

Increasing Prenatal Choice to Breastfeed in a Vulnerable Population

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Table of Contents

Abstract.....3

Background and Significance3

Purpose.....5

Review of Literature..... 5

Conceptual Framework/Theoretical Model.....9

Methods.....9

Project Implementation.....10

Data Analysis.....12

Results.....14

Discussion.....15

Limitations.....15

Conclusion.....16

References.....17

Appendix A: Breastfeeding Resource Handout.....24

Appendix B: Ready Set Baby Handout.....26

Appendix C: Excel Data Tool.....28

Abstract

Background: There is about a 12% decline in exclusive breastfeeding rates from 2010 to 2019, which may be attributed to incomplete or absent information on breastfeeding from healthcare providers given to patients during pregnancy (Kellams, 2022). In low-income, rural communities, the support of a provider is key to the initiation and success of breastfeeding.

Purpose: The purpose of this project is to determine if the implementation of a breastfeeding initiative program increases the decision to exclusively breastfeed at birth.

Methods: A quantitative design method was used to evaluate if there was an increase in the decision to exclusively breastfeed post-implementation of the breastfeeding initiative program compared to pre-implementation.

Results: The results of the Chi-square test were not significant based on an alpha value of .05, $\chi^2(2) = 5.08, p = .079$, suggesting that intervention and feed could be independent of one another. Data gathered from the pre- and post- intervention surveys did not show a statistically significant increase in prenatal choice to exclusively breastfeed at first.

Summary: The toolkit was distributed to all providers at the practice who administer obstetric care. Providers then gave patients in their second trimester of pregnancy the toolkit. The average observation for para was 0.88 and gravida had an average of 2, age had an average of 27 years of age, and gestation had an average of 21 weeks.

Recommendations and Conclusion: The breastfeeding initiative program showed minimal improvement in the mother's choice to initiate exclusive breastfeeding at birth. In the future, it is recommended to introduce the initiative to the patient earlier in the pregnancy and assess the intent to initiate breastfeeding at every patient encounter.

Key words: pregnancy; breastfeeding; breastfeeding education; breastfeeding and providers; quality improvement; education

Increasing Prenatal Choice to Breastfeed in a Vulnerable Population

Breastfeeding is the preferred form of infant nutrition supporting the optimal health of mothers and children (Meek, 2022). Breastfeeding has been on the Healthy People list for several years, including Healthy People 2030, in an attempt to increase exclusive breastfeeding rates for at least six months in the US (2020). According to the Centers for Disease Control and Prevention (CDC), in 2019, the exclusive breastfeeding initiation rate for the US decreased from about 75% to 63% from 2010 to 2017 (2021a). These rates show that mothers want to initiate breastfeeding, but they may not be receiving the support needed to sustain breastfeeding for an extended period of time (CDC, 2020a). Medical training is deficient in preparing healthcare providers to develop the knowledge base, clinical management skills, and attitudes to provide optimal support for breastfeeding families (Radzaminski & Callister, 2015).

According to the CDC (2021b), there are five benefits of breastfeeding: breast milk is the best source of nutrition, protection against some short-term and long-term diseases and illnesses, breast milk shares antibodies from mother to baby, mothers can feed at any time and any place, and breastfeeding reduces the mother's risk of breast and ovarian cancer, type two diabetes, and hypertension. The American Academy of Pediatrics recommends exclusive breastfeeding for at least six months and then continuing to breastfeed while introducing food to a child's diet until 12 months of age (CDC, 2021c). The advice and encouragement of a woman's provider are critical in helping her to make an informed decision about breastfeeding (Kellams, 2022). The earlier breastfeeding education is introduced to the patient, the more likely a positive decision to breastfeed will be made (Kellams, 2022).

