Issue Brief

Enhancing Health Equity in Breastfeeding Opportunities and Outcomes

Background and Introduction

According to the WHO, striving for health equity involves addressing the "differences in health that are judged to be avoidable, unfair, and unjust."[i] Inequities arise when there are different "systemic patterns or gradients in access or outcomes across populations with different levels of underlying social advantage or disadvantage—that is, wealth, power, prestige, or other markers of social stratification."[ii] These social, political, historical, economic, and environmental factors create policies, practices, and social norms that influence women's individual choices about breastfeeding.

These factors, which are referred to as social determinants of health, are often quantified using categories such as income or education levels, racial or ethnic groups, employment levels, or geographic areas. Research shows that these social determinants of health have demonstrated effects on health outcomes. Although difficult to quantify the precise impact of these social determinants, some studies suggest that social circumstances are responsible for anywhere from 15 to 40 percent of adverse health outcomes.[iii] Social determinants powerfully impact health because of how they work together to inform personal behaviors, access to care, and compound the challenges that an individual may face. Social determinants do not influence individuals in isolation; rather, these factors combine in unique ways that are "complex, interdependent, [and] bidirectional," creating a cumulative effect when they interact.[iv]

This issue brief will:

- Outline how health equity and social determinants create inequities in access to breastfeeding support.
- Provide data that illustrate how social determinants of health impact breastfeeding rates.
- Describe how health equity efforts identify and address barriers to breastfeeding.
- Illustrate how states are working towards equitable opportunities for women to breastfeed by increasing access to breastfeeding-friendly hospitals and worksites, as well as expanding community support for breastfeeding.
- Describe state health departments' potential roles in increasing health equity in breastfeeding.

Health Equity and the Impact of Social Determinants of Health on Breastfeeding

The following describe how selected social determinants of health influence breastfeeding outcomes, such as initiation, duration, and rates of exclusive breastfeeding.

- ***Educational attainment***: Women of higher educational attainment are more likely to breastfeed. While only 70 percent of women who have not completed high school initiate breastfeeding, 91 percent of their college-educated peers do so. Roughly one quarter of women who attended or completed high school or some college education continue to breastfeed at one year, compared to 43 percent of their college-educated peers.[v]
- ***Income***: Roughly 80 percent of higher-income women are still breastfeeding at one year as compared to 20 percent of lower-income women. Almost twice as many higher-income women breastfeed exclusively at six months as compared to their lower-income counterparts (28% and 16%, respectively).[vi]

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- ***Marital status***: Married women are more likely to breastfeed at six months and twelve months (62% and 38%) than unmarried women (33% and 15%).[vii]

Additionally, other factors impact breastfeeding that are not social determinants but rather inherent traits, such as age or racial/ethnic group. Although they are not social conditions, the experiences women have because of these traits, as well as the impact these experiences have on access to education, income, and social support, create social dynamics and differential access to policies and norms that impact their individual breastfeeding choices.

- ***Age***: Women above 30 years old are significantly more likely to initiate and continue breastfeeding than younger women (less than 20 years old or 20-29). While 84 percent of women 30 years and older initiate breastfeeding, 75 percent of women 20-29 years old and 59 percent of women younger than 20 years old do so. Thirty-six percent of women older than 30 are still breastfeeding at one year, compared to four percent of women younger than 20 years old. One quarter of women 30 years and older breastfeed exclusively at six months, compared to eight percent of women younger than 20 years.[viii]
- ***Race/ethnicity***: Approximately 83 percent of Asian, Hispanic, Hawaiian-Pacific Islander, and white women initiate breastfeeding, compared to 71 percent of American Indian/Alaska Native and 66 percent of black women. Asian women are most likely to continue breastfeeding for one year (42%), compared to their white (33%), Hispanic (28%), American Indian/Alaska Native (18%), Black (177%), and Hawaiian-Pacific Islander (14%) peers.[ix]

Health equity efforts focus on eliminating the systemic barriers that create these differential experiences for women, designing and implementing policies, practices, and supportive communities that all women have access to, across all social categories and groups.

