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AWHONN POSITION STATEMENT

Breastfeeding

An official position statement of the Association of Women's Health, Obstetric and Neonatal Nurses

Approved by the AWHONN Board of Directors, November 2014.

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Position

The Association of Women's Health, Obstetric and Neonatal Nurses (AWHONN) supports, protects, and promotes breastfeeding as the ideal and normative method for feeding infants, including the provision of human milk for preterm and other vulnerable newborns. Women should be encouraged and supported to exclusively breastfeed for the first six months of an infant's life and continue to breastfeed for the first year and beyond. AWHONN partners with other maternal-child health organization to improve cultural, institutional, and socioeconomic systems so that more women and newborns can experience the numerous physiologic and psychosocial benefits of breastfeeding.

Physiologic and Psychosocial Benefits of Breastfeeding

The myriad of benefits of breastfeeding are documented extensively in the literature, and new benefits continue to be identified. Emerging research also indicates stronger associations between longer duration of exclusive breastfeeding and enhanced maternal and infant benefits (American Academy of Pediatrics [AAP], 2012; Ip, Chung, Raman, Trikalinos, & Lau, 2009).

For infants, breastfeeding has short-term and long-term health benefits. In the short-term, breastfeeding reduces the risk of gastroenteritis, necrotizing enterocolitis, ear infections, pain following minor procedures, hospital readmissions, respiratory infections, Sudden Infant Death Syndrome (SIDS), and urinary tract infections. In the long-term, breastfeeding reduces the risk of asthma, atopic dermatitis, cardiovascular disease, celiac disease, diabetes, childhood inflammatory bowel disease, obesity, and sleep disordered breathing. Further, breastfeeding is associated with increased cognition and neurodevelopment (AWHONN, in press).

Breastfeeding is also beneficial to the mother's health. Postpartum benefits include decreased blood loss, lower risk of postpartum infection and anemia, and greater weight loss. Breastfeeding also has been associated with reduced risk of maternal disease later in life including breast cancer, diabetes (type II), hypertension, cardiovascular disease, metabolic syndrome, ovarian cancer, osteoporosis, and rheumatoid arthritis (AWHONN, in press).

Additionally, mothers who feel empowered to breastfeed successfully are more likely to breastfeed exclusively and continue breastfeeding. Self-efficacy, which has been defined as the woman's perceived ability to successfully master a task such as breastfeeding, is associated with an increased duration of breastfeeding at six months (Kingston, Dennis, & Sword, 2007; McCarter-Spaulding & Gore, 2009; Wilhelm, Rodehorst, Stepans, Hertzog, & Berens, 2008). Researchers have also shown that women who participated support workshops focused on breastfeeding self-efficacy were more likely to exclusively breastfeed at eight weeks postpartum than women who did not attend such workshops (Noel-Weiss, Rupp, Cragg, Bassett, & Woodend, 2006).

Breastfeeding enhances the relationship between a mother and her infant by improving bonding. For example, skin-to-skin contact during breastfeeding has been shown to improve the infants' vital signs, especially immediately after birth (Moore & Anderson, 2007). Indeed, it is theorized that many of the identified health benefits of breastfeeding may be related to not only the composition of human milk, but also to the close contact between the mother and her infant during feeding (Moore, Anderson, Bergman & Doswell, 2012). Breastfed infants also have more control over how much food they eat and when they eat (Hung & Berg, 2011; Widström et al., 2011), which may be part of the association between reduced rates of obesity among breastfed infants (AAP, 2012).

Public Health Benefits of Breastfeeding

In addition to the numerous health benefits associated with breastfeeding, there are a number of financial benefits for families, society, public and private insurers, employers, and government programs. In a cost analysis of the financial benefits of breastfeeding, the authors concluded that if 90% of new mothers breastfed exclusively for six months, 13 billion health care dollars would be saved (Bartick & Reinhold, 2010).

When an infant is breastfed, the family saves approximately $1,500/year in direct costs for feeding supplies and formula. The family also saves indirect costs related to fewer medical bills and fewer lost days of work because the infant is healthier (USDHHS, 2011). When employers supported breastfeeding, they received a $3 return for every $1 invested in a lactation program. Reduced turnover rates led to cost savings in recruitment and training, less absenteeism, and reduced costs for health insurance claims (United States Breastfeeding Committee [USBC], 2013).