In 2019, the rate of initiating any breastfeeding in North Carolina was about 82%. In the community where this project was implemented, the rate is less than or equal to about 70% - this is the lowest on the scale used, so the exact rate is unknown (Community and Clinical

Connections for Prevention and Health Branch, 2018). The only resources located within the community are the hospital and Women Infant Children (WIC) program at the local health department. The percentage of women in the WIC program who initiate breastfeeding is about 55%, those who breastfeed for up to six weeks is about 32% and up to six months is 19% (Community and Clinical Connections for Prevention and Health Branch, 2018). The rate of exclusive breastfeeding through six months of age in 2018 was about 26%, and the goal for Healthy People 2030 is for that to be about 43% (2020)

Purpose

This project addresses the lack of prenatal breastfeeding support and resources provided to obstetric patients at prenatal visits. The number of resources that support breastfeeding in this community is 0.02 per 1000 residents (Community and Clinical Connections for Prevention and Health Branch, 2018). This project used the principles of implementation science to close a practice gap between obstetric providers and the delivery of breastfeeding information and resources provided to expecting mothers in an attempt to increase the initiation of exclusive breastfeeding.

Review of Current Evidence

Exclusive breastfeeding is beneficial for mothers and infants. It provides a healthy foundation for growth, development, nourishment, hydration, and immunity (Parry et al., 2017; CDC, 2021a). Mothers are encouraged to exclusively breastfeed infants for the first six months of life with continued breastfeeding through at least 12 to 24 months in the absence of contraindications to breastfeeding such as maternal HIV infection, maternal use of certain medications, or maternal alcohol or drug abuse (Parry et al., 2017).

Ready, Set, Baby

Educational interventions are essential to breastfeeding promotion and are more

beneficial in the community setting than at-home educational programs (Sinha et al., 2015). Ready Set Baby (RSB) is an educational program for women in any trimester of pregnancy developed by lactation consultants, breastfeeding researchers, maternal and child health students, and health educators (CGBI, 2015; Kayle et al., 2017; Parry et al., 2017; Dumphy, Thompson, & Clark, 2016). Ready Set Baby provides education on what to expect after delivery, breastfeeding, common concerns, resources for support, and solutions for continued breastfeeding after mothers return to work (CGBI, 2015; Parry et al., 2017).

Ready Set Baby facilitates communication between expectant mothers and healthcare providers through the use of flipcharts, vignettes, and open-ended questions (Parry et al., 2017). Not only does the RSB website provide free non-commercial resources to download, it also provides training videos for staff and educational videos for expecting and new mothers. The patient booklet is provided in ten languages and tools are designed to accommodate low literacy levels, making it the best tool to provide in a community such as the one the project was initiated (CGBI, 2015; Parry et al., 2017).

The Antenatal Period

Breastfeeding education by the provider to women during the prenatal period results in over 60% of women exclusively breastfeeding up to approximately two months after delivery (Tan, 2020; Kavle et al., 2017; Su et al., 2007). Antenatal breastfeeding education increases breastfeeding initiation rates and reduces the use of formula milk (Tan, 2020). The updated World Health Organization guidelines on breastfeeding continue to recommend “where facilities provide antenatal care, pregnant women and their families should be counseled about the benefits and management of breastfeeding” (Tan, 2020). Mothers receiving breastfeeding counseling in the antenatal period are more likely to exclusively breastfeed at birth (Su et al., 2007).

Healthcare workers should make every effort possible to educate and counsel mothers in the

antenatal period in order to encourage exclusive breastfeeding (Su et al., 2007). Those who are counseled in the antenatal period are more aware of correct latch and technique in regards to breastfeeding (Sreekumar et al., 2018).

Interventions are essential to breastfeeding promotion (Sinha et al., 2015). Basic knowledge of breastfeeding and intentions to breastfeed are not sufficient to increase exclusive breastfeeding rates; however antenatal breastfeeding education provided in a consistent manner, throughout pregnancy, simplifies the mother's understanding of the breastfeeding relationship (Kavle et al., 2017; Marinelli et al., 2019). Almost all decisions to initiate breastfeeding are made in the preconception or prenatal period making this a critical time in a new mother's journey. Very few women who intend to formula-feed change their minds at birth making the prenatal period a critical time to influence breastfeeding intention, initiation, and subsequent outcomes (Bibbins-Domingo et al., 2016).

