



HOITOTYÖN TUTKIMUSSÄÄTIÖ

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## **BREASTFEEDING SUPPORT FOR MOTHERS AND FAMILIES DURING PREGNANCY AND BIRTH AND AFTER**

### **– A clinical practice guideline**

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## KEY CONCEPTS

The key concepts used in the clinical practice guideline are in line with the National Action Plan for Promoting Breastfeeding 2009-2012.

### *Exclusive breastfeeding*

In exclusive breastfeeding, the only nourishment the infant receives is mother's breast milk, which is either suckled by the baby or expressed. In addition, the infant is given Vitamin D, and possibly also fluoride, vitamin drops intended for premature infants and any medication the infant might need. According to the WHO definition, exclusive breastfeeding does not include giving water to the infant. In some reports, giving small amounts of water to the baby from a bottle, with a spoon or a cup in addition to breastfeeding is included in the definition of exclusive breastfeeding. (1)

### *Partial breastfeeding*

Besides breast milk, the child is given pureed solids, infant formula, clinical nutrition product for infants (2), gruel or other food (2).

### *The Baby Friendly Initiative*

An initiative published by WHO and Unicef in 1991 (the Baby Friendly Hospital Initiative, BFHI) is aimed at improving the implementation of breastfeeding worldwide. The core of the initiative consists of the 'Ten Steps to Successful Breastfeeding', a practical guide aimed to promote and support breastfeeding in maternity wards, and in recent years in primary health care and paediatric care as well (2-5).

### *Breastfeeding counsellor*

A healthcare professional (2) who has undergone the breastfeeding counselling course (20 h) in accordance with the Baby Friendly Initiative.

### *Breastfeeding support*

Refers to breastfeeding-friendly actions and attitudes, both in general and on individual level. Support includes dissemination of information, psychological support, encouragement and help with practical problems. (2)

### *Peer supporter*

Peer support is a form of interaction based on equality, solidarity, being heard and understood, personal contact and mutual support by persons who have undergone similar life experiences and stages of life. Those taking part in peer support are equals, and they usually both give and receive support. In this context, peer supporter refers to a person giving breastfeeding support, who does not have to be a healthcare professional. The peer supporter can be the mother's spouse, grandmother, relative, friend or another breastfeeding mother. (6)

### *Social support*

Social support refers to an intentional interactive relationship involving emotional and concrete support as well as support related to decision-making (7).

### *Healthcare professional*

In this guideline, healthcare professional refers to healthcare professionals working in primary health care and maternity hospitals, including nurses, midwives, public health nurses, dental hygienists and physicians who attend to families with pregnant mothers or young infants.

## INTRODUCTION

Breastfeeding has positive impacts on both the child and the mother (8). It has been reported to reduce childhood obesity (9-10), type I (11) and II diabetes (10), cardiovascular disease (12-) and maternal risk of premenopausal breast cancer (14), ovarian cancer (15), type II diabetes (13, 15), hyperlipidaemia, hypertension and cardiovascular disease (13). Sudden infant death is less frequent among breastfed infants than among those receiving baby formula (15-16). Breastfeeding also protects infants from severe respiratory infections, diarrhoea and ear infections (15). When successful, breastfeeding promotes the well-being of the mother, and thus of the entire family. Breastfeeding problems have been found to be associated with low maternal self-esteem and perceived lack of support on the part of the mother (17-18).

The duration of hospital stay after delivery has become shorter, and mothers' recuperation from delivery poses limitations on counselling and support given to parents in the hospital. In 2007, the average number of hospital days after delivery was 3.4, compared to 4.0 days in 1997 (19). Some parents are discharged after delivery feeling insecure, perceiving the instructions they have received as insufficient and conflicting (20).

WHO recommends exclusive breastfeeding during the first six months of life, and continuing with breastfeeding until the child is two years or older (21). In Finland, breastfeeding recommendations have been published in two national guidelines in 2004 (22–23). The guideline entitled Child, Family and Food (Lapsi, perhe ja ruoka) contains nutrition guidelines that are still in force (22). They recommend that exclusive breastfeeding of normal-weight infants who were born healthy be continued until six months of age. In addition, flexible introduction of solids is recommended based on the child's needs, growth and readiness by the age of six months at the latest, as is the administration of Vitamin D supplement to breastfed infants. Partial breastfeeding is recommended at least up to 12 months of age in addition to giving solids. (22)

