Breastfeeding in Tulare County

Experiences of Women Served by First 5 Tulare

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INTRODUCTION

Breastfeeding is an unequalled way of providing ideal food for the healthy growth and development of infants. The science-based benefits of breastfeeding are so numerous – the right food in the right proportions; antibody protection; healthy weight gain; protection from illness; and possibly lower risk of learning difficulties later on – the American Academy of Pediatrics and other healthcare professionals recommend exclusive breastfeeding for 6 months, and continuing even after solid foods are introduced, until at least age 1 year. At the end of the day, however, the choice is really up to each individual woman within the circumstances that support or constrain it.

Although the value of breastfeeding is well understood, there are many challenges that can make it difficult for women to start and continue breastfeeding. Research of mothers participating in the Supplemental Nutrition Program for Women, Infants, and Children (WIC), for instance, cited lactation complications, early return to work or school, embarrassment toward breastfeeding in public, limited family and social support, and unsupportive childcare as the main barriers.

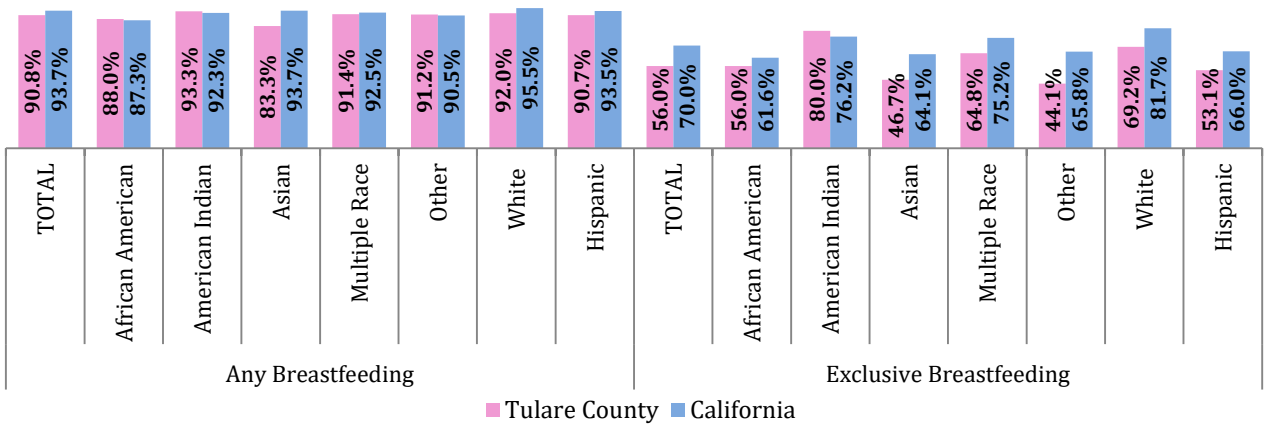
As an early champion of breastfeeding, the First 5 Tulare Commission has long included breastfeeding among its strategic child health priorities. While funded programs have shown favorable results in initiation of breastfeeding, *duration*—whether exclusive or mixed-feeding breastfeeding—continues to be shorter than recommended. The Commission supported this study* that reached nearly 600 Tulare County women to learn more about their breastfeeding attitudes and experiences, including their knowledge about workplace breastfeeding rights. The aim was to provide insights into breastfeeding intentions, practices and problems, to ultimately identify approaches that might increase the choice to breastfeed and the support needed for sustaining it.

Background

Looking at the First 5 grantee data, Tulare County women of all race/ethnic groups generally initiate breastfeeding at least to some extent as women do statewide (Figure 1). However, with the exception of American Indian women, the county's other race/ethnic groups lag somewhat behind when it comes to exclusively breastfeeding; the difference in rates between the county (lower) and statewide average (higher) is most notable for Hispanic and non-Hispanic White women.

* We wish to acknowledge the contribution of Sarah E Beck, MD, who reviewed and provided helpful comments to this report.

