

2011

# REGISTERED NURSES' ROLE IN PROMOTING BREASTFEEDING



Association of  
**Registered Nurses**  
of Newfoundland  
and Labrador



This Position Statement was approved by ARNNL Council in 2011.

The Association of Registered Nurses of Newfoundland and Labrador (ARNNL) supports breastfeeding as the biological norm and recognizes it to be a public health priority for the province.

### Rationale

Breastfeeding is proven to be a key determinant in improving health outcomes. Evidence has shown that there are numerous short and long-term benefits of breastfeeding and conversely, identified health risks for the infant, child and mother for not breastfeeding. Health risks and benefits have been shown in a wide range of areas including: nutritional, immunological, social, developmental, physical and psychological (Steube, 2009). These effects can be measured in both resource-poor and affluent societies (World Health Organization (WHO), 2003). In addition, breastfeeding offers benefits to the community and the health care system.

Newfoundland and Labrador's breastfeeding initiation rate at 65.6% remains the lowest in Canada (Newfoundland and Labrador Provincial Perinatal Program (NLPPP), 2011). By comparison, the 2006/07 national breastfeeding initiation rate was approximately 90% (PHAC, 2009b). There are also wide regional variations within the province, from a high of 77% to a low of 46% (NLPPP, 2011). Further, only 5.8 % of our children receive the benefits of exclusive breastfeeding to six months of age (PHAC, 2009b).

### NEWFOUNDLAND AND LABRADOR'S BREASTFEEDING INITIATION RATE AT 65.6% REMAINS THE LOWEST IN CANADA

Registered nurses are in a position to influence and encourage breastfeeding. However, there is mixed evidence on the extent to which RNs are informed about and support new mothers to make evidence informed decisions on breastfeeding (Registered Nurses Association of Ontario (RNAO), 2003; Steube, 2009).

### Position

- The ARNNL advocates that RNs protect, promote, and support breastfeeding for all infants and young children, in accordance with the following national and international recommendation. *Exclusive breastfeeding is recommended for the first six months of life for healthy term infants, as breast milk is the best food for optimal growth. Infants should be introduced to nutrient-rich, solid foods with particular attention to iron at six months with continued breastfeeding for up to two years and beyond* (Health Canada, 2004).
- The ARNNL advocates that RNs enhance their role in breastfeeding through self-reflection, education and advocacy in collaboration with others, and within supportive health care systems.

### Evidence

Health risks and benefits related to breastfeeding have been shown in a wide variety of areas. Human milk is a complex biological fluid that changes from feed to feed and as the infant grows and their needs change. Breast milk meets the nutritional and anti-infective requirements for healthy growth and development. Human milk contains a wide array of active protective factors including immuno-protective substances, hormones, enzymes, growth factors, vitamins and other essential nutrients (American Academy of Pediatrics, 2005). All of these factors appear to play a role in the short and long-term health effects of breastfeeding.

The research studies and examples presented below are not all inclusive. For further information RNs are encouraged to explore the list of resources cited at the end of this document.



### **Health Outcomes for Infant/Child**

Infants who are not breastfed are at greater risk for a wide range of illnesses and diseases including: obesity, diabetes (Type 1 and Type 2), otitis media, gastroenteritis, severe lower respiratory tract infections, atopic dermatitis, asthma, SIDS, childhood leukemia and urinary tract infections (Horta, Bahl, Martines & Victora, 2007; Ip et al., 2007; Levy et al., 2009; Marild, Gunnell, Owen, & Smith, 2005). For premature infants, not receiving breast milk there is an associated increased risk of contracting necrotizing enterocolitis (Ip et al., 2007). A more recent study from Australia concluded that a shorter duration of breastfeeding may be a predictor of adverse mental health outcomes for the child and onto adolescence (Oddy et al., 2010).

