



## Complete Summary

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### GUIDELINE TITLE

Evidence-based clinical practice guideline. Breastfeeding support: prenatal care through the first year.

### BIBLIOGRAPHIC SOURCE(S)

Association of Women's Health, Obstetric and Neonatal Nurses (AWHONN). Breastfeeding support: prenatal care through the first year. Evidence-based clinical practice guideline. Washington (DC): Association of Women's Health, Obstetric and Neonatal Nurses (AWHONN); 2000 Jan. 33 p. [74 references]

## COMPLETE SUMMARY CONTENT

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## SCOPE

### DISEASE/CONDITION(S)

Pregnancy

### GUIDELINE CATEGORY

Counseling  
Evaluation  
Management

### CLINICAL SPECIALTY

Family Practice  
Nursing  
Obstetrics and Gynecology  
Pediatrics

### INTENDED USERS

Advanced Practice Nurses  
Allied Health Personnel  
Health Care Providers  
Nurses

#### GUIDELINE OBJECTIVE(S)

- To help clinicians apply research-based knowledge to the promotion of breastfeeding
- To provide registered and advanced practice nurses and lactation consultants with the information necessary to accomplish the following:
  - Promote breastfeeding in the community
  - Assess and evaluate factors that influence breastfeeding rates, including demographic variables, knowledge, intent to breastfeed and support of significant others and health care providers during the preconception, prenatal and postpartum periods
  - Provide care and education during the preconception, prenatal and postpartum periods aimed at facilitating a successful breastfeeding experience.

#### TARGET POPULATION

All women of childbearing age and the mother-infant breastfeeding dyad through the first year of the infant's life

#### INTERVENTIONS AND PRACTICES CONSIDERED

##### Assessment

1. Identification of women at risk for lower breastfeeding initiation and continuation
2. Assessment of women's beliefs, attitudes and knowledge about breastfeeding and the long-term benefits of breastfeeding
3. Assessment of women's sources of professional and personal breastfeeding support
4. Assessment of breasts for factors that may hinder or impede breastfeeding
5. When breastfeeding is being established, assessment of breastfeeding technique
6. Assessment of women's ability to recognize infant feeding satisfaction/satiety cues, and evidence infant is getting enough breastmilk
7. Assessment of nipple trauma and engorgement
8. Identification of potential barriers to sustained breastfeeding

##### Interventions/Counseling

1. Provision of information about the maternal and neonatal benefits of breastfeeding during the first preconception or prenatal client contact and throughout pregnancy
2. Exploration of concerns or ambivalence about breastfeeding and correction of misconceptions that may be barriers to breastfeeding

3. Planning and implementation of individualized and culturally sensitive interventions to promote and support breastfeeding
4. Assistance of women to identify significant others, family members, friends, peer counselors and professional who are supportive and knowledgeable about breastfeeding
5. Provision of information about community resources and breastfeeding support groups
6. Assistance with first breastfeeding episode, when feasible
7. Administration of analgesics as needed just prior to feedings
8. Teaching and reinforcement of breastfeeding information (e.g., breastfeeding process and techniques, prevention and treatment of sore nipples and engorgement, recognition of infant cues, long-term benefits of breastfeeding, normal developmental changes in infants that may affect breastfeeding, return to work planning)

#### MAJOR OUTCOMES CONSIDERED

Rates of initiation, duration, and termination of breastfeeding

### METHODOLOGY

#### METHODS USED TO COLLECT/SELECT EVIDENCE

Searches of Electronic Databases

#### DESCRIPTION OF METHODS USED TO COLLECT/SELECT THE EVIDENCE

Not stated

#### NUMBER OF SOURCE DOCUMENTS

Not stated

#### METHODS USED TO ASSESS THE QUALITY AND STRENGTH OF THE EVIDENCE

Weighting According to a Rating Scheme (Scheme Given)

#### RATING SCHEME FOR THE STRENGTH OF THE EVIDENCE

Quality of Evidence

I: Evidence obtained from at least one properly designed 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 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 or reports of expert committees.

