

**INFANT FEEDING AND INSTITUTIONAL COMPLIANCE WITH THE WHO/UNICEF
BABY-FRIENDLY INITIATIVE: AN ASSESSMENT THROUGH MATERNAL
EXPERIENCE**

by

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ABSTRACT

The benefits of breastfeeding are numerous and supported through World Health Organization guidelines. Maternal healthcare in the hours/days following delivery can greatly impact breastfeeding outcomes. The World Health Organization developed the Baby-Friendly Initiative (BFI) to promote optimal infant feeding care in healthcare settings. None of the 40 designated Baby-Friendly facilities in Canada are located in Newfoundland and Labrador (NL) where rates of initiation and exclusive feeding are among Canada's lowest. This research assesses hospital adherence with Steps 3-10 of the BFI at the Janeway Children's Hospital/Health Science Centre in St. John's, NL. Using interpretive phenomenology to explore maternal healthcare experiences, data were collected through semi-structured interviews, focus groups, and hospital policy review. Results indicate a lack of full adherence with Steps 3-10 of the BFI. Reported inconsistencies suggest a need for improved breastfeeding education, training and supportive conditions for nurses; and improved policy communication, monitoring and alignment with BFI guidelines.

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Glossary of Terms

Breastfeeding duration: The duration of breastfeeding practice; the length of time a mother-infant dyad breastfeeds – often measured according to the number of days, weeks, or months breastfeeding continues following delivery

Breastfeeding initiation: The initiation of breastfeeding; the first time a mother-infant dyad breastfeeds; first breastfeeding; beginning of breastfeeding; initiation of breastfeeding

Case room: The area of a hospital where mothers experience labour and childbirth

Complementary feeding: To feed with breast milk and with formula (breast milk substitutes), or other liquids and/or foods; feeding an infant with a combination of breast milk and other liquids/foods/substitutes

Exclusive breastfeeding: To feed with only breast milk and no other liquids, foods, or breast milk substitutes; to feed exclusively and only with breast milk

Exclusive formula feeding: To feed with only formula (breast milk substitutes) and no breast milk or other liquids/foods; to feed exclusively and only with formula (breast milk substitutes)

Formula feeding: To feed an infant with formula; to feed an infant with a breast milk substitute

Healthcare providers / professionals / practitioners: Trained healthcare professionals providing care (physicians, midwives, nurses, lactation consultants)

Infant: A newborn child less than one year of age

Maternity Unit: The area of a hospital where mothers and infants rest and recover after giving birth until discharged from hospital

Mother-infant pair / mother-infant dyad: The biologically related mother and infant

List of Abbreviations

AHRQ – Agency for Healthcare Research and Quality

BCC – Breastfeeding Committee for Canada

BFI / BFHI – Baby-Friendly Initiative / Baby-Friendly Hospital Initiative

CIHR – Canadian Institute for Health Research

LPN – Licensed Practical Nurse

NICU – Neonatal Intensive Care Unit

NL – Newfoundland and Labrador

NLPPP – Newfoundland and Labrador Provincial Perinatal Program

PHAC – Public Health Agency of Canada

PROBIT – Promotion of Breastfeeding Intervention Trial

RDC – Research Development Corporation of Newfoundland and Labrador

RN – Registered Nurse

SIDS – Sudden infant death syndrome

UNICEF – United Nations International Children’s Emergency Fund

WASI – Wechsler Abbreviated Scale of Intelligence

WHA – World Health Assembly

WHO – World Health Organization

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Chapter 1

Introduction

The nutritional, immunological, and social benefits of breastfeeding are well evidenced and promoted through World Health Organization (WHO) and United Nations International Children's Emergency Fund (UNICEF) guidelines for infant feeding practices. The WHO and UNICEF recommend exclusive breastfeeding for the first six months of life for optimal infant health and development. Exclusive breastfeeding means feeding an infant with breastmilk and no other liquids, foods, or breastmilk substitutes. Despite these recommendations, rates of exclusive breastfeeding in Newfoundland and Labrador (NL) for the recommended six-month duration are the lowest in Canada at 5.8% (Chalmers et al., 2009). While many factors contribute to infant feeding practice, healthcare practices in the first minutes, hours, and days following birth have been shown to have a significant impact on breastfeeding rates of initiation, duration, and exclusivity (Kramer et al., 2001). Recognizing this, the WHO and UNICEF developed the Baby-Friendly Hospital Initiative (BFHI) to promote and support optimal infant feeding practices in healthcare settings. To achieve Baby-Friendly status, hospitals and birthing centers must follow best practices for infant feeding outlined in the WHO/UNICEF *Ten Steps to Successful Breastfeeding* guidelines. Although there are currently 40 designated Baby-Friendly facilities in Canada, there are none located in the province of NL.

This research examines hospital adherence with infant feeding guidelines outlined in the BFHI through an exploration of maternal hospital healthcare and infant feeding experiences at the Janeway Children's Hospital/Health Sciences Centre in St. John's, NL in 2012. An interpretive phenomenological framework was applied to facilitate the exploration of how mothers understand, interpret, and assign meaning to their infant feeding experiences. Using

semi-structured interviews and focus groups, maternal accounts of their hospital healthcare experiences were used to indicate hospital adherence with BFHI¹ guidelines. This research highlights areas for improvement with infant feeding healthcare provision, and shines light on the complex struggles, pressures, conflicts and concerns mothers experience with their infant feeding and mothering practices.

1.1 Importance of breastfeeding

The health benefits of breastfeeding are widely evidenced in the literature, and are thoroughly examined and presented in two large systematic reviews and meta-analyses exploring the benefits of breastfeeding – one from the United States Agency for Healthcare Research and Quality (AHRQ) – *Breastfeeding and maternal and infant health outcomes in developed countries*, and the other from the WHO – *Evidence on the long-term effects of breastfeeding*. Both guiding documents analyze outcomes from hundreds of infant feeding studies to provide current data on the health outcomes of breastfeeding. While the AHRQ publication focuses on all potential benefits of breastfeeding for mothers and infants, the WHO publication is limited to the long-term impact of breastfeeding on blood pressure, cholesterol, overweight/obesity, type-2 diabetes, and cognitive development.

Designed to determine the short and long-term effects of breastfeeding for mothers and infants living in developed countries, the United States AHRQ systematic review and meta-analysis includes approximately 400 studies collected using MEDLINE, Cumulative Index to Nursing and Allied Health Literature (CINAHL) and the Cochrane Library. Systematic reviews, meta-analyses, randomized control trials, prospective cohort studies, and case-control studies exploring the health outcomes of breastfeeding were included and analyzed using multivariate

¹ In Canada the BFHI is referred to as the Baby-Friendly Initiative (BFI).

statistical analysis. Results indicated a statistically significant relationship between breastfeeding and reduced risk for acute otitis media, atopic dermatitis, asthma, childhood leukemia, necrotizing enterocolitis, obesity, severe lower respiratory tract infections, sudden infant death syndrome (SIDS), and type-1 and type-2 diabetes in infants and young children (Ip et al., 2007). Notably, there was no significant relationship found between breastfeeding and improved child cognitive development. For mothers, benefits of breastfeeding included a reduced risk of breast cancer, ovarian cancer, type-2 diabetes, and post-partum depression. While the AHRQ provided comprehensive data on the health benefits of breastfeeding for mothers and infants, the WHO provided further evidence.

The WHO's systematic review and meta-analysis assessed the long-term impact of breastfeeding on adult blood pressure, cholesterol, overweight/obesity, type-2 diabetes, and cognitive development. Observational and randomized studies were drawn from MEDLINE and the Scientific Citation Index. Results indicated a statistically significant relationship between breastfeeding and lower rates of blood pressure, cholesterol, overweight/obesity and type-2 diabetes, as well as between breastfeeding and higher cognitive development among subjects who had breastfed compared to those who had not (WHO, 2007). These outcomes suggest that the benefits of breastfeeding extend beyond infancy and childhood to influence health outcomes throughout the life course.

Together these reports provide compelling evidence to support the multiple health benefits of breastfeeding for both mothers and infants. Despite some differing outcomes – the AHRQ study found no significant association between breastfeeding and cognitive development, blood pressure, and cholesterol, while the WHO study did – results from each provide

overwhelming evidence in support of breastfeeding as a beneficial practice with the potential to protect against illness and disease, and improve overall public and population health.

The potential for breastfeeding to promote health and protect against chronic conditions and disease in infancy and adulthood make it an important and cost effective health practice worthy of promotion within the healthcare sector and beyond. The WHO (2006) states, “Interventions to improve breastfeeding practices are cost-effective and rank among those with the highest cost-benefit ratio. The cost per child is low compared to that for curative interventions” (p. 3). As with other preventive health practices, breastfeeding has the potential to lower rates of illness and disease, reduce healthcare spending, and lower demands on the healthcare system through its protective effect against chronic diseases and conditions (WHO, 2006).

Breastfeeding is promoted widely by the WHO and UNICEF, along with other organizations, associations, and health authorities at the international, national, and community level for the promotion of optimal maternal-infant health. The report on Infant and Young Child Nutrition from the 55th World Health Assembly (WHA) states,

Breastfeeding is an unequalled way of providing ideal food for the healthy growth and development of infants; it is also an integral part of the reproductive process with important implications for the health of mothers. As a global public health recommendation, infants should be exclusively breastfed for the first six months of life to achieve optimal growth, development and health. Thereafter, to meet their evolving nutritional requirements, infants should receive nutritionally adequate and safe complementary foods while breastfeeding continues for up to two years of age or beyond. (WHO, 2002, p. 5)

In Canada, the Public Health Agency of Canada (PHAC), Canadian Pediatric Society, Dieticians of Canada, Breastfeeding Committee of Canada, and others recommend exclusive breastfeeding

for the first six-months of life, with complementary feeding for two years and beyond, for optimal infant and child growth and development.

Although breastfeeding and breast milk is optimal for infant health and development, it is important to acknowledge that for social, medical, or other reasons, breastfeeding may not always be possible or optimal for every mother, or every mother-infant dyad. While it is important that breastfeeding is normalized, promoted, and supported in healthcare settings through the provision of optimal care practices, in all cases, it is important that maternal decisions related to infant feeding are respected and supported within the healthcare system. While infant formula should not be encouraged or readily available in hospital, if a mother wishes to supplement with formula, the BFHI recommends she is informed of the health implications of supplementation, supported to make an informed decision, and provided with the information and assistance needed to succeed with her desired mode of infant feeding (UNICEF/WHO, 2009).

1.2 The WHO/UNICEF BFHI Ten Steps to Successful Breastfeeding

The WHO, UNICEF and WHA have worked globally for the past three decades to promote and normalize exclusive breastfeeding. Key initiatives include the development of the International Code of Marketing of Breast-milk Substitutes, the Innocenti Declaration, and the BFHI.

In 1981, the WHO developed The International Code of Marketing of Breast-milk Substitutes, also referred to as *The Code*, to stop the unethical marketing and distribution of infant formula (breast milk substitutes), and to create guidelines for the ethical use of infant formula in healthcare settings. Its purpose was to:

contribute to the provision of safe and adequate nutrition for infants, by the protection and promotion of breastfeeding, and by ensuring the proper use of breast-milk substitutes, when these are necessary, on the basis of adequate information and through appropriate marketing distribution. (WHO, 1981, p. 8)

At the time, no restrictions existed to prevent infant formula companies from inaccurately advertising their formula as nutritionally equal to or better than breast milk, to curb the unethical endorsement of formula by healthcare providers and institutions providing maternity care, or to prevent the advertising and distribution of free formula samples within healthcare facilities (Levitt et al., 2011). Since the Code was enacted in 1981, several resolutions have been passed to clarify and update it to reflect current scientific knowledge and marketing trends. The Code is not legally enforceable without legislative support from individual nation-states, however, where legally incorporated, formula manufacturers must strictly abide by its guidelines. In Canada, adherence to the Code is voluntary and not legally enforced.

To further enhance global promotion of breastfeeding, the WHA developed the Innocenti Declaration on the Protection, Promotion and Support of Breastfeeding in 1990. The Innocenti Declaration set a global policy standard encouraging governments to develop national breastfeeding policies and initiatives to support and promote breastfeeding practice, and formed the foundation from which the WHO/UNICEF BFHI emerged.

The WHO/UNICEF BFHI is a global health promotion initiative committed to improving maternal-infant health by improving rates of exclusive breastfeeding. Targeted toward hospitals and birthing facilities, the BFHI encourages healthcare institutions to implement optimal standards for patient care in pregnancy, childbirth, and the early post-partum period. BFHI guidelines for healthcare provision are clearly outlined in the Ten Steps to Successful Breastfeeding. Each step is informed by evidence and designed to improve breastfeeding

initiation, duration, and exclusivity through the delivery of optimal healthcare conditions in support of breastfeeding. In their joint statement on breastfeeding the WHO and UNICEF (1989) emphasized that,

Of the many factors that affect the normal initiation and establishment of breastfeeding, health care practices, particularly those related to the care of mothers and newborn infants, stand out as one of the most promising means of increasing the prevalence and duration of breastfeeding. (p. 4)

By promoting best practices within hospital settings, the BFHI works to ensure mothers receive the instruction, assistance, information, and support they need to successfully breastfeed in hospital and upon discharge. In 2009, the WHO and UNICEF updated the BFHI to incorporate current evidence on infant feeding.

Since the initiative was launched by the WHO and UNICEF in 1991, it has grown to include more than 20,000 designated Baby-Friendly facilities in 156 countries around the world (UNICEF/WHO, 2009). Any hospital or birthing facility can achieve Baby-Friendly status if able to demonstrate compliance with each of the Ten Steps to Successful Breastfeeding and with the International Code of Marketing of Breast-milk Substitutes.

Although the WHO and UNICEF are the global authority for the BFHI, when appropriate, national organizations can be appointed by the WHO/UNICEF to oversee BFHI implementation and monitoring at a national level (UNICEF/WHO, 2009). Each national authority must be multi-sectoral, must support evidence-informed practices for infant feeding, and must have government endorsement and government funding to dedicate towards protecting and promoting breastfeeding (UNICEF/WHO, 2009). National authorities are responsible for overseeing the implementation and designation of the BFHI and International Code for Marketing of Breast-milk Substitutes; monitoring and evaluating infant feeding programs,

activities and outcomes; and developing national infant feeding plans and activities (UNICEF/WHO, 2009).

In Canada, the Breastfeeding Committee for Canada (BCC) is the national authority for the BFHI, which is referred to nationally as the Baby-Friendly Initiative (BFI). The BCC made this title modification to better “reflect the continuum of care” in Canada by acknowledging that Baby-Friendly healthcare practices extend both beyond hospital environments to include birthing centers/facilities, community services, and supports post-partum (BCC, 2012b). The BCC has adapted each step of the international WHO/UNICEF Ten Steps to Successful Breastfeeding to better reflect the Canadian context by providing guidelines that can be used by both hospitals and community health services (BCC, 2012b). These guidelines are called *the BCC BFI Integrated Ten Steps Practice Outcome Indicators for Hospital and Community Health Services*, and are referred to as the *BFI Ten Steps* or *BFI Integrated Ten Steps*. The BFHI Ten Steps to Successful Breastfeeding and BFI Integrated Ten Steps are presented in Table 1-1.

Table 1-1: BFI Integrated 10 Steps and WHO Code Practice Outcome Indicators

Integrated 10 Steps & WHO Code Practice Outcome Indicators for Hospitals and Community Health Services: Summary		
The WHO 10 Steps to Successful Breastfeeding (1989) and the Interpretation for Canadian Practice (2011)		
Step 1	WHO	Have a written breastfeeding policy that is routinely communicated to all health care staff.
	Canada	Have a written breastfeeding policy that is routinely communicated to all health care providers and volunteers.
Step 2	WHO	Train all health care staff in the skills necessary to implement the policy.
	Canada	Ensure all health care providers have the knowledge and skills necessary to implement the breastfeeding policy.
Step 3	WHO	Inform pregnant women and their families about the benefits and management of breastfeeding.
	Canada	Inform pregnant women and their families about the importance and process of breastfeeding.
Step 4	WHO	Help mothers initiate breastfeeding within a half-hour of birth. WHO 2009: Place babies in skin-to-skin contact with their mothers immediately

		following birth for at least an hour. Encourage mothers to recognize when their babies are ready to breastfeed and offer help if needed.
	Canada	Place babies in uninterrupted skin-to-skin* contact with their mothers immediately following birth for at least an hour or until completion of the first feeding or as long as the mother wishes: encourage mothers to recognize when their babies are ready to feed, offering help as needed.
Step 5	WHO	Show mothers how to breastfeed and how to maintain lactation, even if they should be separated from their infants.
	Canada	Assist mothers to breastfeed and maintain lactation should they face challenges including separation from their infants.
Step 6	WHO	Give newborns no food or drink other than breastmilk, unless medically indicated.
	Canada	Support mothers to exclusively breastfeed for the first six months, unless supplements are <i>medically</i> indicated.
Step 7	WHO	Practice rooming-in – allow mothers and infants to remain together 24 hours a day.
	Canada	Facilitate 24-hour rooming-in for all mother-infant dyads: mothers and infants remain together.
Step 8	WHO	Encourage breastfeeding on demand.
	Canada	Encourage baby-led or cue-based breastfeeding. Encourage sustained breastfeeding beyond six months with appropriate introduction of complementary foods.
Step 9	WHO	Give no artificial teats or pacifiers (also called dummies or soothers) to breastfeeding infants.
	Canada	Support mothers to feed and care for their breastfeeding babies without the use of artificial teats or pacifiers (dummies or soothers).
Step 10	WHO	Foster the establishment of breastfeeding support groups and refer mothers to them on discharge from the hospital or clinic.
	Canada	Provide a seamless transition between the services provided by the hospital, community health services and peer support programs. Apply principles of Primary Health Care and Population Health to support the continuum of care and implement strategies that affect the broad determinants that will improve breastfeeding outcomes.
The Code	WHO	Compliance with the International Code of Marketing of Breastmilk Substitutes.
	Canada	Compliance with the International Code of Marketing of Breastmilk Substitutes.

* The phrase “skin-to-skin care” is used for term infants while the phrase “kangaroo care” is preferred when addressing skin-to-skin care with premature babies.

(BCC, 2012c).

Assessment of hospital compliance to BFI standards involves a number of stages of evaluation before external assessment from a representative national authority for the BFI can occur, and before BFI designation can be granted. In Canada the facility must first complete a self-appraisal of infant feeding practices using the BFI Ten Steps Practice Outcome Checklist. If all criteria from this self-assessment are met, the facility must then pass a BFI pre-assessment

document review and site visit from the provincial or territorial BFI lead representative (BCC, 2012a). If all criteria are met in the pre-assessment, the institution can arrange a formal BFI external assessment from a representative of the BCC. The external assessment involves a two to four day site examination where policies and documents are reviewed, practices are observed, and staff and patients are interviewed (BCC, 2012a). If all BFI criteria are met in the external assessment, the hospital is awarded BFI designation for five years. In order to maintain BFI designation, the facility must complete a re-assessment from the BCC every five years (BCC, 2012a). In each stage of the assessment process, if any criteria are not met, the facility must develop a plan to address its shortcomings, and seek re-assessment once improvements have been made.

As the national authority for the BFI, the BCC has assigned the Baby-Friendly Council of NL (formerly known as the Breastfeeding Coalition of NL) responsibility for monitoring and promoting the implementation of the BFI in the province. Established in 1992 under the leadership of the NL Provincial Perinatal Program and with funding from the Department of Health and Community Services, the Baby-Friendly Council of NL works to promote and support breastfeeding in the province through public education and awareness, research and monitoring, communication and strategic planning, and BFI assessment. The Baby-Friendly Council of NL is made up of representatives from all four Regional Health Authorities, the Department of Health and Community Services, La Leche League Canada, and Memorial University's Faculty of Medicine, School of Pharmacy, and School of Nursing (BCC, 2012d).

1.3 Infant feeding in Canada and NL

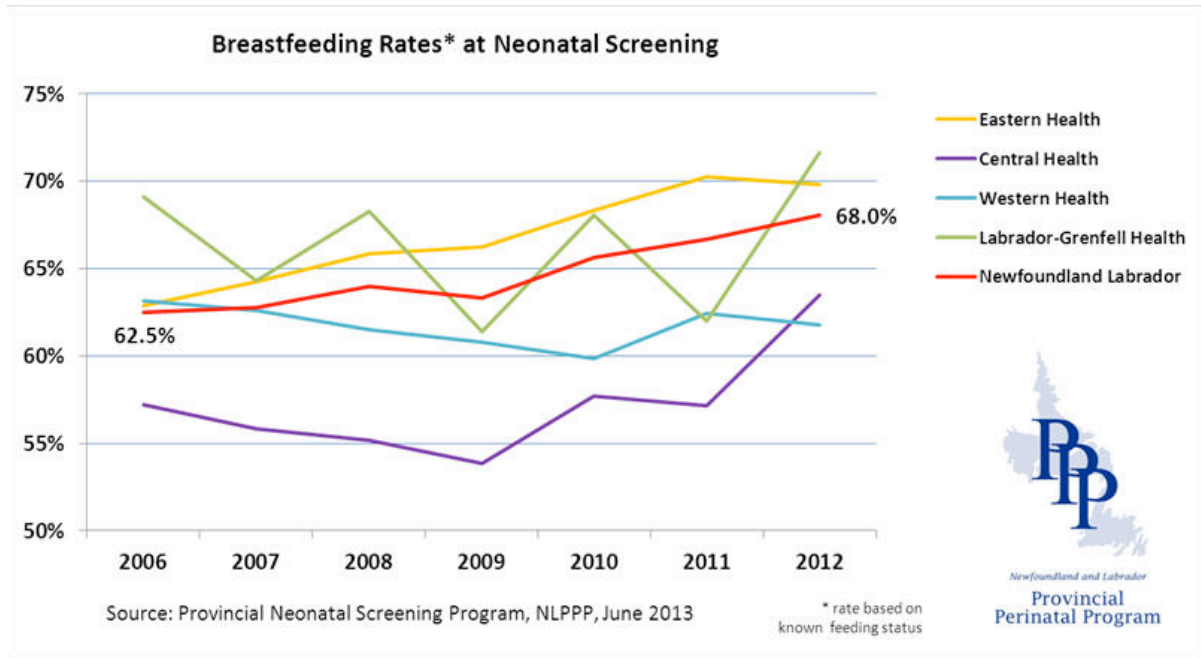
Although recommendations for infant feeding practice are clear, rates of exclusive breastfeeding for the optimal six-month duration in Canada fall much lower than WHO and

UNICEF recommendations (Chalmers et al., 2009; PHAC, 2009). A nationwide study found that 90.3% of women in Canada initiated breastfeeding in 2006, but only 14.4% exclusively breastfed for the recommended 6-month duration (Chalmers et al., 2009; PHAC, 2009). While national rates of exclusive breastfeeding are sub-optimal (especially for the 6-month recommended duration), rates of initiation and exclusive feeding in NL are among the lowest in Canada with 74.6% of mothers initiating breastfeeding (PHAC, 2009) and only 5.8% exclusively breastfeeding for 6-months (Chalmers et al., 2009).

The NL Provincial Perinatal Program reported similar, yet lower, rates of breastfeeding initiation in the province. Provincial Perinatal Surveillance System (2013) data reported a breastfeeding initiation rate² of 68.0% in 2012. Despite low rates of breastfeeding initiation, provincial data suggest steadily increasing rates of breastfeeding initiation in NL over the past two decades (See Figures 1-1). The NL Provincial Perinatal Program reported, “In 1986 the [breastfeeding initiation] rate was 35.3%, ten years later 56.3%, and in 2005, 63.6% with regional variations from a high of 70.7% in the Grenfell region, to a low of 44.5% in the rural Avalon region” (NL Provincial Perinatal Program, 2006). Although trends reflect a positive change in provincial breastfeeding practice, they demonstrate significant regional variations, and a culture of infant feeding in NL where breastfeeding has not always been widely practiced. See Figure 1-2 for data on provincial breastfeeding trends from 1986-2012.

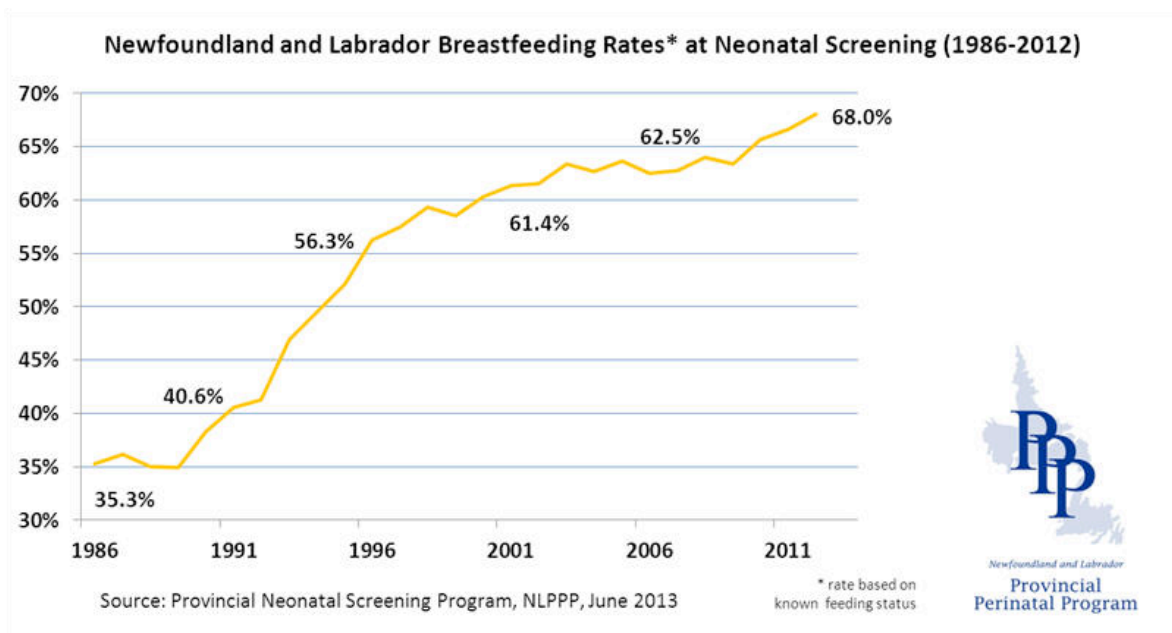
² NL Provincial Perinatal Program initiation rates are taken 48 hours after birth during neonatal screening and therefore better represent breastfeeding rates upon discharge than breastfeeding initiation.

Figure 1-1: Regional Breastfeeding Rates at Neonatal Screening



(NLPPP, 2013).

Figure 1-2: Provincial Breastfeeding Rates at Neonatal Screening



(NLPPP, 2013).

Low rates of breastfeeding initiation and exclusive feeding and the absence of a Baby-Friendly facility in NL highlight an opportunity to improve provincial breastfeeding promotion and support – especially within hospital healthcare facilities. Although midwifery is a newly legislated profession in NL, it is not yet provincially funded, making physicians and nurses the primary care providers, and hospitals the primary birthing facilities available to mothers in NL (Canadian Association of Midwives, 2010, 2012). It is important that hospitals follow optimal care practices to ensure the majority of mother-infant dyads receive the information, care, and support needed to succeed with breastfeeding.

While optimal infant feeding healthcare provision is critically important for the successful establishment of breastfeeding, healthcare practices are one of many factors shaping infant feeding practice. A study exploring maternal infant feeding decisions in NL found that maternal decisions to exclusively formula feed in the province were most commonly made due to social factors, such as maternal embarrassment, distaste, discomfort with breastfeeding, and the belief that breastfeeding is inconvenient and time-consuming (Matthews, Webber, McKim, Banoub-Baddour & Laryea, 1998). Of those in the study who breastfed and switched to formula, the most common reasons were the perception of infant dissatisfaction with breast milk, and the belief that breastfeeding is difficult and time-consuming (Matthews et al., 1998).

Similar results were reported in a study exploring maternal reasons for formula feeding in NL. The study found that the most common reasons for formula supplementation among NL mothers were to: save time, balance care of other children in the home, avoid inconvenience and embarrassment, share infant feeding and child care responsibilities more equally with a partner, recover from difficult labour/delivery, settle the baby, and know how much milk the baby is getting (Ludlow et al., 2012). While some issues, such as breastfeeding difficulty, discomfort,

and concern over milk intake can be addressed through improved breastfeeding education, instruction, and support for lactating mothers within the healthcare system and community, other issues reflect broader social conditions and cultural views of breastfeeding that may be more challenging to address.

In 2008, the NL Provincial Perinatal Program and Baby-Friendly Council of NL released NL's first Breastfeeding Strategic Plan to identify key infant feeding issues in the province and provide clear strategies for protecting, promoting, and enhancing breastfeeding in NL. Two major goals were identified for improving provincial breastfeeding rates. These were: 1) "To increase public awareness of the importance and value of breastfeeding," and 2) "To promote and support the WHO/UNICEF Baby-Friendly Initiative" (Murphy-Goodridge, 2008, p. 16). The document emphasized a need for improved public education and awareness of breastfeeding, improved education and training for healthcare workers, enhanced research and monitoring of breastfeeding, and the ongoing assessment of progress towards reaching BFI standards. Since 2010, the Department of Health and Community Services has provided the Baby-Friendly Council of NL with \$159,000 of annual funding to support breastfeeding initiatives outlined in the NL Breastfeeding Strategic Plan (NLPPP, 2012). The NL Breastfeeding Strategic Plan was updated in 2012 to guide activities from 2012-2015.

The Baby-Friendly Council of NL is divided into four working groups focused on the protection and promotion of breastfeeding in the province through: 1) public education and awareness; 2) research and monitoring; 3) communication and strategic planning; and 4) BFI assessment. Activities include the development of a Breastfeeding Handbook for mothers and families, the development of a Breastfeeding Physician Tool Kit, and the delivery of 20-hour breastfeeding training courses aligned with BFI course guidelines for health professionals in all

four Regional Health Authorities. The Baby-Friendly Council of NL has also developed social marketing tools to normalize and promote breastfeeding in NL (poster campaign “You’ll see plenty of strange things, breastfeeding isn’t one of them”, NL Breastfeeds video campaign featuring provincial celebrities, and the Baby-Friendly Council of NL website, blog and Facebook group). Additional activities include supporting community mother-to-mother initiatives through the Provincial Wellness Program, and conducting research on provincial and regional breastfeeding rates and BFI implementation in provincial hospital facilities.

1.4 Research focus

While a great deal is known about the importance of breastfeeding and evidence-informed care provision, little is known about current adherence to BFI guidelines in hospital facilities in NL, or about the infant feeding healthcare experiences of mother-infant dyads in hospital. At the time this research was conducted, the Baby-Friendly Council of NL was beginning an assessment of hospital adherence with BFI guidelines in provincial hospital healthcare facilities. Their research was quantitative in method and was not designed to examine maternal understandings and interpretations of the care received in hospital. This thesis addresses this important gap by providing rich and descriptive qualitative data on infant feeding healthcare experiences and hospital infant feeding care practices from mothers’ perspectives.

This study was designed in partnership with the Baby-Friendly Council of NL and NL Provincial Perinatal Program to support and advance their work on BFI assessment and monitoring in the province. At the time of this research, the Baby-Friendly Council of NL was researching infant feeding and BFI adherence in NL through province-wide surveys with mothers (Feeding infants in NL Study). Additionally, a physician and researcher from Memorial University (Dr. Anne Drover) was conducting research to assess compliance with the BFI Ten

Steps after an educational intervention for healthcare providers at maternity hospitals in the province through surveys with nurses, physicians, and other hospital staff. This thesis was designed to provide a complimentary and qualitative assessment of hospital adherence with BFI guidelines through an exploration of maternal infant feeding healthcare experiences at the Janeway Children's Hospital/Health Sciences Centre in St. John's, NL.

Using an interpretive phenomenological approach, thesis data were collected and analyzed through semi-structured interviews with mothers one to four weeks post-partum, focus groups with mothers up to twelve months post-partum, and a review of hospital infant feeding policies and protocols. Maternal hospital infant feeding experiences were used to indicate hospital adherence with BFI guidelines. Adherence to Steps 1 and 2 were not assessed in this research, as the routine communication of hospital policies to hospital staff (Step 1), and the training of health care staff with necessary skills to implement BFI policy (Step 2) were expected to be outside the knowledge spectrum of mothers.

The Janeway Children's Hospital in St. John's was selected as the location for this study because it is the only hospital in NL specializing in newborn and pediatric care. Attached to the Health Sciences Centre, General Hospital, and Dr. H. Bliss Murphy Cancer Centre, the Janeway Children's Hospital and Rehabilitation Centre has the largest birthing facility in the province, with approximately 2,500 deliveries each year (NLPPP, 2011). Due to the high number of deliveries at this facility, infant feeding practices within this hospital influence the largest population of mother-infant pairs in the province. Because mothers in this research experienced labour and delivery in the Janeway Children's Hospital, and recovery in the Health Sciences Centre attached, the hospital care facility in this study will be referred to as the Janeway Children's Hospital/Health Sciences Centre.

It is anticipated the Baby-Friendly Council of NL, NL Provincial Perinatal Program, Eastern Health Authority, and Janeway Children's Hospital/Health Sciences Centre will use the findings from this study to inform infant feeding programming, advocacy, and policy recommendations for greater compliance with BFI guidelines. Financial support for this research was provided by the Canadian Institute for Health Research (CIHR), the Research and Development Corporation (RDC) of NL, and Memorial University's Faculty of Medicine.

This study seeks to address the following research questions:

1. Do mothers' reported infant feeding experiences at the Janeway Children's Hospital/Health Sciences Centre indicate institutional adherence with Steps 3-10 of the BFI Ten Steps to Successful Breastfeeding?
2. What discrepancies, if any, exist between reported maternal infant feeding experiences at the Janeway Children's Hospital/Health Sciences Centre and Steps 3-10 of the BFI Ten Steps to Successful Breastfeeding?
3. What do maternal infant feeding experiences at the Janeway Children's Hospital/Health Sciences Centre reveal about opportunities to improve institutional compliance with the Steps 3-10 of the BFI Ten Steps to Successful Breastfeeding?
4. How do infant feeding documents (i.e., policies and protocols) at the Janeway Children's Hospital/Health Sciences Centre compare with recommendations for infant feeding outlined in the BFI?

This research seeks to achieve the following objectives:

1. Provide detailed information on hospital infant feeding practices at the Janeway Children's Hospital/Health Sciences Centre
2. Assess compliance with Steps 3-10 of the BFI Ten Steps to Successful Breastfeeding through an exploration of maternal hospital infant feeding experiences (where reported maternal experiences are used as an indicator of hospital compliance)
3. Review infant feeding documents (policies and protocols) from the Janeway Children's Hospital/Health Sciences Centre and compare them to international documents for infant feeding
4. Provide the Janeway Children's Hospital/Health Sciences Centre, Eastern Health Authority, NL Provincial Perinatal Program, and Baby-Friendly Council of NL with a

detailed assessment of hospital adherence with Steps 3-10 of the BFI Ten Steps to Successful Breastfeeding

5. Provide the Janeway Children's Hospital/Health Sciences Centre, Eastern Health Authority, NL Provincial Perinatal Program, and Baby-Friendly Council of NL with recommendations that can be used to inform infant feeding programming, advocacy, and policy recommendations for the improvement of institutional adherence with BFI guidelines

1.5 Thesis outline

This thesis consists of seven chapters. This chapter introduced the research problem, and provided background information on breastfeeding, the BFI, and infant feeding in NL. Chapter 2 engages with current academic literature on infant feeding, the BFI, Ten Steps to Successful Breastfeeding, factors influencing infant feeding practice, and BFI implementation in healthcare settings. Chapter 3 describes interpretive phenomenology, its application in the research, and the research methods applied. Chapters 4 and 5 present research results on hospital adherence with Steps 3-10 of the BFI and maternal experiences with infant feeding at the Janeway Children's Hospital/Health Sciences Centre. Chapter 6 provides an overview of hospital infant feeding policies and protocols at the Janeway Children's Hospital/Health Sciences Centre, and Chapter 7 discusses research results and recommendations for improved practice.

Chapter 2 Literature Review: Infant feeding and the BFI

2.1 Systematic literature search

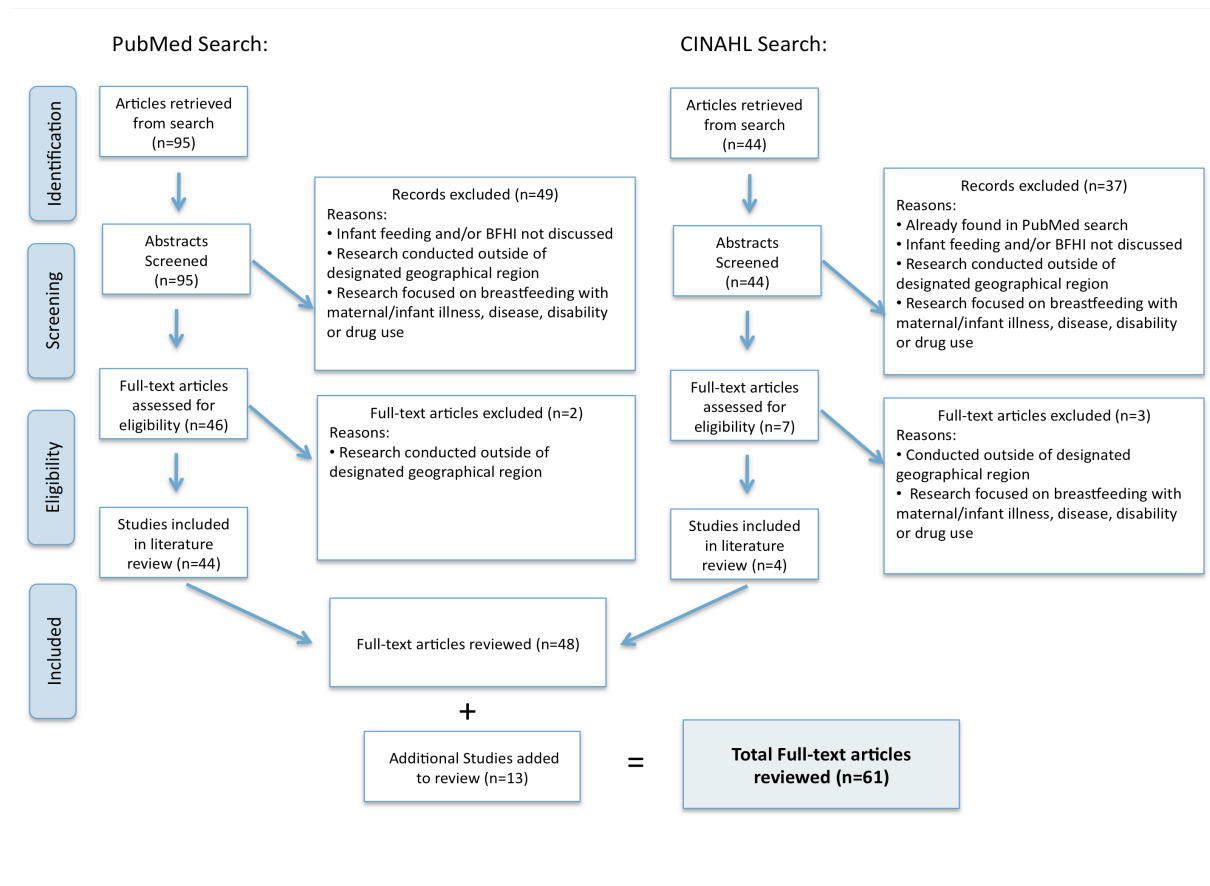
This chapter provides a systematic review of literature on infant feeding, Steps 1-10 of the WHO/UNICEF Baby-Friendly Initiative, and factors influencing breastfeeding initiation, duration and exclusivity. Literature was drawn from two databases, PubMed and CINAHL, that catalogue medical, nursing, and allied health professional research on breastfeeding. All English language studies conducted in North America, Europe, Australia or New Zealand, and published between 2002 and 2012 related to infant feeding and/or the BFI (and any of the Ten Steps to Successful Breastfeeding) were included.

