Providing effective evidence-based support for breastfeeding women in primary care

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<th>What you need to know</th>
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<tr>
<td>• Breastfeeding is beneficial to short and long-term health of mothers and infants and should not be replaced with mixed feeding or top-ups with infant formula unless clinically indicated, or by informed maternal request</td>
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<td>• When breastfeeding women are provided with skilled, sensitive, individualised support they are more likely to continue both exclusive and any breastfeeding</td>
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<td>• Many mothers do not find breastfeeding as easy as they expect and may have concerns or encounter challenges. For the majority, these can be resolved with early, sensitive, skilled help</td>
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<td>• Encourage all mothers to feed in response to their baby’s early feeding cues and ensure that women who have chosen to breastfeed understand that responsive, effective breastfeeding leads to greater breastmilk supply</td>
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<td>• During the Covid-19 pandemic breastfeeding is likely to be even more important and remote breastfeeding support should where possible complement rather than replace face-to-face support</td>
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<th>Case scenario</th>
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<td><strong>Baby Kyle was born at term by Caesarean section after an uneventful first pregnancy. His birthweight was 3.550kg and now at two weeks he has regained his birthweight. His mother Ellie has contacted the surgery to make an appointment with the GP and attends a video consultation. Ellie is breastfeeding Kyle and explains she has struggled to access the breastfeeding support she would have liked due to the pandemic. She is concerned Kyle is not getting enough milk. She reports pain when feeding and explains that he has been crying and unsettled after feeds. Ellie has searched online and wonders if Kyle has a cow’s milk protein allergy and she asks if she should exclude dairy from her diet. She is tearful and reports feeling low and isolated.</strong></td>
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The World Health Organisation recommends exclusive breastfeeding for six months with continued breastfeeding until two years and beyond\(^1^{\text{--}}\)\(^2\). Even in high income countries, babies who are not breastfed are at increased risk of health issues including gastroenteritis\(^3\)\(^4\), otitis media\(^5\), increased rates of obesity and diabetes\(^6\). Women who do not breastfeed are at increased risk of diabetes and breast and ovarian cancer\(^7\). Yet globally in 2019 only around 44 percent of babies were exclusively breastfed birth to 5 months\(^8\). The UK has some of the lowest breastfeeding rates worldwide and 80%
of women stop before they want to. In a recent survey, almost half (45.3%) were still doing any breastfeeding at 6 months, however, 82% of women also used infant formula.

Breastfeeding is learnt by both mother and baby together, but in many countries, including the UK, mothers have never seen a baby breastfeeding and therefore lack this embodied knowledge. Mothers often do not find breastfeeding as easy as they anticipated and may experience challenges, such as concerns about breastfeeding supply or breast and nipple pain that can normally be resolved with timely, skilled support. Evidence from a Cochrane Review shows that when support is offered to breastfeeding women, both exclusivity and duration of breastfeeding are increased. This article provides an overview of best practice information and practical ways for primary care practitioners to support mothers to navigate some common breastfeeding challenges. We also consider what is likely to be most effective when providing support during the Covid-19 pandemic.

**Why do breastfeeding women need support?**
Breastfeeding is more than provision of nutrition for infants; it can provide increased opportunity for relationship building between mother and baby. When women encounter breastfeeding challenges within a context where the superiority of breastmilk is widely known, their sense of themselves as ‘good mothers’ is undermined leading to loss of self-confidence and breastfeeding self-efficacy. Therefore, it is crucial to pay attention to women’s emotional well-being, actively listen and acknowledge women’s concerns (see Box 1).

