The

Michigan Breastfeeding Plan

State Strategies to Advance Breastfeeding Practice 2021-2024

Acknowledgements

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Introduction

Overview

Breastfeeding is the normative standard for infant feeding and nutrition. The evidence shows that breastfeeding provides many short and long-term maternal and infant health benefits, as well as economic and community benefits. Therefore, it is an important public health issue.[1]

The Michigan Breastfeeding Plan ("The *Breastfeeding Plan*") is guided by the vision of removing barriers, advancing equity, and promoting breastfeeding as essential for infant nutrition, social emotional health, and chronic disease prevention by ensuring all families have the opportunity to breastfeed for as long as they choose.

The strategies of the *Breastfeeding Plan* contribute to Michigan's larger goals of ensuring that all families can attain health potential and align with the strategies of the *Mother Infant Health & Equity Improvement Plan* of zero preventable deaths, zero health disparities. Breastfeeding has a significant impact on maternal and infant health. The American Academy of Pediatrics (AAP) recommends that infants be exclusively breastfed for about six months, with continued breastfeeding alongside complementary foods for at least one year.[1] It has been estimated that breastfeeding rates below this recommendation account for an excess 3,340 deaths in the United States (2,619 maternal deaths and 721 infant deaths). For every 597 women who meet these recommendations, one infant or maternal death is prevented.[2] Disparities are measurable differences in outcomes between groups of people. Disparities in breastfeeding contribute to disparities in maternal and infant outcomes. Compared to the Non-Hispanic White population, it has been estimated that the Non-Hispanic Black population has 2.2 times the number of excess child deaths and the Hispanic population has 1.5 times the number of excess child deaths attributable to breastfeeding rates below the AAP recommendation.[3]

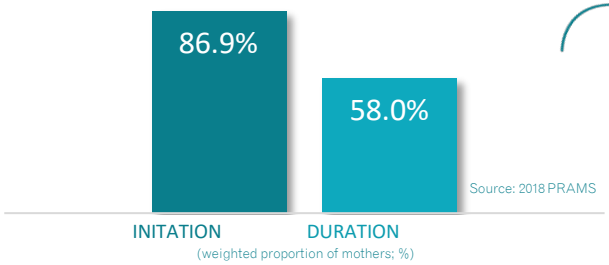
The *Breastfeeding Plan* sets the common agenda necessary for a collaborative approach to protect, promote, and support breastfeeding in Michigan. Institutions, policymakers, government, communities, as well as extended families and friends all play an integral role in improving breastfeeding and achieving equity: the absence of avoidable, unfair, or remediable differences among groups of people. The *Breastfeeding Plan* outlines specific strategies needed to advance breastfeeding initiation, duration, and exclusivity, and eliminate breastfeeding disparities.

[1] While this document uses the word breastfeeding, we recognize the limitations of this word in describing the experience of providing human milk for transgender and non-binary individuals. Alternatives to this word include chestfeeding, nursing, or lactation

The Current State of Breastfeeding in Michigan

The data below shows the current state of breastfeeding in Michigan, highlighting inequities, and serves as ongoing sources of data to track Michigan's progress and the success of the *Breastfeeding Plan*.

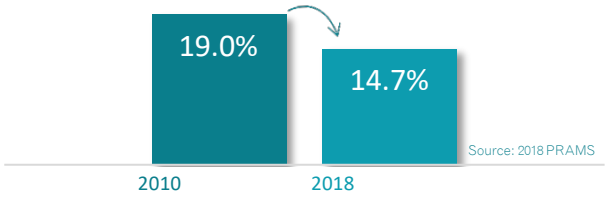
Breastfeeding Initiation and Duration



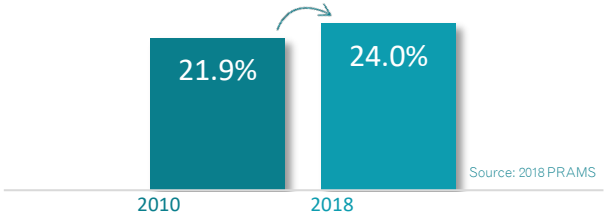
While 86.9 percent of mothers in Michigan reported ever breastfeeding their baby (initiation), only 58.0 percent of mothers reported breastfeeding at three months (duration), and there are disparities in initiation and duration that must be addressed.

★ See Appendix for more information on breastfeeding measures and data sources, including limitations for disaggregating data by race for Hispanic/Latinx, Native American, and Asian mothers.