Eligibility criteria were developed to ensure studies were current; conducted in geographic regions with similar socio-economic, medical, and water-quality conditions as those in Canada; and focused on infant feeding with mother-infant pairs who were free from medical conditions that may interfere with infant feeding practice. Studies focused on breastfeeding with HIV/AIDS, maternal/infant disease, illness, disability, or drug use, were excluded from review. In total, 48 full-text articles from this search met the search criteria. Thirteen primary studies referenced in the first set of articles were also included, bringing the total number of articles reviewed to 61. Of these, 47 were primary studies presenting new data, while 14 were secondary studies or opinion pieces. *Primary studies* refer to original quantitative or qualitative studies providing new/primary research data and include randomized and non-randomized control trials, case-control studies, cohort studies, and/or qualitative data generated through interviews, focus group discussions, observation or ethnography. *Secondary studies*, however, refer to all studies

that present, summarize, discuss or synthesize existing data without creating new primary data, such as systematic literature reviews and meta-analyses.

A critical synthesis of the literature is provided below (see Figure 2-1), using a model adapted from Moher, Liberati, Tetzlaff and Altman (2009).

Figure 2-1: Infant Feeding Systematic Literature Review Process



2.2 The Baby-Friendly Initiative: Evidence and dialogue

The BFI was developed by the WHO and UNICEF to improve maternal-infant health by increasing global rates of breastfeeding initiation, duration and exclusivity. The success of the BFI was well documented in the literature with consistent evidence supporting that Baby-

Friendly facilities improve rates of breastfeeding for the populations they serve (Broadfoot, Britten, Tappin & MacKenzie, 2005; Camurdan et al., 2007; Merewood, Mehta, Chamberlain, Phillip & Bauchner, 2005; Merten, Dratva & Ackermann-Liebrich, 2005; Philipp, Malone, Cimo & Merewood, 2003). Three influential studies examining the impact of the BFI are described below. These include a large randomized control trial from Belarus (Kramer et al., 2001), a nationwide study from the United States (Merewood et al., 2005), and a nationwide study from Switzerland (Merten et al., 2005).

The Promotion of Breastfeeding Intervention Trial (PROBIT) was the largest randomized control trial ever conducted in the field of human lactation, with the participation of 17,046 mother-infant pairs in the Republic of Belarus (Kramer et al., 2001). It was designed to assess the impact of the BFI on breastfeeding duration and exclusivity by comparing data on the infant feeding practices and health indicators of babies born in accredited BFI hospitals with those of infants born in non-BFI hospitals. Belarus was selected as the intervention site for this research because it had similar health services, sanitary conditions, and water quality as other developed countries. Mother-infant pairs were drawn from 31 hospitals, of which 16 were randomly selected to model the Baby-Friendly Hospital intervention, and 15 were randomly assigned to continue with usual infant feeding hospital practices. Each hospital selected to model the BFI received training for all staff providing care to mothers and infants and all resources necessary to model the BFI. These were extensively monitored throughout the duration of the study to ensure ongoing compliance with each of the WHO/UNICEF BFI Ten Steps to Successful Breastfeeding.

To participate, mothers had to intend to breastfeed, deliver a healthy full-term infant (singleton birth) weighing more than 2500g between June 1996 and December 1997, and be free of any health conditions or complications. Data were collected from each mother-infant pair at

1, 2, 3, 6, 9, and 12 months, on mode of feeding, infant feeding practices, infant length, weight, head circumference, number of infant clinical visits and hospitalizations, and the occurrence of any respiratory infections, gastrointestinal infections, and rashes. The study compared outcomes from two groups of breastfed infants – those born in a BFI facility, and those born in a non-BFI facility. For this reason, PROBIT does not provide data demonstrating the full benefits of breastfeeding by comparing breastfed versus not breastfed infants, but rather demonstrates the impact of the BFI on breastfeeding duration, exclusivity, and infant health outcomes, when compared with outcomes from non-BFI facilities (Kramer et al., 2001; Martens, 2012).

Results indicated that infants who received the BFI intervention were breastfed exclusively for a longer duration, were breastfed as a mode of complementary feeding for a longer duration, and experienced fewer hospitalizations, gastrointestinal infections, and cases of atopic eczema than infants who were not born in a BFI facility (Kramer et al., 2001; Martens, 2012). Indeed, “the proportion of women exclusively breastfeeding at 3 months was 7-fold higher in the experimental group (43.3% vs. 6.4%); and more than 12-fold higher at 6 months (7.9% vs. 0.6%)” (Kramer et al., 2001, p. 417). In addition to improving rates of exclusive feeding, the BFI intervention was found to decrease the risk of gastrointestinal tract infection in the first year by 40% and reduce the occurrence of atopic eczema by 46% for infants born in BFI facilities versus non-BFI facilities. Study results indicate that the BFI is an effective strategy for increasing breastfeeding rates and improving infant health outcomes in the first year of life. Results also provide valuable baseline data for follow-up on long-term health benefits of BFI practices.

Kramer and authors (2007a) conducted follow-up research on the PROBIT study in Belarus 6.5 years following the intervention to assess the impact of BFI practices on asthma and

allergy, child behaviour, height, weight, blood pressure, childhood obesity, and cognitive development. Results indicated that although children born in a BFI facility were breastfed for a longer duration, they did not have a reduced risk of asthma or allergy and did not demonstrate behavioural differences when compared to children delivered in non-BFI facilities (Kramer et al., 2007a, 2008a). Additionally, no significant differences were found among groups when assessing child height, weight, or blood pressure (Kramer et al., 2007a, 2009). Significant differences were found however when comparing child cognitive development among BFI and non-BFI intervention groups. Children from the BFI group were found to have higher IQ scores, higher Wechsler Abbreviated Scale of Intelligence (WASI) scores, and higher overall teacher assessments (focused on reading, writing, and mathematics skills) than those in the non-BFI group (Kramer et al., 2008b).

The effectiveness of the BFI was also explored in a nationwide study in the United States. Merewood and colleagues (2005) reviewed hospital records for 34,365 mother-infant pairs (from 28 BFI institutions) to compare rates of breastfeeding initiation and exclusivity with national rates. Results indicated a significant difference in rates of breastfeeding initiation (83.3%) and exclusivity (78.4%) for mother-infant pairs cared for in BFI facilities compared to the national average of 69.5% and 46.3%, respectively. In addition, higher rates of breastfeeding in BFI facilities were found to continue regardless of the presence of demographic factors commonly associated with low breastfeeding rates, such as low family income or educational attainment. The higher rates of initiation and exclusivity found among mother-infant dyads in BFI facilities indicate that the BFI is a successful initiative for improving breastfeeding rates.

Similar results were reported in a study involving 2,861 mother-infant pairs from 145 health facilities across Switzerland (Merten et al., 2005). Rates of breastfeeding initiation,

duration, and exclusivity were found to be significantly higher among mother-infant pairs who received care in a BFI facility compared with those who did not. Although all hospitals were not designated BFI facilities, hospitals with the greatest adherence to WHO/UNICEF guidelines had the highest rates of breastfeeding duration. Together these studies provide compelling evidence in support of the BFI as an effective initiative for improving rates of breastfeeding initiation, duration, and exclusivity.

2.3 The WHO/UNICEF Ten Steps to Successful Breastfeeding

2.3.1 Step 1 – Have a written breastfeeding policy that is routinely communicated to all health care staff

Healthcare policies are designed to shape programs and guide professional practice for a consistent standard of patient care aligned with healthcare goals. The implementation of an effective health policy depends upon a number of factors, such as how well the policy is communicated, understood, and valued by those who implement it; how easy it is to implement in the face of institutional or other barriers; and how well it is monitored (Perrine et al., 2011).

The first step towards becoming a BFI-designated facility involves developing and communicating a breastfeeding policy that supports the BFI Ten Steps to Successful Breastfeeding and adheres to the International Code of Marketing of Breast Milk Substitutes (UNICEF/WHO, 2009). Developing a sound policy aligned with BFI guidelines was discussed in 7 of the 61 studies in this review as a vital component for improving healthcare practices in support of breastfeeding.

Weddig, Baker and Auld (2011) emphasized the need for a strong breastfeeding policy in their study of the breastfeeding knowledge and care practices of nurses within eight American hospitals. When assessing gaps between knowledge and care practices, they found discrepancies

between best-practices for infant feeding, and the knowledge and healthcare practices of maternity care nurses, as well as between hospital policies and evidence-informed policies. Authors noted the critical role of policy in breastfeeding health promotion stating, “a significant barrier to supporting breastfeeding is lack of hospital policy and inappropriate or outdated policy” (p. 166). While these findings support a need for educational and training programs for healthcare professionals (Step 2), they also highlight a need for the development and communication of evidence-informed hospital policies to healthcare providers (Step 1).

Dyson and colleagues (2009) also acknowledged the importance of policy for infant feeding hospital practice. Their study focused on developing a comprehensive list of infant feeding policy recommendations to improve maternal-infant healthcare delivery in the United Kingdom. Drawing data from evidence-informed literature and consultations with 605 healthcare practitioners, 25 key policy recommendations were developed. Recommendations included the development of a coordinated national infant feeding policy aligned with the BFI Ten Steps, the elimination of all policies/procedures conflicting with BFI recommendations, and the development and provision of post-partum follow-up supports. Strategies for policy implementation were also provided. When striving to transition from routine hospital practices towards BFI best-practice standards, a strong breastfeeding policy provides the foundation from which new –and evidence-informed – practices emerge.

2.3.2 Step 2 – Train all health care staff in skills necessary to implement this policy

While a strong breastfeeding policy is vital for achieving BFI designation, policy alone is insufficient for creating change. To quote Perrine and colleagues (2011), “policy does not necessarily indicate practice. To improve practice, hospitals will need to ensure that staff members are sufficiently trained to carry out strong breastfeeding policies, and routinely assess

adherence” (p. 1023). The BFI recommends that all healthcare personnel working with pregnant women, mothers, and babies, be informed about hospital breastfeeding policies, and that at least 80% of clinical staff complete a 20-hour training course modeled after the BFI course program with a minimum of three hours of clinical supervision in the first six months of employment (UNICEF/WHO, 2009). The 20-hour course for healthcare providers focuses on:

the risks and benefits of various feeding options; helping the mother choose what is acceptable, feasible, affordable, sustainable and safe (AFASS) in her circumstances; the safe and hygienic preparation, feeding and storage of breast-milk substitutes; how to teach the preparation of various feeding options, and how to minimize the likelihood that breastfeeding mothers will be influenced to use formula.
(UNICEF/WHO, 2009 p. 32-33)

Such training programs are designed to provide healthcare providers with the information and skills needed to effectively implement a breastfeeding policy aligned with the BFI Ten Steps.

In addition, the BFI requires that at least 80% of clinical staff are able to correctly answer four of five questions on breastfeeding promotion and support, and are able to describe two issues to discuss with a mother who indicates a desire to feed her baby with foods other than breast milk (UNICEF/WHO, 2009). For non-clinical staff providing care to pregnant women and mothers, at least 70% must report that they have received training in the promotion and support of breastfeeding, and are able to describe at least one reason breastfeeding is important, one practice to support breastfeeding, and one thing they can do to support mothers to breastfeed (UNICEF/WHO, 2009). The importance of infant-feeding education and training for health professionals was discussed in 10 of the 61 studies in this review.

Education and training interventions aligned with the WHO/UNICEF 20-hour program were found to improve infant feeding rates and overall compliance with the Ten Steps. In a cohort study exploring the impact of 24-hour health professional training programs on BFI

implementation in eight Italian hospitals, Cattaneo and Buzzetti (2001) found that compliance with the Ten Steps improved from a mean implementation of 2.4 steps before training to a mean implementation of 7.7 steps after training. They reported significant improvements in rates of exclusive breastfeeding upon hospital discharge and at three months, and improvements in any breastfeeding at six months for women who delivered after the health professional training intervention took place. Similarly, Zakarija-Grkovic and authors (2012) found statistically significant improvements in hospital compliance with Step 4, Step 7, and Step 8, and in rates of exclusive breastfeeding upon discharge following the completion of a WHO/UNICEF 20-hour course for healthcare providers in Croatia. Statistically significant improvements in compliance with Step 6 and Step 7 were also noted following a similar training intervention in France (Durand, Labarere, Brunet & Pons, 2002).

Infant feeding training programs may also improve the confidence and ability of health professionals to address breastfeeding issues and concerns. A prospective cohort study of 288 mothers and their clinicians revealed a strong correlation between clinician practices and infant-maternal feeding practices (Taveras et al., 2004). Using multivariate statistical analysis, researchers found that mothers were more likely to discontinue exclusive breastfeeding by 12 weeks postpartum if their pediatricians had recommended formula supplementation for infant weight gain, or thought providing infant feeding advice to mothers was not important. Clinicians' main complaint was their lack of confidence addressing infant feeding problems; obstetricians reported feeling least confident with resolving low breast milk production; and pediatricians with resolving breast pain, tenderness, or cracked nipples. Researchers concluded that policies to enhance clinician comfort with addressing infant feeding problems would likely improve the promotion of breastfeeding.

A literature review of 15 studies exploring the impact of training on health professionals concluded that, “continuing breastfeeding education improves the knowledge, clinical skills and practices, and counseling skills of nurses and midwives and it improves the Baby-Friendly Hospital Initiative compliance of institutions” (Ward & Byrne, 2011, p. 381). It was also noted that the benefits of health worker training accrue regardless of an institution’s commitment to BFI guidelines.

This literature indicates that health professional training can significantly improve BFI policy implementation and overall infant feeding outcomes. Together these studies highlight the need for breastfeeding training programs that provide health professionals with the skills, knowledge, and confidence needed to meet and address breastfeeding challenges.

2.3.3 Step 3 – Inform all pregnant women about the benefits and management of breastfeeding

Effective communication in pregnancy about the benefits and management of breastfeeding is important for maternal breastfeeding decision-making, commitment, and success (Betzold, Laughlin & Shi, 2007; Levitt et al., 2011). BFI guidelines recommend that all pregnant women be informed about:

the importance of breastfeeding, the importance of immediate and sustained skin-to-skin contact, early initiation of breastfeeding, rooming-in on a 24 hour basis, feeding on cue or baby-led feeding, frequent feeding to help assure enough milk, good positioning and attachment, exclusive breastfeeding for the first 6 months, the risks of giving formula or other breast-milk substitutes, and the fact that breastfeeding continues to be important after 6 months when other foods are given.
(UNICEF/WHO, 2009, p. 33)

In assessing compliance with this step, the BFI requires that a minimum of 70% of pregnant women who have attended at least two antenatal appointments be able to confirm that they have received information on breastfeeding from a healthcare provider, and be able to explain what

was discussed about two of three topics: skin-to-skin contact, rooming-in, and risks of supplementation (UNICEF/WHO, 2009). If less than 70% of women are able to do this, adherence to Step 3 is not granted for the institution. The importance of informing women in pregnancy about the benefits and management of breastfeeding was discussed in 6 of the 61 articles reviewed.

The literature shows a positive correlation between breastfeeding education in pregnancy and improved rates of breastfeeding initiation and duration. A systematic review and meta-analysis assessed the impact of primary healthcare interventions on rates of breastfeeding initiation and duration (Guise et al., 2003). The review included 30 randomized and non-randomized control trials and 5 systematic reviews. Results indicated that educating women about the benefits and management of breastfeeding had the greatest positive effect breastfeeding initiation and continuation for up to six months, and that longer-term programs had a greater positive effect than shorter programs. The study also found that the provision of written materials did not significantly improve breastfeeding rates, reaffirming the importance of more active approaches to prenatal care.

Similarly, a descriptive study of a nationally representative sample of 1,229 women in the United States reported breastfeeding initiation rates of 74.6% among women who were encouraged by their physicians to breastfeed, versus 43.2% among women who were not encouraged (Lu, Lange, Slusser, Hamilton & Halfon, 2001). Overall, women who were encouraged by their physicians to breastfeed were more than four times as likely to initiate breastfeeding than those who were not. Physician encouragement improved initiation rates across all income and education levels. The largest improvements were among women with

higher levels of education and with higher incomes, suggesting a link between effective communication about breastfeeding and the social determinants of income and education.

A nationwide infant feeding study of 6,421 women conducted by PHAC assessed compliance with Steps 3-10 in Canadian hospitals and found that 89.2% to 94.9% of women reported receiving sufficient information about breastfeeding in pregnancy (Chalmers et al., 2009). Although this suggests that Step 3 may be widely implemented in Canada, information may also follow social gradients in education and income, as well as other factors. In the same study, authors found that young women, first-time mothers, women with low levels of education, low household income, and vaginal deliveries were less likely to report being informed in pregnancy of the benefits and management of breastfeeding. This suggests that social determinants may shape both the information provided to women by their healthcare providers, and their ability to access, understand, and feel satisfied with the health information received.

2.3.4 Step 4 – Help mothers initiate breastfeeding within a half-hour of birth. Place babies in skin-to-skin contact with their mothers immediately following birth for at least an hour. Encourage mothers to recognize when their babies are ready to breastfeed and offer help if needed.

Skin-to-skin contact involves placing the undressed newborn infant on the mothers' bare chest immediately following delivery. Once against its mother, the infant should be covered with blankets to maintain a comfortable body temperature and kept against its mothers' bare skin for a minimum of one hour, unless there is a medical reason for separation. During skin-to-skin contact, the BFI advises that mothers are encouraged to breastfeed and are assisted with breastfeeding initiation if their infant demonstrates a readiness to feed. To meet BFI standards for Step 4, hospital facilities must be able to confirm that at least 80% of infants delivered vaginally received skin-to-skin contact within five minutes of birth for a minimum of one hour

(unless medically justified), and that mothers were encouraged to breastfeed and offered help to breastfeed if their infant presented feeding cues during skin-to-skin (UNICEF/WHO, 2009). For mothers who delivered through caesarean section under general anesthesia, the BFI requires that at least 50% experienced skin-to-skin once the mother was alert (UNICEF/WHO, 2009). Early breastfeeding initiation and skin-to-skin contact was discussed in 11 of the 61 articles in this review.

Immediate skin-to-skin contact following delivery was found to enhance maternal-infant bonding and improve rates of breastfeeding duration. In a Cochrane review of 30 randomized and quasi-randomized control trials involving 1,925 mother-infant pairs, a significant relationship was found between early skin-to-skin contact and longer breastfeeding duration. The authors noted, “statistically significant and positive effects of early SSC [skin-to-skin contact] on breastfeeding at one to four months post birth (10 trials; 552 participants), and breastfeeding duration (seven trials; 324 participants)” (Moore, Anderson & Bergman, 2009, p. 1). They also reported higher rates of maternal attachment among mother-infant pairs who experienced early skin-to-skin contact than those who did not. Similarly, Lawrence and Lawrence (2011) linked the practice of skin-to-skin contact to improved mother-infant attachment behaviour and longer breastfeeding duration. In addition, a prospective cohort study in Poland reported that infants who received at least 20 minutes of uninterrupted skin-to-skin contact following delivery were exclusively breastfed for 1.35 months longer and were weaned off the breast 2.10 months later, than infants who did not receive skin-to-skin contact (Mikiel-Kostyra, Mazur & Boltruszko, 2002). Together these studies provide compelling evidence in support of immediate skin-to-skin contact following childbirth.

The benefits of early breastfeeding initiation were less clearly identified in the literature than those of skin-to-skin contact. In their study on BFI practices and breastfeeding duration, Pincombe and authors (2006) found no association between the initiation of breastfeeding within the first hour of birth and improved breastfeeding duration. Similarly, Rowe-Murray and Fisher (2002) reported no association between early breastfeeding initiation and the continuation of breastfeeding for up to eight months. In contrast, DiFrisco and colleagues (2011) found that mothers who initiated breastfeeding within the first hour were significantly more likely to still be exclusively breastfeeding two and four weeks postpartum than mothers who did not initiate breastfeeding within the first hour following birth. Although results on the benefits of early breastfeeding initiation varied, literature consistently evidenced benefits of early skin-to-skin contact.

Studies indicated that infants born through cesarean section were less likely to experience skin-to-skin contact and breastfeeding immediately following delivery than infants born vaginally (DiFrisco et al., 2011; Rowe-Murray & Fisher, 2002; Sarasua, Clausen & Frunchak, 2009). Rowe-Murray and Fisher (2002) compared the delay experienced by women with operative deliveries from the time of delivery to the time of first skin-to-skin contact and breastfeeding in BFI and non-BFI hospitals in Australia. The study reported better hospital practices at the BFI facility with significantly shorter times between delivery and first mother-infant contact. A number of practices were recommended to promote early skin-to-skin and breastfeeding following operative delivery. These included: the elimination of immediate routine infant observation for healthy newborns, the delay of infant examinations and procedures until after skin-to-skin and first feeding, the presence of a midwife or nurse who is able to care for the baby next to (or on) the mother while the operation is completed, the ability to regulate

temperature through skin-to-skin contact, and the ability for mother and infant to remain together while transported into recovery area (Rowe-Murray & Fisher, 2002). Outcomes highlight that despite the barrier caesarean delivery poses to the implementation of Step 4, strategies can be implemented to support early skin-to-skin contact and breastfeeding.

Although the benefits of skin-to-skin contact are well evidenced, hospital routines in industrialized countries frequently separate mother-infants dyads and wrap infants following delivery (Forster & McLachlan, 2007; Moore et al., 2009). In Canada, PHAC found that “although 71.9 percent (95% CI 70.7 – 73.2) of women held their baby within five minutes of birth, less than one-third of women held their baby skin-to-skin” (Chalmers et al., 2009, p. 126). While the reasons for separation following uncomplicated vaginal birth may be linked to outdated routines, the perceived need to regulate infant temperature with clothing, or the perceived need for immediate infant exams, these were not widely discussed in the literature.

2.3.5 Step 5 – Show mothers how to breastfeed, and how to maintain lactation even if they should be separated from their infant

The BFI recommends that all mothers are shown how to properly position their infant for feeding, establish and check their latch, determine when their baby is properly attached and suckling, hand express their milk, and if supplementing, how to prepare and feed with formula (UNICEF/WHO, 2009). Showing mothers how to breastfeed and how to maintain lactation if separated from their baby is important for both establishing early breastfeeding success, and for supporting the continuation of breastfeeding through circumstances involving mother-infant separation (Declercq, Lobbok, Sakala & O’Hara, 2009). This ensures mothers have the skills needed to breastfeed, avoid complications that may arise from improper positioning and latching,

and maintain lactation if separated. In this review, 5 of the 61 studies discussed the importance of showing mothers how to breastfeed and how to maintain lactation.

To become a designated BFI facility, guidelines require that a minimum of 80% of breastfeeding mothers are offered breastfeeding assistance within 6 hours of birth, offered help with positioning and attaching their baby, are shown how to hand express their milk or provided with information on hand milk expression, and are able to demonstrate or describe correct positioning and signs of successful attachment and suckling (UNICEF/WHO, 2009). Of mothers who decide to not breastfeed, at least 80% must report they were shown how to prepare milk, how to feed their baby, and must be able to prepare milk on their own and describe the feeding advice they were given. In addition, at least 80% of clinical staff must report teaching mothers how to position and attach their baby and how to hand express milk, and must be able to describe or demonstrate accurate positioning, attachment, and hand expression techniques. A minimum of 80% of clinical staff must also be able to describe how to help supplementing mothers prepare feeds or where to refer them for advice.

Maternal-infant separation requires special milk expression and storage techniques for the establishment and continuation of breastfeeding (Philipp & Merewood, 2004). Separation is common if an infant is admitted into a neonatal intensive care unit (NICU), or if a mother is hospitalized or must return to work shortly after delivery (Declercq et al., 2009). Because such circumstances prevent regular breast stimulation and feeding from the infant, techniques for how to establish and maintain lactation (and how to store and feed expressed milk) are critical for breastfeeding success.

Declercq and colleagues (2009) explored the relationship between maternal intention to breastfeed, hospital infant feeding experience, and breastfeeding exclusivity one-week post-

partum, and found that mothers who were shown how to breastfeed and maintain lactation while in hospital were more likely to be exclusively breastfeeding at one week than mothers who were not. Moreover, 69% of mothers who intended to exclusively breastfeed and received help with breastfeeding in hospital were exclusively breastfeeding at one week, while only 33% of mothers who intended to exclusively breastfeed but did not receive help with breastfeeding in hospital were exclusively breastfeeding at one week.

In Canada, 80.7% of mothers reported they were shown in hospital how to breastfeed and how to maintain lactation if separated from their infant (Chalmers et al., 2009). Interestingly, another Canadian study assessing compliance to Step 5 through reported data from hospital nurses found that compliance to Step 5 ranged from 64% in the province of Alberta to 100% in the provinces of NL and Prince Edward Island (Levitt et al., 2011). Differences in reported compliance rates may indicate biased reporting, possibly recall bias on the part of mothers, or self-representation bias on the part of hospital nurses.

2.3.6 Step 6 – Give newborn infants no food or drink other than breastmilk unless *medically indicated*

The importance of feeding no food or drink other than breast milk unless medically indicated was evidenced in 12 of the 61 studies reviewed. Because the immunological and nutritional benefits of breast milk are strongest with exclusive feeding, the practice avoiding formula supplementation, both in hospital and following discharge, is of critical importance. Lawrence and Lawrence (2011) noted that, “a very clear dose-response relationship has been documented between the amount (full [exclusive], partial, token) and duration of breastfeeding and the benefits gained by the infant and mother” (p. 271). In addition to this dose-response relationship, a number of studies discussed a link between in-hospital supplementation and the

early cessation of breastfeeding (Agboado, Michel, Jackson & Verma, 2010; Declercq et al., 2009; Merten et al., 2005; Perrine et al., 2011).

Declercq and authors (2009) found that a representative sample of 1,573 American mothers were less likely to achieve their exclusive breastfeeding goals if their infant had received formula before hospital discharge. They noted,

The practice of hospital staff providing formula or water to supplement breastfeeding was significantly related to failure to achieve exclusive breastfeeding. Mothers whose babies did not experience supplementation were 4.4 times (primiparas) or 8.8 times (multiparas) more likely to achieve their intention to exclusively breastfeed. (p. 933)

Similar results were reported in a Swiss study examining the influence of hospital compliance with the BFI Ten Steps on breastfeeding duration. The study included data from 3,032 mothers and 2,861 infants, and found that,

If a child had been exclusively breastfed in the hospital, the median duration of exclusive, full, and any breastfeeding was considerably longer than the mean for the entire population or for those who had received water-based liquids or supplements in the hospital. (Merten et al., 2005, p. 702)

Similar outcomes were reported by others (Giovannini et al., 2005; Pincombe et al., 2006), who supported exclusive breastfeeding unless there was a medical reason for supplementation.

Despite this, PHAC found that in Canada “35.8 percent of women reported being given or offered free formula samples by their health care practitioners” (Chalmers et al., 2009, p. 129). Formula was most commonly offered to women who were young, first-time mothers, delivering by cesarean section, and living on a low income with a low level of education. These numbers suggest room for improvement with breastfeeding promotion and the use and distribution of formula in Canadian hospitals.

In order to meet BFI requirements for Step 6, a healthcare facility must be able to demonstrate that at least 80% babies are fed with breast milk or banked human milk, unless medically indicated, and that 80% of mothers who decided not to breastfeed had a clinical staff member discuss feeding options and help them choose an appropriate feeding method (UNICEF/WHO, 2009). Additionally, observation within maternity rooms and wards must demonstrate that at least 80% of infants are fed with breast milk unless there is a medical reason for supplementation (UNICEF/WHO, 2009).

2.3.7 Step 7 – Practice rooming-in – allow mothers and infants to remain together 24 hours a day

The practice of rooming-in refers to keeping mothers and infants together in the same room for 24 hours a day for the duration of their hospital stay. Rooming-in provides mothers and infants with frequent opportunities for close contact, including opportunities for skin-to-skin contact, suckling, breastfeeding on demand, and the learning of infant feeding cues (Cramton, Zain-Ul-Abideen & Whalen, 2009; UNICEF/WHO, 2009). To become a Baby-Friendly institution, a minimum of 80% of mothers randomly selected must report experiencing 24 hour rooming-in with their infant, or if not, must have a medical reason to justify separation (UNICEF/WHO, 2009). Rooming-in was detailed in 6 of the 61 studies in this review.

Rooming-in was reported to have a number of positive effects on breastfeeding such as: providing mothers with the ongoing proximity needed to learn and respond to infant feeding cues, enhancing maternal confidence, enhancing milk production, and improving breastfeeding duration (Bohling-Smith, Moore & Peters, 2012; Bystrova et al., 2007; Merten et al., 2005). Bohling-Smith and authors (2012) encouraged rooming-in to promote feeding on demand by providing mothers with the ability to learn and respond to infant feeding cues, enhance maternal

breastfeeding confidence, and provide reassurance that infants are well. Interestingly, Bystrova and colleagues (2007) found that Russian mothers who roomed-in with their infants and fed on-demand also had higher milk production than mothers who were separated from their infant and fed according to a schedule. Although Pincombe and authors (2006) found no association between rooming in and longer breastfeeding duration, two studies (one from Switzerland [Merten et al., 2005], a second from Italy [Giovannini et al., 2005]), reported a positive link.

The practice of rooming-in ranges broadly in Canada from 16.7% to 78.6% (excluding all infants admitted to NICU after birth) with rooming-in most commonly occurring in Canada's western provinces (Chalmers et al., 2009). These findings indicate a need for change across all Canadian hospitals to better support rooming-in and other Baby-Friendly practices.

2.3.8 Step 8 – Encourage breastfeeding on demand

Breastfeeding on demand involves allowing the timing and duration of feeding to be determined by the infant through feeding cues, rather than by a fixed or timed schedule. This practice is recommended for optimal breastfeeding success, and has been linked to increased milk production, higher milk consumption, and longer breastfeeding duration (Bystrova et al., 2007; DiGirolamo, Grummer-Strawn & Fein, 2008). To meet BFI standards for Step 8, at least 80% of mothers must report being told how to recognize when their baby is hungry, and must be able to describe a minimum of two infant feeding cues (UNICEF/WHO, 2009). At least 80% of mothers must also report that they have been instructed to feed for as long and as often as the baby wishes (UNICEF/WHO, 2009). In this review, the importance of breastfeeding on demand was discussed in 10 of 61 studies.

Close contact and frequent suckling are important for lactation because they stimulate the production and release of prolactin and oxytocin – important milk-producing hormones (Philipp

& Merewood, 2004). These hormones increase milk production to meet infant feeding needs and are important for the establishment of successful breastfeeding. Philipp and Merewood (2004) noted that,

Frequent suckling stimulates the release of the hormones prolactin and oxytocin [which increase milk production]. Infants should go to the breast 8 to 12 times in 24 hours when they demonstrate feeding cues, and they should not be on a schedule. (p. 769)

Bystrova and authors (2007) found that mothers who roomed-in and fed on demand experienced higher milk production and higher infant milk consumption, than mothers who did not room in and who fed according to a fixed schedule. An association between feeding on demand and higher milk production was also discussed by Forster and McLachlan (2007), who linked feeding on demand with protection against low milk production.

Additionally, evidence suggests a potential match between a mother's milk fat content and milk volume, and her infant's needs. Kent and authors (2006) found that the volume of milk produced and consumed from each breast varied with each feeding in a 24-hour period, along with the fat content of milk. Although they found the amount of fat consumed by an infant was not influenced by the frequency of feeding, they found that the fat content of breast milk varied throughout the day, with the highest volume of breast milk consumed in the day and the lowest in the evening. This evidence can be used to support feeding on demand, as it provides infants with an opportunity to regulate their feeding behaviour (length and timing of feeding) according to their needs.

Evidence on the association between feeding on demand and breastfeeding duration was not conclusive. While Pincombe and colleagues (2006) found no association between feeding on

demand and longer breastfeeding duration in their study, Giovannini and authors (2005) found a longer duration of exclusive breastfeeding among mothers who practiced feeding on demand.

Although cue-based feeding is highly recommended in the literature, many hospital facilities continue to promote scheduled feeding (WHO, 2007). For example, in Canada,

rates of demand feeding ranged from 40.3 to 66.5 percent across the country. Older, multiparous, more highly educated women, those living in a household with an income level above the low-income cutoff, and those having vaginal births were more likely to demand feed their babies. (Chalmers et al., 2009, p. 129)

This indicates room for improvement with how on-demand feeding is promoted and supported in Canadian hospitals. It also suggests that social determinants of health, such as income and education, have a role in shaping maternal hospital and breastfeeding experiences.

2.3.9 Step 9 – Give no artificial teats or pacifiers (also called dummies or soothers) to breastfeeding infants

Because successful breastfeeding depends upon the establishment of effective latching and sucking patterns, pacifiers and artificial nipple attachments are not recommended for breastfeeding infants (UNICEF/WHO, 2009). Pacifier use among infants can lead to a phenomenon called *nipple confusion* – difficulty with establishing latching and sucking patterns necessary for the extraction of milk after use of an artificial nipple, such as a bottle or pacifier (Benis, 2002; Jaafar, Jahanfar, Angolkar & Ho, 2012). Additionally, artificial nipples may satisfy infant urge to suck, and thereby reduce their desire to stimulate the nipple and encourage milk production. As Agboado and colleagues (2010) note, “the innate sucking reflex of the infant is satisfied by the teat, decreasing or eliminating the desire for contact with the nipple leading to reduction in breast milk production” (p. 8). For these reasons, the use of pacifiers and/or artificial nipples is discouraged in the BFI.

To meet guidelines for Step 9, maternity ward and room observation must demonstrate that at least 80% of breastfeeding infants are not using pacifiers or bottles with artificial nipple attachments, and if they are, mothers have been informed of the risks (UNICEF/WHO, 2009). The BFI also requires that at least 80% of mothers must also report that their infant has not used a pacifier or a bottle with an artificial nipple attachment.

In this review, 11 of 61 studies engaged with the use of artificial teats and/or pacifiers. Evidence about the impact of pacifier use on breastfeeding was mixed, with some studies emphasizing the importance of pacifier/artificial nipple avoidance, and others demonstrating no negative consequences of pacifier use. It is noteworthy that no studies encouraged pacifier use within the first month of age.

PHAC reports suggest that pacifier use is relatively common among newborn Canadian infants with 44.4% of breastfeeding women reporting they had given a pacifier or soother to their newborn in the first week of life (Chalmers et al., 2009). Because newborns are often discharged from hospital within a day or two following birth, it is unclear whether pacifiers were first introduced at home or in Canadian hospitals. To promote greater compliance with Step 9 of the BFI, it is important parents are informed in hospital of the potential risks of early pacifier use.

A study exploring factors associated with breastfeeding cessation among 2,107 women in the United Kingdom found an association between pacifier use and shorter duration of breastfeeding (Agboado et al., 2010). “Mothers who gave teats to their babies breastfed for a mean duration of 17.2 weeks (median: 17 weeks) compared with 22.8 weeks (median: 27 weeks) for those who did not” (p. 7). An Australian study reported an association between pacifier avoidance and longer breastfeeding duration (Pincombe et al., 2006). Similar findings were reported by Declercq and authors (2009) who found that pacifier use was significantly associated

with failing to meet exclusive breastfeeding intention. Although Benis (2002) reported an association between pacifier use and early weaning from breastfeeding, she proposed that “the use of pacifiers may be a marker for breastfeeding difficulties or reduced motivation by a mother to breastfeed, as opposed to being a cause of early weaning” (p. 265). This suggests the need for additional research exploring when and why pacifiers are used, and how motivation behind use influences breastfeeding duration and exclusivity.

In contrast to the outcomes discussed above, a Cochrane review exploring the impact of pacifier use on breastfeeding duration found no association between pacifier use and duration of exclusive breastfeeding for mothers with healthy babies who intended to exclusively breastfeed. In the meta-analysis, combining two randomized control trials with data from 1,915 infants, it was found that,

Pacifier use in healthy full-term breastfeeding infants had no significant effect on the proportion of infants exclusively breastfed at three months (RR 1.00; 95% CI 0.95 to 1.06), and at four months of age (RR 0.99; 95% CI 0.92 to 1.06) and also had no effect on the proportion of infants partially breastfed at three months (RR 1.00; 95% CI 0.97 to 1.02), and at four months of age (RR 1.01; 95% CI 0.98 to 1.03). (Jaafar et al., 2012, p. 1)

The review also noted that when mothers were motivated to exclusively breastfeed, pacifier use did not impact breastfeeding duration. Despite these results, the authors noted that the impact of pacifier use on breastfeeding duration for women less motivated to exclusively breastfeed was not explored.

Although results on the impact of pacifier use varied, no evidence was found to encourage neonatal pacifier use, and no negative impacts of early pacifier avoidance were reported. The American Academy of Pediatrics, however did recommend pacifier use for sleeping infants four weeks of age and older, because of its ability to protect against SIDS

(Eidelman & Schanler, 2012). Because pacifiers and artificial nipples may cause nipple confusion and reduce the amount of time an infant suckles and stimulates the nipple, recommendations for their avoidance in the days and weeks following delivery are supported in the BFI. More research is needed on the impact of (and motivation behind) early pacifier/artificial nipple use and breastfeeding outcomes.

2.3.10 Step 10 – Foster the establishment of breastfeeding support groups and refer mothers to them on discharge from the hospital or clinic

Breastfeeding support groups are important to ensure mothers are provided with the support needed in the days, weeks, and months following hospital discharge. Often organized through hospitals and run by public health nurses and/or lactation consultants, support groups provide mothers with opportunities to receive breastfeeding information, assistance, and instruction, to ask questions, and to connect with other breastfeeding moms. The BFI recommends hospital facilities foster the establishment of breastfeeding support groups, provide mothers with information about where to get breastfeeding support once discharged from the hospital, and encourage mothers to be seen by a breastfeeding health professional in the community within the first two to four days following birth (UNICEF/WHO, 2009). For a facility to meet Step 10 of the BFI, a minimum of 80% of mothers must report receiving information about breastfeeding support groups and/or other community health services for breastfeeding assistance before hospital discharge. Of the 61 articles in this review, 9 emphasized the importance of post-partum breastfeeding follow-up support.

In a Cochrane review of 13 studies exploring the impact of health professional support on breastfeeding duration, an association was found between postpartum breastfeeding follow-up support and longer breastfeeding duration (Sikorski, Renfrew, Pindoria & Wade, 2000).

Similarly, a case-control study exploring the relationship between breastfeeding support group attendance and breastfeeding duration and exclusivity in Croatia revealed that mothers who attended more than four breastfeeding support groups breastfed for a longer duration than mothers who did not (Bosnjak, Grguric, Stanojevic & Sonicki, 2009). The study also found that mothers most likely to regularly attend breastfeeding support groups had an intention to breastfeed for more than 6 months, a higher income level, and did not smoke during pregnancy. These results indicate a positive association between breastfeeding support group attendance and longer breastfeeding duration, and also highlight socio-economic factors that may shape and influence breastfeeding motivation, support group attendance, and duration.

It should be noted that some types of post-partum breastfeeding follow-up care may be more effective than others. Pincombe and colleagues (2006) found that mothers who received face-to-face home follow-up contact with a breastfeeding professional following hospital discharge had improved rates of breastfeeding duration compared to mothers who did not have a home visit. This study found that,

When comparing the 'home visit' with the 'no home visit' group for days 10-180, the mean aggregated prevalence of exclusive breastfeeding was 45% for the home visits group compared with 13% for the no visits group... in order to sustain the differences seen in hospital after the implementation of the BFI 10 steps, a combination of both hospital and community systems need to be put in place (Pincombe et al., 2006, p. 60).

Similar results were reported in a Cochrane review, where face-to-face breastfeeding support significantly improved breastfeeding duration, while support over the telephone did not (Sikorski et al., 2000). A statistically significant increase in short and long-term breastfeeding duration was reported by Guise and colleagues (2003) for both telephone and face-to-face follow-up support. While the authors emphasized the value of face-to-face community breastfeeding

support, they also emphasized the importance of community supports for ensuring benefits of the BFI are fully realized.

It is important that community breastfeeding support services are encouraged and promoted by health professionals and hospital institutions, as they are evidenced to improve breastfeeding outcomes. Although 86.3% of Canadian mothers reported receiving information about postpartum breastfeeding supports and resources (Chalmers et al., 2009), ongoing investment in this area is important to ensure mothers can access the support they need.

