

Breastfeeding Awareness Month: Breast/ Chestfeeding Considerations for Children, Families, and Diverse Communities

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The National Perinatal Association (NPA) is an interdisciplinary organization that strives to be a leading voice for perinatal care in the United States. Our diverse membership is comprised of healthcare providers, parents & caregivers, educators, and service providers, all driven by their desire to give voice to and support babies and families at risk across the country.

Members of the NPA write a regular peer-reviewed column in Neonatology Today.



Educate. Advocate. Integrate.

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Breastfeeding Awareness Month is dedicated to protecting, promoting, and raising awareness of breast/chestfeeding and decreasing the cultural and racial barriers that can harm the feeder and the child. As a result, Breastfeeding Awareness Month is separated into culturally specific weeks such as [World Breastfeeding Week](#), August 1st-7th, [Indigenous Milk Medicine Week](#), August 8th-14th, [Asian & Pacific Islander Breastfeeding Week](#), August 15th-21st, [Black Breastfeeding Week](#), August 25th-31st, and [Latina/x Breastfeeding Week](#), September 5th-11th. These educational campaigns promote cross-cultural understanding, dismantle barriers, and expand initiatives for healthy breast/chestfeeding practices across all communities.

Breast/chestfeeding is highly beneficial to both the feeder and the child. In the United States, over 80% of birthing parents start breast/chestfeeding but discontinue before the recommended time of 12 to 24 months (1). Although any amount of breast/chestfeeding is better than none, research has indicated that the benefits of breast/chestfeeding increase with prolonged duration (1).

Human milk is a critical source of infant nutrition that contains special components (image 1.) that extensively affect cognition, behavior, mental health, and a sense of security and attachment between the feeder

and child (3). Benefits for breast/chest-fed children include decreased atopic dermatitis, gastroenteritis, asthma, allergies, sudden infant death syndrome, type 2 diabetes, childhood obesity, certain cancers, ear infections, respiratory illnesses, anti-social behaviors, and atypical social development (2, 3). Breast/chestfeeding can also help increase age-appropriate weight gain, intelligence, cognitive development, memory retention, language skills, whole brain volume, cortical thickness, white matter volume, myelination, and temperament (2-4). Furthermore, there are several advantages for the feeder, such as decreased risks of breast cancer, ovarian cancer, type 1 diabetes, type 2 diabetes, hypertension, cardiovascular disease, postpartum depression, anxiety, obesity, hyperlipidemia, muscle contractions, and postpartum bleeding (1-4). Breast/chestfeeding can also increase cardiac vagal tone, generate higher quality sleep, post-pregnancy weight loss, oxytocin release, social bonding, trust, love, relaxation, and uterine involution (2, 3).

“Due to the numerous benefits, every major health organization recommends exclusive breast/chestfeeding for the first six months of life (1, 2) and introducing complementary foods after six months. Despite these recommendations, many feeders discontinue breastfeeding early or do not initiate breast/chestfeeding at all. In the United States,”

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ry foods after six months. Despite these recommendations, many feeders discontinue breastfeeding early or do not initiate breast/chestfeeding at all. In the United States, 81% of women initiate breastfeeding, with 52% continuing for six months and 31% continuing for 12 months (1). The reasons for ceasing breast/chestfeeding are not always known and are always highly personal and complex. Not all factors can be expressed due to the complexity of the physical and emotional nature of breast/chestfeeding. The most common factors that lead to the cessation of breast/chestfeeding are an insufficient milk supply, inadequate latching, and painful nipples or breasts (1).

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There are several ways to address the difficulties that feeders experience with breast/chest feeding, yet these strategies are not always well implemented. One of the most effective methods to increase rates and duration of breast/chestfeeding is to provide post-discharge primary care support (1). This primary care support should promote skin-to-skin contact, early initiation of breast/chestfeeding, lactation support, the Baby Friendly Hospital Initiative (which adheres to The Ten Steps to Successful Breastfeeding), and breast/chestfeeding education (1). It is essential to position the infant correctly to address insufficient milk supply and poor latch; this promotes oxytocin and prolactin release, facilitating milk production (1). To achieve an optimal position, “the infant’s head and body should face the mother’s body, and the infant’s neck should not be hyperextended or flexed to reach the nipple. The nipple should be guided toward the roof of the infant’s mouth, filling the mouth with as much of the areola as possible” (1). Common causes of nipple and breast pain were a result of poor positioning, flat or inverted nipples, ankyloglossia/palatal abnormality, infections, and vasospasm (1). When these concerns were addressed, over half (58%) of the feeders reported decreased pain; however, after common issues were addressed, many breast/chestfeeders continued to report pain, indicating that nipple and breast pain are multifactorial (1).

