Evaluation of institutional support for breastfeeding among low-income women in the metropolitan New Orleans area

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The benefits of breastfeeding for mother and infant are widely documented (1-5). Despite recognized benefits, national breastfeeding rates remain below Healthy People 2010 national health objectives of at least 75% of mothers who breastfeed their babies in the early post-partum period and 50% of mothers who continue breastfeeding until their babies are 5 to 6 months of age (6).

BARRIERS TO BREASTFEEDING
At the societal, institutional, and governmental levels of influence, barriers to initiating and sustaining breastfeeding have been identified as poor access to resources; inadequate support for breastfeeding in maternity hospitals and clinics; inadequate prenatal and postnatal breastfeeding education; lack of timely, routine post-partum care or home health visits; and maternal employment (1,8-9). Lack of or failure to implement institutional policies supportive of breastfeeding—including those that govern formula distribution and use, staff training, and education programs—can negatively affect breastfeeding (9-15).

Breastfeeding rates are associated with demographic factors. The lowest rates are observed among young, single, poor, and uneducated African-American mothers (16-21). Other barriers are convenience of bottle-feeding; conflict with school or work; lack of support from family, peers, or partner; beliefs and expectancies; and lack of peer role models (15-17,22).

Decreasing institutional barriers to breastfeeding is important if individual behaviors are to be achieved (23). The purpose of this study was to explore institutional support for breastfeeding among low-income women in the metropolitan New Orleans area.

METHODS
Information from facilities providing maternity services and care for newborn infants was collected using a questionnaire adapted from the WHO/UNICEF Checklist for Evaluating the Adequacy of Support for Breast-Feeding in Maternity Hospitals, Wards, and Clinics (24-26). Information was collected on breastfeeding policies, staff training, health education, discharge procedures, and delivering mothers' demographics. The modified questionnaire also allowed respondents to provide their views on breastfeeding barriers and key elements of successful promotion efforts.

Key participants were lactation consultants or head nurses in obstetrics departments of hospitals in the metropolitan New Orleans area. They were identified through the use of hospital directories and a list provided by the Louisiana Lactation Consultants Association. After obtaining approval from the University of New Orleans Human Subjects Committee, a research assistant contacted participants via telephone, described the study purpose, and elicited participation. After obtaining verbal consent to participate, the research assistant hand-delivered the self-administered questionnaires to the participants. The questionnaire was accompanied by a cover letter explaining the purpose of the study and providing assurance of confidentiality. Questionnaires were returned via mail in a self-addressed stamped envelope or by fax. Of the 10 hospitals that provided obstetrical services in the area that were contacted, 9 participated.

SPSS analysis (SPSS 9.0 for Windows, 1999, Chicago, Ill) was used to produce descriptive statistics: Spearman's correlation coefficients and a partial correlation. Hospitals were ranked 1 through 9; 1 represented the hospital with the highest breastfeeding rate. One hospital was excluded from the analysis because of missing data on patient ethnicity. Because this study used aggregate hospital data, the researchers could not control for income or race of delivery to isolate specific effects of hospital policy.

RESULTS AND DISCUSSION

General Information
Of the responding hospitals, reported deliveries ranged from 400 to 2,000 births per year, with an average of 1,122 births per year. The percentage of low-income patients—determined by a patient's being a recipient of Medicaid or Special Supplemental Nutrition Program for Women, Infants, and Children or by income level—ranged from 6% to 90% with an average of 47%.

Breastfeeding Rates
The percentage of women who initiated breastfeeding after delivery ranged from 20% to 75%. Only one facility met the Healthy People 2010 objective of 75% of mothers who breastfeed their babies in...
early post-partum period; the other hospitals’ rates were 60% or less. A statistically significant negative correlation (r=−0.84, P<.01) was found between breastfeeding rates and income level, which supports findings in the literature. This negative association maintained significance (r=−0.87, P<.05) when a partial correlation between rates of breastfeeding and income level controlling for African-American ethnicity was performed. A negative correlation was also found between African-American ethnicity and breastfeeding (r=−0.6, P=.08).

**Policy**

The majority of facilities (n=6) had explicit policies for promoting and supporting breastfeeding. Staff training and support appeared to be sufficient. Almost all facilities (n=8) provided specialized training in lactation management to staff members, namely obstetrics and nursery staff. Most facilities (n=7) had at least one designated staff member—either a lactation consultant or nurse with specialized training in lactation management—available full-time to advise breastfeeding mothers during the prenatal period and during their stay at the facility.

Implementation of existing policy appeared to be inconsistent. Although most facilities (n=8) had a policy of allowing babies to stay in the room with their mothers, the respondent at the facility lacking a policy reported that “Babies room-in anyway.” Furthermore, although most facilities (n=7) allowed mothers to have their infants with them in their beds, one respondent from a facility where mothers were not allowed to have their infants with them reported that “They do it anyhow.”

Another example of inconsistent policy implementation was that despite most facilities (n=8) having a policy to restrict infants’ feeding before the establishment of breastfeeding, staff interpretation of this policy at 3 different facilities resulted in food and drink being given to the newborns. When asked whether food or drink was given to infants, positive responses were qualified with additional statements: “Unless the doctor orders feedings for medical reasons, such as blood sugar.” “If we have to supplement, we give it to the infant via dropper or syringe.” “We use no artificial nipples until baby latches well onto breast,” and “We encourage breastfeeding before any food is administered; we give the baby just a drop of water.”

Regarding evaluation of the breastfeeding policy, only 5 respondents reported that data are collected on the prevalence of breastfeeding initiation and breastfeeding at the time of discharge. Even fewer reported a system in place for assessing effectiveness of health care practices and educational materials spe-
RESEARCH AND PROFESSIONAL BRIEFS

APPLICATIONS

Despite the existence of policies supportive of breastfeeding, rates remain below the desired national objective. These findings suggest that hospital facilities need to evaluate existing breastfeeding policies for consistency of interpretation and implementation. Furthermore, if no policy exists, one needs to be created.

The impact of factors other than policy can be demonstrated by looking closely at the hospital that achieved the Healthy People 2010 objective of 75% women who initiate breastfeeding after delivery. In addition to a low percentage of low-income-status women delivering, this facility had patients with a high level of participation in prenatal care, and perhaps most importantly, had a standing lactation consultant who was a strong advocate for breastfeeding in the facility and the community at large.

Another area for further investigation is health education. Practitioners should conduct an assessment of the health education sessions and materials used for low-income women and, where inadequate, consider if relevant health professionals should be trained in using culturally appropriate educational materials and methods.

Although there has been much research on factors that may create barriers to breastfeeding, additional policy research that allows for the control for the known barriers that have been shown to have an effect on women’s breastfeeding decision is needed. Clearly, existence of policy alone is insufficient to promote breastfeeding among low-income women. However, it is a necessary step in supporting and encouraging low-income women to breastfeed and realizing Healthy People 2010 breastfeeding objectives.

References