2020

# Breastfeeding and Reproductive Planning Guidance Document

INDIANA PERINATAL QUALITY IMPROVEMENT COLLABORATIVE [IPQIC]

Approved by the Governing Council, May 2020

# Contents

## Section I: Overview

### Goal:

The goal established for the Breastfeeding and Reproductive Planning Task Force was to develop a guidance document that provided evidence-based information regarding breastfeeding and reproductive planning. This guidance document is designed to support a woman's right to make an informed choice related to postpartum family planning options through shared decision-making while endeavoring to fully support her choice to breastfeed.

### Rationale:

Indiana has a long history of infant and maternal mortality rates that place the state in the bottom ten of states consistently. Indiana currently ranks 42nd for infant mortality and 47th for maternal mortality, with definitive differences based on race and income.[1] [2] Birth spacing and breastfeeding are both evidence-based strategies that are known to reduce maternal and infant mortality and morbidity.[3] [4] [5] The most effective way to assure birth spacing is to use a contraceptive method. There are both hormonal and non-hormonal methods of contraception and those that have been shown to be the most effective with the lowest failure rates are known as long acting reversible contraception (LARC). Research on the importance of breastfeeding as it relates to optimal maternal and infant health is well established. According to the World Health Organization (WHO), the evidence for these health advantages and recommendations for optimal practices continue to grow.[6] The WHO considers breastfeeding a well-researched prevention strategy for reducing child mortality, maternal morbidity, and improving greatly the health and well-being of mom and baby throughout the lifespan. Equally well established is the efficacy of birth spacing for improving maternal and infant outcomes. Optimal birth spacing improves the chances of healthy subsequent pregnancies, promoting term deliveries. The American Academy of Pediatrics (AAP) recommends breastfeeding as the primary nutrition for the first 6

[1] https://www.americashealthrankings.org/explore/annual/measure/IMR/state/IN
[2] https://www.usnews.com/news/best-states/articles/2019-06-12/these-states-have-the-highest-maternal-mortality-rates
[3] https://www.acog.org/Clinical-Guidance-and-Publications/Obstetric-Care-Consensus-Series/Interpregnancy-Care?IsMobileSet=false
[4] https://www.acog.org/-/media/Committee-Opinions/Committee-on-Obstetric-Practice/co736.pdf?dmc=1&ts=20190222T1814547421
[5] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5651965/
[6] https://www.who.int/mediacentre/news/statements/2011/breastfeeding_20110115/en/

months of life and prime complementary feeding thereafter up until 1 year or mother and baby desire to stop.[7]

This document was developed with the reproductive justice framework. This means it is a "human right to maintain personal bodily autonomy, have children, not have children and parent the children we have in safe and sustainable communities."[8] We hope that the following information and recommendations will be used to make informed decisions that will be respected, supported and honored by all those on the care team. We also acknowledge that decisions on contraception are not static and change over time, as well as with different circumstances. Therefore, the importance of ongoing conversations and access to healthcare are vital to assure that the needs of people in our state are met.

Document Creation Process: This document was created by a committee that was convened by the Indiana Perinatal Quality Improvement Collaborative (IPQIC) in 2019 and was comprised of community stakeholders, lactation specialists, clinicians and public health experts. Peer-reviewed, published literature was reviewed and discussed. Limitations included having studies with different outcomes (milk production and quality, breastfeeding initiation, breastfeeding at 6wks, 3mos, 6mos, etc) and conclusions applying to uncomplicated delivery and newborn periods, which presented challenges in terms of ability to compare them. Due to the logistic challenges of conducting breastfeeding research, some studies were not large or conclusive. The committee also relied on large organization recommendations, choosing the United States Centers for Disease Control and Prevention, Medical Eligibility Criteria (US CDC MEC) given the population and audience for which these recommendations were intended.

## Intended Audience

This guidance document is intended to be used by a variety of stakeholders: new mothers and their partners, lactation consultants, nurses, midwives, physicians, employees of the Special Supplemental Nutrition Program for Women, Infants and Children (WIC), community advocacy organization, healthcare organizations and providers to inform their counselling to the families they serve. The goal is to help assure information and messages being received is consistent. Conversations regarding post-partum contraception and feeding plans should be started during the pregnancy and continued for at least one-year post-partum.

[7] https://pediatrics.aappublications.org/content/129/3/e827
[8] https://www.sistersong.net/reproductive-justice

## Abbreviations

AAP: American Academy of Pediatrics
ABM: Academy of Breastfeeding Medicine
ACOG: American College of Obstetrics & Gynecology
CDC: Centers for Disease Control
CHC: Combined Hormonal Contraception
COC: Combined Oral Contraception
DMPA: Depo Medroxyprogesterone Acetate
IUD: Intrauterine Device
IPQIC: Indiana Perinatal Quality Improvement Collaborative
LAM: Lactation Amenorrhea
LARC: Long-Acting Reversible Contraception
POP: Progestin Only Pill
US MEC: United States Medical Eligibility Criteria
VTE: Venous Thromboembolism
WHO: World Health Organization

## Section II: Recommendations

- Contraceptive planning and breastfeeding intentions should be incorporated into all prenatal care as well as postpartum and pediatric care (IMPLICIT toolkit https://www.marchofdimes.org/professionals/implicit-interconception-care-toolkit.aspx)
- Clinical systems and providers should incorporate the World Health Organization 10 steps for Successful Breastfeeding (https://www.who.int/activities/promoting-baby-friendly-hospitals/ten-steps-to-successful-breastfeeding.) (Also, in Appendix C) and promptly refer to lactation support for women having any concerns
- Postpartum Medicaid coverage should be extended to one year post-delivery as per national ACOG recommendations (https://www.acog.org/About-ACOG/ACOG-Departments/State-Legislative-Activities/Giving-Medicaid-Insured-Women-12-Months-of-Coverage-After-Delivery?IsMobileSet=false). This will enable the following to be feasible:
    - Continued management and treatment of chronic illnesses as well as primary care
    - Access to reproductive health care (including contraception) and lactation support.
- Medicaid transportation guidelines should expand to include appointments for lactation support and reproductive planning that are at non-clinical sites

- Promote shared decision making and informed consent with all medical decisions—in particular, those around contraception and breastfeeding.
- Contraception counseling should include a discussion of benefits, side effects and/or discontinuation options at the time of initiation.
- Assure access to providers for no-cost removal of long-acting reversible contraception devices (if desired) and continued support for side-effects of methods of contraception. If telemedicine is an option, it can be incorporated.
- Standardized breastfeeding reimbursement for breastfeeding support – both Medicaid and commercial insurance (talk to Dept of Insurance) and allow reimbursement for a broader spectrum of lactation support and counseling
- Cultural competency and implicit bias training should be available to all practitioners, but especially those interacting with women of child-bearing ages. These trainings should be a required part of state licensure requirements.
- We acknowledge that personal or institutional barriers to contraception provision exist. However, counseling and referral mechanisms should be in place for every patient. Mechanisms for referral should exist without the introduction of bias or burden for the patient.
- Women should have same-day access to all methods of contraception and lactation support.
- Address breastfeeding intentions and progress at every opportunity, especially if there is a change in contraception method
- Have patient materials summarizing contraception methods and their impact on breastfeeding and future fertility
- Continue to examine state-wide breastfeeding rates, contraception use (through pharmacy claims and billing data) and infant/maternal mortality rates
- Examine barriers to contraception and lactation support within the state
- Assure that staff reflects the racial and cultural patient populations being served

## Section III: Cultural Competency

Cultural competency is an important element that is integral to care for all patients, especially women of reproductive age. Thirty-eight percent of women in the US are members of a racial or ethnic minority, and while Indiana has a lower proportion of minorities, those demographics are changing over time.[9] [10] As a health care community, institutions must raise awareness of racial and ethnic disparities in medicine. These issues are complex, and this document will not be able to fully address all the aspects that should be considered; however, a brief overview of data and factors to consider are discussed below.

