So you have a birth plan – what about a breastfeeding plan?

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How often have you heard someone say:

"I wish I had found out more about breastfeeding while I was pregnant"

or

"I thought that breastfeeding would come naturally"

or

"I wanted to breastfeed exclusively but the paediatrician said that my baby needed some formula"?

So many women see their dreams of breastfeeding beginning to slip away almost before they have started. But this need not be the case.

Breastfeeding is most likely to succeed where a mother has been an alert and active participant in the birthing process and when a mother and her baby are together continuously in the days afterwards.

And when a pregnant woman has learned about the normal course of breastfeeding and what to expect from her breastfed baby, she is in a position to have confidence in her own and her baby's ability to initiate and establish a successful breastfeeding relationship in a whole variety of circumstances. At the same time, this confidence is incredibly easily shattered by well-intentioned but institutionalised birthing policies and practices.

'Birth plans' have been around for years. Since the increased medicalisation of childbirth in the 1970s, the trend towards more technology - although lifesaving for those with high risk pregnancies and sick babies - has often resulted in women with normal pregnancies and the capacity to also have normal births needlessly opting into a system where technological practices actually disrupt their capacity to give birth to and feed their babies in the way that biology intended. This well-known phenomenon is called 'the cascade of interventions'.

Birth plans became a common method of encouraging women to think about what was important to them during labour and birth, with the objective of keeping the technology for when it was really needed. A birth plan also works wonderfully as a communication tool and a stimulus for education. It allows the individuals involved to iron out gaps in education and differences in opinion **before** rather than during or after the birth at which time the mother is particularly vulnerable to agreeing to something that she did not want to do.

Somewhere along the line though, the idea that birth and breastfeeding are inextricably linked has been mostly ignored; ignored in that birth plans do not usually include any reference to the first or subsequent breastfeeds, to intensity or duration of skin-to-skin contact or to what priority breastfeeding should receive in the overall care of mother and baby.

Think

To come up with a breastfeeding plan, a mother has to first identify what her goal is, ie exclusive breastfeeding for the early months. The 'plan' is the means by which she is going to reach the goal. Many people get as far as identifying the goal but never work out how they are going to get to it, and this is where problems arise, particularly when someone (healthcare provider, caring relative or other person) questions the adequacy of the breast milk or breastfeeding. How is a mother to respond to that question or concern? She needs to really get to grips with what is important to her and **then** work out how she is going to achieve that. The best way to do this is to think about some of the common challenges to breastfeeding that can occur (eg pre-term birth, maternal diabetes or pre-eclampsia, postmaturity, induction of labour, augmentation of labour, epidural or other pain

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relief, forceps or Caesarean birth, sick mother or baby) and what strategies might be required to ensure that exclusive breastfeeding is achieved.

Discuss

To avoid making spur of the moment decisions that may jeopardise exclusive breastfeeding (and may later be regretted), a mother needs to talk about the worst-case scenarios and how she would handle them. A plan probably cannot cover all eventualities, but it can cover a lot of them and make provision for a decision-making process for anything that has not been covered.

Decide

Everyone needs to be on the same page when it comes to breastfeeding. The mother needs to make sure that all parties involved know what her plan is and are willing and able to help her carry it through. It is better to find out before her baby is born if there is a clash of ideas between her, her partner and her family and the Lead Maternity Carer (LMC) and/or the birthing and postnatal facility.

Making a Plan

There is a saying: "If you fail to plan, then you plan to fail." This means that if everything goes well, then a mother can throw her plan out the window and feel well pleased with herself. Planning for contingencies is her best safeguard to achieving her goal.

The three most common breastfeeding scenarios:

1. **Breastfeeding is initiated and established without any problems.**
2. **Breastfeeding is initiated then supplementary artificial milk feeding is suggested without evidence it is medically indicated** eg medication in labour, forceps or Caesarean birth, pre-term birth, jaundice, Special Care Baby Unit (SCBU) admission, baby feeding at high frequency or waking at night.
3. **Breastfeeding is initiated then supplementary artificial milk feeding is suggested because of evidence that it *is* medically indicated** eg incompatible maternal medications, clinically dehydrated babies, severe maternal illness, active herpes on breast or nipple, sometimes where the mother has HIV, babies with congenital metabolic disease, babies who develop very low blood sugar which does not improve through having increased intake of breast milk or when insufficient expressed/donated breast milk is available.

