



CODEN [USA]: IAJPBB

ISSN : 2349-7750

INDO AMERICAN JOURNAL OF
PHARMACEUTICAL SCIENCES

SJIF Impact Factor: 7.187

<https://doi.org/10.5281/zenodo.8096971>

Available online at: <http://www.iajps.com>

Review Article

THE ROLE OF NURSES AND MIDWIVES IN PROMOTING BREASTFEEDING

RanaaAbdulmohsen Jamman Alharbi,
Hayat Abdullah Alzahrani,
Amna Adam Bakur Hawsawi,
Rasha Abdul Mohsen Alharbi,
Latifa motoq Aziz Aldadai,
Aml Hammad Ali Alqassim,
Ahlam yahya Bakksh,
Aishah Gali Aman Alotibi,
Eman Hameed Allugmani,
Amna Ali Hassan Almashi

Abstract:

In general, nurses and midwives had positive attitudes toward breastfeeding counseling, and they all agreed that breastfeeding is an important part of preventing child-related diseases. We conducted a narrative review through the databases; PubMed and EMbase for relevant studies were published in English studies, up to the beginning of 2023. Mothers' poor compliance with breastfeeding recommendations, too much workload, insufficient time, and logistics for breastfeeding counselling hampered nurses' and midwives' provision of breastfeeding counselling to mothers. Breastfeeding programs and policies that aim to improve nurses' and midwives' breastfeeding competencies, remove barriers to breastfeeding counseling, and provide intensive continuous breastfeeding training are recommended. Implementing these recommendations is critical for providing nurses and midwives with the necessary breastfeeding skills.

Corresponding author:

RanaaAbdulmohsen Jamman Alharbi,

QR code



Please cite this article in press RanaaAbdulmohsen Jamman Alharbi et al, *The Role Of Nurses And Midwives In Promoting Breastfeeding*, Indo Am. J. P. Sci, 2023; 10 (06).

INTRODUCTION:

Midwives and nurses play an important role in protecting, promoting, and supporting breastfeeding all over the world. Midwives and nurses provide skilled breastfeeding support, which helps prevent childhood infections and mortality while also improving cognitive development and lowering rates of obesity, diabetes, and maternal and child cancers. Bonding and attachment are inherent in the breastfeeding relationship and promote both mother and child's mental and emotional health and development [1,2].

Several studies have found that optimal breastfeeding benefits infants, mothers, and society. Breastfeeding, for example, appears to protect against acute otitis media, reduces the risk of diarrhea and respiratory tract infection, and improves child cognitive development [3]. Furthermore, recent evidence in the Lancet series linked breastfeeding to a reduction in overweight and diabetes later in life [4]. Breastfeeding improves birth spacing, prevents breast cancer, and may lower the risk of ovarian cancer and diabetes in mothers [4].

In 2003, the WHO recommended exclusive breastfeeding for the first 6 months, followed by at least 24 months of continued breastfeeding with the introduction of safe and nutritionally adequate complementary feeding [5]. Despite overwhelming evidence supporting the importance of adhering to these recommendations, many developed and developing countries fall short of them [6]. Nursing mothers face numerous complex challenges when attempting to follow breastfeeding recommendations [7,8]. Nurses and midwives play an important role in assisting nursing mothers in overcoming breastfeeding challenges [9]. However, in order for nurses and midwives to assist mothers in overcoming breastfeeding challenges, they must be well trained [10]. Breastfeeding-related education, on the other hand, is frequently neglected in the training of healthcare professionals, with disparities in breastfeeding curriculum across health training institutions and universities [11]. Evidence suggests that several women report a lack of competence on the part of health professionals in addressing lactation issues [12]. In some cases, the information provided by health professionals contradicts other sources of breastfeeding information; in others, it even discourages mothers from breastfeeding [13].

DISCUSSION:

International breastfeeding guidelines recommend that all mothers begin breastfeeding within 1 hour of birth and that mothers who are separated from their infants be taught how to express breast milk [13]. The Japanese guidelines recommend starting milk expression within 6 hours of birth, which differs from the international breastfeeding guidelines. Previous research has found that starting milk expression within 1 hour of birth is the best time [14]. In Japan, the timing for starting milk expression is based on the evidence presented in the study by Furman et al. [15]. The Japanese guidelines should be updated in accordance with international standards because they have not been reviewed since their publication in 2010.

Some Japanese preterm mothers currently do not follow Japanese guidelines because they do not initiate milk expression at the appropriate time and do not express breast milk frequently [16]. As a result, the volume of their breast milk remains low. Some Japanese mothers who gave birth to a premature baby were unaware of their own ability to produce breast milk until they received support from nurses and nurse-midwives, and they struggled to continue producing milk [18].

