Breastfeeding is universally recognized as a low-cost intervention that protects the health of mothers and babies while reducing health care costs. Ongoing efforts in California have resulted in steady increases in exclusive in-hospital breastfeeding, particularly among women of color. However, because the hospital may be the only place mothers have access to skilled support, few mothers meet their breastfeeding goals after discharge. Support should not end when mothers bring their babies home. Resources and encouragement are needed from health care providers, family, friends, employers, child care professionals, and others. Mothers and babies need communities of care as they begin and continue healthy lives together.
Breast milk provides all the nutrients and other factors that a newborn needs to grow, develop, and build a strong immune system. Health care organizations and professionals around the world universally accept breastfeeding as one of the most important preventive care measures for children’s health. Decades of research have confirmed that breastfeeding significantly reduces children’s risk for infections and chronic diseases such as diabetes, asthma, and obesity. Breastfeeding also reduces mothers’ risk for type 2 diabetes and breast and ovarian cancers. Breastfed children require fewer visits to the doctor and take fewer medications than children who are formula fed. The benefits are greatest when babies are breastfed exclusively – that is, breast milk is the baby’s only food – for the first six months of life. Increasing exclusive breastfeeding rates to meet the current pediatric recommendations could save many millions of dollars in unnecessary medical expenditures that burden our state.

The Healthy People 2020 framework includes targets for breastfeeding initiation, duration, and exclusivity as well as objectives in three supporting areas: increased worksite support for breastfeeding, reduced hospital supplementation rates, and improved hospital practices (Figure 1). California has achieved four out of the five breastfeeding objectives. However, these targets, based on older national data, were set not as endpoints, but interim aims considered to be within reach by 2020. These benchmarks are expected to change as progress is made. In 2011, the Surgeon General of the United States released “A Call to Action to Support Breastfeeding,” detailing the steps needed to reach these goals.

Studies show that exclusive breastfeeding during the hospital stay is one of the most important influences on how long babies are breastfed exclusively after discharge. Mothers can be prevented from achieving their infant-feeding goals by hospital practices such as separating mothers from their babies, delaying the first feeding, and routinely providing formula supplementation, even for infants whose mothers intended to breastfeed exclusively. Recognizing hospitals’ influence on infant-feeding practices, the Joint Commission (the accreditation organization for hospitals) includes exclusive breastfeeding rates as core perinatal measures for performance evaluation of maternity hospitals.

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**Figure 1: Healthy People 2020 Breastfeeding-Related Objectives**

<table>
<thead>
<tr>
<th><strong>Breastfeeding Objectives</strong></th>
<th><strong>Process Objectives</strong></th>
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<tbody>
<tr>
<td>Increase ever breastfed to 81.9%</td>
<td>Increase the proportion of employers that have worksite lactation-support programs to 38%.</td>
</tr>
<tr>
<td>Increase any breastfeeding at six months to 60.6%</td>
<td>Reduce the proportion of breastfed newborns who receive formula supplementation within the first two days of life to 14.2%.</td>
</tr>
<tr>
<td>Increase any breastfeeding at one year to 34.1%</td>
<td>Increase the proportion of live births that occur in facilities providing recommended care for lactating mothers and their babies to 8.1%.</td>
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<tr>
<td>Increase exclusive breastfeeding at three months to 46.2%</td>
<td></td>
</tr>
<tr>
<td>Increase exclusive breastfeeding at six months to 25.5%</td>
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The Baby-Friendly Hospital initiative (BFHI) was launched in 1991 by the World Health Organization and the United Nations Children’s Fund to address international concerns about marketing and medical practices that interfere with breastfeeding in hospital settings. The initiative focuses on 10 specific hospital policies or “steps” that are designed to reduce barriers to exclusive breastfeeding (Figure 2). Dozens of research studies have examined the impact of the BFHI on breastfeeding initiation, duration, and exclusivity, as well as on other indicators of maternal and child health; nearly all of the studies indicate that well-monitored implementation of Baby-Friendly hospital policies results in increased breastfeeding rates during and beyond the hospital stay.

