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WOMEN'S HEALTH CARE PHYSICIANS

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## Committee on Health Care for Underserved Women

*This information should not be construed as dictating an exclusive course of treatment or procedure to be followed.*

## Breastfeeding in Underserved Women: Increasing Initiation and Continuation of Breastfeeding

**ABSTRACT:** Maternal and infant benefits from breastfeeding are well documented and are especially important to underserved women. Underserved women are disproportionately likely to experience adverse health outcomes that may improve with breastfeeding. They face unique barriers and have low rates of initiation and continuation of breastfeeding. Through a multidisciplinary approach that involves practitioners, family members, and child care providers, obstetrician–gynecologists can help underserved women overcome obstacles and obtain the benefits of breastfeeding for themselves and their infants.

The American College of Obstetricians and Gynecologists (the College) strongly supports breastfeeding as the preferred method of feeding for newborns and infants and recommends exclusive breastfeeding until the infant is approximately 6 months of age. A longer breastfeeding experience, with gradual introduction of iron-enriched solid foods in the second half of the first year of life, is beneficial. The College calls on its Fellows, other health care professionals who provide care for women and their infants, hospitals, and employers to support women in choosing to breastfeed their infants. All should work to facilitate continuation of breastfeeding in the workplace and public facilities, and advocate for changes to the public environment that support breastfeeding locally and nationally. Although most women can breastfeed, some women will choose not to breastfeed or cannot breastfeed. Health care providers should be sensitive to the needs of women, regardless of whether or not they choose to breastfeed. Health care providers should aim to support women in the vulnerable postpartum period and encourage and assist women who choose to breastfeed and accept the decision of women who choose not to breastfeed. Additionally, health care providers should help women recognize when their newborns are getting enough nutrition and hydration through breast milk so they can confidently continue exclusive breastfeeding or seek assistance if there is a concern.

According to the 2012 Breastfeeding Report Card, 76.9% of infants in the United States were ever breastfed. However, 47.2% of infants were breastfed at 6 months, which decreased to 25.5% at 12 months (1). Although breastfeeding rates have increased over the past several years, Healthy People 2020 goals include increasing the rate of continued breastfeeding as well as improving the rate of exclusive breastfeeding (see Box 1).

Maternal and infant benefits from breastfeeding include protection from infections (2), biologic signals for promoting cellular growth and differentiation (2), decrease in maternal postpartum blood loss (3), and a reduction in the risk of ovarian and breast cancer (4–6). Despite the benefits of breastfeeding, cultural and societal barriers to breastfeeding exist at all levels; from hospitals to the workplace. Underserved women, those who are unable to obtain quality health care by virtue of poverty, cultural differences, race and ethnicity, geographic region, or other factors that contribute to health care disparities, may face greater barriers in the initiation and continuation of breastfeeding.

Overall, national estimates for breastfeeding initiation meet the Healthy People 2010 target of 75%. However, significant disparities exist with breastfeeding initiation among African American women and women in the Special Supplemental Program for Women, Infants and Children (WIC); 58.9% and 66.1% respectively (7, 8).



### Box 1. Healthy People 2020 Targets for Breastfeeding\* ←

- Increase the proportion of infants who are
  - ever breastfed (81.9%)
  - breastfed at 6 months (60.6%)
  - breastfed at 1 year (34.1%)
  - exclusively breastfed through 3 months (46.2%)
  - exclusively breastfed through 6 months (25.5%)
- Employers with on-site lactation support (38%)
- Reduce the proportion of breastfed newborns who receive formula supplementation in first 2 days of life (14.2%)
- Increase the proportion of live births that occur in facilities that provide recommended care for lactating mothers and their babies (8.1%)

Data from Centers for Disease Control and Prevention. Breastfeeding report card—United States, 2012. Atlanta (GA): CDC; 2012. Available at: <http://www.cdc.gov/breastfeeding/pdf/2012BreastfeedingReportCard.pdf>. Retrieved May 17, 2013.

\*Healthy People 2020 targets are shown parenthetically.

Age disparities also exist with initiation rates of 53.0% for women younger than 20 years compared with initiation rates of 69.0% for women aged 20–29 years and 77.5% for women aged 30 years and older (7).

