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Committee on Health Care for Underserved Women
Breastfeeding Expert Work Group

This Committee Opinion was developed by the American College of Obstetricians and Gynecologists' Committee on Health Care for Underserved Women and the Breastfeeding Expert Work Group in collaboration with committee member Caroline E. Rouse, MD, and work group member Lauren E. Hanley, MD, IBCLC.

Barriers to Breastfeeding: Supporting Initiation and Continuation of Breastfeeding

ABSTRACT: Breastfeeding has maternal, infant, and societal benefits. However, many parents experience obstacles to achieving their breastfeeding goals, leading to reduced rates of breastfeeding initiation and continuation. Despite efforts to increase rates of breastfeeding initiation and continuation, inequities still persist. The factors that influence an individual's desire and ability to breastfeed are varied and include individual parent considerations; practitioner influences; hospital barriers; societal factors, such as workplace and parental leave policies; access to lactation support; and social support of their breastfeeding goals. A multidisciplinary approach that involves community, family, parents, and health care professionals will strengthen the support for parents and help them achieve their breastfeeding goals.

Recommendations

The American College of Obstetricians and Gynecologists (ACOG) makes the following recommendations to support initiation and continuation of breastfeeding:

- The American College of Obstetricians and Gynecologists supports individuals' informed decision making about breastfeeding, free from commercial influence, coercion, and bias. Parents have the right to make their own informed choice about whether or not to breastfeed.
- For those parents who desire to breastfeed, the obstetrician–gynecologist should use a multidisciplinary approach that involves practitioners, community lactation support, family members, employers, and childcare providers to help parents overcome obstacles and obtain the benefits of breastfeeding for themselves and their infants.
- The American College of Obstetricians and Gynecologists recommends that practitioners educate parents about the benefits and mechanics of breastfeeding and encourages clinicians, nursing staff, and government assistance agencies to advocate for policy changes that facilitate breastfeeding, including lactation programs, both within hospitals and in the community.
- To benefit the parent–child dyad, including promoting the opportunity to breastfeed, ACOG recommends paid parental leave, with maintenance of full benefits and 100% pay, for a minimum of 6 weeks. Obstetrician–gynecologists and other health care professionals should strongly advocate for policies that enable breastfeeding, including paid parental leave and break time for persons to express milk in the workplace.
- Practitioners should be open and willing to discuss the intersecting barriers to breastfeeding that parents may face to help them achieve their breastfeeding goals.
- The benefits of breastfeeding, as well as patient education, counseling, and support strategies, should be emphasized during medical school and training of residents in obstetrics and gynecology, family medicine, and pediatrics. Ongoing education also should be promoted for all clinicians and hospital staff involved in childbirth.

Statement of Purpose

Maternal and infant benefits of breastfeeding are well documented. However, many parents experience obstacles to achieving their breastfeeding goals, leading to reduced rates of breastfeeding initiation and continuation. The factors that influence an individual's desire and ability to breastfeed are varied and include individual parent considerations; practitioner influences hospital barriers; societal factors, such as workplace and parental leave policies; access to lactation support; and social support of their breastfeeding goals. Obstetrician–gynecologists and other health care professionals should inform parents of the benefits of breastfeeding and support breastfeeding for parents who desire to pursue it. For those parents who desire to breastfeed, the obstetrician–gynecologist should use a multidisciplinary approach that involves practitioners, community lactation support, family members, employers, and childcare providers to help parents overcome obstacles and obtain the benefits of breastfeeding for themselves and their infants. The American College of Obstetricians and Gynecologists urges obstetrician–gynecologists and others who support individuals in their breastfeeding decisions to advocate for policies that increase breastfeeding support.

The American College of Obstetricians and Gynecologists' Breastfeeding Expert Work Group and Committee on Obstetric Practice have developed documents that address many aspects of breastfeeding (See the ACOG Breastfeeding Toolkit and other ACOG breastfeeding resources at www.acog.org/en/Topics/Breastfeeding). Therefore, this document will focus on the barriers to breastfeeding that parents face and strategies to help them achieve their breastfeeding goals.

