Educating Mothers About Breastfeeding Using A Hands-Off Approach

Introduction

The 'Infant Feeding Survey', which looks at breastfeeding across the UK which was last carried out in 2010, explored key findings that at six weeks only 55% of any type of breastfeeding was taking place (Baby Friendly Initiative, 2010). Many women give up breastfeeding even after being aware of the increased benefits there are for themselves and their baby (Coad and Dunstall, 2011). The reasons for stopping breastfeeding can be seen to vary between different age, ethnicity and socio-economic groups however 22-33% of mums experienced their baby rejecting the breast or having sore or cracked nipples causing them to give up (Infant Feeding Survey, 2010). Helping mothers to avoid these complications could result in a rise in the number who prolong breastfeeding (Ingram, Johnson and Greenwood, 2002). Research done by Britton et al (2007) concluded that 'additional professional support was effective in prolonging any breastfeeding'. Thus, making breastfeeding education, training and awareness momentous. One way in teaching mothers breastfeeding skills is through the hands-off approach. This focuses on teaching newborn positioning and attachment with verbal communication or by using model breasts and dolls rather than manoeuvring the breast or neonate (Schafer and Genna, 2015). Additionally, the hands-off technique is used to facilitate learning (Baghany et al., 2013) by allowing the mother to be actively involved when being taught the new skill. This report examines the guidelines and evidence associated with the hands-off technique whilst exploring the midwife's role in being able to use the hands-off approach effectively to support breastfeeding mums, creating women centred care. Additionally, this report will look at midwives' competencies in practice such as being able to successfully assess the skill of breastfeeding.

Guidelines

Within the National Institution for Health and Care Excellence (NICE, 2006) guidelines for postnatal care up to 8 weeks after birth, it states that from the first feed new mums should be 'given information' about the advantages of breastfeeding and 'offered advice' on how to comfortably position their baby and themselves to ensure correct attachment and prevent poor latch that may result in discomfort or pain. The use of terminology such as 'information' which can be defined as using facts (information, 2020) and 'advice' which can be explained as guidance or recommendations (advice, 2020) can be seen to imply the use of a hands-off approach due to the focus on teaching and education.

In 1989 the 'Ten Steps to Successful Breastfeeding' was created by World Health Organisation (WHO) and United Nations International Children's Emergency Fund (UNICEF) to establish an encouraging pathway for women to achieve breastfeeding and provide guidance on training for health care professionals (Ten Steps to Successful Breastfeeding, 2013). Step 5 within the 1989 recommendations state that 'mothers should receive practical support to enable them to initiate and establish breastfeeding and manage common breastfeeding difficulties'. However, in 2017 WHO and UNICEF revised step 5 to become more applicable to all mothers,

infants and facilities. Step 5 now recommends to ‘support mothers to initiate and maintain breastfeeding and manage common difficulties’ (UNICEF, 2018). This amendment can be seen to favour a hands-off approach as UNICEF are now focusing on issues of ‘positioning, suckling and ensuring the mother is prepared’ (UNICEF, 2018) rather than the use of ‘practical support’ which is concerned with actions rather than education (practical, 2020).

Evidence

A non randomised prospective cohort phased intervention study, which took place on 1,400 South Bristol mothers who were discharge from hospital breastfeeding, concluded that in the immediate postnatal period if mothers are educated on positioning and attachment using ‘eight key elements’ this becomes an important factor in breastfeeding success at six weeks. The figures found that at six weeks 79% of the mothers in the study were still breastfeeding, which when compared to the control group, can be seen to be affected by the ‘teaching, technique and associated explanations about breastfeeding’ taught to the experimental group. (Ingram, Johnson and Greenwood, 2002). These finding can be seen to correlate to a study were a similar training programme was introduced in Australia. Fletcher and Harris’ (2000) study into the hands-off technique programme in Australia, which assisted staff to teach women about correct position and attachment, found that this method increased breastfeeding rates by reducing the number of reports of postnatal problems. Evidence by Woolridge (1986) examines that the most important factor in preventing postnatal problems such as sore nipples and ineffective feeding is the positioning of the baby to the breast; with ultrasound evidence showing a baby who is feeding correctly has the nipple positioned at the roof of the mouth where is it protected. This further expresses the importance for informing mothers about how to correctly establish breastfeeding for themselves to ensure they can get a comfortable latch in order for them to continue with breastfeeding.

Studies done have also confirmed that when putting your own baby to the breast for the first term results in more successful outcomes for breastfeeding. A survey carried out in Warwickshire found out of 95 first time mothers, only 46% were still breastfeeding at around 6 weeks. However, those mothers who had put their own baby to the breast for the first feed were at a higher percentage (71%) to continue breastfeeding than those who had someone else position the baby for the them (38%) (Napier, 2001). Therefore, similarly showing that when the breastfeeding technique is done by the women but taught by the midwife, the outcome for breastfeeding is more successful. That said, as only one third of the mothers put their babies to the breast for the first time, further research is needed to ensure the differences are statistically significant.

Qualitative research which was carried out by Bäckström, Wahn and Ekström (2010) within Sweden, where the data came from interviewing the women and midwives about their experience with breastfeeding support, found that one woman was distressed about a midwife who had taught a breastfeeding technique in a ‘careless manner’ and who she believed did not help her breastfeed. She reported that the midwife had “torn” at her breast and “pulled” the baby's head which caused “nothing to be gained” and therefore suggests that a hands-on approach does not benefit women in regard to educating breastfeeding mums. Additionally, another study in Sweden in which 879 women participated in, stated that 38% have experienced the hands-on approach during the first breastfeeding session in which they also reported this as a negative experience (Cato et al., 2014).