Breastfeeding Initiation White-Black Differences Narrowed Over Time



Breastfeeding Duration White-Black Differences Increased Over Time

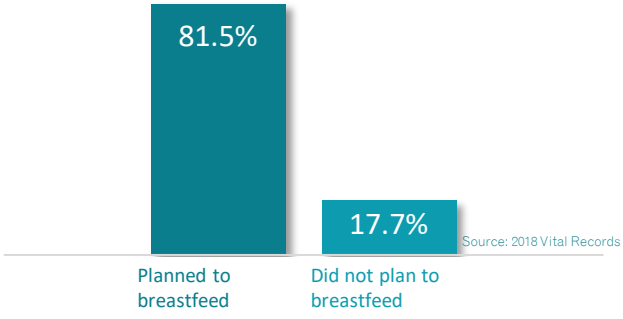


The disparity in initiation for White and Black mothers has decreased over time, but the disparity in three-month duration has not.

Noteworthy Info

While the Pregnancy Risk Assessment Monitoring System (PRAMS) is the best source of data for monitoring breastfeeding rates in Michigan, the sample does not include enough Native Americans to provide reliable estimates for this population. For Native American breastfeeding rates, we can look to Michigan resident live birth files from the Division for Vital Records and Health Statistics at MDHHS. See the appendix for more information on this data source.

81.5 percent of Native American mothers initiated or planned to breastfeed



★ Native Americans are defined by the bridged race code 3 (Native American alone) and code 23 (multiple race, with Native American probable primary race).

The Current State of Breastfeeding in Michigan

By 2024, our goal is to increase initiation and duration and to decrease racial disparities.

	Current (2018)	Goal (2024)
Initiation		
Non-Hispanic White[ii]	89.1%	93.6%
Non-Hispanic Black[ii]	74.4%	86.2%
Native American[iii]	81.5%	88.8%
Duration (Three months)		
Non-Hispanic White[ii]	60.9%	73.1%
Non-Hispanic Black[ii]	36.9%	51.7%

To increase duration, we must look at the top reasons why mothers stop breastfeeding:

Source: 2016-2018 PRAMS, weighted portion of mothers who stopped breastfeeding

55.3% - Perceived low milk supply

36.5% - Perception that breastmilk alone did not satisfy baby

33.2% - Difficulty nursing or latching

23.1% - Too painful, sore/cracked/bleeding nipples

20.8% - Returning to work

★ PRAMS questions reflect individual-level experiences. Societal barriers also affect breastfeeding including systemic racism. For example, perceived low milk supply could indicate a lack of access to skilled lactation support.

We can use data to improve breastfeeding support

Support Black parents experiencing **pain while breastfeeding**.

While the reasons mothers stopped breastfeeding were consistent across racial groups, Black mothers were more likely to cite pain as a reason. This means there is an opportunity to improve how providers are asking about, listening to, and addressing issues of pain for Black parents.

Support parents with perceived **low milk supply** and **latching**.

Perceived low supply has remained the top reason mothers stopped breastfeeding across racial groups and for those who stopped early (before one month) or later (two or more months). Those who stopped early were more likely to cite difficulty nursing/latching as a reason than those who stopped later.

[ii]Michigan Pregnancy Risk Assessment Monitoring System (PRAMS)
[iii]Live birth files, Division for Vital Records and Health Statistics, MDHHS

Breastfeeding Disparities

Disparities in breastfeeding rates are measurable differences in outcomes between groups of people and are the result of systemic conditions and injustices. The root cause of breastfeeding inequity is systemic racism.

For example, the reasons for lower breastfeeding rates in the Black community include the history of slavery and forced wet nursing, racial discrimination, lack of social support and role models for breastfeeding, and the fact that Black parents return to work earlier and have less flexible work conditions.[4]

Many Native American traditions support breastfeeding, but historical trauma and cultural oppression have interrupted the translation of breastfeeding traditions and knowledge between generations.[5]

Due to historical and current systems of oppression, Black, Indigenous, and other people of color are also more likely to live in under-resourced neighborhoods or "First Food Deserts" that lack breastfeeding supports such as Baby-Friendly® hospitals, support groups, lactation consultants, and breastfeeding professionals who share their background.[6]

Any work to address these disparities must look beyond the individual to the social conditions and institutional or governmental policies and practices that discourage or support breastfeeding. The overwhelming majority of families choose to breastfeed. It is incumbent upon all of us with the opportunity to influence systems to ensure that families are able to continue breastfeeding for as long as they desire.

The Plan

Michigan's Strategies to Advance Breastfeeding Practice

Michigan's breastfeeding strategies continue and build upon the strategies outlined in the *State of Michigan Breastfeeding Plan 2017-2019*, based on feedback from partners around the state who were involved in the development or implementation of the previous Plan (e.g. breastfeeding coalitions, community organizations, home visiting programs, WIC, local health departments, and the Regional Perinatal Quality Collaboratives).