Conversely, being breastfed may contribute to long-term cardiovascular health. Evidence suggests that breastfeeding may lower mean blood pressure and total cholesterol later in life (Horta, Bahl, Martines, & Victora, 2007; Martin, Gunnell, Owen, & Smith, 2005; Owen et al., 2008). There is some evidence that breastfeeding protects against Hodgkins disease and neuroblastoma (Martin et al., 2005), as well as Celiac disease (Chertok, 2007). There is emerging evidence indicating a potential association between breastfeeding and lower risks of Crohn's disease and ulcerative colitis (Klement, Cohen, Boxman, Joseph, & Reif, 2004). Exclusive breastfeeding reduces infant mortality due to common childhood illnesses such as diarrhea and pneumonia and helps for a quicker recovery during illness (WHO, 2003). Research has also shown that breastfeeding protects normal dentition by promoting the proper development of the mouth and jaw muscles (Palmer, 1998; Viggiano, 2004). More recent research suggests that prolonged and exclusive breastfeeding improves children's cognitive development (Kramer et al., 2008; Quigley et al., 2009).

### **Health Outcomes for the Mother**

Mothers who choose not to breastfeed can miss out on identified health benefits. A history of not breastfeeding or early cessation of breastfeeding is associated with an increased risk of maternal postpartum depression (Ip et al., 2007; Levine, Zagoory-Shannon, Feldman, & Weller, 2007). Mothers who breastfeed report lower levels of perceived stress and negative mood, and higher levels of maternal attachment. They also tend to perceive their infants as more responsive than mothers who formula-feed, which is proposed to strengthen maternal-child attachment, increase maternal self-esteem and assist mothers in adjusting to motherhood (Boutet, Vercueil, Schelstraete, Buffin, & Legros, 2006; Mezzacappa & Katkin, 2002).

In the early postpartum period, there is a greater likelihood that the new mother who breastfeeds will experience decreased postpartum bleeding and more rapid uterine involution as a result of increased concentrations of oxytocin (Dewey, Heinig, & Nommsen, 1993). Women who breastfeed are more likely to lose weight gained during pregnancy more quickly than those who do not breastfeed (Baker et al., 2008). Breastfeeding also contributes to the mother's health by offering protection for some women against pre-menopausal breast cancer, ovarian cancer, Type 2 diabetes and osteoporosis (Ip et al., 2007; Jordan, Siskind, Green, Whiteman, & Webb, 2010; Stuebe, Willet & Michels, 2009; World Cancer Research Fund, 2007). More recent research suggests that women who breastfeed lower their risk of developing metabolic syndrome, and that lactation may have lasting positive effects on women's cardiovascular health (Gunderson et al., 2010). Furthermore, women who breastfeed have significantly lower body mass index (BMI) in middle age (Bobrow, Quigley, Green, Reeves, & Beral, 2009).

### **Impact for Communities**

Increasing breastfeeding rates is good for the family and community. Supporting breastfeeding families will ensure the next generation has every advantage possible to prepare them for the challenges of growing both physically and mentally as breastfeeding gives the infant and the mother numerous health benefits throughout their lifespan. This point was illustrated when the provision of baby-friendly healthy settings was identified as a key health promotion strategy in the paper, *Curbing Childhood Obesity A Federal, Provincial, Territorial Framework for Action to Promote Healthy Weights* (PHAC, 2010).



Breastfeeding may also offer some protection against certain undesirable social behaviors. A recent study shows that breastfeeding may protect against maternally perpetrated child maltreatment (Strathearn, Mamun, Najman, & O'Callaghan, 2009). Some research shows that breastfed children cry less and are more alert (Baidam, et al., 2000). These advantages may be due to the breast milk itself, being held by mothers in a close and intimate way, frequent skin-to-skin contact, and/or verbal and visual communication between mother and child (Centre for Excellence for Early Childhood Development, 2010).