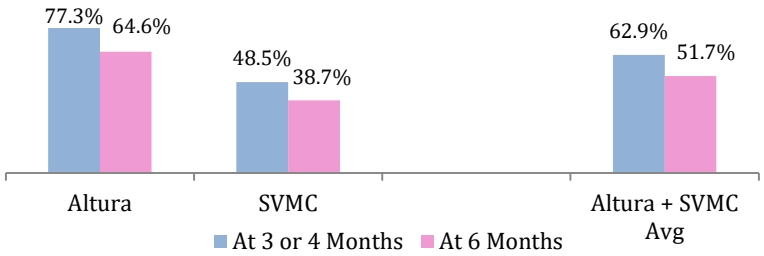
Figure 1. In-Hospital Breastfeeding, Tulare County and Statewide, by Race/Ethnicity, 2019



Source: CA Department of Public Health, 2019 Hospital Data by Race.

Breastfeeding support programs like First 5's can reduce barriers to breastfeeding allowing mothers to breastfeed longer. A 3-year analysis of women served by the breastfeeding grants—Altura Centers for Health and Sierra View Medical Center—who initially breastfed exclusively and were available for contact afterward showed, on average, that 62.9% of them maintained exclusive breastfeeding at the first follow-up period, and 51.7% were exclusively breastfeeding 6 months later (Figure 2). These 3-month follow-up rates are more favorable compared to the rate reported for all Tulare County women reported in the state Maternal and Infant Health Assessment (MIHA) Survey (Table 1) for a relatively similar period.

Figure 2. Percent of First5 Tulare County Women Who Exclusively Breastfed Initially and Where Available at Two Follow-up Periods (Matched Samples), 2018-2021 3-Yr Average



Source: First 5 Tulare County Evaluation Report, Barbara Aved Associates, September 2021.

Table 1. Percent of Women Breastfeeding after Delivery at Follow-up, 2016-2018

	Tulare County	California
Any, 1 mo. after	73.6%	86.0%
Exclusive, 1 mo. after	41.3%	47.8%
Any, 3 mos. after	51.8%	70.6%
Exclusive, 3 mos. after	22.8%	33.5%

Source: Personal communication with California Department of Public Health, special request for early release of Maternal and Infant Health Assessment (MIHA) Survey data. February 1, 2022.

The Study

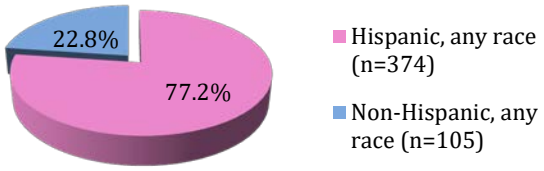
We designed a Breastfeeding Survey in English and Spanish and made it available online and in hard copy for First 5 to send to grantees (primarily the Family Resource Centers) for circulation. The survey ran from mid-November 2021 to mid-January 2022. The study protocol allowed any women in Tulare County who gave birth "within about the last year," regardless of breastfeeding status, to participate. To encourage a broader reach, the host organizations were also asked to inform other clients about the survey so their friends, wives/partners, sisters, cousins and other women would be made aware of it. Boosts through social media by First 5 and the grantees helped to promote awareness.

STUDY RESULTS

Characteristics of the Women

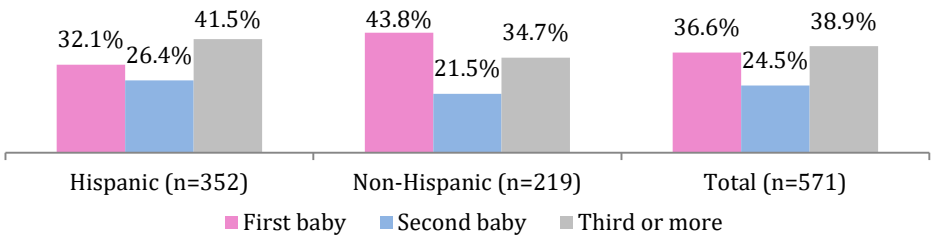
A total of 599 women responded to the survey, 580 (97%) using the English and 19 (3%) using the Spanish version. Because of the unexpectedly small number in the latter group, we could not include information about these respondents. Looking at ethnic group (vs. survey language type), about three-quarters (77.2%) of the women identified as Hispanic (of any race) and close to one-quarter (22.8%) as non-Hispanic (of any race) (Figure 3).