Box 1. Benefits of Breastfeeding

- Decreased rate of common childhood infections, such as diarrhea and ear infections, which results in decreased parental absenteeism from work
- Decreased rates of childhood obesity in children who were breastfed as infants
- Decreased rate of necrotizing enterocolitis
- Decreased risk of sudden infant death syndrome
- Increased bonding between mother and infant
- Decreased rates of hypertension, hyperlipidemia, type 2 diabetes mellitus, and cardiovascular disease among women
- Decreased rates of ovarian and breast cancer in women
- Improved return to prepregnancy weight
- Improved birth spacing

Data from Lawrence RA, Lawrence RM. Breastfeeding: a guide for the medical profession. 7th ed. Maryland Heights, MO: Elsevier Mosby; 2011; Chua S, Arulkumaran S, Lim I, Selamat N, Ratnam SS. Influence of breastfeeding and nipple stimulation on postpartum uterine activity. Br J Obstet Gynaecol 1994;101:804–5; Rosenblatt KA, Thomas DB. Lactation and the risk of epithelial ovarian cancer. The WHO Collaborative Study of Neoplasia and Steroid Contraceptives. Int J Epidemiol 1993;22:192–7; Newcomb PA, Storer BE, Longnecker MP, Mittendorf R, Greenberg ER, Clapp RW, et al. Lactation and a reduced risk of premenopausal breast cancer. N Engl J Med 1994;330:81–7; *and* Breast cancer and breastfeeding: collaborative reanalysis of individual data from 47 epidemiological studies in 30 countries, including 50302 women with breast cancer and 96973 women without the disease. Collaborative Group on Hormonal Factors in Breast Cancer. Lancet 2002;360:187–95.

Background

The value of breastfeeding to both the parents and infant is unequivocal (Box 1). Overall, the national rate of breastfeeding initiation is 84.1% (1), which meets the Healthy People 2020 target of 81.9% (2). However, significant disparities exist within breastfeeding initiation across many variables, including race (Table 1), income (76.6% for women living at less than 100% of the federal poverty level), participation in federal aid programs (77% for women in the Special Supplemental Nutrition Program for Women, Infants, and Children [WIC]), mother's educational status (75.6% for women with a high school diploma or GED), and age (74% for women younger than 20 years) (3). Furthermore, although initiation rates are increasing, continuation rates are not, indicating that more support is needed to help parents achieve their breastfeeding goals (1). Barriers to breastfeeding exist at all levels, from societal and structural obstacles, such as inadequate parental leave policies, to practitioner-specific discomfort with or lack of knowledge about how to support all lactating parents. Policies that protect the right of a woman and her child to breastfeed in public and that accommodate milk expression, such as insurance coverage for breast pumps, paid maternity leave, on-site childcare, break time for expressing milk, and a clean, private location for expressing milk, are essential to sustaining breastfeeding (4).

Obstetrician–gynecologists and other health care professionals are in a unique position to review the medical and nonmedical benefits of breastfeeding with parents and families throughout prenatal care. The American College of Obstetricians and Gynecologists supports each individual's informed decision making about breastfeeding, free from commercial influence, coercion, and bias. Parents have the right to make their own informed choice about whether or not to breastfeed. Recognizing and addressing the specific barriers to breastfeeding initiation and or continuation can be instrumental in helping parents achieve their breastfeeding goals.

Addressing Hospital Barriers to Breastfeeding

Hospitals, through the implementation of lactation support programs, can have a positive influence on

Table 1. Rates of Any and Exclusive Breastfeeding by Race and Ethnicity Among Children Born in 2017

	Ever Breastfed (%)	Exclusive at 3 months (%)	Exclusive at 6 months (%)	Any at 12 months (%)
All women	84.1	46.9	25.6	35.3
Hispanic	84.1	41.5	21.5	33.9
Non-Hispanic White	86.7	52.4	28.7	38.2
Non-Hispanic Black	73.7	38.7	21.2	26.1
Non-Hispanic Asian	90.0	47.7	26.8	50.0
2 or more races	83.7	43.9	26.6	31.0

Modified from Centers for Disease Control and Prevention. Rates of any and exclusive breastfeeding by sociodemographics among children born in 2017 (percentage +/− half 95% confidence interval). Available at: https://www.cdc.gov/breastfeeding/data/nis_data/rates-any-exclusive-bf-socio-dem-2017.html. Retrieved October 16, 2020.

