State of Breastfeeding in Massachusetts 2024

Report to

Massachusetts Department of Public Health

by

Public Consulting Group

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CONTENTS

BACKGROUND

According to the U.S. Centers for Disease Control and Prevention, breast milk is the best source of nutrition for most infants. In addition to being a convenient source of high-quality nutrition, breast milk adapts to the changing nutritional needs of the newborn, protects against short- and long-term illnesses, provides antibodies to support a strong immune system, and can also have health benefits for the breastfeeding parent.

In Massachusetts, the Department of Public Health's (MDPH) Bureau of Family Health and Nutrition (BFHN) provides programs and services ensuring the health of the Commonwealth's mothers, infants, children, and youth, including children and youth with special health needs and their families. As part of this mission, BFHN has completed a state-level needs assessment, supplemented with administrative and survey data to inform their strategic plan to improve the rates of breastfeeding in Massachusetts.

KEY FINDINGS

Massachusetts ranks higher than the national average in its breastfeeding rates, with 90.1 percent of infants having been fed breast milk at some point compared to 86.2 percent nationally according to the National Immunization Survey 2022. These rates decline as the child ages, with 34.4 percent of Massachusetts' infants fed exclusively breastmilk at six months and 35.7 percent receiving any breastmilk at 12 months (the corresponding national figures being 35.7 percent and 34.1 percent, respectively). Disparities exist in these rates, however, particularly in how quickly breastfeeding is terminated among racial and ethnic groups, age groups, income levels, and area of residence.

Medical providers and hospitals in Massachusetts also provide services more conducive to encouraging breastfeeding than the national average, with the 2022 Maternity Practices in Infant Nutrition and Care (mPINC™) survey, which measures supportive breastfeeding practices in hospitals, reporting an overall Massachusetts subscore of 88 out of 100 compared to a score of 81 nationally. From a policy perspective, Massachusetts is also generally supportive of an environment that encourages breastfeeding, with 12 weeks of paid family and medical leave and early care and education regulations that are partially aligned (score = 70 out of 100) with the Caring for our Children standards. The results from surveys and a statewide needs assessment indicate, however, that providers face challenges in finding staff qualified to provide lactation support; training existing staff to provide breastfeeding support; providing these supports in a way that is inclusive and in a patient's language; and addressing cost barriers to care with a particular need to expand insurance coverage for breastfeeding services.

Survey results from the Infant Feeding Family Survey conducted by BFHN and the 2022 WIC Participant Satisfaction Survey conducted by the Massachusetts Women, Infants, & Children Nutrition Program (WIC) Program indicate that birthing persons in Massachusetts are best able to meet their breastfeeding goals when they feel supported by programs such as WIC, their hospital, other medical professionals, or their family and partner. Common needs identified by these individuals included a desire for better access to high quality sources and information about breastfeeding and managing related problems, assistance in affording lactation services, as well as breastfeeding supports from workplaces and schools.

PURPOSE OF REPORT

This report aims to supplement the findings and recommendations developed from the BUSPH needs assessment with the most up-to-date breastfeeding data to provide a snapshot of the current state of breastfeeding in Massachusetts and inform the development of a strategic plan by BFHN. In addition to quantitative information, qualitative information gathered directly from providers and the birthing population as reported in the surveys supplement the understanding of how breastfeeding is experienced in Massachusetts.

Public Consulting Group LLC (PCG) was engaged as a partner to develop this report which concatenates multiple data sources, including administrative data for breastfeeding rates, surveys conducted by BFHN and their partners, and a statewide needs assessment conducted in partnership with the Boston University School of Public Health (BUSPH).

The body of the report is divided into four main sections. Breastfeeding Needs Assessment provides information on the key informant interviews that were conducted with partners from BFHN, care providers, and community organizations providing breastfeeding support. Breastfeeding Rates provides raw data on the rates of breastfeeding in Massachusetts and nationally. Rates are reported from multiple sources, each providing a different lens on the data such as the age of the child, year-over-year trends, and disparities. Provider and Hospital Characteristics provides information on the practices of medical providers and hospitals including challenges to adequate breastfeeding care and alignment with best practice standards. Challenges Faced by Individuals highlights the experiences of birthing persons in breastfeeding their infant(s), including their attitudes, challenges, and supports.

BREASTFEEDING NEEDS ASSESSMENT

MDPH conducted a statewide needs assessment in January 2023 to better understand the strengths of Massachusetts' support for breastfeeding parents, identify opportunities for improving breastfeeding rates, and identify areas where information gaps may be present. To facilitate this, twenty-two community partners across three sectors were interviewed. All seven BFHN subdivisions were represented, as were healthcare providers including hospitals and family practice providers, as well as other community organizations supporting parents both pre- and post-natal.

The interviews revealed several key areas where breastfeeding care and support – and the systems providing that care and support – could be improved. These included educating and supporting parents; collaborating across providers, organizations, and the community; focusing on equity; improving provider education; reducing cost barriers; supporting partners, families, and the community; providing budget and funding; and supporting new parents at discharge from the hospital.

By far the most universal message from the interviews conducted was the need for improving education and support for pregnant parents and those who have just given birth. The general lack of information and education provided to parents was noted by several interviewees, who referenced a need to improve the amount, quality, and accessibility of education and supports provided both throughout pregnancy and after birth. Additionally, there were several common drawbacks identified in the support and education that is provided to parents:

- Education and support need to expand so they can happen where parents are, *i.e.,* at the hospitals and clinics where parents are already receiving pre- and post-natal care, during home visits from providers such as Early Intervention and the Maternal, Infant, and Early Childhood Home Visiting program, through breastfeeding warmlines, food pantries, SMS education, mobile lactation vans, community settings, and social media;
- There is a need to better incorporate culturally and linguistically appropriate practices into breastfeeding education, including increasing the number of Black, Indigenous, and People of Color (BIPOC) staff and counselors as well as those who speak the languages of the communities they serve;
- Information on breastfeeding can be inconsistent between different providers – there is a need for universal messaging surrounding the benefits of breastfeeding and how to breastfeed coming from the healthcare system;
- Many breastfeeding parents indicate they feel they have a low milk supply which makes them feel they need to reduce or stop breastfeeding. Parental education can be improved regarding how much milk they should expect to produce for their infant and how this may change over time, as well as when to contact their doctor;

- Promotion of existing supports and classes needs to be expanded or better targeted to improve community awareness; and
- Education needs to occur for parents and providers that medical challenges to breastfeeding can be overcome and that traditional breastfeeding is not the only way to get breast milk into a child.

Interviewees also spoke of several improvements that could be made by providers of maternity care:

- Collaboration across providers and with community organizations is needed to better support the multifaceted and changing needs of the breastfeeding population;
- Implicit bias training and awareness should be provided for providers to ensure they are advocating for breastfeeding without assuming the family will formula feed or won't be able to afford the needed supports;
- Administrative support is needed for breastfeeding initiatives such as Baby-Friendly Hospital certification;
- An International Board Certified Lactation Consultant (IBCLC) at each WIC program who is focused exclusively on lactation support (as opposed to nutrition or other tasks) would be beneficial;
- Providers' budgets should be increased to gain access to breastfeeding support by hiring sufficient staff, as respondents identified an insufficient number of staff to cover the times of the day or week when parents need to access services, insufficient time for available providers to spend with patients, and insufficient representation of the communities served among existing staff; and
- Support for the parent and infant should be increased at hospital discharge, with greater support needed for the transition between the hospital setting and outpatient services that support parents.

To expand on the need for material and social support, the positive and negative messaging received from these areas of social life were cited as areas that play a major role in a parents' attitude toward breastfeeding and their likelihood to continue breastfeeding for the recommended timeframes. To that end, interviewees recommended providing additional spaces to breastfeed in the workplace, school, and community (such as freestanding Mamava lactation pods) and extending education to employers so they can learn about the benefits of supporting breastfeeding employees and families.

