



*The Royal College of*  
**Midwives**

# Evidence Based Guidelines *for* *Midwifery-Led Care in Labour*

## Early Breastfeeding



## Practice Points

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Practices that support the initiation of breastfeeding include antenatal group discussion, the availability of peer support, and maternity routines that keep mothers and babies together (Bramson et al. 2010; Dyson et al. 2006; Fairbank et al. 2000).

There is no critical period during which the first breastfeed should occur as long as mothers and babies have unrestricted contact in a relaxed atmosphere; the pace and timing of the first feed should be left to them (Colson et al. 2008, Britton et al. 2007; Colson 2007; Moore et al. 2007; Dyson et al. 2006).

Skin-to-skin contact positively impacts on the first breastfeed and on maternal and newborn physiological and behavioural outcomes and there is no evidence of harm (Bramson et al. 2010; Moore et al. 2007). The mother should be ensured opportunities for early skin-to-skin contact.

Routines in practice should not interfere with the opportunity for a mother and baby to be together (DH 2009; Britton et al. 2007; NICE 2006; Olsen 2000).

Mothers should have access to support for their baby's first breastfeed (Dyson et al. 2006; Renfrew et al. 2000).

Mothers should be helped to achieve a comfortable position for themselves and with attaching the baby so that feeding does not hurt (RCM 2002).

Pharmacological analgesia in labour, including those used in epidural administration should be considered carefully in the light of potential effects on the baby and on feeding (Jordan et al 2005; Radzyminki 2005; Renfrew et al. 2000).

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There is considerable evidence available related to the promotion and support of breastfeeding. This includes Cochrane reviews (Moore et al. 2007; Britton et al. 2007), structured reviews such as Enabling women to breastfeed (Renfrew et al. 2000), Evidence for the ten steps to successful breastfeeding (WHO 1998) and Guides for midwifery practice including successful breastfeeding (The Royal College of Midwives 2002). This section will, therefore, not include a re-review of the extensive and easily accessible earlier literature, but will focus on recent research appropriate to supporting breastfeeding in settings where midwifery-led care is provided.

A systematic review identified practices that increased the rate of the initiation of breastfeeding; these include antenatal group discussion, the availability of peer support, particularly amongst women from low-income groups, and maternity routines that support mother-infant contact (Fairbank et al. 2000). A later review of the evidence base for effective interventions in promoting of breastfeeding initiation and duration by Dyson et al. (2006) added to this knowledge by reviewing broader mega, macro and micro level factors. However, the influencing factors for early feeding initiation remained constant.

Key considerations related to early breastfeeding in any birth setting include the timing of the first breastfeed, the mother's overall comfort, access to support, avoiding separation of mother and baby (in the absence of life-threatening situations) and the process and routines of care.

There has been considerable debate about the "correct" timing of the first breastfeed. Previously some authorities advocated initiation of breastfeeding within certain times following birth (WHO 1998), but, although feeding within an hour or so of birth seems optimal (Colson 2007), there is no evidence of a "critical period", thus a less prescriptive approach that does not force the pace or timing of the first feed appears more appropriate (Britton et al. 2007; Enkin et al. 2000). The NICE guidelines on postnatal care stated that most healthy full term babies will demonstrate pre-feeding behaviours within the first hour of life (NICE 2006). Early and close contact between the woman and her baby is essential with breastfeeding taking place when mother and baby are ready (Moore et al. 2007; Dyson et al. 2006). Colson et al.'s (2008) study states the importance of the positioning of the baby to enhance the initiation of breastfeeding. Bramson et al. (2010) showed clear benefits of skin-to-skin contact within first 3 hours post-birth increasing exclusive breastfeeding during hospital stay.

The Department of Health 'Healthy Child programme' (DH 2009) policy recommendations on breastfeeding at birth are:

- Initiate as soon as possible (within one hour of delivery) using support from healthcare professional, or peer unless inappropriate;
- 24-hour rooming-in and continuing skin-to-skin contact where possible.

In providing appropriate care, midwives will need to consider the impact of interventions in labour, for example, the type of analgesia used and its effect on baby's behaviour and breastfeeding (Bramson et al. 2010, Jordan et al. 2005, Ransjo-Arvidson et al. 2001; Widstrom et al. 1987). Negative effects on early breastfeeding include the administration of pethidine (Rajan 1994) and Jordan's et al.'s (2005) study found that intrapartum Fentanyl administration, especially in high doses may impede establishment of breastfeeding. Radzynski (2005) also found that babies with lower neurobehaviour exhibited lower breastfeeding behaviour.

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Women should have access to professional support for their baby's first breastfeed (Dyson et al. 2006, Renfrew et al. 2000). In the UK, midwives will most commonly support early breastfeeding. Support should include helping the mother to achieve a comfortable position for breastfeeding, pain relief if required and use of an enabling rather than controlling approach (RCM 2002). The aim should be that early breastfeeding should be pain-free for the mother and effective for her baby (Mulder 2006). It appears appropriate to ensure privacy and to encourage the first breastfeed to take place whilst the mother's preferred support person is still present (Enkin et al. 2000). Fathers/partners should be supported to stay overnight where possible if the mothers have requested that they do so.

Skin-to-skin contact for women and their babies has been the subject of considerable research. Moore et al. (2007) define skin-to-skin contact as "placing the naked baby, covered across the back with a warm blanket, prone on the mother's bare chest". The most recent systematic review (Moore et al. 2007) concluded that this practice had significant positive effects on initiation of breastfeeding as well as some positive maternal and neonatal physiological and behavioural outcomes. A later study by Bramson et al. (2010) demonstrated that skin-to-skin contact for more than 1 hour during the first 3 hours after birth had a positive impact on breastfeeding. There was no evidence of harm from early skin-to-skin contact. The quality of the methodology in some of the included studies were questioned, but not seen to weaken the conclusions (Moore et al. 2007). It is usually presumed that skin-to-skin contact will involve the mother and her baby; no evidence has been identified that explores skin-to-skin contact provided by fathers.

Separation of a mother from her baby should be avoided unless there is a life-threatening situation. Institutional routines should not interfere with the opportunity for a mother and baby to be together (NICE 2006, Olsen 2000). Some time should elapse between the first breastfeed and administration of oral vitamin K preparations to babies, to avoid negative associations with breastfeeding (Renfrew et al. 2000). The NICE postnatal guidelines (2006) recommend intramuscular administration of Vitamin K. Available studies suggest that breastfeeding can alleviate pain in the neonate and comfort the mother during this procedure (Frank & Gilbert 2003, Shah et al. 2006).

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The guidelines have been developed under the auspices of the RCM Guideline  
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Development, Professional Midwifery Lead.

The guideline review process will commence in 2016 unless evidence requires  
earlier review.

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## Appendix A

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### Sources

The following electronic databases were searched: The Cochrane Database of Systematic Reviews, MEDLINE, Embase and MIDIRS. As this document is an update of research previously carried out, the publication time period was restricted to 2008 to March 2011. The search was undertaken by Mary Dharmachandran, Project Librarian (RCM Collection), The Royal College of Obstetricians and Gynaecologists.

### Search Terms

Separate search strategies were developed for each section of the review. Initial search terms for each discrete area were identified by the authors. For each search, a combination of MeSH and keyword (free text) terms was used.

### Journals hand-searched by the authors were as follows:

- Birth
- British Journal of Midwifery
- Midwifery
- Practising Midwife
- Evidence-based Midwifery