In Finland, infants are breastfed for a shorter period than recommended, and the prevalence of breastfeeding in Finland is the lowest in Scandinavia (2). Exclusive breastfeeding is especially rare in Finland. According to the international Baby Friendly Initiative, other than milk from the baby's mother should only be given to newborns on medical grounds. Giving extra milk to newborns without medical grounds diminishes the effect of exclusive breastfeeding. When the infant is given additional food on medical grounds and the reasons are explained to the mother, the additional milk does not pose a threat to breastfeeding (24). Giving extra milk in addition to breastfeeding is very common in Finnish maternity hospitals (79%) (25). Compared to the year 2000, giving additional food to infants under one month has become more common, and in 2005 only 60% and 51% of infants under one and three months of age, respectively, were exclusively breastfed (1, 26). Compared to other EU countries (27), the percentage of infants who are exclusively breastfed up to six months of age is very low (1%); the corresponding figure in Sweden, for example, is 15% (28). In Finland, the length of the period when babies are exclusively breastfed is on average 1.4 months (28). In Sweden,

both total duration of breastfeeding and duration of exclusive breastfeeding are somewhat longer than in Finland (29).

Total duration of breastfeeding has increased in Finland over the last decade (1, 30). However, there are large regional differences in breastfeeding statistics. As a result of systematic development work, the situation has improved in some municipalities over a ten-year follow-up period (1).

In order to promote breastfeeding, the National Institute for Health and Welfare published the first national action plan in 2009, with the following key guidelines:

- promoting consistent, evidence-based breastfeeding support practices in healthcare units caring for families and children.
- strengthening the professional competence of healthcare professionals engaged in promoting breastfeeding.
- setting up local, regional and national structures needed for promoting breastfeeding (2).

Drawing up clinical practice guidelines supporting breastfeeding is also recommended in order to develop consistent, evidence-based practices. The use of evidence-based methods that support breastfeeding is also required by a recent decree (31).

Information is available on effective methods that promote breastfeeding (32-33). Several international guidelines on various topics associated with breastfeeding have also been drawn up (34). The guidelines deal with topics such as breastfeeding and discharge of neonates from hospital, (35), breastfeeding infants who are healthy (36) or ill (37), glucose monitoring (38), establishing exclusive breastfeeding (33) and mastitis (39).

Breastfeeding is impacted by the surrounding culture; however, the cultural factors associated with breastfeeding have been little studied in Finland. Breastfeeding is often thought of as something private, a personal characteristic of the mother that cannot be influenced to any great extent. Studies indicate that breastfeeding is hampered and shortened by a perceived lack of resources on the part of mothers as they try to live up to expectations, as well as problems associated with breastfeeding in public (40). Mother's attitude towards breastfeeding and spousal support are associated with successful breastfeeding (41).

The role of healthcare professionals in promoting breastfeeding-friendly attitudes is of crucial importance. Effective methods aimed at supporting breastfeeding should be found for their use (42). According to a Finnish study, feeding in infancy according to guidelines varies according to maternal education level. Those with higher education breastfeed their infants longer. (43). In general, Finnish mothers have a positive attitude towards breastfeeding, but there is a great deal of individual variation in attitudes and knowledge (44). Positive attitudes and good knowledge is associated with successful and continued breastfeeding (44-45). Some mothers have very little knowledge about breastfeeding as they come to hospital to give birth, and their knowledge does not necessarily increase sufficiently during the hospital stay (44).

There is only little research data available on the peer support process and its impact on breastfeeding. Similarly, little is known about mothers', healthcare professionals' and peer supporters' views on peer support (46). Mother who were assisted by a support person (doula) during delivery were more likely to initiate breastfeeding and were also more satisfied with their care in hospital than controls who gave birth without a doula (47). Breastfeeding support given by a healthcare professional immediately after delivery is of primary importance. As the child grows, the importance of professional support decreases, while that of peer support increases. In England, where bottle feeding is common, childcare help from female relatives is one of the factors predicting early discontinuation of breastfeeding (48). According to an American study, grandmothers also have a great impact on starting the child on pureed solids earlier than recommended by guidelines (49).

The availability of professional breastfeeding support after delivery varies regionally and locally (2). When designing new initiatives aimed at promoting breastfeeding, peer support should be included (50). The attitudes of the spouse, friends and family as well as peers have an impact on whether the mother initiates breastfeeding, and social support from family and friends has an effect on its continuation. For many mothers, the spouse is the most important provider of breastfeeding support (17, 44, 51).