Patient education may also play an important role. For some parents, the decision to breastfeed can have strong multigenerational and cultural influences and providing high quality, accurate, and culturally sensitive information can help new parents to better

understand and navigate their choices. This conversation needs to be framed, however, as being about benefits and outcomes. Several providers noted that they will not emphasize breastfeeding as they don't want to shame the parent or make them feel as if they are a failure; in the Tufts University Community Evaluator Project interviews, many parents identified feeling as though the providers were doing exactly that: shaming them into breastfeeding. Additional training should be made available to providers to assist them in navigating the balance of providing accurate and reliable information on breastfeeding that is centered around benefits and outcomes without shaming the parent or implying that breastfeeding is just a lifestyle choice.

In addition to the need for equity in services provided in terms of race, ethnicity, and language, individuals of different income levels also experience breastfeeding support very differently. While those of low income can often qualify for and access WIC services and those of higher incomes can afford to pay for the lactation services available, those who fall in the middle are often unable to qualify for or afford these services and are left unsupported. While there are certainly challenges faced by those who are able to access services—regardless of how those services are accessed—this "donut hole" is an area of particular challenge for parents in this middle category. Several interviewees mentioned the need for lactation services to be covered by insurance to ensure that breastfeeding supports remain accessible by all.

BREASTFEEDING RATES

INITIATION, DURATION AND EXCLUSIVITY

Three metrics are used to examine the rates of breastfeeding: breastfeeding initiation, duration, and exclusivity. Breastfeeding initiation refers to whether breastfeeding was ever initiated for the infant, while breastfeeding duration refers to the length of breastfeeding, and breastfeeding exclusivity refers to the length of time the child was fed breast milk exclusive to other sources of nutrition such as formula or solid foods. The American Academy of Pediatrics (AAP) and the 2020–2025 Dietary Guidelines for Americans (Dietary Guidelines) have slightly differing guidelines that recommend that infants be exclusively breastfed for the first six months, with a breastfeeding duration (along with other complementary foods) of 12 months (according to the Dietary Guidelines) and 24 months (according to the AAP).

Using data from the National Immunization Survey 2022 (NIS), rates for these metrics for Massachusetts and nationally are presented in Table 1. Massachusetts has a consistently higher (0.3–3.9 percentage points) rate of breastfeeding than the national rate. Note that the NIS captures data on infants between 19 and 35 months of age at the time of the survey (calendar year 2022, in this case) and will therefore represent infants born between January 2019 and May 2021.

Table 1. Massachusetts and U.S. National Breastfeeding Rates (NIS 2022)

Rate	Proportion
Indicator:	**Ever Fed Breast Milk**
Massachusetts Rate	90.1%
US National Rate	86.2%
Indicator:	**Breastfeeding at Six Months**
Massachusetts Rate	57.5%
US National Rate	55.5%
Indicator:	**Breastfeeding at 12 Months**
Massachusetts Rate	35.7%
US National Rate	34.0%
Indicator:	**Exclusive Breastfeeding at Three Months**
Massachusetts Rate	60.0%
US National Rate	58.8%
Indicator:	**Exclusive Breastfeeding at Six Months**
Massachusetts Rate	34.4%
US National Rate	34.1%

Examining these trends over time by the child's age reveals a rate of breastfeeding decline in Massachusetts over this period that closely mirrors the national average for both breastfeeding duration (Figure 1) and exclusivity (Figure 2).

Figure 1. Breastfeeding Duration by Age of Child in Months (NIS 2022)

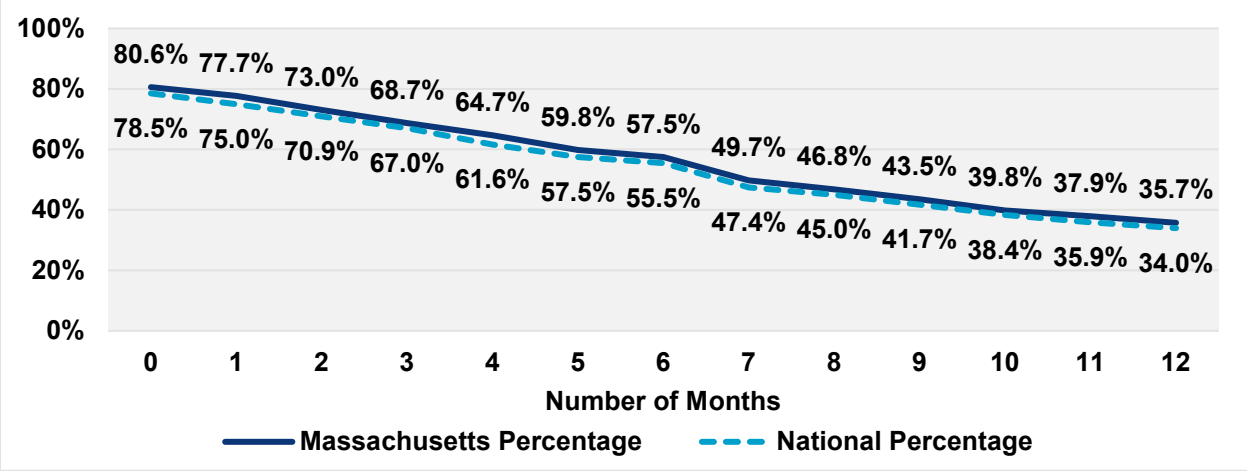
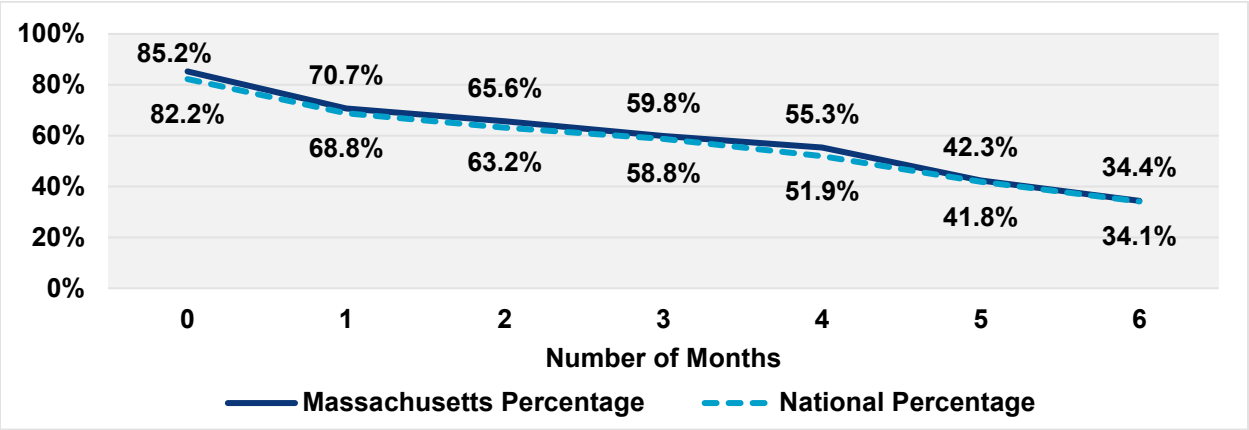


Figure 2. Breastfeeding Exclusivity by Age of Child in Months (NIS 2022)



Initiation, duration, and exclusivity data from the Women, Infants, and Children program allows for a year-over-year comparison, assisting in examining possible trends in breastfeeding. Figures 3 through 5 show WIC breastfeeding initiation, duration, and exclusivity data for fiscal years 2019 through 2023, which reveal a strong upward trend in the breastfeeding rates in Massachusetts.

