

Transitions, the risk and the relationships:
A comprehensive literature review exploring the
postpartum breastfeeding journey

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Abstract

Women's postpartum experiences are influenced by multiple interactions during a period of extraordinary change. In relation to these interactions feeding choices emerge. Breastfeeding, as an important infant feeding option, is of particular interest to health care professionals due to the prevention, health promotion, and early intervention opportunities available. In this project a review of selected literature, within an issues articulation and resolution framework, facilitates exploration of the current state of knowledge about women who choose to breastfeed their babies and identifies issues related to women's breastfeeding experiences. Understanding the context of women's feeding decisions provides direction for reflection on nursing practice development. The challenging balance for nurses is in providing sensitive interventions and individualized care in association with population health and health promotion services. Discussion of the issues provides insight into some of the challenges to providing nursing supports and also identifies areas that need to be made more visible to health care planners and decision makers about the care issues surrounding women, infants, and families during important postpartum transitions. Further research opportunities relate to health care priorities and to learning about effective care approaches especially for women who are more difficult to engage in research.

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Transitions, The Risk and the Relationships

“Breastfeeding for six months begins with breastfeeding for six days” (unknown)

Part I: Overview

Introduction

Women’s postpartum experiences are anchored by multiple influences, interactions, and decisions during a period of extraordinary change. Periods of great change open up an expanded opportunity for positive and negative experiences to occur along with their associated health implications. Feeding experiences begin in the immediate postpartum and continue to develop and change. These changes create opportunities for women and mothers as well as families to grow and develop in their care relationships.

Postpartum feeding experiences are unique to a particular environment, occur within a particular period of time, and are influenced by and influence family interactions and relationships. These experiences are of interest and are appropriately studied by many disciplines, including nursing, given the role of the nurse in working with mothers and families during this period of time. Breastfeeding, as an important infant feeding option, is of particular interest to nursing due to the prevention, health promotion and early intervention opportunities available. Van Esterik (2002) notes that breastfeeding is “not a discrete behaviour” (p. 257) but one that is subject to social valuing and other complex issues that may not logically link to infant feeding. An emphasis on understanding the breastfeeding context by reviewing a range of studies associated with breastfeeding issues can potentially provide valuable direction for nursing practice.

One ongoing concern, with its associated health impacts, is that breastfeeding continuation rates have not kept pace with the measured improvement in initiation rates. Most women tell us that they are interested in breastfeeding however many women become unsure and

discouraged which appears to result in decisions to breastfeed for short durations. This challenge encourages an analysis of issues and influencers focusing on women and mothers, breastfeeding, and the work of the nurse. It is also important that the effectiveness of nursing care in this arena be viewed through a lens of care provided. Nurses have the opportunity and privilege to work with women during this important transition period. Therefore, while the consideration of breastfeeding rates as a measure of success is important, it is equally important to identify and consider other health determinants, such as maternal self confidence or the quality of supports available, and to continue to learn with women and their families.

Scope of the Project and links to Nursing Practice

The intent of this project is to review selected literature toward understanding the current state of knowledge about women who choose to breastfeed their babies and to articulate the issues related to women's breastfeeding experiences. A literature review will focus on research available ten years after the development and declaration of international guidelines designed to support breastfeeding (World Health Organization, Baby Friendly Hospital Initiative, 1991). It is hoped that looking at this period of research may help identify the issues associated with women's feeding situations and choices during the postpartum phase.

The circumstances of longstanding and seemingly irresolvable issues are described by McIntyre and McDonald as frequently "imbedded in health care delivery, nursing practice, and education" (McIntyre & McDonald, 2009, p. 4) contexts. Transitions inherent in the early postpartum phase are also considered in an effort to learn more about possible approaches relevant to nursing practice advancement. The review is intended to contribute to the work of the novice nurse in assisting with feeding when working with young and mature women, who are mothers of healthy full term or late preterm infants. The overall purpose is to position nurses to

view the issues associated with women's limited success in continuing to breastfeed from a broad, inclusive perspective. In addition this review is designed to influence my nursing practice and to identify areas for future nursing research.

Assumptions

Key assumptions focusing on women include: women need timely support during the post partum period whether they are continuing to breast feed or not, most women can successfully breastfeed, not all women have adequate information/resources and support at the right time to continue or to successfully discontinue breastfeeding, women who initiate breastfeeding want to begin or try out breastfeeding.

Key assumptions focusing on breastfeeding experiences include: breastfeeding is more than a physical experience, breastfeeding impacts the mother's health and the baby's health.

Key assumptions focusing on nurses include: nurses are appropriate care providers to support infant feeding, particularly, for women who breastfeed, and during and including the period of transition to other feeding options. Access to care and support is influenced by how health services are structured (can create gaps) and organized. Nursing education appropriately includes learning related to health promotion, prevention, and early intervention approaches, women's health, and infant feeding support, both breastfeeding and other feeding options. Nursing education outcomes continue to prepare nurses to be able to provide support for women and their families, recognizes best practice as dynamic and evidence informed, and encourages critical thinking.

Part 2: What we know and how we know it

Literature review approach

Computerized searches of CINAHL plus with EBESCO, Academic Search Complete databases, Wiley InterScience Search and the Cochrane Database of Systemic Reviews were explored for qualitative and quantitative articles written and published in English. This included a review of relevant reference lists from identified published articles between 2001 and 2009 (October). Multiple searches were completed between July 2009 and October 2009. Search terms include: breastfeeding, breastfeeding duration, postpartum, infant feeding, and baby friendly.

The timeframe was chosen to focus on research ten years after the World Health Organization's launch of the Baby Friendly Hospital initiative in 1991, when international guidelines to promote breastfeeding were announced. Literature was selected from peer reviewed articles found in publications in the areas of nursing, medicine, nutrition, sociology, psychology, anthropology, and lactation. Data were extracted considering key terms related to postpartum breastfeeding influencers and issues and included reflecting on the breastfeeding postpartum experience of women or what women tell us about those experiences. The review also considered, historical, ethical-legal, socio-cultural, political, critical feminist, and economic analysis, and the identification of barriers and strategies. A total of 33 articles, including systematic reviews, were utilized for this review.

Factors influencing breastfeeding duration

Profiling breastfeeding as a desirable infant feeding option is supported at international and national levels through leadership provided by the World Health Organization (1990). A concerted effort to profile the possibilities and advantages of breastfeeding in Canada and other countries has likely encouraged some increase in initiation rates, both nationally and

internationally. However, according to Britton, McCormick, Renfrew, Wade, and King (2009) resistance to changing practices continues in many developed countries. Cattaneo and Quintero-Romero (2006) discuss the fact that breastfeeding rates are higher in many low-income countries. Even with these rates, concerns continue since the risks are very high for any baby that is not breastfed because failure to breastfeed contributes significantly to the infant mortality rate.