### Quality of Evidence Rating for Qualitative Studies

The quality of evidence rating is based on the total scores for each of five categories:

1. descriptive vividness
2. methodological congruence
3. analytical preciseness
4. theoretical connectedness
5. heuristic relevance

QI: Total score of 22.5-30: 75-100% of total criteria met

QII: Total score of 15-22.4: 50-74% of total criteria met

QIII: Total score of 15 or less: 54% or less of total criteria met

The categories are described in the Criteria for Quality Rating in Appendix C of the original guideline document.

## METHODS USED TO ANALYZE THE EVIDENCE

Systematic Review with Evidence Tables

## DESCRIPTION OF THE METHODS USED TO ANALYZE THE EVIDENCE

The Association of Women's Health, Obstetric and Neonatal Nurses (AWHONN) template for guideline development is based on the framework delineated in the American Nurses Association (ANA) Manual to Develop Guidelines (Marek KD, American Nurses Association Committee on Nursing Practices, Standards and Guidelines. Washington [DC]: American Nurses Publishing, American Nurses Foundation, American Nurses Association, 1995). The American Nurses Association Manual to Develop Guidelines models its process on that of the Agency for Healthcare Research Quality (AHRQ), formerly the Agency for Health Care Policy and Research (AHCPR).

Team members participated throughout 1999 and 2000 via teleconferences and extensive review, evaluation and scoring of the breastfeeding literature. A system and tool for scoring the literature was developed based on the method for literature analysis presented in the American Nurses Association Manual to Develop Guidelines (Marek, 1995). Using this framework, each study reviewed by the guideline team was evaluated in the following eight categories:

1. Problem or question studied
2. Sampling
3. Measurement
4. Internal validity
5. External validity
6. Construct validity
7. Statistical conclusion validity
8. Justification for conclusions

A description of the above criteria and a sample scoring tool are presented in the original guideline document.

As the Evidence-Based Clinical Practice Guideline was further developed, the quality of the evidence supporting practice recommendations was determined by team consensus using the U.S. Preventive Services Task Force (1996) Guide to Clinical Preventive Services quality of evidence rating scale.

Because several research reports were qualitative in nature, the team determined different criteria were required to evaluate the quality of such evidence. Consequently, the team generated a scoring tool based on evaluative criteria of qualitative research discussed by Burns and Grove (Understanding nursing research [2<sup>nd</sup> ed.]. Philadelphia: WB Saunders Co., 1999). Criteria for rating included the following (Burns N. Standards for qualitative research. Nurs Sci Quart 1989;2: 44-52):

1. Descriptive vividness
2. Methodological congruence
3. Analytical preciseness
4. Theoretical connectedness
5. Heuristic relevance

A detailed description of these criteria and a sample scoring tool are presented in the Guideline.

Each clinical practice recommendation presented in the Guideline is supported by a referenced rationale using American Psychological Association (APA) format. The column headed Evidence Rating includes the quality of evidence ratings for each reference cited under the column headed Referenced Rationale. Full citations for all references are given in the reference list of the original guideline document.

## METHODS USED TO FORMULATE THE RECOMMENDATIONS

Expert Consensus

## DESCRIPTION OF METHODS USED TO FORMULATE THE RECOMMENDATIONS

During regularly scheduled teleconferences, members reviewed each guideline element and achieved consensus on each clinical practice recommendation, accompanying referenced rationale and quality-of-evidence.

## 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

Peer Review

## DESCRIPTION OF METHOD OF GUIDELINE VALIDATION

This guideline was peer reviewed by a panel of Association of Women's Health, Obstetric and Neonatal Nurses (AWHONN) expert members.

# RECOMMENDATIONS

## MAJOR RECOMMENDATIONS

Quality of Evidence Ratings (I-III and QI-QIII) are defined at the end of the "Major Recommendations" field.