Figure 3. Breastfeeding Initiation Rates in Massachusetts, WIC Data, FY 2019–FY 2023

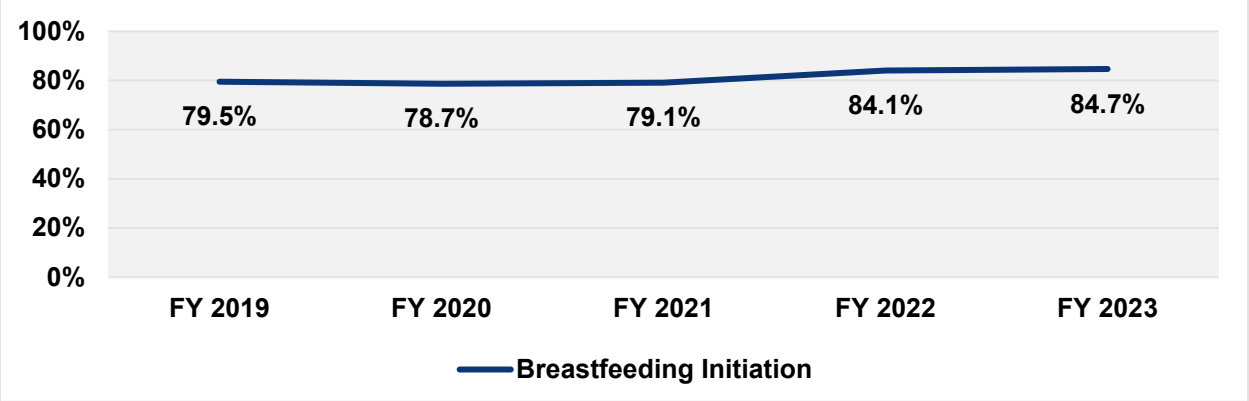


Figure 4. Breastfeeding Duration Rates in Massachusetts, WIC Data, FY 2019–FY 2023

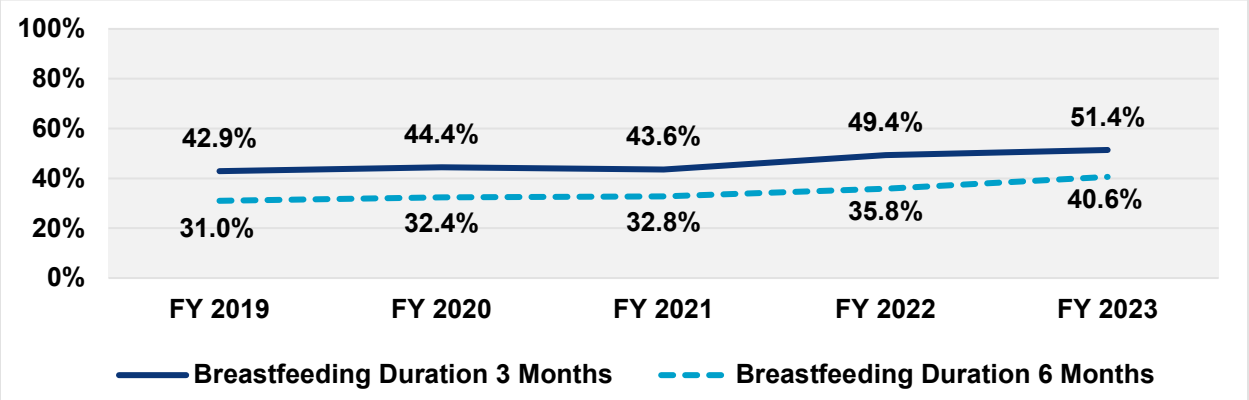
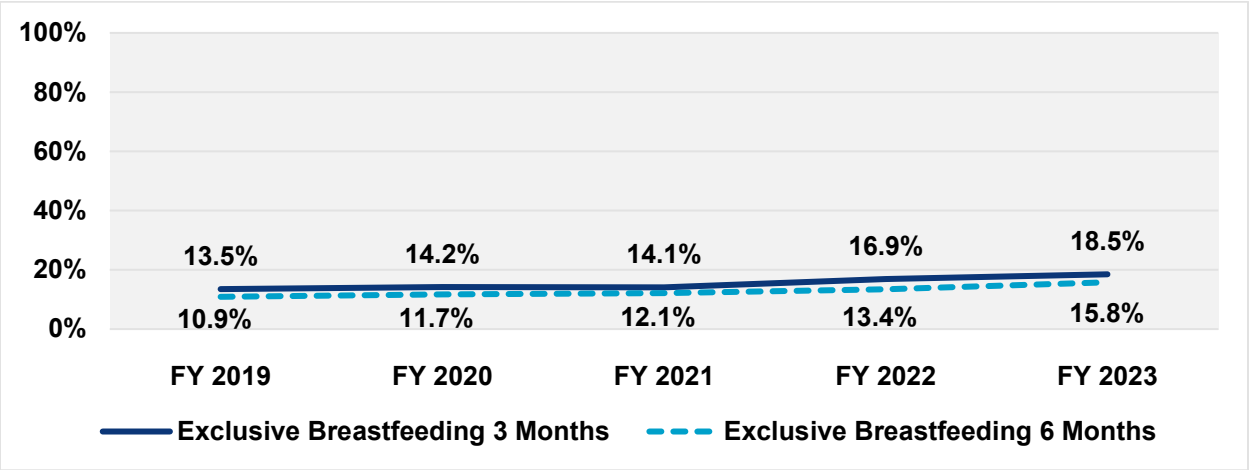


Figure 5. Exclusive Breastfeeding Rates in Massachusetts, WIC Data, FY 2019–FY 2023



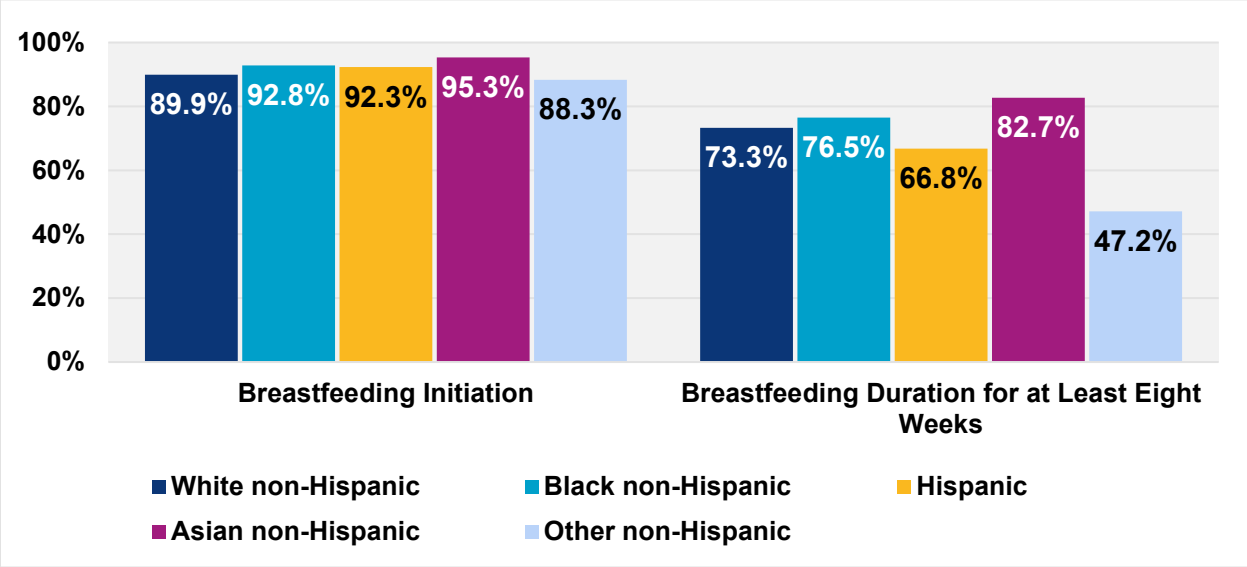
It should be noted that the rates for these measures from those receiving WIC services are typically lower than those for the general population. Additionally, shortages in the supply of formula beginning in the later months of 2021 may be influencing the upward trend of these metrics, as formula supplementation became a less viable alternative to breastfeeding.

DISPARITIES IN BREASTFEEDING RATES

A common theme identified in the needs assessment was the presence of disparities in breastfeeding rates by sociodemographic characteristics and the presence of a lactation services "donut hole," where those who earn more than the threshold for qualifying for WIC services but not enough to pay out of pocket are unable to access breastfeeding support. This and other disparities are apparent based on data from the Massachusetts Pregnancy Risk Assessment and Monitoring System (MA PRAMS) survey.