Gilmore, Hall, McIntyre, Gillies, and Harrison (2009) in a small, qualitative study identify key breastfeeding issues. These issues include limited hospital postpartum support, especially overnight and on weekends, and under developed community capacity. The situations described unfortunately exist in many health care environments. Environmental support issues combined with early maternal fatigue, limited confidence, nipple soreness, and frequent visitors with low support skills are described as substantially influencing the breastfeeding experience. The timing of interventions is noted as particularly important and challenging given the limited availability of professional support and under developed community supports. The study was not intended for generalization. However, it does reflect similar issues noted by Gatti (2008) in her literature review of research articles published from nursing, medicine, and public health, on perceived milk supply concerns during the first six months postpartum in uncomplicated births. Breastfeeding is described as having the highest drop off rate in the first few weeks postpartum (Gatti, 2008) when maternal fatigue and change experiences have a strong influence.

Women's psychological differences and their relationship to breastfeeding duration are explored by O'Brien, Buikstra and Hegney (2008) in their prospective qualitative study of women with healthy, singleton births, who were able to complete an English language questionnaire within two weeks of delivery. The population was randomly selected from both private and public hospitals but resulted in participants with mainly consistent relationships

(either married or cohabitating), more than high school education, and on average thirty years old (between 18-45 yrs). This population is over-represented in many studies. However, in comparing the more limited number of studies with studies of populations that are more socio economically disadvantaged the women's experiences are generally similar.

Faith in breastfeeding and self-efficacy were factors identified in this study as contributing to an increased probability of continuing to breastfeed while the women who planned to breastfeed for six months or less were more likely to have shorter continuation rates. The researchers suggest that other risk factors may be involved and identify the possibility of lack of commitment. This is an interesting assumption considering the complex context in which breastfeeding occurs.

An unexpected finding was that over 44% of the women reported postnatal distress with 34% reporting anxiety. Higher anxiety was associated with earlier weaning suggesting that this is a key factor valuable for nursing assessment. Other factors associated with duration included: dispositional optimism; timing of the infant feeding decision; and breastfeeding expectations. Intentional identification and attention to elements, thought to be more modifiable than socio-demographic variables, are described as holding implications for practice as well as future research. Encouraging goal setting and problem solving, challenging unhelpful beliefs, utilizing positive self talk, increasing breastfeeding knowledge, attention to self care, and mindfulness are strategies emerging from this study.

Predictors of self-efficacy are explored by Dennis (2006) in her qualitative study focusing on the first, fourth, and eighth weeks postpartum. Consistent with other studies, older, more educated and multiparous mothers had higher self-efficacy scores as did women with higher

perceptions of relationship and global support. Mothers with lower scores had higher levels of perceived stress and demonstrated increased conflict with their mother.

Self-efficacy is described in this study as a measure of how much effort mothers will expend on breastfeeding, how long they will persevere, and how resilient they will be in difficult circumstances. Maternal perception of breastfeeding progress, whether feeding was going as planned, and satisfaction with breastfeeding, were the key factors associated with self-efficacy. These factors are noted as demonstrating that breastfeeding self-efficacy can be positively influenced. The confidence enhancing strategies discussed include: attention to progress improvement, positive skill reinforcement, advice consistency, acknowledgement and normalization of anxiety, stress and fatigue, resiliency promotion, and peer support facilitation. These strategies are included in the discussion of the study results. However, there is no evidence provided as to their effectiveness or suggestions for the incorporation of these approaches into existing services. Timing of the suggested strategies is also not discussed and the relative success of one strategy over another is not identified.

Thulier and Mercer (2009) identify key variables contributing to breastfeeding duration organized by demographic, biological, social, and psychological variables in a comprehensive, meta-analysis, international review of qualitative and quantitative literature from 1998 to 2008. The review provides a critical and comparative appraisal of key English language articles found in reliable databases. In this study women of Asian descent demonstrated the highest six month duration rate and black women the lowest. Immigration to the United States is identified as a risk factor for duration. Once again married women showed a higher level of initiation and duration and women with more education breastfed longer.

Socioeconomic status was a key indicator for women in lower income groups who had lower initiation and duration rates. However, women with higher education levels in this same population demonstrated higher overall rates. Negative duration effects were apparent in supplemental nutrition programs where formula was made available. The influencers identified in this study, with the exception of the supplemental nutrition programs, are pointed out by Avery, Zimmermann, Underwood, and Magnus (2009) and Dennis (2006) as largely difficult to modify. This is consistent with the findings in the literature review carried out by Callen (2004) who concludes that women who initiate and continue to breastfeed are generally older and have higher levels of education, income, and social supports than women who do not breastfeed. Consequently this study once again draws attention to the need to address social, economic and cultural environments in promoting an understanding of breastfeeding and to provide supports that are acceptable for a wide range of women.

Variables such as actual milk insufficiency or the perception of insufficiency prompting early formula supplementation are described by Thulier and Mercer (2009) as the most common reason for weaning. Interestingly, infant health concerns such as prematurity requiring more intensive care supports and complex situations requiring Caesarean birth were thought to possibly promote duration. This may be due to the increased availability of professional supports and the timing of these supports. Physical challenges involving lower initiation rates yet a longer duration rate for those that did initiate include: sleep disruption, smoking throughout pregnancy and the postpartum, and parity. Social variables such as maternal work negatively influenced duration, especially full time work. However, mothers who breastfed also missed less work than women who formula fed.

The effectiveness of breastfeeding support is explored in a systematic review carried out by Britton, Renfrew, Wade and King (2009). Thirty four trials were reviewed drawing attention to the need for further exploration of the timing and delivery of support as well as investigation into the lived experiences of women who initiate breastfeeding. Abdulwadud and Snow (2008) note the continuing trend of women working outside the home in the early postpartum in their systematic review and identify a gap in trials that evaluate workplace supports. Burns, Schmied, Sheehan, and Fenwick (2009) identify the need to move away from biomedical to more women centered approaches and for health professionals to provide the opportunity for women to explore their embodied experiences.