Preconception and Prenatal Care

Expected Outcomes:

1. Women of childbearing age and their significant others will be informed about the benefits of breastfeeding through a continuum of breastfeeding education extending from the preconception period through the first year of life.
2. Ideally, accurate, age and culturally, appropriate breastfeeding information will be shared within communities and elementary and secondary schools as a means of promoting breastfeeding.

### Assessment

1. Identify personal and demographic variables that may influence breastfeeding rates:
  - a. Culture
  - b. Age
  - c. Socioeconomic status
  - d. Ethnicity
  - e. Prior experience with or exposure to breastfeeding
  - f. Intent to return to work or school
  - g. Parity

(Humphreys et al., 1998: Evidence Rating: II-2) (Long et al., 1995; O'Campo et al., 1992: Evidence Rating: II-3) (Lawrence & Lawrence, 1999; Ryan, 1997: Evidence Rating: III)

2. Assess women's intent to breastfeed and access to support for breastfeeding, including support from significant others and peer counselors (Morrow et al., 1999: Evidence Rating: I) (Duffy et al., 1997; Sciacca et al., 1995; Caulfield et al., 1998: Evidence Rating: II-1) (O'Campo et al., 1992: Evidence Rating: II-3) (Balcazar et al., 1995; Kessler et al., 1995; Wambach, 1997; Hill, 1988: Evidence Rating: III).
3. Assess attitudes about infant feeding among the following:
  - a. Health care providers
  - b. Significant others
  - c. Pregnant women

(Caulfield et al., 1998; Sciacca et al., 1995: Evidence Rating: II-1)  
(Humphreys et al., 1998: Evidence Rating: II-2) (Kessler et al., 1995: Evidence Rating: III)

4. Assess breasts and nipples for factors that may hinder/impede a woman's ability to breastfeed, including the following:
  - a. Flat or inverted nipples
  - b. Scarring from breast surgery
  - c. Significantly asymmetrical breasts
  - d. Lack of normal pregnancy breast changes

(Riordan & Auerach, 1999: Evidence Rating: III)

### Intervention

1. Identify specific community and cultural beliefs and attitudes toward breastfeeding and tailor interventions to meet the needs of the specific population (Kistin et al., 1990: Evidence Rating II-2) (Long et al., 1995: Evidence Rating: II-3).
2. Whenever possible, educate society about benefits of breastfeeding, including integration of age-appropriate information throughout school curricula (Hill, 1988: Evidence Rating: III).
3. Provide influential significant others with education on the benefits of breastfeeding and ways they can support the new mother (Sciacca et al., 1995: Evidence Rating: II-1) (Humphreys et al., 1998: Evidence Rating: II-2; Rajan & Oakley, 1990: Evidence Rating: III).
4. Provide opportunity for the woman to express concerns related to the condition of nipples and breasts that might impact or interfere with breastfeeding (Biancuzzo, 1999: Evidence Rating: III).
5. Explain that special preparation of the nipples and breasts is unnecessary in many instances (Alexander et al., 1992: Evidence Rating: III).
6. Assist women to identify their personal breastfeeding goals and begin a breastfeeding plan (O'Campo et al., 1992: Evidence Rating II-3).
7. Offer breastfeeding information early during pregnancy (first trimester) through group classes or one-on-one instruction. Information should address the following:
  - a. Benefits for mother and infant

- b. Common misconceptions
- c. Methods to facilitate continued breastfeeding with return to work or school
- d. How milk is produced

(Caulfield et al., 1998: Evidence Rating: I) (Duffy et al., 1997: Evidence Rating: II-1) (Kistin et al., 1990; Humphreys et al., 1998; Hartley & O'Connor, 1996: Evidence Rating: II-2) (Long et al., 1995: Evidence Rating: II-3) (Balcazar et al., 1995: Evidence Rating: III)

8. Offer classes, information and education outside traditional health care settings including the following:
  - a. Homes
  - b. Churches
  - c. Civic organizations
  - d. Health clubs
  - e. Community centers
  - f. Schools
  - g. Local neighborhoods

