



POLICY

Breastfeeding protection, promotion and support

Scope (Staff):	Community Health
Scope (Area):	CACH, WACHS

Child Safe Organisation Statement of Commitment

CAHS commits to being a child safe organisation by applying the National Principles for Child Safe Organisations. This is a commitment to a strong culture supported by robust policies and procedures to reduce the likelihood of harm to children and young people.

This document should be read in conjunction with this [disclaimer](#)

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Aim

This policy aims to:

- describe and promote the normal physiological processes of lactation and breastfeeding, and associated infant behaviours;
- identify the principles and strategies that Child and Adolescent Community Health (CACH) and the WA Country Health Service (WACHS) align with to protect, promote and support lactation and breastfeeding;
- assist CACH and WACHS Community Health nurses (nurses) in their provision of lactation and breastfeeding anticipatory guidance, education and support; and
- guide nurses in their assessment of lactation and breastfeeding concerns.

Risk

The absence of a clearly articulated policy may result in:

- care that does not value or support breastfeeding;
- missed opportunities to provide anticipatory guidance that promotes and supports the initiation and continuation of lactation and breastfeeding; and
- delayed identification of lactation and breastfeeding concerns, and an associated care planning process.

Definitions

A glossary of the key terms used in this policy is provided in [Appendix 1](#).

Key points

- Nurses play a crucial role in promoting breastfeeding, supporting mothers in sustaining lactation and addressing common breastfeeding challenges by identifying deviations from the norm and developing care plans.
- Nurses will provide anticipatory guidance to families at all Universal contacts to encourage, promote and support lactation and breastfeeding.
- If breastfeeding is not possible, nurses will support mothers and families to safely feed their infant using other methods, including with infant formulaⁱ.
- Nurses will work within their scope of practice. Where resolution of a client concern is outside of this scope, a referral will be initiated.

ⁱ In this policy, the term 'infant formula' also refers to formula, baby formula, commercial milk formula and breastmilk substitute.

OD 0435/13 - The term Aboriginal is used in preference to Aboriginal and Torres Strait Islander, in recognition that Aboriginal people are the original inhabitants of Western Australia. No disrespect is intended to our Torres Strait Islander colleagues and community.

- Nurses will inspect visually and adopt a hands-off approach when conducting a breastfeeding assessment.
- Standard precautions are to be applied by nurses when conducting assessments and/or if in contact (or likely to be in contact) with blood or body fluids, non-intact skin and mucous membranes.
- Nurses must follow the organisation's overarching Infection Control Policies ([CAHS](#), [WACHS](#)) and perform hand hygiene in accordance with WA Health guidelines ([CAHS](#), [WACHS](#)) at all appropriate stages of a procedure.
- Nurses will take a family-centred and strengths-based approach, and will uphold the principles outlined in the [CAHS Child and Family Centred Care Policy](#) or the [WACHS Goals of Patient Care Guideline](#).
- Nurses are required to complete training as per the [CAHS-Community Health Practice Framework for Community Health Nurses](#) or the WACHS Practice Framework for Population Health Nurses.
- Nurses will refer to the [Nursing and Midwifery Board AHPRA Decision-making framework](#) in relation to scope of practice and delegation of care to ensure that decision-making is consistent, safe, person-centred and evidence-based.
- Nurses will provide culturally safe service delivery, which demonstrates a welcoming environment and recognises the importance of the cultural beliefs and practices of all clients.

Background

CACH and WACHS affirm the World Health Organization's position that breastfeeding is the biological and social norm for infant feeding.¹ CACH and WACHS promote and support the WHO recommendations that infants be:

- breastfed within one-hour of their birth;
- exclusively breastfed in their first six-months of life; and
- given adequate, safe and complementary foods from six-months of age.¹

In line with the [Australian National Breastfeeding Strategy: 2019 and Beyond](#), CACH and WACHS affirm the importance of supporting mothers and infants to continue breastfeeding, with appropriate complementary foods, until 12-months of age and beyond, for as long as the mother and infant (or child) desire.²

[Appendix 8](#) (Breastfeeding protection, promotion and support – Supporting information) is required pre-reading to implement this policy. It also supports the training that CACH and WACHS nurses are required to complete. The resource provides information to assist nurses in protecting, promoting and supporting breastfeeding. The content covers breastfeeding benefits and data, breastfeeding and breastmilk supply physiology, infant reflexes and feeding cues, attachment and positioning, milk transfer, skin-to-skin contact, expressed breast milk and infant formula, factors influencing breastfeeding, how breast variations may impact lactation and breastfeeding, vaccination and breastfeeding when sick.

How CACH and WACHS promote, protect and support breastfeeding

There is a convincing association between the provision of breastfeeding support during the antenatal and perinatal periods and a longer duration of breastfeeding.³ In the context of the WA Health *Sustainable Health Review*, Enduring Strategy 3 ('*Great beginnings and a dignified end of life*') highlights the significance of breastfeeding.⁴

The following Universal contacts seek to identify health and developmental concerns at key life stages, including in relation to lactation and breastfeeding: [Initial interaction](#), [0-14 days](#), [8 weeks](#), [4 months](#), [12 months](#) and [2 years](#). Lactation and breastfeeding may also be discussed at [Universal plus – child health](#) contacts (to manage, review and resolve concerns). The provision of anticipatory guidance at all Universal contacts is essential. For families with complex concerns, including those that relate to breastfeeding, CACH offers [Partnership – child health service](#) contacts, while WACHS deliver the [Enhanced Child Health Schedule](#).

Nurses working in child health are well-placed to implement the Baby Friendly Health Initiative's (BFHI's) [Seven Point Plan](#) for community health facilities (see Table 2). With their knowledge of maternal and infant healthcare needs, and experience working with families, nurses have a pivotal role in promoting and supporting lactation and breastfeeding.

Table 2 Baby Friendly Health Initiative's Seven Point Plan for community health facilities⁵

Critical management procedures: Relevant points
<p>1a: Have a written infant and young child feeding policy that is routinely communicated to all staff and parents.</p> <p>1b: Comply fully with the International Code of Marketing of Breastmilk Substitutes and Relevant World Health Assembly Resolutions.</p> <p>1c: Establish Ongoing Monitoring and Data-Management Systems.</p> <p>2: Ensure that staff have sufficient knowledge, competence and skills to implement the infant and young child feeding policy.</p>
Key clinical practices: Relevant points
<p>3: Inform women and their families about breastfeeding being the biologically normal way to feed a baby.</p> <p>4: Provide timely support to mothers while they are establishing breastfeeding and during challenges maintaining breastfeeding.</p> <p>5: Support mothers to exclusively breastfeed their infant up to six months of age, with continued breastfeeding along with appropriate introduction of complementary foods.</p> <p>6: Provide a supportive environment and information for all families, regardless of feeding choice.</p> <p>7: Work collaboratively with maternity facilities, breastfeeding support groups and the local community to protect, promote and support breastfeeding.</p>

The following section illustrates how these points are integrated into CACH and WACHS practice.

Process: Providing lactation and breastfeeding anticipatory guidance

(Addresses BFHI Points 1b, 3, 4, 5, 6, 7)

The following table provides nurses with anticipatory guidance that can be discussed with mothers and families at Universal contacts and Universal Plus – child health contacts. To provide a proactive and family-centred approach, nurses must tailor the provision of this guidance to the circumstances and needs of each family.

Nurses may refer families to [print resources](#) and [Videos](#) for more information. If required, families can be referred to [internal](#) and [external](#) support services. As Universal Contact initial interaction appointments take place over the telephone, it is not possible to provide print resources. Depending on individual circumstances, nurses may guide mothers and families to [print resources](#) and [videos](#).

Anticipatory guidance points	Universal contact appointment					
	Initial interaction	0-14 days	8 weeks	4 months	12 months	2 years
Breastfeeding						
• Encourage exclusive breastfeeding until six-months of age	✓	✓	✓	✓		
• Encourage breastfeeding until 12-months and beyond				✓	✓	✓
• No other liquids/foods needed (other than medication) until six-months of age	✓	✓	✓	✓		
• What to expect when lactating and breastfeeding (including potential challenges)	✓	✓	✓	✓		
• Typical daily number of breastfeeds (8-12/day typical in young infants)	✓	✓	✓	✓		
• Avoiding dummies, bottles and teats while establishing breastfeeding	✓	✓				
• Hunger/satiety cues and responsive feeding	✓	✓				
• Skin-to-skin contact, positioning, attachment and signs of effective feeding	✓	✓				
• Expressing breastmilk (how to express, store and use)	✓	✓	✓			
Infant safety						
• Safe sleep: Returning the infant to the cot after feeding	✓	✓	✓	✓	✓	✓

Anticipatory guidance points	Universal contact appointment					
	Initial interaction	0-14 days	8 weeks	4 months	12 months	2 years
Infant formula (if used) and bottle feeding						
• Infant formula usage instructions	✓	✓	✓			
• Bottle feeding, including paced feeding	✓	✓	✓			
Introducing solid foods and other fluids						
• Readiness for complementary foods at around six-months of age and starting solids				✓		
• Consume a wide variety of nutritious family foods by 12-months of age					✓	
• Encourage continued breastfeeding in addition to eating solid foods				✓	✓	✓
• Offer cool, boiled tap water (cow's milk and alternatives can be offered from 12-months of age as per the Australian Dietary Guidelines)				✓	✓	✓
Maternal factors						
• Mother's self-care strategies and building support systems	✓	✓	✓	✓	✓	✓
• Effects of nutrition, and alcohol and other drug use on breastmilk safety	✓	✓	✓	✓	✓	✓
• Balancing breastfeeding and work	✓	✓	✓	✓	✓	✓

For [Universal Plus – child health](#) contacts:

- Provide anticipatory guidance to families that is relevant to the infant and/or maternal concern(s) identified by the nurse or mother/family.
- Refer to the examples of anticipatory guidance listed above and in relevant CACH/WACHS policies for possible discussion topics.

Process: Supporting lactation and breastfeeding when concerns are identified

(Addresses BFHI Points 1b, 2, 3, 4, 5, 6, 7)

If a lactation or breastfeeding concern is identified by the nurse or raised by the mother/family during a Universal contact or Universal Plus – child health contact, an assessment process must be initiated.

Nurses are to conduct a comprehensive and systematic breastfeeding assessment by:

- understanding normal breastfeeding and lactation;
- gathering information about the infant's feeding status and efficiency;
- collecting information about the infant's and mother's health and wellbeing; and
- identifying risk factors known to influence lactation and breastfeeding.⁶

Using this assessment approach provides a framework for determining interventions according to need. Care planning may include referral and/or interventions to ensure the infant's nutritional requirements are being met and the mother's health is maintained, whilst enabling normal developmental feeding milestones.