The first two weeks after birth are the most critical for breastfeeding. During this time, the most common reasons for breastfeeding cessation are insufficient milk, breastfeeding difficulties (attachment issues), insufficient baby weight, and cracked nipples [19]. Inadequate breastfeeding support can also lead to premature cessation. During this time, breastfeeding assistance from a healthcare professional, primarily a midwife, is essential [20]. This assistance has a significant impact on the breastfeeding experience and the choices that mothers make. Schmied et al. [21] discovered that the woman is not always satisfied with the breastfeeding support she receives from the midwife in the first few weeks after birth. This dissatisfaction is more prevalent in the hospital setting and less prevalent in the home care setting, possibly due to fragmented care. The midwife or lactation consultant frequently falls short of the woman's expectations.

Women want the midwife to be an authentic presence with a facilitating approach. This requires the midwife to be available when needed, to listen and sit with women, to observe breastfeeding and to offer tips and practical assistance. Women also want to be able to interact and dialogue with the midwife in order to share their experiences and receive reassurance and encouragement [18,20].

When working in a hospital setting, midwives face numerous challenges such as time constraints, staffing, personal experience, and a lack of belief in policy guidelines. These obstacles make it difficult for them to carry out the role in which they believe, though there are cases where midwives are able to overcome them [21]. These situations must be investigated further in order to plan for change management. For example, if the midwife is able to demonstrate empathy, affirmation, or encouragement, she can have an authentic presence even if there is a lack of continuity of care or limited time [22]. Recognition is critical because most women lack self-confidence and require confirmation that what they are doing is correct [22]. When care is fragmented due to the busyness of the ward, good communication between midwives is required to avoid conflicting advice. When addressing the mother, the midwife must avoid being paternalistic, as this can impair the woman and undermine the mother's self-confidence. When working in a team, it is critical for the midwife to follow common, evidence-based guidelines based on the WHO guidelines for the ten steps to successful breastfeeding. And, when assisting a breastfeeding mother, the midwife should tailor her care to the needs of the mother and her baby, which means that the midwife may need to switch between the roles of technical expert and skilled companion depending on the mother's needs [23].

Women should breastfeed exclusively for at least six months, according to the World Health Organization (WHO). Breastfeeding should be continued as an important component of the infant's nutrition for up to two years after six months [24]. Breastfeeding rates worldwide, and particularly exclusive breastfeeding rates, remain low. Following birth, 78.2% of women in the Flemish Northern part of Belgium exclusively breastfeed their babies. According to the Flemish agency "Public Health, Welfare, and Family," breastfeeding rates drop to 65.3% on day six, and only 33.4% of babies are exclusively breastfed at three months [25]. After six months, the prevalence of exclusive breastfeeding in European region member states ranges from 1% (Greece, Finland, and the United Kingdom) to 49% (Slovakia), with a mean of 13%. International research [26] has clearly demonstrated the importance of breastfeeding support. At 4 months, mothers identify adequate breastfeeding knowledge and a positive attitude toward breastfeeding as critical success factors for exclusive breastfeeding. A common reason for breastfeeding cessation is the mother's incorrect perception of insufficient milk supply during the first weeks after

birth. This perception impedes exclusive breastfeeding rates and can be countered with education [27].

The vast majority of the nurses and midwives in this study indicated that they require additional breastfeeding training/updates. This finding is consistent with a previous study in England, in which the majority of primary healthcare workers indicated that their members could benefit from additional breastfeeding knowledge and expertise [28]. Indeed, in order to provide effective infant and young child feeding counselling, primary care health workers must undergo regular retraining [29].

Perhaps acknowledging their role in breastfeeding counselling will motivate them to protect and promote breastfeeding in their professional practice. Indeed, mothers who receive lactation training from midwives are more likely to successfully breastfeed their babies than mothers who receive lactation training from physicians [30].

In general, the nurses and midwives in this study were pleased with their breastfeeding education experiences. This result demonstrates the importance of breastfeeding satisfaction in increasing nurses' and midwives' confidence in breastfeeding counseling. Breastfeeding education was also found to be effective in increasing nurses' confidence in providing breastfeeding support to mothers in another study [30].

Changes in nurse-midwives by education:

The education program improved nurse-midwives' knowledge and attitude toward breast milk expression care among mothers of preterm infants for up to three months after the program. This improvement confirms that the primary outcome has changed. It has previously been reported that breastfeeding support educational intervention improved NICU nurses' knowledge and attitude toward providing breastfeeding support [22]. However, in the previous study, nurses' knowledge improvement could not be sustained for three months after the education program. In the current study, implementing an education program for only 60 minutes could improve and sustain nurse-midwives' knowledge for up to three months after the program. Nonetheless, we had to repeat the education program 15 times in order for the 36 nurse-midwives with varying work schedules to be able to attend. It was discovered that providing group guidance was difficult because the participation of the nurse-midwives was dependent on their work schedule and ward workload that day. Learners can access e-learning education programs at any time and from any location [29], with no significant difference in knowledge acquisition compared to face-to-face or

lecture-style learning [31]. As a result, such learning methods must be considered and implemented in educational programs.