Buckley (2009) in her study of the perceptions of lactation consultants draws attention to concerns about the potential for technological control/interference in childbirth drifting into the arena of infant feeding. The study identifies patterns and themes that touch on economic, political, ethical, and historical areas. The key concerns illustrated include: changes in society and hospital practices, from luxury to necessity, technological birth-technological breastfeeding (the example of a breast pump for every hospital room is cited), perceived benefits and risks of breast-pumps, increase in mothers control over feeding, and the economic impact of breast-pump sales/rentals.

A variety of research papers from different countries were reviewed by Hannula, Kaunonen, and Tarkka (2008) who discuss the effectiveness of professional and peer support interventions for breastfeeding. Appropriately combination interventions were utilized with all the populations studied. However, this also made it difficult to determine which elements were the most important to provide and when to best provide them. Hospital policies and practices were noted to have a considerable effect on breastfeeding outcomes. Programs that have a

continuum of supports which facilitate transitions between environments appeared to be the most effective when they included a component of peer support. They note that professional sensitivity to individual and cultural needs over the various stages of the feeding relationship continues to be an important approach element.

Part 3: Opening up the Issues

Framework

In examining health care delivery and nursing practice, discussed by McIntyre and McDonald (2010), nurses are encouraged to view issues in new ways through a process of issues articulation and resolution. In proposing this approach the authors acknowledge an intention to move nurses and nursing away from historical problem solving approaches. Problem solving approaches are discussed as frequently resulting in frustration for the nurse and a low level of visibility for the weight of and broad impact of the issues. In short the historical approaches are not working well to effect sustainable change. Hopefully this new approach will energize the novice nurse to take up the challenges inherent in configuring care environments and also assist with the fatigue and frustration that some nurses feel and others exhibit.

A framework, as outlined by McIntyre and McDonald (2010), provides a way to explore, articulate, analyze, and generate possibilities to develop understanding. The issues articulation and resolution approach described by McIntyre and McDonald (2010) encourages a broad exploratory approach consistent with the intent of this project. The framework described by McIntyre and McDonald (2010) proposes: situating the topic, articulating the issue, analyzing the issue including historical, ethical and legal, social and cultural, political, critical feminist and economic analysis, as well as addressing barriers to resolution and developing strategies for resolution.

Situating the topic

Breastfeeding influencers and issues

As an important infant feeding option, breastfeeding is a complex activity within the continuous transitional and at times confusing, postpartum experience (Van Esterik, 2002). In this milieu, infant feeding decisions evolve and are confirmed. The experience of breastfeeding is influenced, some observers would say defined, by connection to other issues. It is important therefore to consider breastfeeding in relation to context. Breastfeeding is discussed by Wambach and Cohen (2009) in their study with urban adolescent mothers, as a series of complex bio-psychosocial processes from initiation, to establishment, and subsequent transition to other feeding options. Semenic, Loiselle, and Gottlieb (2008), in their Canadian study with women age 19 to 42 years, discuss breastfeeding as a multidimensional health behaviour which tends to depersonalize the experience and the considerations within the process. Both studies identify unique social, psychological, and physical complexities and acknowledge important interactions within environmental and political contexts.

Important questions, to reflect on are, how well do we consider these contexts and the experiences of women and mothers within these contexts? How do we provide adequate and effective nursing care in the immediate and early months postpartum? Are the professional supports adequate for initiating, continuing and transitioning to other feeding options associated with women's decisions? Are there other issues that we have not considered?

Nurses are well positioned, within both hospital and community environments, to ask questions, facilitate and support meaningful feeding experiences, and contribute to the continuity of care (Nelson, 2007). Supports from a number of sources (family, friends, and professionals) are frequently described in the literature (Nelson & Sethi, 2005; Gilmour et al, 2009) as

influencing breastfeeding initiation, continuation, and transition to other feeding options.

Exploring infant feeding and specifically breastfeeding, within its complex and interrelated context, anticipates a better understanding of the issues and perhaps moves beyond existing practice approaches, to provide insight into alternative nursing practice questions.

The Global Strategy on Infant and Young Child Feeding adopted by the World Health Organization (2003) recommends sustained breastfeeding for six months in order to achieve the infant and maternal health benefits breastfeeding offers. The clinical benefits of breast milk, for the infant, are well described by Chung, Raman, Trikalinos, and Sau, (2008) as reducing the risk for: acute otitis media, nonspecific gastroenteritis, severe lower respiratory tract infections, atopic dermatitis, childhood leukemia, sudden infant death syndrome, obesity, and possibly asthma. Benefits for mothers and women include a reduced risk for type 2 diabetes, and breast and ovarian cancer. From an epidemiologic vantage point breastfeeding is a very desirable feeding option due to the tangible influences on chronic diseases. However despite considerable national and international effort, the struggle to reach the potential for this infant feeding option continues.

The latest statistics from the Canadian Community Health Survey (2003) highlights improved breastfeeding initiation rates and illustrates an emerging challenge for duration rates. While almost 85% of mothers across Canada initiate breastfeeding, only 48% continue to four months with 38% exclusively breastfeeding and by six months 39% are breastfeeding with 19% exclusively breastfeeding. Table 1 provides an illustration of duration statistics that reflect the national variation and the substantial drop in rates from initiation through to four and six month duration. The province with the lowest initiation rate is New Brunswick at 64% with 26% breastfeeding by four months. The province with the highest duration rate at six months is British

Columbia at 55% with 29% exclusively breastfeeding. Many countries, both high-income (Callen, 2004) and low-income (Cattaneo & Quintero-Romero, 2006), are experiencing similar challenges with breastfeeding duration.

Table 1 Sample 2003 Canadian initiation and duration rates

	Initiation rate	4 months	6 months	Comparison
Canada	85%	48% (38% exclusive)	39% (19% exclusive)	National rate
N.B.	64%	26% (23% exclusive)	17% (10% exclusive)	Lowest rates
B.C.	93%	64% (51% exclusive)	55% (29% exclusive)	Highest rates

The Canadian Maternity Experiences 2006 Survey reported by Chalmers, Levitt, Heaman, O'Brien, Sauve, and Kaczorowski (2008) shows a five percent improvement in the Canadian initiation rates and an almost fifteen percent increase in any breastfeeding at six months. However, the exclusive breastfeeding rate at six months shows a drop from the reported nineteen percent in the Canadian Community Survey (2003) to a reported fourteen percent in the Maternity Experiences Survey (2006), representing a five percent decrease over three years in the six month exclusive breastfeeding rate. The Maternity Experiences Survey also shows that twenty percent of breastfeeding women supplement with other liquids at one week postpartum and that by two weeks postpartum this increases to twenty five percent, reflecting a very short exclusive breastfeeding duration rate over the first few postpartum weeks. It appears that women are able to initiate breastfeeding however are not able to sustain.

