Promote, Protect, and Support Breastfeeding: What is the Role of Obstetricians?

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The World Health Organization recommends exclusive breastfeeding for the first 6 months of an infant's life. In Hong Kong, although many mothers initiate breastfeeding, most do not continue as long as they had planned. Common reasons for discontinuation were insufficient breast milk, tiredness and fatigue, return to work, lack of support, and introduction of formula feeding before 1 month. The American College of Obstetricians and Gynaecologists strongly supports breastfeeding and calls on its Fellows, other related professionals, hospitals, and employers to support women in choosing to breastfeed their infants. Obstetricians, in collaboration with paediatricians, lactation consultants and other disciplines can help promote, protect, and support breastfeeding in the antepartum, intrapartum, and postpartum period. They can also support policy efforts in hospitals and workplaces that enable women to breastfeed. All obstetricians should improve their knowledge about breastfeeding to benefit babies and mothers.
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Introduction

The World Health Organization (WHO) recommends exclusive breastfeeding for the first 6 months of an infant's life. The benefits of breastfeeding to the baby and their mother are well documented and include protection from infection, biological signals to promote cellular growth and differentiation, reduced maternal postpartum blood loss, and reduced risk of ovarian and breast cancer[1-6]. Breastfeeding is also good for society and the environment. This article will discuss the reasons for low exclusive breastfeeding rates at 4 to 6 months, and how obstetricians can help promote, protect, and support breastfeeding.

Discontinuation of Breastfeeding

In Hong Kong, the breastfeeding rate on hospital discharge increased from 19.0% in 2002 to 86.3% in 2015[7]. Nonetheless, the exclusive breastfeeding rate for babies up to 4 to 6 months old was only 27%[7]. In other words, although many mothers initiated breastfeeding, most did not continue. Common reasons for discontinuation were insufficient breast milk, tiredness and fatigue, return to work, lack of support, and introduction of formula feeding before 1 month[7,8]. If mothers experience breastfeeding problems and health care providers are ill-equipped to manage these problems and instead advise mothers to supplement with formula, then mothers are more likely to discontinue exclusive breastfeeding[9]. Previously, residents and obstetrician-gynaecologists have been found to be ill-informed about the benefits of breastfeeding and clinical management[10]. Training in infant nutrition was lacking or inadequate[11].

Support Breastfeeding

Support from health care providers in the hospital, from family members at home, from employers in the workplace, and from the community can increase a mother's confidence and experience in breastfeeding[12-16]. The American College of Obstetricians and Gynaecologists (ACOG) strongly supports breastfeeding and calls on its Fellows, other related professionals, hospitals, and employers to support women in choosing to breastfeed their infants[13]. Obstetricians are in an ideal position to assist women to make an informed decision about feeding, offer anticipatory guidance, support normal lactation, and manage breastfeeding problems[17]. It is preferable to integrate care by the obstetrician, paediatric provider, and lactation consultant and involve family members[17,18]. On the contrary, an opinion leader strategy (i.e. an expert to influence the behaviour of health care professionals) should

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be discouraged as it does not improve breastfeeding rates[19].

Training

Obstetricians should be adequately trained and continuously educated if they are to provide accurate information about breastfeeding to expectant mothers and be prepared to support them should any breastfeeding problems arise. The ACOG recommends that all obstetrician-gynaecologists and other obstetric care providers should develop and maintain knowledge and skills in anticipatory guidance, physical assessment and support for normal breastfeeding, and management of common lactation problems[20]. The Department of Health has prepared an educational CD on breastfeeding for health care workers. The Obstetric and Gynaecological Society of Hong Kong has devised questions based on the CD. Fellows are able to complete the test and earn continuous medical education points that are accredited by the Hong Kong College of Obstetricians and Gynaecologists. In addition to knowledge and practical skills, obstetrician attitude to their responsibility for and the benefits of infant feeding counselling are equally important[19].

Antepartum

The ACOG recommends obtaining a breastfeeding history, identifying concerns and risk factors for breastfeeding difficulties, and communicating these to the infant's health care provider[20]. Physical examination of the breasts can identify congenital anomalies, inverted nipples or prior breast surgery, all of which can hinder lactation[21]. Mothers should be counselled about the benefits of breastfeeding, starting as early as the first trimester[18]. Those who are unable to obtain quality health care for socio-economic reasons are more likely to face greater barriers to initiation and continuation of breastfeeding[18]. Provider encouragement has been shown to significantly increase breastfeeding initiation, especially among low-income, young, less-educated, or single women[22]. Although breast milk is the best, some mothers choose not to or cannot breastfeed. Health care providers should be sensitive to their needs[18]. Patient demographics rather than physician practice predict low breastfeeding rates[23].

Obstetricians can help clarify misconceptions. Maternal hepatitis B virus (HBV) infection, common in Hong Kong, was one of the reasons for the persistently low breastfeeding rate[24]. It is important to provide appropriate counselling on its safety with regard to mother-to-child transmission of HBV after newborns have received hepatitis B vaccine and immunoglobulin at birth, in order to allay the fear and anxiety of HBV surface antigen–positive mothers[24]. Transmission of hepatitis C through breastfeeding has not been documented.