Breastfeeding plays a mediating role in reducing social inequalities as breast milk is free and there is no need to purchase breastmilk substitutes and accessory equipment e.g., bottles, artificial nipples. Breastfeeding creates no pollution as there is no extra packaging and waste by products. There are also substantial costs to the environment in the processing, manufacturing, transporting and disposal of formula and related products. In addition, in communities with limited access to clean water supplies and fuel, the preparation of formula and bottle-feeding expends valuable water and fuel sources (Kouba, 2008). In emergency situations, whether naturally occurring or as a result of conflicts, breastfeeding is the safest and often the only reliable choice for infants and small children (International Lactation Consultant Association [ILCA], nd).

### **Impact for Health Care System**

Breastfeeding decreases health care system costs as breastfed babies are sick less often and therefore require fewer visits to physician offices and hospitals for common childhood illnesses. Smith, Thompson, and Ellwood (2002) published evidence of hospital system costs in Australia of treating five illnesses for which breastfeeding is protective. The attributable costs of early weaning were estimated to be 1.2 million a year for the five illnesses. Recent research by Bartick and Reinhold (2010) proposed that if all babies in the United States were exclusively breastfed for six months the government would save \$13 billion a year. Further, the researchers proposed if 90% of families complied with the breastfeeding recommendation, an excess of 900 deaths could be prevented. The assumption has also been proposed that breastfeeding could reduce the number of days absent from work parents used to care for ill children, given the known health benefits to infants and children.

Improving the provincial breastfeeding rate may assist in the prevention of diabetes and help control obesity (Twells & Newhook, 2010). Newfoundland and Labrador has the highest rate in Canada of both obesity and Type 1 and Type 2 diabetes (Newhook, et al., 2008). These two health issues alone have been shown to have a major impact on the health care system (Birmingham, Muller, Palepu, Spinelli, & Anis, 1999; PHAC, 2009a). In pandemic situations infants who are breastfed are less vulnerable to illness as they receive the protective antibodies and other important immune factors from breastmilk (ILCA, 2009).

## **Role of RNs**

Registered nurses have an important role in protecting, promoting and supporting breastfeeding. This can be accomplished through initiatives aimed at positive attitudes, enhanced education and advocacy.

### **Positive Attitudes**

- Nurses need to portray a positive, non-judgmental attitude towards breastfeeding. The client's perceptions of clinicians' opinions on breastfeeding are directly correlated with breastfeeding duration (Steube, 2009).
- Nurses have a responsibility to assist clients to make informed decisions about infant feeding and to respect and support clients in their decision.
- Nurses need to provide clients with accurate, consistent and evidence informed information on the benefits of breastfeeding and the health consequences for mother and baby of not breastfeeding. The components of informed decision making are outlined in the Breastfeeding Committee for Canada Baby-Friendly Initiative (BFI) documents, [www.breastfeedingcanada.ca](http://www.breastfeedingcanada.ca).



- Nurses involved with breastfeeding families have a responsibility to know and support the principles of the WHO *International Code of Marketing of Breast-milk Substitutes* and all relevant World Health Assembly resolutions. Information on infant formulas should be free from commercial influence i.e., to avoid use of pictures or text which idealize the use of breast milk substitutes (WHO, 1981). Research suggests that advertising, gifts and incentives from industry can unduly influence professional behaviours (Brennan et al., 2006).
- When information is provided on breastmilk substitutes it should include, in a non-judgmental manner, the social, financial and health implications of their use.