Figure 3. Ethnic Group of Respondents (n=479)



Because mothers having their first child could be different in knowledge, attitudes and experience related to infant feeding and care from those having subsequent births, we asked about parity (Figure 4): for 36.6% of the women, this was their first baby; 24.5% their second baby; and 38.9% their third or higher number of births. Non-Hispanic women represented just over one-third (36.0%) more of the women with first births and Hispanics 16.4% more of those with second births.

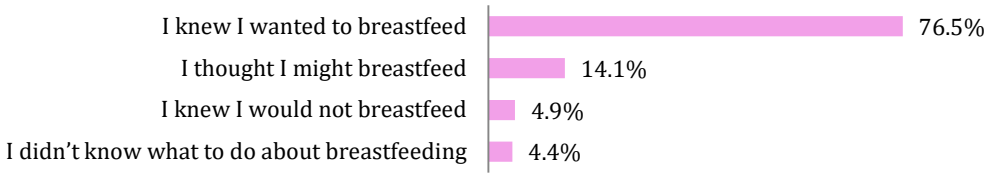
Figure 4. Most Recent Pregnancy (n=571)



Breastfeeding Intentions

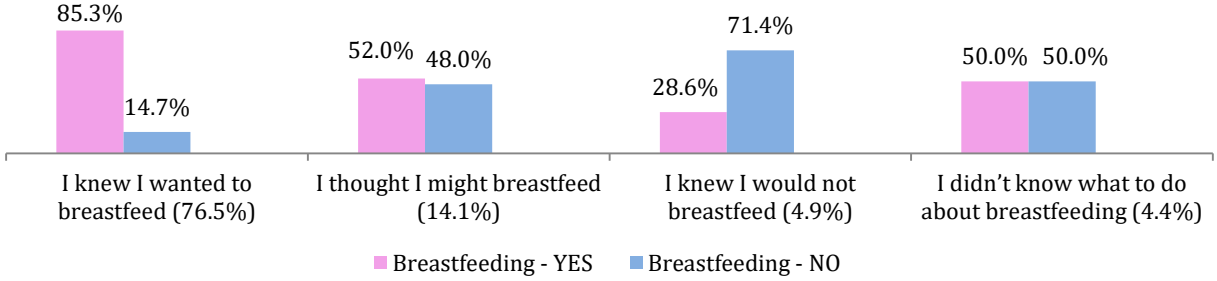
Women's plans around breastfeeding are influenced by a wide range of socio-cultural and physiological factors and can change from their intentions prior to childbirth. During the most recent pregnancy, 76.5% of the mothers said they knew they wanted to breastfeed, while 14.1% were unsure but thought they might, and 4.9% were sure they would not breastfeed (Figure 5). The differences between the ethnic groups were very small.

Figure 5. What Women Thought about Breastfeeding during the Most Recent Pregnancy (n=568)



The women's breastfeeding intentions did not always correlate with what they did ultimately decided to do, however, as indicated by the graph in Figure 6. While 76.5% said they *knew* they wanted to breastfeed after the birth of the baby, a greater proportion, 86.7%, actually ended up doing so. Thinking that they *might* breastfeed didn't always lead to the decision to initiate it; only about half (52%) did. Interestingly, of the small group who said they knew they would *not* breastfeed, 28.6% chose to do so after delivery. The mothers who were unsure or ambivalent at the outset were evenly split in breastfeeding or not.