Social norms around infant feeding vary across different population groups. For example, younger women and those who have spent less time in education are less likely to start and continue to breastfeed, however with skilled support, they are able to feed exclusively and for longer. Therefore recognising the need for additional support for mothers least like to breastfeed can help to reduce inequity. Aggressive marketing of breastmilk substitutes despite the International Code on the Marketing of Breastmilk Substitutes has contributed to the myth that formula milks are almost equivalent to breastmilk. However, there are many bioactive factors present in breastmilk such as immune factors and cytokines that help to protect against infection, and hormones and growth factors which help to regulate energy intake and maturation of the infants’ organs. Breastmilk is also a significant factor in the development of the microbiome which appears to affect gene expression and to be associated with lifelong effects on health and wellbeing (e.g. the prevention of obesity). However, despite this, and most women's desire to breastfeed, the reality can leave
women feeling unsupported and undermined by social norms and subtle influences such as marketing of breastmilk substitutes.

**Box 1: How to support women to continue breastfeeding**

- Actively listen to mothers, encourage them to share what is important to them and reflect back to acknowledge understanding
- Use a facilitative style of support and encourage mothers to return for further support if needed.
- Use a discursive two-way exchange so mothers can understand why a particular suggestion might work
- Provide practical realistic information that is personalised
- Support mothers to spend time with their baby in skin to skin contact
- Encourage mothers to feed their baby in response to feeding cues
- Guide women verbally and consider using models of the breast/baby to explain and demonstrate how to hold their baby for feeding
- Refer to specialist breastfeeding support to ensure effective feeding through good positioning and attachment of the baby at the breast
- Consider concerns relating to breastmilk supply (see Box 2 & 3) and nipple and breast pain
- Consider perinatal mental health at every contact and make use of the RCGP perinatal toolkit in your assessment

**How to support women when they believe they have insufficient breastmilk supply**

Many women are concerned that they do not have enough milk for their baby and this is a common reason for early cessation and/or decreased exclusivity. However, in healthy women there is little evidence to suggest that perceived milk insufficiency is associated with an actual milk insufficiency. Many women lack confidence and it is hard to judge the amount of milk the baby is taking, an unsettled, unpredictable baby combined with undermining comments from friends and family may contribute to this. Women may not understand ‘normal’ infant behaviour so reassure them that young babies feed often and cluster feeding may also occur. Encourage feeding in response to early feeding cues (see Box 2). The most accurate indicator of sufficient feeding is infant weight gain. Women can also be reassured by observable signs such as breasts feeling softer after feeds and nappy content. Interventions that improve self-efficacy are more likely to be effective than education so supportive communication with women when they have such concerns is crucial. In women with long-term conditions and those who have had a Caesarean section there may be a
physiological delay to lactogenesis II so additional early support from infant feeding teams may be necessary.25,26 Key ways of enhancing and maintaining a good supply of breastmilk are presented in Box 2.

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<th>Box 2: How to enhance breastmilk supply when there are concerns27</th>
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<tr>
<td>• Conduct a clinical assessment, take a breastfeeding history and refer early for feeding support to ensure breastfeeding is effective and optimal</td>
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<td>• Encourage mother to be attentive to early feeding cues – such as stirring, opening mouth, sucking fingers, rooting and to offer a feed before the baby is crying</td>
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<td>• Explain that the baby should be able to feed from the first breast until satisfied and then to offer the second breast at each feed. The first breast can be offered again if needed as more milk will have been made.</td>
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<td>• Encourage mothers to look for signs their baby is breastfeeding effectively - long, slow, rhythmic sucking and swallowing, with pauses during the active feeding stage of a feed</td>
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<td>• Encourage unrestricted feeding in response to baby’s feeding cues</td>
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<td>• Reassure mothers that frequent feeding and cluster feeding in response to early cues is normal behaviour</td>
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<td>• Explain the need to avoid over full breasts as this will reduce supply – gentle hand expression of breastmilk may be helpful</td>
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<tr>
<td>• Encourage mother and baby to stay close and spend time skin to skin with her baby to increase production of oxytocin – responsible for ‘let down’ of breastmilk</td>
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<tr>
<td>• Suggest relaxation techniques and skin to skin contact with their baby (to enhance oxytocin production) if mother is feeling stressed because the baby is crying</td>
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<tr>
<td>• Do not suggest supplements of formula unless clinically indicated – reduced suckling at the breast will lead to actual reduced breastmilk supply</td>
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It is crucial to recognise when a baby is not receiving enough milk (Box 3). The most likely reasons for reduced breastmilk supply are restricted access to the breast (i.e. not feeding responsively) and sub-optimal position and attachment of the baby at the breast causing inadequate milk transfer. Prolactin is the hormone responsible for milk production and is stimulated by the baby suckling at the breast. Therefore, to improve milk supply, suggest increased frequency of feeding of baby who is well attached and suckling well with observable swallowing. Refer early to the midwife, health visitor or local infant feeding team for holistic assessment and support. Factors that can affect supply include: moderate to heavy smoking, postpartum haemorrhage,28 diabetes25 and obesity or infant
factors that make it difficult for the infant to remove milk’ such as prematurity, tongue tie, heart disease or neonatal infection. Although these are under-researched, other conditions that may cause actual insufficient milk supply include: breast hypoplasia and some types of breast surgery, especially if ducts have been damaged.