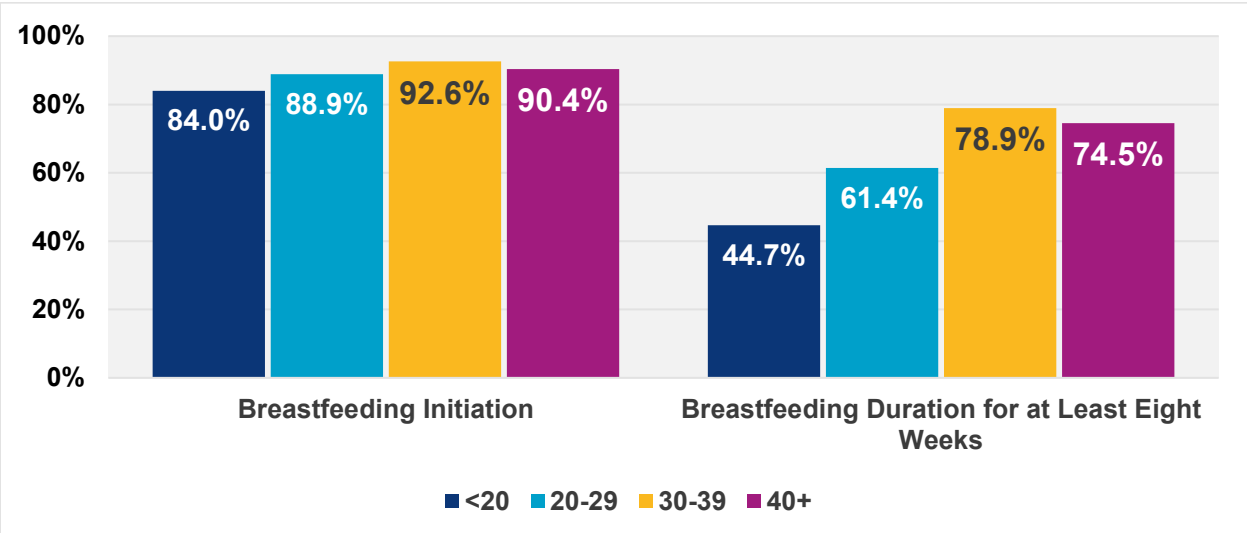
Examining breastfeeding initiation and duration data from MA PRAMS for race and ethnicity (see Figure 6), high rates of initiating breastfeeding are observed among all racial and ethnic groups. These rates are not sustained at the same levels at eight weeks following the birth of an infant, however, with a particularly significant reduction among those who are Hispanic or of Other non-Hispanic race. It should be noted that small sample sizes among the Other non-Hispanic population in particular leads to a high degree of uncertainty in the estimates (95% confidence interval: 22.6% to 73.3%).

Figure 6. Breastfeeding Initiation and Duration of at Least Eight Weeks by Race/Ethnicity, MA PRAMS 2021



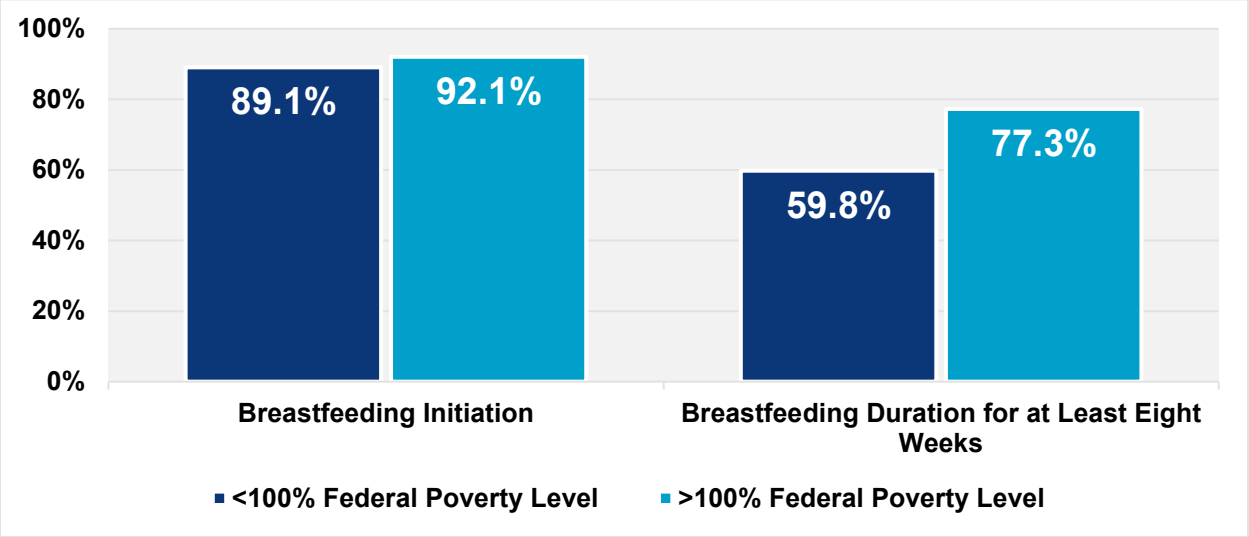
Similar disparities exist in the data for breastfeeding duration by parental age (Figure 7). A high degree of uncertainty due to small sample sizes exists among those under 20 years of age in these data points as well (95% confidence interval: 27.1% to 63.8%).

Figure 7. Breastfeeding Initiation and Duration of at Least Eight Weeks by Parental Age, MA PRAMS 2021



Breastfeeding duration for at least eight weeks is also significantly lower than the initiation rate for those with incomes below the federal poverty level, as shown in Figure 8.

Figure 8. Breastfeeding Initiation and Duration of at Least Eight Weeks by Federal Poverty Level, MA PRAMS 2021



Geographically, disparities exist in the breastfeeding initiation rates by county in Massachusetts, with the county with the lowest rate (Bristol County, at 77.0%) having a slightly more than 20 percentage points lower rate than the county with the highest initiation rate (Dukes County, at 97.3%). County-by-county initiation rates are shown in Figure 9 and in Table 2.