## Disparities in Breastfeeding and Reproductive Planning – What are they?

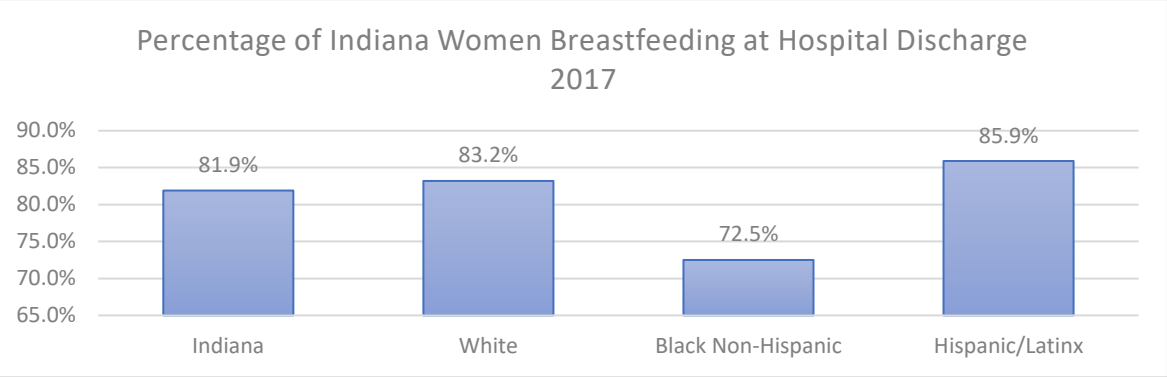
Disparities exist between racial and ethnic groups with regards to both breastfeeding initiation/duration as well as contraception use independent of known socioeconomic influences like education, age, marital status, and income.[11] As these factors often correlate with race, such patterns may reflect a bigger systemic barrier for care among women of non-white racial groups.

## Breastfeeding Disparities

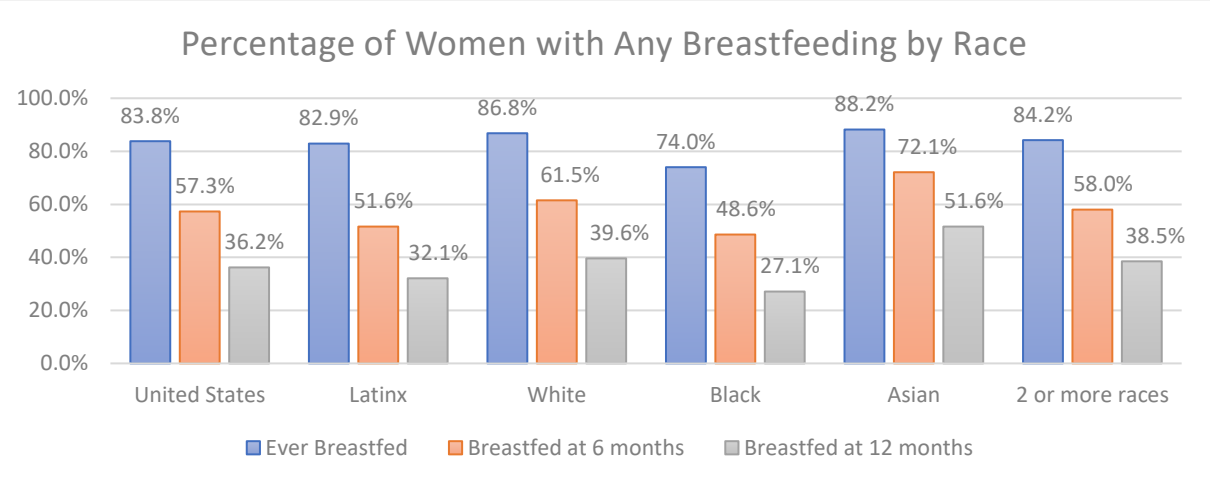
Birth certificate data from 2017 show significant disparities in the rate of breastfeeding initiation in Indiana, such that black, non-Hispanic women are far less likely to report breastfeeding than non-Hispanic white and Hispanic/ Latina women.[12] These patterns mirror national trends. [13] Although not depicted in these figures, Native American/American Indian/Alaska Native populations also have lower rates of breastfeeding initiation and duration, only slightly above the rates for documented Black women.

[9] https://www.americanprogress.org/issues/race/reports/2012/07/17/11923/the-state-of-women-of-color-in-the-united-states/
[10] http://worldpopulationreview.com/states/indiana-population/
[11] Dehlendorf C et al., Disparities in family planning, American Journal of Obstetrics & Gynecology, 2010, 202(3):214–220. 14.
[12] Indiana State Department of Health, Maternal & Child Health Epidemiology Division [November 1, 2018]
Indiana Original Source: Indiana State Department of Health, PHPC, ERC, Data Analysis Team
[13] https://www.cdc.gov/mmwr/volumes/68/wr/mm6834a3.htm

### Indiana Breastfeeding Data[14]




### *National Breastfeeding Data[15]*

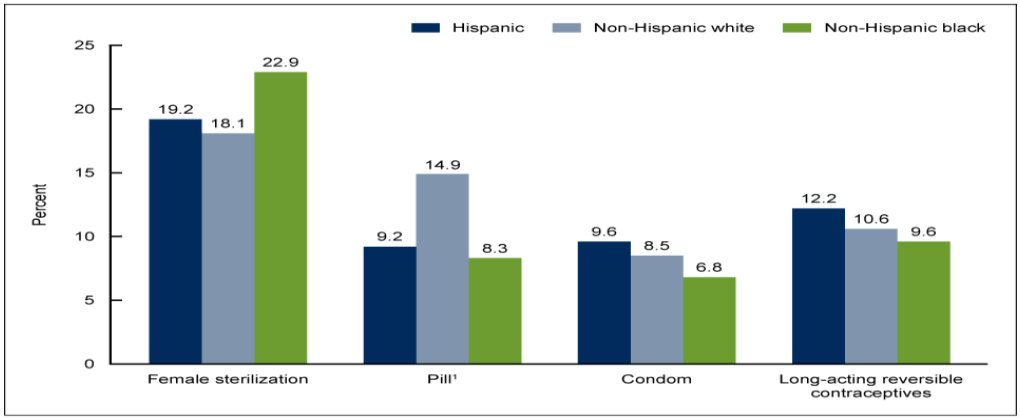



## Reproductive Planning and Use Disparities

There are also marked racial and ethnic differences in the use of contraception among US women.[16] Rates of hormonal contraceptive use are lowest for black women when compared with their Hispanic, Asian, and white counterparts; however, black women have the highest rates of sterilization. While informed consent and shared decision-making have been shown to increase patient knowledge and uptake of contraception, particularly LARC devices, more information about the root of these disparities is needed to help empower patients in their family planning decisions.[17]

[14] Indiana State Department of Health Natality Report http://www.in.gov/isdh/reports/natality/2017/index.html
[15] https://www.cdc.gov/mmwr/volumes/68/wr/mm6834a3.htm
[16] https://www.guttmacher.org/fact-sheet/contraceptive-use-united-states
[17] https://www.ncbi.nim.nih.gov/pmc/articles/PMC3039305/

Percentage of all women aged 15-49 using Contraception by Race/Ethnicity, US 2015-2017[18]




¹Percentages for Hispanic and non-Hispanic black are significantly different from percentage for non-Hispanic white.

## Factors Leading to Health Disparities

While not exhaustive, the following factors could underly the racial and ethnic differences in breastfeeding and contraceptive use:

### *Historical Trauma*.[19]

During slavery, black women breastfed white slave owners' infants and this "wet nurse" image still resonates and impacts some women's decision to breastfeed today. Other breastfeeding beliefs in the black culture persist from slavery, including not "spoiling" the baby and promoting independence. Black women who were slaves believed breastfeeding would coddle their babies, reducing their likelihood of survival, so many did not breastfeed their babies, even if they were able. Many black women were forced to reproduce during slavery and federally funded forced sterilization, which disproportionately affected black women, was legal in 32 states until the late 1970's. These discriminatory practices disrupted the relationship between women of color and family planning providers and has not yet been adequately addressed by the medical community. This legacy has implications for breastfeeding and contraceptive use today. Reproductive justice has been a hard-fought battle for women of color, but an important element given this historical context.