Facilitating Breastfeeding

Multiple factors can influence a person's ability to start and continue breastfeeding. Factors that facilitate breastfeeding include prenatal breastfeeding support from healthcare professionals, an engaged support person, and participation in a breastfeeding support group (Whealan & Kearny, 2015). Prenatal breastfeeding education increases breastfeeding initiation by about 41% and postpartum support improves early breastfeeding successes (Cohen et al., 2018; Nilsson et al., 2020). Continuity of care in breastfeeding is achieved by consistent, collaborative, and seamless delivery of high-quality services from the prenatal period until mothers are no longer breastfeeding (CDC, 2022). Healthcare providers can make breastfeeding attainable and easier. Clinics and provider offices may also develop a written breast-feeding-friendly office policy and implement practices that improve breastfeeding rates by meeting the individual needs of their patient population (*Primary Care Interventions to Promote*

Breastfeeding, 2015). Breastfeeding promotion and support by providers must start prenatally and continue through the intrapartum and postpartum periods.

Conceptual Framework/Theoretical Model

Health Belief Model

The Health Belief Model was developed in the early 1950s by public health social scientists in the US in order to “understand the failure of people to adopt disease prevention strategies or screening tests for the early detection of disease” (Maiman and Becker, 1974). The perception parents have of breastfeeding is a fundamental factor in a mother’s decision to breastfeed. When mothers have the support of family, health counselors, and their healthcare providers, they are more likely to exclusively breastfeed and for a longer time. Cue to action, as well as self-efficacy, coincide together in this situation because the cue to action is to change the practice of providing education to mothers during their prenatal visits and self-efficacy is the ability of the mother to decide to breastfeed based on the given education and support of her provider.

Translational Model

An evidence-based model that integrates a systems approach assimilates a continuum in communication among lactation consultants, nurses, and mothers with infants, within neonatology. The framework selected for this project is the Plan–Do–Study Act (PDSA) model and consists of a four-cycle quality improvement model. The problem is identified through collaboration, in which the best solution is selected with a targeted outcome, evaluated, and established into a permanent change. It is a guiding framework that identifies the importance of inter-professional collaborations among health team members, patients, family, and community.

The foundation of advanced nursing practice involves utilization of evidence, though barriers may exist or the identified problem is the reason for the quality improvement process

and agents of change are selected to implement quality improvement strategies (Stikes and Barber, 2013). Relationship building between the provider and the patient must maintain a communication continuum. Providers can build relationships with expecting mothers which increases knowledge, skills, and positive breastfeeding attitudes (Majra and Silan, 2016). They have the ability to encourage and introduce breastfeeding to parents well before they give birth (Lamb, et al., 2018). Consistent collaboration, using confidence and competence when speaking to mothers of breastfeeding remains a key component towards innovative changes that improve breastfeeding (Denisco and Barker, 2013). Doctor of nursing practice leaders who initiate healthcare policies and programs remain agents of change (Denisco and Barker, 2013).

Methods

Design

This was a quality improvement (QI) project intended to increase the amount of breastfeeding education and support provided to women at their prenatal appointments. It was a retrospective qualitative project over the span of four months. Prior to implementation, no breastfeeding education or resources were provided to women by the providers at their prenatal appointments. A thorough literature review supports how women are more likely to initiate breastfeeding when they are provided tools, resources, and feel supported by their women's health providers at their prenatal appointments.

Population

The defined population was providers who delivered care to obstetric patients in the second trimester of pregnancy in an area of low income and poverty. The population consists of five providers who deliver care to obstetric patients. Inclusion criteria included providers must provide care to obstetric clients in the second trimester of pregnancy. The exclusion criteria were providers did not provide care to obstetric patients.