Key issues noted in descriptive studies (Avery et al, 2009; Gatti, 2008; Gilmour et al, 2009), that influence breastfeeding duration include: painful nipples or other physical difficulties, perceived milk insufficiency, early pacifier use, social influences, and self efficacy.

These key issues are described as influencing infant feeding decisions for both mature and teen mothers (Wambach & Cohen, 2009). Grassley and Nelms (2008) encourage a broad exploration and comprehensive understanding of women's feeding experiences highlighting the importance and impact of transition events over time. Across the health care system are we responding to the challenges mothers face?

Articulating the issue

What are women and their families telling us postpartum?

The experiences of women in two postnatal units are explored by Dykes (2005) in her critical ethnographic study. Women who breastfed describe providing health to their babies from an immunological and nutritional perspective. However, only one woman from a multicultural background referred to the importance of intimacy with her baby in the breastfeeding experience. Why is this an issue? Buckley (2009) notes that limited consideration of interpersonal interactions may influence parent and professional attitudes minimizing the importance of connection within the process of infant feeding and the breastfeeding experience in particular. How does this occur?

Teen mothers studied by Wambach and Cohen (2009) also described similar nutritional and immunological rationale as influencing decisions to breastfeed and in addition identify ease of breastfeeding, particularly with night feeds, as an important influencer. Duration rates for teen mothers and other women and mothers in difficult socio economic circumstances continue to drop off in the early weeks postpartum despite interest in and recognition of the substantial benefit.

Lack of confidence and trust by mothers in their ability to provide adequate milk is a recurring theme discussed by Grassley and Nelms (2009) in their analysis of breastfeeding

stories. Doubts and confidence are described as a greater concern in cultures that historically view breast milk as a product. Van Esterik (2002) discusses the use of language in developed countries that reinforces the view of breastmilk as a product. Health professionals are cautioned to consciously consider the possible effects of language when women who breastfeed, do so, within a bottle feeding culture such as the North American culture.

Burns, Sheehan, and Fenwick (2009) in their synthesis of literature related to women's experiences explore the influence of health professionals and encourage women centered approaches. They caution care providers in the use of language that seeds the potential effect of generating feelings of breastfeeding failure and the use of language that may deny the experiences of women who attempt to breastfeed and those who discontinue. This interpretation is related to the promotional approaches designed to support breastfeeding that are inadvertently insensitive to the women's experience. For example, posters that depict only breastfeeding dyads may inadvertently send the message that feeding with artificial breastmilk substitutes is never the appropriate infant feeding option. Sheehan, Schmied, and Barclay (2009) in their grounded theory study focusing on women's early infant feeding decisions identify pressure issues that can be created for women by health care providers and by the women themselves. Some of the pressure influencers include promotional efforts, professional approaches, and the interconnected feelings and emotions associated with becoming a mother. Pressure influences during periods of substantial change can create additional levels of distress.

Women in the study completed by Grassley and Nelms (2009) expressed a desire to measure and visualize the presence of sufficient milk. Linkages to their infant and signs of contentment were positively expressed. However, uncertainty and anxiety about milk production continued even for women who had successfully breastfed previously. The role of the nurse in

fostering an understanding of specific behaviour cues related to feeding frequency versus fostering concern about demand feeding is also mentioned. There are some simple cues that nurses can share and reinforce with women that may build confidence such as the “in and out” relationship in feeding or linking infant output to sufficient milk production. Investigators also cautioned nurses and health care providers about applying language that may separate women from an understanding of their bodies and their embodied infant. Language constructs our world and is best used with an awareness and understanding of the potential for influence. Confidence and self awareness can either be supported or eroded through the use of language and terminology.

Physical vulnerability associated with breastfeeding experiences are explored by Kelleher (2006) in working with a diverse sample of women who initiated breastfeeding while living in two large urban centers. Ninety percent of the women were still breastfeeding when the study was initiated. The study identifies breastfeeding as an intense experience involving unexpected pain of significant intensity, ranging from mild to unbearable, which caused hesitation in continuing to breastfeed and also influenced the mother-infant interaction. The women generally felt uninformed, overwhelmed, and unprepared for the physical adjustment and energy demand and some became fearful of the pain expected. Some women felt helpless. Health care professionals are described as influencing the experience of women in many ways. Some women felt that they received positive support which they appreciated and others experienced what they described as interference. Sheehan et al (2009) identify an issue for health professionals in maintaining a balance between assisting and supporting women through focusing on their various needs and the potential conflict in promoting breastfeeding based on the positive health effects expected.

Analyzing the issue

Historical perspectives

North American history reflects that in an effort to improve childbirth safety, community based care shifted to institutionally based care, with the result that by the 1940's in North America most births took place in hospital (Smith, 2010). According to Smith (2010) this trend involved standardized, however not necessarily evidence based, interventions and the use of technology that was applied universally.

“Back to..... the future” is a phrase that Smith (2010, p.24) uses to summarize the history of childbirth and infant feeding practices in North America, with an emphasis on the history within the United States. In her discussion she is hopeful that through careful assessment and informed supports, interventions can reflect more of a limited intervention attitude. She suggests that this new attitude can involve continuous evaluation and reflect interventions beneficial to the mother and her infant over the postpartum period.

Through her investigations Smith (2010) explores the community action responses which motivated an inquiry into medical approaches. Her conclusion is that in retrospect the historical medical approaches interfered with childbirth processes and set up scenarios for mother-infant dyads that contributed to breastfeeding difficulty. Some of these interventions included the liberal use of narcotics and amnesiacs during labour, relative isolation in a highly controlled environment, and mother-infant separation following delivery. These interventions essentially limited the influence of the mother and her support system as well as the connection to her infant. The result was a compromised state for the mother described by Smith (2010) as significantly reducing the ability of her infant to organize the movements required for feeding. Providing support and only evidence informed interventions versus universal interventions

during childbirth hold the opportunity to facilitate smoother transitions and improved connections between mothers and their infants. Current childbirth approaches that acknowledge and promote family interactions have the potential to help women and their babies off to a better start.

Smith (2010) suggests that prior to this shift to institutionally based care breastfeeding was the primary approach to infant feeding. Doolan (2008), in focusing on the historical debate of whether women should breastfeed their own children, describes the use of wet nurses for infant feeding and other historical struggles in social attitude, fashion, and power relationships which influenced and limited women's infant feeding choices. It is valuable for nurses, as front line care providers, to have some awareness of historical struggles associated with infant feeding and in particular the influence of power relationships and the role of the nurse in protecting, promoting and restoring health.