### *Access to Services*.

Access to healthcare is a barrier that is tied not only to race, ethnicity and income, but also geography. Families in rural areas often live prohibitively far from breastfeeding and family planning services. Indiana, in particular, has large areas where primary care, including obstetrical care, contraception

[18] https://www.cdc.gov/nchs/products/databriefs/db327.htm
[19] http://centaur.reading.ac.uk/66788/7/article%20%281%29%20%281%29.pdf

access and lactation support are not available.[20] [21] [22] Public transportation is not always an option and the Medicaid cab system does not support trips to non-medical appointments, including those to lactation specialists (when they are not embedded within a clinical system), WIC clinics, hospital/community support groups, or family planning providers, such as Planned Parenthood.

### *Clinician Knowledge*.

Comprehensive and culturally specific patient-centered care for lactation, family planning, and contraception are not core components of medical and nursing school education or requirements for continued licensure/certification. Information about community breastfeeding services is not always available in medical facilities, and when referrals are made, they may not be to appropriate lactation support, particularly culturally represented care for women of color. Furthermore, research has shown that reproductive health counselling differs based on the racial and ethnic identity of patients.[23]

### *Patient Factors.*

Knowledge regarding contraception options and the benefits of breastfeeding is not universal for all women.[24] [25] Lack of access to knowledgeable providers and inexperience interacting with the health care system may exacerbate this issue. Additionally, immigration status affects not only insurance coverage options but also women's comfort and ability to seek family planning services.[26] Data has shown that if providers do not speak patients' native language or have appropriate interpreter services, they are less likely to consent to contraception.[27]

### *Social Norms*.

Cultural beliefs and social norms influence a mother's feeding practices. Women are more likely to breastfeed if those around them have done so, whereas negative attitudes towards breastfeeding may deter a woman. African American women cite inadequate support from family, peers, employers and

[20] Indiana State Department of Health. Health professional shortage area & medically underserved area designations. https://www.in.gov/isdh/23471.htm. Published 2016.

[21] Unal E, Chen S, Waldorf B. Healthcare access in Indiana. https://pcrd.purdue.edu/files/media/Healthcare-Access-in-Indiana.pdf. Published 2008.

[22] Indiana Primary Health Care Association. Indiana primary health care access plan, 2017-2018. https://www.ic4n.org/wp-content/uploads/2017/11/Indiana-Primary-Health-Care-Access-Plan-2017-2018.pdf. Published 2016.

[23] https://www.ncbi.nlm.nih.gov/pubmed/17761569
https://www.ncbi.nlm.nih.gov/pubmed/20598282

[24] Guendelman S et al., Perceptions of hormonal contraceptive safety and side effects among low-income Latina and non-Latina women, Maternal and Child Health Journal, 2000, 4(4):233–239.

[25] Sangi-Haghpeykar H et al., Disparities in contraceptive knowledge, attitude and use between Hispanic and non-Hispanic whites, Contraception, 2006, 74(2):125–132

[26] kff.org/report-section/beyond-the-numbers-access-to-reproductive-health-care-for-low-income-women-in-five-communities-executive-summary/.

[27] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4410446/pdf/bfm.2014.0152.pdf

health care providers as the most common reason for not breastfeeding.[28] The effects of intergenerational cultural behaviors are further demonstrated by higher rates of breastfeeding among immigrant women despite sociodemographic differences, as it is the standard feeding method in most other global countries. However, as 2nd and 3rd generation immigrant families acclimate, breastfeeding rates decrease over time. Often, black and Latinx women do not want to breastfeed in public and are more widely criticized for immodesty. [29]

### *Employment and Insurance.*

Women of lower socioeconomic status often lack maternity leave and return to work sooner than their counterparts, making breastfeeding more of a challenge. In addition, many of these women work in environments where breastfeeding is not convenient or supported by their employers, despite federal laws.[30] Moreover, 86% of US employees have no access to paid parental leave.[31]

Insurance coverage for contraception is provided under the Affordable Care Act in 36 states plus the District of Columbia, but persistent barriers to coverage exist and pregnancy-related coverage typically ends at 60 days postpartum currently in Indiana.[32] [33] Uninsured, underinsured and women of color are most affected by lack of coverage.

### *Implicit Bias & Institutional Racism.*

Implicit bias and institutional racism are also major contributing factors to breastfeeding and contraception use. For example, hospital policies that guide individual practice may contribute to disparities, with research indicating less breastfeeding education for African American women.[34] Furthermore, black and Latina mothers are 9 times more likely to be offered in-hospital formula supplementation, lessening the likelihood of breastfeeding successfully. Disparities in contraception counselling and provision have also been noted in the literature.[35]

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[28] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3543999/pdf/nihms428791.pdf
[29] https://www.ncbi.nim.nih.gov/pmc/articles/PMC4410446/pdf/bfm.2014.0152.pdf
[30] https://www.dol.gov/whd/nursingmothers/
[31] https://www.pewresearch.org/fact-tank/2017/03/23/access-to-paid-family-leave-varies-widely-across-employers-industries/
[32] https://www.kff.org/report-section/beyond-the-numbers-access-to-reproductive-health-care-for-low-income-women-in-five-communities-executive-summary/
[33] https://www.ajmc.com/contributor/susan-kreimer/2016/10/barriers-to-acas-contraception-mandate-remain-part-i
[34] http://files.kff.org/attachment/Executive-Summary-Beyond-the-Numbers-Access-to-Reproductive-Health-Care-for-Low-Income-Women-in-Five-Communities
[35] https://www.ncbi.nlm.nih.gov/pubmed/17761569 https://www.ncbi.nlm.nih.gov/pubmed/20598282 https://pediatrics.aappublications.org/content/138/2/e20152388#T3

Providers may not know the history, social and cultural behaviors, or barriers related to family planning and breastfeeding in black, Latinx, or other communities' cultures. However, factors such as implicit bias and racial stereotyping by health care providers contribute to disparities in health, and all providers must be educated on their role in providing culturally sensitive care to differing ethnic groups. In addition, institutional systems must openly and honestly address inherent biases and train providers to recognize and mitigate those biases, creating a system for more equitable outcomes in infant feeding and family planning

### Summary/Conclusion

Acknowledging the importance of cultural competency and incorporating this into reproductive health planning and breastfeeding support are critical elements. In addition, efforts to assure diversity in both the breastfeeding and family planning workforce are critical to assuring representation reflects the communities served. Community-engagement strategies must be designed to disseminate information to all communities, especially ones that have a history of exclusion.

## Section IV: Patient-Centered Counseling

As with many medical treatments, the most effective therapy is the one the patient will use. Therefore, the most important thing any provider can do to help a patient choose a method for birth spacing is to explore a patient's priorities for both feeding and family planning and to use those priorities to guide contraception choice. Negative prior experiences and preconceived notions about feeding method and contraception are common. It behooves providers to develop an approach to counseling that recognizes this and asks patients to share concerns, while also encouraging them to consider all options against the rubric of their personal priorities.

Topics to assist with this process of values clarification might include the following:

1. Feeding plans: At this point, do you have a plan for how you will feed your baby? What have you heard from others about options for feeding? What concerns do you have about you or baby that would impact your decision? This process of values clarification can open a conversation about the benefits and challenges of all feeding options, and provides an opportunity to address fears, correct misconceptions, and prepare for the postpartum period.

   For those mothers who plan to feed with breast milk, additional questions can help guide contraception choice. Are there any factors about your delivery that might make feeding breast milk more difficult (e.g. preterm delivery, multiple gestation, or postpartum complications)? If you plan to feed the baby breast milk, do you intend to use exclusively breast milk or a combination of milk and

formula? Do you intend to put baby to breast, exclusively pump, or use both methods? Do you plan to use breast milk for feeding for a few weeks, a few months, or until the baby self-weans? These plans can guide the choice of both type and timing of contraception initiation.