Figure 9. Massachusetts Breastfeeding Initiation Rates, by County, 2019

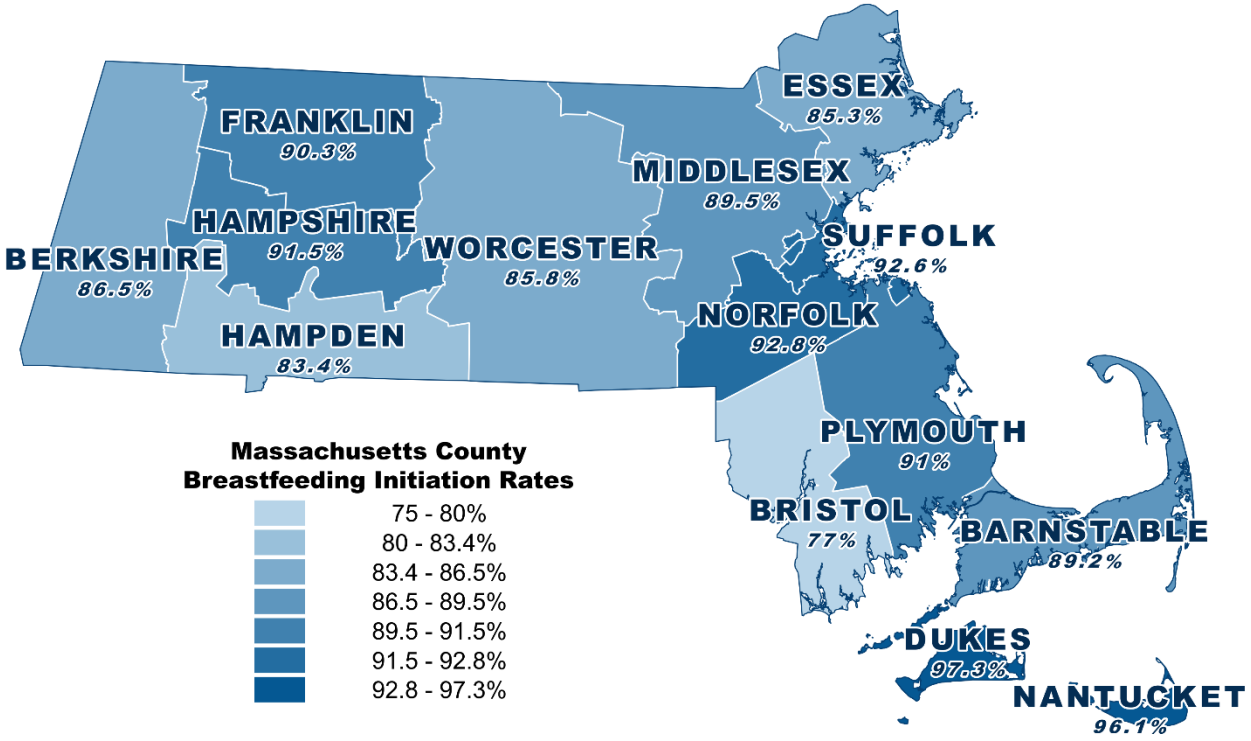


Table 2. Breastfeeding Initiation Rates, by County, 2019

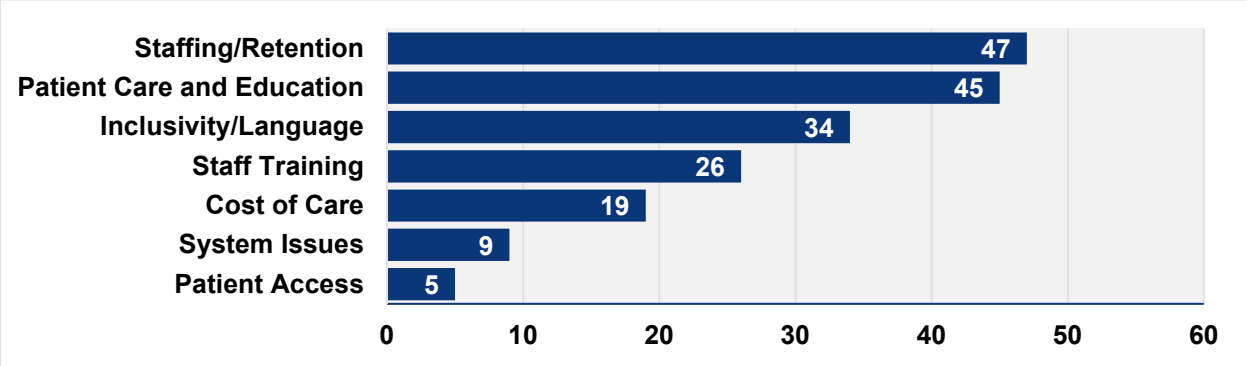
County Name	Breastfeeding Initiation Rate
Bristol County	77.0%
Hampden County	83.4%
Essex County	85.3%
Worcester County	85.8%
Berkshire County	86.5%
Barnstable County	89.2%
Middlesex County	89.5%
Franklin County	90.3%
Plymouth County	91.0%
Hampshire County	91.5%
Suffolk County	92.6%
Norfolk County	92.8%
Nantucket County	96.1%
Dukes County	97.3%

PROVIDER AND HOSPITAL CHARACTERISTICS

In 2023, MA DPH conducted a survey of breastfeeding providers to assess the landscape of issues surrounding breastfeeding in the state. As part of the survey, providers were given the opportunity to identify challenges to best breastfeeding practices in the form of an open-ended narrative. The results of these responses, summarized in Figure 10, reveal challenges that are in line with those identified in the needs assessment – namely, that attracting, training, and retaining staff qualified to provide breastfeeding support is a primary concern, as is the time and attention given to patient care, education, and inclusivity.

Other identified issues included the cost of care to patients and providers – particularly a lack of adequate insurance coverage, systemic issues such as collaboration across providers and departments, and ability of patients to access care due to a lack of transportation or internet access.

Figure 10. Breastfeeding Provider Survey Open-Ended Responses, Most Common Challenges



MATERNITY PRACTICES IN INFANT NUTRITION AND CARE (MPINC™) DATA SUMMARY

The 2022 Maternity Practices in Infant Nutrition and Care (mPINC™) survey measures care practices and policies that impact newborn feeding, feeding education, staff skills, and discharge support. In the 2022 mPINC, Massachusetts received a subscore of 88 (out of 100) for its maternity practices, compared with the national subscore of 81. The mPINC is divided into categories of care practices, with each category measuring between three and five indicators of the proportion of hospitals with the ideal response. In each category of care, the Massachusetts subscore is ranked more highly than the national subscore. Table 3 below provides a summary of these practices as reported in the mPINC.

Table 3. 2022 Maternity Practices in Infant Nutrition and Care (mPINC™) Summary Data

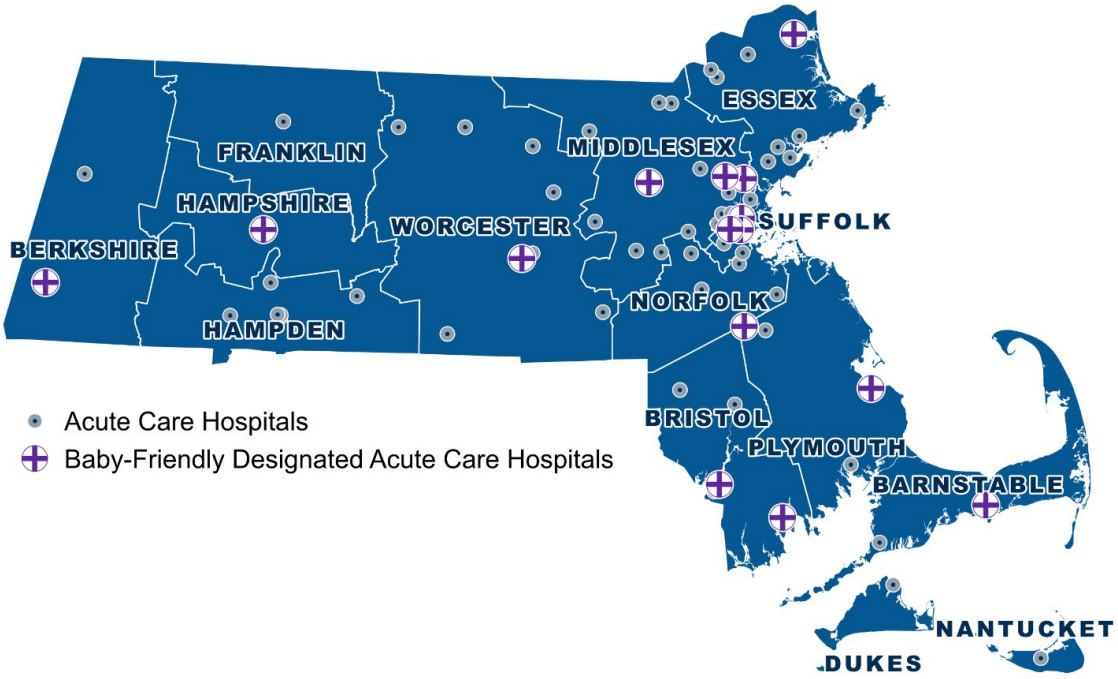
Subscore	mPINC™ Indicator Name
Indicator:	**Immediate Postpartum Care**
Massachusetts Subscore	93
US National Subscore	84
Indicator:	**(Parent and Newborn) Rooming-In**
Massachusetts Subscore	86
US National Subscore	76
Indicator:	**Feeding Practices**
Massachusetts Subscore	82
US National Subscore	81
Indicator:	**Feeding Education and Support**

Subscore	mPINC™ Indicator Name
Massachusetts Subscore	96
US National Subscore	94
Indicator:	Discharge Support
Massachusetts Subscore	86
US National Subscore	78
Indicator:	Institutional Management
Massachusetts Subscore	83
US National Subscore	76

BABY-FRIENDLY FACILITIES

The needs assessment conducted by BFHN and BUSPH revealed stark differences between outcomes among hospitals designated as Baby-Friendly compared to those without the designation. Figure 11 shows the location of the 15 state facilities certified as Baby-Friendly in Massachusetts. In 2021, more than one-third (36.6%) of births in Massachusetts occurred at a Baby-Friendly facility, compared to 28.9 percent of births nationally.