2.4 Other factors influencing breastfeeding initiation, duration, and exclusivity

There is a compelling body of evidence supporting the BFI Ten Steps to Successful Breastfeeding, and the significance of healthcare practices for enhancing breastfeeding initiation, duration, and exclusivity. It is important to note however, that healthcare provision is only one of many factors influencing breastfeeding practice. Other factors, such as maternal age, level of education, income, cultural beliefs, race, family and community support networks, employment status, attitudes towards breastfeeding, personal histories, mode of delivery, parity, and drug and alcohol use, influence maternal breastfeeding decisions and practices (Agboado et al., 2010; Biro, Sutherland, Yelland, Hardy & Brown, 2011; Chalmers et al., 2009; Dabritz, Hinton & Babb, 2008; Declercq et al., 2009; DiFrisco et al., 2011; Gagnon, Leduc, Waghorn, Yang & Platt, 2005; Merten et al., 2005; Philipp et al., 2003; Pincombe et al., 2006; Scott, Binns, Oddy & Graham, 2006). Breastfeeding challenges were also found to contribute to early weaning/cessation in breastfeeding mothers. These include experiences of breastfeeding pain/discomfort (cracked nipples, breast tenderness, engorgement, mastitis etc.), insufficient milk supply or perceived insufficient milk supply, latching difficulty, maternal illness, and/or exhaustion (Sarasua et al., 2009).

Evidence indicates that social determinants of health may have the largest impact on breastfeeding outcomes because they create the conditions that support and facilitate – or discourage and restrict – breastfeeding. Pincombe and authors (2006) argued that, “the duration of breastfeeding is probably determined more strongly by the economic and socio-cultural environment of the first-time mother than by specific care practices during a short stay in a maternity hospital or unit” (p. 60). Some of the challenges mothers face (such as problems with latching and positioning, breastfeeding pain and discomfort, unsupportive care practices, and insufficient follow-up care) can be tackled within the healthcare system, through the provision of high quality healthcare assistance, information, and support for mothers – in both the hospital and community. Other determinants, such as those that create and perpetuate socio-economic inequality, must be addressed more broadly in the social and political sphere.

Although social determinants of health, among other factors, significantly influence breastfeeding behaviour, healthcare delivery (especially the first hours and days following birth) is also a significant predictor of infant feeding practice (Kersting & Dulong, 2002; WHO, 1998). Hospital healthcare delivery aligned with BFI best-practice guidelines is evidenced to improve rates of breastfeeding initiation, duration, and exclusivity among mother-infant pairs. While Baby-Friendly healthcare practices do not address all the conditions that challenge breastfeeding, they do address many problematic factors within healthcare settings demonstrated to hinder breastfeeding success. For this reason, optimal healthcare provision has the ability to serve a preventative role, as mothers who are informed of the benefits of breastfeeding, taught proper positioning and latching, encouraged to feed on demand, and provided with early infant feeding support, are more likely to avoid breastfeeding challenges (such as pain/discomfort and low milk supply) that may prompt early weaning (Declercq et al., 2009; Forster & McLachlan, 2007).

Although a broad range of infant feeding issues and concerns were discussed in the literature, it is noteworthy that no studies in this systematic review engaged with optimal standards of care for mothers in hospital in labour/delivery or recovery, or opportunities to improve maternal care for greater health and wellbeing and/or improved success with infant feeding.

2.5 Implementing the BFI Ten Steps: Strategies and challenges

The process of achieving Baby-Friendly designation can be challenging and lengthy, as many elements must come together for an institution to consistently meet each recommended practice. Walsh, Pincombe, and Henderson (2011) discussed the process of achieving Baby-Friendly designation and the main challenges encountered at their institution, stating, “BFI accreditation is complex but achievable... Difficulties include integrating policy into practice, intra-organizational support, specific funding, education of staff, and continuing the initiative into the community” (p. 606). To achieve BFI designation, a facility must prioritize the promotion of breastfeeding, and must secure financial support to re-write hospital policies, fund breastfeeding training for healthcare staff, develop and offer breastfeeding follow-up support services to mothers, and to equip maternity unit environments with the items needed to follow BFI Ten Steps (e.g., bedside bassinets for 24-hour rooming-in and facilities that allow a guest to stay overnight).

There is evidence that some of Steps are more challenging for facilities to implement than others. Vasquez and Berg (2011) reported that the five most challenging steps to implement at their facility were Step 2 (staff education/training), Step 3 (prenatal breastfeeding education), Step 4 (skin-to-skin), Step 7 (rooming-in,) and Step 9 (no pacifiers). Similarly, Merewood and authors (2005) reported that Step 2, Step 6 (no formula unless medically indicated), and Step 7, were the most challenging to implement. Although every facility is likely to experience the

challenge of designation differently, Walsh and colleagues (2011) provided some suggestions for success. These included: hiring a coordinator to organize, communicate, and monitor the designation process; appointing “area leaders” that are responsible for specific achievable tasks; and developing and widely communicating a clear breastfeeding policy to all healthcare staff.

2.6 Ethical consideration

In this literature review, all studies except for one appeared to follow ethical standards and guidelines aligned with the Tri Council Policy Statement for Ethical Research Involving Humans. The study by Bystrova and authors (2007) had a questionable study design. This study randomly assigned mother-infant pairs into one of four groups and provided each group with differing standards of postpartum healthcare. The purpose was to collect data on the impact of different healthcare practices on maternal milk production, infant milk consumption, and frequency of feeding. Authors describe the intervention received by each group below:

Group I infants (n=37) were placed skin-to-skin in the delivery ward while Group II infants (n=40) were dressed and placed in their mother’s arms. Both groups later roomed-in in the maternity ward... Group III infants (n=38) were kept in a cot in the delivery and maternity ward nurseries with no rooming-in. Group IV infants (n=38) were kept in a cot in a delivery ward nursery and later roomed-in in the maternity ward. (p. 1)

Because the health benefits of skin-to-skin contact, rooming-in, and feeding on demand are well evidenced in the literature and recommended for optimal healthcare delivery, it is unethical to intentionally deny a mother-infant dyad the benefits of this practice. Although it is ethical to collect data retrospectively from mothers who report they did or did not experience any of these care practices, it is not ethical to create healthcare conditions of sub-optimal care (such as those experienced by Group II, III, and IV) to allow for the measurement of the full benefits received from an intervention.

While the authors attempted to justify their experiment by claiming that all participants indicated no preference towards rooming-in, skin-to-skin, or feeding on demand, they did not indicate whether mothers were informed about the benefits or harms of each intervention before participation, and did not refer to ethical protocol in their report. This raises concern over whether informed consent for participation was obtained by study participants, or whether the ethical principles of minimizing harm and maximizing benefit were considered.

Although study results provide valuable primary data about breastfeeding and the impact of BFI recommended practices such as skin-to-skin, rooming-in, and feeding on demand, (because they provide a rare comparison from one end of the breastfeeding healthcare spectrum to the other), the research appears unethical. While results from this research are referenced in this chapter, (Step 7 and 8), the ethical implications of this research should be acknowledged, and problematic study designs discouraged.

2.7 Summary

This systematic review presents a thorough overview of research on Steps 1-10 of the BFI. The literature provides evidence in support of the BFI as an effective intervention for improving rates of breastfeeding initiation, duration and exclusivity; engages with evidence on the Ten Steps to Successful Breastfeeding; highlights factors contributing to infant feeding practice and cessation; and outlines challenges of achieving Baby-Friendly designation. Although contradictory findings occasionally emerged when exploring specific outcomes, all articles supported breastfeeding as the optimal infant feeding practice, and the BFI as an effective intervention for the improvement of breastfeeding initiation, duration, and exclusivity.

Chapter 3

Research Methodology and Methods

This research explores hospital infant feeding practices (and hospital compliance with evidence-informed practice outlined in the BFI) through mothers' lived experience with hospital infant feeding. This section describes the interpretive phenomenological methodology used to guide the research process and study design detailing: research methods, eligibility criteria, participant recruitment, data collection, data analysis, ethical considerations, and the elements used to ensure trustworthiness.

3.1 Interpretive phenomenology

The methodological framework of phenomenology was used to guide this research process. Phenomenology is a philosophy concerned with developing an understanding of reality through an exploration of the experiences and interpretations of others (Bernard, 2006; Green & Thorogood, 2009). Phenomenology focuses on not only *what* is experienced of particular phenomena, but *how* that phenomena is experienced and understood (King & Horrocks, 2010). When applied in research, phenomenology allows for the study of subjective, multidimensional, and complex social phenomena (McWilliam, 2010).

In the early twentieth century, philosopher and mathematician Edmund Husserl (1859-1938) developed a theoretical approach referred to as transcendental or descriptive phenomenology. This approach challenged dominant positivist understandings of reality based on mind/body dualism, and provided an alternative approach to knowledge generation based on the study of conscious experience (Bernard, 2006). As King and Horrocks (2010) noted, "Husserl was concerned that scientists of the time were too ready to impose their own theories on the topic they studied in a premature attempt to construct explanations" (p. 175). In order to

truly understand social reality, Husserl believed scientists must investigate lived experience and consciously work to set aside or ‘bracket off’ any preconceptions or assumptions about the phenomena that could interfere with understanding its true essence (King & Horrocks, 2010). Bracketing off allowed the investigator to view phenomena in a pure state free from preconceptions or with new eyes to uncover new understandings of reality free from judgment once preconceptions were set aside.

Twentieth century philosophers critiqued Husserl’s belief that it is possible to completely bracket off all relevant personal and cultural perceptions to allow phenomena to be viewed objectively (King & Horrocks, 2010). Husserl’s approach was modified by scholars Martin Heidegger (1889-1976), Jean-Paul Sartre (1905-80), and Maurice Merleau-Ponty (1908-61) who became known as existential phenomenologists (King & Horrocks, 2010). They believed that because “existence is intimately bound up with the world we find ourselves in: we can never entirely step outside it to see things objectively as they are” (King & Horrocks, 2010, p. 176). As McWilliam (2010) noted, “unlike transcendental phenomenologists, existential phenomenologists do not consider that we can suspend our preconceptions. Rather, they believe that even the researcher’s presence shapes the lived experience that is being investigated” (p. 231). Existential phenomenologists recommended a shift in focus from working to uncover the true essence of a phenomenon, to describing and interpreting the lifeworld (world of lived experience) of those who experience the phenomenon (King & Horrocks).

Because phenomenology is founded on the principle that reality is generated through experience, interpretation, and understanding, it strives to explore the interpretation of reality, and details of lived experience, rather than ‘reality’ itself (McWilliam, 2010). When studying phenomena,

A situation is sought in which individuals have first-hand experiences that they can describe as they actually took place in their life. The aim is to capture as closely as possible the way in which the phenomenon is experienced within the context in which the experience takes place. (Giorgi & Giorgi, 2008, p. 28)

Through its application, interpretive phenomenology can be used to uncover the key characteristics and lived realities of a phenomenon, however, it is understood that these will always exist within a context of human interpretation and understanding.

This research follows the interpretive/existential phenomenological approach. Three central concepts of phenomenology are discussed below: *intentionality*, *epoche*, and *lifeworld*.

3.1.1 Intentionality

The term *intentionality* refers to one's conscious and relational experience with their reality (King & Horrocks, 2010). A central concept in phenomenology, intentionality proposes that the nature of human consciousness is social, and that all humans have an intentional and conscious relationship to their surroundings (King & Horrocks, 2010).

In seventeenth century Europe, scientists believed that understanding consciousness required an understanding of activity within the brain (the work of neurologists and psychiatrists), rather than an exploration of how people engage and interact with their external world (King & Horrocks, 2010). Gallagher (2012) noted Husserl's critique of this approach, arguing that a thorough understanding of consciousness cannot be gained strictly through an examination of the inner workings of the mind – consciousness must be understood through an exploration of how humans interact and relate with others and objects in their world (Gallagher, 2012). Husserl believed that in order to truly understand the nature of human consciousness; human experiences, interactions, and interpretations of reality must be carefully investigated. As King and Horrocks (2010) note, “consciousness is never some pure, abstract, disembodied state –

it always and inevitably connects us to the world we inhabit” (p. 176). Because human consciousness is relational – conscious experience is shaped in relation to things experienced in the physical world rather than just within the mind (Gallagher, 2012; Luft & Overgaard, 2012).

The inextricable connection between human thought, environment, and conscious experience is central to phenomenology and is applied in this research when exploring maternal infant feeding healthcare experiences. It is understood that maternal experiences with infant feeding in hospital are shaped and exist in relation to other things, such as interactions with the physical environment of the hospital, policies and procedures, healthcare providers, the infant, family, and broader cultural ideas, meanings, and expectations of infant feeding and mothering.

3.1.2 Epoche

The term *epoche* is used in phenomenology to describe a process of consciously recognizing and setting aside (or bracketing off) ideas and assumptions about the phenomenon under study in an attempt to understand it free from judgment (King & Horrocks, 2010). This process involves acknowledging and setting aside, “not only the commonsense understandings prevalent in our society –which phenomenologists sometimes refer to as *the natural attitude* – but also the theories produced from previous academic work in the area” (King & Horrocks, p. 177). It also involves the bracketing off of the researchers own personal beliefs and assumptions about a phenomenon. Giorgi and Giorgi (2008) noted that, “to bracket does not mean to be unconscious of these other sources but rather not to engage them so that there can be no influence from them on the instance being considered” (p. 33). The purpose is to identify and become aware of current understandings of phenomena so their influence on that phenomena can be minimized.

Although existential phenomenologists agree that one can never entirely step outside of the world they experience, they recognize the value of bracketing off assumptions in an attempt to observe phenomena from a new perspective (King & Horrocks, 2010). As the researcher, I attempted to acknowledge and engage with my own assumptions, preconceptions, and attitudes towards infant feeding, hospital practices, and the BFI through personal reflexivity. While I could not fully step outside of my own experience to view the phenomenon unobtrusively, I attempted to make my preconceptions of the research phenomena explicit to minimize their impact on study findings.

3.1.3 Lifeworld

The term *lifeworld* was coined by Husserl to describe the world of experience as lived by people (Giorgi & Giorgi, 2008; King & Horrocks, 2010). King and Horrocks (2010) noted Husserl's belief that as humans we "experience our lifeworld as embodied beings – not *with* our bodies, as if they were tools used by but separate from our minds (the Cartesian dualist view), but *through* our bodies ... as 'body-subjects'" (p. 179). The concept of lifeworld is important to phenomenology because all humans experience their reality as embodied beings. Because phenomenology is focused on the world as it is experienced, rather than how it is imagined or theoretically understood, how humans experience and understand their reality is of great importance. As stated by Gallagher (2012), "lifeworld, in this sense, is not the world that we take as object, as something distinct from ourselves, but is rather a specification of our existence" (p. 2). In interpretive phenomenology, the main objective of research is to gain an understanding of the lived experience of a phenomenon from those who experience it (McWilliam, 2010). In this research, emphasis is placed on the lived and embodied experiences of mothers with infant feeding and hospital infant feeding care practices.

3.2 Personal reflexivity and epistemological stance

3.2.1 Personal reflexivity

Researchers can acknowledge and communicate their role in the research process through *personal reflexivity* – an ongoing process of engagement with personal thoughts, beliefs, opinions, feelings, preconceptions, and assumptions about the research topic. “Reflexivity in qualitative research specifically invites us to look ‘inwards’ *and* ‘outwards’, exploring the intersecting relationships between existing knowledge, our experience, research roles and the world around us” (King & Horrocks, 2010, p. 125). It is through reflexivity that the researcher’s presence and impact on the research becomes visible. Finlay (2003) engages with the importance of reflective practice in qualitative research. She notes,

Without examining ourselves we run the risk of letting our un-elucidated prejudices dominate our research findings. New understanding emerges from a complex dialectic between knower and known; between the researcher’s past pre-understandings and the present research process, between the self-interpreted co-constructions of both participant and researcher. (p. 108)

Through reflexive practice, researchers can acknowledge their prejudices and work to minimize their influence on research findings.

Throughout this research process, I used journaling to maintain an ongoing reflexive practice. Journal entries were written after each interview and focus group, and during the data analysis and writing process to document emerging ideas, thoughts, judgments, beliefs, and/or assumptions relevant to the research. By acknowledging my relationship to the research phenomena, I attempted to set aside my opinions and perceptions to observe them as openly and as unobtrusively as possible. Although I believe I cannot completely bracket off my preconceptions, I believe that by acknowledging my preconceptions I can minimize their impact on the research and make their potential impact known.

I am a 28 year-old female from a middle-class background. My formal education has trained me to approach health and development in a holistic manner, paying special attention to how social determinants influence health and wellbeing. My social position, experiences, and education are inextricably a part of my human experience because they shape how I understand and relate to others and how I make sense of the world. Although I cannot shed my history and context, I endeavor to make my thoughts and beliefs related to the phenomena visible.

I am very interested in reproductive healthcare delivery. My training towards certification as a birth doula has provided me with knowledge about childbirth and breastfeeding, and I am considering studying to become a midwife. Midwifery provides mother-infant dyads with more choice and involvement in their birthing process than medicalized birthing models. I believe childbirth and breastfeeding are natural, healthy processes, rather than processes in need of hospitalization and medical intervention for all mother-infant dyads. My interest in reproductive health and healthcare delivery has inspired me to explore maternal infant feeding healthcare experiences as a graduate student.

As a female of reproductive age, I felt well positioned to explore the topic of childbirth and infant feeding with mothers in NL, however, as woman from Ontario who has never delivered a baby or breastfed, I was aware that some mothers may have perceived me as an outsider. I was aware that my lack of experience as a mother may have influenced the openness with which some research participants shared their feelings and experiences, and that I may have a higher level of education than some research participants. In all cases, I tried to be professional and relaxed with mothers by dressing casually, interviewing in a conversational manner with minimal reference to the script, staying on topic, and choosing relaxed settings for all interviews and focus groups.

My review of the literature convinced me that exclusive breastfeeding is the healthiest option for mother-infant dyads and the BFI is an effective intervention for breastfeeding promotion. Although I support the BFI, I do not believe it should be exempt from critique, as there may be room for improvement in the initiative's design and implementation.

3.2.2 Epistemological stance

As with reflexivity, engaging with epistemology is important in an interpretive phenomenological study as part of acknowledging and making explicit the influence of researcher in the research process. The term *epistemology* refers to the study or theory of knowledge, and focuses on how credible knowledge is acquired, understood, and defined. While the epistemological stance of a researcher is not always openly discussed in scientific research, epistemology plays an important role in shaping how research is designed and communicated. Below I engage with my epistemological stance and its influence on this research.

I decided to conduct qualitative research because I was interested in gaining rich descriptions of experience through conversation, and wanted to allow themes to emerge from participant experience. I wanted to learn about maternal experiences with infant feeding in detail, and wanted to provide mothers with the opportunity to shape and direct research content based on their own experiences in hospital. I noticed most published infant feeding studies I found in my literature review were quantitative, so wanted to explore infant feeding experiences in hospital with a qualitative study design.

I selected interpretive phenomenology to provide a theoretical framework to guide my research through the stages of study design, data collection, and analysis. I felt interpretive phenomenology was an appropriate fit because emphasizes the realities of lived experience, acknowledges the role of the researcher in the research process, prioritizes the voices of research

participants, and provides guidelines for the analysis of qualitative research data. I believed maternal accounts would tell me more about hospital adherence with the BFI and priorities for care improvement than more restrictive quantitative forms of data collection.

Collecting qualitative data through interviews, focus groups, and policy review felt natural to me, however, at times in the research process I felt I was straddling subjective and positivist research paradigms. I was motivated to convey the details, meanings, and nuances of lived experience through participant voices, but also felt motivated to quantify research outcomes to communicate research data. I decided to use both direct participant quotations and number counts when presenting research themes because both were important for the accurate communication of results. Although qualitative research (and interpretive phenomenology) tends to avoid numerical qualifiers, I believed that number counts were important for my research and included them to be as transparent and comprehensive as possible with reporting my results. I recognize this may be inconsistent with interpretive phenomenology, however felt it was important for the communication of adherence with Steps 3-10 of the BFI, and acknowledge this as a limitation in my use of interpretive phenomenology.

Interpretive phenomenology also encourages the researcher to make their presence in the research visible through personal reflexivity and writing in the first person. While I felt comfortable maintaining an ongoing reflective practice, I struggled to write in the first person, and ultimately decided to write from a third person perspective. I acknowledge that writing in the first person did not feel natural to me, which may come from a lack of acceptance of first person dialogue in the academy, especially within scientific literature, and a belief that research findings are more credible when discussed free from personal association. Although this may make it appear that I removed myself from the research, my ongoing reflective practice and

awareness of this issue demonstrates my role and engagement with the research process. While a third person voice is more closely aligned with a positivist rather than interpretive epistemic stance, it influenced my study and should be acknowledged as a limitation in the application of phenomenology to this research.

3.3 Strengths and limitations of phenomenology

Phenomenology has been used as a research methodology in health and nursing research to enhance understandings of lived experience with illness and disease, nursing care, and the healthcare system (Carel, 2012). As stated by McWilliam (2012), phenomenological findings,

afford nurses, and indeed all health disciplines, the opportunity to consider and apply a more holistic health-oriented understanding in their practice, one with the potential to broaden ‘health’ beyond the biomedical model and to deepen ‘care’ to encompass humanistic elements that are too often missing. (p. 236)

Through an engagement with the experienced realities, understandings, and interpretations of those experiencing illness and disease (or other phenomena of interest), interpretive phenomenology offers an approach for new ways of seeing that can be used to inform health policy, practice, and service delivery.

Interpretive phenomenology provides a framework for researchers wishing to engage with complex and multidimensional social phenomena, and offers an approach through which new dimensions of social reality can be explored. With a greater understanding of how specific experiences and interpretations shape – and are shaped by – social reality, researchers can offer new insights and perspectives that can be used to develop effective interventions and solutions to the problems they witness. By focusing on the many dimensions of lived experience, “phenomenology has the potential to promote human development, enhance professional practice, advance the theoretical and practice foundations of disciplines, and inform programs,

services, and policies in ways that promote positive change” (McWilliam, 2010, p. 230). This is of particular value when applied to health research – an area largely dominated by biomedical science and quantitative approaches to knowledge about the body, rather than by an exploration of the social circumstances that influence health, and broader understandings about health and illness (King & Horrocks, 2010; McWilliam, 2010). Because interpretive phenomenology focuses on the context and understanding of lived experience, it reveals truths about human reality that would otherwise not be revealed through a strictly positivist approach.

While phenomenology is an excellent method for the exploration of how phenomena is experienced and understood, it has been critiqued as a philosophically heavy research methodology that can be difficult to understand and apply for researchers without a background in philosophy (Carel, 2012). For this reason, phenomenology can be easily misused, misunderstood and applied to research with insufficient rigor (Carel, 2012). While this critique is more of those who misuse phenomenology than of phenomenology itself, it highlights a need for clearer guidelines on the appropriate use and application of phenomenology in research. An additional critique of phenomenology is that it emphasizes the importance of personal reflexivity with little engagement with how researchers are to go about being reflexive. King and Horrocks (2010) noted that while interpretive phenomenology encourages reflexivity, “little detailed consideration has been presented as to how this [reflexivity] is to be achieved within the procedures offered by the method” (p. 211). Although some phenomenological texts provide researchers with guidelines for their reflexive process (Van Manen, 2002), phenomenology literature does not always provide researchers with a structured reflective practice to follow. Despite these limitations, interpretive phenomenology offers researchers with a theoretical

framework from which to explore lived experience, locate the self in the research process, and organize research processes of data collection, analysis, and communication.

3.4 Research methods

Data were collected through 12 semi-structured interviews with mothers 1-4 weeks post-partum, 3 semi-structured focus group discussions with mothers 0-12 months post-partum, and a review of hospital infant feeding policies and protocols. Each research method used for data collection is described and detailed below.

3.4.1 Semi-structured interviews

Semi-structured interviews are commonly used in interpretive phenomenological studies as a method of data collection focused on exploring the lived experiences and realities of others (Carel, 2012; Fossey, Harvey, McDermott & Davidson, 2002). Semi-structured interviews with pre-established questions have a flexible structure that allows participants to share and place emphasis on the experiences and feelings most important to them (Fossey et al., 2002; Green & Thorogood, 2009). Not only do they allow participants to define issues of relevance related to a particular topic, but also provide the researcher with flexibility to explore new content by probing for more information and asking follow-up questions where applicable. Semi-structured interviews allow the researcher to respond to issues raised, modify the order and wording of questions, and tailor questions to the participant and context. This allows the researcher to explore relevant experiences shared by the participant while maintaining conversational flow, and providing space for new issues and experiences to emerge. As King and Horrocks (2010) noted,

The aim of a qualitative interview is to elicit participants' accounts of aspects of their experience, rather than to collate answers to specific questions as if they were variables in a survey. As such, any insights you gain in the process of carrying out

your first few interviews should inform subsequent ones. ... So long as you remain aware of the way your interviewing practice developed over the course of the project, you should be able to avoid such changes distorting the analysis of the data. (p. 37)

Whether structured or semi-structured, one-to-one interviews provide an intimate environment for the exploration of lived experience, and offer participants a greater level of confidentiality. Some participants may also find it easier to share personal information in a setting where there is less risk of interruption, judgment, or disagreement from others. Additionally, the information shared in a private interview may more accurately reflect the experiences, feelings, and opinions of the participant because the content shared comes directly from the participant free from the influence of other group members. One-to-one interviews also provide a quieter and more orderly environment for the interviewer to ask questions, explore experiences in-depth, and uncover important beliefs, feelings, and meanings of lived experience.

A limitation to one-to-one interviews is that power dynamics between the researcher and the participant are greater, and the one-on-one dynamic may be intimidating or uncomfortable for some (Wilkinson, 2004). It is important for the researcher to reduce power imbalances as much as possible by adjusting personal dress, use of language, and style of questioning for the audience they are interviewing.

Twelve semi-structured one-to-one interviews were conducted with mothers one to four weeks following delivery. Interview questions were consistent throughout, however because interviews were semi-structured, there was flexibility in each interview for the structure and content of the discussion to be shaped by the participant. All questions were designed to assess hospital compliance to steps 3-10 of the BFI Integrated Ten Steps and maternal hospital healthcare experiences. Additional questions were added to the interview guide to assess maternal experiences with self-care in hospital following delivery. Although the original

interview guide did not include any questions about the care mothers received in hospital, the topic of maternal care was raised in all three focus groups, prompting further exploration of this issue in the semi-structured interviews that followed. Please refer to Appendix A for the interview script.

To be eligible to participate in an interview, all mothers had to be over 18 years of age; have given birth to a full term (>37 weeks gestation) healthy singleton infant at the Janeway Children's Hospital/Health Sciences Centre within four weeks of the interview date; have fluent English speaking skills, be free of any serious health conditions or serious disabilities that could interfere with infant feeding, intend to keep and raise their infant, and have the ability to provide free and informed consent.

Interview participants were recruited through a pediatrician during her routine pre-discharge rounds in the Janeway Children's Hospital/Health Sciences Centre Maternity Unit. To reduce selection bias and maximize participant diversity, the pediatrician introduced the study to every mother she visited on her pre-discharge rounds. Recruitment occurred on two separate days, Thursday March 22, 2012 and April 3, 2012. On each of these days, the pediatrician introduced the study to each mother and invited them to participate by providing a short form to fill out and leave on their bedside table in an envelope for collection. She made it clear to each mother that participation was voluntary, and emphasized that she would not know whether or not they chose to participate because their forms would be sealed in an envelope and collected by a nurse. This was emphasized to ensure that mothers would not feel pressured to participate because of a belief that their health care would be improved with participation. The pediatrician also mentioned that participation would not affect healthcare in any way. On each recruitment day, ten mothers were invited to participate, and eight recruitment forms were returned from

mothers interested in participating – a response rate of 80%. A total of 16 forms were completed, collected and picked up by the researcher.

Using this recruitment strategy, a broad range of sample diversity was achieved. Although population samples in qualitative research do not aim to be representative of the study population as a whole, they do aim to have great diversity to provide a broad range of experiences and perspectives (King & Horrocks, 2010). The research sample included first, second and third time mothers, mothers with vaginal deliveries and caesarian section deliveries, mothers who ranged in age from their early 20's to early 40's, who were married, unmarried, in a committed relationship and single, mothers who were exclusively breastfeeding, exclusively formula feeding and combination feeding, mothers living in rural and urban areas, and mothers who were highly educated professionals and who were educated at the high school level. The sample also included one lesbian mother, one aboriginal mother living in poverty, one young mother living with her parents, two mothers with a previous birth experience in the private healthcare system of the United States before moving to NL, and one mother who had struggled with infertility.

Interviews were arranged with each mother interested in participating when contacted by the researcher until thematic saturation (the emergence of no new themes) was reached. On forms where email addresses were provided, the researcher made first contact by email, and later followed up with a telephone call if no reply was received. On forms with only a telephone number, the researcher made first contact by telephone. Of the 16 forms received, 14 mothers were contacted, and 12 interviews were held before thematic saturation was reached. Of the 14 mothers contacted, 2 did not participate – 1 mother failed to return a phone call after two messages were left, and the other requested the researcher call back in five weeks. Although

there was an opportunity to contact the remaining 2 mothers of the 16 who provided contact information, it was unnecessary, as thematic saturation had been reached at 12 interviews. All interviews ran between 20 and 75 minutes in length, were audio recorded with the permission of the participant, and held in a private location.

3.4.2 Semi-structured focus groups

Focus groups are facilitated group discussions designed to uncover experiences, ideas, feelings, and insights about a topic through interaction with others. Commonly held with four to eight participants, focus group discussions are guided by a moderator (often the researcher) who facilitates and directs the discussion to gain insight on a particular topic. Because of their conversational nature, focus groups tend to uncover different elements of lived experience than one-to-one interviews, and can reveal new insights for understanding and relating to a topic or experience. Wilkinson (2004) discussed benefits of generating data using focus groups, stating, “focus groups are more ‘naturalistic’ than interviews (i.e., closer to everyday conversation), in that they typically include a range of communicative processes – such as storytelling, joking, arguing, boasting, teasing, persuasion, challenge, and disagreement” (p. 180). The communicative processes that occur within focus groups reveal not only lived experiences, but also habitual ways of defining, describing, and relating to the phenomenon/lived experience in a group setting (Green & Thorogood, 2009). For example, by examining the use of language and tone, what is shared and not shared, body gestures, responses to others, levels of detail used, disagreements, strong opinions, etc., the researcher can gain new insight into the complexities and multiple dimensions of the research topic. In addition, the conversational nature of focus groups “allow respondents to react to and build upon the responses of other group members, creating a ‘synergistic effect’. This often leads to the production of more elaborated accounts

than are generated in individual interviews” (Wilkinson, 2004, p. 180). Because focus groups bring people with different and potentially diverse experiences together, insights can be revealed and explored in the group setting that may not emerge in a one-to-one interview.

Focus group discussions can also be useful for breaking down and reducing power dynamics between the researcher and the participant because they remove pressure on the individual that may exist in a one-on-one interview setting, and create an environment where others are also sharing personal experiences (Fossey et al., 2002; Wilkinson, 2004). For this reason, they tend to be an effective method for exploring sensitive subject matter (Green & Thorogood, 2009; King & Horrocks, 2010; Wilkinson, 2004). Wilkinson (2004) acknowledges that, “focus groups are well suited to exploring ‘sensitive’ topics, and the group context may actually facilitate personal disclosures” (p. 180). A major benefit of focus groups is that the group atmosphere can improve the comfort experienced by participants allowing for new depths and dimensions of experience to emerge.

Of course, the opposite can also be the case if a participant feels uncomfortable, unwelcome, negatively judged, or disrespected in a focus group. To avoid this, the moderator must lay out ground rules for respectful dialogue at the beginning of each discussion to ensure standards of respect are upheld, however, because the moderator does not have complete control over what respondents say or how they behave, it is always possible for a respondent to feel less comfortable in a group setting than in a private interview. Similarly, there is loss of anonymity and an increased risk to loss of confidentiality in focus groups if a participant discusses the focus group with others following the discussion. The moderator should communicate the importance of confidentiality to all participants before each focus group begins, however because they

cannot control how participants behave once they leave, participants risk a potential loss of confidentiality through participation.

Another downside to collecting data using focus groups is that participants can easily influence one another, which can shape which aspects of experience are shared and discussed and which are not, and how lived experiences are described. This can especially be the case if a respondent feels that their experience or feeling about a topic will not be accepted or understood by other group members (Green & Thorogood, 2009). Also, due to their conversational nature, it may be difficult or even impossible to explore the experience of any one participant in great depth, even if that experience is of great interest to the researcher. Additionally, participants might interrupt one another and might share experiences that take the conversation off topic (Krueger, 1994). While it is the responsibility of the moderator to keep the conversation on track, it can be difficult to return to narrative or personal experience that has been interrupted. Despite these limitations, the ability of focus groups to breakdown power dynamics, generate high-quality data about lived experience, capture habitual ways of interacting and relating to the research topic, and reveal sensitive subject matter; makes them a valuable method for use in qualitative research.

In this research, three focus group discussions were held with groups of four to six mothers who gave birth at the Janeway Children's Hospital/Health Sciences Centre within one year of data collection. Each discussion ran between 60 and 90 minutes in length, was audio recorded, and moderated by the principal investigator. Discussion questions were semi-structured and designed to assess hospital compliance with Step 3-10 of the BFI, and the health care experiences of mothers. Flexibility was provided for the content and direction of the conversation to be shaped by group discussion. The number of focus groups held was

determined by the point at which thematic saturation was reached. This occurred during the third focus group.

To be eligible for participation, mothers had to be over 18 years of age, have delivered a baby at the Janeway Children's Hospital/Health Sciences Centre between May 1st, 2011 and May 1st, 2012, have fluent English speaking skills, have and intend to keep and raise their infant, and have the ability to provide free and informed consent. Focus group participants were not excluded from the study based on the gestational age of the infant (carrying infant to full term not required for participation), the delivery of a healthy baby, or the presence of severe maternal health issues or disability. This provided greater diversity and experience in the research sample, as some focus group participants delivered pre-mature infants with health complications, which provided a greater scope of experience with hospital infant feeding.

All focus group participants were recruited through word of mouth and snowball sampling. Snowball sampling is a technique that involves gaining access to study participants with the help of current research participants. To encourage participation from those with different schedules and geographical locations, discussions were held on different days of the week, different times of day, and in different locations. To reduce recall bias (the communication of inaccurate information due to memory loss over time), only participants who delivered within twelve months of the focus group date were invited to participate. Of the 16 focus group participants, 1 participant from the second focus group delivered her baby before May 1st, 2011. She was included in the discussion to avoid social exclusion in her group of friends, however in order to limit recall bias and maintain consistency with inclusion criteria, all comments made by this participant were removed from the transcript and were not included in the research.

Participants for the first focus group were invited to participate by a friend of the researcher. They were each contacted directly by the researcher's friend in an email, informed of the study, and invited to contact the researcher if interested in participating. Of the four mothers contacted, three replied and one of the three indicated that her friend (who was not originally contacted) was also interested in participating. The researcher followed up with each interested mother by email and telephone, and arranged for the discussion to take place on March 29, 2012 at 10:30am in the Health Sciences Centre. All four mothers attended the discussion with their baby. Two of the four participants in this group knew each other.

The second focus group was organized by a mother who had recently delivered and offered to host a focus group discussion with her friends in her home. She contacted her friends through email to inform them of the research and invite them to participate. Each interested participant was then contacted directly by the researcher. The focus group discussion was held on April 11, 2012 at 3:30pm in the home of the host in Torbay. Of the eight people contacted by email and invited to participate, seven mothers indicated interest. Six attended the discussion and five brought their baby to the discussion. All mothers in this group knew each other.

Participants for the third focus group were recruited through the La Leche League of St. John's, NL. The researcher contacted the leader for the St. John's group with information about the study and requested that the information be circulated to mothers in the group. Details about the study were posted by the La Leche League on their regional Facebook group and interested mothers were instructed to contact the researcher. Seven mothers responded with interest, and six mothers attended the discussion. This focus group was held on April 16, 2012 at 7pm in the Sobey's Community Room in Torbay. All mothers in attendance brought their baby to the discussion, and four knew each other prior to the discussion.

Although the recruitment technique of snowball sampling resulted in a high representation of breastfeeding mothers, the research sample and hospital infant feeding and healthcare experiences of mothers were relatively diverse. The sample included first, second and third time mothers, mothers with vaginal deliveries and caesarian section deliveries, mothers who ranged in age from their early 20's to late 30's, who were married, unmarried, in a committed relationship and single, mothers who were exclusively breastfeeding and combination feeding, and mothers living in rural and urban areas. Because carrying their infant to full term (37 weeks) was not required for participation in a focus group, some focus group participants had premature infants who were cared for in the hospital NICU before discharge. There were no exclusive formula feeding mothers in the focus groups, however a number of mothers combination fed their infant from infancy or switched to exclusive formula feeding shortly after delivery. Because focus groups were held to engage with hospital infant feeding practices and maternal hospital experiences in a group setting, rather than to provide a diverse sample of the maternal population, snowball sampling was an appropriate recruitment strategy.

3.4.3 Infant feeding policy review

The third method of data collection was a review of hospital infant feeding policies. All policies used to guide infant feeding clinical practice for healthy full-term infants at the Janeway Children's Hospital/Health Sciences Centre were carefully reviewed and compared to BFI guidelines. Discrepancies between hospital policies and BFI guidelines were highlighted and discussed along with recommendations for policy improvement. Hospital infant feeding policies were accessed with permission from the Research Proposal Approval Committee of Eastern Health and assistance from the Baby-Friendly Council of NL and the NL Provincial Perinatal Program.

3.5 Interpretive phenomenological analysis (IPA)

Interpretive phenomenological analysis (IPA) offers clear guidelines for the analysis of qualitative research data. Giorgi and authors (2008) identify five stages of interpretive phenomenological analysis (IPA): 1) familiarization with the data, 2) identifying themes, 3) clustering themes, 4) producing a summary table, and 5) integrating themes across cases.

The first stage of IPA involves becoming familiar with research data and its content. This involves reading and re-reading each transcript while make notes of any information that may be relevant to the research (Giorgi & Giorgi, 2008; King & Horrocks, 2010; Smith & Osborn, 2008). In this stage, researchers are advised to focus on becoming familiar with the content of the transcripts, rather than interpreting what is said (Giorgi & Giorgi, 2008; King & Horrocks).

When note-taking,

some of the comments are attempts at summarizing or paraphrasing, some will be associations or connections that come to mind, and others may be preliminary interpretations. ... As you move through the transcript, you are likely to comment on similarities and differences, echoes, amplifications and contradictions in what a person is saying. (Smith et al. p. 67)

Each time a transcript was read, preliminary notes were reviewed and added to capture transcript content. Because phenomenology is concerned with context and generating understanding from the whole picture (Giorgi & Giorgi, 2008), all interview data were read in this stage before proceeding to later stages of analysis.

The second stage of IPA involves identifying themes in the data that describe the nature of the phenomena studied (Giorgi & Giorgi, 2008). Before identifying themes, transcripts and notes were re-read to see if further insight can be drawn from the experiences shared by participants. In the second reading, themes or emerging concepts were identified. As King and Horrocks (2010) noted, “themes are usually defined at a somewhat more abstract level than your

additional notes, and may reflect broad theoretical concerns within your discipline, but should not include concepts associated with a particular theory” (p. 206). The process of identifying emergent themes involved revisiting preliminary notes multiple times to ensure all themes were accurately represented. Once themes were identified, a comprehensive list of all themes within each transcript was developed. Table 3-1 demonstrates how interview content was organized into preliminary notes and emerging themes in this research.