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<th>Box 3: Potential signs of insufficient milk intake</th>
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<td>• Poor weight gain – most infants re-gain birth weight by two weeks of age. If not, refer to the infant feeding team for feeding assessment and support</td>
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<td>• 7-10% weight loss or more (expressed as change in weight /birth weight x100) or later weight faltering through two centiles requires assessment to ensure the infant is not unwell.</td>
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<td>• Fewer than 6 heavy wet nappies per day in a baby more than 5 days old</td>
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<td>• From 4 days old for the first few weeks fewer than two soft yellow stools at least the size of a £2 coin (after 4 to 6 weeks this may change and babies may go a few days without passing stools).</td>
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<td>• Short, or long feeds with the baby unsettled after feeding</td>
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<td>• Baby lethargic and sleepy rather than alert and waking for feeds</td>
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**Nipple pain**

Pain in the nipples is experienced by a high proportion of breastfeeding women, however, numbers vary between studies and range from 36% to 79%. A smaller proportion of women will also experience visible damage to their nipples (e.g. cracks). Nipple pain may be associated with decreased feeding or ineffective removal of milk which can adversely affect breastmilk supply. It can also increase the risk of milk stasis and mastitis. Crucially it is reported by women as one of the most common reasons for breastfeeding cessation in the first week. However, reassure women that it is often transient, responds to adjustment to improve attachment and should reduce after 10 days, and with the right support it is treatable for most women.

In the majority of women, the pain is most frequently a result of trauma to the nipple through suboptimal attachment however, a range of other causes exist. Nipple pain should therefore be assessed and managed using the detailed guidance provided by Amir et al.

**Engorgement and mastitis**

Encourage frequent, effective feeding in response to the baby’s feeding cues to prevent engorgement and mastitis and reassure mothers that breastfeeding is safe in the presence of these conditions. When a woman’s breasts are engorged the milk does not flow well as tissue fluid and
oedema can obstruct the flow of breastmilk within the ducts. Stasis of milk causes an inflammatory response due to components of milk entering the tissues or capillaries. Early recognition of engorgement is crucial to avoid reduction in supply of breastmilk and further problems such as blocked ducts and mastitis\textsuperscript{39}.

Mastitis is inflammation of the breast with or without infection, characterised by a wedge shaped area of the breast that is hot, swollen, red (or changed in colour in women with darker skin) and tender accompanied by a raised temperature and the mother feeling unwell\textsuperscript{40}. The first line of treatment is to encourage frequent feeding starting on the affected breast to lessen the pain during initial milk ejection\textsuperscript{38}. The baby will do this most effectively but gentle hand expression may be helpful to soften the area around the nipple to enable the baby to attach more easily. Some women also find a warm compress or shower helpful. To reduce oedema and help the flow of breastmilk anti-inflammatory drugs e.g. Ibuprofen 400mgs three times a day may be needed. Paracetamol may also help as pain can affect the production of oxytocin and inhibit the let-down of milk. Mastitis is usually self-limiting and if frequent effective breastfeeding is achieved, the mother should begin to feel better within 24 hours. There is a lack of evidence on antibiotic therapy for mastitis\textsuperscript{41}, however, if it is not improving within 24 hours or the mother is increasingly clinically unwell, consider an antibiotic. If the mother remains clinically unwell and there is no improvement within 48 hours of oral antibiotic therapy, sepsis is possible so refer to hospital\textsuperscript{42}.