There is little experience on educating spouses, grandmothers and other peers on breastfeeding, but what is known is positive (42). Developing breastfeeding support in collaboration with peers is natural, because everyone has a common goal: a healthy mother, child and family who are all doing well, as well as continued breastfeeding in the manner desired by the mother.

## **GUIDELINE TOPIC**

The topic of the guideline is the implementation of breastfeeding counselling and support aimed at mothers and families during pregnancy and delivery as well as after delivery in Finland.

### ***Aims of the guideline***

The aim of the guideline is to improve the quality of the support aimed at pregnant women and families with young infants and to achieve more consistent breastfeeding support practices. With the aid of the guideline, the breastfeeding support given to clients can be individually tailored and based on a systematic literature review (52, 53).

## LITERATURE REVIEW USED AS BASIS FOR CLINICAL PRACTICE GUIDELINE

When drawing up the guidelines for breastfeeding counselling and support, the research question was as follows:

1) What kind of breastfeeding support is effective?

### **Research data search**

Data was searched with a systematic literature search (54) in March 2006 from the CINAHL, Medline and Cochrane Central Register databases. The search was updated using the same search terms in February 2008. In addition to the researchers, informaticians from the Central Health Sciences Library Terkko and Helsinki University of Applied Sciences Metropolia (formerly Stadia) took part in the process.

Research data describing breastfeeding support and counselling was searched for with test searches using various search terms. Finally, breastfeeding and its hyponyms in combination with various terms describing education and support were selected as search terms.

Different search terms had to be used in different databases, because the databases' own search term indices were used in the search process (Table 1). The data search was limited to articles published in Finnish, Swedish and English in 2000-2008. The actual data search in 2006 (n=773) and the updated search in 2008 (n=341) yielded a total of 1,114 article references, 334 of them from Cinahl, 684 from Medline and 96 from Cochrane.

Table 1. The databases and search terms used in data search.

Database	Search terms
CINAHL	Exp *Breast Feeding/ and Patient Education/ or Health Education/ or Parenting education/ or counselling/ or anticipatory guidance/ or couples counselling/ or peer counselling/ or exp support, Psychosocial/ or exp Health Promotion/.
Medline	*Breast Feeding/ and Patient Education/ or Health Education/ or counselling/ or directive counselling/ or social support/ or exp Health Promotion/.
Cochrane	Breastfeeding/Breast feeding and Patient education or Health education or Counselling or Directive counselling or Social support or Health promotion

### **Study selection**

In the first part of the data search, two investigators reviewed all the articles (n=773) based on the title. The investigators selected articles that complied with the inclusion and exclusion criteria defined in advance (Table 2) (55). After comparing the selections, abstracts for 427 articles were retrieved. At this stage, articles that remained uncertain based on the title were still included in the material.

Table 2. Study selection criteria.

Inclusion criterion	Exclusion criterion
<ul style="list-style-type: none"> <li>• Study on breastfeeding, breastfeeding counselling or support.</li> <li>• Healthy newborns.</li> <li>• Viewpoint of the mother, father or volunteer.</li> <li>• Original study or systematic review.</li> <li>• Peer-reviewed article.</li> </ul>	<ul style="list-style-type: none"> <li>• The topic was breastfeeding statistics, the health benefits of breastfeeding, giving formula to newborns, prevention of starvation, breastfeeding by seriously ill mothers or infants with illness or premature babies, attitudes towards breastfeeding.</li> <li>• Studies conducted in developing countries.</li> <li>• Non-scientific article.</li> </ul>

Next, the texts were read independently by two investigators, who discarded abstracts that met the exclusion criteria or were overlapping. The exclusion criteria were as follows: not a study or review article, the perspective was that of nurse or doctor, not related to breastfeeding support, breastfeeding promotion or peer support, as well as overlapping articles. Based on the abstract, the full text of a total of 112 articles was retrieved for closer examination. Based on full text, 52 articles were selected.

An updated search from the same databases performed in February 2008 yielded a total of 341 articles; 103 were selected for closer examination based on title and abstract. 46 of the update search articles were selected based on full text. A total of 98 articles were selected for the systematic literature search from the original (n=52) and the update (n=46) search. The data collection process is illustrated in Figure 1.