### Education

- Education of all RNs is a key component in supporting the creation of a strong breastfeeding culture. Studies have shown that women make their decisions about whether or not to breastfeed either before or during their pregnancy (RNAO, 2003).
- Nurses employed in areas responsible for pregnant women and breastfeeding families should have comprehensive education that reflects the core content of the WHO/UNICEF 20 hour breastfeeding course for maternity staff. Participation of front-line staff in this program has been shown to improve breastfeeding outcomes (Kramer et al., 2001; Britton, McCormick, Renfrew, Wade & King, 2007; Cattaneo & Buzzetti, 2001).
- Nurses need additional knowledge, skill, and support to learn how to deliver risk and benefit messages regarding infant feeding options (Ontario Public Health Association [OPHA], 2007).
- Educational initiatives for mothers/expectant families need to reflect the recommendations outlined in the *Education and Support Standards for Pregnancy, Birth and Early Parenting: Newfoundland and Labrador* (2005).
- All prenatal and postnatal interventions should be family centered in an effort to encourage greater support for breastfeeding mothers. Women are more likely to breastfeed if other persons in their support network have breastfeeding experience and/or support their breastfeeding decision, especially fathers (Dennis, 2002). Evidence shows that early professional intervention and support prevents frustration, anxiety and failure rates (RNAO, 2003).
- Nurses working in areas with pregnant women and breastfeeding families need to have easy access to current evidence-based breastfeeding guidelines/protocols.
- Nurses interacting with pregnant women and families must avail of opportunities for education and self-learning on breastfeeding.



### Advocacy

- Nurses need to collaborate with individuals, groups, organizations and public policy makers in all sectors as necessary to protect, promote and support breastfeeding as the norm for infant and young child feeding (Canadian Nurses Association [CNA] & Canadian Association of Midwives [CAM], 2008). Research confirms that multisectoral, integrated and comprehensive approaches are most effective in achieving long term changes in breastfeeding policies (NLPPP, 2008).
- Nurses should advocate for the implementation of all 10 Steps in the Baby-Friendly Initiative within hospitals and community health services. Research shows that facilities that implement baby-friendly practices have higher breastfeeding rates (Abrahams & Labbock, 2009; Bechara-Coutinho, de Lira, de Carvalho Lima & Ashworth, 2005; Braun, et al., 2003; Broadfoot, Britten, Tappin, & MacKenzie, 2005; Merewood, et al., 2005).
- Nurses need to advocate for and initiate measures to ensure a seamless transition from hospital to home for all breastfeeding mothers.
- Nurses need to take a leadership role in promoting breastfeeding and in assisting communities to become breastfeeding friendly places where breastfeeding mothers feel welcomed and supported (i.e., breastfeeding and family friendly workplaces, schools, businesses, community and recreation centres).

## Role of Health Care System

ARNNL recognizes that the culture of the health setting can influence RNs ability to protect, promote, and support breast feeding. Therefore, RNs should advocate for and support implementation/availability of:

- Supportive practice environments to address workload challenges noted to interfere with the nurses ability to provide comprehensive breastfeeding support.
- Organizational breastfeeding policies that are effectively communicated to all staff.
- A provincial, standardized comprehensive breastfeeding assessment tool, implemented pre/postnatally to facilitate the development of a client specific breastfeeding plan (RNAO, 2003).
- Supports so that RNs can accurately document the breastfeeding experience in accordance with appropriate standards within hospital and community services (ARNNL, 2009).
- Adequate resources to support initial and ongoing breastfeeding at the community level for all women. In particular, support for target cohorts of mothers where data indicates lower initiation rates. Studies have consistently shown that younger maternal age, lower education, lower income, and single status are negatively associated with breastfeeding initiation and duration.
- A variety of pre and postnatal strategies to establish and extend the duration of breastfeeding including: International Board Certified Lactation Consultants on per population ratio, community-based health professional support, prenatal education and support, labour and birth support including doulas, 24 hour telephone advice lines, and community-based mother-to-mother support groups such as the La Leche League Canada, Healthy Baby Clubs and Family Resource Centre programs (Britton, McCormick, Renfrew, Wade, & King, 2007; Chung, Raman, Trikalinos, Lau, & Ip, 2008).
- A means for accurately measuring breastfeeding initiation and duration rates, as a health indicator. Data is needed at birth, on hospital discharge and at scheduled intervals in the community using the Breastfeeding Committee for Canada's standardized definitions and timeframes in order to effectively plan, implement and evaluate breastfeeding initiatives (Cattaneo & Buzz etti, 2001; Merewood, Mehta, Chamberlain, Philipp & Buchner, 2005).