What Why When Who How How much

What

What are all the possible alternatives to using artificial milk if it were suggested that the baby needed artificial milk feeding? The pointers below from the *Code of Health and Disability Consumer's Rights*[1] can be used as a guide.

> *"Before giving your consent your doctor or healthcare provider will fully and clearly explain to you*
>
> - *What happens during the procedure*
> - *What other options there might be*
> - *What you can expect after the procedure*
> - *Any risks that might be associated with the procedure*
> - *Answers to any questions that you may have about the procedure*
>
> ***The HDC Code of Health and Disability Consumer's Rights Regulation 1996, Right 7***[1]
> *http://www.hdc.org.nz/theact-thecodeclause2*

If the need for supplementary feeding is anticipated before the birth – for example, where a mother has gestational diabetes – colostrum can be expressed and stored prior to the birth for use afterward if needed.

Why

The following are suggested questions a mother may ask about why her baby might need artificial milk feeding:

- "What evidence do you have that this is actually a problem?"

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- “Is it absolutely necessary to give artificial milk (do this procedure/separate us/other) now or could we wait and see if things improve on their own?”
- “Would you please check with the lactation consultant before we do this?”
- “What experience do you have managing (x) in breastfed babies?”
- “What are your ideas to keep us breastfeeding and together?”

Only under exceptional circumstances can a mother’s milk be considered unsuitable for her infant. For those few health situations where infants cannot, or should not, be breastfed, the choice of the best alternative – expressed breast milk from an infant’s own mother, breast milk from a healthy wet-nurse or a human-milk bank, or a breast-milk substitute fed with a cup, which is a safer method than a feeding bottle and teat – depends on individual circumstances.

Global Strategy for Infant and Young Child Feeding. WHO/UNICEF 2003[2]

For infants who do not receive breast milk, feeding with a suitable breast-milk substitute – for example an infant formula prepared in accordance with applicable Codex Alimentarius standards… and the information given should include adequate instructions ... the health hazards of inappropriate preparation and use. Infants who are not breastfed, for whatever reason, should receive special attention from the health and social welfare system since they constitute a risk group.

Global Strategy for Infant and Young Child Feeding. WHO/UNICEF 2003

When

When would it be appropriate for the baby to receive feeds away from the breast (see Table 1) or be artificial milk fed? What evidence would there be that the breastfeeding management was inappropriate? If there **was** medical evidence of inadequate feeding, a mother would need to have considered and planned for how feeding could be improved without the use of artificial milk.

For babies in SCBU, Neonatal Intensive Care Unit (NICU) or other medical or surgical settings, timing of feeds may be tricky depending on how much access a mother has to her baby. Can the plan describe in which situations staff are permitted to feed the breastfeeding baby and what they are permitted to feed him/her?

Gestational Age	Approx. Weight	Oral Feeding Method
<30 wks		Nasogastric Tube
30 – 32 wks		Cup Feed
32+ wks	≈ 1300g	Breastfeeding possible
36+ wks	≈ 1800g	Breastfeeding usually well-coordinated

Table 1
Guide to methods of feeding Low Birth Weight Babies

Until the mother is available to breastfeed her baby or adequate expressed milk is available, measures such as keeping a nasogastric tube in situ or continuing with intravenous fluids may be preferred options to the use of formula and/or feeding bottles that require a different sucking technique from breastfeeding.

A useful resource, *First Week Daily Breastfeeding Log*, written by Diane Wiessinger,[3] IBCLC, for identifying normal breastfeeding frequencies, and urine/stool output for newborns can be found at http://www.lalecheleague.org.nz/documents/1st_week_bf_log.pdf.

Who

At the time of writing not all health workers or medical/paediatric practitioners have undergone the Baby Friendly Hospital Initiative Breastfeeding Education Course. This education increases skills in the appropriate use of supplementary feeding devices, artificial milk, and how to support the establishment of lactation where mothers and babies are separated or are undergoing medical or surgical treatment.

If the use of artificial milk or procedures which

may have negative side effects on breastfeeding (such as feeding with bottles and teats or the use of pacifiers) are recommended, having a BFHI skilled practitioner advocating for the mother will increase her confidence that sound decisions will be made in her absence.

How

If a baby were to need supplementation how would this be done under a breastfeeding plan? Cup, spoon, dropper syringe or finger feeding are least likely to interfere with the baby's ability to learn to latch effectively for breastfeeding. A baby in NICU may already have a nasogastric tube for feeding.