(Morrow et al., 1999: Evidence Rating: I) (Rajan & Oakley, 1990: Evidence Rating: III)

9. Consider incorporating trained lay counselors into breastfeeding education programs (Morrow et al., 1999: Evidence Rating: I) (Caulfield et al., 1998; Kistin et al., 1994: Evidence Rating: II-1) (Long et al., 1995: Evidence Rating: II-2).
10. Educate health care providers and other caregivers to relay consistent, supportive messages about breastfeeding (Hartley & O'Conner, 1996; Humphreys et al., 1998: Evidence Rating: II-2) (O'Campo et al., 1992: Evidence Rating: II-3) (Balcazar et al., 1995; Rajan & Oakley, 1990: Evidence Rating: III).
11. Evaluate educational plans for the following:
  - a. Culturally and age-appropriate, community-specific information.
  - b. Accurate information that includes benefits of breastfeeding.

(Morrow et al., 1999: Evidence Rating: I) (Kistin et al., 1990: Evidence Rating: II-2) (Long et al., 1995: Evidence Rating: II-3) (Balcazar et al., 1995: Evidence Rating: III)

12. Whenever possible, use standardized measures to evaluate the effectiveness of prenatal breastfeeding classes. These measures may be determined by the purpose of the program or intervention and may include the following:
  - a. Pre- and post-tests
  - b. Evaluation of teacher or counselor performance
  - c. Evaluation of class/program content
  - d. Client outcome variables

(Hartley & O'Connor, 1996: Evidence Rating: II-2)

## Evaluation

1. Use individual client data to evaluate the effectiveness of planned programs and classes:
  - a. Intent to breastfeed
  - b. Planned length of breastfeeding
  - c. Planned level of breastfeeding at various time periods or personal goals (i.e., how long one plans to breastfeed exclusively or partially)
  - d. Achievement of personal goals

(Caulfield et al., 1998: Evidence Rating: II-1) (Labbok & Krasovec, 1990; Balcazar et al., 1995: Evidence Rating: III)

## Postpartum Care - First Two Weeks

### Expected Outcomes:

1. Ideally, infants should not lose more than 7% of their birthweight and should return to birthweight by one to two weeks of age.
2. The postpartum woman is able to identify potential sources of personal and professional support in the hospital and after discharge.
3. The postpartum woman demonstrates or provides verbal validation of successful initiation of breastfeeding.
4. Ideally, the woman verbalizes confidence in her ability to identify and manage problems that arise.
5. The newborn is breastfed exclusively whenever possible.

### Assessment

1. Review intrapartum medications administered and be aware of the effect they may have on initial breastfeeding experience (Riordan et al., 2000: Evidence Rating: II-2) (Righard & Alade, 1990: Evidence Rating: II-3).
2. Assess postpartum women frequently for level of physical discomfort and review medication orders. Whenever possible, pain medications should be selected and administered just prior to feedings to minimize effects on the breastfeeding infant (Biancuzzo, 1999; Hale, 1999: Evidence Rating: III).
3. While mother and baby are hospitalized, observe an entire infant feeding episode two to three times per day or per facility protocol:
  - a. Assess infant's position at the breast, latch, suck and transfer of milk.
  - b. Verify that the infant is positioned correctly and that the infant's nose, cheeks and chin are touching the mother's breast.
  - c. Whenever possible, use a consistent method to observe and assess infant feeding behavior

(Duffy et al., 1997: Evidence Rating: II-1) (AAP, 1997; Humenick et al., 1998; Biancuzzo, 1999; Riordan & Koehn, 1997: Evidence Rating: III) (Lothian, 1995: Evidence Rating: QI)

4. Assess parents ability to identify infant feeding cues:
  - a. Rooting
  - b. Hand-to-mouth movements
  - c. Sucking movement/sounds
  - d. Sucking of fingers or hands
  - e. Opening of mouth in response to tactile stimulation

- f. Transition between behavior states (sleep to drowsy and quietly alert)