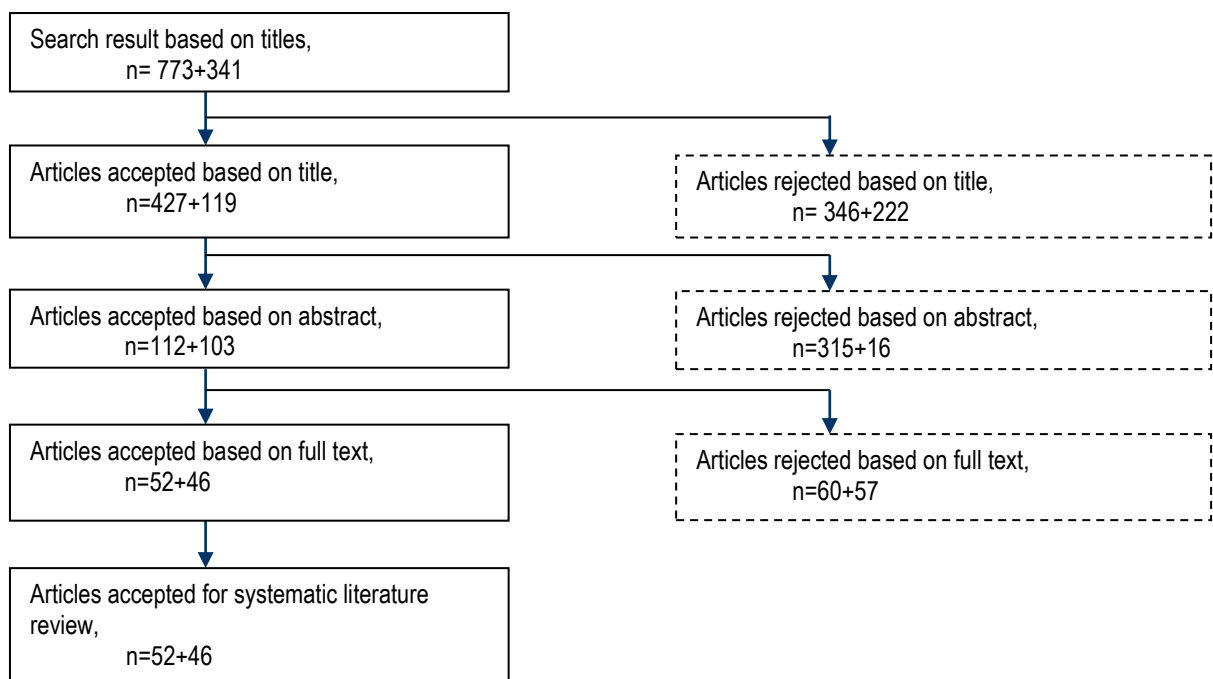


Figure 1. Progress of the data collection process for the systematic literature search.



## ***Assessment of study quality***

When assessing the quality of research data, the focus of attention was on study reliability, interpretation of study data and clinical significance (53). The assessment form developed within the project entitled Appraising Evidence-Based Knowledge (Hoitotieteellisellä näytöllä tuloksiin) was used in the assessment. Each article was assessed by two investigators for the following: 1. background, literature review, 2. purpose of the study and problems or tasks, 3. target group, 4. study design, 5. nursing intervention and its purpose, 6. indicators used in the study, 7. data collection, 8. methods of analysis, 9. reliability, 10. ethical aspects, 11. key findings, 12. clinical significance of the study and 13. applicability of results. The above points were assessed using a three-step scale: high-quality, mediocre or poor.

## ***Data analysis and presentation of results***

A synthesis was performed of the original studies (n=98) selected as study material, describing the findings as well as obvious similarities and differences between the studies. Guideline statements were drafted by an expert panel making use of the syntheses of the articles. After this, the degree of evidence of the guideline statements was assessed on a scale from A to D (54, 56–57), with Level A denoting the highest and Level D the weakest degree of evidence:

- **Level A:** Meta-analysis and a good systematic review.
- **Level B:** Systematic review, one randomised clinical trial (RCT) OR several good quasi-experimental studies with similar results.
- **Level C:** One good quasi-experimental study or several other quasi-experimental studies with similar results OR several quantitative or correlative studies with similar results, OR several good qualitative studies with similar results.
- **Level D:** One good quasi-experimental study or several other quasi-experimental studies with similar results OR several quantitative or correlative studies with similar results, OR several good qualitative studies with similar results.

