Defense Health Agency

Defense Health Agency (DHA) Clinical Communities Speaker Series

Feb 2021 CCSS: Challenges in Women's and Infants' Health

S05: Evidence-Based Practice Guideline: Breastfeeding Support of the Active Duty Servicewoman

Unanswered Questions from the Session

Contact info: For further questions/concerns/feedback, or ideas for ongoing research projects!
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Download the Capstone/Dissertation: https://scholarworks.waldenu.edu/dissertations/8303
Remember, the Capstone has a reference list, and then the EBPG is an appendix with a separate reference list.

1. What is the policy on deploying/not deploying a woman who is breastfeeding up to six months after birth?

Heidi: This appears to be VERY dependent on service branch. Also, field training/TDA/TDY (often fairly distant from baby) can happen earlier than 6 months. This can make it very difficult to maintain lactation as my personal experience is that support/policies in place can be very unevenly applied.

Robyn: As Heidi mentioned, the current polices are in place for deployments, and generally all the services will **not deploy a breastfeeding person under 12 months** (unless they desire to go earlier). However, temporary duty assignments, field training exercises and the like, are NOT covered and as soon as the birth parent is done with convalescent leave, they **can** be sent to the field/TDA/TDY.

2. Could you please address DOD policy on lactation supports/treatments for adoptive service members?

Heidi: I will defer further knowledge/details of this question to Robyn … but, I do not know of any policy that supports the effort to induce lactation. My understanding would be that it would depend on the parents finding a supportive provider who knows what they are doing when inducing lactation.

Robyn: Any service member who is lactating/breastfeeding SHOULD be supported by their respective service's policy on lactation AFTER the infant arrives, it does not matter whether it is through adoption or biological means. As for inducing lactation, that is not covered by any policy. The individual would need to seek the services of a knowledgeable IBCLC to start the process in conjunction with their PCP. And finding the time to pump BEFORE the infant arrives would also NOT be covered by any lactation policy currently written as is, as they are written for after the birth/adoption. TRICARE covers the cost of an electric breast pump (and related supplies) for anyone who adopts an infant.

3. Clarification, will both parents get 12 weeks each?

Heidi: I believe Robyn spoke to this? Newer leave policies up and coming?

Robyn: These policies are changing rapidly as the services attempt to find a work/life balance. I will point you towards this article from Military.com rather than retype it all. If the bill is signed into law, it looks like it will provide up to 12 weeks of leave for each parent (on top the 6 weeks/42 days given to the birth mother). https://www.military.com/daily-news/2021/12/07/troops-would-get-12-weeks-of-paid-parental-leave-part-of-defense-bill-deal.html

4. Where can we get updated policies for all of the services?

Heidi: You may email Robyn (her email was provided in the presentation and also within the references of my Capstone/dissertation work, with her permission); you can try Mom2Mom Global, however it should be noted that they used Robyn's information/branding and may still be doing so in creating their references online, so the most updated information may still come from her personally.

Robyn: See above. I am constantly trying to keep this list updated….

5. What reading information can you recommend to share with the parents during prenatal visits to prepare them better?

Heidi: Kellymom.com is a really good website, with interactive resources. Attending a support group like La Leche League, Breastfeeding USA, or other similar groups prenatally is an excellent tactic – parent-to-parent support is key in success. Also making sure that parents know exactly how to setup a lactation dedicated appt. soon after the birth of a baby (if not immediately available in the birth setting) even if they think things are going well helps reassure parents that it is actually going well and helps catch things that are not going well before they can become major. Remember nurses and pediatricians are not provided extensive training in the skills needed to support successful lactation.