The following table outlines the steps a nurse must take when a lactation or breastfeeding concern has been identified. It is essential that:

- The [Breastfeeding Assessment Guide](#) (BAG) is used to guide the observation and assessment process. A completed BAG must accompany all referrals.
- External resources/websites/applications are not to be used to conduct a lactation or breastfeeding assessment, or establish a care pathway.
- Before an assessment is undertaken, verbal consent has been obtained from the mother (client) and recorded on the BAG and electronically in CDIS or CHIS.
- Nurses will inspect visually and take a hands-off approach where possible (i.e. supporting breastfeeding with no or minimal physical intervention) by:
 - encouraging the mother to observe her infant at the breast;
 - verbally communicating information and suggestions to the mother;
 - discussing key elements of breastfeeding (e.g. infant feeding cues, positioning and attachment, and satiety signs); and
 - using teaching aids (e.g. props, posters, videos and print resources).⁷

Process	Additional information
Step 1: Pre-appointment preparation	
<ul style="list-style-type: none"> • Have a copy of the following forms available: <ul style="list-style-type: none"> ○ BAG (CHS012) ○ My Care Plan (CHS825) 	<ul style="list-style-type: none"> • Reviewing infant and maternal risk factors will help to identify actual or potential lactation or breastfeeding problems, and guide care planning pathways.

Process	Additional information
<ul style="list-style-type: none"> ○ CACH: Clinical Handover/Referral from Community Health Services (CHS663) ○ WACHS: Clinical Handover (Allied & Community Health). • Review the client's health record in CDIS or CHIS. • If a concern has already been identified, use the BAG to: <ul style="list-style-type: none"> ○ capture the child's and mother's names and contact information ○ document any known, relevant risk factors ○ record the infant's birth and discharge weights, head circumference and length. 	
Step 2: Explanation and consent	
<ul style="list-style-type: none"> • At the appointment, explain that you will enquire about the health of the mother and infant, lactation and breastfeeding, and infant feeding patterns. • For all in-person Universal contacts, advise that the following assessments may be conducted (if a concern is apparent): <ul style="list-style-type: none"> ○ infant physical health (including oral anatomy) ○ maternal physical and emotional health (including breast health) ○ observation of a breastfeed ○ infant growth measurements. • Request the mother's verbal consent to conduct the above-listed assessments. Record this consent on the BAG and in CDIS or CHIS. • If consent is refused: <ul style="list-style-type: none"> ○ gently request the reason for refusal ○ reiterate the importance of conducting the assessment ○ communicate the risks of refusing consent. 	<ul style="list-style-type: none"> • For further information about conducting telephone-based initial interactions, see Universal contact initial interaction. • For all in-person Universal contacts, aim to conduct the appointment in a comfortable environment. • Encourage the mother to have a support person present (e.g. partner or extended family member). • Aim to build rapport with those in attendance to encourage open communication. • Consent should always be informed, current and relevant to the treatment in accordance with the CACH Consent for Services Policy or WACHS Engagement Procedure.

Process	Additional information
<ul style="list-style-type: none"> • If consent is still refused, record this on the BAG and use CDIS or CHIS to document the discussion, including the assessment(s) offered, the indicators for offering the assessment(s), the benefits/risks, the reasons for refusal and that the implications of refusal have been communicated to the client. • If consent is refused, do not conduct any assessments. Instead: <ul style="list-style-type: none"> ○ provide relevant information and support resources (see Anticipatory guidance) ○ use clinical judgement to determine if care planning and/or referral are required (see Steps 5, 6, 7, 8). 	
Step 3: Collect background information	
<ul style="list-style-type: none"> • At the first contact with the client, enquire about: <ul style="list-style-type: none"> ○ the pregnancy and birth ○ past lactation and breastfeeding experiences ○ infant feeding goals ○ infant health status ○ maternal health status (physical and emotional) ○ whether any infant or maternal health care plans are in place (if so, review) ○ whether any brief interventions for breastfeeding plans are in place (if so, review) ○ infant feeding status (method of feeding, whether lactation and breastfeeding are going well or there are challenges) ○ current lactation and breastfeeding challenges. • Use the BAG to document any risk factors not previously recorded. 	<ul style="list-style-type: none"> • If any deviations from normal are detected during a Universal contact initial interaction, review the brief interventions that were implemented. If concerns persist, perform a more detailed assessment during the 0-14 day contact. If necessary, restart the process from Step 2 for reassessment. • Be alert to responses that suggest: <ul style="list-style-type: none"> ○ infant physical discomfort ○ maternal physical discomfort ○ difficulties with milk transfer ○ complementary feeds are being used ○ maternal emotional health concerns.

Process	Additional information
<p><u>Concerns identified during a Universal contact initial interaction</u></p> <ul style="list-style-type: none"> • If deviations from normal are identified: <ul style="list-style-type: none"> ○ reinforce an infant's capacity to breastfeed as an essential developmental milestone ○ advise that maternal and infant deviations require early intervention to maximise breastfeeding duration and healthy outcomes ○ implement brief interventions (if not already in place) for review at the Universal contact 0-14 days contact ○ record these details in a My Care Plan ○ document the findings in CDIS or CHIS. <p><u>Concerns identified at all other universal contacts</u></p> <ul style="list-style-type: none"> • <u>Ongoing concerns:</u> If concerns are identified that necessitate further assessment, use the BAG to perform an infant and maternal assessment (see Step 4). • <u>No ongoing concerns:</u> If the initial concerns have been resolved, offer information and resources to promote continued breastfeeding (see Anticipatory guidance). 	
Step 4: Infant and maternal assessment	
<ul style="list-style-type: none"> • Use the BAG to guide an infant: <ul style="list-style-type: none"> ○ anthropometric assessment ○ oral anatomy assessment ○ posture, tone and movement assessment ○ elimination review ○ review of general behaviour. • Use the BAG to guide a breastfeeding observation and assessment: 	<ul style="list-style-type: none"> • Follow Standard precautions, Infection Control Policies and perform hand hygiene as noted in the Key points. • PPE required only if there is a potential risk of exposure with client's blood/body fluids or contact with non-intact skin or mucous membranes.

Process	Additional information
<ul style="list-style-type: none"> ○ observe the breasts and nipples ○ enquire about emotional health, milk volume, expressing and the use of lactation aids and medications ○ consider infant attachment ○ note sucking or swallowing difficulties. • Note the findings on the BAG and in CDIS or CHIS. • No concerns apparent: Offer information and support resources to promote continued breastfeeding (see Anticipatory guidance). • Concerns apparent: Commence the care planning and/or referral pathway: <ul style="list-style-type: none"> ○ Step 5: Care planning ○ Step 6: Referral and clinical handover 	<ul style="list-style-type: none"> • If the infant has recently fed, observing a breastfeed may not be feasible. Gather as much information as possible by talking to the mother/family, asking questions and visually assessing the breast. • The BAG offers guidance on additional information sources that can help nurses identify deviations from typical lactation and breastfeeding behaviours. It directs nurses to the Appendices within this policy. The Appendices are: <ul style="list-style-type: none"> ○ Appendix 2: Maternal breast pain ○ Appendix 3: Maternal nipple pain ○ Appendix 4: Unsettled infant ○ Appendix 5: Ineffective suck ○ Appendix 6: Hypolactation ○ Appendix 7: Hyperlactation • For more information about conducting an infant physical assessment (including mouth and musculoskeletal), see Physical Assessment 0-4 years. • If concerned about maternal emotional health, see Infant and perinatal mental health guideline and Edinburgh Postnatal Depression Scale.
Step 5: Care planning	
<ul style="list-style-type: none"> • Use the relevant Appendix to establish a care plan. • A My Care Plan must be completed in partnership with the client. The care plan will outline: <ul style="list-style-type: none"> ○ a summary of the concern(s) ○ lactation and breastfeeding goals ○ strategies for the client to implement ○ review appointment details ○ referral point/s (see Step 6) ○ when to escalate care. 	<ul style="list-style-type: none"> • Selecting suitable care planning strategies contributes to ensuring: <ul style="list-style-type: none"> ○ the infant's nutritional requirements are being met ○ breastfeeding is continued where possible, acknowledging that alternate strategies may be required until such time as normal feeding skills are achieved ○ the mother's lactation is maintained

Process	Additional information
<ul style="list-style-type: none"> • Give one copy to the client and retain one copy in the client record or ensure strategies are documented in the electronic client record. • If a referral is not required, see Step 7. 	<ul style="list-style-type: none"> ○ the mother's short and longer-term infant feeding goals are considered.
Step 6: Referral and clinical handover	
<ul style="list-style-type: none"> • Determine the need for referral based on the observations and assessments conducted, and other collected information. • In line with the referral information in each Appendix, refer to relevant services when significant anatomical or functional concerns are impacting on maternal or infant health and wellbeing, including lactation and breastfeeding. • Discuss and seek consent for the planned referral from the mother. • Complete a Clinical Handover/Referral from Community Health Services or Clinical Handover (Allied & Community Health) (WACHS) • Include this information in the referral: <ul style="list-style-type: none"> ○ a copy of the completed BAG (attached to the referral) ○ lactation and breastfeeding goals ○ outcomes of implemented strategies ○ growth assessment, including serial measurements of weight, length and head circumference (with trajectories determined). See the following policies for more information: <ul style="list-style-type: none"> - Physical assessment 0-4 years - Head circumference assessment - Length assessment 0-2 years - Weight assessment 0-2 years • When a referral has been initiated and the client is waiting for assessment, provide ongoing care and support, as required. 	<ul style="list-style-type: none"> • Adhere to CACH and WACHS clinical handover processes when handing over or referring a client within or outside of the health service. • Relevant services and professionals include those providing lactation and breastfeeding expertise, such as: <ul style="list-style-type: none"> ○ General Practitioner ○ CACH Breastfeeding Support Service ○ WACHS Telehealth Lactation Service (for mothers of newborns up to seven-weeks of age) ○ The Breastfeeding Centre of WA ○ Australian Breastfeeding Association ○ Raising Children Network ○ Ngala ○ Private services: Click Lactation Consultants, Australia and New Zealand to locate a private Lactation Consultant. <p>Acute illness</p> <ul style="list-style-type: none"> • An acutely ill mother or child must be immediately referred to emergency medical care for assessment. <ul style="list-style-type: none"> ○ Provide a completed Clinical Handover/Referral from Community Health Services or Clinical Handover (Allied & Community Health) (WACHS). ○ Involve CNM and/or Clinical Nurse Specialist, as required.