Figure 11. Map of Baby-Friendly Designated Acute Care Hospitals in Massachusetts



POSTPARTUM DEPRESSION

As the presence of postpartum depression symptoms can influence the ability to breastfeed, it is important that depression screening occur prenatally and postpartum and that postpartum depression is tracked appropriately. According to the 2021 PRAMS report, Massachusetts screens 88.6 percent of the birthing population for depression during prenatal care and 88.3 percent during the postpartum visit. The rate of self-reported postpartum depressive symptoms was 10.4 percent.

ADEQUATE PRENATAL CARE AND BREASTFEEDING DURING THE HOSPITAL STAY

According to the Massachusetts Births 2021 (Birth Report), 78.5 percent of birthing persons in Massachusetts received adequate prenatal care as measured by the Adequacy of Prenatal Care Utilization (APNCU) Index. Additionally, the Birth Report indicates 87.4 percent of infants were breastfed during the hospital stay.

CHALLENGES FACED BY INDIVIDUALS

REASONS FOR NOT BREASTFEEDING

MDPH conducted an Infant Feeding Family Survey in 2024 to better understand the attitudes toward and experiences of breastfeeding among those who have given birth in the last two years (n = 321). The results of the survey reveal that 162 of 213 individuals indicated meeting their breastfeeding goals (76.1%, 108 did not respond), while 248 of 300 individuals (82.7%) report breastfeeding currently or within the past two years (21 did not respond).

Among the 52 individuals (16.2%) responding to the survey who indicated they were not breastfeeding, 44 provided their reason(s). Tables 4 and 5 provide a breakdown of the reason(s) given by these individuals for not breastfeeding among the 10 who indicated a desire or plan to breastfeed and the 34 who did not have a plan or desire to breastfeed. The percentages in Tables 4 and 5 are based on the 44 participants who did not breastfeed and provided a reason.

Table 4. Reasons Given for Not Breastfeeding Among Those Who Indicated a Desire or Plan to Breastfeed

Reason Given	Percent with Count
I wanted to breastfeed, but my medical condition did not allow	4.5% (n=2)
I wanted to breastfeed, but my baby's medical condition did not allow	2.3% (n=1)
I wanted to breastfeed, but my family did not support me breastfeeding	0% (n=0)

Reason Given	Percent with Count
I wanted to breastfeed, but my school or workplace did not support me breastfeeding	2.3% (n=1)
I wanted to breastfeed, but was separated from my baby	0% (n=0)
Other*	13.6% (n=6)

Table 5. Reasons Given for Not Breastfeeding Among Those Who Did Not Indicate a Desire or Plan to Breastfeed

Reason Given	Percent with Count
I was afraid it would be painful	11.4% (n=5)
I was on medication	4.5% (n=2)
I had to return to work or school	13.6% (n=6)
I wanted to smoke	0% (n=0)
I wasn't sure I would know how to do it	0% (n=0)
I wanted to drink alcohol	0% (n=0)
I had other children to care for	11.4% (n=5)
I was afraid of feeling awkward or embarrassed	4.8% (n=2)
I had past problems with breastfeeding	15.9% (n=7)
My family wasn't supportive	2.4% (n=1)
I was afraid I wouldn't make enough milk	11.9% (n=5)
I wasn't sure I would know how often I would need to feed my baby	2.4% (n=1)
I wanted my partner to help me feed the baby	11.4% (n=5)
Other*	27.3% (n=12)

*Other responses are included as Appendix A: Other Reasons for not Breastfeeding from Infant Feeding Family Survey.

Voices from the Infant Feeding Family Survey

WIC program has helped me a lot with questions I had as a new mom breastfeeding.

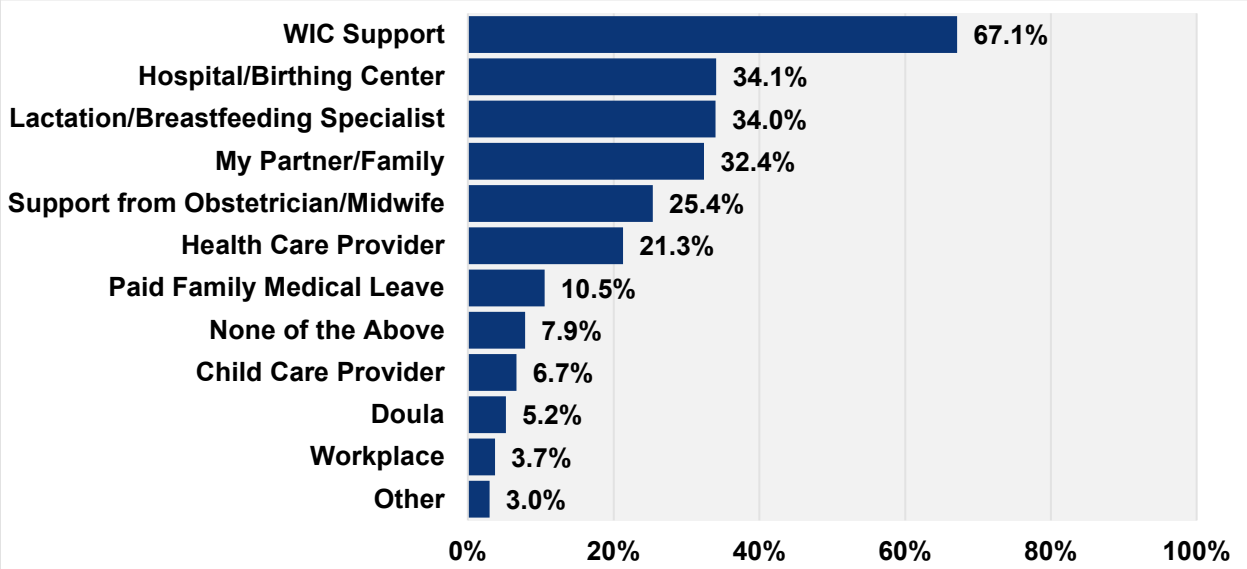
It was hard to find affordable breastfeeding support outside of the hospital settings and even then it was hard to schedule anything with working schedules.

WIC PARTICIPANT SURVEY SUPPLEMENTAL BREASTFEEDING QUESTIONS

The 2022 WIC Participant Satisfaction Survey included five additional questions related to challenges and supports facing breastfeeding individuals in Massachusetts. Of those who responded to the survey, 95.6 percent indicated that they were happy with how WIC talked to them about breastfeeding. As shown in Figure 12, 67.1 percent indicated that WIC breastfeeding support was helpful to them, followed by that of their hospital or birthing center (34.1%), a lactation consultant or breastfeeding specialist support (34.0%), and the individual's partner or family (32.4%).

When support from WIC is examined by race and ethnicity, differences are also found. A substantially lower proportion of White participants—55.5 percent—indicated they found WIC support helpful in comparison to 72.8 percent of those of Asian, Black, Hispanic, Multiracial, and Other races who found this support helpful. White participants, however, indicated a higher rate of finding support from a lactation consultant or breastfeeding specialist helpful (40.6%) compared to those of other races (31.8%). White respondents were more likely than those of other races and ethnicities to report finding support from one's partner and family to be helpful (38.8%and 30.2%, respectively).

Figure 12. WIC Participant Survey Question: "In general, what sources of breastfeeding support did you find helpful?"



Additional responses to questions about breastfeeding are shown in Figures 13 through 15. Common themes are the desire to receive additional information from providers and other trusted sources, support from family and peers, and need for paid medical leave and/or time off from school.