The education program also improved nurse-midwives' care implementation in most areas until three months after the program ended. According to reports, nurses' knowledge of evidence-based practice was related to their attitude toward evidence-based practice; thus, nurses' knowledge and attitude affected the successful implementation of evidence-based practice [32]. Similarly, in the current study, the increase in knowledge from the educational intervention is thought to improve the nurse-midwives' attitude and care implementation.

CONCLUSION:

Nurses and midwives' level of satisfaction with their breastfeeding educational experiences, nurses and midwives were asked to indicate their level of satisfaction with the following breastfeeding educational experiences during school training: whether the amount of time dedicated to breastfeeding education was adequate, whether breastfeeding was integrated into their courses sufficiently, and whether materials were included to allow for their independent study of breastfeeding. In general, nurses and midwives had positive attitudes toward breastfeeding counseling, and they all agreed that breastfeeding is an important part of preventing child-related diseases. Breastfeeding programs and policies that aim to improve nurses' and midwives' breastfeeding competencies, remove barriers to breastfeeding counseling, and provide intensive continuous breastfeeding training are recommended. Implementing these recommendations is critical for providing nurses and midwives with the necessary breastfeeding skills.

REFERENCES:

1. United Nations Children's Fund, WHO Breastfeeding Advocacy Initiative, 2015, https://www.who.int/nutrition/publications/infant_feeding/breastfeeding_advocacy_initiative_overview.pdf?ua=1.
2. Victora CG et al., 'Breastfeeding in the 21st century: epidemiology, mechanisms, and lifelong effect', *The Lancet*, vol. 387, no. 10017, 30 January 2016, pps. 475–90.
3. McFadden A, et al., 'Support for healthy breastfeeding mothers with healthy term babies', *Cochrane Database of Systematic Rev.* vol. 2, no. 2, 28 February 2017, CD001141.
4. Parker LA, Sullivan S, Krueger C, Mueller M. Association of timing of initiation of breast milk expression on milk volume and timing of lactogenesis stage II among mothers of very low-birth-weight infants. *Breastfeed Med.* 2015;10(2):84–91. #
5. Furman L, Minich N, Hack M. Correlates of lactation in mothers of very low birth weight infants. *Pediatrics.* 2002;109(4):e57.
6. Tachiki K, Takahashi S, Takagi T, Numao M, Amagai E, Kaneda Y, et al. The situation of expressing breast milk for babies' mothers in neonatal intensive care unit. *Jichi Med Univ J Nurs.* 2011;8:125–32. https://www.jichi.ac.jp/assets/pdf/nurse/about/publication/journal/journal_08.pdf
7. Tanaka R, Horiuchi S. The current situation and challenges of care to promote breast milk production for mothers of preterm infants in the maternity ward. *J Jpn Acad Midwife.* 2018;32(2):215–225.
8. Iguchi A, Kawaguchi Y, Matsubara M. Factors of breastfeeding continuance for low-birth-weight infants focusing on breast milk expression in the NICU. *Bulletin of St. Mary's College*, vol. 7; 2016. p. 17–25. https://st-mary.sakura.ne.jp/disclosure/pdf/2018/newvol_7.pdf
9. Tanaka R, Nagami K, Wachi S, Bonno M, Gonno S, Fujishiro T, et al. Process of self-formation as a mother through breastfeeding among mothers who have given birth to a premature infant. *Jpn J Matern Health.* 2014;55(2):405–415.
10. Hill PD, Aldag JC, Chatterton RT, Zinaman M. Primary and secondary mediators' influence on milk output in lactating mothers of preterm and term infants. *J Hum Lact.* 2005;21(2):138–150. doi: 10.1177/0890334405275403.
11. Mellin PS, Poplawski DT, Gole A, Mass SB. Impact of a formal breastfeeding education program. *Am J Matern Child Nurs.* 2011;36(2):82–88.
12. Hosoi H. (Supervising Ed.). [Neonatal intensive care unit manual] 6. Tokyo: Shindan to chiryo sha; 2017. pp. 11–14.
13. Tanaka R, Oka M, Kitazono M, Maruyama N, Horiuchi S. Care related to milk expression to promote breast milk production among mothers of preterm infants in early postpartum: a literature review. *J Jpn Acad Midwife.* 2018;32(1):15–26.
14. De La Mora A, Russell DW, Dungy CI, Losch M, Dusdieker L. The Iowa infant feeding attitude scale: analysis of reliability and validity. *J Appl Soc Psychol.* 1999;29(11):2362–2380. doi: 10.1111/j.1559-1816.1999.tb00115.x.