Process	Additional information
<ul style="list-style-type: none"> ○ Consult with CNM/CNS regarding an appropriate plan when required. 	
Step 7: Follow-up	
<ul style="list-style-type: none"> • Conduct a Universal Plus – child health appointment within 5 business days (including public holidays) of the initial contact to review the effectiveness of implemented strategies. Timing of the review will depend on the concern identified. • Concern resolved: Provide anticipatory guidance as per the relevant Universal contact guideline. Resume as a Universal contact. • Concern not resolved: Consult with CNS/CNM where required. Conduct a reassessment using the initial BAG to determine the need for a referral or further care planning strategies. 	<ul style="list-style-type: none"> • Universal Plus appointments can be offered as centre contacts, home visits or via phone call consultation, as appropriate. Use the <i>Reassessment</i> column in the BAG to complete the review. • Nurses must consider their scope of practice and consult with their manager and/or professionals with breastfeeding and lactation expertise, to provide care that is responsive to the needs of the mother and infant.
Step 8: Documentation	
<ul style="list-style-type: none"> • At each child health assessment, record whether feeding status was assessed in CDIS or CHIS. • The <i>Currently Breastfeeding</i> value must be reviewed in CDIS or CHIS, until the child's <i>Age when breastfeeding ceased</i> is entered. • The following feeding events only need to be entered once: Child's age (in completed months) when first introduced to non-human milk, water, solids and ceased breastfeeding. • Observations, decisions, plans and actions (including a decision and justification not to act) must be documented in the child health record, and in CDIS or CHIS. 	<ul style="list-style-type: none"> • CACH nurses: For further information about documenting infant feeding status in CDIS, see Clinical contact screen for child health. • WACHS nurses: For further information about documenting infant feeding status in CHIS, see CHIS Resources (sharepoint.com) (Child Health Clinical User Guide).

Compliance monitoring

Failure to comply with this policy document may constitute a breach of the WA Health Code of Conduct (Code). The Code is part of the [Integrity Policy Framework](#) issued pursuant to Section 26 the [Health Services Act 2016](#) (WA) and is binding on all CAHS and WACHS staff as per Section 27 of the same Act. Compliance monitoring methods may include observation of clinical practice, clinical incident review, client health record documentation audit and/or attendance at identified training sessions.

Related internal and external policies, procedures, guidelines and resources

Related internal policies, procedures and guidelines
The following documents can be accessed in the CACH Clinical Nursing Manual: HealthPoint link or Internet link or for WACHS staff in the WACHS Policy link
Breastfeeding support service
Clinical Handover - Nursing
Growth – birth to 18 years
Growth – downward trajectory
Head circumference assessment
Infant and perinatal mental health
Length assessment 0-2 years and Weight assessment 0-2 years
Nutrition for Children – Birth to 18 years
Partnership – child health service
Physical Assessment 0-4 years
Sleep – 0-5 years
Universal contact initial interaction , Universal contact 0-14 days , Universal contact 8 weeks , Universal contact 4 months , Universal contact 12 months , Universal contact 2 years , Universal Plus - child health
The following documents can be accessed in the CACH Operational Policy Manual
Consent for Services
The following documents can be accessed in the CAHS Policy Manual
Child and Family Centred Care
Safe Infant Sleeping

The following documents can be accessed in the CAHS Infection Control Policies Manual
Infection Control
Hand Hygiene
The following documents can be accessed in the WACHS Policy Manual
Engagement Procedure
Enhanced Child Health Schedule
Goals of Patient Care
Hand Hygiene
Infection Prevention and Control
The following documents can be accessed in the Department of Health Policy Frameworks
Clinical Handover Policy
Integrity Policy Framework

Related external legislation, policies, and guidelines
Nursing and Midwifery Board AHPRA Decision-making framework
Practice Framework for Population Health Nurses (WACHS)
Western Australian Health Services Act 2016

Related internal resources
Organisations/support services
Breastfeeding Support Service (CACH)
Telehealth Lactation Service (WACHS)
Resources
A Solid Start: Introducing solid foods to your baby
Breastfeeding protection, promotion and support – Supporting information
Cleft lip and palate information for parents
Clinical contact screen for child health
CHIS Resources (sharepoint.com)
Edinburgh Postnatal Depression Scale
Healthy WA: Expressing and storing breast milk

Nutrition Resource Catalogue
Practice Framework for Community Health Nurses
Your new baby 0-4 months , Your baby 4-12 months , Your toddler 1-2 years
Forms
Breastfeeding Assessment Guide (CHS012)
My Care Plan (CHS825)
Clinical Handover/Referral from Community Health Services (CHS663)

Related external resources
Organisations/support services
Australian Breastfeeding Association
Australian Dietary Guidelines
BFHI's Seven Point Plan
Eat for health: Infant feeding guidelines (Information for health workers)
Lactation Consultants of Australia and New Zealand
LactaMap (Note: Lactation Care Pathway must not be used by CACH or WACHS nurses)
Medicines information in pregnancy and breastfeeding
Ngala
Raising Children Network
The Breastfeeding Centre of WA
Print resources
Australian National Breastfeeding Strategy 2019 and beyond
Baby Friendly Health Initiative Australia: 10 Steps to Successful Breastfeeding, 7 Point Plan
Breastfeeding positions: in pictures (0-3 months)
Preparing expressed breastmilk
Storing expressed breastmilk
Videos
Breastfeeding
Breastfeeding and tongue-tie
Breastfeeding basics

<u>Breastfeeding: Why it's good</u>
<u>Can I drink alcohol if I'm breastfeeding?</u>
<u>Expressing with an electric breast pump</u>
<u>Hand expressing</u>
<u>Top 7 Reasons to Breastfeed</u>
<u>When and What to Eat</u>

Appendix 1: Glossary

- **Breastfeeding:** Also referred to as nursing, chest feeding and human milk feeding, it is the process of feeding a mother's breastmilk to her baby/infant, either directly from the breast or by expressing the milk from the breast and bottle-feeding.⁸
- **Breastmilk substitute:** Any milk (or product that could be used to replace milk) that is marketed for feeding to infants and children up to three-years of age, including follow-on formula and toddler milk.⁹
- **Chest feeding:** Chest feeding is the process of feeding an infant milk from the chest. It can encompass using a feeding tube attached to the nipple to feed an infant if lactation is not possible. This term covers the act of a masculine-identified transgender person (i.e. a person whose gender identify and assigned sex at birth do not correspond) feeding their baby from their chest, regardless of whether they have had surgery to alter or remove mammary tissue.¹⁰
- **Complementary breastfeeding:** An infant is receiving breastmilk and nutrient-containing solid or semi-solid foods (including infant formula).^{11, 12}
- **Exclusive breastfeeding:** An infant is fed only breastmilk (at the breast or expressed breastmilk) for the first six-months of life (no solid food or food-based fluids, infant formula or water). The infant may receive oral rehydration solution (ORS), drops or syrups (vitamins, minerals and medicine).^{2, 12-14}
- **Ever breastfed:** On at least one occasion, an infant has been breastfed, or received expressed breastmilk or colostrum.¹⁵
- **Infant formula:** An infant formula product that is represented as a breastmilk substitute for infants and satisfies, by itself, the nutritional requirements of infants under the age of four-to-six-months.¹⁶
- **Paced feeding:** A method for bottle-feeding infants (with EBM or infant formula) that mimics breastfeeding. It involves watching for signs that the infant is hungry, using a bottle with a slow-flow teat, positioning the infant upright and allowing breaks during feeding to prevent overfeeding and encourage natural sucking patterns.¹⁷ It allows the infant to decide when to end the feed.¹⁷
- **Partial breastfeeding (mixed feeding):** An infant is receiving some breastfeeds but is also being given other foods or food-based fluids (e.g. weaning foods or infant formula).¹²
- **Predominant breastfeeding:** An infant's main source of nourishment is breastmilk. The infant may receive liquids (e.g. water, water-based drinks, fruit juice) ritual fluids and ORS, drops or syrups (vitamins, minerals and medicines).¹⁸
- **Responsive feeding:** Based on the notion of *feed according to need*, no restrictions are placed on the frequency or length of a baby's breastfeed if the baby is healthy, born at term and feeding effectively. Mothers offer a feed whenever the baby is hungry or as often as the baby shows readiness to feed.¹⁹

Appendix 2: Maternal breast pain

Key references: 20-22

Maternal breast pain is one of the most common reasons for breastfeeding cessation. It is often associated with the build-up or impaired drainage of breastmilk.

Signs and symptoms recorded in the [Breastfeeding Assessment Guide](#)

- Breasts appeared engorged or (overly) full, pain, redness or a change in colour, abscess and/or skin irritation.

General care planning

- To relieve maternal pain, recommend the application of a cool pack or cool cloth (from the refrigerator, not the freezer) after breastfeeding.

Identifying cause(s) and specific care planning

- Use the following table to identify potential causes of maternal breast pain and create an individualised care plan.
- Refer to relevant professionals for further assessment if significant anatomical, functional or medical conditions are suspected, when there has been no improvement from implemented strategies on review, or when there are sustained concerns from the client or nurse.
- For further information about care planning and referral, see [Process – Supporting lactation and breastfeeding when concerns are identified](#).
- Review within 5 business days (including public holidays) to determine effectiveness of strategies.

Possible cause	Care planning and/or referral
<ul style="list-style-type: none"> • External pressure on breast (e.g. underwire bra or restrictive clothing). 	<ul style="list-style-type: none"> • Advise to wear looser clothing
<ul style="list-style-type: none"> • Complications with breast augmentation/reduction. 	<ul style="list-style-type: none"> • Refer to General Practitioner
<ul style="list-style-type: none"> • Sub-optimal positioning and attachment. • Infant ineffective sucking, including strong vacuum/latch. • Abrupt weaning. 	<ul style="list-style-type: none"> • Provide positioning and attachment advice • See Ineffective suck
<ul style="list-style-type: none"> • Hyperlactation 	<ul style="list-style-type: none"> • See Hyperlactation

Possible cause	Care planning and/or referral
<ul style="list-style-type: none"> • Physiological engorgement: Normal, bilateral, diffuse swelling and distension of the breasts that occurs as milk production increases (typically on the third to fifth day after birth). It leads to overfilling of the breasts. • Pathological engorgement: Shows more severe signs of engorgement. It presents as bilateral, swollen, firm, distended, painful, shiny, warm breasts and may be associated with a low-grade fever. May be exacerbated by: <ul style="list-style-type: none"> ○ Infrequent, decreased or changed feeding from usual pattern. ○ Use of supplements, including formula, water and/or solids. 	<ul style="list-style-type: none"> • Discuss normal breast swelling patterns, emphasising that engorgement is normal and usually resolves within a few days of milk coming in. • Encourage frequent breastmilk removal without increasing beyond infant's requirements, as this may upregulate milk production²²: • Refer to Ineffective suck for infant causes and recommended strategies. • Hand express prior to feeding to soften breasts/areola and aid in attachment. • Try 'reverse pressure softening', pushing back fluid from behind and around nipple, to soften the breast tissue and allow easier attachment. • Encourage unrestricted feeding without limiting infant time at the breast. • Alternate which breast is offered first. • Reattaching the infant after the first milk ejection reflex can assist with an even deeper attachment, resulting in increased breast drainage. • Allow infant to self-detach or ensure the first breast has softened before offering the second breast. • When feeding from the unaffected breast, remove bra to allow drainage. • Small volumes of breastmilk can be expressed for comfort following breastfeeding until milk production downregulates. ²² • Cool packs/cloths (from the refrigerator, not freezer) after feeding can relieve swelling associated with oedema. • Avoid using a dummy or complementary feeds.