Breastfeeding is also beneficial to the environment and does not require manufacturing plants, packaging, storage, transportation, or refrigeration; it generates no waste and is a renewable resource (Save the Children, 2012). Researchers estimated that for every one million formula-fed infants, 150 million containers used in formula packaging were disposed of, many in landfills (USDHHS, 2011).

The Role of the Nurse

In the United States, 98% of all births occur in hospitals where nurses are the primary health care providers supporting women from labor and birth through discharge. Nurses play a vital role in preparing, educating, encouraging, and supporting women to breastfeed and are instrumental in facilitating initiation and continuation of breastfeeding.

Nurses and other health care professionals who care for mother-infant dyads should acquire the knowledge and demonstrate the competence needed to provide consistent and evidence-based breastfeeding information and support throughout the preconception, prenatal, and postpartum periods. If the health care professional does not possess the knowledge and skills needed to provide support, consultation with or referral to a lactation specialist or other clinical expert should be offered for all mother-infant dyads.

The USBC has developed core competencies that detail the knowledge, skills, and attitudes that health professionals should possess in order to help women prepare for, initiate, and sustain breastfeeding (USBC, 2010). Academic education programs for all health care professionals should include content on lactation.

All women have the right to expect culturally sensitive breastfeeding promotion and support. Health care providers should strive to understand and be prepared to address cultural issues in all aspects of breastfeeding promotion and support for the population of women they serve. Breastfeeding has different meanings and levels of acceptance in different cultures; therefore, it is essential that providers explore the specific breastfeeding concerns of the individuals with whom they are working. All women have the right to obtain information about the benefits of breastfeeding so that they are able to make informed decisions.

Nurses and other health care providers should support each woman's choice of infant nutrition by providing women with information about the risks and benefits of various feeding options to facilitate informed decision making. There may be certain rare instances when a woman wants to breastfeed, but is unable to or should avoid doing so, including some women who have had breast surgery, women with HIV infection, certain substance use disorders, untreated tuberculosis, or who are taking medications contraindicated in breastfeeding. In these situations, women should be given information by their nurses and encouraged to further consult with their health care providers to help them make infant feeding decisions. There may be other instances where women erroneously think that breastfeeding is contraindicated (e.g., smoking cigarettes), and nurses should provide correct information regarding these misconceptions. Nurses should encourage women to discuss their medications and herbal and other nutritional supplements with a health care provider who has expertise in breastfeeding and is knowledgeable about the interactions of prescription and over-the-counter medications and supplements with breastfeeding.

If a woman chooses to or is required to formula feed instead of breastfeed, nurses should help her, her family, and other support persons understand how to safely prepare, feed, and store formula and bottles. Education and resources should also include information about the risks of contamination of formula, feeding systems, and/or water supply. Women should be advised to monitor whether a particular feeding system and/or formula is recalled for safety or other reasons.

International Code of Marketing of Breast-milk Substitutes

AWHONN supports the goals the World Health Organization (WHO) set forth in the *International Code of Marketing of Breast-milk Substitutes* released in 1981 in an effort to improve

substandard infant feeding practices that cause infant morbidity and mortality worldwide. *The Code* provides recommendations related to the marketing and distribution of infant formula, other milk products, foods and beverages, feeding bottles, and artificial nipples that may interfere with the protection and promotion of breastfeeding (WHO, 1981). AWHONN recognizes that marketing practices must be scrutinized since marketing may influence women's choices and societal opinions related to infant feeding.

The Code contains distinct marketing recommendations for consumers, health care systems, health workers, and manufactures/distributors. For example, *The Code* states there should be "no advertising or other form of promotion to the general public," of the above stated products (Section 5.1, p. 10). In compliance with the Code, AWHONN prohibits formula advertising in its consumer-facing media.

The Code also guides health care systems and health care workers regarding procurement of equipment, materials, education, and information from the manufacturers/distributors of infant formula for the purpose of supporting mothers who do not breastfeed or who do so partially (Section 6.2, p.11; Section 6.8, p.12; Section 7, p.12; Section 8.2, p.13). Nurses teach women how to safely feed formula to infants (Section 6.5, p.11). In accord with *The Code*, AWHONN permits formula manufacturers to provide information at in-person professional meetings and in professional-facing publications. AWHONN, by its own policies, further restricts formula marketing within its professional-facing publications to only those advertisements that also promote breastfeeding as the optimal infant feeding method and human milk as the optimal food for infants within the overall messaging.