**Assessing the crying infant**

GPs may be the first to be contacted by mothers experiencing distress when their baby remains unsettled and crying. Listen carefully to mothers, address concerns, and use supportive and non-judgemental language in the consultation. Remote consultation may be a barrier to establishing rapport when assessing the breastfeeding dyad. Providing continuity of care facilitates remote consultations and helps to build rapport. Consider providing a follow up face to face assessment, especially to assess an infant reported as being unsettled and crying to exclude potential serious causes such as underlying illness. However, an assessment should not seek to over-medicalise normal infant behaviour or maternal concerns. The wish to offer a solution to the mother’s distress in this scenario can be strong but inappropriate treatments can distract or delay the resolution of painful feeds and an unsettled baby. Periods of crying may relate to hunger, discomfort or tiredness. Enlisting the support and expertise of a health visitor or other infant feeding specialist to observe feeding provides useful information and can assist in avoiding misdiagnosis of gastro-oesophageal reflux disease (GORD). Refer to NICE Clinical Knowledge Summaries (CKS) GORD in children\textsuperscript{43} for further information and assessment when GORD is suspected. Over-diagnosis involves the diagnosis
of a condition more than it is actually present. Overtreatment refers to excessive treatment, procedures or medication used to treat diagnosed true conditions as well as behaviours or symptoms which potentially lie within the spectrum of normal physiology and development.\(^{44}\)

In the context of breastfeeding, reflux oesophagitis and non IgE cow’s milk allergy are uncommon. However, diagnosis of these conditions has increased, as evidenced by an increased number of prescriptions for treatment, which belies the true prevalence of these conditions.\(^{45}\) Some of the increased prescribing has been attributed to the development of infant formula industry sponsored guidelines,\(^{46}\) although these have since been revised in terms of advice for breastfeeding mothers.\(^{47}\) Most reflux is physiological, does not cause distress, will improve over time and resolves by the age of 1 year.\(^{48}\) If GORD is suspected, a trial of treatment and review to assess affect within a set time period may be the only way to distinguish cases where there is uncertainty. However, prolonged treatment of reflux without review risks adverse effects such as increased fracture risk in proton pump inhibitor (PPI) use.\(^{49}\)

Non IgE symptoms may present as a cluster of symptoms associated with a family history of allergy, but individual symptoms overlap with observed normal behaviour.\(^{50}\) Colic alone should not prompt advice to exclude cow’s milk from the breastfeeding mother’s diet. Even in infants with proven Non IgE cow’s milk allergy, breastmilk contains insufficient milk allergen to trigger an allergic reaction. There is a risk of harm in over-diagnosis, and overtreatment could jeopardise breastfeeding. Earlier cessation of infant feeding limits both maternal and infant benefits.\(^{7}\) Prolonged treatment without challenge, and therefore confirmation of diagnosis, in the case of suspected non IgE cow’s milk allergy risks early cessation of breastfeeding.\(^{51}\)

Encouraging feeding and referring for infant feeding support to optimise responsive feeding is important. In particular observing a feed, as well as following both NICE and Cochrane guidance should prevent both over-diagnosis and overtreatment, while enabling appropriate diagnosis.\(^{15,48}\) At all reviews, including the GP 6-8 week check, sensitive enquiry about feeding, mood and support is important. Presentation may reflect anxiety over feeding, poor support or both and addressing these is important.

**Medications and breastfeeding**
Some women practice natural weaning and breastfeed beyond infancy so ask about breastfeeding in all women with infants and children when prescribing medication. Ensure the language used to enquire about this is non-judgemental. Using insensitive language has the potential to cause
unnecessary anxiety and weaken the doctor-patient relationship. GP attitudes are varied, but have been implicated in some mothers’ decision to stop feeding, though this may be modified by education\textsuperscript{52,53}. General principles of prescribing for breastfeeding mothers can be found in Box 4.