The strategies are organized into three perinatal phases:

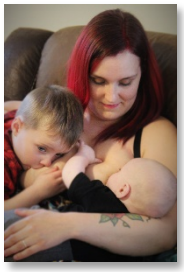
1. Before pregnancy/preconception
   strategies for families prior to pregnancy, as well as promoting a culture of breastfeeding
2. During pregnancy/prenatal
   strategies for the time period of pregnancy and birth
3. After pregnancy/postpartum
   strategies for the time period after birth

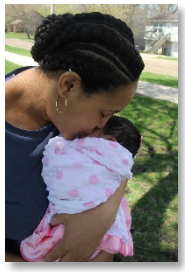
Additionally, this *Breastfeeding Plan* identifies policy priorities to advance breastfeeding. While these strategies create a common agenda for breastfeeding partners across Michigan, The *Breastfeeding Plan* also identifies strategies to which MDHHS commits to take specific action. This does not preclude other partners or MDHHS from working on all strategies.

The *Breastfeeding Plan* recognizes that health equity is not just an outcome, but a process of ending systemic and persistent differences in access to the goods, services, and opportunities of society based on race, class and wealth, gender and gender expression. [7,8] Therefore, the breastfeeding strategies focus on building understanding and capacity for individuals, organizations, and systems to advance birth and breastfeeding equity and address the root causes of inequities.

Each strategy in *The Breastfeeding Plan* will be implemented in a way that:

- Makes the evidence around health inequities and its sources transparent
- Explores the root causes of health inequities – race, class, and gender oppression– and how to address them
- Discusses and responds to the values and needs of the community





Before Pregnancy/ Preconception

All Partners May. . .

- Collaborate with school health experts on including breastfeeding anatomy, physiology, and health benefits in elementary, middle, and high school classes.
- Incorporate breastfeeding content that includes the root causes of inequities in breastfeeding outcomes into education, training, and continuing education for medical and public health professionals such as doctors, nurses, midwives, social workers, dietitians, community health workers, and health educators.
- Integrate breastfeeding education into programs that serve families such as early intervention programs, early learning and childcare, WIC, home visiting, family planning or women's health clinics, school and adolescent health, and classes offered by health plans to members.

MDHHS will. . .

- Use culturally responsive, evidence-based, breastfeeding promotion messages and images to make breastfeeding the norm and integrate breastfeeding information into other relevant public health campaigns.
- Require that MDHHS Maternal Infant Health professionals (e.g., home visiting, reproductive health, WIC, infant safe sleep) have an appropriate level of breastfeeding education, which at a minimum includes the health benefits of breastfeeding to parents and infants, common barriers to breastfeeding, root causes of breastfeeding disparities among racial and ethnic groups, how to have honest and non-judgmental conversations about risk reduction strategies for safe sleep, and resources available to support Michigan families and promote breastfeeding.
- Promote actions to build organizational and system capacity and infrastructure to advance birth and breastfeeding equity in public health and healthcare to address the root causes of inequities (racism, classism, and gender oppression). This will be done through education/ training, structured dialogue, policies, practices, and continuous quality improvement.
- Expand the birth and breastfeeding data that is disaggregated by race and other characteristics to reflect the state's diverse population.
- Explore best practices in community-centered, collaborative models for collection, interpretation, and application of breastfeeding data.

During Pregnancy/ Prenatal

All Partners May. . .

- Provide families with consistent breastfeeding education before, during, and after pregnancy to ensure that they arrive at the hospital prepared to breastfeed their babies.
- Ensure that families are aware of breastfeeding resources and know how to get help if they need it.
- Increase prenatal education that is inclusive of partners, family, and community members who play a key role in breastfeeding outcomes.
- Increase the number of Baby-Friendly hospitals in Michigan and recognize hospitals that adopt breastfeeding-supportive maternity care and infant feeding as best practices.
- Build a team around breastfeeding families to improve continuity of care. Collaboration should include inpatient/outpatient perinatal care providers, other healthcare providers, breastfeeding support professionals (e.g., IBCLC, CLC, IBC, CLS, and Doulas), insurance plans, and home visiting programs.

MDHHS will. . .

- Disseminate informational and educational materials that address the most common breastfeeding issues at the breastfeeding dyad level (e.g. latching) and the most common institutional and community-level barriers (e.g. early learning and childcare; workplace). This also includes information on educating families about proper pump usage and donor milk.
- Use outcomes and program data to identify strategies for addressing inequities in access to quality prenatal care, which includes consistent breastfeeding education.
- Expand home visiting support to eligible families and strengthen breastfeeding knowledge and skills of home visiting professionals including risk reduction strategies for safe sleep.

After Pregnancy/ Postpartum

All Partners May. . .