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In addition to providing accurate education about the benefits of breast/chestfeeding, one of the most important ways a healthcare provider can support parents is to communicate without projecting pressure or passing judgment on feeding choices. All healthcare providers must be approachable and use cultural humility when communicating with patients about breast/chestfeeding and the challenges they are experiencing. Feeders are often met with unrealistic and unachievable expectations for breast/chestfeeding, which results in added pressure and intimidation when communicating with healthcare providers (2). There is a common notion that “breast is best,” which implies that formula feeding is wrong. Some formula-feeding parents may fear harming their infant and avoid conversations about formula feeding with medical staff (2). Some parents may also feel intimidated when healthcare providers promote breast/chestfeeding, which can lead to feelings of discrimination in situations where promotion is not necessarily appropriate (2). Breast/chestfeeding difficulties can contribute to depression and anxiety, and feeders with negative breast/chestfeeding experiences are more likely to have depression and anxiety following birth (2). In addition to the proper medical aid, it is crucial to provide emotional support to feeders and reinforce their identity as a parent when breast/chestfeeding difficulties arise (2). This can be accomplished through support systems such as lactation consultants and support groups to aid in the emotional trauma of breast/chestfeeding difficulties (2).

“Minority populations exclusively breast/chest feed for a decreased amount of time compared to non-Hispanic Whites (7). For new immigrants to the United States, bottle-feeding is more likely to be chosen, even if their country of origin has high breast/chestfeeding rates (6). A parent’s ethnic background and culture can impact who influences the breast/chestfeeder’s view on feeding practices.”

Cultural identities and community affiliations significantly affect the feeder’s perception of breastfeeding/chestfeeding. These cultural influences have an enormous impact on minority populations and initiatives. Breast/chestfeeding rates have increased among all minority groups in the United States, although they remain relatively low (6, 7). Minority populations exclusively breast/chest feed for a decreased amount of time compared to non-Hispanic Whites (7). For new immigrants to the United States, bottle-feeding is more likely to be chosen, even if their country of origin has high breast/chestfeeding rates (6). A parent’s ethnic background and culture can impact who influences the breast/chestfeeder’s view on feeding practices. For example, among the White population, the male partner, mother’s mother, grandmother, and best friend greatly influence breast/chestfeeding choices (6).

Similarly, within the Hispanic population, the mothers, grandmothers, and sisters were a much greater influence than the physicians or nurses (6). Among Southeast Asian communities, the mother-in-law and significant others had the largest influence on breast/chestfeeding, while the healthcare providers had the most significant influence on the Black population with minimal impact from family members (6). In addition to attitudes about breast/chest-

feeding, cultural practices influence feeding and lactation. For example, specific foods are believed to promote milk production in some cultures. As long as it is not harmful, healthcare providers should encourage the consumption of these foods to support an individual's cultural beliefs (6). Weaning practices from breast/chestfeeding also vary according to culture; however, weaning processes should always be collaborative between the feeder and the healthcare providers. To support the specific needs of minority groups, healthcare providers require culturally specific resources and additional education in cross-cultural sensitivity.

Minorities with lower education levels and socioeconomic status are at a heightened risk for breast/chestfeeding problems; Programs and training that increase the well-being of these minority families are imperative (6). Returning to work due to low socioeconomic status leads to suboptimal breast/chestfeeding outcomes (7). Black feeders, in particular, were found to be the most likely to work while trying to breast/chestfeed (62%), followed by Hispanic (59%), Asian (59%), then White (58%) (7). Black and Hispanic populations are more likely to be uninsured, leading to a greater chance of not being educated about the benefits of breast/chestfeeding or receiving medical care if difficulties arise (6). Being in a Baby Friendly Hospital helped improve breast/chestfeeding outcomes in diverse groups and decreased the gap among Black feeders (7).

“Breastfeeding Awareness Month is essential in optimizing breast/chestfeeding practices and reducing disparities in lactation support for minority groups. No matter the cultural group, breast/chestfeeding promotion programs are found to be successful in improving overall breast/chestfeeding rates (6). More interagency collaboration is required to educate parents on the mutual benefits of breast/chestfeeding with innovative strategies that support extended production and use of human milk to optimize development.”

Breastfeeding Awareness Month is essential in optimizing breast/chestfeeding practices and reducing disparities in lactation support for minority groups. No matter the cultural group, breast/chestfeeding promotion programs are found to be successful in improving overall breast/chestfeeding rates (6). More interagency collaboration is required to educate parents on the mutual benefits of breast/chestfeeding with innovative strategies that support extended production and use of human milk to optimize development. These educational programs are most effective when they are designed to be culturally sensitive and developed by individuals from within the target culture (5). When minority populations identify limiting factors, healthcare providers can address the barriers and become more culturally responsive. More advocacy initiatives are needed to ensure that healthcare providers are well

informed and treat all breast/chestfeeding dyads in such a way that is respectful and accepting of all cultural or socioeconomic backgrounds.

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Disclosures: There are no reported disclosures.

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