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<tr>
<th>Box 4: General Principles for prescribing in Breastfeeding Mothers - UKDILAS\textsuperscript{54}</th>
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<tr>
<td>• Avoid unnecessary drug use and limit use of over-the-counter (OTC) products</td>
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<td>• Breastfeeding mothers should seek advice on the suitability of OTC products and can access qualified pharmacists via the Drugs in Breastmilk service <a href="https://m.facebook.com/BfNDrugsinBreastmilkinformation/">https://m.facebook.com/BfNDrugsinBreastmilkinformation/</a></td>
</tr>
<tr>
<td>• Assess the benefit/risk ratio for both mother and infant and share decision making</td>
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<td>• Avoid use of drugs known to cause serious toxicity in adults or children</td>
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<tr>
<td>• Drugs licensed for use in infants do not generally pose a hazard</td>
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<tr>
<td>• Neonates (and particularly premature infants) are at greater risk from exposure to drugs via breast milk, because of immature excretory functions and the consequent risk of drug accumulation</td>
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<tr>
<td>• Choose a regimen and route of administration which presents the minimum amount of drug to the infant</td>
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<tr>
<td>• It is best to avoid long-acting preparations, especially those of drugs likely to cause serious side effects (e.g. antipsychotic agents), as it is difficult to time feeds to avoid significant amounts of drug in breast milk</td>
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<tr>
<td>• Multiple drug regimens may pose an increased risk especially when adverse effects such as drowsiness are additive</td>
</tr>
<tr>
<td>• Infants exposed to drugs via breast milk should be monitored for unusual signs or symptoms</td>
</tr>
<tr>
<td>• Avoid new drugs if a therapeutically equivalent alternative that has been more widely used is available.</td>
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Women commonly present for treatment for depression and anxiety, pain management, treatment of infection, treatment for ongoing chronic conditions as well as newly diagnosed ones. Non-pharmacological management of these conditions, where possible as a first line of treatment, is lower risk for both mother and infant, but is not always feasible. Most medications are unlicensed for breastfeeding women which has led to reticence in prescribing, but there is usually good data available to assess risk and prescribe appropriately. Ultimately, prescribing remains the responsibility of the GP and clinicians should work within their competence, seek advice from specialist pharmacists where appropriate, and consider their local prescribing guidance. Always consider the risk of early cessation of breastfeeding on the health of the mother and her infant. Options including breastfeeding support and donor milk should be available to support prescribing choices which necessitate temporary cessation with a view to re-establishing feeding as soon as feasible. Further information about the use of donor milk can be found in a recent Practice Pointer article\textsuperscript{55}. 
Dr Wendy Jones, a specialist academic pharmacist, has written extensively about this, allowing clinicians to make an effective risk assessment when prescribing and has trained a group of pharmacists to run the Drugs in Breast Milk service. There are also several very helpful resources which should be consulted when prescribing. The GP Infant Feeding Network, Hospital Infant Feeding Network and Breastfeeding Network organised a joint campaign (“Don’t say stop- look it up”) to support GP and primary care staff when prescribing. The BNF has not yet included this data. Common prescribing themes relevant in the postnatal period generally can be seen in Box 5.

**Box 5: Medications commonly prescribed in the postnatal period and breastfeeding**

**Galactologues** – Medication may be prescribed after adequate breastfeeding support and other strategies are attempted to enhance lactation. Although domperidone is no longer recommended where either mother or baby has a cardiac defect or is taking medication that prolongs the QT interval, it has been used to support mothers of preterm infants, and UKDILAS have recommended treatment doses and duration where necessitated. Metoclopramide is also used but can cause maternal depression.

**Anxiety and Depression** - Active supportive listening and sensitive questioning are required to identify this. Under-recognition and under treatment of depression cause significant harm to the mother and wider family. Sertraline is safe and has been used as the antidepressant of choice. Counselling as an adjunct to therapy is advisable. Other SSRIs, and other antidepressants are used depending on the clinical situation, counsel on monitoring for potential effects though these are generally uncommon.