Possible cause	Care planning and/or referral
<ul style="list-style-type: none"> • Mastitis: Presents as pain, oedema, erythema and warmth in the affected breast and/or nipple and temperature of 38c or greater, chills, flu-like myalgia, often with rapid onset. • Factors that can increase the risk of mastitis include: <ul style="list-style-type: none"> ○ nipple trauma, especially if colonised with <i>Staphylococcus aureus</i> ○ maternal or infant illness ○ maternal stress and fatigue ○ history of mastitis. 	<ul style="list-style-type: none"> • CACH and WACHS nurses are <u>not</u> to provide a mastitis diagnosis. • If mother presents acutely unwell and mastitis is suspected, refer immediately to a General Practitioner. • While the client is awaiting a referral appointment, discuss strategies to increase breastmilk drainage (see row above). • Warmth may be applied to the affected area while the infant feeds. • Offer the affected breast first if pain does not prohibit a milk ejection reflex, gently stroke towards the nipple, and change positions to promote drainage from different quadrants. • Reinforce that it is not recommended to wean at this time due to the risk of developing pathological engorgement and an abscess forming. • If breastfeeding is too painful or infant is not feeding well, expressing with a pump is recommended (at same frequency and volume as breastfeeding). Routine sterilisation of pumps is not necessary; handwashing and basic pump cleaning is recommended. For more information on expressing breastmilk and providing expressed breastmilk to the infant, refer to Healthy WA or the ABA. • Discuss reintroducing the infant to breastfeeding as soon as issues have improved or resolved.
<ul style="list-style-type: none"> • Nipple vasospasm: Intermittent and painful ischaemia, presenting with nipple colour change and pain, associated with cold exposure, caffeine or stress; Raynaud's phenomenon; poor attachment.²¹ 	<ul style="list-style-type: none"> • Check attachment/latch and advise as appropriate (see Ineffective suck). • Avoid cold exposure and apply warmth after feeding. • Avoid vasoconstrictive drugs such as nicotine, caffeine and nasal decongestants.

Possible cause	Care planning and/or referral
<ul style="list-style-type: none"> ○ Often mistaken for mastitis or candida albicans infection (thrush). 	<ul style="list-style-type: none"> • If no change, refer to General Practitioner for further management.
<ul style="list-style-type: none"> • <u>Candida</u>: Some recent research does not support the involvement of candida/thrush infection as a cause of breast pain. The more likely cause is microtrauma caused by suboptimal positioning²³ or bacterial infection such as coagulase-negative staphylococci and streptococci.^{20, 21} 	<ul style="list-style-type: none"> • If there is a suspicion of candida infection, immediately refer to a General Practitioner for further assessment and management.

Appendix 3: Maternal nipple pain

Key references: 2, 20, 21, 24

Nipple pain is one of the most common reasons for breastfeeding cessation.

Signs and symptoms recorded in the [Breastfeeding Assessment Guide](#)

- Maternal pain/trauma and concerns with skin irritations, colour, compression, nipple bleb (white spot) or discharge.

General care planning

- Encourage continuation of previously established feeding method (if possible) until the cause of maternal pain is resolved.
- If maternal pain prevents infant from breastfeeding, consider temporary use of nipple shields, and/or hand expressing or pumping.
- Demonstrate hand expressing as required. Ensure the correct size breast shield is used for adequate breast drainage and to prevent further nipple trauma. For more information on expressing breastmilk and providing expressed breastmilk to the infant, refer to [Healthy WA](#) or the [ABA](#).
- Develop a realistic expressing plan with the mother.
- Discuss reintroducing the infant to breastfeeding as soon as pain lessens/resolves.

Identifying cause(s) and specific care planning

- Use the following table to identify potential causes of maternal nipple pain and create an individualised care plan.
- Refer to relevant professionals for further assessment if significant anatomical, functional or medical conditions are suspected, when there has been no improvement from implemented strategies on review, or when there are sustained concerns from the client or nurse.
- For further information about care planning and referral, see [Process – Supporting lactation and breastfeeding when concerns are identified](#).
- Review within 5 business days (including public holidays) to determine effectiveness of strategies.

Possible cause	Care planning and/or referral
<ul style="list-style-type: none"> • Sub-optimal infant positioning impacting on breast attachment. • Ineffective infant sucking: strong sucking vacuum, postural concerns, low muscle tone, oral cavity concerns. 	<ul style="list-style-type: none"> • Observe a breastfeed and assess infant's position, sucking, evidence of pain, and attachment; and nipple compression or change of shape and colour changes upon detaching. • Assess infant oral cavity, posture, low tone for concerns impacting breastfeeding efficiency.

Possible cause	Care planning and/or referral
	<ul style="list-style-type: none"> Consider different positioning and attachment strategies. See Ineffective suck.
<ul style="list-style-type: none"> Compromised skin integrity – eczema, dermatitis, bacterial infections, candida. 	<ul style="list-style-type: none"> Assess the nipples for trauma, skin integrity, compression, shape change, colour changes and discharge. Provide information about how to reduce nipple irritation and promote healing (e.g. replacing breast pads frequently, avoiding shampoo and soap on the nipples). Refer to General Practitioner for further assessment and management if signs of fever, further concerns, or no change following strategies.
<ul style="list-style-type: none"> Nipple bleb: Milk-filled blister on nipple, presents as a white, clear, or yellow dot on nipple and/or areola. 	<ul style="list-style-type: none"> If a bleb is present and causing pain or issues, mother can soak the nipple with a warm moist cloth, and gently exfoliate the fine layer of skin growing over the duct opening, followed by feeding the infant or expressing, to allow the milk to flow again. Do not force removal of bleb.²² If not resolved, refer to General Practitioner for further management.
<ul style="list-style-type: none"> Nipple vasospasm: Intermittent and painful ischaemia, presenting with nipple colour change and pain, associated with cold exposure, caffeine, or stress; Raynaud's phenomenon; poor attachment²¹ <ul style="list-style-type: none"> Often mistaken for mastitis or candida albicans infection (thrush) 	<ul style="list-style-type: none"> Check attachment/latch and advise as appropriate (see Ineffective suck). Avoid cold exposure and apply warmth after feeding. Avoid vasoconstrictive drugs such as nicotine, caffeine and nasal decongestants. If not resolved, refer to General Practitioner for further management.

Appendix 4: Unsettled infant

Key references: 20, 24, 25

It is normal for babies to have unsettled or 'cry-fuss' behaviour (sometimes known as colic) in their first few months, but it can be distressing for parents if not managed. It is a leading cause of early cessation of breastfeeding, and is associated with an increased risk of shaken baby syndrome (also known as 'abusive head trauma') and postnatal depression.²⁶

It is important to conduct a comprehensive assessment to determine the possible cause of the infant's unsettled behaviour to enable appropriate strategies to be implemented. If the infant is otherwise healthy with no underlying cause of crying evident, management should focus on supporting parents and avoiding the medicalisation of normal infant behaviour.

Signs and symptoms recorded in the [Breastfeeding Assessment Guide](#)

- Frequent and sustained crying that parents cannot resolve.
- Decreased sleep and increased awake time for age.
- Breastfeeding duration, frequency and efficiency concerns.
- Reduced parental confidence.
- Parental fatigue or exhaustion.

General care planning

- Provide anticipatory guidance to assist parents with identifying anger, frustration, and/or overwhelm, and management strategies (including gently putting the baby somewhere safe and walking away for 10-15 minutes).
- Assist parents to identify available social and other supports.
- Refer to [Sleep - 0-5 years, Safe Infant Sleeping](#) and [Infant and perinatal mental health](#) guidelines.
- Provide parents with [Ngala Parenting Line](#) and the [ABA](#) for information and support.

Identifying cause(s) and specific care planning

- Use the following table to identify potential causes of unsettled infant behaviour and create an individualised care plan.
- Refer to relevant professionals for further assessment if significant anatomical, functional or medical conditions are suspected, when there has been no improvement from implemented strategies on review, or when there are sustained concerns from the client or nurse.
- For further information about care planning and referral, see [Process – Supporting lactation and breastfeeding when concerns are identified](#).
- Review within 5 business days (including public holidays) to determine effectiveness of strategies.

Possible cause	Care planning and/or referral
<ul style="list-style-type: none"> Normal developmental behaviour – adjustment to extra-uterine life, expected crying patterns. 	<ul style="list-style-type: none"> Discuss normal developmental behaviour including age-appropriate development (e.g. crying, feeding, sleeping, settling strategies and parent coping/support strategies). Provide reassurance.
<ul style="list-style-type: none"> Feeding issues – ineffective suck, insufficient milk transfer, hyperlactation, incorrect infant formula preparation or volume, parent misunderstanding of infant feeding cues and patterns. 	<ul style="list-style-type: none"> If problems with breastfeeding or formula feeding, refer to appropriate guidelines and/or lactation specialist for feeding management.
<ul style="list-style-type: none"> Sensory issues – hypersensitivity to touch, movement or sound.²⁵ 	<ul style="list-style-type: none"> Discuss strategies for lowering sensory stimulation (e.g. feeding in a darkened, quiet room). If ongoing concerns with sensory over-responsivity, refer to General Practitioner for further assessment and management.
<ul style="list-style-type: none"> Infant medical – temporary lactose intolerance, temporary side effects of recent immunisations, infection, allergy, ill health or other underlying medical condition, gastroesophageal reflux. 	<ul style="list-style-type: none"> Consider infant medical history and presentation. If any signs of fever or an underlying medical condition or illness, refer to General Practitioner for further assessment and management.
<ul style="list-style-type: none"> Infant sleep deficits or parent misunderstanding infant sleeping cues and patterns. 	<ul style="list-style-type: none"> Take history of infant sleeping, awake and settling patterns to determine age appropriateness. Discuss normal developmental behaviour and provide reassurance. Refer to Sleep - 0-5 years guideline and Safe Infant Sleeping.