### Barriers to Breastfeeding

Barriers to breastfeeding are multifactorial and include socioeconomic status, education, misperceptions, and social norms. Low-income women have lower rates of breastfeeding because they are more likely to return to work sooner after giving birth and are employed in positions that make breastfeeding at work more difficult than women with higher incomes (9). The Affordable Care Act supports breastfeeding through an amendment to the Fair Labor Standards Act or federal wage and hour law. The amendment, which took effect on March 23, 2010, requires employers to provide reasonable break time and a private place, other than a bathroom, for breastfeeding mothers to express breast milk during the workday for 1 year after the infant's birth (10, 11). The absence of such requirements has been noted previously as a substantial obstacle to breastfeeding. It should be noted that employers with fewer than 50 employees may be exempt from this requirement if they are able to show that compliance would cause them undue hardship (11).

Women with a high school diploma or less are also less likely to breastfeed (12) and may be unaware of the specific benefits of breastfeeding, as well as less familiar with techniques for successful breastfeeding. Poor family and social support also can be a barrier (13). Adolescents often have their own misperceptions about breastfeeding. Common myths, such as “it creates dependency,” have

been demonstrated as reasons for failure of adolescents to initiate breastfeeding (14).

Social norms also present additional barriers to breastfeeding (13). Breastfeeding in public is not a widely accepted practice. In a focus group study conducted in three major U.S. cities, both women and men expressed their disapproval of breastfeeding in public (15). Nearly all states, the District of Columbia, and the Virgin Islands have laws to support breastfeeding in public (16). Health care providers should be aware of their state or territory laws to inform and empower patients to feel comfortable breastfeeding in public. A listing of U.S. laws by state and territory is available at [www.ncsl.org/issues-research/health/breastfeeding-state-laws.aspx](http://www.ncsl.org/issues-research/health/breastfeeding-state-laws.aspx). The social belief that formula feeding is the norm is influenced by the marketing efforts of companies that produce infant formula. Many hospitals give new mothers gift packs that include formula, and many hospitals have not developed lactation programs to provide education and support for breastfeeding. Health care providers should be aware that the giving of gift packs with formula to breastfeeding women is commonly a deterrent to continuation of breastfeeding (17). A professional recommendation of the care and feeding products in the gift pack is implied. For this reason, health care providers may conclude that non-commercial educational alternatives or gift packs without health-related items are preferable.

The effects of social norms in the United States are further demonstrated when breastfeeding rates among immigrant women are compared with those of women born in the United States. Even after controlling for socioeconomic and demographic differences, immigrant women have higher rates of initiation and duration of breastfeeding than women born in the United States (18).

### Importance of Breastfeeding for Underserved Women, Children, and Society

The benefits of breastfeeding apply to all women, but particularly to underserved women (see Box 2). Underserved women have a disproportionate share of adverse health outcomes, such as obesity, diabetes, and cardiovascular disease, which may improve with breastfeeding. The prevalence of obesity is increasing nationally (19). These increases are seen particularly among underserved women and children. Women who exclusively breastfeed experience greater total body weight loss in the postpartum period than women who breastfeed and formula feed (20, 21). Some studies have suggested that the rate of childhood obesity may be decreased in children who were breastfed as infants (22). According to the Centers for Disease Control and Prevention, 12.6 million women or 10.8% of all women aged 20 years and older have diabetes, with a significant prevalence among minority populations (23). In a large prospective, longitudinal study of two cohorts of women, a reduced incidence of type 2



## Box 2. Benefits of Breastfeeding ←

- Decreased rate of common childhood infections, such as ear infection and infection that causes diarrhea, which results in decreased parental absenteeism from work
- Decreased rates of childhood obesity in children who were breastfed as infants
- Decreased rates of hypertension, hyperlipidemia, diabetes, and cardiovascular disease among women who breastfed their infants
- Decreased rates of ovarian and breast cancer in women who breastfed their infants
- Increased bonding between mother and infant
- Lower risk of postpartum depression
- Increased postpartum weight loss
- Decreased unintended pregnancy

