1-1-2016

Perinatal Nurses: Key to Increasing African American Breast-Feeding Rates

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Accepted version. *The Journal of Perinatal & Neonatal Nursing*, Vol. 30 No. 1 (January/March 2016): 3-5. DOI.

Perinatal Nurses: Key to Increasing African American Breast-Feeding Rates

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Disclosure: The author has disclosed that she has no significant relationships with, or financial interest in, any commercial companies pertaining to this article.

Breast milk is the ideal source of nutrition for infants for at least the first 6 months of life.[1] Despite women in the United States reaching national objectives for breast-feeding initiation (75%), racial disparities persist.[2] According to the most recent data, 83% of white mothers initiated breast-feeding whereas only 66% African American mothers did so.[2] Breast-feeding initiation may be amenable to perinatal nursing intervention. Breast-feeding may be a practice that helps bridge the racial divide in perinatal outcomes among African American families. Nurses have an essential role in embracing breast-

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feeding promotion and support to patients who are least likely to initiate.

African American women have yet to achieve the national breast-feeding initiation benchmark.[2] Various modifiable and nonmodifiable factors have been identified as barriers to the breast-feeding gap among African American women. Factors such as self-efficacy (confidence) and lack of support from family, friends, and providers have been shown to have an impact on infant feeding decisions among African American women.[3,4] Culturally appropriate initiatives have been implemented to tackle the issue of breast-feeding disparities, with some improvement in rates. For example, in-hospital implementation of immediate skin-to-skin contact after birth, delaying mother-infant separation for at least the first hour of life, and rooming-in have all been associated with increased breast-feeding initiation rates for mothers across racial backgrounds.[5,6] The use of breast-feeding peer counselors and community nurses has increased breast-feeding continuation, especially among African American mothers.[7] African American mothers who received breast-feeding support postdischarge continued to breast-feed at a rate of 66% compared with mothers without support.[7] Increased focus on postpartum strategies to initiate and sustain breast-feeding that are effective with African American mothers is needed to address this disparity.

There is sufficient evidence that maternity care practices have both positive and negative impacts on breast-feeding initiation and continuation in the early postpartum period among women from minority backgrounds.[6] Thus, nurses caring for mothers and newborns have a critical role in the success or detriment to breast-feeding initiation, especially among African American women. The perinatal nurse may often see this role as merely documenting the client's decision to formula-feed, breast-feed, or both. How this question is asked and how the answers are interpreted can have a significant impact on breast-feeding initiation and continuation. Many times nurses feel that if a mother has made the decision to formula-feed, then it is too late or not the nurse's position to change the mother's mind.[8] When in fact, the immediate and early postpartum period is an ideal time for discussing apprehensions to breast-feeding. Instead of

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simply asking, "Are you breast- or formula-feeding?" nurses can take a more open-ended approach and ask, "How confident are you in your current feeding choice? What questions/concerns do you have regarding breast-feeding?" Keeping the lines of nurse-client communication open for breast-feeding discussions is key in the early postpartum period. Nurses who are successful with using this type of open communications do so while not placing guilt or blame on mothers who have opted out of breast-feeding.[8] Women who verbalize that they want to both breast-feed and formula-feed also present an opportunity for education about the supply and demand nature of breast-feeding. Early formula supplementation can jeopardize the establishment of the breast milk supply. Mothers then discontinue breast-feeding because of insufficient milk.[9] Education to delay supplementation and reassurance that the baby taking formula will eventually be possible may help establish a good milk supply sooner. Nurses have an obligation to guide mothers and families in infant feeding decision making in a manner that unearths all of the underlying barriers and issues.

Among healthcare professionals, nurses are usually knowledgeable about the benefits of breast milk and thus supportive of breast-feeding initiation. Yet, being merely knowledgeable is not enough. A nurse's level of comfort in teaching about breast-feeding is as valuable as being knowledgeable about the benefits of breast milk. Factors contributing to decreased assurance for nurses include inadequate preparation and education.[10] In nursing school, students learn about the anatomy and physiology of the lactating breast, the nutritional properties of colostrum and breast milk, and the common discomforts associated with breast-feeding. Yet, there are gaps in the adequacy of the clinical application of transferring this knowledge to our patients. Nursing students are not always comfortable providing hands-on breast-feeding teaching and support to mothers in the clinical setting.[10] Furthermore, many programs no longer offer a maternity nursing clinical experience. Nursing students who lack self-confidence in providing breast-feeding assistance become nurses who may provide inadequate support. Confidence in the ability to provide quality breast-feeding support is necessary to increase breast-feeding initiation and duration among African American women.