Robyn: There are many good books out there, however I am finding that most of the younger generation doesn't want to read a book. They want info in bite-sized chunks, online that can be accessed via their phone, and they like videos. Books I can wholeheartedly recommend include: The Womanly Art of Breastfeeding (it is a classic for a reason), Breastfeeding Made Simple, Working and Breastfeeding Made Simple, and Making More Milk. Online resources that I refer new moms to include www.Kellymom.com, and First Droplets (great resource to prepare for the first few days after birth https://firstdroplets.com/

6. What 15 hour computer based training is utilized at JBLM?

Heidi: defer to Robyn… I believe this is something she referenced.

Robyn: At JBLM/Madigan Army Medical Center, all RNs and LPNs that are assigned to the Maternal Child Health Section (L&D, NICU, Inpatient Peds, MotherBaby Unit) are required to take the First Latch/Lactation Education Resources 15 hour BFHI Breastfeeding Course https://www.firstlatch.net/our-courses/bfhi-training
And then follow one of our IBCLCs for at least 5 hours (preferably longer) to get their competency signed off.

7. Is there available grant processes to get PODs placed within facilities...I am at a MTF which does not have any, even though across base in administrative building, there are PODs.

Heidi: (Mamava pods for those who are not familiar – note I am not endorsing that brand, as beautiful and convenient spaces can be designed by sites and require few resources.) I do not know how PODS are acquired, the funding sources, etc. This is probably very base specific, and possibly department specific.

Robyn: The Mamava PODs were in place before I arrived at Madigan, but I believe that Madigan just outright bought them as an investment in supporting breastfeeding, after it was brought to their attention the return in saving money via patient satisfaction, less doctor visits due to breastfeeding, and the ability for employees to use them for pumping resulting in higher retention rates (civilian and active duty alike).

8. In the current deployment climate as a commander who is an OB/GYN, I am curious of your thought processes on primary and secondary caregiver leave and impact to mission ops as previously paternity leave could be accomplished within 18 months of birth.

Heidi: In the Air Force department where I worked, this was referred to as secondary caregiver leave. I saw it unevenly applied, in my opinion. For example, for AD spouse in the Army, they were often required to take it right after baby's birth by their command, and if they worked in a job that could include weekend/24-7 shifts, 21 days straight was charged (even if normally the service member would not normally work 21 days in a row). If the AD spouse was a first-time parent, and the birth parent was not, and they were an officer (sometimes the enlisted person could argue it if they had multiple older children as well – it seemed very dependent on command/leadership) they could often use both primary and secondary (although not convalescent) leave. I FIRMLY believe that we will increase readiness when the family unit is supported with adequate leave rather than only supporting the birth parent's leave – for example, I was able to write a supportive letter to the command for an enlisted parent that was being sent to field training away from birth parent with complications s/p emergent surgical birth, plus infant had complications. The birth parent did not drive, had no local friends, and was not supposed to be driving but required f/up appts every few

days with OBGYN. The AD parent was exempted from field training far away and extended leave for this reason.

Robyn: This is a tough one to answer! What is evidence-based as being best for the health of mother and baby (recovery from childbirth, getting breastfeeding established) does come up against the needs of the military who needs to remain mission ready (both on an individual level, as well as unit level). What I am reading is that the new MPLP will be 12 weeks for BOTH parents if they choose to take it, within the first year after birth or adoption. Also looks like it can be spread out if desired. This is in line with what many other countries offer (actually less in most cases) including other militaries across the world (Australian Defence Force offers 52 weeks, Canadian Forces 17 week Maternity/35 weeks Parental, EU 4 months Parental). I believe that it will not impact readiness as much as everyone fears, in fact it will likely INCREASE readiness as both caregivers will come back rested, recovered, and feeling supported by their commands (not to mention this will likely increase retention – so many AD families I work with LEAVE the service due to not being supported after having children). As a bonus, I think as the parental leave policies become the same across the board for both Primary and Secondary caregivers (read – women and men) we are going to see the stigma begin to lessen on the women who bear the brunt of ostracization and harassment over taking 'time off' after birth that the men 'have to take up the slack for'. As with anything there is going to be aperiod of adjustment, once the kinks are worked out I think we will not see as much of an impact as is feared (especially not during peacetime with a volunteer force).