**Pain management** – where possible chronic pain should be managed by pain management services. Low dose amitriptyline can be used safely as an additional treatment for chronic pain. Acute pain can be treated with paracetamol and NSAIDs (except indomethacin). Note use of opiates during labour and post-delivery for 2-3 days is considered compatible with breastfeeding. However, newly initiated ongoing opiates post-partum carries risk and codeine should be avoided in favour of dihydrocodeine for the shortest period post-surgery. Anaesthetics and non-opioid drugs are safe to use in breastfeeding. A guideline has recently been published when considering anaesthesia in breastfeeding mothers. Topical treatments are generally safe. N.B. co-codamol is available in preparations over the counter, and should not be taken.

**Antibiotics, antivirals and antifungals** – always require careful consideration. Quinolones should be avoided. Tetracyclines other than short courses of doxycycline should not be prescribed. Otherwise, most classes of antibiotics, antivirals and antifungals can be used.

**Contraception** - Progesterone only pill (POP) is suitable for use in breastfeeding mothers. There has been reported low risk reducing early lactation, but no substantive evidence of long term suppression of lactation. Prescribing for a month before introducing a long acting reversible contraceptive (LARC) is a feasible option. The combined pill can be used after 6 weeks post-partum but a risk assessment and communication should be undertaken given UKMEC guidance of the risk in drop in lactation below 6 months postpartum.

**Hypertension** - avoid ACEI (except captopril and enalapril), ARBs and diuretics, but beta-blockers such as labetalol, propranolol and metoprolol have been shown to be safe and can be used. Calcium channel blockers such as nifedipine, amlodipine, diltiazem and verapamil have also some study data supporting use. Low dose aspirin can also be used, with no evidence of Reye’s syndrome in available data. Anticoagulants can be used, but avoid novel oral anticoagulants (NOACS).

**Asthma** – medication and non-sedating antihistamines are also compatible with breastfeeding.

**Diabetes** can be treated with insulin and metformin while breastfeeding. **Thyroid disease** is also
treatable with medication while breastfeeding (except for iodine - not usually used now).

Vaccination is both important, is to be encouraged, and should not be delayed in breastfeeding mothers. Covid-19 vaccination is not contra-indicated and is to be encouraged in breastfeeding women.

Support for breastfeeding women during the Covid-19 pandemic
Continuing to support close relationships between mothers and babies and avoiding separation remain essential during the pandemic. There is growing evidence of the importance of breastfeeding to provide antibodies against Covid-19 and no evidence of transmission through breastmilk although respiratory hygiene is recommended. Concurrently, there are increased challenges to providing breastfeeding support and an unprecedented move to online provision of care. A recent systematic review of global evidence found that although remotely provided support can be effective, particularly to sustain exclusive breastfeeding, it should complement rather than replace face-to-face support. In particular, women report finding it difficult to get the necessary support on issues such as latch and tongue tie with remotely provided care. As experience of online interactions has become more commonplace, it has become possible to provide most kinds of support online, for example demonstrating aspects of effective feeding using a doll. However, the closure of many organised support groups can lead to women feeling isolated.

Case scenario conclusion
Following a full feeding assessment from her health visitor, and online support, which helped her learn how to improve his attachment and reduce the pain at the start of feeds, Ellie reported that she was now able to breastfeed Kyle more comfortably without any dietary restrictions. She was feeling more confident breastfeeding and Kyle was much more settled. Ellie received ongoing support and treatment with Sertraline from her GP for low mood.

Education into practice
- Are you familiar with sources of support for breastfeeding women in your local area? There should be an infant feeding lead in the community and/or hospital. Many informal breastfeeding peer support groups are run (some with NHS support, others voluntary sector, and some peer-to-peer only); many advertise on Facebook
- Specialist infant feeding services exist in most areas, and midwives and health visitors can assist with accessing NHS support and help with preliminary feeding support
Mothers are often concerned about insufficient milk and may need help to recognise signs of adequate and effective breastfeeding and normal infant behaviour.

