Call to Action on Breastfeeding

United States Department of Health and Human Services' Office on Women’s Health • Office of the Surgeon General • Centers for Disease Control and Prevention

Testimony Submitted by the Association of Women’s Health, Obstetric and Neonatal Nurses
July 30, 2009

INTRODUCTION

Good morning. I am Dr. Diane Spatz, an advanced practice nurse. Thank you to the members of the Federal Steering Committee of the new Call to Action on Breastfeeding for the opportunity to provide testimony. I am here today on behalf of the 23,000 members of the Association of Women’s Health, Obstetric and Neonatal Nurses, also known as AWHONN. AWHONN is a nonprofit membership organization committed to promoting and improving the health of women and newborns. I am also a fellow of the American Academy of Nursing. The Academy’s 1,500 members serve the public and the nursing profession by advancing health policy and practice through the generation, synthesis, and dissemination of nursing knowledge. I Chair the Academy’s Expert Panel on Breastfeeding.

We applaud your efforts to increase the rates of breastfeeding and appreciate the work you have done to date to accomplish that goal. Nurses are typically the first and most consistent point of contact in the healthcare setting. Evidence suggests that nurses spend more time — up to four times as much — than any other healthcare provider at the bedside. As a result, nurses have a unique perspective on the healthcare system - on the way care is and should be provided to women; and we are ideally positioned to help increase breastfeeding rates among new mothers and to extend the amount of time that women breastfeed.

As a doctorally prepared nurse, I am an educator, researcher and clinician. I share a joint appointment between the University of Pennsylvania School of Nursing and the Children’s Hospital of Philadelphia. In school portion of my job, I teach an entire semester undergraduate course on breastfeeding and human lactation and in the hospital portion of my job I developed
the Breastfeeding Resource Nurse model. I have had multiple research studies funded by the National Institutes of Health. My work focuses on how both NURSES and ADVANCED PRACTICE NURSES can change outcomes related to the use of human milk and breastfeeding in term, preterm and other vulnerable infants and the translation of research in actual clinical practice.

BACKGROUND
The evidence is clear: breastfeeding is the optimal method for providing infant nutrition. New science emerges daily on how human milk protects infants from disease and illness. AWHONN’s complete position statements on Breastfeeding, as well as Breastfeeding and Lactation in the Workplace are available on our website at: www.awhonn.org. Today I will be addressing two specific issues.

PRETERM AND OTHER VULNERABLE INFANTS
While AWHONN broadly supports breastfeeding, the first area that I would like to address relates specifically to the use of human milk and breastfeeding in preterm and other vulnerable infants such as those born with congenital anomalies for example cardiac defects, spina bifida, and lung tumors to name a few. In the United States, nearly 13% of all of babies are born preterm. The cost of initial hospitalization and on-going health care costs are enormous for these infants and risk for morbidity and mortality is significant both short and long term.

While more mothers start breastfeeding today, few infants receive exclusive human milk or are breastfed long term. Preterm and vulnerable infants are at high risk for not receiving their mothers’ own milk due to a lack of health care provider knowledge and lack of access to technology that can support lactation. One case of necrotizing enterocolitis (a disease of the bowel associated with very high morbidity and mortality) can cost over $200,000. We have strong evidence that human milk decreases both the incidence and severity of NEC. Similarly, human milk also protects against late onset sepsis, another major contributor to morbidity and financial burden. In the interest of time, I will provide only these two most compelling exemplars of why human milk matters. Human milk provides nutritional, immunological and developmental components that no infant formula will ever be able to replace.

Additionally, families do not receive appropriate insurance coverage for lactation services or lactation technology. Just this week at CHOP, I had a family with an infant who has an abdominal wall defect- with a predicted hospital stay of three to four months- who despite having two forms of private insurance could not receive reimbursement or coverage for a
hospital grade pump. Thankfully, they had the economic means to pay out of pocket for the breast pump, however many families do not.

While very preterm or other vulnerable infants may require long on-going intervention, the late preterm infant requires different condensed intervention in the first weeks after delivery. Over 70% of preterm births occur between 34 and 36 weeks gestation. These late preterm infants may look like full-term infants however, late preterm infants have immature suck and swallow reflexes and altered sleep-wake states. These infants experience significant challenges in successfully initiating and maintaining breastfeeding and are at high risk for hospital readmission if evidence based breastfeeding care and support is not provided.

We urge members of the steering committee to consider the special needs of preterm & other vulnerable infants in its deliberations. Specifically related to four points:

- #1 Federal and private health plan insurance for “hospital grade” breast pumps to women who need to express milk for the appropriate length of time whether the child be hospitalized or discharged to home
- #2 Access to and coverage of lactation services and technology
- #3 Research dollars designated to determine the ideal models of care to improve breastfeeding success & health outcomes in these infants while decreasing the financial burden
- #4 Education and support for families, health care providers and society

LACTATION SERVICES AND HEALTH CARE PROVIDER EDUCATION

The next topic that I would like to address is health care provider education. In the U.S, most physicians, nurses and other health related professionals receive little to no education regarding breastfeeding in their respective programs. This leads to providers giving inaccurate information or no support or education about breastfeeding. All women and their families deserve the right to receive appropriate and culturally sensitive breastfeeding education and support during the preconception, prenatal and postpartum periods. All women should have access to lactation specialists or nurses with expertise in breastfeeding support in the hospital or birthing setting, and upon discharge from the hospital. Research indicates that the attitudes and level of knowledge of health care providers directly impacts mothers’ short and long term breastfeeding success. AWHONN supports the incorporation of breastfeeding education and the Expert Panel on Breastfeeding of the American Academy of Nursing has published an article in Nursing Outlook (2007) that outlines HOW and WHAT information should be integrated
into nursing school curricula. Also, published in the *Journal of Nursing Education* (2005), as an educational innovation article, is the manuscript that describes my course “The Breastfeeding Case Study: A Model for Educating Nursing Students”.

We would like to urge the steering committee to consider three specific recommendations:

- **#1** Incorporation of breastfeeding and lactation education in all levels of schooling and specifically for those individuals entering the health professions
- **#2** Continuing education on breastfeeding for health care providers working with childbearing families and children/adolescents
- **#3** Increased federal funding for human milk and breastfeeding research
  - Especially for research that directly impacts clinical practice and/or effectively changes short and long term breastfeeding outcomes

**CLOSING**

In closing, I would like to thank the steering committee for your consideration and I greatly appreciate this opportunity to submit testimony. I am happy to take any questions at this time.