9. I am training to eventually become involved in our P3T program. Would you recommend the 20-hour lactation course to be another advocate for this information? Not be the teacher but to provide re-enforcement to the education/policies/challenges that postpartum mothers will face?

Heidi: ANY education you choose to seek will, I believe, always be helpful for reinforcement in providing support. At the very least, you remind yourself that you "don't know what you don't know" or "what is outside my scope of practice and knowledge base?"

Robyn: Yes and no….the 20-hour course is FANTASTIC, (and if you can do it – please do!) but it may be more than you need if not an RN/LPN (as it is geared to those in healthcare), you would also need to follow an IBCLC for at least 5 hours to receive the completion certificate. There are a number of other courses for ancillary staff that might be better suited for you position as a P3T instructor??
https://www.firstlatch.net/our-courses/specialist-courses
Another option is to see if your local IBCLC is willing to be a guest speaker at P3T. Here at JBLM, I teach the breastfeeding portion of the P3T program on a quarterly basis. That being said, I think actually having active duty experience (as I do) makes a huge difference in reaching out to the AD women who attend P3T.

10. Along with providing guidelines for trainings and providing time and place for active duty soldiers for breastfeeding, is there any specific profile provided for active duty soldiers specifically about physical activity while actively breastfeeding?

Heidi: I think this may also be branch dependent, although I think each branch does have a directive, policy, instruction, etc. that states that a woman (they are not using inclusive language) should be provided with a clean place to pump that is not a bathroom, with access to running water (the area doesn't have to have a sink – just access to the water. I know the army even requires this during field training, although they DO NOT require access to shipping milk or storing it, just the ability to express/maintain a supply so the AD member can return to breastfeeding/breastmilk provision when re-united with baby.

11. Do you have a go - to resource for looking up medications for breastfeeding compatibility?

Heidi: I prefer *Hale's Medications and Mother's Milk* (book) as an app that is updated continually, but you do pay a yearly subscription fee (they basically constantly update the medication monographs as new evidence comes forth – it's the book in app form). His group runs the Infant Risk Center, which you can call to get information. There is LactMed, not always the most current, but it is free. Overall, knowing that there are VERY FEW medications that cannot be taken when breastfeeding is probably your key piece of knowledge, so that you know to seek more complete information when a specialist tells a parent they cannot take the med and breastfeed (that's who, along with ER and pharmacy in my personal experience, usually recommends cessation or pump and dump).

Robyn: As stated in the presentation, I use ONLY Medications and Mother's Milk (MMM) as my go to resource. I own both the most recent edition of the book (it comes out every 2 years) and I have the app on my iPhone (it costs $59.99/year – completely worth the price). LACTMED is run by the NIH and has NOT been updated in YEARS, so the information is out-of-date. Brigg's Pregnancy and Lactation book is also not updated nearly as often as MMM. As Heidi stated, you can also call the Infant Risk Center or contact them via their website/email. https://www.infantrisk.com/
Mother to Baby is another newer resource as well (online only, no app or book).
https://mothertobaby.org/
Please understand that there are very few medications that are not safe to take while breastfeeding. If it is safe for a baby in the NICU, it is safe for Mom to take while breastfeeding. But also consider if the medication affects Mom's ability to PRODUCE milk (i.e. – birth control).

12. Is the EBPG being used at any base?

Heidi: Not to my knowledge, but as it was my Capstone/dissertation work, it is available for use, including any needed changes or updates the local/base experts see the need for. Essentially, I have offered it up to the DHA for implementation at any level.

Robyn: I am not aware of any military base/post/station that is using the EBPG unfortunately. Even here at JBLM/Madigan, only portions of it are implemented. We have a hospital-wide Infant Feeding Policy that was written by our IBCLCs, sadly even it is not known, understood, or followed by most other Clinics, Wards, etc. outside of the Maternal Child Health Section.