Restricting feeding can worsen some problems (e.g. milk supply, mastitis, lower weight gain) so women should be supported to feed responsively.

Nipple pain is common but is normally transient with skilled, effective breastfeeding support.

Consider perinatal mental health at every contact.

Although potential serious causes of a crying infant need to be excluded, assessment and management of a crying infant should not seek to over-medicalise normal infant behaviour or maternal concerns.

Most medications or suitable alternative can be prescribed when breastfeeding and mothers should not be routinely advised to stop feeding: check online using the UK Drugs in Lactation Advisory Service or contact the Drugs in Breast Milk information service (links below).

### Further educational resources and sources of support

- **GP Infant Feeding Network GPIFN (UK)** A National Network of Primary Care Professionals and Supportive Colleagues [https://gpifn.org.uk/](https://gpifn.org.uk/)
- **National Breastfeeding Helpline** 0300 100 0212 is open every day of the year from 9.30am to 9.30pm. Support is also available in Welsh and Polish on the same number and in Bengali & Sylheti on 0300 456 2421, and via [ContactSCOTLAND](https://www.breastfeedingnetwork.org.uk/ContactSCOTLAND) for people who have hearing or speech impairments. There is also a webchat function and support via 121 messenger on Facebook and Instagram. [http://www.nationalbreastfeedinghelpline.org.uk/](http://www.nationalbreastfeedinghelpline.org.uk/)
- Human Milk Foundation, a charity that can provide donor milk [https://humanmilkfoundation.org/](https://humanmilkfoundation.org/)
- UK Drugs in Lactation Advisory Service [https://www.sps.nhs.uk/articles/ukdilas/](https://www.sps.nhs.uk/articles/ukdilas/)
- The Breastfeeding Network Drugs in Breastmilk information service [https://m.facebook.com/BfNDrugsinBreastmilkinformation/](https://m.facebook.com/BfNDrugsinBreastmilkinformation/)
- [https://www.breastfeedingnetwork.org.uk/breastfeeding-ad-perinatal-mental-health/](https://www.breastfeedingnetwork.org.uk/breastfeeding-ad-perinatal-mental-health/)
- [https://www.breastfeedingnetwork.org.uk/drugs-factsheets/](https://www.breastfeedingnetwork.org.uk/drugs-factsheets/)
- UNICEF BFI guidance sheets to help health professionals to provide care remotely [https://www.unicef.org.uk/babyfriendly/guidance-documents/](https://www.unicef.org.uk/babyfriendly/guidance-documents/)
- UNICEF e-learning for GPs [https://www.unicef.org.uk/babyfriendly/training/e-learning/e-](https://www.unicef.org.uk/babyfriendly/training/e-learning/e-
Information resources for breastfeeding women

- Attaching your baby at the breast [https://globalhealthmedia.org/portfolio-items/attaching-your-baby-at-the-breast/](https://globalhealthmedia.org/portfolio-items/attaching-your-baby-at-the-breast/)
- Positions for breastfeeding [https://globalhealthmedia.org/portfolio-items/breastfeeding-positions/](https://globalhealthmedia.org/portfolio-items/breastfeeding-positions/)
- Is your baby getting enough milk [https://globalhealthmedia.org/portfolio-items/is-your-baby-getting-enough-milk/](https://globalhealthmedia.org/portfolio-items/is-your-baby-getting-enough-milk/)

How this article was made

This article was created using expertise and clinical guidelines and searches of Ovid Medline, CINAHL, Cochrane Database of Systematic Reviews, Academy of Breastfeeding Medicine and Clinical Guidelines. GPs were consulted using a survey to ask what was important to them.

How breastfeeding women were involved in the creation of this article

Women and breastfeeding peer supporters were asked by a Breastfeeding Network (BfN) peer supporter what aspects of breastfeeding support they thought it was most important for primary care professions to know. The responses were used to inform the focus of the article.
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