2. Family size: Have you completed childbearing? If so, tubal ligation or vasectomy would be a reasonable option.
3. Birth spacing: How long do you desire to wait before your next child? It is important to discuss the advantages of waiting at least 18 months between pregnancies, but a provider must also recognize that other patient priorities that may outweigh those advantages. For example, a patient may desire siblings close in age, or she may have had difficulty conceiving and be averse to delaying the next attempt, or she may be an older mother who prefers to minimize the risks of maternal age in subsequent pregnancies.
4. Menstrual cycles: Are regular cycles important to you? If so, either hormone-free or cyclic combined contraception regimens are likely to be preferable to various progesterone-only options.
5. Ease of use: What is the easiest way for you to use contraception? Some patients already have a regimen that includes daily medication, in which case adding a birth control pill might be very easy for them. Others, though, may work irregular hours or not be in the habit of daily medication, in which case a LARC may be a better choice.
6. Discontinuation: Is it important for you to be able to self-discontinue your contraception? For patients with insecure access to medical care, the need to see a provider to remove a LARC may be a barrier to use.
7. Return to Fertility: It is important to discuss the time between discontinuation and return to fertility for various methods with patients as this may impact their plans for subsequent pregnancies and timing. This is also helpful to dispel any misinformation that the patient may have regarding methods and the ability to get pregnant after use.
8. Desire for private contraception: Do you want discreet contraception that is not apparent to partners, friends, or family? If so, an intrauterine device or injection may be preferable to oral contraception or the contraceptive patch.
9. Timing of contraception: Do you want contraception before discharge from the hospital or at your postpartum visit? Recognizing that many patients are unable to attend their postpartum visit, or have had intercourse prior to that visit, waiting until the postpartum visit may not be ideal for everyone. Addressing this in a non-judgmental way with patients, and discussing which options are appropriate in the immediate postpartum, would assist those patients who desire contraception prior to hospital discharge to access it. Note that many options for immediate postpartum contraception, including subdermal and intrauterine devices, are not FDA approved for immediate postpartum use; however, off-label use is common and standard of practice in many clinical settings. Because this information is included in the package insert, it is useful to have a brief script in mind

that discusses the rationale for off-label medication use and available safety and efficacy data to address any concerns about that package information.

This is a lot to cover in any one visit, and it may require quite a bit of reflection and discernment for the patient. As such, it is best to initiate a discussion of contraception plans early in the course of prenatal care and readdress them at every visit. This allows ample time for the patient to consider options and to ask any questions that may help her to make the choice that best meets her needs. Because some faith-based institutions and insurance plans may have restrictions on what options are available either in the hospital or in the outpatient setting, an early discussion of desires and limitations also allows the patient to understand options available to her and to plan accordingly.

## Section V: Method

There are two major contraceptive method categories for consideration :

- Hormonal contraception
- Non-Hormonal Contraception

The following tables address the different methodologies in these two categories.

## Hormonal Contraception Methods

There are five methods of hormonal contraception that can be categorized in two forms:

- Progestin only:
    - Intrauterine device (IUD) contraception
    - Contraceptive Implant
    - Injectable contraception, Depot medroxyprogesterone acetate (DMPA)
    - Progesterone only pill (POP) contraception
- Combined (progestin and estrogen):
    - Oral Contraceptive Pill (OCP), Transdermal Patch, Vaginal Ring

For all hormonal methods, use medical judgement for patients with a history of low milk supply, prior breastfeeding difficulties, or a premature infant.

| Progestin-only hormonal intrauterine device (IUD) | |
|---|---|
| What types are available? | The most commonly used hormonal IUDs are the two brands of 52mg levonorgestrel-releasing IUDs (Mirena® and Liletta®), which are both FDA-approved for pregnancy prevention for up to 5 years of use (although evidence shows they continue to work for up to 7 years). There are also two lower dose levonorgestrel-releasing IUDs, the Skyla® (13.5mg, approved for up to 3 years) |

| Progestin-only hormonal intrauterine device (IUD) | |
|---|---|
| | and the Kyleena® (19.5mg, approved for up to 5 years). There have not been any studies that compare hormonally related side effects of the different IUDs. |
| How does it work? | It works by preventing ovulation, thickening cervical mucus, and thinning the lining of the uterus to make it less likely for pregnancy to occur. |
| How do you use it? | An IUD is inserted through the cervix and into the uterus by a clinician. |
| How well does it work? | With typical use—less than 1 woman out of 100 (0.2%) will become pregnant during the first year of using this method. [36] |
| When can this be started? | IUDs can safely and easily be placed immediately after delivery (either vaginal or Cesarean) or at a postpartum follow-up visit (as early as 2 weeks after delivery). Insertion immediately after delivery can help prevent rapid repeat pregnancy (pregnancies too close together), especially for women who may have difficulty following up after delivery. However, when IUDs are placed immediately after a vaginal delivery, there is an ~10-20% risk of expulsion (falling out), compared to <5% risk when they are placed immediately after a Cesarean delivery or when they are placed >4 weeks after delivery.[37] |
| Is there evidence of an effect on breastfeeding? | No.<br>While there is concern that insertion immediately after delivery may interfere with early hormonal changes required for breastfeeding, most evidence shows there is very low risk of difficulty with breastfeeding due to receiving a hormonal IUD immediately after delivery or at your postpartum visit. Multiple studies have shown no difference in onset of milk production, overall or exclusive breastfeeding rates, or infant growth when comparing women who received a hormonal IUD immediately after delivery vs. waited until 4-8 weeks after delivery or when |

[36] CDC https://www.cdc.gov/reproductivehealth/unintendedpregnancy/pdf/family-planning-methods-2014.pdf

[37] Jatlaoui TC, Whiteman MK, Jeng G, Tepper NK, Berry-Bibee E, Jamieson DJ, Marchbanks PA, Curtis KM. Intrauterine device expulsion after postpartum placement: A systematic review and meta-analysis. *Obstet Gynecol* 2018;132:895-905.

| Progestin-only hormonal intrauterine device (IUD) | |
|---|---|
| | comparing women who received a hormonal IUD vs. a non-hormonal IUD at 6-8 weeks postpartum.[38 39 40] |
| Does it increase thromboembolic disease risk? | No. |

| Contraceptive Implant | |
|---|---|
| What types are available? | Nexplanon® is the only available contraceptive implant in the US. It is a single-rod etonogestrel-releasing implant, which is FDA-approved for pregnancy prevention for up to 3 years (although evidence shows it continues to work for up to 5 years). |
| How does it work? | It works by preventing ovulation, thickening cervical mucus, and thinning the lining of the uterus to make it less likely for pregnancy to occur. |
| How do you use it? | The implant is a tiny rod that's inserted under the skin of the upper arm. It's so small, most people can't see it once it's inserted |
| How well does it work? | With typical use—less than 1 woman out of 100 (0.05%) will become pregnant during the first year of using this method.[41] |
| When can this be started? | Implants can safely and easily be placed during your hospital stay after delivery (either vaginal or Cesarean) or at a postpartum follow-up visit at any time. Insertion immediately after delivery can help prevent rapid repeat pregnancy (pregnancies too close together), especially for women who may have difficulty following up after delivery. |

[38] Braniff K, Gomez E, Muller R. "A randomised clinical trial to assess satisfaction with the levonorgestrel-releasing intrauterine system inserted at caesarean section compared to postpartum placement." Aust N Z J Obstet Gynaecol. 55: 279–283.

[39] Turok DK, Leeman L, Sanders JN,et al. Immediate postpartum levonorgestrel intrauterinedevice insertion and breast-feeding outcomes: a non-inferiority randomized controlled trial. Am J ObstetGynecol 2017;217:665.e1-8.