Appendix 5: Ineffective suck

Key reference: ²⁰

A general term used to describe inefficient breastfeeding (uncoordinated sucking, swallowing and/or breathing pattern) that may be caused by infant anatomical and/or functional issues. It may present as maternal concerns (e.g. breast or nipple pain). It can be associated with prematurity.

Signs and symptoms recorded in the [Breastfeeding Assessment Guide](#)

Infant

- **If infant shows signs of tachypnoea or stridor, refer immediately to Emergency Department**
- Difficulty attaching and/or detaching
- Coughing, choking, regurgitation and/or dribbling when feeding
- Absence of audible swallowing
- Absence of physical signs of swallowing, e.g. jaw movement
- Concerns with or changes in breastfeeding frequency, duration and efficiency (feeding <8/24hr or >12/24hr; feed length >45 mins)
- Growth trajectory concerns
- Reduced urine and stool volume for age.

Maternal

- Nipple pain, compression and/or colour changes
- Breast pain or discomfort, fullness, engorgement, suspected mastitis.

General care planning

- If ineffective suck is unable to be resolved, alternative feeding methods may be required. For more information on expressing breastmilk and providing expressed breastmilk to the infant, refer to [Healthy WA](#) or the [ABA](#).

Identifying cause(s) and specific care planning

- Use the following table to identify potential causes of ineffective suck and create an individualised care plan.
- Refer to Breast feeding support service and relevant professionals for further assessment, where significant anatomical, functional or medical conditions are suspected, when there has been no improvement from implemented strategies on review, or when there are sustained concerns from client or nurses.
- Assist parents to identify available social and other supports.
- For further information about care planning and referral, see [Process – Supporting lactation and breastfeeding when concerns are identified](#).
- Review within 5 business days (including public holidays) to determine effectiveness of strategies.

Possible cause	Care planning and/or referral
<ul style="list-style-type: none"> Maternal nipple pain or breast pain. 	<ul style="list-style-type: none"> If concerns with nipple pain or breast pain, refer to Maternal breast pain or Maternal nipple pain and implement brief intervention strategies.
<ul style="list-style-type: none"> Sub-optimal infant positioning impacting on breast attachment. 	<ul style="list-style-type: none"> Observe a breastfeed and assess infant's position, sucking, evidence of pain, attachment, nipple compression and shape change, colour changes upon detaching. Discuss innate infant reflexes that aid in positioning and breast attachment. Promote and provide information about baby-led attachment and infant feeding cues. Refer parents to the Raising Children Network - Breastfeeding and baby led attachment video. Consider different positioning and attachment strategies.
<ul style="list-style-type: none"> Hyperlactation, strong milk reflex. 	<ul style="list-style-type: none"> See Hyperlactation
<ul style="list-style-type: none"> Maternal confidence and comfort level with infant/breastfeeding. 	<ul style="list-style-type: none"> Observe breastfeed and discuss concerns with mother.
<ul style="list-style-type: none"> Hypolactation. 	<ul style="list-style-type: none"> See Hypolactation
<ul style="list-style-type: none"> Delayed secretory activation (delayed onset of lactation). 	<ul style="list-style-type: none"> See Hypolactation
<ul style="list-style-type: none"> Infant oral anatomy concerns, including minimal protrusion or sideways movement of tongue, abnormal palate, candida (white plaques). 	<ul style="list-style-type: none"> Assess infant oral cavity. Consider different positioning and attachment strategies. To avoid unnecessary surgical intervention, referral to General Practitioner should only be considered after addressing attachment, milk supply and mother/infant health issues.
<ul style="list-style-type: none"> Infant anatomy concerns including torticollis (sternocleidomastoid tightness, difficulty turning head fully left or right), low tone or unable to tolerate supine, prone or side lying positions. 	<ul style="list-style-type: none"> Look for head position, posture, and/or low tone for concerns impacting breastfeeding efficiency. Consider different positioning and attachment strategies. Consider referral to Child Development Service.

Appendix 6: Hypolactation (low milk volume)

Key references: 20, 24

Most mothers can lactate efficiently with support. In rare circumstances, maternal conditions, or insufficient glandular tissue development or breast surgery may impact milk volume. In these cases, partial breastmilk production may be possible.

Signs and symptoms recorded in the [Breastfeeding Assessment Guide](#)

Maternal

- Delayed secretory activation (delayed onset of lactation) – no evidence by 72 hours postpartum.
- After secretory activation, maternal perception of inadequate milk volume to meet infant needs often resulting in early cessation of breastfeeding.
- Use of lactation aids or medications.

Infant

- Reduced milk transfer, as evidenced by:
 - Growth trajectory concerns including:
 - more than 10% loss of birth weight;
 - not regained birth weight by day 14;
 - slow weight gain, which is not following the expected growth trajectory; and/or
 - reduced elimination – concentrated and offensive urine, still passing meconium on day five of the neonatal period, or brown, dry or firm stools for older infants.
- Unsettled behaviour, frequent or sustained crying, age-inappropriate sleep and awake times, irritability.
- Jaundice.
- Ineffective sucking.

General care planning

- Encourage good maternal nutrition, fluid intake and rest.
- Continuation of previously established feeding methods may be required until the cause of the hypolactation is identified and resolved. If medically indicated and in the absence of available expressed breastmilk, complementary feeding with infant formula may be required. Refer to [Nutrition for Children – Birth to 18 years](#) for further information

Identifying cause(s) and specific care planning

- Use the following table to identify potential causes of hypolactation and create an individualised care plan.

- Refer to relevant professionals for further assessment if significant anatomical, functional or medical conditions are suspected, when there has been no improvement from implemented strategies on review, or when there are sustained concerns from the client or nurse.
- For further information about care planning and referral, see [Process – Supporting lactation and breastfeeding when concerns are identified](#).
- Review within 5 business days (including public holidays) to determine effectiveness of strategies.

Possible cause	Care planning and/or referral
<ul style="list-style-type: none"> • Maternal lack of confidence or perception of insufficient milk. 	<ul style="list-style-type: none"> • If infant is gaining weight and elimination status is appropriate for age, breastmilk supply and transfer is likely to be adequate. • If milk volume is determined to be adequate, discuss sensitively with client to restore maternal confidence; advise on milk production, supply and demand, normal breast softening around six-weeks postpartum.
<ul style="list-style-type: none"> • Ineffective infant sucking which may include duration, frequency, strength, and/or efficiency. 	<ul style="list-style-type: none"> • See Ineffective suck
<ul style="list-style-type: none"> • Sub-optimal attachment, with resultant ineffective sucking. 	<ul style="list-style-type: none"> • Observe and advise on attachment. • See Ineffective suck
<ul style="list-style-type: none"> • Pathological engorgement impacting on milk flow and removal. 	<ul style="list-style-type: none"> • See Maternal breast pain
<ul style="list-style-type: none"> • Delayed secretory activation (delayed onset of lactation). 	<ul style="list-style-type: none"> • Take history of milk flow: <ul style="list-style-type: none"> ○ Colour/type of milk – colostrum, transitional milk ○ Physiological engorgement ○ Physiological signs that let-down is occurring, including tingling/tightening sensation in nipples, leaking from other breast, change in infant's suck pattern from fast to slow/rhythmic. • Assess infant for signs of low milk transfer: <ul style="list-style-type: none"> ○ Loss of >10% body weight in the first three days.

Possible cause	Care planning and/or referral
	<ul style="list-style-type: none"> ○ Birth weight not regained by day 14. ● Assess lactation risk factors – see Breastfeeding Assessment Guide. ● Discuss and advise on optimal feeding plans (see next row).
<ul style="list-style-type: none"> ● Feeding patterns which result in inadequate breast stimulation, including: <ul style="list-style-type: none"> ○ inappropriate or strict feeding routines where infant does not cue to feed ○ use of supplements including formula, water and/or solids ○ not feeding/expressing often enough. 	<ul style="list-style-type: none"> ● Discuss and advise on optimal feeding patterns. ● Increase breastmilk volume by increased feeding: <ul style="list-style-type: none"> ○ Offer both breasts at each feeding session and increase feeding frequency. ○ Allow baby to feed on each breast until the baby has self-detached, then offer second breast. ○ Consider a top-up breastfeed or expressing with a pump 20-30 minutes following the initial breastfeed. ○ Gently massage or stroke the breast towards the nipple whilst breastfeeding. If this does not result in visible nutritive sucking, consider gentle breast compressions if confident in supporting this strategy. Otherwise, refer to a General Practitioner. ○ Encourage breastfeeding in place of dummy use. ○ Develop a realistic expressing plan, allowing some maternal rest time. Determine how milk will be expressed - hand expressing or using a pump (manual, electric – single or double). When using a pump, ensure the correct breast shield size is used (i.e. that the nipple fits freely and easily into the funnel without rubbing the sides, and that the pump is working). ○ For more information on expressing breastmilk and providing expressed

Possible cause	Care planning and/or referral
	breastmilk to the infant, refer to Healthy WA or the ABA . <ul style="list-style-type: none"> ○ Consider referral to a General Practitioner to discuss pharmaceutical galactagogues.
<u>Maternal:</u> <ul style="list-style-type: none"> • Medical – breast hypoplasia, diabetes, hypothyroidism, obesity, polycystic ovarian syndrome, infertility, breast surgery, other underlying health condition. • Birth complications - retained placenta, stressful labour, maternal obesity, maternal diabetes. • Medications/substances - oral contraceptive pill, some cold and flu medications, nicotine, alcohol and some recreational drugs. 	<ul style="list-style-type: none"> • Determine pre-existing maternal medical conditions. • Consider referral to a General Practitioner if not currently managed.

Appendix 7: Hyperlactation (oversupply)

Key references: 20, 24, 27

Oversupply occurs when a breastfeeding mother produces more milk than her infant needs for normal growth. This is common in the early weeks of breastfeeding, as the breasts have the capacity to feed more than one infant. Oversupply usually settles down by around six-weeks postpartum, but sometimes it persists beyond that. It is important to note that oversupply is distinct from physiological and pathological engorgement.

Signs and symptoms recorded in the [Breastfeeding Assessment Guide](#)

Maternal

- Breast fullness/engorgement.
- Forceful, possibly painful milk ejection reflex.

Infant

- Unsettled, detaching from the breast, short feeds, clamping down on nipple, crying, appearing uncomfortable, gulping, refusal.
- Elimination - increased urine output (at least 10 wet nappies in 24 hours), frequent bowel actions, atypical stools (often frothy, explosive, green, may contain mucous).
- Ineffective sucking (unable to manage milk supply).
- Excessive weight gain or compromised growth if prolonged refusal.