## **PROBLEMS ASSOCIATED WITH DRAWING UP THE GUIDELINE**

There is a lot of primarily qualitative research on breastfeeding and breastfeeding support. In quantitative studies, variation in terms of definitions of breastfeeding and follow-up times poses a problem. The follow-up times describing the duration of breastfeeding vary: an infant that has been breastfed once or over a follow-up period ranging from one to two weeks or even several years can be classified as having been breastfed. The definitions of exclusive and partial breastfeeding are also unclear, or have not been defined in the articles analysed.

## CLINICAL PRACTICE GUIDELINE

The clinical practice guideline on breastfeeding support aimed at mothers and families during pregnancy and delivery and after birth consists of two parts: A) Ensuring individual breastfeeding support and B) breastfeeding support during pregnancy and delivery and after birth.

### **A. ENSURING INDIVIDUAL BREASTFEEDING SUPPORT**

#### **1. Education is needed on breastfeeding and breastfeeding support**

Good, consistent basic education and continuing education on breastfeeding and breastfeeding support received by healthcare professionals promotes breastfeeding. (B)  
Education aimed at peer supporters also supports breastfeeding and the skills of peer support mothers. (C)

- Those collaborating with expectant mothers and families with young infants must be properly trained in breastfeeding support (25, 76, 80, 108, 116-118): B.
- Breastfeeding counselling courses that comply with the Baby Friendly Initiative of WHO and Unicef are an efficient way of training staff (46): B.
- Professionals' own attitudes towards breastfeeding have an impact on mothers' breastfeeding behaviour. Professionals must recognise the significance of their own attitudes. (81, 116): C.
- Breastfeeding support education received by healthcare professionals increases mothers' satisfaction with the guidance they receive (80,118): B.
- Nurses and doctors must be offered consistent education on breastfeeding and breastfeeding counselling (77, 119): B.
- Breastfeeding support education aimed at healthcare professionals must be continuous, and it should not be based just on individual interest or voluntariness. The quality of breastfeeding support education should also be assessed. (120): D.
- Breastfeeding is increased by arranging annual breastfeeding support courses as part of continuing education of the staff as well as the adoption of hospital routines that support breastfeeding (77): C.
- Peer supporters benefit from training; they gain more self-confidence and become empowered (6, 121-122): B.
- Acting as peer supporter empowers the breastfeeding mothers who have undergone peer supporter education (6, 121): B.
- In educating peer supporters, training programmes that have already been designed should be utilised (6, 79, 123): B, and educational and counselling material should be streamlined so as to be more consistent (90): D.
- Mothers prefer breastfeeding support groups led by a trained professional to house calls by an untrained peer supporter (106,124): D.

## 2. Individual ways of implementing breastfeeding support

Breastfeeding support is implemented individually according to the needs of the mother and the family using a variety of means and methods. Written guidance alone is not sufficient. (A) Peer support is also provided in a variety of ways. Breastfeeding is supported by collaboration between healthcare professionals and peer supporters *tukee imetystä*. (B)

- Breastfeeding counselling supports mothers' coping and their breastfeeding self-efficacy. Mothers who feel that they are coping well with breastfeeding and have faith in their ability to breastfeed are more likely to breastfeed for at least four weeks. (61): D.
- Breastfeeding counselling must not give rise to a sense of guilt. The mothers who stop breastfeeding also need guidance and support. (62): D.
- Breastfeeding counselling is most effective when a variety of different methods are used (63-64): A.
- Written information, such as leaflets or web pages, is not effective on its own in promoting breastfeeding. (63, 65–66): A.
- Breastfeeding support provided jointly by experienced, trained peer supporters and professionals makes more mothers initiate (63): A, and continue (64, 67–73): B with breastfeeding and is important for low-income mothers. The new contacts provided by the group are appreciated. (71): C. Peer support on its own without any professional support is not sufficient (74): D.
- Individual face-to-face counselling is an effective way of supporting breastfeeding (46, 63–65, 75): A.
- Breastfeeding is supported by house calls (64, 76): B.
- Phone counselling can be provided by healthcare professionals (77): C. or peers (78): B. Phone support provided by a peer is more readily accepted than house calls made by a peer (78): B. Not all mothers use peer support even when it is available (68, 78–79): B.
- Small group meetings led by a trained professional that start during early pregnancy and continue after the baby is born improve mothers' perception of the breastfeeding information they have received and recognising the infant's needs (80): B.
- Breastfeeding support groups can be arranged in a variety of ways, provided that the individual needs of the participants are taken into account (81): C.
- Information and support to mothers who breastfeed in exceptional circumstances can be provided via Internet (82): D.