Setting

This project was implemented in a women's clinic located in rural Southeastern North Carolina. There are seven providers on staff including three obstetricians/gynecologists; three nurse midwives, and one family nurse practitioner. The office is part of a not-for-profit integrated healthcare system owned by the state of North Carolina. The clinic provides care for women of all ages from pre-pubescent to menopause and after.

Project Implementation

With the assistance of a certified nurse midwife, a SmartText tool was developed that was easy to read, could be taken home with the expecting mothers, and that also provides them with local resources they may utilize during their breastfeeding journey. This tool was made available as SmartText via the electronic health record (EHR) with the assistance of information technology (IT) and the team at the clinic. It was made available to all providers within the clinic.

Local community resources and businesses were contacted during the development of the resource tool. Verbal permission was given to list their business or resource on the tool to include two local health departments and three privately owned businesses. Insurance information for Medicaid plans was also provided on the resource tool to determine what breastfeeding and pumping resources and tools are covered. Breast pump coverage and rental information were also included on the tool. Because many mothers will return to work prior to the end of their breastfeeding journey, it was helpful to provide all breastfeeding and pumping resources in one location. The collaboration and support of providers, the stakeholder, and the IT department were critical to the implementation of this project.

Instruments – Resource tool developed (Appendix A). Ready Set Baby education handout (Appendix B). A spreadsheet was developed specifically for this project in order to collect data.

Information included was age, gravida, para, gestation in weeks, intervention, and feed type initiated (B-bottle, C-combination, and EB- exclusive breastfeeding) (Appendix C).

Timeline and critical milestones – IRB approval was granted in early August 2022 to move forward with this QI project. Five of seven providers from the practice met in August in order to present the toolkit and project in its entirety. Collaboration with information technology staff was utilized in order to develop an EPIC SmartText from the toolkit created. The project was implemented in the practice in August 2022. An audit was performed halfway into implementation, and there were some challenges noted. Due to a change in ownership and the EHR, there was trouble running an audit of the tool's usage. This was addressed and implementation continued. The project concluded after a four-month period.

IRB approval – This QI project was approved by the Institutional Review Board (IRB) at Lenoir-Rhyne University in Hickory, NC prior to initiation. Because this was a QI project, there are no physical, psychological/emotional, or economic risks to the participants. All participants are protected by the HIPPA act of 1996, which protects the privacy of patient's health information.

Steps implemented – The project development began by identifying the need for a breastfeeding initiative toolkit that could be provided to the patient, as well as documented in the EHR. A concise list of local resources was also developed after contacting various resources and support programs within a three-county radius. Using this information while also being inclusive to the education level of the local population, a breastfeeding initiative program was developed. It was determined that the RSB education tool was the best fit for this project and because it was a free tool, permission was not needed in order to reproduce and distribute. The toolkit was then presented to five providers and it was agreed that a SmartText tool within the electronic health record would be the best way to utilize the resource. IT was then contacted and a SmartText

document was developed and approved by the stakeholder. The information was distributed by e-mail to all providers at this facility. Implementation began in August 2022 and ended in December 2022.

How data was collected – All data was collected anonymously and only accessible to the PI and faculty committee chairperson. A retrospective chart review was performed on 60 random charts of prenatal appointments in the second trimester. At the conclusion of the implementation period, another retrospective chart review was performed. The pre-intervention sample group was compared to the post-intervention sample group, using the same inclusion criteria, to compare the primary and secondary outcomes and process measures. The data was collected on-site during business hours. It was collected utilizing a developed chart collection tool. With no identifying factors used during the data collection. Data was collected utilizing Microsoft Excel on a password-protected computer that had a firewall protection program to prevent unauthorized persons from gaining access.