[40] Shaamash AH, Sayed GH, Hussien MM, Shaaban MM. A comparative study of the levonorgestrel-releasing intrauterine systemMirenaRversus the Copper T380A intrauterine device during lactation:breast-feeding performance, infant growth and infant developmentContraception 72 (2005) 346–351

[41] CDC https://www.cdc.gov/reproductivehealth/unintendedpregnancy/pdf/family-planning-methods-2014.pdf

| | |
|---|---|
| Is there evidence of an effect on breastfeeding? | No.<br>Because the implant contains similar hormone to the hormonal IUD, there is the same concern that insertion immediately after delivery may interfere with early hormonal changes required for breastfeeding. But similar to the hormonal IUD, many studies have shown that it does not impact breastfeeding. Multiple studies showed no difference in onset of milk production, overall or exclusive breastfeeding rates, or infant growth for women who received the implant within 5 days of delivery vs. women who did not receive any contraception or who received an implant 4-8 weeks after delivery. |
| Does it increase thromboembolic disease risk? | No. |

| **Injectable Contraception Depo medroxyprogesterone acetate (DMPA)** | |
|---|---|
| What types are available? | Depo medroxyprogesterone acetate (DMPA) is an injectable contraceptive given every 12-13 weeks). |
| How does it work? | It works by preventing ovulation, thickening cervical mucus, and thinning the lining of the uterus to make it less likely for pregnancy to occur. |
| How well does it work? | With typical use— meaning that the method may not always be used consistently or correctly - approximately 6 women out of 100 (6%) will become pregnant during the first year of using this method. [42] |
| How do you use it? | An injection every 12 weeks |

[42] CDC

| Injectable Contraception Depo medroxyprogesterone acetate (DMPA) | |
|---|---|
| When can this be started? | Immediately postpartum or any time in the postpartum period. To minimize the risk of early pregnancy in the postpartum period, DMPA should be administered prior to hospital discharge and no later than the third postpartum week.[43] |
| Is there evidence of an effect on breastfeeding? | No.<br>While there is concern that DMPA immediately after delivery may interfere with early hormonal changes required for breastfeeding, most evidence shows there is very low risk of difficulty with breastfeeding due to receiving DMPA immediately after delivery or at your postpartum visit.[44] [45] [46] [47] |
| Does it increase thromboembolic disease risk? | No. |

| Progesterone Only Pills (POPs) | |
|---|---|
| What types are available? | • Northethindrone (0.35mg)-28 active pills<br>  ○ Most common progesterone only pill utilized in the United States<br>  ○ Taken continuously (there is no "pill-free" or "nonhormonal pill" week as with estrogen-progesterone pills<br>• Drospirenone (4mg)-24 active pills/4 placebo bills<br>  ○ MUST be taken at the same time each day; if >3 hours late or a dose is missed back-up contraception is needed for at least 2 days. |

[43] Rodriguez-2009, https://www.ncbi.nlm.nih.gov/pubmed/19501209
[44] Jimenez, Contraception 1984
[45] Pardthaisong Contraception 1992
[46] Karim, Br Med Journal 1971
[47] Halderman Am J Obstet Gynecol 2002;186:1250-8).

| Progesterone Only Pills (POPs) | |
|---|---|
| How does it work? | It works by preventing ovulation, thickening cervical mucus, and thinning the lining of the uterus to make it less likely for pregnancy to occur.[48] |
| How do you use it? | You take a pill every day at the same time. |
| How well does it work? | With typical use— meaning that the method may not always be used consistently or correctly --approximately 9 women out of 100 (9%) will become pregnant during the first year of using this method. However, this method is sensitive to timing and missed doses. The effective rate may be lower if either of these conditions exist.[49] |
| When can this be started? | Immediately after delivery and any time afterwards, regardless of breastfeeding status. |
| Is there evidence of an effect on breastfeeding? | No.<br><br>A systematic review of progestogen-only contraceptives and their impact on breastfeeding outcomes reviewed 47 different studies.[50] Breastfeeding outcome measures were defined as breastfeeding duration, initiation of supplemental feeding and weaning. The authors also reviewed infant outcomes related to infant growth, health and development. The authors' concluded the available evidence does not suggest that POPs have a negative impact on breastfeeding duration, breastmilk or infant growth regardless of whether they are initiated POPs contraceptives prior to 6 weeks post-delivery or after. |
| Does it increase thromboembolic disease risk? | No |

[48] Kaunitz, 2019
[49] https://www.cdc.gov/reproductivehealth/unintendedpregnancy/pdf/contraceptive_methods_508.pdf
[50] Phillips, et al., 2016

| Oral Contraceptive Pill (OCP), Transdermal Patch, Vaginal Ring Combined Methods | |
|---|---|
| What types are available? | Combined contraceptives are available in the oral contraceptive pill, transdermal patch, and intravaginal ring delivery formulations. |
| How does it work? | They all provide estrogen and progesterone together to prevent ovaries from releasing eggs, thickens the cervical mucous and thinning the lining of the uterus to make it less likely for pregnancy to occur. |
| How do you use it? | • Oral Contraceptive Pills (OCPs): Also known as combined oral contraceptives (COCs). The pill is taken each day, although it is somewhat forgiving if one pill is forgotten, it can be made up the following day. Missing more than one dose, however, increases the failure rate of this contraceptive.<br>• Patch: The patch is applied to the upper arm, belly, buttocks or back once weekly for three weeks of a four-week cycle. The fourth week, no patch is placed, and menses occurs.<br>• Ring: The intravaginal ring is placed in the vagina and removed after 21 days. It delivers estrogen and progesterone through the vaginal mucosa. It is left out for 7 days during which menses occurs. |
| How well does it work? | With typical use—meaning that the method may not always be used consistently or correctly—9 women out of 100 (9%) will become pregnant during the first year of using these methods. [51] |
| When can it be started? | Thirty (30) days after delivery or any time after that point. No combined hormonal contraceptives should be used in the first 30 days postpartum. |
| Is there evidence of an effect on breastfeeding? | Yes.<br><br>There is fair evidence that estrogen use in the first 30 days postpartum can affect milk supply and breastfeeding duration. Most evidence suggests that after 30 days, breastfeeding and |

[51] https://www.cdc.gov/reproductivehealth/unintendedpregnancy/pdf/contraceptive_methods_508.pdf

| Oral Contraceptive Pill (OCP), Transdermal Patch, Vaginal Ring Combined Methods | |
|---|---|
| | milk supply are unlikely to be affected by estrogen in combined contraceptives. |
| Does it increase thromboembolic disease risk? | Yes. |

## Non-Hormonal Contraception Methods

There are three non-hormonal contraceptive methods:

- Copper intrauterine device (IUD)
- Lactational Amenorrhea Method
- Barrier Methods including:
  - Condoms
  - Withdrawal
  - Fertility Awareness
  - Spermicide

| Copper IUD | |
|---|---|
| What types are available? | Paragard® is the only FDA approved device in the US and can be used up to 10 years. |
| How does it work? | The copper IUD prevents pregnancy by killing/paralyzing sperm. |
| How do you use it? | A copper IUD is inserted through the cervix and into the uterus by a clinician. |
| How well does it work? | With typical use—less than 1 women out of 100 (0.8%) will become pregnant during the first year of use.[52]<br>Each year after the copper IUD is placed, effectiveness improves. |
| When can this be started? | It can be placed immediately after delivery or any time after 30 days postpartum. It can also be placed within 5 days of unprotected intercourse as a form of emergency contraception.[53]<br>When IUDs are placed immediately after a vaginal delivery, there |

[52] https://www.cdc.gov/reproductivehealth/unintendedpregnancy/pdf/contraceptive_methods_508.pdf

[53] WHO Medical Eligibility Criteria and Centers for Disease Control and Prevention Summary Chart of US Medical Eligibility Criteria for Contraceptive Use Updated June 2012

| Copper IUD | |
|---|---|
| | is an ~10-20% risk of expulsion (falling out), compared to <5% risk when they are placed immediately after a Cesarean delivery or when they are placed >4 weeks after delivery.[54] |
| Is there evidence of an effect on breastfeeding? | No.<br>Because the copper works locally on the uterus, it has no systemic effect and thus, no effect on breastmilk production.[55] |
| Does it increase thromboembolic disease risk? | No. |

| **Lactational Amenorrhea Method** | |
|---|---|
| What types are available? | NA |
| How does it work? | The lactational amenorrhea method works by suppressing ovulation by maintaining a high prolactin level due to frequent breastfeeding.[56]<br><br>Women must be able to answer "yes" to all three questions for the LAM method to be effective:<br><br>1. "Are you amenorrhoeic?" Bleeding in the first 56 days postpartum is discounted. Any two days of consecutive bleeding after 56 days postpartum is considered menstrual bleeding.<br>2. "Are you fully or nearly fully breastfeeding?" Infants receiving supplementary foods or formula would put the mother at risk of return of fertility.<br>3. "Is your infant less than 6 months of age?" |

[54] Jatlaoui TC, Whiteman MK, Jeng G, Tepper NK, Berry-Bibee E, Jamieson DJ, Marchbanks PA, Curtis KM. Intrauterine device expulsion after postpartum placement: A systematic review and meta-analysis. *Obstet Gynecol* 2018;132:895-905.