breastfeeding for parents who desire to breastfeed. In 1991, the World Health Organization and the United Nations Children's Fund (UNICEF) launched the Baby-Friendly Hospital Initiative to motivate facilities providing maternity care to implement the Ten Steps to Successful Breastfeeding (https://www.who.int/activities/promoting-baby-friendly-hospitals/ten-steps-to-successful-breastfeeding). The more "steps" parents are exposed to during Ten Steps care, the more likely parents are to initiate and continue breastfeeding (5). Furthermore, implementation of Ten Steps care has been associated with narrowing the gap with respect to racial inequities and breastfeeding initiation and exclusivity (6). Hospitals should support the Ten Steps and joint decision making to assist parents with their breastfeeding goals, without coercion.

The first step of Ten Steps care addresses advertising of breastmilk substitutes (formula) in health care settings. The marketing efforts of companies that produce infant formula promote the belief that formula feeding is or should be the norm. The strong inverse relationship between breastfeeding and marketing of formula through promotional items led to the World Health Organization Code of Marketing of Breast Milk Substitutes, which, among other requirements, stipulates that "facilities of health care systems should not be used for the display of products within the scope of this Code, for placards or posters concerning such products, or for the distribution of material provided by a manufacturer or distributor" (7). Obstetrician–gynecologists and other health care professionals should be aware that the in-office or in-hospital advertising and distribution of gift packs with formula to breastfeeding parents commonly is a deterrent to continuation of breastfeeding (8). Therefore, health care professionals should seek noncommercial educational alternatives or gift packs without health-related items (9).

Ten Steps care not only addresses the marketing of breastmilk substitutes, but also highlights the importance of in-hospital breastfeeding support as well as continued assistance after discharge from the hospital (10). Lactation consultants should be accessible to parents in the hospital and after the parent goes home. Although the Patient Protection and Affordable Care Act (ACA) covers breastfeeding support without cost sharing, this practice has yet to be fully implemented in most communities because of state licensure or insurance issues, or both. Therefore, the out-of-pocket costs of lactation services have become cost prohibitive for many parents. Additionally, the inclusion of lactation visits in the global prenatal fee has limited the ability of obstetric care professionals to provide services after delivery in the absence of a breast infection or other specific diagnosis. To address lower breastfeeding rates among marginalized groups who participate in WIC, programs and campaigns to increase the rate of breastfeeding among its participants have been introduced, including a robust peer counseling program to help parent–infant dyads. As a result, from 2010 to 2018, there was a 5.7% increase in the number of infants in the WIC program reported as being breastfed (11, 12). This was associated with a decrease in the rate of subscription to the WIC food packages that included formula and an increase in the subscription to exclusive breastfeeding packages (13).

Sometimes breastfeeding is desired but not possible. Practitioners should be familiar with donor human milk banks, which offer a source of pasteurized human milk. The donors have been screened, and collection, storage, and distribution guidelines are in place (4). Donor human milk has been shown to be especially important for high-risk infants, including those who are preterm and with very low birth weight (less than 1500 g) (14–17). The Human Milk Banking Association of North America is a professional, nonprofit organization composed of 27 donor milk banks in the United States and Canada that facilitates the donation and receipt of human milk, which practitioners and parents can access (www.hmbana.org). However, supply, cost, and distribution remain significant barriers to providing donor milk to high-risk infants. These barriers might cause some families to seek out human milk not handled by an established milk bank (informal milk sharing), a practice

that is not supported by the American Academy of Pediatrics because of increased risks of bacterial or viral contamination, as well as the possibility of exposure to medications, drugs, and other substances when milk and donors are not appropriately screened (14). Some states have passed legislation that allows Medicaid coverage of donor milk for high-risk neonates. Policies that advocate for the use of donor human milk based on an infant's medical need, regardless of insurance status, should be advanced by obstetrician–gynecologists and other health care professionals.

Societal Barriers to Breastfeeding

Social and structural determinants of health can have a significant effect on a parent's general health, including their desire or ability to breastfeed (18).