(Moore & Chute, 1996; Riordan & Auerbach, 1999: Evidence Rating: III)  
(Lothian, 1995: Evidence Rating: QI)

- 5. Assess mother-infant interaction and maternal response to feeding cues (Brandt et al., 1998; Humenick et al., 1997: Evidence Rating: III).
- 6. Assess maternal perception of infant satisfaction/satiety cues including the following:
  - a. During the feeding, a gradual decrease in number of sucks
  - b. Pursed lips, pulling away from the breast and releasing the nipple
  - c. Body relaxed
  - d. Legs extended
  - e. Absence of hunger cues
  - f. Sleep, contented state
  - g. Small amount of milk seen in mouth

(Moore & Chute, 1996; Hill et al., 1994; Humenick et al., 1997: Evidence Rating: III) (Lothian, 1995: Evidence Rating: QI)

- 7. Infants discharged before 48 hours of age should be assessed within 48 to 72 hours after discharge by a physician or nurse, who should observe a feeding episode as indicated and assess the following conditions:
  - a. Weight
  - b. Number of feedings per 24 hours
  - c. Number of urine and stool excretions per 24 hours
  - d. Presence of jaundice

(AAP, 1997; AAP, 1998: Evidence Rating: III)

- 8. Assess the breastfeeding woman's ability to identify significant others who are available and supportive of the decision to breastfeed (Humphreys et al., 1998: Evidence Rating: II-2) (Humenick et al., 1997; Kessler et al., 1995; Biancuzzo, 1999; Riordan & Auerbach, 1999: Evidence Rating: III).

### Intervention

- 1. Except as clinically indicated, provide uninterrupted skin-to-skin contact between mother and infant from birth until completion of the first breastfeeding (Righard & Alade, 1990: Evidence Rating: II-3) (AAP, 1997: Evidence Rating: III).
- 2. Assist the woman to breastfeed as soon as possible after birth once she is comfortable and the infant demonstrates feeding cues. Ideally this should occur within the first hour (Aliperti & MacAvoy, 1996: Evidence Rating: II-2) (Rajan & Oakley, 1990; Nyqvist & Ewald, 1997; AAP, 1997: Evidence Rating: III).
- 3. Whenever possible, infants should be awakened at least every three hours for feeding or at least 8 times in 24 hours until they begin to wake on their own (Pearson, 1999; ILCA, 1999: Evidence Rating: III).
- 4. Whenever available, make use of lactation consultant services for inpatient and outpatient breastfeeding women and for staff education (Brent et al.,

- 1995: Evidence Rating: II-2) (Lawrence & Lawrence, 1999: Evidence Rating: III).
5. Use formula supplementation only as medically indicated (AAP, 1997: Evidence Rating: III).
  6. Provide information to breastfeeding women and their significant others about obtaining adequate rest (Pugh & Milligan, 1998: Evidence Rating: II-1).
  7. Whenever possible, avoid the use of pacifiers until the infant is able to latch on and successfully breastfeed with only the assistance of the mother (Schubiger et al., 1997; Howard et al., 1999; Centuori et al., 1999: Evidence Rating: I) (Righard & Alade, 1997: Evidence Rating: II-3).
  8. Provide education to breastfeeding women about breastfeeding that includes:
    - a. Breast massage
    - b. Correct latching on
    - c. Engorgement/nipple soreness
    - d. Breastfeeding patterns
    - e. Breastfeeding positions
    - f. Determining adequate intake

(Riordan & Auerbach, 1999: Evidence Rating: III)