Data from Lawrence RA, Lawrence RM. Breastfeeding: a guide for the medical profession. 7th ed. Maryland Heights (MO): Elsevier Mosby; 2011; Chua S, Arulkumaran S, Lim I, Selamat N, Ratnam SS. Influence of breastfeeding and nipple stimulation on postpartum uterine activity. *Br J Obstet Gynaecol* 1994;101:804–5; Rosenblatt KA, Thomas DB. Lactation and the risk of epithelial ovarian cancer. The WHO Collaborative Study of Neoplasia and Steroid Contraceptives. *Int J Epidemiol* 1993;22:192–7; Newcomb PA, Storer BE, Longnecker MP, Mittendorf R, Greenberg ER, Clapp RW, et al. Lactation and a reduced risk of premenopausal breast cancer. *N Engl J Med* 1994;330:81–7; and Breast cancer and breastfeeding: collaborative reanalysis of individual data from 47 epidemiological studies in 30 countries, including 50,302 women with breast cancer and 96,973 women without the disease. Collaborative Group on Hormonal Factors in Breast Cancer. *Lancet* 2002;360:187–95.

diabetes was associated with a longer duration of breastfeeding (24). Underserved women are also disproportionately affected by cardiovascular disease (25). Some studies indicate that women who have breastfed have lower rates of hypertension, hyperlipidemia, and cardiovascular disease compared with women who have not breastfed (26, 27).

The rate of unintended pregnancy is also higher among underserved women (28). Exclusive breastfeeding delays ovulation and increases the interval between offspring (29). Health care providers should review with patients when breastfeeding can be considered a reliable form of contraception.

Breastfeeding has a societal and socioeconomic benefit. One study estimates that \$3.6 billion would be saved annually in the cost of treating some childhood illnesses if breastfeeding rates were increased (30). Children who were breastfed as infants have fewer childhood illnesses and fewer visits to the pediatrician's office, which leads to decreased parental absenteeism from work. In addition, the estimated cost of formula (up to \$1,200 per year) is four times that of breastfeeding (approximately \$300 per year for increased food for a lactating woman) (31).

## Approaches to Improve Breastfeeding Initiation and Continuation

All practitioners, family members, and child care providers involved with the care of mothers and infants can improve rates of breastfeeding initiation and continuation. The benefits of breastfeeding, as well as patient education, counseling, and support strategies, should be emphasized during training of residents in obstetrics and gynecology, family medicine, and pediatrics. Ongoing education also should be promoted for all women's health care providers and hospital staff involved in child-birth.

Several resources are available to educate practitioners to provide breastfeeding assistance for their patients. The American Academy of Pediatrics has developed a curriculum that incorporates didactics, evaluation tools, and resources to help educate obstetrics and gynecology, pediatric, and family medicine residents in breastfeeding ([www2.aap.org/breastfeeding/curriculum/](http://www2.aap.org/breastfeeding/curriculum/)). Well Start International, a non-profit organization that has promoted and supported breastfeeding for more than 25 years, offers self-study modules on lactation ([www.wellstart.org](http://www.wellstart.org)). The *Breastfeeding Handbook for Physicians* provides guidance for physicians in all specialties (17). The handbook represents the collaborative efforts of the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists.

Obstetrician–gynecologists should counsel patients during prenatal care about the benefits of breastfeeding, starting as early as the first trimester. Counseling to encourage breastfeeding also should involve the patient's partner, a practice shown to improve breastfeeding rates (32). Acknowledging challenges involved in breastfeeding and the difficulties many women experience while breastfeeding, and recognizing that these experiences are risk factors for postpartum depression (33), is critical. Because lack of social support can be a barrier to breastfeeding, especially among the underserved population, health care provider support and knowledge of resources are important to encourage breastfeeding. Health care providers should be aware of community resources, including prenatal lactation classes; lactation consultants; home visiting providers; and support groups, such as La Leche League, WIC peer counselors, and phone support. It is helpful for patients to learn about these resources at the time of discharge or during prenatal care. A campaign to support African American women and breastfeeding has been developed by the Office of Women's Health in the U.S. Department of Health and Human Services ([www.womenshealth.gov/itsonlynatural/](http://www.womenshealth.gov/itsonlynatural/)). The web site contains videos of African American mothers who discuss their real-life experiences with breastfeeding, as well as facts about breastfeeding and a guide to breastfeeding.