Table 3-1: Identifying Themes using IPA

Preliminary Notes	Transcript	Emerging Themes
<p>Feeding every 3 hours recommended and monitored by nurses</p> <p>Nurses checked in every 3 hours to see if baby fed</p> <p>Feeding done more frequently than every 3 hours</p>	<p><i>I: Do you remember in the hospital when they told you it was time to feed her?</i></p> <p>P7: Ah, well they said to me, "feed her every 3 hours." And that was like their... it's law. It's every 3 hours, especially where like they're trying I guess to get your milk to come in. And they didn't really say like they kind of just woke her and me up every 3 hours. But then it got to the point after... I think it was the second night I was there. I didn't have a nurse there, and they used to come in to make sure that I had fed her. And I was already feeding her because she'd wake up beforehand. I think they were just making sure that every 3 hours she was being fed. And if she woke up before then I fed her. I figured that's what she wanted, to be changed and fed.</p>	<p>Timed-based feeding recommended over cue-based feeding</p> <p>Feeding every 3 hours recommended and monitored in hospital</p>
<p>Confused about how long to feed baby</p> <p>Different information received on how long baby should breastfeed for each feeding</p> <p>Belief there is a right and wrong breastfeeding duration</p> <p>Recommended durations inconsistent</p> <p>Recommendations thought to be based on nurse experience and opinion</p>	<p><i>I: Okay, and did they ever give you any indication how long you should feed, or how to know when the feeding's over?</i></p> <p>P7: Um, no. That was something that was confusing to me. It's like anywhere you go to, you ask ten different people, you get ten different answers. And they come and they ask, "how was her feeding? how long was it?" Some people would say, "well 20 minutes is not very long" and sometimes she'd be there anywhere from 20 minutes to 45 minutes. And they'd say, "well 45 minutes is kind of too long, but 20 is not long enough" kind of thing. And then some wouldn't say anything, and would say like, "oh okay, that's good" you know? I guess it all depends. It's like, it's like anywhere you go. It's their own experience</p>	<p>Maternal confusion with how to determine end of feeding</p> <p>Inconsistent information from nurses on feeding duration</p> <p>Feeding completion assessed based on time rather than infant cues</p>

<p>Clarification not found in hospital, but allows baby to determine feeding length</p> <p>Baby regularly weighed following hospital discharge</p> <p>Weight fluctuations in first few weeks thought to be linked to c-section</p> <p>Weight used to indicate successful/sufficient breastmilk intake</p> <p>Because weight gain is normal, breastfeeding assumed to be successful</p>	<p>I guess and what they know.</p> <p><i>I: It depends on...</i></p> <p>P7: I still don't know. I just let her feed until she was ready to come off right?</p> <p><i>I: Yeah, and then I guess you do the regular weighing and things like that?</i></p> <p>P7: Every week now I go to the breastfeeding clinic and get her weighed, and every Thursday for the past few weeks I've had her to my doctor, my family doctor. Because one week, well she lost her weight when she left, she lost 6.5 oz and when I went to the breastfeeding clinic she had gained 12 oz the following week, then the week after she lost an ounce and a half. But the nurses at the breastfeeding clinic said it could be due to me having a c-section and being so pumped with fluid, it would take a couple of weeks to get it through, like reading on her weight. They said that her weight gain is good and stuff, so...</p>	<p>Infant weight gain used to indicate successful/sufficient breastmilk intake</p>
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Once themes were established for all relevant concepts in the transcript, the process of clustering themes began. Any themes that overlapped were merged together under a new title or a title that suited them best. The clustering process involved first merging overlapping themes, then organizing and grouping related themes together to provide a clear breakdown of the main themes present within the transcript.

Once themes were clustered, a summary table was made to organize and display the content of each cluster. To begin this process, each cluster was given an appropriate title that represented the content of all themes making up the cluster. The title of each cluster then became the dominant theme and the clustered themes listed below the title became subordinate/superordinate themes (King & Horrocks, 2010). Clusters were then arranged in a logical order to describe the phenomena. Ordering themes in a coherent manner within the summary table was done to facilitate the process of writing results. The summary table included

page references for each subordinate theme. These references served as quick reference for sections of transcript that clearly demonstrated/exemplified each theme.

Table 3-2: Clustering Themes Using IPA

<p>Time-based feeding recommended over cue-based feeding Feeding every 3 hours recommended and monitored in hospital Feeding completion assessed based on time rather than infant cues Belief there is a right and wrong breastfeeding duration</p>
<p>Inconsistent information led to confusion over how to determine when feeding complete Inconsistent information from nurses on feeding duration Recommendations thought to be based on nurse experience and opinion Maternal confusion with how to determine end of feeding</p>
<p>Infant weight gain used to assess breastfeeding success Weight used to indicate successful/sufficient breastmilk intake Because weight gain is normal, breastfeeding assumed to be successful</p>

The final stage of IPA involved integrating themes across multiple cases. This involved examining themes from each transcript and creating one final table, referred to as the ‘Master Table’. When creating the Master Table, overlapping themes from transcripts were merged together under appropriate headings. The process involved re-visiting clusters and re-arranging groups, however when the Master Table was complete, it included all relevant themes from all transcripts. By following the steps of IPA described, each transcript was carefully reviewed, thematically coded, and integrated.

To ensure transcripts were accurately analyzed and coded, a technique called intercoder reliability was applied. Two interview transcripts were randomly selected and sent to my academic supervisor for independent analysis and coding. These coded transcripts were compared with my coded transcripts to cross verify the analysis of data and identification of transcript content and to assure me that I was competent in performing this new skill. When compared, transcripts had been consistently coded with the same emerging themes highlighted in each. Although the labels we used to identify themes were sometimes slightly different, the

themes and content classifications were very closely aligned and I was confident that the analysis of my data was dependable.

3.6 Trustworthiness

Trustworthiness is a vital component of qualitative research because it allows readers to determine the value of a study and its results. Together, four key components can be examined to determine the trustworthiness of a qualitative study, these are: credibility, transferability, dependability and confirmability (Guba, 1981; Lincoln & Guba, 1985).

Credibility refers to the confidence that can be placed on research data to accurately represent what it is meant to represent (Polit & Hungler, 1999). This involves the appropriate collection, identification, and analysis of data to ensure accuracy (Green & Thorogood, 2009). In this study, credibility was enhanced through the triangulation of research methods, minimization of recall bias, and the use of direct participant quotations and number counts. Research methods were triangulated through three methods of collection – interviews, focus groups, and policy review, to allow for the cross-verification of data across sources. To increase credibility by reducing recall bias, all interviews were conducted within 4 weeks post-partum and all focus groups within 12 months post-partum. Direct participant quotations were used to ensure maternal experiences were accurately represented. Number counts were completed to inform the reader of how many interview participants identified with each theme discussed.

Transferability refers to the possibility of applying research to other contexts and/or populations (Polit & Hungler, 1999). To enhance transferability, the selection criteria and methods used to recruit research participants have been clearly described alongside the demographic characteristics of the research population, and the local context and environment from which research data was collected. These details inform the reader of the study population

and allow them to decide the degree to which research results can be transferred across contexts and/or populations.

Dependability refers to the ability to demonstrate that results are reliable and could therefore be repeated with similar outcomes (Lincoln & Guba, 1985). In this research, dependability was strengthened through the comparative line-by-line coding of two randomly selected interview transcripts. The two selected transcripts were coded and compared to ensure coding accuracy and consistency. To further enhance dependability, all steps in the research process were described to provide transparency for the reader, and the information necessary to repeat the study if desired.

Confirmability refers to the ability to demonstrate how research results and conclusions were derived from the research data (Tobin & Begley, 2004). To enhance confirmability, each step of the research process was clearly detailed, the epistemological stance of the researcher was presented, and personal reflexivity was incorporated into the research process through journaling. Data triangulation, comparative line-by-line coding, and the use of direct participant quotations also enhanced the confirmability of data.

3.7 Ethical considerations

This research adhered to ethical guidelines described in the Tri-Council Policy Statement Ethical Conduct for Research Involving Humans, and was approved by the Health Research Ethics Authority, and the Research Proposal Approval Committee of Eastern Health.

Participants came from a low-risk population, and were able to provide free and informed consent before participation. Privacy and confidentiality, respect for justice and inclusiveness, and a commitment to do no harm were upheld throughout this research process. All participants were aware that participation was voluntary and were informed of any potential risks of

participation. Each participant was provided with an opportunity to ask questions before participating, was given a copy of the research consent form to keep, and informed they could opt out of the study at any time.

3.8 Summary

Interpretive phenomenology was used as a framework in this research to inform study design, procedure, and analysis, and to guide the exploration of mothers lived experiences with hospital infant feeding healthcare practices. Through its application, diverse elements of maternal infant feeding healthcare experience were revealed and explored.

Chapter 4 Institutional Practices and Steps 3-10 of the BFI

Chapters 4 and 5 highlight key themes and set the stage for further discussion and theoretical engagement with maternal infant feeding healthcare experiences. This chapter focuses on institutional adherence to healthcare practices outlined in Steps 3-10 of the BFI Integrated Ten Steps through an engagement with maternal hospital healthcare experiences at the Janeway Children’s Hospital/Health Sciences Centre. Although all maternal accounts reveal valuable information, number counts are only used for one-to-one interviews with mothers one to four weeks postpartum to limit recall bias and reflect hospital care experiences during the narrow time frame of March 15, 2012 to April 5, 2012. In total, 27 mothers participated in this study: 12 interview participants and 15 focus group participants. When discussing research results, “interview participant” refers to someone who participated in a one-to-one interview, while “focus group participant” refers to someone who participated in a focus group discussion.

4.1 Step 3 – Inform pregnant women and their families about the importance and process of breastfeeding

Step 3 of the BFI Ten Steps involves informing pregnant mothers of the importance and process of breastfeeding so they are able to make an informed decision about their infant feeding practice (BCC, 2012b). While the assessment of Step 3 involves speaking with pregnant women of 32 weeks or more gestation who have attended two or more prenatal appointments to assess the quality of prenatal information on breastfeeding received, this research engages only with maternal experiences in hospital from the time of delivery until discharge.

Four indicators were used to explore the degree to which mothers were informed in hospital of the “importance and process of breastfeeding.” These were: whether mothers were asked about infant feeding plans in hospital; whether infant feeding was discussed with a

healthcare provider; whether breastfeeding was recommended by a healthcare provider; and whether written information on the importance and process of breastfeeding were provided to mothers in pamphlets or a similar medium in hospital. While this is not a true assessment of hospital adherence with Step 3 of the BFI, it provides data on the information mothers received in hospital on the importance and process of breastfeeding. These differences in focus are unique to Step 3, and present a limitation that readers may wish to consider when interpreting data on this step. See Table 4-1 for interview data related to Step 3.

Table 4-1: Step 3 Interview Data

	Yes	No
Asked about infant feeding plans	8	4
Discussed infant feeding with healthcare provider	7	5
Breastfeeding recommended by healthcare provider	6	6
Pamphlets provided on importance and management of BF	12	0

Of the twelve mothers interviewed, eight reported being asked by a health professional (physician, nurse, or lactation consultant) about their infant feeding plans in hospital, and seven reported discussing infant feeding with a healthcare provider in hospital. Although exclusive breastfeeding is widely promoted in the BFI, only six of the twelve mothers interviewed reported receiving a recommendation to breastfeed from a healthcare provider in hospital. A number of focus group participants also reported receiving no specific infant feeding recommendation in hospital:

I: Do you remember what was recommended to you in terms of infant feeding at the hospital? Do you remember what was suggested by the nurses or physicians?

P22: Nothing in my case.

I: Nothing?

P25: No, I don't think they...

P24: No, they didn't.

P26: They didn't ask me.

P25: There were lots of signs around, like I noticed there were a lot of signs saying, "breastfeed".

P22: Yeah, but nobody actually said [to do so].

This discussion highlights an absence of explicit dialogue between healthcare providers and mothers about the recommended practice of breastfeeding and the importance and process of breastfeeding. One mother said,

P8: No one really talked to me about breastfeeding... Not really, no. Like when I was trying to breastfeed, they would... I think the first time someone was like, "Okay, I'll just turn his head like this and hold him like this." But no one talked to me about breastfeeding, except for the 3-hour thing [feeding every 3 hours]. ... But no one actively talked to me about it.

Although this mother reported receiving assistance with positioning while learning how to breastfeed, she shared that no one talked to her about why breastfeeding is an important feeding practice. Similarly, another mother said, "The only time I think it was mentioned was in prenatal classes and that was before my son, not before her. And they promoted breastfeeding there, but not in the hospital" (P22).

Some of those interviewed (n=3) speculated that their healthcare provider had not explicitly discussed breastfeeding with them because they had expressed an intention to breastfeed, had already initiated breastfeeding, or had previous breastfeeding experience. Healthcare providers may have interpreted this as an indication that they did not need to be convinced to breastfeed, or educated about the importance and management of breastfeeding. As one mother stated,

P6: I think they do recommend the breastfeeding, but I had already... I breastfed my first daughter so that was something I already decided I wanted to do... And then, once I was up in the caseroom they just kind of asked me and right away I said breastfeeding. So I guess they just left it there instead of trying to convince me.

This suggests that assumptions from healthcare providers on maternal breastfeeding knowledge and experience may have influenced the infant feeding information and care provided in hospital.

Although maternal infant feeding plans and/or experiences may suggest knowledge and awareness of the benefits and processes of breastfeeding, such knowledge cannot be assumed if not discussed and confirmed with each mother.

When asked about written information received in hospital on breastfeeding, all mothers interviewed (n=12) reported receiving pamphlets explaining the importance and process of breastfeeding before they were discharged from the hospital. Similarly, all focus group participants reported receiving written resources when discharged from the hospital.

Although results for Step 3 were not collected from mothers in pregnancy (as recommended in the BFI to assess the quality of prenatal class information), they provide information on the degree to which healthcare providers engaged with mothers about the importance and process of breastfeeding in hospital. Maternal accounts indicate a lack of routine verbal communication about breastfeeding in hospital, highlighting room for improvement with in-hospital communication and breastfeeding promotion.

4.2 Step 4 – Place babies in uninterrupted skin-to-skin contact with their mothers immediately following birth for at least an hour or until completion of the first feeding or as long as the mother wishes: Encourage mothers to recognize when their babies are ready to feed, offering help if needed.

Maternal accounts indicate that skin-to-skin contact immediately following delivery was widely practiced at the Janeway Children’s Hospital/Health Sciences Centre for both vaginal and caesarean section deliveries, however often occurred for a shorter duration than recommended. Eleven of the twelve interview participants reported experiencing direct skin-to-skin contact with their infant within the first hour after birth. Although some (n=4) experienced skin-to-skin contact immediately with an un-wiped baby, others experienced skin-to-skin contact with their

baby after it was wiped clean (n=2) or after it was wiped and wrapped or dressed (n=5). See

Table 4-2 for details on skin-to-skin contact from interview participants.

Table 4-2: Step 4 Interview Data

	Vaginal delivery (n=7)	C-section delivery (n=5)
Skin-to-skin provided:		
Yes	6	5
No	1	0
Infant held by mother for the first time:		
0-5 min after delivery	4	1
6-10 min after delivery	2	0
11-20 min after delivery	1	3
21-30 min after delivery	0	0
31-60 min after delivery	0	1
Elapsed time from delivery to skin-to-skin contact (for mothers who received skin-to-skin):		
0-5 min after delivery	4	0
6-10 min after delivery	1	0
11-20 min after delivery	1	3
21-30 min after delivery	0	0
31-60 min after delivery	0	2
Duration of skin-to-skin contact (for mothers who received skin-to-skin):		
0-5 min	2	0
6-10 min	0	0
11-20 min	1	3
21-30 min	2	0
31-60 min	0	1
61-90 min	1	1
Initiation of breastfeeding in hospital:		
Yes	6	5
No	1	0
Initiation of breastfeeding during skin-to-skin (for mothers who received skin-to-skin):		
Yes	5	5
No	1	0
Elapsed time from delivery to first breastfeeding (for breastfeeding mothers only):		
0-5 min	2	0
6-10 min	0	0
11-20 min	1	2
21-30 min	1	0
31-60 min	1	3
1-2 hours	0	0
2-4 hours	0	0
4-6 hours	1	0

The elapsed time from delivery until skin-to-skin contact was generally shorter for vaginal deliveries than for cesarean section deliveries. Of the seven mothers interviewed who delivered vaginally, six had skin-to-skin contact. Of these, four experienced it within 0-5 minutes following birth, one 6-10 minutes after birth and one 11-20 minutes after birth. Of the five mothers who had cesarean sections, all experienced skin-to-skin contact in the recovery room. Of these, the majority (n=3) experienced skin-to-skin 11-20 minutes following delivery, while two experienced skin-to-skin 31-60 minutes following delivery. Here one mother described her experience with skin-to-skin contact and breastfeeding initiation in hospital:

P3: So they had asked me if I wanted to do skin-to-skin and I did... so as soon as she came out they just put her right on top of me. Immediately... and they weren't hurrying me, or anything. She actually latched in the Case Room, once before they cleaned her up... And then they took her and just sort of cleaned her up and they gave her back to me. She latched before they took her the first time – she latched when we did skin-to-skin before they ever cleaned her up, and then she latched again after they cleaned her up and bundled her.

Another spoke about being given the time she wanted to bond with her newborn immediately after delivery:

P4: They asked me before I delivered if I wanted him on my chest or if I just wanted to look at him and they bring him over and clean him up. I got to hold him right away, and I held him for about an hour and a half, and just kind of sat there and I fed him right away. So they were really good that way, let me feed him because that was really the one thing that I wanted to do... So that was good. They let me do that.

These mothers indicate that they were given a choice to have skin-to-skin contact immediately after delivery to bond and initiate breastfeeding. Subtle statements such as “they let me do that” suggest that mothers may believe the provision and duration of skin-to-skin contact is controlled by hospital staff. This suggests a possible lack of communication between hospital staff and mothers about the ability to maintain skin-to-skin as long as desired.

While Step 4 of the BFI Ten Steps specifies the provision of skin-to-skin for “at least an hour or until completion of the first feeding or as long as the mother wishes,” maternal accounts indicate that the duration of skin-to-skin contact was often long enough to initiate breastfeeding, but was often shorter than one hour, and shorter than mothers wished. One mother described her disappointment over the short duration of skin-to-skin contact experienced in hospital:

P21: Um, I was kind of disappointed. It wasn't horrible, but I was kind of disappointed with my experience because... they brought her over for skin-to-skin, and I might have only got, say 10 minutes, and they [nurse] said, "Okay, we've got to check her temperature now." And I said, "okay" and I thought they were just gonna check and bring her back, but when they brought her back she was fully dressed... I didn't get the opportunity. And I said, "I thought I was supposed to get a full hour of skin-to-skin" and they said, "Well yeah, but you don't really need that. It's not necessary." And so I was kind of disappointed, 'cause I thought, I knew that it was hospital policy, and you know, the nurses weren't on board with that, so I was... You know, it wasn't a horrible experience, but I knew it wasn't skin-to-skin.

This mother demonstrates that although skin-to-skin contact is a beneficial and recommended practice, her nurse did not prioritize it. Her statement highlights how non-urgent routine practices (such as taking infant temperature) can get in the way of optimal care practices such as receiving a full hour of uninterrupted skin-to-skin contact. The BFI recommends that routine infant observations such as assessing temperature, colour, and breathing occur during skin-to-skin contact unless medically indicated (BCC, 2012b). Maternal accounts indicate this may not be normal practice at the Janeway Children’s Hospital/Health Sciences Centre, as many mothers reported separation for infant exams.³

Mothers widely reported inconsistent durations of skin-to-skin contact. Of those interviewed who delivered vaginally (n=7), the duration of skin-to-skin varied widely from 0-90 minutes in length, with the majority (n=5) of mothers with experiencing skin-to-skin contact for

³ Maternal-infant separation in hospital is discussed in further detail in Step 7.

less than 30 minutes. For mothers who had caesarean section deliveries (n=5), the duration of skin-to-skin contact ranged from 11-90 minutes, however the majority (n=3) reported 11-20 minutes of skin-to-skin contact. A mother reported experiencing a very short duration of skin-to-skin contact before her infant was wrapped and dressed:

P8: He was put up on my chest and breastfed right away, from what I remember. And then they took him... he was still in my vision, and they cleaned him up and put a onesie on him, and then brought him right back to me.

I: Do you remember if it was skin-to-skin contact? Did you have him up against your bare skin?

P8: Yes.

I: Do you know how long that lasted for?

P8: I remember he latched right on. It was maybe a few minutes, like 5 minutes maybe.

Ten of the twelve mothers interviewed (and a vast majority of focus group participants) reported the initiation of breastfeeding during skin-to-skin contact. Although mothers were not asked in this research if they were encouraged to look for signs their baby was ready to feed during skin-to-skin contact, the high rate of breastfeeding initiation during skin-to-skin indicates that early breastfeeding initiation was encouraged and supported by healthcare providers in hospital. Although only six of the twelve mothers interviewed reported receiving a recommendation in hospital to breastfeed, reports of high breastfeeding initiation during skin-to-skin suggest that breastfeeding was widely supported in hospital even if it was not recommended verbally.

Of those interviewed who did not initiate breastfeeding during skin-to-skin (n=2), one initiated breastfeeding six hours after delivery, while the other did not experience skin-to-skin contact and did not initiate breastfeeding. The mother who did not experience skin-to-skin contact or initiate breastfeeding had no medical complications preventing skin-to-skin, however

intended to exclusively formula feed. She described what happened in the moments immediately following her vaginal delivery:

P2: They asked me if I wanted him cleaned up or if I wanted him right away... and I wanted him to be cleaned up a bit, and then they brought him to me.

I: Okay, and was he wrapped in a blanket or naked?

P2: Yup, yup. They had him all nice and wrapped.

Her experience demonstrates both a lack of familiarity with the option of skin-to-skin contact and its benefits, and the absence of the routine provision of skin-to-skin contact. Although she was asked whether she preferred to hold her infant un-wiped or wiped, she was not asked whether she wanted to hold her infant against her bare skin, and did not seem aware this was an option. Her plan to exclusively formula feed, and her request that her infant be cleaned first before holding, may have prompted the nurses to wrap/dress her baby rather than offer skin-to-skin contact. It is unknown if maternal infant feeding plans have an influence on the provision of skin-to-skin contact at the Janeway Children's Hospital/Health Sciences Centre.

Discussions with focus group participants suggest that skin-to-skin contact was not routinely practiced in hospital. One participant said she had to explicitly ask for skin-to-skin contact in order to receive it:

P27: I actually had to specially request skin-to-skin, otherwise I don't think I would have had skin-to-skin. It was funny because I remember seeing signs everywhere.

They were saying supposedly it's great, but I remember I had to specially request it.

This statement suggests that although the practice of skin-to-skin contact was promoted on posters in the delivery room, it may not always be followed as routine hospital practice.

Similarly, another mother described needing to ask to hold her baby following a caesarian section in order to have skin-to-skin contact:

P7: They finished suturing me and they congratulated me and stuff, and then they took me into the recovery room. And then the baby was with my boyfriend and I was

like, "Well, can I hold her?" He's all the way over there, and "Can I hold her now?" And they were like, "Oh, you want to hold her?" And I was like, "Yeah, that's the whole point." And she said, "So, do you want skin-to-skin?" and I was like, "Yeah." So, she [nurse] latched her on right away, like as soon as they put her on my chest she was looking for my breast. So they latched her on right away again right? So it was, I would say within 15 minutes after she was born... But I did have to ask.

Another mother described a different experience with skin-to-skin contact following her caesarean section:

P11: She came out and they put her up on my belly, and I held her, I mean for a while like that, and then they were delivering the placenta and things like that, so they took her over, but they still only cleaned her a little bit – they didn't suction her or anything, they just wiped her and wrapped her up and handed her to my mom. And my mom said, "don't you need to examine her and stuff?" And the nurse said, "Oh we'll do that in about 30mins, you just have some time with her."

These very different experiences suggest a lack of consistency with maternal-infant care and contact in the moments following caesarean section delivery. Although both mothers experienced skin-to-skin contact in recovery, one expressed feeling forgotten and overlooked, while the other expressed feeling well cared for and attended to. While skin-to-skin contact was widely reported by mothers in this research, accounts indicate that the duration and quality of skin-to-skin varied considerably from mother to mother. Results indicate uninterrupted skin-to-skin contact was often not practiced for the full recommended duration and was not routinely offered to all. This indicates a shortcoming in the achievement of Step 4.

4.3 Step 5 – Assist mothers to breastfeed and maintain lactation should they face challenges including separation from their infant

Step 5 of the BFI states that all mothers should be provided with breastfeeding assistance for initiating and establishing breastfeeding, and maintaining lactation if separated from their infant (BCC, 2012b). This includes the provision of initial and ongoing breastfeeding assistance and observation in hospital, but also instruction on how to hand express milk, how to recognize

feeding cues,⁴ how to determine if the infant is effectively breastfeeding, and where to access breastfeeding help if needed.⁵ See Table 4-3 for data from interview participants on Step 5.

Table 4-3: Step 5 Interview Data

	Yes	No	N/A*
Breastfeeding assistance offered or provided for first breastfeeding	11	1	1
Breastfeeding assistance offered/provided at subsequent intervals or as needed	8	3	1
Instructed or told how to initiate and maintain lactation if separated from infant	0	11	1
Pumping and breast-milk storage discussed	2	9	1
Instructed or told how to recognize infant feeding cues	4	8	0
Instructed or told how to determine if infant is effectively breastfeeding	2	9	1

* Assistance with breastfeeding and maintaining lactation is not applicable for those exclusively formula feeding.

Of the eleven interview participants who initiated breastfeeding, all reported being offered, or provided with, breastfeeding assistance for their first feeding. The vast majority of focus group participants also indicated receiving breastfeeding assistance for their first feeding. Breastfeeding assistance included help with positioning, latch establishment, breastfeeding technique, milk expression and/or breastfeeding maintenance. Two mothers described the breastfeeding assistance they received when feeding for the first time:

P9: I told them, “I don’t think I have any milk,” and they were like, “No, you have colostrum.” And they, you know, showed me I had colostrum, and we did some breastfeeding then... I remember them telling me, okay, right away they said, “it shouldn’t pinch, it should feel pulling.” And they showed me how he latches on.

P3: She did it on her own. The nurse looked, the nurse watched, and checked the first time. They knew I had breastfed before so um, so they did have a look and see, but no one gave me any instructions.

These statements indicate the provision of immediate assistance with the establishment of breastfeeding. Although physical assistance was not required by either mother, latching and positioning were checked and observed for each to support breastfeeding success. These two

⁴ Instruction on recognizing cue-based feeding is a component of Step 5, but study results on cue-based feeding are consolidated under Step 8.

⁵ Resources provided to mothers to promote transition from hospital to the community are discussed under Step 10.

accounts are largely representative of the experiences reported by mothers who received assistance for the initiation of breastfeeding.

Of those interviewed who received breastfeeding assistance for the first feeding (n=11), eight indicated receiving regular subsequent breastfeeding assistance/observation for the duration of their hospital stay, while three reported receiving no further breastfeeding instruction, observation, or assistance while in hospital. One mother described the attentive breastfeeding care she received in hospital:

P7: They made sure I was latching her on properly and you know, if I had any questions or whatever, they were there to tell me, “yes, no, well whatever feels good for you” or they would get a pillow for me, or propped her up more, or told me “you maybe should have more pillows on this side.” They were awesome. I’ve got to say, the nursing staff were awesome there.

Another mother described the absence of regular breastfeeding assistance and observation:

P4: I was fortunate enough that he did do well, but there was no, you know, “Let’s sit down, see if he breastfeeds, I’ll watch you do it, make sure he’s latching okay.” ... There was no question of you know, “Do you want some help? Do you want us to make sure that he’s doing everything, latching on okay?” or anything like that. I was fortunate enough that they could see that he was, but there was no question on breastfeeding or anything like that, or if I wanted help to make sure that he was on there.

I: Okay. Did you feel like it would be easy to get that if you needed it?

P4: I think if you asked the nurses they might have, yeah, if you did ask. They seemed pretty helpful. I’m sure there’s some nurses in there that might not (laughing)... Yeah, yeah, it all depends on who’s in there.

These statements highlight inconsistency with the provision of breastfeeding assistance, support, and follow-up care in hospital. While one mother reported receiving attentive and patient care with breastfeeding, the other reported an absence of breastfeeding follow-up care. Although she indicated that nurses would likely have helped her with breastfeeding if asked for help, she also acknowledged that help was not offered and shared feelings that some nurses may not help if asked. This indicates not only that breastfeeding follow-up care was not consistently

provided to all mothers at the Janeway Children's Hospital/Health Sciences Centre, but also that some mothers may perceive nurses as unwilling to help with breastfeeding if asked. It also highlights that assistance and observation is not always available or offered to mothers at appropriate intervals, or once per shift, as recommended in Step 5 of the BFI.

While most mothers experienced ongoing subsequent breastfeeding assistance in hospital, experiences with the quality of breastfeeding assistance was mixed with some mothers reporting both positive and negative interactions with nursing staff related to breastfeeding. Of the twelve mothers interviewed, four reported at least one negative experience with the breastfeeding assistance they received in hospital. Negative experiences with hospital breastfeeding assistance were also raised by participants in all three focus group discussions, and were most commonly related to care that was unsupportive, impatient, forceful, or absent. A mother described an unsupportive interaction with a nurse when asking for help with latching her baby on in the hospital maternity unit:

P8: I asked for help once, and the response I got... I was like, "I'm not gonna ask again," and I didn't see a lactation consultant.

I: And what was the response you got?

P8: It was like, frustration... she was like, (impatient voice) "Well what do you want?" And I was like, "I just want, you know, some help with him latching." And they're like, (frustrated sigh), and I'm cowering. So I didn't ring it again because I was like... well you know? But he ate, and I knew he would, but if I was a first time mom, oh my gosh, I would have jumped out of the window. Well, I didn't have a window (laughing) but you know.

This statement demonstrates how a nurse's frustrated response affected a mother's willingness to ask for subsequent breastfeeding help in hospital. The mother reflected upon how challenging breastfeeding would have been for her if she were a first time mother experiencing the same lack of support in hospital as she did with her second child. Similarly, another mother shared her experience with breastfeeding assistance in hospital: "They would come in and just

take your boob, and shove it in, and not stay and try. They would just do it for you because they didn't want to stay and teach you how to do it" (P10). This mother described experiencing forceful breastfeeding assistance from nurses who seemed more concerned with getting the feeding done, than with ensuring she was taught how to successfully establish breastfeeding on her own. She acknowledged that teaching and supporting a mother to breastfeed takes more time than latching a baby on the breast for feeding. Her comment suggests that nurses may lack the time needed to adequately support breastfeeding instruction and learning.

Some participants discussed their frustration with the forceful and rushed breastfeeding assistance received in hospital:

P13: She forced my boob in her mouth.

P14: That's what they did to me too, like they'd just grab you. I found that really invasive.

P15: I was so angry about that.

P14: Yeah, I didn't like that at all.

I: And did you feel that they were teaching you how to breastfeed?

P14: No, because they were like, "You're doing it wrong", but they didn't tell you why.

P13: And they were like, "Don't you have this yet?"

P14: Yup. It was like they were really huddy about it.

I: And did you feel that the instruction that you were getting from them was rushed, or was it sort of, did you have time to...

P14: No, they didn't have any time.

P16: That's what I found too.

P14: It's like they've got better things to do than help you.

P16: Yeah, she had someone else she had to go see.

While the above statements indicate a lack of patient breastfeeding assistance and care provided to mothers in hospital, they also raise concern over the institutional pressures and limitations placed upon hospital nursing staff, and how such limitations may affect the ability of nurses to provide high-quality patient care.⁶

⁶ Institutional pressures and limitations are discussed in greater detail in Chapter 5 and Chapter 7.

Although all of the mothers interviewed who initiated breastfeeding (n=11) received assistance with the initiation of breastfeeding, none reported being informed in the hospital of techniques for maintaining lactation if faced with breastfeeding challenges or if separated from their infant. Here two mothers indicate receiving no communication from healthcare providers about techniques for maintaining lactation if separated from their infant. One mother said, “No one mentioned anything. No, no one mentioned it. I did get a pamphlet on pumping and storage, which I did go through and read, which was helpful” (P7). Another said, “No. I’ve always wondered that” (P9). These statements closely reflect the responses of mothers when asked about information received about maintaining lactation if separated.

Of the mothers interviewed who initiated breastfeeding (n=11), three indicated receiving a pamphlet about pumping and breast milk storage, two reported being told about pumping or breast milk storage while in hospital, and two indicated an awareness of pumping from their own reading or from previous experience. Pumping and safely storing breast milk at appropriate intervals is recommended in cases of maternal-infant separation. Results indicate a lack of routine discussion in hospital about techniques and strategies for maintaining lactation in the case that mothers and infants become separated. It is unknown how many mothers were informed or shown how to hand express breast milk in hospital. Participants were not explicitly asked about hand milk expression in this research and none volunteered this information.

Step 5 also involves ensuring mothers are informed about how to know when their infant is feeding effectively. When asked how to know if their infant was effectively breastfeeding, many mothers expressed feeling uncertain of whether their infant was feeding properly or getting enough milk. Only two of the twelve mothers interviewed reported receiving information from a healthcare provider of signs to look for in their infant during feeding to determine effective

drinking. Measures such as infant weight gain and/or the number of wet and dirty diapers were most commonly (n=4) mentioned by mothers as an indicators of sufficient feeding, rather than signs of jaw movement and swallowing. A mother reflected upon her concern over whether her infant was feeding effectively and receiving enough milk:

P10: Every 3 hours or something they were like, “Did he feed? Did he pee?” “Yeah he peed, he fed.” I’d say he fed but I didn’t know, I didn’t know if he was getting anything... But then they’d say, “Well, what’s his diaper like?”

I: So that was their way of seeing whether he was eating was seeing his diaper?

P10: Yeah, it wasn’t because they were looking at me breastfeeding, no.

She indicates here that although nurses were keeping track of the number of wet and dirty diapers, they were not teaching her to recognize signs of successful breastfeeding, such as infant jaw movement and swallowing. This statement also highlights the emphasis placed on feeding according to a schedule rather than infant feeding cues.⁷ While cue-based feeding is a component of Step 5, results on cue-based feeding are presented under Step 8.

These results indicate insufficient adherence at the Janeway Children’s Hospital/Health Sciences Centre with the practice guidelines outlined for Step 5. Although all breastfeeding mothers reported receiving breastfeeding assistance for their first feeding, some reported receiving no subsequent breastfeeding assistance/observation or offer of assistance/observation while in hospital, indicating inconsistencies in healthcare provision for breastfeeding mothers. Additionally, the majority of mothers reported receiving no guidance on initiating or maintaining lactation if separated from their infant, or on pumping and breast milk storage. While a few reported receiving information/instruction on how to recognize and respond to infant feeding cues, and how to determine if their infant was effectively breastfeeding, the majority indicated they were not informed of this in hospital.

⁷ Cue-based feeding will be explored in further detail under Step 8.

4.4 Step 6 – Support mothers to exclusively breastfeed for the first six months, unless supplements are medically indicated

Step 6 of the BFI focuses on supporting mothers to exclusively breastfeed for the first six months of life, unless supplementing is medically necessary. The BFI emphasizes that those who supplement should either be fully informed of their decision (through the provision of information on the importance of exclusive breastfeeding and implications of supplementation), or advised to supplement for medical reasons (BCC, 2012b). Here data for Step 6 focus on breastfeeding exclusivity in hospital from the time of birth to the time of hospital discharge. See Table 4-4. Data on the breastfeeding support available to participants up to 6 months and beyond were outside the scope of this study.

Table 4-4: Step 6 Interview Data

	Yes	No
Breastfeeding initiated in hospital	11	1
Exclusive breastfeeding in hospital	7	5
Exclusive formula feeding in hospital	1	11
Combination feeding in hospital	4	8*
Free formula samples provided in hospital	2	10

* Of these, seven mothers were exclusively breastfeeding and one was exclusively formula feeding

Eleven of the twelve mothers interviewed reported initiating breastfeeding in hospital. Of these, seven exclusively breastfed for the full duration of their hospital stay, and five supplemented with formula at least once or more. Of those who supplemented with formula (n=5), four combination fed (fed with a combination of breast milk and formula), and one fed exclusively with formula. None of these mothers were medically advised to supplement while in hospital. Three of the four who combination fed decided to supplement in hospital due to a perceived fear of infant hunger, while one decided to supplement for greater ease with feeding. One of the four mothers who introduced formula while combination feeding in hospital began

exclusive formula feeding before hospital discharge. She discussed her decision to switch from breastfeeding to formula feeding while in hospital:

P5: I tried to breastfeed him. I breastfed him for the first couple days and then I found it way too hard because I was so sore and I was so tired. So I just found bottle-feeding to be a lot easier then afterwards.

I: Okay, and do you remember what they recommended to you in the hospital? Was there any sort of method that they recommended or were they sort of open to either?

P5: Um, well they wanted breastfeeding but the nurse said it was okay if I found it easier to bottle feed, a lot of people did, especially if it was your first child and you don't know what to expect.

While her decision to supplement was motivated by physical exhaustion and pain with breastfeeding, her decision to switch to formula was made after trying formula in hospital. She reported feeling supported by her nurse with her decision:

I: Did you feel that the nurses and the doctors were supportive of your decision to breastfeed and then switch to formula?

P5: Yup, they were really good. I was afraid 'cause a lot of people told me that nurses like would harass you to breastfeed, or that they had been harassed and were almost in tears. So I was afraid to say that I wanted [to feed with formula] but the nurse that I had... she was really good, she said that it was fine, she completely understood and she was very supportive of it, so that was good.

It is clear the decision to supplement with formula was made by the mother and supported/facilitated by her nurse, who normalized and validated her decision. It is unclear whether her decision to supplement was fully informed, as she did not indicate any discussion with her nurse about the importance of breastfeeding, its health benefits over formula, or ways to address the challenges she was experiencing with breastfeeding.

Similarly, another mother spoke about her conversation with nurses in hospital about her plans to exclusively formula feed. She mentioned receiving no specific infant feeding recommendations in hospital, and indicated that her decision to supplement was accepted by healthcare providers without further discussion.

I: And do you remember what was recommended in terms of infant feeding? Did they have a preference over breastfeeding or formula feeding, or was it sort of...

P2: Um no. All they did was they just asked me if I was bottle feeding or breastfeeding, and I just said bottle feeding, so they said that it was fine.

Although these mothers easily accessed formula in hospital, it is important to note that not all mothers who supplemented with formula in hospital were encouraged or readily provided with formula. While nurses discouraged supplementation for two of the four known cases of in-hospital supplementation, (one case of supplementation was unknown to nurses, as the mother reported that she supplemented secretly without informing healthcare providers), formula was provided upon maternal request. None of the mothers who supplemented with formula mentioned engaging in discussion with a healthcare provider about the health implications of supplementation.

Free infant formula was provided upon hospital discharge to two of the twelve mothers interviewed, however, only those who were exclusively formula feeding in hospital at the time of discharge (n=2) were offered free infant formula to take home.

Although mothers who used infant formula at the Janeway Children's Hospital/Health Sciences Centre may have not been fully informed of the health implications of their decision to supplement, those who openly decided to supplement (n=4) were supported in their decision by their healthcare providers and were given information on appropriate use of breast milk substitutes. It is unknown if mothers were provided with an opportunity to discuss sustained breastfeeding with staff (recommended in Step 6), as mothers in this research were not asked if they discussed sustained breastfeeding with their healthcare provider(s) in hospital. This reflects a study limitation.

Results for Step 6 indicate a lack of routine dialogue between healthcare providers and mothers who supplemented with formula about the importance of exclusive breastfeeding and implications of supplementation. Although exclusive breastfeeding was encouraged as routine practice in hospital, reported cases of supplementation occurred for non-medical reasons, and with little or no discussion about the importance of exclusive breastfeeding and implications of feeding with formula. Results suggest insufficient compliance with the guidelines outlined in Step 6, and highlight a need for improved communication between healthcare providers and mothers about the importance of breastfeeding and implications of supplementation.

4.5 Step 7: Facilitate 24-hour rooming-in for all mother-infant dyads: mothers and infants remain together

Step 7 of the BFI recommends that mothers and infants remain together in hospital 24 hours a day, and that mothers are able to have a support person with them in hospital 24 hours a day if desired (BCC, 2012b). Maternal accounts indicate routine mother-infant separation for infant cleaning, examination, and the first night in hospital, as well as a lack of ability for mothers to have a support person remain with them for 24 hours a day. While Step 7 recommends that all mothers receive information in hospital about safe co-sleeping and bed sharing, and are provided with the option to hold their infant skin-to-skin and breastfeed through any painful infant procedures, these were not examined in this research. See Table 4-5 for data from interview participants on experiences with Step 7.

Table 4-5: Step 7 Interview Data

	Yes	No
Mother-infant separated first night in hospital	10	2
If separated overnight, infant brought in for breastfeeding	9	1*
24-hour rooming-in remainder of hospital stay (after 1 st night)	12	0
Support person able to stay in hospital 24-hours a day	5	7

* This infant was exclusively formula fed and was not brought to mother for feeding during first night

Ten of the twelve mothers interviewed reported overnight separation from their infant their first night in hospital following delivery. Of these, none were separated for a medical reason. The majority of focus group participants also reported overnight separation during the first night in hospital. All breastfeeding infants that were separated from their mother were brought to their mother for breastfeeding at appropriate feeding intervals (often every 3 hours). Mothers reported receiving encouragement to send their baby to the nursery for the first night to allow for maternal rest. Focus Group participants discussed their experience with being separated from their infant overnight in hospital:

P21: I was told on my way up, “We really recommend that you don’t room-in, that you put the baby in the nursery.”

P19: So you could sleep?