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The healthcare environment can have a direct and often negative impact on attitudes toward breast-feeding. Institutional constraints can hinder the ability to provide optimal breast-feeding support. For example, on some units, the nurse-to-patient ratio for stable mother-infant dyads exceeds the Association of Women's Health, Obstetric and Neonatal Nurses' (AWHONN's) recommendations of the 1:3 ratio 2 hours after birth.[11] Furthermore, nurses in some settings may not have access to an in-hospital or on-call lactation personnel.[11] These institutionalized barriers have an impact on the quality and quantity of breast-feeding assistance nurses can adequately provide to mothers and infants. Assistance has been shown to be vital to breast-feeding initiation for vulnerable populations such as African American mothers.[11] Mothers have expressed a desire to avoid being seen as a burden and less inclined to communicate breast-feeding difficulties to a nurse who appears to be overwhelmed or too busy.[12] In addition, because of the multiple tasks required of the nurse, patients who tend not to make needs known may receive less time or attention on a busy day. Poor breast-feeding experiences in hospital have been shown to lead to premature formula supplementation or breast-feeding cessation among African American mothers.[8,9,12]

The Baby-Friendly Hospital Initiative set the standard on breast-feeding policies.[13] This program acknowledges hospitals and birth centers that have integrated practices and policies affording an environment for successful breast-feeding initiation. One key practice in earning Baby-Friendly Hospital status is the implementation of the Ten Steps to Successful Breast-Feeding as shown in Table 1.[14] This evidence-based initiative has been shown to improve breast-feeding initiation and continuation rates in populations that include African American women.[15] Yet, of the thousands of hospitals and birth centers providing maternity services in the United States, to date, only 300 have received the designation of being Baby-Friendly.[13] Therefore, many of the nation's most vulnerable women and infants are not exposed to this evidence-based national and global initiative.

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1. Have written breast-feeding policy that routinely is communicated to all healthcare personnel
2. Train all healthcare personnel in the skills needed to implement policy
3. Inform all pregnant mothers about breast-feeding benefits and management
4. Help mothers initiate breast-feeding within 1 h of birth
5. Show mothers how to breast-feed and maintain lactation, even if they are separated from their infants
6. Give no food or drink to infants other than breast milk, unless medically indicated
7. Practice rooming-in: allowing mothers and infants to remain together 24 h/d
8. Encourage on-demand breast-feeding
9. Give no pacifiers or artificial nipples to breast-feeding infants
10. Foster the establishment of breast-feeding support groups and offer them to mothers at hospital or birth center discharge

[a]Adapted from Baby-Friendly USA.[14]

Table 1. Ten Steps to Successful Breast-Feeding[a]

This lack of designation does not prevent nurses from providing evidenced-based care to foster successful breast-feeding for patients, but it may require a more coordinated effort. Indeed, nurses and other healthcare providers can advocate for hospital policy change to include the Ten Steps. The difficulty lies with the financial implications with instituting all of these steps. For more than 50 years, infant formula companies have had partnerships with hospitals.[16] In a marketing strategy, these companies provide hospitals with complimentary "goody bags" that include formula for new mothers, regardless of breast-feeding status. Hospitals are reluctant to dissolve these partnerships because formula companies often provide financial incentives such as funding for supplies and conferences.[16] Nurses can be proactive in advocating for hospital policy changes that encourage the use of at least some of the Ten Steps. The implementation of at least half of these steps has shown to increase in-hospital breast-feeding initiation rates compared with facilities that use none.[17]

Nursing support during the postpartum hospital stay has a direct impact on breast-feeding initiation and continuation.[6] African American infants need breast milk because they are vulnerable to perinatal morbidity and mortality disproportionately more than infants of other races. Perinatal nurses can be a part of best care practices and education that support informed decision making about feeding choices, foster breast-feeding initiation, and promote continuation among African American mothers. Perinatal nurses are in an opportune position to lay the foundation for breast-feeding success for all women, especially those who are most vulnerable to not initiating or continuing breast-feeding.