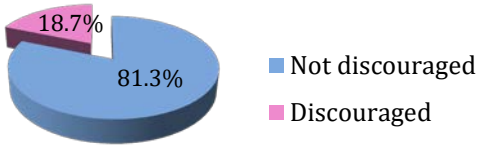
Figure 6. Women's Intentions about Breastfeeding during the Most Recent Pregnancy Compared to their Actual Breastfeeding Decision (n=543)



Family and Social Support

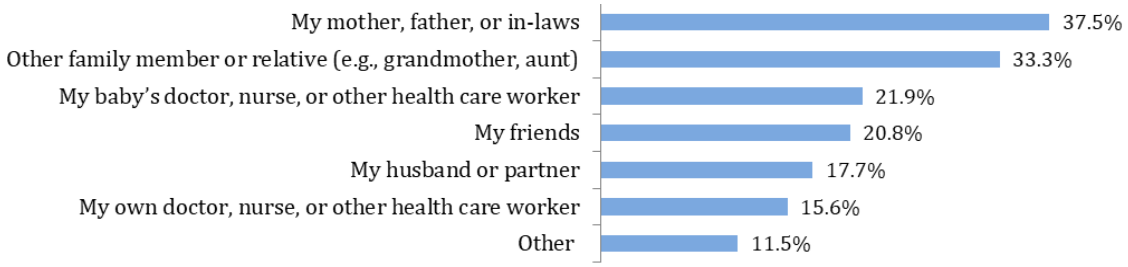
Lack of support from close family and friends can affect decisions about feeding. Negative attitudes and beliefs about breastfeeding by others (partners, family members, support people and the general public) can be discouraging. Close to 1 in 5 of the women—about the same proportion for Hispanic and non-Hispanic women—reported "someone suggested I not breastfeed my new baby" (Figure 7).

Figure 7. Percent of Women Discouraged from Breastfeeding (n=578)



Close family members (mother, father, and in-laws), followed by other family members were the most common source of discouraging women from breastfeeding (Figure 8).

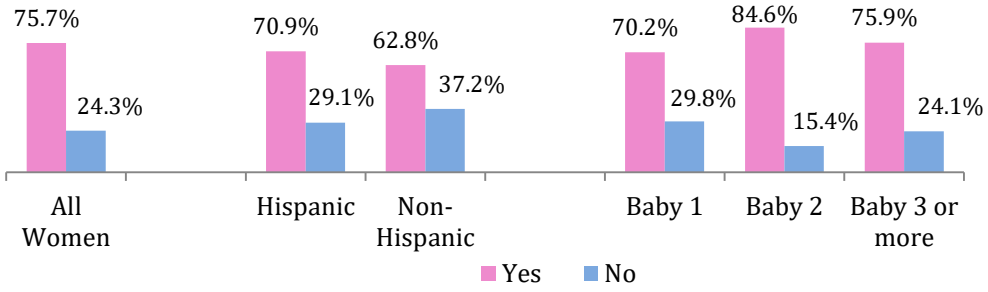
Figure 8. Sources of non-Support for Breastfeeding (n=93)