P21: Yup, they said, “They gotta get a bath anyway, we really recommend you don’t take her” and I was like, “Are you serious?” I was really disappointed but not like ready to argue it I guess, so I couldn’t sleep, I mean like I was in a ward with two people who were in labour, so I wasn’t sleeping. And so at 4am when I knew I should be feeding, I buzzed and said, “Can you bring the baby in?” and I said, “You can leave her here now.” Like I didn’t... they really strongly encouraged her not to room in.

P20: Yeah, the first night he didn’t stay with me.

P21: But that first night, like not being given the option, I felt really... like knowing that it should be policy that they should be.

P17: You’re like, “this is my baby.”

P21: I know, and I’m like, “You’re taking her away?”

P17: It was an option for us.

P21: I mean, I suppose it could have been an option. I suppose I could have demanded it but I felt like it was strongly discouraged.

Contrary to BFI recommendations, results indicate that healthcare providers at the Janeway Children’s Hospital/Health Sciences Centre recommended maternal-infant separation the first night following delivery. Although some mothers expressed disappointment with being separated from their infant overnight and acknowledged that 24-hour rooming-in should be hospital policy, few challenged the recommended practice of overnight separation. A mother

shared her interaction with a nurse regarding overnight separation, stating “I didn’t want them to take her. They were like, “Are you sure? You can get a good night’s sleep.” I’m like, ‘No, that’s okay’” (P6). Mothers had bedside bassinets and the ability to room-in overnight if requested, however few seemed aware it was an option. Below a mother shared her experience of being separated from her infant shortly after birth:

P2: Right after he was born, they took him and kept him. I was supposed to sleep but I couldn’t sleep. But they had him, they had him in the room where they keep all the little babies... Six hours they had him. I had him at 2 o’clock, and they brought him to me at 8 o’clock in the morning, so... so I was supposed to sleep, but I couldn’t sleep because I didn’t know where he was. I knew he was being taken care of... it’s just that I got to spend what, I think about a half an hour with him [after delivery] before they took him.

This statement indicates a lack of communication between staff and new mothers about overnight separation and the option of rooming-in. This mother not only shared her feelings of concern in hospital over where her baby was and when it would be returned, but also indicated experiencing a very short amount of time with her baby following birth before overnight separation. Because she was not breastfeeding, her infant was not returned to her overnight at feeding intervals, but was fed by a nurse in the nursery. She acknowledged that although the purpose of overnight separation was to provide her with time for uninterrupted sleep, she was unable to sleep due to concerns of separation.

Not all mothers expressed disappointment with overnight separation. A mother shared her feelings about infant separation the first night:

P11: The first night you're there, they'll take the baby to the nursery if you want, and they kind of... well it seemed to me anyway, that's what they recommended. And after the first night you're on your own, so... So I said, “yes take the baby, let me try to get some sleep.”

Although overnight separation tended to be the longest duration of separation in hospital, separation was also commonly reported for infant bathing, weighing, and physical examinations.

A mother listed all the times she was separated from her infant in hospital:

P1: The only time he was away from me was when we were brought up to the maternity floor, when they brought him down to give him his bath and weigh him and all that stuff... After that, they had him for the first night, and then I had him for the rest of the time.

Although she expressed feeling that she was separated from her infant very little in hospital (and reported no disappointment or frustration with separation), her statement highlights that separation occurred more frequently than recommended or deemed necessary by the BFI. According to the BFI, mothers and infants are to remain together for 24-hours a day without separation (this includes remaining together during in-hospital relocation, infant bathing, weighing, and examination) unless separation is deemed medically necessary

In addition to 24-hour rooming-in, Step 7 recommends mothers are able to have a support person stay with them in hospital 24-hours a day if desired. Results indicate the majority of mothers were unable to have a support person to stay in hospital with them 24-hours a day because hospital policy restricted overnight guests in shared hospital rooms, and there was a lack of physical space. Although private rooms were offered to mothers when available for a cost of \$100/night, fewer than half (n=18) of the beds in the maternity unit are in private rooms. The other twenty beds are located in shared wards with four beds per room.

Seven of those interviewed reported being unable to have a support person stay with them overnight in hospital. Of these, three reported feeling upset about being alone in hospital without a support person. Two mothers described their experience of being in hospital overnight without a support person:

P14: A ward is free and a private room is \$100 a night, and so I didn't even think about getting a private room 'cause I didn't know if we had insurance. I really regret it because it was really... I gave birth at 11pm and was there all night alone until they let him [partner] back in at 7:30am.

P13: That would have been horrible.

P14: Yeah, it was really, really bad. I was really upset... It was really terrible. I didn't realize, like if they would have said "If you get a ward room, no one can stay with you" I would have got a private room no matter the cost, but that should have been given with the information.

A mother who experienced a difficult delivery talked about spending the first night without the support of her husband:

P8: I could cry talking about it. I was so upset. I was like... I mean after something like that it's just devastating. I just wanted to go home at that point. It was really bad. I did not expect that. I mean, I thought there was gonna be a couch or... And they were like [to husband] "No you have to get out at 12am."

Both excerpts emphasize the importance of 24-hour support following delivery.

Although one mother was offered the option of staying in a private room, she declined for financial reasons without knowing that her decision would prevent her from having the overnight support of her partner. This highlights the issue that access to 24-hour support for mothers at the Janeway Children's Hospital/Health Sciences Centre is not only determined by private room availability, but also by the income and social status of the mother. One mother identified the cost of a private room as a barrier for mothers living on a low income without full health insurance:

I: Were you in a ward or did you have a private room?

P2: I was in a ward. They asked me which one I wanted and I just said, "A ward is fine." We wouldn't have been able to afford to be in one of those rooms.

Although private rooms were not always available for those who could afford them (due to lack of vacancy), they were always restricted for those who could not.

Of the five interviewees who were able to have a support person stay with them in hospital 24-hours a day, four reported a lack of comfortable seating and sleeping arrangements for their support person in hospital. While the provision of comfortable seating and sleeping arrangements for support persons is not addressed in Step 7 of the BFI, mothers indicated it was an important determinant in shaping whether their support person stayed overnight in hospital:

P4: There was nowhere really comfortable for the dads to even sit... If he had to stay, there's no real good place for him to lie down. ... It makes it a lot easier for the mom to have the husband there, so it would have been nice for them to have something like that to lie on at least, you know?

P5: Um, they said they had chairs that folded into beds, but they only had four of them and they were in use. So he kind of slept in the chair and then in the middle of the night he was so uncomfortable, so I let him get into the bed with me and I kind of squished over, but it was... it was half comfortable for both of us I guess.

Although a few fold-out chairs were available to facilitate overnight support, there were a limited number, leaving the majority of support people with only a basic chair to sit/sleep on. While partners could stay overnight with mothers in a private room, many decided to leave because of insufficient sitting/sleeping arrangements.

Although 24-hour rooming-in was widely practiced in hospital following the first night of separation, it was not routinely practiced for the full duration of hospital stay, and during routine infant care, falling short of BFI recommendations. Results also indicate that while some mothers had the option of a support person remaining with them in hospital 24-hours a day, the option was dependent upon the availability of a private room and the financial ability of a mother to pay for a private room (or to access coverage through a plan). Because of this, access to a support person 24-hours a day had a social gradient; with mothers who were unable to afford a private room denied the option of overnight support. Poor rooming-in practices during the first 24-hours

and a lack of ability for all mothers to have a support person remain in hospital 24-hours a day highlight important shortcomings in the implementation of Step 7.

4.6 Step 8: Encourage baby-led or cue-based breastfeeding. Encourage sustained breastfeeding beyond six months with appropriate introduction of complementary foods.

Step 8 of the BFI involves ensuring that mothers are encouraged to practice cue-based feeding, feeding for an unrestricted frequency or duration, are informed how to identify signs of effective breastfeeding,⁸ and how to recognize signs that their infant is ready for solid foods at 6-months of age or beyond (BCC, 2012b). Step 8 also recommends that mothers report being given an opportunity to discuss sustained breastfeeding with staff for the first 6-months following birth and beyond. Because interview data were collected from mothers within 4 weeks following delivery, data were not collected on sustained breastfeeding up to 6-months and the introduction of solid foods.

Results indicate that mothers were encouraged to feed according to a fixed schedule rather than according to infant feeding cues at the Janeway Children’s Hospital/Health Sciences Centre. When asked how to know when it was time to feed their baby, all twelve interview participants mentioned receiving instruction in hospital to feed their infant on a 2.5 to 3 hour schedule. See Table 4-6.

Table 4-6: Step 8 Interview Data

	Yes	No
Aware of infant feeding cues and feeding on demand in hospital	6	6
Encouraged to feed every 2.5 to 3 hours	12	0

⁸ Data on the signs of effective breastfeeding was discussed in Step 5.

In the statements below, two mothers discussed the recommendations they received. These were largely representative of maternal responses when asked how they knew it was time to feed their infant.

P3: They were recommending every 3 hours, so they were checking that, monitoring that, and even when she was rooming-in with me, the nurse, cause I had said I have an alarm and stuff so I can set it to wake me up, but they were checking that part, they were checking to make sure I was feeding every 3 hours.

P7: They said to me, “Feed her every 3 hours.” And that was like... it’s law. It’s every 3 hours, especially where they’re trying to get your milk to come in. And they didn’t really say, they just kind of woke her and me up every 3 hours.

Mothers in all three focus group discussions consistently reported receiving instruction in hospital to feed every 2.5 to 3 hours. Maternal accounts also suggested that feeding on a 3-hour schedule was closely monitored in hospital.

Although few participants mentioned receiving advice to feed their infant on demand, six of the twelve mothers interviewed expressed an awareness of infant feeding cues and on-demand feeding:

P4: Every 2-3 hours they were gauging, sometimes they’ll feed every hour and sometimes he’d feed every 4 hours, so they just give you the basics of every 2-3 hours. And you’d know when he was ready to feed, he’d open his mouth or he’d be trying to pick at your fingers, or something like that, so those kind of signs.

P1: They told me, “Make sure he’s nursed every 2.5 to 3 hours when he’s young.” You know, turning his head to the side, you know mouthing stuff, and that kind of thing. Most of that I did remember, but most of the nurses did remind me at the same time.

While one mother mentioned being reminded of infant feeding cues from a nurse, it is unknown where most mothers learned of cue-based feeding. Of the six interview participants aware of infant feeding cues and demand feeding, five were multiparous with previous breastfeeding experience and mentioned learning about cues and on-demand feeding from a

source outside of the hospital (such as from a prenatal class, previous breastfeeding experience, personal research, their social network, or family doctor). This highlights that while some mothers may have learned about on-demand feeding in hospital, it was not routinely recommended, taught, or practiced in hospital.

One mother shared that while she was instructed to feed ever 2.5 to 3 hours in hospital, she was encouraged in her prenatal class to feed according to infant feeding cues. She felt concerned about the feeding of her infant when she wanted to eat more frequently than every 2.5 to 3 hours.

P6: They wanted me to feed every 2.5 to 3 hours, and I don't remember who really told me. I think it might have been one of the nurses. But I remember in the prenatal classes again, her saying like, "Don't wait till the baby's crying for it, you'll see them you know like (smacking lips) doing that kind of thing and that's when they want to feed." And um, we did have a night where it seemed like she wanted to feed a lot more often and I was able to call the Public Health Nurse and she just explained to me about cluster feeding and stuff, that sometimes they do that when they're trying to increase the milk supply and everything.

Although this mother was aware she should recognize and respond to infant feeding cues, she had not been informed about cluster feeding and had not been told that much more frequent feeding was normal in newborns. While she was able to ask a public health nurse about her baby's feeding behaviour after discharge, her concern reflects a lack of discussion in hospital about normal infant feeding frequencies/patterns.

While cue-based feeding was not frequently discussed or recommended in hospital, most mothers who reported cue-based feeding mentioned feeling supported by healthcare staff as long as they fed at least once within a 3-hour period. In one case, however, a mother reported being challenged by a nurse for deviating from the recommended 3-hour schedule by feeding more frequently than every 3 hours:

P24: I had one nurse get upset with me because I was on-demand feeding her. I fed her the 2-hour break in between, and I the nurse happened to walk by and she looked and she said, "What are you doing?" And I said, "I'm feeding her." And she said, "Well it's not time to feed her." And I said, "Well, she's up and she's upset." She said, "You have to learn other ways to soothe your baby." And I said, "Ah, no. I really have issues with getting my milk to come in." And she looked at me with the size of my breasts, and she says, "But you've got huge breasts." (Laughing). And I said, "That really has nothing to do with it, so I'm gonna feed my baby when she wants to eat." But most of the nurses were very, you know, helpful. But I had the, you know, "If you feed them when they want to feed, you're never gonna get any time to yourself." And then I had other ones that were like, "Yeah, just feed her. If she wants to feed every 15 minutes in the beginning, then do it." I said, "That's what I'm gonna do."

Although most mothers were not discouraged from feeding more frequently, this statement indicates that some healthcare providers at the Janeway Children's Hospital/Health Sciences Centre may not be aware of best practices for infant feeding, or their role as a healthcare provider in supporting breastfeeding on-demand. Moreover, scheduled feeding may be so deeply emphasized as correct practice, that when a mother deviates from this practice to use cue-based feeding, nurses may regard this as a problem.

Step 8 recommends that no restriction be placed on infant feeding duration, as duration should be determined by the length of time the infant is actively feeding. Despite this, most mothers reported receiving information at the Janeway Children's Hospital/Health Sciences Centre on how long (in minutes) they should breastfeed their baby for each feeding:

I: Do you know how long they recommended you feed for each feeding?

P1: I think it's usually 10-15 minutes on each side.

Another mother expressed confusion with how to know when her infant was finished feeding:

I: Did they give you any indication of how long you should feed, or how to know when feedings over?

P7: Um no. That's something that was confusing to me. It's like, anywhere you go, you ask ten different people, you get ten different answers. And they come and they ask, "How was her feeding? How long was it?" Some people would say, "Well, 20 minutes is not very long." And sometimes she'd be there anywhere from 20 minutes

to 45 minutes, and they'd say, "Well 45 minutes is kind of too long, but 20 is not long enough," kind of thing. And then, some wouldn't say anything, and would say, like, "Oh. Okay, that's good," you know? I guess it all depends. It's like anywhere you go. It's their own experience I guess and what they know.

These statements reflect hospital recommendations to breastfeed for a specific length of time, rather than according to infant feeding cues and desires. Different recommendations from healthcare providers on the duration of feeding indicate inconsistent communication with mothers about optimal feeding duration. They also indicate no discussion about signs of successful feeding (visible/audible swallowing and jaw movement) from which to assess whether an infant is actively feeding at the breast. Confusion about how long to breastfeed and how to assess when feeding is complete is demonstrated in the statement below.

I: Did they ever give you any information on how long each feeding should be, or how to tell if he's had enough?

P9: That was always an issue. I remember I kept asking people and it was mostly just inconsistent. Some of them said, mostly the response I got was, "Well you know, wait to see what the baby... let him tell you when he's done." But he never came off, so I was begging, "Just give me a number people." And they'd be like, "Oh, you know, 20 minutes." Especially where I didn't have any milk, so he'd just sit there suckling. So they said about 20 minutes. But then the pediatrician came in, and she said, "I don't know why everybody's there with their blackberry timing it." She's like, "You look at the baby, not the clock."

While this mother was encouraged by nurses to let her infant determine the length of feeding duration, she seemed unsure of how to assess the difference between feeding and suckling at the breast. This seemed to raise confusion for her about how long to keep her infant at her breast for feeding, which prompted her to ask nurses for a specific length of feeding time. Interestingly, she mentioned that her pediatrician commented on the fact that she and other mothers in the unit were timing their feeds to determine the end of feeding, rather than looking at their baby for signs of drinking. This comment suggests that mothers may have been told to time their

breastfeeding, rather than to watch for infant jaw movement and other signs of effective feeding.⁹ This also suggests that at least one pediatrician was knowledgeable and willing to inform mothers about how to use infant feeding cues.

Research results indicate that mothers who delivered at the Janeway Children's Hospital/Health Sciences Centre were not consistently encouraged or instructed to practice cue-based feeding, were not well informed of infant feeding cues, and were not consistently instructed to breastfeed with unspecified frequency or duration. Although some mothers demonstrated knowledge of infant feeding cues and feeding on-demand, few discussed learning about cues or on-demand feeding in hospital. Results for this section indicate inconsistent adherence with Step 8 at the Janeway Children's Hospital/Health Sciences Centre.

4.7 Step 9: Support mothers to feed and care for their breastfeeding babies without the use of artificial teats or pacifiers (dummies or soothers).

Step 9 of the BFI involves supporting mothers to feed and care for their babies without using artificial teats or pacifiers, and providing mothers with appropriate information on feeding and caring for their babies without using artificial teats (BCC, 2012b). It is recommended in Step 9 that when an infant is given a bottle or pacifier, the decision is either medically indicated, or an informed decision made by the mother.

Of the twelve mothers interviewed, none reported pacifier use, or the use of an artificial teat/nipple in hospital. Of those who supplemented with formula (n=5), all did so for a non-medical reason and indicated their infant received formula from a bottle (with an artificial nipple attachment). Although participants did not explicitly connect feeding with a bottle to the use of

⁹ Refer to Step 5 for further information on signs of effective feeding.

an artificial nipple, reports indicate that artificial nipples were used in hospital when supplementing occurred. See Table 4-7.

Table 4-7: Step 9 Interview Data

	Yes	No
Use of pacifiers in hospital	0	12
Use of artificial teat when supplementing (use of bottle with nipple)	5	7

Those who supplemented with formula did not report receiving any information or encouragement from healthcare providers to supplement without the use of a bottle with an artificial nipple attachment. In the statement below, a focus group participant supplementing for medical reasons mentioned using a bottle for feeding because no other feeding options or methods were available. Although another focus group participant recalled alternative techniques to feeding with an artificial nipple being encouraged in her prenatal class, the supplementing mother shared that while she wanted to feed without using an artificial teat, no alternative options or methods were encouraged for supplementation.

P19: At the breastfeeding clinic, they try to do everything to try to get you to avoid using a bottle. If you have to, like I had to express milk because he was jaundice and not gaining enough weight, and I didn't want to supplement formula, but they said to pump up extra and get it in that way...

P18: I wasn't given an option... there was no other method.

This indicates that although the avoidance of artificial nipple attachments is recommended in hospital prenatal classes, alternatives may not always be available or promoted to supplementing mothers in hospital. While supplementation was medically recommended in this case, the mother indicated she would have preferred an alternative method for feeding that did not use an artificial teat. She later mentioned that breastfeeding was a constant struggle with her daughter, and attributed her difficulty with breastfeeding to her baby's preference for a bottle after weeks of formula supplementation with an artificial nipple. She stated, "She took to the bottle really

really well. That’s why... why she never took to breastfeeding. She took to the bottle right away” (P18).

A major concern with the use of artificial nipples for feeding is the possibility it will interfere with breastfeeding, as an infant may develop a preference for an artificial nipple, or may experience nipple confusion (Jaafar et al., 2012). A focus group participant discussed nipple confusion and her struggle to breastfeed her son after supplementing with a bottle for a medical reason stating, “I can attest to nipple confusion because my little one got it and he forgot how to latch altogether. It was the most stressful experience” (P19). These statements illustrate the breastfeeding challenges some mothers faced after using an artificial nipple, and are aligned with evidence supporting the avoidance of artificial teats (Agboado et al., 2010; Benis, 2002; Declercq et al., 2009).

Although research results do consistently demonstrate the absence of pacifier use in hospital, they highlight a lack of full adherence to Step 9 due to the frequent use of artificial nipple attachments on bottles and evidence suggesting a lack of engagement with mothers about artificial nipple and pacifier use.

4.8 Step 10: Provide a seamless transition between the services provided by the hospital, community health services and peer support programs. Apply principles of Primary Health Care and Population Health to support the continuum of care and implement strategies that affect the broad determinants that will improve breastfeeding outcomes.

Step 10 of the BFI Ten Steps recommends that mothers are provided with accessible support and resources to facilitate a smooth transition from the hospital to the community. This involves ensuring mothers are provided with a way to access breastfeeding support outside of office hours, have access to peer support programs, and live in a community that is supportive of

breastfeeding (BCC, 2012b). Table 4-8 presents data on the community support and resources provided in hospital as reported by mothers interviewed.

Table 4-8: Step 10 Interview Data

	Yes	No
Referred to a community support group	12	0
Received written information on breastfeeding, pumping, and post partum care	12	0
Received information on how to access breastfeeding support outside of office hours	unknown	unknown
Received follow-up call or visit from public health nurse following hospital discharge	12	0

Of those interviewed (n=12), all reported being referred to a community peer support program or group in their area, and all reported receiving written information on breastfeeding, pumping, and post partum care before being discharged from the hospital:

P4: They gave me a pamphlet on the breastfeeding support groups, which we've been to, and they gave me all the different ones and what days are which and the times on them and stuff, so they explained all that right before we were discharged.

I: So did you feel like you got enough information if you needed to seek something out later on?

P4: Yeah, they told us which ones had the lactation consultants and which ones were more social, which ones just for the groups to go see a nurse. It was nice, we wouldn't have known otherwise.

P8: I had a whole packet of stuff, and the nurse that told me about it was very methodical about, you know, the paperwork on the way out. Like she'd done it a thousand times. So that was good. I mean, I think for a first time mom it would be really good. ... And I liked the numbers and stuff, there's numbers you can call for this organization or that.

These statements indicate mothers felt they were provided with information on how to access breastfeeding support and peer support programs. It is unknown whether mothers received information in hospital about accessing support outside of office hours once discharged, as this was not explicitly asked. It is also unknown if support groups exist for mothers who were not breastfeeding. While most mothers expressed feeling well informed from the information

they received upon discharge, a few reported feeling that pamphlets were not the best way to communicate information. Other mothers, however, mentioned that pamphlets were helpful because they could read them at their own leisure in the days/weeks following hospital discharge.

All twelve mothers interviewed reported experiencing at least one follow-up call or visit from a public health nurse within the first few days following hospital discharge. Mothers mentioned receiving information from their public health nurse on peer support groups/programs, infant feeding, bathing, weighing, and maternal self-care in recovery. Maternal experiences with public health nurses were widely reported as positive however were not explored in this research.

Step 10 also details that mothers should be able to report that they live in a community that is supportive of breastfeeding. All mothers interviewed (n=12) reported being informed and aware of breastfeeding peer support groups in their community (the existence of breastfeeding support groups indicates support for breastfeeding), however it is unclear if this was sufficient to meet the BFI criterion, as this question was not explicitly asked. Despite this, four mothers mentioned feeling uncomfortable with the idea of breastfeeding in public. While this may not reflect an unsupportive breastfeeding community, it does reflect broader social norms about breastfeeding, motherhood, and appropriate bodily practice in the public sphere. Cultural attitudes and maternal discomforts with breastfeeding in public will be explored in greater detail in Chapter 5.

4.9 Summary

Maternal healthcare experiences at the Janeway Children's Hospital/Health Sciences Centre reveal a lack of complete and consistent adherence with optimal care practices outlined in the Steps 3-10 of the BFI Integrated Ten Steps. While maternal accounts suggest that some

healthcare practices are more closely aligned with guidelines than others, gaps are evident, and highlight areas for improvement with infant feeding healthcare provision.

Maternal reports reveal a need for routine communication between healthcare providers and mothers in hospital on: the importance and process of breastfeeding (Step 3), the implications of supplementation (Step 6), how to initiate and maintain lactation if separated (Step 5), how to pump and store breastmilk (Step 5), recognize infant feeding cues (Step 5), and recognize signs of effective feeding (Step 5). Accounts also indicate a need for: longer durations of skin-to-skin contact (Step 4), the provision of breastfeeding assistance at subsequent intervals (Step 5), and the provision of rooming-in the first night in hospital (Step 7). Practices could also be improved by: ensuring that all mother-infant dyads remain together for infant exams (Step 7), are able to have a support person stay with them overnight in hospital (Step 7), are encouraged to feed according to infant feeding cues (Step 8), and informed of how to feed without the use of an artificial nipple attachment (Step 9). Accounts suggest possible adherence to Step 10, however indicate that current hospital infant feeding practices do not adhere to guidelines specified in Steps 3-9 of the BFI Integrated Ten Steps.

Reported inconsistencies with infant feeding care provision at the Janeway Children's Hospital/Health Sciences Centre suggest there may be a need for improved policy communication, policy monitoring, breastfeeding education and training, and support for healthcare providers. Inconsistencies in hospital care practices may reflect broader institutional conditions and barriers that limit the ability of healthcare professionals to provide evidence-informed care. These concerns will be discussed in Chapter 7.

Chapter 5 Maternal Experiences with Hospital Care and Infant Feeding

This chapter presents emerging themes from interview and focus group discussions on maternal experiences with hospital healthcare provision, infant feeding, and mothering. Maternal experiences with healthcare providers, hospital environment, inconsistencies, guilt, the challenges, pains and rewards of breastfeeding, infant feeding culture in NL, pressures to breastfeed, personal sacrifice, and personal care, are presented along with maternal recommendations for healthcare improvement. While some themes shine light on hospital practices related to adherence with Steps 3-10 of the BFI, others provide information on other relevant components of maternal infant feeding care and experience in hospital. Although maternal experiences with labour and delivery, feelings of lack of choice/agency, and lack of privacy of the body were emerging themes in this research, they do not directly relate to infant feeding care provision at the Janeway Children's Hospital/Health Sciences Centre and are therefore detailed in Appendix B.

Themes presented in this section highlight opportunities for improvement with maternal and infant feeding healthcare delivery and engage with the complex struggles, pressures, decisions, conflicts, and concerns mothers experience with their own healthcare, infant feeding, and mothering practice. Themes highlight opportunities for improvement with infant feeding healthcare provision at the Janeway Children's Hospital/Health Sciences Centre, and engage with possible social, cultural, and institutional factors contributing to infant feeding decision-making and practice.

5.1 Maternal experiences with healthcare providers

5.1.1 Nursing care: Variations in quality and access

Maternal accounts indicate that nurses were the primary providers of care for mothers in labour, delivery, and post-partum recovery at the Janeway Children's Hospital/Health Sciences Centre. Data suggests that nurses interacted with mothers in hospital more than any other healthcare professionals, and were the primary contacts for breastfeeding information, assistance, advice, observation, and support. As one mother stated:

P7: As far as I'm concerned, the whole hospital runs on the nursing staff... I saw the doctors this much (holds fingers an inch apart)... The doctor, I saw her the day she came to check my incision and then the following day she came and asked me, "So when do you want to go?" So I'd only seen her for maybe 10 minutes of the whole thing. But the nurses were steady, coming in, checking you out, making sure the baby was latched on right.

While the majority (n=11) of mothers interviewed (n=12) reported positive experiences and interactions with hospital nursing staff, some (n=4) also reported one or more negative experience with nursing care in hospital. A few mothers in each focus group discussion also reported some negative interactions with nurses. The following accounts demonstrate the range of experience reported by mothers regarding nursing care: "They were perfect. They were very helpful, they make sure that, you know, anytime you need anything, just push the buzzer and they come right away. They ask, "Is there anything you need?" I found them very helpful" (P1). Another mother reported, "I did find a big difference with the nurses. Some of them were great, some of them were horrible" (P25).

As discussed in Chapter 4, negative experiences with nurses most commonly related to painful/forceful breastfeeding assistance, rude/impatient interactions, and a general lack of assistance and support. Five of the twelve mothers interviewed reported feeling that nurses in

hospital were overworked and exhausted. This concern was also raised by mothers in all three focus group discussions and is evident in the following interaction:

P24: They are incredibly overworked.

P26: I know that.

P24: And I'm not trying to say that they... it's just that you can tell that they're overworked and overtired and annoyed.

P25: It's true.

This excerpt highlights a potential issue with institutional working conditions for nurses, possibly related to insufficiently staffed Maternity Units, long and challenging schedules, and/or insufficient supports for nursing staff at the Janeway Children's Hospital/Health Sciences Centre. When engaging with the breastfeeding assistance and support received by mothers in hospital (Step 5), poor nursing care experiences were often understood by mothers as a result of nurses not having enough time to assist and support breastfeeding, or to check in with mothers regularly.¹⁰

It is important to note that while positive maternal experiences with nursing staff indicate satisfaction with care, they do not always mean that optimal care was provided. This is demonstrated in the following statement: "The nurse that I had, she was really good. She said it was fine [to feed with formula] she completely understood and she was very supportive of it, so that was good" (P5). While this care experience was positive for the mother, it is clear that it was not optimal, as this mother indicated receiving no information on the health implications of supplementation before receiving formula in hospital.

Although most interactions with nurses were reported as positive, a number of mothers also shared negative experiences and interactions with nurses. While this section provides a very broad overview of the nursing care received by mothers, it reveals that nurses were the primary

¹⁰ Please refer to Chapter 4, Step 5 for more details.

infant feeding care providers in hospital, that maternal care experiences with nurses were both positive and negative, and that nurses may experience working conditions that make the provision of optimal infant feeding care challenging.

5.1.2 Lactation consultants: Helpful but hard to access

Mothers reported that lactation consultants were available to provide breastfeeding information, assistance, and support at the Janeway Children's Hospital/Health Sciences Centre. Although not routinely seen by all breastfeeding mothers, mothers indicated that lactation consultants were often available to help those with breastfeeding challenges and uncertainties, and who requested an appointment before discharge.

While only four of the twelve mothers interviewed reported seeing a lactation consultant before hospital discharge, all who did reported that their lactation consultant was knowledgeable and helpful. As one mother stated, "the lactation consultants have been fantastic and critical in all of the things that we have to do" (P3). When asked if seeing a lactation consultant made a difference, focus group participants responded:

P17: Oh, big time.

P19: Yeah, for sure. Yeah. They're just so calming and they just help you look at the bigger picture... that was my feeling.

P20: Well once I saw her in the clinic, I got a lot more confident. So I didn't have the hospital experience, but I did make sure I got to see one in the first few weeks.

P17: Yeah, they're just so much more knowledgeable.

Those who reported seeing a lactation consultant often discussed feeling more confident about their ability to exclusively breastfeed following the visit:

P7: There was nothing they could do for the soreness, but I was comfortable that she was latching on good, like the lactation consultants said, "My dear, you got no worries. You can see she's got lots of milk, the baby's latching on great" she said, "You're gonna have no trouble." So that was... that made me feel a little better that day, like being able to go home.

While mothers from both interviews and focus groups reported positive interactions with lactation consultants, a number shared that they were not able to meet with a lactation consultant within the first 24 hours following delivery. The issue of having to wait more than 24 hours following delivery to see a lactation consultant was raised by mothers in a few interviews, and in all three focus group discussions. A mother shared:

P7: If you're gonna be breastfeeding, they should offer you a lactation consultant that day you have the baby, but I was told that the lactation consultant won't come unless you're there at least 24 hours, which I thought was a bit, you know? If you're gonna breastfeed, you should be able to have a lactation consultant right away instead of a day later when you're probably already sore.

This statement communicates a belief that seeing a lactation consultant early is a preventative measure to avoid breast pain and discomfort caused by an improper latch. Another mother shared:

P24: She was born on Saturday and I didn't get to see the consultant until Monday because they don't come in on the weekends apparently. And that was a bit frustrating that I wanted a consultant right away. You know, I knew that I couldn't have it instantly, but I would have liked to have it before the first 8 hours because, you know, the first 8 hours when you're breastfeeding is vital in my mind.

While waiting a minimum of 24 hours before accessing a lactation consultant was sometimes frustrating for mothers, depending on their day of delivery, it was not uncommon for mothers to wait longer to see a lactation consultant because they were not available in hospital on weekends. A mother described her frustration with being told that she could not see a lactation consultant because it had not yet been a 24 hours since her delivery, even though it was before a long weekend:

P3: I made that request to see the lactation consultant and they said, "Well, you know, they don't come until you've been here for 24 hours, and tomorrow [Friday] is a holiday. You can go to the breastfeeding clinic on Tuesday.

While lactation consultants were extremely helpful for addressing breastfeeding issues and providing reassurance, maternal reports suggest that they were not always accessible or available when mothers felt they needed them. Reports indicate that early breastfeeding difficulty and discomfort from improper latching could be avoided by allowing mothers to see a lactation consultant within the first 24 hours following delivery, and by expanding the availability of lactation consultants through the weekend.

5.1.3 Physicians: Limited interaction

Physicians were rarely mentioned in maternal discussions of labour, delivery, infant feeding, or post-partum recovery. When asked about the quality of the physician care received, the majority of mothers reported positive experiences however mentioned limited interaction and engagement with physicians. As one mother stated, “She only came in for the last 10 minutes I think. That’s the only memory I have of her, was the last couple of minutes when he crowned. The nurse buzzed the doctor in” (P14, FG 1). Similarly, another mother stated, “Um, they weren’t a big part of anything really” (P8). A few mothers expressed concern and surprise over how little they saw and interacted with physicians, and some shared feelings that physician care was not very accessible when requested.

P9: I felt like it was hard to get access to a doctor. My baby had a blocked tear duct, and I kept asking people, “Why is there green goop coming out of his eye? Can I see a pediatrician?” I felt I was asking for it, and it was like an hour before we left when we got to finally see a pediatrician, you know, even though they’d written a note. And you know, for myself to see a doctor, like in hindsight I probably should have asked, but I just assumed I would get to see a doctor... I just felt like there wasn’t much physician access.

This statement highlights that gaining access to a physician was not always easy for mother-infant dyads in the Maternity Unit. When discussing personal medical care in recovery, a few mothers expressed feeling they should have received personal follow-up care from a physician in

hospital before discharge. While this may be more indicative of maternal perceptions of a medical need to see a physician following delivery, than an actual medical need for follow-up care, it was an interesting trend. This issue will be discussed in further detail when examining the theme of maternal self-care/aftercare in recovery.

Although maternal accounts indicate that interactions with physicians were limited, most mothers reported positive interactions, and did not discuss physicians as major actors in their hospital or infant feeding experience. This suggests that interventions focused on improving hospital infant feeding practice may be most effective if directed towards nurses and lactation consultants (primary infant feeding care providers for mothers) rather than physicians.

5.2 Differences in quality of nursing care received pre- and post- partum

Mothers frequently reported a noticeable difference in the quality of nursing care experienced in the Case Room where they laboured and delivered their baby, compared to the Maternity Unit, where they rested and recovered after delivery. As one mother stated, “The case room staff were a little more hands on, and probably a bit more supportive than the staff upstairs. Yup, we were sort of left to our own devices a little more upstairs” (P3). Similarly, another mother stated,

P4: I think they're more attentive to you in the delivery room, they're more concerned. They're just around more, you know, they seem like they made the time to sit with you a little bit, whereas the nurses upstairs [in the Maternity Unit] just came from patients and you don't get the kind of connection that we got in the delivery room with the nurses, they're kinda just in, checking on you, and then they leave.

These statements indicate more attentive care from nurses in the Case Room than in the Maternity Unit. Although this difference may be attributed to more immediate care needs in

labour and delivery than in recovery, mothers indicated feeling as though they did not always receive the care they needed in the Maternity Unit. As one mother described:

P14: I found the labour nurses were fantastic. I loved the labour ward, even though the delivery was un-nerving, and the nurse that I had... I had a really good pushing and delivery, and I found that it was mainly because of her. She was really good at like telling you what to do, when to push, and she was really nice about it. And then after, in the maternity ward... I think there was one day-nurse I had that was half-decent. But the rest I just found were kind of hindering any kind of progress I was making with breastfeeding.

Differences in physical environment were also commonly mentioned, with mothers typically describing the Case Room as spacious, comfortable, and clean, and the Maternity Unit as crowded, uncomfortable, and dirty. The physical environment of the Janeway Children's Hospital/Health Sciences Centre and its contribution to maternal care experiences is discussed in greater detail below.

5.3 Hospital environment

Mothers commonly referred to the physical environment of the Janeway Children's Hospital/Health Sciences Centre when discussing their hospital healthcare experiences. Dialogue most often focused on hospital cleanliness, comfort, space, and noise, as well as the conditions within private rooms and ward rooms. Of the twelve mothers interviewed, ten reported at least one or more negative experience with the hospital environment. In many cases, experiences with the physical environment of the hospital had an impact on infant feeding experience.

As mentioned briefly in the section above, mothers reported a difference in the physical environment and quality of nursing care received in the Case Room, where they laboured and delivered, compared to the Maternity Unit, where they stayed following delivery. These differences are detailed in the following excerpts:

P10: On the labour floor, they were really really wonderful, really wonderful, just a great team. They work well together. They were really helpful, it seemed like any questions we had, they were always there to answer. The level of care was there. The room was awesome. The amenities were great. ... I could not ask for a better place to give birth, or you know, to stay during that time... The bad part happens right after the c-section, when you move to the Maternity Unit.

When reflecting upon her experience in the Maternity Unit, she later stated:

P10: The bed I had was ancient. I couldn't even sit up straight... on an angle leaning forward after having a c-section! The chair was wood. Where was I going to [breastfeed]? I had to get used to holding the baby. I couldn't even imagine breastfeeding on a wooden chair. Luckily I took my nursing pillow with me, because if I didn't my back would have been broke from leaning this way or that way in the bed... I had to learn what to do for the first time and they didn't even have a rocking chair or a bed that worked properly. It was horrible. And after having a section... there was nowhere for [partner] to sleep. They could at least have had a comfortable chair there so she could stay with me.

Similarly, another mother shared her experience with the physical environment of the Case

Room and Maternity Unit:

P4: The delivery room was great. I thought it was a good size, you know, there were lots of places to sit and stuff. It seemed really good, lots of room, it wasn't too cramped, and everything was kind of out of the way. As for the other rooms [in Maternity Unit] they were small... they're a little bit outdated. I think they should have been more comfortable, especially after just having a baby and stuff. Even for my husband, they just had a basic chair, like something you'd see in a waiting room... there was nowhere even comfortable for the dad's to even sit... It makes it a lot easier for the mom to have the husband there, so it would have been nice for them to have something.

These statements highlight the importance of a comfortable hospital bed and comfortable chair, both for facilitating rest and breastfeeding, and for accommodating a guest for overnight support.

In the first case, uncomfortable facilities made breastfeeding more challenging and physically uncomfortable, and in both cases, it also made it difficult for a support person to stay in hospital overnight.

Research participants frequently discussed uncomfortable facilities in the Maternity Unit.

In the excerpt below, focus group participants discuss the hospital beds:

P16: I wish I had a longer bed. It was torture for a tall person.

P14: Yeah, yeah.

P13: They were short. Those beds were awful.

P15: No problem for me.

P13: Yeah, I'm only 5'8" so it was bad.

P14: They were really uncomfortable.

Of the twelve mothers interviewed, six reported uncomfortable hospital beds and chairs. Of these, three mentioned that uncomfortable beds and chairs made breastfeeding more challenging because it was difficult to get into a position for breastfeeding that was comfortable and supportive. A mother stated:

P1: The beds are uncomfortable. Especially having the c-section. I found it difficult getting in and out of the bed without trying to pull. Everything else was fine. The chair that was in my room was uncomfortable. I couldn't sit in that at all. It just caused me too much back pain. Everything else was fine. The bathroom and stuff was fine.

When discussing the hospital environment, seven of the twelve mothers interviewed frequently raised the issue of noise. The most common noises mothers mentioned were loudly ringing telephones, crying babies, and the heart monitors of other patients in ward rooms. Mothers who discussed noise often mentioned that it disrupted their sleep and ability to relax. Not surprisingly, those who stayed in a ward room with other mother-infant dyads reported noise as a greater issue than those who stayed in a private room. As one mother stated, "The hospital's really noisy and I just found it really difficult to get any rest, and I went home exhausted. I really found it very noisy" (P17). Another mother shared:

P11: Being up on the maternity ward, the only issue that I had was that there were no private rooms available. So I was in a ward with three other women and three other babies, right across from the nursery, and it was... it was non-stop chaos the whole time.

I: Okay, and did you find that it was hard to rest then?

P11: Oh, there was no rest, no, not at all. Because even, even when my baby was quiet, and I was trying to sleep, there was bound to be someone else in the room, on the phone, or with a visitor, or their baby was crying... or, you know what I mean? The one or two times that everybody in the room quieted down, there were babies in the nursery crying. So it was just... it was madness. It was crazy.

Mothers also commonly reported limited space and privacy in ward rooms. When reflecting upon the physical space of her ward room, a mother stated, “It would have been a nice to have a little more room. It was cumbersome for them [husband and daughter] to move around... they were banging into the bed and into the wall” (P4). Lack of privacy in ward rooms was raised by a number of mothers and is detailed in Appendix B.