The Code facilitates variation in creating environments supportive of breastfeeding from country to country by "appreciating that there are a number of social and economic factors affecting breastfeeding" (p.6). Abbreviated or unpaid maternity leave is one of the many factors influencing sustained breastfeeding in the United States. The U.S. Census Bureau reported that nearly one-third of women return to work less than 12 weeks after an infant's birth; more than half return within five months; and 83% return in the first year, 36% of whom are single mothers (Laughlin, 2011). Since "mothers in the United States tend to return to work much more quickly" (Laughlin, 2011, p. 13), choices about breast pumps, bottles, and supplies for feeding human milk are especially important. However, *The Code* recommends that the marketing of bottles and artificial nipples to consumers not take place (p. 8). Many women in the United States, particularly those who work outside the home, rely on bottles, artificial nipples, and other breastfeeding support products to provide human milk to their infants and toddlers to support their breastfeeding goals. These same women also rely on education and advice from their health care providers, including nurses, to choose appropriate resources and products that support continued breastfeeding and human milk provision.

In support of breastfeeding, AWHONN allows the advertising of breast milk feeding supplies, including bottles and artificial nipples, in its consumer-facing media; AWHONN maintains that the benefits of ensuring exclusive human milk feeding through the use of breastfeeding supplies, when necessary, far outweigh any risks that marketing of these supplies may imply. Further, the WHO defines exclusive breastfeeding as "no other food or drink except breast milk (including milk expressed or from a wet nurse)." *The Code* does not state that the infant must be fed at the breast. In light of this distinction, AWHONN permits advertising for bottles and other breastfeeding-support supplies in its media.

The Code does not specifically address pacifiers, but some interpret "artificial teats" and pacifiers to be synonymous. Researchers have demonstrated that pacifiers should be restricted in the first few weeks after an infant is born. Once breastfeeding is established (typically by three to four weeks of life), a pacifier may be offered when the infant is sleeping to help prevent Sudden Infant Death Syndrome (SIDS) (AAP, 2011, 2012).

AWHONN supports ongoing efforts by the WHO to implement national policies and laws that support and protect breastfeeding worldwide.

Baby-Friendly Hospital Initiative

AWHONN supports the implementation of The Ten Steps to Successful Breastfeeding developed by the Baby-Friendly Hospital Initiative (BFHI), of which nurses are key leaders (BFHI, 2014). The implementation of these practices increases initiation and duration of breastfeeding, whether a facility has achieved Baby Friendly designation or not. Researchers found that women who

experienced at least four of the 10 Baby-Friendly hospital practices, including implementing skin-to-skin at birth and 24-hour rooming in, had a greater likelihood of breastfeeding at one and four months than women who experienced fewer than four of these practices (Brodribb, Kruske, & Miller, 2013).

Measurement of compliance with BFHI practices is a key step in achieving Baby-Friendly designation. AWHONN encourages the measurement of the quality of nursing care (AWHONN, 2014b) and in particular has developed the following nursing care quality measures that track nursing practices that support breastfeeding (AWHONN, 2014c):

- Skin-to-Skin is Initiated Immediately Following Birth
- Duration of Uninterrupted Skin-to-Skin Contact
- Eliminating Supplementation of Breast Milk Fed Healthy, Term Newborns

The BFHI Ten Steps are targeted to the term infant population only; therefore, additional and individualized strategies to promote and support breastfeeding in the NICU population are needed (Spatz, 2004).

Breastfeeding and the Use of Human Milk for Preterm and Vulnerable Newborns

Because the feeding of human milk to preterm and vulnerable newborns provides health and nutritional benefits, it should be promoted, supported, and protected as the ideal and normative method for feeding preterm and vulnerable newborns. Nurses, other health care providers, and facilities should implement strategies to assist the mothers of vulnerable and preterm infants to provide human milk whenever possible.