Breastfeeding Experience

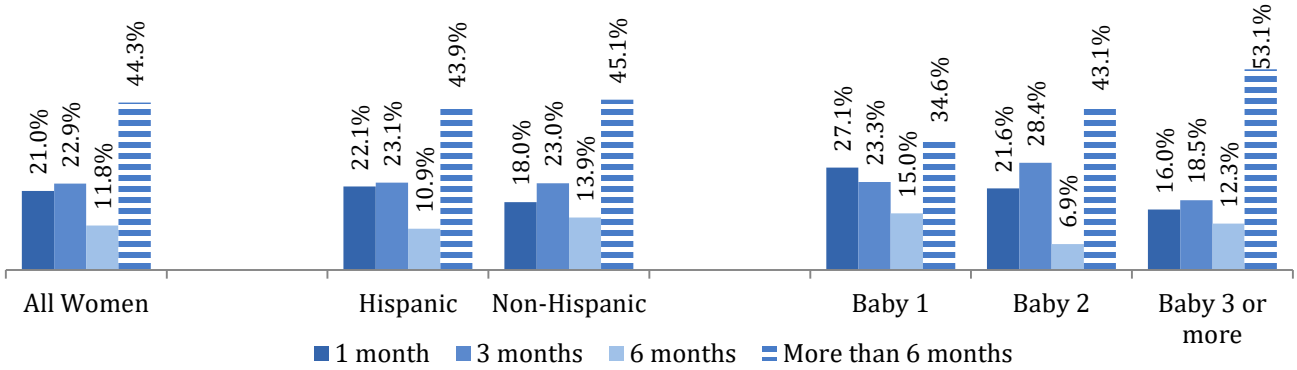
Overall, three-quarters of the women responding to this survey were currently breastfeeding or had breastfed any amount of time during their last pregnancy, with Hispanic women doing so in a higher proportion than non-Hispanic women (Figure 9). While not necessarily predictive of breastfeeding, multiparous women (those with more than one live birth), reported the highest proportions of breastfeeding experience.

Figure 9. Percentage of Women Reporting Breastfeeding, by Ethnicity and Number of Births (n=548)



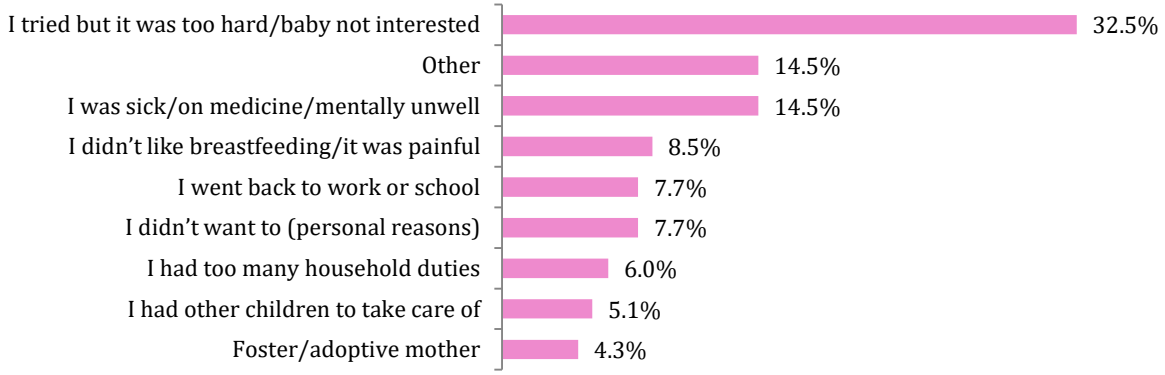
The share of women in this study who were currently or had breastfed their last baby, including mixed-feeding with formula, at various follow-up periods was slightly lower than in the population-based MIHA Survey referred to earlier. Of particular interest, however, was the high proportion of women in this survey who reported breastfeeding *past 6 months*, highest among women with three or more births—a very favorable finding (Figure 10).

Figure 10. Length of Time Women Breastfed Most Recent Baby, by Ethnicity and Number of Births (n=415)



Women's main reasons for not breastfeeding were related to the difficulty of the experience, cited by 32.5% of the women: feeling unsuccessful, not producing enough milk, not having enough information about breastfeeding, baby not adequately latching.

Figure 11. Reasons Cited by Women for not Breastfeeding (n=117)



The comments below written by women for "Other Reasons"—which are verbatim—also have important implications for breastfeeding support programs:

- "It was my personal choice and we should not be told by WIC staff upon enrollment we have to the first month because formula will not be provided."
- "I could not produce, WIC workers were very condescending about it."
- "The Early Steps/Save the Children home visitor suggested I shouldn't breastfeed my baby."
- "I struggle with mental health issues such as depression and PTSD the thought of having a pump or a child attached to me often did not feel right to me considering all the stress I already have."
- "I was positive for cocaine and was told not to breastfeed until I tested negative and by then, I had given up and my milk was gone."