A couple (n=2) of those interviewed reported very negative experiences with the cleanliness of the hospital Maternity Unit. Their experiences are communicated in the statements below:

P8: It was really unsanitary. They had one shower [in ward room] that was basically a closet and there were like dirty rags, like bloody in the shower. And I was like, “What country are we in?” It was crazy. And the bathroom was some level of cleanliness, but there were smears of blood on the floor, like not full smears, it looked like it was wiped up, but it wasn’t, you could still see it. So I was really stressed about just like getting some crazy disease, or my child getting sick, you know? So I was disappointed and upset. And I guess I had higher standards because I came from an awesome hospital in the U.S. [first delivery experience]. I just thought it would be a normal hospital experience, but it was really really bad.

P9: I felt like it was dirty. I wanted to come home because I felt like it was dirty. Someone told me, “Don’t bring slippers you ever want to see again.” My husband actually picked them up with a bag to put them in the garbage before we left. The floors are filthy. The beds are uncomfortable. The pillows are plastic. The pillowcases kept slipping off. It was so uncomfortable. I just couldn’t wait to get back home, back to my own house. And the showers, I was in a private room but my shower didn’t work, so I had to go to a ward room to shower, and I was just trying not to touch anything as much as I could. I mean, it was just motley.

Although reports of unsanitary hospital conditions were not frequently raised, those with concerns over hospital cleanliness reported very poor sanitary conditions that affected their

ability to rest and feel comfortable in hospital. Their accounts highlight a possible need for more thorough and frequent housekeeping within the Maternity Unit to keep up with high patient use, as well as for better monitoring and response to poor sanitary conditions.

While reference to hospital environment was common, reports from mothers were not always negative. Some mothers mentioned no problem with beds and chairs, noise, physical space or cleanliness in hospital, and some reported positive experiences with the hospital environment. One mother shared, “It was good, like I didn’t have any negative experiences with anything at all... I don’t think I would have changed anything really... The experience was really positive for me” (P6). Similarly, another stated:

P3: I noticed a lot of posters and stuff to encourage women to breastfeed and to encourage them to room-in and have skin-to-skin. And I think from that point of view it’s very positive, but no one was pushy about it... They were encouraging. I thought it was a positive environment. We were quite happy.

Although experiences were mixed, the majority of mothers reported one or more negative experience with the hospital environment. Overall, mothers reported a need for more comfortable sitting and sleeping arrangements in hospital rooms, and improved cleanliness in hospital rooms and bathrooms. Although it may be difficult to reduce noise in a ward room with four mother-infant dyads, it may be possible to reduce the volume of the telephone or to develop an alternative method for contacting hospital reception (such as though a low-volume cell phone or beeper device) in order to reduce noise and promote rest in the Maternity Unit. Accounts suggest that mothers were often not getting the rest they feel they need in hospital, highlighting a need for improved hospital amenities.

5.4 Inconsistencies with care

Inconsistent care provision was a common theme raised by mothers when discussing hospital infant feeding care experiences. In Chapter 4 inconsistencies were most commonly raised when discussing the duration of skin-to-skin contact, the recommended duration of breastfeeding, and the provision of breastfeeding assistance, support, and follow-up care. As one mother noted, “I just felt like I was getting such different advice from all the ladies [nurses], and they were all so sure” (P8). Similarly, focus group participants discussed inconsistent messages in hospital:

P16: It felt like everybody was telling me something different.

P14: Especially if you have problems.

P16: Yeah, and I know every nurse is going on their own experience, and what they’ve found over their career, but still. You get one bit of information from a nurse and then something almost contradictory.

Of the twelve mothers interviewed, five reported receiving inconsistent information in hospital. Of these, four reported receiving inconsistent breastfeeding assistance with positioning and latching, two reported inconsistent information about how long to breastfeed during each feeding, and one reported receiving inconsistent information about when to begin pumping. Inconsistent information and assistance was often experienced by mothers as confusing and frustrating. One mother said, “Every nurse kind of did something or said something a little bit differently to me, and I found that really stressed me out” (P19). Although inconsistent breastfeeding instruction was stressful for most, one mother found varied breastfeeding advice and instruction helpful because it provided her with new strategies to try. She stated:

P9: Every shift there’s a change in nurse, so I had a different nurse every 12 hours. And every single one of them I would ask them to come in, like, “Can you show me how to get him latched on again?” You know? And they all had a different technique, which was interesting, but it was really helpful because it was a number of different

ways for me to try to get him latched on. And anyways, so yeah, anytime I wanted help, someone was there.

While inconsistent information and assistance confused and frustrated most mothers, in some cases it was found to be helpful. Reported inconsistencies with breastfeeding information and care provision indicate that mothers experienced different care depending on their healthcare provider. This highlights a potential need for improved policy communication and monitoring, and breastfeeding education and training to ensure healthcare providers follow consistent evidenced-informed practices.

5.5 Less breastfeeding support for 2nd or 3rd time mothers

A few mothers in this research mentioned they received much less breastfeeding instruction and support in hospital with their second and/or third child than they had with their first because it was assumed they knew what they were doing. This is communicated in the statements below:

P17: I was a second time mom for this one and I found that they just sort of assumed that I knew how to do it, and I didn't really have a lot of questions. I just kind of remembered what I needed to do and did it, but I found they just kind of left me. They didn't even come to say, "Did you feed your baby?"... The second time it's like they didn't teach me anything.

P1: A couple of times nurses said, you know, "How are you doing with this?" I'd say, "I'm fine." "Oh, okay, well you're an old pro at this," you know, "you're good." One of the nurses even told me, "Well I haven't checked in on you very much today because I figured I'd give you a little more time to rest, and you're a pro at this. This is your third time around..." But there are still a few things that I'd forgotten between. Well, my last one was two years ago, um, you know, no one reminded me about proper alignment while you're nursing. And I remembered that on my own. How, I don't know. So it's... there were a few things I think that were just overlooked because it was my third.

Although the BFI recommends that routine breastfeeding assistance and observation be provided to all mothers in hospital, these statements suggest it may not always be provided to second or

third time mothers at the Janeway Children's Hospital/Health Sciences Centre. Maternal reports indicate that, even with previous breastfeeding experience, many second and third time mothers felt a need for initial and ongoing breastfeeding assistance and monitoring.

5.6 Breastfeeding as challenging, painful, gendered, and rewarding

Maternal experiences with infant feeding varied considerably, however the majority of mothers reported at least some difficulty and discomfort with breastfeeding, especially in the first days and weeks following delivery. Breastfeeding was often described by mothers as painful, demanding, and much more difficult than expected. The most common challenges mothers reported were establishing a successful feeding position and latch, assessing whether their baby was receiving enough milk, and coping with physical pain and discomfort. These challenges are captured in the following statements:

P9: It's very time consuming to breastfeed. I didn't realize they fed so much. The pain is definitely... and even though he's latched on right, it's still hard because he's pulling off a lot. It's at the point where I don't want him to wake up 'cause it's gonna hurt, you know? And you just, you don't want pain 8 times a day for 20 minutes. That's a lot of time.

P8: People don't tell you it hurts so bad in the beginning. It's not just the chapped nipples, it's like the whole experience is painful... it's like the first 2 minutes, or maybe the first minute... you're just, it's just, I don't know how to describe it. You have to hold on to something. Then it kind of goes away.

P10: It was harder than the labour, it was harder than the contractions, it was harder than the surgery, it was harder than the recovery. It was harder to learn, and just the stress of it, am I doing it right? Is he getting enough? And just thinking after that, it took me an hour to feed him. I tried for an hour, but I didn't know if he was getting enough. After that, they'd bring him again and I'd be sweating, I'd be thinking to myself, I don't know if I can do this.

These excerpts highlight the physical demands of breastfeeding on the mother.

Participants most commonly reported breastfeeding discomfort in the first days after delivery when their milk was coming in, and when they were learning how to establish proper positioning

and latching. When learning how to breastfeed, mothers frequently reported feeling confused and unsure of what to do, especially in the first hours and days following delivery. A few discussed feeling they needed frequent help because breastfeeding was less natural and more challenging than expected, and a number expressed feeling they did not receive the assistance and support from healthcare personnel hospital they felt they needed.

P19: I just sought help all the time. Every time there was a nurse there I was like, “come and look at me,” because I had zero confidence. I don’t know how you guys felt, but I didn’t know what I was doing. And I thought, being you know a little more educated about breastfeeding than the normal person... that it was gonna be all natural. But you don’t know what you’re doing and the baby doesn’t know what he’s doing. There’s so much learning involved that I just felt like I needed to ask, I needed to ask someone all the time.

P12: They didn’t even look in her mouth even though I was saying I was having problems, and I was already having bleeding and chapping. I knew that there were issues and it just wasn’t really... it’s like, “okay, it should just be suck, suck, swallow” and if it doesn’t happen then you pump. There was no additional help for that. I felt kind of abandoned in the breastfeeding department.

Maternal experiences with breastfeeding assistance and support in hospital were detailed in the previous chapter when engaging with Step 5 and Step 6. Although a number of mothers described breastfeeding as challenging, most reported experiencing improved breastfeeding comfort and confidence with time. As one mother shared, “My nipples are very tender and are still sore, but it’s not half as bad as it was right? So I just had to stick it out, and once I stuck it out for 2 or 3 weeks, it’s fine now” (P7).

Similarly, mothers with previous breastfeeding experience reported greater ease, higher confidence, and less discomfort with breastfeeding than those experiencing breastfeeding for the first time: “It was my third [child] so I knew exactly what to expect. Everything went pretty much the way I thought it would” (P1). Although most mothers reported greater breastfeeding

ease with time, a few decided to switch to exclusive formula feeding in hospital or at home due to breastfeeding discomfort and challenges in the first few days. As one mother stated:

P5: It was really uncomfortable just to have to hold him there, plus you have to feed him more often, and then you're having to feed him in the nighttime, and you don't know how much he's getting or if he's getting any at all. And when I had the little bottle just to try bottle-feeding him, I found it so much easier just to do. And then my partner could feed him in the nighttime too.

This statement demonstrates how discomfort with breastfeeding and uncertainty over how much an infant is eating can lead to a decision to switch to formula, even if breastfeeding was originally planned. It also highlights the gendered role of breastfeeding, and how infant care is often the sole responsibility of the breastfeeding mother, rather than the father. In this case, formula feeding was described as an equalizer that allowed for greater maternal rest and the division of infant feeding care and responsibility. Of the twelve mothers interviewed, three were exclusively formula feeding within 2-3 days following delivery. Each of these three mothers discussed sharing the responsibility of infant feeding with their partner (especially in the nighttime) as a major benefit of formula feeding.

The gendered nature of breastfeeding was raised by a number of mothers when discussing breastfeeding challenges. In the statement below, a mother discussed the pain of breastfeeding and the physical and gendered demands experienced by breastfeeding mothers.

P7: I think that's why people quit. I think it's the pain of the breastfeeding on top of the every 3 hours, and no one can help you. Like you're basically on your own and no one can help you. You're doing it on your own for the first little while until you're able to pump. Or if you're smart enough to pump early to get a break, but I thought I was gonna lose my mind in the first couple of weeks, just from the no help thing, like cause it's all on you getting up every 3 hours and maybe more. And by the time you feed her, it's really like every hour and a half, because by the time she's fed, burped, changed, you put her down, and an hour and a half later you gotta get up and do it all over again.

While a supportive partner may be able to assist with infant feeding, this statement clearly demonstrates the physical demands of breastfeeding on the mother. It highlights the elements of breastfeeding that are most challenging for mothers, and that most commonly lead to early supplementation.

Although many mothers reported breastfeeding pain and discomfort, some reported ease with breastfeeding and no issues or complications. As one mother reflected, “It went pretty good, you know, he seemed to take to [breastfeeding] right away... it seemed like it came pretty natural to me” (P4). Another noted, “I hear about all of these issues [with breastfeeding] but I didn’t have any... most people I know, like in my family, haven’t had any and have all been fine” (P15). Similarly, another reported, “We had no problems with the latch at all, he seemed to know exactly what he was supposed to do, and he just did it” (P1). Mothers with few breastfeeding complications had a tendency to talk less of their infant feeding experiences than those who experienced challenges and difficulty.

Many mothers also reported positive experiences with breastfeeding such as enhanced mother-infant bonding, greater ease and convenience with each feeding, and a sense of pride and accomplishment. As one mother stated, “There’s no bottles or cleaning or mixing formula – it’s much easier. If I have to take her out somewhere, I don’t have to worry about where I’m gonna heat up a bottle... it’s very convenient” (P7). Another discussed how the experience of breastfeeding made her feel connected to her baby:

P10: You're keeping someone alive by your own body, I feel like a lioness. I feel like an animal. I do. I feel like I know he's hungry right now, and I know in about five minutes he's going to wake up... I can feel it. My timing is an instinct like no other. I know when he's done, I know when he needs to burp, I know everything, the instinct is like a cat. It feels amazing to be able to do that for another human being, you know? Just looking at him and how much he enjoys being cuddled into my boob and on my skin, and him smelling me. The first couple days [partner] was next to him,

and he wasn't resting right, and I thought we should switch sides because if he was on my side he could smell me and be all right, and he was because he could smell me next to him. So that felt like, wow, amazing.

While maternal experiences with breastfeeding were reported as both positive and negative, most breastfeeding mothers reported feeling happy they had continued breastfeeding through the challenges they experienced. Mothers commonly reported feeling they were providing their baby with the best start through breastfeeding. One mother shared, "I'm glad I'm doing it [breastfeeding]. I'm glad I stuck it out because in the long run, I'm hoping that it's gonna be the best for her" (P7). Another stated,

P4: You know, the benefits are definitely way better than trying to formula. If you can get something out of it for a little while, it's much better for them. She's [older daughter] been so healthy and I know it helps with their immune system and stuff.

Reports indicate a diverse range of breastfeeding experience; however it was common for mothers to experience breastfeeding difficulty and discomfort. When challenges with breastfeeding were raised, they most frequently related to breastfeeding pain and discomfort, and uncertainty with how to properly position and latch an infant, and how to know if an infant was getting enough milk. These challenges and uncertainties suggest a need for improved breastfeeding instruction, assistance, information and support from healthcare providers in hospital. Accounts also suggest a potential need for improved breastfeeding education and training for healthcare professionals to ensure the provision of effective and consistent breastfeeding assistance and information. A number of mothers said a visit with a lactation consultant early following delivery would have likely been helpful for establishing early breastfeeding success.

5.7 Maternal guilt and infant feeding

Mothers who struggled with breastfeeding frequently mentioned experiencing feelings of guilt and inadequacy. Those who experienced low milk production leading to supplementation, or other struggles leading to supplementation, most often raised these feelings. The following excerpt is largely representative of accounts shared by mothers who intended to exclusively breastfeed but had to supplement:

P13: My mom's an OBGYN and she breastfed all her kids. It was the way to feed a baby. It was never formula... and look at me now, I have to supplement her. This has given me so much guilt. Just that I have to do this, but I feel like I'm giving my baby some sort of drug. But at least I'm still breastfeeding her too.

P14: I started him on cereal and I'm gonna start giving him one bottle in the evening so I can go out more often. I find pumping, where I had big engorgement problems, that pumping actually makes it worse.

P13: It makes it worse, yeah.

P14: And so I haven't been able to bottle any breast milk, so I can't go out without him... so he's gonna start drinking some formula in the next month, and I feel really bad about that actually.

P13: Well, they don't tell you about that guilt either. That's the thing, is they don't tell you that it can happen.

P16: I had to supplement her as well because of supply issues and it was... I was fine, I didn't have any baby blues or anything, but as soon as I realized that I had to do that, it hit me. I felt really upset about it. And I talked to the public health nurse and they were really supportive about it, but still it was kind of... it almost felt like they were reading a script, it wasn't like they really related to me. They were like, "Oh, it's okay, as long as she's getting nourished" and all this kind of stuff, but they didn't really take it as a real problem.

P13: Well, they're the ones who suggested it for me too, yeah. They don't think it's a problem because they see tonnes of babies who are formula fed who are fine, you know? But that's what they say... when I finally came out as having post partum depression, it was due to this issue, the issue of supplementing

P16: Well you feel like something's wrong.

I: Do you think that was part of it was feeling guilty or feeling upset because you wanted to breastfeed and there were issues?

P13: Oh ya, that was definitely the issue. And it was horrible, the only... the time that I actually felt like I was freed from it was in a La Leche League meeting... I finally said, this happened to me [post partum depression] because of guilt, because I couldn't be like those other moms.

This extended excerpt demonstrates the complex emotional nature of breastfeeding and the impact a need for supplementation can have on a mother who wishes to exclusively breastfeed. It engages with feelings of maternal guilt and post partum depression related to supplementation, and highlights a common belief that exclusive breastfeeding fits within an idealized form of motherhood, while supplementing does not. Another mother discusses the guilt she experienced when she needed to supplement her first child.

P3: I carried a lot of guilt [with my first child] because I didn't make enough milk for him. I didn't really ever make enough milk for him. I never really accepted that because I was devastated that I couldn't exclusively breastfeed, so I think psychologically I was having trouble with that. I think it's better this time because I have him [first child] to look at and he turned out perfectly fine even though he got formula. And it's not poison, and it's not evil. You have to feed your child, and if I'm not making enough milk, you have to get it from somewhere, and I've accepted that faster with her [2nd child]. I've accepted that it needs to happen because you can only do what you can do, because my child has to eat.

While this mother mentions feeling less guilt over her need to supplement her second child, she acknowledges struggling and feeling very upset when her plans to exclusively breastfeed were not possible. Later in her interview, she mentioned that receiving medical advice to supplement from a pediatrician and lactation consultant helped with her guilt because it made the act of supplementing feel more acceptable.

Maternal guilt was a very common theme in interviews and focus groups. While most experiences of guilt were connected to supplementation, some were connected to other mothering experiences, such as not rooming-in overnight the first night in hospital or not enjoying breastfeeding because of pain and discomfort.

5.8 Infant feeding practices in NL

A number of mothers spoke about infant feeding culture in the province of NL. Mothers most frequently acknowledged a history of widespread supplementation in NL, a general low

uptake of breastfeeding, and a lack of cultural comfort with breastfeeding outside of the home.

These are evident in the follow statements:

P11: In my mom's generation nobody breastfed basically. It was all formula feeding, and so, you know, the other part is that my mom's looking at me and going, "Why are you wasting your time at this? Just give the kid a bottle."

P7: I think it's starting to... I mean, when we were younger, we were all on Carnation milk right? That was like tin milk you use in your coffee or whatever. That's what they used to feed us, and I think it's starting to come around more to breast milk. That's what I think. More and more people if they can hang in there and get over the pain of it for the first couple of weeks.

P16: I wonder if there's a resurgence of breastfeeding. I wonder if we're all the generation that has our minds made up that that's what we want to do.

P14: Yeah, and then the nurses that belong to the other...

P13: The other generation, like my mom.

P14: Yeah, that's true.

P16: Yeah, because [breastfeeding's] something that I wanted to do as soon as I found out I was pregnant. My mother saw me doing that in the hospital and was like, "I can't believe you're doing that." Because she's like, "We didn't do it."

While accounts suggest that breastfeeding may be gaining popularity, they also highlight the presence of a generational gap in breastfeeding knowledge and practice that may affect familial support networks for new breastfeeding mothers (because breastfeeding knowledge can no longer be easily transferred from one generation to another). Through statements like, "It was all formula feeding" and "We were all on Carnation milk", mothers described a culture where supplementation was normalized, and where few exclusively breastfed or witnessed others breastfeeding.

A young mother described her experience with breastfeeding in a culture where formula feeding was normal practice. She highlighted the discomfort others demonstrated when she breastfed in public, and contrasted the demands of breastfeeding with the freedom of supplementation.

P14: I'm from out around the bay, so when I go home and I'm like pulling out my boobs, everyone looks away and they're just like really embarrassed about it. So it's kind of... and all the people that I know have kids that are my age, or around my age, and the only person that I'm friends with that's breastfeeding is here [friend in focus group]. I have maybe ten friends that I went to high school with that have kids just because that's what you do when you live around the bay, so a lot of people are having kids and all of them are formula feeding – and their moms take them and take care of them for hours and hours on end. They all go out a lot, they have a social life, and I'm st... I get jealous. You know, I love breastfeeding and I love being able to do it, but I do get jealous that people get to go out and I don't.

This statement highlights a norm of discomfort in NL with the practice of breastfeeding in front of others. It engages with the physical constraints of breastfeeding and a loss of freedom associated with exclusive breastfeeding practice. Similarly, a mother mentioned feeling upset about missing out on play with her other children because of a need to remain in the house while breastfeeding. She stated, “It's not easy being stuck in here nursing him when the kids are outside playing. ‘Mommy, come out and play!’ ‘Mommy can't, mommy's breastfeeding’” (P1). Her statement, as with others, communicates a physical restriction in the space mothers they can appropriately occupy while breastfeeding. Accounts suggest a culture in NL where the practice of breastfeeding is acceptable within some spaces, such as in the home, but not in others, such as outside or in the public sphere.

5.9 Infant feeding culture and the pressure to breastfeed

Although many mothers acknowledged a low uptake of breastfeeding in NL, and a general lack of acceptance with breastfeeding in public, many also discussed feeling that breastfeeding was desired and expected of mothers. A social pressure to breastfeed and lack of acceptance of formula was widely discussed, with a number of mothers linking this expectation to feelings of guilt and judgment. This is evident in the following excerpts:

P9: It's not a local thing – it's international really. I mean, but, everything is "breast is best" and I understand, I agree, and that's why I chose to breastfeed, but I think that,

you know basically, they whole, "don't feed any formula" and um, one of the nurses... cause we were in the hospital and the baby was hungry, and I was like, "Feed him formula, he's hungry, I have no milk. Give him formula. I don't care." Right, I'm not letting my baby go hungry. And um, you know, she sort of had to sneak it past the lactation consultant to get in into my room. You know, like they were nervous doing that. So there is this whole thing that formula is evil, and it's not. And it's not a local thing, you know, I use the internet, and I Google a lot of stuff, and it's all these mothers that are going to crazy lengths to keep breastfeeding, right? And it makes you feel awful that you're... it makes you feel like formula's poison. And we were all raised on formula, like for the most part, anyways, so it took me a while. Basically last night the guilt of him not getting all he wants at my breast because I have to keep pulling him off cause it hurts me too much, is starting to overwhelm the guilt of giving him formula.

P11: When I told them [lactation consultants] that I was giving him formula, that's when I was made to feel like the worst mother in the world. They'd say, "But your body can do this. Your body was made to feed the baby." That kind of mentality... I felt this pressure that I should be breastfeeding my child solely, and that if I didn't, or if I couldn't, there was something wrong with me.

P3: Because I whip out this bottle that clearly has formula in it, and I feel I have to explain it to people, even though it's none of their business, I feel like I have to because people are judging, you know what I mean? Like, "How come you're giving your three week old baby a bottle?" And I wouldn't be giving my three-week-old baby a bottle if I could avoid it. But it's something we do to ourselves. I think it's something I do to myself. You carry that sort of defensive part with you... The expectation is that you're going to do the best thing for your child, which is what we're trying to do. But I think you kind of do it to yourself, because I'm sure there's no one looking at me thinking, "Oh god, she's giving her a bottle." But I feel like they are.

These statements suggest an infant feeding culture where breastfeeding is idealized and expected of mothers – or where mothers believe breastfeeding is expected of them. Mothers expressed feelings of guilt and judgment over needing to supplement due to supply issues or breastfeeding difficulty, and acknowledged a culture of breastfeeding expectation and pressure, both internationally, and in the province of NL.

5.10 Breastfeeding as not always possible

Although breastfeeding should be physically possible for the majority of women, the idea that breastfeeding may not be physically possible was frequently mentioned by mothers in this research. When reflecting upon her decision to breastfeed a mother states, “I said if I could [breastfeed] I would. Yup, if I was able to, because I know there’re issues with things. But if I was able to, I wanted to” (P7). It was common for mothers to mention that women frequently experience breastfeeding issues and complications, and that some are unable to breastfeed. A mother acknowledged this commonly discussed belief and shared her feeling that breastfeeding would be possible for her:

P20: I was breastfed myself, so I just always assumed that I would. I never had... I hear a lot of women say things like, “I hope to be able to breastfeed.” I never realized I couldn’t, I just assumed that I would, that if I wanted to that I could work at it.

While it is unknown why mothers shared a belief that breastfeeding may not be possible, this belief may reflect a broader issue of struggle with breastfeeding in NL, possibly linked to a history of widespread supplementation in the province and lost knowledge and breastfeeding skill transfer from generation to generation.

5.11 Mothering and breastfeeding as sacrifice

Mothers frequently referred to mothering and breastfeeding as sacrifice. They commonly discussed the physical pain/discomfort, exhaustion, and demands of breastfeeding as something they needed to endure and get through. As one mother stated:

P25: I had a lot of pain with the breastfeeding. Really really sore nipples. They scabbed over, um, I had a toe-curling pain of a let down, which is not abnormal. But they, the nurses there all knew I was in agony and they came up to see me. And ah, really I guess what I got was that, “This is normal, you just gotta grit your teeth and get through it.”

Similarly, when discussing the challenges of breastfeeding, and her determination to breastfeed another mother stated:

P10: He was latching on, and I'd let him latch on to just my nipple, because at least then he's latched on. And I was like, "I'll destroy my body because I want to feed you." ...I wanted to do it, and I wouldn't have given up no matter what torture I went through anyway, but that was just me.

These statements express a maternal willingness to sacrifice the self to provide the benefits of breast milk to their infant. They suggest not only a willingness to endure pain and discomfort, but a belief that bodily sacrifice is a natural part of mothering. In the statement below a mother acknowledged being tied down by breastfeeding as a reasonable short-term sacrifice for her baby. She stated, "So I mean its 6 months of your life. Yeah, you're tied down for a little bit, but it's only 6 months" (P7).

While a maternal willingness to sacrifice bodily comforts and social mobility to care for an infant may be a part of mothering, a willingness and desire to sacrifice the self reflects a broader cultural phenomenon where maternal sacrifice is idealized and commended. Although some mothers indicated a readiness to endure physical discomfort for the promotion of infant health and wellbeing, their willingness to do so may be indicative of a culture where breastfeeding is both expected of mothers, and a vital component of idealized motherhood.

5.12 Need for improved maternal self-care/aftercare

A common theme running through interviews and focus groups was a need for improved maternal care and aftercare in hospital. Of the twelve mothers interviewed, six reported receiving insufficient information and follow-up care in the hospital following delivery. All six reported feeling they did not receive enough information about self care before hospital discharge, while five reported receiving no information about what to expect in recovery, and

four reported no follow-up check or information about caring for their incision or vaginal tare before discharge. Similar reports of lack of attention to maternal care in the hospital emerged in all three focus group discussions. Two mothers engaged with the issue of not receiving enough information in hospital about self-care following delivery:

P14: The biggest problem that I had when I was being discharged was that I found nobody told me how to take care of myself after. There all like, “here’s how you take care of the baby, like this is what you do”, then I went home and I was in so much pain, like my back hurt and I couldn’t stand up right. I was taking 5 minutes to walk up the stairs to go to the bathroom, and then I had... I only had 4 or 5 stitches, but they broke open right away when I got home. I bent over to pick something up off the floor and all my stitches busted open. So I called the public health nurse, and she told me that they don’t do the stitches back up. ... And so that was really the worst part of it for me was the recovery took so long and was really painful. I had no idea what to do to take care of myself.

P8: I felt like after I had the baby, it was like, “See ya.” They told me to use a squirt bottle and then just, you know, clean my wound by myself and if I had a clot any bigger than a toonie or something, you know, call someone in. That’s it. ... That was IT. I was like, “holy crow, this is crazy.”

Another mother shared:

P4: I had some stitches and stuff, and there was no talk of when the stitches were going to come out or how to care for them, how much pain you’re going to have with them, there was no talk of that.

Below, two focus group participants discussed and linked their experience of re-admission to the hospital with health complications to inadequate maternal follow-up care prior to discharge:

P25: So there I was, 3 days after having him, and I had to go back into emergency. It was a nightmare, but they got us through really quick, and they decided that I may have thrush, so they gave me antibiotics. But I don't think I had thrush.

P23: They just discharged me on Wednesday and I was back in an hour.

P25: Yeah, I find there's not enough investigation... that's what I really couldn't understand. The day that I was released, I was sent back into emergency because they thought I had thrush. I thought somebody would have picked up on that in the hospital you would think, right.

These accounts suggest a need for a more mother-friendly approach to care within the Janeway Children's Hospital/Health Sciences Centre. They raise concern over whether the healthcare needs of mothers following delivery are provided at the standard needed to promote maternal health, wellbeing, and comfort, and highlight a lack of emphasis on maternal care and aftercare in the BFI.

5.13 Maternal recommendations for improved care in hospital

When asked how hospital healthcare experience could have been improved, mothers mentioned a need for more consistent breastfeeding information and assistance from nurses, more information and follow-up care related to maternal health and caring for the self post-partum, earlier consultation with lactation consultants in hospital, and more comfortable hospital beds and chairs to promote rest and facilitate overnight partner support. These recommendations are clearly communicated in the statements below.

P24: Inconsistency... that's my biggest complaint. If they could just be consistent, and better mother care, then I would be happy.

P22: I really think that they should do more talk of breastfeeding, especially for people that are on the fence. Because not everybody did prenatal, and of course not everybody did the breastfeeding class.

P7: In my eyes, if anything needs to change at the hospital, is if you're gonna be breastfeeding, they should offer you a lactation consultant that day you have the baby, but I was told that the lactation consultant won't come in unless you're there at least 24 hours... which I thought was a bit, you know? If you're gonna breastfeed, you should be able to have a lactation consultant right away instead of a day later when you're probably already sore.

P4: Of course it would be nice to have a better room or something... nicer facilities, but a lot of people in other parts of the hospital, like in the cancer wards, would like that too. I think the aftercare part of it is the big thing you know. They seem to have all the baby stuff taken care of pretty well... Self-care, baby blues, they give you a little bit of information on it, just the aftercare is a big part that they didn't really touch on.

P11: Continuity of nurses would be a good idea. Every shift change brought a different nurse... It just would have been nice to have a person and say, “okay, this is my nurse, this is her name” you know? And obviously it couldn’t be 24 hours a day, but even if the day nurse was the same and the night nurse was the same.

These accounts reiterate a number of the themes raised in Chapter 4 and discussed in this chapter, and highlight opportunities to improve quality of care in hospital, especially related to maternal care and breastfeeding instruction/support.

5.14 Summary

When viewed together, results from Chapter 4 and Chapter 5 convey hospital infant feeding practices and broader socio-cultural and gendered ideas of motherhood shape how mothers, infants, policy-makers, physicians, nurses, and lactation consultants relate to infant feeding within a hospital setting. Emerging themes highlight areas for improvement with maternal-infant healthcare delivery in hospital, and shine light on the complex struggles, pressures, decisions, conflicts, and concerns mothers experience related to their own infant feeding and mothering practices.

Chapter 6 Hospital Infant Feeding Policy and the BFI

This section provides an overview of Eastern Health hospital infant feeding policies used to inform infant feeding care provision at the Janeway Children’s Hospital/Health Sciences Centre, and other hospital facilities within the Eastern Health region. The first policy, *Skin-to-Skin Contact Immediately Following Birth*, provides protocol for the administration/provision of skin-to-skin contact. The second policy, *Alternative Feeding Methods for Breastfed Babies*, details clinical procedures for alternative feeding methods (such as cup feeding, finger feeding, supplemental feeding system, syringe or eye dropper feeding, and spoon feeding), and formula supplementation. The third, *Breastfeeding Care of the Well Newborn*, provides protocols for health professionals to follow when assisting breastfeeding mothers and infants with the initiation of breastfeeding, assessment of positioning, assessment of latch, and preparation for discharge; while the fourth, *Breastfeeding: Protection, Promotion and Support for Healthy Term Infants* provides protocol related to Steps 3-10 of the BFI.

Together, these policies guide hospital infant feeding practice within Eastern Health and the Janeway Children’s Hospital/Health Sciences Centre. Policies for infant feeding care were received in April 2012 from a lactation consultant at the Janeway Children’s Hospital/Health Sciences Centre. Updated versions were received from the same lactation consultant and the Program Coordination of the NL Provincial Perinatal Program in June 2013. All updated/re-issued policies detailed the same clinical guidelines and procedures as their earlier versions.

Guidelines and procedures from Eastern Health’s *Skin-to-Skin Contact Immediately Following Birth*, and *Alternative Feeding Methods for Breastfed Babies*, *Breastfeeding Care of the Well Newborn*, and *Breastfeeding: Protection, Promotion and Support for Healthy Term*

Infants are presented below, and compared with infant feeding guidelines outlined in the BFI Integrated Ten Steps. Discrepancies between each policy and BFI guidelines are highlighted and discussed, and recommendations provided.

6.1 Policy Document 1: Skin-to-Skin Contact Immediately Following Birth

The policy *Skin-to-Skin Immediately Following Birth* was issued by the Regional Director of Children’s and Women’s Health Program on May 1st, 2009 [Policy: 270 (WH) II-D-83], to describe hospital procedures for skin-to-skin contact. The policy was written for registered nurses, physicians, and students working within hospital Case Rooms. On October 24th, 2012 the policy was re-issued by the Regional Director of Children’s and Women’s Health [Policy: 270MNG-ALD-405], with all procedures and guidelines for skin-to-skin remaining the same.

In Table 6-1, guidelines from Eastern Health’s policy on skin-to-skin contact are presented alongside guidelines from Step 4 of the BFI Integrated Ten Steps. Each document outlines desired hospital procedures and protocols for skin-to-skin contact following delivery. Guidelines from each policy are presented side-by-side to facilitate comparison.

Table 6-1: Skin-to-Skin Contact

BFI Policy: Step 4	Eastern Health: Skin to skin contact immediately following birth	
Policy: <i>“Place babies in uninterrupted skin-to-skin contact with their mothers immediately following birth for at least an hour or until completion of the first feeding or as long as the mother wishes: Encourage mothers to recognize when their babies are ready to feed, offering help as needed.”</i>	Policy: <i>“Benefits of skin-to-skin contact will be provided during labour. Skin-to-skin contact of mothers and babies will be offered immediately following birth. Skin-to-skin contact means no layer of clothing between mother and baby. Blankets and sheets will be placed over both.”</i>	
BFI Policy: Step 4	Eastern Health Policy: Skin-to-skin contact immediately following birth	Difference
“Mothers report that, unless there were medical indications for delayed contact, their baby placed skin-to-skin immediately after	“Skin-to-skin contact of mothers and babies will be offered immediately following birth.” “The newborn should be placed prone	Immediacy of skin-to-skin with the use of general anesthesia not addressed.

birth (vaginal or C-section delivery without general anesthesia), or as soon as mother is responsive or alert (after C-section with general anesthesia).”	on the mother’s abdomen or chest. This can be achieved with having the mother wear the hospital gown with the opening in the front.”	
“This [skin-to-skin] occurred for an uninterrupted period of at least 60 minutes, or until completion of first feed, or as long as mother wished.”	“The newborn should remain skin-to-skin for minimum of 30 minutes.”	Recommended minimum duration of skin-to-skin 30 minutes rather than 60 minutes. No mention of skin-to-skin until the completion of first feed or as long as the mother wishes.
“Mothers confirm that they were encouraged to look for signs that baby was ready to feed and that they were offered assistance as needed.”	“If breastfeeding, mother can be assisted to breastfeed when newborn exhibits breastfeeding cues.”	Mothers not explicitly encouraged to look for signs baby is ready to feed.
“Mothers with babies in special care report that they were able to hold their baby skin-to-skin as soon as mother and baby were stable, unless medical indications for delayed contact.”	Not discussed.	Contingencies for mothers or babies in special care not addressed in policy.
“All mothers report that they had been informed prenatally of the importance of skin-to-skin contact and were encouraged to discuss this with their health care providers.”	Not discussed.	Policy does not address prenatal health promotion related to the importance of skin-to-skin contact.
“Mothers transferred to a different area (e.g., by stretcher or wheelchair) confirm that skin-to-skin contact was maintained as long as mothers wished even after completion of the first feeding.”	Not discussed.	Contingencies for mothers transferred to other areas not identified in policy.
“When the baby is well but mother was ill or unavailable, mothers confirm that skin-to-skin contact with another support person of her choice (commonly her partner) was encouraged.”	Not discussed.	Skin-to-skin with partner or person of choice not addressed in policy. Contingencies for maternal illness or unavailability not identified.
“The manager confirms that skin-to-skin care is initiated immediately after birth unless separation is medically indicated, and describes how this practice is monitored.”	“Document reasons why skin to skin contact was not initiated.”	Manager reporting responsibilities not identified.
“The staff confirm that normal observations and monitoring of the mother and baby (temperature, breathing, colour, tone) continue	“The initial assessment is performed and suctioning is done if medically indicated while newborn is on the mother’s abdomen.”	Policy does not address observation or monitoring of the mother. Policy does not specify

throughout the period of skin-to-skin contact. The baby is removed only if medically indicated or requested by the mother, and this is recorded in the baby’s chart.”	“Mother’s refusal will be respected.”	which infant monitoring procedures should occur during skin-to-skin contact.
“Documents show that skin-to-skin contact remains unhurried and uninterrupted for at least one hour or until the completion of first breastfeed, unless there is a medical indication for separation.”	Not discussed.	Policy does not address documentation of skin-to-skin duration.
“Routine procedures, monitoring and measurements are delayed until after the first breastfeed. Medications required by baby are given while the baby is on mother’s chest, preferably near end of first breastfeed in order to decrease pain.”	“The placement of newborn identification bands can be performed while the newborn is skin-to-skin with the mother” “All other procedures including weight, eye ointment and vitamin K injection are delayed until after this period of contact.”	Addressed in policy.
“In the hospital and community health service, written information for clients outlines information consistent with issues cited above.”	Not discussed.	No instruction for providing the mother with information is given in the policy.

(BCC, 2012b; Bursey, 2012).

Using the BFI Integrated Ten Steps as a standard for optimal and evidence-informed care, this comparison reveals gaps within Eastern Health’s current skin-to-skin policy, and opportunities for improvement to more closely reflect the guidelines and protocols of the BFI. While both policies recommend and promote immediate skin-to-skin contact, breastfeeding during skin-to-skin in response to infant feeding cues, the provision of breastfeeding assistance, infant observation and monitoring during skin-to-skin, and the delay of non-urgent procedures until skin-to-skin is completed, Eastern Health’s policy falls short of optimal guidelines specified in the BFI. Recommendations for modifying Eastern Health’s policy are listed below and are based on guidelines for skin-to-skin contact from Step 4 of the BFI Integrated Ten Steps.

It is recommended Eastern Health's policy, *Skin-to-Skin Contact Immediately Following Birth*, be updated with the following policy modifications:

- Include skin-to-skin protocol for mothers who deliver under general anesthesia that supports skin-to-skin contact as soon as the mother is responsive and alert
- Increase the minimum duration of skin-to-skin contact from 30 minutes to 60 minutes
- Encourage skin-to-skin continue until the completion of the first feeding, or as long as the mother wishes
- Encourage mothers to look for and respond to infant feeding cues during skin-to-skin contact
- Include skin-to-skin protocol for mothers with babies in special care that supports skin-to-skin contact as soon as the infant is stable, unless medically indicated
- Include protocol to ensure mothers are informed of the benefits of skin-to-skin prenatally and encouraged to discuss skin-to-skin with their healthcare provider
- Include protocol for skin-to-skin contact if the mother is transferred in hospital (via stretcher or wheelchair) following birth, encourage skin-to-skin until the completion of the first feeding or as the mother wishes
- If skin-to-skin with the mother is not possible, encourage the option of skin-to-skin with a person of her choice
- Include protocol for manager confirmation of skin-to-skin contact (unless there is a medical reason for separation), encourage manager to be able to describe monitoring of skin-to-skin
- Encourage observation and monitoring of mother during skin-to-skin contact
- Include specification of which infant monitoring procedures should occur during skin-to-skin contact (temperature, breathing, colour, tone)
- If infant is removed from skin-to-skin early, encourage documentation of reason for removal on chart
- Encourage documentation of skin-to-skin duration
- Include protocol for providing mothers with written information on skin-to-skin contact consistent with recommended practice

Although the Eastern Health policy *Skin-to-Skin Immediately Following Birth* is closely aligned with Step 4 of the BFI, the suggested modifications and additions would bring it closer to meeting evidence-informed BFI standards. While some policy recommendations may be easier to implement than others, if applied and implemented, they would likely aid with moving the Janeway Children's Hospital/Health Sciences Centre towards greater alignment with BFI guidelines.