It is curious that over centuries of history, controversy has continued to revolve around infant feeding and the role and value of a mother. The value of breast milk as the optimum source of nutrition, however, had not been open for debate until childbirth became institutionally based. A further observation is that only recently have alternate sources of milk for infants evolved to be described as artificial, acknowledging and messaging that alternate sources of milk are sub optimal to breast milk. The Nurses Association of New Brunswick (2006) has a position statement titled, *Breastfeeding and Artificial Breast Milk Substitutes*, which acknowledges the attributes of breast milk and the artificiality of all other options. Once again language is powerful in marketing and the way in which information is presented provides messages that as health care providers, nurses may not consistently be aware.

Ethical-Legal perspectives

Ethical-legal perspectives have not specifically emerged within the articles that were reviewed as part of this literature search. However, while the literature review was relatively silent in this area, there are ethical challenges and legal constraints that are relevant and concerning when considering infant feeding and specifically breastfeeding duration.

The responsibilities and obligations of a registered nurse, in providing care, are clearly described in the Canadian Nurses Association, Code of Ethics for Registered Nurses (2008). Ethical dimensions and associated tensions related to infant feeding and breastfeeding duration may be available through a literature review utilizing other search terms necessary to surface relevant articles.

A hint of the challenges in balancing realities is noted by Buckley (2009) who focused on nurse lactation consultants in independent practice, surfacing the dilemma arising from nurse consultants who sell breast pumps as part of their lactation consultant activities. The purpose of selling the pumps is related to making them available to women and is also identified as part of the economic reality of practice given the contribution that the sale of breast pumps makes to the viability of a business. The resulting dilemma between making breast pumps available to those women who will benefit and selling a pump to someone who wants one but does not really need one is apparent. While sales may be part of sustaining a business it is important to remember that lactation support is not just any business. When the lactation consultant is a nurse all the ethical responsibilities and practice required of a nurse apply and as Buckley (2009) discovered can create professional tensions.

Sheehan, Schmied, and Barclay (2009) mention the connection between informed choice and the association of this process to the principle of informed consent as both a legal and ethical

concept. This is a particularly important relationship for nurses to identify and consider in all aspects of care provided. The study reveals that some women felt denied access to information on formula feeding and bottle feeding and others felt judged and coerced to breastfeed. It appears that professional acknowledgement of the health benefits of breastfeeding combined with the influence of national and international promotion efforts have made it difficult for professionals to provide a balanced approach. Similar challenges can arise in facilitating informed choices and ensuring informed consent with immunization services. Again the overwhelming benefits of these interventions to population health and perhaps the time available to work with clients due to limited professional availability and associated service costs contribute to the challenge.

Considering the large numbers of nurses working in organizations that provide early care for women and their infants it is concerning that some of the relatively easy to implement components of the WHO Baby Friendly recommendations (1991) such as early skin to skin contact, early initiation of breastfeeding for mothers who want to try breastfeeding, and reduced or no use of soothers has not yet consistently materialized. As Chaparro and Lutter (2009) discuss the need for health care providers to consider the impact of interventions on the long term when providing immediate interventions. The skill of connecting short term interventions to long term outcomes continues to be a critical element of care. Their findings result in a plea for increased care integration and attention to evidence informed practices that look to the future while attending to the immediate. They strongly encourage every practitioner to consider the consequences of early care and to be aware of the implications when there is a failure to initiate simple options, such as early skin to skin and early breastfeeding.

Thulier and Mercer (2009) note that inconsistent professional support, largely related to lack of knowledge and skill in supporting new mothers, negatively influenced duration. The

perception of first time mothers in the Ekstrom study (2009) was that the best information on breastfeeding was provided while in the maternity unit. Because the quality of information prenatally and in the community postpartum was not at issue, it is hypothesized that mothers were most receptive to breastfeeding information while in hospital. Given the shorter hospital stays further emphasis on effective and timely supports associated with the transition home may be even more critical.

Nurses have the opportunity to work with women and their families in both hospitals and the community during identifiable postpartum periods of vulnerability and hold the responsibility of supporting recommendations and practices that further the health of women and their families rather than interfere with future health. Is it, therefore, misinformation, lack of information on informed practice, or limited practice opportunity, or all three that contributes to nurses not employing evidence informed guidelines when working with mothers who want to try breastfeeding? Equally given this period of vulnerability for women it is important that nurses remain sensitive to women's experiences and developing decisions and also support women who wish to transition to other feeding options.

In working with mothers who want to try breastfeeding, the first few postpartum days and weeks sets the stage for breastfeeding continuation (Gatti, 2008) and requires coordination across multiple transitions and environments. Mobilizing nurses prepared to assist families with transitions within hospital environments and between the hospital and the community environment is critical to the provision of care. The early postpartum is a confusing time for women and mothers who are often very fatigued and experiencing continuing physical changes. Nurses are perhaps the only providers who can comprehensively provide these supports and therefore hold an obligation to do so.

Ethical choice in structuring collaborative professional relationships is within the realm of the role of the nurse. There is a responsibility for nurses to mentor and guide each other as well as the client toward evidence informed practices, while remaining sensitive to women and the decisions that work best for them in the context of their particular lives.

Social-cultural perspectives

Support from significant others is highlighted by Thulier and Mercer (2009). The positive influence of informed fathers especially in managing difficulties is highlighted. However, they also note that in situations of relationship conflict negative influences occurred. Assessing relationships and risks as well as facilitating connection, where possible, continue to be key nursing approaches important to this area of practice. The influence of the maternal grandmother was researched by Ekstron, Widstrom and Nissen (2003) in their qualitative retrospective study of primipara and multipara mothers with full term, healthy, singleton babies who were delivered vaginally. The study showed that a mother's awareness of her mother's breastfeeding experience was prevalent in those who breastfed longer consequently they recommend that nurses providing support assess this factor. This type of assessment may also assist nurses to understand the context of women's decisions and better support those who wish to transition to other feeding options. It is important that nurses remain sensitive to the woman's social context resulting in differing care needs.

Dennis (2006) in exploring breastfeeding self efficacy found that women in conflict with their mother showed significantly lower breastfeeding self efficacy. This may mean that further supports and earlier connection to peer support environments can benefit women who may be challenging the historical mothering patterns within their larger family grouping. Breastfeeding duration was also correlated to the length of time a partner spent with first time mothers post

delivery and it is hypothesized that this enriches the family bonding process. For both primipara's and multipara's, confidence at six to twelve months after their babies were born, was enhanced for families whose partners stayed for a longer time post delivery.