15. Furman L, Minich N, Hack M. Correlates of lactation in mothers of very low birth weight infants. *Pediatrics*. 2002;109(4):e57. Bowen DJ, Kreuter M, Spring B, Cofta-Woerpel L, Linnan L, Weiner D, Bakken S, Kaplan CP, Squiers L, Fabrizio C, Fernandez M. How we design feasibility studies. *Am J Prev Med*. 2009;36(5):452–457. doi: 10.1016/j.amepre.2009.02.002.
16. Bernaix LW, Schmidt CA, Arrizola M, Iovinelli D, Medina-Poelinez C. Success of a lactation education program on NICU nurses' knowledge and attitudes. *J Obstet Gynecol Neonatal Nurs*. 2008;37(4):436–445.
17. Alqahtani N, Oh KM, Kitsantas P, Rodan M. Nurses' evidence-based practice knowledge, attitudes and implementation: a cross-sectional study. *J Clin Nurs*. 2020;29(1-2):274–283.
18. Zhang, Z., Zhang, L., Wan, H., 2018. What factors influence exclusive breastfeeding based on the theory of planned behaviour. *Midwifery* 62, 177–182.
19. Quinn P, Tanis SL. Attitudes, perceptions, and knowledge of breastfeeding among professional caregivers in a community hospital. *Nurs Womens Health*. 2020;24:77-83.
20. Schmied, V., Beake, S., Sheehand, A., McCourt, C., Dykes, F., 2011. Women's perceptions and experiences of breastfeeding Support: a metasynthesis. *Birth* 38, 49–60.
21. Brodribb W, Fallon A, Jackson C, Hegney D. The relationship between personal breastfeeding experience and the breastfeeding attitudes, knowledge, confidence and effectiveness of Australian GP registrars. *Matern Child Nutr*. 2008;4:264-274.
22. Lee TY, Lin F. The effectiveness of an e-learning program on pediatric medication safety for undergraduate students: a pretest-post-test intervention study. *Nurse Educ Today*. 2013;33(4):378–383. doi: 10.1016/j.nedt.2013.01.023.
24. Lahti M, Hätönen H, Välimäki M. Impact of e-learning on nurses' and student nurses' knowledge, skills, and satisfaction: a systematic review and meta-analysis. *Int J Nurs Stud*. 2014;51(1):136–149.
23. Parker LA, Hoffman J, Darcy-Mahoney A. Facilitating early breast milk expression in mothers of very low birth weight infants. *Am J Matern Child Nurs*. 2018;43(2):105–110.
24. Goyal, N.K., Attanasio L.B., Kozhimannil, K.B., 2014. Hospital care and early breastfeeding outcomes among late preterm, early – term, and term infants. *Birth* 41, 330 -338.
25. Rayner, J., Forster, D., McLachlan, H., Yelland, J., Davey, M., 2008. A state – wide review of hospital postnatal care in Victoria, Australia: The views and experiences of midwives 24, 310 – 320.
26. Zhang, Z., Zhang, L., Wan, H., 2018. What factors influence exclusive breastfeeding based on the theory of planned behaviour. *Midwifery* 62, 177–182.
27. Renfrew, MJ., McCormick, FM., Wade, A., Quin, B., Dowswell, T., 2012. Support for healthy breastfeeding mothers with healthy term babies. *Cochrane Database Syst. Rev.* (5) 1–25
28. Gross, S., Resnik, A., Nanda, J., Cross – Barnet, C., Augustyn, M., Kelly, L., Paige, D., 2011. Early postpartum: a critical period in setting the path for breastfeeding success. *Breastfeed. Med.* 6, 407–412.
29. Hall, H., McLelland G., Gilmour, C., Cant, R., 2014. 'It's those first few weeks': Women's views about breastfeeding support in an Australian outer metropolitan region. *Women and Birth* 27, 259 – 265.
30. Fu, ICY., Fong, DYT, Heys, M., Lee, ILY., Sham, A., Tarrant., M., 2014. Professional breastfeeding support for first – time mothers: a multicenter cluster randomized controlled trial. *Royal College of Obstetricians and Gynaecologists*, 1 – 11.
31. Burns, E., Schmied, V., Fenwick J., Sheehan, A., 2012. Liquid gold from the milkbar: Constructions of breastmilk and breastfeeding women in the language and practices of midwives. *Social Science & Medicine* 75, 1737 – 1745.