General care planning

- Reassure mother that the excessive milk volume is usually temporary and normal, and will often settle as the body adjusts to the infant's requirements.
- When breasts remain uncomfortably full, consider expressing for 'comfort' (if the infant is not ready to breastfeed) and to alleviate potential complications. For more information on expressing breastmilk, refer to [Healthy WA](#) or the [ABA](#).
- Discuss options for storing milk and/or donation of surplus breastmilk to a human milk bank, if available.
- A cool pack placed under the breast between breastfeeds may offer comfort.
- Provide anticipatory guidance on mastitis.
- Some mothers perceive that if their baby is unsettled, they have a low milk volume. However, infants may present as being unsettled when mothers have hyperlactation. Assess maternal knowledge about efficient milk transfer, milk production, supply and demand, and infant growth and development.

Identifying cause(s) and specific care planning

- Use the following table to identify potential causes of hyperlactation and create an individualised care plan.

- Refer to relevant professionals for further assessment if significant anatomical, functional or medical conditions are suspected, when there has been no improvement from implemented strategies on review, or when there are sustained concerns from the client or nurse.
- For further information about care planning and referral, see [Process – Supporting lactation and breastfeeding when concerns are identified](#).
- Review within 5 business days (including public holidays) to determine effectiveness of strategies.

Possible causes	Care planning and/or referral
<ul style="list-style-type: none"> • Excessive feeding (>12/24hr, >45 mins in length). 	<ul style="list-style-type: none"> • Aim to adjust the breastmilk volume by trying different methods to decrease overstimulation whilst meeting the infant's nutritional requirements: <ul style="list-style-type: none"> ○ Recognise infant feeding cues and breastfeed according to infant's need. ○ Try shorter, more frequent feeds (up to eight minutes in duration, more than 10 times in 24 hours). ○ 'Block feeding' for a short period of several days: During the day, feed for 3 hours on one breast, then switch breasts for next 3 hours (may need to express from rested breast to prevent overfilling). Feed from both breasts overnight. Monitor carefully to avoid over draining breast or continuing after symptoms are resolved.²⁷
<ul style="list-style-type: none"> • Ineffective infant attachment and sucking. 	<ul style="list-style-type: none"> • Expressing a small amount before breastfeeding may assist the infant with attaching to the breast.
<ul style="list-style-type: none"> • Inappropriate use of galactagogues. 	<ul style="list-style-type: none"> • Refer to General Practitioner or pharmacist to discuss any medications the mother may be taking.
<ul style="list-style-type: none"> • Delayed diagnosis and management of infant or maternal concerns. • Maternal conditions – hyperthyroidism, pituitary tumour (rare). • Specific diseases or medications that impact on dopamine secretion. 	<ul style="list-style-type: none"> • Ask about maternal and infant health and wellbeing, including history of illness. • Refer to a General Practitioner for further assessment and management.

Appendix 8: *Breastfeeding protection, promotion and support* – Supporting information

Breastfeeding in Australia

The *National Health Survey 2022* found that 91% of Australian children aged up to three-years had ever received breastmilk, 37% were exclusively breastfed to six-months of age, 64% were introduced to solid foods at six-months of age or later and 43% were still receiving breastmilk at 12-months of age.¹

Western Australian (WA) data from the *2020-21 National Health Survey* indicated that 43% of infants aged up to three-years were exclusively breastfed for at least six-months.² The *2022 Health and Wellbeing Surveillance System* found that 92% of Western Australian children aged up to four-years had received some breastmilk.³

The *Child Development Information System (CDIS)*, managed by the WA Child and Adolescent Health Service, holds data on infant feeding practices for 25,739 children born in the state in 2022. Almost all (99.6%) started breastfeeding. In their first month, 57% were exclusively breastfed, while 88% were given some amount of breastmilk (*any breastfeeding*). By the time these infants reached three-months of age, the percentage of those exclusively breastfed dropped to 42% and those receiving any breastmilk fell to 75%.²

The reduced transmission of cultural breastfeeding practices and the introduction of infant formula and bottle feeding has impacted breastfeeding rates among Aboriginal mothers.² The rate of breastfeeding initiation and continuation among Aboriginal mothers varies across Australia and between geographical locations.⁴

The *2018-19 Aboriginal and Torres Strait Islander Health Survey* found that 85% of Aboriginal infants aged up to three-years had ever breastfed, and 12% were exclusively breastfed to six-months and continued to breastfeed to 12-months of age.² The level of geographical remoteness increased the *ever received* breastmilk rate (94% in remote areas compared to 82% in major cities).² In WA, 80% of Aboriginal infants had ever received breastmilk and 23% had been exclusively breastfed for at least six-months.²

There is a paucity of data exploring breastfeeding rates among culturally and linguistically diverse (CALD) mothers in Australia. The *Australian National Infant Feeding Survey 2010* found that the rate of breastfeeding initiation was similar in mothers born overseas (96.4%) and Australian-born mothers (95.8%).⁵ The duration of exclusive breastfeeding to six-months of age was higher among mothers born in Australia (16%) than those born overseas (14%).⁵

² Data source: Extracted from CDIS, CACH on 06/05/2024

Benefits of breastfeeding

Breastfeeding has health, economic and environmental benefits.² It supports the healthy growth and development of infants and young children, and many of its benefits extend into adult life.⁶

Breastmilk is safe, clean and contains antibodies that reduce the risk of common childhood infections and illnesses.^{7, 8} Commencing breastfeeding within the first day of an infant's life has been linked to a reduction in the risk of neonatal mortality.⁹ It can protect infants against otitis media (middle ear infection), sudden infant death syndrome (SIDS) and sudden unexpected death in infancy (SUDI), and childhood leukaemia.¹⁰⁻¹²

Breastfed infants may achieve greater cognitive development, and have a reduced risk of developing chronic diseases, and becoming overweight or obese.^{13, 14} In early infancy, exclusive breastfeeding contributes to the establishment of a healthy and diverse gut microbiome.¹⁵ Probiotics and prebiotics are passed from mother to infant through breastmilk.¹⁵ This can protect against gastroenteritis (necrotising enterocolitis for pre-term infants) and respiratory infections.^{16, 17}

After birth, breastfeeding reduces maternal bleeding and infection, and can help mothers to space their pregnancies and maintain a healthy weight.² Breastfeeding reduces the maternal risk of ovarian, breast and endometrium cancers, cardiovascular disease, coronary heart disease and stroke.¹⁸⁻²⁰ It positively impacts maternal mood and stress levels, and enhances the ability to respond to positive emotions in others.²¹

Hormonal interactions involving oxytocin and prolactin strengthen the maternal-infant bond, reduce the risk of postpartum depression and boost self-confidence.²² Breastfeeding mothers tend to engage in more physical touch with their infants, exhibit greater responsiveness and share prolonged mutual gazes during feedings compared to bottle-feeding mother–infant pairs.²¹

Economically, breastfeeding incurs little or no cost to families and results in lower healthcare costs due to its protection against a range of illnesses.^{2, 23} Feeding with infant formula has almost twice the carbon footprint of breastmilk due to its impact on cattle farming, deforestation, packaging and transportation.^{24, 25}

Breastfeeding policy landscape

CACH and WACHS are committed to creating and maintaining a community health service environment in which breastfeeding is promoted, protected and supported. This policy aligns with the aims of key international and Australian breastfeeding policy and strategy documents (see Table 1).

Table 1 Policies/strategies guiding CACH and WACH breastfeeding practice

International documents	
Infant and Young Child Feeding - Innocenti Declaration 2005	Achievement of an environment that enables mothers, families and other caregivers to make informed decisions about optimal feeding. ²⁶
2017 International Code of Marketing of Breast-milk Substitutes	Contribute to the provision of safe and adequate nutrition for infants by protecting and promoting breastfeeding and ensuring the proper use of breastmilk substitutes, if needed. ²⁷
WHO Resolution on the Inappropriate Promotion of Foods for Infants and Young Children	Calls on countries to implement this Resolution to protect breastfeeding, prevent obesity and chronic disease, and promote a healthy diet. ²⁸
Australian documents	
Australian National Breastfeeding Strategy: 2019 and beyond (ANBS)	Aims to increase the proportion of Australian infants who are exclusively breastfed to six-months of age (increase to 50% by 2025) and continue breastfeeding with appropriate complementary foods until 12-months of age and beyond, for as long as the mother and child desire. ²⁹
National Preventative Health Strategy 2021-2030	Decrease structural and environmental barriers to breastfeeding through policy. Meet the ANBS target of 50% of infants being exclusively breastfed to six-months of age by 2025. ³⁰
Baby Friendly Health Initiative Australia (BFHI)	Use the Ten Steps to Successful Breastfeeding and Seven Point Plan to support maternity and community facilities become Baby Friendly. Improve infant and maternal healthcare by providing all mothers with unbiased information, regardless of their feeding choice. ³¹

Breastfeeding physiology

Breastmilk

Breastmilk is a vital biological fluid that contains all the nutrients that infants require to grow and develop in their first six-months of life.³² Beyond providing a source of energy and nutrition, it contains various bioactive agents that influence gastrointestinal function, immune system development and brain growth.³³ Being a dynamic fluid, it adjusts to meet the evolving requirements of the growing child.³³ Further information about the composition of breastmilk and how it is impacted by alcohol and other drug use can be found in the [Nutrition for Children – Birth to 18 years Guideline](#).

Lactogenesis, lactation and the anatomy of the lactating breast

Lactogenesis refers to the process when milk secretion begins in the mammary glands.³⁴ It involves the transformation of undifferentiated mammary glands (not yet specialised for milk production) into fully functional lactating tissue.³⁵ Lactogenesis comprises several stages:

- **Stage I** (secretory differentiation): Occurs in the second half of pregnancy and lasts until a few days after giving birth.³⁴ Estrogen and progesterone levels rise, causing the milk ducts in the breasts to grow in number and size.³⁴ The breasts develop the

capacity to secrete breastmilk, including colostrum.³⁴ Colostrum is the yellowish and thick secretion from the breast that contains essential immune factors.³⁶

- **Stage II** (secretory activation): Beginning about two to three days postpartum, hormonal changes (a drop in estrogen and progesterone, and an increase in prolactin) cause the milk to transition from colostrum to mature milk (milk coming in).³⁴ It is common for breasts, and in some instances, under the armpits, to enlarge, feel heavy and become uncomfortable (engorgement) due to increased breastmilk production at this time.³⁷ This typically does not impact milk flow or an infant's ability to latch and feed effectively.³⁷
- **Stage III** (galactopoiesis): Ensures the production and maintenance of mature milk from approximately day 10 postpartum.³⁸
- **Stage IV** (involution): The mammary glands stop producing milk after weaning has occurred.³⁹ This marks the end of lactation.