Intrapartum

Maternal care practices can influence breastfeeding rates. Facilitating immediate skin-to-skin contact between mother and infant and early initiation of breastfeeding are well known measures to improve breastfeeding[25]. Obstetricians should be aware that a prolonged second stage of labour and Caesarean delivery are associated with delayed lactogenesis, while unmedicated spontaneous vaginal delivery is associated with positive breastfeeding outcomes[26]. Mother-friendly care including non-pharmacological pain relief, mobilisation, and presence of partner during labour should be encouraged.

Postpartum

When there are concerns about lactation during the first few days following birth, the infant must be carefully assessed for jaundice, as well as weight loss[25,26]. Parents should be supported in their decision to breastfeed[25]. Lactation consultants can provide valuable support and education for new mothers. Obstetricians can educate women who breastfeed about the option of breast pumps and expressed breast milk[25]. For newborn's excessive weight loss (more than 10% of the birth weight) or neonatal jaundice that requires phototherapy, a paediatric consultation should be arranged.

Infants in the Neonatal Intensive Care Unit

For preterm infants, human milk offers special benefits in host defence, gastrointestinal development, special nutrition, and neurological outcome[1,27,28]. Human milk is associated with improving outcomes of infants in the neonatal intensive care unit (NICU). Yet, mothers in the NICU face difficulties including delayed onset of lactation and insufficient milk. Obstetricians can help mothers make an informed decision to breastfeed in NICU and provide appropriate support[29]. Mothers may prefer pumping milk to feeding from the breast. It is important to select an appropriate breast pump to optimise breast milk supply and prevent injury. As women are unique in their response to individual pumps, one particular pump style or brand may not suit all[30].

Infection

Good hygiene during expression, storage, and feeding should be in place to reduce contamination of human milk with group B streptococcus, methicillin-resistant *Staphylococcus aureus*, or other pathogens[31]. In

the presence of varicella-zoster virus, measles, or herpes on the breast, the mother can temporarily pump and discard her milk until the infection is clear. Human immunodeficiency virus and active tuberculosis before treatment are contra-indications to breastfeeding.

Breast Pain

Some level of breast pain is common in breastfeeding women. Early nipple pain due to suboptimal positioning and latch need to be corrected. For persistent pain, other causes including dermatitis, infection, vasospasm, depression, functional pain, and other rare concerns should be investigated. A careful history should be obtained along with physical examination of the mother's breasts for mass or infection, and the infant's mouth for tongue tie, infection, and abnormal suck mechanics[31]. When women experience breastfeeding problems, they are at risk of postpartum depression, and should be screened and managed appropriately[21]. Treatment of the underlying cause, and working with a lactation consultant are recommended[31].

Medications

The effects of medication on breast milk or feeding should be assessed before being prescribed[26]. Most medications appear in breast milk in very small and safe amounts, and are compatible with breastfeeding[32]. The few exceptions are drugs of abuse, antimetabolites such as chemotherapy, and radioactive compounds. It is not good practice to stop breastfeeding when a new medication is prescribed because little or no information is immediately available. Up-to-date resources are available online, for example, LactMed Drugs and Lactation Database (https://toxnet.nlm.nih.gov/newtoxnet/lactmed.htm). Before prescribing, careful assessment of the infant is necessary in all cases, especially in vulnerable infants including those who are preterm, at risk of apnoea, sick, or poorly growing[32]. The use of multiple drugs with similar side-effects of respiratory depression and sedation should be avoided. For contraception, non-hormonal contraceptive methods are preferred as oestrogen-containing oral contraceptives can decrease milk supply. As a second choice, progestogen-only pills may be prescribed.

After prescription, the infant should be monitored for non-specific signs including sedation, drowsiness, or changes in sleep pattern[32]. If non-specific signs occur, proxy markers can be assessed. For example, checking infant prothrombin time if the mother is taking warfarin, or plasma drug levels when taking antiepileptic drugs is recommended.

Policy

The ACOG recommends that obstetrician-gynaecologists and other obstetric care providers should be at the forefront of policy efforts to enable women to breastfeed[21].

Baby-friendly Hospital Initiative

In 1991, the WHO and the United Nations Children's Fund (UNICEF) first launched the Baby-friendly Hospital Initiative (BFHI) aiming to give every baby the best start in life by removing breastfeeding barriers in health facilities and encouraging women to implement the 'Ten Steps to Successful Breastfeeding'[33,34]. Delivery at designated 'baby-friendly' facilities has been shown to increase breastfeeding rates[35]. Different hospitals in Hong Kong have different levels of participation in the BFHI.

Marketing Code

The International Code of Marketing of Breast-milk Substitutes was developed by the WHO and UNICEF in 1981 to protect breastfeeding[36]. Similar coding was drafted in Hong Kong. Some of the relevant rules include: (a) no promotion of products (breastfeeding substitutes, feeding bottles or teats) in or through health care facilities, (b) no gifts or personal samples to health care workers, and (c) health care workers should never pass samples on to mothers[36]. In the past, formula company–produced infant feeding literature, pregnancy literature, and free formula offers were commonly used[12].

Support at the Working Place

Allowing breastfeeding breaks, provision of safe working conditions, and a comfortable, private place to breastfeed and express milk are all effective means of supporting and protecting breastfeeding[37].

Conclusions

Obstetricians, in collaboration with the paediatric provider, lactation consultant and other disciplines, can help promote, protect, and support breastfeeding in the antepartum, intrapartum, and postpartum period. They can also support policy efforts in hospitals and the workplace that enable women to breastfeed. All obstetricians should improve their education about breastfeeding to benefit babies and their mothers.

Declaration

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