The number of Baby-Friendly hospitals in California has increased dramatically, from only 12 in 2006 to 62 in 2014 and the proportion of babies born in these hospitals has more than doubled since 2010. Still, only one in four California hospitals are certified as Baby-Friendly. With all California hospitals required to have this designation, or adopt comprehensive policies by 2025, prompt actions are needed to ensure all hospitals are providing the best care to mothers and babies. Although not all of the California hospitals with high exclusive breastfeeding rates have become Baby-Friendly, hospitals with high rates of exclusive breastfeeding have adopted policies ensuring that all mothers are supported in their infant-feeding decisions. Improvements in hospital policies have been reflected in increasing scores on the CDC Maternity Practices in Infant Nutrition and Care (mPINC) Survey. Between 2007 and 2011, the California composite score rose from 69 (ranking 11th in the US) to 79 (ranking 6th in the US). While improvements occurred within all dimensions of care assessed by the mPINC survey, marked improvements occurred in labor and delivery care, breastfeeding assistance, and removal of discharge packs containing formula samples. However, less than one third of California hospitals report that they supplement breastfed infants only rarely, allow infants to remain in the room for assessments and procedures, or provide patients with appropriate discharge plans for ongoing support.

Figure 2: The Ten Steps to Successful Breastfeeding

1. Maintain a written breastfeeding policy that is routinely communicated to all health care staff.
2. Train all health care staff in skills necessary to implement this policy.
3. Inform all pregnant women about the benefits and management of breastfeeding.
4. Help mothers initiate breastfeeding within one hour of birth.
5. Show mothers how to breastfeed and how to maintain lactation, even if they are separated from their infants.
6. Give infants no food or drink other than breast milk, unless medically indicated.
7. Practice “rooming in”— allow mothers and infants to remain together 24 hours a day.
8. Encourage unrestricted breastfeeding.
9. Give no pacifiers or artificial nipples to breastfeeding infants.
10. Foster the establishment of breastfeeding support groups and refer mothers to them on discharge from the hospital or clinic.

Breastfeeding in California Hospitals

In 2013, more than nine out of every 10 California babies began life breastfeeding, yet about 30 percent of those babies were given formula before they were discharged from the hospital, typically 24 to 48 hours after birth. Although it is expected that some infants in each hospital will have medical conditions that require supplementation with formula, in 26 California hospitals, more than 60% of breastfed infants are given supplements during the short hospital stay. In other hospitals, supplementation rates are quite low. Ongoing efforts by advocates and policy-makers throughout the state have brought about substantial changes in many facilities to provide better support for breastfeeding patients and their families. As a result, exclusive breastfeeding in these hospitals has increased dramatically. From 2010 to 2013, exclusive in-hospital breastfeeding rates among all California women rose by eight percent (representing over 34,000 mothers). The highest increases occurred among Hispanic (10.3%), Pacific Islander (8.8%) and African-American (7.6%) mothers. In the past, providers may have mistakenly believed that differences in breastfeeding rates were driven predominantly by cultural practices. However, the data show that for hospitals with policies that support breastfeeding, such as those outlined in the BFHI, these disparities are significantly reduced.

Unfortunately, differences in breastfeeding rates have persisted in different parts of the state, with the highest exclusive breastfeeding rates found among hospitals in the northern part of the state, particularly in mountain and coast communities. The lowest exclusive breastfeeding rates occur in the Central Valley and in southern California. Further, 73% of the lowest-performing hospitals for breastfeeding in 2013 are those that serve predominantly low-income families and women of color – the very population at greatest risk for poor health outcomes. Conversely, two-thirds of the hospitals with the highest rates of exclusive breastfeeding provide care largely to higher income mothers. These persistent disparities indicate that ongoing efforts are needed to bring needed changes to all California hospitals.