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References

[1] American Academy of Pediatrics. Policy statement: breastfeeding and the use of human milk. *Pediatrics*. 2012;129(3):e827–841. doi:10.1542/peds.2011-3552.

[2] Centers for Disease Control and Prevention. *Rates of Any and Exclusive Breastfeeding by Socio-demographics Among Children Born in 2012.* National Immunization Survey. Atlanta, GA: Centers for Disease Control and Prevention; 2014. http://www.cdc.gov/breastfeeding/data/nis_data/rates-any-exclusive-bf-socio-dem-2012.htm. Accessed October 23, 2015.

[3] Robinson K, VandeVusse L. African American women's infant feeding choices: prenatal breast-feeding self-efficacy and narratives from a black feminist perspective. *J Perinat Neonatal Nurs.* 2011;25(4):320–328. doi:10.1097/JPN.0b013e31821072fb.

[4] Lewallen LP, Street DJ. Initiating and sustaining breast-feeding in African American women. *J Obstet Gynecol Neonatal Nurs.* 2010;39:667–674. doi:10.1111/j1552-6909.2010.01196.x.

[5] Perrine CG, Galuska DA, Dohack JL, et al. Vital signs: improvements in maternity care policies and practices that support breast-feeding—United States, 2007-2013. *MMWR Morb Mortal Wkly Rep.* 2015;64(39):1112–1117.

[6] Ahluwalia IB, Morrow B, D'Angela D, Li R. Maternity care practices and breast-feeding experiences of women in different racial and ethnic groups: Pregnancy Risk Assessment and Monitoring System (PRAMS). *Matern Child Health J.* 2012;16:1672–1678. doi:10.1007s/10995-011-0871-0.

[7] Pugh LC, Serwint JR, Frick KD, et al. A randomized controlled community-based trial to improve breast-feeding rates among urban low-income mothers. *Acad Pediatr*. 2010;10:14–20.

[8] Radzyminski S, Clark Callister L. Health professionals' attitudes and beliefs about breast-feeding. *J Perinat Ed*. 2015;24(2):102–109. doi:http://dx.doi.org/10.1891/1058-1243.24.2.102.

[9] Schafer R, Watson Genna C. Physiologic breast-feeding: a contemporary approach to breast-feeding initiation. *J Midwifery Womens Health.* 2015;60(5):546–553. doi:10.1111/jmwh.12319.

[10] Showalter DA. Formation of breast-feeding attitudes among nursing students. *Clin Lact*. 2012;3(2):69–74.

[11] Association of Women's Health, Obstetric and Neonatal Nurses. *Guidelines for Professional Registered Nurse Staffing for Perinatal Units*.

Washington, DC: Association of Women's Health, Obstetric and Neonatal Nurses; 2010.

[12] Jones KM, Power ML, Queenan JT, Schulkin J. Racial and ethnic disparities in breast-feeding. *Breastfeed Med*. 2015;10(4):186–196. doi:10.1089/bfm.2014.0152.

[13] Baby-Friendly USA. *Baby-Friendly Initiative*. https://www.babyfriendlyusa.org/about-us/baby-friendly-hospital-initiative. Updated 2012. Accessed October 23, 2015.

[14] Baby-Friendly USA. *The Ten Steps to Successful Breast-Feeding*. https://www.babyfriendlyusa.org/about-us/baby-friendly-hospital-initiative/the-ten-steps. Updated 2012. Accessed October 23, 2015.

[15] DiFrisco E, Goodman KE, Budin WC, Lilienthal MW, Kleinman A, Holmes B. Factors associated with exclusive breast-feeding 2 to 4 weeks following discharge from a large, urban, academic medical center striving for Baby-Friendly designation. *J Perinat Ed*. 2011;20(1):28–35. doi:10.1891/1058-1243.20.1.28.

[16] Rosenberg KD, Eastham CA, Kasehagen LJ, Sandoval AP. Marketing infant formula through hospitals: the impact of commercial hospital discharge packs on breast-feeding. *Am J Public Health*. 2008;98(2):290–295.

[17] Declercq E, Labbok MH, Sakala C, O'Hara MA. Hospital practices and women's likelihood of fulfilling their intention to exclusively breastfed. *Am J Public Health*. 2009;99(5):929–935.