- Increase community-driven support and community-clinical linkages, especially for early experiences with breastfeeding. Focus on support where families live, work, and play, and center grassroots community-driven models.
- Increase access to early learning and childcare programs that support breastfeeding families by increasing adoption of best practices such as *Caring for Our Children*[iv] standards.
- Encourage that postpartum breastfeeding support is inclusive of partners, family, and community members who play a key role in breastfeeding outcomes.
- Increase access to remote professional support such as telephone hotlines, telehealth, online chats, and text services to reduce barriers and address inequities.
- Increase cultural diversity and equitable hiring practices and compensation for breastfeeding professionals, in particular IBCLC/CLC/IBC/CLS, to reflect the communities in which they work and to improve racial and cultural representation in the breastfeeding field.
- Educate employers, schools, colleges, and universities on how to best support breastfeeding families.
- Support parents and families on their breastfeeding goals, including ability to continue breastfeeding while at work or in school.
- Support parents and families to advocate for their breastfeeding rights and needs, such as insurance benefits, workplace accommodations, and breastfeeding in public.
- Ensure that breastfeeding services and supports, such as quality pumps and lactation services, are both covered by insurance and accessible to families.

MDHHS will. . .

- Use outcomes and program data to identify strategies for addressing inequities in access to and effectiveness of breastfeeding support.
- Prioritize financially supporting community groups and organizations led by and specifically serving Black, Indigenous, and People of Color.

[iv] https://nrckids.org/CFOC

Policy Priorities

The below policy priorities are necessary to support breastfeeding families in Michigan, particularly by keeping families together during the breastfeeding years. The priorities can be accomplished through legislative, institutional, or organizational action and may be accomplished through incremental change.

- Extend Medicaid coverage from 60 days to 12 months postpartum.
- Provide insurance coverage, equitable compensation, and pay equity for quality breastfeeding support, such as non-licensed breastfeeding professionals (IBCLC/CLC/IBC/CLS), peer support providers, and doulas. Including equitable compensation for community involvement.
- Expand paid family leave and affordable early learning and childcare.
- Expand and enforce breastfeeding accommodation to all employees regardless of legal status and employment classification.
- Increase insurance coverage of donor milk.
- Develop policies to improve breastfeeding surveillance data for populations of color (e.g., Spanish language PRAMS, sampling and reporting for Native Americans, Latinx, and Arab and Chaldean Americans).
- Ensure that emergency preparedness plans include provisions for the protection, promotion, and support of breastfeeding, and address the needs of families of color.
- MDHHS will inform policy priorities by using data to identify strategies to address structural inequities that impact breastfeeding.

Appendix: Data Sources

The American Academy of Pediatrics recommends that infants be exclusively breastfed for about six months, with continued breastfeeding alongside complementary foods for at least one year. There are two measures used to monitor breastfeeding. Initiation describes whether a baby was ever breastfed, and duration describes how long a baby was breastfed. *Michigan's Breastfeeding Plan* sets goals for initiation and 3-month duration because these are the measures that have the most reliable data for Michigan. This data comes from the Pregnancy Risk Assessment Monitoring System.

Michigan Pregnancy Risk Assessment Monitoring System

The Michigan Pregnancy Risk Assessment Monitoring System (PRAMS) is the best source of breastfeeding data for Michigan because it includes a large, representative sample of Michigan mothers.

PRAMS collects information about health history, health conditions, health care, insurance, life stressors/experiences, activities, and health behaviors from the year before conception through the time when a new baby is between four to nine months of age. PRAMS is a random population-based survey of one out of every 50 mothers in Michigan who have had a baby during the survey year.

PRAMS oversamples mothers of low birth weight infants and African American mothers. The most recent data is from 2018 and provides a good picture of Michigan's breastfeeding initiation rates and disparities.

One limitation of PRAMS data is that it is cross-sectional, and therefore does not capture the full length of time that respondents breastfeed. Because the survey is completed between four and nine months postpartum, it can provide data on breastfeeding duration through three months for all respondents and does not capture breastfeeding rates for older infants.

For mothers who have stopped breastfeeding by the time they complete the survey, PRAMS data does capture important information on barriers to breastfeeding and the reasons mothers stop breastfeeding. Another limitation is that the sample does not include enough mothers from racial-ethnic groups other than Non-Hispanic White and Non-Hispanic Black to provide reliable estimates for these populations without combining multiple years of data.

Appendix: Data Sources

Vital Records Live Birth Files

Michigan's birthing hospitals collect breastfeeding initiation data that is then analyzed by the Division for Vital Records and Health Statistics at MDHHS. This data is also sometimes referred to as birth certificate data. One limitation of live birth files is that they only capture initiation, not duration. Also, the breastfeeding information collected after a live birth is initiated, planned, and not planned. There are no definitions available for these categories, so it is possible they are interpreted differently by different people completing the Vital Records form. Our best estimate of breastfeeding initiation rates from this data source is to combine the initiated and planned response categories.

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Maternal and Child Health Epidemiology Section
https://www.michigan.gov/mchepi

Mother Infant Health and Equity Improvement Plan
https://www.michigan.gov/miheip

Michigan WIC
https://www.michigan.gov/wic

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