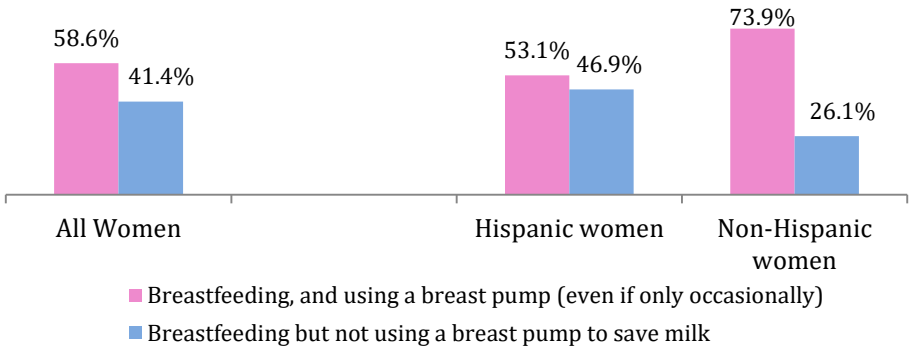
Research shows women who have problems breastfeeding in the early weeks are less likely to continue breastfeeding unless they access help from professionals or trained counsellors. This seems to be true for the women in this study. About 40% of the women who answered the question said they had started to breastfeed but then stopped. Their reasons for stopping were similar to their reasons for never starting except that a larger percentage of them specifically mentioned the baby's difficulty latching or nursing (56.8%) and nipple pain (35.1%) as the primary reasons.

Workplace Environment

Many mothers who are trying to balance breastfeeding and work depend on pumping to store milk for when they are away from the baby. In this study, 58.6% of the women were using a breast pump, independent of being employed, even if only occasionally. The graph in Figure

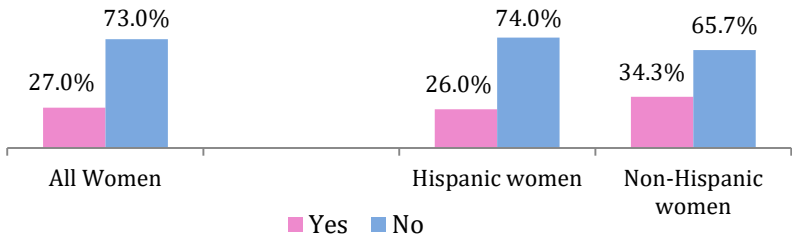
12 shows a higher proportion, 73.9%, of non-Hispanic women reported using a breast pump. The extent of use by this group could reflect having more time to pump, having better access to pumping equipment and places to pump, different perceptions about acceptance, less embarrassment at pumping, or other factors.

Figure 12. Use of a Breast Pump when Breastfeeding (n=261)



Pumping milk *while at work*, particularly for women in service/agricultural industries who do not have the benefit of private office space, can pose a particular challenge. Just over one-quarter (27%) of the women in this survey said they had ever pumped milk while at work (Figure 13). Although a very small sample, of the 19 women who took the survey in Spanish, only 1 (5.3%) reported ever pumping at work. The higher proportion (34.3%) of pumping experience at work by non-Hispanic respondents could reflect some of the same positive factors that facilitate pumping in general. One factor includes having more adequate workplace support such as a private area to pump and a place to store expressed milk. *

