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Supporting the 75%: Overcoming Barriers After Breastfeeding Initiation

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Introduction

There are many challenges to adequately supporting breastfeeding mothers in the primary care setting. Herein I will address: (1) what we mean by support; (2) the gap between initiation and duration that we hope to impact; (3) why women do not meet their goals and describe findings from our study on breastfeeding problems and cessation; (4) outline the challenges to support breastfeeding in primary care; and (5) briefly review the evidence around primary care interventions.

We often talk about protecting, promoting, and supporting breastfeeding. I was intrigued to find that essentially *all* of the definitions of support[1] apply. The first unfortunately applies too often to the status quo—as women *bravely endure* breastfeeding problems without enough other support. To *maintain a desired level or keep something going* could apply at either the individual or the public health level. *To assist or help* is primarily the focus of my talk, with emphasis on the clinical setting. But financial (*to pay the costs of*) and moral (*to keep from yielding*) support is also necessary.

According to the 2007 National Immunization Survey, 75% of infants born in our country are ever breastfed.[2] The mothers of these infants, the 75% of women who initiate breastfeeding, are the current focus. By 6 months, greater than 40% of mothers who initiate—almost one in two—are no longer breastfeeding, and by 12 months, almost three out of four have stopped. The 2020 goal is to increase the breastfeeding rate at 6 months to 60.5%, which represents a decrease to about one in four of the 81.9% targeted initiation rate stopping this early.[3] We would of course like to also support breastfeeding exclusivity among the initiators, and the 44.3% exclusive breastfeeding target at 3 months represents an increase from around 45% to about 55% of initiators. We can see that supporting women who initiate breastfeeding to do so more exclusively and for longer is where the 2020 goals focus—more than on increasing initiation rates.

So what are the barriers for breastfeeding mothers? We are familiar with many. For example, the recent retrospective study of Haughton et al.[4] of 162 Connecticut Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) participants reported that breastfeeding duration was related to whether the pregnancy was planned as well as the mothers' age and length of time residing in the United States. The most common reasons for stopping breastfeeding were age of the child, work, sore nipples (as we might expect, more common among those stopping earlier), breast refusal, lack of access to breast pumps, and free formula provided by WIC. A couple of these reasons suggest intent is relevant to duration: The *planned* pregnancy and weaning because of the child's age. The latter suggests the mothers had reached their intended breastfeeding duration. We wanted to know more about barriers that prevented mothers from reaching their intended breastfeeding duration and therefore studied early lactation success prospectively.

Early Lactation Success Outcomes at University of California Davis

Our objectives in the Early Lactation Success study at University of California Davis (K. Dewey et al., University of California Davis, unpublished data) were to compare actual versus intended breastfeeding duration and exclusivity (up to 2 months postpartum) and to describe breastfeeding problems and reasons for breastfeeding cessation. In 2006 and 2007, we recruited Spanish- or English-speaking women expecting their first liveborn child prenatally and collected data on prenatal breastfeeding intentions using the validated Infant Feeding Intentions Scale and breastfeeding problems and practices to 60 days with in-person visits at days 0, 3, and 7 and phone calls on days 14, 30, and 60. The sample of 448 mothers with healthy, term infants was very diverse. For example, 39% had a high school education or less, but nearly as many (36%) were college grads; there was nearly a 50:50 split with private versus public insurance (used as a proxy for income), and, as with California births overall, white, non-Hispanic mothers were a minority at 41%, with other race-ethnicities being well represented. Most relevant to this discussion is the strong breastfeeding intentions: 90% intended to breastfeed longer than 6 months, and of the 91% who intended to exclusively breastfeed, 84% intended to do so for at least 3 months.