Several hospital protocols and practices have been shown to increase rates of successful breastfeeding (see Box 3) (34, 35) and should be the basis for hospital and



### Box 3. Ten Hospital Practices to Encourage and Support Breastfeeding\* ↵

1. Maintain a (supportive) written breastfeeding policy that is communicated to all health care staff.
2. Train all pertinent health care staff in the skills necessary to implement this policy.
3. Inform all pregnant women about the benefits of breastfeeding.
4. Offer all mothers the opportunity to initiate breastfeeding within 1 hour of giving birth.
5. Show breastfeeding mothers how to breastfeed and how to maintain lactation, even if they are separated from their newborns.
6. Give breastfeeding newborns only breast milk, unless medically indicated.
7. Facilitate rooming in and encourage all mothers and newborns to remain together during their hospital stay.
8. Encourage unrestricted breastfeeding when the newborn exhibits hunger cues or signals or on request of the mother.
9. Encourage exclusive suckling at the breast by providing no pacifiers or artificial nipples<sup>†</sup>.
10. Refer mothers to established breastfeeding support groups and services and foster the establishment of these services when they are not available.

Data from Healthy Mothers, Healthy Babies National Coalition. Baby friendly hospital initiative feasibility study: final report. Washington, DC: HMHBNC; 1994 and Breastfeeding and the use of human milk. Section on Breastfeeding. *Pediatrics* 2012;129:e827–41.

\*The 1994 report of the Healthy Mothers, Healthy Babies National Coalition Expert Work Group recommended that the UNICEF-WHO Baby Friendly Hospital Initiative be adapted for use in the United States as the United States Breastfeeding Health Initiative, using the adapted 10 steps above.

<sup>†</sup>The American Academy of Pediatrics endorsed the UNICEF-WHO *Ten Steps to Successful Breastfeeding* but does not support a categorical ban on pacifiers because of their role in reducing the risk of sudden infant death syndrome and their analgesic benefit during painful procedures when breastfeeding cannot provide the analgesia.

community breastfeeding programs. Lactation consultants should be accessible to women both in the hospital and after discharge. However, the cost of lactation services and the low rate of reimbursement have made such support unobtainable for many women. Additionally, the inclusion of lactation visits in the global prenatal fee has limited the ability of childbirth care providers to provide services after delivery in the absence of a breast infection. The Affordable Care Act addresses this by requiring non-grandfathered plans and issuers to provide coverage without cost sharing (for costs of renting breastfeeding equipment and comprehensive lactation support and counseling by a trained health care provider during preg-

nancy, or in the postpartum period, or both) in the first plan year that begins on or after August 1, 2012 (36). This also applies to the essential benefits baseline for plans sold inside the exchanges, which in turn serves as the baseline for the Medicaid benchmark plans for the new expansion population (37). Patients should be educated about this coverage.

To address lower breastfeeding rates among minorities who participate in the WIC program, WIC has introduced programs and campaigns to increase the rate of breastfeeding among its participants. As a result, from 2010 to 2011, there was a 1.5% increase in the number of WIC infants reported by WIC as being breastfed (38). This was associated with a decrease in the rate of subscription to the WIC food packages that included formula and an increase in the subscription to exclusive breastfeeding packages (39).

### Summary

Breast milk is well established as the best source of nutrition for newborns and infants. Breastfeeding has many maternal, infant, and societal benefits. Although national rates of breastfeeding initiation are acceptable, the United States falls short of goals for continuation of breastfeeding, particularly among underserved populations. The College supports efforts to educate patients on the benefits and mechanics of breastfeeding, and encourages health care providers, nursing staff, and government assistance agencies to remain strong advocates for breastfeeding, including lactation programs within hospitals. A multidisciplinary approach that involves community, family, patients, and all involved clinicians will strengthen the support for and feasibility of the desired Healthy People 2020 breastfeeding goals.

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