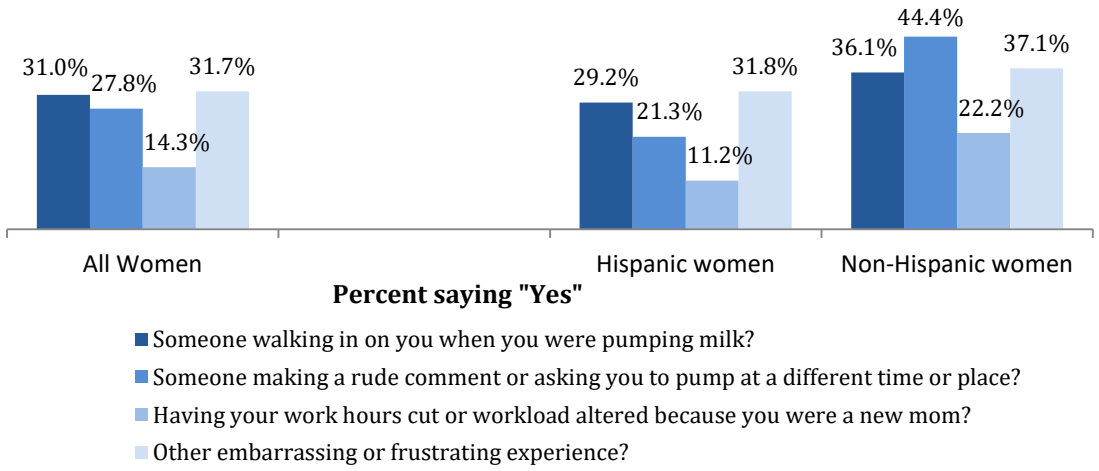
Figure 13. Ever Pumped Breast Milk at Work (n=455)



Despite federal and California laws, not all workplaces have a private area with an outlet (not a bathroom) for mothers to pump their breast milk, and stories of embarrassment or frustration related to this are very common. On average, about one-third of the women had experienced discourteous situations when pumping breast milk at work; for instance, someone walking in on them when they were pumping (Figure 13). Overall, non-Hispanic women reported a higher incidence of rude or inappropriate behavior; this could reflect their actual experience or might indicate having less tolerance for such situations or less hesitancy in recognizing it. A relatively low percentage of the women, particularly the Hispanic women, said they had not had their work hours cut or workload altered because they were trying to combine breastfeeding with employment.

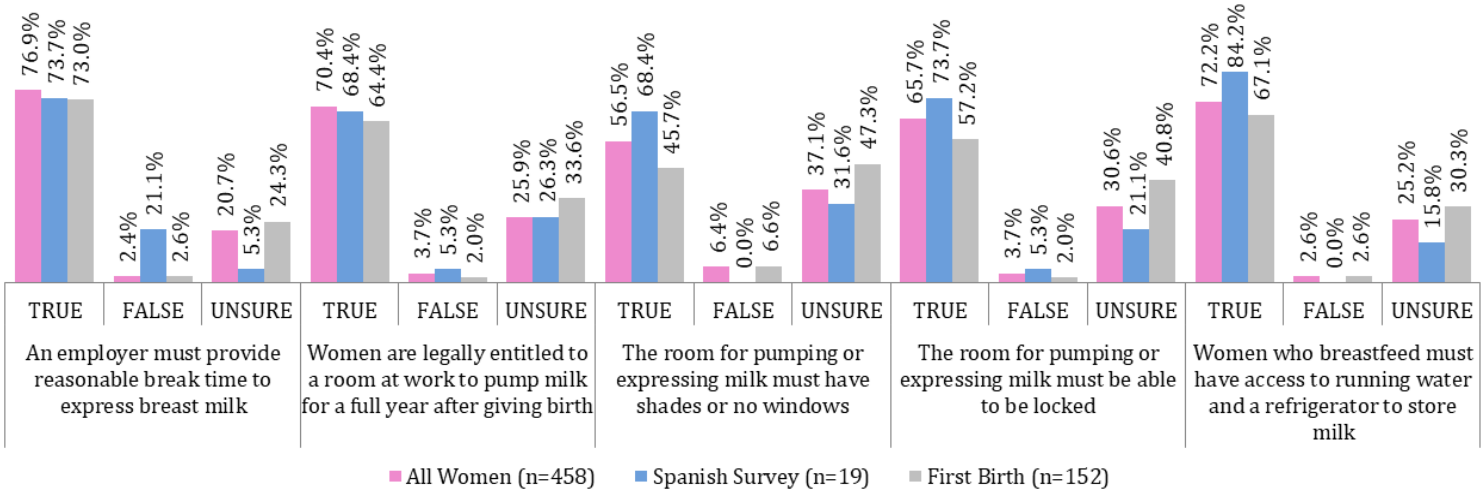
* We cannot know for sure, however, as the survey did not ask for type of work or work setting—an oversight that should be corrected in future breastfeeding surveys.

