

Standard:	Guidelines for Breastfeeding
Approved By:	Council
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## **GUIDELINES FOR BREASTFEEDING for Midwives Practicing in Newfoundland and Labrador**

The breastfeeding competencies and the breastfeeding guidelines that follow provide the framework for midwives' practice. Midwives protect, promote, and support breastfeeding. To this end midwives should possess the knowledge, skills and attitudes that reflect a commitment to breastfeeding and a respect for informed choice. Evidence has shown that there are significant benefits of breastfeeding for the infant, child and mother (Canadian Paediatric Society, 2012; Newfoundland and Labrador Public Health Association, 2011). The benefits are many and include nutritional, immunological, physical, developmental, social and psychological benefits. Breastfeeding can also be said to offer significant benefits to the community and health care system in terms of costs, lower infant hospital admission rates and lower numbers of infant infections. As well, there are health consequences for not breastfeeding, including the costs, preparation and risks of using breastmilk substitutes (Steube, 2009).

Newfoundland and Labrador has the lowest breastfeeding initiation rate in Canada at 59.3% in 2012 (Statistics Canada, 2014) compared with the national Canadian rate of 90.3% in 2012 (Statistics Canada, 2014). At six months the rate of exclusive breastfeeding in Newfoundland and Labrador was only 17.1% compared with the national rate of 24.2% in 2012 (Statistics Canada, 2014) in spite of recommendations by Health Canada, the Canadian Paediatric Society (CPS), Dieticians of Canada, the Breastfeeding Committee for Canada (BCC) (Health Canada, 2014) and the World Health Organization (WHO) (2009) that breastfeeding be exclusive for the first six months, and continued for up to two years or longer with appropriate complementary feeding. It is therefore crucial that all breastfeeding women receive support, especially those who are most vulnerable and least likely to be successful (e.g. younger maternal age, low income and single status).

Midwives are expected to have current knowledge of the benefits of breastfeeding and the risks of not breastfeeding and have the ability to share this information with the public and childbearing women and their families, in a supportive and empowering manner. As leaders in advocating for normal birth, midwives have an integral role in promoting optimal breastfeeding outcomes. As well, in this role they can act as role models during the labour and birth experience.

1. The midwife supports the pregnant woman, her partner and her family to make an informed decision about infant feeding by providing information about the benefits of breastfeeding. As well, the midwife should explain the health consequences for mother and baby of not breastfeeding, including the costs, preparation and risks of using breastmilk substitutes. The midwife respects the pregnant woman and her partner's informed decision regarding infant feeding
2. The midwife understands and complies with the WHO/UNICEF Baby-Friendly Initiative (BFI) (CPS, 2012) and practices in accordance with the WHO International Code of

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Marketing of Breastmilk Substitutes (1981) and all subsequent, relevant World Health Assembly resolutions.

3. The midwife has the knowledge of the anatomy and physiology of lactation and factors that influence the production of breastmilk.
4. The midwife has a practical knowledge of both physiology and behaviour in the normal breastfed neonate, and factors that affect the neonate's ability to breastfeed successfully.
5. The midwife is able to take a comprehensive history of a woman's previous lactation experiences, relevant medication history and medical conditions, and takes steps to ensure any identified problems are addressed prenatally. The midwife should also ensure supports are in place for a positive breastfeeding experience after the birth.
6. The midwife has the knowledge and skills to assess the mother's breasts and nipples, offer advice and implement supportive measures when indicated. As well, the midwife must assess the effectiveness of these measures.
7. The midwife has the skills to demonstrate hand expression to the mother and guiding the mother to practice this herself.
8. The midwife where possible facilitates uninterrupted skin-to-skin contact immediately after birth (for at least one hour or until completion of first breastfeed, or as long as the mother wishes), can identify early feeding cues and is able to describe them to the mother.
9. The midwife is able to assist the mother to achieve effective positions for breastfeeding, according to the mother's and her baby's needs, including baby-led latching.
10. The midwife can use one of the standardized assessment tools to assess correct positioning and latch for optimal feeding and offer suggestions when necessary.
11. The midwife observes the baby breastfeed and is able to assess effective suckling and swallowing, and ensure that the mother is also able to recognize the same.
12. The midwife is cognizant of factors during labour and birth, including labour medications and operative birth, which may impact the baby's readiness and ability to breastfeed effectively during the first days postpartum.
13. The midwife understands and utilizes practises that support breastfeeding, such as 24 hours rooming in, continued skin-to-skin contact, baby-led, cue-based feeding with no restrictions and no supplementation with a breastmilk substitute (e.g. formula) unless medically indicated.

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14. The midwife is able to assess a sleepy baby to ensure she/he is not compromised.
15. The midwife is aware of and skilled in methods that may help a sleepy baby to breastfeed, including skin-to-skin contact and cue-based feeding to promote exclusive breastfeeding, better milk volume, less jaundice, less weight loss, and stable blood glucose levels, etc.
16. The midwife has the knowledge and skills to identify when supplementation is medically indicated for a breastfed baby and how to use methods other than a bottle, to feed a breastfed baby when necessary, ensuring the baby receives colostrum and expressed breastmilk (EBM) as the first step for medical supplementation. If necessary, information should be given on correct preparation and administration of formula supplements when colostrum/EBM or donor human milk is not available.
17. The midwife has the ability to assist in the initiation and establishment of lactation by methods other than breastfeeding (hand expression or pumping) when a mother is separated from her baby such as a baby in special care or if her baby is not able to breastfeed. Strategies include advice about frequent expression of milk (beginning within six hours of birth and eight or more times in 24 hours), storage and handling of breastmilk, where to obtain equipment and how to clean it.
18. The midwife evaluates the effectiveness of breastfeeding by ensuring the baby is thriving by monitoring the baby's weight gain, the baby's behaviour throughout a breastfeed, the frequency and length of breastfeeds, and the baby's urinary and stool output. As well, the midwife should assess the mother's satisfaction with the baby's feeding and behaviour.
19. The midwife is competent to provide age-appropriate and anticipatory guidance regarding common breastfeeding concerns and to resolve problems as they arise.
20. The midwife can identify concerns and problems that require consultation (e.g. with lactation consultant or physician) and initiates consultation when required.
21. The midwife has knowledge of community supports available to breastfeeding mothers and provides this information to the mothers. This includes mother-to-mother support such as the La Leche League, Healthy Baby Clubs, professional breastfeeding support groups, community health nurses, internet and other online resources available to new mothers. This helps ensure a seamless transition from midwifery care to the community.
22. The midwife participates in provincial data collection to accurately measure breastfeeding initiation and duration rates, as a health indicator, using the BCC's (2012) standardized definitions and time frames in order to effectively plan, implement and evaluate breastfeeding initiatives.

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23. The midwife will refer to BCC's (2012) *Support for non-breastfeeding mothers checklist, Appendix 2.3*, if a mother is unable to breastfeed or makes an informed decision not to breastfeed.

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