that Candida is commensal in some women, while others experience pain with only small numbers of organisms.  
  

**Raynaud Phenomenon of the Nipples**

- Characterized by vasospasm of arterioles, causing intermittent ischemia, and subsequent reflex vasodilation.
- A classic episode of vasospasm presents as triphasic, or biphasic, color change: 1) ischemic pallor; followed by de-oxygenation (cyanosis) in severe episodes; followed by 3) reflex vasodilatation and reperfusion manifested as erythema.
- Raynaud phenomenon commonly manifests in the hands and feet and affects up to 22% of women in the childbearing years. The role of vasospasm in causing nipple pain in breastfeeding women is thought to be underestimated.  
  

**Raynaud Phenomenon of the Nipples**

- Raynaud phenomenon of the nipples may be triggered by trauma (i.e. incorrect latch or sucking), breast or nipple infections, emotional stress, or previous breast surgery. Always look for an underlying cause of any vasospasm.
- Pain can range from moderate to severe sharp, shooting, or stabbing pain before, during, and after breastfeeding.
- Suspect Raynaud phenomenon if: 1) you observe or mother reports color changes of the nipple, esp. with cold exposure; 2) cold sensitivity or color changes of the hands or feet with cold exposure; or 3) mother has been treated with an antifungal for presumed Candida infection, without improvement.  
  

**Mamatoto**

- Keeping mothers and infants together (mamatoto —a Swahili word for the mother-baby unit) is the best way to encourage unrestricted breastfeeding.
- Regularly removing milk by frequent breastfeeding (or expressing milk if Mom is separated from her baby) helps ensure that mothers continue to produce an abundant milk supply throughout their baby’s 1st year.
- Empower mothers concerning their right to breastfeed in public places.
- Teach mothers how to breastfeed discreetly in front of others.  
  
  *“Just in Case”*

- Many WIC breastfeeding clients request formula “just in case” they might need it.
- Expressing and storing surplus milk—especially after morning feedings when the breasts are fuller—helps to maintain a plentiful supply.
- Frozen stores of a mother’s expressed milk serve as a visual reminder that she has more than enough for her baby and doesn’t need any “just-in-case” formula.
Avoid a Long Night Interval Without Removing Milk

- For many breastfeeding women, going too long at night without draining their breasts results in a decrease in milk production, a decline in blood prolactin level, and the return of their menses.
- Once her baby starts to sleep through the night, a mother can express her milk before she retires to shorten the nighttime interval during which her breasts do not get drained.
- Mom also can express remaining milk from both breasts after the morning feeding to ensure both are well drained after a long night interval.

Preparation for Breastfeeding and Working

- While on maternity leave, begin early to pump after 1 or 2 morning feedings, when the breasts usually are fuller, to establish a plentiful supply and become comfortable with milk expression.
- Stockpile frozen stores of milk (in appropriate feeding volumes) as a buffer against dwindling milk production after mother returns to work.
- Tailor a plan for how often to pump at work, based on the woman’s breast storage capacity, her baby’s age, and usual feeding frequency.

The “Magic Number” Teaching Tool

- The Magic Number represents a teaching tool that helps breastfeeding mothers who are partially or fully expressing their milk to calculate the number of times each day they need to remove milk by feeding and/or expressing in order to maintain their milk production.
- Before returning to work, a fully breastfeeding mother should count how often she breastfeeds or expresses milk each 24 hours. This daily total represents her Magic Number, or how often she needs to continue to remove milk from her breasts each day.

A Sample Plan for Achieving Mom’s “Magic Number” for Daily Milk Removal (8 times)

- 5:30 a.m. Breastfeed at home (ideally pump after the 1st feeding, due to long night interval)
- 7:30 a.m. Breastfeed or pump at Child Care site
- 10:00 a.m. Pump at workplace
- 12:30 p.m. Pump at workplace
- 3:00 p.m. Pump at workplace
- 5:30 p.m. Breastfeed at Child Care site
- 8:00 p.m. Breastfeed at home
- 10:30 p.m. Pump before retiring at night

Optimal Workplace Pumping Routines

- Ideally, use a highly efficient, daily-use, or hospital-grade electric pump with a double collection system.
- Pump for 10-15 minutes approximately every three hours while away from your infant—morning, noon, and afternoon. Keep EBM in a refrigerator or cooler.
- Do not let your breasts become hard and lumpy by going too long without pumping. Overfull breasts will slow down your milk production.
- With a generous milk supply, your baby is more likely to go back and forth easily between breast and bottle-feeding.

Starting Complementary Foods

- Exclusive breastfeeding is sufficient to support optimal infant growth and development for approximately the first 6 months of life.
- Observe infant for signs of readiness for solids: loss of the tongue-thrust reflex, bringing objects to the mouth, taking an interest in what adults are eating.
- Solid foods should complement, not replace, breast milk in the baby’s diet.
- Begin by offering solids after first nursing and later in the day, when Mom’s milk supply usually is lowest, rather than in the morning, when the breasts typically are fuller.
Starting Complementary Foods

- 40% of infants in the IFPS II had consumed infant cereal by 4 months, and 17% had been fed fruit or vegetable products.
- Mothers who introduced solids early were more likely to be younger, single, to have lower education and income, and to be enrolled in WIC.
- Compared to those who were not fed solids by 4 mos, infants who were fed solids early were more likely to have discontinued breastfeeding at 6 mos (70% vs 34%) and to have been fed fatty or sugary foods by 12 months (75% vs 62%).

Prevalence and Reasons for the Early Introduction of Solid Foods to Breastfed Infants

Among mothers of breastfed infants, 24.3% reported starting solid foods before 4 months of age.

- 55.5% of these mothers said they were advised to start solids by a health professional.
- Nearly 20% cited advice by friends or relatives.
- 46.4% said they started solids to help their baby sleep longer at night.
- More than 20% thought their baby was nursing too much or that they didn't have enough milk.

Identify Source of Breastfeeding Support

- Partners, extended family members, friends
- Lactation consultants and other HCPs
- WIC staff, including Breastfeeding Peer Counselors
- Visiting nurses
- La Leche League & hospital-based support groups
- Breastfeeding Cafés and other community support
- Child care providers; workplace lactation programs
- Online mommy blogs
- Black Mothers’ Breastfeeding Association

Family Support Explains Some of the Racial and Ethnic Differences in Breastfeeding

- Family breastfeeding history and demographic characteristics helped explain the higher breastfeeding rates of Hispanic mothers relative to white and black mothers.
- In addition to family history of breastfeeding, higher rates of co-resident fathers and marriage among Hispanic women explained some of the breastfeeding disparities between black and Hispanic women.

How Significant Others Can Support Their Breastfeeding Partners

- Convey that breastfeeding is a high priority.
- Provide emotional support and encouragement; remind Mom to seek expert help when needed.
- Perform infant care (burping, diapering, bathing, rocking) and spend extra time with older children.
- Perform housekeeping duties, such as meal preparation, laundry, dishes, etc.
- Protect Mom from excessive visitors.
- Foster a unique bond with the infant.

Support from Health Professionals

- Give women the information they need to make an informed feeding decision.
- Congratulate women on their choice to breastfeed their baby.
- Share your own positive experience with breastfeeding and your strong belief in its value.
- Acknowledge mothers’ commitment to stick with breastfeeding: “Good for you.” “I’m proud of you.” “You are giving your baby the best.”
- Invite mothers to describe their commitment to breastfeeding in their own words: “What’s the best part of breastfeeding for you?”
### References