Figure 13. Women's Experiences when Pumping Breast Milk at Work (n=132)



Because workplace environments can also affect breastfeeding duration, we asked 5 questions about breastfeeding rights. Studies show fewer than 1 in 5 working mothers who breastfeed know their rights in the workplace, influencing how long a woman will breastfeed.* Between 70% and 76% of the women, on average, answered most of the workplace breastfeeding questions correctly; a lower proportion, about half to two-thirds, knew that employers are supposed to provide women with a room with specific features for breastfeeding or pumping. Women who took the survey in Spanish (although a very small sample size) were generally correct more often than women who took it in English. The first-time mothers were the least likely to answer correctly and the most often to be unsure of their rights (Figure 14).

Figure 14. Women's Responses to Breastfeeding Rights



* While the Affordable Care Act included requirements for coverage of breastfeeding support, supplies, and counseling, it left room for coverage variation among insurance policies. For example, the provision generally covers hourly workers but not salaried employees. Hourly workers face greater barriers to breastfeeding compared with salaried workers as they have less control in their schedules. (Source: U.S. Department of Health and Human Services. *The Surgeon General's Call to Action to Support Breastfeeding.* Washington, DC: U.S. Department of Health and Human Services; 2011.)

SUMMARY

Promoting breastfeeding is an important public health intervention, with benefits for infants and mothers. Even modest increases in prevalence and duration may yield considerable benefits. The findings in this study support the continuation of breastfeeding promotion as a strategic priority for the First 5 Tulare Commission, and suggest the following for consideration:*

- The difficulties associated with breastfeeding (pain, insufficient milk, latching problems) are the likeliest barriers to continuing to breastfeed once initiated, making women feel unsuccessful and contributing to quitting. More intensive breastfeeding supportive services such as frequent live virtual visits for the first month, especially for first-time mothers, and making products more accessible to treat nipple pain and/or latching problems would increase maintenance.
- Early childhood providers and teachers influence the health of the families they serve and can be an important source of support for mothers who want to breastfeed, including those who work. The Tulare County ECE programs could increase the distribution of printed materials and resources to pregnant clients and their partners that communicate the benefits *and rights* associated with breastfeeding and welcome mothers to breastfeed on-site and provide a space.
- Funded lactation support programs should routinely include return to work consultation with ongoing support for maintaining breastfeeding in the workplace; studies show that such anticipatory guidance can have a positive impact on duration of breastfeeding. Building confidence is especially important for first-time mothers who are less experienced and, if this study is any indication, less sure of their workplace rights.
- Healthcare providers, case managers, home visitors and other staff with inadequate knowledge about breastfeeding or negative personal attitudes and experiences can lead to inappropriate advice, such as what a few women in this study shared. Breastfeeding support training could be incorporated into professional development or other continuing education opportunities that are funded for staff of these programs.
- Social marketing has been established as an effective behavioral change model for several public health issues, including breastfeeding. It can also be used to educate decision makers. The Commission could consider a campaign that raises more visibility of the topic through social marketing, promoting the many benefits of breastfeeding and making it seem like the norm, which in turn would make it seem a more feasible and attainable goal for many women. Because African American women—though a relatively small population in Tulare County—have the lowest rates of breastfeeding, appropriate campaign strategies could be especially effective for these families.
- The Commission could consider recognition strategies that highlight Tulare County employers with exemplary breastfeeding friendly programs.

* Some of the recommendations are adapted from *The CDC Guide to Strategies to Support Breastfeeding Mothers and Babies,* available at https://www.cdc.gov/breastfeeding/pdf/bf-guide-508.pdf