Camurdan, Ilhan, Beyazova, Sahin, Vantandas, and Eminoglu (2008) raise the challenge of being sensitive to cultural contexts and encourage recognition of determinants for breastfeeding patterns within specific cultural groups. In this study similar issues of milk insufficiency, pacifier use, and early mixed feeding had an influence on breastfeeding duration. Issues of paid leave, length of leave, and support for breastfeeding in the work place were also noted as influencers. They also note from their study, done in Turkey, that women who breastfed exclusively for the first 3 months were six times more likely to continue some form of breastfeeding until 12 months. Again they emphasize the uniqueness of completing studies specific to a cultural group and the value of this information for health care workers in understanding the context for women and mothers.

Critical feminist perspectives

Critical feminist dimensions are profiled by Crossley (2009) as an alternate view to socially perceived empowerment aspects of breastfeeding for women and mothers. This study brings forward implications surrounding breastfeeding as a moral imperative prompting analysis that centers on emotional, social, and psychological experiences and tensions that can negatively influence the breastfeeding experience. We are reminded through this study that breastfeeding occurs in an interactive social context involving social pressures and within the context of personal relationships, motivations, and identities. As such it is relevant for nurses to be aware of the impact of this dynamic and provide caring support central to the health of women, their infants, and families.

Physical processes such as breastfeeding are interdependent and complex and as such are not entirely predictable. The richness and effectiveness of support is linked to multiple relationships including those that parents establish with care systems and providers. Considerations within the social context, of individual circumstances, vulnerabilities and realities, as well as access to supports through transitions are illustrated as paramount in planning care.

Dykes (2005) recommends the re-conceptualization of breastfeeding to address policy, practice, and education in moving toward relationality (dependence, independence, and interdependency) versus the prevalent mechanization approaches. Kelleher (2006) encourages further visibility for the physical challenges of breastfeeding such that women are positioned to be informed, less surprised, and can interpret challenges to reduce possible feelings of failure as they experience both the vulnerability and empowering aspects of the physicality of this embodied process. Situating women to transition to other feeding options in a positive environment is perhaps the balance that requires further emphasis in care environments.

Political perspectives

In a quantitative, nationally reflective study, based on time limited telephone interviews, Chalmers, Levitt, Heaman, O'Brien, Sauve, and Kaczorowski (2008) demonstrate that while the Canadian hospital environment for breastfeeding has improved only three of the ten steps defined in the World Health Organization (WHO) Baby Friendly Hospital Initiative have been implemented in ways that are consistent with WHO expectations. Therefore, while women are being encouraged to breastfeed, support is limited and practices that are known to support duration and exclusivity have not been adequately implemented. Included in the steps that have not been fully realized, according to mothers interviewed, are some very simple expectations for

rooming in, not using a pacifier in the hospital, exclusive breastmilk feeding, and skin to skin contact between mother and infant promptly following birth.

In a recent literature review examining effective care considerations that are required immediately or very shortly following birth, Chaparro and Lutter (2009) explore the evidence or not surrounding cord clamping processes, skin to skin contact between mother and babe, and prompt breastfeeding. They highlight the largely absent evidence for some protocols and summarize their findings as “tragically missed opportunities” (Chaparro & Lutter, 2009, p.323) to promote a healthy start. The missed opportunity perspective is illustrated by the multiple points of care that can support effective transitions. These include skin to skin for lactation stimulation, body temperature regulation, and a timely breastfeeding start to minimize weight loss and promote perceptions of success that can support duration. The colonization of normal human flora between the mother and babe, reduced chance of maternal hemorrhage, and antibody transfer through breastmilk are also profiled for their extended protective impact.

The debate over guidelines and definitions, such as what constitutes exclusive breastfeeding and differences in developed versus developing countries, brings forward the measurement and evaluation of infant feeding recommendations discussed by Anderson, Malley, and Snell (2009). Her study involved a current review of the literature focusing on the evidence supporting or not the changes in recommendations promoting exclusive breastfeeding up to six months as a global initiative. She also addresses allergy concerns related to the introduction of solids. A review of this type is relevant and important, however, also raises the commodity perspective described by Van Esterik (2002) in focusing on nutritional adequacy and highlights the political nature of these types of recommendations. It is of note that some of the studies while not fully supportive of the extension of the guidelines to 6 months also emphasized the

importance of considering the individual infant. Some of the studies recommended extension without specific comparisons acknowledging the generally protective factors of breastmilk and the low existing duration rates. Micronutrient infant stores of zinc and iron were raised as concerns and the social aspects of solids introduction are mentioned in conjunction with attention to infant cues and the phasing of foods considered more allergenic.

Economic perspectives

A number of articles (Callen, 2004) highlight the Women, Infants, and Children supplemental nutrition program for low income mothers in the United States and its apparent negative influence on breastfeeding initiation and continuation rates through the provision of formula in the absence of breastfeeding promotion and support. While there have been improvements in some components of the program to assist and support breastfeeding and an increase in the initiation rates, debate continues as to whether this program sufficiently addresses the determinants of health. Women who are more socio economically disadvantaged are often more vulnerable to the perceived ease of formula feeding and perhaps the marketing that has surrounded formula feeding. When formula is made readily available through social support agencies and breastfeeding supports are minimal it is not surprising that women make the choice to formula feed. Workplace supports are also factors that may influence these decisions.

When faced with the cost of formulas, particularly for babies that can only tolerate the more expensive formulas, women are often dismayed and reflect that they wish that they had known more about the challenges for some babies in tolerating formula. They also mention interest in learning earlier about the relative costs of formula feeding versus breastfeeding generally as they consider decisions to discontinue breastfeeding.

The literature review conducted by Callen (2004) encourages continued examination of the differences in countries given the variable initiation and duration rates. She notes that both Australia and Europe have better rates overall than Canada and the United States with the United States having substantially lower rates than other countries. She also confirms the well documented understanding that women, who successfully breastfeed, are generally older, married, better educated and have higher incomes than those who do not. These comparisons bring a further focus into the political and consequently economic structures that facilitate or not the opportunity for women to breastfeed over the time periods that are individually appropriate for them as women and mothers and the vulnerability of women and mothers in more difficult economic circumstances.