An individual's racialized experience in the world can greatly affect their ability to meet their breastfeeding goals. Historical factors, such as predatory marketing of infant formulas in the 1950s, might play into breastfeeding decisions made by Black American parents today (19). People of color are more likely to live in under-resourced areas where access to breastfeeding support is less available than in well-resourced areas (20). Research has also shown an association between the experience of racism and discrimination in the job setting and lower odds of breastfeeding at 3–5 months (21). Structural racial inequities result in parents of color being disproportionately affected by barriers common to most individuals who desire to breastfeed, such as inadequate parental leave policies (20, 22). Resources are available to support families of color and identify solutions to overcome disparities in breastfeeding (Box 2).

American Indians and Alaska Natives also have breastfeeding rates lower than the national average, but literature on feeding behavior is limited compared with other racial and ethnic groups. Studies have shown that social networks can have a positive effect on breastfeeding rates among indigenous persons (23). Native Nation governments also have a role in educating individuals about the importance of breastfeeding. Multiple active coalitions exist, such as the Native American Breastfeeding Coalition of Washington and the Navajo Breastfeeding Coalition (24). All thirteen Indian Health Service hospitals that provide maternity care have implemented the Ten Steps, reinforcing the health services' commitment to encouraging breastfeeding (25).

Lack of or inadequate parental leave policies may have a detrimental effect on breastfeeding in parents who return to work. Many individuals with fewer resources have low rates of breastfeeding because they are more likely to return to work soon after giving birth and are employed in positions that make breastfeeding at work more difficult than those with higher incomes (26). A 2018 report from the University of California Hastings College of the Law found lactation discrimination to be widespread, with particularly harsh effects for low-wage workers, who are more likely to be people of color (27).

Box 2. Breastfeeding Resources for Families of Color

- Black Mothers' Breastfeeding Association (https://blackmothersbreastfeeding.org)
- It's Only Natural (https://www.womenshealth.gov/its-only-natural)
- National Medical Association–Breastfeeding (https://www.nmanet.org/page/Breastfeeding)
- ROBE: Reaching Our Brothers Everywhere (https://breastfeedingrobe.org)
- ROSE: Reaching Our Sisters Everywhere (http://www.breastfeedingrose.org)

Policy changes can have a beneficial effect on breastfeeding in the workplace. For example, statewide paid family leave policies in California and New Jersey are associated with increased exclusive breastfeeding rates (28, 29). The ACA supports breastfeeding in several ways. First, it mandates access to breastfeeding support and counseling and provides breastfeeding supplies, such as a breast pump, with no cost sharing. Furthermore, through an amendment to the Fair Labor Standards Act known as "Break Time for Nursing Mothers," the ACA requires employers to provide reasonable break time and a private place, other than a bathroom, for breastfeeding individuals to express breast milk during the workday for 1 year after the infant's birth (30, 31). Despite this requirement, the 2018 report from the University of California Hastings College of the Law finds that over 25 million workers of childbearing age in the United States are left without adequate protections for breastfeeding while working (27).

Unfortunately, not all individuals benefit from the Fair Labor Standards Act amendment. Employers with fewer than 50 employees may apply for exemption if they are able to show that compliance would cause them undue hardship (31). In addition, many salaried employees are exempt from this law and must do their own negotiation and advocacy if they plan to express milk in the workplace (27). Knowledge of their rights related to breastfeeding may be beneficial as parents return to work. A Better Balance (www.abetterbalance.org) and the University of California Hastings College of the Law Center for Work-Life Law (worklifelaw.org) are examples of organizations dedicated to combating workplace discrimination based on pregnancy and family status. State-specific resources that inform breastfeeding mothers about state and local breastfeeding laws are available on individual websites.

Paid parental leave has been demonstrated to increase initiation and maintenance of breastfeeding (29). Strong support of paid parental leave is unanimous across national organizations, including the Society for Maternal-Fetal Medicine (12 weeks recommended) and the American Academy of Pediatrics (12 weeks recommended) (32, 33). To benefit the parent–child dyad, including promoting the opportunity to breastfeed, ACOG recommends paid parental leave, with maintenance of full benefits and 100% pay, for a minimum of 6 weeks. Obstetrician–gynecologists and other health care professionals should strongly advocate for policies that enable breastfeeding, including paid parental leave and break time for all persons to express milk in the workplace (34).