6.2 Policy Document 2: Alternative Feeding Methods for Breastfed Babies

The policy *Alternative Feeding Methods for Breastfed Babies* [Policy: 270CWH-NB-15] was issued by the Regional Director of Children's and Women's Health Program on October 24th, 2012. Although not formally issued until October 2012, this policy was in place as a draft policy to guide alternative feeding practices at the time of data collection. The policy was developed for all nurses working with mothers and their newborn infants. Table 6-2 highlights guidelines and protocols from Eastern Health's policy *Alternative Feeding Methods for Breastfed Babies*, and Step 9 of the BFI Integrated Ten Steps. Both policies address alternative feeding methods (to breastfeeding), the use of artificial teats/pacifiers, and formula supplementation. Guidelines and protocols from each policy are presented side-by-side to facilitate comparison.

While both policies encourage and promote exclusive breastfeeding, alternative feeding only when necessary and without the use of an artificial nipple, alternative feeding with breast milk if available, and supplementation with formula only if medically indicated and/or requested/approved by the mother, a comparison between policies reveals some shortcomings in Eastern Health's policy. Recommendations for modifying Eastern Health's *Alternative Feeding Methods* policy are listed below. Suggested changes to the current policy are based on BFI guidelines for infant feeding without the use of artificial teats or pacifiers (Step 9).

Table 6-2: Alternative Feeding Methods for Breastfed Babies

BCC BFI: Step 9	Eastern Health: Alternative Feeding Methods	
<p>Policy: <i>“Support mothers to feed and care for their breastfeeding babies without the use of artificial teats or pacifiers (dummies or soothers).”</i></p>	<p>Policy: <i>“The ultimate goal is exclusive breastfeeding. Alternative feeding methods to provide oral nourishment or medically indicated supplementation of breastfed babies should only be initiated after careful assessment. Consultation with the lactation consultant, health care provider skilled in managing complex breastfeeding issues and/or physician is required when alternate individually-suited feeding methods may be necessary to develop a plan of care with the parent(s) and their family. Informed verbal consent is required prior to carrying out any alternative feeding methods. Communicating the indications, purpose and procedures for alternative feeding methods is essential to fully informing the parent(s) and family.”</i></p>	
BCC BFI Policy: Step 9	Eastern Health Policy: Alternative Feeding Method	Difference
<p>“Mothers report that they received information and support to feed and care for their breastfeeding babies without the use of artificial teats or pacifiers.”</p>	<p>“Alternative feeding methods include finger, cup, supplemental feeding system, syringe, and spoon feeding to safely provide oral nourishment or medically indicated supplementation of the breastfed baby. Alternative feeding methods are recommended during prolonged separation of the infant and mom for any reason(s), and/or until the infant is able to properly latch, stay alert, and establish feeding at the breast”</p>	<p>Policy does not emphasize provision of information and support on caring and feeding babies without use of artificial teats/pacifiers, although does emphasize breastfeeding as a priority and does mention that alternative methods are only discussed if medically necessary.</p>
<p>“If the baby has been given a bottle or pacifier, the mother confirms that this was her informed decision or a medical indication.”</p>	<p>“Informed verbal consent is required prior to carrying out any alternative feeding methods. Communicating the indications, purpose and procedures for alternative feeding methods is essential to fully informing the parent(s) and family.”</p>	<p>Addressed in policy.</p>
<p>“The manager provides records confirming that mothers of breastfeeding infants are supported to find alternative solutions or make an informed decision regarding the use of artificial teats.”</p>	<p>“Consultation with the lactation consultant, health care provider skilled in managing complex breastfeeding issues and/or physician is required when alternate individually-suited feeding methods may be necessary to develop a plan of care with the parent(s) and their family.”</p>	<p>Policy does not address record keeping of informed consent.</p>

“Staff describe feeding alternatives recommended for breastfeeding infants requiring supplemental feeding (e.g., cups, spoons) and soothing techniques for all infants.”	Not discussed.	Policy does not encourage staff to be able to describe feeding alternatives or soothing techniques.
“Documents show evidence of support and informed decision-making.”	“Informed verbal consent is required prior to carrying out any alternative feeding methods.”	Policy does not include instructions to document support and informed decision-making.
“Written information for clients outlines the risks associated with artificial teats and describes alternatives.”	Not discussed.	Policy does not instruct staff to deliver written information to mothers outlining risks associated with artificial teats. Policy does not instruct staff to provide written information to mothers describing alternatives.

(BCC, 2012b; Bursey & Goobey, 2012).

It is recommended Eastern Health’s policy, *Alternative Feeding Methods*, be updated with the following policy modifications:

- Encourage staff to provide mothers with information and support about how to feed their breastfeeding baby without the use of artificial nipples/teats or pacifiers
- If an alternative feeding strategy is necessary, ensure mothers are supported to effectively master an alternative feeding strategy
- Encourage managers to confirm (through written documentation) that mothers are supported to find alternative feeding solutions when necessary
- Ensure staff are able to describe effective alternative feeding and soothing techniques
- Instruct staff to document evidence of support and informed decision making related to alternative feeding
- Instruct staff to provide mothers with written information on the risks of feeding with artificial nipples/teats and the risks of alternative feeding methods
-

Eastern Health’s policy on alternative feeding methods is closely aligned with evidence-informed guidelines outlined in Step 9 of the BFI Integrated Ten Steps, however could be improved through policy modifications that ensure mothers are fully informed, instructed, and supported to choose and succeed with an alternative feeding method if necessary, and that staff are fully prepared to communicate alternative feeding arrangements to mothers and document feeding arrangements. The recommended modifications above would align Eastern Health’s policy with national (and international) guidelines for alternative feeding and pacifier use outlined in Step 9 of the BFI.

6.3 Policy Document 3: Breastfeeding Care of the Well Newborn

Breastfeeding Care of the Well Newborn provides evidence-informed practical tips for health professionals caring for and assisting breastfeeding mother-infant dyads. Because it is focused more on providing step-by-step instructions to healthcare providers on how to support mothers with breastfeeding than on outlining desired infant feeding practice, it is detailed but not compared alongside the BFI. At the time of data collection, this policy was in place to guide practice as a draft policy. It has not yet been officially issued and, as of August 2013, remains in place as a draft policy. Its guidelines and protocols were developed for registered nurses (RNs) and licensed practical nurses (LPNs) in Eastern Health and are highlighted in Table 6-3.

This policy clearly promotes and supports exclusive breastfeeding as well as evidence-informed care provision and support for breastfeeding mothers. The stated purpose of *Breastfeeding Care of the Well Newborn* is to “provide a consistent, evidence-based, informed approach for care providers who assist with breastfeeding families.” While the policy provides healthcare professionals with practical procedures for assisting mother-infant dyads with breastfeeding, it is not a comprehensive hospital infant feeding policy. Although the procedures

it details are important, this policy is strengthened when viewed alongside policies and protocols on *Skin-to-Skin Contact Immediately Following Childbirth*, *Alternative Feeding Methods for Breastfed Babies*, and *Breastfeeding: Protection, Promotion and Support for Healthy Term Infants*.

Table 6-3: Breastfeeding Care of the Well Newborn

Eastern Health Policy “Breastfeeding Care of the Well Newborn”	
Policy	“Registered Nurses (RNs), Licensed Practical Nurses (LPNs) must protect, promote and support breastfeeding families to achieve their breastfeeding goals. Accurate information about breastfeeding and providing practical help, when necessary, with positioning and attachment of newborn will enable mothers to succeed. Supporting families to achieve their breastfeeding goals in the early days of hospitalization is paramount.”
Purpose	“To provide a consistent, evidence-based, informed approach for care providers who assist with breastfeeding families”
1) Initiation:	<ul style="list-style-type: none"> - “Initiate skin-to-skin contact immediately after birth as per skin-to-skin policy delaying all procedures for minimum of 20-30 minutes.” - “Provide assistance to ensure proper latch is achieved if mom requires help and when baby is willing.” - “Discuss the feeding cues of newborns (baby in a calm alert state, showing rooting and searching behaviors).”
2) Assessment of positioning:	<ul style="list-style-type: none"> - “Mom is positioned comfortably with her back well supported.” - “Baby is skin to skin in diaper.” - “Baby is well supported at the level of the breast with ear, shoulder, and hip in a straight line. Baby’s head will be tipped back slightly.” - “Mom’s nipple lines up with the baby’s nose when the mouth is closed.”
3) Assessment of latch:	<ul style="list-style-type: none"> - “Baby should gape and take a large mouthful of the breast which includes the entire nipple and a good portion of the areola.” - “Baby’s chin should be in the breast and nose not.” - “The baby should have the lips flanged, a full cheek and may have a pause in the suckle, which indicates swallow.” - “Mom feels comfortable, feels a tugging sensation with no pain.”
4) Preparation for Discharge:	<ul style="list-style-type: none"> - “Mom is aware of keeping her baby with her to observe for feeding cues.” - “Mom is aware of offering her baby the breast at least 8 times in 24 hours and that babies should be offered both breasts at a feed but may not necessarily take both.” - “Prior to discharge, documentation should include at least 2 feeds where mom functioned independently. Note should include comment on, breast fullness, positioning, latch, suckle, swallow and comfort level.” - “Referral to public health nursing, breastfeeding support group or family physician at discharge.”

(Women and Children’s Health Program, 2012).

In its recommendations for breastfeeding initiation, *Breastfeeding Care of the Well Newborn*, supports BFI recommendations of immediate skin-to-skin contact, the provision of breastfeeding assistance during skin-to-skin contact, the delay of non-urgent medical procedures until the completion of skin-to-skin contact, and feeding according to infant cues. While these are well-aligned with recommendations detailed in Step 4 of the BFI, the minimum recommended duration of skin-to-skin in this policy (20 – 30mins) is shorter than the minimum recommended duration in the policy *Skin-to-Skin Immediately Following Birth* (30mins) and even shorter than recommended in the BFI (60mins). Eastern Health guidelines for the effective assessment of positioning and latching are more detailed here than guidelines for positioning and latching in the BFI. Details on preparation for hospital discharge encourage feeding on demand and the provision of information on infant feeding cues (Step 8), and a smooth transition from hospital to the community through the establishment of breastfeeding before hospital discharge and referral to breastfeeding medical/community supports (Step 10).

Although *Breastfeeding Care of the Well Newborn* does not address or include each step of the BFI Ten Steps, it appears to serve its purpose as a reference guide for healthcare professionals assisting mother-infant dyads with breastfeeding. Although infant feeding recommendations in this policy are aligned with evidence-informed practice, when viewed on its own without a more comprehensive infant feeding policy, *Breastfeeding Care of the Well Newborn* is insufficient to guide infant feeding protocol to the standards outlined in the BFI.

6.4 Policy Document 4: Breastfeeding: Protection, Promotion and Support for Healthy Term Infants

The final policy, *Breastfeeding: Protection, Promotion and Support for Healthy Term Infants* [Policy: PRC-011] did not exist at the time of data collection, but was issued shortly after

data collection was completed (May 2012) by the Vice President of Eastern Health's Children's and Women's Health Program. The policy was created for employees and students working within Children's and Women's Health and Public Health Programs at the Janeway Children's Hospital/Health Sciences Centre, and outlines procedures for each of the BFI Ten Steps.

Procedures from Eastern Health's *Breastfeeding: Protection, Promotion and Support for Healthy Term Infants* for Steps 3-10 of the BFI are compared with those detailed for Steps 3-10 of the BFI Integrated Ten Steps in Table 6-4 (Please see Appendix C).

Outcomes of this comparison reveal a clear commitment to promoting and upholding BFI practice standards of care at the Janeway Children's Hospital/Health Sciences Centre. While it may be with intention that only certain components of each step were addressed in the Eastern Health policy (perhaps to facilitate the prioritization of specific components of each step), outcomes of the comparison reveal gaps in the Eastern Health policy for Step 3-10 of the BFI. It is recommended that Eastern Health update *Breastfeeding: Protection, Promotion and Support for Healthy Term Infants* to reflect all components outlined in the BFI. Table 6-4 may be used to facilitate this process.

6.5 Policy discussion

Although Eastern Health's infant feeding policies encourage, promote, and support exclusive breastfeeding, when compared to BFI Integrated Ten Steps, policy gaps are evident. While Eastern Health's policies emphasize a clear commitment to BFI practice standards through policies detailing breastfeeding positioning and assistance, skin-to-skin contact, informed decision-making, and the use of alternative feeding methods in support of exclusive breastfeeding, they do not thoroughly address all components of Steps 3-10 of the BFI.

There was no mention in Eastern Health's infant feeding policies of Step 1 (Have a written breastfeeding policy that is routinely communicated to all health care providers and volunteers) or Step 2 (Ensure all health care providers have the knowledge and skills necessary to implement the breastfeeding policy) of the BFI. While Step 1 and 2 do not directly involve policies and protocols for care provision, they do outline institutional infant feeding priorities, policy communication and monitoring, as well as health professional training, assessment, and monitoring to ensure optimal guidelines are known and practiced.

It should be noted that Eastern Health policies in this review were developed for the care of well newborns with no specialized care or feeding needs. Infant feeding policies and protocols for un-well newborns were beyond the scope of this research.

Although written to promote and support exclusive breastfeeding, and to adhere to policies and protocols outlined in the BFI, this review indicates that Eastern Health infant feeding policies fall short of meeting all policy standards for each of the BFI Integrated Ten Steps. It is recommended that Eastern Health modify *Skin-to-Skin Immediately Following Birth* and *Alternative Feeding Methods* to more comprehensively reflect Step 4 and Step 9 of the BFI, and develop one large comprehensive policy to guide infant feeding protocol for each of the BFI Integrated Ten Steps (modified policies for Step 4 and Step 9 should be integrated into this policy). While *Breastfeeding: Protection, Promotion and Support for Healthy Term Infants* attempts to do this, it does not comprehensively address each step to the specifications required by the BFI. A comprehensive policy addressing all BFI steps is recommended to facilitate ease with policy communication and clinical/procedural guidance in hospital.

Chapter 7

Discussion

This research explored adherence with Steps 3-10 of the BFI at the Janeway Children's Hospital/Health Sciences Centre in St. John's, NL. Using interpretive phenomenology, maternal infant feeding healthcare experiences were explored, providing rich and descriptive data on hospital adherence with BFI guidelines, social forces shaping infant feeding practice, maternal challenges with breastfeeding, and opportunities for improvement with maternal-infant healthcare provision in hospital. Maternal accounts provided an excellent indicator for the assessment of hospital care practices and adherence with Steps 3-10 of the BFI at the Janeway Children's Hospital/Health Sciences Centre. A review of hospital infant feeding policies revealed an institutional commitment to evidence-informed practices outlined in the BFI Ten Steps, and a clear desire to promote exclusive breastfeeding at the Janeway Children's Hospital/Health Sciences Centre. However, when compared to BFI guidelines, gaps and discrepancies were found, and recommendations were provided. This chapter begins by revisiting the research questions and summarizing findings.

7.1 Adherence with Steps 3-10 of the BFI: Shortcomings and recommendations

Maternal accounts indicated a lack of full adherence with guidelines for Steps 3-10 of the BFI at the Janeway Children's Hospital/Health Sciences Centre in St. John's, NL. While some steps of the BFI were more closely implemented than others, maternal reports indicated that care practices often fell short of meeting evidence-informed standards of care.

A need for the routine communication of evidence-informed infant feeding practices was evident in the assessment of adherence with Steps 3-10 of the BFI. Maternal reports highlighted a lack of routine dialogue between healthcare providers and mothers on the importance and

process of breastfeeding (Step 3), the recommended practice of breastfeeding, and the risks and implications of formula supplementation (Step 6). Similarly, mothers indicated they were not informed about how to recognize and respond to infant feeding cues (Steps 4, 5, and 8), how to pump and store breastmilk (Step 6), or how to recognize signs of effective feeding (Step 8). Mothers also reported a lack of routine communication about feeding with unrestricted frequency and duration (Step 8), and alternative feeding methods for the avoidance of artificial nipple attachments if supplementing with formula or pumped breast milk (Step 9). While these reflect important shortcomings in the achievement of BFI guidelines at the Janeway Children's Hospital/Health Sciences Centre, they highlight clear opportunities for improving breastfeeding promotion in this facility through improved dialogue between healthcare providers and mothers.

In addition, maternal reports indicated a need for change in the provision of specific care practices at the Janeway Children's Hospital/Health Sciences Centre. Accounts indicated that while skin-to-skin contact was widely practiced (Step 4), it often occurred for a shorter duration than recommended because mothers and infants were separated for non-urgent infant observation – a practice that could easily be changed if routine observations occurred during, or after, one full hour of skin-to-skin contact. Similarly, mothers frequently reported the practice of overnight separation the first night in hospital, suggesting that the recommended practice of 24-hour rooming-in (Step 7) was not followed or encouraged. Although bedside bassinets existed to support 24-hour rooming-in following delivery, mothers indicated they were only used after the first night of separation, highlighting an opportunity for change. Another practice in need of improvement was the provision on subsequent and ongoing breastfeeding assistance, support, and observation in hospital (Step 5). While all breastfeeding mothers reported receiving assistance and support with their first feeding, subsequent and ongoing breastfeeding support,

assistance, and observation was not provided to all mothers, highlighting a need for more routine infant feeding follow-up care.

While the routine communication of best-practices to mother-infant dyads and the provision of optimal care practices may require additional and ongoing education and training for hospital healthcare providers so they are familiar with guidelines and able to educate and assist mothers with accuracy, it may also require that policies be updated, routinely communicated, and monitored; and that institutional conditions be modified to support improved dialogue and care provision in hospital. This would ensure that all mothers are able to make informed decisions about their infant feeding practice, and are equipped with the information and support needed to establish early success with breastfeeding.

7.2 Maternal infant feeding experience and opportunities to improve adherence with Steps 3-10 of the BFI

Maternal accounts indicated that hospital infant feeding care practices at the Janeway Children's Hospital/Health Sciences Centre were relatively inconsistent, with some mothers reporting excellent, attentive care, and others reporting poor quality, inaccessible care. Inconsistencies found in this research most frequently related to the duration of skin-to-skin contact, the recommended duration of breastfeeding, the quality, frequency, and accessibility of breastfeeding assistance, and the provision of maternal follow-up care. While inconsistencies may reflect a need for improved policy communication and monitoring, they also may reflect a need for improved education and training, and possibly more supportive employment and working conditions for healthcare professionals. Maternal accounts suggest that improving the consistency of information and care at the Janeway Children's Hospital/Health Sciences Centre will be important and necessary if BFI guidelines are to be achieved. Similarly, accounts

indicate a need for a greater prioritization of maternal care needs and informed decision-making in hospital. These are detailed in the following section.

7.2.1 Education and training for health professionals

Reports of inconsistent care highlight a possible need for improved and ongoing health professional education and training to ensure all healthcare providers are equipped with the information and skills needed to implement evidence-informed practices; improved policy communication and monitoring to ensure optimal guidelines are known, understood and implemented in hospital;¹¹ improved support and working conditions for healthcare professionals providing care; and improved prioritization of maternal care. Although mothers reported receiving care from physicians in labour/delivery and before hospital discharge, maternal accounts revealed that nurses were the primary providers of care in hospital, and the main contacts for information, assistance, and support with infant feeding.

Health professionals who care for women in pregnancy, childbirth, and the postpartum period have a unique ability to promote and facilitate early breastfeeding success (Taveras et al., 2004). However, ongoing training and support for health professionals is necessary to consistently implement policies designed to promote optimal infant feeding practices, including those outlined in the BFI. Step 2 of the BFI involves ensuring that health professionals are trained with the necessary knowledge and skills to implement breastfeeding policy. The BFI recommends that breastfeeding training programs for health professionals are 20-hours in length and involve three hours of clinical observation to ensure staff have the knowledge and skills needed to provide care aligned with BFI guidelines (BCC, 2012b).

¹¹ Policy communication and monitoring is addressed under Research Question 4.

Breastfeeding education and training programs for health professionals have been linked to improved hospital adherence with Steps 3-10 of the BFI, and higher rates of breastfeeding initiation and duration (Cattaneo & Buzzetti, 2001; Durand, 2002; Zakarija-Grkovic, et al., 2012). In a study examining the impact of a 18-hour breastfeeding education and training program for health professionals, Cattaneo and Buzzetti (2001) reported a significant improvement in hospital compliance with the BFI Ten Steps, a significant improvement in the knowledge scores of health professionals, and a significant increase in rates of exclusive breastfeeding at discharge, and any breastfeeding at six months. Similarly, Zakarija-Grkovic and colleagues (2012) found a statistically significant improvement in hospital compliance with the BFI Ten Steps following the implementation of 20-hour breastfeeding training program for health professionals. Durand and colleagues (2002) reported similar outcomes from their 20-hour training intervention, demonstrating the benefits of continuing education for health professionals.

Breastfeeding education and training for health professionals has been found to improve the knowledge of health professionals, the quality of infant feeding care delivery, and overall breastfeeding outcomes. Ward and Byrne (2011) state, “continuing breastfeeding education improves the knowledge, clinical skills and practices, and counseling skills of nurses and midwives, and it improves the Baby-Friendly Hospital Initiative compliance of institutions” (p. 381). Additionally, they found that higher knowledge levels among health professionals led to more supportive (and less regulating and controlling) interactions between health professionals and breastfeeding mothers. Continuing education and training programs for health professionals were found to have many benefits, most of which were found to occur after the intervention even without institutional commitment to achieving BFI designation (Ward & Byrne, 2011).

Breastfeeding education and training courses for health professionals have been prioritized NL and have been delivered (and continue to be delivered) to hospital staff working with mothers in delivery and maternity units in all four Regional Health Authorities in NL. This demonstrates a provincial commitment to BFI practice standards, an acknowledgement of the importance of infant feeding education and training for health professionals aligned with BFI guidelines, and a commitment to improving the consistency of infant feeding care in the province.

At the time of this study, the 20-hour infant feeding courses were mandatory for all health professionals providing regular care to women in pregnancy, labour/delivery, and the post partum period in the Eastern Health Authority. Each course was structured to follow the recommended content and 20-hour course structure detailed in the BFI. The first round of courses began in the Eastern Health Authority in October 2011. As of August 2013, all required health professionals within the Eastern Health Authority had not yet completed courses. At the time of data collection for this research (March 2012), 56% of Case Room and Obstetrics nurses working at the Janeway Children's Hospital/Health Sciences had completed the required 20-hour course, and 44% had not (Stuckless, 2013). For this reason, the infant feeding education and training of health professionals at the Janeway Children's Hospital/Health Sciences Centre was inconsistent at the time of data collection. It is also unknown the degree to which reported inconsistencies with care in hospital correspond with the training status of health professionals. Additional research on institutional adherence with Steps 3-10 at the Janeway Children's Hospital/Health Sciences Centre is recommended after the completion of this education and training intervention.

It is anticipated that infant feeding education and training programs aligned with BFI guidelines will result in improved consistency with care practices in hospital and greater adherence with BFI guidelines at the Janeway Children's Hospital/Health Sciences Centre. It is also anticipated that the 20-hour education and training intervention provided is unlikely to create lasting change if staff education and training is not reviewed or ongoing. Additionally, without supportive working conditions for hospital nurses and the regular communication and monitoring of evidence-informed policies, education and training is unlikely to result in widespread sustained change (Ward & Byrne, 2011; Zakarija-Grkovic, et al., 2012).

7.2.2 (Un)supportive employment and working conditions for nurses

While the employment and working conditions of nurses were not examined in this research, maternal accounts indicated that the employment and working conditions of nurses at the Janeway Children's Hospital/Health Sciences Centre may have influenced their ability to provide optimal care. When discussing nursing care experiences, mothers frequently reported that nurses were "overworked", "exhausted", "rushed" and "had no time". These accounts suggest there may be underlying institutional working conditions and pressures at the Janeway Children's Hospital/Health Sciences Centre affecting nurse ability to care for patients at optimal evidence-informed standards.

Nurses' working conditions have been explored in the literature, and indicate that nurses in Canada often work long hours, feel unsupported in the workplace, and experience a great deal of work related stress (Shields & Wilkins, 2006). While it is likely many factors contribute to challenging working conditions for nurses, these issues may be related to understaffing and higher workloads caused by healthcare restructuring. As noted by Zboril-Benson (2002), in Canada, "restructuring initiatives have included decreasing the number of nursing personnel,

reducing the length of patient stays, developing multi-skilled workers by cross-training nurses, decentralizing services to patient-care units, and increasing the number of unlicensed personnel” (p. 2). A national survey on the work and health of Canadian nurses by Statistics Canada reported that, “more than one-third of Newfoundland and Labrador’s nurses (35%) – the second highest proportion in the country – were classified as experiencing high job strain” (Shields et al. p.5). High patient work loads, long working hours, and understaffing for nurses may be an issue at the Janeway Children’s Hospital/Health Sciences Centre, and may contribute to observed inconsistencies and reports of impatient and insufficient nursing care.

Zakarija-Grkovic and colleagues (2012) engage with the importance of supportive institutional conditions for the delivery of optimal care. They note,

The implementation of a step requires more than staff competency; it requires adequate staff training, structure, policies, routines, managerial support, interdisciplinary care, and patient-centered care. Health practitioners are affected by organizational constraints on their ability to provide effective breastfeeding support. (p. 9)

It makes sense that the organizational and supportive conditions experienced by healthcare providers (i.e., scheduling, patient loads, length of shifts, access to resources etc.) influence their ability to provide care. Although breastfeeding education and training programs are important, successful outcomes rely more heavily on institutional supports for health professionals than on education and training programs (Ward & Byrne, 2011). Future research into the institutional employment and working conditions of nurses in the Case Room and Maternity Unit of the Janeway Children’s Hospital/Health Sciences Centre is recommended for a broader understanding of the institutional factors influencing infant feeding care provision.

7.2.3 Maternal care and the BFI

Maternal accounts indicate that mothers did not always receive patient and accessible information and support in hospital during labour and delivery, when learning how to breastfeed, or when caring for the self following delivery. These suggest a need for greater attention to maternal care and wellbeing in labour/delivery and the post partum period.

While few critiques of the BFI emerged in the literature, the BFI has been critiqued for focusing primarily on the promotion of optimal infant nutrition through breastfeeding, while neglecting the prioritization of positive birthing and healthcare experiences for mothers. Although the connection between supportive maternal care practices and the ability to succeed with exclusive breastfeeding may be obvious, it is important to note that maternal care in hospital is not prioritized in the BFI. Chalmers (2004) discusses this issue and its contradictory relationship to breastfeeding success:

During the time that the BFHI was being implemented, increasing medicalization of birthing was ignored. Practices such as operative delivery, use of epidural anesthesia or pharmacological analgesia for birth, supine positions for deliveries and inappropriate practices such as routine episiotomies or cervical assessment after delivery have often flourished, despite their impact on breastfeeding. Nor were the sensitivity of caregivers to the emotional needs of women, continuity caregiver support in labour or in the postpartum period emphasized by the BFHI. For some reason, women were expected to rise above these frequently unpleasant experiences to experience the magic of ‘bonding’ and to breastfeed joyfully and with success. (p. 198)

It is not surprising that a mother’s hospital care experience in childbirth and the early days of motherhood affect her wellbeing, ability to care for her infant, and experience with infant feeding. Chalmers’ (2004) analysis highlights that BFI does not place enough emphasis on maternal care and wellbeing – an oversight that may cause harm to breastfeeding mothers, and mothers who for structural, or other reasons, cannot or choose not to breastfeed. A lack of focus

on maternal care and wellbeing in a policy as highly regarded (and widely promoted) as the BFI may result in the creation or continuation of infant-centered hospital practices that render the care needs of mothers as secondary – rather than complementary – to the care needs of infants.

Interestingly, of the articles systematically reviewed in this research on the topic of infant feeding and the BFI, none focused on maternal care needs in hospital, impacts of maternal care interventions, or opportunities and strategies for better maternal care practices. The majority of scholarly articles had an infant-centered focus exploring infant care practices, feeding outcomes, factors leading to breastfeeding cessation, and the benefits of breastfeeding. This observation may be indicative of a broader issue in infant feeding discourse of limited engagement with maternal care. While the reason for this is unknown, it may relate to broader socio-cultural views of mothering roles and practice.

High quality maternal care involves open communication and dialogue between mothers and healthcare professionals, accurate information, and the respectful and timely provision of assistance, support, and follow-up care when needed and/or requested. In addition, high quality care includes sensitivity to the social determinants of health, support for informed decision-making, and an emphasis on personal choice and agency. While many mothers in this research reported satisfaction with their hospital care experiences, many also shared feelings that they did not receive the information, respect, and care in hospital they believed they needed.

Supportive maternal care in pregnancy, labour and delivery, and the post partum period is important not only for maternal health and wellbeing, but also for infant health and wellbeing. Bialoskurski, Cox, and Wiggins (2002) note that the satisfaction of maternal needs leads to improved wellbeing for both mothers and their infants. Because mothers who are healthy and happy are better able to direct their energy towards infant care provision than those who are not,

maternal care and wellbeing should be prioritized by initiatives working to promote optimal infant feeding practice.

While the BFI emphasizes the importance of providing mothers with regular infant feeding assistance, observation, and support in hospital (and upon transition into the community), it does not stress the importance of involving mothers in the labour and delivery process, or of ensuring that mothers are emotionally supported in labour/delivery and recovery. Similarly, it does not prioritize the physical comfort of mothers in hospital or the provision of information and support about how to care for the self in recovery. Interestingly, many maternal issues with healthcare experience in this study related to feeling ignored and disrespected in labour and delivery,¹² unsupported and physically uncomfortable in hospital, and ill informed about how to care for the self and what to expect in recovery. This suggests that shortcomings in the BFI model may influence and shape maternal hospital healthcare experiences. Future research in this area is recommended.

Because the BFI is a detailed and lengthy document guiding hospital infant feeding care practices, it may be used by hospitals as a complete and comprehensive policy for infant and maternal care, rather than simply as the comprehensive infant feeding healthcare policy it is intended to be. Further research into optimal maternal healthcare practices for labour/delivery and post-partum recovery and their implementation in hospital is recommended.

7.2.4 Breastfeeding challenging, gendered, and socially complex

The majority of mothers indicated they were the primary care provider for their infant and held the greatest level of responsibility and involvement with the day-to-day tasks of childcare. Although many indicated they had supportive partners and family members to assist with

¹² Maternal experiences in labour and delivery are presented in Appendix B.

childcare responsibilities, gendered roles of parenting were very visible, with caring roles falling primarily upon mothers. This seemed especially true for mothers who were exclusively breastfeeding and could not rely on others to feed their infant at regular intervals (especially at night). While a number of mothers indicated experiencing joy and satisfaction with being primary care providers, many also described feeling exhausted, overwhelmed, and isolated in their mothering roles. Many also discussed feeling social pressure to breastfeed, guilt associated with supplementation, and a willingness to make personal sacrifices for their infant. This highlights both the gendered role of mothering and the real demands of motherhood – both of which are shaped by social and cultural expectations and mothering ideals.

Gendered roles and expectations of mothers are socially and culturally shaped and reinforced, and relate to the concept of *biological determinism* – the idea that all things are causal and pre-determined by biological or genetic factors (Bunnin & Yu, 2004). When applied to parenting, biological determinism would infer that because mothers carry and deliver infants and lactate, they are biologically predetermined to be the primary care provider for their children (even though men have an equal ability to assist with the majority of childcare responsibilities). Because breastfeeding requires regular and ongoing care from mothers, it can reinforce gendered parenting roles that many women are trying to change. As Rippeyoung (2009) notes,

Breastfeeding places a unique form of responsibility on the nursing mother, by making her tied to the baby for feeding, and even should she pump her milk, she needs to do so every few hours. This also sets in motion patterns of parenting where the mother is seen as the primary care provider for the child. (p. 41)

While most mothers indicated an acceptance of their gendered care role, some expressed frustration with the gendered demands of breastfeeding, and some shared that they began supplementing with formula to equalize parenting roles. In all cases where mothers discussed

supplementing with formula for non-medical reasons, they indicated they did so because of the demands, challenges, and physical discomforts of breastfeeding.

Most mothers reported experiencing challenges, pain, and discomfort with breastfeeding at some point in their breastfeeding experience, and many shared that breastfeeding was more difficult and demanding than expected. It is possible that some of the challenges and discomforts mothers experienced with breastfeeding could have been avoided if they had received more breastfeeding assistance and help with positioning and latching in hospital. Although mothers who saw a lactation consultant reported improved comfort and confidence with breastfeeding, the majority of mothers reported no visit with a lactation consult in hospital. Some indicated no need to see one, while others mentioned that lactation consultants were unavailable or difficult to access in hospital. A few mothers expressed frustration with having to wait 24 hours to see a lactation consultant, and some suggested that an earlier consultation could have helped them avoid breast and nipple pain from improper latching technique. While maternal accounts highlight the importance of care from lactation consultants and a potential need for greater access and availability of lactation consultants following delivery, they also suggest that hospital nurses were unable to provide the same degree of breastfeeding assistance and support.

When discussing infant feeding practices and healthcare experiences, many mothers indicated feeling social and cultural pressures to breastfeed. Interestingly, some also suggested a lack of cultural comfort and acceptance with breastfeeding practice in NL. This presented an interesting contradictory relationship between what is idealized and expected of mothers, and what is socially acceptable in the public sphere. Maternal accounts indicate that breastfeeding in public is not yet accepted as normal female body practice in the province of NL. Matthews and authors (1998) reported maternal embarrassment with breastfeeding in NL as a reason for

supplementation in the province. While efforts are being made to change attitudes towards breastfeeding through public education, outreach, and social media campaigns in support of breastfeeding, social and cultural perceptions of breastfeeding (and mothering practice) may influence and continue to influence maternal feeding decisions and practices in NL.

7.2.5 Informed decision making

In a climate where breastfeeding can become an avenue through which good and bad motherhood is defined, it is important health professionals ensure that mothers are provided with optimal care in birth and recovery, are informed of infant feeding options and their implications, and are supported to make decisions that are right for them. While evidence of the nutritional, immunological, and social benefits of breastfeeding over alternatives make its promotion important and necessary within the healthcare system, it can be problematic when promotion limits a woman's ability to choose or access information and support with dignity and respect.

Friedman (2009) engages with the importance of exercising choice when it comes infant feeding, stating that breastfeeding “must be viewed through the language of choice, acknowledging the tremendous physical and emotional impact on mothers, rather than simply looking at the benefits for their babies” (p.26). Dignifying choice implies a duty to witness and act upon the social patterns that structure opportunity and limit choice. While it is important to encourage and facilitate evidence-informed health practice, it is important to do so in a way that acknowledges personal health needs, and leaves space for informed decision-making.

In a report presenting lessons learned from a recently BFI accredited institution, Vasquez and Berg (2012) reflect upon the mistake of forcing exclusive breastfeeding upon mothers rather than enabling and supporting mothers to make an informed decision about the infant feeding practice best for them. They share that on their journey towards achieving BFI designation,

“errors were made along the way, including insisting that mothers exclusively breastfeed. It is much better to educate and empower. In this quality improvement project, potential allies were lost by rigidly trying to force the process” (p. 43). This reflection shows how easily maternal choice can be neglected in efforts to achieve institutional health goals. It highlights the counterproductive nature of forceful health promotion practices, and reinforces the value of policies and care practices that empower and enable mothers to make their own informed decisions about infant feeding. Although the BFI encourages informed decision making and the provision of support and assistance for supplementing mothers (and does not penalize hospitals for informed supplementation), as Vasquez and Berg (2012) noted, institutional desires to improve breastfeeding rates can get in the way of maternal agency and hinder efforts to promote exclusive breastfeeding.

Maternal accounts from the Janeway Children’s Hospital/Health Sciences Centre suggest that most mothers were supported to feed according to their desired mode of infant feeding, however were often not informed of the importance of breastfeeding or implications of supplementation. While it is important to ensure maternal infant feeding choices are supported and respected in hospital, it is also important to ensure decisions are fully informed.

7.3 Comparing hospital infant feeding policies to BFI guidelines

Four infant feeding policies were used to guide and inform infant feeding practice for the healthy newborn at the Janeway Children’s Hospital/Health Sciences Centre at the time of data collection. These documents were reviewed and compared to BFI policy guidelines to identify discrepancies and areas for improvement. Although all Eastern Health Authority policies demonstrated a clear commitment to BFI guidelines and a clear desire to promote evidence-informed care aligned with BFI standards, gaps in Eastern Health Authority policies were found.

Because policies set standards and priorities for care, they are of vital importance for shaping and updating clinical practice. Weddig and colleagues (2011) acknowledge that nursing care practices are shaped by formal and informal hospital policies, and note that inappropriate or outdated hospital policies pose a significant barrier to the support of breastfeeding. Similarly, Philipp and Merewood (2004) emphasize that updating policy is a critical step towards changing outdated hospital practices and routines. With this in mind, updating infant feeding policies to better reflect guidelines identified in the BFI is a reasonable priority for improving clinical practice.

The influence of infant feeding policy on practice was visible in this research when exploring patterns of adherence (and lack of adherence) to Steps 3-10 of the BFI. Results indicated a relationship between gaps in hospital policies, and maternal reports indicating low adherence to those steps in practice. For example, while skin-to-skin contact (Step 4) was thoroughly detailed in an Eastern Health Authority policy, the policy specified a shorter duration of skin-to-skin contact (20-30mins) than recommended in the BFI (60 min), and corresponded with maternal reports of shorter-than-optimal skin-to-skin duration in hospital. Similarly, Eastern Health Authority policies did not instruct staff to provide mothers with information or instruction on how to maintain lactation if separated from their infant (part of Step 5), and mothers consistently reported receiving no information or instruction in hospital about how to maintain lactation if separated from their infant. These observations suggest a likely relationship between policy and practice, and are suggestive of opportunities to improve outcomes through improved policy development, communication, and monitoring.

Comprehensive and evidence-informed infant feeding policies have been found to improve breastfeeding care provision and infant feeding outcomes (Fairbank et al., 2004;

Rosenberg, Stull, Adler, Kasehagen & Crivelli-Kovach, 2008). When studying the impact of infant feeding policy on practice, Rosenberg and authors (2008) found an association between a written infant feeding policy and higher rates of continued breastfeeding at two weeks post partum. Dorfman and Gehlert (2010) emphasized the role of policy in instigating change with breastfeeding:

Increasing exclusive breastfeeding rates and decreasing health disparities is only possible if women's efforts to breastfeed are supported by structural changes at the policy level. These efforts include eliminating the marketing of free formula, improving staff training and breastfeeding policies at hospitals, reducing language-, culture- and income-based barriers to breastfeeding support services, and expanding legislation that supports breastfeeding by working mothers. (p. 14)

Similarly, Fairbank and colleagues (2004) reported an association between evidence-informed breastfeeding policy and higher rates of breastfeeding initiation – reaffirming the connection between evidence-informed infant feeding policy, better clinical practice, and improved breastfeeding outcomes.

It is clear that policies are an indicator of intention with the ability to set and guide standards of practice, however if unaccompanied by regular communication and monitoring, training programs for healthcare staff, and supportive working conditions, setting priorities and articulating intentions may be insufficient to create change. As Perrine and authors (2011) note, “policy does not necessarily indicate practice. To improve practice, hospitals will need to ensure that staff members are sufficiently trained to carry out strong breastfeeding policies, and routinely assess adherence” (p. 1023). It is evident that policy development, communication and monitoring are vital for successful and sustained BFI implementation. It is also clear, however, that the provision of ongoing breastfeeding education and training for health professionals and

supportive employment and working conditions for healthcare providers are vital for successful BFI implementation.

7.4 Study limitations

When interpreting results on hospital adherence to Steps 3-10 of the BFI at the Janeway Children's Hospital/Health Sciences Centre, the following limitations should be noted: the full range of adherence to Step 3 could not be assessed because the study focused on in-hospital care practices from the time of admission for birth until discharge; in the assessment of Step 4 mothers were not asked if they were informed prenatally of the importance of skin-to-skin contact; in the assessment of Step 5 mothers were not asked if they received information on hand milk expression; in the assessment of Step 6 mothers were not asked if they discussed sustained breastfeeding or the introduction of complementary foods with their healthcare provider; in the assessment of Step 7 mothers were not asked if they received information on safe co-sleeping and bed sharing; and in the assessment of Step 10 mothers were not asked if they felt they lived in a community that supported breastfeeding.