[55] Rodrigues de Cunha AC1, Dorea JG, Cantuaria AA. Intrauterine device and maternal copper metabolism during lactation. Contraception 2001; 63; 37-39

[56] Carolina Global Breastfeeding Institute Department of Maternal and Child Health, Gillings School of Global Public Health, University of North Carolina, Chapel Hill, North Carolina.)

| Lactational Amenorrhea Method | |
|---|---|
| How well does it work? | In first six months postpartum, if all three criteria are met, the LAM method is fairly effective at pregnancy prevention. A Cochrane review showed pregnancy rates in women using LAM were 0.45% to 2.45% in controlled studies. In uncontrolled studies, pregnancy rates were 0% to 7.5%. [57] This method is no longer effective after six months or when no longer exclusively breastfeeding. |
| When can this be started? | The LAM method, by definition, starts immediately after delivery. Women choosing LAM should have an alternative contraceptive method easily and readily available should she choose to stop breastfeeding, change her contraceptive method or should one of the required "yes" answers change to "no."[58] |
| Is there evidence of an effect on breastfeeding? | No. |
| Does it increase thromboembolic disease risk? | No. |

| Condoms | |
|---|---|
| What types are available? | Male and female condoms |
| How does it work? | They create a barrier to prevent semen from entering the vagina. |
| How do you use it? | • Male Condom: Placed on the erect penis and unrolled all the way to the base<br>• Female Condom: Placed inside the vagina prior to intercourse |
| How well does it work? | With typical use—meaning that the method may not always be used consistently or correctly—18 women out of 100 (18%) will become pregnant using male condoms and 21 women out of |

[57] Van der Wijden C, Kleijnen J, Van den Berk T. Lactational amenorrhea for family planning. Cochrane Database Syst Rev 2003; (4) CD001329

[58] ABM Clinical Protocol #13: Contraception During Breastfeeding, Revised 2015

| Condoms | |
|---|---|
| | 100 (21%) will become pregnant using female condoms during the first year of use. [59] |
| When can it be started? | Any time prior to starting intercourse |
| Is there evidence of an effect on breastfeeding? | No. |
| Does it increase thromboembolic disease risk? | No. |

| Withdrawal | |
|---|---|
| What types are available? | N/A |
| How does it work? | Ejaculation occurs outside of the vagina, preventing sperm from reaching the vagina. |
| How do you use it? | Men remove their penis from the vagina prior to ejaculation. |
| How well does it work? | With typical use—meaning that the method may not always be used consistently or correctly—22 women out of 100 (22%) will become pregnant during the first year of use. This method requires a lot of self-control. [60] |
| When can it be started? | Any time |
| Is there evidence of an effect on breastfeeding? | No. |
| Does it increase thromboembolic disease risk? | No. |

| Fertility Awareness | |
|---|---|
| What types are available? | Multiple |
| How does it work? | Avoiding sexual intercourse during ovulation periods, therefore, minimizing sperm and egg meeting. |

[59] https://www.cdc.gov/reproductivehealth/unintendedpregnancy/pdf/contraceptive_methods_508.pdf
[60] See Footnote 59

| Fertility Awareness | |
|---|---|
| How do you use it? | Using various ovulation predictors (body temperature, calendars, cervical mucous) women are aware of their ovulation periods and avoid sexual intercourse |
| How well does it work? | With typical use—meaning that the method may not always be used consistently or correctly—24 women out of 100 (24%) will become pregnant during the first year of use. [61] |
| When can it be started? | Any time. |
| Is there evidence of an effect on breastfeeding? | No. |
| Does it increase thromboembolic disease risk? | No. |

| Spermicide | |
|---|---|
| What types are available? | Creams, gels and foams |
| How does it work? | Spermicides block the cervix (the opening to the uterus) and slow sperm down to make it harder for them to swim to an egg. |
| How do you use it? | The spermicide is placed deep in the vagina, close to the cervix before sexual intercourse. |
| How well does it work? | With typical use—meaning that the method may not always be used consistently or correctly—28 women out of 100 (28%) will become pregnant during the first year of use. [62] |
| When can it be started? | Any time. |
| Is there evidence of an effect on breastfeeding? | No. |
| Does it increase thromboembolic disease risk? | No. |

[61] https://www.cdc.gov/reproductivehealth/unintendedpregnancy/pdf/contraceptive_methods_508.pdf
[62] See footnote 61

| Diaphragm | |
|---|---|
| What types are available? | Multiple |
| How does it work? | The diaphragm covers the cervix (the opening to the uterus) to prevent sperm from entering the uterus. |
| How do you use it? | The diaphragm is placed over the cervix prior to sexual intercourse. |
| How well does it work? | With typical use—meaning that the method may not always be used consistently or correctly—12 women out of 100 (12%) will become pregnant during the first year of use. [63] |
| When can it be started? | Any time. |
| Is there evidence of an effect on breastfeeding? | No. |
| Does it increase thromboembolic disease risk? | No. |

[63] https://www.cdc.gov/reproductivehealth/unintendedpregnancy/pdf/contraceptive_methods_508.pdf