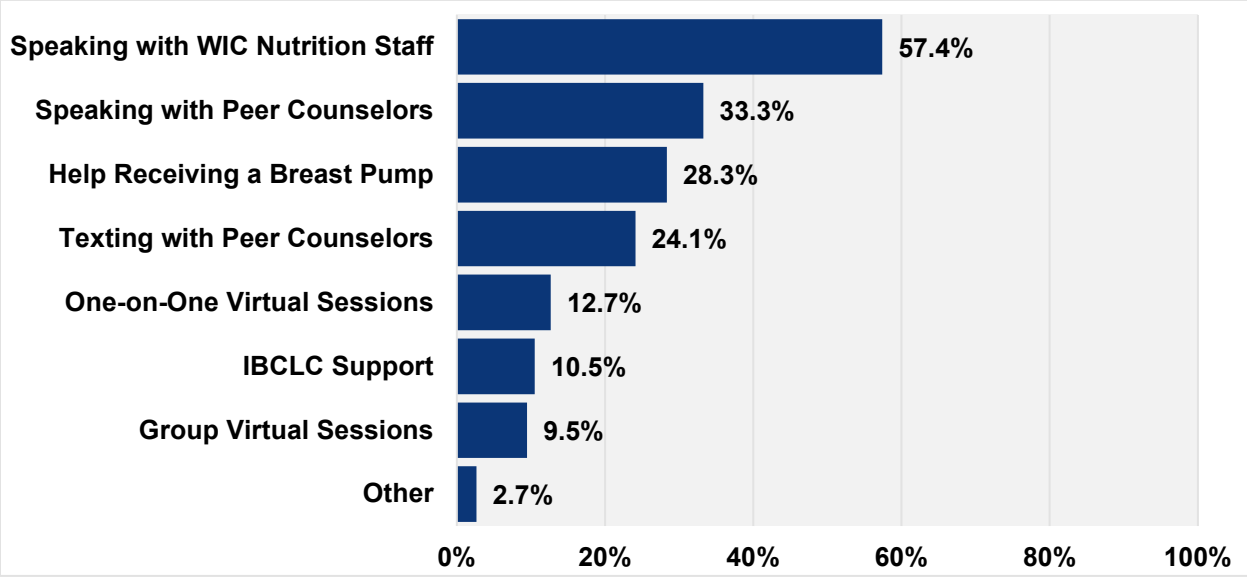
WIC Participant Survey Common Themes

- Additional Information from Providers and other Trusted Sources
- Support from Family and Peers
- Paid Medical Leave and/or Time Off from School

When WIC participants were asked which support services they found helpful, the race and ethnicity data again indicates some interesting trends. Black parents indicated a much lower rate of finding support helpful from an IBCLC compared to the other race groups (5.1% and 12.6%, respectively). Those of Hispanic ethnicity found support from WIC nutrition staff to be much more helpful, with 61.2 percent of Hispanic respondents finding this support to be helpful in comparison to 54.1 percent of those of other races and ethnicities.

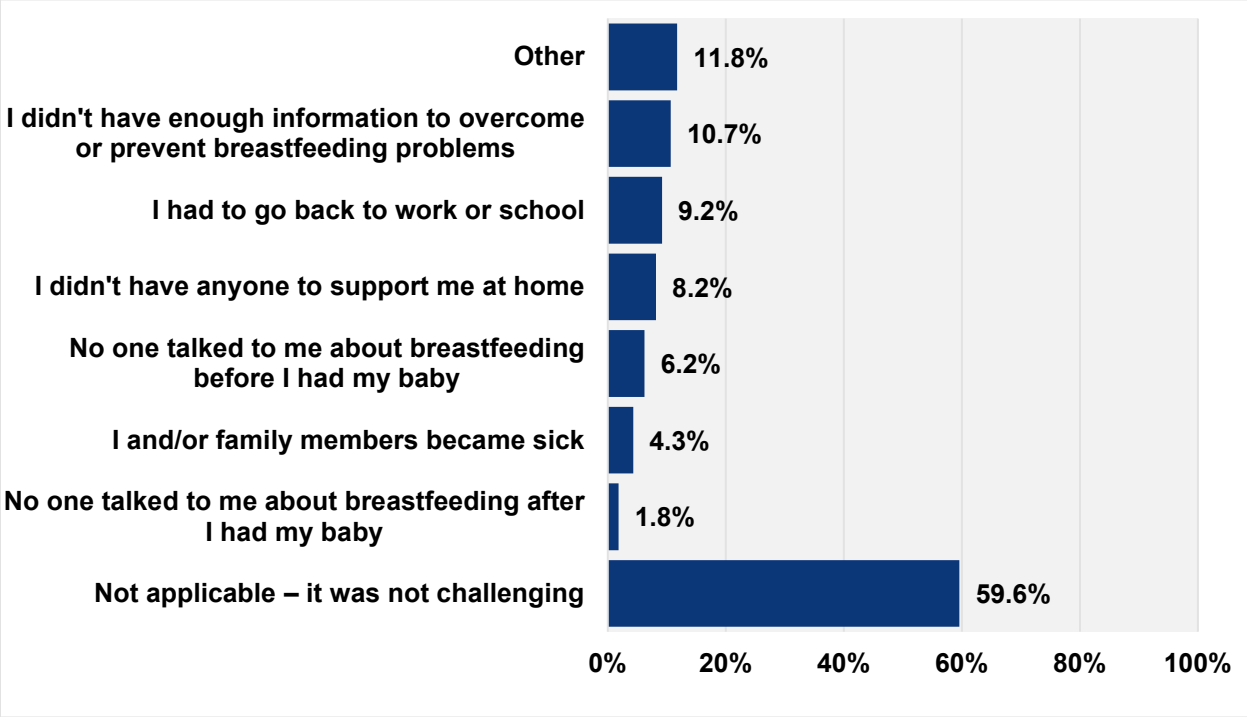
Note the proportions calculated for this question and those represented in Figure 13 only include responses from survey participants who received WIC breastfeeding support services (73.2% of survey participants).

Figure 13. WIC Participant Survey Question: "Which of the following WIC breastfeeding support services have been helpful to you?"



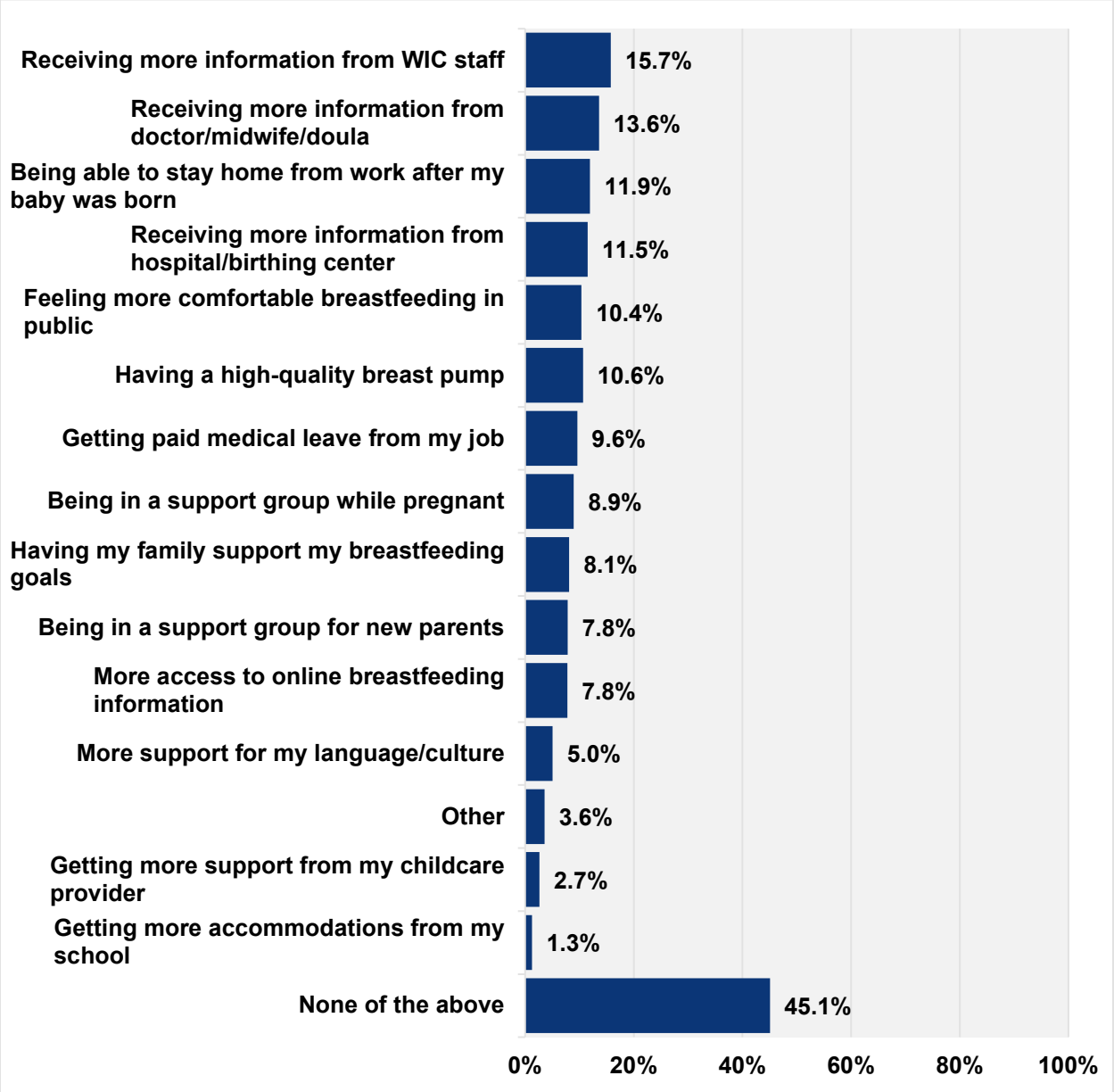
The race and ethnicity data for the question "What, if anything, made it challenging for you to meet your breastfeeding goals?" had some interesting differences by race and ethnicity as well. Those of Asian descent were much more likely to indicate that a lack of information on how to overcome or prevent problems breastfeeding was a challenge (21.2%) compared to those of other races (10.2%). Those of Hispanic ethnicity were more likely to indicate that meeting their breastfeeding goals was not challenging (62.7%) versus those of other races and ethnicities (57.0%). White participants were more likely to indicate that they faced other challenges at a rate of 18.2 percent compared to 9.7 percent of respondents of Asian, Black, Hispanic, Multiracial, and Other races (Figure 14).