The mother should consider if she would want her baby to be breastfed by another lactating woman temporarily if her own capacity to breastfeed was compromised. Would she include the option of using a supplemental nursing system if artificial milk was required, to keep her baby at the breast?

How much

The mother needs to consider and discuss how she could plan for the eventuality that there was evidence that the baby required supplemental artificial feeding. What would the appropriate minimum volume be to keep the baby safe, well and growing whilst preserving breastfeeding and breast milk production. For example, if a newborn (0 - 2 days old) receives on average 5 - 7ml colostrum per breastfeed, carefully assess whether it is appropriate to offer a baby 40ml of artificial milk? 30ml?? 20ml???

Conclusion

The mother, family/whanau, Lead Maternity Carer and any other health practitioners involved in the care of a mother or her baby are a team. The breastfeeding plan is a powerful means by which the mother can communicate with the 'team'. Although the plan probably cannot cover all eventualities, it can make provision for a decision-making process for unexpected issues that might crop up, and it can be a basis for dialogue.

Of everyone, the parents have the greatest vested interest in the wellbeing of their baby, and play a pivotal role in advocating for the baby's access to breast milk as well as for the mother-baby breastfeeding relationship.

Mothers need to identify their goals and then become informed so they can plan how to achieve them. When things look like they might be going wrong, knowing the questions to ask is the first step to getting the answers and outcomes they want and the second is to keep up good communication with their team.

A Breastfeeding Plan template written by Liz Weatherly is available on pages 6-7 and also online at http://www.lalecheleague.org.nz/

About the Author

Liz Weatherly trained as a general and obstetric nurse in the early 1980s, she worked in general practice nursing and then trained as a midwife in 1991 and as an LLL Leader following the birth of her first child in 1994. While working as a nurse, Liz developed an interest in the relationship between patients and health workers and the way that the responsibility for outcomes often rested mainly on the health worker, rather than on the patient or was a shared responsibility. The idea for a 'breastfeeding plan' grew from this interest and years of teaching breastfeeding classes, facilitating breastfeeding support groups and counselling breastfeeding mothers, and is an attempt to address the oft - heard comment "I wish I had thought about breastfeeding more before my baby was born."

References

1. The HDC Code of Health and Disability Services Consumers' Rights Regulation 1996, Right 7 http://www.hdc.org.nz/theact-thecodeclause2

2. *Global Strategy for Infant and Young Child Feeding,* World Health Organisation, 2003

3. Wiessinger D. A first week breastfeeding log. http://www.lalecheleague.org.nz/documents/1st_week_bf_log.pdf

Suggested reading list

LLLI leaflets available from LLLNZ:

- *Breastfeeding after a Caesarian Birth.* LLLI, April 2004, LLLNZ Publication no. L080.

- Gotsch G. *Breastfeeding your Premature Baby.* LLLI, 1999, LLLNZ Publication no, B012

- *Babies and Children in Hospital.* LLLI, May

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1998, LLLNZ Publication no. L198.

- *Nipple confusion: What's Real and What's Not?* LLLI, December 2004, LLLNZ Publication no. L032

- *Newborn Jaundice.* LLLI, March 2005, LLLNZ Publication no L1689.

Lactation Consultant Series booklet available from LLLI:

- Riordan J, Riordan S. *The Effects of Labour Epidurals on Breastfeeding*, The Lactation Consultant Series 2, LLLI, 2000, LLLI Publication no. 899-19.

Other

- Akre J. *Infant Feeding: The Physiological Basis.* Bulletin of the World Health Organisation 1989; 67 (suppl.).

- *Global Strategy for Infant and Young Child Feeding.* WHO/UNICEF, 2003. http://www.who.int/child_adolescent_health/documents/9241562218/en/index.html

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Exclusive Breastfeeding Plan

For: ..……….....…………………………………. (Mother)

My Breastfeeding Priorities

- My goal is for my baby to be exclusively breastfed in the early months. I have educated myself about and prepared for a natural and non-medicated birth and exclusive breastfeeding.
- If unexpected issues arise that are not covered by my plan (eg multiple pregnancy, preterm birth, or a sick baby) I want my baby's access to breast milk (mine or donor) to be given the same priority as other lifesaving and health-saving measures.
- At all times, I give the utmost priority to my baby and me being together and only interrupted if evidence exists to justify separating us and interrupting the initiation and establishment of breastfeeding.

