

The Impact of Structural Health Inequities on the AAP's 2022 Policy: Breastfeeding and the Use of Human Milk

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Introduction

Over the past decade, extensive research has highlighted the health benefits of breastfeeding in both infants and their mothers. In premature infants, it decreases the incidence of chronic lung disease, necrotizing enterocolitis (NEC), sepsis, and the length of the NICU stay (2). In term babies, breastfeeding is associated with a lower incidence of diarrhea, gastroenteritis, asthma, allergies, ear infections, respiratory illnesses, thrush, and sudden infant death syndrome (2). As these infants slowly grow into adulthood, the positive implications are a higher IQ, better eyesight, and a decreased incidence of leukemia, obesity, and Type 1 and 2 Diabetes (2).

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Similarly, breastfeeding mothers experience immediate advantages, including increased oxytocin, decreased postpartum depression, and improved weight loss. As they reach menopause, breastfeeding reduces the incidence of osteoporosis, heart disease, T2DM, and breast, uterine, and ovarian cancers (2,3). Thus, breastfeeding improves short-term health outcomes and provides

long-term protection against chronic diseases (3). This translates into cost savings and a lower fiscal burden on the US healthcare system (4,5). However, in this discussion, we will address how past and current US policies regarding parental leave are hindering this economic progress. We will also investigate how structural determinants of health block adherence to guidelines set by the American Academy of Pediatrics (AAP) regarding breastfeeding and the use of human milk (6).

2012 AAP Guidelines:

In March 2012, the AAP released a policy statement that strongly encouraged new mothers to exclusively breastfeed for six months with continued breastfeeding for at least one year to experience the widespread health benefits (2). Less than a year before this recommendation, the AAP also published a study that contributed to the growing evidence that new mothers who delay their time to return to work have a longer duration of breastfeeding. (1) Considering these findings, it was reasonable to expect a structural change in parental leave policies that complemented the 2012 guidelines. Unfortunately, this did not occur. To this day, the United States is one of six countries worldwide and the only wealthy nation that does not have a formalized federal policy to guarantee paid parental leave to workers (7,8). The Family and Medical Leave Act (FMLA), established in 1993, provides up to 12 weeks of unpaid leave for new parents. However, unpaid leave is not feasible for most people, and 44% of US workers do not qualify for benefits through FMLA (8). This paradox occurs because FMLA eligibility requirements are to work for a company with at least 50 employees within a 75-mile radius, to be employed for at least one year, and to complete 1,250 hours within the last 12 months (14). FMLA ineligibility disproportionately affects families of color (8). As of 2022, only 11 individual US states provide some form of paid family and medical leave, but the length and qualification requirements drastically vary between states (9). This failure to enact a uniform policy protecting parental leave is reflected in mothers struggling to meet the 2012 AAP guidelines and in staggering US healthcare spending costs.

The Center for Disease Control (CDC) found that for infants born in 2011, only 27% were breastfeeding at 12 months. After the AAP guidelines were released in 2012, it was found that for infants born in 2013, this percentage rose to 30.7%, and of that, only 22.3% of moms were exclusively breastfeeding until six months (10,11). In response to this stagnation, the *Healthy People 2020* objectives aimed to increase worksite lactation support programs and live births in facilities that provide care for lactating mothers and their babies. It also sought to reduce the proportion of breastfed newborns who receive formula supplementation within the first two days of life (10,11). However, despite these initiatives and

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increased access to lactation specialists, it was found that for infants born in 2019, only 35.9% were breastfeeding at one year, with 24.9% of moms exclusively breastfeeding until six months (12). The reality is that more than half of new mothers stop exclusively breastfeeding at three months, which coincides with the typical length of maternity leave in the United States (8,12). Of the American women who work during pregnancy, 52% of women work until the time of delivery, and 59% of them are back to work within three months of giving birth (7,14). This is because American women, compared to their non-U.S. counterparts with protected maternity leave, are more apprehensive about taking advantage of these benefits due to their perceived impact on future employment, career advancement, and gender equity (14). The financial implications of this are profound. As of 2020, the United States spends 4.1 trillion dollars annually on healthcare, with 31% of this reflected in hospital care services (13). Paid parental leave is a straightforward solution to this high fiscal spending. It promotes better health outcomes and behaviors and is associated with a 47% reduced risk of infant re-hospitalization and a 51% reduced risk of re-hospitalizing mothers after delivery (8,15). This would help mitigate in-hospital care spending.