13. How do you get provider buy-in on learning about lactation support? For example, an ENT at my MTF cut a lip tie and then the single ADSM mother was left alone in the room to try to get baby to latch, while baby was obviously in pain. I wish there was an SOP for all providers.

Heidi: Bravo for even getting the ENT to perform the procedure, but yes ideally the mother will then have support, because the baby now has to learn new functioning skills. Sometimes an SLP may be available, and if familiar with babies/children, may be able to perform and support oro-motor function assessment, before and after release. Lip-tie is much more unusual to require release (esp. stand-alone release without tongue-tie), so there should have been people associated with the evaluation leading up to the release … yes, I would always want someone there after a release that can support lactation. BUY-IN? Ongoing interaction and conversation discussing evidence-informed literature. Know your WHY – use a guiding framework (see theories in my Capstone).

Robyn: This has been a major struggle at every MTF I have worked at…it has taken a concerted effort for years now to make any headway, via multiple pathways, and we still have many roadblocks in place. Currently at MAMC, our ENTs do NOT revise tongue or lip ties. We have an Infant Feeding clinic to refer patients to first, but they often tell parents that no TT/ULT exists, so we then provide a list of vetted Pediatric Dentists in town to see. Inpatient we have our Peds and Family Medicine Residents follow us IBCLCs on Rounds (they SEE the difference first-hand that a revision makes while they are still impressionable!), we give Staff In-services on TT/ULT, we talk about lip/tongue-ties incessantly (using evidence-based materials, studies, and validated tools such as Martinelli and Hazelbaker), and we have a super supportive Inpatient Pediatrician who believes in TT (not ULT) supporting us and who will clip TT before the family leaves to go home after birth. Finally, we have a weekly breastfeeding support group to provide on-going support before and after the tongue/lips are clipped (usually out in town by a Ped Dentist if we can't get it done before they leave the hospital after birth). It isn't perfect but it is better than it was 6 years ago. Persistence and EDUCATION is needed. I agree that a DOD-wide SOP would be wonderful.

14. Did you say that those women who received a vaccine or booster while pregnant were MORE likely to be hospitalized, with the Covid pandemic?

Heidi: No, to clarify – if a mother received the COVID vaccine or booster (allowing for the transfer of some passive immunity via her antibody production), the baby was much less likely to be hospitalized for severe COVID-related illness in the first 6 months of life.

Robyn: NO! The exact opposite, those women receiving the vaccine and/or booster were LESS likely to be hospitalized with COVID as their symptoms are milder, AND the antibodies are seen in breatmilk for AT LEAST 10 months after birth (as that is when various studies have stopped, it is likely the effects may last as long as the mother continues to lactate). There are numerous studies showing the safety and efficacy of the COVID vaccines (mRNA) in use just by going to PubMed and searching "COVID vaccine and Breastfeeding (or Pregnancy)". Additionally, all the major organizations (ACOG, AAFP, AAP, ABM, MFM) endorse giving the vaccine while pregnant (or breastfeeding). And resources such as Infant Risk Center or Mother to Baby have statements and information for providers and patients alike.
https://www.infantrisk.com/covid-19-vaccine-pregnancy-and-breastfeeding
https://mothertobaby.org/pregnancy-breastfeeding-exposures/covid-19/

15. Will there ever be offered the chance for leave before the baby's actual arrival? Some of the stresses experienced during pregnancy while in the workforce exacerbate the complication of "saving" leave time for the baby's arrival.

Heidi: That's an EXCELLENT question for DHA as higher-level clinicians develop policies but would be excellent. Obviously, a parent may be put on bed rest in a high-risk situation (would that be a profile?) but I don't think that counts against postpartum or convalescent leave. Something else to think about: Parent(s) have a NICU baby … they really need extra time as the baby transitions home as well!
Robyn: It is certainly needed, but I haven't heard anything about this in the pipeline.