Other Barriers to Breastfeeding

Practitioners should be open and willing to discuss the intersecting barriers to breastfeeding that parents may face to help them achieve their breastfeeding goals. Acknowledging challenges involved in breastfeeding, the difficulties many parents experience while breastfeeding, and recognizing that these experiences are risk factors for postpartum depression, is critical (35). Additionally, it is important that breastfeeding support not be coercive, and that the parent's informed decision about whether or not to breastfeed be respected (4).

Practitioner Barriers

Practitioner knowledge of resources is important to encourage breastfeeding. The American College of Obstetricians and Gynecologists lists physician resources in "The Physician's Role in Human Milk Feeding" at www.acog.org/education-and-events/publications/the-physicians-role-in-human-milk-feeding. Clinicians should be aware of community resources, including prenatal lactation classes, lactation consultants, home-visiting practitioners, and local and national support groups. Telehealth interventions, including text messages and web-based interactive support, have shown promise to extend breastfeeding continuation (36–39). It is helpful for parents to learn about these resources during prenatal care. All practitioners, family members, and childcare providers involved with the care of pregnant and postpartum patients and their infants can support breastfeeding initiation and continuation. The benefits of breastfeeding, as well as patient education, counseling, and support strategies, should be emphasized during medical school and training of residents in obstetrics and gynecology, family medicine, and pediatrics. Ongoing education also should be promoted for all clinicians and hospital staff involved in childbirth.

Parents With a History of or Current Trauma

Obstetrician–gynecologists and other health care professionals should be aware of the effect that a history of trauma can have on an individual's health and interaction with the health care system, including their desire to breastfeed (40). The principles of trauma-informed care should be used when counseling about breastfeeding. Physical abuse during pregnancy has been linked with early cessation of exclusive breastfeeding (41). Similarly, psychological intimate partner violence increases the avoidance of breastfeeding (42). Patients with a history of sexual trauma may choose not to breastfeed, but those who do often report positive bodily connections while breastfeeding and feelings of empowerment by their choice to do so (43).

Barriers for Patients With Complex Medical Issues

Patients with complex medical issues breastfeed at lower rates and for a shorter duration than patients without medical conditions (44–46). Prenatally, practitioners should identify patients with medical comorbidities, assess the patient's intention to breastfeed, and ensure there is no contraindication to breastfeeding (4). Although the decision to breastfeed is influenced by many factors, programs that assist patients with medically complex pregnancies and deliveries may improve rates of breastfeeding in this population (47). Most medications are compatible with breastfeeding; however, patients who require medications during pregnancy or postpartum, or both, might be hesitant to breastfeed or take prescribed medications because of concerns related to infant drug exposure through lactation (48). Practitioners should be familiar with the Drugs and Lactation Database, called LactMed (www.ncbi.nlm.nih.gov/books/NBK501922), which provides comprehensive information on excretion of medications into breastmilk, including suggestions for alternative medications in cases in which a specific medication is contraindicated.

Barriers for Lesbian, Gay, Bisexual, Transgender, and Queer (LGBTQ+) Parents

The LGBTQ+ community is ethnically, socioeconomically, and geographically diverse, and there is a paucity of information related to lactation support for LGBTQ+ parents. Research generally has focused on white lesbian and gay individuals and may not reflect the experiences of all LGBTQ+ people. LGBTQ+ patients may face unique challenges with breastfeeding, such as co-nursing and induced lactation (49). Transgender men who choose to breastfeed, also referred to as "chestfeed," may have difficulty with milk supply if they have had chest reduction surgery (50). Transgender women who desire to breastfeed may induce lactation with a combination of medications and breast pumping (51). For transgender men, the decision not to lactate may be driven by body dysmorphia, and the decision to resume testosterone treatment soon after pregnancy, which will suppress lactation. Clinicians should be aware of resources, such as La Leche League International, the Academy of Breastfeeding Medicine, and the United States Breastfeeding Committee, that offer information and support for LGBTQ+ individuals who choose to pursue lactation (50, 52, 53).