9. Provide education to women and their significant others about infant feeding cues, infant behavior and temperament including how these influence breastfeeding, along with signs of infant transition from sleep to quietly alert (Brandt et al., 1998: Evidence Rating: III) (Lothian, 1995; Locklin, 1995: Evidence Rating: QI).
10. Assist the breastfeeding woman to identify significant others, family and friends who are supportive and knowledgeable about the advantages of breastfeeding for mothers and infants (Humenick et al., 1997: Evidence Rating: III) (Locklin, 1995: Evidence Rating: QI).
11. Avoid providing hospital discharge packs that contain formula samples or advertising unless the mother request one (Dungy et al., 1997: Evidence Rating: I) (Bliss et al., 1997: Evidence Rating: II-2) (Michaelsen et al., 1994: Evidence Rating: III).
12. Provide information about community resources and breastfeeding support groups such as LaLeche League and hospital-based groups (Saadeh & Akre, 1996: Evidence Rating: III).
13. Whenever possible or per facility protocol, provide breastfeeding women with home visits and peer counselors (Caulfield et al., 1998: Not rated) (Morrow et al., 1999; Pugh & Milligan, 1998: Evidence Rating: I) (Kistin et al., 1994: Evidence Rating: II-1) (Wright et al., 1997: Evidence Rating: II-2) (Long et al., 1995: Evidence Rating: II-3) (Locklin, 1995: Evidence Rating: QI).
14. Prevent, when possible, and manage common problems associated with breastfeeding (Duffy et al., 1997; Evidence Rating: II-1):
  - a. Sore nipples:
    - Reinforce information related to proper positioning at the breast and latch as primary means of preventing sore nipples.
    - Instruct women to express colostrum or breast milk on the nipple and areola at the end of each feeding (Centuori et al., 1999; Pugh et al., 1996: Evidence Rating: I) (Biancusso, 1999; Lawrence & Lawrence, 1999: Evidence Rating: III).
    - Consider the use of warm moist compresses should nipple pain occur (Buchko et al., 1996: Evidence Rating: II-2).

- Avoid the use of hydrogel wound dressings to treat sore nipples, until further research validates the efficacy and safety of this type of dressing (Brent et al., 1998: Evidence Rating: I).
  - Instruct women to avoid the use of pacifiers and supplemental feedings whenever possible (Centuori et al., 1999: Evidence Rating: I).
- b. Breast engorgement:
- Encourage the breastfeeding woman to feed on demand.
  - Prior to nursing, using warm compresses, breast massage and manual expression of milk facilitates let down and helps soften the breast.
  - Between feedings, standing in the shower with warm water flowing over the back and chest increases comfort.
  - Observe for signs of mastitis and refer to primary health care provider as indicated

(Biancuzzo, 1999; Riordan & Auerbach, 1999: Evidence Rating: III)

## Postpartum Care - Two Weeks Through First Year

### Expected Outcomes:

1. Ideally, the infant should gain at least four to seven ounces per week after the first two weeks or at least one pound per month.
2. Whenever possible, the breastfeeding woman will breastfeed as long as she plans; ideally, she will verbalize satisfaction with the breastfeeding experience and have confidence in her ability to identify or manage problems that may develop.
3. Ideally, the only source of milk given to the infant during the first year of life will be breast milk.

### Assessment

1. Determine length of time the woman intends to breastfeed and her knowledge about strategies to facilitate continued breastfeeding during return to work or school (Hill et al., 1997: Evidence Rating: II-3) (Wright et al., 1997: Evidence Rating: III).
2. Assess mother-infant interaction and maternal response to feeding cues (Brandt et al., 1998: Evidence Rating: III).
3. Assess maternal perception of infant satisfaction/satiety with breastfeeding (Hill et al., 1997; Matthews et al., 1998: Evidence Rating: II-3).
4. Assess parental knowledge related to the benefits of continued breastfeeding for both the infant and mother and how continued breastfeeding can help the infant and mother make the transition back to work or school (Hill et al., 1997: Evidence Rating: II-3).
5. Determine whether mothers have a supportive work/school environment including the following factors:
  - a. Supportive supervisor
  - b. An appropriate place to pump
  - c. Access to lactation consultants and health care providers

(Cohen & Mrtek, 1994: Evidence Rating: III)