Preterm infants and other infants requiring intensive care experience additional environmental stressors, and feeding human milk to these infants has been shown to reduce some of the complications associated with prematurity. Human milk significantly reduces the risk of necrotizing enterocolitis and sepsis in this population of newborns (Schanler, 2011). Researchers also found that that neurodevelopmental outcomes are improved among infants cared for in the NICU when they are provided with human milk (AAP, 2012).

Because the evidence points to the benefits of human milk to reduce infant morbidity and mortality, all mothers should receive evidence-based education and support with which to make informed decisions regarding pumping milk and establishing and maintaining milk supply during the entire hospital stay. Nurses should assist and support mothers' efforts to establish milk volume for their premature infants (AWHONN, 2014c). The AAP recommended the use of donor milk if a mother's own milk is not available or its use is contraindicated (2012). All hospitals that care for critically ill infants should develop a plan to access milk from a milk bank.

Preterm infants born between 34 weeks, 0 days through 36 weeks, 6 days gestation, known as late preterm infants, may appear to act like full-term infants; however, they have many of the same physiologic vulnerabilities as younger preterm infants, including immature suck and swallow reflexes and altered sleep-wake states. Therefore, this population of mother-infant dyads requires additional support and monitoring from nurses (AWHONN, 2014a). The mother may need assistance in establishing milk supply, recognizing and responding quickly to early infant feeding cues, encouraging more frequent feeding, and using a hospital grade breast pump. The infant may require assistance to facilitate milk transfer at the breast. Establishing pre- and post- feeding weights with an accurate scale (± 2 grams) facilitates the nurses' ability to guide breastfeeding and protect the infant from under consumption.

Recommendations

AWHONN supports the implementation of legislation, policies, and public health initiatives that ensure the right to breastfeed; increase the rate of initiating and maintaining exclusive breastfeeding in the United States; raise awareness of the benefits of breastfeeding; and expand research related to breastfeeding. Such initiatives include the following:

- Legislation that appropriately supports breastfeeding in public and private locations.
- Exclusion of breastfeeding from state and federal indecency legislation.
- Culturally specific public health campaigns that encourage women to breastfeed, particularly within populations at-risk for not breastfeeding (e.g., African-American, Native American, and Asian-Pacific Islander).
- Exemption from jury duty or an option to defer service for up to one year for lactating women.

- Increased funding for peer counseling in the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) breastfeeding program.
- Increased funding for the breastfeeding programs of the Centers for Disease Control and Prevention to ensure continued federal emphasis on breastfeeding.
- Expansion of insurance coverage for the services of lactation specialists and breastfeeding supplies, including scale rental for infants requiring close monitoring (pre- and post-feeding weights during the post-discharge period) in private and public health insurance plans; insurance coverage for breast pumps should not be limited to hand pumps but instead should be based on the clinical needs of the woman and her infant(s). For example, some women will need hospital grade pumps post-discharge; these should be covered by insurance.
- Legislation and policies that mandate employers to facilitate lactation in the workplace, including breaks for breastfeeding women and access to a private area for breastfeeding or milk expression that is not a bathroom.
- Enhanced family medical leave policies that provide women with paid maternity leave in order to fully establish and maintain exclusive breastfeeding for at least the first six months of their infants' lives. Such policy changes could include support for flexible work schedules during the latter six months of the first year of an infant's life when a woman is breastfeeding.
- Increased funding for breastfeeding research and the National Institutes of Health and other research institutions.
- Clarification of the *International Code of Marketing of Breast-milk Substitutes* regarding marketing recommendations for artificial nipples and bottles, particularly for countries where women do not have adequate economic support or maternal leave policies.
- Increased funding for nurse home visiting programs that help women maintain breastfeeding after hospital discharge.
- Insurance coverage in public and private markets for donor milk in NICU populations.

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The "Breastfeeding" position statement was approved by the AWHONN Board of Directors November, 2014. It was previously two, separate position statements titled "Breastfeeding" and "Breastfeeding and Lactation in the Workplace." These position statements were combined and revised to create the current position statement.

The "Breastfeeding" position statement was first approved by the Executive Board, November 1991, 1993, and 1995; it was withdrawn for revision in 1997; and approved by the AWHONN Board of Directors, June 1999. It was revised and reaffirmed December 2007.

The "Breastfeeding and Lactation in the Workplace" position statement was approved by the AWHONN Board of Directors, June 1999. It was revised and reaffirmed in June 2008.