Figure 14. WIC Participant Survey Question: "What, if anything, made it challenging for you to meet your breastfeeding goals?"



As seen in Figure 15, when indicating what they would have found helpful in meeting their breastfeeding goals, a higher proportion of Asian participants (27.7%) indicated they would have found more information from their doctor, midwife, or doula to be helpful compared to those of Black, Hispanic, Multiracial, White, and Other race (12.7%). Those of Asian descent also indicated that receiving more information from WIC staff would have been helpful at a rate of 19.7 percent compared to 11.2 percent of those of other races. A higher rate of Asian participants also indicated that additional online breastfeeding information would have been helpful compared to those of other racial groups (16.8% and 7.6%, respectively). A small percentage of Black and Asian respondents indicated that they would have found feeling more comfortable breastfeeding in public a helpful factor as well compared to those in the other racial and ethnic categories (6.9%and 11.5%, respectively).

Figure 15. WIC Participant Survey Question: "Which, if any, of the following would have been helpful to you in reaching your breastfeeding goals?"



TUFTS UNIVERSITY COMMUNITY EVALUATOR PROJECT

BFHN, in partnership with Tufts University, conducted two surveys of participants to better understand the perspectives of parents who have recently given birth (18 years of age and older) who experienced barriers to breastfeeding. Key questions involved the support systems and resources they had access to, their feelings and decisions, barriers they experienced, and how they obtained information about breastfeeding.

Two populations were surveyed: those living in Barnstable County who had attempted to breastfeed in the last three years, and those living in the Fall River area who have

breastfed in the last three years and who spoke English or Spanish. While the final results of the surveys are not yet available, common themes and recommendations from the preliminary findings are depicted in Table 6 (common themes) and Table 7 (recommendations).

The themes identified largely mirror those reported in the WIC Participant Satisfaction Survey such as the need for more education, information, and support during pregnancy and postpartum; support from one's partner, family, and peers; issues with understanding or accessing paid family medical leave; and a lack of places within workplaces to pump.

Additional insights provided by the preliminary results also indicate that feelings of stigma are felt by many of the participants who are unable or choose not to breastfeed, and that there is a lack of awareness or ability to access existing breastfeeding support services. Recommendations to address these issues include greater promotion of existing services; more education, guidance, and support during and after pregnancy (particularly to those who have just given birth); and additional education for lactation professionals. It is worth noting that, in the needs assessment, many providers often cited the fear of making parents feel ashamed as reasons they did not emphasize the importance of breastfeeding. Addressing these two seemingly contradictory challenges will involve educating providers on providing breastfeeding information that is centered on the benefits and outcomes while being sensitive to the potential sense of stigma that can occur among parents.

Table 6: Tufts University Community Evaluator Project – Common Themes (Preliminary Results)

Mental and physical toll of breastfeeding, including maternal health problems, or issues surrounding the mechanics of breastfeeding such as latching, positioning, or monitoring the baby's output.
Feelings of stigma and unsupportive messaging surrounding breastfeeding for those who do not or are unable to breastfeed.
Lack of information and education for new parents during pregnancy and postpartum.
Lack of awareness or ability to access existing breastfeeding support services.
Positive impact having support from one's partner, family, and community (or negative impact of the lack of such support) has on the ability to breastfeed – particularly during the first few weeks of life.
Issues returning to work, including lack of understanding of paid family medical leave and how to access it, as well as the lack of an adequate space to pump in the workplace and not feeling comfortable doing so.

Table 7: Tufts University Community Evaluator Project – Recommendations (Preliminary Results)

Recommendation
Engage in greater promotion of services already established in the community via handouts tailored to the area where parents deliver, on social media, or through other means
Provide more regular guidance and more consistent follow-up to those who have just given birth, including frequent check-ins from lactation staff
Provide more education during and after pregnancy, including how to breastfeed, potential complications, what to watch out for, and how specific medical diagnoses can impact breastfeeding
Provide continuing education to lactation professionals emphasizing that every situation is different and that breastfeeding should not be a one-size-fits-all model
Provide priority in education and care to those who have immediate difficulty with breastfeeding

CONCLUSION

Breastfeeding practices among Massachusetts residents are above the national average in every indicator measured, but there is still room for improvement. The needs assessment identified lactation services as a "donut hole," where individuals of low-to-moderate income levels who are unable to pay out of pocket for lactation services but who are unable to qualify for WIC are left unsupported in breastfeeding. Administrative support in hospitals for breastfeeding programs and certifications, such as the Baby-Friendly designation, is also vital for providing the structural support needed by new parents after giving birth. State policies regarding paid family medical leave and early care and education regulations could also be improved to bring them more in line with the Caring for our Children standards.

More generally, the themes reported from supplemental data mirror those identified in the needs assessment. Namely, birthing individuals need better and more consistent access to high-quality information; significant effort needs to be made to reduce disparities in breastfeeding rates; providers need additional staff, time, and training to provide care to patients; and lactation services need to be covered by insurance. Additional promotion of existing lactation services in the community should also be a priority, so those with a desire to breastfeed can access as many available services as possible.

Supporting new parents after the baby is born was another identified area of need, especially when discharging them from the hospital and transitioning to outpatient care. One particularly interesting finding coming out of the Tufts University Community Evaluator Project was that the parents interviewed often felt stigmatized by providers for not breastfeeding, while the interviewed providers in the needs assessment indicated providers often felt the need to deemphasize breastfeeding so as not to shame their patients. Training for providers should be focused on how to approach this conversation in a way that is centered on the benefits and outcomes of breastfeeding, without making individuals feel stigmatized and doing so in a culturally effective way. Finally, additional support and training needs to be provided for both providers and parents on navigating complex medical needs, whether those needs are of the parent or the child, so all Massachusetts families can attain their breastfeeding goals.

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APPENDIX A: OTHER REASONS FOR NOT BREASTFEEDING FROM INFANT FEEDING FAMILY SURVEY

Table 8: Other Reasons for Not Breastfeeding from Infant Feeding Family Survey

Among Those Who Indicated a Desire or Plan to Breastfeed*
My baby didn’t want to take
He couldn't latch and I wasn't producing enough so I formula supplemented
Overwhelmed
Didn't produce a lot of milk
Got sick from my c-section and I couldn’t produce milk
Among Those Who Did Not Indicate a Desire or Plan to Breastfeed
Had twins. Too difficult
Not enough milk for 3 babies
My son have medical issues, he’s in tracheostomy
My baby’s didn't take it
I wanted to bottle feed with breast milk

*One additional response among those who indicated a desire or plan to breastfeed was provided in Russian.