Addressing Barriers and Opportunities for Breastfeeding: ASTHO Breastfeeding Learning Community

Public health professionals and their partners use data to illustrate differences in breastfeeding rates to help illustrate and begin to understand how social determinants of health might inhibit breastfeeding, potentially leading to opportunities to address structural barriers. These include:

- Policies and practices not supportive of breastfeeding in certain institutions where women live and work, such as hospitals and worksites.
- Social norms—the beliefs and practices of a mother's core social group or community—that are unsupportive or actively undermine breastfeeding.
- Lack of family and peer support.[x,xi,xii]

To address these barriers, experts recommend developing comprehensive, multi-sector strategies that help institutions and communities implement policies and practices that more effectively support mothers.

To assist state health departments and their partners in promoting health equity, ASTHO, with funding from CDC, supported eighteen states and the District of Columbia since 2014 using a Learning Community Model. The ASTHO Learning Community states receive funding to address at least one of the following three evidence-based strategies to increase breastfeeding rates:

1) Increase hospital policies and practices supportive of breastfeeding.
2) Improve access to professional and peer breastfeeding support.

3) Create breastfeeding friendly worksites.

State Efforts in Implementing Evidence-Based Strategies to Increase Health Equity in Breastfeeding
Within the framework of the three strategies, ASTHO state teams designed initiatives to address health equity and meet the needs of women most susceptible to adverse health outcomes related to social determinants of health. The following are examples of states' approaches for increasing health equity in each strategy area.

Increasing hospital policies and practices supportive of breastfeeding
The Illinois team concentrated on Touchette Regional Hospital, an urban facility serving primarily African-American women, a group with lower breastfeeding rates than their white counterparts. The team complemented ongoing efforts piloted in East St. Louis, in which care teams work with communities that need changes to breastfeeding policy and practice. State leads from the Illinois Department of Public Health convened a team including hospital leaders, the local health department, and other community-based organizations to build collective impact for the breastfeeding initiative. These relationships, combined with a strong regional health officer, made the Touchette Regional Hospital community an ideal site to address health equity issues.

The team formulated consistent messages about breastfeeding, as well as complementary information and resources designed to change social norms and make breastfeeding a natural, expected activity in this community. They included information about breastfeeding in a community news publication, reaching more than 1,000 homes in the area served by Touchette Regional Hospital. Additionally, the team supported training and professional development at the hospital to help the staff better support women in initiating breastfeeding.

During the project, Touchette Regional Hospital's three-month breastfeeding rate rose from 19 percent to 43 percent. In addition, women reporting post-natal skin-to-skin contact increased from 47 percent to 90 percent.

Improving access to professional and peer breastfeeding support
The District of Columbia Department of Health, in collaboration with the D.C. Breastfeeding Coalition, leveraged their ongoing relationship with Children's National Health System and Town Hall Education Arts Recreation Center (THEARC) to increase low-income, African-American mothers' access to breastfeeding peer counselors. Through one-on-one counseling and group support classes, peer counselors provide breastfeeding support to all women with an infant or child being seen at the Children's Health Center at THEARC. This model removes barriers to care for women and their babies, from the prenatal period through infancy, and is complemented by a Lactation Support Center that includes classes, community support, new mother support groups, and back-to-work consultations.

Oklahoma's project, led by the Coalition of Oklahoma Breastfeeding Advocates (COBA) in collaboration with the Oklahoma State Department of Health, increased access to qualified lactation consultants for African-American and American Indian women. The Oklahoma team adopted a community support model for breastfeeding, Baby Cafés, to provide a site for women to meet with other nursing mothers, talk to facilitators, and ask questions of certified lactation consultants.[xiii]

The first COBA Baby Café sought to recruit African-American women in Oklahoma City by operating cafés in three locations that were accessible to women in this population. The team recruited African-American facilitators to reflect the population and created a comfortable, friendly environment for families. The team recently opened another Baby Café at a clinic serving American Indian women.

Creating breastfeeding friendly worksites

New Mexico's Department of Health and the New Mexico Breastfeeding Task Force collaborated to focus on two communities in the state, piloting an approach that simultaneously addressed employer and employee needs. A breastfeeding worksite liaison connected with the chambers of commerce in the two counties to conduct outreach to and build relationships with business leaders, sharing information about the initiative. The liaison provided support to employers requesting assistance, including a toolkit, handouts, door hangers for pumping rooms, and other evidence-based resources.