Part IV: Locating the issues within Nursing

Nursing Theory

According to Chinn and Kramer (2004) nursing theories propose and/or describe key practice elements that illustrate purpose and intent and make visible unique or foundational perspectives. A theory is designed to describe, explain, and predict practice such that the important and perhaps invisible elements of nursing practices that underlie and contribute to defined processes and tasks become visible. The theory of caring as a middle range theory, developed by Swanson, may assist in understanding the relationship challenges in infant feeding and the dilemmas surrounding breastfeeding duration and perhaps can be applied by nurses in developing service approaches that attend to the voice of women and their families. Considering her theory may assist in developing timely, evidence informed interventions and in attending to the opportunity for continuity between hospital and community environments.

Swanson (1991) in describing her theory of caring focuses on nursing approaches that recognize caring as situated in a belief in people and their capacities. Much of her work involves observations of the ways in which nurses listen to mothers and their families and how nurses provide supportive guidance that makes a difference in the ability of families to move forward. Swanson describes five important processes that include: knowing, being with, doing for, enabling, and maintaining belief. It is of note that the ways in which nurses validated (and corrected misconceptions) in Swanson's research facilitated a positive forward momentum in positive parenting skills.

The context of caring described in the 2008 Canadian Community Health Nursing (CCHN) Practice Standards is described as based on the principles of social justice and on developing relationships which value the uniqueness of the individual and the community. The key nursing values and beliefs highlighted in this document, for caring and empowerment, appear to be linked to health promotion theories and while not referenced as such, could be viewed a linking to the approaches Swanson describes, such as, her enabling considerations that facilitate transitions.

In the standards document the individual and community are profiled as an active partner for achieving health and well being. This could be viewed as paralleling Swanson's process of enabling and maintaining belief. Empowerment in the CCHN standards document is described as people finding their strengths and moving toward action. Perhaps what is missing here or is simply not described is the role of the nurse in being with, as Swanson describes nursing presence, listening and sharing.

Implications for practice structures and considerations of how women are supported to breastfeed are identified by Sheehan et al (2009) in their research on women's infant feeding

decisions. Their research draws attention to the pressure and in some cases coercion that women felt from health care professionals to breastfeed. Attention to Swanson's theory of caring may assist nurses in working with individuals and populations to maintain the balance that is necessary for ethical practice. It is almost as if, by attending to population health approaches, health care providers may risk burdening the client and in doing so facilitate the development of additional health issues. Swanson's considerations of not-burdening the client may be an area for analysis and evaluation in relation to some of the health promotion campaigns that have been launched. Sheehan et al (2009) mention the extreme risk interpretations some women hold as associated with the promotional breastfeeding campaigns. From these discussions the slogan, breast is best, may have been more balanced as, breast is better, which then leaves some option for other alternatives to be considered and women to make informed choices with increased comfort.

Maintaining belief for Swanson (1991) is about recognizing capacity through transitions and mobilizing this capacity. This approach may assist nurses in identifying and addressing the self efficacy concerns raised as a key challenge to breastfeeding continuation profiled through my literature search.

In developing a literature review utilizing an issues articulation framework, my hope was to explore and discover complexities that could contribute to practice understanding and advancement. I propose that specific attention and application of Swanson's Theory of Caring between both the hospital and community nursing structures may hold an opportunity to unite these environments and more effectively address and support the challenges for families in receiving support for informed choices. These choices can involve initiating and continuing breastfeeding and in confidently transitioning to other feeding options when the timing is right

for the woman and mother. The choices may also involve decisions to formula feed as the better option for the woman and mother and family given their unique circumstances. Incorporating practice elements that consider Swanson's approaches into the description of the community health nursing standards may assist in further developing how nurses most effectively work in facilitating transitions and balance population health approaches with individualized care approaches.

Contributions to disciplinary knowledge

An enhanced understanding of the multiple variables influencing women's postpartum breastfeeding experiences can assist nurses to focus their work both in the hospital and the community. Part of the nurses role is continuing to listen and respond to women who want to breastfeed and to those who want to transition to other feeding options. Blyth, Creedy, Dennis, Moyle, Pratt, and De Vries, (2002) identify the importance of assessing women at risk for early cessation and breastfeeding self efficacy as an important variable. They encourage application of the self efficacy framework developed by Dennis (1999) to develop assessment, intervention, and evaluation guidelines that can assist in planning individualized early supports. In this study they also acknowledge and encourage the opportunity for health care providers to facilitate timely peer support as this has been shown to positively influence confidence. Peer support is very important, however, in many health services structures these supports are underutilized.

Encouraging health care providers to view birth and infant feeding as an integrated process and to attend to the perceptions and doubts of women that contribute to their decisions about the process of breastfeeding is discussed by Smith (2009) and Avery et al (2009). The connection between confidence and commitment is identified by Avery et al (2009) as an issue that influences a women's ability to overcome breastfeeding challenges. An understanding of

this dynamic is important for nurses in facilitating infant feeding decisions that are consistent with women's breastfeeding goals. Commitment to breastfeeding and the ability to manage difficulties is thought to be dependent on women's confidence in the process of breastfeeding. Use of the word "try" (Avery, 2009, p.146) by new mothers is identified as a key to assessing and communicating confidence concerns. Mothers identified concerns about being able to assess infant well being, when breastfeeding, which resulted in low confidence levels. This once again reinforces the importance of nurses facilitating an opportunity for peer support. Peer support is an approach that can build confidence in the process of breastfeeding through modelling or assist women who decide to transition to other options.

Working through breastfeeding challenges and assisting women to find their way may also be augmented by educating either or both fathers and maternal grandmothers according to Ekstrom et al (2003). Utilizing this dimension in developing support strategies, guided by nurses, is likely an underdeveloped approach that may be effective in widening the circle of support for the breastfeeding mother and for the mother who wants to transition to other options.

The ability of nurses to foster confidence and refute misconceptions by listening and identifying teachable moments, discussed by Swanson (1991) as enabling, cannot be emphasized enough given the feelings of helplessness expressed by some of the mothers in the studies reviewed. Nurses also need to be skilled in promoting a good start to breastfeeding and parenting, identifying and assisting when difficulties arise, and supporting the woman to make the better infant feeding decisions given specific life circumstances for the woman and mother, her infant, and family.

Implications for nursing practice

Confidence in mother's milk supply or concerns related to milk insufficiency is the most frequently identified variable influencing early cessation. Dykes (2005) in her research on breastfeeding and relationality draws attention to the work of the nurse in assisting a mother to identify signals that can enhance confidence in her milk supply. These observational and communication opportunities are available to nurses in both hospital and community environments and offer a consistent strategy to assist with transitions between environments.