## 3. Recognising the need for support and targeting breastfeeding counselling

Awareness of the groups at risk of discontinuing breastfeeding makes it easier to identify problems and target support according to mothers' individual needs. Recognising the groups at risk of discontinuing breastfeeding (B) and targeted support aimed at those increases the duration of breastfeeding (C).

- Mothers at risk of early weaning must be recognised (76, 83): B.  
Groups at risk include:
  - young mothers (84-86): B.
  - mothers with low education and poor economy (86-91): B.
  - mothers belonging to minority groups (72, 89, 91-94): B.
  - mothers who smoke (86): B.
  - mothers who are planning to breastfeed only for a short period of time (95): C.
  - mothers who were delivered by caesarean section (93, 96): C.
  - mothers who have experienced a traumatic delivery (97): C.
  - mothers who feel that they are not coping well with breastfeeding and who had difficulties breastfeeding in the maternity hospital (25, 61, 97–99): C.
  - mothers who wean their infants earlier than they had originally planned due to breastfeeding

- problems are in need of special support (100): D.
- mothers who feel that they do not have enough milk (101): D.
- mothers who feel that they get no support for breastfeeding (102): B.
- mothers who go back to work or their studies early (103): B.
- Targeted breastfeeding support for those at risk:
  - The number of those who initiate breastfeeding and continue breastfeeding for six months is increased by counselling and individual guidance during pregnancy, frequent contacts with the mother and house calls, if needed (104): C.
  - Providing psychosocial support and practical breastfeeding guidance during house calls supports exclusive breastfeeding and continued breastfeeding (76): C.
  - Tailored peer support groups for high-risk (young mothers with low education and low income) and low-risk (older mothers with high education and high income) mothers increase mothers' satisfaction with the breastfeeding experience. Mothers benefit from group counselling with others in the same life situation. (84): C.
  - Especially mothers living in an environment where breastfeeding is not prevalent benefit from the example provided by breastfeeding peers (105–106): D.
  - Combining professional support and peer support at breastfeeding clinic or in support group increases breastfeeding among immigrants (72): D.
  - The cultural background of the mother must be taken into account in the counselling (89, 91–94): B.
  - Mothers benefit from peer support given by someone from the same cultural and ethnic background (72, 107): D.

#### 4. Involving family members in breastfeeding education

Family members, such as the child's father or mother's spouse and the child's grandmothers, are taken into account as potential supporters of breastfeeding. (B)  
Family members' breastfeeding awareness can be increased with parenting education and house calls, for example.

- The views on breastfeeding of the spouse and grandmother, especially maternal grandmother, have an impact on mothers' decision to breastfeed (73, 108-114): B.
- It is a good idea to arrange education for spouses during pregnancy; just a single breastfeeding education session during pregnancy increases breastfeeding (111-112): B.
- Those who take part in the family's everyday life are involved in breastfeeding coaching. They benefit from instructions telling them how they can support the breastfeeding mother in a concrete manner. (114–115): D.
- A combination of professional and peer support that takes into account the father, other family members and friends is important. Mothers taking part in a breastfeeding support group are more likely to breastfeed longer (at least two months). (73): D.

## **B. BREASTFEEDING SUPPORT DURING PREGNANCY AND DELIVERY AND AFTER BIRTH**

### **5. Uninterrupted breastfeeding support from antenatal care to child welfare clinic**

Breastfeeding support is initiated at the antenatal clinic, and it proceeds in a consistent manner in the maternity hospital and child welfare clinic. (B)  
Professional support is complemented by peer support at all stages. (B)

- Breastfeeding support that starts during pregnancy supports exclusive breastfeeding and continued breastfeeding in the early stages of breastfeeding (25, 63, 80, 104, 125-127): A.
- The prevalence of breastfeeding is increased by consistent nursing practices that support breastfeeding implemented in hospitals and primary healthcare (70, 80, 102, 104, 119, 128-129): B.
- One-off interventions in maternity hospital or maternity clinic are not effective; what is needed is support that is versatile and continuous. (130-136): B.
- Individual support provided by a peer supporter after delivery is not effective, unless boosted support is offered during pregnancy and during stay in maternity hospital (74, 137): B.
- Peer support must be available throughout pregnancy until weaning (79, 84, 108, 123): B.