My Breastfeeding Plan

- My plan is to be active during labour and I will use the following measures to help with labour pains ………………………………………………………………………………

  (eg massage, acupuncture, acupressure, shower, bath, birthing pool, TENS, aromatherapy, self hypnosis, controlled breathing, other)
- I would prefer to use the following natural methods to initiate labour if my baby is overdue, and to stimulate labour if it is slow …………………………………………..

  (eg walking, nipple stimulation, acupuncture, acupressure, other)
- If, having laboured as long as I can without pain relief, I decide to opt for pain medication or if my baby needs to be born with obstetrical assistance, I would prefer the lowest practicable dose of analgesic or anaesthetic to minimise the sedating effect on my baby.
- As soon as my baby is born please put him/her (unwrapped) on my bare abdomen and leave there to crawl to my breast and feed. During this time, I request that only checks or procedures **that cannot safely be delayed for one to two hours** be carried out. (If there is evidence that checks are urgently required please endeavour to do them with my baby still on me). I am happy for the baby's back, legs, arms and head to be dried and covered. **Please leave the baby's hands un-wiped to enhance the baby's instincts to find my breast.**
- Unless there is evidence that it needs to be done urgently, please do not clamp or cut my baby's umbilical cord until it stops pulsating so as to optimise the baby's iron levels.
- After my baby's birth please ensure that the birthing room is warm, the lights dimmed, and that we are allowed at **least** an hour of privacy. I would like to be given time to for us to interact at our own pace and for my baby to self-attach to my breast. I will ask for help if I think we need it.
- In the hours and days after the birth my aim is to have prolonged skin to skin contact with my baby (including at night), and for my baby to have unrestricted access to my breast while we learn to breastfeed.
- If skin-to-skin contact immediately following the birth must be delayed or interrupted for one of us to receive life-saving medical treatment, please help me to 're-enact' the skin to skin experience at the earliest possible opportunity. If I am unable to interact independently with my baby I ask that someone else place my baby in skin to skin contact with me, as I know this will be of great benefit to both of us.

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- I plan to offer my baby my breast when he/she shows cues for feeding. If **for any reason and at any time during our hospitalisation** I am not physically able to hold my baby or to help him/her reach my breast myself, when cues are made, I ask that I have help available to assist my baby to get to my breast instead.
- If, **for medical reasons**, my baby needs supplementary feeding, I request that:
  A) If this is anticipated before the birth I be told so that I can immediately begin expressing colostrum to freeze for use when my baby is born.
  B) I be given time and support to express colostrum or milk as soon as the need for supplementary feeding arises (I understand that this may be as soon as within the first 3 – 4 hours after the birth), and then as frequently as my baby needs to be fed until the need for supplements has passed and he/she is breastfeeding effectively.
  C) If I cannot do this for myself I request that a midwife or my support person express my breasts for my baby's feeds every two to three hours.
  D) In the event that my own milk is insufficient for my baby's needs, that donor milk from a licensed human milk bank, or from a screened donor under the supervision of a doctor, midwife or lactation specialist, be the first choice for my baby. I am aware of the risks and benefits associated with the use of donor milk.
  E) **Where there is medical evidence** that my own and/or the donor milk is insufficient for my baby's needs**, the minimum necessary quantity of artificial milk be used.**
  F) If my baby is too premature or ill to have full feeds at the breast, or because I cannot be with him during a feed, I request that all feeding away from the breast be **expressed / donor milk only.** (Also see D above).
  G) All feeding away from the breast be only via a nasogastric tube (or spoon / cup / finger feeder if the baby is able).
  H) No bottles and teats are ever used for feeding.
  I) No pacifiers be offered to my baby (except when I am not able to be present and the lactation consultant and senior staff member on duty **both** agree that it is necessary during feeds or medical procedures).

I acknowledge that some of these requests may conflict with normal practices or hospital policies, in which case I ask that we work together to enable me to have a successful and satisfying breastfeeding relationship with my baby.

Signed ……………………………………………………………………….. (Mother)

I am happy to work with……………………………………… and will support her to establish a successful and satisfying breastfeeding relationship

Signed ………………………………………………………………………

Name ……………………………..……………..(Lead Maternity Carer)

Position………………………………………

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