Thurlier and Mercer (2009) advocate early identification of women at risk for early cessation as a nursing activity in association with applying evidence-based practice interventions. They further encourage a heightened awareness on the part of the nurse regarding the power they have to positively or negatively influence breastfeeding comfort, safety, and decisions. Mechanistic views of feeding, missed opportunities to guide mothers to infant cues, and failure to attend to the mothers concerns were observed by Dykes (2005). The interactions with midwives, discussed in the study, resulted in confusion for the mother which interfered with breastfeeding goals. Caregiver interaction, resulting in mixed experiences for women, was also noted by Kelleher (2006) as either reducing or enhancing feelings of vulnerability. This further illustrates the need for communication and for nurses to evaluate their effectiveness in interactions with women who are breastfeeding. While the emphasis in this paper focuses on breastfeeding continuation there is an equal responsibility for nurses to assist women and mothers who have made an informed decision to transition to other feeding options. A quick reference checklist for the beginning nurse can be found in Appendix A and was developed in association with and in consideration of the findings within this paper.

Recommendations for further research

According to Thulier and Mercer (2009) and noted by Wambach et al (2005) that while milk insufficiency remains the main reason for early weaning, clinical trials with the primary aim of preventing or treating milk insufficiency have not yet been conducted. Gatti (2008) also notes that milk supply adequacy is frequently based on maternal perception and the accuracy of these perceptions is as yet undetermined. The effect of the birth process on breastfeeding initiation and duration is also identified by Thulier and Mercer (2009) and Smith (2009) as an area requiring further study particularly given the high percentage of caesarean births in North America (approximately 30% across jurisdictions).

Chezem et al (2003) encourage further research with women who identify an early intention to both breastfeed and use alternate nutrition sources. This results from their research illustrating that women who intend to combination feed consequently breastfeed for a limited duration and often did not meet their breastfeeding goals. Further research into the supports most effective in assisting women to identify and achieve their goals is needed.

Nommsen-Rivers and Dewey (2009) developed and piloted a simple, easy to administer, validated, Infant Feeding Intentions tool designed to probe intended breastfeeding duration and the strength of intention to breastfeed. The investigation that led to the development of this tool identifies the intention to breastfeed as one of the variable for nurses to assess. Further the study indicates that many mothers were not able to meet their breastfeeding goals therefore research is needed to adequately understand and be able to effectively respond to the discrepancy between intention and outcome.

Another area to be considered for further research includes the influence and effect of doula care on breastfeeding initiation and duration. This may be particularly important and

timely given the emerging application of the centering pregnancy model of care in North America and the evolution of doula care in some programs, for both birth support and as culture brokers. Nommsen-Rivers and Dewey (2009) validated their breastfeeding intention scale with doulas as well as other providers and identified the need to better understand how to narrow the gap observed in their study between intention and outcome behaviour. Blyth et al (2002) encourage further research into the effectiveness of confidence building strategies with women at high risk for early cessation when they hold a high intention to breastfeed. Further research into health care partnerships between a variety of providers such as partnerships between families, doulas, nurses, midwives and physicians as a means of practical support may also provide a valuable contribution to future approaches to care.

Cattano and Quintero-Romero (2006) in considering breastfeeding initiation and duration rates in low income countries recommend further research on the impact of political will in maintaining breastfeeding priorities given the emergence of pandemic concerns such as HIV/AIDs and influenzas competing for program resources. While they have focused on low income countries there is relevance for this type of research for high income countries as well, given the protective effect of breastfeeding on improving child health and reducing childhood disease.

Issues of economic necessity and integration of women into the work force brings forward another set of challenges. Some workplace and environmental supports have been developed however further research into the effects of these supports, particularly for low paying occupations, and the development of other relevant strategies continues to be required.

Further research is also needed related to moral and ethical experiences of both the nurse and the women and their families. One area that merits further review is the issue of informed

consent for interventions such as soother use and the limited or untimely aspects of care that limit the opportunity for an infant to develop effective sucking skills.

Conclusion

Exploring the postpartum breastfeeding journey requires locating questions that open up a broad discussion of key issues and acknowledges multiple and diverse relationships and life situations. Relationships are established between nurses and women/families, nurses and other practitioners, and nurse to nurse in coordinating a variety of hospital and community services within complex environments. Nurses hold a responsibility for intentionally discussing the varied issues that influence or interfere with women achieving their breastfeeding goals or interfere with smooth transitions to other feeding options. Nurses also have a substantial role in facilitating transitions and within this role to apply unique knowledge and insights that guide nursing practice approaches and associated outcomes.

Nurses are well positioned to influence women's experiences with infant feeding during one of life's important transition periods. Exploring the complex historical, social, cultural, scientific, political, and economic milieu that surrounds women and mothers and influences infant feeding and breastfeeding experiences can aid our understanding and more sensitively guide our nursing interventions. Nurses hold a moral responsibility to make visible to health care planners and decision makers the care issues that better support women, infants, and families during this important transition period.

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Appendix A

Checklist for the beginning nurse in supporting women who choose to breastfeed

- Approach infant feeding as an interactive transitional opportunity to provide nursing support
- Be present for the mother- listen to and hear her story- assess power relationships and maternal confidence- facilitate informed choices linked to the principle of informed consent
- Increase your awareness of the family history of breastfeeding in prioritizing risk for early cessation
- Remain aware of socio economic and more modifiable factors when considering supports
- Focus first on the situations amenable to nursing interventions
 - Strive to facilitate consistent messages across service structures
 - Locate the opportunities for transitioning experiences- women tell us that information provided in hospital makes a difference- this is an important teaching opportunity
 - Assess maternal anxiety and satisfaction level- inquire whether breastfeeding is going as planned- facilitate transitions based on women's cues
 - Facilitate family post delivery support- family postpartum bonding
 - Encourage positive self talk in managing physical changes and self care
 - Facilitate environments that maintain a low tech approach
 - Be the provider that is aware of language and facilitates and utilizes supportive language
 - Coordinate communication that is effective across transition points
- Identify strategic nursing supports to facilitate early mother-infant interaction/feeding choices
 - Early mother-babe or partner-babe skin to skin contact
 - Opportunity for early breastfeeding opportunities
 - Informed consent and other approaches designed to empower or at least not disempower
 - Early peer to peer support
- Locate the teachable moments to:
 - Support the development of confidence within the change environment
 - Clarify misperceptions and unhelpful beliefs
 - Guide the learning of infant cues and address concerns re milk sufficiency
- Broaden the support circle, educating fathers and grandmothers to assist with breastfeeding difficulties
- Facilitate the awareness of available support resources and advocate for improvements

“Breastfeeding for six months begins with breastfeeding for six days” (unknown)