Data Analysis

The type of feed was measured by three different levels: bottle, combination, and exclusive breastfeeding. Data was also differentiated by the intervention, yes or no. Other data collected was gravida, para, age, race and gestation in weeks. This project was designed to determine if the effects of a breastfeeding toolkit changed the determination of a mother to initiate exclusive breastfeeding at birth. The data generated from the spreadsheet was interpreted using the Chi-square method in the Status Intellectus program. Data collected was securely entered into Intellectus software using inferential statistics. Pre and post implementation data was created by retrospective chart reviews.

There were a total of 120 patients randomly selected, 60 pre-implementation and 60 post-implementation, that met criteria for this project as seen in Table 1. The most frequently

observed category of feed was bottle at 45%. The most frequently observed category of race was white at 42.50%. The intervention had no significance on the choice of feed at birth.

Frequencies and percentages of feeding, rates, and intervention are presented in Table 1.

Table 1

Variable	<i>n</i>	%
Feed		
Bottle	54	45.00
Combination	32	26.67
Exclusive breastfeeding	34	28.33
Race		
American Indian	39	32.50
White	51	42.50
African American	21	17.50
Hispanic	7	5.83
Other	2	1.67
Intervention		
No	60	50.00
Yes	60	50.00

Note. Due to rounding errors, percentages may not equal 100%.

Summary Statistics

The toolkit was distributed to all providers at the practice who administer obstetric care. The providers then gave patients in their second trimester of pregnancy the toolkit. The average observation for para was 0.88 and gravida had an average of 2. Age had an average of 27 years of age. The observations for the gestation had an average of 21 weeks. The summary statistics can be found in the next table; Table 2.

Table 2

Summary Statistics Table for Interval and Ratio Variables

Variable	<i>M</i>	<i>SD</i>	<i>n</i>	<i>SE_M</i>	Min	Max	Skewness	Kurtosis
Gravida	2.12	0.94	120	0.09	1.00	5.00	0.66	0.18

Para	0.88	0.83	120	0.08	0.00	4.00	0.77	0.60
Gestation_weeks	21.13	3.80	120	0.35	14.00	28.00	0.01	-0.84
Age	27.80	5.87	120	0.54	16.00	41.00	0.16	-0.63

Results

A Chi-square test of independence was conducted to examine the relation between intervention and type of feed. The relation between these variables was not significant based on an alpha value of .05, $\chi^2(2) = 5.08, p = .079$. This result suggests that the RSB toolkit did not have an impact on the mother’s type of feeding choice. It implies that the observed frequencies were not significantly different than the expected frequencies. Data gathered from the pre- and post- intervention surveys did not show a statistically significant increase in the decision to breastfeed. Table 3 presents the results of the Chi-square test.

Table 3

Observed and Expected Frequencies

Feed	Intervention		χ^2	df	p
	N	Y			
Bottle	26[27.00]	28[27.00]	5.08	2	.079
Combination	21[16.00]	11[16.00]			
Exclusive Breastfeeding	13[17.00]	21[17.00]			

Note. Values formatted as Observed[Expected].

(Intellectus, 2022)

Discussion

At the conclusion of this project, it was determined that there was very little statistical improvement in the pre-intervention group and post-intervention group. There were several barriers noted including a change in ownership, providers admission of forgetfulness, and utilizing paper handouts because they were unable to utilize more than one SmartText per chart.

Moving forward it can be suggested to check in with providers more frequently to determine if there are barriers to implementation. Providers should also be encouraged to present the breastfeeding initiative to every prenatal patient at every encounter in an effort to encourage discussion about breastfeeding and increase exclusive breastfeeding initiation. Anticipated findings were that the introduction of this initiative would increase the number of instances a provider presented breastfeeding and its benefits, along with local resources to expecting women. In turn, this would increase the exclusive breastfeeding rate. Unanticipated findings were that the commencement of this initiative would not significantly increase the exclusive breastfeeding initiation rate. These results could be due to poor follow-through in providing the toolkit or omission in documenting education.