Simultaneously, the team sought to assist women directly in their negotiations with employers for breastfeeding accommodations in compliance with the law. The team focused efforts on lower-income women who were less likely to have power within their worksites to negotiate or advocate for time or space for lactation. The team piloted an approach in which breastfeeding counselors in the Supplemental Nutrition Program for Women, Infants, and Children (WIC) worked closely with mothers prenatally, sometimes in the hospital, and then through post-delivery WIC nutrition counseling. WIC counselors provided information and advice about women's rights to lactation accommodations and helped them negotiate these accommodations with employers. Additionally, 22 home visiting agency staff members were trained to better support breastfeeding for clients returning to work.

Opportunities for State Health Departments to Increase Health Equity in Breastfeeding

As these examples illustrate, state health departments and their partners play an important role in addressing social determinants of health, with the goal of increasing health equity in breastfeeding, by helping institutions reduce barriers and increase access to breastfeeding opportunities and support. Specifically, state health departments can:

- ***Highlight health equity*** in initiatives by addressing and reducing structural and systemic barriers for populations at greatest risk for adverse health outcomes.
- ***Meaningfully engage multi-sector partners***, such as hospitals, worksites, WIC, schools, and others, in creating policies and practices that reduce or eliminate women's barriers to breastfeeding. This "Health in All Policies" approach can also be applied to reduce other barriers to healthy lifestyles, building on these relationships.[xiv,xv]
- ***Collaborate with community members*** to better understand barriers to breastfeeding and jointly create and implement approaches to change policies, practices, and social norms that inhibit breastfeeding.
- ***Ensure that lactation consultants and supportive counselors reflect the community***, or, at minimum, are of the same race or speak the same language as the population they serve, to the extent practicable.
- ***Require that program staff are culturally competent*** and understand the community, including cultural traditions, values, and practices. This can include professional development, in addition to ongoing engagement with community members.
- ***Provide education and marketing materials*** that use images reflecting a range of breastfeeding women.

Conclusion

Social determinants of health influence women's individual preferences, opinions, and experiences around initiating and continuing breastfeeding. While experts recommend women breastfeed through the first year of an infant's life, many women continue to face barriers that impede their ability to do so, including access to breastfeeding-friendly hospitals, community and family support, and worksite accommodations. These barriers affect women differently across age, income, race, ethnic, and education groups. States in the ASTHO learning community have advanced health equity by engaging their local communities and identifying practical approaches to implementing evidence-based strategies. Using these states as a model, state health departments across the nation have the opportunity to collaborate with communities, change policies and practices, and establish social norms that create equitable breastfeeding access and support for all women.

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[i] Sadana R and Blas E. "What Can Public Health Programs do to Improve Health Equity?" *Public Health Reports*. 2013. Supplement 3(128): 12-20.

[ii] Ibid

[iii] Health Affairs. "The Relative Contribution of Multiple Determinants to Health Outcomes." Available at: http://healthaffairs.org/healthpolicybriefs/brief_pdfs/healthpolicybrief_123.pdf. Accessed on 7-16-16.

[iv] Ibid

[v] Ibid.

[vi] Ibid.

[vii] Ibid.

[viii] Centers for Disease Control and Prevention. "Breastfeeding Among U.S. Children Born 2002-2012: Results from the National Immunization Survey. Rates of any and exclusive breastfeeding by socio-demographics among children born in 2012." Available at: https://www.cdc.gov/breastfeeding/data/nis_data/rates-any-exclusive-bf-socio-dem-2012.htm. Accessed on Accessed on 7-16-16.

[ix] Ibid.

[x] Mitchell-Box K, Braun K. "Impact of Male-Partner Focused Intervention on Breastfeeding Initiation, Exclusivity, and Continuation." *J Hum Lact*. 2013. 29: 473-479.

[xi] Stremler J, Lovera D. "Insight from a Breastfeeding Peer Support Pilot Program for Husbands and Fathers of Texas WIC Participants." *J Hum Lact.* 2004. 20: 417-422.

[xii] Grassley J, Eschiti V. "Grandmother Breastfeeding Support: What do Mothers Need and Want?" *Birth.* 2008. 35:329–335.

[xiii] Baby Cafés had either a Certified Lactation Consultant onsite or an International Board Certified Lactation Consultant available by telephone.

[xiv] Ehlinger E. "We Need a Triple Aim for Health Equity." *Minnesota Medicine*. October 2005: 28-29.

[xv] Ibid

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