Substance Use Disorder and Breastfeeding

Substance use disorder should not be considered a categorical contraindication to breastfeeding. For example, patients with opioid use disorder who are stable on medication-assisted therapy, and without other contraindications, should be encouraged to breastfeed. On the other hand, patients actively using illicit substances, such as methamphetamine or cocaine, should not breastfeed (48, 54, 55). Many parents with substance use disorder have coinciding hepatitis C infection, which is not a contraindication to breastfeeding, unless nipples are cracked and bleeding (56). While nipples are healing, the parent should pump and discard the milk until the nipple skin is healed and breastfeeding can resume safely.

Parents who are entering recovery should be counseled that if they would like to maintain lactation by pumping until their milk is safer, they should be encouraged to do so. Obstetrician–gynecologists should be prepared to discuss these safety issues with their patients and advise as appropriate (54, 55, 57).

Although marijuana use is becoming more common, data related to its effects on infants is limited, and marijuana use during breastfeeding is strongly discouraged. However, the choice to breastfeed an infant in this setting is not absolutely contraindicated (48, 57–59). Practitioners should use harm-reduction strategies without imposing arbitrary restrictions.

Incarcerated Parents and Breastfeeding

Incarcerated parents face unique barriers to providing breast milk for their infants. Many prisons and jails do not have policies or equipment that allow parents to express milk or directly breastfeed infants at contact visits. This lack of access decreases breastfeeding initiation rates for parents who give birth while in custody and disrupts milk supply for those who enter as lactating parents. Some institutions of incarceration do have supportive policies and pumping equipment, which demonstrate that it is feasible to support breastfeeding for incarcerated parents. The American College of Obstetricians and Gynecologists and the National Commission on Correctional Health Care support such programs (60). Even when systems are in place, challenges remain in the transfer of breastmilk to an infant's caregiver, in the low availability of lactation consultations for parents in custody, the lack of adequate privacy, and the psychological difficulties of being separated from one's child. Obstetrician–gynecologists and other health care professionals can facilitate lactation support services for incarcerated parents, especially while the parent is in the hospital, by educating prison and jail staff about the maternal and child benefits of breastfeeding and advocating that legislation support such programs (61).

Social Support and Breastfeeding

Lack of family and social support also can be a barrier to achieving breastfeeding goals (62). Partner demographics such as race, education, and exposure to breastfeeding are associated with attitudes about breastfeeding that can affect the decision to breastfeed (63). Education directed at the partner has been demonstrated to improve breastfeeding rates (64). An example of a community organization focused specifically on African American fathers is Reaching Our Brothers Everywhere (ROBE; breastfeedingrobe.org). Their goal is to educate, equip and empower men about breastfeeding, which increases rates of breastfeeding and decreases infant mortality rates in the African American community. Peer support programs also have been shown to increase the initiation, duration, and exclusivity of breastfeeding (65–68).

Adolescent Parents and Breastfeeding

Adolescent parents are less likely to breastfeed their children (74%) compared with those older than 20 years (82.4–85.2%) (3). Among adolescents, factors such as the effect of breastfeeding on social and intimate relationships and the availability of social support have a significant influence on the decision to breastfeed (69). Adolescents also face other barriers to breastfeeding, including inadequate education on the importance of breastfeeding, lack of support to initiate and continue breastfeeding, and lack of school-based or work-based facilities in which to breastfeed or pump (70). The obstetric and pediatric community should encourage adolescent and young parents who desire to breastfeed and offer augmented support systems, such as formal parenting programs and support groups (71). Ten Steps care also has been shown to increase the initiation and continuation of breastfeeding in this group (72).

Summary

Breast milk is well established as the best source of nutrition for infants. Breastfeeding has maternal, infant, and societal benefits. Despite efforts to increase rates of breastfeeding initiation and continuation, inequities still persist. The American College of Obstetricians and Gynecologists recommends that practitioners educate parents about the benefits and mechanics of breastfeeding and encourages clinicians, nursing staff, and government assistance agencies to advocate for policy changes that facilitate breastfeeding, including lactation programs, both within hospitals and in the community. Joint decision making between parents and health care professionals is vital to minimize the risk of coercion. A multidisciplinary approach that involves community, family, parents, and health care professionals will strengthen the support for parents and help them achieve their breastfeeding goals.

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