## Intervention

1. Teach the breastfeeding woman and her significant other(s) about the important benefits of continued breastfeeding for both the infant and mother through the first year of life (Hills-Bonczyk et al., 1994: Evidence Rating: II-3) (Humenick et al., 1997; Tarkka et al., 1999: Evidence Rating: III).
2. Provide professional support by lactation consultants and knowledgeable health care providers when possible through the first year of life in both inpatient and outpatient settings (Brent et al., 1995: Evidence Rating: II-1) (Buckner & Matsubara, 1993: Evidence Rating: III).
3. Provide the woman and her significant other(s) with information about normal developmental changes in infants that may influence breastfeeding through the first year of life, such as growth spurts (that usually occur at about two weeks, six weeks and three months) and curiosity and exploration of their environment (Biancuzzo, 1999: Evidence Rating: III) (Locklin, 1995: Evidence Rating: QI).
4. Teach parents about enhanced disease prevention associated with continued breastfeeding (AAP, 1997: Evidence Rating: III) (Locklin, 1995: Evidence Rating: QI).
5. Continue to provide information for women and their significant others about resources for support:
  - a. Peer counselors through community programs or home visits
  - b. Community resources such as LaLeche League or other hospital-based breastfeeding support groups

(Morrow et al., 1999: Evidence Rating: I) (Saadeh & Akre, 1996: Evidence Rating: III) (Locklin, 1995: Evidence Rating: QI)

6. Educate breastfeeding women returning to work and school about the following issues:
  - a. Pumping and storage of breast milk
  - b. Introduction of bottles before returning to work
  - c. Methods for maintaining breast milk supply such as relaxation, reducing stress and frequent nursing in the evening and on days off
  - d. Coping with fatigue
  - e. Alternative feeding options including having the infant brought to her; access to day care setting for feeding during lunch or breaks and having child care providers give expressed breast milk
  - f. Providing education for day care providers about appropriate storage and care of breast milk
  - g. Finding appropriate places to pump milk at work
  - h. Reassurance that partial breastfeeding through the first year of life and beyond can provide significant nutritional benefits and can promote mother-infant/child bonding
  - i. Providing women with material for their employers that highlight corporate economic benefits of supporting breastfeeding
  - j. Identifying individuals and programs in the workplace that are supportive of breastfeeding and breastfeeding mothers

(Kearney & Cronenwett, 1991; Hills-Bonczyk et al., 1993: Evidence Rating: II-3) (Riordan & Auerbach, 1999; Cohen & Mrtek, 1994: Evidence Rating: III)

Refer to the original guideline document for detailed referenced rationales for each clinical practice recommendation.

### Quality of Evidence

I: Evidence obtained from at least one properly designed 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 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 or reports of expert committees.

### Quality of Evidence Rating for Qualitative Studies

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QIII: Total score of 15 or less: 50% or less of total criteria met

The categories are described in the Criteria for Quality Rating in Appendix C of the original guideline document.

### 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 supporting evidence is identified and graded for each recommendation (see "Major Recommendations").

## BENEFITS/HARMS OF IMPLEMENTING THE GUIDELINE RECOMMENDATIONS

### POTENTIAL BENEFITS

The guideline developers hope that these management strategies, which are designed to give guidance in providing optimal care to women of childbearing age and the mother-infant breastfeeding dyad through the first year of the infant's life, will improve both breastfeeding initiation and duration rates.

Benefits of breastfeeding for infants, include:

- Decreased incidence or severity of infections such as otitis media, pneumonia, gastroenteritis, meningitis and urinary tract infections.
- Potential protective effect against sudden infant death syndrome (SIDS), insulin-dependent diabetes, allergies, asthma, lymphoma, Crohn's disease, ulcerative colitis.
- Natural sources of nutrients necessary for optimal growth and development during the first six months.
- Less gastric reflux and constipation than formula feeding.
- Potential for enhanced cognitive development.

Benefits of breastfeeding for women, include:

- Enhanced uterine involution and less postpartum blood loss.
- Potential for earlier return to pre-pregnancy weight than women who do not breastfeed.
- Delayed resumption of ovulation that may facilitate child spacing.
- Reduced risk of osteoporosis, ovarian cancer and premenopausal breast cancer.
- Enhanced mother-infant attachment, maternal role attainment and self-esteem.
- Financial savings: breastfeeding is less expensive than formula feeding and can contribute to significant health care cost savings.

