Update on the Carolina Global Breastfeeding Institute

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The Carolina Global Breastfeeding Institute (CGBI)

• CGBI was created in 2006 specifically to:
  – address the need for breastfeeding support in North Carolina and beyond, and,
  – serve as a center of innovation to further the evidence, to translate this research into action, and to train future leadership.

• Work closely with the State Division of Public Health Breastfeeding leadership, and support NC IOM, NC Safe Sleep Working Group, NC Breastfeeding Coalition, and associated national organizations.

• No State funding to date
Why?

- Exclusive breastfeeding for 6 months, with continued breastfeeding, reduces mortality for virtually all children.
- Donor human milk saves the lives and reduces costs of prematurity and low birth weight babies.
- In NC, concerted support for women to enable them to achieve intended breastfeeding patterns would result in huge health cost savings and 10s to 100 or so lives saved.
- About 75% of women in NC initially breastfeed, but do not achieve their full breastfeeding plans due to multiple health, social and economic/political barriers.
- Bottom line: Support for women to achieve their intentions is a public health imperative, not only a lifestyle ‘choice'

Carolina Global Breastfeeding Institute Goals

1. Create and disseminate the evidence base for action

2. Educate and mobilize future leaders and influential groups, and developing new and innovative curricula and approaches

3. Communicate/Share: creating the go-to site for breastfeeding as a reproductive and health issue

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5. Serve, Partner, Provide technical assistance: leveraging action at the State, National and International levels through partnering with individuals, communities and organizations; and technical assistance, including support for evaluation, meetings, policy enhancement, etc.

6. Become a Sustainable Contributor to the supporting innovation and progress in the Three Bs: Maintaining CGBI as a functioning administrative unit
ZITS

1. Health Care Systems and Providers
   - Informed Societal Demand
   - 1) Pre-/inter conceptional knowledge, attitudes and plans
   - 2) Antenatal prospective counseling
   - 3) Perinatal and birth support
   - 4) Immediate postpartum support days 0-2 (lactogenesis 2)
   - 5) Adaptation days 3-12 (lactogenesis 3)
   - 6) Establishment of supply (up to 6 weeks)
   - 7) Maintenance of supply (6-12 weeks)
   - 8) Continued EBF (4-6 months)

2. Social, Economic/Workplace and Political Factors

3. Media and Marketing Practices
Breastfeeding-friendly Healthcare:

• CGBI/BFHC
  – Toolkits
  – Preliminary findings in facilities that serve low wealth populations: individually supported hospitals are more likely to reach their breastfeeding goals
  – Existing datasets: determine which steps have most impact
  – Support PQCNC

• North Carolina Maternity Center Breastfeeding-Friendly Designation: CGBI is part of the advisory group convened by the NC Nutrition Branch of the Division of Public Health
  – the hospitals we work with gained stars, and UNC-H was designated Breastfeeding-friendly by the national initiative

• Education and Training
  – Mary Rose Tully Training Initiative
  – Multiple courses

Breastfeeding-friendly Community Care:

• Breastfeeding in Child Care:
  – Materials and curriculum were developed to train child care providers and directors, and >60 centers have participated in trainings.
  – Significant impact on providers’ knowledge, attitudes and practices.
  – The NC Kids Eat Smart Move More

• Breastfeeding-friendly Community Based Participatory work:
  – Teen pregnancy and pregnancy prevention
  – Reducing inequities
Mothers’ understanding
• breastfeeding and formula advertising
• ‘safe sleep’ messaging

Others’ understanding
• User-friendly materials for disseminating information on inequity and disparities in North Carolina
• Seminars and conferences: Women and Breastfeeding in 8th year

Evidence based Advocacy
• Lactation Consultants
• Research for Program and Policy Improvements
• North Carolina Breastfeeding Coalition
Updates on federal perinatal health promotion
Secretary’s Advisory Committee on Infant Mortality

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Draft Ideas under Discussion
Towards Recommendations for a National Strategy to Reduce infant Mortality: Background

- International standing and trends in US infant mortality
- Racial/ethnic and income disparities continue
- Preterm birth continues to be a major contributor
- However, US full term infant mortality rate is higher compared to other developed countries than preterm, so other leading causes of infant mortality need to be addressed.
- Recommendations from past SACIM reaffirmed:
  - reproductive health continuum must be addressed with high quality services.
  - Prenatal care
- Evidence-based strategies exist but must be communicated to each new generation/cohort of infants (e.g., breastfeeding, immunization, safe sleep).
- Informing and involving patients/families is critical to achieving success.
Draft Ideas under Discussion
Towards Recommendations for a National Strategy to Reduce Infant Mortality

Building on:
• CMS/CMMI’s Strong Start for Mothers and Newborns
• HRSA’s Collaborative Innovation and Improvement Network (COiiN) on Infant Mortality in 13 Southern States (Regions IV and VI) developed state plans to reduce infant mortality
  – preterm elective delivery,
  – improve women’s health through preconception and interconception care,
  – promote safe sleep to reduce SIDS/SUIDS,
  – promote smoking cessation, and
  – strengthen perinatal regional programs and their NICUs.