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2022 AAP Policy:

A decade after the 2012 guidelines, the AAP issued a revised policy statement in June 2022 regarding breastfeeding and the use of human milk. The new policy aligns with the World Health Organization (WHO) recommendations and extends the recommended breastfeeding duration to at least two years (16). This extension helps ensure that mothers who choose to breastfeed beyond one year do not feel ashamed, judged, or alienated (17). The history of negative attitudes toward breastfeeding can be traced back to infant formula companies using marketing techniques described as “unacceptably pervasive, misleading, and aggressive” by the Director-General of WHO (20). Nevertheless, cultural differences and sociodemographic factors (occupation, education level, age, marital status) play considerable roles in breastfeeding initiation rates and health disparities. African American and American Indian populations are less likely to initiate breastfeeding than non-Hispanic white and Hispanic people (16). Yet, in contrast, the US Bureau of Labor Statistics recorded higher access to paid leave for African American parents (41%) compared to Hispanic parents (23%) (8). This may contradict the previous assumption that access to paid parental leave will improve breastfeeding rates. However, it is important to note that parental leave, while significant in dictating maternal and child health outcomes, is not the only driving factor (7). It has been reported that African American mothers experience structural racism and barriers to care, seen through a lack of social support and inadequate counseling by healthcare providers, at higher levels than any other group. This is associated with earlier cessation of breastfeeding (21). Simi-

larly, low-income, young (age less than 20 years) or low-education (high school or less) mothers also have lower rates of breastfeeding (16,19). The downstream consequences are health inequities across racial, ethnic, and socioeconomic classes.

The recommendation to extend the breastfeeding duration to two years has encountered criticism from some mothers. Mothers already feel pressure to pump more frequently due to the ongoing formula shortage crisis. However, current workplace policies do not give moms adequate time to accomplish this, nor do they support a breastfeeding duration past one year (18). The Fair Labor Standards Act (FLSA) is a federal law that requires employers to provide “reasonable break time” for nursing employees to express their breast milk, but this provision is only for one year after the child’s birth (22). Furthermore, the FLSA does not require these breaks to be compensated, which forces working moms to utilize their allotted break time to provide milk (22). On average, a working mom should be pumping for 15 minutes every 3-4 hours (23). Understandably, there is a palpable frustration among these mothers, who felt inadequate for being unable to reach 2012 guidelines. Under these circumstances, the new guidelines are simply unattainable without policy changes.

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Discussion:

During the height of the COVID-19 pandemic, one study examined how “lactation in quarantine” magnified the pre-existing inequities regarding breastfeeding. The author summarized the key issues by stating that “in the United States, most people feed their children human milk against all odds in the absence of universal basic income, paid parental leave for at least six months, paid lactation leaves and breaks, affordable housing, universal health care, equal access to high-quality, non-discriminatory, and culturally appropriate healthcare (including lactation support), sliding fee childcare programs, and more” (24). Our suggested action plan to address these issues incorporates policy, hospital, and individual provider changes.

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The primary item for change on a policy level is for lawmakers to update the Family and Medical Leave Act (FMLA) to expand eligibility and provide paid leave for women who undergo childbirth. It has been 29 years since this legislation was implemented, but it falls severely short of guaranteeing basic protection to new

mothers and families. The current eligibility criteria based on work site, number of employees, and duration of employment unfairly exclude vulnerable populations, particularly women who are part-time workers or receiving welfare assistance (14).

The modifications on a hospital level include promoting equitable postpartum breastfeeding support to alleviate racial disparities. An example is the Baby-Friendly Hospital Initiative developed by The World Health Organization (WHO) and United Nations Children's Fund (UNICEF). This includes interventions that provide a prenatal infant feeding plan, postpartum educational video with teach-back, cue-based feeding log, breastfeeding education guidelines, and team engagement (25). Additionally, facilitating videoconferencing between mothers and hospitalized premature infant helps improve their pumping experience and connect the whole family to the infant (26).

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Personal and healthcare provider developments increase awareness of implicit and systemic bias to help improve the structural and social landscape surrounding lactation. The research supports that having pediatricians communicate with families about the benefits of breastfeeding increases the initiation, duration, and exclusivity. Furthermore, peer-supported interventions by Women, Infant, and Children (WIC) programs also improve breastfeeding and reduce disparities (16,19).

Conclusion

The period from conception through the first few years of life is critical for family development. However, the only federal legislative guarantee of job protection during this time is 12 weeks of unpaid leave for about half of the US workforce (7). The lack of uniform laws to protect growing families further solidifies health inequities. The children most at risk of not being breastfed, being born preterm or low birth weight, or dying in the first years of life, are those whose parents cannot take time off work (7). We are paying a financially heavy price for this social injustice done to society's most vulnerable members. The United States is the highest-spending country on healthcare worldwide. Yet, it has the lowest life expectancy and the highest rate of chronic disease, suicide, hospitalizations from preventable causes, and avoidable deaths compared to 10 other high-income nations (27). However,

all hope is not lost. When other countries, such as Norway, converted from 12 weeks of unpaid parental leave to 18 weeks of paid job-protected leave, the benefits observed in child development lasted for decades (7). Therefore, while the 2022 AAP guidelines are a step in the right direction, the most pressing need is for policy changes that provide paid parental leave and lactation breaks. By shifting our focus to address these structural issues, we will alleviate disparities and provide more reasonable expectations for mothers in achieving the new guidelines.

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Financial Disclosures: The authors have no financial disclosures to report.

Conflict of Interest: The authors have no conflict of interest.

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