This research did not explore infant feeding care provision for unwell mothers or infants in hospital; and did not explore the availability and quality of prenatal programs, community support programs, and public health services for breastfeeding mothers. It also did not engage with the perspectives of health professionals providing care to mothers in hospital.

It should also be noted that the focus group recruitment strategy of snowball sampling may have limited participant diversity, as all focus group participants had experience with breastfeeding and were supportive of breastfeeding. The 20-hour breastfeeding health professional education/training intervention in the Eastern Health Authority was not complete at time of data collection, so not all nurses at the Janeway Children's Hospital/Health Sciences

Centre had completed the course when data was collected. Finally, this study did not include an observational component or exploration of medical records for data verification, so research outcomes on adherence with BFI guidelines depend upon accurate reporting from mothers.

7.5 Recommendations for future research

Future research is recommended to explore: the institutional employment and working conditions of nurses and lactation consultants in the Janeway Children's Hospital/Health Sciences Centre Case Room and Maternity Unit, cultural attitudes towards breastfeeding and acceptable maternal body practices in NL, shortcomings of the BFI model and their potential impact on the delivery of optimal care practices for mothers, and the privacy and agency of mothers in labour and delivery at the Janeway Children's Hospital/Health Sciences Centre.

7.6 Conclusion

Breastfeeding is widely evidenced as a nutritionally, immunologically, and socially optimal infant feeding practice with numerous health benefits for mothers and infants. Globally promoted through the WHO/UNICEF Baby-Friendly Initiative for its ability to reduce infant mortality and morbidity, protect against infections and chronic conditions, promote optimal growth and development, and enhance maternal health; breastfeeding has the ability to improve overall population health by supporting positive health outcomes for mothers and their children. While there are currently no accredited BFI healthcare institutions in the province of NL, meeting BFI practice guidelines is a healthcare goal supported by the Government of NL, NL Provincial Perinatal Program, Baby-Friendly Council of NL, and all four Regional Health Authorities.

An examination of maternal healthcare experiences and infant feeding policy guidelines at the Janeway Children's Hospital/Health Sciences Centre reveals discrepancies between BFI

guidelines and hospital infant feeding healthcare practices. Maternal accounts indicate a lack of full adherence with the guidelines specified for Steps 3-9 of the BFI (and possible adherence with Step 10). Inconsistencies in care provision were commonly reported, indicating a potential need for improved breastfeeding education, training, and supportive working conditions for nurses; and improved policy communication, monitoring, and alignment with BFI guidelines.

Maternal reports suggest that breastfeeding is an emotionally and physically demanding practice that is idealized and expected of mothers, while also not culturally accepted in the public sphere in NL. This reinforces the importance of community supports for mothers, and interventions focused on changing cultural attitudes towards breastfeeding in the public sphere.

Although breastmilk is optimal for infant health and development, for a number of reasons, breastfeeding may not always be possible or optimal for every mother or mother-infant dyad. For this reason, ensuring mothers are supported to make informed decisions about their infant feeding practice with dignity and respect is of critical importance for the promotion of optimal maternal-infant care. While the BFI emphasizes informed decision-making and the provision of support for supplementing mothers, it is important this is upheld in healthcare settings despite institutional goals to promote exclusive breastfeeding (or achieve specific breastfeeding rates).

While healthcare institutions play an important role in facilitating early and ongoing success with breastfeeding, healthcare provision is only one of many factors contributing to breastfeeding success. For this reason, breastfeeding promotion must extend beyond the healthcare system to the broader community and political sphere where social factors, determinants of health, and attitudes, shape and define the choices mothers have, and the spaces they inhabit.

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Appendix A

Interview & Focus Group Question Guide

Can you tell me about what happened when you first arrived at the hospital? Where did you go? What happened in your delivery? How did things unfold?

Step 4

Can you tell me about what happened in the moments immediately following childbirth?

“How soon after birth did you first hold your baby?”*

“The first time you held your baby, was your baby naked? That is, not wrapped, dressed, or in a diaper,” and “The first time you held your baby was your baby against your naked skin?”*

If skin-to-skin: How long did you hold your baby with uninterrupted skin-to-skin contact?

“How long after birth was your baby first put to the breast?”* and breastfed?

Step 3

While in the hospital, did you receive any information about how to feed your baby? If so, what information did you receive?

What practices were recommended?

Do you feel that you received enough information about how best to feed your baby while in the hospital?

Can you tell me about the first time your baby was fed after he/she was born?

Step 5

“Did you health care providers help you or offer to help you start breastfeeding?”* If so, what help or support did you receive? Can you tell me about what happened?

Did the help or support you received feel sufficient?

Did they teach you how to maintain lactation if you were separated from your baby?

Step 6

What feeding method did your healthcare provider recommend in hospital? What was recommended?

Were liquids such as water or formula fed to your infant before hospital discharge? If so, was there a medical reason?

Were you given any formula samples to take home?

Step 7

How was the hospital environment? What was the physical environment like?

Did you and your baby stay together 24 hours/day throughout your hospital stay?

If you and your baby were separated, what was the reason?

How many hours in total were you and your baby separated (in separate room) during the first 24 hours after birth?

Step 8

How did you know when it was time to feed your baby? What was recommended?

How much time was recommended for each feeding? How did you know when each feeding was finished?

Step 9

Did your baby have an artificial nipple or pacifiers (dummies or soothers) to suck on while at the hospital?

If so, were they provided by your health care provider?

Did your baby drink from a bottle with an artificial nipple attachment in hospital?

Step 10

“Did your health care providers give you information about community breastfeeding support resources for ongoing help?”*

If so, what support resources did they recommend?

Additional Questions:

- Were your health care providers supportive of your decision to breastfeed / formula feed your infant?
- Was a health care provider available to assist you with any infant feeding questions, concerns, issues, or complications that arose while at the hospital?
- Did you feel you received enough information in hospital about caring for yourself?
- Is there anything that could have improved your overall hospital experience? Are there any changes you'd recommend?

* Questions come from the Public Health Agency of Canada's Maternity Experiences Survey Tool. (PHAC, 2007).

Appendix B

Maternal Experience of Delivery

Delivery experience

Mothers frequently discussed the topic of labour and delivery in detail. Although not explicitly a focus of this research, maternal accounts indicate that birth experiences had a large impact on their feelings and attitudes towards their healthcare experience. A wide range of both positive and negative delivery experiences were described. Mothers who described a negative or traumatic delivery had a tendency to return to the topic of their delivery many times throughout the interview or focus group discussion, and often went into more detail about their experience than mothers with positive experiences.

While the majority of mothers reported no major issues in labour/delivery, three of the twelve mothers interviewed reported a negative labour and/or delivery care experience. Of these, two expressed feeling ignored and dismissed in delivery when they did not receive an epidural to help manage pain in labour after requesting it many times, and one reported a negative experience with physician conduct during a failed forceps delivery involving a medical resident and her physician supervisor. The following excerpts demonstrate the range of labour/delivery experiences reported by mothers:

P17: I had my baby and it was really quiet in there, it wasn't busy. It was in the morning, the lights were off, it was just me, and my husband, and the nurse. She was born and the nurse just laid her there and we just all hung out for about an hour. It was really peaceful and there was nobody else around.

P7: There was a little tiny girl [medical intern] at the end of the bed with 10 doctors and they were trying to get her to use forceps. There was another doctor in there that said, "You don't know your left from your right." And then the other doctor had to step in and put them on... Then I had a c-section. It was a failed forceps delivery. So it wasn't, I just think it was a bit like a cattle call truthfully – the birthing part of it...

the nurses were amazing, the doctors I wasn't pleased with, especially the one there. When they said forceps I looked to my nurse who was there with me for 12 hours so I trusted her, and the doctor said to me, "Who are you looking at?" She said, "Don't look at her, look at us." She said, "Never mind her."

While most mothers reported positive care experiences in labour and delivery (even those with challenging delivery experiences), negative experiences highlight areas for improvement with care provision.

One mother discussed feeling that she was not part of her birthing process because she was not included or consulted. She mentioned no discussion about birthing preferences, how she was feeling, or what was happening, and expressed belief that healthcare providers would not respect birthing plans or preferences if she had communicated them.

P8: I didn't feel like I was part of anything. I just felt like I was a body... I don't know what I expected, like, "This is gonna happen now," or "This is what we're doing"... I don't think I wanted a step-by-step what's gonna happen, but you know, "How are you feeling?" or "What do you want when he's born?" The whole idea of a birth plan is a joke. I mean, even if I told them that I had a birth plan, which I didn't, they would have laughed at me. You know, it's just maybe something for the States because here I think it's just survival. I don't know what it is. They just get it done. So, I felt like everyone seemed very educated on that floor. They seemed like proficient people, and that wasn't the worry, it was just, I didn't feel part of anything... They were talking to each other a lot, so I was just kind of the body.

This account highlights a possible lack of regard for maternal birthing preferences and inclusion in the birthing process, as well as the absence of routine dialogue between mothers and healthcare providers in labour/delivery. It also suggests that lack of inclusion in the birthing process created a situation where a mother felt disempowered. She compared the quality of care received to that of the private healthcare system in the United States, and hinted that childbirth was something that was done to her by physicians, rather than something she owned herself and did with her own body. While this experience of little to no engagement in delivery was not

common, other mothers shared similar experiences, indicating a need for improved maternal care and inclusion in labour/delivery at the Janeway Children's Hospital/Health Sciences Centre.

Whether experiences were positive or negative, discussions about labour/delivery suggest that childbirth was a major life experience for mothers, and had a large impact on overall hospital experiences. Although most reported positive care experiences, those who did not highlight a need for improved dialogue between mothers and their healthcare providers, and more mother-friendly birthing practices.

Feelings about lack of choice/agency

Related to the theme of maternal engagement in delivery, is the theme of experiencing lack of choice and agency in hospital. This theme emerged in all three focus group discussions, and in three of twelve interviews. When lack of choice/agency was raised by mothers, it frequently related to feeling not listened-to, not consulted, and/or not informed of medical options or decisions in labour/delivery. This is expressed in the following statement:

P21: As soon as I got in, I said to the nurse, "I really don't want extra medical students" [attending the delivery]. I said, I know there's people that are necessary... but I prefer to not have a room full of un-necessary people in the room." And she said, "Well I'm not sure if that's possible." And then I mentioned it again and she's like, "Okay, we'll try to not have medical students." And when the delivery happened, cause you know once I started pushing she came out so quick, and then the resident came, there was a student following with her and whoever else, and I never got a chance to object. I felt it was within my rights to ask not to have extra people, and I knew it was, but I didn't get that. So I was a bit disappointed with that cause I made it clear, you know?

This mother reported a lack of choice and agency during an important part of her delivery experience.

Similarly, a mother shared her experience of not being listened to in labour when she asked for an epidural. She mentioned feeling that she would have accepted her outcome of not

receiving an epidural if she had known the nurses and doctors had listened to her and tried to get it for her, rather than dismissing her. She stated:

P11: If they had called the anesthesiologist and they didn't get there in time, that's fine, but at least I would know they were listening to me. But I felt, I felt like I was in a room by myself. I felt like I was talking to the wall. And that's not good when you're trying to bring a body into the world.

This indicates a lack of maternal choice regarding conditions of labour and personal care. Both mothers expressed feeling that clear and reasonable requests were communicated and not addressed or respected by healthcare providers. They described a power imbalance between healthcare providers and mothers in hospital, especially in the vulnerable moments of labour/delivery. Their accounts suggest a need for a more mother-friendly approach to care at the Janeway Children's Hospital/Health Sciences Centre.

Lack of privacy of the body

Mothers raised experiencing a lack of personal privacy in the hospital in four of twelve interviews, and in two of three focus group discussions. Of those interviewed who raised this issue (n=4), all mentioned concern over private moments being seen by others. Three raised concern over the lack of privacy experienced in their ward room, while two mentioned feelings that more health professionals and/or students saw their breasts and vagina in hospital than was necessary. These experiences are captured in the following statements:

P9: You know, you're bleeding on the floor basically because you have an ice pack on, and you really really want to be in a private room. They shouldn't even have ward rooms anymore. I think it's absolutely ridiculous. There's no privacy, there's a curtain separating you and the next person.

P8: I felt really uncomfortable when there were men there [male visitors in the ward room], cause you're shuffling around and there's one bathroom, so where I was right at the back, I have to shuffle to the bathroom and it's just embarrassing... the big pads you have to wear, and your belly's out, and your breasts are leaking, and then there's like men there. I understand why, but it's not a choice.

P1: There's no privacy left by the time you're done having a baby. I think after having three of them, I think everybody from the maintenance staff, everybody... "Come on in!" (Laughing) Yeah, they knock on the door, "Can I come in?" You kind of get used to it.

P11: There's four beds [in ward room] and they're all separated by the curtains, and by the time I felt I knew the medical history and problems of the three women in the room.

I: Yeah, so you don't really have privacy and confidentiality.

P11: Yeah, like do I really need to know that? And do they really need to know that somebody else knows that, right? And one woman was actually trying to whisper because she was embarrassed, or I don't know, but you could still hear it, right? It's terrible.

These excerpts highlight issues of limited privacy and confidentiality in ward rooms, where personal medical histories can be heard by others patients, and private bodily moments seen by others with little or no choice. Not surprisingly, privacy and confidentiality was most often raised as an issue by mothers who stayed in a shared ward room, but was also raised by some as an issue in delivery when many people (including groups of medical students) entered the room in the final stages of labour with no prior consultation. As one mother stated, "I swear they had everybody in the medical school there, like there were at least 30 people in the room when I finally gave birth" (P20).

Although it may be important for medical students to attend births as part of their education, maternal accounts indicate it is also important that mothers are informed of – and consent to – extra medical personnel attending their delivery. Statements about poor privacy within ward rooms also highlighted a need for improved privacy measures within hospital.

Appendix C

Policy Document 4: *Breastfeeding: Protection, Promotion and Support for Healthy Term Infants*

Table 6-4: BFI and Breastfeeding: Protection, Promotion and Support for Healthy Term Infants

BFI Policy	Eastern Health: Breastfeeding: Protection, Promotion and Support for Healthy Term Infants	Difference
Step 3 “Inform pregnant women and their families about the importance and process of breastfeeding.”	“Inform pregnant women and their families about the benefits and management of breastfeeding.”	
“Pregnant women (at 32 weeks or more gestation) who use a prenatal service and who have had two or more prenatal visits or classes, confirm that they are given sufficient opportunity to discuss their infant feeding decisions with knowledgeable staff. They also confirm that the importance of exclusive breastfeeding has been discussed with them.”	“Provide prenatal education that includes information to help women and their families make an informed decision about infant feeding that includes the risk of not breastfeeding. The basics of breastfeeding management and the common experiences they may encounter will also be included. The aim is to give women confidence in their ability to breastfeed.”	Policy does not ensure mothers are provided with opportunity to discuss feeding decisions with staff
Pregnant women “can describe at least two benefits of breastfeeding and the importance of skin-to-skin contact, in addition to two of the following: exclusivity of breastfeeding, risks of non-medically indicated supplementation, cue-based feeding, position and latch, rooming-in, and sustained breastfeeding.”	“Provide prenatal education that includes information to help women and their families make an informed decision about infant feeding that includes the risk of not breastfeeding.”	Policy does not emphasize verbal communication with mothers to detect understanding of breastfeeding benefits
Pregnant women “confirm they have received no group education on the use of human milk substitutes. Hospitalized pregnant women confirm they have also received information appropriate to their needs.”	No discussion.	Policy does not address group education about human milk substitutes. Policy does not address information received by hospitalized pregnant women.
“The manager of a hospital shows that breastfeeding information is provided to at least 80% of pregnant women using the facilities prenatal services. The manager shows liaison with the local hospital(s) and collaboration regarding the development of the	“Provide all pregnant women with information on breastfeeding through <i>A New Life</i> parent booklets and the provincial <i>Breastfeeding Handbook</i> .”	Documentation of percent of women receiving prenatal education not addressed in policy. Collaborative development of prenatal curriculum not

prenatal curriculum.”		discussed.
“Staff providing prenatal education confirm that they have received breastfeeding education as outlined in Step 2.”	No discussion.	Policy does not detail staff education and training.
“A written curriculum for prenatal education used by the hospital... and written information for prenatal clients (such as booklets, leaflets, handbooks, and text books with general information on pregnancy, parenting, infant feeding and child care) provide accurate, evidence-based information. They are free from information on the feeding of human milk substitutes.”	“Provide all pregnant women with information on breastfeeding through <i>A New Life</i> parent booklets and the provincial <i>Breastfeeding Handbook</i> .”	Policy does not specify that all written materials are free from information on feeding with human milk substitutes.
“Women who have made an informed decision not to breastfeed receive written materials on the feeding of human milk substitutes that is current, appropriate and separate from breastfeeding information. All written material is free from promotional material for products or companies that fall within the scope of the WHO Code of Marketing of Breast-Milk Substitutes.”	“Respect the informed feeding decision of each mother and provide written and one on one teaching of breast milk substitute preparation and feeding.”	Policy does not specify that written information provided is free from promotional material for milk substitutes.
Not discussed in BFI	“Identify women at risk for early breastfeeding cessation and provide extra assistance, support and education. This includes such factors as lack of support, isolation (social, emotional or geographical), young age, low education and low socio-economic status.”	Addressed in policy.
Not discussed in BFI	“Determine mothers’ decision about breastfeeding choice upon hospital admission.”	Addressed in policy.
Step 4 “Place babies in uninterrupted skin-to-skin contact with their mothers immediately following birth for at least an hour or until completion of the first feeding or as long as the mother wishes: Encourage mothers to recognize when their babies are ready to feed, offering help as needed.”	“Help mothers initiate breastfeeding within one hour after birth *Place all babies skin-to-skin for at least one hour after birth.”	
“Mothers report that, unless there were medical indications for delayed contact, their baby placed skin-to-skin immediately after birth (vaginal or C-section delivery	“Encourage all mothers or support persons to hold babies skin-to-skin.” “Place all babies skin-to-skin for at least one hour after birth.” “Allow/encourage as much uninterrupted	Addressed in policy.

without general anesthesia), or as soon as mother is responsive or alert (after C-section with general anesthesia).”	skin-to-skin as possible.”	
“This [skin-to-skin] occurred for an uninterrupted period of at least 60 minutes, or until completion of first feed, or as long as mother wished.”	“Place all babies skin-to-skin for at least one hour after birth.” “Allow/encourage as much uninterrupted skin-to-skin as possible.”	Addressed in policy.
“Mothers confirm that they were encouraged to look for signs that baby was ready to feed and that they were offered assistance as needed.”	“Teach infant feeding cues to all mothers and their support persons.” “Promote breastfeeding by teaching mothers to respond to their infants feeding cues by breastfeeding whenever the infant shows signs of interest in feeding.”	Addressed in policy.
“Mothers with babies in special care report that they were able to hold their baby skin-to-skin as soon as mother and baby were stable, unless medical indications for delayed contact.”	Not discussed.	Policy does not address skin-to-skin procedures for babies in special care.
“All mothers report that they had been informed prenatally of the importance of skin-to-skin contact and were encouraged to discuss this with their health care providers.”	No discussed.	Policy does not emphasize the provision of prenatal education on the importance of skin-to-skin contact. Policy does not address discussing skin-to-skin with healthcare providers in pregnancy.
“Mothers transferred to a different area (e.g., by stretcher or wheelchair) confirm that skin-to-skin contact was maintained as long as mothers wished even after completion of the first feeding.”	Not discussed.	Contingency for skin-to-skin during hospital transfer not mentioned.
“When the baby is well but mother was ill or unavailable, mothers confirm that skin-to-skin contact with another support person of her choice (commonly her partner) was encouraged.”	“Encourage all mothers or support persons to hold babies skin-to-skin.”	Addressed in policy.
“The manager confirms that skin-to-skin care is initiated immediately after birth unless separation is medically indicated, and describes how this practice is monitored.”	Not discussed.	Manager confirmation and monitoring of skin-to-skin not mentioned.
“The staff confirm that normal observations and monitoring of the mother and baby (temperature, breathing, colour, tone) continue throughout the period of skin-to-skin contact. The baby is removed	“Perform procedures according to and respecting the needs of mothers and babies e.g., weighing, bathing”	Separating mother and infant during first hour of skin-to-skin only if medically indicated not addressed.

only if medically indicated or requested by the mother, and this is recorded in the baby's chart."		
"Documents show that skin-to-skin contact remains unhurried and uninterrupted for at least one hour or until the completion of first breastfeed, unless there is a medical indication for separation."	"Place all babies skin-to-skin for at least one hour after birth."	Documentation of skin-to-skin duration not addressed in policy. Separating mother and infant during first hour of skin-to-skin only if medically indicated not addressed.
"Routine procedures, monitoring and measurements are delayed until after the first breastfeed. Medications required by baby are given while the baby is on mother's chest, preferably near end of first breastfeed in order to decrease pain."	"Perform patient procedures, e.g., weighing, eye prophylaxis, bathing, according to the needs of mothers and babies." "Complete infant procedures while the mother is present and at the bedside where possible."	The delay of routine procedures, monitoring and measurements until after the first breastfeed not addressed.
"In the hospital and community health service, written information for clients outlines information consistent with issues cited above."	Not discussed.	Policy does not discuss consistency of written information.
Not discussed in BFI.	"Consider the needs of mothers and babies for warmth, privacy and tranquility."	Addressed in policy.
Step 5 "Assist mothers to breastfeed and maintain lactation should they face challenges including separation from their infants."	"Show mothers how to breastfeed and how to maintain lactation even if they are separated from their infants. Provide the mother with help and encouragement to express her milk and to maintain her lactation during periods of separation from her baby."	
"All postpartum mothers report that they were offered further assistance with breastfeeding within six hours of delivery and at appropriate subsequent intervals. Observations of feedings are completed as needed and at least once per shift."	"Show mothers how to position and latch their babies, how to recognize good latch, and how to recognize their babies are getting enough." "Teach mothers and their support persons that colostrum is adequate nourishment for their babies for the first 48 to 72 hours, and that some weight loss is normal."	Timing of assistance after delivery not specified. Frequency of assistance not specified.
"Mothers discharged from hospital or birthing centre confirm that assistance with breastfeeding concerns is available within 24 hours and routine follow-up is available within 48 hours after discharge."	"Refer all new mothers to the community health nurse within 24 hours of discharge from hospital, so the mother will have the opportunity for early face-to-face assessment of breastfeeding. Breastfeeding progress will be assessed at appropriate intervals."	Addressed in policy.
"Mothers report that they were offered timely help with positioning and latch and that feeding was assessed."	"Show mothers how to position and latch their babies, how to recognize good latch, and how to recognize their babies are getting enough."	Timing of assistance not addressed in policy.
"All mothers describe hand expression of their milk and have	"Provide all breastfeeding mothers with information and demonstration on how to	Policy does not mention provision of

written information on expression and/or advised where they could get help, should they need it.“	hand express breast milk prior to hospital discharge.”	written material on hand expression or information about where to get help.
“All mothers explain cue-based feeding.”	“Teach infant feeding cues to all mothers and their support persons.” “Promote breastfeeding by teaching mothers to respond to their infants feeding cues by breastfeeding whenever the infant shows signs of interest in feeding.”	Addressed in policy.
“All mothers are aware of the signs that their infant is breastfeeding effectively, and they know when to seek help should they need it. Mothers have written information on available and knowledgeable support persons (health professionals or peer support).”	“Show mothers... how to recognize good latch and how to recognize their babies are getting enough.” “Provide contact information for community-based breastfeeding support services to all breastfeeding mothers upon discharge.” “Provide information to all mothers on how to access breastfeeding support 24 hours a day via Information lines.”	Addressed in policy.
“Mothers who are breastfeeding demonstrate effective positioning and latch. All relate they have been given age-appropriate anticipatory guidance about possible breastfeeding concerns, their solutions and available resources that will assist with breastfeeding.”	“Show mothers how to position and latch their babies, how to recognize good latch, and how to recognize their babies are getting enough.”	Policy does not address providing mothers with anticipatory guidance on breastfeeding concerns and solutions.
“Mothers who have made the decision not to breastfeed, or who elected to supplement their babies with human milk substitutes for non-medically indicated reasons report that: they received information to support an informed decision, and were assisted to choose what is acceptable, feasible, affordable and safe, were instructed about correct preparation, storage and feeding of supplements.”	“Respect the informed feeding decision of each mother and provide written and one on one teaching of breast milk substitute preparation and feeding.” “Provide prenatal education that includes information to help women and their families make an informed decision about infant feeding that includes the risk of not breastfeeding.”	Addressed in policy.
“Mothers with babies in special care, or mother with babies who are unable to breastfeed, or who are separated from their babies during illness, or while at work or school, confirm that they received instruction on the maintenance of lactation by frequent expression of milk (beginning within six hour of birth and eight or more times in 24 hours to establish lactation), how to store and handle milk, and where to obtain equipment and how to clean it.”	“Instruct mothers who are separated from their newborn babies to express milk 6 to 8 times in a 24-hour period.” “In special situations where mothers or infants are sick, provide mothers with access to electric pumps and encourage to start pumping within 6-12 hours from birth and to continue pumping at least 6 times per day. All equipment cleaned as per manufacturer’s guidelines.” “Inform breastfeeding mothers of the protocol for the storage and transportation of frozen breast milk if baby is being cared for in another hospital.”	Addressed in policy.

	<p>“Encourage mothers to express their own milk if a supplement is medically necessary and if needed provide them with access to an electric breast pump while in hospital.”</p> <p>“Promote breastfeeding by giving mothers information about hand expression or pumping at home if a supplement is needed after discharge.”</p>	
<p>Step 6</p> <p>“Support mothers to exclusively breastfeed for the first six months, unless supplements are medically indicated.”</p>	<p>“Give newborn infants no food or drink other than breastmilk, unless medically indicated”</p>	
<p>“Mothers of babies younger than about six months confirm that their baby is exclusively breastfed, or that they made an informed decision to supplement for a medical or personal reason.”</p>	<p>“Promote and protect breastfeeding by giving breastfeeding infants no supplementary or complementary feeds unless medically indicated according to WHO/UNICEF guidelines.”</p> <p>“Obtain informed consent from parents if supplementary feeds are required.”</p>	<p>Addressed in policy.</p>
<p>“Mothers report that they have received anticipatory guidance and an opportunity to discuss sustained breastfeeding with staff, exclusivity for the first six months, then for two years and beyond, along with the introduction of appropriate complementary foods.”</p>	<p>“Provide prenatal education and postnatal follow up by staff that will reflect the aim of exclusive breastfeeding for two years and beyond with appropriate introduction of complementary foods.”</p> <p>“The basics of breastfeeding management and the common experiences they may encounter will also be included.”</p>	<p>Providing mothers with an opportunity to discuss sustained breastfeeding and the introduction of complementary foods with staff not emphasized.</p>
<p>“Mothers, including those mothers with babies in special care who have made an informed decision not to breastfeed, report that the staff discussed feeding options with them and supported their informed selection of an appropriate human milk substitute.”</p>	<p>“Obtain informed consent from parents if supplementary feeds are required.”</p> <p>“Respect the informed feeding decision of each mother and provide written and one on one teaching of breast milk substitute preparation and feeding.”</p>	<p>Addressed in policy.</p>
<p>“The manager provides annual data for the facility showing breastfeeding initiation rates, exclusive breastfeeding rates of babies from birth to discharge, supplementation rates, and a reliable system of data collection”</p>	<p>Not discussed.</p>	<p>Policy does not outline reporting of annual data from facility.</p>
<p>“Staff describe the importance of exclusive breastfeeding, the medical indications for supplementation, and information provided to mothers to support informed decision making about feeding their own expressed breastmilk, human donor milk and human milk substitutes without the use of bottles or artificial teats.</p>	<p>“Provide prenatal education and postnatal follow up by staff that will reflect the aim of exclusive breastfeeding for two years and beyond with appropriate introduction of complementary foods.”</p> <p>“Protect breastfeeding by making parents aware of the risks of breast milk substitutes and glucose water supplements through verbal and written instructions, if the mother asks to use them.”</p>	<p>Addressed in policy.</p>

Staff record this important information in clients' charts."	"Record any supplements that are prescribed or recommended in the baby's hospital chart or health record."	
Not discussed in BFI.	"Inform parents of their right to have accommodations in the workplace that support and sustain breastfeeding."	Addressed in policy.
	"Protect breastfeeding by making parents aware of the risks of breast milk substitutes and glucose water supplements through verbal and written instructions, if the mother asks to use them."	Addressed in policy.
Not discussed in BFI.	"Promote breastfeeding by encouraging early and frequent feeds of infants at risk for hypoglycemia, jaundice or excess water loss."	Addressed in policy.
Not discussed in BFI.	"Protect breastfeeding by using medications for the mothers that are compatible with breastfeeding wherever possible; and if not possible, maintain lactation by expressing breastmilk and resuming breastfeeding as soon as possible."	Addressed in policy.
	"Record any supplements that are prescribed or recommended in the baby's hospital chart or health record. The preferred methods of supplementation are lactation aids used at the breast, cup, syringe or finger feeding."	Addressed in policy.
Not discussed in BFI (Detailed in International Code of Marketing of Breast Milk Substitutes).	"Breast milk substitute supplies and feeding equipment will be stored out of sight."	Storage of milk substitute detailed in International Code of Marketing of Breast Milk Substitutes.
Step 7 "Facilitate 24-hour rooming-in for all mother-infant dyads: mothers and infants remain together."	"Practice rooming-in. Allow mothers and babies to remain together 24 hours a day."	
"Postpartum mothers including those with caesarean deliveries, report that from birth (or from the time that they were able to respond to their babies in the case of general anesthetic) their infants have remained with them, and that a support person was welcomed to stay with them day and night."	"Support breastfeeding by assisting mothers and infants remain together from birth. Promote 24 hour rooming-in and encourage all mothers to keep their babies with them." "Welcome a support person to stay with the mother during labour and birth and to give assistance with breastfeeding."	Addressed in policy.
"All mothers relate they have received accurate information about safe co-sleeping and bed sharing."	Not discussed.	Policy does not provide details on safe co-sleeping and bed sharing.
"All mothers confirm that they are not separated from their infants and are invited to hold their babies skin-to-skin and breastfeed if painful procedures are necessary."	"Complete infant procedures while the mother is present and at the bedside where possible." "Promote 24 hour rooming-in and encourage all mothers to keep their babies with them."	Policy does not emphasize maternal confirmation that there was no separation. Policy does not address

		holding baby if painful procedures are necessary.
“The manager confirms that teaching and examinations occur at the mother’s bedside or with her present. The manager confirms that breastfeeding is welcome everywhere, including all public areas, and that facilities for privacy are available on request.”	“Complete infant procedures while the mother is present and at the bedside where possible.”	Policy does not emphasize manager confirmation.
“Staff report that mothers and babies are separated only for medical reasons, and that anticipatory guidance is given to mothers to protect, promote and support breastfeeding. Staff report that examination, teaching and procedures occur at the mother’s bedside or in her presence, and that mothers are encouraged to hold and settle their babies if painful procedures are necessary.”	“Complete infant procedures while the mother is present and at the bedside where possible.” “The basics of breastfeeding management and the common experiences they may encounter will also be included. The aim is to give women confidence in their ability to breastfeed.”	Policy does not emphasize staff confirmation that separation only occurs for medical reasons. Policy does not address holding baby if painful procedures are necessary.
“Staff describe how mothers are welcomed to breastfeed anytime, anywhere.”	Not discussed.	Breastfeeding anytime and anywhere not addressed in policy.
“Documents show evidence of medical implications for separation of mothers and babies, the length of separation and anticipatory guidance to protect, promote and support breastfeeding.”	Not discussed.	Documentation of medical implications for separation not discussed.
“A support person was welcomed to stay with them day and night.”	“Inform mothers they may have a support person with them whenever possible and provide guidance to the support person about their role to ‘mother the mother’.”	Addressed in policy.
Not discussed in BFI.	“Encourage mothers whose babies are in the Neonatal Intensive Care Unit (NICU), if possible, to room-in with their babies for a minimum of 24 hours prior to discharge.”	Addressed in policy.
Step 8 “Encourage baby-led or cue-based breastfeeding. Encourage sustained breastfeeding beyond six months with appropriate introduction of complementary foods.”	“Encourage baby-led breastfeeding.”	
“Mothers describe age-appropriate, cue-based, effective feeding (feeding cues, unrestricted frequency and length of breastfeeds, signs of effective breastfeeding, signs of readiness for	“Teach infant feeding cues to all mothers and their support persons.” “Promote breastfeeding by teaching mothers to respond to their infants feeding cues by breastfeeding whenever the infant shows signs of interest in feeding.”	Maternal knowledge of age-appropriate cue-based effective feeding not addressed.

solids).”		
“Mothers confirm that they have received anticipatory guidance and an opportunity to discuss sustained breastfeeding with staff, exclusively for the first six months, then for two years and beyond, after introduction of appropriate complementary foods.”	“Support mothers to establish and maintain exclusive breastfeeding to six months, foster the establishment of breastfeeding support groups and refer mothers to them on discharge from the hospital or clinic.”	Maternal confirmation of discussion with staff about sustained breastfeeding, exclusive feeding for six months, feeding for two years and beyond, and the introduction of complementary foods no addressed in policy.
“The manager relates that staff offer timely anticipatory guidance and problem solving to mothers regarding effective, cue-based feeding as per Canadian and international guidelines.”	Not discussed.	Manager confirmation of timely anticipatory guidance not addressed.
“Staff describe the information mothers are taught about age-appropriate differences in infant variables (behaviour, output and feeding frequency) and how to assess their babies for signs of effective breastfeeding. Staff confirm they discuss breastfeeding progress with mothers at each contact, unless a medical or other emergency takes precedence.”	“Assist and counsel each mother for at least one feed every shift or as often as each mother needs assistance.”	Staff ability to describe information provided to mothers about age-appropriate differences in infant variables and signs of effective feeding not addressed.
“Documents show evidence that mothers receive information on cue-based feeding and continued breastfeeding.”	No discussed.	The provision and documentation of information on cue-based feeding and continued breastfeeding not addressed.
Not discussed in BFI.	“Encourage mothers to feed infants at least 8-12 times in 24 hours.”	Addressed in policy.
Not discussed in BFI.	“Teach mothers and their support persons that colostrum is adequate nourishment for their babies for the first 48 to 72 hours, and that some weight loss is normal.”	Addressed in policy.
Not discussed in BFI.	“Mothers and babies who are having difficulties will be referred to a lactation consultant or a health care provider skilled in managing complex breastfeeding issues.”	Addressed in policy.
“Mothers who are breastfeeding demonstrate effective positioning and latch. All relate they have been given age-appropriate anticipatory guidance about possible breastfeeding concerns, their solutions and available resources that will assist with breastfeeding.”	“Ensure that breastfeeding mothers are offered support and assistance to acquire the skills of positioning and latch. Staff skilled in breastfeeding management will provide instruction and support in such a manner that will empower mothers to become confident and self-reliant in basic breastfeeding management. Nurses will provide information	Addressed in policy.

<p>“Mothers who are breastfeeding demonstrate effective positioning and latch. All relate they have been given age-appropriate anticipatory guidance about possible breastfeeding concerns, their solutions and available resources that will assist with breastfeeding.”</p> <p>“All postpartum mothers report that they were offered further assistance with breastfeeding within six hours of delivery and at appropriate subsequent intervals. Observations of feedings are completed as needed and at least once per shift.”</p>	<p>and guidance that will allow the mother to place the baby to the breast herself. The mother is in control of the breastfeeding situation. The nurse will provide as much hands off support as possible and directly intervene only when necessary.”</p>	
<p>Step 9</p> <p>“Support mothers to feed and care for their breastfeeding babies without the use of artificial teats or pacifiers (dummies or soothers).”</p>	<p>“Give no artificial teats or pacifiers to breastfeeding infants. Protect breastfeeding by giving no pacifiers to breastfeeding infants and not selling any pacifiers in the hospital.”</p>	
<p>“Mothers report that they received information and support to feed and care for their breastfeeding babies without the use of artificial teats or pacifiers.”</p>	<p>“Inform and educate parents on the risks of pacifier use in early breastfeeding, until breastfeeding is well established (6 weeks).”</p> <p>“Do not use bottles or nipples for breastfeeding infants whenever a supplement is necessary but use alternate feeding methods such as lactation aids, finger feeding, cup feeding, and spoon feeding.”</p>	<p>Addressed in policy.</p>
<p>“If the baby has been given a bottle or pacifier, the mother confirms that this was her informed decision or a medical indication.”</p>	<p>“Promote and protect breastfeeding by giving breastfeeding infants no supplementary or complementary feeds unless medically indicated according to WHO/UNICEF guidelines.”</p> <p>“Obtain informed consent from parents if supplementary feeds are required.”</p>	<p>Addressed in policy.</p>
<p>“The manager provides records confirming that mothers of breastfeeding infants are supported to find alternative solutions or make an informed decision regarding the use of artificial teats.”</p>	<p>“Use nipple shields only after consultation with a lactation consultant or a health care provider skilled in managing complex breastfeeding issues.”</p>	<p>Manager confirmation not addressed.</p>
<p>“Staff describe feeding alternatives recommended for breastfeeding infants requiring supplemental feeding (e.g., cups, spoons) and soothing techniques for all infants.”</p>	<p>Not discussed.</p>	<p>Staff knowledge of alternative feeding methods not addressed.</p>
<p>“Documents show evidence of support and informed decision-making.”</p>	<p>Not discussed.</p>	<p>Documentation of informed decision-making not addressed.</p>
<p>“Written information for clients outlines the risks associated with artificial teats and describes</p>	<p>Not discussed.</p>	<p>Policy does not address the provision of written information on risks of</p>

alternatives.”		artificial teats and alternatives.
Step 10 “Provide a seamless transition between the services provided by the hospital, community health services and peer support programs. Apply principles of Primary Health Care and Population Health to support the continuum of care and implement strategies that affect the broad determinants that will improve breastfeeding outcomes.”	“Support mothers to establish and maintain exclusive breastfeeding to six months, foster the establishment of breastfeeding support groups and refer mothers to them on discharge from the hospital or clinic.”	
“Mothers confirm an effective transition from hospital, birthing centre or midwife to CHS and know at least one way to access breastfeeding support outside of office hours. Mothers confirm that they are able to access peer support programs. Mothers report that they live in a community that supports a positive breastfeeding culture.”	“Refer all new mothers to the community health nurse within 24 hours of discharge from hospital, so the mother will have the opportunity for early face-to-face assessment of breastfeeding. Breastfeeding progress will be assessed at appropriate intervals.” “Provide contact information for community-based breastfeeding support services to all breastfeeding mothers upon discharge.” “Provide information to all mothers on how to access breastfeeding support 24 hours a day via Information lines.” “Provide services to breastfeeding women in the community based on best practices.” “Provide breastfeeding women requiring admission into hospital the necessary support to continue breastfeeding and maintain lactation.”	Addressed in policy.
“The manager describes an adequate procedure for the transition from hospital to CHS and describes the liaison and collaboration between hospital, CHS and peer support programs to protect, promote and support breastfeeding.”	“Refer all new mothers to the community health nurse within 24 hours of discharge from hospital, so the mother will have the opportunity for early face-to-face assessment of breastfeeding.” “Breastfeeding progress will be assessed at appropriate intervals.”	Policy does not address manager knowledge of procedures for transition from hospital at community.
“Community manager and staff describe the strategies and approaches used to support principles of primary health care and population health to improve breastfeeding outcomes.”	Not discussed.	Manager confirmation and staff knowledge of approaches used to support primary care not addressed.
“Staff describe effective transition for all mothers between hospital or birthing centre and community programs and can locate the written support materials provided to mothers.”	“Provide information to all mothers on how to access breastfeeding support 24 hours a day via Information lines.”	Staff knowledge of transition into the community or written resources not addressed.
“Documents show evidence of	Not discussed.	Policy does not address

liaison and collaboration across the continuum of care.”		documentation of collaboration across continuum of care.
“Written information for clients lists hospital, community health and peer support providers.”	“Provide contact information for community-based breastfeeding support services to all breastfeeding mothers upon discharge.” “Provide information to all mothers on how to access breastfeeding support 24 hours a day via Information lines.”	Addressed in policy.
Not discussed in BFI.	“Ensure formal systems for communicating a mother’s breastfeeding progress from hospital to the community is in place e.g., Live Birth Notification System and Healthy Beginning Referral Form.”	Addressed in policy.

(BCC, 2012b; Crocker, 2012).