SACIM will call for a multi-faceted strategy to reduce infant mortality:
• a life course perspective
• health coverage and access to a continuum of high-quality, patient-centered care for all
• Protect key federal investments that make up a “maternal and child health safety net”, Title V Block Grant; Title X Family Planning; Community Health Centers; Healthy Start; Maternal, Infant, and Early Childhood Home Visiting program; WIC Supplemental Nutrition Program, Public Health and Prevention Fund
• Implement strategies to create health equity
• Maximize interagency, public-private, and multi-disciplinary collaboration
1. Improve the health of women before pregnancy:

- ACA
- Medicaid innovations offer ways to deliver effective, evidence-based interventions to high risk women and infants.

2. Assure the safety and quality of services access to high-quality, patient-centered before, during and after pregnancy

- COiiN strategy: capitalize on partnership of MCHB/HRSA, ASTHO, NGA, and MOD.
- Medicaid, particularly innovations and quality improvement project funding,
- Monitor quality
- Support quality improvement efforts through CMS, HRSA, AHRQ, CDC, and other parts of HHS.
- Maximize the ACA investments in workforce capacity, patient-centered health homes, and quality measures will all support our infant mortality reduction goals.
3. Communicate using new messages to redeploy key evidence-based, highly effective preventive interventions to a new generation. (3a. Ensure availability of skilled healthcare support)

need to emphasize what works and reduce missed opportunities, particularly in the following areas.

– Immunization  
– Breastfeeding  
– SIDS/SUID  
– Smoking cessation  
– Family planning

4. Reduce racial/ethnic and income disparities, influence social determinants, and increase health equity through place-based initiatives in higher risk communities and other investments to reduce poverty.

• Transform Healthy Start, community health centers, home visiting, housing (healthy homes), education and job training, child care/Head Start, transportation, and other federal resources.
• Address and alleviate poverty, with its known correlation and impact on infant mortality through use of income support through TANF, child credit tax policies, etc.
5. Invest in adequate data, monitoring, and surveillance systems to measure access, quality, and outcomes

- Improve data capacity to monitor progress and measure outcomes, in particular we need timely and accurate birth and death statistics. The National Vital Statistics system should assure timely, and accurate birth and maternal and infant death statistics.
- Encourage reporting of Medicaid perinatal data from every state, based on a uniform set of measures (e.g., measures related to prenatal, birth/perinatal, newborn care, postpartum visits, and well-baby visits throughout the first year of life)
- Extend the Pregnancy Risk Assessment and Monitoring System (PRAMS) to every state in order to monitor the health of women and infants.

6. Maximize the potential of interagency, public-private, and multi-disciplinary collaboration

- Giving priority to research into the causes and prevention of infant mortality through NIH, AHRQ, HRSA, CDC, CMS, and other parts of HHS.
- Partner with Department of Education, Department of Agriculture, HUD, EPA, etc. As demonstrated in the National Prevention Strategy, we cannot achieve our goals by working in silos, in the health system alone.
- Strengthen and reinvigorate federal-state partnerships through new activities such as the HRSA/MCHB COiiN and CMS Medicaid innovations.
- Maximize the potential of public-private partnerships (e.g., Partnership for Patients), and engage private organizations such as the March of Dimes which have a distinct focus on preventing infant mortality.
Summary of ideas that are being developed into a draft SACIM framework – Given that:

- Prematures and LBWs contribute most to our infant mortality, but our non-premature mortality rates are even worse;
- Provision of human milk vastly reduces premature in-hospital mortality, also reducing duration of stay, thereby massively reducing costs;
- The studies on the importance of breastfeeding for full term growth, health and survival are mostly done with women who breastfeed (at the breast) as opposed to supply-based milk expression and later feeding;
- Only about 5% of hospitals in this country have broken down the barriers to breastfeeding success;
- Inequities in health outcomes are too often due to disparities in both health seeking behaviors and health care provision and support; and,
- Unwanted births are highly associated with increased morbidity and mortality

Therefore, we must go for the “unimaginable” in our recommendation. Minimally, these must include:

1. Definitely require that all health professionals not only are able to promote immunization, breastfeeding, SIDS/SIUDs prevention, smoking prevention and family planning, but also obesity reduction, but are also able - through increased pre-service and in-service education and reimbursement – to support mothers in each of these six skill areas.

2. Fiscal and training support for the establishment of human donor milk banking in all states (preferably in all large hospitals). (ongoing evaluation by CGBI)

3. Include the quality of care practices that are outlined in the Ten Steps for successful breastfeeding in the requirement for any hospital to receive federal funding.
4. **Increase the ACA support**, which now includes some support and supplies for lactation in the workplace for some and increased support through reimbursement, to include *breastfeeding accommodation and support for all workers*.

5. Require that maternities and healthcare providers **collect and regularly review progress on activities undertaken in each of these six areas to decrease disparities**.

6. Consideration of the ten steps for **improved birthing care** developed by CIMS for federal support in some manner.

7. Ensure active interconception health care reimbursement to include **active fiscal and health service support for adequate birthspacing**.

8. **Vastly increase targeted social marketing** for the population at large, specific groups, AND health care workers to support behaviors that reduce inequities in both seeking services and receiving adequate support in these six areas.

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**Thank you**