From 2010 to 2013, exclusive in-hospital breastfeeding rates among all California women rose by 8%. The highest increases occurred among Hispanic, Pacific Islander, and African-American mothers.

Going Home May Mean Going without Support

Unfortunately, the successes in so many of California’s hospitals are not extended beyond discharge. Once home, many breastfeeding women find that they must navigate common challenges with limited or no access to skilled support. As a result, many California women abandon their goals early. In a 2011 survey, more than 62% of mothers reported that they intended to breastfeed their babies exclusively, yet only 39% reported they were doing so at one month postpartum. By three months, only 23% of women reported they were still exclusively breastfeeding. According to data from the CDC, only 38% of California women are providing any breast milk to their babies at 12 months, as recommended by pediatricians. Our progress in improving breastfeeding rates should not stop at the hospital door.
New Mothers Must Come Home to Communities of Care

The 10th and last step in the “10 Steps to Successful Breastfeeding” requires hospitals to refer mothers to support groups and resources after discharge. According to most recent statewide mPINC results (2011) only 28% of California hospitals provide appropriate discharge planning which includes outpatient breastfeeding support through specialized clinics, home visits, phone calls or by referrals to community resources including support groups, lactation consultants, and WIC. In some communities, referrals do not occur because hospital staff members are not aware of local resources. In others, these resources are quite limited or do not exist. Without efficient referral to skilled support, mothers with urgent issues may miss the opportunity to solve these challenges before they discontinue breastfeeding.

Access to culturally competent, skilled support from health care professionals including doctors, nurses, physician assistants, lactation consultants, and peer counselors is needed by mothers who may have breastfeeding questions or problems. Sadly, many California mothers are denied vital professional services because of limited access, linguistic differences, or lack of insurance coverage. Projects to improve access to professional care through localized training programs and guidance for lactation support reimbursement for physicians and lactation clinics and virtual or mobile contacts for mothers have shown promise.

Promising Policies: Breastfeeding-Friendly Community Clinics

After the hospital stay, mothers’ first contact with medical professionals is most often with a pediatrician. Therefore, ensuring that pediatric professionals and staff have sufficient training to support breastfeeding mothers may serve a vital role in promoting and sustaining exclusive breastfeeding. During 2013, the California Department of Public Health (CDPH), California Chronic Disease and Injury Control (CDIC) Division funded 15 community health centers to participate in a statewide pilot project to increase breastfeeding duration in California’s communities of color by supporting their ability to provide sustainable, quality, culturally competent breastfeeding services. The project aligned with, among others, a key action described in the Surgeon General’s Report, to develop systems to guarantee continuity of skilled support for lactation between hospitals and health care settings in the community. Project clinics developed staffing and billing systems for lactation support in order to comply with insurance and Affordable Care Act requirements. At the same time, an expert panel developed criteria for a “Breastfeeding Friendly Health Care Provider” designation. Preliminary outcomes indicate that mothers attending these pioneering clinics were more likely to breastfeeding exclusively and for longer periods of time than those who did not. (www.cdph.ca.gov/programs/COPP)
Even after breastfeeding is established, new mothers face barriers that may discourage them from continuing beyond the first few weeks. Common barriers include concerns about milk supply, lack of social support from family and friends, returning to unsupportive work environments, unaccommodating child care providers, and clinical difficulties. Without communities of support around them, mothers may feel they are alone in dealing with these challenges. Improving the health of mothers and babies requires ongoing and collaborative efforts from many of the organizations and individuals in mothers’ lives, especially in areas where extended breastfeeding is not a common practice.

Fortunately, evidence exists to identify which interventions are most likely to lead to longer and more exclusive breastfeeding after the hospital stay. Many policies and practices that are known to support new mothers and babies have been described in the Surgeon General’s Call to Action to Support Breastfeeding and by the CDC in their Guide to Strategies to Support Breastfeeding Mothers and Babies. These strategies include:

- **Peer Counseling and Mother-to-Mother Support** – Peer counseling programs such as those found in WIC and other public health programs offer a cost-effective, culturally competent approach to support mothers through the common issues that new mothers face. These programs have been shown to increase the initiation, duration, and exclusivity of breastfeeding among low-income women. For generations, mothers have also benefited from the regional and national efforts of mother-to-mother support groups such as La Leche League and Nursing Mothers Council.