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At each visit we collected data on breastfeeding problems (as perceived by the mother) occurring since the previous visit. Women were allowed to report more than one problem, which were then coded into broad themes. On day 3, the majority (53%) reported having had difficulties since the day 0 visit getting the baby to effectively feed (e.g., infant was too sleepy or wouldn't latch or suckle effectively). This was followed in frequency by breastfeeding pain, concerns about milk quantity, lack of confidence, and concerns about signs or symptoms of inadequate infant intake. Remarkably, *only 8% of mothers reported no problems*. By the day 7 visit, breastfeeding pain was the most commonly reported concern since the day 3 visit, with infant breastfeeding difficulty right behind. Concerns over milk quantity, lack of confidence, and infant intake remained prominent; *only 17% of these new mothers reported no breastfeeding problems between days 3 and 7*.

We asked mothers the degree of problem resolution (none, some, or complete) at each visit and whether they had received help from an outpatient nurse, lactation consultant, or physician. Although most mothers noted their problems were either fully or partially resolved at both days 3 (73%) and 7 (87%), only 49% of mothers reported full resolution by day 7. Furthermore, less than half of these mothers reported receiving support from anybody in the primary care setting—despite the early hospital follow-up visit. And without problem resolution, women give formula. In this same cohort, there was an astounding 44% incidence of delayed lactogenesis[5] and excess weight loss among 19% of exclusively breastfed infants.[6]

At 60 days, 23% of women were no longer breastfeeding—including eight mothers who intended to breastfeed less than 3 months but 94 who intended to breastfeed for longer. Remember 90% of these women intended to breastfeed longer than 6 months, so cessation by 2 months represents a greatly abbreviated duration. Forty-five percent were no longer exclusively breastfeeding—including 51 who intended to do so for less than 3 months but also 138 who intended to exclusively breastfeed longer than 3 months. In fact, there was a fairly constant rate of breastfeeding cessation over the first 2 months, not what we would expect if work was the major culprit. Why did mothers wean their babies? The primary reason to stop breastfeeding by day 3 was pain. Beyond that, by far the single most common reason was maternal concern about milk quantity.

Looking at the big picture, it seems the sequence is that the vast majority of first-time mothers have early breastfeeding problems (especially with pain, infant feeding difficulties, and milk supply), coupled with low confidence. Most problems are not fully resolved, resulting in early formula use—which in some cases may perpetuate the problem and/or creates new problems (via lesser supply from lesser demand or breast refusal) and reduces the duration of exclusive and any breastfeeding.

Discussion

Why did these women not receive adequate assistance in the primary care setting (or for too many, anywhere)? Barriers in our current healthcare systems abound. Ample studies document lack of knowledge about basic breastfeeding assessment and management of common problems among primary care providers.[7] Continuing education can be expensive, and content is typically discretionary. Assisting a breastfeeding dyad can be time intensive; problems at the early hospital follow-up visit may not be anticipated, and, accordingly, adequate time is often not allotted. Furthermore, payer reimbursement for this time is inconsistent. Other funding (e.g., grants) may not be sustainable.

What is the evidence about effective ways to support breastfeeding in the primary care setting? In a word, it is lacking. A systematic review and meta-analysis by Chung et al.[8] provide some guidance. Professional support at an individual level does improve "intermediate" breastfeeding rates. In general, programs with (vs. without) lay support are more effective, as are interventions combining both pre- and postnatal programs versus one or the other. We also know the American Academy of Pediatrics Breastfeeding Curriculum works—residents improved their knowledge, practice patterns, and confidence and their patients' exclusive breastfeeding rates.[9] Another recent study found that routine postdischarge lactation consultation coordinated with the primary care practice improves breastfeeding intensity.[10]

In sum, breastfeeding problems among primiparous women are nearly universal and are usually not fully resolved early on, resulting in less breastfeeding exclusivity and duration than mothers intend. Adequate support for mothers requires greater attention to prevention and resolution of these very common problems. Physicians and their staff must be competent to do so. Primary care interventions can improve breastfeeding durations, but lactation problems must be routinely addressed at early hospital follow-up visits. Can we do better at supporting breastfeeding in primary care? To quote a well-known gentleman here in Washington, "Yes we can!"

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Disclosure Statement

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