### **6. Breastfeeding support during pregnancy**

Breastfeeding support during pregnancy strengthens knowledge about breastfeeding and promotes positive attitudes towards it. (B) Breastfeeding support during pregnancy is implemented through individual visits and house calls or in small interactive groups. (C) Support methods based on single sessions only during pregnancy do not promote continued breastfeeding. (B)

- Flexible support during pregnancy aimed at increasing knowledge about breastfeeding and promoting positive attitudes increases breastfeeding (63, 80, 104, 125-127): A.
- Counselling provided by a public health nurse during pregnancy makes more mothers initiate breastfeeding (69): C.
- Information about the most common breastfeeding problems should be given during pregnancy. It should also be pointed out that life will change after the baby is born. (100): D.
- Breastfeeding is supported by house calls and individual counselling (103, 138): C.
- Ante- and postnatal house calls are not effective without guidance given in hospital (134): B.
- Group counselling of short duration consisting of lectures given exclusively during pregnancy does not result in more mothers initiating or continuing with breastfeeding (139-140): B.
- Interactive group counselling during pregnancy may increase breastfeeding (63, 80, 104, 125, 127): A.
- A breastfeeding support group arranged by a healthcare professional and possibility for individual peer support increases the prevalence of breastfeeding and its duration (106): D.
- Early interaction is supported by education on breastfeeding and pregnancy given by maternity clinic personnel as well as by group sessions that continue after the baby is born (80): B.
- The involvement of a trained peer supporter in group counselling that is led by a professional, starts during pregnancy and takes risk groups into account increases the duration of exclusive breastfeeding and satisfaction with the breastfeeding experience (84): C.
- Peer support during pregnancy increases breastfeeding in maternity hospital, but its impact is no longer seen six weeks after discharge (141): C.

## 7. Breastfeeding support in maternity hospital

In maternity hospitals, compliance with nursing practices that follow the Baby Friendly Initiative (immediate skin-to-skin contact and early breastfeeding within one hour of birth, exclusive breastfeeding in the hospital, 24-hour rooming-in, breastfeeding on demand, no dummies) increases exclusive breastfeeding and the duration of breastfeeding. (B)

Family-centeredness in the maternity hospital increases exclusive breastfeeding at home. (C)

- Initiating breastfeeding within one hour of birth increases exclusive breastfeeding and the duration of breastfeeding in general (25, 142–144): C.
- Initiating breastfeeding in the delivery room is associated with exclusive breastfeeding during hospital stay (145): C.
- Exclusive breastfeeding in hospital is associated with exclusive breastfeeding at home and longer duration of breastfeeding in general (25, 95, 142–144, 146-147): C.
- 24-hour rooming-in increases exclusive breastfeeding and the duration of breastfeeding (25, 142–144): C.
- Breastfeeding on demand increases exclusive breastfeeding and the duration of breastfeeding (142–143): D.
- Not using dummies in hospital is associated with exclusive breastfeeding and longer duration of breastfeeding in general (25, 95, 142–144, 146-147): C.
- The duration of breastfeeding is increased by compliance with the Baby Friendly Initiative (25, 63, 77, 119, 130, 142–143): A; compliance with all the steps of the initiative is most efficient in increasing the duration of breastfeeding (88, 142–143): C, increasing exclusive breastfeeding of both the child in question and the next child (148): C.
- Expert breastfeeding support in maternity hospital increases coping with breastfeeding; this is especially true of groups of mothers among whom breastfeeding is otherwise less common than average (149): C.
- Exclusive breastfeeding is increased by the use of single rooms or family rooms and a designated nurse. The education given to mothers should be individual and consistent. (25): C.
- Verbal ('hands-off') counselling aimed at mothers during actual breastfeeding situations in the hospital decreases breastfeeding problems and increases exclusive and partial breastfeeding at least up to six weeks (150): D.
- Combining peer support with professional support (BFHI) makes more mothers initiate breastfeeding (67, 77): C.
- Peer support as part of the hospital's Baby Friendly Initiative is effective. Breastfeeding is supported by a breastfeeding support group led by a trained peer supporter and lending breast pumps for home use. (77): C.