Lactation is the process by which milk is synthesised and secreted from the mammary glands.⁴⁰ It is brought on by hormonal changes, occurs naturally during pregnancy and is maintained by the ongoing removal of milk from the breast.³⁴ Lactation changes the size, shape and composition of the breast.³⁴ Normal human lactation is comfortable for the mother and infant, provides adequate breastmilk for optimum infant growth and development, and is supported by good maternal and infant health.³⁹

Figure 1 shows the structure of a lactating human breast. A non-pregnant, non-lactating breast is primarily adipose and collagenous tissue.⁴⁰ During pregnancy, the ducts within the mammary glands expand and branch extensively in response to hormonal changes.⁴⁰

Clusters of alveoli bud from the ducts and become lined with milk-secreting cells (lactocytes).⁴⁰ When these cells secrete milk, it fills the alveoli and is squeezed into the ducts and nipple pores.⁴⁰ The nipple is surrounded by the areola that contain Montgomery's glands.⁴¹ These glands secrete an oily fluid that protects the skin of the nipple and areola during lactation.⁴¹

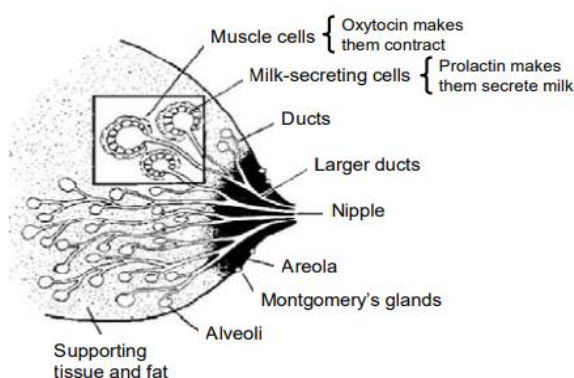


Figure 1: Structure of the lactating breast⁴²

Prolactin and oxytocin are hormones that affect breastfeeding.⁴¹ Prolactin promotes the establishment and maintenance of breastmilk supply.⁴⁰ Oxytocin promotes the contraction of the cells around the alveoli, which releases breastmilk into the ducts.⁴¹ The oxytocin reflex is commonly referred to as the let-down reflex.⁴¹ Oxytocin promotes a state of calm, can lower stress and may enhance mother-infant bonding.⁴¹

When mothers experience stress, their bodies release cortisol (i.e. the stress hormone), which affects optimal lactation.⁴³ When the sympathetic nervous system is highly active in times of stress, there is a reduction in the amount of oxytocin and prolactin released from the pituitary gland.⁴³ Milk production and the milk ejection reflex are disrupted, which has an adverse effect on breastfeeding.⁴³

Let-down reflex

The let-down reflex occurs naturally in the body when an infant begins to breastfeed (see Figure 2).⁴⁴ Some mothers do not notice any physical signs of this reflex, while other may experience a tingling sensation in the breasts, feel a sudden fullness in the breasts (and possibly discomfort), milk leakage or increased thirst.⁴⁴

All mothers should be encouraged to watch for a shift in their infant's sucking pattern. Initially, the infant will engage in quick and shallow sucks, but as the milk begins to flow, they will transition to a rhythmic suck-swallow pattern, indicating that they are drinking deeply.⁴⁴

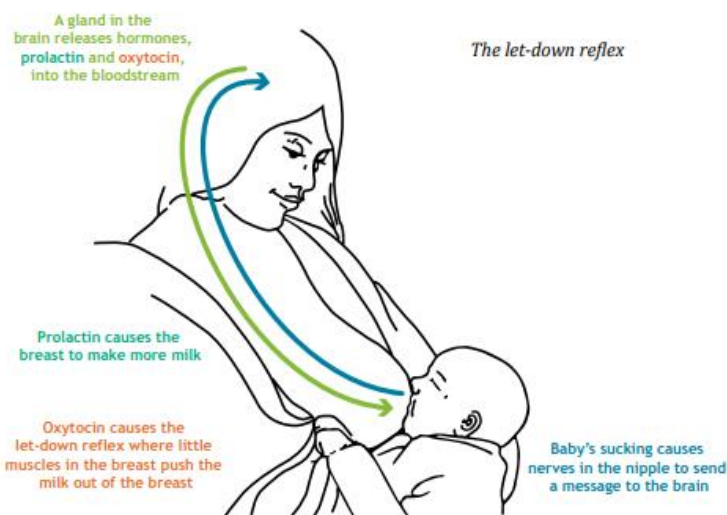


Figure 2: Let-down reflex as illustrated by the Australian Breastfeeding Association⁴⁴

Breastmilk supply physiology

Milk supply is controlled by a feedback inhibitor of lactation, a substance found in breastmilk.⁴⁵ If milk is not removed from the breast via feeding or expressing, the

inhibitor substance builds up and prevents further secretion of milk.⁴⁵ Conversely, when milk is removed, the inhibitor substance is removed and further secretion can occur.⁴⁵ The amount of milk produced is determined by how much the baby needs; that is, by the frequency and volume of feeding and expression.⁴⁵

Galactagogues are pharmacological (e.g. domperidone and metoclopramide) and non-pharmacological (herbal) substances thought to initiate, maintain or increase maternal milk supply.⁴⁶ Research on the use of galactagogues remains inconclusive and potential adverse effects are a concern.⁴⁶ Even with the supervised prescription of galactagogues, effective and frequent breastmilk removal is required.⁴⁶

Breastfeeding frequency

The frequency of breastfeeding sessions varies over time. As noted by the ABA:

- Breastmilk is easy for newborn babies with small stomachs to digest.⁴⁷ It is common for newborn babies to feed frequently (some may feed every one to two hours).⁴⁷ This is normal and assists the establishment of a mother's breastmilk supply.⁴⁷
- In the early weeks, it is typical for babies to feed eight to fourteen times a day.⁴⁷
- Initially, an infant may be content with feeding from one breast per feed. As time goes on, they will likely begin to feed from both breasts.⁴⁸
- Feed length can vary. It is not essential for an infant to take a 'full' breastfeed every time.⁴⁸ Cluster feeding (very frequent or grouped together) may occur.⁴⁸
- Feeding frequencies may vary (e.g. if the infant is unwell, upset or hot).⁴⁸
- As infants grow, their feeding frequency typically decreases.⁴⁸
- Monitoring elimination (the number/frequency of wet and dirty nappies) is an important indicator of whether an infant is receiving enough breastmilk.⁴⁹

Infant elimination

When an infant passes their first stool (meconium), it appears black and sticky. After a few days, the stool transitions to a mustard-yellow hue, is less sticky and increases in volume.⁴⁷ Table 2 shows the number of wet (urine) and dirty (stool) nappies an infant might produce during the first week after birth until solid foods are introduced. As an infant grows, their bowel movements may become less frequent, occurring once every seven to 10 days.⁴⁹ There should be a substantial amount of soft or runny stool with each of these bowel movements.⁴⁹ Click [here](#) for information on infant stools.

Table 2 Typical number of wet and dirty nappies⁴⁷

Day postpartum	Wet nappies	Dirty nappies
1	1	3 or more
2	2	
3	3	
4	4	
5 onward	At least 5 disposable or 6-8 cloth nappies	

Infant reflexes

Infants are born with the following innate reflexes (i.e. involuntary reactions to certain stimuli) that are important for breastfeeding⁵⁰:

- **Rooting:** The infant turns to find a stimulus (e.g. their mother's breast) on their lips or cheek, opens their mouth and puts their tongue forward or down.^{41, 51}
- **Suck-swallow:** The infant sucks rhythmically on the nipple, which is coordinated with a swallow.⁵¹ During breastfeeding, effective suckling is facilitated by good attachment and is evident when the infant takes slow, deep suckles followed by a visible or audible swallow.⁴¹ Ineffective suckling may be evidenced by an infant suckling constantly and quickly, not swallowing, having drawn in cheeks, and leaving the nipple squashed or with a pressure-induced line.⁴¹
- **Tongue-thrust:** When the lips are touched, the tongue protrudes forward and out of the mouth. This reflex helps with breastfeeding but not consuming solid foods.⁵¹
- **Gag:** If an object is placed towards the back of the mouth, the tongue will push it forward to protect against choking.⁵¹ This reflex generally lessens at around six-months of age.⁵¹

Understanding these reflexes is important when supporting breastfeeding.⁴¹ The level of maturation of these reflexes will determine whether they can breastfeed or if a temporary, alternate method of feeding is needed.⁴¹

Infant feeding cues

Being able to recognise and respond to early infant feeding cues enables a breastfeed to be offered while the infant is alert and calm, which increases their likelihood of attaching and feeding effectively.⁵² For a list of common feeding and satiety cues, see the [Nutrition for Children – Birth to 18 years Guideline](#).

Baby-led attachment, maternal positioning, milk transfer and skin-to-skin contact

Baby-led attachment allows an infant to initiate and control the breastfeeding process by seeking out the breast and attaching at their own pace.⁵³ Correct positioning and attachment enhances mother-infant bonding, reduces the risk of nipple pain and breastfeeding cessation, and is assisted by the mother:

- recognising and responding to early infant feeding cues;
- assuming a comfortable position;
- holding the infant close;
- ensuring clothing does not obstruct the infant's face;

- allowing the breast to fall naturally;
- bringing the infant to the chest;
- placing the infant's hand on the breast; and
- ensuring the infant's spine is aligned and the neck is moderately extended.^{54, 55}

Correct infant attachment is evidenced by an invisible lower lip, a wide and open mouth, full cheeks, sealed lips around areola/breast, the chin pressed into the breast and easy breathing.⁵⁶

Signs of effective milk transfer between a mother and their infant include: proper latch is achieved and maintained; mother feels a gentle pulling but no pain; infant is at ease and demonstrates a regular and rhythmic suck/swallow/breathing pattern; 'kah' sound may be heard as the infant swallows (no clicking or smacking sounds); infant's breathing remains quiet during sucking pauses; infant takes more pauses throughout the feed; infant detaches looking relaxed and sleepy; mother's breasts feel softer and less full; and the mother's nipple is not pinched or damaged, but may be elongated.⁵⁷

Skin-to-skin contact helps newborns breastfeed successfully and can be continued beyond the first feed.^{55, 58} Benefits to the infant include the regulation of heart rate, temperature and blood sugar levels, fostering better attachment to the breast and providing an early feeding cue.⁵⁸ Skin-to-skin contact can help a mother to bond with her infant, recognise feeding cues and release milk-producing hormones for breastfeeding or expressing breastmilk.⁵⁸

Videos on baby-led attachment, attachment and positioning can be viewed [here](#).

Expressed breastmilk (EBM)

There are many reasons for expressing breastmilk, including giving birth to a premature baby who is unable to suck well, the breasts feeling too full, increasing milk supply, leaving the baby in the care of another person and returning to work.⁵⁹ Videos of expressing can be viewed here: [hand expressing](#) and [breast pump expressing](#). EBM should be stored in food-grade and BPA-free plastic bags, baby-feeding bottles, plastic cups with tight-fitting lids or small glass jars.⁶⁰ EBM storage guidelines are available from the ABA [here](#). It is vital that EBM is not frozen or heated more than once.⁶⁰ To view the instructions for preparing EBM, click [here](#).