Limitations

This QI project had limitations, including a change in the EHR during implementation and upon obtaining results, which resulted in a discrepancy in being able to obtain data. Other limitations included providers not being able to utilize multiple SmartText for one visit. Paper handouts of the information were also provided to the office, potentially creating a skew in the data results of those who received the information. More appropriate timing of discussing breastfeeding with patients and providing the SmartText information may facilitate more robust results of the quality improvement project. Additionally, there was a lack of knowledge of the providers, despite a presentation of the project to all providers and an e-mail reminder to all providers, many providers verbally admitted to forgetting that the SmartText was available to use. Finally, there was a limited timeframe of four months. Given an extended time frame of more than four months, improvements may have been shown in the providers use of the toolkit.

At the eight-week mark of the implementation phase, it was determined that there was a barrier to obtaining the statistical information needed from the SmartText tool. IT was included

in this troubleshooting, and it was thought that the issue was resolved, however, at the conclusion of implementation phase the issue had not been resolved. While this did create some issues, a randomized chart review was able to be performed and the information needed for the project was obtained. A reminder was given to the providers during the implementation phase of the ability to utilize this SmartText tool for their benefit and the education of patients.

Conclusion

The program was mildly successful in improving breastfeeding knowledge and resources provided to obstetric patients, increasing documentation of this in the EHR, and increasing maternal knowledge of breastfeeding benefits and local resources to increase exclusive breastfeeding. Breastfeeding remains the cornerstone of disease prevention and health promotion throughout the lifespan. This quality improvement project was developed in an effort to improve breastfeeding outcomes among new mothers and their infants in Southeastern rural North Carolina. The project site is continuing to use the tool to meet the ongoing needs of expectant mothers. The results will be distributed to the stakeholder and other providers at the clinic by presentation to include a copy of the completed poster.

In future QI, the providers need to be made aware of utilizing the tool at every patient encounter during the prenatal period. Research supports that breastfeeding should be addressed at every encounter during the prenatal period in order to show support to the patient and the breastfeeding journey in order to increase initiation of exclusive breastfeeding at birth. Unfortunately, the initiative was not provided to about 80% of mothers at their appointment. Improved consistency may increase intentional decision to exclusively breastfeed at birth.

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Appendix A

Breastfeeding Resources

Robeson, Cumberland, and Scotland Counties

LATCH – Breastfeeding and Postpartum Wellness Center (Fayetteville)

Breastfeeding and pumping support

Postpartum and perinatal mental health (depression, anxiety, OCD) support

Book online at www.nclatch.com

910.849.9221

Credit/Debit card is required to book, but insurance will be billed directly -We are in network with and accept Tricare (Select and Prime - no referral needed), NC Medicaid, MedCost, Aetna, Cigna, UHC, BCBSNC, and more!

The Fayetteville Doulas (Fayetteville)

Breast pumps

Classes (breastfeeding, birth prep, newborn care, comfort measures, postpartum prep and recovery)

Birth doula services

Postpartum doula services

[910-920-0181](tel:910-920-0181)

www.fayettevilledoulas.com

hello@fayettevilledoulas.com

Mother's Helper (Fayetteville)

Basic and complex breastfeeding issues

Advanced support for NICU grads and other fragile infants

Returning to work

Induced lactation and re-lactation

Breast pump sales and rentals

910-486-8705

www.mothershelperhhs.com



Other Breastfeeding Classes:

- Robeson County WIC Program (910) 608-2114
- Southeastern Health Hospital (virtual) (910) 671-3200
- Robeson Health Care Corp (910) 521-2900
- Scotland County Health Department (910) 277-2440