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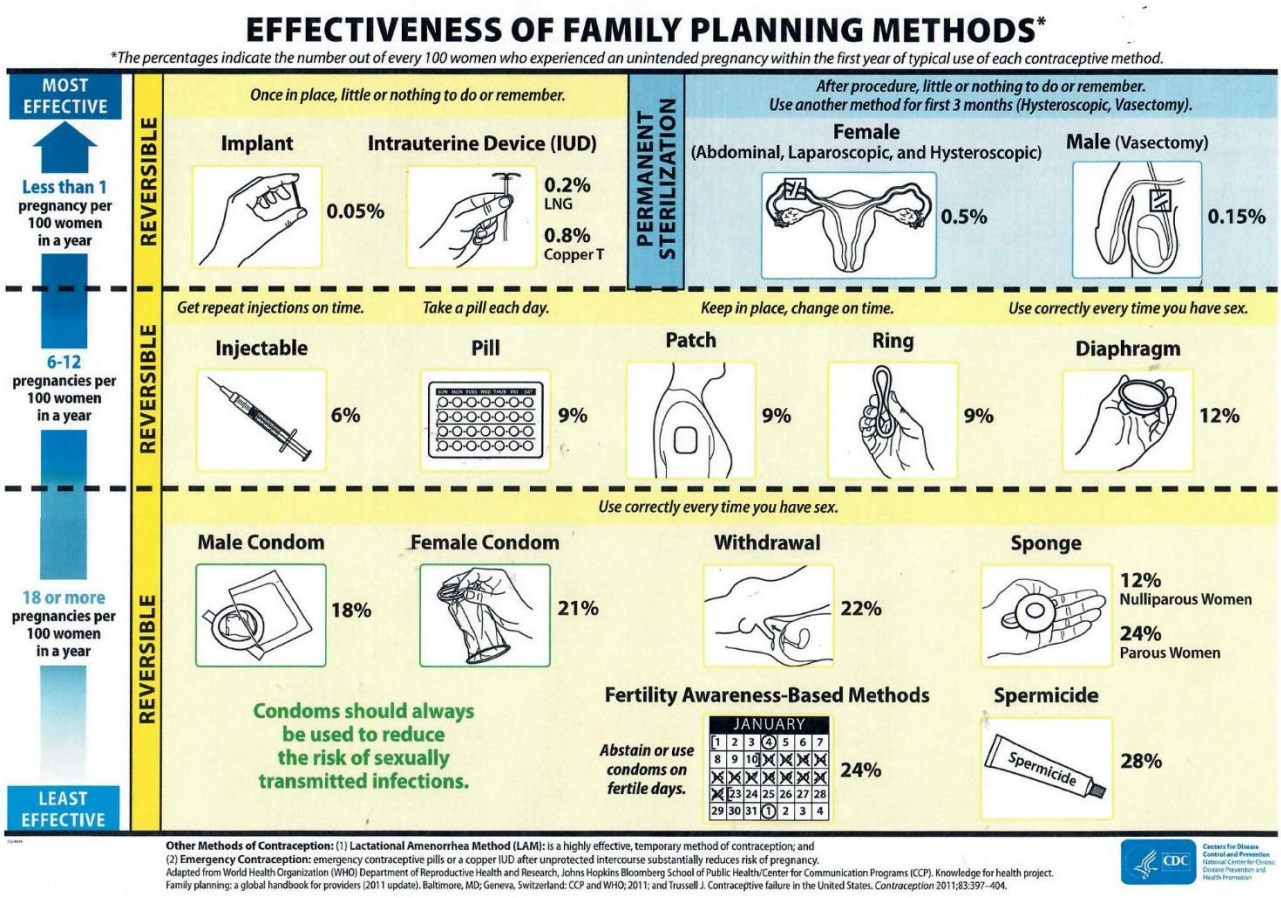
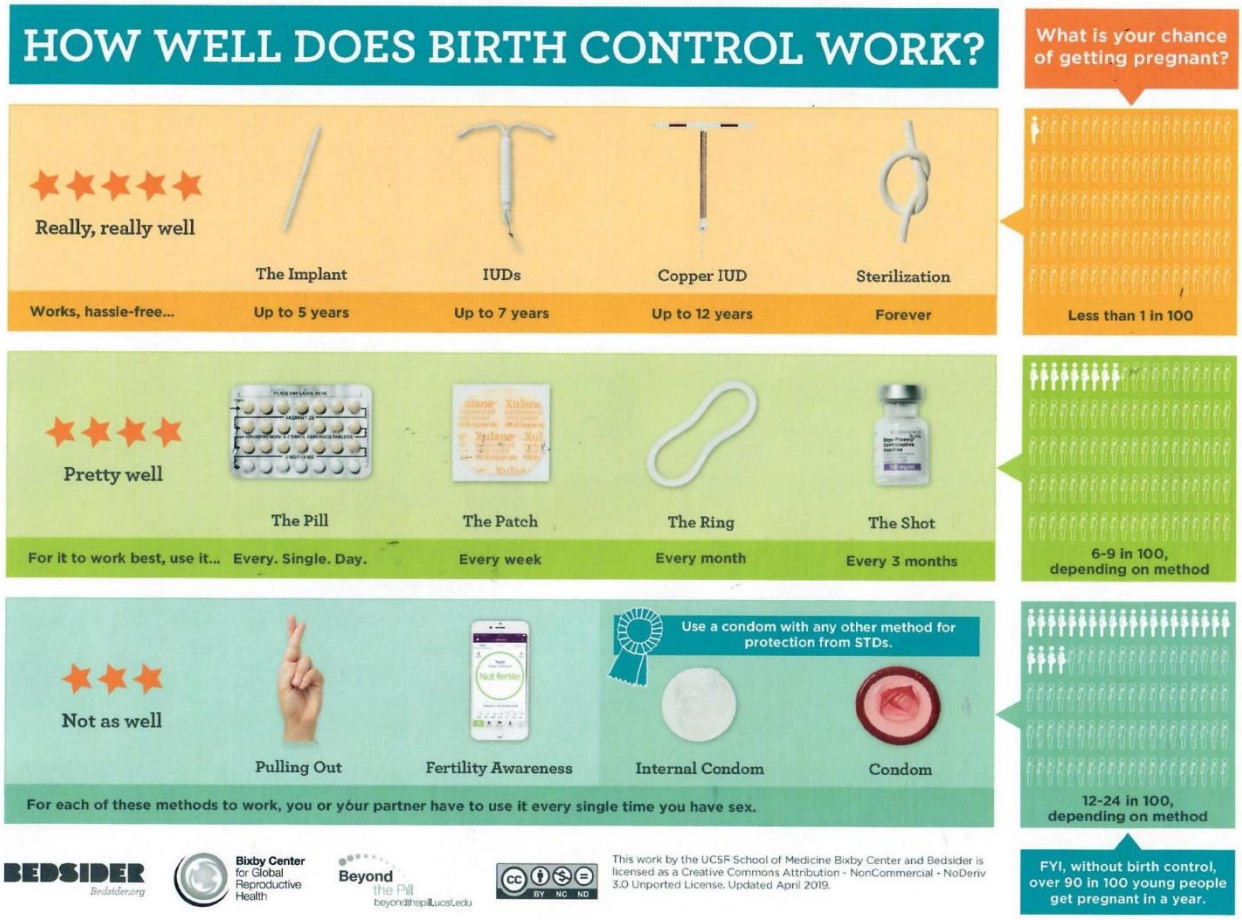
## Appendix A: CDC Effectiveness of Family Planning Methods Chart




https://www.cdc.gov/reproductivehealth/unintendedpregnancy/pdf/family-planning-methods-2014.pdf

## Appendix B: Bedsider Effectiveness Chart




https://beyondthepill.ucsf.edu/sites/beyondthepill.ucsf.edu/files/Tiers%20of%20Effectiveness_English-043019.pdf

This chart is also available in Spanish at:

https://beyondthepill.ucsf.edu/sites/beyondthepill.ucsf.edu/files/Tiers%20of%20Effectiveness-Spanish-043019.pdf

## Appendix D. The Ten Steps to Successful Breastfeeding

# The TEN STEPS to Successful Breastfeeding

## 1 HOSPITAL POLICIES

Hospitals **support mothers** to breastfeed by...

- Not promoting infant formula, bottles or teats
- Making breastfeeding care standard practice
- Keeping track of support for breastfeeding

## 2 STAFF COMPETENCY

Hospitals **support mothers** to breastfeed by...

- Training staff on supporting mothers to breastfeed
- Assessing health workers' knowledge and skills

## 3 ANTENATAL CARE

Hospitals **support mothers** to breastfeed by...


- Discussing the importance of breastfeeding for babies and mothers
- Preparing women in how to feed their baby

## 4 CARE RIGHT AFTER BIRTH

Hospitals **support mothers** to breastfeed by...

- Encouraging skin-to-skin contact between mother and baby soon after birth
- Helping mothers to put their baby to the breast right away

## 5 SUPPORT MOTHERS WITH BREASTFEEDING

Hospitals **support mothers** to breastfeed by...

- Checking positioning, attachment and suckling
- Giving practical breastfeeding support
- Helping mothers with common breastfeeding problems

## 6 SUPPLEMENTING

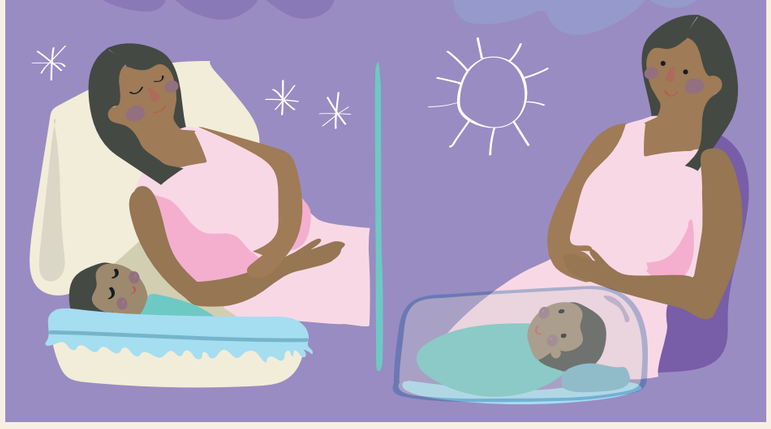
Hospitals **support mothers** to breastfeed by...