- **Parenting Education and Support** – Many women who express concerns about their milk supply may be misinterpreting common healthy infant behaviors as incessant signs of hunger. Programs that include efforts to support parents' knowledge and skills about infant behavior and development include the California WIC Baby Behavior Campaign, Early Head Start, and First 5 California. More work is needed to ensure that all California families receive this important information.

- **Family Involvement** – Fathers, grandmothers, and other close family members and friends have a strong influence on mothers' infant-feeding decisions. Innovative programs targeting influential family members have been shown to increase breastfeeding rates.

- **Workplace Accommodation** – With 57.5% of mothers with infants in the workplace, there is a great need for workplace accommodation, especially for low-income women of color who are more likely to return to non-traditional or unsupportive work environments than other working women. Recently, ongoing advocacy has led to supportive changes in California labor laws and the development of industry-specific guidance for employers but employer education is needed to translate these gains into benefits for all working families.

- **Child Care Regulations and Training** – In California, many working mothers are the sole providers for their families. Quality childcare is an important priority for these mothers and its scarcity is often a source of stress. California child care licensing regulations include language supportive of breastfeeding but providers need access to education and training to gain the skills needed to encourage and support exclusive breast milk feeding for the children in their care.
During the last few years, many hospitals in California have made the changes necessary to improve breastfeeding support for the mothers and infants they serve. These efforts have paid off with state-wide increases in in-hospital exclusive breastfeeding. While this work must expand and continue, improvements are needed to address the lack of services and support that mothers face after they leave the hospital. Hospitals, public health agencies, and community partners must work together to ensure that all mothers have the information, confidence, and skills they need to carry out informed infant-feeding decisions.

STATE-LEVEL ACTIONS

1. Department of Health Care Services and Covered California should require health plans to provide best practices for lactation support, including in-person access to International Board Certified Lactation Consultants (IBCLCs), and timely and appropriate provision of quality breast pumps.

2. Policy makers and health insurers must continue to make in-hospital breastfeeding support services for all families a top priority. Value-based purchasing, as part of hospital reimbursement, should include provisions for breastfeeding policies and outcomes for exclusive breastfeeding.

3. Collaborative partnerships comprised of advocacy groups, state and local agencies, mother-to-mother groups, health care insurers, and medical professionals should convene to target and improve post-discharge services in the lowest-performing regions in the state.

4. Department of Health Care Services, Insurance and Managed Health Care should work with CDPH and state epidemiologists to identify breastfeeding data that health plans should be required to collect and report annually. Electronic Medical Records should track breastfeeding rates and infant-feeding data.

5. Breastfeeding support at WIC needs to be better integrated with health systems through staffing in community clinics and medical offices and collaboration to develop coordinated data systems.

6. Improved enforcement of the California worksite Lactation Accommodation law is needed to ensure that all working mothers are able to achieve their infant-feeding goals.

7. Education and training should be mandated for child care providers to ensure they have the knowledge and skills necessary to support exclusive breastfeeding for the families they serve.

HOSPITAL AND COMMUNITY ACTIONS

8. To reduce unnecessary supplementation, hospital policy-makers must ensure that sufficient numbers of qualified professionals are available for proper assessment and support for all breastfeeding mothers during the hospital stay.

9. All California hospitals must adopt, communicate, and implement breastfeeding policies aligned with the 10 Steps to Successful Breastfeeding, as required by law.22

10. All California hospitals must provide prompt and effective referrals to culturally and linguistically competent support services to mothers and babies who need them.

11. Hospitals, health care providers, public health agencies, health plans, durable medical equipment (breast pump) providers, and support groups must work collaboratively to create a perinatal continuum of care within each community.
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