* Lactation support is covered without prior authorization through Medicaid *

Healthy Blue	EdgePark www.edgeparkbreastpumps.com/order (855) 504-2099 Monday - Friday, 8:00 AM to 9:00 PM Eastern
United Healthcare	United Healthcare partners with Aeroflow to process electric breast pump requests. Aeroflow https://aeroflowbreastpumps.com/qualify-through-insurance To submit an online request, families will have to provide an email address. 1-844-867-9890 Monday - Friday, 8:00 AM - 5:30 PM
AmeriHealth	AmeriHealth is currently working to add breast pump coverage as soon as possible.
Caroline Complete Health	Carolina Complete Health offers a Start Smart for Your Baby program for members that includes resources for breastfeeding and infant nutrition. In addition, eligible members can receive a breast pump and infant car seat through Carolina Complete Health's Value-Added Services. Visit http://www.carolinacompletehealth.com/members/medicaid/resources/vas/newmothers.html
WellCare	Well Care will provide an electric breast pump to a pregnant or new parent and will also encourage participants to enroll in WIC if not already enrolled. To request a breast pump, families or care managers can contact Customer Service by calling 866-799- 5318. Primary care providers can send a prescription for a breast pump to an in network medical equipment vendor.
Medicaid Direct	If you are covered under Medicaid Direct, breast pumps could be considered under Durable Medical Equipment (DME) services with a medical necessity review. However, Medicaid is currently assessing this policy.

For a full list and instructions on obtaining a breast pump, contact your local WIC office.

***If you have private insurance, contact the number on the back of your card to determine how they would like for you to obtain an electric pump.**

Breast Pump Rentals:

- Robeson County WIC (910) 671-3200
- Southeastern Medical Supply (910) 671-5600
- Mother's Helper (910) 486-8705

Internet Resources

- www.ncbfc.org
- <http://www.nutritionnc.com/wic/>
- www.kellymom.com
- www.llofnc.org
- www.womenshealth.gov/breastfeeding
- www.mommymeds.com

Appendix B

Ready, Set, Baby



**Breastfeeding
information & tips**

**Early and exclusive
breastfeeding: your milk
and nothing else**

Early breastfeeding starting within an hour of your baby's birth

Helps contract the uterus and slow bleeding (important for your recovery)

Provides antibodies and nutrition to your baby

Exclusive breastfeeding means your baby gets all his or her food and drink from breastfeeding. It is recommended that your baby receives only your milk for the first 6 months. Talk with your healthcare team about your individual needs and goals for infant feeding.

Did you know?
Babies do NOT need water when it is hot outside. Your milk provides all the hydration your baby needs.

Your milk has everything your baby needs to grow strong and healthy. And it changes according to what your baby needs!

Why no other liquids or solids until 6 months?

Builds a healthy milk supply and keeps it up

Protects your baby from sickness and disease

Benefits of breastfeeding

For moms

Convenient - always warm and ready

Smart - nothing to buy or prepare

Linked with lower risk of disease for breast and ovarian cancers, and Type-2 diabetes

Helps your body recover after delivery

Increases time before next pregnancy

For babies

Early milk (colostrum) is the perfect first food

Provides antibodies to help fight off diseases

Ease to digest = less cramping and gas

Did you know?

Babies who are breastfed have a lower chance of death from Sudden Infant Death Syndrome (SIDS)

These conditions are less common in babies who are breastfed

Ear infections

Diarrhea

Pneumonia

Diabetes

Sudden Infant Death Syndrome

Stomach infections

Overweight and obesity

Childhood cancers

Heart Disease

Avoid "follow-up" and "weaning" formulas for babies aged 6 months and older. These are costly, high in sugar, and not necessary.

Continued breastfeeding

Begin offering other foods to your baby after a full breastfeed when your baby is 6 months old. The American Academy of Pediatrics recommends continued breastfeeding through at least the first year, and beyond for as long as you and your baby desire. Continued breastfeeding is beneficial for your baby's growth and development, and for protection from diseases for both of you.

Appendix C

Patient	Age	Gravida	Para	Race	Gestation (weeks)	Feed	Intervention
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