- Giving only breast milk unless there are medical reasons
- Prioritizing donor human milk when a supplement is needed
- Helping mothers who want to formula feed to do so safely

## 7 ROOMING-IN

Hospitals **support mothers** to breastfeed by...

- Letting mothers and babies stay together day and night
- Making sure that mothers of sick babies can stay near their baby



## 8 RESPONSIVE FEEDING

Hospitals **support mothers** to breastfeed by...

- Helping mothers know when their baby is hungry
- Not limiting breastfeeding times

## 9 BOTTLES, TEATS AND PACIFIERS

Hospitals **support mothers** to breastfeed by...

- Counsel mothers on the use and risks of feeding bottles, teats, and pacifiers

## 10 DISCHARGE

Hospitals **support mothers** to breastfeed by...

- Referring mothers to community resources for breastfeeding support
- Working with communities to improve breastfeeding support services

World Health Organization

unicef

## Appendix C: Consumer Education Chart

# Your postpartum birth control options

Indiana State Department of Health

***MORE EFFECTIVE**** 

Less than 1 pregnancy per 100 women in a year

6-12 pregnancies per 100 women in a year

***LESS EFFECTIVE**** More than 18 pregnancies per 100 women in a year

| TYPE OF BIRTH CONTROL | HOW SOON AFTER DELIVERY CAN IT BE STARTED? | DOES IT IMPACT BREASTFEEDING? | WILL IT IMPACT MY ABILITY TO GET PREGNANT IN THE FUTURE? | OTHER CONSIDERATIONS |
|---|---|---|---|---|
| **Tubal Ligation or Vasectomy** | Tubal ligation can be performed at the time of delivery (during a C-section) or shortly after a vaginal delivery. It can also be performed any time 6 weeks after you have delivered. Your partner can obtain a vasectomy at any time. | No | Yes, if you choose this method of contraception, it is generally permanent. | Requires surgery. |
| **Intrauterine Device** (hormonal = Mirena® & others, or copper/non- hormonal = Paragard®) | An IUD can be inserted at the time of delivery (vaginal or C-section) or in the office as soon as a few weeks after. | No | No. You may be able to get pregnant again as soon as you have the IUD removed, even within a few days. | Lasts 3-12 years. Hormonal IUDs may cause irregular bleeding or no period at allwhile the copper IUD may cause heavier/crampier periods. |
| **Arm Implant** (Nexplanon®) | The implant can be inserted at any time after delivery, often given before discharge from the hospital. | No | No. For some people, it may take a few months for their periods to become regular again. | Lasts 5 years. You may have irregular bleeding or no period at all. |
| **The Shot** (Depo-provera®) | The shot can be started at any time after delivery, often given before discharge from the hospital. | No | No. For some people, it may take a up to 1 year for their periods to be regular again. | Lasts 3 months. You may have irregular bleeding or no period at all. |
| **Combined estrogen + progestin Pills, Patch** (Xulane®) **or Ring** (Nuvaring®) | Birth control with estrogen should not be started until at least 3 weeks (if not breastfeeding) or 6 weeks (if breastfeeding) after delivery, depending on your circumstances. | Yes – birth control with estrogen should not be started until milk supply is established. | No | You must take a pill daily, change patch weekly, or change vaginal ring monthly. |
| **Progestin-only Pill** (POP) | The progestin-only pills can be started any time after delivery, often started as soon as you go home from the hospital. | No | No | You must take a pill daily & pregnancy can occur if a pill is taken even a few hours late. |
| **Lactational Amenorrhea Method** (LAM) | This method is only effective if you are exclusively breastfeeding, have no periods, and your infant is less than 6 months of age. | No | No | This method is not effective if your periods have returned, your baby is over 6 months of age or you are supplementing with formula. |
| **Barrier Methods** (condoms, diaphragms, cervical caps, spermicides) **or withdrawal** | Diaphragm or cervical caps may not be effective before 6 weeks after delivery. Otherwise, they can be used as soon as you return to sexual activity. | No | No | All methods have to be used as instructed, some methods depend on your partner. |
| **Fertility Awareness Methods** | This method is not effective until your regular and predictable periods return after a pregnancy. | No | No | This method is only effective if your cycles are very regular. |

*Effectiveness based on typical use of contraceptive method

Appendix E: Enhancing Health Equity in Breastfeeding Opportunities and Outcomes

# 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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# Appendix F: Resources

Breastfeeding

- Community Health Network: https://www.ecommunity.com/services/womens-care/newborn-care/breastfeeding-support-options
- Deaconess Women's: https://www.deaconess.com/The-Womens-Hospital/Services/Breastfeeding-Services
- Lutheran Health Network: https://www.lutheranhospital.com/breastfeeding
- Parkview: https://www.parkview.com/community/dashboard/getting-started
- Community Health Network: https://www.ecommunity.com/services/womens-care/newborn-care/breastfeeding-support-options
- IU Health: https://iuhealth.org/find-medical-services/breastfeeding-support
- Ascension St Vincent: https://stvincent.org/-/media/files/inind/maternity-services/final_500456_breastfeedingresources_bi_fold_rev.ashx?la=en
- Peyton Manning: http://www.peytonmanningch.org/in-the-community/kids-wellness-programs/
- Beacon Health: https://www.beaconhealthsystem.org/breastfeeding-services/
- Franciscan Alliance Indy/Mooresville: https://www.franciscanhealth.org/healthcare-facilities/franciscan-health-lactation-clinic-indianapolis-1930
- WIC breastfeeding support: **https://www.in.gov/isdh/24775.htm**
- La Leche League of Indiana: http://lllofindiana.org/
- The Milk Bank: https://www.themilkbank.org/
- Breastfeeding USA: https://breastfeedingusa.org/content/breastfeeding-counselor-locations
- US Dept of Health & Human Services, Office of Women's Health: https://www.womenshealth.gov/Breastfeeding/
- Cleveland Project: https://www.birthcontrol4breastfeeding.org/

Family Planning:

- Centers for Disease Control and Prevention: https://www.cdc.gov/reproductivehealth/unintendedpregnancy/pdf/family-planning-methods-2014.pdf
- Bedsider: https://www.bedsider.org/
- Indiana Medicaid: https://www.in.gov/medicaid/providers/858.htm
- Family Planning National Training Center: https://www.fpntc.org/
- World Health Organization: https://www.who.int/reproductivehealth/topics/family_planning/en/

Cultural Competency and Implicit Bias:

- US Department of Health & Human Services, A Physician's Practical guide to Culturally Competent Care (target audience: physicians, physician assistants, nurse practitioners, : https://thinkculturalhealth.hhs.gov/education/physicians
- American Association of Medical Colleges: https://www.aamc.org/what-we-do/mission-areas/diversity-inclusion/unconscious-bias-training
- The EveryONE training: https://www.aafp.org/news/practice-professional-issues/20200115implicitbias.html
- Institute for Healthcare Improvement: http://www.ihi.org/communities/blogs/how-to-reduce-implicit-bias
- March of Dimes Training (to be released in 2020)
- Crossroads Training
- Peace Learning Center https://www.peacelearningcenter.org

Some organizations that are actively doing community work and other resources that are culturally relevant include:

- Reaching Our Sisters Everywhere (ROSE): http://www.breastfeedingrose.org/
- Black Mamas Matter Alliance: https://blackmamasmatter.org/
- Sister Song: https://www.sistersong.net/reproductive-justice
- Black Mothers Breastfeeding Association: https://blackmothersbreastfeeding.org/
- United States Breastfeeding Committee: http://www.usbreastfeeding.org/
- Indiana Black Breastfeeding Coalition: https://www.indianablackbreastfeedingcoalition.com/