## 8. Breastfeeding support after hospital discharge

During the first few weeks, breastfeeding support given by healthcare professionals prevents breastfeeding problems and is of significant importance for successful breastfeeding. (B).

After discharge from hospital, support from healthcare professionals should be easily available, because continued breastfeeding is ensured by individual support (B). The role of peer support grows as breastfeeding continues (B), and mothers/families are guided towards peer support.

- The combination of complementary breastfeeding interventions, such as professional support and peer support, increases breastfeeding. Peer support may be beneficial both in terms of initiating breastfeeding and its duration. (63): A.
- Individual and targeted support after delivery promotes continued breastfeeding (104, 117, 151-153): B.
- Breastfeeding support during the first few weeks after delivery is significant in terms of preventing breastfeeding problems (117, 153-154): B.
- Mothers need quick and expert help with their breastfeeding problems. What they need in particular is that they are sensitively listened to and given support in adapting to problematic situations. (100): D.
- Providing psychosocial support and practical breastfeeding guidance during house calls supports exclusive breastfeeding and continued breastfeeding (76): C.
- Expert breastfeeding counselling and support over the phone after delivery increases exclusive breastfeeding among highly educated mothers. Low-income mothers need other types of breastfeeding support as well. (155): C.
- A breastfeeding clinic operating as part of primary health care is a form of support that deserves consideration. In a breastfeeding clinic, professional support and peer support can be combined. (154): C.
- The support provided by a breastfeeding support group arranged jointly by a healthcare professional and a trained peer supporter is important for mothers and increases breastfeeding (71–72, 84): C.
- Exclusive breastfeeding and the duration of breastfeeding is increased by a combination of support provided by a public health nurse and a peer supporter that is initiated during hospital stay and continues at home (70): B.
- Phone support by trained peer supporters after delivery promotes continued breastfeeding (69): C.
- Breastfeeding is increased by support provided by spouse and peers. Breastfeeding is increased for up to two months by interventions involving professional support, while the effect of peer support lasts longer. (108): D.

## **SUMMARY AND APPLICATION OF THE CLINICAL PRACTICE GUIDELINE**

The health and other benefits of breastfeeding are well known. International and national guidelines emphasise the significance for health and well-being of exclusive breastfeeding for six months and partial breastfeeding for at least up to one year of age. In Finland, the support and guidance that mothers receive with the aim of encouraging breastfeeding behaviour in keeping with the guideline is not consistent. There is regional variation as well as variation between professional groups, organisations and individual employees. With the aid of the clinical practice guideline, the know-how and counselling expertise of nursing staff can be improved and the implementation of education in problematic situations facilitated. Furthermore, the education received by clients is based on research data, contributing to more consistent education practices within the nursing sector. The psychosocial support received by mothers in problematic breastfeeding situations is improved, while the number of mothers who feel guilty or stop breastfeeding altogether because they experience problems is decreased.

The aim of this clinical practice guideline is to improve the quality of the support aimed at pregnant women and families with young infants and to achieve more consistent breastfeeding guidance practices. With the aid of the guideline, clients will receive individual breastfeeding education that is based on up-to-date research data. The clinical practice guideline is intended as a national guideline, especially to be used in practical work in primary health care and hospitals. Those in charge of nursing, maternity care and paediatric services in different sectors must make sure that the guideline can be implemented in practice. The actions associated with the adoption of the guideline are in line with the programme entitled "Promoting breastfeeding in Finland – Action Plan 2009-2012". Key points include arranging breastfeeding counselling courses for those working in maternity care and in child welfare clinics and developing national, regional and local guidance, collaboration and division of tasks. The actions involved in the implementation of the guideline are in line with the actions included in the action plan, and the adoption of the guideline will not give rise to any added costs in addition to the costs of the action plan. As a result of the positive health effects of breastfeeding, the adoption of the guideline may result in cost savings thanks to decreased morbidity (2).

The guideline is based on studies published in 2000-2008. A project entitled Urban parenthood – Assessment of the Impact of Interventions Aimed at Families with Young Infants is currently underway in Finland. The project is aimed at developing and assessing interventions that support parenthood and breastfeeding. One of the interventions included in the project was a Web-based service called Vauvankaa.fi, aimed at providing support for parenthood, caring for babies and breastfeeding. Parents had a positive attitude towards the Web-based service and felt that it gave them emotional support that boosted their self-confidence (58). Other findings of the study have been and will be reported in scientific journals (e.g. 50, 51, 58–60).



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