### POTENTIAL HARMS

Not stated

## QUALIFYING STATEMENTS

### QUALIFYING STATEMENTS

- The guideline was developed for the Association of Women's Health, Obstetric, and Neonatal Nurses (AWHONN) as a resource for nursing practice. The guideline does not define a standard of care, nor is it intended to dictate an exclusive course of management. It presents general methods and techniques of practice that are currently acceptable, based on current research and used by recognized authorities. Proper care of individual patients may depend on many individual factors as well as professional judgment. The information presented is not designed to define standards of practice for employment, licensure, discipline, legal or other purposes. Variations and innovations that are consistent with law, and that demonstrably improve the quality of patient care should be encouraged.
- Although the purpose and focus of this Guideline is to promote and support breastfeeding, nurses and other health care providers should ensure that childbearing women who cannot or who choose not to breastfeed receive appropriate care, support, and education. Their care should also be based on current clinical guidelines for infant nutrition and feeding.
- There are a few important instances in which breastfeeding is contraindicated. The American Academy of Pediatrics 1997 Policy Statement "Breastfeeding and the Use of Human Milk" referenced in the guideline, indicates that an infant with galactosemia, an infant whose mother abuses drugs, an infant whose mother has untreated active tuberculosis or an infant whose mother is infected with human immunodeficiency virus (in industrialized countries) should not breastfeed.

## 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)

Association of Women's Health, Obstetric and Neonatal Nurses (AWHONN). Breastfeeding support: prenatal care through the first year. Evidence-based clinical practice guideline. Washington (DC): Association of Women's Health, Obstetric and Neonatal Nurses (AWHONN); 2000 Jan. 33 p. [74 references]

## ADAPTATION

Not applicable: The guideline was not adapted from another source.

## DATE RELEASED

2000 Jan

## GUIDELINE DEVELOPER(S)

Association of Women's Health, Obstetric, and Neonatal Nurses - Professional Association

## SOURCE(S) OF FUNDING

Association of Women's Health, Obstetric and Neonatal Nurses (AWHONN)

## GUIDELINE COMMITTEE

Evidence-based Clinical Practice Guideline Development Team

## COMPOSITION OF GROUP THAT AUTHORED THE GUIDELINE

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## FINANCIAL DISCLOSURES/CONFLICTS OF INTEREST

Not stated

## GUIDELINE STATUS

This is the current release of the guideline.

An update is not in progress at this time.

## GUIDELINE AVAILABILITY

Electronic copies: Not available at this time.

Print copies: Available by contacting the Association of Women's Health, Obstetric and Neonatal Nurses (AWHONN), 2000 L Street, N.W. Suite 740, Washington, D.C. 20036; Phone: (800) 354-2268; Web site: [www.awhonn.org](http://www.awhonn.org).

## AVAILABILITY OF COMPANION DOCUMENTS

The following are available:

- Evidence-based clinical practice guideline. Breastfeeding support: prenatal care through the first year: Monograph. Washington (DC): Association of Women's Health, Obstetric and Neonatal Nurses (AWHONN), 2000 Jan. 36 p.
- Breastfeeding support: prenatal care through the first year. Quick care guide. Washington (DC): Association of Women's Health, Obstetric and Neonatal Nurses (AWHONN), 2000 Jan. 2 p.

Electronic copies: Not available at this time.

Print copies: Available by contacting the Association of Women's Health, Obstetric and Neonatal Nurses (AWHONN), 2000 L Street, N.W. Suite 740, Washington, D.C. 20036; Phone: (800) 354-2268; Web site: [www.awhonn.org](http://www.awhonn.org).

#### PATIENT RESOURCES

None available

#### NGC STATUS

This NGC summary was completed by ECRI on April 9, 2002. The information was verified by the guideline developer on June 7, 2002.

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