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However, in more recent years within the ‘Infant Feeding Survey Chapter 4’, (2010) it was found that ‘nearly three quarters of mothers who breastfed initially put their baby to the breast (74%)’ (Infant Feeding Survey, 2010). This demonstrates that a hands-off approach is now being used by more commonly within the UK.

Midwives responsibilities

As stated by the Nursing and Midwifery Council (NMC, 2009) a key competency is to ‘teach women about the importance of nutrition in child development’. Breast milk can be seen to provide the best food for growth, development and increased protection against infectious diseases due to the immune defence aspect (Coad and Dunstall, 2011). For mothers to provide their baby with breast milk essential for their nutrition, it is important they are taught with up to date evidence by midwives who have a knowledge of anatomy and physiology to underpin the findings and guidance they provide for breastfeeding women. Prolactin and oxytocin are the two hormones which directly affect milk production. Prolactin is released by the anterior pituitary gland when the baby is suckling, this stimulates the production of milk for the next feed. Oxytocin is released by the posterior pituitary gland when stimulated by suckling or by seeing, touching or hearing her baby. Oxytocin works to compress the myoepithelial cells which are wrapped around the alveoli causing them to contract in the ‘let down flex’ or milk ejaculation. Oxytocin is inhibited by adrenaline and therefore stress or pain can stop milk flow (Coad, Pedley and Dunstall, 2019). Additionally, Feedback Inhibitor of Lactation (FIL) is a whey protein, that if milk is not removed the inhibitor builds up and prevents the lactocytes secreting anymore. Therefore, by removing breastmilk, FIL is also removed and milk production resumes (World Health Organisation, 2009). When mothers are taught about this it can ensure that they are breastfeeding in the right environment to maintain adequate milk production. This also shows that when in postnatal care, midwives should account for the environment breastfeeding is taking place. NICE (2006) states that this involves making arrangements for ‘24 hour rooming with skin to skin where possible, privacy and having adequate rest without interruption from hospital routine’ and therefore midwives have a responsibility to ensure the women is comfortable which will aid breastfeeding.

Another responsibility for midwives is to assess and monitor the breastfeeding. Ingram, Johnson and Greenwood (2002) stated that successful breastfeeding was described as “pain free”. Neifert (2004) suggested that a poor latch and positioning will prevent successful sucking and sufficient milk removal and therefore it is a midwife's provision of care to ensure that a good latch is determined. The assessment of a good latch can be done using a numerical scoring system from 0 to 2 with 2 being associated with a grasped breast, tongue down, lips flanged, 1 representing repeating attempts, holding nipple in mouth and 0 correlating to no latch achieved. The assessment of a good latch can be in conjunction with the assessment of audible swallowing, type of nipple, comfort and hold which also uses a numerical score from 2 to 0 (Kumar, Mooney, Wieser and Havstad, 2006). When interviewing midwives in Sweden, they would ask the women to call them over when the baby is signalling for food as this straight away allows the midwife to look at how the baby is lying and being held (Bäckström, Wahn and Ekström 2010). A combination of watching a feed, numerical scoring and talking to the women allows an individual breastfeeding support plan to be made, personalised to individual needs.

Woman centred approach

Hands-off studies suggest that women find this style ‘less objectifying’ and ‘more empowering’, when compared to hands-on approach, which results in self assurance and self confidence (Schafer and Genna, 2015). Various studies, especially in a NICU setting, report that a hands-on approach is correlated with maternal dissatisfaction. In one study, some women felt their breasts ‘did not belong to them’ and they were like an ‘inanimate object’ and additionally felt that the hands-on experience was ‘brutal, unpleasant and violated their integrity’ (Weimers et al., 2006). This demonstrates how a hands-off method allows midwives to act with respect, kindness and dignity by taking into consideration the women’s needs and feelings in relation to breastfeeding. Fletcher and Harris (2000) recognised that it is difficult to change the midwifery culture around breastfeeding into predominantly using a hands-off approach however the advantages for mothers and babies makes it valuable. Within Bristol, it was seen that most staff seemed committed to practice the hands-off approach as they believed it would ‘empower mothers’ and ‘reduce conflicting advice’. The use short pragmatic training sessions in this study were intended to fit into midwives busy schedules and therefore make it easier to implant the technique to benefit mothers (Ingram, Johnson and Greenwood, 2002). Taking this into consideration, a hands-off approach can be seen to increase confidence in the mothers own capacities and therefore can result in a prolonged duration of breastfeeding (Weimers et al., 2006).

Conclusions

80% of mothers who stop breastfeeding would have continued for longer however stated they normally stopped due to difficulties or lack of support (Fox, McMullen and Newburn, 2015). Research has shown that mothers tend to value social support as more important than health service support. This shows that changes are necessary within the health services to recognise the needs of both mothers and midwives (McInnes and Chambers, 2008). Noticeably, it can be seen that a hands-off training programme is beneficial in promoting exclusive breastfeeding. It demonstrates how hospitals need to evolve their polices and replace breastfeeding teaching to a hands-off approach (Baghany et al., 2013) (if they have not done so already) which will move away from mechanical positioning and attachment and instead reinforce a relationship centred breastfeeding experience which incorporates a women's own breastfeeding capability (Schafer and Genna, 2015). Women's experiences of hands-on technique demonstrates the necessity to adapt outdated practices to benefits mothers and babies.