16. Please mention that service and family members can be referred to the New Parent Support Program, a free program across all branches. Many of the staff now have lactation certification and can provide breastfeeding education and facilitate breastfeeding support groups.

Heidi: I think we might have briefly mentioned NPSP … however, there are restrictions r/t hands-on assistance (even if by luck the visiting RN – who I believe sees only parents living on-base – is an IBCLC or other accredited lactation counselor).

Robyn: We mentioned New Parent Support Program. I was a NPSP Specialist for a few years back in the day and whole-heartedly recommend their services! Offering a Support Group to answer questions, provide education, and give that much-needed parent-to-parent peer support is vitally important, but if a new parent needs hands-on help with lactation, or the situation warrants it, please know when to refer to an IBCLC!

17. Will lactation experts be available in various races? Note that the density of breasts varies from race to race.

Heidi: Providing support to organizations that are providing training and focusing on diversity in lactation providers is definitely a great way to proceed. For example, ROSE (Reach Our Sisters Everywhere). Consider a (free) login to access United States Breastfeeding Committee which is focused on diversity and providing education on support and policy-changing actions – and again, as an individual this can be freely accessed.

Robyn: This is such an important question and one that needs to be addressed ASAP! YES! We need more POC to become lactation experts at every level from peer counselors to IBCLCs. As stated, not only are there distinct differences in breast/nipple physiology between races, but it is vitally important to have someone that looks like you, and understands the many barriers in place that POC face **on a daily basis** regardless of feeding choice, helping you with such an intimate and personal journey. Maternal (and child) mortality is highest amongst AA, who also have the lowest rates of breastfeeding. The pathways to this profession are often out of reach for many POC and combined with not seeing other POC in the profession, I can only imagine makes it infinitely harder to even get started on becoming a lactation expert. I will second ROSE as a way to get started on becoming a lactation professional. USBC also has a directory of Lactation Training Resources, including some specifically for POC. http://www.usbreastfeeding.org/page/trainingdirectory Additionally - there is a new resource I was just made aware of – The Melanated Mammary Atlas is full of photos of breasts of POC https://www.mmatlas.com/

18. Recommendations for standardized training on proper latch? At my location I see a lot of outdated lactation support/education techniques and unnecessary distribution of nipple shields.

Heidi: Attend local, regional, national trainings whenever possible. In the current COVID climate this is more difficult, but look online, there are some excellent resources for learning this information.

Robyn: I second what Heidi said, please attend trainings and conferences whenever possible (many have moved to online courses due to COVID) to stay up-to-date with the latest research. GOLD Online Lactation Conference, iLactation, ILCA, USLCA, First Drops, all have great information and training opportunities. And as I answered above (question #6) you can't go wrong with any of the trainings offered by Lactation Education Resources/First Latch. See if your MTF(?) will pay for the training if the misinformation and nipple shield use is coming from within your organization. If it coming from outside sources, stay up-to-date on YOUR training and combat it as best as possible when helping your clients.

19. Are there any policies being developed to help women ship frozen breastmilk during a PCS?

Heidi: I believe there may be some in the works – and depending on resources (I find that officers are able to engineer this, or a very supportive provider can help if they know what they are doing with enlisted personnel).

Robyn: No policies that I am aware of for covering the cost of shipping breastmilk for a PCS move. There is one policy in place for covering the cost when on TDY orders or deployments.
Coast Guard - https://content.govdelivery.com/accounts/USDHSCG/bulletins/24d7b73 The JTR (Joint Travel Regulation) is being looked at to change it to reimburse the cost of shipping breastmilk, while on Official Orders across the DOD, but has not been changed as of this writing.

Addressing Feedback:
Heidi: I would like to address other questions/concerns that were elicited and presented to us in feedback from the surveys. I LOVE feedback!