Infant formula

For more information about infant formula (i.e. safety standards, types, uses, contraindications, guide to formula volumes and safe preparation), refer to the [Nutrition for Children – Birth to 18 years Guideline](#). Information about bottle feeding (EBM and infant formula), and cleaning teats and bottles can also be found in this Guideline.

As per Australia's *Infant Feeding Guidelines*, breastmilk or infant formula should be the main drink in the first year of life.⁶¹ Cool, boiled water can be offered from around six-months of age.⁶¹ An infant should not be given drinks other than breastmilk, infant formula or water prior to 12-months of age (e.g. no cow's milk, fruit juice or sugar-sweetened drinks).⁶¹

After 12-months-of-age:

- breastfeeding is recommended, for as long as the mother and child desire;
- water (clean and safe) and cow's milk should be the main drinks offered if not breastfeeding or consuming breastmilk;
- a child no longer requires infant formula;
- toddler milk (also referred to as stage 3 formula, follow-on formula, growing up milk and toddler milk) is not required or recommended (see [Nutrition for Children – Birth to 18 years](#) for more information); and
- all of a child's nutritional requirements can be met through family foods in accordance with the [Australian Dietary Guidelines](#). Breastmilk offers additional nutrition and immunological benefits.⁶¹

Factors influencing breastfeeding

Almost all mothers can breastfeed successfully, however a small number of infant and maternal health conditions may temporarily or permanently prevent breastfeeding.⁶²

There are many social and environmental factors that enable breastfeeding, including supportive social norms and attitudes, community education, restricting the advertising of breastmilk substitutes, policies and research, infant feeding guidelines that meet WHO standards, baby-friendly hospitals and community health services, education and training for health professionals, and breastfeeding-friendly environments.²⁹

Among Aboriginal mothers, a key enabling factor is that breastfeeding is an accepted traditional practice. Having family support, knowledge that breastfeeding is the healthiest option for the infant and incurs no (or little) cost, and access to culturally appropriate health practitioners and services also enable breastfeeding.⁶³

Healthcare professionals, including nurses, play a crucial role in supporting breastfeeding. Understanding the factors that can adversely influence breastfeeding is essential to enabling the provision of information, support and guidance throughout a mother's breastfeeding journey.

As guided by the WHO, infants should not receive breastmilk or any other milk (except specialised formula) if they have galactosemia, maple syrup urine disease or phenylketonuria.⁶⁴ Infants born weighing less than 1500g, born before 32-weeks' gestation or with an increased risk of hypoglycaemia should receive breastmilk but may require the administration of other food in addition to breastmilk.⁶⁴

The oral anatomy and functioning of an infant may affect their ability to breastfeed successfully.⁶⁵ Examples of oral conditions that may impact breastfeeding include:

- **Ankyloglossia** (tongue-tie): The thin piece of skin (sublingual frenulum) under the tongue is abnormally short or thick, which can restrict tongue movement and function.^{66, 67} There is no universally accepted definition of tongue-tie, and a lack of consensus on how to diagnosis and treat it.⁶⁸ Some babies with a tongue-tie can attach to the breast and feed effectively, and others face breastfeeding challenges.⁶⁹ While some healthcare professionals recommend releasing tongue-ties (frenotomy) to improve breastfeeding, the evidence remains inconclusive.⁶⁸
- **Inelastic labial frenulum** (lip-tie): A tight or inflexible tissue connecting the upper or lower lip to the gums.⁷⁰ There is no conclusive published evidence supporting the release of lip-ties (or cheek/buccal ties) as a solution for breastfeeding problems.⁶⁹
- **Cleft (lip or palate)**: Cleft lip and cleft palate result from incomplete fusion of the upper lip or the roof of the mouth (palate) during early pregnancy.⁷¹
- **Atypical muscle tone**: Untreated, this condition can disrupt effective latch and milk transfer, causing nipple trauma and reducing milk supply.⁶⁵

If nurses are concerned about an infant's oral anatomy and/or function, an assessment and care planning process, which may include referral, must be initiated to determine a course of action that supports continued breastfeeding (see the [process section](#) of this policy).

Maternal health conditions that impact breastfeeding include breast abscesses, mastitis, human immunodeficiency virus, severe illness (e.g. sepsis), herpes simplex virus type 1, ingestion of some medications, chemotherapy, hepatitis, alcohol and other drug use, and tuberculosis.⁶⁴

While breastfeeding provides an ideal opportunity for mother-infant bonding, it may cause stress and frustration if the following common challenges arise: nipple health issues (e.g. dry, sore, cracked, bleeding or thrush); discomfort due to engorgement of the breasts; mastitis; and the time taken to express and store breastmilk.^{72, 73} If these concerns are identified, nurses are ideally placed to support mothers through care planning and/or referral.

Childhood maltreatment and trauma in mothers have been linked to decreased and a shorter duration of breastfeeding.⁷⁴ Difficulties include managing touch, navigating the relationship with health care professionals and addressing trauma symptoms.⁷⁴ Nurses should avoid assuming that mothers impacted by trauma will not breastfeed. Instead, they should engage in a discussion about the mother's breastfeeding goals and provide trauma-informed support to encourage and support breastfeeding.⁷⁵

The *2010 Australian National Infant Feeding Survey* found the primary self-reported reasons for breastfeeding cessation were:

- perceived insufficient milk supply;
- having an unsettled baby;
- the baby was not attaching properly; and
- the child lost interest or was old enough to stop.⁵

Other barriers to breastfeeding include:

- lack of knowledge and access to breastfeeding education and support;
- lactation concerns;
- lack of partner, family and/or social support;
- social norms and embarrassment;
- maternal mental health concerns;
- religious and cultural beliefs;
- a perception that feeding with infant formula leads to more content and settled infants; and
- returning to employment.^{1, 76}

Returning to employment does not have to mean the end of breastfeeding. With proper planning, information and support, mothers can breastfeed and work.⁷⁷ In Australia, all states have legislation safeguarding a mother's right to breastfeed while employed.⁷⁷ Creating a plan to facilitate a smooth transition back to work may be helpful.⁷⁷ For more details on supporting breastfeeding during employment and developing a plan, visit the ABA's [website](#).

The most common reasons cited for breastfeeding cessation in Aboriginal mothers are not producing any/adequate milk supply, feeling it was time to stop and a belief that the infant was not satisfied'.⁷⁸ Other obstacles include the normalisation of bottle feeding, shame over breastfeeding in public and a lack of family/partner support.⁶³

For CALD mothers (including migrant and refugee women), the challenges of breastfeeding while establishing themselves and their family in a new country, a lack of family support, and having little or no access to traditional postpartum practices are thought to adversely impact breastfeeding rates.⁷⁹

With a multidisciplinary and culturally appropriate approach that involves the mother and their support network, nurses, and other healthcare professionals and support services, many of these barriers can be overcome to allow the initiation and continuation of breastfeeding.^{78, 80}

Educating mothers through anticipatory guidance (exploring what to expect when lactating and breastfeeding, the challenges that may arise and how these can be overcome) can improve breastfeeding outcomes.⁸¹

Tattoos, piercings, breast surgery and breastfeeding

Research on the effects of getting a tattoo while breastfeeding is limited, and its impact on breastmilk production and composition is unknown.⁸² There is a risk of an allergic reaction, inflammation and infection at the tattoo site, which may cause breastfeeding complications.⁸² It is recommended that mothers complete the weaning process prior to having laser tattoo removal.⁸²

Nipple piercings may interfere with milk flow and result in an increased risk of maternal infection.⁸³ Nipple jewellery can make it difficult for an infant to latch-on to the breast correctly, and there is a risk of choking if the jewellery dislodges during a feed.⁸³ Nipple jewellery should be removed while breastfeeding and a nipple piercing should not be obtained for at least three-months post-weaning.⁸³

Many mothers who have undergone breast surgery can breastfeed in various ways and should be encouraged to try.⁸⁴ Some are able to fully breastfeed without requiring top-up feeds, while others may partially breastfeed with some supplementation, or rely on medication to boost milk supply.⁸⁴ The extent to which a mother can breastfeed depends on the type of surgery she has undergone.⁸⁴ For example:

- **Breast reduction surgery:** This type of surgery may adversely affect milk supply. The surgical technique used will determine whether a mother can breastfeed.⁸⁵ Retaining the tissue surrounding the nipple and areola is associated with an increased chance of breastfeeding success.⁸⁵ If the nipple was repositioned, the nerve supply to the nipple and areola could be disrupted.⁸⁴ The nerves can regenerate over time, and glandular tissue can develop during pregnancy.⁸⁴
- **Breast augmentation surgery:** When this procedure is performed due to insufficient breast tissue it can lead to milk supply challenges.⁸⁴ The likelihood of issues increases if nerves and milk ducts were severed during the surgery.⁸⁴
- **Breast implants:** Breastfeeding with breast implants is possible, however it is impacted by several factors, including implant size, placement and the type of surgery undertaken.⁸⁶ Incisions under the fold of the breast or through the armpit may not affect breastfeeding.⁸⁶ Incisions around the areola may result in breastfeeding challenges if milk ducts have been severed.⁸⁶
- **Mastectomy or partial mastectomy:** Following a mastectomy or partial mastectomy, it is possible to breastfeed from the remaining breast.⁸⁴ Following radiotherapy after a partial mastectomy, some mothers may be able to partially breastfeed on the affected side.⁸⁴

Vaccination and breastfeeding

It is recommended that women who are planning to breastfeed visit their General Practitioner to have their vaccination requirements assessed before pregnancy. For more information, refer to the [Australian Immunisation Handbook](#).


Breastfeeding when sick

Nurses should encourage mothers to continue breastfeeding when they are ill, such as during a cold, influenza, COVID-19 or gastroenteritis.⁸⁷ Breastmilk contains immune-protective factors that help safeguard their infant from infections.⁸⁷ If a mother feels too sick to breastfeed, they may express milk to continue providing it to their infant.⁸⁷

When unwell, a mother should consult their General Practitioner for guidance, while adhering to basic hygiene principles (such as washing hands with soap and water before and after touching their infant, cleaning and disinfecting surfaces that have been touched, and maintaining the cleanliness of expressing equipment).⁸⁷

Nurses should also encourage mothers to telephone the Women and Newborn Health Service's [Obstetrics Medicine Information Service](#) for free, up-to-date and evidenced based information about the safe use of prescription and over-the-counter medicines and vitamins while breastfeeding.

This document can be made available in alternative formats on request.

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