## Summary

The Association of Registered Nurses of Newfoundland and Labrador supports breastfeeding as the biological norm and recognizes it to be a public health priority for the province. Breastfeeding is proven to be a key determinant in improving health outcomes. Evidence has shown that there are numerous short and long-term benefits of breastfeeding and conversely, identified health risks for the infant, child and mother for not breastfeeding.

Registered nurses are in a position to influence and encourage breastfeeding. However, there is mixed evidence on the extent to which RNs are informed about and support new mothers to make evidence informed decisions on breastfeeding.

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## Resources

To promote evidence-informed decision-making on breastfeeding ARNNL recognizes the following key provincial, national, and international sources:

- *Achieving Health and Wellness: Provincial Wellness Plan for Newfoundland and Labrador*, (Government of NL, 2006). [www.gohealthy.ca/goto/Publications.html](http://www.gohealthy.ca/goto/Publications.html)
- *Baby Friendly Hospital Initiative: Revised, updated and expanded for integrated care*, (WHO/UNICEF 2009). [www.who.int/nutrition/publications/infantfeeding/9789241594950/en/index.html](http://www.who.int/nutrition/publications/infantfeeding/9789241594950/en/index.html)
- Breastfeeding Coalition of Newfoundland and Labrador- Strategies outlined in the *Breastfeeding Strategic Plan II Newfoundland and Labrador* (2008-2011), (NLPPP, 2008). [www.nlppp.ca/BSP-jan20.pdf](http://www.nlppp.ca/BSP-jan20.pdf)
- Breastfeeding Committee for Canada Baby-Friendly Initiative documents [www.breastfeedingcanada.ca](http://www.breastfeedingcanada.ca)
- *Breastfeeding Best Practice Guidelines for Nurses*, (RNAO, 2007). [www.rnao.org/Page.asp?PageID=924&ContentID=795](http://www.rnao.org/Page.asp?PageID=924&ContentID=795)
- *Education and Support Standards for Pregnancy, Birth and Early Parenting: Newfoundland and Labrador* (Government of NL, 2005). [www.health.gov.nl.ca/health/publications/edsup\\_en.pdf](http://www.health.gov.nl.ca/health/publications/edsup_en.pdf)
- *International Code of Marketing of Breast-milk Substitutes* (WHO, 1981), and subsequent, relevant WHA resolutions. <http://breastfeedingcanada.ca/TheCode.aspx>
- *Poverty Reduction Strategy*, (Government of NL, 2010). <http://www.hrle.gov.nl.ca/hrle/poverty/poverty-reduction-strategy.pdf>
- *Global Strategy for Infant and Young Child Feeding*, (WHO, 2003). [http://www.who.int/nutrition/publications/gs\\_infant\\_feeding\\_text\\_eng.pdf](http://www.who.int/nutrition/publications/gs_infant_feeding_text_eng.pdf)



## Notes

The Baby-Friendly Initiative is a global program sponsored by the World Health Organization (WHO) and the United Nations Children's Fund (UNICEF) to encourage and recognize hospitals, birthing centers and community health services that offer an optimal level of care for lactation. The Breastfeeding Committee for Canada is the national authority for the Baby-Friendly Initiative in Canada.

The *International Code of Marketing of Breast-milk Substitutes* bans all promotion of bottle-feeding and outlines the requirements for labeling and information on infant feeding. Any activity which undermines breastfeeding also violates the aim and spirit of the Code. The Code and its subsequent World Health Assembly Resolutions are intended as a minimum requirement in all countries.

Exclusive breastfeeding, based on the WHO definition, refers to the practice of feeding only breast milk (including expressed breast milk) and allows the baby to receive vitamins, minerals or medicine. Water, breast milk substitutes, other liquids and solid foods are excluded.

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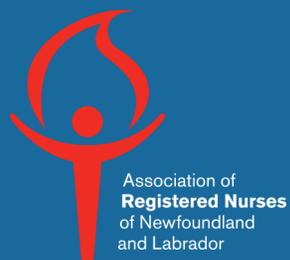
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