1. There were concerns expressed that "we" were promoting the book *Breastfeeding in Combat Boots*. Note that I addressed specific questions in the CHAT that asked about this book, which was acknowledged to be outdated, but for which updating is currently considered a conflict of interest for Ms. Roche-Paull. For these reasons, we were even restricted from placing this as a conflict of interest or disclosure on our DISCLOSURE slides. However, it is not legal or ethical to fail to acknowledge or answer direct questions posed by attendees. Additionally, it should be noted that verbally, in the Final Remarks slide, and in the reference list w/in the Capstone and EBPG, contact information for Ms. Roche-Paull is provided so that the most current available list of POLICIES may be requested FOR FREE from her directly. At no point did we or do we encourage people to purchase an outdated reference. Please feel free to provide Feedback on proper disclosures (rather than removal of same) to DHA J-7 CEPO. There was also a remark about product endorsement, and I don't remember either of us doing that – it is possible that comment also concerned the book – which again was brought up by multiple attendees who noted that Ms. Roche-Paull is the author of a book and asked about when/if it will be updated. Additionally, it is in my original references for this Capstone project, and removing it from the academically published dissertation is not permitted.
    a. Robyn – I disclosed my book on the DISCLOUSRE slide and it was removed by the DHA organizers. I, in no way, attempted to promote my book. I work for the DHA and take seriously **any** potential conflicts of interest or even the appearance of a conflict of interest. That was not my intention, and it should be noted at NO TIME did *I* mention my book.

2. Most found the project evidence-informed and scientifically rigorous. For the 2 who did not, I would suggest you might want to review the reference list in more detail. Or take up the challenge and produce some research – I feel as if we all could do more of this in all areas of practice!

3. Much of the feedback around use of the information in practice setting included it being not applicable for attendees. Those that found it applicable appeared to mostly value the awareness engendered around the potential lactation support needs of active-duty personnel, a few indicated actual practice changes they plan to use in their settings. For all I would suggest that you are either involved in policy-making, supervising parents that may be lactating, or in clinical care. Lactation affects so many patients in clinical settings, even if it's just the awareness to double-check your knowledge and find more information (like the person who stated they would decrease automatic pump and dump recommendations).
    a. Robyn – If you got nothing else from this presentation, I hope it is that Active Duty servicemembers who are chest/breastfeeding NEED your support! There is far more than we could ever hope to cover in one presentation about breastfeeding in the military. I have a DEGREE in Human Lactation, and I'm still learning everyday via the AD patients I see! Take this presentation as a way to start making change personally (more training/education) and within your organization (policy change). But don't forget the Mom in combat boots who is pumping in a storage closet….help her by providing the regulation so she can speak up to her supervisor, or start an AD Breastfeeding Support Group!

4. Feedback about specifics that attendees plan to utilize was so empowering to see: From plans to speak up and participate in general policy and support (including of pumping coworkers) to utilization in the Food Insecurity Initiative! Remember that Diffusion of Innovations! Early Adopters are those that support and speak up in every facet of health and workplace support.

5. Regarding concerns expressed about the activity: "It felt like someone presenting their dissertation." That's what it essentially was – I did my doctoral work on this issue because it needs to be addressed, and I am gifting it as a base for adoption at local, regional, and the DHA level. I did indicate at the beginning of the presentation that it was my Capstone (and Robyn's participation was requested by me due to some more recent updates in policy). I desired awareness that this is available as a download and for future work and changes by others (with credit as we all do when we research). Please! Download it – the EBPG is an appendix and can be certainly separated out – or contact me if you want a word.docx! Run with it! (As far as structure of how the course is attended, how to connect to post-tests, etc. we had no say/control over that – sorry!)

I did read all the feedback, and always appreciate it. I do agree that a follow-up series perhaps guided by the points in the EBPG would be a great series and would address concerns of those who felt they did not get much out of the presentation (especially those on the policy end, or who do not generally see a lot of lactation – the series could include a session for how those in other aspects of care or command can/should be supportive).